Patient Survey: Adult Mental Health and Substance Use

**Preamble/Introduction**

We are currently conducting a survey about the care for mental health symptoms and substance use issues provided in *insert the name of your community(s).* We want to know about your experience of receiving care for mental health symptoms and/or substance use issues in *insert name of community(s).* From this information, we will work with our community of patients and health care providers to determine ways in which we can enhance the care of patients with mental health symptoms and/or substance use issues.

Mental health symptoms and substance use issues can be:

**Mild**: when a person has a few symptoms that can have a limited effect on their daily life.

**Moderate**: when a person has more symptoms that can make their daily life much more difficult than usual.

**Severe** : when a person has many symptoms that often make their daily life extremely difficult.

A person may experience different levels at different times.

**Online version of this survey can be accessed at:** *Optional – provide an online link to the survey*

Optional for Divisions: After you have completed the survey, please enter to win a (Divisions determine number and type of gift). Incentives are encouraged.

**What are the risks or harms of completing this survey?**

Answering the survey may cause some discomfort because some of the questions are personal. If you feel discomfort, you are may opt out of this survey. If you wish to discuss your feelings, please connect with your care provider.

**How do we protect your information?**

We are asking for your consent to participate in this survey. Your participation will provide us with valuable information that will be used to improve the primary health care system in our community. Your responses are totally anonymous – you won’t be identified in any way.

It is important that you know that:

* **Participating in the survey is not necessary for you to receive health services**.
* You may withdraw from the survey at any time.

The survey is anonymous, and no one will be able to link your answers back to you.

* We will not record your name.
* Like all other information you share with your care provider, this form will be treated privately.
* We will not match your survey answers to your medical record at this clinic/hospital.
* Results will be grouped and reported in group form only.
* You have the option of not answering any or all questions.
* This will not impact the care you receive here.
* By completing this survey, you are giving us consent for your data to be pooled together to inform enhance care in your community and to identify provincial trends
* We are collecting identifiable information in accordance with section 26(e) of the Freedom of Information and Protection of Privacy Act.

If you have any questions, concerns or comments about this survey, please contact [insert local division information here].

**ABOUT YOU**

1. **Are you currently seeking or receiving care for mental health symptoms?**
* Yes
* No

If yes, please describe your mental health symptoms here (e.g. mild anxiety)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, how would you describe the impact of your mental health symptoms:

* Mild. I have a few symptoms that can have a limited effect on my daily life.
* Moderate. I have symptoms that can make my daily life much more difficult than usual.
* Severe. I have many symptoms that often make my daily life extremely difficult.
1. **Are you currently seeking or receiving care for substance use issues?**
*
* Yes
* No

If yes, please describe your substance use issues here (e.g. alcohol or drug use – please specify drug. If cannabis, please see question 3)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, how would you describe the impact of your substance use issues:

* Mild. I have a few symptoms that have a limited effect on my daily life.
* Moderate. I have symptoms that can make my daily life much more difficult than usual.
* Severe. I have many symptoms that often make my daily life extremely difficult.
1. **Do you have any concerns about your cannabis use?**
* Yes,
* No

If yes, please describe your concerns here (e.g. frequency, impact)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, how would you describe the impact of your cannabis use issues:

* Mild. I have a few symptoms that have a limited effect on my daily life.
* Moderate. I have symptoms that can make my daily life much more difficult than usual.
* Severe. I have many symptoms that often make my daily life extremely difficult.

## ACCESS TO CARE: For your mental health symptoms and/or substance use issues:

1. **What type of care provider provides most of your care? Check ONE only please.**
* My family doctor
* Family doctor other than my regular doctor
* Psychiatrist
* Other Specialist(s), please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Emergency department doctor
* Nurse Practitioner
* Psychologist
* Nurse
* Counsellor
* Social Worker
* Complementary or alternative provider (e.g., acupuncturist, chiropractor, registered massage therapist, etc.)
* Other. Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_
1. **How many times have you visited:**

your main care provider in the past year? \_\_\_\_\_\_\_

your family doctor in the past year (if different than above)? \_\_\_\_\_\_ I do not have a family doctor \_\_\_\_\_

a walk-in clinic in the past year? \_\_\_\_\_\_\_

your emergency department in the past year? \_\_\_\_\_\_\_

1. **How easy or difficult was it for you to find a care provider?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Very easy
 | * Acceptable
 | * Easy
 | * Difficult
 | * Very difficult
 |

1. **Please select any barriers for you to attend your scheduled appointments? Check all that apply.**
* Transportation or money for transportation
* Childcare availability
* Location of clinic
* My work/school schedule
* Time of appointment
* Mental or physical health
* Lack of medical coverage/MSP
	+ Service not available in the area
* Issues with provider/clinic
* Time required for recommended treatments
	+ Costs associated with treatment
	+ A specialist was unavailable
	+ Did not know where to go
	+ Do not have personal/family doctor
	+ Waited too long to get an appointment
	+ Waited too long in the waiting room
	+ Language barriers
	+ Cultural barriers
* Other. Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* No barriers

**Please use this space to elaborate on anything above:**

## Other than the care provider selected above, who else did/do you see for your mental health symptoms and/or substance use issues? Check all that apply.

* My family doctor
* Family doctor other than my regular doctor
* Psychiatrist
* Other Specialist(s), please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Emergency department doctor
* Nurse Practitioner
* Psychologist
* Nurse
* Counsellor
* Social Worker
* Complementary or alternative provider (e.g., acupuncturist, chiropractor, registered massage therapist, etc.)
* Other. Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## ABOUT YOUR CARE: For your mental health symptoms and/or substance use issues:

1. **What type(s) of care have you tried/are you trying? Check all that apply****.**
* Medication
* **In-office counselling with your physician**
* **Education/Self-management**
* **Group medical visits**
* **Private counselling**
* **Group counselling**
* **Community support group**
* **Crisis line**
* **Emergency department**
* Narcotic substitution therapy **/** **opioid agonist treatments**
* **Exercise**
* **Complementary and Alternative Medicine (e.g. acupuncture, herbal medicine, meditation, massage, nutritional regime**
* Other. Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In general, do you feel this care is helping?**

|  |  |  |  |
| --- | --- | --- | --- |
| * Yes, completely
 | * Yes, somewhat
 | * Too soon to tell
 | * No
 |

1. **What type(s) of care have worked well for you?**

**Please use this space to elaborate on anything above:**

## EXPERIENCE & SATISFACTION

**Thinking about the care provider who provides *most* of your care** **for your mental health symptoms and/or substance use issues:**

1. **How satisfied are you with the care you receive?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Very satisfied
 | * Satisfied
 | * Acceptable
 | * Dissatisfied
 | * Very dissatisfied
 |

## How satisfied are your family and/or friends with the care you receive?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Very satisfied
 | * Satisfied
 | * Acceptable
 | * Dissatisfied
 | * Very dissatisfied
 |

1. **How satisfied are you with how your care provider involves you in decisions about your care?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Very satisfied
 | * Satisfied
 | * Acceptable
 | * Dissatisfied
 | * Very dissatisfied
 |

1. **How comfortable do you feel with the care provided?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Very comfortable
 | * Comfortable
 | * Acceptable
 | * Uncomfortable
 | * Very uncomfortable
 |

1. **How comfortable do you feel talking with your care provider?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Very comfortable
 | * Comfortable
 | * Acceptable
 | * Uncomfortable
 | * Very uncomfortable
 |

1. **Does your care provider take your concerns seriously?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Always
 | * Frequently
 | * Half the time
 | * Occasionally
 | * Never
 |

1. **Does your care provider spend enough time with you?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Always
 | * Frequently
 | * Half the time
 | * Occasionally
 | * Never
 |

1. **Does your care provider treat you with care and respect?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Always
 | * Frequently
 | * Half the time
 | * Occasionally
 | * Never
 |

**Thinking about the TEAM of care providers who provide your care, (if this section does not apply to you, please skip to the section, improving care)**

1. **How satisfied are you with the care you receive from your team of care providers?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Very satisfied
 | * Satisfied
 | * Acceptable
 | * Dissatisfied
 | * Very dissatisfied
 |

1. **How satisfied are you with how your care is coordinated by your team of providers?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Very satisfied
 | * Satisfied
 | * Acceptable
 | * Dissatisfied
 | * Very dissatisfied
 |

1. **How satisfied are you with the time you wait for care (appointments, treatments or tests)?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Very satisfied
 | * Satisfied
 | * Acceptable
 | * Dissatisfied
 | * Very dissatisfied
 |

1. **Do you know what the next steps of your care plan are?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Always
 | * Frequently
 | * Half the time
 | * Occasionally
 | * Never
 |

1. **Do you know whom to talk to if you have questions about your care?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Always
 | * Frequently
 | * Half the time
 | * Occasionally
 | * Never
 |

1. **Do you have enough support from your team of care providers?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Always
 | * Frequently
 | * Half the time
 | * Occasionally
 | * Never
 |

## IMPROVING CARE: For your mental health symptoms and/or substance use issues:

1. **What is needed to improve care in your community?**
2. **Is there anything else you would like to share about the care you receive or your experience?**

**DEMOGRAPHICS**

1. **Gender**
* Male
* Female
* X
1. **What year were you born \_\_\_\_\_ (year)**
2. **Do you have a family doctor?**
* Yes, I had a family doctor before my mental health symptoms/substance use issues
* Yes, I have a family doctor since developing my mental health symptoms/substance use issues
	+ No
1. **Do you live in the same community where you receive your care?**
* Yes
* No

If no, why not?

1. **How long does it take to get to your appointments? \_\_\_\_\_ (minutes)**
2. **In what community do you receive most of your care? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **In what other community(ies) do you receive some of your care? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

--Thank-you for your time and feedback--