DMH South Carolina Department of Mental Health

SCDMH School-Based Satisfaction Survey
YOUTH SERVICES SURVEY FOR FAMILIES

Please help our agency make services better by answering some questions about the services your child received **OVER THE LAST 6 MONTHS**. Your answers are confidential and will not influence the services you or your child receive. Please indicate if you **Strongly Disagree**, **Disagree**, **Are Undecided**, **Agree**, or **Strongly Agree** with each of the statements below. Fill in the circle that best describes your answer. Thank You!

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
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.	○	○	○	○	○
<u>As a result of the services my child and/or family received:</u>					
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. What has been the most helpful thing about the services you and your child received over the last 6 months?

23. What would improve services here?

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☐☐ ☐☐☐ **MHC Code Survey Number**

SCDMH FORM PS-301

8472246935

SCDMH School-Based Satisfaction Survey

YOUTH SERVICES SURVEY FOR FAMILIES

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

24. How long did your child receive services from this Center?
O Less than 1 month O 1-2 months O 3-5 months O 6 months to 1 year O More than 1 year

24a. How often was your child seen by the school counselor?
O Once a week O More than once a week O Three times a month O Twice a month O Once a month

25. Is your child still getting services from this Center? O Yes O No

26. Is your child currently living with you? O Yes O No

27. Has your child lived in any of the following places in the last 6 months? (CHECK ALL THAT APPLY)

O With one or both parents
O With another family member
O Foster Home
O Therapeutic foster home
O Crisis shelter
O Homeless shelter
O Group home
O Residential treatment center
O Hospital
O Local jail or detention facility
O State correctional facility
O Runaway/homeless/on the streets
O Other (describe) _____

28. 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)
O Yes, in a clinic or office O Yes, but only in a hospital emergency room O No O Do not remember

29. Is your child on medication for emotional/behavioral problems? O Yes O No

29a. If yes, did the doctor or nurse tell you and/or your child what side effects to watch for? O Yes O No

30. In the last month, did your child get arrested by the police? O Yes O No

30a. In the last six months, did your child get arrested by the police? O Yes O No

31. In the last month, did your child go to court for something he/she did? O Yes O No

31a. In the last six months, did your child go to court for something he/she did? O Yes O No

32. How often was your child absent from school during the last six months?
O 1 day or less O 3 to 5 days O More than 10 days O Do not remember
O 2 days O 6 to 10 days O Not applicable/not in school

33. Have your child's grades improved? O Yes O No

34. My child would not be able to receive counseling services if they were not provided at school. O Yes O No

35 Overall, are you satisfied with the services your child receives through the school based mental health program? O Yes O No

36. Would you recommend this program to other families? O Yes O No

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

Child's Race (Check two if needed)

O American Indian/Alaska Native O White (Caucasian) O Black (African American)
O Asian/Pacific Islander O Other (describe): _____

Child'sGender: O Male O Female **Are either of the child's parents Spanish/Hispanic/Latino?** O Yes O No

Do you have Medicaid insurance? O Yes O No

TODAY'S DATE ☐☐ / ☐☐ / ☐☐☐☐

Birth Date ☐☐ / ☐☐ / ☐☐☐☐

Thank you for taking the time to answer these questions!

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☐☐☐☐☐☐☐ **Department of Education School ID Number**

☐☐☐☐ **School/ Grant Number**