



Screening and Assessment of Co-Occurring Disorders in the Justice System



SAMHSA
Substance Abuse and Mental Health

This combined screen requires approximately 15–20 minutes to administer and score. For individuals who screen positive to the previous set of screens and for whom a more comprehensive assessment and/or diagnosis is needed, the following instruments are recommended:

1. The Posttraumatic Symptom Scale (PSS-I), which provides a current diagnosis of PTSD.
- (or)
2. The Posttraumatic Diagnostic Scale (PDS), which serves as both a screen and diagnostic instrument.
- (or)
3. The Clinician Assisted PTSD Scale for DSM-5 (CAPS-5). These assessment and diagnostic tools require approximately 25–30 minutes to administer and score.

Screening Instruments for Motivation and Readiness for Treatment

Several brief screening instruments have been developed to examine motivation and readiness for behavioral health treatment. These are sometimes used to identify individuals who are inappropriate for admission to substance use treatment, to flag issues that are important to address in early stages of treatment, and to monitor changes in motivation and readiness over the course of treatment. Although motivational screens are not always provided during the intake process, they may be used in different settings to determine readiness for change. Motivation and readiness for treatment have been found to predict treatment outcomes (Hiller, Knight, Leukefeld, & Simpson, 2002; Olver, Stockdale, & Wormith, 2011), including retention in and graduation from treatment programs, and may be particularly useful in matching individuals to different levels or “stages” of treatment. Motivation screens can be administered as a repeated measure to monitor progress over time.

A caveat to the use of motivational screens in matching people who have CODs to treatment in the criminal justice system is that this population is not typically motivated to participate in treatment and has a wide range of other psychosocial issues (e.g., housing, financial support) and personality factors (e.g., antisocial cognitions and attitudes) that may take precedence over treatment. Thus, motivation should not be viewed as a predicate for placing offenders in treatment. Instead, techniques aimed at increasing self-efficacy (setting small obtainable goals during treatment) and motivation (e.g., motivational interviewing techniques) for those who lack motivations and who are ambivalent about change can improve treatment outcomes in the justice system (CSAT, 2005b).

It is important to note several concerns regarding the validity of motivational screening instruments. First, not all of these instruments provide equivalent types of assessment of readiness for change, as some do not directly align with the stages of changes (e.g., SOCRATES), as defined by the transtheoretical model (TTM; Prochaska, DiClemente, & Norcross, 1992). Moreover, these instruments may provide variable results in assigning offenders to different “stages of change” or in identifying readiness for treatment, resulting in matching individuals to different levels of treatment. Thus, these measures should not be used as the primary tools to accomplish treatment matching.

Screening Instruments for Motivation and Readiness for Treatment

Circumstances, Motivation, Readiness, and Suitability Scale (CMRS)

The CMRS (DeLeon & Jainchill, 1986) was developed to assess risk for dropout from a therapeutic community (TC) program and to identify participants most likely to remain in substance use treatment. The CMRS is a 42-item scale that takes approximately 30 minutes to complete. The instrument has four subscales, Circumstances, Motivation, Readiness, and

Suitability, that measure (1) external pressures to seek treatment; (2) internal reasons to seek change; (3) perceived need for treatment to achieve change; and (4) acceptance of the TC approach, reflected by the willingness to make major lifestyle changes, long-term commitment to an intensive treatment program, and rejection or exhaustion of other treatment modalities or options. A shortened 18-item version of the instrument (CMR) includes three subscales: Circumstances, Motivation, and Readiness.

Positive Features

- The CMRS is widely used among offenders (DeLeon, Melnick, Thomas, Kressel, & Wexler, 2000; Goethals, Vanderplasschen, Van de Velde, & Broekaert, 2012; Fiorentine, Nakashima, & Anglin, 1999; Melnick, DeLeon, Thomas, Kressel, & Wexler, 2001) and people with substance use disorders (Battjes, Gordon, O'Grady, Kinlock, & Carswell, 2003; DeLeon, Melnick, & Cleland, 2010; Gholab & Magor-Blatch, 2013; Najavits et al., 1997)
- The CMRS consistently predicts retention and entry into prison-based TCs and entry into aftercare TCs following release from custody (DeLeon, Melnick, Thomas, Kressel, & Wexler, 2000)
- The abbreviated CMR instrument predicts involvement in substance use aftercare treatment following release from prison (Melnick, DeLeon, Hawke, Jainchill, & Kressel, 1997)
- Among participants in the Drug Abuse Treatment Outcome Study (DATOS), scores on the treatment readiness scale of the CMRS predict treatment retention across treatment settings, supporting the predictive validity of the measure (Joe, Simpson, & Broome, 1999)
- The CMR is positively related to aftercare involvement in prisoners enrolled in TCs, and higher scores on the CMR predict aftercare entry and lower reincarceration rates at a 1-year follow-up (Melnick et al., 2001)
- Among offenders enrolled in TC programs, treatment motivation scores on the CMR predict treatment readiness (Morgen & Kressel, 2010)
- Among offenders in TC programs, treatment motivation as indexed by the CMRS is related to environmental factors, such as understanding the rules of conduct and treatment goals (Goethals et al., 2012)
- Treatment motivation as indexed by the CMR is directly related to treatment alliance, treatment participation, and treatment outcomes (Melnick et al., 2001)
- The CMRS is useful in predicting 30-day retention in long-term TC treatment in the community (DeLeon et al., 1994)
- Young (2002) found that external factors measured by the Circumstances scale of the CMRS predicted 90-day retention of criminal justice clients in community-based residential treatment programs, while the Readiness scale of the CMRS predicted 180-day retention
- Melnick et al. (1997) found that age was significantly correlated with scores on the CMRS and that the instrument successfully predicted short-term retention rates in TC treatment across age groups
- DeLeon, Melnick, Kressel, and Jainchill (1994) found that CMRS scales are more effective predictors of 30-day and 10-month treatment retention than a range of demographic and background variables, including legal status
- People mismatched to treatment in the DATOS had significantly lower CMR treatment motivation scores at baseline in comparison to those who were properly matched to treatment (DeLeon et al., 2010)
- Higher motivation for mental health treatment as indexed by the CMR predicts greater adherence to treatment among psychiatric patients (Magura, Mateu, Rosenblum, Matusow, & Fong, 2014)
- The CMR has good predictive utility for treatment outcomes across race and

ethnicity (DeLeon, Melnick, Schoket, & Jainchill, 1993)

- Reliability of the CMRS total score as measured by Cronbach's alpha is .84 (Melnick et al., 2001), and reliabilities for individual scale scores range from .53 for the Circumstances scale to .84 for the Readiness scale
- The CMRS has good internal consistency (alphas = .84–.87; .67–.83; DeLeon et al., 1994; Goethals et al., 2012; Melnick, 1999)

Concerns

- CMRS scores vary significantly for offenders of differing intellectual functioning (Van de Velde, Broekaert, Schuyten, & Van Hove, 2005)
- The CMRS items are related to TCs, and thus, the instrument may not generalize to other treatment settings for assessing circumstances, motivation, and readiness for change (Groshkova, 2010; Zemore & Ajzen, 2014)
- The validity of the CMRS has not been examined among individuals with CODs
- The CMRS has not been thoroughly evaluated to determine its usefulness in predicting retention in jail or community-based offender treatment programs
- Circumstances scale scores have low reliability (Van de Velde et al., 2005)
- The Circumstances scale may consist of two factors, Pressures to Enter Treatment, and Pressures to Leave Treatment (DeLeon et al., 2000), thus explaining difficulties related to low reliability. Caution should be used when interpreting this scale

Availability and Cost

The CMRS manual and instruments can be obtained free of charge at the following site: <http://www.emcdda.europa.eu/html.cfm/index3597EN.html>

Readiness for Change Questionnaire (RCQ)

The RCQ (Rollnick, Heather, Gold, & Hall, 1992) is a 12-item measure based on the transtheoretical “stages-of-change” model, developed by Prochaska and DiClemente (1992). The instrument was originally developed to identify specific stages of change among heavy drinkers who are not seeking treatment, but it has been used far more broadly among a range of substance-involved populations. The RCQ-CV (clinician's version) consists of three scales, Pre-contemplation, Contemplation, and Action, each consisting of four items. Item responses are provided on a five-point scale ranging from “strongly agree” to “strongly disagree,” with higher scores on the RCQ representing greater willingness to change. The 15-item RTCQ-TV (treatment version) was designed for individuals in treatment or who are seeking treatment (Share, McCrady, & Epstein, 2004) and is used to determine the level of readiness to engage in treatment and to assist in treatment planning. A revised 12-item version of the RTCQ-TV is also available (Heather & Honekopp, 2008). Both the RCQ-CV and RTCQ-TV take approximately 2–3 minutes to administer, are designed for both adolescents and adults, and are available in the public domain. The RCQ has been adapted to measure readiness to change in other areas, such as violent behavior, criminal behaviors, and anger problems. Neither instrument requires training to administer or score.

Positive Features

- The RCQ is brief to administer
- The self-administered format of the RCQ is advantageous for use in hospital and other settings in which there is limited time to compile information (Rollnick et al., 1992). The RCQ has been used with several offender populations (Casey, Day, Howells, & Ward, 2007; Day et al., 2009; McMurrin et al., 1998; Watt, Shepherd, & Newcombe, 2008) and with people with substance use disorders (Freeman et al., 2005; Heather,

Luce, Peck, Dunbar, & James, 1999; Gregoire, & Burke, 2004; Share, McCrady, & Epstein, 2004; Wells-Parker, Kenne, Spratke, & Williams, 2000)

- The RCQ has been adapted for use with offenders (Readiness to Change Offending, RCOQ) to address motivation to change criminal behaviors (McMurran et al., 1998)
- The RCQ is related to a newly developed offender instrument that examines readiness for change, the Corrections Victoria Treatment Readiness Questionnaire (CVTR), and demonstrates moderate to strong correlations with the CVTR scales (Casey et al., 2007)
- The RCQ has been adapted to measure readiness to change violent behaviors among offenders and is correlated with another treatment readiness scale, the Violence Treatment Readiness Questionnaire (VTRQ; Day et al., 2009)
- Convergent validity of the RCQ among people involved in substance use treatment is supported by correlations with another well-validated measure of readiness for change, the URICA (r scores range .39–.56; Heather et al., 1999)
- Violent offenders who received no intervention were more likely to be in the pre-contemplation stage for changing drinking behaviors compared to those receiving a treatment intervention, supporting the validity of the RCQ in assessing readiness for change (Watt et al., 2008)
- Convergent validity of the instrument is also indicated among people with substance use disorders, in which RCQ scores indicating pre-contemplation, contemplation, and action stages are related to scores from the URICA, another well-validated measure of readiness for change (Napper et al., 2008)
- Support for the concurrent validity of the RCQ is provided among a substance-involved sample, in which people scoring in the pre-contemplation range showed significantly more injection drug use relative to those in the action stage. People scoring in the pre-contemplation range also remained in treatment for fewer weeks than those scoring in the contemplation range (Napper et al., 2008)
- People who had received substance use treatment were more likely to receive RCQ scores in the action stage. Moreover, those who had better treatment outcomes were more likely to be in the action or contemplation stage compared with those who had poor treatment outcomes, supporting the validity of the measure for assessing readiness for change (Heather et al., 1999)
- The RCQ's validity is supported among a sample of offenders who were court-mandated to outpatient substance use treatment because they were more likely to be in the action or contemplation stage compared to those not receiving treatment, even after controlling for level of substance use problems (Gregoire & Burke, 2004)
- In a sample of repeat DUI offenders, those determined to be in the contemplation stage by the RCQ for changing level of alcohol consumption had higher self-efficacy for controlling their drinking and had lower levels of alcohol consumption relative to those in the pre-contemplation stage (Freeman et al., 2005). Another study (Wells-Parker et al., 2000) indicates that those determined to be in the action stage by the RCQ for reducing drinking and driving behaviors have lower rates of criminal recidivism. These studies support the concurrent validity of the RCQ instrument
- Several other studies demonstrate the discriminant and convergent validity of the RCQ in measuring readiness for change among DUI offenders (Freeman et al., 2005; Wells-Parker & Williams, 2002)
- The RCQ has good predictive validity for changes in drinking behavior over time (Share, McCrady, & Epstein, 2004)

- The revised RCQ-TV shows a good fit with a three-factor structure, supporting the three scales of the RCQ-TV (Heather & Honekopp, 2008)
- The revised RCQ-TV total scale score shows good internal consistency (alpha > .70), particularly for the Action scale (alpha = .85; Heather & Honekopp, 2008). Previous studies indicated that the RCQ has satisfactory internal consistency, with Cronbach's alphas of .73 for the Pre-contemplation subscale, .80 for the Contemplation scale, .85 for the Action scale (Rollnick et al., 1992; Napper et al., 2008), and .71 for the entire scale (Day et al., 2009)
- Test-retest reliability for the RCQ scales has been found to be satisfactory (Rollnick et al., 1992), with correlations of .82 (Pre-contemplation), .86 (Contemplation), and .78 (Action). Test-retest reliability of the RCQ among those enrolled in substance use treatment is quite good over a 3-day interval (r scores range .69–.86 across RCQ scales; Heather et al., 1999). Good test-retest reliability of the revised RCQ-TV has also been demonstrated among people enrolled in alcohol treatment (r scores range .76–.88) for all stages of change, over a 3-month interval (Heather & Honekopp, 2008)

Concerns

- The validity of the RCQ has not been widely studied among offenders and additional research on its psychometric properties among this population is needed
- Little evidence has been found to support concordance between interviewer-determined stage of change and stage of change assessed by the RCQ (kappas range .08–.45; Addington, El-Guebaly, Duchak, & Hodgins, 1999)
- The internal consistency of the RCQ may be somewhat low (alpha = .69; Casey et al., 2007), particularly for the Pre-contemplation scale (alpha = .68; Napper et al., 2008) and the Contemplation scale

(alpha = .60–.65; Heather et al., 1999; Napper et al., 2008)

- The revised RCQ-TV shows low internal consistency for the Pre-contemplation (alpha = .66) and Contemplation scales (alpha = .66; Heather & Honekopp, 2008)
- The RCQ (McMurrin et al., 1998) shows low internal consistency for the Pre-contemplation (alpha = .60) and Contemplation (alpha = .49) scales

Availability and Cost

The RCQ is copyrighted but is available free of charge.

The RCQ–CV measures and related materials can be accessed at no cost at the following site, which includes information regarding scoring, interpretation, and reliability and validity of the instrument: <http://www.addiction.ucalgary.ca/researchers/instruments>

The revised RCQ-TV can be obtained at the following site, as part of a manuscript describing the validity of the instrument. Scoring and interpretation guidelines are provided in the manuscript appendices: http://www.researchgate.net/publication/232067129_A_revised_edition_of_the_Readiness_to_Change_Questionnaire_Treatment_Version

Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)

The SOCRATES provides a family of instruments designed to examine readiness for change among substance-involved populations, according to the “stages-of-change” model (Prochaska & DiClemente, 1992). The SOCRATES was developed through funding by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and is a “public domain” instrument. The original instrument provided five separate scales corresponding with the stages-of-change model, while a more recent factor analysis of the SOCRATES has led to the development of three scales: Ambivalence, Recognition, and Taking

Steps, each of which reflects different stages of motivation and readiness for treatment. The SOCRATES is often used as a repeated measure to assess change in motivation over time related to involvement in motivational interviewing interventions and substance use treatment. The 19-item version has the following recommended cut-off scores for the Recognition scale: low scores are ≤ 30 , medium scores are 31–34, and high scores are ≥ 35 . For the Ambivalence scale, cut-offs for low scores are ≤ 13 , medium scores are 14–16, and high scores are ≥ 17 .

Several versions of the SOCRATES have been developed for different populations, including the following:

- 8D/A (19 items)—drug and alcohol questionnaire for clients
- 7A-SO-M (32 items)—alcohol questionnaire for significant others of males
- 7A-SO-F (32 items)—alcohol questionnaire for significant others of females
- 7D-SO-F (32 items)—drug and alcohol questionnaire for significant others of females
- 7D-SO-M (32 items)—drug and alcohol questionnaire for significant others of males

Positive Features

- The instrument is brief to administer and is easily scored
- The SOCRATES has been used with a range of offender populations (Brocato & Wagner, 2008; Evans, Huang, & Hser, 2011; Morris & Moore, 2009; Prendergast et al., 2009; Vanderburg, 2003) and people with substance use disorders (Gossop, Stewart, & Marsden, 2007; Kelly, Finney, & Moos, 2005; Napper et al., 2008; Zhang, Harmon, Werkner, & McCormick, 2004) and is commonly used with offenders to assess readiness for change (Gunter, Antoniak, 2010)

- The Recognition and Taking Steps scales of the SOCRATES have been identified as important factors in motivation for change and are reliably distinguishable in the beginning of treatment (Carey, Maisto, Carey, & Purnine, 2001; Isenhardt, 1997; Miller & Tonigan, 1996)
- Scores on the SOCRATES are correlated with attempts to quit both alcohol and drug use (Henderson, Saules, & Galen, 2004; Isenhardt, 1997; Zhang et al., 2004)
- In support of the concurrent validity of the SOCRATES 19-item version, people scoring higher on the Recognition scale have greater drug use and symptoms of depression and anxiety than people scoring higher on the Taking Steps scale (Gossop et al., 2007)
- Also supporting the concurrent validity of the SOCRATES 19-item instrument, people with substance use disorders who spent a shorter amount of time in drug treatment were more likely to score at the Pre-contemplation stage compared to those scoring at the Determination and Action stage. Those scoring at the Action stage also had significantly fewer days of drug use than people who were at the Pre-contemplation and Determination stage (Napper et al., 2008)
- In a sample of nonviolent offenders who had committed drug crimes, the SOCRATES Recognition scale predicted arrests within the past 12 months, and both the Ambivalence and Taking Steps scales predicted drug arrests during the past 12 months (Prendergast et al., 2009)
- Among offenders with alcohol use problems, those who received a motivational interviewing intervention scored higher on the Recognition scale of the SOCRATES, in addition to change from the Pre-contemplation to Contemplation stage of change, as measured by the University of Rhode Island Change Assessment Scale (URICA) and RCQ, supporting the convergent validity of the

- SOCRATES 19-item instrument (Mann, Ginsburg, & Weekes, 2002)
- In a study of offenders who were court-mandated to substance use treatment, those who remained longer in treatment had significantly higher total scores on the SOCRATES compared to dropouts, supporting the validity of the measure (Brocato & Wagner, 2008). The SOCRATES total score also predicted length of treatment stay, and the Recognition scale predicted therapeutic alliance and length of treatment stay across groups differing by race/ethnicity and type of primary drug use
- The SOCRATES ambivalence scale shows reliable and clinically significant change from pre to post-treatment among offenders, supporting its ability to assess change in motivation over time (Morris & Moore, 2009)
- In a sample of substance-involved military personnel, the SOCRATES Ambivalence, Recognition, and Taking Steps scales are related to commitment to abstinence, disease attribution, and powerlessness, as measured by the Addiction Treatment Attitude Questionnaire (ATAQ; Mitchell & Angelone, 2006). The same study found that the SOCRATES Ambivalence scale is related to treatment completion, supporting the concurrent validity of the measure
- Internal consistency coefficients for the SOCRATES are quite good, with alphas ranging .81–.93 for the Recognition scale, .84–.88 for Taking Steps, and .71 for Ambivalence (Gossop et al., 2007; Mitchell, Francis, & Tafrate, 2005; Brocato & Wagner, 2008)
- The test-retest reliability of the SOCRATES is quite high among correctional populations (Peters & Greenbaum, 1996). Test-retest reliability (Miller & Tonigan, 1996) of the SOCRATES over a 2-day interval is also quite good across different scales, including Ambivalence (r score = .83), Recognition (r score = .99), and Taking Steps (r score = .93)

- The SOCRATES Recognition scale has moderately good sensitivity and specificity in identifying substance-dependent offenders (Peters & Greenbaum, 1996)

Concerns

- The validity of the SOCRATES has not been widely examined among individuals with CODs
- The SOCRATES may contain some confusing and ambiguous language, which can detract from effective assignment of individuals to different stages of change. The determination of stages of change by the SOCRATES is not always consistent with stages of change determined by other measures, such as by the RCQ (Burrowes & Needs, 2009; Lechner, Brug, De Vries, van Assesma, & Muddle, 1998; Littell & Girvin, 2002; Williamson, Day, Howells, Bubner, & Jauncey, 2003)
- The SOCRATES may not be able to clearly distinguish among the five stages of change (DiClemente, Schlundt, & Gemmell, 2004)
- Although a study conducted by Nochajski and Stasiewicz (2005) did not support the use of the SOCRATES with DUI offenders, the Ambivalence and Recognition subscales were found to be associated with binge drinking
- The SOCRATES 19-item version may not detect changes in motivation among drug-involved offenders who received a motivational interviewing intervention, as well as the RCQ (Vanderburg, 2003)
- Not all subscales of the SOCRATES may be useful in predicting treatment retention. For example, the Ambivalence and Taking Steps scales were not found to predict length of stay in treatment among offenders (Brocato & Wagner, 2008)
- The SOCRATES may be more useful when used in combination with the URICA to assess readiness to change (DiClemente et al., 2004)
- In a review of the existing literature, DiClemente, Schlundt, and Gemmell

(2004) found only modest support for the predictive validity of the SOCRATES

- Research provides support for both two- and three-factor structures for the SOCRATES (Demmel, Beck, Richter, & Reker 2004; Figlie, Dunn, & Laranjeira, 2005; Mitchell et al., 2005) and indicates that the number of items could be reduced
- The internal consistency of the SOCRATES is low when used to determine readiness for change via stages of change (Hodgins, 2001) that include Pre-contemplation, Contemplation, Determination, and Maintenance, with alphas < .61 (Napper et al., 2008)
- Internal consistency of the Ambivalence scale is low ($\alpha = .38$; Gossop et al., 2007)
- The SOCRATES exhibits low agreement with other validated measures of readiness to change, such as the URICA and RCQ, across the various stages of change (<40 percent agreement; Napper et al., 2008)

Availability and Cost

The SOCRATES is available free of charge at the following site: <http://casaa.unm.edu/inst/socratesv8.pdf>

Texas Christian University Motivation Form (TCU MOTForm)

The TCU MOTForm is a 36-item instrument that examines not only readiness for change but also motivation and readiness for treatment. Items are worded specifically for drug-involved populations. The instrument includes five scales, including Problem Recognition (PR), Desire for Help (DH), Treatment Readiness (TR), Pressures for Treatment (PT), Treatment Needs (TN), and Accuracy (Attentiveness). Accuracy is a single item that identifies whether the respondent is paying attention while completing the measure. Respondents indicate how strongly they agree or disagree with the statement on a one (disagree strongly) to five (agree strongly) scale. Higher scores indicate higher levels of motivation for

treatment. The TCU MOTForm can be used prior to treatment to examine motivation and readiness for change and as a repeated measure to monitor change over time. It was developed for criminal justice settings.

Positive Features

- The TCU MOTForm is brief to administer, score, and interpret
- The TCU MOTForm was developed for use in criminal justice settings
- A greater desire for help (DH) as measured by the TCU MOTForm is related to greater treatment participation (Joe, Simpson, Greener, & Rowan-Szal, 1999)
- Treatment readiness (TR) as measured by the TCU MOTForm is related to improved post-treatment outcomes (Joe, Simpson, Greener et al., 1999; Simpson, Joe, Greener, & Rowan-Szal, 2000)
- Among offender and community-based treatment samples, the TCU MOTForm scales of PR, DH, and TR are correlated with treatment engagement, satisfaction, counselor rapport, and peer support (Joe, Simpson, & Broom, 1999; Pankow et al., 2012; Simpson et al., 2000; Simpson et al., 2012). The DH, TR, and TN scales also predict significant variance in treatment participation, supporting the predictive validity of the scales (Simpson et al., 2012)
- Across gender groups among offender samples, people with higher scores on the TCU MOTForm have higher levels of treatment participation, supporting the validity of the measure (Simpson et al., 2012)
- Across prison and community-based treatment settings, the TCU MOTForm scales are related to scales from the Addiction Severity Index (ASI). Specifically, the PR, DH, and TN scales are positively related to higher scores on the psychiatric, medical, legal, drug, alcohol, and employment scales of the ASI, supporting the concurrent validity of the TCU MOTForm (Pankow et al., 2012)

- Among offenders, higher scores on the TCU MOTForm (particularly the DH, TR, and TN scales) are negatively correlated with criminal thinking scales such as power orientation, coldheartedness, criminal rationalization, and entitlement (Garner, Knight, Flynn, Morey, & Simpson, 2007), supporting the concurrent validity of the TCU MOTForm
- An exploratory factor analysis of the MOTForm instrument shows a good fit for each scale, as evidenced by a single factor structure for each subscale (Simpson et al., 2012)
- The TCU MOTForm has good internal consistency for each scale, PR ($\alpha = .87-.90$), DH ($\alpha = .66-.81$), TR ($\alpha = .75-.84$), and TN ($\alpha = .64$), in both community and criminal justice settings (Garner et al., 2007; Simpson et al., 2012; Simpson & Joe, 1993)
- The test-retest reliability of the TCU MOTForm is quite high over a 2-week interval (r scores range .74-.88)

Concerns

- Additional research is needed regarding the predictive validity of the TCU MOTForm in criminal justice and community settings and with populations who have CODs
- The TCU MOTForm scales of TN and DH may have lower internal consistency ($\alpha = .64-.67$) in comparison to the other scales (Garner et al., 2007; Simpson et al., 2012)
- A confirmatory factor analysis provides inconsistent results to support a single factor structure for each scale, and some scales may be multidimensional in nature. The authors of the MOTForm report that these results may be due to combining results obtained prior to treatment with those obtained during the course of treatment, at which time the meaning of motivation and readiness may have changed with treatment progress (Garner et al., 2007; Simpson et al., 2012)

Availability & Cost

The TCU MOTForm is available in the public domain, and the instrument along with materials related to scoring and interpretation can be found at the following site: <http://ibr.tcu.edu/forms/treatment-motivation-scales/>

University of Rhode Island Change Assessment Scale (URICA)

The URICA (DiClemente & Hughes, 1990; McConaughy, Prochaska, & Velicer, 1983) includes 24-, 28-, and 32-item versions of the self-report questionnaire examining motivation and readiness for treatment. The 32-item URICA consists of four scales made up of 8 items each, while the 28-item and the 24-item versions have four scales consisting of 7 and 6 items, respectively. The 24-item version has been adapted to those with CODs (URICA-M). The URICA-M uses simpler language, defines problems identified by the instrument with the respondent, and can be administered as an interview for those who have problems related to literacy or sight. A 12-item version of the URICA is available that examines readiness to change drinking behaviors and includes four scales. The four scales were developed to examine each of the theoretical stages of change (Pre-contemplation, Contemplation, Action, and Maintenance) related to individual motivation for treatment (DiClemente & Prochaska 1982, 1985; Prochaska & DiClemente, 1992).

The URICA appears to identify two distinctive subtypes: pre-contemplation and contemplation/action (Blanchard, Morgenstern, Morgan, Labouvie, & Bux, 2003; Edens & Willoughby, 1999, 2000). Readiness to change (RTC) can be calculated from the URICA instrument by subtracting mean Pre-contemplation scores from Contemplation, Action, and Maintenance scores (Connors et al., 2000; Project MATCH Research Group, 1997). A Contemplative Action score (CA) can be calculated by subtracting mean Contemplation scores from Action scores

(Pantalon, Nich, Frankforter, & Carroll, 2002). The following cut-off scores may be appropriate for the general population: < 8 to be classified as “Pre-contemplators,” 8–11 to be classified as “Contemplators,” and 11–14 to be classified as “Preparators into Action Takers.” URICA scale scores may vary across different settings and stages of change in the particular settings. Thus, use of the URICA to classify individuals to various stages of change should consider profiles generated from the particular setting that correspond with stages of change in that setting. The URICA differs from the SOCRATES and several other motivational screens in that it does not directly ask about motivation for alcohol or drug treatment but instead presents questions in a more general manner. The URICA does not require clinical training to administer or score.

Positive Features

- The URICA is brief to administer and score
- The URICA has been used with offender populations (Alexander & Morris, 2008; Brodeur, Rondeau, Brochu, Lindsay, & Phelps 2008; Levesque, Gelles, & Velicer, 2000; Polaschek, Anstiss, & Wilson, 2010; Tierney & McCabe, 2004), people with substance use disorders (Callaghan et al., 2008; Budney, Higgins, Radnovich, & Novy, 2000; Budney, Moore, Rocha, & Higgins, 2006; Field, Adinoff, Harris, Ball, & Carroll, 2009; Jungerman, Andreoni, & Laranjeira, 2007), and those with CODs (Bellack et al., 2006; Kinnaman, Bellack, Brown, & Yang, 2007; Nidecker, DiClemente, Bennett, & Bellack, 2008)
- The URICA has been adapted for domestic violence offenders (URICA-DV), and the instrument properties are consistent with the original URICA four-scale model. The URICA-DV shows good psychometric properties and is correlated with domestic violence behaviors such as history of violence, blame, and changing violent behaviors (Levesque et al., 2000)
- The URICA-DV demonstrates good concurrent validity (Alexander & Morris, 2008) such that those determined to be in later stages of change (higher scores on contemplation, action and maintenance) report less psychological aggression against their partner during the previous 6 months
- The URICA’s validity in assessing readiness for change is demonstrated in outpatient substance use treatment settings (Field, Duncan, Washington, & Adinoff, 2007), where RTC scores are correlated with increased anger problems and experience of recent life stressors, suggesting that RTC reflects the desire to change and seek help. In these settings, CA scores are negatively correlated with alcohol problems and anxiety, indicating that CA may reflect commitment to change substance use behaviors. Three studies involving outpatient substance use treatment participants (Budney et al., 2000; Budney et al., 2006; Jungerman et al., 2007) found that URICA scores were negatively correlated with marijuana use and related problems after treatment, supporting the concurrent validity of the URICA (Callaghan et al., 2008)
- Support for the convergent and concurrent validity of the URICA has been shown in outpatient treatment settings, in which higher RTC scores are correlated with more severe drug and alcohol problems (Field et al., 2009), while higher CA scores are associated with less severe alcohol and drug use problems and less severe familial and medical problems (Field et al., 2009)
- The validity of the URICA has also been demonstrated among people with CODs. Among this population, higher psychiatric distress is correlated with endorsement of negative aspects of drinking and higher scores on the Maintenance scale of the URICA, indicating greater difficulties in attempts to maintain sobriety (Velasquez, Carbonari, & DiClemente, 1999)
- In support of the convergent validity of the URICA among people who have CODs, the URICA-M is correlated with other measures of change, such as the Process

of Change Scale (POC; DiClemente, Carbonari, Addy, & Velazquez, 1996) and its subscales and the “cons” of drug use from the Decisional Balance Scale (DBS; Velicer, DiClemente, Prochaska, & Brandenburg, 1985). The relationship between the POC and the URICA-M are strongest among depressed individuals (Nidecker et al., 2008)

- The URICA is able to discriminate between readiness to change among people who are alcohol dependent, with and without co-occurring depression (Shields & Hufford, 2005)
- The concurrent and convergent validity of the URICA in predicting change in criminal behaviors among offenders is supported by high correlations (r score = .80) with the Criminogenic Needs Inventory (CNI; Coebergh, Bakker, Anstiss, Maynard, & Percy, 2001) and low correlations (r score = -.42) with an inventory of deceptive behaviors, the Balanced Inventory of Desirable Responding (BIDR; Paulhus, 1998; Polaschek et al., 2010)
- The URICA has good psychometric properties in predicting change in criminal behaviors (Field et al., 2009; Tierney & McCabe, 2004; Polaschek et al., 2010)
- The URICA-M demonstrates good psychometric properties as a unitary scale among those with CODs (Nidecker et al., 2008), as the Pre-contemplation scale is negatively correlated with other scales (-.25 to -.30), while Contemplation, Action, and Maintenance scales are positively correlated with each other (r scores range .48–.80)
- The URICA has good internal consistency among people with CODs (Pantalon & Swanson, 2003). When applied to changing criminal behavior among offenders, internal consistency is acceptable for the 32-item URICA (α = .82) and across scales of Pre-contemplation (α = .75–.83), Contemplation (α = .60–.90), Action (α = .81–.93), and Maintenance (α = .89–.90; Polaschek et al., 2010;

Tierney & McCabe, 2004). Internal consistency of the URICA is also good when applied to changing substance use behaviors, for scales of Pre-contemplation (alphas range .73–.80), Contemplation (alphas range .72–.90), Action (alphas range .71–.81), and Maintenance (alphas range .67–.74; Field et al., 2009; Nidecker et al., 2008)

- The URICA has good reliability, with estimates ranging .79–.88 (Carey, Purine, Maisto, & Carey, 1999). Reliability estimates for the URICA are .68–.85 among alcohol, opiate, cocaine, and nicotine-dependent individuals (Blanchard et al., 2003)

Concerns

- Additional research is needed to establish the validity of the URICA with offenders
- Among people with CODs, the URICA may not predict levels of treatment participation, treatment retention, dropout, or other treatment outcomes (Bellack et al., 2006; Kinnaman et al., 2007)
- Research examining the validity of the URICA has yielded mixed results. Studies involving people with alcohol user disorders and psychotherapy clients provide support for the validity of the URICA’s four scales, but studies involving people with other drug use disorders do not provide similarly strong support (Carey et al., 1999; DiClemente et al., 2004)
- Although good concurrent validity was found for the four URICA scales and for the overall score, one study found that neither the scales, nor the overall score successfully predicted treatment outcome (Blanchard et al., 2003)
- The URICA produces scores related to four stages of change. However, these aren’t precisely aligned with the most recent transtheoretical model of change (Prochaska et al., 1992), in which the Preparation stage has been eliminated due to poor fit with the instrument’s underlying factor structure (Polaschek et al., 2010)

- When applied to changing criminal behavior, the four-factor structure of the URICA may be more accurately represented by deletion of items 2, 8, and 24, based on findings of improved internal consistency and fit across the various scales (Polaschek et al., 2010). The internal consistency of the Contemplation scale may also be low among offenders when applied to changing criminal behaviors ($\alpha = .90$; Polaschek et al., 2010)

Availability and Cost

The URICA is available free of charge. The URICA instruments and materials describing scoring and interpretative guidelines can be found at the following site: <http://habitslab.umbc.edu/urica/>

Recommendations for Motivational Screening Instruments

Information regarding motivational screening instruments is based on a critical evaluation of the literature, including comparative research examining the efficacy of these instruments. Important factors in determining the utility of motivational screens include empirical evidence supporting the reliability and validity of the instruments, cost of the instruments, and ease of administration and scoring within the criminal justice settings. Motivation can also be focused on a variety of domains (e.g., substance use, mental health, criminal justice involvement). Specific to the area of motivational screening, instruments recommended are those that closely align with the transtheoretical model (TTM) and stages of change and that have demonstrated validity within the criminal justice system. The following instruments are recommended:

1. The Texas Christian University Motivation Form (TCU-MOTForm). This instrument is unique in identifying not only readiness to change but also variables related to motivation and treatment engagement, including problem recognition, desire for help and treatment readiness.

(or)

2. The University of Rhode Island Change Assessment Scale (URICA), which provides efficient identification of readiness to change and directly maps onto four out of the five transtheoretical stages of change. The URICA-M is specifically designed for people with CODs and provides simpler language and a shorter administration time.

Both of these instruments have been examined in the criminal justice system and/or among people with CODs. The URICA is recommended for settings in which it is important to determine readiness to change, while the TCU-MOTForm can also be used to assess issues related to treatment engagement. Each of these measures requires approximately 10–15 minutes to administer and score.

Assessment Instruments for Substance Use and Treatment Matching Approaches

The use of assessment to match justice-involved individuals to appropriate levels of behavioral health services has been recognized as among the most fundamental of evidence-based approaches (CSAT, 2005b). The goal of treatment matching is to provide an individualized examination of a range of mental and substance use disorders and other related psychosocial problems to assist in matching offenders to appropriate levels of services. Triage to appropriate services is particularly important among offenders who have CODs, as mental and/or substance use disorders often go undetected, and this population is often mismatched to less intensive services than are needed. This section describes several treatment matching approaches, as well as specific assessment instruments to assist in matching offenders with CODs to specific services. Matching approaches include the Risk-Need-Responsivity model and the American Society of Addiction Medicine's Patient Placement Criteria (ASAM PPC). Both of these approaches provide

detailed frameworks for assessing substance use disorders, mental disorders, and other areas related to placement in treatment and supervision services. Assessment instruments and treatment matching approaches should be administered by mental health professionals with advanced clinical training related to mental and substance use disorders, diagnosis, referral to treatment, and treatment planning. Several of the structured and standardized self-report assessment instruments described in this section can be administered by nonclinicians, although staff should be knowledgeable about appropriate referral sources.

Specific assessment instruments described in this section include the Addiction Severity Index (ASI), the Timeline Followback (TLFB), and the TCU Correctional Justice instruments (TCU CJ).

Identifying Gaps in Offender Services

Despite the availability of several treatment matching approaches and instruments, there are significant challenges in matching offenders who have CODs to appropriate levels of care, due to the lack of available treatment and supervision services in many jurisdictions. Belenko & Peugh (2005) developed a protocol to identify gaps in treatment services (primarily substance misuse services) within correctional systems. In order to identify offenders' treatment needs, guidelines were developed to assess substance use severity, recency of substance use problems, consequences of substance use, and other psychosocial and health problems. The second step involved surveying available correctional treatment resources and categorizing them according to the following schema: (1) no treatment (low level of drug use, no drug related consequences), (2) short-term intervention (self-help, motivational interviewing), (3) outpatient treatment (individual or group counseling), and (4) residential treatment (separate housing, long-term intensive treatment for those with several drug related consequences and frequent drug use). Using this protocol, they compared offenders' treatment needs with actual treatment received within a large correctional

sample. Results indicated that approximately a third of male and female prisoners needed residential treatment, and approximately 16–18 percent needed outpatient treatment. A survey of correctional institutions revealed that only 19 percent of males and 23 percent of females actually received substance use treatment, and of those receiving treatment, about a third received only drug education or self-help groups (e.g., AA/NA). These findings highlight the importance of using a formal assessment approach to identify needs of offenders and to provide matching to specific levels of treatment services, and challenges in treatment matching within an environment that often includes scarce treatment resources and with a population that has pronounced treatment needs (e.g., offenders with CODs).

Treatment Matching Approaches

Risk-Need-Responsivity Model

The Risk-Need-Responsivity (RNR) model identifies the importance of identifying “criminogenic needs” of offenders that are related to recidivism and using this information to match offenders to different levels of treatment and supervision (Andrews & Bonta, 2010b). The “risk principle” encourages assessment of criminal risk to ensure that intensive resources (e.g., CODs treatment, substance use treatment) are reserved for offenders who are at moderate to high risk levels. Key predictors of criminal risk include “static” or unchanging factors (e.g., age, age at first arrest, number of prior arrests/convictions) and “dynamic” or changeable factors, such as criminal attitudes and beliefs, criminal peers, substance use problems, employment, education, family problems, and lack of prosocial leisure skills.

The most important predictors of criminal risk are past criminal behavior and antisocial attitudes, beliefs, and peers, although substance use problems also represents an important risk factor. Although mental illness is not an independent risk factor for recidivism, offenders who have

mental disorders are at elevated criminal risk due to having high levels of criminogenic needs (e.g., ingrained criminal belief systems, poor employment history, lack of education). Offenders who have CODs are at particularly high risk for recidivism and should be a priority population for programming and specialized supervision (Drake, 2011). A range of risk assessment instruments has been developed that examines both static and dynamic risk factors and provides overall criminal risk scores and recommendations for placement in different levels of treatment and supervision. Various risk assessment instruments are described in the "Risk Assessment" section of this monograph.

The RNR model asserts that dynamic risk factors ("criminogenic needs") should be targeted in individualized assessment and offender programming to most effectively reduce recidivism. Many offender programs, including those providing treatment for CODs, do not address a range of these criminogenic needs, and as a result, are less likely to reduce recidivism (Lowenkamp & Latessa, 2005). Research indicates that there is a cumulative effect in addressing criminogenic needs, resulting in a linear relationship between the number of needs addressed in offender treatment and supervision and positive outcomes related to recidivism (Bonta & Andrews, 2010; Carey & Waller, 2011).

The RNR model also indicates the need to address "responsivity" in offender programs, referring to factors that influence the offender's engagement in evidence-based treatment (e.g., services that address dynamic risk factors/criminogenic needs). Responsivity factors include mental health problems, need for gender-specific services, history of trauma/PTSD, need for culturally sensitive programming, and various disabilities. If unaddressed, responsivity factors can undermine engagement, retention, and outcomes in offender treatment and supervision.

Consideration of the three components of the RNR model (risk, criminogenic needs, responsivity)

provides a very useful framework for matching offenders to different types and intensity of treatment and supervision. Appropriate matching based on these principles leads to reductions in recidivism and other positive outcomes in offender programs (Andrews et al., 2006). In summary, offenders who are assessed to be at higher risk should be prioritized for intensive services, and these services should target criminogenic needs and responsivity factors in order to reduce recidivism and improve outcomes in treatment and supervision. Lower risk offenders do not require the same services or intensity of services to achieve comparable outcomes (Thanner & Taxman, 2003).

Risk-Needs-Responsivity (RNR) Simulation Tool

Crites & Taxman (2013) have developed a web-based Risk-Needs-Responsivity (RNR) Simulation Tool that categorizes community treatment programs according to their focus on evidence-based practices related to criminogenic needs and matches offenders to their particular level of risk and needs. The RNR Simulation Tool is based on the ASAM PPC model and a similar treatment matching model, Level of Care Utilization System (LOCUS), developed by the American Association of Community Psychiatrists (2009). The RNR Simulation Tool classifies offender programs by assessing several domains: target, content, dosage, and implementation quality. These domains are linked to increased effectiveness of offender programs (Andrews & Dowden, 2005). Information from each domain is then used to match offenders to specific programs. The following types of information are compiled for each domain:

- Target addresses the behavior(s) that are the focus of the particular treatment program. These include reducing the severity of substance use problems, cognitive restructuring of criminal thinking and reducing criminal peers, self-improvement and self-management strategies (e.g.,

improving social skills, problem solving, self-control), improving social/interpersonal skills, identifying deficits in physical/life needs (e.g., employment, education, housing), and implementing a sanctions-only approach for those who are at low risk. As noted previously, effective “targets” for offender treatment programs are those that address criminogenic needs that are linked to reducing recidivism (Andrews, 2012; Andrews & Bonta, 2010a, 2010b)

- Content addresses the therapeutic orientation of treatment programs, including the main area of treatment focus, services provided, and reinforcement of treatment skills. The content of offender programs should be a CBT skills-based approach to address factors such as antisocial behaviors, thinking, and peers, in addition to substance use disorders (Lipsey, Landenberger, & Wilson, 2007). Other key content includes social restrictiveness or supervision (e.g., curfews, probation visits, and mandatory daily program attendance), which can reduce recidivism (Drake, Aos, & Miller, 2009)
- Dosage addresses the amount (total number of hours), duration (number of weeks or months), frequency (number of times per week), and quantity (number of hours per week) of services provided by treatment programs. Dosage serves to moderate the risk for recidivism (Lipsey & Landenberger, 2005). Moreover, risk level determines the appropriate dosage necessary, with high-risk offenders generally requiring at least 300 hours of cognitive-behavioral treatment (CBT) and related services, moderate-risk offenders requiring approximately 200 hours of CBT and related services; and low-risk offenders requiring approximately 100 hours of services (Bourgon & Armstrong, 2005)
- Implementation Quality addresses whether programs are implemented as designed. Key factors include adherence to treatment protocols, proper staff training in delivering

services, certification in administration of treatment protocols, supervision of staff who implement treatment protocols, use of quality assurance measures, and adequate staff communication regarding participants’ treatment progress

A second part of the RNR Simulation Tool involves profiling of offenders, based on offenders’ risk level for recidivism. Risk level is composed of factors related to criminal history (leading to classification as “low,” “moderate,” or “high-risk” offenders), primary needs (e.g., substance use disorders, criminal thinking), clinical destabilizers (e.g., presence of mental disorders), lifestyle destabilizers (e.g., poor social supports, lack of education, unemployment, lack of stable housing), and stabilizers (i.e., opposite of destabilizing factors, such as educational achievement, stable housing, social support). Programs are categorized according to these features and placed in one of six groups (Crites & Taxman, 2013) that are differentiated by recidivism risk level, primary needs, responsivity (appropriate match between individual’s needs and program services), dosage, program integrity (factors associated with implementation fidelity), and social restrictiveness.

Summary of Key Issues

- The Risk-Needs-Responsivity (RNR) Simulation Tool uses a series of algorithms generated from the Bureau of Justice Assistance, Survey of Inmates data set to match offenders with appropriate programs
- The tool also helps to identify gaps between offenders’ needs and the existing program resources in a particular community (Crites & Taxman, 2013)
- The RNR model provides a useful framework to identify and address criminogenic needs and responsivity factors that influence treatment outcomes among offenders with CODs, including relapse and recidivism
- The RNR Simulation Tool is based on an empirically derived theoretical approach to identify the appropriate level of treatment

and supervision services that are needed to promote positive outcomes among offenders who have substance use problems and CODs

Concerns

- Although the RNR Simulation Tool is based on a sound theoretical model to determine treatment matching for those involved in the justice system, it is a new approach and requires application and testing to assess its validity, including its effectiveness in reducing recidivism
- Several other assessment tools are available to examine offenders' risk and needs for psychosocial interventions. These include the Addiction Severity Index (ASI; McLellan et al., 1985), the Global Assessment of Individual Needs (Dennis, Titus, White, Unsicker, & Hodgkins, 2003), the Level of Service Inventory-Revised (Andrews & Bonta, 1995), and a range of other risk assessment instruments

Availability and Cost

Information regarding the RNR Simulation Tool is available at the following site: <http://www.gmuace.org/tools/>. Direct link to the RNR Simulation Tool: <http://www.gmuace.org/tools/program-tool>

American Society of Addiction Medicine-Patient Placement Criteria (ASAM PPC)

The ASAM PPC is a widely used assessment and triage approach that employs patient placement criteria to identify appropriate levels of care for people who have substance use disorders and CODs. The ASAM PPC for the Treatment of Psychoactive Substance Use Disorders (Hoffman, Halikas, Mee-Lee, & Weedman, 1991) were developed through a consensus process, and this approach has subsequently been used in a number of states and increasingly by managed care organizations to modify treatment matching approaches for use in the behavioral health field. The ASAM PPC were revised in 1996 and again in 2001 (ASAM PPC-2R; Mee-Lee, Shulman,

Fishman, Gastfriend, & Griffith, 2001). The most recent revision, ASAM Criteria-Treatment Criteria for Addictive, Substance Related, and Co-occurring Conditions (Mee-Lee, 2013), reflects changes to the DSM-5 diagnostic criteria.

Underlying concepts of the ASAM PPC (Mee-Lee & Shulman, 2003) include the following: (1) the biopsychosocial perspective of addiction that encompasses etiology, expression, and treatment of addiction, allowing for a more comprehensive assessment and treatment approach; (2) individualized treatment that provides a patient-driven approach; (3) multidimensional assessment (see the six domains below) that determines level of services needed; (4) treatment matching that integrates all six domains (described in the following section) and addresses issues of motivation to change, management of social/occupational risk factors, medication management (e.g., detoxification, craving management), and other services (e.g., self-help/12-step groups, such as NA and Dual Recovery Anonymous); and (5) monitoring of care that includes relapse prevention, treatment engagement and retention, and other important social/occupational factors.

The ASAM PPC provide separate guidelines for placement in adolescent and adult treatment services. The ASAM PPC-2R guidelines operationalize six assessment dimensions that define biopsychosocial severity within the context of behavioral health services: (1) acute intoxication and/or withdrawal potential; (2) biomedical conditions and complications; (3) emotional, behavioral, or cognitive conditions and complications; (4) readiness to change; (5) relapse, continued use, or continued problem potential; and (6) recovery/living environment. Criteria described for each of the six dimensions are then used to guide placement in one of five levels of treatment services, which vary by the intensity of services provided: (1) level 0.5—Early intervention, (2) level I—Outpatient treatment, (3) level II—Intensive outpatient/partial hospitalization treatment, (4) level III—

Residential/inpatient treatment, and (5) level IV—Medically managed intensive inpatient treatment.

The ASAM PPC-2R (2001) were the first to identify the need for substance use programs to provide integrated services for CODs. The ASAM PPC-2R supplement also reviews issues related to medically assisted treatment for alcohol use disorders (AUDs), detoxification, and relapse prevention. The ASAM PPC-2R guidelines recognize that for people with CODs, whichever disorder causes the most functional impairment should be considered in making the placement to a particular type of treatment setting. Treatment programs described in the PPC-2R may be either “dual diagnosis capable” or “dual diagnosis enhanced,” to address people with CODs who demonstrate a wide range of psychopathology. Specifically, dual-diagnosis capable programs are those that address the comorbidity between substance use disorders and more stable mental health problems, where the co-occurring mental health problems do not interfere with engagement and progress in addiction treatment. Policies and procedures address dual diagnoses and allow for collaboration with mental health services to appropriately handle CODs and provide psychopharmacological monitoring/assessment both on site and via coordinated off-site services. Dual diagnosis enhanced programs accept individuals who have CODs and more unstable mental disorders. These programs allow for mental health problems to be managed simultaneously with addictions, providing continuity in the overall treatment approach. Policies and procedures include more stringent monitoring of participants and integration of mental health treatment with addictions treatment, which allows for treatment continuity for both disorders. For each level of treatment, criteria are specified (within dimensions 2–6) for dual-diagnosis capable and enhanced programs.

ASAM developers provide a range of information to aid in standardizing clinical assessment and placement, in addition to materials to encourage individualized treatment planning. Tutorials and

distance learning are also provided to help train individuals in proper assessment and appropriate treatment placement. The instrument also employs automated software that utilizes an algorithm (Turner, Turner, Reif, Gutowski, & Gastfriend, 1999) for matching individuals with appropriate treatment programs. This software application demonstrates good concurrent validity with other standardized assessments, such as the Addiction Severity Index (ASI), and predicts treatment outcomes for those who are appropriately matched (Magura et al., 2003; Sharon et al., 2003).

One caveat to these research findings is that many individuals were mismatched for treatment or did not show up to treatment and thus were not included in these results (Angarita et al., 2007; Gastfriend & Mee-Lee, 2011). In a study of alcohol users, those who were mismatched to more intensive levels of treatment did not show greater improvement in treatment outcomes than those who were correctly matched to treatment. However, people mismatched to less intensive levels of treatment showed poorer treatment outcomes (Magura et al., 2003). Another study indicated that those who needed higher levels of care did not receive it (e.g., residential treatment Level III versus hospitalization Level IV) and were in treatment significantly longer than those who were matched to the correct level of care (Sharon et al., 2003).

Difficulty in treatment matching may be due in part to substantial disagreement (81 percent) between computerized algorithm results and clinician recommendations (Sharon et al., 2003). Clinicians may judge the algorithm’s matching recommendations as too restrictive. The algorithm may classify individuals into higher levels of treatment based on one item in the PPC criteria rather than considering other items that provide more relevant coverage of that particular dimension. For example, concerns related to emotion/behavioral functioning may lead to matching people to Level IV, but these people may be just as well suited as people matched to Level III to complete the treatment program successfully.

Challenges in Applying the ASAM Criteria in Justice Settings

Although the ASAM criteria have been commonly used in community-based settings to guide treatment matching, they have only recently been implemented in the justice system. For example, only about a third of drug court survey respondents indicated the use of the ASAM PPC (American University, 2001). Several states now use the ASAM criteria to place individuals convicted of DUI/DWI offenses in different types of treatment programs. The ASAM PPC or similar approaches provide a structured approach to potentially match justice-involved individuals more effectively to different levels of treatment intensity, structure, and supervision (CSAT, 2005b).

There are several challenges in implementing the ASAM criteria in justice settings (Mee-Lee, 2013). First, specific to readiness to change, there may be an unreasonable expectation, particularly in the first few months of treatment, that offenders are in the “action stage” of recovery and are able to comply with justice system mandates for abstinence from drugs and alcohol and fully engage with treatment services. In addition, some treatment programs that are mandated by the courts may be too short in duration for participants to reach the “action stage” of recovery and to maintain healthy and prosocial behaviors.

Some judges or community supervision officers may also place offenders in mandated treatment based on their own view of what level of care is needed rather than by conducting a formal assessment to identify treatment needs and match people to appropriate services. In contrast, some courts may recommend treatments that seem more “restrictive” such as residential programs, in part because the proxy of confinement gives a sense of comfort related to criminal recidivism potential or violence risk reduction. This can be problematic if the treatment needs are not as intensive as the treatment that falls under a court order.

In other justice settings, offenders are placed in treatment based on the resources that are

available rather than on individualized needs for treatment. As a result, offenders may not receive a comprehensive assessment or the optimal services that are needed. Another consideration is that the recent emphasis on risk assessment procedures in justice settings may result in offenders receiving treatment and supervision that is focused primarily on antisocial behaviors, attitudes, and peers, without considering the importance of other factors, such as co-occurring mental disorders and substance use issues, employment, education, and family services, that also influence criminal involvement and recovery.

Finally, the ASAM PPC are based on a medical model of substance use treatment that includes an emphasis on individual counseling and oversight provided by medical personnel, whereas group counseling is the preferred approach for offenders (including those with substance use disorders), and oversight is typically provided by justice or substance use treatment personnel. A related concern is that the ASAM PPC do not currently provide a “dimension” that addresses risk for criminal recidivism, nor does the PPC provide recommendations for how to modify “levels” of treatment to address the unique resources and limitations related to drug courts, day treatment, other community correctional treatment programs, or jail and prison-based programs.

Summary of Key Issues

- Implementation of the ASAM PPC-2R criteria includes the use of standardized assessment tools and computerized software, which can improve accuracy in matching individuals to appropriate treatment programs (Baker & Gastfriend, 2003; Gastfriend & Mee-Lee, 2011)
- A study involving outpatient treatment programs provides support for the ASAM model in treatment matching and indicates that programs using standardized ASAM PPC assessment tools are more likely to provide both counseling and other support services that follow practice guidelines

developed by ASAM or CSAT (Rieckmann, Fuller, Saedi, & McCarty, 2010)

- The Addiction Severity Index (ASI) is a common standardized assessment tool used in ASAM implementation in outpatient settings and criminal justice settings (Cohen, Mankey, & Wendt, 2003; Koob, Brocato, & Kleinpeter, 2011; Magura et al., 2003; Marlowe, Festinger, Dugosh, Arabia, & Kirby, 2008; Rieckmann et al., 2010)
- The Global Assessment of Functioning (GAF) and Structured Clinical Interview for Diagnostic Statistical Manual (SCID) are commonly used for mental health assessment and diagnosis in treatment settings that use the ASAM criteria (Kosanke, Magura, Staines, Foote, & DeLuca, 2002; Magura et al., 2003; Rieckmann et al., 2010)

Concerns

- Challenges in implementing the ASAM PPC criteria in justice settings include the need to address criminal risk as it affects placement in various levels of treatment and supervision, matching to specialized offender programs (e.g., drug courts), the need to triage offenders to programs that provide group treatment services, and the need to integrate specialized CODs treatment services with intensive supervision and court monitoring
- Further research is needed to establish the validity of the ASAM PPC in improving treatment outcomes among offenders who have substance use disorders and CODs
- Although the ASAM PPC computerized software helps to predict treatment outcomes among people matched to various levels of treatment, studies examining placement outcomes using the ASAM PPC criteria generally do not include people who were mismatched to treatment and who did not attend treatment. Many individuals who are mismatched to treatment show poorer treatment outcomes. In addition, there is significant disagreement between ASAM

PPC treatment placements generated by the computerized algorithm and clinician-recommended treatment placements. It is important to consider factors that may contribute to these disparities, including the emphasis placed on certain dimensional criteria by the computerized algorithm. Further research is needed to examine treatment outcomes among people who are mismatched to treatment based on the ASAM PPC computerized algorithm, and to identify strategies to reduce these mismatches

- The ASAM PPC materials are somewhat costly to purchase

Availability and Cost

The most recent version of the ASAM PPC, The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-occurring Conditions and the ASAM PPC supplement can be purchased from the American Society of Addiction Medicine at the following site: <http://www.asam.org/publications/the-asam-criteria>

The cost of the ASAM PPC is \$95 (\$85 for members of ASAM), and the supplement costs \$65 and is available for the Kindle.

ASAM recommends a set of assessment and placement instruments that adhere to ASAM criteria, and these are available for purchase. Assessment and placement instruments cost between \$50 and \$80, and each instrument contains 25 copies. Instruments can be obtained at the following site: <http://changecompanies.net/asamcriteria/assessments.php>

Substance Use Assessment Instruments and Treatment Matching

Several assessment instruments have been developed for treatment matching as part of the RNR Simulation Model and the ASAM PPC, as described in previous sections. A number of risk assessment instruments are also available to assist in matching to treatment and supervision, as described in the "Risk Assessment" section

of this monograph. Several other substance use assessment instruments are frequently used in treatment matching in behavioral health settings and are described in this section. These include the Addiction Severity Index (ASI), the Texas Christian University intake and assessment forms/instruments, and the Timeline Followback (TLFB).

Addiction Severity Index-Fifth Version (ASI-5/ASI-6)

The ASI (McLellan et al., 1992; McLellan, Luborsky, Woody, & O'Brien, 1980) is one of the most widely used instruments for screening, assessment, and treatment planning related to substance use disorders. The 155-item instrument was designed as a structured interview to examine symptoms, frequency of substance use, and other psychosocial areas that are frequently affected by substance use. The ASI requires 45–60 minutes to administer and 10–20 minutes to score. Additional versions of the instrument have been developed for clinical and training purposes (ASI-CTV), and a brief version is available that takes approximately 30 minutes to administer (ASI-Lite). The ASI-Lite has been adapted for use in the VA system (ASI-L-VA).

Self-report and clinician administered computerized versions of the ASI are available (ASI-Net and CA ASI-Net), as are versions designed for interactive voice response (ASI-IVR) and automated telephone administration (Brodey et al., 2004; Rosen et al., 2000). The ASI-Multimedia Version (ASI-MV; Butler et al., 2001) is a computerized form of the instrument, and was designed to reduce burden on treatment counselors. The instrument provides virtual simulation of a clinician-administered interview and includes audio and video presentations as well as “skip-logic.” The instrument has been found to be reliable and valid (Butler et al., 2001) and generates two summary scores: (1) composite scores for each ASI domain, and (2) severity ratings by domain for problems occurring during the past month. The composite scores generated by the interview and automated versions of the

ASI are highly correlated (.91), indicating high reliability between the different versions of the instrument (Brodey et al., 2004).

The ASI includes seven domains of functioning commonly affected by substance use, including drug and alcohol use (separate sections), legal status, family and social relationships, employment and support status, medical status, and psychiatric status. The ASI examines the severity of problems in each of these domains over the past month and the need for treatment. The instrument also reviews indicators of emotional, physical, and sexual abuse. Although the ASI measures frequency of use, it does not address quantity of use, as quantity may be underestimated and frequency is easier to recall (McLellan et al., 1992). The ASI-5 includes interviewer severity ratings (ISR) that combine current and lifetime symptoms within each domain to help assess the need for treatment. The ASI composite summary scores (CS) are generated for each domain and assess the current severity of symptoms. Evaluation factors (EF) are available for five of the domains, and clinical factors (CF) are included for all seven domains. CFs measure current and lifetime functioning scores that reflect a global severity rating. EFs measure individual functioning during the past month.

Many offender programs have developed modified versions of the ASI for use in substance use screening. A sixth edition of the ASI is now available. Revisions to the ASI-6 include replacement of the ISR ratings with clinical indices of lifetime functioning (CIs). An interval of 6 months has been added in addition to past month and lifetime ratings. The ASI-6 includes “skip-out” questions that can reduce administration time to approximately 1 hour, and the instrument provides more specific wording of questions to increase reliability. Item Response Theory (IRT) analysis indicates that in comparison to previous versions, the ASI-6 is better able to address changes in substance use problems and treatment needs of diverse populations (e.g., welfare clients, drug court participants, individuals

who are homeless) and has improved psychometric properties across the seven domains. The ASI-6 consists of nine summary scores (“Recent Status Scores” or RSS) that map to the seven Composite Scores in the ASI-5, with two additional summary scores that address family/social support and child problems (McLellan, Cacciola, Alterman, Rikoon, Carise, 2006; Denis, Cacciola, Alterman, 2013). The ASI-6 also contains a follow-up interview that addresses change in symptoms over time. Items from the ASI-6 differentiate between current symptoms (past 30 days) and those experienced since the last administration of the ASI interview.

Positive Features

- The ASI-6 has been translated into Spanish and several other languages
- The ASI is a public domain instrument and is available at no cost
- The ASI describes recent and long-term patterns of substance use and examines a range of different legal and illegal substances. The ASI can also be used to screen for trauma and PTSD (Cacciola et al., 2007; Najavits et al., 1998). The ASI-6 provides more structure than previous versions of the instrument and enhanced ability to identify drug, alcohol, and mental health problems (Cacciola, Alterman, Habing, & McLellan, 2011)
- Recent validity studies indicate improvement of several scales on the ASI-6 in comparison to the ASI-5 (Denis et al., 2013)
- Many criminal justice agencies have used sections of the ASI-6 for substance use screening (McLellan et al., 1985; Peters et al., 2000), as well as the full ASI-6 for assessment purposes (Eriksson et al., 2013; Ettner et al., 2006; Pankow et al., 2012; Proctor, 2012; Serowik & Yanos, 2013)
- Among offenders, the ASI-6 (McLellan et al., 2006) shows good concurrent validity, including significant correlations with the Texas Christian University Drug Screen II (TCUDS-II), a validated substance use screening measure. Scores from the ASI-6 domains are significantly correlated with scales from other TCU instruments. For example, the ASI-6 is significantly correlated with the TCU psychological functioning (PSYForm)–self-esteem scale; the TCU social functioning (SOCForm) scales of social desirability, social functioning, and hostility; the psychological functioning scales of anxiety/depression; and the TCU criminal thinking scales (CTS; Pankow et al., 2012). The ASI-6 (Pankow et al., 2012) is also significantly correlated with other validated psychological measures, such as the K10 (Kessler et al., 2003) and the PTSD Checklist (PCL; Weathers et al., 1993)
- ASI normative data is available for criminal justice populations (McLellan et al., 1992)
- The ASI is highly correlated with objective indicators of addiction severity (McLellan et al., 1980, 1985; Searles et al., 1990) and with alcohol use disorder and substance use disorder diagnoses (Rikoon, Cacciola, Carise, Alterman, & McLellan, 2006). The ASI-Drug Use section was one of three sets of screening instruments found to be the most effective in identifying substance-dependent offenders (Peters et al., 2000)
- Among people seeking substance use treatment, the ASI-6 domains/scales show good concurrent validity with other related measures and are correlated with measures of the following: (1) medical problems and physical health, as measured by the Short Form Mental Health Survey (SF-12, r score = $-.64$); (2) family/social support, as measured by the Social Readjustment Scale Self-Report, SAS-SR-social (r score = $-.34$); (3) family and social problems, as measured by the SAS-SR social (r score = $.40$); (4) employment, as measured by the SAS-SR Work, (r score = $.76$), (5) alcohol problems, as measured by the Short Index of Problems (SIP-Alcohol, r score = $.68$; Alterman, Cacciola, Ivey, Habing, & Lynch, 2009); (6) drug problems, as measured by the SIP-Drugs (r score = $.61$; Alterman et al., 2009); (7) legal problems,

as measured by prior arrests (r score = .15); and (8) mental health problems, as measured by the Symptom Checklist Revised (SCL-10R, r score = .68; Cacciola Alterman, Habing, & McLellan, 2011)

- Among people with substance use disorders, the ASI-5 domains/scales also demonstrate good concurrent validity with other related measures of physical health, current/lifetime alcohol problems, recent/lifetime drug problems, legal problems, and family/social problems (Alterman et al., 2009). The ASI-6 domains may provide better coverage than the original ASI-5 domains, particularly the family/social area and its subscales (Denis et al., 2013). The ASI-6 also demonstrates higher correlations than the ASI-5 with concurrent validity measures in five of the seven original domains (employment, psychiatric, family/social, legal, and drug; Denis et al., 2013)
- The ASI-6 has good internal consistency across all domains, the summary scales, and across different race/ethnicity groups (alphas range .73–.94; Cacciola et al., 2011). Most of the ASI-6 RSS domains are highly correlated with the ASI-5 CS scales (Denis et al., 2013)
- When administered over a 2–3 day period to a treatment-seeking sample, the ASI-5 has good interrater reliability for agreement with the ASI-L-VA on most ISR ratings and scores for CS, CF, and EF, across domains of alcohol, drugs, and psychiatric problems (ICCs range .62–.89; Cacciola et al., 2007). Similarly, the ASI-5 has adequate test-retest reliability for most ISRs ratings and CS, CF, and EF scores, when readministered after short intervals (Cacciola et al., 2007)
- The seven domains of the ASI-5 have good internal consistency (alphas range .73–.92) for both current and lifetime problems (Alterman, Cacciola, Habing, & Lynch, 2007)
- The ASI-5 has acceptable internal consistency for most summary scales (CFs, CSs, Efs; alphas range .72–.89; Cacciola et al., 2007). The ASI-L-VA has acceptable

internal consistency across the same summary scales (Cacciola et al., 2007)

- Research indicates that the ASI is reliable and valid for use with people who have CODs (Carey, 1997)
- In comparison to the ASI-MV, the ASI-5 demonstrated no significant differences in responses for particular domains such as employment, and items specific to alcohol use (Butler, Villapiano, & Malinow, 2009). Areas of significant differences that were found could be due to higher rates of disclosure by participants on the computerized interview as compared to face-to-face interviews (Butler et al., 2009; Garb, 2007)

Concerns

- The ASI-6 is still in the process of development and is not as widely used as the ASI-5
- The ASI requires approximately 45–90 minutes to administer, although the alcohol and drug sections can be completed in significantly less time
- Substantial training is needed to administer and score the ASI
- The ASI-6 Spanish version demonstrates variable psychometric properties, including poor to good internal consistency (alphas range .47–.95; Díaz-Mesa et al., 2010) and poor to excellent test-retest reliability (.36–1.0; Díaz-Mesa et al., 2010)
- The ASI-5 legal scales may be more valid than those of the ASI-6 (Denis et al., 2013). For example, ASI-5 arrest results from the ASI-5 legal domain are more highly correlated with the history of arrest than the ASI-6 (Denis et al., 2013)
- Among those seeking substance use treatment, the ASI-5 has lower interrater reliability for agreement ISR ratings in domains of employment and family-social problems and lower EFs, CFs, and CSs for family-social problems when compared to the ASI-L-VA (ICCs < .60; Cacciola et al.,

2007), indicating that these domains may generate inconsistent or inaccurate ratings

- The ASI-5 may have poor test-retest reliability for EF, CS, and ISR ratings related to the family/social domain (ICCs < .60; Cacciola et al., 2007)
- The ASI-5 may have lower internal consistency for certain summary scales, such as drug (CS) and legal problems (CS/CF; alphas < .70; Cacciola et al., 2007). The ASI-L-VA also exhibits lower internal consistency on these scales (Cacciola et al., 2007)
- Results from the ASI-MV (Butler et al., 2001) and face-to-face interview versions of the ASI may be inconsistent, as differences in scores were obtained in the following domains: drug, alcohol, legal, family, and psychiatric problems (Butler et al., 2009)
- The ASI may have reduced reliability and validity for people who have significant substance use problems and co-occurring mental disorders (Carey, 1997; Corse, Hirschinger, & Zanis, 1995; McLellan, Cacciola, & Alterman, 2004; Zanis, McLellan, & Corse, 1997)

Availability and Cost

The ASI is a public domain instrument that was developed by the Treatment Research Institute, 600 Public Ledger Building, 150 South Independence Mall West, Philadelphia, PA 19106, (215) 399-0980. The instrument is available at the following site: <http://www.tresearch.org/index.php/tools/download-asi-instruments-manuals/>

This site also provides several manuals that include information on administration, scoring, and interpreting the ASI.

The ASI-6 is available at no charge on a case-by-case basis. Additional information regarding the ASI-6 can be obtained by emailing the help desk at ASIHeline@tresearch.org

Texas Christian University (TCU) Intake and Assessment Instruments

The TCU intake and assessment instruments (Simpson & Knight, 1998) are available in the public domain and include versions tailored specifically for criminal justice and community treatment settings. The instruments assess a broad range of psychosocial issues, including drug, alcohol, and mental health problems, as well as other social, occupational, and treatment areas. TCU instruments described here include both interviewer administered and self-report scales. Instruments developed for justice settings are referred to as the Criminal Justice treatment forms (TCU CJ) and contain an interviewer-administered CJ Comprehensive Intake (TCU CJ CI), and a self-report CJ Client Evaluation of Self and Treatment (TCU CJ CEST-intake). Instruments developed for community treatment settings include an interviewer-administered Brief Intake (TCU BI), a Comprehensive Intake (TCU CI), and a self-report Client Evaluation of Self and Treatment, Intake version (TCU CEST-Intake).

The self-report CEST forms for both criminal justice and community settings contain several sections, or short forms, that can be administered separately. A follow-up CEST form is also available for both community and justice settings and can be used to evaluate treatment progress over time. Other self-report instruments can be combined with both the criminal justice and community CEST forms, including the TCU Drug Screen V (TCUDS V), the TCU Criminal Thinking Scales (TCU CTS), and other mental health scales that integrate components of the K6 and K10 instruments (Kessler et al., 2003). Several TCU short forms are based on sections contained in the original interviewer-administered intake instrument. These include the global risk assessment (TCU RSKForm), the Family and Friends assessment (TCU FMFRForm), the mental health and PTSD screen (TCU TRMAForm), and physical and mental health screens (TCU HTLHForm). The TCU HTLHForm contains items from the K10 and is designed to examine

psychological distress. The short forms provide a vehicle for individualized assessment to address CODs relevant to involvement in treatment.

Criminal Justice Instruments:

- The TCU CJ Comprehensive Intake (TCU CJ CI) is administered 1 to 3 weeks after program entry and queries about the past month or the past 6 months prior to incarceration. The TCU CJ CI contains sections assessing the following domains:
 - » Sociodemographic background
 - » Family background, including quality of relationships with family members
 - » Peer relations, including quality of relationships with friends and gang affiliations
 - » Criminal history, including prior arrests, involvement in illegal activities, and legal status
 - » Health and psychological status, including physical and mental health (e.g., anxiety, depression), and history of hospitalization
 - » Drug history, including frequency of alcohol and drug use over the past month and past 6 months and prior treatment history. Alcohol use is assessed in more detail, including quantity and patterns of drinking over the past month. Problems caused by drug and alcohol use are based on DSM-IV criteria
 - » AIDS risk assessment, including risky behaviors

The TCU CJ CI requires approximately 90 minutes to administer. Instructions are provided to the interviewer to read aloud to the participant explaining the purpose of the assessment, in addition to answer cards to help guide the format of participants' responses. "Skip logic" items are provided that can reduce the duration of administration.

- The TCU CJ Client Evaluation of Self and Treatment (TCU CJ CEST; Joe, Broome,

Rowan-Szal, & Simpson, 2002; Knight, Simpson, & Morey, 2002) is a self-report instrument for use with offenders. The instrument examines treatment motivation and a range of other psychosocial factors affecting treatment. The TCU CJ CEST reviews the following domains:

- » Treatment motivation, with subscales of problem recognition (PR), desire for help (DH), treatment readiness (TR), and pressure for treatment index (PT)
- » Psychological functioning, with subscales of self-esteem (SE), depression (DP), anxiety (AX), and decision making (DM)
- » Social functioning, with subscales of childhood problems (CP), hostility (HS), and risk taking (RT)

A scoring guide is provided to help interpret results from the instrument. Each of the TCU CJ CEST domains can be administered as separate one-page forms, in combination with each other, with other scales (TCU CTS, TCUDS V, K6/K10), or with other short forms, as described previously, to provide a more individualized assessment approach. The short forms and scales are designed to supplement intake assessments that are used by different justice programs. Individual scoring manuals are provided for each of the short forms. The follow-up version of the CEST also contains a "treatment progress domain" that provides subscales related to treatment participation (TP), treatment satisfaction (TP), counseling rapport (CR), peer support (PS), and social support (SS). The treatment progress domain can also be administered as a separate one-page form. A follow-up version of the CEST can be administered over the course of treatment to assess change over time for each of the domains and to examine engagement and retention, as indicated by the treatment progress domain.

Community Treatment Forms:

The TCU community treatment instruments are similar to the criminal justice instruments but are

designed primarily for outpatient and residential treatment settings.

- **The Brief Intake interview (TCU BI)** contains sections similar to the CJ Comprehensive Intake but is significantly shorter. The instrument includes the following sections:
 - » Background information
 - » Psychosocial functioning during the past 6 months
 - » Drug use background, including information describing substance use in the past 6 months and during the lifetime
 - » Drug use problems in the past year, including areas addressed by the DSM criteria for substance use disorders
- **The Comprehensive Intake Interview (TCU CI)** is similar to the TCU CJ CI interview but is geared towards those receiving treatment in the community and includes special instructions for those entering treatment from jail or prison. Domains of the TCU CI are similar to those in the TCU CJ CI, but there are several differences in the item structure and wording of individual items. For example, the sociodemographic background section provides detailed information about childhood history. The drug history section includes questions addressing treatment support from family and friends and problems related to gambling. An additional section is provided to record interviewer comments about the quality of participant responses. The TCU CI requires approximately 90 minutes to administer, and like the TCU CJ CI, includes answer cards and instructions for administration.
- **The Client Evaluation of Self and Treatment Intake Version (TCU CEST-Intake)** is a self-report instrument that is similar to the TCU CJ CEST and that includes similar domains addressing treatment motivation, psychological functioning, treatment motivation, and

social functioning. As with the TCU CJ CEST, each domain of the TCU CEST-Intake can function as a stand-alone instrument or be combined with other short forms. Unique to the TCU CEST-Intake is a self-efficacy scale (Pearlin Mastery Scale (Pearlin & Schooler, 1978) that is embedded in the psychological functioning domain. A social consciousness scale is also included in the social functioning domain and examines social values. The follow-up CEST-Intake is identical to the CJ CEST version in coverage of domains and analysis of treatment engagement, retention, and progress. A manual is provided to assist in scoring and interpretation of the CEST-Intake.

Positive Features

- The TCU intake and assessment instruments have been used in a wide variety of offender settings (Farabee, Prendergast, & Cartier, 2002; Czuchry & Dansereau, 2000; Joe, Rowan-Szal, Greener, Simpson, & Vance, 2010; Pankow & Knight, 2012)
- The TCU CJ CEST and community CEST instruments include norms for both offender and community treatment populations
- The TCU intake and assessment instruments provide two sets of forms that are tailored for offender and community treatment settings
- Each of the TCU intake and assessment instruments is fully structured and addresses multiple domains, including diagnostic criteria for various disorders. The instruments can be administered by nonclinicians and include a straightforward set of items/questions
- The self-report CEST forms can be administered as short, one-page assessments or can be combined to provide a more comprehensive assessment, thus allowing programs flexibility to tailor their approach to the needs of participants and to the needs of the program. For example,

several short forms are available to assess mental health, social functioning and other related domains, and these can be administered individually or in combination with CEST forms

- The assessment forms examine DSM criteria for drug and alcohol use disorders. The self-report TCU CJ CEST can be combined with other forms, such as the TCU CTS, to assess risk for recidivism and to provide a more comprehensive assessment. Criminal thinking as measured by the TCU CTS is correlated with lower treatment motivation/engagement and poorer psychological and social functioning (Garner et al., 2007)
- TCU CJ CEST motivation scales are correlated with treatment engagement among offenders (Pankow et al., 2012; Simpson et al., 2012)
- The TCU CJ CEST domains of psychological functioning, social functioning, and motivation are related to relevant domains on the Addiction Severity Index, supporting the convergent validity of the CEST instrument. For example, treatment motivation and psychological and social functioning are correlated with ASI measures of legal status, drug problems, and psychiatric problems (Pankow et al., 2012)
- Among female offenders, the TCU TRMAForm and TCU HLTHForm are highly correlated with the psychological functioning scales/domains of anxiety and depression in addition to social functioning scales/domains of hostility and risk taking, supporting the concurrent validity of these measures (Rowan-Szal et al., 2012)
- The TCU CJ CEST shows acceptable internal consistency in justice settings across domains of treatment motivation (alphas range .60–.80), psychological functioning (alphas range .71–.74), and social functioning (alphas range .71–.80; Garner et al., 2007). Other studies provide support for the internal consistency of the entire CEST instrument (Simpson, 2004;

Simpson, Knight, Dansereau, 2004) and for the specific domains that can be used as independent assessment instruments (e.g., TCU psychological functioning and TCU social functioning domains; Rowan-Szal et al., 2012; Simpson et al., 2012)

- TCU CJ CEST subscales of social functioning and psychological functioning represent unitary dimensions, as indicated by confirmatory factor analyses (Garner et al., 2007; Simpson et al., 2012)
- The CJ CEST domains have good test-retest reliability across subscales (Garner et al., 2007)
- The TCU CEST Community Treatment forms demonstrate good internal consistency for domains of treatment motivation (alphas range .88–.90), social functioning (.71–.90), and psychological functioning (.80–.91; Joe et al., 2002; Simpson, 2004)
- The TCU TRMAForm, TCU HLTHForm, and their subscales show good internal consistency among female offenders (alphas range .75–.94; Rowan-Szal et al., 2012)

Concerns

- Further study is needed to determine the validity and reliability of both the TCU intake and assessment forms in detecting the severity and scope of substance use disorders, mental disorders, and related psychosocial problems
- Many of the existing studies of the TCU intake and assessment forms in justice settings have been conducted by the developers of the instruments. Studies conducted by other research teams are needed to confirm these results
- The criminal justice and community treatment intake and assessment forms do not include a module to detect psychosis
- The TCU CEST does not address antisocial behaviors
- The domain of treatment motivation and its subscales appear to have relatively

low internal consistency, particularly the subscales related to desire for help ($\alpha = .67$) and treatment needs ($\alpha = .60$). Results of confirmatory factors analyses indicate that the four treatment motivation subscales may lack structural integrity and may not represent unitary dimensions (Garner et al., 2007)

Availability and Cost

Each of the TCU intake and assessment instruments is available at no cost. The community treatment forms, including scoring interpretation and norms can be found at the following site: <http://ibr.tcu.edu/forms/tcu-core-forms/>

Criminal justice treatment forms including scoring, interpretation and norms can be found at the following sites:

<http://ibr.tcu.edu/forms/forms-archives/cj-forms-correctional-residential-treatment/>

<http://ibr.tcu.edu/forms/forms-archives/cj-forms-correctional-outpatient-treatment/>

The individual CEST domains as one-page forms and a scoring guide for the implementation of the CEST can be obtained from the following site: <http://ibr.tcu.edu/forms/client-evaluation-of-self-and-treatment-cest/>

Other TCU forms can be found at the following site, which links the user to archives containing various forms and descriptions of each form: <http://ibr.tcu.edu/forms/forms-archives/>

Timeline Followback (TLFB)

The Timeline Followback (TLFB) protocol provides a detailed daily history of alcohol and other substance use over a specific period of time (from 7 days to 2 years) but is employed most frequently to examine substance use within the previous 3 months. The TLFB involves using a blank calendar to help produce a detailed pattern of substance use and nicotine use over specified time intervals. The calendar is used to help

individuals identify and note memorable occasions over these time intervals (e.g., the past 30 days) to aid in the recall of daily patterns of substance use and nicotine use. Common variables computed for alcohol use include the number of drinking days, average drinks, total drinks per month, and maximum drinks consumed during one occasion (Pedersen & LaBrie, 2006). For drug use, variables calculated include the number of days of use, the longest period of use, and the longest period of abstinence; however, this varies across drug class. For example, the quantity of marijuana use can be more accurately assessed in terms of frequency (number of joints; Robinson, Sobell, Sobell, & Leo, 2012). The TLFB approach provides a more accurate and comprehensive assessment of individual drinking and drug use patterns compared with typical quantity and frequency measures that may underestimate substance use behavior (Sobell et al., 2003). The TLFB protocol requires approximately 10–30 minutes to complete and is available in several languages.

Positive Features

- The TLFB measure can be administered via interview or computer. The computerized version provides detailed instructions for self-administration and allows measurement of time intervals up to 12 months. The computerized version of the TLFB requires the same amount of time to administer as the interview version
- The TLFB has been used successfully with justice populations (Broner, Mayrl, & Landsberg, 2005; Easton et al., 2007), including DUI/DWI offenders (Brown et al., 2008; Fridell, Hesse, & Billsten, 2007; Palmer, Ball, Rounsaville & O'Malley, 2007)
- In a meta-analysis of drug-involved populations (Hjorthøj, Hjorthøj, & Nordentoft, 2012), agreement between biological assessment (e.g., urine drug tests) and the self-report TLFB is quite good across drug classes (79–94 percent). Agreement between biological measures

and the self-report TLFB is quite good across different time periods assessed by the TLFB. For example, with a period of less than 30 days, TLFB agreement ranges 81–85 percent, and for over 30 days, agreement ranges 87–93 percent. The TLFB produces few false negative errors for most categories of drugs when compared to urinalysis (Westerberg, Tonigan, & Miller, 1998)

- In comparing biological assays and the TLFB for specific drug classes during the past 60 days, agreement was 86–92 percent for cocaine and 84–87 percent for cannabis (Stasiewicz et al., 2008). Agreement across multiple substances during the past 6 months is also high (kappas = .74–.94; Morgenstern, Hogue, Dauber, Dasaro, & McKay, 2009), providing support for the reliability and validity of the TLFB over time
- Comparisons between the TLFB and ASI for people with CODs have found high rates of agreement between the two instruments (kappa = .79; Carey, 1997). However, the TLFB may yield higher estimates of drinking than the ASI over a 30-day interval
- In support of the concurrent validity of the TLFB among those enrolled in residential substance use treatment, the TLFB shows adequate agreement with the ASI (past 30 days) for reported alcohol use among people with substance use disorders (SUDs) only and for people who have CODs (91–93 percent agreement, kappas range .60–.70). Agreement is also high for drug use (82–87 percent, kappas range .63–.70; DeMarce et al., 2007)
- For samples with either SUDs or CODs, the TLFB demonstrates good agreement with collateral reports of alcohol use (90–91 percent; kappas range .50–.61) and with drug use (77–81 percent; kappas range .45–.62). Good agreement was also found between the TLFB and frequency of drinking days, as measured by the ASI (r scores range .70–.78) and collateral reports

(r scores range .52–.62) in both samples (DeMarce et al., 2007)

- The TLFB is highly correlated with self-report measures of drug use frequency (DUF) over the previous 6 months across all drug classes (O’Farrell, Fals-Stewart, Murphy, & Murphy, 2003; r scores range .83–.96). Very high rates of agreement have also been found between the TLFB and DUF on use versus non-use across all drug classes (r scores range .97–1.00; O’Farrell et al., 2003)
- The TLFB is highly correlated with measures of general life functioning (r scores = .62–.99; Westerberg et al., 1998)
- The test-retest reliability of the TLFB over 1–2 weeks is quite good among people with substance use disorders seeking treatment, for percent of days abstinent, longest period of use, and longest period of abstinence over 30, 60, and 360 days, for both cocaine (ICCs range .74–.90; r scores range .75–.91) and marijuana (ICCs range .89–.96; r scores range .81–.96). Test-retest reliability was also quite good for the total number of marijuana joints used (ICC = .78–.94; r scores range .79–.95) and number of joints used per day (ICCs = .85–.93, r scores range .80–.94; Robinson et al., 2012)
- The TLFB has very good test-retest reliability for drinking, illicit drug use, and psychosocial functioning (r score > .90; Tonigan, Miller, & Brown, 1997). The TLFB shows good test-retest reliability over 5 days among substance-involved outpatients and for 30, 60, and 90 days across a range of drinking variables (Carey, Carey, Maisto, & Henson, 2004; Pedersen & LaBrie, 2006)

Concerns

- Completion time for the TLFB depends on the time period covered and the individual pattern of consumption
- There are lower agreement rates on the TLFB for shorter recall periods (e.g., shorter number of days assessed; Hjorthøj et al., 2012)

- The quantity of drug use may not be adequately assessed for drugs such as cocaine and amphetamines. A related concern to cannabis/marijuana is that the type of measurement used (e.g., number of joints) may not adequately assess the amount consumed

Availability and Cost

The TLFB instrument is available online at no charge from the Nova Southeastern University, Center for Psychological Studies at the following site: http://www.nova.edu/gsc/online_files.html

Calendars, instructions, and method manuals for alcohol, drugs, and nicotine can be downloaded at no cost. The Timeline Followback-User's Guide is available for \$29.95 from the Centre for Addiction and Mental Health at the following site: http://www.camhx.ca/Publications/CAMH_Publications/timeline_followbk_usersgd.html

Recommendations for Assessment of Substance Use and Treatment Matching

Information in this section provides a critical review of treatment matching approaches and a description of specific instruments that can be used for assessing and matching offenders who have CODs to appropriate services. The assessment instruments described in this section vary considerably in the level of detail provided for mental disorders and CODs. This analysis is based on a review of research examining the reliability and validity of these approaches and instruments, the relative cost of instruments, ease of administration of instruments, and potential for application within the justice system. Although summaries of instruments are based on DSM-IV criteria, instrument recommendations are based on the potential for alignment with the DSM-5 criteria to allow for a more seamless transition to the newly implemented DSM-5 diagnostic classification system. Recommendations for assessment of substance use and treatment matching instruments include those that address criminogenic needs (i.e., “dynamic risk factors”)

as articulated by the RNR theoretical model. Recommendations for substance use and treatment matching instruments in the justice system include the following:

1. The TCU short forms (e.g., TCUDS V, TCU CEST, TCU TRMA, TCU HLTH). These forms address key criminogenic needs and psychosocial factors related to treatment intake and matching, and can be tailored according to the specific resources and assessment needs of a particular justice program or setting.
- (and/or)
2. The TCU Criminal Justice Comprehensive Intake (TCU CJ CI), which can be used in settings that do not currently utilize a standardized intake instrument. The TCU CJ CI intake can be combined with other short forms to provide a full assessment and to assist in treatment matching.

The TCU short forms each take approximately 5–10 minutes to administer and score and can be administered by nonclinicians who are trained in scoring and administration procedures and aware of appropriate referral procedures. The TCU CJ CI takes approximately 90 minutes to administer and score and should be conducted by a trained and licensed/certified clinician.

Assessment Instruments for Mental Disorders

The assessment instruments described below require significant training in administration, scoring, and interpretation. As a result, these instruments should be administered by trained mental health staff who are licensed, certified, or otherwise credentialed in assessing and diagnosing mental disorders and related psychosocial problems.

Minnesota Multiphasic Personality Inventory-2 (MMPI-2/MMPI-2 RF)

The MMPI (Hathaway & McKinley, 1951; Hathaway & McKinley, 1967; Hathaway & McKinley, 1989) is one of the most widely used instruments for assessment of mental disorders. The MMPI has been used in correctional settings since 1945 to classify individuals and to predict behaviors while incarcerated and after release (Megargee et al., 1979; Megargee & Carbonell, 1995). The MMPI-2 replaced the MMPI (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989) following several rounds of scale revisions. The instrument is a self-report measure with 567 items and 10 main clinical scales, including Hypochondriasis, Depression, Hysteria, Psychopathic Deviancy, Masculinity-Femininity, Paranoia, Psychasthenia (obsessive-compulsive features), Schizophrenia, Hypomania, and Social Introversion. The MMPI provides 15 supplementary content scales that address internal traits, external traits, and general problems. In addition, the MMPI contains six validity scales that examine response sets, including unanswered items, endorsement of uncommon items, inconsistent responding, malingering, overreporting of symptoms, and faking good. An abbreviated version of the MMPI-2 includes 370 items, but scores obtained are not as comprehensive as the original 567-item version (Butcher & Hostetler, 1990). The MMPI-2 Restructured Clinical (RC) scales (Tellegen et al., 2003) are revised versions of the original clinical scales and improve upon the overlapping item content and high correlations between scales.

The most recent version of the instrument is the MMPI-2 Restructured Form (MMPI-2 RF; Ben-Porath & Tellegen, 2008), which is based on norms from the MMPI-2 and retains the same RC scales. The MMPI-2 RF has 338 items and 51 scales. These scales include Validity scales, Higher-Order scales (HO), RC scales, Somatic/Cognitive, Internalizing, Externalizing, Interpersonal, Interest, and Personality Psychopathology Five (PSY-5). Changes to the

MMPI-2RF include improvement in the validity scales for nonresponding, inconsistent responding, overreporting, and underreporting of symptoms. The “?” or “cannot say” scale (CNS) has not been altered from the MMPI-2.

The MMPI-2 RF features revised versions of the MMPI-2 validity scales, including the following: Variable Response Inconsistency (VRIN-r) and True Response Inconsistency (TRIN-r); the Lie scale, which is now Uncommon Virtues (L-r); and the K-Scale (Correction Scale), now referred to as Adjustment Validity (K-r). The latter two scales address underreporting of symptoms. The other four validity scales address overreporting of symptoms and improve upon three of the MMPI-2 scales of Infrequent Response (F-r), Infrequent Psychopathology Responses (Fp-r), and Symptom Validity (FBS-r, previously Fake Bad Scale; Ben-Porath, Tellegen, & Graham, 2008). An additional scale, the Infrequency Somatic Response (Fs) was added to identify overreporting of somatic complaints. The final scale, the Response Bias Scale (RBS; Gervais, Ben-Porath, Wygant, & Green, 2007), identifies overreporting in personal injury or medical disability settings and negative response bias in forensic settings.

All revised scales are shorter than the original validity scales and feature improved psychometric methods for testing the validity of these scales in detecting inconsistent responding and underreporting or overreporting of symptoms. The MMPI-RF T scores are not K-corrected (correction used to represent the accuracy of scores and to compensate for faking good or faking bad) nor are they gender specific. This allows for clinician judgment when examining differences between the non-K corrected clinical scale T scores and the K-corrected clinical scale T scores because previous research indicates that the K-corrected scales have poor validity. The RC (Restructured Clinical) scales are the same as those in the MMPI-2.

The MacAndrew Alcoholism Scale-Revised (MAC-R) was developed to differentiate

alcoholic from nonalcoholic psychiatric patients. This supplementary scale on the MMPI-2 includes 49 items that provide a subtle screening measure to differentiate alcoholics from nonalcoholics (Searles et al., 1990). A 13-item Addiction Acknowledgment Scale (Weed, Butcher, McKenna, & Ben-Porath, 1992) was developed using items in the MMPI-2 whose content is clearly related to substance use. The Addiction Potential Scale was also developed, which included heterogeneous items related to extroversion, excitement seeking, risk taking, and lack of self-efficacy.

The MMPI-2 Criminal Justice and Correctional Report was developed for use in justice settings. This report assists in determining diagnoses and analyzing the MMPI-2 validity, clinical, content scales, and supplementary scales. The report provides information relevant to assessment, risk assessment, and treatment and program planning for individuals involved with the justice system. The report contains several behavioral dimensions that examine the need for further mental health assessment, conflict with authorities, extroversion, likelihood of favorable response to academic or vocational programming, and hostile peer relations. Several potential problem areas are also identified, related to alcohol or substance use, manipulation of others, hostility, and anger control.

Positive Features

- Only a sixth-grade reading level is required
- The MMPI-2 was normed using a large sample that was representative of the U.S. population
- A specialized interpretive report is available for justice-involved individuals
- Scales and profile configurations, which indicate personality profiles, have similar correlates in forensic settings as in other settings (Graham, 2006)
- The MMPI-2 has been used extensively with justice-involved individuals (Claes, Tavernier, Roose, Bijttebier, Smith, & Lillienfeld, 2012; Mattson, Powers, Halfaker, Akeson, & Ben-Porath, 2012; Wilson, 2012)
- The MMPI-2 is available in several languages and can be administered using a paper and pencil format, by audio recording, or via a computerized version of the instrument
- The MMPI-2 is well validated in a variety of settings and has good psychometric properties (Butcher, Graham, Ben-Porath, Tellegen, & Dahlstrom, 2001; Graham, 2000; Greene, 2000)
- A derived MMPI-RF measure of psychopathy corresponds well with other validated measures (e.g., Psychopathic Personality Inventory; Lilienfeld & Andrews, 1996) and traits (antisocial behaviors, narcissism; Phillips, Sellbom, Ben-Porath, & Patrick, 2014; Sellbom, Ben-Porath, Lilienfeld, Patrick & Graham, 2005; Sellbom et al., 2012)
- The MMPI-2 RC scales demonstrate concurrent validity with other similar substantive measures (Tellegen, Ben-Porath, & Sellbom, 2009). For example, RC2-low positive emotion is correlated with depressive mood symptoms (Arbisi, Sellbom, & Ben-Porath, 2008; Forbey & Ben-Porath, 2007; Handel & Archer, 2008) and social anxiety (Forbey & Ben-Porath, 2008), and RC1-somatic symptoms are correlated with somatoform problems (Arbisi et al., 2008; Forbey & Ben-Porath, 2007, 2008)
- The MMPI-2 RC scales indicate high internal consistency across gender groups in clinical representative samples (alphas range .78–.95; Rogers, Sewell, Harrison, & Jordan, 2006). The RC scales show improvement over the clinical scale in reducing interscale correlations (Rogers, Gillard, Berry, & Granacher, 2011; Tellegen et al., 2003)
- Several studies support the validity of the revised or added RF validity scales for the MMPI-2RF. The VRIN-r, TRIN-r, L-r, and

K-r are useful in identifying underreporting among both clinical and nonclinical samples (Sellbom & Bagby, 2008). The Fp-R indicates incremental utility in detecting overreporting of psychopathology (Tellegen & Ben-Porath, 2008). The Fs scale also provides incremental utility in identifying exaggerated or “faked” somatic complaints (Wygant et al., 2007). The FBS-r, F-r, and F-s are able to identify neurocognitive, emotional, and somatic complaints (Wygant et al., 2010). Among offenders, the F-r and Fp-r were able to identify malingering of psychopathology (Sellbom, Toomey, Wygant, Kurcharski, & Duncan, 2010; Wygant et al., 2011), and these scales have been shown to be effective when compared to the Structured Interview of Reported Symptoms (SIRS; Rogers, Bagby, & Dickens, 1992)

- The Response Bias Scale (RBS; Gervais et al., 2007) is able to identify the validity of reported symptoms in forensic settings as demonstrated by its discriminatory ability to distinguish between those who pass or fail the symptom validity tests (Word Memory Test: Green, 2003; Test of Memory Malingering: Tombaugh, 1996). The RBS scale is also associated with other symptom validity scales such as the F-r, Fp-r, and Fs. Combinations of these scales can improve the specificity of overreported psychopathology and somatic complaints (Wygant et al., 2010)

Concerns

- The MMPI-2 requires somewhat more time to administer than the PAI
- The MMPI-2 RF does not include updated norms and is based on norms from the MMPI-2. Many validation studies of the MMPI-2RF employ the original validation data for the MMPI-2, and few studies have been conducted by those other than the instrument developers
- The MMPI-2 RC scales provide poor convergent validity for related areas of psychopathology (Rogers et al., 2011)
- Clinical elevations on the RC scales are difficult to interpret when used in combination, as scales can provide contradictory information. For example, RC1 demonstrates clinical elevations in over 60 percent of cases (somatic complaints), but these profiles were classified as within normal limits. The RCd, which reflects general psychiatric distress, shows no elevation for those who endorsed persecutory ideation on RC6 (Rogers et al., 2011)
- Although the RBS scale improves identification of symptom validity, other symptom validity tests are still recommended during the assessment process (Heilbronner et al., 2009)
- The FBS-r and Fs may not perform well in detecting malingering, as they are focused more on somatic and cognitive deficit complaints (Sellbom et al., 2010)
- Many of the studies that validate scales of the MMPI-2 RF use archival data sets that have previously been used in validating the MMPI-2 and thus employ convenience sampling rather than replication in diverse samples
- Since the MMPI-2 is based on psychological constructs developed in the 1940s, both the content and clinical scales are somewhat heterogeneous. As such, there is some overlap among scales, which lessens the discriminant validity of this measure. For example, while it is possible to differentiate between bipolar disorder and schizophrenia using the Depression (Dep) content scale, no clinical or content scales on the MMPI-2 are able to differentiate between bipolar depression and unipolar depression (Bagby et al., 2005)
- The K correction scale does not have empirical support in many populations (Barthlow, Graham, Ben-Porath, Tellegen, & McNulty, 2002), and there is some disagreement regarding the cut-off scores to use for different validity scales to detect

malinger (Meyers, Millis, & Volkert, 2002)

- Hispanic respondents produce higher scores on the Lie scale, and culturally specific norms or corrections have not been developed for this scale
- The MMPI-2 scale names do not reflect the domains that are measured
- The MMPI was developed using an empirical approach with the goal of discriminating between individuals with psychiatric diagnoses and individuals without any diagnosis. However, items were not selected based on theory or psychopathology research
- The MAC-R scale does not have good internal consistency (.56 for men and .45 for women; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989). In addition, several studies have urged caution when using the MAC-R scale with African Americans (Graham, 2006)

Availability and Cost

Information describing the MMPI-2 RF can be found at the following location, including scales, frequently asked questions, references, and an interpretation guide: <http://www.upress.umn.edu/test-division/MMPI-2-RF/mmpi-2-rf-publications>

The MMPI-2 RF manual, scoring sheets, and scoring/interpretive software can be purchased at the following location and are quite costly: <http://psychcorp.pearsonassessments.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=PAg523>

Millon Clinical Multiaxial Inventory-III (MCMI-III)

The MCMI-III (Millon, 1983, 1997) is an objective, self-report psychological assessment measure consisting of 175 true/false items. The MCMI is designed to assess DSM-IV Axis II (personality) disorders and related clinical syndromes (Axis I) and is particularly useful in identifying personality disorders that may affect involvement in treatment. The Personality

Inventory consists of 14 Personality Disorder Scales and 10 Clinical Syndrome Scales, both of which include separate Moderate and Severe Syndrome Scales. In addition, there are Correction Scales that help detect random responding and consist of three modifying indices (disclosure, desirability, and debasement) and one validity index. The MCMI-III contains three Facet Scales for each MCMI-III Personality Scale. The Facet Scales were developed using factor analytic techniques and are included to guide clinicians in the interpretation of the Clinical Personality Patterns and the Severe Personality Pathology Scales. The scales aid in identifying specific personality processes (e.g., self-image, interpersonal conduct, cognitive style) that contribute to overall scale elevations. Base rates of disorders in the specific population are used as cut-off scores to indicate clinically significant levels of severity (i.e., > 75 percent = moderate level, > 85 percent = severe level; Millon, 1997).

Two of the Moderate Syndrome Scales of the MCMI-III address substance use (B-Alcohol Dependence, T-Drug Dependence). The MCMI-III is well suited for use in correctional settings. A separate Correctional Summary includes the use of special correctional norms for certain scales and a one-page summary of likely needs and behaviors relevant to corrections settings, including the need for mental health and substance use treatment. The report classifies a justice-involved individual's probable needs as low, medium, or high in the areas of mental health intervention, substance use treatment, and anger management services. In addition, escape risk, reaction to authority, disposition to malingering, and suicidal tendencies are evaluated.

Positive Features

- The MCMI-III is brief to administer, requiring approximately 25 minutes to complete
- The MCMI-III provides an interpretive report that describes potential DSM-IV diagnoses that may apply

- The instrument can be administered via paper and pencil, audiotape, CD, or computer
- The instrument is available in English and Spanish
- The measure was normed with adult inpatient and outpatient clinical samples and with individuals in jail and prison
- The MCMI-III has been used in justice/forensic settings (Bow, Flens, & Gould, 2010; Ferragut, Ortiz-Tallo, Loinaz, 2012; Morgan, Fisher, Duan, Mandracchia, & Murray, 2010; Young, Wells, & Gudjonsson, 2011)
- The AUC, sensitivity, and specificity are acceptable for the MCMI-III as determined by comparison with clinician-rated DSM-IV diagnoses (Millon, 1997)
- AUCs ($> .70$) for the MCMI-III scales are adequate for alcohol, drug, psychotic (MCMI-III delusions scale only), and major depressive disorders when compared to DSM-IV diagnoses (Hsu, 2002)
- The MCMI-III personality disorder scales show relatively good convergent validity with the MMPI scales for most disorders (Rossi, Hauben, Van den Brande, & Sloore, 2003)
- The MCMI-III demonstrates adequate diagnostic accuracy for Axis I disorders in international settings when compared with results from the Mini International Neuropsychiatric Interview (MINI; AUCs $> .70$), with the exception of psychotic disorders (Hesse, Guldager, & Holm Linneberg, 2012). This same study supports the convergent validity of MCMI-III scales with other measures, such as the Beck Anxiety Inventory and the MINI
- Another international study indicates acceptable sensitivity for the anxiety scale of the MCMI-III (73 percent), as identified by diagnoses obtained from the MINI (Saulsman, 2011)
- The sensitivity and specificity of MCMI-III Scales B (alcohol) and T (drug) are significantly improved from equivalent

scales on the MCMI I and MCMI II (Craig, 1997)

- The MCMI-III disclosure, desirability, and debasement validity scales are effective in detecting malingering among traumatic brain injury patients (Aguerrevere, Greve, Bianchini, & Ord, 2011)

Concerns

- Little research has been conducted to examine the cultural sensitivity of the MCMI-III
- An eighth-grade reading level is required, which may be problematic in some justice settings
- AUCs for the MCMI-III anxiety and dysthymia scales are quite poor in detecting DSM-IV anxiety disorders or dysthymia (Hsu, 2002)
- An international study found poor agreement between the MCMI-III and the MINI in diagnosing treatment-seeking people with substance use disorders (Hesse et al., 2012)
- Another international study of a mental health treatment-seeking population indicated poor sensitivity for the MCMI-II in detecting anxiety disorders, dysthymia, and major depressive disorder and poor specificity for anxiety disorders and dysthymia, as indexed by the MINI clinical interview (Saulsman, 2011). The MCMI-III also did not adequately distinguish between anxiety disorders and depressive disorders
- Several studies examining the validity of the MCMI-III (Millon, 1994; Millon, 1997) indicate significant differences in diagnostic accuracy and raise methodological concerns (Hsu, 2002; Millon, 1994; Millon, 1997; Retzlaff 1996) related to the impact of varying levels of clinician skills and uneven interviewing procedures
- Some MCMI-III scales do not perform better than chance in detecting mental disorders and may not adequately

discriminate between diagnoses (Hsu, 2002)

- The MCMI-III thought disorder scale (SS) may reflect general psychiatric distress, and it is correlated with measures such as the Beck Anxiety Inventory and Montgomery Asberg Depression Rating Scale (MADRS; Hesse et al., 2012)
- Based on the MCMI-III manual, approximately 13 percent of people who randomly respond on the instrument have invalid and noninterpretable results (Charter & Lopez, 2002). This study also indicates that too few items may be contained in the validity scale of the MCMI-III
- The MCMI-III may underreport personality disorders among justice-involved individuals (Retzlaff, Stoner, & Kleinsasser, 2002)
- In prior versions of the MCMI, the Drug Abuse Scale was found to have poor sensitivity (39 percent) but high specificity (88 percent) in identifying people with substance use disorders (Calsyn, Saxon, & Daisy, 1990)

Availability and Cost

The MCMI, manual, and hand-scoring guide can be purchased at the following site: <http://psychcorp.pearsonassessments.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=PAg505>

Costs for the MCMI vary depending on the desired format. Scoring software is available that provides interpretive reports.

Personality Assessment Inventory (PAI)

The PAI is a self-administered objective test of personality and psychopathology developed to provide information related to treatment planning and evaluation. Although the instrument was introduced more recently than the MMPI and the MCMI, it has received considerable attention by clinicians and researchers because of its rigorous methodology. The development of the PAI was

based on a construct-validation framework that emphasized a rational and quantitative method of scale development. A strong emphasis is placed on a theoretically informed approach to the development and selection of items (Morey, 1998). Key areas examined by the PAI include response styles, clinical syndromes, interpersonal style, treatment complications, and subject's environment.

The PAI instrument includes 344 items and 22 nonoverlapping full scales, with 4 validity scales, 11 clinical scales, 4 treatment consideration scales, and 2 interpersonal scales. Validity scales include inconsistent responding (ICN), infrequency of endorsed response (INF), negative impression management (NIM), and positive impression management (PIM). Clinical scales include separate measures for alcohol problems (ALC), drug problems (DRG), somatic complaints (SOM), anxiety (ANX), anxiety-related disorders (ARD), depression (DEP), mania (MAN), paranoia (PAR), schizophrenia (SCZ), borderline personality disorder (BOR), and antisocial personality disorder (ANT). Treatment consideration scales include aggression (AGG), suicide ideation (SUI), stress (STR), nonsupport or lack of social support (NON), and treatment rejection (RxR). Interpersonal scales include dominance (DOM) and warmth (WRM). A T score ≥ 70 on the clinical scales, treatment scales, and interpersonal scales indicates clinically significant problems. There are 27 critical items that indicate acute problems (e.g., suicidal ideation) for which follow-up with the client should be provided. The PAI requires approximately 50 minutes to complete (Morey, 2007).

Positive Features

- The PAI was standardized on a sample that matched the 1995 census on gender, race, and age (Morey, 1998)
- PAI test items and scales were empirically derived and are based on clinical research and personality theory (Morey, 1991)
- A Spanish version of the PAI is available

- Additional software for justice settings is available that is geared towards assessment of risk, psychological needs, and rehabilitation
- Validity scales allow the clinician to detect whether items are left unanswered, answers are inconsistent, infrequent items are endorsed, and whether attempts are made to provide an overly negative or positive impression
- Information regarding symptom severity is provided, which helps in developing assessment and treatment recommendations
- The PAI includes 27 critical items, chosen based on their importance as indicators of potential crisis situations. These items facilitate follow-up probes to examine the need for crisis or other clinical services
- An interpretative profile is provided with each report to guide the clinician in developing treatment approaches
- The PAI is widely used in justice settings and substance use settings (Boccaccini, Murrie, Hawes, Simpler, & Johnson, 2010; Boccaccini, Rufino, Jackson, & Murrie, 2013; Magyar et al., 2012; Patry, Magaletta, Diamond, & Weinman, 2011; Ruiz et al., 2012; Salekin, 2008; Walters, Duncan, & Geyer, 2003)
- The PAI is used in the criminal sentencing process, including cases involving capital sentencing (Mullen & Edens, 2008)
- The PAI-ANT scale is related to other measures of antisocial behaviors and criminal thinking (Bradley et al., 2007; Douglas et al., 2007; Walters & Geyer, 2005), such as the Shedler-Westen Assessment Procedure (SWAP-200; Westen & Shedler, 1999a, 1999b), and measures of psychopathy (Douglas, Guy, Edens, Boer, & Hamilton, 2007; Patrick, Poythress, Edens, Lilienfeld, & Benning, 2006; Edens & Ruiz, 2005), such as the Psychopathy Checklist-Revised (PCL-R; Hare & Vertommen, 2003) and the Psychopathic Personality Inventory (PPI; Lilienfeld & Andrews, 1996)
- The ANT scale contains subscales examining aggression, dominance, and violence potential and provides an assessment of risk factors that predict recidivism and violence in offenders (Boccaccini et al., 2010; Morey, Warner, & Hopwood, 2007)
- The ANT, AGG, and DRG scales have been found to predict prison infractions in an international offender sample, including violent, nonviolent, and drug-related infractions and recidivism (Newberry & Shuker, 2012), as indexed by the Offender Group Reconviction Scale (OGRS, Copas & Marshall, 1998)
- Incremental validity for the PAI-ANT scale has been found in predicting disciplinary problems, verbal and physical aggression, and recidivism (Buffington-Vollum, Edens, Johnson, & Johnson, 2002; Walters & Duncan, 2005; Walters et al., 2003) in comparison to clinical measures such as the PCL-R (Hare & Vertommen, 2003). The scale performs as well as the Static-99 (Hanson & Thornton, 1999) and Minnesota Sex Offender Screening Tool-Revised (Epperson, Kaul, Hesselton, 1998) in predicting recidivism among sexual offenders (Boccaccini et al., 2010)
- In an offender sample, incremental validity has been found for the AGG scale in predicting noncompliance (e.g., gambling, stealing) and aggressive behaviors (both verbal and physical) above and beyond scales such as ANT and BOR. Overall, AGG, BOR, and ANT scales have been found to predict aggressive or disruptive behaviors (Magyar et al., 2012)
- The concurrent validity of the PAI with offenders is supported by findings indicating that the DRG and ALC scales are correlated with other indices of alcohol use and drug use from the Federal Bureau of Prisons mental health data base, psychological intake questionnaire, and presentencing reports (Patry et al., 2011)
- In support of the PAI's external validity among offenders who are court mandated

to substance use treatment, higher scores on the AGG scale are correlated with a history of assault. Similarly, higher ANT scale scores are related to rule-breaking while in treatment, particularly among offenders who have higher scores on the DRG scale. The SUI scale accurately identifies those who have a history of suicide attempts (Hopwood, Baker, & Morey, 2008)

- Also supporting external validity of the PAI with both psychiatric inpatients and outpatients, the PAI clinical scales show moderate to strong correlations with life events that are relevant to PAI scales. For example, the ANT scale is correlated with history of arrest, alcohol, and drug problems, and lower education level. Similarly, the DRG, ALC, BOR, and AGG scales are correlated with the history of arrest. The ARD scale is also correlated to trauma and prior history of hospitalization, and the DEP scale is correlated with prior hospitalization (Slavin-Mulford et al., 2012)
- Within offender samples, the PAI clinical scales may reflect a two-dimensional structure of “internalizing” and “externalizing” tendencies, as indicated by statistical taxometric procedures and confirmatory factor analysis (Ruiz & Edens, 2008)
- The overall psychometric properties of the PAI are quite favorable (Morey, 1991; Morey, 2007) and include high internal consistency of scales (Magyar et al., 2012)
- Full-scale reliability estimates for the PAI are high, averaging .82 (Boone, 1998)

Concerns

- The PAI is a commercially available instrument
- Only trained mental health professionals can administer and interpret the PAI
- The PAI may be lengthy to administer, typically requiring an hour but sometimes requiring up to 2.5 hours to complete

- The Spanish version of the PAI may not provide psychometric properties that are equivalent to the English version (Fernandez, Boccaccini, & Noland, 2008; Rogers, Flores, Ustad, & Sewell, 1995)
- Several unique issues should be considered in interpreting the PAI’s validity scales in justice and treatment settings. For example, people seeking treatment may have higher NIM scale scores as they may exaggerate symptoms to secure treatment. PIM scores may also be elevated in justice settings as a result of attempts to deny potential problems, such as substance use (Douglas et al., 2007; Morey & Quigley, 2002; Newberry & Shuker, 2012). INF and ICN scores may also be inflated among offenders, who tend to respond inconsistently and to endorse items with low base rates (Douglas et al., 2007; Newberry & Shuker, 2012). However, scale scores may be affected by poor reading abilities (Nikolova, Hendry, Douglas, Edens, & Lilienfeld, 2012)
- Inappropriate use of cut-off scores with offenders may lead to misclassification in determining “risk” level and in assignment to services (Edens, Poythress, & Watkins-Clay, 2007)
- For offenders with high PIM scale scores (T scores ≥ 57), the violence potential index (composed of items from different PAI scales, including drug use, aggression, and antisocial behaviors) and the SUI and STR scales may not be useful in assessing risk, and ANT scale scores may not as effectively predict problem behaviors (Walters, 2007)
- The PAI’s alcohol and drug scales are susceptible to denial since the item content is not subtle

Availability and Cost

The PAI is available at cost from Psychological Assessment Resources at the following site: <http://www4.parinc.com/Search.aspx?q=PAI>

There are numerous PAI resources available, including the instrument, scoring sheets, an interpretive guide, a user manual, and scoring software that generates interpretive reports. Supplementary software is also available that generates interpretive reports geared for correctional settings.

A PAI kit can be purchased for \$315 and includes the professional manual, answer booklets, the instrument, and materials for hand scoring (e.g., profile forms).

Recommendations for Assessment of Mental Disorders

Information describing assessment instruments for mental disorders is based on a critical evaluation of the research examining the efficacy of these instruments. Important indicators used in evaluating instruments include the following: empirical evidence supporting both the reliability and validity of the instrument, ability to assess multiple mental health problems/disorders, the relative cost of the instrument, ease of administration and interpretation, and previous use within justice settings. Although the assessment instruments provide information that addresses the range of mental disorders described in the DSM-IV, it is highly desirable for these instruments to be closely aligned with the newly implemented DSM-5 criteria to allow for a seamless transition from the DSM-IV to DSM-5 diagnostic classification systems. Based on these considerations, the following instrument is recommended for use in assessing mental disorders for people with co-occurring disorders in the justice system:

- The Personality Assessment Inventory (PAI)

The PAI assesses personality traits, mental health problems/disorders, and other treatment-related problems and requires approximately 45–60 minutes to administer and 25–30 minutes to score and interpret. The PAI provides several validity indices and facilitates clinician follow-up to individual item responses. The PAI should

be administered and interpreted by a trained and licensed/certified mental health professional.

Assessment and Diagnostic Instruments for Co-occurring Mental and Substance Use Disorders

This section reviews instruments that are used to diagnose or assess CODs. Included are assessment instruments that examine other biopsychosocial domains related to CODs. Diagnostic instruments include those that evaluate DSM or ICD disorders and provide a diagnosis for a range of mental and substance use disorders. Some instruments, such as the GAIN and MINI, which include multiple versions (e.g., screening, assessment) are described in this and other sections. In contrast to instruments described in screening sections, assessment instruments described in this section require more time to administer; provide more detailed and comprehensive coverage of issues related to the various disorders; and are designed to yield formal diagnoses and treatment plan recommendations, including levels and types of services that are needed. The assessment and diagnostic instruments described below require significant training in administration, scoring and interpretation. As a result, these instruments should be administered by trained clinicians who are licensed, certified, or otherwise credentialed in assessing and diagnosing mental and substance use disorders and related psychosocial problems.

Assessment Instruments for Co-occurring Mental and Substance Use Disorders

Alcohol Use Disorders and Associated Disabilities Interview (AUDADIS-IV)

The AUDADIS-IV (Grant & Dawson, 2000) is both an assessment and diagnostic instrument, and is a fully structured clinical interview that is based on the DSM-IV and ICD-10 criteria. The AUDADIS-IV assesses alcohol, drug, and nicotine use disorders. It also assesses mental disorders,

including mood disorders, anxiety disorders, and DSM-IV personality disorders, in addition to the family history of mental disorders. The instrument is standardized to diminish the unreliability that is often found in other structured interviews and navigates complex diagnostic criteria by use of multiple short questions. If the respondent meets criteria for a particular diagnosis, all questions in the module are asked to provide a more complete dimensional assessment of related problems. The instrument requires approximately 1 hour to administer and provides both lifetime (prior to past 12 months) and current diagnoses (past 12 months). The AUDADIS-IV examines the onset of disorders; duration of symptoms of each disorder; the presence of co-occurring disorders; severity and impairment of symptoms, including “rule out” causes of symptoms (e.g., use of medication or drugs); frequency of substance use, patterns of use; and quantity of use. The most recent version of the AUDADIS-IV includes additional risk factor scales related to social and occupational functioning, such as the self-reported discrimination scales (e.g., reported bias against race, weight, ethnicity, culture). The instrument also examines stressful life events and perceived stress.

Positive Features

- The AUDADIS-IV is fully structured and translates DSM-IV criteria into simpler language and thus can be administered by nonclinicians
- The AUDADIS-IV has been translated into Spanish
- The AUDADIS-IV was designed to comprehensively assess for CODs among people who have substance use disorders
- The AUDADIS-IV provides adequate coverage of quantity, frequency, and duration of substance use disorders
- The AUDADIS-IV provides improved coverage of the chronology of symptoms and disorders in comparison to other structured assessment interview instruments (Grant et al., 2003)
- The AUDADIS-IV has been used with offenders to study antisocial behaviors and their correlates (e.g. drug use, low income,) in a large national epidemiological survey (Gelhorn, Sakai, Kato Price, & Crowley, 2007; Hoertel, Le Strat, Schuster, & Limosin, 2012; Vaughn et al., 2011; Vaughn et al., 2010)
- The AUDADIS-IV has also been used as a diagnostic/assessment tool in justice settings (Kerridge, 2009)
- The concurrent validity of the AUDADIS-IV is supported by findings of high comorbidity of nicotine disorders with other substance use disorders and is correlated with mental health scores on the SF-12; (Short Form Health Survey, Compton, Thomas, Stinson, & Grant, 2007; Gandek et al., 1998; Grant et al., 2004; Hasin, Stinson, Ogburn, & Grant, 2007; Kessler et al., 1994)
- The concurrent validity of the AUDADIS-IV is also supported by findings from a large epidemiological study that yielded high rates of co-occurring substance use, anxiety, and mood disorders (Grant et al., 2004). This same study indicated that personality disorders were associated with lower mental health scores as measured by the SF-12 (Grant et al., 2004). Borderline personality disorder was associated with increased mental and social difficulties, which is consistent with findings from other studies (Grant et al., 2008)
- Concurrent validity is also supported by findings of high rates of co-occurring depression among offenders who have substance use disorders (Kerridge, 2009)
- In large representative samples, interrater reliability for drinking and tobacco use frequency and quantity were quite good over an average 10-week period, with ICCs ranging .69–.84 (Grant, Dawson, Stinson, Chou, Kay, & Pickering, 2003). Interrater reliability for current and lifetime alcohol use disorders is also quite good (kappas range .70–.74; Grant et al., 2003)

- Interrater reliability for depressive disorders is acceptable (kappas range .59–.65), and reliability for severe anxiety is quite good (ICCs range .71–.86). Interrater reliability for adult ADHD and current/lifetime PTSD is adequate (kappas range .63–.77; Ruan et al., 2008)
- The Spanish version of the AUDADIS-IV demonstrates good psychometric properties, including test-retest reliability and interrater reliability for agreement on diagnoses (Mestre, Rossi, & Torrens, 2013)
- Internal consistency of the additional risk factor scales related to perceived stress and stressful life events are good (alphas range .82–.94), and discrimination for current/lifetime symptoms is acceptable (alphas range .59–.78; Ruan et al., 2008)

Concerns

- The AUDADIS-IV was developed in the general population and would benefit from further validation in clinical, criminal justice, and substance use settings
- Further validation is needed for AUDADIS-IV modules examining PTSD and DSM-IV personality disorders
- The AUDADIS-IV does not assess for psychosis other than inquiring about lifetime diagnosis of schizophrenia and assessment of schizoid personality disorder (Grant et al., 2003)
- The AUDADIS-IV may not effectively diagnose current/lifetime anxiety disorders (ICCs range .40–.52, Grant et al., 2003)
- The discrimination scales indicate relatively low internal reliability across current and lifetime time periods (Ruan et al., 2008)

Availability and Cost

The AUDADIS-IV is available free of charge and can be obtained by contacting Dr. Bridget Grant at bgrant@willco.niaaa.nih.gov

The Composite International Diagnostic Interview (CIDI)

The CIDI is a structured comprehensive interview developed by WHO to assess mental disorders according to the definitions and criteria of the International Classification of Disease (ICD, ICD-10) and the DSM (DSM-IV). The CIDI is one of the most widely used structured diagnostic interviews internationally, as it was developed specifically for use among different cultures and settings. The instrument was derived from the Diagnostic Interview Schedule (DIS; Robins, Helzer, Croughan, & Ratcliff, 1981) and accommodates diagnoses based on the definitions and criteria of both the ICD and DSM. The CIDI was first used in 1990 and was revised and expanded in 1998 by the WHO World Mental Health (WMH) initiative to address subthreshold impairment, symptom severity and persistence, risk factors, internal and external (global) impairment, consequences, patterns of treatment, and treatment adequacy, in addition to diagnosis of mental disorders (Kessler & Üstün, 2004). The WMH-CIDI contains 22 diagnostic sections, including anxiety, mood, eating, tobacco, and substance use disorders, attention deficit hyperactivity disorder (ADHD), conduct disorder, psychosis, and personality disorders. There are four sections assessing functioning and physical comorbidity, two sections assessing treatment, seven sections assessing sociodemographics, and two sections assessing methodological factors (e.g., interviewer observations). The CIDI-SAM (Substance Abuse Module) can be used separately, if desired, to diagnose substance use disorders.

Positive Features

- Administration of the CIDI does not require use of mental health professionals or significant clinical training to administer
- The CIDI provides both ICD-10 and DSM-IV diagnoses
- A diverse sample was used to develop the instrument, including individuals with a broad range of alcohol and drug use severity

- The WMH-CIDI has been translated into several languages using the standard WHO translation and back-translation protocol
- A computerized version of the CIDI is available, which contains a scoring algorithm to provide a diagnosis. The computerized version has the ability to handle more elaborate “skip” patterns, while covering the same information as the paper and pencil version (WHO, 2004)
- The CIDI has been used to diagnose disorders among people with intoxicated driving charges (Lapham, Baca, McMillan, & Lapidus, 2006; Shaffer et al., 2007), prisoners (Brinded, Simpson, Laidlaw, Fairley, & Malcolm, 2001), and juvenile offenders (Steinberg, Blatt-Eisengart, & Cauffman, 2006)
- The CIDI-SAM shows acceptable agreement with the Schedules for Clinical Assessment in Neuropsychiatry (SCAN; Wing et al., 1990) in diagnosing alcohol use disorders ($\kappa = .69$) and cocaine use disorders (.61; Compton, Cottler, Dorsey, Spitznagel, & Mager, 1996). A nationally representative U.S. survey also indicates positive findings for the AUC for the WMH-CIDI for substance use disorders ($AUC = .72-.99$), anxiety disorders ($AUC = .74-.93$), mood disorders ($AUC = .87-.97$), and “any” disorder ($AUC = .76$; Haro et al., 2006). According to this same survey, the CIDI-SAM demonstrates good test-retest reliability for substance use disorders over a 1-week period (kappas range .63-.80; Horton, Compton, & Cottler, 2000)
- The CIDI has good sensitivity (74 percent) and specificity (98 percent) for any substance use diagnosis (Haro et al., 2006) and has adequate sensitivity for anxiety disorders (84 percent), mood disorders (69 percent), or “any” disorder (78 percent). The CIDI has excellent specificity (93 percent, 97 percent, and 91 percent for each of these respective disorders; Haro et al., 2006), and good positive predictive values and negative predictive values
- The WMH-CIDI demonstrates good sensitivity, specificity, positive predictive values, and negative predictive values across different mental disorders and severe substance use disorders (Kessler et al., 1998), although the reliability of substance use diagnoses have been less than adequate in several studies (Kessler et al., 1998; Üstün et al., 1997)
- The WMH-CIDI provides adequate agreement with the SCID-I for substance use diagnoses (Haro et al., 2006)

Concerns

- The CIDI is quite lengthy and requires an average of 2 hours to administer
- Use of the WMH-CIDI requires completion of a training program that reviews interviewing techniques and field quality control
- In a large U.S. survey, the WMH-CIDI exhibited low accuracy in identifying substance use disorders and a range of mental disorders when compared with the SCID-I (Haro et al., 2006)
- Little data is available regarding the CIDI’s effectiveness in justice settings

Availability and Cost

Both printable to paper and computerized versions of the CIDI can be obtained free of charge from the World Health Organization at the following site: <https://www.hcp.med.harvard.edu/wmhcid/download-the-who-wmh-cidi-instruments/>

Information regarding training in use of the CIDI can be found at the following site: <https://www.hcp.med.harvard.edu/wmhcid/who-wmh-cidi-training/>

Global Appraisal of Needs (GAIN)

The GAIN (Dennis, Titus, White, Unsicker, & Hodgkins, 2006) includes a set of instruments developed to provide screening and assessment of psychosocial issues related to mental and substance use disorders. A more detailed

description of the GAIN family of instruments is provided in the section entitled, “Screening Instruments for Co-occurring Mental and Substance Use Disorders.” The GAIN instruments can be administered via interview or self-administered by paper and pencil or by computer. A wide variety of software is available to score and interpret results of the GAIN instruments. The Quick version of the GAIN (GAIN-Q3) requires 25–35 minutes to administer and includes assessment of nine individual sections related to a wide range of psychosocial and behavioral health issues in adults and adolescents. The GAIN examines areas such as substance use, mental health status, physical health, stress, work problems, life satisfaction, behavioral problems, and service utilization in the past 90 days. The GAIN instrument can also be used as a follow-up tool to assess and monitor progress. The GAIN-Q provides a recommended cut-off score of ≥ 3 for both adults and adolescents in identifying people with a mental disorder (Dennis et al., 2006). Other versions of the instrument include the GAIN-Q3-Lite, which consists of nine individual screeners and requires approximately 25 minutes to administer. The GAIN-Q3-MI (motivational interviewing) includes information regarding readiness for treatment and change.

The GAIN-Initial requires approximately 120 minutes to administer and provides a full assessment of psychosocial issues related to substance use treatment, as well as internalizing and externalizing disorders and problems related to crime and violence. The GAIN-Initial is useful for diagnostic purposes, treatment planning, placement in different levels of treatment services, and monitoring offender and/or program outcomes. Several versions of the GAIN-Initial have been developed for various programs, primarily those funded by CSAT and by the Robert Wood Johnson Foundation. Several follow-up forms are available to examine change over time in psychosocial areas related to treatment. The GAIN-I Lite is shorter to administer, requiring approximately 60 minutes, but is not as detailed as the full version. It contains the GAIN-Q3, other

items needed for diagnosis, and the American Society of Addiction Medicine (ASAM) placement criteria for treatment planning and referral. The GAIN-I Core is used when the GAIN-Initial cannot be administered and contains less detailed information examining service utilization and treatment history. The GAIN-I core requires 60–75 minutes to administer. The GAIN-M90 monitors treatment progress and is administered at 6, 9, and 12 months following treatment initiation; it requires approximately 60 minutes to administer.

Positive Features

- The GAIN-Q and GAIN-I is designed for use in justice settings, primary care settings, substance use treatment programs, and other social service programs
- Norms for the GAIN have been developed for adults and adolescents and for different levels of care. Additional norms are being developed by gender, race/ethnicity, CODs, and for juvenile and adult offenders
- Scoring software is available to interpret scores for purposes of diagnosis and treatment planning. Personal feedback reports (PFR) are also available
- Computerized versions of the GAIN are available that provide interpretation of assessment and validity reports to identify erroneous or missing data. A wide variety of support services are available through the GAIN Coordinating Center
- The GAIN has been used to assess mental disorders among juvenile and adult offenders (Belenko, 2006; Hussey, Drinkard, & Flannery, 2007; Sacks et al 2007b, Ramchand, Morral, & Becker, 2009)
- The GAIN has been widely used to assess mental health problems among adolescents and adults enrolled in substance use treatment (Chan, Dennis, & Funk, 2008; Dennis, White, & Ives, 2009; Shinn et al., 2007)
- Among adults, the GAIN-I demonstrates good predictive utility related to recidivism

- and relapse (Dennis, Scott, & Funk, 2003; Dennis et al., 2006)
- The GAIN-I–Substance Problem Scale is correlated with increased risk of internalizing and externalizing disorders among adults. The Behavior Complexity Scale is correlated with severity of substance use problems, and the Crime/Violence Scale is correlated with future criminal behavior (Dennis et al., 2006)
 - A confirmatory factor analysis supports the factor structure of the GAIN in adults, including its use as a unidimensional measure (total score) and use of the individual subscales (Dennis et al., 2006)
 - The GAIN-I and its subscales have good internal consistency for use with adults, with alphas ranging .71–.96 (Dennis et al., 2006). Studies examining concurrent validity have been conducted primarily with adolescents, but are quite promising (Dennis et al., 2006)
 - The GAIN-Q and its subscales have adequate internal consistency among adults (GAIN Coordinating Center, 2013)
 - The GAIN-I demonstrates good internal consistency for three comorbidity subscales related to internal mental distress, behavior complexity, and crime/violence, with alphas ranging .78–.96. The condensed versions of these scales, the internal behavior scale, and the external behavior scale also demonstrate good internal consistency, with alphas ranging .69–.90 (Titus, Dennis, Lennox, & Scott, 2008). The GAIN original scales are highly correlated with the subscales for adults
 - The GAIN-I has good test-retest reliability for the main subscales (internal mental distress, behavior complexity scale, substance problem scale, crime/violence scale), with r score = .70 and kappas = .60. The GAIN-I also has good agreement with timeline followback, urinalysis, treatment, and other measures of substance use disorders (r score \geq .70 and kappa \geq .60; Dennis et al., 2006)
 - Among adolescents, the GAIN-I shows good agreement with diagnoses of ADHD, mood disorders, conduct disorder/oppositional defiant disorder, and adjustment disorder and distinguishes between co-occurring psychopathology (kappas range .65–1.00; Shane, Jasiukaitis & Green, 2003)
 - Among adolescents, the GAIN-I has good internal consistency for three subscales of internal mental distress, behavior complexity, and crime/violence (Dennis et al., 2006; Titus et al, 2008). Original scales were highly correlated with shortened subscales among both adults and adolescents (Titus et al., 2008)

Concerns

- Training is strongly recommended before administering the GAIN. The GAIN training is costly and includes separate trainings to administer the instrument and to train others on how to use the measure
- The GAIN is a copyrighted instrument, and there are separate costs to purchase the set of instruments and for the software
- License agreement paperwork and a separate user agreement are required at cost
- Further validation among offender populations is needed to examine the GAIN’s psychometric properties, including predictive utility of diagnoses and diagnostic impressions. Self-reported substance use on the GAIN is only moderately correlated with drug testing and other collateral information (Dennis et al., 2006)
- Item response theory (IRT) analyses show that the crime/violence scale on the GAIN may be less reliable for adults, particularly among adult females, potentially leading to errors in clinical diagnoses (Conrad et al., 2010)

Availability and Cost

Scoring and diagnostic interpretation using the paper version of the GAIN-I and GAIN-Q are

described in the GAIN manual. Using the hand-scored approach requires substantially more time than automated scoring provided using the web version. The various GAIN manuals and information describing administration, scoring, and norms can be found at the following locations:

GAIN-I: <https://chestnut.app.box.com/v/GAIN-I-Materials>

GAIN-Q: <https://chestnut.box.com/v/GAIN-Q3-Materials>

The GAIN-ABS (Assessment Building System) is an online system that provides administration, scoring, and interpretative reports for the GAIN-I and GAIN-Q3. This version requires the license agreement as noted above, in addition to separate user agreements. Interpretative reports are only available using the web version of the GAIN. Costs for utilizing the GAIN depend on the number of users within an agency accessing the cloud-based system, a one-time set up fee, and the annual user fee for each authorized user. A quote based on project needs can be requested by email at gaininfo@chestnut.org or by calling (309) 451-7900. Administration training costs range from \$500 to \$1,800. Different training is provided to administer the GAIN-I and GAIN-Q3. Training recipients are not authorized to train others on how to administer the instrument. Local training certification is provided for those who would like to train other users. These certificates cost between \$1,500 and \$2,400 for the GAIN-I and GAIN-Q3. Each type of training is available online; however, there are designated time limits in which the training must be completed (i.e., 3–6 months).

Diagnostic Instruments for Co-occurring Mental Health and Substance Use Disorders

Diagnostic Interview Schedule—Fourth Edition (DIS-IV)

The DIS-IV is a fully structured diagnostic interview instrument designed for research

purposes (Blouin, Perez, & Blouin, 1988; Robins et al., 1981) and has been updated to coincide with revisions to diagnostic categories in the DSM. Revised versions of the DIS have improved accuracy in identifying a range of mental disorders. A self-administered computerized version of the DIS is available (C-DIS), although staff must be present to address respondents' questions. Administration of the DIS does not require clinical experience. The DIS-IV has 19 diagnostic modules covering over 30 Axis I disorders, which include demographic and risk factors, sequencing of comorbid disorders, observations of psychotic symptoms or other problems during the interview, and a range of individual modules examining different types of disorders related to mood, anxiety, eating, schizophrenia spectrum, somatization, substance use disorders, antisocial personality disorder, ADHD, dementia, and gambling. The DIS provides information regarding both current and lifetime diagnoses of common mental disorders.

Positive Features

- The DIS can be administered by nonclinicians, requires minimal training, and has been translated into many languages
- The DIS has been used to diagnose mental disorders among offenders (Lo & Stephens, 2000; Teplin et al., 1996; Wiesner, Kim, & Capaldi, 2005) and people with substance use disorders (Havassy, Alvidrez, & Owen, 2004; Horton, Compton, & Cottler, 1998)
- In addition to detecting the presence of mental disorders in the justice system, the DIS has been used to refer offenders to treatment (Lo, 2004; Teplin, 1990)
- The DIS includes an antisocial personality disorder (ASPD) module. DIS-IV diagnoses of ASPD are correlated with substance use and chronic patterns of offending (Wiesner et al., 2005)
- The DIS has good agreement with the MAST (.79) in detecting alcohol disorders among individuals treated for mental disorders (Goethe & Fisher, 1995).

Reliability of DIS diagnoses is quite good because interview questions, probes, and coding procedures are carefully described (Compton & Cottler, 2004)

- The DIS has adequate agreement with the SCAN for diagnosis of substance use disorders and for depression (Compton & Cottler, 2004) and has excellent specificity (90 percent) in detecting depression (Eaton Neufeld, Chen, & Cai, 2000)
- The DIS demonstrates adequate agreement with medical chart diagnoses (Robins, Helzer, Ratcliff, & Seyfried, 1982)
- The DIS diagnoses provide adequate agreement with most lifetime disorders, as determined by the DSM-III-R among psychiatric patients ($kappas \geq .5$; Robins et al., & Ratcliff, 1981; Robins et al., 1982). Similarly, in college students, interrater agreement for both current and lifetime disorders on the DIS is acceptable (median kappas range .43–.46; Vandiver & Sher, 1991)
- Wittchen et al. (1989) found good agreement (kappas range .50–.70) between the clinician-administered and nonclinician-administered interviews for the DIS, as well as good test-retest reliability between administrations of the DIS ($kappa > .6$).
- The DIS has good test-retest reliability (95 percent agreement for severe disorders) in diagnosing men who are incarcerated in jail (Abram & Teplin, 1991)

Concerns

- The DIS is quite lengthy, requiring 90–120 minutes to administer. However, it is possible to omit sections of the DIS that are not of interest
- Further validation of DIS diagnoses is needed with offenders
- Structured instruments such as the DIS may fail to detect 25 percent of those abusing alcohol (Drake et al., 1990) and possibly a higher proportion who are abusing illicit substances (Stone, Greenstein, Gamble, & McLellan, 1993)

- There is poor agreement between the DIS and the Schedule for Affective Disorders and Schizophrenia- Lifetime (SADS-L) in diagnosing depression among individuals who have CODs (Hasin & Grant, 1987)
- The DIS may be overly sensitive in diagnosing major depressive disorder (Helzer et al., 1985)
- The DIS has low agreement with the SCAN for diagnosis of depression (Eaton et al., 2000)
- The DIS may not accurately diagnose anxiety disorders (e.g., panic, social phobia) or schizophrenia (Anthony et al., 1985; Cooney, Kadden, & Litt, 1990; Erdman et al., 1987; Summerfeldt & Antony, 2002)
- Caution is urged when using the DIS as a primary diagnostic tool, as agreement between the DIS and clinician diagnosis has sometimes been poor in comparison to that of the SCID (Blanchard & Brown, 1998)
- The C-DIS provides poor to moderately good (–.05–.70) test-retest reliability in diagnosing CODs, depending on the type of mental disorder (Ross, Swinson, Doumani, & Larkin, 1995)
- The DIS is not sensitive to response styles and does not provide methods for detecting dissimulation (Alterman et al., 1996)

Availability and Cost

A copy and license for the use of the DIS (computerized version) may be purchased at the following site: <http://epidemiology.phhp.ufl.edu/assessments/c-dis-iv/brochure/>

The cost for licensing ranges from \$1,000 to \$2,000.

The Mini International Neuropsychiatric Interview (MINI)

The MINI (Sheehan et al., 1998) is a 120-question structured diagnostic interview used to evaluate DSM and ICD Axis I mental disorders (although

the DSM-5 does not have axes, some of these frameworks are built around DSM-IV and earlier versions), including substance use disorders. The instrument was designed as a brief diagnostic screen and has been used in numerous research and clinical settings. The MINI provides a family of structured interviews, which includes the MINI, MINI-Kid, MINI-Plus, and MINI-Screen. Another section, “Screening Instruments for Co-occurring Mental and Substance Use Disorders,” provides a more detailed description of the MINI screening tool. The MINI-Plus is a fully structured instrument that assesses the presence of 23 DSM-IV-TR Axis I disorders, including attention deficit hyperactivity disorder (ADHD) and one Axis II disorder (antisocial personality disorder), chronology of disorders, and rule-out questions to accurately identify the presence of comorbid disorders. The Mini-Kid screens for common childhood and adolescent psychopathology, including mood disorders, anxiety disorders, substance use disorders, externalizing disorders, and developmental disorders. Other MINI instruments have been developed to examine bipolar and psychotic disorders and suicidality. The most recent version of the MINI, MINI 7.0.2, is also available for administration by computer.

Positive Features

- Only brief training is required to use the instrument
- The MINI provides a diagnostic impression for major “Axis I disorders” and examines a broad range of symptoms. The instrument requires approximately 20 minutes to administer to individuals who do not have a mental disorder
- The MINI has been translated into many languages and includes norms for several subpopulations (Sheehan et al., 1998)
- The MINI-Plus has been used with offenders to assess current and lifetime mental and substance use disorders (Black et al., 2007; Cuomo, Sarchiapone, Di Giannantonio, Mancini, & Roy, 2008; Gunter et al., 2008), including antisocial personality disorder (Black, Gunter, Loveless, Allen, & Sieleni, 2010). In a study of the MINI-Plus with a prison sample (Black et al., 2004), the measure was easily administered by correctional staff, well received by prisoners, and it accurately assessed mental disorders in this population
- The MINI clinician-administered interview demonstrates good sensitivity (62–96 percent) and specificity (86–100 percent) across almost all current/lifetime Axis I disorders as determined by the SCID-I patient clinical interview (Sheehan et al., 1998). Similarly, the MINI patient rated self-report instrument has adequate sensitivity (60–89 percent) and good specificity (74–99 percent) for many of the current/lifetime Axis-I diagnoses. The MINI also has good sensitivity (67–89 percent) and specificity (72–97 percent) for many CIDI (Composite International Diagnostic Interview) DSM-III-R disorders. Overall specificity is good for the MINI as compared to other structured clinical interviews (Sheehan et al., 1998)
- Agreement between MINI clinician-rated and CIDI diagnoses for psychotic disorders is adequate (kappas range .68–.82), as are those between the MINI and SCID-I diagnoses (Sheehan et al., 1998)
- Interrater reliability estimates for the clinician-administered version of the MINI ranges .79–1.00 for all subscales. Fourteen of the 23 test-retest reliability values are greater than .75 (range = .35–1.00, and only one is below .50; Sheehan et al., 1998)
- The MINI shows good concordance with SCID DSM-IV diagnoses (kappas range .90–1.0; Sheehan et al., 1998)
- The MINI-Kid shows good sensitivity (71–100 percent) and specificity (74–99 percent) in identifying mental disorders as determined by the K-SADS-PL (Schedule for Affective Disorders and Schizophrenia for School-Aged Children; Kaufman et al., 1997). For individual diagnosis, sensitivity is adequate (67–100 percent) and specificity (73–99 percent) is good across

most disorders (Sheehan et al., 2010). Interrater reliability for the MINI-Kid is also good (Sheehan et al., 2010)

- Test-retest reliability for the MINI-Kid is good for any disorder and .75–1.00 for individual disorders over 1–5 days (Sheehan et al., 2010)

Concerns

- Further validation is needed of the MINI-Screen with offender populations
- The MINI does not consider symptom severity, and thus may generate unnecessary referrals for treatment. The MINI does not assess cognitive impairment
- The MINI-Plus requires an average of 41 minutes to administer to offenders, which may inhibit broad use of the instrument with this population (Black et al., 2004)
- Although malingering, denial of symptoms, and other response sets are common problems in justice settings, the MINI is not able to detect the presence of these response sets
- The psychosis and major depression modules of the MINI-Plus can be somewhat difficult and confusing to administer (Black et al., 2004)
- The MINI-Plus clinician-administered interview exhibits lower sensitivity for substance use disorder and dysthymia (42–52 percent), as determined by the SCID-I patient version. Further, MINI patient rated self-report diagnoses for many anxiety disorders, bulimia, and current/lifetime mania have low sensitivity (17–55 percent). Low sensitivity for the MINI clinician-administered interview was found for agoraphobia, simple phobia, and lifetime bulimia (46–63 percent), as determined by the CIDI
- Agreement between the clinician administered MINI and the SCID-I was low for many current/lifetime anxiety disorders, current psychotic disorders, current/lifetime substance use disorder, and dysthymia (kappas range 43–67 percent)

- Agreement between the clinician administered MINI and CIDI was low for many anxiety disorders, bulimia, and current/lifetime manic diagnoses (kappas range 43–68 percent; Sheehan et al., 1998)
- The MINI-Kid has poor sensitivity for current/lifetime psychotic disorder, major depressive disorder, dysthymia and panic disorders (43–64 percent; Sheehan et al., 2010), as determined by the K-SADS-PL

Availability and Cost

The MINI is available in paper and computerized versions. The paper form may be downloaded twice for \$10; however, a download is not a license agreement for use. A computerized version may be ordered for \$295 or more, depending upon the version. The following website can be accessed to contact the author for permission to use the MINI or to obtain more information about the MINI 7.0.2, eMINI 6.0 (computerized version) and Dolphin EDC (MINI administered via internet browser): <http://harmresearch.org/index.php/mini-international-neuropsychiatric-interview-mini/>

The MINI Plus 7 can be downloaded at the following location: <http://harmresearch.org/index.php/mini-international-neuropsychiatric-interview-mini/>

Psychiatric Research Interview for Substance and Mental Disorders (PRISM)

The PRISM is a semi-structured interview designed to diagnose psychopathology among substance-involved people. The instrument requires approximately 90 minutes to administer. As a result of the increasing recognition of the relevance of CODs, DSM-IV and DSM-5 emphasize the importance of distinguishing between substance-induced psychiatric symptoms related to active use and withdrawal and “primary” mental disorders (Samet, Nunes, & Hasin, 2004). Since specific guidelines for these diagnostic decisions did not exist prior to DSM-IV, in the past there have been problems with the reliability

and validity of mental health diagnoses among people with substance use disorders. The PRISM examines current and lifetime substance use, mental disorders, and borderline and antisocial personality disorders. The substance use sections are presented prior to other diagnostic sections. Therefore, the interviewer has the substance use history information available when assessing mental disorders.

A computerized version of the PRISM (PRISM-CV-IV) is also available. The PRISM-CV-IV reviews the consistency of respondents' answers, and incorporates skip logic, reducing administration time to approximately 70 minutes (Hasin, Samet, Nunes, Mateseoane, & Waxman, 2006). A diagnostic report is produced to assist with scoring and interpretation. Differences between the paper and computerized version of the PRISM include use of a question format (e.g., multiple questions in the paper version are presented as individual questions in the computerized version). The order of modules is also different in the paper and computerized versions. Additional modules in the computerized version include nicotine use, suicidality assessment, ADHD, and Pathological Gambling. The PRISM paper version is no longer supported by the PRISM website.

Positive Features

- The instrument distinguishes between primary and substance-induced disorders
- The PRISM was developed using a racially/ethnically diverse sample
- A Spanish version of the PRISM is available and appears to have some advantages over the Spanish version of the SCID in diagnosing major depression and borderline personality disorders among substance-involved people (Torrens, Serrano, Astals, Pérez-Domínguez, & Martín-Santos, 2004)
- The PRISM addresses the problem of diagnosing depression among people with substance use disorders

- The PRISM-CV has been widely used in both mental health and general medical settings
- Severity measures, consisting of a continuous rating of the number of symptoms present, are provided for some mental disorders, such as major depressive disorder and substance use disorders
- The PRISM has been used with several populations that have CODs (Coombes & Wratten, 2007; Hasin et al., 2002; Vergara-Moragues et al., 2012), with individuals who are homeless (Caton et al., 2005), and with offenders (Kravitz, Cavanaugh, & Rigsbee, 2002)
- Among substance-involved populations, the PRISM exhibits good agreement with DSM-IV diagnoses for current and lifetime diagnoses (kappas range .62–.82; Hasin et al., 2006)
- Among people with substance use disorders, the PRISM demonstrates good reliability for agreement in severity across most types of disorders, including both current and lifetime disorders (Hasin et al., 2006)
- Among people with substance use disorders, the PRISM shows adequate agreement with DSM-IV diagnoses of current and lifetime major depressive disorder and manic episodes, psychotic disorders, eating disorders, and personality disorders (Hasin et al., 2006)
- The PRISM has excellent reliability in diagnosing major depression (Hasin, Samet, Nunes, Mateseoane, & Waxman, 2006)

Concerns

- The PRISM interview must be administered by a trained clinician
- The PRISM website no longer supports the paper instrument services, such as data entry or diagnostic programs for scoring and interpretation
- The PRISM has not been widely used or tested in criminal justice populations

- Agreement with DSM-IV diagnoses of many substance use disorders has been found to be low in some samples (Hasin et al., 2006)
- Reliability for the PRISM severity of stimulant disorder is low, as determined by symptoms counts on the DSM-IV for both current and lifetime disorder (ICCs range .55–.64; Hasin et al., 2006)
- The PRISM’s anxiety disorders module does not have good reliability for primary or substance-induced anxiety disorders ($\kappa = .57$), nor dysthymic disorder ($\kappa = .36$; Hasin et al., 2006)

Availability and Cost

The author of the PRISM maintains a website (<http://www.columbia.edu/~dsh2/prism/>) containing information regarding computer software related to the instrument. The site also contains information regarding the PRISM’s psychometric properties and available training.

The training manual for the PRISM is available at the following location: <http://www.columbia.edu/~dsh2/prism/files/PRISMman266.pdf>

The PRISM-CV-IV is available for purchase and includes all software required for administration, scoring, and interpretation. PRISM administration does not require the software, but it is recommended that a license be purchased from Blaise® Licensing. Information including cost (approximately \$200) can be obtained by requesting a software quote through the following site: <https://www.westat.com/our-work/information-systems/blaise-percentC2-percentAE-distribution-training/blaise-licensing-ordering>

The PRISM-CV-IV software package includes the interview protocol, a codebook that defines interview questions and diagnostic variables, a manual that provides diagnostic information for scoring and interpretation of interviews, a user guide, and information on how to export data to other statistical software programs. The cost of this package is \$1,800.

Training and certification for administration of the PRISM-CV-IV is available. The cost of training workshops is \$3,000 and certification costs are \$200.

Paper instruments including the training manual for scoring and interpretation are available upon request by sending email correspondence to the following address: AivadyaC@nyspi.columbia.edu

Psychiatric Diagnostic Screening Questionnaire (PDSQ)

The PDSQ (Zimmerman & Mattia 2001b) is a 126-item self-administered instrument that assesses 13 of the most common DSM-IV mental disorders in outpatient mental health settings. The instrument was designed to assess current and recent symptomatology and to provide background information prior to providing a more extensive diagnostic evaluation. The PDSQ examines five areas, including eating disorders, mood disorders, anxiety disorders, substance use disorders, and somatoform disorders. The PDSQ also includes a six-item screen for psychosis. The instrument has undergone several iterations to enhance the reliability and validity, and indices of mania, dysthymic disorder, and anorexia were eliminated from the instrument due to poor psychometric features. At recommended cut-off scores, the PDSQ has sensitivity of greater than 90 percent for major depressive disorder, obsessive-compulsive disorder, PTSD, generalized anxiety disorder (GAD), panic/agoraphobia/social phobia, alcohol use disorders, and bulimia or somatoform disorders (Zimmerman, 2002; Zimmerman & Mattia, 2001a).

Positive Features

- The PDSQ requires only 15 minutes to administer, yet reviews a range of mental disorders
- The PDSQ was developed to be aligned with DSM diagnostic classifications
- The PDSQ has been used extensively with populations that have CODs and may

- assist in detecting disorders that are missed during unstructured clinical evaluations
- Cut-off scores were chosen to optimize sensitivity (> 90 percent; Zimmerman & Mattia, 2001a)
- The PDSQ has been used to diagnose mental disorders in justice settings (Stuart, Moore, Gordon, Ramsey, & Kahler, 2006; Swogger, Walsh, Houston, Cashman-Brown, & Connor, 2010; Weitzel, Nochajski, Coffey, & Farrell, 2007) and among people with substance use disorders (Simmons, Lehmann, & Cobb, 2008; Weitzel et al., 2007)
- PDSQ subscales related to depression are correlated with victimization of women and PTSD among women who are arrested for domestic violence (Stuart et al., 2006)
- Among offenders, the PDSQ subscales of GAD and PTSD are correlated with impulsive aggression (Swogger et al., 2010)
- The PDSQ results in a 42 percent rate of referral for further mental health evaluation among drug offenders, a rate similar to those referred for evaluation in other substance-involved populations (Harris & Edlund, 2005; Watkins et al., 2004; Weitzel et al., 2007)
- The PDSQ has a low false positive rate in identifying Axis I disorders (30 percent; Zimmerman & Chelminski, 2006). Among psychiatric outpatients, the AUC for the PDSQ is good for those with and without diagnosed substance use disorders (.83 and .86 respectively) as determined by the SCID-I, across a range of disorders (Zimmerman, 2008; Zimmerman, Sheeran, Chelminski, & Young, 2004)
- Among psychiatric outpatients with substance use disorders, the PDSQ has good sensitivity (92 percent) and adequate specificity (63 percent) in identifying co-occurring mental disorders (Zimmerman, 2008; Zimmerman & Chelminski, 2006; Zimmerman et al., 2004)

- The PDSQ has good to excellent internal consistency (alphas $\geq .80$ for 12 out of 13 subscales); test-retest reliability over two weeks (r score $\geq .80$ for nine subscales, mean r score = .83); and discriminant, convergent, and concurrent validity (Zimmerman & Mattia, 2001a)

Concerns

- The validity of the PDSQ has not been widely studied in justice-involved populations for the diagnosis of mental disorders
- Various cut-off scores are recommended to achieve optimal sensitivity for mental disorders, which may lead to difficulties in scoring and interpreting results
- The PDSQ's alcohol and drug subscales do not distinguish between levels of substance use severity (Stuart et al., 2006)
- The PDSQ has low specificity for generalized anxiety disorder, obsessive-compulsive disorder, social phobia, and PTSD among people who are diagnosed with substance use disorders, as determined by the SCID-I (Zimmerman, 2008; Zimmerman et al., 2004)
- Positive predictive values for the PDSQ vary widely across mental disorders, indicating that some individuals may not be correctly diagnosed as having a disorder (Zimmerman, 2008; Zimmerman & Chelminski, 2006)
- The sensitivity of the PDSQ's psychosis subscale is not particularly high (Zimmerman, 2008; Zimmerman & Chelminski, 2006; Zimmerman & Mattia, 2001a)
- No current PDSQ validity indices are available for mania, dysthymic disorder, or anorexia

Availability and Cost

The PDSQ can be purchased at the following site: <http://www.wpspublish.com/store/p/2901/psychiatric-diagnostic-screening-questionnaire-pdsq>

The cost to purchase the PDSQ is \$130 for 25 test booklets, 25 summary sheets, an instruction manual, and a CD containing 13 follow-up interview guides (one for each of 13 disorders).

Schedule of Affective Disorders and Schizophrenia—Third Edition (SADS)

The SADS is a semi-structured interview designed for use by trained clinicians to evaluate current and lifetime affective and psychotic disorders (Endicott & Spitzer, 1978). The instrument predates the SCID and offers specified probes for diagnostic criteria. The SADS includes Part I (Current) and Part II (Lifetime). Part I assesses current episodes, particularly the most severe period of the current episode. The SADS also examines six graduated levels of symptoms experienced, ranging from “not at all” to “extreme.” Part II of the SADS reviews lifetime history of symptoms and episodes of the disorders and features two graduated levels of symptoms experienced (“presence” or “absence”). Several alternate versions of the SADS have also been developed. For example, the SADS-L is similar to Part II of the SADS in that it provides a description of lifetime symptoms and dedicates very little time to current symptoms. The 45-item SADS-C examines current symptoms and changes in these symptoms. The global assessment scale of the SADS-I describes symptoms experienced over particular intervals of time following the initial SADS-L interview.

Positive Features

- The SADS has been found to be more effective than the DIS in diagnosing depressive disorders (Hasin & Grant, 1987)
- Interrater reliability is excellent for current disorders and is good for past disorders
- The SADS has been translated into several languages
- The instrument examines symptom severity and ancillary symptoms that are related to, but not part of, formal diagnostic criteria
- The SADS has been used in justice settings to diagnose mental disorders (Blackburn & Coid, 1998; Hodgins, Lapalme, & Toupin, 1999) and has been found to be effective in these settings (Rogers, Sewell, Ustad, Reinhardt, & Edwards, 1995; Rogers, Jackson, Salekin, & Neumann, 2003)
- The SADS is useful in inpatient, outpatient, and primary health care settings for diagnosing CODs and providing referral to services (Rogers, Jackson & Cashel, 2004)
- The SADS has adequate concurrent validity for mental disorders when compared with other diagnostic interview instruments (Farmer et al., 1993; Rogers et al., 2004; Hesselbrock, Stabenau, Hesselbrock, Mirkin, & Meyer, 1982)
- The SADS-C has good reliability in diagnosing mental disorders (McDonald-Scott & Endicott, 1984)
- The SADS-C subscales of schizophrenia, depression, and bipolar disorder are significantly correlated with similar scales on the Referral Decision Scale (Rogers, Sewell et al., 1995), and other studies provide evidence of concurrent validity of the SADS-C (Johnson, Magaro, & Stern, 1986)
- Within justice settings, the SADS-C shows good interrater reliability for symptoms and subscales (ICC = .92, range .94–.97; Rogers et al., 2003) in both treatment seeking and emergency care settings
- Across multiple studies, the SADS exhibits good interrater reliability for symptom ratings and diagnosis (Andreasen et al., 1982; Endicott, & Spitzer, 1978; Keller et al., 1981; Rogers, Sewell et al., 1995)
- The SADS’s test-retest reliability is moderate to high (McDonald-Scott & Endicott, 1984; Rapp, Parisi, Walsh, & Wallace, 1988) when the elapsed time between administrations is less than 6 months

Concerns

- The SADS was developed concurrently with the DSM-III and does not use DSM-IV or DSM-5 terminology or classification systems
- There is poor agreement between the SADS and the DIS in diagnosing depression among individuals with substance use problems (Hasin & Grant, 1987)
- The SADS does not adequately address all substance use disorders, and thus, other interviews such as SCID may be preferred (Rogers, 2001)
- The SADS has not been used extensively in justice settings
- The SADS is rather lengthy and complex to administer and requires clinical judgment
- Significant training is required for administration and scoring of the SADS
- The instrument is not very sensitive to response styles, and participants can fake positive symptoms of disorders. Research has examined the potential use of some SADS-C subscales to detect malingering (Rogers et al., 2003)
- The SADS provides limited breadth of coverage, with a focus on evidence of affective and psychotic disorders
- The SADS is not recommended for assessment of personality disorders (Rogers, 2001)

Availability and Cost

A description of the SADS can be found in the following article: Endicott, J., & Spitzer, R. L. (1978). A diagnostic interview: The Schedule of Affective Disorders and Schizophrenia. *Archives of General Psychiatry*, 35, 837–844.

This instrument is no longer in print and thus copies of the instrument may be difficult to obtain.

Structured Clinical Interview for DSM-IV (SCID-IV)

The SCID is a semi-structured psychological assessment interview developed for administration by trained clinicians (First, Spitzer, Gibbon, & Williams, 1996). The SCID-I is one of the most widely used structured interview instruments developed to diagnose DSM disorders and is considered to be the “gold standard” for diagnostic assessment (Shear et al., 2000). The SCID-I obtains diagnoses for all mental disorders, using the DSM criteria. Standard threshold questions are provided and the administrator may reword questions to clarify them, as needed. The Substance Use Disorders module identifies lifetime and past 30-day diagnoses for alcohol and other drugs. The SCID-IV also differentiates between different levels of severity of substance use disorders. A separate instrument (SCID-II) examines Axis II Personality Disorders and is published separately.

Both research (SCID-RV) and clinical versions (SCID-CV) of the SCID-I and II are available. The clinical version is shorter (45–90 minutes) and examines disorders frequently seen in clinical settings (First, Spitzer, Gibbon, & Williams, 2001), while excluding most of the subtypes, severity, and course specifiers included in the research version. Some disorders are not fully evaluated but instead are assessed briefly at the end of the SCID administration (e.g., social and specific phobia, generalized anxiety disorder, eating disorders, hypochondriasis). The full SCID-I Research Version examines the mental disorders. The Research Version requires approximately 1.5–2 hours to administer and 10 minutes to score.

The SCID-RV and SCID-CV for DSM-5 are now available, in addition to user guides for these instruments. These instruments are available from the American Psychiatric Publishing Inc. (see “Availability and Cost”). Revisions are also underway for the SCID-II, which will be renamed the “SCID for Personality Disorders” (SCID-PD).

Positive Features

- Diagnoses are made according to DSM-IV, DSM-IV TR, or DSM-5 criteria
- The SCID has been translated into several languages. Several foreign language versions have been shown to have good psychometric properties (Lobbestael, Leurgans & Arntz, 2011; Schneider et al., 2004)
- Computer-assisted interview versions of the SCID (SCID-CV) are available, including the research version. A shorter, computer-administered self-report screening version of the SCID is also available. However, this latter version does not yield definitive diagnoses but rather diagnostic impressions that should be confirmed through use of a SCID interview or full clinical evaluation
- The instrument has been used with psychiatric, medical, nonsymptomatic adults in the community and justice populations (Cohen et al., 2002; Dolan & Blackburn, 2006; Morgan, Fisher, Duan, Mandracchia, & Murray, 2010; First et al., 2001; Peters. Greenbaum, Edens, Carter, and Ortiz, 1998; Peters et al., 2000)
- SCID diagnoses have been found to be more accurate and more comprehensive than unstructured clinical interviews (Basco et al., 2000; Kranzler et al., 1995)
- The SCID has been used to assess CODs, including treatment-seeking individuals who have substance use disorders (Kidorf et al., 2004)
- In a community sample, the SCID for Axis II disorders shows adequate interrater reliability for diagnoses (kappas range .85–.95) in addition to adequate agreement for the presence of individual traits related to mental disorders (ICCs range .87–.99). The self-report SCID-II demonstrates good interrater reliability for the diagnosis of the personality disorders (kappas range .66–.99; Farmer & Chapman, 2002)
- Peters et al. (1998) examined the use of the SCID among correctional populations using DSM-IV guidelines. Kappas were

moderately high for alcohol disorders (current diagnosis, .80; lifetime diagnosis, .78) and varied considerably for drug use disorders (current diagnosis, .48–1.00; lifetime diagnosis, .04–1.00), although these were generally quite high

- The SCID shows good interrater reliability in people receiving outpatient treatment across mental disorders (Zimmerman & Mattia, 1999a) and for both lifetime and past month alcohol and drug disorders among offenders (Peters et al., 2000)
- The internal consistency of the SCID-II is good, with alphas ranging .71–.94 (Maffei et al., 1997)

Concerns

- The SCID was designed for use by a trained clinician at the masters or doctoral level, although in research settings, it has also been used by bachelors-level technicians with extensive training. Significant training is required for both administration and scoring of the SCID
- Administration of the SCID I and II may each require more than 2 hours for individuals who have multiple diagnoses. The Psychoactive Substance Use Disorders module requires 30–60 minutes, when administered separately
- For people with cognitive impairment or psychotic symptoms, the SCID may need to be administered across several sessions
- Clinical judgment is required to determine whether symptoms are present for a particular disorder
- An eighth-grade reading level is required for the SCID
- The SCID provides a dichotomous decision (yes/no) regarding diagnoses, and it does not provide subthreshold diagnoses or take into account symptoms that may be experienced along a continuum
- The SCID is quite costly to purchase

Availability and Cost

The SCID is available for purchase from American Psychiatric Publishing, Inc., 1400

Street, N.W., Washington, DC 20005, at the following site: <http://www.appi.org/home/search-results?FindMeThis=SCID>

Available materials include SCID user's guides, administration booklets, and score sheets. The Research Version of the SCID can be obtained by contacting Biometrics Research at (212) 960-5524.

The user's guide and administration booklet cost approximately \$80 for either the SCID-I or SCID-II. A packet of SCID score sheets costs approximately \$80.

The SCID-5 products can be purchased at the following site: <https://www.appi.org/products/structured-clinical-interview-for-dsm-5-scid-5>

Recommendations for Assessment and Diagnosis of CODs

Information describing assessment and diagnostic instruments related to co-occurring mental and substance use disorders is based on a critical review of the instruments and research examining their efficacy. Key considerations in recommending instruments are based upon empirical evidence supporting both the reliability and validity of the instrument, relative cost of the instrument, ease of administration, and use within justice settings. Although summaries of instruments are based on DSM-IV criteria, instruments recommendations are those that align more closely with DSM-5, allowing for a more seamless transition from DSM-IV to DSM-5. Recommendations for assessment and diagnosis of co-occurring mental and substance use disorders include instruments that provide comprehensive examination of multiple disorders and related biopsychosocial problems. The following instruments are recommended:

1. The Alcohol Use Disorders and Associated Disabilities Interview (AUDADIS-IV), which provides a comprehensive assessment and examines a range of co-occurring substance use and mental health problems, including

personality disorders and psychosocial risk factors.

(or)

2. The Mini International Neuropsychiatric Interview (MINI) or the Structured Clinical Interview (SCID), which address a full range of co-occurring mental health and substance use disorders and provide a diagnostic impression of multiple disorders.

Each instrument requires between 45-120 minutes to administer, dependent on the symptom presentation and particular problems that are selected for assessment. The measures can be administered in their entirety, or specific modules can be administered that are tailored to the individual's assessment needs and set of symptoms. The different options provided here for assessment and diagnosis of co-occurring disorders may be appealing dependent on the specific needs in a particular justice setting. The MINI and SCID provide diagnosis of the full set of disorders, while the AUDADIS provides a comprehensive assessment of the disorders and a review of related biopsychosocial problems. These instruments should be administered by trained clinicians who are licensed, certified, or otherwise credentialed in assessing and diagnosing CODs and related psychosocial problems.

Suggested Reading

Improving Cultural Competence: Treatment Improvement Protocol Series No. 59

Source: Substance Abuse and Mental Health Services Administration

Availability: <http://store.samhsa.gov/product/TIP-59-Improving-Cultural-Competence/SMA14-4849>

Description: Assists professional care practitioners and administrators in understanding the role of culture in the delivery of substance use and mental health services. Discusses racial, ethnic, and cultural considerations and the core elements of cultural competence. Appendix D briefly reviews a selection of screening and assessment instruments, noting their utility with specific racial and ethnic groups.

Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide

Source: National Institutes of Health

Availability: <http://www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations/principles>

Description: Describes the treatment principles and research findings that have particular relevance to the criminal justice community and to treatment professionals working with substance abusing offenders.

Screening, Assessment, and Treatment Planning for Persons with Co-Occurring Disorders: Overview Paper 2

Source: Substance Abuse and Mental Health Services Administration

Availability: <http://store.samhsa.gov/product/Screening-Assessment-and-Treatment-Planning-for-Persons-With-Co-Occurring-Disorders/PHD1131>

Description: Gives an overview of integrated screening, assessment, and treatment planning for people with co-occurring disorders of substance use and mental illness. Discusses staffing, protocols, methods, systems issues, financing, and client-centered services.

Substance Abuse Treatment for Persons with Co-Occurring Disorders: Treatment Improvement Protocol Series No. 42

Source: Substance Abuse and Mental Health Services Administration

Availability: <http://store.samhsa.gov/product/TIP-42-Substance-Abuse-Treatment-for-Persons-With-Co-Occurring-Disorders/SMA13-3992>

Description: Provides substance use treatment and service practitioners with updated information on co-occurring substance use and mental disorders and advances in treatment for people with co-occurring disorders. Discusses terminology, assessment, and treatment strategies and models.

Trauma-Informed Care in Behavioral Health Services: Treatment Improvement Protocol Series No. 57

Source: Substance Abuse and Mental Health Services Administration

Availability: <http://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816>

Description: Assists behavioral health professionals in understanding the impact and consequences for those who experience trauma. Discusses patient assessment, treatment planning strategies that support recovery, and building a trauma-informed care workforce. Chapter 4 addresses screening and assessment.

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Contributors

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