

Division of Behavioral Health Substance Use Disorder Outcome Tool INITIAL

Today's Date: ____/____/____

Client STARS ID: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

- | | |
|---|---|
| <p>Program</p> <p><input type="checkbox"/> 1.0 Outpatient</p> <p><input type="checkbox"/> 2.1 Intensive Outpatient
(Including 2.1/3.1)</p> <p><input type="checkbox"/> 2.5 Day Treatment</p> <p><input type="checkbox"/> 3.1 Low Intensity Residential</p> <p><input type="checkbox"/> 3.7 Intensive Inpatient
Treatment</p> <p><input type="checkbox"/> Adult Outpatient EBP (CJI Clients
Only)</p> <p><input type="checkbox"/> Adult Outpatient EBP/MRT (CJI
Clients Only)</p> <p><input type="checkbox"/> Adult Outpatient EBP/MRT/3.1
Services (CJI Clients Only)</p> <p><input type="checkbox"/> MRT Telehealth Based Services
(CJI Clients Only)</p> <p><input type="checkbox"/> IMT</p> | <p><input type="checkbox"/> 1.0 Gambling Outpatient</p> <p><input type="checkbox"/> 2.1 Gambling Intensive
Outpatient</p> <p><input type="checkbox"/> 2.5 Gambling Day Treatment</p> <p><input type="checkbox"/> 3.7 Gambling Intensive Inpatient
Treatment</p> <p><input type="checkbox"/> MRT (CJI Clients Only)</p> <p><input type="checkbox"/> Adult Outpatient EBP/3.1 Services
(CJI Clients Only)</p> <p><input type="checkbox"/> Adult Telehealth Outpatient EBP
(CJI Clients Only)</p> <p><input type="checkbox"/> Adult Outpatient EBP/MRT
Telehealth (CJI Clients Only)</p> |
|---|---|

1. Would you say that in general your health is:

- Excellent
 Very Good
 Good
 Fair
 Poor

a. Now thinking about your physical health, which includes physical illness and injury, how many days during the past 30 days was your physical health not good? _____

b. Now thinking about your mental health, which includes stress, depression, and problems with emotions, how many days during the past 30 days was your mental health not good? _____

c. During the past 30 days, approximately how many days did your poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation? _____

2. At this moment, how important is it that you change your current behaviors and/or symptoms? Please circle a number on the scale below:

Not important at all			About as important as most of the other things I would like to achieve now					Most important thing in my life right now		
0	1	2	3	4	5	6	7	8	9	10

3. At this moment, how confident are you that you will change your current behaviors and/or symptoms? Please circle a number on the scale below:

Not important at all			About as important as most of the other things I would like to achieve now					Most important thing in my life right now		
0	1	2	3	4	5	6	7	8	9	10

Adult SUD Form –Initial

4. Please answer the following question	Number of Nights/Times	Don't know
--	---------------------------	---------------

In the past 30 days, how many times have you been arrested? _____
 *Federally Required Element

5. Please answer the following questions based on the past 30 days...		
--	--	--

- a. Have you gotten into trouble at home, at school, work, or in the community, because of your use of alcohol, drugs, inhalants, or gambling? Yes No
- b. Have you missed school or work because of using alcohol, drugs, inhalants, or gambling? Yes No

*Federally Required Element

6. Please answer the following questions based on the past 30 days...	Number of Nights/Times	Don't know
--	---------------------------	---------------

- a. How many times have you gone to an emergency room for a psychiatric or emotional problem? _____
- b. How many nights have you spent in a facility for:
- i. Detoxification? _____
 - ii. Inpatient/Residential Substance Use Disorder Treatment? _____
 - iii. Mental Health Care? _____
 - iv. Illness, Injury, Surgery? _____
- c. How many nights have you spent in a correctional facility including jail or prisons (as a result of an arrest, parole or probation violation)? _____
- d. How many times have you tried to commit suicide? _____

7. I would be able to resist the urge to drink heavily and/or use drugs...	Not at all confident Very Confident
... if I were angry at the way things had turned out	0 1 2 3 4 5 6 7 8 9 10
... if I had unexpectedly found some booze/drugs or happened to see something that reminded me of drinking/using drugs	0 1 2 3 4 5 6 7 8 9 10
... if other people treated me unfairly or interfered with my plans	0 1 2 3 4 5 6 7 8 9 10
... if I were out with friends and they kept suggesting we go somewhere to drink/use drugs	0 1 2 3 4 5 6 7 8 9 10

Adult SUD Form –Initial

8. Please indicate your level of agreement or disagreement with the statements by checking the choice that best represents your feelings or opinion over the past 30 days. (Please answer for relationships with persons other than your behavioral health provider(s).) Source: MHSIP Survey *Federally Required

	Response Options						
	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	Not applicable	Refused
Domain: Social Connectedness Questions 1-4							
1. I am happy with the friendships I have.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I have people with whom I can do enjoyable things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I feel I belong in my community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. In a crisis, I would have the support I need from family or friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Domain: Improved Functioning Domain: Questions 5-8							
5. I do things that are more meaningful to me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I am better able to take care of my needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I am better able to handle things when they go wrong.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I am better able to do things that I want to do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Question **required** to be completed by Clinician

10. At this interval period, what is your (clinician’s) assessment of the client’s understanding and willingness to engage in their treatment program? Please circle a number on the scale below:

Unengaged and Blocked	Minimal Engagement in Recovery	Limited Engagement in Recovery	Positive Engagement in Recovery	Optimal Engagement in Recovery
1	2	3	4	5