THE IOWA CONSORTIUM
FOR SUBSTANCE ABUSE RESEARCH AND EVALUATION

SYT-I Instructions for New Forms

All forms are sent to Heather Hershberger at
heather-hershberger@uiowa.edu

Created April, 2016

Updated June, 2016

Intake form

- Please complete and send within 7 days of the GPRA intake.
- If you do not have access to the Unique Client Number, please enter "pending"
  - We will send a reminder to update the Consortium with UCN
- If there is more than one other adult participating in treatment, please document in an email with the relationship to the client.

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

State Youth Treatment – Implementation (SYT-I)
Client Intake Form

**** Please complete and send within 7 days of the GPRA intake. ****

Date Client Intake Form Completed: (Date format 01/01/16)	
Staff Member Completing Form:	
Agency:	
Assigned Therapist:	
GPRA Client ID: (include special agency letters)	
GPRA Intake Date: (This date should match the Intake Date (Interview Date) entered in the GPRA record.)	
Unique Client Number: (10 digit number)	
Admission Date: (This date should match the Admission Date entered in the treatment admission record.)	
Treatment Plan (check all that apply)	**MDFT** ☐ **MET/CBT** ☐
Family Member(s) or Other Adult Participating in Treatment (check all that apply):	
Please specify the relationship of "other" to the client (if there is more than one other, please document in an email):	**Mom** ☐
	Dad ☐
	Sibling ☐
	Grandparent ☐
	Other ☐

Revised 4/1/16

Discharge form

- Please complete and send within 7 days of discharge from SYT-I grant.
- For the Total Number of Sessions of Family and Other Adults Attending, use the following examples for data entry:
  - If Mom, Sibling, and Grandma attend 3 sessions all together with client, then 3 would be entered on the line.
  - If Mom attended 4, and 2 of those sessions included Dad and other, then 4 would be entered on the line.

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State Youth Treatment – Implementation (SYT-I)
Client Discharge Notification Form

Please complete and send within 7 days of discharge from the SYT-I grant.

Date Discharged Intake Form Completed:
(Date format 01/01/16)

Staff Member Completing Form:

Agency:

Assigned Therapist:

GPRA Client ID:
(include special agency letters)

GPRA Discharge Date:
(This date should match Question #1, Discharge Date, in Section J of the GPRA.)

Unique Client Number:
(10 digit number)

Discharge Date:
(This date should match the Discharge Date entered in the treatment discharge record. If still in treatment, write that instead of the date.)

Completion of Treatment (check one):
Completion/Graduate ☐ Termination ☐

Treatment Plan (check all that apply) MDFT ☐ MET/CBT ☐

CASI Assessment: Yes ☐ No ☐

Screened for Co-occurring Diagnosis: Yes ☐ No ☐

Co-occurring Diagnosis: Yes ☐ No ☐

Number of Sessions Client Attended MDFT _____ MET/CBT _____

Parents, Siblings, Grandparents, and Other Adults participating in treatment:

Relationship to the Client	# of MDFT sessions attended	Age	Gender (circle gender)	Race (circle race)	Ethnicity (circle ethnicity)
Mom			F M	White/Caucasian African American/Black American Indian Other	Not Hispanic or Latino Puerto Rican Mexican Other Hispanic or Latino
Dad			F M	White/Caucasian African American/Black American Indian Other	Not Hispanic or Latino Puerto Rican Mexican Other Hispanic or Latino
Sibling			F M	White/Caucasian African American/Black American Indian Other	Not Hispanic or Latino Puerto Rican Mexican Other Hispanic or Latino
Grandparent			F M	White/Caucasian African American/Black American Indian Other	Not Hispanic or Latino Puerto Rican Mexican Other Hispanic or Latino
Other (specify relationship):			F M	White/Caucasian African American/Black American Indian Other	Not Hispanic or Latino Puerto Rican Mexican Other Hispanic or Latino

Please include only the total number of sessions that family members and/or other adults attended: _____

Revised 4/4/2016

Global Outcome Measures - Client

- Please complete 6 months post discharge.
- We will send updates when a client is in the window for a Global Outcome Measures.

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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…	○	○	○
2. Would you say your family interactions are…	○	○	○
3. Would you say your substance use is…	○	○	○
4. Would you say your mental health is…	○	○	○
5. Would you say your peer relations are…	○	○	○

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

Revised 4/6/2016

Global Outcome Measures - Family

- Please complete 6 months post discharge.
- We will send updates when a client is in the window for a Global Outcome Measures.

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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…	○	○	○
2. Would you say your family interactions are…	○	○	○
3. Would you say your adolescent's substance use is…	○	○	○
4. Would you say your adolescent's mental health is…	○	○	○
5. Would you say your adolescent's peer relations are…	○	○	○

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

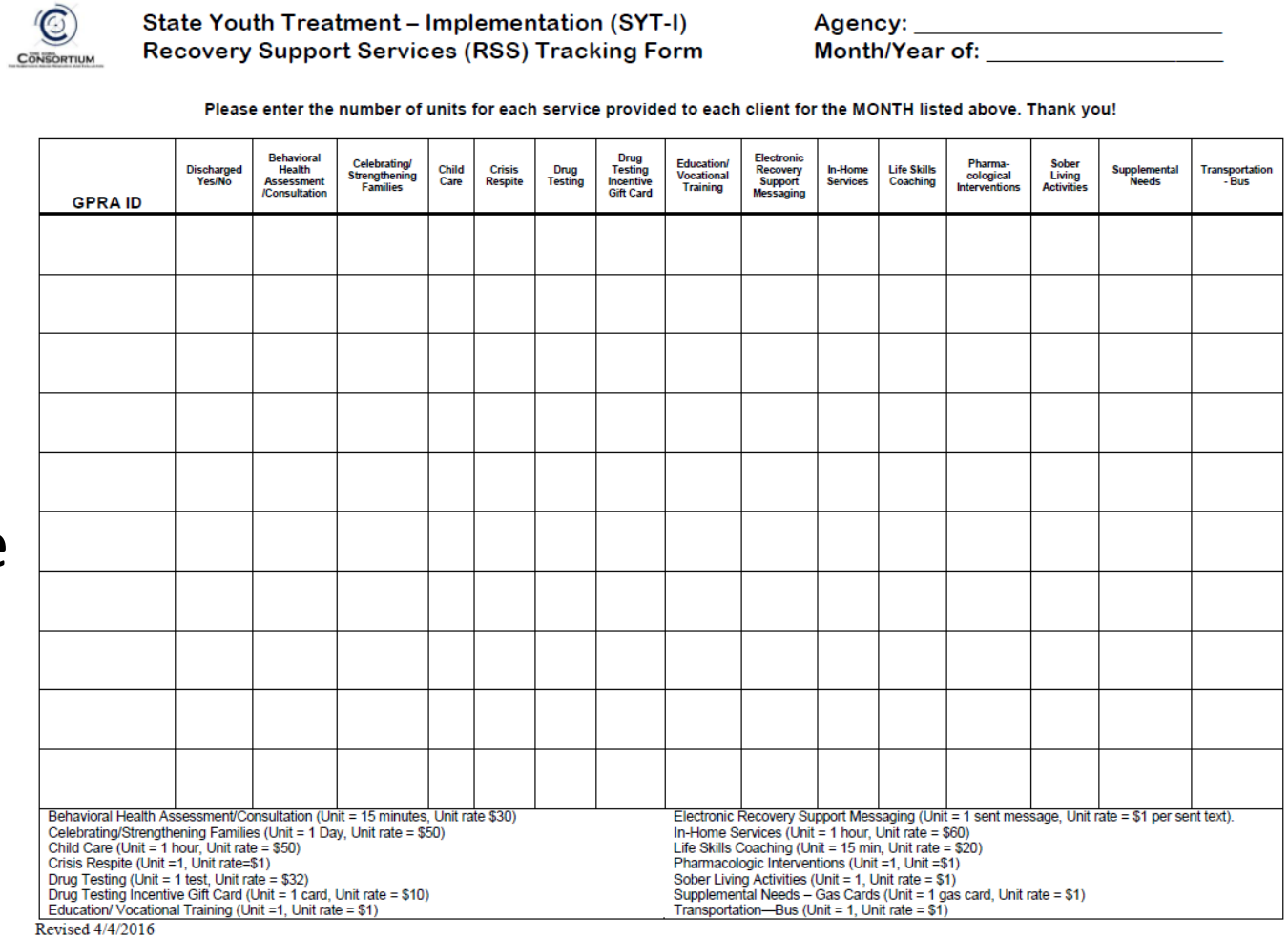
In general, do you agree that the agency staff was considerate of your adolescent's cultural needs (if any)? (please circle one)

Disagree	Neutral	Agree

Monthly Forms

Recovery Support Services (RSS)

- The services are for the month listed on form
- We will populate this form each month with the GPRA ID
- Please note anyone who has been discharged.



State Youth Treatment – Implementation (SYT-I)
Recovery Support Services (RSS) Tracking Form

Agency: _____
Month/Year of: _____

Please enter the number of units for each service provided to each client for the MONTH listed above. Thank you!

GPRA ID	Discharged Yes/No	Behavioral Health Assessment /Consultation	Celebrating/ Strengthening Families	Child Care	Crisis Respite	Drug Testing	Drug Testing Incentive Gift Card	Education/ Vocational Training	Electronic Recovery Support Messaging	In-Home Services	Life Skills Coaching	Pharma-cological Interventions	Sober Living Activities	Supplemental Needs	Transportation - Bus

Behavioral Health Assessment/Consultation (Unit = 15 minutes, Unit rate $30)
Celebrating/Strengthening Families (Unit = 1 Day, Unit rate = $50)
Child Care (Unit = 1 hour, Unit rate = $50)
Crisis Respite (Unit =1, Unit rate=$1)
Drug Testing (Unit = 1 test, Unit rate = $32)
Drug Testing Incentive Gift Card (Unit = 1 card, Unit rate = $10)
Education/ Vocational Training (Unit =1, Unit rate = $1)
Electronic Recovery Support Messaging (Unit = 1 sent message, Unit rate = $1 per sent text).
In-Home Services (Unit = 1 hour, Unit rate = $60)
Life Skills Coaching (Unit = 15 min, Unit rate = $20)
Pharmacologic Interventions (Unit =1, Unit =$1)
Sober Living Activities (Unit = 1, Unit rate = $1)
Supplemental Needs – Gas Cards (Unit = 1 gas card, Unit rate = $1)
Transportation—Bus (Unit = 1, Unit rate = $1)

Revised 4/4/2016

Please scan and email to: Heather Hershberger at heather-hershberger@uiowa.edu

Staff Training - Each month we will send a pre-populated form with the current information.

State Youth Treatment – Implementation (SYT-I)
Staff Training Tracking Form

Agency:
Month/Year of:

Please update any information that has changed thank you.

Staff Member Title Email Address		MDFT	MDFT Supervisor	MDFT Trainer	MET/CBT	MI	CASI	Trauma-Informed Care	FIT	Demographics	Currently in the project? Yes or No
	Trained?									Gender:	
	Original Certification Date									Race:	
	If not completed, estimated certification date									Ethnicity:	If no, date left:
	Recertification Date										

Was this record updated? Yes_____ or No _____ (put an X on the line)

- Please correct and/or update the information listed.
- If there are new staff on the project, please add them in the blank fields on the last page.
- If any staff leaves the project, be sure to update that field.

Infrastructure - Meetings

- Please only include meetings associated with SYT-I

State Youth Treatment – Implementation (SYT-I)
Infrastructure Events Form

Agency_____ Month/Year_____

MEETINGS

Meeting Date:	Start Time:	End Time:
Purpose / Topic of Meeting:		
Participants (who meeting was with):		
☐Face- to-Face ☐Telephone ☐Conference Call ☐Visual conferencing (e.g. Zoom) ☐Webinar		
Additional Information/Notes:		

Meeting Date:	Start Time:	End Time:
Purpose / Topic of Meeting:		
Participants (who meeting was with):		
☐Face- to-Face ☐Telephone ☐Conference Call ☐Visual conferencing (e.g. Zoom) ☐Webinar		
Additional Information/Notes:		

Revised 4/1/16

Please scan and email to: Heather Hershberger at heather-hershberger@uiowa.edu

Infrastructure – Presentations

- Please only include presentations associated with SYT-I

State Youth Treatment – Implementation (SYT-I)
Infrastructure Events Form

Agency_____ Month/Year_____

PRESENTATIONS

Presentation Date:	Start Time: End Time:
Topic of Presentation:	Location of Presentation:
Audience:	
☐Face- to-Face ☐Telephone ☐Conference Call ☐Visual conferencing (e.g. Zoom) ☐Webinar	
Additional Information/Notes:	

Presentation Date:	Start Time: End Time:
Topic of Presentation:	Location of Presentation:
Audience:	
☐Face- to-Face ☐Telephone ☐Conference Call ☐Visual conferencing (e.g. Zoom) ☐Webinar	
Additional Information/Notes:	

Revised 4/1/16