

Section 6: Service use

1. Use of primary care

1a. Have you seen your GP or a practice nurse at the surgery in the **last 12 months**?

Yes

No (go to Q1b)

Not answered

If 'Yes', how many times?

GP times

Practice nurse times

1b. Have you been visited at home in the **last 12 months** by a GP, practice nurse?

Yes

No (go to Q1c)

Not answered

If 'Yes', how many times?

GP times

Practice nurse times

1c. Have you contacted NHS Direct (by telephone or Internet) over the **past 12 months**?

Yes

No (go to Q1d)

Not answered

1d. Have you visited an NHS walk in centre over the **past 12 months**?

Yes

No (go to Q2)

Not answered

If 'Yes', how many times? times

1e. Have you received any prescriptions over the **past 12 months**?

Yes

No (go to Q2)

Not answered

2. Use of hospital services

Have you visited hospital as a patient for any type of treatment, including A and E, in the **last 12 months**?

Yes

No (go to Q3)

Not answered

2a. Have you visited a hospital A and E Dept in the **last 12 months**?

Yes

No (go to Q2b)

Not answered

If 'Yes', how many times? times

How many nights did you stay in total in A&E? nights

Did you ever travel in an ambulance?

Yes

No

Not answered

If 'Yes', how many times did you use an emergency (999) ambulance? times

2b. Have you stayed in hospital as an inpatient in the **last 12 months**? i.e. stayed overnight, excluding A and E

Yes

No (go to Q2c)

Not answered

If 'Yes', how many times have you stayed in hospital as an inpatient? times

If 'Yes', how many nights did you stay in total during the period(s)? nights

2c. Have visited hospital as an outpatient?

Yes

No (go to Q3)

Not answered

If 'Yes', how many times? times

3. Accidents

3a. Have you had an accident in the **last 12 months**?

	Had accident?	Times?	How many times did you attend hospital as a result?
Motor vehicle accident	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Personal injury (exclude road accidents)	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Injury to another person (exclude road accidents)	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

3b. If you had an accident describe what happened?

3c. Was your accident related to your drug or alcohol use?

4. Education

4a. Are you currently in education?

Yes

No (go to Q5)

Not answered

4b. How many days have you been absent from school or college in the **last 12 months**? days

4c. How many of these days absent were the result of drug or alcohol use? days

4d. Do you think your performance at school or college has been affected as a result of drug or alcohol use over the **past 12 months**?

Yes

No

Not answered

If 'Yes', on how many days over the last 12 months has your productivity at school or college been affected? days

On average, would you say your school performance has been affected...

Slightly?

Moderately?

Considerably?

Extremely?

5. Employment (including work-related training)

5a. Have you had a job in the **last 12 months**?

Yes

No (go to Q6)

Not answered

5b. If 'Yes', how many weeks have you been working? Not answered

5c. How many hours a week do you work on average? Not answered

5d. How many days have you been absent from work in the **last 12 months**? days

5e. How many of these days absent were the result of drug or alcohol use? days

5f. Do you think your performance at work has been affected as a result of drug or alcohol use over the **past 12 months**?

Yes

No

Not answered

If 'Yes', on how many days over the last 12 months has your productivity at work been affected?

days

On average, would you say your work performance has been affected...

Slightly?

Moderately?

Considerably?

Extremely?

6. Crime

6a. Have you committed any of the following criminal acts in the **last 12 months**?

	Committed	No of times	Arrested	No of times
Violence or assault against a person	<input type="checkbox"/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="checkbox"/>	<input type="text" value=""/> <input type="text" value=""/>
Sexual offences	<input type="checkbox"/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="checkbox"/>	<input type="text" value=""/> <input type="text" value=""/>
Robbing/mugging	<input type="checkbox"/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="checkbox"/>	<input type="text" value=""/> <input type="text" value=""/>
Burglary in a dwelling or commercial premises	<input type="checkbox"/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="checkbox"/>	<input type="text" value=""/> <input type="text" value=""/>
Theft (not of vehicle), including shoplifting	<input type="checkbox"/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="checkbox"/>	<input type="text" value=""/> <input type="text" value=""/>
Vehicle theft	<input type="checkbox"/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="checkbox"/>	<input type="text" value=""/> <input type="text" value=""/>
Criminal damage (damage to property) (If 'Yes', go to 6b)	<input type="checkbox"/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="checkbox"/>	<input type="text" value=""/> <input type="text" value=""/>
Drinking driving (16+)	<input type="checkbox"/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="checkbox"/>	<input type="text" value=""/> <input type="text" value=""/>
Other motoring offences (16+)	<input type="checkbox"/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="checkbox"/>	<input type="text" value=""/> <input type="text" value=""/>

6b. Have you caused any damage to property/persons over the **last 12 months**?

Yes

No

Not answered

If 'Yes', was this damage to:

Parent's/guardian's home

Someone else's home/premises

Parent's/guardian's vehicle

Someone else's vehicle

Other people (bodily harm)

6c. In the **last 12 months** have you answered bail?

Yes

No

Not answered

If 'Yes', how many times?

6d. In the **last 12 months** have you had contact with a probation officer?

Yes

No

Not answered

If 'Yes', how many times?

6e. In the **last 12 months** have you appeared in court for any reason?

Yes

No

Not answered

If 'Yes': Magistrates Court Total number of **days** Crown Court Total number of **appearances**

6f. Have you spent any time in a Secure Children's Home/Young Offenders Institution in the **past 12 months**?

Yes

No

Not answered

If 'Yes', how many days did you spend in total?

Not answered

7. **Social Services**

7a. Have you had any involvement with social services?

Yes

No

Not answered

7b. If "Yes", please explain:

7c. In the **past 12 months** how many times have you been visited by a social worker at home? times

7d. In the **past 12 months** how many times have you visited a social worker at their office? times

**Y-SBNT Study:
Treatment Session Record Form - YSBNT Group**

Participant's Trial ID number This number **must** be filled in

Date of planned treatment session / /
day month year

Appointment time : Appointment Length (minutes)

Appointment location

Planned treatment session number 1* 2 3* 4 5 6
(please cross relevant box)

*Following sessions 1 and 3 therapist and participant should both complete a Working Alliance Inventory form

Did the participant attend? (please cross relevant box) Yes No

If 'No', please give reason if known

Was the session audio recorded? (please cross relevant box) Yes No

If 'No', please give reason if known

Did network members attend? Yes No If 'Yes', how many?
(please cross relevant box)

Relationship(s) to young person?

What materials were used in the session? (please list all)

Are any network members willing to be interviewed at a later date? Yes* No *If 'Yes', please ask for contact details so they can be passed onto researcher

Please turn over...

**Y-SBNT Study:
Treatment Session Record Form - Treatment as Usual Group**

Participant's Trial ID number This number **must** be filled in

Date of planned treatment session / / 2 0
day month year

Appointment time : Appointment Length (minutes)

Appointment location

Planned treatment session number 1* 2 3* 4 5 6 7 8 9 10 11 12
(please cross relevant box)

*Following **sessions 1 and 3** therapist and participant should both complete a Working Alliance Inventory form

Did the participant attend? *(please cross relevant box)* Yes No

If 'No', please give reason if known

Was the session audio recorded? *(please cross relevant box)* Yes No

If 'No', please give reason if known

What materials were used in the session? *(please list all)*

Therapist's name

Therapist's signature

How far did you travel from your base to provide today's session? miles

What was your mode of transport? *(please write)*

How long did it take you to travel? hours mins

Date form completed / / 2 0
day month year