Form Approved

OMB No. 0930-0208

Expiration Date: 02/28/2022

Substance Abuse and Mental Health Services Administration (SAMHSA)

Center for Substance Abuse Treatment (CSAT)

Government Performance and Results Act (GPRA) Client Outcome  
Measures for Discretionary Programs

SAMHSA’s Performance Accountability and Reporting System (SPARS)

March 2019

Public reporting burden for this collection of information is estimated to average 36 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information, if all items are asked of a client/participant; to the extent that providers already obtain much of this information as part of their ongoing client/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 15E21B, 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 0930-0208.

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# A. RECORD MANAGEMENT

Client ID |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|

Client Type:

Treatment client

Client in recovery

Contract/Grant ID |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|

Interview Type *[CIRCLE ONLY ONE TYPE.]*

Intake ***[GO TO INTERVIEW DATE.]***

6-month follow-up:Did you conduct a follow-up interview? Yes No   
***[IF NO, GO DIRECTLY TO SECTION I.]***

3-month follow-up ***[ADOLESCENT PORTFOLIO ONLY]***:   
Did you conduct a follow-up interview? Yes No  
***[IF NO, GO DIRECTLY TO SECTION I.]***

Discharge**:** Did you conduct a discharge interview? Yes No  
***[IF NO, GO DIRECTLY TO SECTION J.]***

Interview Date |\_\_\_\_|\_\_\_\_| / |\_\_\_\_|\_\_\_\_| / |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|  
 Month Day Year

# A. BEHAVIORAL HEALTH DIAGNOSES

***[REPORTED BY PROGRAM STAFF.]***

**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, Fifth Edition* (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 |  |  |  |  |

A. BEHAVIORAL HEALTH DIAGNOSES (CONTINUED)

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

A. BEHAVIORAL HEALTH DIAGNOSES (CONTINUED)

| **Behavioral Health Diagnoses** | **Diagnosed?** | **For each diagnosis selected, please indicate whether 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 |  |  |  |  |

A. BEHAVIORAL HEALTH DIAGNOSES (CONTINUED)

| **Behavioral Health Diagnoses** | **Diagnosed?** | **For each diagnosis selected, please indicate whether 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

A. BEHAVIORAL HEALTH DIAGNOSES (CONTINUED)

1. In the past 30 days, was this client diagnosed with an opioid use disorder?

Yes

No ***[SKIP TO 2.]***

Don’t know ***[SKIP TO 2.]***

**a. *[IF YES]* In the past 30 days, which U.S. Food and Drug Administration (FDA)-approved medication did the client receive for the treatment of this opioid use disorder? *[CHECK ALL THAT APPLY.]***

Methadone ***[IF RECEIVED]*** Specify how many days received |\_\_\_|\_\_\_|

Buprenorphine ***[IF RECEIVED]*** Specify how many days received |\_\_\_|\_\_\_|

Naltrexone ***[IF RECEIVED]*** Specify how many days received |\_\_\_|\_\_\_|

Extended-release naltrexone ***[IF RECEIVED]*** Specify how many days received |\_\_\_|\_\_\_|

Client did not receive an FDA-approved medication for an opioid use disorder

Don’t know

1. In the past 30 days, was this client diagnosed with an alcohol use disorder?

Yes

No ***[SKIP TO 3 IF INTAKE. SKIP TO SECTION B IF FOLLOW-UP OR DISCHARGE.]***

Don’t know ***[SKIP TO 3 IF INTAKE. SKIP TO SECTION B IF FOLLOW-UP OR DISCHARGE.]***

**a. *[IF YES]* In the past 30 days, which FDA-approved medication did the client receive for the treatment of this alcohol use disorder? *[CHECK ALL THAT APPLY.]***

Naltrexone ***[IF RECEIVED]*** Specify how many days received |\_\_\_|\_\_\_|

Extended-release naltrexone ***[IF RECEIVED]*** Specify how many days received |\_\_\_|\_\_\_|

Disulfiram ***[IF RECEIVED]*** Specify how many days received |\_\_\_|\_\_\_|

Acamprosate ***[IF RECEIVED]*** Specify how many days received |\_\_\_|\_\_\_|

Client did not receive an FDA-approved medication for an alcohol use disorder

Don’t know

***[FOLLOW-UP AND DISCHARGE INTERVIEWS: SKIP TO SECTION B.]***

3. Was the client screened by your program for co-occurring mental health and substance use disorders?

YES

NO ***[SKIP 3a.]***

3a. *[IF YES]* Did the client screen positive for co-occurring mental health and substance use   
disorders?

Yes

No

***[Screening, brief intervention, and referral to treatment (sbirt) GRANTS continue. all others go to section a, “planned services.”]***

A. BEHAVIORAL HEALTH DIAGNOSES (CONTINUED)

***THIS SECTION FOR SBIRT GRANTS ONLY [ITEMS 4, 4a, AND 5 REPORTED ONLY AT INTAKE/BASELINE].***

4. How did the client screen for your SBIRT?

NEGATIVE

POSITIVE

4a. What was his/her screening score?

Alcohol Use Disorders Identification Test (AUDIT) = |\_\_\_\_|\_\_\_\_|

CAGE = |\_\_\_\_|\_\_\_\_|

Drug Abuse Screening Test (DAST) = |\_\_\_\_|\_\_\_\_|

DAST-10 = |\_\_\_\_|\_\_\_\_|

National Institute on Alcohol Abuse and Alcoholism   
(NIAAA) Guide = |\_\_\_\_|\_\_\_\_|

Alcohol, Smoking and Substance Involvement   
Screening Test (ASSIST)/Alcohol Subscore = |\_\_\_\_|\_\_\_\_|

Other (Specify) = |\_\_\_\_|\_\_\_\_|  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Was he/she willing to continue his/her participation in the SBIRT program?

YES

NO

# A. PLANNED SERVICES

***[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT INTAKE/BASELINE.]***

**Identify the services you plan to provide to the client during the client’s course of treatment/recovery. *[SELECT “YES” OR “NO” FOR EACH ONE.]***

Modality Yes No

***[SELECT AT LEAST ONE MODALITY.]***

1. Case Management

2. Day Treatment

3. Inpatient/Hospital (Other Than Detox)

4. Outpatient

5. Outreach

6. Intensive Outpatient

7. Methadone

8. Residential/Rehabilitation

9. Detoxification (Select Only One)

A. Hospital Inpatient

B. Free-Standing Residential

C. Ambulatory Detoxification

10. After Care

11. Recovery Support

12. Other (Specify)

***[SELECT AT LEAST ONE SERVICE.]***

Treatment Services Yes No

***[SBIRT GRANTS: You must SELECT “Yes” for at least one of the Treatment Services numbered 1–4.]***

1. Screening

2. Brief Intervention

3. Brief Treatment

4. Referral to Treatment

5. Assessment

6. Treatment/Recovery Planning

7. Individual Counseling

8. Group Counseling

9. Family/Marriage Counseling

10. Co-Occurring Treatment/  
Recovery Services

11. Pharmacological Interventions

12. HIV/AIDS Counseling

13. Other Clinical Services   
(Specify)

Case Management Services Yes No

1. Family Services (Including Marriage Education, Parenting, Child Development Services)

2. Child Care

3. Employment Service

A. Pre-Employment

B. Employment Coaching

4. Individual Services Coordination

5. Transportation

6. HIV/AIDS Service

7. Supportive Transitional Drug-Free Housing Services

8. Other Case Management Services  
(Specify)

Medical Services Yes No

1. Medical Care

2. Alcohol/Drug Testing

3. HIV/AIDS Medical Support and Testing

4. Other Medical Services  
(Specify)

After Care Services Yes No

1. Continuing Care

2. Relapse Prevention

3. Recovery Coaching

4. Self-Help and Support Groups

5. Spiritual Support

6. Other After Care Services  
(Specify)

Education Services Yes No

1. Substance Abuse Education

2. HIV/AIDS Education

3. Other Education Services  
(Specify)

Peer-to-Peer Recovery Support Services Yes No

1. Peer Coaching or Mentoring

2. Housing Support

3. Alcohol- and Drug-Free Social Activities

4. Information and Referral

5. Other Peer-to-Peer Recovery Support Services (Specify)

# A. DEMOGRAPHICS

***[ASKED ONLY AT INTAKE/BASELINE.]***

1. What is your gender?

MALE

FEMALE

TRANSGENDER

OTHER (SPECIFY)

REFUSED

1. Are you Hispanic or Latino?

YES

NO

REFUSED

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

Ethnic Group Yes No Refused

Central American

Cuban

Dominican

Mexican

Puerto Rican

South American

Other ***[IF YES, SPECIFY BELOW.]***

(SPECIFY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What is your race? Please answer yes or no for each of the following. You may say yes to more than one.

Race Yes No Refused

Black or African American

Asian

Native Hawaiian or other Pacific Islander

Alaska Native

White

American Indian

1. What is your date of birth?\*

|\_\_\_\_|\_\_\_\_| / |\_\_\_\_|\_\_\_\_| ***[\*THE SYSTEM WILL ONLY SAVE MONTH AND YEAR.***  
 Month Day ***TO MAINTAIN CONFIDENTIALITY, DAY IS NOT SAVED.]***

|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|  
 Year

REFUSED

# A. MILITARY FAMILY AND DEPLOYMENT

1. Have you ever served in the Armed Forces, in the Reserves, or in the National Guard? *[IF SERVED]* In which area, the Armed Forces, Reserves, or National Guard did you serve?

No

Yes, in the armed forces

Yes, in the Reserves

Yes, in the national Guard

Refused

Don’t know

***[IF NO, REFUSED, OR DON’T KNOW, SKIP TO QUESTION A6.]***

5a. Are you currently on active duty in the Armed Forces, in the Reserves, or in the National Guard? *[IF ACTIVE]* In which area, the Armed Forces, Reserves, or National Guard?

No, separated or retired from the armed forces, reserves, or national guard

Yes, in the armed forces

Yes, in the Reserves

Yes, in the national Guard

Refused

Don’t know

5b. Have you ever been deployed to a combat zone? *[CHECK ALL THAT APPLY.]*

Never deployed

Iraq or Afghanistan (e.g., Operation Enduring Freedom [OEF]/ Operation Iraqi Freedom [OIF]/ Operation New Dawn [OND])

Persian Gulf (Operation Desert Shield/Desert Storm)

Vietnam/Southeast Asia

Korea

WWII

Deployed to a combat zone not listed above (e.g., Bosnia/Somalia)

Refused

Don’t know

***[SBIRT GRANTEES: FOR CLIENTS WHO SCREENED NEGATIVE, THE INTAKE INTERVIEW IS NOW COMPLETE.]***

A. MILITARY FAMILY AND DEPLOYMENT (CONTINUED)

1. Is anyone in your family or someone close to you on active duty in the Armed Forces, in the Reserves, or in the National Guard or separated or retired from the Armed Forces, Reserves, or National Guard?

No

Yes, only one

Yes, more than one

Refused

Don’t know

***[IF NO, REFUSED, OR DON’T KNOW, SKIP TO SECTION B.]***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***[IF YES, ANSWER FOR UP TO 6 PEOPLE.]* What is the relationship of that person (Service Member) to you? *[WRITE RELATIONSHIP IN COLUMN HEADING.]***  1 = Mother 2 = Father  3 = Brother 4 = Sister  5 = Spouse 6 = Partner  7 = Child 8 = Other (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| **Has the Service Member experienced any of the following? *[CHECK ANSWER IN APPROPRIATE COLUMN FOR ALL THAT APPLY.]*** | **\_\_\_\_\_\_\_\_\_ (Relationship) 1.** | **\_\_\_\_\_\_\_\_\_ (Relationship) 2.** | **\_\_\_\_\_\_\_\_\_ (Relationship) 3.** | **\_\_\_\_\_\_\_\_\_ (Relationship) 4.** | **\_\_\_\_\_\_\_\_\_ (Relationship) 5.** | **\_\_\_\_\_\_\_\_\_ (Relationship) 6.** |
| **6a. Deployed in support of combat operations (e.g., Iraq or Afghanistan)?** | Yes  No  Refused  Don’t know | Yes  No  Refused  Don’t know | Yes  No  Refused  Don’t know | Yes  No  Refused  Don’t know | Yes  No  Refused  Don’t know | Yes  No  Refused  Don’t know |
| **6b. Was physically injured during combat operations?** | Yes  No  Refused  Don’t know | Yes  No  Refused  Don’t know | Yes  No  Refused  Don’t know | Yes  No  Refused  Don’t know | Yes  No  Refused  Don’t know | Yes  No  Refused  Don’t know |
| **6c. Developed combat stress symptoms/difficulties adjusting following deployment, including post-traumatic stress disorder (PTSD), depression, or suicidal thoughts?** | Yes  No  Refused  Don’t know | Yes  No  Refused  Don’t know | Yes  No  Refused  Don’t know | Yes  No  Refused  Don’t know | Yes  No  Refused  Don’t know | Yes  No  Refused  Don’t know |
| **6d. Died or was killed?** | Yes  No  Refused  Don’t know | Yes  No  Refused  Don’t know | Yes  No  Refused  Don’t know | Yes  No  Refused  Don’t know | Yes  No  Refused  Don’t know | Yes  No  Refused  Don’t know |

# B. DRUG AND ALCOHOL USE

Number  
 of Days REFUSED DON’T KNOW

1. During the past 30 days, how many days have you used the following:

a. Any alcohol *[IF ZERO, SKIP TO ITEM B1c.]* |\_\_\_\_|\_\_\_\_|

b1. Alcohol to intoxication (5+ drinks in one sitting) |\_\_\_\_|\_\_\_\_|

b2. Alcohol to intoxication (4 or fewer drinks in one sitting and felt high) |\_\_\_\_|\_\_\_\_|

c. Illegal drugs *[IF B1a OR B1c = 0, REFUSED (RF), DON’T KNOW (DK), THEN SKIP TO ITEM B2.]* |\_\_\_\_|\_\_\_\_|

d. Both alcohol and drugs (on the same day) |\_\_\_\_|\_\_\_\_|

**Route of Administration Types:**1. Oral 2. Nasal 3. Smoking 4. Non-intravenous (IV) injection 5. IV\*Note the usual route. For more than one route, choose the most severe. The routes are listed from least severe (1) to most severe (5).

2. During the past 30 days, how many days have you used any of the following: *[IF THE VALUE IN ANY ITEM B2a–B2i > 0, THEN THE VALUE IN B1c MUST BE > 0.]*

Number  
 of Days RF DK Route\* RF DK

a. Cocaine/Crack |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

b. Marijuana/Hashish (Pot, Joints, Blunts, Chronic, Weed, Mary Jane) |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

c. Opiates:

1. Heroin (Smack, H, Junk, Skag) |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

2. Morphine |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

3. Dilaudid |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

4. Demerol |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

5. Percocet |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

6. Darvon |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

7. Codeine |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

8. Tylenol 2, 3, 4 |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

9. OxyContin/Oxycodone |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

d. Non-prescription methadone |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

e. Hallucinogens/psychedelics, PCP (Angel Dust, Ozone, Wack, Rocket Fuel), MDMA (Ecstasy, XTC, X, Adam), LSD (Acid, Boomers, Yellow Sunshine), Mushrooms, or Mescaline |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

f. Methamphetamine or other amphetamines (Meth, Uppers, Speed, Ice, Chalk, Crystal, Glass, Fire, Crank) |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

B. DRUG AND ALCOHOL USE (CONTINUED)

**Route of Administration Types:**1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV\*Note the usual route. For more than one route, choose the most severe. The routes are listed from least severe (1) to most severe (5).

2. During the past 30 days, how many days have you used any of the following: *[IF THE VALUE IN ANY ITEM B2a–B2i > 0, THEN THE VALUE IN B1c MUST BE > 0.]*

Number  
 of Days RF DK Route\* RF DK

g. 1. Benzodiazepines: Diazepam (Valium); Alprazolam (Xanax); Triazolam (Halcion); and Estasolam (Prosom and Rohypnol, also known as roofies, roche, and cope) |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

2. Barbiturates: Mephobarbital (Mebacut) and pentobarbital sodium (Nembutal) |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

3. Non-prescription GHB (known as Grievous Bodily Harm, Liquid Ecstasy, and Georgia Home Boy) |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

4. Ketamine (known as Special K or Vitamin K) |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

5. Other tranquilizers, downers, sedatives, or hypnotics |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

h. Inhalants (poppers, snappers, rush, whippets) |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

i. Other illegal drugs (Specify) |\_\_\_\_|\_\_\_\_| |\_\_\_\_|

3. In the past 30 days, have you injected drugs? *[IF ANY ROUTE OF ADMINISTRATION IN B2a–B2i = 4 or 5, THEN B3 MUST = YES.]*

YES

NO

Refused

Don’t know

***[If no, refused, or don’t know, skip to Section C.]***

4. 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

# C. FAMILY AND LIVING CONDITIONS

1. In the past 30 days, where have you been living most of the time? *[DO NOT READ RESPONSE OPTIONS TO CLIENT.]*

Shelter (safe havens, transitional living center [TLC], low-demand facilities, reception centers, other temporary day or evening facility)

Street/outdoors (sidewalk, doorway, park, public or abandoned building)

Institution (hospital, nursing home, jail/prison)

Housed: ***[if housed, check appropriate subcategory:]***

Own/rent apartment, room, or house

Someone else’s apartment, room, or house

Dormitory/college residence

Halfway house

Residential treatment

Other housed (Specify)

Refused

Don’t know

1. How satisfied are you with the conditions of your living space?

Very dissatisfied

Dissatisfied

Neither satisfied nor dissatisfied

Satisfied

Very satisfied

REFUSED

DON’T KNOW

1. During the past 30 days, how stressful have things been for you because of your use of alcohol or other drugs? *[IF B1a OR B1c > 0, THEN C3 CANNOT = “NOT APPLICABLE.”]*

Not at all

Somewhat

Considerably

Extremely

Not applicable ***[Use only if b1a and b1c = 0.]***

Refused

Don’t know

1. During the past 30 days, has your use of alcohol or other drugs caused you to reduce or give up important activities? *[IF B1a OR B1c > 0, THEN C4 CANNOT = “NOT APPLICABLE.”]*

Not at all

Somewhat

Considerably

Extremely

Not applicable ***[Use only if b1a and b1c = 0.]***

Refused

Don’t know

C. FAMILY AND LIVING CONDITIONS (CONTINUED)

1. During the past 30 days, has your use of alcohol or other drugs caused you to have emotional problems? *[IF B1a OR B1c > 0, THEN C5 CANNOT = “NOT APPLICABLE.”]*

Not at all

Somewhat

Considerably

Extremely

Not Applicable ***[use ONLY IF b1a and b1c = 0.]***

Refused

Don’t know

1. *[IF NOT MALE]* Are you currently pregnant?

YES

NO

REFUSED

DON’T KNOW

1. Do you have children?

YES

NO

REFUSED

DON’T KNOW

***[IF NO, REFUSED, OR DON’T KNOW, SKIP TO SECTION D.]***

a. How many children do you have? *[IF C7 = YES, THEN THE VALUE IN C7a MUST BE > 0.]*

|\_\_\_\_|\_\_\_\_|  Refused  Don’t know

b. Are any of your children living with someone else due to a child protection court order?

YES

NO

REFUSED

DON’T KNOW

***[IF NO, REFUSED, OR DON’T KNOW, SKIP TO ITEM C7d.]***

c. *[IF YES]* How many of your children are living with someone else due to a child protection court order? *[THE VALUE IN C7c CANNOT EXCEED THE VALUE IN C7a.]*

|\_\_\_\_|\_\_\_\_|  Refused  Don’t know

d. For how many of your children have you lost parental rights? *[THE CLIENT’S PARENTAL RIGHTS WERE TERMINATED.] [THE VALUE IN ITEM C7d CANNOT EXCEED THE VALUE IN C7a.]*

|\_\_\_\_|\_\_\_\_|  Refused  Don’t know

# D. EDUCATION, EMPLOYMENT, AND INCOME

1. Are you currently enrolled in school or a job training program? *[IF ENROLLED]* Is that full time or part time? *[IF CLIENT IS INCARCERATED, CODE D1 AS “NOT ENROLLED.”]*

Not enrolled

Enrolled, full time

Enrolled, part time

Other (Specify)

Refused

Don’t know

1. What is the highest level of education you have finished, whether or not you received a degree?

Never attended

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

College or university/1st year completed

College or university/2nd year completed/associate’s degree (AA, AS)

College or university/3rd year completed

Bachelor’s degree (BA, BS) or higher

VOCATIONAL/TECHNICAL (VOC/tech) program after high school but no VOC/tech diploma

VOC/tech diploma after high school

Refused

Don’t know

1. Are you currently employed? *[CLARIFY BY FOCUSING ON STATUS DURING MOST OF THE PREVIOUS WEEK, DETERMINING WHETHER CLIENT WORKED AT ALL OR HAD A REGULAR JOB BUT WAS OFF WORK. IF CLIENT IS “ENROLLED, FULL TIME” IN D1 AND INDICATES “EMPLOYED, FULL TIME” IN D3, ASK FOR CLARIFICATION. IF CLIENT IS INCARCERATED AND HAS NO WORK OUTSIDE OF JAIL, CODE D3 AS “UNEMPLOYED, NOT LOOKING FOR 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

D. EDUCATION, EMPLOYMENT, AND INCOME (CONTINUED)

1. Approximately, how much money did YOU receive (pre-tax individual income) in the past 30 days from … *[IF D3 DOES NOT = “EMPLOYED” AND THE VALUE IN D4a IS GREATER THAN ZERO, PROBE. IF D3 = “UNEMPLOYED, LOOKING FOR WORK” AND THE VALUE IN D4b = 0, PROBE. IF D3 = “UNEMPLOYED, RETIRED” AND THE VALUE IN D4c = 0, PROBE. IF D3 = “UNEMPLOYED, DISABLED” AND THE VALUE IN D4d = 0, PROBE.]*

RF DK

a. Wages $ |\_\_|\_\_|\_\_| , |\_\_|\_\_|\_\_|

b. Public assistance $ |\_\_|\_\_|\_\_| , |\_\_|\_\_|\_\_|

c. Retirement $ |\_\_|\_\_|\_\_| , |\_\_|\_\_|\_\_|

d. Disability $ |\_\_|\_\_|\_\_| , |\_\_|\_\_|\_\_|

e. Non-legal income $ |\_\_|\_\_|\_\_| , |\_\_|\_\_|\_\_|

f. Family and/or friends $ |\_\_|\_\_|\_\_| , |\_\_|\_\_|\_\_|

g. Other (Specify) \_\_\_\_\_\_\_\_ $ |\_\_|\_\_|\_\_| , |\_\_|\_\_|\_\_|

5. Have you enough money to meet your needs?

Not at all

A little

Moderately

Mostly

Completely

REFUSED

DON’T KNOW

# 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 NO ARRESTS, SKIP TO ITEM E3.]***

1. In the past 30 days, how many times have you been arrested for drug-related offenses? *[THE VALUE IN E2 CANNOT BE GREATER THAN THE VALUE IN E1.]*

|\_\_\_\_|\_\_\_\_| times  Refused  Don’t know

1. In the past 30 days, how many nights have you spent in jail/prison? *[IF THE VALUE IN E3 IS GREATER THAN 15, THEN C1 MUST = INSTITUTION (JAIL/PRISON). IF C1 = INSTITUTION (JAIL/PRISON), THEN THE VALUE IN E3 MUST BE GREATER THAN OR EQUAL TO 15.]*

|\_\_\_\_|\_\_\_\_| nights  Refused  Don’t know

1. In the past 30 days, how many times have you committed a crime? *[CHECK NUMBER OF DAYS USED ILLEGAL DRUGS IN ITEM B1c. ANSWER HERE IN E4 SHOULD BE EQUAL TO OR GREATER THAN NUMBER IN B1c BECAUSE USING ILLEGAL DRUGS IS A CRIME.]*

|\_\_\_\_|\_\_\_\_|\_\_\_\_| times  Refused  Don’t know

1. Are you currently awaiting charges, trial, or sentencing?

Yes

No

Refused

Don’t know

1. Are you currently on parole or probation?

Yes

No

Refused

Don’t know

# F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY

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

Excellent

Very good

Good

Fair

Poor

Refused

Don’t know

1. During the past 30 days, did you receive:

| **a. Inpatient treatment for:** | **YES** | ***[IF YES]* Altogether  for how many nights** | **NO** | **RF** | **DK** |
| --- | --- | --- | --- | --- | --- |
| i. Physical complaint |  | nights |  |  |  |
| ii. Mental or emotional difficulties |  | nights |  |  |  |
| iii. Alcohol or substance abuse |  | nights |  |  |  |

| **b. Outpatient treatment for:** | **YES** | ***[IF YES]* Altogether  for how many times** | **NO** | **RF** | **DK** |
| --- | --- | --- | --- | --- | --- |
| i. Physical complaint |  | times |  |  |  |
| ii. Mental or emotional difficulties |  | times |  |  |  |
| iii. Alcohol or substance abuse |  | times |  |  |  |

| **c. Emergency room treatment for:** | **YES** | ***[IF YES]* Altogether  for how many times** | **NO** | **RF** | **DK** |
| --- | --- | --- | --- | --- | --- |
| i. Physical complaint |  | times |  |  |  |
| ii. Mental or emotional difficulties |  | times |  |  |  |
| iii. Alcohol or substance abuse |  | times |  |  |  |

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (CONTINUED)

1. During the past 30 days, did you engage in sexual activity?

Yes

No ***[SKIP TO F4.]***

NOT PERMITTED TO ASK ***[SKIP TO F4.]***

REFUSED ***[SKIP TO F4.]***

Don’t know ***[SKIP TO F4.]***

***[IF YES]* Altogether, how many:**

Contacts RF DK

a. Sexual contacts (vaginal, oral, or anal) did you have? |\_\_\_\_|\_\_\_\_|

b. Unprotected sexual contacts did you have? ***[THE VALUE IN F3b SHOULD NOT BE GREATER THAN THE VALUE IN F3a.] [IF ZERO, SKIP TO F4.]*** |\_\_\_\_|\_\_\_\_|\_\_\_\_|

c. Unprotected sexual contacts were with an individual who is or was ***[NONE OF THE VALUES IN F3c1–F3c3 CAN BE GREATER THAN THE VALUE IN F3b.]***

1. HIV positive or has AIDS |\_\_\_\_|\_\_\_\_|\_\_\_\_|

2. An injection drug user |\_\_\_\_|\_\_\_\_|\_\_\_\_|

3. High on some substance |\_\_\_\_|\_\_\_\_|\_\_\_\_|

1. Have you ever been tested for HIV?

Yes ***[GO TO F4a.]***

No ***[SKIP TO F5.]***

Refused ***[SKIP TO F5.]***

Don’t know ***[SKIP TO F5.]***

a. Do you know the results of your HIV testing?

Yes

No

1. How would you rate your quality of life?

Very poor

Poor

Neither poor nor good

Good

Very good

REFUSED

DON’T KNOW

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (CONTINUED)

1. How satisfied are you with your health?

Very dissatisfied

Dissatisfied

Neither satisfied nor dissatisfied

Satisfied

Very satisfied

REFUSED

DON’T KNOW

1. Do you have enough energy for everyday life?

Not at all

A little

Moderately

Mostly

Completely

REFUSED

DON’T KNOW

1. How satisfied are you with your ability to perform your daily activities?

Very dissatisfied

Dissatisfied

Neither satisfied nor dissatisfied

Satisfied

Very satisfied

REFUSED

DON’T KNOW

1. How satisfied are you with yourself?

Very dissatisfied

Dissatisfied

Neither satisfied nor dissatisfied

Satisfied

Very satisfied

REFUSED

DON’T KNOW

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (CONTINUED)

1. In the past 30 days, not due to your use of alcohol or drugs, how many days have you:

Days RF DK

a. Experienced serious depression |\_\_\_\_|\_\_\_\_|

b. Experienced serious anxiety or tension |\_\_\_\_|\_\_\_\_|

c. Experienced hallucinations |\_\_\_\_|\_\_\_\_|

d. Experienced trouble understanding, concentrating, or remembering |\_\_\_\_|\_\_\_\_|

e. Experienced trouble controlling violent behavior |\_\_\_\_|\_\_\_\_|

f. Attempted suicide |\_\_\_\_|\_\_\_\_|

g. Been prescribed medication for psychological/emotional problem |\_\_\_\_|\_\_\_\_|

***[IF CLIENT REPORTS ZERO DAYS, RF, OR DK TO ALL ITEMS IN QUESTION F10, SKIP TO ITEM F12.]***

1. How much have you been bothered by these psychological or emotional problems in the past 30 days?

Not at all

Slightly

Moderately

Considerably

Extremely

Refused

Don’t know

F. VIOLENCE AND TRAUMA

1. Have you ever experienced violence or trauma in any setting (including community or school violence; domestic violence; physical, psychological, or sexual maltreatment/assault within or outside of the family; natural disaster; terrorism; neglect; or traumatic grief)?

Yes

No

Refused

Don’t know

***[IF NO, REFUSED, OR DON’T KNOW, SKIP TO ITEM F13.]***

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

12a. Have had nightmares about it or thought about it when you did not want to?

Yes

No

Refused

Don’t know

F. VIOLENCE AND TRAUMA (CONTINUED)

12b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?

Yes

No

Refused

Don’t know

12c. Were constantly on guard, watchful, or easily startled?

Yes

No

Refused

Don’t know

12d. Felt numb and detached from others, activities, or your surroundings?

Yes

No

Refused

Don’t know

1. In the past 30 days, how often have you been hit, kicked, slapped, or otherwise physically hurt?

Never

A few times

More than a few times

REFUSED

DON’T KNOW

# G. SOCIAL CONNECTEDNESS

1. 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 ***[IF YES]*** Specify how many times |\_\_\_\_|\_\_\_\_|  Refused  Don’t know

No

Refused

Don’t know

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

Yes ***[IF YES]*** Specify how many times |\_\_\_\_|\_\_\_\_|  Refused  Don’t know

No

Refused

Don’t know

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

Yes ***[IF YES]*** Specify how many times |\_\_\_\_|\_\_\_\_|  Refused  Don’t know

No

Refused

Don’t know

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

Yes

No

Refused

Don’t know

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

No One

Clergy Member

Family Member

Friends

REFUSED

DoN’T KNOW

Other (Specify)

1. How satisfied are you with your personal relationships?

Very dissatisfied

Dissatisfied

Neither satisfied nor dissatisfied

Satisfied

Very satisfied

REFUSED

don’t KNOW

# 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.***

# H1. PROGRAM-SPECIFIC QUESTIONS

***[QUESTION 1 SHOULD BE REPORTED BY GRANTEE STAFF AT FOLLOW-UP AND DISCHARGE.]***

1. Which of the following occurred for the client subsequent to receiving treatment? *[CHECK ALL THAT APPLY.]*

Client was reunited with child (or children)

Client avoided out-of-home placement for child (or children)

None of the above

Don’t know

# H2. PROGRAM-SPECIFIC QUESTIONS

***[QUESTION 1 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE.]***

1. **Did the *[INSERT GRANTEE NAME]* help you obtain any of the following benefits? *[CHECK ALL THAT APPLY.]***

Private health insurance

Medicaid

Supplemental Security Income (SSI)/ Social Security disability insurance (SSDI)

Temporary Assistance for Needy Families (TANF)

Supplemental Nutrition Assistance Program (SNAP)

Other (Specify) \_\_\_\_\_\_\_\_\_\_

NONE OF THE ABOVE

REFUSED

DON’T KNOW

# H3. PROGRAM-SPECIFIC QUESTIONS

***[QUESTION 1 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE.]***

1. **Have you achieved any of the following since you began receiving services or supports from *[INSERT GRANTEE NAME]*? If yes, do you believe that the services you received from *[INSERT GRANTEE NAME]* helped you with this achievement?**

| **Status** | **Achieved?** | **If yes, do you believe that the services you received from *[INSERT GRANTEE NAME]* helped you with this achievement?** |
| --- | --- | --- |
| 1a. Enrolled in school | * Yes * No * DON’T KNOW * REFUSED | * Yes * No * DON’T KNOW * REFUSED |
| 1b. Enrolled in vocational training | * Yes * No * DON’T KNOW * REFUSED | * Yes * No * DON’T KNOW * REFUSED |
| 1c. Currently employed | * Yes * No * DON’T KNOW * REFUSED | * Yes * No * DON’T KNOW * REFUSED |
| 1d. Living in stable housing | * Yes * No * DON’T KNOW * REFUSED | * Yes * No * DON’T KNOW * REFUSED |

# H4. PROGRAM-SPECIFIC QUESTIONS

***[QUESTION 1 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE.]***

1. **Please indicate the degree to which you agree or disagree with the following statements:**
   1. **Receiving treatment in a nonresidential setting has enabled me to maintain parenting and family responsibilities while receiving treatment.**

Strongly disagree

Disagree

Undecided

Agree

Strongly agree

REFUSED

DON’T KNOW

* 1. **As a result of treatment, I feel I now have the skills and support to balance parenting and managing my recovery.**

Strongly disagree

Disagree

Undecided

Agree

Strongly agree

REFUSED

DON’T KNOW

# H5. PROGRAM-SPECIFIC QUESTIONS

***[QUESTION 1 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE.]***

1. **Please indicate the degree to which you agree or disagree with the following statements:**
   1. **Receiving treatment in a residential setting with my child (or children) has enabled me to focus on my treatment without distractions of parenting and family responsibilities.**

Strongly disagree

Disagree

Undecided

Agree

Strongly agree

REFUSED

DON’T KNOW

* 1. **As a result of treatment, I feel I now have the skills and support to balance parenting and managing my recovery.**

Strongly disagree

Disagree

Undecided

Agree

Strongly agree

REFUSED

DON’T KNOW

# H6. PROGRAM-SPECIFIC QUESTIONS

***[QUESTION 1 SHOULD BE REPORTED BY GRANTEE STAFF AT INTAKE/BASELINE, FOLLOW-UP, AND DISCHARGE].***

1. **Please indicate which type of funding was/will be used to pay for the SBIRT services provided to this client. *[CHECK ALL THAT APPLY.]***

Current SAMHSA grant funding

Other federal grant funding

State funding

Client’s private insurance

Medicaid/Medicare

Other (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Don’t know

***[IF FOLLOW-UP OR DISCHARGE INTERVIEW, SKIP TO H3.]***

***[QUESTION 2 SHOULD BE REPORTED BY GRANTEE STAFF ONLY AT INTAKE/BASELINE.]***

1. **If the client screened positive for substance misuse or a substance use disorder, was the client assigned to the following types of services? *[IF CLIENT SCREENED NEGATIVE, SELECT “NO” FOR EACH SERVICE BELOW.]***

Yes No Don’t Know

Brief Intervention

Brief Treatment

Referral to Treatment

***[QUESTION 3 SHOULD BE REPORTED BY GRANTEE STAFF AT INTAKE, BASELINE, FOLLOW-UP, AND DISCHARGE.]***

1. **Did the client receive the following types of services?**

Yes No Don’t Know

Brief Intervention

Brief Treatment

Referral to Treatment

# H7. PROGRAM-SPECIFIC QUESTIONS

***[QUESTION 1 SHOULD BE ANSWERED BY THE CLIENT AT INTAKE/BASELINE, FOLLOW-UP, AND DISCHARGE.]***

1. **Did the program provide the following?**

**a. 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 CLIENT SCREENED POSITIVE]* Were you connected to HIV treatment services?**

* Yes
* No
* REFUSED
* DON’T KNOW

**b. 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 CLIENT SCREENED POSITIVE]* Were you connected to HBV treatment services?**

* Yes
* No
* REFUSED
* DON’T KNOW

H7. PROGRAM-SPECIFIC QUESTIONS (CONTINUED)

**c. Hepatitis C (HCV) test**

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.]***

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

Positive

Negative ***[SKIP TO SECTION I OR J/K.]***

Indeterminate ***[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.]***

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

* Yes
* No
* REFUSED
* DON’T KNOW

# H8. PROGRAM-SPECIFIC QUESTIONS

***[QUESTIONS 1 AND 2 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE.]***

1. **Have you achieved any of the following since you began receiving peer services through *[INSERT GRANTEE NAME]*? If yes, do you believe that the peer services you received from *[INSERT GRANTEE NAME]* helped you with this achievement?**

| **Status** | **Achieved?** | **If yes, do you believe that the peer services you received from *[INSERT GRANTEE NAME]* helped you with this achievement?** |
| --- | --- | --- |
| 1a. Enrolled in school | * Yes * No * DON’T KNOW * REFUSED | * Yes * No * DON’T KNOW * REFUSED |
| 1b. Enrolled in vocational training | * Yes * No * DON’T KNOW * REFUSED | * Yes * No * DON’T KNOW * REFUSED |
| 1c. Currently employed | * Yes * No * DON’T KNOW * REFUSED | * Yes * No * DON’T KNOW * REFUSED |
| 1d. Living in stable housing | * Yes * No * DON’T KNOW * REFUSED | * Yes * No * DON’T KNOW * REFUSED |

1. **To what extent has this program improved your quality of life?**

To a great extent

Somewhat

Very little

Not at all

REFUSED

DON’T KNOW

# H9. PROGRAM-SPECIFIC QUESTIONS

***[QUESTION 1 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE.]***

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

**i. The use of technology accessed through *[INSERT GRANTEE NAME]* has helped me communicate with my provider.**

Strongly disagree

Disagree

Undecided

Agree

Strongly agree

NOT APPLICABLE

REFUSED

DON’T KNOW

**ii. The use of technology accessed through *[INSERT GRANTEE NAME]* has helped me reduce my substance use.**

Strongly disagree

Disagree

Undecided

Agree

Strongly agree

NOT APPLICABLE

REFUSED

DON’T KNOW

**iii. The use of technology accessed through *[INSERT GRANTEE NAME]* has helped me manage my mental health symptoms.**

Strongly disagree

Disagree

Undecided

Agree

Strongly agree

NOT APPLICABLE

REFUSED

DON’T KNOW

**iv. The use of technology accessed through *[INSERT GRANTEE NAME]* has helped me support my recovery.**

Strongly disagree

Disagree

Undecided

Agree

Strongly agree

NOT APPLICABLE

REFUSED

DON’T KNOW

# H10. PROGRAM-SPECIFIC QUESTIONS

***[QUESTIONS 1 AND 1A SHOULD BE REPORTED BY GRANTEE STAFF AT INTAKE/BASELINE, FOLLOW-UP, AND DISCHARGE. QUESTION 1B SHOULD BE REPORTED BY GRANTEE STAFF AT FOLLOW-UP/DISCHARGE IF THE CLIENT HAS BEEN REFERRED FOR SERVICES.]***

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

Client screened positive

Client screened negative ***[SKIP TO H2.]***

Client was not screened ***[SKIP TO H2.]***

Don’t know ***[SKIP TO H2.]***

**a. *[IF POSITIVE]* Was the client referred to mental health services?**

Yes

No ***[SKIP TO H2.]***

Don’t know ***[SKIP TO H2.]***

**b. *[IF YES]* Did the client receive mental health services?**

Yes

No

Don’t know

***[QUESTIONS 2 AND 2A SHOULD BE REPORTED BY GRANTEE STAFF AT INTAKE/BASELINE, FOLLOW-UP, AND DISCHARGE. QUESTION 2B SHOULD BE REPORTED BY GRANTEE STAFF AT FOLLOW-UP/DISCHARGE IF THE CLIENT HAS BEEN REFERRED FOR SERVICES.]***

1. **Did the client screen positive for a substance use disorder?**

Client screened positive

Client screened negative

Client was not screened

Don’t know

***[IF THIS IS AT INTAKE/BASELINE AND THE RESPONSE IS NEGATIVE, NOT SCREENED, OR DON’T KNOW, SECTION H IS DONE. IF THIS IS AT FOLLOW-UP OR DISCHARGE AND THE RESPONSE IS NEGATIVE, NOT SCREENED, OR DON’T KNOW, SKIP TO QUESTION 3.]***

**a. *[IF POSITIVE]* Was the client referred to substance use disorder services?**

Yes

No

Don’t know

***[IF THIS IS AT INTAKE/BASELINE, SECTION H IS DONE. IF THIS IS AT FOLLOW-UP OR DISCHARGE AND THE RESPONSE IS NO OR DON’T KNOW, SKIP TO QUESTION 3.]***

H10. PROGRAM-SPECIFIC QUESTIONS (CONTINUED)

**b. *[IF YES]* Did the client receive substance use disorder services?**

Yes

No

Don’t know

***[QUESTION 3 SHOULD BE ANSWERED BY THE CLIENT AT FOLLOW-UP AND DISCHARGE.]***

1. **Please indicate the degree to which you agree or disagree with the following statement: Receiving community-based services through *[INSERT GRANTEE NAME]* 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

# I. FOLLOW-UP STATUS

***[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT FOLLOW-UP.]***

1. What is the follow-up status of the client? *[THIS IS A REQUIRED FIELD: NA, REFUSED, DON’T KNOW, AND MISSING WILL NOT BE ACCEPTED.]*

01 = Deceased at time of due date

11 = Completed interview within specified window

12 = Completed interview outside specified window

21 = Located, but refused, unspecified

22 = Located, but unable to gain institutional access

23 = Located, but otherwise unable to gain access

24 = Located, but withdrawn from project

31 = Unable to locate, moved

32 = Unable to locate, other (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is the client still receiving services from your program?

Yes

No

***[IF THIS IS A FOLLOW-UP INTERVIEW, STOP NOW; THE INTERVIEW IS COMPLETE.]***

# J. DISCHARGE STATUS

***[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT DISCHARGE.]***

1. On what date was the client discharged?

|\_\_\_\_|\_\_\_\_| / |\_\_\_\_|\_\_\_\_| / |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|  
Month Day Year

1. What is the client’s discharge status?

01 = Completion/Graduate

02 = Termination

If the client was terminated, what was the reason for termination? *[Select one response*.*]*

01 = Left on own against staff advice with satisfactory progress

02 = Left on own against staff advice without satisfactory progress

03 = Involuntarily discharged due to nonparticipation

04 = Involuntarily discharged due to violation of rules

05 = Referred to another program or other services with satisfactory progress

06 = Referred to another program or other services with unsatisfactory progress

07 = Incarcerated due to offense committed while in treatment/recovery with satisfactory progress

08 = Incarcerated due to offense committed while in treatment/recovery with unsatisfactory progress

09 = Incarcerated due to old warrant or charged from before entering treatment/recovery with satisfactory progress

10 = Incarcerated due to old warrant or charged from before entering treatment/recovery with unsatisfactory progress

11 = Transferred to another facility for health reasons

12 = Death

13 = Other (Specify)

J. DISCHARGE STATUS (continued)

1. Did the program test this client for HIV?

Yes ***[SKIP TO SECTION K.]***

No ***[GO TO J4.]***

1. *[IF NO]* Did the program refer this client for testing?

Yes

No

# K. SERVICES RECEIVED

#### [REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT DISCHARGE.]

**Identify the number of DAYS of services provided to the client during the client’s course of treatment**/**recovery. *[ENTER ZERO IF NO SERVICES PROVIDED. YOU SHOULD HAVE AT LEAST ONE DAY FOR MODALITY.]***

Modality Days

1. Case Management |\_\_\_|\_\_\_|\_\_\_|

2. Day Treatment |\_\_\_|\_\_\_|\_\_\_|

3. Inpatient/Hospital (Other Than Detox) |\_\_\_|\_\_\_|\_\_\_|

4. Outpatient |\_\_\_|\_\_\_|\_\_\_|

5. Outreach |\_\_\_|\_\_\_|\_\_\_|

6. Intensive Outpatient |\_\_\_|\_\_\_|\_\_\_|

7. Methadone |\_\_\_|\_\_\_|\_\_\_|

8. Residential/Rehabilitation |\_\_\_|\_\_\_|\_\_\_|

9. Detoxification (Select Only One):

A. Hospital Inpatient |\_\_\_|\_\_\_|\_\_\_|

B. Free-Standing Residential |\_\_\_|\_\_\_|\_\_\_|

C. Ambulatory Detoxification |\_\_\_|\_\_\_|\_\_\_|

10. After Care |\_\_\_|\_\_\_|\_\_\_|

11. Recovery Support |\_\_\_|\_\_\_|\_\_\_|

12. Other (Specify) |\_\_\_|\_\_\_|\_\_\_|

**Identify the number of SESSIONS provided to the client during the client’s course of treatment**/‌**recovery. *[ENTER ZERO IF NO SERVICES PROVIDED.]***

Treatment Services Sessions

***[SBIRT GRANTS: You must have at least one session for one of the Treatment Services numbered 1–4.]***

1. Screening |\_\_\_|\_\_\_|\_\_\_|

2. Brief Intervention |\_\_\_|\_\_\_|\_\_\_|

3. Brief Treatment |\_\_\_|\_\_\_|\_\_\_|

4. Referral to Treatment |\_\_\_|\_\_\_|\_\_\_|

5. Assessment |\_\_\_|\_\_\_|\_\_\_|

6. Treatment/Recovery Planning |\_\_\_|\_\_\_|\_\_\_|

7. Individual Counseling |\_\_\_|\_\_\_|\_\_\_|

8. Group Counseling |\_\_\_|\_\_\_|\_\_\_|

9. Family/Marriage Counseling |\_\_\_|\_\_\_|\_\_\_|

10. Co-Occurring Treatment/Recovery Services |\_\_\_|\_\_\_|\_\_\_|

11. Pharmacological Interventions |\_\_\_|\_\_\_|\_\_\_|

12. HIV/AIDS Counseling |\_\_\_|\_\_\_|\_\_\_|

13. Other Clinical Services   
(Specify) |\_\_\_|\_\_\_|\_\_\_|

Case Management Services Sessions

1. Family Services (Including Marriage Education, Parenting, Child Development Services) |\_\_\_|\_\_\_|\_\_\_|

2. Child Care |\_\_\_|\_\_\_|\_\_\_|

3. Employment Service

A. Pre-Employment |\_\_\_|\_\_\_|\_\_\_|

B. Employment Coaching |\_\_\_|\_\_\_|\_\_\_|

4. Individual Services Coordination |\_\_\_|\_\_\_|\_\_\_|

5. Transportation |\_\_\_|\_\_\_|\_\_\_|

6. HIV/AIDS Service |\_\_\_|\_\_\_|\_\_\_|

7. Supportive Transitional Drug-Free Housing Services |\_\_\_|\_\_\_|\_\_\_|

8. Other Case Management Services (Specify) |\_\_\_|\_\_\_|\_\_\_|

Medical Services Sessions

1. Medical Care |\_\_\_|\_\_\_|\_\_\_|

2. Alcohol/Drug Testing |\_\_\_|\_\_\_|\_\_\_|

3. HIV/AIDS Medical Support and Testing |\_\_\_|\_\_\_|\_\_\_|

4. Other Medical Services   
(Specify) |\_\_\_|\_\_\_|\_\_\_|

After Care Services Sessions

1. Continuing Care |\_\_\_|\_\_\_|\_\_\_|

2. Relapse Prevention |\_\_\_|\_\_\_|\_\_\_|

3. Recovery Coaching |\_\_\_|\_\_\_|\_\_\_|

4. Self-Help and Support Groups |\_\_\_|\_\_\_|\_\_\_|

5. Spiritual Support |\_\_\_|\_\_\_|\_\_\_|

6. Other After Care Services   
(Specify) |\_\_\_|\_\_\_|\_\_\_|

Education Services Sessions

1. Substance Abuse Education |\_\_\_|\_\_\_|\_\_\_|

2. HIV/AIDS Education |\_\_\_|\_\_\_|\_\_\_|

3. Other Education Services  
(Specify) |\_\_\_|\_\_\_|\_\_\_|

Peer-to-Peer Recovery Support Services Sessions

1. Peer Coaching or Mentoring |\_\_\_|\_\_\_|\_\_\_|

2. Housing Support |\_\_\_|\_\_\_|\_\_\_|

3. Alcohol- and Drug-Free Social Activities |\_\_\_|\_\_\_|\_\_\_|

4. Information and Referral |\_\_\_|\_\_\_|\_\_\_|

5. Other Peer-to-Peer Recovery Support Services (Specify) |\_\_\_|\_\_\_|\_\_\_|

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