



MHSA Three-Year Program & Expenditure Plan 2017 - 2020: Adult/Family Member Stakeholder Survey

Introduction

Welcome to the Adult/Family Stakeholder Survey! The purpose of this survey is to hear from you about the mental health needs and services in Yolo County. The information you provide will help the Yolo County’s Department Health & Human Services improve its services in order to meet the needs of its community members. All of the answers you provide will be confidential and the survey will take about 5 minutes to complete. **We appreciate you taking the time to share your experience with us!**

*(In the questions below, “**Provider**” means: Doctor, psychiatrist, psychologist, therapist, counselor, case manager, practitioner or any professional that provides mental health services.)*

1. The following questions are about your experience in getting mental health help:

Obtaining Services	Not at all true	A little bit true	Mostly true	Very true	The Situation Does Not Apply
I know where to go if I or someone needs mental health services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is easy for me or my loved one to schedule appointments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health services are in an accessible location for me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is easy for me or my loved one to get to appointments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I or my loved one was able get an appointment in time.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When I or my loved one is experiencing crisis, it is easy to get the care needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. The following questions are about your experiences with receiving help:

Receiving Services	Not at all true	A little bit true	Mostly true	Very true	The Situation Does Not Apply
The provider asks me or my loved one for my or their opinion.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I or my loved one felt respected by the provider.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services provided are reflective of my or my loved one’s culture.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services were available in my or my loved one’s preferred language.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. The following questions are about your experiences with mental health recovery:

Recovery and Outcomes	Not at all true	A little bit true	Mostly true	Very true	The Situation Does Not Apply
The mental health services provided met my or my loved one’s needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services have helped me or my loved one with my or their recovery.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Demographic Form

1. Do you identify yourself as a consumer or a family member of a consumer of mental health services?
 - No
 - Consumer
 - Family Member
2. What is your stakeholder affiliation?
 - Government agency, City or County
 - Government agency, State
 - Community-based organization
 - Law Enforcement
 - Education agency
 - Social service agency
 - Veterans or Veterans Organizations
 - Provider of mental health services
 - Provider of alcohol and other drug services
 - Medical or health care organization
 - Other: _____
3. Please indicate your age range:
 - Under 16
 - 16-24
 - 25-59
 - 60 and older
4. What is your ethnicity?
 - Hispanic/Latino
 - Non-Hispanic/Latino
5. What is your race? (select all that apply)
 - White/Caucasian
 - African American/Black
 - Asian or Pacific Islander
 - American Indian/Native Alaskan
 - Multi-Race
 - Other: _____
6. In which part of Yolo County do you live?
 - Brooks
 - Capay
 - Clarksburg
 - Conaway
 - Davis
 - Dunnigan
 - El Macero
 - Esparto
 - Guinda
 - Knights Landing
 - Madison
 - Monument Hills
 - Plainfield
 - Rumsey
 - West Sacramento
 - Winters
 - Woodland
 - Yolo
 - Zamora
7. Please indicate your gender:
 - Female
 - Male
 - Transmale/transman
 - Transfemale/transwoman
 - Intersex
 - Genderqueer
 - Prefer not to answer
 - Other: _____
8. Is English your preferred language?
 - Yes No
 - If you answered "no," what is your preferred language? _____

Thank you for taking our survey!