



GPRA Discharge Interview

READ TO THE CLIENT THE RESPONSE CATEGORIES THAT APPEAR IN LOWER-CASE LETTERING. IF ALL RESPONSE CATEGORIES ARE IN CAPITAL LETTERS, ASK THE QUESTION OPEN-ENDED (IN OTHER WORDS, DO NOT READ THE RESPONSE, BUT INSTEAD LET THE CLIENT ANSWER AND MARK WHICH RESPONSE THE CLIENT SAYS). NEVER OFFER "REFUSED" OR "DON'T KNOW" TO THE CLIENT AS AN ANSWER.

A. RECORD MANAGEMENT [REPORTED BY PROGRAM STAFF]

Client Name: _____ Client ID: _____

Facility Name: _____

Interviewer Name: _____

Interview Date: |__|_|/|__|_|/|__|_|_|_|
Month Day Year

Did you conduct a discharge interview?

Yes | No

[IF NO, SKIP TO SECTION J - DISCHARGE STATUS]

B. DRUG AND ALCOHOL USE

1. During the past 30 days, how many days have you used the following:

	# of Days	REFUSED	DON'T KNOW	NOT APPLICABLE
a. Any alcohol [IF NO USE, MARK B1 & B2 AS "NOT APPLICABLE"]	__ _	<input type="checkbox"/>	<input type="checkbox"/>	-
b1. Alcohol to intoxication (5+ drinks in one sitting)	__ _	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b2. Alcohol to intoxication (4 or fewer drinks in one sitting and felt high)	__ _	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Illegal drugs	__ _	<input type="checkbox"/>	<input type="checkbox"/>	-
d. Both alcohol and drugs (on the same day) (IF 0 ALCOHOL AND ILLEGAL DRUG USE, MARK AS "NOT APPLICABLE")	__ _	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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: [IF THE CLIENT REPORTS 0 DAYS OF USE, MARK ROUTE AS "NOT APPLICABLE"]

	# of Days	REFUSED	DON'T KNOW	Route	REFUSED	DON'T KNOW	NOT APPLICABLE
a. Cocaine / Crack	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Marijuana / Hashish (<i>Pot, Joints, Blunts, Chronic, Weed, Mary Jane</i>)	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Opiates:							
1. Heroin (<i>Smack, H, Junk, Skag</i>)	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Morphine	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Diluadid	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Demerol	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Percocet	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Darvon	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Codeine	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Tylenol 2, 3, 4	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Oxycontin / Oxycodone	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Non-prescription methadone	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Hallucinogens / Psychedelics, PCP (<i>Angel Dust, Ozone, Wack, Rocket Fuel</i>), MDMA (<i>Ecstasy, XTC, X, Adam</i>), LSD (<i>Acid, Boomers, Yellow Sunshine</i>), Mushrooms or Mescaline	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Methamphetamine or other amphetamines (<i>Meth, Uppers, Speed, Ice, Chalk, Crystal, Glass, Fire, Crank</i>)	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IF NO METHAMPHETAMINE USE IN LAST 30 DAYS, PROBE CLIENT IF ANY IN LAST 90 DAYS. ANY USE IN THE LAST 90 DAYS? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT APPLICABLE							
g. 1. Benzodiazepines: Diazepam (<i>Valium</i>); Alprazolam (<i>Xanax</i>); Triazolam (<i>Halcion</i>); and Estazolam (<i>Prosom & Rohypnol</i> – also known as <i>roofies, roche, & cope</i>)	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Barbiturates: Mephobarbital (<i>Mebacut</i>); and pentobarbital sodium (<i>Nembutal</i>)	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Non-prescription GHB (<i>known as Grievous Bodily Harm, Liquid Ecstasy, & Georgia Home Boy</i>)	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Ketamine (<i>known as Special K or Vitamin K</i>)	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Other tranquilizers, downers, sedatives or hypnotics	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Inhalants (<i>poppers, snappers, rush, whippets</i>)	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Other Illegal Drugs (Specify: _____)	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IF THE VALUE IN ANY OF THE DRUGS IS GREATER THAN ZERO, THEN B1c. (ILLEGAL DRUGS) MUST BE GREATER THAN ZERO.



B. DRUG AND ALCOHOL USE (CONTINUED)

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

- YES | NO | REFUSED | DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, MARK 4 AS "NOT APPLICABLE"]

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
 NOT APPLICABLE

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 - **IF HOUSED, CHECK APPROPRIATE SUBCATEGORY:**
 OWN / RENT APARTMENT, ROOM, OR HOUSE SOMEONE ELSE'S APARTMENT, ROOM OR HOUSE
 DORMITORY / COLLEGE RESIDENCE 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 [USE ONLY IF ALL IN B1 (ANY ALCOHOL OR DRUG USE) WAS 0 DAYS]
 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 [USE ONLY IF ALL IN B1 (ANY ALCOHOL OR DRUG USE) WAS 0 DAYS]
 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 [USE ONLY IF ALL IN B1 (ANY ALCOHOL OR DRUG USE) WAS 0 DAYS]
 REFUSED
 DON'T KNOW

5. [IF NOT MALE] Are you currently pregnant? [IF CLIENT IS MALE, MARK AS "NOT APPLICABLE"]

- YES | NO | REFUSED | DON'T KNOW | NOT APPLICABLE

6. Do you have children?

- YES | NO | REFUSED | DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, MARK 6A., 6B., 6C., AND 6D. AS "NOT APPLICABLE"]

a. How many children do you have? |__|__| REFUSED
 DON'T KNOW
 NOT APPLICABLE

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

- YES | NO | REFUSED | DON'T KNOW | NOT APPLICABLE

[IF NO, REFUSED, OR DON'T KNOW, MARK 6C. AS "NOT APPLICABLE"]

c. [IF YES] How many of your children are living with someone else due to a child protection court order? |__|__| REFUSED
 DON'T KNOW
 NOT APPLICABLE

d. For how many of your children have you lost parental rights? (The client's parental rights were terminated) |__|__| REFUSED
 DON'T KNOW
 NOT APPLICABLE

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



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, MARK E2 AS "NOT APPLICABLE"]

2. In the past 30 days, how many times have you been arrested for drug-related offenses? TIMES | REFUSED | DON'T KNOW | NOT APPLICABLE

[THIS CANNOT EXCEED NUMBER OF ARRESTS IN E1]

3. In the past 30 days, how many nights have you spent in jail/prison? NIGHTS | REFUSED | DON'T KNOW

4. In the past 30 days, how many times have you committed a crime? TIMES | REFUSED | DON'T KNOW

[CHECK THE NUMBER OF DAYS USED ILLEGAL DRUGS IN ITEM B1c. ANSWER HERE IN E4 SHOULD BE EQUAL TO OR GREATER THAN NUMBER IN B1c BECAUSE USING ILLEGAL DRUGS IS A CRIME.]

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

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

	YES	[IF YES] Altogether for how many nights or times	NO	REFUSED	DON'T KNOW
a. Inpatient Treatment for:					
i. Physical complaint	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> NIGHTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii. Mental or emotional difficulties	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> NIGHTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii. Alcohol or substance abuse	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> NIGHTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Outpatient Treatment for:					
i. Physical complaint	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> TIMES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii. Mental or emotional difficulties	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> TIMES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii. Alcohol or substance abuse	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> TIMES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Emergency Room Treatment for:					
i. Physical complaint	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> TIMES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii. Mental or emotional difficulties	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> TIMES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii. Alcohol or substance abuse	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> TIMES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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

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

- YES | NO | REFUSED | DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, MARK 3a., 3b., AND 3c. AS "NOT APPLICABLE"]

[If YES], Altogether, how many:

	# of Contacts	REFUSED	DON'T KNOW	NOT APPLICABLE
a. Sexual contacts (vaginal, oral, or anal) did you have?	_ _ _	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Unprotected sexual contacts did you have? [IF 0 CONTACTS, MARK 3C. AS "NOT APPLICABLE"]	_ _ _	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Unprotected sexual contacts were with an individual who is or was:				
1. HIV Positive or has AIDS	_ _ _	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. An injection drug user	_ _ _	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. High on some substance	_ _ _	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Have you ever been tested for HIV?

- YES | NO | REFUSED | DON'T KNOW [IF NO, REFUSED, OR DON'T KNOW, MARK 4A. AS "NOT APPLICABLE"]

a. Do you know the results of your HIV Testing? | YES | NO | NOT APPLICABLE

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

	Days	REFUSED	DON'T KNOW	NOT APPLICABLE
a. Experienced serious depression	_ _	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Experienced serious anxiety or tension	_ _	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Experienced hallucinations	_ _	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Experienced trouble understanding, concentrating, or remembering	_ _	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Experienced trouble controlling violent behavior	_ _	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Attempted suicide	_ _	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Been prescribed medication for psychological / emotional problem	_ _	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

[IF CLIENT REPORTS ZERO (0) DAYS, REFUSED, OR DON'T KNOW TO ALL ITEMS IN QUESTION F5 MARK F6. AS "NOT APPLICABLE"]

6. 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
- NOT APPLICABLE



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 were 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): _____



K. SERVICES RECEIVED [REPORTED BY PROGRAM STAFF]

Identify the number of DAYS of services provided under modality AND identify the number of SESSIONS provided to the client during the client's course of treatment/recovery. Enter zero if no services were provided.

Services

<u>Modality</u>	<u># OF DAYS</u>
1. Case Management	_ _ _
2. Outpatient	_ _ _
3. Intensive Outpatient	_ _ _
4. Recovery Support	_ _ _

Treatment Services

OF SESSIONS

1. Assessment	_ _ _
2. Individual Counseling	_ _ _
3. Group Counseling	_ _ _
4. Family / Marriage Counseling	_ _ _
5. Education	_ _ _

Recovery Support Services

OF SESSIONS

1. Family / Marital / Life Skills	_ _ _
2. Transportation	_ _ _
3. Drug / Alcohol Testing	_ _ _
4. Child Care	_ _ _
5. Adult Staffed Safe & Sober Housing	_ _ _