

BRIEFEST SACA: ANSWER THE NEXT SECTION AT EACH REPORT:

MA. In the last 3 months, has (YOUTH) stayed overnight in a hospital, treatment center, group or foster home, juvenile justice facility, or emergency shelter for problems with drugs or alcohol, behaviors, or feelings?

YES.
NO.....GO TO MB

Has (YOUTH) stayed overnight in a (READ EACH AND CODE): IF "YES," ANSWER COL. A AND B.

				IF YES: COL A. # NIGHTS IN LAST 3 MOS	IF YES: CHECK TYPES OF SERVICES GIVEN:	
1.	Hospital for problems with drugs or alcohol, behaviors, or feelings	NO	YES	DK	__ __ __ nts.	<input type="checkbox"/> assessment <input type="checkbox"/> individual treatment/therapy <input type="checkbox"/> group treatment <input type="checkbox"/> family/parent treatment/ed <input type="checkbox"/> medication <input type="checkbox"/> education/training
2.	Drug or alcohol treatment unit	NO	YES	DK	__ __ __ nts.	<input type="checkbox"/> assessment <input type="checkbox"/> individual treatment/therapy <input type="checkbox"/> group treatment <input type="checkbox"/> family/parent treatment/ed <input type="checkbox"/> medication <input type="checkbox"/> education/training
3.	Residential treatment center	NO	YES	DK	__ __ __ nts.	<input type="checkbox"/> assessment <input type="checkbox"/> individual treatment/therapy <input type="checkbox"/> group treatment <input type="checkbox"/> family/parent treatment/ed <input type="checkbox"/> medication <input type="checkbox"/> education/training
4.	Group home	NO	YES	DK	__ __ __ nts.	<input type="checkbox"/> assessment <input type="checkbox"/> individual treatment/therapy <input type="checkbox"/> group treatment <input type="checkbox"/> family/parent treatment/ed <input type="checkbox"/> medication <input type="checkbox"/> education/training
5.	Foster home	NO	YES	DK	__ __ __ nts.	<input type="checkbox"/> assessment <input type="checkbox"/> individual treatment/therapy <input type="checkbox"/> group treatment <input type="checkbox"/> family/parent treatment/ed <input type="checkbox"/> medication <input type="checkbox"/> education/training
6.	Detention center/Prison or jail	NO	YES	DK	__ __ __ nts.	<input type="checkbox"/> assessment <input type="checkbox"/> individual treatment/therapy <input type="checkbox"/> group treatment <input type="checkbox"/> family/parent treatment/ed <input type="checkbox"/> medication <input type="checkbox"/> education/training
7.	Emergency shelter for problems with behaviors or feelings.	NO	YES	DK	__ __ __ nts.	<input type="checkbox"/> assessment <input type="checkbox"/> individual treatment/therapy <input type="checkbox"/> group treatment <input type="checkbox"/> family/parent treatment/ed <input type="checkbox"/> medication <input type="checkbox"/> education/training
8.	Other: describe _____	NO	YES	DK	__ __ __ nts.	<input type="checkbox"/> assessment <input type="checkbox"/> individual treatment/therapy <input type="checkbox"/> group treatment <input type="checkbox"/> family/parent treatment/ed <input type="checkbox"/> medication <input type="checkbox"/> education/training

9. If "Yes" to any of above:

Did client have an episode that resulted in use of mechanical or chemical restraints?

YES NO

**MB. In the last 3 months, has (YOUTH) received outpatient help (not overnight) from a
(IF YES ANSWER COLS A & B):**

				IF YES: COL A NUMBER OF HOURS OR DAYS OF SERVICE	IF YES: CHECK TYPES OF SERVICES GIVEN:
9.	Community mental health center or other outpatient mental health clinic	NO	YES	DK	___ hrs. ___ days ___assessment ___individual treatment/therapy ___group treatment ___family/parent treatment/ed ___medication ___education/training ___case management
10.	Professional like a psychologist, psychiatrist, social worker, or family counselor not part of a service or clinic already mentioned	NO	YES	DK	___ hrs. ___assessment ___individual treatment/therapy ___group treatment ___family/parent treatment/ed ___medication ___education/training ___case management
11.	Partial hospitalization or day treatment program	NO	YES	DK	___ hrs. ___ days ___assessment ___individual treatment/therapy ___group treatment ___family/parent treatment/ed ___medication ___education/training
12.	Drug or alcohol clinic	NO	YES	DK	___ hrs. ___ days ___assessment ___individual treatment/therapy ___group treatment ___family/parent treatment/ed ___medication ___education/training
13.	Therapist or counselor or family preservation worker who came to your home	NO	YES	DK	___ hrs. ___ days ___assessment ___individual treatment/therapy ___group treatment ___family/parent treatment/ed ___medication ___education/training ___case management
14.	Emergency room for problems with behaviors or feelings	NO	YES	DK	___ hrs. ___assessment ___individual treatment/therapy ___family/parent treatment/ed ___medication
15.	Pediatrician or family doctor for problems with behaviors or feelings	NO	YES	DK	___ hrs. ___assessment ___individual treatment/therapy ___group treatment ___family/parent treatment/ed ___medication ___education/training
16.	Probation or juvenile corrections officer or a court counselor	NO	YES	DK	___ hrs. ___assessment ___individual treatment/therapy ___group treatment ___family/parent treatment/ed ___medication ___education/training
17.	Priest, Minister or Rabbi for problems with behaviors or feelings	NO	YES	DK	___ hrs. ___assessment ___individual treatment/therapy ___group treatment ___family/parent treatment/ed ___education/training
18.	Acupuncturist/Chiropractor	NO	YES	DK	___ hrs. ___assessment ___individual treatment/therapy ___group treatment ___family/parent treatment/ed ___medication ___education/training
19.	Crisis hotline	NO	YES	DK	___ hrs.
20.	Any self-help group like Alcoholics Anonymous or peer counseling	NO	YES	DK	___ hrs.
21	Other: describe _____	NO	YES	DK	___ hrs.

MC. Has (YOUTH) received the following types of help in school (IF YES ANSWER COL A. AND B.):

		IF YES: COL A. NUMBER OF HOURS OR DAYS SERVICE	IF YES: CHECK TYPES OF SERVICES GIVEN:
22. Being placed in a special school for students with problems with behaviors or feelings	NO YES DK	___ ___ ___ days	<input type="checkbox"/> assessment <input type="checkbox"/> individual treatment/therapy <input type="checkbox"/> group treatment <input type="checkbox"/> family/parent treatment/ed <input type="checkbox"/> medication
23. Being placed in a special classroom for problems with drugs or alcohol, behaviors, or feelings	NO YES DK	___ ___ ___ hrs. ___ ___ ___ days	<input type="checkbox"/> assessment <input type="checkbox"/> individual treatment/therapy <input type="checkbox"/> group treatment <input type="checkbox"/> family/parent treatment/ed
24. Getting special help (such as tutoring or training) in the regular classroom for problems with behaviors or feelings	NO YES DK	___ ___ ___ hrs. ___ ___ ___ days	<input type="checkbox"/> assessment <input type="checkbox"/> individual treatment/therapy <input type="checkbox"/> group treatment <input type="checkbox"/> family/parent treatment/ed
25. Other counseling or therapy in school, related to problems with drugs or alcohol, behaviors, or feelings	NO YES DK	___ ___ ___ hrs.	<input type="checkbox"/> assessment <input type="checkbox"/> individual treatment/therapy <input type="checkbox"/> group treatment <input type="checkbox"/> family/parent treatment/ed
26. Other: describe: _____	NO YES DK	___ ___ ___ hrs.	<input type="checkbox"/> assessment <input type="checkbox"/> individual treatment/therapy <input type="checkbox"/> group treatment <input type="checkbox"/> family/parent treatment/ed <input type="checkbox"/> medication <input type="checkbox"/> education/training

MD. In past 3 months, has (YOUTH or YOUTH's FAMILY) received:

	Youth	Youth's Family	IF YES: COL A. NUMBER OF HOURS SERVICE
27. mentor services	NO YES DK	NO YES DK	___ ___ ___
28. transitional living services	NO YES DK	NO YES DK	___ ___ ___
29. parent aide	NO YES DK	NO YES DK	___ ___ ___
30. recreational/community activities	NO YES DK	NO YES DK	___ ___ ___
31. incidental/clothing/transportation	NO YES DK	NO YES DK	___ ___ ___
32. supported work	NO YES DK	NO YES DK	___ ___ ___
33. other (describe: _____)	NO YES DK	NO YES DK	___ ___ ___