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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

Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System

Treatment Improvement Protocol (TIP) Series

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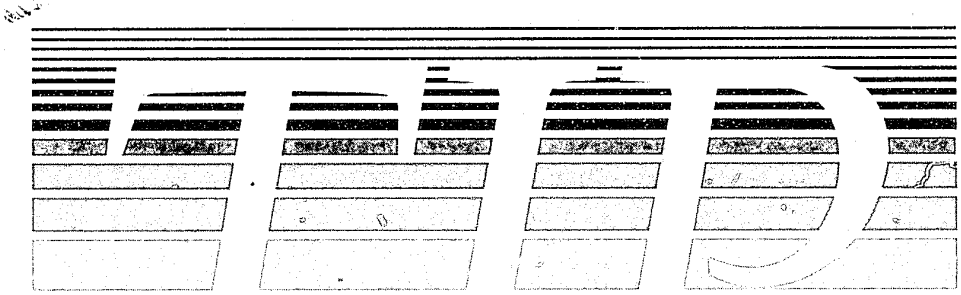

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Treatment Improvement Protocol (TIP) Series

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ACQUISITIONS

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Consensus Panel Chair

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
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The opinions expressed herein are the views of the consensus panel members and do not reflect the official position of SAMHSA or any other part of the U.S. Department of Health and Human Services (DHHS). No official support or endorsement of SAMHSA or DHHS is intended or should be inferred. The guidelines proffered in this document should not be considered as substitutes for individualized patient care and treatment decisions.

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What Is a TIP?

CSAT Treatment Improvement Protocols (TIPs) are prepared by the Quality Assurance and Evaluation Branch to facilitate the transfer of state-of-the-art protocols and guidelines for the treatment of alcohol and other drug (AOD) abuse from acknowledged clinical, research, and administrative experts to the Nation's AOD abuse treatment resources.

The dissemination of a TIP is the last step in a process that begins with the recommendation of an AOD abuse problem area for consideration by a panel of experts. These include clinicians, researchers, and program managers, as well as professionals in such related fields as social services or criminal justice.

Once a topic has been selected, CSAT creates a Federal resource panel, with members from pertinent Federal agencies and national organizations, to review the state of the art in treatment and program management in the area selected. Recommendations from this Federal panel are then transmitted to the members of a second group, which consists of non-Federal experts who are intimately familiar with the topic. This group, known as a non-Federal consensus panel, meets in Washington for 5 days, makes recommendations, defines protocols, and arrives at agreement on protocols. Its members represent AOD abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A chair for the panel is charged with responsibility for ensuring that the resulting protocol reflects true group consensus.

The next step is a review of the proposed guidelines and protocol by a third group whose members serve as expert field reviewers. Once their recommendations and responses have been reviewed, the Chair approves the document for publication. The result is a TIP reflecting the actual state of the art of AOD abuse treatment in public and private programs recognized for their provision of high quality and innovative AOD abuse treatment.

This TIP provides practical information regarding the screening and assessment of AOD abuse among adults in the criminal justice system. It contains discussions of screening and assessment and treatment planning. The TIP also examines assessment issues related to primary health care, sexually transmitted diseases, mental health, safety, and relapse. Legal and ethical issues, such as the Federal regulations on confidentiality, are reviewed.

This TIP, titled *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System*, represents another step by CSAT toward its goal of bringing national leadership to bear in the effort to improve AOD abuse treatment.

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Foreword

The Treatment Improvement Protocol Series (TIPs) fulfills CSAT's mission to improve alcohol and other drug (AOD) abuse and dependency treatment by providing best practices guidance to clinicians, program administrators, and payers. This guidance, in the form of a protocol, results from a 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 employs a consensus process to produce the product. This panel's work is reviewed and critiqued by field reviewers as it evolves.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have bridged the gap between the promise of research and the needs of practicing clinicians and administrators. I am grateful to all who have joined with us to contribute to advance our substance abuse treatment field.

Susan L. Becker
Associate Director for State Programs
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Chapter 1—Introduction

Alcohol and other drug (AOD) abuse and AOD abuse-related problems are among society's most pervasive medical and social concerns. Reliable, valid, and clinically useful instruments, as well as procedures for wide general use in screening and assessment for AOD-abusing adults, are available as complements to clinicians' experience.

A panel of experienced researchers and clinicians who work with AOD-abusing adult offenders was convened in 1993 by the Center for Substance Abuse Treatment (CSAT) to develop guidelines for screening and assessing drug users' problems as the basis for appropriate program referral and treatment. This treatment improvement protocol (TIP) on screening and assessment is an outgrowth of that meeting. It should be viewed as a companion volume to two other TIPs that are available or being developed for use by State AOD abuse agencies and AOD abuse treatment programs in the criminal justice system that are funded with Substance Abuse Prevention and Treatment Block Grant funds. The other two TIPs are:

- *Combining Alcohol and Other Drug Abuse Treatment Services with Intermediate Sanctions for Adults in the Criminal Justice System*
- *Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System*

The panel on AOD abuse screening and assessment among adults in the criminal justice system was charged with developing guidelines to:

- Identify AOD abuse screening and assessment services that need to be provided to offenders with various levels of AOD abuse problems and concurrent needs for correctional supervision
- Identify specific screening and assessment tools that appear to be particularly appropriate for offender populations and help to facilitate treatment planning
- Assist criminal justice agencies in the use of screening and assessment tools to enhance treatment outcomes.

The emphasis of this document is on practical screening, assessment, and treatment planning procedures that can help to improve care and treatment outcomes. Underlying the clinical experience reflected in the consensus panel membership, and in this TIP, is the goal to prepare guidelines, based on best practices, that can be used easily by clinicians and other workers in the field. This TIP summarizes the results of the consensus panel's deliberations. The intention is to provide guidelines, based on best practices, to criminal justice and AOD abuse treatment personnel based on considerations by individuals with broad experience in the field. The TIP does not prescribe any particular screening or assessment tool. Nor is it a manual for learning how to administer instruments. However, it does provide a starting point for increased and improved coordination among providers of AOD abuse services to adults at various points in the criminal justice process.

Three basic principles guided the panel's efforts:

- Adult offenders should receive effective and appropriate care. Thus, health and social service agency personnel, corrections staff, prosecutors, judiciary, police, and a variety of other personnel who come into regular contact with adult offenders should use appropriate and effective means to identify potential AOD abuse problems among this group. In turn, adult offenders have an obligation to follow screening and assessment procedures with appropriate treatment and interventions that are indicated by the results of the assessment procedures when the interventions are available.[1]
- Adult offenders have a right to privacy and to the confidential handling of any information they provide. Screening and assessment are not neutral or passive procedures. Used intelligently, they can provide vital information to appropriate professionals, thus contributing to effective care. Used in a careless or unprofessional manner, there is the potential for significant harm to the

individuals who need help. In the discussions that follow, the offenders' rights to privacy and confidentiality are emphasized to make clear the need for professional and sensitive handling of information at each step of the screening, assessment, and treatment planning process.

- Cultural, ethnic, and gender concerns must be considered in all aspects of the screening and assessment process. It is vital for program staff to keenly understand the impact that culture, ethnicity, and gender of both the adult offender and the staff member can have on everything discussed herein. Multicultural programs are essential in today's society. People involved in screening, assessment, and treatment planning must understand how their own culture, ethnic background, and life experiences affect this process. These concerns are discussed in the TIP.

Definitions and Limitations Of Terms Used in This TIP

This TIP and the others that address the continuum of AOD abuse among adults in the criminal justice system discuss the interface between two delivery systems—AOD abuse treatment and criminal justice—with different generic mandates. In Appendix B, the *CSAT Criminal Justice Treatment Planning Chart* illustrates interfaces between the two delivery systems where screening, assessment, and treatment planning for AOD abuse can be most effectively provided. It is critical for personnel in both systems to know and understand each other's vocabulary. Attaining this shared knowledge and understanding will lead to improved outcomes for both systems.

To facilitate shared understanding, terms that may have different meanings in the two fields are used as defined below by the consensus panel:

Abstinence—The complete abstention from the use of alcoholic beverages and/or other drugs of abuse.

Acculturation—The process of change in which the members of one culture take on the elements of another, after continuous contact with that culture.

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

Adult offender—Any person over the age of 17 charged with a criminal offense.

AIDS—Acquired immunodeficiency syndrome, a severe manifestation of infection with the human immunodeficiency virus (HIV).

AOD abuse—The use of alcohol or other drugs at a level that creates problems in one or more areas of functioning and requires intervention.

Assessment—The collection of detailed information concerning the client's AOD abuse, emotional and physical health, social roles, and other relevant areas.

Case management—A problem-solving activity designed to address inadequacies in the service delivery network that become barriers to a client's acquiring needed benefits, support, and care.

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

Community corrections—Adjudications that provide alternatives to incarceration such as court diversion programs, house arrest and electronic monitoring, intensive supervision, probation and parole, restitution, community service, and work release.

Constitutional law—The legal rules and principles that define the nature and limits of governmental power and the duties and rights of individuals in relation to the State.

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

Cultural appropriateness—Demonstrating both sensitivity to cultural differences and similarities and effectiveness in using cultural symbols to communicate a message.

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

Cultural sensitivity—An awareness of the nuances of one's own and other cultures.

Culture—The shared values, norms, traditions, customs, art, history, folklore, and institutions of a group of people.

Gender issues—Factors, problems, and concerns that are specific to members of a particular gender.

Habilitation—A person's *initial* socialization into a productive and responsible way of life (as contrasted with a return to a way of life previously known and perhaps to the term "rehabilitation," which emphasizes the forgotten or rejected).

HIV—Human immunodeficiency virus, the causative agent of AIDS.

Three Basic Principles

- Adult offenders should have effective and appropriate care.
- Adult offenders have a right to privacy and to confidential handling of any and all information they provide.
- Cultural, racial, ethnic, and gender concerns must be considered in all aspects of the screening and assessment process.

Jail—Local detention facility for temporary confinement.

Multicultural—Designed for or pertaining to two or more distinct cultures.

Parole—The status of being released from a correctional institution after serving part of a sentence, on the condition of maintaining good behavior and remaining under the supervision of an agency until a final discharge is granted.

Presentence investigation—An investigation into the background and character of a defendant that assists the court in determining the most appropriate disposition.

Prison—A correctional institution maintained by a State or the Federal Government for the confinement of convicted felons.

Probation—A sentence not involving confinement that imposes conditions and retains authority in the sentencing court to modify the conditions of the sentence or to resentence the offender if he or she violates the conditions.

Readiness for treatment—A client's perception and acceptance of his or her need for treatment in order to achieve personal change.

Screening—A gathering and sorting of information used to determine if an individual has a problem with AOD abuse, and if so, whether a detailed clinical assessment is appropriate.

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

Treatment planning—The process of planning a client's total course of treatment.

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

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

Organization of This Volume

The comprehensive screening, assessment, and treatment planning process described in this volume exists in only a few criminal justice systems. In hopes of remedying this situation, CSAT consensus panel members worked to identify and develop the guidelines and related basic requirements for an integrated and practical screening, assessment, and treatment planning system that could be put into practice in a variety of criminal justice settings.

Chapter 2 provides an overview of the criminal justice setting and the screening, assessment, and treatment planning that should occur there.

Chapter 3 covers treatment screening, needs assessment, and readiness for treatment, including how the AOD-abusing adult offender enters the criminal justice system, who should do the assessment, assessment indicators and sources of information, and issues involving availability and nonavailability of treatment. It also covers clinical assessment and treatment planning, including such areas as assessment and diagnosis, setting treatment goals, and identifying available treatment resources. Specific instruments are reviewed, and some samples are included in the appendices.

Chapter 4 discusses assessments for treatment progress, its components, sources of information, related criminal justice issues, issues of integrity, and limitations in reaching treatment goals.

Chapter 5 addresses special issues such as race, ethnicity, gender, sexual orientation, physical disability, infectious disease risk and status, history of abuse, and the incorporation of these relevant data into the treatment plan.

Chapter 6 reviews constitutionality, confidentiality, and ethics as these relate to the rights of the AOD-abusing adult offender.

There are several appendices at the end of this document. Appendix A is a list of references cited and a brief bibliography. A more comprehensive bibliography regarding screening and assessment appears in Appendix D. Appendix B is the *CSAT Criminal Justice Treatment Planning Chart*. Appendix C consists of several screening and assessment instruments, and Appendix D is a description of numerous supplementary assessment instruments.

Endnote

1. Although most professionals involved with treating adult offenders with AOD problems believe these offenders have the right to treatment, this philosophy has not been upheld by the courts.

In *O'Connor v. Donaldson (422 U.S. 563)*, a 1975 case involving mental patients, the U.S. Supreme Court refused to decide on the matter of rights to treatment. Other decisions, while recognizing the right of prisoners to basic medical care, have specifically ruled that there is no constitutional duty imposed on a government entity to rehabilitate prisoners. AOD abuse treatment is not universally considered an aspect of basic medical care by everyone in the medical and legal professions.

Chapter 2—Criminal Justice and Assessment: An Overview

This chapter presents an overview of screening and assessment for alcohol and other drug (AOD) abuse problems. It first defines these processes and clarifies how assessment differs from the classification of offenders as performed by the criminal justice system. This is followed by descriptions of the basic elements of a comprehensive assessment. Next, the chapter details the training and qualifications needed by professionals who perform clinical screening and assessment. A rationale is offered for increased coordination between criminal justice and AOD abuse treatment programs and guidelines for building successful linkages. The chapter concludes by reviewing several special issues involved in the assessment of criminal justice clients and the selection of treatment options for these clients. These issues are explored in greater detail in Chapters 4, 5, and 6.

Classification, Screening, and Clinical Assessment

Classification

The term *classification* is used by the criminal justice system to refer to the process by which a jail, prison, probation, parole, or other criminal justice program assesses both the security risk represented by the individual offender and, ideally, the individual's need for social services.

In its broadest sense, classification is the process in which the educational, vocational, treatment, and custodial needs of the offender are determined. In theory, it is a system by which a correctional agency reckons differential handling and care, and fits the rehabilitation and security programs of the institution to the requirements of the individual (Inciardi, 1993).

In practice, many criminal justice programs attempt to assess and meet the human service needs of offenders, but this assessment is subordinated to the need to maintain security and to protect the community.

Clinical Screening

A *clinical screening* is a preliminary gathering and sorting of information used to determine if an individual has a problem with AOD abuse, and if so, whether a detailed clinical assessment is appropriate.

The screening may be performed by personnel from the criminal justice system, a treatment program, or a linkage system such as Treatment Alternatives to Street Crime (TASC).[1]

The limited availability of funds for clinical assessment necessitates this screening process. Screening also filters out individuals who have medical, legal, or psychological problems that must be addressed before they can participate fully in treatment. A screening program should connect individuals with these and related problems to a specialized social service program tailored to meet such primary needs. Assessment for the specialized program will occur at the special program site.

Eligibility criteria for AOD abuse treatment programs vary. This is true in part because treatment programs provide services that are appropriate for some patients but not others. Similarly, patients have specific needs that may or may not be met at a specific program. In some cases, a treatment program screens out an individual but refers him or her to another treatment program that can provide the specialized assessment and treatment that the individual needs.

The screening process consists of asking a few questions designed to:

- Identify the existence of an AOD use problem
- Identify individuals with a history of violent offenses or severe medical or psychiatric problems
- Identify individuals who have severe mental retardation
- Identify individuals who would not for any reason be eligible for release to treatment or accepted by a treatment program.

Most importantly, however, the screening process is designed to determine who can benefit from treatment

and which general category of treatment (for example, long-term versus short-term; residential versus outpatient; drug-free, etc.) is most appropriate for each client.

Clinical Assessment

Current practices of clinical assessment evolved from the classification schemes found in correctional systems and prison reception centers. A *clinical assessment* is the collection of detailed information concerning the client's substance use, emotional and physical health, social roles, and other areas that may reflect the severity of the client's abuse of alcohol or other drugs, as a basis for identifying an appropriate treatment regimen. The clinical assessment is performed by trained treatment professionals. The primary purpose of clinical assessment is to develop a picture of the client's substance abuse pattern and history, social and psychological functioning, and general treatment needs. With the benefit of this detailed portrait, the treatment program can prepare an appropriate clinical response.

A second function of assessment is to initiate the process of treatment. The assessment can serve this function only if the interviewer succeeds in actively engaging the client in the assessment process. In a clinical assessment, the individual is confronted with the consequences of his or her substance abuse and challenged to see that the continuance of this behavior represents a personal choice. Together, the client and the clinician determine the behavioral changes that the client wants to make. The recommendations of the assessment are later reviewed with the client, who then decides whether to consent to treatment.

Elements of Clinical Assessment

The many dimensions of the clinical assessment are grouped here under three broad domains—socio-behavioral, psychological, and physical. In addition to gathering detailed, multidimensional information, the clinician should prepare a summary statement that integrates and interprets the information.

Sociobehavioral Domain

An assessment of clinical risk explores the social world and behavioral history of the individual to gather information concerning the individual's history of AOD abuse, involvement in the criminal justice system, social support and social roles, educational and vocational needs, and spirituality.

History of AOD Abuse

The assessor gathers information about how and when the client's use of AODs began, the frequency and pattern of use, the types of drugs used, the client's previous attempts at self-help, previous formal treatment and its results, and patterns of AOD abuse in the individual's family. Given the health risks associated with tobacco smoking and passive exposure to smoke, and given that treatment options exist for nicotine addiction, the assessment should include questions related to nicotine addiction.

Involvement in the Criminal Justice System

The assessment interview should document the client's past involvement in the criminal justice system and current legal charges. Clients may be removed from treatment as a result of a disposition concerning pending charges against them. Thus, information on current charges is necessary for treatment planning.

Social Support and Social Roles

The clinician should ascertain the extent and quality of social support the client receives. Do the client's family members and friends support his or her treatment and recovery, or do they act as codependents who enable the individual's addiction to continue? The assessment of social roles should also explore the individual's care-giving responsibilities, the place the individual occupies in the structure of the immediate and extended family, and the individual's employment status. In the case of female clients, it is especially important to gather information about their responsibility for taking care of dependents. Clinical assessments often fail to gather this information, but it has great bearing on the form of treatment that is appropriate for many female clients.

Educational and Vocational Needs

Information gathered about the individual's current employment status, level of educational attainment, and marketable skills helps determine the individual's need for education or job training.

Spirituality

Spirituality here refers to a belief in a Higher Power, a general "sense of belonging in the universe," or a sense of community. There is evidence that spirituality plays a positive role in an individual's recovery from alcohol or other drug abuse. Information on spirituality is not gathered for later use in persuading the client to accept any particular religious belief or

doctrine. Rather, this information helps match the individual with appropriate services. In fact, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) requires that the organizations it accredits assess the client's spirituality as a part of the clinical assessment.

Psychological Domain

As noted earlier, the initial clinical screening filters out seriously disturbed individuals in order to refer them to appropriate psychological treatment. A client's serious emotional disorders and disturbances must be treated first, if they are primary, or concurrently, to enable the client to benefit from treatment. The psychological portion of the clinical assessment may likewise identify an individual who should be referred to psychological treatment before receiving treatment for AOD abuse. The clinical assessment also builds a psychological profile of the client that facilitates the provision of treatment. The interview should assess the following:

- Levels of anxiety and depression
- Personality disorders
- Locus of control
- Level of psychological development
- Organic brain syndromes
- Central nervous system function and impairment
- History of sexual, emotional, and/or physical abuse
- History of violent behavior.

Biomedical Domain

The biomedical portion of the assessment determines the client's general state of medical and dental health and identifies any chronic or acute medical problems, including nutritional deprivation. The assessment also obtains information on the client's history of infectious and contagious diseases, including HIV and tuberculosis. The rationale for the biomedical assessment is threefold. First, this assessment, like the psychological assessment, provides information to help the treatment program staff design the optimal treatment. Second, this assessment makes it possible for the treatment program to refer clients to appropriate medical services. Third, by performing standard medical assessments, treatment programs can gather data that can be used to raise public awareness of the increasingly limited availability of basic health care services.

Summary Statement

The assessment should conclude with an integrated summary of critical information and diagnostic impressions concerning the individual and his or her treatment needs. This summary should comment on the individual's general quality of life and level of functioning. It should also set priorities for the treatment of the various problems related to the client's abuse of alcohol or other drugs. Such a summary is required of institutions accredited by the JCAHO.

Qualifications for Individuals Conducting Screening and Assessment

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

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

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

To provide consistent information for individual treatment planning as well as program evaluation and systemwide service planning, it is important for programs to use standard assessment instruments. It

is also appropriate for programs to develop additional clinical instruments to meet their particular needs. Standard assessments should not be the sole means of assessing a client's needs. Rather, they should be used in combination with the interviewer's structured, clinical, and intuitive assessment of the client.

Linkages: Coordinating Treatment and Criminal Justice Programs

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

Criminal justice and treatment systems cannot achieve enhanced coordination simply by reaching a formal agreement to collaborate. To encourage a team approach to treatment assessment, referral, and case management, the two systems need to develop or strengthen arrangements that support linkages at the institutional level and in the management of each client's treatment. In addition, cross-training can maximize the effect of both systems' screening and assessment efforts and minimize the need for duplication of effort.

Coordination Between Institutions

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

- The needs and goals of each institution
- The means by which these needs and goals will be met, with suggested timeframes
- Guidelines for sharing information at the various stages of the assessment and treatment process, within the framework of consent regulation
- Guidelines for providing a continuum of care that makes it possible to match the particular treatment needs of a client with a specified level of treatment, often at transitional points in the correctional process. For example, when the client is transferred from prison to a community correctional program, he or she may be able to enter an outpatient treatment program.

Individual Case Management

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

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

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

Improving Coordination With Existing Resources

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

Special Issues in Assessment

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

Literacy and Communication Skills

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

Language

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

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

Cultural Identity and Ethnicity

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

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

The importance of making appropriate inferences from information about an individual's culture makes it imperative that programs involved in assessment exert a strong effort in good faith to hire assessors representative of the populations they serve. When qualified professionals from these cultural groups are not on staff, treatment programs can seek to employ counselors or support staff from these groups, in order to create a diverse multicultural program environment.

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

Gender

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

Treatment programs should guard against perpetuating institutional sexism—institutional policies and practices that systematically ignore the special diagnostic, assessment, and treatment needs of women. They should also be aware that female clients may not have received a full exploration of findings that suggest treatment need. For example, many current assessment tools were developed specifically for male clients. These instruments tend to explore factors related to men's traditional roles such as performance in the workplace. (The Addiction Severity Index now includes modified severity indexes for women, as well as sections on living arrangements and relationships that are more sensitive to women's lives than previous versions. Instruments need to be tailored in this way for men and women.) Furthermore, women's abuse of AODs may go unnoticed because women are less likely to have contact with employers or others who would press them into treatment. Fear of the male offender is another impetus for the criminal justice system to refer men to assessment and treatment while neglecting the assessment needs of women, who may be viewed as less threatening to society.

Misdiagnosis can occur if the person performing the assessment has preconceptions about the kinds of psychological dysfunction that women are likely to present. For example, physicians or psychologists may misread symptoms of alcoholism as symptoms of depression. Rates of depression for male alcoholics are comparable to the rate for males in the general population, but female alcoholics are significantly more likely to have a diagnosis of depression than either women in the general population or male alcoholics. Professionals performing medical assessments must be aware of physical differences in the ways that the abuse of AODs is manifested in men and women. Some research suggests that there may be differences in the way alcohol is processed in men and women.

Sexual Orientation and Identity

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

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

Poverty and Socioeconomic Status

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

Religion and Spirituality

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

Physical Disability

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

Assessment for HIV Risk

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

Treatment professionals working with criminal justice populations have a particular responsibility for addressing the AIDS epidemic, for several reasons. First, analysis indicates that the criminal justice system

comes in contact with the portion of the AOD-abusing population that is most at risk for HIV infection. Second, there is a disproportionately high incidence of HIV seropositivity in prisons. Third, because the prison population is captive, treatment programs have an opportunity to assess HIV risk and encourage preventive measures.

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

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

As noted earlier in this chapter, assessment is the first step in the treatment process. Assessment is a good place to begin educating the client about the risks and consequences of HIV infection. It is imperative that clients who engage in high-risk behaviors be referred to programs that emphasize ongoing risk reduction education.

Endnote

1. For a discussion of TASC, see Inciardi, J.A., and McBride, D.C. *Treatment Alternatives to Street Crime (TASC): History, Experiences, and Issues.* Rockville, MD: National Institute on Drug Abuse, 1991.

Chapter 3—Screening, Assessment, and Readiness for Treatment

Screening, clinical assessment, and determining a client's readiness for treatment represent the beginning of the treatment process. The elements of each of these activities are detailed at length in this chapter.

Screening

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

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

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

Why Screen?

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

Because arrestees are often in a state of psychological crisis, arrest can be an excellent stage for screening. Arrestees are often anxious, depressed, and frightened. The negative consequences of their AOD abuse are often obvious and severe, and hard for the arrestee to deny. At this point, offenders may offer information about their AOD abuse. Once released from the criminal justice system, their concern for the gravity of their situation will usually fade.

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

General Considerations

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

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

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

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

Components of Screening

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

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

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

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

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

Training the Screener

Screening can be done with a minimum of special training by almost any criminal justice official. Screening education strategies can vary, based on the need and/or point in the system. The orientation to the process can be included in routine training and ongoing staff development. This orientation should be done systemwide, so that everyone from the arresting officer to the judge knows the importance of screening and the screening decision, and what screening decisions mean. Screening should be a fairly "seamless" process. That is, screeners should be fully integrated in the process and not be seen as adjuncts to the overall process. In fact, to a large extent, the degree to which screening is integrated with other processing activities will determine its success in the criminal justice system.

Screening is possible at every contact point in the criminal justice system. Screening at an early point in the system does not preclude screening further down the line. Screeners should understand that their own impressions may change, even in the short time in which they have contact with a client. Many abusers use more than one drug, and various effects and withdrawal symptoms may become evident at different times, causing a variety of unanticipated behaviors. Screeners should be trained to expect the unexpected. Offenders' behavior and motivation to admit to AOD abuse also fluctuates; consequently, screening at all points in the system is likely to identify potential candidates for assessment despite their earlier denial of use.

Screening Instruments

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

The CAGE Questionnaire

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

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

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

The Michigan Alcoholism Screening Test

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

The Offender Profile Index

The OPI measures the client's drug use severity as well as his or her "stakes in conformity" within a variety of contexts: family support, education, and school involvement; work, home, and correctional history; psychological and treatment history; drug use severity; and HIV-risk behaviors. It can be administered in about 30 minutes by an experienced probation officer, counselor, or other trained clinician. It includes a straightforward grading guide to help interpret the seriousness of an AOD abuser's problem. A day of training is required to be able to administer it, and a training manual is available. The client's numerical score has a corresponding treatment recommendation. The OPI is reproduced in Appendix C.[1]

Assessment

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

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

Assessment has a number of specific goals and purposes:

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

Who Does the Assessment?

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

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

or chemical dependency counselor should be available.

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

Components of Assessment

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

- Archival data on the client, including—but not limited to—prior arrests and contacts with the criminal justice system, as well as previous assessments and treatment records
- Patterns of AOD use (see below)
- Impact of AOD abuse on major life areas such as marriage, family, employment record, and self-concept
- Risk factors for continued AOD abuse, such as family history of AOD abuse and social problems
- Available health and medical findings, including emergency medical needs
- Psychological test findings
- Educational and vocational background
- Suicide, health, or other crisis risk appraisal
- Client motivation and readiness for treatment
- Client attitudes and behavior during assessment.

As this listing of professionally accepted data and criteria suggests, the assessment process must be driven by specific data and criteria. For example, in considering the patterns of AOD use, the assessor should determine the presence or absence of such signs and symptoms as:

- Tolerance (High tolerance suggests that a client has a history of heavy drinking or drug use.)
- History of physical withdrawal symptoms
- Episodes of uncontrolled drug or alcohol use, binges, or overdoses
- Use of AODs for "self-medication" of painful and unpleasant emotions
- Attempts to hide use
- Physical signs of drug use, such as needle track marks, emaciation, and alcohol odor
- Positive drug test results
- History of attempts to quit AOD use
- Family dysfunctioning relative to AOD abuse
- History and onset of drug use
- Drug use behavior (e.g., does client use drugs alone? For sex? To go to work?)
- Method of administration, including injection, snorting, smoking, or drinking.

Assessment Instruments

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

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

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

The Addiction Severity Index

The Addiction Severity Index (ASI) is perhaps the most widely used assessment instrument. It can be administered in about 60 minutes by a trained counselor. The premise of the ASI is that addiction must be evaluated within the context of problems that may have contributed to or resulted from AOD use. It collects data to estimate the client's level of discomfort in seven areas: alcohol use, medical condition, drug use, employment, financial support, illegal activity, family and social relations, and psychiatric problems. It incorporates both the client's and the assessor's assessment of his or her needs and priorities. A copy of the ASI is reproduced in Appendix C.

The Wisconsin Uniform Substance Abuse Screening Battery

This battery combines identification, classification, and treatment assessment instruments with personality profiles and measurements of specific offender needs. It is composed of four instruments: the Alcohol Dependence Scale, the Offender Drug Use History, the Client Management Classification interview, and the Megargee offender typology derived from the Minnesota Multiphasic Personality Inventory (MMPI). The battery provides sound data that can move with the offender through the entire correctional system. It determines not only treatment needs but also the need for specific programs. Two weaknesses of the battery are that the MMPI is an expensive tool and the

Alcohol Dependence Scale is copyrighted, requiring a fee for its use. Another alcohol component can be substituted in place of the alcohol component in the instrument.

The AIDS Initial Assessment Jail/Prison Supplement

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

Biological Testing

Biological tests can be valuable instruments to determine AOD use, especially when such use is denied by the client. Urinalysis, breathalyzer tests, blood tests, and all other available physical tests should be considered when AOD use is not self-reported. Such tests can be used when a client acknowledges AOD use but may be unclear about exactly what drug or drugs have been used.

Therefore, if at all possible, self-reports should be corroborated with biological testing. Given the reemergence of TB in many correctional populations, it is important that testing be done.[2] The presence of TB, furthermore, is often an indicator for HIV infection. The cost and timeliness associated with biological testing must be factored into decisions regarding the use of the tests.

Presentation of Findings

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

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

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

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

The narrative document should include a defensible paragraph or two explaining how and why the assessor has reached his or her conclusions. For example, writing only that "Mr. Jones is an alcohol abuser" is insufficient. A more useful rationale for the conclusions reached might be:

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

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

program can handle, that they may be dealing with another condition in addition to an AOD problem, and that a more sophisticated neuropsychiatric workup is needed.

Confidentiality and Client Consent

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

The client is also entitled to know what recommendations are made in the assessment report. It is important that the judge know if the client does not agree with the determinations and recommendations of the assessment. In most States, clients are entitled to a second opinion, although they usually have to pay for it themselves. Chapter 6, Legal and Ethical Issues, includes a full discussion on confidentiality and client consent.

Quality Assurance And Improvement

Quality assurance and improvement are important in any treatment system. Quality assurance is defined by the Joint Commission on Accreditation of Healthcare Organizations as the ongoing activities designed to objectively and systematically evaluate the quality of client care and services, pursue opportunities to improve the quality of client care and services, and resolve identified problems.

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

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

Readiness for Treatment

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

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

Readiness can be measured both by subjective impression and objective quantification. One scale measures readiness for treatment (and other factors) on a 1-to-5 scale, asking for responses to statements like, "I am sure that I would go to jail if I don't come to treatment," "I am worried that my spouse will leave me if I don't come to treatment," and "I feel that my AOD use is a very serious problem in my life" (De Leon and Jainchill, 1986).

Increasing someone's readiness for treatment begins with the assessment process, during which the assessor should not just record information, but also feed back impressions to the client. For example, "You say you don't have a drinking problem. Well, how about those five marriages? How about those six jobs in 2 years? How about the fact that you're on probation for your third DUI? Don't you think any of this indicates a drinking problem?"

Among clients mandated to treatment from the criminal justice system, it is unusual for a client to be genuinely enthusiastic about entering treatment. Most clients are not ready, do not want to be in treatment, and do not like it. Usually, though, they see treatment

as a more attractive alternative than incarceration. This is not necessarily totally negative. Research data have suggested that coerced treatment can be as effective as voluntary treatment, if not more so (Leukefeld and Tims, 1988). In the language used by Alcoholics Anonymous, "Bring the body, and the mind will follow." Indeed, one of the typical traits of the AOD abuser is denial, the inability or unwillingness to recognize the significance of a problem. Only after a client is in treatment can the subject of denial receive the direct and systematic attention it requires. Excluding people from treatment merely because of a lack of readiness, based on denial, would mean that the treatment process would never begin for many. It is essential to link clients who exhibit denial to the most appropriate program that will address the denial problem. Indeed, addressing denial is an integral aspect of treatment.

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

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

Assessing Readiness

Research indicates that readiness for treatment is strongly associated with an individual's perception of needing assistance in the process of personal change, compared to alternative options (De Leon and Jainchill, 1986; Collins and Allison, 1983). These researchers' work with the Circumstance, Motivation, Readiness, and Suitability Scales suggests that retention in treatment may be related to an individual's understanding of treatment options.

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

Treating "Unready" Clients

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

Most AOD abusers experience a stage of ambivalence about changing their destructive patterns of behavior (Shaffer, 1992). An increased awareness of the impact of destructive behavior on every aspect of an individual's life is required to shift ambivalence toward an acceptance of responsibility for behavior change. Programs that employ the results of a comprehensive assessment to inform the AOD user set the stage for promoting treatment readiness. The resultant shift of perception, coupled with the motivational crisis created by coercion into treatment, leads the way for further efforts toward motivation and eventual retention in the process of treatment and recovery.

The previous discussion notes the common reality for AOD abuse treatment—most recipients of services are not voluntary participants. For years, treatment professionals and paraprofessionals believed that a person needed to "hit bottom" in order to be "ready for change."

Today, it is recognized that people can be ready for treatment without "hitting bottom" and that many people can receive benefits from treatment even if they aren't completely ready for treatment. One of the major constructs currently recognized for understanding the process of addiction and recovery is the Developmental Model of Recovery. According to this model, several tasks are involved in working through the ambivalence associated with the first stage in the process of recovery, which Gorski calls the Transitional Stage (Gorski, 1991). Developing motivating problems, which refers to behaviors resulting in "hitting bottom," and accepting the need for abstinence and help are a few of these tasks. Clinicians can identify an individual's position along the process of recovery by assessing which stage-specific tasks must be resolved. The primary focus of the transitional stage is recognizing the addiction and developing the motivation to become abstinent.

Generally a client can be considered "ready" for treatment when he or she wants to be, sees AOD abuse treatment as a way to become drug or alcohol free, and recognizes that he or she cannot do it alone without professional assistance. But readiness is not often so clearcut. In reality, readiness for treatment is

a question of degree, not absolutes. Even more important than readiness are linking clients with the appropriate level of service, and using inducements and the leverage of the criminal justice system to maintain them in treatment, with the expectation that their own changing perceptions will soon keep them in treatment of their own volition.

Endnotes

1. The OPI and a copy of its training materials are reproduced in: Inciardi, J.A., ed. *Drug Treatment and Criminal Justice.* Newbury Park, CA: Sage Publications, 1993.
2. CSAT convened a consensus panel to design and recommend two screening instruments, which are now being tested. One is for AOD-abuse staff to screen for possible infectious disease in AOD clients. The other is for public health workers to screen clients for AOD abuse.

Chapter 4—Treatment Planning And Treatment Progress

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

The Treatment Plan

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

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

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

Components of the Treatment Plan

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

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

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

Treatment Planning Goals and Objectives

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

Goals should be specific, measurable, and quantitative. For example, the goal of "having a better life" is inadequate. Rather, a goal should be specific: "Find an apartment to live in," "Get back with my wife," "Stay away from my dealer friends," or "Exercise four times a week." The treatment plan should help the client establish a positive sense of self and self-esteem. Abstinence-based therapeutic goals are customary in most AOD treatment programming today (except in methadone maintenance programs), but the treatment plan should have some flexibility to

accommodate some relapses or slips during treatment. It can be therapeutic to set realistic early goals, such as, "Fewer dirty urines a month, for the next 3 months." For some clients, merely getting to an appointment sober is the most realistic goal that can be set.

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

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

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

Treatment Flexibility

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

- Attrition
- Noncompliance
- Inadequate progress.

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

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

Client Accountability

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

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

Who Is on the Treatment Team?

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

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

Potential Conflicts Between Treatment and Criminal Justice

As noted briefly in Chapter 2 of this TIP, there is the potential for conflict between treatment and criminal justice agencies. This conflict can be anticipated and avoided, to a certain extent, if certain points are made clear from the beginning of the treatment planning process. Criminal justice officials need to understand that the treatment system does not coddle the client and that the goals of treatment are consistent with the aim of getting the client out of the criminal justice system. Treatment providers need to understand the legal obligations of criminal justice personnel—to ensure public safety and to protect the rights of the offender.

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

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

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

Another TIP, *Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System*, discusses the conflicts between the treatment and criminal justice systems, and how they can be resolved.

Assessment of Treatment Progress

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

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

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

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

How This Differs From Other Assessments

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

Goals set for progress assessments must be realistic, individualized, and determined through a participatory process that includes the client. As part of the assessment process, it should be made clear to the client and the criminal justice system that treatment is not punishment. This can be a very difficult concept for mandated clients to understand, particularly those who see themselves as controlled by the criminal justice system, often with treatment

linked to their sentences. It is necessary to emphasize that treatment is not punishment, so that clients do not feel that "doing time" is all that is required of them in treatment. It is unlikely that a client with this attitude will be a participatory member of the process and reach the goals that have been set.

Who Does Treatment Progress Assessments?

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

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

How Often Should Assessments Be Conducted?

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

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

Specific Assessment Instruments

The assessment instrument is a tool used to quantitatively measure progress. There is a need for valid, reliable, and widely recognized tools, and they must be standardized, understandable by both the AOD and the criminal justice systems, and culturally sensitive and appropriate. Whatever tool is used should be repeated to foster consistent measurement and reliability of data.

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

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

Criteria for Measuring Treatment Progress

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

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

Different issues will be addressed at different points of assessment, and individual issues should not

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

Sources of Information

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

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

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

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

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

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

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

Potential Conflict Between Systems

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

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

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

There are inherent conflicts as well between the

treatment community's need to factor cost into its decisions and the mandate of the criminal justice system to protect public safety and security. Cost considerations may lead to the least restrictive program that can be appropriate. A judge or other criminal justice official may not be willing to accept this recommendation. "We do our best to inform the criminal justice system of our assessment," said a Chicago-area counselor in the Treatment Alternatives for Special Clients program. "And when we recommend residential treatment, it's usually favorably received. But when we recommend outpatient treatment, the judge tells you where he thinks that client should go."

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

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

Attrition and Noncompliance Issues

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

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

It is also helpful if the treatment counselor and criminal justice representative discuss certain general trends in advance. Such particulars as retention rates, the most likely dropout points, and relapse rates in various stages of treatment, can be used to alert case managers in other systems to potential problem periods and when they are be likely to occur.

Limitations in Reaching Treatment Goals

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

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

Chapter 5—Special Assessment Issues

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

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

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

- The assessor's skills regarding ethnic and cultural diversity
- The assessor's approach to gender issues
- The assessor's ability to deal with issues of spirituality, religious belief and practice, and creativity.

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

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

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

Basic Considerations Underlying Assessment

Who Should Do the Assessment?

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

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

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

Laying the Groundwork For Assessment

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

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

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

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

Addressing the Client's Basic Needs

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

- The trial date and what can be expected in court.
- Fears of sexual victimization in jail or prison.
- Basic survival issues such as homelessness, hunger, and lack of employment.
- Health issues. Women may be very anxious about such conditions as pregnancy, pelvic inflammatory disease, or other gynecological problems. Both men and women are likely to be concerned about contracting HIV infection—if they are not already infected—and other sexually transmitted diseases.
- Withdrawal symptoms.
- Physical disability.

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

Literacy Level and Linguistic Competence

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

The Assessor-Client Relationship

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

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

involvement. Thus, the client can begin to take some measure of control. This can be a first step toward self-determination.

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

Ethnic Origin, Culture, And Gender

Issues of Diversity

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

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

It is important to be aware of the degree to which an individual has internalized the cultural stereotypes of his or her ethnic group and gender. Sometimes, for example, a person from a very low socioeconomic area may identify with and have the characteristics of someone from a very different socioeconomic area. Another person from an affluent neighborhood may identify with and seem to be representative of people from a deprived socioeconomic background. It can be helpful to elicit from clients a story of their first memory of the recognition that they were African- or Mexican-American, female, etc. This exercise can help the assessor determine how individuals perceive themselves in relation to that first awareness. One way to do this is to ask them what they consider to be the strengths and weaknesses of their racial or cultural group. It may be revealed that an individual may not be aware of institutionalized oppression or may believe that he or she is unaffected by racism or sexism. These stories can give clues to underlying attitudes. It should not be assumed that because an individual is the member of an ethnic or cultural group that she or he automatically has a sense of having been discriminated against.

Gender

Men's Issues

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

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

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

- Who are your heroes, and why?

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

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

It may be hard for men to express feelings of vulnerability and powerlessness. Imprisonment is often an emasculating experience. Thus, it is important to recognize the role that AODs have in giving men a sense of control over themselves and their destiny. Men may make such statements as, "I can talk to girls after I've had a beer." A man may feel—or actually be—more sexually potent after using cocaine or heroin. For some men, prison eliminates or suspends sex in two ways. First, prison generally deprives heterosexual men of the ability to engage in heterosexual sex. Second, prison often deprives men of access to AODs that, for some men, are triggers for sexual feelings. Thus, being in prison robs some men of their sense of control or empowerment.

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

Women's Issues

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

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

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

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

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

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

Age

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

Spiritual Issues

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

1. Do you sometimes have spiritual feelings? Are

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

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

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

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

Comprehensive Health and Mental Health Assessment

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

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

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

General Health

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

- Nutrition, weight, and eating disorders (being overweight, obese, or underweight)
- Dental hygiene
- HIV/AIDS
- Other sexually transmitted diseases
- Endocrine disorders, including diabetes
- Sleep disorders
- Cardiovascular disorders (hypertension and heart disease)
- Pulmonary and upper respiratory diseases, specifically tuberculosis
- Hematologic disorders
- Renal disease (which may or may not be associated with hypertension)
- Neurologic disorders (seizures)
- Mental status (depression, withdrawal symptoms, and psychoses)
- Gynecologic disorders, pregnancy, and cervical abnormalities
- Urologic diseases
- Developmental disabilities (including deafness, learning disabilities, and mental retardation)
- Gastrointestinal disorders.

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

Physical and Sexual Abuse

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

required to heal them may result only in exacerbating and compounding the client's experience of victimization.

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

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

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

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

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

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

Risk for HIV and STDs

The accompanying chart, which can be copied and kept at the assessor's desk or in his or her notebook, provides questions that can be asked to gather information for assessment of risk. See Exhibit 5-1.

Mental Health

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

A close relationship exists between mental health issues and AOD abuse. A mental health evaluation is an important component of a comprehensive assessment. Intervention and followup assessment needs to be done by a trained and competent mental health clinician with experience in the field. The mental health assessment should look for the following:

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

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

Safety

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

Indirect questioning may be helpful in eliciting information from a client concerning violent incidents in which he or she may have been involved and in obtaining an idea of whether the client may be currently threatened inside the facility. An example of

Exhibit 5-1
Questions on Sexually Transmitted Disease Risks

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

such indirect questioning is: "What fears did you have about jail before you went there?" The answer to this question may indicate current areas of apprehension or fear, or actual events that have taken place during the individual's incarceration.

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

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

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

Assessment of Relapse Potential

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

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

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

Recognizing Potential Triggers For Relapse

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

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

It is not uncommon for a client to hold onto elements from his or her former days of AOD abuse. Often clients report that maintaining these ties gives them a sense of security, "just in case." The assessor should identify what "residual objects" or reservations they are keeping around, such as drug works or paraphernalia, stash, or contacts. The assessor should also find out if the client has had sexual contact with anyone with whom he or she shared AOD use. Other clues in assessing the potential for relapse may be provided by dreams reported by the client regarding AOD abuse. Such dreams can indicate unconscious desires to get high. It is useful to advise the client that when the desire to use returns, changing patterns may help. For example, getting up at a different hour, increasing exercise, or improving eating habits may help to assuage these desires.

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

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

counterproductive patterns in order to avoid repeating the experiences that led to relapse.

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

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

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

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

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

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

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

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

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

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

Conclusion

This chapter has presented general tips and guidelines for use when conducting assessments. They are important tools that can help to ensure that the client perceives that he or she is being treated as an individual and that the assessor recognizes his or her essential worth and individual strengths—rather than merely flaws or personality or character defects. Conducting assessments with attention to the factors discussed in this chapter will increase the possibility that an effective and productive relationship between the client and the assessor can be established.

Chapter 6—Legal and Ethical Issues

Making appropriate screening, assessment, and treatment available to people with alcohol and other drug (AOD) abuse problems is a responsibility of the courts, correctional systems, and treatment programs. Coordination among these systems raises a number of important ethical and legal issues including:

- The responsibility of the systems to actively advocate for more AOD abuse treatment services
- The guidelines used to allocate treatment slots
- The need to avoid overzealous participation by law enforcement in the "recruitment" of potential clients for treatment
- The courts' responsibility to determine the effectiveness of mandated treatment
- The need to protect the confidentiality rights and other rights of criminal justice clients in treatment.

Overview

Advocacy

It is the ethical responsibility of treatment programs and is in the best interests of criminal justice programs and the courts to advocate for the provision of additional funding for treatment programs for AOD-involved offenders. Greater coordination between treatment and criminal justice and the use of more comprehensive assessment processes will lead to the identification of greater numbers of people who need AOD treatment. However, assessment is an intrusive process that should be conducted only if it results in the provision of appropriate services.

The conditions in jails and prisons often produce severe limitations to good therapeutic practice. When treatment programs are developing working agreements for coordination with criminal justice agencies, they may find it appropriate to advocate for the placement of treatment services in a separate unit within criminal justice facilities for those AOD abusers whom the courts will not release to community-based treatment.

As the assessment of AOD abuse problems among the criminal justice population increases, criminal justice clients may gain access to treatment slots at the expense of other individuals in the community who require treatment. Because the prison population is predominantly male, it is possible that more men, and fewer women, will have access to treatment. Ideally, however, the judicial emphasis on treatment will result in an increase among the States for support of treatment for all who need it.

The Danger of Restrictions On Freedom

While criminal justice and treatment programs have a responsibility to coordinate their work and to serve as advocates for increased treatment services, the effect of their efforts should not be to increase the States' role in restricting individual freedoms. That is, the purpose of linking systems is not to change law enforcement practices, but to offer treatment services to those already identified and processed under current applications of the law. It would be inappropriate for the criminal justice and treatment systems to work so intimately that the police identify and arrest people with AOD abuse problems who would not otherwise have come under the purview of the criminal justice system.

Priorities for Use of Scarce Resources

While an expansion of available treatment services is desirable, in most cases, treatment programs that provide services to criminal justice clients must set priorities for the allocation of an inadequate number of treatment slots. In doing so, treatment programs should give priority to those individuals who are ready to benefit from treatment. For the purpose of

setting priorities, criminal justice clients with AOD abuse problems can be grouped into four categories:

1. Young people who have been abusing AODs for a brief period of time and have not experienced serious negative consequences of AOD abuse.
2. Individuals who have had AOD problems for 5 or more years and have experienced negative consequences, but have not yet "hit bottom," either in their AOD experiences and personal lives, or in their involvement with the criminal justice system.
3. Individuals whose AOD abuse has caused a personal crisis that could motivate them to participate in treatment. This crisis may be the destruction of a personal relationship, the onset of a life-threatening stage of the addiction process, the loss of employment, or a judge's warning that the individual will face lengthy incarceration if brought into court for another criminal offense.
4. Career criminals with AOD abuse problems.

Clinical research suggests that clients in the first and third categories are the most amenable to treatment: the former because they are in the early stages of their AOD-abusing careers, and the latter because they are more likely to be motivated to participate actively in treatment.

Focusing treatment resources on clients who are amenable to treatment has additional advantages. Early treatment can prevent the individual's involvement in future AOD-related crime. The needs of new offenders for education, employment, and other auxiliary services are not always as intensive as the needs of people whose lives have been devastated by AOD abuse problems.

Clients in the first and third groups—young people who have not experienced serious consequences and individuals who can be motivated to be treated because of an AOD-related crisis—should perhaps be the primary targets for assessment and services. However, it is also important to provide a continuum of services to all AOD-abusing offenders. These services might emphasize education and motivation with the goal of preparing offenders to enter treatment.

Confidentiality: Protecting The Rights of Clients

Staff of AOD abuse treatment programs serving criminal justice populations should be aware of legal and ethical issues that affect program operations. Of primary concern is confidentiality: the protection of the right to privacy.

For example, staff members of a program that provides assessment and treatment placement services are often interested in seeking information about the offenders they screen from other sources, such as family, employers, and mental health providers. How can the program approach these sources and at the same time protect the offender's right to privacy? How can the agencies that are concerned with or charged with the offender's welfare communicate with each other about the offender's assessment or progress in treatment without violating the confidentiality rules? Are there special rules for programs operating in the criminal justice area? If the offender is threatening harm to him- or herself or another person, can the program call the authorities? This section attempts to answer these questions and is divided into several subsections.

- The first subsection provides an overview of the Federal law that protects the right to privacy of any person, including an offender, when that person is seeking or receiving AOD abuse assessment or treatment services.
- The second subsection is a detailed discussion of the rules regarding the use of consent forms to get an offender's permission to release information about seeking or receiving AOD services.
- The third subsection reviews the rules for communicating with others about issues concerning an offender involved with AOD assessment or treatment services (including how diverse agencies can communicate with each other and warn others of an offender's threats to harm).
- The fourth subsection is a discussion about other kinds of exceptions to the general rules that prevent disclosure of information about persons involved with AOD abuse assessment or treatment services—such as reporting crimes on program premises or against program personnel.
- The final subsection includes several points concerning an offender's right to confidential services and the need for programs to obtain legal assistance.

The Offender's Right to Privacy

Two Federal laws and a set of regulations guarantee the strict confidentiality of information about persons—including offenders—receiving AOD abuse prevention, assessment, and treatment services.[2]

These laws and regulations are designed to protect patients' privacy rights in order to attract people into treatment. The regulations restrict communications more tightly, in many instances, than either the doctor-patient or the attorney-client privilege. Violating the regulations is punishable by a fine of up to $500 for a first offense or up to $5,000 for each subsequent offense. (§ 2.4).[2] Some may view these

Federal regulations governing communication about the offender and protecting patients' privacy rights as an irritation or a barrier to achieving program goals. However, most of the nettlesome problems that may crop up under the regulations can easily be avoided by planning ahead. Familiarity with the requirements of the regulations will ease communication. It can also reduce the confidentiality-related conflicts among the treatment program, the patient, and the criminal justice agency to a few relatively rare situations.

Programs Governed by Regulations

Any program that specializes, in whole or in part, in providing treatment, counseling, and/or assessment and referral services for offenders with AOD problems must comply with the Federal confidentiality regulations (42 C.F.R. § 2.12(e)). Although the Federal regulations apply only to programs that receive Federal assistance, this assistance includes indirect forms of Federal aid such as tax-exempt status, or State or local government funding coming (in whole or in part) from the Federal Government.

Coverage under the Federal regulations does not depend on the way a program labels its services. Calling itself a "prevention program" or "assessment program" does not excuse a program from adhering to the confidentiality rules. The kind of services actually provided, not the label, determines whether the program must comply with the Federal law.

The General Rule

The Federal confidentiality laws and regulations protect any information about an offender if the offender has applied for or received any AOD abuse-related services from a program that is covered under the law. Services applied for or received can include assessment, diagnosis, individual counseling, group counseling, treatment, or referral for treatment.[3] The restrictions on disclosure apply to any information that would identify the offender as an AOD abuser, either directly or by implication. The general rule applies from the time the offender makes an appointment. It also applies to former clients or patients. The rule applies whether or not the person making an inquiry already has the information, has other ways of getting it, has some form of official status, is authorized by State law, or comes armed with a subpoena or search warrant.

When Information May Be Shared

Information that is protected by the Federal confidentiality regulations may always be disclosed after the offender has signed a proper consent form. The regulations also permit disclosure without the offender's consent in several situations, including medical emergencies, program evaluations, and communication among staff.

The most commonly used exception to the general rule prohibiting disclosures is for a program to obtain the offender's consent. The regulations provide for two different forms of consent for mandated criminal justice clients (§§ 2.31 and 2.35). For communications between a program and the person or entity within the criminal justice system that is referring or monitoring the offender's compliance with assessment or treatment, the program should use the special criminal justice system consent form (Exhibit 6-1). For all other consented disclosures, the program should use the general consent form authorized by the regulations (Exhibit 6-2). The regulations' requirements regarding consent are somewhat unusual and strict, and must be carefully followed.

Consent: Rules About Consent Forms

Most disclosures are permissible if an offender has signed a valid consent form that has not expired or been revoked (§ 2.31).[4]

A proper consent form must be in writing and must contain each of the items contained in § 2.31, as follows:

- The name or general description of the program(s) making the disclosure
- The name or title of the individual or organization that will receive the disclosure
- The name of the patient who is the subject of the disclosure
- The purpose or need for the disclosure
- How much and what kind of information will be disclosed
- A statement that the patient may revoke (take back) the consent at any time, except to the extent that the program has already acted on it
- The date, event, or condition upon which the consent expires, if not previously revoked
- The signature of the patient
- The date on which the consent is signed (§ 2.31(a)).

A general medical release form, or any consent form that does not contain all of the elements listed above, is not acceptable. (See sample consent form in Exhibit 6-2.) A number of items on this list deserve further explanation and are discussed under the bullets below: the purpose of the disclosure and how much and what kind of information will be disclosed, the offender's right to revoke the consent, the expiration of the consent form, the required notice against re-releasing information, and agency use of the form.

Exhibit 6-1
Consent for the Release of Confidential Information:
Criminal Justice System Referral

I, _____, hereby consent to
(Name of defendant)

communication between _____ _____and
(treatment program)

_____
(Court, probation, parole, and/or other referring agency)

the following information: _____
(Nature of the information, as limited as possible)

The purpose of and need for the disclosure is to inform the criminal justice agenc(ies) listed above of my attendance and progress in treatment. The extent of information to be disclosed is my diagnosis, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, and

_____

_____

I understand that this consent will remain in effect and cannot be revoked by me until:

_____ There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment, or

_____ _____
(other time when consent can be revoked and/or expires)

I also understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of AOD abuse patient records and that recipients of this information may redisclose it only in connection with their official duties.

_____ _____
(Date) (Signature of defendant/patient)

Exhibit 6-2
Consent for the Release of Confidential Information

I, _____, authorize
(Name of patient)

_____
(Name or general designation of program making disclosure)

to disclose to _____
(Name of person or organization to which disclosure is to be made)

the following information: _____
(Nature of the information, as limited as possible)

_____

_____

The purpose of the disclosure authorized herein is to: _____

_____
(Purpose of disclosure, as specific as possible)

_____

I understand that my records are protected under the Federal regulations governing Confidentiality of AOD Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____
(Specification of the date, event, or condition upon which this consent expires)

Dated: _____

_____
(Signature of participant, authorized representative if required)

Purpose of Disclosure, and Type and Amount of Information

The purpose of disclosure and of the type and amount of information are closely related. All disclosures, and especially those made pursuant to a consent form, must be limited to information that is necessary to accomplish the need or purpose for the disclosure (§ 2.13(a)). It would be improper to disclose everything in an offender's file if the recipient of the information only needs one specific piece of information.

In completing a consent form, it is important to determine the purpose or need for the communication of information. Once this has been identified, it is easier to determine how much and what kind of information will be disclosed, tailoring it to what is essential to accomplish the need or purpose that has been identified.

As an illustration, if a program is assessing an offender's treatment needs and seeks records from a mental health provider, the purpose of the disclosure would be "to obtain mental health treatment records to complete the assessment." The disclosure would then be limited to a statement that "John Doe (the offender) is being assessed by the XYZ Program." No other information about John Doe would be released to the mental health provider.

Offender's Right to Revoke Consent

The general consent form authorized by the Federal regulations permits the offender to revoke consent at any time, and the consent form must include a statement to this effect. This is a key difference between the general consent form being discussed here and the criminal justice system consent form, which does not permit revocation (see below). Revocation need not be in writing. If a program has already made a disclosure prior to the revocation, the program has acted in reliance on the consent—in other words, the program was relying on the consent form when it made the disclosure. Therefore, the program is not required to try to retrieve the information it has already disclosed.

The regulations state that "acting in reliance" includes the provision of services while relying on the consent form to permit disclosures to a third-party payer. (Third-party payers are health insurance companies, Medicaid, or any party that pays the bills other than the patient's family or the treatment agency.) Thus, a program can bill the third-party payer for past services provided before the consent was revoked. However, a program that continues to provide services after a patient has revoked a consent authorizing disclosure to a third-party payer does so at its own financial risk.

Expiration of Consent Form

The form must also contain a date, event, or condition on which consent will expire if not previously revoked. A consent must last "no longer than reasonably necessary to serve the purpose for which it is given" § 2.31(a)(9). If the purpose of the disclosure can be expected to be accomplished in 5 or 10 days, it is better to fill in that amount of time rather than a longer period or to have all consent forms uniformly expire in 60 or 90 days.

The consent form does not need to contain a specific expiration date, but may instead specify an event or condition. For example, if an offender has been placed on probation at school or work on the condition that she or he attend counseling at the program, a consent form should be used that does not expire until the completion of the probation period. Or, if an offender is being referred to a specialist for a single appointment, the consent form should provide that it will expire after he or she has seen "Dr. X."

Required Notice Against Redisclosure

Once the consent form has been properly completed, there remains one last formal requirement. Any disclosure made with written patient consent must be accompanied by a written statement that the information being disclosed is protected by Federal law and that the person receiving the information cannot make any further disclosure of such information unless permitted by the regulations (§ 2.32). This statement, not the consent form itself, should be delivered and explained to the recipient at the time of disclosure or earlier. (See Exhibit 6-3.)

The prohibition on redisclosure is clear and strict. Those who receive the notice are prohibited from rereleasing information except as permitted by the regulations. (Of course, an offender may sign a consent form authorizing such a redisclosure.)

Note on the Use of Consent Forms

The fact that an offender has signed a proper consent form authorizing the release of information does not force a program to make the proposed disclosure, unless the program has also received a subpoena or court order (§§ 2.3(b); 2.61(a)(b)). The program's only obligation is to refuse to honor a consent that is expired, is deficient, or otherwise known to be revoked, false, or invalid (§ 2.31(c)).

In most cases, the decision whether to make a

Exhibit 6-3
Prohibition on Redisclosing Information Concerning AOD Abuse Treatment Patients

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

disclosure pursuant to a consent form is within the discretion of the program unless State law requires or prohibits disclosure once consent is given. In general, it is best to follow this rule: Disclose only what is necessary, for only as long as is necessary, keeping in mind the purpose of the communication.

Special Rules About Consent Forms Regarding Offenders

Programs assessing and treating offenders who are mandated into assessment or treatment must also follow the confidentiality rules that generally apply to AOD abuse programs. However, some special rules apply when an offender comes for assessment or treatment as an official condition of probation, sentence, dismissal of charges, release from detention, or other disposition of any criminal proceeding, and information is being disclosed to the mandating agency.

A consent form (or court order) is still required before any disclosure can be made about an offender who is mandated into assessment or treatment. However, the rules concerning the length of time that a consent remains valid are different. Also, a "criminal justice system consent" cannot be revoked before its expiration event or date. Specifically, the regulations require that the following factors be considered in determining how long a criminal justice system consent will remain in effect:

- The anticipated duration of treatment
- The type of criminal proceeding in which the offender is involved
- The need for treatment information in dealing with the proceeding
- When the final disposition will occur
- Anything else the patient, program, or criminal justice agency believes is relevant.

These rules allow programs to continue to use a traditional expiration condition for a consent form that once was the only one allowed—"when there is a substantial change in the patient's justice system status." This formulation appears to work well. A substantial change in status occurs whenever the offender moves from one phase of the criminal justice system to the next. For example, if an offender is on probation, there would be a change in criminal justice status when the probation ends, either by successful completion or revocation. Thus, the program could provide an assessment or periodic reports to the probation officer monitoring the offender, and could even testify at a probation revocation hearing if it so desired, since no change in criminal justice status would occur until after that hearing.

As for the revocability of the consent (the rules under which the offender can take back his or her consent), the regulations allow the consent form to state that consent cannot be revoked until a certain specified date or until a particular condition occurs. The regulations permit the criminal justice system consent form to be irrevocable so that an offender who has agreed to enter treatment in lieu of prosecution or punishment cannot then prevent the court, probation department, or other agency from monitoring his or her progress. Note that although a criminal justice system consent may be made irrevocable for a specified period of time, its irrevocability must end no later than the final disposition of the criminal proceeding. Thereafter, the offender may freely revoke consent. (See Exhibit 6-1.)

Several other considerations relating to criminal justice system referrals are important. First, any information that one of the eligible criminal justice agencies receives from a treatment program can be used by that justice agency only in connection with its official duties with respect to a particular criminal proceeding. The information may not be used in other proceedings, for other purposes, or with respect to other individuals (§ 2.34(d)).

Second, whenever possible, it is best to have the judge or referring agency require that a proper consent form of the criminal justice system be signed

by the offender before he or she is referred to the treatment program. If that is not possible, the treatment program should have the offender sign a criminal justice system form at his or her very first appointment. With a proper signed form from the criminal justice system, the AOD program can communicate with the referring agency even if the offender appears for assessment or treatment only once. This avoids the problems that can arise if an offender mandated into assessment or treatment does not sign a consent form and leaves before the assessment or treatment has been completed.

If a program fails to have the offender sign a criminal justice system form and the offender fails to complete the assessment process or treatment, the treatment program has few options when faced with a request for information from the referring criminal justice agency. The program could attempt to locate the offender and ask him or her to sign a consent form, but that, of course, is unlikely to happen. And there is some question whether a court can issue an order to authorize the program to release information about a referral who has left the program in this type of case. This is so because the regulations allow a court to order disclosure of treatment information for the purpose of investigating or prosecuting a patient for a crime only where the crime was "extremely serious," and a parole or probation violation generally will not meet that criterion.

Therefore, unless a consent form is obtained by the judge or criminal justice agency or by the treatment program at the very beginning of the assessment or treatment process, the program may end up in a position where it is prevented from providing any information to the criminal justice agency that referred the offender.

If the offender referred by a criminal justice agency never applies for or receives services from the program, that fact may be communicated to the referring agency without patient consent (§ 2.13(c)(2)). But once an offender even makes an appointment to visit the program, consent or a court order is needed for any disclosures.

Finally, when a treatment program decides to establish an ongoing relationship with a criminal justice system agency, it is best to have a complete discussion about the objectives of each partner, the expectations each partner has about the obligation of the other, and communications between the treatment program and the criminal justice agency. For programs treating offenders, two crucial issues include who will make certain decisions and what kinds of information will be reported. For example, is it the program or the criminal justice agency that will decide when an offender's relapse into AOD use is a treatment issue or a violation of the conditions of probation? How detailed will the program's reports to the criminal justice agency be? Matters such as these should be resolved between the program and criminal justice agency before problems arise in individual cases. A memorandum of understanding or letter of agreement should be drafted to set forth the rules decided upon.

Communicating With Others About the Offender

Given these rules regarding consent, consider the questions introduced at the beginning of this chapter: How can programs seek information from collateral sources about offenders they are assessing? How can the many diverse criminal justice and treatment agencies effectively communicate without violating the Federal rules? Do programs have a duty to warn others of threats by offenders, and if so, how do they communicate the warning?

Seeking Information From Collateral Sources

Making inquiries of employers, schools, doctors, and other health care entities might, at first glance, seem to pose no risk to an offender's right to confidentiality. But it does.

When a program that screens, assesses, or treats offenders asks an employer, physician, family member, or mental health professional to verify information it has obtained from the offender, it is making a patient-identifying disclosure that the offender has sought its services. In other words, when program staff seek information from other sources, they are letting these sources know that the offender has asked for AOD abuse services. The Federal regulations generally prohibit this kind of disclosure unless the offender consents.

How then is a screening or assessment program to proceed? The easiest way is to get the offender's consent to contact the employer, family member, school, health care facility, etc. Another method involves the program's asking the offender to sign a consent form that permits it to make a disclosure for purposes of seeking information from collateral sources to any one of a number of entities or persons listed on the consent form. Note that this combination form must still include "the name or title of the individual or the name of the organization" for each collateral source the program may contact. Whichever method the program chooses, it must use the general consent form, not the special criminal justice system consent form.

Ongoing Communications Among Agencies

Programs performing assessments of offenders mandated to AOD services need to be able to communicate with the referring criminal justice agency for a brief span of time—long enough to perform the assessment, write a report, and make a presentation to the court or agency. Programs performing assessments should have the offender sign a criminal justice system consent form that expires after the offender's next change in criminal justice status.

For example, suppose the offender has been convicted of a crime and has not yet been sentenced, but is being considered for probation. The program performing the assessment (Program A) should make sure that the offender signs a criminal justice system consent form that expires after the offender's sentencing. In that way, Program A is assured of being able to continue communicating with the agency that referred the offender (whether it be the court or probation department) until a final decision has been reached. Thereafter, Program B, the agency to which the offender is assigned for his or her mandated treatment, should have the offender sign a second form permitting communication with the referring criminal justice agency until the period of probation is completed—either successfully or through revocation proceedings.

Now, suppose that the agency in which the offender has been placed for treatment (Program B) wants to see the assessment, which was done by a different program (Program A). How can Program B get a copy?

In this example, a change in criminal justice status has occurred: the offender has been sentenced. Therefore, Program B must obtain the offender's consent to get a copy of the assessment report. The assessment report prepared by Program A may well be a part of the offender's criminal justice record maintained by the probation department. But it is still protected by the Federal regulations and cannot be released to Program B—or anyone else—without the offender's consent once his or her criminal justice status has changed.[5]

If Program B needs the assessment report prepared by Program A, it should have the offender sign consent forms permitting it to ask Program A for the report (since Program A has now become a collateral source) and permitting Program A to release the report to Program B.

As noted above, Program B must also have the offender sign a criminal justice system consent form permitting it to have ongoing communications with the criminal justice agency that mandated the offender into treatment. All other communications by Program B with the outside world—including other criminal justice agencies—must be dealt with on an individual basis: either by consent or by ensuring that the proposed disclosure falls within one of the narrow exceptions permitted by the Federal regulations.

These same issues must be thought through when an offender is treated for AOD abuse in a jail or prison and is then referred to aftercare at a community-based program.

Duty to Warn: Rules Concerning an Offender's Threat to Harm Another

For most treatment professionals, the issue of reporting a patient's threat to harm another or to commit a crime is a troubling one. Many professionals feel that they have an ethical, professional, or moral obligation to prevent a crime when they are in a position to do so, particularly with respect to serious crime.

There has been a developing trend in the law to require psychiatrists and other therapists to take "reasonable steps" to protect an intended victim when they learn that a patient presents a "serious danger of violence to another." This trend started with the case of *Tarasoff v. Regents of the University of California*, 17 Cal.3d 425 (1976), in which the California Supreme Court held a psychologist liable for money damages because he failed to warn a potential victim his patient threatened to kill, and then did so. The court ruled that if a psychologist knows that a patient poses a serious risk of violence to a particular person, the psychologist has a duty "to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances."

While the *Tarasoff* ruling, strictly speaking, applies only in California, courts in a number of other States have followed *Tarasoff* in finding therapists liable for money damages when they failed to warn someone threatened by a patient. Most of these cases are limited to situations where patients threaten a specific identifiable victim, and they do not usually apply where a patient makes a general threat without identifying the intended target. States that have enacted laws on the subject have similarly limited the duty to warn to such situations.

If an offender's counselor thinks the offender poses a serious risk of violence to someone, he or she may well have a duty to warn either the potential victim or the police. The question is, can the program make a report without violating the Federal regulations?

One way the program can act is to make a report to the criminal justice agency that mandated the offender into treatment, so long as it has a criminal

justice system consent form signed by the offender that is worded broadly enough to allow this sort of information to be disclosed. The criminal justice agency can then act on the information. However, the regulations limit what the criminal justice agency can do with the information. Section 2.35(d) states that anyone receiving information pursuant to a criminal justice system consent "may redisclose and use it only to carry out that person's official duties with regard to the patient's conditional release or other action in connection with which the consent was given."

Thus, the disclosure can be used by the referring criminal justice agency to revoke an offender's conditional release. If the referring criminal justice agency wants to warn the potential victim or to notify another law enforcement agency of the threat, it must be careful that no mention is made that the source of the tip was an AOD program or that the offender is in AOD assessment or treatment. Disclosures that do not identify the offender as someone with an AOD problem are permitted. See discussion below on communications that do not disclose patient-identifying information. However, the disclosure most likely cannot be used to prosecute the offender for a separate crime (in other words, for making the threat). The only way to prosecute an offender based on information obtained from a program is to obtain a special court order in accordance with § 2.65. See Court-Ordered Disclosures, below.

If the offender has not signed a consent form permitting such disclosures to a criminal justice agency, the program faces a difficult problem: the apparent conflict between the Federal confidentiality requirements and the *Tarasoff* case. The Federal confidentiality law and regulations prohibit the type of disclosure that *Tarasoff* and similar cases require, unless the disclosure is made pursuant to a court order or is made without identifying the individual who threatens to commit the crime as a patient.[6] Moreover, the Federal regulations make it clear that Federal law overrides any State law that conflicts with the regulations (§ 2.20). In the only case, as of this writing, that addresses this conflict between Federal and State law (*Hasenie v. United States*, 541 F. Supp. 999 (D. Md. 1982)), the court ruled that the Federal confidentiality law prohibited any report.

Confronted with conflicting moral and legal obligations, what should a program do? A program that learns that an offender is threatening violence to a particular person or persons may be well advised to seek a court order permitting a report or to make a report without revealing patient-identifying information. If a counselor believes there is clear and imminent danger to a particular person, it is probably wiser to err on the side of making an effective report about the danger to the authorities or to the threatened individual. This is especially true in States that currently follow the *Tarasoff* rule.

While each case presents different questions, it is doubtful that any prosecution (or successful civil lawsuit) under the confidentiality regulations would be brought against a counselor who warned about potential violence when he or she believed in good faith that there was real danger to a particular individual. On the other hand, a civil lawsuit for failure to warn may well result if the threat is actually carried out. In any event, the counselor should at least try to make the warning in a manner that does not identify the individual as an AOD abuser, as discussed below.[7]

"Duty to warn" issues present an area in which staff training, as well as a staff review process, may be helpful.

Eight Exceptions to the General Rule

Reference has been made to other exceptions to the general rule of the Federal confidentiality rules prohibiting disclosure regarding offenders who are assessed or treated for AOD abuse. In this section, eight additional exceptions to the general rule are explained.

Communications That Do Not Disclose Patient-Identifying Information

The Federal regulations permit programs to disclose information about an offender if the program reveals no patient-identifying information. "Patient-identifying" information is information that identifies someone as an AOD abuser. Thus, a program may disclose information about an offender if that information does not identify him or her as an AOD abuser or support anyone else's identification of the offender as an AOD abuser.

There are two basic ways a program may make a disclosure that does not identify a patient. The first way is obvious: A program can report aggregate data about its population (summing up information that gives an overview of the patients served in the program) or some portion of its populations. Thus, for example, a program could tell the newspaper that in the last 6 months it screened 43 offenders, 10 female and 33 male.

The second way is trickier: A program can communicate information about an offender in a way that does not reveal the offender's status as an AOD abuse patient (§ 2.12(a)(i)). For example, a program that provides services to clients with other problems

or illnesses as well as AOD abuse may disclose information about a particular client as long as the fact that the client has an AOD abuse problem is not revealed. Consider an even more specific example: A program that is part of a general hospital can have a counselor call the police about a client's threat, so long as the counselor does not disclose that the client has an AOD abuse problem or is a client of the AOD abuse treatment program.

Programs that provide only AOD services cannot disclose information that identifies a client under this exception, since letting someone know a counselor is calling from the "XYZ Treatment Program" will automatically identify the offender as someone in the program. However, a freestanding program can sometimes make "anonymous" disclosures, that is, disclosures that do not mention the name of the program or otherwise reveal the offender's status as an AOD abuser.

Court-Ordered Disclosures

A State or Federal court may issue an order that will permit a program to make a disclosure about an offender that would otherwise be forbidden. A court may issue one of these authorizing orders, however, only after it follows certain special procedures and makes particular determinations required by the regulations. A subpoena, search warrant, or arrest warrant, even when signed by a judge, is not sufficient, standing alone, to require or even to permit a program to disclose information[8] (§ 2.61).

Before a court can issue a court order authorizing a disclosure about an offender, the program and any offenders whose records are sought must be given notice of the application for the order and some opportunity to make an oral or written statement to the court.[9] Generally, the application and any court order must use fictitious (made-up) names for any known offender, and all court proceedings in connection with the application must remain confidential unless the offender requests otherwise (§§ 2.64(a), (b), 2.65, 2.66).

Before issuing an authorizing order, the court must find that there is "good cause" for the disclosure. A court can find "good cause" only if it determines that the public interest and the need for disclosure outweigh any negative effect that the disclosure will have on the patient, or the doctor-patient or counselor-patient relationship, and the effectiveness of the program's treatment services. Before it may issue an order, the court must also find that other ways of obtaining the information are not available or would be ineffective (§ 2.64(d)). The judge may examine the records before making a decision (§ 2.64(c)).

If the purpose of seeking the court order is to obtain authorization to disclose information in order to investigate or prosecute a client for a crime, the court must also find that:

- The crime involved is extremely serious, such as an act causing or threatening to cause death or serious injury
- The records sought are likely to contain information of significance to the investigation or prosecution
- There is no other practical way to obtain the information
- The public interest in disclosure outweighs any actual or potential harm to the client, the doctor-patient relationship, and the ability of the program to provide services to other patients.

When law enforcement personnel seek the order, the court must also find that the program had an opportunity to be represented by independent counsel. (If the program is a governmental entity, it *must* be represented by counsel) (§2.65(d)).

There are also limits on the scope of the disclosure that a court may authorize, even when it finds good cause. The disclosure must be limited to information essential to fulfill the purpose of the order, and it must be restricted to those persons who need the information for that purpose. The court should also take any other steps that are necessary to protect the offender's confidentiality, including sealing court records from public scrutiny (§ 2.64(e)).

The court may order disclosure of "confidential communications" by an offender to the program only if the disclosure:

- Is necessary to protect against a threat to life or of serious bodily injury, or
- Is necessary to investigate or prosecute an extremely serious crime (including child abuse), or
- Is in connection with a proceeding at which the offender has already presented evidence concerning confidential communications (for example, "I told my counselor . . .") (§ 2.63).

Medical Emergencies

A program may make disclosures to public or private medical personnel "who have a need for information about [an offender] for the purpose of treating a condition which poses an immediate threat to the health" of the offender or any other individual. The regulations define "medical emergency" as a situation that poses an immediate threat to health and requires immediate medical intervention (§ 2.51).

The medical emergency exception only permits disclosure to medical personnel. This means that the exception cannot be used as the basis for a disclosure

to the police or other nonmedical personnel, including family members.

Whenever a disclosure is made to cope with a medical emergency, the program must document in the offender's records:

- The name and affiliation of the recipient of the information
- The name of the individual making the disclosure
- The date and time of the disclosure
- The nature of the emergency.

Crimes on Program Premises Or Against Program Personnel

When an offender has committed or threatened to commit a crime on program premises or against program personnel, the regulations permit the program to report the crime to a law enforcement agency or to seek its assistance. In such a situation, the program, without any special authorization, can disclose the circumstances of the incident, including the suspect's name, address, last known whereabouts, and status as a patient in the program (§ 2.12(c)(5)).

Sharing Information with an Agency that Provides Services to the Program

If a program routinely needs to share certain information with an outside agency that provides services to the program, it can enter into what is known as a qualified service organization agreement (QSOA).

A QSOA is a written agreement between a program and a person providing services to the program, in which that person: 1) acknowledges that in receiving, storing, processing, or otherwise dealing with any patient records from the program, he or she is fully bound by [the Federal confidentiality] regulations; and 2) promises that, if necessary, he or she will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by these regulations (§§ 2.11, 2.12(c)(4)).

A sample QSOA is provided in Exhibit 6-4. A QSOA should only be used when an agency or official outside of the program is providing a service to the program itself. An example is when laboratory analyses or data processing is performed for the program by an outside agency.

A QSOA is not a substitute for individual consent in other situations. Disclosures under a QSOA must be limited to information that is needed by others so that their program can function effectively. QSOAs may not be used between programs providing AOD services.

Internal Program Communications

The Federal regulations permit some information to be disclosed to individuals within the same program:

> The restrictions on disclosure in these regulations do not apply to communications of information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of alcohol or drug abuse if the communications are (i) within a program or (ii) between a program and an entity that has direct administrative control over that program (§ 2.12(c)(3)).

In other words, staff who have access to patient records because they work for or administratively direct the program—including full- or part-time employees and unpaid volunteers—may consult among themselves or otherwise share information if their AOD abuse work so requires (§ 2.12(c)(3)).

A question that frequently arises is whether this exception allows a program that assesses or treats offenders and that is part of a larger entity—such as a probation department or correctional facility—to share confidential information with others who are not part of the assessment or treatment unit itself. The answer to this question is among the most complicated in this area. In brief, there are circumstances where the assessment unit can share information with other units, but it is essential before such a system is set up that an expert in the area be consulted for assistance.

Reporting Child Abuse and Neglect

All 50 States and the District of Columbia have statutes requiring reporting when there is reasonable cause to believe or suspect child abuse or neglect. While many State statutes are similar, each has different rules about what kinds of conditions must be reported, who must report, and when and how reports must be made.

Most States now require not only physicians but also educators and social service workers to report child abuse. Most States require an immediate oral (usually telephone) report and many now have toll-free numbers to facilitate reporting. Half the States require that both oral and written reports be made. All States extend immunity from prosecution to persons reporting child abuse and neglect. (In other words, a person who reports child abuse or neglect cannot be brought into court.) Most States provide for penalties for failure to report.

The Federal confidentiality regulations permit

Exhibit 6-4
Qualified Service Organization Agreement

XYZ Service Center ("the Center") and the _____

_____
(Name of the program)

("the Program") hereby enter into a qualified service organization agreement, whereby the Center agrees to provide the following services:

_____
(Nature of services to be provided)

_____

_____

Furthermore, the Center:

1. Acknowledges that in receiving, storing, processing, or otherwise dealing with any information from the Program about the patients in the Program, it is fully bound by the provisions of the Federal regulations governing Confidentiality of AOD Abuse Patient Records, 42 CFR Part 2: and

2. Undertakes to resist in judicial proceedings any effort to obtain access to information pertaining to patients otherwise than as expressly provided for in the Federal confidentiality regulations, 42 CFR Part 2.

Executed this _____ day of _____, 199__.

_____ _____
President
XYZ Service Center
(Address)

_____
Program Director
(Name of Program)
(Address)

programs to comply with State laws that require the reporting of child abuse and neglect. Thus, if an offender reveals to program staff that he or she has neglected or abused children, that fact may well have to be reported to State authorities. Note, however, that this exception to the general rule prohibiting disclosure of any information about a client applies only to initial reports of child abuse or neglect. Programs may not respond to followup requests for information or even subpoenas for additional information, even if the records are sought for use in civil or criminal proceedings resulting from the program's initial report, unless the offender consents or the appropriate court issues an order under subpart E of the regulations.

Because of the variation in State laws, programs should consult an attorney familiar with State law to ensure that their reporting practices are in compliance.

Research, Audit, or Evaluation

The confidentiality regulations also permit programs to disclose patient-identifying information to researchers, auditors, and evaluators without patient consent, providing certain safeguards are met (§§ 2.52, 2.53).[10]

Other Rules About Offenders' Rights

Patient Notice and Access to Records

The Federal confidentiality regulations require programs to notify clients of their right to confidentiality and to give them a written summary of the regulations' requirements. The notice and summary should be handed to offenders when they begin participating in the program or soon thereafter (§ 2.22(a)). The regulations also contain a sample notice.

Programs can use their own judgement to decide when to permit offenders to view or obtain copies of their records, unless State law grants patients the right of access to records. The Federal regulations do not require programs to obtain written consent from patients before permitting them to see their own records.

The Federal regulations require programs to keep written records in a secure room, a locked file cabinet, a safe, or other similar container.[11] The program should establish written procedures that regulate access to and use of offenders' records. Either the program director or a single staff person should be designated to process inquiries and requests for information (§ 2.16).

Endnotes

1. The legal citation for these laws and regulations is 42 U.S.C. §§ 290dd-3 and ee-3 and 42 C.F.R. Part 2.
2. Citations in the form "§ 2..." refer to specific sections of 42 C.F.R. Part 2.
3. Only offenders who have "applied for or received" services from a program are protected. If an offender has not yet been assessed or counseled by a program and has not him- or herself sought help from the program, the program is free to discuss the offender's AOD problems with others. But, from the time the offender applies for services or the program first conducts an assessment or begins to counsel the offender, the Federal regulations govern.
4. Note, however, that no information that is obtained from a program (even if the patient consents) may be used in a criminal investigation or prosecution of a patient unless a court order has been issued under the special circumstances set forth in § 2.65. 42 U.S.C. §§ 290dd-3(c), ee-3(c); 42 C.F.R. §2.12(a),(d).
5. Suppose the offender has already been sentenced and has been assessed by Program A, but is being treated by Program B. Would § 2.35(d) permit the probation department to release the assessment to Program B without a separate consent from the offender? It would, since the offender's criminal justice status would not have changed and it would be doing so "to carry out [its] official duties with regard to ... [the criminal justice status] action in connection with which the consent was given."
6. The court order exception and the exception for nonpatient-identifying disclosures are discussed below.
7. For instance, a counselor employed by an AOD program that is part of a mental health facility could phone the police or the potential target of an attack, identify herself as "a counselor at the Cherry Valley Mental Health Clinic" and explain the risk to the potential target. This would convey the vital information without identifying the offender as an AOD abuser. Counselors at freestanding AOD units cannot give the name of the program.
8. For an explanation about dealing with subpoenas and search and arrest warrants, see *Confidentiality: A Guide to the Federal Laws and Regulations*, published in 1990 by the Legal Action Center, 153 Waverly Place, New York, NY 10014.
9. However, if the information is being sought to investigate or prosecute a patient for a crime, only the program need be notified (§ 2.65). And if the information is sought to investigate or prosecute the program, no prior notice at all is required (§ 2.66).
10. For a more complete explanation of the requirements of §§ 2.52 and 2.53, see *Confidentiality: A Guide to the Federal Laws and Regulations*, published in 1990 by the Legal Action Center, 153 Waverly Place, New York, NY 10014.
11. Staff in correctional facilities may face special problems maintaining records in accordance with the regulations. However, procedures must be worked out that follow the regulations as closely as possible.

Appendix A—References and Bibliography

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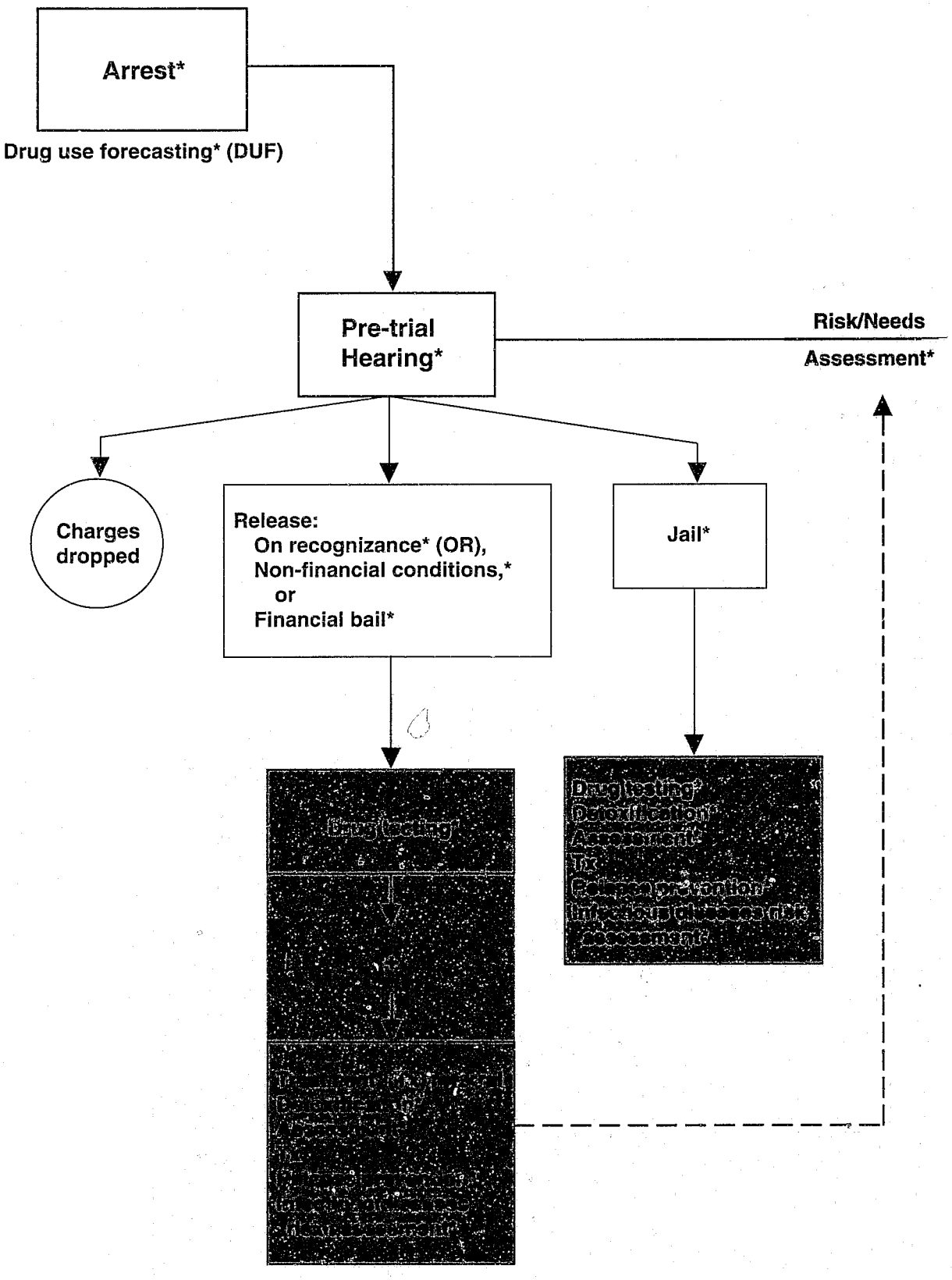
Appendix B—CSAT Criminal Justice Treatment Planning Chart


Arrest*
Drug use forecasting* (DUF)
Pre-trial Hearing*
Risk/Needs Assessment*
Charges dropped
Release:
On recognizance* (OR),
Non-financial conditions,*
or
Financial bail*
Jail*
Drug testing*
Detoxification*
Assessment*
Tx
Relapse prevention*
Infectious disease risk assessment*

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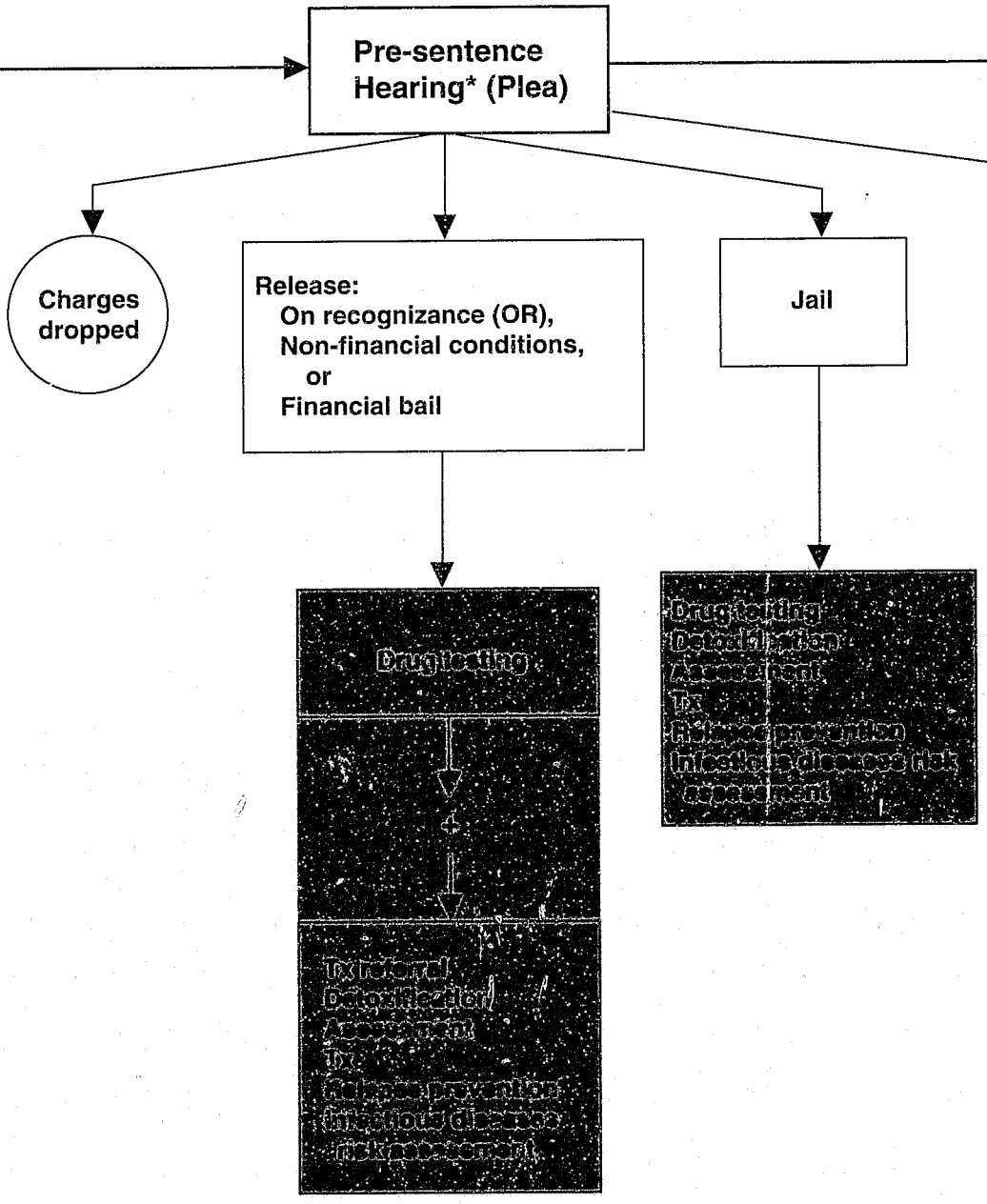

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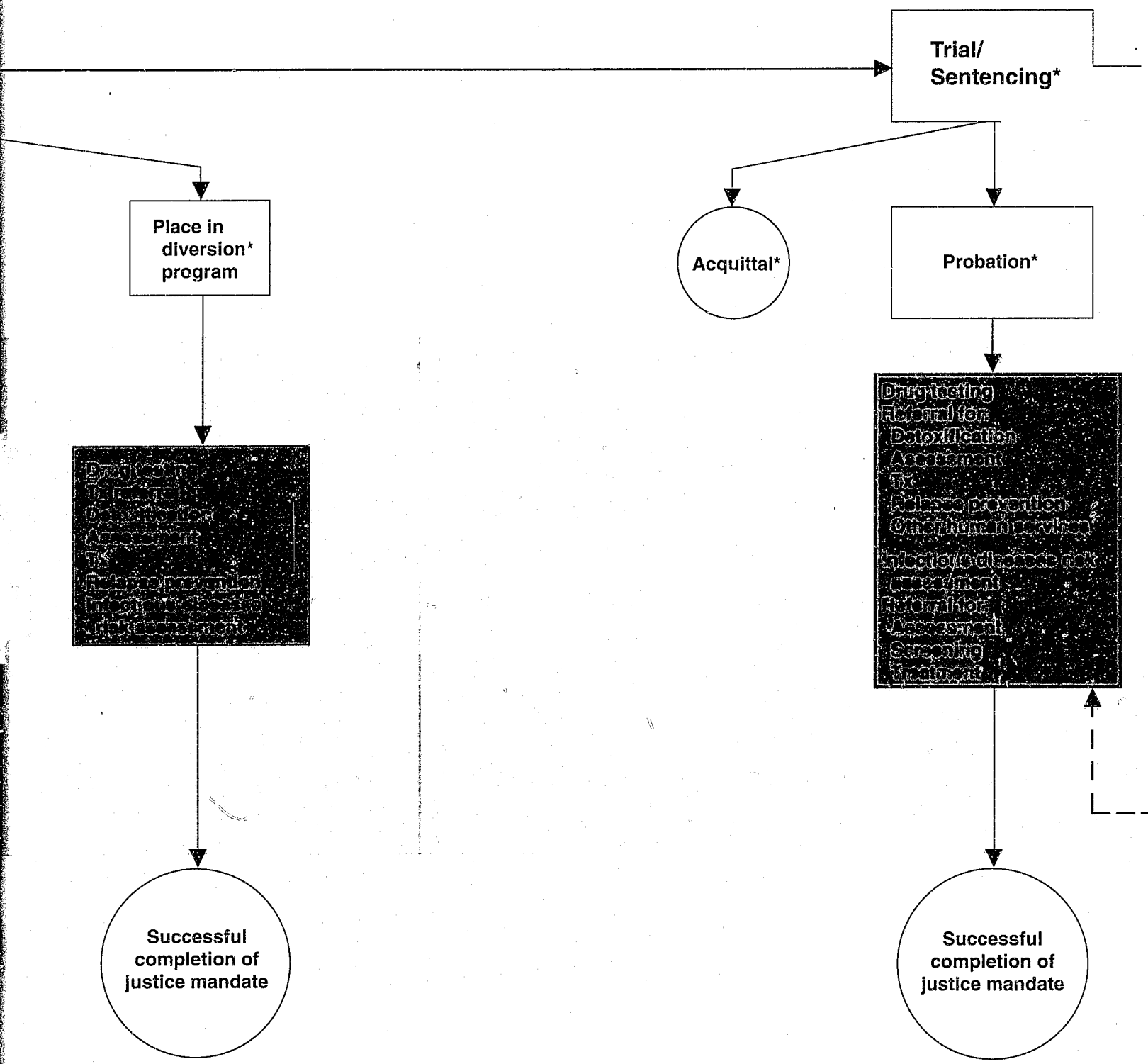
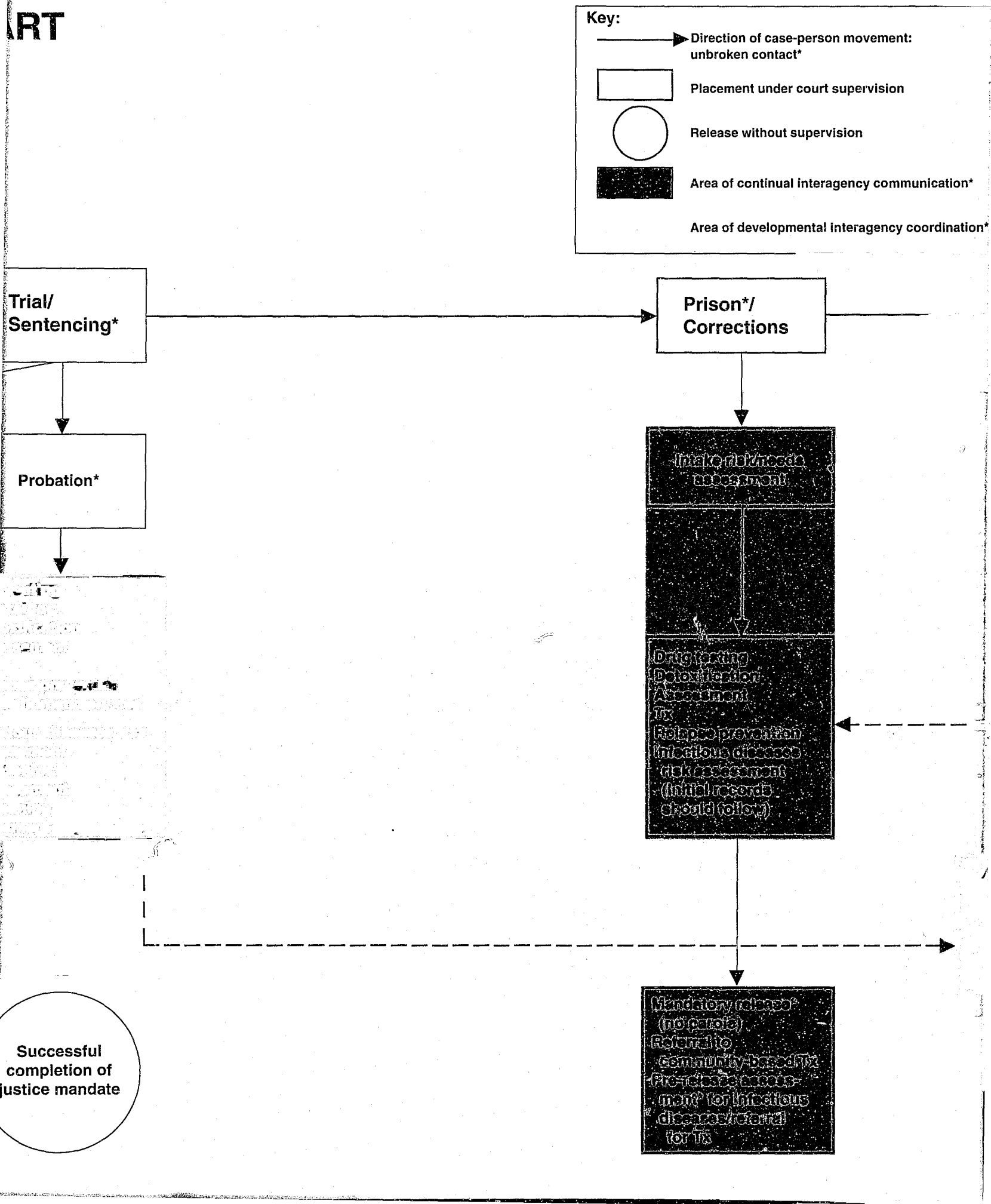
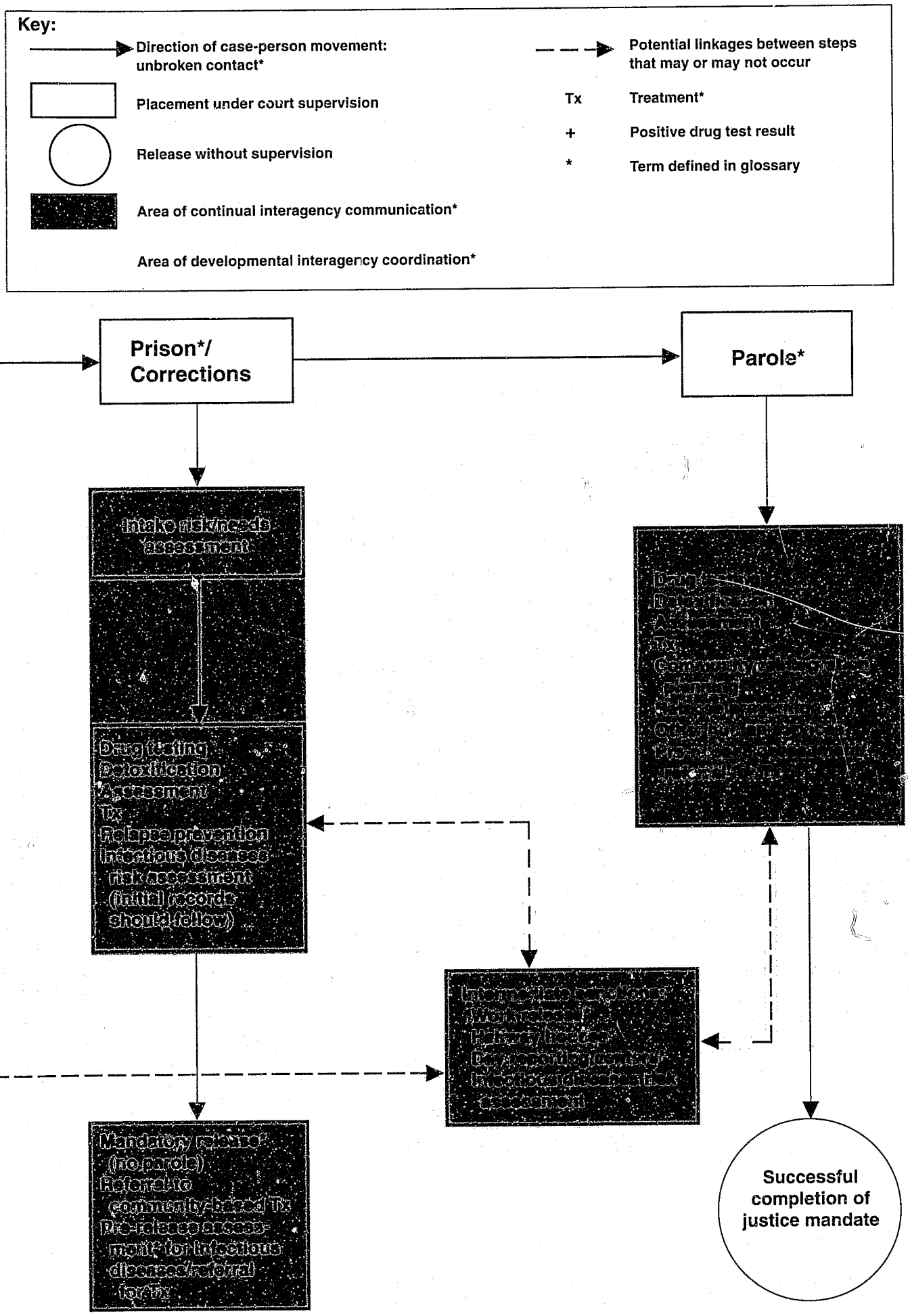
MINAL JUSTICE TREATMENT PLANNING CHART



ART


Key:
Direction of case-person movement: unbroken contact*
Placement under court supervision
Release without supervision
Area of continual interagency communication*
Area of developmental interagency coordination*
Trial/ Sentencing*
Prison*/ Corrections
Probation*
Intake risk/needs assessment
Drug testing
Detoxification
Assessment
Tx
Relapse prevention
Infectious disease risk assessment
(Initial records should follow)
Mandatory release* (no parole)
Referral to community-based Tx
Pre-release assessment* for infectious disease/referral for Tx
Successful completion of justice mandate


Key:
Direction of case-person movement: unbroken contact*
Potential linkages between steps that may or may not occur
Placement under court supervision
Tx
Treatment*
Release without supervision
+
Positive drug test result
*
Term defined in glossary
Area of continual interagency communication*
Area of developmental interagency coordination*
Prison*/ Corrections
Parole*
Intake risk/needs assessment
Drug testing
Detoxification
Assessment
Tx
Relapse prevention
Infectious disease risk assessment
(initial records should follow)
Mandatory release* (no parole)
Referral to community-based Tx
Pre-release assessment for infectious disease/referral for Tx
Successful completion of justice mandate

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

Arrest—Holding in legal custody, either at the scene of a crime or as a result of investigations. Arrest could also be the result of a complaint filed by a third party, an outstanding warrant, or a revocation of probation or parole.

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

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

Continual interagency communication—The ongoing cooperative effort among treatment personnel, justice personnel, and public health personnel necessary to successfully treat and supervise the drug-involved offender. Communication among criminal justice, treatment, and public health systems facilitates a united approach. Such an approach shows the offender that the systems are omnipresent and omnipotent, which enhances the offender's treatment.

Day reporting center—Place where offenders must report while on probation or parole to receive supervision. Day reporting centers may include educational services, vocational training, treatment, and other service deliveries.

Detoxification—Structured medical or social milieu in which the individual is monitored for withdrawal from the acute physical and psychological effects of addiction.

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

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

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

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

Financial bail—Amount of money, set by the judge, that is used to ensure the defendant's appearance at court.

Halfway house—Transitional facility where the client is involved in school, work, training, etc. The client lives onsite while either stabilizing or reentering society drugfree. The client usually receives individual counseling as well as group/family/marital therapy.

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

Infectious diseases screening/testing—Administration of screening tests that are sensitive and specific for the detection of tuberculosis, sexually transmitted diseases, HIV/AIDS, and other infectious diseases (e.g., the Mantoux (purified protein derivative) test for tuberculosis, serologies for syphilis (nontreponemal tests and treponemal confirmatory tests), and Western blot and ELISA for HIV/AIDS).

GLOSSARY

Intermediate sanctions—Community-based program providing increased surveillance, tighter controls on movement, more intense treatment for a wider assortment of maladies or deficiencies, increased offender accountability, and greater emphasis on payments to victims and/or corrections authorities.

Jail—To hold a person in lawful custody, usually while he or she is awaiting trial. In some jurisdictions, jails are used punitively for offenders serving short-term sentences or sentences to work release or weekends in jail. Jails range in size from rural jails having a dozen cells to urban jails having thousands of cells.

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

Non-financial conditions—Requirements for release set by the judge that do not include monetary payment (e.g., required participation in supporting services, such as substance abuse treatment).

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

Other human services—Supplemental services provided outside the treatment facility, such as job placement, training, food stamps, and vocational rehabilitation.

Parole—Process of being released from prison before the completion of a sentence. Parole involves supervision and other stipulations and prohibitions on certain activities imposed by a board of parole.

Pre-release assessment—Infectious diseases risk assessment recommended for all potential parolees. This information should be available to the judge, prosecutor, and other participants at the time of the pre-sentence hearing or trial/sentencing. If the individual is paroled, this information should be conveyed to the parole officer for followup and evaluation. Recommendations for referral for treatment can be made at this time.

Pre-sentence hearing—Event at which the prosecutor, defense attorney, and judge meet prior to a trial to establish parameters for the trial. A plea bargain is often negotiated at this point.

Pre-trial hearing—Appearance in court be at which bond is set or a determination is jail or release.

Prison—Secure institution in which offen after sentencing for crimes. Prisons are c mum, medium, or maximum security fa the need for internal institutional fortifica similarly classified, by severity of offen behavior, and are usually assigned to pris responding level of security.

Probation—Sentence of community-based bation includes stipulations and prohib activities and often includes fines impose the time of sentencing.

Relapse prevention—Strategy to train subs cope more effectively and to overcom triggers in their environments that may lea drug use and dependency.

Risk/needs assessment—Comprehensive re the client's social, criminal, and other hi usually includes a recommendation for s client is found guilty.

Treatment—Any intervention that may chan stance abuse treatment involves plann intervention, with the ultimate goal o continuing the substance use or abuse. treatment generally consists of specific mo to meet a client's need for structure.

Trial/sentencing—Court hearing at which a sents a case against the defendant to show guilty of a crime; the judge or jury decides tencing is the disposition of a case whe imposed.

Unbroken contact—Early, thorough, and s stance abuse treatment delivered in an un throughout the entire criminal case-handli arrest through the completion of the sente nents of the system must transfer not only also the cumulative record of what the sys and what it has done.

Work release—Alternative to total incarcer inmates are permitted to work for pay in tl nity but must return to the institution du working hours.

Pre-trial hearing—Appearance in court before a magistrate at which bond is set or a determination is made to retain in jail or release.

Prison—Secure institution in which offenders are confined after sentencing for crimes. Prisons are classified as minimum, medium, or maximum security facilities, based on the need for internal institutional fortification. Inmates are similarly classified, by severity of offense and/or other behavior, and are usually assigned to prisons having a corresponding level of security.

Probation—Sentence of community-based supervision. Probation includes stipulations and prohibitions on certain activities and often includes fines imposed by the court at the time of sentencing.

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

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

Treatment—Any intervention that may change behavior. Substance abuse treatment involves planned, therapeutic intervention, with the ultimate goal of the client discontinuing the substance use or abuse. Substance abuse treatment generally consists of specific modalities designed to meet a client's need for structure.

Trial/sentencing—Court hearing at which a prosecutor presents a case against the defendant to show that he or she is guilty of a crime; the judge or jury decides the verdict. Sentencing is the disposition of a case where penalties are imposed.

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

Work release—Alternative to total incarceration, whereby inmates are permitted to work for pay in the free community but must return to the institution during their nonworking hours.

The Center for Substance Abuse Treatmen
has developed the Criminal Justice P
Chart, which presents a simplified mod
flow of cases through a typical crimina
system. The chart illustrates the major
points in the criminal justice system w
ordinated strategies for substance abuse tr
interventions may be applied: pre-trial, j
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standing of the critical substance abuse tre

This publication was developed under
sentation and discussion at a conference
Treatment for Criminal Justice Popul
1994. Richard Bast served as the CSAT
the conference program director and CS
John Clark, M.D., Chief Medical Officer
infectious diseases and criminal justice,
Programs of the National Association fo
the development of the publication. Melo
Gerry Vigdal of the Wisconsin Departm
eral Bureau of Prisons served as advisor

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Revised edition, March 1994

Available from: National Clearinghouse fo
Rockville, MD 20852. Telephone: 1–8
301–468–2600). Order No. PH295.

The Center for Substance Abuse Treatment (CSAT) has developed the Criminal Justice Planning Chart, which presents a simplified model of the flow of cases through a typical criminal justice system. The chart illustrates the major decision points in the criminal justice system where coordinated strategies for substance abuse treatment interventions may be applied: pre-trial, jail, trial, sentencing, probation, corrections, and parole.

An understanding of the flow of the case-handling process, from arrest to release, is essential for coordination and linkage between and among the treatment and criminal justice systems. An understanding of the critical substance abuse treatment components is equally important to the development of comprehensive substance abuse treatment plans within the criminal justice system.

Some States and local jurisdictions may not use all the features suggested in the chart, whereas others may use many more decision points and options for treating offenders having addictive disorders. However, CSAT encourages States and local treatment systems to work together with criminal justice systems, adapting and using the chart as a planning and coordinating tool to develop improvements in their own substance abuse treatment services.

This publication was developed under contract 270–93–0004 from CSAT. It was prepared for presentation and discussion at a conference entitled **Creating Linkages To Improve Substance Abuse Treatment for Criminal Justice Populations** in April 1991 and revised in May 1991 and March 1994. Richard Bast served as the CSAT Government project officer, and Roberta Messalle served as the conference program director and CSAT technical coordinator. Duiona Baker, M.P.H., CSAT, and John Clark, M.D., Chief Medical Officer of the Los Angeles County Jail, were technical advisors for infectious diseases and criminal justice, respectively. Beth Weinman, Director of Criminal Justice Programs of the National Association for State Alcohol and Drug Abuse Directors, contributed to the development of the publication. Melody Heaps of Treatment Alternatives to Street Crime (TASC), Gerry Vigdal of the Wisconsin Department of Corrections, and Donald W. Murray, Jr., of the Federal Bureau of Prisons served as advisors.

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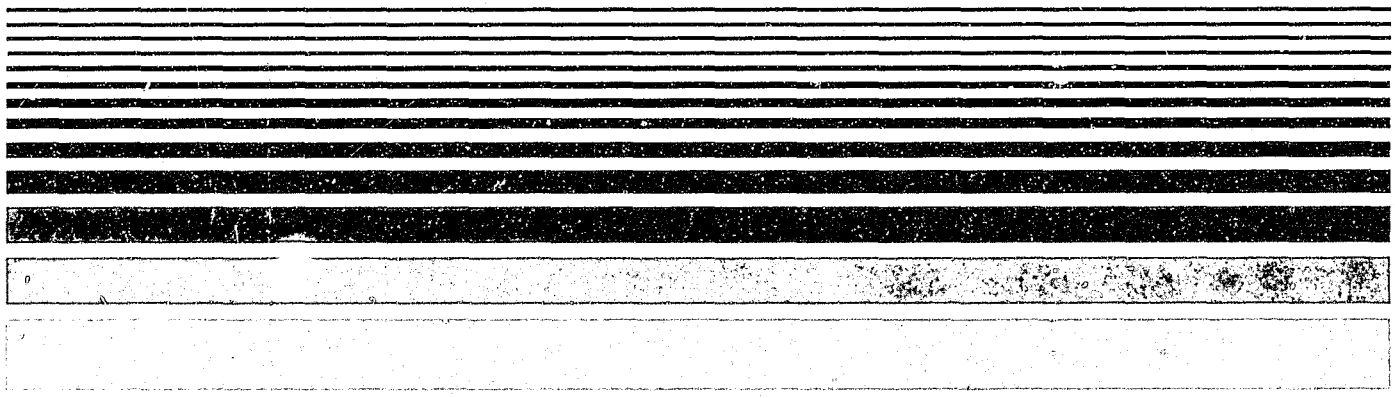
Revised edition, March 1994

Available from: National Clearinghouse for Alcohol and Drug Information (NCADI), P.O. Box 2345, Rockville, MD 20852. Telephone: 1–800–729–6686 (in the metropolitan Washington area, 301–468–2600). Order No. PH295.

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

Center for Substance Abuse Treatment

Criminal Justice Treatment Planning Chart



Appendix C—Screening and Assessment Instruments

This appendix includes several screening and assessment instruments that are readily available, in widespread use, and in the public domain. Two alcohol abuse screening instruments are included—the CAGE questionnaire and the Short Michigan Alcohol Screening Test. Two instruments designed to screen for drug abuse are included—the Substance Abuse Screening Instrument and the Offender Profile Index. The Addiction Severity Index, which can facilitate a comprehensive assessment, is also included.

A brief HIV risk assessment is included as part of the Offender Profile Index. For an assessment of HIV risks while incarcerated, the AIDS Initial Assessment Jail Supplement is reproduced here. Information on the costs for training and utilization of these instruments is also included. Additional instruments are discussed in Appendix D, Supplementary Instruments Recommended for the Assessment of Life Domains and Problem Areas of Adult Clients.

The CAGE Questionnaire

The CAGE questionnaire is a self-report screening tool for alcoholism. Among validated instruments, it is perhaps the shortest. It consists of four questions:

1. Have you felt the need to *C*ut down on your drinking?

2. Do you feel *A*nnoyed by people complaining about your drinking?

3. Do you ever feel *G*uilty about your drinking?

4. Do you ever drink an *E*ye-opener in the morning to relieve the shakes?

Two or more affirmative responses suggest that the client is a problem drinker. A discussion of the CAGE questionnaire and other alcoholism screening techniques appears in the following article: Allen, J.P., Eckardt, M.J., and Wallen, J. Screening for alcoholism: techniques and issues. *Public Health Reports* 103:586-592, 1988.

Cost: Since the CAGE is in the public domain, there is no cost for its reproduction and use. Furthermore, as a self-report screening tool, there are no interviewing or administration costs.

Short Michigan Alcohol Screening Test

The Short Michigan Alcohol Screening Test is a 13-item questionnaire that requires a 7th grade reading level, and only a few minutes to complete (see next page). It was developed from the Michigan Alcoholism Screening Test. Evaluation data indicate that it is an effective diagnostic instrument, and does not have a tendency for false positives, as does the Michigan Alcoholism Screening Test. Research demonstrates a high degree of reliability with Latino populations, but is useful with all populations.

Administration: Self-administered. All questions are to be answered with "Yes" or "No" answers only.

Scoring: Each "Yes" answer equals one (1) point.

A score of 1 or 2 indicates there is no alcohol problem. A score of 3 indicates a borderline alcohol problem. A score of 4 or more indicates an alcohol problem.

Cost: Since the Short Michigan Alcohol Screening Test is in the public domain, there is no cost for its reproduction and use. Furthermore, as a self-report screening tool, there are no interviewing or administration costs.

Substance Abuse Screening Instrument

The Substance Abuse Screening Instrument is a questionnaire designed to be used as an initial screen

Short Michigan Alcohol Screening Test

	Answer Yes or No
1. Do you feel that you are a normal drinker? (By "normal" we mean that you drink less than or as much as most other people.)	_____
2. Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking?	_____
3. Do you ever feel guilty about your drinking?	_____
4. Do friends or relatives think you are a normal drinker?	_____
5. Are you able to stop drinking when you want to?	_____
6. Have you ever attended a meeting of Alcoholics Anonymous?	_____
7. Has drinking ever created problems between you and your wife, husband, a parent, or other near relative?	_____
8. Have you ever gotten into trouble at work because of your drinking?	_____
9. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?	_____
10. Have you ever gone to anyone for help about your drinking?	_____
11. Have you ever been in a hospital because of drinking?	_____
12. Have you ever been arrested for driving under the influence of alcoholic beverages?	_____
13. Have you ever been arrested, even for a few hours, because of other drunken behavior?	_____

for substance abuse problems among people entering the criminal justice system (see next page). Although it was developed for youths, it is appropriate for other populations as well. The purpose of this screening instrument is to identify people for whom further substance abuse assessment is indicated. The Substance Abuse Screening Instrument is comprised of 15 self-report items. The instrument has been designed to be brief, and should take no more than 5 minutes to implement. The instrument is easy to administer and score, and no specialized clinical skills or lengthy training are required. The instrument is useful, since the information obtained will be immediately useful to the individual administering it.

A manual for this screening instrument is available from the National Center for Juvenile Justice, 701 Forbes Avenue, Pittsburgh, Pennsylvania 15219.

Cost: Since the Substance Abuse Screening Instrument is in the public domain, there is no cost for its reproduction and use. Furthermore, as a self-report screening tool, there are no interviewing or administration costs.

Offender Profile Index

The Offender Profile Index (OPI) (see page 61) is not a clinically oriented instrument designed to yield a comprehensive substance abuse treatment plan. Rather, it is a broad "sorting" or classification instrument, appropriate for determining which type of drug abuse treatment intervention should be used: long-term residential, short-term residential, intensive outpatient, regular outpatient, or urine monitoring only. Diagnoses and assessments for comprehensive treatment planning are best accomplished at the particular program to which the client is directed.

Administering the OPI involves a face-to-face interview that can be completed in about 30 minutes. It can be administered by any trained professional with basic interviewing skills. The assessment is essentially self-scoring, and a numerical score corresponds with a specific referral recommendation.

The OPI and its associated service recommendations are based on "stakes in conformity." Research findings have indicated that individuals with high stakes in

Substance Abuse Screening Instrument

Please Read Carefully and Circle the Appropriate Response

Have you ever done something crazy while high and had to make excuses for your behavior later? YES/NO

Have you ever felt really burnt out for a day after using drugs? _____ YES/NO

Have you ever gotten out of bed in the morning and really felt wasted? _____ YES/NO

Did you ever get high in school? _____ YES/NO

Have you gotten into a fight while you were high (including drinking)? _____ YES/NO

Did you think about getting high a lot of the time? _____ YES/NO

Have you ever thought about committing suicide when you were high? _____ YES/NO

Have you run away from home, partly because of an argument over drug use? _____ YES/NO

Did you ever try to stick to one drug after a bad experience mixing drugs? _____ YES/NO

Have you gotten into a physical fight during a family argument over drugs? _____ YES/NO

Have you ever been suspended because of something you did while high? _____ YES/NO

Have you ever had a beer or some booze to get over a hangover? _____ YES/NO

Do you usually keep a supply [of drugs] for emergencies, no matter how small? YES/NO

Have you ever smoked some pot to get over a hangover? _____ YES/NO

Have you ever felt nervous or cranky after you stopped using for a while? _____ YES/NO

Thank You for Your Cooperation

ID#: _____ Age: _____ Gender: _____ Race: _____

Results: #YES: _____ #NO: _____

Offense(s): _____

_____

Comments: _____

_____

Referred for Further Assessment? Yes _____ No _____

conformity (as measured by educational attainment, employment history, living arrangements, and arrest history) are less likely to commit crimes than persons with low stakes in conformity. Research also indicates that persons with high stakes who commit crimes are less likely to do so than recidivists or persons with low stakes and, therefore, require less supervision and fewer services than persons with low stakes in conformity.

The specific background data and stake-in-conformity indices included in the OPI are:

1. Socio-demographic and Offense Characteristics
2. Drug Severity Index
3. Family/Support Sub-Index
4. Educational Stake Sub-Index
5. School Stake Sub-Index
6. Work Stake Sub-Index
7. Home Stake Sub-Index
8. Criminal Justice History Sub-Index
9. Psychological Stake Sub-Index
10. Treatment Stake Sub-Index
11. HIV Risk Behaviors Sub-Index

A manual on the OPI is available from the National Association of State Alcohol and Drug Abuse Directors, located at 444 North Capitol Street, Washington, D.C. 20001. The instrument and manual also appear in: Inciardi, J.A. *Drug Treatment and Criminal Justice.* Newbury Park, CA: Sage Publications, 1993.

Cost: Since the OPI is in the public domain, there is no cost for its reproduction and use. Other costs are as follows: **Training Cost:** $1,000 to $1,500 plus travel expenses for an on-site trainer. A self-training manual is reproduced in James A. Inciardi (ed.), *Drug Treatment and Criminal Justice.* Newbury Park, CA: Sage Publications, 1993. Further information on the OPI may be obtained from its developers: James A. Inciardi (302-831-6286) or Duane C. McBride (616-471-3576). **Administrative and scoring cost:** 1 hour of clinical staff time.

Addiction Severity Index

The 5th edition of the Addiction Severity Index (ASI) is a 161-item multidimensional clinical and research instrument for diagnostic evaluation and for the assessment of change in client status and treatment outcome (see page 77). It consists of two parts: 1) identifying personal and family background data, and 2) questions on current status and problems in six life areas or domains. It is based on the premise that treatment for substance abuse should address the "problems which may have contributed to and/or resulted from the chemical abuse."

The ASI is probably the most widely used standardized instrument in the field and is used for client clinical assessment and research purposes. ASI data have been published on many different samples of drug abuse clients.

A "technology transfer" package, which will include a detailed users guide, a 90-minute training videotape, and audiocassettes is currently being developed by NIDA. This will help to familiarize service providers with the use of the ASI for clinical assessment and client treatment planning.

Cost: Since the ASI is in the public domain, there is no cost for reproduction and use. Other costs are as follows: **Training cost:** $1,500 to $3,000 plus travel expenses for an on-site trainer. Self-training tapes and manuals are available from ABT Associates (301-913-0500). **Administration and scoring cost:** 1 to 1-1/2 hours of clinical staff time.

AIDS Initial Assessment Jail Supplement

The AIDS Initial Assessment Jail Supplement was developed by researchers in the Comprehensive Drug Research Center at the University of Miami School of Medicine (see page 91). The purpose of the instrument is to elicit information on AIDS risk behaviors in which the client may have participated while incarcerated. Since the instrument does not yield a numerical score, the interviewer or clinician administering this tool must be knowledgeable of the risks for HIV infection. This is necessary in order to make the subjective decision whether a client is in need of AIDS prevention education and/or should be urged to have an AIDS test.

Cost: Since the AIDS Initial Assessment Jail Supplement is in the public domain, there is no cost for its reproduction and use. Since the instrument is self-explanatory, there are no training costs. Administration and scoring cost: 30 to 45 minutes of interviewer or clinical staff time.

OFFENDER PROFILE INDEX

CASE # _ _ _ _ _ _

CRIMINAL JUSTICE VERIFICATION

Arrests Verified: _____

Date of Verification: ____

Not Verified: _____

URINALYSIS RESULTS (PRELIMINARY):

Negative for All Drugs: ____

Positive for:

Cocaine	_____
Opiates	_____
Amphetamines	_____
THC	_____
Benzodiazepines	_____
Barbiturates	_____
Phencyclidine	_____

Date of Test: _____

Confirmed: Yes __ No __

PART I: Background Information

Jurisdiction: _____

Client's Name: _____
Last First Middle

Social Security Number: ___-___-____

Date of Birth: ___/___/___
Month Day Year

Age: ____

Please circle appropriate responses:

Sex: 1. Male 2. Female

Ethnicity:

1. White
2. Black American
3. Black/Haitian
4. Black/Other Caribbean
5. Native American
6. Asian or Pacific Islander
7. Hispanic/Mexican
8. Hispanic/Cuban
9. Hispanic/Puerto Rican
10. Hispanic/Other

Type of Client:

1. Pre-Sentencing
2. Sentencing
3. Post-Sentencing

Offenses:

1. _____
2. _____
3. _____
4. _____

UNCOOPERATIVE/DISORIENTED CLIENTS: If client refuses to cooperate or appears too disoriented to provide the information requested, the interview should be terminated and the appropriate indicator circled.

Client was:

1. Mentally Disoriented
2. Uncooperative
3. Cooperative, continue interview

_____
Interviewer's Signature

_____
Date of Interview

PART II: DRUG SEVERITY INDEX

Illegal Drugs and/or Non-Medical Use of Prescription Drugs	Age of 1st Use	Age of 1st Continued Use	CODING FREQUENCY: 3=daily 2=1/wk or more 1=less than 1/wk
A.			
1. ALCOHOL	____	____	_____
2. MARIJUANA, kif hashish, etc.	____	____	_____
B.			
3. INHALANTS, glue solvents, etc.	____	____	_____
4. HALLUCINOGENS LSD, PCP, etc.	____	____	_____
5. PILLS, downers, prescribed sedatives, tranquilizers	____	____	_____
C.			
6. PILLS, uppers, speed, crank	____	____	_____
7. AMPHETAMINES, Ice, crystals	____	____	_____
8. OPIATES, pills, Dilaudid, codeine, T's and Blues	____	____	_____
9. COCAINE, non-IV, inhalation, snorting	____	____	_____
10. CRACK, freebase	____	____	_____
11. BASUCO, coca paste	____	____	_____
D.			
12. HEROIN, (IV)	____	____	_____
13 COCAINE, (IV)	____	____	_____
14. SPEED, (IV)	____	____	_____
15. OTHER IV NARCOTICS	____	____	_____

Illegal Drugs and/or Non-Medical Use of Prescription Drugs	Age of 1st Use	Age of 1st Continued Use	CODING FREQUENCY: 3=daily 2=1/wk or more 1=less than 1/wk
16. COCAINE/HEROIN (IV) speedball	____	____	_____
17. ILLEGAL METHADONE	____	____	_____

SCORING:

6 = 0 in A - D OR 1 in A
5 - 2 in A OR 1 in B
4 = 3 in A OR 2 or 3 in only 1 drug in B
3 = 2 or 3 in TWO or more drugs in B OR 1 in C
2 = 2 or 3 in C
1 = 1 in D
0 = 2 or 3 in D

DRUG SEVERITY SCORE _____

PART III: STAKE IN CONFORMITY INDEX

A. Family/Support Stake Sub-Index

1. With whom are you currently living? ____

a.	spouse/sex partner	= 2
b.	parents/family	= 2
c.	alone/friends	= 1
d.	street/institution	= 0

2. If (a) or (b) above, how long have you been living in that arrangement? ____

1 year or longer	= 2
6 to 12 months	= 1
less than 6 months	= 0

3. Has your spouse/sex partner or any of the people with whom you are currently living EVER been incarcerated for 30 days or longer? (1) Yes (2) No ____

4. Has your spouse/sex partner or any of the people with whom you are living ever been treated for a drug or alcohol problem or gone through detox? (1) Yes (2) No ____

5. How many close friends do or did you have prior to your arrest? ____ (not scored)

6. How many of these friends have EVER been incarcerated for 30 days or longer? ____

half or more	= 0
less than half	= 1
none or almost none	= 2

7. How many of these friends have ever been treated for a drug or alcohol problem, or have gone through detox? ____

half or more	= 0
less than half	= 1
none or almost none	= 2

TOTAL COMPOSITE SCORE for questions 1, 2, 6, 7 above: ____

Family/Support Stake Sub-Index Scoring

Assign a weight of 0 for a composite score of 0 - 3
Assign a weight of 1 for a composite score of 4 - 5
Assign a weight of 2 for a composite score of 6 or greater

FAMILY/SUPPORT STAKE SCORE (circle the appropriate score): 0 1 2

B. Educational Stake Sub-Index

1. What is the highest grade in school that you completed? (If 12 years or more, proceed to scoring below) ___

2. If less than 12, did you receive a GED? 2) Yes 1) No (If client received GED, proceed to scoring below)

3. Have you attended any vocational/technical courses? (If no, proceed to scoring) 2) Yes 1) No

4. If yes, what courses or training programs did you complete?

_____

_____

Educational Stake Sub-Index Scoring

Assign a weight of 2 for: 12 or more years of schooling, or GED, or 9 or more years + completed skills training

Assign a weight of 1 for: 9 - 11 years without completed skills training

Assign a weight of 0 for: 8 years or less

EDUCATIONAL STAKE SCORE (circle the appropriate score): 0 1 2

C. **School Stake Sub-Index**

1. Are you currently attending school? 2) Yes 1) No
2. If **No,** score 0 below and go to Work Stake Sub-Index
3. If **Yes,** is schooling full- or part-time?

   If Full-time, score 2 below

   If Part-time, score 1 below

Interviewer: Obtain enrollment verification information below:

1) Not Verified 2) Inaccurate 3) Accurate

Enrollment Verification Information

Name of School: _____

Address: _____

_____

Telephone Number: _____

SCHOOL STAKE SCORE (circle the appropriate score): 0 1 2

D. Work Stake Sub-Index

1. How many weeks have you worked outside the home and/or as a homemaker (with responsibility for others) during the past 12 months? ___

   Assign a weight of 2 for 35 weeks or more
   Assign a weight of 1 for 20 - 34 weeks
   Assign a weight of 0 for less than 20 weeks ___

2. Are you currently employed outside the home and/or as a homemaker (with responsibility for others)? 2) Yes 1) No ___

3. If YES, how many hours a week do you typically work? ___

   Assign a weight of 2 for 35 or more hours/week
   Assign a weight of 1 for 15 - 34 hours/week
   Assign a weight of 0 for less than 15 hours/week ___

4. If NO, how many hours a week did you work on your last job? ___

   Assign a weight of 2 for 35 hours or more/week
   Assign a weight of 1 for 15 - 34 hours/week
   Assign a weight of 0 for less than 15 hours/week ___

INTERVIEWER: Obtain employment verification information below

Employment Verification Number

Name of Employer: _____

Address: _____

Telephone Number: _____

Supervisor's Name: _____

1) Not Verified 2) Inaccurate 3) Accurate

Work Stake Sub-Index Scoring

Sum of Scores (from questions 1 and 3 or 4) = ___

Assign a weight of 2 for a composite score of 4
Assign a weight of 1 for a composite score of 2 - 3
Assign a weight of 0 for a composite score of 0 - 1

WORK STAKE SCORE (circle the appropriate score): 0 1 2

E. Home Stake Sub-Index

1. What is your most recent residence:

   _____
   Street

   _____
   City State Zip Code

   Telephone: _____

2. Dates you resided there: From _____ to _____

3. Number of months at that residence: _____
   (If 12 months or more, proceed to question #5)

4. How many residences have you had during the past 12 months? ___

5. During the past 12 months, how much were you contributing to the rent or mortgage of the place(s) you were living?
   1) ___ none 2) ___ some 3) ___ all

   VERIFICATION

   ___ place of last residence verified as correct
   ___ dates of last residence verified as correct
   ___ place of last residence verified as incorrect
   ___ dates of last residence verified as incorrect
   ___ residence not verified

Date of residence check: _____

Name of checker: _____

Home Stake Sub-Index Scoring

Assign a weight of 0 if the client: made no contribution to the rent of mortgage during the past 12 months or had 6 or more residences, or if most recent residence was false.

Assign a weight of 1 if the client: made some contribution to the rent or mortgage during the past 12 months or had 4 - 5 residences, and most recent residence was verified as correct.

Assign a weight of 2 if the client: made the total contribution to the rent or mortgage, and had less than 4 residences, and the residence was verified as correct.

HOME STAKE SCORE (circle the appropriate score): 0 1 2

F. **Criminal Justice History Sub-Index**

1. Total arrests in last 5 years: ____
2. Total convictions in last 5 years: ____
3. Total time served (months) in last 5 years: ____

Criminal Justice History Scoring

Assign a weight of 2 if client: no more than 2 arrests and/or 45 days incarcerated in the last 5 years

Assign a weight of 1 if client: 3 to 10 arrests and/or 6 months incarcerated in the last 5 years

Assign a weight of 0 if client: 11 or more arrests and/or more than 6 months incarcerated in the last 5 years

NOTE: In scoring, time incarcerated should weigh more heavily than # of arrests.

CRIMINAL JUSTICE SCORE (circle the appropriate score): 0 1 2

G. Psychological Stake Sub-Index

1. Have you ever felt if you had acted out of control, or have others told you that you had acted out of control, at any time when you were NOT under the influence of alcohol or drugs? 1) Yes 2) No

   If "**YES,**" how many times in the last year? ____

   Score 2 if none
   Score 1 if only 1 time
   Score 0 if 2 or more times ____

2. Have you ever attempted suicide? 1) Yes 2) No

   If "**NO,**" have you ever seriously considered suicide?
   1) Yes 2) No

   Score 2 if no to both questions
   Score 1 if yes to considered
   Score O if yes to attempted ____

3. Have you ever been treated for nervous or mental problems? 1) Yes 2) No

   If "**YES,**" how many times did you receive treatment? ____
   Score 2 if never treated
   Score 1 if treated once
   Score 0 if treated 2 or more times ____

TOTAL COMPOSITE SCORE FOR QUESTIONS 1 - 3 ABOVE: ____

Psychological Stake Sub-Index Scoring

Assign a weight of 2 for a composite score of 5 - 6
Assign a weight of 1 for a composite score of 2 - 4
Assign a weight of 0 for a composite score of 0 - 1

PSYCHOLOGICAL STAKE SCORE (circle appropriate score): 0 1 2

H. Treatment Stake Sub-Index

1. How many months have you spent in drug abuse treatment during the past 5 years? ____

   Assign a weight of 2 for 12 months or more
   Assign a weight of 0 for less than 12 months

TREATMENT STAKE SCORE (circle the appropriate score): 0 1 2

I. HIV Risk Behaviors Sub-Index

1. How many sex partners have you had in the last year? ____

2. What proportion of the time were condoms used?

    1. None
    2. About a quarter
    3. About half
    4. About three-quarters
    5. Almost all

FOR MALES ONLY

3. What proportion of your sex partners were prostitutes?

    1. Almost all
    2. About three-quarters
    3. About half
    4. About a quarter
    5. None

4. What proportion of these sex partners were IV drug users?

    1. Almost all
    2. About three-quarters
    3. About half
    4. About a quarter
    5. None

5. What proportion of these sex partners were males?

    1. Almost all
    2. About three-quarters
    3. About half
    4. About a quarter
    5. None

6. If any were males, what proportion of the time did sexual contact involve anal penetration?

    1. Almost all
    2. About three-quarters
    3. About half
    4. About a quarter
    5. None

FOR FEMALES ONLY

7. What proportion of your sexual partners were IV drug users?

    1. Almost all
    2. About three-quarters
    3. About half

4. About a quarter
5. None

8. What proportion of the time did sexual intercourse involve anal penetration?

1. Almost all
2. About three-quarters
3. About half
4. About a quarter
5. None

ASK BOTH MALES AND FEMALES (IV DRUG USERS ONLY)

9. When you had your own works, how often did you share them with others?

1. More than half the time
2. About half the time
3. About a quarter of the time
4. Almost never

10. After sharing your works, how often did you clean them before using them yourself?

1. Almost never
2. About a quarter of the time
3. About half the time
4. More than half the time
5. Never shared

11. What do you usually use to clean your works?

1. Never clean them
2. Other (specify) _____
3. Water
4. Alcohol
5. Bleach

12. When you did not have your own works, how often did you clean the works you borrowed?

1. Almost never
2. About a quarter of the time
3. About half the time
4. More than half the time

13. On these occasions, how did you clean these works?

1. Never clean them
2. Other (specify) _____
3. Water
4. Alcohol
5. Bleach

INTERVIEWER: Is client at high risk for HIV infection? Yes No

PART IV: PROFILE SUMMARY

1. Drug Use Severity (from page 3) ___

2. Stake in Conformity

   A. Family/Support Score (from page 5) ___

   B. Educational Stake Score (from page 6) ___

   C. School Stake Score (from page 7) ___

   D. Work Stake Score (from page 8) ___

   E. Home Stake Score (from page 9) ___

   F. Criminal Justice Stake Score (from page 10) ___

   G. Psychological Stake Score (from page 11) ___

   H. Treatment Stake Score (from page 12) ___

TOTAL STAKE IN CONFORMITY SCORE ___

Profiles (circle one)

1.	**Long-term Residential Treatment**	0 or 1 drug severity
2.	**Short-term Residential Treatment**	2 in drug severity plus conformity stake of less than 12
3.	**Intensive Outpatient Treatment** (must have contact with client in a therapeutic session of at least one hour's duration, 3 times/week or more)	a) 3 in drug severity plus conformity stake of less than 12 OR b) 2 in drug severity plus conformity stake of at least 12
4.	**Outpatient Treatment** (must have contact with client in a therapeutic session of at least one hours duration, no less than one time/week	a) 4 in drug severity plus conformity stake of less then 12 OR b) 3 in drug severity plus conformity stake of at least 12
5.	**Urine Only**	a) 5 or 6 drug severity OR b) 4 drug severity plus conformity stake of at least 12

Is AIDS prevention/intervention indicated? Yes No

In completing the interview it has been determined that the client experiences overriding mental health problems and is not suitable for drug intervention. (Circle) Yes No

Addiction Severity Index 5th Edition

Clinical/Training Version

(Sponsored by: QuickStart Systems, Inc.)
Harold C. Urschel, III, M.D.
Jacqueline Blair
A. Thomas McLellan, Ph.D.

Remember: This is an interview, not a test.

Call QuickStart Systems at (214) 342-9020 for:
- Free copies of the Clinical Training ASI,
- Additional information about the Addiction Severity Index,
- Certified Training in the administration of the ASI,
- The Easy-ASI software, and
- Other Treatment Tracking Software.

INTRODUCING THE ASI:

Seven potential problem areas:
Medical, Employment/Support Status, Alcohol, Drug, Legal, Family/Social, and Psychological.

All clients receive this same standard interview.

All information gathered is confidential.

There are two time periods we will discuss:
1. The past 30 days
2. Lifetime Data

Patient Rating Scale:

Patient input is important. For each area, I will ask you to use this scale to let me know how bothered you have been by any problems in each section. I will also ask you how important treatment is for you for the area being discussed.

The scale is:
0 - Not at all
1 - Slightly
2 - Moderately
3 - Considerably
4 - Extremely

If you are uncomfortable giving an answer, then don't answer.
Please do not give inaccurate information!

INTERVIEWER INSTRUCTIONS:

1. Leave no blanks.
2. Make plenty of **Comments** (if another person reads this ASI, they should have a relatively complete picture of the client's perceptions of his/her problems).
3. X = Question not answered.
   N = Question not applicable.
4. Terminate interview if client misrepresents two or more sections.
5. When noting comments, please write the question number.
6. **Tutorial/Clarification Notes** are preceded with ">".

HALF TIME RULE: If a question is interested in the number of months, you can round up periods of 14 days or more to 1 month. If the question is only interested in the number of years and not months, you can round 6 months or more up to 1 year.

CONFIDENCE RATINGS:
> Last two items in each section.
> Do not over interpret.
> Denial does not warrant misrepresentation.
> Misrepresentation = overt contradiction in information.

PROBE AND MAKE PLENTY OF COMMENTS!

HOLLINGSHEAD CATEGORIES:

1. Higher execs, major professionals, owners of large businesses.
2. Business managers if medium sized businesses, lesser professions, i.e., nurses, opticians, pharmacists, social workers, teachers.
3. Administrative personnel, managers, minor professionals, owners/proprietors of small businesses, i.e., bakery, car dealership, engraving business, plumbing business, florist, decorator, actor, reporter, travel agent.
4. Clerical and sales, technicians, little businesses (bank teller, bookkeeper, clerk, draftsman, timekeeper, secretary).
5. Skilled manual - usually having had training (baker, barber, brakeman, chef, electrician, fireman, lineman, machinist, mechanic, paperhanger, painter, repairman, tailor, welder, policeman, plumber).
6. Semi-skilled (hospital aide, painter, bartender, bus driver, cutter, cook, drill press, garage guard, checker, waiter, spot welder, machine operator).
7. Unskilled (attendant, janitor, construction helper, unspecified labor, porter, including unemployed).
8. Homemaker.
9. Student, disabled, no occupation.

LIST OF COMMONLY USED DRUGS:

Alcohol:	Beer, wine, liquor
Methadone:	Dolophine, LAAM
Opiates:	Pain killers = Morphine, Dilaudid, Demerol, Percocet, Darvon, Talwin, Codeine, Tylenol 2,3,4, Syrups = Robitussin, Fentanyl
Barbiturates:	Nembutal, Seconal, Tuinol, Amytal, Pentobarbital, Secobarbital, Phenobarbital, Fiorinol
Sed/Hyp/Tranq:	Benzodiazepines = Valium, Librium, Ativan, Serax Tranxene, Dalmane, Helcion, Xanax, Miltown, Other = ChloralHydrate (Noctex), Quaaludes
Cocaine:	Cocaine Crystal, Free-Base Cocaine or "Crack, and "Rock Cocaine"
Amphetamines:	Monster, Crank, Benzedrine, Dexedrine, Ritalin, Preludin, Methamphetamine, Speed, Ice, Crystal
Cannabis:	Marijuana, Hashish
Hallucinogens:	LSD (Acid), Mescaline, Mushrooms (Psilocybin), Peyote, Green, PCP (Phencyclidine), Angel Dust, Ecstacy
Inhalants:	Nitrous Oxide, Amyl Nitrate (Whippits, Poppers), Glue, Solvents, Gasoline, Toulene, Etc.

Just note if these are used: Antidepressants,
Ulcer Meds = Zantac, Tagamet
Asthma Meds = Ventoline Inhaler, Theodur
Other Meds = Antipsychotics, Lithium

ALCOHOL/DRUG USE INSTRUCTIONS:

The following questions look at two time periods: the past 30 days and lifetime. Lifetime refers to the time prior to the last 30 days. If the client has been detained or incarcerated during the past 30 days, and this period of incarceration is less than 1 year, you would use the 30 days prior to incarceration, in answering the 30 days questions. However, if the client has been incarcerated for more than 1 year, you would only gather lifetime use information, unless the client admits to significant alcohol/drug use during incarceration. This guideline applies only to the alcohol/drugs section.

> 30 day questions only require the number of days used.
> Lifetime use is asked to determine extended periods of use.
> Regular use = 3+ times per week, 2+ day binges, or problematic irregular use in which normal activities are compromised.
> Alcohol to intoxication does not necessarily mean "drunk", use the words "felt the effects", "got a buzz", "high", etc. instead of intoxication. As a rule of thumb, 5+ drinks in one setting, or within a brief period of time defines intoxication.
> How to ask these questions?
  >How many days in the past 30 have you used....?
  >How many years in your life have you regularly used....?

Addition Severity Index, Fifth Edition

(Clinical/Training Version)

GENERAL INFORMATION

ID No.: ☐☐☐☐☐☐☐☐☐☐☐

SS No.: ☐☐☐ - ☐☐ - ☐☐☐☐

Date of Admission: ☐☐ / ☐☐ / ☐☐

Date of Interview: ☐☐ / ☐☐ / ☐☐

Time Begun: HOUR: MINUTES ☐☐ : ☐☐

Time Ended: HOUR:MINUTES ☐☐ : ☐☐

Class: 1. Intake 2. Follow-up ☐

Contact Code: 1. In person 3. Mail
2. Telephone (Intake ASI must be in person) ☐

Gender: 1. Male 2. Female ☐

Treatment Episode No.: ☐☐

Interviewer Code No.: ☐☐

Special: 1. Patient terminated
2. Patient refused 3. Patient unable to respond ☐

Name

Address 1

Address 2

City State Zip Code

1. How long have you lived at this address? (Years/Months) ☐☐ / ☐☐

2. Is this address owned by you or your family? 0-No 1-Yes ☐

3. Date of birth: (Month/Day/Year) ☐☐ / ☐☐ / ☐☐

4. Of what race do you consider yourself? ☐
   1. White (not Hisp) 5. Asian/Pacific 9. Hispanic-Other
   2. Black (not Hisp) 6. Hispanic-Mexican
   3. American Indian 7. Hispanic-Puerto Rican
   4. Alaskan Native 8. Hispanic-Cuban

5. Do you have a religious preference? ☐
   1. Protestant 3. Jewish 5. Other
   2. Catholic 4. Islamic 6. None

6. Have you been in a controlled environment in the past 30 days? ☐
   1. No 4. Medical Treatment
   2. Jail 5. Psychiatric Treatment
   3. Alcohol/Drug Treat. 6. Other: _____
   > A place, theoretically, without access to drugs/alcohol.

7. How many days? ☐☐
   > "NN" if Question No. 6 is No. Refers to total number of days detained in the past 30 days.

ADDITIONAL TEST RESULTS

_____	☐☐☐
_____	☐☐☐
_____	☐☐
_____	☐☐☐
_____	☐☐
_____	☐☐☐
_____	☐☐☐
_____	☐☐☐
_____	☐☐☐

PROBLEMS	SEVERITY PROFILE									
	0	1	2	3	4	5	6	7	8	9
MEDICAL										
EMP/SUP										
ALCOHOL										
DRUGS										
LEGAL										
FAM/SOC										
PSYCH										

GENERAL INFORMATION COMMENTS

(Include the question number with your notes)

MEDICAL STATUS

1. How many times in your life have you been hospitalized for medical problems? ☐
   > Include O.D.'s, D.T.'s. Exclude detox, alcohol/drug, and psychiatric treatment and childbirth (if no complications). Enter the number of overnight hospitalizations for medical problems.

2. How long ago was your last hospitalization for a physical problem? ☐☐ Yrs. / ☐☐ Mos.
   > If no hospitalizations in Question 1, then this should be "NN".

3. Do you have any chronic medical problems which continue to interfere with your life? 0 - No 1- Yes ☐
   If "Yes" specify in comments.
   > A chronic medical condition is a serious physical or medical condition that requires regular care, (i.e., medication, dietary restriction) preventing full advantage of their abilities.

3b. <OPTIONAL> Number of months pregnant: ☐ Mos.
   > "N" for males, "0" for not pregnant.

4. Are you taking any prescribed medication on a regular basis for a physical problem? 0 - No 1 - Yes ☐ If yes, specify in comments.
   > Medication prescribed by a MD for medical conditions; not psychiatric medicines. Include medicines prescribed whether or not the patient is currently taking them. The intent is to verify chronic medical problems.

5. Do you receive a pension for a physical disability? 0 - No 1 - Yes ☐
   > Include Workers' compensation, exclude psychiatric disability.
   If "Yes" specify in comments.

6. How many days have you experienced medical problems in the past 30 days? ☐☐
   > Do not include ailments directly caused by drugs/alcohol. Include flu, colds, etc. Include serious ailments related to drugs/alcohol, which would continue even if the patient were abstinent (e.g., cirrhosis of liver, abscesses from needles, etc.).

For Questions 7 & 8, ask the patient to use the Patient Rating scale.

7. How troubled or bothered have you been by these medical problems in the past 30 days? ☐
   > Restrict response to problem days of Question 6

8. How important to you now is treatment for these medical problems? ☐
   > Refers to the need for additional medical treatment by the patient.

INTERVIEWER SEVERITY RATING

9. How do you rate the patient's need for medical treatment? ☐
   > Refer to the patient's need for additional medical treatment.

CONFIDENCE RATINGS

Is the above information significantly distorted by:

10. Patient's misrepresentation? 0 - No 1 - Yes ☐

11. Patient's inability to understand? 0 - No 1 - Yes ☐

MEDICAL COMMENTS

(include question number with your notes)

EMPLOYMENT/SUPPORT STATUS

1. Education completed (Years/Months) ☐☐ / ☐☐
   > GED = 12 years, note in comments.
   > Include formal education only. Yrs. Mos.
2. Training or Technical education completed: ☐☐
   > Formal/organized training only. For military training, only include training that can be used in civilian life, i.e., electronics vs. artillery. Mos.
3. Do you have a profession, trade, or skill? 0-No 1-Yes ☐
   > Employable, transferrable skill acquired through training.
   If "Yes" (specify)_____
4. Do you have a valid driver's license? 0-No 1-Yes ☐
   > Valid license; not suspended/revoked.
5. Do you have an automobile available? 0-No 1-Yes ☐
   > If answer to No. 4 is "No", then No. 5 must be "No". Does not require ownership, only requires availability on a regular basis.
6. How long was your longest full time job? ☐☐ / ☐☐
   > Full time = 35+ hours weekly; does not necessarily mean most recent job. Yrs. Mos.
7. Usual (or last) occupation? ☐
   (specify) _____
   (use Hollingshead Categories Reference Sheet)
8. Does someone contribute to your support in anyway? 0-No 1-Yes ☐
   > Is patient receiving any regular support (i.e., cash, food, housing) from family/friend. Include spouse's contribution; exclude support by an institution.
9. Does this constitute the majority of your support? 0-No 1-Yes ☐
   > If No. 8 is "No", then No. 9 is "N" for N/A.
10. Usual employment pattern, past three years? ☐
    1. Full time (35+ hours)
    2. Part time (regular hours)
    3. Part time (irregular hours)
    4. Student
    5. Service
    6. Retired/Disability
    7. Unemployed
    8. In controlled environment
    > Answer should represent the majority of the last 3 years, not just the most recent selection. If there are equal times for more than one category, select that which best represents more current situation.
11. How many days were you paid for working in the past 30 days? ☐☐
    > Include "under the table" work, paid sick days and vacation.

<u>How much money did you receive from the following sources in the past 30 days?</u>

12. Employment? ☐☐☐☐☐
    > Net or "take home" pay, include any "under the table" money
13. Unemployment Compensation? ☐☐☐☐☐
14. Welfare? ☐☐☐☐☐
    : include food stamps, transportation money provided by an agency to go to and from treatment.
15. Pensions, benefits or Social Security? ☐☐☐☐☐
    > Include disability, pensions, retirement, veteran's benefits, SSI & workers' compensation.

EMPLOYMENT/SUPPORT COMMENTS

(include question number with your notes)

EMPLOYMENT/SUPPORT (cont.)

16. Mate, family, or friends? ☐☐☐☐
> Money for personal expenses, (i.e. clothing), include unreliable sources of income (eg. gambling). Record cash payments only, include windfalls (unexpected), money from loans, gambling, inheritance, tax returns, etc.)

17. Illegal? ☐☐☐☐
> Cash obtained from drug dealing, stealing, fencing stolen goods, gambling, prostitution, etc. Do not attempt to convert drugs exchanged to a dollar value.

18. How many people depend on you for the majority of their food, shelter, etc.? ☐☐
> Must be regularly depending on patient, do include alimony/child support, do not include the patient or self-supporting spouse, etc.

19. How many days have you experienced employment problems in the past 30 days? ☐☐☐☐
> Include inability to find work, if they are actively looking for work, or problems with present job in which that job is jeopardized.

For Questions 20 & 21, ask the patient to use the Patient Rating scale.

20. How troubled or bothered have you been by these employment problems in the past 30 days? ☐
> If the patient has been incarcerated or detained during the past 30 days, they cannot have employment problems. In that case an "N" response is indicated.

21. How important to you now, is counseling for these employment problems? ☐
> The patient's ratings in Questions 20 & 21 refer to Question 19. Stress help in finding or preparing for a job, not giving them a job.

INTERVIEWER SEVERITY RATING

22. How would you rate the patient's need for employment counseling? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

23. Patient's misrepresentation? 0-No 1-Yes ☐

24. Patient's inability to understand? 0-No 1-Yes ☐

EMPLOYMENT/SUPPORT COMMENTS

(Include question number with your notes)

DRUG/ALCOHOL USE

Route of Administration Types:
1. Oral 2. Nasal 3. Smoking 4. Non-Iv injection 5. IV
Note the usual or most recent route. For more than one route, choose the most severe. The routes are listed from least severe to most severe.

		Past 30 Days	Lifetime	Route of Admin
01	Alcohol (any use at all)			
02	Alcohol (to intoxication)			
03	Heroin			
04	Methadone			
05	Other Opiates/Analgesics			
06	Barbiturates			
07	Sedatives/Hypnotics/ Tranquilizers			
08	Cocaine			
09	Amphetamines			
10	Cannabis			
11	Hallucinogens			
12	Inhalants			
13	More than 1 substance per day (including alcohol)			

14. According to the interviewer, which substance is the major problem? ☐☐
> Interviewer should determine the major drug of abuse. Code the number next to the drug in questions 01-12, "00" = no problem, "15" = alcohol & one or more drugs, "16" = more than one drug. Ask patient when not clear.

14b. <OPTIONAL> According to the patient, which substance is the major problem? ☐☐

15. How long was your last period of voluntary abstinence from this major substance? ☐☐ Mos.
> Last attempt of at least one month, not necessarily the longest. Periods of hospitalizaton/incarceration do not count. Periods of anatabuse, methadone, or naltrexone use during abstinence do count. Only show periods 30 days or greater.

00 = never abstinent.

16. How many months ago did this abstinence end? ☐☐ Mos.
> "NN" if question 15 = "00"
> Refers to question 15; "00" = still abstinent.

17. How many times have you had:
Alcohol DT's? ☐
Overdosed on Drugs? ☐☐

Deliurm Tremens (DT's): Occur 24-48 hours after last drink, or significant decrease in alcohol intake, shaking, severe disorientation fever, hallucinations, they usually require medical attention.
Overdoses (OD): Requires intervention by someone to recover, not simply sleeping it off, include suicide attempts by OD.

DRUG/ALCOHOL USE COMMENTS

(Include question number with your notes)

DRUG/ALCOHOL USE (cont.)

18. How many times in your life have you been treated for: Alcohol abuse? ☐☐
    Drug abuse? ☐☐
    > Include detoxification, halfway houses, in/outpatient counseling, and AA or NA (if 3+ meetings within one month period).

19. How many of these were detox only?
    Alcohol? ☐☐
    Drugs? ☐☐
    > If question 18 = "00", then question 19 = "NN"

20. How much money would you say you spent during the past 30 days on:
    Alcohol? ☐☐☐☐
    Drugs? ☐☐☐☐
    > Only count actual money spent. What is the financial burden caused by drugs/alcohol?

21. How many days have you been treated as an outpatient for alcohol or drugs in the past 30 days? (include AA/NA) ☐☐

21b. <OPTIONAL> How many days have you been treated as an in-patient for alcohol or drugs in the past 30 days? ☐☐

22. How many days in the past 30 have you experienced: Alcohol problems? ☐☐
    Drug problems? ☐☐
    > Include only: Craving, withdrawal symptoms, disturbing effects of use, or wanting to stop and being unable to.

<u>For questions 23 & 24, ask the patient to use the Patient Rating scale. The Patient is rating the need for additional substance abuse treatment.</u>

23. How troubled or bothered have you been in the past 30 days by these:
    Alcohol problems? ☐
    Drug problems? ☐

24. How important to you now is treatment for these: Alcohol problems? ☐
    Drug problems? ☐

INTERVIEWER RATING

25. How would you rate the patient's need for treatment: Alcohol problems? ☐
    Drug problems? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

26. Patient's misrepresentation? 0-No 1-Yes ☐

27. Patient's inability to understand? 0-No 1-Yes ☐

DRUG/ALCOHOL USE COMMENTS

(include question number with your notes)

LEGAL STATUS

1. Was this admission prompted or suggested by the criminal justice system? 0 - No 1 -Yes
   > judge, probation/parole officer, etc.

2. Are you on parole or probation? 0 - No 1 -Yes
   > Note duration and level in comments.

3. How many times in your life have you been arrested and charged with the following:

03 Shoplift./Vandal.		10 Assault	
04 Parole/Probation		11 Arson	
05 Drug Charges		12 Rape	
06 Forgery		13 Homicide/Mansl.	
07 Weapons Offense		14a Prostitution	
0 8 Burglary/Larceny/B&E		14b Contempt of Court	
08 Robbery		14c Other: _____	

> Include total number of counts, not just convictions. Do not include juvenile (pre-age 18) crimes, unless they were charged as an adult. Include formal charges only.

15. How many of these charges resulted in convictions?
    > If 03-14 = "00", then question 15 = "NN".
    > Do not include misdemeanor offenses in questions 16-18 below.
    > Convictions include fines, probation, incarcerations, suspended sentences, and guilty pleas.

How many times in your life have you been charged with the following:

16. Disorderly conduct, vagrancy, public intoxication?

17. Driving while intoxicated?

18. Major driving violations?
    > Moving violations: speeding, reckless driving, no license, etc.

19. How many months were you incarcerated in your life? Mos.
    > If incarcerated 2 weeks or more, round this up to 1 month. List total number of months incarcerated.

20. How long was your last incarceration? Mos.
    > Enter "NN" if never incarcerated.

21. What was it for?
    > Use code 03-14, 16-18. If multiple charges, use most severe code. Enter "NN" if never incarcerated.

22. Are you presently awaiting charges, trial, or sentence? 0 - No 1 - Yes

23. What for?
    > Refers to Q# 22. If more than one, choose most severe. Don't include civil cases, unless a criminal offense is involved.

24. How many days in the past 30, were you detained or incarcerated?
    > Include being arrested and released on the same day.

LEGAL COMMENTS

(Include question number with your notes)

LEGAL STATUS (cont.)

25. How many days in the past 30, have you engaged in illegal activities for profit? ☐☐
> Exclude simple drug possession. Include drug dealing, prostitution, selling stolen goods, etc. May be cross checked with Question 17 under Employment/Family Support Section.

For questions 26 & 27, ask the patient to use the Patient Rating scale.

26. How serious do you feel your present legal problems are? > exclude civil problems ☐

27. How important to you now is counseling or referral for these legal problems? ☐
> Patient is rating a need for additional referral to legal counsel for defense against criminal charges.

INTERVIEWER SEVERITY RATING

28. How would you rate the patient's need for legal services or counseling? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

29. Patient's misrepresentation? 0 - No 1- Yes ☐

30. Patient's inability to understand? 0 - No 1- Yes ☐

LEGAL COMMENTS

(Include question number with your notes)

FAMILY HISTORY

Have any of your blood-related relatives had what you would call a significant drinking, drug use, or psychiatric problem. One that did or should have led to treatment?

Mother's Side	Alcohol	Drug	Psych.	Father's Side	Alcohol	Drug	Psych.	Siblings	Alcohol	Drug	Psych.
Grandmother	☐	☐	☐	Grandmother	☐	☐	☐	Brother 1	☐	☐	☐
Grandfather	☐	☐	☐	Grandfather	☐	☐	☐	Brother 2	☐	☐	☐
Mother	☐	☐	☐	Father	☐	☐	☐	Sister 1	☐	☐	☐
Aunt	☐	☐	☐	Aunt	☐	☐	☐	Sister 2	☐	☐	☐
Uncle	☐	☐	☐	Uncle	☐	☐	☐				

0 = Clearly No for all relatives in that category
1 = Clearly Yes for all relatives in that category
X = Uncertain or don't know
N = Never was a relative

> In cases where there is more than one person for a category, report the most severe. Accept the patient's judgement on these questions.

FAMILY HISTORY COMMENTS

FAMILY/SOCIAL RELATIONSHIPS

1. Marital Status
   1-Married 3-Widowed 4-Divorced
   2-Remarried 4-Separated 6-Never Married
   > Common-law marriage = "1". Specify in comments.

2. How long have you been in this marital status (Q #1)? ☐☐ / ☐☐ Yrs. Mos.
   > If never married, then since age 18.

3. Are you satisfied with this situation? 0-No 1-Indifferent 2-Yes
   > Satisfied = generally liking the situation.
   Refers to Questions 1 & 2.

4. Usual living arrangements (past 3 years):
   1-With sexual partner & children
   2-With sexual partner alone
   3-With children alone
   4-With parents
   5-With family
   6-With friends
   7-Alone
   8-Controlled Environ.
   9-No stable arrangement
   > Choose arrangements most representative of the past 3 years. If there is an even split in time between these arrangements, choose the most recent arrangement.

5. How long have you lived in these arrangements? ☐☐ / ☐☐ Yrs. Mos.
   > If with parents or family, since age 18.
   > Code years and months living in arrangements from Question 4.

6. Are you satisfied with these arrangements? 0-No 1-Indifferent 2-Yes
   > If with parents or family, since age 18.
   > Code years and months living in arrangements from Question 4.

Do you live with anyone who:

6a. Has a current alcohol problem? 0-No 1-Yes

6b. Uses non-prescribed drugs? 0-No 1-Yes

7. With whom do you spend most of your free time? 1-Family 2-Friends 3-Alone
   > If a girlfriend/boyfriend is considered as a family by patient, then they must refer to them as family throughout this section, not a friend. Family is not to be referred to as "friend".

8. Are you satisfied with spending your free time this way? 0-No 1-Indifferent 2-Yes
   > A satisfied response must indicate that the person generally likes the situation. Referring to Question 7.

9. How many close friends do you have?
   > Stress that you mean close. Exclude family members. These are "reciprocal" relationships or mutually supportive relationships.

9A. Would you say you have had a close reciprocal relationship with any of the following people:

Mother	☐	Sexual Partner/Spouse	☐
Father	☐	Children	☐
Brothers/Sisters	☐	Friends	☐

0 = Clearly No for all in class, X = Uncertain or Unknown,
1 = Clearly Yes for any in class, N = Never was a relative.

> By reciprocal, you mean "that you would do anything you could to help them out and vice versa".

FAMILY/SOCIAL COMMENTS

(Include question number with your notes)

FAMILY/SOCIAL (cont.)

Have you had significant periods in which you have experienced serious problems getting along with:

	0 - No 1 - Yes	Past 30 days	In Your Life
10. Mother		☐	☐
11. Father		☐	☐
12. Brother/Sister		☐	☐
13. Sexual Partner/Spouse		☐	☐
14. Children		☐	☐
15. Other Significant Family (specify)_____		☐	☐
16. Close Friends		☐	☐
17. Neighbors		☐	☐
18. Co-workers		☐	☐

"Serious problems" mean those that endangered the relationship. A "problem" requires contact of some sort, either by telephone or in person.

Did any of these people (Question 10 - 18) abuse you?

	0 - No 1 - Yes	Past 30 days	In Your Life
18a. Emotionally? > Made you feel bad through harsh words.		☐	☐
18b. Physically? > Caused you physical harm.		☐	☐
18c. Sexually? > Forced sexual advances/acts.		☐	☐

How many days in the past 30 have you had serious conflicts:

19a. With your family? ☐☐

19b. With other people (excluding family)? ☐☐

For Questions 20-23, ask the patient to use the Patient Rating scale.

How troubled or bothered have you been in the past 30 days by:

20. Family problems ☐

21. Social problems ☐

How important to you now is treatment or counseling for these:

22. Family problems ☐
> Patient is rating his family's need for counseling for family problems, not whether they would be willing to attend.

23. Social problems ☐
> Exclude patient's need to seek treatment for such social problems as loneliness, inability to socialize, and dissatisfaction with friends. Patient rating should refer to dissatisfaction, conflicts, or other serious problems. Exclude problems that would be eliminated if patient had no substance abuse.

INTERVIEWER SEVERITY RATING

24. How would you rate the patient's need for family and/or social counseling? ☐

CONFIDENCE RATING

Is the above information significantly distorted by:

25. Patient's misrepresentation? 0-No 1-Yes ☐

26. Patient's inability to understand? 0-No 1-Yes ☐

FAMILY/SOCIAL COMMENTS

(Include question number with your notes)

PSYCHOLOGICAL STATUS

1. How many times have you been treated for any psychological or emotional problems:
   In a Hospital or inpatient setting? ☐☐
   Outpatient/private patient? ☐☐
   > Do not include substance abuse, employment, or family counseling. Treatment episode = a series of more or less continuous visits or treatment days, not the number of visits or treatment days.
   > Enter diagnosis in comments if known.

2. Do you receive a pension for a psychiatric disability? 0-No 1-Yes ☐

Have you had a significant period of time (that was not a direct result of alcohol/drug use) in which you have:

	0-No 1-Yes	Past 30 Days	Lifetime
3. Experienced serious depression-sadness, hopelessness, loss of interest, difficulty with daily function?		☐	☐
4. Experienced serious anxiety/ tension-uptight, unreasonably worried, inability to feel relaxed?		☐	☐
5. Experienced hallucinations-saw things or heard voices that were not there?		☐	☐
6. Experienced trouble understanding, concentrating, or remembering?		☐	☐
7. Experienced trouble controlling violent behavior including episodes of rage, or violence? > Patient can be under the influence of alcohol/drugs.		☐	☐
8. Experienced serious thoughts of suicide? > Patient seriously considered a plan for taking his/her life.		☐	☐
9. Attempted suicide? > Include actual suicidal gestures or attempts.		☐	☐
10. Been prescribed medication for any psychological or emotional problems? > Prescribed for the patient by MD. Record "Yes" if a medication was prescribed even if the patient is not taking it.		☐	☐

11. How many days in the past 30 have you experienced these psychological or emotional problems? ☐☐
    > This refers to problems noted in Questions 3-9.

For Question 12-13, ask the patient to use the Patient Rating scale.

12. How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days? ☐
    > Patient should be rating the problem days from Question 11.

13. How important to you now is treatment for these psychological or emotional problems? ☐

PSYCHOLOGICAL STATUS COMMENTS

(Include question number with your comments)

PSYCHOLOGICAL STATUS (cont.)

The following items are to be completed by the interviewer:

At the time of the interview, the patient was: 0-No 1-Yes

14. Obviously depressed/withdrawn ☐
15. Obviously hostile ☐
16. Obviously anxious/nervous ☐
17. Having trouble with reality testing, thought disorders, paranoid thinking ☐
18. Having trouble comprehending, concentrating, remembering ☐
19. Having suicidal thoughts ☐

INTERVIEWER SEVERITY RATING

20. How would you rate the patient's need for psychiatric/psychological treatment? ☐

CONFIDENCE RATING

21. Patient's misrepresentation? 0-No 1-Yes ☐
22. Patient's inability to understand? 0-No 1-Yes ☐

PSYCHOLOGICAL STATUS COMMENTS

(Include question number with your notes)

AIDS Initial Assessment Jail Supplement*

1. Have you ever committed a crime?

Skip to Q5 ←	NO	0
	YES	1
	DK/UNSURE	7
	REFUSED	8
	N/A	9

2. What was the first crime you ever committed? (RECORD CODE FROM LIST BELOW) ____ ____ DK/UNSURE 77 REFUSED 88 N/A 99

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01. SELL TO DEALERS
02. MANUFACTURE OR SMUGGLE DRUGS
03. SELL TO USERS
04. ROBBERY (INCL. DRUGS)
05. BURGLARY (B & E)
06. MOTOR VEHICLE THEFT (GRAND THEFT AUTO)
07. THEFT FROM MOTOR VEH.
08. SHOPLIFTING (INCL. FOR PERSONAL USE)
09. PROSTITUTION (FOR DRUGS OR MONEY)
10. PROCURING
11. PROSTITUTE'S THEFT FROM CLIENTS
12. CON GAME
13. PICKPOCKET
14. BAD PAPER (RX, CHECK, CREDIT CARD)
15. OTHER THEFT (INCL. DRUGS) SPECIFY _____
16. STOLEN GOODS (SELL, TRADE, OWN, OTHER)
17. UNARMED ASSAULT (WITH ANY OF THE ABOVE)
18. WEAPON (SHOW OR OTHER USE)
19. OTHER ASSAULT
20. OTHER CRIME

*The AIDS Initial Assessment Jail Supplement has been retyped for inclusion in this Treatment Improvement Protocol. Those who wish to administer the AIDS Initial Assessment Jail Supplement should obtain a copy of the original for verification. This iteration of the AIDS Initial Assessment Jail Supplement is for general reference purposes only.

INTERVIEWER: READ ACROSS CHART FOR EACH CRIME.

3. Next, I will read a list of different crimes and ask some questions about each one.

   3a. Have you ever _____?
   3b. How old were you the first time you _____?
   3c. Have you ever _____ regularly (3 or more/week) for at least a month?
   3d. How old were you when you started _____ regularly?

	3a EVER		3b AGE 1ST TIME	3c REGULARLY		3d AGE REG.
	N	Y		N	Y	
A. Sold drugs (or conducted other drug business or other activity)	0	1		0	1	
B. Robbed anyone (incl. purse snatch or drug robbery)	0	1		0	1	
C. Been a prostitute	0	1		0	1	
D. Done thefts	0	1		0	1	
E. Assaulted anyone (violence)	0	1		0	1	

4. Now, please think back to the first time you were arrested:

			DK/UNSURE	REFUSED	N/A
4a.	What was the offense? (USE CATEGORIES FROM Q.2)	___ ___	77	88	99
4b.	How old were you when first arrested?	___ ___	77	88	99

4c. What was the disposition of your case?

Never prosecuted	1
Found not guilty	2
Suspend sentence	3
Probation	4
Incarceration:	
1 year or less	5
Greater than 1 year	6
DK/UNSURE	7
Refused	8
N/A	9

		DK/UNSURE	REFUSED	N/A
5. How many times have you been arrested in your lifetime? (RECORD EXACT NUMBER OF TIMES)	___ ___	77	88	99

6. Except for the last few days, have you ever been incarcerated?

TERMINATE INTERVIEW ←	NO	0
	YES	1
	DK/UNSURE	7
	REFUSED	8
	N/A	9

		DK/UNSURE	REFUSED	N/A
7.	How old were you when you were first incarcerated? (RECORD EXACT AGE) ___ ___	77	88	99

8.	Were you incarcerated in the last 6 months?	NO	0
		YES	1
		DK/UNSURE	7
		REFUSED	8
		N/A	9

INTERVIEWER: READ ACROSS CHART FOR EACH DRUG
HAND CARD B

CODES
A=Never/None
B=Less than 4 times per month
C=About 1 time a week
D=2-6 times a week
E=About 1 time a day
F=2-3 times a day, almost every day
G=4 or more times a day, almost every day
7=DK/UNSURE
8=REFUSED
9=N/A

9. Next, I will ask some questions about the time when you were incarcerated and your use of drugs.

9a. Have you ever injected _____ while incarcerated?

INTERVIEWER: IF NOT INCARCERATED IN LAST 6 MONTHS, DO NOT ASK 9b OR 9c. TERMINATE INTERVIEW AFTER ALL 9a's ARE ASKED.

9b. How often have you injected _____ over the past 6 months when you were incarcerated?

9c. How often have you injected _____ over the past 5 years when you were incarcerated?

		EVER		FREQ. 6 MO.	FREQ. 5 yr.
		N	Y		
A	Cocaine by itself	0	1		
B	Amphetamine/Prescription stimulant by itself	0	1		
C	Heroin by itself	0	1		
D	Heroin and cocaine mixed together	0	1		
E	Nonprescription methadone	0	1		
F	Other opiates or narcotics	0	1		
G	Barbiturates	0	1		
H	Tranquilizers	0	1		
I	PCP	0	1		
J	Hallucinogens/Psychedelics: MDA	0	1		
K	Nitrites and poppers	0	1		
L	Other drugs (Specify: _____ _____)	0	1		
M	Other drugs in combination (Specify: _____ _____)	0	1		
		0			

HAND CARD A
ENTER CODE FROM BOX

CODES
A=Always
B=More than half the time
C=About half the time
D=Less than half the time
E=Never
7=DK/UNSURE
8=REFUSED
9=N/A

		Last 6 Mo.	Last 5 Yrs.
10.	Still thinking about the time you were incarcerated, how often did you have your own works?	____	____
11.	How often did you share your works with someone else?	____	____
12.	How often did you clean your works before you used them yourself?	____	____
13.	When you cleaned your works, how often did you use any of the following methods?		
	ENTER CODE FROM BOX		
A.	Used bleach or clorox and rinsed with water?	____	____
B.	Used alcohol and rinsed with water?	____	____
C.	Boiled in water?	____	____
D.	Rinsed in water only?	____	____
E.	Used some other method I have not mentioned? (Specify _____)	____	____

14. Did you borrow your works?

NO	0
YES	1
DK/UNSURE	7
REFUSED	8
N/A	9

14a. How often did you clean works that you borrowed?

Last 5 Yrs. _____
Last 6 Mos. _____

HAND CARD A
ENTER CODE FROM BOX

CODES
A=Always
B=More than half the time
C=About half the time
D=Less than half the time
E=Never
7=DK/UNSURE
8=REFUSED
9=N/A

15. When you cleaned the works that you borrowed, how often did you use any of the following methods to clean the works before you used them?

ENTER CODE FROM BOX		Last 6 Mo.	Last 5 Yrs.
A.	Used bleach or clorox and rinsed with water?	____	____
B.	Used alcohol and rinsed with water?	____	____
C.	Boiled in water?	____	____
D.	Rinsed in water only?	____	____
E.	Used some other method I have not mentioned? (Specify _____)	____	____

16. Next, I will ask some questions about your sexual activities, while you were incarcerated. During the time you were incarcerated in the last 6 months, how many people did you have sex with?

	DK/UNSURE	REFUSED	N/A
___ ___ ___	777	888	999

(RECORD NUMBER)

IF MORE THAN ONE, DK, OR REFUSED, SKIP TO Q.19

ASK IF ONLY ONE PARTNER:

17. Is your sex partner

TERMINATE INTERVIEW ←	OR	Male?	1
		Female?	2
		REFUSED	8
		N/A	9

18. Still thinking about the time you were incarcerated in the last 6 months, please tell me how often you've done each kind of sex.

INTERVIEWER:
HAND CARD B OR READ ENTER CODE FROM BOX

CODES
A=Never/none
B=Less than 4 times per month
C=About 1 time a week
D=2-6 times a week
E=About 1 time a day
F=2-3 times a day, almost every day
G=4 or more times a day, almost every day
7=DK/UNSURE
8=REFUSED
9=N/A

(WATCH SKIP PATTERNS CLOSELY)

	With a Condom?	Without a Condom?
18a. ASK ONLY MALE RESPONDENT WITH MALE PARTNERS	A	B
	9	9
CIRCLE 9 IF COLUMN "a or b" IS NOT APPLICABLE		
ORAL (1) Your penis in your partner's mouth	____	____
ANAL (2) Your penis in your partner's anus	____	____

FOR MORE THAN ONE PARTNER ONLY

19a. How many of these partners were female?

	DK/UNSURE	REFUSED	N/A
___ ___ ___	777	888	999
___ ___ ___	777	888	999

IF NO MALE PARTNERS, TERMINATE INTERVIEW

20. Please tell me how often you've done each kind of sex during the last 6 months while you were incarcerated.

INTERVIEWER:
HAND CARD B OR READ CODES FROM BOX
(WATCH SKIP PATTERNS CLOSELY)
20a. ASK ONLY MALE RESPONDENT WITH MALE PARTNERS!

CODES
A=Never/none
B=Less than 4 times per month
C=About 1 time a week
D=2-6 times a week
E=About 1 time a day
F=2-3 times a day, almost every day
G=4 or more times a day, almost every day
7=DK/UNSURE
8=REFUSED
9=N/A

	With a Condom?	Without a Condom?
	A	B
CIRCLE 9 IF COLUMN "a or b" IS NOT APPLICABLE	9	9
ORAL (1) Your penis in your partner's mouth	___	___
ANAL (2) Your penis in your partner's anus	___	___

Appendix D—Supplementary Instruments Recommended for the Assessment of Life Domains and Problem Areas of Adult Clients[1]

DOMAIN/PROBLEM AREA	ADULT ASSESSMENT INSTRUMENTS
1. SUBSTANCE USE/ABUSE	*The Michigan Alcoholism Screen Test (MAST)* Selzer, M.L. (1971); Zung, B.J. (1982) *The Drug Abuse Screening Test (DAST)* Skinner, H.A. (1982) *Manson Evaluation (ME) Revised* Manson, M.P., and Huba, G.J. (1987) *Chemical Dependency Assessment Profile (CDAP)* Harrell et al. (1991) *The Structured Clinical Interview for Diagnosis (SCID)* (for DSM-III-R diagnoses of substance abuse and dependence) Spitzer, R.L., et al. (1990) *Quantitative Cocaine Inventory* Gawin, F. (1984)
2. MEDICAL/PHYSICAL HEALTH (STATUS AND PROBLEMS)	*General Health Rating Index (GHRI)* Davis, A.R., and Ware, J.E., Jr. (1976)
3. ACADEMIC SKILLS	*The Wide Range Achievement Test (WRAT)* Jastak, S.F., and Wilkinson, G.S. (1984)
4. EMPLOYMENT	*Index of Job Satisfaction* Brayfield, A.H., and Rothe, H.F. (1951)
5. SOCIAL/LIFE STYLE	*Social Life Feelings Scale (SLFS)* Schuessler, K.F. (1982) *Social Intelligence Test* Moss, F.A., et al. (1990)

[1]This appendix is reprinted from *Assessment Instruments for Drug-Abusing Adolescents and Adults*, published by the National Institute on Drug Abuse. The NIDA manual is available through the National Clearinghouse for Alcohol and Drugs Information (NCADI). Call 1-800-729-6686 for information.

DOMAIN/PROBLEM AREA	ADULT ASSESSMENT INSTRUMENTS
6. FAMILY AND MARITAL RELATIONSHIPS	*Family Environment Scale (FES)* Moos, R.H., and Moos, B.S. (1981) *Family Assessment Measure (FAM)* Skinner, H.A., et al. (1983) *Self-Report Family Inventory (SRF) of the Family Satisfaction Scale* Olson, D.H., et al. (1982) *Family Crisis-Oriented Personal Evaluation Scales (F-COPES)* McCubbin, H., et al. (1982) *The ENRICH Inventory* Fournier, D.G., et al. (1983) *The ENRICH Inventory* Fournier, D.G., et al. (1983) *Dyadic Adjustment Scale (DAS)* Spanier, G.B. (1976)
7. PSYCHOLOGICAL/ PSYCHIATRIC PROBLEMS (MENTAL HEALTH STATUS, DIAGNOSIS)	*Symptom Check List (SCL-90-R)* Derogatis, L.R., et al. (1976) *Maudsley Neuroticism Scale* Eysenck, H.J. (1959) *Beck Depression Inventory (BDI)* Beck, A.T., and Ward, J. (1972) *IPAT Depression Scale* Krug, S.E., and Laughlin, J.E. (1976) *Structured Clinical Interview for DSM-III-R (SCID)* Spitzer, R.L., et al. (1990) *The Mini-SCID* Spitzer, R.L., et al. (1992)
8. ILLEGAL BEHAVIOR	*Law Encounter Severity Scale (LESS)* Witherspoon, A.D., et al. (1973); Jenkins, W.O., et al. (1974)

1. SUBSTANCE ABUSE ASSESSMENT, DIAGNOSIS, AND RELATED PROBLEMS

Michigan Alcoholism Screening Test (MAST) (Selzer, 1971). The MAST is a relatively simple, inexpensive, and widely used alcoholism screening instrument that was designed principally to provide a quantifiable, structured interview instrument for the detection of alcoholism. It has been widely used with many different subject groups. These include alcoholics, persons convicted of driving while intoxicated, other social or problem drinkers, drug abusers, psychiatric patients, and general medical patients. It consists of 25 face-valid questions that require a simple "yes" or "no" answer, which can be rapidly administered.

The original normative sample, used by Selzer (1971) to develop a scoring system with a cut-off score for diagnosing the subject as having an alcohol problem, consisted of 1) 41 white males admitted to the hospital for alcoholism; 2) 67 white male blue-collar employees; and 3) 36 white males visiting an allergy clinic. The age range was 19 to 73 years. The convergent validity of the MAST was assessed originally by searching the records of legal, social, and medical agencies and reviewing subjects' driving and criminal records. In the original study by Selzer (1971), of 128 diagnosed as problem drinkers, the MAST test missed only two. But Rounsaville and associates (1983) later reported that one-fourth of a group identified as alcohol dependent by the Research Diagnostic Criteria (RDC) indicated that they had no alcohol-related problems on the MAST. The accuracy of the screening of alcoholics by MAST has been found to be only "moderately satisfactory," according to Hedlund and Vieweg (1984). In a validation study, (Moore 1972), of 400 adult psychiatric inpatients, 78 percent agreement was found between the MAST and the psychiatrists' opinions on whether the patient was a "problem drinker" or "alcoholic." Its internal consistency and test-retest reliability appear to be satisfactory. Reported alpha coefficients from nine different studies ranged from .83 to .95. Zung (1982) reported test-retest reliability coefficients of .97 for 1-day retest interval, .86 for 2-day interval, and .85 for 3-day interval, when using a psychiatric population (N = 120). Skinner and Sheu (1982) obtained a test-retest reliability coefficient of .84 for an average 4.8 month retest interval, with a sample of 91 psychiatric patients. The time required to administer is approximately 7 minutes.

Test items are available from the source listed below (either without cost or at nominal cost).

Access:

Melvin L. Selzer, M.D.
6967 Paseo Laredo
La Jolla, CA 92037
(619) 299-4043

The Drug Abuse Screening Test (DAST) (Harvey A. Skinner, Ph.D.).

Introduction/Purpose:

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

Type of Assessment:

This 20-item instrument may be given in either a self-report or in a structured interview format; a "yes" or "no" response is requested from each of 20 questions. It is constructed similarly to the earlier Michigan Alcoholism Screening Test (MAST), and the DAST items tend to parallel those of the MAST. The DAST apparently has sufficient independence from the MAST, since the correlation of the scores derived from the two instruments, administered to a sample of 501 substance abusers, was only .19. The currently recommended 20-item version of the DAST was found to correlate almost perfectly (r=.99) with the original 28-item version.

Life Areas and Problems Assessed:

The DAST obtains no information on alcohol use/abuse, or problems related to alcohol use. It obtains no information on the various types of drugs used, or on the frequency or duration of the drug use. There is a question regarding multiple drug use, and some of the types of problems caused by drug use/abuse in the following life areas are surveyed: marital-family relationships, social relationships, employment, legal, and physical (medical symptoms and conditions). A brief examination of the individual item responses indicates the specific life problem areas.

Reading Level:

Sixth grade, minimum, for use of the self-report form of the DAST.

Credentials/Training:

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

Completion Time:	5 minutes.
Scoring Procedures:	A factor analysis of the 20 items has indicated that the DAST is essentially a unidimensional scale. Accordingly, it is planned to yield only one total or summary score ranging from 0 to 20, which is computed by summing all items that are endorsed in the direction of increased drug problems. Only two items are keyed for a "No" response: "Can you get through the week without using drugs?" and "Are you always able to stop using drugs when you want to?" A DAST score of six or above is suggested for case finding purposes, since most of the clients in the normative sample score six or greater. It is also suggested that a score of 16 or greater be considered to indicate a very severe abuse or a dependency condition.
Normative Information:	A normative sample consisted of 501 patients, representative of those applying for treatment in Toronto, Canada. The sample was 52 percent male, 48 percent female. The mean age was 34.7 years (S.D. = 10.9). While 45 percent graduated high school, 9 percent had a college degree, and 59 percent were unemployed. Fifty-six (56) percent had a DSM-III alcohol disorder, 36 percent had a DSM-III drug disorder, and some had both.
Psychometrics:	An internal consistency coefficient of .92 was obtained for a sample of 256 drug/alcohol abuse clients. Adequate concurrent or convergent validity was reported to have been demonstrated by the fact that the DAST attained 85 percent overall accuracy in classifying clients according to DSM-III diagnosis, and also to have been demonstrated by significant correlations of the DAST scores with frequency of various types of drugs used during the preceding 12 months. The statistical significance of the DAST scores to distinguish between DSM-III diagnosed abuse "cases" from "non-cases" is reported evidence of discriminant validity. The DAST scores were found to be only "moderately correlated" with scores for social desirability and denial.
Pricing Information:	The DAST form and scoring key are available (either without cost or at nominal cost): The Addiction Research Foundation Marketing Department 33 Russell Street Toronto, Ontario M5S-2S1 (416) 595-6000
General Commentary:	Since the DAST is one of the few instruments for assessment of drug use and related problems that has reported the relationship of the scores obtained to diagnosis of abuse, it may be of interest to those programs that are more diagnostically or psychiatrically oriented.
Access:	Harvey A. Skinner, Ph.D. Department of Behavioral Science Faculty of Medicine, McMurrick Building University of Toronto, Ontario, M5S-1A8 (415) 978-8989 (416) 978-2087 Fax

Manson Evaluation (ME) Revised (Manson and Huba, 1987). This 72-item instrument has been administered to more than a quarter of a million individuals for use as a screening measure of alcohol abuse. It also measures anxiety, depression, depressive fluctuations, emotional sensitivity, resentfulness, aloneness, and quality of

interpersonal relations. Five to 10 minutes are required for either individual or group administration. The test form is easy to use and has a unique AutoScore system, which makes it possible to score, profile, and interpret the test in just a minute or two. A Probability Index for Alcohol Abuse Proneness indicates the degree of likelihood that the subject is abuse prone. Scoring can be done by computers and interpretive reports generated.

A normative sample developed in 1985 consisted of 326 applicants (147 males and 179 females) for clerical, manual labor, and professional positions at a medium-size company in Los Angeles. The age range was from 16 to 60 years; mean age, 30 years (S.D., 9 years). The mean education was 14 years of school completed (S.D. = 2 years). No race/ethnic distribution is reported.

The Cronbach Alpha internal consistency reliability was .87 for this total sample. Validity was determined in a study in which each of the 71 items analyzed separately differentiated known alcoholics from known non-alcoholics to a statistically significant degree. Also, a cut-off score of 21 points for males and 26 points for females correctly diagnosed 79 percent of males and 84 percent of females as alcoholic.

Costs:

Item No.	Description	Price
W-3	Kit, including 25 autoscore test profile forms for hand scoring and one manual	$ 55.00
W-3A	Autoscore test profile forms, price per pkg. of 25 1 pkg. 2 - 9 pkgs. 10 or more pkgs.	 29.00 26.60 25.10
W-3B	Manual	27.50
W-56C	Mail-in computer-scored answer sheets 1 - 9 answer sheets, price each 10 or more answer sheets, price each	 9.50 8.60
	Disk for computerized administration, good for 25 uses (will also score the tests and complete an interpretive report)	125.00

Add 10% shipping and handling, plus applicable tax in California. Call for current prices and ordering information.

Access:

Western Psychological Services
12031 Wilshire Blvd.
Los Angeles, CA 90025
(310) 478-2061 or (800) 648-8857

The Chemical Dependency Assessment Profile (CDAP) (Harrell et al., 1991) is a 235-item, multiple-choice, and true-false self-report instrument, to assess alcohol and drug use and chemical dependency problems. The 11 dimensions measured include quantity/frequency of use, physiological symptoms, situational stressors, antisocial behaviors, interpersonal problems, affective dysfunction, attitude toward treatment, degree of life impact, and three "use expectancies" (i.e., the client's expectation that use of the substance a) reduces tension; b) facilitates socialization; or c) enhances mood. An example of a "use expectancy" item is, "I get aggressive or violent when using alcohol."

This instrument probably develops as much detailed information related to substance use, abuse, and dependency as any of the others described in this manual; there are 90 items on alcohol use and problems alone. The questionnaire covers chemical use history, patterns of use, reinforcement dimension of use, perception of situational stressors, and attitudes about treatment, self-concept, and interpersonal relations.

Adequate internal consistency reliability coefficients, calculated separately for each of the 11 dimensions, ranged from .60 to .88. Test-retest reliability (after 6 to 9 days) was supported by correlations ranging from .77 to .96 separately for the 11 dimensions.

The degree of validity of the CDAP (i.e., the degree to which it measured what it is intended to measure) was determined by the degree to which the 11 CDAP scores were found to correlate with 1) MAST scores, and 2) a factor score of Alcohol Use Inventory (AUI). The correlations with the MAST ranged from .33 to .77. The correlations with the AUI ranged from .35 to .79. The best correlations were with the "Use Quantity/Frequency" and "Degree of Life Impact Dimensions" of the CDAP.

Normative data are available thus far on only 86 subjects, including 31 polydrug abusers, 27 alcohol abusers, and 28 social drinkers. In this sample, there were 52 males and 48 females, with mean age of 35.3 years (S.D. = 11.6), and mean years of education of 13.2 years (S.D. = 3.1). The race/ethnic distribution was 93 percent Caucasian, 4 percent Black, and 3 percent Hispanic. (A discriminant function classification analysis of the alcohol abuse group vs. polydrug abuse group yielded correct classification of 100 percent of the subjects.) This finding suggests that the normative data are useful, even for this small sample (Harrell et al., 1991).

The CDAP can be administered by computer, as well as in paper and pencil format, and a three- to eight-page computerized report can be generated. This report includes the subscale scores for the 11 dimensions.

Costs:

Item No.	Description	Price
B-CD1-5B	IBM 5 1/4"	$295.00
B-CD1-3B	IBM 3 1/2"	295.00
B-CD1-MA	Macintosh	295.00
B-CD1P	Paper Version (16 pages, 20/pkg.)	22.00

Access:

Multi-Health Systems (MHS) Publishers
65 Overlea Blvd., Suite 218
Toronto, Ontario
M4H 1P1 Canada
(800) 456-3003

or

908 Niagara Falls Blvd.
North Tonawanda, NY 14120-2060

The Structured Clinical Interview for Diagnosis (SCID) (Spitzer et al., 1990), and **The Revised Diagnostic Interview for Children and Adults (DICA-R)** (Reich et al., 1990). These two psychiatric interview forms use the DSM-III-R diagnostic criteria for enabling the interviewer to either rule out or to establish a diagnosis of "drug abuse" or "drug dependence" and/or " alcohol abuse" or "alcohol dependence." The DSM-III-R criteria for substance abuse diagnoses are the same for adolescents as for adults. The SCID can be used for adolescents as well as for adults. The questions on the DICA-R are worded somewhat more appropriately for adolescents.

These diagnoses can be made by the examiner asking a series of approximately 10 questions of a client. The DSM-III-R criteria for determining a diagnosis of "Psychoactive Substance Abuse" are:

A. A maladaptive pattern of psychoactive substance use indicated by at least one of the following: 1) continued use despite knowledge of having a persistent or recurrent social, occupational, psychological, or physical problem that is caused or exacerbated by use of the psychoactive substance; 2) recurrent use in situations in which use is physically hazardous (e.g., driving while intoxicated).

B. Some symptoms of the disturbance have persisted for a least 1 month, or have occurred repeatedly over a longer period of time.

C. Never met the criteria for Psychoactive Substance Dependence for this substance.

The criteria required for establishing a DSM-III-R diagnosis of "dependency" are more severe than required for "abuse." Two of these criteria, for example, are: 1) "Characteristic Withdrawal Symptoms," and 2) "Marked Tolerance" (need for at least a 50% increase in the amounts of substance used to achieve intoxication or desired effect). (There are apparently no normative data available as yet, based on a general population sample, for either adolescents or adults.)

The interview time for determining the presence of a substance abuse/dependency diagnosis with the SCID is approximately 10 minutes.

The SCID *only* is available from:

American Psychiatric Press, Inc.
1400 K Street, N.W., Suite 1101
Washington, DC 20005
(800) 368-5777

A Starter Kit, Item 84S1, including a user's guide and 10 instruments, is priced at $10.

The DICA-R *only* is available from:

Dr. Wendy Reich
Washington University
Division of Child Psychiatry
4940 Childrens Place
St. Louis, MO 63110
(314) 454-2307

Kit is available for $50.

The SCID and the DICA-R are available from:

Multi-Health Systems (MHS) Publishers
65 Overlea Blvd., Suite 218
Toronto, Ontario
M4H 1P1 Canada
(800) 456-3003

or

908 Niagara Falls Blvd.
North Tonawanda, NY 14120-2060

MHS prices for the SCID and DICA-R are as follows:

Item No.	Description	Price
B-SC1P	SCID-P Starter Kit (User's Guide with 10 SCID-P forms)	$ 87.75
B-SC2P	SCID-P with Psychotic Screen Starter Kit (User's Guide with 10 SCID-P forms)	81.95
B-SC5P	SCID User's Guide	46.75
B-SC6P	SCID-P (10 forms/pkg.)	46.75
B-SC7P	SCID-P with Psychotic Screen (10 forms/pkg.)	40.95
B-DI3-5B	DICA-R IBM 5 1/4" Both Versions	825.00
B-DI3-3B	DICA-R IBM 3 1/2" Both Versions	825.00
B-DI1-5B	IBM 5 1/4" Parent Version	450.00
B-DI3-3B	IBM 3 1/2" Parent Version	450.00
B-DI2-5B	IBM 5 1/4" Child/Adolescent Version	450.00
B-DI2-3B	IBM 3 1/2" Child/Adolescent Version	450.00

The Quantitative Cocaine Inventory (Gawin, 1984). This instrument was developed specifically for use with cocaine-abusing individuals to survey varied aspects of their functioning with respect to the use/abuse of cocaine. There are 110 items in the instrument consisting of blanks to be filled in as responses to factual questions, and scaled evaluation on varied aspects of behavior. The items are divided among three subsections as follows: 1) 27 items for a Quantitative Cocaine Inventory - Weekly; 2) 4 items for a Cocaine Craving Scale; and 3) 79 items for a Quantitative Cocaine History.

Time for Administration: 10 to 15 minutes

Training for Administration: None required beyond general experience with interviewing and test administration.

Type of Administration: Individual administration is recommended, but may be group administered.

Standardization Population: Sixty male and female adult cocaine abusers in the New Haven, Connecticut, area. They were 75 percent male and 25 percent female, 50 percent white, 30 percent black, and 20 percent Hispanic.

Norms: None are available. Interpretation of results is to be based on clinical impressions.

Reliability: None as yet.

Validity: None as yet.

Cost: Duplication and mailing costs.

Access:

Tom Kosten, M.D.
or Cynthia Morgan
Dept. of Psychiatry
Yale University
27 Sylvan Ave.
New Haven, CT 06519

2. MEDICAL PROBLEMS AND PHYSICAL HEALTH STATUS

General Health Rating Index (GHRI) (Davis and Ware, 1981; Ware, 1984; Ware, 1976). This 23-item self-administered questionnaire measures "perceptions of past, present, and future health status, as well as worry about health and personal views regarding susceptibility to illness." This questionnaire, which requires approximately 7 minutes to complete, differs from other instruments for evaluating health status in that it does not include items on specific illnesses, diseases, symptoms, or components of health. It appears to assess the physical and social role limitations due to poor health and/or acute physical and psychiatric symptoms. This instrument was used in the Rand Health Insurance Study (HIS) on a sample of 4,444 adults and children at six sites in four States. Norms for various age groups and for the two genders are available based on the general populations of these four States, including representation from various minority ethnic groups. The curve of the GHRI score distribution is roughly symmetrical in a general population.

The GHRI has demonstrated internal consistency reliability of .89 in a general population. Empirical evidence of validity is also favorable. Test-retest reliability coefficients, based on retesting at 2- to 6-week intervals, are "somewhat lower" than the internal consistency coefficients. Construct validity was established by a factor analysis, which confirmed the basis for the six subscales. Convergent validity for various ways to use the GHRI has been established by developing significant correlations of the GHRI summary scores with 35 different measures of health status. The summary score was also shown to discriminate between those with and without a chronic disease. Administration time is 10 minutes to complete.

A copy of the GHRI form and of the norms for scoring have been available thus far for no cost.

Access:

Dr. John E. Ware, Jr.
N.E.M.C.H.
750 Washington St.
Health Institute, Box 345
Boston, MA 02111
(617) 350-8098
(617) 350-8077 Fax

3. ACADEMIC SKILLS

The Wide Range Achievement Test Revised (WRAT-R) (Jastak and Wilkinson, 1984). This is a well-standardized test that is widely used with children, adolescents, and adults for a quick evaluation of reading, spelling, and arithmetic skills and performance. Two levels of the test are available: Level 1 (ages 5-11) and Level 2 (ages 12-adult). It is a time-limited test with approximately 5 to 10 minutes allowed for each of three sections. Reliability coefficients range from .90 to .97 for various ages. Validity is well related to external criteria, such as some longer tests of reading, spelling, and arithmetic skills. Norms based on a national, stratified sample (including varied ethnic and racial groups) are available for raw scores, grade equivalents, standard scores, and percentile ranks. The test is hand scorable.

Costs:

Description	Price
Manual (Admin. & Scoring)	$25.00
Level 1 Test Forms (pkg. of 25)	15.00
Level 2 Test Forms (pkg. of 25)	15.00
Reading/Spelling Plastic Cards	10.00
Reading/Spelling Tape Cassette	25.00

Access:

Sarah Jastak, Ph.D.
Jastak Assessment Systems
P.O. Box 3410
Wilmington, DE 19804
(302) 652-4990

A revised edition of the WRAT—WRAT3—was released in September 1993. The WRAT3 features a new national stratified sample, new grade ratings, scaling and item analysis by the Rasch Method, and new test forms. Prices are as follows:

Item No.	Description	Price
R9SS	WRAT3 Starter Set (R91, R92B, R92T, R93, R95 & WR1)	$95.00
R91	Manual for Administration & Scoring	30.00
R92B	Blue Test Forms (25)	20.00
R92T	Tan Test Forms (25)	20.00
R93	Profile/Analysis Form (25)	10.00
R95	Plastic Cards for Reading Spelling	10.00
WR1	Wide Range Soft Attache Case	20.00

4. EMPLOYMENT

Index of Job Satisfaction (Brayfield and Rothe, 1951). This instrument provides a measure of how much the individual is pleased with the work in which he/she is currently employed. It is a brief test of 18 statements to which the individual responds on a 5-point scale ranging between "strongly agree" and "strongly disagree." Results with this instrument have been found to be reliable, (split half correlation of .87) as well as valid (correlation of .92 with the Hoppock Job Satisfaction scale). The scale also distinguishes between individuals placed on jobs appropriate to their training and interests from those in occupations not in line with their expressed interests. The time required to administer is 5-10 minutes.

Cost:

Not available.

Access:

Brayfield, A.H., and Rothe, H.F. (1951). *Journal of Applied Psychology*, 35, pp. 307-311.

Miller, D.C. (1991). *Handbook of Research Design and Social Measurement*, (5th ed.), Newbury Park, CA: Sage Publications, pp. 466-468.

Note on assessment of employment: Possibly standardized employment instruments are appropriate for use with substance-abusing clients. This task can also be accomplished in a less formal, but systematic, fashion by asking the client to review his/her educational-vocational training and employment history. The combination of this background information, the client's current employment status, and expressed attitudes toward work should enable the counselor to judge whether there is any relationship between the substance abuse and job experiences. It may also identify employment history links with other social and emotional problems. This is relevant to the type of rehabilitation or treatment program most appropriate for the client.

5. SOCIAL LIFE STYLE AND PROBLEMS

Social Life Feelings Scales (SLFS) (Schuessler, 1982). This instrument consists of 12 relatively independent scales. Each scale consists of 5 to 14 statements in which the individual is asked whether he/she agrees or disagrees. For each scale, there are norms to judge the social life feelings of the individual. The examiner need not administer all 12 scales, but merely select those perceived as appropriate for the person being assessed.

Some of the scales that seem most useful for evaluating a drug abuser's social adjustment are Doubt About Self-Determination; Doubt About Trustworthiness of People; Job Satisfaction/Career Concerns; People Cynicism (cynical about people's motives); Feeling Demoralized/Future Outlook.

Norms: The SLFS was designed and standardized on a national sample of adults. Separate norms (means, medians, and standard deviations) are available for each of the 12 scales, on a representative sample of adults from a U.S. national sample of 1,522 respondents. A German sample of 2,003 respondents was also tested, and these norms are available.

Internal consistency reliability coefficients for the 12 scales range between .53 and .80. Tucker-Lewis reliability for the 12 scales ranges between .86 and .96. Criterion validity was not established; no independent criterion of that measured was available for comparison. The scales discriminated between age groups, race/ethnicity groups, and income groups.

Administration: The scales can be administered by means of a structured interview or by self-administration with an interviewer reading directions. The subject is asked to sort cares, each containing a statement from a male, which is placed into two piles: "agree" or "disagree." Each scale can be completed in about 2 or 3 minutes.

Test items are available from the source listed below (either without cost or at nominal cost).

Access:
K.F. Schuessler
Indiana University
Bloomington, IN 47405
(812) 855-8592

Social Intelligence Test (Moss et al., 1990). This test, intended to evaluate the subject's social perceptions and sensitivity, consists of items to which the individual is asked to express an opinion. An examiner is required for administration. Six factors are measured: 1) judgement in social situations; 2) recognition of the mental state of another person; 3) the feelings that another person is experiencing; 4) accuracy when observing human behavior; 5) memory for names and faces; 6) sense of humor. Percentile norms are provided separately for high school, college, and adult populations, by means of which a client's social perceptions and sensitivity can be evaluated.

Administration time is 50 minutes. A hand key is available for scoring. Pkg. of 25 is $12.00.

Access:

The Center for Psychological Service
1511 K Street, N.W., Suite 430
Washington, DC 20005
(202) 347-4069

6. FAMILY AND MARITAL RELATIONSHIPS AND PROBLEMS

The Family Environment Scale (FES) (Moos and Moos, 1981), is a "whole family" assessment, an instrument that measures the family environment or climate. This 90-item questionnaire includes 10 subscales, each composed of nine items, and these subscales compose three primary domains: 1) personal growth (independence, achievement orientation, intellectual-cultural orientation, active recreational orientation, moral-religious emphasis); 2) family interaction and relationships (cohesion, expressiveness, conflict); 3) system; maintenance dimensions (organization, control).

Three different test booklets are available: 1) the Real Form, which measures an individual's perception of the family as it is; 2) the Ideal Form, which asks the individual how the family should be; and 3) the Expected Form, which asks the individual to predict family behavior in new situations. Administrative time of the test ranges from 15-20 minutes.

Norms are available, based on 285 families of various sizes, and including adequate numbers of African-American and Mexican-American families, but low SES families are underrepresented in this original normative sample. As reported by Moos (1990), "...the FES subscales generally show adequate internal consistency, reliability, and stability over time when applied in samples that are diverse; the items also have good content and face validity. An extensive body of research supports the construct, concurrent, and predictive validity of the FES." The internal consistency reliability coefficients, based on 814 subjects, are acceptable, ranging from .64 to .79 for the 10 subscales. The test-retest reliability coefficients, based on 47 subjects, with an 8-week interval between testings, are acceptable, ranging from .73 to .86 for the 10 subscales. Discriminant validity was established by the fact that the inter-correlations between the 10 subscales scores, for the 814 subjects, range from .01 to .38, and the average inter-correlation was .20.

Costs:

Description	Price
1 pkg. of 25 Form I Test Booklets	$17.00
1 pkg. of 25 Form R Test Booklets	16.00
1 pkg. of 25 Form E Test Booklets	17.00
1 pkg. of 25 Answer Sheets	6.00
1 pkg. of 25 Profiles	5.00
Scoring Key	8.00
Manual (1986)	13.00
User's Guide	10.00

Access:

Consulting Psychologist's Press, Inc.
P.O. Box 10096, 3803 E Bayshore Road
Palo Alto, CA 94303
(415) 969-8901

The Family Assessment Measure (FAM-III) (Skinner et al., 1983), which was developed to provide quantitative indices of family strengths and weaknesses, is a 134-item self-report instrument that can be completed by a parent and child with adequate reading ability in approximately 45 minutes. The most recent version, FAM-III, consists of three scales, each of which provides a different perspective on the family: 1) a 50-item "General Scale" examines overall family health; 2) a 42-item "Dyadic Relationships Scale" measures how each family member views independently the dyadic relationships of each family dyad; and 3) a "Self-Scale" (42 items), which reports the family member's perception of his/her functioning in the family. FAM-III also has seven subscales to assess dimensions of family functioning and status: Task Accomplishment; Role Performance; Communication; Affective Expression; Involvement; Control; and Values and Norms (which include specific cultural influences and values handed down from earlier generations).

The FAM-III also includes subscales that measure the response biases ("Denial/Defensiveness") of the individual family member completing the form "Social Desirability."

Norms based on 247 normal adults and 65 normal adolescents, as well as on clinical families, are available by writing to Dr. Harvey Skinner (see address below).

The statistical analyses to determine reliability and validity involved 475 families (933 adults and 502 children). Internal consistency reliability coefficients were very adequate: General Scale (.93), Dyadic Scale (.95), and Self-Rating Scale (.89). Intercorrelations between the content subscales were moderately high (.55 to .79) suggesting "that a general factor of family health or pathology underlies the content subscales" (Skinner, 1978).

Discriminant validity was supported by the power of FAM-III to differentiate 133 "problem families" (defined as having one or more members receiving professional help for psychiatric, emotional, alcohol, drug, or school problems) from 342 nonproblem families. The problem families reported more dysfunction, to a significant degree, in the areas of Role Performance and Involvement (interest in each other). Only a moderate level of agreement between spouses was found in the rating of family functioning: 1) a median correlation of .36 for the profiles of the subscale scores of 74 normal couples, and 2) a median correlation of .51 for the profiles of the subscale scores of 43 clinical couples. Reliability, as measured by internal consistency estimates, is reported to be excellent. Studies on its validity are incomplete. Only the Role Performance and Involvement dimensions have been shown thus far to differentiate problem families from nonproblem families.

Inquiries:

Harvey A. Skinner
Addiction Research Foundation
33 Russell St.
Toronto, Ontario, Canada M5S-251
(416) 595-6000

Access:

Multi-Health Systems (MHS) Publishers
65 Overlea Blvd., Suite 218
Toronto, Ontario
M4H-1P1 Canada
(800) 456-3003

or

908 Niagara Falls Blvd.
North Tonawanda, NY 14120-2060

Item No.	Description	Price
B-FA1P	FAM-III Starter Kit (includes 10 of each test booklet, 50 General Scale answer sheets, 75 Dyadic Relationship Scale answer sheets, 50 Self-Rating Scale answer sheets, 25 General Scale Profile sheets, 50 Dyadic Relationship/Self-Rating Scale Profile sheets, 1 Administration & Interpretation Guide)	$95.00
B-FA4P	FAM-III General Scale Test Booklets - reusable (10/pkg.)	7.00
B-FA5P	FAM-III Dyadic Relationship Test Booklets - reusable (10/pkg.)	7.00
B-FA6P	FAM-III Self-Rating Scale Test Booklets - reusable (10/pkg.)	7.00
B-FA7P	FAM-III General Scale Answer Sheets (25/pkg.)	10.00
B-FA8P	FAM-III Dyadic Relationship Scale Answer Sheets (25/pkg.)	10.00
B-FA9P	FAM-III Self-Rating Scale Answer Sheets (25/pkg.)	10.00
B-FA10P	FAM-III General Scale Profile Sheets (25/pkg.)	4.00
B-FA11P	FAM-III Dyadic Relationship/Self-Rating Scale Profile Sheets (25/pkg.)	4.00
B-FA3P	FAM-III Administration & Interpretation Guide	10.00
B-FA2P	FAM-III Specimen Set (includes 1 of each test booklet, 5 General Scale answer sheets, 10 Dyadic Relationship Scale answer sheets, 5 Self-Rating Scale answer sheets, 2 General Scale Profile sheets, 5 Dyadic Relationship/Self-Rating Scale Profile sheets, 1 Administration & Interpretation Guide)	20.00

Family Satisfaction Scale (Olson et al., 1982). This brief instrument consists of 14 items, each of which is a 5-point rating scale measuring the degree of satisfaction to 14 different aspects of family life. The theoretical model on which this instrument was constructed results in two underlying factors: family cohesion and family adaptability. The focus of the items is on the subject's degree of satisfaction with the amount of the cohesion dimension and the amount of adaptability dimension perceived in the family.

The norms for this scale were derived from the scores obtained in it by 412 adolescents who participated in a national survey of families that were "primarily Caucasian and Lutheran." The standardization sample was 433 university students. Cronbach Alpha coefficients of reliability of .82 and .86 were obtained for the cohesion and adaptability subscale, respectively. The total scale yielded a Cronbach Alpha of .90.

Access: See Family Inventories Project (FIP) Price Schedule, below.

The Family Crisis-Oriented Personal Evaluation Scales (F-COPES) (McCubbin et al., 1982) is a brief 29-item, 5 subscales inventory that measures two types of family coping mechanisms: internal ("the ways in which the family handles difficulties and problems that arise between family members"); and external ("the ways in which the family handles problems and demands which come from the social environment"). The five subscales are: Acquiring Social Support; Reframing (defined as "...the family's capability to redefine stressful events in order to make them more manageable"); Seeking Spiritual Support; Mobilizing the Family to Acquire and Accept Help; and Passive Appraisal. These five scales were derived by a factor analysis of the 49 items of a pilot instrument.

The prefix for all items is, "When we face problems or difficulties in our family, we respond by [-item-]." The F-COPES can be readily completed by most subjects over 12 years of age. Norms are available separately for males and females, and for adolescents and adults. A normative sample (N = 2.692), consisting of 1,140 couples and 412 adolescents, was derived from 31 States. This sample was predominantly Lutheran and Caucasian.

Cronbach's Alpha coefficients of reliability ranged from .63 for the Passive Appraisal scale to .83 for the Acquiring Social Support scale, (based on a sample of 2,582 subjects). The test-retest (over a 4- to 5-week period) reliability coefficients ranged from .61 for the Reframing scale to .95 for the Seeking Spiritual Support scale.

The administration time is 15–20 minutes to complete. A manual entitled *Family Inventories: Inventories Used in a National Survey of Families Across the Family Life Cycle* is available (see FIP Price Schedule, on the next page). The forms required for administering the F-COPES (as well as the ENRICH and the Parent-Adolescent Communicating instruments) are presented in the NIDA manual and may be photocopied with the permission of Dr. Olson.

The Enrich Inventory (Fournier et al., 1983). This 125-item instrument to which the individual responds on a 5-point scale ranging between "strongly disagree" and "strongly agree," probes various aspects of a couple's relationship, such as communication, satisfaction with the relationship, roles, leisure activities and interests, financial management, and personality issues. There are 10 items to measure each of 11 content categories: Idealistic Distortion; Marital Satisfaction; Personality Issues; Communication; Conflict Resolution; Financial Management; Leisure Activities; Sexual Relationship; Children and Marriage; Family and Friends; Equalitarian Roles; and Religious Orientation. Also included are 15 items on "Idealistic Distortion," a revision of the Edmond's Social Desirability Scale. The manual presents the definitions and concepts for each of the 11 content categories, and clarifies the meaning of the individual scores.

Separate norms for males and females are available for ENRICH, based on 672 couples (1,344 individuals), referred from Lutheran churches in Minnesota. Test-retest reliability coefficients, which are adequate, range between .77 and .92. It is reported (Fournier et al., 1983) that validity was demonstrated by findings. Significant correlations have been found between ENRICH scores and scores of previously established marital satisfaction tests such as the Locke-Wallace Marital Adjustment Scale. The administration time is 30–45 minutes.

Dyadic Adjustment Scale (DAS) for marital and couple adjustment (Spanier, 1976). The DAS consists of 37 statements to which the individual responds. Some of the scales have five points, others have six points, and a few have seven points. Each item deals with the quality of how members of a couple relate to each other; they deal with such factors as agreement, affection, dyadic satisfaction, and cohesion. The instrument was carefully developed and has been widely used both for research and in clinical practice. Reliability coefficients for internal consistency range between .76 and .96, which are quite favorable. The scales validly discriminate between married and divorced samples, as well as between distressed and non-distressed groups of individuals. Construct validity is reported as .86 and .88, which is unusually high.

The Dyadic Adjustment Scale is a self-report measure of relationship adjustment. A comprehensive manual describes the development and clinical uses of this scale. Extensive research with over 1,000 published studies has supported the use of this measure in determining the degree of relationship dissatisfaction couples are experiencing.

A total score below 100 points is indicative of a relationship distress. Four factored subscales are scored that include: Dyadic Satisfaction; Dyadic Cohesion; Dyadic Consensus; Affectional Expression.

The DAS can be administered using either QuikScore™ profile forms or directly on the computer. Brief interpretive statements are also output from the computer version. Each person's responses can be saved for future reference or research purposes. The computer program allows for 50 administrations.

Access:

Multi-Health Systems, Inc.
65 Overlea Blvd., Suite 218
Toronto, Ontario, M4H 1P1, Canada
(800) 456-3003

or

908 Niagara Falls Blvd.
North Tonawanda, NY 14120-2060

Family Inventories Project (FIP) Price Schedule
Price Include Manuals and Scales

I. **Family Inventories Manual (10 inventories)** — $65.00
1. FACES II
2. Family Satisfaction
3. Parent-Adolescent Communication
4. ENRICH
   a. Marital Satisfaction
   b. Marital Communication
   c. Marital Conflict Resolution
5. Family Strengths
6. Quality of Life
7. FILE
8. A-FILE
9. F-COPES

II. **Individual Family Inventories**

FACES II (For Research Projects)	30.00
FACES III (For Clinical Work)	30.00
Family Satisfaction	10.00
ENRICH Couple Research Scales (Satisfaction, Communication, Conflict Resolution)	10.00
Parent-Adolescent Communication	10.00
CRS-Clinical Rating Scale	5.00

III. **Marital Scales** — 30.00
PAIR (For Research Projects)
ENRICH (For Clinical Work) - Please contact:

Dr. David H. Olson
PREPARE/ENRICH, Inc.
P.O. Box 190
Minneapolis, MN 55440
(612) 331-1731

Mailing cost for materials:
All orders must be prepaid by check or purchase order.
Make checks payable to: University of Minnesota

U.S.	5.00
International	10.00
U.S. Express	15.00

Order from:
Family Inventories Project
Family Social Science
University of Minnesota
290 McNeal Hall
St. Paul, MN 55108

(612) 625-7250
(612) 625-4227 Fax

Costs for Dyadic Adjustment Scale:

Item No.	Description	Price
B-DA1P	DAS Complete Kit (includes Manual and 20 QuikScore™ forms)	$40.00
B-DA2P	DAS QuikScore™ Forms (hand-scorable) (20 forms - 10 couples/pkg.)	25.00
B-DA3P	Dyadic Adjustment Scale Manual	19.00
B-DA1-5B	IBM 5 1/4" (50 uses)	125.00
B-DA1-3B	IBM 3 1/2" (50 uses)	125.00
B-DA1-AP	Apple II	125.00

7. PSYCHOLOGICAL/PSYCHIATRIC PROBLEMS (MENTAL HEALTH STATUS; DIAGNOSIS)

Symptom Check List (SCL-90) (Derogatis et al., 1976). The SCL-90-R is designed to measure nine psychopathology dimensions. These are: depression, anxiety, somatization, obsessive-compulsive, and paranoid ideation. It also provides three global indices. It is a 90-item self-report symptom inventory that requires the patient to respond to each item in terms of a 5-point scale of distress, from "not-at-all" to "extremely." It requires 20 minutes for patient completion, plus 2–5 minutes of administrative introduction. A factor analytic study has confirmed the clinical dimensions reported (Derogatis and Cleary, 1977). Validity studies have been conducted (Derogatis et al., 1976; Boleloucky and Horvath, 1974), and high levels of both internal consistency and test-retest reliability reported (Derogatis, 1977; Edwards et al., 1978).

Administer to:	Adults and adolescents 13 years or older
Reading Level:	Sixth grade
Administration Time:	12–15 minutes (90 items, 5-point rating scale)
Formats:	Paper and pencil, audiocassette, or on-line administration
Scoring Options:	Hand scoring, computer scoring, teleprocessing
Access:	NCS Assessments ATTN: Order Processing P.O. Box 1416 Minneapolis, MN 55440 (800) 627-7271, ext. 5151 (612) 939-5199

DSM-III-R Diagnosis of "Antisocial Personality Disorder." The criteria required for establishing a lifetime diagnosis of Antisocial Personality Disorder in an adolescent or adult at least 18 years of age are: 1) evidence of Conduct Disorder with onset before age 15, and 2) a pattern of irresponsible and antisocial behavior since age of 15, as indicated by at least 4 of 10 possible types of behavior (e.g., (a) "repeatedly destroying property, harassing others, stealing, pursuing an illegal occupation, whether arrested or not"; or (b) "lacks remorse, feels justified in having hurt, mistreated, or stolen from another").

The sources for the DICA-R and SCID instruments are listed above (see A. Substance Use/Abuse Assessment).

The Maudsley Neuroticism Scale of the Maudsley Personality Inventory (MPI) (Eysenck, 1959) is one of the most extensively used and researched personality assessment instruments available. However, a limitation of this Neuroticism scale is that it is suitable only for the assessment of milder forms of psychopathology, and not suitable for assessment of major affective or psychotic disorders. Although it is brief, requiring 10 to 15 minutes to administer, the Maudsley is sufficiently reliable for individual use. The value of the MPI is derived in part from the years of intensive research and theory building on the dimensions of personality. Two relatively independent "Super Factors," "extroversion-introversion" and "neuroticism," were found to account for a large part of the variance in "personality." The Neuroticism scale is the one more specifically recommended for assessment of drug abuse clients.

Normative data for the MPI are available for several different types of populations, including: 1) 714 male and 350 female American "normals" (college students); 2) 1,931 British male and female employees (primarily blue-collar workers); 3) 468 male and female psychiatric patients, as well as for a population of criminals. (The other demographic characteristics of these normative samples have not been provided.) Although there are no norms available specifically for adolescent subjects, the items of the inventory are appropriate for adolescents.

Socioeconomic level was found to have a negligible relationship to the neuroticism scores. Split-half and Kuder Richardson reliability coefficients were derived for numerous samples for the Neuroticism scale, and were found to range from .75 to .87, and from .85 to .90, respectively. Test-retest reliabilities were reported at .83 and .81. Convergent or concurrent validity of the Neuroticism scale was established by studies; each showed high correlations ≥ .01) with other scales purported to measure neuroticism; for example, a correlation of .76 was found for a sample of 254 college students with the scores of the Taylor Manifest Anxiety Scale, and the following significant correlations: 1) .42, with Cattell's Neuroticism (NSQ) factor scale; and 2) .70 with Cattell's Anxiety (SAF) factor scale.

Costs:

Description	Price
Pkg. of 100 Forms	$27.25
Manual	2.90
Set of Hand-Scoring Keys	7.00

Access:

EDITS: Educational and Industrial Testing Service
Box 7234
San Diego, CA 92107
H.J. Eysenck, *The Maudsley Personality Inventory*, London: University of London Press, 1959.

Beck Depression Inventory (BDI) (Beck and Ward, 1972). This instrument is widely used for assessing the degree of depression of psychiatric patients, and the possible existence of depression in other populations. Depression symptoms are very common in alcohol and drug abuse patients. The BDI is sensitive to measuring change in these patients as they respond to treatment. The instrument is quite brief, consisting of 21 multiple choice items. For each item, the respondents indicate which of four multiple-choice statements best indicate how they have been feeling over the past week.

The BDI was originally standardized on 598 psychiatric patients, but has since been applied to other populations. An internal consistency coefficient of .95 was found with a sample of 101 male alcoholics. A 1-month test-retest reliability coefficient of .82 was reported for a group of 27 alcoholics. A split-half reliability correlation of .86 was also reported. Concurrent validity correlations ranging between .55 and .196 have been reported between BDI scores and independent clinical judgments (Beck et al., 1988).

The test is self-administered or it can be read to the patient. The administration time is approximately 10 minutes.

Costs:

Description	Price
Kit, including instruction manual and 25 record forms	$43.00

Access:

The Psychological Corporation
555 Academic Court
San Antonio, TX 78204-2498
(800) 228-0752

IPAT Depression Scale (Krug and Laughlin, 1976). This is a brief, 40-item questionnaire that requires about 10 minutes to administer and is quite easy to score. It is standardized on over 1,000 individually diagnosed patients and on 1,900 non-patients. It is intended for adults of most educational levels. Satisfactory internal consistency reliability of .93, and validity that distinguished effectively between relevant groups, are reported. Also reported was a correlation of .32 with the MMPI Depression Scale, which is not so encouraging.

Costs:

Description	Price
Depression Scale Testing Kit (contains manual, test booklet, and scoring key)	$12.95
Depression Scale Manual	9.75
Test Booklets, pkg./25	8.80
Scoring Key	3.45

Access:

IPAT
1801 Woodfield Drive
Savoy, IL 61874
(217) 352-4739

The Structured Clinical Interview for DSM-III-R (SCID) (Spitzer et al., 1990). This is a semi-structured interview designed specifically to determine the diagnoses of all of the 50 major DSM-III-R psychiatric diagnoses in Axis I, and the 12 types of personality disorder in Axis II. Axis I includes the substance abuse/dependence disorders. The DSM-III-R criteria for each disorder are presented alongside the interview questions. A User's Guide includes illustrative case vignettes to demonstrate how the SCID can be used. Although inter-rater reliabilities are in the process of being established, research with the SCID at the Center for Cognitive Therapy at the University of Pennsylvania Medical School (Luborsky, L., personal communication, 1991) indicates that satisfactory levels of inter-rater agreement can be achieved (Riskind et al., 1987). The SCID takes approximately 75 minutes to administer by a trained interviewer. A training program, which is several days in duration, is required for someone with clinical experience, preferably a psychiatrist, psychologist, or psychiatric social worker.

Costs:

Description	Price
User's Guide with 10 SCID "full patient" forms	$75.00
10 SCID-II forms (Personality Disorders)	19.95

Access:

The American Psychiatric Press, Inc.
1400 K Street, N.W., Suite 1101
Washington, DC 20005
(202) 682-6262
(800) 368-5777

The Mini-SCID (Spitzer et al., 1992) is a computerized, shortened version of the SCID, for a quick method of screening for many of the major adult Axis I psychiatric disorders, such as mood disorders and anxiety disorders, in addition to substance use disorders. The Mini-SCID can be completed by the client in 25 minutes, after a brief tutorial introduces the client to the keyboard, and allows a choice between responding by using simple highlighted menu bars, or by pressing the letter to indicate choice of response.

The Mini-SCID provides three different report options: complete summary of patient responses; concise summary of possible diagnoses that you should consider; and an expanded version of the concise summary that includes additional diagnostic tips, which are your "next steps" in the diagnostic process.

Costs:

Description	Price
IBM 5 1/4" or 3 1/2"	$295.00

Access:

Multi-Health System, Inc.
65 Overlea Blvd., Suite 218
Toronto, Ontario, M4H 1P1 Canada
(800) 456-3003
(416) 424-1736 Fax

or

908 Niagara Falls Blvd.
North Tonawanda, NY 14120-2060

8. ILLEGAL BEHAVIOR

Law Encounter Severity Scale (LESS) (Witherspoon et al., 1973). The 38-item interview aims to assess the severity of an individual's encounter with the law enforcement system. Types of criminal offenses are surveyed, along with their frequency, severity, and consequences. Results from the interview can range from no encounter with illegal behavior, to felonies that may lead to imprisonment for life. Since each point on a 5-point scale of severity of illegal behavior is clearly defined in detail, the severity of each offense can be scored. The normative data were based on the post-release illegal behavior of 142 male felons in Alabama. Three judges independently ranked the illegal and law encounter behavior for severity of the type of offense, based on a 5-point scale of severity, and agreed in 90 percent of the cases. (The demographic characteristics of the normative sample are not reported.)

The time required to administer is 20 minutes.

Costs:

Description	Price
Instruction manual and 25 test forms	$25.00

Access:

John McKee
The Behavior Science Press
3710 Resource Drive
Tuscaloosa, AL 35401
(205) 758-2885

SUPPLEMENT FOR ASSESSING COCAINE-CRACK USE AND RELATED BEHAVIORS (Cocaine Use and Craving Scales)

Some of the assessment instruments recommended here, such as the Addiction Severity Index (ASI), were developed before the advent of the cocaine epidemic of recent years, and thus do not collect sufficient information regarding cocaine use. For example, they do not distinguish between smoking "crack," freebasing, IV use, and snorting cocaine. These methods of use have various serious consequences. Accordingly, the administration of a brief supplementary instrument is recommended for this specific purpose. Measures of cocaine use and cocaine craving have been developed by Gawin and Kleber (1984). These measures were more recently adapted by Carroll and associates (1991).

The cocaine use instrument provides questions regarding the amount, method, and frequency of the patient's cocaine use throughout his/her cocaine-using career. For example, for 1 month ago, 3 months ago, and 6 months ago, the patient is asked how many grams of cocaine were used per week, the number of days used per week, and the usual method of administration. This instrument also includes questions regarding the areas of the patient's life being disturbed by cocaine use.

The cocaine craving scale is a brief, 64-item self-report form that assesses the intensity of the patient's current desire for cocaine on a 20-point scale ranging form "0" = "none at all" to "20 = "more than ever." The quality of the cocaine high experienced by the patient and the amount of control over his or her urge for cocaine are also assessed.

The articles by Carroll and associates (1991) and Gawin and Kleber (1984) may facilitate the effort to obtain copies of the two brief instruments.

SUPPLEMENT FOR ASSESSING AIDS RISK BEHAVIOR

The instruments recommended here, other than the DATOS and DATAR instruments, do not include an assessment of AIDS risk behavior. Since applicants for drug abuse treatment who are IV users of drugs or who engage in certain types of sexual behavior are particularly at risk for the HIV infection, and subsequently for AIDS, administration of an AIDS Risk Behavior questionnaire is recommended as a supplement to one of the comprehensive drug-problem screening instruments.

It is therefore recommended that those programs that do not plan to use the DATOS or DATAR instruments as their comprehensive intake screening procedure should use the "AIDS Risk Behavior" section of the DATOS Pre-treatment Interview Form, or the "AIDS Risk Assessment" section of the DATAR, as a supplement to whatever comprehensive instrument they elect to use. This section of the DATOS includes 17 questions (items) for male clients and 13 questions (items) for female clients. The DATAR section includes a total of 41 items. The information required for gaining access to these two instruments can be found in the earlier section of this brochure, which describes the whole DATOS instrument.

For those clients for whom it appears, based on this brief survey of their risk behavior, that they may in fact be at risk for HIV infection, it is further recommended that a more thorough study of their risk behavior be conducted. The instrument that has been developed by NIDA for this later purpose for the National AIDS Research Project, is the Risk Behavior Assessment Questionnaire (RBA). The RBA sections are "Sexual Activity," "Sex for Money/Drugs," "Sex-Related Diseases," "Health Status," and "IV and Needle Use Behavior."

Access:

NIDA
Community Research Branch
5600 Fishers Lane
Rockville, MD 20857
(301) 443-6720

Endnote

1. This appendix is a revision and update of *Assessment Instruments for Drug Abusing Adolescents and Adults*, published by the National Institute on Drug Abuse. The original NIDA manual is available through the National Clearinghouse for Alcohol and Drugs Information (NCADI) (800) 729-6686.

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