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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)

April 2024

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# RECORD MANAGEMENT

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| --- |
| 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:

| * **Baseline Assessment**
 | * **Reassessment** (3-month or 6-month)
 | * **Clinical Discharge Assessment**
 |
| --- | --- | --- |
| **Enter the MONTH and YEAR when the client first received services under this grant for this episode of care.**  |  |   |
| |\_\_\_\_|\_\_\_\_| / |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_| MONTH YEAR |  |   |

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

 |\_\_\_\_|\_\_\_\_| / |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|

 MONTH YEAR

 3. Was the assessment interview conducted?

| * Yes
 | * No
 |
| --- | --- |
| **When?**|\_\_\_\_|\_\_\_\_| / |\_\_\_\_|\_\_\_\_| /|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_| MONTH DAY YEAR | **Why not? Choose only one.*** Not able to obtain consent from proxy
* Client was impaired or unable to provide consent
* Client refused this interview
* Client was not reached for interview
* 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
1. 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
1. 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

|  |  |
| --- | --- |
| **MENTAL HEALTH DIAGNOSES**  | **Diagnosed?** |
| Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders |  |
| 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 | 🌕 |
| Mood [affective] disorders |  |
| 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 | 🌕 |
| Phobic Anxiety and Other Anxiety Disorders |  |
| F40 – Phobic anxiety disorders | 🌕 |
| F40.00 – Agoraphobia, unspecified  | 🌕 |
| F40.01 – Agoraphobia with panic disorder | 🌕 |
| F40.02 – Agoraphboia without panic disorder | 🌕 |
| F40.1 – Social phobias (Social anxiety disorder) | 🌕 |
| F40.10 – Social phobia, unspecified  | 🌕 |
| F40.11 – Social phobia, generalized | 🌕 |
| F40.2 – Specific (isolated) phobias | 🌕 |
| F41 – Other anxiety disorders | 🌕 |
| F41.0 – Panic disorder | 🌕 |
| F41.1 – Generalized anxiety disorder | 🌕 |
| Obsessive-compulsive disorders |  |
| F42 – Obsessive-compulsive disorder | 🌕 |
| F42.2 – Obsessive-compulsive disorder with mixed obsessional thoughts and acts | 🌕 |
| F42.3 – Hoarding disorder | 🌕 |
| F42.4 – Excoriation (skin-picking) disorder | 🌕 |
| F42.8 – Other obsessive-compulsive disorder | 🌕 |
| F42.9 – Obsessive-compulsive disorder, unspecified | 🌕 |
| **MENTAL HEALTH DIAGNOSES**  | **Diagnosed?** |
| Reaction to severe stress and adjustment disorders |  |
| F43 – Acute stress disorder; reaction to severe stress, and adjustment disorders | 🌕 |
| F43.10 – Post traumatic stress disorder, unspecified | 🌕 |
| F43.2 – Adjustment disorders | 🌕 |
| F44 – Dissociative and conversion disorders | 🌕 |
| F44.81 – Dissociative identity disorder | 🌕 |
| F45 – Somatoform disorders | 🌕 |
| F45.22 – Body dysmorphic disorder | 🌕 |
| F48 – Other non-psychotic mental disorders  | 🌕 |
| Behavioral syndromes associated with physiological disturbances and physical factors |  |
| F50 – Eating disorders | 🌕 |
| F51 – Sleep disorders not due to a substance or known physiological condition | 🌕 |
| Disorders of adult personality and behavior |  |
| F60.0 – Paranoid personality disorder | 🌕 |
| F60.1 – Schizoid personality disorder | 🌕 |
| F60.2 – Antisocial personality disorder | 🌕 |
| F60.3 – Borderline personality disorder | 🌕 |
| F60.4 – Histrionic personality disorder | 🌕 |
| F60.5 – Obsessive-compulsive personality disorder | 🌕 |
| F60.6 – Avoidant personality disorder | 🌕 |
| F60.7 – Dependent personality disorder | 🌕 |
| F60.8 – Other specific personality disorders | 🌕 |
| F60.9 – Personality disorder, unspecified | 🌕 |
| F63.3 – Trichotillomania | 🌕 |
| F70–F79 – Intellectual disabilities | 🌕 |
| F80–F89 – Pervasive and specific developmental disorders | 🌕 |
| Behavioral and emotional disorders with onset usually occurring in childhood and adolescence |  |
| F90 – Attention-deficit hyperactivity disorders | 🌕 |
| F91 – Conduct disorders | 🌕 |
| F93 – Emotional disorders with onset specific to childhood | 🌕 |
| F93.0 – Separation anxiety disorder of childhood | 🌕 |
| F94 – Disorders of social functioning with onset specific to childhood or adolescence | 🌕 |
| F94.0 – Selective mutism | 🌕 |
| F94.1 – Reactive attachment disorder of childhood | 🌕 |
| F94.2 – Disinhibited attachment disorder of childhood | 🌕 |
| F95 – Tic disorder | 🌕 |
| F98 – Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence | 🌕 |
| F99 – Unspecified mental disorder | 🌕 |
|  |  |
| Z codes – Persons with potential health hazards related to socioeconomic and psychosocial circumstances | **Diagnosed?** |
| Z55 – Problems related to education and literacy | 🌕 |
| Z56 – Problems related to employment and unemployed | 🌕 |
| Z57 – Occupational exposure to risk factors | 🌕 |
| Z59 – Problems related to housing and economic circumstances | 🌕 |
| Z60 – Problems related to social environment | 🌕 |
| Z62 – Problems related to upbringing | 🌕 |
| 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 | 🌕 |
| Z64 – Problems related to certain psychological circumstances | 🌕 |
| Z65 – Problems related to other psychosocial circumstances | 🌕 |

|  |  |
| --- | --- |
| **SUBSTANCE USE DIAGNOSES**  | **Diagnosed?** |
| **Alcohol related disorders** |  |
| F10.10 – Alcohol abuse, uncomplicated | 🌕 |
| F10.11 – Alcohol abuse, in remission | 🌕 |
| F10.20 – Alcohol dependence, uncomplicated | 🌕 |
| F10.21 – Alcohol dependence, in remission | 🌕 |
| F10.9 – Alcohol use, unspecified | 🌕 |
| **Opioid related disorders** |  |
| F11.10 – Opioid abuse, uncomplicated, | 🌕 |
| F11.11 – Opioid abuse, in remission | 🌕 |
| F11.20 – Opioid dependence, uncomplicated | 🌕 |
| F11.21 – Opioid dependence, in remission | 🌕 |
| F11.9 – Opioid use, unspecified | 🌕 |
| **Cannabis related disorders** |  |
| F12.10 – Cannabis abuse, uncomplicated | 🌕 |
| F12.11 – Cannabis abuse, in remission | 🌕 |
| F12.20 – Cannabis dependence, uncomplicated | 🌕 |
| F12.21 – Cannabis dependence, in remission | 🌕 |
| F12.9 – Cannabis use, unspecified | 🌕 |
| **Sedative, hypnotic, or anxiolytic related disorders** |  |
| F13.10 – Sedative, hypnotic, or anxiolytic abuse, uncomplicated | 🌕 |
| F13.11 – Sedative, hypnotic, or anxiolytic abuse, in remission | 🌕 |
| F13.20 – Sedative, hypnotic, or anxiolytic dependence, uncomplicated | 🌕 |
| F13.21 – Sedative, hypnotic, or anxiolytic dependence, in remission | 🌕 |
| F13.9 – Sedative, hypnotic, or anxiolytic-related use, unspecified | 🌕 |
| **Cocaine related disorders** |  |
| F14.10 – Cocaine abuse, uncomplicated | 🌕 |
| F14.11 – Cocaine abuse, in remission | 🌕 |
| F14.20 – Cocaine dependence, uncomplicated | 🌕 |
| F14.21 – Cocaine dependence, in remission | 🌕 |
| F14.9 – Cocaine use, unspecified | 🌕 |
| **Other stimulant related disorders** |  |
| F15.10 – Other stimulant abuse, uncomplicated | 🌕 |
| F15.11 – Other stimulant abuse, in remission | 🌕 |
| F15.20 – Other stimulant dependence, uncomplicated | 🌕 |
| F15.21 – Other stimulant dependence, in remission | 🌕 |
| F15.9 – Other stimulant use, unspecified  | 🌕 |
| **Hallucinogen related disorders** |  |
| F16.10 – Hallucinogen abuse, uncomplicated | 🌕 |
| F16.11 – Hallucinogen abuse, in remission | 🌕 |
| F16.20 – Hallucinogen dependence, uncomplicated | 🌕 |
| F16.21 – Hallucinogen dependence, in remission | 🌕 |
| F16.9 – Hallucinogen use, unspecified | 🌕 |
| **SUBSTANCE USE DIAGNOSES**  | **Diagnosed?** |
| **Inhalant related disorders** |  |
| F18.10 – Inhalant abuse, uncomplicated | 🌕 |
| F18.11 – Inhalant abuse, in remission | 🌕 |
| F18.20 – Inhalant dependence, uncomplicated | 🌕 |
| F18.21 – Inhalant dependence, in remission | 🌕 |
| F18.9 – Inhalant use, unspecified | 🌕 |
| **Other psychoactive substance related disorders** |  |
| F19.10 – Other psychoactive substance abuse, uncomplicated | 🌕 |
| F19.11 – Other psychoactive substance abuse, in remission | 🌕 |
| F19.20 – Other psychoactive substance dependence, uncomplicated  | 🌕 |
| F19.21 – Other psychoactive substance dependence, in remission | 🌕 |
| F19.9 – Other psychoactive substance use, unspecified | 🌕 |
| **Nicotine dependence** |  |
| F17.20 – Nicotine dependence, unspecified | 🌕 |
| F17.21 – Nicotine dependence, cigarettes | 🌕 |

|  |
| --- |
| **For BASELINE:*** **If an interview WAS conducted, go to Demographic Data.**
* **If an interview WAS NOT conducted, go to Section G (if applicable) or 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 G (if applicable) or 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
1. Do you think of yourself as…
* Straight or Heterosexual
* Homosexual (Gay Or Lesbian)
* Bisexual
* Queer
* Pansexual
* Questioning
* Asexual
* Something Else? Please Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* REFUSED
1. 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
1. 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
1. [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) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
1. [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.]***
1. [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

1. 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 |
| a. I am [my child is] handling daily life. | 🌕 | 🌕 | 🌕 |
| b. I am [my child is] able to deal with unexpected events in my [their] life. | 🌕 | 🌕 | 🌕 |
| c. I [my child does] get along with friends and other people. | 🌕 | 🌕 | 🌕 |
| d. I [my child does] get along with family members. | 🌕 | 🌕 | 🌕 |
| e. I do [my child does] well in social situations. | 🌕 | 🌕 | 🌕 |
| f. I do [my child does] well in school and/or work. | 🌕 | 🌕 | 🌕 |
| g. I have [my child has] had a safe place to live. | 🌕 | 🌕 | 🌕 |

1. 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 |
| a. Nervous? | ○ | ○ | ○ |
| b. Hopeless? | ○ | ○ | ○ |
| c. Restless or fidgety? | ○ | ○ | ○ |
| d. So depressed that nothing could cheer you [your child] up? | ○ | ○ | ○ |
| e. That everything was an effort? | ○ | ○ | ○ |
| f. Worthless? | ○ | ○ | ○ |
| g. Bothered by psychological or emotional problems? | ○ | ○ | ○ |

# B. STABILITY IN HOUSING

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

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

1. 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 |
| a. Been arrested? | ○ | ○ | ○ |
| b. Spent time in jail or a correctional facility or been on probation? | ○ | ○ | ○ |

|  |
| --- |
| **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 |
| 1. Staff here believe that I [my child] can grow, change, and recover.
 | ○ | ○ | ○ |
| 1. I [my child] felt free to complain.
 | ○ | ○ | ○ |
| 1. I [my child] was given information about my [my child’s] rights.
 | ○ | ○ | ○ |
| 1. Staff encouraged me [my child] to take responsibility for how I [they] live my [their] life.
 | ○ | ○ | ○ |
| 1. Staff told me [my child] what side effects to watch out for.
 | ○ | ○ | ○ |
| 1. Staff respected my [my child’s] wishes about who is and who is not to be given information about my [my child’s] treatment.
 | ○ | ○ | ○ |
| 1. Staff were sensitive to my [my child’s] cultural background (e.g., race, religion, language).
 | ○ | ○ | ○ |
| 1. 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.
 | ○ | ○ | ○ |
| 1. I [my child] was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).
 | ○ | ○ | ○ |
| 1. I [my child] felt comfortable asking questions about my [their] treatment and medication.
 | ○ | ○ | ○ |
| 1. I [my child], not staff, decided my [my child’s] treatment goals.
 | ○ | ○ | ○ |
| 1. I [my child] like[s] the services received here.
 | ○ | ○ | ○ |
| 1. I [my child] would still get services from this agency if there were other choices.
 | ○ | ○ | ○ |
| 1. I [my child] would recommend this agency to a friend or family member.
 | ○ | ○ | ○ |

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

1. **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 |
| 1. I am [my child is] happy with my [their] friendships.
 | ○ | ○ | ○ |
| 1. I have [my child has] people with whom I [they] can do enjoyable things.
 | ○ | ○ | ○ |
| 1. I feel [my child feels] that I [they] belong in the community.
 | ○ | ○ | ○ |
| 1. In a crisis, I [my child] would have the support needed from family or friends.
 | ○ | ○ | ○ |
| 1. I have [my child has] family or friends that are supportive of my [their] recovery.
 | ○ | ○ | ○ |
| 1. I [my child] generally accomplish[es] what I [they] set out to do.
 | ○ | ○ | ○ |

**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**](#_G1._ASSISTED_OUTPATIENT)

G2. [**LAW ENFORCEMENT AND BEHAVIORAL HEALTH PARNTERSHIPS FOR EARLY DIVERSION**](#_G2._LAW_ENFORCEMENT)

G3. [**PROMOTING THE INTEGRATION OF PRIMARY AND BEHAVIORAL HEALTH CARE**](#_G3._PROMOTING_THE)

G4. [**MINORITY AIDS – SERVICE INTEGRATION**](#_G4._MINORITY_AIDS)

G5. [**HEALTHY TRANSITIONS**](#_G5._HEALTHY_TRANSITIONS)

G6. [**ASSERTIVE COMMUNITY TREATMENT**](#_G6._ASSERTIVE_COMMUNITY)

G7. [**CLINICAL HIGH RISK FOR PSYCHOSIS**](#_G7._CLINICAL_HIGH)

G8. [**CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS**](#_G7._CERTIFIED_COMMUNITY)

G9. [**NATIONAL CHILD TRAUMATIC STRESS INITIATIVE – CATEGORY 3**](#_G9._NATIONAL_CHILD)

# G1. ASSISTED OUTPATIENT TREATMENTPROGRAM-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.** |

1. **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 Sections H.** **If this is a CLINICAL DISCHARGE assessment, go to Section H.** |

# G2. LAW ENFORCEMENT AND BEHAVIORAL HEALTH PARNTERSHIPS FOR EARLY DIVERSIONPROGRAM-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.** |

1. **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 CAREPROGRAM-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 |
| a. Been to the emergency room for a physical healthcare problem? | ○| | ○ | ○ |
| b. Been hospitalized overnight for a physical healthcare problem? | ○ | ○ | ○ |

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

1. Health measurements

|  |  |  |  |
| --- | --- | --- | --- |
| a. | Systolic blood pressure |   | mmHg |
| b. | Diastolic blood pressure |   | mmHg |
| c. | Weight |   | kg |
| d. | Height |   | cm |
| f. | Breath CO for smoking status |   | ppm |

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

a. Date of blood draw: |\_\_\_\_|\_\_\_\_| / |\_\_\_\_|\_\_\_\_| / |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|
 MONTH DAY YEAR

|  |  |  |  |
| --- | --- | --- | --- |
| b. | Fasting plasma glucose  |   | mg/dL |
| c. | HgBA1c |   | % |
| d. | Total Cholesterol |   | mg/dL |
| e. | LDL Cholesterol |  | 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 INTEGRATIONPROGRAM-SPECIFIC QUESTIONS

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

1. **Are you currently taking Pre-Exposure Prophylaxis (PrEP) for HIV prevention, or are you taking medication for the treatment of HIV?**
* PrEP
* Treatment for HIV (ART)
* Neither
* REFUSED

**2. Did the program provide an HIV test?**

* Yes
* No
* REFUSED
* DON’T KNOW

**2a. Have you ever tested for HIV?**

* Yes
* No
* REFUSED
* DON’T KNOW

**2b. *[IF QUESTION 2 or 2a IS YES]* What was the result of your most recent HIV test?**

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

**2c. *[IF QUESTION 2b IS POSITIVE]* Were you connected to HIV treatment services within 30 days of the positive test result?**

* Yes
* No
* REFUSED
* DON’T KNOW

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

* Yes
* No
* REFUSED
* DON’T KNOW

**3a. Have you ever been tested for HBV?**

* Yes
* No
* REFUSED
* DON’T KNOW

**3b**. ***[IF QUESTION 3 or 3a IS YES]* What was the result of your most recent HBV test?**

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

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

* Yes
* No
* REFUSED
* DON’T KNOW

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

* Yes
* No
* REFUSED
* DON’T KNOW

**4a. Have you ever been tested for HCV?**

* Yes
* No
* REFUSED
* DON’T KNOW

**4b. *[IF QUESTION 4 or 4a IS YES]* What was the result of your most recent HCV test?**

* Positive
* Negative ***[SKIP TO QUESTION 5.]***
* Indeterminate ***[SKIP TO QUESTION 5.]***
* REFUSED ***[SKIP TO QUESTION 5.]***
* DON’T KNOW ***[SKIP TO QUESTION 5.]***

**4c. *[IF QUESTION 4b IS POSITIVE]* Were you connected to HCV treatment services?**

* Yes
* No
* REFUSED
* DON’T KNOW

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

* Yes
* No
* REFUSED
* DON’T KNOW

**Question 6 should be answered by grantee staff at BASELINE, REASSESSMENT, and CLINICAL DISCHARGE.**

1. **Was the client offered a Hepatitis A and B Vaccination?**
* Yes
* No – Not eligible for vaccine or previously administered
* No

**6a. [IF QUESTION 6 is YES] Was the client referred out for vaccination?**

* Yes
* No – Administered by grantee
* Unknown

# G5. HEALTHY TRANSITIONSPROGRAM-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 TREATMENTPROGRAM-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
1. **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 PSYCHOSISPROGRAM-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 CLINICSPROGRAM-SPECIFIC QUESTIONS

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

* 1. During the past 30 [thirty] days, did the client receive the following services?
		1. Crisis mental health services 🌕 Yes 🌕 No
		2. Screening, assessment, diagnosis 🌕 Yes 🌕 No
		3. Patient-centered treatment planning 🌕 Yes 🌕 No
		4. Outpatient mental health services 🌕 Yes 🌕 No
		5. Physical health screening/monitoring 🌕 Yes 🌕 No
		6. Targeted case management 🌕 Yes 🌕 No
		7. Psychiatric rehabilitation services 🌕 Yes 🌕 No
		8. Peer support services 🌕 Yes 🌕 No
		9. Family psychoeducation and support 🌕 Yes 🌕 No
		10. Services for veterans and military members 🌕 Yes 🌕 No

Question 2, program-specific health items are reported by grantee staff at BASELINE, REASSESSMENT, and CLINICAL DISCHARGE.

* 1. Health measurements:

|  |  |  |  |
| --- | --- | --- | --- |
| a. | Systolic blood pressure |   | mmHg |
| b. | Diastolic blood pressure |   | mmHg |
| c. | Weight |   | kg |
| d. | Height |   | cm |

|  |
| --- |
| **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 3PROGRAM-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 | NOT APPLICABLE |
| **1.** As a result of treatment and services received, my [my child’s] trauma and/or loss experiences were identified and addressed. | ○ | ○ | ○ | ○ |
| **2.** As a result of treatment and services received for trauma and/or loss experiences, my [my child’s] problem behaviors/symptoms have decreased. | ○ | ○ | ○ | ○ |

|  |
| --- |
| **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** | **Provided** | **Unknown** | **Service Not Available** |
| --- | --- | --- | --- |
| **Yes** | **No** |
| 1. Screening
 | ○ | ○ | ○ | ○ |
| 1. Assessment
 | ○ | ○ | ○ | ○ |
| 1. Treatment Planning or Review
 | ○ | ○ | ○ | ○ |
| 1. Psychopharmacological Services
 | ○ | ○ | ○ | ○ |
| 1. Mental Health Services
 | ○ | ○ | ○ | ○ |
| 1. Co-occurring Services
 | ○ | ○ | ○ | ○ |
| 1. Case Management
 | ○ | ○ | ○ | ○ |
| 1. Trauma-specific Services
 | ○ | ○ | ○ | ○ |
| 1. Was the client referred to another provider for any of the above core services?
 | ○ | ○ | ○ | ○ |

| **Support Services** | **Provided** | **Unknown** | **Service Not Available** |
| --- | --- | --- | --- |
| **Yes** | **No** |
|  1j. Medical Care | ○ | ○ | ○ | ○ |
| 1. Employment Services
 | ○ | ○ | ○ | ○ |
| 1. Family Services
 | ○ | ○ | ○ | ○ |
| 1. Child Care
 | ○ | ○ | ○ | ○ |
| 1. Transportation
 | ○ | ○ | ○ | ○ |
| 1. Education Services
 | ○ | ○ | ○ | ○ |
| 1. Housing Support
 | ○ | ○ | ○ | ○ |
| 1. Social Recreational Activities
 | ○ | ○ | ○ | ○ |
| 1. Consumer-Operated Services
 | ○ | ○ | ○ | ○ |
| 1. HIV Testing
 | ○ | ○ | ○ | ○ |
| 1. Was the client referred to another provider for any of the above support services?
 | ○ | ○ | ○ | ○ |

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

1. On what date was the client discharged?

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

1. 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)