Substance Abuse and Mental Health Services Administration (SAMHSA) Unified Performance Reporting Tool (SUPRT) - A

ADMINISTRATIVE REPORT

Version: August 2024

Public reporting burden for this collection of information is estimated to average 15 minutes per response if all applicable sections are completed. To the extent that providers are able to incorporate and obtain much of this information as part of their ongoing client/consumer/participant intake, client record keeping, or follow-up, less time will be required for collection from clients specifically for this collection. Send comments regarding this burden estimate, or any other aspect of this collection of information, to the Substance Abuse and Mental Health Services Administration (SAMHSA) Reports Clearance Officer, Room 15E57B, 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The control number for this project is 0930-NEW.

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1. RECORD MANAGEMENT

Client ID |__|__|__|__|__|__|__|__|__|__|__|__|

Site ID |__|__|__|__|__|__|__|__|__|__|

Grant ID |__|__|__|__|__|__|__|__|

1. **[AT BASELINE] What is the client's month and year of birth (MM/YYYY)?** |____|____| / |____|____|____|____|

2. **What is the date of the assessment** (MM/DD/YYYY)**?**

|____|____| / |____|____| /|____|____|____|____|
MONTH DAY YEAR

3. **Which assessment type?**
   - ○ Baseline
   - ○ Reassessment (for clients in care)
   - ○ Annual (for clients in care for more than 12 months)

4. **[AT BASELINE ASSESSMENT ONLY] When did the client first receive services under this grant (MM/YYYY)?** |____|____| / |____|____|____|____|

5. **[AT REASSESSMENT OR ANNUAL] On what date did the client most recently receive services (MM/YYYY)?** |___|___| / |___|___|___|___|

6. **[AT REASSESSMENT] Did the client die since last assessment?**
   - □ Yes
   - □ No

6a. [IF QUESTION 6 IS YES] What was the cause of death?

- □ Suicide
- □ Overdose
- □ Other behavioral health cause
- □ Other cause
- □ Not documented
- □ Not applicable

2. BEHAVIORAL HEALTH HISTORY

1. What insurance does the client or guarantor have? Select all that apply.

- □ Medicare
- □ Medicaid
- □ Private Insurance or Employer Provided
- □ TRICARE, CHAMPUS, or other military health care
- □ Indian Health Service Tribal Health Care
- □ An assistance program [for example, a medication assistance program]
- □ Any other type of health insurance or health coverage plan
- □ None
- □ Not documented or not documented using this standard

2. In the past 30 days, was the client admitted to a hospital?

- ○ Yes – Behavioral health reasons, for example mental health or substance use disorder
- ○ Yes – Other health reasons, for example injury or illness
- ○ No
- ○ Not documented or not documented using this standard

3. In the past 30 days, did the client visit an emergency department?

- ○ Yes – Behavioral health reasons, for example mental health or substance use disorder
- ○ Yes – Other health reasons, for example injury or illness
- ○ No
- ○ Not documented or not documented using this standard

4. In the past 30 days, did the client experience a behavioral health crisis or requested crisis response, for example from 988 or 911?

- ○ Yes
- ○ No
- ○ Not documented or not documented using this standard

4a. [IF QUESTION 4 IS YES] What was the primary crisis issue?

- ○ Suicide risk
- ○ Other risk of harm to self or others (e.g. NSSI, homicidal thoughts)
- ○ Mental health
- ○ Substance use
- ○ Overdose
- ○ Other
- ○ Not documented or not documented using this standard
- ○ Not applicable

5. In the past 30 days, did the client spend one or more nights at a residential behavioral health treatment facility, for example crisis stabilization or residential substance use disorder treatment

facility, including for withdrawal management?

- ○ Yes
- ○ No
- ○ Not documented or not documented using this standard

6. **[CLIENTS 11 YEARS OR OLDER ONLY] In the past 90 days, was the client arrested, taken into custody, or detained?**

   - ○ Yes
   - ○ No
   - ○ Not documented or not documented using this standard
   - ○ Not applicable

7. **[CLIENTS 11 YEARS OR OLDER ONLY] In the past 90 days, did the client spend one or more nights in jail or a correctional facility?**

   - ○ Yes
   - ○ No
   - ○ Not documented or not documented using this standard
   - ○ Not applicable

8. **[CLIENTS 11 YEARS OR OLDER ONLY] In the past 90 days, has the client been on probation, parole, or intensive pretrial supervision for one or more days?**

   - ○ Yes
   - ○ No
   - ○ Not documented or not documented using this standard
   - ○ Not applicable

3. BEHAVIORAL HEALTH SCREENINGS

Please indicate the client's screening results, **as documented in an individual clinical or client record** (whether paper or electronic).

1. **Within the past 30 days, was the client screened or assessed by your program for risk of suicidality?**

   ○ Yes – Screening result was negative (no or low risk)
   ○ Yes – Screening result was positive (at risk)
   ○ No, not screened or assessed
   ○ Not documented or not documented using this standard

2. **Within the past 30 days, was the client screened or assessed by your program for substance use?**

   ○ Yes – Screening result was negative (no or low risk for substance use disorder (SUD))
   ○ Yes – Screening result was positive (at risk for SUD)
   ○ No, not screened or assessed
   ○ Not documented or not documented using this standard

3. **[IF QUESTION 2 IS "YES"] During the screening and assessment process, what was the reported use for the following substances?**

Substance	**Recent use** ***(within the past 30 days)***	**Past use** ***(greater than 30 days*****)**	**Never used**	**Not documented**
a. Alcohol	O	O	O	O
b. Opioids	O	O	O	O
c. Cannabis	O	O	O	O
d. Sedative, hypnotic, or anxiolytics	O	O	O	O
e. Cocaine	O	O	O	O
f. Other stimulants	O	O	O	O
g. Hallucinogens or psychedelics	O	O	O	O
h. Inhalants	O	O	O	O
i. Other psychoactive substances	O	O	O	O
j. Tobacco or nicotine	O	O	O	O

4. Within the past 30 days, was the client screened or assessed by your program for the following disorders?

Disorder	Not indicated	Screened / Assessed	Not screened	Not documented
a. Depression, depressive disorders	O	O	O	O
b. Anxiety disorders	O	O	O	O
c. Bipolar disorders	O	O	O	O
d. Psychosis, psychotic disorders	O	O	O	O
e. Trauma disorders, including PTSD	O	O	O	O
f. [IF CLIENT < 18 YEARS] Developmental, neurologic disorders	O	O	O	O
g. [IF CLIENT < 18 YEARS] Behavioral and emotional	O	O	O	O

4. BEHAVIORAL HEALTH DIAGNOSIS

Please indicate the client's current behavioral health diagnoses using the most current version of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes or corresponding Diagnostic Statistical Manual of Mental Disorders (e.g. DSM-5)**, as made by a clinician and documented in a clinical record**.

1. Substance use disorder diagnosis (record up to 3)

1a. Enter ICD-10-CM/DSM-5 code F10-F19- or indicate no diagnosis _____
1b. Enter ICD-10-CM /DSM-5 code F10-F19- or indicate no diagnosis _____
1c. Enter ICD-10-CM /DSM-5 code F10-F19- or indicate no diagnosis _____

2. Mental health diagnosis (record up to 3)

2a. Enter ICD-10-CM /DSM-5 code F20-F99- or indicate no diagnosis _____
2b. Enter ICD-10-CM /DSM-5 code F20-F99- or indicate no diagnosis _____
2c. Enter ICD-10-CM /DSM-5 code F20-F99- or indicate no diagnosis _____

3. Other factors influencing health status (record up to 3)

3a. Enter ICD-10-CM /DSM-5 code Z55-Z65- or Z69-Z76- or indicate none identified _____
3b. Enter ICD-10-CM /DSM-5 code Z55-Z65- or Z69-Z76- or indicate none identified _____
3c. Enter ICD-10-CM /DSM-5 code Z55-Z65- or Z69-Z76- or indicate none identified _____

Other Health Status Questions

Please indicate additional health status information as applicable and **as documented in a clinical record**.

4. Is the client currently pregnant?

- ○ Yes
- ○ No
- ○ Not applicable
- ○ Not documented or not documented using this standard

[CLINICAL HIGH RISK PSYCHOSIS CLIENTS ONLY]

5. [AT REASSESSMENT OR ANNUAL] Has the client experienced an episode of psychosis since their last assessment?

- ○ Yes
- ○ No
- ○ Not documented or not documented using this standard

[SUBSTANCE USE DISORDER TREATMENT CLIENTS ONLY]

6. In the previous 30 days, did the client experience an overdose or take too much of a substance that resulted in needing supervision or medical attention?

- ○ Yes
- ○ No
- ○ Not documented or not documented using this standard
- ○ Not applicable

6a. [IF QUESTION 6 IS YES] After taking too much of a substance or overdosing, what intervention did the client receive? Select all that apply.

- □ Naloxone (Narcan) or other opioid overdose reversal medication
- □ Care in an emergency department
- □ Care from a primary care provider
- □ Admission to a hospital
- □ Supervision by someone else
- □ Other
- □ Not documented or not documented using this standard
- □ Not applicable

[MAI PROGRAM CLIENTS ONLY]

7. Has the client ever tested positive for HIV?

- ○ Yes – currently taking ART
- ○ Yes – not currently taking ART
- ○ No – currently taking HIV PrEP
- ○ No – not currently taking HIV PrEP
- ○ Not documented or not documented using this standard
- ○ Not applicable

8. Has the client ever tested positive for hepatitis C?

- ○ Yes – currently taking viral hepatitis treatment
- ○ Yes – took treatment and cured
- ○ Yes – not currently taking viral hepatitis treatment
- ○ No or not with current active hepatitis C infection
- ○ Not documented or not documented using this standard
- ○ Not applicable

5. SERVICES RECEIVED

Services Received is collected by grantee staff at reassessment and annual assessments.

Identify all the services your grant project provided to the client since their previous assessment.

1. Behavioral Health Services

	Yes – Provided	Referred for Service	No – Not Provided or Referred	Not Documented / Unknown
1a. Screening, diagnosis, assessment	○	○	○	○
1b. Case or care management or coordination	○	○	○	○
1c. Person- or family-centered treatment planning	○	○	○	○
1d. Substance use psychoeducation	○	○	○	○
1e. Mental health psychoeducation	○	○	○	○
1f. Mental health therapy	○	○	○	○
1g. Co-occurring therapy (substance use & mental health)	○	○	○	○
1h. Group counseling	○	○	○	○
1i. Individual counseling	○	○	○	○
1j. Family counseling	○	○	○	○
1k. Psychiatric rehabilitation services	○	○	○	○
1l. Prescription medication for mental health disorder	○	○	○	○
1m. Medication for substance use disorder	○	○	○	○
1n. Intensive day treatment	○	○	○	○
1o. Withdrawal management (whether in hospital, residential, or ambulatory)	○	○	○	○
lp. After care planning and referrals	○	○	○	○
1q. Co-occurring (including developmental or neurologic)	○	○	○	○

2. [IF 1m – Medication for substance use disorder IS YES – PROVIDED] Indicate medication received

	Yes – Received	No – Not Received	Not Documented / Unknown
2a. Naltrexone	○	○	○
2b. Extended-release Naltrexone	○	○	○
2c. Disulfiram	○	○	○
2d. Acamprosate	○	○	○
2e. Methadone	○	○	○
2f. Buprenorphine	○	○	○
2g. Nicotine replacement	○	○	○
2h. Bupropion	○	○	○
2i. Varenicline	○	○	○

3. Crisis Services

	Yes – Provided	Referred for Service	No – Not Provided or Referred	Not Documented / Unknown
3a. Crisis response planning	○	○	○	○
3b. Crisis response	○	○	○	○
3c. Crisis stabilization	○	○	○	○
3d. Crisis follow-up	○	○	○	○

4. Recovery and Support Services

	Yes – Provided	Referred for Service	No – Not Provided or Referred	Not Documented / Unknown
4a. Employment support	○	○	○	○
4b. Family support services, including family peer support	○	○	○	○
4c. Childcare	○	○	○	○
4d. Transportation	○	○	○	○
4e. Education support	○	○	○	○
4f. Housing support	○	○	○	○
4g. Recovery housing	○	○	○	○
4h. Social recreational and cultural activities	○	○	○	○
4i. Mutual support groups	○	○	○	○
4j. Peer support specialist services, coaching or mentoring	○	○	○	○
4k. Respite care	○	○	○	○
4l. Therapeutic foster care	○	○	○	○

5. Integrated Services

	Yes – Provided	Referred for Service	No – Not Provided or Referred	Not Documented / Unknown
5a. Primary health care	○	○	○	○
5b. Maternal health care or OB/GYN	○	○	○	○
5c. HIV testing	○	○	○	○
5d. Viral hepatitis testing	○	○	○	○
5e. HIV treatment	○	○	○	○
5f. HIV pre-exposure prophylaxis (PrEP)	○	○	○	○
5g. Viral hepatitis treatment	○	○	○	○
5h. Other STI testing or treatment	○	○	○	○
5i. Dental care	○	○	○	○