

Substance Abuse and Mental Health Services

Administration (SAMHSA)

Unified Performance Reporting Tool

(SUPRT) - A

ADMINISTRATIVE REPORT

Version: August 2024

Public reporting burden for this collection of information is estimated to average 20 minutes per response if all applicable sections are completed. To the extent that providers are able to incorporate and obtain much of this information as part of their ongoing client/consumer/participant intake, client record keeping, or follow-up, less time will be required for collection from clients specifically for this collection. 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-NEW.

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**A. RECORD MANAGEMENT**

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

Site ID        |\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|

Grant ID      |\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|

**1. [AT BASELINE] What is the client's month and year of birth (MM/YYYY)?**

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

**2. What is the date of the assessment (MM/DD/YYYY)?**|\_|\_|\_|\_|\_| / |\_|\_|\_|\_|\_| / |\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|  
MONTH       DAY                   YEAR**3. Which assessment type?**

- ☐ Baseline
- ☐ Reassessment (for clients in care at 3 or 6 months)
- ☐ Annual (for clients in care for more than 12 months)
- ☐ Record Closeout

**4. [AT BASELINE ASSESSMENT ONLY] When did the client first receive services under this grant (MM/YYYY)?** |\_|\_|\_|\_|\_| / |\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|**5. [AT REASSESSMENT OR ANNUAL OR CLOSEOUT] When did the client most recently receive services under this grant (MM/YYYY)?** |\_|\_|\_|\_|\_| / |\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|**6. [AT RECORD CLOSEOUT] Why are you closing out this client's record?**

- ☐ Completed the program
- ☐ No contact
- ☐ Withdrew from/Refused Treatment
- ☐ Referred out
- ☐ Transferred to different grant program
- ☐ Incarceration
- ☐ Moved
- ☐ Death
- ☐ Other

**6a. [IF QUESTION 6 IS DEATH] What was the cause of death?**

- ☐ Suicide
- ☐ Overdose
- ☐ Other behavioral health cause
- ☐ Other cause

- ☐ Not documented in record
- ☐ Not applicable

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## B. BEHAVIORAL HEALTH HISTORY

### 1. What insurance does the client or guarantor have? Select all that apply.

- ☐ Medicare
- ☐ Medicaid
- ☐ Private Insurance or Employer Provided
- ☐ TRICARE, CHAMPUS, CHAMPVA or other veteran or military health care
- ☐ Indian Health Service Tribal Health Care
- ☐ An assistance program [for example, a medication assistance program]
- ☐ Any other type of health insurance or health coverage plan
- ☐ None
- ☐ Not documented in records or not documented in records using this standard

### 2. In the past 30 days, was the client admitted to a hospital?

- ☐ Yes – Behavioral health reasons, for example mental health or substance use disorder
- ☐ Yes – Other health reasons, for example injury or illness
- ☐ No
- ☐ Not documented in records or not documented in records using this standard

### 3. In the past 30 days, did the client visit an emergency department?

- ☐ Yes – Behavioral health reasons, for example mental health or substance use disorder
- ☐ Yes – Other health reasons, for example injury or illness
- ☐ No
- ☐ Not documented in records or not documented in records using this standard

### 4. In the past 30 days, did the client experience a behavioral health crisis or request crisis response, for example from 988 or 911?

- ☐ Yes
- ☐ No
- ☐ Not documented in records or not documented in records using this standard

#### 4a. [IF QUESTION 4 IS YES] What was the primary crisis issue?

- ☐ Suicide risk
- ☐ Other risk of harm to self or others (e.g. NSSI, homicidal thoughts)
- ☐ Mental health
- ☐ Substance use other than overdose
- ☐ Overdose
- ☐ Other
- ☐ Not documented in records or not documented in records using this standard

### 5. In the past 30 days, did the client spend one or more nights at a residential behavioral health

**treatment facility, for example crisis stabilization or residential substance use disorder treatment facility, including for withdrawal management?**

- ☐ Yes
- ☐ No
- ☐ Not documented in records or not documented in records using this standard

**6. [CLIENTS 11 YEARS OR OLDER ONLY] In the past 90 days, was the client arrested, taken into custody, or detained?**

- ☐ Yes
- ☐ No
- ☐ Not documented in records or not documented in records using this standard
- ☐ Not applicable

**7. [CLIENTS 11 YEARS OR OLDER ONLY] In the past 90 days, did the client spend one or more nights in jail or a correctional facility?**

- ☐ Yes
- ☐ No
- ☐ Not documented in records or not documented in records using this standard
- ☐ Not applicable

**8. [CLIENTS 11 YEARS OR OLDER ONLY] In the past 90 days, has the client been on probation, parole, or intensive pretrial supervision for one or more days?**

- ☐ Yes
- ☐ No
- ☐ Not documented in records or not documented in records using this standard
- ☐ Not applicable

## C. BEHAVIORAL HEALTH SCREENINGS

Please indicate the client's screening results, as documented in an individual clinical or client record (whether paper or electronic).

**1. Within the past 30 days, was the client screened or assessed by your program for risk of suicidality?**

- ☐ Yes – Screening result was negative (no or low risk)
- ☐ Yes – Screening result was positive (at risk)
- ☐ No, not screened or assessed
- ☐ Not documented in records or not documented in records using this standard

**2. Within the past 30 days, was the client screened or assessed by your program for substance use?**

- ☐ Yes – Screening result was negative (no or low risk for substance use disorder (SUD))
- ☐ Yes – Screening result was positive (at risk for SUD)
- ☐ No, not screened or assessed
- ☐ Not documented in records or not documented in records using this standard

**3. [IF QUESTION 2 IS “YES”] During the screening and assessment process, what was the reported use for the following substances?**

Substance	Recent use (within the past 30 days)	Past use (greater than 30 days)	Never used	Not documente d
a. Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Opioids	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Cannabis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Sedative, hypnotic, or anxiolytics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Cocaine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Methamphetamine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Other stimulants	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Hallucinogens or psychedelics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Inhalants	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Other psychoactive substances	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Tobacco or nicotine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. Within the past 30 days, was the client screened or assessed by your program for the following disorders? (Please select one per disorder)

Disorder	Not applicable	Screened / Assessed	Not screened	Not documented in records
a. Depression, depressive disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Anxiety disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Bipolar disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Psychosis, psychotic disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Trauma disorders, including PTSD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. [IF CLIENT < 18 YEARS] Developmental, neurologic disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. [IF CLIENT < 18 YEARS] Behavioral and emotional	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## D. BEHAVIORAL HEALTH DIAGNOSIS

Please indicate the client's current behavioral health diagnoses using the most current version of the International Classification of Diseases, 10<sup>th</sup> Revision, Clinical Modification (ICD-10-CM) codes or corresponding Diagnostic Statistical Manual of Mental Disorders (e.g. DSM-5), **as made by a clinician and documented in a clinical record.**

### 1. Substance use disorder diagnosis (record up to 3)

- 1a. Enter ICD-10-CM/DSM-5 code F10-F19- or indicate no diagnosis \_\_\_\_\_  
 1b. Enter ICD-10-CM /DSM-5 code F10-F19- or indicate no diagnosis \_\_\_\_\_  
 1c. Enter ICD-10-CM /DSM-5 code F10-F19- or indicate no diagnosis \_\_\_\_\_

### 2. Mental health diagnosis (record up to 3)

- 2a. Enter ICD-10-CM /DSM-5 code F20-F99- or indicate no diagnosis \_\_\_\_\_  
 2b. Enter ICD-10-CM /DSM-5 code F20-F99- or indicate no diagnosis \_\_\_\_\_  
 2c. Enter ICD-10-CM /DSM-5 code F20-F99- or indicate no diagnosis \_\_\_\_\_

### 3. Other factors influencing health status (record up to 3)

- 3a. Enter ICD-10-CM /DSM-5 code Z55-Z65- or Z69-Z76- or indicate none identified \_\_\_\_\_  
 3b. Enter ICD-10-CM /DSM-5 code Z55-Z65- or Z69-Z76- or indicate none identified \_\_\_\_\_  
 3c. Enter ICD-10-CM /DSM-5 code Z55-Z65- or Z69-Z76- or indicate none identified \_\_\_\_\_

**Other Health Status Questions**

Please indicate additional health status information as applicable and **as documented in a clinical record**.

**4. Is the client currently pregnant?**

- ☐ Yes
- ☐ No
- ☐ Not applicable
- ☐ Not documented in records or not documented in records using this standard

**[CLINICAL HIGH RISK PSYCHOSIS CLIENTS ONLY]****5. [AT REASSESSMENT OR ANNUAL] Has the client experienced an episode of psychosis since their last assessment?**

- ☐ Yes
- ☐ No
- ☐ Not documented in records or not documented in records using this standard

**[SUBSTANCE USE DISORDER TREATMENT CLIENTS ONLY]****6. In the previous 30 days, did the client experience an overdose or take too much of a substance that resulted in needing supervision or medical attention?**

- ☐ Yes
- ☐ No
- ☐ Not documented in records or not documented in records using this standard
- ☐ Not applicable

**6a. [IF QUESTION 6 IS YES] After taking too much of a substance or overdosing, what intervention(s) did the client receive? Select all that apply.**

- ☐ Naloxone (Narcan) or other opioid overdose reversal medication
- ☐ Care in an emergency department
- ☐ Care from a primary care provider
- ☐ Admission to a hospital
- ☐ Supervision by someone else
- ☐ Other
- ☐ Not documented in records or not documented in records using this standard
- ☐ Not applicable

**[MAI PROGRAM CLIENTS ONLY]****7. Has the client ever tested positive for HIV?**

- ☐ Yes, HIV-positive
- ☐ No, HIV-negative
- ☐ Not documented in records or not documented in records using this standard

**7a. [IF 7 is Yes, HIV-infected] Is the client currently on ART?**

- ☐ Yes, currently taking ART
- ☐ No, not currently taking ART

- ☐ Not documented in records or not documented in records using this standard

7b. [If 7 is No, HIV-negative] Is the client currently taking HIV PrEP?

- ☐ Yes, currently on PrEP
- ☐ No, not currently on PrEP
- ☐ Not documented in records or not documented in records using this standard

8. Has the client ever tested positive for Hepatitis C?

- ☐ Yes, active or previous Hepatitis C infection
- ☐ No, never had Hepatitis C
- ☐ Not documented in records or not documented in records using this standard

8a. [IF 8 is Yes, active or previous Hep C] Is the client currently taking viral hepatitis C treatment?

- ☐ Yes, currently taking viral hepatitis C treatment
- ☐ No, took treatment and cured
- ☐ No, hepatitis C infection naturally cleared without need for treatment
- ☐ No, not currently taking treatment
- ☐ Not documented in records or not documented in records using this standard



**E. SERVICES RECEIVED**

**Services Received is collected by grantee staff at Reassessment, Annual Assessments and Closeout.**

Identify all the services your grant project provided to the client since their previous assessment.

**1. Behavioral Health Services**

Since the previous administrative assessment, did the project provide or refer the client for one or more behavioral health services?

☐ Yes

☐ No

☐ Not documented in records

If Yes, please indicate which:

	Yes – Provided	Referred for Service	No – Not Provided or Referred	Not Documented in records / Unknown
1a. Case or care management or coordination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1b. Person- or family-centered treatment planning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1c. Substance use psychoeducation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1d. Mental health psychoeducation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1e. Mental health therapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1f. Co-occurring therapy (substance use & mental health)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1g. Group counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1h. Individual counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1i. Family counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1j. Psychiatric rehabilitation services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1k. Prescription medication for mental health disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1l. Medication for substance use disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1m. Intensive day treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1n. Withdrawal management (whether in hospital, residential, or ambulatory)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1o. After care planning and referrals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1p. Co-occurring disorders (including developmental or neurologic)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**2. [IF 1m – Medication for substance use disorder IS YES – PROVIDED] Indicate medication received**

	Yes – Received	No – Not Received	Not Documented in records / Unknown
2a. Naltrexone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2b. Extended-release Naltrexone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2c. Disulfiram	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2d. Acamprosate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2e. Methadone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2f. Buprenorphine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2g. Nicotine cessation therapy (eg. Nicotine patch, gum, lozenge)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2h. Bupropion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2i. Varenicline	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2j. Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**3. Crisis Services**

Since the previous administrative assessment, did the project provide or refer the client for one or more crisis services?

☐ Yes☐ No☐ Not documented in records

If Yes, please indicate which:

	Yes – Provided	Referred for Service	No – Not Provided or Referred	Not Documented in Records / Unknown
3a. Crisis response planning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3b. Crisis response	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3c. Crisis stabilization	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3d. Crisis follow-up	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**4. Recovery and Support Services**

Since the previous administrative assessment, did the project provide or refer the client for one or more recovery support services?

- ☐ Yes
 ☐ No
 ☐ Not documented in record

If Yes, please indicate which:

	Yes – Provided	Referred for Service	No – Not Provided or Referred	Not Documented in Records / Unknown
4a. Employment support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4b. Family support services, including family peer support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4c. Childcare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4d. Transportation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4e. Education support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4f. Housing support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4g. Recovery housing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4h. Spiritual, ceremonial, and/or traditional activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4i. Mutual support groups	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4j. Peer support specialist services, coaching or mentoring	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4k. Respite care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4l. Therapeutic foster care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**5. Integrated Services**

Since the previous administrative assessment, did the project provide or refer the client for one or more integrated services?

- ☐ Yes
 ☐ No
 ☐ Not documented in records

If Yes, please indicate which:

	Yes – Provided	Referred for Service	No – Not Provided or Referred	Not Documented in Records / Unknown
5a. Primary health care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5b. Maternal health care or OB/GYN	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5c. HIV testing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5d. Viral hepatitis testing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5e. HIV treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5f. HIV pre-exposure prophylaxis (PrEP)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5g. Viral hepatitis treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5h. Other STI testing or treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5i. Dental care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## F. DEMOGRAPHICS

**Demographics is collected by grantee staff at Baseline only if the Client or Caregiver declined consent for the SUPRT-C..**

If the individual declined the Client or Caregiver SUPRT-C form at baseline, please provide demographic information below. These data can be pulled from other internal sources, however it should still come directly from clients, with the exact categories or response options as indicated below, and not be assumed.

**1. What is the client's race or ethnicity? Select all that apply and enter additional details in the spaces below.**

☐ White – Provide details below.

☐ German

☐ Italian

☐ Irish

☐ Polish

☐ English

☐ French

☐ Enter, for example, Scottish, Norwegian, Dutch, etc. \_\_\_\_\_

☐ Hispanic or Latino – Provide details below.

☐ Mexican or Mexican American

☐ Salvadoran

☐ Puerto Rican

☐ Dominican

☐ Cuban

☐ Colombian

☐ Enter, for example, Guatemalan, Spaniard, Ecuadorian, etc. \_\_\_\_\_

☐ Black or African American – Provide details below.

☐ African American

☐ Nigerian

☐ Jamaican

☐ Ethiopian

☐ Haitian

☐ Somali

☐ Enter, for example, Ghanaian, South African, Barbadian, etc. \_\_\_\_\_

☐ Asian – Provide details below.

☐ Chinese

☐ Vietnamese

☐ Filipino

☐ Korean

☐ Asian Indian

☐ Japanese

☐ Enter, for example, Pakistani, Cambodian, Hmong, etc. \_\_\_\_\_

☐ American Indian or Alaska Native – Provide details below.

☐ Enter, for example, Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Tlingit, etc. \_\_\_\_\_

☐ Middle Eastern or North African – Provide details below.

☐ Lebanese

☐ Syrian

☐ Iranian

☐ Moroccan

☐ Egyptian

☐ Israeli

☐ Enter, for example, Algerian, Iraqi, Kurdish, etc. \_\_\_\_\_

**SAMHSA Unified Performance Reporting Tool (SUPRT) - A (Administrative Report)**

**OMB 0930-NEW**

**EXPIRES: MM/DD/YYYY**

- ☐ Native Hawaiian or Pacific Islander – Provide details below.
  - ☐ Native Hawaiian
  - ☐ Samoan
  - ☐ Chamorro
  - ☐ Enter, for example, Palauan, Tahitian, Chuukese etc. \_\_\_\_\_
  - ☐ Tongan
  - ☐ Fijian
  - ☐ Marshallese
- ☐ Race/ethnicity not captured in grantee records using detailed OMB categories.
- ☐ Client/caregiver declined to provide race/ethnicity

**2. ] What is the individual's sex?**

Female

Male