Form Approved

OMB No. 0930-0208

Expiration Date 01/31/2020

CSAT GPRA Client Outcome
Measures for Discretionary Programs

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# A. Record Management

Client ID |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|

Client Type:

 Treatment client

 Client in recovery

Contract/Grant ID |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|

Interview Type *[CIRCLE ONLY ONE TYPE.]*

Intake ***[GO TO INTERVIEW DATE.]***

6-month follow-up **→ → →** Did you conduct a follow-up interview? Yes No
***[IF NO, GO DIRECTLY TO SECTION I.]***

3-month follow-up ***[ADOLESCENT PORTFOLIO ONLY]* →**
Did you conduct a follow-up interview? Yes No
***[IF NO, GO DIRECTLY TO SECTION I.]***

Discharge **→ → →** Did you conduct a discharge interview? Yes No
***[IF NO, GO DIRECTLY TO SECTION J.]***

Interview Date |\_\_\_\_|\_\_\_\_| / |\_\_\_\_|\_\_\_\_| / |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|
 Month Day Year

# A. BEHAVIORAL HEALTH DIAGNOSES *[Reported by program staff.]*

**Please indicate the client’s current behavioral health diagnoses using the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM) codes listed below. Please note that some substance use disorder ICD-10-CM codes have been crosswalked to Diagnostic and Statistical Manual of Mental Disorders, (DSM-5) descriptors.**

**Select up to three diagnoses. For diagnosis selected, please indicate whether it is primary, secondary, or tertiary, if known. Only one diagnosis can be primary, only one can be secondary, and only one can be tertiary.**

|  | **Diagnosed?** | **For each diagnosis selected, please indicate whether diagnosis is primary, secondary or tertiary if known.** |
| --- | --- | --- |
|  | **Select up to three.** | **Primary** | **Secondary** | **Tertiary** |
| **SUBSTANCE USE DISORDER DIAGNOSES** |
|  |  |  |  |  |
| **Alcohol Related Disorders** |  |  |  |  |
| F10.10 – Alcohol use disorder, uncomplicated, mild |  |  |  |  |
| F10.11 – Alcohol use disorder, mild, in remission |  |  |  |  |
| F10.20 – Alcohol use disorder, uncomplicated, moderate/severe |  |  |  |  |
| F10.21 – Alcohol use disorder, moderate/severe, in remission |  |  |  |  |
| F10.9 – Alcohol use, unspecified |  |  |  |  |
| **Opioid related disorders** |  |  |  |  |
| F11.10 – Opioid use disorder, uncomplicated, mild |  |  |  |  |
| F11.11 – Opioid use disorder, mild, in remission |  |  |  |  |
| F11.20 – Opioid use disorder, uncomplicated, moderate/severe |  |  |  |  |
| F11.21 – Opioid use disorder, moderate/severe, in remission |  |  |  |  |
| F11.9 – Opioid use, unspecified |  |  |  |  |
| **Cannabis related disorders** |  |  |  |  |
| F12.10 – Cannabis use disorder, uncomplicated, mild |  |  |  |  |
| F12.11 – Cannabis use disorder, mild, in remission |  |  |  |  |
| F12.20 – Cannabis use disorder, uncomplicated, moderate/severe |  |  |  |  |
| F12.21 – Cannabis use disorder, moderate/severe, in remission |  |  |  |  |
| F12.9 – Cannabis use, unspecified |  |  |  |  |
| **Sedative, hypnotic, or anxiolytic related disorders** |  |  |  |  |
| F13.10 – Sedative, hypnotic, or anxiolytic-related use disorder, uncomplicated, mild |  |  |  |  |
| F13.11 – Sedative, hypnotic, or anxiolytic-related use disorder, mild, in remission |  |  |  |  |
| F13.20 – Sedative, hypnotic, or anxiolytic-related use disorder, uncomplicated, moderate/severe |  |  |  |  |
| F13.21 – Sedative, hypnotic, or anxiolytic-related use disorder, moderate/severe, in remission |  |  |  |  |
| F13.9 – Sedative, hypnotic, or anxiolytic-related use, unspecified |  |  |  |  |
| **Cocaine related disorders** |  |  |  |  |
| F14.10 – Cocaine use disorder, uncomplicated, mild |  |  |  |  |
| F14.11 – Cocaine use disorder, mild, in remission |  |  |  |  |
| F14.20 – Cocaine use disorder, uncomplicated, moderate/severe |  |  |  |  |
| F14.21 – Cocaine use disorder, moderate/severe, in remission |  |  |  |  |
| F14.9 – Cocaine use, unspecified |  |  |  |  |
| **Other stimulant related disorders** |  |  |  |  |
| F15.10 – Other stimulant use disorder, uncomplicated, mild |  |  |  |  |
| F15.11 – Other stimulant use disorder, mild, in remission |  |  |  |  |
| F15.20 – Other stimulant use disorder, uncomplicated, moderate/severe |  |  |  |  |
| F15.21 – Other stimulant use disorder, moderate/severe, in remission |  |  |  |  |
| F15.9 – Other stimulant use, unspecified  |  |  |  |  |
| **Hallucinogen related disorders** |  |  |  |  |
| F16.10 – Hallucinogen use disorder, uncomplicated, mild |  |  |  |  |
| F16.11 – Hallucinogen use disorder, mild, in remission |  |  |  |  |
| F16.20 – Hallucinogen use disorder, uncomplicated, moderate/severe |  |  |  |  |
| F16.21 – Hallucinogen use disorder moderate/severe, in remission |  |  |  |  |
| F16.9 – Hallucinogen use, unspecified |  |  |  |  |
| **Inhalant related disorders** |  |  |  |  |
| F18.10 – Inhalant use disorder, uncomplicated, mild |  |  |  |  |
| F18.11 – Inhalant use disorder, mild, in remission |  |  |  |  |
| F18.20 – Inhalant use disorder, uncomplicated, moderate/severe |  |  |  |  |
| F18.21 – Inhalant use disorder, moderate/severe, in remission |  |  |  |  |
| F18.9 – Inhalant use, unspecified |  |  |  |  |
| **Other psychoactive substance related disorders** |  |  |  |  |
| F19.10 – Other psychoactive substance use disorder, uncomplicated, mild |  |  |  |  |
| F19.11 – Other psychoactive substance use disorder, in remission |  |  |  |  |
| F19.20 – Other psychoactive substance use disorder, uncomplicated, moderate/severe |  |  |  |  |
| F19.21 – Other psychoactive substance use disorder, moderate/severe, in remission |  |  |  |  |
| F19.9 – Other psychoactive substance use, unspecified |  |  |  |  |
| **Nicotine dependence** |  |  |  |  |
| F17.20 – Tobacco use disorder, mild/moderate/severe |  |  |  |  |
| F17.21 – Tobacco use disorder, mild/moderate/severe, in remission |  |  |  |  |
| **MENTAL HEALTH DIAGNOSES**  |
| F20 – Schizophrenia |  |  |  |  |
| F21 – Schizotypal disorder |  |  |  |  |
| F22 – Delusional disorder |  |  |  |  |
| F23 – Brief psychotic disorder |  |  |  |  |
| F24 – Shared psychotic disorder |  |  |  |  |
| F25 – Schizoaffective disorders |  |  |  |  |
| F28 – Other psychotic disorder not due to a substance or known physiological condition |  |  |  |  |
| F29 – Unspecified psychosis not due to a substance or known physiological condition |  |  |  |  |
| F30 – Manic episode |  |  |  |  |
| F31 – Bipolar disorder |  |  |  |  |
| F32 – Major depressive disorder, single episode |  |  |  |  |
| F33 – Major depressive disorder, recurrent |  |  |  |  |
| F34 – Persistent mood [affective] disorders |  |  |  |  |
| F39 – Unspecified mood [affective] disorder |  |  |  |  |
| F40-F48 – Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders |  |  |  |  |
| F50 – Eating disorders |  |  |  |  |
| F51 – Sleep disorders not due to a substance or known physiological condition |  |  |  |  |
| F60.2 – Antisocial personality disorder |  |  |  |  |
| F60.3 – Borderline personality disorder |  |  |  |  |
| F60.0, F60.1, F60.4-F69 – Other personality disorders |  |  |  |  |
| F70-F79 – Intellectual disabilities |  |  |  |  |
| F80-F89 – Pervasive and specific developmental disorders |  |  |  |  |
| F90 – Attention-deficit hyperactivity disorders |  |  |  |  |
| F91 – Conduct disorders |  |  |  |  |
| F93 – Emotional disorders with onset specific to childhood  |  |  |  |  |
| F94 – Disorders of social functioning with onset specific to childhood or adolescence |  |  |  |  |
| F95 – Tic disorder |  |  |  |  |
| F98 – Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence |  |  |  |  |
| F99 – Unspecified mental disorder |  |  |  |  |

 🌕 DON’T KNOW

 🌕 NONE OF THE ABOVE

1. In the past 30 days, was this client diagnosed with an opioid use disorder?

 Yes

 No ***[SKIP TO 2.]***

 Don’t know ***[SKIP TO 2.]***

**a. *[IF YES]* In the past 30 days, which FDA-approved medication did the client receive for the treatment of this opioid use disorder? *[CHECK ALL THAT APPLY.]***

 Methadone ***[IF RECEIVED]*** Specify how many days received |\_\_\_|\_\_\_|

 Buprenorphine ***[IF RECEIVED]*** Specify how many days received |\_\_\_|\_\_\_|

 Naltrexone ***[IF RECEIVED]*** Specify how many days received |\_\_\_|\_\_\_|

 Extended‒release Naltrexone ***[IF RECEIVED]*** Specify how many days received |\_\_\_|\_\_\_|

 Client did not receive an FDA-approved medication for an opioid use disorder

 Don’t know

1. In the past 30 days, was this client diagnosed with an alcohol use disorder?

 Yes

 No ***[SKIP TO 3 IF INTAKE. SKIP TO SECTION B IF FOLLOW-UP OR DISCHARGE.]***

 Don’t know ***[SKIP TO 3 IF INTAKE. SKIP TO SECTION B IF FOLLOW-UP OR DISCHARGE.]***

**a. *[IF YES]* In the past 30 days, which FDA-approved medication did the client receive for the treatment of this alcohol use disorder? *[CHECK ALL THAT APPLY.]***

 Naltrexone ***[IF RECEIVED]*** Specify how many days received |\_\_\_|\_\_\_|

 Extended‒release Naltrexone ***[IF RECEIVED]*** Specify how many days received |\_\_\_|\_\_\_|

 Disulfiram ***[IF RECEIVED]*** Specify how many days received |\_\_\_|\_\_\_|

 Acamprosate ***[IF RECEIVED]*** Specify how many days received |\_\_\_|\_\_\_|

 Client did not receive an FDA-approved medication for an alcohol use disorder

 Don’t know

##  [FOLLOW-UP AND DISCHARGE INTERVIEWS: SKIP TO SECTION B.]

3. Was the client screened by your program for co-occurring mental health and substance use disorders?

 YES

 NO ***[SKIP 3a.]***

3a. *[IF YES]* Did the client screen positive for co-occurring mental health and substance use
disorders?

 Yes

 No

***[sbirt continue. all others go to section a “planned services.”]***

### THIS SECTION FOR SBIRT GRANTS ONLY [ITEMS 4, 4a, & 5 - REPORTED ONLY AT INTAKE/BASELINE].

4. How did the client screen for your SBIRT?

 NEGATIVE

 POSITIVE

4a. What was his/her screening score? AUDIT = |\_\_\_\_|\_\_\_\_|

CAGE = |\_\_\_\_|\_\_\_\_|

DAST = |\_\_\_\_|\_\_\_\_|

DAST-10 = |\_\_\_\_|\_\_\_\_|

NIAAA Guide = |\_\_\_\_|\_\_\_\_|

ASSIST/Alcohol Subscore = |\_\_\_\_|\_\_\_\_|

Other (Specify) = |\_\_\_\_|\_\_\_\_|
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Was he/she willing to continue his/her participation in the SBIRT program?

 YES

 NO

# A. Record Management - Planned Services *[Reported by program staff about client only at intake/baseline.]*

**Identify the services you plan to provide to the client during the client’s course of treatment/recovery. *[CIRCLE “Y” FOR YES OR “N” FOR NO FOR EACH ONE.]***

Modality Yes No

***[SELECT AT LEAST ONE MODALITY.]***

1. Case Management Y N

2. Day Treatment Y N

3. Inpatient/Hospital (Other Than Detox) Y N

4. Outpatient Y N

5. Outreach Y N

6. Intensive Outpatient Y N

7. Methadone Y N

8. Residential/Rehabilitation Y N

9. Detoxification (Select Only One)

A. Hospital Inpatient Y N

B. Free Standing Residential Y N

C. Ambulatory Detoxification Y N

10. After Care Y N

11. Recovery Support Y N

12. Other (Specify) Y N

***[SELECT AT LEAST ONE SERVICE.]***

Treatment Services Yes No

***[SBIRT GRANTS: You must circle “Y” for at least one of the Treatment Services numbered 1 through 4.]***

1. Screening Y N

2. Brief Intervention Y N

3. Brief Treatment Y N

4. Referral to Treatment Y N

5. Assessment Y N

6. Treatment/Recovery Planning Y N

7. Individual Counseling Y N

8. Group Counseling Y N

9. Family/Marriage Counseling Y N

10. Co-Occurring Treatment/
Recovery Services Y N

11. Pharmacological Interventions Y N

12. HIV/AIDS Counseling Y N

13. Other Clinical Services
(Specify) Y N

Case Management Services Yes No

1. Family Services (Including Marriage Education, Parenting, Child Development Services) Y N

2. Child Care Y N

3. Employment Service

A. Pre-Employment Y N

B. Employment Coaching Y N

4. Individual Services Coordination Y N

5. Transportation Y N

6. HIV/AIDS Service Y N

7. Supportive Transitional Drug-Free Housing Services Y N

8. Other Case Management Services
(Specify) Y N

Medical Services Yes No

1. Medical Care Y N

2. Alcohol/Drug Testing Y N

3. HIV/AIDS Medical Support & Testing Y N

4. Other Medical Services
(Specify) Y N

After Care Services Yes No

1. Continuing Care Y N

2. Relapse Prevention Y N

3. Recovery Coaching Y N

4. Self-Help and Support Groups Y N

5. Spiritual Support Y N

6. Other After Care Services
(Specify) Y N

Education Services Yes No

1. Substance Abuse Education Y N

2. HIV/AIDS Education Y N

3. Other Education Services
(Specify) Y N

Peer-to-Peer Recovery Support Services Yes No

1. Peer Coaching or Mentoring Y N

2. Housing Support Y N

3. Alcohol- and Drug-Free Social Activities Y N

4. Information and Referral Y N

5. Other Peer-to-Peer Recovery Support Services (Specify) Y N

# A. Record Management - Demographics *[Asked only at intake/baseline.]*

1. What is your gender?

 MALE

 FEMALE

 TRANSGENDER

 OTHER (SPECIFY)

 REFUSED

1. Are you Hispanic or Latino?

 YES

 NO

 REFUSED

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

 Yes No Refused

Central American Y N REFUSED

Cuban Y N REFUSED

Dominican Y N REFUSED

Mexican Y N REFUSED

Puerto Rican Y N REFUSED

South American Y N REFUSED

Other Y N REFUSED ***[IF YES, SPECIFY BELOW.]***(Specify)

1. What is your race? Please answer yes or no for each of the following. You may say yes to more than one.

 Yes No Refused

Black or African American Y N REFUSED

Asian Y N REFUSED

Native Hawaiian or other Pacific Islander Y N REFUSED

Alaska Native Y N REFUSED

White Y N REFUSED

American Indian Y N REFUSED

1. What is your date of birth?\*

|\_\_\_\_|\_\_\_\_| / |\_\_\_\_|\_\_\_\_| / ***[\*THE SYSTEM WILL ONLY SAVE MONTH AND YEAR.***
 Month Day ***TO MAINTAIN CONFIDENTIALITY, DAY IS NOT SAVED.]***

|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|
 Year

 REFUSED

# MILITARY FAMILY AND DEPLOYMENT

1. Have you ever served in the Armed Forces, in the Reserves, or in the National Guard? *[IF SERVED]* What area, the Armed Forces, Reserves, or National Guard did you serve?

 No

 Yes, in the armed forces

 Yes, in the Reserves

 Yes, in the national Guard

 Refused

 Don’t know

***[IF NO, REFUSED, OR DON’T KNOW, SKIP TO QUESTION A6.]***

5a. Are you currently on active duty in the Armed Forces, in the Reserves, or in the National Guard? *[IF ACTIVE]* What area, the Armed Forces, Reserves, or National Guard?

 No, separated or retired from the armed forces, reserves, or national guard

 Yes, in the armed forces

 Yes, in the Reserves

 Yes, in the national Guard

 Refused

 Don’t know

5b. Have you ever been deployed to a combat zone? *[CHECK ALL THAT APPLY.]*

 Never deployed

 Iraq or Afghanistan (e.g., OEF/OIF/OND)

 Persian Gulf (Operation Desert Shield/Desert Storm)

 Vietnam/Southeast Asia

 Korea

 WWII

 Deployed to a combat zone not listed above (e.g., Bosnia/Somalia)

 Refused

 Don’t know

***[SBIRT GRANTEES: FOR CLIENTS WHO SCREENED NEGATIVE, THE INTAKE INTERVIEW IS NOW COMPLETE.]***

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

 No

 Yes, only one

 Yes, more than one

 Refused

 Don’t know

***[IF NO, REFUSED, OR DON’T KNOW, SKIP TO SECTION B.]***

|  |
| --- |
| ***[IF YES, ANSWER FOR UP TO 6 PEOPLE]* What is the relationship of that person (Service Member) to you? *[WRITE RELATIONSHIP IN COLUMN HEADING]***1 = Mother 2 = Father3 = Brother 4 = Sister5 = Spouse 6 = Partner7 = Child 8 = Other (Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Has the Service Member experienced any of the following? *[CHECK ANSWER IN APPROPRIATE COLUMN FOR ALL THAT APPLY]*** | **\_\_\_\_\_\_\_\_\_(Relationship)1.** | **\_\_\_\_\_\_\_\_\_(Relationship)2.** | **\_\_\_\_\_\_\_\_\_(Relationship)3.** | **\_\_\_\_\_\_\_\_\_(Relationship)4.** | **\_\_\_\_\_\_\_\_\_(Relationship)5.** | **\_\_\_\_\_\_\_\_\_(Relationship)6.** |
| **6a. Deployed in support of combat operations (e.g., Iraq or Afghanistan)?** |  Yes No Refused Don’t know |  Yes No Refused Don’t know |  Yes No Refused Don’t know |  Yes No Refused Don’t know |  Yes No Refused Don’t know |  Yes No Refused Don’t know |
| **6b. Was physically injured during combat operations?** |  Yes No Refused Don’t know |  Yes No Refused Don’t know |  Yes No Refused Don’t know |  Yes No Refused Don’t know |  Yes No Refused Don’t know |  Yes No Refused Don’t know |
| **6c. Developed combat stress symptoms/ difficulties adjusting following deployment, including PTSD, depression, or suicidal thoughts?** |  Yes No Refused Don’t know |  Yes No Refused Don’t know |  Yes No Refused Don’t know |  Yes No Refused Don’t know |  Yes No Refused Don’t know |  Yes No Refused Don’t know |
| **6d. Died or was killed?** |  Yes No Refused Don’t know |  Yes No Refused Don’t know |  Yes No Refused Don’t know |  Yes No Refused Don’t know |  Yes No Refused Don’t know |  Yes No Refused Don’t know |

# B. Drug and Alcohol Use

 Number
 of Days REFUSED DON’T KNOW

1. During the past 30 days, how many days have you used the following:

a. Any alcohol *[IF ZERO, SKIP TO ITEM B1c.]* |\_\_\_\_|\_\_\_\_|

b1. Alcohol to intoxication (5+ drinks in one sitting) |\_\_\_\_|\_\_\_\_|

b2. Alcohol to intoxication (4 or fewer drinks in one sitting and felt high) |\_\_\_\_|\_\_\_\_|

c. Illegal drugs *[IF B1a OR B1c = 0, RF, DK, THEN SKIP TO ITEM B2.]* |\_\_\_\_|\_\_\_\_|

d. Both alcohol and drugs (on the same day) |\_\_\_\_|\_\_\_\_|

**Route of Administration Types:**1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV\*Note the usual route. For more than one route, choose the most severe. The routes are listed from least severe (1) to most severe (5).

2. During the past 30 days, how many days have you used any of the following: *[IF THE VALUE IN ANY ITEM B2a THROUGH B2i > 0, THEN THE VALUE IN B1c MUST BE > 0.]*

 Number
 of Days RF DK Route\* RF DK

a. Cocaine/Crack |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

b. Marijuana/Hashish (Pot, Joints, Blunts, Chronic, Weed, Mary Jane) |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

c. Opiates:

1. Heroin (Smack, H, Junk, Skag) |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

2. Morphine |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

3. Dilaudid |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

4. Demerol |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

5. Percocet |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

6. Darvon |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

7. Codeine |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

8. Tylenol 2, 3, 4 |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

9. OxyContin/Oxycodone |\_\_\_\_|\_\_\_\_| |\_\_\_\_| ‘

d. Non-prescription methadone |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

e. Hallucinogens/psychedelics, PCP (Angel Dust, Ozone, Wack, Rocket Fuel), MDMA (Ecstasy, XTC, X, Adam), LSD (Acid, Boomers, Yellow Sunshine), Mushrooms, or Mescaline |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

f. Methamphetamine or other amphetamines (Meth, Uppers, Speed, Ice, Chalk, Crystal, Glass, Fire, Crank) |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

# B. DRUG AND ALCOHOL USE (continued)

**Route of Administration Types:**1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV\*Note the usual route. For more than one route, choose the most severe. The routes are listed from least severe (1) to most severe (5).

2. During the past 30 days, how many days have you used any of the following: *[IF THE VALUE IN ANY ITEM B2a THROUGH B2i > 0, THEN THE VALUE IN B1c MUST BE > 0.]*

 Number
 of Days RF DK Route\* RF DK

g. 1. Benzodiazepines: Diazepam (Valium); Alprazolam (Xanax); Triazolam (Halcion); and Estasolam (Prosom and Rohypnol—also known as roofies, roche, and cope) |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

2. Barbiturates: Mephobarbital (Mebacut) and pentobarbital sodium (Nembutal) |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

3. Non-prescription GHB (known as Grievous Bodily Harm, Liquid Ecstasy, and Georgia Home Boy) |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

4. Ketamine (known as Special K or Vitamin K) |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

5. Other tranquilizers, downers, sedatives, or hypnotics |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

h. Inhalants (poppers, snappers, rush, whippets) |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

i. Other illegal drugs (Specify) |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

3. In the past 30 days, have you injected drugs? *[IF ANY ROUTE OF ADMINISTRATION IN B2a THROUGH B2i = 4 or 5, THEN B3 MUST = YES.]*

 YES

 NO

 Refused

 Don’t know

***[If no, refused, or don’t know, skip to Section C.]***

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

 Always

 More than half the time

 Half the time

 Less than half the time

 Never

 Refused

 Don’t know

# C. Family and Living Conditions

1. In the past 30 days, where have you been living most of the time? *[DO NOT READ RESPONSE OPTIONS TO CLIENT.]*

 Shelter (safe havens, transitional living center [TLC], low-demand facilities, reception centers, other temporary day or evening facility)

 Street/outdoors (sidewalk, doorway, park, public or abandoned building)

 Institution (hospital, nursing home, jail/prison)

 Housed: ***[if housed, check appropriate subcategory:]***

 Own/rent apartment, room, or house

 Someone else’s apartment, room, or house

 Dormitory/college residence

 Halfway house

 Residential treatment

 Other housed (Specify)

 Refused

 Don’t know

1. How satisfied are you with the conditions of your living space?

 Very Dissatisfied

 Dissatisfied

 Neither Satisfied nor Dissatisfied

 Satisfied

 Very Satisfied

 REFUSED

 DON’T KNOW

1. During the past 30 days, how stressful have things been for you because of your use of alcohol or other drugs? *[IF B1a OR B1c > 0, THEN C3 CANNOT = “NOT APPLICABLE.”]*

 Not at all

 Somewhat

 Considerably

 Extremely

 Not applicable ***[Use only if b1a and b1c = 0.]***

 Refused

 Don’t know

1. During the past 30 days, has your use of alcohol or other drugs caused you to reduce or give up important activities? *[IF B1a OR B1c > 0, THEN C4 CANNOT = “NOT APPLICABLE.”]*

 Not at all

 Somewhat

 Considerably

 Extremely

 Not applicable ***[Use only if b1a and b1c = 0.]***

 Refused

 Don’t know

# C. Family and Living Conditions (continued)

1. During the past 30 days, has your use of alcohol or other drugs caused you to have emotional problems? *[IF B1a OR B1c > 0, THEN C5 CANNOT = “NOT APPLICABLE.”]*

 Not at all

 Somewhat

 Considerably

 Extremely

 Not Applicable ***[use ONLY IF b1a and b1c = 0.]***

 Refused

 Don’t know

1. *[IF NOT MALE]* Are you currently pregnant?

 YES

 NO

 REFUSED

 DON’T KNOW

1. Do you have children?

 YES

 NO

 REFUSED

 DON’T KNOW

***[IF NO, REFUSED, OR DON’T KNOW, SKIP TO SECTION D.]***

a. How many children do you have? *[IF C7 = YES, THEN THE VALUE IN C7a MUST BE > 0.]*

|\_\_\_\_|\_\_\_\_|  Refused  Don’t know

b. Are any of your children living with someone else due to a child protection court order?

 YES

 NO

 REFUSED

 DON’T KNOW

***[IF NO, REFUSED, OR DON’T KNOW, SKIP TO ITEM C7d.]***

c. *[IF YES]* How many of your children are living with someone else due to a child protection court order? *[THE VALUE IN C7c CANNOT EXCEED THE VALUE IN C7a.]*

|\_\_\_\_|\_\_\_\_|  Refused  Don’t know

d. For how many of your children have you lost parental rights? *[THE CLIENT’S PARENTAL RIGHTS WERE TERMINATED.] [THE VALUE IN ITEM C7d CANNOT EXCEED THE VALUE IN C7a.]*

|\_\_\_\_|\_\_\_\_|  Refused  Don’t know

# D. Education, Employment, and Income

1. Are you currently enrolled in school or a job training program? *[IF ENROLLED]* Is that full time or part time? *[IF CLIENT IS INCARCERATED, CODE D1 AS “NOT ENROLLED.”]*

 Not enrolled

 Enrolled, full time

 Enrolled, part time

 Other (Specify)

 Refused

 Don’t know

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

 Never attended

 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

 College or university/1st year completed

 College or university/2nd year completed/associates degree (AA, AS)

 College or university/3rd year completed

 Bachelor’s degree (BA, BS) or higher

 VOC/tech program after high school but no VOC/tech diploma

 VOC/tech diploma after high school

 Refused

 Don’t know

1. Are you currently employed? *[CLARIFY BY FOCUSING ON STATUS DURING MOST OF THE PREVIOUS WEEK, DETERMINING WHETHER CLIENT WORKED AT ALL OR HAD A REGULAR JOB BUT WAS OFF WORK.] [IF CLIENT IS “ENROLLED, FULL TIME” IN D1 AND INDICATES “EMPLOYED, FULL TIME” IN D3, ASK FOR CLARIFICATION. IF CLIENT IS INCARCERATED AND HAS NO WORK OUTSIDE OF JAIL, CODE D3 AS “UNEMPLOYED, NOT LOOKING FOR 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

# D. Education, Employment, and Income (continued)

1. Approximately, how much money did YOU receive (pre-tax individual income) in the past 30 days from… *[IF D3 DOES NOT = “EMPLOYED” AND THE VALUE IN D4a IS GREATER THAN ZERO, PROBE. IF D3 = “UNEMPLOYED, LOOKING FOR WORK” AND THE VALUE IN D4b = 0, PROBE. IF D3 = “UNEMPLOYED, RETIRED” AND THE VALUE IN D4c = 0, PROBE. IF D3 = “UNEMPLOYED, DISABLED” AND THE VALUE IN D4d = 0, PROBE.]*

 RF DK

a. Wages $ |\_\_|\_\_|\_\_| , |\_\_|\_\_|\_\_|

b. Public assistance $ |\_\_|\_\_|\_\_| , |\_\_|\_\_|\_\_|

c. Retirement $ |\_\_|\_\_|\_\_| , |\_\_|\_\_|\_\_|

d. Disability $ |\_\_|\_\_|\_\_| , |\_\_|\_\_|\_\_|

e. Non-legal income $ |\_\_|\_\_|\_\_| , |\_\_|\_\_|\_\_|

f. Family and/or friends $ |\_\_|\_\_|\_\_| , |\_\_|\_\_|\_\_|

g. Other (Specify) $ |\_\_|\_\_|\_\_| , |\_\_|\_\_|\_\_|

1. Have you enough money to meet your needs?

 Not at all

 A little

 Moderately

 Mostly

 Completely

 REFUSED

 DON’T KNOW

# 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 NO ARRESTS, SKIP TO ITEM E3.]***

1. In the past 30 days, how many times have you been arrested for drug-related offenses? *[THE VALUE IN E2 CANNOT BE GREATER THAN THE VALUE IN E1.]*

|\_\_\_\_|\_\_\_\_| times  Refused  Don’t know

1. In the past 30 days, how many nights have you spent in jail/prison? *[IF THE VALUE IN E3 IS GREATER THAN 15, THEN C1 MUST = INSTITUTION (JAIL/PRISON). IF C1 = INSTITUTION (JAIL/PRISON), THEN THE VALUE IN E3 MUST BE GREATER THAN OR EQUAL TO 15.]*

|\_\_\_\_|\_\_\_\_| nights  Refused  Don’t know

1. In the past 30 days, how many times have you committed a crime? *[CHECK NUMBER OF DAYS USED ILLEGAL DRUGS IN ITEM B1c ON PAGE 7. ANSWER HERE IN E4 SHOULD BE EQUAL TO OR GREATER THAN NUMBER IN B1c BECAUSE USING ILLEGAL DRUGS IS A CRIME.]*

|\_\_\_\_|\_\_\_\_|\_\_\_\_| times  Refused  Don’t know

1. Are you currently awaiting charges, trial, or sentencing?

 Yes

 No

 Refused

 Don’t know

1. Are you currently on parole or probation?

Yes

No

Refused

Don’t know

# F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY

1. How would you rate your overall health right now?

Excellent

Very good

Good

Fair

Poor

Refused

Don’t know

1. During the past 30 days, did you receive:

| **a. Inpatient Treatment for:** | **YES** | ***[IF YES]*Altogether for how many nights** | **NO** | **RF** | **DK** |
| --- | --- | --- | --- | --- | --- |
| i. Physical complaint |  |  nights |  |  |  |
| ii. Mental or emotional difficulties |  |  nights |  |  |  |
| iii. Alcohol or substance abuse |  |  nights |  |  |  |

| **b. Outpatient Treatment for:** | **YES** | ***[IF YES]*Altogether for how many times** | **NO** | **RF** | **DK** |
| --- | --- | --- | --- | --- | --- |
| i. Physical complaint |  |  times |  |  |  |
| ii. Mental or emotional difficulties |  |  times |  |  |  |
| iii. Alcohol or substance abuse |  |  times |  |  |  |

| **c. Emergency Room Treatment for:** | **YES** | ***[IF YES]*Altogether for how many times** | **NO** | **RF** | **DK** |
| --- | --- | --- | --- | --- | --- |
| i. Physical complaint |  |  times |  |  |  |
| ii. Mental or emotional difficulties |  |  times |  |  |  |
| iii. Alcohol or substance abuse |  |  times |  |  |  |

# F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (continued)

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

 Yes

 No → ***[SKIP TO F4.]***

 NOT PERMITTED TO ASK → ***[SKIP TO F4.]***

 REFUSED → ***[SKIP TO F4.]***

 Don’t know → ***[SKIP TO F4.]***

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

 Contacts RF DK

a. Sexual contacts (vaginal, oral, or anal) did you have? |\_\_\_\_|\_\_\_\_|

b. Unprotected sexual contacts did you have? ***[THE VALUE IN F3b SHOULD NOT BE GREATER THAN THE VALUE IN F3a.] [IF ZERO, SKIP TO F4.]*** |\_\_\_\_|\_\_\_\_|\_\_\_\_|

c. Unprotected sexual contacts were with an individual who is or was: ***[NONE OF THE VALUES IN F3c1 THROUGH F3c3 CAN BE GREATER THAN THE VALUE IN F3b.]***

1. HIV positive or has AIDS |\_\_\_\_|\_\_\_\_|\_\_\_\_|

2. An injection drug user |\_\_\_\_|\_\_\_\_|\_\_\_\_|

3. High on some substance |\_\_\_\_|\_\_\_\_|\_\_\_\_|

1. Have you ever been tested for HIV?

 Yes ***[GO TO F4a.]***

 No ***[SKIP TO F5.]***

 Refused ***[SKIP TO F5.]***

 Don’t know ***[SKIP TO F5.]***

a. Do you know the results of your HIV testing?

 Yes

 No

# F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (continued)

1. How would you rate your quality of life?

 Very poor

 Poor

 Neither poor nor good

 Good

 Very Good

 REFUSED

 DON’T KNOW

1. How satisfied are you with your health?

 Very dissatisfied

 Dissatisfied

 Neither satisfied nor dissatisfied

 Satisfied

 Very satisfied

 REFUSED

 DON’T KNOW

1. Do you have enough energy for everyday life?

Not at all

A little

Moderately

Mostly

Completely

 REFUSED

 DON’T KNOW

1. How satisfied are you with your ability to perform your daily activities?

Very Dissatisfied

Dissatisfied

Neither Satisfied nor Dissatisfied

Satisfied

Very Satisfied

 REFUSED

 DON’T KNOW

1. How satisfied are you with yourself?

Very Dissatisfied

Dissatisfied

Neither Satisfied nor Dissatisfied

Satisfied

Very Satisfied

 REFUSED

 DON’T KNOW

# F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (continued)

1. In the past 30 days, not due to your use of alcohol or drugs, how many days have you:

 Days RF DK

a. Experienced serious depression |\_\_\_\_|\_\_\_\_|

b. Experienced serious anxiety or tension |\_\_\_\_|\_\_\_\_|

c. Experienced hallucinations |\_\_\_\_|\_\_\_\_|

d. Experienced trouble understanding, concentrating, or remembering |\_\_\_\_|\_\_\_\_|

e. Experienced trouble controlling violent behavior |\_\_\_\_|\_\_\_\_|

f. Attempted suicide |\_\_\_\_|\_\_\_\_|

g. Been prescribed medication for psychological/emotional problem |\_\_\_\_|\_\_\_\_|

***[IF CLIENT REPORTS ZERO DAYS, RF, OR DK TO ALL ITEMS IN QUESTION F10, SKIP TO ITEM F12.]***

1. How much have you been bothered by these psychological or emotional problems in the past 30 days?

 Not at all

 Slightly

 Moderately

 Considerably

 Extremely

 Refused

 Don’t know

## VIOLENCE AND TRAUMA

1. 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 ***[skip to Item F13.]***

 Refused

 Don’t know

***[IF NO, REFUSED, OR DON’T KNOW, SKIP TO ITEM F13.]***

# F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (continued)

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

12a. Have had nightmares about it or thought about it when you did not want to?

 Yes

 No

 Refused

 Don’t know

12b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?

 Yes

 No

 Refused

 Don’t know

12c. Were constantly on guard, watchful, or easily startled?

 Yes

 No

 Refused

 Don’t know

12d. Felt numb and detached from others, activities, or your surroundings?

 Yes

 No

 Refused

 Don’t know

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

 Never

 A few times

 More than a few times

 REFUSED

 DON’T KNOW

# G. Social Connectedness

1. In the past 30 days, did you attend any voluntary self-help groups for recovery that were not affiliated with a religious or faith-based organization? In other words, did you participate in a non-professional, peer-operated organization that is devoted to helping individuals who have addiction-related problems such as: Alcoholics Anonymous, Narcotics Anonymous, Oxford House, Secular Organization for Sobriety, or Women for Sobriety, etc.?

 Yes ***[IF YES]*** Specify how many times |\_\_\_\_|\_\_\_\_|  Refused  Don’t know

 No

 Refused

 Don’t know

1. In the past 30 days, did you attend any religious/faith-affiliated recovery self-help groups?

 Yes ***[IF YES]*** Specify how many times |\_\_\_\_|\_\_\_\_|  Refused  Don’t know

 No

 Refused

 Don’t know

1. In the past 30 days, did you attend meetings of organizations that support recovery other than the organizations described above?

 Yes ***[IF YES]*** Specify how many times |\_\_\_\_|\_\_\_\_|  Refused  Don’t know

 No

 Refused

 Don’t know

1. In the past 30 days, did you have interaction with family and/or friends that are supportive of your recovery?

 Yes

 No

 Refused

 Don’t know

1. To whom do you turn when you are having trouble? *[SELECT ONLY ONE.]*

 No One

 Clergy Member

 Family Member

 Friends

 REFUSED

 DoN’T KNOW

 Other (Specify)

1. How satisfied are you with your personal relationships?

 Very Dissatisfied

 Dissatisfied

 Neither Satisfied nor Dissatisfied

 Satisfied

 Very Satisfied

 REFUSED

 don’t KNOW

# YOU ARE NOT RESPONSIBLE FOR COLLECTING DATA ON ALL SECTION H QUESTIONS. YOUR GPO HAS PROVIDED YOU WITH GUIDANCE ON WHICH SPECIFIC SECTION H QUESTIONS YOU ARE TO COMPLETE. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT YOUR GPO.

**H1. PROGRAM SPECIFIC QUESTIONS**

**[QUESTION 1 SHOULD BE REPORTED BY GRANTEE STAFF AT FOLLOW-UP AND DISCHARGE]**

1. Which of the following occurred for the client, subsequent to receiving treatment? *[CHECK ALL THAT APPLY]*

 Client was reunited with child (or children)

 Client avoided out of home placement for child (or children)

 None of the above

 Don’t know

# H2. PROGRAM SPECIFIC QUESTIONS

**[QUESTION 1 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE]**

1. **Did the [insert grantee name] help you obtain any of the following benefits? *[CHECK ALL THAT APPLY]***

 Private health insurance

 Medicaid

 SSI/SSDI

 TANF

 SNAP

 Other (Specify)

 NONE OF THE ABOVE

 REFUSED

 DON’T KNOW

# H3. PROGRAM SPECIFIC QUESTIONS

**[QUESTION 1 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE.]**

**1. Have you achieved any of the following since you began receiving services or supports from [insert grantee name]? If yes, do you believe that the services you received from [insert grantee name] helped you with this achievement?**

|  |  |  |
| --- | --- | --- |
|  | Achieved? | If yes, do you believe that the services you received from [insert grantee name] helped you with this achievement? |
| 1a. Enrolled in school |  Yes No DON’T KNOW REFUSED |  Yes No DON’T KNOW REFUSED |
| 1b. Enrolled in vocational training |  Yes No DON’T KNOW REFUSED |  Yes No DON’T KNOW REFUSED |
| 1c. Currently employed |  Yes No DON’T KNOW REFUSED |  Yes No DON’T KNOW REFUSED |
| 1d. Living in stable housing |  Yes No DON’T KNOW REFUSED |  Yes No DON’T KNOW REFUSED |

# H4. PROGRAM SPECIFIC QUESTIONS

**[QUESTION 1 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE]**

1. **Please indicate the degree to which you agree or disagree with the following statements:**

**a. Receiving treatment in a non-residential setting has enabled me to maintain parenting and family responsibilities while receiving treatment.**

 Strongly disagree

 Disagree

 Undecided

 Agree

 Strongly Agree

 REFUSED

 DON’T KNOW

1. **As a result of treatment, I feel I now have the skills and support to balance parenting and managing my recovery.**

 Strongly disagree

 Disagree

 Undecided

 Agree

 Strongly Agree

 REFUSED

 DON’T KNOW

# H5. PROGRAM SPECIFIC QUESTIONS

**[QUESTION 1 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE]**

1. **Please indicate the degree to which you agree or disagree with the following statements:**
2. **Receiving treatment in a residential setting with my child (or children) has enabled me to focus on my treatment without distractions of parenting and family responsibilities.**

 Strongly disagree

 Disagree

 Undecided

 Agree

 Strongly Agree

 REFUSED

 DON’T KNOW

1. **As a result of treatment, I feel I now have the skills and support to balance parenting and managing my recovery.**

 Strongly disagree

 Disagree

 Undecided

 Agree

 Strongly Agree

 REFUSED

 DON’T KNOW

# H6. PROGRAM SPECIFIC QUESTIONS

**[QUESTION 1 SHOULD BE REPORTED BY GRANTEE STAFF AT INTAKE/BASELINE, FOLLOW-UP, AND DISCHARGE].**

1. **Please indicate which type of funding was/will be used to pay for the SBIRT services provided to this client. *[CHECK ALL THAT APPLY.]***

 Current SAMHSA grant funding

 Other federal grant funding

 State funding

 Client’s private insurance

 Medicaid/Medicare

 Other (Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Don’t know

***[IF FOLLOW-UP OR DISCHARGE INTERVIEW, SKIP TO H3.]***

**[QUESTION 2 SHOULD BE REPORTED BY GRANTEE STAFF ONLY AT INTAKE/BASELINE]**

1. **If the client screened positive for substance misuse or a substance use disorder, was the client assigned to the following types of services? *[IF CLIENT SCREENED NEGATIVE, SELECT “NO” FOR EACH SERVICE BELOW]***

 Yes No DK

Brief Intervention Y N

Brief Treatment Y N

Referral to Treatment Y N

**[QUESTION 3 SHOULD BE REPORTED BY GRANTEE STAFF AT INTAKE, BASELINE, FOLLOW-UP AND DISCHARGE]**

1. **Did the client receive the following types of services?**

 Yes No DK

Brief Intervention Y N

Brief Treatment Y N

Referral to Treatment Y N

# H7. PROGRAM SPECIFIC QUESTIONS

**[QUESTION 1 SHOULD BE ANSWERED BY THE CLIENT AT INTAKE/BASELINE, FOLLOW-UP AND DISCHARGE]**

1. **Did the program provide the following?**

**a. HIV test**

 YES

 NO ***[SKIP TO H1b]***

 REFUSED ***[SKIP TO H1b]***

 DON’T KNOW ***[SKIP TO H1b]***

***[IF YES]* What was the result?**

 Positive

 Negative ***[SKIP TO H1b]***

 Indeterminate ***[SKIP TO H1b]***

 REFUSED ***[SKIP TO H1b]***

 DON’T KNOW ***[SKIP TO H1b]***

***[IF CLIENT SCREENED POSITIVE]* Were you connected to HIV treatment services?**

* Yes
* No
* REFUSED
* DON’T KNOW

 **b. Hepatitis B (HBV) test**

 YES

 NO [***SKIP TO H1c]***

 REFUSED [***SKIP TO H1c]***

 DON’T KNOW [***SKIP TO H1c]***

 ***[IF YES]* What was the result?**

 Positive

 Negative [***SKIP TO H1c]***

 Indeterminate [***SKIP TO H1c]***

 REFUSED [***SKIP TO H1c]***

 DON’T KNOW [***SKIP TO H1c]***

 ***[IF CLIENT SCREENED POSITIVE]* Were you connected to HBV treatment services?**

* Yes
* No
* REFUSED
* DON’T KNOW

# H7. PROGRAM SPECIFIC QUESTIONS (continued)

**c. Hepatitis C (HCV) test**

 YES

 NO ***[SKIP TO SECTION I OR J/K]***

 REFUSED ***[SKIP TO SECTION I OR J/K]***

 DON’T KNOW ***[SKIP TO SECTION I OR J/K]***

 ***[IF YES]* What was the result?**

 Positive

 Negative ***[SKIP TO SECTION I OR J/K]***

 Indeterminate ***[SKIP TO SECTION I OR J/K]***

 REFUSED ***[SKIP TO SECTION I OR J/K]***

 DON’T KNOW ***[SKIP TO SECTION I OR J/K]***

 ***[IF CLIENT SCREENED POSITIVE]* Were you connected to HCV treatment services?**

* Yes
* No
* REFUSED
* DON’T KNOW

# H8. PROGRAM SPECIFIC QUESTIONS [QUESTIONS 1 AND 2 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE]

**1. Have you achieved any of the following since you began receiving peer services from [insert grantee name]? If yes, do you believe that the services you received from [insert grantee name] helped you with this achievement?**

|  |  |  |
| --- | --- | --- |
|  | Achieved? | If yes, do you believe that the services you received from [insert grantee name] helped you with this achievement? |
| 1a. Enrolled in school |  Yes No DON’T KNOW REFUSED |  Yes No DON’T KNOW REFUSED |
| 1b. Enrolled in vocational training |  Yes No DON’T KNOW REFUSED |  Yes No DON’T KNOW REFUSED |
| 1c. Currently employed |  Yes No DON’T KNOW REFUSED |  Yes No DON’T KNOW REFUSED |
| 1d. Living in stable housing |  Yes No DON’T KNOW REFUSED |  Yes No DON’T KNOW REFUSED |

1. **To what extent has this program improved your quality of life?**

 To a great extent

 Somewhat

 Very little

 Not at all

 REFUSED

 DON’T KNOW

# H9. PROGRAM SPECIFIC QUESTIONS

**[QUESTION 1 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE]**

1. **Please indicate the degree to which you agree or disagree with the following statements:**

**i. The use of technology accessed through [insert grantee name] has helped me communicate with my provider.**

 Strongly disagree

 Disagree

 Undecided

 Agree

 Strongly Agree

 NOT APPLICABLE

 REFUSED

 DON’T KNOW

**ii. The use of technology accessed through [insert grantee name] has helped me reduce my substance use.**

 Strongly disagree

 Disagree

 Undecided

 Agree

 Strongly Agree

 NOT APPLICABLE

 REFUSED

 DON’T KNOW

**iii. The use of technology accessed through [insert grantee name] has helped me manage my mental health symptoms.**

 Strongly disagree

 Disagree

 Undecided

 Agree

 Strongly Agree

 NOT APPLICABLE

 REFUSED

 DON’T KNOW

**iv. The use of technology accessed through [insert grantee name] has helped me support my recovery.**

 Strongly disagree

 Disagree

 Undecided

 Agree

 Strongly Agree

 NOT APPLICABLE

 REFUSED

 DON’T KNOW

# H10. PROGRAM SPECIFIC QUESTIONS

**[QUESTIONS 1 AND 1A SHOULD BE REPORTED BY GRANTEE STAFF AT INTAKE/BASELINE, FOLLOW-UP, AND DISCHARGE]**

**[QUESTION 1B SHOULD BE REPORTED BY GRANTEE STAFF AT FOLLOW-UP/DISCHARGE IF THE CLIENT HAS BEEN REFERRED FOR SERVICES]**

1. **Did the client screen positive for a mental health disorder?**

 Client screened positive

 Client screened negative ***[SKIP TO H2.]***

 Client was not screened ***[SKIP TO H2.]***

 Don’t know ***[SKIP TO H2.]***

**a. *[IF POSITIVE]* Was the client referred to mental health services?**

 Yes

 No ***[SKIP TO H2.]***

 Don’t know ***[SKIP TO H2.]***

**b. *[IF YES]* Did the client receive mental health services?**

 Yes

 No

 Don’t know

**[QUESTIONS 2 AND 2A SHOULD BE REPORTED BY GRANTEE STAFF AT INTAKE/BASELINE, FOLLOW-UP, AND DISCHARGE]**

**[QUESTION 2B SHOULD BE REPORTED BY GRANTEE STAFF AT FOLLOW-UP/DISCHARGE IF THE CLIENT HAS BEEN REFERRED FOR SERVICES]**

1. **Did the client screen positive for a substance use disorder?**

 Client screened positive

 Client screened negative

 Client was not screened

 Don’t know

***[IF THIS IS AN INTAKE/BASELINE AND THE RESPONSE IS NEGATIVE, NOT SCREENED, OR DON’T KNOW, SECTION H IS DONE. IF THIS IS A FOLLOW-UP OR DISCHARGE AND THE RESPONSE IS NEGATIVE, NOT SCREENED, OR DON’T KNOW, SKIP TO QUESTION 3]***

**a. *[IF POSITIVE]* Was the client referred to substance use disorder services?**

 Yes

 No

 Don’t know

***[IF THIS IS AN INTAKE/BASELINE, SECTION H IS DONE. IF THIS IS A FOLLOW-UP OR DISCHARGE AND THE RESPONSE IS NO OR DON’T KNOW, SKIP TO QUESTION 3]***

# H10. PROGRAM SPECIFIC QUESTIONS (continued)

**b. *[IF YES]* Did the client receive substance use disorder services?**

 Yes

 No

 Don’t know

**[QUESTION 3 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE]**

1. **Please indicate the degree to which you agree or disagree with the following statement: Receiving community-based services through [insert grantee name] has helped me to avoid further contact with the police and the criminal justice system.**

 Strongly disagree

 Disagree

 Undecided

 Agree

 Strongly Agree

 REFUSED

 DON’T KNOW

# I. Follow-Up Status

***[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT FOLLOW-UP.]***

1. What is the follow-up status of the client? *[THIS IS A REQUIRED FIELD: NA, REFUSED, DON’T KNOW, AND MISSING WILL NOT BE ACCEPTED.]*

 01 = Deceased at time of due date

 11 = Completed interview within specified window

 12 = Completed interview outside specified window

 21 = Located, but refused, unspecified

 22 = Located, but unable to gain institutional access

 23 = Located, but otherwise unable to gain access

 24 = Located, but withdrawn from project

 31 = Unable to locate, moved

 32 = Unable to locate, other (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is the client still receiving services from your program?

 Yes

 No

***[IF THIS IS A FOLLOW-UP INTERVIEW, STOP NOW; THE INTERVIEW IS COMPLETE.]***

# J. Discharge Status

***[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT DISCHARGE.]***

1. On what date was the client discharged?

|\_\_\_\_|\_\_\_\_| / |\_\_\_\_|\_\_\_\_| / |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|
Month Day Year

1. What is the client’s discharge status?

 01 = Completion/Graduate

 02 = Termination

If the client was terminated, what was the reason for termination? *[Select one response*.*]*

 01 = Left on own against staff advice with satisfactory progress

 02 = Left on own against staff advice without satisfactory progress

 03 = Involuntarily discharged due to nonparticipation

 04 = Involuntarily discharged due to violation of rules

 05 = Referred to another program or other services with satisfactory progress

 06 = Referred to another program or other services with unsatisfactory progress

 07 = Incarcerated due to offense committed while in treatment/recovery with satisfactory progress

 08 = Incarcerated due to offense committed while in treatment/recovery with unsatisfactory progress

 09 = Incarcerated due to old warrant or charged from before entering treatment/recovery with satisfactory progress

 10 = Incarcerated due to old warrant or charged from before entering treatment/recovery with unsatisfactory progress

 11 = Transferred to another facility for health reasons

 12 = Death

 13 = Other (Specify)

1. Did the program test this client for HIV?

 Yes [SKIP TO SECTION K.]

 No [GO TO J4.]

1. *[IF NO]* Did the program refer this client for testing?

 Yes

 No

# K. Services Received

***[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT DISCHARGE.]***

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

Modality Days

1. Case Management |\_\_\_|\_\_\_|\_\_\_|

2. Day Treatment |\_\_\_|\_\_\_|\_\_\_|

3. Inpatient/Hospital (Other Than Detox) |\_\_\_|\_\_\_|\_\_\_|

4. Outpatient |\_\_\_|\_\_\_|\_\_\_|

5. Outreach |\_\_\_|\_\_\_|\_\_\_|

6. Intensive Outpatient |\_\_\_|\_\_\_|\_\_\_|

7. Methadone |\_\_\_|\_\_\_|\_\_\_|

8. Residential/Rehabilitation |\_\_\_|\_\_\_|\_\_\_|

9. Detoxification (Select Only One):

A. Hospital Inpatient |\_\_\_|\_\_\_|\_\_\_|

B. Free Standing Residential |\_\_\_|\_\_\_|\_\_\_|

C. Ambulatory Detoxification |\_\_\_|\_\_\_|\_\_\_|

10. After Care |\_\_\_|\_\_\_|\_\_\_|

11. Recovery Support |\_\_\_|\_\_\_|\_\_\_|

12. Other (Specify) |\_\_\_|\_\_\_|\_\_\_|

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

Treatment Services Sessions

***[SBIRT GRANTS: You must have at least one session for one of the Treatment Services numbered 1 through 4.]***

1. Screening |\_\_\_|\_\_\_|\_\_\_|

2. Brief Intervention |\_\_\_|\_\_\_|\_\_\_|

3. Brief Treatment |\_\_\_|\_\_\_|\_\_\_|

4. Referral to Treatment |\_\_\_|\_\_\_|\_\_\_|

5. Assessment |\_\_\_|\_\_\_|\_\_\_|

6. Treatment/Recovery Planning |\_\_\_|\_\_\_|\_\_\_|

7. Individual Counseling |\_\_\_|\_\_\_|\_\_\_|

8. Group Counseling |\_\_\_|\_\_\_|\_\_\_|

9. Family/Marriage Counseling |\_\_\_|\_\_\_|\_\_\_|

10. Co-Occurring Treatment/Recovery Services |\_\_\_|\_\_\_|\_\_\_|

11. Pharmacological Interventions |\_\_\_|\_\_\_|\_\_\_|

12. HIV/AIDS Counseling |\_\_\_|\_\_\_|\_\_\_|

13. Other Clinical Services
(Specify) |\_\_\_|\_\_\_|\_\_\_|

Case Management Services Sessions

1. Family Services (Including Marriage Education, Parenting, Child Development Services) |\_\_\_|\_\_\_|\_\_\_|

2. Child Care |\_\_\_|\_\_\_|\_\_\_|

3. Employment Service

A. Pre-Employment |\_\_\_|\_\_\_|\_\_\_|

B. Employment Coaching |\_\_\_|\_\_\_|\_\_\_|

4. Individual Services Coordination |\_\_\_|\_\_\_|\_\_\_|

5. Transportation |\_\_\_|\_\_\_|\_\_\_|

6. HIV/AIDS Service |\_\_\_|\_\_\_|\_\_\_|

7. Supportive Transitional Drug-Free Housing Services |\_\_\_|\_\_\_|\_\_\_|

8. Other Case Management Services (Specify) |\_\_\_|\_\_\_|\_\_\_|

Medical Services Sessions

1. Medical Care |\_\_\_|\_\_\_|\_\_\_|

2. Alcohol/Drug Testing |\_\_\_|\_\_\_|\_\_\_|

3. HIV/ AIDS Medical Support & Testing |\_\_\_|\_\_\_|\_\_\_|

4. Other Medical Services
(Specify) |\_\_\_|\_\_\_|\_\_\_|

After Care Services Sessions

1. Continuing Care |\_\_\_|\_\_\_|\_\_\_|

2. Relapse Prevention |\_\_\_|\_\_\_|\_\_\_|

3. Recovery Coaching |\_\_\_|\_\_\_|\_\_\_|

4. Self-Help and Support Groups |\_\_\_|\_\_\_|\_\_\_|

5. Spiritual Support |\_\_\_|\_\_\_|\_\_\_|

6. Other After Care Services
(Specify) |\_\_\_|\_\_\_|\_\_\_|

Education Services Sessions

1. Substance Abuse Education |\_\_\_|\_\_\_|\_\_\_|

2. HIV/AIDS Education |\_\_\_|\_\_\_|\_\_\_|

3. Other Education Services
(Specify) |\_\_\_|\_\_\_|\_\_\_|

Peer-to-Peer Recovery Support Services Sessions

1. Peer Coaching or Mentoring |\_\_\_|\_\_\_|\_\_\_|

2. Housing Support |\_\_\_|\_\_\_|\_\_\_|

3. Alcohol- and Drug-Free Social Activities |\_\_\_|\_\_\_|\_\_\_|

4. Information and Referral |\_\_\_|\_\_\_|\_\_\_|

5. Other Peer-to-Peer Recovery Support Services (Specify) |\_\_\_|\_\_\_|\_\_\_|