

Division of Behavioral Health

Substance Use Disorder Outcome Tool

Youth Update

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 Treatment (PRFT) |
| <input type="checkbox"/> 3.1 Low Intensity Residential | |
| <input type="checkbox"/> Adolescent EBP Services | |

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. Please answer the following question

In the past 30 days, how many times have you been arrested?

*Federally Required Element

*Federally Required Element

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

Number of Nights/Times	Don't know
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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 JDC or Jail (as a result of an arrest, parole or probation violation)? _____

d. How many times have you tried to commit suicide? _____

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4. 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).) *Federally Required	Response Options						
	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	Not applicable	Refused
Domain: Social Connectedness Questions 1-4							
1. I know people who will listen and understand me when I need to talk.	<input type="checkbox"/>						
2. In a crisis, I would have the support I need from family and friends.	<input type="checkbox"/>						
3. I have people that I am comfortable talking with about my problems.	<input type="checkbox"/>						
4. I have people with whom I can do enjoyable things.	<input type="checkbox"/>						
Domain: Improved Functioning/ Outcomes Domain: Questions 5-11							
5. I am better able to do things I want to do.	<input type="checkbox"/>						
6. I get along better with family members.	<input type="checkbox"/>						
7. I get along better with friends and other people.	<input type="checkbox"/>						
8. I am doing better in school and/or work.	<input type="checkbox"/>						
9. I am better able to cope when things go wrong.	<input type="checkbox"/>						
10. I am better at handling my daily life.	<input type="checkbox"/>						
11. I am satisfied with my family life right now.	<input type="checkbox"/>						
Domain: Perception of Access to Services Questions 12-13							
12. The location of services was convenient.	<input type="checkbox"/>						
13. Services are available at times that are convenient for me.	<input type="checkbox"/>						
Domains: Perception of Cultural Sensitivity Questions 14-17							
14. Staff treat me with respect.	<input type="checkbox"/>						
15. Staff respect my family's religious/spiritual beliefs.	<input type="checkbox"/>						
16. Staff speak with me in a way that I understand.	<input type="checkbox"/>						
17. Staff are sensitive to my cultural/ethnic background.	<input type="checkbox"/>						
Domain: Perceptions of Participation in Treatment Planning Questions 18-20							
18. I helped to choose my services.	<input type="checkbox"/>						
19. I helped to choose my treatment goals.	<input type="checkbox"/>						
20. I participated in my own treatment.	<input type="checkbox"/>						
Domain: General Satisfaction Questions 21-26							
21. Overall I am satisfied with the services I have received here.	<input type="checkbox"/>						
22. The people helping me have stuck with me no matter what.	<input type="checkbox"/>						
23. I feel I have someone to talk to when I am troubled.	<input type="checkbox"/>						
24. I received services that were right for me.	<input type="checkbox"/>						
25. I have gotten the help I want.	<input type="checkbox"/>						
26. I have gotten as much help as I need.	<input type="checkbox"/>						

Youth SUD Form – Update Interval

Question to be answered by Clinician

GAIN Short Screener (GAIN-SS) Scoring					
Screeners	Items	Past Month (4)	Past 90 Days (4, 3)	Past Year (4, 3, 2)	Ever (4, 3, 2, 1)
IDScr	1a – 1f				
EDScr	2a – 2g				
SDScr	3a – 3e				
CVScr	4a – 4e				
TDSer	1a – 4e				