NATIONAL ALLIANCE ON MENTAL ILLNESS NJ
(in collaboration with NJ State Psychiatric Hospitals)
FAMILY SATISFACTION SURVEY

In order to provide the best possible mental health services, we need to know what you think about the services your family member received during their stay in the hospital and your experience as a family member. There is space at the end of the survey to provide your own comments. Alternatively, you can scan the QR Code near the bottom of the page with your smartphone camera. This will give you a link to the survey you can fill out using your phone.

Which Hospital? Place X in appropriate column:

Ancora	Ann Klein	Greystone	Trenton

Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**	**Not Applicable**

1. Overall I am satisfied with the services my family member received.
   1 2 3 4 5 N/A

2. I received a Family Handbook and Contact information for my family member's treatment team.
   1 2 3 4 5 N/A

3. My phone calls were returned on a timely basis (2 business days).
   1 2 3 4 5 N/A

4. Staff encouraged my family member to include me/us in their treatment.
   1 2 3 4 5 N/A

5. The staff treats me/us with respect
   1 2 3 4 5 N/A

6. I have received resources specific to being a family member of a loved one receiving mental health services.
   1 2 3 4 5 N/A

7. The staff respects the religious or spiritual beliefs of my family member.
   1 2 3 4 5 N/A

8. Staff were sensitive to my family's cultural or ethnic background.
   1 2 3 4 5 N/A

9. I feel welcomed by the staff when visiting my family member.
   1 2 3 4 5 N/A

10. The cleanliness and appearance of the facility encourages recovery.
    1 2 3 4 5 N/A

11. The staff makes safety a priority.

1 2 3 4 5 N/A

12. I see my family member making progress in their treatment.

1 2 3 4 5 N/A

13. My family member was encouraged to use consumer-run programs (support groups, peer counselors, etc.).

1 2 3 4 5 N/A

14. I feel free to voice a concern regarding my family member's treatment.

1 2 3 4 5 N/A

15. How long has your family member been in this facility? (Please Circle)
    a. Less than 6 months
    b. 6 months to 1 year
    c. 1 year to 2 years
    d. More than 2 years

16. What is your family member's gender? (Please Circle)
    a. Female
    b. Male
    c. Trans female
    d. Trans male
    e. Other
    f. Prefer not to answer

17. What is your family member's age? _____years

18. What is your family member's race or ethnic background? (Please Circle)
    a. American Indian/ Alaska Native
    b. Asian
    c. Black / African American
    d. Native Hawaiian / Pacific Islander
    e. White / Caucasian
    f. More than one race or ethnic group
    g. Other

19. Do you consider your family member Hispanic / Latino / Spanish Origin?
    a. Yes
    b. No

20. Do you have any comments that may improve your family member's experience at this hospital?

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