What Else Matters? The BEARS-Youth Survey
(12 years or older)

BC Children's Hospital wants to make services better for youth like you. We are inviting you to take part in this project because you get care from BC Children's Hospital or associated clinics (BCCH sites). We want to better understand what makes it hard for you to get the care you need (for example financial or social concerns).

Your participation is voluntary. This means you can choose to do this survey or not do it. Feel free to answer only the questions you want and skip questions you do not feel comfortable answering. You may stop at any time. Choosing to stop will not have any negative effects on the medical care, education, or other services that you receive.

A copy of your survey answers will be added to your clinic chart so that your care team can better help you or maybe involve others to help.

When you complete the survey, your responses will be put into a secure computer database stored in BC Children's Hospital Research Institute's Secured Network for five years. Only the people who are running this survey (the principal investigators) and your healthcare team will be able to see your answers.

We will ask you to provide your name and birthname. You will also be asked to share information under the BEARS categories below:

Barriers to care

Economic Factors

Adversity

Resiliency

Social Capital

For open ended responses, please do not share information that might identify you or someone else.

We do not intend to identify you. Your personal information is protected by 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. This means your confidentiality will be respected and that NO personal identifying information will be in any reports of this project without asking you first or if we are required to do so by law. When survey results are reported, presented, or published, we will not include any data that could identify you.

We would like your feedback on this survey. Your comments at the end will help us provide better care for youth like you in the future. Thank you for thinking about it.

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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We would like to thank the BC Children's Hospital Youth Advisory Committee (YAC) for their help in making this survey.

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 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 15 minutes.

If you have any questions or feedback, please contact Will Lau in person or by email wlau@alumni.ubc.ca.

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| What could health providers do to help you attend your appointments? (check all that apply)

- ☐ Transportation support: parking help, bus pass, ferry voucher, etc.
- ☐ Reminders: email, text, phone, etc.
- ☐ Language/cultural support
- ☐ Emotional support
- ☐ Family support: letter for time off, sibling/childcare, etc.
- ☐ Companion to take me/ someone to keep me company
- ☐ Youth-friendly care: age appropriate, training/experience working with youth, **ask me what matters to me**, etc.
- ☐ To treat me as an equal and included in decisions about my care
- ☐ Other (there is more space at the end on page 8)

ECONOMIC FACTORS

1| Do you feel that you are able to go to your health provider with your concerns?

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

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| Have you ever spent 3 or more nights in a row without a stable address?

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

4| Have you ever lived away from parents, guardians or caregivers?

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

5| Think about your current living status. Do you have worries with any of the following? (<u>check all that apply</u>)

- ☐ Pests (bugs, ants, mice, etc.)
- ☐ Mold
- ☐ Lead paint or pipes
- ☐ Appliances (oven, stove, fridge) not working
- ☐ Smoke detectors missing or not working
- ☐ Water leaks
- ☐ Utilities: electricity, heating, gas, etc. is off
- ☐ No issues
- ☐ Other safety concerns: _____

6| Are you currently working?

- ☐ I work full-time
- ☐ I work part-time
- ☐ I work more than 1 job
- ☐ I work seasonal/temporary
- ☐ I am looking for a job now
- ☐ I am not working now

7| Do you have someone who relies on you for financial support? *(for example: children, siblings, elderly relatives, parents, partner, pets)*

- ☐ Yes
- ☐ No

8| Have you ever experienced or worried about food running out before there was money to buy more?

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

9| Do you 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

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

- ☐ Yes
- ☐ No

11| Do you submit income tax forms each year?

- ☐ Yes
- ☐ No
- ☐ Unsure

12| Do you have extended health benefits above what is provided by the government *(for example: free coverage for medications, physiotherapy, etc.)?*

- ☐ Yes
- ☐ No
- ☐ Unsure

ADVERSITY

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

- ☐ Yes
- ☐ No

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

- ☐ Yes
- ☐ No
- ☐ Unsure

The following question is sensitive. It is optional. Your health care team is available to talk. You may skip question 3 and proceed to question 4.

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.

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

- ☐ Yes
- ☐ No
- ☐ Unsure

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

- ☐ Yes
- ☐ No
- ☐ Unsure

RESILIENCY & SOCIAL CAPITAL

1| Do you participate in after school or weekend activities? *(for example: sports, arts, music, drama, cultural or traditional activities, community centre, library activities or other activities)*

- ☐ Always
- ☐ Sometimes
- ☐ Never

2| Where/who do you feel connected or feel like you belong/are supported? (<u>check all that apply</u>)

- ☐ Family
- ☐ Friends
- ☐ Partner
- ☐ Online friends
- ☐ School/alternative school
- ☐ Work
- ☐ Elder
- ☐ Land/Nature
- ☐ Neighbourhood/community
- ☐ Sports group/team/class
- ☐ Arts or performance group/team/class
- ☐ Volunteer group
- ☐ Social or cultural groups
- ☐ Community spaces (including community centre, library)
- ☐ Care team (health care, mental health, etc.)
- ☐ Other: _____

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

- ☐ Always
- ☐ Sometimes
- ☐ Never

4| In times of stress, how many adults 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
- ☐ More than 4

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

- ☐ Yes
- ☐ No

6| Childhood Experiences

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

7| Where do you see yourself in 5 years? There is more space at the end of the survey

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 *(for example: made me very emotional or upset)* and I want to talk to someone soon	☐ Agree	☐ Disagree

How did this survey make you feel?

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 with a project staff.

Extra Space for Responding

OPTIONAL

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. You may choose to skip these 2 questions.

a|

Of the statements below, please COUNT HOW MANY apply to you and write the total number in the box. ☐

At any point since you were born…

- Your parents or guardians were separated or divorced
- You lived with a household member who served time in jail or prison
- You lived with a household member who was depressed, mentally ill or attempted suicide
- You saw or heard household members hurt or threaten to hurt each other
- 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
- 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
- More than once, you went without food, clothing, a place to live, or had no one to protect you
- Someone pushed, grabbed, slapped or threw something at you OR you were hit so hard that you were injured or had marks
- You lived with someone who had a problem with drinking or using drugs
- You often felt unsupported, unloved and/or unprotected

b|

Of the statements below, please COUNT HOW MANY apply to you and write the total number in the box. ☐

At any point since you were born…

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

Thank you for Participating!

Name: _____

Date of birth: _____

Today's date: _____

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

We may send you emails from time to time. Webmail services like Gmail, Hotmail, etc., may send or store emails outside of Canada (for example: United States). Since emails will have your name and other personal information about you, we need to ask you if it is ok to email you (FIPPA). We will only use the email address that you provide below. We will keep confidential all the information you provide us, including information about the care you receive. Providing your email means that you voluntarily agree and give your consent for us to email your personal information to you.

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

Email/ text/phone: _____