Form Version Updated: 12/03/2019

Yakama Nation Behavioral Health Intake Form

Child/Adolescent or Caregiver Interview

For clients 15 years old or younger

SAMHSA's Performance Accountability and Reporting System (SPARS)
March 2019

Used when either the child / adolescent (15 years old or younger); or the caregiver is being interviewed on behalf of the child or adolescent. This version includes the question stems for both the child/adolescent and caregiver; the interviewer would adjust the question according to who is being interviewed.

Please note – Either the child or the child's caregiver must be interviewed for the purposes of the SPARS data collection; interviews of both individuals **are not required**. The table below describes the appropriate interviewee and criteria.

Interviewee / Respondent	**Criteria**
1. Child or Adolescent	Child age 11 to 15 years old
2. Caregiver (on behalf of the child / adolescent)	Child age 10 and younger
3. Either the child / adolescent ***or*** the Caregiver (on behalf of the child / adolescent)	Dependent on who is being interviewed

Note: If possible, please attempt to maintain consistency across client interviews to avoid problems related to inter-rater reliability; i.e., if the child is interviewed initially, the child should be interviewed for reassessments and for the duration of his/her treatment.

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Table of Contents: CHILD / ADOLESCENT Interview

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General Instructions

1. Before starting the interview, use a calendar to mark off the past 30 calendar days since many of the questions refer to the past 30 days / 4 weeks.
2. At the beginning of each section, introduce the next set of questions, (e.g., "Now, I'm going to ask you some questions about…").
3. Read each question as it is written. Instructions written in all CAPITALS and *italicized* should not be read to the client.
4. Read response categories that appear in sentence-case lettering, which is a normal mix of upper-case and lower-case (e.g., Central American or Strongly Disagree). Do NOT read response categories that are in ALL CAPITAL letters.
    a. If all response categories are in ALL CAPITAL letters, ask the question open-ended; do NOT read any of the response categories listed.

Summary of Questions by Respondent & Interview

- Record management & Behavioral Health Diagnoses is ALWAYS answered, whether or not there was an interview conducted and regardless of who is the respondent.

	RESPONDENT		
SECTION	**Child / Adolescent ONLY**	**BOTH**	**Caregiver ONLY**
Record management	Answered by interviewer at very time point		
Behavioral health diagnoses	Answered by interviewer at very time point		
Billing information	Every time point *(if an interview is conducted)*		
A. Demographic data		BL Only	
B. Social connectedness	Every time point		
C. Functioning		Every time point	
Mental Health	Every time point		
Trauma Exposure	Every time point		
Substance Use	Every time point		
Substance Use Supplement	Every time point *(if applicable)*		
Child Behavioral Check List (CBCL)			Every time point
Military		BL Only	
D. Stability in housing		Every time point	
E. Education		Every time point	
F. Crime & criminal justice		Every time point	
G. Perception of care		RA & CD only	
H. Program-Specific: Clients		Every time point	
Program-Specific: Clinic	Answered by interviewer at every time point		
I. Reassessment status	Answered by interviewer at reassessment (RA)		
J. Clinical discharge status	Answered by interviewer at clinical discharge (CD)		
K. Services Received	Answered by interviewer at RA & CD		

Note. BL = Baseline / Intake; RA = Reassessment; CD = Clinical discharge

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RECORD MANAGEMENT

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

1. Client IHS Chart number |____|____|____|____|____|____|____|____|____|____|____|____|

2. Grant ID (Grant/Contract/Cooperative Agreement) |____|____|____|____|____|____|____|____|____|____|____|____|

a. Is this a HEALTHY TRANSITIONS client? ○ YES ○ NO

3. Site where the interview was conducted

☐ YN Behavioral Health
☐ YNBH – White Swan
☐ Higher Education & AVT Programs
☐ Nak Nu Weesha Program
☐ Tiin?wit Program
☐ Tiin?wit Program - Youth Treatment
☐ YN Adult Probation
☐ YN Adult Vocational Rehabilitation Training (AVRT)
☐ YN Corrections & Rehabilitation Center
☐ YN Housing Authority
☐ Youth Court Services
☐ Work Force Development
☐ Other (please describe below)
_____
_____

4. Indicate Assessment Type:

○ Baseline	○ Reassessment **Which 6-month reassessment?** |____|____| ***[ENTER 06 FOR A 6-MONTH, 12 FOR A 12-MONTH, 18 FOR AN 18-MONTH ASSESSMENT, ETC.]***	○ Clinical Discharge

5. Was the interview conducted?

○ Yes	○ No
6. When? |____|____| / |____|____| / |____|____|____|____| MONTH DAY YEAR **6a. Interviewer first & last name:** _____ **(Please print)**	**Why not? Choose only one.** ○ Not able to obtain consent from proxy ○ Client was impaired or unable to provide consent ○ Client refused this interview only ○ Client was not reached for interview ○ Client refused all interviews ***[GO TO QUESTION 9: Diagnosis, page 2.]***

7. What is the month and year when the client first received services under the grant for *this* episode of care?

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

Episode of care begins when the client enters treatment or services as defined by the program & ends when the client is discharged & no longer receiving treatment or services. A NEW episode of care begins when a client returns for treatment after a lapse of services of 90 calendar days or more OR after being discharged.

8. Was the respondent the child or the caregiver?

○ Child ***[PREFER CHILD AGE 11 AND OLDER.]*** ○ Caregiver

BEHAVIORAL HEALTH DIAGNOSES

9. Behavioral Health Diagnoses ***[REPORTED BY CLINIC / PROGRAM STAFF AT EVERY TIMEPOINT.]***

Please indicate the client's current behavioral health diagnoses using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes listed below. 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-related 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

BILLING INFORMATION

10. Who is the clinical supervisor responsible for this case? _____

11. Which provider / counselor interviewed the client today? _____

12. Please enter the appropriate CPT Code(s) for this visit. |____|____|____|____|____|____|____|____|____|___|

|____|____|____|____|____|____|____|____|____|___|

|____|____|____|____|____|____|____|____|____|___|

13. What is the client's date of birth? |____|____| / |____|____| / |____|____|____|____|
MONTH DAY YEAR

14. What is the client's age? _____

Billing

[IF THIS IS A BASELINE, GO TO SECTION A: Demographic data, page 7]

[FOR ALL REASSESSMENTS:

IF AN INTERVIEW WAS CONDUCTED, GO TO SECTION B: Social Connectedness, page 8.

IF AN INTERVIEW WAS NOT CONDUCTED, GO TO SECTION I: Reassessment status, page 25.]

[FOR A CLINICAL DISCHARGE:

IF AN INTERVIEW WAS CONDUCTED, AND

IF THE CLIENT IS THE RESPONDENT, GO TO SECTION B: Social Connectedness, page 8.

THE CAREGIVER IS THE RESPONDENT, GO TO SECTION C: Functioning, page 10.

IF AN INTERVIEW WAS NOT CONDUCTED, GO TO SECTION J: Clinical discharge status, page 25.]

A. DEMOGRAPHIC DATA

[SECTION A IS ONLY COLLECTED AT <u>BASELINE</u>. IF THIS IS NOT A BASELINE, GO TO SECTION B: Social Connectedness, page 8.]

1. What is your [child's] gender?

- ○ MALE
- ○ FEMALE
- ○ TRANSGENDER
- ○ OTHER (SPECIFY) _____
- ○ REFUSED

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

	YES	NO	REFUSED
a. Alaska Native	○	○	○
b. American Indian	○	○	○
c. Asian	○	○	○
d. Black or African American	○	○	○
e. Native Hawaiian or other Pacific	○	○	○
f. White	○	○	○

3. Are you [Is your child] Hispanic or Latino?

- ○ YES
- ○ NO ***[GO TO SECTION B. SOCIAL CONNECTEDNESS, page 8.]***
- ○ REFUSED ***[GO TO SECTION B. SOCIAL CONNECTEDNESS, page 8.]***

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

	YES	NO	REFUSED	
a. Central American	○	○	○	
b. Cuban	○	○	○	
c. Dominican	○	○	○	
d. Mexican	○	○	○	
e. Puerto Rican	○	○	○	
f. South American	○	○	○	
g. OTHER	○	○	○	***[IF YES, SPECIFY BELOW.]***

(SPECIFY) _____

[IF AN INTERVIEW WAS CONDUCTED, CONTINUE TO SECTION B: Social Connectedness, page 8.]

[IF AN INTERVIEW WAS <u>NOT</u> CONDUCTED, GO TO SECTION H: Program Specific Questions, page 22.]

Demographic

B. SOCIAL CONNECTEDNESS: Answered by the CLIENT only.

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 CLIENT.]

STATEMENT	RESPONSE OPTIONS					
	Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**	**REFUSED**
a. I know people who will listen and understand me when I need to talk.	○	○	○	○	○	○
b. I have people that I am comfortable talking with about my problems.	○	○	○	○	○	○
c. In a crisis, I would have the support I need from family or friends.	○	○	○	○	○	○
d. I have people with whom I can do enjoyable things.	○	○	○	○	○	○

QUESTION	RESPONSE OPTIONS	
2. The following questions ask about being Native American and culture.	**Yes**	**No**
a. I know my cultural / spiritual name	○	○
b. I can understand some of my Native language.	○	○
c. In certain situations, I believe things like animals and rocks have a spirit like Native people.	○	○
d. I use tobacco for guidance.	○	○
e. I have participated in a cultural ceremony (examples, Sweat lodge, Moon Ceremony, Sundance, Longhouse, Feast or Giveaway)	○	○
f. I have helped prepare for a cultural ceremony (examples, Sweat lodge, Moon Ceremony, Sundance, Longhouse, Feast or Giveaway)	○	○
g. I have offered food or feasted someone something for a cultural reason.	○	○
h. Someone in my family or someone I am close with attends cultural ceremonies.	○	○
i. I plan on attending a cultural ceremony in the future.	○	○
j. I plan on trying to find out more about my Native culture, such as its history, traditions, and customs.	○	○
k. I have a traditional person or Elder who I talk to.	○	○

B. SOCIAL CONNECTEDNESS (CONTINUED)

STATEMENT	RESPONSE OPTIONS					
3. How much do you agree with the following statements	**Strongly Disagree**	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**	**REFUSED**
a. I have spent time trying to find out more about being Native, such as its history, traditions and customs.	○	○	○	○	○	○
b. I have a strong sense of belonging to my Native community or Nation.	○	○	○	○	○	○
c. I have done things that help me understand my Native background better.	○	○	○	○	○	○
d. I have talked to other people in order to learn more about being Native.	○	○	○	○	○	○
e. When I learn something about my Native culture, I will ask someone more about it later.	○	○	○	○	○	○
f. I feel a strong attachment towards my Native community or Nation.	○	○	○	○	○	○
g. If a traditional person or elder spoke to me about being Native, I would listen to them carefully.	○	○	○	○	○	○
h. I feel a strong connection to my ancestors.	○	○	○	○	○	○
i. Being Native means I sometimes have a different way of looking at the world.	○	○	○	○	○	○
j. The eagle feather has a lot of meaning to me.	○	○	○	○	○	○
k. It is important to me that I know my Native language.	○	○	○	○	○	○
l. When I am physically ill, I look to my Native culture for help.	○	○	○	○	○	○
m. When I need to make a decision about something, I look to my Native culture for help.	○	○	○	○	○	○
n. When I am feeling spiritually disconnected, I look to my Native culture for help.	○	○	○	○	○	○

QUESTION	RESPONSE OPTIONS					
4. How often do you…	**Every day**	**Every week**	**Every month**	**Once / twice per year**	**Never**	**REFUSED**
a. Make tobacco offerings for cultural purposes?	○	○	○	○	○	○
b. Use sage, sweet grass, or cedar in any way or form?	○	○	○	○	○	○
c. Does someone in your family or someone you are close with use sage, sweet grass, or cedar in any way or form?	○	○	○	○	○	○

C. FUNCTIONING

1. How would you rate your [your child's] overall health right now?

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor
- ○ REFUSED
- ○ DON'T KNOW

2. In order to provide the best possible mental health and related services, we need to know what you think about how well you were [your child was] able to deal with 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 CLIENT or CAREGIVER.]

STATEMENT	RESPONSE OPTIONS						
	Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**	**REFUSED**	**N/A**
a. I am [My child is] handling daily life.	○	○	○	○	○	○	
b. I get [My child gets] along with family members.	○	○	○	○	○	○	○
c. I get [My child gets] along with friends and other people.	○	○	○	○	○	○	
d. I am [My child is] doing well in school and/or work.	○	○	○	○	○	○	○
e. I am [My child is] able to cope when things go wrong.	○	○	○	○	○	○	
f. I am satisfied with our family life right now.	○	○	○	○	○	○	

[IF THE CAREGIVER IS THE RESPONDENT, GO TO the Child Behavioral Checklist (CBCL), page 17.]

[IF THE CLIENT IS THE RESPONDENT, GO TO QUESTION C3, page 11.]

C. FUNCTIONING (CONTINUED): Mental Health

[IF THE CAREGIVER IS THE RESPONDENT, GO TO the Child Behavioral Checklist (CBCL), page 19.]

3. 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 CLIENT.]

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**	**RF**	**DK**
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?	○	○	○	○	○	○	○

RF = REFUSED
DK = DON'T KNOW

C. FUNCTIONING (CONTINUED): Trauma Exposure

[IF THE CAREGIVER IS THE RESPONDENT, GO TO the Child Behavioral Checklist (CBCL), page 17; OTHERWISE, ASK THE CLIENT THE FOLLOWING QUESTIONS.]

4. Have you ever experienced violence or trauma in any setting (including neighborhood or school violence; domestic violence; being or seeing someone be slapped, punched, beat up, attacked, stabbed, shot at or hurt badly, someone older touching your private parts or someone pressuring you for sex; natural disaster; terrorism; neglect or someone close to you dying suddenly or violently)?

- ○ YES
- ○ NO *[GO TO 6.]*
- ○ REFUSED *[GO TO 6.]*
- ○ DON'T KNOW *[GO TO 6.]*

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

In the past and / or present you …	RESPONSE OPTIONS			
	YES	**NO**	**RF**	**DK**
a. Have had bad dreams or nightmares about it or thought about it when you didn't want to?	○	○	○	○
b. Tried hard not to think about it or went out of your way to avoid people or places that remind you of it?	○	○	○	○
c. Were constantly on guard, watchful, or easily startled / surprised?	○	○	○	○
d. Feeling numb or detached from other people, activities, or your surroundings?	○	○	○	○

6. In 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. FUNCTIONING (CONTINUED): Substance Use: Answered by CLIENT ONLY

7. 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 CLIENT.]

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. ***[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 FEMALE]*** **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).*]*	○	○	○	○	○	○
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.): _____	○	○	○	○	○	○

[IF CLIENT SAYS YES TO ANY OF THE SUBSTANCES ABOVE, GO TO Substance Use Supplement, page 14]

[IF CLIENT SAYS NO TO ANY OF THE SUBSTANCES ABOVE, GO TO Military Family & Deployment, page 17]

C. FUNCTIONING (CONTINUED): Substance Use Supplement: Answered by CLIENT ONLY

S1. During the past 30 days, how many days have you used any of the following opiates

	# of Days	RF	DK
a. Heroin (Smack, H, Junk, Skag)	|____|____|	○	○
b. Morphine	|____|____|	○	○
c. Dilaudid	|____|____|	○	○
d. Demerol	|____|____|	○	○
e. Percocet	|____|____|	○	○
f. Darvon	|____|____|	○	○
g. Codeine	|____|____|	○	○
h. Tylenol 2, 3, 4	|____|____|	○	○
i. OxyContin/Oxycodone	|____|____|	○	○
j. Non-prescription methadone	|____|____|	○	○

S2. In the past 30 days, have you injected drugs?

○ YES
○ NO **[SKIP TO S3]**
○ REFUSED **[SKIP TO S3]**
○ DON'T KNOW **[SKIP TO S3]**

S2a. In the past 30 days, how often did you use a syringe / needle, cooker, cotton, or water that someone else used?

○ Always
○ More than half the time
○ Half the time
○ Less than half the time
○ Never
○ REFUSED
○ DON'T KNOW

Substance Use Supplement: Family & Living Conditions

S3. During the past 30 days, how stressful have things been for you because of your use of alcohol or other drugs?

○ Not at all
○ Somewhat
○ Considerably
○ Extremely
○ REFUSED
○ DON'T KNOW

SU Supplement

C. FUNCTIONING (CONTINUED): Substance Use Supplement (cont.)

S4. During the past 30 days, has your use of alcohol or other drugs caused you to reduce or give up important activities?

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely
- ○ REFUSED
- ○ DON'T KNOW

S5. During the past 30 days, has your use of alcohol or other drugs caused you to have emotional problems?

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely
- ○ REFUSED
- ○ DON'T KNOW

Substance Use Supplement: Crime & Criminal Justice

S6. Are you currently on parole or probation?

- ○ YES
- ○ NO
- ○ REFUSED

Substance Use Supplement: Mental & Physical Health & Treatment Recovery

S7. During the past 30 days, did you receive Emergency Room treatment for alcohol or substance use?

- ○ YES **How many times**: **|____|____|, if unsure, please provide your best guess or estimate.**
- ○ NO
- ○ REFUSED

Substance Use Supplement: Social Connectedness

S8. In the past 30 days, did you attend any voluntary self-help groups for recovery that were not affiliated with a religious or faith-based organization? In other words, did you participate in a nonprofessional, peer-operated organization that is devoted to helping individuals who have addiction-related problems, such as Alcoholics Anonymous, Narcotics Anonymous, Oxford House, Secular Organization for Sobriety, or Women for Sobriety, etc.?

- ○ YES **How many times**: **|____|____|, if unsure, make your best guess or estimate**
- ○ NO
- ○ DON'T KNOW
- ○ REFUSED

B. FUNCTIONING (CONTINUED): Substance Use Supplement (cont.)

S9. In the past 30 days, did you attend any religious/faith-affiliated recovery self-help groups?

- ○ YES **How many times**: **|____|____|, if unsure, make your best guess or estimate**
- ○ NO
- ○ DON'T KNOW
- ○ REFUSED

S10. In the past 30 days, did you attend meetings of organizations that support recovery other than the organizations described above?

- ○ YES **How many times**: **|____|____|, if unsure, make your best guess or estimate**
- ○ NO
- ○ DON'T KNOW
- ○ REFUSED

S11. In the past 30 days, did you have interaction with family and/or friends that are supportive of your recovery?

- ○ YES **How many times**: **|____|____|, if unsure, make your best guess or estimate**
- ○ NO
- ○ DON'T KNOW
- ○ REFUSED

S12. To whom do you turn when you are having trouble? [SELECT ONLY ONE.]

- ○ NO ONE
- ○ CLERGY / SPIRITUAL LEADER
- ○ FAMILY MEMBER
- ○ FRIENDS
- ○ REFUSED
- ○ DON'T KNOW
- ○ OTHER (SPECIFY) _____

C. FUNCTIONING (CONTINUED)

[IF THE RESPONDANT IS THE CAREGIVER, THEN, Pause interview. Provide caregiver with the paper and pencil version of the Child Behavior Checklist for ages 6-18 (CBCL/6-18). Resume interview after they have completed the CBCL/6-18]

[ENTER CHILD BEHAVIOR CHECKLIST (CBCL) TOTAL PROBLEMS T SCORE REPORTED BY GRANTEE STAFF AT PROJECT'S DISCRETION.]

DATE CBCL WAS ADMINISTERED: |____|____| / |____|____| / |____|____|____|____|
MONTH DAY YEAR

WHAT WAS THE CLIENT'S SCORE? TOTAL PROBLEMS T SCORE = |____|____|____|

C. FUNCTIONING: Military and Family Deployment

[QUESTIONS 9 AND 10 ARE ONLY ASKED AT BASELINE. IF THIS IS NOT A BASELINE, GO TO SECTION D : Stability in Housing, page 18]

8. Is anyone in your [your child's] family or someone close to you [your child] 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

D. STABILITY IN HOUSING

1. In the past 30 days, how many …	Number of Nights/ Times	REFUSED	DON'T KNOW
a. nights have you [has your child] been homeless?	|____|____|	○	○
b. nights have you [has your child] spent in a hospital for mental health care?	|____|____|	○	○
c. nights have you [has your child] spent in a facility for detox/inpatient or residential substance abuse treatment?	|____|____|	○	○
d. nights have you [has your child] spent in correctional facility including juvenile detention, 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 1 A–1D, <u>CANNOT</u> EXCEED 30 NIGHTS).***	|____|____|	***[ADD ALL NIGHTS TOGETHER <u>BEFORE</u> MOVING ON TO Question C1e.]***	
e. times have you [has your child] gone to an emergency room for a psychiatric or emotional problem?	|____|____|	○	○

[IF 1A, 1B, 1C, OR 1D IS <u>16 OR MORE NIGHTS</u>, GO TO SECTION E: Education, page 19.]

[IF <u>15 NIGHTS OR LESS</u>, GO TO QUESTION 2.]

2. In the past 30 days, where have you [has your child] been living most of the time?

[DO NOT READ RESPONSE OPTIONS TO CLIENT or CAREGIVER. SELECT ONLY ONE.]

- ○ CAREGIVER'S OWNED OR RENTED HOUSE, APARTMENT, TRAILER, OR ROOM
- ○ INDEPENDENT OWNED OR RENTED HOUSE, APARTMENT, TRAILER, OR ROOM
- ○ SOMEONE ELSE'S HOUSE, APARTMENT, TRAILER, OR ROOM
- ○ HOMELESS (SHELTER, STREET/OUTDOORS, PARK)
- ○ GROUP HOME
- ○ FOSTER CARE (SPECIALIZED THERAPEUTIC TREATMENT)
- ○ TRANSITIONAL LIVING FACILITY
- ○ HOSPITAL (MEDICAL)
- ○ HOSPITAL (PSYCHIATRIC)
- ○ DETOX/INPATIENT OR RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
- ○ CORRECTIONAL FACILITY (JUVENILE DETENTION CENTER/JAIL/PRISON)
- ○ OTHER HOUSED (SPECIFY) _____
- ○ REFUSED
- ○ DON'T KNOW

E. EDUCATION

1. During the past 30 days of school, how many days were you [was your child] absent for any reason?

- ○ 0 DAYS
- ○ 1 DAY
- ○ 2 DAYS
- ○ 3 TO 5 DAYS
- ○ 6 TO 10 DAYS
- ○ MORE THAN 10 DAYS
- ○ REFUSED
- ○ DON'T KNOW
- ○ NOT APPLICABLE

a. *[IF ABSENT]*, how many days were unexcused absences?

- ○ 0 DAYS
- ○ 1 DAY
- ○ 2 DAYS
- ○ 3 TO 5 DAYS
- ○ 6 TO 10 DAYS
- ○ MORE THAN 10 DAYS
- ○ REFUSED
- ○ DON'T KNOW
- ○ NOT APPLICABLE

2. What is the highest level of education you have (your child has) finished, whether or not you (he/she has) received a degree?

- ○ NEVER ATTENDED
- ○ PRESCHOOL
- ○ KINDERGARTEN
- ○ 1ST GRADE
- ○ 2ND GRADE
- ○ 3RD GRADE
- ○ 4TH GRADE
- ○ 5TH GRADE
- ○ 6TH GRADE
- ○ 7TH GRADE
- ○ 8TH GRADE
- ○ 9TH GRADE
- ○ 10TH GRADE
- ○ 11TH GRADE
- ○ 12TH GRADE/HIGH SCHOOL DIPLOMA/EQUIVALENT (GED)
- ○ VOCATIONAL/TECHNICAL (VOC/TECH) DIPLOMA
- ○ SOME COLLEGE OR UNIVERSITY
- ○ REFUSED
- ○ DON'T KNOW

F. CRIME AND CRIMINAL JUSTICE STATUS

1. In the past 30 days, how many times have you [has your child] been arrested?

|____|____| TIMES ○ REFUSED ○ DON'T KNOW

[IF THIS IS A BASELINE, GO TO SECTION H: Program Specific Questions, page 22 OTHERWISE, GO TO SECTION G: Perception of care, page 22.]

G. PERCEPTION OF CARE

[SECTION F IS NOT COLLECTED AT BASELINE. FOR BASELINE INTERVIEWS, GO TO SECTION H: Program Specific Questions, page 22.]

1. In order to provide the best possible mental health and related services, we need to know what you think about the services you [your child] 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 CLIENT or CAREGIVER.]

STATEMENT	RESPONSE OPTIONS					
	Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**	**REFUSED**
a. Staff here treated me with respect.	○	○	○	○	○	○
b. Staff respected my family's religious/spiritual beliefs.	○	○	○	○	○	○
c. Staff spoke with me in a way that I understood.	○	○	○	○	○	○
d. Staff was sensitive to my cultural/ethnic background.	○	○	○	○	○	○
e. I helped choose my [my child's] services.	○	○	○	○	○	○
f. I helped to choose my [my child's] treatment goals.	○	○	○	○	○	○
g. I participated in my [my child's] treatment.	○	○	○	○	○	○
h. Overall, I am satisfied with the services I [my child] received.	○	○	○	○	○	○
i. The people helping me [my child] stuck with me [us] no matter what.	○	○	○	○	○	○
j. I felt I had [my child had] someone to talk to when I [he/she] was troubled.	○	○	○	○	○	○
k. The services I [my child and/or family] received were right for me [us].	○	○	○	○	○	○
l. I [My family] got the help I [we] wanted [for my child].	○	○	○	○	○	○
m. I [My family] got as much help as I [we] needed [for my child].	○	○	○	○	○	○

G. PERCEPTION OF CARE (CONTINUED)

2. ***[INDICATE WHO ADMINISTERED SECTION F, PERCEPTION OF CARE, TO THE CLIENT or CAREGIVER FOR THIS INTERVIEW.]***

- ○ ADMINISTRATIVE STAFF
- ○ CARE COORDINATOR
- ○ CASE MANAGER
- ○ CLINICIAN PROVIDING DIRECT SERVICES
- ○ CLINICIAN NOT PROVIDING SERVICES
- ○ CLIENT PEER
- ○ DATA COLLECTOR
- ○ EVALUATOR
- ○ FAMILY ADVOCATE
- ○ RESEARCH ASSISTANT STAFF
- ○ SELF-ADMINISTERED
- ○ OTHER (SPECIFY) _____

H. PROGRAM-SPECIFIC QUESTIONS: Client Questions

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

[IF THE CLIENT IS RESPONDENT]

1. In the past 30 days:	**Number of Times**	**REFUSED**	**DON'T KNOW**
a. How many times have you thought about killing yourself?	|____|____|	○	○
b. How many times did you attempt to kill yourself?	|____|____|	○	○

[IF THE CAREGIVER IS THE RESPONDENT]

1. In the past 30 days:	**Yes**	**No**	**REFUSED**	**DON'T KNOW**
a. Has your child expressed thoughts to you about killing himself or herself?	○	○	○	○
b. Did your child attempt to kill himself or herself?	○	○	○	○

H. Client Ques.

[QUESTIONS 2, 3, AND 4 SHOULD BE ANSWERED BY THE CLIENT/CAREGIVER AT BASELINE, REASSESSMENT, AND CLINICAL DISCHARGE.]

Please indicate your agreement with the following items:

[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CLIENT/CAREGIVER.]

STATEMENT	RESPONSE OPTIONS						
	Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**	**REFUSED**	**DON'T KNOW**
2. As a result of treatment and services received, my [my child's] trauma and/or loss experiences were identified and addressed.	○	○	○	○	○	○	○
3. As a result of treatment and services received for trauma and/or loss experiences, my [my child's] problem behaviors/symptoms have decreased.	○	○	○	○	○	○	○
4. As a result of treatment and services received, I [my child has] have shown improvement in daily life, such as in school or interacting with family or friends.	○	○	○	○	○	○	○

THIS IS THE END OF THE CLIENT / CAREGIVER QUESTIONS.
THE NEXT SET OF QUESTIONS ARE TO BE ANSWERED BY THE CLINIC OR PROGRAM STAFF.

H. PROGRAM-SPECIFIC QUESTIONS: Clinic / Program Questions

[QUESTION 1 SHOULD BE REPORTED BY CLINIC / PROGRAM STAFF AT BASELINE, REASSESSMENT, AND CLINICAL DISCHARGE.]

1. Please indicate which type of funding source(s) was (were)/will be used to pay for the services provided to this client since their last interview. (Check all that apply):

- ○ Current SAMHSA grant funding
- ○ Other federal grant funding
- ○ State funding
- ○ Client's private insurance
- ○ Medicaid/Medicare
- ○ Other (Specify): _____

[PROGRAM-SPECIFIC HEALTH ITEMS ARE REPORTED BY CLINIC / PROGRAM STAFF ABOUT THE CLIENT.]

2. Client's health measurements:

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

[IF THIS IS A BASELINE, 

HERE.]

[IF THIS IS A REASSESSMENT OR CLINICAL DISCHARGE, GO TO Question 3, page 24.]

H. PROGRAM-SPECIFIC QUESTIONS (CONTINUED): Clinic / Program Questions

[QUESTION 3 SHOULD BE REPORTED BY CLINIC / PROGRAM STAFF AT REASSESSMENT AND CLINICAL DISCHARGE.]

3. Has the client 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 client initially experienced the FEP.

|___|___| / |___|___|___|___|
MONTH YEAR

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

- ○ Yes
- ○ No
- ○ DON'T KNOW

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

|___|___| / |___|___|___|___| DON'T KNOW
MONTH YEAR ○

[IF THIS IS A REASSESSMENT INTERVIEW, PLEASE GO TO SECTION I, page 25 THEN TO SECTION K, page 26.]

[IF THIS IS A CLINICAL DISCHARGE INTERVIEW, PLEASE GO TO SECTION J, page 25 THEN TO SECTION K, page 26.]

I. REASSESSMENT STATUS

[SECTION I IS REPORTED BY CLINIC / PROGRAM STAFF AT REASSESSMENT.]

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

- ○ Yes
- ○ No

2. Is the client still receiving services from your project?

- ○ Yes
- ○ No

[GO TO SECTION K: Services received, page 26.]

J. CLINICAL DISCHARGE STATUS

[SECTION J IS REPORTED BY CLINIC / PROGRAM STAFF ABOUT THE CLIENT AT CLINICAL DISCHARGE.]

1. On what date was the client discharged?

|___|___| / |___|___|___|___|
MONTH YEAR

2. What is the client's discharge status?

- ○ Mutually agreed cessation of treatment
- ○ Withdrew from/refused treatment
- ○ No contact within 90 days of last encounter
- ○ Clinically referred out
- ○ Death
- ○ Other (Specify) _____

[GO TO SECTION K: Services received, page 26.]

K. SERVICES RECEIVED

[SECTION K IS REPORTED BY CLINIC / PROGRAM STAFF AT REASSESSMENT AND DISCHARGE UNLESS THE CLIENT REFUSED THIS INTERVIEW OR ALL INTERVIEWS, IN WHICH CASE THE SECTION IS OPTIONAL.]

1. On what date did the client last receive services? |___|___| / |___|___|___|___|
MONTH YEAR

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

Core Services	**Provided**		**UNKNOWN**	**SERVICE NOT AVAILABLE**
	Yes	**No**		
1. Screening	○	○	○	○
2. Assessment	○	○	○	○
3. Treatment Planning or Review	○	○	○	○
4. Psychopharmacological Services	○	○	○	○
5. 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
- ○ Week
- ○ Month
- ○ Year

UNKNOWN ○

Core Services (Continued)	**Provided**		**UNKNOWN**	**SERVICE NOT AVAILABLE**
	Yes	**No**		
6. Co-occurring Services	○	○	○	○
7. Case Management	○	○	○	○
8. Trauma-specific Services	○	○	○	○
9. Was the client referred to another provider for any of the above core services?	○	○	○	○

Support Services	**Provided**		**UNKNOWN**	**SERVICE NOT AVAILABLE**
	Yes	**No**		
1. Medical Care	○	○	○	○
2. Employment Services	○	○	○	○
3. Family Services	○	○	○	○
4. Child Care	○	○	○	○
5. Transportation	○	○	○	○
6. Education Services	○	○	○	○
7. Housing Support	○	○	○	○
8. Social Recreational Activities	○	○	○	○
9. Client-Operated Services	○	○	○	○
10. HIV Testing	○	○	○	○
11. Was the client referred to another provider for any of the above support services?	○	○	○	○