SERVICE USE INITIAL MODULE
(SECTION SV)

Now I would like to ask you some questions about treatments or help [CHILD] may have received for emotional, behavioral, or drug or alcohol problems. For the rest of this interview, when I talk about emotional or behavioral problems, I will also mean any problems with drugs and alcohol.

Please look at this list of services. HAND R CARD A. If you don't know what some of these mean, ask me and I'll try to explain.

Has [CHILD] ever stayed <u>overnight</u> at an inpatient facility such as a (READ EACH AND CODE):	NO	YES	DK	COL. B AGE FIRST USED	COL. C USED PAST YEAR NOYES	COL. D PAST YEAR USE START MONTH	STOP MONTH
SV1. Psychiatric hospital	0	1	9	___ ___	0 1	___ ___	___ ___
SV2. Psychiatric unit in a general hospital	0	1	9	___ ___	0 1	___ ___	___ ___
SV3. Drug or alcohol treatment unit	0	1	9	___ ___	0 1	___ ___	___ ___
SV4. Residential treatment center	0	1	9	___ ___	0 1	___ ___	___ ___
SV5. Group home	0	1	9	___ ___	0 1	___ ___	___ ___
SV6. Foster home	0	1	9	___ ___	0 1	___ ___	___ ___
SV7. Detention center or Training school	0	1	9	___ ___	0 1	___ ___	___ ___
SV8. Prison or jail	0	1	9	___ ___	0 1	___ ___	___ ___
SV9. Summer treatment program	0	1	9	___ ___	0 1	___ ___	___ ___
SV10. Inpatient medical or pediatric unit for emotional or behavioral problems							
SV11. Emergency shelter for emotional or behavioral problems	0	1	9	___ ___	0 1	___ ___	___ ___
SV12. Boarding school for emotional or behavioral problems	0	1	9	___ ___	0 1	___ ___	___ ___
	0	1	9	___ ___	0 1	___ ___	___ ___
HAND R CARD B. Has [CHILD] ever received outpatient help or treatment (not overnight) from a (READ EACH AND CODE):							
SV13. Community mental health center or other outpatient mental health clinic	0	1	9	___ ___	0 1	___ ___	___ ___
SV14. Partial hospitalization or day treatment program	0	1	9	___ ___	0 1	___ ___	___ ___
SV15. Drug or alcohol clinic	0	1	9	___ ___	0 1	___ ___	___ ___
SV16. In-home therapist or counselor or family preservation worker	0	1	9	___ ___	0 1	___ ___	___ ___
SV17. Emergency room for emotional or behavioral problems	0	1	9	___ ___	0 1	___ ___	___ ___
SV18. Pediatrician or family doctor for emotional or behavioral problems	0	1	9	___ ___	0 1	___ ___	___ ___
SV19. Probation or juvenile corrections officer or a court counselor	0	1	9	___ ___	0 1	___ ___	___ ___
SV20. Priest, Minister or Rabbi for emotional or behavioral problems	0	1	9	___ ___	0 1	___ ___	___ ___

	NO	YES	DK	COL. B AGE FIRST USED	COL. C USED LAST YEAR NOYES	COL. D PAST YEAR USE START MONTH	STOP MONTH
SV21. Professional like a psychologist, psychiatrist, social worker, or marriage or family counselor not as part of services already mentioned	0	1	9	___ ___	0 1	___ ___	___ ___
SV22. Healer/Shaman/Curandero	0	1	9	___ ___	0 1	___ ___	___ ___
SV23. Acupuncturist or Chiropractor	0	1	9	___ ___	0 1	___ ___	___ ___
SV24. Crisis hotline	0	1	9	___ ___	0 1	___ ___	___ ___
SV25. Self-help group like Alcoholic Anonymous or peer help or counseling	0	1	9	___ ___	0 1	___ ___	___ ___
SV26. Respite Care Provider	0	1	9	___ ___	0 1	___ ___	___ ___

HAND R CARD C. Has [CHILD] ever received any services at school such as (READ EACH AND CODE):

SV27. Services in a special school for students with emotional or behavioral problems	0	1	9	___ ___	0 1	___ ___	___ ___
SV28. Services in a special classroom in a regular school for emotional, behavioral, or drug or alcohol problems	0	1	9	___ ___	0 1	___ ___	___ ___
SV29. Special help in the regular classroom for emotional, behavioral, or drug or alcohol problems	0	1	9	___ ___	0 1	___ ___	___ ___
SV30. Counseling in school, related to emotional, behavioral or alcohol or drug problems	0	1	9	___ ___	0 1	___ ___	___ ___

SV31. IF ANY QS IN SV1-30 CODED 1, GO TO SV32.
IF NO SERVICE, CONTINUE. So, [CHILD] has never received any service for an emotional, behavioral, or drug or alcohol problem?

CORRECT, NEVER HAS. . .GO TO SECTION FS 0
NOT CORRECT, HAS RECEIVED . .CHANGE QS 1

SV32 Let's talk about the services just mentioned.

A. How old was [CHILD] when (he/she) first received services from (NAME SERVICE)? CODE AGE IN COL. B IN SV1-30

B. Did (he/she) use this service within the last year, that is since (DATE 12 MONTHS AGO)? CODE IN COL. C IN SV1-30

SV33. REPEAT SV32A AND SV32B FOR EACH SERVICE CODED 1 IN SV1-30.

SV34. HOW MANY SERVICES WERE USED IN PAST 12 MONTHS (COL. C)?

0GO TO SECTION FS 0
1-31
4+ 2

You mentioned [CHILD] received services in the past 12 months. I want to know when in the past 12 months [CHILD] received each of these services, so please take a minute to look at this timeline. PULL OUT CHART TL WITH INTERVIEW DATE, 12 MONTHS PRIOR TO THE INTERVIEW, AND JAN. 1 PREVIOUSLY MARKED ON THE LINE.

SV35. Beginning 12 months ago, when did [CHILD] first receive services from [SERVICE]? CODE START MONTH IN COL. D. IF CURRENT TX EPISODE STARTED MORE THAN 12 MONTHS AGO, CODE 13 IN START MONTH COL.

A. Is [CHILD] still using this service?
IF YES, CODE 00 IN STOP MONTH, COL. D.
IF NO, ASK: In what month did [CHILD] last use this service?

B. REPEAT SV35 AND SV35A UNTIL ALL SERVICES ARE ASKED.

SV36. LEFT BLANK.

SV37. Before [CHILD] ever used any services, who did you talk to about (his/her) problems? Did you discuss them with: (READ LIST AND CODE FOR EACH IN COL. 1.)

	COL. 1 NO	YES	DK	COL. 2 REF NO	YES
a. your (spouse or partner)?	01	9		01	
b. [CHILD] (him or herself)?	01	9		01	
c. other family member?	01	9		01	
d. your friends or neighbors?	01	9		0	1
e. [CHILD'S] friends?	01	9		01	
f. a school social worker, counselor, psychologist or nurse?	01	9		01	
g. a teacher?	01	9		01	
h. a principal, vice-principal, or administrator?	01	9		01	
i. a minister, priest, or rabbi?	01	9		0	1
j. a pediatrician, medical doctor, family doctor or nurse?	01	9		01	
k. a counselor, therapist, social worker or psychologist not at school?	01	9		01	
l. a Probation Officer, Judge or Lawyer?	01	9		01	
m. Case manager?	01	9		01	
n. Any other person, not mentioned? Specify:_____	01	9		0	1

SV38. IF SV37a-n COL. 1 ALL CODED NO, GO TO BOX.
Did [PERSON NAMED IN SV37] suggest [CHILD] needed services? CODE IN COL. 2. REPEAT FOR EACH.

GO TO FIRST SERVICE MODULE USED IN PAST 12 MONTHS.

RESPONDENT ID #: ___ ___ ___ ___ ___ ___ ___ ___

INPATIENT SERVICE SETTING: Psychiatric Hospital

(SECTION UA)
USE IF SV1 COL. C = YES

UA1. During the past 12 months, how many different times was [CHILD] admitted to a psychiatric hospital where (he/she) stayed overnight? ADMISSIONS: ___ ___

IF ADMISSION = 02+, ASK A WITH PARENS.

A. What was the name and address of the psychiatric hospital [CHILD] was in during the past 12 months (starting with the most recent)?

HOSPITAL NAME	ADDRESS CITY, STATE	CODE
#1_____ MOST RECENT	_____	___ ___ ___ ___
#2_____	_____	___ ___ ___ ___
#3_____	_____	___ ___ ___ ___

UA2. How many nights all together has [CHILD] stayed overnight in any psychiatric hospital since [DATE 12 MONTHS AGO]? NIGHTS: ___ ___ ___

UA3. What were the most important behavioral or emotional reasons [CHILD] was admitted to [PLACE IN UA1A1]? (IF ANSWER NOT SPECIFIC, ASK: What was there about [CHILD'S] behavior or emotions that caused you to use [PLACE IN UA1A1]?) RECORD UP TO THREE. CODE

#1_____ ___ ___ ___ ___

#2_____ ___ ___ ___ ___

#3_____ ___ ___ ___ ___

UA4. Who referred [CHILD] or told you to take (him/her) to [PLACE IN UA1A1]? CIRCLE CLASSIFICATION OF ALL PERSONS WHO REFERRED CHILD.

[CHILD'S] SCHOOL OR TEACHER 1
FRIEND/NEIGHBOR 2
JUDGE/COURT/POLICE 3
SOCIAL WORKER/
CASE MANAGER 4
PSYCHIATRIST/PSYCHOLOGIST/
COUNSELOR 5
PEDIATRICIAN/FAMILY DOCTOR 6
PRIEST/RABBI/CLERGY 7
NO ONE 8
OTHER: SPECIFY:_____ 9

UA5. Now I am going to read a list of the types of treatments, services, and counseling programs that might be provided in a psychiatric hospital. We realize that you may not know whether [CHILD] received some of these. In those cases, it is fine to say you don't know. In (his/her) most recent admission to a psychiatric hospital, did [CHILD]:

	NO	YES	DK
a. Receive therapy or counseling?	0	1	9
b. Have case management or a contact person who coordinated (his/her) services?	0	1	9
c. Receive medications?	0	1	9
d. Receive evaluations or testing?	0	1	9
Did you or your family receive:			
e. Counseling, training or education in how to deal with [CHILD]?	0	1	9
f. Counseling or therapy for your relationships with other family members?	0	1	9
g. Counseling or therapy for <u>your</u> own problems, worries, or stresses?	0	1	9
h. Help with rent, money, food, clothing, or shelter?	0	1	9
i. Any other service? Specify:_____	0	1	9

UA6. A. How many days were there between the time the hospital was first contacted about [CHILD'S] problem and when (he/she) was admitted? IF 000, GO TO UA7.

DAYS: ___ ___ ___

B. During this waiting period did anyone from the hospital speak with you or [CHILD] to determine (his/her) need for services?

NO ...0
YES..1

UA7. Was a set of treatment goals outlined at the start of [CHILD's] treatment?

NO ...0
YES..1

UA8. Who was the person in charge of [CHILD'S] treatment at [PLACE IN UA1A1]? NAME:_____

UA9. IF SV1 COL. D STOP MONTH CODED 00, GO TO UA11.
You mentioned that [CHILD] is no longer in a psychiatric hospital. Is this because (READ ALL AND CODE):

		NO	YES	DK
a.	[CHILD] improved? (IF YES, GO TO UA10.)	0	1	9
b.	the program was complete (IF YES, GO TO UA10.)	0	1	9
c.	[CHILD] showed little improvement? (IF YES, GO TO UA10.)	0	1	9
d.	there were negative experiences with the treatment providers?	0	1	9
e.	[CHILD] was treated unfairly or badly on purpose?	0	1	9
f.	the therapist left or moved away?	0	1	9
g.	[CHILD] felt out of place in the treatment setting?	0	1	9
h.	the policies of agencies hassled you?	0	1	9
i.	there were problems with a lack of time, schedule change or lack of transportation?	0	1	9
j.	you or your child moved?	0	1	9
k.	you couldn't pay for services?	0	1	9
l.	insurance or managed care company limited the treatment?	0	1	9
m.	there were negative reactions of family and friends to treatment?	0	1	9

UA10. Who decided that [CHILD] should leave [PLACE IN UA1A1]? Was it:

	NO	YES
1. Your child's therapist?	0	1
2. You?	0	1
3. [CHILD]?	0	1
4. Someone else? Specify:_____	0	1

A. Did [CHILD] get any mental health services within 30 days after leaving the hospital?
NO GO TO UA11 0
YES..1

B. Were these services arranged by the hospital staff?
NO ...0
YES..1

C. How well did the staff follow-up with [CHILD] after (he/she) left the facility?
Not well 0
Okay.1
Very well 2

UA11. Thinking about this most recent hospitalization:

A. How well do you think the treatment chosen for [CHILD] matched (his/her) needs?

Not well 0
Okay.1
Very well 2

B. How well did the staff explain [CHILD'S] problems and treatments to you?

Not well 0
Okay.1
Very well 2

C. IF R IS PRIMARILY ENGLISH SPEAKING, GO TO UA12.
IF R IS NOT PRIMARILY ENGLISH SPEAKING, CONTINUE.

Did the staff speak to [CHILD] in the language that (he/she) is most comfortable with?

NO ...0
YES..1

D. Did the staff speak to you and your family in the language that you were most comfortable with?

NO ...0
YES..1

UA12. How much has [CHILD] benefited from treatment at [PLACE IN UA1A1] in your opinion?

Not at all 0
Some 1
A lot .2

UA13. IF CHILD STILL IN FACILITY (SV1 COL. D STOP MONTH CODED 00), GO TO INSTRUCTION BOX. What is the total charge for [CHILD'S] most recent stay in [PLACE IN UA1A1]. CODE AND GO TO UA14. IF DK, CONTINUE.

$___ ___ ___ ___ ___

A. Is this because (CODE FIRST YES):

The bill has not come yet? 1
You are unsure?2
The bill (will be/was) paid by another source? 3

UA14. Did you or anyone else in [CHILD'S] household pay anything out of pocket for this most recent stay or visit?

NO .....GO TO UA15 0
YES.....1

A. How much was paid out of pocket? IF DK, GO TO UA14B. OTHERS GO TO UA15.

$___ ___ ___ ___

B. What percent of the bill was paid out of pocket?

___ ___ ___%

UA15. Will you or anyone else in [CHILD'S] household pay anything (more) out of pocket for (his/her) stay in [PLACE IN UA1A1]?

NO .....GO TO UA15C 0
YES..... GO TO UA15A 1

A. How much will your household pay out of pocket for [CHILD'S] stay in [PLACE IN UA1A1]? IF DK, GO TO

$___ ___ ___ ___

UA15B. OTHERS GO TO UA15C.

B. What percent of the bill will be paid out of pocket? ___ ___ ___%

C. IF UA14 OR UA15 = 1, CONTINUE.
Will you be reimbursed for all of these expenses, some of these expenses, or none of these expenses?

NONE 0
SOME 1
ALL 2

UA16. Which other sources will cover the charges?

		NO	YES
a.	Will private insurance?	0	1
b.	Will an HMO or other prepaid plan?	0	1
c.	Will the Veterans Administration (VA)?	0	1
d.	Will welfare or Medicaid?	0	1
e.	Will the Indian Health Service?	0	1
f.	Will the service be provided free of charge?	0	1
g.	Any other sources?	0	1

Specify_____

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE USED, GO TO SECTION FS.

RESPONDENT ID #: ___ ___ ___ ___ ___ ___ ___ ___

INPATIENT SERVICE SETTING:
Psychiatric Unit in a General Hospital

(SECTION UB)
USE IF SV2 COL. C = YES

UB1. During the past 12 months, how many different times was [CHILD] admitted to a psychiatric unit in a general hospital where (he/she) stayed overnight? ADMISSIONS: ___ ___

IF ADMISSION = 02+, ASK A WITH PARENS.

A. What was the name and address of the general hospital [CHILD] was in during the past 12 months (starting with the most recent)?

HOSPITAL NAME	ADDRESS CITY, STATE	CODE
#1_____ MOST RECENT	_____	___ ___ ___ ___
#2_____	_____	___ ___ ___ ___
#3_____	_____	___ ___ ___ ___

UB2. How many nights all together has [CHILD] stayed overnight in any psychiatric unit in a general hospital since [DATE 12 MONTHS AGO]? NIGHTS: ___ ___ ___

UB3. What were the most important behavioral or emotional reasons [CHILD] was admitted to [PLACE IN UB1A1]? (IF ANSWER NOT SPECIFIC, ASK: What was there about [CHILD'S] behavior or emotions that caused you to use [PLACE IN UB1A1]?) RECORD UP TO THREE. CODE

#1_____ ___ ___ ___ ___

#2_____ ___ ___ ___ ___

#3_____ ___ ___ ___ ___

UB4. Who referred [CHILD] or told you to take (him/her) to [PLACE IN UB1A1]? CIRCLE CLASSIFICATION OF ALL PERSONS WHO REFERRED CHILD.

[CHILD'S] SCHOOL OR TEACHER 1
FRIEND/NEIGHBOR 2
JUDGE/COURT/POLICE 3
SOCIAL WORKER/
CASE MANAGER 4
PSYCHIATRIST/PSYCHOLOGIST/
COUNSELOR 5
PEDIATRICIAN/FAMILY DOCTOR 6
PRIEST/RABBI/CLERGY 7
NO ONE 8
OTHER: SPECIFY:_____ 9

UB5. Now I am going to read a list of the types of treatments, services, and counseling programs that might be provided in a psychiatric unit in a general hospital. We realize that you may not know whether [CHILD] received some of these. In those cases, it is fine to say you don't know. In the most recent admission, did [CHILD]:

	NO	YES	DK
a. Receive therapy or counseling?	0	1	9
b. Have case management or a contact person who coordinated (his/her) services?	0	1	9
c. Receive medications?	0	1	9
d. Receive evaluations or testing?	0	1	9
Did you or your family receive:			
e. Counseling, training or education in how to deal with [CHILD]?	0	1	9
f. Counseling or therapy for your relationships with other family members?	0	1	9
g. Counseling or therapy for <u>your</u> own problems, worries, or stresses?	0	1	9
h. Help with rent, money, food, clothing, or shelter?	0	1	9
i. Any other service? Specify:_____	0	1	9

UB6. A. How many days were there between the time the hospital was first contacted about [CHILD'S] problem and when (he/she) was admitted? IF 000, GO TO UB7.

DAYS: ___ ___ ___

B. During this waiting period did anyone from the hospital speak with you or [CHILD] to determine (his/her) need for services?

NO ...0
YES..1

UB7. Was a set of treatment goals outlined at the start of [CHILD's] treatment?

NO ...0
YES..1

UB8. Who was the person in charge of [CHILD'S] treatment at [PLACE IN UB1A1]?

NAME:_____

UB9. IF SV2 COL. D STOP MONTH CODED 00, GO TO UB11. You mentioned that [CHILD] is no longer in a psychiatric unit. Is this because (READ ALL AND CODE):

	NO	YES	DK
a. [CHILD] improved? (IF YES, GO TO UB10.)	0	1	9
b. the program was complete (IF YES, GO TO UB10.)	0	1	9
c. [CHILD] showed little improvement? (IF YES, GO TO UB10.)	0	1	9
d. there were negative experiences with the treatment providers?	0	1	9
e. [CHILD] was treated unfairly or badly on purpose?	0	1	9
f. the therapist left or moved away?	0	1	9
g. [CHILD] felt out of place in the treatment setting?	0	1	9
h. the policies of agencies hassled you?	0	1	9
i. there were problems with a lack of time, schedule change or lack of transportation?	0	1	9
j. you or your child moved?	0	1	9
k. you couldn't pay for services?	0	1	9
l. insurance or managed care company limited the treatment?	0	1	9
m. there were negative reactions of family and friends to treatment?	0	1	9

UB10. Who decided that [CHILD] should leave [PLACE IN UB1A1]? Was it:

	NO	YES
1. Your child's therapist?	0	1
2. You?	0	1
3. [CHILD]?	0	1
4. Someone else? Specify:_____	0	1

A. Did [CHILD] get any mental health services within 30 days after leaving the hospital?

NOGO TO UB11 0
YES..1

B. Were these services arranged by the hospital staff?

NO ...0
YES..1

C. How well did the staff follow-up with [CHILD] after (he/she) left the facility?

Not well 0
Okay.1

Very well 2

UB11. Thinking about this most recent hospitalization:

A. How well do you think the treatment chosen for [CHILD] matched (his/her) needs?
Not well 0
Okay.1
Very well 2

B. How well did the staff explain [CHILD'S] problems and treatments to you?
Not well 0
Okay.1
Very well 2

C. IF R IS PRIMARILY ENGLISH SPEAKING, GO TO UB12.
IF R IS NOT PRIMARILY ENGLISH SPEAKING, CONTINUE.

Did the staff speak to [CHILD] in the language that (he/she) is most comfortable with?
NO ...0
YES..1

D. Did the staff speak to you and your family in the language that you were most comfortable with?
NO ...0
YES..1

UB12. How much has [CHILD] benefited from treatment at [PLACE IN UB1A1] in your opinion?
Not at all 0
Some 1
A lot .2

UB13. IF CHILD STILL IN FACILITY (SV2 COL. D STOP MONTH CODED 00), GO TO INSTRUCTION BOX. What is the total charge for [CHILD'S] most recent stay in [PLACE IN UB1A1]. CODE AND GO TO UB14. IF DK, CONTINUE.
$___ ___ ___ ___ ___

A. Is this because (CODE FIRST YES):

The bill has not come yet? 1
You are unsure?2
The bill (will be/was) paid by another source? 3

UB14. Did you or anyone else in [CHILD'S] household pay anything out of pocket for this most recent stay or visit?
NO .....GO TO UB15 0
YES.....1

A. How much was paid out of pocket? IF DK, GO TO UB14B. OTHERS GO TO UB15.
$___ ___ ___ ___

B. What percent of the bill was paid out of pocket?
___ ___ ___%

UB15. Will you or anyone else in [CHILD'S] household pay anything (more) out of pocket for (his/her) stay in [PLACE IN
NO .....GO TO UB15C 0

UB1A1]? YES.....GO TO UB15A 1

A. How much will your household pay out of pocket for [CHILD'S] stay in [PLACE IN UB1A1]? IF DK, GO TO UB15B. OTHERS GO TO UB15C. $___ ___ ___ ___

B. What percent of the bill will be paid out of pocket? ___ ___ ___%

C. IF UB14 OR UB15 = 1, CONTINUE.
Will you be reimbursed for all of these expenses, some of these expenses, or none of these expenses?
NONE 0
SOME 1
ALL 2

UB16. Which other sources will cover the charges?

		NO	YES
a.	Will private insurance?	0	1
b.	Will an HMO or other prepaid plan?	0	1
c.	Will the Veterans Administration (VA)?	0	1
d.	Will welfare or Medicaid?	0	1
e.	Will the Indian Health Service?	0	1
f.	Will the service be provided free of charge?	0	1
g.	Any other sources? Specify_____	0	1

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE USED, GO TO SECTION FS.

RESPONDENT ID #: ___ ___ ___ ___ ___ ___ ___ ___

INPATIENT SERVICE SETTING:
Drug/Alcohol Treatment Unit

(SECTION UC)
USE IF SV3 COL. C = YES

UC1. During the past 12 months, how many different times was [CHILD] admitted to a drug or alcohol treatment unit where (he/she) stayed overnight?

ADMISSIONS: ___ ___

IF ADMISSION = 02+, ASK A WITH PARENS.

A. What was the name and address of the treatment unit [CHILD] was in during the past 12 months (starting with the most recent)?

SETTING NAME	ADDRESS CITY, STATE	CODE
#1_____ MOST RECENT	_____	___ ___ ___ ___
#2_____	_____	___ ___ ___ ___
#3_____	_____	___ ___ ___ ___

UC2. How many nights all together has [CHILD] stayed overnight in any drug or alcohol treatment unit since [DATE 12 MONTHS AGO]?

NIGHTS: ___ ___ ___

UC3. PURPOSELY LEFT BLANK.

UC4. Who referred [CHILD] or told you to take (him/her) to [PLACE IN UC1A1]? CIRCLE CLASSIFICATION OF ALL PERSONS WHO REFERRED CHILD.

[CHILD'S] SCHOOL OR TEACHER 1
FRIEND/NEIGHBOR 2
JUDGE/COURT/POLICE 3
SOCIAL WORKER/ CASE MANAGER 4
PSYCHIATRIST/PSYCHOLOGIST/ COUNSELOR 5
PEDIATRICIAN/FAMILY DOCTOR 6

PRIEST/RABBI/CLERGY 7
NO ONE 8
OTHER: SPECIFY:_____ 9

UC5. Now I am going to read a list of the types of treatments, services, and counseling programs that might be provided in a drug or alcohol treatment unit. We realize that you may not know whether [CHILD] received some of these. In those cases, it is fine to say you don't know. In (his/her) most recent admission to a drug or alcohol treatment unit, did [CHILD]:

	NO	YES	DK
a. Receive therapy or counseling?	0	1	9
b. Have case management or a contact person who coordinated (his/her) services?	0	1	9
c. Receive medications?	0	1	9
d. Receive evaluation or testing?	0	1	9
Did you or your family receive:			
e. Counseling, training or education in how to deal with [CHILD]?	0	1	9
f. Counseling or therapy for your relationships with other family members?	0	1	9
g. Counseling or therapy for <u>your</u> own problems, worries, or stresses?	0	1	9
h. Help with rent, money, food, clothing, or shelter?	0	1	9
i. Any other service? Specify:_____	0	1	9

UC6. A. How many days were there between the time the unit was first contacted about [CHILD'S] problem and when (he/she) was admitted? IF 000, GO TO UC7.

DAYS: ___ ___ ___

B. During this waiting period did anyone from the unit speak with you or [CHILD] to determine (his/her) need for services?

NO 0
YES.....1

UC7. Was a set of treatment goals outlined at the start of [CHILD'S] treatment?

NO 0
YES.....1

UC8. Who was the person in charge of [CHILD'S] treatment at [PLACE IN UC1A1]?

NAME:_____

UC9. IF SV3 COL. D STOP MONTH CODED 00, GO TO UC11. You mentioned that [CHILD] is no longer in the unit. Is this because (READ ALL AND CODE):

	NO	YES	DK
a. [CHILD] improved? (IF YES, GO TO UC10.)	0	1	9
b. the program was complete (IF YES, GO TO UC10.)	0	1	9

c.	[CHILD] showed little improvement? (IF YES, GO TO UC10.)	0	1	9
d.	there were negative experiences with the treatment providers?	0	1	9
e.	[CHILD] was treated unfairly or badly on purpose?	0	1	9
f.	the therapist left or moved away?	0	1	9
g.	[CHILD] felt out of place in the treatment setting?	0	1	9
h.	the policies of agencies hassled you?	0	1	9
i.	there were problems with a lack of time, schedule change or lack of transportation?	0	1	9
j.	you or [CHILD] moved?	0	1	9
k.	you couldn't pay for services?	0	1	9
l.	insurance or managed care company limited the treatment?	0	1	9
m.	there were negative reactions of family and friends to treatment?	0	1	9

UC10. Who decided that [CHILD] should leave [PLACE IN UC1A1]? Was it:

	NO	YES
1. [CHILD'S] therapist?	0	1
2. You?	0	1
3. [CHILD]?	0	1
4. Someone else? Specify:_____	0	1

A. Did [CHILD] get any mental health services within 30 days after leaving the treatment unit?

NOGO TO UC110
YES.....1

B. Were these services arranged by the unit staff?

NO 0
YES.....1

C. How well did the staff follow-up with [CHILD] after (he/she) left the facility?

Not well 0
Okay.....1
Very well.....2

UC11. Thinking about this most recent stay in the drug or alcohol treatment unit:

A. How well do you think the treatment chosen for [CHILD] matched (his/her) needs?

Not very 0
Okay.....1
Very well.....2

B. How well did the staff explain [CHILD'S] problems and

Not well 0

treatments to you?

Okay.....1
Very well.....2

C. IF R IS PRIMARILY ENGLISH SPEAKING, GO TO UC12.
IF R IS NOT PRIMARILY ENGLISH SPEAKING, CONTINUE.

Did the staff speak to [CHILD] in the language that (he/she) is most comfortable with?

NO 0
YES.....1

D. Did the staff speak to you and your family in the language that you were most comfortable with?

NO 0
YES.....1

UC12. How much has [CHILD] benefited from treatment at [PLACE IN UC1A1] in your opinion?

Not at all 0
Some 1
A lot 2

UC13. IF CHILD STILL IN FACILITY (SV3 COL. D STOP MONTH CODED 00), GO TO INSTRUCTION BOX. What is the total charge for [CHILD'S] most recent stay in [PLACE IN UC1A1]. CODE AND GO TO UC14. IF DK, CONTINUE.

$___ ___ ___ ___ ___

A. Is this because (CODE FIRST YES):

The bill has not come yet? 1
You are unsure? 2
The bill (will be/was) paid by another source? 3

UC14. Did you or anyone else in [CHILD'S] household pay anything out of pocket for this most recent stay or visit?

NO .....GO TO UC15 0
YES.....1

A. How much was paid out of pocket? IF DK, GO TO UC14B. OTHERS GO TO UC15.

$___ ___ ___ ___

B. What percent of the bill was paid out of pocket?

___ ___ ___%

UC15. Will you or anyone else in [CHILD'S] household pay anything (more) out of pocket for (his/her) stay in [PLACE IN UC1A1]?

NO .....GO TO UC15C 0
YES.....GO TO UC15A 1

A. How much will your household pay out of pocket for [CHILD'S] stay in [PLACE IN UC1A1]? IF DK, GO TO UC15B. OTHERS GO TO UC15C.

$___ ___ ___ ___

B. What percent of the bill will be paid out of pocket?

___ ___ ___%

C. IF UC14 OR UC15 = 1, CONTINUE.
Will you be reimbursed for all of these expenses, some of

NONE 0
SOME 1

these expenses, or none of these expenses? ALL 2

UC16. Which other sources will cover the charges?	NO	YES
a. Will private insurance?	0	1
b. Will an HMO or other prepaid plan?	0	1
c. Will the Veterans Administration (VA)?	0	1
d. Will welfare or Medicaid?	0	1
e. Will he Indian Health Service?	0	1
f. Will the service be provided free of charge?	0	1
g. Any other sources? Specify_____	0	1

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE USED, GO TO SECTION FS.

RESPONDENT ID #: ___ ___ ___ ___ ___ ___ ___ ___

INPATIENT SERVICE SETTING:
Residential Treatment Center

(SECTION UD)
USE IF SV4 COL. C = YES

UD1. During the past 12 months, how many different times was [CHILD] admitted to a residential treatment center where (he/she) stayed overnight? ADMISSIONS: ___ ___

IF ADMISSION = 02+, ASK A WITH PARENS.

A. What was the name and address of the residential treatment center [CHILD] was in during the past 12 months (starting with the most recent)?

	HOSPITAL NAME	ADDRESS CITY, STATE	CODE
#1	_____ MOST RECENT	_____	___ ___ ___ ___
#2	_____	_____	___ ___ ___ ___
#3	_____	_____	___ ___ ___ ___

UD2. How many nights all together has [CHILD] stayed overnight in any residential treatment center since [DATE 12 MONTHS AGO]? NIGHTS: ___ ___ ___

UD3. What were the most important behavioral or emotional reasons [CHILD] was admitted to [PLACE IN UD1A1]? (IF ANSWER NOT SPECIFIC, ASK: What was there about [CHILD'S] behavior or emotions that caused you to use [PLACE IN UD1A1]?) RECORD UP TO THREE.

		CODE
#1	_____	___ ___ ___ ___
#2	_____	___ ___ ___ ___

#3_____ ___ ___ ___ ___

UD4. Who referred [CHILD] or told you to take (him/her) to [PLACE IN UD1A1]? CIRCLE CLASSIFICATION OF ALL PERSONS WHO REFERRED CHILD.

[CHILD'S] SCHOOL OR TEACHER 1
FRIEND/NEIGHBOR 2
JUDGE/COURT/POLICE 3
SOCIAL WORKER/ CASE MANAGER 4
PSYCHIATRIST/PSYCHOLOGIST/ COUNSELOR 5
PEDIATRICIAN/FAMILY DOCTOR 6
PRIEST/RABBI/CLERGY 7
NO ONE 8
OTHER: SPECIFY:_____ 9

UD5. Now I am going to read a list of the types of treatments, services, and counseling programs that might be provided in a residential treatment center. We realize that you may not know whether [CHILD] received some of these. In those cases, it is fine to say you don't know. In (his/her) most recent admission to a residential treatment center, did [CHILD]:

	NO	YES	DK
a. Receive therapy or counseling?	0	1	9
b. Have case management or a contact person who coordinated (his/her) services?	0	1	9
c. Receive medications?	0	1	9
d. Receive evaluations or testing?	0	1	9
Did you or your family receive:			
e. Counseling, training or education in how to deal with [CHILD]?	0	1	9
f. Counseling or therapy for your relationships with other family members?	0	1	9
g. Counseling or therapy for <u>your</u> own problems, worries, or stresses?	0	1	9
h. Help with rent, money, food, clothing, or shelter?	0	1	9
i. Any other service? Specify:_____	0	1	9

UD6. A. How many days were there between the time the hospital was first contacted about [CHILD'S] problem and when (he/she) was admitted? IF 000, GO TO UD7.

DAYS: ___ ___ ___

B. During this waiting period did anyone from the hospital speak with you or [CHILD] to determine (his/her) need for services?

NO ...0
YES..1

UD7. Was a set of treatment goals outlined at the start of [CHILD's] treatment?

NO ...0
YES..1

UD8. Who was the person in charge of [CHILD'S] treatment at [PLACE IN UD1A1]?

NAME:_____

UD9. IF SV4 COL. D STOP MONTH CODED 00, GO TO UD11. You mentioned that [CHILD] is no longer in the residential treatment center. Is this because (READ ALL AND CODE):

	NO	YES	DK
a. [CHILD] improved? (IF YES, GO TO UD10.)	0	1	9
b. the program was complete (IF YES, GO TO UD10.)	0	1	9
c. [CHILD] showed little improvement? (IF YES, GO TO UD10.)	0	1	9
d. there were negative experiences with the treatment providers?	0	1	9
e. [CHILD] was treated unfairly or badly on purpose?	0	1	9
f. the therapist left or moved away?	0	1	9
g. [CHILD] felt out of place in the treatment setting?	0	1	9
h. the policies of agencies hassled you?	0	1	9
i. there were problems with a lack of time, schedule change or lack of transportation?	0	1	9
j. you or your child moved?	0	1	9
k. you couldn't pay for services?	0	1	9
l. insurance or managed care company limited the treatment?	0	1	9
m. there were negative reactions of family and friends to treatment?	0	1	9

UD10. Who decided that [CHILD] should leave [PLACE IN UD1A1]? Was it:

	NO	YES
1. Your child's therapist?	0	1
2. You?	0	1
3. [CHILD]?	0	1
4. Someone else? Specify:_____	0	1

A. Did [CHILD] get any mental health services within 30 days after leaving the residential treatment center?

NOGO TO UD11 0
YES..1

B. Were these services arranged by the center staff?

NO ...0
YES..1

C. How well did the staff follow-up with [CHILD] after (he/she) left the facility?

Not well 0
Okay.1

Very well 2

UD11. Thinking about this most recent stay in the residential treatment center:

A. How well do you think the treatment chosen for [CHILD] matched (his/her) needs?
Not well 0
Okay.1
Very well 2

B. How well did the staff explain [CHILD'S] problems and treatments to you?
Not well 0
Okay.1
Very well 2

C. IF R IS PRIMARILY ENGLISH SPEAKING, GO TO UD12.
IF R IS NOT PRIMARILY ENGLISH SPEAKING, CONTINUE.

Did the staff speak to [CHILD] in the language that (he/she) is most comfortable with?
NO ...0
YES..1

D. Did the staff speak to you and your family in the language that you were most comfortable with?
NO ...0
YES..1

UD12. How much has [CHILD] benefited from treatment at [PLACE IN UD1A1] in your opinion?
Not at all 0
Some 1
A lot .2

UD13. IF CHILD STILL IN FACILITY (SV4 COL. D STOP MONTH CODED 00), GO TO INSTRUCTION BOX. What is the total charge for [CHILD'S] most recent stay in [PLACE IN UD1A1]. CODE AND GO TO UD14. IF DK, CONTINUE.
$___ ___ ___ ___ ___

A. Is this because (CODE FIRST YES):

The bill has not come yet? 1
You are unsure? 2
The bill (will be/was) paid by another source? 3

UD14. Did you or anyone else in [CHILD'S] household pay anything out of pocket for this most recent stay or visit?
NO .....GO TO UD15 0
YES.....1

A. How much was paid out of pocket? IF DK, GO TO UD14B. OTHERS GO TO UD15.
$___ ___ ___ ___

B. What percent of the bill was paid out of pocket?
___ ___ ___%

UD15. Will you or anyone else in [CHILD'S] household pay anything
NO .....GO TO UD15C 0

(more) out of pocket for (his/her) stay in [PLACE IN UD1A1]?

YES..... GO TO UD15A 1

A. How much will your household pay out of pocket for [CHILD'S] stay in [PLACE IN UD1A1]? IF DK, GO TO UD15B. OTHERS GO TO UD15C.

$___ ___ ___ ___

B. What percent of the bill will be paid out of pocket?

___ ___ ___%

C. IF UD14 OR UD15 = 1, CONTINUE.

NONE 0
SOME 1
ALL 2

Will you be reimbursed for all of these expenses, some of these expenses, or none of these expenses?

UD16. Which other sources will cover the charges?

		NO	YES
a.	Will private insurance?	0	1
b.	Will an HMO or other prepaid plan?	0	1
c.	Will the Veterans Administration (VA)?	0	1
d.	Will welfare or Medicaid?	0	1
e.	Will the Indian Health Service?	0	1
f.	Will the service be provided free of charge?	0	1
g.	Any other sources? Specify_____	0	1

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE USED, GO TO SECTION FS.

RESPONDENT ID #: ___ ___ ___ ___ ___ ___ ___ ___

INPATIENT SERVICE SETTING:
Group Home

(SECTION UE)
USE IF SV5 COL. C = YES

UE1. During the past 12 months, how many different times was [CHILD] admitted to a group home where (he/she) stayed overnight?

ADMISSIONS: ___ ___

IF ADMISSION = 02+, ASK A WITH PARENS.

A. What was the name and address of the group home [CHILD] was in during the past 12 months (starting with the most recent)?

HOSPITAL NAME	ADDRESS CITY, STATE	CODE
#1_____ MOST RECENT	_____	___ ___ ___ ___
	_____	
#2_____	_____	___ ___ ___ ___
	_____	
#3_____	_____	___ ___ ___ ___
	_____	

UE2. How many nights all together has [CHILD] stayed overnight in any group home since [DATE 12 MONTHS AGO]?

NIGHTS: ___ ___ ___

UE3. What were the most important behavioral or emotional reasons [CHILD] was admitted to [PLACE IN UE1A1]? (IF ANSWER NOT SPECIFIC, ASK: What was there about [CHILD'S] behavior or emotions that caused you to use [PLACE IN UE1A1]?) RECORD UP TO THREE.

CODE

#1_____ ___ ___ ___ ___

#2_____ ___ ___ ___ ___

#3_____ ___ ___ ___ ___

UE4. Who referred [CHILD] or told you to take (him/her) to [PLACE IN UE1A1]? CIRCLE CLASSIFICATION OF ALL PERSONS WHO REFERRED CHILD.

[CHILD'S] SCHOOL OR TEACHER 1
FRIEND/NEIGHBOR 2
JUEGE/COURT/POLICE 3
SOCIAL WORKER/
CASE MANAGER 4
PSYCHIATRIST/PSYCHOLOGIST/
COUNSELOR 5
PEDIATRICIAN/FAMILY DOCTOR 6
PRIEST/RABBI/CLERGY 7
NO ONE 8
OTHER: SPECIFY:_____ 9

UE5. Now I am going to read a list of the types of treatments, services, and counseling programs that might be provided in a group home. We realize that you may not know whether [CHILD] received some of these. In those cases, it is fine to say you don't know. In (his/her) most recent admission to a group home, did [CHILD]:

	NO	YES	DK
a. Receive therapy or counseling?	0	1	9
b. Have case management or a contact person who coordinated (his/her) services?	0	1	9
c. Receive medications?	0	1	9
d. Receive evaluations or testing?	0	1	9
Did you or your family receive:			
e. Counseling, training or education in how to deal with [CHILD]?	0	1	9
f. Counseling or therapy for your relationships with other family members?	0	1	9
g. Counseling or therapy for <u>your</u> own problems, worries, or stresses?	0	1	9
h. Help with rent, money, food, clothing, or shelter?	0	1	9
i. Any other service? Specify:_____	0	1	9

UE6. A. How many days were there between the time the hospital was first contacted about [CHILD'S] problem and when (he/she) was admitted? IF 000, GO TO UE7.

DAYS: ___ ___ ___

B. During this waiting period did anyone from the hospital speak with you or [CHILD] to determine (his/her) need for services?

NO ...0
YES..1

UE7. Was a set of treatment goals outlined at the start of [CHILD's]

NO ...0

treatment? YES..1

UE8. Who was the person in charge of [CHILD'S] treatment at [PLACE IN UE1A1]? NAME:_____

UE9. IF SV5 COL. D STOP MONTH CODED 00, GO TO UE11.
You mentioned that [CHILD] is no longer in the group home.
Is this because (READ ALL AND CODE):

		NO	YES	DK
a.	[CHILD] improved? (IF YES, GO TO UE10.)	0	1	9
b.	the program was complete (IF YES, GO TO UE10.)	0	1	9
c.	[CHILD] showed little improvement? (IF YES, GO TO UE10.)	0	1	9
d.	there were negative experiences with the treatment providers?	0	1	9
e.	[CHILD] was treated unfairly or badly on purpose?	0	1	9
f.	the therapist left or moved away?	0	1	9
g.	[CHILD] felt out of place in the treatment setting?	0	1	9
h.	the policies of agencies hassled you?	0	1	9
i.	there were problems with a lack of time, schedule change or lack of transportation?	0	1	9
j.	you or your child moved?	0	1	9
k.	you couldn't pay for services?	0	1	9
l.	insurance or managed care company limited the treatment?	0	1	9
m.	there were negative reactions of family and friends to treatment?	0	1	9

UE10. Who decided that [CHILD] should leave [PLACE IN UE1A1]? Was it:

	NO	YES
1. Your child's therapist?	0	1
2. You?	0	1
3. [CHILD]?	0	1
4. Someone else? Specify:_____	0	1

A. Did [CHILD] get any mental health services within 30 days after leaving the group home? NOGO TO UE11 0
YES..1

B. Were these services arranged by the center staff? NO ...0
YES..1

C. How well did the staff follow-up with [CHILD] after (he/she) left the facility?

Not well 0
Okay.1
Very well 2

UE11. Thinking about this most recent stay in the group home:

A. How well do you think the treatment chosen for [CHILD] matched (his/her) needs?
Not well 0
Okay.1
Very well 2

B. How well did the staff explain [CHILD'S] problems and treatments to you?
Not well 0
Okay.1
Very well 2

C. IF R IS PRIMARILY ENGLISH SPEAKING, GO TO UE12.
IF R IS NOT PRIMARILY ENGLISH SPEAKING, CONTINUE.

Did the staff speak to [CHILD] in the language that (he/she) is most comfortable with?
NO ...0
YES..1

D. Did the staff speak to you and your family in the language that you were most comfortable with?
NO ...0
YES..1

UE12. How much has [CHILD] benefited from treatment at [PLACE IN UE1A1] in your opinion?
Not at all 0
Some 1
A lot .2

UE13. IF CHILD STILL IN FACILITY (SV5 COL. D STOP MONTH CODED 00), GO TO INSTRUCTION BOX. What is the total charge for [CHILD'S] most recent stay in [PLACE IN UE1A1]. CODE AND GO TO UE14. IF DK, CONTINUE.
$___ ___ ___ ___ ___

A. Is this because (CODE FIRST YES):

The bill has not come yet? 1
You are unsure? 2
The bill (will be/was) paid by another source? 3

UE14. Did you or anyone else in [CHILD'S] household pay anything out of pocket for this most recent stay or visit?
NO ..... GO TO UE15.....0
YES.....1

A. How much was paid out of pocket? IF DK, GO TO UE14B. OTHERS GO TO UE15.
$___ ___ ___ ___

B. What percent of the bill was paid out of pocket?
___ ___ ___%

UE15. Will you or anyone else in [CHILD'S] household pay anything (more) out of pocket for (his/her) stay in [PLACE IN UE1A1]?
NO .....GO TO UE15C 0
YES.....GO TO UE15A 1

A. How much will your household pay out of pocket for [CHILD'S] stay in [PLACE IN UE1A1]? IF DK, GO TO UE15B. OTHERS GO TO UE15C. $___ ___ ___ ___

B. What percent of the bill will be paid out of pocket? ___ ___ ___%

C. IF UE14 OR UE15 = 1, CONTINUE.
Will you be reimbursed for all of these expenses, some of these expenses, or none of these expenses?

NONE 0
SOME 1
ALL 2

UE16. Which other sources will cover the charges?

	NO	YES
a. Will private insurance?	0	1
b. Will an HMO or other prepaid plan?	0	1
c. Will the Veterans Administration (VA)?	0	1
d. Will welfare or Medicaid?	0	1
e. Will the Indian Health Service?	0	1
f. Will the service be provided free of charge?	0	1
g. Any other sources? Specify_____	0	1

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE USED, GO TO SECTION FS.

RESPONDENT ID #: ___ ___ ___ ___ ___ ___ ___ ___

INPATIENT SERVICE SETTING: Foster Home

(SECTION UF)
USE IF SV6 COL. C = YES

UF1. During the past 12 months, how many different times was [CHILD] placed in a foster home where (he/she) stayed overnight?

ADMISSIONS: ___ ___

UF2. How many nights has [CHILD] stayed overnight in a foster home in the past 12 months?

NIGHTS: ___ ___ ___

A. (Was/Is) the foster parent a relative?

NO 0
YES.....1

B. (Did/Does) the foster parent have any special training to help children with behavioral, emotional, drug or alcohol problems?

NO 0
YES.....1

UF3. What were the reasons [CHILD] was placed in the (most recent) foster home in the past 12 months? RECORD UP TO THREE.

	CODE
#1_____	___ ___ ___ ___
#2_____	___ ___ ___ ___
#3_____	___ ___ ___ ___

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE USED, GO TO SECTION FS.

INPATIENT SERVICE SETTING:
Detention Center or Training School

(SECTION UG)
USE IF SV7 COL. C = YES

UG1. During the past 12 months, how many different times was [CHILD] admitted to a Detention Center or Training School where (he/she) stayed overnight?

ADMISSIONS: ___ ___

UG2. How many nights has [CHILD] stayed in a Detention Center or Training School during the past 12 months?

NIGHTS: ___ ___ ___

UG3. What were the reasons [CHILD] was admitted to the (most recent) Detention Center or Training School in the past 12 months? RECORD UP TO THREE.

	CODE
#1_____	___ ___ ___ ___
#2_____	___ ___ ___ ___
#3_____	___ ___ ___ ___

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE USED, GO TO SECTION FS.

RESPONDENT ID #: ___ ___ ___ ___ ___ ___ ___

INPATIENT SERVICE SETTING:
Prison or Jail

(SECTION UH)
USE IF SV8 COL. C = YES

UH1. During the past 12 months, how many different times was [CHILD] placed in a Prison or Jail where (he/she) stayed overnight? ADMISSIONS: ___ ___

UH2. How many nights all together has [CHILD] stayed in a Prison or Jail during the past 12 months? NIGHTS: ___ ___ ___

UH3. Why was [CHILD] placed in the (most recent) Prison or Jail in the past 12 months? RECORD UP TO THREE.

	CODE
#1_____	___ ___ ___ ___
#2_____	___ ___ ___ ___
#3_____	___ ___ ___ ___

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE USED, GO TO SECTION FS.

INPATIENT SERVICE SETTING:
Summer Treatment Program

(SECTION UZ)
USE IF SV9 COL. C = YES

UZ1. During the past 12 months, how many different times was [CHILD] admitted to a Summer Treatment Program where (he/she) stayed overnight? ADMISSIONS: ___ ___

UZ2. How many nights has [CHILD] stayed in a Summer Treatment Program during the past 12 months? NIGHTS: ___ ___ ___

UZ3. What were the reasons [CHILD] was admitted to the (most recent) Summer Treatment Program in the past 12 months? RECORD UP TO THREE.

	CODE
#1_____	___ ___ ___ ___
#2_____	___ ___ ___ ___
#3_____	___ ___ ___ ___

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE USED, GO TO SECTION FS.

RESPONDENT ID #: ___ ___ ___ ___ ___ ___ ___ ___

INPATIENT SERVICE SETTING:
Inpatient Medical or Pediatric Unit

(SECTION UK)
USE IF SV10 COL. C = YES

UK1. During the past 12 months, how many different times was [CHILD] admitted to an inpatient medical or pediatric unit for emotional, behavioral, or alcohol or drug problems where (he/she) stayed overnight? ADMISSIONS: ___ ___

IF ADMISSION = 01, ASK A WITHOUT PARENS.

UK2. What were the names and addresses of the inpatient medical or pediatric units (he/she) was in during the past 12 months for these kinds of problems (starting with the most recent)?

SETTING NAME	ADDRESS CITY, STATE	CODE
#1_____ MOST RECENT	_____	___ ___ ___ ___
#2_____	_____	___ ___ ___ ___
#3_____	_____	___ ___ ___ ___

UK3. How many nights has [CHILD] stayed in an inpatient medical or pediatric unit for emotional, behavioral, or alcohol or drug problems during the past 12 months? NIGHTS: ___ ___ ___

UK4. What were the most important behavioral or emotional reasons [CHILD] was admitted to [PLACE IN UK1A1] in the past 12 months? RECORD UP TO THREE.

	CODE
#1_____	___ ___ ___ ___
#2_____	___ ___ ___ ___
#3_____	___ ___ ___ ___

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE USED, GO TO SECTION FS.

INPATIENT SERVICE SETTING:
Emergency Shelter

(SECTION UL)
USE IF SV11 COL. C = YES

UL1. During the past 12 months, how many different times was [CHILD] admitted to an Emergency Shelter because of emotional, behavioral, or alcohol or drug problems where (he/she) stayed overnight?

ADMISSIONS: ___ ___

UL2. How many nights has [CHILD] stayed in an Emergency Shelter because of these problems during the past 12 months?

NIGHTS: ___ ___ ___

UL3. What were the reasons [CHILD] was admitted to the (most recent) Emergency Shelter in the past 12 months? RECORD UP TO THREE.

	CODE
#1_____	___ ___ ___ ___
#2_____	___ ___ ___ ___
#3_____	___ ___ ___ ___

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE USED, GO TO SECTION FS.

INPATIENT SERVICE SETTING:
Boarding School

(SECTION UM)
USE IF SV12 COL. C = YES

UM1. During the past 12 months, how many different times was [CHILD] admitted to a Boarding School for emotional, behavioral, or alcohol or drug problems where (he/she) stayed overnight?

ADMISSIONS: ___ ___

UM2. How many nights has [CHILD] stayed in a Boarding School for these kinds of problems during the past 12 months?

NIGHTS: ___ ___ ___

UM3. What were the reasons [CHILD] was admitted to the (most recent) Boarding School in the past 12 months? RECORD UP TO THREE.

	CODE
#1_____	___ ___ ___ ___
#2_____	___ ___ ___ ___
#3_____	___ ___ ___ ___

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE USED, GO TO SECTION FS.

RESPONDENT ID #: ___ ___ ___ ___ ___ ___ ___

OUTPATIENT SERVICE SETTING: Community Mental Health Center or Other Mental Health Center

(SECTION VA)
USE SV13 COL. C = YES

VA1. During the past 12 months, how many visits for services did [CHILD] have to a mental health center or clinic? IF DK, CODE 999.

TIMES ___ ___ ___

VA2. Has [CHILD] gone to more than one mental health center or clinic the past 12 months?

NO 0
YES.....1

A. What was the name and address of the mental health center or clinic (he/she) was in during the past 12 months (starting with the most recent)?

	NAME	ADDRESS CITY, STATE	CODE
#1 MOST RECENT	_____	_____	___ ___ ___ ___
		_____	
#2	_____	_____	___ ___ ___ ___
		_____	
#3	_____	_____	___ ___ ___ ___
		_____	

IF ONLY ONE MENTAL HEALTH CENTER, GO TO VA3.

B. How many visits did [CHILD] make to [PLACE IN VA2A1]?

VISITS: ___ ___

VA3. What were the most important behavioral or emotional reasons [CHILD] went to [PLACE IN VA2A1]? (IF ANSWER NOT SPECIFIC, ASK: What was there about [CHILD'S] behavior or emotions that caused you to use [PLACE IN VA2A1]?) RECORD UP TO THREE.

CODE

#1_____ ___ ___ ___ ___

#2_____ ___ ___ ___ ___

#3_____ ___ ___ ___ ___

VA4. Who referred [CHILD] or told you to take (him/her) to [PLACE IN VA2A1]? CIRCLE ALL THAT APPLY.

[CHILD'S] SCHOOL OR TEACHER 1
FRIEND/NEIGHBOR 2
JUDGE/COURT/POLICE 3
SOCIAL WORKER/
CASE MANAGER 4
PSYCHIATRIST/PSYCHOLOGIST/
COUNSELOR 5
PEDIATRICIAN/FAMILY DOCTOR 6
PRIEST/RABBI/CLERGY 7
NO ONE 8
OTHER: SPECIFY:_____ 9

VA5. Now I am going to read a list of the types of treatments, services, and counseling programs that might be provided in a mental health center. We realize that you may not know whether [CHILD] received some of these. In those cases, it is fine to say you don't know. At [PLACE IN VA2A1], did (he/she):

		NO	YES	DK
a.	Receive therapy or counseling?	0	1	9
b.	Have case management or a contact person who coordinated (his/her) services?	0	1	9
c.	Receive a prescription for medications?	0	1	9
d.	Receive evaluation or testing?	0	1	9
	Did you or your family receive:			
e.	Counseling, training or education in how to deal with [CHILD]?	0	1	9
f.	Counseling or therapy for your relationships with other family members?	0	1	9
g.	Counseling or therapy for your own problems, worries, or stresses?	0	1	9
h.	Help with rent, money, food, clothing, or shelter?	0	1	9
i.	Any other service? Specify:_____	0	1	9

VA6. A. How many days were there between the time [PLACE IN VA2A1] was first contacted about [CHILD'S] problem and when (he/she) was seen? IF 000, GO TO VA7.

DAYS: ___ ___ ___

B. During this waiting period did anyone speak with you or [CHILD] to determine (his/her) need for services?

NO 0
YES.....1

VA7. Was a set of treatment goals outlined at the start of [CHILD'S] treatment?

NO 0
YES.....1

VA8. Who was the person in charge of [CHILD'S] treatment at

NAME:_____
__

[PLACE IN VA2A1]?

VA9. IF SV13 COL. D STOP MONTH CODED 00, GO TO VA11. OTHERS CONTINUE.
You mentioned that [CHILD] is no longer receiving services from [PLACE IN VA2A1]. Is this because: (READ ALL AND CODE)

		NO	YES	DK
a.	[CHILD] improved? (IF YES, GO TO VA10.)	0	1	9
b.	the program was complete (IF YES, GO TO VA10.)	0	1	9
c.	[CHILD] showed little improvement? (IF YES, GO TO VA10.)	0	1	9
d.	there were negative experiences with the treatment providers?	0	1	9
e.	[CHILD] was treated unfairly or badly on purpose?	0	1	9
f.	the therapist left or moved away?	0	1	9
g.	[CHILD] felt out of place in the treatment setting?	0	1	9
h.	the policies of agencies hassled you?	0	1	9
i.	there were problems with a lack of time, schedule change or lack of transportation?	0	1	9
j.	you or [CHILD] moved?	0	1	9
k.	you couldn't pay for services?	0	1	9
l.	insurance or managed care company limited the treatment?	0	1	9
m.	there were negative reactions of family and friends to treatment?	0	1	9

VA10. Who decided that treatment should end? Was it:

	NO	YES
1. [CHILD'S] therapist?	0	1
2. You?	0	1
3. [CHILD]?	0	1
4. Someone else? Specify:_____	0	1

A. Did [CHILD] get any mental health services within 30 days after leaving the treatment center?
NOGO TO VA110
YES.....1

B. Were these services arranged by the center staff?
NO 0
YES.....1

C. How well did the staff follow-up with [CHILD] after (he/she) left the center?
Not well 0
Somewhat.....1
Very well.....2

VA11. Thinking about this most recent treatment:

A. How well do you think the treatment chosen for [CHILD] matched (his/her) needs?
Not well 0
Somewhat.....1
Very well.....2

B. How well did the staff explain [CHILD'S] problems and treatments to you?
Not well 0
Somewhat.....1
Very well.....2

C. IF R IS PRIMARILY ENGLISH SPEAKING, GO TO VA12.
IF R IS NOT PRIMARILY ENGLISH SPEAKING, CONTINUE.

Did the staff speak to [CHILD] in the language that (he/she) is most comfortable with?
NO 0
YES.....1

D. Did the staff speak to you and your family in the language that you were most comfortable with?
NO 0
YES.....1

VA12. How much has [CHILD] benefited from treatment at [PLACE IN VA2A1] in your opinion?
Not at all 0
Some 1
A lot 2

VA13. I want to ask you some questions about the most recent visit [CHILD] made to [PLACE IN Q2A1].

A. Who took [CHILD] the last time?

	NO	YES
1. You	0	1
2. Spouse/partner	0	1
3. Other adult in [CHILD'S] household	0	1
4. Other:_____	0	1

B. About how long did it take to travel one way to [PLACE IN VA2A1]?
MINUTES: ___ ___ ___

C. On the average, how long did an appointment take from the time you arrived until the time you left [PLACE IN VA2A1]?
MINUTES: ___ ___ ___

VA14. IF CHILD STILL IN FACILITY, SV13 COL. D STOP MONTH CODED 00, GO TO INSTRUCTION BOX. What is the total charge for [CHILD'S] most recent visit to [PLACE IN VA2A1]. CODE AND GO TO VA15. IF DK, CONTINUE.

$___ ___ ___ ___ ___

A. Is this because (CODE FIRST YES):

The bill has not come yet? 1
You are unsure?2
The bill (will be/was) paid by another source? 3

VA15. Did you or anyone else in [CHILD'S] household pay anything out of pocket for this most recent visit?

NO .....GO TO VA16 0
YES.....1

A. How much was paid out of pocket? IF DK, GO TO VA15B. OTHERS GO TO VA16.

$___ ___ ___ ___

B. What percent of the bill was paid out of pocket?

___ ___ ___%

VA16. Will you or anyone else in [CHILD'S] household pay anything (more) out of pocket for (his/her) visit to [PLACE IN VA2A1]?

NO .....GO TO VA16C 0
YES..... GO TO VA16A 1

A. How much will your household pay out of pocket for [CHILD'S] visit to [PLACE IN VA2A1]? IF DK, GO TO VA16B. OTHERS GO TO VA16C.

$___ ___ ___ ___

B. What percent of the bill will be paid out of pocket?

___ ___ ___%

C. IF VA15 OR VA16 = 1, CONTINUE. OTHERS GO TO VA17.
Will you be reimbursed for all of these expenses, some of these expenses, or none of these expenses?

NONE 0
SOME 1
ALL 2

VA17. Which sources cover the charges?

		NO	YES
a.	Will private insurance?	0	1
b.	Will an HMO or other prepaid plan?	0	1
c.	Will the Veterans Administration (VA)?	0	1
d.	Will welfare or Medicaid?	0	1
e.	Will the Indian Health Service?	0	1
f.	Will the service be provided free of charge?	0	1
g.	Any other sources? Specify_____	0	1

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE

USED, GO TO SECTION FS.

RESPONDENT ID #: ___ ___ ___ ___ ___ ___ ___

OUTPATIENT SERVICE SETTING:
Partial Hospitalization/Day Treatment Program

(SECTION VB)
USE SV14 COL. C = YES

VB1. During the past 12 months, how many visits for services did [CHILD] have to a partial hospitalization/day treatment program? IF DK, CODE 999.

TIMES ___ ___ ___

VB2. Has [CHILD] gone to more than one partial hospitalization/day treatment program the past 12 months?

NO 0
YES.....1

A. What was the name and address of the partial hospitalization/day treatment program (he/she) was in during the past 12 months (starting with the most recent)?

	NAME	ADDRESS CITY, STATE	CODE
#1 MOST RECENT	_____	_____ _____	___ ___ ___ ___
#2	_____	_____ _____	___ ___ ___ ___
#3	_____	_____ _____	___ ___ ___ ___

IF ONLY ONE PARTIAL HOSPITALIZATION/DAY TREATMENT PROGRAM, GO TO VB3.

B. How many visits did [CHILD] make to [PLACE IN VB2A1]?

VISITS: ___ ___

VB3. What were the most important behavioral or emotional reasons [CHILD] went to [PLACE IN VB2A1]? (IF ANSWER NOT SPECIFIC, ASK: What was there about [CHILD'S] behavior or emotions that caused you to use [PLACE IN VB2A1]?) RECORD UP TO THREE.

		CODE
#1	_____	___ ___ ___ ___
#2	_____	___ ___ ___ ___
#3	_____	___ ___ ___ ___

VB4. Who referred [CHILD] or told you to take (him/her) to [PLACE IN VB2A1]? CIRCLE ALL THAT APPLY.

[CHILD'S] SCHOOL OR TEACHER 1
FRIEND/NEIGHBOR 2
JUDGE/COURT/POLICE 3
SOCIAL WORKER/
CASE MANAGER 4
PSYCHIATRIST/PSYCHOLOGIST/
COUNSELOR 5
PEDIATRICIAN/FAMILY DOCTOR 6
PRIEST/RABBI/CLERGY 7
NO ONE 8
OTHER: SPECIFY:_____ 9

VB5. Now I am going to read a list of the types of treatments, services, and counseling programs that might be provided in a partial hospitalization/day treatment program. We realize that you may not know whether [CHILD] received some of these. In those cases, it is fine to say you don't know. At [PLACE IN VB2A1], did (he/she):

		NO	YES	DK
a.	Receive therapy or counseling?	0	1	9
b.	Have case management or a contact person who coordinated (his/her) services?	0	1	9
c.	Receive a prescription for medications?	0	1	9
d.	Receive evaluation or testing?	0	1	9
	Did you or your family receive:			
e.	Counseling, training or education in how to deal with [CHILD]?	0	1	9
f.	Counseling or therapy for your relationships with other family members?	0	1	9
g.	Counseling or therapy for your own problems, worries, or stresses?	0	1	9
h.	Help with rent, money, food, clothing, or shelter?	0	1	9
i.	Any other service? Specify:_____	0	1	9

VB6. A. How many days were there between the time [PLACE IN VB2A1] was first contacted about [CHILD'S] problem and when (he/she) was seen? IF 000, GO TO VB7.

DAYS: ___ ___ ___

B. During this waiting period did anyone speak with you or [CHILD] to determine (his/her) need for services?

NO 0
YES.....1

VB7. Was a set of treatment goals outlined at the start of [CHILD'S] treatment?

NO 0
YES.....1

VB8. Who was the person in charge of [CHILD'S] treatment at

NAME:_____

[PLACE IN VB2A1]? __

VB9. IF SV14 COL. D STOP MONTH CODED 00, GO TO VB11. OTHERS CONTINUE.
You mentioned that [CHILD] is no longer receiving services from [PLACE IN VB2A1]. Is this because: (READ ALL AND CODE)

		NO	YES	DK
a.	[CHILD] improved? (IF YES, GO TO VB10.)	0	1	9
b.	the program was complete (IF YES, GO TO VB10.)	0	1	9
c.	[CHILD] showed little improvement? (IF YES, GO TO VB10.)	0	1	9
d.	there were negative experiences with the treatment providers?	0	1	9
e.	[CHILD] was treated unfairly or badly on purpose?	0	1	9
f.	the therapist left or moved away?	0	1	9
g.	[CHILD] felt out of place in the treatment setting?	0	1	9
h.	the policies of agencies hassled you?	0	1	9
i.	there were problems with a lack of time, schedule change or lack of transportation?	0	1	9
j.	you or [CHILD] moved?	0	1	9
k.	you couldn't pay for services?	0	1	9
l.	insurance or managed care company limited the treatment?	0	1	9
m.	there were negative reactions of family and friends to treatment?	0	1	9

VB10. Who decided that treatment should end? Was it:

	NO	YES
1. [CHILD'S] therapist?	0	1
2. You?	0	1
3. [CHILD]?		0 1
4. Someone else? Specify:_____		0 1

A. Did [CHILD] get any mental health services within 30 days after leaving the partial hospitalization/day treatment program?
NOGO TO VB110
YES.....1

B. Were these services arranged by the program staff?
NO 0
YES.....1

C. How well did the staff follow-up with [CHILD] after (he/she) left the program?
Not well 0
Somewhat.....1
Very well.....2

VB11. Thinking about this most recent treatment:

A. How well do you think the treatment chosen for [CHILD] matched (his/her) needs?
Not well 0
Somewhat.....1
Very well.....2

B. How well did the staff explain [CHILD'S] problems and treatments to you?
Not well 0
Somewhat.....1
Very well.....2

C. IF R IS PRIMARILY ENGLISH SPEAKING, GO TO VB12.
IF R IS NOT PRIMARILY ENGLISH SPEAKING, CONTINUE.

Did the staff speak to [CHILD] in the language that (he/she) is most comfortable with?
NO 0
YES.....1

D. Did the staff speak to you and your family in the language that you were most comfortable with?
NO 0
YES.....1

VB12. How much has [CHILD] benefited from treatment at [PLACE IN VB2A1] in your opinion?
Not at all 0
Some 1
A lot 2

VB13. I want to ask you some questions about the most recent visit [CHILD] made to [PLACE IN Q2A1].

A. Who took [CHILD] the last time?

	NO	YES
1. You	0	1
2. Spouse/partner	0	1
3. Other adult in [CHILD'S] household	0	1
4. Other:_____	0	1

B. About how long did it take to travel one way to [PLACE IN VB2A1]?
MINUTES: ___ ___ ___

C. On the average, how long did an appointment take from the time you arrived until the time you left [PLACE IN VB2A1]?
MINUTES: ___ ___ ___

VB14. IF CHILD STILL IN FACILITY, SV14 COL. D STOP MONTH CODED 00, GO TO INSTRUCTION BOX. What is the total charge for [CHILD'S] most recent visit to [PLACE IN VB2A1]. CODE AND GO TO VB15. IF DK, CONTINUE.

$___ ___ ___ ___ ___

A. Is this because (CODE FIRST YES):

The bill has not come yet? 1
You are unsure?2
The bill (will be/was) paid by another source? 3

VB15. Did you or anyone else in [CHILD'S] household pay anything out of pocket for this most recent visit?

NO .....GO TO VB16 0
YES.....1

A. How much was paid out of pocket? IF DK, GO TO VB15B. OTHERS GO TO VB16.

$___ ___ ___ ___

B. What percent of the bill was paid out of pocket?

___ ___ ___%

VB16. Will you or anyone else in [CHILD'S] household pay anything (more) out of pocket for (his/her) visit to [PLACE IN VB2A1]?

NO .....GO TO VB16C 0
YES.....GO TO VB16A 1

A. How much will your household pay out of pocket for [CHILD'S] visit to [PLACE IN VB2A1]? IF DK, GO TO VB16B. OTHERS GO TO VB16C.

$___ ___ ___ ___

B. What percent of the bill will be paid out of pocket?

___ ___ ___%

C. IF VB15 OR VB16 = 1, CONTINUE. OTHERS GO TO VB17.
Will you be reimbursed for all of these expenses, some of these expenses, or none of these expenses?

NONE 0
SOME 1
ALL 2

VB17. Which sources cover the charges?

		NO	YES
a.	Will private insurance?	0	1
b.	Will an HMO or other prepaid plan?	0	1
c.	Will the Veterans Administration (VA)?	0	1
d.	Will welfare or Medicaid?	0	1
e.	Will the Indian Health Service?	0	1
f.	Will the service be provided free of charge?	0	1
g.	Any other sources? Specify_____	0	1

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE

USED, GO TO SECTION FS.

RESPONDENT ID #: ___ ___ ___ ___ ___ ___ ___

OUTPATIENT SERVICE SETTING:
Drug/Alcohol Clinic

(SECTION VC)
USE SV15 COL. C = YES

VC1. During the past 12 months, how many visits for services did [CHILD] have to a drug/alcohol clinic? IF DK, CODE 999.

TIMES ___ ___ ___

VC2. Has [CHILD] gone to more than one drug/alcohol clinic in the past 12 months?

NO 0
YES.....1

A. What was the name and address of the drug/alcohol clinic (he/she) was in during the past 12 months (starting with the most recent)?

	NAME	ADDRESS CITY, STATE	CODE
#1	_____ MOST RECENT	_____ _____	___ ___ ___ ___
#2	_____	_____ _____	___ ___ ___ ___
#3	_____	_____ _____	___ ___ ___ ___

IF ONLY ONE DRUG/ALCOHOL CLINIC, GO TO VC3.

B. How many visits did [CHILD] make to [PLACE IN VC2A1]?

VISITS: ___ ___

VC3. Who referred [CHILD] or told you to take (him/her) to [PLACE IN VC2A1]? CIRCLE ALL THAT APPLY.

[CHILD'S] SCHOOL OR TEACHER 1
FRIEND/NEIGHBOR 2
JUDGE/COURT/POLICE 3
SOCIAL WORKER/ CASE MANAGER 4
PSYCHIATRIST/PSYCHOLOGIST/ COUNSELOR 5
PEDIATRICIAN/FAMILY DOCTOR 6
PRIEST/RABBI/CLERGY 7
NO ONE 8
OTHER: SPECIFY:_____ 9

VC4. Now I am going to read a list of the types of treatments, services, and counseling programs that might be provided in a drug/alcohol clinic. We realize that you may not know whether [CHILD] received some of these. In those cases, it is fine to say you don't know. At [PLACE IN VC2A1], did (he/she):

		NO	YES	DK
a.	Receive therapy or counseling?	0	1	9
b.	Have case management or a contact person who coordinated (his/her) services?	0	1	9
c.	Receive a prescription for medications?	0	1	9
d.	Receive evaluation or testing?	0	1	9

Did you or your family receive:

e.	Counseling, training or education in how to deal with [CHILD]?	0	1	9
f.	Counseling or therapy for your relationships with other family members?	0	1	9
g.	Counseling or therapy for your own problems, worries, or stresses?	0	1	9
h.	Help with rent, money, food, clothing, or shelter?	0	1	9
i.	Any other service? Specify:_____	0	1	9

VC5. A. How many days were there between the time [PLACE IN VC2A1] was first contacted about [CHILD'S] problem and when (he/she) was seen? IF 000, GO TO VC6. # DAYS: ___ ___ ___

B. During this waiting period did anyone speak with you or [CHILD] to determine (his/her) need for services? NO .....0 YES.....1

VC6. Was a set of treatment goals outlined at the start of [CHILD'S] treatment? NO .....0 YES.....1

VC7. Who was the person in charge of [CHILD'S] treatment at [PLACE IN VC2A1]? NAME:_____ __

VC8. IF SV15 COL. D STOP MONTH CODED 00, GO TO VC10. OTHERS CONTINUE.
You mentioned that [CHILD] is no longer receiving services from [PLACE IN VC2A1]. Is this because: (READ ALL AND CODE)

		NO	YES	DK
a.	[CHILD] improved? (IF YES, GO TO VC9.)	0	1	9
b.	the program was complete (IF YES, GO TO VC9.)	0	1	9
c.	[CHILD] showed little improvement? (IF YES, GO			

	TO VC9.)	0	1	9
d.	there were negative experiences with the treatment providers?	0	1	9
e.	[CHILD] was treated unfairly or badly on purpose?	0	1	9
f.	the therapist left or moved away?	0	1	9
g.	[CHILD] felt out of place in the treatment setting?	0	1	9
h.	the policies of agencies hassled you?	0	1	9
i.	there were problems with a lack of time, schedule change or lack of transportation?	0	1	9
j.	you or [CHILD] moved?	0	1	9
k.	you couldn't pay for services?	0	1	9
l.	insurance or managed care company limited the treatment?	0	1	9
m.	there were negative reactions of family and friends to treatment?	0	1	9

VC9. Who decided that treatment should end? Was it:

	NO	YES
1. [CHILD'S] therapist?	0	1
2. You?	0	1
3. [CHILD]?	0	1
4. Someone else? Specify:_____	0	1

A. Did [CHILD] get any mental health services within 30 days after leaving the drug/alcohol clinic?
NOGO TO VC100
YES.....1

B. Were these services arranged by the program staff?
NO 0
YES.....1

C. How well did the staff follow-up with [CHILD] after (he/she) left the program?
Not well 0
Somewhat.....1
Very well.....2

VC10. Thinking about this most recent treatment:

A. How well do you think the treatment chosen for [CHILD] matched (his/her) needs?
Not well 0
Somewhat.....1
Very well.....2

B. How well did the staff explain [CHILD'S] problems and treatments to you?
Not well 0
Somewhat.....1
Very well.....2

C. IF R IS PRIMARILY ENGLISH SPEAKING, GO TO VC11.

IF R IS NOT PRIMARILY ENGLISH SPEAKING, CONTINUE.

Did the staff speak to [CHILD] in the language that (he/she) is most comfortable with?
NO 0
YES.....1

D. Did the staff speak to you and your family in the language that you were most comfortable with?
NO 0
YES.....1

VC11. How much has [CHILD] benefited from treatment at [PLACE IN VC2A1] in your opinion?
Not at all 0
Some 1
A lot 2

VC12. I want to ask you some questions about the most recent visit [CHILD] made to [PLACE IN Q2A1].

A. Who took [CHILD] the last time?

	NO	YES
1. You	0	1
2. Spouse/partner	0	1
3. Other adult in [CHILD'S] household	0	1
4. Other:_____	0	1

B. About how long did it take to travel one way to [PLACE IN VC2A1]?
MINUTES: ___ ___ ___

C. On the average, how long did an appointment take from the time you arrived until the time you left [PLACE IN VC2A1]?
MINUTES: ___ ___ ___

VC13. IF CHILD STILL IN FACILITY, SV15 COL. D STOP MONTH CODED 00, GO TO INSTRUCTION BOX. What is the total charge for [CHILD'S] most recent visit to [PLACE IN VC2A1]. CODE AND GO TO VC14. IF DK, CONTINUE.

$___ ___ ___ ___ ___

A. Is this because (CODE FIRST YES):

The bill has not come yet? 1
You are unsure?2
The bill (will be/was) paid by another source? 3

VC14. Did you or anyone else in [CHILD'S] household pay anything out of pocket for this most recent visit?

NO .....GO TO VC15 0
YES.....1

A. How much was paid out of pocket? IF DK, GO TO VC14B. OTHERS GO TO VC15.

$___ ___ ___ ___

B. What percent of the bill was paid out of pocket?

___ ___ ___%

VC15. Will you or anyone else in [CHILD'S] household pay anything (more) out of pocket for (his/her) visit to [PLACE IN VC2A1]?

NO .....GO TO VC15C 0
YES.....GO TO VC15A 1

A. How much will your household pay out of pocket for [CHILD'S] visit to [PLACE IN VC2A1]? IF DK, GO TO VC15B. OTHERS GO TO VC15C.

$___ ___ ___ ___

B. What percent of the bill will be paid out of pocket?

___ ___ ___%

C. IF VC14 OR VC15 = 1, CONTINUE. Will you be reimbursed for all of these expenses, some of these expenses, or none of these expenses?

NONE 0
SOME 1
ALL 2

VC16. Which sources cover the charges?

		NO	YES
a.	Will private insurance?	0	1
b.	Will an HMO or other prepaid plan?	0	1
c.	Will the Veterans Administration (VA)?	0	1
d.	Will welfare or Medicaid?	0	1
e.	Will the Indian Health Service?	0	1
f.	Will the service be provided free of charge?	0	1
g.	Any other sources? Specify_____	0	1

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE

USED, GO TO SECTION FS.

RESPONDENT ID #: ___ ___ ___ ___ ___ ___ ___ ___

OUTPATIENT SERVICE SETTING: In-Home Therapist/ Counselor or Family Preservation Worker

(SECTION VD)
USE IF SV16 COL. C = YES

VD1. During the past 12 months, how many visits were made by an in-home therapist/counselor or preservation worker? IF DK, CODE 999. # TIMES: ___ ___ ___

VD2. For each in-home organization that has been involved with [CHILD] the past 12 months, please tell me the name and address of the organization (starting with the most recent).

ORGANIZATION NAME	ADDRESS CITY, STATE	CODE
#1_____ MOST RECENT	_____	___ ___ ___ ___
#2_____	_____	___ ___ ___ ___
#3_____	_____	___ ___ ___ ___

VD3. What were the most important behavioral or emotional reasons [CHILD] was visited by the in-home therapist/counselor or preservation worker most recently? (IF ANSWER NOT SPECIFIC, ASK: What was there about [CHILD'S] behavior or emotions that caused you to use [PLACE IN VD2.1]?) RECORD UP TO THREE. CODE

#1_____ ___ ___ ___ ___

#2_____ ___ ___ ___ ___

#3_____ ___ ___ ___ ___

VD4. Who was [CHILD'S] main counselor or preservation worker at [PLACE IN VD2.1]?

NAME:_____

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS.
IF NO OTHER SERVICE USED, GO TO SECTION FS.

RESPONDENT ID #: ___ ___ ___ ___ ___ ___ ___ ___

OUTPATIENT SERVICE SETTING:
Emergency Room

(SECTION VE)
USE IF V17 COL. C = YES

VE1. During the past 12 months, how many different times did [CHILD] use an emergency room for behavioral, emotional, drug or alcohol problems? TIMES: ___ ___

IF TIMES = 02+, ASK A WITH PARENS.

VE2. What was the name and address of the emergency room (he/she) was in during the past 12 months for these kinds of problems (starting with the most recent)?

ORGANIZATION NAME	ADDRESS CITY, STATE	CODE
#1_____ MOST RECENT	_____	___ ___ ___ ___
#2_____	_____	___ ___ ___ ___
#3_____	_____	___ ___ ___ ___

VE3. What were the most important behavioral or emotional reasons [CHILD] used the emergency room (most recently)? (IF ANSWER NOT SPECIFIC, ASK: What was there about [CHILD'S] behavior or emotions that caused you to use [PLACE IN VE2.1]?) RECORD UP TO THREE. CODE

#1_____ ___ ___ ___ ___

#2_____ ___ ___ ___ ___

#3_____ ___ ___ ___ ___

VE4. I want to ask you some questions about the most recent visit [CHILD] made to

[PLACE IN VE2.1].

A. Who took [CHILD] the last time?

	NO	YES
1. You	0	1
2. Spouse/partner	0	1
3. Other adult in [CHILD'S] household	0	1
4. Other:_____	0	1

B. About how long did it take to travel one way to [PLACE IN VE2.1]? MINUTES: ___ ___ ___

C. On the average, how long did an appointment take from the time you arrived until the time you left [PLACE IN VE2.1]? MINUTES: ___ ___ ___

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE USED, GO TO SECTION FS.

RESPONDENT ID #: ___ ___ ___ ___ ___ ___ ___ ___

OUTPATIENT SERVICE SETTING:
Pediatrician/Family Doctor

(SECTION VF)
USE IF SV18 COL. C = YES

VF1. During the past 12 months, how many different times has [CHILD] received treatment for behavioral, emotional, drug or alcohol problems from a pediatrician or family doctor? TIMES: ___ ___

IF TIMES = 02+, ASK VF2 WITH PARENS.

VF2. What was the name and address of the pediatrician or family doctor (he/she) has visited for these problems during the past 12 months (starting with the most recent)?

NAME	ADDRESS CITY, STATE	CODE
#1_____ MOST RECENT	_____	___ ___ ___ ___
#2_____	_____	___ ___ ___ ___
#3_____	_____	___ ___ ___ ___

VF3. What were the most important behavioral or emotional reasons [CHILD] visited a pediatrician/family doctor (most recently)? (IF ANSWER NOT SPECIFIC, ASK: What was there about [CHILD'S] behavior or emotions that caused you to use [PLACE IN VF2.1]?) RECORD UP TO THREE.

CODE

#1_____ ___ ___ ___ ___

#2_____ ___ ___ ___ ___

#3_____ ___ ___ ___ ___

VF4. I want to ask you some questions about the most recent visit [CHILD] made to

[PLACE IN VF2.1].

A. Who took [CHILD] the last time?

	NO	YES
1. You	0	1
2. Spouse/partner	0	1
3. Other adult in [CHILD'S] household	0	1
4. Other:_____	0	1

B. About how long did it take to travel one way to [PLACE IN VF2.1]? MINUTES: ___ ___ ___

C. On the average, how long did an appointment take from the time you arrived until the time you left [PLACE IN VF2.1]? MINUTES: ___ ___ ___

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE USED, GO TO SECTION FS.

RESPONDENT ID #: ___ ___ ___ ___ ___ ___ ___

OUTPATIENT SERVICE SETTING:
Probation, Juvenile Corrections Officer or a Court Counselor

(SECTION VG)
USE IF SV19 COL. C = YES

VG1. During the past 12 months, how many different times has [CHILD] been assigned to a Probation Officer? TIMES: ___ ___ ___

VG2. What were the most important reasons [CHILD] was assigned to a Probation Officer (most recently)? RECORD UP TO THREE.

CODE

#1_____ ___ ___ ___ ___

#2_____ ___ ___ ___ ___

#3_____ ___ ___ ___ ___

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE USED, GO TO SECTION FS.

RESPONDENT ID #: ___ ___ ___ ___ ___ ___ ___

OUTPATIENT SERVICE SETTING:
Priest/Minister/Rabbi

(SECTION VH)
USE IF SV20 COL. C = YES

VH1. During the past 12 months, how many different times did [CHILD] receive counseling from a priest, minister or rabbi for a behavioral or emotional problem?

TIMES: ___ ___ ___

VH2. What were the most important emotional or behavioral reasons [CHILD] received counseling from this person (most recently)? RECORD UP TO THREE.

	CODE
#1_____	___ ___ ___ ___
#2_____	___ ___ ___ ___
#3_____	___ ___ ___ ___

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE USED, GO TO SECTION FS.

RESPONDENT ID #: ___ ___ ___ ___ ___ ___ ___

OUTPATIENT SERVICE SETTING: Professional like a Psychologist, Psychiatrist, or Social Worker

(SECTION VZ)
USE IF SV21 COL. C = YES

VZ1. During the past 12 months, how many visits did [CHILD] make to a professional like a psychologist, psychiatrist, or social worker? IF DK, CODE 999.

TIMES ___ ___ ___

VZ2. Has [CHILD] gone to more than one professional in the past 12 months?

NO 0
YES.....1

A. What was the name and address of the professional (he/she) visited in the past 12 months (starting with the most recent)?

	NAME	ADDRESS CITY, STATE	CODE
#1	_____ MOST RECENT	_____ _____	___ ___ ___ ___
#2	_____	_____ _____	___ ___ ___ ___
#3	_____	_____ _____	___ ___ ___ ___

IF ONLY ONE PROFESSIONAL, GO TO VZ3.

B. How many visits did [CHILD] make to [PERSON IN VZ2A1]?

VISITS: ___ ___

VZ3. What were the most important behavioral or emotional reasons [CHILD] went to [PLACE IN VZ2A1]? (IF ANSWER NOT SPECIFIC, ASK: What was there about [CHILD'S] behavior or emotions that caused you to use [PLACE IN VZ2A1]?) RECORD UP TO THREE.

CODE

#1_____ ___ ___ ___ ___

#2_____ ___ ___ ___ ___

#3_____ ___ ___ ___ ___

VZ4. Who referred [CHILD] or told you to take (him/her) to [PLACE IN VZ2A1]? CIRCLE ALL THAT APPLY.

[CHILD'S] SCHOOL OR TEACHER 1
FRIEND/NEIGHBOR 2
JUDGE/COURT/POLICE 3
SOCIAL WORKER/
CASE MANAGER 4
PSYCHIATRIST/PSYCHOLOGIST/
COUNSELOR 5
PEDIATRICIAN/FAMILY DOCTOR 6
PRIEST/RABBI/CLERGY 7
NO ONE 8
OTHER: SPECIFY:_____ 9

VZ5. Now I am going to read a list of the types of treatments, services, and counseling programs that might be provided by a professional like a psychologist, psychiatrist, or social worker. We realize that you may not know whether [CHILD] received some of these. In those cases, it is fine to say you don't know. In (his/her) most recent visit to [PLACE IN VZ2A1], did [CHILD]:

		NO	YES	DK
a.	Receive therapy or counseling?	0	1	9
b.	Have case management or a contact person who coordinated (his/her) services?	0	1	9
c.	Receive a prescription for medications?	0	1	9
d.	Receive evaluation or testing?	0	1	9
	Did you or your family receive:			
e.	Counseling, training or education in how to deal with [CHILD]?	0	1	9
f.	Counseling or therapy for your relationships with other family members?	0	1	9
g.	Counseling or therapy for your own problems, worries, or stresses?	0	1	9
h.	Help with rent, money, food, clothing, or shelter?	0	1	9
i.	Any other service? Specify:_____	0	1	9

VZ6. A. How many days were there between the time [PLACE IN VZ2A1] was first contacted about [CHILD'S] problem and when (he/she) was seen? IF 000, GO TO VZ7.

DAYS: ___ ___ ___

B. During this waiting period did anyone speak with you or [CHILD] to determine (his/her) need for services?

NO 0
YES.....1

VZ7. Was a set of treatment goals outlined at the start of [CHILD'S] treatment?

NO 0
YES.....1

8. PURPOSELY LEFT BLANK.

9. IF SV21 COL. D STOP MONTH CODED 00, GO TO VZ11.
You mentioned that [CHILD] is no longer receiving services from [PLACE IN VZ2A1]. Is this because: (READ ALL AND CODE)

		NO	YES	DK
a.	[CHILD] improved? (IF YES, GO TO VZ10.)	0	1	9
b.	the program was complete (IF YES, GO TO VZ10.)	0	1	9
c.	[CHILD] showed little improvement? (IF YES, GO TO VZ10.)	0	1	9
d.	there were negative experiences with the treatment provider?	0	1	9
e.	[CHILD] was treated unfairly or badly on purpose?	0	1	9
f.	the therapist left or moved away?	0	1	9
g.	[CHILD] felt out of place in the treatment setting?	0	1	9
h.	there were problems with a lack of time, schedule change or lack of transportation?	0	1	9
i.	you or [CHILD] moved?	0	1	9
j.	you couldn't pay for services?	0	1	9
k.	insurance or managed care company limited the treatment?	0	1	9
l.	there were negative reactions of family and friends to treatment?	0	1	9

VZ10. Who decided that treatment should end? Was it:

	NO	YES
1. [CHILD'S] therapist?	0	1
2. You?	0	1
3. [CHILD]?	0	1
4. Someone else? Specify:_____	0	1

A. Did [CHILD] get any mental health services within 30 days after leaving [PLACE IN VZ2A1]?
NOGO TO VZ110
YES.....1

B. Were these services arranged by [PLACE IN VZ2A1]?
NO 0
YES.....1

C. How well did the [PLACE IN VZ2A1] follow-up with [CHILD] after (he/she) left the professional?
Not well 0
Somewhat.....1
Very well.....2

VZ11. Thinking about this most recent visit to the professional:

A. How well do you think the treatment chosen for [CHILD] matched (his/her) needs?

Not well 0
Somewhat.....1
Very well.....2

B. How well did [PLACE IN VZ2A1] explain [CHILD'S] problems and treatments to you?

Not well 0
Somewhat.....1
Very well.....2

C. IF R IS PRIMARILY ENGLISH SPEAKING, GO TO VZ14.
IF R IS NOT PRIMARILY ENGLISH SPEAKING, CONTINUE.

Did [PLACE IN VZ2A1] speak to [CHILD] in the language that (he/she) is most comfortable with?

NO 0
YES.....1

D. Did [PLACE IN VZ2A1] speak to you and your family in the language that you were most comfortable with?

NO 0
YES.....1

VZ12. How much has [CHILD] benefited from treatment from [PLACE IN VZ2A1] in your opinion?

Not at all 0
Some 1
A lot 2

VZ13. I want to ask you some questions about the most recent visit [CHILD] made to [PLACE IN VZ2A1].

A. Who took [CHILD] the last time?

	NO	YES
1. You	0	1
2. Spouse/partner	0	1
3. Other adult in [CHILD'S] household	0	1
4. Other:_____	0	1

B. About how long did it take to travel one way to

MINUTES: ___ ___ ___

[PLACE IN VZ2A1]?

C. On the average, how long did an appointment take from the time you arrived until the time you left [PLACE IN VZ2A1]? MINUTES: ___ ___ ___

VZ14. IF CHILD STILL IN FACILITY, SV21 COL. D STOP MONTH CODED 00, GO TO INSTRUCTION BOX. What is the total charge for [CHILD'S] most recent visit to [PLACE IN VZ2A1]. CODE AND GO TO VZ15. IF DK, CONTINUE. $___ ___ ___ ___ ___

A. Is this because (CODE FIRST YES):

The bill has not come yet? 1
You are unsure?2
The bill (will be/was) paid by another source? 3

VZ15. Did you or anyone else in [CHILD'S] household pay anything out of pocket for this most recent visit?
NO ..... GO TO VZ16.....0
YES.....1

A. How much was paid out of pocket? IF DK, GO TO VZ15B. OTHERS GO TO VZ16. $___ ___ ___ ___

B. What percent of the bill was paid out of pocket? ___ ___ ___%

VZ16. Will you or anyone else in [CHILD'S] household pay anything (more) out of pocket for (his/her) visit to [PLACE IN VZ2A1]?
NO .....GO TO VZ16C 0
YES.....GO TO VZ16A 1

A. How much will your household pay out of pocket for [CHILD'S] visit to [PLACE IN VZ2A1]? IF DK, GO TO VZ16B. OTHERS GO TO VZ16C. $___ ___ ___ ___

B. What percent of the bill will be paid out of pocket? ___ ___ ___%

C. IF VZ15 OR VZ16 = 1, CONTINUE. Will you be reimbursed for all of these expenses, some of these expenses, or none of these expenses?
NONE 0
SOME 1
ALL 2

VZ17. Which sources cover the charges?

		NO	YES
a.	Will private insurance?	0	1
b.	Will an HMO or other prepaid plan?	0	1
c.	Will the Veterans Administration (VA)?	0	1
d.	Will welfare or Medicaid?	0	1
e.	Will the Indian Health Service?	0	1
f.	Will the service be provided free of charge?	0	1
g.	Any other sources? Specify_____	0	1

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE

USED, GO TO SECTION FS.

OUTPATIENT SERVICE SETTING:
Healer/Shaman/Curandero

(SECTION VJ)
USE IF SV22 COL. C = YES

VJ1. During the past 12 months, how many different times did [CHILD] receive treatment from a healer, shaman, or curandero for a behavioral, emotional, or drug or alcohol problem?

TIMES: ___ ___ ___

VJ2. What were the most important reasons [CHILD] received treatment from a healer, shaman, or curandero (most recently)? RECORD UP TO THREE.

	CODE
#1_____	___ ___ ___ ___
#2_____	___ ___ ___ ___
#3_____	___ ___ ___ ___

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE USED, GO TO SECTION FS.

RESPONDENT ID #: ___ ___ ___ ___ ___ ___ ___ ___

OUTPATIENT SERVICE SETTING:
Acupuncturist or Chiropractor

(SECTION VK)
USE IF SV23 COL. C = YES

VK1. During the past 12 months, how many different times did [CHILD] receive treatment by an acupuncturist or chiropractor?

TIMES: ___ ___ ___

VK2. What were the most important reasons [CHILD] used an acupuncturist or chiropractor in the past 12 months? RECORD UP TO THREE.

CODE

#1_____ ___ ___ ___ ___

#2_____ ___ ___ ___ ___

#3_____ ___ ___ ___ ___

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE USED, GO TO SECTION FS.

RESPONDENT ID #: ___ ___ ___ ___ ___ ___ ___

OUTPATIENT SERVICE SETTING: Crisis Hotline

(SECTION VL)
USE IF SV24 COL. C = YES

VL1. During the past 12 months, how many times did [CHILD] use a crisis hotline? TIMES: ___ ___ ___

VL2. What were the most important reasons [CHILD] used a crisis hotline (most recently)? RECORD UP TO THREE.

	CODE
#1_____	___ ___ ___ ___
#2_____	___ ___ ___ ___
#3_____	___ ___ ___ ___

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE USED, GO TO SECTION FS.

OUTPATIENT SERVICE SETTING: Self Help Group like Alcoholics Anonymous or Peer Help or Counseling

(SECTION VM)
USE IF SV25 COL. C = YES

VM1. During the past 12 months, how many times did [CHILD] use a self help group like Alcoholics Anonymous or peer counseling? TIMES: ___ ___ ___

VM2. What were the most important reasons [CHILD] used a self help group (most recently)? RECORD UP TO THREE.

	CODE
#1_____	___ ___ ___ ___
#2_____	___ ___ ___ ___
#3_____	___ ___ ___ ___

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE USED, GO TO SECTION FS.

OUTPATIENT SERVICE SETTING:
Respite Care

(SECTION VN)
USE IF SV26 COL. C = YES

VN1. During the past 12 months, how many days did [CHILD] use respite care for behavioral, emotional, drug or alcohol problems? TIMES: ___ ___

IF TIMES = 02+, ASK A WITH PARENS.

VN2. What was the name and address of the respite care service (he/she) used in the past 12 months for these kinds of problems (starting with the most recent)?

ORGANIZATION NAME	ADDRESS CITY, STATE	CODE
#1_____ MOST RECENT	_____	___ ___ ___ ___
#2_____	_____	___ ___ ___ ___
#3_____	_____	___ ___ ___ ___

VN3. What were the most important behavioral or emotional reasons [CHILD] used respite care (most recently)? (IF ANSWER NOT SPECIFIC, PROBE: What was there about [CHILD'S] behavior or emotions that caused you to use [PLACE IN VN2.1]?) RECORD UP TO THREE.

CODE

#1_____ ___ ___ ___ ___

#2_____ ___ ___ ___ ___

#3_____ ___ ___ ___ ___

VN4. I want to ask you some questions about the most recent visit [CHILD] made to

[PLACE IN VN2.1].

A. Who took [CHILD] the last time?

	NO	YES
1. You	0	1
2. Spouse/partner	0	1
3. Other adult in [CHILD'S] household	0	1
4. Other:_____	0	1

B. About how long did it take to travel one way to [PLACE IN VN2.1]? MINUTES: ___ ___ ___

C. On the average, how long did an appointment take from the time you arrived until the time you left [PLACE IN VN2.1]? MINUTES: ___ ___ ___

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE USED, GO TO SECTION FS.

RESPONDENT ID #: ___ ___ ___ ___ ___ ___ ___ ___

SCHOOL-BASED SERVICES:
Special School for Students with Problems

(SECTION KA)
USE IF SV27 COL. C = YES

KA1. Did [CHILD] go to more than one special school for students with emotional or behavioral problems in the past 12 months?
NO 0
YES.....1

IF KA1 = NO, ASK WITHOUT PARENS.

A. What was the name and address of the school where [CHILD] went to in the past 12 months (starting with the most recent)?

NAME	ADDRESS CITY, STATE	CODE
#1_____ MOST RECENT	_____ _____	___ ___ ___ ___
#2_____	_____ _____	___ ___ ___ ___
#3_____	_____ _____	___ ___ ___ ___

B. How many days a week was [CHILD] in the special school for students with emotional or behavioral problems this past year? # DAYS: ___

C. How many minutes a day did [CHILD] spend in the class? # MINUTES: ___ ___ ___

KA2. What were the most important reasons [CHILD] was enrolled in the special school? (IF ANSWER NOT SPECIFIC, ASK: What was there about [CHILD'S] behavior or emotions that caused [CHILD] to use [PLACE IN KA1A1]?) RECORD UP TO THREE.

CODE

#1_____ ___ ___ ___ ___

#2_____ ___ ___ ___ ___

#3_____ ___ ___ ___ ___

KA3. Now I am going to read a list of the types of treatments, services, and counseling programs that might be provided in a special school. We realize that you may not know whether [CHILD] received some of these. In those cases, it is fine to say you don't know. At [PLACE IN KA1A1], did [CHILD]:

	NO	YES	DK
a. Receive therapy or counseling?	0	1	9
b. Have case management or a contact person who coordinated (his/her) services?	0	1	9
c. Receive special testing?	0	1	9
Did you or your family receive:			
d. Counseling, training or education in how to deal with [CHILD]?	0	1	9
e. Counseling or therapy for your relationships with other family members?	0	1	9
f. Counseling or therapy for your own problems, worries, or stresses?	0	1	9
g. Any other service? Specify:_____	0	1	9

KA4. A. How many days were there between the time [CHILD] was eligible and when the school services began? IF 000, GO TO KA5.

DAYS: ___ ___ ___

B. During this waiting period did anyone speak with you or [CHILD] to determine (his/her) need for services?

NO 0
YES.....1

KA5. Who was the person in charge of [CHILD'S] school program?

NAME:_____
CODE:___ ___ ___

KA6. IF SV27 COL. D STOP MONTH CODED 00, GO TO KA8. OTHERS CONTINUE.
You mentioned that [CHILD] stopped attending special school. Is this because (READ ALL AND CODE):

	NO	YES	DK
a. [CHILD] improved? (IF YES, GO TO KA7.)	0	1	9
b. the program was complete (IF YES, GO TO KA7.)	0	1	9
c. [CHILD] showed little improvement? (IF YES, GO TO KA7.)	0	1	9
d. there were negative experiences with the teachers?	0	1	9
e. [CHILD] was treated unfairly or badly on purpose?	0	1	9
f. teacher left or moved away?	0	1	9
g. [CHILD] felt out of place in the educational PLACE IN KA1A1?	0	1	9

h.	school policies hassled you?			
i.	there were problems with a lack of time, schedule change or lack of transportation?	0 0	1 1	9 9
j.	you or [CHILD] moved?			
k.	there were negative reactions of family and friends to the special services?	0	1	9

KA7. Who decided that [CHILD] should stop attending the special school? Was it:

	NO	YES
1. [CHILD'S] teacher?	0	1
2. You?	0	1
3. [CHILD]?	0	1
4. Other source? Specify:_____	0	1

A. Did [CHILD] get any mental health services within 30 days after leaving the school?
NO .GO TO KA8 0
YES.....1

B. Were these services arranged by the school staff?
NO 0
YES.....1

C. How well did the staff follow-up with [CHILD] after (he/she) left the school program?
Not well 0
Somewhat.....1
Very well.....2

KA8. Thinking about this most recent service:

A. How well do you think the special school matched (his/her) needs?
Not well 0
Somewhat.....1
Very well.....2

B. How well did the staff explain [CHILD'S] problems and the program to you?
Not well 0
Somewhat.....1
Very well.....2

C. IF R IS PRIMARILY ENGLISH SPEAKING, GO TO KA9.
IF R IS NOT PRIMARILY ENGLISH SPEAKING, CONTINUE.

Did the staff speak to [CHILD] in the language that (he/she) is most comfortable with?
NO 0
YES.....1

D. Did the staff speak to you and your family in the language that you were most comfortable with?
NO 0
YES.....1

KA9. How much has [CHILD] benefited from [PLACE IN KA1A1] in your opinion?

Not at all 0
Some 1
A lot 2

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE USED, GO TO SECTION FS.

RESPONDENT ID #: ___ ___ ___ ___ ___ ___ ___ ___

SCHOOL-BASED SERVICES:
Special Classroom in a Regular School

(SECTION KB)
USE IF SV28 COL. C = YES)

KB1. Did [CHILD] go to more than one school with a special classroom for emotional or behavioral problems in the past 12 months?

NO 0
YES.....1

IF KB1 = NO, ASK WITHOUT PARENS.

A. What was the name and address of the school where [CHILD] attended the special classrooms in the past 12 months (starting with the most recent)?

NAME	ADDRESS CITY, STATE	CODE
#1_____ MOST RECENT	_____	___ ___ ___ ___
#2_____	_____	___ ___ ___ ___
#3_____	_____	___ ___ ___ ___

B. How many days a week was [CHILD] in any special classroom for emotional or behavioral problems in the past 12 months?

DAYS: ___

C. How many minutes a day did [CHILD] spend in the class?

MINUTES: ___ ___ ___

KB2. What were the most important reasons [CHILD] was enrolled in the special classroom? (IF ANSWER NOT SPECIFIC, ASK: What was there about [CHILD'S] behavior or emotions that caused you to use [PLACE IN KB1A1]?) RECORD UP TO THREE.

CODE

#1_____ ___ ___ ___ ___

#2_____ ___ ___ ___ ___

#3_____ ___ ___ ___ ___

KB3. Now I am going to read a list of the types of treatments, services, and counseling programs that might be provided in a school. We realize that you may not know whether [CHILD] received some of these. In those cases, it is fine to say you don't know. At [PLACE IN KB1A1], did [CHILD]:

		NO	YES	DK
a.	Receive therapy or counseling?	0	1	9
b.	Have case management or a contact person who coordinated (his/her) services?	0	1	9
c.	Receive special testing?	0	1	9

Did you or your family receive:

d.	Counseling, training or education in how to deal with [CHILD]?	0	1	9
e.	Counseling or therapy for your relationships with other family members?	0	1	9
f.	Counseling or therapy for your own problems, worries, or stresses?	0	1	9
g.	Any other service? Specify:_____	0	1	9

KB4. A. How many days were there between the time [CHILD] was eligible and when the school services began? IF 000, GO TO KB5. # DAYS: ___ ___ ___

B. During this waiting period did anyone speak with you or [CHILD] to determine (his/her) need for services? NO 0
YES.....1

KB5. Who was the person in charge of [CHILD'S] school program? NAME:_____
CODE:___ ___ ___

KB6. IF SV28 COL. D STOP MONTH CODED 00, GO TO KB8. OTHERS CONTINUE.
You mentioned that [CHILD] stopped having special classroom lessons. Is this because (READ ALL AND CODE):

		NO	YES	DK
a.	[CHILD] improved? (IF YES, GO TO KB7.)	0	1	9
b.	the program was complete (IF YES, GO TO KB7.)	0	1	9
c.	[CHILD] showed little improvement? (IF YES, GO TO KB7).	0	1	9
d.	there were negative experiences with the teachers?	0	1	9

e.	[CHILD] was treated unfairly or badly on purpose?	0	1	9
f.	teacher left or moved away?	0	1	9
g.	[CHILD] felt out of place in the educational setting?	0	1	9
h.	school policies hassled you?	0	1	9
i.	there were problems with a lack of time, schedule change or lack of transportation?	0	1	9
j.	you or [CHILD] moved?	0	1	9
k.	there were negative reactions of family and friends to the special services?	0	1	9

KB7. Who decided that the special classroom lessons should end? Was it:

	NO	YES
1. [CHILD'S] teacher?	0	1
2. You?	0	1
3. [CHILD]?	0	1
4. Other source? Specify:_____	0	1

A. Did [CHILD] get any mental health services within 30 days after leaving the special class?
NO . GO TO KB8 0
YES.....1

B. Were these services arranged by the school staff?
NO 0
YES.....1

C. How well did the staff follow-up with [CHILD] after (he/she) left the school program?
Not well 0
Somewhat.....1
Very well.....2

KB8. Thinking about this most recent service:

A. How well do you think the special classroom lessons matched (his/her) needs?
Not well 0
Somewhat.....1
Very well.....2

B. How well did the staff explain [CHILD'S] problems and special classroom lessons to you?
Not well 0
Somewhat.....1
Very well.....2

C. IF R IS PRIMARILY ENGLISH SPEAKING, GO TO KB9.
IF R IS NOT PRIMARILY ENGLISH SPEAKING, CONTINUE.

Did the staff speak to [CHILD] in the language that
NO 0

(he/she) is most comfortable with? YES.....1

D. Did the staff speak to you and your family in the language that you were most comfortable with? NO 0
YES.....1

KB9. How much has [CHILD] benefited from [PLACE IN KB1A1] in your opinion? Not at all 0
Some 1
A lot 2

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE USED, GO TO SECTION FS.

RESPONDENT ID #: ___ ___ ___ ___ ___ ___ ___

SCHOOL-BASED SERVICES:
Special Help or Tutoring in the Regular Classroom

(SECTION KC)
USE IF SV29 COL. C = YES

KC1. A. What were the names and addresses of the schools where [CHILD] received special help or tutoring in the regular classroom in the past 12 months, starting with the most recent?

NAME	ADDRESS CITY, STATE	CODE
#1_____ MOST RECENT	_____ _____	___ ___ ___ ___
#2_____	_____ _____	___ ___ ___ ___
#3_____	_____ _____	___ ___ ___ ___

B. How many days a week did [CHILD] receive special help or tutoring in the classroom? # DAYS: ___

C. How many minutes a day did [CHILD] receive special help or tutoring in the classroom? # MINUTES: ___ ___ ___

D. In the past 12 months, how many weeks in all did [CHILD] receive special help or tutoring in the classroom? # WEEKS: ___ ___

E. Who was the person in charge of [CHILD'S] special help or tutoring at [PLACE IN KC1A1]? NAME:_____ CODE: ___ ___ ___

KC2. What were the most important reasons [CHILD] received special help or tutoring in the classroom? (IF ANSWER NOT SPECIFIC, ASK: What was there about [CHILD'S] behavior or emotions that caused you to use [PLACE IN KC1A1]?) RECORD UP TO THREE.

	CODE
#1_____	___ ___ ___ ___
#2_____	___ ___ ___ ___

#3_____ ___ ___ ___ ___

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE USED, GO TO SECTION FS.

SCHOOL-BASED SERVICES:
Counseling in School

(SECTION KD)
USE IF SV30 COL. C = YES

KD1. Did [CHILD] have more than one counselor in school in the past 12 months for behavioral or emotional problems?
NO 0
YES.....1

IF KD1 = NO, ASK WITHOUT PARENS.

A. What was the name and address of the school where [CHILD] received counseling in the past 12 months (starting with the most recent)?

NAME	ADDRESS CITY, STATE	CODE
#1_____ MOST RECENT	_____	___ ___ ___ ___
#2_____	_____	___ ___ ___ ___
#3_____	_____	___ ___ ___ ___

B. In the past 12 months, how many days a week was [CHILD] in counseling at school for emotional or behavioral problems? # DAYS: ___

C. How many minutes a day on the average did [CHILD] spend with the counselor at school? # MINUTES: ___ ___ ___

D. Over the past 12 months, how many weeks in all did [CHILD] receive counseling at school? # WEEKS: ___ ___

KD2. What were the most important behavioral or emotional reasons [CHILD] received counseling at school? (IF ANSWER NOT SPECIFIC, ASK: What was there about [CHILD'S] behavior or emotions that caused you to use [PLACE IN KD1A1?)

RECORD UP TO THREE. CODE

#1_____ ___ ___ ___ ___

#2_____ ___ ___ ___ ___

#3_____ ___ ___ ___ ___

KD3. Now I am going to read a list of the types of treatments and services and counseling programs that might be provided by the counselor. We realize that you may not know whether [CHILD] received some of these. In those cases, it is fine to say you don't know. At [PLACE IN KD1A1], did [CHILD]:

	NO	YES	DK
a. Have case management or a contact person who coordinated (his/her) services?	0	1	9
b. Receive special testing?	0	1	9
Did you or your family receive:			
c. Counseling, training or education in how to deal with your problems?	0	1	9
d. Counseling or therapy for relationships with other family members?	0	1	9
e. Counseling or therapy for their own problems, worries, or stresses?	0	1	9
f. Any other service? Specify:_____	0	1	9

KD4. A. How many days were there between the time [CHILD] was eligible and when counseling began? IF 000, GO TO KD5. # DAYS: ___ ___ ___

B. During this waiting period did anyone speak with you or [CHILD] to determine (his/her) need for services? NO 0
YES.....1

KD5. Who was [CHILD'S] school counselor? NAME:_____
CODE:___ ___ ___

KD6. IF SV30 COL. D STOP MONTH CODED 00, GO TO KD8. OTHERS CONTINUE.
You mentioned that [CHILD] is no longer receiving counseling at school. Is this because (READ ALL AND CODE):

	NO	YES	DK
a. (he/she) improved? (IF YES, GO TO KD7.)	0	1	9
b. the program was completed? (IF YES, GO TO KD7.)	0	1	9
c. [CHILD] showed little improvement? (IF YES, GO TO KD7.)	0	1	9

d.	there were negative experiences with the counselor?	0	1	9
e.	[CHILD] was treated unfairly or badly on purpose?	0	1	9
f.	counselor left or moved away?	0	1	9
g.	(he/she) felt out of place?	0	1	9
h.	school policies hassled you?	0	1	9
i.	there were problems with a lack of time, schedule change or lack of transportation?	0	1	9
j.	you or [CHILD] moved?	0	1	9
k.	there were negative reactions of family and friends to the special services?	0	1	9

KD7. Who decided counseling should end? Was it:

	NO	YES
1. [CHILD'S] counselor?	0	1
2. You?	0	1
3. [CHILD]?	0	1
4. Other source? Specify:_____	0	1

A. Did [CHILD] get any mental health services within 30 days after leaving the school counselor?
NO....GO TO KD8 0
YES.....1

B. Were these services arranged by the school counselor?
NO 0
YES.....1

C. How well did the school counselor follow-up with [CHILD] after (he/she) left counseling?
Not well 0
Somewhat.....1
Very well.....2

KD8. Thinking about this most recent service:

A. How well do you think the school counseling matched (his/her) needs?
Not well 0
Somewhat.....1
Very well.....2

B. How well did the school counselor explain [CHILD'S] problems to you?
Not well 0
Somewhat.....1
Very well.....2

C. IF R IS PRIMARILY ENGLISH SPEAKING, GO TO KD9.
IF R IS NOT PRIMARILY ENGLISH SPEAKING, CONTINUE.

Did the counselor speak to [CHILD] in the language that (he/she) is most comfortable with?
NO 0
YES.....1

D. Did the counselor speak to you and your family in the language that you were most comfortable with?

NO 0
YES.....1

KD9. How much has [CHILD] benefited from the school counselor in your opinion?

Not at all 0
Some 1
A lot 2

GO TO NEXT SERVICE MODULE USED IN PAST 12 MONTHS. IF NO OTHER SERVICE USED, GO TO SECTION FS.

RESPONDENT ID #: ___ ___ ___ ___ ___ ___ ___ ___

FINAL SERVICES MODULE

(SECTION FS)

FS1. DID [CHILD] USE ANY SERVICE IN PAST 12 MONTHS? (I.E., WERE ANY IN-PATIENT, OUT-PATIENT, OR SCHOOL-SERVICE MODULES FILLED IN?)

NOGO TO FS8 0
YES....1

FS2. IF [CHILD] USED ONLY ONE SERVICE, GO TO FS4. You said [CHILD] has been seen by [REVIEW SERVICES USED IN PAST 12 MONTHS FROM FS1]. Of these, which has been the most helpful for (his/her) problems?

NAME:_____
CODE: ___ ___

FS3. Which has helped the least?

NAME:_____
CODE: ___ ___

FS4. Were there any other services, besides the ones [CHILD] used, that you thought (he/she) needed?

NO . . . .GO TO SECTION KG 0
YES....1

Did you feel (he/she) needed:		NO	YES
a.	school-based services?	0	1
b.	hospital services?	0	1
c.	out-patient services?	0	1
d.	services through your church or temple?	0	1
e.	juvenile justice services?	0	1
f.	drug or alcohol treatment?	0	1
g.	something else or perhaps something more specific? Specify:_____	0	1

FS5. You mentioned that you thought that [CHILD] needed additional services. Please tell me if any of these reasons kept [CHILD] from getting that additional care in the past 12 months:

		NO	YES
a.	You thought [CHILD'S] problems were not so serious?		
b.	You decided you could handle (his/her) problems on your own?	0	1
c.	You lacked confidence in those who recommended professional help?	0	1
d.	Help was too expensive?	0	1
e.	Services were too inconvenient to use?	0	1
f.	The services were too far away?	0	1
g.	You had a negative experience with the professionals?	0	1
h.	You were afraid of what your family or friends would say?	0	1
i.	You were afraid you would lose your parental rights?	0	1

j.	You were afraid you would lose custody?	0	1
k.	You thought treatment would not help?	0	1
l.	The people you trusted most did not recommend professional help?	0	1
m.	You did not know who to trust for advice?	0	1
n.	You didn't know where to go?	0	1
o.	You had no way to get there?	0	1
p.	You had to wait a long time for an appointment?	0	1
q.	[CHILD] did not want to go?	0	1
r.	IF FS5q = 1 CONTINUE. OTHERS GO TO FS5s. Could you explain why [CHILD] didn't want to go--what made [CHILD] feel that way? SPECIFY:_____	0	1
s.	Was there any other reason that kept [CHILD] from getting additional care in the past 12 months? SPECIFY:_____	0	1

FS6. The next questions ask how long it would take you to travel one way from your home to a place where you could get help for emotional or behavioral problems [CHILD] might have. If you are not sure where your insurance company would refer you or if you don't know an exact answer, it is okay to give us your best guess. If you wanted to get help for [CHILD'S] behavioral or emotional problems, about how many minutes would it take you to get to:

		MINUTES
a.	A psychiatrist, or a medical doctor specially trained to treat emotional or behavioral problems?	___ ___ ___
b.	A psychologist or social worker?	___ ___ ___
c.	A hospital that helps only people with behavioral or emotional problems?	___ ___ ___
d.	A general hospital?	___ ___ ___

FS7. I'm going to read a statement. Tell me if it is very true, somewhat true, or not at all true.

"During the past year, [CHILD] needed professional help for problems with behaviors, emotions or feelings, drugs or alcohol, but (he/she) was not able to get that help."

Very true	1
Somewhat true	2
Not at all true	3

GO TO SECTION KG.

FS8. You said [CHILD] has not been admitted to a hospital, seen a professional, or received school services for behavioral, emotional, or drug or alcohol problems in the past 12 months. During the past 12 months, has there been a time when you thought (he/she) might need help for these problems?

NOGO TO FS12 0
YES....1

FS9. When was the first time you thought this?

___ ___ ___ ___
MO YR

A. Do you still feel this way?

NO.....0
YESGO TO FS10 1

B. When was the last time you felt this way?

___ ___ ___ ___
MO YR

FS10. What were the most important behavioral or emotional reasons [CHILD] needed help? RECORD UP TO THREE.

	CODE
#1_____	___ ___ ___
#2_____	___ ___ ___
#3_____	___ ___ ___

FS11. What were the main reasons that [CHILD] was <u>not</u> taken to a hospital, a mental health specialist, or some other place or person outside the home for help? READ EACH AND CODE.

		NO	YES
a.	You thought [CHILD'S] problems were not so serious?		
b.	You decided you could handle (his/her) problems on your own?	0	1
c.	You lacked confidence in those who recommended professional help?	0	1
d.	Help was too expensive?	0	1
e.	Services were too inconvenient to use?	0	1
f.	The services were too far away?	0	1
g.	You had a negative experience with the professionals?	0	1
h.	You were afraid of what your family or friends would say?	0	1
i.	You were afraid you would lose your parental rights?	0	1
j.	You were afraid you would lose custody?	0	1
k.	You thought treatment would not help?	0	1
l.	The people you trusted most did not recommend professional help?	0	1
m.	You did not know who to trust for advice?	0	1
n.	You didn't know where to go?	0	1
o.	You had no way to get there?	0	1

p.	You had to wait a long time for an appointment?	0	1
q.	[CHILD] did not want to go?	0	1
r.	IF FS11q = 1 CONTINUE. OTHERS GO TO FS11s. Could you explain why [CHILD] didn't want to go--what made [CHILD] feel that way? SPECIFY:_____	0	1
s.	Was there any other reason that kept [CHILD] from getting additional care in the past 12 months? SPECIFY:_____	0	1

FS12. The following questions ask you about how long it would take you to travel one way from your home to a place where you could get help for emotional or behavioral problems [CHILD] might have. If you are not sure where your insurance company would refer you or if you don't know an exact answer, it is okay to give us your best guess. If you wanted to get help for [CHILD'S] behavioral or emotional problems, about how many minutes would it take you to get to:

		MINUTES
a.	A psychiatrist or a medical doctor specially trained to treat emotional or behavioral problems?	___ ___ ___
b.	A psychologist or social worker?	___ ___ ___
c.	A hospital that helps only people with behavioral or emotional problems?	___ ___ ___
d.	A general hospital?	___ ___ ___

IF FS8 = 0, GO TO SECTION KG. OTHERS CONTINUE.

FS13. I'm going to read a statement. Tell me if it is very true, somewhat true, or not at all true.

"During the past year, [CHILD] needed professional help for problems with behaviors, emotions or feelings, drugs or alcohol, but (he/she) was not able to get that help."	Very true	1
	Somewhat true	2
	Not at all true	3