**Kentucky Drug Court Eligibility Risk and Needs Assessment**

*BEFORE YOU START:*

* *Be sure macros are enabled (see Section 1 of the manual)*
* *If you are giving this assessment in a jail or prison, use “prior to incarceration” in questions where that is part of the question. If the defendant is not incarcerated, leave out “prior to incarceration” where that is part of the question.*
* *Make it clear to the defendant that any time a question refers to “drugs” that it means “drugs or alcohol” unless it refers to a specific drug.*

Date of Interview (m/d/yyyy):

Interviewer:       Drug Court Site (county):

**Have you ever been in a Kentucky Drug Court Program?**

1. ***CONTACT INFORMATION***

**This first section asks about your contact information.**

1. Referral Information:

 First Name:

 Last Name:

 Middle Initial:

1a. Maiden name/alias:

 1b. Date of Birth:(m/d/yyyy)       Current Age:

1c. Social Security Number:       (please verify)

1. Gender:

\* \* \* \* \* \* \* \* \*

*Please state the following to the defendant: “The next two questions are for statistical purposes only and will not be considered in the decision of entry/non-entry into Drug Court.”*

1. Race:
2. Ethnicity:

\* \* \* \* \* \* \* \* \*

1. What is your current address?
2. Who else resides in your household? (List name, age, and relationship of all those residing in the household)
3. What is your marital status?
4. What is the best phone number to reach you?       Home or Cell?
5. What is your cell phone number?       What is your landline #?
6. Do you have an email address? If so, what is it?
7. Emergency Contact – Name, Address, Phone #, Relationship
8. Do you have a valid driver’s license?

[ ] NO If NO, why not?

[ ] YES If YES, what is your driver’s license number?       (please verify)

 12a. Do you have an automobile available for use?

 12b. If yes, please provide the year, make, and model.

12c. If you do not have a car to use and do not have a license, how will you get to drug court activities?

13. Have you served in the National Guard or the United States Armed Forces?

 13a. While in the service, were you ever in combat?

14. **Comments on contact information:**

***B. RISK SCREENING***

*Tell the defendant: “We need to get some information about you in order to make a decision about whether drug court is a good fit for you and to find out what services you might need.”*

1. Do you have any prior arrests or convictions?

\*\*2. How many times have you been convicted of a felony as an adult (not counting the current offense)?

\* 3. How old were you when you were arrested for the first time?

3a. What was your first arrest for?

4. As an adult, have you ever had a warrant filed for failure-to-appear to court?

4a. How many times?

\* 4b. How many times during the past two years?

4c. What happened as a result?

5. Have you ever been incarcerated in jail or prison as a result of a conviction? ***(****Probe to make sure that incarceration was a result of sentencing and not simply pretrial detention).*

5a. How many times in jail?

5b. How many times in prison?

5c. \*(total for questions 5a and 5b): 0

\*\*6. Are you currently employed?  If yes, name of employer:

6a. If you are employed, is your work temporary, seasonal, or permanent?

6b. If employed, how long have you worked at your current job?       (number)  (days/weeks/months/years)

6c. What type of work is this job?

6d. How long did you work at your last job? (number)

 Comments:

\* 6e. Were you employed at the time of this arrest?

6f. Have you ever lost or left a job due to substance abuse issues?

6g. How many days have you experienced employment problems in the past 30 days (or past 30 days prior to incarceration?)

7. Are you in school?

7a. How many years of education have you completed?

7b. Did you obtain a diploma or GED?

\* 8. How long have you lived at your current residence? (number)

8a. Is this your primary residence?

If no, please explain:

8b. Do you own or rent?

8c. If you have moved within the past six months, what was the reason?

9. Have you ever had a problem with drugs or alcohol?

9a. If yes, please explain:

9b. How old were you when you first used any drug or alcohol?

10. Have you ever been arrested for drug or alcohol use?

10a. If yes, please explain:

10b. When?

11. What drugs have you used?

12. How often on average do you use?

13. When was the last time you used alcohol or drugs (prior to incarceration)?

 \* 13a. Have you used within the past 6 months (prior to incarceration)?

14. How has your alcohol or drug use affected other parts of your life?

14a. For example, has a medical professional ever told you to quit using drugs?

14b. Have you ever had problems at work because of alcohol or drug use?

14c. How does your family feel about your alcohol or drug use?

14d. (Probe further if needed about problems with health, relationships (family and social), legal, etc. related to substance abuse)

\* 15. If I asked you to rate the severity of your alcohol or drug use problem on a scale from 1 to 5, with 1 being few or no problems and 5 being many problems, what score would you give yourself?

16. Tell me about the neighborhood you live in.

\*\*16a. How easy would you say it is to acquire drugs in your neighborhood?

17. How many close friends would you say that you have?

17a. Have any of your close friends been involved with criminal behavior?

\*\*17b. How many of your close friends have been in trouble with the law?

17c. What kinds of things have they been involved with?

**Comments on Risk Screening**:

**Recidivism Risk Score:** **0 Recidivism Risk Level:** **Low Risk**

**Social Risk Score:** **0 Social Risk Level:** **Low Risk**

***C. SUBSTANCE ABUSE SCREENING***

*Tell the defendant: “Now I am going to ask you more specific questions related to your drug or alcohol use”*

During the last 12 months (before being incarcerated, if applicable):

|  |  |
| --- | --- |
| 1. Did you use larger amounts of drugs or use them for a longer time than you planned or intended?  |  |
| 2. Did you try to control or cut down on your drug use but were unable to do it?  |  |
| 3. Did you spend a lot of time getting drugs, using them, or recovering from their use?  |  |
| 4. Did you have a strong desire or urge to use drugs?  |  |
| 5. Did you get so high or sick from using drugs that it kept you from working, going to school, or caring for children?  |  |
| 6. Did you continue using drugs even when it led to social or interpersonal problems?  |  |
| 7. Did you spend less time at work, school, or with friends because of your drug use? |  |
| 8. Did you use drugs that put you or others in physical danger?  |  |
| 9. Did you continue using drugs even when it was causing you physical or psychological problems?  |  |
| 10a. Did you need to increase the amount of a drug you were taking so that you could get the same effects as before? 10b. Did using the same amount of a drug lead to it having less of an effect as it did before?  | *(Yes to either question is a* *yes)* |
| 11a. Did you get sick or have withdrawal symptoms when you quit or missed taking a drug? 11b. Did you ever keep taking a drug to relieve or avoid getting sick or having withdrawal symptoms?  | *(Yes to either question is a yes)* |

**Substance Abuse Score:** **0 Disorder Level:** **No Associated Substance Abuse Disorder**

1. Are you currently on any medically assisted treatment for a substance abuse disorder?

12a. If Yes, what drug are you being prescribed?

12b. Name of provider for medically assisted treatment

1. How important is it for you to get drug treatment now?
2. Substance Use History:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Drug/Alcohol Information** | **History of Use**Ever Used | **Frequency of Use**# Days used in the past 30 days(not including jail time) | **Duration of Use**# Years Used in Lifetime | **Intensity of Use**How has your use changed since you began? | **Method of Use**(Select all that apply) |
| **Alcohol**, any use | [ ]  NO[ ]  YES Age of first use:       |       |       |       | [ ]  IV[ ]  Oral[ ]  Smoke[ ]  Snort |
| **Amphetamines** (Adderall, Desoxyn) Uppers, Speed, Blue Boy, Blacks, Ecstasy | [ ]  NO[ ]  YESAge of first use:       |       |       |       | [ ]  IV[ ]  Oral[ ]  Smoke[ ]  Snort |
| **Barbiturates** (Fiorinal, Seconal**)**Downers, Barbs, Barbies  | [ ]  NO[ ]  YESAge of first use:       |       |       |       | [ ]  IV[ ]  Oral[ ]  Smoke[ ]  Snort |
| **Benzodiazepines** (Ativan, Halcion, Klonopin, Librium, Prosom, Valium, Xanax)Forget Pills, Roofies | [ ]  NO[ ]  YESAge of first use:       |       |       |       | [ ]  IV[ ]  Oral[ ]  Smoke[ ]  Snort |
| **Cocaine** Crack, Coke, Blow, Snow, Flake | [ ]  NO[ ]  YESAge of first use:       |       |       |       | [ ]  IV[ ]  Oral[ ]  Smoke[ ]  Snort |
| **Club Drugs** (Ecstasy/MDMA, GHB, Ketamine, Rohypnol**)**Love Drug, Roofies, Soap, Special K, Vitamin K, X, XTC | [ ]  NO[ ]  YESAge of first use:       |       |       |       | [ ]  IV[ ]  Oral[ ]  Smoke[ ]  Snort |
| **Designer Drugs**K-2, Spice, Kratom, Salvia, Bath Salts | [ ]  NO[ ]  YESAge of first use:       |       |       |       | [ ]  IV[ ]  Oral[ ]  Smoke[ ]  Snort |
| **Hallucinogens** (Ketamine, LSD, PCP)Acid, Angel, Angel Dust, Blotter, Dots, Ozone, Trip  | [ ]  NO[ ]  YESAge of first use:       |       |       |       | [ ]  IV[ ]  Oral[ ]  Smoke[ ]  Snort |
| **Heroin** H, Junk, Ska, Smack | [ ]  NO[ ]  YESAge of first use:       |       |       |       | [ ]  IV[ ]  Oral[ ]  Smoke[ ]  Snort |
| **Inhalants** (Glue, Gas, Paint, Nitrous Oxide)Poppers, snappers, Whippets | [ ]  NO[ ]  YESAge of first use:       |       |       |       | [ ]  IV[ ]  Oral[ ]  Smoke[ ]  Snort |
| **Marijuana** (THC)Ganga, Grass, Pot, Weed  | [ ]  NO[ ]  YESAge of first use:       |       |       |       | [ ]  IV[ ]  Oral[ ]  Smoke[ ]  Snort |
| **Methadone** (Amidone, Dolophine)Fizzies  | [ ]  NO[ ]  YESAge of first use:       |       |       |       | [ ]  IV[ ]  Oral[ ]  Smoke[ ]  Snort |
| **Methamphetamine** Chalk, Crank, Crystal, Glass, Ice, Meth, Speed  | [ ]  NO[ ]  YESAge of first use:       |       |       |       | [ ]  IV[ ]  Oral[ ]  Smoke[ ]  Snort |
| **Opiates** (Darvon, Demerol, Dilaudid, Lortab, Morphine, Oxycontin, Percoset, Vicodin) Antifreeze, Aunt Hazel, Horse | [ ]  NO[ ]  YESAge of first use:       |       |       |       | [ ]  IV[ ]  Oral[ ]  Smoke[ ]  Snort |
| **Stimulants** (Adderal, Concerta, Dexedrine, Ritalin) | [ ]  NO[ ]  YESAge of first use:       |       |       |       | [ ]  IV[ ]  Oral[ ]  Smoke[ ]  Snort |
| **Suboxone** (Buprenorphine) | [ ]  NO[ ]  YESAge of first use:       |       |       |       | [ ]  IV[ ]  Oral[ ]  Smoke[ ]  Snort |
| **Other Medications**Neurontin, Ultram, Soma | [ ]  NO[ ]  YESAge of first use:       |       |       |       | [ ]  IV[ ]  Oral[ ]  Smoke[ ]  Snort |

1. Which substance is the major problem?

|  |  |  |
| --- | --- | --- |
| None [ ]  | Alcohol [ ]  | Amphetamines [ ]  |
| Barbiturates [ ]  | Benzodiazepines [ ]  | Cocaine [ ]  |
| Club Drugs [ ]  | Designer Drugs [ ]  | Hallucinogens [ ]  |
| Heroin [ ]  | Inhalants [ ]  | Marijuana [ ]  |
| Methadone [ ]  | Methamphetamines [ ]  | Opiates [ ]  |
| Stimulants [ ]  | Suboxone [ ]  | Other [ ]  |

15a. (if other, please specify):

1. How many days in the past 30 days (not including jail time) have you experienced any life problems that were a direct result of your alcohol or drug use?

16a. Alcohol problems?       days

16b. Drug problems?       days

1. How long was your last period of voluntary abstinence from alcohol or

 other drugs? (number)

17a. When did this abstinence end?

1. How many times have you had:

DT’s (horrors)?       times

Overdosed on drugs?       times

Experienced Withdrawal symptoms?       times Describe symptoms:

1. How many times in the last 30 days, or the last 30 days on the street, did you stay up past 4 a.m. because of drug or alcohol use?
2. Have you ever been treated for alcohol or other drugs of abuse?

20a. How many times, not including AA/NA, have you have been treated for

 alcohol or other drugs of abuse:

|  |  |  |
| --- | --- | --- |
|  | LIFETIME | PAST YEAR |
| How many times were you treated for drug abuse in an outpatient treatment program? *(not AA/NA*)  |        |        |
| How many times were you treated for drug abuse in a residential or in-patient program? |        |        |
| How many of those were Detox only? |        |        |

20b. Have you ever completed in-patient treatment?

 If YES, when and where

**Comments on drug and alcohol information**:

**D. MENTAL HEALTH SCREENING\*\*\***

*Say to the defendant: “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 and help 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 anyone outside of the drug court team without your permission. If you do not know how to answer these questions, ask me 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…”*

|  |  |  |
| --- | --- | --- |
| Question | Yes/No | Details: (for yes answers in Questions 5-17, ask the questions in this column)  |
| 1. Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem?  |  | Please explain:        |
| 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?  |  | Please explain:       |
| 3. Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem?  |  | If yes, what medications have you been prescribed?      Have you been prescribed medication (or taken any prescribed medication) for any psychological or emotional problem in the past 30 days? If Yes, what?       |
| 4. Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons?  |  | Please explain:      If yes, how many times?       |
| 5. Have you ever heard voices no one else could hear or seen objects or things which others could not see?  |  | If yes, When did the problem first develop?     How long did it last?       Did the problem develop before, during, or after you started using the substances?)       Have you had these symptoms in the past 30 days? Have you ever received any treatment or counseling services for this? If so, please describe       |
| 6a. 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?  |  | If yes, When did the problem first develop?     How long did it last?      Did the problem develop before, during, or after you started using the substances?)     Have you had these symptoms in the past 30 days? Have you ever received any treatment or counseling services for this? If so, please describe       |
| 6b. Did you ever attempt to kill yourself?  |  | If yes, When did the problem first develop?      How long did it last?     Did the problem develop before, during, or after you started using the substances?)     Have you had these symptoms in the past 30 days? Have you ever received any treatment or counseling services for this? If so, please describe       |
| 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, sexual abuse, emotional abuse, physical abuse, incest, a car accident, being shot or stabbed, witnessing these things happening to others, etc?*) |  | If yes, When did the problem first develop?     How long did it last?      Did the problem develop before, during, or after you started using the substances?)      Have you had these symptoms in the past 30 days? Have you ever received any treatment or counseling services for this? If so, please describe       |
| 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?* ) |  | If yes, When did the problem first develop?     How long did it last?      Did the problem develop before, during, or after you started using the substances?)      Have you had these symptoms in the past 30 days? Have you ever received any treatment or counseling for this? If so, please describe       |
| 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?  |  | If yes, When did the problem first develop?     How long did it last?      Did the problem develop before, during, or after you started using the substances?)      Have you had these symptoms in the past 30 days? Have you ever received any treatment or counseling for this? If so, please describe       |
| 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?  |  | If yes, When did the problem first develop?     How long did it last?      Did the problem develop before, during, or after you started using the substances?)      Have you had these symptoms in the past 30 days? Have you ever received any treatment or counseling for this? If so, please describe       |
| 11. Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner?  |  | If yes, When did the problem first develop?     How long did it last?      Did the problem develop before, during, or after you started using the substances?)      Have you had these symptoms in the past 30 days? Have you ever received any treatment or counseling for this? If so, please describe       |
| 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?*)) |  | If yes, When did the problem first develop?     How long did it last?      Did the problem develop before, during, or after you started using the substances?)      Have you had these symptoms in the past 30 days? Have you ever received any treatment or counseling for this? If so, please describe       |
| 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?  |  | If yes, When did the problem first develop?     How long did it last?      Did the problem develop before, during, or after you started using the substances?)      Have you had these symptoms in the past 30 days? Have you ever received any treatment or counseling for this? If so, please describe       |
| 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?  |  | If yes, When did the problem first develop?     How long did it last?      Did the problem develop before, during, or after you started using the substances?)      Have you had these symptoms in the past 30 days? Have you ever received any treatment or counseling for this? If so, please describe       |
| 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*).  |  | If yes, When did the problem first develop?     How long did it last?      Did the problem develop before, during, or after you started using the substances?)      Have you had these symptoms in the past 30 days? Have you ever received any treatment or counseling for this? If so, please describe       |
| 16. 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?  |  | If yes, When did the problem first develop?     How long did it last?      Did the problem develop before, during, or after you started using the substances?)      Have you had these symptoms in the past 30 days? Have you ever received any treatment or counseling for this? If so, please describe       |
| 17. Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem?  |  | If yes, When did the problem first develop?     How long did it last?      Did the problem develop before, during, or after you started using the substances?)      Have you had these symptoms in the past 30 days? Have you ever received any treatment or counseling for this? If so, please describe       |

Do you receive a pension for a psychiatric disability?

**Comments on mental health information**:

*It is recommended that a mental health professional be consulted about any “yes” response to questions 3 through 17. This person can help determine if there are issues that could affect the client’s ability to successfully participate in drug court, and may suggest a diagnostic interview prior to admission to drug court. A “yes” response to any of questions 5 through 17 does not, by itself, ensure that a mental health problems exists now. A “yes” response raises only the possibility of a current problem, which is why talking with a mental health specialist is recommended.*

***E. Medical Health Information***

**The following questions ask about your medical history.**

1. How many times in your life have you been hospitalized for medical problems? (Include ODs and DTs; exclude birth of a child)       times (If 0, skip to Question #2)

1a. How long ago was your last hospitalization for a physical problem? (Exclude child birth)

1. Do you have any medical problems that affect your activities of daily living or your ability to work?  If YES, please describe:

 2a. Indicate degree of severity:

3. Have you ever had any of the following health problems? If yes, explain in comments.

[ ]  None [ ]  Hepatitis (B,C) [ ]  Chlamydia (NGU) [ ]  Syphilis

[ ]  Gonorrhea (GC, clap, dose) [ ]  Pelvic Inflammatory Disease (PID)

[ ]  Genital Warts (HPV, venereal warts) [ ]  HIV+ [ ]  AIDS

[ ]  TB [ ]  MRSA [ ]  Herpes Comments

4. Have you ever had a fit or seizure?

4a. If YES, what caused the seizure?

4b. How long ago was your last seizure?

5. Are you taking any prescribed medication on a regular basis for a physical problem?

 If YES, what?

5a. Do you have any allergies?

 If so, what?

5b. Do you have a regular physician?

       (name, address, phone number)

6. Do you have health insurance?

6a. If yes, what type?  If other, please explain:

7. Do you receive a pension for a physical disability? (Exclude psychiatric disability)

 If YES, what?

8. How many days have you experienced medical problems in the past 30?

(Not pregnancy related)

**Comments on medical health information:**

***F. Criminal Justice History Information***

**The following questions ask about your criminal justice history.**

1. Are your currently on probation or parole?

 1a. If Yes, what county and state?

 1b. Have you ever been on probation or parole?

 1c. If YES, what county and state?

2. Have you ever been arrested in a state other than Kentucky?

2a. If YES, what state?

2b. What were you charged with?

2c. If convicted, what charge(s) were you convicted of?

3. How long have you been incarcerated in your life?

 County Jail: (number)

 Prison: (number)

4. How long was your last incarceration?

5. Are you presently awaiting charges, trial, or sentence in this county or any other?

5a. Reason(s) for awaiting charges?

**Comments on criminal justice involvement information**:

1. ***Family/Social/ History Information***

**The following questions ask about your family and social history.**

1. Do you have children?  (if no, skip to #2)

1a. Name/Age of all children

1b. Which children are in your custody?

1c. Who has custody of the other children?

1d. Do you owe child support or arrearage?  Amount

2. Are you expecting a child?

3. What has your usual living arrangements been in the past 12 months (past year)?

3a. Are you satisfied with these living arrangements?

3b. Do you live with anyone that has a drug and/or alcohol problem?

4. Have the majority of your romantic relationships been with partners who use or abuse substances?

5. Do you believe that your family relationships negatively impact your life?

5a. If YES, please describe:

6. Do you believe that your social relationships negatively impact your life?

6a. If Yes, please describe:

7. Does someone contribute to your support in any way?

7a. Who is the person who contributes the most to your support?

7b. Does the support from (insert answer to Question #7) constitute the majority of your support?

**Comments on family and/or social history information**:

**Please record any final comments you have about this defendant and/or this defendant’s interview**:

**Eligibility and Appropriateness for Drug Court**

Name:

**RISK SCREENING SCORES**

|  |  |
| --- | --- |
| [ ]  | Has not been convicted of a violent or sexual crime (Courtnet/ NCIC)  |
| [ ]  | Has stable housing (Section A) |
| [ ]  | Has reliable transportation (Section A)  |
| [ ]  | Has Recidivism Risk Screening score of 6 or more (Section B) |
| [ ]  | Has Social Risk Screening score of 3 or more for males, 4 or more for females (Section B) |
| [ ]  | Has Substance Abuse Screening score of 6 or more (Section C) |

**ADDITIONAL CONSIDERATIONS:**

|  |  |
| --- | --- |
|  | Mental Health Professional input (from Section D) obtained, if needed |
|  | Medical Professional input for chronic pain/medical issues (from Section A) needed |
|  | Additional considerations to discuss prior to admission  |

Additional Considerations Comments: