YOUTH SERVICES SURVEY FOR FAMILIES SPRING 2023

DHCS California Department of HealthCareServices

ENGLISH

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 fill in the circle completely.** ***EXAMPLE:*** Correct ● Incorrect ✗ ✓

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 statements below. If the question is about something you or your child have not experienced, fill in the circle for **Not Applicable** to indicate that this item does not apply.

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

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

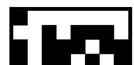
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Not Applicable
16. My child is better at handling daily life.	○	○	○	○	○	○
17. My child gets along better with family members.	○	○	○	○	○	○
18. My child gets along better with friends and other people.	○	○	○	○	○	○
19. My child is doing better in 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.	○	○	○	○	○	○

CSI County Client Number
Must be entered on EVERY page

Version 05/2023

Subunit

56692



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

As a result of the services my child and / or family received:	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Not Applicable
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.	○	○	○	○	○	○

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? **(Mark 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 (describe): ____________________

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? **(Mark ONLY one.)**

○ 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? **(Mark ONLY one.)**

- ○ This is my child's first visit here.
- ○ My child has had more than one visit but has received services for less than one month.
- ○ 1 - 2 Months
- ○ 3 - 5 Months
- ○ 6 months to 1 year

If you choose from this box GO TO SECTION A ON THE NEXT PAGE

- ○ More than 1 year

If you choose from this box GO TO SECTION B ON THE NEXT PAGE

SECTION A - ONE YEAR OR LESS

Please answer Questions #6-11 if your child has been receiving mental health services for ONE YEAR OR LESS.
If your child has been receiving mental health services for MORE THAN ONE YEAR, please skip to question 12 below.

6. Was your child arrested since beginning to receive mental health services? O Yes O No

7. Was your child arrested during the 12 months prior to that? O Yes O No

8. Since your child began to receive mental health services, have their encounters with the police:
   - O been reduced (for example, they have not been arrested, hassled by police, taken by police to a shelter or crisis program)
   - O stayed the same
   - O increased
   - O not applicable (they had no police encounters this year or last year)

9. Was your child expelled or suspended since beginning services? O Yes O No

10. Was your child expelled or suspended during the 12 months prior to that? O Yes O No

11. Since starting to receive services, the number of days my child was in school is:
   O greater O about the same O less O does not apply **(Please select why this does not apply)**
   - O child did not have a problem with attendance before starting services
   - O child is too young to be in school
   - O child was expelled from school
   - O child is home schooled
   - O child dropped out of school
   - O other: ____________________

A

SKIP TO QUESTION #18 ON NEXT PAGE

SECTION B - MORE THAN ONE YEAR

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

12. Was your child arrested during the last 12 months? O Yes O No

13. Was your child arrested during the 12 months prior to that? O Yes O No

14. Over the last year, have your child's encounters with the police:
   - O been reduced (for example, they have not been arrested, hassled by police, taken by police to a shelter or crisis program)
   - O stayed the same
   - O increased
   - O not applicable (they had no police encounters this year or last year)

15. Was your child expelled or suspended during the last 12 months? O Yes O No

16. Was your child expelled or suspended during the 12 months prior to that? O Yes O No

17. Over the last year, the number of days my child was in school is:
   O greater O about the same O less O does not apply **(Please select why this does not apply)**
   - O child did not have a problem with attendance before starting services
   - O child is too young to be in school
   - O child was expelled from school
   - O child is home schooled
   - O child dropped out of school
   - O other: ____________________

B

Please answer the following questions to let us know a little about <u>your child.</u>

18. What is your **child's** gender? ○ Female ○ Male ○ Other

19. Are either of the **child's** parents of Mexican / Hispanic / Latino origin? ○ Yes ○ No ○ Unknown

20. What is your **child's** race? **(Mark all that apply.)**
   - ○ American Indian / Alaskan Native
   - ○ Asian
   - ○ Black / African American
   - ○ Native Hawaiian / Other Pacific Islander
   - ○ White / Caucasian
   - ○ Other________________________
   - ○ Unknown

21. What is your **child's** date of birth? (Write it in the boxes AND fill in the circles that correspond. See Example.)

Date of Birth (mm-dd-yyyy)

☐☐ - ☐☐ - ☐☐☐☐

	m	m	d	d	y	y	y	y
0	⓪	⓪	⓪	⓪	⓪	⓪	⓪	⓪
1	①	①	①	①	①	①	①	①
2	②	②	②	②	②	②	②	②
3	③	③	③	③	③	③	③	③
4	④	④	④	④	④	④	④	④
5	⑤	⑤	⑤	⑤	⑤	⑤	⑤	⑤
6	⑥	⑥	⑥	⑥	⑥	⑥	⑥	⑥
7	⑦	⑦	⑦	⑦	⑦	⑦	⑦	⑦
8	⑧	⑧	⑧	⑧	⑧	⑧	⑧	⑧
9	⑨	⑨	⑨	⑨	⑨	⑨	⑨	⑨

<u>EXAMPLE: Date of birth on April 30, 1997:</u>

1. Write in your child's date of birth
2. Fill in the corresponding circles

Date of Birth (mm-dd-yyyy)

04 - 30 - 1997

	m	m	d	d	y	y	y	y
0	●	○	○	●	○	○	○	○
1	○	○	○	○	●	○	○	○
2	○	○	○	○	○	○	○	○
3	○	○	●	○	○	○	○	○
4	○	●	○	○	○	○	○	○
5	○	○	○	○	○	○	○	○
6	○	○	○	○	○	○	○	○
7	○	○	○	○	○	○	○	●
8	○	○	○	○	○	○	○	○
9	○	○	○	○	○	●	●	○

22. Does your child have Medi-Cal (Medicaid) insurance? ○ Yes ○ No

23. Were the services your child received provided in the language he / she preferred? ○ Yes ○ No

24. Was written information (e.g., brochures describing available services, your rights as a consumer, and mental health education materials) available to you in the language you prefer? ○ Yes ○ No

25. Please identify who helped you complete any part of this survey **(Mark all that apply):**
   - ○ I did not need any help.
   - ○ A mental health advocate / volunteer helped me.
   - ○ Another mental health consumer helped me.
   - ○ A member of my family helped me.
   - ○ A professional interviewer helped me.
   - ○ My child's clinician / case manager helped me.
   - ○ A staff member other than my child's clinician or case manager helped me.
   - ○ Someone else helped me. Who?: ________________________

Thank you for taking the time to answer these questions!

<u>FOR OFFICE USE ONLY</u>

<u>REQUIRED Information:</u>

Date of Survey Administration

0 5 – ☐☐ – 2 0 2 3

Subunit

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

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CSI County Client Number

Must be entered on EVERY page

Reason for Non-Completion (if applicable):

- ○ Refused
- ○ Impaired (Cognitive, Mental, Physical or Medical Impairment)
- ○ Language (Not available in client's language)
- ○ No Show (Parent / Caregiver did not show up for scheduled visit)
- ○ Caregiver Unavailable (e.g. Child lives in group home or receiving facility)
- ○ New Client: First Visit
- ○ Other__________________

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This section of the survey has questions about your child's mental health and experiences with different types of therapy.

1. How is your child's mental health currently?

○ Very Good ○ Good ○ Fair ○ Poor ○ Very Poor

2. Do you know what group therapy is? ○ Yes (Go to question #2.1) ○ No (Go to question #3)

2.1 Has your child ever participated in group therapy? ○ Yes ○ No

3. Are you open to your child receiving group therapy instead of individual therapy?

○ Yes (Go to question #4) ○ No (Go to question #3.1)

3.1 Why would you NOT want your child to receive group therapy instead of individual therapy? ***Please mark all that apply.***

○ My child would be nervous or anxious talking in front of others
○ I'm worried about my child's confidentiality
○ I prefer my child to have one-on-one sessions
○ I'm worried about scheduling difficulties for my child
○ I do not think it would be as effective for my child
○ Other (Please describe)

____

4. Are you open to your child receiving group therapy in addition to individual therapy?

○ Yes (Go to question #5) ○ No (Go to question #4.1)

4.1 Why would you NOT want your child to receive group therapy in addition to individual therapy? ***Please mark all that apply.***

○ My child would be nervous or anxious talking in front of others
○ I'm worried about my child's confidentiality
○ I prefer my child to have one-on-one sessions
○ I'm worried about scheduling difficulties for my child
○ I do not think it would be as effective for my child
○ Other (Please describe)

____

5. I would be more comfortable with my child receiving group therapy if the groups were: ***Please mark all that apply.***

○ With small groups
○ With same gender groups
○ With same sexual orientation groups
○ With strangers rather than with peers
○ With peers rather than strangers
○ If groups were kept confidential
○ If participation gave my child an elective credit at school
○ If I knew group therapy was effective
○ Other (Please describe)

____

6. What is your preferred way of your child receiving therapy?
Please rank the options from first to last (1st choice=1, 2nd choice=2...last choice=7).

- [ ] Individual - In-person
- [ ] Individual - Online
- [ ] Individual - Hybrid
- [ ] Group - In-person
- [ ] Group - Online
- [ ] Group - Hybrid
- [ ] Other ***(Please describe)*** ____________

The next section asks about your experiences with mental health providers.
Your responses are anonymous and will not be shared with your child's mental health provider.

HEALTH EQUITY	**Strongly Agree**	**Agree**	**Undecided**	**Disagree**	**Strongly Disagree**
7. My child is treated with less courtesy or respect than other clients in this program.	○	○	○	○	○
8. My child receives poorer treatment or services than other clients in this program.	○	○	○	○	○
9. I am more comfortable if my child's mental health provider has a racial/ethnic background like theirs.	○	○	○	○	○
10. I am more comfortable if my child's mental health provider has the same gender as my child.	○	○	○	○	○
11. I am more comfortable if my child's mental health provider has the same sexual orientation as my child.	○	○	○	○	○

12. My child's mental health provider's racial/ethnic background is like theirs. ○ Yes ○ No ○ I don't know

13. My child's mental health provider's gender is like theirs. ○ Yes ○ No ○ I don't know

14. My child's mental health provider's sexual orientation is like theirs. ○ Yes ○ No ○ I don't know

To enhance the quality of care, the comments on this page will be shared with the program after **all identifying information is removed** so that your comments will be anonymous.

1. What has been the most helpful thing about the services you and your child received over the last 6 months?

2. What would improve the services here?

3. Please provide comments here and /or on the back of this form, if needed.
   We are interested in both positive and negative feedback.