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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

For Adult Programs

SAMHSA’s Performance Accountability and Reporting System (SPARS)

November 2021

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# RECORD MANAGEMENT

*[RECORD MANAGEMENT IS REPORTED BY GRANTEE STAFF AT BASELINE, REASSESSMENT, AND DISCHARGE, REGARDLESS OF WHETHER AN INTERVIEW IS CONDUCTED.]*

Consumer ID |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|

Grant ID (Grant/Contract/Cooperative Agreement) |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|

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

1. Indicate Assessment Type:

|  Baseline |  Reassessment |  Clinical Discharge |
| --- | --- | --- |
| ***[ENTER THE MONTH AND YEAR WHEN THE CONSUMER FIRST RECEIVED SERVICES UNDER THE GRANT FOR THIS EPISODE OF CARE.]*** | **Which 6-month reassessment?**|\_\_\_\_|\_\_\_\_| |   |
| |\_\_\_\_|\_\_\_\_| / |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_| MONTH YEAR | ***[ENTER 06 FOR A 6-MONTH, 12 FOR A 12-MONTH, 18 FOR AN 18-MONTH ASSESSMENT, ETC.]*** |   |

1. Was the interview conducted?

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

# BEHAVIORAL HEALTH DIAGNOSES

1. Behavioral Health Diagnoses *[REPORTED BY PROGRAM STAFF.]*

**Please indicate the consumer’s current behavioral health diagnoses using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes listed below. Please note that some substance use disorder ICD-10-CM codes have been crosswalked to the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) descriptors. Select up to three diagnoses. For each diagnosis selected, please indicate whether it is primary, secondary, or tertiary, if known. Only one diagnosis can be primary, only one can be secondary, and only one can be tertiary.**

| **Behavioral Health Diagnoses** | **Diagnosed?** | **For each diagnosis selected, please indicate whether the diagnosis is primary, secondary, or tertiary, if known** |
| --- | --- | --- |
| **Select up to 3** | **Primary** | **Secondary** | **Tertiary** |
| **SUBSTANCE USE DISORDER DIAGNOSES** |
| **Alcohol-related disorders** |  |  |  |  |
| F10.10 – Alcohol use disorder, uncomplicated, mild |  |  |  |  |
| F10.11 – Alcohol use disorder, mild, in remission |  |  |  |  |
| F10.20 – Alcohol use disorder, uncomplicated, moderate/severe |  |  |  |  |
| F10.21 – Alcohol use disorder, moderate/severe, in remission |  |  |  |  |
| F10.9 – Alcohol use, unspecified |  |  |  |  |
| **Opioid-related disorders** |  |  |  |  |
| F11.10 – Opioid use disorder, uncomplicated, mild |  |  |  |  |
| F11.11 – Opioid use disorder, mild, in remission |  |  |  |  |
| F11.20 – Opioid use disorder, uncomplicated, moderate/severe |  |  |  |  |
| F11.21 – Opioid use disorder, moderate/severe, in remission |  |  |  |  |
| F11.9 – Opioid use, unspecified |  |  |  |  |
| **Cannabis-related disorders** |  |  |  |  |
| F12.10 – Cannabis use disorder, uncomplicated, mild |  |  |  |  |
| F12.11 – Cannabis use disorder, mild, in remission |  |  |  |  |
| F12.20 – Cannabis use disorder, uncomplicated, moderate/severe |  |  |  |  |
| F12.21 – Cannabis use disorder, moderate/severe, in remission |  |  |  |  |
| F12.9 – Cannabis use, unspecified |  |  |  |  |
| **Sedative-, hypnotic-, or anxiolytic-related disorders** |  |  |  |  |
| F13.10 – Sedative, hypnotic, or anxiolytic use disorder, uncomplicated, mild |  |  |  |  |
| F13.11 – Sedative, hypnotic, or anxiolytic use disorder, mild, in remission |  |  |  |  |

BEHAVIORAL HEALTH DIAGNOSES (CONTINUED)

| **Behavioral Health Diagnoses** | **Diagnosed?** | **For each diagnosis selected, please indicate whether the diagnosis is primary, secondary, or tertiary, if known** |
| --- | --- | --- |
| **Select up to 3** | **Primary** | **Secondary** | **Tertiary** |
| F13.20 – Sedative, hypnotic, or anxiolytic use disorder, uncomplicated, moderate/severe |  |  |  |  |
| F13.21 – Sedative, hypnotic, or anxiolytic use disorder, moderate/severe, in remission |  |  |  |  |
| F13.9 – Sedative, hypnotic, or anxiolytic use, unspecified |  |  |  |  |
| **Cocaine-related disorders** |  |  |  |  |
| F14.10 – Cocaine use disorder, uncomplicated, mild |  |  |  |  |
| F14.11 – Cocaine use disorder, mild, in remission |  |  |  |  |
| F14.20 – Cocaine use disorder, uncomplicated, moderate/severe |  |  |  |  |
| F14.21 – Cocaine use disorder, moderate/severe, in remission |  |  |  |  |
| F14.9 – Cocaine use, unspecified |  |  |  |  |
| **Other stimulant-related disorders** |  |   |   |   |
| F15.10 – Other stimulant use disorder, uncomplicated, mild |  |  |  |  |
| F15.11 – Other stimulant use disorder, mild, in remission |  |  |  |  |
| F15.20 – Other stimulant use disorder, uncomplicated, moderate/severe |  |  |  |  |
| F15.21 – Other stimulant use disorder, moderate/severe, in remission |  |  |  |  |
| F15.9 – Other stimulant use, unspecified  |  |  |  |  |
| **Hallucinogen-related disorders** |  |  |  |  |
| F16.10 – Hallucinogen use disorder, uncomplicated, mild |  |  |  |  |
| F16.11 – Hallucinogen use disorder, mild, in remission |  |  |  |  |
| F16.20 – Hallucinogen use disorder, uncomplicated, moderate/severe |  |  |  |  |
| F16.21 – Hallucinogen use disorder moderate/severe, in remission |  |  |  |  |
| F16.9 – Hallucinogen use, unspecified |  |  |  |  |
| **Inhalant-related disorders** |  |  |  |  |
| F18.10 – Inhalant use disorder, uncomplicated, mild |  |  |  |  |
| F18.11 – Inhalant use disorder, mild, in remission |  |  |  |  |
| F18.20 – Inhalant use disorder, uncomplicated, moderate/severe |  |  |  |  |
| F18.21 – Inhalant use disorder, moderate/severe, in remission |  |  |  |  |
| F18.9 – Inhalant use, unspecified |  |  |  |  |

BEHAVIORAL HEALTH DIAGNOSES (CONTINUED)

| **Behavioral Health Diagnoses** | **Diagnosed?** | **For each diagnosis selected, please indicate whether the diagnosis is primary, secondary, or tertiary, if known** |
| --- | --- | --- |
| **Select up to 3** | **Primary** | **Secondary** | **Tertiary** |
| **Other psychoactive substance–related disorders** |  |  |  |  |
| F19.10 – Other psychoactive substance use disorder, uncomplicated, mild |  |  |  |  |
| F19.11 – Other psychoactive substance use disorder, in remission |  |  |  |  |
| F19.20 – Other psychoactive substance use disorder, uncomplicated, moderate/severe |  |  |  |  |
| F19.21 – Other psychoactive substance use disorder, moderate/severe, in remission |  |  |  |  |
| F19.9 – Other psychoactive substance use, unspecified |  |  |  |  |
| **Nicotine dependence** |  |  |  |  |
| F17.20 – Tobacco use disorder, mild/moderate/severe |  |  |  |  |
| F17.21 – Tobacco use disorder, mild/moderate/severe, in remission |  |  |  |  |
| **MENTAL HEALTH DIAGNOSES**  |  |  |  |  |
| F20 – Schizophrenia |  |  |  |  |
| F21 – Schizotypal disorder |  |  |  |  |
| F22 – Delusional disorder |  |  |  |  |
| F23 – Brief psychotic disorder |  |  |  |  |
| F24 – Shared psychotic disorder |  |  |  |  |
| F25 – Schizoaffective disorders |  |  |  |  |
| F28 – Other psychotic disorder not due to a substance or known physiological condition |  |  |  |  |
| F29 – Unspecified psychosis not due to a substance or known physiological condition |  |  |  |  |
| F30 – Manic episode |  |  |  |  |
| F31 – Bipolar disorder |  |  |  |  |
| F32 – Major depressive disorder, single episode |  |  |  |  |
| F33 – Major depressive disorder, recurrent |  |  |  |  |
| F34 – Persistent mood [affective] disorders |  |  |  |  |
| F39 – Unspecified mood [affective] disorder |  |  |  |  |
| F40–F48 – Anxiety, dissociative, stress-related, somatoform, and other nonpsychotic mental disorders |  |  |  |  |
| F50 – Eating disorders |  |  |  |  |
| F51 – Sleep disorders not due to a substance or known physiological condition |  |  |  |  |
| F60.2 – Antisocial personality disorder |  |  |  |  |
| F60.3 – Borderline personality disorder |  |  |  |  |

BEHAVIORAL HEALTH DIAGNOSES (CONTINUED)

| **Behavioral Health Diagnoses** | **Diagnosed?** | **For each diagnosis selected, please indicate whether the diagnosis is primary, secondary, or tertiary, if known** |
| --- | --- | --- |
| **Select up to 3** | **Primary** | **Secondary** | **Tertiary** |
| F60.0, F60.1, F60.4–F69 – Other personality disorders |  |  |  |  |
| F70–F79 – Intellectual disabilities |  |  |  |  |
| F80–F89 – Pervasive and specific developmental disorders |  |  |  |  |
| F90 – Attention-deficit hyperactivity disorders |  |  |  |  |
| F91 – Conduct disorders |  |  |  |  |
| F93 – Emotional disorders with onset specific to childhood |  |  |  |  |
| F94 – Disorders of social functioning with onset specific to childhood or adolescence |  |  |  |  |
| F95 – Tic disorder |  |  |  |  |
| F98 – Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence |  |  |  |  |
| F99 – Unspecified mental disorder |  |  |  |  |

* Don’t know
* None of the above

***[IF THIS IS A BASELINE, GO TO SECTION A.]***

***[FOR ALL REASSESSMENTS:***

***IF AN INTERVIEW WAS CONDUCTED, GO TO SECTION B.]***

***IF AN INTERVIEW WAS NOT CONDUCTED, GO TO SECTION I.]***

***[FOR A CLINICAL DISCHARGE:***

***IF AN INTERVIEW WAS CONDUCTED, GO TO SECTION B.]***

***IF AN INTERVIEW WAS NOT CONDUCTED, GO TO SECTION J.]***

# A. DEMOGRAPHIC DATA

*[SECTION A IS ONLY COLLECTED AT BASELINE. IF THIS IS NOT A BASELINE, GO TO SECTION B.]*

1. What is your gender?

 MALE

 FEMALE

 TRANSGENDER

 OTHER (SPECIFY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 REFUSED

1. Are you Hispanic or Latino?

 YES

 NO ***[GO TO 3.]***

 REFUSED ***[GO TO 3.]***

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

| **Ethnic Group** | **YES** | **NO** | **REFUSED** |
| --- | --- | --- | --- |
| Central American |  |  |  |
| Cuban |  |  |  |
| Dominican |  |  |  |
| Mexican |  |  |  |
| Puerto Rican |  |  |  |
| South American |  |  |  |
| OTHER |  |  | ***[IF YES, SPECIFY BELOW.]*** |
| (SPECIFY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. What race do you consider yourself? Please answer yes or no for each of the following. You may say yes to more than one.

| **Race** | **YES** | **NO** | **REFUSED** |
| --- | --- | --- | --- |
| Alaska Native |  |  |  |
| American Indian |  |  |  |
| Asian |  |  |  |
| Black or African American |  |  |  |
| Native Hawaiian or other Pacific Islander |  |  |  |
| White |  |  |  |

1. What is your month and year of birth?

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

 MONTH YEAR

 REFUSED

A. DEMOGRAPHIC DATA (CONTINUED)

1. Which one of the following do you consider yourself to be?

 Heterosexual; that is, straight

 [IF FEMALE, THEN “Lesbian”] or Gay

 Bisexual

 OTHER (SPECIFY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 REFUSED

 DON’T KNOW

*[IF AN INTERVIEW WAS CONDUCTED, CONTINUE TO SECTION B.]*

*[IF AN INTERVIEW WAS NOT CONDUCTED, STOP HERE.]*

# B. FUNCTIONING

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

 Excellent

 Very Good

 Good

 Fair

 Poor

 REFUSED

 DON’T KNOW

1. Please select the one answer that most closely matches your situation. *I feel capable of managing my health care needs:*

 On my own most of the time

 On my own some of the time and with support from others some of the time

 With support from others most of the time

 Rarely or never

 REFUSED

 DON’T KNOW

B. FUNCTIONING (CONTINUED)

1. In order to provide the best possible mental health and related services, we need to know what you think about how well you were able to deal with your everyday life during the past 30 days. Please indicate your disagreement/agreement with each of the following statements.

***[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]***

| STATEMENT | RESPONSE OPTIONS |
| --- | --- |
| **Strongly Disagree** | **Disagree** | **Undecided** | **Agree** | **Strongly Agree** | **REFUSED** | **NOT APPLICABLE** |
| 1. **I deal effectively with daily problems.**
 |  |  |  |  |  |  |   |
| 1. **I am able to control my life.**
 |  |  |  |  |  |  |   |
| 1. **I am able to deal with crisis.**
 |  |  |  |  |  |  |   |
| 1. **I am getting along with my family.**
 |  |  |  |  |  |  |  |
| 1. **I do well in social situations.**
 |  |  |  |  |  |  |   |
| 1. **I do well in school and/or work.**
 |  |  |  |  |  |  |  |
| 1. **My housing situation is satisfactory.**
 |  |  |  |  |  |  |   |
| 1. **My symptoms are not bothering me.**
 |  |  |  |  |  |  |   |

1. The following questions ask about how you have been feeling during the past 30 days. For each question, please indicate how often you had this feeling.

***[READ EACH QUESTION FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]***

| QUESTION | RESPONSE OPTIONS |
| --- | --- |
| **During the past 30 days, about how often did you feel …** | **All of the Time** | **Most** **of the Time** | **Some of the Time** | **A Little of the Time** | **None of the Time** | **REFUSED** | **DON’T KNOW** |
| **a. nervous?** |  |  |  |  |  |  |  |
| **b. hopeless?** |  |  |  |  |  |  |  |
| **c. restless or fidgety?** |  |  |  |  |  |  |  |
| **d. so depressed that nothing could cheer you up?** |  |  |  |  |  |  |  |
| **e. that everything was an effort?** |  |  |  |  |  |  |  |
| **f. worthless?** |  |  |  |  |  |  |  |

| QUESTION | RESPONSE OPTIONS |
| --- | --- |
| **During the past 30 days…** | **Not at All** | **Slightly** | **Moderately** | **Considerably** | **Extremely** | **REFUSED** | **DON’T KNOW** |
| **g. how much have you been bothered by these psychological or emotional problems?** |  |  |  |  |  |  |  |

B. FUNCTIONING (CONTINUED)

1. The following questions ask about how you have been feeling during the last 4 weeks.

***[READ EACH QUESTION FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]***

| QUESTION | RESPONSE OPTIONS |
| --- | --- |
| **In the last 4 weeks …** | **Very Poor** | **Poor** | **Neither Good nor Poor** | **Good** | **Very Good** | **REFUSED** | **DON’T KNOW** |
| 1. **how would you rate your quality of life?**
 |  |  |  |  |  |  |  |

| QUESTION | RESPONSE OPTIONS |
| --- | --- |
| **In the last 4 weeks …** | **Not at All** | **A Little** | **Moderately** | **Mostly** | **Completely** | **REFUSED** | **DON’T KNOW** |
| 1. **do you have enough energy for everyday life?**
 |  |  |  |  |  |  |  |

| QUESTION | RESPONSE OPTIONS |
| --- | --- |
| **In the last 4 weeks …** | **Very Dissatisfied** | **Dissatisfied** | **Neither Satisfied nor Dissatisfied**  | **Satisfied** | **Very Satisfied** | **REFUSED** | **DON’T KNOW** |
| 1. **how satisfied are you with your ability to perform your daily living activities?**
 |  |  |  |  |  |  |  |
| 1. **how satisfied are you with your health?**
 |  |  |  |  |  |  |  |
| **e. how satisfied are you with yourself?** |  |  |  |  |  |  |  |
| **f. how satisfied are you with your personal relationships?** |  |  |  |  |  |  |  |

B. FUNCTIONING (CONTINUED)

1. The following questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we’ll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed.

*[READ EACH QUESTION FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]*

| QUESTION | RESPONSE OPTIONS |
| --- | --- |
| **In the past 30 days, how often have you used …** | **Never** | **Once or Twice** | **Weekly** | **Daily or Almost Daily** | **REFUSED** | **DON’T KNOW** |
| 1. **tobacco products (cigarettes, chewing tobacco, cigars, etc.)?**
 |  |  |  |  |  |  |
| 1. **alcoholic beverages (beer, wine, liquor, etc.)?**
 |  |  |  |  |  |  |
| **b1. *[IF B ≥ ONCE OR TWICE, AND RESPONDENT IS MALE]* How many times in the past 30 days have you had five or more drinks in a day? *[CLARIFY IF NEEDED:* A standard alcoholic beverage (e.g., 12 oz. beer, 5 oz. wine, 1.5 oz. liquor).*]*** |  |  |  |  |  |  |
| **b2. *[IF B ≥ ONCE OR TWICE, AND RESPONDENT IS NOT MALE]* How many times in the past 30 days have you had four or more drinks in a day? *[CLARIFY IF NEEDED:* A standard alcoholic beverage (e.g., 12 oz. beer, 5 oz. wine, 1.5 oz. liquor).*]*** |  |  |  |  |  |  |
| 1. **cannabis (marijuana, pot, grass, hash, etc.)?**
 |  |  |  |  |  |  |
| 1. **cocaine (coke, crack, etc.)?**
 |  |  |  |  |  |  |
| 1. **prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)?**
 |  |  |  |  |  |  |
| 1. **methamphetamine (speed, crystal meth, ice, etc.)?**
 |  |  |  |  |  |  |
| 1. **inhalants (nitrous oxide, glue, gas, paint thinner, etc.)?**
 |  |  |  |  |  |  |
| 1. **sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)?**
 |  |  |  |  |  |  |
| 1. **hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)?**
 |  |  |  |  |  |  |
| 1. **street opioids (heroin, opium, etc.)?**
 |  |  |  |  |  |  |
| 1. **prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)?**
 |  |  |  |  |  |  |
| 1. **other – specify (e-cigarettes, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
 |  |  |  |  |  |  |

B. FUNCTIONING (CONTINUED)

*[OPTIONAL**:* *GLOBAL ASSESSMENT OF FUNCTIONING (GAF) SCORE REPORTED BY GRANTEE STAFF AT PROJECT’S DISCRETION.]*

DATE GAF WAS ADMINISTERED: |\_\_\_\_|\_\_\_\_| / |\_\_\_\_|\_\_\_\_| / |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|

 MONTH DAY YEAR

WHAT WAS THE CONSUMER’S SCORE? GAF = |\_\_\_\_|\_\_\_\_|\_\_\_\_|

# B. MILITARY FAMILY AND DEPLOYMENT

*[QUESTIONS 7 THROUGH 10 ARE ONLY ASKED AT BASELINE. IF THIS IS NOT A BASELINE, GO TO 11.]*

1. Have you ever served in the Armed Forces, the Reserves, or the National Guard?
* YES
* NO ***[GO TO 8.]***
* REFUSED ***[GO TO 8.]***
* DON’T KNOW ***[GO TO 8.]***

***[IF YES]* In which of the following have you ever served? Please answer for each of the following. You may say yes to more than one.**

| **Branch of Service** | **YES** | **NO** | **REFUSED** | **DON’T KNOW** |
| --- | --- | --- | --- | --- |
| * Armed Forces
 |  |  |  |  |
| * Reserves
 |  |  |  |  |
| * National Guard
 |  |  |  |  |

7a. Are you currently serving on active duty in the Armed Forces, the Reserves, or the National Guard?

* YES
* NO ***[GO TO 7b.]***
* REFUSED ***[GO TO 7b.]***
* DON’T KNOW ***[GO TO 7b.]***

***[IF YES]* In which of the following are you currently serving? Please answer for each of the following. You may say yes to more than one.**

| **Branch of Service** | **YES** | **NO** | **REFUSED** | **DON’T KNOW** |
| --- | --- | --- | --- | --- |
| * Armed Forces
 |  |  |  |  |
| * Reserves
 |  |  |  |  |
| * National Guard
 |  |  |  |  |

B. MILITARY FAMILY AND DEPLOYMENT (CONTINUED)

7b. Have you ever been deployed to a combat zone?

* YES
* NO ***[GO TO 8.]***
* REFUSED ***[GO TO 8.]***
* DON’T KNOW ***[GO TO 8.]***

***[IF YES]* To which of the following combat zones have you been deployed? Please answer for each of the following. You may say yes to more than one.**

| **Combat Zones** | **YES** | **NO** | **REFUSED** | **DON’T KNOW** |
| --- | --- | --- | --- | --- |
| Iraq or Afghanistan (e.g., Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn) |  |  |  |  |
| Persian Gulf (Operation Desert Shield or Desert Storm) |  |  |  |  |
| Vietnam/Southeast Asia |  |  |  |  |
| Korea |  |  |  |  |
| WWII |  |  |  |  |
| Deployed to a combat zone not listed above (e.g., Somalia, Bosnia, Kosovo) |  |  |  |  |

1. Is anyone in your family or someone close to you currently serving on active duty in or retired/separated from the Armed Forces, the Reserves, or the National Guard?
* Yes, only one person
* Yes, more than one person
* No
* REFUSED
* DON’T KNOW

# VIOLENCE AND TRAUMA

1. Have you ever experienced violence or trauma in any setting (including community or school violence; domestic violence; physical, psychological, or sexual maltreatment/assault within or outside of the family; natural disaster; terrorism; neglect; or traumatic grief)?
* YES
* NO ***[GO TO 11.]***
* REFUSED ***[GO TO 11.]***
* DON’T KNOW ***[GO TO 11.]***

B. VIOLENCE AND TRAUMA (CONTINUED)

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

|  **In the past and/or present you …** | **YES** | **NO** | **REFUSED** | **DON’T KNOW** |
| --- | --- | --- | --- | --- |
| 1. **Have had nightmares about it or thought about it when you did not want to?**
 |  |  |  |  |
| 1. **Tried hard not to think about it or went out of your way to avoid situations that remind you of it?**
 |  |  |  |  |
| 1. **Were constantly on guard, watchful, or easily startled?**
 |  |  |  |  |
| 1. **Felt numb and detached from others, activities, or your surroundings?**
 |  |  |  |  |

1. In the past 30 days, how often have you been hit, kicked, slapped, or otherwise physically hurt?
* Never
* Once
* A few times
* More than a few times
* REFUSED
* DON’T KNOW

# STABILITY IN HOUSING

| 1. In the past 30 days, how many … | **Number of Nights/Times** | **REFUSED** | **DON’T KNOW** |
| --- | --- | --- | --- |
| a. nights have you been homeless? | |\_\_\_\_|\_\_\_\_| |  |  |
| b. nights have you spent in a hospital for mental health care? | |\_\_\_\_|\_\_\_\_| |  |  |
| c. nights have you spent in a facility for detox/inpatient or residential substance abuse treatment? | |\_\_\_\_|\_\_\_\_| |  |  |
| d. nights have you spent in correctional facility including jail or prison? | |\_\_\_\_|\_\_\_\_| |  |  |
| ***[ADD UP THE TOTAL NUMBER OF NIGHTS SPENT HOMELESS, IN HOSPITAL FOR MENTAL HEALTH CARE, IN DETOX/INPATIENT OR RESIDENTIAL SUBSTANCE ABUSE TREATMENT, OR IN A CORRECTIONAL FACILITY. (ITEMS 1A–1D, CANNOT EXCEED 30 NIGHTS.)]*** | |\_\_\_\_|\_\_\_\_| |   |   |
| e. times have you gone to an emergency room for a psychiatric or emotional problem? | |\_\_\_\_|\_\_\_\_| |  |  |

***[IF 1A, 1B, 1C, OR 1D IS 16 OR MORE NIGHTS, GO TO SECTION D.]***

C. STABILITY IN HOUSING (CONTINUED)

1. In the past 30 days, where have you been living most of the time?

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

* + OWNED OR RENTED HOUSE, APARTMENT, TRAILER, ROOM
	+ SOMEONE ELSE’S HOUSE, APARTMENT, TRAILER, ROOM
	+ HOMELESS (SHELTER, STREET/OUTDOORS, PARK)
	+ GROUP HOME
	+ ADULT FOSTER CARE
	+ TRANSITIONAL LIVING FACILITY
	+ HOSPITAL (MEDICAL)
	+ HOSPITAL (PSYCHIATRIC)
	+ DETOX/INPATIENT OR RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
	+ CORRECTIONAL FACILITY (JAIL/PRISON)
	+ NURSING HOME
	+ VA HOSPITAL
	+ VETERAN’S HOME
	+ MILITARY BASE
	+ OTHER HOUSED (SPECIFY)
	+ REFUSED
	+ DON’T KNOW

**3. In the last 4 weeks …**

***[READ THE QUESTION FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]***

| QUESTION | RESPONSE OPTIONS |
| --- | --- |
| **In the last 4 weeks …** | **Very Dissatisfied** | **Dissatisfied** | **Neither Satisfied nor Dissatisfied** | **Satisfied** | **Very Satisfied** | **REFUSED** | **DON’T KNOW** |
| **a. how satisfied are you with the conditions of your living place?** |  |  |  |  |  |  |  |

# D. EDUCATION AND EMPLOYMENT

* 1. Are you currently enrolled in school or a job training program?

***[IF ENROLLED]* Is that full time or part time?**

* + - NOT ENROLLED
		- ENROLLED, FULL TIME
		- ENROLLED, PART TIME
		- OTHER (SPECIFY)
		- REFUSED
		- DON’T KNOW

D. EDUCATION AND EMPLOYMENT (CONTINUED)

* 1. What is the highest level of education you have finished, whether or not you received a degree?
		+ 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
	2. Are you currently employed?

***[CLARIFY BY FOCUSING ON STATUS DURING MOST OF THE PREVIOUS WEEK, DETERMINING WHETHER CONSUMER WORKED AT ALL OR HAD A REGULAR JOB BUT WAS OFF WORK.]***

* + - EMPLOYED FULL TIME (35+ HOURS PER WEEK OR WOULD HAVE BEEN)
		- EMPLOYED PART TIME
		- UNEMPLOYED, LOOKING FOR WORK
		- UNEMPLOYED, DISABLED
		- UNEMPLOYED, VOLUNTEER WORK
		- UNEMPLOYED, RETIRED
		- UNEMPLOYED, NOT LOOKING FOR WORK
		- OTHER (SPECIFY)
		- REFUSED
		- DON’T KNOW

**3a. *[IF EMPLOYED.]***

| **Employment Status** | **Yes** | **No** | **REFUSED** | **DON’T KNOW** |
| --- | --- | --- | --- | --- |
| * **Are you paid at or above the minimum wage?1**
 |  |  |  |  |
| * **Are your wages paid directly to you by your employer?**
 |  |  |  |  |
| * **Could anyone have applied for this job?**
 |  |  |  |  |

* 1. In the last 4 weeks …

***[READ THE QUESTION FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]***

| QUESTION | RESPONSE OPTIONS |
| --- | --- |
| **In the last 4 weeks …** | **Not at All** | **A Little** | **Moderately** | **Mostly** | **Completely** | **REFUSED** | **DON’T KNOW** |
| **a. have you enough money to meet your needs?** |  |  |  |  |  |  |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
1 For information on federal minimum wage, go to <https://www.dol.gov/general/topic/wages>.

# E. CRIME AND CRIMINAL JUSTICE STATUS

* 1. In the past 30 days, how many times have you been arrested?

| | | TIMES REFUSED DON’T KNOW

***[IF THIS IS A BASELINE, GO TO SECTION G. OTHERWISE, GO TO SECTION F.]***

# F. PERCEPTION OF CARE

***[SECTION F IS NOT COLLECTED AT BASELINE. FOR BASELINE INTERVIEWS, GO TO SECTION G.]***

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

***[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]***

| STATEMENT | RESPONSE OPTIONS |
| --- | --- |
| **Strongly Disagree** | **Disagree** | **Undecided** | **Agree** | **Strongly Agree** | **REFUSED** | **NOT APPLICABLE** |
| 1. **Staff here believe that I can grow, change, and recover.**
 |  |  |  |  |  |  |   |
| 1. **I felt free to complain.**
 |  |  |  |  |  |  |   |
| 1. **I was given information about my rights.**
 |  |  |  |  |  |  |   |
| 1. **Staff encouraged me to take responsibility for how I live my life.**
 |  |  |  |  |  |  |   |
| 1. **Staff told me what side effects to watch out for.**
 |  |  |  |  |  |  |  |
| 1. **Staff respected my wishes about who is and who is not to be given information about my treatment.**
 |  |  |  |  |  |  |  |
| 1. **Staff were sensitive to my cultural background (race, religion, language, etc.).**
 |  |  |  |  |  |  |   |
| 1. **Staff helped me obtain the information I needed so that I could take charge of managing my illness.**
 |  |  |  |  |  |  |  |
| 1. **I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).**
 |  |  |  |  |  |  |  |
| 1. **I felt comfortable asking questions about my treatment and medication.**
 |  |  |  |  |  |  |  |

F. PERCEPTION OF CARE (CONTINUED)

| STATEMENT | RESPONSE OPTIONS |
| --- | --- |
|   | **Strongly Disagree** | **Disagree** | **Undecided** | **Agree** | **Strongly Agree** | **REFUSED** | **NOT APPLICABLE** |
| 1. **I, not staff, decided my treatment goals.**
 |  |  |  |  |  |  |   |
| 1. **I like the services I received here.**
 |  |  |  |  |  |  |   |
| 1. **If I had other choices, I would still get services from this agency.**
 |  |  |  |  |  |  |   |
| 1. **I would recommend this agency to a friend or family member.**
 |  |  |  |  |  |  |   |

1. ***[INDICATE WHO ADMINISTERED SECTION F, PERCEPTION OF CARE, TO THE RESPONDENT FOR THIS INTERVIEW.]***

 ADMINISTRATIVE STAFF

* + - CARE COORDINATOR
		- CASE MANAGER
		- CLINICIAN PROVIDING DIRECT SERVICES
		- CLINICIAN NOT PROVIDING SERVICES
		- CONSUMER PEER
		- DATA COLLECTOR
		- EVALUATOR
		- FAMILY ADVOCATE
		- RESEARCH ASSISTANT STAFF
		- SELF-ADMINISTERED
		- OTHER (SPECIFY)

# G. SOCIAL CONNECTEDNESS

* 1. Please indicate your disagreement/agreement with each of the following statements. Please answer for relationships with persons other than your mental health provider(s) over the past 30 days.

***[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]***

| STATEMENT | RESPONSE OPTIONS |
| --- | --- |
| **Strongly Disagree** | **Disagree** | **Undecided** | **Agree** | **Strongly Agree** | **REFUSED** |
| **a. I am happy with the friendships I have.** |  |  |  |  |  |  |
| **b. I have people with whom I can do enjoyable things.** |  |  |  |  |  |  |
| **c. I feel I belong in my community.** |  |  |  |  |  |  |
| **d. In a crisis, I would have the support I need from family or friends.** |  |  |  |  |  |  |
| **e. I have family or friends that are supportive of my recovery.** |  |  |  |  |  |  |
| **f. I generally accomplish what I set out to do.** |  |  |  |  |  |  |

**IF YOUR PROGRAM DOES NOT REQUIRE SECTION H:**

**If this is a BASELINE INTERVIEW – stop here, the interview is complete.**

**If this is a REASSESSMENT INTERVIEW, please complete Section I and Section K.**

**If this is a CLINICAL DISCHARGE INTERVIEW, please complete Section J and Section K.**

**IF YOUR PROGRAM DOES REQUIRE SECTION H:**

**If this is a BASELINE INTERVIEW, complete Section H, then stop (the interview will be complete)**

**If this is a REASSESSMENT INTERVIEW, please complete Section H, Section I, and Section K.**

**If this is a CLINICAL DISCHARGE INTERVIEW, please complete Section H, Section J, and Section K.**

# H. PROGRAM-SPECIFIC QUESTIONS

**YOU ARE NOT RESPONSIBLE FOR COLLECTING DATA ON ALL SECTION H QUESTIONS. YOUR GOVERNMENT PROJECT OFFICER (GPO) HAS PROVIDED GUIDANCE ON WHICH SPECIFIC SECTION H QUESTIONS YOU ARE TO COMPLETE. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT YOUR GPO.**

**FOR A LIST OF PROGRAMS THAT HAVE PROGRAM-SPECIFIC DATA REQUIREMENTS, SEE APPENDIX A OF THE NOMS CLIENT-LEVEL MEASURES QUESTION-BY-QUESTION INSTRUCTION GUIDE FOR ADULT PROGRAMS.**

# H1. PROGRAM-SPECIFIC QUESTIONS

***[QUESTION 1 SHOULD BE ANSWERED BY THE CONSUMER AT BASELINE, REASSESSMENT, AND CLINICAL DISCHARGE]***

1. **In the past 30 days, how often have you taken all of your psychiatric medication(s) as prescribed to you?**
	* Always
	* Usually
	* Sometimes
	* Rarely
	* Never
	* REFUSED
	* DON’T KNOW
	* NOT APPLICABLE

***[QUESTION 2 SHOULD BE REPORTED BY GRANTEE STAFF ABOUT THE CONSUMER AT REASSESSMENT AND CLINICAL DISCHARGE]***

1. **In the past 30 days, how compliant has the consumer been with their treatment plan?**
* Not compliant
* Minimally compliant
* Moderately compliant
* Highly compliant
* Fully compliant
* DON’T KNOW
* NOT APPLICABLE

# H2. PROGRAM-SPECIFIC QUESTIONS

***[QUESTIONS 1 AND 2 SHOULD BE REPORTED BY GRANTEE STAFF AT BASELINE, REASSESSMENT, AND CLINICAL DISCHARGE.]***

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

 Consumer screened positive

 Consumer screened negative

 Consumer was not screened

* 1. ***[IF CONSUMER SCREENED POSITIVE]* Was the consumer referred to the following type of services?**

 YES NO

Mental health services  

* 1. ***[IF CONSUMER WAS REFERRED TO SERVICES]* Did they receive the following services?**

 YES NO DON’T KNOW NOT APPLICABLE

Mental health services    

**2. Did the consumer screen positive for a substance use disorder?**

 Consumer screened positive

 Consumer screened negative

 Consumer was not screened

1. ***[IF CONSUMER SCREENED POSITIVE]* Was the consumer referred to the following type of services?**

 YES NO

Substance use disorder services  

1. ***[IF CONSUMER WAS REFERRED TO SERVICES]* Did they receive the following services?**

 YES NO DON’T KNOW NOT APPLICABLE

Substance use disorder services    

***[QUESTION 3 SHOULD BE ANSWERED BY THE CONSUMER AT REASSESSMENT AND CLINICAL DISCHARGE.]***

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

**Receiving community-based services through the *[INSERT GRANTEE NAME]* program has helped me to avoid further contact with the police and the criminal justice system.**

* Strongly Disagree
* Disagree
* Undecided
* Agree
* Strongly Agree
* REFUSED
* DON’T KNOW

# H3. PROGRAM-SPECIFIC QUESTIONS

***[QUESTIONS 1, 2, AND HEALTH ITEMS SHOULD BE COMPLETED AT BASELINE, REASSESSMENT, AND DISCHARGE]***

***[QUESTION 1 SHOULD BE ANSWERED BY THE CONSUMER]***

|  |  |  |  |
| --- | --- | --- | --- |
| **1. In the past 30 days, how many times have you …** | **Number of Times** | **REFUSED** | **DON’T KNOW** |
| **a. Been to the emergency room for a physical healthcare problem?** | |\_\_\_\_|\_\_\_\_| |  |  |
| **b. Been hospitalized overnight for a physical healthcare problem?*[REPORT NUMBER OF NIGHTS HOSPITALIZED.]*** | |\_\_\_\_|\_\_\_\_| |  |  |

***[QUESTION 2 AND PROGRAM-SPECIFIC HEALTH ITEMS ARE REPORTED BY GRANTEE STAFF ABOUT THE CONSUMER]***

1. **Please indicate which type of funding source(s) was (were)/will be used to pay for the services provided to this consumer since their last interview. (Check all that apply):**
	* Current SAMHSA grant funding
	* Other federal grant funding
	* State funding
	* Consumer’s private insurance
	* Medicaid/Medicare
	* Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Program-Specific Health Items**

1. Health measurements:

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

1. Did patient successfully fast for 8 hours prior to providing the blood sample?
2. Blood test results:

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

***[FOR 3b AND 3c: ENTER ONE OR THE OTHER, NOT BOTH.]***

|  |  |  |  |
| --- | --- | --- | --- |
| b. | Fasting plasma glucose  |   | mg/dL |
| c. | HgBA1c |   | % |
| d. | Total Cholesterol |   | mg/dL |
| e. | HDL Cholesterol |   | mg/dL |
| f. | LDL Cholesterol |   | mg/dL |
| g. | Triglycerides |   | mg/dL |

# H4. PROGRAM-SPECIFIC QUESTIONS

***[QUESTIONS 1 AND 2 SHOULD BE ANSWERED BY THE CONSUMER AT BASELINE, REASSESSMENT, AND CLINICAL DISCHARGE.]***

**1a. Did the program provide an HIV test?**

* Yes
* No ***[SKIP TO H1b.]***
* REFUSED ***[SKIP TO H1b.]***
* DON’T KNOW ***[SKIP TO H1b.]***

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

* Positive
* Negative ***[SKIP TO H1b.]***
* Indeterminate ***[SKIP TO H1b.]***
* REFUSED ***[SKIP TO H1b.]***
* DON’T KNOW ***[SKIP TO H1b.]***

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

* Yes
* No
* REFUSED
* DON’T KNOW

**1b. Did the program provide a hepatitis B (HBV) test?**

* Yes
* No ***[SKIP TO H1c.]***
* REFUSED ***[SKIP TO H1c.]***
* DON’T KNOW ***[SKIP TO H1c.]***

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

* Positive
* Negative ***[SKIP TO H1c.]***
* Indeterminate ***[SKIP TO H1c.]***
* REFUSED ***[SKIP TO H1c.]***
* DON’T KNOW ***[SKIP TO H1c.]***

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

* Yes
* No
* REFUSED
* DON’T KNOW

**1c. Did the program provide a hepatitis C (HCV) test?**

* Yes
* No ***[SKIP TO H2a.]***
* REFUSED ***[SKIP TO H2a.]***
* DON’T KNOW ***[SKIP TO H2a.]***

H4. PROGRAM-SPECIFIC QUESTIONS (CONTINUED)

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

* Positive
* Negative ***[SKIP TO H2a.]***
* Indeterminate ***[SKIP TO H2a.]***
* REFUSED ***[SKIP TO H2a.]***
* DON’T KNOW ***[SKIP TO H2a.]***

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

* Yes
* No
* REFUSED
* DON’T KNOW

**2a. *[If HIV STATUS IS POSITIVE]* Did you receive a referral from *[INSERT GRANTEE NAME]* to medical care?**

* Yes
* No
* REFUSED
* DON’T KNOW

**2b. Have you been prescribed an antiretroviral medication (ART)?**

* Yes
* No ***[SKIP TO SECTION I OR J/K]***
* REFUSED ***[SKIP TO SECTION I OR J/K]***
* DON’T KNOW ***[SKIP TO SECTION I OR J/K]***

***[FOR CONSUMERS WHO REPORT BEING PRESCRIBED AN ART]* In the past 30 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.]***

# H5. PROGRAM-SPECIFIC QUESTIONS

***[QUESTIONS 1 AND 2 SHOULD BE REPORTED BY GRANTEE STAFF AT BASELINE, REASSESSMENT, AND CLINICAL DISCHARGE.]***

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

 Consumer screened positive

 Consumer screened negative

 Consumer was not screened

**a. *[IF CONSUMER SCREENED POSITIVE]* Was the consumer referred to the following type of services?**

 YES NO

Mental health services  

**b. *[IF CONSUMER WAS REFERRED TO SERVICES]* Did they receive the following services?**

 YES NO DON’T KNOW NOT APPLICABLE

Mental health services    

**2. Did the consumer screen positive for a substance use disorder?**

 Consumer screened positive

 Consumer screened negative

 Consumer was not screened

**a*. [IF CONSUMER SCREENED POSITIVE]* Was the consumer referred to the following type of services?**

 YES NO

Substance use disorder services  

**b. *[IF CONSUMER WAS REFERRED TO SERVICES]* Did they receive the following services?**

 YES NO DON’T KNOW NOT APPLICABLE

Substance use disorder services    

# H6. PROGRAM-SPECIFIC QUESTIONS

***[QUESTION 1 SHOULD BE ANSWERED BY THE CONSUMER AT BASELINE, REASSESSMENT, AND CLINICAL DISCHARGE.]***

| **1. In the past 30 days:** | **Number of Times** | **REFUSED** | **DON’T KNOW** |
| --- | --- | --- | --- |
| **a. How many times have you thought about killing yourself?** | |\_\_\_\_|\_\_\_\_| |  |  |
| 1. **How many times did you attempt to kill yourself?**
 | |\_\_\_\_|\_\_\_\_| |  |  |

***[QUESTION 2 SHOULD BE ANSWERED BY THE CONSUMER AT REASSESSMENT AND CLINICAL DISCHARGE.]***

1. **How often does a member of your team interact with you?**
* Several times a day
* Almost every day
* A few times a week
* About once a week
* A few times a month
* About once a month
* Less than once per month
* REFUSED
* DON’T KNOW

# H7. PROGRAM-SPECIFIC QUESTIONS

***[QUESTION 1 SHOULD BE REPORTED BY GRANTEE STAFF AT REASSESSMENT AND CLINICAL DISCHARGE.]***

1. **Has the consumer experienced a first-episode of psychosis (FEP) since their last interview?**
* Yes
* No
* DON’T KNOW

**a. *[IF YES]* Please indicate the approximate date that the consumer initially experienced the FEP.**

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

**b. *[IF YES]* Was the consumer referred to FEP services?**

* Yes
* No
* DON’T KNOW

***[IF CONSUMER WAS REFERRED TO FEP SERVICES]* Please indicate the date that the consumer first received FEP services/treatment.**

|\_\_\_|\_\_\_| / |\_\_\_|\_\_\_|\_\_\_|\_\_\_| DON’T KNOW
 MONTH YEAR 

***[QUESTION 2 SHOULD BE ANSWERED BY THE CONSUMER AT BASELINE, REASSESSMENT, AND CLINICAL DISCHARGE IF THEY ARE CURRENTLY ENROLLED IN SCHOOL.]***

1. *[IF THE CONSUMER INDICATED THAT THEY WERE ENROLLED IN SCHOOL]* During the past 30 days of school, how many days were you absent for any reason?

|\_\_\_|\_\_\_| # OF DAYS REFUSED DON’T KNOW NOT APPLICABLE

# H8. PROGRAM-SPECIFIC QUESTIONS

***[HEALTH ITEMS ARE REPORTED BY THE GRANTEE ABOUT THE CONSUMER AT BASELINE, REASSESSMENT, AND DISCHARGE]***

* 1. Health measurements:

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

***[IF THIS IS A BASELINE, STOP HERE.]***

***[IF THIS IS A REASSESSMENT, GO TO SECTION I.]***

***[IF THIS IS A CLINICAL DISCHARGE, GO TO SECTION J.]***

# I. REASSESSMENT STATUS

***[SECTION I IS REPORTED BY GRANTEE STAFF AT REASSESSMENT.]***

1. Have you or other grant staff had contact with the consumer within 90 days of the last encounter?

 Yes

 No

1. Is the consumer still receiving services from your project?

 Yes

 No

***[GO TO SECTION K.]***

# J. CLINICAL DISCHARGE STATUS

***[SECTION J IS REPORTED BY GRANTEE STAFF ABOUT THE CONSUMER AT CLINICAL DISCHARGE.]***

1. On what date was the consumer discharged?

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

1. What is the consumer’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)

***[GO TO SECTION K.]***

# K. SERVICES RECEIVED

***[SECTION K IS REPORTED BY GRANTEE STAFF AT REASSESSMENT AND DISCHARGE UNLESS THE CONSUMER REFUSED THIS INTERVIEW OR ALL INTERVIEWS, IN WHICH CASE THE SECTION IS OPTIONAL.]***

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

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

***[IDENTIFY ALL OF THE SERVICES YOUR PROJECT PROVIDED TO THE CONSUMER SINCE HIS/HER LAST NOMS INTERVIEW; THIS INCLUDES CMHS-FUNDED AND NON-CMHS-FUNDED SERVICES.]***

| **Core Services** | **Provided** | **UNKNOWN** | **SERVICENOT AVAILABLE** |
| --- | --- | --- | --- |
| **Yes** | **No** |
| 1. Screening
 |  |  |  |  |
| 1. Assessment
 |  |  |  |  |
| 1. Treatment Planning or Review
 |  |  |  |  |
| 1. Psychopharmacological Services
 |  |  |  |  |
| 1. Mental Health Services
 |  |  |  |  |

***[IF THE ANSWER TO QUESTION 5, “MENTAL HEALTH SERVICES,” IS YES, PLEASE ESTIMATE HOW FREQUENTLY MENTAL HEALTH SERVICES WERE DELIVERED.]***

|  |  |  |
| --- | --- | --- |
| **Number of times \_\_\_\_ per** | * Day
 | **UNKNOWN** |
|  | * Week
 |  |
|  | * Month
 |  |
|  | * Year
 |  |

| **Core Services (Continued)** | **Provided** | **UNKNOWN** | **SERVICENOT AVAILABLE** |
| --- | --- | --- | --- |
| **Yes** | **No** |
| 1. Co-occurring Services
 |  |  |  |  |
| 1. Case Management
 |  |  |  |  |
| 1. Trauma-specific Services
 |  |  |  |  |
| 1. Was the consumer referred to another provider for any of the above core services?
 |  |  |  |  |

| **Support Services** | **Provided** | **UNKNOWN** | **SERVICENOT AVAILABLE** |
| --- | --- | --- | --- |
| **Yes** | **No** |
| 1. 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 consumer referred to another provider for any of the above support services?
 |  |  |  |  |