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Screening and Assessment of Clients in the Criminal Justice System

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This distance learning course was developed for CEUMatrix by Kevin R. Scheel, MS, MAC, LADC. It is based on information found in the Treatment Improvement Protocol (TIP) Series 44 – *Substance Abuse Treatment for Adults in the Criminal Justice System. (*Center for Substance Abuse Treatment. *Substance Abuse Treatment for Adults in the Criminal Justice System.* Treatment Improvement Protocol (TIP) Series 44. DHHS Publication No. (SMA) 05-4056. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.)

Copies of this TIP may be obtained free of charge from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI), (800) 729-6686 or 240-221-4017; TDD (for hearing impaired), (800) 487-4889; (877) 767-8432 Hablamos Espanol, or electronically through the following Internet World Wide Web site: http://www.kap.samhsa.gov/

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About the Instructor:

Kevin R. Scheel is a Masters prepared chemical dependency counselor with more than twenty-three years of experience in the human service field. He has served as the director of programs in the public sector as well as in private care facilities, both in the profit and not-for-profit arenas. He has been involved in the delivery of education services to the field since 1986 as an instructor at McLennan Community College in Waco, Texas, and as a private training consultant with Hazelden. Mr. Scheel is the author of "Alcohol: Chemistry & Culture," as well as a series of education videotapes on the various drugs of abuse, published and marketed by WRS Group, Inc. He has also created a preparation and review manual that is currently in use by a variety of colleges and universities in Texas, designed to aid students preparing for their Texas chemical dependency credential.

While in Texas, Kevin served as the Texas Coordinator for the federally funded Project for Addiction Counselor Training (PACT) program. For this project Mr. Scheel designed a 270 curriculum for beginning counselors, delivering over 45,000 hours of classroom training to 415 minority students. As a result of his efforts, 268 of these students have gone on to obtain their credentials to practice chemical dependency counseling in Texas.

Kevin also served in the position as Coordinator for the Texas Addiction Training Center (currently the Texas Addition Technology Transfer Center), a federally funded project from the Center for Substance Abuse Treatment in Washington, D.C. In Texas this project worked with 8 major colleges and universities to increase the level of addiction education to the various disciplines offering counseling services to drug and alcohol affected clients.

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Screening and Assessment of Clients in the Criminal Justice System

Screening and in-depth assessment are important first steps in the substance abuse treatment process; currently no comprehensive national guidelines for screening and assessment approaches exist in the criminal justice system. In the absence of such guidelines, information in this course can help clinicians and counselors develop effective screening and referral protocols that will enable them to

- Screen out offenders who do not need substance abuse treatment.
- Assess the extent of offenders' treatment needs in order to make appropriate referrals.
- Ensure that offenders receive the treatment that they need, rather than being released into the community with a high probability of re-offending.

This course addresses the issues relevant to screening and assessment and makes recommendations for the appropriate use of screening and assessment tools in specific settings within the criminal justice system. For information on how to use screening and assessment to match the offender to services and to identify an appropriate treatment plan, see the CCJP.com course entitled "*Treating Clients in the Criminal Justice System.*" More information on specific screening and assessment instruments is provided for you in Appendix A of this course.

Overview

- **Definitions of Terms**
- **Screening Guidelines**
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- **Assessment Guidelines**
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Definitions of Terms

Information gathered during screening and assessment plays an important role in identifying offender needs and making appropriate referrals for services. Throughout this course, the following definitions will be used for screening, assessment, and related terms in the criminal justice setting:

- *Screening*—A process for evaluating someone for the possible presence of a particular problem. The screening process does not necessarily identify what kind of problem the person might have or how serious it might be but determines whether or not further assessment is warranted. Screening does not typically include assignment of DSM-IV-TR (*Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision [American Psychiatric Association {APA} 2000]) diagnoses of alcohol or drug abuse or dependence and may only identify DSM-related problem areas. During the screening process staff members use instruments that are limited in focus, simple in format, quick to administer, and usually able to be administered by nonprofessional staff. There are seldom any legal or professional restraints on who can be trained to conduct a screening.
- *Assessment*—A process for defining the nature of a problem and developing specific treatment recommendations for addressing the problem. A basic *assessment* consists of gathering key information and engaging in a process with the client that enables the counselor to understand the client's readiness for change, problem areas, any diagnosis(es), disabilities, and strengths. The assessment process typically requires trained professionals to administer and interpret results, based on their experience and training. A clinical diagnosis has important legal ramifications since judges tend to rely on assessments to identify an offender's needs and risks, and to determine the offender's disposition.

In correctional settings, "screening" and "assessment" are equated with "eligibility" and "suitability," respectively. "Eligibility" is determined in pretrial and jail settings by screening for offenders who may need substance abuse treatment. "Suitability" for placement in one of several different levels of treatment services is determined by an assessment to help identify key psychosocial problems related to referral to treatment and/or supervision. Accordingly, the following considerations are suggested:

- *Eligibility*- Does the offender meet the system's criteria for receiving treatment services? A quick screen, typically applicable in prisons and community corrections settings, can determine whether a person warrants assessment to determine if that person has a drug or alcohol problem.

- *Suitability*- Is the offender suitable for the type of program services that are available? An assessment can determine whether the offender is capable of benefiting from treatment or responding to a particular intervention. The question of suitability arises once it has been determined that offenders meet the eligibility criteria for receiving services.

In essence, screening and assessment vary based on the goals of the evaluation and the setting where they are used. For drug court and jail settings, a source for operational treatment and criminal justice definitions is the article "Guideline for Drug Courts on Screening and Assessment" (Peters and Peyton 1998).

Common Myths About Screening and Assessment

Following are several common myths about substance abuse screening and assessment, and the facts that debunk those myths.

- *Myth:* Screening and assessment are no better than intuition in detecting a person's need for treatment.
    - *Fact:* Objective screening and assessment measures can result in treatment that is better targeted to a client's needs, resulting in better outcomes.
- *Myth:* Only a single screening is needed to place people in different levels of treatment services.
    - *Fact:* Accurate evaluation requires a battery of assessment instruments that examine how substance use has affected all the domains of the client's life. When treatment options are severely limited, however, a basic screening may be sufficient to determine both eligibility and suitability for treatment.
- *Myth:* Untrained professionals can conduct screening and assessments.
    - *Fact:* Although some screenings can be administered and scored without significant training, placement decisions are greatly improved when they are made by professionally trained staff. This includes staff with relevant certification in substance abuse treatment, those with advanced professional degrees, and those with specialized training in the use of particular screening and assessment instruments. For those screening and assessment approaches that require an interview with the offender, specialized training is also needed in basic counseling techniques such as rapport building and reflective listening. Use of trained professional staff in the triage and placement process helps to minimize the number of inappropriate referrals for treatment.

- *Myth:* Screening and assessment are always compromised because you cannot trust self-report information from offenders.
    - *Fact:* Research generally validates the reliability, and to some degree, the validity of information obtained through self-reports. Collateral sources such as the offender's family and friends can improve the reliability of the information gathered (or "the full picture"). Offenders do supply a certain amount of misinformation in some settings to avoid unwanted consequences, however.
- *Myth:* All screening and assessment instruments are equally effective.
    - *Fact:* Research shows significant variability in the reliability and validity of different instruments with different populations.
- *Myth:* Because an instrument is widely used, it must be effective.
    - *Fact:* Many highly marketed and widely used instruments do not have a research base supporting the validity of their use. In fact, some of the widely marketed and used instruments have been shown to be less effective than those available in the public domain.
- *Myth:* Screening and assessment should not examine the history of physical and sexual abuse and related trauma because this may aggravate the offender's level of stress and psychological instability, and staff may not be able to deal effectively with the consequences.
    - *Fact:* Screening and assessment of all forms of abuse is essential for both male and female offenders, because it is now recognized that the effects of trauma contribute to many mental disorders. Clinical outcomes are likely to be compromised if these abuse and trauma issues are not explored, and if strategies addressing these issues are not developed and integrated into treatment plans for mental and substance use disorders. However, it is important to emphasize that in screening for a history of trauma it can be damaging to ask the client to describe traumatic events in detail. To screen, it is important to limit questioning to very brief and general questions, such as "Have you ever experienced childhood physical abuse? Sexual abuse? A serious accident? Violence or the threat of it? Have there been experiences in your life that were so traumatic they left you unable to cope with day-to-day life?"

Screening Guidelines

This section presents broad guidelines and considerations for developing an effective screening protocol. (See the following section for additional guidelines related to assessment protocols.) More specific guidelines based on the criminal justice setting and the characteristics of the population are discussed in later sections.

When creating a screening protocol, counselors will need to ask the following questions:

- What is the purpose of the screening?
- What screening tools will be used and under what circumstances?

Purpose of Screening

The first issue to consider is the purpose of the screening. In addition to screening for drug use, counselors may consider screening for other problem areas. For example, given that many infectious diseases are associated with the use of drugs (Varghese and Fields 1999), health screening can be important in identifying offenders in need of healthcare services to ensure that clients receive needed medication and to prevent the spread of disease. Screening to identify special needs for offenders with co-occurring mental problems can improve the effectiveness of treatment. It can identify individuals who may pose a threat to themselves or others, prevent crises, and promote immediate intervention. Screening content should identify key issues that need to be addressed in placing offenders in treatment. Content can be specific to several domains, including substance use, criminal, physical health, mental health, and special considerations. Figure 1 summarizes the information relevant to each domain.

Figure 1: Screening Guidelines by Domain

Domain	Information
Substance Use	• Substance use history • Motivation and desire for treatment • Severity and frequency of use • Detoxification needs, acute intoxication • Treatment history (e.g., number and type of episodes, outcomes)

Criminal Involvement	• Criminal thinking • Current offense(s) • Prior charges • Prior convictions • Age at first offense • Type of offense(s) • Number of incarcerations • Prior successful completion of probation or parole drug use offenses • Prior involvement in diversionary programs • History of diagnosis of any personality disorder
Health	• Intoxication, infectious disease (tuberculosis, hepatitis, sexually transmitted diseases, HIV status) • Pregnancy • General health • Acute conditions
Mental Health	• Suicidality • History of treatment and prior diagnosis • Past diagnoses • Treatment outcome • Current and past medications • Acute symptoms • Psychopathy
Special Considerations	• Educational level • Reading level/literacy • Language/cultural barriers • Physical disability • Developmental disability • Learning disability • Health and biomedical record • Housing • Dependents/family issues • History of abuse (victim and/or perpetrator), including trauma experienced as a result of physical and sexual abuse

Screening guidelines will vary by setting. A professional screening of an individual who has just been arrested will include different questions and require different information than a long-term prisoner being considered for parole. For a probationer, screening might be used to determine the appropriate level of supervision; a jail inmate may be screened to assess his or her suitability for treatment. Figure 2 highlights the different screening considerations for each setting.

Figure 2: Screening Guidelines by Setting

Setting	Purpose	Special Considerations
Jails	• For early identification, if getting out of jail early • To determine eligibility for drug courts and pretrial diversion programs • For diversion to specialized mental health courts or programs focused on behavioral problems • To determine behavioral management problems and acute needs (including crisis intervention) • To identify suitability for placement in jail treatment programs • For classification to different housing units	Look for previous correctional substance abuse treatment, readiness for treatment, past institutional behavior problems, prior correctional treatment, and court orders.

Prisons	• To match time left to serve with time for receiving treatment or for custody level classification • To identify suitability for placement in prison treatment programs	Look at prison record, treatment history (including treatment for issues other than substance abuse), and behavior.
Pretrial and Community Supervision	• To determine the need for housing, transportation, employment, or economic benefits • To identify suitability for placement in community treatment programs • To assess for public safety risk and level of supervision needed, pursuant to consideration for placement in diversion programs	Look for community or corrections records or collateral information (e.g., information from family members).

Selection of Screening Tools

In addition to identifying the purpose of screening, the protocol should also identify the screening tools to be used and the conditions under which they are used. Basic information can be acquired from any number of sources, including

- Booking records
- Self-report/interview information
- Results of instruments and surveys administered
- Past correctional records (presentence investigations)
- Past treatment records
- Police reports
- Correctional staff reports (for bail hearings, early release)
- Prior offense records (for driving under the influence [DUI], possession, trafficking)
- Emergency medical reports

- Drug test results (from examination of hair, sweat, urinalysis, Breathalyzer®)

Some jurisdictions may be required to use a particular instrument or information source to gather information consistently from all offenders, even though corroborative information, such as urine test results, is often available. Such universal screenings can help route nonviolent, low-risk offenders to treatment placements in the community so that recovery can begin. A more detailed discussion of selection of screening instruments is provided later in this course.

Assessment Guidelines

The goal of assessment is to gather enough information about clients to describe how the treatment system can address their substance abuse problems and the impact of those problems. An assessment examines how the offender's emotional and physical health, social roles, and employment could be affected by substance abuse (Center for Substance Abuse Treatment [CSAT] 1994*a*). In addition, assessments can help identify the factors that could prompt a return to drug use or criminal behavior. These include lack of social support networks, unstable employment history, poor health, criminality, unresolved legal problems, inadequate housing, lack of motivation to change, a history of physical and sexual abuse, mental illness, learning disabilities, and other social and psychological factors. These factors need to be carefully examined during assessment to plan for potential gaps in services that can affect relapse and criminal recidivism.

While assessments are more comprehensive than screenings, their depth and scope varies across settings according to the following factors:

- Amount of time available to conduct the assessment
- Physical setting of assessment (e.g., holding pen, booking room, medical unit, reception center, lockup, community/corrections office)
- Factors influencing the confidentiality or privacy of the assessment process and the uses of assessment findings
- Availability of qualified staff, caseload volume, and interagency cooperation
- Availability of financial resources (e.g., staffing, type of assessment chosen)
- Availability of treatment options in the community
- Number of sources of information

The instruments and sources of information used during an assessment are determined by the purpose of the assessment. Jurisdictions may elect the quickest and most efficient approach to assess who goes into treatment. In other cases, the court may want the greatest amount of information available about an offender. In this case, in addition to police, corrections, and medical records, an assessment should include family and other collateral sources for historical information.

The following guidelines pertain to assessment protocols:

- *Purpose* - In pretrial or diversion settings, assess for linkage to the community and placement to different types of services.
- *Content* - In all settings, deepen the information obtained from previous screenings (psychopathy, antisocial).
- *Source* - In pretrial or diversion settings, seek more expansive collateral information from family and social service staff. In jails, prisons, or community supervision settings, correctional officers and/or collateral offenders may be additional sources of information.

Once a screening has identified the need for treatment, assessments should be conducted before offenders are given permanent placements. Assessments feed into treatment planning, decisions about treatment intensity and services needed (e.g., treatment planning and matching), and reentry and continuing care plans.

Advice to the Counselor: Screening and Assessment

- It is critical to administer screening and assessment instruments in a way that encourages honesty. Offenders often think the results of these screenings will be used against them and may try to skew the results to influence the outcome of a trial.
- The consequences of honest or dishonest responses should be clarified with the offender.
- Counselors should use available collateral information, such as drug testing results, to verify the accuracy of the information.

Key Issues Related to Screening and Assessment

The distinctions between screening and assessment are defined above. This section highlights key issues relevant to both.

Accuracy of Information

Accuracy of screening and assessment information is clearly dependent on the honesty of the offender. It is critical to administer screening and assessment instruments in a way that encourages honest answers. The consequences of honest and dishonest responses should be clarified, and the setting for the screening can be important in this regard (Knight et al. 2002). Some factors that contribute to greater accuracy of responses include using collateral information, using concurrent drug testing, and reviewing with the offender the purposes of information obtained during screening and assessment.

In some contexts (e.g., pretrial and presentence settings), offenders are often concerned that screening and assessment results will be used against them; for example to coerce them into a long-term treatment program. The individual may also want to avoid being labeled as having an addiction problem. Conversely, an offender may purposely try to skew the results to influence the outcome of trial, sentencing, or placement in custody and/or treatment settings. It is important for those administering screening and assessment to recognize the factors that may influence the accurate disclosure of information, and to craft their findings accordingly.

Unless potential concerns related to the screening and assessment process are addressed directly, it is unlikely that screening and assessment results will provide an accurate picture of the offender's substance abuse problems and treatment needs. Offenders should be briefed in advance regarding who will have access to screening and assessment information and how the information will be used. Counselors and criminal justice professionals should also clearly indicate their own role in the information gathering process. It may also help to address myths regarding court-ordered or other mandated treatment and treatment program requirements, and to describe the benefits of participating in treatment. Counselors working in criminal justice settings should also be aware of issues related to confidentiality and informed consent in the context of screening and assessment (see CSAT 2004 and www.hipaa.samhsa.gov).

Continuity of Information

Screening and assessment are not single events but continuous processes that can be repeated by a variety of professionals in a variety of settings (CSAT 1994*a*). Efforts should be made to ensure the continuity of the information and to preserve the rights of the client. Ongoing communication and data sharing are important aspects of the screening and assessment process. Substance abuse treatment and criminal justice system staff, at all points in the process, need to pass on information obtained from substance abuse screening and assessment. Key information can be summarized and consolidated using a brief format, but this information should be maintained in a case file—even if a client does not go on to criminal prosecution—so that it can be used in case of subsequent arrest. It is helpful to standardize the format used to document screening and assessment information so that staff can be trained to more readily access, interpret, and communicate this information (CSAT 1994*a*).

Effective treatment programs require assessment and coordination between substance abuse treatment and criminal justice programs and an understanding of the goals of both systems. Coordination also leverages the scarce resources for substance abuse treatment (CSAT 1994*a*). To encourage a team approach to treatment, assessment, referral, and case management, the two systems need to develop or strengthen arrangements that support linkages at the institutional and procedural levels. In addition, cross-training can promote the use of screening and assessment results and can reduce duplication of efforts (CSAT 1994*a*).

Systemwide Information Sharing

Frequently, those in the criminal justice system who conduct initial substance abuse screening and assessment maintain the information, while others who have contact with the offender later in the course of criminal justice processing have to re-screen or reassess the individual. (See CSAT 2004 and www.hipaa.samhsa.gov for information about confidentiality and certain restrictions regarding sharing of information.) The use of multilevel agreements to share information is one approach that can minimize duplication of screening and assessment activities. One way to achieve this is to convene stakeholder meetings with representatives from all of the involved agencies in the system to develop these agreements. The benefits of multilevel agreements tend to be quite persuasive. Following are two examples:

- Agency A is spending $15 per drug screen in addition to staff time. If that agency works out an implementation plan with Agency B, both agencies can share the information, avoiding the unnecessary costs of duplicating tests.
- Hospitals that have laboratory test results can add them to a database to confirm or refute self-report information.

At each stage of the criminal justice process there can be individuals or agencies that do not support sharing of substance abuse screening and assessment information. These groups have legitimate concerns that need to be expressed, and they need to be brought into the decision-making process as full stakeholders. Jurisdictions that establish interagency agreements can preserve limited staff time and resources and help avoid unexpected resistance to systemwide sharing of screening and assessment information at any stage in the criminal justice process. See the text box below for examples of programs that have developed multilevel agreements for sharing information systemwide.

Examples of Multilevel Agreements for Systemwide Sharing of Information

Developing multilevel agreements is a difficult task and can take years to complete. Large criminal justice systems will clearly benefit from having an intermediary case management or placement system to increase communication and coordination between in-custody programs, community-based providers, and parole offices. Below are several working models of multilevel agreements for systemwide sharing of information.

Lane County, Oregon

Lane County uses client consent and a multilevel agreement between agencies to facilitate sharing of information. In this model, the client and agencies must agree up front if someone wants shared access to information. A correctional/mental health official developed a screening and reporting system where every person in jail is screened for drugs, risk, and mental health with a brief instrument. The screening information is available systemwide (i.e., jail, diversion, and community programs), including a tear-off copy for mental health information (National GAINS Center 2000).

High Intensity Drug Trafficking Areas Automated Tracking System

The University of Maryland developed a nonproprietary Management Information System (MIS) called HATS, the HIDTA [High Intensity Drug Trafficking Areas] Automated Tracking System, that links substance abuse treatment, mental health, juvenile, and community information. HIDTA is a program within the Office of National Drug Control Policy that coordinates drug control efforts in 28 regions around the country. A layered set of informed consent agreements is used to provide different access levels to different stakeholders (e.g., judges, parole, treatment programs). Users gain HATS access by signing an agreement to share any improvements made to the system, to benefit all stakeholders. The MIS is in use from coast to coast as a seamless care screening, assessment, case matching, and monitoring database (Taxman and Sherman 1998). For more information, go to the Washington/Baltimore HIDTA HATS site at www.hidta.org.

Maricopa County, Arizona

Maricopa County has a data-link feed between the jail and behavioral health authority to determine whether offenders entering jail have a previous record of mental health services or substance abuse treatment (National GAINS Center 1999*c*).

Orange County Probation Department

As part of the implementation of Proposition 36, the Orange County (California) Probation Department developed an MIS that links the Drug and Alcohol Division of the County Health Care Agency (HCA) with myriad treatment providers in the county. The law requires that the offender have an assessment and be referred to treatment within 7 days of sentencing. In processing offenders, the Probation Department conducts an initial assessment, while the HCA conducts a clinical assessment to determine the appropriate treatment level. On receiving the case from the court, the Probation Department sends a referral through the system to HCA, who then completes the assessment, selects a provider, and sends a notice through the system to the selected provider. The system then allows the provider to send periodic progress reports to the Probation Department, including when release of information forms have been signed, assessment levels, drug test results, and progress in treatment (Orange County Probation Department 2002).

The Need to Rescreen and Reassess

There are many reasons to rescreen and reassess. Offenders who may fear the consequences of self-disclosing substance abuse problems in one setting (e.g., pretrial detention) may be more open to discussing their need for treatment at a later stage (e.g., community supervision or prison).

Offenders' motivation for treatment may change over time; for example, as they become more familiar with peer mentors, counseling staff, program expectations, and their own self-defeating behaviors from the past. Another example is participants in drug courts who initially appear resistant to treatment during status hearings and who are unresponsive to early efforts by the judge and/or treatment counselors to instill motivation (e.g., through praise, use of sanctions, and engagement in more intensive treatment), but who later surprise program staff by their progress toward recovery over the course of a year or more of program participation. For these individuals, assessment may reflect a gradual process of uncovering reasons to quit their substance use, and identifying strengths that can be built on during treatment. Another key reason for conducting multiple screenings and assessments over time is that previous information obtained may become outdated and may not include recent events that are relevant to treatment, such as relapse episodes, undetected mental disorders, or domestic violence.

Advice to the Counselor: The Need to Rescreen

- An offender's motivation and willingness to enter treatment may change over time. Those who fear the consequences of self-disclosing substance abuse in a pretrial setting may be more open to discussing their need for treatment while under community supervision or in prison. Others who initially appear resistant to treatment may later surprise program staff by their progress toward recovery.
- Multiple assessments may uncover an offender's reason to quit substance use and identify strengths that can be built on during treatment.

Timing of Screening and Assessment

In some criminal justice settings only a single screening is needed, due to limited treatment options available or to the fact that assessment will be provided at a later stage. This screening is typically focused on issues related to eligibility criteria and suitability for treatment. In cases in which several treatment options and sufficient time are available, screening is often followed by a more comprehensive assessment.

Although screening is usually conducted as early as possible after the offender's entrance into the criminal justice system, assessment may be delayed due to the offender's sentence length, anticipated date of enrollment in substance abuse treatment services, and other factors. For example, most prison treatment programs provide services for inmates who are serving the last 24 months of their sentence, and routinely wait to provide a comprehensive assessment until the inmate is nearing the enrollment date for treatment services.

When Is a Formal Diagnosis Necessary?

When identified with a diagnosis that will follow them throughout the system or even their lifetime (if entered into the criminal justice system's computer), people sometimes feel labeled and stigmatized. This is particularly true of diagnoses related to mental disorders. Because symptoms of mental disorders are often mimicked by recent drug or alcohol use, or withdrawal from these substances, it is particularly important to defer diagnosis until an adequate assessment period is provided under conditions of abstinence. A "people first" description such as "offender who uses drugs" is preferable to the label "drug user." Moreover, diagnostic classification can sometimes preclude offenders from receiving

needed services. For example, a mental disorder diagnosis can preclude access to substance abuse services. Likewise, a substance abuse diagnosis can preclude access to mental health services, resulting in no services being rendered. A substance abuse diagnosis can also limit an offender's access to certain work assignments or vocational training.

To avoid these problems, formal diagnoses should be made based on sound clinical practice. A formal diagnosis may be required when

- Reimbursement for services requires it (e.g., Medicaid or Medicare reimbursement is not possible without a DSM-IV-TR code).
- Pharmacological intervention is suggested (e.g., methadone, Antabuse).
- Potential psychiatric concerns emerge (e.g., when the counselor is trying to rule out substance abuse or when symptoms may be drug induced, organic, or psychiatric).
- The counselor needs to clarify co-occurring disorders that affect treatment decisions.
- The information is for research or evaluation purposes.

Drug Testing

Drug testing is frequently used as a screening device in community-based and institutional settings. For example, in pretrial settings drug testing is used to identify and monitor drug use and to reduce the number of re-arrests among defendants (Bureau of Justice Assistance 1999). A major objective of pretrial drug testing is to offer courts alternatives to either detention or unsupervised release during the pretrial period. In community settings drug testing provides a powerful tool for treatment staff, the courts, and community supervision staff to monitor and address relapse episodes and treatment progress. In institutional settings, drug testing is helpful in monitoring abstinence and can serve as an "early warning" device in detecting problems among therapeutic residential programs. In all settings, drug testing serves both as a deterrent to use and as a strong incentive for offenders to remain abstinent.

Because of advancements in drug testing technologies, drug testing can easily be incorporated into the pretrial risk assessment process. For instance, using hand-held devices, commercial laboratories can conduct analyses of urine, perspiration, and hair to identify the presence of a variety of drugs. Pretrial screening for five drugs can cost anywhere from $5 to $120 (Henry and Clark 1999). However, protocols for collecting, testing, and disposing of specimens must be carefully observed to preserve the chain of evidence in the pretrial setting. Counselors should ensure that the rights of detainees and offenders are not violated (see the CCJP.com course “*Major Treatment Issues for Offenders Who Use Substances*”).

Areas to Address in Screening and Assessment

This section describes the key areas that are important for effective screening and assessment.

Substance Abuse History

Major topics covered during screening and assessment include observable signs and symptoms of alcohol or drug use, signs of acute drug or alcohol intoxication and withdrawal effects, drug tolerance effects, negative consequences associated with substance abuse, the self-reported history of substance abuse, age and pattern of first substance abuse, recent patterns of use, drug(s) of choice, and motivation for using substances. A full examination is made of the prior involvement in treatment, both in criminal justice and non-criminal-justice settings. Family history of substance abuse is also important, including current patterns of abuse by family members who have contact with the offender.

Screening instruments

The effectiveness of substance abuse assessment and screening instruments may vary according to the criminal justice setting and the goals of gathering information in that setting. For example, in one study (Peters et al. 2000), eight different substance abuse screening instruments were examined for use among male prisoners. Each of the instruments was found to have adequate test-retest reliability (the extent to which the scores are the same on two administrations of the instrument with the same people), although the validity of the instruments varied, as described later in this section. The screening instruments examined in the study included the following:

- Alcohol Dependence Scale (ADS)
- Addiction Severity Index (ASI)-Alcohol Use subscale (ASI-Alcohol)
- ASI-Drug Use subscale (ASI-Drug)
- Drug Abuse Screening Test (DAST-20)
- Michigan Alcoholism Screening Test (MAST short version)
- Substance Abuse Subtle Screening Inventory-2 (SASSI-2)
- Simple Screening Instrument for Substance Abuse (SSI-SA)
- TCU Drug Screen (TCUDS) (Knight et al. 2002)

However, these instruments varied considerably in sensitivity, specificity, and positive predictive value with different subpopulations (see Appendix B for glossary of terms). For example, the SASSI-2 had significantly lower positive predictive value for African Americans than for Caucasians and Hispanics/Latinos (Peters et al. 2000). Figure 3 lists recommendations for brief screening instruments based on this research.

Figure 3: Recommended Substance Abuse Screening Instruments

Instrument	Purpose	Description
Alcohol Dependence Scale (ADS)	A 25-item instrument developed to screen for alcohol dependence symptoms; performs adequately in community and institutional settings	• The ADS (Skinner and Horn 1984) can be coupled with the ASI-Drug Use section to provide an effective screen for alcohol and drug use problems among offenders. For more information on the ADS, contact the Center for Addiction and Mental Health (formerly the Addiction Research Foundation) at (800) 661-1111. The ASI is reprinted in TIP 7, *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System* (CSAT 1994*e*). As TIP 7 is currently out of print, information on ordering copies of the ASI can be found in Appendix C.
Simple Screening Instrument for Substance Abuse (SSI-SA)	A 16-item screening instrument that examines symptoms of both alcohol and drug dependence	• An expert panel developed the SSI-SA as a tool for outreach workers. The SSI-SA, which can be administered without training, includes items related to alcohol and drug use, preoccupation and loss of control, adverse consequences of use, problem recognition, and tolerance and withdrawal effects. The SSI-SA is reproduced along with instructions in TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*c*).
TCU Drug Screen (TCUDS)	A 15-item substance abuse diagnostic screen	The TCU Drug Screen is completed by the offender and serves to quickly identify individuals who report heavy drug use or dependency (based on the DSM-IV-TR and the National Institute of Mental Health Diagnostic Interview Schedule) and who therefore might be eligible for treatment. For more information regarding the TCUDS and other related instruments go to www.ibr.tcu.edu.

Source: Peters et al. 2000.

Findings indicated that either the TCUDS or a combination of the ADS and ASI-Drug screen should be used in situations in which it is important to reduce inappropriate referrals to substance abuse treatment. These instruments may be particularly useful for treatment programs that have limited "slots" available and significant consequences for mismatching offenders to the program (e.g., therapeutic communities or other residential programs). The SSI-SA is recommended for use in situations in which it is desirable to identify the largest number of offenders who need treatment (Peters et al. 2000). Some correctional systems have begun to use the SSI-SA for initial screening at the time of prison admission, with conducting additional assessment later to verify the need for treatment and to determine the specific level of services needed.

In conducting screening and assessment with female offenders, counselors may want to consider use of the Alcohol Use Disorders Identification Test (AUDIT) and the Tolerance, Worried, Eye Openers, Amnesia, Kut Down test (TWEAK), both of which were developed for women and are more sensitive than the CAGE. The AUDIT and TWEAK also provide equivalent sensitivity in African Americans and Caucasians. For screening of alcohol problems among female offenders, counselors may also want to consider use of the Rapid Alcohol Problems Screen (RAPS), which has been shown to be more sensitive than other measures with AfricanAmerican, Hispanic, and Caucasian women (Cherpitel 1997).

Assessment instruments

A wide variety of substance abuse assessment instruments is available for use in the criminal justice system. The most commonly used assessment instrument is the ASI (McLellan et al. 1980, 1992), which is used for screening, assessment, and treatment planning. The ASI was supported by the National Institute on Drug Abuse and is reproduced in TIP 7, *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System* (CSAT 1994*e*), and TIP 38, *Integrating Substance Abuse Treatment and Vocational Services* (CSAT 2000*c*). As TIP 7 is currently out of print, I've included information on ordering copies of the ASI in Appendix C. The instrument provides a structured interview format to examine seven areas of functioning that are commonly affected by substance abuse, including drug/alcohol use, family/social relationships, employment/support status, and mental health status. Many agencies, including those in criminal justice settings, have adapted modified versions of the ASI for use as a substance abuse screening instrument. Two separate sections of the ASI that examine drug and alcohol use are frequently used as screening instruments.

A positive feature of the ASI is that it has been validated for use in criminal justice populations (McLellan et al. 1985, 1992; Peters et al. 2000). For example, the ASI is highly correlated with objective indicators of addiction severity. The ASI is also one of the few instruments that measure several different functional aspects of psychosocial functioning related to substance abuse and provide a concise estimate of the history of substance abuse as well as recent use. The instrument provides severity ratings in each functional area assessed, which are useful both clinically and for research purposes. In using the ASI for assessment, significant training is needed to administer and score the instrument. The interview version of the ASI requires 45 - 75 minutes to administer, although the alcohol and drug use sections require considerably less time. A self-report version of the ASI was developed that has been shown to be a reliable and accurate alternative to the counselor administered instrument (Butler et al. 1998, 2001).

Detoxification Needs

Screening should address current evidence of intoxication, dependence, overdose, and withdrawal. This is particularly relevant in community corrections and jail settings, in which there may be significant periods of substance abuse that precede contact with the criminal justice system. Criminal justice and treatment staff should be trained to detect signs and symptoms of substance abuse and to refer clients to medical staff to assist in cases of acute intoxication. Once an individual is referred for detoxification, medical staff should perform a comprehensive assessment to determine the level of prior and recent use, and the level of substance abuse or dependence.

Safe withdrawal from substances such as stimulants, cocaine, hallucinogens, and inhalants can be achieved with psychological support, symptomatic treatment, and periodic reassessments by healthcare providers. Frequent clinical assessments, along with appropriate treatment adjustments, are also important since the intensity of withdrawal cannot always be predicted accurately (Federal Bureau of Prisons 2000). Some substances, such as alcohol, sedative-hypnotics, and anxiolytics, can produce dangerous withdrawal syndromes once physiological dependence has developed. Offenders who have severe and life-threatening symptoms of intoxication or withdrawal should be placed immediately under medical supervision. The Federal Bureau of Prisons (2000) recommends that "inmates presenting with alcohol intoxication should be presumed to have alcohol dependence until proven otherwise" (p. 8).

Not all substances of abuse produce clinically significant withdrawal syndromes, but abstinence generally results in some psychological changes. Offenders should thus be reassessed often. Substance abuse may mask co-occurring mental disorders, such as depression, or symptoms of mental illness may disappear when the offender is not using. In some cases, withdrawal may cause symptoms of mental disorders that can be identified and treated.

For more information on the signs and symptoms of intoxication and withdrawal and the treatment of individuals undergoing detoxification, see the forthcoming TIP *Detoxification and Substance Abuse Treatment* (CSAT in development *a*). The *Federal Bureau of Prisons Clinical Practice Guidelines: Detoxification of Chemically Dependent Inmates, December, 2000* can be accessed online at www.nicic.org/pubs/2000/016554.pdf.

Advice to the Counselor: Screening for Detoxification

- Screening forms should note evidence of intoxication, dependence, overdose, and withdrawal. This is particularly important in community corrections and jail settings, in which there may be significant periods of substance abuse that precede contact with the criminal justice system.
- Besides the potential need for detoxification services, screening should address conditions that may affect the offender's involvement in treatment, such as physical disabilities.
- It is helpful to note whether a client is receptive to treatment and may be committed to recovery (readiness to change).

Physical Health Conditions

Besides the potential need for detoxification services, screening should also address significant medical conditions that may affect the offender's involvement in treatment, such as physical disabilities, tuberculosis, hepatitis, HIV/AIDS, and other debilitating diseases.

Readiness for Treatment

In addition to examining the severity of substance abuse problems, it is helpful to know whether a client is receptive to treatment and is committed to recovery goals. Readiness for treatment provides an important indicator regarding where the substance abuse treatment should begin.

Readiness for treatment is not always clearly defined or apparent at the onset of treatment. Most clients do not volunteer for treatment and experience significant ambivalence about the process and level of commitment required. For years, treatment professionals and paraprofessionals believed that a person needed to "hit bottom" to be ready for change. Today, it is recognized that people can be ready for treatment without "hitting bottom" and that many people can receive benefits from treatment even if they are not completely ready. For example, motivational interviewing (MI) techniques (discussed in detail in the DLCAS.com course on *Motivational Change in Substance Abuse Treatment*) can be used to help clients resolve their ambivalence toward treatment and toward making changes in their lives. MI provides an empathic, supportive, and directive counseling style that attempts to persuade and guide the client toward change rather than to create motivation through confrontation of the client's substance abuse problems and labeling the client as an "addict."

Many individuals who successfully recovered from substance abuse problems were coerced into treatment, either by family, employers, or the criminal justice system. Coerced treatment by the criminal justice system has been shown to be at least as effective as non-coerced treatment, when time in treatment is held constant (CSAT 1994*a* ; De Leon 1988; Hubbard et al. 1988). Coercion can come from multiple sources. Many offenders reported that pressures from "psychological, financial, social, familial, and medical domains" had more influence in their decision to enter treatment than did the legal system (Marlowe et al. 1996, p. 81). However, their decision to stay in treatment is more often based on motivational readiness (Knight et al. 2000) and external leverage. Thus, for clients with low internal motivation, coercive interventions may help to increase their readiness for treatment. Excluding people as "unready" or "unmotivated" would exclude the vast majority of clients and would mean that treatment and recovery would never begin for many (CSAT 1994*a*). For example, Alcoholics Anonymous counsels people who abuse alcohol to "bring the body, and the mind will follow," believing that motivational readiness will grow as the program takes hold.

An individual's readiness for change is one of the most important factors that substance abuse counselors and clinicians should examine during the screening and assessment process, and has been found to be predictive of treatment retention and other outcomes. Studies have shown that initial motivation for treatment influences enrollment in post-release treatment services (De Leon et

al. 2000; Simpson and Joe 1993). Several treatment interventions (e.g., MI, motivational enhancement therapy) (Miller and Rollnick 2002) have been developed to explore and enhance readiness for treatment. Many substance abuse programs in the criminal justice system include a "pretreatment," or "readiness" phase designed to address the needs of offenders not yet committed to recovery goals and ongoing involvement in treatment. This initial phase of treatment addresses offenders' goals, expectations, and motivation for change. This intervention helps identify offenders who are ready for more intensive treatment services that require full participation in activities designed to encourage changes in attitudes and behaviors.

Assessing readiness includes obtaining information about clients' awareness of a substance problem, their ability to acknowledge their need for help, their willingness to accept help, their perception of how others feel about their need for help, and whether they have taken steps to change on their own (Wanberg and Milkman 1998). Generally, clients can be considered "ready" for treatment if they want to abstain from substance abuse, see treatment as a means to become drug- or alcohol-free, and recognize the difficulty in abstaining from substance abuse without professional assistance (CSAT 1994*a*). Figure 4 describes several brief instruments that can be used to assess readiness for treatment.

Figure 4: Instruments for Evaluating Readiness for Treatment

Instrument	Description
The University of Rhode Island Change Assessment Scale (URICA)	URICA was developed to assess stage of change. The instrument is known to be valid with different populations in a variety of settings. El-Bassel and colleagues have determined that URICA is useful, reliable, and valid among incarcerated women who use drugs (el-Bassel et al. 1998). The URICA and other similar instruments are reprinted in TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*b*).
The TCU Treatment Motivation Scales	The TCU Treatment Motivation Scales can be used to track the stages of change in treatment motivation. For further information, go to www.ibr.tcu.edu.

The Circumstances, Motivation, Readiness, and Suitability Scales (CMRS)	The CMRS scales were designed to predict retention based on dynamic client factors related to seeking and remaining in treatment (DeLeon et al. 1994). The Circumstances scale is defined as the external pressure to engage and remain in treatment. The Motivation scale is defined as the internal pressure to change; the Readiness scale is defined as the perceived need for treatment; and the Suitability scale is defined as the individual's perception of the treatment modality or setting as appropriate for himself. A prison version has been developed. A revised version of the CMRS, the CMR, is also available. The CMR is copyrighted and can be obtained by contacting the National Development and Research Institute, Inc., 71 W. 23rd Street, 8th Floor, New York, New York 10010, or mail@ndri.org.
Stages of Change, Readiness, and Treatment Eagerness Scale (SOCRATES)	SOCRATES includes items specifically focused on alcohol abuse and can be used as a starting point for discussion. A Spanish translation is available. The SOCRATES and other similar instruments are reprinted in TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*b*).

Co-Occurring Disorders

A substantial percentage of those under criminal justice supervision have one or more co-occurring mental disorders in addition to their substance use disorder. There were an estimated 283,800 incarcerated individuals in 1998 who had a major mental disorder, including 16 percent of State prison inmates, 7 percent of Federal prison inmates, and 16 percent of jail inmates (Ditton 1999). Of all of these individuals, 49 - 65 percent were under the influence of drugs or alcohol at the time of their offense, and 24 - 38 percent had a history of alcohol dependence. Because individuals often require therapeutic intervention for co-occurring disorders, accurate screening and assessment are of particular importance.

Much of the literature related to co-occurring disorders in the criminal justice system has focused on the most severe mental disorders (e.g., schizophrenia, bipolar disorder, and major depression) (Broner et al. 2002). However, less severe disorders (e.g., anxiety, phobia disorders, and posttraumatic stress disorder [PTSD], along with less severe depression, attention deficit disorders, and various types of personality disorders) are also common among offenders with substance use and mental disorders, and can affect treatment outcomes (Broner et al. 2002; Haywood et al. 2000; Henderson 1998; Peters and Hills 1997, 1999; Teplin et al. 1996).

An important first step in treating offenders with co-occurring disorders is to develop a systematic approach to screen and assess for these disorders. Relatively few jurisdictions systematically screen for mental health problems or co-occurring disorders upon arrest, prior to or following the arraignment process, or upon entrance into the jails. Despite the high prevalence of co-occurring disorders, these disorders are not always detected from the individual's arrest charge or mental status during booking. Unless the screening process is systematic, the target population may not be identified. As a result, many individuals are not diverted into specialized programs or provided effective discharge planning - strategies that are likely to reduce recidivism (Broner et al. 2001*a*).

Screening and assessment for co-occurring disorders should occur soon after entry into involvement in the criminal justice system. Many individuals who are screened or assessed in court, community corrections, or jail settings may be under the influence of alcohol or drugs and may need to be detoxified before determining whether they have co-occurring disorders. Acute symptoms of alcohol or drug use and residual effects of detoxification can mimic a wide variety of mental disorders, including anxiety, bipolar disorder, depression, and schizophrenia. Most prison inmates screened for co-occurring disorders will have been detoxified by the time of admission to treatment, although chronic residual side effects of drug use may cloud the initial symptom picture. It is therefore important to identify patterns of recent substance abuse and to observe mental health symptoms over time to see if they resolve as the individual detoxifies. It is often useful to defer diagnosis (or to provide a provisional diagnosis, if needed) until the interactive effects of co-occurring disorders can be determined.

Steps for Assessing the Interactive Effects of Co-Occurring Disorders

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1. Assess the significance of the substance use disorder. Obtain a chronological history describing the onset of mental disorder and substance abuse symptoms.
   - Determine whether mental disorder symptoms occur only in the context of substance abuse.
   - Determine whether ongoing abstinence leads to rapid and full resolution of mental disorder symptoms.
2. Determine the duration of the current period of abstinence.
   - If there has not been a 4–6 week period of abstinence, repeat assessment and diagnosis after such a period, depending on clinical judgment about the particular drug abuse history and the offender's physical status.
3. Reassess mental disorder symptoms at the end of 4–6 weeks of abstinence or at any time such symptoms appear or change.

4. If mental disorder symptoms are fully resolved, consider referral for traditional substance abuse treatment; if not, consider referral for mental health or specialized co-occurring disorders services.

5. Provide ongoing reevaluation of the offender's mental disorder symptoms and progress in treatment.

No single instrument can adequately screen for all mental and substance use disorders, particularly given the constraints of length, cost, and required training—but a combination of instruments can be used (Peters and Hills 1999). The choice of substance abuse screening instruments should be based on the purpose of the screening, ethnic or racial characteristics, language spoken, and gender (Broner et al. 2002). Figure 5 provides a list and description of instruments used to screen and assess for mental disorders.

Broner and colleagues recommend the Mini-International Neuropsychiatric Interview for mental disorder screening in court-based diversion programs (without the Antisocial Personality Disorder and Substance and Alcohol Abuse modules and with a substance use rule-out question added to reduce false-dsmpositives). Several sources recommend the TCUDS, SSI, or ADS/ASI combination for substance abuse screening among offenders with mental health problems (Broner et al. 2001*a*; Peters and Bartoi 1997). For assessment of psychiatric disorders, Broner and colleagues recommend the Structured Clinical Interview for DSM-IV (SCID) (Broner et al. 2001*a*).

Figure 5: Instruments for Screening and Assessing Mental Disorders

Instrument	Description
Beck Depression Inventory II (BD-III) (Beck et al. 1996)	• A 21 -item self-report of symptoms that screens for symptoms of depression. • Requires no significant training to administer. • Found to be the most effective instrument in detecting depression among individuals who abuse alcohol (Weiss and Mirin 1989). • Should not be used as a sole indicator of depression but in conjunction with other instruments (Weiss and Mirin 1989; Willenbring 1986).

Brief Symptom Inventory (BSI) (Derogatis 1975*a*)	• A short form of the Symptom Checklist 90 - Revised (SCL-90-R). • Comprising 53 items, including three global indices of psychopathology (General Severity Index, Positive Symptom Total, Positive Symptom Distress Index) and nine primary psychiatric symptom dimensions. • Quick to administer and requires no significant training to administer. • Only a 6th grade reading level is required. • May be most useful as a general indicator of psychopathology (Boulet and Boss 1991).
General Behavior Inventory (GBI) (Depue and Klein 1988)	• A 73-item self report instrument that examines mood disorders. • Requires no significant training to administer. • Differentiates between unipolar and bipolar depression.
Hamilton Depression Scale (HAM-D) (Hamilton 1960)	• A 17-item scale completed by an interviewer based on self-report information. • Examines several key elements of depression, including sleep disturbance, somatization, anxiety-depression, and apathy. • Requires training to administer.
Mental Health Screening Form-III (MHSF-III) (Carroll and McGinley 2001)	• Eighteen simple questions designed to screen for present or past symptoms of most of the main mental disorders. • A "rough" screening device and asks only one question for each disorder for which it attempts to screen. • Reproduced in TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*c*).

Millon Clinical Multiaxial Inventory (MCMI-III) (Millon 1983; Millon et al. 1994)	• A self report measure with several subscales. • Useful in assessing Axis II (personality) disorders that may affect involvement in treatment. • Includes the Drug Abuse Scale (DAS), an instrument designed to measure personality characteristics often associated with drug abuse (Calsyn and Saxon 1989).
Minnesota Multiphasic Personality Inventory (MMPI-2) (Butcher et al. 2001)	• A self report measure with 567 items, 10 main clinical scales, and 10 supplementary scales. • A restandardized version of the MMPI. • Frequently used in correctional settings for classification and assignment to housing or inmate programs, and to predict an inmate's response to placement in a correctional setting. • Useful in identifying characteristics of antisocial personality disorder. • Designed to identify psychopathology and not to identify substance use disorders.
Personality Assessment Inventory (PAI) (Morey 1991)	• A self-report measure with 344 items and 22 scales. • Eleven clinical scales include separate measures of alcohol problems and drug problems. • Five treatment scales are also provided in the PAI.
Referral Decision Scale (RDS) (Teplin and Swartz 1989)	• A 14-item measure of mental disorder symptoms developed to identify mental health problems. • Developed and validated in a criminal justice setting. • Found to be useful in detecting the presence of major mental illness among jail inmates. • Requires no training to administer. • Self administered. • Examines only a few mental disorders (depression, bipolar disorder, schizophrenia).

Symptom Checklist 90 - Revised (SCL-90-R) (Derogatis 1975*b*)	• A 90-item, multidimensional self-report inventory designed to assess recently experienced physical and psychological distress. • Requires no training to administer. • Self-administered. • Short amount of time to administer. • Frequently used in criminal justice settings. • Covers a wide range of symptom dimensions that include somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism.

Advice to the Counselor: Screening for Co-Occurring Disorders

- Screening and assessment for co-occurring disorders should occur on entry into the criminal justice system, given the high prevalence of co-occurring disorders in this population.
- Individuals in community corrections or jail settings may need to be detoxified before screening for co-occurring disorders. The acute symptoms of alcohol or drug use and the residual effects of detoxification can mimic a wide variety of mental disorders, including anxiety, bipolar disorder, depression, and schizophrenia.

History of Trauma

Rates of trauma in men and women entering the criminal justice system are higher than are rates found in community samples. For example, Teplin et al. (1996) found that 34 percent of female jail inmates had PTSD. According to the DSM-IV-TR, trauma is defined by two characteristics:

1. A person experiences, witnesses, or is threatened by physical harm.
2. The person's response to the event includes "intense fear, helplessness or horror" (APA 2000*a*, p. 463).

This definition highlights that trauma is not simply an event of a particular type but includes a subjective dimension in that the person's response to the event is powerfully negative. For example, one person may survive a car accident and not react with "fear, helplessness, or horror," while another person does experience such feelings.

Among female State prisoners, 40–80 percent report a history of emotional, physical, or sexual abuse (Bloom et al. 1994; Snell 1994). Female prison inmates are three times more likely to report a history of any abuse and six times more likely to report a history of sexual abuse in comparison to male inmates. A history of physical or sexual abuse has been linked to many types of mental disorders, including PTSD, depression and suicidal behavior, and borderline personality disorder and other personality disorders (Spielvogel and Floyd 1997).

Despite high rates of physical and sexual abuse among offenders, screening and assessment in the criminal justice system has not historically addressed these issues, nor have treatment services been provided in jail, prison, or community settings. There are many compelling reasons to address abuse and trauma issues during screening and assessment in the criminal justice system. For many offenders, the guilt, shame, and low self-esteem related to their trauma history may lead to social isolation and may reduce participation in treatment activities. For example, given the close relationship between past physical or sexual abuse and substance abuse, treatment that does not address one of the "root" contributors to substance abuse may be perceived as unimportant or irrelevant and may not provide sufficient incentives for the offender to change his or her attitudes and behavior. The offender's resulting lack of engagement in program services may be misinterpreted as resistance to treatment or lack of motivation rather than to psychological issues related to abuse and trauma. Forced abstinence during jail or prison may also deprive offenders of their primary means of coping with negative emotions related to past abuse and trauma (i.e., use of drugs and alcohol). When this coping mechanism is no longer available, many offenders are left vulnerable and may begin to exhibit symptoms of depression and other mental disorders that can interfere with treatment. If unaddressed, past trauma can also trigger substance abuse relapse (during or after treatment), through emotional, physical, or situational cues associated with prior abuse experiences.

Only trained counselors should inquire about abuse and trauma issues. The counselor should be prepared for how to respond to self-disclosed experiences related to physical and sexual abuse and how to provide referral for services. In most substance abuse settings, the goal of screening or an intake interview is not to compile detailed and comprehensive information regarding past trauma, but to identify that the offender has a history of trauma for purposes of treatment

planning, triage, and referral for more intensive services. As a result, counselors should be familiar with and have ready access to resources (e.g., counselors with mental health training, liaisons from women's shelters and treatment programs) to refer persons who wish to discuss their histories of trauma in more detail.

Although clinicians are sometimes concerned about addressing material that is potentially uncomfortable or even overwhelming for either the client or themselves, these adverse consequences are rarely experienced when these issues are raised by well-trained staff. In fact, offenders are typically relieved to talk frankly about their abuse and trauma experience, albeit in an appropriately limited fashion. In-depth discussion of the specific events surrounding traumatic experiences is typically conducted in follow-up individual or group treatment sessions that specifically address this topic area. Treatment for trauma issues progresses in stages, with early treatment goals focused on issues of ensuring safety in relationships, the place of residence, and in the workplace. Later work explores issues of recovery and reconciliation, if appropriate. This later work is frequently conducted by therapists with advanced degrees and in most cases is not appropriately addressed by paraprofessional staff.

Most commonly, assessment of trauma has been conducted through a clinical interview. In these settings, it is preferable to use standardized questions that avoid the use of terms such as "abuse," "trauma," or "perpetrator" and that instead focus on description of specific events or experiences.

Sample interview questions could include:

- Were you ever hit or punished in ways that left bruises, burns, or cuts? Were you ever threatened with knives or guns? Were you ever made to go without eating? Did you ever witness anyone else getting hurt? Did you ever have to be taken from your parents' care?
- As a child, did you have any sexual experiences? With whom and for how long did this go on? Were you ever threatened about it? Were any photos taken? Did any of these experiences lead to medical or other problems? Do you have any recurrent memories of these events now?
- Are you safe in your current relationship? Has your safety ever been threatened in any of your adult relationships? Have you been punched, shoved, or hit? Did you ever seek any medical help as a result? Have you talked to people about these experiences? (Spielvogel and Floyd 1997).

Structured interview assessments

Trauma Assessment & Treatment Resource Book

New York State Office of Mental Health's Trauma Initiative
Design Center
44 Holland Ave
Albany, NY 12229
Fax requests: (518) 473-2684

The Integrated Biopsychosocial Assessment that includes trauma history questions in an assessment form appropriate for a mental health or substance abuse setting. Available from:

Colleen Clark, Ph.D.
Louis de la Parte Florida Mental Health Institute
13301 Bruce B. Downs Blvd./ MHC 1345
Tampa, FL 33612-3899
Requests by e-mail: Cclark@fmhi.usf.edu

Self-report instruments

The Traumatic Antecedent Questionnaire (TAQ) (van der Kolk 1992). A widely used measure of lifetime experiences of trauma in 10 domains, i.e., physical, sexual, witnessing trauma, etc.

The Dissociative Experiences Scale (DES) (Bernstein and Putnam 1986). A self-report measure examining several domains of dissociative phenomena, often sequelae of trauma, i.e., amnesia, identity alterations, spontaneous trance states, etc.

The Clinician Administered PTSD Scale (CAPS) (Blake et al. 1998). A clinician-administered scale that provides an accurate diagnosis of PTSD.

The Trauma Symptom Inventory (TSI) (Briere 1995). A 100-item self-report instrument that evaluates symptoms in adults that may have arisen from childhood or adult traumatic experiences. Includes 10 clinical scales and 3 validity scales. An alternate version (TSI-A) includes no references to sexual issues. The companion Trauma Symptom Checklist 40 (Briere 1995; Briere and Runtz 1989) is a 40-item instrument that contains 6 sub-scales. Items are rated on a 4-point scale covering frequency over the past 2 months.

Posttraumatic Disorder Scale (PTDS) (Foa et al. 1993). Measures trauma history and specific symptoms associated with posttraumatic stress disorder.

Advice to the Counselor: Screening for Trauma

- Trained counselors are best equipped to inquire about abuse and trauma issues. Offenders who have experienced abuse or trauma and who are undergoing forced abstinence while in jail or prison may be deprived of their primary means of coping with the negative emotions related to past trauma. These offenders may begin to exhibit signs of depression or other mental disorders that can interfere with treatment.
- Counselors should be familiar with and have ready access to resources to refer persons who wish to discuss their histories of trauma in more detail.

Psychopathy and Risk for Violence and Recidivism

A number of criminogenic "risk factors" are often assessed in justice settings to determine eligibility for admission to substance abuse treatment programs and community release (e.g., parole), and for placement in institutional housing or in different levels of supervision (Borum 1996; Douglas and Webster 1999; Otto 2000). This information is particularly helpful to identify offenders likely to be disruptive in treatment programs, to be rearrested, or to commit violent crimes after release from institutions. Risk factors can be categorized as static or dynamic. Static risk factors are those that cannot change, such as gender and race, or are relatively enduring traits such as the diagnosis of a mental disorder, criminal history, family history, and the characteristics of the offender's victims. Dynamic risk factors are those likely to change over time and that change according to the client's environment, social situation, or experiences, such as drug use or homelessness. Following is a discussion of the risk factors for psychopathy and for violence and recidivism.

Psychopathy

One stable risk factor often found among offenders with substance use disorders is psychopathy and the closely related antisocial personality disorder defined in the DSM-IV classification system. Personality disorders are persistent and pervasive patterns of maladaptive behavior that are usually exhibited early in life. Historically, many terms have been used to describe personality disorders that involve criminogenic characteristics. Four closely linked terms are "sociopath" (and the trait of sociopathy), "antisocial personality" (and antisocial traits), "dissocial personality" (dissocial behavioral traits), and "psychopathic personality

disorder" (psychopathy or psychopathic traits). Whereas the first three formulations of criminogenic personality types focus on social deficits and mild emotional and cognitive problems resulting in impulsivity and poor school achievement, psychopathy focuses on primary and severe deficits in attachment and interpersonal bonding, lack of empathy for others' experiences, lack of remorse, and shallow emotional functioning. These relatively stable traits are thought to have a biological basis. As previously indicated, psychopathy is related to the DSM-IV antisocial personality disorder but represents a more extreme version of that disorder. Some would argue that psychopathy represents a distinct diagnostic group. From 40 to 60 percent of male prison inmates meet the criteria for antisocial personality disorder, whereas only 10 to 20 percent of male prison inmates meet the criteria for psychopathy (Hare et al. 1991).

Psychopathy is an important predictor of treatment dropout, level of involvement in violence, and criminal justice recidivism (Hart et al. 1994; Hemphill et al. 1998; Ogloff et al. 1990; Rice et al. 1992). Offenders identified as having a high degree of psychopathy may require specialized, more structured treatment approaches, although there is not a large body of evidence describing effective therapeutic interventions that have been applied to this population. Assessment for psychopathy is often used in criminal justice settings to rule out individuals for treatment involvement, particularly if there are not sufficiently structured treatment programs available.

Few short screening instruments exist for psychopathy because of the complexity of dimensions that need to be examined. The most widely used instrument to identify psychopathy is the Hare Psychopathy Checklist-Revised (PCL-R) (Hare 1998*b* ; Hare et al. 1991; Hart et al. 1994). The PCL-R is considered the "gold standard" for measuring psychopathy. It requires a significant amount of time to review archival information and to conduct an interview. A shorter screening version of this instrument—the PCL-SV—has also been developed for use with this population and validated in substance abuse treatment settings (Hart et al. 1995). Another shorter (60-item) measure, the self-report Psychopathy (SRP) instrument, has been developed for use in criminal justice settings by the author of the PCL-R.

Several other short self-report screening instruments for psychopathy have been developed but have yet to be fully validated with criminal justice populations. These include the Psychopathic Personality Inventory (Lilienfeld and Andrews 1996), the Psychopathy Q-Sort (Reise and Oliver 1994; Reise and Wink 1995), and the Levenson Self-Report Psychopathy Scale (Brinkley et al. 2001; Levenson et al. 1995). A number of other screening and assessment instruments examine personality features related, but not identical, to psychopathy (Zimmerman 2000), as described in Figure 6

Advice to the Counselor: Screening for Psychopathy

- Psychopathy is an important predictor of treatment dropout, level of involvement in violence, and criminal justice recidivism. Offenders identified as having a high degree of psychopathy may require specialized, more structured treatment approaches, although there is not a large body of evidence describing effective therapeutic interventions for this population.

Violence and recidivism

Although psychopathy may be the single most important risk factor for criminal recidivism, other risk factors are important to assess among offenders with substance abuse problems. Even offenders determined to have low levels of psychopathy may still be at high risk for violence or recidivism due to other risk factors. Other major risk factors for violence and criminal recidivism include

- Antisocial attitudes
- Criminal peers
- Prior history of crime and violence, and early age at time of first offense/violent act
- Active symptoms of severe mental illness
- Impulsivity
- Environmental stress
- Treatment nonadherence
- Personality disorders (generally)

A number of environmental stressors can lead to renewed substance use and risk for recidivism when offenders are released from custody or when their daily structure and level of supervision is reduced (Peters 1993; Wanberg and Milkman 1998). During these transitions, many offenders face employment and financial problems, and few have family or social supports. Meanwhile, there are immediate demands to organize daily activities, develop and maintain constructive relationships, manage personal or household finances and problems, and participate in community supervision. Many offenders involved with drugs have never learned the requisite skills to accomplish these tasks, and some rapidly return to substance abuse in the absence of opportunities to learn and rehearse those skills.

Many offenders have long histories of psychosocial problems that have contributed to their substance abuse and criminal involvement. These include interpersonal difficulties with family members, difficulties in sustaining long-term relationships, emotional and psychological difficulties, difficulties in managing anger and stress, educational and vocational skills deficits, and employment problems (Belenko and Peugh 1998; Peters 1993). Offenders do not typically plan or seek out addictive lifestyles or relapse. Rather, it is their lack of planning, personal objectives, and self-monitoring that leads to substance abuse or dependence or relapse. The lack of basic coping skills to manage life and social pressures further contributes to the risk for relapse and recidivism.

Reunification with family members is often accompanied by stress related to the family's distrust and anger over offenders' past drug use, unresolved conflicts with the partner or spouse, shifting parental roles, and added financial obligations, as well as drug use in the family or neighborhood. Elements of community supervision can also increase an offender's stress during re-entry to the community. These include drug testing, use of house arrest, and other surveillance or reporting activities, as well as the offender's recognition of the significant level of effort and adherence required by community supervision programs. The community's ongoing leverage to maintain the offender's involvement in treatment following release from custody or other secure settings can be a further stressor (U.S. Department of Justice 1991). Figure 6 provides descriptions of three general assessment instruments related to the risk for violence and recidivism.

Figure 6: Instruments Examining Psychopathy and Risk for Violence and Recidivism

	Instruments	Description
Psychopathy assessment instruments	Psychopathy Checklist - Revised (PCL-R)	• A 20-item assessment measure that requires use of a semi-structured interview and review of archival records. • Requires 90–120 minutes for the interview section and 60 minutes for the collateral records review. • Measures the extent to which individuals exhibit psychopathic features on a 40-point scale, with a cutoff score of approximately 30 indicating psychopathy. • Has considerable validation for use with offenders and is highly predictive of violence and criminal recidivism.
	Psychopathy Checklist - Screening Version (PCL-SV)	• A 12-item measure examining the same construct of psychopathy as the PCL-R. • Requires 45 minutes for the interview section and 30 minutes for the collateral records review. • Scored on a 24point scale with a cutoff of approximately 18 indicating psychopathy.
Other instruments related to psychopathy	Carlton Psychological Survey	• Used as an intake screening in correctional settings. • Contains scale scores for five categories: antisocial tendencies, chemical abuse, self-depreciation, thought disturbance, and validity. • Especially useful for those with low education and literacy as it requires only a 4th-grade reading level.

	Jesness Inventory	• Examines moral development throughout the life span.
	Paulus Deception Scales	• Gauges the extent of deception provided through offenders' self-report.
	Millon Clinical Multi-Axial Inventory-III (MCMI-III)	• Provides an assessment of personality disorders and psychopathy. • Correctional version of the MCMI-III provides early identification of substance abuse and mental health problems. • The 175-question test takes 25 minutes to complete. • Spanish versions available (Millon et al. 2002).
	Minnesota Multiphasic Personality Inventory (MMPI-2)	• A self-report objective assessment measure with 567 items, 10 main clinical scales, and 10 supplementary scales (Hathaway and McKinley 1989). • The Psychopathic Deviate Scale on the MMPI identifies individuals with psychopathic and antisocial features. • Frequently used in criminal justice settings (particularly in prisons) for classification and assignment to housing or offender programs and to predict an offender's response to placement in prison setting. • MMPI subtypes described by Megargee et al. (1979) are often used to identify offenders who require more intensive supervision and structured program activities.

	Personality Assessment Instrument (PAI)	• Self-report instrument for assessing traits associated with psychopathy. • Includes 344 items and requires 50–60 minutes to administer. • Contains scales for Negative Impression Management, Malingering, and Defensiveness (Morey and Lanier 1998). • The Antisocial Features (ANT) scale is the most highly correlated with psychopathy and focuses on antisocial behaviors, egocentricity, and stimulation-seeking.
General assessment instruments related to the risk for violence and recidivism	Level of Service Inventory (LSI)-Revised	• A 54-point scale used to predict the chances of criminal recidivism or supervision failure among offenders. • Useful for identifying those in need of more intensive levels of treatment, placement in halfway houses, and level of supervision and security classification (Andrews and Bonta 1995). • Used by jurisdictions to support an increase or decrease in the level of community supervision. • Includes assessment of drug use and is sometimes used in tandem with substance abuse treatment decisions.

	Historical, Clinical, Risk Management (HCR-20)	Provides a comprehensive risk assessment based on historical, clinical, and risk management assessments. Composed of static and dynamic factors with information derived from clinical interview, standardized assessment (e.g., the PCL-R or PCL-SV), and collateral sources. Includes three sections—10 historical items, 5 clinical items, and 5 risk management items—with a final risk rating of low, medium, or high (Webster et al. 1997; Webster et al. 2001).
	The Violence Risk Appraisal Guide (VRAG) (Harris et al. 1993)	• An assessment tool for predicting violent recidivism. • Is an actuarial measure based on 12 objective variables that are linked to recidivism. • Requires interview and archival review, and incorporates results of diagnostic testing, IQ testing, the PCL-R, criminal history, and indicators of adult adjustment.

Selection and Implementation of Instruments

Using well-accepted and standardized instruments can bring uniformity, quality control, and structure to the process. Some instruments may be more appropriate than others for particular purposes (CSAT 1994*a*), depending on the information needed for treatment decisions. For example, some instruments focus on drug dependence and not abuse, some identify those for whom specific treatment options are appropriate, and some are validated for use with criminal justice populations.

The appropriateness of particular instruments depends on the type of client being referred to a specific criminal justice program and the goals related to program admission. For instance, drug education programs are generally provided to a wide number of offenders, and a substance abuse screen that tends to be overly inclusive for this intervention might be preferred to a more exclusive screen. On the other hand, because of the limited access to treatment for offenders with co-

occurring substance use and mental disorders, screening for mental disorders as well as for drug use problems may need to be conservative to avoid referring someone who does not need services. Therefore, flexibility in developing screening and assessment approaches is needed, depending on specific program parameters (e.g., type of staff, client goals and needs).

This section describes the various factors that are important in the selection of screening and assessment instruments, including length, cost, window of detection, interview versus self-administered instruments, staff training required, literacy, language, and computerization.

What Guidelines Are Available Regarding the Effectiveness of Instruments?

Screening and assessment instruments vary considerably in their ability to detect substance use disorders and in the coverage of related areas such as mental health and other health issues, family and social functioning, and employment. Several guidelines should be considered when selecting substance abuse instruments for a particular criminal justice setting, in addition to the time and cost of administration. These guidelines, also known as "psychometric properties," are often described in research reports examining a particular instrument or in manuals that accompany the instruments. Five major statistical guidelines are used to gauge an instrument's accuracy for use with client populations:

- *Overall accuracy*—the extent to which the instrument classifies respondents correctly.
- *Sensitivity*—the extent to which the instrument accurately identifies those with substance use disorders (true positives).
- *Specificity*—the extent to which the instrument accurately identifies those without substance use disorders (true negatives).
- *Positive predictive value*—the proportion of offenders identified by the instrument as having substance abuse problems, compared to the total number having substance abuse problems.
- *Negative predictive value*—the proportion of offenders identified by the instrument as not having substance abuse problems, compared to the total number not having substance abuse problems.

Psychometric information helps counselors decide the usefulness of a screening instrument in a specific criminal justice setting. Questions counselors should ask include

- Are there normative scores for the population?
- Does the research show the instrument is valid for use with offenders and for relevant ethnic/cultural groups represented?
- Is it better to err on the side of false-positive or false-negative results? In other words, a decision must be made about whether to err on the side of sending someone to treatment who does not need it or not sending someone who does need it.

Length

Another critical factor that enters into the choice of a substance abuse screening instrument is how long it takes to administer. Although many drug use assessments are well designed and serve as broad sorting tools for treatment and intervention, they tend to take longer to administer than correctional agencies can afford (Knight et al. 2002). Rather, correctional systems usually have a short period of time to determine which of a large number of offenders need treatment. For example, the Program and Services Division of the Texas Department of Criminal Justice coordinates a drug abuse screening and treatment referral process for several hundred inmates monthly. The division lacks the staff, time, or financial resources to administer lengthy individual interviews for each new admission. Therefore, simple logic dictates that an instrument should not be used if it takes longer to administer than the staff time available.

Cost

The cost of instruments varies according to whether they are publicly or commercially available, whether the instrument is computerized, and the unit costs per administration that are assigned by the publisher. There are several screening and assessment instruments available at no cost in the public domain. Other commercially available instruments are available that can often be administered for $1 to $5 per unit.

Window of Detection

Questions phrased to ask about a relatively short window of detection—focusing on current rather than lifetime alcohol and drug problems—are recommended for screening (Cherpitel 1997; Knight et al. 2002) because there is a greater chance of obtaining valid responses. However, shorter detection windows could be too restrictive, and some who need treatment could be overlooked (e.g., offenders who abstained from substances while awaiting trial).

Interview Versus Self-Administered Instruments

The method used to administer an assessment instrument has implications for staffing, language, literacy, and reading level. A face-to-face interview can ensure that the respondent understands the items and answers them, but it is more time consuming and costly. The interview, which may be broken into several sessions, might be more appropriate for those with physical or cognitive disabilities. If cost is a concern, self-administered instruments could be used. Use of small-group interviews is another less costly alternative to individual interviews (Broome et al. 1996*b*).

Research suggests that the reliability of the administration method varies by setting and the content evaluated (Broner et al. 2002; Broome et al. 1996*b* ; Knight et al. 1998). The method chosen (e.g., interview or self-administered) also affects the amount of training required to administer the screening.

Staff Training Required

Training will have a major impact on instrument selection. Logically, if resources for intensive training are not available, instruments should be selected that do not require interpretation. Although most screening instruments do not require substantial staff training, some, such as the SASSI, may require more training than others. Further, even when little training is required, such as for the CAGE or interview-based instruments, the level of training can influence the validity of results. For assessment instruments such as the ASI, training may have a significant impact on the interpretation of results, administration of the instrument, and development of basic counseling techniques related to engaging clients, eliciting problems, interviewing strategies, and dealing with resistance.

Even with qualified staff, extensive training may be difficult to implement. Choosing a brief, easily administered screening instrument that requires little staff training can solve these difficulties. In some instances, correctional staff members who have been trained to administer an instrument can, in turn, train others to use it (Knight et al. 2002).

Literacy

A brief screening for literacy is recommended if it is suspected that a client may not be able to complete a paper-and-pencil test. The Slosson Oral Reading Test-Revised (www.slosson.com) may be useful if a counselor wants to know whether a client can read at a particular grade level. It is important to note, however, that a client's inability to read or write does not mean he or she cannot take an active part in the assessment. Rather, the counselor can substitute an interview for a paper-and-pencil assessment and a thumbprint for a signature.

Language

Optimally, the instrument chosen should be written in the individual's language of choice, whether English or another language. However, it should not be assumed that individuals who can speak a particular language can also read that language, or any other. To that end, the client may need to communicate in "street language." In this case, the counselor should mirror and leverage whatever vocabulary the client uses. Professional or clinical jargon should be avoided (CSAT 1994*a*).

Translating an instrument on the fly, such as for the Hispanic/Latino population, will greatly reduce the reliability and validity of screening results. Each population has different usages of language; misunderstandings and inaccuracies can impact engagement in treatment and client motivation for change.

Computerization

Some instruments allow screening through computerization (e.g., ASI). Computerization can reduce the personnel time needed to conduct screening and assessment but can also reduce the comprehensiveness of information gathered compared to clinical interviews. Research indicates that a computerized version of the ASI provides good reliability and validity for use with substance-involved clients (Butler et al. 1998, 2001). One report (Budman 2002) concluded that the computerized ASI is "more reliable, faster to administer, more accepted by patients, and more cost-effective" in comparison to the interview version of the ASI. While computerization can decrease the effort and time required for scoring, it can be an obstacle for offenders who are unfamiliar with computer technology and introduce added up-front and ongoing costs.

Screening and Assessment Considerations for Specific Populations

Within different treatment settings in the criminal justice system, screening and assessment instruments and procedures are sometimes altered to address the unique needs of specific clinical populations, such as ethnic and cultural minorities, women, and offenders with co-occurring disorders. For example, there is a growing recognition that instruments vary in their ability to detect substance abuse and other problems among these specific populations and that in some cases new instruments need to be developed. A related concern is that if a screening or assessment instrument is substantially modified for use with specific populations, research is needed to validate the effectiveness of the new

instrument in that setting. Another concern is that if items are added or deleted, this may affect the overall scoring of the instrument. The following section presents issues to consider when screening and assessing specific populations and suggests strategies for modifications to instruments and procedures.

Racial and Ethnic Minorities

When the counselor and the offender are from different racial or ethnic groups, the potential for misunderstanding is considerable. These differences can affect the staff's ability to assess client needs and/or to recommend culturally competent services for clients from other cultures and can jeopardize the client's chances for treatment success. The sources of misunderstanding originate in culture, socioeconomic class, and language (Sue and Sue 1999), as well as in race, gender (Broner et al. 2001*a*), literacy, and physical or cognitive inability to respond to the instrument (CSAT 1994*a*).

A general introduction to a screening or assessment could include statements about the effects of substance abuse on society or on the client's culture, along with information about the purpose of the process. Counselors should ask clients directly about how they view or describe themselves and their preferred usage of terms such as black, African American, person of color, Hispanic, Latino, Chicana, Pacific Islander, gay, homosexual, or lesbian. Counselors should also be aware of general cultural beliefs and expectations. For example, screening American-Indian populations can prove difficult because gaining trust is sometimes a challenge. Moreover, some tribal cultures dictate silence about substance abuse issues. As a result, a screening that detects the need for further assessment brings the stigma of losing dignity in the tribe. American-Indian men and women may also be the victims of other types of abuse that can impede the screening and assessment process. Further barriers of language, literacy, and comprehension are also present in this population (Sue and Sue 1999).

It may be necessary for a counselor to modify screening and assessment instruments to be sensitive to cultural differences. Individuals interested in modifying instruments should consult the research literature to identify adaptations that have already been developed and validated or new scales that have been adapted for the instruments. For example, several adaptations of the ASI have been developed for use with American Indians (Carise et al. 1998) and with women (CSAT 1997*c*). Also, new intake and follow-up scales have been developed for the ASI (Alterman et al. 1998). Counselors are encouraged to determine whether norms for an instrument make sense with the population they are testing. If the recognized criterion score results in too many individuals being excluded from treatment, perhaps the counselor should consider lowering it.

Women

Counselors also need to be aware of special issues in screening and assessing female offenders. Women respond differently to the screening process than men (Kassebaum 1999), and a longer, more flexible format is often useful, particularly to explore unanticipated areas that may arise. Females are more likely than males to have a co-occurring mental disorder and trauma-related problems. In addition, they are more likely to be affected by poverty, abuse histories, unstable social supports, and medical problems (el-Bassel et al. 1996; Fullilove et al. 1993; Haywood et al. 2000; Henderson 1998; Jacobson and Herald 1990; Jordan et al. 1996; Richie and Johnsen 1996; Teplin et al. 1996). In addition, many have lost custody of their children as a result of incarceration.

Most substance abuse screening and assessment instruments were developed and tested in male populations. Those working with female offenders should carefully review screening and assessment instruments to examine whether they have included content that is relevant to female offenders, such as information related to custody of children and parenting, history of physical and sexual abuse, and symptoms of trauma. Test instruments should be examined to determine if they were developed and normed using female populations, and if not, whether there are other instruments that may be more suitable for this population. One example of an instrument that has been tested with both male and female populations is the TCUDS II, which has been found to have good reliability for both genders (Knight 2001). Other screening instruments such as TWEAK have been developed specifically for women.

Offenders with Co-Occurring Mental Disorders

As noted previously, specialized screening and assessment approaches are needed for offenders with co-occurring disorders. Integrated screening and assessment approaches should be used to determine the scope, symptoms, and consequences (e.g., level of cognitive and intellectual functioning) of mental and substance use disorders and to examine the relationship between these disorders and criminal behavior. Because of the high rates of co-occurring disorders among offenders in criminal justice settings, identification of a single disorder (i.e., either mental health or substance use) should immediately trigger screening for the other type of disorder. Somewhat longer periods of screening and assessment may be needed for offenders with cognitive deficits (e.g., limited attention span) related to their mental disorders. Counselors may need to allow breaks during interview sessions, move at a slower pace during the interview, and obtain collateral information to verify key information related to mental disorder symptoms, treatment and medication use, and interactive effects of co-occurring disorders.

Depending on the criminal justice setting, screening may include a brief interview, use of self-report instruments, and review of archival records. A number of short self-report instruments are also available to examine the presence of mental disorder symptoms (Peters and Bartoi 1997). A mental status examination is also provided during many screenings for co-occurring disorders. In addition to examining key symptoms, mental health treatment history, and family history of mental disorder, it is helpful to assess the interactive effects of both disorders to determine whether there is an independent mental disorder, or if mental disorder symptoms are present only when the offender uses drugs or alcohol.

Screening for suicidal thoughts and behavior should occur on an ongoing basis for all offenders with co-occurring disorders in the criminal justice system. This screening is particularly important for offenders with severe depression or schizophrenia and individuals who are experiencing stimulant withdrawal. Suicide screening should be conducted at the time of transfer to new institutions, or at different stages in the justice system (e.g., arrest, pretrial diversion, probation). All suicidal behavior should be taken seriously and assessed promptly to identify the types of services needed.

Advice to the Counselor: Screening Specific Populations

- It may be necessary for a counselor to modify screening and assessment instruments to be sensitive to cultural and other differences.
- Women respond differently to the screening process than men, and a longer, more flexible form is often useful to explore unanticipated areas that may arise.
- Many adaptations have already been developed and validated. For instance, new versions of the ASI have been developed for use among American Indians and with women.
- Counselors interested in modifying instruments should consult the research literature to identify new adaptations or scales for existing instruments.

Integrated Screening and Assessment—Sample Approaches

Programs often integrate a variety of screening and assessment instruments to place clients in the most appropriate treatment program. Several sample models of integrated screening and assessment implementations are described below.

Colorado Department of Corrections (CDOC)

Colorado has a unique screening and assessment approach applied to offenders in both prison and community settings. All inmates transferred to CDOC for supervision receive a comprehensive screening and assessment for substance abuse problems, including the Alcohol and Substance Use Screening and the Level of Service Inventory-Revised (LSI-R). Based on the instruments, an extensive treatment matching approach places offenders in correctional settings where intensity varies from no treatment to therapeutic communities. The treatment matching approach defines key criteria for admission to each level of correctional treatment services based on the history of involvement in correctional treatment, individual motivation, social support, living arrangements (if in non-institutional settings), level of mental disorder and substance abuse symptoms, substance dependence symptoms, and other factors (O'Keefe 2000).

Florida Department of Corrections (FDOC)

Florida has developed an integrated screening and assessment system for all inmates entering its reception centers. The system uses the SSISA coupled with a records review (e.g., referrals from drug courts, history of DUI or drug offenses, FDOC treatment history) and a self-report gathered from interviews during the reception process. Responses from the various sources are weighted and then used to determine the offender's needed intensity of treatment and placement. Those inmates placed in services are administered a further assessment on transfer to a permanent institution, including the ASI and other psychosocial information. Key screening and assessment information is computerized and available to treatment, classification, and probation and parole staff (U.S. Department of Justice 1991).

Jacksonville, Florida, Adult Drug Court Programs

This jurisdiction takes an integrated approach to screening and assessment that blends information from screening instruments, interviews, and archived records. For example, in the Jacksonville Adult Drug Court program, offenders are first interviewed and offered treatment by their attorneys and the public defender. After that, several steps are followed:

1. Treatment Accountability for Safer Communities (TASC) screens every offender in the program (either in jail or in the TASC office) for the likelihood of substance abuse or dependency, using the agency's screening form, coupled with a commercially available screen.
2. For offenders with substance use disorders, the need for treatment is evaluated using section 1 of the American Society of Addiction Medicine (ASAM) *Patient Placement Criteria*, Second Edition, Revised (PPC-2R) (ASAM 2001).
3. For offenders who need treatment, placement criteria are assessed with the other sections of the ASAM PPC-2R, which include prior treatment history; biomedical, emotional, and behavioral conditions and complications; treatment acceptance/resistance; relapse and continued use potential, and recovery environment.
4. For offenders placed in treatment, a DSM-IV diagnosis is provided.

All screening and assessment information, the offender's treatment progress, and program evaluation and monitoring data are stored in an MIS that is available to drug court staff, including the drug court judge who can access key information such as recent drug test results during drug court status hearings. The MIS was developed by the drug court staff, court technology staff, and the City of Jacksonville. A juvenile MIS is being developed (Cooper 2002).

Orange County, California, Drug Court Program

Orange County targets nonviolent offenders charged with possession or being under the influence of illicit drugs, first determining the offender's eligibility and suitability for the Drug Court Program. To determine eligibility for the Drug Court Program, the district attorney's office flags offenders charged with possession or being under the influence. Then, probation staff reviews prior arrest history and interviews the offender about substance abuse history and willingness and ability to comply with program requirements. Finally, clinical staff from the program’s treatment providers completes a screening interview.

Eligible candidates are given a predetermined period of time in which to either plead guilty or opt into the treatment program. When candidates opt for treatment, suitability is then determined. This entails a full assessment, including a complete review of criminal history, the circumstances surrounding the charged offense, the results of any prior interactions with the criminal justice system, and a risk/needs assessment (with the National Institute of Corrections' version of the LSI) to assess treatment needs and risk of reoffense. Finally, clinical staff conducts an ASI and a full psychosocial history to determine the offender's motivation for treatment, desire for change, emotional stability, and ability to

comply with program requirements. The program runs for 18 months, with reassessments every 6 months to re-evaluate risk/needs scores (again using the LSI). The new scores are then used by the Drug Court Team (e.g., clinical staff, judge) to adjust supervision and treatment strategies.

Conclusions and Recommendations

The following are important points and recommendations about screening and assessment for criminal justice populations:

- An effective screening and assessment approach will encourage appropriate referral of offenders to different levels of treatment and will reduce the likelihood that offenders are released to the community without treatment.
- Appropriate assessment for substance abuse treatment in criminal justice settings examines the substance abuse history, psychopathy and related risk factors, history of mental health problems, and other psychosocial areas that are affected by substance abuse.
- Intensive treatment should clearly be reserved for offenders who have at least moderate substance abuse problems and at least moderate risk for criminal recidivism. Intensive treatment for low-risk offenders will have only a minor impact on reincarceration rates. However, there is still considerable work to be done to determine the most effective procedures for treatment matching with offenders.
- Failure to identify incarcerated offenders who need postrelease treatment reduces the impact of positive change that occurred during correctional treatment.
- Improved instruments and procedures for substance abuse screening and assessment will assist in matching offenders to appropriate postrelease treatment services.
- Matching has not been consistently demonstrated to be effective, and only limited alternative approaches are available.
- Because reports of offenders' drug problems are incomplete or contain contradictory information, other collateral sources of information need to be obtained (e.g., drug test results, correctional records) that can be combined with self-report information to make referral decisions. For example, in many correctional facilities, drug tests are used to flag the need for treatment—even when an offender denies recent substance abuse. Similarly, criminal records may indicate substance abuse problems, based on a history of drug-related or DUI/DWI arrests, or presentence investigation results.

- While most staff may conduct screenings, staff with appropriate training should provide assessments and related diagnoses and treatment plan recommendations.
- Screening and assessment instruments vary considerably in their ability to detect substance use disorders and to provide information regarding other areas related to substance abuse. A range of substance abuse screening and assessment instruments have been validated for use with offenders, and some are available at relatively little expense.
- The psychometric properties of screening and assessment instruments should be carefully reviewed, and choice of instruments based on demonstrated reliability and validity within substance abuse populations, and optimally, the utility of instruments in criminal justice settings.
- A tiered screening and assessment approach could be developed in settings in which several types of treatment services are available. The initial screening includes a broad filter to detect those who have substance abuse problems, while the more intensive assessment reviews specific treatment needs and risk levels so that the offender can be assigned to an appropriate level of treatment.
- Screening and assessment information should be obtained at each major point of transition within the criminal justice system (e.g., booking to jail, placement on probation). In some cases, relevant information can be obtained from previous stages in the system, for example through transfer of records from probation to institutional settings.
- Offenders initially assessed with symptoms of co-occurring disorders should be evaluated over an extended period of time to examine whether these symptoms resolve in the absence of substance abuse. This reassessment should be conducted by staff members who understand patterns of symptom interaction among co-occurring disorders.
- Screening and assessment for a prior history of physical and sexual abuse should be conducted routinely, particularly in settings that include large numbers of female offenders. Staff training is needed to develop effective interviewing approaches related to the prior history of abuse, counseling approaches in dealing with abuse and trauma issues, and in making referral to mental health services.
- Memoranda of understanding and other formal agreements can be developed across different agencies working within the criminal justice system to promote sharing of screening and assessment information. Key information related to treatment progress, outcomes, diagnoses, and ancillary services needs should be communicated across different points in the criminal justice system.

Appendix A: Screening and Assessment Instruments

Addiction Severity Index (ASI)

Purpose: The ASI is most useful as a general intake screening tool. It effectively assesses a client's status in several areas, and the composite score measures how a client's need for treatment changes over time.

Clinical utility: The ASI has been used extensively for treatment planning and outcome evaluation. Outcome evaluation packages for individual programs or for treatment systems are available.

Groups with whom this instrument has been used: Designed for adults of both sexes who are not intoxicated (drugs or alcohol) when interviewed. Also available in Spanish.

Norms: The ASI has been used with males and females with drug and alcohol disorders in both inpatient and outpatient settings.

Format: Structured interview.

Administration time: 50 minutes to 1 hour.

Scoring time: 5 minutes for severity rating.

Computer scoring? Yes.

Administrator training and qualifications: A self-training packet is available as well as onsite training by experienced trainers.

Fee for use: No cost; minimal charges for photocopying and mailing may apply.

Available from:
A. Thomas McLellan, Ph.D.
Building 7
PVAMC
University Avenue
Philadelphia, PA 19104
Ph: (800) 238-2433

The Alcohol Use Disorders Identification Test (AUDIT)

Purpose: The purpose of the AUDIT is to identify persons whose alcohol consumption has become hazardous or harmful to their health.

Clinical utility: The AUDIT screening procedure is linked to a decision process that includes brief intervention with heavy drinkers or referral to specialized treatment for patients who show evidence of more serious alcohol involvement.

Groups with whom this instrument has been used: Adults, particularly primary care, emergency room, surgery, and psychiatric patients; DWI offenders, criminals in court, jail, and prison; enlisted men in the armed forces; workers in employee assistance programs and industrial settings.

Norms: Yes, heavy drinkers and people with alcohol use disorders.

Format: A 10-item screening questionnaire with 3 questions on the amount and frequency of drinking, 3 questions on alcohol dependence, and 4 questions on problems caused by alcohol.

Administration time: 2 minutes.

Scoring time: 1 minute.

Computer scoring? No.

Administrator training and qualifications: The AUDIT is administered by a health professional or paraprofessional. Training is required for administration. A detailed user's manual and a videotape training module explain proper administration, procedures, scoring, interpretation, and clinical management.

Fee for use: No.

Available from: Can be downloaded from Project Cork Web site:

www.projectcork.org

Beck Depression Inventory-II (BDI-II)

Purpose: To screen for the presence and rate the severity of depression symptoms.

Clinical utility: Like its predecessor, the BDI-II consists of 21 items to assess the intensity of depression. The BDI-II can also be used as a screening device to determine the need for a referral for further evaluation. Each item is a list of four statements arranged in increasing severity about a particular symptom of depression. These new items bring the BDI-II into alignment with *Diagnostic and Statistical Manual for Mental Disorders, 4th edition* (DSM-IV) criteria.

Items on the new scale replace items that dealt with symptoms of weight loss, changes in body image, and somatic preoccupation. Another item on the BDI that tapped work difficulty was revised to examine loss of energy. Also, sleep loss and appetite loss items were revised to assess both increases and decreases in sleep and appetite. The BDI-II shows improved clinical sensitivity and higher reliability than the BDI.

Groups with whom this instrument has been used: All clients aged 13 through 80 who can read and understand the instructions and clients who cannot read (requires reading the statements to them).

Norms: The BDI has been used with people with substance use disorders, psychiatric patients, medical inpatients, and many other populations.

Format: Paper-and-pencil self-administered test.

Administration time: 5 minutes, either self-administered or administered verbally by a trained administrator.

Scoring time: N/A.

Computer scoring? No. Any staff member can perform the simple scoring.

Administrator training and qualifications: Doctoral-level training or masters-level training with supervision by a doctoral-level clinician are required to interpret test results.

Fee for use: $66 for manual and package of 25 record forms.

Available from:
The Psychological Corporation
19500 Bulderve
San Antonio, TX 78259
Ph: (800) 872-1726
www.psychcorp.com

CAGE Questionnaire

Purpose: The purpose of the CAGE Questionnaire is to detect alcoholism.

Clinical utility: The CAGE Questionnaire is a very useful bedside, clinical desk instrument and has become the favorite of many family practice and general internists—also very popular in nursing.

Groups with whom this instrument has been used: Adults, adolescents (over 16 years).

Norms: Yes.

Format: Very brief, relatively nonconfrontational questionnaire for detection of alcoholism, usually beginning "have you ever" but which can be phrased to refer to past month or current behavior.

Administration time: Less than 1 minute.

Scoring time: Instantaneous.

Computer scoring? No.

Administrator training and qualifications: No training required for administration; it is easy to learn, easy to remember, and easy to replicate.

Fee for use: No.

Available from: May be downloaded from the Project Cork Web site

www.projectcork.org

Circumstances, Motivation, and Readiness Scales (CMR Scales)

Purpose: The instrument is designed to predict retention in treatment and is applicable to both residential and outpatient treatment modalities.

Clinical utility: The instrument consists of four derived scales measuring external pressure to enter treatment, external pressure to leave treatment, motivation to change, and readiness for treatment. Items were developed from focus groups of recovering staff and clients and retain much of the original language. Clients entering substance abuse treatment perceive the items as relevant to their experience.

Groups with whom this instrument has been used: Adults.

Norms: Norms are available from a large secondary analysis of more than 10,000 clients in referral agencies, methadone maintenance, drug-free outpatient and residential treatment. Norms are also available for specific populations, such as clients with COD, prison-based programs, and women's programs.

Format: 18 items at approximately a third-grade reading level. Responses to the items consist of a 5-point Likert scale on which the individual rates each item on a scale from Strongly Disagree to Strongly Agree. Versions are also available in Spanish and Norwegian.

Administration time: 5 to 10 minutes.

Scoring time: Can be easily scored by reversing negatively worded items and summing the item values.

Computer scoring? No.

Administrator training and qualifications: Self-administered; no training required for administration.

Fee for use: N/A.

Available from:
George De Leon, Ph.D., or Gerald Melnick, Ph.D.
National Development and Research Institutes, Inc.
71 West 23rd Street
8th Floor
New York, NY 10010
Ph: (212) 845-4400
Fax: (917) 438-0894
E-mail: gerry.melnick@ndri.org
www.ndri.org

The Drug Abuse Screening Test (DAST)

Purpose: The purpose of the DAST is (1) to provide a brief, simple, practical, but valid method for identifying individuals who are abusing psychoactive drugs; and (2) to yield a quantitative index score of the degree of problems related to drug use and misuse.

Clinical utility: Screening and case finding; level of treatment and treatment/goal planning.

Groups with whom this instrument has been used: Individuals with at least a sixth grade reading level.

Norms: Yes. A normative sample consisting of 501 patients, representative of those applying for treatment in Toronto, Canada.

Format: A 20-item instrument that may be given in either a self-report or in a structured interview format; a "yes" or "no" response is requested from each of 20 questions.

Administration time: 5 minutes.

Scoring time: N/A.

Computer scoring? No. The DAST is planned to yield only one total or summary score ranging from 0 to 20, which is computed by summing all items that are endorsed in the direction of increased drug problems.

Administrator training and qualifications: For a qualified drug counselor, only a careful reading and adherence to the instructions in the "DAST Guidelines for Administration and Scoring," which is provided, is required. No other training is required.

Fee for use: The DAST form and scoring key are available either without cost or at nominal cost.

Available from:
Centre for Addiction and Mental Health
Marketing and Sales Services
33 Russell Street
Toronto, Ontario, Canada M5S 2Sl
Ph: (800) 661-1111 (Continental North America)
International and Toronto area: (416) 595-6059

Michigan Alcoholism Screening Test (MAST)

Purpose: Used to screen for alcoholism with a variety of populations.

Clinical utility: A 25-item questionnaire designed to provide a rapid and effective screen for lifetime alcohol-related problems and alcoholism.

Groups with whom this instrument has been used: Adults.

Norms: N/A.

Format: Consists of 25 questions.

Administration time: 10 minutes.

Scoring time: 5 minutes.

Computer scoring? No.

Administrator training and qualifications: No training required.

Fee for use: Fee for a copy, no fee for use.

Available from:
Melvin L. Selzer, M.D.
6967 Paseo Laredo
La Jolla, CA 92037-6425

Structured Clinical Interview for DSM-IV Disorders (SCID)

Purpose: Obtains Axis I and II diagnoses using the DSM-IV diagnostic criteria for enabling the interviewer to either rule out or to establish a diagnosis of "drug abuse" or "drug dependence" and/or "alcohol abuse" or "alcohol dependence."

Clinical utility: A psychiatric interview.

Groups with whom this instrument has been used: Psychiatric, medical, or community-based normal adults.

Norms: No.

Format: A psychiatric interview form in which diagnosis can be made by the examiner asking a series of approximately 10 questions of a client.

Administration time: Administration of Axis I and Axis II batteries may require more than 2 hours each for patients with multiple diagnoses. The Psychoactive Substance Use Disorders module may be administered by itself in 30 to 60 minutes.

Scoring time: Approximately 10 minutes.

Computer scoring? No.

Administrator training and qualifications: Designed for use by a trained clinical evaluator at the master's or doctoral level, although in research settings it has been used by bachelor's-level technicians with extensive training.

Fee for use: Yes.

Available from:
American Psychiatric Publishing, Inc.
1400 K Street, N.W.
Washington, DC 20005
www.appi.org/

University of Rhode Island Change Assessment (URICA)

Purpose: The URICA operationally defines four theoretical stages of change—precontemplation, contemplation, action, and maintenance—relevant to change of a "problem" determined by the subjects, each assessed by eight items. For an alcohol problem population, a 28-item version with 7 items per subscale is available.

Clinical utility: Assessment of stages of change/readiness construct can be used as a predictor of treatment and outcome variables.

Groups with whom this instrument has been used: Both inpatient and outpatient adults.

Norms: Yes, for outpatient alcoholism treatment population.

Format: The URICA is a 32-item inventory designed to assess an individual's stage of change, located along a continuum of change, in people who abuse alcohol or drugs.

Administration time: 5 to 10 minutes to complete.

Scoring time: 4 to 5 minutes.

Computer scoring? Yes, computer-scannable forms.

Administrator training and qualifications: N/A.

Fee for use: No; instrument is in the public domain. Available from author.

Available from:
Carlo C. DiClemente
University of Maryland
Psychology Department
1000 Hilltop Circle Baltimore, MD 21250 Ph: (410) 455-2415

Appendix B: Glossary of Terms

Acquittal: Judicial deliverance from a criminal charge on a verdict or finding of not guilty.

ADAM: Arrestee Drug Abuse Monitoring Program; a program sponsored by the National Institute of Justice that periodically administers drug tests and short research interviews to samples of new arrestees in selected cities.

Addiction: Drug craving accompanied by physical dependence that motivates continuing use, resulting in a tolerance to the drug's effects and a syndrome of identifiable symptoms.

Addiction Severity Index (ASI): A standardized assessment tool used to conduct a comprehensive drug evaluation and to match offenders' drug problems with treatment approaches. (See also **Offender Profile Index**.)

Adjudication (for adults): The process of resolving a criminal case through the determination of guilt or innocence and determining a sentence if the person is convicted of the crime.

Adult offender: In most States people 18 or older are considered adult offenders and processed through the adult criminal justice system, but in three States people 16 or older are processed as adults and in some other States it is 17 or older.

Aftercare: Treatment that occurs after completion of inpatient or residential treatment.

Alcoholics Anonymous: The best known of self-help support groups, which serves as an important adjunct to treatment.

Ancillary treatment services: These include education about substance abuse, self-help groups (Alcoholics Anonymous, Narcotics Anonymous), and skills training.

Arrest: The physical taking of a person into custody on the grounds that there is probable cause to believe he or she has committed a criminal offense. An arrest may follow an investigation by law enforcement and is authorized by a warrant issued by a court.

Assessment: Evaluation or appraisal of a candidate's suitability for substance abuse treatment and placement in a specific treatment modality/setting. This evaluation includes information on current and past use/abuse of drugs; justice system involvement; medical, familial, social, educational, military, employment, and treatment histories; and risk for infectious diseases (e.g., sexually transmitted diseases, tuberculosis, HIV/AIDS, and hepatitis). (See also **Screening**.)

Bail: Security (usually financial) provided as a guarantee that an arrested person will appear for trial; release from imprisonment based on that security. (See also **Financial bail** and **Nonfinancial conditions**.)

Behavior contracts: An agreement between counselor and client about the sanctions and incentives that are to be applied when specified when the client performs specified behaviors.

Bond hearing: Proceeding before a judge to determine what (if any) conditions to set for a detainee's release pending trial.

Booking facility: A secure lockup usually operated by the local police or sheriff's department. New arrestees are taken to and held in booking facilities for paper processing, fingerprinting, criminal records, and warrant checks, pending the initial appearance before a judge.

Boot camp: Typically, a sentence to a boot camp (also called shock incarceration) is for a relatively short time (3–6 months). These camps are characterized by intense regimentation, physical conditioning, manual labor, drill and ceremony, and military-style obedience.

Boundary-spanner: An individual with knowledge of both substance abuse treatment and criminal justice systems who can facilitate the interaction of the two for the purpose of obtaining substance abuse treatment for offenders under criminal justice supervision.

Center for Substance Abuse Treatment: CSAT is a Federal agency within the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA is part of the Public Health Service, under the Cabinet-level Department of Health and Human Services.

Classification: The process by which a jail, prison, probation office, parole, or other criminal justice agency assesses the security risk of an individual offender and the individual's need for social services.

Clinical formulation: The process of integrating information obtained through assessment into larger patterns or processes.

Clinicians: (See Counselors and clinicians.)

Coercion: The use of incentives and sanctions to encourage participation in substance abuse treatment.

Cognitive-behavioral therapy: Treatment that focuses on learning and practicing coping skills, some of which are cognitive in nature.

Community corrections: A model of corrections that has a primary goal of reintegrating the offender into the community. Typically will consist of judicial dispositions that involve alternatives to incarceration, such as diversion program, house arrest, electronic monitoring, probation, and parole.

Community notification laws: Laws that allow law enforcement to inform the public of the whereabouts (in some jurisdictions the specific home address) of offenders. The laws generally apply to sex offenders and typically include the "risk" level of the offender. Community notification laws are in effect in 50 States and the District of Columbia.

Community reintegration planning: Preparation and strategy for each prisoner's release from custody. The plan prepares for the prisoner's return to the community in a law-abiding role after release.

Community supervision or Community-supervised activities: These are outside the formal criminal justice system. Such activities include, for example, drug testing, programs to promote sobriety and prevent relapses, and day reporting centers.

Community treatment: This is a program outside the formal criminal justice setting. It may be run by public or private organizations (nonprofit or profit-making). Treatment may take place in a residential group (e.g., a halfway house) or a nonresidential activity (e.g., required attendance at Alcoholics Anonymous meetings). Treatment methods may vary. Both community treatment and community supervision are usually mandated by a court. An active partnership between these two should be built into planning activities for both.

Conditional release: Release from custody under specified conditions.

Confidentiality: The right of privacy for a client's/offender's personal information, except in certain law-enforcement situations.

Continual interagency communication: The ongoing cooperative effort among treatment/criminal justice/public health personnel needed to successfully treat and supervise offenders involved with drugs. Communication among these systems facilitates a united approach.

Co-occurring disorders: The co-occurrence of a mental disorder and a substance use disorder. Other uses of the term include substance abuse accompanied by one or more physical or psychological conditions. Sometimes referred to as dual disorders.

Corrections system: Includes jails and detention centers, prisons, and community supervised settings.

Counselors and clinicians: Treatment professionals serving clients who abuse substances and are involved in the criminal justice system.

Court-mandated treatment: A court order to participate in treatment as part of a sentence or in lieu of some aspect of the judicial process.

Cultural competence: A set of academic and interpersonal skills that helps individuals increase their understanding and appreciation of cultural differences and similarities within, among, and between groups. It requires a willingness and ability to draw on community-based values, traditions, and customs and to work with knowledgeable people from the community in developing focused interventions, communication, and support.

Curfew: In the criminal justice context, a rule or condition applied to individuals on probation or parole, requiring them to be in their residence and remain there by a specific time. An individual sentenced to house arrest will have a curfew.

Day reporting center: An intermediate sanction, this is a place where offenders on probation or parole must report to receive supervision for a certain number of hours each day. These centers may include educational services, vocational or skills training, and other service delivery. Offenders may also report by phone from a job or treatment site during the day.

Denial breaking: An intervention strategy designed to confront thought processes that prevent the individual from acknowledging problems related to his or her use of alcohol or illicit substances.

Detention: Holding a defendant in jail or other facility pending trial or determination of guilt.

Detention center: For adults, a holding facility such as a jail.

Determinate sentence: A sentence in which the length of incarceration is fixed by the court.

Deterrence: Being deterred from criminal activity because of fear of involvement in the criminal justice system or other punishment.

Detoxification: A structured medical or social milieu in which an individual is monitored for withdrawal from the acute physical and psychological effects of addiction.

Developmental interagency coordination: Collaboration among personnel from criminal justice, treatment, and public health to form expert justice/treatment/public health systems. For example, developmental interagency coordination is essential in the assessment of the drug-involved offender and in the development of referral procedures and reporting policies, as well as in understanding each system's definition of success and failure.

Disposition: The final resolution of a criminal case (e.g., in a case in which an individual is found not guilty, the disposition is an acquittal and release).

Diversion: The process whereby a defendant's prosecution is deferred or dropped if certain conditions are met. Diversion also is the judicial option to refer prison-bound cases to a review board, which in turn may recommend that the original sentence be modified or suspended and that the offender be placed in a residential or nonresidential program.

Drug courts/Drug treatment courts: Specialized courts commonly designed to handle only felony drug cases, usually involving adult nonviolent offenders. Drug courts can involve intensive monitoring, drug testing, outpatient treatment, and support services. They often operate with probation supervision and services.

Drug testing: Technical examination of urine samples to determine the presence or absence of specified drugs or their metabolized traces.

Drug use forecasting: Arrestee urinalysis data based on studies conducted under the Drug Use Forecasting (DUF) System of the National Institute of Justice.

DSM-IV: *Diagnostic and Statistical Manual, 4th edition,* published by the American Psychiatric Association, a standard manual used to categorize psychological or psychiatric conditions.

Due Process (of Law): Legal proceedings established to protect individual rights and liberties.

DUI, DWI: Driving under the influence or driving while intoxicated.

Duty to warn: A treatment professional's duty to report a patient's threat to harm another or to commit a crime (does not apply to knowledge of a client's past offenses).

Electronic monitoring: A sanction in which an electronic device is worn by an offender that can alert corrections officials to the unauthorized absence from the house of a person under curfew/house arrest. (See also **House arrest**.)

Financial bail: An amount of money, set by a judge, that is used to ensure the defendant's appearance at court. (See also **Bail** and **Nonfinancial conditions**.)

Habilitation: Training in social problemsolving skills for people with mental illness requiring the client to**:** (1) define the problem; (2) generate alternative solutions; (3) choose the best solution, (4) make a plan, and execute it; and (5) evaluate the outcome.

Halfway house: A transitional facility where a client is involved in school, work, training, etc. The client lives onsite while either stabilizing or reentering society drug free. The client usually receives individual counseling, as well as group/family/marital therapy. He or she may leave the site only for work, school, or treatment. This facility can be in the community or attached to a jail or similar institution. (See also **Work release** .)

House arrest: The restriction of offenders to their homes for various periods of time. (See also **Electronic monitoring** .)

Incarceration: Holding a person in a detention center, jail, or prison (State or Federal) because of suspected or actual involvement in criminal activity.

Indeterminate sentence: A prison sentence in which the amount of time to be served is indeterminate and is usually determined by a Parole Board after a minimum period of incarceration. Judges generally impose a minimum and maximum incarceration term in indeterminate sentences.

Infectious diseases risk assessment: Evaluation of a person's risk for sexually transmitted diseases, tuberculosis, HIV/AIDS, and other infectious diseases, including information regarding current and past history, screening, and treatment of such diseases. Testing and referral for treatment are recommended for those with substance use disorders who are assessed as at high risk for such diseases. Those with substance use disorders who are assessed as at low risk should be reassessed intermittently. Thus, collaboration between criminal justice personnel, treatment personnel, and public health personnel must be developed in order to ensure interagency coordination in the assessment and treatment of the drug-involved offender at various stages throughout the criminal justice continuum and in the development of referral procedures and reporting policies, as well as in understanding each system's definitions of success and failure.

Intermediate sanctions: Community-based programs providing increased surveillance, tighter controls on movement, more intense treatment for a wider assortment of maladies or deficiencies, increased offender accountability, and greater emphasis on payments to victims and/or corrections authorities. Intermediate sanctions are less punitive than incarceration but more punitive than simple probation. (See also **Sanctions**.)

Interpersonal issues: Those between the client and counselor in the therapeutic relationship. Includes boundaries, training, the need for peer role models and cultural sensitivity, respect for confidentiality and privacy, and the counselor's duty to report certain client crimes.

Intrapersonal issues: Those stemming from an individual's psychological makeup and/or physical conditions (including co-occurring disorders), as well as one's social skills, educational status, and personal support system.

Jail: A place for holding a person in lawful custody, usually while he or she is awaiting trial. In some jurisdictions, jails are used punitively for offenders serving short-term sentences or those involving work release or weekends in incarceration. Jails range in size from small rural ones with a dozen or so cells to urban settings with thousands of cells. Jails usually are operated by cities or counties.

Linkages: The provider establishes working relationships with various agencies and facilities in order to refer clients with multiple life problems to accessible, appropriate vocational training, medical, assisted living, and legal assistance services.

Management Information System (MIS): A computer system that assists in organizing information for the purposes of planning and maintaining a business or other organization.

Mandatory release: Required release of an inmate from incarceration upon the expiration of a certain period, as stipulated by a determinate sentencing law or by parole guidelines.

Memorandum of understanding (MOU): A written but noncontractual agreement between two or more agencies or other parties to take a certain course of action.

Methadone treatment: Medically supervised outpatient treatment that provides counseling while maintaining a client on the drug methadone (used mainly for heroin or other opioid addiction).

Monitoring for compliance: Surveillance of an offender to ensure that the conditions imposed on an individual are being adhered to.

Narcotics Anonymous: A self-help and support group similar to Alcoholics Anonymous.

National Treatment Plan Initiative: Developed by CSAT, this initiative is a blueprint for improving substance abuse treatment.

Negative predictive value: The proportion of offenders identified by a screening or assessment instrument as not having substance abuse problems, compared to the total number not having substance abuse problems.

Nonfinancial conditions: Release requirements set by a judge that do not include monetary payment (e.g., required participation in supporting services, such as substance abuse treatment). (See also **Bail** and **Financial bail**.)

Nonresidential treatment of incarcerated people: In this form of treatment, prisoners receive treatment either through day care programs, regularly scheduled therapeutic groups, or other nonresidential programs.

"No Wrong Door": This key component of CSAT's National Treatment Initiative indicates that no matter where they enter the health or social service system, people should be able to get treatment for substance abuse, either directly or through appropriate referral.

Offender Profile Index: A standardized assessment tool used to conduct a comprehensive drug evaluation and to match offenders' drug problems with treatment approaches. (See also **Addiction Severity Index**.)

On recognizance: Release on one's own responsibility (e.g., with an obligation to appear in court, but the release is not secured by financial bail).

Overall accuracy: The extent to which a screening or assessment instrument classifies respondents correctly.

Parole: The conditional release of an inmate from prison under supervision after part of a sentence has been served. The inmate is subject to specific terms and conditions which are monitored by an officer/agent.

Peer staff: Individuals in recovery from substance abuse disorders who have been trained for work in the treatment or criminal justice areas.

Personal bond: Release from court on one's own promise to appear in court, without financial conditions. Similar to release **on recognizance**.

Pharmacotherapies: Treatment of disease with drugs. In substance abuse treatment, these include methadone, naltrexone, and buprenorphine.

Placement: Assigning substance abuse treatment program participants with appropriate community substance abuse treatment facilities when such individuals leave the correctional facility at the end of a sentence or on parole.

Plea bargain: An agreement by a defendant to plead guilty to a criminal charge with the expectation of receiving some consideration from the prosecution for doing so. Typically the consideration is a reduction of the charge. The defendant's goal is a penalty lighter than the one warranted by the charged offense.

Positive predictive value: The proportion of offenders identified by a screening or assessment instrument as having substance abuse problems, compared to the total number having substance abuse problems.

Preliminary hearing: A court hearing in which initial information about the case is presented. This hearing usually is used to determine if there is sufficient evidence of guilt to continue the case, resolve evidentiary issues, or make initial case decisions.

Prerelease assessment: This information on an individual's situation/condition, as provided by treatment professionals, should be available to the judge, prosecutor, and other participants at the time of a presentence hearing or trial/sentencing. If an individual is paroled, the information should be conveyed to the parole officer for follow-up and evaluation. Recommendations for referral for treatment can be made at this time.

Presentence hearing: An event at which the prosecutor, defense attorney, and judge meet before a trial to establish parameters for that trial. A plea bargain is often negotiated at this point.

Presentence investigation: An investigation into the background and character of a defendant that assists the court in determining the most appropriate sentence in a case. Typically occurs after the person has been convicted, but prior to sentencing.

Pretrial hearing: Appearance in court before a magistrate, at which time bond is set or a determination is made to retain a person in jail or release him or her.

Pretrial stage: Activities in the criminal justice process that occur between arrest and trial.

Prison: A secured institution (Federal or State) in which convicted felons are confined after sentencing for crimes. Prisons are classified as minimum-, medium-, or maximum-security facilities, based on the need for internal institutional fortification. Inmates are similarly classified, according to severity of offense and/or other behavior and are usually assigned to prisons having a corresponding level of security.

Probation: A sentence in which the offender is allowed to remain in the community in lieu of incarceration. The individual is supervised and is ordered to comply with specific terms and conditions.

Problem-solving courts: These specialized court settings include drug courts, family courts, jail courts, and mental health courts.

Process evaluation: Determination of whether individuals actually received the treatment as it was intended to be delivered; examines implementation and operation of a program in comparison with the stated intent.

Protocol: Consists of guidelines and procedures for dealing with a particular issue or activity.

Psychopharmacology: The science dealing with the effect of medications in treating psychiatric conditions.

Recidivism: The commission of crime after an offender has been sentenced and/or released.

Re-entry formulation: The process of providing counseling and community-based supports to ex-offenders who abused substances and who are returning to society.

Relapse prevention: Strategy to train people with substance use disorders to cope more effectively and to overcome the stressors/triggers in their environments that may lead them back into drug use and dependency.

Reparation: (See Restoration.)

Residential treatment: Inpatient treatment, in which the client spends 24 hours a day in the treatment environment.

Restoration: Sometimes referred to as reparation, its aim is to restore the community to its state before a crime was committed. It does this in part by preventing the offender from reoffending through rehabilitation, incapacitation, or deterrence.

Restitution: Payment by an offender of the costs of a victim's losses or injuries and/or damages to the victim. Payment can be made to a general victim compensation fund or to the community as a whole (with the payment going to the municipal or State treasury).

Risk/needs assessment: A comprehensive report that includes a client's social, criminal, and other history. The report usually includes a recommendation for sentencing if the client is found guilty.

Sanctions: Legally binding orders of a court or paroling authority that deprive or restrict offender liberty or property. An **intermediate sanction** (see above) is more rigorous than traditional probation but less so than total incarceration.

Screening: Gathering and sorting of information used to determine if an individual has a problem with substance abuse and, if so, whether a detailed clinical assessment is appropriate. (See also **Assessment**.)

Security classification (in criminal justice): The process of assigning an inmate to a category based on the perceived likelihood of an offender's attempt at escape, propensity for violence, or management concerns.

Sensitivity: The extent to which a screening or assessment instrument accurately identifies those with substance use disorders (true positives).

Sentencing: The disposition of a case where penalties are imposed.

Skills training: This includes job and vocational skills, life skills (budgeting, leisure, etc.), literacy and GED classes, anger management, general coping skills, communication skills, parenting classes, building families and relationships, and social skills.

Sobering station: A 24-hour facility where individuals can be housed and monitored while under the influence of mood-altering substances.

Sobriety maintenance: The last step in recovery when the client has achieved stable sobriety and efforts are directed toward maintaining that stability.

Special-needs probation programs or caseloads: In these approaches to intermediate sanctions, officers with special training carry a restricted caseload. Typically, these approaches are used with offenders who have committed certain categories of domestic violence, sex offenses, and DUI, and with offenders who are mentally ill, developmentally disabled, or abuse substances. This situation can mean more intensive or intrusive supervision than in routine caseloads; enhanced social and psychological services; and/or specific training or group activities, such as anger management classes.

Specific populations: These include a wide range of people facing a wide range of issues—for example, racial/ethnic/sexual minorities and women, people with disabilities, older people, and those who are underserved or underrepresented in treatment. This term can also include violent offenders, sexual offenders, victims or perpetrators of domestic abuse, psychopaths, and offenders with life sentences.

Specificity: The extent to which a screening or assessment instrument accurately identifies those without substance use disorders (true negatives).

Split sentence: A sentence involving a short period of incarceration followed by probation or some other form of community supervision.

Stakeholders: Those who have a key interest/investment in an issue or activity—includes clients, treatment and criminal justice personnel, and policymakers.

Test-retest reliability: This quality of a screening or assessment instrument, expressed as a coefficient, is "obtained by administering the same test a second time to the same group after a time interval and correlating the two sets of scores" (American Educational Research Association 1999, p. 183).

Therapeutic community: Traditionally, this is a long-term (up to 24 months) rehabilitative model that relies mainly on peer staff and on work as education and therapy. Other staff include treatment and mental health professionals and vocational and educational counselors. The aim here is a global change in a person's lifestyle, focused on developing vocational, educational, and social skills. Most residents have been involved with the criminal justice system.

Treatment: Refers to the broad range of primary and supportive services - including identification, brief intervention, assessment, diagnosis, counseling, medical services, psychological services, and follow-up - provided for people with alcohol and illicit drug problems. The overall goal of treatment is to eliminate the use of alcohol and illicit drugs as a contributing factor to physical, psychological, and social dysfunction and to arrest, retard, or reverse progress of associated problems.

Treatment matching: Pairing clients with treatments and services that reflect their particular traits and needs in order to enhance the potential for better outcomes.

Treatment planning: The process of planning a client's total course of treatment, based on the findings of assessment procedures.

Treatment progress assessment: A process that determines the value of the chosen course of treatment, its suitability for the client, and how it should be extended or adjusted if necessary.

Triage: A process for sorting injured people into groups based on their need for medical treatment—in short, immediate attention and first-stage treatment for people with substance abuse disorders and others.

Trial: A court hearing at which a prosecutor presents a case against a defendant to show that he or she is guilty of a crime. The defendant presents information to support the plea that he or she is not guilty. The judge or jury decides the verdict.

Unbroken contact: Early, thorough, and substantial substance abuse treatment delivered in an unbroken manner throughout the entire criminal case-handling process, from arrest through the completion of the sentence. The components of the system must transfer not only the offender but also the cumulative record of what the system has learned and what it has done.

Urinalysis: The testing of a urine sample for the presence of drugs.

Waiver: A court action in which the defendant agrees to forgo certain legal rights, such as the right to a grand jury hearing or the right to a speedy trial. The term is also used to indicate the transfer of a juvenile offender to the adult criminal justice system when he or she has been accused of committing certain serious crimes.

Work release: An alternative to total incarceration, whereby inmates are permitted to work for pay in the free community but must return to a secure facility during their nonworking hours. (See also **Halfway House**.)

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Special Note:

A copy of the fifth edition of the ASI form and administration manual are available at no charge by writing the developer:

Thomas McLellan, Ph.D.
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University of Pennsylvania
Philadelphia, PA 19104
(215) 823-6095

Free copies of the National Institute on Drug Abuse (NIDA) *ASI* technology transfer package can also be obtained by calling the National Clearinghouse for Alcohol and Drug Information (NCADI) at (800) 729-6686 and asking for package BKD 122.

Appendix D: Post Test and Evaluation for Screening and Assessment of Clients in the Criminal Justice System

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test to us for processing. This can be done in any **one** of the following manners:

1. *Submit your test via the Internet.* All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions using the answer sheet found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

   http://www.ceumatrix.com/studentcenter

   Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'Take Exam' and you will be presented with the electronic exam.

   To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the course evaluation. , which is the final step in the process. Once you submit the evaluation, you will receive a link to the Certificate of Completion. This is the final step in the process, and you may save and / or print your Certificate of Completion.

   If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

   OR

2. *Submit your test by mail using the answer sheet found at the end of this package.* First, complete the cover page that will identify the course and provide us with the information that will be included in your Certificate of Completion. Then, answer each of the questions by selecting the best response available and marking your answers on the sheet. The final step is to complete the course evaluation (most certifying bodies require a course evaluation before certificates of completion can be issued). Once completed, mail the information, answer and evaluation sheets to this address:

   CEU Matrix - The Institute for Addiction and Criminal Justice Studies
   P.O. Box 2000
   Georgetown, TX 78627

   Once we receive your exam and evaluation sheets, we will grade your test and notify you of the results.

   If successful, you will be able to access your Certificate of Completion and print it. Access your browser and go to the Student Center located at:

   http://www.ceumatrix.com/studentcenter

   Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'Certificate' and you will be presented with a download of your Certificate of Completion that you may save / and or print. If you would rather have your Certificate of Completion mailed to you, please let us know when you mail your exam and evaluation sheets; or contact us at ceumatrix@ceumatrix.com or 800.421.4609.

   If you do not obtain the required 80% score, we will provide you with feedback and instructions for retesting.

   OR

3. *Submit your test by fax.* Simply follow the instructions above, but rather than mailing your sheets, fax them to us at **((512) 863-2231**.

If you have any difficulty with this process, or need assistance, please e-mail us at **ceumatrix@ceumatrix.com** and ask for help.

Answer the following questions by selecting the most appropriate response.

1. Screening is the evaluation or appraisal of a candidate's suitability for substance abuse treatment and placement in a specific treatment modality.

    a. True
    b. False

2. A basic assessment consists of gathering key information to understand the client's:

    a. readiness for change.
    b. problem areas, including any diagnoses.
    c. strengths and disabilities.
    d. Both A and B are correct responses
    e. All of the above are correct responses

3. Screening typically includes assignment of DSM-IV-TR diagnoses of alcohol or drug abuse or dependence.

    a. True
    b. False

4. In cases when the court may want the greatest amount of information available about an offender, the assessment should also include which of the following?

    a. Administration of at least three diverse instruments
    b. Historical information from family and other collateral sources
    c. Hypnosis
    d. Obtaining all medical and employment records

5. Research shows significant variability in the reliability and validity of different assessment instruments with different populations.

    a. True
    b. False

6. Key issues related to screening and assessment include all but which of the following?

    a. System-wide information sharing
    b. Accuracy of information
    c. Continuity of information
    d. Comprehensiveness of information

7. The acronym ASI stands for “Alcohol Screening Instrument.”

    a. True
    b. False

8. It is critical to administer screening and assessment instruments in a way that encourages:

        a. emotional expression.
        b. honesty.
        c. personal growth.
        d. historical perspective.
        e. All of the above

9. Collateral sources such as friends and family can improve the reliability of the information gathered by the offender’s self-report.

    a. True
    b. False

10. Counselors working the criminal justice settings should be aware of issues related to confidentiality and informed consent in the context of screening and assessment.

    a. True
    b. False

11. Peters found that the SASSI-2 had significantly lower positive predictive value for:

    a. Hispanics/Latinos.
    b. African Americans.
    c. Caucasians.
    d. American Indians.

12. Cross-training between the treatment and criminal justice systems can promote the use of screening and assessment results, as well as reduce duplication of efforts.

    a. True
    b. False

13. A 16-item screening instrument that examines symptoms of both alcohol and drug dependence is the:

    a. SASSI-2.
    b. ASI.
    c. SSI-SA.
    d. MAST short version.
    e. DAST-16.

14. For screening of alcohol problems among female offenders, counselors may want to consider use of the:

    a. Alcohol Dependence Scale (ADS).
    b. Rapid Alcohol Problems Screen (RAPS).
    c. Michigan Alcoholism Screening Test (MAST short version).
    d. CAGE.
    e. None of the above

15. New versions of which instrument have been developed and validated for use with American Indians and with women?

    a. ASI
    b. MAST
    c. SASSI
    d. MMPI
    e. SOCRATES

16. Which of the following is NOT used to examine psychopathy and risk for violence and recidivism?

    a. MMPI-2
    b. Psychopathy Checklist-Revised (PCL-R)
    c. Personality Assessment Instrument (PAI)
    d. Clinical Deception Inventory (CDI-2)
    e. Level of Service Inventory (LSI)-Revised

17. Screening should address evidence of:

    a. intoxication.
    b. dependence.
    c. overdose.
    d. withdrawal.
    e. All of the above

18. When treatment is held constant, coerced treatment by the criminal justice system has been shown to be at least as effective as non-coerced treatment.

    a. True
    b. False

19. Of the instruments described to evaluate readiness for treatment, only the _____ has a Spanish language version.

    SOCRATES
    TCE Treatment Motivation Scales
    CMRS-Sp
    URICA
    ASI

20. The choice of substance abuse screening instruments should be based on all of the following EXCEPT:

    a. Gender.
    b. ethnic or racial characteristics.
    c. language spoken.
    d. Age.
    e. purpose of the screening.

21. The _____ is a 73-item self-report instrument that examines mood disorders.

    a. Hamilton Depression Scale
    b. Beck Depression Inventory
    c. Mental Health Screening Form
    d. General Behavior Inventory
    e. None of the above

22. Because acute symptoms of alcohol or drug use can mimic a wide variety of mental disorders, it is recommended that assessment and diagnosis be repeated after ____ weeks of abstinence or at any time symptoms appear or change.

    a. 2-4
    b. 4-6
    c. 6-8
    d. 10-12

23. Rates of trauma in men and women entering the criminal justice system are comparable to rates found in community samples.

    a. True
    b. False

24. Only trained counselors should inquire about abuse and trauma issues.

    a. True
    b. False

25. A history of trauma has been linked to many types of mental disorders including:

    a. PTSD.
    b. depression.
    c. suicidal behavior.
    d. borderline and other personality disorders.
    e. All of the above

26. Forced abstinence during incarceration may deprive offenders who have experienced physical or sexual abuse of their major coping mechanism.

    a. True
    b. False

27. Of the four terms used to describe personality disorders that involve criminogenic characteristics, _____ is the most severe, and is present in 10-20% of male prison inmates.

    a. sociopathy
    b. antisocial personality
    c. disocial personality
    d. psychopathy

28. Most substance abuse screening and assessment instruments were developed and tested in female populations.

    a. True
    b. False

29. Important recidivism and violence risk factors to assess include all but which of the following?

    a. Criminal peers
    b. School failure, drop-out
    c. Treatment non-adherence
    d. Environmental stress
    e. Personality disorders

30. _____ is an important predictor of treatment dropout, level of involvement in violence, and criminal justice recidivism.

    a. Disocial personality
    b. Psychopathy
    c. Sociopathy
    d. Antisocial personality
    e. All of the above

31. One example of an instrument that has been tested with both male and female populations, and found to have good reliability, is the:

    a. TWEAK.
    b. ASI.
    c. TCUDS II.
    d. AUDIT.
    e. Beck Depression Inventory-II.

32. Counselors should ask clients directly about how they view or describe themselves, and their preferred usage of terms such as black, African American, person of color, Hispanic, Latin, Pacific Islander, gay, homosexual or lesbian.

    a. True
    b. False

33. The extent to which an assessment instrument accurately identifies those with substance use disorders (true positives) is called:

    a. overall accuracy.
    b. sensitivity.
    c. specificity.
    d. positive predictive value.
    e. negative predictive value.

34. The extent to which the instrument classifies respondents correctly is called:

    a. overall accuracy.
    b. sensitivity.
    c. specificity.
    d. positive predictive value.
    e. negative predictive value.

35. The Minnesota Multiphasic Personality Inventory (MMPI-2) is rarely used in a prison setting because of its length (567 items) and complexity of scoring.

    a. True
    b. False

36. Screening for suicidal thoughts and behavior should occur on an ongoing basis for all offenders:

    a. with a history of violence.
    b. with co-occurring disorders.
    c. who are experiencing stimulant withdrawal.
    d. Both a and b
    e. Both b and c

37. Assessment and evaluation should be obtained:

    a. at each major point of transition with the criminal justice system.
    b. regularly for persons with a history of physical and sexual abuse.
    c. on an ongoing basis for offenders with symptoms of co-occurring disorders.
    d. using instruments that are designed for the appropriate sub-populations.
    e. All of the above

38. Collateral sources of information in the assessment process include:

    a. family members.
    b. drug test results.
    c. pre-sentence investigations.
    d. drug- or DWI-related arrests.
    e. All of the above

39. One of the factors in the assessment process is the prohibitive cost of assessment instruments.

    a. True
    b. False

40. Women respond differently to the screening process than men, and a longer, more flexible form is often useful to explore unanticipated areas that may arise.

    a. True
    b. False

Fax/Mail Answer Sheet

CEU Matrix - The Institute for Addiction and Criminal Justice Studies

Test results for the course "Screening and Assessment of Clients in the Criminal Justice System

If you submit your test results online, you do not need to return this form.

Name*:_____

(* Please print your name as you want it to appear on your certificate)

Address: _____

City: _____

State: _____

Zip Code: _____

Social Security #*: _____

(*Most certifying bodies require a personal identification number of some sort – last 4 digits or License is perfect.)

Phone Number: _____

Fax Number: _____

E-mail Address: _____

On the following sheet, mark your answers clearly. Once you have completed the test, please return this sheet and the answer sheet in ***one*** of the following ways:

1. Fax your answer sheets to the following phone number: **(512) 863-2231**. This fax machine is available 24 hours per day. **OR**

2. Send the answer sheet to:
   CEU Matrix - The Institute for Addiction and Criminal Justice Studies
   P.O. Box 2000
   Georgetown, TX 78627

You will receive notification of your score within 48 business hours of our receipt of the answer sheet. If you do not pass the exam, you will receive instructions at that time**.**

Name: _____

Course: **Screening and Assessment of Clients in the Criminal Justice System**_

1. [A] [B] [C] [D] [E]
2. [A] [B] [C] [D] [E]
3. [A] [B] [C] [D] [E]
4. [A] [B] [C] [D] [E]
5. [A] [B] [C] [D] [E]
6. [A] [B] [C] [D] [E]
7. [A] [B] [C] [D] [E]
8. [A] [B] [C] [D] [E]
9. [A] [B] [C] [D] [E]
10. [A] [B] [C] [D] [E]
11. [A] [B] [C] [D] [E]
12. [A] [B] [C] [D] [E]
13. [A] [B] [C] [D] [E]
14. [A] [B] [C] [D] [E]
15. [A] [B] [C] [D] [E]
16. [A] [B] [C] [D] [E]
17. [A] [B] [C] [D] [E]
18. [A] [B] [C] [D] [E]
19. [A] [B] [C] [D] [E]
20. [A] [B] [C] [D] [E]
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30. [A] [B] [C] [D] [E]
31. [A] [B] [C] [D] [E]
32. [A] [B] [C] [D] [E]
33. [A] [B] [C] [D] [E]
34. [A] [B] [C] [D] [E]
35. [A] [B] [C] [D] [E]
36. [A] [B] [C] [D] [E]
37. [A] [B] [C] [D] [E]
38. [A] [B] [C] [D] [E]
39. [A] [B] [C] [D] [E]
40. [A] [B] [C] [D] [E]

The Institute for Addiction and Criminal Justice Studies

Course Evaluation – Hard Copy Format

The final step in the process required to obtain your course certificate is to complete this course evaluation. These evaluations are used to assist us in making sure that the course content meets the needs and expectations of our students. Please fill in the information completely and include any comments in the spaces provided. Then, if mailing or faxing your test results, return this form along with your answer sheet for processing. **If you submit your evaluation online, you do <u>not</u> need to return this form.**

NAME:_____

COURSE TITLE: <u>Screening and Assessment of Clients in the Criminal Justice System</u>

DATE:_____

<u>COURSE CONTENT</u>		
Information presented met the goals and objectives stated for this course	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information was relevant	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information was interesting	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information will be useful in my work	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Format of course was clear	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
POST TEST		
Questions covered course materials	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Questions were clear	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Answer sheet was easy to use	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good

_____

COURSE MECHANICS		
Course materials were well organized	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Materials were received in a timely manner	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Cost of course was reasonable	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
OVERALL RATING		
I give this distance learning course an overall rating of:	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
FEEDBACK		
How did you hear about CEU Matrix?	☐ Web Search Engine ☐ Mailing ☐ Telephone Contact ☐ E-mail posting ☐ Other Linkage ☐ FMS Advertisement ☐ Other: _____	
What I liked BEST about this course:		
I would suggest the following IMPROVEMENTS:		
Please tell us how long it took you to complete the course, post-test and evaluation:	_____ minutes were spent on this course.	
Other COMMENTS:		