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. IF YES: # NIGHTS IN CHECK TYPES OF LAST 3 MOS SERVICES GIVEN: NO YES DK assessment Hospital for problems with drugs or individual treatment/therapy alcohol, behaviors, or feelings group treatment _family/parent treatment/ed medication _education/training 2. assessment Drug or alcohol treatment unit NO YES DK nts. __individual treatment/therapy group treatment __family/parent treatment/ed _medication _education/training 3. NO YES DK Residential treatment center nts. assessment _individual treatment/therapy group treatment _family/parent treatment/ed medication education/training assessment 4. Group home NO YES DK nts. _individual treatment/therapy _group treatment _family/parent treatment/ed __medication _education/training 5. NO YES DK assessment Foster home nts. __individual treatment/therapy group treatment family/parent treatment/ed medication education/training Detention center/Prison or jail NO YES DK _assessment __nts. __individual treatment/therapy group treatment _family/parent treatment/ed _medication _education/training Emergency shelter for problems with NO YES DK assessment nts. __ _individual treatment/therapy behaviors or feelings. group treatment _family/parent treatment/ed medication _education/training NO YES DK __assessment Other: describe nts. __individual treatment/therapy __group treatment __family/parent treatment/ed __medication education/training

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

YES NO

^{9.} If "Yes" to any of above:

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	IF YES:
			HOURS OR DAYS OF SERVICE	CHECK TYPES OF SERVICES GIVEN:
9.	Community mental health center or other			_assessment
	outpatient mental health clinic	NO YES DK	hrs.	individual treatment/therapy group treatment
				family/parent treatment/ed
			days	medication education/training
-10				case management
10.	Professional like a psychologist, psychiatrist,			assessment individual treatment/therapy
	social worker, or family counselor not part of a service or clinic already mentioned		1	group treatment
	service of crime arready mentioned	NO YES DK	hrs.	family/parent treatment/ed medication
				education/training
11.	Partial hospitalization or day treatment program			case management assessment
11.	ration inospitalization of day treatment program	NO YES DK	hrs.	individual treatment/therapy
			111.5.	group treatment family/parent treatment/ed
			days	medication
12.	Deno an alaahal alimia	NO YES DK		education/trainingassessment
12.	Drug or alcohol clinic	NO 1ES DK	1	assessment individual treatment/therapy
			hrs.	group treatment family/parent treatment/ed
			days	nedication
13.	Therepist or counselor or family preservation		days	education/training assessment
13.	Therapist or counselor or family preservation worker who came to your home		1	assessment individual treatment/therapy
	worker who came to your nome	NO YES DK	hrs.	group treatment family/parent treatment/ed
			days	medication
			days	education/training case management
14.	Emergency room for problems with behaviors or			assessment
17.	feelings		hrs.	individual treatment/therapy
		NO YES DK	ms.	family/parent treatment/ed medication
15.	Pediatrician or family doctor for problems with			assessment
	behaviors or feelings	NO TIEG DV	hrs.	individual treatment/therapy group treatment
		NO YES DK		family/parent treatment/ed
				medication education/training
16.	Probation or juvenile corrections officer or a			assessment
	court counselor	NO TIEG DY	hrs.	individual treatment/therapy group treatment
		NO YES DK		family/parent treatment/ed
				medication education/training
17.	Priest, Minister or Rabbi for problems with			assessment
	behaviors or feelings	NO YES DK	hrs.	individual treatment/therapy group treatment
				family/parent treatment/ed
18.	Acupuncturist/Chiropractor			education/training assessment
10.	Teapanetarist emiopraetor			individual treatment/therapy
		NO YES DK	hrs.	group treatment family/parent treatment/ed
				medication
19.	Crisis hotline		hrs.	education/training
		NO YES DK		
20.	Any self-help group like Alcoholics Anonymous		hrs.	
	or peer counseling	NO YES DK		
21 Oth	er: describe	NO VEG DI	hrs.	
		NO YES DK		

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	assessment individual treatment/therapy group treatment family/parent treatment/ed medication	,
23. Being placed in a special classroom for problems with drugs or alcohol, behaviors, or feelings	NO YES DK	hrs.	assessment individual treatment/therapy group treatment family/parent treatment/ed	
		days		
24. Getting special help (such as tutoring or training)		hrs.	assessment individual treatment/therapy	,
he regular classroom for problems with behaviors or lings	NO YES DK	days	group treatmentfamily/parent treatment/ed	
25. Other counseling or therapy in school, related to problems with drugs or alcohol, behaviors, or feelings	NO YES DK	hrs.	assessment individual treatment/therapy group treatment family/parent treatment/ed	
26. Other: describe:	NO YES DK	hrs.	assessment _individual treatment/therapy _group treatment _family/parent treatment/ed _medication _education/training	
MD. In past 3 months, has (YOUTH or YOUTH's FA	MILY) received:			
	Youth	Youth's Fan	rily IF YES: COL. A. NUMBER OF HOURS SERVICE	
27. mentor services	NO YES DK	NO YES I	OK	_
28. transitional living services	NO YES DK	NO YES I	OK	_
29. parent aide	NO YES DK	NO YES I	OK	_
30. recreational/community activities	NO YES DK	NO YES I	OK	_
31. incidental/clothing/transportation	NO YES DK	NO YES I	OK .	

NO

YES

NO YES DK

DK

NO

YES DK

NO YES DK

32. supported work

33. other (describe:_