Arkansas Department of Education
Special Education Office

INIITIAL SURVEY TO ESTABLISH SCHOOL-BASED MENTAL HEALTH SERVICE BASELINE

School District:_____ LEA # _____ Date _____

LEA Supervisor: _____ Individual Completing Survey _____

Does your district have School Based Mental Health Services ? Yes No Don't Know
If yes, name your provider:

Check the type of relationship your district has with your provider: _____ Employee ____ Medicaid/RSPMI Agency
Purchased Service Contract: _____ Company ____ Individual ___Other:

What services are provided ? (Check all that apply)

Individual Therapy ☐
Group Therapy ☐
Family Therapy ☐
Case Management ☐
Parenting Education ☐
Other ☐ **List:**

How often are services provided ?

Daily ☐
Weekly ☐
Other ☐

Is there a research component to the program ? Yes No Don't Know

If yes, name the instruments being used:

How satisfied are you with the services provided? Not Satisfied Satisfied Very Satisfied

How satisfied are you with your mental health provider? Not Satisfied Satisfied Very Satisfied

Are you interested in participating in research to evaluate the impact of School Based Mental Health Services?
Yes No
Are you interested in participating in a statewide conference on school based mental health services?
Yes No
Are you interested in or in need of training on mental health problems and interventions?
Yes No
If yes, please identify areas:
Please make any additional comments:

AFTER COMPLETION, PLEASE FAX TO TONY BOAZ AT (501) 682-4313