Attachment 1-2

CSAT GPRA Client Outcome Measures for Discretionary Programs Instrument

Form Approved
OMB No. 0930-0208
Expiration Date 01/31/2007

CSAT GPRA Client Outcome Measures for Discretionary Programs

Public reporting burden for this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information, if all items are asked of a client/participant; to the extent that providers already obtain much of this information as part of their ongoing client/participant intake or followup, less time will be required. Send comments regarding this burden estimate or any other aspect of this collection of information to SAMHSA Reports Clearance Officer, Room 7-1044, 1 Choke Cherry Road, 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 OMB control number. The control number for this project is 0930-0208.

A. RECORD MANAGEMENT

Client ID |____|____|____|____|____|____|____|____|____|____|____|

Client Type:

- ○ Treatment client
- ○ Client in recovery

Contract/Grant ID |____|____|____|____|____|____|____|____|____|____|

Interview Type ***[CIRCLE ONLY ONE TYPE.]***

Intake [GO TO INTERVIEW DATE]

6 month follow-up → → → Did you conduct a follow-up interview? ○ Yes ○ No
[IF NO, GO DIRECTLY TO SECTION I.]

3 month follow-up ***[ADOLESCENT PORTFOLIO ONLY]*** →
Did you conduct a follow-up interview? ○ Yes ○ No ***[IF NO, GO DIRECTLY TO SECTION I.]***

Discharge → → → Did you conduct a discharge interview? ○ Yes ○ No
[IF NO, GO DIRECTLY TO SECTION J.]

Interview Date |____|____| / |____|____| / |____|____|____|____|
Month Day Year

FOR SBIRT GRANTS ONLY: REPORTED ONLY AT INTAKE/BASELINE

How did the client screen? ○ Negative ○ Positive

What was his/her screening score?

AUDIT = |____|____|

CAGE = |____|____|

DAST = |____|____|

DAST-10 = |____|____|

NIAAA Guide = |____|____|

Other (Specify) ______________ = |____|____|

Was he/she willing to continue his/her participation in the SBIRT program? ○ Yes ○ No

[FOLLOW-UP AND DISCHARGE INTERVIEWS: SKIP TO SECTION B.]

A. RECORD MANAGEMENT (Continued)

PLANNED SERVICES [*REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT INTAKE/BASELINE]*

Identify the services you plan to provide to the client during the client's course of treatment/recovery. *[CIRCLE 'Y' FOR YES OR 'N' FOR NO FOR EACH ONE.]*

Modality	Yes	No
[SELECT AT LEAST ONE MODALITY.]		
1. Case Management	Y	N
2. Day Treatment	Y	N
3. Inpatient/Hospital (Other Than Detox)	Y	N
4. Outpatient	Y	N
5. Outreach	Y	N
6. Intensive Outpatient	Y	N
7. Methadone	Y	N
8. Residential/Rehabilitation	Y	N
9. Detoxification (Select Only One)		
A. Hospital Inpatient	Y	N
B. Free Standing Residential	Y	N
C. Ambulatory Detoxification	Y	N
10. After Care	Y	N
11. Recovery Support	Y	N
12. Other (Specify)____________________	Y	N

Treatment Services	Yes	No
[SBIRT GRANTS: YOU MUST CIRCLE 'Y' FOR AT LEAST ONE OF THE TREATMENT SERVICES NUMBERED 1 THROUGH 4.]		
1. Screening	Y	N
2. Brief Intervention	Y	N
3. Brief Treatment	Y	N
4. Referral to Treatment	Y	N
5. Assessment	Y	N
6. Treatment/Recovery Planning	Y	N
7. Individual Counseling	Y	N
8. Group Counseling	Y	N
9. Family/Marriage Counseling	Y	N
10. Co-Occurring Treatment/ Recovery Services	Y	N
11. Pharmacological Interventions	Y	N
12. HIV/AIDS Counseling	Y	N
13. Other Clinical Services (Specify)_________________________	Y	N

Case Management Services	Yes	No
1. Family Services (Including Marriage Education, Parenting, Child Development Services)	Y	N
2. Child Care	Y	N
3. Employment Service		
A. Pre-Employment	Y	N
B. Employment Coaching	Y	N
4. Individual Services Coordination	Y	N
5. Transportation	Y	N
6. HIV/AIDS Service	Y	N
7. Supportive Transitional Drug-Free Housing Services	Y	N
8. Other Case Management Services (Specify)_________________________	Y	N

Medical Services	Yes	No
1. Medical Care	Y	N
2. Alcohol/Drug Testing	Y	N
3. HIV/AIDS Medical Support & Testing	Y	N
4. Other Medical Services (Specify)_________________________	Y	N

After Care Services	Yes	No
1. Continuing Care	Y	N
2. Relapse Prevention	Y	N
3. Recovery Coaching	Y	N
4. Self-Help and Support Groups	Y	N
5. Spiritual Support	Y	N
6. Other After Care Services (Specify)_________________________	Y	N

Education Services	Yes	No
1. Substance Abuse Education	Y	N
2. HIV/AIDS Education	Y	N
3. Other Education Services (Specify)_________________________	Y	N

Peer-To-Peer Recovery Support Services	Yes	No
1. Peer Coaching or Mentoring	Y	N
2. Housing Support	Y	N
3. Alcohol- and Drug-Free Social Activities	Y	N
4. Information and Referral	Y	N
5. Other Peer-to-Peer Recovery Support Services (Specify)_________________________	Y	N

A. RECORD MANAGEMENT - DEMOGRAPHICS *[ASKED ONLY AT INTAKE/BASELINE]*

1. What is your gender?

- ○ MALE
- ○ FEMALE
- ○ TRANSGENDER
- ○ OTHER (SPECIFY)_______________________________________
- ○ REFUSED

2. Are you Hispanic or Latino?

- ○ YES
- ○ NO
- ○ REFUSED

[IF YES] **What ethnic group do you consider yourself? Please answer yes or no for each of the following. You may say yes to more than one.**

	Yes	**No**	**Refused**
Central American	Y	N	Refused
Cuban	Y	N	Refused
Dominican	Y	N	Refused
Mexican	Y	N	Refused
Puerto Rican	Y	N	Refused
South American	Y	N	Refused
Other	Y	N	Refused *[IF YES, SPECIFY BELOW]*

(Specify)________________________________

3. What is your race? Please answer yes or no for each of the following. You may say yes to more than one.

	Yes	**No**	**Refused**
Black or African American	Y	N	Refused
Asian	Y	N	Refused
Native Hawaiian or other Pacific Islander	Y	N	Refused
Alaska Native	Y	N	Refused
White	Y	N	Refused
American Indian	Y	N	Refused

4. What is your date of birth?*

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

|____|____|____|____|
YEAR

○ REFUSED

****THE SYSTEM WILL ONLY SAVE MONTH AND YEAR**. DAY IS NOT SAVED TO MAINTAIN CONFIDENTIALITY.*

B. DRUG AND ALCOHOL USE

		Number of Days	REFUSED	DON'T KNOW
1.	**During the past 30 days how many days have you used the following:**			
a.	Any alcohol ***[IF ZERO, SKIP TO ITEM B1c.]***	|____|____|	○	○
b1.	Alcohol to intoxication (5+ drinks in one sitting)	|____|____|	○	○
b2.	Alcohol to intoxication (4 or fewer drinks in one sitting and felt high)	|____|____|	○	○
c.	Illegal drugs	|____|____|	○	○
d.	Both alcohol and drugs (on the same day)	|____|____|	○	○

Route of Administration Types:

1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV

*NOTE THE USUAL ROUTE. FOR MORE THAN ONE ROUTE, CHOOSE THE MOST SEVERE. THE ROUTES ARE LISTED FROM LEAST SEVERE (1) TO MOST SEVERE (5).

		Number of Days	RF	DK	Route*	RF	DK
2.	**During the past 30 days, how many days have you used any of the following:**						
a.	Cocaine/Crack	|____|____|	○	○	|____|	○	○
b.	Marijuana/Hashish (Pot, Joints, Blunts, Chronic, Weed, Mary Jane)	|____|____|	○	○	|____|	○	○
c.	Opiates:						
	1. Heroin (Smack, H, Junk, Skag)	|____|____|	○	○	|____|	○	○
	2. Morphine	|____|____|	○	○	|____|	○	○
	3. Diluadid	|____|____|	○	○	|____|	○	○
	4. Demerol	|____|____|	○	○	|____|	○	○
	5. Percocet	|____|____|	○	○	|____|	○	○
	6. Darvon	|____|____|	○	○	|____|	○	○
	7. Codeine	|____|____|	○	○	|____|	○	○
	8. Tylenol 2,3,4	|____|____|	○	○	|____|	○	○
	9. Oxycontin/Oxycodone	|____|____|	○	○	|____|	○	○
d.	Non-prescription methadone	|____|____|	○	○	|____|	○	○
e.	Hallucinogens/psychedelics, PCP (Angel Dust, Ozone, Wack, Rocket Fuel) MDMA (Ecstasy, XTC, X, Adam), LSD (Acid, Boomers, Yellow Sunshine), Mushrooms or Mescaline	|____|____|	○	○	|____|	○	○
f.	Methamphetamine or other amphetamines (Meth, Uppers, Speed, Ice, Chalk, Crystal, Glass, Fire, Crank)	|____|____|	○	○	|____|	○	○

B. DRUG AND ALCOHOL USE (Continued)

Route of Administration Types:
1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV
*NOTE THE USUAL ROUTE. FOR MORE THAN ONE ROUTE, CHOOSE THE MOST SEVERE. THE ROUTES ARE LISTED FROM LEAST SEVERE (1) TO MOST SEVERE (5).

2. During the past 30 days, how many days have you used any of the following:	**Number of Days**	**RF**	**DK**	**Route***	**RF**	**DK**
g. 1. Benzodiazepines: Diazepam (Valium); Alprazolam (Xanax); Triazolam (Halcion); and Estasolam (Prosom and Rohypnol–also known as roofies, roche, and cope)	|____|____|	○	○	|____|	○	○
2. Barbiturates: Mephobarbital (Mebacut); and pentobarbital sodium (Nembutal)	|____|____|	○	○	|____|	○	○
3. Non-prescription GHB (known as Grievous Bodily Harm; Liquid Ecstasy; and Georgia Home Boy)	|____|____|	○	○	|____|	○	○
4. Ketamine (known as Special K or Vitamin K)	|____|____|	○	○	|____|	○	○
5. Other tranquilizers, downers, sedatives or hypnotics	|____|____|	○	○	|____|	○	○
h. Inhalants (poppers, snappers, rush, whippets)	|____|____|	○	○	|____|	○	○
i. Other illegal drugs (Specify)	|____|____|	○	○	|____|	○	○

3. In the past 30 days have you injected drugs?

○ YES
○ NO
○ REFUSED
○ DON’T KNOW

[IF NO, REFUSED, OR DON’T KNOW GO TO SECTION C.]

4. In the past 30 days, how often did you use a syringe/needle, cooker, cotton or water that someone else used?

○ Always
○ More than half the time
○ Half the time
○ Less than half the time
○ Never
○ REFUSED
○ DON’T KNOW

C. FAMILY AND LIVING CONDITIONS

1. In the past 30 days, where have you been living most of the time? *[DO NOT READ RESPONSE OPTIONS TO CLIENT.]*

- ○ SHELTER (SAFE HAVENS, TRANSITIONAL LIVING CENTER [TLC], LOW DEMAND FACILITIES, RECEPTION CENTERS, OTHER TEMPORARY DAY OR EVENING FACILITY)
- ○ STREET/OUTDOORS (SIDEWALK, DOORWAY, PARK, PUBLIC OR ABANDONED BUILDING)
- ○ INSTITUTION (HOSPITAL, NURSING HOME, JAIL/PRISON)
- ○ HOUSED:
  - ○ OWN/RENT APARTMENT, ROOM, OR HOUSE
  - ○ SOMEONE ELSE'S APARTMENT, ROOM OR HOUSE
  - ○ HALFWAY HOUSE
  - ○ RESIDENTIAL TREATMENT
  - ○ OTHER HOUSED (SPECIFY)___________________________
- ○ REFUSED
- ○ DON'T KNOW

2. During the past 30 days, how stressful have things been for you because of your use of alcohol or other drugs?

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely
- ○ NOT APPLICABLE
- ○ REFUSED
- ○ DON'T KNOW

3. During the past 30 days, has your use of alcohol or other drugs caused you to reduce or give up important activities?

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely
- ○ NOT APPLICABLE
- ○ REFUSED
- ○ DON'T KNOW

C. FAMILY AND LIVING CONDITIONS (Continued)

4. During the past 30 days, has your use of alcohol or other drugs caused you to have emotional problems?

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely
- ○ NOT APPLICABLE
- ○ REFUSED
- ○ DON’T KNOW

5. *[IF NOT MALE,]* Are you currently pregnant?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON’T KNOW

6. Do you have children?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON’T KNOW

[IF NO, REFUSED, OR DON’T KNOW GO TO SECTION D.]

a. How many children do you have?

|____|____| ○ REFUSED ○ DON’T KNOW

b. Are any of your children living with someone else due to a child protection court order?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON’T KNOW

[IF NO, REFUSED, OR DON’T KNOW GO TO SECTION D.]

c. *[IF YES,]* How many of your children are living with someone else due to a child protection court order?

|____|____| ○ REFUSED ○ DON’T KNOW

C. FAMILY AND LIVING CONDITIONS (Continued)

d. For how many of your children have you lost parental rights? *[THE CLIENT'S PARENTAL RIGHTS WERE TERMINATED.]*

|____|____| ○ REFUSED ○ DON'T KNOW

D. EDUCATION, EMPLOYMENT, AND INCOME

1. Are you currently enrolled in school or a job training program? *[IF ENROLLED,]* Is that full time or part time?

○ NOT ENROLLED
○ ENROLLED, FULL TIME
○ ENROLLED, PART TIME
○ OTHER (SPECIFY)____
○ REFUSED
○ DON'T KNOW

2. What is the highest level of education you have finished, whether or not you received a degree?

○ NEVER ATTENDED
○ 1ST GRADE
○ 2ND GRADE
○ 3RD GRADE
○ 4TH GRADE
○ 5TH GRADE
○ 6TH GRADE
○ 7TH GRADE
○ 8TH GRADE
○ 9TH GRADE
○ 10TH GRADE
○ 11TH GRADE
○ 12TH GRADE/HIGH SCHOOL DIPLOMA/EQUIVALENT
○ COLLEGE OR UNIVERSITY/1st YEAR COMPLETED
○ COLLEGE OR UNIVERSITY/2nd YEAR COMPLETED/ASSOCIATES DEGREE (AA, AS)
○ COLLEGE OR UNIVERSITY/3rd YEAR COMPLETED
○ BACHELOR'S DEGREE (BA, BS) OR HIGHER
○ VOC/TECH PROGRAM AFTER HIGH SCHOOL BUT NO VOC/TECH DIPLOMA
○ VOC/TECH DIPLOMA AFTER HIGH SCHOOL
○ REFUSED
○ DON'T KNOW

D. EDUCATION, EMPLOYMENT, AND INCOME (Continued)

3. Are you currently employed? ***[CLARIFY BY FOCUSING ON STATUS DURING MOST OF THE PREVIOUS WEEK, DETERMINING WHETHER CLIENT WORKED AT ALL OR HAD A REGULAR JOB BUT WAS OFF WORK.]***

- ○ EMPLOYED FULL TIME (35+ HOURS PER WEEK, OR WOULD HAVE BEEN)
- ○ EMPLOYED PART TIME
- ○ UNEMPLOYED, LOOKING FOR WORK
- ○ UNEMPLOYED, DISABLED
- ○ UNEMPLOYED, VOLUNTEER WORK
- ○ UNEMPLOYED, RETIRED
- ○ UNEMPLOYED, NOT LOOKING FOR WORK
- ○ OTHER (SPECIFY)____
- ○ REFUSED
- ○ DON'T KNOW

4. Approximately, how much money did YOU receive (pre-tax individual income) in the past 30 days from…

			RF	DK
a.	Wages	$ |__|__|__| , |__|__|__|	○	○
b.	Public assistance	$ |__|__|__| , |__|__|__|	○	○
c.	Retirement	$ |__|__|__| , |__|__|__|	○	○
d.	Disability	$ |__|__|__| , |__|__|__|	○	○
e.	Non-legal income	$ |__|__|__| , |__|__|__|	○	○
f.	Family and/or friends	$ |__|__|__| , |__|__|__|	○	○
g.	Other (Specify) ______________________	$ |__|__|__| , |__|__|__|	○	○

E. CRIME AND CRIMINAL JUSTICE STATUS

1. In the past 30 days, how many times have you been arrested?

|____|____| TIMES ○ REFUSED ○ DON'T KNOW

[IF NO ARRESTS, GO TO ITEM E3.]

2. In the past 30 days, how many times have you been arrested for drug-related offenses?

|____|____| TIMES ○ REFUSED ○ DON'T KNOW

3. In the past 30 days, how many nights have you spent in jail/prison?

|____|____| NIGHTS ○ REFUSED ○ DON'T KNOW

E. CRIME AND CRIMINAL JUSTICE STATUS (Continued)

4. In the past 30 days, how many times have you committed a crime? ***[CHECK NUMBER OF DAYS USED ILLEGAL DRUGS IN ITEM B1c ON PAGE 4. ANSWER HERE IN E4 MUST BE EQUAL TO OR GREATER THAN NUMBER IN B1c BECAUSE USING ILLEGAL DRUGS IS A CRIME.]***

|____|____|____| TIMES ○ REFUSED ○ DON'T KNOW

5. Are you currently awaiting charges, trial, or sentencing?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

6. Are you currently on parole or probation?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY

1. How would you rate your overall health right now?

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor
- ○ REFUSED
- ○ DON'T KNOW

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (Cont.)

2. During the past 30 days, did you receive:

a. Inpatient Treatment for:

	YES	*[IF YES]* **Altogether for how many nights**	NO	RF	DK
i. Physical complaint	○	________nights	○	○	○
ii. Mental or emotional difficulties	○	________nights	○	○	○
iii. Alcohol or substance abuse	○	________nights	○	○	○

b. Outpatient Treatment for:

	YES	*[IF YES]* **Altogether for how many times**	NO	RF	DK
i. Physical complaint	○	_________times	○	○	○
ii. Mental or emotional difficulties	○	_________times	○	○	○
iii. Alcohol or substance abuse	○	_________times	○	○	○

c. Emergency Room Treatment for:

	YES	*[IF YES]* **Altogether for how many times**	NO	RF	DK
i. Physical complaint	○	_________times	○	○	○
ii. Mental or emotional difficulties	○	_________times	○	○	○
iii. Alcohol or substance abuse	○	_________times	○	○	○

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (Cont.)

3. During the past 30 days, did you engage in sexual activity?

- ○ Yes
- ○ No → ***[GO TO F4.]***
- ○ NOT PERMITTED TO ASK → ***[GO TO F4.]***
- ○ REFUSED → ***[GO TO F4.]***
- ○ DON'T KNOW → ***[GO TO F4.]***

[IF YES] **Altogether, how many:**

		Contacts	RF	DK
a.	Sexual contacts (vaginal, oral, or anal) did you have?	|____|____|____|	○	○
b.	Unprotected sexual contacts did you have? ***[IF ZERO, GO TO F4.]***	|____|____|____|	○	○
c.	Unprotected sexual contacts were with an individual who is or was:			
	1. HIV positive or has AIDS	|____|____|____|	○	○
	2. An injection drug user	|____|____|____|	○	○
	3. High on some substance	|____|____|____|	○	○

4. In the past 30 days, not due to your use of alcohol or drugs, how many days have you:

		Days	RF	DK
a.	Experienced serious depression	|____|____|	○	○
b.	Experienced serious anxiety or tension	|____|____|	○	○
c.	Experienced hallucinations	|____|____|	○	○
d.	Experienced trouble understanding, concentrating, or remembering	|____|____|	○	○
e.	Experienced trouble controlling violent behavior	|____|____|	○	○
f.	Attempted suicide	|____|____|	○	○
g.	Been prescribed medication for psychological/emotional problem	|____|____|	○	○

[IF CLIENT REPORTS ZERO DAYS TO ALL ITEMS IN QUESTION 4, SKIP TO SECTION G.]

5. How much have you been bothered by these psychological or emotional problems in the past 30 days?

- ○ Not at all
- ○ Slightly
- ○ Moderately
- ○ Considerably
- ○ Extremely
- ○ REFUSED
- ○ DON'T KNOW

G. SOCIAL CONNECTEDNESS

1. In the past 30 days, did you attend any voluntary self-help groups for recovery that were not affiliated with a religious or faith-based organization? In other words, did you participate in a non-professional, peer-operated organization that is devoted to helping individuals who have addiction related problems such as: Alcoholics Anonymous, Narcotics Anonymous, Oxford House, Secular Organization for Sobriety, or Women for Sobriety, etc.

- ○ YES ***[IF YES]*** SPECIFY HOW MANY TIMES ______ ○ REFUSED ○ DON'T KNOW
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

2. In the past 30 days, did you attend any religious/faith affiliated recovery self-help groups?

- ○ YES ***[IF YES]*** SPECIFY HOW MANY TIMES ______ ○ REFUSED ○ DON'T KNOW
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

3. In the past 30 days, did you attend meetings of organizations that support recovery other than the organizations described above?

- ○ YES ***[IF YES]*** SPECIFY HOW MANY TIMES ______ ○ REFUSED ○ DON'T KNOW
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

4. In the past 30 days, did you have interaction with family and/or friends that are supportive of your recovery?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

5. To whom do you turn when you are having trouble? ***[SELECT ONLY ONE.]***

- ○ NO ONE
- ○ CLERGY MEMBER
- ○ FAMILY MEMBER
- ○ FRIENDS
- ○ REFUSED
- ○ DON'T KNOW
- ○ OTHER SPECIFY: ______________________________

[IF THIS IS AN INTAKE/BASELINE INTERVIEW, STOP NOW, THE INTERVIEW IS COMPLETE. REMEMBER TO FILL IN PLANNED SERVICES ON PAGE 2.]

I. FOLLOW-UP STATUS

[*REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT FOLLOW-UP]*

1. What is the follow-up status of the client? ***[THIS IS A REQUIRED FIELD: NA, REFUSED, DON'T KNOW, AND MISSING WILL NOT BE ACCEPTED].***

- ○ 01 = Deceased at time of due date
- ○ 11 = Completed interview within specified window
- ○ 12 = Completed interview outside specified window
- ○ 21 = Located, but refused, unspecified
- ○ 22 = Located, but unable to gain institutional access
- ○ 23 = Located, but otherwise unable to gain access
- ○ 24 = Located, but withdrawn from project
- ○ 31 = Unable to locate, moved
- ○ 32 = Unable to locate, other (SPECIFY) ________________________

2. Is the client still receiving services from your program?

- ○ Yes
- ○ No

[IF THIS IS A FOLLOW-UP INTERVIEW STOP NOW, THE INTERVIEW IS COMPLETE.]

J. DISCHARGE STATUS

[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT DISCHARGE]

1. On what date was the client discharged?

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

2. What is the client's discharge status?

- ○ 01 = Completion/Graduate
- ○ 02 = Termination

  If the client was terminated, what was the reason for termination? [*SELECT ONE RESPONSE*.]

  - ○ 01 = Left on own against staff advice with satisfactory progress
  - ○ 02 = Left on own against staff advice without satisfactory progress
  - ○ 03 = Involuntarily discharged due to nonparticipation
  - ○ 04 = Involuntarily discharged due to violation of rules
  - ○ 05 = Referred to another program or other services with satisfactory progress
  - ○ 06 = Referred to another program or other services with unsatisfactory progress
  - ○ 07 = Incarcerated due to offense committed while in treatment/recovery with satisfactory progress
  - ○ 08 = Incarcerated due to offense committed while in treatment/recovery with unsatisfactory progress
  - ○ 09 = Incarcerated due to old warrant or charged from before entering treatment/recovery with satisfactory progress
  - ○ 10 = Incarcerated due to old warrant or charged from before entering treatment/recovery with unsatisfactory progress
  - ○ 11 = Transferred to another facility for health reasons
  - ○ 12 = Death
  - ○ 13 = Other (Specify)___________________________________

K. SERVICES RECEIVED

[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT DISCHARGE]

Identify the number of DAYS of services provided to the client during the client's course of treatment/recovery. *[ENTER ZERO IF NO SERVICES PROVIDED. YOU SHOULD HAVE AT LEAST ONE DAY FOR MODALITY.]*

Modality	**Days**
1. Case Management	|___|___|___|
2. Day Treatment	|___|___|___|
3. Inpatient/Hospital (Other Than Detox)	|___|___|___|
4. Outpatient	|___|___|___|
5. Outreach	|___|___|___|
6. Intensive Outpatient	|___|___|___|
7. Methadone	|___|___|___|
8. Residential/Rehabilitation	|___|___|___|
9. Detoxification (Select Only One)	
A. Hospital Inpatient	|___|___|___|
B. Free Standing Residential	|___|___|___|
C. Ambulatory Detoxification	|___|___|___|
10. After Care	|___|___|___|
11. Recovery Support	|___|___|___|
12. Other (Specify)_________________	|___|___|___|

Identify the number of SESSIONS provided to the client during the client's course of treatment/ recovery. *[ENTER ZERO IF NO SERVICES PROVIDED.]*

Treatment Services	**Sessions**
[SBIRT GRANTS: YOU MUST HAVE AT LEAST ONE SESSION FOR ONE OF THE TREATMENT SERVICES NUMBERED 1 THROUGH 4.]	
1. Screening	|___|___|___|
2 Brief Intervention	|___|___|___|
3. Brief Treatment	|___|___|___|
4. Referral to Treatment	|___|___|___|
5. Assessment	|___|___|___|
6. Treatment/Recovery Planning	|___|___|___|
7. Individual Counseling	|___|___|___|
8. Group Counseling	|___|___|___|
9. Family/Marriage Counseling	|___|___|___|
10. Co-Occurring Treatment/ Recovery Services	|___|___|___|
11. Pharmacological Interventions	|___|___|___|
12. HIV/AIDS Counseling	|___|___|___|
13. Other Clinical Services (Specify)______________________	|___|___|___|

Case Management Services **Sessions**

1. Family Services (Including Marriage Education, Parenting, Child Development Services) |___|___|___|
2. Child Care |___|___|___|
3. Employment Service
   A. Pre-Employment |___|___|___|
   B. Employment Coaching |___|___|___|
4. Individual Services Coordination |___|___|___|
5. Transportation |___|___|___|
6. HIV/AIDS Service |___|___|___|
7. Supportive Transitional Drug-Free Housing Services |___|___|___|
8. Other Case Management Services (Specify)_______________ |___|___|___|

Medical Services **Sessions**

1. Medical Care |___|___|___|
2. Alcohol/Drug Testing |___|___|___|
3. HIV/ AIDS Medical Support & Testing |___|___|___|
4. Other Medical Services (Specify)_______________________ |___|___|___|

After Care Services **Sessions**

1. Continuing Care |___|___|___|
2. Relapse Prevention |___|___|___|
3. Recovery Coaching |___|___|___|
4. Self-Help and Support Groups |___|___|___|
5. Spiritual Support |___|___|___|
6. Other After Care Services (Specify)_______________________ |___|___|___|

Education Services **Sessions**

1. Substance Abuse Education |___|___|___|
2. HIV/AIDS Education |___|___|___|
3. Other Education Services (Specify)_______________________ |___|___|___|

Peer-To-Peer Recovery Support Services **Sessions**

1. Peer Coaching or Mentoring |___|___|___|
2. Housing Support |___|___|___|
3. Alcohol- and Drug-Free Social Activities |___|___|___|
4. Information and Referral |___|___|___|
5. Other Peer-to-Peer Recovery Support Services (Specify)_______________________ |___|___|___|