

WACHS Office Use Only

Date ____/____/20____

WACHS Region:

Point of Service:

Appointment conducted at:

Clinic Location:

☐ 1st Contact

☐ 3 month review

☐ Discharge

☐ Clinic

☐ Home

☐ ED

☐ Other _____

☐ Inpatient Unit

Your Experience of Service

Service:

Your feedback is important. This survey was developed with mental health consumers. It is based on the Recovery Principles of the Australian National Standards for Mental Health Services. It aims to help mental health services and consumers to work together to build better services. If you would like to know more about the survey please ask us.

Completion of the survey is voluntary. All information collected in this survey is anonymous. None of the information collected will be used to identify you. It would be helpful if you could answer all questions, but please leave any question blank if you don't want to answer it.

Please put a cross in just one box for each question, like this ...

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These questions ask *how often* we did the following things ...

Thinking about the care you have received from this service within the last 3 months or less , what was your experience in the following areas:	Never	Rarely	Sometimes	Usually	Always	Not Applicable
1. You felt welcome at this service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Staff showed respect for how you were feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. You felt safe using this service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Staff showed hopefulness for your future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. The facilities and environment met your needs (such as cleanliness, private space, reception area, furniture, common areas, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. You were listened to in all aspects of your care and treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Staff discussed the effects of your medication and other treatments with you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. You had opportunities to discuss your progress with the staff caring for you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. There were activities you could do that suited you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. You had opportunities for your family and carers to be involved in your treatment and care if you wanted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Thank you for your time.
Please return the survey to an administrative officer at reception.



These questions ask *how well* we did the following things ...

Thinking about the care you have received from this service within the last 3 months or less , what was your experience in the following areas:	Poor	Fair	Good	Very Good	Excellent	Not Applicable
11. Information given to you about this service (such as how the service works, which staff will be working with you, how to make a complaint, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. Explanation of your rights and responsibilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. Access to peer support (such as information about peer workers, referral to consumer programs, advocates, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14. Development of a care plan with you that considered all of your needs (such as health, living situation, age, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15. Convenience of the location for you (such as close to family and friends, transport, parking, community services you use, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

As a result of your experience with the service in the last 3 months or less please rate the following:	Poor	Fair	Good	Very Good	Excellent
16. Overall, how would you rate your experience of care with this service in the last 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

As a result of your experience with the service in the last 3 months or less please rate the following:	Very Unlikely	Unlikely	Unsure	Likely	Very Likely
17. How likely are you to recommend this service to your family and friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

As a result of your experience with the service in the last 3 months or less please rate the following:	Not True	Partly True	True	Don't Know
18. My cultural needs were met	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. My experience with this service would have been better if...

20. The best things about this service were...

This information helps to show whether some groups of people are missing out on giving their feedback. It also shows if some groups of people have a better or worse experience than others. Knowing this helps to focus efforts to build better services. No information collected in this section will be used to identify you.

What is your gender?

☐ Male☐ Female☐ Other, please specify

What is the main language you speak at home?

☐ English☐ Other

Are you of Aboriginal or Torres Strait Island origin?

☐ No☐ Yes - Aboriginal☐ Yes - Torres Strait Islander☐ Yes - Aboriginal and Torres Strait Islander

What is your age?

☐ Under 18 years☐ 18 to 24 years

☐ 25 to 34 years☐ 35 to 44 years

☐ 45 to 54 years☐ 55 to 64 years

☐ 65 years and over