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Characteristics of Arrestees at Risk for Co-Existing Substance Abuse and Mental Disorder in Cleveland, Ohio, 2003

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Data Collection Instruments

National Institute of Justice
Data Resources Program

ICPSR

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Terms of Use

Cleveland Dual Diagnosis Screening Instrument

I am going to ask you a few questions about how you have been feeling recently. By recently, I mean the past 30 days or past month.

Need for Mental Health Services		Score
Do your thoughts go so fast that you are unable to think clearly about things or plan activities?	Yes = 1 No = 0	
Do people tell you that they can't understand what you are saying, even though it makes sense to you?	Yes = 1 No = 0	
Are you hearing or seeing things that people say they cannot see or hear?	Yes = 1 No = 0	
Do your emotions or feelings make it hard for you to do the normal day to day activities that you need or want to do?	Yes = 1 No = 0	
Do you feel depressed and hopeless most of the time?	Yes = 1 No = 0	
Have you been thinking about hurting yourself or committing suicide?	Yes = 1 No = 0	
Mental Health Services Need Total		

Need for Alcohol or Drug Addiction Services		Score
Have you felt that you drink too much alcohol or use too much drugs?	Yes = 1 No = 0	
Has drinking or other drug use caused problems between you and your family or friends?	Yes = 1 No = 0	
Have you been arrested due to your alcohol or drug use?	Yes = 1 No = 0	
Have you needed to drink more or use more drugs to get the effect that you want?	Yes = 1 No = 0	
Do you spend a lot of time thinking about or trying to get alcohol or drugs?	Yes = 1 No = 0	
Do you feel bad or guilty about your drinking or drug use?	Yes = 1 No = 0	
Alcohol and Drug Addiction Services Total		

If this Total is 1 or more **AND** **If this Total is 1 or more**

Additional Questions		Score
Has anyone in your family ever had a mental illness?	Yes = 1 No = 0	
Has anyone in your family ever had a drinking or drug problem?	Yes = 1 No = 0	
Have you ever been treated by a counselor, social worker or doctor for a mental health problem?	Yes = 1 No = 0	
Have you ever been treated for alcohol or drug abuse or for detox?	Yes = 1 No = 0	
Do you have health insurance?	Yes = 0 No = 1	
Have you been living on the street or in a shelter?	Yes = 1 No = 0	
Other than this time, have you ever been in jail?	Yes = 1 No = 0	
In the past 30 days, have you been unemployed?	Yes = 1 No = 0	
Additional Total		

Mental Health Services Need Total

Alcohol and Drug Addiction Services Need Total

Need for Additional Services Total

Dual Services Need Total

ADAM ID #_____ **Start Time**_____

Dual Diagnosis Supplement

1. Are you being treated by a doctor for a medical problem?

   ( ) Yes: For what problem? _____
   ( ) No

2. Are you taking medication given to you or prescribed for you by a doctor?

   ( ) Yes: What do you take?_____
   ( ) No

3. Are you currently taking any over-the-counter medications, that is medicine that you buy for yourself at the drug store or health store?

   ( ) Yes: What do you take?_____
   ( ) No

4. Have you ever been told by a counselor, social worker, or a doctor that you have a mental illness or emotional problem?

   ( )Yes: What was the diagnosis (What did they tell you)? _____
   Past 6 months? ( ) Yes ( ) No
   Past 30 days? ( ) Yes ( ) No

   ( )No

5. Have you ever been treated by a counselor, social worker or doctor for a mental health problem? ( ) Yes ( ) No
   Past 6 months? ( ) Yes ( ) No
   Past 30 days? ( ) Yes ( ) No

6. Have you ever been hospitalized for a mental health problem? ( ) Yes ( ) No
   Past 6 months? ( ) Yes ( ) No
   Past 30 days? ( ) Yes ( ) No

7. Have you ever been given or prescribed medication for a mental health, emotional, or psychiatric problem? ( ) Yes ( ) No
   Past 6 months? ( ) Yes ( ) No
   Past 30 days? ( ) Yes ( ) No

Now, I am going to do a quick screening for mental health problems.

8. Do you think people are watching you, spying on you, or following you?
   ( ) Yes Who? _____
   ( ) No

9. Do you think people are trying to kill you?
   ( ) Yes Who ? _____
   ( ) No

10. Do your thoughts go so fast that you are unable to think clearly about things or plan activities?
    ( ) Yes
    ( ) No

11. Do people tell you that they can't understand what you are saying, even though it makes sense to you?
    ( ) Yes
    ( ) No

12. Are you hearing or seeing things that people say they cannot see or hear?
    ( ) Yes
    ( ) No

13. Do your emotions / feelings make it hard for you to do the normal day to day activities that you need or want to do?
    ( ) Yes
    ( ) No

14. Do you feel depressed and hopeless most of the time?
    ( ) Yes
    ( ) No

15. Have you ever thought about hurting yourself or committing suicide?
    ( ) Yes ( ) No
    Past 6 months? ( ) Yes ( ) No
    Past 30 days? ( ) Yes ( ) No

16. Have you ever tried to hurt or kill yourself?
    ( ) Yes ( ) No
    Past 6 months? ( ) Yes ( ) No
    Past 30 days? ( ) Yes ( ) No

17. Has anyone in your family ever had a mental illness?
    ( ) Yes
    ( ) No
    Past 6 months? ( ) Yes ( ) No
    Past 30 days? ( ) Yes ( ) No

Now, I would like to talk to you about use of alcohol and drugs.

18. Have you ever felt that you use too much alcohol or other drugs?
( ) Yes ( ) No
    Past 6 months? ( ) Yes ( ) No
    Past 30 days? ( ) Yes ( ) No

19. Have you ever felt sick, shaky, or depressed when you stopped drinking or using drugs ( ) Yes ( ) No
    Past 6 months? ( ) Yes ( ) No
    Past 30 days? ( ) Yes ( ) No

20. Have you ever felt "coke bugs," or a crawling feeling under your skin, after you stopped using drugs ( ) Yes ( ) No
    Past 6 months? ( ) Yes ( ) No
    Past 30 days? ( ) Yes ( ) No

21. Have you ever used needles to shoot drugs ( ) Yes ( ) No
    Past 6 months? ( ) Yes ( ) No
    Past 30 days? ( ) Yes ( ) No

22. Has drinking or other drug use ever caused problems between you and your family or friends? ( ) Yes ( ) No
    Past 6 months? ( ) Yes ( ) No
    Past 30 days? ( ) Yes ( ) No

23. Has drinking or other drug use ever caused problems at school or at work?
( ) Yes ( ) No
    Past 6 months? ( ) Yes ( ) No
    Past 30 days? ( ) Yes ( ) No

24. Have you ever been arrested due to your alcohol or drug use? ( ) Yes ( ) No
    Past 6 months? ( ) Yes ( ) No
    Past 30 days? ( ) Yes ( ) No

25. Have you ever lost your temper or gotten into arguments or fights while drinking or using drugs? ( ) Yes ( ) No
    Past 6 months? ( ) Yes ( ) No
    Past 30 days? ( ) Yes ( ) No

26. Has there ever been a time when you needed to increase the amount you drink or you needed to use more drugs to get the effect your want? ( ) Yes ( ) No
    Past 6 months? ( ) Yes ( ) No
    Past 30 days? ( ) Yes ( ) No

27. Has there ever been a time when you spent a lot of time thinking about or trying to get alcohol or other drugs? ( ) Yes ( ) No
    Past 6 months? ( ) Yes ( ) No
    Past 30 days? ( ) Yes ( ) No

28. Has there ever been a time when you felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No
    Past 6 months? ( ) Yes ( ) No
    Past 30 days? ( ) Yes ( ) No

29. Have you ever used alcohol or street drugs to relieve a hang-over or to help you sleep? ( ) Yes ( ) No
    Past 6 months? ( ) Yes ( ) No
    Past 30 days? ( ) Yes ( ) No

30. Have you ever used alcohol or drugs even though you had been told to stop due to a physical or mental health problem? ( ) Yes ( ) No
    Past 6 months? ( ) Yes ( ) No
    Past 30 days? ( ) Yes ( ) No

31. Have you ever been diagnosed with alcohol abuse/dependence or drug abuse/dependence? ( ) Yes ( ) No
    Past 6 months? ( ) Yes ( ) No
    Past 30 days? ( ) Yes ( ) No

32. Have you ever gone to anyone for help because of your drinking or drugs use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.) ( ) Yes ( ) No
    Past 6 months? ( ) Yes ( ) No
    Past 30 days? ( ) Yes ( ) No

33. Have you ever received treatment for alcohol or drug abuse or for detox? ( ) Yes ( ) No
    Past 6 months? ( ) Yes ( ) No
    Past 30 days? ( ) Yes ( ) No

34. Have you received outpatient care for alcohol or drug abuse? ( ) Yes ( ) No
    Past 6 months? ( ) Yes ( ) No
    Past 30 days? ( ) Yes ( ) No

35. Have any of your family members ever had a drinking or drug problem? ( ) Yes ( ) No
    Past 6 months? ( ) Yes ( ) No
    Past 30 days? ( ) Yes ( ) No

    This is the end of the interview. Now that we have finished, I am going to give you a list of how you can get help for an alcohol, drug, or mental health problem when you leave here. I will also give you the name of the person to talk to on this shift here at the jail if you want immediate attention.

    End Time_____ Interviewer Initials _____

    NOTES: