

Transformation Accountability (TRAC)
Center for Mental Health Services

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

**SERVICES TOOL
For Adult Programs**



March 2013
Version 11

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 2-1057, 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="checkbox"/> <input type="checkbox"/> 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="checkbox"/> <input type="checkbox"/> Reassessment Which 6-month reassessment? _ _ _ _ _ <i>[ENTER 06 FOR A 6-MONTH, 12 FOR A 12-MONTH, 18 FOR AN 18-MONTH ASSESSMENT, ETC.]</i>	<input type="checkbox"/> <input type="checkbox"/> Clinical Discharge
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2. Was the interview conducted?

<input type="checkbox"/> Yes When? _ _ _ _ _ / _ _ _ _ _ / _ _ _ _ _ _ _ _ _ _ MONTH DAY YEAR	<input type="checkbox"/> No Why not? Choose only one. <input type="checkbox"/> <input type="checkbox"/> Not able to obtain consent from proxy <input type="checkbox"/> Consumer was impaired or unable to provide consent <input type="checkbox"/> Consumer refused this interview only <input type="checkbox"/> Consumer was not reached for interview <input type="checkbox"/> 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 H (IF APPLICABLE), THEN SECTION I.]

[FOR A CLINICAL DISCHARGE:

IF AN INTERVIEW WAS CONDUCTED, GO TO SECTION B.

IF AN INTERVIEW WAS NOT CONDUCTED, GO TO SECTION H (IF APPLICABLE), THEN 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.

	YES	NO	REFUSED
Central American	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cuban	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dominican	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mexican	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Puerto Rican	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
South American	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OTHER (SPECIFY) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> [IF YES, SPECIFY BELOW.]

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.

	YES	NO	REFUSED
Alaska Native	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
American Indian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Black or African American	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Native Hawaiian or Other Pacific Islander	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
White	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. What is your month and year of birth?

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

5. Which one of the following do you consider yourself to be?

- Heterosexual, that is straight;
- [IF FEMALE THEN “Lesbian or”] Gay
- Bisexual
- DON’T KNOW/REFUSED

[IF THE BASELINE INTERVIEW WAS CONDUCTED CONTINUE TO SECTION B.]

[IF THE BASELINE INTERVIEW WAS NOT CONDUCTED:

PRIMARY AND BEHAVIORAL HEALTH CARE INTEGRATION (PBHCI) GRANTEES GO TO SECTION H;

GRANTEES IN ALL OTHER PROGRAMS STOP HERE.]

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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. I am able to control my life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. I am able to deal with crisis.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. I am getting along with my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I do well in social situations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
f. I do well in school and/or work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. My housing situation is satisfactory.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
h. My symptoms are not bothering me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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

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 FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]

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

[Vicodin], methadone, buprenorphine, etc.)?						
l. other – specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 = |_|_|_|_|_|_|_|_|

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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reserves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
National Guard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reserves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
National Guard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persian Gulf (Operation Desert Shield or Desert Storm)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vietnam/Southeast Asia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Korea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WWII	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deployed to a combat zone not listed above (e.g., Somalia, Bosnia, Kosovo)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.]*

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

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

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="checkbox"/>	<input type="checkbox"/>
b. nights have you spent in a hospital for mental health care?	_ _ _	<input type="checkbox"/>	<input type="checkbox"/>
c. nights have you spent in a facility for detox/inpatient or residential substance abuse treatment?	_ _ _	<input type="checkbox"/>	<input type="checkbox"/>
d. nights have you spent in correctional facility including jail, or prison?	_ _ _	<input type="checkbox"/>	<input type="checkbox"/>

[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="checkbox"/>	<input type="checkbox"/>
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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 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

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]

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

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

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

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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I have people with whom I can do enjoyable things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I feel I belong in my community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. In a crisis, I would have the support I need from family or friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

[IF YOUR PROGRAM DOES NOT REQUIRE SECTION H:

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

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

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

[IF YOUR PROGRAM DOES REQUIRE SECTION H:

IF THIS IS A BASELINE INTERVIEW, PLEASE PROCEED TO SECTION H THEN STOP. THE INTERVIEW WILL BE COMPLETE.]

IF THIS IS A REASSESSMENT INTERVIEW, PROCEED TO SECTION H, THEN I AND K.]

IF THIS IS A CLINICAL DISCHARGE INTERVIEW, PROCEED TO SECTION H, THEN J AND K.]

H. PROGRAM SPECIFIC QUESTIONS

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

FOR A LIST OF PROGRAMS THAT HAVE PROGRAM SPECIFIC DATA, SEE APPENDIX A OF THE NOMS CLIENT-LEVEL MEASURES FOR DISCRETIONARY PROGRAMS PROVIDING DIRECT SERVICES QUESTION-BY-QUESTION INSTRUCTION GUIDE FOR ADULT PROGRAMS.

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.]

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.]

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

/
 MONTH YEAR

[IDENTIFY ALL OF THE SERVICES YOUR PROJECT PROVIDED TO THE CONSUMER SINCE HIS/HER LAST NOMS INTERVIEW; THIS INCLUDES CMHS-FUNDED AND NON-FUNDED SERVICES.]

Core Services	Provided		UNKNOWN	SERVICE NOT AVAILABLE
	Yes	No		
1. Screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Treatment Planning or Review	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Psychopharmacological Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Mental Health Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Number of times _____ per
 Day
 Week
 Month
 Year
 UNKNOWN

	Provided		UNKNOWN	SERVICE NOT AVAILABLE
	Yes	No		
6. Co-Occurring Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Case Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Trauma-specific Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Was the Consumer referred to another provider for any of the above core services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Support Services	Provided		UNKNOWN	SERVICE NOT AVAILABLE
	Yes	No		
1. Medical Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Employment Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Family Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Child Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Education Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Housing Support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Social Recreational Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Consumer Operated Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. HIV Testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Was the Consumer referred to another provider for any of the above support services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

