SAN FRANCISCO MENTAL HEALTH BOARD

Edwin Lee
Mayor

1380 Howard Street, 2nd Floor
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@mhbsf.org
www.mhbsf.org
www.sfgov.org/mental_health

CLIENT SATISFACTION SURVEY

1. Tell me a few things about this program or service that you like the best?

2. In what ways does this program, or these services help you the most?

3. Do you feel that your needs are being met? (examples: culturally, gender responsive, language, other, etc.)

4. Do you have children, elderly parents, or anyone else whom you are responsible to care for? What are some ways that this program supports you in balancing your needs and your caregiving needs (for example, providing toys and a play space for children, discussing how to bring up treatment with relatives, etc)?

5. Are there ways in which this program or service is new and different for you than other programs or services you have been involved with? (for example, is it better or is it worse?)

6. Does the staff ask you for your ideas about services you might need?

Yes ☐ No ☐

Comment:

7. Do you feel the staff listens to or uses your ideas about services you might need?

Yes ☐ No ☐

Comment:

8. Do you feel the staff respects you?

Yes ☐ No ☐

Comment:

9. Do you feel safe in this program?

Yes ☐ No ☐

Comment:

10. How do you get to and from this program? How long does it take you to get here from where you live? Do you feel safe in this program's neighborhood?

Yes ☐ No ☐

Comment:

11. How long have you been getting these services? How long do you expect to be in this program?

_____ _____

12. Do you feel this program is the right one for you?

Yes ☐ No ☐

Comment:

_____

13a Does the staff recognize your individual strengths, skills, and capabilities? (for example, your leadership abilities, compassion for others, artistic talents, musical ability, etc.)

Yes ☐ No ☐

Comment:

13b. Does the staff help you use these strengths in your recovery?

Yes ☐ No ☐

Comment:

14.Does the staff help you connect with other resources? (for example, medical needs, vision, dental, legal, housing, male/female issues, etc)

Yes ☐ No ☐

Comment:

15.What could be added to this program or service to make it work better for you?

16.Is the staff willing to make appointments that are convenient for you?

Yes ☐ No ☐

Comment:

17.Are you taking medications? If Yes, go to #21. If No, skip ahead to question 22

Yes ☐ No ☐

18.Where do you get your medications? Is it convenient for you?

---

a. Did you sign any papers agreeing to take medications?

Yes ☐ No ☐

b. Did you understand them?

Yes ☐ No ☐

c. Did a doctor or staff person talk to you about what the medications were for?

Yes ☐ No ☐

d. Did a doctor talk to you about the side effects of the medications?

Yes ☐ No ☐

e. Did a doctor or staff talk to you about alternatives to medication, such as other kinds of treatment programs?

Yes ☐ No ☐

f. Did the doctor or staff answer all of your questions about your medications?

Yes ☐ No ☐

g. *For women clients*: Did a doctor talk to you about the impact of medication on your hormones, menstrual cycle, menopause, pregnancy or sexual function?

Yes ☐ No ☐

h. *For male clients*: Did a doctor talk to you about the impact of medication on your hormones, or sexual function?

Yes ☐ No ☐

i. *For transgender clients*: Did a doctor talk to you about the impact of medication on your hormones, or sexual function?

Yes ☐ No ☐

j. Do you feel the medications you are taking are helping you?

Yes ☐ No ☐

k. If you had a problem with your medications, did the doctor or staff listen to your concerns? What did they do about your concerns?

Yes ☐ No ☐

Comment:

---

19. Think of the documents you've signed:

l. Did you have the chance to look them over? Yes ☐ No ☐

m. Did you read them? Yes ☐ No ☐

n. Could you read them? (for exp. Can't read) Yes ☐ No ☐

o. Did you understand what you were signing? Yes ☐ No ☐

Comment:

20. Did you ever sign a document you didn't want to sign?

Yes ☐ No ☐

Comment:

21. Do you know that information about you cannot be given to anyone unless you sign a release?

Yes ☐ No ☐

Comment:

22. Do you feel that staff keeps your treatment records confidential?

Yes ☐ No ☐

Comment:

23. Do you know what WRAP is? (Wellness and Recovery Action Plan)*

Yes ☐ No ☐

24. Do you have a WRAP plan?

Yes ☐ No ☐

25. Do you have a Mental Health Advanced Directive? (also known as Psychiatric Advanced Directive)

Yes ☐ No ☐

26. Is there anything else you would like to tell me about?

*WRAP is a self-designed plan to help people with mental health conditions stay well and to help individuals to feel better when not feeling well, increase personal responsibility, and improve quality of life. WRAP consists of the following: Wellness Toolbox, Daily Maintenance Plan, Identifying Triggers and an Action Plan, Identifying Early Warning Signs and an Action Plan, Identifying When Things Are Breaking Down and an Action Plan, and Crisis Planning and Post Crisis Planning.

** MENTAL HEALTH ADVANCED DIRECTIVE: Document developed voluntarily by a person with a mental health condition when the person is doing well to ensure that during periods, when the person lacks the capacity to make an informed decision about mental health care, their choices regarding treatment and services shall be carried out.
The potential benefits of Mental Health Advance Directives include increasing treatment collaboration by improving communication between the individual and his/her treatment team; allowing for consumer-centered care and treatment planning; expediting crisis interventions; preventing unnecessary guardianship procedures; and promoting individual autonomy and empowerment in the recovery from mental illnesses.