Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA Unified Performance Reporting Tool (SUPRT) – A

QUESTION-BY-QUESTION GUIDE

September 2025 V1.0

SPARS

SAMHSA
Substance Abuse and Mental Health Services Administration

Contents

Guide Overview

These instructions are for collecting and reporting administrative client-level data for Substance Abuse and Mental Health Services Administration's (SAMHSA) Unified Performance Reporting Tool– Administrative (SUPRT-A). Data collected through this tool are entered into SAMHSA's Performance Reporting and Accountability System (SPARS).

The following is a summary of each section of this document:

1. **Deadlines and Reporting Requirements** – This section provides an explanation of the SUPRT-A requirement(s), when SUPRT-A should be completed, and when data collected using the SUPRT-A tool should be entered in SPARS.
2. **Data Collection Guidelines** – This section explains how to fill out the questions in SUPRT-A.
3. **Question-by-Question Guide** – This section is organized according to the sections of the tool. For each section, if offers clarification on selected questions that may benefit from additional guidance in one or more of the following areas:

Intent/Key Points	Explains the intent of each question.
Skip Pattern	Indicates which items should be skipped and under what circumstances. There are certain questions that are not applicable based on a previously answered question.
Responses and Definitions	Lists all response options for the question. Clarifies how to count or record certain responses and provides definitions if necessary.
Follow-on Questions	Clarifies if there are other follow-up questions to ask depending on the answer to the previous question in the tool.
Considerations for Grantee Staff	Applicable for questions answered by grantee staff; offers additional information for grantee staff to consider that may help them provide answers.

Deadlines and Reporting Requirements

SAMHSA grantees that provide direct services to clients are required to collect SUPRT-A data for each client who receives services. Grantee staff must collect data on all clients who enroll for treatment or services unless sampling has been approved for the program cohort.

SUPRT-A is completed by grantee and includes questions about the client's behavioral health history, behavioral health screenings, behavioral health diagnosis, services received, and demographics.

SUPRT-A is to be completed by the grantee at each assessment type: baseline, 3 or 6 month reassessment, annual assessment, and closeout assessment:

- **Baseline:** Baseline assessments must be completed 30 days before or after the client first receives services under the grant. Clients can receive multiple baselines if they have additional episodes of care under the same grant (i.e. they return to services after having been administratively closed out of the services).
- **Reassessment:** Reassessments are due either 3 or 6 months (90 or 180 days) after the baseline assessment date. Consult your NOFO to determine which reassessment (i.e., 3 or 6 month), is required. For most grant programs, the reassessment window spans 60 days; reassessments must be completed within the window of 30 days before through 30 days after the reassessment is due. Programs designated by SAMSHA may have a reassessment window of 120 days, including 60 days before to 60 days after the 3 or 6 month due date, based on the baseline assessment date.
- **Annual:** Annual assessments are due 365 days after the date of the client's baseline assessment and every 365 days thereafter. The annual assessment window spans 60 days; annual assessments may be completed 30 days before through 30 days after the annual assessment is due. Programs designated by SAMHSA, may have an annual assessment window of 120 days, including 60 days before to 60-days after the 12-month anniversary of the baseline assessment.
- **Closeout:** Closeout assessments are completed when the client is no longer receiving services through the grant program. Once a closeout is completed, any reassessment or annual assessments are no longer required. If a client returns for services after close out, a new cycle of baseline, reassessment, annual, and close out assessments would be required for the new episode of care.

If a client has a closeout record and re-enrolls in services from your grant, the grantee must complete a new baseline assessment, creating a new episode of care using the original client ID. Reassessments and annual assessments due dates would be 3 months/6 months or 12 months after the date of first services *for the new episode of care*.

More information about deadlines and details of the transition from CSAT Government Performance and Results Act Client Outcome Measures for Discretionary Programs Tool (GPRA) and CMHS National Outcome Measures (NOMs) can be found in the SUPRT-A Frequently Asked Questions (FAQ) in the Resources section on SPARS. Grantees can also contact their GPO for more information.

Data Collection Guidelines

Information reported in SUPRT-A should be sourced from data recorded in the grantee's record-keeping system(s), for example client intake forms, program documentation, or health records, including electronic health records. Additionally, if the data were collected for another grant

program, grantees can use that information if it was collected within 30 days before the client's first date of services received with the current program.

There is a 60-day window to complete SUPRT-A data collection for each client due for assessment. It must be completed within 30 days before or after initial services (baseline) or reassessment and annual assessment due dates. Some programs designated by SAMHSA may have a 120-day window to complete the baseline, 3 or 6 month reassessment and annual assessment.

NOTE: SUPRT-A does not need to be completed at the same time as SAMHSA's Unified Performance Reporting Tool – Client/Caregiver (SUPRT-C).

Grantees should review their current internal data collection processes to identify where to gather the data required for SUPRT-A and whether internal processes need to be adjusted to reflect the requirements. When data are not available through record-keeping systems(s) for grantee staff to report, grantee staff should select that the data are "**Not documented in records or not documented in records using this standard**." For example, when entering "In the past 30 days, was the client admitted to a hospital?" and grantees were not able to determine this, grantees should select "**Not documented in records or not documented in records using this standard**."

For Section F. Demographics, there are additional considerations in the collection and reporting of the data, please see that section for more details.

Table 1 outlines the sections of SUPRT-A and the type of information collected in each section.

Table 1. SUPRT-A Tool Sections, and Description

Tool Section	Description
A. Record Management	Collects administrative details including the Client ID, Site ID, Grant ID, and date of assessment.
B. Behavioral Health History	Collects client's insurance type, acute services utilized in the past 30 days, and justice system involvement in the past 90 days.
C. Behavioral Health Screenings	Collects client's screening or assessment results in the past 30 days.
D. Behavioral Health Diagnosis	Collects client's current behavioral health diagnosis, and other health conditions.
E. Services Received	Collects information about services provided through the grant.
F. Demographics	Collects client's demographic information, including race/ethnicity and sex. Grantee staff are asked to collect demographic information on SUPRT-A **only if a client declines SUPRT-C entirely**. If a client begins SUPRT-C, even if they do not complete it, then grantee staff will not collect demographic data in SUPRT-A.

Grantees can access the SUPRT-A in the Resources section of the SPARS website. A SPARS account is required to access resources.

Not every section or question is required at each assessment. Please see Table 2 for an overview of required SUPRT-A sections by assessment type.

Table 2. Required SUPRT-A Sections by Assessment Type

SUPRT-A Section	Baseline	Reassessment	Annual	Closeout
A. Record Management	Yes*	Yes*	Yes*	Yes*
B. Behavioral Health History	Yes	Yes	Yes	No
C. Behavioral Health Screenings	Yes	Yes	Yes	No
D. Behavioral Health Diagnosis	Yes	Yes	Yes	No
E. Services Received	No	Yes	Yes	Yes
F. Demographics	Yes**	No	No	No

*Not all questions are required

**This section is not required if clients consent to SUPRT-C at baseline.

Consent

The client or caregiver may decline consent for sharing information with SAMHSA, including behavioral health history, behavioral health screenings, behavioral health diagnosis, and demographics.

Processes to obtain and document consent for data sharing should be part of the participant protection documentation submitted to SAMHSA at grant award.

Question-by-Question Guide

This section provides additional information for individual questions within each section of the SUPRT-A. Questions are presented here in the order that they appear in the tool.

Section A. Record Management

This section collects client and grantee identification. This information helps SAMHSA track and manage client data, ensure proper documentation, and maintain the accuracy of program reporting and evaluation. Grantee staff collect administrative client identification information such as client ID, site ID, and date of assessment for SPARS entry and tracking.

Section Instructions

RECORD MANAGEMENT information is collected by grantee staff at baseline, reassessment, annual assessment, and closeout, even when SUPRT-C is not required or completed. RECORD MANAGEMENT information is collected in the SUPRT-A by grantee staff using the client's data documented in the record-keeping system.

Enter the Client ID—The Client ID is a unique client identifier that the grantee assigns to each client. It can be between 1 and 9 characters and can include both numerals and letters. This ID is intended to track a specific client through their assessments (intake, reassessment, annual, and closeout), while maintaining the anonymity of the client. Each client must have their own unique ID. Grantees should use the same unique client ID each time that client is assessed, even if the client has more than one episode of care. For confidentiality reasons, do not use any part of the client's date of birth, Social Security Number, Medicaid/Medicare number, name or other personally identifiable information in the Client ID.

Enter the Site ID— Site IDs can be used to differentiate between multiple locations under the same grant. The SUPRT-A tool will provide a dropdown of Site IDs associated with the grant. If a grant does not have an associated Site ID, grantees can leave this field blank. For example, CSAT has not historically had Site IDs and subsequently will leave this field blank.

Enter the Grant ID—The Grant ID is the SAMHSA-assigned grant identification number. Grant IDs can be found on the Notification of Award (NOA).

A1. [AT BASELINE] What is the client's month and year of birth (MM/YYYY)?

Intent/Key Points	The intent is to record the client's month and year of birth to understand who the program is reaching and whether child or adult prompts and skip patterns should be used.
Skip Pattern	Only answer this question if this is a Baseline assessment. Skip this question if this is not a Baseline assessment.
Responses and Definitions	Enter date as MM/YYYY. EXAMPLE: January, 2000, should be entered as 01/2000. This question is required for record submission.

A2. What is the date of the assessment (MM/DD/YYYY)?

Intent/Key Points	The intent is to record the date the assessment is completed.
Skip Pattern	None
Responses and Definitions	Enter date as MM/DD/YYYY. EXAMPLE: January 3, 2000, should be entered as 01/03/2000. This question is required for record submission.

A3. Which assessment type?

Intent/Key Points	The intent is to record the assessment type for which data are being collected.
Skip Pattern	None
Responses and Definitions	• *Baseline* – The assessment completed when a client begins a new episode of care. • *Reassessment* – The assessment completed when a client has been in care for 3 or 6 months since their first services received for the current episode of care if a record close out has not been completed. • *Annual* – The assessment completed when a client has been in care for 12 months since their first services received for the current episode of care, and every 12 months thereafter until a record close out is completed. • *Record closeout* – The assessment completed when a client completes the program or is no longer engaged in grant services (e.g., client lost to contact, client withdrew from/refused care, client referred/transferred out of care, client was incarcerated/moved out of the area/died, etc.). Record closeouts are required for all active clients at the end of the grant project. This question is required for record submission.

A4. [AT BASELINE ASSESSMENT ONLY] When did the client first receive services under this grant (MM/YYYY)?

Intent/Key Points	The intent is to record the first date the client began receiving services as a result of the grant in the current episode of care.
Skip Pattern	Only answer this question if this is a Baseline assessment. Skip this question if this is not a Baseline assessment.
Responses and Definitions	Enter date as MM/YYYY. EXAMPLE: January, 2000, should be entered as 01/2000. This question is required for baseline record submission. If the client is starting a new episode of care (second, third, etc.), enter the date that the client started receiving services under the grant in this new episode of care.

A5. [AT REASSESSMENT OR ANNUAL OR CLOSEOUT] When did the client most recently receive services under this grant (MM/YYYY)?

Intent/Key Points	The intent is to record the most recent date the client received services during the current episode of care.
Skip Pattern	Only answer this question if this is a Reassessment or Annual or Closeout assessment. Skip this question if this is a Baseline assessment.
Responses and Definitions	Enter date as MM/YYYY. EXAMPLE: January, 2000, should be entered as 01/2000. This question is required for reassessment, annual, or closeout record submission.

A6. [For CLOSEOUT ASSESSMENT] Why are you closing out this client's record?

A6a. [IF QUESTION A6 IS DEATH] What is the cause of death?

Intent/Key Points	The intent is to record the reason the client is no longer actively receiving SAMHSA grant services.
Skip Pattern	Only answer this question if this is a Closeout assessment. Skip this question if this is not a Closeout assessment.
Responses and Definitions	• *Completed the program* – The client completed the program or left before completion with treatment staff approval. • *No contact* – The client was not in contact with the grant, and grant staff were unable to reach them over a period set forth in their internal policy or a period of 12 months. • *Withdrew from/Refused treatment* – The client chose to end or not follow the treatment plan against clinical advice. • *Referred out* – The client was directed to another program or service, including those not funded by SAMHSA. • *Transferred to a different grant program* – The client was transferred to another grant program within the grantee organization and is no longer served under this grant. • *Incarceration* – The client was incarcerated while receiving services • *Moved* – The client relocated and can no longer continue treatment or services through the grant. • *Death* – The client died prior to completing services or treatment. • *Other* – The client's record close out does not fit any of the categories listed.
Follow-on Questions	If the client's reason for closeout is "Death," answer the follow-up question A6a: • **A6a. [IF QUESTION A6 IS DEATH] What is the cause of death?** Response options: – *Suicide* – *Overdose* – *Other behavioral health cause* – *Other cause* – *Not documented in record* – If grantee's do not know the cause of death, they should not assume and select not documented in record.

Section B. Behavioral Health History

This section collects information on the client's insurance, use of hospitals or emergency services, and their involvement with the justice system. **These data are used** to monitor program outcomes such as increasing access to care and decreased use of emergency systems or justice system involvement.

B1. What insurance does the client or guarantor have? Select all that apply.

Intent/Key Points	The intent is to record what insurance the client or guarantor has. Clients may have more than one insurance.
Skip Pattern	Skip at closeout.

Responses and Definitions	• *Medicare* – A federal health insurance program for individuals who are 65 or older; certain younger individuals with disabilities; individuals with End-Stage Renal Disease (permanent kidney failure requiring dialysis or transplant). • *Medicaid* – Health care provided by the states and the federal government to assist low-income people, families and children, pregnant women, the elderly, and people with disabilities. • *Private Insurance or Employer Provided* – Health care provided by various sources, including the individual's employer and a state or federal marketplace. It includes health maintenance organizations (HMOs), participating provider options (PPOs), exclusive provider organizations (EPOs), and point-of-service (POS) plans. The government does not provide private health insurance. • *TRICARE, CHAMPUS, CHAMPVA or other veteran or military health care* – Health programs specifically designed for active duty/retired U.S. Military/Armed Forces members, National Guard/Reserve members, and their families (e.g., spouses/children). • *Indian Health Service Tribal Health* –Healthcare provided by Indian health care programs, including Indian Health Service (IHS), a Tribe, or an urban Indian health program. • *An assistance program [for example, a medication assistance program]* – Programs which help individuals connect with health care and coverage. Often based on age, income, and/or employment guidelines. For example, a medication assistance program, which provides financial help to lower prescription costs for adults aged 65+. • *Any other type of health insurance or health coverage plan* – Other health insurance or health coverage plan not mentioned above. • *None* – Client does not have health insurance • *Not documented in records or not documented in records using this standard* – Clients health insurance information is not documented or not able to align to response options. *Guarantor* is the person responsible for covering the expenses for the behavioral health services. This person is not necessarily the one receiving care but may hold the insurance for the family or as a guardian especially if the client is a minor.
Considerations for Grantee Staff	This is a select all that apply question. If "*None*" or "*Not documented in records or not documented in records using this standard*" is selected, no other health insurance type can be selected.

B2. In the past 30 days, was the client admitted to a hospital?

Intent/Key Points	The intent is to record whether the client was hospitalized in the past 30 days and, if so, the reason for the admission.

Skip Pattern	Skip at closeout.
Responses and Definitions	• *Yes – Behavioral health reasons, for example mental health or substance use disorder* - Use this response if the client was hospitalized (one or more nights) one or more times for mental health or substance use or a behavioral health crisis. • *Yes – other health reasons, for example injury or illness* - Use this response if the client did not have any hospitalization(s) for a behavioral health reason but was hospitalized for injury or illness. Note that if the physical injury was a result of a behavioral health crisis, it should be reported under behavioral health reasons. • *No* – Information about hospitalizations visits is routinely collected and documented, but none occurred during the past 30 days. • *Not documented in records or not documented in records using this standard* - Information about hospitalization(s) is not available in client records or documentation does not provide reason for hospitalization and/or date.

B3. In the past 30 days, did the client visit an emergency department?

Intent/Key Points	The intent is to record whether the client visited an emergency department (ED) in the past 30 days and, if so, the reason for the visit.
Skip Pattern	Skip at closeout.
Responses and Definitions	• *Yes – Behavioral health reasons, for example mental health or substance use disorder* - Use this response if the client visited an emergency department one or more times for mental health or substance use or a behavioral health crisis. • *Yes – other health reasons, for example injury or illness* - Use this response if the client did not have any urgent care, emergency department or emergency room visits for a behavioral health reason but did have to use the emergency room or urgent care for injury or illness. Note that if the physical injury was a result of a behavioral health crisis, it should be reported under behavioral health reasons. • *No* – Information about ED visits is documented, but none occurred during the past 30 days. • *Not documented in records or not documented in records using this standard* - Information about ED visits is not available in client records or documentation does not provide reason for use and/or date. *Emergency department* includes emergency department, or emergency room.

B4. In the past 30 days, did the client experience a behavioral health crisis or request crisis response, for example for 988 or 911?

B4a. [IF QUESTION B4 IS YES] What is the primary crisis issue?

Intent/Key Points	The intent is to record whether the client experienced a behavioral health crisis or sought crisis response in the past 30 days.
Skip Pattern	Skip at closeout.
Responses and Definitions	• *Yes* – Behavioral health crisis or requested crisis response in the 30 days prior to the assessment. • *No* – Clients are routinely asked about behavioral crises and their responses are documented in records, but no crisis occurred in the 30 days prior to the assessment. • *Not documented in records or not documented in records using this standard* – Use this response when no crisis is reported and data is not routinely collected and documented about behavioral health crisis and/or the date of the crisis was not recorded.

Follow-on Questions	If the answer to Question B4 is "Yes," answer the follow-up question B4a: • **B4a. What is the primary crisis issue?** Respondents should select from one of the following response options: – *Suicide risk-an individual being at an immediate, or imminent risk of death by suicide.* – *Other risk of harm to self or others (e.g. Non-suicidal Self-Injury (NSSI), homicidal thoughts)-a substantial probability that a person will, in the near future, cause serious physical injury to themselves or another person.* – *Mental health-a situation where a person's emotional or mental state poses an immediate danger to themselves or other or severely impairs their ability to function and care for themselves.* – *Substance use other than overdose-the consumption of substances, including illegal drugs, alcohol, and the misuse of prescription medications.* – *Overdose-an overdose occurs when a toxic amount of a substance, or a combination of substances, overwhelms the body's ability to function properly. An overdose can lead to serious injury and even death.* – *Other* – *Not documented in records or not documented in records using this standard*
Considerations for Grantee Staff	If a client had multiple behavioral health crises or requested crisis responses for different reasons, select "*Other*" for item B4a.

B5. 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?

Intent/Key Points	The intent is to record whether the client spent one or more nights in a residential behavioral health treatment facility in the past 30 days.
Skip Pattern	Skip at closeout.
Responses and Definitions	• *Yes* – In the 30 days prior to the assessment, client spent one or more nights at a residential behavioral health treatment facility, for example crisis stabilization, residential substance use disorder treatment facility, residential mental health treatment, or withdrawal management. Intensive day treatment at a residential facility should not be included here. Nights spent at a hospital for behavioral health reasons should not be reported here. • *No* – Information about behavioral health residential treatment is routinely collected and documented in client records, and client did not have any nights at this type of facility during the 30 days prior to the assessment. • *Not documented in records or not documented in records using this standard* - Use this response when no residential treatment is reported and data is not routinely collected and documented about behavioral health residential treatment and/or the date of the treatment was not recorded.

B6. [CLIENTS 11 YEARS OR OLDER ONLY] In the past 90 days, was the client arrested, taken into custody, or detained?

Intent/Key Points	The intent is to record whether the client was arrested, taken into custody, or detained in the past 90 days.
Skip Pattern	Only answer this question if the client is 11 years or older. Skip if the client is under age 11. Skip at closeout.
Responses and Definitions	• *Yes* – In the 30 days prior to the assessment, it was reported to and documented by the grantee that the client was arrested, taken into custody, or detained one or more times. Someone who was stopped by the police but was free to go would not be reported here. • *No* • *Not applicable* • *Not documented in records or not documented in records using this standard*

B7. [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?

Intent/Key Points	The intent is to record whether the client spent one or more nights in jail or a correctional facility in the past 90 days.
Skip Pattern	Only answer this question if the client is 11 years or older. Skip if the client is under 11 years of age. Skip at closeout.
Responses and Definitions	• *Yes* • *No* • *Not applicable* • *Not documented in records or not documented in records using this standard*

B8. [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?

Intent/Key Points	The intent is to record whether the client was on probation, parole, or intensive pretrial supervision for one or more days in the past 90 days.
Skip Pattern	This question is only to be answered if the client is 11 years or older. Skip if the client is under 11 years of age. Skip at closeout.
Responses and Definitions	• *Yes* – In the client records, there is documentation that in the 90 days prior to the assessment, the client was on probation, parole, or intensive supervision for one or more days. • *No* – Client probation, parole, or intensive supervision is routinely collected and documented in client records and the client did not have any days as such in the 90 days prior to the assessment. • *Not applicable* – Client is younger than 11 years old or this is a Closeout record. • *Not documented in records or not documented in records using this standard.*

Section C. Behavioral Health Screenings

This section collects behavioral health information, including screenings for suicidality, substance use, and mental health disorders. These data are used track client behavioral health outcomes. Grantee staff should refer to the client's records for this information.

C1. Within the past 30 days, was the client screened or assessed by your program for risk of suicidality?

Intent/Key Points	The intent is to record whether the client was screened or assessed for suicide risk in the past 30 days. There is no specific required tool for the suicide screening. However, it is preferred that, where possible, grantees use available technical assistance from SAMHSA to select standardized tools that have been validated or adapted for their context; it may be that the grantee needs to have different tools selected for different populations being served. For further guidance: Grantees wanting to learn more about how to incorporate suicide screening, how to develop a suicidal safety plan or assess access to lethal means are encouraged to start with SAMHSA's Suicide Prevention Resource Center (SPRC) at www.sprc.org.
Skip Pattern	Skip at closeout.
Responses and Definitions	• *Yes – Screening result was negative (no or low risk)* – Use this response if the client was screened for suicide risk and was not found to be at risk. • *Yes – Screening result was positive (at risk)* – Use this response if the client was screened one or more times in the 30 days prior to the assessment for suicide risk and was found to be at risk on any one or more of the screens. • *No, not screened or assessed* – Use this response if the client was not screened for suicide risk in the 30 days prior to the assessment, including if the screening was not indicated because of age or previous screenings. • *Not documented in records or not documented in records using this standard* Use this response if results of suicide risk assessments are not documented in the client records and/or if the date of the documented assessment is not documented.

C2. Within the past 30 days, was the client screened or assessed by your program for substance use?

Intent/Key Points	The intent is to record whether the client was screened or assessed by your program for alcohol or substance use in the past 30 days.
Skip Pattern	Skip at closeout.
Responses and Definitions	• *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 in records or not documented in records using this standard*

C3. [IF QUESTION C.2 IS "YES"] During the screening and assessment process, what was the reported use for the following substances?

a. Alcohol
b. Opioids
c. Cannabis
d. Sedative, hypnotic, or anxiolytics
e. Cocaine
f. Methamphetamine
g. Other Stimulants
h. Hallucinogens or psychedelics
i. Inhalants
j. Other psychoactive substances
k. Tobacco or nicotine

Intent/Key Points	The intent is to record whether the client reported alcohol or substance use during screening or assessment, and if so, the recency of that use.
Skip Pattern	Only answer this question if question C2 is "Yes." Skip if answer to Question C2. is "No, not screened or assessed" or "Not documented in records or not documented in records using this standard." Skip at closeout.

Responses and Definitions	Respondents should select the client's reported use of each of the eleven listed substances: Respondents should indicate the client's reported use for each listed substance from the following response options: • *Recent use (within the past 30 days)* • *Past use (greater than 30 days)* • *Never used* • *Not documented* If the client refused to answer or could not recall their substance use at screening or assessment, select "Not documented." If a client has reported recent and past use, please only record that they have used recently.

C4. Within the past 30 days, was the client screened or assessed by your program for the following disorders? (Please select one per disorder)

a. Depression, depressive disorders

b. Anxiety disorders

c. Bipolar disorders

d. Psychosis, psychotic disorder

e. Trauma disorders, including PTSD

f. [IF CLIENT < 18 YEARS]
Developmental, neurologic disorders

g. [IF CLIENT < 18 YEARS]
Behavioral and emotional

Intent/Key Points	The intent is to record whether the client was screened or assessed by your program for certain behavioral health disorders in the past 30 days. There is no specific required tool for the mental health needs indicated below. However, it is preferred that, where possible, grantees use available technical assistance from SAMHSA to select standardized tools that have been validated or adapted for their context; it may be that the grantee needs to have different tools selected for different populations being served. See below for more specific examples.
Skip Pattern	Skip at closeout.

Responses and Definitions	• *Screened/assessed* • *Not screened* • *Not applicable –for C4f and C4g, clients who are 18 years or older.* • *Not documented* a. *Depression, depressive disorders* - … b. Anxiety disorders c. Bipolar disorders d. Psychosis, psychotic disorder e. *Trauma disorders, including PTSD* f. *[IF CLIENT < 18 YEARS] Developmental, neurologic disorders* – Use for screening of …… If the client is older the age of 18, select "Not applicable" g. *[IF CLIENT < 18 YEARS] Behavioral and emotional* Use for screening of …… If the client is older the age of 18, select "Not applicable"

Section D. Behavioral Health Diagnosis

This section collects information on diagnoses, including substance use, mental health, and other physical health diagnoses. These data are used to track clients' health outcomes.

D1. Substance use disorder diagnosis (record up to 3)

Intent/Key Points	The intent is to record the client's current substance use disorder diagnoses. The ICD-10 is a classification code set for categorizing diagnoses and the reason for visits in all healthcare settings which is mandated for medical coding for anyone covered under the Health Insurance Portability and Accountability Act (HIPAA). If a diagnosis has been made, it should be documented here using the standard coding. For more information, on ICD-10, see ICD-10 | CMS (https://www.cms.gov/medicare/coding-billing/icd-10-codes).
Skip Pattern	Skip at closeout.
Responses and Definitions	Respondents should indicate the diagnosis codes for each of the client's current substance use disorders: • *Enter ICD-10-CM F10-F19 (up to 3)* • *No diagnosis* F10 Alcohol related disorders F11 Opioid related disorders F12 Cannabis related disorders F13 Sedative, hypnotic, or anxiolytic related disorders F14 Cocaine related disorders F15 Other stimulant related disorders F16 Hallucinogen related disorders F17 Nicotine dependence F18 Inhalant related disorders F19 Other psychoactive substance related disorders Note that the descriptive label for each of the F category codes above was provided to assist in capturing records; however, refer to ICD-10 | CMS at https://www.cms.gov/medicare/coding-billing/icd-10-codes for updates. Report only the three character category for the diagnosis code, even if the more detailed information is available in the client record. e.g. report both F10.13 and F10.182 as F10. If more than three codes apply, indicate the codes most relevant to the client's participation in SAMHSA grant services.
Considerations for grantees staff	The paper tool allows for staff to write in the diagnosis code. Data entry will present a drop down of the codes listed above.

D2. Mental health diagnosis (record up to 3)

Intent/Key Points	The intent is to record the client's current mental health diagnosis. The ICD-10 is a classification code set for categorizing diagnoses and the reason for visits in all healthcare settings which is mandated for medical coding for anyone covered under the Health Insurance Portability and Accountability Act (HIPAA). If a diagnosis has been made, it should be documented here using the standard coding. For more information, on ICD-10, see ICD-10 | CMS (https://www.cms.gov/medicare/coding-billing/icd-10-codes).
Skip Pattern	Skip at closeout.
Responses and Definitions	Respondents should indicate the diagnosis codes for each of the client's current mental health diagnoses: • *Enter ICD-10-CM codes F20-F34, F39-F45, F48, F50-F51, F60, F63, F90, F91, F93-F95, F98-F99 (up to 3)* • *No diagnosis* F20 Schizophrenia F21 Schizotypal disorder F22 Delusional disorders F23 Brief psychotic disorder F24 Shared psychotic disorder F25 Schizoaffective disorders F28 Other psychotic disorder not due to a substance or known physiological condition F29 Unspecified psychosis not due to a substance or known physiological condition F30 Manic episode F31 Bipolar disorder F32 Depressive episode F33 Major depressive disorder, recurrent F34 Persistent mood [affective] disorders F39 Unspecified mood [affective] disorder F40 Phobic anxiety disorders F41 Other anxiety disorders F42 Obsessive-compulsive disorder F43 Reaction to severe stress, and adjustment disorders F44 Dissociative and conversion disorders F45 Somatoform disorders F48 Other nonpsychotic mental disorders F50 Eating disorders F51 Sleep disorders not due to a substance or known physiological condition

Responses and Definitions (cont.)	F60 Specific personality disorders F63 Impulse disorders F90 Attention-deficit hyperactivity disorders F91 Conduct disorders F93 Emotional disorders with onset specific to childhood F94 Disorders of social functioning with onset specific to childhood and adolescence F95 Tic disorder F98 Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence F99 Mental disorder, not otherwise specified Note that the descriptive label for each of the F category codes above was provided to assist in capturing records; however, refer to ICD-10 | CMS at https://www.cms.gov/medicare/coding-billing/icd-10-codes for updates. Report only the three character category for the diagnosis code, even if the more detailed information is available in the client record. e.g. report both F25.1 and F25.8 as F25. Only use F99 if this is the diagnosis code documented in the client record. If the client has a diagnosis category code that is not included in the list above for valid responses, report the diagnoses that are included or indicate no diagnosis. If more than three codes apply, indicate the codes most relevant to the client's participation in SAMHSA program services.
Considerations for grantees staff	The paper tool allows for staff to write in the diagnosis code. Data entry will present a drop down of the codes listed above.

D3. Other factors influencing health status (record up to 3)

Intent/Key Points	The intent is to record the other clinically determined social factors (e.g., problems related to education and literacy, employment, psychological or psychosocial circumstances) influencing the client's health status diagnosis. While "Z" codes are included in the ICD-10-CM classifications, they are an encounter reason code used to document social drivers of health (SDOH), not a diagnosis. Therefore, "Z" codes can be selected "based on self-reported data and/or information documented by any member of the care team" if their documentation is included in the client record.
Skip Pattern	Skip at closeout.
Responses and Definitions	Respondents may record up to 3 current other factors influencing health diagnosis codes or indicate no "diagnosis": • *Enter ICD-10-CMcode Z55-Z57, Z59-Z60, Z62-Z65, Z69 (up to 3)* • *No diagnosis* Z55 Problems related to education and literacy Z56 Problems related to employment and unemployment Z57 Occupational exposure to risk factors Z59 Problems related to housing and economic circumstances Z60 Problems related to social environment Z62 Problems related to upbringing Z63 Other problems related to primary support group, including family circumstances Z64 Problems related to certain psychosocial circumstances Z65 Problems related to other psychosocial circumstances Z69 Encounter for mental health services for victim and perpetrator of abuse Note that the descriptive label for each of the Z codes above was provided to assist in capturing records; however, refer to ICD-10 | CMS at https://www.cms.gov/medicare/coding-billing/icd-10-codes for updates. Report only the three character category for the Z code, even if the more detailed information is available in the client record. e.g. report both Z69.81 and Z69.02 as Z69. If the client has a Z category code that is not included in the list above for valid responses, report the Z codes that are included or indicate no diagnosis. If more than three codes apply, indicate the codes most relevant to the client's participation in the SAMHSA grant program.
Considerations for grantees staff	The paper tool allows for staff to write in the diagnosis code. Data entry will present a drop down of the codes listed above.

Other Health Status Questions

Respondents will document additional health status information as applicable and as documented in a clinical record.

D4. Is the client currently pregnant?

Intent/Key Points	The intent is to record the client's current pregnancy status.
Skip Pattern	Skip at closeout.
Response and Definitions	Respondents should select one of the following response options: • *Yes* • *No* • *Not applicable* • *Not documented in records or not documented in records using this standard*

D5. [CLINICAL HIGH RISK PSYCHOSIS CLIENTS ONLY] [AT REASSESSMENT OR ANNUAL] Has the client experienced an episode of psychosis since their last assessment?

Intent/Key Points	The intent is to record whether the client has experienced a recent episode of psychosis.
Skip Pattern	Only answer this question if the grant program is a Community Program for Outreach and Intervention with Youth and Young Adults at Clinical High Risk for Psychosis (CHR-P) and the assessment is 3- or 6-month Reassessment or Annual assessment. Skip this question at Baseline and Closeout assessment.
Response Options	Respondents should select one of the following response options: • *Yes* • *No* • *Not documented in records or not documented in records using this standard*
Considerations for Grantee Staff	For batch upload: Programs other than CHR-P can use the value of -1 to indicate this item is not applicable. For manual data entry: Programs other than CHR-P, please leave this question blank and during data cleaning a value of -1 to indicate this item is not applicable will be added to this variable.

D6. [SUBSTANCE USE DISORDER TREATMENT CLIENTS ONLY] 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?

D6a. [IF QUESTION D6 IS YES] After taking too much of a substance or overdosing, what interventions(s) did the client receive? Select all that apply.

Intent/Key Points	The intent is to record whether the client has experienced an overdose or otherwise required supervision or medical attention as a result of their substance use in the past 30 days.
Skip Pattern	Only answer this question if the grant program is a Center for Substance Abuse Treatment (CSAT) grant, otherwise skip. Skip at closeout.
Responses and Definitions	Respondents should select one of the following response options: • *Yes* • *No* • *Not applicable* • *Not documented in records or not documented in records using this standard*
Follow-on Questions	If the answer to question D6. is "Yes," provide a response to the following question: • **D6a. After taking too much of a substance or overdosing, what interventions(s) did the client receive? Select all that apply.** Response options: – *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 applicable* – If the answer to D6 is "No," or if grant is a CMHS grant – *Not documented in records or not documented in records using this standard*
Considerations for Grantee Staff	For batch upload: Programs housed in CMHS or CSAP can use the value of -1 to indicate this item is not applicable. For manual data entry: Programs housed in CMHS or CSAP, please leave this question blank and during data cleaning a value of -1 to indicate this item is not applicable will be added to this variable.

D7. [MAI PROGRAM CLIENTS ONLY] Has the client ever tested positive for HIV?

D7a. [IF QUESTION D.7 IS YES, HIV-INFECTED] Is the client currently on ART?

D7b. [IF QUESTION D.7 IS NO, HIV-NEGATIVE] Is the client currently taking HIV PrEP?

Intent/Key Points	The intent is to record whether the client has ever tested positive for human immunodeficiency virus (HIV).
Skip Pattern	Only answer this question if the grant program is a Minority Aids Initiative – Service Integration (MAI-SI) program. Skip at closeout.
Responses and Definitions	Respondents should select one of the following response options: • *Yes, HIV-positive* • *No, HIV-negative* • *Not documented in records or not documented in records using this standard*
Follow-on Questions	If the answer to D7 is "Yes, HIV-positive," complete question D7a: • **D7a. Is the client currently on ART?** Response Options: – *Yes, currently taking ART* – *No, not currently taking ART* – *Not documented in records or not documented in records using this standard* *ART* - antiretroviral therapy (ART) is a combination of medications that the individual must take every day (NIH, 2021). If the answer to D7 is "No, HIV-negative" complete question D7b.: • **D7b. Is the client currently taking HIV PrEP?** Response Options: – *Yes, currently on PrEP* – *No, not currently on PrEP* – *Not documented in records or not documented in records using this standard* *HIV PrEP* - Pre-Exposure Prophylaxis (PrEP) is medication used to prevent HIV infection in individuals who have tested negative but are at high risk of exposure (CDC, 2021). Emtricitabine in combination with tenofovir disoproxil fumarate (Truvada) or Emtricitabine in combination with tenofovir alafenamide (Descovy) are pills taken daily. The third medication, cabotegravir (Apretude), is an injection provided every 2 months
Considerations for Grantee Staff	For batch upload: Programs other than MAI can use the value of -1 to indicate this item is not applicable. For manual data entry: Programs other than MAI, please leave this question blank and during data cleaning a value of -1 to indicate this item is not applicable will be added to this variable.

D8. Has the client ever tested positive for Hepatitis C?

D8a. [IF QUESTION 8 IS YES, ACTIVE OR PREVIOUS HEPATITIS C INFECTION] Is the client currently taking viral Hepatitis C treatment?

Intent/Key Points	The intent is to record whether the client has ever tested positive for Hepatitis C.
Skip Pattern	Only answer this question if the grant program is a MAI-SI program. Skip at closeout.
Responses and Definitions	• *Yes, active or previous Hepatitis C infection* – use this response for any positive Hepatitis C test • *No, never had Hepatitis C* – use this response for negative Hepatitis C tests • *Not documented in records or not documented in records using this standard* - use this response for no documentation, and for clients who have never been tested for Hepatitis C
Follow-on Questions	If the answer to question D8 is "Yes, active or previous Hepatitis C infection," complete question D8a: • **D8a. Is the client currently taking viral Hepatitis C treatment?** Response Options: – *Yes, currently taking viral Hepatitis C treatment* – *No, took treatment and cured* – *No, Hepatitis C infection naturally cleared without need for treatment* – *No, not currently taking treatment* – *Not documented in records or not documented in records using this standard*

Section E. Services Received

This section collects information on the services the client received since the previous assessment. **These data are used to track service use. Grantee staff should skip this section at baseline.**

E1. Since the previous administrative assessment, did the project provide or refer the client for one or more behavioral health services?

E1a-o. If yes, please indicate which:

a. Case or care management or coordination
b. Person- or family-centered treatment planning
c. Substance use psychoeducation
d. Mental health psychoeducation
e. Mental health therapy
f. Co-occurring therapy (substance use & mental health)
g. Group counseling
h. Individual counseling
i. Family counseling
j. Psychiatric rehabilitation services
k. Prescription medication for mental health disorder
l. Medication for substance use disorder
m. Intensive day treatment
n. Withdrawal management (whether in hospital, residential, or ambulatory)
o. After care planning and referrals

Intent/Key Points	The intent is to record whether the grantee directly provided or referred the client to one or more behavioral health services since their previous assessment.
Skip Pattern	Skip if Baseline assessment.
Responses and Definitions	• Yes – The client was provided or referred to one or more behavioral health services. • No – The client was NOT provided or referred to one or more behavioral health services. • Not documented in records – There is no documentation of one or more behavioral services provided or referred for this client in the record.
Follow on Questions	If the answer to E1. is “Yes,” complete question E1a-o. • **E1a-o. If yes, please indicate which:** Response options: – *Yes – provided* – *Referred for service* – *No – not provided or referred* – *Not documented in records / unknown*

E2. [IF E1aI = MEDICATION FOR SUBSTANCE USE DISORDER IS YES – PROVIDED] Indicate medication received

a. Naltrexone
b. Extended-release Naltrexone
c. Disulfiram
d. Acamprosate
e. Methadone
f. Buprenorphine
g. Nicotine cessation therapy (e.g., Nicotine patch, gum, lozenge)
h. Bupropion
i. Varenicline
j. Other

Intent/Key Points	The intent is to record which medications for substance use disorder the grantee provided to the client.
Skip Pattern	Skip at Baseline. Skip if the answer to E1aI is "No" or "Not documented in records/unknown."
Responses and Definitions	Respondents should select one of the following options for each of the ten listed medications for substance use disorder: • *Yes – received* • *No – not received* • *Not documented in records/unknown* Grantee staff should not record medications the client received outside of grant funding. • Naltrexone • Extended-release Naltrexone • Disulfiram • Acamprosate • Methadone • Buprenorphine • Nicotine cessation therapy (e.g., Nicotine patch, gum, lozenge) • Bupropion • Varenicline • Other
Considerations for grantee staff	If "*Other*" is selected, no specification is needed.

E3. Since the previous administrative assessment, did the project provide or refer the client for one or more crisis services?

E3a-d. If yes, please indicate which:

a. Crisis response planning
b. Crisis response
c. Crisis stabilization
d. Crisis follow-up

Intent/Key Points	The intent is to record whether the grantee directly provided or referred the client to crisis services since the previous assessment.
Skip Pattern	Skip at Baseline.
Responses and Definitions	• *Yes* • *No* • *Not documented in records*
Follow-on Questions	If the answer to question E3. Is "Yes," complete question E3a: • **E3a-d. If yes, please indicate which:** Response options: – *Yes – provided* – *Referred for service* – *No – not provided or referred* – *Not documented in records/unknown* • Crisis response planning • Crisis response • Crisis stabilization • Crisis follow-up

E4. Since the previous administrative assessment, did the project provide or refer the client for one or more recovery support services?

E4a-l. If yes, please indicate which:

a. Employment support
b. Family support services, including family peer support
c. Childcare
d. Transportation
e. Education support
f. Housing support
g. Recovery housing
h. Spiritual, ceremonial, and/or traditional activities
i. Mutual support groups
j. Peer support specialist services, coaching or mentoring
k. Respite care
l. Therapeutic foster care

Intent/Key Points	The intent is to record whether the grantee directly provided or referred the client to recovery support services since the previous assessment.
Skip Pattern	Skip at Baseline.
Responses and Definitions	Respondents may choose from the following response options: • *Yes* • *No* • *Not documented in records*
Follow-on Questions	If the answer to question E4. Is "Yes," complete questions E4a-l: • **E4a-l. If yes, please indicate which:** Response options: – *Yes – provided* – *Referred for service* – *No – not provided or referred* – *Not documented in records / unknown*

E.5. Since the previous administrative assessment, did the project provide or refer the client for one or more integrated services?

E5a-i. If yes, please indicate which:

a. Primary health care
b. Maternal health care or OB/GYN
c. HIV testing
d. Viral hepatitis testing
e. HIV treatment
f. HIV pre-exposure prophylaxis (PrEP)
g. Viral hepatitis treatment
h. Other STI testing or treatment
i. Dental care

Intent/Key Points	The intent is to record whether the grantee directly provided or referred the client to integrated services since the previous assessment.
Skip Pattern	Skip at Baseline.
Responses and Definitions	Respondents may choose from the following response options: • *Yes* • *No* • *Not documented in records*
Follow-on Questions	If the answer to E5 is "Yes," please complete questions E5a -i. • **E5a-i. If yes, please indicate which:** Response options: – *Yes – provided* – *Referred for service* – *No – not provided or referred* – *Not documented in records / unknown*

Section F. Demographics

This section collects demographic information on race and sex only for clients that did not consent to SUPRT-C.

Grantee staff should not speculate on demographic characteristics if they are not listed in the client's record.

1. What is the client's race or ethnicity? Select all that apply and enter additional details in the spaces below.

Intent/Key Points	The intent is to record the race and/or ethnicity of clients receiving grant services.
Skip Pattern	**This section collects** demographic information on race and sex, **but should only be completed if both of the following are true:** **1.** The client/caregiver has declined to respond to the baseline SUPRT-C where it would have been provided directly; **AND** **2.** The grantee has collected and documented the information from the client/caregiver in another internal process (for example, intake to the clinic) using the same response options as indicated below.
Responses and Definitions	*Response options:* • *White – Provide details below.* – *German* – *Irish* – *English* – *Italian* – *Polish* – *French* – *Enter, for example, Scottish, Norwegian, Dutch, etc.* • *Hispanic or Latino – Provide details below.* – *Mexican or Mexican American* – *Puerto Rican* – *Cuban* – *Salvadoran* – *Dominican* – *Colombian* – *Enter, for example, Guatemalan, Spaniard, Ecuadorian, etc.* • *Black or African American – Provide details below.* – *African American* – *Jamaican* – *Haitian* – *Nigerian* – *Ethiopian* – *Somali* – *Enter, for example, Ghanaian, South African, Barbadian, etc.*

Responses and Definitions (continued)	• *Asian – Provide details below.* – *Chinese* – *Filipino* – *Asian Indian* – *Vietnamese* – *Korean* – *Japanese* – *Enter, for example, Pakistani, Cambodian, Hmong, etc.* • *American Indian or Alaska Native – Provide details below.* – *Specify, for example, Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Tlingit, etc.* • *Middle Eastern or North African – Provide details below.* – *Lebanese* – *Iranian* – *Egyptian* – *Syrian* – *Moroccan* – *Israeli* – *Enter, for example, Algerian, Iraqi, Kurdish, etc.* • *Native Hawaiian or Pacific Islander – Provide details below.* – *Native Hawaiian* – *Samoan* – *Chamorro* – *Tongan* – *Fijian* – *Marshallese* – *Enter, for example, Palauan, Tahitian, Chuukese, etc.* • *Race/ethnicity not captured in grantee records using detailed OMB categories.* • *Client/caregiver declined to provide race/ethnicity.* If any one of the detailed race or ethnicity categories are checked, the race/ethnicity category for that detailed race or ethnicity will automatically be selected. • *White* refers to individuals with origins in any of the original peoples of Europe, including, for example, German, Irish, English, Italian, Polish, and French. • *Hispanic or Latino* refers to individuals who have origins in Spanish-speaking countries of Latin America and Spain, including, for example, Mexican, Puerto Rican, Cuban, Salvadoran, Dominican, and Guatemalan. • *Black or African American* refers to individuals who have origins in any of the Black racial groups of Africa, including, for example, African American, Jamaican, Haitian, Nigerian, Ethiopian, and Somali. • *Asian* refers to individuals who have origins in any of the original peoples of the continent of Asia, including, for example, Chinese, Asian Indian, Filipino, Vietnamese, Korean, and Japanese.

Responses and Definitions (continued)	• *American Indian or Alaska Native* refers to individuals who have origins in any of the original peoples of North, Central, and South America, including, for example, Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, and Tlingit. • *Middle Eastern or North African* refers to individuals with origins in the geographic region of the Middle East and North Africa, including, for example, Lebanese, Iranian, Egyptian, Syrian, Moroccan, and Israeli. • *Native Hawaiian or Pacific Islander* refers to individuals who have origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands, including, for example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, and Marshallese. • *Enter:* If the client/caregiver specified another race or ethnicity enter the free text response it in the space provided. • *Race/ethnicity not captured in grantee records using detailed OMB categories.* These data can be sourced from other internal records but must reflect the client's own responses and exactly match a specific response option(s). Grantee staff should not speculate or assume the client's race or ethnicity. If no client- or caregiver-reported demographic data are available, select "Not documented in records or not documented in records using this standard." • *Client/caregiver declined to provide race/ethnicity.* If the client does not wish to answer this question, respondents should indicate "client/caregiver declined to provide race/ethnicity."

F2. What is the individual's sex?

Intent/Key Points	The intent is to record the sex of clients receiving grant services.
Skip Pattern	**This question** on sex should only be reported under SUPRT-A, **if both of the following are true:** **1.** The client/caregiver has declined to respond to the baseline SUPRT-C where it would have been provided directly; **AND** **2.** The grantee has collected and documented the information from the client/caregiver in another internal process (for example, intake to the clinic) using the same response options as indicated below
Responses and Definitions	Respondents may choose from the following response options: • *Female* • *Male* These data can be sourced from other internal records but must reflect the client/caregiver's own response and exactly match the specific response option. Grantee staff should not speculate or assume the client's sex. If no client- or caregiver-reported data about the sex of the client is available for whatever reason (client declined, question not asked, response options not the same, other response indicated) leave this question blank in SPARS.

References

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