

**CMHS NOMS Child Consumer Outcome  
Measures for Discretionary Programs  
Caregiver Respondent Version**

---

Public reporting burden for this collection of information is estimated to average 20 minutes per response if all items are asked of a client/participant; to the extent that providers already obtain much of this information as part of their ongoing client/participant intake or followup, less time will be required. Send comments regarding this burden estimate or any other aspect of this collection of information to SAMHSA Reports Clearance Officer, Room 7-1045, 1 Choke Cherry Road, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to a

collection of information unless it displays a currently valid OMB control number. The control number for this project is 0930-xxxx.

---

**A. RECORD MANAGEMENT**

**Consumer ID**            |\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|

**Grant ID (Grant/Contract/Collaborative Agreement)** |\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|

**Site ID**                |\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|

**Interview Type**        **[Select only one]**

**Baseline**

Did you conduct a baseline interview?

Yes            **[Select a consumer type then fill in the interview date and the rest of Section A]**

No            **[Select a consumer type then fill in the rest of Section A]**

**Consumer Type**        **[Select only one]**

New            **[A first-time consumer to your grant]**

Continuing **[A consumer who was previously screened, assessed, treated, or referred by your grant]**

**3 month reassessment** [All programs except CMHI]

Did you conduct a reassessment interview?

Yes            **[Fill in interview date, then skip to Section B]**

No            **[Skip to Section I]**

**6 month reassessment** [CMHI only]

Did you conduct a reassessment interview?

Yes **[Fill in interview date, then skip to Section B]**

No            **[Skip to Section I]**

**Clinical Discharge**

Did you conduct a discharge interview?

Yes **[Fill in interview date, then skip to Section B]**

No            **[Skip to Section J]**

**Interview Date**        |\_|\_|\_|\_| / |\_|\_|\_|\_| / |\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|  
                                    Month                      Day                      Year

**A. RECORD MANAGEMENT (Continued) - DEMOGRAPHICS**

[Demographics are collected only at the baseline interview]

1. What is your child's gender?

- Male
- Female
- Transgender
- Other (Specify) \_\_\_\_\_
- Refused

2. Is your child Hispanic or Latino?

- Yes
- No
- Refused

[If Yes] What ethnic group do you consider your child? Please answer yes or no for each of the following. You may say yes to more than one.

	Yes	No	Refused
Central American	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cuban	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dominican	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mexican	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Puerto Rican	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
South American	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (Specify) _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> [If Yes, Specify Below]

3. What race do you consider your child? Please answer yes or no for each of the following. You may say yes to more than one.

	Yes	No	Refused
Black or African American	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asian	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Native Hawaiian or other Pacific Islander	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alaska Native	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
White	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
American Indian	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (Specify) _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> [If Yes, Specify Below]

4. What is your child's month and year of birth?

|\_|\_| / |\_|\_|\_|\_|\_|\_|  
Month Year

- Refused

[For CMHI grantees that are sampling, if the consumer is not part of the sample, stop here. No additional information is required.]

**FUNCTIONING**

In order to provide the best possible mental health services, we need to know what you think about how well your child was able to deal with his/her everyday life during the last 30 days. Please indicate your agreement/disagreement with each of the following statements.

[Read each statement followed by the response options to the caregiver]

STATEMENT	RESPONSE OPTIONS					
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Refused
1. My child is handling daily life.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. My child gets along with family members.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. My child gets along with friends and other people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. My child is doing well in school and/or work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. My child is able to cope when things go wrong.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. I am satisfied with our family life right now.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

[Optional: GAF score reported by program staff at program's discretion]

What was the consumer's score? GAF = |||

Date GAF was administered: || / || / ||||  
 Month Day Year

---

**C. STABILITY IN HOUSING**

**1. In the past 30 days, where has your child been living most of the time?**

**[Do not read response options to the caregiver. Select only one.]**

- Caregiver's owned or rented house, apartment, trailer, or room
- Someone else's house, apartment, trailer, or room
- Homeless (Shelter, street/outdoors, park)
- Group home
- Foster care (Specialized Therapeutic Treatment)
- Transitional living facility
- Halfway house
- Residential Treatment Center
- Hospital (Medical)
- Hospital (Psychiatric)
- Correctional facility (Juvenile Detention Center/Jail/Prison)
- Other Housed (Specify) \_\_\_\_\_
- Refused
- Don't Know

**2. Who has your child lived with during the past 30 days? You may choose more than one answer.**

- Biological parent(s)
- Adoptive parent(s)
- Relative other than parent(s)
- Non-relative
- Independent living
- Refused
- Don't Know

---

**D. EDUCATION**

**1. During the last 30 days of school, how many days was your child absent for any reason?**

- 0 days
- 1 day
- 2 days
- 3 to 5 days
- 6 to 10 days
- More than 10 days
- Refused
- Don't Know
- Not Applicable

**a. How many days were unexcused absences?**

- 0 days
- 1 day
- 2 days
- 3 to 5 days
- 6 to 10 days
- More than 10 days
- Refused
- Don't Know
- Not Applicable

**2. What is the highest level of education your child has finished, whether or not he or she received a degree?**

- Never Attended
- 1<sup>ST</sup> Grade
- 2<sup>ND</sup> Grade
- 3<sup>RD</sup> Grade
- 4<sup>TH</sup> Grade
- 5<sup>TH</sup> Grade
- 6<sup>TH</sup> Grade
- 7<sup>TH</sup> Grade
- 8<sup>TH</sup> Grade
- 9<sup>TH</sup> Grade
- 10<sup>TH</sup> Grade
- 11<sup>TH</sup> Grade
- 12<sup>TH</sup> Grade/High school diploma/Equivalent (GED)
- Voc/Tech diploma
- Some college or university
- Refused
- Don't Know

---

**E. CRIME AND CRIMINAL JUSTICE STATUS**

**1. In the past 30 days, how many times has your child been arrested?**

|\_\_| |\_\_| Times                       Refused                       Don't Know

**[For baseline interviews, skip to Section G]**

**F. PERCEPTION OF CARE**

[Section F is collected only at the reassessment or the discharge interview]

[For baseline interviews, skip to Section G]

In order to provide the best possible mental health services, we need to know what you think about the services your child received during the last 30 days, the people who provided it, and the results. Please indicate your agreement/disagreement with each of the following statements.

[Read each statement followed by the response options to the caregiver]

STATEMENT	RESPONSE OPTIONS					
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Refused
1. Staff here treated me with respect.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Staff respected my family's religious/spiritual beliefs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Staff spoke with me in a way that I understood.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Staff was sensitive to my cultural/ethnic background.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. I helped to choose my child's services.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. I helped to choose my child's treatment goals.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. I participated in my child's treatment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Overall, I am satisfied with the services my child received.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. The people helping my child stuck with us no matter what.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. I felt my child had someone to talk to when he/she was troubled.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. The services my child and/or family received were right for us.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. My family got the help we wanted for my child.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. My family got as much help as we needed for my child.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



---

**G. SOCIAL CONNECTEDNESS**

Please indicate your agreement/disagreement with each of the following statements. Please answer for relationships with persons other than your child's mental health provider(s) over the past 30 days.

[Read each statement followed by the response options to the caregiver]

STATEMENT	RESPONSE OPTIONS					
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Refused
1. I know people who will listen and understand me when I need to talk.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. I have people that I am comfortable talking with about my child's problems.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. In a crisis, I would have the support I need from family or friends.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. I have people with whom I can do enjoyable things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

[If this is a baseline interview stop now, the interview is complete.]

[If this is a reassessment interview (3 or 6 month) go to the next page, Section I.]

[If this is a clinical discharge interview, skip to Section J.]

---

**I. REASSESSMENT STATUS**

**[Section I is reported by program staff only at reassessment]**

**1. What is the reassessment status of the consumer?**

**[This is a required field: NA, Refused, Don't Know, and Missing will not be accepted]**

- 01 = Deceased at time of due date
- 11 = Completed interview within specified window
- 12 = Completed interview outside specified window
- 21 = Refused interview
- 31 = No contact within 90 days of last encounter
- 32 = Other (Specify) \_\_\_\_\_

**2. Is the consumer still receiving services from your program?**

- Yes
- No

**[Skip to Section K]**

---

**J. CLINICAL DISCHARGE STATUS**

**[Section J is reported by program staff only if a consumer is discharged from the program]**

**1. On what date was the consumer discharged?**

|\_|\_|\_| / |\_|\_|\_| / |\_|\_|\_|\_|\_|\_|  
Month Day Year

**2. What is the consumer's discharge status?**

- 01 = Mutually agreed cessation of treatment
- 02 = Death
- 03 = No contact
- 04 = Clinically referred out
- 05 = Other (Specify) \_\_\_\_\_

**[Go to next page, Section K]**

---

**K. SERVICES RECEIVED**

[Section K is reported by program staff only at reassessment or discharge]

1. On what date did the consumer last receive services?

|\_|\_|/|\_|\_|/|\_|\_|\_|\_|\_|  
Month Day Year

---

[Identify all of the services your program provided to the consumer since his/her last NOMs interview; this includes CMHS-funded and non-funded services.]

Core Services	Provided	
	Yes	No
1. Screening	<input type="radio"/>	<input type="radio"/>
2. Assessment	<input type="radio"/>	<input type="radio"/>
3. Treatment Planning or Review	<input type="radio"/>	<input type="radio"/>
4. Psychopharmacological Services	<input type="radio"/>	<input type="radio"/>
5. Mental Health Services	<input type="radio"/>	<input type="radio"/>

[If Yes, please select the frequency mental health services were delivered]:

Daily  Weekly  Monthly  Less than Monthly

6. Co-Occurring Services	<input type="radio"/>	<input type="radio"/>
7. Case Management	<input type="radio"/>	<input type="radio"/>
8. Trauma-specific Services	<input type="radio"/>	<input type="radio"/>

9. Was the consumer referred to another provider for any of the above core services?

Yes  No

Support Services	Provided	
	Yes	No
1. Primary Care	<input type="radio"/>	<input type="radio"/>
2. Employment Services	<input type="radio"/>	<input type="radio"/>
3. Family Services	<input type="radio"/>	<input type="radio"/>
4. Child Care	<input type="radio"/>	<input type="radio"/>
5. Transportation	<input type="radio"/>	<input type="radio"/>
6. Education Services	<input type="radio"/>	<input type="radio"/>
7. Housing Support	<input type="radio"/>	<input type="radio"/>
8. Social Recreational Activities	<input type="radio"/>	<input type="radio"/>
9. Consumer Operated Services	<input type="radio"/>	<input type="radio"/>
10. Medical Support & HIV Testing	<input type="radio"/>	<input type="radio"/>

11. Was the consumer referred to another provider for any of the above support services?

Yes  No