OMB No. 0930-0285
Expiration Date 03/30/2028

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

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

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

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

3. Was the assessment interview conducted?

○ Yes **When?** |____|____| / |____|____| /|____|____|____|____| MONTH DAY YEAR	○ No **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

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_____)

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

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.

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

- O Spanish
- O 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
- *O* 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
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.	○	○	○

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
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?	○	○	○

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

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:**

- O Administrative staff
- O Care coordinator
- O Case manager
- O Clinician providing direct services
- O Clinician not providing direct services
- O Consumer/peer
- O Data collector/evaluator
- O Family advocate
- O 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
a. I am [my child is] happy with my [their] friendships.	O	O	O
b. I have [my child has] people with whom I [they] can do enjoyable things.	O	O	O
c. I feel [my child feels] that I [they] belong in the community.	O	O	O
d. In a crisis, I [my child] would have the support needed from family or friends.	O	O	O
e. I have [my child has] family or friends that are supportive of my [their] recovery.	O	O	O
f. I [my child] generally accomplish[es] what I [they] set out to do.	O	O	O

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 PARNTERSHIPS 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 Sections H.

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

G2. LAW ENFORCEMENT AND BEHAVIORAL HEALTH PARNTERSHIPS 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?

O Yes ○ No

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

O Yes ○ No

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

O Yes ○ No

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

O 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?

O Yes
O No
O 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
a. Been to the emergency room for a physical healthcare problem?	O|	O	O
b. Been hospitalized overnight for a physical healthcare problem?	O	O	O

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

2. 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 INTEGRATION PROGRAM-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.

6. **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 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

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?

a.	Crisis mental health services	○ Yes	○ No
b.	Screening, assessment, diagnosis	○ Yes	○ No
c.	Patient-centered treatment planning	○ Yes	○ No
d.	Outpatient mental health services	○ Yes	○ No
e.	Physical health screening/monitoring	○ Yes	○ No
f.	Targeted case management	○ Yes	○ No
g.	Psychiatric rehabilitation services	○ Yes	○ No
h.	Peer support services	○ Yes	○ No
i.	Family psychoeducation and support	○ Yes	○ No
j.	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.

2. 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 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	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**		
1a. Screening	○	○	○	○
1b. Assessment	○	○	○	○
1c. Treatment Planning or Review	○	○	○	○
1d. Psychopharmacological Services	○	○	○	○
1e. Mental Health Services	○	○	○	○
1f. Co-occurring Services	○	○	○	○
1g. Case Management	○	○	○	○
1h. Trauma-specific Services	○	○	○	○
1i. 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	○	○	○	○
1k. Employment Services	○	○	○	○
1l. Family Services	○	○	○	○
1m. Child Care	○	○	○	○
1n. Transportation	○	○	○	○
1o. Education Services	○	○	○	○
1p. Housing Support	○	○	○	○
1q. Social Recreational Activities	○	○	○	○
1r. Consumer-Operated Services	○	○	○	○
1s. HIV Testing	○	○	○	○
1t. Was the client referred to another provider for any of the above support services?	○	○	○	○

2. On what date was the client discharged?

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

|___|___| / |___|___|___|___|
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) _____