Attachment 9

OMB No. 0930-03xx
Expiration Date: xx/xx/xx

CHILDREN'S MENTAL HEALTH INITIATIVE

NATIONAL SYSTEM OF CARE EXPANSION EVALUATION

CHILD AND FAMILY LEVEL INSTRUMENTS

Public Burden Statement: 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 OMB control number for this project is 0930-03xx. Public reporting burden for this collection of information is estimated to average 23 minutes per respondent, per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 2-1057, Rockville, Maryland, 20857.

Attachment 9a

CMHI SOC Evaluation: Child and Family Outcomes Evaluation Components

Overview

- Grantees will interview children and families using the tools listed below to collect the CMHI SOC Evaluation Child and Family Outcomes data. The age of the child/youth in treatment determines who is interviewed for the Evaluation.

    - The CMHI Evaluation will utilize data from the SAMHSA Common Database Platform (CDP) Client-Level Services Measures for Discretionary Programs, CMHS PROGRAM ONLY instrument. The Evaluation will also add questions to the CDP's grant-specific portion of that instrument (Section H).

    - The CMHI Caregiver Tool will be used for collecting data from caregivers of all children ages 5 to 17 (inclusive); only the caregiver is interviewed for this age group.

    - The CMHI Child and Youth Tool will be used for collecting data from children and youth between the ages of 11 and 17.
        - Note: In the CDP Client-Level Services Measures for Discretionary Programs, CMHS PROGRAM ONLY data collection protocol, if the child is 11 – 17, the caregiver is not interviewed. However, the evaluation needs this data on both the child and the family member. And since the rest of the CDP Performance Measures will be used by the evaluation as well, we will also be collecting the full CDP Client-Level Services Measures survey on the caregivers for the 11 – 17 year olds. Our burden estimates reflect this.

    - The CMHI Young Adult Tool will be used for collecting data from individuals ages 18 and above; only the young adult is interviewed for this age group.

    - CMHI Services Received questions collect service receipt data using an augmented version of the CDP Client-Level Services Measures for Discretionary Programs, CMHS PROGRAM ONLY instrument. These questions will be collected by the grantee through a review of client records. The proposed questions are presented in this attachment after Section H subsection 5 as a modified section K for each of the three versions of the tools below.

    - Section K of the CDP Client-Level Services Measures for Discretionary Programs, CMHS PROGRAM ONLY, is collected at discharge. For the CMHI Evaluation, Section K will also be collected at the 6 and 12 month reassessment data collection time points.

    - Section A: Administrative Data and Section K: Services Received is obtained by grant staff through administrative records – consumers and family are not asked these questions directly. In addition to Sections A and K, several questions in the grant specific section, located in Section H Subsection 1, are also answered by staff from administrative and clinical records.

    - Section H Subsections 2-5 are obtained by grant staff through caregiver, youth, or young adult client interviews.

- Only one local service systems within each Jurisdiction will be involved in the local system level data collection which includes the Child and Family Study.

- Data will be collected only from those families of children served in the local service system that also participate in the SOCEA and network analysis.

- Within a local service system, we will ask for data on **all** served children and families. If we learn that sample sizes are high and follow up response rates are good, we will consider employing some sampling method in the future.

- The evaluation pieces will be imbedded in the CDP Client-Level Services Measures for Discretionary Programs, CMHS PROGRAM ONLY data collection survey and will only be collected at baseline, 6 months, and 12 months or discharge if the client's treatment ends prior to either follow-up; reassessments are not every 6 months ongoing as in the CDP data collection protocol.

INFORMED CONSENT

Informed Consent will be obtained using the consent form by the clinician, counselor, or other staff designated by the service provider who administers this tool.

CHILDREN'S MENTAL HEALTH INITIATIVE
NATIONAL SYSTEM OF CARE EXPANSION EVALUATION

CHILD AND FAMILY LEVEL OUTCOMES INSTRUMENT
PROGRAM SPECIFIC QUESTIONS (CMHI)

CAREGIVER RESPONDENT VERSION

INTRODUCTION

Thank you for your willingness to participate in the child and family outcomes survey. The purpose of this survey is to assess changes in the mental health and wellbeing of children and their families while they are participating and receiving services from the Systems of Care.

CONFIDENTIALITY/INFORMED

Your responses to these questions will be kept confidential and will not be shared outside of the evaluation team. In any of our reports, your responses will be combined with other people's responses, so your answers will never be attributed to your name. Please sign the consent form prior to completing this questionnaire.

Child and Family Outcomes

Sample Caregiver Consent Form

Purpose

The Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States Department of Health and Human Services is sponsoring an evaluation of children's mental health services and systems of care. A System of Care is a coordinated network of community-based services and supports that are organized to meet the challenges that children and youth with serious mental health needs and their families face. These systems of care are funded to improve services for children and families. (***The system of care name***), where your child has received services is a part of this study. The purpose of this interview is to find out the ways in which children and youth are involved in their systems of care. In this study, we will ask you about you and your child's behaviors and emotions, what you and your child do at home, in school, and around your neighborhood, types of services your child receives, how your child feels about these services and other information about your family. The results of the project will be used to help improve services for children, young adults and their families.

Description of Participation

Participation in this evaluation is voluntary. You will be asked to participate in up to three interviews: an interview at intake, 6-months, and 12-months and/or at discharge if your child is enrolled in the program for less than 12 months. The interviews will take approximately 20 minutes each. Data will be collected by (**system of care name**) staff through interviews with you and use of some routinely collected information from your records. You will be asked these questions during a regular visit so additional visits will not be required. There are no right or wrong answer to the questions.

If your child is age 11 or older, or reaches age 11 at any time during the study, we will ask your child if we can interview him or her. At that time, we will ask for your permission to talk to your child. We will also describe the interview process to your child.

Risks

You may feel uncomfortable about answering some questions about you and your child's experiences. At any time, you can stop, take a break, or skip any questions you do not want to answer. You may discontinue participation at any time.

Benefits

You will not get any direct benefit from being interviewed. However, the information you provide may help improve the services offered to children, youth, and their families.

Confidentiality

The information you share with us will only be used for the purposes of this study. We will keep you and your child's information private to the extent permitted by law. If you say anything about the intent to harm yourself or others, we have to report it to the proper authorities.

Your child's healthcare services or insurance coverage will not be affected by anything you say during the interview. Your name or your child's name will not be used in any reports we write. This signed consent form and any other forms and records from the study will be kept in a secure place that only project staff will be able to access.

Contact Information

If you have any questions about this project, you may call SAMHSA's Project Officer for this evaluation, Ms. Kaitlyn Harrington at 240-276-1928.

If you have any questions about your rights and welfare as a research participant, you may contact [insert name of grantee IRB representative] at [insert contact phone of grantee IRB representative].

Voluntary Consent

Rights Regarding Decision to Participate: I understand that I will not be in trouble if I do not want to be in the evaluation, do not want my child to be involved or if I decide to quit later. I do not have to answer questions that I do not want to answer. If I change my mind and quit, all of my answers to questions will be destroyed, if that is what I want. No one will say that I cannot be in other projects because I do not want to be in this project. No one can say that I cannot get services because I do not want to be in this project.

I have read this form or, it has been read to me, and I understand what it says. My questions have been answered. A copy of this form will be given to me. By signing my name below, I freely agree to take part in this project.

Printed Name: _____

Signature: _____

Date: ___/___/____

CAREGIVER VERSION

INSTRUCTIONS

This version will be administered to the caregiver of children ages 5 to 17 at every data collection time point unless otherwise noted.

1. Subsection 1: Review of client records
2. Subsection 2: Family/Living Information
3. Subsection 3: Columbia Impairment Scale – self report
4. Subsection 4: Pediatric Symptom Checklist-17 – self report
5. Subsection 5: Caregiver Strain Questionnaire
6. CMHI Services Received

There are two components of this instrument. The first part, Subsection 1, is answered by staff using information from administrative and clinical records for the child receiving services. The second part, including Subsections 2-5, is to be administered verbally to the caregiver by local systems staff.

H. PROGRAM SPECIFIC QUESTIONS (CMHI)

Questions H1-H
OMB No. xxxx-xxxx
Expiration Date: xx/xx/201x

Subsection 1: Administrative Data

[SUBSECTION 1 IS COMPILED BY GRANTEE STAFF FROM RECORDS.]

1. Is the child enrolled in the CMHI Outcome Evaluation?

☐ Yes ***[IF THIS IS A BASELINE, GO TO SUBSECTION 1, QUESTION 2. OTHERWISE SKIP TO SUBSECTION 1, QUESTION 6.]***

☐ No ***[END OF SECTION H.]***
[IF THIS IS A BASELINE, STOP HERE.]
[IF THIS IS A REASSESSMENT, GO TO SECTION I.]
[IF THIS IS A DISCHARGE, SKIP TO SECTION J.]

2. What is the date of the child's…

2a. First assessment for the system of care?

|__|__|/|__|__|/|__|__|__|__|
DD MM YEAR

2b. First service (after assessment) received through the system of care?

|__|__|/|__|__|/|__|__|__|__|
DD MM YEAR

2c. Most recent service planning team meeting in the system of care?

|__|__|/|__|__|/|__|__|__|__|
DD MM YEAR

H. PROGRAM SPECIFIC QUESTIONS (CMHI)

Subsection 1: Administrative Data (Continued)

3. Who participated in the development of the child's service plan? *[Select all that apply and specify role as noted.]*

- ☐ Child's caregiver or guardian
- ☐ Child
- ☐ Other family member
- ☐ Case manager/service coordinator
- ☐ Wraparound facilitator (if not case manager/service coordinator)
- ☐ Therapist
- ☐ Other mental health staff (e.g., behavioral aide, respite worker) (*Specify role*: _____)
- ☐ Intellectual disabilities provider
- ☐ Family advocate
- ☐ Parent/Peer support provider
- ☐ Youth advocate
- ☐ Youth/Peer support provider
- ☐ Education staff (e.g., teacher, counselor) (*Specify role:* _____)
- ☐ Child welfare staff (e.g., case worker) (*Specify role:* _____)
- ☐ Juvenile justice staff (e.g., probation officer) (*Specify role:* _____)
- ☐ Physical health staff (e.g., pediatrician, nurse) (*Specify role:* _____)
- ☐ Other (*For up to three people*) (*Specify role:* _____)
  (*Specify role:* _____)
  (*Specify role:* _____)

4. Which agency or individual referred the child to the program?

- ☐ Mental Health Agency/Clinic/Provider
- ☐ Physical Health Care Agency/Clinic/Provider
- ☐ Substance Abuse Agency/Clinic/Provider
- ○ Intellectual Disabilities Agency/Clinic/Provider
- ☐ School
- ☐ Early Care
- ☐ Child Welfare/Child Protective Services
- ☐ Family Court
- ☐ Juvenile Court/Corrections/Probation/Police
- ☐ Caregiver
- ☐ Youth/Child referred himself or herself
- ☐ Other (*Please specify:* _____)

H. PROGRAM SPECIFIC QUESTIONS (CMHI)

Subsection 1: Administrative Data (Continued)

5. What led to the child being referred for services? *[Select all that apply.]*

- ☐ Conduct/delinquency-related behaviors (including physical aggression, extreme verbal abuse, non-compliance, sexual acting out, property damage, theft, running away, sexual assault, fire setting, cruelty to animals, truancy, police contact)
- ☐ Intellectual disabilities
- ☐ Hyperactive and attention-related behaviors (including hyperactive, impulsive, attentional difficulties)
- ☐ School performance
- ☐ Depression (including major depression, dysthymia, sleep disorders, somatic complaints)
- ☐ Anxiety (including fears and phobias, generalized anxiety, social avoidance, obsessive compulsive behavior, post-traumatic stress disorder)
- ☐ Adjustment-related issues (including changes in behaviors or emotions in reaction to a significant life stress)
- ☐ Suicide-related thoughts or actions (including suicide ideation, or suicide attempt)
- ☐ Self-Injury (self-injurious behavior, hair pulling, cutting, etc)
- ☐ Psychotic behaviors (including hallucinations, delusions, strange or odd behaviors)
- ☐ Substance use, abuse, and drug dependency behaviors
- ☐ Learning disabilities
- ☐ Eating disorders (including anorexia, bulimia)
- ☐ Sleeping problems
- ☐ Current home unable to meet child's needs
- ☐ Maltreatment (child abuse and neglect)
- ☐ Behavioral concerns (including aggression, severe defiance, acting out, impulsivity, recklessness, and excessive level of overactivity)
- ☐ Excessive crying/tantrums
- ☐ Persistent noncompliance (when directed by caregivers/adults)
- ☐ Pervasive developmental disabilities (including autistic behaviors, extreme social avoidance, stereotypes, perseverative behavior)
- ☐ Specific developmental disabilities (including enuresis, encopresis, expressive or receptive speech and language delay)
- ☐ Separation problems
- ☐ Feeding problems (including failure to thrive)
- ☐ Excluded from preschool or childcare due to behavioral or developmental problems
- ☐ Attachment problems
- ☐ Other concerns/issues that are related to child's health (cancer, illness, or disease related-problems)
- ☐ Other (*Please specify:* _____)

H. PROGRAM SPECIFIC QUESTIONS (CMHI)

Subsection 1: Administrative Data (Continued)

6. With which of the following agencies is the child involved? *[Select all that apply.]*

☐ Mental Health Agency/Clinic/Provider
☐ Physical Health Care Agency/Clinic/Provider
☐ Substance Abuse Agency/Clinic/Provider
☐ Intellectual Disabilities Agency/Provider
☐ School
☐ Early Care
☐ Child Welfare/Child Protective Services
☐ Family Court
☐ Juvenile Court/Corrections/Probation/Police
☐ Other (*Please specify:* _____)

7. During the past 6 months, was the child insured through...? *[Select all that apply.]*

☐ Medicaid
☐ CHIP
☐ SSI
☐ Private Insurance
☐ Other (*Please specify:* _____)
☐ No insurance

8. What is the census block group of the address where the child currently lives? _____

H. PROGRAM SPECIFIC QUESTIONS (CMHI)

Subsection 1: Administrative Data (Continued)

9. What is the date of the child's most recent diagnostic evaluation?

|__|__|/|__|__|/|__|__|__|__|
DD MM YEAR

10. Which diagnostic classification system was used?

☐ DSM IV-TR
☐ DSM V
☐ ICD-10

11. What is the child's clinical diagnosis? Indicate the diagnostic code and/or diagnosis below.

		Diagnostic code	Diagnosis (Text)
11a.	**Primary Diagnosis**	_____.____	_____
11b.	**Secondary Diagnosis**	_____.____	_____
11c.	**Additional Diagnosis**	_____.____	_____

[IF AN INTERVIEW WAS CONDUCTED, GO TO SUBSECTION 2, FAMILY/LIVING INFORMATION.]

[IF AN INTERVIEW WAS NOT CONDUCTED:

IF THIS IS A BASELINE, STOP; DATA COLLECTION IS COMPLETE.

IF THIS IS A REASSESSMENT, GO TO SECTION I, THEN SECTION K.

IF THIS IS A DISCHARGE, GO TO SECTION J, THEN SECTION K.]

H. PROGRAM SPECIFIC QUESTIONS (CMHI)

Subsection 2: Family/Living Information

[READ THE FOLLOWING QUESTIONS TO THE CAREGIVER.]

1. What is your gender?

☐ MALE
☐ FEMALE
☐ TRANSGENDER
☐ OTHER (SPECIFY) _____
☐ REFUSED

2. What is your relationship to (*child's name*)?

☐ BIRTH PARENT
☐ STEP-PARENT
☐ ADOPTIVE PARENT
☐ FOSTER PARENT
☐ GRANDPARENT (BIOLOGICAL, STEP, OR ADOPTIVE)
☐ SIBLING (BIOLOGICAL, STEP, OR ADOPTIVE)
☐ OTHER RELATIVE (*Please specify*:_____)
☐ NON-RELATIVE NOT PREVIOUSY LISTED (E.G., OTHER CAREGIVING ADULT)
(*Please specify*:_____)
☐ REFUSED

Subsection 2: Family/Living Information

3. Does *(child's name)* **live alone?**

☐ YES *[GO TO 4.]*
☐ NO
☐ REFUSED *[GO TO 4.]*
☐ DON'T KNOW *[GO TO 4.]*

3a. ***[IF NO],* with whom does** *(child's name)* **live? Please answer yes or no for each of the following. You may say yes to more than one.**

	YES	NO	REFUSED
Birth Mother	☐	☐	☐
Birth Father	☐	☐	☐
Adoptive Mother	☐	☐	☐
Adoptive Father	☐	☐	☐
Foster Mother	☐	☐	☐
Foster Father	☐	☐	☐
Stepmother	☐	☐	☐
Stepfather	☐	☐	☐
Grandmother (Birth, Step, or Adoptive)	☐	☐	☐
Grandfather (Birth, Step, or Adoptive)	☐	☐	☐
Sibling(s) (Biological, Step, or Adoptive)	☐	☐	☐
Spouse/Partner	☐	☐	☐
Youth's Own Children	☐	☐	☐
Friends	☐	☐	☐
Other Specify	☐	☐	☐

Please Specify: _____

Subsection 2: Family/Living Information (Continued)

4. Who has legal custody of *(child's name)* **currently?**

☐ TWO PARENTS (INCLUDES TWO BIRTH PARENTS, OR ONE BIRTH PARENT AND A STEP OR ADOPTIVE PARENT)
☐ BIRTH MOTHER ONLY
☐ BIRTH FATHER ONLY
☐ ADOPTIVE PARENT(S)
☐ SIBLING(S)
☐ AUNT AND/OR UNCLE
☐ GRANDPARENT(S)
☐ ADULT FRIEND
☐ WARD OF THE STATE
☐ EMANCIPATED
☐ OTHER (*Please specify:* _____)
☐ REFUSED
☐ DON'T KNOW

[QUESTIONS 5 AND 6 ARE ONLY ASKED AT BASELINE. IF THIS IS A REASSESSMENT OR DISCHARGE SKIP TO SUBSECTION 3.]

5. How many children, including *(child's name)***, are in the** ☐☐ **household?**

○ REFUSED
○ DON'T KNOW

6. What is your family's annual income?

☐ LESS THAN $2,500
☐ $2,500 TO $4,999
☐ $5,000 TO $9,999
☐ $10,000 TO $14,999
☐ $15,000 TO $24,999
☐ $25,000 TO $34,999
☐ $35,000 TO $49,999
☐ $50,000 TO $74,999
☐ $75,000 TO $100,000
☐ GREATER THAN $100,000
○ REFUSED
○ DON'T KNOW

Subsection 3: The Columbia Impairment Scale (C.I.S.) Parent Version

[READ THE BELOW INSTRUCTIONS TO THE CAREGIVER FOLLOWED BY THE QUESTIONS ON THE NEXT PAGE.]

To help us improve the quality of the treatment that your child receives, we are asking you to complete the following rating scale (C.I.S.). This will help us determine the area or areas in which your child needs help and the progress that your child makes in these areas. It also will give us information that will assist us in making changes in his/her treatment plan to better meet his/her needs.

There are thirteen areas of your child's behavior for you to rate from 0 to 4 with 0 being no problem and 4 being a very bad problem. Using your best judgment, rate each item by indicating the number that best describes your child's behavior **within the past 6 months**. You can ask for clarification if you do not understand an item or items.

Subsection 3: CIS - Parent Version (Continued)

Grantee Staff: Please circle the number that you think best describes the child's situation:
0 ……1 ……2 ……3 …….4
No problem Very bad problem

[READ THE FOLLOWING QUESTIONS TO THE CAREGIVER.]

In general, how much of a problem or difficultly do you think [she/he] has with…?							
1)…getting into trouble?	0	1	2	3	4		REFUSED
2)…getting along with (you/[her/his] mother/mother figure).	0	1	2	3	4	N/A	REFUSED
3)…getting along with (you/[her/his] father/father figure).	0	1	2	3	4	N/A	REFUSED
4)…feeling unhappy or sad?	0	1	2	3	4		REFUSED
How much of a problem or difficulty would you say [she/he] has:							
5)…with [her/his] behavior at school (or at [her/his] job)?	0	1	2	3	4	N/A	REFUSED
6)…with having fun?	0	1	2	3	4		REFUSED
7)…getting along with adults other than his/her parents (child's mother and/or father)?	0	1	2	3	4		REFUSED
How much of a problem or difficulty does [she/he] have:							
8)…with feeling nervous or afraid?	0	1	2	3	4		REFUSED
9)…getting along with [her/his] sister(s) and/or brother(s)?	0	1	2	3	4	N/A	REFUSED
10) …getting along with other kids [her/his] age?	0	1	2	3	4		REFUSED
How much of a problem or difficulty would you say [she/he] has:							
11)…getting involved in activities like sports or hobbies?	0	1	2	3	4		REFUSED
12)…with [her/his] school work (doing [her/his] job)?	0	1	2	3	4	N/A	REFUSED
13)…with [her/his] behavior at home?	0	1	2	3	4		REFUSED

PROGRAM SPECIFIC QUESTIONS (CMHI)

Subsection 4: Pediatric Symptom Checklist—Parent Report (P-PSC-17)

[READ THE FOLLOWING INSTRUCTIONS AND STATEMENTS TO THE CAREGIVER.]

Emotional health and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions.

Please indicate which statement best describes your child's behaviors and emotions in the past 6 months.

1. Fidgety, unable to sit still	☐Never	☐Sometimes	☐Often	☐Refused
2. Feels sad, unhappy	☐Never	☐Sometimes	☐Often	☐Refused
3. Daydreams too much	☐Never	☐Sometimes	☐Often	☐Refused
4. Refuses to share	☐Never	☐Sometimes	☐Often	☐Refused
5. Does not understand other people's feelings	☐Never	☐Sometimes	☐Often	☐Refused
6. Feels hopeless	☐Never	☐Sometimes	☐Often	☐Refused
7. Has trouble concentrating	☐Never	☐Sometimes	☐Often	☐Refused
8. Fights with other children	☐Never	☐Sometimes	☐Often	☐Refused
9. Is down on himself or herself	☐Never	☐Sometimes	☐Often	☐Refused
10. Blames others for his or her troubles	☐Never	☐Sometimes	☐Often	☐Refused
11. Seems to be having less fun	☐Never	☐Sometimes	☐Often	☐Refused
12. Does not listen to rules	☐Never	☐Sometimes	☐Often	☐Refused
13. Acts as if driven by motor	☐Never	☐Sometimes	☐Often	☐Refused
14. Teases others	☐Never	☐Sometimes	☐Often	☐Refused
15. Worries a lot	☐Never	☐Sometimes	☐Often	☐Refused
16. Takes things that do not belong to him/her	☐Never	☐Sometimes	☐Often	☐Refused
17. Distracted easily	☐Never	☐Sometimes	☐Often	☐Refused

Subsection 5: Caregiver Strain Questionnaire (CGSQ)

Grantee Staff: Please indicate who administered this interview ☐☐Person providing services to child ☐☐Data collector

[READ THE FOLLOWING INSTRUCTIONS AND QUESTIONS TO THE CAREGIVER.]

Please think back over the past 6 months and try to remember how things have been for your family. We are trying to get a picture of how life has been in your household over that time. For each question, please tell me which response (which number) fits best.

In the past 6 months, how much of a challenge was the following:

	Not at all	A little	Some-what	Quite a bit	Very much	REFUSED
1. Interruption of personal time resulting from your child's emotional or behavioral challenges?	☐	☐	☐	☐	☐	☐
2. Your missing work or neglecting other duties because of your child's emotional or behavioral challenges?	☐	☐	☐	☐	☐	☐
3. Disruption of family routines due to your child's emotional or behavioral challenges?	☐	☐	☐	☐	☐	☐
4. Any family member having to do without things because of your child's emotional or behavioral challenges?	☐	☐	☐	☐	☐	☐
5. Financial strain for your family as a result of your child's emotional or behavioral challenges?	☐	☐	☐	☐	☐	☐
6. Disruption or upset of relationships within the family due to your child's emotional or behavioral challenges?	☐	☐	☐	☐	☐	☐

Subsection 5: CGSQ (Continued)

In this section, please continue to look back and try to remember how you have felt during the past 6 months.

For each question, please tell me which response fits best.

In the past 6 months:

	Not at all	A little	Some-what	Quite a bit	Very much	REFUSED
7. How sad or unhappy did you feel as a result of your child's emotional or behavioral challenges?	☐	☐	☐	☐	☐	☐
8. How embarrassed did you feel about your child's emotional or behavioral challenges?	☐	☐	☐	☐	☐	☐
9. How angry did you feel toward your child?	☐	☐	☐	☐	☐	☐
10. How worried did you feel about your child's future?	☐	☐	☐	☐	☐	☐
11. How worried did you feel about your family's future?	☐	☐	☐	☐	☐	☐
12. How guilty did you feel about your child's emotional or behavioral challenges?	☐	☐	☐	☐	☐	☐
13. How resentful did you feel toward your child?	☐	☐	☐	☐	☐	☐

K. SERVICES RECEIVED

[SECTION K IS REPORTED BY GRANTEE STAFF AT REASSESSMENT AND DISCHARGE UNLESS THE CONSUMER REFUSED THIS INTERVIEW OR ALL INTERVIEWS, IN WHICH CASE IT IS OPTIONAL.]

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

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

[IDENTIFY ALL OF THE SERVICES PROVIDED THROUGH THE SYSTEMS OF CARE TO THE CONSUMER <u>SINCE HIS/HER LAST NOMS INTERVIEW</u>; THIS INCLUDES CMHS-FUNDED AND NON-FUNDED SERVICES.]

Core Services	**Provided**			**SERVICE**
	Yes	**No**	**UNKNOWN**	**NOT AVAILABLE**
1. Screening	☐	☐	☐	☐
2. Assessment	☐	☐	☐	☐
3. Treatment Planning or Review	☐	☐	☐	☐
4. Psychopharmacological Services	☐	☐	☐	☐
5. Mental Health Services	☐	☐	☐	☐

[IF THE ANSWER TO 5 'MENTAL HEALTH SERVICES' IS YES, PLEASE ESTIMATE HOW FREQUENTLY THE FOLLOWING MENTAL HEALTH SERVICES WERE DELIVERED.]

	Provided		**If yes, in the past 6 months:**
	Yes	No	
5a. Outpatient therapy	☐	☐☐	# of sessions _____
5b. Group therapy	☐	☐ ☐☐☐☐	# of sessions _____
5c. Family therapy (including child)	☐	☐☐☐☐☐	# of sessions _____
5d. Partial hospitalization/ day treatment	☐	☐☐☐☐☐	# of days _____
5e. Psychiatric hospitalization	☐	☐☐☐☐☐	# of days _____

	Yes	**No**	**UNKNOWN**	**SERVICE NOT AVAILABLE**
6. Co-Occurring Services	☐	☐	☐	☐
7. Wraparound Planning Team/Services	☐	☐	☐	☐
8. Trauma-specific Services	☐	☐	☐	☐
9. Was the Consumer referred to another provider for any of the above core services?	☐	☐	☐	

Support Services	**Provided**			**SERVICE**
	Yes	**No**	**UNKNOWN**	**NOT AVAILABLE**
1. Medical Care	☐	☐	☐	☐
2. Employment Services	☐	☐	☐	☐
3. Family Services	☐	☐	☐	☐
3a. Peer-support partner for youth	☐	☐	☐	☐
3b. Peer-support partner for caregiver/family				
3c. Respite Family Services				
4. Child Care				
5. Transportation	☐	☐	☐	☐
6. Education Services	☐	☐	☐	☐
7. Housing Support	☐	☐	☐	☐

8. Social Recreational Activities	☐	☐	☐	☐
9. Consumer Operated Services	☐	☐	☐	☐

K. SERVICES RECEIVED (Continued)

Support Services	**Provided**		**UNKNOWN**	**SERVICE NOT AVAILABLE**
	Yes	**No**		
10. HIV Testing	☐	☐	☐	☐
11. Was the Consumer referred to another provider for any of the above support services?	☐	☐	☐	☐
12. Substance abuse related services and support?	☐	☐	☐	☐
13. Intellectual disabilities	☐	☐	☐	☐

End of Instrument:

Thank you for participating in the child and family outcomes portion of the National System of Care Expansion Evaluation.

Attachment 9d

OMB No. xxxx-xxxx
Expiration Date: xx/xx/201x

CHILDREN'S MENTAL HEALTH INITIATIVE
NATIONAL SYSTEM OF CARE EXPANSION EVALUATION

CHILD AND FAMILY LEVEL OUTCOMES INSTRUMENT

CHILD/YOUTH RESPONDENT VERSION

INTRODUCTION

Thank you for your willingness to participate in the child and family outcomes survey. The purpose of this survey is to assess changes in the mental health and wellbeing of children and their families while they are participating and receiving services from the Systems of Care.

CONFIDENTIALITY/INFORMED

Your responses to these questions will be kept confidential and will not be shared outside of the evaluation team. In any of our reports, your responses will be combined with other people's responses, so your answers will never be attributed to your name. Please sign the consent/assent form prior to completing this questionnaire.

Sample Parental Permission Form

Purpose

The Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States Department of Health and Human Services is sponsoring an evaluation of children's mental health services and systems of care. A System of Care is a coordinated network of community-based services and supports that are organized to meet the challenges that children and youth with serious mental health needs and their families face. We are asking for your permission to have your child participate in an interview with a trained interviewer who will ask a set of questions about his/her involvement in (**system of care name**). The purpose of this interview is to find out the ways in which children and youth are involved in their system of care. In this research, we will ask about things like how your child's behaviors and emotions, what he/she does at home, in school, and around your neighborhood, types of services your child receives, and how he/she feels about these services. The results of the study will be used to help improve services for children, young adults and their families.

Description of Participation

Participation in this survey is voluntary and your child's participation is completely his/her choice. Your child will be asked to participate in up to three interviews: an interview at intake, 6-months, and 12-months or at discharge if your child is enrolled in the program for less than 12 months. The interviews will take about 10 minutes each. Data will be collected by (**system of care name**) staff through interviews with your child and use of some routinely collected information from your child's records. Your child will be asked these questions during a regular visit so additional visits will not be required. There are no right or wrong answer to the questions.

Risks

Your child may feel uncomfortable about answering some questions about his/her experiences**.** At any time, your child can stop, take a break, or skip any questions s/he does not want to answer. Your child may discontinue participation at any time.

Benefits

Your child will not get any direct benefit from being interviewed. However, the information your child provides may help improve the services offered to children, youth, and their families.

Confidentiality

The information your child shares with us will only be used for the purposes of this study. We will not share your child's answers with you. We will keep your child's information private to the extent permitted by law. If your child says anything about hurting themselves or others, we have to report it to the proper authorities.

Your child's healthcare services or insurance coverage will not be affected by anything s/he says during the interview. This signed consent form and any other forms and records from the study will be kept in a secure place that only project staff will be able to access.

Contact Information

If you or your child has any questions about this project, you may call SAMHSA's Project Officer for this study, Ms. Kaitlyn Harrington at 240-276-1928.

If you have any questions about your child's rights and welfare as a research participant, you may contact [insert name of grantee IRB representative] at [insert contact phone of grantee IRB representative].

Parental Permission

I have read the above, or it has been read to me. I understand what it says. My questions (if any) have been answered. A copy of this form will be given to me. By signing my name below, I give permission for my child to be in this study.

Printed Name: _____

Signature: _____

Name of Child being interviewed: _____

Date: ___/___/____

Sample Youth Agreement to Participate Form (ages 11-17)

Purpose

You have been asked to participate in the Child and Family Outcomes Survey because you are receiving services through (**system of care name**). We would like to ask you some questions about yourself, and what you think about the services you receive. We want to find out if the services you receive help you. If they do, they may also help other children and their families.

What you will be asked to do

Participation in this survey is voluntary. The decision to participate in this interview is completely your own. Your parent or caregiver already gave us permission to talk with you. You will be asked to participate in up to three interviews: when you first come in, 6-months after that, and 12-months after that or at your last visit. The interviews will take about 10 minutes each. You will be asked interview questions during one of your regular visit.

You will be asked questions about how you feel about various things such as, your behavior and things you do at home, in school, and in your neighborhood. You will be asked about what activities you do with your family and friends. You will be asked about the services you have received. There is no right or wrong answer to the survey questions.

Risks

There are very few risks to being in this study. You may feel uncomfortable about answering questions about yourself. At any time you can stop, take a break, or skip any questions you do not want to answer. You may discontinue participation at any time.

Benefits

There are no direct benefits to this study. However, the information you provide may help improve the services offered to children, youth, and their families.

Confidentiality

The information you share with us will only be used for the purposes of this evaluation and will not be shared with your parents or anyone else outside of this project. Papers

with your name on them will be kept in a locked filing cabinet and only a few project staff will have access to your data. We will keep your information private to the extent permitted by law. However, if you say anything about hurting yourself or someone else, we have to report it.

Your interview will always take place in private. We will not use any information that identifies you or your family in any reports we write. The care you get when you come to this office will not be affected by anything you say.

Contact Information

If you have any questions about this project, you may call SAMHSA's Project Officer for this evaluation Ms. Kaitlyn Harrington at 240-276-1928.

If you have any questions about your rights and welfare as a research participant, you may contact [insert name of grantee IRB representative] at [insert contact phone of grantee IRB representative].

Voluntary Agreement to Participate

Rights Regarding Decision to Participate: I understand that I will not be in trouble if I do not want to be in the survey or if I decide to quit later. I do not have to answer questions that I do not want to answer. If I change my mind and quit, all of my answers to questions will be destroyed, if that is what I want. No one will say that I cannot be in other studies because I do not want to be in this study. No one can say that I cannot get services because I do not want to be in this study.

I read this form or it has been read to me. I understand what it says. My questions (if any) have been answered. A copy of this form will be given to me. By signing my name below, I freely agree to participate in this survey.

Printed Name: _____

Signature: _____

Date: ___/___/____

INSTRUCTIONS

This version will be administered directly to children ages 11 to 17 at baseline/entry into services and at six and twelve months as well as discharge. This version includes the following:

1. Subsection 1: Review of client records
2. Subsection 2: Family/Living Information (intentionally missing)
3. Subsection 3: Columbia Impairment Scale – self report
4. Subsection 4: Pediatric Symptom Checklist-17 – self report
5. Subsection 5: Caregiver Strain Questionnaire (intentionally missing)
6. CMHI Services Received

There are two components of this instrument. The first part, Subsection 1, is answered by staff using information from administrative and clinical records. The second part, Subsections 2-5 are to be administered verbally to the youth by local systems staff.

Subsection 1: Administrative Data

[SUBSECTION 1 IS COMPILED BY GRANTEE STAFF FROM RECORDS.]

1. Is the child/youth enrolled in the CMHI Outcome Evaluation?

☐ Yes ***[IF THIS IS A BASELINE, GO TO SUBSECTION 1, QUESTION 2. OTHERWISE SKIP TO SUBSECTION 1, QUESTION 6.]***

☐ No ***[END OF SECTION H.]***
[IF THIS IS A BASELINE, STOP HERE.]
[IF THIS IS A REASSESSMENT, GO TO SECTION I.]
[IF THIS IS A DISCHARGE, SKIP TO SECTION J.]

2. What is the date of the child/youth's…

2a. First <u>assessment</u> for the system of care?

|__|__|/|__|__|/|__|__|__|__|
DD MM YEAR

2b. First <u>service</u> (after assessment) received through the system of care?

|__|__|/|__|__|/|__|__|__|__|
DD MM YEAR

2c. Most recent service planning team meeting in the system-of-care?

|__|__|/|__|__|/|__|__|__|__|
DD MM YEAR

H. PROGRAM SPECIFIC QUESTIONS (CMHI)

Subsection 1: Administrative Data (Continued)

3. Who participated in the development of the child/youth's service plan? *[Select all that apply and specify role as noted.]*

- ☐ Child/youth's caregiver or guardian
- ☐ Child/youth
- ☐ Other family member
- ☐ Case manager/service coordinator
- ☐ Wraparound facilitator (if not case manager/service coordinator)
- ☐ Therapist
- ☐ Other mental health staff (e.g., behavioral aide, respite worker) (*Specify role*: _____)
- ☐ Intellectual disabilities provider
- ☐ Family advocate
- ☐ Parent/Peer support provider
- ☐ Youth advocate
- ☐ Youth/Peer support provider
- ☐ Education staff (e.g., teacher, counselor) (*Specify role:* _____)
- ☐ Child welfare staff (e.g., case worker) (*Specify role:* _____)
- ☐ Juvenile justice staff (e.g., probation officer) (*Specify role:* _____)
- ☐ Physical health staff (e.g., pediatrician, nurse) (*Specify role:* _____)
- ☐ Other (*For up to three people*) (*Specify role:* _____)
  (*Specify role:* _____)
  (*Specify role:* _____)

4. Which agency or individual referred the child/youth to the program?

- ☐ Mental Health Agency/Clinic/Provider
- ☐ Physical Health Care Agency/Clinic/Provider
- ☐ Substance Abuse Agency/Clinic/Provider
- ○ Intellectual Disabilities Agency/Clinic/Provider
- ☐ School
- ☐ Early Care
- ☐ Child Welfare/Child Protective Services
- ☐ Family Court
- ☐ Juvenile Court/Corrections/Probation/Police
- ☐ Caregiver
- ☐ Child/Youth referred himself or herself
- ☐ Other (*Please specify:* _____)

Subsection 1: Administrative Data (Continued)

5. What led to the child/youth being referred for services? *[Select all that apply.]*

- ☐ Conduct/delinquency behaviors (including physical aggression, extreme verbal abuse, non-compliance, sexual acting out, property damage, theft, running away, sexual assault, fire setting, cruelty to animals, truancy, police contact)
- ☐ Intellectual disabilities
- ☐ Hyperactive and attention-related behaviors (including hyperactive, impulsive, attentional difficulties)
- ☐ School performance
- ☐ Depression (including major depression, dysthymia, sleep disorders, somatic complaints)
- ☐ Anxiety (including fears and phobias, generalized anxiety, social avoidance, obsessive compulsive behavior, post-traumatic stress disorder)
- ☐ Adjustment-related issues (including changes in behaviors or emotions in reaction to a significant life stress)
- ☐ Suicide-related thoughts or actions (including suicide ideation or suicide attempt)
- ☐ Self-Injury (self-injurious behavior, hair pulling, cutting, etc)
- ☐ Psychotic behaviors (including hallucinations, delusions, strange or odd behaviors)
- ☐ Substance use, abuse, and drug dependency behaviors
- ☐ Learning disabilities
- ☐ Eating disorders (including anorexia, bulimia)
- ☐ Sleeping problems
- ☐ Current home unable to meet child/youth's needs
- ☐ Maltreatment (child abuse and neglect)
- ☐ Other concerns/issues that are related to child's health (cancer, illness, or disease related-problems)
- ☐ Other (*Please specify:* _____)

Subsection 1: Administrative Data (Continued)

6. With which of the following agencies is the child/youth involved? *[Select all that apply.]*

☐ Mental Health Agency/Clinic/Provider
☐ Physical Health Care Agency/Clinic/Provider
☐ Substance Abuse Agency/Clinic/Provider
☐ Intellectual Disabilities Agency/Clinic/Provider
☐ School
☐ Early Care
☐ Child Welfare/Child Protective Services
☐ Family Court
☐ Juvenile Court/Corrections/Probation/Police
☐ Other (*Please specify:* _____)

7. What is the census block group of the address where the child/youth currently lives?

_____

8. During the past 6 months, was the child/youth insured through...? *[Select all that apply.]*

☐ Medicaid
☐ CHIP
☐ SSI
☐ Private Insurance
☐ Other (*Please specify:* _____)
☐ No insurance

H. PROGRAM SPECIFIC QUESTIONS (CMHI)

Subsection 1: Administrative Data (Continued)

9. What is the date of the child/youth's most recent diagnostic evaluation?

|__|__|/|__|__|/|__|__|__|__|
DD MM YEAR

10. Which diagnostic classification system was used?

☐ DSM IV-TR
☐ DSM V
☐ ICD-10

11. What is the child/youth's clinical diagnosis? Indicate the diagnostic code and/or diagnosis below.

		Diagnostic code	Diagnosis name
11a.	**Primary Diagnosis**	_____.____	_____
11b.	**Secondary Diagnosis**	_____.____	_____
11c.	**Additional Diagnosis**	_____.____	_____

[IF AN INTERVIEW WAS CONDUCTED, GO TO SUBSECTION 3, COLUMBIA IMPAIRMENT SCALE.]

[IF AN INTERVIEW WAS NOT CONDUCTED:

IF THIS IS A BASELINE, STOP; DATA COLLECTION IS COMPLETE.

IF THIS IS A REASSESSMENT, GO TO SECTION I, THEN SECTION K.

IF THIS IS A DISCHARGE, GO TO SECTION J, THEN SECTION K.]

Subsection 2: Family/Living Information

Internal note: Subsection 2, Family/Living Information, is intentionally excluded from this version; it appears on the Caregiver version.

Subsection 3: The Columbia Impairment Scale (C.I.S.) Youth Version

[READ THE BELOW INSTRUCTIONS TO THE CHILD/YOUTH FOLLOWED BY THE QUESTIONS ON THE NEXT PAGE.]

All of the remaining questions I will ask you today will focus on events in the **past 6 months**.

To help us improve the quality of the treatment that you receive, we are asking you to complete the following rating scale (C.I.S.). This will help us determine the area or areas in which you need help and the progress that you make in these areas. It also will give us information that will assist us in making changes in your treatment plan to better meet your needs.

There are thirteen areas of your behavior for you to rate from 0 to 4 with 0 being no problem for you, and 4 being a very bad problem. After I read each question, tell me the number that best describes your behavior **within the past 6 months**. You can ask me for help if you don't understand a question.

Subsection 3: CIS - Youth Version (Continued)

Grantee Staff: Please circle the number that you think best describes the child or youth's situation:
0 ……1 ……2 ……3 ……4
No problem Very bad problem

[READ THE FOLLOWING QUESTIONS TO THE CHILD/YOUTH.]

In general, how much of a problem or difficulty do you think you have with:							
1)…getting into trouble?	0	1	2	3	4		REFUSED
2)…getting along with your mother/mother figure.	0	1	2	3	4	N/A	REFUSED
3)…getting along with your father/father figure.	0	1	2	3	4	N/A	REFUSED
4)…feeling unhappy or sad?	0	1	2	3	4		REFUSED
How much of a problem or difficulty would you say you have:							
5)…with your behavior at school (or at your job)?	0	1	2	3	4	N/A	REFUSED
6)…with having fun?	0	1	2	3	4		REFUSED
7)…getting along with adults other than your mother and/or your father?	0	1	2	3	4		REFUSED
How much of a problem or difficulty do you have:							
8)…with feeling nervous or afraid?	0	1	2	3	4		REFUSED
9)…getting along with your sister(s) and/or brother(s)?	0	1	2	3	4	N/A	REFUSED
10) …getting along with other kids your age?	0	1	2	3	4		REFUSED
How much of a problem or difficulty would you say you have:							
11)…getting involved in activities like sports or hobbies?	0	1	2	3	4		REFUSED
12)…with your school work (doing your job)?	0	1	2	3	4	N/A	REFUSED
13)…with your behavior at home?	0	1	2	3	4		REFUSED

PROGRAM SPECIFIC QUESTIONS (CMHI)

Subsection 4: Pediatric Symptom Checklist—Youth Report (Y-PSC-17)

[READ THE FOLLOWING INSTRUCTIONS AND STATEMENTS TO THE CHILD/YOUTH.]

Please indicate which statement best describes your behaviors and emotions in the past 6 months.

1.	Fidgety, unable to sit still	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
2.	Feel sad, unhappy	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
3.	Daydream too much	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
4.	Refuse to share	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
5.	Do not understand other people's feelings	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
6.	Feel hopeless	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
7.	Have trouble concentrating	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
8.	Fight with other children	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
9.	Down on yourself	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
10.	Blame others for your troubles	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
11.	Seem to be having less fun	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
12.	Do not listen to rules	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
13.	Act as if driven by motor	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
14.	Tease others	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
15.	Worry a lot	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
16.	Take things that do not belong to you	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
17.	Distracted easily	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused

Subsection 5: Caregiver Strain Questionnaire (CGSQ)

Internal note: Subsection 5, the CGSQ, is intentionally excluded from this version; it appears on the Caregiver version.

K. SERVICES RECEIVED

[SECTION K IS REPORTED BY GRANTEE STAFF AT REASSESSMENT AND DISCHARGE UNLESS THE CONSUMER REFUSED THIS INTERVIEW OR ALL INTERVIEWS, IN WHICH CASE IT IS OPTIONAL.]

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

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

[IDENTIFY ALL OF THE SERVICES PROVIDED THROUGH THE SYSTEMS OF CARE TO THE CONSUMER <u>SINCE HIS/HER LAST NOMS INTERVIEW</u>; THIS INCLUDES CMHS-FUNDED AND NON-FUNDED SERVICES.]

Core Services	**Provided**			
	Yes	**No**	**UNKNOWN**	**SERVICE NOT AVAILABLE**
1. Screening	☐	☐	☐	☐
2. Assessment	☐	☐	☐	☐
3. Treatment Planning or Review	☐	☐	☐	☐
4. Psychopharmacological Services	☐	☐	☐	☐
5. Mental Health Services	☐	☐	☐	☐

[IF THE ANSWER TO 5 'MENTAL HEALTH SERVICES' IS YES, PLEASE ESTIMATE HOW FREQUENTLY THE FOLLOWING MENTAL HEALTH SERVICES WERE DELIVERED.]

	Provided		**If yes, in the past 6 months:**
	Yes	No	
5a. Outpatient therapy	☐	☐☐☐☐	# of sessions _____
5b. Group therapy	☐	☐ ☐☐☐☐	# of sessions _____
5c. Family therapy (including child)	☐	☐☐☐☐☐	# of sessions _____
5d. Partial hospitalization/ day treatment	☐	☐☐☐☐☐	# of days _____
5e. Psychiatric hospitalization	☐	☐☐☐☐☐	# of days _____

	Yes	**No**	**UNKNOWN**	**SERVICE NOT AVAILABLE**
6. Co-Occurring Services	☐	☐	☐	☐
7. Wraparound Planning Team/Services	☐	☐	☐	☐
8. Trauma-specific Services	☐	☐	☐	☐
9. Was the Consumer referred to another provider for any of the above core services?	☐	☐	☐	

Support Services	**Provided**			
	Yes	**No**	**UNKNOWN**	**SERVICE NOT AVAILABLE**
1. Medical Care	☐	☐	☐	☐
2. Employment Services	☐	☐	☐	☐
3. Family Services	☐	☐	☐	☐
3a. Peer-support partner for youth	☐	☐	☐	☐
3b. Peer-support partner for caregiver/family				
3c. Respite Family Services				
4. Child Care				
5. Transportation	☐	☐	☐	☐
6. Education Services	☐	☐	☐	☐
7. Housing Support	☐	☐	☐	☐

8. Social Recreational Activities	☐	☐	☐	☐
9. Consumer Operated Services	☐	☐	☐	☐

K. SERVICES RECEIVED (Continued)

Support Services	Provided		UNKNOWN	SERVICE NOT AVAILABLE
	Yes	No		
10. HIV Testing	☐	☐	☐	☐
11. Was the Consumer referred to another provider for any of the above support services?	☐	☐	☐	☐
12. Substance abuse related services and support?	☐	☐	☐	☐
13. Intellectual disabilities	☐	☐	☐	☐

End of Instrument:

Thank you for participating in the child and family outcomes portion of the National System of Care Expansion Evaluation.

OMB No. xxxx-xxxx
Expiration Date: xx/xx/201x

CHILDREN'S MENTAL HEALTH INITIATIVE
NATIONAL SYSTEM OF CARE EXPANSION EVALUATION

CHILD AND FAMILY LEVEL OUTCOMES INSTRUMENT

YOUNG ADULT RESPONDENT VERSION

INTRODUCTION

Thank you for your willingness to participate in the child and family outcomes survey. The purpose of this survey is to assess changes in the mental health and wellbeing of children and their families while they are participating and receiving services from the Systems of Care.

CONFIDENTIALITY/INFORMED

Your responses to these questions will be kept confidential and will not be shared outside of the evaluation team. In any of our reports, your responses will be combined with other people's responses, so your answers will never be attributed to your name. Please sign the consent form prior to completing this questionnaire.

SAMPLE INFORMED CONSENT – YOUNG ADULT VERSION (AGES 18-21)

Purpose

The Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States Department of Health and Human Services is sponsoring an evaluation of children's mental health services and systems of care. A system of Care is a coordinated network of community-based services and supports that are organized to meet the challenges that children and youth with serious mental health needs and their families. You were invited to participate in this study because you currently receive or have received such services in the past. The purpose of this interview is to find out the ways in which youth are involved in their system of care. In this study, we will ask you about your behaviors and emotions, what activities you do at home, in school, and around your neighborhood, types of services you receive, and how you feel about these services. The results of the project will be used to help improve services for children, young adults and their families.

Description of Participation

Participation in this survey is completely voluntary. You will be asked to participate in up to three interviews: an interview at intake, 6-months, and 12-months or at discharge if you are enrolled in the program for less than 12 months. The interviews will take about 15 minutes each. Data will be collected by (**system of care name**) staff through interviews with you and use of some routinely collected information from your records. You will be asked these questions during a regular visit so additional visits will not be required. There are no right or wrong answer to the questions.

Risks

You may feel uncomfortable about answering some questions about your experiences. At any time, you can stop, take a break, or skip any questions you do not want to answer. You may discontinue participation at any time.

Benefits

You will not get any direct benefit from being interviewed. However, the information you provides may help improve the services offered to children, youth, and their families.

Confidentiality

The information you share with us will only be used for the purposes of this study. We will keep your information private to the extent permitted by law. If you report any intent to harm yourself or someone else, we have to report it to the proper authorities.

Your healthcare services or insurance coverage will not be affected by you says during the interview. Your name will not be used in any reports we write. This signed consent form and any other forms from the study will be kept in a secure place that only project staff will be able to access.

Contact Information
If you have any questions about this project, you may call SAMHSA's Project Officer for this evaluation, Ms. Kaitlyn Harrington at 240-276-1928.

If you have any questions about your rights and welfare as a research participant, you may contact [insert name of grantee IRB representative] at [insert contact phone of grantee IRB representative].

Voluntary Consent
Rights Regarding Decision to Participate: I understand that I will not be in trouble if I do not want to be in the survey or if I decide to quit later. I do not have to answer questions that I do not want to answer. If I change my mind and quit, all of my answers to questions will be destroyed, if that is what I want. No one will say that I cannot be in other projects because I do not want to be in this project. No one can say that I cannot get services because I do not want to be in this project.

I read this form or it has been read to me. I understand what it says. My questions (if any) have been answered. A copy of this form will be given to me. By signing my name below, I freely agree to be in the project.

Printed Name: _____

Signature: _____

Date: __/__/___

YOUNG ADULT VERSION

INSTRUCTIONS

This version will be administered directly to young adults ages 18 and up at baseline/entry into services and at six and twelve months as well as discharge. This version includes the following:

1. Subsection 1: Review of client records
2. Subsection 2: Family/Living Information- self report
3. Subsection 3: Columbia Impairment Scale – self report
4. Subsection 4: Pediatric Symptom Checklist-17 – self report
5. Subsection 5: Caregiver Strain Questionnaire (intentionally missing)
6. CMHI Services Received

There are two components of this instrument. The first part, Subsection 1, is answered by staff using information from administrative and clinical records. The second part, Subsections 2-5 are to be administered verbally to the young adult by local systems staff.

H. PROGRAM SPECIFIC QUESTIONS (CMHI)

Questions H1-H
OMB No. xxxx-xxxx
Expiration Date: xx/xx/201x

Subsection 1: Administrative Data

[SUBSECTION 1 IS COMPILED BY GRANTEE STAFF FROM RECORDS.]

1. Is the young adult enrolled in the CMHI Outcome Evaluation?

☐ Yes ***[IF THIS IS A BASELINE, GO TO SUBSECTION 1, QUESTION 2. OTHERWISE, SKIP TO SUBSECTION 1, QUESTION 6.]***

☐ No ***[END OF SECTION H.]***
[IF THIS IS A BASELINE, STOP HERE.]
[IF THIS IS A REASSESSMENT, GO TO SECTION I.]
[IF THIS IS A DISCHARGE, SKIP TO SECTION J.]

2. What is the date of the young adult's…

2a. First <u>assessment</u> for the system of care?

|__|__|/|__|__|/|__|__|__|__|
DD MM YEAR

2b. First <u>service</u> (after assessment) received through the system of care?

|__|__|/|__|__|/|__|__|__|__|
DD MM YEAR

2c. Most recent service planning team meeting in the system-of-care?

|__|__|/|__|__|/|__|__|__|__|
DD MM YEAR

Subsection 1: Administrative Data (Continued)

3. Who participated in the development of the young adult's service plan? *[Select all that apply and specify role as noted.]*

- ☐ Young adult's caregiver or guardian
- ☐ Young adult
- ☐ Other family member
- ☐ Case manager/service coordinator
- ☐ Wraparound facilitator (if not case manager/service coordinator)
- ☐ Therapist
- ☐ Other mental health staff (e.g., behavioral aide, respite worker) (*Specify role*: _____)
- ☐ Intellectual disabilities provider
- ☐ Family advocate
- ☐ Parent/Peer support provider
- ☐ Youth advocate
- ☐ Youth/Peer support provider
- ☐ Education staff (e.g., teacher, counselor) (*Specify role:* _____)
- ☐ Child welfare staff (e.g., case worker) (*Specify role:* _____)
- ☐ Juvenile justice staff (e.g., probation officer) (*Specify role:* _____)
- ☐ Physical health staff (e.g., pediatrician, nurse) (*Specify role:* _____)
- ☐ Other (*For up to three people*) (*Specify role:* _____)
  (*Specify role:* _____)
  (*Specify role:* _____)

4. Which agency or individual referred the young adult to the program?

- ☐ Mental Health Agency/Clinic/Provider
- ☐ Physical Health Care Agency/Clinic/Provider
- ☐ Substance Abuse Agency/Clinic/Provider
- ☐ Intellectual Disabilities Agency/Clinic/Provider
- ☐ School
- ☐ Child Welfare/Child Protective Services
- ☐ Family Court
- ☐ Juvenile Court/Corrections/Probation/Police
- ☐ Caregiver
- ☐ Young adult referred himself or herself
- ☐ Other (*Please specify:* _____)

Subsection 1: Administrative Data (Continued)

5. What led to the young adult being referred for services? *[Select all that apply.]*

- ☐ Conduct/delinquency-related behaviors (including physical aggression, extreme verbal abuse, non-compliance, sexual acting out, property damage, theft, running away, sexual assault, fire setting, cruelty to animals, truancy, police contact)
- ☐ Intellectual disabilities
- ☐ Hyperactive and attention-related behaviors (including hyperactive, impulsive, attentional difficulties)
- ☐ School performance
- ☐ Depression (including major depression, dysthymia, sleep disorders, somatic complaints)
- ☐ Anxiety (including fears and phobias, generalized anxiety, social avoidance, obsessive compulsive behavior, post-traumatic stress disorder)
- ☐ Adjustment-related issues (including changes in behaviors or emotions in reaction to a significant life stress)
- ☐ Suicide-related thoughts or actions (including suicide ideation or suicide attempt)
- ☐ Self-Injury (self-injurious behavior, hair pulling, cutting, etc)
- ☐ Psychotic behaviors (including hallucinations, delusions, strange or odd behaviors)
- ☐ Substance use, abuse, and drug dependency behaviors
- ☐ Learning disabilities
- ☐ Eating disorders (including anorexia, bulimia)
- ☐ Sleeping problems
- ☐ Current home unable to meet young adult's needs
- ☐ Maltreatment (child abuse and neglect)
- ☐ Other concerns/issues that are related to young adult's health (cancer, illness, or disease related-problems)
- ☐ Other (*Please specify:* _____)

Subsection 1: Administrative Data (Continued)

6. With which of the following agencies is the young adult involved? *[Select all that apply.]*

☐ Mental Health Agency/Clinic/Provider
☐ Physical Health Care Agency/Clinic/Provider
☐ Substance Abuse Agency/Clinic/Provider
☐ Intellectual Disabilities Agency/Clinic/Provider
☐ School
☐ Child Welfare/Child Protective Services
☐ Family Court
☐ Juvenile Court/Corrections/Probation/Police
☐ Other (*Please specify:* _____)

7. What is the census block group of the address where the young adult currently lives?

_____

8. During the past 6 months, was the young adult insured through...? *[Select all that apply.]*

☐ Medicaid
☐ CHIP
☐ SSI
☐ Private Insurance
☐ Other (*Please specify:* _____)
☐ No insurance

H. PROGRAM SPECIFIC QUESTIONS (CMHI)

Subsection 1: Administrative Data (Continued)

9. What was the date of the young adult's most recent diagnostic evaluation?

|__|__|/|__|__|/|__|__|__|__|
DD MM YEAR

10. Which diagnostic classification system was used?

☐☐DSM IV-TR
☐☐DSM V
☐☐ICD-10

11. What is the young adult's clinical diagnosis? Indicate the diagnostic code and/or diagnosis below.

		Diagnostic code	Diagnosis name
11a.	**Primary Diagnosis**	_____.____	_____
11b.	**Secondary Diagnosis**	_____.____	_____
11c.	**Additional Diagnosis**	_____.____	_____

[IF AN INTERVIEW WAS CONDUCTED, GO TO SUBSECTION 2, FAMILY/LIVING INFORMATION.]

[IF AN INTERVIEW WAS NOT CONDUCTED:

IF THIS IS A BASELINE, STOP; DATA COLLECTION IS COMPLETE.

IF THIS IS A REASSESSMENT, GO TO SECTION I, THEN SECTION K.

IF THIS IS A DISCHARGE, GO TO SECTION J, THEN SECTION K.]

Subsection 2: Family/Living Information

[READ THE FOLLOWING QUESTIONS TO THE YOUNG ADULT.]

[QUESTIONS 1 AND 2 DO NOT APPLY TO THE YOUNG ADULT TOOL.]

3. Do you live alone?

☐ YES *[GO TO 6.]*
☐ NO
☐ REFUSED *[GO TO 6.]*
☐ DON'T KNOW *[GO TO 6.]*

3a. *[IF NO],* with whom do you live? Please answer yes or no for each of the following. You may say yes to more than one.

	Yes	No	REFUSED
Birth Mother	☐	☐	☐
Birth Father	☐	☐	☐
Adoptive Mother	☐	☐	☐
Adoptive Father	☐	☐	☐
Foster Mother	☐	☐	☐
Foster Father	☐	☐	☐
Stepmother	☐	☐	☐
Stepfather	☐	☐	☐
Grandmother (Biological, Step, or Adoptive)	☐	☐	☐
Grandfather (Biological, Step, or Adoptive)	☐	☐	☐
Sibling(s) (Biological, Step, or Adoptive)	☐	☐	☐
Spouse/Partner	☐	☐	☐
Youth's Own Children	☐	☐	☐
Friends	☐	☐	☐
Other Specify	☐	☐	☐

Please Specify: _____

Subsection 2: Family/Living Information (Continued)

[QUESTIONS 4 AND 5 DO NOT APPLY TO THE YOUNG ADULT TOOL.]

[QUESTION 6 IS ONLY ASKED AT BASELINE. IF THIS IS A REASSESSMENT OR DISCHARGE SKIP TO QUESTION 7.]

6. What is your family's annual income?

- LESS THAN $2,500
- $2,500 TO $4,999
- $5,000 TO $9,999
- $10,000 TO $14,999
- $15,000 TO $24,999
- $25,000 TO $34,999
- $35,000 TO $49,999
- $50,000 TO $74,999
- $75,000 TO $100,000
- GREATER THAN $100,000
- REFUSED
- DON'T KNOW

7. Are you currently enrolled in school or a job training program? *[IF ENROLLED]* Is that full time or part time?

- NOT ENROLLED
- ENROLLED, FULL TIME
- ENROLLED, PART TIME
- OTHER (SPECIFY)_____
- REFUSED
- DON'T KNOW

8. What is the highest level of education you have finished, whether or not you received a degree?

- LESS THAN 12TH GRADE
- 12TH GRADE/HIGH SCHOOL DIPLOMA/EQUIVALENT (GED)
- VOC/TECH DIPLOMA
- SOME COLLEGE OR UNIVERSITY
- BACHELOR'S DEGREE (BA, BS)
- GRADUATE WORK/GRADUATE DEGREE
- REFUSED
- DON'T KNOW

Subsection 2: Family/Living Information (Continued)

9. Are you currently employed? ***[CLARIFY BY FOCUSING ON STATUS DURING MOST OF THE PREVIOUS WEEK, DETERMINING WHETHER CONSUMER WORKED AT ALL OR HAD A REGULAR JOB BUT WAS OFF WORK.]***

- ○ EMPLOYED FULL TIME (35+ HOURS PER WEEK, OR WOULD HAVE BEEN)
- ○ EMPLOYED PART TIME
- ○ UNEMPLOYED, LOOKING FOR WORK
- ○ UNEMPLOYED, DISABLED
- ○ UNEMPLOYED, VOLUNTEER WORK
- ○ UNEMPLOYED, RETIRED
- ○ UNEMPLOYED, NOT LOOKING FOR WORK
- ○ OTHER (SPECIFY) _____
- □ REFUSED
- ○ DON'T KNOW

9a. ***[IF EMPLOYED]***

	Yes	No	REFUSED	DON'T KNOW
• **Are you paid at or above the minimum wage[1]?**	□	□	□	□
• **Are your wages paid directly to you by your employer?**	□	□	□	□
• **Could anyone have applied for this job?**	□	□	□	□

[1] For information on Federal minimum wage go to http://www.dol.gov/dol/topic/wages/.

PROGRAM SPECIFIC QUESTIONS (CMHI)

Subsection 2: Family/Living Information (Continued)

[QUESTIONS 10 AND 11 ARE ONLY ASKED AT BASELINE. IF THIS IS NOT A BASELINE SKIP TO QUESTION 12.]

10. Have you ever experienced violence or trauma in any setting (including community or school violence; domestic violence; physical, psychological, or sexual maltreatment/assault within or outside of the family; natural disaster; terrorism; neglect; or traumatic grief)?

- ☐ YES
- ○ NO *[GO TO 12.]*
- ○ REFUSED *[GO TO 12.]*
- ○ DON'T KNOW *[GO TO 12.]*

11. Did any of these experiences feel so frightening, horrible, or upsetting that in the past and/or the present you:

	YES	NO	REFUSED	DON'T KNOW
11a. Have had nightmares about it or thought about it when you did not want to?	☐	☐	☐	☐
11b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?	☐	☐	☐	☐
11c. Were constantly on guard, watchful, or easily startled?	☐	☐	☐	☐
11d. Felt numb and detached from others, activities, or your surroundings?	☐	☐	☐	☐

12. In the past 30 days, how often have you been hit, kicked, slapped, or otherwise physically hurt?

- ☐ Never
- ☐ Once
- ☐ A few times
- ☐ More than a few times
- ☐ REFUSED
- ☐ DON'T KNOW

H. PROGRAM SPECIFIC QUESTIONS (CMHI)

Subsection 2: Family/Living Information (Continued)

Internal note: Questions 1, 2, 4 and 5 of Subsection 2, family/living shown on the caregiver version are intentionally excluded from this version. Questions 10, 11, and 12 are added from Section B of the Adult TRAC tool and Questions 1, 2, and 3 are added from Adult TRAC section D.

H. PROGRAM SPECIFIC QUESTIONS (CMHI)

Subsection 3: The Columbia Impairment Scale (C.I.S.) Youth Version

[READ THE BELOW INSTRUCTIONS TO THE YOUNG ADULT FOLLOWED BY THE QUESTIONS ON THE NEXT PAGE.]

All of the remaining questions I will ask you today will focus on events in the **past 6 months**.

To help us improve the quality of the treatment that you receive, we are asking you to complete the following rating scale (C.I.S.). This will help us determine the area or areas in which you need help and the progress that you make in these areas. It also will give us information that will assist us in making changes in your treatment plan to better meet your needs.

There are thirteen areas of behavior for you to rate from 0 to 4 with 0 being no problem for you, and 4 being a very bad problem. Rate each item by indicating the number that best describes your behavior **within the past 6 months**. You can ask for clarification if you do not understand an item or items.

Subsection 3: CIS - Youth Version (Continued)

Grantee Staff: Please circle the number that you think best describes the young adult's situation:
0 ……1 ……2 ……3 ……4
No problem Very bad problem

[READ THE FOLLOWING QUESTIONS TO THE YOUNG ADULT.]

In general, how much of a problem or difficulty do you think you have with:							
1)…getting into trouble?	0	1	2	3	4		REFUSED
2)…getting along with your mother/mother figure.	0	1	2	3	4	N/A	REFUSED
3)…getting along with your father/father figure.	0	1	2	3	4	N/A	REFUSED
4)…feeling unhappy or sad?	0	1	2	3	4		REFUSED
How much of a problem or difficulty would you say you have:							
5)…with your behavior at school (or at your job)?	0	1	2	3	4	N/A	REFUSED
6)…with having fun?	0	1	2	3	4		REFUSED
7)…getting along with adults other than (your mother and/or your father)?	0	1	2	3	4		REFUSED
How much of a problem or difficulty do you have:							
8)…with feeling nervous or afraid?	0	1	2	3	4		REFUSED
9)…getting along with your sister(s) and/or brother(s)?	0	1	2	3	4	N/A	REFUSED
10) …getting along with other people your age?	0	1	2	3	4		REFUSED
How much of a problem or difficulty would you say you have:							
11)…getting involved in activities like sports or hobbies?	0	1	2	3	4		REFUSED
12)…with your school work (doing your job)?	0	1	2	3	4	N/A	REFUSED
13)…with your behavior at home?	0	1	2	3	4		REFUSED

PROGRAM SPECIFIC QUESTIONS (CMHI)

Subsection 4: Pediatric Symptom Checklist—Youth Report (Y-PSC-17)

[READ THE FOLLOWING INSTRUCTIONS AND STATEMENTS TO THE YOUNG ADULT.]

Please indicate which statement best describes your behaviors and emotions in the past 6 months.

1.	Fidgety, unable to sit still	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
2.	Feel sad, unhappy	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
3.	Daydream too much	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
4.	Refuse to share	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
5.	Do not understand other people's feelings	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
6.	Feel hopeless	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
7.	Have trouble concentrating	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
8.	Fight with other children	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
9.	Down on yourself	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
10.	Blame others for your troubles	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
11.	Seem to be having less fun	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
12.	Do not listen to rules	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
13.	Act as if driven by motor	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
14.	Tease others	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
15.	Worry a lot	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
16.	Take things that do not belong to you	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused
17.	Distracted easily	☐☐Never	☐☐Sometimes	☐☐Often	☐☐Refused

Subsection 5: Caregiver Strain Questionnaire (CGSQ)

Subsection 5: The Caregiver Strain Questionnaire (CGSQ) is intentionally excluded from this version.

K. SERVICES RECEIVED

[SECTION K IS REPORTED BY GRANTEE STAFF AT REASSESSMENT AND DISCHARGE UNLESS THE CONSUMER REFUSED THIS INTERVIEW OR ALL INTERVIEWS, IN WHICH CASE IT IS OPTIONAL.]

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

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

[IDENTIFY ALL OF THE SERVICES PROVIDED THROUGH THE SYSTEMS OF CARE TO THE CONSUMER <u>SINCE HIS/HER LAST NOMS INTERVIEW</u>; THIS INCLUDES CMHS-FUNDED AND NON-FUNDED SERVICES.]

Core Services	**Provided**			**SERVICE**
	Yes	**No**	**UNKNOWN**	**NOT AVAILABLE**
1. Screening	☐	☐	☐	☐
2. Assessment	☐	☐	☐	☐
3. Treatment Planning or Review	☐	☐	☐	☐
4. Psychopharmacological Services	☐	☐	☐	☐
5. Mental Health Services	☐	☐	☐	☐

[IF THE ANSWER TO 5 'MENTAL HEALTH SERVICES' IS YES, PLEASE ESTIMATE HOW FREQUENTLY THE FOLLOWING MENTAL HEALTH SERVICES WERE DELIVERED.]

	Provided		**If yes, in the past 6 months:**
	Yes	No	
5a. Outpatient therapy	☐	☐☐☐☐	# of sessions _____
5b. Group therapy	☐	☐ ☐☐☐☐	# of sessions _____
5c. Family therapy (including child)	☐	☐☐☐☐☐	# of sessions _____
5d. Partial hospitalization/ day treatment	☐	☐☐☐☐☐	# of days _____
5e. Psychiatric hospitalization	☐	☐☐☐☐☐	# of days _____

	Yes	**No**	**UNKNOWN**	**SERVICE NOT AVAILABLE**
6. Co-Occurring Services	☐	☐	☐	☐
7. Wraparound Planning Team/Services	☐	☐	☐	☐
8. Trauma-specific Services	☐	☐	☐	☐
9. Was the Consumer referred to another provider for any of the above core services?	☐	☐	☐	

Support Services	**Provided**			**SERVICE**
	Yes	**No**	**UNKNOWN**	**NOT AVAILABLE**
1. Medical Care	☐	☐	☐	☐
2. Employment Services	☐	☐	☐	☐
3. Family Services	☐	☐	☐	☐
3a. Peer-support partner for youth	☐	☐	☐	☐
3b. Peer-support partner for caregiver/family				
3c. Respite Family Services				
4. Child Care				
5. Transportation	☐	☐	☐	☐
6. Education Services	☐	☐	☐	☐
7. Housing Support	☐	☐	☐	☐

8. Social Recreational Activities	☐	☐	☐	☐
9. Consumer Operated Services	☐	☐	☐	☐

K. SERVICES RECEIVED (Continued)

Support Services	Provided		UNKNOWN	SERVICE NOT AVAILABLE
	Yes	No		
10. HIV Testing	☐	☐	☐	☐
11. Was the Consumer referred to another provider for any of the above support services?	☐	☐	☐	☐
12. Substance abuse related services and support?	☐	☐	☐	☐
13. Intellectual disabilities	☐	☐	☐	☐

End of Instrument:

Thank you for participating in the child and family outcomes portion of the National System of Care Expansion Evaluation.