Government of **Western Australia**
WA Country Health Service

Experience of Service Questionnaire (ESQ)

Community Adolescent Mental Health Service (Parent/Carer)

Child's Age: _____ Child's gender is: _____

I consider my child to be Aboriginal or Torres Strait Islander: ☐ Yes ☐ No

At home, the language my child speaks is: ☐ English ☐ A language other than English

Please think about the contact you, your child and family have had with our service. For each item below, rate how true it has been for you.

1. The people who have seen my child listened to me.
   ☐ True ☐ Partly True ☐ Not True ☐ Don't Know
2. It was easy to talk to the people who have seen my child.
   ☐ True ☐ Partly True ☐ Not True ☐ Don't Know
3. I was treated well by the people who saw my child.
   ☐ True ☐ Partly True ☐ Not True ☐ Don't Know
4. My views and worries were taken seriously.
   ☐ True ☐ Partly True ☐ Not True ☐ Don't Know
5. The people here know how to help with the problem I came for.
   ☐ True ☐ Partly True ☐ Not True ☐ Don't Know
6. I have been given enough explanation about the help available here.
   ☐ True ☐ Partly True ☐ Not True ☐ Don't Know
7. The people who have seen my child are working together to help with the problem/s?
   ☐ True ☐ Partly True ☐ Not True ☐ Don't Know
8. The facilities here are comfortable (e.g. waiting area, toilets, offices).
   ☐ True ☐ Partly True ☐ Not True ☐ Don't Know
9. The appointments are usually at a convenient time (e.g. don't interfere with work or school).
   ☐ True ☐ Partly True ☐ Not True ☐ Don't Know

10. It is quite easy to get to the place where the appointments are.

☐ True ☐ Partly True ☐ Not True ☐ Don't Know

11. If a friend needed this sort of help, I would recommend that he or she come here.

☐ True ☐ Partly True ☐ Not True ☐ Don't Know

12. Overall, the assistance I have received here has been good.

☐ True ☐ Partly True ☐ Not True ☐ Don't Know

13. What did you like about the service?

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14. Was there anything you didn't like or anything that needs improving? If so, what could we do better?

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15. Is there anything else you want to tell us about the service you received?

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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 Child & Adolescent reception area.

OFFICE USE ONLY

Date: ___/___/___ MH ☐ CADS ☐

Point of Service:

☐ Choice ☐ Partnership ☐ Transfer of care

Appointment conducted at:

☐ Clinic ☐School ☐ Home ☐ ED ☐ Other

Processed by Admin: ☐