OMB No. 0930-0285
Expiration Date 5/21/2013

Transformation Accountability (TRAC)
Center for Mental Health Services

NOMs Client-Level Measures for Discretionary Programs Providing Direct Services

SERVICES TOOL
Child/Adolescent *or* Caregiver
Combined Respondent Version

CMHS
Center for Mental Health Services
SAMHSA

March 2011
Version 7

RECORD MANAGEMENT

Consumer ID |____|____|____|____|____|____|____|____|____|____|____|____|

Grant ID (Grant/Contract/Cooperative Agreement) |____|____|____|____|____|____|____|____|____|____|____|____|

Site ID |____|____|____|____|____|____|____|____|____|____|____|____|

1. Assessment

○ Baseline Assessment		
○ 6-Month Reassessment	○ 12-Month Reassessment	○ 18-Month Reassessment
○ 24-Month Reassessment	○ 30-Month Reassessment	○ 36-Month Reassessment
○ 42-Month Reassessment	○ 48-Month Reassessment	○ 54-Month Reassessment
○ 60-Month Reassessment	○ 66-Month Reassessment	○ Clinical Discharge

2. Interview Conducted?

○ Yes ***[GO TO 3]***
○ No

2a. Why was the interview not conducted? Choose only one.

[PLEASE MARK YOUR ANSWER UNDER THE COLUMN RELATING TO THE ASSESSMENT TYPE]

	Baseline Assessment	Reassessments	Clinical Discharge
Consumer refused interview	○	○	○
Not able to obtain consent from proxy	○	○	○
Consumer was impaired/unable to provide consent	○	○	○
Consumer cannot be reached for interview		○	○
Staff previously indicated "Administrative data only" or "No data" would be submitted		○ ***[IF THIS ANSWER IS SELECTED, GO TO SECTION I]***	○ ***[IF THIS ANSWER IS SELECTED, GO TO SECTION J]***

[IF THIS IS A CLINICAL DISCHARGE, GO TO 2c]

RECORD MANAGEMENT (Continued)

2b. What data will be submitted for the <u>next</u> reassessment?

- ○ Interview data
- ○ Administrative data only - [Record Management, Sections I or J &K] – will not attempt any subsequent interviews
- ○ No data - will only provide discharge status [Record Management & Section J] when discharged

[GO TO 3]

2c. *[CLINICAL DISCHARGE ONLY]* What data will be submitted for this Clinical Discharge?

- ○ Administrative data only - [Record Management and Sections J &K]
- ○ No data – will only provide discharge status [Record Management & Section J]

3. When was the interview conducted or attempted?

***[REASSESSMENTS AND CLINICAL DISCHARGE: IF ANSWERED "CONSUMER CANNOT BE REACHED FOR INTERVIEW" IN 2a, GO TO INSTRUCTIONS BELOW 5*]**

|____|____| / |____|____| / |____|____|____|____|
MONTH DAY YEAR

[IF THIS IS A BASELINE GO TO 4, ALL OTHERS GO TO 5]

4. When did the consumer first receive services under the grant for <u>this</u> episode of care?

|____|____| / |____|____|____|____|
MONTH YEAR

5. Was the respondent the child or the caregiver?

- ○ Child *[PREFER CHILD AGE 11 AND OLDER]*
- ○ Caregiver

[IF THIS IS A BASELINE, GO TO SECTION A.]

[FOR ALL REASSESSMENTS:
IF AN INTERVIEW WAS CONDUCTED, GO TO SECTION B.]
IF AN INTERVIEW WAS NOT CONDUCTED, GO TO SECTION I.]

[FOR A CLINICAL DISCHARGE:
IF AN INTERVIEW WAS CONDUCTED, GO TO SECTION B.]
IF AN INTERVIEW WAS NOT CONDUCTED, GO TO SECTION J.]

A. DEMOGRAPHIC DATA

[SECTION A IS ONLY COLLECTED AT BASELINE. IF THIS IS NOT A BASELINE, GO TO SECTION B.]

1. What is your [child's] gender?

- ○ MALE
- ○ FEMALE
- ○ TRANSGENDER
- ○ OTHER (SPECIFY) _____
- ○ REFUSED

2. Are you [Is your child] Hispanic or Latino?

- ○ YES
- ○ NO *[GO TO 3]*
- ○ REFUSED *[GO TO 3]*

[IF YES] **What ethnic group do you consider yourself [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	○	○	○
Cuban	○	○	○
Dominican	○	○	○
Mexican	○	○	○
Puerto Rican	○	○	○
South American	○	○	○
OTHER (SPECIFY) _____	○	○	○ *[IF YES, SPECIFY BELOW]*

3. What race do you consider yourself [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	○	○	○
Asian	○	○	○
Native Hawaiian or other Pacific Islander	○	○	○
Alaska Native	○	○	○
White	○	○	○
American Indian	○	○	○

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

|____|____| / |____|____|____|____|
MONTH YEAR ○ REFUSED

[***STOP HERE IF BASELINE INTERVIEW WAS NOT CONDUCTED AND DEMOGRAPHIC DATA WAS ABSTRACTED FROM RECORDS. ALL OTHERS CONTINUE.***]

B. FUNCTIONING

1. How would you rate your [your child's] overall health right now?

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor
- ○ REFUSED
- ○ DON'T KNOW

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

[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER (CAREGIVER).]

STATEMENT	RESPONSE OPTIONS						
	Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**	**REFUSED**	**NOT APPLICABLE**
a. I am [my child is] handling daily life.	○	○	○	○	○	○	
b. I get [my child gets] along with family members.	○	○	○	○	○	○	○
c. I get [my child gets] along with friends and other people.	○	○	○	○	○	○	
d. I am [my child is] doing well in school and/or work.	○	○	○	○	○	○	○
e. I am [my child is] able to cope when things go wrong.	○	○	○	○	○	○	
f. I am satisfied with our family life right now.	○	○	○	○	○	○	

B. FUNCTIONING (Continued)

[IF THE CAREGIVER IS THE RESPONDENT GO TO THE OPTIONAL GAF QUESTION.]

3. The following questions ask about how you have been feeling during the past 30 days. For each question, please indicate how often you had this feeling.

[READ EACH QUESTION FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]

QUESTION	RESPONSE OPTIONS						
During the past 30 days, about how often did you feel …	**All of the Time**	**Most of the Time**	**Some of the Time**	**A Little of the Time**	**None of the Time**	**REFUSED**	**DON'T KNOW**
a. nervous?	○	○	○	○	○	○	○
b. hopeless?	○	○	○	○	○	○	○
c. restless or fidgety?	○	○	○	○	○	○	○
d. so depressed that nothing could cheer you up?	○	○	○	○	○	○	○
e. that everything was an effort?	○	○	○	○	○	○	○
f. worthless?	○	○	○	○	○	○	○

B. FUNCTIONING (Continued)

[IF THE CAREGIVER IS THE RESPONDENT GO TO THE OPTIONAL GAF QUESTION.]

4. The following questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we'll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed.

[READ EACH QUESTION FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]

QUESTION	RESPONSE OPTIONS					
In the past 30 days, how often have you used…	**Never**	**Once or Twice**	**Weekly**	**Daily or Almost Daily**	**REFUSED**	**DON'T KNOW**
a. tobacco products (cigarettes, chewing tobacco, cigars, etc.)?	○	○	○	○	○	○
b. alcoholic beverages (beer, wine, liquor, etc.)?	○	○	○	○	○	○
b1. *[IF B >= ONCE OR TWICE, AND RESPONDENT MALE],* **How many times in the past 30 days have you had five or more drinks in a day***?* *[CLARIFY IF NEEDED:* **(A standard alcoholic beverage (e.g., 12 oz beer, 5 oz wine, 1.5 oz liquor)/.**	○	○	○	○	○	○
b2. *[IF B >= ONCE OR TWICE, AND RESPONDENT NOT MALE],* **How many times in the past 30 days have you had four or more drinks in a day?** *[CLARIFY IF NEEDED:* **(A standard alcoholic beverage (e.g., 12 oz beer, 5 oz wine, 1.5 oz liquor)/.**	○	○	○	○	○	○
c. cannabis (marijuana, pot, grass, hash, etc.)?	○	○	○	○	○	○
d. cocaine (coke, crack, etc.)?	○	○	○	○	○	○
e. prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)?	○	○	○	○	○	○
f. methamphetamine (speed, crystal meth, ice, etc.)?	○	○	○	○	○	○
g. inhalants (nitrous oxide, glue, gas, paint thinner, etc.)?	○	○	○	○	○	○
h. sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)?	○	○	○	○	○	○
i. hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)?	○	○	○	○	○	○
j. street opioids (heroin, opium, etc.)?	○	○	○	○	○	○
k. prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)?	○	○	○	○	○	○
l. other – specify:	○	○	○	○	○	○

B. FUNCTIONING (Continued)

[OPTIONAL: GAF SCORE REPORTED BY GRANTEE STAFF AT PROJECT'S DISCRETION.]

DATE GAF WAS ADMINISTERED: |____|____| / |____|____| /|____|____|____|____|
MONTH DAY YEAR

WHAT WAS THE CONSUMER'S SCORE? GAF = |____|____|____|

[OPTIONAL: CBCL TOTAL PROBLEMS T-SCORE REPORTED BY GRANTEE STAFF AT PROJECT'S DISCRETION.]

DATE CBCL WAS ADMINISTERED: |____|____| / |____|____| /|____|____|____|____|
MONTH DAY YEAR

WHAT WAS THE CONSUMER'S SCORE? TOTAL PROBLEMS T-SCORE = |____|____|____|

C. STABILITY IN HOUSING

1. In the past 30 days how many …	Number of Nights/ Times	REFUSED	DON'T KNOW
a. nights have you [has your child] been homeless?	|____|____|	○	○
b. nights have you [has your child] spent in a hospital for mental health care?	|____|____|	○	○
c. nights have you [has your child] spent in a facility for detox/inpatient or residential substance abuse treatment?	|____|____|	○	○
d. nights have you [has your child] spent in correctional facility including juvenile detention, jail, or prison?	|____|____|	○	○
[ADD UP THE TOTAL NUMBER OF NIGHTS SPENT HOMELESS, IN HOSPITAL FOR MENTAL HEALTH CARE, IN DETOX/INPATIENT OR RESIDENTIAL SUBSTANCE ABUSE TREATMENT, OR IN A CORRECTIONAL FACILITY. (ITEMS A-D, CANNOT EXCEED 30 NIGHTS)]	|____|____|		
e. times have you [has your child] gone to an emergency room for a psychiatric or emotional problem?	|____|____|	○	○

[IF 1A, 1B, 1C, OR 1D IS 16 OR MORE NIGHTS, GO TO SECTION D.]

2. In the past 30 days, where have you [has your child] been living most of the time?

[DO NOT READ RESPONSE OPTIONS TO CONSUMER (CAREGIVER). SELECT ONLY ONE.]

- ○ CAREGIVER'S OWNED OR RENTED HOUSE, APARTMENT, TRAILER, OR ROOM
- ○ INDEPENDENT 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
- ○ HOSPITAL (MEDICAL)
- ○ HOSPITAL (PSYCHIATRIC)
- ○ DETOX/INPATIENT OR RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
- ○ CORRECTIONAL FACILITY (JUVENILE DETENTION CENTER/JAIL/PRISON)
- ○ OTHER HOUSED (SPECIFY) _____
- ○ REFUSED
- ○ DON'T KNOW

D. EDUCATION

1. During the past 30 days of school, how many days were you [was your child] absent for any reason?

- ○ 0 DAYS
- ○ 1 DAYS
- ○ 2 DAYS
- ○ 3 TO 5 DAYS
- ○ 6 TO 10 DAYS
- ○ MORE THAN 10 DAYS
- ○ REFUSED
- ○ DON'T KNOW
- ○ NOT APPLICABLE

a. *[IF ABSENT]*, how many days were unexcused absences?

- ○ 0 DAYS
- ○ 1 DAYS
- ○ 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 you have (your child has) finished, whether or not you (he/she has) received a degree?

- ○ NEVER ATTENDED
- ○ PRESCHOOL
- ○ KINDERGARTEN
- ○ 1ST GRADE
- ○ 2ND GRADE
- ○ 3RD GRADE
- ○ 4TH GRADE
- ○ 5TH GRADE
- ○ 6TH GRADE
- ○ 7TH GRADE
- ○ 8TH GRADE
- ○ 9TH GRADE
- ○ 10TH GRADE
- ○ 11TH GRADE
- ○ 12TH 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 have you [has your child] been arrested?

|____|____| TIMES ○ REFUSED ○ DON'T KNOW

[IF THIS IS A BASELINE, GO TO SECTION G. OTHERWISE, GO TO SECTION F.]

F. PERCEPTION OF CARE

[SECTION F IS NOT COLLECTED AT BASELINE. FOR BASELINE INTERVIEWS, GO TO SECTION G.]

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

[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER (CAREGIVER).]

STATEMENT	RESPONSE OPTIONS					
	Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**	**REFUSED**
a. Staff here treated me with respect.	○	○	○	○	○	○
b. Staff respected my family's religious/spiritual beliefs.	○	○	○	○	○	○
c. Staff spoke with me in a way that I understood.	○	○	○	○	○	○
d. Staff was sensitive to my cultural/ethnic background.	○	○	○	○	○	○
e. I helped choose my [my child's] services.	○	○	○	○	○	○
f. I helped to choose my [my child's] treatment goals.	○	○	○	○	○	○
g. I participated in my [my child's] treatment.	○	○	○	○	○	○
h. Overall, I am satisfied with the services I [my child] received.	○	○	○	○	○	○
i. The people helping me [my child] stuck with me [us] no matter what.	○	○	○	○	○	○
j. I felt I had [my child had] someone to talk to when I [he/she] was troubled.	○	○	○	○	○	○
k. The services I [my child and/or family] received were right for me [us].	○	○	○	○	○	○
l. I [my family] got the help I [we] wanted [for my child].	○	○	○	○	○	○
m. I [my family] got as much help as I [we] needed [for my child].	○	○	○	○	○	○

F. PERCEPTION OF CARE (Continued)

2. *[INDICATE WHO ADMINISTERED SECTION F - PERCEPTION OF CARE TO THE CONSUMER (CAREGIVER) FOR THIS INTERVIEW.]*

- ○ ADMINISTRATIVE STAFF
- ○ CARE COORDINATOR
- ○ CASE MANAGER
- ○ CLINICIAN PROVIDING DIRECT SERVICES
- ○ CLINICIAN NOT PROVIDING SERVICES
- ○ CONSUMER PEER
- ○ DATA COLLECTOR
- ○ EVALUATOR
- ○ FAMILY ADVOCATE
- ○ RESEARCH ASSISTANT STAFF
- ○ SELF-ADMINISTERED
- ○ OTHER (SPECIFY) _____

G. SOCIAL CONNECTEDNESS

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

[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER (CAREGIVER).]

STATEMENT	RESPONSE OPTIONS					
	Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**	**REFUSED**
a. I know people who will listen and understand me when I need to talk.	○	○	○	○	○	○
b. I have people that I am comfortable talking with about my [my child's] problems.	○	○	○	○	○	○
c. In a crisis, I would have the support I need from family or friends.	○	○	○	○	○	○
d. I have people with whom I can do enjoyable things.	○	○	○	○	○	○

[IF THIS IS A BASELINE, STOP NOW. THE INTERVIEW IS COMPLETE.]

[IF THIS IS A REASSESSMENT INTERVIEW, GO TO SECTION I.]

[IF THIS IS A CLINICAL DISCHARGE INTERVIEW, GO TO SECTION J.]

H. PROGRAM SPECIFIC QUESTIONS

SOME PROGRAMS HAVE PROGRAM SPECIFIC DATA THAT IS SUBMITTED TO TRAC. CMHS WILL LET YOU KNOW IF YOU ARE REQUIRED TO DO SECTION H, AND YOU WILL HAVE A SEPARATE SECTION H FORM.

NO CHILD PROGRAMS ARE REQUIRED TO COLLECT DATA FOR SECTION H AT THIS TIME.

I. REASSESSMENT STATUS

[SECTION I IS REPORTED BY GRANTEE STAFF AT REASSESSMENT.]

1. Have you or other grant staff had contact with the consumer within 90 days of last encounter?

- ○ Yes
- ○ No

2. Is the consumer still receiving services from your project?

- ○ Yes
- ○ No

GO TO SECTION K.

J. CLINICAL DISCHARGE STATUS

[SECTION J IS REPORTED BY GRANTEE STAFF ABOUT THE CONSUMER AT CLINICAL DISCHARGE]

1. On what date was the consumer discharged?

|____|____| / |____|____|____|____|
MONTH YEAR

2. What is the consumer's discharge status?

- ○ Mutually agreed cessation of treatment
- ○ Withdrew from/refused treatment
- ○ No contact within 90 days of last encounter
- ○ Clinically referred out
- ○ Death
- ○ Other (Specify) _____

IF A DISCHARGE INTERVIEW WAS CONDUCTED, CONTINUE TO SECTION K.

IF A DISCHARGE INTERVIEW WAS NOT CONDUCTED AND:

- ***IF STAFF PREVIOUSLY INDICATED "ADMINISTRATIVE DATA ONLY" WOULD BE SUBMITTED, CONTINUE TO SECTION K.***
- ***IF STAFF PREVIOUSLY INDICATED "NO DATA" WOULD BE SUBMITTED, STOP HERE.***

K. SERVICES RECEIVED

[SECTION K IS REPORTED BY GRANTEE STAFF AT REASSESSMENT AND DISCHARGE UNLESS STAFF PREVIOUSLY INDICATED "NO DATA" WOULD BE SUBMITTED]

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

|____|____| / |____|____|____|____|
MONTH YEAR

[IDENTIFY ALL OF THE SERVICES YOUR PROJECT 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	○	○
2. Assessment	○	○
3. Treatment Planning or Review	○	○
4. Psychopharmacological Services	○	○
5. Mental Health Services	○	○

[IF YES, PLEASE ESTIMATE HOW FREQUENTLY MENTAL HEALTH SERVICES WERE DELIVERED.]

Number of times _____ per
- ○ Day
- ○ Week
- ○ Month
- ○ Year

	Yes	**No**
6. Co-Occurring Services	○	○
7. Case Management	○	○
8. Trauma-specific Services	○	○

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

Yes ○ No ○

Support Services	**Provided**	
	Yes	**No**
1. Medical Care	○	○
2. Employment Services	○	○
3. Family Services	○	○
4. Child Care	○	○
5. Transportation	○	○
6. Education Services	○	○
7. Housing Support	○	○
8. Social Recreational Activities	○	○
9. Consumer Operated Services	○	○
10. HIV Testing	○	○

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

Yes ○ No ○