Guidelines for Using the Mental Health Screening Form III

The Mental Health Screening Form-III (MHSF-III) was initially designed as a rough screening device for clients seeking admission to substance abuse treatment programs.

Each MHSF-III question is answered either "yes" or "no." All questions reflect the respondent's **entire life history**; therefore all questions begin with the phrase "Have you **ever**..."

The **preferred** mode of administration is for staff members to read each item to the respondent and get their "yes" and "no" responses. Then, **after** completing all 18 questions (question 6 has two parts), the staff member should inquire about any "yes" response by asking "**When** did this problem first develop?"; "**How long** did it last?"; "Did the problem develop **before**, **during**, or **after** you started using substances?"; and, "**What** was happening in your life at that time?" This information can be written below each item in the space provided. There is additional space for staff member comments at the bottom of the form.

The MHSF-III can also be given directly to clients for them to complete, providing they have sufficient reading skills. If there is any doubt about someone's reading ability, have the client read the MHSF-II instructions and question number one to the staff member monitoring this process. If the client can not read and/or comprehend the questions, the questions must be read and/or explained to him/her.

Whether the MHSF-III is read to a client or s/he reads the questions and responds on his/her own, the completed MHSF-III **should be carefully reviewed** by a staff member to determine how best to use the information. It is strongly recommended that a **qualified mental health specialist** be consulted about any "yes" response to questions 3 through 17. The mental health specialist will determine whether or not a follow-up, face-to-face interview is needed for a diagnosis and/or treatment recommendation.

The MHSF-III features a "**Total Score**" line to reflect the total number of "yes" responses. The maximum score on the MHSF-III is 18 (question 6 has two parts). This feature will permit programs to do research and program evaluation on the mental health-chemical dependence interface for their clients.

The first four questions on the MHSF-III are not unique to any particular diagnosis; however, **questions 5 through 17 reflect symptoms associated with the following diagnoses/diagnostic categories**: Q5, Schizophrenia; Q6, Depressive Disorders; Q7, Post-Traumatic Stress Disorder; Q8, Phobias; Q9, Intermittent Explosive Disorder; Q10, Delusional Disorder; Q11, Sexual and Gender Identity Disorders; 12Q Eating Disorders (Anorexia, Bulimia); Q13 Manic Episode; Q14 Panic Disorder; Q15 Obsessive-Compulsive Disorder; Q16 Pathological Gambling; Q17 Learning Disorder and Mental Retardation.

The relationship between the diagnoses/diagnostic categories and the above cited questions was investigated by having four mental health specialists independently "select the one MHSF-III question that best matched a list of diagnoses/diagnostic categories." All of the mental health specialists matched the questions and diagnoses/diagnostic categories in the same manner, that is, as we have noted in the preceding paragraph.

A "yes" response to any of questions 5 through 17 does **not**, by itself, insure that a mental health problems exists at this time. A "yes" response raises only the **possibility** of a **current** problem, which is why a consult with a mental health specialist is strongly recommended.

J.F.X. Carroll, Ph.D. & John J. McGinley, M.S., M.S.W., M.A.

Mental Health Screening Form III

Instructions: In this program, we help people with all their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you to deal with any emotional problems you may have, but we can do this only if we are aware of the problems. Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside person or agency without your permission. If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note, each item refers to your entire life history, not just your current situation, this is why each question begins –"Have you ever ...."

1) Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem?

YES NO

2) Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems? YES NO

3) Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem? YES NO

4) Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons?

YES NO

5) Have you ever heard voices no one else could hear or seen objects or things which others could not see?

YES NO

6) a) Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself? YES NO

b) Did you ever attempt to kill yourself? YES NO

7) Have you ever had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed?

YES NO

8) Have you ever experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help?

YES NO

9) Have you ever given in to an aggressive urge or impulse, on more than one occasion, that resulted in serious harm to others or led to the destruction of property? YES NO

OVER

10) Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior? YES NO

11) Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner? YES NO

12) Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up? YES NO

13) Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything? YES NO

14) Have you ever had spells or attacks when you suddenly felt anxious, frightened, uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint? YES NO

15) Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate.
YES NO

16) 1.Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling? YES NO

17) Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem?
YES NO

Print Client's Name: _____ Program to which client will be assigned: _____

Name of Admissions Counselor: _____ Date: _____

Reviewer's Comments: _____

_____

_____

Total Score: _____ (each yes = 1 pt.)

FOR ADMINISTRATIVE PURPOSES

TCU Drug Screen II

Instruction Page

The following questions ask about your drug use (including alcohol) in the past 12 months. Please answer them by marking only one circle for each question. If you do not feel comfortable giving an answer to a particular question, you may skip it and move on to the next question.

If you are an inmate, please refer to the 12-month period immediately before you were locked up; that is, the last time you were in the "free world."

Also, alcohol is a drug. Your answers to questions about drug use need to include alcohol use, such as drinking beer.

The example below shows how to mark the circles --

	Yes	No
1. I like ice cream.	○	●

FOR ADMINISTRATIVE PURPOSES

TCU DRUG SCREEN II

During the last 12 months (before being locked up, if applicable) –

	Yes	No
1. Did you use larger amounts of drugs or use them for a longer time than you planned or intended?	O	O
2. Did you try to cut down on your drug use but were unable to do it?	O	O
3. Did you spend a lot of time getting drugs, using them, or recovering from their use?	O	O
4. Did you get so high or sick from drugs that it –		
a. kept you from doing work, going to school, or caring for children?	O	O
b. caused an accident or put you or others in danger?	O	O
5. Did you spend less time at work, school, or with friends so that you could use drugs?	O	O
6. Did your drug use cause –		
a. emotional or psychological problems?	O	O
b. problems with family, friends, work, or police?	O	O
c. physical health or medical problems?	O	O
7. Did you increase the amount of a drug you were taking so that you could get the same effects as before?	O	O
8. Did you ever keep taking a drug to avoid withdrawal symptoms or keep from getting sick?	O	O
9. Did you get sick or have withdrawal symptoms when you quit or missed taking a drug?	O	O

10. Which drug caused the most serious problem? [CHOOSE ONE]

O *None*
O *Alcohol*
O *Marijuana/Hashish*
O *Hallucinogens/LSD/PCP/Psychedelics/Mushrooms*
O *Inhalants*
O *Crack/Freebase*
O *Heroin and Cocaine (mixed together as Speedball)*
O *Cocaine (by itself)*
O *Heroin (by itself)*
O *Street Methadone (non-prescription)*
O *Other Opiates/Opium/Morphine/Demerol*
O *Methamphetamines*
O *Amphetamines (other uppers)*
O *Tranquilizers/Barbiturates/Sedatives (downers)*

FOR ADMINISTRATIVE PURPOSES

11. How often did you use each type of drug during the last 12 months?

	DRUG USE IN LAST 12 MONTHS				
	NEVER	ONLY A FEW TIMES	1-3 TIMES A MONTH	1-5 TIMES A WEEK	ABOUT EVERY DAY
a. Alcohol	O	O	O	O	O
b. Marijuana/Hashish	O	O	O	O	O
c. Hallucinogens/LSD/PCP/ Psychedelics/Mushrooms	O	O	O	O	O
d. Inhalants	O	O	O	O	O
e. Crack/Freebase	O	O	O	O	O
f. Heroin and Cocaine (mixed together as Speedball)	O	O	O	O	O
g. Cocaine (by itself)	O	O	O	O	O
h. Heroin (by itself)	O	O	O	O	O
i. Street Methadone (non-prescription)	O	O	O	O	O
j. Other Opiates/Opium/Morphine/Demerol	O	O	O	O	O
k. Methamphetamines	O	O	O	O	O
l. Amphetamines (other uppers)	O	O	O	O	O
m. Tranquilizers/Barbiturates/Sedatives (downers)	O	O	O	O	O
n. Other *(specify)* _____	O	O	O	O	O

12. During the last 12 months, how often did you inject drugs with a needle?

O *Never* O *Only a few times* O *1-3 times per month* O *1-5 times per week* O *Daily*

13. How serious do you think your drug problems are?

O *Not at all* O *Slightly* O *Moderately* O *Considerably* O *Extremely*

14. How many times before now have you ever been in a drug treatment program?
[DO NOT INCLUDE AA/NA/CA MEETINGS]

O *Never* O *1 time* O *2 times* O *3 times* O *4 or more times*

15. How important is it for you to get drug treatment now?

O *Not at all* O *Slightly* O *Moderately* O *Considerably* O *Extremely*

Scoring for the TCU Drug Screen II

Page 1 of the TCU Drug Screen is scored as follows:

1. Give 1-point to each "yes" response to 1-9 (Questions 4 and 6 are worth one point each if a respondent answers "yes" to any portion).

2. The total score can range from 0 to 9; score values of 3 or greater indicate relatively severe drug-related problems, and correspond approximately to DSM drug dependence diagnosis.

3. Responses to Question 10 indicate which drug (or drugs) the respondent feels is primarily responsible for his or her drug-related problems.

The TCU Drug Screen II was developed as part of NIJ Grant 1999-MU-MU-K008, *Assessment of a Drug Screening Instrument.*

For more information on the TCU Drug Screen II, please contact:

Institute of Behavioral Research
Texas Christian University
TCU Box 298740
Fort Worth, TX 76129
(817) 257-7226
(817) 257-7290 FAX
Email: ibr@tcu.edu
Web site: www.ibr.tcu.edu

Screening Instrument:

SSI-AOD (Simple Screening Instrument for Alcohol and Other Drug Abuse)

During the last 6 months…

1. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin, or other opiates, uppers, downers, hallucinogens, or inhalants)
   Yes_____ No_____

2. Have you felt that you use too much alcohol or drugs?
   Yes_____ No_____

3. Have you tried to cut down or quit drinking or using alcohol or other drugs?
   Yes_____ No_____

4. Have you gone to anyone to help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.)
   Yes_____ No_____

5. Have you had any health problems? For example have you:
   __Had blackouts or other periods of memory loss?
   __Injured your head after drinking or using drugs?
   __Had convulsions, delirium tremens ("DTs")?
   __Had hepatitis or other liver problems?
   __Felt sick, shaky, or depressed when you stopped?
   __Felt "coke bugs" or a crawling feeling under your skin after you stopped using drugs?
   __Been injured after drinking or using?
   __Used needles to shoot drugs?

6. Has drinking or other drug use caused problems between you and your family or friends?
   Yes_____ No_____

7. Has your drinking or other drug use caused problems at school or at work?
   Yes_____ No_____

8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft or drug possession.)
   Yes_____ No_____

9. Have you lost your temper or gotten into arguments or fights while drinking or using drugs?
   Yes_____ No_____

10. Are you needing to drink or use drugs more and more to get the effect you want?
    Yes_____ No_____

11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?
    Yes_____ No_____

12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone?
    Yes_____ No_____

13. Do you feel bad or guilty about your drinking or drug use?
    Yes_____ No_____

14. Have you ever had a drinking or other drug problem?
    Yes_____ No_____

15. Have any of your family members ever had a drinking or drug problem?
    Yes_____ No_____

16. Do you feel that you have a drinking or drug problem now?
    Yes_____ No_____

Scoring the Instrument:

Items 1 and 15 are not scored, score all other responses 1 for yes and 0 for no:

___2
___3
___4
___5 (1 point for each item with a positive response)
___6
___7
___8
___9
___10
___11
___12
___13
___14
___16

0-1 indicates a low risk for substance abuse
2-3 indicates need for brief intervention
4 or higher indicates a need for full intervention

The Impact of Event Scale - Revised

Below is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you DURING THE PAST SEVEN DAYS with respect to _____, how much were you distressed or bothered by these difficulties?

		Not at all	A little bit	Moderately	Quite a bit	Extremely
1.	Any reminder brought back feelings about it	0	1	2	3	4
2.	I had trouble staying asleep	0	1	2	3	4
3.	Other things kept making me think about it	0	1	2	3	4
4.	I felt irritable and angry	0	1	2	3	4
5.	I avoided letting myself get upset when I thought about it or was reminded of it	0	1	2	3	4
6.	I thought about it when I didn't mean to	0	1	2	3	4
7.	I felt as if it hadn't happened or wasn't real	0	1	2	3	4
8.	I stayed away from reminders about it	0	1	2	3	4
9.	Pictures about it popped into my mind	0	1	2	3	4
10.	I was jumpy and easily startled	0	1	2	3	4
11.	I tried not to think about it	0	1	2	3	4
12.	I was aware that I still had a lot of feelings about it, but I didn't deal with them	0	1	2	3	4
13.	My feelings about it were kind of numb	0	1	2	3	4
14.	I found myself acting or feeling as though I was back at that time	0	1	2	3	4
15.	I had trouble falling asleep	0	1	2	3	4
16.	I had waves of strong feelings about it	0	1	2	3	4
17.	I tried to remove it from my memory	0	1	2	3	4
18.	I had trouble concentrating	0	1	2	3	4
19.	Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart	0	1	2	3	4
20.	I had dreams about it	0	1	2	3	4
21.	I felt watchful or on-guard	0	1	2	3	4
22.	I tried not to talk about it	0	1	2	3	4

Scoring:
Intrusion Subscale = mean of items 1, 2, 3, 6, 9, 14, 16, 20
Avoidance Subscale = mean of items 5, 7, 8, 11, 12, 13, 17, 22
Hyperarousal Subscale = mean of items 4, 10, 15, 18, 19, 21
IES-R score: Sum of the above 3 clinical scales.

	I (8)	A (8)	H (6)
Total scores			
Total			

D.C. Trauma Collaboration
VIOLENCE AND TRAUMA SCREENING

Name: _____

1. At any time in your life have you witnessed someone seriously injured or killed due to an unnatural event such as a shooting, stabbing, or hit-and-run accident?

a. **LIFETIME** Yes/No b. **PAST 12 MONTHS** Yes/No

Comments and services needed:

_____
_____
_____

2. At any time in your life have you witnessed a physical or sexual assault against a family member, friend, or other significant person?

a. **LIFETIME** Yes/No b. **PAST 12 MONTHS** Yes/No

Comments and services needed:

_____
_____
_____

3. At any time in your life has anyone touched you sexually when you did not want them to?

a. **LIFETIME** Yes/No b. **PAST 12 MONTHS** Yes/No

Comments and services needed:

_____
_____
_____

4. At any time in your life has anyone forced you to have sex when you did not want to?

a. **LIFETIME** Yes/No b. **PAST 12 MONTHS** Yes/No

Comments and services needed:

_____
_____
_____

5. At any time in your life has anyone slapped, pushed, grabbed, or shoved you?

a. **LIFETIME** Yes/No b. **PAST 12 MONTHS** Yes/No

Comments and services needed:

_____

_____

_____

6. At any time in your life has anyone choked, kicked, bit, or punched you?

a. **LIFETIME** Yes/No b. **PAST 12 MONTHS** Yes/No

Comments and services needed:

_____

_____

_____

7. At any time in your life has anyone threatened you with, or actually used, a knife, gun, or other weapon to scare or hurt you?

a. **LIFETIME** Yes/No b. **PAST 12 MONTHS** Yes/No

Comments and services needed:

_____

_____

_____

8. At any time in your life have you been afraid that a specific person (whether it was someone you knew well or not) would hurt you physically?

a. **LIFETIME** Yes/No b. **PAST 12 MONTHS** Yes/No

Comments and services needed:

_____

_____

_____

Recommendations for Treatment:

_____

_____

_____

_____

Clinician Signature: _____ **Date:**_____

Section 2: Posttraumatic Stress Disorder Checklist (PCL-C)

[PCL-C for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD -Behavioral Science Division]

I'm going to read a list of problems and complaints people sometimes have in response to stressful life experiences. For each item, please tell me how much you've been bothered by that problem in the past month.

	Not at all	A little bit	Moderately	Quite a bit	Extremely	RF	DK
7.09a. Repeated disturbing *memories*, *thoughts*, or *images* of a stressful experience from the past? *[Read response options.]*	1	2	3	4	5	8	9
7.09b. Repeated, disturbing dreams of a stressful experience from the past? *[Read response options.]*	1	2	3	4	5	8	9
7.09c. Suddenly acting or feeling as if a stressful experience from the past *were happening again* (as if you were reliving it)?	1	2	3	4	5	8	9
7.09d. Feeling *very upset* when *something reminded you* of a stressful experience from the past?	1	2	3	4	5	8	9
7.09e. Having *physical reactions* (e.g. heart pounding, trouble breathing, sweating) when *something reminded you* of a stressful experience from the past?	1	2	3	4	5	8	9
7.09f. Avoiding *thinking about* or *talking about* a stressful experience from the past?	1	2	3	4	5	8	9
7.09g. Avoiding *activities* or *situations* because *they reminded you* of a stressful experience from the past? *[Read response options.]*	1	2	3	4	5	8	9
7.09h. Trouble *remembering important parts* of a stressful experience from the past?	1	2	3	4	5	8	9
7.09i. *Loss of interest* in activities that you used to enjoy?	1	2	3	4	5	8	9
7.09j. Feeling *distant* or *cut off* from other people?	1	2	3	4	5	8	9
7.09k. Feeling *emotionally numb* or being unable to have loving feelings for those close to you?	1	2	3	4	5	8	9
7.09l. Felling as if your *future* will somehow be *cut short* *[Read response options.]*	1	2	3	4	5	8	9
7.09m. Trouble *falling* or *staying asleep*?	1	2	3	4	5	8	9
7.09n. Feeling *irritable* or having *angry outbursts*?	1	2	3	4	5	8	9
7.09o. Having *difficulty concentrating*?	1	2	3	4	5	8	9
7.09p. Being "*super-alert*" or watchful or on guard?	1	2	3	4	5	8	9
7.09q. Feeling *jumpy* or easily startled? *[Read response options.]*	1	2	3	4	5	8	9

CTCR
CENTER FOR THERAPEUTIC COMMUNITY RESEARCH

CIRCUMSTANCES, MOTIVATION, and READINESS SCALES for SUBSTANCE ABUSE TREATMENT

CMR FACTOR SCALES
Intake Version

CLIENT ID NUMBER .....(___/___/___/___/___/___/___/___) (1-8)

CLIENT GENDER ..... (___) (9)
1=Male 2=Female

CLIENT ETHNICITY ..... (___) (10)
1=African American 2=Hispanic 3=White 4=Other

CLIENT AGE ..... (___/___) (11-12)

PRIMARY DRUG ..... (___/___) (13-14)
1=Non-crack cocaine
2=Crack
3=Opiates
4=Marijuana
5=Alcohol
6=Poly Drug
8=Other

TREATMENT MODALITY ..... (___/___) (15-16)
1=Drug Free Outpatient
2=Day Treatment
3=Methadone Maintenance
4=Short Term Residential
5=Long Term Residential
6=No Treatment Entered
7=Detoxification Only
8= Detoxification as Entry into Treatment
9=Hospital Inpatient
10=Referral Center
11=Other

DATE OF ADMINISTRATION .....(___/___/___/___/___/___) (17-22)

FOR CTCR USE ONLY. PLEASE LEAVE BLANK.

INSTRUMENT VERSION..... (___) (23)

PROGRAM NUMBER..... (___/___) (24-25)

How you feel can have a powerful effect on treatment. These feelings include your circumstances, the problems in your life, your feelings about yourself, and your feelings about treatment. Carefully consider each of the questions below and indicate how closely they describe your own thoughts and feelings.

Circle the number that best describes your response.

1	2	3	4	5	9
Strongly Disagree	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly Agree**	**Not Applicable**

CIRCUMSTANCES

1.	I am sure that I would go to jail if I didn't enter treatment.	1----2----3----4----5----9	___ (26)
2.	I am sure that I would have come to treatment without the pressure of my legal involvement.	1----2----3----4----5----9	___ (27)
3.	I am sure that my family will not let me live at home if I did not come to treatment.	1----2----3----4----5----9	___ (28)
4.	I believe that my family/relationship will try to make me leave treatment after a few months.	1----2----3----4----5----9	___ (29)
5.	I am worried that I will have serious money problems if I stay in treatment.	1----2----3----4----5----9	___ (30)
6.	Basically, I feel I have too many outside problems that will prevent me from completing treatment (parents, spouse/relationship, children, loss of job, loss of income, loss of education, family problems, loss of home/place to live, etc.).	1----2----3----4----5----9	___ (31)

MOTIVATION

7.	Basically, I feel that my drug use is a very serious problem in my life.	1----2----3----4----5----9	___ (32)
8.	Often I don't like myself because of my drug use.	1----2----3----4----5----9	___ (33)
9.	Lately, I feel if I don't change, my life will keep getting worse.	1----2----3----4----5----9	___ (34)
10.	I really feel bad that my drug use and the way I've been living has hurt a lot of people.	1----2----3----4----5----9	___ (35)
11.	It is more important to me than anything else that I stop using drugs.	1----2----3----4----5----9	___ (36)

1 Strongly Disagree	2 Disagree	3 Neither Agree or Disagree	4 Agree	5 Strongly Agree	9 Not Applicable

READINESS

12.	I don't really believe that I have to be in treatment to stop using drugs, I can stop anytime I want.	1----2----3----4----5----9	___ (37)
13.	I came to this program because I really feel that I'm ready to deal with myself in treatment.	1----2----3----4----5----9	___ (38)
14.	I'll do whatever I have to do to get my life straightened out.	1----2----3----4----5----9	___ (39)
15.	Basically, I don't see any other choice for help at this time except some kind of treatment.	1----2----3----4----5----9	___ (40)
16.	I don't really think I can stop my drug use with the help of friends, family or religion, I really need some kind of treatment.	1----2----3----4----5----9	___ (41)
17.	I am really tired of using drugs and want to change, but I know I can't do it on my own.	1----2----3----4----5----9	___ (42)
18.	I'm willing to enter treatment as soon as possible.	1----2----3----4----5----9	___ (43)

Brief Jail Mental Health Screen

Section 1

Name: _____ (First MI Last)	Detainee #: _____	Date: ___/___/_____	Time: _____ AM PM

Section 2

Questions	No	Yes	General Comments
1. Do you *currently* believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head?			
2. Do you *currently* feel that other people know your thoughts and can read your mind?			
3. Have you *currently* lost or gained as much as two pounds a week for several weeks without even trying?			
4. Have you or your family or friends noticed that you are *currently* much more active than you usually are?			
5. Do you *currently* feel like you have to talk or move more slowly than you usually do?			
6. Have there *currently* been a few weeks when you felt like you were useless or sinful?			
7. Are you *currently* taking any medication prescribed for you by a physician for any emotional or mental health problems?			
8. Have you <u>ever</u> been in a hospital for emotional or mental health problems?			

Section 3 (Optional)

Officer's Comments/Impressions (check *all* that apply):

☐ Language barrier ☐ Under the influence of drugs/alcohol ☐ Non-cooperative

☐ Difficulty understanding questions ☐ Other, specify: _____

Referral Instructions: This detainee should be referred for further mental health evaluation if he/she answered:

- **YES to item 7; OR**
- **YES to item 8; OR**
- **YES to at least 2 of items 1 through 6; OR**
- **If you feel it is necessary for any other reason**

☐ Not Referred

☐ Referred on ___ ___/___ ___/___ ___ ___ ___ to _____

Person completing screen _____

INSTRUCTIONS ON REVERSE

INSTRUCTIONS FOR COMPLETING THE BRIEF JAIL MENTAL HEALTH SCREEN

GENERAL INFORMATION:

This Brief Jail Mental Health Screen (BJMHS) was developed by Policy Research Associates, Inc., with a grant from the National Institute of Justice. The BJMHS is an efficient mental health screen that will aid in the early identification of severe mental illnesses and other acute psychiatric problems during the intake process.

This screen should be administered by Correctional Officers during the jail's intake/booking process.

INSTRUCTIONS FOR SECTION 1:

NAME:	Enter detainees name — first, middle initial, and last
DETAINEE#:	Enter detainee number.
DATE:	Enter today's month, day, and year.
TIME:	Enter the current time and circle AM or PM.

INSTRUCTIONS FOR SECTION 2:

ITEMS 1-6:

Place a check mark in the appropriate column (for "NO" or "YES" response).

If the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES." Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.

ITEMS 7-8:

ITEM 7: This refers to any *prescribed* medication for any emotional or mental health problems.

ITEM 8: Include any stay of one night or longer. Do NOT include contact with an Emergency Room if it did not lead to an admission to the hospital

If the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES." Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.

General Comments Column:

As indicated above, if the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES." Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.

All "YES" responses require a note in the General Comments section to document:

(1) Information about the detainee that the officer feels relevant and important
(2) Information specifically requested in question

If at any point during administration of the BJMHS the detainee experiences distress, he/she should follow the jails procedure for referral services.

INSTRUCTIONS FOR SECTION 3:

OFFICER'S COMMENTS: Check any one or more of the four problems listed if applicable to this screening. If any other problem(s) occurred, please check OTHER, and note what it was.

REFERRAL INSTRUCTIONS:

Any detainee answering YES to Item 7 or YES to Item 8 or YES to at least two of Items 1-6 should be referred for further mental health evaluation. If there is any other information or reason why the officer feels it is necessary for the detainee to have a mental health evaluation, the detainee should be referred. Please indicate whether or not the detainee was referred.