SAN FRANCISCO MENTAL HEALTH BOARD

Edwin Lee
Mayor

1380 Howard Street, 2nd Floor
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@mhbsf.org
www.mhbsf.org
www.sfgov.org/mental_health

CHILD AND YOUTH SATISFACTION SURVEY

1. Tell me a few things about this program or service that you like the best?

_____

_____

_____

_____

2. Do you know why you are here?

_____

_____

_____

3. Do you have anyone you take care of (elderly parents, sibling, child)

_____

4. Does the staff ask you for your ideas about services you might need?

Yes ☐ No ☐

Comment: _____

5. Do you feel the staff listens to or uses your ideas about services you might need?

Yes ☐ No ☐

Comment: _____

6. Do you feel the staff respects you?

Yes ☐ No ☐

Comment: _____

7. Do you feel safe in this program?

Yes ☐ No ☐

Comment:

8. How do you get to and from this program? How long does it take you to get here from where you live? Do you feel safe in this program's neighborhood?

Yes ☐ No ☐

Comment:

9. How long have you been getting these services? How long do you expect to be in this program?

_____ _____

10. Do you feel this program is the right one for you?

Yes ☐ No ☐

Comment:

_____

11. Does the staff recognize your individual strengths, skills, and capabilities? (for example, your leadership abilities, compassion for others, artistic talents, musical ability, etc.)

Yes ☐ No ☐

Comment:

12. Does the staff help you use these strengths in your recovery?

Yes ☐ No ☐

Comment:

13. Does the staff help you connect with other resources? (for example, programs in your school and neighborhood, medical needs, vision, dental, legal, housing, male/female issues, etc)

Yes ☐ No ☐

Comment:

14.What could be added to this program or service to make it work better for you?

15.Is the staff willing to make appointments that are convenient for you?

Yes ☐ No ☐

Comment:

16.Are you taking medications? If Yes, ask questions a to I,.If No, go to question 17.

Yes ☐ No ☐

a. Did a doctor or staff person talk to you about what the medications were for?

   Yes ☐ No ☐

b. Did a doctor talk to you about the side effects of the medications?

   Yes ☐ No ☐

c. Did a doctor or staff talk to you about alternatives to medication, such as other kinds of treatment programs?

   Yes ☐ No ☐

d. Did the doctor or staff answer all of your questions about your medications?

   Yes ☐ No ☐

e. *For female clients*: Did a doctor talk to you about the impact of medication on your hormones, menstrual cycle, pregnancy or sexual function?

   Yes ☐ No ☐

f. *For male clients*: Did a doctor talk to you about the impact of medication on your hormones, or sexual function?

   Yes ☐ No ☐

g. *For transgender clients*: Did a doctor talk to you about the impact of medication on your hormones, or sexual function?

   Yes ☐ No ☐

h. Do you feel the medications you are taking are helping you?

Yes ☐ No ☐

i. If you had a problem with your medications, did the doctor or staff listen to your concerns? What did they do about your concerns?

Yes ☐ No ☐

Comment: _____

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17. Has the staff shared with you the documents your parents signed?:

j. Did you have the chance to look them over? Yes ☐ No ☐

k. Did you read them? Yes ☐ No ☐

l. Could you read them? (for exp. Can't read) Yes ☐ No ☐

m. Do you understand what they signed? Yes ☐ No ☐

Comment: _____

_____

_____

18. Do you feel that staff keeps your treatment records confidential?

Yes ☐ No ☐

Comment: _____

19 Do you know what WRAP is? (Wellness and Recovery Action Plan)*

Yes ☐ No ☐

20. Do you have a WRAP plan?

Yes ☐ No ☐

21. Is there anything else you would like to tell me about?

_____

_____

*WRAP is a self-designed plan to help people with mental health conditions stay well and to help individuals to feel better when not feeling well, increase personal responsibility, and improve quality of life. WRAP consists of the following: Wellness Toolbox, Daily Maintenance Plan, Identifying Triggers and an Action Plan, Identifying Early Warning Signs and an Action Plan, Identifying When Things Are Breaking Down and an Action Plan, and Crisis Planning and Post Crisis Planning.