

Division of Behavioral Health  
 Substance Use Disorder Outcome Tool  
 Family  
 INITIAL

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Client STARS ID: |\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|

- Program**
- |  |   |
|--|---|
| <input type="checkbox"/> 1.0 Outpatient                | <input type="checkbox"/> 2.1 Intensive Outpatient |
| <input type="checkbox"/> 2.5 Day Treatment             | <input type="checkbox"/> 3.7 Intensive Inpatient  |
| <input type="checkbox"/> 3.1 Low Intensity Residential | Treatment (PRFT)                                  |
| <input type="checkbox"/> Adolescent EBP Services       |   |

**1. Would you say that in general your child's health is:**

- Excellent     Very Good     Good     Fair     Poor

**a.** Now thinking about your child's physical health, which includes physical illness and injury, how many days during the past 30 days was your child physical health not good? \_\_\_\_\_

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

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

**2. At this moment, how important is it that your child change their 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 that your child will change their 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

**4. Please answer the following question**

In the past 30 days, how many times has your child been arrested?

\*Federally Required Element

Number of  
Nights/Times

\_\_\_\_\_

Don't  
know

## Family SUD Form –Initial Interview

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

- a. Has your child gotten into trouble at home, at school, work, or in the community, because of their use of alcohol, drugs, inhalants, or gambling?  Yes  No
- b. Has your child 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 has your child gone to an emergency room for a psychiatric or emotional problem?	—	<input type="checkbox"/>
b. How many nights has your child 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 has your child spent in a correctional facility including JDC or Jail (as a result of an arrest, parole or probation violation)?	—	<input type="checkbox"/>
d. How many times has your child tried to commit suicide?	—	<input type="checkbox"/>

### 7. My child would be able to resist the urge to drink heavily and/or use drugs...

	Not at all confident <span style="float: right;">Very Confident</span>										
	0	1	2	3	4	5	6	7	8	9	10
... if he/she were angry at the way things had turned out											
... if he/she had unexpectedly found some booze/drugs or happened to see something that reminded him/her of drinking/using drugs											
... if other people treated he/she unfairly or interfered with his/her plans											
... if he/she were out with friends and they kept suggesting they go somewhere to drink/use drugs											

## Family SUD Form –Initial Interview

<b>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</b>	Response Options						
	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	Not applicable	Refused
<b>Domain: Social Connectedness Questions 1-4</b>							
1. My child knows people who will listen and understand them when they need to talk.	<input type="checkbox"/>						
2. In a crisis, my child would have the support they need from family and friends.	<input type="checkbox"/>						
3. My child has people that he/she are comfortable talking with about their problems.	<input type="checkbox"/>						
4. My child has people with whom they can do enjoyable things.	<input type="checkbox"/>						
<b>Domain: Improved Functioning Domain: Questions 5-11</b>							
5. My child is able to do things he or she wants to do.	<input type="checkbox"/>						
6. My child gets along with family members.	<input type="checkbox"/>						
7. My child gets along with friends and other people.	<input type="checkbox"/>						
8. My child does well in school and/or work.	<input type="checkbox"/>						
9. My child is able to cope when things go wrong.	<input type="checkbox"/>						
10. My child is able to handle daily life.	<input type="checkbox"/>						
11. I am satisfied with our family life right now.	<input type="checkbox"/>						

Question to be answered by Clinician

<b>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:</b>				
Unengaged and Blocked	Minimal Engagement in Recovery	Limited Engagement in Recovery	Positive Engagement in Recovery	Optimal Engagement in Recovery
<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>