# What Else Matters? The Mini-BEARS' Survey
## (All ages)

You are invited to participate in this quality improvement project because you are receiving care from BC Children's Hospital or associated clinic (BCCH sites). Our project aims to better understand the health needs of children, youth and families and what matters to you.

Your participation is voluntary. If you decide to participate, you may withdraw at any time without any negative consequences to the medical care, education, or other services that you are entitled to or are presently receiving.

We recognize that some of the questions are sensitive. If at any time you feel uncomfortable with these questions, you can skip them or stop.

We would appreciate your feedback on this. Your comments at the end will help guide us to provide better care in the future.

A copy of your survey response will be added to your clinic visit record so that our team may be more informed and responsive to you. Your doctor, nurse or nurse practitioner may also help refer you to others for assistance. You may choose to provide your name and contact information at the end if you have more questions or want us to follow-up directly with you.

When you complete the survey, your anonymous responses will be recorded into a secure database stored in BC Children's Hospital Research Institute's Secured Network electronically for five years. Access to your survey responses will be limited to the principal investigators, your health care team and technical support team at BC Children's Hospital Research Institute.

Your confidentiality will always be respected. You will not be identified by name in any reports of the completed project. All records will be kept confidential.

Your personal information is subject to protections under the BC Freedom of Information and Protection of Privacy Act (FIPPA). The collection of your individually identifiable information is authorized by section 26 (c)(e) of FIPPA. The identifiable information collected through the survey will only be used for the purposes listed on this form.

You will be asked to share information under the BEARS categories below. We do not intend to identify you. For open ended responses, please do not share information that might identify you or someone else. When survey results are reported, presented, or published we will not include any data that could identify you.

## BEARS-Youth:

**B**arriers to care

**E**conomic Factors

**A**dversity

**R**esiliency

**S**ocial Capital

**Thank you for completing the survey.**

If you have any questions about your information and this survey, or you would like to withdraw your consent, please contact us.


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## Please keep this page to contact us or look up extra resources.

**For extra information and resources, please scan the QR code below or follow the link.**

http://www.opsei.bc.ca/SurgeryAndSociety.html

# WHAT MATTERS TO YOU?

BC Children's Hospital wants to make services better for children and youth. A copy of this will be added to your clinic chart. **NO** personal identifying information will be in any reports of this project.

You can choose to do this survey or not to do it. **Feel free to answer only the questions you want and skip questions.** You may stop at any time. If you have any questions or would like help completing the survey, please ask a for help. This survey will take less than 10 minutes.

If you have additional questions or feedback, please contact our team directly. (See page 2)

## BARRIERS TO CARE

**1| Where do you go for health care? (check all that apply)**

- ☐ Family Doctor
- ☐ Nurse Practitioner/Outreach Nurse
- ☐ Emergency room
- ☐ Counsellor/psychologist
- ☐ Walk-in clinic
- ☐ Youth clinic
- ☐ After hours clinic
- ☐ School student health/wellness services
- ☐ Traditional/alternative health or healer
- ☐ I have regular scheduled appointments/clinics
- ☐ I do not get health care
- ☐ Other: _____

**2| Do you feel that you are able to go to your health provider with your concerns or for extra help? e.g. Support for help with nutrition/caloric supplements, disability, housing, or transportation related forms, etc.?**

- ☐ Yes
- ☐ No
- ☐ I do not have a regular health provider

## ECONOMIC FACTORS

**1| Overall, do you feel like you have enough money to live on?**

- ☐ Yes
- ☐ No

**2| What is your current living status?**

- ☐ I have a stable place to live
- ☐ I have a stable place to live today, but **I am worried** about losing it in the future
- ☐ I do not have a stable place to live

**3| Do you have MSP health benefits** *(free coverage to see doctors and go to hospital)?*

- ☐ Yes
- ☐ No
- ☐ Pending (e.g. interim refugee)
- ☐ Unsure

**4| Do you have any extended health or disability benefits** *(status card, free coverage for medications, disability tax credits, etc.)?*

- ☐ Yes
- ☐ No
- ☐ Unsure

**3| What is your family estimated annual household income?**

- ☐ $0 - $40,000
- ☐ $40,000 - $80,000
- ☐ $80,000 -120,000
- ☐ Over $120,000

- ☐ **How many people live with you? _____**

**4| Do you ever rely on social services for food?** *(for example: social worker, community centres, community kitchens, food vouchers, food bank, etc.)*

- ☐ Yes, currently
- ☐ Yes, in the past
- ☐ No

## ADVERSITY

**1| Do you identify as a minority?** *(for example: due to your race, culture of origin, color, religion, age, gender, LGBTQ, disability, etc.)*

- ☐ Yes
- ☐ No

**2| Are you Indigenous, First Nations, or Métis?**

- ☐ Yes
- ☐ No
- ☐ Unsure

**3| Have you ever felt you are/were discriminated against in health care because of your language, culture, appearance, or social status?**

- ☐ Yes
- ☐ No

**The following question is sensitive. It is optional. Your health care team is available to talk. You may skip question and proceed to question 5.**

We wish to participate on the journey towards Truth and Reconciliation and acknowledge the impact of colonialism on generations of Aboriginal, Indigenous, First Nations and Métis people. We ask this question with respect and because we care about you and wish to support you on your health journey.

**4| Has anyone in your family been sent to Canadian Indian Residential School or Day School?**

- ☐ Yes
- ☐ No
- ☐ Unsure

**5| Do you wish to learn more about Truth and Reconciliation?**

- ☐ Yes
- ☐ No
- ☐ Unsure

## RESILIENCY & SOCIAL CAPITAL

**1| Do you have someone you could call if you needed help at any time (for example, 4am)?**

- ☐ Yes
- ☐ No

**2| How often do you feel lonely or isolated from those around you?**

- ☐ Always
- ☐ Sometimes
- ☐ Never

**3| In times of stress, how many people can you turn to for support?** *(for example, friends, partner, parents, siblings, neighbors, elders, spiritual/religious guide, teacher, coach, health nurse, doctor, co-worker, social worker etc.)?*

- ☐ No one
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ **5-8**
- ☐ More than 8

**4|"Protective" Childhood Experiences: These questions were designed for youth and young adults. Please indicate your role if you are answering for someone else: _____**

| | | | |
|---|---|---|---|
| I talk to my family about how I feel | ☐ Always | ☐ Sometimes | ☐ Never |
| My family stand by me during difficult times | ☐ Always | ☐ Sometimes | ☐ Never |
| I feel safe and protected by the adult(s) at home | ☐ Always | ☐ Sometimes | ☐ Never |
| I have 2 (or more) supportive adults, outside of family, who take genuine interest in me | ☐ Always | ☐ Sometimes | ☐ Never |
| I feel supported by my friends | ☐ Always | ☐ Sometimes | ☐ Never |
| I feel I belong at my school | ☐ Always | ☐ Sometimes | ☐ Never |
| I enjoy participating in community traditions | ☐ Always | ☐ Sometimes | ☐ Never |
| I push myself to achieve my goals even when things go wrong | ☐ Always | ☐ Sometimes | ☐ Never |
| My activities are meaningful to me | ☐ Always | ☐ Sometimes | ☐ Never |
| People listen to my ideas | ☐ Always | ☐ Sometimes | ☐ Never |

**5|How do your friends describe you?**

_____

**6|Where do you see yourself in 5 years?**

_____

## Feedback

| | | |
|---|---|---|
| I liked this survey | ☐ Agree | ☐ Disagree |
| It is important my care provider know this | ☐ Agree | ☐ Disagree |
| This survey is too personal | ☐ Agree | ☐ Disagree |
| This survey is too long | ☐ Agree | ☐ Disagree |
| This survey was triggering and I want to talk to someone soon | ☐ Agree | ☐ Disagree |

**How did this survey make you feel?**

_____

**What is your role? Check all that apply**

- ☐ I am the patient
- ☐ Mother /Father
- ☐ Adoptive Parent
- ☐ Grandparent
- ☐ Other family member (sister, aunt, uncle, etc.)
- ☐ Foster Parent
- ☐ Social Worker
- ☐ Legal Guardian
- ☐ Other: _____

**Is there anything your doctors or this clinic could do to support you or to make your visits easier on you and your family? Do you have any suggestions to improve this survey? You may also write directly on the questions or chat today with your health providers or other project staff.**

**See first and last pages for additional ways to contact us.**

## Extra Space for Responding

# OPTIONAL – FOR PARENTS/CAREGIVERS REPRESENTING CHILDREN AND YOUTH

**Adverse Childhood experiences**

Childhood experiences, both positive and negative, can impact lifelong health. Many young people develop ways of coping that allow them to thrive. Your health care team can help you to decrease harms from experiences that happened in childhood. The following asks about adverse or negative childhood experiences that you may have lived through.

**We know these questions are more sensitive. They are optional. <u>You may choose to skip these 2 questions.</u>**

**a|**

**Of the statements below, please COUNT HOW MANY apply to you and write the total number in the box.**
**If you feel comfortable, you may also check the statements that apply to you.**
**Note: We will work with you together to address concerns such as a history of abuse and neglect, and link you with supports and resources when there is a duty to report.**

*At any point since your child was born…*

- o Your child's parents or guardians were separated or divorced.
- o Your child lived with a household member who was depressed, mentally ill, or attempted suicide.
- o Your child lived with a household member who served time in jail or prison.
- o Your child saw or heard household members hurt or threaten to hurt each other.
- o Your child lived with someone who had a problem with drinking or using other drugs.
- o A household member swore at, insulted, humiliated, or put down your child in a way that scared your child, OR a household member acted in a way that made your child afraid that s/he might be physically hurt.
- o Someone touched your child's private parts or asked your child to touch their private parts in a sexual way.
- o More than once, your child went without food, clothing, a place to live, or had no one to protect him/her.
- o Someone pushed, grabbed, slapped, or threw something at your child OR your child was hit so hard that your child was injured or had a bruise or mark.
- o Your child often felt unsupported, unloved, and/or unprotected.

| **Total:** | |
|---|---|

**b|**

**Of the statements below, please COUNT HOW MANY apply to you and write the total number in the box. If you feel comfortable, you may also check the statements that apply to you.**

*At any point since your child was born…*

- o You child experiences harassment or bullying at school.
- o Your child lived with a parent or guardian who died.
- o Your child was separated from their primary care giver during deportation or immigration.
- o Your child was in foster care.
- o Your child had a serious medical procedure or life-threatening illness.
- o Your child often saw or heard violence in their neighborhood.
- o Your child was often treated badly because of race, sexual orientation, place of birth, disability, or beliefs.

| **Total:** | |
|---|---|

# OPTIONAL – FOR YOUTH AND YOUNG ADULTS

**Adverse Childhood experiences**

Childhood experiences, both positive and negative, can impact lifelong health. Many young people develop ways of coping that allow them to thrive. Your health care team can help you to decrease harms from experiences that happened in childhood. The following asks about adverse or negative childhood experiences that you may have lived through.

**We know these questions are more sensitive. They are optional. <u>You may choose to skip these 2 questions</u>.**

**a|**

**Of the statements below, please COUNT HOW MANY apply to you and write the total number in the box.**
**If you feel comfortable, you may also check the statements that apply to you.**
**Note: We will work with you together to address concerns such as a history of abuse and neglect, and link you with supports and resources when there is a duty to report.**

*At any point since you were born…*

- o Your parents or guardians were separated or divorced
- o You lived with a household member who served time in jail or prison
- o You lived with a household member who was depressed, mentally ill or attempted suicide
- o You saw or heard household members hurt or threaten to hurt each other
- o A household member swore at, insulted, humiliated, or put you down in a way that scared you OR a household member acted in a way that made you afraid that you might be physically hurt
- o Someone touched your private parts or asked you to touch their private parts in a sexual way that was unwanted, against your will, or made you feel uncomfortable
- o More than once, you went without food, clothing, a place to live, or had no one to protect you
- o Someone pushed, grabbed, slapped or threw something at you OR you were hit so hard that you were injured or had marks
- o You lived with someone who had a problem with drinking or using drugs
- o You often felt unsupported, unloved and/or unprotected

| **Total:** | |
|---|---|

**b|**

**Of the statements below, please COUNT HOW MANY apply to you and write the total number in the box. If you feel comfortable, you may also check the statements that apply to you.**

*At any point since you were born…*

- o You have been in foster care, group home or youth agreement
- o You have experienced harassment or bullying including cyberbullying
- o You have lived with a parent or guardian who died
- o You have been separated from your primary caregiver through deportation or immigration
- o You have had a serious medical procedure or life-threatening illness
- o You have often seen or heard violence in the neighborhood or in your school neighborhood
- o You have been detained, arrested or incarcerated
- o You have often been treated badly because of race, sexual orientation, place of birth, disability or religion
- o You have experienced verbal or physical abuse or threats from a romantic partner (i.e. boyfriend or girlfriend)

| **Total:** | |
|---|---|

# Thank you for Participating!

To protect your privacy in the study,
this page will be separated from your responses.

In order to communicate with you we would like to send you emails from time to time. Although you may not be aware of this fact, emails sent to some webmail services (e.g. Gmail, Hotmail, etc.), may be stored/routed outside of Canada (for example, in the United States). Due to the fact that future emails will contain personal information about you, including your name, the Freedom of Information and Protection of Privacy Act requires that we obtain your consent before we continue. We will only send your personal information to the email address which you have provided to us. All of the information which you provide to us, including information about the care you receive, will be kept completely confidential. Providing your email means that you voluntarily agree and give your consent for us email your personal information to you.

Name: _____

Year of birth: _____

Today's date: _____

Best way to reach you if you want us to contact you:

Email/ text/phone: _____