

Substance Abuse and Mental Health Services Administration (SAMHSA)

Center for Mental Health Services (CMHS)

National Outcome Measures (NOMs) Client-Level Measures for Discretionary Programs Providing Direct Services

SERVICES TOOL

SAMHSA's Performance Accountability and Reporting System (SPARS)
August 2022

Public reporting burden for this collection of information is estimated to average 20 minutes per response if all items are asked of a client/consumer/participant; to the extent that providers already obtain much of this information as part of their ongoing client/consumer/participant intake or follow-up, less time will be required. Send comments regarding this burden estimate, or any other aspect of this collection of information, to the Substance Abuse and Mental Health Services Administration (SAMHSA) Reports Clearance Officer, Room 15E57B, 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The control number for this project is 0930-0285.

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RECORD MANAGEMENT

RECORD MANAGEMENT information is collected by grantee staff at BASELINE, REASSESSMENT, and DISCHARGE, even when an assessment interview is not conducted.

Client ID | | | | | | | | | | | | | | | |

Grant ID | | | | | | | | | | | | | | | |

Site ID | | | | | | | | | | | | | | | |

1. Indicate Assessment Type:

| | | |
|---|---|--|
| <input type="radio"/> Baseline Assessment 1a. <i>[IF QUESTION 1 IS BASELINE]</i> Enter the MONTH and YEAR when the client first received services under this grant for this episode of care. / MONTH YEAR | <input type="radio"/> Reassessment (3-month or 6-month) | <input type="radio"/> Clinical Discharge Assessment |
|---|---|--|

2. What is the client's month and year of birth?

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

3. Was the assessment interview conducted?

| | |
|---|---|
| <input type="radio"/> Yes 3a. <i>[IF QUESTION 3 IS YES]</i> When? / / MONTH DAY YEAR | <input type="radio"/> No 3b. <i>[IF QUESTION 3 IS NO]</i> Why not? Choose only one. <input type="radio"/> Not able to obtain consent from proxy <input type="radio"/> Client was impaired or unable to provide consent <input type="radio"/> Client refused this interview <input type="radio"/> Client was not reached for interview <input type="radio"/> Client refused all interviews |
|---|---|

4. [CHILD ONLY] Was the respondent the child or the caregiver?

- Child
- Caregiver

BEHAVIORAL HEALTH DIAGNOSES

BEHAVIORAL HEALTH DIAGNOSES information is collected by grantee staff at BASELINE, REASSESSMENT and DISCHARGE, even when an assessment interview is not conducted.

1. Was the client screened or assessed by your program for trauma-related experiences?

- Yes
- No
- DON'T KNOW

1a. [IF QUESTION 1 IS NO] Please select why:

- No time during interview
- No training around trauma screening/disclosure
- No institutional/organizational policy around screening
- No referral network and/or infrastructure for trauma services currently available
- Other

1b. [IF QUESTION 1 IS YES] Was the screen positive?

- Yes
- No
- DON'T KNOW

2. Did the client have a positive suicide screen?

- Yes
- No
- DON'T KNOW

2a. [IF QUESTION 2 IS YES] Was a suicidal safety plan developed?

- Yes
- No
- DON'T KNOW

2b. [IF QUESTION 2 IS YES] Was access to lethal means assessed?

- Yes
- No
- DON'T KNOW

3. Behavioral Health Diagnoses

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, **as made by a clinician**. Please note that some substance use disorder ICD-10-CM codes have been crosswalked to the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* descriptors. Select up to three behavioral health diagnoses from the mental health, Z-codes, and substance use diagnoses below.

If no mental health diagnosis, select reason:

- No clinician assessment
- High risk factors requiring intervention and not yet meeting criteria for a DSM/ICD diagnosis
- Only met criteria for a “Z” code
- Other (please specify _____)

| <u>MENTAL HEALTH DIAGNOSES</u> | Diagnosed? |
|--|--------------------------|
| Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders | |
| F20 – Schizophrenia | <input type="checkbox"/> |
| F21 – Schizotypal disorder | <input type="checkbox"/> |
| F22 – Delusional disorder | <input type="checkbox"/> |
| F23 – Brief psychotic disorder | <input type="checkbox"/> |
| F24 – Shared psychotic disorder | <input type="checkbox"/> |
| F25 – Schizoaffective disorders | <input type="checkbox"/> |
| F28 – Other psychotic disorder not due to a substance or known physiological condition | <input type="checkbox"/> |
| F29 – Unspecified psychosis not due to a substance or known physiological condition | <input type="checkbox"/> |
| Mood [affective] disorders | |
| F30 – Manic episode | <input type="checkbox"/> |
| F31 – Bipolar disorder | <input type="checkbox"/> |
| F32 – Major depressive disorder, single episode | <input type="checkbox"/> |
| F33 – Major depressive disorder, recurrent | <input type="checkbox"/> |
| F34 – Persistent mood [affective] disorders | <input type="checkbox"/> |
| F39 – Unspecified mood [affective] disorder | <input type="checkbox"/> |
| Phobic Anxiety and Other Anxiety Disorders | |
| F40 – Phobic anxiety disorders | <input type="checkbox"/> |
| F40.00 – Agoraphobia, unspecified | <input type="checkbox"/> |
| F40.01 – Agoraphobia with panic disorder | <input type="checkbox"/> |
| F40.02 – Agoraphobia without panic disorder | <input type="checkbox"/> |
| F40.1 – Social phobias (Social anxiety disorder) | <input type="checkbox"/> |
| F40.10 – Social phobia, unspecified | <input type="checkbox"/> |
| F40.11 – Social phobia, generalized | <input type="checkbox"/> |
| F40.2 – Specific (isolated) phobias | <input type="checkbox"/> |
| F41 – Other anxiety disorders | <input type="checkbox"/> |
| F41.0 – Panic disorder | <input type="checkbox"/> |
| F41.1 – Generalized anxiety disorder | <input type="checkbox"/> |
| Obsessive-compulsive disorders | |
| F42 – Obsessive-compulsive disorder | <input type="checkbox"/> |
| F42.2 – Obsessive-compulsive disorder with mixed obsessional thoughts and acts | <input type="checkbox"/> |
| F42.3 – Hoarding disorder | <input type="checkbox"/> |
| F42.4 – Excoriation (skin-picking) disorder | <input type="checkbox"/> |
| F42.8 – Other obsessive-compulsive disorder | <input type="checkbox"/> |
| F42.9 – Obsessive-compulsive disorder, unspecified | <input type="checkbox"/> |

| MENTAL HEALTH DIAGNOSES | Diagnosed? |
|--|--------------------------|
| Reaction to severe stress and adjustment disorders | |
| F43 – Acute stress disorder; reaction to severe stress, and adjustment disorders | <input type="checkbox"/> |
| F43.10 – Post traumatic stress disorder, unspecified | <input type="checkbox"/> |
| F43.2 – Adjustment disorders | <input type="checkbox"/> |
| F44 – Dissociative and conversion disorders | <input type="checkbox"/> |
| F44.81 – Dissociative identity disorder | <input type="checkbox"/> |
| F45 – Somatoform disorders | <input type="checkbox"/> |
| F45.22 – Body dysmorphic disorder | <input type="checkbox"/> |
| F48 – Other non-psychotic mental disorders | <input type="checkbox"/> |
| Behavioral syndromes associated with physiological disturbances and physical factors | |
| F50 – Eating disorders | <input type="checkbox"/> |
| F51 – Sleep disorders not due to a substance or known physiological condition | <input type="checkbox"/> |
| Disorders of adult personality and behavior | |
| F60.0 – Paranoid personality disorder | <input type="checkbox"/> |
| F60.1 – Schizoid personality disorder | <input type="checkbox"/> |
| F60.2 – Antisocial personality disorder | <input type="checkbox"/> |
| F60.3 – Borderline personality disorder | <input type="checkbox"/> |
| F60.4 – Histrionic personality disorder | <input type="checkbox"/> |
| F60.5 – Obsessive-compulsive personality disorder | <input type="checkbox"/> |
| F60.6 – Avoidant personality disorder | <input type="checkbox"/> |
| F60.7 – Dependent personality disorder | <input type="checkbox"/> |
| F60.8 – Other specific personality disorders | <input type="checkbox"/> |
| F60.9 – Personality disorder, unspecified | <input type="checkbox"/> |
| F63.3 – Trichotillomania | <input type="checkbox"/> |
| F70–F79 – Intellectual disabilities | <input type="checkbox"/> |
| F80–F89 – Pervasive and specific developmental disorders | <input type="checkbox"/> |
| Behavioral and emotional disorders with onset usually occurring in childhood and adolescence | |
| F90 – Attention-deficit hyperactivity disorders | <input type="checkbox"/> |
| F91 – Conduct disorders | <input type="checkbox"/> |
| F93 – Emotional disorders with onset specific to childhood | <input type="checkbox"/> |
| F93.0 – Separation anxiety disorder of childhood | <input type="checkbox"/> |
| F94 – Disorders of social functioning with onset specific to childhood or adolescence | <input type="checkbox"/> |
| F94.0 – Selective mutism | <input type="checkbox"/> |
| F94.1 – Reactive attachment disorder of childhood | <input type="checkbox"/> |
| F94.2 – Disinhibited attachment disorder of childhood | <input type="checkbox"/> |
| F95 – Tic disorder | <input type="checkbox"/> |
| F98 – Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence | <input type="checkbox"/> |
| F99 – Unspecified mental disorder | <input type="checkbox"/> |

| Z codes – Persons with potential health hazards related to socioeconomic and psychosocial circumstances | Diagnosed? |
|--|--------------------------|
| Z55 – Problems related to education and literacy | <input type="checkbox"/> |
| Z56 – Problems related to employment and unemployed | <input type="checkbox"/> |
| Z57 – Occupational exposure to risk factors | <input type="checkbox"/> |
| Z59 – Problems related to housing and economic circumstances | <input type="checkbox"/> |
| Z60 – Problems related to social environment | <input type="checkbox"/> |
| Z62 – Problems related to upbringing | <input type="checkbox"/> |

| Z codes – Persons with potential health hazards related to socioeconomic and psychosocial circumstances | Diagnosed? |
|--|--------------------------|
| Z63 – Other problems related to primary support group, including family circumstances | <input type="checkbox"/> |
| Z64 – Problems related to certain psychological circumstances | <input type="checkbox"/> |
| Z65 – Problems related to other psychosocial circumstances | <input type="checkbox"/> |

| SUBSTANCE USE DIAGNOSES | Diagnosed? |
|--|--------------------------|
| Alcohol related disorders | |
| F10.10 – Alcohol abuse, uncomplicated | <input type="checkbox"/> |
| F10.11 – Alcohol abuse, in remission | <input type="checkbox"/> |
| F10.20 – Alcohol dependence, uncomplicated | <input type="checkbox"/> |
| F10.21 – Alcohol dependence, in remission | <input type="checkbox"/> |
| F10.9 – Alcohol use, unspecified | <input type="checkbox"/> |
| Opioid related disorders | |
| F11.10 – Opioid abuse, uncomplicated, | <input type="checkbox"/> |
| F11.11 – Opioid abuse, in remission | <input type="checkbox"/> |
| F11.20 – Opioid dependence, uncomplicated | <input type="checkbox"/> |
| F11.21 – Opioid dependence, in remission | <input type="checkbox"/> |
| F11.9 – Opioid use, unspecified | <input type="checkbox"/> |
| Cannabis related disorders | |
| F12.10 – Cannabis abuse, uncomplicated | <input type="checkbox"/> |
| F12.11 – Cannabis abuse, in remission | <input type="checkbox"/> |
| F12.20 – Cannabis dependence, uncomplicated | <input type="checkbox"/> |
| F12.21 – Cannabis dependence, in remission | <input type="checkbox"/> |
| F12.9 – Cannabis use, unspecified | <input type="checkbox"/> |
| Sedative, hypnotic, or anxiolytic related disorders | |
| F13.10 – Sedative, hypnotic, or anxiolytic abuse, uncomplicated | <input type="checkbox"/> |
| F13.11 – Sedative, hypnotic, or anxiolytic abuse, in remission | <input type="checkbox"/> |
| F13.20 – Sedative, hypnotic, or anxiolytic dependence, uncomplicated | <input type="checkbox"/> |
| F13.21 – Sedative, hypnotic, or anxiolytic dependence, in remission | <input type="checkbox"/> |
| F13.9 – Sedative, hypnotic, or anxiolytic-related use, unspecified | <input type="checkbox"/> |
| Cocaine related disorders | |
| F14.10 – Cocaine abuse, uncomplicated | <input type="checkbox"/> |
| F14.11 – Cocaine abuse, in remission | <input type="checkbox"/> |
| F14.20 – Cocaine dependence, uncomplicated | <input type="checkbox"/> |
| F14.21 – Cocaine dependence, in remission | <input type="checkbox"/> |
| F14.9 – Cocaine use, unspecified | <input type="checkbox"/> |
| Other stimulant related disorders | |
| F15.10 – Other stimulant abuse, uncomplicated | <input type="checkbox"/> |
| F15.11 – Other stimulant abuse, in remission | <input type="checkbox"/> |
| F15.20 – Other stimulant dependence, uncomplicated | <input type="checkbox"/> |
| F15.21 – Other stimulant dependence, in remission | <input type="checkbox"/> |
| F15.9 – Other stimulant use, unspecified | <input type="checkbox"/> |
| Hallucinogen related disorders | |
| F16.10 – Hallucinogen abuse, uncomplicated | <input type="checkbox"/> |
| F16.11 – Hallucinogen abuse, in remission | <input type="checkbox"/> |
| F16.20 – Hallucinogen dependence, uncomplicated | <input type="checkbox"/> |
| F16.21 – Hallucinogen dependence, in remission | <input type="checkbox"/> |
| F16.9 – Hallucinogen use, unspecified | <input type="checkbox"/> |
| SUBSTANCE USE DIAGNOSES | Diagnosed? |

| | |
|---|--------------------------|
| Inhalant related disorders | |
| F18.10 – Inhalant abuse, uncomplicated | <input type="checkbox"/> |
| F18.11 – Inhalant abuse, in remission | <input type="checkbox"/> |
| F18.20 – Inhalant dependence, uncomplicated | <input type="checkbox"/> |
| F18.21 – Inhalant dependence, in remission | <input type="checkbox"/> |
| F18.9 – Inhalant use, unspecified | <input type="checkbox"/> |
| Other psychoactive substance related disorders | |
| F19.10 – Other psychoactive substance abuse, uncomplicated | <input type="checkbox"/> |
| F19.11 – Other psychoactive substance abuse, in remission | <input type="checkbox"/> |
| F19.20 – Other psychoactive substance dependence, uncomplicated | <input type="checkbox"/> |
| F19.21 – Other psychoactive substance dependence, in remission | <input type="checkbox"/> |
| F19.9 – Other psychoactive substance use, unspecified | <input type="checkbox"/> |
| Nicotine dependence | |
| F17.20 – Nicotine dependence, unspecified | <input type="checkbox"/> |
| F17.21 – Nicotine dependence, cigarettes | <input type="checkbox"/> |

For BASELINE:

- **If an interview WAS conducted, go to Demographic Data.**
- **If an interview WAS NOT conducted, STOP HERE.**

For REASSESSMENT or CLINICAL DISCHARGE:

- **If an interview WAS conducted, go to Section A.**
- **If an interview WAS NOT conducted, go to Section H.**

DEMOGRAPHIC DATA

DEMOGRAPHIC DATA are only collected at BASELINE. If this is NOT a BASELINE, go to Section A.

1. What do you consider yourself to be? [READ CHOICES.]

- Male
- Female
- Transgender (Male to Female)
- Transgender (Female to Male)
- Gender non-conforming
- OTHER (Specify) _____
- REFUSED

2. Do you think of yourself as...

- Straight or Heterosexual
- Homosexual (Gay Or Lesbian)
- Bisexual
- Queer
- Pansexual
- Questioning
- Asexual
- Something Else? Please Specify _____
- REFUSED

3. Are you [is your child] Hispanic, Latino/a, or of Spanish origin?

- Yes
- No **[SKIP TO QUESTION 4.]**
- REFUSED **[SKIP TO QUESTION 4.]**

**3a. [IF QUESTION 3 IS YES] What ethnic group do you [your child] consider yourself [themselves]?
You may indicate more than one.**

- Central American
- Cuban
- Dominican
- Mexican
- Puerto Rican
- South American
- OTHER (Specify) _____
- REFUSED

4. What is your [your child's] race? You may indicate more than one.

- Black or African American
- White
- American Indian
- Alaska Native
- South Asian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander
- OTHER (Specify) _____
- REFUSED

5. [IF CLIENT 5 YEARS OLD OR OLDER] Do you [does your child] speak a language other than English at home?

- Yes
- No
- NOT APPLICABLE

5a. [IF CLIENT 5 YEARS OLD OR OLDER] [IF QUESTION 5 IS YES] What is this language?

- Spanish
- OTHER (Specify) _____

6. [ADULT ONLY] Have you ever served in the Armed Forces, the Reserves, or the National Guard?

- Yes
- No *[GO TO SECTION A.]*
- DON'T KNOW *[GO TO SECTION A.]*
- NOT APPLICABLE *[GO TO SECTION A.]*

7. [ADULT ONLY] [IF QUESTION 6 IS YES] Are you currently serving on active duty in the Armed Forces, the Reserves, or the National Guard?

- Yes
- No
- REFUSED
- DON'T KNOW

A. FUNCTIONING

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

- Excellent
- Very Good
- Good
- Fair
- Poor
- NO RESPONSE/REFUSED

2. To provide the best mental health and related services, we need to know how well you were [your child was] able to deal with everyday life during the past 30 [thirty] days. Please indicate your [your child's] response to each of the following statements:

[READ EACH STATEMENT TO THE CLIENT OR CAREGIVER, FOLLOWED BY RESPONSE OPTIONS OF YES OR NO]

| During the past 30 [thirty] days | Yes | No | NO RESPONSE/ REFUSED |
|--|--------------------------|--------------------------|--------------------------|
| 2a. I am [my child is] handling daily life. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2b. I am [my child is] able to deal with unexpected events in my [their] life. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2c. I [my child does] get along with friends and other people. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2d. I [my child does] get along with family members. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2e. I do [my child does] well in social situations. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2f. I do [my child does] well in school and/or work. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2g. I have [my child has] had a safe place to live. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

3. The following questions ask about how you have [your child has] been feeling during the past 30 [thirty] days. Please indicate your [your child's] response to each question:

| During the past 30 [thirty] days, did you [your child] feel ... | Yes | No | NO RESPONSE/ REFUSED |
|---|--------------------------|--------------------------|--------------------------|
| 3a. Nervous? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3b. Hopeless? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3c. Restless or fidgety? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3d. So depressed that nothing could cheer you [your child] up? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3e. That everything was an effort? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3f. Worthless? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3g. Bothered by psychological or emotional problems? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

B. STABILITY IN HOUSING

1. In the past 30 [thirty] days, have you [has your child] ...

| | Yes | No | NO RESPONSE/ REFUSED |
|---|--------------------------|--------------------------|--------------------------|
| 1a. Been homeless? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1b. Spent time in a hospital for mental health care? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1c. Spent time in a facility for detox/inpatient treatment for a substance abuse disorder? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1d. Spent time in a correctional facility (e.g., jail, prison, [juvenile] facility)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1e. Gone to an emergency room for a mental health or emotional problem? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1f. Been satisfied with the conditions of your living space? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

2. In the past 30 [thirty] days, where have you [has your child] been living most of the time?

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

- PRIVATE RESIDENCE
- FOSTER HOME
- RESIDENTIAL CARE
- CRISIS RESIDENCE
- RESIDENTIAL TREATMENT CENTER
- INSTITUTIONAL SETTING
- JAIL/CORRECTIONAL FACILITY
- HOMELESS/SHELTER
- OTHER (SPECIFY) _____
- DON'T KNOW

C. EDUCATION AND EMPLOYMENT

1. Are you [is your child] currently enrolled in school or a job training program?

- Yes
- No
- NO RESPONSE/REFUSED

2. [ADULT ONLY] What is the highest level of education you have finished, whether or not you received a degree? [SELECT ONLY ONE]

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

3. [ADULT ONLY] Are you currently employed? [SELECT ONLY ONE]

- Employed full-time (35+ HOURS PER WEEK)
- Employed, part-time
- Unemployed, but looking for work
- Not Employed, NOT looking for work
- Not working due to a disability
- Retired, not working
- OTHER (SPECIFY) _____
- REFUSED
- DON'T KNOW

4. In the past 30 [thirty] days, did you have enough money to meet your [your child's] needs?

- Yes
- No
- NO RESPONSE/REFUSED
-

D. CRIME AND CRIMINAL JUSTICE STATUS

1. In the past 30 [thirty] days, have you [has your child]...

| | Yes | No | NO RESPONSE/ REFUSED |
|---|--------------------------|--------------------------|--------------------------|
| 1a. Been arrested? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1b. Spent time in jail or a correctional facility or been on probation? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If this is a BASELINE assessment, go to Section F.

If this is a REASSESSMENT or a CLINICAL DISCHARGE assessment, go to Section E.

Section E data is collected only for the REASSESSMENT interview and the CLINICAL DISCHARGE assessment.

E. PERCEPTION OF CARE

1. In order to provide the best possible mental health and related services, we need to know what you [your child] think[s] about the services you [they] received during the past 30 [thirty] days, the people who provided it, and the results. Please indicate your [your child's] disagreement/agreement with each of the following statements.

[READ EACH STATEMENT TO THE CLIENT OR CAREGIVER, FOLLOWED BY RESPONSE OPTIONS OF YES OR NO]

| Statement | Yes | No | NO RESPONSE/ REFUSED |
|--|--------------------------|--------------------------|--------------------------|
| 1a. Staff here believe that I [my child] can grow, change, and recover. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1b. I [my child] felt free to complain. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1c. I [my child] was given information about my [my child's] rights. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1d. Staff encouraged me [my child] to take responsibility for how I [they] live my [their] life. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1e. Staff told me [my child] what side effects to watch out for. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1f. Staff respected my [my child's] wishes about who is and who is not to be given information about my [my child's] treatment. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1g. Staff were sensitive to my [my child's] cultural background (e.g., race, religion, language). | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1h. Staff helped me [my child] obtain the information I [my child] needed so that I [my child] could take charge of managing my [their] illness. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1i. I [my child] was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.). | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1j. I [my child] felt comfortable asking questions about my [their] treatment and medication. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1k. I [my child], not staff, decided my [my child's] treatment goals. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1l. I [my child] like[s] the services received here. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1m. I [my child] would still get services from this agency if there were other choices. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1n. I [my child] would recommend this agency to a friend or family member. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Question 2 should be answered by grantee staff at REASSESSMENT and CLINICAL DISCHARGE.

2. Indicate which grantee staff administered section E to the client for this interview:

- Administrative staff
- Care coordinator
- Case manager
- Clinician providing direct services
- Clinician not providing direct services
- Consumer/peer
- Data collector/evaluator
- Family advocate
- Other (Specify) _____

F. SOCIAL CONNECTEDNESS

1. Please indicate YES or NO for 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 [thirty] days.

[READ EACH STATEMENT TO THE CLIENT OR CAREGIVER, FOLLOWED BY RESPONSE OPTIONS OF YES OR NO]

| Statement | Yes | No | NO RESPONSE/ REFUSED |
|---|--------------------------|--------------------------|--------------------------|
| 1a. I am [my child is] happy with my [their] friendships. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1b. I have [my child has] people with whom I [they] can do enjoyable things. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1c. I feel [my child feels] that I [they] belong in the community. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1d. In a crisis, I [my child] would have the support needed from family or friends. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1e. I have [my child has] family or friends that are supportive of my [their] recovery. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1f. I [my child] generally accomplish[es] what I [they] set out to do. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

IF YOUR PROGRAM DOES NOT REQUIRE SECTION G and this is a ...

BASELINE ASSESSMENT, stop now – the interview is completed.

REASSESSMENT interview or CLINICAL DISCHARGE – go to Section H.

IF YOUR PROGRAM DOES REQUIRE SECTION G, and this is a ...

BASELINE interview – go to Section G for your program and then stop.

REASSESSMENT interview or CLINICAL DISCHARGE interview – go to Section G for your program, and then to Section H.

G. PROGRAM-SPECIFIC QUESTIONS

You are NOT responsible for collecting data on ALL Section G questions. Only complete the Section G which is specific to your program.

Your GPO will provide guidance on which specific Section G questions you are to complete. If you have any questions, please contact your GPO.

G1. [ASSISTED OUTPATIENT TREATMENT](#)

G2. [LAW ENFORCEMENT AND BEHAVIORAL HEALTH PARTNERSHIPS FOR EARLY DIVERSION](#)

G3. [PROMOTING THE INTEGRATION OF PRIMARY AND BEHAVIORAL HEALTH CARE](#)

G4. [MINORITY AIDS – SERVICE INTEGRATION](#)

G5. [HEALTHY TRANSITIONS](#)

G6. [ASSERTIVE COMMUNITY TREATMENT](#)

G7. [CLINICAL HIGH RISK FOR PSYCHOSIS](#)

G8. [CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS](#)

G9. [NATIONAL CHILD TRAUMATIC STRESS INITIATIVE – CATEGORY 3](#)

G1. ASSISTED OUTPATIENT TREATMENT PROGRAM-SPECIFIC QUESTIONS

1. In the past 30 [thirty] days, have you taken your psychiatric medication(s) as prescribed to you?

- Yes
- No
- REFUSED
- NOT APPLICABLE

Question 2 should be answered by grantee staff at REASSESSMENT and CLINICAL DISCHARGE.

2. In the past 30 [thirty] days, has the client followed their treatment plan?

- Yes
- No
- Refused
- Not applicable

If this is a BASELINE assessment, stop here.

If this is a REASSESSMENT, go to Section H.

If this is a CLINICAL DISCHARGE assessment, go to Section H.

G2. LAW ENFORCEMENT AND BEHAVIORAL HEALTH PARTNERSHIPS FOR EARLY DIVERSION PROGRAM-SPECIFIC QUESTIONS

Questions 1 and 2 should be answered by grantee staff at BASELINE, REASSESSMENT, and CLINICAL DISCHARGE.

1. Was the client referred to mental health services?

- Yes No

1a. [IF QUESTION 1 IS YES] Did they receive mental health services?

- Yes No

2. Was the client referred to substance use disorder services?

- Yes No

2a. [IF QUESTION 2 IS YES] Did they receive substance use disorder services?

- Yes No

Question 3 should be answered by the client only at REASSESSMENT and CLINICAL DISCHARGE.

3. Has this program helped you avoid further contact with the police and criminal justice system?

- Yes
 No
 NO RESPONSE/REFUSED

If this is a BASELINE assessment, stop here.

If this is a REASSESSMENT, go to Section H.

If this is a CLINICAL DISCHARGE assessment, go to Section H.

**G3. PROMOTING THE INTEGRATION OF PRIMARY AND BEHAVIORAL HEALTH CARE
PROGRAM-SPECIFIC QUESTIONS**

Question 1 should be answered by the client at BASELINE, REASSESSMENT, and CLINICAL DISCHARGE.

- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| 1. In the past 30 [thirty] days, have you | Yes | No | REFUSED |
| 1a. Been to the emergency room for a physical healthcare problem? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1b. Been hospitalized overnight for a physical healthcare problem? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Program-Specific Health Items should be answered by grantee staff at BASELINE, REASSESSMENT, and CLINICAL DISCHARGE.

2. Health measurements

- | | | |
|----------------------------------|----------------------|------|
| 2a. Systolic blood pressure | <input type="text"/> | mmHg |
| 2b. Diastolic blood pressure | <input type="text"/> | mmHg |
| 2c. Weight | <input type="text"/> | kg |
| 2d. Height | <input type="text"/> | cm |
| 2e. Breath CO for smoking status | <input type="text"/> | ppm |

3. Blood test results. Please choose one of b or c only.

- 3a. Date of blood draw: / /
- MONTH DAY YEAR
- | | | |
|----------------------------|----------------------|-------|
| 3b. Fasting plasma glucose | <input type="text"/> | mg/dL |
| 3c. HgBA1c | <input type="text"/> | % |
| 3d. Total Cholesterol | <input type="text"/> | mg/dL |
| 3e. LDL Cholesterol | <input type="text"/> | mg/dL |

If this is a BASELINE assessment, stop here.

If this is a REASSESSMENT, go to Section H.

If this is a CLINICAL DISCHARGE assessment, go to Section H.

G4. MINORITY AIDS – SERVICE INTEGRATION PROGRAM-SPECIFIC QUESTIONS

Questions should be answered by the client at BASELINE, REASSESSMENT, and CLINICAL DISCHARGE.

1. Did the program provide an HIV test?

- Yes
- No *[SKIP TO QUESTION 2.]*
- REFUSED *[SKIP TO QUESTION 2.]*
- DON'T KNOW *[SKIP TO QUESTION 2.]*

1a. *[IF QUESTION 1 IS YES]* What was the result?

- Positive
- Negative *[SKIP TO QUESTION 2.]*
- Indeterminate *[SKIP TO QUESTION 2.]*
- REFUSED *[SKIP TO QUESTION 2.]*
- DON'T KNOW *[SKIP TO QUESTION 2.]*

1b. *[IF QUESTION 1a IS POSITIVE]* Were you connected to HIV treatment services?

- Yes
- No
- REFUSED
- DON'T KNOW

2. Did the program provide a Hepatitis B (HBV) test?

- Yes
- No *[SKIP TO QUESTION 3.]*
- REFUSED *[SKIP TO QUESTION 3.]*
- DON'T KNOW *[SKIP TO QUESTION 3.]*

2a. *[IF QUESTION 2 IS YES]* What was the result?

- Positive
- Negative *[SKIP TO QUESTION 3.]*
- Indeterminate *[SKIP TO QUESTION 3.]*
- REFUSED *[SKIP TO QUESTION 3.]*
- DON'T KNOW *[SKIP TO QUESTION 3.]*

2b. *[IF QUESTION 2a IS POSITIVE]* Were you connected to HBV treatment services?

- Yes
- No
- REFUSED
- DON'T KNOW

3. Did the program provide a Hepatitis C (HCV) test?

- Yes
- No *[SKIP TO QUESTION 4.]*
- REFUSED *[SKIP TO QUESTION 4.]*
- DON'T KNOW *[SKIP TO QUESTION 4.]*

3a. *[IF QUESTION 3 IS YES]* What was the result?

- Positive
- Negative *[SKIP TO QUESTION 4.]*
- Indeterminate *[SKIP TO QUESTION 4.]*
- REFUSED *[SKIP TO QUESTION 4.]*
- DON'T KNOW *[SKIP TO QUESTION 4.]*

3b. *[IF QUESTION 3a IS POSITIVE]* Were you connected to HCV treatment services?

- Yes
- No
- REFUSED
- DON'T KNOW

4. Did you receive a referral form from *[INSERT GRANTEE NAME]* to medical care?

- Yes
- No
- REFUSED
- DON'T KNOW

5. Have you been prescribed an Antiretroviral Medication (ART)?

- Yes
- No
- REFUSED
- DON'T KNOW

5a. *[IF QUESTION 5 IS YES]* In the past 30 [thirty] days, how often have you taken your ART as prescribed to you?

- Always
- Usually
- Sometimes
- Rarely
- Never
- REFUSED
- DON'T KNOW
- NOT APPLICABLE *[IF THE PRESCRIPTION WAS GIVEN FOR THE FIRST TIME AT THIS APPOINTMENT, SELECT NOT APPLICABLE.]*

If this is a BASELINE assessment, stop here.

If this is a REASSESSMENT, go to Section H.

If this is a CLINICAL DISCHARGE assessment, go to Section H.

**G5. HEALTHY TRANSITIONS
PROGRAM-SPECIFIC QUESTIONS**

Questions should be answered by grantee staff at BASELINE, REASSESSMENT and CLINICAL DISCHARGE.

1. Was the client referred to mental health services?

YES NO

1a. [IF QUESTION 1 IS YES] Did they receive mental health services?

YES NO

2. Was the client referred to substance use disorder services?

YES NO

2a. [IF QUESTION 2 IS YES] Did they receive substance use disorder services?

YES NO

If this is a BASELINE assessment, stop here.

If this is a REASSESSMENT, go to Section H.

If this is a CLINICAL DISCHARGE assessment, go to Section H.

G6. ASSERTIVE COMMUNITY TREATMENT PROGRAM-SPECIFIC QUESTIONS

Questions should be answered by the client at REASSESSMENT and CLINICAL DISCHARGE. If this is a BASELINE assessment, stop here.

1. How often does a member of your team interact with you?

- At least daily
- At least weekly
- At least monthly
- Never
- REFUSED
- DON'T KNOW

2. If I need to talk with someone on my team, I know who to call.

- Yes
- No
- REFUSED
- NOT APPLICABLE

If this is a REASSESSMENT, go to Section H.

If this is a CLINICAL DISCHARGE assessment, go to Section H.

G7. CLINICAL HIGH RISK FOR PSYCHOSIS PROGRAM-SPECIFIC QUESTIONS

Question 1 is answered by grantee staff at REASSESSMENT and CLINICAL DISCHARGE. If this is a BASELINE assessment, stop here.

1. Has the client experienced an episode of psychosis since their last interview?

- Yes
- No
- DON'T KNOW

1a. [IF QUESTION 1 IS YES] Please indicate the approximate date that the client initially experienced psychosis.

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

1b. [IF QUESTION 1 IS YES] Was the client referred to services?

- Yes
- No
- DON'T KNOW

1c. [IF QUESTION 1b IS YES] Please indicate the date that the client received services/treatment.

 |_|_|_| / |_|_|_|_|_| DON'T KNOW
 MONTH YEAR □

If this is a REASSESSMENT, go to Section H.

If this is a CLINICAL DISCHARGE assessment, go to Section H.

G8. CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS PROGRAM-SPECIFIC QUESTIONS

Questions should be answered by grantee staff at BASELINE, REASSESSMENT and CLINICAL DISCHARGE.

1. During the past 30 [thirty] days, did the client receive the following services?

- | | | |
|---|------------------------------|-----------------------------|
| 1a. Crisis mental health services | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 1b. Screening, assessment, diagnosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 1c. Patient-centered treatment planning | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 1d. Outpatient mental health services | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 1e. Physical health screening/monitoring | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 1f. Targeted case management | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 1g. Psychiatric rehabilitation services | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 1h. Peer support services | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 1i. Family psychoeducation and support | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 1j. Services for veterans and military members | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

2. Health measurements:

- | | | |
|-------------------------------------|----------------------|------|
| 2a. Systolic blood pressure | <input type="text"/> | mmHg |
| 2b. Diastolic blood pressure | <input type="text"/> | mmHg |
| 2c. Weight | <input type="text"/> | kg |
| 2d. Height | <input type="text"/> | cm |

If this is a BASELINE assessment, stop here.

If this is a REASSESSMENT, go to Section H.

If this is a CLINICAL DISCHARGE assessment, go to Section H.

**G9. NATIONAL CHILD TRAUMATIC STRESS INITIATIVE – CATEGORY 3
PROGRAM-SPECIFIC QUESTIONS**

Questions should be answered by the client or caregiver at REASSESSMENT and CLINICAL DISCHARGE. If this is a BASELINE assessment, stop here.

[READ EACH STATEMENT BELOW TO THE CLIENT OR CAREGIVER AND NOTE RESPONSE.]

| Statement | Yes | No | NO RESPONSE/ REFUSED | NOT APPLICABLE |
|--|--------------------------|--------------------------|-------------------------------------|---------------------------|
| 1. As a result of treatment and services received, my [my child's] trauma and/or loss experiences were identified and addressed. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. As a result of treatment and services received for trauma and/or loss experiences, my [my child's] problem behaviors/symptoms have decreased. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If this is a REASSESSMENT, go to Section H.

If this is a CLINICAL DISCHARGE assessment, go to Section H.

H. SERVICES RECEIVED AND CLINICAL DISCHARGE STATUS

Question 1 is answered by grantee staff at REASSESSMENT and CLINICAL DISCHARGE only.

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

/
 MONTH YEAR

Identify all the services your grant project provided to the client during their participation in the program. This includes grant-funded and non-grant funded services.

| Core Services | <u>Provided</u> | | Unknown | Service Not Available |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| | Yes | No | | |
| 1a. Screening | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1b. Assessment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1c. Treatment Planning or Review | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1d. Psychopharmacological Services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1e. Mental Health Services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1f. Co-occurring Services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1g. Case Management | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1h. Trauma-specific Services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1i. Was the client referred to another provider for any of the above core services? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| Support Services | <u>Provided</u> | | Unknown | Service Not Available |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| | Yes | No | | |
| 1j. Medical Care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1k. Employment Services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1l. Family Services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1m. Child Care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1n. Transportation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1o. Education Services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1p. Housing Support | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1q. Social Recreational Activities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1r. Consumer-Operated Services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1s. HIV Testing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1t. Was the client referred to another provider for any of the above support services? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Questions 2 and 3 are answered by grantee staff at CLINICAL DISCHARGE only.

2. On what date was the client discharged?

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

3. What is the client's discharge status?

- Mutually agreed cessation of treatment
- Withdrew from/refused treatment
- No contact within 90 days of last encounter
- Clinically referred out
- Death
- Other (Specify) _____