



**Thinking about the care you have received from this service within the last 3 months, what was your experience in the following areas:**

*These questions ask how well we did the following:*

- 8. Information available to you about this service (such as how the service works, what to expect, how to make a complaint, upcoming changes that may affect you, etc.)
- 9. Explanation of your rights and responsibilities
- 10. Access to peer support (such as information about peer workers, referral to peer programs, advocates, etc.)
- 11. Development of a plan with you that addresses all of your support or care needs (such as accommodation, advocacy, employment, health, etc.)
- 12. Convenience of the location of the service for you (such as access to parking or transport, distance from your home, etc.)

	Poor	Fair	Good	Very Good	Excellent	Not Applicable
8. Information available to you about this service (such as how the service works, what to expect, how to make a complaint, upcoming changes that may affect you, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Explanation of your rights and responsibilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Access to peer support (such as information about peer workers, referral to peer programs, advocates, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Development of a plan with you that addresses all of your support or care needs (such as accommodation, advocacy, employment, health, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Convenience of the location of the service for you (such as access to parking or transport, distance from your home, etc.)	<input type="checkbox"/>	<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, please rate the following:**

- 13. Overall, how would you rate your experience with this service in the last 3 months?

	Poor	Fair	Good	Very Good	Excellent	Not Applicable
13. Overall, how would you rate your experience with this service in the last 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. My experience would have been better if...

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

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The information in this section helps us to know if we are missing out on feedback from some groups of people. It also tells us if some groups of people have a better or worse experience than others. Knowing this helps us focus our efforts to improve services. No information collected in this section will be used to identify you.

16. What is your gender?

- Male    Female    Other

17. What is the main language you speak at home?

- English    Other

Please specify: .....

18. Are you of Aboriginal or Torres Strait Island origin?

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

19. What is your age?

- |  |   |
|--|---|
| <input type="checkbox"/> Under 18 years    | <input type="checkbox"/> 18 to 24 years |
| <input type="checkbox"/> 25 to 34 years    | <input type="checkbox"/> 35 to 44 years |
| <input type="checkbox"/> 45 to 54 years    | <input type="checkbox"/> 55 to 64 years |
| <input type="checkbox"/> 65 years and over |   |

20. How long have you been receiving support or care from this service?

- |   |   |
|---|---|
| <input type="checkbox"/> Less than 24 hours | <input type="checkbox"/> 1 day to 2 weeks   |
| <input type="checkbox"/> 3 to 4 weeks       | <input type="checkbox"/> 1 to 3 months      |
| <input type="checkbox"/> 4 to 6 months      | <input type="checkbox"/> More than 6 months |

21. Did someone help you complete this survey?

- No
- Yes – family or friend  
 Yes - language or cultural interpreter  
 Yes – lived experience/peer worker  
 Yes – a staff member  
 Yes – someone else

Thank you for taking the time to complete this questionnaire, your feedback is important to us.

**Please place your completed questionnaire in the ESQ Return Box located in the Mental Health & Alcohol & Drug reception area.**

<b>OFFICE USE ONLY</b>	
Date: ___/___/___	MH <input type="checkbox"/> CADS <input type="checkbox"/>
Point of Service:	
<input type="checkbox"/> Choice <input type="checkbox"/> Partnership <input type="checkbox"/> Transfer of care	
Appointment conducted at:	
<input type="checkbox"/> Clinic <input type="checkbox"/> School <input type="checkbox"/> Home <input type="checkbox"/> ED <input type="checkbox"/> Other	
Processed by Admin: <input type="checkbox"/>	