



PLEASE EMAIL OR FAX TO: Heather Hershberger
 FAX: 319-335-4484 heather-hershberger@uiowa.edu

**State Youth Treatment – Implementation (SYT-I)
 Client Global Outcome Measures**

Please complete at 6 months post discharge.

 Name of Staff Member Completing Form

 Date Administered

 Agency Name

 Treatment Program

 GPRA Client ID

 GPRA Discharge Date

Please rate your total improvement whether or not, in your judgment, it is due entirely to the treatment program.

Compared to the month before you entered the program:	Improved	Same (no change)	Worse
1. In general, would you say you are...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Would you say your family interactions are...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Would you say your substance use is...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Would you say your mental health is...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Would you say your peer relations are...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How convenient was it to attend treatment? (please circle one)

Convenient	Neutral	Inconvenient
------------	---------	--------------

How satisfied are you with the services you received? (please circle one)

Satisfied	Neutral	Dissatisfied
-----------	---------	--------------

In general, do you agree that the agency staff was considerate of your cultural needs (if any)? (please circle one)

Disagree	Neutral	Agree
----------	---------	-------



PLEASE EMAIL OR FAX TO: Heather Hershberger
FAX: 319-335-4484 heather-hershberger@uiowa.edu

**State Youth Treatment – Implementation (SYT-I)
Family Global Outcome Measures**

Please complete at 6 months post discharge.

Name of Staff Member Completing Form

Date Administered

Agency Name

Family Member Relationship to Adolescent

GPRA Client ID

GPRA Discharge Date

Please rate your total improvement whether or not, in your judgment, it is due entirely to the treatment program.

Compared to the month before you entered the program:	Improved	Same (no change)	Worse
1. In general, would you say your adolescent is...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Would you say your family interactions are...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Would you say your adolescent's substance use is...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Would you say your adolescent's mental health is...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Would you say your adolescent's peer relations are...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How convenient was it to attend treatment? (please circle one)

Convenient	Neutral	Inconvenient
------------	---------	--------------

How satisfied are you with the services your adolescent received? (please circle one)

Satisfied	Neutral	Dissatisfied
-----------	---------	--------------

In general, do you agree that the agency staff was considerate of your adolescent's cultural needs (if any)? (please circle one)

Disagree	Neutral	Agree
----------	---------	-------



PLEASE EMAIL OR FAX TO: Heather Hershberger
FAX: 319-335-4484 heather-hershberger@uiowa.edu

**State Youth Treatment – Implementation (SYT-I)
Family Global Outcome Measures**

Revised 4/6/2016