

SENITA

Your unique serial number

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Baseline

☐

6 months follow-up

☐

12 months follow-up

☐

(Please tick assessment time point)

CLIENT SERVICE RECEIPT INVENTORY

4 - 11 YEAR OLD PARENT/CAREGIVER VERSION

FACETO FACE

To the parent or caregiver completing this form

In this form we are asking your help in telling us about your family circumstances and service use, to help us understand the impacts to you and your child **in the last 6 months at baseline interview and at 6 and 12 month follow-up assessments.**

We know that this can be sensitive information, so if you don't want to answer the questions feel free to say you do not wish to answer.

All information will be treated in the strictest confidence and no names will be divulged under any circumstances whatsoever, unless there are concerns about someone's safety.

NOTES:

Please do not leave any sections blank

Please enter a response, a zero or a missing code into every box.

Missing codes:

-888 = not applicable

-999 = don't know

-777 = respondent does not wish to answer

EXAMPLE

Have there been any days when the care recipient's behaviour meant that you felt you could not take part in your usual activities?

This question relates to the last 6 months?

Yes..... ☒ 1

If yes, how many days?

No..... ☐ 2

This means that for 12 days (not necessarily consecutively) you were unable to take part in usual activities since your last interview.

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A. AUTISM INTERVENTION PACKAGES DIRECTLY WITH CHILD

In this section we are interested in any autism intervention packages you have received other than as part of the study. We are only interested in packages with a minimum of 4 sessions in the last 6 months .

1. Have you used any autism intervention packages other than as part of this study in the last 6 months?

Yes..... ☐ 1

No..... ☐ 2

a. **If yes,** which of the following services have you used in the last 6 months?

	Average number of sessions	Average duration of session
ABA/EIBI (intensive behavioural intervention))	<input type="text"/>	<input type="text"/>
Son-Rise Programme	<input type="text"/>	<input type="text"/>
Relationship Development Intervention	<input type="text"/>	<input type="text"/>
Social skills programme (directly with child)	<input type="text"/>	<input type="text"/>
Other intensive home-based autism treatment package. Please give details:	<input type="text"/>	<input type="text"/>

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B AUTISM-RELATED PARENT TRAINING

In this section we are interested in any autism-related parent focused training other than as part of the study. If you have attended any courses, workshops or training related to your child's autism, please indicate the number of sessions and the average duration of the sessions. We are only interested in courses, workshops or training with a minimum of 4 sessions in the last 6 months .

2. Have you used any autism-related parent training other than as part of this study in the last 6 months?

Yes..... ☐ 1

No..... ☐ 2

a. **If yes**, which of the following services have you used in the last 6 months?

	Average number of sessions	Average duration of session
Parent-mediated communication programme (Include only group sessions)	<input type="text"/>	<input type="text"/>
EarlyBird/Help	<input type="text"/>	<input type="text"/>
Behaviour management training	<input type="text"/>	<input type="text"/>
Alternative and augmentative systems, including PECS, sign language (e.g. BSL, Makaton)	<input type="text"/>	<input type="text"/>
Other autism-related parent , please give details:	<input type="text"/>	<input type="text"/>
Other autism-related parent training, please give details:	<input type="text"/>	<input type="text"/>

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Section C SERVICE USE BY THE CHLD
EDUCATION

3. What type of education provision (e.g. school/ flexi school) does/did [child's name] *usually* receive? Indicate all that apply for the last school year.

If [child's name] has recently been permanently/temporarily excluded from school or does not attend school please tick box ☐ and **indicate their last usual** type(s) of formal education received prior to the permanently/temporarily exclusion or other reasons.

	Part-time	Full time	No. of terms in the last school year	Fees paid Yes/No
Mainstream day school/college				
Special education unit in mainstream school				
Special residential school				
Special day school				
Pupil Referral Unit (PRU)				
Home education/school				
Other (please specify)				

4. Did [child's name] have any help with education in the last 6 months?

Yes..... ☐ 1

No..... ☐ 2

- a. **If yes**, please state for the support shown in the table below the number of hours each week in the last 6 months?

	No	Yes	No. hours each week on average <u>in the last 6 months</u>
Individual tuition at home			

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1:1 support in school (e.g. Learning Support Assistant [LSA])			
Group support in school (e.g. small group work with a LSA).			
Other support 1 (please specify)			
Other support 2 (please specify)			
No additional help <u>in the last 6 months</u>			

5. Did [child's name] see any of the following people in pre-school, primary school in the last 6 months?

	No	Yes	No. of contacts on average <u>in the last 6 months</u>	Duration of contact on average <u>in the last 6 months</u>
School nurse				
Educational psychologist				
Counsellor/learning mentor				
SENCO				
Other support 1 (please specify)				
Other support 2 (please specify)				

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6. Does [child's name] have a 'Statement of Special Educational Needs' or 'Education and Health Care Plan'?

Yes..... ☐ 1

No..... ☐ 2

Not sure..... ☐ 3

7. Has [child's name] been excluded from nursery/school for short periods?

Yes..... ☐ 1 **If yes, how many days in the last 6 months?** ☐

No..... ☐ 2

8. Has [child's name] been excluded from nursery/school informally?

Yes..... ☐ 1 **If yes, how many days in the last 6 months?** ☐

No..... ☐ 2

HEALTH AND SOCIAL CARE

9. Has [child's name] made contact with any health and social care services in the last 6 months?

Yes..... ☐ 1

No..... ☐ 2

- a. **If yes**, which of the following services has [child's name] used in the last 6 months?

	No	Yes	If yes, how many times on average <u>in the last 6 months</u> ?
GP (<i>visits or calls</i>)			
Practice nurse (<i>visits</i>)			
SLT (contacts)			
Community paediatrician (contacts)			
CAMHS psychiatrist (local service) (contacts)			
Clinical psychologist (contacts)			
Counsellor/Psychotherapist (contacts)			

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Behaviour support team member (contacts)			
Social worker (contacts)			
Respite care (sessions)			
Outreach worker/ Family support worker (contacts)			
Inpatient admission – mental health (<i>overnight stay</i>)			
Inpatient admission - physical health (<i>overnight stay</i>)			
Accident and emergency (<i>not requiring a stay in hospital</i>)			
Accident and emergency (<i>requiring a stay in hospital</i>)			
Other (e.g. Occupational therapist, Physiotherapist, Dentist, Dietician, Optician, alternative therapies) (please specify)			
Other 2 (please specify).....			
Other 3 (please specify).....			

POLICE AND YOUTH JUSTICE SYSTEM

10. Has [child's name] been involved with the police or the youth justice system in the last 12 months? **(Tick all that apply).**

Yes, as a victim.....

☐

1

Ask Q11 then skip to section D

Yes, as a witness.....

☐

2

Skip to section D.

Yes, as a suspect (e.g. someone thought they might have done something wrong)....

☐

3

If this box is ticked, do not skip to section D. Even if other boxes are ticked above.

No contact

☐

4

Skip to section D.

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11. Has [child's name] appeared in court in the last 12 months??Yes..... ☐ 1No..... ☐ 2

a. If yes, how many times in the last 12 months? _____

12. Has [child's name] had formal police cautions in the last 12 months?Yes..... ☐ 1No..... ☐ 2If no, skip to Section
Da. If **yes**, how many times in the last 12 months? _____

b. Reasons for cautions? (please specify)

.....

.....

.....

Section D CAREGIVER HEALTH13. Do you think that [child's name] behaviour has affected your health in the last 6 months?Yes..... ☐ 1No..... ☐ 2a. **If yes**, which of the following services have you used in the last 6 months?

	No	Yes	If yes, how many times on average <u>in the last 6 months</u> ?
GP (<i>visits or calls</i>)			
Practice nurse (<i>visits</i>)			
Counsellor (<i>visits</i>)			
Self-help or support group (<i>visits</i>)			
Alternative therapist (shiatsu etc.) (<i>visits</i>)			
Telephone help-line (<i>calls</i>)			
Hospital outpatient clinic (<i>appointments</i>)			

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Accident and emergency (<i>contact, not requiring admission</i>)			
Accident and emergency (<i>contacts requiring admission</i>)			
Inpatient admission (<i>nights</i>)			
Other 1 (not stated above, please specify)			
Other 2 (not stated above, please specify)			
Other 3 (not stated above, please specify)			

Section E SIBLING HEALTH

14. Do you think that [child's name] behaviour has led to their siblings needing additional mental or physical health-related support, e.g. counselling, in the last 6 months?

Yes..... ☐ 1

No..... ☐ 2

a. **If yes**, please specify in the table below:

	How many times on average <u>in the last 6 months</u>
Counsellor	
Other support (please specify).....	
Other support (please specify).....	

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Section F OUT-OF-POCKET EXPENSES

In this section we are asking your help in telling us about any **out-of-pocket expenses** you have incurred to provide for the needs of your child. Out-of-pocket expenses are defined as any payments made from personal funds to cover treatment, support and care as a result of autism and mental health problems. These payments represent money paid by you over and above any contributions from statutory services (such as benefit payments) and voluntary organisation.

15. Have you incurred expenses as a result of [child's name] behaviour in the last 6 months?

Yes..... ☐ 1

No..... ☐ 2

a. **If yes**, please fill in the table below

	Total out-of-pocket expenses in an average week <u>in the last 6 months</u>
Adaptation/alterations to home (e.g. sensory room)	
Expenses for special toys or equipment.....	
Replacement cost or repair of damage to toys and furniture.....	
Expenses for medication.....	
Extra help expenses (e.g. child care) (please specify)	
Expenses for special education (please specify) (e.g. private school fees, tutor).....	
Expenses for therapy (please specify)	
Expenses for special activities (please specify)	
Travel expenses to treatment or assessment.....	
Other (please describe) Include additional specifications mentioned above and any other not included in the list.....	

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Other (please describe) Include additional specifications mentioned above and any other not included in the list_____	
Other (please describe) Include additional specifications mentioned above and any other not included in the list_____	

Section G UNPAID SUPPORT

Note to Researcher: Please ensure that the data in this section is filled in by the **main unpaid caregiver**. If the respondent is retired or not currently working, record most recent main paid job and occupation.

16. Is the main caregiver currently unemployed **and** has never been in paid employment?

Yes..... ☐ 1

No..... ☐ 2

Questions 16-23 refer to **main caregiver/parent's** current or last main job and occupation. **If the respondent is retired or not currently working, record most recent main paid job /occupation.**

17. Employee or self-employed:

Do/did you work as an employee or are/were you self-employed?

Employee

☐

Self-employed with employees

☐

Self-employed/freelance without employees

☐

Go to 20

18. Number of employees:

For employees: How many people work/worked for your employer at the place where you work/worked?

For self-employed: How many people do/did you employ?

1-24..... ☐

25 or more..... ☐

19. Supervisory status:

Do/did you supervise any other employees? (A supervisor or foreman is responsible for overseeing the work of other employees on a day-to-day basis).

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Yes.....	<input type="checkbox"/>	1
No.....	<input type="checkbox"/>	2

20. Occupation:

Tick one box to show which best describes the sort of work caregiver/parent does. If caregiver/parent is not working now, ask him/her to tick a box to show what they did in their last job.

Modern professional occupations such as: teacher – nurse –
physiotherapist – social worker – welfare officer – artist –
musician – police officer (sergeant or above) – software designer ☐

Clerical and intermediate occupations such as: secretary –
personal assistant – clerical worker – office clerk – call centre
agent – nursing auxiliary – nursery nurse ☐

Senior managers or administrators (usually responsible for
planning, organising and co-ordinating work, and for finance)
such as: finance manager – chief executive ☐

Technical and craft occupations such as: motor mechanic – fitter
– inspector – plumber – printer – tool maker – electrician –
gardener – train driver ☐

Semi-routine manual and service occupations such as: postal
worker – machine operative – security guard – caretaker – farm
worker – catering assistant – receptionist – sales assistant ☐

Routine manual and service occupations such as: HGV driver –
van driver – cleaner – porter – packer – sewing machinist –
messenger – labourer – waiter/waitress – bar staff ☐

Middle or junior managers such as: office manager – retail
manager – bank manager – restaurant manager – warehouse
manager – publican ☐

Traditional professional occupations such as: accountant –
solicitor – medical practitioner – scientist – civil/mechanical
engineer ☐

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21. What is your approximate gross pay per year (before tax) for your current or most recent employment?

1	Under £5,000	8	£35001-£40000
2	£5001 - £10000	9	£40001-£45000
3	£10001 - £15000	10	£45001-£50000
4	£15001-£20000	11	£50001-£75000
5	£20001-£25000	12	£75001-£100000
6	£25001-£30000	13	£100001 plus
7	£30001-£35000		

22. How many hours do/did your employer expect you to work in a typical 7-day week for your current or most recent employment? If it varies, estimate the average. If more than 97 enter 97.

How many hours?

23. How many half days have you been absent from work due to [child's name] condition in the last 6 months?

How many half days in the last 6 months?

24. Have you taken time off work due to [child's name] condition in the last 6 months?

Yes.....

1

If yes, how many half days in the last 6 months?

No.....

2

25. Have you taken time off work due to [child's name] condition in the last 6 months?

Yes.....

1

If yes, how many half days in the last 6 months?

No.....

2

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26. In your opinion, has [child's name]'s condition affected your employment/career prospects?

Yes..... ☐ 1

No..... ☐ 2

If yes, please state how? -----

27. In your opinion, has [child's name] condition affected your family/romantic relationships?

Yes..... ☐ 1

No..... ☐ 2

If yes, please state how? -----

28. In your opinion, are there any services and support you are not getting now, you would like to receive?

Yes..... ☐ 1

No..... ☐ 2

If yes, please state -----

You have come to the end of the form
We would like to thank you for your time