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Experiences of Adolescents Receiving Mental Health Services:

A Study of the Benefits, Limitations and Recommendations

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Abstract

This study focused on youths' experience of receiving school-based mental health services and community-based mental health services. This qualitative study utilized a sample of eight girls and boys, ages 15-17 years old, who attended school within the district of Timmins. Data was collected using individual interviews and analyzed using thematic analysis. Results of the study revealed benefits to services, limitations to services, and some recommendations for changes to services. This research helped to explain what the participants, who have had experiences with mental health services, thought about the services they have had; it also provided some recommendations the participants made for changes to the mental health services based on their experiences. The conclusion of this study involved a connection between this study and social work practice, and offered suggestions for future research in the field of children's mental health services.

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Children's mental health is a significant concern because social and emotional challenges in childhood can lead to mental health problems later in life. One in five children and adolescents have an emotional or behavioural problem to warrant a mental health diagnosis (Aviles, Anderson, Davila, 2006; Berner, Weist, Adelman, Taylor, & Vernon-Smiley, 2007; Children's Mental Health Ontario [CMHO], 2009). However, only one in five of those with identifiable mental health symptoms actually receive help (Wei & Kutcher, 2011). Researchers have found that school-based mental health services and community-based mental health services is an effective way of addressing some of the social and emotional needs of students. The experiences of adolescents receiving mental health services do remain misunderstood because of the limited literature on the perspective of youth. Many children's mental health organizations are lacking in sufficient resources to fully address the growing need of children's mental health along with inadequate policies to address the growing problem (Williams, Horvath, Wei, Van Dorn & Jonson-Reid, 2007). There are some queries based on the existing research about the reasons schools and the community are not fully addressing the social and emotional needs of youth. This research helps to explain these queries in more details.

The purpose of this thesis project is to allow a small group of northeastern Ontario youth to explain their perspective related to receiving mental health services and what changes they would like to see occur. I have an interest in knowing some of the factors that motivate adolescents to seek help for particular social or emotional needs. I believe that, with the information gathered from this study, greater awareness of the issues can be promoted, and, possibly, ideas can be gained as to how to improve service delivery in certain school boards and other community mental health organizations.

School-based mental health (SBMH) as defined in this study covers a range of services such as assessment, therapy, consultation and offers prevention and intervention to high school students (Nabors & Prodente, 2002). The SBMH practitioners related to in this study include mainly child and youth worker or a guidance counsellor. Community-based mental health (CBMH) includes services such as assessment, treatment utilizing various evidence-based treatment programs, case management, coordination, and advocacy and monitoring of services (Pumariega & Vance, 1999). The CBMH providers related to in this study include social workers, crisis workers and psychologists and others that were not disclosed.

In order to gain a further understanding of the perspective of youth receiving mental health services, I chose to conduct a qualitative study looking at the experiences of youth who have had experience receiving school-based mental health services and community-based mental health services. A review of the literature was conducted in order to gain a better understanding of what was available on this topic and what were the deficiencies in the literature. Following this review of the literature, it was identified that there were limited studies looking at the experiences of youth receiving mental health services from the perspective of youth. The information was collected using face to face interviews with youth participants who were between the ages of 15-17 years old from the District School Board Ontario North East in Timmins, ON. The data was analyzed using thematic analysis and further retrieved three main themes that represented the experiences of youth receiving mental health services.

Chapter 2 - Literature Review

In this chapter, some of the existing research related to the topic of adolescent mental health services will be reviewed. The following literature relates to past studies about the various perspectives of the needs and the experiences of adolescents receiving mental health services at the school and in the community. In order to gather relevant literature, I reviewed numerous online databases and websites related to this research topic. The articles reviewed were mostly retrieved from, but not limited to, the Desmarais Library online multidisciplinary database called EBSCO host and the Social Work database where I retrieved articles from the *Journal of Child and Adolescent Mental Health, Children & Schools Journal, Journal of Child and Family Studies, Psychology in Schools, Journal of Pediatric Nursing* and the *Journal of Education, Journal of School Health,* and *Mental Health Service Research*. The research included key words such as school-based mental health, youth mental health, adolescent mental health, school social workers, effectiveness of school-based mental health, youth perspective on school-based mental health, and social and emotional needs of adolescents, community-based mental health, and ecological theory.

It is important to note that there were a limited number of studies involving community-based mental health services and limited information on mental health needs from the perspective of adolescents themselves. In this search I retrieved both quantitative and qualitative research papers, study reviews and policy-oriented papers. Some of the studies included program evaluation of school-based mental health services and others focused on school-based mental health services from the perspective of others such as teachers, parents and social workers. Other studies were based on secondary data analysis. The articles gathered for this literature review ranged from the years 1996 to 2013. The following literature review highlights 17 years of substantial research that has contributed to the depth of knowledge in the field of the

social and emotional needs of adolescents and the impact of mental health services on these needs.

There are four main components to this review of the literature that will help justify the need for further research in the area of adolescent mental health services. The first section will explore the significance of children's mental health and will highlight current issues. The second section will review the social and emotional needs of adolescents and the impact these have on life functioning. The third section will review the differences between, and commonalities of, school-based mental health services and community-based services. The fourth section includes the theoretical perspective of the ecological framework and its impact when discussing adolescents. The fifth and final section will review the deficiencies from the literature and will address the needs for future research based on the gaps identified.

Children's Mental Health: Conceptualization and History

The term "mental health" has been around for many years and the definition has expanded throughout the last century. The World Health Organization (WHO) (2013) defined the concept of mental health as subjective well-being, perceived self-efficacy, autonomy, competence intergenerational dependence, and self-actualization of one's intellectual and emotional potential. Although the WHO provided this definition, they also highlight that mental health is generally a broader term than the absence of mental illness, and cross-culturally, it is subjective. The WHO (2013) emphasized that "mental health" has no clear and agreed upon definition in research and it can be interpreted differently based on the researcher's perspective and other contributing factors. It is important to consider the subjectivity of the term when looking at literature on "mental health". Children's Mental Health Ontario (CMHO) (2013) shares: "What's common to many definitions is that mental health isn't just about the absence of mental health disorders; and it's not about being

happy all of the time". This statement allures to the fact that individuals can have mental health needs and still have good coping skills to maintain a perfectly healthy life.

The transition from childhood to adolescence is a significant developmental phase that has shown to have an impact on the mental health of youth. According to Costello, Copeland and Angold (2011) who reviewed 15 years of published papers between 1974-1999, varying from longitudinal to cross-section studies, indicated that the prevalence of mental health disorders during the transition of childhood to adolescence (10-15 years old) increases 8.6 percent at 8-10 years old to 9.6 percent at 11-12 years old, and 12.2 percent at 13-15 years old. The most prominent mental health disorder for adolescent girls was an increased rate of depression; however, also an increase in drug abuse, panic disorder, agoraphobia, decrease in attention deficit hyperactive disorder symptoms, separation anxiety disorders, conduct disorders, and oppositional defiant disorders (Costello, Copeland & Angold, 2011; Gampetro, Wojciechowski & Amer, 2012). Gampetro, Wojciechowski and Amer (2012) reported on a study that examined the prevalence of mental health disorders in 3,042 youth ranging from 8-15 years old. According to that report, 15.2 percent of these children and youth had a mental health disorder and half of these youth did not get treatment for their mental health needs. In a study by Amaral, Geirstanger, Soleimanpour and Brindis (2011), it was identified that 80% of youth who have a mental health need do not access help. Future research recommendations from the study by Amaral et al. (2011) stated that it would be useful to examine what adolescents need to successfully navigate into young adulthood. Mental health disorders according to the research seem to be prevalent in adolescence and this is a significant reason why mental health is a need that should be addressed in early development. If mental health needs are not properly addressed in early life, there are risks that mental health symptoms can arise in adulthood. Gampetro et al. (2012) stated, "The National Institute of Mental Health (NIMH) estimates that 57.7 million (26.2%) American adults suffer from a mental health disorder" (p.24).

Amaral et al. (2011) completed a study exploring the help seeking behaviours of adolescents who accessed school-based mental health workers and those who did not. The purpose was to compare mental health risk profile and health utilization behaviours of adolescent school-based health center users and non-users. This study was a quantitative study that used survey methods to gather the data of 4,640 students' perspectives from grade nine to eleven. Based on this study, it was determined that youth who reported feelings of sadness, trouble sleeping, suicide ideation, alcohol or marijuana use, a loss of a close friend or relationship or other difficulty were more likely to seek school-based services compared to other youth. This same study concluded that they have been able to reach students with the most serious mental health concerns. However, the question still remains: what happens to the children and youth who do not have significant mental health symptoms and cannot be easily identified? What type of services do they receive?

Mental health services for children and adolescents in Canada are comparable to the services of the Europeans and Americans, which began to show significance in the late 1800's to early 1900's. Service delivery of children's mental health began in the United States around the 19th century (Bronstein et al., 2011; Pumariega & Vance, 1999). Children's mental health services started as a response to the need for counselling school children and juvenile offenders as opposed to having them incarcerated with adult offenders (Pumariega & Vance, 1999). According to Pumariega and Vance (1999), the very first mental health program for children was founded at the University of Pennsylvania around 1896 to address school issues. Following the creation of this new program, juvenile clinics, which staffed social workers, physicians and psychologists, were developed. The program was the first interdisciplinary children's mental health program in the entire nation. Furthermore, it became a way of regulating truancy and supporting a rising number of immigrants joining the educational systems. These clinics were deemed to be quite successful

and commissioned a study, which speared funding for the development of child guidance clinics throughout the United States in 1922 (Pumariega & Vance, 1999).

The movement to have psychiatry seen as a more medical field transferred the "guidance clinics" to a hospital-based tertiary care model (Pumariega & Vance, 1999). This became a problem for the community-based mental health programs as they no longer had psychiatric input for their own clinics and, therefore, became quite neglected, understaffed and underfunded. Due to the de-institutionalization of mental health services during the 1960's, children and youth along with the adult services were transferred to access programs offered in the community.

The de-institutionalization to community-based mental health in Canada occurred in three phases according to Parliament of Canada Report (2012). Phase one was the shift from psychiatric institutions to general hospitals, which cut the hospital bed availability in half. Phase two occurred during the 1970's to 1980's, where the push was to have community mental health services and supports for those residing in the communities. At that time, the government was providing funding to community-based agencies and funding case-managers to ensure coordination of the services being offered. Phase three began in the 1990's and involved enhancing effectiveness and integrating mental health services and supports. This phase entailed building on the community services and an emphasis on empirical research and developing evidence-based practices (Parliament of Canada Report, 2012).

One of the most substantial events to have impacted school-based mental health services occurred in 1995 when the Ontario conservative government cut educational grants by $440 million dollars. This cut in funding pushed mental health services out of the schools and into community-based mental health programs. Hospital and municipalities had to compensate for these funding cuts from their own budget and 78% of school boards hiked taxes because of the lost revenue. The Ontario premier at the time, M. Harris, and his government, seemed to be the driving force that

pushed mental health services out of the schools and into community-based mental health programs (Janigan & Wilson-Smith, 2010). As a result, based on the reviewed literature, many school-based mental health services remain underfunded, misused and misunderstood.

Mental health, more precisely the lack of children's mental health services, remains a problem to this day. One in five children and adolescents have an emotional or behavioural problem to warrant a mental health diagnosis (Aviles, Anderson, & Davila, 2006; Berner, Weist, Adelman, Taylor, & Vernon-Smiley, 2007; Children's Mental Health Ontario, 2009). A study from the Ministry of Child and Youth Services suggested that 15 to 21 percent of children and youth in Ontario have at least one mental health disorder (Gitterman, 2010). That represents between 467,000 and 654,000 children and youth in Ontario alone who have a mental health need ranging from minimal to significant (Ministry of Child and Youth Services, 2006). However, only one in five of those with identifiable mental health symptoms actually receive treatment (Wei & Kutcher, 2011). Children's mental health is a significant concern that is growing at an alarming rate and this indicates cause for concern. There are some contributing factors that do affect adolescents' mental health and make them more susceptible to developing mental health vulnerabilities. According to Children's Mental Health Ontario, (2012) such factors include biology such as genetic predisposition to certain mental illnesses, negative early life experiences, individual factors, and current social circumstances. These noted factors can increase the risks for unwanted mental health symptoms. If the symptoms are not addressed early on, it can have a major or potentially life-long impact on someone's mental health.

Some protective factors that help to reduce the likelihood of developing a mental illness are a healthy emotional and social development. There is more than a decade of research that shows the benefits of mental health promotion and mental illness prevention throughout childhood. Families have been shown to be a protective factor (Pathak et al., 2011). Hoagwood et al. (2007) reviewed

64 articles published between 1990- 2006, that examined both mental health and educational outcome of elementary students. Based on this review, they found that the studies which were identified as having the most positive impact on mental health had less intense services and included more family involvement. Some of this research will be described in the next section. The need for more mental health services is rising steadily as children and youth suffer extensive waitlists and underfunded programs, particularly within the context of Northeastern Ontario. The question remains whether the mental health services are actually meeting the needs of the youth they serve and exactly what are the identified needs.

Adolescence: Social and Emotional Needs

Adolescence is defined by the World Health Organization (WHO) as a period of life between ages 10 - 19 years when youth are developing their individuality while still conforming to societal norms (Pathak et al., 2011). Gampetro et al. (2012) claimed that adolescence is defined as age 11 through 21 years old and Costello et al. (2011) defined it as the range between 12-19 years of age. There are different schools of thoughts when it comes to the exact stage of adolescence. The common denominator is somewhere between puberty and adulthood (Costello et al., 2011). Adolescence is a time when identity is forming and social relationships and experiences help to shape their sense of self. It is a phase of development where youth take on more adult responsibilities and their relationships with others become more meaningful and have an impact on their identity formation (Jones & Deutsch, 2013). According to the WHO, mental illness and maladaptive behaviour is on the rise among the adolescent population (Pathak et al., 2011). The question that remains is what factors are contributing to the rise in children's mental illness and disruption in their social and emotional needs? The social and emotional needs of adolescents and the impact these have in adolescence are considered next.

The social development of adolescence is the ability to connect with friends, family, peers at school, work and in the community which also reduces the likelihood of engaging in antisocial behaviours that would affect relationships, such as bullying (American Psychological Association, 2002; Jones & Deutsch, 2013; Waters, Lester, Wenden & Cross, 2012). Developing and maintaining social relationships helps youth prepare for adulthood. Social changes in adolescence do impact on individual development due to being caught between the need for independence and autonomy and still having to follow the expectations of adults (Jones & Deutsch, 2013). Emotional health on the other hand, according to Waters, Lester, Wenden and Cross (2012) is defined as: "The development of a sense of identity, self-esteem and self-worth, establishing personal values, psychological autonomy, decision-making, problem-solving skills and behavioural regulation represent key emotional skills, tasks and characteristics built during adolescence" (p.191). Santrok (2001) in American Psychological Association (2002) mentioned that emotional development is being able to relate to others and to learn to cope with stress and manage different emotions. Should there be an absence of any of these indicators of emotional health; it could lead to a mental health problem (Waters et al. 2012). As emphasized in this paragraph, social and emotional health is an important contributor to healthy adolescent development.

The phase of adolescence involves various developmental tasks. These tasks include adjusting to body changes, developing a self-identity, abstract thinking development, interpersonal skill building, autonomy, acquiring values, negotiating a new relationship with family, setting goals for the future and choosing a career path (Gampetro et al., 2012). There is no doubt, based on these tasks that youth are expected to undertake, that adolescents would develop some particular emotional needs. However these needs seem to still be quite misunderstood. Over the past ten years, few research studies represent the perception of adolescents receiving mental health services and whether their needs are being met (Gampetro et al., 2012). Gampetro et al. (2012) identified some

mental health needs from youth's perspective. This was a qualitative study using a single face to face, semi-structured interview at a school-based mental health clinic where the researchers explored the perception of mental health needs of 18 inner–city youth ages 12-18 years old who had been diagnosed with a mental health or behavioural issue. The conclusion of this study was that mental health needs expressed by the adolescents in this study involved personal, family relationships, education and vocational goals, health maintenance and financial independence. The most significant needs identified by the participants were to receive support and develop coping skills that could help with daily challenges.

Social and emotional development in childhood is as important as their cognitive development. If a child fails to meet the acquired skills necessary for each phase of development it can impair their development in certain ways. Similarly with social and emotional development, if a youth does not acquire the skills required for their particular stage of development, they will lag in this area later on in life, which may result in the development of unhealthy or maladaptive coping skills (Aviles et al., 2006). Some social-emotional disturbances identified by the schools, according to the National Information Center for Children and Youth with Disabilities (2004) are inabilities to learn what cannot be explained by intellectual abilities such as inability to build or maintain satisfactory interpersonal relationships with peers and teachers, inappropriate type of behaviour or feelings under normal circumstances, general pervasive mood, unhappiness or depression, or a tendency to develop physical symptoms or fears and social problems (Aviles et al., 2006). These are signs that teachers have to be aware of as it would typically indicate a social or emotional problem. Children and adolescents who do not obtain the skills needed to grow socio-emotionally are at larger risk of falling behind academically and have greater chances of developing behavioural, emotional and academic challenges (Aviles et al., 2006). Aviles et al. (2006) also mentioned that limited social and emotional skills are associated with poor performance in school.

A large portion of the literature on adolescent mental health shows that youth have growing social and emotional disturbances. Untreated social, emotional and psychological disturbances can eventually result in major mental disorders such as depression, bipolar disorders, anxiety disorders and schizophrenia because their onset is during adolescence or young adulthood (Szumila, Kutcher, Leblanc & Langille, 2010). Sometimes, such needs may not be identified until a crisis occurs (Aviles et al., 2006) and, by that point, for some youth it may have already caused considerable damage to their academic performance and social and emotional state. The social and emotional struggles experienced by adolescents have an impact on various areas of their lives; academically, psychologically and socially. When children struggle at school academically or behaviourally, it could be an indication of an underlying cause of physical, behavioural health or problems of poverty or abuse (Brener, Weist, Adelman, Taylor & Vernon-Smiley, 2007).

Risk factors. Some risk factors associated with mental health illness are things such as bullying, learning disabilities, poverty, emotional, and behavioural issues and can also be attributed to a decline in academic performance such as low graduation rates and behavioural or emotional disorders (Gitterman, 2010). Other risk factors in early life experiences are also important to consider. According to Aviles et al. (2006), Bailey (2000), and McKay (2010), there is a correlation between childhood maltreatment, exposure to violence, and youth who have inappropriate displays of expression such as fighting with peers, self-mutilation or underdeveloped social and problem-solving skills, and school failure. When youth have experienced early trauma such as abuse, neglect or loss, it does have an impact on their mental health and if untreated, it can lead to problems later on in adulthood. According to the study by Pathak et al. (2011), about twice the number of youth who have a history of physical abuse had some behavioural or emotional problems. Chrisi, Patten and Christian (as cited in Pathak et al. 2011) reported that studies have showed a psychiatric comorbidity with children who have been victims of physical abuse or

punishment. This same study reports that children who have suffered abuse are seven times more likely to experience depression. Pathak et al. (2011) also highlighted divorce as another risk factor that affected self-esteem in children of divorced parents. However, youth who are from loving families with marital stability can experience this as a protective factor against social and emotional challenges.

Protective Factors. One significant risk factor is identified as school connectedness. Connectedness is a term that surfaced in the literature about school-based mental health as a need to belong. McLaughlin and Clark (2010) confirmed that when measuring the level of support offered to students, it's not the actual support offered; however, more the perceived level of support by the student or youth. Waters et al. (2012) stated that for a youth, a connection to school, peers and family, means that they are less likely to be involved in antisocial or risk taking behaviours such as initiating drug use, being absent from school, being bullied or experiencing mental health difficulties. McLaughlin and Clarke (2010) also agreed that youth who have a sense of belonging to the school have a better sense of well-being and a higher rate of graduation from high school. These youth are less likely to have symptoms of anxiety or depression and are less likely to use drugs. When students were asked about what was considered important for a good life in general, they mentioned teachers who are supportive and kind and who make learning fun and interesting (McLaughlin & Clark, 2010). Despite schools sometimes being such an important place for connectedness and support, the environment can also be a detriment to some young people who do not feel they receive the support required. The negative aspects of school can be the bullying behaviours of others, school work and other stressors related to school (McLaughlin & Clark, 2010). Supportive teachers happen to be a very positive attribute about schools and can help protect youth from experiencing mental health related symptoms and challenges just by fostering feelings of connectedness and belonging.

Adolescent Mental Health Service Delivery: School-Based Services

In the literature on school-based mental health and school-based mental health history, it appears that services provided in the schools are imperative to addressing student needs. Pathak et al. (2011), among others, claimed that school can be utilized to identify needs of students and provide support to youth at the earliest signs of any signs or symptoms of mental health needs due to the large amount of time that youth spend at school in comparison to elsewhere. School-based mental health is defined as prevention and pre-referral intervention to address severe and pervasive mental health problems (Bailey, 2000; Bronstein et al., 2011). However, Pumariega and Vance (1999) believe that community-based approaches are utilized for the treatment of children with moderate to serious emotional disturbance or mental illness. There are various schools of thoughts when it comes to determining which service provider is best for which degree of need. Hoagwood and Erwin (1997) highlighted, in their review of the literature between the years 1985-1995, that schools were the primary source of providing mental health services. To this day, schools continue to play a vital role in service delivery of mental health support for children and youth; however, they are no longer the only providers of mental health services.

School-based mental health services now take on different roles within the educational system; however, little research has identified how these mental health services being offered are actually meeting youths' needs. According to Pumariega and Vance (1999), the number of students with learning disabilities and emotional needs is placing burden on schools financially. According to this same source, schools are in a good position to provide support to students without them necessarily needing to be identified with any special needs.

Nabors and Prodente (2002) examined the change in adolescent reports of behavioural and emotional functioning for youth receiving school mental health services. This was a longitudinal study that assessed the outcome of school mental health services. This research, despite looking at

youths' perspective, was also about the evaluation of one program in particular and therefore, does not give the general sense of what need was being met. Some intensive school-based programs have implemented services such as school-day treatment and, as will be discussed later, they have been shown to be successful with youth and have also shown better outcomes than traditional outpatient or residential treatment services. Some of the benefits from this model have shown a reduction in school absences, lower drop-out rates and lower utilization of services such as the juvenile system and mental health residential facilities (Pumariega & Vance, 1999).

School-based mental health services representing the perspective of youth have been understudied and underrepresented in the literature. Even more limited and non-existent is youths' perspective on receiving community-based mental health treatment. Very limited studies actually looked at the perspective of the adolescents among all of the articles retrieved on school-based mental health services. Szumila et al. (2010) was one of the few studies found that focused on youth's self-reported needs of mental health support. Szumila et al. (2010) used secondary analysis which concluded that the mental health needs of students were not being met. This same study also shared that male students were more likely to access school-based mental health services versus community-based mental health services.

Mental health intervention is said to be effective and necessary for adolescents (Aviles et al., 2006; McCullough, 2010; Masia-Warner, Nangle & Hansen, 2006). If mental health services are not accessible to adolescents in a timely manner, as discussed previously, this may cause future academic and other life problems. Nabors, Reynold and Weist (2000), and Nabors and Prodente (2002) are two major studies that have looked at adolescent mental health needs and services from the perspective of youth themselves. Other studies that have been conducted from the perspectives of youth receiving mental health services have identified dissatisfaction with the services. Nabors et al. (2000) conducted a qualitative study on the expanded school mental health program in a high-

school in Maryland, Baltimore. This study was also focused on the student's own perspectives. The data collection was completed through the use of focus groups with youth. This study evaluated the expanded school mental health program from the perspective of adolescent who were recipients of the service. Nabor et al. (2000) further suggested that future study on this topic include quasi-experimental methods in addition to a qualitative study.

Bailey (2000) reported that students who participated in school-based mental health clinics were more likely to stay in school and graduate in comparison to students who did not attend mental health clinics. Offering adolescents guidance and treatment in the early stages of their development can help to support them with more effective coping skills to deal with stressors. Early treatment for youth provides an ideal opportunity to address any possible emergence of mental illness or address the physical and psychological changes that come with the transition phase of being an adolescent (Aviles et al., 2006). Both school-based services and community services can provide such early prevention intervention; however, there is misunderstanding of what youth perceive to be the roles of these service providers.

Adolescent Mental Health Service Delivery: Community-Based

Community-based mental health services are referred to as outpatient services, non-residential community interventions such as family preservation, wrap-around services, day treatment, school-based services, community-based residential services, brief and acute inpatient services (Pumariega & Vance, 1999). Such services include assessment, treatment utilizing various evidence-based treatment programs, case management, coordination, and advocacy and monitoring of services (Pumariega & Vance, 1999). Due to the misunderstanding of the community and the school support roles, gaps remain in the literature requiring a better understanding of the reason youth chose one service over the other and what needs are being met by accessing each of those services. Williams, Horvath, Wei, Van Dorn and Johnson-Reid (2007) highlighted the limited understanding in the

literature about how students get referred to services at school and what barriers students face at the referral level. This study was based on the perspectives of teachers about the mental health needs of elementary school students. Another significant finding of this study included the limitation that students face when accessing mental health services based on the perspective of teachers. The barrier identified was that parents would fail to follow-up on the recommendations from teachers when it came to students' mental health needs. Historically, the concept of community-based systems of care was utilized to offer individual services to children and youth by providing them with the best access to the best possible resource. The best resources as suggested in this particular study involved families, communities, and other service providers to partner up and maximise the service delivery (Pumariega & Vance, 1999). Community-based approaches are said to be effective with children who have moderate to severe emotional disturbances. It targets those who are identified as "seriously emotionally disturbed children" (Pumariega & Vance, 1999, p. 373). It is used as a prevention measure and least intrusive intervention to in-patient or residential facilities. Overall, Pumariega and Vance (1999) are very much in support with the idea that community-based mental health services and school-based systems of care be closely coordinated and be integrated into each of the care plans. The research on children's mental health speaks to the effectiveness of community-based mental health treatment for youth.

There are some differences between the services offered in the community versus in the schools. According to Pumariega and Vance (1999), community-based approaches are utilized for the treatment of children with moderate to serious emotional disturbance or mental illness, and school-based mental health workers provide more prevention intervention (Bronstein et al., 2011). I could not find many research studies that distinguished the differences between these two mental health delivery systems. Slade (2002, p.163) reported that there is "weak evidence" to say that school-based counselling is a substitute for community-based counselling. It remains unknown

exactly what the difference is between schools and community-based services. Bailey (2000) conducted a study that looked at the role of school-based mental health services and identified the gaps in the literature as requiring more research to identify the difference between school-based mental health services and community-based mental health services. Slade (2002) looked at the effects of mental health programs on mental health services used by adolescents in school and in the community; however it was not very helpful in determining what the differences were between community-based and school-based services offered. It was also an American-based study and it was unclear on whether school-based mental health complemented or substituted for counselling services outside of the school. Slade (2002) did conclude in his report that onsite counselling services will increase the probability of using mental health counselling services. If youth are being seen for services at the schools by a community-mental health worker or a school-based mental health worker there is a better chance that they will access this service. There remains a need for more research to expand on Slade's question about what exactly are the differences between community-based mental health services and school-based mental health services based on the view of adolescents.

Based on the literature, it would be safe to say that the school and the community services have their own separate but overlapping roles when it comes to providing mental health service and addressing the mental health needs of youth. Vanderbleek (2004) reviewed the barriers of mental health services. The suggestions from the Vanderbleek study are that mental health workers work collaboratively with student services in order to further understand the barriers that are getting in the way of youth from accessing mental health supports. The Aviles et al. (2006) study explored the social-emotional development in children and how it impacts their academic outcome and stated that schools play an important role in working with youth who have emotional and social challenges. Aviles et al. said that "School is the primary environment in which all children must

negotiate and function" (p.33). This study and Slade (2002) reported that schools are often not prepared to counsel adolescents or may lack appropriate services in general. Aviles et al. (2006) claimed that schools who are ill equipped with suitable mental health services tend to receive support from community mental health programs until schools can adopt those programs and service youths' social and emotional needs. Community programs have been increasing their collaboration with the schools in order to address the students' needs. Schools are important partners in providing mental health services to children and youth. Williams et al. (2007) pointed out that a stronger partnership between schools, parents, communities, faith-based organizations, schools of social work and community-based treatment providers are crucial to meeting students' needs. At the school levels there must also be a sense of partnership and buy-in from all administration and teachers in order to offer the best effective mental health treatment. There have been many identified reasons for why students are accessing mental health services and very limited research is done on the reasons why youth are not seeking services. A study by Masia-Warner et al. (2006) reported that there are misunderstanding about those who are receiving mental health services and those who are not. Some barriers to community based treatment have been transportation, family and demographic factors (Masia-Warner et al., 2006). This study also emphasized the need for more research in order to promote policy changes at the school level. The Masia-Warner et al. study reported an interesting perspective because rather than looking at the reasons why some mental health services are helpful, they said that there is a need to understand what is not helpful or what is not meeting the need of the youth who require the support and those who are not receiving it.

Theoretical Perspective

The one theoretical model that seems to surface quite often when researching adolescent mental health services is the ecological model. The ecological framework is a perspective that looks at the larger social context and environment of a person's problems and, in this literature review, it relates to the environment of the person and his/her mental health needs. Rather than blaming the individual as the problem, the ecological model supports the importance of addressing the root of the concern and the structural barriers as required (Haynes, 2002; Vanderbleek, 2004). Bronfenbrenner's ecological system of human development consists of five interrelated systems, the microsystem (immediate family, daycare), mesosystem (neighbours, school, religious groups), exosystem (government, extended family and family network), and the macrosystem (values, laws and cultures) (Swick & Williams, 2006). Each of these systems impacts children and adolescents in various ways during their developmental stages. The ecological system suggests that mental health and social and emotional issues are more than just individual problems. Doll, Spies and Champion (2012) stated that vocation and social success are ecological factors contributing to a student's life success overlapping with academic success. The ecological model also helps young people understand their own life issues from a more systemic perspective and depersonalizes some of the related struggles they may be encountering. In fact, Sun and Hui (2007) indicated "…the importance of the human ecological theory of Bronfenbrenner highlights that adolescent development is interlocked with their surroundings, and thus adolescents are troubled when there is a lack of balance between systems" (p.299).

Some researchers have demonstrated through the review of various studies, the positive impact it has on children and adolescent's mental health when the ecological system is part of the prevention and intervention approach in the schools. McManama O'Brien et al. (2011) reviewed 24 studies related to the use of the ecological systems approach in mental health and education, and

were able to determine that 15 of these studies demonstrated a positive impact related to the use of the ecological model with students seeking mental health support. The positive aspects of the ecological model are that it can be utilized as a prevention and intervention approach and can be utilized by all of the mental health supports within the schools (McManama O'Brien et al., 2011). This framework of ecological systems emphasized the importance of a community and school partnership that can help address the social and emotional needs of adolescents.

Summary and Conclusion

Most of the studies related to children's mental health needs have used quantitative methods to gather their data and very few utilized qualitative methods that would enable an in-depth exploration of viewpoints and experiences. The limitation in the quantitative method of gathering information is that it is restricted to questionnaires or a survey. The other limitation in the literature is the lack of youth self-representation about their perspectives of experiences with mental health services. There have been few studies in the past 10 years that have studied mental health services from the perspective of adolescents (Gampetro et al., 2012). Limited research highlights the factors that influence or motivates youth to access mental health supports either at school or in the community. Also, little research explores the positive and negative experiences of receiving mental health support at the school or outside of the school. These two topics need to be further examined in order to contribute to the body of literature involving youth and their experiences with mental health services. There is also a need to further understand youths' social and emotional needs from school-based support and community-based support. Utilizing the ecological theoretical framework to help in understanding the experiences of adolescents with social and emotional needs will contextualize some of the larger issues that are impacting youth. It may also help to clarify some of the different perceived roles of mental health supporters from the adolescent's perspective. My

proposed study will attempt to address these identified gaps related to youths' experiences with mental health services from an adolescent's perspective.

This literature review considered many aspects of children's mental health needs along with the history and reviewing the roles of the mental health services being offered through the schools and the community. The mental health needs of children and adolescents are important to consider so that children and youth can be assisted to develop into healthy adults who can live to their potential and contribute to their communities. Mental health services in Canada have evolved over the last century to address the needs of children and youth, however there is some confusion about the roles of schools and the community when it comes to delivering mental health services. In the literature related to the reasons why youth access mental health services, the primary reasons are due to social and emotional needs which can that start a young age. There are many related factors for why youth do experience these social and emotional needs that is the driving force for youth accessing mental health supports. The following chapter will explain the methods that were utilized to undertake my thesis research.

Chapter 3 - Research Design and Procedures

The purpose of this qualitative study is to understand the perspective of youths aged 15-18 years old that have had the experience of receiving school-based mental health services (SBMH) or those who have had the experience of receiving community-based mental health (CBMH) services. The other rationale for doing this research study is to gain a better understanding about youths' perspectives related to their own experiences with mental health services. Adolescents' motivation for accessing mental health services is an important perspective to understand in order to help better meet their needs. . Through an analysis of the data collected from the face to face interviews, I will be able to gain a better perspective of what youth consider to be positive and challenging aspects to mental health services at school and in the community.

The research questions to be addressed in this study were based on a review of the literature and my own experiences as a youth mental health practitioner. The questions were: What are youths' experiences (positive and negative) receiving school-based mental health (SBMH) services and community-based mental health (CBMH) services? What are youths' self-identified needs and how have they been met (or not) through SBMH and CBMH services? What are some further recommendations to improve SBMH and CBMH services? The methodology section below will highlight how this research study was conducted.

Methodology

Qualitative Research

The method used for this study is a qualitative research method. Qualitative research is the study of a phenomenon or research topic that tends to be exploratory in nature looking at the *how* and the *what* rather than the *why* (Hays & Singh, 2011). Qualitative studies attempt to draw out the meaning of people's words and behaviours in a more natural way compared to using a quantitative method (Tutty, Rothery & Grinnell, 1996). In qualitative analysis, there is a

tendency to focus on narratives and words over numbers, quality over quantity, which provides a more meaningful account of the participant's perspectives (Hays & Singh, 2011). One point to consider and appreciate about qualitative research is the flexibility it gives to the researcher and participants. Some important components of qualitative research are the consideration of participants' perspectives including cultural practices, building trust and rapport, and being supportive to the participant's meanings and understanding (Hays & Singh, 2011).

The use of a qualitative approach in this study is best suited to answer my research questions because in order to get a thorough understanding of youths' experiences with mental health services, the information needs to come from them directly. According to Creswell (2007), qualitative research helps to gain a better understanding of an issue that cannot be understood by any other method than through talking with the person face to face. Youth who have received mental health services are already seen as vulnerable and therefore a qualitative approach to sharing their stories can help empower youth and minimize the power relationship between the youth and the researcher. The topic of mental health and youth is already a sensitive topic that deserves to be explored with care and respect. Qualitative studies are more personable and give more control to the participant. The approach is also more comfortable considering these young people's vulnerabilities. The adolescent population is assumed to respond better to this form of research because it promotes egalitarianism, cultural sensitivity, collaboration and respect (Hays & Singh, 2011). Allowing adolescents to express their own ideas and being heard give them a sense of autonomy (Morrow & Richards, 1996). Some argue that qualitative research is more easily interpretable to the general public and policy makers, which can help guide and monitor program implementation in a way to improve feasibility when doing advocacy research (Nabors et al., 2000). The focus of this research is exploratory and will be analysed using an interpretive thematic analysis.

Setting

The setting for this research was two high schools within the region of Timmins, Ontario. Permission was granted by the Superintendent of the District School Board Ontario North East to do research with a sample of students from Timmins High and Vocational School, and Roland Michener Secondary (see Appendix A for the letter of support from the Superintendent). Creswell (2009) indicates that qualitative researchers tend to collect data at the site where participants are more likely to experience the issue or problem being studied. In this study, the school setting is an appropriate place for the population group that is being interviewed (youth 15-18 years old). Since the participants are youths, they may not have available transportation or time to attend an interview elsewhere in the community. If the adolescents required debriefing following the interview session, the school social worker, child and youth worker, or walk-in mental health clinician would be available for support as necessary. I also provided each youth with a list of other resources available for them to access (see Appendix B for more information on the community resource list).

There was a designated meeting area that each school had set up for the interviews. The child and youth worker office was available at Roland Michener Secondary School every afternoon except for Thursdays. The counselling office at Timmins High and Vocational School was available every Thursday and Friday. Both of these high schools were very accommodating and whenever a youth did not remember the scheduled appointment, I would ask the secretaries to call the student after having received their verbal permission during the initial call to set up the first interview.

Sampling

The recruitment method to obtain the 8 participants in this study was done by the use of flyers and poster advertisement throughout the two high schools (see Appendix C for the

recruitment flyer). Also, the school child and youth workers and vice principals were also involved in this process of recruitment by discussing it with students who they believed would be interested in participating and who met the inclusion criteria. The interested participants were advised on the flyer to take one, fill out the corresponding information such as name, contact number, email address, and place it in an attached sealing envelope. The potential participants were then instructed to seal the envelope and leave it in an area determined by each of the schools, or simply hand in to the child and youth workers and it would be picked up by the student researcher. The eight youth were recruited from the two high schools as indicated above but one was recruited from North Eastern Ontario Family and Children's Services (NEOFACS), a child and family community-based counselling agency in Timmins using the same process as in the schools. The North Eastern Ontario Family and Children's Services (NEOFACS) Ethics Committee granted approval on May 8, 2013 to recruit participants. The Laurentian University Research Ethics Board granted approval for all of the study's procedures on March 17, 2013.

Initially, the goal was to obtain a sample of 10-15 youth who had experience with receiving mental health services at least one time from a school-based mental health service or a community-based mental health service. The recruitment of the youth took several months starting on November 18, 2102 and ending on May 30, 2013; a final sample of eight youth were recruited and participated. There were four youth who expressed interest, however declined when it was time to do the interview. The difficulty in recruitment was surprising as I did not think that it would have taken as long as it had. Purposeful sampling was the strategy used as I wanted to purposefully select the youth who have had at least one experience seeing a school-based mental health worker or at least one experience seeing a community mental health worker. The inclusion criteria for participating in the study were quite clear on the recruitment poster and

this was explained in details to both school vice-principals and child and youth workers during several meetings and email correspondence.

There are a few reasons that I believe may have contributed to the difficulty with recruitment and why it took so long to recruit the eight youths. I may have been too dependent on the Child and Youth Workers at the schools for various reasons. Part of their role involved promotion of the research study; they were asked to mention the research study with the students who came to see them for mental health support. This process worked quite well at the start of the study as I was able to recruit five participants prior to the beginning of 2013. In 2013, exams and March break may have impacted the rate of interested participants. Another contributing factor to the slowed recruitment phase could have been due to the passing of the controversial Bill 115 *Putting Students First Act* that caused Ontario Secondary School Teachers' Federation to strike back by working according to their collective agreement such as working only the required amount of hours and having to take all of their breaks; it involved child and youth workers as well. The other assumed reason I did not recruit 10 youth is that perhaps there was not enough incentives for them to participate in the first place. Despite youth being able to be excused from class without penalty, I believe they may have responded better if an incentive was provided, something tangible such as a gift certificate or voucher to a local restaurant. Also, perhaps if I had expanded my recruitment location to include the North Eastern Ontario Family and Children's Services earlier on in the recruitment phase, I could have potentially recruited more youth. I think that these reasons may have impacted my goal of recruiting 10-15 participants. However, the participants I did obtain provided a diverse sense of youths' experiences with receiving mental health services.

Participants

This study focused on participants of both genders who were between the ages of 15-18 years old. During the first two months of recruitment, the age criteria included 16-17 years old. After two months of slowed recruitment, along with some feedback from the child and youth workers stating that there were a lot of 15 years old who had expressed interest in participating, I made a request to the Research Ethics Board (REB) at Laurentian University for an amendment to the initial application. On January 17, 2013, the REB approved the request. Once this request was approved, the criterion for participation was expanded to 15-18 years old.

There were two main reasons why this age group was chosen. First, it was due to the level of assumed maturity of the particular age group in comparison to those of early adolescence. Older youth may be able to express themselves more effectively and do not require parental consent to participate in the study; 15 year olds do require parental consent (see Appendix D for parent consent form). The second reason for choosing this particular age group of 15-18 years old is because there is a higher chance that some participants have had mental health services for a longer period of time and would potentially have more experiences to share regarding receiving mental health services.

As I indicated earlier, the youths who volunteered to be participants in this study ranged from the ages of 15-17 years old. There were no youth 18 years old that volunteered to participate in this study. What follows is a description of the youth participants including their chosen pseudonym, the reasons for accessing mental health support, and the type of supports they received. The youth are identified as Frank, Sam, Sara, Lucy, Tyler, Effie, Madrox and Thirteen. There were eight youth who chose to participate in this study. Of the eight youth, four were male and four were female. There was one youth who was fifteen years old, two youth were sixteen years old, and four youth were seventeen years old. These youth varied from grade

10-12. Two of the youth were in grade 10, three were in grade 11, and three were in grade 12. One of the youth identified as being Aboriginal.

The participants also had past and present experience with receiving community-based mental health (CBMH) services and school-based mental health (SBMH) services. Two of the youth had past experience receiving both SBMH services and CBMH services and four had experience receiving just CBMH services. Currently, one is receiving both SBMH and CBMH services. Five of the youth are receiving SBMH services and three of them are receiving CBMH services only. These youth were referred to CBMH and SBMH services by different people and this was indicated as a significant reason they chose to access mental health services. Four of the youth were referred to SBMH by their teachers; two of the youth were referred to CBMH by their parent; one by their extended family member; and one by the family doctor.

Their reasons for accessing mental health support varied for each youth. The most significant mental health concern that affected four of the eight participants was anxiety. The other predominant mental health concern experienced by these youth was depression and suicidal thoughts with four youths stating that they had these thoughts in the past. Three of the youths had anger management issues, and two had a diagnosis of Attention Deficit Hyperactivity Disorder. Other reasons for accessing mental health support as indicated by the youth were due to bullying; family relationship problems; dating relationship problems; grief; autism; homicidal thoughts and hallucinations.

Researcher Role

As the student researcher, I have taken the lead role of collecting and analyzing the data from the interviews with the participants. I have a particular interest in hearing adolescents' personal opinions about their experiences in accessing and receiving mental health services at school and in the community. I have been working in the field of social work with youth for

almost five years, and I have noticed from the literature that youth do not have much of a voice when it comes to expressing their needs related to mental health services. I believe that there is a misunderstanding of what motivates youth to seek help and remain in counselling. Also, there is limited information from a youth's perspective related to their experiences. I have a strong belief that if we understood more about adolescents' social and emotional needs, service providers could offer more specific, relevant, and meaningful services or programming, taking into account what is helpful to youth..

As a researcher, I am self-aware of my natural privileged position in society being a middle-class Caucasian French Canadian, and I am aware of how the privileges may be perceived by the participants that I will be interviewing. I recognize that my educational background and training in the field of social work are factors that I need to reflect upon when listening to youth as they share their experiences. As a community mental health clinician for children, youth and families, I am aware that I needed to be reflexive and mindful throughout the research study about my role as a researcher. I had to continuously keep in mind that my role is as a researcher and not a mental health worker. I believe this was the biggest piece of reflexive practice that I needed to do at every interview and throughout every step of the interview. Whenever I needed someone to debrief with, I would notify my thesis supervisors Dr. Diana Coholic and Dr. Leigh MacEwan who helped me process any difficulties that I encountered with self-reflection and other ethical challenges.

Ethical Considerations

Children and young people are defined as anyone under the age of 18 years (Morrow, n.d.; Morrow & Richards, 1996; Schenk & Williamson, 2005) and are considered part of a vulnerable population (Liamputton, 2007). In this study, I needed to ensure that ethical principles for my participants were been respected at all stages of this research by following the principles

set out by the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS-2), Ontario College of Social Workers and Social Service Workers (OCSWSSW) and other suggestions important to consider based on the literature related to doing research with vulnerable people. For example, researchers interested in studying the vulnerable must keep in mind their own ethical principles that are guiding their research (Hesse-Biber & Leavy, 2006). Ethical reflection is an important part of research, especially so when studying a group of vulnerable people such as children and adolescents. Hesse-Biber and Leavy (2006) suggested using "reflexivity" to help challenge our personal ethical standpoint and confront personal biases in order to avoid any negative impact on the research and on the young participants. All of these suggestions were taken into consideration in this study.

Children and adolescents are considered a vulnerable group because they are marginalised in an adult dominated society due to the unequal power relations with adults in their lives (Liamputtong, 2007; Morrow & Richards, 1996). They are also marginalized due to the life experiences they have suffered, which have lead them into the mental health and child welfare systems. For example childhood abuse, neglect and trauma-related experiences are often the root cause of some of the mental health challenges that children and youth face. According to Pathak et al. (2011), youth who have been physically abused often have some form of social or emotional need requiring mental health services. Pathak et al. also reported that children who reported abuse were seven times more likely to develop a mental health disorder such as depression than of children who had not reported abuse. Youth deserve to have input about the services that are designed for them. As Schenk and Williamson (2005) argued, "it is unethical to prevent children and adolescents from participating in decision-making about things that effect their lives" (p.5). Many of the mental health services are geared to youth; however, youth involvement in the decision-making of these services appeared to be limited.

The three most important principals related to research with children, as indicated in the literature and the TCPS-2 report is consent to participation, protection from harm, and confidentiality. The first principle of consent relates to Farrell's argument that researchers should listen to children as competent participants and respect their informed consent to participate and as well their right to decline or withdraw from research (Skanfors, 2009). This was established in the consent for participation at the very first interview where I would read through line per line of the entire consent form, checking to make sure they understood what they were agreeing to do and why. The second principle is protection from harm. Schenk and Williamson (2005) say that the benefits and risks of research must be distributed equitably without bias of the interpretation of the researcher. As children and adolescents disclose information which raises some concerns such as child protection issues, researchers must be ready to facilitate access to follow-up services as appropriate (Schenk & Williamson, 2005). In order to address the possibility of risks that some questions may trigger the youths' emotional responses or sensitivity, I ensured that a school-based mental health worker such a social worker, a child and youth worker or a clinician from the walk-in mental health clinic was available to respond in the event should such a situation occurred. The youth participants were each given a list of resources to contact with addresses and telephone numbers should they want mental health services or simply to debrief following the interview. The third principle is confidentiality, which has been explained to the participant in a way that they will understand in the consent for participation form.

In order to ensure full ethical consideration I have followed the standards of the Laurentian University Research Ethics Board and the Code of Ethics of the Ontario College of Social Workers and Social Service Workers throughout the data collection and information storage process.

Individual Interviews

I chose to utilize face-to-face semi-structured interviews as my method of data collection. According to Liamputtong (2007), an in-depth interviewing method is most commonly used by qualitative researchers. It permits the youth participants to articulate their worldview and provides more freedom in terms of self-expression (Liamputtong, 2007). Through in-depth interviewing, the hope was that the youths would be more comfortable sharing thorough information about their experiences. Having individual face-to-face interviews can encourage youth participation due to the increased confidentiality and identity protection from other students in comparison to other methods such focus groups or group interviews. Confidentiality and privacy is very important considering the topic being on mental health and asking youth to talk about their own experiences with accessing mental health services. Another advantage to doing a face-to-face interview is that I was also available to use observation to help me guide the interviews, for instance, I was cognisant of any significant non-verbal cues. The method of observing is useful to help explore topics that may be uncomfortable (Creswell, 2003) and further intervene as necessary if the participant becomes too uncomfortable.

The interviews were audio-recorded utilizing my Sony Dragon recorder and, as a back-up method, I utilized my iPhone to record the interviews with the participants. For this study, there were two face-to-face interviews scheduled with each of the participants. The first interview took about 30 minutes to 60 minutes to complete. At that time, I read out loud to the participants the entire consent form to ensure that they felt comfortable asking any questions. Furthermore, they were asked to sign the consent before the audio-recorder was turned on and the interview started. Once the interview was completed, I transcribed each interview verbatim. The follow-up interview was then typically scheduled a couple of weeks after the first interview. The purpose of the follow-up interview was to review the transcript with the participants and ensure that the

information that was typed up was accurate. This second interview, which took about 10 to 20 minutes per individual, was also part of the data collection and analysis; however, this was not transcribed. Notes were taken during this second interview for the few participants who added comments.

Sam identified some typing errors where I added the same word twice. Effie asked to change a word "he" to "she". She also stated that transportation was an accessibility challenge to attending community-based mental health appointments. She highlighted that rescheduling appointments was really difficult because the clinicians were so busy. Effie suggested that if possible that the clinician from the community could come to the schools as it would make it much easier to participate with less school being missed. Thirteen had a couple of things to add as I had asked her a couple of more questions to clarify the data. She reported that it would be helpful if CBMH services had ongoing contact with SBMH services. She also clarified that it was her family physician that encouraged her to access CBMH services and not her mother, which is what I had understood in the initial interview.

Approach to Data Analysis

The data was analyzed inductively utilizing interpretive thematic analysis. According to Braun and Clark (2006) an inductive approach means that the themes extracted from the data are strongly linked to the data themselves rather than picking out data that fits the belief of the researcher or a theory. Thematic analysis is a method for identifying, analysing and reporting themes within data that is collected through research. It is widely utilized; however, it was not a well-defined method of analysis until recently (Braun & Clarke, 2006, 2012). Thematic analysis gives the data analysis process credibility and clarity about how certain themes and patterns came from the particular data being analyzed and it complements the features of flexibility in

qualitative research. This method has six phases to the analysis, and I used the step-by-step guide provided by Braun and Clarke (2006, 2012).

In step one of Braun and Clarke's model of thematic analysis, the researcher has to familiarise themselves with the information collected. They do so by reading and re-reading the data that was transcribed or listening to the audio of the interviews. In step two, the researcher must generate initial codes and begin building the analysis which is sort of a summary of bits of the data. The third step is about searching for themes from the codes identified. The theme will capture important information about the data as it encompasses the codes to form a theme. Step four is reviewing potential themes and making sure that it really tells a story about the gathered data and codes. In doing so, the researcher is "quality checking" the themes, according to Braun & Clarke (2012, p.65). In step five, the researcher is defining and naming the themes to be able to give a clear definition to each of the given themes. Step six is actually producing the written report such as a journal article. The purpose of this phase is to provide a story of the data.

In my analysis of the data collected, the process of thematic analysis commenced immediately after I completed my first interview. In phase one, I familiarized myself with the data by choosing to transcribe the audio-recording interviews myself and read through it a second time to ensure that there were no errors in the transcripts. In phase two, I began to generate initial codes by writing on the side of the pages and circling the important and relevant information that was pertinent to my research questions. Using a pencil, I would draw a box around the relevant questions and circle the important answers along with what I thought was relevant to help with the analysis. Furthermore in this phase, I wrote on a separate page, in point form, all of the different codes from the original transcript. This helped me to make sense of the information and broke the process down to a more manageable task. In phase three, I began searching for themes by reviewing the data codes over and over again. As I was reviewing the

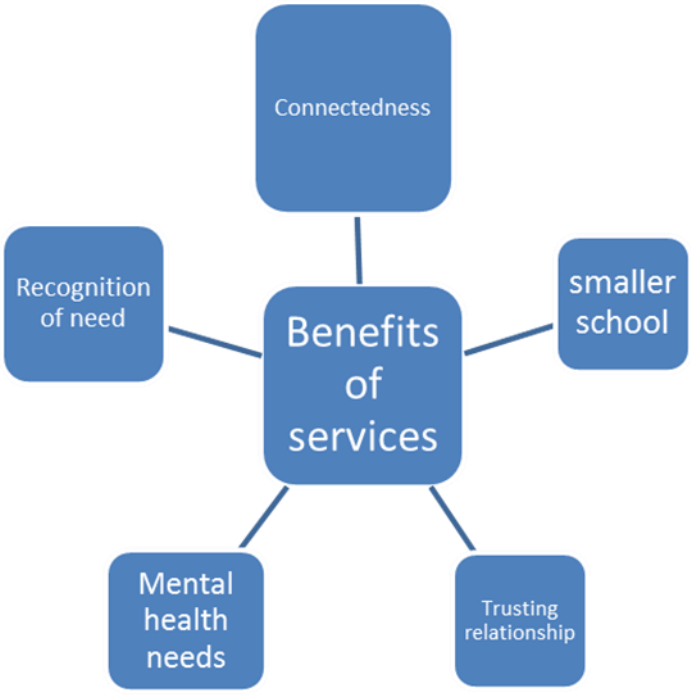
codes, themes started coming to light as I was able to make associations with common codes from each participants. In phase four, I reviewed the potential themes to ensure that they were actually relevant to the codes and fit well with my research questions. I reviewed many times over to make sure that it was telling a story about the data and closely related to the research question. In phase five, I defined and named the themes, which is also known as "define and refine" (Braun & Clarke, 2006, p.92). In this phase, I was able to explain what all of the themes and sub-themes signified and how they related to the research topic.

My initial codes were comprised of four major groupings. The first code was connectedness. This code represented the importance of having a connection with the person the youth were working with in order to promote a good therapeutic relationship. Some felt their child and youth workers, teachers and others understood and others felt that their teachers could have been more caring and concerned. Smaller schools were identified as a more supportive environment compared to the larger schools. The participants reported that despite feeling connected to their school, they also would have liked for their school to be connected with the outside community-based agencies. Even though, most youth felt understood by their clinicians through SBMH and CBMH, there seemed to have been quite a communication gap between CBMH and SBMH services. The next code that was identified in the initial coding was trust. Trust was identified as being important in all of the participants meaning of what a good therapeutic relationship was. They reported that trust was above all the key to feeling comfortable with their clinician and feeling understood. They reported that it does take time to trust someone to talk to about your most personal stories and problems. The other code identified was recognizing a problem. This code was significant to the fact that all of the youth interviewed reported that they would have never accessed support if it had not been for someone who recognized the problem and referred them. These people included parents, teachers, principals,

extended family and family doctors. This was important to these youth as it meant that they did not have to do it alone, which fits in well with feeling connected and supported. The last code identified in this initial coding phase was social and emotional needs of youth. This code represents the needs and the reasons that motivated youth to access mental health services. These mental health-related reasons included anxiety, depression, autism and suicidal thoughts. Some of the signs that a few participants identified as being a clear need for help was them missing school, being bullied, having anger problems and experiencing family relationship problems. What most of these youth needed was to be understood by their school and/or community mental health providers.

In phase five, I was able to refine my four major themes into three final themes that are representative of the overall story of my data and remain true to my research question. I believe this phase is a reflection of the data collected and the identified codes. There are three major themes identified within the gathered data. The first theme represents the benefits of services that adolescents experienced receiving school-based mental health services and community-based mental health services (See Figure I for benefits of services). Some participants identified that trust and connection with their clinician or mental health worker was very important and considered to be a crucial aspect of the therapeutic relationship and work. Another important subtheme to highlight is that youth felt that someone had recognized their need for support and made it clear that if it had not been for those particular people they would have not considered getting support for themselves. The participants believed that they received the support they needed to address their need reported at the time of the interviews.

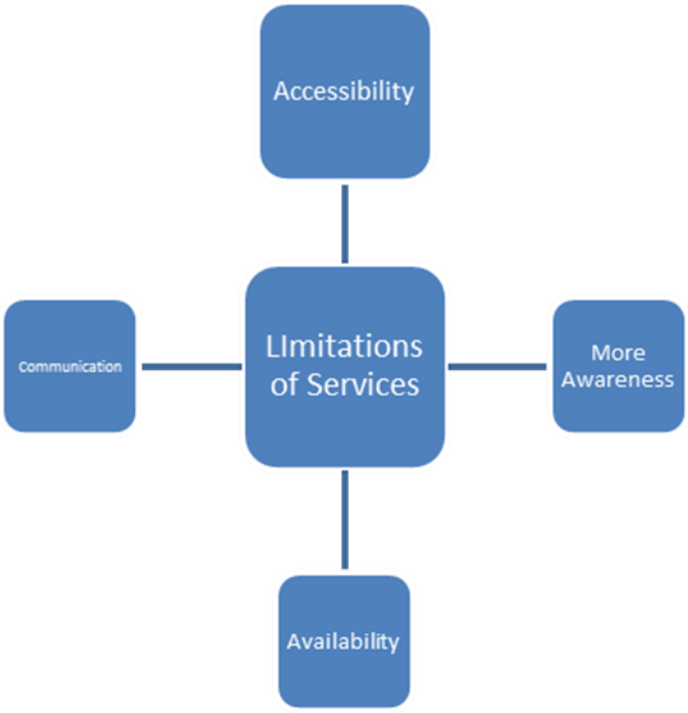
Figure I. Benefits of services



The second major theme was youth's negative experiences related to mental health services (see Figure II for limitations of services). Communication is a sub-theme that emerged quite often in relation to the lack of communication between schools and community agencies. There were comments made that the two programs work in silo of each other and very rarely are they connected. The connections at the schools among the teachers, mental health workers and principal is lacking in larger schools and is more commonly seen in smaller schools. Other subthemes that had been discovered were that schools need more awareness about services being offered at school and in the community. There also needs to be more awareness amongst the teachers about mental health symptoms and education on ways that they can provide support to the students in need. The accessibility of the service is also something that was an apparent limitation. Youth who do not drive or who reside far away from community-based mental health agency may not be able to always attend the appointments after school. The availability of time to receive support seems to be based on prioritizing between one's mental health or educational needs. Mental health services such as SBMH or CBMH are normally offered during the day. It

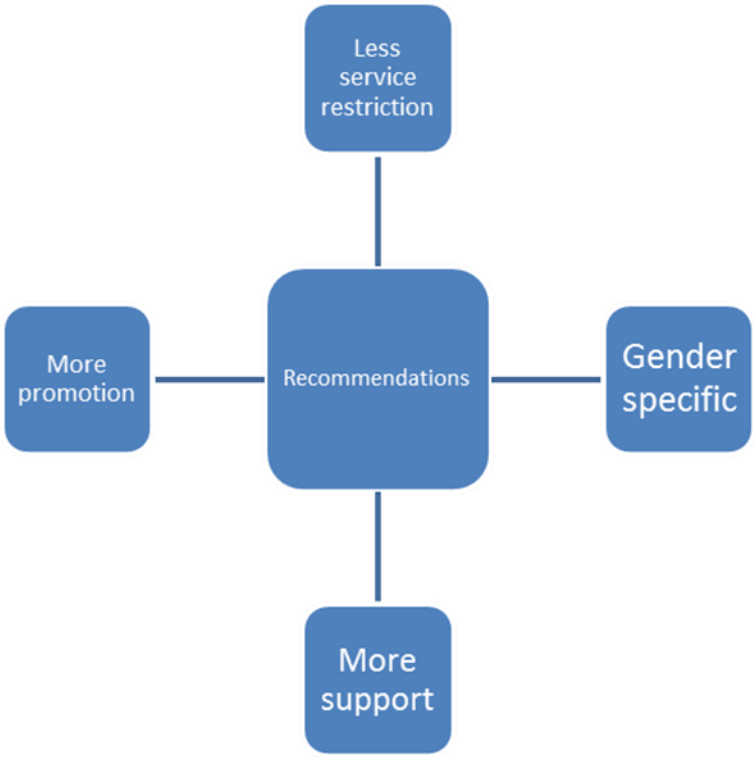
has been mentioned that youth sometimes feel torn between attending their appointments and staying in class, which makes them have to prioritize between academic need and mental health needs. If they are falling behind academically they may choose to put off services in order to attend classes, which impact the treatment they are receiving.

Figure II. Limitations of services



The third theme is recommendations of changes needing to be made based on youth's experiences with mental health services (see Figure III for recommendations) The youth were asked what they would have liked to see change based on their experiences with mental health services thus far. One of the common subthemes was promotion. The youth would like to see mental health services better advertised at school. They would also like to see clinicians with one of each gender at schools to accommodate youth who may not be comfortable with a particular gender. Another recommendation is to have more support at school and less restrictions of service delivery.

Figure III. Recommendations



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Validating Findings

In order to validate my research findings, I will be clarifying my researcher bias and including a discussion about member checking. According to Creswell (2007, p.208), "clarifying research bias from the onset of the study is important so that the reader understands the researcher's position and any biases or assumptions that impact the inquiry." I have made it clear in the section on *Researcher Role* that a large part of the reason for doing this research is due to my personal interest in the topic of my research study. I have also been open and honest in this research paper about my current work in the field of social work particularly with children, adolescents and families and the biases that could potentially impact the analysis. These biases could involve the way that my questions are worded. I already have the assumption that some schools offer more support to their students then do other schools; however, I needed to remain objective and open to the viewpoints that were being presented to me. My other bias is staying

true to the research study process by ensuring that the questions I asked were purposeful to the overall research question. As a mental health clinician, there were some times when I really wanted to inquire more on certain topics; however, using my self-awareness during this time helped me to redirect to my role as a researcher. Due to the above noted reason, I needed to be continuously self-aware of my role as a researcher versus my typical role of mental health clinician. I have been able to remain conscious of this distinction by writing in my reflexive journal, discussing with my thesis supervisors and speaking with my peers.

Member checking is considered by Lincoln and Guba (1985) to be one of the most critical techniques to establish credibility (Creswell, 2007). In this study, the initial interviews were approximately 30 minutes to one hour in length. Once I completed the interview and transcribed the data recorded, I provided the youth participants with a copy of the transcript and gave them each a length of time to review it. The way this was arranged was that I would leave the transcript in a sealed envelope at the secretary's office. I set up a subsequent interview with each participant to review their feedback about the transcript that they had read and asked them to verbally share if there was anything that they would have liked to add to the information that had already been gathered or whether there was something in the transcript that was misunderstood. The subsequent interview took approximately 10-20 minutes. I ensured that the participants had a period of a couple of days to review thoroughly the transcript prior to meeting up with them. I was able to complete this subsequent interview face to face with 7 of the participants and one by telephone. The purpose of meeting with the participants twice was to ensure that they felt like they were part of the process and also to provide them with the opportunity to share additional information that they may not have thought about during the initial interview. The second interview is also part of the data collection and analysis, however had not been transcribed like

the initial interview. In fact, this data was collected by note taking as stated in the *interview section*.

Conclusion

This chapter included a summary of the steps taken that helped to conduct the research to gather the necessary data from the participants. The steps that were taken to conduct this study were carefully chosen and the hope is that is best represents the youth participants as well as gives justice to the youths' experiences with accessing and receiving mental health services at the schools and in the community. The themes are well represented as they provided a very good summary of the positive aspects about mental health services in the community and in the schools along with some limitations and recommendations all based on the experiences and perspectives of youth themselves.

In the next chapter, I will utilize the results from this study and explore in more depth the interpretation of each of the themes based on each youth's direct perspective using quotes from the participants. In the discussion chapter, the main themes will help to highlight the importance of this information and also provide some recommendations for future research that could help expand on the current study results.

Chapter 3 - Discussion

This chapter is a discussion of a qualitative study designed to explore the experiences of youth who have received school-based mental health services and community-based mental health services. It will include three main sections: a summary of the study, a discussion of the findings of the study, and a review of the ecological system of human development.

Summary of the Study

A qualitative study was conducted using individual interviews with a sample of eight participants who had the experience of accessing school-based mental health services (SBMH) and community-based mental health (CBMH) services. The research question was; what are the social and emotional needs of youth accessing SBMH services and CBMH services? The interviews were also guided by the following sub questions: What are youths' experiences (positive and negative) receiving SBMH services and CBMH services? What are youths' self-identified needs and how have they been met (or not) through SBMH and CBMH services? What are some further recommendations to improve SBMH and CBMH services?

The interviews were transcribed verbatim and analyzed using an inductive approach to thematic analysis. Thematic analysis is a method for identifying, analysing and reporting themes within data that is collected through research. According to Braun and Clark (2006) an inductive approach means that the themes extracted from the data are strongly linked to the data themselves rather than selecting data that fits the belief of the researcher or a theory. This method has six phases to the analysis, and I used the step-by-step guide provided by Braun and Clarke (2006, 2012).

The perspective of the ecological system of human development was used to gain an understanding of how different systems in youths' lives can have an impact on their social and emotional state. There are risk factors and protective factors in youths' environment that can

have an impact on adolescents' social and emotional needs. According to the ecological theory of human development, the perceived experiences of adolescents receiving mental health services can be highly dependent on their connection with their environment (Sun and Hui, 2007). For example, Sun and Hui (2007) reported that support from parents, peers and teachers has been linked to lowering the levels of youth depression and promoting a higher self-esteem in adolescence.

Discussion of Findings

In the literature review on the topic of adolescent mental health services, there is a wide range of studies about the impact of school-based mental health services; however, it is very important to note the limited information on the impact of community-based mental health services with regards to its benefits and its limitations. This chapter will present a discussion of the findings of the study by describing: the reasons participants gave for accessing mental health support; how participants were referred for services; the differences between school-based mental health services and community-based mental health services; benefits of services; and the recommendations for service improvement from the perspective of the participants who were part of this study.

Reasons For Accessing Mental Health Support

All of the participants shared their various reasons for accessing mental health support. They said their needs including issues such as autism, suicidal ideations, attention deficit hyperactivity disorder, anxiety and depression. Anxiety and depression were the prominent issues for half of the participants and three out of the four girls expressed having had suicidal thoughts in the past. This is consistent with the statement that the most common mental health disorder for adolescent girls is depression (Costello et al., 2011; Gampetro et al., 2012). The fact that all participants had significant mental health symptoms was reflected in the literature. One in

five children and adolescents have an emotional or behavioural problem to warrant a mental health diagnosis (Berner et al., 2007; Aviles et al., 2006).

The participants in this study related that mental health services were not only accessed for treatment of mental health disorder, but were also utilized by participants who needed support dealing with other social and emotional needs such as bullying, school truancy, academic stressors, family relationships, dating relationships, anger management, grief support and other life stressors. Madrox had some anger management difficulties as a child and remembers he and the SBMH worker would "just talk about ways instead of trying to get angry or trying to fight, different ways to release my anger and stress so that I wouldn't like burst out and attack people sort of thing." Effie expressed in reference to receiving school-based support her mental health illness, "And I suffer from severe social anxiety so I have to go to her if there's a class there's too many people in it, I have to go see her and she has to do her best to try either have me get in class or like calm down or get me into a different class." For another example, Frank shared that it (SBMH) helped to reduce his anger. He learned ways to manage his anger and this helped to calm him down when feeling upset. Frank stated, "If I didn't have services at all, well I would be on an insane rampage by now". One participant who was seeking treatment at a CBMH agency shared that her social anxiety symptoms reduced significantly after being seen by a CBMH worker and starting medication treatment. Effie claimed, "It completely changed my life…"

How Participants Were Referred for Services

One important point to consider is that all participants from this study have identified that if it were not for someone encouraging them or suggesting them to seek mental health support; they would not have accessed any services. Frank was asked if he would have come to see the CYW on his own without being referred, he answered "most likely not". Effie and Sara shared

the same response. If not for their mother recognizing and referring them to mental health services, they would not have participated. Effie related,

> I don't know, my mom was trying to get me to see a counsellor and I had been really...really didn't want to go at all and she got into contact with social services and they said that they could help as long as you have to be under 18 to get any form of service from them for that. So, she just called them and set up the appointment.

Participants seem to need someone who will recognize their social and emotional needs. Madrox explained the reasons for seeking support, "Uh the reasons were honestly, I'm honest 'cause I was really depressed and I was having suicidal thoughts so...and then my parents found out and they suggested that I go see him...not him specifically but the counsellor there so..." All the participants in this study reported that each of them had been recommended to attend counselling by someone they knew such as family, teachers and doctors. Sara remembers, "I was dropping out of school and my guidance counsellor was like go see her and I'm like NO. She kind of basically forced me to go see her."

The participants who accessed SBMH services were all referred by teachers or the principal. In Sara's situation she shared, "my mom made the referral, she said...you know, my mom referred me to the guidance counsellor and that's when we [she and the school counsellor] started talking." Effie shared "...I had an anxiety attack in class and I went to the guidance office and said I need to get out 'cause I couldn't do it and then, she came out and she started talking to me and I told her I was seeing a social service worker and I had these problems or whatever and that's when she [school CYW] actually got involved with it." Tyler stated, "I just went to her office there. After the principal tell Laura (CYW) there to help this kid or something." Williams et al. (2007) reinforced this finding by stating that referrals for children to access mental health services at school primarily begin with teachers.

The youth who accessed CBMH were suggested to attend by their parents, extended family members or their family doctor. Lucy remembered her experience with a psychologist, "The person I went to see before the school started was the professional psychologist my parents sent me to...during that time I was in an extremely deep depression, so yeah...I was thirteen, just turned 13....and my dad just kind of stopped taking me." Sara's mother also referred her to services in the community, "My mom was talking to the secretary and then you know. That's when we [Sara and her pastor] started seeing each other you know so..." A term that is identified in the literature relating to social and emotional need is help-seeking behaviours. As I have discussed earlier, the help-seeking behaviours identified in this study by the participants are related to relationship issues, bullying, losing a friend, suicidal thoughts, school truancy and social isolation. Amaral et al. (2011) reported that youth who experienced feelings of sadness, trouble sleeping, suicidal ideation, alcohol or marijuana use, a loss of a close friend or relationship or other health seeking behaviours were more likely to access school-based services. Should these help-seeking behaviours go unrecognized by people in the youths' lives, it could be a missed opportunity to prevent a possible future mental health problem. Based on this study, it appears that adolescents benefit from having someone to recognize when they are distressed and need someone to tell them how to access support. In this study, there were no distinctions made related to the reasons why some youth were referred to CBMH services versus SBMH services. It seemed to have been simply based on the awareness of services from the person who made the suggestions.

The Differences Between SBMH and CBMH Services

All participants but one, at the time of the study, had received mental health services from SBMH services and all of the participants had at one point or another received CBMH services. Therefore, they were able to provide a good understanding of both services. School-based mental

health services were available to students as needed on a daily basis and sometimes just to "touch base" with, while community-based mental health services were available by appointment only. The professional designation, according to the youth, and from my conversations with the child and youth workers (CYW), is that school-based mental health providers were child and youth workers and that the community-based mental health workers were social workers and psychologists. Participants in this study identified differences between SBMH and CBMH services as being both helpful and having some limitations.

Helpful services. Frank and Sam both agree that school-based mental health services were helpful in reducing their anger and helped to provide an alternative perspective on things. Frank stated, "It's just been helping to get it [his anger] all out and finally." Sam shared, "It [counselling] helped me see more about life". It provided Sam a different perspective on life. School-based mental health services were seen more as supportive counselling from the perspective of these participants and CBMH services were seen as treatment interventions. Lucy shared that SBMH service was a "good starter point" and provides daily support and according to Sara, it was "more hands on" in comparison to CBMH services.

Likewise, Pathak et al. (2011) claimed that school can be helpful to identify needs of students and provide support to youth at the earliest signs or symptoms of mental health needs due to the large amount of time that youth spend at school in comparison to what community-based services can offer. Schools are important partners in providing mental health services to children and youth. Based on this study, schools seem to be a convenient location for those requiring services. Williams et al. (2007) pointed out that a stronger partnership between schools, parents, communities, faith-based organizations, schools of social work and community-based treatment providers are crucial to meeting students' needs. The belief is that schools need

to be the primary service providers of support for children and youth and that community programs offer support (Aviles et al. 2006).

Lucy shared, related to her experience with CBMH services, "It was pretty helpful. I found the experience rather enjoyable". Frank spoke of good experiences with CBMH services because "they figured out what my problem is", as he further explained that they were able to offer him a diagnosis of his related mental health concerns. Effie spoke of an aspect of community services as that, "they work mostly out of booklets and stuff, so like group session booklets…" Aviles et al. (2006) claimed that schools who are ill equipped with suitable mental health services tend to receive support from community mental health programs until schools can adopt those programs and service youths' social and emotional needs. Community-based approaches are said to be effective with children who have moderate to severe emotional disturbances. It targets those who are identified as "seriously emotionally disturbed children" (Pumariega & Vance, 1999, p. 373). Based on this study, one could argue this point because the social and emotional needs of participants in this study who were seeking SBMH services were as serious as those seeking CBMH services. Sara sees CBMH services as less personal than that of SBMH services. She stated:

> …..they (SBMH) get to know you, your actions, they get to know your daily routine and exactly what you do at that certain time and they get to watch you, but with community-based, for example child and family services, they do not see you only when you go to counselling for that one hour and then the next week after that. But like, this individual will be able to watch how you communicate with your friend and where you go wrong and so...with child and family services they don't see you interacting with your friends you know...like if, for example she would flip out, she would see me flip out, she would know exactly like what happen and what went

> wrong and how I reacted and what I did. She would be able to observe and learn more about that person so...Community services you know, they don't get to really watch that.

Limitations of services. On the other hand, just like any other services there are some limitations identified related to SBMH services and CBMH services and these will be identified in this section. These limitations described by participants in this study were limitations in expertise, cultural barriers, accessibility, availability, the lack of awareness and lack of communication.

Limitations in expertise. One participant said that SBMH are limited in their expertise. Effie reported, while referring to SBMH services, "They don't really do much". She continues, "If you're having a problem in the class, then they'll kind of like help you kind of cope with it or find a solution to it but then after, it's really up to you." Similarly, Slade (2003) reported that schools are often not prepared to counsel adolescents or may lack appropriate services in general. Effie related, "...like Nat here, like she understands to a point of what's going on...but there's just stuff that's over her head that she can't understand. It's the same with the counsellors, like if you just get a counsellor that can't really get a feel for how you are then it really doesn't help at all. Madrox did not want to utilize SBMH due to his fear that it might not be as confidential as CBMH services. He stated, "...I sometimes feel like if I see her she can help but then people will walk by, look and see me in here and they'll start, oh you gotta go see a counsellor, ha ha ha...and then they'll start using that against me."

Cultural barriers. Cultural barriers, especially in smaller northern Ontario communities, can become problematic for some. Tyler shares a good connection with Aboriginal community-based workers; however, according to him the school does not offer culturally-specific mental health services. Tyler remembers his experiences with Aboriginal traditional healing methods.

He stated, “I went to Native ceremonies and they took away my pains there.” Tyler attended ceremonies such as “sweat lodge” and “drumming”. He had been referred by his paternal uncle to attend these ceremonies. Tyler also talked to “some Native lady” from a local Aboriginal mental health services. Tyler shares, “If you are around a Native person, you can feel their energy.” This aspect of cultural support is quite important for Tyler. He stopped services because “my mom’s always working.” According to Jackson and Samuels (2011), it is important for clinicians to understand the risk and protective factors that are distinct for the people of different cultures. Offering a culturally competent practice aside from addressing the presenting problem is an important consideration when working respectfully with someone who is of a different culture than that of the practitioner. Despite the fact that Tyler would prefer an Aboriginal worker, he claims that the CYW that he sees at the school helps. He states, “I feel better” when he talks to her.

Accessibility. Accessibility such as transportation has also been identified in the literature as being a limitation to CBMH services. In the area where this research was conducted, the community-based agencies are quite dispersed and away from the school. Thirteen reported that she typically has to walk “45 minutes to one hour depending on the weather” to get to her weekly appointments in the community. Masia-Warner et al. (2006) have also identified transportation as a limitation to community based treatment. Tyler shared that he is unable to practice cultural traditional healing due to his lack of time after school caused by other responsibilities at home and having no transportation to get to the location. He stated, “Like I would see a Native counsellor too but my mom she’s working after school. My dad start working at the same time I’m going to be home alone with my brothers. My mom and dad know I’m ready, to babysit my brothers.”

Availability. Participants also identified availability of the mental health service as a limitation. School mental health workers have very limited time to spend with students. Effie stated: "it would be a lot easier if they (CYW) were more accessible because you have to be part of the (resource) group to just have, you know, actually face to face time with the consultant here. Because the CYW is really hard to find, like, they are never in the office or anything". The "group" she is referring to is people who have been identified as requiring special needs. Effie is referring to the availability of the support at school and believes it should be more available. In terms of CBMH, Effie shared that the challenge was that if an appointment was cancelled, it was really difficult to get another appointment in a timely manner due to the clinician's busy schedule. Effie related,

> "like before I went to Nat myself, no one paid any attention to missing school a lot or ditching classes halfway through because they just think you're being a stupid teenage. Yeah, there gets to a point that if you're missing three weeks at a time that there's actually something wrong".

Effie also commented. Possibly, if the service providers had more time, they would be better at recognizing the mental health needs in the schools.

Lack of awareness. Some of the participants identified that teachers were not well aware about how to recognize their social and emotional needs nor did they know how to help address these needs. Effie expressed, "no one paid attention to missing school a lot". Again Effie explained when referring to not feeling supported, "Yeah, I think it would have been a lot easier to come to school if I would have felt that there was someone there that I could go to that if I needed help..." The level of awareness about mental health needs in the schools is very important to the participants and it has been identified as a limitation. Effie stated, "I think that would really help if the teachers understood more about mental awareness like how to help us

and stuff. It would make it a lot easier and just better." Some participants did not feel as though their school was supportive of their social or emotional needs and this made it quite difficult for them to attend school altogether.

Effie and Thirteen both had struggles with anxiety symptoms and missed a lot of school. Effie shared, "the school kind of knew because I was never in class...I just avoided people entirely so they started realizing there's something wrong here 'cause she's never around and she avoids us like the plague." Thirteen shared her experiences with anxiety, "I get really like worried in class and stuff sometimes and I don't really know what to do with it because nobody else knows about it." Based on their perspective, no one from the school acknowledged that they were struggling and they were never offered support by their teachers. Teachers are instrumental in recognizing mental health needs and referring children and youth for mental health support (Williams et al., 2007). Since teachers could have an instrumental role in referring youth for mental health services, some participants think that they should be provided with more education to help them recognize signs and symptoms of mental health needs. Thirteen felt that if the teachers in her classroom had been more educated on symptoms of mental health they could have recognized her need for support and addressed the issue earlier. She shared, "there are teachers who don't understand and they're just basically on you all the time thinking you're just a crazy student trying to get in trouble all the time but you're not, you just can't control that." Effie explained a similar situation where she requested help from the support staff at the school while experiencing an anxiety attack; however, no one was able to help her with how to deal with these symptoms of anxiety. She explained, "I had an anxiety attack during lunch one time and I went to the office and they had no idea what to do."

Lack of communication. Another limitation found in this study was the lack of communication between CBMH and SBMH services and within the school environment when it

comes to supporting participants. The participants who had CBMH services expressed a gap in the continuity of services at the school which is seen as beneficial support. Effie shared that while she was receiving CBMH services, the teachers or CYW were never made aware of what her struggles were and felt that people at school did not understand her needs. She stated, "It would be even easier if the school and social services had more of a like aligned to each other. Because it's really cut-off, they're completely two separate places." Effie was struggling with social anxiety and missed a lot of school. She remembers that no one addressed her repeatedly missing school and she believes that it was simply seen as her being a "rebellious teenager" rather than as help-seeking behaviour that needed attention. Thirteen had a similar experience whereas she expressed that she did not even know that SBMH services were in existence in the two years that she had been in high school. She states, "I didn't know there were people here for it." Lucy also believed that CBMH services and SBMH services should go "hand in hand" and work in collaboration with each other to provide effective support.

Brener et al. (2007) stated that collaboration between school mental health and community-based mental health is critical to the success of SBMH programs. Aviles et al. (2006) also supported the importance of collaboration between teachers and the mental health professionals at CBMH services as the service options can get quite confusing for adolescents particularly when discussing treatment processes. Participants expressed at times feeling confused and not knowing what to expect from the support. Effie remembered feeling confused when she was waiting for a telepsychiatry consultation while receiving CBMH services. She remembers this having taken so long and no one explained to her the reasons for the wait. Effie was feeling, "totally in the dark". Sam also had difficulty understanding the role of the clinicians that were involved and would get confused particularly between the roles of the mental health workers and child protection workers. He stated, "if they had less workers and would explain some of the

stuff better maybe I could understand." The services had not been made very clear for him at the time.

Should these issues be addressed, it could encourage more youth to participate in mental health services. The importance of this has been identified by Brener et al. (2007) who said that failing to provide students with the appropriate mental health services has played a significant role in school performances such as high dropout rates and poor grades. The limitations to CBMH and SBMH services have been significant as all of the participants have expressed some type of concerns with the services. The following section will identify how youth have been referred to these mental health services.

Despite the perceived helpful and limitation aspects to both CBMH services and SBMH services, they do offer different services related to the identified purposes and needs. Bronstein et al. (2011) pointed out that although the role of the SBMH services and CBMH services may have some differences and similarities the services are both considered prevention intervention.

Benefits of services. The participants in this study expressed that they were pleased with the services received from school-based mental health (SBMH) services and from the community-based mental health (CBMH) services. This section discusses participants' thoughts on the size of the school and the importance of the therapeutic relationship and connectedness as benefits of the services they had received.

The size of the school. Participants in this study noted that the size of the school matters. The size of the schools was a theme that was discussed by a few of the participants. It was reported that in a smaller school environment, youths' social and emotional needs could be more easily recognized and addressed. Frank reported that in his smaller school, his behaviours tended to be noticed much more in comparison to his old school. He shared, "It's a small school, they can find out fast", while relating to a time when he acted out and reacted in anger at school.

Another participant, Sara shared that being in a small school helped her to avoid getting into an altercation with another student due to the vice-principal having intervened before the problem got bigger. Another advantage to being in a smaller school was being held accountable to apply the strategies suggested by the clinician at the school.

Sara stated that with CBMH it was less likely that she was held accountable for not practicing the strategies that were recommended because therapy was based primarily on self-reported information. She stated, "with a counsellor at a community service you know like they don't know the real story and they just take your word for it you know so...yeah." Based on the interviews, it seemed that participants from smaller schools felt more supported at school and school staff were more prepared and available to intervene than at the larger schools. In the larger schools, the participants noticed that even though the teachers would notice that they were not in class or skipping classes, they would not inquire about it. Effie stated, "They never really did anything but they knew what was going on". This might have been due to the teachers not knowing what to do or not knowing how to approach the matter with the students.

Connectedness. All of the eight participants agreed that connectedness and trust were important qualities in a helping professional. The participants have supported that connections are one of the main reasons they return for services after the first time; they say, it is because a connection was made and they feel a sense of belonging. Sam admits that he does not like talking about his "problems;" he prefers to just touch base with the child and youth worker simply because he feels "she worries about me" and stops in to see her in her office to talk about his day "so she doesn't worry about me." Sam does not attend school very often; however when he does, he makes it a point to touch base. This is a clear example of how powerful good connections can be for adolescents.

Connectedness is a term that appears frequently in the literature about SBMH support. In a study by Nabors et al. (2000), they reinforced this finding by stating that youths in their study reported that counselling was a place where they could work through problems and feel a sense of connectedness with their school and learn important life-skills. The comfort of feeling as though they matter to someone is part of what secures that connection. Sara stated that she enjoys going to see the CYW at her school as it makes her feel as though someone at school cares for her. Sara stated, "…she (CYW) doesn't seem like she gets paid to be here…" The noted quality as identified by the participants is also recognized by Nabors and Prodente (2002) who shared that adolescents, who see their relationship with their therapist as being warm and caring and perceived their therapeutic relationship as being positive, reported high levels of satisfaction with their services. To build a connection with a mental health worker takes time, according to Sam who said, "To make the service [SBMH] more attractive to youth, they would need to get used to the counsellor." This point reflected that connection and trust takes time and this may not be something that youths consider when they first think about seeking support.

Trust was described in this study as a sense of comfort in being able to share personal things with the therapist. It was also defined as feeling a sense of mutual understanding. In this study, all participants have indicated that trust was important to them. Effie stated: "If they (clinicians) don't understand you, they can't help". Lucy shared her belief that first impressions are very important and will determine if a youth will want to go back for more services. Effie referred to trust and comfort being important because "…it [counselling] makes you want to talk about things that you really don't want to but know you have to." In order to be able to open up and get help, youth are stating that trust and connection permits them to do so and therefore create a more successful treatment outcome.

However, some of the participants like Effie did not feel a connection to her school because according to her, no one really inquired about their state of her mental health despite numerous absences from school. Effie shared her experience, "I think it would be easier to come to school if you knew that the teachers actually kind of cared that you were, you know...they're just, they don't care if you're having mental issues you got to do how everyone else is doing." Thirteen did not even know there were services available "I didn't know there were people here for it", she expressed related to SBMH services. Despite the lack of perceived support at their schools, both did feel a sense of connection to their CBMH worker. The participants in this study expressed the need to feel connected and to feel as though someone cared for them as it provided a sense of belonging and made them want to come to school. Waters et al. (2012) shared the same message that for adolescents, a connection to school, peers and family, means that they are less likely to be involved in antisocial or risk taking behaviours such as initiating drug use, being absent from school, being bullied or experiencing mental health difficulties. Sun and Hui (2007) also emphasized the importance of belonging and connecting as a protective factor against mental health illnesses.

This study consistently reported that it was important for participants to feel a connection and a sense of belonging. The section above discussed the benefits of mental health services, which is deemed to evidently provide some positive experiences to participants who utilized it and have had some positive outcomes for addressing the social and emotional needs of participants. The other, less positive side to services are the limitations to services which are further discussed in the next section.

Recommendations Made by the Participants

There have been three recommendations identified by participants on ways to improve SBMH and CBMH services based on their own experiences. These include promotion of

services, having access to a clinician or CYW of either gender, more support and less service restriction.

Promotion of Services

The first recommendation that was discussed by most of the participants was increasing the promotion of the services being offered and ways to access it. The concern was that some participants did not even know that mental health services were even in place at their school. For example, Thirteen stated, "I didn't know there were people here for it." She had no idea that mental health services were offered at the school and she is now finishing her second year in that particular high school. Many recommendations were made on how to promote the services in the schools. Thirteen recommended putting "posters all over the school" to advertise for the counselling services. She was surprised that the school has posters all over to advertise for concerts being held at the school; however, there were none that advertised the counselling services. Lucy suggested "I think instead of just having an assembly about being aware of abuse and reporting it to a teacher, have an assembly about how you can stop it (abuse) and if you're aware somebody who can go to help you, someone like Mr. D. [CYW]". Sara also recommended when asked what would help in promoting services at the school, she responded "...for people who are shy and have nobody like I don't know, signs around schools, like more..." Sara suggested that the school CYW facilitate a type of activity like a potluck where students could begin to build a connection with the CYW and possibly other students who have mental health needs. Sara stated,

> Sometimes they do activities in the gyms and stuff like that. Do them with the counsellor, like get a group of people ask teachers who you think should get into this group and even for people who don't need it so that it doesn't look as obvious and so get people to all do an activity together and then a trust thing. They'll be like oh you know, she's pretty cool

you know, and do more activities just one you know...more activities with people, you know...

Clinicians of Either Gender

The second recommendation suggested by the participants was having access to clinicians of both genders available to provide mental health services to adolescents. The hope would be that having access to a clinician of either gender would make the services more motivating to youth who may not be comfortable receiving services from someone because of their gender. In this study, the participants related their interest in seeking services from someone of their gender preference as it was more comforting to them and easier to open up to about personal issues. Lucy shared, "I do think that gender matters. Because personally, I'm more comfortable with men than I am with women." Lucy proposed that it would also be ideal to match the personality of the clinician to the personality of the youth. Lucy stated, "I think perhaps that maybe before somebody gets assigned to a worker that the workers should each have a profile and then the client should be interviewed before being assigned a worker." Sara also agreed that there would be a significant benefit to having both genders available for counselling services. She stated, "I personally think that because if you feel that ah well, it's a girl, you know I don't like girls and you know...you get to talk to a male or something...you never know if it could save somebody's life. You know..." Sara also stated, "I think they should still have both counsellors male and female. Because then, I personally think it would lower the rate of suicide". This is Sara's belief based on her life experience; however it has not been justified in the literature.

More Support

The third recommendation identified by participants is to feel more supported at school and in the community with less service restrictions. The participants have suggested that CBMH and SBMH services collaborate more with one another in order to provide the best services. As

much as it was suggested that CBMH services communicate more openly with the schools, they also said that schools need to collaborate and communicate with community services in order to offer the best support possible. Some of the participants identified that they would like for their CBMH workers to connect more closely with their schools as they would feel more supported at school and outside of school. Effie and Thirteen explained how much they would have benefitted from the school support at the time if they had been aware that this was available. When Effie was asked if she would have reached out for help from the school if she had known about the mental health services being offered, earlier on she stated, "I think it would have been a lot easier to come to school if I would have felt that there was someone there that I could go to that if I needed help…"

Madrox expressed that even though he felt comfortable with the idea of seeking services from the CYW, he chose not to because of feelings that the CYW or the teachers could not do anything about the bullying anyway. He stated, "I don't know if there's anything really negative that sort of had on it other than the fact that kids if they found out they can use it like against me….Yeah, if the bullies found out then they would just…they would just have a lot more to use against me." Consistent with Madrox' concerns, Sun and Hui's (2007) indicated from their study, that one youth reported that he could not share info with his teachers, social workers or others because those people could not control the teasing that was happening. Their conclusion from that study was that one person providing support is sufficient to foster adolescent adjustment; therefore, if at least one teacher or school staff got involved, they can offer support as they recognize the need.

As has been discussed earlier, Brener et al. (2006) affirmed that collaboration is critical to the success of SBMH programs and both programs should be continuously finding better ways to collaborate. Frank also stated that if it had been suggested to him, he would have accessed

CBMH services. Participants want to feel cared for and supported by their schools and that means being offered the support. Sui and Hui (2007) emphasized that a caring and supportive school system in general, with close teacher to student relationships, is vital to adolescent mental health. This can also strengthen a youth's sense of school belonging. Mental health professionals need to be mindful that sometimes youth may need more than what the service can provide. Sometimes, services that are offered to help students may be limited to the professional's scope of practice or level of comfort and they may need to refer elsewhere.

Less Service Restrictions

Participants suggested that there be less service restrictions related to the delivery of the service. Some participants identified SBMH services to be restrictive in terms of their delivery of service. A couple of them proposed the possibility of having more CBMH services come to their school. Tyler shared that he would have liked to have an Aboriginal worker come to the school to provide culturally focused mental health services. He stated, "I just need a Native counsellor and I'm good to go." Thirteen shared that it would be nice if a CBMH worker could come to the school to provide services as it would address the barrier of transportation and stated, "The long walk, yeah...if it was closer it would definitely be a lot more helpful."

Another service restriction that would be beneficial to address, according to the participants, is for the mental health professionals to expand their scope of practice and to have it more individualized to the service recipient's needs. Lucy gave an example that the women in crisis service is a lot more flexible with meeting the needs of the individuals they service than the school was able to offer. Lucy stated in reference to the services provided by women in crisis, "...it's not, it's more of like a charity organization rather than a public service. So it's a lot easier for them to be able to help more than the other ones without having all the legal boundaries." For example as Lucy stated, "they'll help find housing for you, they'll find furniture for you, and

they'll find clothing for you, anything." This was a need that was important to this particular participant. Schools unfortunately do not have that availability or the time to offer this support and community-based programs do not have the time and it is not typically a service they offer, according to Lucy. Lucy stated, "Mr. D. kind of goes like beyond his call of duty where he goes to the extent where he is taking people to where they need to go and he's driving people to appointments."

As indicated in this chapter, there are various aspects to this analysis that will be helpful in understanding the perspective of participants' views of receiving mental health services at school and in the community. As much as there are benefits to these services, there are also limitations that impact youths' interest in reaching out for help or to continue receiving support due to these limitations. Based on the four recommendations identified in this study, there are ways that services can be improved to best help youths in need of social and emotional support. As has been seen in the Literature Review, there are benefits for youth who access mental health services. The Children's Mental Health Ontario data testing of 1998-99 showed that mental health treatment at any age resulted in a 67-76% reduction of mental health problems (Stevenson, 2003). Therefore, it may benefit youth if we considered and addressed these recommendations provided by the participants as it would serve as an advantage to support adolescents who accessed mental health support.

A Review of the Ecological System of Human Development

In this particular study looking at the social and emotional needs of adolescents and how those needs were met was reflective of how the ecological system of human development identifies the needs of youths. The ecological system of human development was used to describe different perspectives of participants' environment and systems that impact the need for mental health

services. The reasons this theoretical framework was utilized in this thesis project, was to take into consideration the different systems that offer support to participants. Bronfenbrenner's ecological system of human development consists of five interrelated systems, the microsystem (immediate family, daycare), mesosystem (neighbours, school, religious groups), exosystem (government, extended family and family network), and the macrosystem (values, laws and cultures) (Swick & Williams, 2006). Each of these systems impacts children and adolescents in various ways during their developmental stages. The ecological system of human development suggested that mental health and social and emotional issues are more than just individual problems. Doll, Spies and Champion (2012) stated that vocational and social successes are ecological factors contributing to a student's life success overlapping with academic success. The ecological system of human development also helps young people understand their own life issues from a more systemic perspective and depersonalizes some of the related struggles they may be encountering. In fact, Sun and Hui (2007) indicated "…the importance of the human ecological theory of Bronfenbrenner highlights that adolescent development is interlocked with their surroundings, and thus adolescents are troubled when there is a lack of balance between systems" (p.299).

Participants identified that the support they received from schools, immediate family, pastor, extended family, employment funding for counselling services were some of the reasons they actually went through with accessing mental health support. The participants, who recommended changes to the mental health services in schools and in communities, identified some changes that were part of a larger system change. They identified that changes needed to be made at the Ministry level such as needing more CYWs, and the participants also recognized the importance in using the media posters to promote and educate the schools about mental health. Thirteen mentioned, "I just think maybe if they had like a commercial on T.V., like around the community or even if they had posters up in the school..." when relating to the

promotion of the services. The participants also recognized the importance in having someone in their environment that can support them and encourage them to access mental health services such as their family, extended family, teachers and family doctors as identified above in the section on connectedness.

The ecological system of human development was helpful in identifying the recommendations from the participants' perspective related to the changes that could be made to mental health services and also for the purpose of future research on this topic. The rational for this approach is that rather than blaming the individual youth as being the problem, the ecological model of human development supports the importance of addressing the root of the concern and the structural barriers as required (Haynes, 2002; Vanderbleek, 2004). Participants who were part of this study commented on how good it felt that their experiences could be utilized to impact mental health services in one way or another and potentially instil systemic changes. The ecological model, in addressing the social and emotional needs of youth, cannot be overlooked in either setting at the school or in the community. It is a vital piece that keeps youth connected and supported to their systems.

Conclusion

This chapter reflected a discussion about the results of this study, which highlighted the data collected from the participants and created a link between the participants' perspective and the existing literature. The next chapter will capture the conclusion, strengths, limitations of the study, the implications to social work practice and recommendations for future research.

Chapter 4 - Conclusion

This study used a qualitative method to explore the social and emotional needs and perceptions of youth accessing school-based mental health services and community-based mental health services. Seven of eight participants in this study had accessed mental health services in the community and all of the participants had accessed mental health support at school. Therefore, it would appear as though schools are also important locations to address the social and emotional needs of adolescents. This study highlighted themes about the benefits of mental health services, limitations to mental health services, and participants' recommendations to improve the services. It is hoped that these recommendations will provide future guidance on ways to address the needs of youth accessing mental health support in the community or in the schools. The theoretical underpinnings of this study, ecological system of human development theory, helped to understand youths' challenges from a structural context rather than as an individualized challenge. Sun and Hui (2007) have said that the ecological model helped young people to understand their own life issues from a more systemic perspective and depersonalized some of the related struggles they may be encountering. In this chapter, I will be discussing a summary of the study, the strengths and limitations of this study, recommendations for future research, and the implications for social work practice.

Summary of the Study

The purpose of this thesis project was to understand the social and emotional needs of adolescents receiving school-based mental health services and community-mental health services. The method utilized to gather this data was through individually interviewing eight participants between the ages 15 to 17 years old. The conclusion was that participants had positive experiences with the services they were receiving at the time of the interviews and they also expressed some limitations to services.

This study helped to clarify some questions that were identified in the literature about adolescent mental health needs and other important components to adolescent mental health services from the perspective of youth. This study has some definite strengths such as the fact that it has added to our understanding about youths' perspectives regarding mental health services. However, it also has some limitations related to the fact that it did not fully address the initial research question which was intended to explain the social and emotional needs that motivate youth to want to access mental health services, and the differences between the services that they reach out to for support. Despite not having the question fully addressed, the project did provide some understanding about what participants want from service providers, what participants feel are challenges, and what participants would like to see happen differently. Overall, this study was a good contribution to the knowledge related to mental health services from the perspectives of youth; however, there are questions that remain to be explored through research on adolescent mental health mostly related to the differences between CBMH and SBMH services.

Study Strengths

This thesis project was meant to be a reflection of participants' experiences with mental health services received in the community and at school. In my experience, the participants in this study were very forthcoming with information and open about sharing their experiences; they all appeared to have a level of comfort with the interview process. The first strength identified in this study is that, because I did the individual interviews, I was able to hear first-hand the information provided and start the analysis from the moment the information was shared. This helped me to really follow the participants' stories without imposing my own interview agenda or restrict the participants to only the interview questions. I was able to encourage the interview to flow naturally while still remaining true to my research questions.

The interviews were based on what the participants felt comfortable sharing. The participants seemed to have had a positive experience as they were not hesitant to meet with me again for a follow-up interview. A few of them were comfortable sharing in-depth information about their social and emotional reasons for seeking mental health services. This allowed me to obtain a general sense of the positive and negative experiences they had with mental health services. Also, it helped me to obtain an understanding of how services and processes could be changed according to the youths' recommendations, which were based on their past experiences.

The second strength was that this study provided knowledge about the topic to the community including the schools providing the mental health services, and me as a mental health practitioner (which I will share with my agency and colleagues). This knowledge is based on what participants found helpful and beneficial and what was considered to be a limitation to mental health services along with their recommendations on how these services could be improved. This study will be helpful to me personally as a mental health practitioner because I have taken into consideration all of the participants' feedback regarding how important the connectedness with a practitioner is for youth who are receiving mental health services. The information gleaned from this study will be shared with those in my community who provide mental health services to adolescents; the results may serve as a guideline for recommendations to instill change in the current and future services in the field of adolescent mental health. The only other study that was similar to mine was the one conducted by Nabors et al. (2000) who had interviewed youth about their experiences with a school-based mental health service in one particular school. In that study, they utilized focus groups as their method for data collection. I utilized individual interviews which was helpful in providing youth the opportunity to share their personal stories about their own experiences in a private and confidential setting. The richness of the information gathered from the interviews is a significant strength of this study.

A third strength is that participants all had experiences receiving both types of services, CBMH and SBMH, from the past up to the present day, except for one of the participants who had not received school-based mental health services before. The participants all presented a good discussion of their experiences related to each of these services and provided their own personal version and perspective.

Study Limitations

Although there are strengths to this study there are some limitations to consider. The initial hope when I first started the interviews was to understand in-depth the social and emotional needs that motivated youth to access mental health services at school and in the community. As the interviews began, it was clear that these aspects were really difficult for the youth to articulate; however, when participants were asked what their experiences were with mental health services, they began to identify their personal experiences with the particular service and talked somewhat about their social and emotional needs which motivated them to access mental health services. It seemed that the reasons youth accessed support in the first place was related to mental health symptoms, anger management difficulties, and experiences of bullying. The study shifted from wanting to understand why youth seek CBMH and SBMH services to a greater focus on what their impressions were (positive and negative) related to their experiences with mental health services. Most of the participants were comfortable enough to tell me the overall reasons they were seeking mental health services; however, not everyone was able to remember what their exact steps were for accessing services. I chose to follow the flow of the participant's conversation during the interview by simply trying to gain a general sense of their experiences, why they chose to access services and if they would do it again. I also asked the participants about what they would change about the service they received. Despite my initial intent to understand why the participants had chosen to seek services, I think that I have accessed

substantial information about their overall experiences. Another limitation of this study is the sample of participants was smaller than had been anticipated. The goal was to obtain 10-15 participants and only eight could be recruited to participate. If I had more youth participants, my understanding of the issues highlighted in this study would be more rich and in-depth.

In considering the strengths and the limitations of this study, there are some topics that could be further explored in order to contribute to our understanding of the experiences of adolescents receiving mental health services. The next section will explore some of the suggestions for future research on this topic.

Suggestions for Future Research

Based on this study, there are few aspects that I would recommend to be further explored. It would be interesting to know more about the distinction between the CBMH services and SBMH services as this study was not able to gather a thick description of the participants' full understanding of what the role of each service was and what treatment one service provider could offer versus the other. There could be a study done on the differences between SBMH and CBMH services based on the perspective of youth along with the perspective of the service providers. Consistent with Bailey (2000), there is a need for future research in the area that does a comparison between school-based mental health services and community-based mental health services. It would be interesting to understand the differences between the types of services the provider offers and what types of services are perceived and desired by the service user. It would also be helpful to understand the reasons that certain services are being utilized versus the other and whether they are actually meeting the needs of youth.

Despite having touched on some of it in this study, there is still a need for further understanding of what is offered to youth in community–based programs in comparison to school-based mental health services related to the treatment modalities being offered in each of

the service areas such as evidence-based treatment models and supportive counselling In addition, future research may include the educational background or expertise of the service providers of both CBMH and SBMH along with evaluating whether this impacts or limits the treatment intervention. It would help to clarify the roles of clinicians based on their scope of practice and whether this has an impact on the effectiveness of meeting the needs of youth. This particular research study did not involve the educational background and scope of practice related to the service provider. Finally, an area that would be interesting to explore in future research is gaining a better understanding of what the supports are that youth perceive as being a helpful factor in meeting their needs aside from mental health services. Also, what roles do families play in fostering mental health care for adolescents? That topic was not addressed although it was mentioned briefly by a few of the participants in this study.

Implications for Social Work Practice

In this thesis project after having heard youths' experiences about receiving mental health services, they have provided several recommendations that social workers who practice in the community and in schools can implement to improve the services they offer. Participants described interagency collaboration and how important it is for clinicians to communicate with each other in order to provide the best system of care for youth. Although McManama O'Brien et al. (2011) reported that school social workers' collaboration with teachers is limited; participants in this study have suggested that more collaboration is required in order for them to feel supported in their environment. As social workers, we also need to understand more about the differences between the roles of mental health providers at school versus the mental health providers in the community as this, along with collaborative communication, may help to identify what needs should be addressed in school and what needs should be addressed in the community and how we, as social workers, can provide optimal social work services.

Another aspect for social workers to consider is how important the therapeutic relationship and connection were to the participants of this study. Their recommendations were mainly related to services provided by the school as most participants from this study expressed feeling comfortable accessing school support and services. According to Nabors et al. (2000), youth participants saw counselling as a place where they could work through emotional difficulties and increase their level of connectedness not only to their schools but to also to their families, and learn important life skills and improve academic performance. These are considered protective factors for adolescents to improve their mental and physical health (Nabors et al., 2000). Sun and Hui (2007) agreed by stating that school guidance and counselling helps to reduce adolescent suicide risk and promote support of families, schools and peers along with improving adolescent resiliency. This same study related the importance of educating teachers to build a friendly and approachable rapport with the students and initiate the contact. These are all interesting points from the literature and are important to the field of social work related to the direct practice with adolescents, and also for advocacy work related to educating teachers and other professionals regarding the importance of therapeutic relationships and connectedness with youth.

One participant in particular highlighted the need for culturally-specific mental health services. This participant said that Native cultural healing methods should be incorporated in the mental health service delivery for Aboriginal youth who express interest. According to Jackson and Samuels (2011), "providing culturally competent practice, irrespective of the presenting problem and its cause, is a central tenant of ethical social work practice" (p.236). As social workers, ensuring the availability of culturally-specific services for Aboriginal youth could further support them in ways that non-traditional services could not.

There is also a need for additional mental health support in northeastern Ontario. One child and youth worker for a school of approximately 900 students is not nearly enough to provide

effective support with mental health needs; this was the case for one of the schools where the interviews were conducted. Harsy (2012) has recommended a caseload of 300 students per school counsellor. Social workers should advocate for additional mental health in small northern Ontario communities such as the one in which this study was conducted, especially when it comes to children and adolescents. Social workers could also be educating the Ministry of Education and Ministry of Child and Youth Services to help support more research relating to the social and emotional needs of youth. This would mean implementing more mental health workers in the school in order to further benefit youth and the mental health services with which they are provided.

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Appendix A
Letter of Support

DISTRICT SCHOOL BOARD ONTARIO NORTH EAST

☐ Schumacher Board Office
Mailing Address:
P.O. Box 1020
Timmins, ON P4N 7H7
Tel.: 705-360-1151
Fax: 705-268-7100

☐ New Liskeard Board Office
Mailing and Street Address:
R.R.#1, 198022 River Road
New Liskeard, ON P0J 1P0
Tel.: 705-647-7394
Fax: 705-647-9212

October 10, 2012

District School Board Ontario North East
Schumacher Board Office
383 Birch Street North
Timmins, ON
P4N 2B7

Susan James
President of Research Ethics Board
Laurentian University
935 Ramsey Lake Road
Sudbury, ON
P3E 2C6

Dear Ms. James,

I am writing this letter on behalf of District School Board Ontario North East consenting for Tanya Genier to proceed with her research taking place in both of the high schools within the District School Board Ontario North East of the Timmins area. The high schools include Roland Michener Secondary School and Timmins High and Vocational School.

Should you have any further questions, please do not hesitate to contact me at 1-705-360-1151.

Yours sincerely,

Steve Pladzyk
Superintendent of Schools

Appendix B
Community Resource List

Community Resource List

North Easter Ontario Family and Children's Services	707 Ross Avenue Timmins, Ontario P4N 8R1	***Tel: (705) 360- 7100*** *Fax: (705) 360- 7200*
Kunowanimano Child & Family Services	38 Pine St. North, Suite 120 Timmins, ON P4N 6K6	***Tel: (705) 268- 9033*** *Fax: (705) 268- 9272*
Misiway Eniniwuk Community Health Centre	130 Wilson Avenue Timmins, Ontario P0N 1H0	***Tel: (705) 264- 2200*** *Fax: (705) 267- 5688*
South Cochrane Addiction Services	85 Pine Street, Suite 2 Timmins, Ontario P4N 2K1	***Tel: (705) 264-5202*** *Fax: (705) 264-3011*
Timmins & District Hospital	700 Ross Avenue East Timmins, Ontario P4N 8P2	***Tel: (705) 264-3003 (crisis)*** *Tel: (705) 267-6309* *(in-patient)* *Fax: (705) 264-6525*
Kid's Help Phone		**1-800-668-6868**

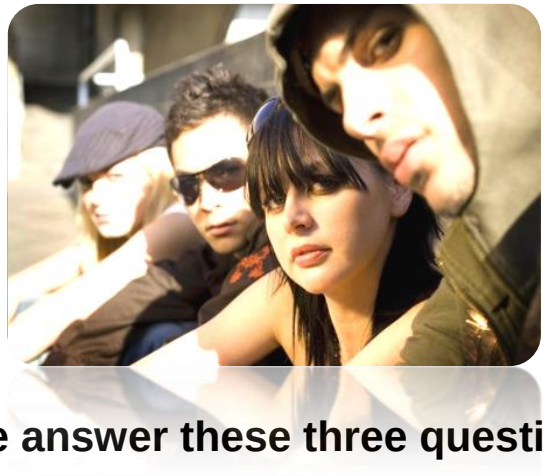
Appendix C
Recruitment Flyer

WANT TO MAKE A DIFFERENCE TO CHILDREN'S MENTAL HEALTH SERVICES OF NORTH EASTERN ONTARIO?

Have you ever received mental health services in your school or other places in the community?
Are you interested in sharing your experiences?
Do you have one hour to spare?

Would you like to be part of a research study?

YES??



Please answer these three questions:

1. Are you between the ages of 16-17 years old?
2. Have you received school-based mental health services from a child and youth worker, guidance counsellor or social worker since starting grade nine?
3. Have you received other mental health or counselling services through the community (North Eastern Ontario Family and Children's Services, psychology services, private counsellors) since starting grade nine?

If all three answers are YES?

Please write your name, contact number, and/or email address, place it in the attached sealing envelope so that it remains confidential, and give it to your school child and youth worker who will gladly forward it to the student researcher Tanya Genier: tx_genier@laurentian.ca and will be contact with you to meet to hear what you have to say

Name: _____ Telephone Number: _____ Email:_____

When would be a good time to contact you? _____

Appendix D
Consent Form

CONSENT

Study: Exploring the Social and Emotional Needs of Adolescents Receiving School-Based Mental Health Services and Community-Based Mental Health Services.

Investigator: Tanya Genier , M.S.W. student: tx_genier @ laurentian.ca

Supervisors: Dr. Diana Coholic and Dr. Leigh MacEwan, School of Social Work

I am a Master of Social Work student at Laurentian University in Sudbury, Ontario. I am interested in learning about the social and emotional needs of youth ages 16-17 years old who are attending a high school within the District School Board Ontario Northeast in Timmins, Ontario and have seen a school-based mental health worker (for example, a child and youth worker, social worker or a guidance counselor) and/or received community-based mental health services. I would like to understand your ideas about this helping experience. Some of the benefits of participating in this study are that you can help us better understand the needs of adolescents in your community to hopefully create positive changes to the services offered in the schools and the community.

By sharing your ideas with me, it is possible that your experiences will help us to understand how helping services should be provided in or out of the schools. There is a chance that you might feel some stressful feelings during our discussion. If this happens, it is important that you talk to someone about it. I will give you a list of people you could call or you could talk to such as the district school social worker, your teacher, or the guidance counselor. If you feel uncomfortable at any time, we can stop the interview. You can decide to leave the study any time you want without any penalty or consequence. I only want to talk to youth who want to be part of this project. It is completely up to you whether you are involved or not.

If you agree to be part of this project, you are asked to participate in two interviews. Our first discussion might take about 60 minutes and will be audio-recorded to ensure that I do not miss anything that you have told me. We can meet at your school at a time that suits you. In this interview, we can talk about your experiences and ideas related to your mental health services. After I have a chance to think about what everyone has told me, I would like to talk to you again to check my ideas. This second conversation will take about 30 minutes. During this conversation, you will be able to tell me if there are things that I may not have understood properly and you will be able to add any other thoughts that you have thought about since our first discussion.

The information that you share with me will be kept confidential which means that only I and my supervisors have access to it. However, if you are under l6 years of age or if you are over l6 but still involved with the Children's Aid Society, I have a legal obligation to report to them if

you were to tell me that you are being hurt by someone. There are some limitations to the information I am allowed to keep confidential. I have a professional obligation to report to the proper authorities if you tell me that you are having serious thoughts of ending your life, if you are having thoughts of seriously hurting other people, if you tell me that yourself or someone under the age of 16 years old are being abused or neglected. In a summary of the report, otherwise, you will never be identified with your name or any other identifying information and particularly when I share results of the project with others.

Once this research project is done, my supervisor (Diana Coholic) will keep your contact information/consent form in a locked filing cabinet at Laurentian University for 5 years; after 5 years, she will shred this information. I will erase our interview from the digital recorder and my USB key when the project is done.

Should you have any questions about the project, you could call or email my supervisors:
Diana Coholic, dcoholic@laurentian.ca, 1-800-461-4030, 5053, or
Leigh MacEwan, lmacewan@laurentian.ca, 1-800-461-4030, 5059.
If you have questions about the research ethics, you could email the ethics officer at ethics@laurentian.ca, 1-800-461-4030

My contact details are: Tanya Genier, tx_genier@laurentian.ca

By signing this form, you agree to take part in this project and you're letting us know that you understand everything on this form. You will get a copy of this form that you can keep.

Participant Name: _____ Date of Birth: _____

Participant Signature: _____ Date: _____

Witness: _____ Date: _____

School: _____ Grade: _____ Gender: M / F

If you could like a copy of a report about the results of this study, please provide me with an email address or mailing address, and I will send this to you when I am finished this project:

Email address: _____ Mailing address: _____

_____

_____

Telephone number: (home) _____ (cell)_____