Treatment Perceptions Survey (Adult)

Print PDF as needed.
Do not photocopy!

2024

County / Provider Use Only

CalOMS Provider ID (required)

Program Reporting Unit (if required by your county):

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
1. The location was convenient (public transportation, distance, parking, etc.).	○	○	○	○	○	○
2. Services were available when I needed them.	○	○	○	○	○	○
3. I chose the treatment goals with my provider's help.	○	○	○	○	○	○
4. Staff gave me enough time in my treatment sessions.	○	○	○	○	○	○
5. Staff treated me with respect.	○	○	○	○	○	○
6. Staff spoke to me in a way I understood.	○	○	○	○	○	○
7. Staff were sensitive to my cultural background (race/ethnicity, religion, language, etc.).	○	○	○	○	○	○
8. I felt welcomed here.	○	○	○	○	○	○
9. As a direct result of the services I am receiving, I am better able to do things that I want to do.	○	○	○	○	○	○
10. As a direct result of the services I am receiving, I feel less craving for drugs and alcohol.	○	○	○	○	○	○
11. Staff here work with my physical health care providers to support my wellness.	○	○	○	○	○	○
12. Staff here work with my mental health care providers to support my wellness.	○	○	○	○	○	○
13. Staff here helped me to connect with other services as needed (social services, housing, etc.).	○	○	○	○	○	○
14. Overall, I am satisfied with the services I received.	○	○	○	○	○	○
15. I was able to get all the help/services that I needed.	○	○	○	○	○	○
16. I would recommend this agency to a friend or family member.	○	○	○	○	○	○

17. 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

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

19. **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

20. 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

21. Do you think of yourself as (Please select all that apply):
○ Straight/Heterosexual
○ Gay or Lesbian
○ Bisexual
○ Queer
○ Another sexual orientation
○ Unknown

22. Are you of Mexican/Hispanic/Latinx descent?
○ Yes ○ No ○ Unknown

23. 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

24. Age Range:
○ 18-25 ○ 26-35 ○ 36-45
○ 46-55 ○ 56-64 ○ 65+

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Thank you for taking the time to answer these questions!