

377381

Youth Assessment of Care Survey



Dear Youth,

This survey was developed by parents and youth, family and youth advocates, service providers, and the New York State Office of Mental Health (NYS OMH) to help us get your input on how services work for you.

- This survey is **anonymous** - you don't put your name on the paper.
- This survey is **confidential** - agency staff won't see your completed survey.
- Please answer the survey questions about the last **6 months** of services your child and family received from this program.
- The NYS OMH uses the information you provide to help agencies improve services for families and youth in New York State.
- Please fill out and return the survey in the envelope provided to agency survey coordinator at the NYS OMH PME 44 Holland Avenue Albany, NY 12229 within the **next two weeks**.

If you have any questions about the survey, please call the family survey coordinator toll free at 1-800-430-3586. Para asistencia en español, favor de llamar al 1-800-430-3586.

Thank You!

Agency Information:

Agency Name and Program:

New York State
omh
Office of Mental Health



New York State Office of Mental Health
Youth Assessment of Care Survey (YACS)

Please help our agency improve services by answering some questions about your services during the last 6 months. There are no right or wrong answers and all responses will be kept private.

How long have you received services from the program listed on the front page of this survey?

- Less than 1 month 3-5 months More than 1 year - 3 years
- 1-2 months 6 months to 1 year More than 3 years

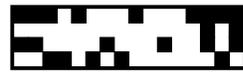
Are you still getting services from this program? Yes No

Place an in the box that best shows how much you agree with each statement.

	Agree	Agree Slightly	Disagree Slightly	Disagree
1 I got services that were helpful for me.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 I had someone to talk to when I was troubled.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Services helped me make positive changes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Staff treated me with respect.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Staff was sensitive to my cultural/ethnic background.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Staff spoke with me in a way that I understood.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 I felt safe in the places I received services.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 I could get services when I needed them.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 It was easy to get to/from services.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 I was able to get help in a crisis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 I was included as a partner in planning my services.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12 I had a say in the kinds of treatment/services I got.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13 My treatment goals were in my own words.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14 I have a safety plan that would work for me if I needed one.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15 Overall, I am happy with the services I received.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Because of these services:

16 I am behaving better in school.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17 I am happier with my life.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18 I am better able to cope when faced with challenges.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19 I have been able to make friends.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20 I get along better with my family.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20a I am more hopeful.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

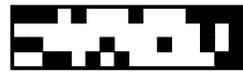


Youth Assessment of Care Survey

- 21 Do you take medication for emotional or behavioral reasons?..... Yes No (Skip to 22)
- If yes.....
- | | Agree | Agree Slightly | Disagree Slightly | Disagree |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 21a My medications were explained to me in a way that I understood..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21b I know what medication side effects to watch for..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21c I had choices about taking medications..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21d My medication has helped me..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21e I feel comfortable about taking medication..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- 22 Have you been given a diagnosis for your emotional/mental health issues?..... Yes No
- If yes.....
- 22a (*check all that apply*)
- | | | | |
|--|--|--|--|
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Bipolar | <input type="checkbox"/> Disruptive (e.g. ODD, CD) | <input type="checkbox"/> Schizophrenia/Psychosis |
| <input type="checkbox"/> Anxiety (e.g., OCD, PTSD) | <input type="checkbox"/> Developmental (e.g., PDD, Autism) | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Substance Use |
| <input type="checkbox"/> Attachment/Separation Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Tourettes/Tics |
| | | | <input type="checkbox"/> Other _____ |
- 22b Have you been informed of therapy options? Yes No
- 23 Do you have access to a peer advocate (a youth with prior mental health experience, who works for a mental health agency)? Yes No Unsure
- 24 Were you arrested since you started receiving services?
 Yes No
- 25 Were/are you on PINS (Person In Need of Supervision) or PINS diversion since starting services?
 Yes No Unsure
- 26 Were you expelled or suspended from school since you started receiving services?
 Yes No No, but was prior to starting services Does not apply
- 27 Since starting to receive services, the number of days you were in school is:
 Greater About the same Less Does not apply

Please tell us a little more about yourself

- 28 Your age group (*check one*)
- | | |
|--|--|
| <input type="checkbox"/> 9-11 years old | <input type="checkbox"/> 15-18 years old |
| <input type="checkbox"/> 12-14 years old | <input type="checkbox"/> 19-21 years old |
- 29 Your gender:
 Female Male
- 30 Are you of Hispanic ethnicity?
 Yes No Unsure
- 31 Your race is (*check as many as needed*)
- | | |
|---|---|
| <input type="checkbox"/> American Indian/Native Alaskan | <input type="checkbox"/> Native Hawaiian/Pacific Islander |
| <input type="checkbox"/> Asian | <input type="checkbox"/> White/Caucasian |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Other _____ |
- 32 Where do you live?
 At Home (with parent/parents)
 At Home (with relatives -e.g., aunt, grandparent)
 Foster Home
 Residential Program
 Other _____



Youth Assessment of Care Survey

35 What additional services and/or supports would be helpful to you? *(Check all that apply)*

- School Work
- Work Readiness
- After School Programs/Community Activities
- Make Friends
- Sex Education
- Anger Management Skills
- Food/Nutrition
- Driving/Transportation
- Self Advocacy/Empowerment
- Health/Hygiene
- Leadership Training
- College/Continuing Education
- Recreation
- Money Management
- Non-medication therapy options
- Service Eligibility (SSI, Medicaid, HEAP)
- Natural Supports (e.g., extended family, community)
- Youth Peer Advocate
- Other _____

36 What additional services would be helpful to you or your family? *(Check all that apply)*

- Respite
- Sibling Support
- Transition Planning
- Parenting Skills
- Advocacy Skills
- Education & Training
- Parent Support
- Family Counseling
- Other _____

We would appreciate your feedback on this survey.

37 What did you think of the overall survey? *(Check all that apply)*

- Length was just right
- Words were easy to read
- Questions were things that are important to me
- Hard to fill out
- Too short
- Too long
- Hard to understand
- Other _____

38 Did someone help you complete this form?..... Yes No
If yes.....

38a How did that person help you? *(Check all that apply)*

- Wrote down the answers I gave
- Translated into my language
- Read the questions to me
- Helped in some other way _____

Other Comments/
Suggestions: _____

Please return your survey to your program or to:
 NYS OMH Performance Measurement and Evaluation
 44 Holland Ave
 Albany, NY 12229

If you have any questions about the survey you can call toll free at 1-800-430-3586.
 Para asistencia en español, favor de llamar al 1-800-430-3586.

Thank you for filling out this survey!



Family Assessment of Care Survey



Dear Parent/Guardian,

This survey was developed by parents and youth, family and youth advocates, service providers, and the New York State Office of Mental Health (NYS OMH) to help us get your input on how services work for you.

- This survey is *anonymous* - you don't put your name on the paper.
- This survey is *confidential* - agency staff won't see your completed survey.
- Please answer the survey questions about the last **6 months** of services your child and family received from this program.
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If you have any questions about the survey, please call the family survey coordinator toll free at 1-800-430-3586. Para asistencia en español, favor de llamar al 1-800-430-3586.

Thank You!

Agency Information:

Agency Name and Program:

New York State Office of Mental Health
Family Assessment of Care Survey (FACS)



3341594

Please answer the following questions about the Children's Single Point of Access (SPOA): The SPOA is a process to help ensure that children with serious emotional disturbance have access to appropriate mental health services that best fit their needs

Were you referred to the program listed on the front page of this survey through SPOA? Yes No Unsure
 If yes.....

Did SPOA make it easier to access services?..... Yes No

Through SPOA, I was directly involved with determining what services my child received..... Yes No

My child's and family's strengths were recognized during the SPOA process..... Yes No

How long has your child received services from the program listed on the front page of this survey? (check one):

Less than 1 month 3-5 months More than 1 year - 3 years

1-2 months 6 months to 1 year More than 3 years

Is your child still getting services from this program?..... Yes No

Place an in the box that best shows how much you agree with each statement.

	Agree	Agree Slightly	Disagree Slightly	Disagree
1 The services my child and/or family received were helpful for us.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 My child had someone to talk to when he/she was troubled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Services helped my family make positive changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Staff treated me with respect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Staff was sensitive to our cultural/ethnic background.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Staff spoke with me in a way that I understood.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 My child could get services when he/she needed them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 The location of services was convenient for us.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 My child was able to get help in a crisis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 I was included as a partner in planning my child's services.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 There was a way for me to be involved in my child's services.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12 I had a say in the kinds of treatment and services my child received.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13 My child and I have a safety plan that would work for us if we needed one.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14 My out-of-pocket expenses for services are affordable.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15 My child's treatment was comprehensive. (Included school, home, therapy, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16 My child's services were coordinated. (Providers were on the same page.).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17 Overall, I am satisfied with the services my child received.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How have things changed for your child and family?

18 My child is behaving better in school.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19 My child is happier with his/her life.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20 My child is better able to cope when faced with challenges.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21 My child has been able to make friends.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22 We get along better as a family.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How have things changed for you?

23 I have more time to do social activities.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24 In a crisis, I have someone who would help.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25 I have the support I need from others.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26 My life is less stressful.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27 My relationship with my child is better.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Family Assessment of Care Survey

- 28 Does your child take medication for emotional or behavioral reasons?..... Yes No (Skip to 29)
 If yes.....
- | | Agree | Agree Slightly | Disagree Slightly | Disagree |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 28a I understand what my child's medications are for..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28b I know what medication side effects to watch for in my child..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28c My child and I had choices about taking medications..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28d Medication has helped my child..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28e My child feels comfortable about taking medication..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Family Support Services

- 29 I was encouraged to utilize Family Support Services.....
- 30 Someone explained how these services would be helpful to my family.....
- 31 To access Family Support Services, I was given the name(s) of a Family Peer Support Partner*.....

- 32 I received Family Support Services directly from a Family Peer Support Partner*..... Yes No (Skip to 34)
 If yes.....

- | | Agree | Agree Slightly | Disagree Slightly | Disagree |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 33 It was important to me that the family support services offered were delivered by a Family Peer Support Partner*..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Through the assistance of these services:

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 33a I have a better sense of my family's strengths..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 33b I have the information I need to make decisions about my child's treatment..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 33c I have the support I need to make decisions about my child's treatment..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 33d I feel less alone and isolated..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 33e I connected more with friends and relatives..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 33f I increased my involvement in my community..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 33g I understand better how to take care of myself..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 33h I gained skills to better help my child..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

*A Family Peer Support partner is a parent/caregiver who has or is currently raising a child with behavioral health challenges. Family Peer Support Partners may also be referred to as Parent Partners, Family Advocates, Family Peer Support Advocate, Family Peer Support Partner, Parent Advocate, Family Liaison, Parent Advisor.

- 34 Have you been given a diagnosis for your child's emotional/mental health issues?..... Yes No
 If Yes.....

34a (check all that apply)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Bipolar | <input type="checkbox"/> Disruptive (e.g. ODD, CD) | <input type="checkbox"/> Schizophrenia/Psychosis |
| <input type="checkbox"/> Anxiety (e.g., OCD, PTSD) | <input type="checkbox"/> Developmental (e.g., PDD, Autism) | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Substance Use |
| <input type="checkbox"/> Attachment/Separation Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Tourettes/Tics |
| | | | <input type="checkbox"/> Other _____ |

- 34b Have you been informed of therapy options?..... Yes No

- 35 Do you have access to a family advocate?
 Yes No Unsure

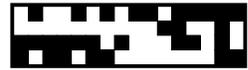
- 36 Was your child arrested since starting to get services from this program?
 Yes No

- 37 Was your child on PINS (Person In Need of Supervision) or PINS diversion since starting services?
 Yes No Unsure Does not apply

- 38 Was your child expelled or suspended from school since starting to receive services from this program?
 Yes No No, but was prior to starting services Does not apply

- 39 Since starting to receive services from this program, the number of days your child was in school is:
 Greater About the same Less Does not apply

Family Assessment of Care Survey



3341594

Please tell us a little more about your child (who is receiving services) and family:

- 40 Your child's age (check one)
 4 years old or under 9-11 years old 15-18 years old
 5-8 years old 12-14 years old 19-21 years old
- 41 Your child's gender:
 Female Male
- 42 Is your child of Hispanic ethnicity?
 Yes No Unsure
- 43 Your child's race is (check as many as needed):
 American Indian/Native Alaskan Native Hawaiian/Pacific Islander
 Asian White/Caucasian
 Black/African American Other _____
- 44 What is your relationship to this child?
 Parent/Parents Foster Parent
 Relative (e.g., aunt, grandparent) Other _____
- 45 Where does your child live?
 At Home (with parent/parents) Foster Home Other _____
 At Home (with relatives- e.g., aunt, grandparent) Residential Program
- 46 What is your family's county of residence?(e.g. Ulster) _____
- 47 What additional services and/or supports would be helpful to your child? (Check all that apply)
 School Work Work Readiness After School Programs/Community Activities
 Make Friends Sex Education Anger Management Skills
 Food/Nutrition Driving/Transportation Self Advocacy/Empowerment
 Health/Hygiene Leadership Training College/Continuing Education
 Recreation Money Management Non-medication therapy options
 Service Eligibility (SSI, Medicaid, HEAP) Natural Supports (e.g., extended family, community) Youth Peer Advocate
 Other _____
- 48 What additional services would be helpful to you or your family? (Check all that apply)
 Respite Sibling Support Transition Planning
 Parenting Skills Advocacy Skills Education & Training
 Parent Support Family Counseling Other _____

We would appreciate your feedback on this survey.

- 49 What did you think of the overall survey? (Check all that apply)
 Length was just right Words were easy to read Questions were things that are important to me
 Hard to fill out Too short
 Too long Hard to understand Other _____
- 50 Did someone help you complete this form?..... Yes No
If Yes.....
- 50a How did that person help you? (Check all that apply)
 Wrote down the answers I gave Translated into my language
 Read the questions to me Helped in some other way _____

Other Comments/
Suggestions: _____

