Survey Dates:
Fall 2011

CALIFORNIA DEPARTMENT OF Mental Health

ENGLISH Family Survey

YOUTH SERVICES SURVEY FOR FAMILIES (YSS-F)

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.	○	○	○	○	○	○

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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.	○	○	○	○	○	○

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

28. What would improve the services here?

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

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? (Check 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?

- ○ 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
- ○ 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.
If your child has been receiving mental health services for 'MORE THAN ONE YEAR,' skip to question 12 below.

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: _____

SKIP to Question #18 on the next page ➡

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? ○ 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 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 ○ Native Hawaiian / Other Pacific Islander ○ Unknown
○ Asian ○ White / Caucasian
○ Black / African American ○ Other

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)

	-	-	
0	○ ○	○ ○	○ ○ ○ ○
1	○ ○	○ ○	○ ○ ○ ○
2	○ ○	○ ○	○ ○ ○ ○
3	○ ○	○ ○	○ ○ ○ ○
4	○ ○	○ ○	○ ○ ○ ○
5	○ ○	○ ○	○ ○ ○ ○
6	○ ○	○ ○	○ ○ ○ ○
7	○ ○	○ ○	○ ○ ○ ○
8	○ ○	○ ○	○ ○ ○ ○
9	○ ○	○ ○	○ ○ ○ ○

EXAMPLE: Date of birth on April 30, 1990:

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

Date of Birth (mm-dd-yyyy): 04 - 30 - 1990

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!

FOR OFFICE USE ONLY:

REQUIRED Information:

County Code: ☐☐

Date of Survey Administration:

11 - ☐☐ - 2011

Reason (if applicable):

○ Ref ○ Imp ○ Lan ○ Oth

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

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Optional County Questions:

County Question #1 (mark only ONE bubble):

○ 01 ○ 02 ○ 03 ○ 04 ○ 05 ○ 06 ○ 07 ○ 08 ○ 09 ○ 10
○ 11 ○ 12 ○ 13 ○ 14 ○ 15 ○ 16 ○ 17 ○ 18 ○ 19 ○ 20

County Question #2 (mark only ONE bubble):

○ 01 ○ 02 ○ 03 ○ 04 ○ 05 ○ 06 ○ 07 ○ 08 ○ 09 ○ 10
○ 11 ○ 12 ○ 13 ○ 14 ○ 15 ○ 16 ○ 17 ○ 18 ○ 19 ○ 20

County Question #3 (mark only ONE bubble):

○ 01 ○ 02 ○ 03 ○ 04 ○ 05 ○ 06 ○ 07 ○ 08 ○ 09 ○ 10
○ 11 ○ 12 ○ 13 ○ 14 ○ 15 ○ 16 ○ 17 ○ 18 ○ 19 ○ 20

County Reporting Unit:

☐☐☐☐☐☐☐☐

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