BRIEFEST SACA: ANSWER THE NEXT SECTION AT EACH REPORT:

MA. In the last 3 months, have you 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

Have you stayed <u>overnight</u> 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.	__assessment __individual treatment/therapy __group treatment __family/parent treatment/ed __medication __education/training
2. Drug or alcohol treatment unit	NO YES DK	__ __ __nts.	__assessment __individual treatment/therapy __group treatment __family/parent treatment/ed __medication __education/training
3. Residential treatment center	NO YES DK	__ __ __nts.	__assessment __individual treatment/therapy __group treatment __family/parent treatment/ed __medication __education/training
4. Group home	NO YES DK	__ __ __nts.	__assessment __individual treatment/therapy __group treatment __family/parent treatment/ed __medication __education/training
5. Foster home	NO YES DK	__ __ __nts.	__assessment __individual treatment/therapy __group treatment __family/parent treatment/ed __medication __education/training
6. Detention center/Prison or jail	NO YES DK	__ __ __nts.	__assessment __individual treatment/therapy __group treatment __family/parent treatment/ed __medication __education/training
7. Emergency shelter for problems with behaviors or feelings.	NO YES DK	__ __ __nts.	__assessment __individual treatment/therapy __group treatment __family/parent treatment/ed __medication __education/training
8. Other: describe_____	NO YES DK	__ __ __nts.	__assessment __individual treatment/therapy __group treatment __family/parent treatment/ed __medication __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, have you 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. Have you 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. __ __ __days	__assessment __individual treatment/therapy __group treatment __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	__assessment __individual treatment/therapy __group treatment __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.	__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, have you or your family received:

	You	Your 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	___ ___ ___