SCHOOL-BASED HEALTH HUB (SBHH) CHANGE PACKAGE

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Vancouver CoastalHealth

SQI SPREADING QUALITY IMPROVEMENT
Specialist Services Committee

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EXECUTIVE SUMMARY

Imagine a school where a child or youth struggling with trauma and untreated health issues can step out of math class and walk down the hallway to access a doctor, counsellor, nurse practitioner, or youth worker in a safe, familiar setting. That's what School-Based Health Hubs (SBHHs) achieve. SBHHs are a proven, community-driven solution that breaks down barriers to care, improves health outcomes, and strengthens academic success. Born from the passion of physicians, school staff, and child and youth services, these hubs provide accessible, youth-centred health care where it's needed. The evidence is powerful: fewer emergency room visits, lower teen pregnancy rates, stronger graduation outcomes, and—most importantly—youth who feel seen, supported, and cared for.

This report captures the lessons, strategies, and impact of SBHHs across BC to date, such as:

- **Proven impact data:** evidence shows reduced ER visits, increased graduation rates, and an $8.31 return on every $1 invested (Legare and Associates, 2017).
- **Success strategies:** examples of how communities have built thriving hubs through partnerships, sustainable funding, and team-based care.
- **Challenges and solutions:** real-world insights on staffing, succession planning, funding models, and integration with multidisciplinary approaches.

If you're considering an SBHH in your community, the first steps may include:

Engage early partners – Convene school administrators, counsellors, and other local health providers (Family Physicians, Nurse Practitioners, Consultant Specialists, Public Health, Child and Youth Mental Health (CYMH), Ministry of Children and Family Development (MCFD), and Local Health Authority). Engage students, families and the community to assess gaps and needs.

Identify your hub team – Build a multidisciplinary group based on local needs (family physicians (FPs) and consultants, Nurse Practitioners (NPs), school counsellors, Indigenous supports, CYMH, Public Health, and other local champions).

Leverage and connect existing structures – Explore partnerships with Primary Care Networks (PCNs), Foundry, Integrated Child & Youth (ICY) teams, Public Health nursing, and community organizations.

Secure sustainable funding – Blend sources initially (health authorities, PCNs, Foundrys, community grants) and join us in advocating for sustainable provincial support.

SBHHs are a strategic, scalable, and sustainable solution to some of our province's most pressing health and education challenges. The data is clear. The stories are compelling. The need is urgent. By investing in SBHHs, communities and governments can create a legacy of healthier children and youth, stronger families, and more equitable futures. The work has already begun in BC—this report is your invitation to join the movement.

INTRODUCTION & BACKGROUND

School-Based Health Hubs (SBHHs) have been developed across British Columbia as an ad hoc response to a community need for accessible child and youth mental and physical health care. These SBHHs came together to share learnings in an effort to develop a resource for communities desiring to establish an SBHH, while bolstering support for existing SBHHs. To learn more about the history of this project, see Appendix A.

Context & Definitions

SBHHs have been called in-school health clinics, wellness centres, school-based health centres, pediatric clinics, integrated school health programs, and school clinics. Throughout the duration of this project, they have been referred to as school-based health hubs (SBHHs), and that terminology is reflected throughout the report.

Community partners and community services are referenced throughout the report and refer to any youth-serving programs, agencies, or staff that are based in the community.

SBHHs can provide services for children (school-aged children from about 5-12) and youth (aged approximately 13-18). SBHHs can be child-based or youth-based. Child-based SBHHs require parent support to access services, whereas a youth-based model allows youth to access their own health care services[1]. Throughout this report, there is no distinction made, but depending on whether the SBHH is being developed in an elementary school or a secondary school, the type of model and how the child or youth can access care should be considered.

[1] According to the Infants Act in BC, a person under the age of 19 can consent to their own healthcare, provided they have been assessed by the healthcare provider to be capable of understanding the nature and consequences of the treatment (as explained by the healthcare provider) (BC Government, 2025, Part 2, Section 17).

WHAT IS AN SBHH?

History and Development

An SBHH is a collaborative team providing child and youth healthcare located in either an elementary or secondary school. The members of the hub vary for each community but always include providers with skills in mental and physical health care needs for young people. Some examples include family physicians, pediatricians, nurse practitioners, social workers, Indigenous supports, school counsellors and staff (including teachers, principals, inclusion and learning support teachers, child/youth family support workers), child psychiatrists, CYMH counsellors, public health nurses, and administrators/assistants. SBHHs do not replace established relationships with longitudinal care in the community, but enhance those services and aid children and youth who are disconnected from care. As each community is unique, each SBHH is tailored to the needs of that community and the availability of partners. However, all share the common goal of increasing access to healthcare services for students who face barriers and challenges to accessing adequate healthcare (Yau & Newton, 2012). One project participant said that SBHHs have been "created on the passion and commitment of those involved."

Across the province of British Columbia, SBHHs have been initiated by medical professionals and school staff as a response to the local medical needs of children and youth. These responses begin through a partnership between physicians and other medical professionals, and schools. Then they refine their response to meet the needs of the children and youth they serve with feedback over time.

Most SBHHs report needing a designated person to facilitate bringing the child or youth to the service. This designated person could be a coordinator, medical office assistant (MOA), or even the school counsellor. The coordinator facilitates communication with multidisciplinary team partners and provides education about services available. Coordinators work closely with school staff who help make referrals, build relationships, and engage students. School counsellors are an important partner in SBHHs due to their accessibility to and relationship with the students, and can therefore assist with engagement and earlier diagnoses of problems.

For a summary of the current state of SBHHs in British Columbia, see Appendix B.

IMPORTANCE OF SBHHs

Youth in British Columbia face significant barriers in accessing adequate mental and physical healthcare, leading to poorer health outcomes, increased emergency room visits, and reduced academic success. Existing healthcare services often fail to meet the unique needs of this population, particularly those from marginalized communities, due to issues like transportation, family dynamics, lack of awareness, and discomfort with available services. In Canada, statistics show that nearly half of children and youth with early mental health needs have difficulty accessing mental health or substance use services (CIHI, 2024). Some of the barriers reported include limited choices of where and when to access services, discomfort with the services available, and timing of services available (CIHI, 2024).

SBHHs address the following:

1. **Bridge gaps in healthcare access for children and youth.** SBHHs provide services within a familiar, accessible, and safe school environment. The accessibility of SBHHs also fosters trust between students, families, and healthcare providers, encouraging early intervention and preventive care (Nemours, 2023). Focus groups report that the inclusion of such services within schools creates a more casual setting that is more comfortable, allows for increased youth engagement, and reduces barriers to service. The consistent presence of an SBHH facilitates the development of trust and relationship building between the service provider and the child or youth. It has been noted that this can be especially the case for Indigenous children, youth, and their families. This relationship experience lasts long into adulthood, allowing greater comfort in seeking medical services later in life. Additionally, some SBHHs provide services to the immediate families of students, thus reducing overall parental/family stress.

2. **Improve health outcomes.** SBHHs enable earlier intervention, preventive care, and comprehensive support, addressing mental health, behavioural health, substance use, and physical health concerns. SBHHs not only provide immediate healthcare services but also contribute to long-term health equity by addressing underlying social determinants of health (Knopf et al., 2016). Physicians reported that SBHHs lead to earlier intervention and treatment through team-based care and more ready access to a wider scope of care (e.g. transgender care, mental health care, and substance use care). Early intervention leads to more positive outcomes for children and youth. By connecting students and families to community resources and providing culturally competent care, these hubs help to mitigate the impact of poverty, discrimination, and other systemic barriers on student health (Knopf et al., 2016; Solcz, 2024).

3. **Promote health equity**. SBHHs focus on creating equitable access for marginalized populations, supporting all students to reach their potential regardless of their socioeconomic background. Research demonstrates an accessibility gap between the availability of services in general and what is accessible to marginalized communities (Yau & Newton, 2012). SBHHs, conveniently located within schools, address critical barriers to healthcare access, ensuring that students, particularly those from isolated and/or marginalized communities, receive the medical, mental, and social support they need to thrive (Knopf et al., 2016; Nemours, 2023; Solcz, 2024).

4. **Enhance educational engagement.** SBHHs improve student attendance, academic performance, and overall educational engagement as a result of accessible primary care appointments, mental health counselling, chronic disease management, and health education. SBHHs reduce absenteeism, improve academic outcomes, and foster a healthier school environment (Nemours, 2023; Solcz, 2024).

5. **Improve collaboration.** SBHHs strengthen relationships between school staff and healthcare providers due to the proximity of services and through the development of a network of support. Collaboration between health providers and school staff results in a greater sense of staff wellbeing. Many physicians connected to SBHHs reported having high job satisfaction. One family physician stated, “This work is the only reason I won’t burn out.” Specialists who engaged in the focus groups also reported being passionate about providing care in a relationship-focused way.

Given the compelling evidence of their positive impact on student health, academic achievement, and health equity, SBHHs should be considered a necessary resource for every community. Integration of healthcare services into the school setting creates a comprehensive support system that empowers students to reach their full potential, regardless of their socioeconomic status or background (Knopf et al., 2016; Nemours, 2023; Solcz, 2024).

To learn more about what the data shows regarding SBHHs, see Appendix C & Appendix D.

STEPS TO ESTABLISH AN SBHH

This section summarizes recommendations from SBHHs that were collected throughout three focus group sessions (held in November 2023, March 2025, and June 2025). Although these steps can occur in a different order, it is recommended that a community consider each step throughout their process to achieve overall success.

Step 1

Build Community and School Partnerships

Engage early with school administration, counsellors, student representatives, and community organizations to foster collaboration and tailor services. One SBHH reported that strong collaboration with school district leadership was the key to the establishment of their SBHH. Many SBHHs report that strengthening connections between SBHHs and PCNs, Foundry, ICY teams, and health authorities allows for a coordinated approach. One SBHH recommended connecting school districts with other school districts to share successes and encourage investment and commitment. To learn more about how SBHHs can integrate with other multidisciplinary approaches, see Appendix E.

Step 2

Leverage Existing Structures

Utilize existing relationships and services to expand current services and identify gaps. Areas identified for leveraging include PCN funding, Foundry collaborations, and community relationships to support staffing and service integration. Several SBHHs reported utilizing their existing clinic's Electronic Records Management (EMR) systems.

Step 3

Develop a Team-Based Care Model

Incorporate allied health professionals such as youth care workers, social workers, and school staff to create comprehensive, multidisciplinary teams. A community in the development phase of their SBHH reported determining who should form their team by child and youth feedback.

Step 4

Embed Services Within Schools

Establish dedicated spaces and workflows that promote confidentiality, trust, and accessibility, especially for vulnerable and marginalized populations. SBHHs report that having a consistent presence within schools and demonstrating a safe space leads to increased youth engagement and increased comfort level in disclosing to physicians. Utilize designated coordinators (or peer support workers when trained) to provide facilitation and linkages to medical services.

Step 5

Flexible and Sustainable Funding

Identify funding opportunities. It may be necessary to use a blend of funding sources. Some sources identified include health authority budgets, PCN contracts, Foundry staffing, and community grants. Sustainable payment models help attract and retain staff. Many SBHHs utilize PCN funding, and some have flexibility within that funding model to allocate funding according to need. Other SBHHs utilize Foundry funding and staff to support their programs. Several SBHHs are supported by their health authority, and some SBHHs have even applied for community grants to fund their initiative.

Step 6

Focus on Early Identification

Prioritize early screening and diagnosis of mental health issues, behavioural health (neurodiversity, ADHD, and learning disabilities) and other vulnerabilities in elementary and secondary schools. Many physicians attached to SBHHs commented that early intervention was one of the significant benefits of SBHHs, as it leads to improved opportunities for treatment and support.

Step 7

Enhanced Transition Pathways

Collaborate with community partners and Primary Care Providers (PCPs) to facilitate seamless transitions from SBHHs to community primary care.

Step 8

Data-Driven Decision Making

Implement ongoing data collection on staffing, funding, service usage, and outcomes to inform strategic planning and demonstrate value. One SBHH highlighted using data outside the SBHH to inform decision making, such as: McCreary Centre Society BC Adolescent Health Survey (McCreary Centre Society, 2025), EMR data, Child Health BC Data Sources (Child Health BC, 2025), School District data, and the Canadian Community Health Survey (Statistics Canada, 2023). For more information on suggested data tracking, see subheading “Data Tracking for SBHHs” below and Appendix F.

Step 9

Advertise Services to Youth

Engage youth in service development. Increase awareness of available services by developing posters and using social media. Teaching students how to navigate the healthcare system and how to establish and maintain PCP attachments empowers youth.

DATA TRACKING FOR SBHHs

Tracking data is essential to demonstrate the effectiveness of the SBHH, build a case for support for funding, and adapt services to meet the needs of the children and youth served. For example, one SBHH's data demonstrated that 6 years after operationalizing an SBHH, they experienced:

- significant reduction in youth ER visits (by 38%)
- reduction in mental health ER visits (by 18%)
- significant increase in youth comfort level with accessing healthcare (student self-report measures).

Research by Legare et al. (2018) suggests using nine strategic questions to track the evaluation of your SBHH (Legare et al., 2018):

1. To what extent do the wellness centres support access to health and wellness services?
2. What are the important components and service provider team composition for school-based wellness centres?
3. To what extent are the wellness centres serving the student population and at-risk youth?
4. To what extent do the wellness centres support youth wellness and resiliency?
5. To what extent do the wellness centres support improved capacity for appropriate use of health services?
6. To what extent do the wellness centres support educational achievement?
7. To what extent are the wellness centres sustainable? What facilitators and barriers to providing school-based wellness services have been identified?
8. What is the social return on investment of wellness centres?
9. To what extent do the wellness centres support the school community and comprehensive school health?

These questions have been developed into an evaluation framework, as seen in Appendix G.

SBHHs in BC have suggested additionally tracking data that includes measures of demographic data, health access and utilization, health outcomes, educational outcomes, and systems-level outcomes. For a complete list of suggested tracking metrics, see Appendix F.

An example of a measurement tool to build your own data tracking evaluation can be found in Appendix H.

COMMON SBHH PROBLEMS AND SOLUTIONS

1. Provider Turnover and Succession Planning

Challenge: Leadership and staffing changes threaten service continuity. Attrition of practitioners leads to deterioration in how services are delivered. Full-time and part-time roles, including physicians and allied health professionals, face recruitment challenges due to compensation and workload.

Solutions: Focus on provider recruitment and retention strategies, and advocate for dedicated roles with sustainable funding, including physician and allied health support. When a change in provider or partners occurs, support proactive succession planning. Establish transition meetings to support shadowing and relationship transfer. The budget should allow for sufficient overlap of staff.

2. Funding and Compensation Constraints

Challenge: Limited or unstable funding, inadequate billing models, and challenges in securing dedicated contracts hinder staffing stability. Securing additional resources to grow and formalize programs remains an ongoing challenge. Using a fee-for-service model is challenging, and other funding is inadequate to cover the services provided. PCN funding can be limited, due to attachment goals, although some SBHHs have expressed success with negotiating government contracts. Lack of funding for a clinic coordinator or other support roles leads to challenges in service provision, such as increased waitlists and reduced communication with school staff. This lack of funding leads to increased reliance on school counsellors to support the SBHH.

Solutions: Develop effective payment models by exploring blended billing and innovative payment approaches to improve physician recruitment and retention. Develop partnerships and collaborate with other multidisciplinary approaches to provide staffing support. Implement robust data collection. Regularly collect data on staffing, funding, patient outcomes, and service utilization to demonstrate value. Explore local community funding opportunities. Consider involving parent advisory committees to help with fundraising initiatives. Work to develop a sustainable provincial funding model for SBHHs.

3. Transition of Care

Challenge: Transition of care can refer to students transitioning from high school or transitioning from an SBHH to a community practice. Transitions also occur when patients move from acute care into community care or between specialized care. At all of these transition points, a child or youth can fall through the cracks.

Solutions: Establishing formal partnerships with local private practices, general practitioners, and specialized clinics will help transition children and youth into community care. For example, in some communities, PCN- or Foundry-funded healthcare providers have facilitated consistent primary care attachments for children and youth, reducing gaps in care. Implementing collaborative agreements among key stakeholders—such as school counsellors, PCPs, and allied health professionals—enhances information sharing during transitions. This agreement can involve shared EMRs or care notes, structured referral pathways, and joint meetings to coordinate care plans, especially when youth are aging out of school or leaving the school-based setting. Utilizing an SBHH coordinator to help facilitate collaboration and shared communication can lessen the administrative burden on physicians.

4. Structural Barriers

Challenge: Lack of formalized structures, administrative burdens, and logistical issues in booking, follow-up, and engagement impede progress. Remote communities and vulnerable populations face ongoing barriers to accessing services. Limited PCN involvement, especially pediatrician inclusion, and system silos restrict a seamless care continuum.

Solutions: Enhance service delivery models. Use mobile clinics, virtual care, and flexible spaces to reach remote and vulnerable populations. Implement youth and school feedback to adapt services to meet the needs of each unique community. Strengthen relationships and formalize agreements with PCNs, Foundry, ICY teams, and other providers to support resource sharing and aligned care.

5. Data Tracking

Challenge: Some SBHHs report challenges with tracking data due to physician time and compensation. Additionally, there is a reported lack of understanding of what data is most important, who wants to see it, or how it will impact the sustainability of their SBHH. Lack of administrative support and the difficulty of collecting client data, specifically the voice of the patient, present additional challenges.

Solutions: Some sites utilize their partners' data tracking (such as Foundry or PCN). Others use their clinic's EMR to track client data. Neither of these options will comprehensively track all the suggested outcomes; however, one suggestion was to hire a master's student to implement a data tracking system that would be easily accessible and utilized by participating providers. SBHHs that have administrative support or a program lead tend to use those roles to oversee the data collection.

6. Engagement of School and Community Leaders

Challenge: Lack of ongoing commitment from school staff and community partners remains a barrier. Time constraints and staff changeover can make ongoing relationship building difficult. Initial excitement and commitment to establish an SBHH can slow, making continued and ongoing support challenging.

Solutions: Establish strong partnerships amongst providers and community partners. Involve school administration and counsellors early and promote ongoing collaboration throughout the development and operation of the SBHH. Promote a culture of continuous improvement. Use feedback from families, youth, and school staff to refine programs and demonstrate success. Engage student council, or offer volunteer opportunities for students to be involved in the SBHH. Encourage student voice in how services are catered to their particular environment. Involve parent advisory committees to support the SBHH and assist with fundraising.

7. Legal and Liability Concerns

Challenge: School district liability and insurance concerns can slow the full integration of health services.

Solutions: Clarify liability issues, insurance coverage, and legal frameworks to ease barriers to embedding services within schools. Reach out to the network of SBHHs to identify solutions and information that can be shared with local schools. Connecting school districts with other school districts that are champions in school-based care can be effective.

SUSTAINABILITY OF YOUR SBHH

Several strategies outlined previously were identified by SBHHs as being necessary to the sustainability of service provision. These approaches were explored in detail at the March 2025 and June 2025 focus group events and were synthesized into these fundamental strategies.

Staffing & Succession Planning

To ensure the sustainability of SBHHs, it is essential to implement practical strategies that address staffing stability and succession planning.

Approach 1: Establish a dedicated local action team. This will facilitate ongoing stakeholder engagement, allowing for proactive planning and adaptation to community needs. This team should include school administrators, health partners (including Public Health), and allied health professionals to foster collaboration and shared accountability. This allows for agile and strategic leadership, which facilitates model adaptation in response to evolving demands, such as expanding services or integrating new team members.

Approach 2: Ensure job descriptions are updated and clear. Job descriptions should be inclusive of all services provided and include the evolution of services. Keeping job descriptions updated helps ensure future hired staff will continue providing relevant and agreed-upon services, instead of reverting to old ways of operating.

Approach 3: Consider embedding allied health professionals into SBHH teams. This supports holistic care delivery and helps mitigate recruitment challenges. Moving towards integrated service models over fragmented contractual arrangements will also help with staff continuity and comprehensive care, minimizing disruptions and enhancing long-term stability.

Approach 4: Active engagement with school staff and systems. Schools can incorporate SBHHs into existing structures, such as staff meetings and planning sessions, to promote understanding and support. Succession planning should include mentorship programs and cross-training to transfer knowledge and skills, ensuring continuity even amidst staff transitions. Building relationships with community partners further enhances the hub's capacity to sustain a stable, well-rounded team committed to long-term success.

Strong Partnerships

SBHHs can become more sustainable by establishing strong partnerships with various stakeholders from the outset.

Approach 1: Develop collaborations with community partners, school administration, and counsellors, which build a solid foundation for ongoing support. Strengthen partnerships with primary care through ongoing discussions with integrated care pathways and allied health professionals.

Approach 2: Involve student representatives to provide continuous feedback. This ensures services are tailored effectively to meet students' needs.

Approach 3: Develop collective responsibility by sharing contributions. This fosters sustainability as a team.

Approach 4: Build upon existing community structures, such as local integrated care teams and other available children and youth services. This allows for resource optimization and minimizes duplication. As needs evolve, identify service gaps and proactively develop new partnerships to ensure adaptability and resilience. Leverage established relationships to provide a solid foundation upon which to build trust, facilitate open communication, and foster innovative solutions that support student well-being and program sustainability.

Funding & Delivery Models

Sustainable funding models are the backbone of long-term SBHH viability.

Approach 1: Leverage existing funding sources. Explore PCN arrangements to support core staffing and services. Examples include North Vancouver's use of PCN funding to attach youth to Foundry clinics or Terrace's integration of CYMH within PCN-supported physician roles. Other models include the Sunshine Coast, in which Vancouver Coastal Health funds physicians' clinical time through sessionals. At Elphinstone and Chatelech Secondary Schools, clerical/coordinator support is provided by the school administrative team. Victoria's SBHH is supported by their health authority, with its funds covering an NP, MOA, and a program coordinator. Shared financial commitments foster a sense of ownership and long-term investment.

Approach 2: Explore innovative payment models, such as blended funding approaches that combine support from integrated care teams, health authorities, and community contributions.

Approach 3: Advocate to the provincial government and health authorities to fund SBHHs on an ongoing basis. A first step is to formalize partnerships and embed SBHHs within broader health and education policies, which can lead to more predictable and stable funding streams, reducing reliance on ad hoc grants or project-based funding. Use existing data to clearly demonstrate the need and effectiveness of SBHHs.

CONCLUSION

This project was the beginning of exploring the collaboration and support possible for SBHHs across BC. Future efforts should continue building community partnerships, exploring innovative funding models, and advocating for policies that facilitate seamless care continuity across settings. The Advisory Group recommends that there be support to continue convening SBHHs across BC to achieve the following aims:

Foster Community of Practice: Encourage SBHHs to share successes, challenges, and innovative strategies, promoting a provincial learning environment.

Explore Funding Opportunities: Collectively brainstorm funding opportunities to address the needs of underfunded SBHHs and enhance care access, particularly for marginalized children and youth. Advocate for provincial funding support for SBHHs.

Identify Pathways: Discuss successful referral pathways and collaborations that can be replicated in other communities.

APPENDIX A - History of Project

This SQI project brought together collaborative SBHH clinicians and administrators from around the province. Each SBHH team in BC has developed as an ad hoc response to a community need for accessible child and youth mental and physical health care. The goal was to share learnings while building relationships in developing a template of successes, barriers, and guiding steps in supporting the establishment of school health hubs in new communities and sustaining existing hubs. The Advisory Committee also sought to develop a case for support from the government in the sustainable spread of these hubs throughout the province.

The Advisory Group was established in 2023 and is comprised of members of the Primary Care Network working group of the provincial Child and Youth Mental Health and the Substance Use Community of Practice (supported by the Shared Care Committee of Doctors of BC).

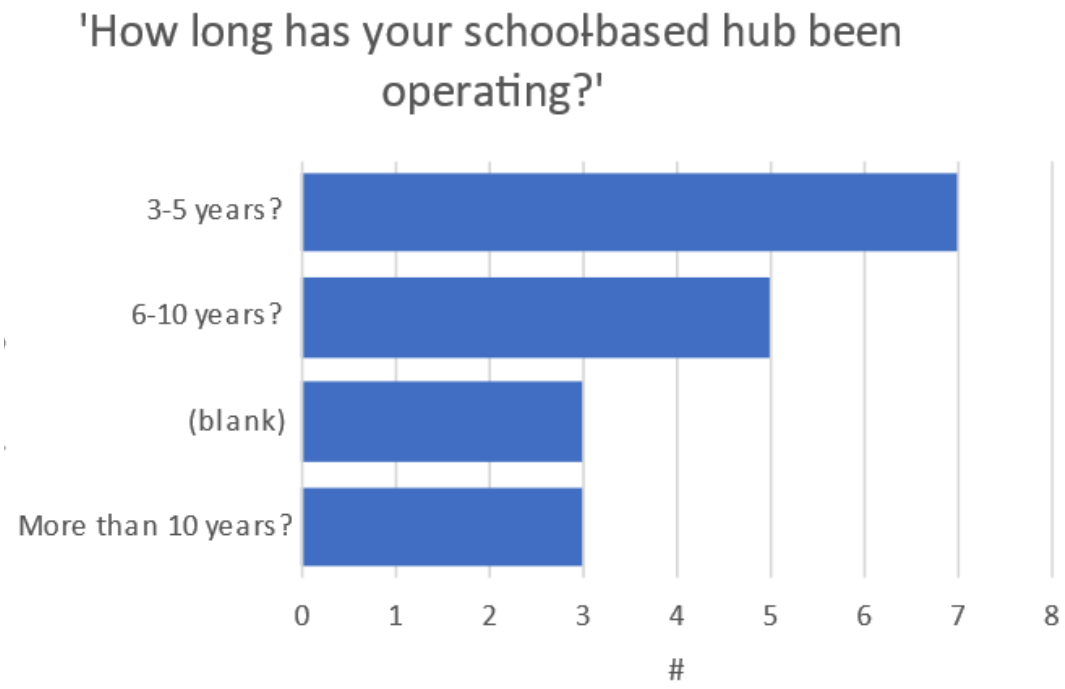
This initiative came from the recognition that several working group members had established School Health Hubs out of community need. Each group was different in membership, although all had physician involvement. However, none had substantial awareness of other SBHHs in the province or how they operated. Individual hubs recognized that SBHHs offer critical service, so they formed a group to collaborate, share stories, and build a common voice.

Initially, the work was supported through a Shared Care project, which funded an initial focus group session in November 2023. All SBHHs in the province of BC that the Advisory Group members were aware of were invited to attend this initial session. After the first focus group event, the work continued and was then supported by Spreading Quality Improvement (SQI). The purpose of SQI is to support the spread and scale-up of successful quality improvement initiatives and accelerate impact, resulting in better patient outcomes. Shared Care and the Specialist Services Committee, through SQI, supported the development of this provincial change package.

This template has been created using data collected during focus group sessions that examined the SBHHs in communities identified by the working group. The working group acknowledges there may be other SBHHs in existence throughout the province of which this group is currently unaware.

APPENDIX B - Summary of Current State of SBHHs in British Columbia

At the November 2023 focus group event, key themes were identified regarding the development of SBHH across the province. Twenty-nine participants, including family physicians, pediatricians, counsellors, nurse practitioners, public health, and other collaborators in SBHHs around the province, provided information. Of the SBHHs represented, seven had been operating for three to five years, five had been operating for six to ten years, and three had been operating for more than ten years. One clinic had commented that they have been operating for more than twenty-five years (North Vancouver).



SBHHs reported having varying origins, some having developed when public health nurses worked to increase access for students. Others focused on contraception and STI treatment initially and then expanded over time. Other SBHHs originated out of a Child and Youth Mental Health and Substance Use Collaborative. However, all SBHHs eventually developed into collaborative medical hubs with teams, with some being connected to Foundry and ICY teams. All SBHHs reported that they began with a recognition of the scarcity of medical resources for children and youth and a desire to enhance preventative and treatment services where the most vulnerable children and youth are located. The goal was to meet youth where they are at and work with them in an environment where they are most comfortable. This child-centred approach allows for direct access to services. In remote communities, it is reported that some sixty percent of students are bussed to the community for school and have low access to primary care and community services.

APPENDIX C - SBHHs Social Return on Investment (SROI)

(Arruda et al., 2019)

PHYSICIAN QUALITY IMPROVEMENT
An SSC Initiative

Seeing the Invisible Children

Improving pediatric care for marginalized children & their families by developing a model for elementary school-based pediatric services

PROBLEM

Many children and youth are identified as needing a pediatric assessment by schools. In Nanaimo some children and their families live in marginalized circumstances and have difficulty accessing services through the traditional physician referral process. As such, these children and their families have difficulty accessing pediatric care.

1. ***What is the impact on the child, their families and the schools when they cannot access pediatrician services?***
2. ***Is there a different model of care that can improve access and support that is different than the traditional model of referral practice?***

AIM STATEMENT

Within 6 months, 100% of children who fit the project criteria will be identified and referred for school-based pediatric consults through a standardized process.

CHANGE IDEA

For children and their families who are not attached to a family physician, are underserved, or are living in marginalized circumstances and cannot access pediatric services through the standard referral pathway:

1. To develop and trial standardized processes at Georgia Avenue Elementary School for:
   a. Identification of children who need pediatric assessment and support.
   b. Obtaining parent/guardian consent for referral/assessment.
   c. Referral of children to pediatric services.
2. To use these tools to evaluate the outcome of the assessments.

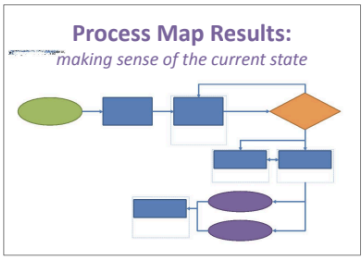
PROJECT TEAM

PQI Physician Lead: Dr. Wilma Arruda

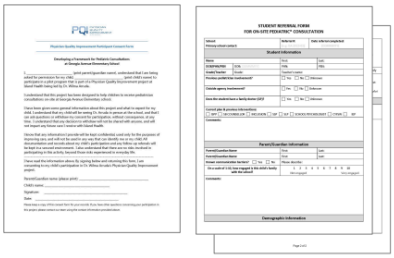
Project Participants:
- **Cindi Ashbee** (CYC Georgia Avenue),
- **Claudio Aguilera** (Manager TLAFCHC),
- **Bob Esliger** (A Superintendent SD 68),
- **Deb Chaplain** (Director CYMH IH),
- **Jan Tatlock** (Director PH),
- **Erin Kenning** (CC PH Nanaimo).
- **Kirstin Funke Robinson** (SD 68 Psychologist),
- **Lynn Brown** (SW, SD 68)
- **Chelsea Wakelyn** (PQI Coordinator)
- **Curtis Bilson** (PQI Data Analyst)

PDSA Cycles

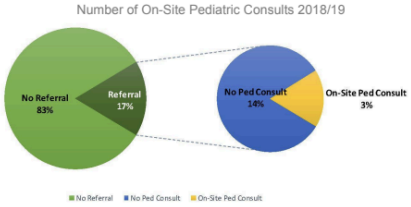
PDSA 1: Mapping ideal process with project team



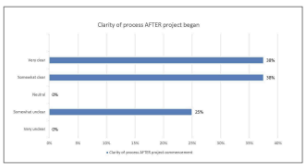
PDSA 2: Creating/distributing new Consent & Referral Forms



PDSA 3: School District baseline data collection



PDSA 4: Collecting feedback from school-based team



DATA ANALYSIS

Referral criteria were developed in collaboration with school district representatives. Data was collected through the development and use of a standardized referral tool that captures:
- D.O.B.
- Health system interactions (e.i. GP yes/no)
- Previous interventions
- Psychosocial barriers (poverty, transience etc.)

FINDINGS

- **80%** of children referred had no GP or were unable to access a GP
- **80%** of referrals resulted in a face-to-face pediatric assessment.
- **40%** of children seen were referred for other health services

CONCLUSION

Due to their life circumstances some children do not receive pediatric assessment when it is needed. These are children who are not well represented in MoH data and should be seen as "invisible" by the health care system. This project is not yet complete but early findings suggest that an alternative model of care more appropriately supports these children's health care needs and, as such, will support the health and wellbeing of the child in the family structure.

PROJECT SPREAD

- Standardized package for interested schools. Implementing "one piece flow" process of referral through to assessment using one form that doubles as a data collection tool.
- Recording and analyzing assessment outcomes to support project's value.
- Presentation to school district and health authority leadership to gain endorsement for program spread.

The PQI Initiative provides training and support to physicians, through technical resources and expertise, to lead quality improvement (QI) projects, which build QI capacity. This investment increases physician involvement in quality improvement and enhances the delivery of patient care.
Please see our website for more details: sscbc.ca

island health

APPENDIX D - What the Data Shows

Across evaluations, the evidence consistently demonstrates positive outcomes associated with SBHHs.

1. Increased Access to Care

- **Reduced ER Visits:** In Vanderhoof, BC, after the Nechako Valley Secondary School (NVSS) clinic opened, youth ER visits dropped by 1,437 cases over 6 years (Campbell, Roberge, & Goretzky, 2023).
- **Increased Access to Care:** SBHHs significantly improve access to healthcare for students, particularly those who may not otherwise seek care due to barriers such as lack of transportation or concerns about confidentiality (Campbell, Roberge, & Goretzky, 2023; Dunn, 2025). Thousands of students have accessed services that they otherwise would not have received. For example, over 1,500 visits were made by students to the John Barsby and Nanaimo school wellness centres between 2019–2020 (Kenning, Barlow, & Arruda, 2020).
- **Enhanced School Environment:** SBHHs contribute to a more positive and supportive school environment by fostering collaboration between health and education staff, promoting health literacy, and addressing the social determinants of health (Legare and Associates, 2018).

2. Improved Health Outcomes

- **Reductions in Youth Pregnancies:** First prenatal appointments fell from 44 pre-clinic to 16 post-clinic, and terminations dropped from 4 pre-clinic to 0 post-clinic at the NVSS SBHH (Campbell, Roberge, & Goretzky, 2023).
- **Improved Health Equity:** Embedded care in schools addresses barriers like transportation, cost, and language (Yau & Newton, 2012).

3. Enhanced Mental Health Support

- **Improved Mental Health**: Self-reported student data demonstrates significant improvements in mental health and improved confidence to manage health and wellness (Kenning, Barlow, & Arruda, 2020). The NVSS SBHH data demonstrated increased access to mental health information, screening, diagnosis and management, and resulted in 48 fewer youth mental health visits to the ER during their first five years of operation (Campbell, Roberge, & Goretzky, 2023).
- **Increased Access to Mental Health Services**: SBHHs demonstrate higher use of mental health services, provide increased access to services, and reduce the stigma of seeking mental health care (Kutcher, 2017).

4. Strengthened Educational Engagement

- **Improved Performance:** Educators report that untreated health issues (particularly anxiety and mental health) are a leading cause of poor attendance and academic underperformance. School wellness centres help students "get to the point where they can focus on the academics" (Kenning, Barlow, & Arruda, 2020).
- **Increased Attendance:** SBHHs result in fewer absences, higher educational aspirations, higher grades, and higher graduation rates (Legare & Associates, 2017).

5. Reduced Gaps for Marginalized Populations

- **Filling the Gaps:** Evaluation of Nanaimo's pediatric consult initiative found that 80% of children referred had no family doctor or were unable to access a family doctor, highlighting how school-based services capture "invisible" children otherwise missed in health system data (Arruda, 2019).
- **Marginalized Community Support:** Toronto's in-school clinics demonstrated that much-needed support was provided to immigrant families, low-income households, and children without health coverage (Yau & Newton, 2012).
- **Positive Student Perceptions:** Students report feeling safe, supported, and respected at SBHHs, and they value the convenience and accessibility of on-site care (Kenning, Barlow & Arruda, 2020; Legare and Associates, 2018).

A social return on investment study concluded that for every $1 in staff costs per year, at least $8.31 in social value is created (Kenning, Barlow, & Arruda, 2020)

APPENDIX E - SBHHs and Other Multidisciplinary Approaches

Multidisciplinary approaches serving children and youth may exist in various communities, which makes collaboration with SBHH essential to avoid duplication of services. In most instances, SBHHs report such programs to be complementary and helpful to the services offered by SBHHs, as opposed to an impediment to service. When working collaboratively, each multidisciplinary team fills a specific niche that together contributes to a holistic range of services available to youth.

Foundry

Foundry[2] provides mental health care, substance use services, physical and sexual health care, youth peer support and social services for youth aged 12-24 (Foundry, 2025). They do not exist in every community in BC, but are expanding their service offerings throughout the province.

One SBHH that also has a Foundry in its community has found success integrating the team-based structure of a Foundry into a school. In this instance, Foundry provides the infrastructure, and the physician and peer-support worker attend the school, with follow-up services offered through the main Foundry clinic. However, limitations on Foundry's mandate (serves youth aged 12-24) can lead to challenges in fully integrating with SBHHs.

SBHHs increase equity by being on-site for student access; some provide elementary school care and therefore are providing services to children younger than 12 years of age, as well as their families. SBHHs are therefore additive when a Foundry centre is present, and the two services can be synergistic when they collaborate.

Primary Care Networks (PCNs)

Primary Care Networks (PCNs)[3] are clinical networks of primary care service providers that include family physicians, nurse practitioners and may include community registered nurses, pharmacists, social workers, midwives, mental health professionals, Indigenous supports, dieticians, physiotherapists, occupational therapists, community services and others (BC Government, 2025a). They provide primary care in a team-based manner, developing a coordinated wellness plan for patients using a variety of models of care. Their combined knowledge and experience collectively support patient needs. PCNs are driven by local needs and can be comprised of different services based on each individual community.

SBHHs report successes with collaborating with PCN teams. The core attributes of PCNs include attachment for all patients and providing coordinated care (BC Government, 2025a). This provides a foundation for PCNs to be involved with and supportive of SBHHs. Some SBHHs utilize PCN staff as part of their SBHH team, and others have received funding support from PCNs. However, over half of SBHHs in BC report not being connected with PCNs due to

[2] foundrybc.ca/
[3] www2.gov.bc.ca/gov/content/health/accessing-health-care/bcs-primary-care-system

challenges with integrating the two approaches. Several SBHHs reported that some PCNs focus on community needs that exclude the needs of children and youth (for example, prioritization of chronic disease or the elderly). Some report difficulty connecting with and engaging with PCNs. Additionally, attachment requirements in PCN contracts result in care being provided only to patients who are already attached to healthcare professionals, excluding those who do not already have access to health services due to the previously described barriers. Other SBHHs who are not connected to PCNs report a preference for separation, feeling that they have more autonomy over service delivery and can be more responsive to the needs of children and youth without additional input.

Integrated Child & Youth Teams (ICYs)

Integrated Child & Youth Teams (ICYs)[4] bring multidisciplinary partners together to support children and youth from early years to age 19 (even up to 21 in some instances) (BC Government, 2025b). Team members may include CYMH clinicians, youth substance use clinicians, youth peer supports, and other support roles (BC Government, 2025b). ICYs do not have a physician as part of their intended structure; therefore, collaboration with SBHHs can be complementary. In fact, several SBHHs report a synergistic relationship by referring children and youth between each service and have experienced success working with ICY teams.

[4]www2.gov.bc.ca/gov/content/governments/about-the-bc-government/mental-health-and-addictions-strategy/integrated-child-youth-teams

APPENDIX F - Current SBHH's Data Tracking

Evaluation of SBHH is crucial to its ongoing success. Some work in this area has already been conducted, for example, the *Wellness Centres Evaluation Framework Initiative: Performance Monitoring, Progress and Impact Evaluation Framework for Secondary School-Based Wellness Centres in BC* report (Legare & Associates, 2017).

The following are measurements SBHHs have been using to evaluate success. Although most of the data is from SBHH evaluations in British Columbia, some references include data from the United States and other parts of Canada. Evaluations of SBHHs often employ a mixed-methods approach, combining quantitative data on service utilization and health outcomes with qualitative data on student, staff, and community perspectives (Legare and Associates, 2017). As a result, some data has been extrapolated from information collected by the clinic staff, and other data was collected using self-report measures from youth patients.

Data Tracking

1. Health Access and Utilization

A. Service Uptake

- Number of students seen
- Ages of students
- Reasons for visits (e.g., contraception, mental health, immunizations, illness/injury, etc.) (Kenning, Barlow, & Arruda, 2020)
- Number of youth referred to other services
- Source of student referral
- Demographics of students accessing services
  - Marginalized population
  - Social determinants
  - Average client PHQ-9 and GAD7 scores

B. Access Alternatives

- Surveys assessing where students would have gone without school-based services (e.g., walk-in clinic, family physician, or no care) (Kenning, Barlow, & Arruda, 2020)

C. Equity in Access

- Percentage of students without family doctors and/or from marginalized groups (Yau & Newton, 2012)

D. Student Comfort

- Increase in student comfort level in establishing a relationship with health service providers

2. Health Outcomes

A. **Physical Health**
- Reasons for visit (Including complexity of problems (ICD-9 codes))
- Average number of visits each student made
- Immunization rates
- Management of chronic conditions
- Injury treatment, contraception use
- STI prevention
- Pregnancy rates (Campbell, Roberge, & Goretzky, 2023)
- Physician attachment

B. **Mental Health**
- Number of counselling/psychiatric consultations
- Early detection of disorders
- Emergency room visits for psychiatric issues (Dunn, 2025; Campbell, Roberge, & Goretzky, 2023)

3. Educational Outcomes

A. Graduation Rates
- Long-term school completion in relation to wellness supports (Legare and Associates, 2017)

B. Grade point average:
- Changes in grades after support by SBHH (Legare and Associates, 2017)

C. Absenteeism
- Absences before and after SBHH implementation (Legare and Associates, 2017)

4. Systems-Level Outcomes

A. Emergency Room Diversion
- ER use for primary care or mental health issues (Campbell, Roberge, & Goretzky, 2023)

B. Referral Pathways
- Effectiveness of standardized referral processes for children lacking primary care providers (Arruda, 2019)

C. Stakeholder Satisfaction
- Feedback from students, parents, school staff, and community partners regarding their experiences, perceived benefits, and areas for improvement (Legare and Associates, 2017)

D. Collaboration

- Improvement of relationships among healthcare professionals, school staff, community partners, and youth

5. Balancing Measures for Consideration

- Long-term benefits of decreasing physician workload by early intervention for physical and mental health issues, therefore decreasing chronic illness later in life. This may counterbalance a temporary detraction in services available when a physician's time is spent at an SBHH instead of in another primary care setting, thus creating a need in that setting.
- Track the quality of health services and ensure SBHHs are well-resourced to avoid a decrease in the quality of health services available due to limitations such as reduced access to medical equipment, support staff, and EMR systems.

APPENDIX G - Wellness Centres Evaluation Framework Initiative

(Legare et al., 2018)

9.2 Evaluation Framework

Table 4: Wellness Centres Evaluation Framework (July 2017)

KEY: WC = Wellness Centre | Longer-term outcomes = UPPER CASE

Evaluation Questions	Areas of Inquiry (Y1&2)			Intermediate and LONGER-TERM* Outcomes	Data Sources
	Direct Outcomes	Indicators	Data Sources		
1. To what extent do the wellness centres provide increased access to health and wellness services?	- Service scope - Service stats - Waits for WC service - Activities to increase student awareness of WC service availability	- Use by youth without a regular primary care provider - Student satisfaction - Protocols and practices regarding communication with other members of the student's heath care team	- WC administrative data - Student survey - WC staff survey/ interviews	- Appropriate school-based physical, mental, emotional and spiritual health and wellness services Students and young adults reporting: - Increased protective factors - Decreased risk factors - Strengthened assets - Improved cultural wellness index (First Nations Health and Wellness Indicators Framework, 2016)	- McCreary Reports - BC Vital Stats - BC Centre for Disease Control (BCCDC) - First Nations Population Health and Wellness Indicators (2016-2026) (not yet implemented) - HELP-BC Youth Development Index (not yet developed)
2. What are the important components and service provider team composition for school-based wellness centres?	- Service type by provider type - Waits for service by service type and provider type	- WC capacity to manage service demand (by type and service provider) - Unmet service needs within WC scope of service - Desired service mix – student, management and stakeholder perceptions - Appropriate staff training - Wait times for WC appointments and referral appointments by type	- WC administrative data - WC staff surveys/ interviews - Student surveys/focus group - Stakeholder interviews/focus groups		
3. To what extent are the wellness centres serving the student population and at risk youth?	- Service stats - Engagement strategies - Screening, early ID, management and referral of youth reporting health risks - Activities to increase awareness of WC among students, school staff and parents - Joint school/WC protocols for appropriate use of WC and management of student health issues - WC support to school staff	- Per cent of students accessing WC service - Per cent of students reporting risk behaviours accessing WC services - Per cent of youth referred to other health services/providers by type - Use of "drop in" lounge area - "Youth-friendly", non-judgemental, culturally appropriate and safe environment and service provision - Student engagement - School staff awareness of WC - Protocols with school identifying service scope	- WC administrative data - Student survey - WC staff surveys/ interviews		

Evaluation Questions	Areas of Inquiry (Y1&2)			Intermediate and LONGER-TERM* Outcomes	Data Sources
	Direct Outcomes	Indicators	Data Sources		
		and appropriate response to student physical and mental health issues - Number and type of joint school/WC activities			
4. To what extent do the wellness centres support youth wellness and resiliency?	- Health promotion and health literacy approaches built into service model - Individual screening and advice/care to support the modification of risk behaviours and enhancement of protective factors - Collaboration with school staff re: promotion of youth wellness and identification and appropriate response to student needs - Collaboration with school staff to enhance awareness of protective and risk behaviours and clarify role of school staff and WC staff	- Student self-report learning and behaviour change - Student self-report change in stress/anxiety and depression - Student self-report perceived mental, emotional and spiritual health - WC staff learnings on best approaches to support wellness and resiliency - School staff learnings on collaborative approaches to supporting youth wellness and resiliency - Interprofessional collaboration/learning	- Student survey - WC staff interviews/focus groups - School staff interviews/focus groups	- Improved knowledge re: self-care, risk and protective factors - Improved capacity for self-care - Improved behaviours to support physical health (fruit and vegetable intake, physical activity, sleep) - Improved behaviours to support mental, emotional and spiritual health - Improved mental, emotional and spiritual wellbeing - Improved physical health - Sexually transmitted infection, pregnancy - Substance use - Suicide rates - EMPOWERED, HEALTHY AND RESILIENT YOUTH - DECREASED INCIDENCE OF CHRONIC DISEASE	
5. To what extent do the wellness centres support improved capacity for appropriate use of health services?	- WC staff activities to support health literacy and student agency - WC staff activities to support health education and self-care	- Number and per cent of students making and keeping appointments and follow-up - Student self-report learning and behaviour change	- Student survey - WC Staff interviews	- INCREASED CAPACITY FOR SELF-CARE - MORE APPROPRIATE USE OF THE HEALTH CARE SYSTEM	

Evaluation Questions	Areas of Inquiry (Y1&2)			Intermediate and LONGER-TERM* Outcomes	Data Sources
	Direct Outcomes	Indicators	Data Sources		
6. To what extent do the wellness centres support educational achievement?	- Onsite access reduces school absence for health-related visits - Better health increases potential for optimal educational achievement	- Student self-report school missed for health appointments - Student self-report improved schoolwork since coming to wellness centre - Staff learnings re: impacts of WC on educational achievement	- Student survey - School staff survey/focus groups	- Career intention - Grade progression - Graduation rates - Transition to post-secondary education	- McCreary Reports - BC Ministry of Education
7. To what extent are the wellness centres sustainable? What facilitators and barriers to providing school-based wellness services have been identified?	- Student voice incorporated into planning, service delivery and evaluation of wellness centres - WC policy and protocols integrated with primary care, public health, mental health and community partners - Partnerships and collaborations - Partnership agreements - Inter-professional, inter-agency and inter-ministry protocols - Communication with stakeholders - Partnerships and resources to sustain services - Alignment with major partner and organizational strategic direction - Integration of health and wellness services within school environment - Facilitators and barriers	- Student engagement Partner/collaborator engagement - Partner/collaborator satisfaction - WC staff satisfaction - School staff satisfaction - Student satisfaction - Parent satisfaction - Wellness centre/comprehensive school health approach to determinants of health - Lessons learned	- Stakeholder, WC staff and School staff interviews/ focus groups - No current data source for student engagement - No current data source for parent satisfaction	- Increased integration and alignment of public health, community and primary care health services in public schools - SUSTAINABLE, RELEVANT AND APPROPRIATE HEALTH AND WELLNESS SERVICES IN SECONDARY SCHOOL SETTINGS	
8. What is the social return on investment	- Avoided unnecessary health and acute care services	- Student report of where they would have gone to seek care if WC had not	- Student survey - Data modelling	- Gap analysis of per cent of students meeting healthy	- McCreary Reports - BC's Guiding

Evaluation Questions	Areas of Inquiry (Y1&2)			Intermediate and LONGER-TERM* Outcomes	Data Sources
	Direct Outcomes	Indicators	Data Sources		
(SROI) of the wellness centres?	- Improved prevention of chronic disease - Early identification and management of health and mental health issues - Costs of appropriate service avoidance	been available		lifestyle behaviour targets current state vs. BC Guiding Framework Targets - IMPROVED SUSTAINABILITY OF THE HEALTH CARE SYSTEM	Framework for Public Health
9. To what extent do the wellness centres support the school community and comprehensive school health?	- Strengthened capacity to support wellness in schools, by school staff and wellness centre staff	- Number and type of services provided by WC staff to school community - Number and type of services provided by school community to WC staff - Key informant reports of impact of wellness centres on integration and alignment of WC and school policies, protocols and activities - School staff and WC staff report on the impact of the wellness centres (co-location of educational and health and wellness staff) on capacity to support wellness in schools	- Administrative data - School staff survey - WC staff interviews	- ENHANCED CAPACITY TO PROVIDE AN EFFECTIVE COMPREHENSIVE SCHOOL HEALTH ENVIRONMENT - ENHANCED CAPACITY TO ACHIEVE COMPREHENSIVE SCHOOL HEALTH OUTCOMES	

APPENDIX H - QI Measurement Tool

(Health Quality Ontario, n.d.)

Measurement Plan
TOOL

What? What is being measured? How is it related to other measures? What related data will be captured? Is it a process, outcome, or balancing measure? What type of data is being gathered (e.g., a process time, a defect count, etc.)?			**How?** How will the related data be captured? What data is produced by a computer and what is collected manually? If manually, which Data Collection Sheet is used?	**When?** When and how frequently will the data collection take place (e.g., day of week, time of day, frequency)?	**Where?** On which unit, area, department will the data be collected (e.g., medication room, unit 4F)?	**Who?** Who is responsible for • capturing the raw data? • aggregating/ collecting the data sheets? • updating the quality board?
Process, Outcome, or Balancing Measure?	**Measure?**	**Type of Data**				

ISBN 978-1-4606-0983-5 (PDF)

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British Columbia SBHHs

- Salmon Arm
- Sicamous
- Shoreline
- Nelson (in development)
- Kaslo
- Sunshine Coast
- Victoria
- Cranbrook
- Nanaimo
- Chilliwack
- Abbotsford
- Rutland/Kelowna
- Revelstoke
- Creston

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