

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)
March 2019

Public reporting burden for this collection of information is estimated to average 40 minutes per response if all items are asked of a consumer/participant; to the extent that providers already obtain much of this information as part of their ongoing consumer/participant intake or follow-up, less time will be required. Send comments regarding this burden estimate, or any other aspect of this collection of information, to the Substance Abuse and Mental Health Services Administration (SAMHSA) Reports Clearance Officer, Room 15E57B, 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The control number for this project is 0930-0285.

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Table of Contents

RECORD MANAGEMENT	1
BEHAVIORAL HEALTH DIAGNOSES.....	2
A. DEMOGRAPHIC DATA.....	6
B. FUNCTIONING.....	7
B. MILITARY FAMILY AND DEPLOYMENT.....	11
B. VIOLENCE AND TRAUMA	12
C. STABILITY IN HOUSING	13
D. EDUCATION AND EMPLOYMENT.....	14
E. CRIME AND CRIMINAL JUSTICE STATUS.....	16
F. PERCEPTION OF CARE	16
G. SOCIAL CONNECTEDNESS	18
H. PROGRAM-SPECIFIC QUESTIONS.....	19
H1. PROGRAM-SPECIFIC QUESTIONS.....	20
H2. PROGRAM-SPECIFIC QUESTIONS.....	21
H3. PROGRAM-SPECIFIC QUESTIONS.....	22
H4. PROGRAM-SPECIFIC QUESTIONS.....	23
H5. PROGRAM-SPECIFIC QUESTIONS.....	25
H6. PROGRAM-SPECIFIC QUESTIONS.....	26
H7. PROGRAM-SPECIFIC QUESTIONS.....	27
H8. PROGRAM-SPECIFIC QUESTIONS.....	28
I. REASSESSMENT STATUS.....	29
J. CLINICAL DISCHARGE STATUS.....	29
K. SERVICES RECEIVED.....	30

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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:

<p><input type="radio"/> Baseline</p> <p><i>[ENTER THE MONTH AND YEAR WHEN THE CONSUMER FIRST RECEIVED SERVICES UNDER THE GRANT FOR <u>THIS</u> EPISODE OF CARE.]</i></p> <p> / </p> <p>MONTH YEAR</p>	<p><input type="radio"/> Reassessment</p> <p>Which 6-month reassessment?</p> <p> </p> <p><i>[ENTER 06 FOR A 6-MONTH, 12 FOR A 12-MONTH, 18 FOR AN 18-MONTH ASSESSMENT, ETC.]</i></p>	<p><input type="radio"/> Clinical Discharge</p>
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2. Was the interview conducted?

<p><input type="radio"/> Yes</p> <p>When?</p> <p> / / </p> <p>MONTH DAY YEAR</p>	<p><input type="radio"/> No</p> <p>Why not? Choose only one.</p> <p><input type="radio"/> Not able to obtain consent from proxy</p> <p><input type="radio"/> Consumer was impaired or unable to provide consent</p> <p><input type="radio"/> Consumer refused this interview only</p> <p><input type="radio"/> Consumer was not reached for interview</p> <p><input type="radio"/> Consumer refused all interviews</p>
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BEHAVIORAL HEALTH DIAGNOSES

3. 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
<u>SUBSTANCE USE DISORDER DIAGNOSES</u>				
<u>Alcohol-related disorders</u>				
F10.10 – Alcohol use disorder, uncomplicated, mild	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F10.11 – Alcohol use disorder, mild, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F10.20 – Alcohol use disorder, uncomplicated, moderate/severe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F10.21 – Alcohol use disorder, moderate/severe, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F10.9 – Alcohol use, unspecified	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<u>Opioid-related disorders</u>				
F11.10 – Opioid use disorder, uncomplicated, mild	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F11.11 – Opioid use disorder, mild, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F11.20 – Opioid use disorder, uncomplicated, moderate/severe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F11.21 – Opioid use disorder, moderate/severe, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F11.9 – Opioid use, unspecified	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<u>Cannabis-related disorders</u>				
F12.10 – Cannabis use disorder, uncomplicated, mild	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F12.11 – Cannabis use disorder, mild, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F12.20 – Cannabis use disorder, uncomplicated, moderate/severe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F12.21 – Cannabis use disorder, moderate/severe, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F12.9 – Cannabis use, unspecified	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<u>Sedative-, hypnotic-, or anxiolytic-related disorders</u>				
F13.10 – Sedative, hypnotic, or anxiolytic use disorder, uncomplicated, mild	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F13.11 – Sedative, hypnotic, or anxiolytic use disorder, mild, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F13.21 – Sedative, hypnotic, or anxiolytic use disorder, moderate/severe, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F13.9 – Sedative, hypnotic, or anxiolytic use, unspecified	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<u>Cocaine-related disorders</u>				
F14.10 – Cocaine use disorder, uncomplicated, mild	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F14.11 – Cocaine use disorder, mild, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F14.20 – Cocaine use disorder, uncomplicated, moderate/severe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F14.21 – Cocaine use disorder, moderate/severe, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F14.9 – Cocaine use, unspecified	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<u>Other stimulant-related disorders</u>				
F15.10 – Other stimulant use disorder, uncomplicated, mild	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F15.11 – Other stimulant use disorder, mild, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F15.20 – Other stimulant use disorder, uncomplicated, moderate/severe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F15.21 – Other stimulant use disorder, moderate/severe, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F15.9 – Other stimulant use, unspecified	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<u>Hallucinogen-related disorders</u>				
F16.10 – Hallucinogen use disorder, uncomplicated, mild	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F16.11 – Hallucinogen use disorder, mild, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F16.20 – Hallucinogen use disorder, uncomplicated, moderate/severe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F16.21 – Hallucinogen use disorder moderate/severe, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F16.9 – Hallucinogen use, unspecified	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<u>Inhalant-related disorders</u>				
F18.10 – Inhalant use disorder, uncomplicated, mild	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F18.11 – Inhalant use disorder, mild, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F18.20 – Inhalant use disorder, uncomplicated, moderate/severe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F18.21 – Inhalant use disorder, moderate/severe, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F18.9 – Inhalant use, unspecified	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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
<u>Other psychoactive substance-related disorders</u>				
F19.10 – Other psychoactive substance use disorder, uncomplicated, mild	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F19.11 – Other psychoactive substance use disorder, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F19.20 – Other psychoactive substance use disorder, uncomplicated, moderate/severe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F19.21 – Other psychoactive substance use disorder, moderate/severe, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F19.9 – Other psychoactive substance use, unspecified	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<u>Nicotine dependence</u>				
F17.20 – Tobacco use disorder, mild/moderate/severe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F17.21 – Tobacco use disorder, mild/moderate/severe, in remission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<u>MENTAL HEALTH DIAGNOSES</u>				
F20 – Schizophrenia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F21 – Schizotypal disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F22 – Delusional disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F23 – Brief psychotic disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F24 – Shared psychotic disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F25 – Schizoaffective disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F28 – Other psychotic disorder not due to a substance or known physiological condition	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F29 – Unspecified psychosis not due to a substance or known physiological condition	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F30 – Manic episode	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F31 – Bipolar disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F32 – Major depressive disorder, single episode	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F33 – Major depressive disorder, recurrent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F34 – Persistent mood [affective] disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F39 – Unspecified mood [affective] disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F40–F48 – Anxiety, dissociative, stress-related, somatoform, and other nonpsychotic mental disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F50 – Eating disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F51 – Sleep disorders not due to a substance or known physiological condition	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F60.2 – Antisocial personality disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F60.3 – Borderline personality disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F70–F79 – Intellectual disabilities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F80–F89 – Pervasive and specific developmental disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F90 – Attention-deficit hyperactivity disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F91 – Conduct disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F93 – Emotional disorders with onset specific to childhood	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F94 – Disorders of social functioning with onset specific to childhood or adolescence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F95 – Tic disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F98 – Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F99 – Unspecified mental disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

- 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

2. 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cuban	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dominican	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mexican	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Puerto Rican	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
South American	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
OTHER (SPECIFY) _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> <i>[IF YES, SPECIFY BELOW.]</i>

3. 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
American Indian	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asian	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Black or African American	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Native Hawaiian or other Pacific Islander	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
White	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. What is your month and year of birth?

____/____
MONTH YEAR

- REFUSED

A. DEMOGRAPHIC DATA (CONTINUED)

5. 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

2. 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)

3. 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
a. I deal effectively with daily problems.	<input type="radio"/>						
b. I am able to control my life.	<input type="radio"/>						
c. I am able to deal with crisis.	<input type="radio"/>						
d. I am getting along with my family.	<input type="radio"/>						
e. I do well in social situations.	<input type="radio"/>						
f. I do well in school and/or work.	<input type="radio"/>						
g. My housing situation is satisfactory.	<input type="radio"/>						
h. My symptoms are not bothering me.	<input type="radio"/>						

4. 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?	<input type="radio"/>						
b. hopeless?	<input type="radio"/>						
c. restless or fidgety?	<input type="radio"/>						
d. so depressed that nothing could cheer you up?	<input type="radio"/>						
e. that everything was an effort?	<input type="radio"/>						
f. worthless?	<input type="radio"/>						

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?	<input type="radio"/>						

B. FUNCTIONING (CONTINUED)

5. 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
a. how would you rate your quality of life?	<input type="radio"/>						

QUESTION	RESPONSE OPTIONS						
In the last 4 weeks ...	Not at All	A Little	Moderately	Mostly	Completely	REFUSED	DON'T KNOW
b. do you have enough energy for everyday life?	<input type="radio"/>						

QUESTION	RESPONSE OPTIONS						
In the last 4 weeks ...	Very Dissatisfied	Dissatisfied	Neither Satisfied nor Dissatisfied	Satisfied	Very Satisfied	REFUSED	DON'T KNOW
c. how satisfied are you with your ability to perform your daily living activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. how satisfied are you with your health?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. how satisfied are you with yourself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. how satisfied are you with your personal relationships?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

B. FUNCTIONING (CONTINUED)

6. 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
a. tobacco products (cigarettes, chewing tobacco, cigars, etc.)?	○	○	○	○	○	○
b. alcoholic beverages (beer, wine, liquor, etc.)?	○	○	○	○	○	○
b1. <i>[IF B ≥ ONCE OR TWICE, AND RESPONDENT IS MALE]</i> How many times in the past 30 days have you had five or more drinks in a day? <i>[CLARIFY IF NEEDED: A standard alcoholic beverage (e.g., 12 oz. beer, 5 oz. wine, 1.5 oz. liquor).]</i>	○	○	○	○	○	○
b2. <i>[IF B ≥ ONCE OR TWICE, AND RESPONDENT IS NOT MALE]</i> How many times in the past 30 days have you had four or more drinks in a day? <i>[CLARIFY IF NEEDED: A standard alcoholic beverage (e.g., 12 oz. beer, 5 oz. wine, 1.5 oz. liquor).]</i>	○	○	○	○	○	○
c. cannabis (marijuana, pot, grass, hash, etc.)?	○	○	○	○	○	○
d. cocaine (coke, crack, etc.)?	○	○	○	○	○	○
e. prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)?	○	○	○	○	○	○
f. methamphetamine (speed, crystal meth, ice, etc.)?	○	○	○	○	○	○
g. inhalants (nitrous oxide, glue, gas, paint thinner, etc.)?	○	○	○	○	○	○
h. sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)?	○	○	○	○	○	○
i. hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)?	○	○	○	○	○	○
j. street opioids (heroin, opium, etc.)?	○	○	○	○	○	○
k. prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)?	○	○	○	○	○	○
l. 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.]

7. 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
• Reserves	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
• National Guard	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
• Reserves	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
• National Guard	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Persian Gulf (Operation Desert Shield or Desert Storm)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vietnam/Southeast Asia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Korea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
WWII	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Deployed to a combat zone not listed above (e.g., Somalia, Bosnia, Kosovo)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8. 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

B. VIOLENCE AND TRAUMA

9. 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)

10. 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
a. Have had nightmares about it or thought about it when you did not want to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Were constantly on guard, watchful, or easily startled?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Felt numb and detached from others, activities, or your surroundings?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

11. 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

C. 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?	____ ____	<input type="radio"/>	<input type="radio"/>
b. nights have you spent in a hospital for mental health care?	____ ____	<input type="radio"/>	<input type="radio"/>
c. nights have you spent in a facility for detox/inpatient or residential substance abuse treatment?	____ ____	<input type="radio"/>	<input type="radio"/>
d. nights have you spent in correctional facility including jail or prison?	____ ____	<input type="radio"/>	<input type="radio"/>

[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? | ____ ____ | <input type="radio"/> | <input type="radio"/> |
|---|-----------|-----------------------|-----------------------|

____|____

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

C. STABILITY IN HOUSING (CONTINUED)

2. 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)

2. 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

3. 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
• Are your wages paid directly to you by your employer?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
• Could anyone have applied for this job?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. 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?	<input type="radio"/>						

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
a. Staff here believe that I can grow, change, and recover.	<input type="radio"/>						
b. I felt free to complain.	<input type="radio"/>						
c. I was given information about my rights.	<input type="radio"/>						
d. Staff encouraged me to take responsibility for how I live my life.	<input type="radio"/>						
e. Staff told me what side effects to watch out for.	<input type="radio"/>						
f. Staff respected my wishes about who is and who is not to be given information about my treatment.	<input type="radio"/>						
g. Staff were sensitive to my cultural background (race, religion, language, etc.).	<input type="radio"/>						
h. Staff helped me obtain the information I needed so that I could take charge of managing my illness.	<input type="radio"/>						
i. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	<input type="radio"/>						
j. I felt comfortable asking questions about my treatment and medication.	<input type="radio"/>						

F. PERCEPTION OF CARE (CONTINUED)

STATEMENT	RESPONSE OPTIONS						
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	REFUSED	NOT APPLICABLE
k. I, not staff, decided my treatment goals.	<input type="radio"/>						
l. I like the services I received here.	<input type="radio"/>						
m. If I had other choices, I would still get services from this agency.	<input type="radio"/>						
n. I would recommend this agency to a friend or family member.	<input type="radio"/>						

2. [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.	<input type="radio"/>					
b. I have people with whom I can do enjoyable things.	<input type="radio"/>					
c. I feel I belong in my community.	<input type="radio"/>					
d. In a crisis, I would have the support I need from family or friends.	<input type="radio"/>					
e. I have family or friends that are supportive of my recovery.	<input type="radio"/>					
f. I generally accomplish what I set out to do.	<input type="radio"/>					

[IF YOUR PROGRAM DOES NOT REQUIRE SECTION H:

IF THIS IS A BASELINE INTERVIEW, STOP NOW. THE INTERVIEW IS COMPLETE.]

IF THIS IS A REASSESSMENT INTERVIEW, PLEASE GO TO SECTION I, THEN TO SECTION K.]

IF THIS IS A CLINICAL DISCHARGE INTERVIEW, PLEASE GO TO SECTION J, THEN TO SECTION K.]

[IF YOUR PROGRAM DOES REQUIRE SECTION H:

IF THIS IS A BASELINE INTERVIEW, PLEASE GO TO SECTION H, THEN STOP. THE INTERVIEW WILL BE COMPLETE.]

IF THIS IS A REASSESSMENT INTERVIEW, PLEASE GO TO SECTION H, THEN SECTIONS I AND K.]

IF THIS IS A CLINICAL DISCHARGE INTERVIEW, PLEASE GO TO SECTION H, THEN SECTIONS J AND 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.]

2. 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

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

	YES	NO
Mental health services	<input type="radio"/>	<input type="radio"/>

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

	YES	NO	DON'T KNOW	NOT APPLICABLE
Mental health services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>	<input type="radio"/>

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

	YES	NO	DON'T KNOW	NOT APPLICABLE
Substance use disorder services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

3. 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

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

- | 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? | _ _ _ | <input type="radio"/> | <input type="radio"/> |
| b. Been hospitalized overnight for a physical healthcare problem?
<i>[REPORT NUMBER OF NIGHTS HOSPITALIZED.]</i> | _ _ _ | <input type="radio"/> | <input type="radio"/> |

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

2. 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 ARE REPORTED BY THE GRANTEE ABOUT THE CONSUMER.]

Program-Specific Health Items (Report Quarterly)

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 |

2. Did patient successfully fast for 8 hours prior to providing the blood sample?

3. 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	<input type="radio"/>	<input type="radio"/>

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

	YES	NO	DON'T KNOW	NOT APPLICABLE
Mental health services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>	<input type="radio"/>

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

	YES	NO	DON'T KNOW	NOT APPLICABLE
Substance use disorder services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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? | _ _ _ | <input type="radio"/> | <input type="radio"/> |
| b. How many times did you attempt to kill yourself? | _ _ _ | <input type="radio"/> | <input type="radio"/> |

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

2. 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.]

2. ***[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

[PROGRAM-SPECIFIC HEALTH ITEMS ARE REPORTED BY THE GRANTEE ABOUT THE CONSUMER.]

1. Health measurements: (report quarterly)

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

2. 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

2. 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	SERVICE NOT AVAILABLE
	Yes	No		
1. Screening	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Assessment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Treatment Planning or Review	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Psychopharmacological Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Mental Health Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

[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
 Week
 Month
 Year
 UNKNOWN

Core Services (Continued)	Provided		UNKNOWN	SERVICE NOT AVAILABLE
	Yes	No		
6. Co-occurring Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Case Management	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Trauma-specific Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Was the consumer referred to another provider for any of the above core services?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Support Services	Provided		UNKNOWN	SERVICE NOT AVAILABLE
	Yes	No		
1. Medical Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Employment Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Family Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Child Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Transportation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Education Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Housing Support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Social Recreational Activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Consumer-Operated Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. HIV Testing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Was the consumer referred to another provider for any of the above support services?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>