

Division of Behavioral Health Substance Use Disorder Outcome Tool DISCHARGE

Today's Date: ____/____/____

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

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

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 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 |

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4. Please answer the following question	Number of Nights/Times	Don't know
In the <u>past 30 days</u> , how many times have you been arrested? <small>*Federally Required Element</small>	_____	<input type="checkbox"/>

5. Please answer the following questions based on the <u>past 30 days</u>...		
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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Have you missed school or work because of using alcohol, drugs, inhalants, or gambling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

6. Please answer the following questions based on the <u>past 30 days</u>...	Number of Nights/Times	Don't know
a. How many times have you gone to an emergency room for a psychiatric or emotional problem?	_____	<input type="checkbox"/>
b. How many nights have you spent in a facility for:		
i. Detoxification?	_____	<input type="checkbox"/>
ii. Inpatient/Residential Substance Use Disorder Treatment?	_____	<input type="checkbox"/>
iii. Mental Health Care?	_____	<input type="checkbox"/>
iv. Illness, Injury, Surgery?	_____	<input type="checkbox"/>
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)?	_____	<input type="checkbox"/>
d. How many times have you tried to commit suicide?	_____	<input type="checkbox"/>
<small>*Element agreed upon by the DOWG</small>		

7. Please check the appropriate box on how you are doing since entering the program that best tells us what you think.	Before the Program				Now (At end of Program)			
	Poor 1	Average 2	Good 3	Excellent 4	Poor 1	Average 2	Good 3	Excellent 4
a. Controlling alcohol use.	<input type="checkbox"/>							
b. Controlling drug use.	<input type="checkbox"/>							

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8. 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

9. 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 *Element Agreed upon by DOWG	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"/>						
2. I have people with whom I can do enjoyable things.	<input type="checkbox"/>						
3. I feel I belong in my community.	<input type="checkbox"/>						
4. In a crisis, I would have the support I need from family or friends.	<input type="checkbox"/>						
Domain: Improved Functioning Domain: Questions 5-8							
5. I do things that are more meaningful to me.	<input type="checkbox"/>						
6. I am better able to take care of my needs.	<input type="checkbox"/>						
7. I am better able to handle things when they go wrong.	<input type="checkbox"/>						
8. I am better able to do things that I want to do.	<input type="checkbox"/>						
Domain: Perception of Access to Services Questions 9-13							
9. The location of services was convenient.	<input type="checkbox"/>						
10. Staff was willing to see me as often as I felt it was necessary	<input type="checkbox"/>						
11. Staff returned my calls within 24 hours.	<input type="checkbox"/>						
12. Services were available at times that were good for me.	<input type="checkbox"/>						
13. I was able to get all the services I thought I needed.	<input type="checkbox"/>						
Domains: Perception of Quality and Appropriateness Questions 14-21							
14. Staff believed that I could grow, change and recover.	<input type="checkbox"/>						
15. I felt free to complain.	<input type="checkbox"/>						
16. Staff respected my wishes about who is and is not to be given information about my treatment.	<input type="checkbox"/>						

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17. Staff was sensitive to my cultural/ethnic background.	<input type="checkbox"/>						
18. Staff helped me obtain the information needed so I could take charge of managing my illness.	<input type="checkbox"/>						
19. I was given information about my rights.	<input type="checkbox"/>						
20. Staff encouraged me to take responsibility for how I live my life.	<input type="checkbox"/>						
21. I was encouraged to use consumer-run programs.	<input type="checkbox"/>						
Domain: Perceptions of Outcomes Questions 22-29							
22. I deal more effectively with daily problems.	<input type="checkbox"/>						
23. I am better able to control my life.	<input type="checkbox"/>						
24. I am better able to deal with crisis.	<input type="checkbox"/>						
25. I am getting along better with my family.	<input type="checkbox"/>						
26. I do better in social situations.	<input type="checkbox"/>						
27. I do better in school and/or work.	<input type="checkbox"/>						
28. My symptoms are not bothering me as much.	<input type="checkbox"/>						
29. My housing situation has improved.	<input type="checkbox"/>						
Domain: Perceptions of Participation in Treatment Planning Questions 30-31							
30. I felt comfortable asking questions about my treatment.	<input type="checkbox"/>						
31. I, not staff, decided my treatment goals.	<input type="checkbox"/>						
Domain: General Satisfaction Questions 32-34							
32. I liked the services that I received here.	<input type="checkbox"/>						
33. If I had other choices, I would still get services at this agency.	<input type="checkbox"/>						
34. I would recommend this agency to a friend or family member.	<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