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Substance Abuse Screening and Assessment in Criminal Justice Systems

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This distance learning coursework was developed for CEUMatrix by Robert A. Shearer, Ph.D.

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He has been teaching, training, consulting and conducting research in the fields of Criminal Justice, human behavior, and addictions for over thirty-six years. He is the author of over sixty professional and refereed articles in Criminal Justice and behavior. He is also the author of *Interviewing: Theories, techniques, and practices, 5th edition* published by Prentice Hall. Dr. Shearer has also created over a dozen measurement, research, and assessment instruments in Criminal Justice and addictions.

He has been a psychotherapist in private practice and served as a consultant to dozens of local, state, and national agencies. His interests continue to be substance abuse program assessment and evaluation. He has taught courses in interviewing, human behavior, substance abuse counseling, drugs-crime-social policy, assessment and treatment planning, and educational psychology. He has also taught several university level psychology courses in the Texas Department of Criminal Justice Institutional Division, led group therapy in prison, trained group therapists, and served as an expert witness in various courts of law.

He has been the president of the International Association of Addictions and Offender Counseling and the editor of the *Journal of Addictions and Offender Counseling* as well as a member of many Criminal Justice, criminology, and counseling professional organizations prior to retirement.

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Substance Abuse Screening and Assessment in Criminal Justice Systems: A Course of Study

by Robert A. Shearer, Ph.D.

Goal of the Course

The goal of the course is for the learner to understand the principles, elements, procedures, and issues in screening and assessing for substance abuse in the criminal justice system.

Objectives of the Course

1. Identify the issues associated with assessment.

2. Understand the difference between screening and assessment.

3. Understand what a screening protocol is.

4. Understand the critical areas for screening in substance abuse programs.

5. Understand the principles of effective interventions with offenders.

6. Identify the properties of assessment instruments.

7. Understand what is meant by readiness for treatment.

8. Identify the components of a pretreatment orientation program.

9. Understand ways to assess readiness.

10. Understand the difference between phase and track treatment designs.

11. Understand the relationship between assessment and treatment plans.

12. Understand how program progress can be assessed.

13. Explain the issue of screening accuracy: false positive and false negative.

14. Explain what should be included in an assessment report.

15. Understand how to assess treatment resistance.

Introduction

The criminal justice system continues to be overwhelmed by the number of offenders with substance abuse problems. The impact of the large number of substance abusing offenders now is achieving attention in and out of the system. For example, a recent Bureau of Justice Statistics publication estimated that 36 percent of convicted offenders, under the jurisdiction of corrections agencies, were consuming alcohol at the time of the offense. When the numbers for drugs are combined with the numbers for alcohol, the estimates appear to reach 80 percent to 90 percent of offenders who have serious substance abuse problems.

In some correctional agencies, this large number of offenders is their single greatest challenge. For example, in some state correction systems, it is not unusual for the agency to be in-processing 3,000 to 4,000 offenders a month. Included in the offenders' general processing is usually a determination of the offender's involvement with alcohol and other drugs (AOD) or substance use disorders (SUDs). Some of the problems created by unprecedented numbers of offenders being processed through the system were foreseen. Inadequate selection/diagnostic process to ensure that offenders selected for these programs are the ones likely to benefit from them is a critical problem amplified by the sheer number of offenders to be screened and assessed for substance abuse as they enter correctional facilities.

Clinical screening and assessment have been identified as two of the basic tasks and responsibilities (known as core functions) of an addiction counselor. In this course some of the unique issues and challenges created by the large number of offenders needing screening and assessment will be identified in the discussion that follows. Understanding these issues and challenges clearly is important for correctional managers and program supervisors because a lack of screening and assessment procedures is one of the key factors where there have been problems with implementing substance abuse programs.

The primary focus of this course will be to present the key elements of screening and assessment which serve as the foundation for modern *Addiction Treatment Technology.* (ATT).

ATT consists of:

a. Sound theories of the drug-crime relationship.
b. Evidence-based treatment practice.

Consequently, screening and assessment, as it is presented in this course, should be based on scientific research evidence that has indicated what works effectively with substance abusing offenders.

Finally, screening and assessment with substance abusing offenders should proceed from the assumption that the offender has, at least, a dual disorder. This dual disorder consists of:

1. AOD problems
2. Criminal tendencies

This means that relapse and recidivism are related or intertwined. Treating one without the other is not likely to serve the needs of the person in society. Treating only one of the disorders would result in either a sober criminal or a non-deviant addict. Traditional (free world) approaches to substance abuse treatment fail to address the criminal tendencies which usually result in recidivism that may occur independent of the offenders substance abuse.

Qualifications for Individuals Conducting Screening and Assessment

Any professional staff member of a treatment or criminal justice program can be trained to conduct the initial clinical screening. To perform an in-depth clinical assessment, an individual needs training, professional experience working with substance abusers, and an intuitive or learned ability to engage the client's active participation. With appropriate training, ex-offenders and other people recovering from AOD abuse can become very effective clinical interviewers from some segments of the overall clinical assessment process.

To contact the psychological and sociobehavioral portions of the assessment reliably, the interviewer must have sufficient professional training and clinical experience. The interviewer must also be able to communicate the findings of the assessment concisely and accurately to the client and all other relevant parties. Appropriate professionals for this task include psychologists, social workers, certified substance abuse or addiction counselors, and clinical nurse specialists. The individual's understanding of the assessment process is as important as the type of professional credential he or she holds. The biomedical portion of the assessment should be conducted by a licensed medical professional with training in diagnostic skills, such as a physician, physician's assistant, nurse practitioner, or nurse clinical specialist.

Training for all portions of the clinical assessment, including the medical assessment, should build several kinds of skills: 1) the ability to establish rapport; 2) the ability to conduct nonjudgmental, nonthreatening interviews; 3) the ability to succinctly document information throughout the assessment and in the integrated summary; and 4) cultural competence. Specific training should also be given for the use of any specific assessment instrument.

To provide consistent information for individual treatment planning as well as program evaluation and system wide service planning, it is important for programs to use standard assessment instruments. It is also appropriate for programs to develop additional clinical instruments to meet their particular needs. Standard assessments should not be the sole means of assessing a client's needs. Rather, they should be used in combination with the interviewer's structured, clinical, and intuitive assessment of the client.

Linkages: Coordinating Treatment and Criminal Justice Programs

Coordination between treatment and criminal justice programs makes assessment and treatment programs more effective. Criminal justice decisions regarding treatment can be more appropriately made, and are more acceptable to treatment personnel, when consultation between the two groups has occurred. It is important for treatment and criminal justice staff to understand the goals of both systems. Policies and practices in the criminal justice system are more likely to support the goals of treatment when consultation has occurred, and vice versa. Finally, scarce resources for the treatment of AOD abuse are put to the best possible use when they are used after consultation between the two systems.

Criminal justice and treatment systems cannot achieve enhanced coordination simply by reaching a formal agreement to collaborate. 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 level and in the management of each client's treatment. In addition, cross-training can maximize the effect of both systems' screening and assessment efforts and minimize the need for duplication of effort.

Coordination Between Institutions

At the institutional level, the team managing coordination between the two systems should include the director of probation or prison director, judges, prosecutors, representatives of the defense bar where appropriate and the treatment director. Led by this team, the two systems should collaborate to develop broad statements of working policies that specify the principles and rationales guiding the new collaborative relationships. In particular, those documents should provide details on the following:

- The need and goals of each institution
- The means by which these needs and goals will be met, with suggested time frames
- Guidelines for sharing information at the various stages of the assessment and treatment process, within the framework of consent regulation
- Guidelines for providing a continuum of care that make it possible to match the particular treatment needs of a client with a specified level of treatment,

often at transitional points in the correctional process. For example, when the client is transferred from prison to a community correctional program, he or she may be able to enter an outpatient treatment program.

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Individual Case Management

The management team for each client should include a representative of each institution involved (for example, the probation officer and a treatment counselor). Criminal justice personnel must be included in the individual case management team at each stage of the treatment process, beginning with clinical assessment.

The case management team should reach formal agreement on the answers to the following questions:

- What are the goals and time frame for treatment?
- What guidelines will govern the kinds of information that will be shared? (For example, will the parole officer expect the treatment program to report if the offender relapses to drug use?)
- What process will be followed to reach decisions concerning such questions as whether pretrial release, probation, or parole should be revoked; when treatment should be considered a failure; and how personnel in both systems will respond in the event of specific treatment problems?

Improving Coordination With Existing Resources

The intent of these recommendations is not to create new bureaucratic systems, but, rather, to use existing agencies and personnel to achieve close coordination among systems. The use of coordinated case management teams is necessary to make efficient use of scarce resources and to increase the effectiveness of case management. Increased coordination does not require new personnel, but only new training of existing personnel in all systems.

Special Issues in Assessment

Professionals working in systems that link treatment and corrections must be aware of a broad range of special issues in assessment related to clients' gender, culture, ethnicity, sexual orientation, educational level, religious affiliation or spirituality, and other such sociocultural characteristics. Issues related to a number of these characteristics are discussed below.

1. Literacy and communication skills

The person performing the assessment must be able to tailor the interviewing process to the client's level of literacy, verbal communication, and listening skills.

The person performing the assessment needs to establish sufficient rapport with the client to make sure that the client understands the questions asked and the information being shared. The interviewer should avoid presupposing the client's literacy level based on social class, race, or ethnicity. The interviewer should also be aware that a client's inability to read or write does not make the client unable to take an active part in the assessment. For some clients, it may be necessary to substitute an oral interview for a paper-and-pencil assessment.

2. Language

It may be necessary to perform the assessment in the primary language of the individual, which may not be English. Assessors should avoid the assumption that a speaker of any given language can also read that language. The client may not be functionally literate in any language. Another part of the staff member's sensitivity to language should be an awareness that the client may need to communicate in "street language." The assessor should be attentive to the kind of vocabulary that the individual client feels most comfortable using. To the extent possible, concepts should be stated in lay language, even street language, if appropriate, but not professional or clinical jargon.

Using appropriate language is an essential part of making a true connection with the individual, so that he or she becomes engaged in the assessment process. While good assessment may be largely an intuitive process, specific assessment skills can be taught. Training can be provided in nonjudgmental interviewing techniques, rapport building, sensitive probing, and multicultural sensitivity.

3. Cultural Identity and Ethnicity

For appropriate assessment, it is critical that culturally and linguistically competent staff are available. The assessor must be aware of the importance of the client's cultural identity and the extent of his or her acculturation into the dominant culture. Some programs attempt to draw on traditional cultural strengths of the individual in specific ways; these may be appropriate for the individual who has a strong identification with his or her culture or origin, but it may be inappropriate for other individuals of the same group. It is necessary to gain some sense of the meaning that the individual's culture holds for him or her personally, rather than relying on presuppositions.

The client's culture has many potential implications for the process of the assessment. Some cultures view direct questioning as inappropriate. Therefore, individuals from this type of culture may view the assessment process as highly intrusive. A goal of the assessment process is to understand the client's world from his or her own cultural perspective.

The importance of making appropriate inferences from information about an individual's culture makes it imperative that programs involved in assessment exert a

strong effort in good faith to hire assessors representative of the populations they serve. When qualified professionals from these cultural groups are not on staff, treatment programs can seek to employ counselors or support staff from these groups, in order to create a diverse multicultural program environment.

For effective assessment and placement, it is necessary to recognize that institutional and individual discrimination may exist in the criminal justice system and other institutions, and that bias can negatively affect classification, screening, and assessment.

4. Gender

In the past decade, the growth in women's prison populations has been dramatic. According to the Bureau of Justice Statistics, the average daily population of women confined in local jails rose by more than 95 percent, as compared with only a 50 percent increase in the male jail population. The need for sensitivity to gender issues is apparent.

Treatment programs should guard against perpetuating institutional sexism—institutional policies and practices that systematically ignore the special diagnostic, assessment, and treatment needs of women. They should also be aware that female clients may not have received a full exploration of findings that suggest treatment need. For example, many current assessment tools were developed specifically for male clients. These instruments tend to explore factors related to men's traditional roles such as performance in the workplace. (The Addiction Severity Index now includes modified severity indexes for women, as well as sections on living arrangements and relationships that are more sensitive to women's lives than previous versions. Instruments need to be tailored in this way for men and women.)

Furthermore, women's abuse of AODs may go unnoticed because women are less likely to have contact with employers or others who would press them into treatment. Fear of the male offender is another impetus for the criminal justice system to refer men to assessment and treatment while neglecting the assessment needs of women, who may be viewed as less threatening to society.

Misdiagnosis can occur if the person performing the assessment has preconceptions about the kinds of psychological dysfunction that women are likely to present. For example, physicians or psychologists may misread symptoms of alcoholism as symptoms of depression. Rates of depression for male alcoholics are comparable to the rate for males in the general population, but female alcoholics are significantly more likely to have a diagnosis of depression than either women in the general population or male alcoholics.

Professionals performing medical assessments must be aware of physical differences in the ways that the abuse of AODs is manifested in men and women.

Some research suggests that there may be differences in the way alcohol is processed in men and women.

5. Sexual Orientation and Identity

A complete biopsychosocial assessment includes nonjudgmental questions designed to assess the individual's sexual orientation, the individual's understanding of and attitudes toward his or her own sexual orientation, and the family and social supports available to the gay or lesbian client. This information has implications for the etiology of AOD abuse, for related mental health issues, and for the placement of the individual in treatment. Some treatment programs, because of their institutional culture, may not be appropriate for homosexual, bisexual, or lesbian clients.

Questions intended to explore the individual's sexual orientation should be framed neutrally. For example, "How do you identify yourself--- as gay, lesbian, bisexual, heterosexual…?" Clients may be at varying stages in exploring and defining their sexual identity. Asking questions in an open-ended way gives clients the opportunity to explore their sexual identity in the course of the assessment and treatment.

6. Poverty and Socioeconomic Status

As public funding has declined, treatment programs concerned about their economic survival have often become biased against the poor. A common assumption is that in allotting limited treatment slots, treatment programs should sacrifice the treatment of the poor. The many common negative stereotypes about the poor and their motivations contribute to this bias. Programs that are committed to providing services to the poor must recognize that indigent people may require more intensive services because they have not had access to adequate food, shelter, or medical treatment.

7. Religion and Spirituality

The person performing the assessment should be respectful of all religious affiliations and of the nonreligious client. The assessor should be sufficiently familiar with the beliefs and practices of various religious groups in the community to avoid offending the client and to refer the client, when appropriate, to a treatment program that can make use of the client's spirituality or religious belief as strength. As mentioned earlier, belief in a Higher Power or a sense of "belongingness" within one's family and the universe has a positive association with effective treatment. Working together with corrections, treatment personnel should also serve as advocates for religious freedom in prison as a part of treatment services in prisons.

8. Physical Disability

The assessment process should include an assessment of any physical disabilities. The physically handicapped client must be placed in a treatment program that is physically accessible. Some clients will be screened out of placement in a particular treatment program if it is inaccessible; others will not be screened out but will need some accommodation for their special needs. This is an important part of the treatment match; the assessor should take care to gain specific information about what the disabled client can and cannot do for himself or herself, in order to place the client in a workable setting.

9. Assessment of HIV Risk

The primary risk factors for HIV infection that should be assessed include the frequency of drug injections, the sharing of drugs and injection equipment, the use of bleach to sterilize needles, the number of sexual partners, patterns of condom use, sex-for-drug exchanges, and a history of sexually transmitted diseases. Given that more than one-fourth of individuals who have been diagnose with AIDS are drug injectors, all assessments performed should include an evaluation of the client's risk of contracting HIV. For women and people of African-American, Hispanic, and Caribbean origin, drug injection or sexual relations with a drug injector are principal risk factors for HIV transmission. One of the purposes of this evaluation is to develop a plan for reducing the client's HIV risk behavior.

Treatment professionals working with criminal justice populations have a particular responsibility for addressing the AIDS epidemic, for several reasons. First, analysis indicates that the criminal justice system comes in contact with the portion of the AOD-abusing population that is most at risk for HIV infection. Second, there is a disproportionately high incidence of HIV seropositivity in prisons. Third, because the prison population is captive, treatment programs have an opportunity to assess HIV risk and encourage preventive measures.

It is important to emphasize that risk behaviors, as well as HIV status, should be assessed. However, HIV testing should not be mandatory, for several reasons. First, the decision of an individual to learn his or her HIV status is a private one that requires pretest and post-test counseling. Second, knowledge that an individual is HIV-positive can threaten his or her access to services, personal safety in the prison environment, and access to medical insurance. Third, massive HIV testing clouds the issue because the focus of HIV prevention efforts should be on reducing risk, not identifying individuals' HIV status. Fourth, mandatory testing would override confidentiality regulations and violates some State laws.

When symptoms of AIDS are discovered during the course of a medical assessment, HIV testing may well be indicted. Individuals diagnosed with HIV infection or AIDS should be referred to appropriate counseling and medical services.

As noted earlier in this section, assessment is the first step in the treatment process. Assessment is a good place to begin educating the client about the risks

and consequences of HIV infection. It is imperative that clients who engage in high-risk behaviors be referred to programs that emphasize ongoing risk reduction education.

Screening

The goals of screening criminal justice offenders for alcohol and other drugs (AOD) problems are to identify potential candidates for treatment intervention as early as possible in their criminal justice processing and to interrupt their cycles of addiction and crime. The screening process can begin when a police officer responds to a complaint or make an arrest. At an initial screening, a few quick and simple, and direct questions can yield useful answers. Not asking them will yield no information. Simple questions might include:

- Did you ever do anything while drinking or using drugs that you regretted later?
- Have you ever gotten into a fight because of your drinking or drug use?

After this initial point of contact, there are several more points where either formal or informal AOD screening can be conducted as AOD users move through the criminal justice system. These points include: in the jail or the lockup, at arraignment, at pretrial investigation, at meetings with prosecutors and public defenders, in interactions with various officer of the court and representatives of the criminal justice system, and at probation violation hearings. These officials can be made aware of their potential impact on AOD abuse treatment, and taught basic screening techniques. Despite the lack of nationwide uniformity in the various agencies and institutions that comprise the criminal justice system, similar techniques can be applied systemwide, and can effectively identify a large number of offenders for further assessment—which is the point of screening.

Why Screen?

The use of AODs is pervasive in today's criminal justice population. Study results vary, but most suggest that up to 80 percent of the street crime in this country involves AOD use. Offenders may use AODs and/or steal to feed drug habits, and violence often results from AOD abuse and during drug deals. Nearly half of all traffic fatalities involve the abuse of alcohol. There are high correlations between AOD abuse and certain public health problems. Moreover, AOD screening can be an opportunity to screen for diseases such as tuberculosis (TB), hepatitis, and HIV infection and other sexually transmitted diseases. Thus, as increasing numbers of AOD abusers are screened and treated, the potential exists to reduce associated crimes, deaths, and accidents.

Because arrestees are often in a state of psychological crisis, arrest can be an excellent stage for screening. Arrestees are often anxious, depressed, and

frightened. The negative consequences of their AOD abuse are often obvious and severe, and hard for the arrestee to deny. At this point, offenders may offer information about their AOD abuse. Once released from the criminal justice system, their concern for the gravity of their situation will usually fade.

From the standpoint of public safety, the pretrial phase, when the largest number of potential abusers are in the system and under control, provides the greatest potential for early identification. Without identification and intervention, most AOD-using offenders will rejoin the general population with little or no knowledge of their AOD abuse problem or resources that exist to assist them.

General Considerations

An initial screening is useful in separating those who are likely to be addicted from those who are not. Screening does not require extensive training. It begins with being aware, and includes listening and noticing behavior and actions.

Screening interview should be done in private. Offenders have a right to privacy and to confidential handling of all information they provide.

Most users are likely to abuse several drugs. Sometimes the AOD involvement is obvious. The smell of alcohol may be readily apparent; a suspect's behavior may be bizarre or disoriented; drugs may be evident on the scene. Sometimes the AOD involvement is less obvious. Episodes of domestic or fighting among friends may involve AOD abuse that is hidden from sight. However, police officers can learn to look for signs of AOD use and to trust their instincts, intuition, and judgment about the possible role of AODs. They can pass their impressions on the next criminal justice official handling the case. Ongoing communication and data-sharing are important aspects of the screening process. Screening is not a single event, but a continuous process that can be repeated by a variety of professionals in a variety of settings.

A number of basic screening instruments are available, such as the CAGE questionnaire, which has four simple questions to look for potential alcohol involvement. More indepth screening and assessment can be done by using the Michigan Alcoholism Screening Test (MAST) or the Offender Profile Index (OPI). Certain biological measures such as Breathalyzer, blood-alcohol, and urine tests are also important screening tools.

Components of Screening

Screening is a hierarchical, although flexible, procedure. If it errs, it should err toward the false positive. The idea is to rule out people without problems, and raise the index of suspicion regarding others. A positive screening, at any point in the process, is a trigger for a more formal and thorough AOD use assessment.

Those involved in the screening process can include police officers, city and county jail employees, defenders, probation officers, magistrates, prosecutors, hearing officers, and counselors. Screening can be conducted in the lockup, the probation office, the prosecutor's office; the detective's interviewing room, the arraignment or hearing officer's courtroom or chambers, and the jail or prison orientation room.

It is the function of criminal justice system officers, at the points of the process, to pass on information they have obtained from the AOD screening procedure. Although screening does not have to involve much paperwork, information should be documented in written form in a case file, even if a client does not go on to criminal prosecution, so that it can be acted upon in cases of subsequent arrest. It helps if a standardized format is used so that it will be understandable to people in justice and treatment who refer to it in the future.

If a client acknowledges having an AOD problem and recognizes the extent of the problem, much has been accomplished—for this represents the end of the screening, a signal to initiate further AOD assessment. If he or she denies AOD involvement, the screener should look for evidence in major life areas, including;

- Relationship of the current charge to AOD use
- Recent or current AOD use
- Past treatment history
- Health problems (including the presence of HIV infection, TB, hepatitis B)
- Criminal justice system history
- History or evidence of mental illness
- Results of urine, breath, or blood testing
- Problems with family, social integration, employment, housing, or financial instability, or homelessness

Training the Screener

Screening can be done with a minimum of special training by almost any criminal justice official. Screening education strategies can vary based on the need and/or point in the system. The orientation to the process can be included in routine training and ongoing staff development. This orientation should be done systemwide, so that everyone from the arresting officer to the judge knows the importance of screening and the screening decision, and what screening decisions mean. Screening should be a fairly "seamless" process. That is, screeners should be fully integrated in the process. In fact, to a large extent, the degree to which screening is integrated with other processing activities will determine its success in the criminal justice system.

Screening is possible at every contact point in the criminal justice system. Screening at an early point in the system does not preclude screening further down

the line. Screeners should understand that their own impressions may change, even in the short time in which they have contact with a client. Many abusers use more than one drug, and various effects and withdrawal symptoms may become evident at different times, causing a variety of unanticipated behaviors. Screeners should be trained to expect the unexpected. Offenders' behavior and motivation to admit to AOD abuse also fluctuates; consequently, screening at all points in the system is likely to identify potential candidates for assessment despite their earlier denial of use.

Screening Instruments

Screening instruments are the objective arm of the screening procedures, providing uniformity, quality control, and structure to the process. Some instruments may be more appropriate than others in certain settings. Among the more commonly used instruments are the CAGE questionnaire, the MAST, and the OPI.

The CAGE Questionnaire

The CAGE questionnaire is a simple but effective test designed to screen for alcohol abuse. It consists of four questions:

- Have you ever felt the need to Cut down on your drinking?
- Do you feel Annoyed by people complaining about your drinking?
- Do you ever feel Guilty about your drinking?
- Do you ever drink an Eye-opener in the morning to relieve the shakes?

Studies reveal that two "yes" answers to the CAGE questionnaire will correctly identify 75 percent of the alcoholics who respond to it and accurately eliminate 96 percent of nonalcoholics. Modifying the CAGE questionnaire for other drugs involves simply substituting "drug use" for "drinking" in the first three questions, and asking for the fourth question, "Do you use one drug to change the effects of another drug?" or "Do you ever use drugs first thing in the morning to 'take the edge off'?"

The Michigan Alcoholism Screening Test

The MAST is a frequently used test that is more detailed than the CAGE questionnaire. The MAST consists of 25 questions and can be used during longer interview or in holding and confinement situations. It is a commonly used indicator of alcoholism.

The Offender Profile Index

The OPI measures the client's drug use severity as well as his or her "stakes in conformity" within a variety of contexts: family support, education, and school involvement; work, home, and correctional history; psychological and treatment history; drug use severity; and HIV-risk behaviors. It can be administered in about 30 minutes by an experienced probation officer, counselor, or other trained clinician. It includes a straightforward grading guide to help interpret the seriousness of an AOD abuser's problem. A day of training is required to be able to administer it, and a training manual is available. The client's numerical score has a corresponding treatment recommendation.

Accuracy

Most substance abuse programs obviously would prefer a screening instrument that only identified offenders who had serious substance abuse problems. Unfortunately, most instruments have psychometric properties that produce either over-or under-identification of substance abuse problems. When an instrument over-identifies substance abuse, it is termed a *false positive*. This means the screening instrument has indicated that the offender has a problem when, in reality, the offender does not. When an instrument under-identifies substance abuse, it is termed a *false negative*. This means the screening instrument has indicated that the offender does not have a problem when the offender actually does.

For typical substance abuse programs, the preferred outcome is to err on the side of false positive and reduce false negatives because it is important that individuals with substance abuse problems not be missed in the screening process. Offenders who are over-identified can be eliminated from the program by the subsequent assessment process using more detailed diagnostic instruments.

The issue for agencies screening large numbers of offenders is one of consciously or unconsciously moving in the direction of *false negative*. Because of strained assessment and treatment resources, there is a greater advantage in screening instruments with false negative psychometric tendencies. In other words, it might be better to initially under-identify substance-abusing offenders and later conduct a document or criminal records check to see if a decision is warranted to override the initial screen. On the other hand, missing offenders with serious substance abuse problems would seem to be counter to the mission of the treatment programs and concerns for public safety. The challenge is to achieve a high level of screening accuracy.

Screening Protocol

A screening protocol is a set of procedures indicating the priorities for screening. This priority is determined by the agency or treatment program. The protocol specifies what is the most and least important characteristic of the offender

that needs to be screened in the screening process. This is a clinical or treatment decision. **Figure: 1** presents a hypothetical screening protocol. Any one or group of these screening considerations could lead to a designation of treatment being *contraindicated*. This does not mean that treatment will not, or would never, work with this individual. It means that treatment would not be recommended because of a high risk of program disruption or individual failure.

In criminal justice agencies, the two screenings of practical importance are intellectual functioning and psychopathy. In addition to psychopathy, a personality disorder, not being a treatable disorder, psychopaths or antisocial personality offenders can be very disruptive to a program. They tend to manipulate other offenders or the staff and run “con games” while in treatment.

Figure: 1
Hypothetical Screening Protocol

Does the offender have an existing alcohol or drug problem?

YES ↓ or NO ↓ Treatment Counterindicated

Does the offender have a clean history of violent offenses?

YES ↓ or NO ↓ Treatment Counterindicated

Does the offender have a clean history of serious medical problems?

YES ↓ or NO ↓ Treatment Counterindicated

Does the offender have a clean history of psychiatric problems, specifically psychopathy or antisocial personality?

YES ↓ or NO ↓ Treatment Counterindicated

Does the offender have a clean history of sexual, physical, or emotional abuse as a child?

YES ↓ or NO ↓ Treatment Counterindicated

Does the offender function in a normal range of intellectual ability? (Read?)

YES ↓ Treatment or NO ↓ Treatment Counterindicated

Intellectual functioning is critical because most treatment programs are based on the offender bringing to the treatment:

a. reasonable insight
b. normal reasoning ability
c. normal introspection
d. some degree of anxiety and discomfort over personal ineffectiveness
e. normal communication skills

Another way of explaining this screening dilemma is that our treatment options become very limited if the person being treated brings either diminished intellectual capacity or limited communication (speaking or reading) skills to a "talk therapy." Most of our treatment approaches are developed, normed, and applied to individuals with normal ranges of functioning.

Assessment

The goals of assessment are to gather information about the client and to describe how the treatment system can address his or her AOD-abuse problems and the impact these problems have on the client's life. The assessment process is descriptive as well as prescriptive. It identifies the client's individual strengths, weaknesses, and readiness for treatment, and recommends a level of services appropriate to address the client's problem and/or deficits.

Typically, an assessment is conducted in a 2- to 3- hour procedure, although this can vary. In most cases, assessment involves a combination of clinical interview, personal history taking, biological testing, and paper-and-pencil testing. Depending on the methods used, the assessment may require more than one session.

Assessment has a number of specific goals and purposes:

- To determine the extent and severity of the AOD abuse problem.
- To determine the client's level of maturation and readiness for treatment.
- To ascertain concomitant problems such as mental illness.
- To determine the type of intervention that will be necessary to address the problems.
- To evaluate the resources the client can muster to help solve the problem. Typical resources include family support, social support, educational and vocational attainment, and personal qualities such as motivation that the client brings to treatment.
- To engage the client in the treatment process.

Foundation of Assessment

The foundations of assessment are the principles of effective intervention with offenders. These principles are directly tied to the types of assessments, treatment planning, and treatment intensity and can be seen in **Figure: 2, page 35.**

The Risk Principle

The principle states:

A. The level of service provided the client (offender) should reflect the level of risk the client exhibits.

B. Higher levels of service or supervision should be for higher risk cases.

C. The most intensive treatment should be for higher risk cases.

D. Lower risk cases should be matched to minimal or less intensive treatment.

The Need Principle

The need principle states:

A. The targets of intervention should be matched with the criminogenic needs (characteristics) of the offender.

B. Criminogenic needs include antisocial attitudes, thinking errors, peer associations, chemical dependencies, self-control, and social skill deficiencies.

C. Non-criminogenic needs include self-esteem, anxiety, and depression.

D. Criminogenic include all factors that, if changed, reduce the chances of recidivism or relapse.

The Responsively Principle

The responsivity principle states:

A. The learning style, personality, and cultural characteristics should be matched to the treatment approach.

B. The characteristics of the offender should be matched with those of the treatment provider.

C. The skills of the treatment provider should be matched to the type of program.

D. The offender should learn new pro-social skills.

E. The primary factors of responsivity are motivation for and resistance to treatment.

The determination of the level of functioning related to these three principles is accomplished through a thorough and accurate assessment.

Who Does the Assessment?

Assessment can be done by an independent assessment group (such as a systemwide central intake unit or an independent Treatment Alternatives to Street Crime program) or by the same professionals who will be providing treatment if it is determined that the type of intervention they provide is appropriate for the particular client.

The assessor should be a qualified human service professional with demonstrated competence in AOD programs, such as an addiction counselor, a licensed social worker, or other trained clinician. A credentialed and/or certified alcoholism, substance abuse, or chemical dependency counselor should be available.

It is desirable that each individual assessor work in a licensed or certified setting to ensure that there are adequate resources and a multidisciplinary approach, to take advantage of the collective wisdom of the agency. Ongoing training and supervision are critical to ensure the skill level and accountability of the service providers.

In any case, the person doing the assessment should have the technical training to conduct assessments and interpret the results. This training would include the understanding of the properties of assessment instruments discussed in the next section of this course.

Components of Assessment

The assessment process should include a broad variety of components that will yield an evaluation of the client that is as comprehensive and holistic as possible. The assessment should provide the information required to recommend the most appropriate course of treatment. Areas that should be investigated in the assessment include:

- Archival data on the client, including—but not limited to—prior arrests and contacts with the criminal justice system, as well as previous assessments and treatment records

- Patterns of AOD use (see below)
- Impact of AOD abuse on major life areas such as marriage, family, employment record, and self-concept
- Risk factors for continued AOD abuse, such as family history of AOD abuse and social problems
- Available health and medical findings, including emergency medical needs
- Psychological test findings
- Educational and vocational background
- Suicide, health, or other crisis risk appraisal
- Client motivation and readiness for treatment
- Client attitudes and behavior during assessment. As this listing of professional accepted data and criteria suggests, the assessment process must be driven by specific data and criteria. For example, in considering the patterns of AOD use, the assessor should determine the presence or absence of such signs and symptoms as:
- Tolerance (High tolerance suggests that a client has a history of heavy drinking or drug use.)
- History of physical withdrawal symptoms
- Episodes of uncontrolled drug or alcohol use, binges, or overdoses
- Use of AODs for “self-medication” of painful and unpleasant emotions
- Attempts to hide use
- Physical signs of drug use, such as needle track marks, emaciation, and alcohol odor
- Positive drug test results
- History of attempts to quit AOD use
- Family dysfunctioning relative to AOD abuse
- History and onset of drug use
- Drug use behavior (e.g., does client use drugs alone? For sex? To go to work?)
- Method of administration, including injection, snorting, smoking, or drinking.

Assessment Instruments

Assessment instruments are standardized tools that are productively used in tandem with the personal history data obtained by the clinician in formulating a clinical impression. Instruments provide another data source for the assessor to use in evaluating the client.

Instruments are an integral part of any assessment. Their results should be used in conjunction with good clinical judgment. There is no single litmus test applicable to all situations and all clients. It is recommended that practitioners review available instruments and then use, combine, and/or adapt them to suit their own assessment and planning needs.

Properties of Assessment Instruments

There are several properties of assessment instruments that individuals conducting assessment should take note of.

Administrator's Manual—all instruments should be accompanied by a manual that explains the administrative procedures, reliability, validity, and norms for the instrument.

Reliability—this property refers to the stability of the instrument form one time to another. This should be reported in the administrator's manual.

Validity—this property refers to the fidelity or trueness of the instrument. It provides an answer to the question of whether the instrument measures what it is designed to measure. For example, if the instrument is designed to measure risk of relapse, do people who score high on the instrument relapse at high rates? Validity information should be also reported in the administrator's manual.

Norms—this property refers to the group of individuals that the instrument has been developed on. Norms are the reference group for the instrument. Some questions that are important in selecting an instrument are:

1. Is the instrument normed on both male and female substance abusers?
2. Is the instrument normed on juvenile or adult substance abusers?
3. Is the instrument normed for free world substance abusers?
4. Is the instrument culture sensitive or is it normed on white males?
5. What is the assumed reading level for the items on the instrument?
6. Is the instrument designed for individual or group administration?
7. Is the instrument normed on voluntary or involuntary substance abusers?
8. Does the instrument have a "fake good," "fake bad," or social desirability element built into the instrument?

The final property of assessment instruments is *control*. Assessment instruments are usually divided as to whether they are *proprietary* or *public domain*. If they are proprietary, they usually require a fee for their use and/or scoring. Other instruments are in the public domain and do not require a fee, but they may be copyrighted.

The following instruments, while they may have some limitations, can provide useful and valuable information.

The Addiction Severity Index

The Addiction Severity Index (ASI) is perhaps the most widely used assessment instrument. It can be administered in about 60 minutes by a trained counselor. The premise of the ASI is that addiction must be evaluated within the

context of problems that may have contributed to or resulted from AOD use. It collects data to estimate the client's level of discomfort in eight areas: alcohol use, medical condition, drug use, employment, financial support, illegal activity, family and social relations, and psychiatric problems. It incorporates both the client's and the assessor's assessment of his or her needs and priorities.

The Wisconsin Uniform Substance Abuse Screening Battery

This battery combines identification, classification, and treatment assessment instruments with personality profiles and measurements of specific offender needs. It is composed of four instruments: The Alcohol Dependence Scale, the Offender Drug Use History, the Client Management Classification interview, and the Megargee offender typology derived from the Minnesota Multiphasic Personality inventory (MMPI). The battery provides sound data that can move with the offender through the entire correctional system. It determines not only treatment needs but also the need for specific programs. Two weakness of the battery are that the MMPI is an expensive tool and the Alcohol Dependence Scale is copyrighted, requiring a fee for its use. Another alcohol component can be substituted in place of the alcohol component in the instrument.

It is important that the student in this course be aware that there are dozens of assessment instruments used in the field. The discussion of all of these instruments would be beyond the scope of the course. It is recommended, therefore, that interested students:

a. Start a file on assessment instruments.
b. Read a variety of administrator's manuals.
c. Search both public and private sources for instruments to assess substance abuse. The source for many instruments can be accessed on the internet.

The Aids Initial Assessment Jail/Prison Supplement

This tool was developed by researchers at the Comprehensive Drug Research Center at the University of Miami School of Medicine as part of the National AIDS Demonstration Research Program of the National Institute on Drug Abuse. Primarily focused on assessing HIV risk, it also measures criminal history, legal history, injection drug use, needle use and sharing during incarceration and sexual activity during incarceration. It is best used in conjunction with other assessment tools.

Biological Testing

Biological tests can be valuable instruments to determine AOD use, especially when such use is denied by the client. Urinalysis, breathalyzer tests, blood tests, and all other available physical test should be considered when AOD

use is not self-reported. Such tests can be used when a client acknowledges AOD use but may be unclear about exactly what drug or drugs have been used.

Therefore, if at all possible, self-reports should be corroborated with biological testing. Given the reemergence of TB in many correctional populations, it is important that testing be done. The presence of TB, furthermore, is often an indicator for HIV infection. The cost and timeliness associated with biological testing must be factored into decisions regarding the use of the test.

Presentation of Findings

The results of the assessment process should be presented in a valid, reliable, and clinically useful document, one that clearly makes its point, can be replicated, and contains data that will be relevant in treatment. A good assessment avoids simplistic formulations that reduce a client to a number, a source, a check list, or a simplistic label.

The presentation of data backing up the assessment should be offered in language that is sufficiently jargon-free to be understood by all relevant personnel, including the client, with only minimal interpretation. Acronyms and abbreviations should be explained when used. In most jurisdictions, the client is entitled to access his or her record, and the client and his or her attorney should be able to read and understand it.

The screening and assessment instruments provide data on each area surveyed. These data, along with the more extensive history form the clinical interview; need to be fused into a narrative document. Any summary assessment needs to relate to its supporting data and show how the data were collected and interpreted. For the purpose of a court, many judges are comfortable with just a summary paragraph of assessment and do not want to be inundated with extra information. But even in a condensed report, there should be at least three definable, well-organized sections:

- An introduction, explaining how this assessment came to be, who ordered it, and why.
- A section on methodology, explaining how the data were collected, what tests were used, and how the results were interpreted.
- A straightforward presentation of the data, relating to various content areas suggested above (see Components of Assessment) without interpretation, followed by a clinical impression and recommendations. This is essentially a strategic management plan. It should include recommendations for additional referrals or assessment, when necessary.

The narrative document should include a defensible paragraph or two explaining how and why the assessor has reached his or her conclusions. For

example, writing only that "Mr. Jones is an alcohol abuser" is insufficient. A more useful rationale for the conclusions reached might be:

> *We met with Mr. Jones and determined, based on his life circumstances and personal observations, that he is having trouble with alcohol. His third marriage is ending, and he cannot keep a job more than 9 months. He misses work because of his drinking. He came to his interview smelling of alcohol. The test results confirmed the initial impressions. We believe he definitely has an alcohol problem, and appropriate treatment should be provided.*

A client may refuse to cooperate with the assessment process, refuse to provide information that is intentionally or internally inconsistent and contradictory. That might result in a "cannot assess" report. But there may be other, more hidden problems than simple recalcitrance. The client may not know or may be unable to relate the answers to the questions that he or she is being asked. Recognition of this may trigger a need for further assessment to ascertain if mental illness, brain damage, or other organic indicators might explain the clinical picture. Assessors should realize that getting to the bottom of this client's problem may be more than their program can handle, that they may be dealing with another condition in addition to an AOD problem, and that a more sophisticated neuropsychiatric work-up is needed.

Confidentiality and Client Consent

The results of the assessment can be useful to a number of different individuals and agencies. However, in many cases, results cannot be presented to anyone—including the judge or referring criminal justice representative—without the signed consent of the client, in accordance with Federal confidentiality regulations. Once a client is asked to sign a release, he or she should know the precise reason for the release and understand what is covered in it.

The client is also entitled to know what recommendations are made in the assessment report. It is important that the judge know if the client does not agree with the determinations and recommendations of the assessment. In most States, clients are entitled to a second opinion, although they usually have to pay for it themselves.

Quality Assurance and Improvement

Quality assurance and improvement are important in any treatment systems. Quality assurance is defined by the Joint Commission on Accreditation of Healthcare Organizations as the ongoing activities designed to objectively and systematically

evaluate the quality of client care and services, pursue opportunities to improve the quality of client care and services, and resolve identified problems.

There are two types of quality improvement: internal and external. Both are recommended. External review tends to be a one-time or intermittent evaluation, while internal review should be an ongoing process, with each review providing a foundation for subsequent reviews. In external quality assurance, an outside source, such as an independent contractor or a State licensing agency, conducts the evaluation. It is recommended that external reviews be conducted on a yearly basis to ensure the integrity of the process.

Internal review is done by both peer and supervisory personnel and can be a relatively quick and informal process designed to weed out flagrant problems. A more formal internal review is a self-study that should be done routinely as required by State or local regulations and should include an audit and a survey of assessments to see if any patterns are suggested. This survey can be used to set certain goals for the agency; for example, when one instrument shows up repeatedly in assessments, all staff members should be taught to understand the instrument.

Readiness for Treatment

A client is ready for treatment when he or she perceives and accepts the need for treatment in order to achieve personal change. Readiness for treatment has to do with a client's insight into his or her own condition, willingness to effect change, and the appreciation that prior attempts at effecting change have not yielded desirable results, at least not consistently.

Readiness can be prompted in two ways: by circumstances or extrinsic pressures such as loss (of job, family support, money, etc.) or fear (of incarceration, violence, health risks including overdose, or even suicide). Intrinsic pressures or motivation bring a client closer to readiness. These pressures include guilt, self-hatred, and despair; weariness with the drug-related lifestyle; and a feeling that life can be better. Note that simply acknowledging the need for personal change does not necessarily imply readiness for treatment. Rather, people with AOD problems may seek treatment alternatives, such as self-change; getting help through friends, relationships, religion, and employment; or geographic relocation as a way to stop AOD use.

Readiness can be measured both by subjective impression and objective quantification. One scale measures readiness for treatment (and other factors) on a 1-to-5 scale, asking for responses to statements like, "I am sure that I would go to jail if I don't come to treatment," "I am worried that my spouse will leave me if I don't come to treatment," and "I feel that my AOD use is a very serious problem in my life"

Increasing someone's readiness for treatment begins with the assessment process, during which the assessor should not just record information, but also feed

back impressions to the client. For example, "You say you don't have a drinking problem. Well, how about those five marriages? How about the fact that you're on probation for your third DUI? Don't you think any of this indicates a drinking problem?'

Among clients mandated to treatment from the criminal justice system, it is unusual for a client to be genuinely enthusiastic about entering treatment. Most clients are not ready, and do not like it. Usually, though, they see treatment as a more attractive alternative than incarceration. This is not necessarily totally negative. Research data have suggested that coerced treatment can be as effective as voluntary treatment, if not more so. In the language used by Alcoholics Anonymous, "Bring the body, and the mind will follow." Indeed, one of the typical traits of the AOD abuser is denial, the inability or unwillingness to recognize the significance of a problem. Only after a client is in treatment can the subject of denial receive the direct and systematic attention it requires. Excluding people from treatment merely because of a lack of readiness, based on denial, would mean that the treatment process would never begin for many. It is essential to link clients who exhibit denial to the most appropriate program that will address the denial problem. Indeed, addressing denial is an integral aspect of treatment.

Not all clients, of course, are reluctant to enter treatment. Many men and women view treatment as an alternative to incarceration, job loss, or losing custody of their dependent children.

Clients are less likely to drop out of treatment if they understand the treatment process and if they've been prepared for assuming the role of patient. A strong incentive to keep clients in treatment is the knowledge that they will benefit from the treatment, not only for AOD abuse, but also for other problems and issues in their lives.

Consequently, a pretreatment orientation program is an absolute necessity for working with resistant offenders. Some of the components of a pretreatment orientation program are:

1. An explanation of how treatment works and how it can be successful.
2. An explanation of the cultural convergences with treatment.
3. Testimonies by successful program graduates who can serve as models for the program goals and objectives.
4. An overview of confidentiality and informed consent issues.

Assessing Readiness

Research indicates that readiness for treatment is strongly associated with an individual's perception of needing assistance in the process of personal change, compared to alternative options. Retention in treatment may be related to an individual's understanding of treatment options.

The task of assessing individuals' readiness for treatment is related to their perceptions of the severity of their AOD abuse problems; their understanding of what treatment options are available, compared to the alternatives; the extent of their ambivalence about a need for personal change; and, in the case of a non-voluntary participant, what measures can be employed to create a motivational crisis that makes them amenable to treatment.

Several intriguing assessment instruments are available for use in substance abuse programs to determine the offender's readiness, suitability, and amenability for treatment. Two of these are:

URICA. An offender is ready for treatment when the offender perceives and accepts that he or she is the problem and "owns" the problem. In coerced treatment settings, readiness traditionally has been a challenge for assessment personnel.

Assessing readiness for treatment has been conceptualized as following several distinct stages of change that offenders may move through as they experience ambivalence about changing their addictive lifestyle. The issue of valuable treatment resources makes the assessment of readiness a primary focus of a comprehensive assessment process.

In order to measure treatment readiness, the University of Rhode Island Change Assessment scale (URICA), has been experimentally tested with offender populations. This is a self-report, paper-and-pencil questionnaire that classifies an offender on one of the five sequential stages of change: pre-contemplation, contemplation, preparation, action, and maintenance. An important implication of the model, with its discrimination of different stages of change, is that a counselor should engage in a different set of counseling procedures depending on the readiness for change of the client. The URICA shows promise in assessing offenders in their motivation for change so that those in the pre-contemplative stage, at least, can be matched to a different program for treatment, such as AOD education programs.

CTRS. Traditionally, offenders have reported low readiness for treatment. This result has been attributed to minimalization, denial, and resistance. In the latter case, offenders who are resistant to treatment, who are identified as such, may well require pre-treatment intervention in order for the overall treatment program to be comprehensive and effective. We are not sure why offenders are resistant to treatment, but the question is certainly an important one.

An experimental attempt to identify offenders' resistance to treatment, and answer why they are resistant, is represented by the Correctional Treatment Resistance Scale (CTRS). The CTRS measures an offender's response to three factors:

1. Cynicism. This component of CTRS seems to be measuring denial of any need for counseling. The strongest item on this scale is the item which indicated that the subject thought that prison counseling was "useless bull sessions."

2. Distrust. This component measures distrust of counselors and a reluctance to share personal problems with a counselor. This component also measures the desire for isolation and low self-disclosure.

3. Cultural Issues. This component of the CTRS measures cultural issues in treatment resistance. A strong score on this component means that the offender is resistant to treatment because counseling is not the way personal problems are solved "where they come from." This component has the strongest validity based on research with the

CTRS.

The CTRS has shown strong promise in assessing resistance to treatment in offender populations. Initial reliability and validity results are strong. Finally, CTRS can be adapted for use with institutional or community corrections populations.

Conclusions

Screening and assessment is the beginning of the substance abuse treatment process. Improper assessment and faulty diagnosis can lead counselors to create ineffective treatment plans, have inappropriate expectations for therapy, and instill the overall sense of frustration in the client and the therapist. One cannot treat what one does not recognize or understand.

The large number of offenders entering the system, maintaining adequately trained substance abuse treatment personnel, and the cost and accuracy of screening have become major challenges. In addition, recent research has indicated the need for screening for psychopathy, criminal attitudes, and value systems. Several intriguing assessments, such as change readiness and treatment resistance, are currently being tested in substance abuse programs.

By identifying these issues and challenges, the critical elements of treatment can move forward so that 1) appropriate offender-treatment matching is possible and; 2) scarce treatment resources can be used wisely by conducting careful assessments before designing and implementing treatment plans. With the large number of offenders entering the system, accurate screening and assessment increase cost effectiveness. In addition, offenders need an accurate picture of their substance use or abuse and how the behaviors relate to offense patterns. Specifically, the feedback of screening and assessment information can give the offender a more realistic estimation of the challenge and effort required to overcome addictions.

Finally, screening and assessing someone as drug or alcohol dependent can bring about serious consequences for that individual. When the screening and assessment is based on instruments that are self-report or brief interviews, the consequences can be devastating. As a result of this rather inexact science, substance abuse counselors ethically are obligated to exercise caution and be professionally certain about the critical issues in screening and assessment when using instruments that are designed to distinguish between those people whose use of substances raises the probability of criminal behavior and those whose substance use does not.

Treating "Unready" Clients

AOD-involved offenders may be referred to a program for assessment and/or treatment as a result of a court order or another compulsory effort requiring compliance. Often their motivation for change does not correspond to their desire to comply with these compulsory measures in order to avoid negative consequences. As noted earlier, research has demonstrated that coerced treatment is at least as effective as voluntary treatment, suggesting the importance of connecting even non-motivated AOD-involved offenders with assessment and treatment resources.

Most AOD abusers experience a stage of ambivalence about changing their destructive patterns of behavior. An increased awareness of the impact of destructive behavior on every aspect of an individual's life is required to shift ambivalence toward an acceptance of responsibility for behavior change. Programs that employ the results of a comprehensive assessment to inform the AOD user set the stage for promoting treatment readiness. The resultant shift of perception, coupled with the motivational crises created by coercion into treatment, leads the way for further efforts toward motivation and eventual retention in the process of treatment and recovery.

The previous discussion notes the common reality for AOD abuse treatment—most recipients of services are not voluntary participants. For years, treatment professionals and paraprofessionals believed that a person needs to "hit bottom" in order 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 aren't completely ready for treatment. One of the major constructs currently recognized for understanding the process of addiction and recovery is the Developmental Model of Recovery. According to this model, several tasks are involved in working through the ambivalence associated with the first stage in the process of recovery. This is the Transitional Stage. Developing motivating problems, which refer to behaviors resulting in "hitting bottom," and accepting the need for abstinence and help, are a few of these tasks. Clinicians can identify an individual's position along the process

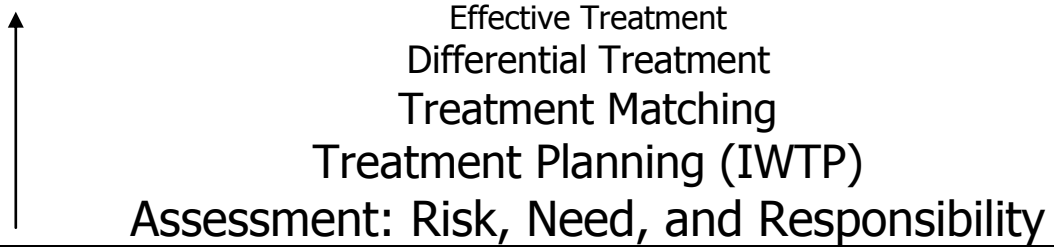
of recovery by assessing which stage-specific tasks must be resolved. The primary focus of the transitional stage is recognizing the addiction and developing the motivation to become abstinent.

Generally, a client can be considered "ready" for treatment when he or she wants to be, sees AOD abuse treatment as a way to become drug or alcohol free, and recognizes that he or she cannot do it alone without professional assistance. But readiness is not often so clear-cut. In reality, readiness for treatment is a question of degree, not absolutes. Even more important than readiness are linking clients with the appropriate level of service, and using inducements and the leverage of the criminal justice system to maintain them in treatment, with the expectation that their own changing perceptions will soon keep them in treatment of their own volition.

Assessment, Treatment Planning, Program Design and Treatment Progress Assessment.

Assessment serves as the foundation for effective treatment planning. A graphic example of this importance can be seen in **Figure 2**. In addition, assessment allows for treatment matching and a differential program design.

Figure 2: Assessment: The Foundation for Effective Treatment



Program Design

In substance abuse treatment programs, there have traditionally been two program designs, *a phase* design and a *track* design. By far, the phase design is the most commonly used. These two designs can be seen in **Figures 3 and 4.**

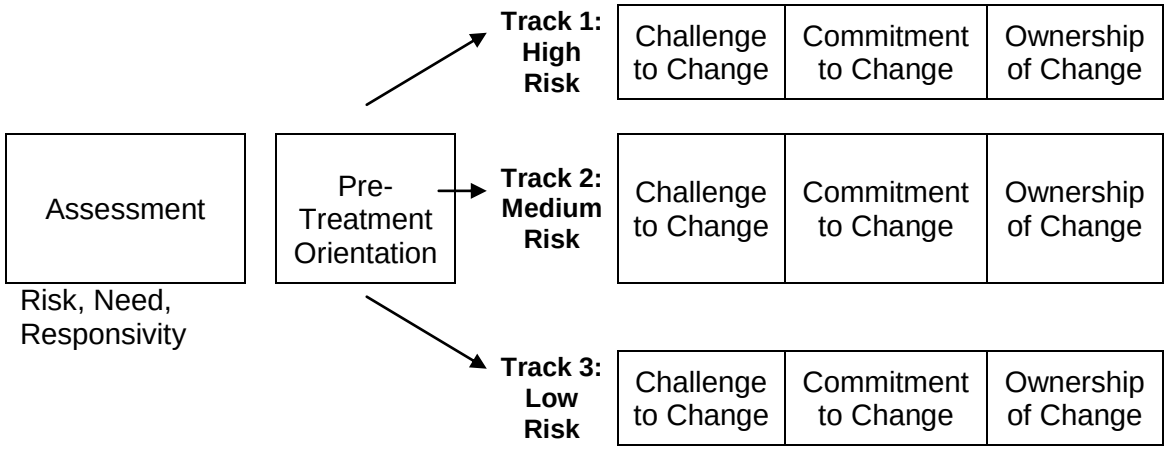
A phase design can be described as homogenous, one-size-fits-all, and one-dimensional. The assumption in a phase design is that all participants enter with common risk, need, and responsivity characteristics. There is no treatment matching in a phase design and not much need for an assessment, even though assessments are frequently conducted. The assessment becomes rather meaningless if all participants are going to receive the same treatment. Assessments can be made to determine progress through the phases.

A track design is based on assessments and treatment matching. A track design assumes a heterogeneous treatment group who possesses different risk, need, and responsivity characteristics. Offenders are matched to a specific program track and treatment providers. Assessment is the foundation for making critical clinical decisions in the track on differential program design.

Figure 3: Homogenous Treatment Program (Phase) Design (One size fits all)

Assessment	_____	Phase One Orientation	_____	Phase Two Treatment	_____	Phase Three Re-entry and Aftercare

Figure 4: Heterogeneous Treatment Program (Track) Design



The Treatment Plan

The treatment plan is the overall management strategy for treating people with alcohol and other drug (AOD) problems. Ideally, the plan incorporates, to some extent, the World Health Organization's five dimensions of health: physical, social, mental, spiritual, and intellectual.

Treatment planning should develop from the assessment process and embrace the importance of appropriate client-treatment matching. Matching clients to treatment can be difficult in small communities with limited resources or even in larger communities where funding is an issue. But matching a client with the first empty slot is generally not the best way to meet his or her needs—or the community's needs.

The difficulty of addressing these needs is underscored by the debilitated nature of many AOD clients in the criminal justice system. Many have never had a stable home, are functionally illiterate, and have had few employment experiences. An AOD-abusing client may come from a family with generations of AOD abusers. The treatment plan must address not only the need for rehabilitation, but also for "habilitation." Rehabilitation emphasizes the return to a way of life previously known and forgotten or rejected; habilitation is the client's *initial* socialization into a productive and responsible way of life.

The treatment plan is based on each client's identified needs, problems, and resources. It seeks to match the client with what the assessment process has identified as the best level and modality of intervention. The good treatment plan is a comprehensive set of tools and strategies that address problems and deficits. It presents an approach for sequencing resources and activities, and identifies benchmarks of progress to guide evaluation.

Components of the Treatment Plan

Two key concepts guide the development of every treatment plan for every client:

- The plan should be individualized.
- The plan should be participatory.

The counselor does not devise the treatment plan for the client. Instead, the counselor's values should not be superimposed on the process. The client should have part ownership of the treatment plan, and she or he should be able to honestly look at the plan as a shared effort to work toward a common goal, not as something imposed from without. Other professionals from the treatment agency may also have input into the plan. Ideally, the final version of the plan will include the

collective wisdom of the agency staff and contributions from referring and supervising criminal justice personnel, as well as from the counselor and client.

Treatment Planning Goals and Objectives

The treatment plan should have clearly stated goals and objectives. Goals should be realistic end points. There should not be too many goals, and goal-setting should be ongoing. An unnecessarily ambitious treatment plan is nearly as likely to fail as an inadequate one.

Goals should be specific, measurable, and quantitative. For example, the goal of "having a better life" is inadequate. Rather, a goal should be specific: "find an apartment to live in," "Get back with my wife," "Stay away from my dealer friends," or "Exercise four times a week." The treatment plan should help the client establish a positive sense of self and self-esteem. Abstinence-based therapeutic goals are customary in most AOD treatment programming today (except in methadone maintenance programs), but the treatment plan should have some flexibility to accommodate some relapses or slips during treatment. It can be therapeutic to set realistic early goals, such as, "Fewer dirty urines a month, for the next 3 months." For some clients, merely getting to an appointment sober is the most realistic goal that can be set.

However, goals must conform to limitations imposed by the court, by the parole or probation department, or by any other criminal justice agency with jurisdiction over the client. The client participates in the process of setting goals, but does not dictate them. For example, if the halfway house that the client is living in requires proof that he or she is drug-free, then abstinence must be an immediate goal. However, it is important that criminal justice officials understand the incremental nature of change and the necessity of individualized objectives for the AOD-abusing offender.

Incorporated into these goals and objectives should be examples for the client regarding the handling of life and relationships without AOD in a variety of arenas, including friends, fun, family, sex, employment, and problem-solving. The client must be shown illustrations of successful living, especially positive examples in his or her own life, if any are identifiable.

Therapeutic goals must translate to behavioral indicators. Measures of improvement to be considered include changes in appearance, making different friends, and abstinence from or cutbacks in AOD use. Goals and objectives can also encompass elements that address the client's spiritual and social life. Examples that can be considered include attending Alcoholics Anonymous, Narcotics Anonymous, other self-help groups, or church; having healthy friends; or taking part in activities, hobbies, or volunteer service.

Treatment Flexibility

The treatment plan must be custom-tailored to the client, as much as resources and time will allow. A good plan is organic, dynamic, evolving, and flexible. Events occur over time that necessitate altering goals and objectives. A good plan is designed to address three types of potential problems:

- Attrition
- Noncompliance
- Inadequate Progress

Mechanisms should be built in to handle these problems. For example, noncompliant clients could be required to report back to the supervisory criminal justice authority, experience some kind of sanctions, be reevaluated and referred to more appropriate services, or be terminated from the treatment program. In some cases, flexibility must work the other way. Sometimes the client responds so well that treatment can be accelerated or streamlined. This can lead to reduced supervision from criminal justice agencies.

It is important to note here that not all treatment failures or examples of inadequate progress are the responsibility of the client. In some cases, inadequate assessment, poor planning, or inappropriate services may be the primary cause. Therefore, each client failure should provide the program with an opportunity to evaluate itself and its services, in order to identify areas for improvement.

Client Accountability

Just as clients must be allowed to help design the treatment plan, so must they be responsible to it and accountable to its rules. Clients must know what the results of noncompliance and poor progress are and must understand the penalties for breaking rules that are intended to guide behavior. Clients must understand that treatment programs have certain unbreakable rules (for example, no violence or intimidation), and that penalties for breaking rules can include dismissal from the program, return to court, and incarceration.

These penalties should be specifically spelled out, so there is no room for rationalizations later. There should be no doubt in the client's mind regarding the consequences of specific misbehavior. Accountability also includes objective measures and monitoring as a basis for measuring the client's progress and determining the need for reassessment.

Who is on the Treatment Team?

The answer to this question depends on the jurisdiction and the resources available to the system. Ideally, a treatment team should consist of whatever

specialists are necessary to address the client's problems and deficits. These may include a drug and alcohol counselor, a clinical director, a licensed social worker, a case manager, and whatever medically trained personnel are necessary to address acute or chronic illnesses that have been diagnosed at assessment. A registered nurse is a valuable member of a good treatment team.

Short of this ideal, at minimum the team needs a case manager and counselor who are certified and experienced in providing AOD treatment. The criminal justice system should be represented on the team. Members of the treatment team need to be culturally and ethnically sensitive, and some of them should be members of the same group as the client being treated. There should be no linguistic barriers.

Potential Conflicts between Treatment and Criminal Justice

There is the potential for conflict between treatment and criminal justice agencies. This conflict can be anticipated and avoided, to a certain extent, if certain points are made clear from the beginning of the treatment planning process. Criminal justice officials need to understand that the treatment system does not coddle the client and that the goals of treatment are consistent with the aim of getting the client out of the criminal justice system. Treatment providers need to understand the legal obligations of criminal justice personnel—to ensure public safety and to protect the rights of the offender.

It is best to spell out these points in a memorandum of understanding (MOU) between the two agencies. This is a formal agreement between two parties that specifies expectations, roles, communication procedures, decision-making processes, and action steps to be taken in response to clearly delineated unacceptable behavior. The MOU should list specific actions of the client that can result in dismissal from the treatment program or a change in supervisory status. It should spell out expectations, definition of terms, methods of communication, deliverables, roles, grievance procedures, and crises management. The MOU can also answer the following questions:

- How often should details of treatment be communicated to the criminal justice system?
- What access to treatment and assessment records should the probation or other criminal justice officer have, and to what level?
- How is client confidentiality to be respected?
- Which members of the treatment team are to have contact with the criminal justice system?
- What sanction mechanisms begin on the criminal justice side in the case of noncompliance and relapses?

The client should be also aware of the details of the MOU so that the consequence of relapse or noncompliance does not come as a surprise. And, in a similar vein, criminal justice officials must understand that the treatment process is not a linear function to be interrupted or declared a failure by a single relapse. Rather, it can be viewed as a graph to be plotted over time; success occurs over an overall upward slope, regardless of sporadic, non-critical dips.

Assessment of Treatment Progress

The process of assessment does not end once a client has been classified, assessed, and assigned to a treatment program. Assessment is part of the ongoing treatment process, an essential tool that can determine:

- The value of the course of treatment chosen
- How that course should be adjusted
- How realistic are the goals that have been set
- What linkages need to be made to obtain services for the client from other agencies
- When maximum benefit of the intervention has been achieved
- The plan for further intervention.

The purpose of assessment during the treatment process is to determine how effective the treatment has been up to the assessment point, what kind of progress the client is making, the appropriateness of the present treatment, and what the next level of treatment should be. Assessment in the course of treatment is a dynamic, longitudinal process, not a single event. It is an objective, quantifiable measure of the progress achieved by the client and the treatment program.

Ongoing assessment of treatment progress using standardized criteria is a cost-effective procedure, revealing early in the treatment process such problems as inappropriate referral, misdirected treatment, or unrealistic goals.

SUDS

One of the challenges for treatment providers is to measure treatment progress by changes in subjective internal states. These subjective internal states can be quite elusive and difficult to objectify. A technique for getting specific information about emotions is to quantify the emotional intensity. This can be done by creating a hierarchy of emotional intensity for the client when a particular emotion is being assessed. The resulting behavior could be a manifestation of the emotion which is serious or critical (relapse/recidivism). This assessment can be done by scaling the emotion and identifying *subjective units of discomfort*, frequently referred to a SUDs.

First, an imaginary hierarchy is created, with the emotion in question, ranging from the most intense experience to the least intense. A hierarchy with a ten-point range (0-10) would be appropriate for clients with limited levels of abstract visualization. For other clients, a scale between 0 and 100 is appropriate. In either case, 0 represents the lowest level of emotional intensity and 10 or 100 represents the highest level.

Second, the client is asked to choose a number that represents the current emotional state on the scale. Third, once the number has been selected, the counselor can then have the interviewee speculate on what the emotional intensity is likely to lead to or how the intensity has changed in relation to program progress.

Finally, the most often used assessment of emotional states and program progress has been with *cravings* for alcohol or drugs. But, other emotional states critical for program progress can also be assessed using SUDs.

Some of these are:

- Anxiety
- Stress
- Depression
- Anger
- Desperation
- Fear

The use of SUDs can assist in determining ongoing program success or progress, particularly when progress is based on reduction of cravings, urges, triggers, fantasies, or other intense emotional states.

How This Differs From Other Assessments

Progress assessment is a clinical management tool focusing on the client already in treatment. In contrast to an intake assessment, which establishes a baseline for the client, progress assessment measures the client's response to the treatment that has been provided. It also measures change and degree of change, if any. This change may be either positive or negative. It is important that progress assessment be compatible with intake assessment, so that the treatment team will have a consistent continuum to use as a guide in considering a client's progress.

Goals set for progress assessments must be realistic, individualized, and determined through a participatory progress that includes the client. As part of the assessment process, it should be made clear to the client and the criminal justice system that treatment is not punishment. This can be a very difficult concept for mandated clients to understand, particularly those who see themselves as controlled by the criminal justice system, often with treatment linked to their sentences. It is necessary to emphasize that treatment is not punishment, so that clients do not feel that "doing time" is all that is required of them in treatment. It is unlikely that a client with this attitude will be a participatory member of the process and reach the goals that have been set.

Who Does Treatment Progress Assessments?

The assessment of treatment progress should be routinely performed by a clinician and the treatment team. It is important that the treatment team be equipped to handle linguistic and cultural diversity, as well as gender issues.

If security needs are an issue, a representative of the criminal justice system should inform the treatment team regarding matters of security. Criminal justice requirements must be considered, but they should not dictate the treatment agenda. This is discussed in more detail later in this chapter.

How Often Should Assessments Be Conducted?

According to some involved in the treatment process, the answer to this question is, "As often as you can afford to." There are no set standards for the frequency of treatment progress assessments, and frequency is often dependent on financial resources and the availability of technical support. Different instruments also specify differing time periods between progress assessments. Different types of interventions—long-term, short-term, residential, or outpatient—may be needed at differing intervals.

The frequency of treatment progress assessment should be agreed upon by the client and the clinician at the beginning of treatment and adjusted, if necessary, as treatment continues. State licensing requirements often mandate treatment planning reviews at specific intervals. Thus, the treatment program may not have a choice regarding the frequency of assessment. Assessment can be part of the ongoing treatment plan.

Specific Assessment Instruments

The assessment instrument is a tool used to quantitatively measure progress. There is a need for valid, reliable, and widely recognized tools, and they must be

standardized, understandable by both the AOD and the criminal justice systems, and culturally sensitive and appropriate. Whatever tool is used should be repeated to foster consistent measurement and reliability of data.

The most objective tools for measuring progress are urine and blood tests for the presence of AODs. These tests can be used beyond their obvious pass/fail connotations as therapeutic tools to measure progress. For example, treatment might be divided into three phases, with a goal of "clean urine 50 percent of the time in Phase 1, 75 percent of the time in Phase 2, and 100 percent of the time in Phase 3. Another important consideration with respect to urine testing is the context within which it is done. A positive urine test from a client who has just begun treatment in a maximum security institution has considerably different implications than a test from someone who has received extensive treatment and is currently in a community-based residential program. Urine testing should not be employed independently as a measure of progress but, rather, used only in conjunction with other measures of progress.

There is disagreement within the treatment community regarding how standardized and objective assessment instruments should be used. On the one hand, standardized, quantitative methods of measurement provide clear and easily accessible documentation of progress in treatment. But many treatment personnel resist what they see as the "robotization" of assessment and prefer assessments that are subjective and individualized. There are few assessment instruments designed specifically for measuring progress in AOD abuse treatment programs for a population referred from the criminal justice system. However, a number of existing instruments, such as the Addiction Severity Index, can be adapted for this purpose.

Criteria for Measuring Treatment Programs

The treatment plan, developed as an important component of the clinical assessment, is reviewed, assessed, updated, and revised throughout the course of treatment. Ideally, the plan is adapted as intermediate goals are met successfully. Then, at the end of a successful process, the treatment plan evolves into a discharge plan. All treatment plans should address specific substantive issues. Among these are:

- Employment, vocational, and educational needs
- Housing in an environment that is free from AODs
- Medical and psychological concerns
- Recovery support
- Self-esteem development
- Relapse prevention
- Stress management
- Self-help resources

- Abstinence or reduced AOD use.

Different issues will be addressed at different points of assessment, and individual issues should not be considered in isolation but, rather, in the context of the treatment process. For example, was the client successful in finding housing because of his or her own efforts, or because of the efforts of a counselor? The aim is not for the counselor to overly facilitate the solving of the client's problems. Rather, it is for the clients to make internal changes in the way they view the world and themselves. Internal changes in the way the clients view the world and themselves are desirable.

Sources of Information

Obtaining information to assess progress is a pragmatic procedure that is dependent on a number of sources. The most obvious, of course, is the client. What must be emphasized, however, is something that every treatment professional knows: Clients often tell us what they think we want to hear, and unintentionally deceive themselves. What the client says must be considered within this context and verified whenever possible. Verification is discussed in greater detail later in this document.

The assessor should try to remain current with events in the client's life: where he or she is living, with whom, etc. This information can be gathered either through interview or through a self-administered form, if the client has sufficient literacy. Beyond this basic biographical information, the assessor should try to get the client to describe what he or she has learned throughout the treatment process. For example, what has the client learned about addiction? It cannot be assumed that clients are learning merely because information has been provided to them.

Observation of the client's appearance is another way the assessor can gather information. If clients are unemployed and wearing expensive clothes and jewelry, their denial of drug dealing is suspect. This kind of sensibility and sensitivity can be applied by the clinician to a wide range of clients' behavioral cues.

The counselor should also elicit information about the impact of treatment. For example, has the client moved away from a previous circle of drug-using friends? Is the client consciously exercising impulse control when confronted by a situation that a few weeks ago would have triggered a dangerous rage? What does the client think about treatment? Is the client satisfied with his or her complaints? There are sure to be complaints and they should be noted and considered seriously.

The assessor can also gather information from family members and others close to the client. Input from these sources can corroborate information about the client's altitudinal and behavioral changes.

Contacts with sources in the criminal justice system can provide additional information about the client, as well as verify information received from other sources, such as a social services agency. This exchange of information can be specifically described in a memorandum of understanding between the two agencies, listing how and when the communication can take place.

Information shared between agencies should be written whenever possible, but other types of verification can be used. For example, if clients are attending self-help meetings, they should be able to describe the meeting format, their reactions to the meetings, and the issues that were addressed. This kind of verification is often more valid than the results of a standardized test, where there is no assurance that a client is responding truthfully.

Potential Conflict between Systems

It is important for the treatment and criminal justice systems to recognize each other's needs, and to understand each other's methods and goals. Sometimes these needs, methods, and goals may differ, but with the same clients passing through both systems, it is imperative that coordination, understanding, and synchronization be achieved if the best interests of the clients, the systems, and society are to be served.

Information must be shared between the two systems for mutual benefit. A treatment counselor needs to know if the client has had new encounters with the law or has been noncompliant with conditions of probation and parole, since these are indicators of serious behavior problems. If a probation officer learns that a client is compliant with treatment and is progressing well, he can adjust the level of supervision and better allocate the resources of an overtaxed agency. The two professionals can also work together to avoid duplication of effort in handling such things as Social Security and Medicaid eligibility.

There can be areas of tension between the treatment counselor and the criminal justice official. A counselor may be satisfied that a client is making good progress toward specific treatment goals. The criminal justice officer might respond, "Sure, treatment may be going well, but what about these other behavior problems? This guy is still testing the conditions of release and is hanging out with his undesirable associates."

There are inherent conflicts as well between the treatment community's need to factor cost into its decisions and the mandate of the criminal justice system to protect public safety and security. Cost considerations may lead to the least restrictive program that can be appropriate. A judge or other criminal justice official may not be willing to accept the recommendation. "We do our best to inform the criminal justice system of our assessment," said a Chicago-area counselor in the Treatment Alternatives for Special Clients program. "And when we recommend

residential treatment, it's usually favorably received. But when we recommend outpatient treatment, the judge tells you where he thinks that client should go."

Somehow these conflicts must be resolved and the tensions used constructively. Ultimately, an offender's fate is in the hands of the criminal justice system, and AOD abuse is only one of a number of factors that must be considered in determining placement. Treatment personnel must consider the whole client in their dealings with the criminal justice system, or they will lack credibility with criminal justice personnel. Likewise, criminal justice staff
can learn to understand that treatment involves many shades of gray. For example, just because a client is not in a residential program does not mean that she or he is not in an intensive treatment regimen. Residential treatment should not be viewed by the criminal justice system as punishment due to its restrictive nature.

Meetings should be set up between criminal justice representatives and AOD abuse treatment representatives to consider such issues as supervision, community protection, and treatment content and progress. It is important that judges understand that they should not sentence offenders to specific treatment plans. Rather, they should order clinical assessment at an early stage, and then mandate treatment based on the outcome of the assessment and under the supervision of the treatment provider and/or the probation department.

Attrition and Noncompliance Issues

The problems of attrition and noncompliance should be anticipated early in treatment. If they are noted sufficiently early in the treatment process, it may be possible to avert them. Regarding issues of noncompliance, a proactive attitude is needed from the treatment counselor. The criminal justice representative should be alerted when noncompliance occurs, long before a client is actually expelled from a program, if it appears that a situation leading to this outcome is developing.

The client needs to know that there are certain nonnegotiable rules in treatment, and that breaking one of these rules can result in expulsion from the program. Some programs are more rigid than others. The criminal justice representative, as well as the client, needs to be informed about the specifics of these rules, so that if expulsion becomes necessary, the course of action will be understood. For example, if a client physically assaults a counselor, and assaulting counselors is specified in the rules as a cause for expulsion, an expulsion should be a surprise to no one. Obviously , any infraction such as this should be documented in writing and immediately communicated to the supervising criminal justice authority.

It is also helpful if the treatment counselor and criminal justice representative discuss certain general trends in advance. Such particulars as retention rates, the most likely dropout points, and relapse rates in various stages of treatment, can be

used to alert case managers in other systems to potential problem periods and when they are likely to occur.

Limitations in Reaching Treatment Goals

Every clinician knows that the limits to reaching treatment goals can span a wide variety of circumstances, both predictable and unforeseen. The treatment my no longer are effective. The client may have other serious life problems that preclude successful treatment. The counselor may leave the program, and the client may feel he or she does not have the energy to start again with someone new.

Another limitation in reaching goals derives from the complex problems of the clients being seen today in the criminal justice system. Compared to problems seen in clients 10 or 15 years ago, the problems of today's generation of clients are far more complex and multilayered. In many cases, the issues are not simply poverty or AOD abuse, but problems stemming from generations of poverty and generations of AOD abuse. This population is more debilitated than previous generations. Clients may be illiterate and often lack a sense of family, structure, or purpose. They may not have any concept of the value of employment. They may need help in developing qualities that provide the underpinnings needed to be productive members of society. The treatment program can be an important part of the habilitative process.

Assessment Issues

This section contains tips and guidelines regarding several areas of the assessment of clients in the criminal justice system. The first part of the section discusses basic considerations regarding the client and the assessor that underlie the assessment process. These include:

- Determining who should do the assessment
- Laying the foundation for assessment
- Addressing the client's basic needs
- Consideration of the client's literacy
- Reviewing the assessor-client relationship

The second part of the section discusses the skills and knowledge needed to effectively conduct the parts of the assessment on cultural, educational, ethnic, racial, and gender issues. The topics discussed include:

- The assessor's skills regarding ethnic and cultural diversity

- The assessor's approach to gender issues

The assessor's ability to deal with issues of spirituality, religious belief and practice, and creativity

The final part of the section discusses processes and approaches used to obtain assessment data on various aspects of the client's health and mental health status. These include:

- General health status
- Physical and sexual abuse
- Risk for HIV and other sexually transmitted diseases
- Mental health status
- Safety concerns
- Relapse potential

The overarching aim of the section is to help increase the skills of practitioners who assess clients in the criminal justice system. An additional aim of the section is to help assessors develop skills in establishing a bond with clients that will facilitate successful treatment.

Basic Considerations Underlying Assessment

Who Should Do the Assessment?

The assessor should not be part of the correctional system. Having assessment done by someone in the criminal justice system can reduce the likelihood that the client will thoroughly trust the assessor and the assessment process, and increase the potential for conflict of interest in the assessor. If the assessor is employed by the correctional system, achieving his or her primary responsibility—protecting society from the incarcerated—may interfere with acting in the best interests of the client. An assessor must be able to act in the best interests of the client.

Moreover, the assessor should be able to provide follow up services to the client following incarceration or other disposition regarding continuing treatment services. The individual performing the assessment should be an advocate for the client. Ideally, long- term follow-up should be done by someone with whom the client has established a relationship. The ability to conduct accurate assessments and use appropriate tools derives from training and the continual updating of knowledge and development of skills in working with members of special groups such as minorities.

The individual who is assessing clients who belong to minority ethnic or cultural groups should be trained and experienced in cultural competence and sensitivity issues. A curriculum designed for the training of assessors should address the different patterns of alcohol and other drug (AOD) use in different populations, the historical and cultural aspects of AOD use, and the effects of the different drugs of abuse in different populations.

Laying the Groundwork for Assessment

Ideally, an assessor should provide clients with pre-assessment information that is designed to educate them about the value of assessments and motivate them to participate in the assessment process. Pre-assessment education should include information about the effects of AOD abuse on society and on the client's specific group, if appropriate. Generally, information about the effects of AOD abuse is easier for clients to accept if it is not directed to them personally as individuals but is of a general nature. The educational effort should include information on:

- The impact of AOD abuse on relationships with significant others
- Empowerment issues: how addiction and abuse diminish an individual's self-determination
- HIV/AIDS, other sexually transmitted diseases, and tuberculosis

In the absence of preassessment education, the assessor should attempt to gather information regarding several specific areas of the client's sense of self that can be relevant to treatment success:

- The overall belief system or world view of clients: whether they see themselves as victims of circumstances or as agents of their own fate
- Whether they have a relationship with a higher spiritual power.
- Their sense of self-esteem. Eliciting a sense of clients' self-perceptions is an early step in the establishment of a sound relationship between the interviewer and the client—a relationship that will facilitate meaningful assessment and treatment.

Addressing the Client's Basic Needs

In an assessment for AOD abuse, the assessor should determine the immediate concerns of the client. These may range from issues of survival and self-preservation in the correctional system to the safety of dependents at home while their primary caretaker, the client, is in prison. Attempts to address the client's basic needs prior to treatment will help to ensure the client's cooperation in assessment. The primary concerns of the client may be related to:

- The trial date and what can be expected in court
- Fears of sexual victimization in jail or prison
- Basic survival issues such as homelessness, hunger, and lack of employment
- Health issues. Women may be very anxious about such conditions as pregnancy, pelvic inflammatory disease, or other gynecological problems. Both men and women are likely to be concerned about contracting HIV

infection—if they are not already infected—and other sexually transmitted diseases
- Withdrawal symptoms
- Physical disability

Addressing such concerns is very important in building the relationship of trust that is essential for conducting an effective and useful assessment.

Literacy Level and Linguistic Competence

Some innovative programs provide bilingual services in English and Spanish or Portuguese. Increasingly, people who speak languages other than English or who are learning English are entering the criminal justice system with AOD problems. In addition to assessment problems that can be created because of a client's poor grasp of English and the assessor's inability to understand a second language, the accuracy of an assessment can be compromised if the client has literacy problems in his or her own native language. It should not be assumed that the client has an adequate level of literacy in any language. The literacy level of the client should be assessed prior to the selection of terminology used in the assessment. A good example of miscommunication created by inadequate language competence is the mistaken understanding of the term "positive" when applied to the results of HIV testing. An individual who is informed that an HIV test has come back "positive" may take this to mean a "good" result, and mistakenly believe that the virus was not found.

The Assessor-Client Relationship

The process of assessment is more than just obtaining a client's responses to predetermined questions. The process involves engaging the client in a meaningful dialogue. A two-way dialogue must take place between two motivated participants in order to build a relationship based on mutual trust, acceptance, and respect.

To build such a relationship, the assessor must find a way to bond with the client. The assessor must have an attitude of sincerity, empathy, and understanding, and find ways to communicate these qualities to the client. One way to begin this is to elicit the client's "story." The assessor could ask the client to describe the circumstances leading to his or her criminal justice system involvement. The assessor can write this information on paper, give the document to the client, and ask the client to modify or expand it. The act of "owning" one's "story" can be the client's first step in realizing that he or she can take responsibility for his or her role in the process that led to AOD abuse and criminal justice system involvement. Thus, the client can begin to take some measure of control. This can be a first step toward self-determination.

The story notes taken by the assessor and given to the client can become the first page of a journal or diary kept by the client. The client can be encouraged to take notes on his or her experiences while in treatment. This journal can be reviewed periodically with the client. If the client is concerned about divulging illegal activities in such a journal, the interviewer may suggest the use of code language to ensure confidentiality. Another useful technique is to suggest that the journal have two parts, with one part describing AOD abuse-related issues and another part describing "good" or positive issues.

Ethnic Origin, Culture, and Gender

Issues of Diversity

The assessor's knowledge of AOD abuse patterns in specific cultures is an important consideration in assessment among culturally diverse populations; the assessor needs to be familiar with cultures other than his or her own. Few clinicians are adequately trained to handle issues related to ethnic and class bias, gender and sexual bias, sexual harassment, and cultural and linguistic sensitivity, competency, and diversity. The assessor also needs to have an appreciation of acculturation and its significance. The accuracy of the assessment and the appropriateness of the tools for individual clients derive from the clinicians' skills, knowledge, and training in the use of the tools, and their ability to apply these skills and knowledge to clients from special groups such as ethnic and cultural groups and women. Onsite training for all assessors is ideal.

The agency staff and other individuals who conduct assessments should be aware of cultural differences and the acculturation process. Acculturation is the process of the cultural change in which the members of one culture assume the characteristics of another after continuous contact with that culture. Differences among people from different geographic areas, social settings, and social classes must also be taken into account. Individuals from rural areas, large cities, and even different areas in the same city may have very different perceptions of themselves and others—even if they are of the same race or gender. Counselors should ask clients directly about how they view or describe themselves and about their preferred usage of terms such as black, African-American, person of color, Hispanic, Latino, Chicana, Pacific Islander, gay, homosexual, or lesbian. The assessor should also be aware of cultural differences among ethnic subgroups, such as Mexican-Americans, Cubans, and Puerto Ricans. These groups have very different cultural identities, attitudes, values, and customs.

It is important to be aware of the degree to which an individual has internalized the cultural stereotypes of his or her ethnic group and gender. Sometimes, for example, a person from a very low socioeconomic area may identify with and have the characteristics of someone from a very different socioeconomic area. Another person from an affluent neighborhood may identify with and seem to

be representative of people from a deprived socioeconomic background. It can be helpful to elicit from clients a story of their first memory of the recognition that they were African- or Mexican-American, female, etc. This exercise can help the assessor determine how individuals perceive themselves in relation to that first awareness. One way to do this is to ask them what they consider to be the strengths and weaknesses of their racial or cultural group. It may be revealed that an individual may not be aware of institutionalized oppression or may believe that he or she is unaffected be racism or sexism. These stories can give clues to underlying attitudes. It should not be assumed that because an individual is the member of an ethnic or cultural group that she or he automatically has a sense of having been discriminated against.

Gender

Men's Issues

Many incarcerated men feel a sense of loss of effectiveness—as men, as fathers, as husbands or lovers, and as providers for themselves and their families. Their ability to function in these roles, which is the source of their identity and feeling of masculinity on many levels, has been interrupted and taken away in prison. Men often express feelings of powerlessness, particularly in anger, which is one of the few acceptable emotions for them to express.

The assessor must try to recognize specifically what the loss of freedom means, in terms of the self-perceptions of the men being assessed. Questions that may be asked to explore this area include:

- What does it mean to you to be a father, a husband, and a man?
- What are your earliest memories of a sense of effectiveness, recognition, and creativity—of first having a sense of yourself as male?
- When do you remember being or feeling empowered?
- Who are your heroes, and why?

Questions can be asked about anger and its effects. The purpose of such questions is to get the male client to use thought processes for reflection instead of physical aggression. Some examples follow.

- If you weren't angry, what emotions might you feel?
- What does this make you feel like?
- At what other times do you get angry?

It may be hard for men to express feelings of vulnerability and powerlessness. Imprisonment is often an emasculating experience. Thus, it is important to recognize the role that AODs have in giving men a sense of control over themselves and their destiny. Men my make such statements as, "I can talk to girls after I've

had a beer." A man may feel—or actually be—more sexually potent after using cocaine or heroin. For some men, prison eliminates or suspends sex in two ways. First, prison generally deprives heterosexual men of the ability to engage in heterosexual sex. Second, prison often deprives men of access to AODs that, for some men, are triggers for sexual feelings. Thus, being in prison robs some men of their sense of control or empowerment.

Some men experience problems related to grief, loss, fear of death, and guilt regarding HIV infection and AIDS. They may have lost many friends. They may feel alone and vulnerable, and may need special assessment and/or counseling related to these issues.

Women's Issues

Many women in the criminal justice system also experience themselves as incompetent on multiple levels: as mothers, as career and working women, and as wives. They may be overwhelmed by the number of ways in which their sense of competency is taken away by the prison experience. The requirements of the court that a woman participate in a recovery program, coupled with interruption in career and caretaking requirements may set up a cycle of failure. The farther away a woman is from what she sees as her traditional roles, the more important her issues of control and self-determination will be.

The assessment of parenting skills and responsibility for child care and care of other dependents should be included in the assessment of all women clients. The assessor should consider the role of the woman within the family as it relates to the culture with which she identifies. A special concern for the women may be the need to direct attention to the immediate issues and daily struggles in their lives. The assessment must address their basic needs. The following issues should be considered when assessing women:

- Whether the woman is in withdrawal from AODs
- Child care history of violence or rape
- Underemployment, limited income, and poor and hazardous working patterns (such as prostitution or selling drugs)
- Poor health care, inadequate birth control, lack of prenatal care, and lack of other medical information
- Limited opportunities for education and intellectual growth
- Inadequate support for aging and single parents
- Guilt associated with a woman's self-concept as a "bad mother."

Specific issues for older women may include alcoholism, isolation, and fear of violence. They may have different reasons for incarceration than other inmates.

Lesbians often feel deeply oppressed because of their gender and sexual orientation. They are discriminated against, sometimes resulting in the loss of their children and their jobs. They are sometimes physically mistreated and threatened.

It is important to help empower women, to enable them to negotiate with authorities from a position of strength rather than powerlessness. For both men and women, issues of self-esteem are important.

Age

Age is a factor in both habilitation and rehabilitation, with habilitation being more difficult for persons who began using AODs at a very early age. Those in midlife often tend to be better candidates for treatment because they have had more addiction-related negative experiences and losses than younger people. They may be ready to change their lives. Developmentally, midlife is often a good time for people to change. However, it may be more difficult for those in midlife than for younger clients to change their habits.

Spiritual Issues

Different cultures and different people place different emphases on spiritual and religious values. Although treatment can be enhanced by an individual's spiritual or religious practice or by the expression of creativity, no one can assess a person's spiritual or creative development. However, it is possible to determine a client's external value system, and incorporate that into the assessment. Asking certain questions can accomplish this task. These questions should be asked in a sensitive manner, not in a way that would create a judgment about belief or lack of belief. For example, consider the following questions.

1. Do you sometimes have spiritual feelings? Are they helpful to you?
2. Do you believe in a Higher Power?
3. Has that always been true?
4. What person or persons do you respect greatly?
5. What do you respect about them?
6. Who has "always been there" for you?
7. What has that support meant to you throughout your life?

Another area to be explored is the expression of creativity and creative endeavors: music, art, dance, cooking, gardening, and the like. Asking a client "Is there a kind of music that you use to soothe yourself when you are angry or upset?" may provide useful information. This line of assessment must be pursued sensitively, so that the client is not left with the feeling of failing to meet some untold expectations of the assessor if he lacks feelings or creativity. The assessor may be able to help clients develop a treatment plan based on their values.

It can be helpful to elicit information about inspirational activities. The information obtained in response to these questions will determine what type of treatment plan may not be effective. For example, treatment based on the concepts of Alcoholics Anonymous might be inappropriate for a client who has a strong conviction that there is no God or Higher Power.

Do not assume that an individual practices a certain religion simply because she or he belongs to a particular cultural, ethnic, or racial group.

Comprehensive Health and Mental Health Assessment

Many offenders in the correctional system, particularly repeat offenders, have never had access to adequate health care. The implications of this in terms of the prognosis for the individual, as well as the costs to society, cannot be overstated. Health issues also have an impact on recovery from AOD abuse. Moreover, misdiagnosis or non-diagnosis of significant medical problems is common in incarcerated populations.

Conversely, incarceration can represent an opportunity to treat basic health problems that would otherwise go unattended. In many areas of the country, collaborative efforts are underway among medical schools and associated training programs, primary care providers, and community health centers that are conducting studies and providing quality care to these “hidden” ill populations.

This section addresses health areas that need special assessment or attention among AOD abusers in the criminal justice system.

General Health

Individuals who conduct health assessments should not only have medical competence but also be trained to work with incarcerated persons and those from ethnic and cultural groups different from their own. Certain health issues are seen more often in correctional institutions than elsewhere. Health assessments in these institutions should consider:

- Nutrition, weight, and eating disorders (being overweight, obese, or underweight)
- Dental hygiene
- HIV/AIDS
- Other sexually transmitted diseases
- Endocrine disorders, including diabetes
- Sleep disorders
- Cardiovascular disorders (hypertension and heart disease)

- Pulmonary and upper respiratory diseases, specifically tuberculosis
- Hematologic disorders
- Renal disease (which may or may not be associated with hypertension)
- Neurologic disorders (seizures)
- Mental status (depression, withdrawal symptoms, and psychoses)
- Gynecologic disorders, pregnancy, and cervical abnormalities
- Urologic diseases
- Developmental disabilities (including deafness, learning disabilities, and mental retardation)
- Gastrointestinal disorders

There may be a need to address issues that are of immediate concern, such as life-threatening emergencies. If so, the immediate needs of the patient must be prioritized in terms of such factors as physical withdrawal, suicidal intent, etc.

Physical and Sexual Abuse

A history of physical or sexual abuse should be taken. This is of particular importance for, but not limited to, women. An assessment for abuse must be individualized and "client driven." In taking such a history, the assessor should attempt to gain a sense of the current living situation to which an abused person may be returning after court adjudication or incarceration. Among other things, the length of stay in confinement must be taken into account. For example, an assessor may wisely avoid probing too deeply into profoundly traumatic issues with a client who will be incarcerated for only a short period of time because of the impossibility of providing adequate follow-up counseling and care during a brief stay. An opening of wounds without the measures required to heal them may result only in exacerbating and compounding the client's experience of victimization.

The assessor should ask the client if he or she has experienced physical, sexual, and emotional abuse. Abuse must be addressed if it is directly related to the reason for the client's incarceration. For example, a woman who is in jail for having stabbed her abusive boyfriend requires assessment and treatment for physical and emotional abuse. Assessment about abuse must be individualized to fit the client's specific situation and will require the clinical judgment of the assessor. To ensure the effective assessment and management of an abused individual, a treatment plan must be prepared that will address issues of abuse during and after incarceration. It must be included as part of the discharge plan.

The purpose of assessment for physical and sexual abuse is to refine the interventions needed to deal with AOD abuse, since the AOD abuse may be directly linked to an abusive living situation or an experience of abuse during childhood. It is recommended that the assessor be from outside the facility to ensure confidentiality and objectivity.

General questions about a person's attitudes about fighting and violence may provide important clues to her or his own history of victimization. Examples include:

- Have you ever been involved in an incident where someone has been injured?
- Do you belong to a street gang? The interviewer should look for identifying marks, such as tattoos. If the individual reports belonging to a gang, then additional questions can be asked: what does one have to do to be initiated? Did the initiation rites involve physical or sexual abuse?
- Have you been injured in the past? If so, how? In general, questions about fear of injury can also be helpful with both women and men.
- What is your earliest sexual memory?
- Are you aware of non-consenting sexual acts that have happened to anyone in your family?

The goal of these questions is to enable the client to talk about past abuse without reliving the experience of victimization.

If a comprehensive assessment for physical and sexual abuse is undertaken, it should include education about the client's rights in pressing charges against an abuser. In addition, the assessor should be mindful of threats that may have been delivered by a perpetrator, who may have been another family member. Attention should be given to the possible effects of such threats in terms of the client's immediate safety, including thoughts of suicide sparked by fear of testifying against the perpetrator.

Risk for HIV and STDs

The accompanying chart, which can be copied and kept at the assessor's desk or in his or her notebook, provides questions that can be asked to gather information for assessment of risk. See **Figure 5**.

Mental Health

In order to be effective, an assessment of mental health issues should be carried out by mental health professionals. Ideally, they should have specific training or experience that qualifies them to work with offender populations.

A close relationship exists between mental health issues and AOD abuse. A mental health evaluation is an important component of a comprehensive assessment. Intervention and follow-up assessment needs to be done by a trained and competent

mental health clinician with experience in the field. The mental health assessment should look for the following:

- Signs and symptoms of depression
- Sleeping disorders (insomnia or hypersomnia)
- Recurrent dreams and nightmares
- Symptoms of psychotic disorders (such as hallucinations)
- Symptoms of dissociative disorders, such as “losing time”
- Self-mutilation and thoughts of self-injury
- Suicidal ideation

Some of these issues may need to be treated over an extended period of time. Initial assessment and/or treatment may be done whenever the client is in a jail or correctional facility. Mental health assessment should always be conducted as part of the discharge plan.

Figure 5: Questions on Sexually Transmitted Disease Risks

1. Have you ever been tested for HIV infection? Do you know the results of the test?
2. (If female) Have you given birth to an HIV-infected infant?
3. Are you sexually active?
4. Do you engage in anal intercourse (voluntary or forced)?
5. (If male) Do you have sex with other men? (Men should be asked specifically whether they have ever had sex with other men, not whether they are "homosexual" or "gay," because they may not identify with the use of these terms.)
6. Did you use condoms the last time you had sex? (Ask this to determine consistency of condom use, rather than asking, "Do you use condoms?")
7. How many sexual partners have you had in the last 6 months? (Ask about the number of sexual partners over a specific period of time, such as 6 months. Questions such as "How many sexual partners do you have?" may elicit the answer, "one," despite a history of serial monogamy.)
8. Do you know about you partner's risk history (his or her drug use, sexual partners, blood transfusions, etc.)?
9. Have you ever traded sex for something (money, drugs, shelter, etc.)?
10. Have you ever been forced to have sexual activity against your will?
11. Have you ever injected drugs?
12. Have you ever shared drug-injecting paraphemalia?
13. Have you ever had a transfusion of blood or blood products?
14. Have you ever had any other sexually transmitted diseases, including:
    - Human papillomavirus?
    - Herpes simplex virus?
    - Hepatitis B and C?
    - Gonorrhea?
    - Chlamydia?
    - Syphilis?
    - Chancroid?
    - Lymphogranuloma venereum?

Safety

One of the compelling reasons for the importance of safety concerns at every step in the criminal justice system is the direct bearing that these issues have on relapse. Although the physical aspects of the safety of the incarcerated population are ultimately the responsibility of the correctional institution, it is the responsibility of the assessor to evaluate the individual safety of the client. As part of that assessment of clients in prison, the assessor needs to be concerned about the client's sense of safety in terms of physical and sexual abuse and gang behavior.

Indirect questioning may be helpful in eliciting information from a client concerning violent incidents in which he or she may have been involved and in obtaining an idea of whether the client may be currently threatened inside the facility. An example of such indirect questioning is: "What fears did you have about jail before you went there?" The answer to this question may indicate current areas of apprehension or fear, or actual events that have taken place during the individual's incarceration.

As an offender's period of incarceration approaches the end, the assessment must take into account the living circumstances to which he or she will be returning. It is particularly important to determine the extent of drug availability in the environment that the client is in or will return to upon release. For treatment to be successful, it is vital to evaluate the daily circumstances of the individual's life.

If a client is returning to an environment where he or she will be continually confronted with the easy availability of drugs, encouragement to create an alternative safe, drug-free space may be appropriate. Even if it is not immediately possible to escape such an environment, such as when the client is living with an AOD user, it may be possible to create a space within the living environment that will be kept free of drugs. In such cases, clients must be encouraged to find ways to protect themselves. They can learn that they can remove themselves, even if only temporarily, from a situation in which drugs are being used.

At the assessment interview, applications for social services, food stamps, social security disability, and social security income should be reviewed. The eligibility of the client for these services should be determined.

Assessment of Relapse Potential

The potential for relapse in AOD users is largely dependent upon three key factors:

- Duration of treatment. The longer the treatment, the better the chances of success.
-
- Duration of time before relapse. As the length of time that the client stays abstinent increases, the chances continue to increase that he or she will remain abstinent.
-
- Duration of AOD use following relapse. If treatment is sought immediately following a relapse to alcohol or other drugs, the chances of success are increased.
-

The key to preventing relapse later is keeping the client in treatment now. In assessing the potential for relapse, the assessor should be mindful of the length of time that the client has successfully stayed AOD-free, keeping in mind that enforced abstinence during the prison term may not be indicative of his or her ability to maintain abstinence after release.

Recognizing Potential Triggers for Relapse

It may be useful to assess with the client those factors that are likely to act as triggers for relapse after release. Some examples of relapse triggers include, but are not limited to:

- Ready availability of AODs in the home environment or neighborhood
- Anger or other emotional stress (such as death of a loved one)
- Any situation that repeats the past traumas that led to the AOD use
- Sexual partners who are AOD users
- Reactions (such as depression) to anniversaries or holidays
- Fears of failure or actual failure in critical life experiences (such as the failure to obtain employment or regain custody of children
- Newfound freedom to have choices
- Having money for the first time in a long while.

It is not uncommon for a client to hold onto elements from his or her former days of AOD abuse. Often clients report that maintaining these ties gives them a sense of security, “just in case.” The assessor should identify what “residual objects” or reservations they are keeping around, such as drug works or paraphernalia, stash, or contacts. The assessor should also find out if the client has had sexual contact with anyone with whom he or she shared AOD use. Other clues

in assessing the potential for relapse may be provided by dreams reported by the client regarding AOD abuse. Such dreams can indicate unconscious desires to get high. It is useful to advise the client that when the desire to use returns, changing patterns may help. For example, getting up at a different hour, increasing exercise, or improving eating habits may help to assuage these desires.

Clients must have realistic and practical expectations. The assessors can assist the client in planning activities based on these expectations such as job seeking, attending employment skills classes, or receiving social services or rehabilitation. For example, it may be unrealistic for a client to plan to attend three classes or therapy sessions a week while still in drug rehabilitation. Unrealistic or overly ambitious expectations can prompt a client to repeat the cycle of failure that led to the AOD abuse in the first place. In this regard, issues of child care and transportation are critical components of AOD abuse treatment success.

It is also important to assess the client's personal relationships that have been associated with relapse in the past. The goal is to empower the client to recognize, choose, and create options for changing old, counterproductive patterns in order to avoid repeating the experiences that led to relapse.

In assessing the potential for relapse, it can be useful to ask the client, "What will happen if you succeed?" "What will happen if you fail?" "Who would like it and who would not?" The answers to these questions could be an indication of what needs to be addressed in treatment before success can be achieved. For instance, the client may express the fear that a partner may leave if he or she quits using. This could indicate a trigger for relapse. The client must be helped to recognize such potential relapse triggers and old patterns, and encouraged to explore alternatives. For example, since living with an AOD-abusing partner is a trigger, the assessor can help the client to identify temporary living arrangements.

Assessing a client's sense of self-worth is critical to determining the potential for relapse. This is key to indicating how successful treatment will be. A simple rating scale can be used in determining this area. The client can be asked the following questions?

- What are your strong points?
- Tell me something good about yourself.
- What are you proud of?
- What have you done well?

Alternatively, the client can be asked to rate himself or herself on a scale of 1 to 5, with 1 low and 5 high. The assessor can then discuss the ratings with the client. For example, if the client has rated himself or herself as a 3, the assessor can ask, "What would it take to be a 5?" or "Why aren't you a 2?"

The assessor's evaluation regarding whether this individual has positive or negative feelings of self-worth has to be incorporated into the treatment plan, taking into account issues of ethnic and cultural background and gender. One way to assess self-worth in relation to these areas is to ask the following:

- What is your potential for success and for being self-sufficient? (The client may mention ethnicity or gender as a limiting factor.)
- What are you particularly proud of about being [a man, a woman, an African-American woman, etc.]?
- What has been difficult about it?

An answer of "I don't know" to the first two questions above may result from the inability to find any value in oneself as a result of being a member of a particular ethnic or cultural group or gender. In this example, a treatment plan could contain plans for rectifying low self-esteem. It may also be helpful to assess previous levels of independence and previous experiences of success.

Since failure—such as the failure to obtain a particular job or regain custody of children—can be a significant relapse trigger, the client should be helped to recast such a loss as an opportunity for learning. A client can learn that a specific failure does not signify his or her failure as a human being. Rather, experiences of failure can be opportunities for personal growth and learning more about recovery.

The creativity of the client must also be assessed in an effort to determine what the client would like to be doing in his or her life. The assessor can encourage clients to fantasize about what they would like to be doing if they were not in jail, if they were not using AODs, and if money were not an issue. These fantasies can provide important clues to help with goal setting.

The ultimate goal of assessment is for the client to be able to do an accurate self-assessment—to know his or her own weaknesses and limitations in order to anticipate possible triggers for relapse. Relapse is best prevented when the client can see himself or herself as a person who is able to choose options.

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Appendix A:

SUBSTANCE ABUSE CONSEQUENCES SCALE – REVISED (SACS-R)

Robert A. Shearer, Ph.D.

Substance abuse has become a major social, legal, and medical problem in this country. In response to the problem, a variety of programs have been developed to treat substance abuse. Many of these programs include a treatment component that is designed to help abusers make decisions that are based on the risks and negative consequences of abusing substances. Like many other behaviors, substance abuse consequences can vary in severity and from one individual to another.

Consequences

Nowinski (1996) indicates that the negative consequences of alcohol abuse can be physical, legal, social, sexual and financial. He stresses that an inventory of consequences of and drug use should be a major part of the assessment process. Carroll (1998), Velasquez, Maurer, Crouch, and DiClemente (2001), Wanberg and Milkman (1998), and Bush, Glick, & Taymans (1997) include an appreciation of the negative consequences resulting from irresponsible substance, as a part of a structured treatment program. The treatment programs that include the importance of consequences tend to focus on changing a maladaptive thought process that leads to maladaptive behavior, because the thought process does not include a consideration of the negative consequences of substance abuse. These negative consequences are frequently side tracked or diminished by the immediate positive consequences of drug or alcohol use. In addition, broad-based, lower intensity substance abuse education programs, frequently include, in the curriculum, consciousness raising about the risks and consequences of substance abuse.

The Theory

The treatment programs that focus on decision making, the importance of effective choices, and consequences tend to be cognitive-behavioral and social learning oriented. Consequently, the theory that serves as a foundation for these programs springs from behavioral and social learning principles. The specific principle of behavioral analysis that is used is the *consequent control of operants* which points to the likelihood of an act recurring, such as substance abuse. The change in the chance of an act recurring is due to the relatively immediate environmental consequences of an act. These consequences can be either positive or negative (Andrews & Bonta, 1998).

This principle of consequent control directs that several procedures are necessary to treat substance abuse:

1. An appreciation for the negative consequences of substance abuse must be increased.
2. The short-term positive consequences of intoxication must be decreased.
3. A cost-benefits analysis is an effective way to change the appreciation of the negative consequences.
4. The final goal is to increase self-control, self-management, and problem-solving skills.

The research knowledge supporting these principles is strong, but more research is needed to support the importance for an appreciation of the consequences of substance abuse.

The Research

Some research has been conducted concerning the importance of consequences. Redgrave, Swartz, & Romanoski (2003) found that the risk factors and consequences of alcohol misuse are different for women and men. Women are more susceptible to the ill effects of alcohol, in smaller amounts, than men. Women are less likely to abuse alcohol than men, but when they do, are more likely to suffer adverse medical consequences earlier and less likely to get into treatment. Liebschultz, Savetsky, Saitz, Horton, Lloyd-Travaglini, and Samet (2002) examined the relationship between a history of physical and sexual abuse and drug and alcohol related consequences. They found, using *The Inventory of Drug Use Consequences (In DUC)*, that for women, physical and sexual abuse was associated with more substance abuse consequences than for men. In their study, substance abuse consequences were the result of physical and sexual abuse rather than substance abuse leading to physical and sexual abuse. Apparently, the primary focus of studies of the consequences of substance abuse has been the development of an individual, clinical assessment and not on assessing broader levels of appreciation for the consequences. The following discussion concerns an attempt to assess levels of appreciation for the consequences of substance abuse.

Description of the Instrument

The SACS-R is a 12 item, self report instrument that uses an agree, undecided, disagree format for responding to the items. The instrument measures the respondent's appreciation and perception of the consequences of using or abusing drugs or alcohol. Two scale scores are obtained: Resistance to Control (RC) and Appreciation for Consequence (AC). A higher score on the scale indicates a greater appreciation for consequences and a lower score indicates less concern

for consequences. Scores on the scale can range from “0”, a complete lack of concern, to “24” which indicates a total concern for consequences.

Reliability

An initial study of the internal reliability of the SACS produced coefficients of .63 for factor 1 (RC), and .54 for factor 2 (AC). A second study (N = 125) produced internal reliability coefficients of .53 for the RC scale and .59 for the AC scale and .61 for the total scale. Each scale contained six items in the second study of internal reliability.

A test – re-test reliability (N = 46) using a two week interval produced correlation coefficients of .445 and the RC scale, .601 on the AC scale, and .547 on the total SACS-R scale. All of these correlations were significant at the .01 level.

Validity

An exploratory factor analysis reduced the original pool of 27 items in the original SACS to the current 12 items and produced two factors with item loadings over .40. The eight original numbers, new numbers, and loadings are:

Factor 1			Factor 2		
Old	New	Value	Old	New	Value
6	1	.67	17	8	.60
7	3	.60	25	6	.52
11	5	.52	26	4	.56
16	7	.63	27	2	.50
21	9	retained and reworded	--	10	new item
--	11	new item	--	12	new item

Two new items were added to each scale in order to increase the eigenvalues for each scale that explain the variance

A subsequent confirmatory factor analysis of the 12 items on the SACS-R yielded new factor loadings that strongly supported the original exploratory analysis.

The items and their loadings were:

Factor 1	Loading	Factor 2	Loading
Item 1	.44	Item 2	.51
Item 3	.43	Item 4	.57
Item 5	.49	Item 6	.57
Item 7	.72	Item 8	.59
Item 9	----	Item 10	.57

Item 11 .78 Item 12 .56

The only item that did not match the original was Item 9 which concerned the legal limit of alcohol allowed while driving. This item did not load once again on either of the two factors. Item 9 apparently is measuring something different than the two other factors. Item 9 has been retained, nevertheless, because of its potential value in assessing consequences in populations where "driving while intoxicated" or "driving under the influence of drugs" is a concern.

Finally, all of these statistical indicators of reliability and validity fall within acceptable ranges for an experimental instrument, and the SACS-R should be considered as initially indicating a considerable amount of potential. On the other hand, it should be considered as experimental until further research provides more information about the properties of the instrument.

Norms

Table 1 presents the norms for the SACS-R.

Item Structure

Factor 1: Resistance to control (RC)

1. The harmful effects of drugs and alcohol are greatly exaggerated.

3. The harmful effects of drugs or alcohol are one big lie.

5. People should be able to put into their bodies whatever they want.

7. Drug laws are too strict.

9. The legal limit for the amount of alcohol allowed in your blood, while driving, should be raised.

11. Too many people are being arrested for using illegal drugs.

Factor 2: Appreciation of consequences (AC)

2. People underestimate the consequences of drugs and alcohol abuse because they are uneducated about the consequences.

4. People underestimate the consequences of drugs and alcohol because they are in a state of denial.

6. Most people who abuse drugs or alcohol don't think about the consequences.

8. Most people who abuse drugs or alcohol underestimate the consequences.

10. The consequences of abusing alcohol or drugs are rarely considered by most people.

12. The consequences of abusing alcohol or drugs surprise a lot of people.

Table 1

Means, Ns, & SDs for groups of
Research interest on the SACS-R

Group	Scale	N	Mean	SD
Under Graduate Students		125		
	AC		8.69	2.83
	RC		8.73	2.47
	Total		17.43	4.34
Under Graduate Students		46		
	AC		8.84	3.11
	RC		9.08	2.17
	Total		17.95	3.43

Note: No significant differences were found in gender comparisons in undergraduate students (N = 125/46) for any of the SACS-R Scales.

Table 2

SACS-R inter scale correlations
(N = 125)

Scale	AC	RC	TOTAL
AC	----	.268 **	.826 **
RC		----	.764 **
TOTAL			----

Significant at the .01 level

SUBSTANCE ABUSE CONSEQUENCES SCALE- REVISED (SACS-R)

Directions: Blacken the circle in the space to the left of each statement according to whether you agree or disagree with the statement. If you are not sure about the statement, blacken the circle in the middle space under undecided.

Example:

Agree	Undecided	Disagree	
●	O	O	Legal prescription drugs may be sometimes abused by individuals.

Agree	Undecided	Disagree	
O	O	O	1. The harmful effects of drugs and alcohol are greatly exaggerated.
O	O	O	2. People underestimate the consequences of drug and alcohol abuse because they are uneducated about the consequences.
O	O	O	3. The harmful effects of drugs or alcohol are a big lie.
O	O	O	4. People underestimate the consequences of drugs and alcohol because they are in a state of denial.
O	O	O	5. People should be able to put into their bodies whatever they want.
O	O	O	6. Most people who abuse drugs or alcohol don't think about the consequences.
O	O	O	7. Drug laws are too strict.
O	O	O	8. Most people who abuse drugs or alcohol underestimate the consequences.
O	O	O	9. The legal amount of alcohol allowed in our blood, while driving, should be raised.
O	O	O	10. The consequences of abusing alcohol or drugs are rarely considered by most people.
O	O	O	11. Too many people are being arrested for using illegal drugs.
O	O	O	12. The consequences of abusing alcohol or drugs surprise a lot of people.

SACS - R

Scoring Key

Standard Scoring		**Reverse Scoring (R)**	
Agree	= 2	Agree	= 0
Undecided	= 1	Undecided	= 1
Disagree	= 0	Disagree	= 2

Items are scored in the direction of appreciation for the consequences of using and abusing alcohol or drugs. Total Range: 0 – 24, Scale Range: 0 - 12

Standard Scored Items (AC) Scale	**Reverse Scored Items (RC) Scale**
2, 4, 6, 8, 10, 12	1, 3, 5, 7, 9, 11

Resistance to Control (RC) Scale Score _____

Appreciation of Consequences (AC) Scale Score _____

Total Score _____

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Appendix A: Post Test and Evaluation for *Substance Abuse Screening and Assessment in Criminal Justice Systems*

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. The percent of offenders in corrections who were consuming alcohol at the time of the offense was:

    a. 10%.
    b. 50%.
    c. 90%.
    d. 36%.
    e. 0%.

2. The percent of offenders in corrections who were consuming alcohol or drugs at the time of the offense was:

    a. 10%.
    b. 50%.
    c. 90%.
    d. 36%.
    e. 75%.

3. AOD stands for:

    a. Alcohol and other drugs.
    b. Attention observation disorder.
    c. Addiction or dependence.
    d. After original diagnosis.
    e. None of the above

4. SUDs stands for:

    a. Substance use disorder.
    b. Standard urban diagnosis.
    c. Subjective unit of discomfort.
    d. Both a and c
    e. Both a and b

5. ATT stands for:

    a. Attention timing task.
    b. Addiction treatment technology.
    c. Addiction training tasks.
    d. Assessing treatment tasks.
    e. Assessing treatment typologies.

6. Screening and assessment of substance abusing offenders should proceed form the assumption of a:

    a. Diagnostic anomaly.
    b. Dual disorder.
    c. Dual mandate.
    d. Dualistic fallacy.
    e. Psychopathic personality.

7. An individual trained to conduct assessments should have the skill of:

    a. Multi tasking.
    b. Disassociation.
    c. Cognitive restructuring.
    d. Reframing.
    e. Cultural competence.

8. Most current assessment tools were developed for:

    a. Female clients.
    b. Male clients.
    c. Cross cultural clients.
    d. Black clients.
    e. Hispanic clients.

9. The percent of individuals who have been diagnosed with AIDS that are drug injectors is:

    a. 90%.
    b. 10%.
    c. 25%.
    d. 50%.
    e. 75%.

10. The goal of screening is to identify _____ for treatment intervention.

    a. Treatment curriculum
    b. Potential candidates
    c. Assessments
    d. Techniques
    e. Treatment manuals

11. An excellent stage for screening is:

    a. Release.
    b. Transition.
    c. Orientation.
    d. Conviction.
    e. Arrest.

12. Screening should be:

    a. Hierarchial.
    b. Flexible.
    c. Inflexible.
    d. Random.
    e. Both a and b

13. If screening errs, it should err toward the:

    a. False negative.
    b. Psychological.
    c. Sociological.
    d. False positive.
    e. Physiological.

14. Important biological measures can be used in screening such as:

    a. Blood-alcohol level.
    b. Urine test.
    c. Breathalyzer.
    d. All of the above
    e. Only a and c

15. When an instrument over-identifies substance abuse it is termed:

    a. False positive.
    b. A urine test.
    c. Transition.
    d. False negative.
    e. MAST.

16. When treatment and assessment resources are strained, instruments which are _____ are more useful.

    a. False positive
    b. Valid
    c. Reliable
    d. False negative
    e. Physiological

17. A screening protocol identifies:

    a. False negatives.
    b. Defaults.
    c. Physiological mandates.
    d. Priorities.
    e. SUDs.

18. When treatment would not be recommended it is referred to as:

    a. Countracepted.
    b. Countradictive.
    c. Countraindicated.
    d. False negative.
    e. Defaulted.

19. The two most important screening considerations are for intellectual functioning and:

    a. Pathogens.
    b. Psychopathy.
    c. Neurasthenia.
    d. Obsessive-compulsive disorder.
    e. PTSD.

20. Intellectual functioning is critical in screening because most treatment programs are based on:

    a. Insight.
    b. Reasoning ability.
    c. Introspection.
    d. Anxiety and discomfort.
    e. All of the above

21. The principles of effective intervention with offenders are based on:

a. Risk, classification, and capacity.
b. Responsivity and classification.
c. Risk, need, and classification.
d. Institutional needs and finances.
e. Risk, need and responsivity.

22. Which of the following would not be a criminolgenic need?

a. Anxiety
b. Antisocial attitudes
c. Self-control
d. Chemical dependency
e. Peer associations

23. The responsivity principle concerns:

a. Resistance.
b. Self-control.
c. Anxiety.
d. Motivation.
e. Both a and d

24. Assessment instruments should be accompanied by:

a. Coupons.
b. A key.
c. A transcript.
d. A ledger.
e. A manual.

25. The consistency of an assessment instrument is referred to as:

a. Validity.
b. Fidelity.
c. Trueness.
d. Reliability.
e. Norms.

26. If an instrument measures what it is supposed to measure, it is:

    a. Valid.
    b. Reliable.
    c. Consistent.
    d. Stable.
    e. None of the above

27. A score on an assessment instrument should be compared to:

    a. Norms.
    b. A reference group.
    c. Similar individuals.
    d. All of the above
    e. None of the above

28. The proprietary or public properties of assessment instruments concerns which of the following?

    a. Norms
    b. Control
    c. Validity
    d. Reliability
    e. Stability

29. Proprietary instruments may require which of the following?

    a. Permission for use
    b. A fee for their use
    c. A fee for scoring
    d. All of the above
    e. None of the above

30. The validity of an assessment instrument ultimately is determined by:

    a. Relapse.
    b. Progress.
    c. Attitude.
    d. Personality.
    e. None of the above

31. The most widely used assessment instrument is the:

a. BSI.
b. CSI.
c. MIST.
d. ISA.
e. ASI.

32. The presentation of data backing up the assessment should be:

a. Fat free.
b. Number free.
c. Jargon free.
d. Aids free.
e. Narrative free.

33. Even in a condensed assessment report there should be how many sections?

a. Undermined
b. Sufficient
c. Six
d. Two
e. Three

34. Which of the following would not be extrinsic pressure for treatment?

a. Loss of job
b. Loss of money
c. Loss of family support
d. Guilt
e. Fear of incarceration

35. Which of the following would not be intrinsic pressure for treatment?

a. Guilt
b. Self-hatred
c. Despair
d. Anxiety
e. Fear of suicide

36. Which of the following would be essential for working with resistant offenders?

    a. Pre-treatment orientation
    b. Transitional treatment
    c. Aftercare
    d. Phase one treatment
    e. Phase two treatment

37. An offender is ready for treatment when the offender _____ the problem.

    a. Denies
    b. Confronts
    c. Owns
    d. Deflects
    e. Challenges

38. The CTRS measures:

    a. Readiness.
    b. Resistance.
    c. Relapse.
    d. Reflection.
    e. Recommitment.

39. The strongest scale of the CTRS is the _____ scale.

    a. Social issues
    b. Antisocial
    c. Violence issues
    d. Psychological issues
    e. Cultural issues

40. A technique for quantifying drug or alcohol cravings is:

    a. URICA.
    b. CTRS.
    c. SUDs.
    d. SOAP.
    e. OUDs.

41. Most AOD abusers experience a stage of:

a. Perceptual expansion.
b. Perceptual constriction.
c. Univalence.
d. Ambivalence.
e. Ambience.

42. Assessment allows for a _____ program design.

a. Ambivalent
b. Differential
c. Mandated
d. Compulsory
e. Deflective

43. In substance abuse treatment, there have traditionally been phase and _____ designs.

a. Track
b. Transition
c. Step
d. Consolidated
e. Individualized

44. The assumption of a phase design is that all participants enter with common:

a. Risk characteristics.
b. Need characteristics.
c. Responsivity characteristics.
d. All of the above
e. None of the above

45. The treatment plan should focus on rehabilitation and _____.

a. Habilitation
b. Stabilization
c. Integration
d. Initial socialization
e. Both a and d

46. The development of a treatment plan should be individualized and _____.

    a. Centralized
    b. Randomized
    c. Participatory
    d. Ambulatory
    e. Exculpatory

47. Goals of a treatment plan should be:

    a. Specific, measurable, and quantitative.
    b. Quantitive and qualitative.
    c. Measurable, qualitative, and nonspecific.
    d. Objective and subjective.
    e. Subjective, measurable, and tentative.

48. A good treatment plan is organic, dynamic, evolving and _____.

    a. Permanent
    b. Verbal
    c. Rigid
    d. Flexible
    e. Subjective

49. Potential conflicts between treatment and criminal justice agencies can be avoided with a:

    a. Risk contract.
    b. MOU.
    c. CTRS.
    d. AOD contract.
    e. UOM.

50. An important clue to a person's history of victimization would be his/her attitudes about:

    a. Tripping.
    b. Fighting.
    c. Stealing.
    d. Working.
    e. Cussing.

Fax/Mail Answer Sheet

CEU Matrix - The Institute for Addiction and Criminal Justice Studies

Test results for the course "Substance Abuse Screening and Assessment in Criminal Justice Systems"

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: Substance Abuse Screening and Assessment in Criminal Justice Systems _____

1. [A] [B] [C] [D] [E]
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45. [A] [B] [C] [D] [E]
46. [A] [B] [C] [D] [E]
47. [A] [B] [C] [D] [E]

48. [A] [B] [C] [D] [E]

49. [A] [B] [C] [D] [E]

50. [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 not need to return this form.**

NAME:_____

COURSE TITLE: Substance Abuse Screening and Assessment in Criminal Justice Studies

DATE:_____

COURSE CONTENT		
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:		