

Common Study Discharge Form

Section 1: Administrative Information *(Do not need to ask young adult or caregiver directly.)*

Today's date: / /
Month Day Year

Young adult ID #:

1. Was the interview conducted? No **[GO TO 1A]** Yes When?

/ /
Month Day Year

[GO TO 2]

1a. Why not? Choose only one.

- Consumer refused this interview only
- Consumer refused all interviews
- Not able to obtain consent from proxy
- Consumer was impaired/unable to provide consent
- Consumer was not reached for interview

2. Was the respondent the young adult or caregiver? Young Adult (Preferred!) Caregiver

3. On what date was the consumer discharged?

/
Month Year

4. What is the consumer's discharge status?

- Mutually agreed cessation of treatment
- Withdrew from / refused treatment
- Death
- No contact within 90 days of last encounter
- Clinically referred out
- Other (Specify) _____

Section 2: Services Received (Do not need to ask young adult or caregiver directly.)

1. On what date did the consumer last receive services? /
 Month Year

[IDENTIFY ALL OF THE SERVICES YOUR PROJECT PROVIDED TO THE CONSUMER SINCE HIS/HER LAST COMMON STUDY INTERVIEW; THIS INCLUDES YIT-FUNDED AND NON-FUNDED SERVICES.]

Core Services	Provided			Service Not Available
	Yes	No	Unknown	
1. Screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Treatment planning or review	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Psychopharmacological services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>[IF YES, ESTIMATE HOW FREQUENTLY MENTAL HEALTH & RELATED SERVICES WERE DELIVERED]:</i> Number of times _____ per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year				
6. Co-Occuring services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Trauma-specific services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Was the consumer referred to another provider for any of the above core services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Support Services	Provided			Service Not Available
	Yes	No	Unknown	
1. Medical care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Employment services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Family services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Child care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Education services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Housing support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Social recreational services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Consumer operated services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. HIV testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Was the consumer referred to another provider for any of the above support services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

[STOP HERE IF DISCHARGE INTERVIEW WAS NOT CONDUCTED AND ADMINISTRATIVE & SERVICES DATA WAS ABSTRACTED FROM RECORDS. ALL OTHERS CONTINUE.]

Section 3: Functioning (These questions must be asked of young adult or caregiver.)

1. How would you rate your (your child's) overall health right now?

- Excellent
 Very Good
 Good
 Fair
 Poor
 REFUSED
 DON'T KNOW

2. In order to provide the best possible mental health and related services, we need to know what you think about how well you were (your child was) able to deal with your everyday life during the last 30 days. Please indicate your disagreement/agreement with each of the following statements.

[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE YOUNG ADULT(CAREGIVER)]	RESPONSE OPTIONS						
	<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Undecided</i>	<i>Agree</i>	<i>Strongly Agree</i>	<i>REFUSED</i>	<i>Not Applicable</i>
a. I am (my child is) handling daily life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. I get (my child gets) along with family members.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I get (my child gets) along with friends and other people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. I am (my child is) doing well in school and/or work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I am (my child is) able to cope when things go wrong.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
f. I am satisfied with our family life right now.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

[IF THE CAREGIVER IS THE RESPONDENT GO TO SECTION 4.]

Section 3: Functioning (Continued)

3. The following questions ask about how you have been feeling during the past 30 days. For each question, please indicate how often you had this feeling.

[READ EACH QUESTION FOLLOWED BY THE RESPONSE OPTIONS TO THE YOUNG ADULT]

<i>During the past 30 days, about how often did you feel...</i>	RESPONSE OPTIONS						
	<i>All of the time</i>	<i>Most of the time</i>	<i>Some of the time</i>	<i>A little of the time</i>	<i>None of the time</i>	<i>REFUSED</i>	<i>Don't know</i>
a. nervous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. restless or fidgety?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. so depressed that nothing could cheer you up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. that everything was an effort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. worthless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

[IF THE CAREGIVER IS THE RESPONDENT GO TO SECTION 4.]

Section 3: Functioning (Continued)

4. The following questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we'll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed.

[READ EACH QUESTION FOLLOWED BY THE RESPONSE OPTIONS TO THE YOUNG ADULT]

<i>In the past 30 days, how often have you used...</i>	RESPONSE OPTIONS					
	<i>Never</i>	<i>Once or Twice</i>	<i>Weekly</i>	<i>Daily or Almost Daily</i>	<i>REFUSED</i>	<i>DON'T KNOW</i>
a. tobacco products (cigarettes, chewing tobacco, cigars, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. alcoholic beverages (beer, wine, liquor, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b1. IF B >= ONCE OR TWICE, AND RESPONDENT MALE ASK: How many times in the past 30 days have you had five or more drinks in a day? <i>[CLARIFY IF NEEDED: (A standard alcoholic beverage (e.g., 12 oz beer, 5 oz wine, 1.5 oz liquor))]</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b2. IF B >= ONCE OR TWICE, AND RESPONDENT NOT MALE ASK: How many times in the past 30 days have you had four or more drinks in a day? <i>[CLARIFY IF NEEDED: (A standard alcoholic beverage (e.g., 12 oz beer, 5 oz wine, 1.5 oz liquor))]</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. cannabis (marijuana, pot, grass, hash, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. cocaine (coke, crack, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. methamphetamine (speed, crystal meth, ice, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. inhalents (nitrous oxide, glue, gas, paint thinner, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. street opioids (heroin, opium, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. other – specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 4: Stability in Housing (These questions must be asked of young adult or caregiver.)

1. In the past 30 days how many...	Number of Nights / Times	REFUSED	DON'T KNOW
a. nights have you (has your child) been homeless?	_ _	<input type="checkbox"/>	<input type="checkbox"/>
b. nights have you (has your child) spent in a hospital for mental health care?	_ _	<input type="checkbox"/>	<input type="checkbox"/>
c. nights have you (has your child) spent in a facility for detox/inpatient or residential substance abuse treatment?	_ _	<input type="checkbox"/>	<input type="checkbox"/>
d. nights have you (has your child) spent in correctional facility including juvenile detention, jail, or prison?	_ _	<input type="checkbox"/>	<input type="checkbox"/>
[ADD UP THE TOTAL NUMBER OF NIGHTS SPENT HOMELESS, IN HOSPITAL FOR MENTAL HEALTH CARE, IN DETOX/INPATIENT OR RESIDENTIAL SUBSTANCE ABUSE TREATMENT, OR IN A CORRECTIONAL FACILITY. (ITEMS A-D, CANNOT EXCEED 30 NIGHTS)]	_ _		
e. times have you (has your child) gone to an emergency room for a psychiatric or emotional problem?	_ _	<input type="checkbox"/>	<input type="checkbox"/>

[IF 1A, 1B, 1C, OR 1D IS 16 OR MORE NIGHTS, GO TO SECTION 5]

2. In the past 30 days, where have you (has your child) been living most of the time?

[DO NOT READ RESPONSE OPTIONS TO THE YOUNG ADULT. SELECT ONLY ONE.]

- CAREGIVER'S OWNED OR RENTED HOUSE, APARTMENT, TRAILER, OR ROOM
- INDEPENDENT OWNED OR RENTED HOUSE, APARTMENT, TRAILER, OR ROOM
- SOMEONE ELSE'S HOUSE, APARTMENT, TRAILER, OR ROOM
- HOMELESS (SHELTER, STREET/OUTDOORS, PARK)
- GROUP HOME
- FOSTER CARE (SPECIALIZED THERAPEUTIC TREATMENT)
- TRANSITIONAL LIVING FACILITY
- HOSPITAL (MEDICAL)
- HOSPITAL (PSYCHIATRIC)
- DETOX/INPATIENT OR RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
- CORRECTIONAL FACILITY (JUVENILE DETENTION CENTER/JAIL/PRISON)
- OTHER HOUSED (SPECIFY) _____
- REFUSED
- DON'T KNOW

Section 5: Education (These questions must be asked of young adult or caregiver.)

1. During the past 30 days of school, how many days were you (was your child) absent for any reason?

- | | | |
|---------------------------------|--|---|
| <input type="checkbox"/> 0 DAYS | <input type="checkbox"/> 3 TO 5 DAYS | <input type="checkbox"/> REFUSED |
| <input type="checkbox"/> 1 DAY | <input type="checkbox"/> 6 TO 10 DAYS | <input type="checkbox"/> DON'T KNOW |
| <input type="checkbox"/> 2 DAYS | <input type="checkbox"/> MORE THAN 10 DAYS | <input type="checkbox"/> NOT APPLICABLE |

a. [If absent], how many days were unexcused absences?

- | | | |
|---------------------------------|--|---|
| <input type="checkbox"/> 0 DAYS | <input type="checkbox"/> 3 TO 5 DAYS | <input type="checkbox"/> REFUSED |
| <input type="checkbox"/> 1 DAY | <input type="checkbox"/> 6 TO 10 DAYS | <input type="checkbox"/> DON'T KNOW |
| <input type="checkbox"/> 2 DAYS | <input type="checkbox"/> MORE THAN 10 DAYS | <input type="checkbox"/> NOT APPLICABLE |

2. What is the highest level of education you have (your child has) finished, whether or not you (he/she has) received a degree?

- | | | |
|---|--|---|
| <input type="checkbox"/> NEVER ATTENDED | <input type="checkbox"/> 7TH GRADE | <input type="checkbox"/> VOC/TECH DIPLOMA |
| <input type="checkbox"/> PRESCHOOL | <input type="checkbox"/> 8TH GRADE | <input type="checkbox"/> SOME COLLEGE OR UNIVERSITY |
| <input type="checkbox"/> KINDERGARTEN | <input type="checkbox"/> 9TH GRADE | <input type="checkbox"/> REFUSED |
| <input type="checkbox"/> 1ST GRADE | <input type="checkbox"/> 10TH GRADE | <input type="checkbox"/> DON'T KNOW |
| <input type="checkbox"/> 2ND GRADE | <input type="checkbox"/> 11TH GRADE | |
| <input type="checkbox"/> 3RD GRADE | <input type="checkbox"/> 12TH GRADE / HIGH SCHOOL DIPLOMA / EQUIVALENT (GED) | |
| <input type="checkbox"/> 4TH GRADE | | |
| <input type="checkbox"/> 5TH GRADE | | |
| <input type="checkbox"/> 6TH GRADE | | |

Section 6: Crime and Criminal Justice Status (These questions must be asked of young adult or caregiver.)

1. In the past 30 days, how many times have you (has your child) been arrested?

- |__|__| TIMES REFUSED DON'T KNOW

Section 7: Social Connectedness (These questions must be asked of young adult or caregiver.)

Please indicate your disagreement/agreement with each of the following statements. Please answer for relationships with persons other than your (your child's) mental health provider(s) over the past 30 days.

[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE YOUNG ADULT(CAREGIVER)]	RESPONSE OPTIONS					
	<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Undecided</i>	<i>Agree</i>	<i>Strongly Agree</i>	<i>REFUSED</i>
1. I know people who will listen and understand me when I need to talk.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I have people that I am comfortable talking with about my problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. 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"/>
4. 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"/>

Section 8: Perceptions of Care (These questions must be asked of young adult or caregiver.)

1. In order to provide the best possible mental health and related services, we need to know what you think about the services you (your child) received during the past 30 days, the people who provided it, and the results. Please indicate your disagreement/agreement with each of the following statements.

[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE YOUNG ADULT(CAREGIVER)]	RESPONSE OPTIONS					
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	REFUSED
a. Staff here treated me with respect.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Staff respected my family's religious/spiritual beliefs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Staff spoke with me in a way that I understood.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Staff was sensitive to my cultural / ethnic background.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I helped to choose my services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. I helped to choose my treatment goals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. I participated in my treatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Overall, I am satisfied with the services I received.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. The people helping me stuck with me no matter what.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. I felt I had someone to talk to when I was troubled.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. The services I received were right for me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. I got the help I wanted.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. I got as much help as I needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. [INDICATE WHO ADMINISTERED SECTION 8 - PERCEPTION OF CARE TO THE CONSUMER (CAREGIVER) FOR THIS INTERVIEW.]

- | | |
|---|--|
| <input type="radio"/> ADMINISTRATIVE STAFF | <input type="radio"/> DATA COLLECTOR |
| <input type="radio"/> CARE COORDINATOR | <input type="radio"/> EVALUATOR |
| <input type="radio"/> CASE MANAGER | <input type="radio"/> FAMILY ADVOCATE |
| <input type="radio"/> CLINICIAN PROVIDING DIRECT SERVICES | <input type="radio"/> RESEARCH ASSISTANT STAFF |
| <input type="radio"/> CLINICIAN NOT PROVIDING SERVICES | <input type="radio"/> SELF-ADMINISTERED |
| <input type="radio"/> CONSUMER PEER | |
| <input type="radio"/> OTHER (SPECIFY) _____ | |