

**Transformation Accountability (TRAC)**  
Center for Mental Health Services

**NOMs Client-Level Measures for Discretionary  
Programs Providing Direct Services**

**SERVICES TOOL**  
**TCE NOMS**



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Public reporting burden for this collection of information is estimated to average 30 minutes per response if all items are asked of a consumer/participant; to the extent that providers already obtain much of this information as part of their ongoing consumer/participant intake or follow-up, 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 0930-0285.

**RECORD MANAGEMENT**

*[RECORD MANAGEMENT IS REPORTED BY GRANTEE STAFF AT BASELINE, REASSESSMENT AND DISCHARGE REGARDLESS OF WHETHER AN INTERVIEW IS CONDUCTED.]*

Consumer ID \_\_\_\_\_

Grant ID (Grant/Contract/Cooperative Agreement) \_\_\_\_\_

Site ID \_\_\_\_\_

**1. Indicate Assessment Type:**

<input type="radio"/> Baseline  <i>[ENTER THE MONTH AND YEAR WHEN THE CONSUMER FIRST RECEIVED SERVICES UNDER THE GRANT FOR THIS EPISODE OF CARE.]</i>  _____/_____ MONTH                  YEAR	<input type="radio"/> Reassessment  <b>Which 6-month reassessment?</b>  _____  <i>[ENTER 06 FOR A 6-MONTH, 12 FOR A 12-MONTH, 18 FOR AN 18-MONTH ASSESSMENT, ETC.]</i>	<input type="radio"/> Clinical Discharge
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**2. Was the interview conducted?**

<input type="radio"/> Yes  <b>When?</b>  _____/_____/_____ MONTH          DAY          YEAR	<input type="radio"/> No  <b>Why not? Choose only one.</b>  <input type="radio"/> Not able to obtain consent from proxy <input type="radio"/> Consumer was impaired or unable to provide consent <input type="radio"/> Consumer refused this interview only <input type="radio"/> Consumer was not reached for interview <input type="radio"/> Consumer refused all interviews
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*[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 gender?**

- MALE
- FEMALE
- TRANSGENDER
- OTHER (SPECIFY) \_\_\_\_\_
- REFUSED

**2. Are you Hispanic or Latino?**

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

*[IF YES] What ethnic group do you consider yourself? Please answer yes or no for each of the following. You may say yes to more than one.*

	<b>YES</b>	<b>NO</b>	<b>REFUSED</b>
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"/> <i>[IF YES, SPECIFY BELOW.]</i>

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

	<b>YES</b>	<b>NO</b>	<b>REFUSED</b>
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"/>

**4. What is your month and year of birth?**

\_\_\_\_|\_\_\_\_| / \_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|  
MONTH                      YEAR                       REFUSED

*[IF THE BASELINE INTERVIEW WAS NOT CONDUCTED, GO TO SECTION H. ALL OTHERS CONTINUE TO SECTION B.]*

**B. FUNCTIONING**

**1. How would you rate your 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 able to deal with your 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.]*

STATEMENT	RESPONSE OPTIONS						
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	REFUSED	NOT APPLICABLE
a. I deal effectively with daily problems.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
b. I am able to control my life.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
c. I am able to deal with crisis.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
d. I am getting along with my family.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. I do well in social situations.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
f. I do well in school and/or work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. My housing situation is satisfactory.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
h. My symptoms are not bothering me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**B. FUNCTIONING (Continued)**

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

**B. FUNCTIONING (Continued)**

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 TO THE CONSUMER. IF THE # OF DAYS IS GREATER THAN 0 ASK THE ROUTE OF ADMINISTRATION. NOTE THE USUAL ROUTE. IF MORE THAN ONE ROUTE, CHOOSE THE MOST SEVERE. THE ROUTES ARE LISTED FROM LEAST SEVERE (1) TO MOST SEVERE (5).]*

Route of Administration Types:

1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV

*[IF THE VALUE IN ANY ITEM B4g THROUGH B4t > 0, THEN THE VALUE IN B4e MUST BE > 0.]*

QUESTION	RESPONSE OPTIONS					
	# of Days	REFUSED	DON'T KNOW	Route	REFUSED	DON'T KNOW
During the past 30 days, how many days have you used...						
a) Tobacco products (cigarettes, chewing tobacco, cigars, etc.)?		<input type="radio"/>	<input type="radio"/>			
b) Alcoholic beverages (beer, wine, liquor, etc.)? <i>[IF b=0, RF, DK, THEN SKIP TO ITEM e.]</i>		<input type="radio"/>	<input type="radio"/>			
c) Alcohol to intoxication (5+ drinks in one sitting)?		<input type="radio"/>	<input type="radio"/>			
d) Alcohol to intoxication (4 or fewer drinks in one sitting and felt high)?		<input type="radio"/>	<input type="radio"/>			
e) Illegal drugs?		<input type="radio"/>	<input type="radio"/>			
<i>[IF b or e =0, RF, DK, THEN SKIP TO ITEM g.]</i> f) Both alcohol and drugs (on the same day)?		<input type="radio"/>	<input type="radio"/>			
g) Cannabis (marijuana, pot, grass, hash, joints, blunts, chronic, weed, Mary Jane, etc.)?		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
h) Cocaine (coke, crack, etc.)?		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
i) Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)?		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
j) Methamphetamine or other amphetamines (crystal meth, uppers, speed, ice, chalk, glass, fire, crank, etc.)?		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
k) Inhalants (nitrous oxide, glue, gas, paint thinner, poppers, snappers, rush, whippets, etc.)?		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>

**B. FUNCTIONING (Continued)**

During the past 30 days, how many days have you used...	# of Days	REFUSED	DON'T KNOW	Route	REFUSED	DON'T KNOW
l) Benzodiazepines, sedatives or sleeping pills (Serepax, Ativan, Librium, Rohypnol, GHB, etc.) Diazepam (Valium); Alprazolam (Xanax); Triazolam (Halcion); and Estazolam (Prosom and Rohypnol—also known as roofies, roche, and cope)?	_	<input type="radio"/>	<input type="radio"/>	_	<input type="radio"/>	<input type="radio"/>
m) Barbiturates: Mephobarbital (Mebacut) and pentobarbital sodium (Nembutal)?	_	<input type="radio"/>	<input type="radio"/>	_	<input type="radio"/>	<input type="radio"/>
n) Non-prescription GHB (known as Grievous Bodily Harm; Liquid Ecstasy; and Georgia Home Boy)?	_	<input type="radio"/>	<input type="radio"/>	_	<input type="radio"/>	<input type="radio"/>
o) Ketamine (known as Special K or Vitamin K)?	_	<input type="radio"/>	<input type="radio"/>	_	<input type="radio"/>	<input type="radio"/>
p) Other tranquilizers, downers, sedatives or hypnotics?	_	<input type="radio"/>	<input type="radio"/>	_	<input type="radio"/>	<input type="radio"/>
q) Hallucinogens/psychedelics, PCP (Angel Dust, Ozone, Wack, Rocket Fuel) MDMA (Ecstasy, XTC, X, Adam), LSD (Acid, Boomers, Yellow Sunshine), Mushrooms or Mescaline?	_	<input type="radio"/>	<input type="radio"/>	_	<input type="radio"/>	<input type="radio"/>
r) Street opiates – heroin (Smack, H, Junk, Skag, opium etc.)?	_	<input type="radio"/>	<input type="radio"/>	_	<input type="radio"/>	<input type="radio"/>
s) Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, morphine, Diluadid, Demerol, Darvon, codeine, Tylenol 2, 3, 4, etc.) or non-prescription methadone?	_	<input type="radio"/>	<input type="radio"/>	_	<input type="radio"/>	<input type="radio"/>
t) Other illegal drugs – specify: _____	_	<input type="radio"/>	<input type="radio"/>	_	<input type="radio"/>	<input type="radio"/>

*[IF ANY ROUTE OF ADMINISTRATION IN B4g – B4t = 4 or 5, THEN CONTINUE TO B4A; OTHERWISE SKIP TO GAF SCORE.]*

**4A. In the past 30 days, how often did you use a syringe/needle, cooker, cotton or water that someone else used?**

- Always
- More than half the time
- Half the time
- Less than half the time
- Never
- REFUSED
- DON'T KNOW

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**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 = |\_|\_|\_|\_|\_|



**B. MILITARY FAMILY AND DEPLOYMENT**

*[QUESTIONS 5 THROUGH 8 ARE ONLY ASKED AT BASELINE. IF THIS IS NOT A BASELINE, GO TO 9.]*

**5. Have you ever served in the Armed Forces, the Reserves, or the National Guard?**

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

***[IF YES]*** In which of the following have you ever served? Please answer for each of the following. You may say yes to more than one.

	YES	NO	REFUSED	DON'T KNOW
Armed Forces	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reserves	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
National Guard	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**5a. Are you currently serving on active duty in the Armed Forces, the Reserves, or the National Guard?**

- YES
- NO *[GO TO 5b.]*
- REFUSED *[GO TO 5b.]*
- DON'T KNOW *[GO TO 5b.]*

***[IF YES]*** In which of the following are you currently serving? Please answer for each of the following. You may say yes to more than one.

	YES	NO	REFUSED	DON'T KNOW
Armed Forces	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reserves	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
National Guard	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**5b. Have you ever been deployed to a combat zone?**

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

***[IF YES]*** To which of the following combat zones have you been deployed? Please answer for each of the following. You may say yes to more than one.

	YES	NO	REFUSED	DON'T KNOW
Iraq or Afghanistan (e.g., Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Persian Gulf (Operation Desert Shield or Desert Storm)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vietnam/Southeast Asia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Korea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
WWII	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Deployed to a combat zone not listed above (e.g., Somalia, Bosnia, Kosovo)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**B. MILITARY FAMILY AND DEPLOYMENT (Continued)**

**6. Is anyone in your family or someone close to you currently serving on active duty in or retired/separated from the Armed Forces, the Reserves, or the National Guard?**

- Yes, only one person
- Yes, more than one person
- No *[GO TO 7.]*
- REFUSED *[GO TO 7.]*
- DON'T KNOW *[GO TO 7.]*

**For the first person:**

**6.a.1 What is the relationship of that person (Service Member) to you?**

- MOTHER/FATHER
- BROTHER/SISTER
- SPOUSE/PARTNER
- CHILD
- OTHER, SPECIFY \_\_\_\_\_
- REFUSED
- DON'T KNOW

**6.b.1 Has the Service Member experienced any of the following? Please answer for each of the following. You may say yes to more than one.**

	<b>YES</b>	<b>NO</b>	<b>REFUSED</b>	<b>DON'T KNOW</b>
Deployed in support of Combat Operations (e.g. Iraq or Afghanistan)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Was physically injured during Combat Operations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Developed combat stress symptoms/difficulties adjusting following deployment, including PTSD, depression, or suicidal thoughts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Died or was killed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

***[IF THE RESPONSE TO 6 WAS "YES, ONLY ONE PERSON", GO TO 7. OTHERWISE, CONTINUE.]***

**B. MILITARY FAMILY AND DEPLOYMENT (Continued)**

**For the second person:**

**6.a.2 What is the relationship of that person (Service Member) to you?**

- MOTHER/FATHER
- BROTHER/SISTER
- SPOUSE/PARTNER
- CHILD
- OTHER, SPECIFY \_\_\_\_\_
- REFUSED
- DON'T KNOW

**6.b.2 Has the Service Member experienced any of the following? Please answer for each of the following. You may say yes to more than one.**

	YES	NO	REFUSED	DON'T KNOW
Deployed in support of Combat Operations (e.g. Iraq or Afghanistan)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Was physically injured during Combat Operations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Developed combat stress symptoms/difficulties adjusting following deployment, including PTSD, depression, or suicidal thoughts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Died or was killed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**[IF THE CONSUMER HAS INFORMATION FOR ANOTHER SERVICE MEMBER, CONTINUE. OTHERWISE, GO TO 7.]**

**For the third person:**

**6.a.3 What is the relationship of that person (Service Member) to you?**

- MOTHER/FATHER
- BROTHER/SISTER
- SPOUSE/PARTNER
- CHILD
- OTHER, SPECIFY \_\_\_\_\_
- REFUSED
- DON'T KNOW

**6.b.3 Has the Service Member experienced any of the following? Please answer for each of the following. You may say yes to more than one.**

	YES	NO	REFUSED	DON'T KNOW
Deployed in support of Combat Operations (e.g. Iraq or Afghanistan)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Was physically injured during Combat Operations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Developed combat stress symptoms/difficulties adjusting following deployment, including PTSD, depression, or suicidal thoughts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Died or was killed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**[IF THE CONSUMER HAS INFORMATION FOR ANOTHER SERVICE MEMBER, CONTINUE. OTHERWISE, GO TO 7.]**

**B. MILITARY FAMILY AND DEPLOYMENT (Continued)**

**For the fourth person:**

**6.a.4 What is the relationship of that person (Service Member) to you?**

- MOTHER/FATHER
- BROTHER/SISTER
- SPOUSE/PARTNER
- CHILD
- OTHER, SPECIFY \_\_\_\_\_
- REFUSED
- DON'T KNOW

**6.b.4 Has the Service Member experienced any of the following? Please answer for each of the following. You may say yes to more than one.**

	YES	NO	REFUSED	DON'T KNOW
Deployed in support of Combat Operations (e.g. Iraq or Afghanistan)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Was physically injured during Combat Operations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Developed combat stress symptoms/difficulties adjusting following deployment, including PTSD, depression, or suicidal thoughts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Died or was killed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**[IF THE CONSUMER HAS INFORMATION FOR ANOTHER SERVICE MEMBER, CONTINUE. OTHERWISE, GO TO 7.]**

**For the fifth person:**

**6.a.5 What is the relationship of that person (Service Member) to you?**

- MOTHER/FATHER
- BROTHER/SISTER
- SPOUSE/PARTNER
- CHILD
- OTHER, SPECIFY \_\_\_\_\_
- REFUSED
- DON'T KNOW

**6.b.5 Has the Service Member experienced any of the following? Please answer for each of the following. You may say yes to more than one.**

	YES	NO	REFUSED	DON'T KNOW
Deployed in support of Combat Operations (e.g. Iraq or Afghanistan)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Was physically injured during Combat Operations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Developed combat stress symptoms/difficulties adjusting following deployment, including PTSD, depression, or suicidal thoughts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Died or was killed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**[IF THE CONSUMER HAS INFORMATION FOR ANOTHER SERVICE MEMBER, CONTINUE. OTHERWISE, GO TO 7.]**

**B. MILITARY FAMILY AND DEPLOYMENT (Continued)**

For the sixth person:

**6.a.6 What is the relationship of that person (Service Member) to you?**

- MOTHER/FATHER
- BROTHER/SISTER
- SPOUSE/PARTNER
- CHILD
- OTHER, SPECIFY \_\_\_\_\_
- REFUSED
- DON'T KNOW

**6.b.6 Has the Service Member experienced any of the following? Please answer for each of the following. You may say yes to more than one.**

	YES	NO	REFUSED	DON'T KNOW
Deployed in support of Combat Operations (e.g. Iraq or Afghanistan)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Was physically injured during Combat Operations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Developed combat stress symptoms/difficulties adjusting following deployment, including PTSD, depression, or suicidal thoughts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Died or was killed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**B. VIOLENCE AND TRAUMA**

**7. 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 9.]*
- REFUSED *[GO TO 9.]*
- DON'T KNOW *[GO TO 9.]*

**8. 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
<b>8a. Have had nightmares about it or thought about it when you did not want to?</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>8b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>8c. Were constantly on guard, watchful, or easily startled?</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>8d. Felt numb and detached from others, activities, or your surroundings?</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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**B. VIOLENCE AND TRAUMA (Continued)**

**9. 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

**C. STABILITY IN HOUSING**

1. In the past 30 days how many ...	Number of Nights/ Times	REFUSED	DON'T KNOW
a. nights have you been homeless?	_ _ _	<input type="radio"/>	<input type="radio"/>
b. nights have you spent in a hospital for mental health care?	_ _ _	<input type="radio"/>	<input type="radio"/>
c. nights have you spent in a facility for detox/inpatient or residential substance abuse treatment?	_ _ _	<input type="radio"/>	<input type="radio"/>
d. nights have you spent in correctional facility including jail, or prison?	_ _ _	<input type="radio"/>	<input type="radio"/>

***[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 gone to an emergency room for a psychiatric or emotional problem?	_ _ _	<input type="radio"/>	<input type="radio"/>
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***[IF 1A, 1B, 1C, OR 1D IS 16 OR MORE NIGHTS, GO TO SECTION D.]***

**2. In the past 30 days, where have you been living most of the time?**

***[DO NOT READ RESPONSE OPTIONS TO THE CONSUMER. SELECT ONLY ONE.]***

- OWNED OR RENTED HOUSE, APARTMENT, TRAILER, ROOM
- SOMEONE ELSE'S HOUSE, APARTMENT, TRAILER, ROOM
- HOMELESS (SHELTER, STREET/OUTDOORS, PARK)
- GROUP HOME
- ADULT FOSTER CARE
- TRANSITIONAL LIVING FACILITY
- HOSPITAL (MEDICAL)
- HOSPITAL (PSYCHIATRIC)
- DETOX/INPATIENT OR RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
- CORRECTIONAL FACILITY (JAIL/PRISON)
- NURSING HOME
- VA HOSPITAL
- VETERAN'S HOME
- MILITARY BASE
- OTHER HOUSED (SPECIFY) \_\_\_\_\_
- REFUSED
- DON'T KNOW

**D. EDUCATION AND EMPLOYMENT**

**1. 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

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

- LESS THAN 12<sup>TH</sup> GRADE
- 12<sup>TH</sup> 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

**3. 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

**3a. [IF EMPLOYED]**

- |  | <b>Yes</b>            | <b>No</b>             | <b>REFUSED</b>        | <b>DON'T KNOW</b>     |
|--|-----------------------|-----------------------|-----------------------|-----------------------|
| • Are you paid at or above the minimum wage <sup>1</sup> ? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| • Are your wages paid directly to you by your employer?    | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| • Could anyone have applied for this job?                  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

<sup>1</sup> For information on Federal minimum wage go to <http://www.dol.gov/dol/topic/wages/>.



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**E. CRIME AND CRIMINAL JUSTICE STATUS**

**1. In the past 30 days, how many times have you 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 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.]*

STATEMENT	RESPONSE OPTIONS						
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	REFUSED	NOT APPLICABLE
a. Staff here believe that I can grow, change and recover.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
b. I felt free to complain.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
c. I was given information about my rights.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
d. Staff encouraged me to take responsibility for how I live my life.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
e. Staff told me what side effects to watch out for.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Staff respected my wishes about who is and who is not to be given information about my treatment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
g. Staff were sensitive to my cultural background (race, religion, language, etc.).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
h. Staff helped me obtain the information I needed so that I could take charge of managing my illness.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
i. I was encouraged to use consumer run programs (support groups, drop-in centers, crisis phone line, etc.).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
j. I felt comfortable asking questions about my treatment and medication.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
k. I, not staff, decided my treatment goals.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
l. I like the services I received here.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
m. If I had other choices, I would still get services from this agency.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
n. I would recommend this agency to a friend or family member.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

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**F. PERCEPTION OF CARE (Continued)**

**2. [INDICATE WHO ADMINISTERED SECTION F - PERCEPTION OF CARE TO THE RESPONDENT 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 mental health provider(s) over the past 30 days.

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

STATEMENT	RESPONSE OPTIONS					
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	REFUSED
a. I am happy with the friendships I have.	○	○	○	○	○	○
b. I have people with whom I can do enjoyable things.	○	○	○	○	○	○
c. I feel I belong in my community.	○	○	○	○	○	○
d. In a crisis, I would have the support I need from family or friends.	○	○	○	○	○	○

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**H. PROGRAM SPECIFIC QUESTIONS**

***[QUESTIONS 1 AND 2 APPLY ONLY TO BASELINES. IF THIS IS NOT A BASELINE GO TO QUESTION 3.]***

**1. INDICATE THE PROGRAMMATIC FOCUS FOR THE CLIENT/CONSUMER BELOW.**

	<b><i>1a. PROGRAMMATIC FOCUS (CHECK ALL THAT APPLY.)</i></b>	<b><i>1b. PREDOMINANT FOCUS (CHECK ONLY ONE.)</i></b>
<b><i>SUBSTANCE ABUSE TREATMENT</i></b>	<input type="radio"/>	<input type="radio"/>
<b><i>MENTAL HEALTH TREATMENT</i></b>	<input type="radio"/>	<input type="radio"/>
<b><i>SUBSTANCE ABUSE PREVENTION</i></b>	<input type="radio"/>	<input type="radio"/>

**2. How would you describe your sexual orientation?**

- Straight or heterosexual
- Bisexual
- Gay or lesbian
- REFUSED
- DON'T KNOW

***[IF THIS IS A BASELINE AND THE INTERVIEW WAS NOT CONDUCTED STOP HERE]***

**3. Do you have health care coverage?**

- Yes, government insurance
- Yes, private insurance
- No
- REFUSED
- DON'T KNOW

**The following questions pertain to your attitudes and beliefs about alcohol, tobacco, and drugs.**

**4. How much do people risk harming themselves physically or in other ways when they smoke one or more packs of cigarettes per day?**

- No risk
- Slight risk
- Moderate risk
- Great risk
- REFUSED
- DON'T KNOW

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## H. PROGRAM SPECIFIC QUESTIONS

5. How much do people risk harming themselves physically or in other ways when they smoke marijuana once or twice a week?

- No risk
- Slight risk
- Moderate risk
- Great risk
- REFUSED
- DON'T KNOW

6. How much do people risk harming themselves physically or in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?

- No risk
- Slight risk
- Moderate risk
- Great risk
- REFUSED
- DON'T KNOW

The following questions pertain to your beliefs and attitudes about sex.

How much do people risk harming themselves physically...

7. if they have sex without a condom?

- No risk
- Slight risk
- Moderate risk
- Great risk
- REFUSED

8. if they have sex under the influence of alcohol?

- No risk
- Slight risk
- Moderate risk
- Great risk
- REFUSED

9. if they have sex while high on drugs?

- No risk
- Slight risk
- Moderate risk
- Great risk
- REFUSED

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## **H. PROGRAM SPECIFIC QUESTIONS**

### **HIV/AIDS and Substance Abuse Prevention**

**The following questions are to determine what you know about HIV/AIDS and substance abuse prevention.**

**10. Birth control pills protect women from getting the HIV/AIDS virus.**

- True
- False
- REFUSED
- DON'T KNOW

**11. There are drugs available to treat HIV that can lengthen the life of a person infected with the virus.**

- True
- False
- REFUSED
- DON'T KNOW

**12. There is no cure for AIDS.**

- True
- False
- REFUSED
- DON'T KNOW

**13. Would you know where to go in your community to see a health care professional regarding HIV/AIDS or sexually transmitted health issues?**

- YES
- NO
- REFUSED

**14. Would you know where to go in your community to see a health care professional regarding a drug or alcohol problem?**

- YES
- NO
- REFUSED

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**H. PROGRAM SPECIFIC QUESTIONS**

**Recent Sexual Activity**

The following questions are regarding recent sexual activity.

**15. During the past 30 days, did you engage in sexual activity?**

- YES [*GO TO 15a.*]
- NO
- NOT PERMITTED TO ASK
- REFUSED
- DON'T KNOW

**[IF THE RESPONSE TO 15 WAS "NO", "NOT PERMITTED TO ASK", "REFUSED", OR "DON'T KNOW", SKIP 15a, b, AND c.]**

**[IF YES] Altogether, how many...**

**CONTACTS**

**REFUSED**

**DON'T KNOW**

**a. sexual contacts (vaginal, oral, or anal) did you have?**

--	--	--

**b. unprotected sexual contacts did you have?**

--	--	--

**[THE VALUE IN 15b CANNOT BE GREATER THAN THE VALUE IN 15a.]**

**[IF THE RESPONSE TO 15b IS 0, REFUSED, OR DON'T KNOW, SKIP 15c1-3.]**

**c. unprotected sexual contacts were with an individual who is or was:**

**CONTACTS**

**REFUSED**

**DON'T KNOW**

**1. HIV positive or has AIDS?**

--	--	--

**2. an injection drug user?**

--	--	--

**3. high on some substance?**

--	--	--

**[THE VALUE IN 15c1, 15c2, or 15c3 CANNOT BE GREATER THAN THE VALUE IN 15b.]**

**[IF THIS IS A BASELINE INTERVIEW, 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.]**



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**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 the last encounter?**

- Yes
- No

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

- Yes
- No

*[GO TO SECTION K.]*

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**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) \_\_\_\_\_

*[GO TO SECTION K.]*

**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.]**

**[IF THE INFORMATION BELOW IS UNKNOWN, RECORD "UNK" IN THE SPACE PROVIDED. IF THE SERVICE IS NOT AVAILABLE PLEASE ENTER "SNA" IN THE SPACE PROVIDED.]**

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

**Identify the number of DAYS of services provided to the client during the client's course of treatment/recovery. [ENTER ZERO IF NO SERVICES PROVIDED. YOU SHOULD HAVE AT LEAST ONE DAY FOR MODALITY.]**

Modality	Days
1. Case Management	_ _ _
2. Day Treatment	_ _ _
3. Inpatient/Hospital (Other than Detox)	_ _ _
4. Outpatient	_ _ _
5. Outreach	_ _ _
6. Intensive Outpatient	_ _ _
7. Methadone	_ _ _
8. Residential/Rehabilitation	_ _ _
9. Detoxification (Select only one)	
A. Hospital Inpatient	_ _ _
B. Free Standing Residential	_ _ _
C. Ambulatory Detoxification	_ _ _
10. After Care	_ _ _
11. Recovery Support	_ _ _
12. Other (Specify)_____	_ _ _

**Identify the number of SESSIONS provided to the client during the client's course of treatment/recovery. [ENTER ZERO IF NO SERVICES PROVIDED.]**

Treatment Services	Sessions
1. Screening	_ _ _
2. Referral to Treatment	_ _ _
3. Assessment	_ _ _
4. Treatment/Recovery Planning	_ _ _
5. Individual Counseling	_ _ _
6. Group Counseling	_ _ _
7. Family/Marriage Counseling	_ _ _
8. Co-Occurring Treatment/Recovery Services	_ _ _

	Sessions
9. Pharmacological Interventions	_ _ _
10. HIV/AIDS Counseling	_ _ _
11. Other Clinical Services (Specify)_____	_ _ _

Case Management Services	Sessions
1. Family Services (Including Marriage Education, Parenting, Child Development Services)	_ _ _
2. Child Care	_ _ _
3. Employment Service	
A. Pre-Employment	_ _ _
B. Employment Coaching	_ _ _
4. Individual Services Coordination	_ _ _
5. Transportation	_ _ _
6. HIV/AIDS Service	_ _ _
7. Supportive Transitional Drug-Free Housing Services	_ _ _
8. Other Case Management Services (Specify)_____	_ _ _

Medical Services	Sessions
1. Medical Care	_ _ _
2. Alcohol/Drug Testing	_ _ _
3. HIV/AIDS Medical Support & Testing	_ _ _
4. Other Medical Services (Specify)_____	_ _ _

After Care Services	Sessions
1. Continuing Care	_ _ _
2. Relapse Prevention	_ _ _
3. Recovery Coaching	_ _ _
4. Self-Help and Support Groups	_ _ _
5. Spiritual Support	_ _ _
6. Other After Care Services (Specify)_____	_ _ _

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**K. SERVICES RECEIVED (Continued)**

**Education Services**

- |   | <b>Sessions</b> |
|---|-----------------|
| 1. Substance Abuse Education                  | _ _ _           |
| 2. HIV/AIDS Education                         | _ _ _           |
| 3. Other Education Services<br>(Specify)_____ | _ _ _           |

**Peer-To-Peer Recovery Support Services**

- |  | <b>Sessions</b> |
|--|-----------------|
| 1. Peer Coaching or Mentoring  | _ _ _           |
| 2. Housing Support   | _ _ _           |
| 3. Alcohol- and Drug-Free Social<br>Activities                       | _ _ _           |
| 4. Information and Referral  | _ _ _           |
| 5. Other Peer-To-Peer Recovery<br>Support Services<br>(Specify)_____ | _ _ _           |