

2025 YOUTH SERVICES SURVEY FOR FAMILY MEMBERS (YSS-F)

Administered by Acentra Health for the West Virginia Department of Human Services (DoHS)
Bureau for Behavioral Health (BBH)

This survey is for family members of children up to age 17 who received mental health or co-occurring behavioral health services at any point between October 2024 and now. Please help BBH make services better by answering some questions about your experiences. Your answers are confidential and will not influence the services you or your child receives. Thank you for your time completing the survey.

Please put an (X) in the box that best describes your answer to each statement.

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Not Applicable
1. Overall, I am satisfied with the services my child received.						
2. I helped choose my child's services.						
3. I helped choose my child's treatment goals.						
4. The people helping my child stuck with us no matter what.						
5. I felt my child had someone to talk to when they were troubled						
6. I participated in my child's treatment.						
7. The services my child or family received were right for us.						
8. The location of the services was convenient for us.						
9. Services were available at times that were convenient for us.						
10. My family got the help we wanted for my child.						
11. My family got as much help as we needed for my child.						
12. Staff treated me with respect.						
13. Staff respected my family's religious or spiritual beliefs.						
14. Staff spoke with me in a way that I understood.						
15. Staff were sensitive to my cultural or ethnic background.						
As a result of the services my child or family received:						
16. My child is better at handling daily life.						
17. My child gets along better with family members.						
18. My child gets along better with friends and other people.						
19. My child is doing better in school or work.						
20. My child is able to cope better when things go wrong.						
21. I am satisfied with our family life right now.						
22. My child is better able to do things they want to do.						

Please answer the following questions about your relationships with persons other than your mental health provider(s). As a result of the services my child or family received:						
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Not applicable
23. I know people who will listen and understand me when I need to talk.						
24. I have people with whom I am comfortable talking about my child's problems.						
25. In a crisis, I would have the support I need from family or friends.						
26. I have people with whom I can do enjoyable things.						

27. What has been the most helpful thing about the services you and your child received?

28. What would improve the services?

29. In what county did you primarily receive services? If you mainly received services by phone or in your home, please select your home county. _____

30. Did you receive services from a Comprehensive Behavioral Health Center or Certified Behavioral Health Clinic? Please check all that apply.

- ☐ Appalachian Community Health Center
- ☐ EastRidge Health Systems
- ☐ FMRS Health Systems
- ☐ HealthWays
- ☐ Mountain Laurel Integrated Healthcare
- ☐ Northwood Health Systems
- ☐ Potomac Highlands Guild
- ☐ Prestera Health Services
- ☐ Seneca Health Services
- ☐ Southern Highlands Community Mental Health Center
- ☐ Healthy Minds Clarksburg/United Summit Center
- ☐ Valley HealthCare System (Marion, Monongalia, Preston, or Taylor County)
- ☐ Westbrook Health Services
- ☐ None of these
- ☐ I don't know

31. Please list any other behavioral health provider agency or agencies that served you. _____

32. Is your child currently living with you? ____Yes ____No

33. Has your child lived in any of the following places in the last year? Please check all that apply.

- ☐ With one or both parents
- ☐ With another family member
- ☐ Foster home
- ☐ Therapeutic foster home
- ☐ Crisis shelter
- ☐ Homeless shelter
- ☐ Group home
- ☐ Residential treatment center
- ☐ Hospital
- ☐ Local jail or detention facility
- ☐ State correctional facility
- ☐ Runaway/homeless/on the streets
- ☐ Other - Please describe

34. In the last year, did your child see a medical or other healthcare professional when they were sick?
Please check one.

- ☐ Yes, in a clinic or office
- ☐ Yes, but only in a hospital emergency room
- ☐ No
- ☐ Do not remember

35. Is your child taking medication for emotional/behavioral needs? ____Yes ____No

36. If yes, did the doctor or health care provider tell you and/or your child the possible side effects of the medication? ____Yes ____No

37. Is your child still receiving mental health or co-occurring behavioral health services? ____Yes ____No

38. How long did your child receive services?

- ☐ One time
- ☐ More than one time but less than 1 month
- ☐ 1-5 months
- ☐ 6 months to 1 year
- ☐ More than 1 year

If your child received services for <i>a year or less</i> , please answer questions 39-44.	If your child received services for <i>more than a year</i> , please answer questions 45-50.
39. Was your child arrested since beginning to receive mental health services? ____Yes ____No	45. Was your child arrested in the last 12 months? ____Yes ____No
40. Was your child arrested in the 12 months prior to that? ____Yes ____No	46. Was your child arrested in the 12 months prior to that? ____Yes ____No
41. Since your child began receiving mental health services, have their encounters with police <input type="radio"/> been reduced <input type="radio"/> stayed the same <input type="radio"/> increased <input type="radio"/> not applicable (no police encounters before or after services)	47. Over the last year, have your child's encounters with police <input type="radio"/> been reduced <input type="radio"/> stayed the same <input type="radio"/> increased <input type="radio"/> not applicable (no police encounters before or after services)
42. Was your child expelled or suspended since beginning services? ____Yes ____No	48. Was your child expelled or suspended in the past 12 months? ____Yes ____No
43. Was your child expelled or suspended in the 12 months prior to that? ____Yes ____No	49. Was your child expelled or suspended in the 12 months prior to that? ____Yes ____No
44. Since starting to receive services, the number of days my child was in school is <input type="radio"/> Greater <input type="radio"/> About the same <input type="radio"/> Less <input type="radio"/> Does not apply If it does not apply, the reason is my child <input type="radio"/> had no attendance problems before or after receiving services <input type="radio"/> is too young to be in school <input type="radio"/> was expelled or suspended from school <input type="radio"/> is home-schooled <input type="radio"/> dropped out of school <input type="radio"/> Other - Please share <input type="text"/>	50. Over the last year, the number of days my child was in school is <input type="radio"/> Greater <input type="radio"/> About the same <input type="radio"/> Less <input type="radio"/> Does not apply If it does not apply, the reason is my child <input type="radio"/> had no attendance problems before or after receiving services <input type="radio"/> is too young to be in school <input type="radio"/> was expelled or suspended from school <input type="radio"/> is home-schooled <input type="radio"/> dropped out of school <input type="radio"/> Other - Please share <input type="text"/>

Please let us know a little more about your child for statistical purposes.

52. Are either of the child's parents of Spanish, Hispanic or Latino origin?

- ☐ Yes
- ☐ No
- ☐ I don't know

53. What is your child's race? Please check all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black (African American)
- ☐ Native Hawaiian or Pacific Islander
- ☐ White (Caucasian)
- ☐ Other - Please describe _____

54. What is your child's age? _____

55. What is your child's sex?

- ☐ Female
- ☐ Male
- ☐ Prefer not to answer

56. Does your child have Medicaid insurance?

- ☐ Yes
- ☐ No

57. Do your child have insurance other than Medicaid?

- ☐ Yes
- ☐ No

58. Do you have any other feedback you'd like to share? Your input is important to us and could help improve behavioral health services in West Virginia.