APPENDIX A
Needs Assessment Survey

CHILDREN AND ADOLESCENT MENTAL HEALTH SURVEY:
Needs and Interests among Family Physicians, General Practitioners and Paediatricians located in Rural and Remote Areas. A Canadian National Collaborative Study

INSTRUCTIONS: Please check your responses unless otherwise specified.

SECTION 1: DEMOGRAPHICS

1. Are you a ...
   ○ Family Physician; ○ General Practitioner registered with CFPC; ○ Paediatrician.
   (If you are not a Family Physician or a General Practitioner or a Paediatrician, please disregard this survey and thank you for your time.)

2. Please indicate your gender.
   ○ Male; ○ Female.

3. How old are you?
   ○ 25-30 years old; ○ 31-40 years old; ○ 41-50 years old;
   ○ 51-60 years old; ○ 61-65 years old; ○ 66+ years old.

4. How many years have you been in practice? Please check one.
   ○ 0-5 years; ○ 6-10 years; ○ 11-15 years; ○ 16-20 years;
   ○ 21-25 years; ○ 26-30 years; ○ 31-35 years; ○ >35 years.

5. What is the population of the main community you practice in? Please check one.
   ○ <1,000 ○ 1,000-10,000 ○ 10,001-25,000 ○ 25,001-100,000 ○ 100,001–250,000 ○ >250,000

6. Please write the COUNTY/DISTRICT you practice in.

7. In which PROVINCE do you practice in? (check only one)
   ○ Alberta; ○ British Columbia; ○ Manitoba; ○ New Brunswick;
   ○ Newfoundland & Labrador; ○ Ontario; ○ Nova Scotia; ○ Prince Edward Island;
   ○ Quebec; ○ Saskatchewan; ○ Yukon; ○ Nunavut; ○ Northwest Territories

8. Have you seen any children and adolescents in your practice in the last 6 months?
   ○ Yes ○ No - Please disregard this survey and thank you for your time.
   If “YES”, what percentage of your practice is made up of the following. Please use the percentage range on the right and give your best estimate.
   ○ 0%; ○ 1%-10%; ○ 11%-20%; ○ 21%-30%; ○ 31%-40%; ○ 41%-50%;
   ○ 51%-60%; ○ 61%-70%; ○ 71%-80%; ○ 81%-90%; ○ 91%-100%
   ____% - ____%: Children, 0 - 5 years old
   ____% - ____%: Children, 6 - 11 years old
   ____% - ____%: Adolescents, 12 - 18 years old

SECTION 2: TRAINING

1. Where was your place of medical training? Check all that apply.
   MEDICAL DEGREE (M.D.)
   ○ Dalhousie University; ○ McGill University; ○ McMaster University;
   ○ Memorial University of Newfoundland; ○ Northern Ontario Medical School;
   ○ Queen’s University; ○ The University of Western Ontario; ○ Université de Sherbrooke;
   ○ Université de Montréal; ○ Université Laval; ○ University of Alberta;
   ○ University of British Columbia; ○ University of Calgary; ○ University of Manitoba;
   ○ University of Ottawa; ○ University of Saskatchewan; ○ University of Toronto
   Other1: Please indicate University and Country
   Other2: Please indicate University and Country
RESIDENCY / INTERNSHIP
○ Dalhousie University; ○ McGill University; ○ McMaster University;
○ Memorial University of Newfoundland; ○ Northern Ontario Medical School;
○ Queen’s University; ○ The University of Western Ontario; ○ Université de Sherbrooke;
○ Université de Montréal; ○ Université Laval; ○ University of Alberta;
○ University of British Columbia; ○ University of Calgary; ○ University of Manitoba;
○ University of Ottawa; ○ University of Saskatchewan; ○ University of Toronto
Other1: Please indicate University and Country
Other2: Please indicate University and Country

2. Please indicate all your qualifications. Check all that apply.
○ MD; ○ CCFP; ○ Paediatrics; ○ American Paediatrics;
○ Other (specify): ____________________________

3. Have you ever received formal training in child and adolescent psychiatry?
○ Yes; ○ No – Go to SECTION 3

If “YES”, please place one checkmark in each row that describes the nature of your training.

TOTAL NUMBER OF HOURS

<table>
<thead>
<tr>
<th>NATURE OF TRAINING</th>
<th>1-5 hrs.</th>
<th>6-10 hrs.</th>
<th>11-19 hrs.</th>
<th>&gt;20 hrs.</th>
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<tr>
<td>Lecture(s): M.D. program</td>
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<td>Lecture(s): Specialist training</td>
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<td>Post licensure CME – Clinical</td>
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<td>Other (describe):</td>
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SECTION 3: REFERRALS TO CHILD/ADOLESCENT PSYCHIATRISTS

1. Do you treat children or adolescents with mental health issues?
○ Yes; ○ No.

2. If you are a family physician (FP) or a general practitioner (GP), do you refer to a paediatrician to assess children and adolescents with mental health problems?
○ Yes; ○ Sometimes; ○ No; ○ I am not a FP/GP.

3. Do you refer to other mental health programs or services to assess/treat children and adolescents with mental health problems?
○ Yes; ○ Sometimes; ○ No.

4. Do you refer to child/adolescent psychiatrists?
○ Yes; ○ Sometimes; ○ No.

If your answer to #4 is, “NO or SOMETIMES”, please indicate in the table the reason(s) why YOU WOULD NOT REFER to child/adolescent psychiatrists. Please check one box for each reason that is applicable to your practice.

NOT IMPORTANT; SOMEWHAT IMPORTANT; VERY IMPORTANT.

___ Other health professionals come to my office and see patients.
___ Child/adolescent psychiatrist is located too far away.
___ Feel confident in own ability to manage psychiatric disorders.
___ Patients refuse to be seen by a psychiatrist.
___ Parents refuse to have child/adolescent seen by a psychiatrist.
___ Unsure of whether case is severe enough to warrant a referral.
___ Unsure of how to refer a child/adolescent for a psychiatric assessment.
___ Wait times are too long.

Other1 (describe): ____________________________ Other2 (describe): ____________________________
5. In the last six months, how many children and adolescents have you referred to a child/adolescent psychiatrist for the following age ranges. Write a number for each age range. If unsure, please give your best estimate.
   ______ Children, 0 years old to 5 years of old
   ______ Children, 6 years old to 11 years old
   ______ Adolescents, 12 years old to 18 years old

6. If you have referred to a child/adolescent psychiatrist, how long on average was the wait? If unsure, please give your best estimate. (check one).
   ○ < 1 week;          ○ Between 1 week – 1 month;        ○ Between 1 month – 2 months;
   ○ Between 2 months – 4 months;     ○ Between 4 months – 6 months;
   ○ Between 6 months – 12 months;     ○ Over 12 months;            ○ Not applicable.

7. Do you use a standard questionnaire or a checklist to determine whether to refer to child/adolescent psychiatrist / paediatrician / children’s mental health services?
   ○ Yes;  ○ No – Go to #8
   If "YES", please list the ones you use. __________________________

8. Please indicate the proportion of how often you refer to a child/adolescent psychiatrist when patients present with the following disorders. Please check one box for each presenting problem. Not Applicable/Don’t see problem (0%); (0%) Don’t Refer; (1-33%) Rarely Refer; (34-66%) Sometimes Refer; (67-100%) Often Refer.
   PRESENTING PROBLEM
   ___Mood;       ____Anxiety;       ___Attention Problems and/or Hyperactivity; ___Behavioural;
   ___Eating;     ___Developmental (e.g. Autism/Asperger’s); ___Psychosis; ___Substance abuse;
   ___Patient has been physically/sexually abused; ___Patient violent/abusive;
   ___Self-harm behavior; ___Suicidal ideation / suicide attempt.
   Other1 (specify): ______________________  Other2 (specify): ______________________

9. Sometimes you refer to a child/adolescent psychiatrist and sometimes you don’t refer to a child/adolescent psychiatrist. Which of the following are reasons why you WOULD REFER a patient to a child /adolescent psychiatrist? Please check one box for each reason that is applicable to your practice.
   NOT IMPORTANT;      SOMEWHA T IMPORTANT;   VERY IMPORTANT
   REASON
   ____To obtain a second opinion about a mental health diagnosis or a mental health problem.
   ____To obtain recommendations about medication.
   ____To obtain non-pharmacological treatment.
   ____To assess a patient that is non-responsive to treatment
   Other1 (describe): ______________________  Other2 (describe): ______________________
SECTION 4: IDENTIFICATION OF NEEDS AND INTERESTS

   1. Completely Lacking in Confidence  
   2. Somewhat Lacking in Confidence  
   3. Somewhat Confident in Confidence  
   4. Very Confident in Confidence

   1. Completely Lacking in Confidence  
   2. Somewhat Lacking in Confidence  
   3. Somewhat Confident in Confidence  
   4. Very Confident in Confidence

3. Please rate your level of confidence in making appropriate referrals to child/adolescent psychiatrists or other mental health programs. Please CIRCLE ONE NUMBER on the line.  
   1. Completely Lacking in Confidence  
   2. Somewhat Lacking in Confidence  
   3. Somewhat Confident in Confidence  
   4. Very Confident in Confidence

4. How confident do you feel your referrals will meet the needs of your child and adolescent patients for mental health problems in a timely manner? Please CIRCLE ONE NUMBER on the line.  
   1. Completely Lacking in Confidence  
   2. Somewhat Lacking in Confidence  
   3. Somewhat Confident in Confidence  
   4. Very Confident in Confidence

5. Do you feel you need more continuing professional development in child/adolescent psychiatry?  
   ○ Yes; ○ No - Go to #6
   If your answer to #5 is “YES”, what method of professional development would you find most beneficial? Please rate your top 5 choices. Use number 1 as your first choice and number 5 as your last choice.  
   ___Handouts  
   ___Continuing Medical Education lectures in your community.  
   ___Continuing Medical Education lectures at a teaching centre.  
   ___Small group peer tutoring.  
   ___Small group teaching by a child/adolescent psychiatrist.  
   ___Small group teaching by child/adolescent psychiatrist and family physician.  
   ___Correspondence.  
   ___Self-instructional package including videotapes, readings and self-evaluation.  
   ___A one-year Fellowship at a university training centre.  
   ___Telemedicine training.  
   ___Web based structured learning (computer online).  
   ___Independent internet research  
   ___One-day conference.  
   ___Other (specify): ______________________________________
6. Please rank 1 to 5 the most important topics in child/adolescent psychiatry that you believe family physicians, general practitioners and paediatricians in under serviced areas will need to know in their practice. Use number 1 as your first choice and number 5 as your last choice.

___Mood
___Anxiety
___Attention Problems and/or Hyperactivity
___Behavoural
___Eating
___Developmental (e.g. Autism/Asperger’s)
___Psychosis
___Substance abuse
___Patient has been physically / sexually abused.
___Patient violent / abusive
___Self-harm behaviour
___Suicidal ideation/suicide attempt
___Other (specify): __________________________________________

7. In considering your multiple learning needs how would you rate your professional development needs in child/adolescent psychiatry in relation to your needs in other areas? Please CIRCLE ONE NUMBER on the line.

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<th>3</th>
<th>4</th>
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<tbody>
<tr>
<td>Minimal</td>
<td>High</td>
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<td>Need</td>
<td>Need</td>
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8a) Do you currently have opportunities to increase your confidence/competence in child/adolescent psychiatry?
   ○ Yes; ○ No.

8.b) If not available in your area, would you be willing to participate in increasing your confidence/competence by having continuing professional development in child/adolescent psychiatry?
   ○ Yes; ○ No; ○ There are opportunities in my area.

8.c) If funding was available in your area, would you take advantage of the opportunity to increase your confidence/competence by having continuing professional development in child/adolescent psychiatry?
   ○ Yes; ○ No.

9. Are there any other issues that you would like to address that pertain to child/adolescent psychiatry for family physicians, general practitioners and paediatricians working in under serviced areas?

________________________________________________________________________

The summary of the results will be mailed to you.

THANK YOU VERY MUCH FOR YOUR TIME.