

- Please help our agency make services better by answering some questions. Your answers are confidential and will not influence current or future services you or your child will receive. For each survey item below, please fill in the circle that corresponds to your choice.
- Please answer the following questions based on the LAST 6 MONTHS, or if services have not been received for 6 months, just give answers based on the services that have been received so far. Indicate if you **Strongly Disagree, Disagree, are Undecided, Agree, or Strongly Agree** with each of the following statements. If the question is about something you or your child have not experienced, select "**Not Applicable**" to indicate that this item does not apply.
- Please fill in the circle completely.

Correct ● Incorrect ○ ⊗ ⊗

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Not Applicable
1. Overall, I am satisfied with the services my child received.	<input type="radio"/>					
2. I helped to choose my child's services.	<input type="radio"/>					
3. I helped to choose my child's treatment goals.	<input type="radio"/>					
4. The people helping my child stuck with us no matter what.	<input type="radio"/>					
5. I felt my child had someone to talk to when he/she was troubled.	<input type="radio"/>					
6. I participated in my child's treatment.	<input type="radio"/>					
7. The services my child and/or family received were right for us.	<input type="radio"/>					
8. The location of services was convenient for us.	<input type="radio"/>					
9. Services were available at times that were convenient for us.	<input type="radio"/>					
10. My family got the help we wanted for my child.	<input type="radio"/>					
11. My family got as much help as we needed for my child.	<input type="radio"/>					
12. Staff treated me with respect.	<input type="radio"/>					
13. Staff respected my family's religious/spiritual beliefs.	<input type="radio"/>					
14. Staff spoke with me in a way that I understood.	<input type="radio"/>					
15. Staff were sensitive to my cultural/ethnic background.	<input type="radio"/>					

The MHSIP Consumer Survey was developed through a collaborative effort of consumers, the Mental Health Statistics Improvement Program (MHSIP) community, and the Center for Mental Health Services.

* CSI County Client Number

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As a direct result of the services my child and/or family received:

- 16. My child is better at handling daily life.
- 17. My child gets along better with family members.
- 18. My child gets along better with friends and other people.
- 19. My child is doing better in school and/or work.
- 20. My child is better able to cope when things go wrong.
- 21. I am satisfied with our family life right now.
- 22. My child is better able to do things he or she wants to do.

Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Not Applicable
<input type="radio"/>					
<input type="radio"/>					
<input type="radio"/>					
<input type="radio"/>					
<input type="radio"/>					
<input type="radio"/>					
<input type="radio"/>					

For Questions #23-26, please answer for relationships with persons other than your mental health provider(s)

As a direct result of the services my child and/or family received:

- 23. I know people who will listen and understand me when I need to talk.
- 24. I have people that I am comfortable talking with about my child's problem(s).
- 25. In a crisis, I would have the support I need from family or friends.
- 26. I have people with whom I can do enjoyable things.

<input type="radio"/>					
<input type="radio"/>					
<input type="radio"/>					
<input type="radio"/>					

27. What has been the most helpful thing about the services you and your child received over the last 6 months? What would improve the services here? Please provide comments here and /or on the back of this form, if needed. We are interested in both positive and negative feedback.

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Please answer the following questions to let us know how your child is doing.

1. Is your child currently living with you? Yes No

2. Has your child lived in any of the following places in the last 6 months?
Please select all that apply
 - With one or both parents
 - With another family member
 - Foster home
 - Therapeutic foster home
 - Crisis shelter
 - Homeless shelter
 - Group home
 - Residential treatment center
 - Hospital
 - Local jail or detention facility
 - State correctional facility
 - Runaway / homeless / on the streets
 - Other

3. In the last year, did your child see a medical doctor (or nurse) for a health check-up or because he/she was sick?
 - Yes, in a clinic or office
 - Yes, but only in a hospital or emergency room
 - No
 - Do not remember

4. Is your child on medication for emotional/behavioral problems? Yes No
 - 4a. *If yes, did the doctor or nurse tell you and/or your child what side effects to watch for?* Yes No

5. Approximately, how long has your child received services here?
 - This is my child's first visit here.
 - My child has had more than one visit but have received services for less than one month.
 - 1 - 2 Months
 - 3 - 5 Months
 - 6 months to 1 year
 - More than 1 year

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Please answer questions #6-11 if your child has been receiving mental health services for  **ONE YEAR OR LESS**

- 6. Was your child arrested since beginning to receive mental health services?
 Yes No
- 7. Was your child arrested during the 12 months prior to that?
 Yes No
- 8. Since your child began to receive mental health services, have their encounters with the police...
 Been reduced
For example, they have not been arrested, hassled by police, taken by police to a shelter or crisis program
 Stayed the same
 Increased
 Not applicable
They had no police encounters this year or last year
- 9. Was your child expelled or suspended since beginning services?
 Yes No
- 10. Was your child expelled or suspended during the 12 months prior to that?
 Yes No
- 11. Since starting to receive services, the number of days my child was in school is:
 Greater About the same Less
 Does not apply 
Please select why this does not apply
 Child did not have a problem with attendance before starting services
 Child is too young to be in school
 Child was expelled from school
 Child is home schooled
 Child dropped out of school
 Other

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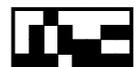
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Must be entered on EVERY page

Please answer questions #12-17 if your child has been receiving mental health services for  **MORE THAN ONE YEAR**

- 12. Was your child arrested during the last 12 months?
 Yes No
- 13. Was your child arrested during the 12 months prior to that?
 Yes No
- 14. Over the last year, have your child's encounters with the police...
 Been reduced
For example, they have not been arrested, hassled by police, taken by police to a shelter or crisis program
 Stayed the same
 Increased
 Not applicable
They had no police encounters this year or last year
- 15. Was your child expelled or suspended during the last 12 months?
 Yes No
- 16. Was your child expelled or suspended during the 12 months prior to that?
 Yes No
- 17. Over the last year, the number of days my child was in school is:
 Greater About the same Less
 Does not apply 
Please select why this does not apply
 Child did not have a problem with attendance before starting services
 Child is too young to be in school
 Child was expelled from school
 Child is home schooled
 Child dropped out of school
 Other

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Please answer the following questions to let us know a little about your child.

18. What is your child's sex? Male Female
19. Are either of the child's parents of Mexican / Hispanic / Latino origin? Yes No Unknown
20. What is your child's race?
Please select all that apply
- American Indian / Alaskan Native White / Caucasian
 Asian Another Race
 Black / African American Unknown
 Native Hawaiian / Other Pacific Islander
21. What is your child's date of birth?
- month*
day
year
- -
22. Does your child have Medi-Cal (Medicaid) insurance? Yes No
23. Were written documents and / or the services your child received provided in the language he / she preferred?
brochures describing available services, your rights as a consumer, and mental health education materials Yes No

24. Now thinking about the services your child received, how much of it was by telehealth?
by telephone or video-conferencing
- None Very little About half Almost all All
25. How helpful were the telehealth visits compared to traditional in-person visits for your child?
- Much worse Somewhat worse About the same Somewhat better Much better
 Not applicable
26. I would prefer to receive more of my child's mental health treatment at this program by
- Strongly Disagree Disagree I am Neutral Agree Strongly Agree
 Not applicable



Thank you for taking the time to answer these questions!

FOR OFFICE USE ONLY

County Code: Date of Survey Administration: County Reporting Unit (optional):

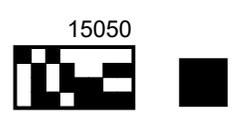
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Code for not completing the survey (if applicable):
 Refused Impaired Language Other

Make sure the same CSI County Client Number is written on all pages of this survey.

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