



Oklahoma Systems of Care

National Outcome Measures

Youth Name: _____ Interview Date: ____/____/____

Assessment: Baseline 6-Month 12-Month 18-Month
 24-month 30-Month 36-Month Exit

Functioning

How would you rate your child's overall health right now?

Excellent Very Good Good Fair Poor Refused Don't Know

We need to know what you think about how well your child was able to deal with everyday life during the last 30 days. Please indicate your disagreement/agreement with each of the following statements.

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Refused
My child is handling daily life.	1	2	3	4	5	9
My child gets along with family members.	1	2	3	4	5	9
My child gets along with friends and other people.	1	2	3	4	5	9
My child is doing well in school and/or work.	1	2	3	4	5	9
My child is able to cope when things go wrong.	1	2	3	4	5	9
I am satisfied with our family life right now.	1	2	3	4	5	9

Is anyone in your child's family currently serving on active duty in or retired/separated from the Armed Forces, the Reserves, or the National Guard?

Yes No *(This question will not appear in the Youth Information System)*

If the answer is 'yes', complete the 'Military Family and Deployment' form and fax to Kelly Phillips and John Vetter at (405) 325-5257.

Stability in Housing

In the past 30 days how many . . .	# Days / Times	Refused	Don't know
Nights has your child been homeless?	_____	<input type="checkbox"/>	<input type="checkbox"/>
Nights has your child spent in a hospital for MH care?	_____	<input type="checkbox"/>	<input type="checkbox"/>
Nights has your child spent in a substance abuse treatment facility?	_____	<input type="checkbox"/>	<input type="checkbox"/>
Nights has your child spent in a correctional facility (including juvenile justice)?	_____	<input type="checkbox"/>	<input type="checkbox"/>
Times your child has gone to an emergency room for a psychiatric or emotional problem?	_____	<input type="checkbox"/>	<input type="checkbox"/>

**In the past 30 days, where has your child been living most of the time?
(Do not read the list. Select only one.)**

- | | |
|---|--|
| <input type="checkbox"/> Caregiver's owned/rented house, apartment, trailer, room | <input type="checkbox"/> Hospital (medical) |
| <input type="checkbox"/> Independently owned/rented house, apartment, trailer, room | <input type="checkbox"/> Hospital (psychiatric) |
| <input type="checkbox"/> Someone else's house, apartment, trailer, room | <input type="checkbox"/> Detox / Inpatient or Residential Substance Abuse Treatment Facility |
| <input type="checkbox"/> Homeless | <input type="checkbox"/> Transitional Living Facility |
| <input type="checkbox"/> Group Home | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Foster Care (therapeutic) | <input type="checkbox"/> Refused |
| <input type="checkbox"/> Correctional Facility | <input type="checkbox"/> Don't Know |

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

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Refused
I know people who will listen and understand me when I need to talk.	1	2	3	4	5	9
I have people that I am comfortable talking with about my child's problems.	1	2	3	4	5	9
In a crisis, I would have the support I need from family or friends.	1	2	3	4	5	9
My child has people with whom s/he can do enjoyable things.	1	2	3	4	5	9

Education

1. During the last 30 days of school, how many days was your child absent for any reason?
- | | | |
|---------------------------------|--|---|
| <input type="checkbox"/> 0 Days | <input type="checkbox"/> 3 to 5 Days | <input type="checkbox"/> Refused |
| <input type="checkbox"/> 1 Day | <input type="checkbox"/> 6 to 10 Days | <input type="checkbox"/> Don't Know |
| <input type="checkbox"/> 2 Days | <input type="checkbox"/> More than 10 Days | <input type="checkbox"/> Not Applicable |
2. How many days were unexcused absences?
- | | | |
|---------------------------------|--|---|
| <input type="checkbox"/> 0 Days | <input type="checkbox"/> 3 to 5 Days | <input type="checkbox"/> Refused |
| <input type="checkbox"/> 1 Day | <input type="checkbox"/> 6 to 10 Days | <input type="checkbox"/> Don't Know |
| <input type="checkbox"/> 2 Days | <input type="checkbox"/> More than 10 Days | <input type="checkbox"/> Not Applicable |
3. What is the highest level of education your child has finished, whether or not s/he received a degree?
- | | |
|--|--|
| <input type="checkbox"/> Never Attended | <input type="checkbox"/> 8 th Grade |
| <input type="checkbox"/> Pre-School | <input type="checkbox"/> 9 th Grade |
| <input type="checkbox"/> Kindergarten | <input type="checkbox"/> 10 th Grade |
| <input type="checkbox"/> 1 st Grade | <input type="checkbox"/> 11 th Grade |
| <input type="checkbox"/> 2 nd Grade | <input type="checkbox"/> 12 th Grade / HS Diploma / GED |
| <input type="checkbox"/> 3 rd Grade | <input type="checkbox"/> Voc/Tech Diploma |
| <input type="checkbox"/> 4 th Grade | <input type="checkbox"/> Some College / University |
| <input type="checkbox"/> 5 th Grade | <input type="checkbox"/> Refused |
| <input type="checkbox"/> 6 th Grade | <input type="checkbox"/> Don't Know |
| <input type="checkbox"/> 7 th Grade | |

Criminal Justice

1. In the past 30 days, how many times has your child been arrested?
- _____ Times Refused Don't Know

<If this is a baseline, the form is complete. Do not continue.>

NOTE: The following sections – ‘Perception of Care’ and ‘Services Received’ – are intended for follow-up assessments only. Do not complete these sections during baselines.

Perception of Care

We need to know what you think the services your child received during the last 30 days, the people who provided them, and the results. Please indicate your disagreement/agreement with each of the following statements.

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Refused
Staff here treated me with respect.	1	2	3	4	5	9
Staff respected my family's religious/spiritual beliefs.	1	2	3	4	5	9
Staff spoke with me in a way that I understood.	1	2	3	4	5	9
Staff was sensitive to my cultural/ethnic background.	1	2	3	4	5	9
I helped choose my child's services.	1	2	3	4	5	9
I helped to choose my child's treatment goals.	1	2	3	4	5	9
I participated in my child's treatment.	1	2	3	4	5	9
Overall, I am satisfied with the services my child received.	1	2	3	4	5	9
The people helping my child stuck with us no matter what.	1	2	3	4	5	9
I felt my child had someone to talk to when s/he was troubled.	1	2	3	4	5	9
The services my child and family received were right for us.	1	2	3	4	5	9
My family got the help we wanted for my child.	1	2	3	4	5	9
My family got as much help as we needed for my child.	1	2	3	4	5	9

Services Received (Staff Report)

On what date did the youth last receive services? _____ / _____
Month Year

Check the service types from the list below that your project provided to the consumer since his/her last assessment.

Core Services Provided

- Screening
- Assessment
- Treatment Planning or Review
- Psychopharmacological Services
- Mental Health Services

[If Mental Health is selected, please estimate how frequently MH services were delivered]

- _____ times per Day
 Week
 Month
 Year

- Co-occurring Services
- Case Management
- Trauma-specific Services

Was the consumer referred to another provider for any of the above core services?

- Yes No

Support Services Provided

- | | |
|--|---|
| <input type="checkbox"/> Medical Care | <input type="checkbox"/> Education Services |
| <input type="checkbox"/> Employment Services | <input type="checkbox"/> Housing Support |
| <input type="checkbox"/> Family Services | <input type="checkbox"/> Social Recreational Activities |
| <input type="checkbox"/> Child Care | <input type="checkbox"/> Consumer Operated Services |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> HIV Testing |

Was the consumer referred to another provider for any of the above support services?

- Yes No