OMB No. 0930-0285
Expiration Date: XX/XX/XXXX

Center for Mental Health Services

NOMs Client-Level Measures for Discretionary Programs Providing Direct Services

SERVICES TOOL
Child/Adolescent *or* Caregiver
Combined Respondent Version

CMHS

Center for Mental Health Services
SAMHSA

SPARS Version 3.0

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 ***[ENTER THE MONTH AND YEAR WHEN THE CONSUMER FIRST RECEIVED SERVICES UNDER THE GRANT FOR <u>THIS</u> EPISODE OF CARE.]*** |____|____| / |____|____| / |____|____|____|____| MONTH DAY YEAR	☐ 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

2. Was the interview conducted?

☐☐Yes **When?** |____|____| / |____|____| / |____|____|____|____| MONTH DAY YEAR	☐☐No **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 ***[GO TO THE INSTRUCTIONS BELOW QUESTION 4.]***

3. Was the respondent the child or the caregiver?

☐☐Child ***[PREFER CHILD AGE 11 AND OLDER]***
☐☐Caregiver

4. Behavioral Health Diagnoses

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 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.

	Diagnosed?	For each diagnosis selected, please indicate whether diagnosis is primary, secondary or tertiary if known.		
	Select up to three.	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-related use disorder, uncomplicated, mild	☐	☐	☐	☐
F13.11 – Sedative, hypnotic, or anxiolytic-related use disorder, mild, in remission	☐	☐	☐	☐
F13.20 – Sedative, hypnotic, or anxiolytic-related use disorder, uncomplicated, moderate/severe	☐	☐	☐	☐
F13.21 – Sedative, hypnotic, or anxiolytic-related use disorder, moderate/severe, in remission	☐	☐	☐	☐
F13.9 – Sedative, hypnotic, or anxiolytic-related use, unspecified	☐	☐	☐	☐
Cocaine related disorders				

	Diagnosed?	For each diagnosis selected, please indicate whether diagnosis is primary, secondary or tertiary if known.		
	Select up to three.	Primary	Secondary	Tertiary
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	☐	☐	☐	☐
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	☐	☐	☐	☐

	Diagnosed?	For each diagnosis selected, please indicate whether diagnosis is primary, secondary or tertiary if known.		
	Select up to three.	Primary	Secondary	Tertiary
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	☐	☐	☐	☐
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	☐	☐	☐	☐

	Diagnosed?	For each diagnosis selected, please indicate whether diagnosis is primary, secondary or tertiary if known.		
	Select up to three.	**Primary**	**Secondary**	**Tertiary**
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 [child's] gender?

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

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

- ☐ YES
- ☐ NO *[GO TO 3.]*
- ☐ REFUSED *[GO TO 3.]*

***[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
Central American	☐	☐	☐
Cuban	☐	☐	☐
Dominican	☐	☐	☐
Mexican	☐	☐	☐
Puerto Rican	☐	☐	☐
South American	☐	☐	☐
OTHER (SPECIFY)	☐	☐	☐ *[IF YES, SPECIFY BELOW.]*

3. 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
Alaska Native	☐	☐	☐
American Indian	☐	☐	☐
Asian	☐	☐	☐
Black or African American	☐	☐	☐
Native Hawaiian or other Pacific Islander	☐	☐	☐
White	☐	☐	☐

4. What is your [your child's] month and year of birth?

|____|____| / |____|____|____|____|
MONTH YEAR ☐ REFUSED

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

[IF AN INTERVIEW WAS NOT CONDUCTED:
GO TO SECTION H (IF APPLICABLE).

GRANTEES IN ALL OTHER PROGRAMS STOP HERE.]

B. 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 <u>during the past 30 days</u>. Please indicate your disagreement/agreement with each of the following statements.

[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER (CAREGIVER).]

STATEMENT	RESPONSE OPTIONS						
	Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**	**REFUSED**	**NOT APPLICABLE**
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.	□	□	□	□	□	□	

B.

[IF THE CAREGIVER IS THE RESPONDENT, GO TO THE OPTIONAL GAF QUESTION.]

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 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?	□	□	□	□	□	□	□

B. FUNCTIONING (Continued)

[IF THE CAREGIVER IS THE RESPONDENT, GO TO THE OPTIONAL GAF QUESTION.]

4. 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. *[IF B >= ONCE OR TWICE, AND RESPONDENT 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 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)*].*	☐	☐	☐	☐	☐	☐
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.

[OPTIONAL: GAF SCORE REPORTED BY GRANTEE STAFF AT PROJECT'S DISCRETION.]

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

WHAT WAS THE CONSUMER'S SCORE? GAF = |____|____|____|

[OPTIONAL: CBCL TOTAL PROBLEMS T-SCORE REPORTED BY GRANTEE STAFF AT PROJECT'S DISCRETION.]

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

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

B. MILITARY FAMILY AND DEPLOYMENT

[QUESTIONS 5 AND 6 ARE ONLY ASKED AT BASELINE. IF THIS IS NOT A BASELINE, GO TO SECTION C.]

[IF THE CAREGIVER IS THE RESPONDENT, GO TO QUESTION 6.]
[IF THE CONSUMER IS YOUNGER THAN 18 YEARS OLD, GO TO QUESTION 6.]

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

- YES
- NO
- REFUSED
- DON'T KNOW

6. 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

C. 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 A-D, CANNOT EXCEED 30 NIGHTS).]	|___|___|		
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 16 OR MORE NIGHTS, GO TO SECTION D.]

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

[DO NOT READ RESPONSE OPTIONS TO CONSUMER (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

D. EDUCATION

5. 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

6. 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)
- ○ VOC/TECH DIPLOMA
- ○ SOME COLLEGE OR UNIVERSITY
- ○ REFUSED
- ○ DON'T KNOW

E. CRIME AND CRIMINAL JUSTICE STATUS

5. 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 G. OTHERWISE, GO TO SECTION F.]

F. PERCEPTION OF CARE

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

5. 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 CONSUMER (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].	☐	☐	☐	☐	☐	☐

F. PERCEPTION OF CARE (Continued)

2. ***[INDICATE WHO ADMINISTERED SECTION F - PERCEPTION OF CARE TO THE CONSUMER (CAREGIVER) 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 [your child's] mental health provider(s) over the past 30 days.

[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER (CAREGIVER).]

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 [my child's] 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.	□	□	□	□	□	□

[IF YOUR PROGRAM <u>DOES NOT</u> 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 K.]

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

[IF YOUR PROGRAM <u>DOES</u> REQUIRE SECTION H:

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

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

IF THIS IS A CLINICAL DISCHARGE INTERVIEW, PROCEED TO SECTION H, THEN J AND K.]

H. PROGRAM SPECIFIC QUESTIONS

YOU ARE NOT RESPONSIBLE FOR COLLECTING DATA ON ALL SECTION H QUESTIONS. YOUR GPO HAS PROVIDED YOU 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, SEE APPENDIX A OF THE NOMS CLIENT-LEVEL MEASURES FOR DISCRETIONARY PROGRAMS PROVIDING DIRECT SERVICES QUESTION-BY-QUESTION INSTRUCTION GUIDE FOR CHILD PROGRAMS.

H1. PROGRAM SPECIFIC QUESTIONS

[QUESTION 1 SHOULD BE ANSWERED BY THE CONSUMER/CAREGIVER 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?	|___|___|	☐	☐
b. How many times did you attempt to kill yourself?	|___|___|	☐	☐

[CAREGIVER RESPONSE:]

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

[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): _____

H2. PROGRAM SPECIFIC QUESTIONS

[QUESTIONS 1, 2, AND 3 SHOULD BE ANSWERED BY THE CONSUMER/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 CONSUMER/CAREGIVER.]

STATEMENT	RESPONSE OPTIONS						
	Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**	**REFUSED**	**DON'T KNOW**
1. As a result of treatment and services received, my [my child's] trauma and/or loss experiences were identified and addressed.	□	□	□	□	□	□	□
2. As a result of treatment and services received for trauma and/or loss experiences, my [my child's] problem behaviors/symptoms have decreased.	□	□	□	□	□	□	□
3. 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.	□	□	□	□	□	□	□

H3. PROGRAM SPECIFIC QUESTIONS

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

1. Health measurements: (Report Quarterly)

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

H4. 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 ☐

[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 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 J IS REPORTED BY GRANTEE STAFF AT REASSESSMENT AND DISCHARGE UNLESS THE CONSUMER REFUSED THIS INTERVIEW OR ALL INTERVIEWS, IN WHICH CASE IT 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 <u>SINCE HIS/HER LAST NOMS INTERVIEW</u>; THIS INCLUDES CMHS-FUNDED AND NON-FUNDED SERVICES.]

Core Services	**Provided**			
	Yes	**No**	**UNKNOWN**	**SERVICE NOT AVAILABLE**
1. Screening	□	□	□	□
2. Assessment	□	□	□	□
3. Treatment Planning or Review	□	□	□	□
4. Psychopharmacological Services	□	□	□	□
5. Mental Health Services	□	□	□	□

[IF THE ANSWER TO 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**			
	Yes	**No**	**UNKNOWN**	**SERVICE NOT AVAILABLE**
6. Co-Occurring Services	□	□	□	□
7. Case Management	□	□	□	□
8. Trauma-specific Services	□	□	□	□
9. Was the Consumer referred to another provider for any of the above core services?	□	□	□	□

Support Services	**Provided**			
	Yes	**No**	**UNKNOWN**	**SERVICE NOT AVAILABLE**
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. Consumer Operated Services	□	□	□	□
10. HIV Testing	□	□	□	□
11. Was the Consumer referred to another provider for any of the above support services?	□	□	□	□