Service Evaluation Questionnaire

CONNECTIONS

At Crossroads we are committed to a quality program. Your feedback is very important to us. Thank you for taking the time to complete this form. Please seal it in the envelope provided and return.

Date: ______ Child's Name: ______

Your Name: ______ Relationship to Child: ______

Program: ______ Worker: ______

Please complete the following sections:

PROGRAM EFFECTIVENESS	Very true	Mostly true	Somewhat true	Not true	Not true at all
Did Collaborative Problem Solving (CPS) help your child to deal more effectively with his/her problems?	❍	❍	❍	❍	❍

	Very satisfied	Mostly satisfied	Mildly satisfied	Not satisfied	Quite dissatisfied
Overall, how satisfied were you with CPS?	❍	❍	❍	❍	❍

	Yes, definitely	Probably would	Might or might not	Probably not	Definitely not
Would you recommend CPS to others?	❍	❍	❍	❍	❍

Please include any comments and/or suggestions:

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CONFIDENTIALITY	Very satisfied	Mostly satisfied	Mildly satisfied	Not satisfied	Quite dissatisfied
Were you satisfied that our program kept your problems and your child's problems confidential?	❍	❍	❍	❍	❍

COMMUNICATION	Very satisfied	Mostly satisfied	Mildly satisfied	Not satisfied	Quite dissatisfied
Were you satisfied with the amount of communication you received from the person working most closely with your child?	❍	❍	❍	❍	❍
When you called the person working with you most closely were you satisfied with the amount of time it took to receive a call back?	❍	❍	❍	❍	❍

OVERALL	Very satisfied	Mostly satisfied	Mildly satisfied	Not satisfied	Quite dissatisfied
In summary, how satisfied were you with the services you and your child have received at Crossroads?	❍	❍	❍	❍	❍

Was there a service that you wanted that you did not receive? Please tell us what it was:

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INVOLVEMENT IN SERVICE PLANNING AND DELIVERY – HOW INVOLVED WERE YOU IN (degree of involvement)	Very Involved	Mostly Involved	Somewhat Involved	Rarely Involved	Never Involved
Identifying strengths and prioritizing needs for service.	❍	❍	❍	❍	❍
Developing/agreeing on a service plan to address needs.	❍	❍	❍	❍	❍
Monitoring impact of service	❍	❍	❍	❍	❍
Providing input on/agreeing to goals for treatment/service.	❍	❍	❍	❍	❍
Being kept informed about the status of services/plans.	❍	❍	❍	❍	❍
Determining readiness for discharge.	❍	❍	❍	❍	❍
Identifying/agreeing with outcomes as a result of services.	❍	❍	❍	❍	❍

Please include any comments and/or suggestions:

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CHANGES AS A RESULT OF SERVICES – ANTICIPATED IMPACT OF SERVICES (To what extent did you experience these changes):	A great deal	To some extent	A little change	Very little change	No change
Needs/symptoms/severity of needs decreased over time.	❍	❍	❍	❍	❍
Functioning/Abilities increased over time.	❍	❍	❍	❍	❍
Goals established for service were achieved.	❍	❍	❍	❍	❍

	Very pleased with outcomes	Mostly pleased with outcomes	Somewhat pleased with outcomes	Very little change	No change
Your overall perception of outcome as a result of service.	❍	❍	❍	❍	❍

Please include any comments and/or suggestions:

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INDICATE THE DEGREE TO WHICH SERVICES WERE COMPREHENSIVE AND COORDINATED	Extremely well	Mostly well	Somewhat well	Not very well	Not at all
How well did the service plan include/address all of the needs identified.	❍	❍	❍	❍	❍
How well were services coordinated/integrated across different providers.	❍	❍	❍	❍	❍
To what extent did the mental health agency/service provider communicate with you and with other key stakeholders (e.g., school, physician) regarding needs, services and outcomes.	❍	❍	❍	❍	❍

Please include any comments and/or suggestions:

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DESCRIBE REASONS FOR ENDING SERVICE (CHECK ALL THAT APPLY)

☐ Brief Services Only Required ☐ I/we no longer need/want service (describe: ____)

☐ I/we moved out of community ☐ I/we are no longer eligible due to age ☐ Service Plan is Complete ☐ Goals achieved

☐ No additional services required

Please include any comments and/or suggestions:

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STATUS AT DISCHARGE

At this time I feel that I/we:

☐ Do not required any further service

☐ Require additional services but are not being offered or supported to access additional services

☐ Require additional services and are being offered or supported to access these services.

Please include any comments and/or suggestions:

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Would you agree to have your comments and your child's comment posted on our website with no names or other identifiers?

☐ Yes ☐ No

Would you be interested in helping us advocate for Child and Youth Mental Health Services?

☐ Yes ☐ No

If yes, how would you prefer being contacted?

- ❑ via email @ the following address: ______
- ❑ via telephone @ the following number: ______

Please know that this information will not be used for any purposes other than for helping us advocate for Child and Youth Mental Health

ADDITIONAL COMMENTS AND/OR SUGGESTIONS:

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