Substance Abuse Treatment For Adults in the Criminal Justice System

A Treatment Improvement Protocol

TIP 44

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

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What Is a TIP?

Treatment Improvement Protocols (TIPs) are developed by the Center for Substance Abuse Treatment (CSAT), part of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). Each TIP involves the development of topic-specific best-practice guidelines for the prevention and treatment of substance use and mental disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts of various forms of treatment and prevention. TIPs are distributed to facilities and individuals across the country. Published TIPs can be accessed via the Internet at http://store.samhsa.gov.

Although each consensus-based TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that behavioral health is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. If research supports a particular approach, citations are provided.

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Foreword

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities by providing evidence-based and best practice guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses their particular area of expertise until they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

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Executive Summary

For men and women whose struggle with substance abuse brings them into contact with the legal system, the personal losses can be enormous: families can break apart, health deteriorates, freedom is restricted, and far too often, lives are lost. But this is just the beginning of the potential devastation. Personal costs to the victims of crime are immeasurable. The effects of every theft, burglary, and violent crime reverberate throughout the whole community. Economic losses include the costs of arresting, processing, and incarcerating offenders, as well as the costs of police protection, increased insurance rates, and property losses.

Strong empirical evidence over the past few decades consistently has shown that substance abuse treatment reduces crime. For many people in need of alcohol and drug treatment, contact with the criminal justice system is their first opportunity for treatment. A substance use disorder may be recognized and diagnosed for the first time, and legal incentives to enter substance abuse treatment sometimes motivate the individual to begin recovery. For other offenders, arrest and incarceration are part of a recurring cycle of drug abuse and crime. Ingrained patterns of maladaptive coping skills, criminal values and beliefs, and a lack of job skills may require a more intensive treatment approach, particularly among offenders with a prolonged history of substance abuse and crime.

This TIP was developed to provide recommendations and best practice guidelines to counselors and administrators based on the research literature and the experience of seasoned treatment professionals. It covers the full range of criminal justice settings and all the phases through which an individual progresses in the criminal justice system. It addresses both clinical and programmatic areas of treatment. The consensus panel defined the areas highlighted below as important in efforts to achieve the treatment objectives of recovery and a life in the community for everyone.

Screening and Assessment

A vital first step in providing substance abuse treatment to people under criminal justice supervision is to identify offenders in need of treatment. In the criminal justice system, screening often is equated with "eligibility," and assessment often is equated with "suitability." To do this effectively, the consensus panel recommends that protocols be developed to determine which offenders need substance abuse treatment, assess the extent of their treatment needs, and ensure that they receive the treatment they need. Obtaining accurate and reliable information during screening and assessment can be a challenge; offenders do not always accurately report drug or alcohol problems. Other collateral sources of information (e.g., drug test results, correctional records) can be combined with self-report information to make referral decisions. For example, in many correctional facilities, urine tests are used to flag the need for treatment—even when an offender denies recent substance abuse.

Many offenders who abuse substances have co-occurring mental disorders that can make treatment more complex. They should therefore be screened for other psychological or emotional problems. Offenders who are initially assessed as having symptoms of co-occurring disorders should be evaluated over an extended period of time to determine whether these symptoms resolve in the absence of substance use.

A significant number of offenders who abuse substances also have histories of trauma and physical or sexual abuse. Screening and assessment of a history of physical and sexual abuse should be conducted routinely, particularly in settings that include female offenders. Staff training is needed to develop effective interviewing approaches related to the history of abuse, counseling approaches for addressing abuse and trauma issues, and in making referrals to mental health services.

Triage and Placement in Treatment Services

Information obtained in screening and assessment is used to place offenders in the treatment program that is best suited to their needs. More offenders can receive appropriate treatment if a range of substance abuse treatment options is provided in criminal justice settings, particularly in institutions and community settings where offenders are supervised for long periods of time. In addition to key information regarding substance abuse problems, risk for criminal recidivism, and mental health problems, triage and placement decisions also should consider the offender's motivation and readiness for change, the length of sentence or incarceration, history of previous treatment, violence potential, and other related security or management issues. The consensus panel recommends that in general, offenders who have moderate-to-high levels of substance abuse problems and criminal risk should be prioritized for placement in substance abuse treatment services, rather than in other types of institutional programs.

Treatment Planning

After placement, a treatment plan is developed that specifies which services the offender-client needs, at what level of intensity, and which of the available resources (e.g., personal, program-based, or criminal justice) will be most beneficial. The treatment plan takes into consideration the severity of substance abuse-related problems and the presence of co-occurring mental disorders because these influence the treatment approach. Also important are factors such as criminal attitudes and psychopathy, which may suggest persistent criminality unrelated to the need to maintain a drug habit. The degree to which an individual is motivated and ready for change is another critical factor that will determine whether motivational enhancement interventions, sanctions, or more self-directed treatments are appropriate. Finally, personal strengths are taken into

account in planning. The offender should be involved in the treatment planning process.

The most effective treatment programs have the resources necessary for comprehensive assessment and treatment planning activities including adequate staffing, clerical support, and access to computers and management information systems that contain information regarding the offender. Mechanisms for sharing information among agencies will expedite treatment as clients move through the criminal justice system. For example, monitoring, consultation, and written agreements are needed to define the types of information that will be shared, with whom, and under what circumstances. Procedures that ensure the smooth and timely flow of relevant information will enable staff to proceed with treatment without interruption. Effective management information systems allow for access to clinical information as well as other offender data. At the same time, however, confidentiality regulations require that clinical information be maintained separately from the corrections or supervision case files, and access to clinical files be restricted to staff who have primary clinical responsibilities.

Major Treatment Issues and Approaches

Clients under criminal justice supervision share many of the same clinical issues faced by others receiving substance abuse treatment, but some are unique. For example, many offenders have problems with the very issues that brought them to the attention of law enforcement, particularly, criminal thinking and values. These clients often have problems dealing with anger and hostility and have the stigma of being criminals, along with the guilt and shame that accompany this stigma. Their identity as criminals may need to be offset by exposure to more prosocial values and identities such as those of family member and wage earner.

Adapting Offender Treatment for Specific Populations

General clinical strategies for working with offender-clients include interventions to address criminal thinking and to provide basic problemsolving skills; however, substance abuse treatment approaches should be modified to meet specific client needs. Because of their histories or life experiences, certain populations are recognized as having somewhat different treatment needs. For example, people from cultural minorities have had different stresses from those in the majority culture. Women are more likely to have been traumatized by physical and sexual abuse than men and to have urgent concerns about their children. Offenders with co-occurring substance use and mental disorders need help that integrates treatment for both. Other groups with specific needs include older adults, violent offenders, people with disabilities, and sex offenders.

Treatment Issues Specific to Pretrial and Diversion Settings

Treatment varies not only because of the specific population to which an offender belongs but also because of a client's stage in the criminal justice system. After arrest and before trial, a large number of individuals move relatively quickly through the system, and many different agencies are involved with each case and its supervision. If offered, the offender may opt for treatment instead of formal charges, trial, sentencing, incarceration, or to reduce the length of incarceration.

Variations in local prosecution and diversion practices may affect a jurisdiction's ability to develop criminal justice and treatment linkages. Not all jurisdictions have established procedures or programs for individuals who abuse substances; those jurisdictions that do have programs to treat offenders often maintain

such programs with limited resources. However, the pressure of overcrowded jails and prisons is serving to expand and institutionalize programs for drug treatment in pretrial and diversion settings nationwide. Still, outside of formal drug court and diversion programs, treatment access is limited. Types of treatment used in the pretrial setting are necessarily brief and include brief motivational interventions, behavior contracts, and referrals to detoxification and other services. A variety of sanctions also are available.

In the pretrial setting, the question of an individual's guilt or innocence has not been legally determined. It is vitally important, therefore, to note that treatment should not compromise the due process rights of defendants. Treatment professionals need to bear in mind the presumption of innocence that exists during the pretrial period. Defendants' due process rights affect what they are willing to agree to and the type of information that they are willing to disclose. Defendants should not be coerced into waiving due process rights, although a court may order substance abuse treatment as a condition of pretrial release.

Treatment Issues Specific to Jails

Those incarcerated in jails are undergoing significant stress related to arrest, the uncertainties of their legal situation, and the potential loss of their job or custody of their children. Appropriate treatment services for these individuals are based on the expected duration of incarceration and the information obtained from screening for a variety of possible problems. Brief treatment (less than 30 days) usually focuses on supplying information and making referrals but can include motivational interviewing. Short-term programs (1–3 months) have the time to work on communication, problemsolving, and relapse prevention skills; introduce anger management techniques; and encourage participation in self-help groups. Longer term programs (3 months–1 year) can provide additional skills training, vocational and educational activities, and examine criminal thinking errors. The consensus panel recommends that jail staff implement discharge planning that includes gathering information regarding the need for a range of community services, including housing and health care.

Treatment Issues Specific to Prisons

The unique characteristics of prisons have important implications for developing and implementing treatment programs. In-prison drug abuse treatment, particularly when followed by community-based continuing care treatment, has been credited with reducing short-term recidivism and relapse rates among offenders who are involved with drugs. More recently, the sustained effects on longer term outcomes have been documented by studies indicating that 9–12 months of prison treatment followed by at least 3 months of community treatment are needed to produce significant improvement and reductions in recidivism and relapse. Because of the comparative stability of the prison population, several treatment options of differing intensities can be made available. The full range of services can be offered, including comprehensive assessment; treatment planning; placement; group, individual, family, and specialty group counseling; self-help groups; educational and vocational training; and planning for transition to the community. Therapeutic communities (TCs) are among the most successful in-prison treatment programs. They are highly structured, hierarchical, and intense interventions lasting a minimum of 6 months. TC participants live together, often separate from the general prison population, and take responsibility for their recovery process. Participants work at increasingly more responsible positions as they learn self-sufficiency and become competent.

Treatment for Offenders Under Community Supervision

Parolees and probationers are both under community supervision; nonetheless, they generally represent different ends of the criminal justice continuum. Whereas parolees are serving a term of conditional supervised release following a prison term, probationers are under community supervision instead of a jail or prison term. Both parolees and probationers generally can be controlled and managed effectively by a combination of treatment and surveillance while under community supervision at a far lower cost than incarceration in jail or prison. The level of supervision varies according to individual circumstances, including the terms under which probation or parole was granted. Offenders under community supervision in urban areas who have substance use disorders have available several levels treatment and supervision, including residential, outpatient, halfway, and day reporting centers. Parolees may have difficulty meeting their basic needs when they are released and benefit from case management services to help with housing and employment. Reunification with family members and social support may also prove problematic.

Relapse prevention is extremely important for those under community supervision. Relapse, which is not unusual, can be met by increased supervision and an intensification of the level of treatment. Likewise, the intensity of supervision and treatment should decrease as the individual meets treatment goals. For both parolees and probationers, reassessment should be periodically conducted throughout the phase of community supervision. Following their contact with the criminal justice system, both parolees and probationers benefit from continuing contact with the substance abuse treatment system as a means of reducing relapse and recidivism.

Key Issues Related to Program Development

Offender-clients will best be served by substance abuse treatment and criminal justice systems that are working together to help them in recovery and in becoming law-abiding citizens. This requires leaders in both systems who promote their mutual goals, endorsement for mutual goals from leaders, clarification of the goals, and recruitment of stakeholders in pursuit of the goals. The challenge for substance abuse treatment practitioners and criminal justice professionals is to work together to provide a coordinated response to ensure that offenders' needs are addressed while protecting public safety.

1 Introduction

In This Chapter…

The Purpose of This TIP

Key Definitions

Audience for This TIP

Contents of This TIP

When the prison gates slam behind an inmate, he does not lose his human quality; his mind does not become closed to ideas; his intellect does not cease to feed on a free and open interchange of opinions; his yearning for self-respect does not end; nor is his quest for self-realization concluded. If anything, the needs for identity and self-respect are more compelling in the dehumanizing prison environment.

—Thurgood Marshall (Procunier v. Martinez, 416 U.S. 396 [1974])

Overview

Research consistently demonstrates a strong connection between criminal activity and substance abuse (Chaiken 1986; Inciardi 1979; Johnson et al. 1985). Eighty-four percent of State prison inmates who expected to be released in 1999 were involved with alcohol or illicit drugs at the time of their offense; 45 percent reported that they were under the influence when they committed their crime; and 21 percent indicated that they committed their offense for money to buy drugs (Office of National Drug Control Policy [ONDCP] 2003). Data from the Arrestee Drug Abuse Monitoring program indicate that in 2000, 64 percent of male arrestees tested positive for at least one of five illicit drugs (cocaine, opioids, marijuana, methamphetamines, and PCP). Additionally, 57 percent reported binge drinking in the 30 days prior to arrest, and 36 percent reported heavy drinking (Taylor et al. 2001).

The consequences of crime related to substance abuse are substantial. The Bureau of Justice Statistics reports that in 1999 alone, 12,658 homicides—4.5 percent of all homicides for that year—were drug related (Dorsey et al. 1999). The emotional costs to people with substance use disorders, their families, and the victims of their crimes are immeasurable. The ONDCP estimates that the total crime-related costs of drug abuse were more than $100 billion in 2000 (ONDCP 2001).

The devastating emotional and financial costs of drug-related crimes have led to a number of strategies to break the link between drugs and

crime, including stricter drug laws, “three strikes and you’re out” legislation, increased surveillance, mandatory sentencing laws, and severe penalties for drunk drivers, to name just a few. These approaches have had mixed results, and opinions vary on their usefulness.

One consistent research finding is that involvement in substance abuse treatment reduces recidivism (a tendency to return to criminal habits) for offenders who use drugs (Anglin and Hser 1990; Harwood et al. 1988; Hubbard et al. 1984, 1989; Knight et al. 1999*a*; Martin et al. 1999; McLellan et al. 1983; Wexler et al. 1988, 1999*a*; Wisdom 1999). For example, when researchers conducted followup studies of clients treated through comprehensive treatment demonstration programs funded by the Center for Substance Abuse Treatment (CSAT), they found substantial reductions in criminal activity, including a 64-percent decrease in arrests (Wisdom 1999). In part because of the reduced criminal activity associated with substance abuse treatment for offenders, treatment has also been found to be cost-effective. According to the California Drug and Alcohol Treatment Assessment study (Gerstein et al. 1994), for example, every dollar invested in treatment saved approximately $7 in future costs.

In response to research demonstrating the success of treatment in reducing criminal activity as well as the cost benefits of such treatment, policymakers over the past two decades have implemented a wide variety of strategies at the Federal, State, and local levels. These initiatives are aimed at improving the availability and quality of treatment for offenders. Drug Courts—courts with special unified dockets for individuals charged with crimes who are drug or alcohol involved—serve to divert offenders with substance use disorders away from the criminal justice system into a supervised treatment plan or to incorporate a coerced treatment plan as part of a judicial sentence. Other programs have been established for people with special needs, including individuals with co-occurring mental disorders. At the same time, other initiatives have increased funding for people already in prisons and jails. Examples of such initiatives include

- Project REFORM and later Project RECOVERY. These programs, funded in the late 1980s by the Bureau of Justice Assistance (BJA) and in the early 1990s by CSAT, provided technical assistance to 20 States in planning and developing substance abuse programming for prisoners with substance abuse problems (Wexler 1995).
- Residential Substance Abuse Treatment for State Prisoners Formula Grant Program. This program funds States seeking to develop comprehensive approaches to treatment for offenders who abuse substances, including intensive programs for inmates and relapse prevention training. Further information is available at http://www.cfda.gov.
- The National Drug Control Strategy, prepared annually by the Office of National Drug Control Policy (1997, 1998, 1999, 2000, 2001). This program has encouraged the development of treatment and rehabilitation services for offenders who use drugs (e.g., Treatment Accountability for Safer Communities, formerly Treatment Alternatives to Street Crime; drug court programs; prison treatment programs). For further information, go to http://www.whitehouse.gov/ondcp.
- The BJA, Office of Justice Programs, U.S. Department of Justice. Formerly known as the Drug Courts Program Office, established to administer the drug court grant program, the BJA provides financial and technical assistance, training, and programmatic guidance for drug courts throughout the country. BJA offers grants that enable communities to develop, implement, or improve drug courts. Information is available at http://www.bja.gov
- The Serious and Violent Offender Reentry Initiative. In conjunction with several Federal partners, the U.S. Department of Justice is spearheading this initiative to

provide funding to promote successful reintegration of serious, high-risk offenders into the community. The Initiative seeks to address all obstacles to successful reentry, including substance abuse. Information is available online at http://www.crimesolutions.gov/ProgramDetails.aspx?ID=167.

In part because of initiatives such as these, the availability of substance abuse treatment for criminal offenders is on the rise. After 3 years of decline in the mid-1990s, the number of inmates in drug treatment programs began rising again in 1997 and 1998 (Corrections Yearbook 1998). A report based on a 1997 nationwide survey of Federal and State correctional facilities (Office of Applied Studies 2000) indicates that 93.8 percent of Federal prisons and 56.3 percent of State prisons provide some form of substance abuse treatment.

Although an increasing number of prisons offer some form of treatment, the actual number of programs and slots remains limited (National Center on Addiction and Substance Abuse at Columbia University 1998; Peters and Matthews 2002). For example, although more than half of prison inmates have a lifetime prevalence of drug use disorders (Peters et al. 1998), fewer than 15 percent of inmates receive substance abuse treatment services while in prison (Mumola 1999; Simpson et al. 1999*b*). Moreover, while the number of substance abuse programs for offenders is on the rise, so too is the number of offenders in need of services. Substance abuse treatment services for offenders have not kept pace with the growing need for these services (Belenko and Peugh 1998; Simpson et al. 1999*b*).

This TIP highlights some of the best practices and innovative programs created to treat offenders. It describes the unique needs of offenders with substance abuse and dependence disorders. Finally, it addresses the challenges counselors and criminal justice personnel are likely to face at every stage of the criminal justice continuum.

The Purpose of This TIP

This TIP updates and combines three TIPs originally published in 1994 and 1995: TIP 7, *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System* (CSAT 1994*d*); TIP 12, *Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System* (CSAT 1994*a*); and TIP 17, *Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System* (CSAT 1995*b*).

> One consistent research finding is that involvement in substance abuse treatment reduces recidivism for offenders who use drugs.

The new TIP presents clinical guidelines to assist counselors in dealing with problems that routinely arise because of their clients' status in the criminal justice system. These clients have multiple needs; they often have poor health, have histories of trauma, lack job and communication skills, and have educational deficits. A special feature throughout the TIP—"Advice to the Counselor"—provides the TIP's most direct and accessible guidance for the counselor. Readers with basic backgrounds, such as addiction counselors or other practitioners, can study these boxes first for the most immediate practical guidance. In particular, the Advice to the Counselor boxes provide a distillation of what the counselor needs to know and what steps to take, which can be followed by a more detailed reading of the relevant material in the section or chapter.

The events of September 11, 2001, dramatically altered the political climate of our Nation and caused a shift in focus from the "tough on drugs" policies previously in place

to the war on terrorism. These changes have impacted both the sanctions against people in the criminal justice system and the availability of substance abuse treatment for those populations. While it is beyond the scope of this TIP to address the implications of these shifts or to predict their ultimate outcomes, the core content of this document reflects the current best practices for providing substance abuse treatment for adults in the criminal justice system.

This TIP aims to provide tools and resources to increase the availability and improve the quality of substance abuse treatment to criminal justice clients. It should assist the criminal justice system in meeting the challenges of working with offenders with substance use disorders and encourage the implementation of evidence-based clinical approaches to treatment.

Other guiding principles of this publication are to

- Provide the relevant information that will inform and enable treatment providers to feel more confident in their approach to offender and ex-offender populations.
- Help people in community treatment understand the criminal justice system and how it works in step with their treatment services.
- Encourage collaboration between the criminal justice and treatment communities.
- Help readers understand the multiple perspectives that often lead to confusion and misunderstandings—public safety versus public health, treatment versus corrections, differing client needs, issues of culture and society, and local characteristics of the criminal justice system.
- Provide practical solutions and approaches to complex problems.

Key Definitions

In this TIP, the term "substance abuse" is used to denote both *substance abuse* and *substance dependence* as they are defined by the *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition, Text Revision (DSM-IV-TR) (American Psychiatric Association 2000). This term was chosen partly because substance abuse treatment professionals commonly use the term "substance abuse" to describe any excessive use of addictive substances. Readers should attend to the context in which the term occurs to determine the possible range of meanings it covers; in most cases, however, the term will refer to all varieties of substance use disorders described by DSM-IV-TR.

According to DSM-IV-TR, *substance abuse* is a maladaptive pattern of substance use marked by recurrent and significant negative consequences related to the repeated use of substances. *Substance dependence* is defined as a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual is continuing use of the substance despite significant substance-related problems. A person experiencing substance dependence shows "a pattern of repeated self-administration that usually results in tolerance, withdrawal, and compulsive drug-taking behavior" (p. 192). A diagnosis of substance dependence can be applied to every class of substances except caffeine.

Treatment is defined according to the Institute of Medicine (IOM 1990), as cited in CSAT's National Treatment Plan Initiative (CSAT 2000*a*, *b*):

> Treatment refers to the broad range of [primary and supportive] services—including identification, brief intervention, assessment, diagnosis, counseling, medical services, psychiatric services, psychological services, social services, and followup—provided for people with alcohol [and/or drug] problems. The overall goal of treatment is to reduce or eliminate the use of alcohol [and/or drugs] as a contributing factor to physical, psychological, and social dysfunction and to arrest,

retard, or reverse the progress of any associated problems (CSAT 2000*a*, p. 7).

The *criminal justice system,* as discussed in this TIP, includes four subsystems: pretrial and diversion settings, jails and detention centers, prisons (State and Federal), and community supervision settings. Definitions of other terms relevant to criminal justice and substance abuse treatment are given in appendix B, Glossary.

For the purposes of this TIP, an *offender* is a person who has been arrested, charged with a crime, or convicted of a crime and under the supervision of the criminal justice system.

Audience for This TIP

This TIP is written primarily for substance abuse counselors and clinicians who treat clients involved in the criminal justice system or who are under full or partial supervision and for administrators whose programs serve clients under criminal justice supervision. It also will be useful for counselors who work in correctional institutions and those in community agencies with clients on probation, parole, or pretrial release.

Others who work in the criminal justice system may also find this TIP helpful. This includes judges and prosecutors; probation and parole officers, case managers, public defenders and other criminal defense attorneys; jail, detention center, and prison personnel; and people working in pretrial/diversion and in probation and parole settings.

Program developers and grant writers will find that this TIP provides information about a variety of programs and resources. Finally, this TIP is of value to anyone concerned with reducing overcrowding in correctional facilities, addressing the crimes committed by untreated drug-involved offenders, and meeting the challenges that these offenders face on their journey toward recovery.

Contents of This TIP

The chapters that follow will focus on the following areas:

- Chapter 2 focuses on screening and assessment of criminal justice clients in the relevant domains. It includes a discussion of special concerns (e.g., gender and sexual orientation, literacy, a client's primary language, and learning disabilities) and specific populations. See also appendix C, which contains more information on screening and assessment instruments.
- Although it is recognized that treatment can be effective, it is also clear that different treatment approaches may work better with some clients than with others. Chapter 3 discusses triage and placement in treatment services and reviews the complex area of treatment matching.
- Chapter 4 discusses the available treatment options in the criminal justice system. It also presents guidelines for developing treatment plans.
- Chapter 5 addresses the major treatment issues for offenders who use substances. These include a wide range of themes, including engagement and retention, stigma and shame, the client–counselor relationship, and major treatment levels (e.g., residential, nonresidential, outpatient, community supervised, and self-help and other ancillary services).

> This TIP aims to provide tools and resources to increase the availability and improve the quality of substance abuse treatment to criminal justice clients.

- Chapter 6 describes treatment issues and approaches for special populations for whom modifications in treatment may be appropriate: people of ethnic and racial minorities, women, violent offenders, people with disabilities, older inmates, people with co-occurring substance use and mental disorders, and sex offenders, among others.
- Chapters 7 through 10 describe the specific treatment needs and strategies for individuals in particular criminal justice settings. Chapter 7 addresses treatment provided in diversion and other pretrial settings. Chapter 8 provides a detailed discussion of treatment for offenders in jails and detention centers, while chapter 9 focuses on offenders in prison. Chapter 10 outlines treatment for people under community supervision.
- Finally, chapter 11 discusses the issues related to program development.

2 Screening and Assessment

In This Chapter...

Definitions of Terms

Screening Guidelines

Assessment Guidelines

Key Issues Related to Screening and Assessment

Areas To Address in Screening and Assessment

Selection and Implementation of Instruments

Screening and Assessment Considerations for Specific Populations

Integrated Screening and Assessment—Sample Approaches

Conclusions and Recommendations

Overview

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

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

This chapter addresses the issues relevant to screening and assessment and makes recommendations for the appropriate use of screening and assessment tools in specific settings. For information on how to use screening and assessment to match the offender to services and to identify an appropriate treatment plan, see chapters 3 and 4. For more information on specific screening and assessment instruments see appendix C.

Definitions of Terms

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

- *Screening*—A process for evaluating someone for the possible presence of a particular problem. The screening process does not necessarily identify what kind of problem the person might have or how serious it might be but determines whether or not further assessment is warranted. Screening does not typically include assignment of DSM-

IV-TR (*Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision [American Psychiatric Association {APA} 2000]) diagnoses of alcohol or drug abuse or dependence and may only identify DSM-related problem areas. During the screening process staff members use instruments that are limited in focus, simple in format, quick to administer, and usually able to be administered by nonprofessional staff. There are seldom any legal or professional restraints on who can be trained to conduct a screening.

- *Assessment*—A process for defining the nature of a problem and developing specific treatment recommendations for addressing the problem. A basic *assessment* consists of gathering key information and engaging in a process with the client that enables the counselor to understand the client's readiness for change, problem areas, any diagnosis(es), disabilities, and strengths. The assessment process typically requires trained professionals to administer and interpret results, based on their experience and training. A clinical diagnosis has important legal ramifications since judges tend to rely on assessments to identify an offender's needs and risks, and to determine the offender's disposition.

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

- *Eligibility*—Does the offender meet the system's criteria for receiving treatment services? A quick screen, typically applicable in prisons and community corrections settings, can determine whether a person warrants assessment to determine if that person has a drug or alcohol problem.
- *Suitability*—Is the offender suitable for the type of program services that are available? An assessment can determine whether the offender is capable of benefiting from treatment or responding to a particular intervention. The question of suitability arises once it has been determined that offenders meet the eligibility criteria for receiving services.

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

Common Myths About Screening and Assessment

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

- *Myth:* Screening and assessment are no better than intuition in detecting a person's need for treatment.
- *Fact:* Objective screening and assessment measures can result in treatment that is better targeted to a client's needs, resulting in better outcomes.
- *Myth:* Only a single screening is needed to place people in different levels of treatment services.
- *Fact:* Accurate evaluation requires a battery of assessment instruments that examine how substance use has affected all the domains of the client's life. When treatment options are severely limited, however, a basic screening may be sufficient to determine both eligibility and suitability for treatment.

- *Myth:* Untrained professionals can conduct screening and assessments.
- *Fact:* Although some screenings can be administered and scored without significant training, placement decisions are greatly improved when they are made by professionally trained staff. This includes staff with relevant certification in substance abuse treatment, those with advanced professional degrees, and those with specialized training in the use of particular screening and assessment instruments. For those screening and assessment approaches that require an interview with the offender, specialized training is also needed in basic counseling techniques such as rapport building and reflective listening. Use of trained professional staff in the triage and placement process helps to minimize the number of inappropriate referrals for treatment.
- *Myth:* Screening and assessment are always compromised because you cannot trust self-report information from offenders.
- *Fact:* Research generally validates the reliability, and to some degree, the validity of information obtained through self-reports. Collateral sources such as the offender's family and friends can improve the reliability of the information gathered (or "the full picture"). Offenders do supply a certain amount of misinformation in some settings to avoid unwanted consequences, however.
- *Myth:* All screening and assessment instruments are equally effective.
- *Fact:* Research shows significant variability in the reliability and validity of different instruments with different populations.
- *Myth:* Because an instrument is widely used, it must be effective.
- *Fact:* Many highly marketed and widely used instruments do not have a research base supporting the validity of their use. In fact, some of the widely marketed and used instruments have been shown to be less effective than those available in the public domain.
- *Myth:* Screening and assessment should not examine the history of physical and sexual abuse and related trauma because this may aggravate the offender's level of stress and psychological instability, and staff may not be able to deal effectively with the consequences.
- *Fact:* Screening and assessment of all forms of abuse is essential for both male and female offenders, because it is now recognized that the effects of trauma contribute to many mental disorders. Clinical outcomes are likely to be compromised if these abuse and trauma issues are not explored, and if strategies addressing these issues are not developed and integrated into treatment plans for mental and substance use disorders. However, it is important to emphasize that in screening for a history of trauma it can be damaging to ask the client to describe traumatic events in detail. To screen, it is important to limit questioning to very brief and general questions, such as "Have you ever experienced childhood physical abuse? Sexual abuse? A serious accident? Violence or the threat of it? Have there been experiences in your life that were so traumatic they left you unable to cope with day-to-day life?"

Screening and Assessment" (Peters and Peyton 1998).

Screening Guidelines

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

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

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

Purpose of Screening

The first issue to consider is the purpose of the screening. In addition to screening for drug use, counselors may consider screening for other problem areas. For example, given that many infectious diseases are associated with the use of drugs (Varghese and Fields 1999), health screening can be important in identifying offenders in need of healthcare services to ensure that clients receive needed medication and to prevent the spread of disease. Screening to identify special needs for offenders with co-occurring mental problems can improve the effectiveness of treatment. It can identify individuals who may pose a threat to themselves or others, prevent crises, and promote immediate intervention. Screening content should identify key issues that need to be addressed in placing offenders in treatment. Content can be specific to several domains, including substance use, criminal, physical health, mental health, and special considerations. Figure 2-1 summarizes the information relevant to each domain.

Screening guidelines will vary by setting. A professional screening of an individual who has just been arrested will include different questions and require different information than a long-term prisoner being considered for parole. For a probationer, screening might be used to determine the appropriate level of supervision; a jail inmate may be screened to assess his or her suitability for treatment. Figure 2-2 (see p. 12) highlights the different screening considerations for each setting.

Selection of Screening Tools

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

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

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

Assessment Guidelines

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

Figure 2-1
Screening Guidelines by Domain

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

Figure 2-2
Screening Guidelines by Setting

Setting	Purpose	Special Considerations
Jails	• For early identification, if getting out of jail early • To determine eligibility for drug courts and pretrial diversion programs • For diversion to specialized mental health courts or programs focused on behavioral problems • To determine behavioral management problems and acute needs (including crisis intervention) • To identify suitability for placement in jail treatment programs • For classification to different housing units	Look for previous correctional substance abuse treatment, readiness for treatment, past institutional behavior problems, prior correctional treatment, and court orders.
Prisons	• To match time left to serve with time for receiving treatment or for custody level classification • To identify suitability for placement in prison treatment programs	Look at prison record, treatment history (including treatment for issues other than substance abuse), and behavior.
Pretrial and Community Supervision	• To determine the need for housing, transportation, employment, or economic benefits • To identify suitability for placement in community treatment programs • To assess for public safety risk and level of supervision needed, pursuant to consideration for placement in diversion programs	Look for community or corrections records or collateral information (e.g., information from family members).

in services that can affect relapse and criminal recidivism.

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

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

The instruments and sources of information used during an assessment are determined by the purpose of the assessment. Jurisdictions may elect the quickest and most efficient approach to assess who goes into treatment. In other cases, the court may want the greatest amount of information available about an

offender. In this case, in addition to police, corrections, and medical records, an assessment should include family and other collateral sources for historical information.

The following guidelines pertain to assessment protocols:

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

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

Key Issues Related to Screening and Assessment

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

Accuracy of Information

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

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

Unless potential concerns related to the screening and assessment process are addressed directly, it is unlikely that screening and assessment results will provide an

Advice to the Counselor: Screening and Assessment

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

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

Continuity of Information

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

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

Systemwide Information Sharing

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

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

At each stage of the criminal justice process there can be individuals or agencies that do not support sharing of substance abuse

screening and assessment information. These groups have legitimate concerns that need to be expressed, and they need to be brought into the decisionmaking process as full stakeholders. Jurisdictions that establish interagency agreements can preserve limited staff time and resources and help avoid unexpected resistance to systemwide sharing of screening and assessment information at any stage in the criminal justice process. See the text box below for examples of programs that have developed multilevel agreements for sharing information systemwide.

Examples of Multilevel Agreements for Systemwide Sharing of Information

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

Lane County, Oregon

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

High Intensity Drug Trafficking Areas Automated Tracking System

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

Maricopa County, Arizona

Maricopa County has a data-link feed between the jail and behavioral health authority to determine whether offenders entering jail have a previous record of mental health services or substance abuse treatment (National GAINS Center 1999c). (See also chapter 8.)

Examples of Multilevel Agreements for Systemwide Sharing of Information (continued)

Orange County Probation Department

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

The Need To Rescreen and Reassess

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

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

Advice to the Counselor: The Need To Rescreen

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

Timing of Screening and Assessment

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

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

When Is a Formal Diagnosis Necessary?

When identified with a diagnosis that will follow them throughout the system or even their lifetime (if entered into the criminal justice system's computer), people sometimes feel labeled and stigmatized. This is particularly true of diagnoses related to mental disorders. Because symptoms of mental disorders are often mimicked by recent drug or alcohol use, or withdrawal from these substances, it is particularly important to defer diagnosis until an adequate assessment period is provided under conditions of abstinence. A "people first" description such as "offender who uses drugs" is preferable to the label "drug user." Moreover, diagnostic classification can sometimes preclude offenders from receiving needed services. For example, a mental disorder diagnosis can preclude access to substance abuse services. Likewise, a substance abuse diagnosis can preclude access to mental health services, resulting in no services being rendered. A substance abuse diagnosis can also limit an offender's access to certain work assignments or vocational training.

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

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

Drug Testing

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

Because of advancements in drug testing technologies, drug testing can easily be incorporated into the pretrial risk assessment process. For instance, using hand-held devices, commercial laboratories can conduct analyses of urine, perspiration, and hair to identify the presence of a variety of drugs. Pretrial screening for five drugs can cost anywhere from $5 to $120 (Henry and Clark 1999). However, protocols for collecting, testing, and disposing of specimens must be carefully observed to preserve the chain of evidence in the pretrial setting. Counselors should ensure that the rights of detainees and offenders are not violated (see chapter 7).

Areas To Address in Screening and Assessment

This section describes the key areas that the consensus panel felt were important for effective screening and assessment.

Substance Abuse History

Key areas addressed during substance abuse screening and assessment are reviewed in several published TIPs, including numbers 7, *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System* (CSAT 1994*d*); 11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* (CSAT 1994*e*); 31, *Screening and Assessing Adolescents for Substance Use Disorders* (CSAT 1999*c*); and 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*c*). Major topics covered during screening and assessment include observable signs and symptoms of alcohol or drug use, signs of acute drug or alcohol intoxication and withdrawal effects, drug tolerance effects, negative consequences associated with substance abuse, the self-reported history of substance abuse, age and pattern of first substance abuse, recent patterns of use, drug(s) of choice, and motivation for using substances. A full examination is made of the prior involvement in treatment, both in criminal justice and non–criminal-justice settings. Family history of substance abuse is also important, including current patterns of abuse by family members who have contact with the offender.

Screening instruments

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

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

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

Figure 2-3
Recommended Substance Abuse Screening Instruments

Instrument	Purpose	Description
Alcohol Dependence Scale (ADS)	A 25-item instrument developed to screen for alcohol dependence symptoms; performs adequately in community and institutional settings	The ADS (Skinner and Horn 1984) can be coupled with the ASI-Drug Use section to provide an effective screen for alcohol and drug use problems among offenders. For more information on the ADS, contact the Center for Addiction and Mental Health (formerly the Addiction Research Foundation) at (800) 661-1111. The ASI is reprinted in TIP 7, *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System* (CSAT 1994*e*).
Simple Screening Instrument for Substance Abuse (SSI-SA)	A 16-item screening instrument that examines symptoms of both alcohol and drug dependence	An expert panel developed the SSI-SA as a tool for outreach workers. The SSI-SA, which can be administered without training, includes items related to alcohol and drug use, preoccupation and loss of control, adverse consequences of use, problem recognition, and tolerance and withdrawal effects. The SSI-SA is fully described in TIP 11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* (CSAT 1994*f*) and is reproduced along with instructions in TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*c*).
TCU Drug Screen (TCUDS)	A 15-item substance abuse diagnostic screen	The TCU Drug Screen is completed by the offender and serves to quickly identify individuals who report heavy drug use or dependency (based on the DSM-IV-TR and the National Institute of Mental Health Diagnostic Interview Schedule) and who therefore might be eligible for treatment. For more information regarding the TCUDS and other related instruments go to http://www.ibr.tcu.edu.

Source: Peters et al. 2000.

recommendations for brief screening instruments based on this research (refer also to appendix C for the administration time and uses of specific instruments).

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

In conducting screening and assessment with female offenders, counselors may want to

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

Assessment instruments

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

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

Detoxification Needs

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

Safe withdrawal from substances such as stimulants, cocaine, hallucinogens, and inhalants can be achieved with psychological support, symptomatic treatment, and periodic reassessments by healthcare providers. Frequent clinical assessments, along with appropriate treatment adjustments, are also important since the intensity of withdrawal cannot always be predicted accurately (Federal Bureau of Prisons 2000). Some substances, such as alcohol, sedative-hypnotics,

and anxiolytics, can produce dangerous withdrawal syndromes once physiological dependence has developed. Offenders who have severe and life-threatening symptoms of intoxication or withdrawal should be placed immediately under medical supervision. The Federal Bureau of Prisons (2000) recommends that "inmates presenting with alcohol intoxication should be presumed to have alcohol dependence until proven otherwise" (p. 8).

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

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

Physical Health Conditions

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

Readiness for Treatment

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

Readiness for treatment is not always clearly defined or apparent at the onset of treatment. Most clients do not volunteer for treatment and experience significant ambivalence about the process and level of commitment required. For years, treatment professionals and paraprofessionals believed that a person needed to "hit bottom" to be ready for change. Today, it is recognized that people can be ready for treatment without "hitting bottom" and that many people can receive benefits from treatment even if they are not completely ready. For example, motivational interviewing (MI) techniques (discussed in detail in TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT 1999*b*]) can be used to help clients resolve their ambivalence toward treatment and toward making changes in their lives. MI provides an empathic, supportive, and directive counseling style that attempts to persuade

Advice to the Counselor: Screening for Detoxification

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

and guide the client toward change rather than to create motivation through confrontation of the client's substance abuse problems and labeling the client as an "addict."

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

An individual's readiness for change is one of the most important factors that substance abuse counselors and clinicians should examine during the screening and assessment process, and has been found to be predictive of treatment retention and other outcomes. Studies have shown that initial motivation for treatment influences enrollment in post-release treatment services (DeLeon et al. 2000; Simpson and Joe 1993). Several treatment interventions (e.g., MI, motivational enhancement therapy) (Miller and Rollnick 2002) have been developed to explore and enhance readiness for treatment. Many substance abuse programs in the criminal justice system include a "pre-treatment," or "readiness" phase designed to address the needs of offenders not yet committed to recovery goals and ongoing involvement in treatment. This initial phase of treatment addresses offenders' goals, expectations, and motivation for change. This intervention helps identify offenders who are ready for more intensive treatment services that require full participation in activities designed to encourage changes in attitudes and behaviors.

Assessing readiness includes obtaining information about clients' awareness of a substance problem, their ability to acknowledge their need for help, their willingness to accept help, their perception of how others feel about their need for help, and whether they have taken steps to change on their own (Wanberg and Milkman 1998). Generally, clients can be considered "ready" for treatment if they want to abstain from substance abuse, see treatment as a means to become drug- or alcohol-free, and recognize the difficulty in abstaining from substance abuse without professional assistance (CSAT 1994*a*). Figure 2-4 describes several brief instruments that can be used to assess readiness for treatment. For more detailed information on this topic, see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*b*). See also chapter 3 for a discussion of the stages of change model.

Co-Occurring Disorders

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

Figure 2-4
Instruments for Evaluating Readiness for Treatment

Instrument	Description
The University of Rhode Island Change Assessment Scale (URICA)	URICA was developed to assess stage of change. The instrument is known to be valid with different populations in a variety of settings. El-Bassel and colleagues have determined that URICA is useful, reliable, and valid among incarcerated women who use drugs (el-Bassel et al. 1998). The URICA and other similar instruments are reprinted in TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*b*).
The TCU Treatment Motivation Scales	The TCU Treatment Motivation Scales can be used to track the stages of change in treatment motivation. For further information, go to http://www.ibr.tcu.edu.
The Circumstances, Motivation, Readiness, and Suitability Scales (CMRS)	The CMRS scales were designed to predict retention based on dynamic client factors related to seeking and remaining in treatment (DeLeon et al. 1994). The Circumstances scale is defined as the external pressure to engage and remain in treatment. The Motivation scale is defined as the internal pressure to change; the Readiness scale is defined as the perceived need for treatment; and the Suitability scale is defined as the individual's perception of the treatment modality or setting as appropriate for himself. A prison version has been developed. A revised version of the CMRS, the CMR, is also available. The CMR is copyrighted and can be obtained by contacting the National Development and Research Institute, Inc., 71 W. 23rd Street, 8th Floor, New York, New York 10010, or mail@ndri.org.
Stages of Change, Readiness, and Treatment Eagerness Scale (SOCRATES)	SOCRATES includes items specifically focused on alcohol abuse and can be used as a starting point for discussion. A Spanish translation is available. The SOCRATES and other similar instruments are reprinted in TIP 35, E*nhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*b*).

co-occurring disorders, accurate screening and assessment are of particular importance.

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

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

Steps for Assessing the Interactive Effects of Co-Occurring Disorders

1. Assess the significance of the substance use disorder. Obtain a chronological history describing the onset of mental disorder and substance abuse symptoms.
   - Determine whether mental disorder symptoms occur only in the context of substance abuse.
   - Determine whether ongoing abstinence leads to rapid and full resolution of mental disorder symptoms.
2. Determine the duration of the current period of abstinence.
   - If there has not been a 4–6 week period of abstinence, repeat assessment and diagnosis after such a period, depending on clinical judgment about the particular drug abuse history and the offender's physical status.
3. Reassess mental disorder symptoms at the end of 4–6 weeks of abstinence or at any time such symptoms appear or change.
4. If mental disorder symptoms are fully resolved, consider referral for traditional substance abuse treatment; if not, consider referral for mental health or specialized co-occurring disorders services.
5. Provide ongoing reevaluation of the offender's mental disorder symptoms and progress in treatment.

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

No single instrument can adequately screen for all mental and substance use disorders, particularly given the constraints of length, cost, and required training—but a combination of instruments can be used (Peters and Hills 1999). The choice of substance abuse screening instruments should be based on the purpose of the screening, ethnic or racial characteristics, language spoken, and gender (Broner et al. 2002). Figure 2-5 provides a list and description of instruments used to screen and assess for mental disorders.

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

Figure 2-5
Instruments for Screening and Assessing Mental Disorders

Instrument	Description
Beck Depression Inventory II (BDI-II) (Beck et al. 1996)	• A 21-item self-report of symptoms that screens for symptoms of depression. • Requires no significant training to administer. • Found to be the most effective instrument in detecting depression among individuals who abuse alcohol (Weiss and Mirin 1989). • Should not be used as a sole indicator of depression but in conjunction with other instruments (Weiss and Mirin 1989; Willenbring 1986).
Brief Symptom Inventory (BSI) (Derogatis 1975*a*)	• A short form of the Symptom Checklist 90 - Revised (SCL-90-R). • Comprising 53 items, including three global indices of psychopathology (General Severity Index, Positive Symptom Total, Positive Symptom Distress Index) and nine primary psychiatric symptom dimensions. • Quick to administer and requires no significant training to administer. • Only a 6th grade reading level is required. • May be most useful as a general indicator of psychopathology (Boulet and Boss 1991).
General Behavior Inventory (GBI) (Depue and Klein 1988)	• A 73-item self-report instrument that examines mood disorders. • Requires no significant training to administer. • Differentiates between unipolar and bipolar depression.
Hamilton Depression Scale (HAM-D) (Hamilton 1960)	• A 17-item scale completed by an interviewer based on self-report information. • Examines several key elements of depression, including sleep disturbance, somatization, anxiety-depression, and apathy. • Requires training to administer.
Mental Health Screening Form-III (MHSF-III) (Carroll and McGinley 2001)	• Eighteen simple questions designed to screen for present or past symptoms of most of the main mental disorders. • A "rough" screening device and asks only one question for each disorder for which it attempts to screen. • Reproduced in TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*c*).
Millon Clinical Multiaxial Inventory (MCMI-III) (Millon 1983; Millon et al. 1994)	• A self-report measure with several subscales. • Useful in assessing Axis II (personality) disorders that may affect involvement in treatment. • Includes the Drug Abuse Scale (DAS), an instrument designed to measure personality characteristics often associated with drug abuse (Calsyn and Saxon 1989).

Figure 2-5 (continued)
Instruments for Screening and Assessing Mental Disorders

Instrument	Description
Minnesota Multiphasic Personality Inventory (MMPI-2) (Butcher et al. 2001)	• A self-report measure with 567 items, 10 main clinical scales, and 10 supplementary scales. • A restandardized version of the MMPI. • Frequently used in correctional settings for classification and assignment to housing or inmate programs, and to predict an inmate's response to placement in a correctional setting. • Useful in identifying characteristics of antisocial personality disorder. • Designed to identify psychopathology and not to identify substance use disorders.
Personality Assessment Inventory (PAI) (Morey 1991)	• A self-report measure with 344 items and 22 scales. • Eleven clinical scales include separate measures of alcohol problems and drug problems. • Five treatment scales are also provided in the PAI.
Referral Decision Scale (RDS) (Teplin and Swartz 1989)	• A 14-item measure of mental disorder symptoms developed to identify mental health problems. • Developed and validated in a criminal justice setting. • Found to be useful in detecting the presence of major mental illness among jail inmates. • Requires no training to administer. • Self-administered. • Examines only a few mental disorders (depression, bipolar disorder, schizophrenia).
Symptom Checklist 90 - Revised (SCL-90-R) (Derogatis 1975*b*)	• A 90-item, multidimensional self-report inventory designed to assess recently experienced physical and psychological distress. • Requires no training to administer. • Self-administered. • Short amount of time to administer. • Frequently used in criminal justice settings. • Covers a wide range of symptom dimensions that include somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism.

colleagues recommend the Structured Clinical Interview for DSM-IV (SCID) (Broner et al. 2001*a*). Refer to appendix C for these and other examples of instruments that are recommended for use with specific populations. For more information on screening for co-occurring disorders see chapter 4 of TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*c*).

History of Trauma

Rates of trauma in men and women entering the criminal justice system are higher than are rates found in community samples. For

Advice to the Counselor: Screening for Co-Occurring Disorders

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

example, Teplin et al. (1996) found that 34 percent of female jail inmates had PTSD. According to the DSM-IV-TR, trauma is defined by two characteristics:

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

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

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

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

Only trained counselors should inquire about abuse and trauma issues. The counselor should be prepared for how to respond to self-disclosed experiences related to physical and sexual abuse and how to provide referral for services. In most substance abuse settings,

the goal of screening or an intake interview is not to compile detailed and comprehensive information regarding past trauma, but to identify that the offender has a history of trauma for purposes of treatment planning, triage, and referral for more intensive services. As a result, counselors should be familiar with and have ready access to resources (e.g., counselors with mental health training, liaisons from women's shelters and treatment programs) to refer persons who wish to discuss their histories of trauma in more detail.

Although clinicians are sometimes concerned about addressing material that is potentially uncomfortable or even overwhelming for either the client or themselves, these adverse consequences are rarely experienced when these issues are raised by well-trained staff. In fact, offenders are typically relieved to talk frankly about their abuse and trauma experience, albeit in an appropriately limited fashion. Indepth discussion of the specific events surrounding traumatic experiences is typically conducted in followup individual or

Screening and Assessment of Abuse and Trauma History

Structured interview assessments

- Trauma Assessment & Treatment Resource Book
  New York State Office of Mental Health's Trauma Initiative
  Design Center
  44 Holland Ave
  Albany, NY 12229
  Fax requests: (518) 473-2684
- The Integrated Biopsychosocial Assessment that includes trauma history questions in an assessment form appropriate for a mental health or substance abuse setting. Available from:

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

Self-report instruments

- The Traumatic Antecedent Questionnaire (TAQ) (van der Kolk 1992). A widely used measure of lifetime experiences of trauma in 10 domains, i.e., physical, sexual, witnessing trauma, etc.
- The Dissociative Experiences Scale (DES) (Bernstein and Putnam 1986). A self-report measure examining several domains of dissociative phenomena, often sequelae of trauma, i.e., amnesia, identity alterations, spontaneous trance states, etc.
- The Clinician Administered PTSD Scale (CAPS) (Blake et al. 1998). A clinician-administered scale that provides an accurate diagnosis of PTSD.
- The Trauma Symptom Inventory (TSI) (Briere 1995). A 100-item self-report instrument that evaluates symptoms in adults that may have arisen from childhood or adult traumatic experiences. Includes 10 clinical scales and 3 validity scales. An alternate version (TSI-A) includes no references to sexual issues. The companion Trauma Symptom Checklist 40 (Briere 1995; Briere and Runtz 1989) is a 40-item instrument that contains 6 sub-scales. Items are rated on a 4-point scale covering frequency over the past 2 months.
- Posttraumatic Disorder Scale (PTDS) (Foa et al. 1993). Measures trauma history and specific symptoms associated with posttraumatic stress disorder.

group treatment sessions that specifically address this topic area. Treatment for trauma issues progresses in stages, with early treatment goals focused on issues of ensuring safety in relationships, the place of residence, and in the workplace. Later work explores issues of recovery and reconciliation, if appropriate. This later work is frequently conducted by therapists with advanced degrees and in most cases is not appropriately addressed by paraprofessional staff.

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

Sample interview questions could include:

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

For more information on this topic see also TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT 1997*b*), TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT 2000*d*), and the forthcoming TIP *Substance Abuse and Trauma* (CSAT in development *f*).

Psychopathy and Risk for Violence and Recidivism

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

Advice to the Counselor: Screening for Trauma

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

tors for psychopathy and for violence and recidivism.

Psychopathy

One stable risk factor often found among offenders with substance use disorders is psychopathy and the closely related antisocial personality disorder defined in the DSM-IV classification system. Personality disorders are persistent and pervasive patterns of maladaptive behavior that are usually exhibited early in life. Historically, many terms have been used to describe personality disorders that involve criminogenic characteristics. Four closely linked terms are "sociopath" (and the trait of sociopathy), "antisocial personality" (and antisocial traits), "dissocial personality" (dissocial behavioral traits), and "psychopathic personality disorder" (psychopathy or psychopathic traits). Whereas the first three formulations of criminogenic personality types focus on social deficits and mild emotional and cognitive problems resulting in impulsivity and poor school achievement, psychopathy focuses on primary and severe deficits in attachment and interpersonal bonding, lack of empathy for others' experiences, lack of remorse, and shallow emotional functioning. These relatively stable traits are thought to have a biological basis. As previously indicated, psychopathy is related to the DSM-IV antisocial personality disorder but represents a more extreme version of that disorder. Some would argue that psychopathy represents a distinct diagnostic group. From 40 to 60 percent of male prison inmates meet the criteria for antisocial personality disorder, whereas only 10 to 20 percent of male prison inmates meet the criteria for psychopathy (Hare et al. 1991).

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

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

Several other short self-report screening instruments for psychopathy have been developed but have yet to be fully validated with criminal justice populations. These include the Psychopathic Personality

Advice to the Counselor: Screening for Psychopathy

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

Inventory (Lilienfeld and Andrews 1996), the Psychopathy Q-Sort (Reise and Oliver 1994; Reise and Wink 1995), and the Levenson Self-Report Psychopathy Scale (Brinkley et al. 2001; Levenson et al. 1995). A number of other screening and assessment instruments examine personality features related, but not identical, to psychopathy (Zimmerman 2000), as described in Figure 2-6 on the next page.

Violence and recidivism

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

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

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

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

Reunification with family members is often accompanied by stress related to the family's distrust and anger over offenders' past drug use, unresolved conflicts with the partner or spouse, shifting parental roles, and added financial obligations, as well as drug use in the family or neighborhood. Elements of community supervision can also increase an offender's stress during re-entry to the community. These include drug testing, use of house arrest, and other surveillance or reporting activities, as well as the offender's recognition of the significant level of effort and adherence required by community supervision programs. The community's ongoing leverage to maintain the offender's involvement in treatment following release from custody or other secure settings can be a further stressor (U.S. Department of Justice 1991). Figure 2-6 (next page) provides descriptions of three general assessment instruments related to the risk for violence and recidivism.

Figure 2-6
Instruments Examining Psychopathy and Risk for Violence and Recidivism

	Instruments	Description
Psychopathy assessment instruments	Psychopathy Checklist – Revised (PCL-R)	• A 20-item assessment measure that requires use of a semi-structured interview and review of archival records. • Requires 90–120 minutes for the interview section and 60 minutes for the collateral records review. • Measures the extent to which individuals exhibit psychopathic features on a 40-point scale, with a cutoff score of approximately 30 indicating psychopathy. • Has considerable validation for use with offenders and is highly predictive of violence and criminal recidivism.
	Psychopathy Checklist – Screening Version (PCL-SV)	• A 12-item measure examining the same construct of psychopathy as the PCL-R. • Requires 45 minutes for the interview section and 30 minutes for the collateral records review. • Scored on a 24-point scale with a cutoff of approximately 18 indicating psychopathy.
Other instruments related to psychopathy	Carlton Psychological Survey	• Used as an intake screening in correctional settings. • Contains scale scores for five categories: antisocial tendencies, chemical abuse, self-depreciation, thought disturbance, and validity. • Especially useful for those with low education and literacy as it requires only a 4th-grade reading level.
	Jesness Inventory	• Examines moral development throughout the life span.
	Paulus Deception Scales	• Gauges the extent of deception provided through offenders' self-report.
	Millon Clinical Multi-Axial Inventory-III (MCMI-III)	• Provides an assessment of personality disorders and psychopathy. • Correctional version of the MCMI-III provides early identification of substance abuse and mental health problems. • The 175-question test takes 25 minutes to complete. • Spanish versions available (Millon et al. 2002).
	Minnesota Multiphasic Personality Inventory (MMPI-2)	• A self-report objective assessment measure with 567 items, 10 main clinical scales, and 10 supplementary scales (Hathaway and McKinley 1989). • The Psychopathic Deviate Scale on the MMPI identifies individuals with psychopathic and antisocial features. • Frequently used in criminal justice settings (particularly in prisons) for classification and assignment to housing or offender programs and to predict an offender's response to placement in prison setting. • MMPI subtypes described by Megargee et al. (1979) are often used to identify offenders who require more intensive supervision and structured program activities.

Figure 2-6 (continued) Instruments Examining Psychopathy and Risk for Violence and Recidivism		
	Instruments	**Description**
Other instruments related to psychopathy	Personality Assessment Instrument (PAI)	• Self-report instrument for assessing traits associated with psychopathy. • Includes 344 items and requires 50–60 minutes to administer. • Contains scales for Negative Impression Management, Malingering, and Defensiveness (Morey and Lanier 1998). • The Antisocial Features (ANT) scale is the most highly correlated with psychopathy and focuses on antisocial behaviors, egocentricity, and stimulation-seeking.
General assessment instruments related to the risk for violence and recidivism	Level of Service Inventory (LSI) - Revised	• A 54-point scale used to predict the chances of criminal recidivism or supervision failure among offenders. • Useful for identifying those in need of more intensive levels of treatment, placement in halfway houses, and level of supervision and security classification (Andrews and Bonta 1995). • Used by jurisdictions to support an increase or decrease in the level of community supervision. • Includes assessment of drug use and is sometimes used in tandem with substance abuse treatment decisions.
	Historical, Clinical, Risk Management (HCR-20)	• Provides a comprehensive risk assessment based on historical, clinical, and risk management assessments. • Composed of static and dynamic factors with information derived from clinical interview, standardized assessment (e.g., the PCL-R or PCL-SV), and collateral sources. • Includes three sections—10 historical items, 5 clinical items, and 5 risk management items—with a final risk rating of low, medium, or high (Webster et al. 1997, 2000).
	The Violence Risk Appraisal Guide (VRAG) (Harris et al. 1993)	• An assessment tool for predicting violent recidivism. • Is an actuarial measure based on 12 objective variables that are linked to recidivism. • Requires interview and archival review, and incorporates results of diagnostic testing, IQ testing, the PCL-R, criminal history, and indicators of adult adjustment.

Selection and Implementation of Instruments

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

some are validated for use with criminal justice populations.

The appropriateness of particular instruments depends on the type of client being referred to a specific criminal justice program and the goals related to program admission. For instance, drug education programs are generally provided to a wide number of offenders, and a substance abuse screen that tends to be overly inclusive for this intervention might be preferred to a more exclusive screen. On the other hand, because of the limited access to treatment for offenders with co-occurring substance use and mental disorders, screening for mental disorders as well as for drug use problems may need to be conservative to avoid referring someone who does not need services. Therefore, flexibility in developing screening and assessment approaches is needed, depending on specific program parameters (e.g., type of staff, client goals and needs).

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

What Guidelines Are Available Regarding the Effectiveness of Instruments?

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

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

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

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

Length

Another critical factor that enters into the choice of a substance abuse screening instrument is how long it takes to administer. Although many drug use assessments are well designed and serve as broad sorting tools for treatment and intervention, they tend to take longer to administer than correctional agen-

cies can afford (Knight et al. 2002). Rather, correctional systems usually have a short period of time to determine which of a large number of offenders need treatment. For example, the Program and Services Division of the Texas Department of Criminal Justice coordinates a drug abuse screening and treatment referral process for several hundred inmates monthly. The division lacks the staff, time, or financial resources to administer lengthy individual interviews for each new admission. Therefore, simple logic dictates that an instrument should not be used if it takes longer to administer than the staff time available.

Cost

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

Window of Detection

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

Interview Versus Self-Administered Instruments

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

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

Correctional staff members who have been trained to administer an instrument can, in turn, train others to use it.

Staff Training Required

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

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

Literacy

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

Language

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

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

Computerization

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

Screening and Assessment Considerations for Specific Populations

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

the overall scoring of the instrument. The following section presents issues to consider when screening and assessing specific populations and suggests strategies for modifications to instruments and procedures.

Racial and Ethnic Minorities

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

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

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

Women respond differently to the screening process than men, and a longer, more flexible format is often useful.

Women

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

2000; Henderson 1998; Jacobson and Herald 1990; Jordan et al. 1996; Richie and Johnsen 1996; Teplin et al. 1996). In addition, many have lost custody of their children as a result of incarceration. Important counseling and treatment approaches for women are described in CSAT's Technical Assistance Publication (TAP) 23, *Substance Abuse Treatment for Women Offenders: Guide to Promising Practices* (Kassebaum 1999), and the forthcoming TIP *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT in development *g*). Additional guidelines for screening and assessment of trauma history among female offenders are discussed earlier in this chapter.

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

Advice to the Counselor: Screening Specific Populations

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

Offenders With Co-Occurring Mental Disorders

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

Depending on the criminal justice setting, screening may include a brief interview, use of self-report instruments, and review of archival records. A number of short self-report instruments are also available to examine the presence of mental disorder symptoms (Peters and

Bartoi 1997). A mental status examination is also provided during many screenings for co-occurring disorders. In addition to examining key symptoms, mental health treatment history, and family history of mental disorder, it is helpful to assess the interactive effects of both disorders to determine whether there is an independent mental disorder, or if mental disorder symptoms are present only when the offender uses drugs or alcohol.

Screening for suicidal thoughts and behavior should occur on an ongoing basis for all offenders with co-occurring disorders in the criminal justice system. This screening is particularly important for offenders with severe depression or schizophrenia and individuals who are experiencing stimulant withdrawal. Suicide screening should be conducted at the time of transfer to new institutions, or at different stages in the justice system (e.g., arrest, pretrial diversion, probation). All suicidal behavior should be taken seriously and assessed promptly to identify the types of services needed. For more information see TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*c*).

Integrated Screening and Assessment—Sample Approaches

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

Colorado Department of Corrections (CDOC)

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

Florida Department of Corrections (FDOC)

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

Jacksonville, Florida, Adult Drug Court Programs

This jurisdiction takes an integrated approach to screening and assessment that blends information from screening instruments, interviews, and archived records. For example, in the Jacksonville Adult Drug Court program, offenders are first inter-

viewed and offered treatment by their attorneys and the public defender. After that, several steps are followed:

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

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

Orange County, California, Drug Court Program

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

Eligible candidates are given a predetermined period of time in which to either plead guilty or opt into the treatment program. When candidates opt for treatment, suitability is then determined. This entails a full assessment, including a complete review of criminal history, the circumstances surrounding the charged offense, the results of any prior interactions with the criminal justice system, and a risk/needs assessment (with the National Institute of Corrections' version of the LSI) to assess treatment needs and risk of reoffense. Finally, clinical staff conducts an ASI and a full psychosocial history to determine the offender's motivation for treatment, desire for change, emotional stability, and ability to comply with program requirements. The program runs for 18 months, with reassessments every 6 months to re-evaluate risk/needs scores (again using the LSI). The new scores are then used by the Drug Court Team (e.g., clinical staff, judge) to adjust supervision and treatment strategies.

Conclusions and Recommendations

The consensus panel believes that the following are important points and recommendations about screening and assessment for criminal justice populations:

- An effective screening and assessment approach will encourage appropriate referral of offenders to different levels of treatment and will reduce the likelihood that offenders are released to the community without treatment (see chapter 3 for related discussion).

- Appropriate assessment for substance abuse treatment in criminal justice settings examines the substance abuse history, psychopathy and related risk factors, history of mental health problems, and other psychosocial areas that are affected by substance abuse.
- Intensive treatment should clearly be reserved for offenders who have at least moderate substance abuse problems and at least moderate risk for criminal recidivism. Intensive treatment for low-risk offenders will have only a minor impact on reincarceration rates. However, there is still considerable work to be done to determine the most effective procedures for treatment matching with offenders.
- Failure to identify incarcerated offenders who need postrelease treatment reduces the impact of positive change that occurred during correctional treatment.
- Improved instruments and procedures for substance abuse screening and assessment will assist in matching offenders to appropriate postrelease treatment services.
- Matching has not been consistently demonstrated to be effective, and only limited alternative approaches are available.
- Because reports of offenders' drug problems are incomplete or contain contradictory information, other collateral sources of information need to be obtained (e.g., drug test results, correctional records) that can be combined with self-report information to make referral decisions. For example, in many correctional facilities, drug tests are used to flag the need for treatment—even when an offender denies recent substance abuse. Similarly, criminal records may indicate substance abuse problems, based on a history of drug-related or DUI/DWI arrests, or presentence investigation results.
- While most staff may conduct screenings, staff with appropriate training should provide assessments and related diagnoses and treatment plan recommendations.
- Screening and assessment instruments vary considerably in their ability to detect substance use disorders and to provide information regarding other areas related to substance abuse. A range of substance abuse screening and assessment instruments have been validated for use with offenders, and some are available at relatively little expense.
- The psychometric properties of screening and assessment instruments should be carefully reviewed, and choice of instruments based on demonstrated reliability and validity within substance abuse populations, and optimally, the utility of instruments in criminal justice settings.
- A tiered screening and assessment approach could be developed in settings in which several types of treatment services are available. The initial screening includes a broad filter to detect those who have substance abuse problems, while the more intensive assessment reviews specific treatment needs and risk levels so that the offender can be assigned to an appropriate level of treatment.
- Screening and assessment information should be obtained at each major point of transition within the criminal justice system (e.g., booking to jail, placement on probation). In some cases, relevant information can be obtained from previous stages in the system, for example through transfer of records from probation to institutional settings.

A range of substance abuse screening and assessment instruments have been validated for use with offenders, and some are available at relatively little expense.

- Offenders initially assessed with symptoms of co-occurring disorders should be evaluated over an extended period of time to examine whether these symptoms resolve in the absence of substance abuse. This reassessment should be conducted by staff members who understand patterns of symptom interaction among co-occurring disorders.
- Screening and assessment for a prior history of physical and sexual abuse should be conducted routinely, particularly in settings that include large numbers of female offenders. Staff training is needed to develop effective interviewing approaches related to the prior history of abuse, counseling approaches in dealing with abuse and trauma issues, and in making referral to mental health services.
- Memoranda of understanding and other formal agreements can be developed across different agencies working within the criminal justice system to promote sharing of screening and assessment information. Key information related to treatment progress, outcomes, diagnoses, and ancillary services needs should be communicated across different points in the criminal justice system.