Form Approved
OMB No. 0930-0208
Expiration Date 06/30/2010

CSAT GPRA Client/Participant Outcome Measures for Discretionary Programs

GPRA SHORT FORM, Section A& B

Use this GPRA Version for a Client who has been screened using Audit/Dast and for whom NO other ATR Services are Planned

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Name of Primary Counselor/Interviewer:_________________________Tribal Access Site:_______

REMEMBER:

ANSWER EVERY QUESTION!!!

CHECK YOUR WORK!!!!!!!

*THIS FORM WILL NOT BE COUNTED BY CSAT UNLESS IT IS **COMPLETE***

***ONCE A CLIENT ID # IS ASSIGNED, DO NOT CHANGE IT**. IT STAYS WITH THE CLIENT NO MATTER HOW MANY INTAKES OR FOLLOW-UPS ARE DONE.*

Put the Client ID # on the bottom of EVERY page of this form.

FAX TO INTER-TRIBAL COUNCIL OF MICHIGAN
906-632-7744

Public reporting burden for this collection of information is estimated to average 20 minutes per response, including 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 follow-up, 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/Participant ID |____|____|____|____|____|____|____|____|____|____|

- **Client Type** **O** Treatment client

Contract/Grant ID |__T_|_I__|_1__|__9_|__4_|__4_|_9_|__A_|_ _|____|

Interview Type (circle only one type)

Intake [GO TO INTERVIEW DATE]
O 1st Intake O 2nd Intake O 3rd Intake

6 month follow-up → → → Did you conduct a follow-up interview? O Yes O No
[IF NO, GO DIRECTLY TO SECTION I]
O 1st 6 month follow-up O 2nd 6 month follow-up O 3rd 6 month follow-up

Discharge → Did you conduct a follow-up interview? O Yes O No
[IF NO, GO DIRECTLY TO SECTION J]
O 1st discharge O 2nd discharge O 3rd discharge

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

Is this a methamphetamine client? ____ yes ____ no (complete page 4 before answering this question)

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

NOTE: In Sections A through G, whenever the answers to the questions are given in CAPITAL letters, do NOT read the options to the client: wait for the client to respond and fill in the corresponding option. We are looking for the client's perception, not that of the interviewer.

A. RECORD MANAGEMENT

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

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]

[SELECT AT LEAST ONE MODALITY]

Modality		Yes	No
1.	Case Management	y	n
2.	Day Treatment	y	n
3.	Inpatient/Hospital (not 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
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

Indigenous Services		Yes	No
1.	Indigenous Language	y	n
2.	Storytelling, Cultural Teaching	y	n
3.	Daily Living Skills	y	n
4.	Talking Circle	y	n
5.	Tribal Song and Dance	y	n
6.	Tribal Arts and Crafts	y	n
7.	Traditional Healing Services	y	n
8.	Sweat Lodge	y	n
9.	Anishnaabek Healing Ceremony	y	n
10.	Referral to Traditional Practitioner	y	n
11.	Other (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 Medial Support and 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 & 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	y	n
	A. Anishnaabek Cultural Teaching	y	n
	B. 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 & Drug Free Social Activities	y	n
4.	Information & Referral	y	n
5.	Other Peer-to-Peer Recovery Support Services Specify _________________	y	n

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

1. What is your gender?

- O MALE
- O FEMALE
- O TRANSGENDER
- O OTHER (SPECIFY) ________________
- O REFUSED

2. Are you Hispanic or Latino?

O YES O NO O REFUSED

[If yes] **What ethnic group do you consider yourself? Please answer yes or no for each of the following. You may say yes or no 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

O 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.]***	[___|___]	O	O
b1.	Alcohol to intoxication (5+ drinks in one sitting)	[___|___]	O	O
b2.	Alcohol to intoxication (4 or fewer drinks in one sitting and felt high)	[___|___]	O	O
c.	Illegal drugs ***[IF B1a OR B1c,=, RF, DK, THEN SKIP TO ITEM B2]***	[___|___]	O	O
d.	Both alcohol and drugs (on the same day)	[___|___]	O	O

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? ***[Illegal use ONLY – DO NOT INCLUDE LEGALLY PRESCRIBED DRUGS][IF THE VALUE IN ANY ITEM B2a THROUGH B2i>0, THEN THE VALUE IN B1c MUST BE >0.1]***

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

An ATR methamphetamine client is one who has used meth in the last 90 days(prior to Intake) AND who will be receiving services through ATR specifically related to meth use.

For those clients coming from a restricted environment (jail, prison, hospital, institution etc.), a methamphetamine client is one who has used meth in the last 90 days prior to entry into the restricted setting AND who will be receiving services through ATR specifically related to meth use.

Is this a methamphetamine client? ____ yes ____ no
(If yes, please also record on page one)

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? ***[ILLEGAL USE ONLY – DO NOT INCLUDE LEGALLY PRESCRIBED DRUGS][IF THE VALUE IN ANY ITEM B2a THROUGH B2i>0, THEN THE VALUE IN B1c MUST BE >0.1]***

			# of Days	RF	DK	Route*	RF	DK
g.	1.	Benzodiazepines: Diazepam (Valium); Alprazolam (Xanax); Triazolam (Halcion); And Estrasolam (Prosom and Rohypnol – also known as roofies, roche, and cope)	[___|___]	O	O	[___]	O	O
	2.	Barbiturates: Mephobarbital (Mebacut)l and Pentobarbital sodium (Nembutal)	[___|___]	O	O	[___]	O	O
	3.	Non- prescription GHB (known as Grievous Bodily Harm; Liquid Ecstasy; and Georgia Home Boy)	[___|___]	O	O	[___]	O	O
	4.	Ketamine (known as Special K or Vitamin K)	[___|___]	O	O	[___]	O	O
	5.	Other tranquilizers, downers, sedatives or Hypnotics	[___|___]	O	O	[___]	O	O
h.		Inhalants (poppers, snappers, rush, whippets)	[___|___]	O	O	[___]	O	O
i.		Other illegal drugs (Specify) ____________________ *(Include tobacco use if a minor)*	[___|___]	O	O	[___]	O	O

3. In the past 30 days, have you injected drugs? [IF ANY ROUTE OF ADMINISTRATION IN B2a THROUGH B2i = 4 or 5, THEN B3 MUST = YES.]

O YES
O NO
O REFUSED
O 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?

O Always
O More than half the time
O Half the time
O Less than half the time
O Never
O REFUSED
O DON'T KNOW