

# Treatment Perceptions Survey (Youth)

Print PDF as needed. 2023

Do not photocopy!

**County / Provider Use Only**

CalOMS Provider ID (required)

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Program Reporting Unit (if required by your county):

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Treatment Setting (required):  OP/IOP  Residential  OTP/NTP  Detox/WM (standalone)  Partial hospitalization

• Please answer these questions about your experience at this program to help improve services. Use “Not applicable” if the question is about something you have not experienced. Your answers are confidential and will not influence current or future services you receive.

• Please fill in bubbles completely

Correct: ●

Incorrect: ⊙ ⊗ ⊖

Strongly Agree  
Agree  
I Am Neutral  
Disagree  
Strongly Disagree  
Not Applicable

- The location of services was convenient for me.
- Services were available at times that were convenient for me.
- I had a good experience enrolling in treatment.
- My counselor and I worked on treatment goals together.
- I received services that were right for me.
- Staff treated me with respect.
- I feel my counselor took the time to listen to what I had to say.
- I developed a positive, trusting relationship with my counselor.
- Staff were sensitive to my cultural background (race/ethnicity, religion, language, etc.).
- I feel my counselor was sincerely interested in me and understood me.
- I liked my counselor here.
- My counselor is capable of helping me.
- Staff here make sure that my health and emotional health needs are being met (physical exams, depressed mood, etc.).
- Staff here helped me with other issues and concerns I had related to legal/probation, family and educational systems.
- My counselor provided necessary services for my family.
- As a direct result of the services I am receiving, I am better able to do things that I want to do.
- As a direct result of the services I am receiving, I feel less craving for drugs and alcohol.
- Overall, I am satisfied with the services I received.
- I would recommend the services to a friend who is in need of similar help.
- 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
- How helpful were your telehealth visits compared to traditional in-person visits?  
 Much better  Somewhat better  About the same  Somewhat worse  Not applicable

22. Please let us know your comments. What was most helpful about this program? What would you change about this program?

Please do not write any information that may identify you. For example, DO NOT write your name or phone number.

## NOW TELL US A LITTLE ABOUT YOURSELF

- What is your gender (Please select all that apply)?  
 Male  
 Female  
 Transgender: Female to Male  
 Transgender: Male to Female  
 Non-Binary (neither Male nor Female)  
 Another Gender Identity
- Do you think of yourself as (Please select all that apply):  
 Straight/Heterosexual  
 Gay or Lesbian  
 Bisexual  
 Queer  
 Another sexual orientation  
 Unknown
- Are you of Mexican/Hispanic/Latinx descent?  
 Yes  No  Unknown
- Race/Ethnicity (Please select all that apply):  
 American Indian/Alaska Native  
 Asian  
 Black/African-American  
 Native Hawaiian/Other Pacific Islander  
 White/Caucasian  
 Another race  
 Unknown
- Age: 

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Thank you for taking the time to answer these questions!