Service Evaluation Questionnaire

DAY TREATMENT

Crossroads Children's Centre
www.crossroadschildren.ca

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: _____

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?	❍	❍	❍	❍	❍

SERVICE EFFECTIVENESS	**Very satisfied**	**Mostly satisfied**	**Mildly satisfied**	**Not satisfied**	**Quite dissatisfied**
When you called the person working most closely were you satisfied with the amount of time it took to receive a call back?	❍	❍	❍	❍	❍

	Always	**Usually**	**Sometimes**	**Rarely**	**Never**
Was the person working with you flexible in setting hours which met your needs?	❍	❍	❍	❍	❍
Did you feel listened to and respected during the program?	❍	❍	❍	❍	❍

	Very satisfied	**Mostly satisfied**	**Mildly satisfied**	**Not satisfied**	**Quite dissatisfied**
Overall, how satisfied were you with your assigned worker?	❍	❍	❍	❍	❍

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

_____

_____

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: