STAPLE

Do Not Use Photocopied Forms

DHCS California Department of Health Care Services

MHSIP Consumer Survey - OLDER ADULT
2026

English

- Please help our agency make services better by answering some questions. Your answers are confidential and will not influence current or future services you will receive. For each survey item below, please fill in the circle that corresponds to your choice.
- Please answer the following questions based on the LAST 6 MONTHS OR if you have not received services for 6 months, just give answers based on the services you have received so far. Indicate if you **Strongly Agree, Agree, are Neutral, Disagree, or Strongly Disagree** with each of the statements below. If the question is about something you have not experienced, select **Not Applicable** to indicate that this item does not apply to you.
- Please fill in the circle completely. Correct ● Incorrect ⊙ ⊗ ✓

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
1. I like the services that I received here.	○	○	○	○	○	○
2. If I had other choices, I would still get services from this agency.	○	○	○	○	○	○
3. I would recommend this agency to a friend or family member.	○	○	○	○	○	○
4. The location of services was convenient. *parking, public transportation, distance, etc.*	○	○	○	○	○	○
5. Staff were willing to see me as often as I felt it was necessary.	○	○	○	○	○	○
6. Staff returned my calls within 24 hours.	○	○	○	○	○	○
7. Services were available at times that were good for me.	○	○	○	○	○	○
8. I was able to get all the services I thought I needed.	○	○	○	○	○	○
9. I was able to see a psychiatrist when I wanted to.	○	○	○	○	○	○
10. Staff here believe that I can grow, change, and recover.	○	○	○	○	○	○
11. I felt comfortable asking questions about my treatment and medication.	○	○	○	○	○	○
12. I felt free to complain.	○	○	○	○	○	○
13. I was given information about my rights.	○	○	○	○	○	○
14. Staff encouraged me to take responsibility for how I live my life.	○	○	○	○	○	○
15. Staff told me what side effects to watch out for.	○	○	○	○	○	○
16. Staff respected my wishes about who is and who is not to be given information about my treatment.	○	○	○	○	○	○

The MHSIP Consumer Survey was developed through a collaborative effort of consumers, the Mental Health Statistics Improvement Program (MHSIP) community, and the Center for Mental Health Services.

35990

*** CSI County Client Number**

0	0	0						

Must be entered on EVERY page

DHCS 1744 EN

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
17. I, not staff, decided my treatment goals.	○	○	○	○	○	○
18. Staff were sensitive to my cultural background. *race, religion, language, etc.*	○	○	○	○	○	○
19. Staff helped me obtain the information I needed so that I could take charge of managing my illness.	○	○	○	○	○	○
20. I was encouraged to use consumer-run programs. *support groups, drop-in centers, crisis phone line, etc.*	○	○	○	○	○	○
As a direct result of the services I received:						
21. I deal more effectively with daily problems.	○	○	○	○	○	○
22. I am better able to control my life.	○	○	○	○	○	○
23. I am better able to deal with crisis.	○	○	○	○	○	○
24. I am getting along better with my family.	○	○	○	○	○	○
25. I do better in social situations.	○	○	○	○	○	○
26. I do better in school and/or work.	○	○	○	○	○	○
27. My housing situation has improved.	○	○	○	○	○	○
28. My symptoms are not bothering me as much.	○	○	○	○	○	○
29. I do things that are more meaningful to me.	○	○	○	○	○	○
30. I am better able to take care of my needs.	○	○	○	○	○	○
31. I am better able to handle things when they go wrong.	○	○	○	○	○	○
32. I am better able to do things that I want to do.	○	○	○	○	○	○
For Questions #33-36, please answer for relationships with persons other than your mental health provider(s)						
As a direct result of the services I received:						
33. I am happy with the friendships I have.	○	○	○	○	○	○
34. I have people with whom I can do enjoyable things.	○	○	○	○	○	○
35. I feel I belong in my community.	○	○	○	○	○	○
36. In a crisis, I would have the support I need from family or friends.	○	○	○	○	○	○

35990

*** CSI County Client Number**

0	0	0						

Must be entered on EVERY page

Please answer the following questions to let us know how you are doing.

1. Approximately, how long have you received services here?
   - ○ This is my first visit here.
   - ○ I have had more than one visit but I have received services for less than one month
   - ○ 1 - 2 Months
   - ○ 3 - 5 Months
   - ○ 6 months to 1 year
   - ○ More than 1 year

Please answer questions #2-4 if you have been receiving mental health services for **ONE YEAR OR LESS**	Please answer questions #5-7 if you have been receiving mental health services for **MORE THAN ONE YEAR**
2. Were you arrested since you began to receive mental health services? ○ Yes ○ No	5. Were you arrested during the last 12 months? ○ Yes ○ No
3. Were you arrested during the 12 months prior to that? ○ Yes ○ No	6. Were you arrested during the 12 months prior to that? ○ Yes ○ No
4. Since you began to receive mental health services, have your encounters with the police… ○ Been reduced *For example, I have not been arrested, hassled by police, taken by police to a shelter or crisis program* ○ Stayed the same ○ Increased ○ Not applicable *I had no police encounters this year or last year*	7. Over the last year, have your encounters with the police… ○ Been reduced *For example, I have not been arrested, hassled by police, taken by police to a shelter or crisis program* ○ Stayed the same ○ Increased ○ Not applicable *I had no police encounters this year or last year*

Please answer the following questions to let us know a little about you.

8. What is your sex? ○ Male ○ Female

9. Are you of Mexican / Hispanic / Latino origin? ○ Yes ○ No ○ Unknown

10. What is your race? *Please select all that apply*
    - ○ American Indian / Alaskan Native
    - ○ Asian
    - ○ Black / African American
    - ○ Native Hawaiian / Other Pacific Islander
    - ○ White / Caucasian
    - ○ Another Race
    - ○ Unknown

35990

*** CSI County Client Number**

0	0	0						

Must be entered on EVERY page

11. What is your date of birth? *month* [ ][ ] - *day* [ ][ ] - *year* [ ][ ][ ][ ]

12. Were written documents and or the services you received provided in the language you prefer? *brochures describing available services, your rights as a consumer, and mental health education materials* ○ Yes ○ No

13. Now thinking about the services you received, how much of it was by telehealth? *by telephone or video-conferencing*
○ None ○ Very little ○ About half ○ Almost all ○ All

14. How helpful were your telehealth visits compared to traditional in-person visits?
○ Much worse ○ Somewhat worse ○ About the same ○ Somewhat better ○ Much better
○ Not applicable

15. I would prefer to receive more of my mental health treatment at this program by telehealth.
○ Strongly disagree ○ Disagree ○ I am neutral ○ Agree ○ Strongly agree
○ Not applicable

16. Please provide comments here and / or on the back of this form, if needed. We are interested in both positive and negative feedback. Also, if there are areas which were not covered by this questionnaire which you feel should have been, please write them here. Thank you for your time and cooperation in completing this questionnaire.

Thank you for taking the time to answer these questions!

FOR OFFICE USE ONLY

County Code: [4][0]

Date of Survey Administration: [0][5] / [ ][ ] / [2][0][2][6]

County Reporting Unit (optional): Select from drop down below

Code for not completing the survey (if applicable):
○ Refused ○ Impaired ○ Language ○ Other

Make sure the same CSI County Client Number is written on all pages of this survey.
*** CSI County Client Number**
[0][0][0][ ][ ][ ][ ][ ][ ]
Must be entered on EVERY page

35990