Survey 3: Survey of child and youth clients

Client demographics

1. Client's Gender:

   ☐ Male
   ☐ Female
   ☐ Transgender

2. Client's Age: _____

3. Ethnicity as identified by the client and/or the parent(s) or caregiver(s):

   ☐ White
   ☐ Chinese
   ☐ Black
   ☐ Filipino
   ☐ Latin American
   ☐ South Asian (e.g., East Indian, Pakistan, Sri Lankan, etc.)
   ☐ Southeast Asian (e.g. Cambodian, Indonesian, Laotian, Vietnamese, etc.)
   ☐ West Asian (e.g., Afghan, Iranian, etc.)
   ☐ Arab
   ☐ Japanese
   ☐ Korean
   ☐ Aboriginal Peoples of North America (North American Indian, Métis, Inuit)
   ☐ Other (*please specify*):_____

4. Client's language spoken at home:

   ☐ English
   ☐ French
   ☐ Other (*please specify*):
   _____

5.1. Was the client born in Canada or did the client move to Canada?

- ☐ Born in Canada
- ☐ Not born in Canada, and has lived here for _____ years

5.2. Under what status did the client move to Canada?

- ☐ Immigrant
- ☐ Refugee
- ☐ Unknown

6. Sexual orientation as reported by the identified client, if known:

- ☐ Heterosexual
- ☐ Gay/lesbian
- ☐ Bisexual
- ☐ Unknown

7. What is the client's current family structure?

- ☐ Two married parents
- ☐ Two parents living common law
- ☐ Single parent
- ☐ Blended family (e.g., step-parents, step-siblings)
- ☐ Extended family as caregivers (e.g., grandparents, uncles, aunts, etc.)
- ☐ Adult siblings as caregivers
- ☐ Other (*please specify*): _____

8. Client's living arrangements:

- ☐ Single residence
- ☐ Multiple residences
- ☐ Foster care
- ☐ Group home
- ☐ Homeless or shelter
- ☐ Other (*please specify*) _____

9. 1. Does the identified client attend school regularly?

- ☐ Yes
- ☐ No (Skip to 12)
- ☐ Unknown (Skip to 12)
- ☐ Not applicable, client is not school-aged (Skip to 13)

9.2. What school grade is the identified client in? _____

10. What type of school does the identified client attend?

- ☐ Publicly funded school
- ☐ Privately funded school
- ☐ Client is home-schooled

11. Does the client attend special programs or classes for any of the following? (*Check all that apply)*

- ☐ Learning disorder
- ☐ Developmental disability
- ☐ Behaviour
- ☐ Slow learner
- ☐ Gifted
- ☐ Other (*please specify*): _____
- ☐ None

12. Has the identified client ever been held back a grade?

- ☐ Yes
- ☐ No
- ☐ Unknown

13. (1) Does the client have paid work in any capacity?

- ☐ Full-time
- ☐ Part-time
- ☐ No (Skip to 14)
- ☐ Unknown (Skip to 14)
- ☐ Not applicable (Skip to 14)

13. (2) If the client works, what does s/he do?

_____
_____
_____

14. Client resides in:

- ☐ Major urban centre
- ☐ Suburb of major urban centre
- ☐ Smaller city or town
- ☐ Rural setting

Client service characteristics

15. Language in which service is provided to client:

☐ English
☐ French
☐ Other (*please specify*):
_____

16. What service(s) did you provide to the client during this session? (*Check all that apply*)

☐ Assessment
☐ Treatment
☐ Consultation

17. Please specify and briefly describe the type of assessment, therapy, and/or consultation you provided:

_____
_____
_____
_____

18. Including today's session, how many THERAPY sessions have you had related to the identified client? (Include sessions with parents, teachers, etc.) _____

19. Including today's session, how many ASSESSMENT sessions have you had related to the identified client? (Include sessions with parents, teachers, etc.) _____

20. Including today's session, how many CONSULTATION sessions have you had related to the identified client? (Include sessions with parents, teachers, etc.) _____

21. How many more sessions of all types do you anticipate providing to or about the identified client? (Include sessions with parents, teachers, etc.)

_____

22. Over all sessions to date, did you consult anyone from the school system in relation to the treatment of the identified client? *(Check all that apply)*

- ☐ Teacher(s)
- ☐ Educational Assistant
- ☐ Other psychologist
- ☐ Principal or Vice-principal
- ☐ Other (*please specify*): _____
- ☐ No
- ☐ Not applicable, client is not school-aged

23. Over all sessions to date, who are you seeing connected with the treatment of the identified client (apart from the client his/herself)? *(Check all that apply)*

- ☐ Parent(s)
- ☐ Other family member(s)
- ☐ Family physician
- ☐ Other (*please specify)*: _____

24. (1) In this session, did you *only* see the identified client?

- ☐ Yes
- ☐ No

24.2. In this session, who else was included in the delivery of the service? (*Check all that apply)*

- ☐ Parent(s)
- ☐ Other family member(s) other than caregivers
- ☐ Other caregiver(s)
- ☐ Other service provider(s)
- ☐ Other (*please specify*):_____

25. Is this client receiving services from another regulated healthcare provider for the same presenting problem?

- ☐ Yes
- ☐ No

25.2. From whom are they receiving these services?

- ☐ Psychiatrist
- ☐ Family practitioner or general physician
- ☐ Nurse practitioner
- ☐ Psychologist
- ☐ Counsellor
- ☐ Social worker
- ☐ Speech language pathologist
- ☐ Occupational therapist
- ☐ Social service agencies
- ☐ Physiotherapist
- ☐ Other (*please specify*):_____

26.1. Is the client or caregiver receiving or participating in community services or support related to the client's presenting problem?

- ☐ Yes
- ☐ No

26.2. What type of community service or support?

- ☐ Big Brother/Big Sister
- ☐ Therapy camps
- ☐ Support groups (e.g., bereavement, divorce)
- ☐ Social skills
- ☐ Assertive Community Treatment team
- ☐ Parenting training
- ☐ Community resource or health centre
- ☐ Other (*please specify*): _____

27. How was the client referred to you?

- ☐ Self
- ☐ Parent(s)
- ☐ Other client
- ☐ Legal system
- ☐ Family member
- ☐ School system
- ☐ Psychologist
- ☐ Psychiatrist
- ☐ Physician
- ☐ Other health care professional
- ☐ Insurance system
- ☐ Community service
- ☐ Social services (e.g., CAS)
- ☐ Professional referral service

28. Have you made any referrals for this client or related to this client for: (*check all that apply*)

- ☐ Substance abuse
- ☐ Other mental health
- ☐ Psychological assessment (neuropsychological, educational, vocational)
- ☐ Educational (e.g., tutoring)
- ☐ Parent training or support
- ☐ Activities of daily living

- ☐ Housing
- ☐ Child and family services
- ☐ Social services other than child and family services
- ☐ Medication
- ☐ Other health (e.g., speech language, occupational therapy)
- ☐ Support or self help
- ☐ Other (*please specify*): _____
- ☐ No referrals made

29. Service setting is in:

- ☐ Major urban centre
- ☐ Suburb of major urban centre
- ☐ Smaller city or town
- ☐ Rural setting

30. In what type of setting or organization did you provide the service to this client?

- ☐ Private practice setting – group practice
- ☐ Private practice setting – individual practice
- ☐ Public health care organization (e.g. hospital, clinic)
- ☐ Detention centre
- ☐ Community program
- ☐ Child welfare agency
- ☐ School

31. How did the client or the client's caregiver pay for the service?

- ☐ Paid for services directly, with no extended health insurance reimbursement
- ☐ Paid for services directly, some of which is reimbursed by extended health insurance
- ☐ Paid for services directly, all or most of which is reimbursed by extended health insurance
- ☐ Received services within a publicly funded institution (e.g., hospital, school, correctional facility)
- ☐ Received services paid in part by a publicly funded agency

☐ Received services paid in whole by a publicly funded agency
☐ Received pro-bono services
☐ Other (*please specify*):_____

32. Briefly, what are the top 3 factors that challenged you in providing or ensuring the best possible service for this particular client? (e.g., lack of specialized services in the community, lack of funding for a needed service, lack of collaboration among partners in care, lack of support from parents or others involved in child's care)

_____
_____
_____

<u>Client psychosocial functioning</u>

33. Does the client have any identifiable risk factors for mental health problems? (*Check all that apply*)

☐ Parental mental disorder and/or family history of mental health problem
☐ Physical disability and/or long-term illness in the family
☐ Marital problems in the family (e.g., separation, divorce, family instability)
☐ Bereavement
☐ Mobility (e.g., frequent moves)
☐ Physical and/or sexual abuse
☐ Removal from family by child welfare authorities; multiple placements
☐ Attachment difficulties
☐ Bullying
☐ Aggression and/or anger
☐ Unusual fears, phobias
☐ Academic performance problems
☐ School avoidance, truancy
☐ Pre-term birth
☐ Congenital health problems (including genetic conditions)
☐ Other health problems

- ☐ Exposure to traumatic events
- ☐ Brain injury (developmental or acquired)
- ☐ Other (*please specify*): _____
- ☐ Unknown
- ☐ No risk factors

34. What are the reasons for which the client is seeking services or was brought for services? (*Check as many that apply*):

- ☐ Mood problems or disorders
- ☐ Anxiety problems or disorders
- ☐ Behaviour problems or disorders
- ☐ Intrapersonal issues (e.g., self-esteem, self-confidence, anger, shyness)
- ☐ Attentional problems or disorders (e.g., ADD, ADHD)
- ☐ Learning problems or disorders
- ☐ Gifted assessment
- ☐ School readiness
- ☐ Attachment problems or disorders
- ☐ Cognitive problems other than learning (including developmental delays)
- ☐ Autism spectrum disorders
- ☐ Self-harm behaviours (e.g., suicidal gestures or thoughts, self-injury)
- ☐ Psychosis
- ☐ Managing health, injury, and illness
- ☐ Adjustment to life stressors
- ☐ Parental separation or divorce
- ☐ Adoption consultation
- ☐ Eating disorders
- ☐ Sleep problems or disorders
- ☐ Somatoform disorders (e.g., chronic pain)
- ☐ Sexual abuse and trauma
- ☐ Physical abuse and trauma
- ☐ Psychosexual problems
- ☐ Substance use and/or abuse disorders
- ☐ Other (*please specify*):_____

35. (1) Does your client have any DSM-IV diagnoses?

- ☐ Yes
- ☐ No
- ☐ Diagnostic evaluation not yet completed
- ☐ Unknown
- ☐ I do not use the DSM

35. (2) If you do not use the DSM, do you make diagnoses using a different classification? (e.g., ICD-10)

- ☐ Yes, please specify:
  _____
- ☐ No

35. (3) Enter the names of the client's diagnoses: (Click here for DSM-IV Diagnostic Names)

Primary Diagnosis:_____

Additional Diagnosis:_____

Additional Diagnosis:_____

Additional Diagnosis:_____

36. Please rate the extent to which you believe, prior to seeing you, the client's daily functioning was negatively affected by his or her presenting problem(s):

- ☐ None
- ☐ Little
- ☐ Moderately
- ☐ Severely
- ☐ Unknown

37. Thus far in your work with this client how much change has there been in his or her presenting problem(s)?

- ☐ Recovered
- ☐ Greatly improved
- ☐ Improved
- ☐ No change
- ☐ Deterioration
- ☐ Not applicable

38. (1) Does the client report problems *related* to a chronic disease, disorder or condition, but that is *not* the presenting problem?

- ☐ Yes
- ☐ No
- ☐ Unknown

38.2. What functions are involved in the client's chronic disorder(s)? (*Check all that apply)*

- ☐ Neurological functions
- ☐ Mental functions
- ☐ Gross and fine motor functions
- ☐ Visual functions
- ☐ Auditory functions
- ☐ Speech and language functions
- ☐ Gastrointestinal functions
- ☐ Endocrinological functions
- ☐ Cardiological functions
- ☐ Respiratory functions
- ☐ Immunological functions
- ☐ Other (*please specify*)

  _____

39. Please rate the extent to which you believe the client's daily functioning is restricted by his or her chronic disease(s), disorder(s) or conditions:

- ☐ None
- ☐ Little
- ☐ Moderate
- ☐ Severe
- ☐ Unknown

40. Please rate the extent to which you believe the client's chronic disease(s), disorder(s), or condition(s) impacts the family:

- ☐ None
- ☐ Little
- ☐ Moderate
- ☐ Severe
- ☐ Unknown

41. Client's or parents' appraisal of client's health status:

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Unknown

42. Does your client have a substance use problem or disorder which is not the presenting problem but is concomitant with it?

- ☐ Yes
- ☐ No
- ☐ Unknown

43.1. Is the client receiving psychotropic medication for a *mental health problem*?

- ☐ Yes
- ☐ No (skip to 35)
- ☐ Unknown (skip to 35)

43.2. If yes, what medication(s)? (*Check all that apply*)

- ☐ Antidepressant
- ☐ Anxiolytic
- ☐ Antipsychotic
- ☐ Stimulant
- ☐ Hypnotic
- ☐ Mood Stabilizer
- ☐ Unknown
- ☐ Other (*please specify)*: _____

43.3. If yes, this medication is prescribed to the client by:

- ☐ Family physician or general practitioner
- ☐ Paediatrician
- ☐ Other specialist physician
- ☐ Psychiatrist
- ☐ Nurse-practitioner
- ☐ Other health specialist

44. Does your client take medication for a *health problem* which is related to the presenting problem? (e.g., receiving services related to the diagnosis of ADHD and taking Ritalin)

- ☐ Yes
- ☐ No
- ☐ Unknown

45. Does your client take medication for another health problem *unrelated* to the presenting problem? (e.g., receiving services related to a learning problem but the client also takes insulin for diabetes)

☐ Yes
☐ No
☐ Unknown