

# CSA

# Screening

# Packet

**Developed by**



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# Screening Information

Please fill-in this form completely. When this form is collected, you will be asked to complete any missing information.

## Facilitator Information

Screening Date:	
Screening Source:	Select only one: <input type="checkbox"/> Institution <input type="checkbox"/> Community <input type="checkbox"/> Drug Court
Screening Location:	
Facilitator Name:	

## Personal Information

Full name:			
MDOC:		Gender (M/F):	
Birth date:		Age:	
Marital Status:	Check the best answer: <input type="checkbox"/> Single, never married <input type="checkbox"/> Living as married <input type="checkbox"/> Married <input type="checkbox"/> Separated/divorced <input type="checkbox"/> Widowed		
Education:	Check the best answer: <input type="checkbox"/> 8 <sup>th</sup> grade or less <input type="checkbox"/> Some high school, did not graduate; no GED <input type="checkbox"/> High school graduate/GED <input type="checkbox"/> Vocational school <input type="checkbox"/> Some college <input type="checkbox"/> College graduate		
Occupation:			
Age at First Arrest:		Age at First Conviction:	
Current Offense(s):			
Current Sentence:			
How old were you when you used alcohol and/or drugs for very first time?			
Have you received a past substance abuse treatment program?			

When complete, proceed to the next page.

# SADD Questionnaire

The following questions cover a wide range of topics having to do with drinking.

*Please read each question carefully, but do not think too much about its exact meaning. Think about your most recent drinking habits and answer each question by checking the best choice.*

*Please base your responses on your behavior during the 12 MONTHS BEFORE YOUR ARREST.*

## SADD

<b>Directions:</b> The following questions cover a wide range of topics having to do with drinking. Please <u>read each question carefully</u> , but do not think too much about its exact meaning. Think about your <u>most recent</u> drinking habits and answer each question by placing a check mark in the box in the <u>most appropriate</u> column. <b>Please base your responses on your behavior during the 12 MONTHS BEFORE YOUR ARREST</b>		<b>Never</b>	<b>Sometimes</b>	<b>Often</b>	<b>Nearly Always</b>
1.	Do you find difficulty in getting the thought of drinking out of your mind?				
2.	Is getting drunk more important to you than the next meal?				
3.	Do you plan your day around when and where you can drink?				
4.	Do you drink in the morning, afternoon and evening?				
5.	Do you drink for the effect of alcohol without caring what the drink is?				
6.	Do you drink as much as you want regardless of what you are doing the next day?				
7.	Given that many problems might be caused by alcohol, do you still drink too much?				
8.	Do you know you won't be able to stop drinking once you start?				
9.	Do you try to control your drinking by giving it up completely for days or weeks at a time?				
10.	The morning after a heavy drinking session do you need your first drink to get going?				
11.	The morning after a heavy drinking session do you wake up with definite shakiness in your hands?				
12.	After a heavy drinking session do you wake up and wretch or vomit?				
13.	The morning after a heavy drinking session do you go out of your way to avoid people?				
14.	The morning after a heavy drinking session do you see frightening things that later you realize were imaginary?				
15.	Do you go drinking and the next day find out that you have forgotten what happened the night before?				

When complete, please proceed to the next page.

# SDS Questionnaire

In the next questionnaire, please follow the instructions on the next page.

*Please base your responses on your behavior during the 12 MONTHS BEFORE YOUR ARREST.*

## SDS, Part 1

**Directions:** This questionnaire asks about your use of drugs other than alcohol. If you have never used drugs other than alcohol please check the box below, and go no further in this questionnaire.

I have never used drugs other than alcohol.

If you have used drugs other than alcohol, please indicate up to three drugs you have used most. Check only drugs that you used on a regular basis (more than one time per month when you were using):

1. Cocaine                       2. Heroin                       3. Marijuana  
 4. Amphetamines               5. LSD/Hallucinogens  
 6. Prescription Drugs

***Please base your responses on your behavior during the 12 MONTHS BEFORE YOUR ARREST.***

Next, please enter the Letter of the drug you used <u>MOST</u> here ↓:		For example, the number for <b>Cocaine</b> is <b>1</b> (see list above). If you use Cocaine the most, write <b>1</b> in this box. ←			
For that drug <i>only</i> , please answer the following questions by placing a check mark in the box under the best answer for each question, as pertains to you.		Never / Almost Never	Sometimes	Often	Always / Nearly Always
1.	Did you think your use of this drug was out of control?				
2.	Did the prospect of missing a fix or dose or not chasing the drug make you anxious or worried?				
3.	Did you worry about your use of this drug?				
4.	Did you wish you could stop using the drug?				
5.	Did you find it difficult to stop using or go without this drug?				

When complete, please proceed to the next page.

**Please base your responses on your behavior during the 12 MONTHS BEFORE YOUR ARREST.**

### SDS, Part 2

Next, please enter the number of the drug you used <u>NEXT MOST</u> here ↓:		<b>For example</b> , the number for <b>Cocaine</b> is <b>1</b> (see list in Part 1). If you use Cocaine the <u>NEXT MOST</u> , write <b>1</b> in this box. ←			
For that drug <i>only</i> , please answer the following questions by placing a check mark in the box under the best answer for each question, as pertains to you.		<b>Never / Almost Never</b>	<b>Sometimes</b>	<b>Often</b>	<b>Always / Nearly Always</b>
1.	Did you think your use of this drug was out of control?				
2.	Did the prospect of missing a fix or dose or not chasing the drug make you anxious or worried?				
3.	Did you worry about your use of this drug?				
4.	Did you wish you could stop using the drug?				
5.	Did you find it difficult to stop using or go without this drug?				

**Please base your responses on your behavior during the 12 MONTHS BEFORE YOUR ARREST.**

### SDS, Part 3

Next, please enter the number of the drug you used <u>THIRD MOST</u> here ↓:		<b>For example</b> , the number for <b>Cocaine</b> is <b>1</b> (see list in Part 1). If you use Cocaine the <u>THIRD MOST</u> , write <b>1</b> in this box. ←			
For that drug <i>only</i> , please answer the following questions by placing a check mark in the box under the best answer for each question, as pertains to you.		<b>Never / Almost Never</b>	<b>Sometimes</b>	<b>Often</b>	<b>Always / Nearly Always</b>
1.	Did you think your use of this drug was out of control?				
2.	Did the prospect of missing a fix or dose or not chasing the drug make you anxious or worried?				
3.	Did you worry about your use of this drug?				
4.	Did you wish you could stop using the drug?				
5.	Did you find it difficult to stop using or go without this drug?				

When complete, please proceed to the next page.

# MAST Questionnaire

In the next questionnaire, please answer each question by checking the answer that applies to you.

*Please answer the questions based on your alcohol use over your lifetime.*

## MAST

<b>Directions:</b> Answer each question by checking the answer that applies to you.		<b>Yes</b>	<b>No</b>
1.	Do you feel you are a normal drinker?		
2.	Have you ever awakened the morning after some drinking the night before and found you could not remember a part of the evening before?		
3.	Does your wife, husband, partner or parents ever worry or complain about your drinking?		
4.	Can you stop drinking without a struggle after one or two drinks?		
5.	Do you ever feel bad about your drinking?		
6.	Do friends and relatives think you are a normal drinker?		
7.	Do you ever limit your drinking to certain times of the day or to certain places?		
8.	Are you always able to stop drinking when you want to?		
9.	Have you ever attended a meeting of Alcoholics Anonymous (AA)?		
10.	Have you gotten into fights when drinking?		
11.	Has drinking ever created problems with you and your spouse/partner?		
12.	Has your spouse/partner/other family member ever gone to anyone for help about your drinking?		
13.	Have you ever lost friends or girlfriends/boyfriends because of drinking?		
14.	Have you ever gotten into trouble at work because of drinking?		
15.	Have you ever lost a job because of drinking?		
16.	Have you ever neglected your obligations, your family or your work for two or more days in a row because you were drinking?		
17.	Do you ever drink before noon?		
18.	Have you ever been told you have liver trouble or cirrhosis?		
19.	Have you ever had delirium tremens (DTs), severe shaking, heard voices, or seen things that weren't there after heavy drinking?		
20.	Have you ever gone to anyone for help about your drinking?		
21.	Have you ever been in a hospital because of drinking?		
22.	Have you ever been a patient in a psychiatric hospital or mental health clinic or on a psychiatric ward of a hospital where drinking was part of the problem?		
23.	Have you ever been seen at a psychiatric or mental health clinic or gone to a doctor, social worker or clergyman for help with an emotional problem in which drinking had played a part?		
24.	Have you ever been arrested, even for a few hours, because of drunk behavior?		
25.	Have you ever been arrested for drunk driving or driving after drinking?		

When complete, please proceed to the next page.

# DAST Questionnaire

In the next questionnaire, please answer each question by checking the answer that applies to you.

*Please answer the questions based on your substance use over your lifetime.*

## DAST

<b>Directions:</b> Answer each question by checking the answer that applies to you.		<b>Yes</b>	<b>No</b>
1.	Have you used drugs other than those required for medical reasons?		
2.	Have you abused prescription drugs?		
3.	Do you abuse more than one drug at a time?		
4.	Can you get through the week without using drugs (other than those required for medical reasons)?		
5.	Are you always able to stop using drugs when you want to?		
6.	Do you abuse drugs on a continuous basis?		
7.	Do you try to limit your drug use to certain situations?		
8.	Have you had "blackouts" or "flashbacks" as a result of drug use?		
9.	Do you ever feel bad about your drug use?		
10.	Does your spouse/partner/parents ever complain about your involvement with drugs?		
11.	Do your friends or relatives know or suspect you use drugs?		
12.	Has drug abuse ever created problems between you and your spouse/partner?		
13.	Has any family member ever sought help for problems related to your drug use?		
14.	Have you ever lost friends because of your drug use?		
15.	Have you ever neglected your family or missed work because of drug use?		
16.	Have you ever been in trouble at work because of drug use?		
17.	Have you ever lost a job because of drug use?		
18.	Have you gotten into fights when under the influence of drugs?		
19.	Have you ever been arrested because of unusual behavior while under the influence of drugs?		
20.	Have you ever been arrested for driving while under the influence of drugs?		
21.	Have you engaged in illegal activities in order to obtain drugs?		
22.	Have you ever been arrested for possession of illegal drugs?		
23.	Have you ever experienced withdrawal symptoms as a result of heavy drug intake?		
24.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc)		
25.	Have you ever gone to anyone for help for a drug problem?		
26.	Have you ever been in a hospital for medical problems related to your drug use?		
27.	Have you ever been involved in a treatment program specifically related to drug use?		
28.	Have you been treated as an outpatient for problems related to drug use?		

When complete, please proceed to the next page.

# SOCRATES A Questionnaire

Please read the following statements carefully. Each one describes a way you might (or might not) feel about your drinking.

For each statement, check one choice to indicate how much you agree or disagree with it *right now*.

Please answer the questions based on how you feel about your substance use *right now*.

## SOCRATES-A

<p><b>Directions:</b> Please read the following statements carefully. Each one describes a way you might (or might not) feel about your drug use. For each statement circle one number on the scale at the right to indicate how much you agree or disagree with it <u>right now</u>. Please circle one and only one number for each statement.</p>		Strongly Disagree	Disagree	Undecided / Unsure	Agree	Strongly Agree
1.	I really want to make changes in my drinking.					
2.	Sometimes I wonder if I'm an alcoholic.					
3.	If I don't change my drinking soon, my problems are going to get worse.					
4.	I have already started making some changes in my drinking.					
5.	I was drinking too much at one time, but have managed to change my drinking.					
6.	Sometimes I wonder if my drinking is Hurting other people.					
7.	I am a problem drinker.					
8.	I am not just thinking about changing my drinking, I'm already doing something about it.					
9.	I have already changed my drinking, and I am looking for ways to keep from slipping back to my old pattern.					
10.	I have a serious problem with drinking.					
11.	Sometimes I wonder if I am in control of my drinking.					
12.	My drinking is causing a lot of harm.					
13.	I am actively doing things right now to cut down or stop drinking.					
14.	I want help to keep from going back to the drinking problems that I had before.					
15.	I know that I have a drinking problem.					
16.	There are times when I wonder if I drink too much.					
17.	I am an alcoholic.					
18.	I am working hard to change my drinking.					
19.	I have made some changes in my drinking, and I want some help to keep from going back to the way I used to drink.					

When complete, please proceed to the next page.

# SOCRATES D Questionnaire

Please read the following statements carefully. Each one describes a way you might (or might not) feel about your drug use.

For each statement, click one choice to indicate how much you agree or disagree with it *right now*.

Please answer the questions based on how you feel about your substance use *right now*.

## SOCRATES-D

<p><b>Directions:</b> Please read the following statements carefully. Each one describes a way you might (or might not) feel about your drug use. For each statement circle one number on the scale at the right to indicate how much you agree or disagree with it <u>right now</u>. Please circle one and only one number for each statement.</p>		Strongly Disagree	Disagree	Undecided / Unsure	Agree	Strongly Agree
1.	I really want to make changes in my drug use.					
2.	Sometimes I wonder if I'm a drug addict.					
3.	If I don't change my drug use soon, my problems are going to get worse.					
4.	I have already started making some changes in my drug use.					
5.	I was using drugs too much at one time, but have managed to change my drug use.					
6.	Sometimes I wonder if my drug use is hurting other people.					
7.	I am a problem drug user.					
8.	I am not just thinking about changing my drug use, I'm already doing something about it.					
9.	I have already changed my drug use, and I am looking for ways to keep from slipping back to my old pattern.					
10.	I have a serious problem with drugs.					
11.	Sometimes I wonder if I am in control of my drug use.					
12.	My drug use is causing a lot of harm.					
13.	I am actively doing things right now to cut down or stop my drug use.					
14.	I want help to keep from going back to the drug problems that I had before.					
15.	I know that I have a drug problem.					
16.	There are times when I wonder if I use drugs too much.					
17.	I am a drug addict.					
18.	I am working hard to change my drug use.					
19.	I have made some changes in my drug use, and I want some help to keep from going back to the way I used to use drugs.					

When complete, please



You have finished the screening.