OMB Control No. XXXX-XXXX
Expiration Date: XX/XX/XX

CHILDREN'S MENTAL HEALTH INITIATIVE
NATIONAL EVALUATION

CHILD AND FAMILY LEVEL OUTCOMES INSTRUMENT

CHILD- AND FAMILY-LEVEL INSTRUMENTS

CMHI National Evaluation: Child and Family Outcomes Study Components

Overview

- The purpose of the Child and Family Outcomes Study is to describe grantees' client populations served, track outcomes over time, and assess youth and caregiver appraisals of their service experience

- The Child and Family Outcomes Study has three different respondent versions:
  - The CMHI Caregiver Tool
  - The CMHI Child and Youth Tool
  - The CMHI Young Adult Tool

- Grantees will interview children, youth and caregivers using the tools below to collect the CMHI National Evaluation's Child and Family Outcomes Study data. The age of the child/youth receiving services determines who is interviewed for the National Evaluation.

  - The CMHI Caregiver Tool will be used for collecting data from caregivers of all children ages 0 to 17 (inclusive); the caregiver is only 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.
  - The CMHI Young Adult Tool will be used for collecting data from individuals ages 18-26; only the young adult is interviewed for this age group.

- The CMHI National Evaluation plans to build the Child and Family Outcomes Study tools into the CMHI National Evaluation web-portal.

- The "Section 1: Administrative Data" and "Services Received" questions are obtained by grant staff through administrative records – children and families are not asked these questions directly. The "Services Received" questions will be collected at the 6- and 12-month reassessment data collection time points and at discharge

- Sections 2-8 are obtained by grant staff through caregiver, youth, or young adult client interviews.

- We will use SAMHSA's existing data reporting requirements for the National Outcomes Measures (NOMS) system to identify persons for whom data will be collected for The Child and Family Outcome Study.

- The Child and Family Outcomes Study components will be collected at baseline, 6 months, and 12 months or discharge if the client's treatment ends prior to either follow-up.

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 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 well-being of children and their families while they are participating and receiving services from the Systems of Care.

CONFIDENTIALITY/INFORMED CONSENT

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 be used only 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 health care 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, Dr. Kirstin Painter, at 240-276-1932.

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: ___/___/____

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 15 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 be used only 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, Dr. Kirstin Painter, at 240-276-1932. 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: ___/___/____

CAREGIVER VERSION

INSTRUCTIONS

This version will be administered to the caregiver of children ages 0 to 17 at every data collection time point unless otherwise noted.

Section 1: Administrative Data
Section 2: Functioning
Section 3: Columbia Impairment Scale – self-report
Section 4: BITSEA: Brief Infant-Toddler Social and Emotional Assessment
Section 5: Pediatric Symptom Checklist-17 – self-report
Section 6: Baby Pediatric Symptom Checklist (BPSC)
Section 7: Preschool Pediatric Symptom Checklist (PPSC)
Section 8: Caregiver Strain Questionnaire

There are two components of this instrument. Section 1 (administrative data, including CMHI services received) are answered by staff using information from administrative and clinical records for the child receiving services. The remaining sections, Sections 2-8, are to be administered verbally to the caregiver by local systems staff.

CAREGIVER VERSION

IDENTIFYING INFORMATION: COLLECTED AT BASELINE, REASSESSMENT AND DISCHARGE

Client ID |____|____|____|____|____|____|____|____|____|____|____|____|

Contract/Grant ID |____|____|____|____|____|____|____|____|____|____|

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

1. Interview Type (SELECT ONLY ONE TYPE.)

- ☐ Baseline
- ☐ Reassessment: |____|____| months (e.g., enter 06 for six months; enter 12 for one year)
- ☐ Discharge: Client completed services
- ☐ Discharge: Administrative

2. Was the interview conducted?

- ☐ Yes
- ☐ No

3. If an interview was conducted, when did it take place?

Interview Date: |____|____| / |____|____| / |____|____|____|____|
Month Day Year

SECTION 1: ADMINISTRATIVE DATA

[SECTION 1 ADMINISTRATIVE DATA IS COMPILED BY GRANTEE STAFF FROM RECORDS AT BASELINE.
IF THIS IS A BASELINE, GO TO QUESTION 1 BELOW. IF THIS IS NOT A BASELINE, SKIP TO QUESTION 10.]

1. What is the child's date of birth?

(MONTH AND YEAR MUST BE ENTERED. DAY IS OPTIONAL.)

Date of Birth: |____|____| / |____|____| / |____|____|____|____|
Month Day Year

- ☐ Declined
- ☐ Don't Know/Information Not Available

2. Is the child Hispanic, Latino/a, or of Spanish origin? (ONE OR MORE CATEGORIES MAY BE SELECTED.)

- ☐ Yes, Central American
- ☐ Yes, Cuban
- ☐ Yes, Dominican
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, South American
- ☐ Yes, another Hispanic, Latino/a, or Spanish Origin (Specify): _____
- ☐ No, not of Hispanic, Latino/a, or Spanish Origin
- ☐ Declined
- ☐ Don't Know/Information Not Available

3. What is the child's race? (ONE OR MORE CATEGORIES MAY BE SELECTED.)

- ☐ White
- ☐ Black or African American
- ☐ American Indian
- ☐ Alaska Native
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Declined
- ☐ Don't Know/Information Not Available

4. What is your child's gender?

- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ Other (Specify): _____
- ☐ Refused

5. (ONLY FOR CLIENTS 12 YEARS OF AGE OR OLDER): Which one of the following does the child consider him/herself to be?

- ☐ Straight
- ☐ Lesbian (IF FEMALE) or Gay (IF MALE)
- ☐ Bisexual
- ☐ Declined
- ☐ Don't Know/Information Not Available

6. What is the date of the child's…

6a. First <u>assessment</u> for the system of care?

|____|____| / |____|____| / |____|____|____|____|
Month Day Year

6b. First <u>service</u> (after assessment) received through the system of care?

|____|____| / |____|____| / |____|____|____|____|
Month Day Year

6c. Most recent service planning team meeting in the system-of-care?

|____|____| / |____|____| / |____|____|____|____|
Month Day Year

7. 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): _____

8. 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 (Specify): _____

9. 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 (Specify): _____

10. 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 (Specify): _____

11. During the past 6 months, was the child insured through...? (SELECT ALL THAT APPLY.)

- ☐ Medicaid
- ☐ CHIP
- ☐ SSI
- ☐ Private insurance
- ☐ Other (Specify): _____
- ☐ No insurance

12. What is the address where the child currently lives?

Street Address _____

City/Town _____

Zip Code _____

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

|____|____| / |____|____| / |____|____|____|____|
Month Day Year

14. Which diagnostic classification system was used?

- ☐ DSM-IV-TR
- ☐ DSM-V
- ☐ ICD-10

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

	Diagnostic code	**Diagnosis (name)**
15a. Primary Diagnosis	_____.____	_____
15b. Secondary Diagnosis	_____.____	_____
15c. Additional Diagnosis	_____.____	_____

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 = |____|____|____|

[IF THIS IS A BASELINE:

IF AN INTERVIEW WAS CONDUCTED: GO TO SECTION 2, FUNCTIONING

IF AN INTERVIEW WAS NOT CONDUCTED: STOP; DATA COLLECTION IS COMPLETE.]

[IF THIS IS A REASSESSMENT OR DISCHARGE, CONTINUE TO NEXT PAGE SERVICES RECEIVED.]

Administrative Data Subsection 2: Services Received

[SUBSECTION 2 IS REPORTED BY GRANTEE STAFF AT REASSESSMENT AND DISCHARGE]

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		Unknown	Service Not Available
	Yes	No		
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 _____

	Provided		Unknown	Service Not Available
	Yes	No		
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?.....	☐	☐	☐	☐

Subsection 2: Services Received (Continued)

Support Services	Provided		Unknown	Service Not Available
	Yes	No		
1. Medical Care	☐	☐	☐	☐
2. Employment Services	☐	☐	☐	☐
3. Family 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	☐	☐	☐	☐
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	☐	☐	☐	☐

Subsection 3: Reassessment Status

[SUBSECTION 3 IS REPORTED BY GRANTEE STAFF AT REASSESSMENT.]

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

☐ Yes
☐ No

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

☐ Yes
☐ No

Subsection 4: Clinical Discharge Status

[SUBSECTION 4 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

[IF AN INTERVIEW WAS CONDUCTED, GO TO SECTION 2, FUNCTIONING]

SECTION 2: FUNCTIONING

Subsection A: Family/Living Arrangement

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

- ☐ Yes **[GO TO 3]**
- ☐ No
- ☐ Refused **[GO TO 3]**
- ☐ Don't Know **[GO TO 3]**

1a. *[IF NO],* with whom does *(child's name)* live? (SELECT ALL THAT APPLY.)

- ☐ 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): _____
- ☐ Refused
- ☐ Don't Know

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

- ☐ Birth Parent
- ☐ StepParent
- ☐ Adoptive Parent
- ☐ Foster Parent
- ☐ Grandparent (biological, step, or adoptive)
- ☐ Sibling (biological, step, or adoptive)
- ☐ Other Relative (*Please specify:*_____)
- ☐ Non-relative not previously listed (e.g., other caregiving adult)
  (Specify): _____
- ☐ Refused

3. 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 (Specify): _____
- ☐ Refused
- ☐ Don't Know

[QUESTIONS 4 AND 5 ARE ONLY ASKED AT BASELINE. IF THIS IS A REASSESSMENT OR DISCHARGE SKIP QUESTION 4 AND 5 AND MOVE TO SUBSECTION B.]

4. How many children, including (child's name), are in the household? |____|____|

- ☐ Refused
- ☐ Don't Know

5. 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

Section 2: Functioning (Continued)

Subsection B: Functioning

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

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Refused
- ☐ Don't know

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

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

Statement	Response Options						
	S trongly	D isagree	U ndecided	A gree	S trongly	R efused	N o
a. I my child is handling daily life.....	☐	☐	☐	☐	☐	☐	☐
b. My child gets along with family members.....	☐	☐	☐	☐	☐	☐	☐
c. My child gets along with friends and other people..…	☐	☐	☐	☐	☐	☐	☐
d. My child is doing well in school and/or work.....	☐	☐	☐	☐	☐	☐	☐
e. My child is able to cope when things go wrong.....	☐	☐	☐	☐	☐	☐	☐
f. I am satisfied with our family life right now.....	☐	☐	☐	☐	☐	☐	☐

QUESTIONS 3 AND 4 ARE NOT ASKED IN THE CAREGIVER PROTOCOL.

MILITARY FAMILY AND DEPLOYMENT

QUESTION 5 IS NOT ASKED IN THE CAREGIVER PROTOCOL

QUESTION 6 IS ASKED ONLY AT BASELINE. IF THIS IS NOT A BASELINE, GO TO SUBSECTION C STABILITY IN HOUSING

6. Is anyone in your child's family or someone close to your child 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
- ☐ Refused
- ☐ Don't know

Subsection C: Stability In Housing

1. In the past 30 days how many …

	Number of Nights/ Times	Refused	Don't Know
a. nights has your child been homeless?.....	|____|____|	☐	☐
b. nights has your child spent in a hospital for mental health care?.....	|____|____|	☐	☐
c. nights has your child spent in a facility for detox/inpatient or residential substance abuse treatment?.....	|____|____|	☐	☐
d. nights has your child spent in correctional facility including juvenile detention, jail, or prison?.....	|____|____|	☐	☐
[ADD UP THE TOTAL NUMBER OF NIGHTS SPENT HOMELESS, IN HOSPITAL FOR MENTAL HEALTH CARE, IN DETOX/INPATIENT OR RESIDENTIAL SUBSTANCE ABUSE TREATMENT, OR IN A CORRECTIONAL FACILITY. (ITEMS A-D, CANNOT EXCEED 30 NIGHTS).]	|____|____|		
e. times has your child gone to an emergency room for a psychiatric or emotional problem?.....	|____|____|	☐	☐
[IF 1A, 1B, 1C, OR 1D IS 16 OR MORE NIGHTS, GO TO SUBSECTION D.]	|____|____|	☐	☐

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

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

- ☐ Caregiver's owned or rented house, apartment, trailer, or room
- ☐ Independent owned or rented house, apartment, trailer or room
- ☐ Someone else's house, apartment, trailer, or room
- ☐ Homeless (shelter, street/outdoors, park)
- ☐ Group home
- ☐ Foster care (specialized therapeutic treatment)
- ☐ Transitional living facility
- ☐ Hospital (medical)
- ☐ Hospital (psychiatric)
- ☐ Detox/inpatient or residential substance abuse treatment facility
- ☐ Correctional facility (juvenile detention center/jail/prison)
- ☐ Other housed (specify): _____
- ☐ Refused
- ☐ Don't know

Subsection D: Education

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

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

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

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

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

- ☐ Never attended
- ☐ Preschool
- ☐ Kindergarten
- ☐ 1ST grade
- ☐ 2ND grade
- ☐ 3RD grade
- ☐ 4TH grade
- ☐ 5TH grade
- ☐ 6TH grade
- ☐ 7TH grade
- ☐ 8TH grade
- ☐ 9TH grade
- ☐ 10TH grade
- ☐ 11TH grade
- ☐ 12TH grade/High School Diploma/Equivalent (GED)
- ☐ Voc/Tech diploma
- ☐ Some college or university
- ☐ Refused
- ☐ Don't Know

Subsection E: Crime and Criminal Justice Status

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

|____|____| Times

☐ Refused
☐ Don't Know

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

Subsection F: Perception of Care

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

1. In order to provide the best possible mental health and related services, we need to know what you think about the services you [your child] received <u>during the past 30 days</u>, 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 CAREGIVER.

Statement	Response Options					
	S trongly	D isagree	U ndecided	A gree	S trongly	R efused
a. Staff here treated me with respect.....	☐	☐	☐	☐	☐	☐
b. Staff respected my family's religious/spiritual beliefs.....	☐	☐	☐	☐	☐	☐
c. Staff spoke with me in a way that I understood.....	☐	☐	☐	☐	☐	☐
d. Staff was sensitive to my cultural/ethnic background.....	☐	☐	☐	☐	☐	☐
e. I helped choose my child's services.....	☐	☐	☐	☐	☐	☐
f. I helped to choose my child's treatment goals.....	☐	☐	☐	☐	☐	☐
g. I participated in my child's treatment.....	☐	☐	☐	☐	☐	☐
h. Overall, I am satisfied with the services my child received….	☐	☐	☐	☐	☐	☐
i. The people helping my child stuck with us no matter what….	☐	☐	☐	☐	☐	☐
j. I felt child had someone to talk to when I [he/she] was troubled.....	☐	☐	☐	☐	☐	☐
k. The services my child and/or family received were right for us.....	☐	☐	☐	☐	☐	☐
l. My family got the help we wanted for my child.....	☐	☐	☐	☐	☐	☐
m. My family got as much help as we needed for my child	☐	☐	☐	☐	☐	☐

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

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

Subsection G: Social Connectedness

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

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

Statement	Response Options					
	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	Refused
a. I know people who will listen and understand me when I need to talk.....	☐	☐	☐	☐	☐	☐
b. I have people that I am comfortable talking with about my child's problems.....	☐	☐	☐	☐	☐	☐
c. In a crisis, I would have the support I need from family or friends.....	☐	☐	☐	☐	☐	☐
d. I have people with whom I can do enjoyable things.....	☐	☐	☐	☐	☐	☐

Subsection H: Suicidality

[THE FOLLOWING THREE QUESTIONS (1–3) ARE ONLY FOR CLIENTS 10 YEARS OF AGE OR OLDER. IF CLIENT IS AGED 9 OR YOUNGER, SKIP TO SUBSECTION I.]

[QUESTION 1 IS ASKED ONLY AT BASELINE. IF THIS IS A REASSESSMENT OR DISCHARGE INTERVIEW, SKIP TO QUESTION 2.]

This next question is about suicide.

1. Has your child ever tried to kill himself/herself?

- ☐ Yes
- ☐ No
- ☐ Declined
- ☐ Don't Know/Information Not Available
- ☐ Not Applicable

[QUESTIONS 2 AND 3 ARE ONLY ASKED AT REASSESSMENT AND DISCHARGE. IF THIS IS A BASELINE INTERVIEW, SKIP TO SUBSECTION I.]

These next two questions are about suicide.

2. At any time in the past 6 months (including today), did your child seriously think about trying to kill himself/herself?

- ☐ Yes
- ☐ No
- ☐ Declined
- ☐ Don't Know/Information Not Available
- ☐ Not Applicable

3. During the past 6 months (including today), did your child try to kill himself/herself?

- ☐ Yes
- ☐ No
- ☐ Declined
- ☐ Don't Know/Information Not Available
- ☐ Not Applicable

Subsection I: Network Analysis Survey for Caregivers

The survey assesses relationships between your child and members of his/her support team within your Children's Mental Health Initiative System of Care.

Instructions for the interviewer:

In the following section, I will ask you to name as many as 10 of the most important people that are involved in providing mental health services for your child. If there are more than 10 individuals, just name the first 10 that come to mind. I'll write these names in column 1 as you speak. For the remaining columns, I'll ask you to provide some additional information as they apply to the name you have listed in column 1.

Name	2. What is _____'s relationship to your child? [select from list provided in interviewer guide]	3. What is _____'s organiza-tional affiliation?	4. Does _____ reside in the same city as your child?	5. In your view, what type of resources does _____ bring to address your child's mental health needs?	6. Is _____ a member of your child's wraparound team?	7. In general, how frequently does your child **interact** (e.g. communicate, visit) with _____ about mental health issues?	8. Which of the following best describes the **type of support** that your child receives from _____ ?	9. To what degree do you **trust** _____ to meet your child's mental health needs?	10. How much **influence** does _____ have on decisions about your child's mental health needs?
Name 1			1 ☐Yes 2 ☐No 3☐Don't know	1☐Mental Health expertise 2☐Health Expertise 3☐Supports in Daily Living 4☐Family support 5☐Community Supports 6☐Advocacy	1☐Yes 2☐No	1☐Daily 2☐Weekly 3☐Monthly 4☐Every 2-3 months 5☐1-3 times a year	1☐Emotional 2☐Infomational 3☐Instrumental 4☐Appraisal [see interviewer guide for definitions]	1☐Not at all 2☐A small amount 3☐A fair amount 4☐A great deal	1☐None 2☐A small amount 3☐A fair amount 4☐A great deal
Name 2									
Name 3									
Name 4									
Name 5									
Name 6									

Name 7									
Name 8									
Name 9									
Name 10									

11. Based on your impressions, how well do the people listed above work together to meet your child's mental health needs?

1 ☐ Not at all well 2 ☐ Fairly well 3 ☐ Well 4 ☐ Very well

12. Is there anything else you would like to tell us about your child's support system for mental health services?

Interviewer Guide

Question 2. As an additional prompt, the interviewer may help respondents think of someone who is an important member of their child's support structure by referring to the list of relationships shown below.

Example: Can you think of any additional people who are important members of your child's support structure? For instance, would you consider any individual like the ones in this list?

Professional staff	Community members	Family/Friends	Others in CMHI network
1. Physician – psychiatrist, pediatrician, other specialties 2. Nurse (RNs, NPs, PAs) 3. Pharmacist 4. Social worker 5. Therapist 6. Teacher 7. School nurse 8. Lawyer	9. Spiritual mentor/coach (chaplain, pastor) 10. Youth leader 11. Online support group 12. Probation officer	13. Mother 14. Father 15. Relative (grandparent, aunt/uncle, cousin etc.) 16. Friend 17. Foster parents	18. Organizations and groups from stakeholder interviews 19. Local Childhood Councils 20. Advocacy groups 21. Service Delivery Organization 22. State Department of Education 23. State Health Department

Question 8.

Types of social support:

1. **Emotional support**: provides comfort, there when your child needs someone to talk to
2. **Informational support**: provides useful tips and advice
3. **Instrumental support**: help your child build skills, tangible service and aid
4. **Appraisal support**: help you assess your child’s current condition

SECTION 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 13 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.

Section 3: CIS - Parent Version (Continued)

Grantee Staff: Please circle the number that the caregiver thinks best describes the child's situation:

0	1	2	3	4	
No problem				Very problem	bad

[READ THE FOLLOWING QUESTIONS TO THE CAREGIVER.]

In general, how much of a problem or difficulty 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

SECTION 4: BITSEA: BRIEF INFANT-TODDLER SOCIAL AND EMOTIONAL ASSESSMENT

Administer to caregivers of children ages 0 to 4 years 11 months
IF THE CHILD IS 5 YEAR OR OLDER SKIP TO SECTION 5 PEDIATRIC SYMPTOM CHECKLIST

The BITSEA is a brief comprehensive screening instrument that evaluates social and emotional behavior in very young children.

BITSEA

Parent Form

Child's name _____ Sex ☐ Boy ☐ Girl Date of birth ____/____/____

Parent/Guardian's name _____ Date of test ____/____/____

Was your child born prematurely? ☐ No ☐ Yes If yes, what was the expected date of birth? ____/____/____

Instructions: Many statements describe normal feelings and behaviors, but some describe feelings and behaviors that may be problems. Please do your best to respond to every item. Please circle the ONE response that best describes your child's behavior in the LAST MONTH.

	0 = Not true / Rarely	1 = Somewhat true / Sometimes	2 = Very true / Often	
1.	Shows pleasure when he or she succeeds (for example, claps for self).	0 1 2	*	
2.	Gets hurt so often that you can't take your eyes off him or her.	0 1 2		
3.	Seems nervous, tense, or fearful.	0 1 2		
4.	Is restless and can't sit still.	0 1 2		
5.	Follows rules.	0 1 2	*	
6.	Wakes up at night and needs help to fall asleep again.	0 1 2		
7.	Cries or has a tantrum until he or she is exhausted.	0 1 2		
8.	Is afraid of certain places, animals or things. *What is he or she afraid of?* _____	0 1 2		
9.	Has less fun than other children.	0 1 2		
10.	Looks for you (or other parent) when upset.	0 1 2	*	
11.	Cries or hangs onto you when you try to leave.	0 1 2		
12.	Worries a lot or is very serious.	0 1 2		
13.	Looks right at you when you say his or her name.	0 1 2	*	
14.	Does not react when hurt.	0 1 2		
15.	Is affectionate with loved ones.	0 1 2	*	
16.	Won't touch some objects because of how they feel.	0 1 2		
17.	Has trouble falling asleep or staying asleep.	0 1 2		
18.	Runs away in public places.	0 1 2		
19.	Plays well with other children (not including brother/sister). (Circle N if there is no contact with other children)	N 0 1 2	*	
20.	Can pay attention for a long time (other than when watching TV).	0 1 2	*	
21.	Has trouble adjusting to changes.	0 1 2		
22.	Tries to help when someone is hurt (for example, gives a toy).	0 1 2	*	
23.	Often gets very upset.	0 1 2		
24.	Gags or chokes on food.	0 1 2		
25.	Imitates playful sounds when you ask him or her to.	0 1 2	*	
26.	Refuses to eat.	0 1 2		
27.	Hits, shoves, kicks, or bites children (not including brother/sister). (Circle N if there is no contact with other children)	N 0 1 2		
28.	Is destructive. Breaks or ruins things on purpose.	0 1 2		
29.	Points to show you something far away.	0 1 2	*	
30.	Hits, bites or kicks you (or other parent).	0 1 2		
31.	Hugs or feeds dolls or stuffed animals.	0 1 2	*	
32.	Seems very unhappy, sad, depressed, or withdrawn.	0 1 2		
33.	Purposely tries to hurt you (or other parent).	0 1 2		
34.	When upset, gets very still, freezes, or doesn't move.	0 1 2		

The following statements describe feelings and behaviors that can be problems for young children. Some of the descriptions may be a bit hard to understand, especially if you have not seen the behavior in your child. Please do your best to respond to all statements. Please circle the ONE response that best describes your child's behavior in the LAST MONTH.

35.	Puts things in a special order over and over and gets upset if he or she is interrupted.	0 1 2	
36.	Repeats the same action or phrase over and over without enjoyment. *Please give an example:* _____	0 1 2	
37.	Repeats a particular movement over and over (like rocking, spinning). *Please give an example:* _____	0 1 2	
38.	Spaces out. Is totally unaware of what's happening around him or her.	0 1 2	
39.	Does not make eye contact.	0 1 2	
40.	Avoids physical contact.	0 1 2	
41.	Hurts self on purpose (for example, bangs his or her head). *Please describe:* _____	0 1 2	
42.	Eats or drinks things that are not edible (like paper or paint). *Please describe:* _____	0 1 2	

	1 = Not at all worried	2 = A little worried	3 = Worried	4 = Very worried
A.	How worried are you about your child's behavior, emotions, or relationships?	1 2 3 4		
B.	How worried are you about your child's language development?	1 2 3 4		

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SECTION 5: PEDIATRIC SYMPTOM CHECKLIST—PARENT REPORT (P-PSC-17)

ADMINISTER TO CAREGIVERS OF CHILDREN AGES 5 AND OVER:

IF CHILD IS 1 TO 18 MONTHS SKIP TO SECTION 6: BABY PEDIATRIC SYMPTOM CHECKLIST (PPSC)

IF CHILD IS 18 TO 60 MONTHS SKIP TO SECTION 7: PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST (PPSC)

[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 <u>in the past 6 months</u>.

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

SECTION 6: BABY PEDIATRIC SYMPTOM CHECKLIST (BPSC)

ADMINISTER TO CAREGIVERS OF CHILDREN AGES 1 MONTH TO 17 MONTHS

IF CHILD IS 18 TO 60 MONTHS SKIP TO SECTION 7: PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST (PPSC)

IF CHILD IS AGE 5 OR OVER SKIP TO SECTION 8: CAREGIVER STRAIN QUESTIONNAIRE

The Baby Pediatric Symptom Checklist is a brief social/emotional screening instrument for children less than 18 months.

BPSC:

1 month, 0 days to 17 months, 31 days
V1.05, 5/16/16

Child's Name:

Birth Date:

Today's Date:

BABY PEDIATRIC SYMPTOM CHECKLIST (BPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

	Not at all	Somewhat	Very Much
Does your child have a hard time being with new people?	0	1	2
Does your child have a hard time in new places?	0	1	2
Does your child have a hard time with change?	0	1	2
Does your child mind being held by other people?	0	1	2
Does your child cry a lot?	0	1	2
Does your child have a hard time calming down?	0	1	2
Is your child fussy or irritable?	0	1	2
Is it hard to comfort your child?	0	1	2
Is it hard to keep your child on a schedule or routine?	0	1	2
Is it hard to put your child to sleep?	0	1	2
Is it hard to get enough sleep because of your child?	0	1	2
Does your child have trouble staying asleep?	0	1	2

Floating Hospital for Children at Tufts Medical Center

SECTION 7: PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST (PPSC)

ADMINISTER TO CAREGIVERS OF CHILDREN AGES 18 MONTHS TO 60 MONTHS
IF CHILD'S AGE IS NOT BETWEEN 18 MONTHS TO 60 MONTHS SKIP TO SECTION 8: CAREGIVER STRAIN QUESTIONNAIRE

The Preschool Pediatric Symptom Checklist is a social/emotional screening instrument for children 18–60 months of age.

PPSC:

18 months, 0 days to 65 months, 31 days
V1.05, 5/16/16

Child's Name:

Birth Date:

Today's Date:

PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST (PPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

		Not at all	Somewhat	Very Much
Does your child...	Seem nervous or afraid?	0	1	2
	Seem sad or unhappy?	0	1	2
	Get upset if things are not done in a certain way?	0	1	2
	Have a hard time with change?	0	1	2
	Have trouble playing with other children?	0	1	2
	Break things on purpose?	0	1	2
	Fight with other children?	0	1	2
	Have trouble paying attention?	0	1	2
	Have a hard time calming down?	0	1	2
	Have trouble staying with one activity?	0	1	2
Is your child...	Aggressive?	0	1	2
	Fidgety or unable to sit still?	0	1	2
	Angry?	0	1	2
Is it hard to...	Take your child out in public?	0	1	2
	Comfort your child?	0	1	2
	Know what your child needs?	0	1	2
	Keep your child on a schedule or routine?	0	1	2
	Get your child to obey you?	0	1	2

Floating Hospital for Children at Tufts Medical Center

SECTION 8: 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?.....	☐	☐	☐	☐	☐	☐

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?.....	☐	☐	☐	☐	☐	☐

End of Instrument:

Thank you for participating in the child and family outcomes portion of the CMHI National Evaluation.

CHILDREN'S MENTAL HEALTH INITIATIVE
NATIONAL 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 well-being of children and their families while they are participating and receiving services from the Systems of Care.

CONFIDENTIALITY/INFORMED CONSENT

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.

CHILDREN'S MENTAL HEALTH INITIATIVE
NATIONAL EVALUATION
CHILD AND FAMILY OUTCOMES

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 15 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 be used only 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, Dr. Kirstin Painter, at 240-276-1932.

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: ___/___/____

CHILD/YOUTH VERSION

INSTRUCTIONS

This version will be administered directly to children ages 11 to 17 at baseline/entry into services and at 6 and 12 months as well as at discharge. This version includes the following:

Section 1: Administrative Data
Section 2: Functioning
Section 3: Columbia Impairment Scale – self-report
Section 4: BITSEA: Brief Infant-Toddler Social and Emotional Assessment – Intentionally missing
Section 5: Pediatric Symptom Checklist-17 – self-report
Section 6: Baby Pediatric Symptom Checklist (BPSC) - Intentionally missing
Section 7: Preschool Pediatric Symptom Checklist (PPSC) - Intentionally missing
Section 8: Caregiver Strain Questionnaire - Intentionally missing

There are two components of this instrument. Subsection 1 (administrative data, including CMHI services received) are answered by staff using information from administrative and clinical records for the child receiving services. Sections 2, 3, and 5 are to be administered verbally to the youth by local systems staff. Before administering the instrument to the child/youth, please ask them to sign the consent/assent form.

IDENTIFYING INFORMATION: COLLECTED AT BASELINE, REASSESSMENT AND DISCHARGE

Client ID |____|____|____|____|____|____|____|____|____|____|____|____|

Contract/Grant ID |____|____|____|____|____|____|____|____|____|____|

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

1. Interview Type (SELECT ONLY ONE TYPE.)

- ☐ Baseline
- ☐ Reassessment: |____|____| months (e.g., enter 06 for six months; enter 12 for one year)
- ☐ Discharge: Client completed services
- ☐ Discharge: Administrative

2. Was the interview conducted?

- ☐ Yes
- ☐ No

3. If an interview was conducted, when did it take place?

Interview Date: |____|____| / |____|____| / |____|____|____|____|
Month Day Year

SECTION 1: ADMINISTRATIVE DATA

[SECTION 1 ADMINISTRATIVE DATA IS COMPILED BY GRANTEE STAFF FROM RECORDS AT BASELINE.
IF THIS IS A BASELINE, GO TO QUESTION 1 BELOW. IF THIS IS NOT A BASELINE, SKIP TO QUESTION 10.]

1. What is the child's date of birth?

(MONTH AND YEAR MUST BE ENTERED. DAY IS OPTIONAL.)

Date of Birth: |____|____| / |____|____| / |____|____|____|____|
Month Day Year

- ☐ Declined
- ☐ Don't Know/Information Not Available

2. Is the child Hispanic, Latino/a, or of Spanish origin? (ONE OR MORE CATEGORIES MAY BE SELECTED.)

- ☐ Yes, Central American
- ☐ Yes, Cuban
- ☐ Yes, Dominican
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, South American
- ☐ Yes, another Hispanic, Latino/a, or Spanish Origin (Specify): _____
- ☐ No, not of Hispanic, Latino/a, or Spanish Origin
- ☐ Declined
- ☐ Don't Know/Information Not Available

3. What is the child's race? (ONE OR MORE CATEGORIES MAY BE SELECTED.)

- ☐ White
- ☐ Black or African American
- ☐ American Indian
- ☐ Alaska Native
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Declined
- ☐ Don't Know/Information Not Available

4. What is the child's gender?

- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ Other (Specify): _____
- ☐ Refused

5. (ONLY FOR CLIENTS 12 YEARS OF AGE OR OLDER): Which one of the following does the child consider him/herself to be?

- ☐ Straight
- ☐ Lesbian (IF FEMALE) or Gay (IF MALE)
- ☐ Bisexual
- ☐ Declined
- ☐ Don't Know/Information Not Available

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

6a. First assessment for the system of care?

|____|____| / |____|____| / |____|____|____|____|
Month Day Year

6b. First <u>service</u> (after assessment) received through the system of care?

|____|____| / |____|____| / |____|____|____|____|
Month Day Year

6c. Most recent service planning team meeting in the system-of-care?

|____|____| / |____|____| / |____|____|____|____|
Month Day Year

7. 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): _____

8. 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/Educational Facility/Staff
- ☐ Early Intervention
- ☐ Child Welfare/Child Protective Services
- ☐ Family Court
- ☐ Juvenile Court/Corrections/Probation/Police
- ☐ Caregiver
- ☐ Child/Youth referred himself or herself
- ☐ Other (*Please specify:* _____)

9. 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/Educational 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)
- ☐ 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/youth's health (cancer, illness, or disease related-problems)
- ☐ Other (*Please specify:* _____)

10. 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/Educational Facility
- ☐ Early Care
- ☐ Child Welfare/Child Protective Services
- ☐ Family Court
- ☐ Juvenile Court/Corrections/Probation/Police
- ☐ Other (Please specify: _____)

11. During the past 6 months, was the child/youth insured through...? (SELECT ALL THAT APPLY.)

- ☐ Medicaid
- ☐ CHIP
- ☐ SSI
- ☐ Private Insurance
- ☐ Other (Specify): _____
- ☐ No insurance

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

_____

Please note: To obtain the census block group of the consumer, you will need the consumer's address. This should be obtained from consumer records. The address must be entered into the system to generate the census block; however, the system will not save the address of the consumer, only the census block group.

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

|____|____| / |____|____| / |____|____|____|____|
Month Day Year

14. Which diagnostic classification system was used?

- ☐ DSM-IV-TR
- ☐ DSM-V
- ☐ ICD-10

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

	Diagnostic code	**Diagnosis name**
15a. Primary Diagnosis	_____.____	_____
15b. Secondary Diagnosis	_____.____	_____
15c. Additional Diagnosis	_____.____	_____

[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 = |____|____|____|

[IF THIS IS A BASELINE:
IF AN INTERVIEW WAS CONDUCTED: GO TO SECTION 2, FUNCTIONING
IF AN INTERVIEW WAS NOT CONDUCTED: STOP; DATA COLLECTION IS COMPLETE.]

[IF THIS IS A REASSESSMENT OR DISCHARGE, CONTINUE TO NEXT PAGE SERVICES RECEIVED.]

Administrative Data Subsection 2: Services Received

[SUBSECTION 2 IS REPORTED BY GRANTEE STAFF AT REASSESSMENT AND DISCHARGE]

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		Unknown	Service Not Available
	Yes	No		
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 _____

	Provided		Unknown	Service Not Available
	Yes	No		
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?.....	☐	☐	☐	☐

Subsection 2: Services Received (Continued)

Support Services	Provided		Unknown	Service Not Available
	Yes	No		
1. Medical Care.....	☐	☐	☐	☐
2. Employment Services.....	☐	☐	☐	☐
3. Family 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.....	☐	☐	☐	☐
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.....	☐	☐	☐	☐

Subsection 3: Reassessment Status

[SUBSECTION 3 IS REPORTED BY GRANTEE STAFF AT REASSESSMENT.]

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

☐ Yes
☐ No

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

☐ Yes
☐ No

Subsection 4: Clinical Discharge Status

[SUBSECTION 4 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

[IF AN INTERVIEW WAS CONDUCTED, GO TO SECTION 2, FUNCTIONING]

SECTION 2: FUNCTIONING

Subsection A: Family/Living Arrangement is intentionally excluded from this version; it appears in the Caregiver version. Continue to Subsection B.

Subsection 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 everyday life <u>during the past 30 days</u>. 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						
	S trongly	D isagree	U ndecided	A gree	S trongly	R efused	N ot
a. I am handling daily life.....	☐	☐	☐	☐	☐	☐	☐
b. I get along with family members.....	☐	☐	☐	☐	☐	☐	☐
c. I get along with friends and other people.....	☐	☐	☐	☐	☐	☐	☐
d. I am doing well in school and/or work.....	☐	☐	☐	☐	☐	☐	☐
e. I am able to cope when things go wrong.....	☐	☐	☐	☐	☐	☐	☐
f. I am satisfied with our family life right now.....	☐	☐	☐	☐	☐	☐	☐

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	Most of	Some of the	A little of	None of the	Refused	Not
a. nervous?.....	☐	☐	☐	☐	☐	☐	☐
b. hopeless?.....	☐	☐	☐	☐	☐	☐	☐
c. restless or fidgety?.....	☐	☐	☐	☐	☐	☐	☐
d. so depressed that nothing could cheer you up?.....	☐	☐	☐	☐	☐	☐	☐
e. that everything was an effort?.....	☐	☐	☐	☐	☐	☐	☐
f. worthless?.....	☐	☐	☐	☐	☐	☐	☐

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…	N ever	O nce or	W eekly	D aily or	R efused	N ot
a. tobacco products (cigarettes, chewing tobacco, cigars, etc.)?.....	☐	☐	☐	☐	☐	☐
b. alcoholic beverages (beer, wine, liquor, etc.)?.....	☐	☐	☐	☐	☐	☐
b1. **[IF B >= ONCE OR TWICE, AND RESPONDENT MALE],** How many times in the past 30 days have you had five or more drinks in a day*?*..... **[CLARIFY IF NEEDED: A standard alcoholic beverage (e.g., 12 oz. beer, 5 oz. wine, 1.5 oz. liquor)].**	☐	☐	☐	☐	☐	☐
b2. **[IF B >= ONCE OR TWICE, AND RESPONDENT NOT MALE],** How many times in the past 30 days have you had four or more drinks in a day?..... **[CLARIFY IF NEEDED: A standard alcoholic beverage (e.g., 12 oz. beer, 5 oz. wine, 1.5 oz. liquor)]**	☐	☐	☐	☐	☐	☐
c. cannabis (marijuana, pot, grass, hash, etc.)?.....	☐	☐	☐	☐	☐	☐
d. cocaine (coke, crack, etc.)?.....	☐	☐	☐	☐	☐	☐
e. prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)?.....	☐	☐	☐	☐	☐	☐
f. methamphetamine (speed, crystal meth, ice, etc.)?.....	☐	☐	☐	☐	☐	☐
g. inhalants (nitrous oxide, glue, gas, paint thinner, etc.)?.....	☐	☐	☐	☐	☐	☐
h. sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)?.....	☐	☐	☐	☐	☐	☐

Subsection B: Functioning (Continued)

Question	Response Options					
In the past 30 days, how often have you used…	Never	Once or twice	Weekly	Daily or almost daily	Refused	Not at
i. hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)?.....	☐	☐	☐	☐	☐	☐
j. street opioids (heroin, opium, etc.)?.....	☐	☐	☐	☐	☐	☐
k. prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)?.....	☐	☐	☐	☐	☐	☐
l. other – specify (e-cigarettes, etc.):_____...	☐	☐	☐	☐	☐	☐

MILITARY FAMILY AND DEPLOYMENT

QUESTION 5 IS NOT ASKED IN THE CHILD/YOUTH PROTOCOL

[QUESTION 6 IS ASKED ONLY AT BASELINE. IF THIS IS NOT A BASELINE, SKIP QUESTION 6].

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
- ☐ Refused
- ☐ Don't know

Subsection 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?.....	|____|____|	☐	☐
b. nights have you spent in a hospital for mental health care?.....	|____|____|	☐	☐
c. nights have you spent in a facility for detox/inpatient or residential substance abuse treatment?.....	|____|____|	☐	☐
d. nights have you spent in correctional facility including juvenile detention, jail, or prison?.....	|____|____|	☐	☐
[ADD UP THE TOTAL NUMBER OF NIGHTS SPENT HOMELESS, IN HOSPITAL FOR MENTAL HEALTH CARE, IN DETOX/INPATIENT OR RESIDENTIAL SUBSTANCE ABUSE TREATMENT, OR IN A CORRECTIONAL FACILITY. (ITEMS A-D, CANNOT EXCEED 30 NIGHTS).]	|____|____|		
e. times have you gone to an emergency room for a psychiatric or emotional problem?.....	|____|____|	☐	☐
[IF 1A, 1B, 1C, OR 1D IS 16 OR MORE NIGHTS, GO TO SUBSECTION D.]	|____|____|	☐	☐

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

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

- ☐ Caregiver's owned or rented house, apartment, trailer, or room
- ☐ Independent owned or rented house, apartment, trailer or room
- ☐ Someone else's house, apartment, trailer, or room
- ☐ Homeless (shelter, street/outdoors, park)
- ☐ Group home
- ☐ Foster care (specialized therapeutic treatment)
- ☐ Transitional living facility
- ☐ Hospital (medical)
- ☐ Hospital (psychiatric)
- ☐ Detox/inpatient or residential substance abuse treatment facility
- ☐ Correctional facility (juvenile detention center/jail/prison)
- ☐ Other housed (specify): _____
- ☐ Refused
- ☐ Don't know

Subsection D: Education

1. During the past 30 days of school, how many days were you absent for any reason?

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

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

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

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

- ☐ Never attended
- ☐ Preschool
- ☐ Kindergarten
- ☐ 1ST grade
- ☐ 2ND grade
- ☐ 3RD grade
- ☐ 4TH grade
- ☐ 5TH grade
- ☐ 6TH grade
- ☐ 7TH grade
- ☐ 8TH grade
- ☐ 9TH grade
- ☐ 10TH grade
- ☐ 11TH grade
- ☐ 12TH grade/High School Diploma/Equivalent (GED)
- ☐ Voc/Tech diploma
- ☐ Some college or university
- ☐ Refused
- ☐ Don't Know

Subsection 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 SUBSECTION G. OTHERWISE, GO TO SUBSECTION F.]

Subsection F: Perception of Care

[SUBSECTION F IS NOT COLLECTED AT BASELINE. FOR BASELINE INTERVIEWS, GO TO SUBSECTION 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 <u>during the past 30 days</u>, 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					
	S trongly	D isagree	U ndecided	A gree	S trongly	R efused
a. Staff here treated me with respect.....	☐	☐	☐	☐	☐	☐
b. Staff respected my family's religious/spiritual beliefs.....	☐	☐	☐	☐	☐	☐
c. Staff spoke with me in a way that I understood.....	☐	☐	☐	☐	☐	☐
d. Staff was sensitive to my cultural/ethnic background.....	☐	☐	☐	☐	☐	☐
e. I helped choose my services.....	☐	☐	☐	☐	☐	☐
f. I helped to choose my treatment goals.....	☐	☐	☐	☐	☐	☐
g. I participated in my treatment.....	☐	☐	☐	☐	☐	☐
h. Overall, I am satisfied with the services I received.....	☐	☐	☐	☐	☐	☐
i. The people helping me stuck with me no matter what.....	☐	☐	☐	☐	☐	☐
j. I felt I had someone to talk to when I was troubled.....	☐	☐	☐	☐	☐	☐
k. The services I received were right for me.....	☐	☐	☐	☐	☐	☐
l. I got the help I wanted.....	☐	☐	☐	☐	☐	☐
m. I got as much help as I needed.....	☐	☐	☐	☐	☐	☐

2. ***[INDICATE WHO ADMINISTERED SUBSECTION F – PERCEPTION OF CARE TO THE CONSUMER 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): _____

Subsection 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 know people who will listen and understand me when I need to talk.....	☐	☐	☐	☐	☐	☐
b. I have people that I am comfortable talking with about my problems.....	☐	☐	☐	☐	☐	☐
c. In a crisis, I would have the support I need from family or friends.....	☐	☐	☐	☐	☐	☐
d. I have people with whom I can do enjoyable things.....	☐	☐	☐	☐	☐	☐

Subsection I: Network Analysis Survey for Child/Youth

The survey assesses relationships between you and members of your support team within your Children's Mental Health Initiative System of Care.

Instructions for the interviewer:
In the following section, I will ask you to name as many as 10 of the most important people that are involved in providing your mental health services. If there are more than 10 individuals, just name the first 10 that come to mind. I'll write these names in column 1 as you speak. For the remaining columns, I'll ask you to provide some additional information as they apply to the name you have listed in column 1.

Name	2. What is _____'s relationship to you? [select from list provided in interviewer guide]	3. What is _____'s organiza-tional affiliation?	4. Does _____ reside in the same city as you?	5. In your view, what type of resources does _____ bring to address your mental health needs?	6. Is _____ a member of your wraparound team?	7. In general, how frequently do you **interact** (e.g. communicate, visit) with _____ about mental health issues?	8. Which of the following best describes the **type of support** that you receive from _____ ?	9. To what degree do you **trust** _____ to meet your mental health needs?	10. How much **influence** does _____ have on decisions about your mental health needs?
Name 1			1 ☐Yes 2 ☐No 3☐Don't know	1. ☐Mental Health expertise 2.☐Health Expertise 3.☐Supports in Daily Living 4.☐Family support 5.☐Community Supports 6. ☐Advocacy	1☐Yes 2☐No	1☐Daily 2☐Weekly 3☐Monthly 4☐Every 2-3 months 5☐1-3 times a year	1☐Emotional 2☐Infomational 3☐Instrumental 4☐Appraisal [see interviewer guide for definitions]	1☐Not at all 2☐A small amount 3☐A fair amount 4☐A great deal	1☐None 2☐A small amount 3☐A fair amount 4☐A great deal
Name 2									
Name 3									
Name 4									
Name 5									
Name 6									
Name 7									

Name 8									
Name 9									
Name 10									

11. Based on your impressions, how well do the people listed above work together to meet your child's mental health needs?

1 ☐ Not at all well 2 ☐ Fairly well 3 ☐ Well 4 ☐ Very well

12. Is there anything else you would like to tell us about your support system for mental health services?

Interviewer Guide

Question 2. As an additional prompt, the interviewer may help respondents think of someone who is an important member of their support structure by referring to the list of relationships shown below.
Example: Can you think of any additional people who are important members of' your support structure? For instance, would you consider any individual like the ones in this list?

Professional staff	Community members	Family/Friends	Others in CMHI network
1. Physician – psychiatrist, pediatrician, other specialties 2. Nurse (RNs, NPs, PAs) 3. Pharmacist 4. Social worker 5. Therapist 6. Teacher 7. School nurse 8. Lawyer	9. Spiritual mentor/coach (chaplain, pastor) 10. Youth leader 11. Online support group 12. Probation officer	13. Mother 14. Father 15. Relative (grandparent, aunt/uncle, cousin etc.) 16. Friend 17. Foster parents	18. Organizations and groups from stakeholder interviews 19. Local Childhood Councils 20. Advocacy groups 21. Service Delivery Organization 22. State Department of Education

			23. State Health Department

Question 8.

Types of social support:

1. **Emotional support**: provides comfort, there when you needs someone to talk to
2. **Informational support**: provides useful tips and advice
3. **Instrumental support**: help you build skills, provide tangible service and aid
4. **Appraisal support**: help you assess your current condition

SECTION 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 13 areas of your behavior for you to rate on a scale 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.

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

Grantee Staff: Please circle the number that the child or youth thinks best describes his or her situation:

0	1	2	3	4	
No problem				Very problem	bad

[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	N/A	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

SECTION 4: BITSEA: BRIEF INFANT-TODDLER SOCIAL AND EMOTIONAL ASSESSMENT

THIS SECTION IS INTENTIONALLY EXCLUDED FROM THIS VERSION; IT APPEARS IN THE CAREGIVER VERSION.

SECTION 5: 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 <u>in the past 6 months</u>.

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

SECTION 6: BABY PEDIATRIC SYMPTOM CHECKLIST (BPSC)

SECTION 7: PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST (PPSC)

SECTION 8: CAREGIVER STRAIN QUESTIONNAIRE (CGSQ)

THESE SECTIONS ARE INTENTIONALLY EXCLUDED FROM THIS VERSION; THEY APPEAR IN THE CAREGIVER VERSION.

End of Instrument:

Thank you for participating in the child and family outcomes portion of the CMHI National Evaluation.

CHILDREN'S MENTAL HEALTH INITIATIVE
NATIONAL 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 well-being of children and their families while they are participating and receiving services from the Systems of Care.

CONFIDENTIALITY/INFORMED CONSENT

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 18-26)

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. 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 be used only 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 health care services or insurance coverage will not be affected by anything you say 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, Dr. Kirstin Painter, at 240-276-1932.

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 6 and 12 months as well as discharge. This version includes the following:

Section 1: Administrative Data
Section 2: Functioning
Section 3: Columbia Impairment Scale – self-report
Section 4: BITSEA: Brief Infant-Toddler Social and Emotional Assessment – Intentionally missing
Section 5: Pediatric Symptom Checklist-17 – self-report
Section 6: Baby Pediatric Symptom Checklist (BPSC) - Intentionally missing
Section 7: Preschool Pediatric Symptom Checklist (PPSC) - Intentionally missing
Section 8: Caregiver Strain Questionnaire - Intentionally missing

There are two components of this instrument. Section 1 (administrative data, including CMHI services received) are answered by staff using information from administrative and clinical records for the young adult receiving services. Sections 2, 3, and 5 are to be administered verbally to the youth by local systems staff. Before administering the instrument to the young adult, please ask them to sign the consent/assent form.

IDENTIFYING INFORMATION: COLLECTED AT BASELINE, REASSESSMENT AND DISCHARGE

Client ID |____|____|____|____|____|____|____|____|____|____|____|____|

Contract/Grant ID |____|____|____|____|____|____|____|____|____|____|

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

1. Interview Type (SELECT ONLY ONE TYPE.)

- ☐ Baseline
- ☐ Reassessment: |____|____| months (e.g., enter 06 for six months; enter 12 for one year)
- ☐ Discharge: Client completed services
- ☐ Discharge: Administrative

2. Was the interview conducted?

- ☐ Yes
- ☐ No

3. If an interview was conducted, when did it take place?

Interview Date: |____|____| / |____|____| / |____|____|____|____|
Month Day Year

SECTION 1: ADMINISTRATIVE DATA

[SECTION 1 ADMINISTRATIVE DATA IS COMPILED BY GRANTEE STAFF FROM RECORDS AT BASELINE.
IF THIS IS A BASELINE, GO TO QUESTION 1 BELOW. IF THIS IS NOT A BASELINE, SKIP TO QUESTION 10.]

1. What is the young adult's date of birth?

(MONTH AND YEAR MUST BE ENTERED. DAY IS OPTIONAL.)

Date of Birth: |____|____| / |____|____| / |____|____|____|____|
Month Day Year

- ☐ Declined
- ☐ Don't Know/Information Not Available

2. Is the young adult Hispanic, Latino/a, or of Spanish origin? (ONE OR MORE CATEGORIES MAY BE SELECTED.)

- ☐ Yes, Central American
- ☐ Yes, Cuban
- ☐ Yes, Dominican
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, South American
- ☐ Yes, another Hispanic, Latino/a, or Spanish Origin (Specify): _____
- ☐ No, not of Hispanic, Latino/a, or Spanish Origin
- ☐ Declined
- ☐ Don't Know/Information Not Available

3. What is the young adult's race? (ONE OR MORE CATEGORIES MAY BE SELECTED.)

- ☐ White
- ☐ Black or African American
- ☐ American Indian
- ☐ Alaska Native
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Declined
- ☐ Don't Know/Information Not Available

4. What is the young adult's gender?

- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ Other (Specify): _____
- ☐ Refused

5. Which one of the following does the young adult consider him/herself to be?

- ☐ Straight
- ☐ Lesbian (IF FEMALE) or Gay (IF MALE)
- ☐ Bisexual
- ☐ Declined
- ☐ Don't Know/Information Not Available

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

6a. First <u>assessment</u> for the system of care?

|____|____| / |____|____| / |____|____|____|____|
Month Day Year

6b. First <u>service</u> (after assessment) received through the system of care?

|____|____| / |____|____| / |____|____|____|____|
Month Day Year

6c. Most recent service planning team meeting in the system-of-care?

|____|____| / |____|____| / |____|____|____|____|
Month Day Year

7. 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): _____

8. 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/Educational Facility/Staff
- ☐ Early Intervention
- ☐ Child Welfare/Child Protective Services
- ☐ Family Court
- ☐ Juvenile Court/Corrections/Probation/Police
- ☐ Caregiver
- ☐ Young adult referred himself or herself
- ☐ Other (*Please specify:* _____)

Section 1: Administrative Data (Continued)

9. 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/Educational 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)
- ☐ Behavioral concerns (including aggression, severe defiance, acting out, impulsivity, recklessness, and excessive level of overactivity)
- ☐ Persistent noncompliance (when directed by caregivers/adults)
- ☐ Pervasive developmental disabilities (including autistic behaviors, extreme social avoidance, stereotypes, perseverative behavior)
- ☐ Other concerns/issues that are related to young adult's health (cancer, illness, or disease related-problems)
- ☐ Other (*Please specify:* _____)

10. 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/Educational Facility
- ☐ Early Intervention
- ☐ Child Welfare/Child Protective Services
- ☐ Family Court
- ☐ Juvenile Court/Corrections/Probation/Police
- ☐ Other (Please specify: _____)

11. During the past 6 months, was the young adult insured through...? (SELECT ALL THAT APPLY.)

- ☐ Medicaid
- ☐ CHIP
- ☐ SSI
- ☐ Private Insurance
- ☐ Other (Specify): _____
- ☐ No insurance

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

_____

Please note: To obtain the census block group of the consumer, you will need the consumer's address. This should be obtained from consumer records. The address must be entered into the system to generate the census block; however, the system will not save the address of the consumer, only the census block group.

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

|____|____| / |____|____| / |____|____|____|____|
Month Day Year

14. Which diagnostic classification system was used?

- ☐ DSM IV-TR
- ☐ DSM V
- ☐ ICD-10

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

	Diagnostic code	**Diagnosis name)**
15a. Primary Diagnosis	_____.____	_____
15b. Secondary Diagnosis	_____.____	_____
15c. Additional Diagnosis	_____.____	_____

[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 = |____|____|____|

[IF THIS IS A BASELINE:
IF AN INTERVIEW WAS CONDUCTED: GO TO SECTION 2, FUNCTIONING
IF AN INTERVIEW WAS NOT CONDUCTED: STOP; DATA COLLECTION IS COMPLETE.]

[IF THIS IS A REASSESSMENT OR DISCHARGE, CONTINUE TO NEXT PAGE SERVICES RECEIVED.]

Administrative Data Subsection 2: Services Received

[SUBSECTION 2 IS REPORTED BY GRANTEE STAFF AT REASSESSMENT AND DISCHARGE]

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		Unknown	Service Not Available
	Yes	No		
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 _____

	Provided		Unknown	Service Not Available
	Yes	No		
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?.....	☐	☐	☐	☐

Subsection 2: Services Received (Continued)

Support Services	Provided		Unknown	Service Not Available
	Yes	No		
1. Medical Care	☐	☐	☐	☐
2. Employment Services	☐	☐	☐	☐
3. Family 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	☐	☐	☐	☐
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	☐	☐	☐	☐

Subsection 3: Reassessment Status

[SUBSECTION 3 IS REPORTED BY GRANTEE STAFF AT REASSESSMENT.]

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

☐ Yes
☐ No

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

☐ Yes
☐ No

Subsection 4: Clinical Discharge Status

[SUBSECTION 4 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

[IF AN INTERVIEW WAS CONDUCTED, GO TO SECTION 2, FUNCTIONING]

SECTION 2: FUNCTIONING

Subsection A: Family/Living Arrangement

[READ THE FOLLOWING QUESTIONS TO THE YOUNG ADULT.]
[QUESTIONS 2, 3, AND 4 DO NOT APPLY TO THE YOUNG ADULT TOOL AND ARE OMITTED.]

1. Do you live alone?

- ☐ Yes **[GO TO 6]**
- ☐ No
- ☐ Refused **[GO TO 6]**
- ☐ Don't Know **[GO TO 6]**

1a. *[IF NO],* with whom do you live? (SELECT ALL THAT APPLY.)

- ☐ 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): _____
- ☐ Refused
- ☐ Don't Know

[QUESTION 5 IS ASKED ONLY AT BASELINE. IF THIS IS A REASSESSMENT OR DISCHARGE, SKIP TO QUESTION 6.]

5. 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

6. 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

7. 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

8. 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

9. [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?.....	☐	☐	☐	☐

[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]**

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

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

Subsection 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 everyday life <u>during the past 30 days</u>. 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						
	S trongly	D isagree	U ndecided	A gree	S trongly	R efused	N o
a. I am handling daily life.....	☐	☐	☐	☐	☐	☐	☐
b. I get along with family members.....	☐	☐	☐	☐	☐	☐	☐
c. I get along with friends and other people.....	☐	☐	☐	☐	☐	☐	☐
d. I am doing well in school and/or work.....	☐	☐	☐	☐	☐	☐	☐
e. I am able to cope when things go wrong.....	☐	☐	☐	☐	☐	☐	☐
f. I am satisfied with our family life right now.....	☐	☐	☐	☐	☐	☐	☐

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	Most of	Some of the	A little of	None of the	Refused	Not
a. nervous?.....	☐	☐	☐	☐	☐	☐	☐
b. hopeless?.....	☐	☐	☐	☐	☐	☐	☐
c. restless or fidgety?.....	☐	☐	☐	☐	☐	☐	☐
d. so depressed that nothing could cheer you up?.....	☐	☐	☐	☐	☐	☐	☐
e. that everything was an effort?.....	☐	☐	☐	☐	☐	☐	☐
f. worthless?.....	☐	☐	☐	☐	☐	☐	☐

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…	N ever	O nce or	W eekly	D aily or	R efused	N ot
a. tobacco products (cigarettes, chewing tobacco, cigars, etc.)?.....	☐	☐	☐	☐	☐	☐
b. alcoholic beverages (beer, wine, liquor, etc.)?.....	☐	☐	☐	☐	☐	☐
b1. **[IF B >= ONCE OR TWICE, AND RESPONDENT MALE],** How many times in the past 30 days have you had five or more drinks in a day*?*..... **[CLARIFY IF NEEDED: A standard alcoholic beverage (e.g., 12 oz. beer, 5 oz. wine, 1.5 oz. liquor)].**	☐	☐	☐	☐	☐	☐
b2. **[IF B >= ONCE OR TWICE, AND RESPONDENT NOT MALE],** How many times in the past 30 days have you had four or more drinks in a day?..... **[CLARIFY IF NEEDED: A standard alcoholic beverage (e.g., 12 oz. beer, 5 oz. wine, 1.5 oz. liquor)]**	☐	☐	☐	☐	☐	☐
c. cannabis (marijuana, pot, grass, hash, etc.)?.....	☐	☐	☐	☐	☐	☐
d. cocaine (coke, crack, etc.)?.....	☐	☐	☐	☐	☐	☐
e. prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)?.....	☐	☐	☐	☐	☐	☐
f. methamphetamine (speed, crystal meth, ice, etc.)?.....	☐	☐	☐	☐	☐	☐
g. inhalants (nitrous oxide, glue, gas, paint thinner, etc.)?.....	☐	☐	☐	☐	☐	☐
h. sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)?.....	☐	☐	☐	☐	☐	☐

Subsection B: Functioning (Continued)

Question	Response Options					
In the past 30 days, how often have you used…	Never	Once or twice	Weekly	Daily or almost daily	Refused	Not at all
i. hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)?.....	☐	☐	☐	☐	☐	☐
j. street opioids (heroin, opium, etc.)?.....	☐	☐	☐	☐	☐	☐
k. prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)?.....	☐	☐	☐	☐	☐	☐
l. other – specify (e-cigarettes, etc.):_____...	☐	☐	☐	☐	☐	☐

MILITARY FAMILY AND DEPLOYMENT

[QUESTIONS 5 AND 6 ARE ASKED ONLY AT BASELINE. IF THIS IS NOT A BASELINE, SKIP QUESTIONS 5 AND 6].

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

- ☐ Yes
- ☐ No
- ☐ Refused
- ☐ Don't know

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
- ☐ Refused
- ☐ Don't know

Subsection 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?.....	|____|____|	☐	☐
b. nights have you spent in a hospital for mental health care?.....	|____|____|	☐	☐
c. nights have you spent in a facility for detox/inpatient or residential substance abuse treatment?.....	|____|____|	☐	☐
d. nights have you spent in correctional facility including juvenile detention, jail, or prison?.....	|____|____|	☐	☐
[ADD UP THE TOTAL NUMBER OF NIGHTS SPENT HOMELESS, IN HOSPITAL FOR MENTAL HEALTH CARE, IN DETOX/INPATIENT OR RESIDENTIAL SUBSTANCE ABUSE TREATMENT, OR IN A CORRECTIONAL FACILITY. (ITEMS A-D, CANNOT EXCEED 30 NIGHTS).]	|____|____|		
e. times have you gone to an emergency room for a psychiatric or emotional problem?.....	|____|____|	☐	☐
[IF 1A, 1B, 1C, OR 1D IS 16 OR MORE NIGHTS, GO TO SUBSECTION D.]	|____|____|	☐	☐

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

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

- ☐ Caregiver's owned or rented house, apartment, trailer, or room
- ☐ Independent owned or rented house, apartment, trailer or room
- ☐ Someone else's house, apartment, trailer, or room
- ☐ Homeless (shelter, street/outdoors, park)
- ☐ Group home
- ☐ Foster care (specialized therapeutic treatment)
- ☐ Transitional living facility
- ☐ Hospital (medical)
- ☐ Hospital (psychiatric)
- ☐ Detox/inpatient or residential substance abuse treatment facility
- ☐ Correctional facility (juvenile detention center/jail/prison)
- ☐ Other housed (specify): _____
- ☐ Refused
- ☐ Don't know

Subsection D: Education

1. During the past 30 days of school, how many days were you absent for any reason?

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

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

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

2. What is the highest level of education you have finished, whether or not you (he/she has) received a degree?

- ☐ Never attended
- ☐ Preschool
- ☐ Kindergarten
- ☐ 1ST grade
- ☐ 2ND grade
- ☐ 3RD grade
- ☐ 4TH grade
- ☐ 5TH grade
- ☐ 6TH grade
- ☐ 7TH grade
- ☐ 8TH grade
- ☐ 9TH grade
- ☐ 10TH grade
- ☐ 11TH grade
- ☐ 12TH grade/High School Diploma/Equivalent (GED)
- ☐ Voc/Tech diploma
- ☐ Some college or university
- ☐ Refused
- ☐ Don't Know

Subsection 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 SUBSECTION G. OTHERWISE, GO TO SUBSECTION F.]

Subsection F: Perception of Care

[SUBSECTION F IS NOT COLLECTED AT BASELINE. FOR BASELINE INTERVIEWS, GO TO SUBSECTION 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 <u>during the past 30 days</u>, 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					
	S trongly	D isagree	U ndecided	A gree	S trongly	R efused
a. Staff here treated me with respect.....	☐	☐	☐	☐	☐	☐
b. Staff respected my family's religious/spiritual beliefs.....	☐	☐	☐	☐	☐	☐
c. Staff spoke with me in a way that I understood.....	☐	☐	☐	☐	☐	☐
d. Staff was sensitive to my cultural/ethnic background.....	☐	☐	☐	☐	☐	☐
e. I helped choose my services.....	☐	☐	☐	☐	☐	☐
f. I helped to choose my treatment goals.....	☐	☐	☐	☐	☐	☐
g. I participated in my treatment.....	☐	☐	☐	☐	☐	☐
h. Overall, I am satisfied with the services I received.....	☐	☐	☐	☐	☐	☐
i. The people helping me stuck with me no matter what.....	☐	☐	☐	☐	☐	☐
j. I felt I had someone to talk to when I was troubled.....	☐	☐	☐	☐	☐	☐
k. The services I received were right for me.....	☐	☐	☐	☐	☐	☐
l. I got the help I wanted.....	☐	☐	☐	☐	☐	☐
m. I got as much help as I needed.....	☐	☐	☐	☐	☐	☐

2. ***[INDICATE WHO ADMINISTERED SUBSECTION F – PERCEPTION OF CARE TO THE CONSUMER 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): _____

Subsection 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 know people who will listen and understand me when I need to talk.....	☐	☐	☐	☐	☐	☐
b. I have people that I am comfortable talking with about my problems.....	☐	☐	☐	☐	☐	☐
c. In a crisis, I would have the support I need from family or friends.....	☐	☐	☐	☐	☐	☐
d. I have people with whom I can do enjoyable things.....	☐	☐	☐	☐	☐	☐

Subsection H: Suicidality

[QUESTION 1 IS ASKED ONLY AT BASELINE. IF THIS IS A REASSESSMENT OR DISCHARGE INTERVIEW, SKIP TO QUESTION 2.]

This next question is about suicide.

1. You ever tried to kill yourself?

- ☐ Yes
- ☐ No
- ☐ Declined
- ☐ Don't Know/Information Not Available
- ☐ Not Applicable

[QUESTIONS 2 AND 3 ARE ONLY ASKED AT REASSESSMENT AND DISCHARGE. IF THIS IS A BASELINE INTERVIEW, SKIP TO SUBSECTION I.]

These next two questions are about suicide.

2. At any time in the past 6 months (including today), did you seriously think about trying to kill yourself?

- ☐ Yes
- ☐ No
- ☐ Declined
- ☐ Don't Know/Information Not Available
- ☐ Not Applicable

3. During the past 6 months (including today), did you try to kill yourself?

- ☐ Yes
- ☐ No
- ☐ Declined
- ☐ Don't Know/Information Not Available
- ☐ Not Applicable

Subsection I: Network Analysis Survey for Young Adult

The survey assesses relationships between you and members of your support team within your Children's Mental Health Initiative System of Care.

Instructions for the interviewer:
In the following section, I will ask you to name as many as 10 of the most important people that are involved in providing your mental health services. If there are more than 10 individuals, just name the first 10 that come to mind. I'll write these names in column 1 as you speak. For the remaining columns, I'll ask you to provide some additional information as they apply to the name you have listed in column 1.

Name	2. What is _____'s relationship to you? [select from list provided in interviewer guide]	3. What is _____'s organiza-tional affiliation?	4. Does _____ reside in the same city as you?	5. In your view, what type of resources does _____ bring to address your mental health needs?	6. Is _____ a member of your wraparound team?	7. In general, how frequently do you **interact** (e.g. communicate, visit) with _____ about mental health issues?	8. Which of the following best describes the **type of support** that you receive from _____?	9. To what degree do you **trust** _____ to meet your mental health needs?	10. How much **influence** does _____ have on decisions about your mental health needs?
Name 1			1 ☐Yes 2 ☐No 3☐Don't know	1. ☐Mental Health expertise 2.☐Health Expertise 3.☐Supports in Daily Living 4.☐Family support 5.☐Community Supports 6. ☐Advocacy	1☐Yes 2☐No	1☐Daily 2☐Weekly 3☐Monthly 4☐Every 2-3 months 5☐1-3 times a year	1☐Emotional 2☐Infomational 3☐Instrumental 4☐Appraisal [see interviewer guide for definitions]	1☐Not at all 2☐A small amount 3☐A fair amount 4☐A great deal	1☐None 2☐A small amount 3☐A fair amount 4☐A great deal
Name 2									
Name 3									
Name 4									
Name 5									
Name 6									
Name 7									

Name 8									
Name 9									
Name 10									

11. Based on your impressions, how well do the people listed above work together to meet your child's mental health needs?

1 ☐ Not at all well 2 ☐ Fairly well 3 ☐ Well 4 ☐ Very well

12. Is there anything else you would like to tell us about your support system for mental health services?

Interviewer Guide

Question 2. As an additional prompt, the interviewer may help respondents think of someone who is an important member of their support structure by referring to the list of relationships shown below.

Example: Can you think of any additional people who are important members of' your support structure? For instance, would you consider any individual like the ones in this list?

Professional staff	Community members	Family/Friends	Others in CMHI network
1. Physician – psychiatrist, pediatrician, other specialties 2. Nurse (RNs, NPs, PAs) 3. Pharmacist 4. Social worker 5. Therapist 6. Teacher 7. School nurse	9. Spiritual mentor/coach (chaplain, pastor) 10. Youth leader 11. Online support group 12. Probation officer	13. Mother 14. Father 15. Relative (grandparent, aunt/uncle, cousin etc.) 16. Friend 17. Foster parents	18. Organizations and groups from stakeholder interviews 19. Local Childhood Councils 20. Advocacy groups 21. Service Delivery Organization 22. State Department of

8. Lawyer			Education 23. State Health Department

Question 8.

Types of social support:

1. **Emotional support**: provides comfort, there when you needs someone to talk to
2. **Informational support**: provides useful tips and advice
3. **Instrumental support**: help you build skills, provide tangible service and aid
4. **Appraisal support**: help you assess your current condition

SECTION 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.

Section 3: CIS – Youth Version (Continued)

Grantee Staff: Please circle the number that the young adult thinks best describes his or her situation:

0	1	2	3	4	
No problem				Very problem	bad

[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

SECTION 4: BITSEA: BRIEF INFANT-TODDLER SOCIAL AND EMOTIONAL ASSESSMENT

This section is intentionally excluded from this version; it appears in the Caregiver version.

SECTION 5: 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 <u>in the past 6 months</u>.

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

SECTION 6: BABY PEDIATRIC SYMPTOM CHECKLIST (BPSC)

SECTION 7: PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST (PPSC)

SECTION 8: CAREGIVER STRAIN QUESTIONNAIRE (CGSQ)

THESE SECTIONS ARE INTENTIONALLY EXCLUDED FROM THIS VERSION; THEY APPEAR IN THE CAREGIVER VERSION.

End of Instrument:

Thank you for participating in the child and family outcomes portion of the CMHI National Evaluation.