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Screening and Referral for Substance Abuse Treatment in the Criminal Justice System

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According to the Bureau of Justice Statistics (BJS), the U.S. adult prison and jail inmate population is rapidly approaching the two million mark, with drug-involved offenders comprising the majority of the incarcerated population (Bureau of Justice Statistics, 2000). In a 1997 BJS survey, approximately half of all state and federal inmates reported that they had used drugs in the month before their offense, and over three-quarters indicated that they had used drugs during their lifetime (Bureau of Justice Statistics, 1999). Almost one in three prisoners said they had committed their current offense while under the influence of drug, and about one in six had committed their offense to get money for drugs. In addition, a quarter of state and a sixth of federal prisoners had experienced problems consistent with a history of alcohol abuse or dependence. For example, 41% of state prisoners and 30% of federal prisoners reported having consumed as much as a fifth of liquor in a single day, and 40% state and 29% of federal prisoners said they had a past alcohol-related domestic dispute.

Along with contributing to a record level for inmate capacity, offenders with serious drug problems are having a profoundly negative impact on our nation's public safety and financial health. For example, in a report by the National Center on Addiction and Substance Abuse (1998), almost half (43%) of those identified as "regular drug users" in state correctional systems were incarcerated for a violent offense, including murder, manslaughter, rape, robbery, kidnapping, and aggravated assault. Financially, the U.S. spends $246 billion annually in direct costs related to alcohol and drug abuse (Harwood, Fountain, & Livermore, 1998), with an additional $30 billion spent each year to incarcerate offenders with drug problems (National Center on Addiction and Substance Abuse, 1998).

By providing therapeutic intervention, however, criminal justice agencies have a unique opportunity to identify and rehabilitate (or habilitate) drug-involved offenders who are likely, if untreated, to return to a personally and socially destructive pattern of drug use and criminal activity following release from prison. Indeed, research has shown that focused rehabilitation-oriented treatment services can lead to favorable outcomes following incarceration (Andrews et al., 1990; Gendreau, 1996). Particularly within correctional settings, intensive long-term treatment programs (such as modified in-prison therapeutic communities) have been found to reduce post-incarceration relapse (i.e., return to drug use) and recidivism (i.e., arrests, reconviction, and reincarceration). For example, recent evaluations of Delaware's Key-Crest, California's Amity, and Texas' Kyle New Vision prison-based therapeutic community (TC) treatment programs have shown that, compared to their untreated counterparts, drug-involved inmates who complete in-prison drug treatment are significantly less likely to return to a life of drug use and crime following release from prison (Knight, Simpson, & Hiller, 1999; Martin, Butzin, Saum, & Inciardi, 1999; Wexler, Melnick, Lowe, & Peters, 1999). Furthermore, these findings are even more pronounced among those who participate in aftercare treatment (Griffith, Hiller, Knight, & Simpson, 1999; Hiller, Knight & Simpson, 1999).

Nonetheless, the demand for treatment services within the criminal justice system continues to far exceed the supply, with the gap actually getting wider over the past decade. For example, nearly 90,000 drug offenders have been added to state and Federal prison populations since 1991 (Bureau of Justice Statistics, 1999), but the number of intensive treatment slots decreased over this same time period (National Center on Addiction and Substance Abuse, 1998). Among prisoners in a 1997 BJS survey who admitted using drugs in the month before their offense, approximately 15% reported receiving drug treatment during their current prison term--down considerably from a 1991 BJS survey where a third reported receiving treatment. Likewise, 18% of those who had been using drugs at the time of their offense indicated participation in drug

treatment programs, compared to about 40% in 1991 (Bureau of Justice Statistics, 1999).
Despite recent initiatives to provide additional treatment services (such as those in
California, Delaware, and Texas), it is unlikely that the demand for treatment can ever be
met fully within correctional settings.

Therefore, since it is neither possible nor necessary to provide services
(particularly intensive residential treatment) to every drug-involved offender, referral
decisions must be made regarding whether an offender's drug-related problems are
serious enough to warrant treatment. Furthermore, when serious problems are identified,
referral decisions must also be made regarding the most appropriate type and intensity of
treatment. For example, research suggests that priority for receiving intensive treatment
services should be assigned to those with the more severe problems (Knight et al., 1999;
Griffith et al., 1999).

Unfortunately, treatment referral decisions often are based on incomplete and
irrelevant information, potentially resulting in unclear or even conflicting objectives
(Hepburn, 1994). Inmates who have more severe drug problems may be preempted from
being referred to an intensive drug treatment program because of competing institutional
work assignments or education programs. Likewise, political pressures and
organizational constraints--such as the need to fill bed space--can result in an individual
with either no (or less severe) drug use problems being referred to an intensive residential
treatment program. Similar problems exist when referral is based on subjective criteria,
such as an interviewer's judgment about an inmate's need for treatment. For example, a
"suspicious" offender may be referred to treatment simply because of an interviewer's
unsubstantiated belief that the inmate was lying about drug use. These types of
inappropriate referrals needlessly consume valuable staff time and program funds that are
better used on inmates who actually have drug problems.

An objective screening and referral protocol, on the other hand, can serve to
provide a consistent means of identifying drug-involved offenders most likely to benefit

from limited treatment resources. This chapter addresses come of the important factors that correctional agencies should consider when developing a system of screening and referral.

Developing a Screening and Referral Protocol

The development of an effective and efficient screening and referral protocol requires carefully consideration to three key factors: a) selecting an instrument appropriate for a specific correctional environment, b) obtaining truthful responses, and c) providing suitable treatment options.

Selecting an Appropriate Instrument

Because most correctional agencies do not have the financial and staffing resources to conduct comprehensive assessments of drug problems for every newly admitted inmate, they often rely on the use of a brief screening instrument. As the initial component of a comprehensive screening and referral protocol, a drug use screen typically is administered as part of a larger battery of assessments given shortly after an inmate is incarcerated. By including the drug screen along with other assessments, decisions regarding the need for treatment can be made in conjunction with other important considerations, such as custody level and educational needs. For example, immediate referral to treatment services for an inmate who self-admits having serious drug problems only can be made when there is an assignment to a custody level where services are available. Also, by administering the screen as soon as possible, the potential for other inmates being able to influence how an inmate responds to the screen is minimized.

The first step in this process is the selection of an appropriate screening instrument. This process should include careful consideration to the instrument's accuracy, length, cost, and window of detection. Other important factors include whether the instrument assesses drug dependence or abuse, is self-administered or given as part of a clinical interview, and whether it requires extensive and continued staff training.

Accuracy. Perhaps the most critical aspect of a screening instrument is its ability to discriminate accurately between those who do and do not have drug problems. Because classification error is inevitable, a decision has to be made regarding whether it is better to select an instrument that is more likely to result in someone being referred to treatment that does not need it, or one that is more likely to result in denying treatment to someone who truly does need it.

Five statistical guidelines can be examined to help inform the decision process (see Cherpitel, 1997, and Peters et al., 2000). First, a measure of overall accuracy is a good general indicator of the instrument's utility. Based on the entire sample of screened offenders, it represents the overall percentage of those who were classified correctly, with higher values being more desirable. However, because a drug screen's overall accuracy is not likely to be 100%, four other statistics also need to be considered; they include sensitivity, specificity, positive predictive value, and negative predictive value.

Sensitivity focuses only on offenders who *actually have drug problems* and provides a percentage of those the *screen* accurately identifies as having problems. For agencies that are mandated to identify and provide services to drug-involved offenders, selecting an instrument with high sensitivity can help improve the chances that those with drug problems are detected. An instrument with a high sensitivity score also tends to identify the largest number of treatment eligible inmates, which may be particularly valuable when treatment slots are empty and need to be filled.

As a counterpart to sensitivity, specificity includes only the offenders who *actually do not have drug problems* and is a percentage of those the *screen* correctly identifies as not having problems. A screen with high specificity decreases the probability that an offender without drug problems will be sent to treatment and may be particularly important for agencies that have few treatment options and a large number of inmates from which to draw. For agencies already having a difficult time filling

treatment slots with qualified offenders, a screening instrument with high sensitivity may be more desirable.

Positive predictive value examines only those offenders the *screen* identifies as having drug problems and provides a proportional measure of how many *actually have drug problems*. For agencies that strive to maximize the number of appropriate referrals, positive predictive value deserves special attention. A high value suggests that those the screen identifies as having drug problems actually do have problems and should receive treatment services. This statistic is particularly helpful for agencies with a limited number of treatment options and that want to make sure the distribution of those services is highly efficient.

Based strictly on inmates the *screen* classifies as not having drug problems, negative predictive value indicates the proportion who *actually do not have drug problems*. In general, a screen with a relatively high positive predictive value will tend to have a relatively low negative predictive value, potentially failing to identify inmates who may be able to benefit from treatment.

Ultimately, the most appropriate instrument is one that has sensitivity and specificity scores, as well as positive and negative predictive values, that correspond with the needs of a specific correctional setting. Under these circumstances, financial and staffing expenditures on inappropriate inmates are minimized.

Length. Another factor to consider when deciding on a drug screen is the amount of time it takes for administration. Correctional systems usually must determine the need for treatment for large numbers of offenders in a short period of time. For example, the Texas Department of Criminal Justice (TDCJ)-Program and Services Division (PSD) coordinates the drug abuse screening and treatment referral process of over 3,300 new inmates each month. They have neither the available staff time nor financial resources to administer lengthy individual interviews with each new admission. Although many popular assessments for drug problems are well designed and serve as

broad sorting tools that can be used to assist in making recommendations for general treatment or intervention alternatives, they tend to be fairly lengthy and take more time to administer than correctional agencies can afford.

Cost. Another concern is whether to choose a screen that is in the "public domain" and available for free, or one that is available commercially for a fee. For example, the Substance Abuse Subtle Screening Inventory (SASSI; Fuller, Fishman, Taylor, & Wood, 1994; Miller, 1985; Svanum & McGrew, 1995) is a commercially available drug screen used by several correctional agencies, including the TDCJ-Institutional Division (ID) until recently. By switching to the Texas Christian University Drug Screen (TCUDS; Simpson, Knight, & Broome, 1997)--a "public domain" instrument--the agency was able to save thousands of dollars annually. For smaller correctional agencies, cost may be less of a concern, particularly if the instrument meets diagnostic needs and is already part of the traditional assessment protocol.

Window of detection. Another consideration is whether an instrument assesses drug use problems that occurred over the course of several years or during a more recent, restricted time frame. Because there is an increased probability of obtaining valid responses when the diagnostic emphasis is on identifying "current" alcohol or drug problems, a relatively short "window of detection" is usually recommended (Cherpitel, 1997). However, shorter detection windows, such as the past 30 days, may be too restrictive to fill the available treatment services. Furthermore, those who need treatment may be overlooked. For example, a 30-day detection window may fail to detect offenders with drug problems who abstained from recent drug use because of legal pressures or surveillance while waiting for trial. On the other hand, if the instrument assesses the presence of drug use problems at any point during an offender's life, a long waiting list for treatment may result. In this case, those who may not have had serious drug problems recently could be referred to treatment while those with current drug problems are forced to wait.

Dependence versus abuse. Diagnostic criteria can vary considerably across instruments, with some focusing on drug dependence and others on abuse. Screens that are based on highly conservative criteria, such as the Diagnostic and Statistical Manual (DSM) of Mental Disorders, are designed to detect individuals with serious drug problems (American Psychiatric Association, 1994). These types of instruments are the most likely to identify individuals who could benefit from intensive treatment services. An instrument with diagnostic criteria for abuse, rather than dependence, may be more desirable if an agency's goal is to provide offenders who may have any range of drug problem severity with less intensive treatment services, such as drug education classes.

Interview or self-administered. The way an instrument is delivered also can play an important role in the selection of a screening instrument. For example, the Addiction Severity Index (ASI) is a comprehensive clinical assessment of drug use problems, designed to be administered as part of a face-to-face interview. Other instruments, such as the SSI and the TCUDS, were designed to be brief, self-administered drug screens. Although a lengthy structured clinical interview, such as the ASI, may be the preferred choice of many counselors, time and personnel constrains often make shorter self-administered instruments necessary. When a drug use screen cannot be given as part of a one-on-one interview, research suggests that results can be obtained reliably when self-administered as part of a small group interview (Broome, Knight, Joe, & Simpson, 1996).

Required staff training. Because of high staff turnover, correctional agencies often find that they are deficient in the number of staff who have the clinical experience and credentials necessary to administer certain diagnostic instruments. Even when qualified staff are available, providing extensive and continued training on form administration may be difficult. Therefore, selecting a brief, easily administered screening instrument that requires little staff training can ease this burden greatly. Furthermore, on-going training on some instruments, such as the TCUDS, can be

provided by existing correctional staff who have experience administering the screen, eliminating the need to hire an outside "expert" whenever new staff are hired.

Obtaining Truthful Responses

After selecting a screen, a protocol for administration needs to be developed that encourages inmates to respond honestly. Although the accuracy of self-reported drug use with treatment populations can vary considerably across situations, research shows valid drug use data can be obtained when forms are administered in settings where conditions are favorable for truthful self-disclosure (Wish, 1988).

Perceived consequences. One of the primary influences on an offender's willingness to self report drug problems is the perceived consequences of disclosure. Inmates fear that correctional decision-making boards will make custody assignments and post-release supervision level decisions based, in part, on what is reported on the drug screen. Unlike community treatment settings where a client is guaranteed confidentiality, correctional staff cannot provide such guarantees. They can, however, make it clear to an inmate that there are positive consequences for responding honestly, such as getting access to drug treatment services. Likewise, dishonest responding can result in negative consequences. For example, parole decisions are based on whether an inmate poses an unacceptable risk to society if released. This risk may be determined, in part, by whether or not an inmate has been deceptive while incarcerated, such as failing to self admit drug use on a screen when there is a criminal record of drug-related offenses. In short, honest responding is more likely to occur when an offender understands that it is in his or her best interest to be honest when completing the screening instrument.

Setting. Obtaining accurate data also is influenced by the setting in which a screening instrument is administered. For example, when a large number of offenders are confined into a small testing area, the overcrowded conditions can lead to offender management problems that dominate the administrator's time--shifting the focus away from the intent of the screen. In cases where the form can be administered only in a large

group setting, proctors can provide invaluable assistance to the interviewer by offering individualized attention to those who may need help, particularly with respect to literacy and behavioral problems. In addition, correctional staff can encourage truthful responding by providing an overview of the instrument, informing inmates why honest responding is important, giving detailed instructions on how to complete the instrument, and encouraging questions. Underreporting is inevitable when the interviewer makes it obvious that the primary goal is to get though the screen as quickly as possible.

Providing Suitable Treatment Options

Appropriate instrument selection and implementation should be followed by referral to appropriate treatment options. Correctional systems that provide two options (e.g., no treatment or intensive TC treatment) do not need elaborate and complex screening and referral protocols that classify inmates into more than two categories of treatment need. Similarly, if multiple treatment options are available, the assessment protocol needs greater precision. For example, those with relatively minor drug problems can be assigned to receive drug education while incarcerated. Those with moderate problems could be required to participate in weekly counseling sessions and encouraged to attend self-help group meetings. Finally, those with the most severe problems could be referred to the most intensive programs available, such as in-prison TC treatment (see Knight et al., 1999). Although this concept of treatment matching has been around for many years, there still is little science to provide detailed guidance in designing the proper protocol.

Other factors, such as co-occurring psychological problems, the length of an inmate's sentence, and the type of current and prior offenses also play a major role in determining which, if any, treatment options are viable. For drug-involved offenders with severe psychological problems, referral is made ideally to a specialized treatment program that provides both substance abuse treatment and mental health care (Peters & Hills, 1999). When this type of program is not available, correctional officials have to

decide whether psychiatric problems are too severe for the offender to be referred to a drug treatment program. In addition, a large percentage of many state correctional populations serve less than a year in confinement, making it impossible for an inmate to complete lengthier residential treatment programs, such as 9 to 12 month in-prison TC programs. For these offenders, a drug screen may serve only to determine if a short-term intensive treatment program or drug education program is warranted. Finally, inmates with certain types of offenses also may be excluded from available treatment options. For example, Texas inmates who have committed certain types of aggravated offense are precluded from participating in an in-prison TC program because of their possible disruptive influence. Although intensive treatment programs may not be an option in each of these specific cases, correctional agencies may want to consider at least offering these inmates access to self-help groups and drug education classes.

Available Screens

Although several screening instruments have been developed over the past few years for use in a variety of community settings (see Cherpitel, 1997; Hepburn, 1994; McPherson & Hersch, 2000), their application within correctional settings has been tested only recently (Peters, Greenbaum, & Edens, 1998; Peters et al., 2000). For example, Peters and his colleagues (2000) conducted a field test of screening instruments with 400 newly admitted male inmates to a Texas prison transfer facility in 1996. Overall, 51% of the sample indicated a lifetime prevalence of alcohol or drug dependence disorders, based on the Structured Clinical Interview for DSM-IV (SCID-IV, Version 2.0, Substance Abuse Disorders module; First, Spitzer, Gibbon, & Williams, 1996). Clinical diagnoses were then compared with seven popular screening instruments, including the Texas Christian University Drug Screen (TCUDS; Simpson et al., 1997), Alcohol Dependence Scale (ADS; Skinner & Horn, 1984), Addiction Severity Index (ASI Drug Use and Alcohol Use Sections; McLellan et al., 1992), Drug Abuse Screening Test (DAST; Skinner, 1982), Michigan Alcohol Screening Test--Short Version (MAST; Selzer, 1971),

Substance Abuse Subtle Screening Inventory (SASSI; Miller, 1985), and the Simple

Screening Instrument (SSI; Center for Substance Abuse Treatment, 1994). Based on

their findings, the authors concluded that the TCUDS, the SSI, and a combined

instrument (the ADS/ASI) were the most effective in identifying substance abuse and

dependence disorders. The SSI and ADS/ASI are described briefly below, followed by a

more comprehensive overview of the TCUDS.

ADS/ASI

The Alcohol Dependence Scale (ADS; Skinner & Horn, 1984) is a brief screen

of 25 items designed to assess alcohol dependency. The Addiction Severity Index (ASI,

McLellan et al., 1992) was developed as a comprehensive diagnostic interview and

focuses on seven problem areas: alcohol use, medical condition, drug use,

employment/support, illegal activity, family/social relations, and psychiatric problems

(McLellan et al., 1992). For the purposes of screening, the alcohol and drug use sections

of the ASI were combined with the Alcohol Dependence Screen to form a single

screening instrument. Peters et al. (2000) found that the ASI/ADS screen had high

positive predictive value as well as high sensitivity, providing a high degree of accuracy

in excluding nondependent participants and an ability to identify a high proportion of

substance dependent participants. The combined instrument had high overall accuracy

(83%), sensitivity (74%), specificity (92%), positive predictive value (89%), and negative

predictive value (80%). Although the ASI/ADS combined instrument had good utility

within correctional settings, it is important to note that the ADS portion is only available

commercially and the ASI alcohol and drug use sections were two parts of a lengthier

one-on-one interview format and would need to be tested as part of a self-administered

stand-alone component.

SSI

The Simple Screening Instrument (SSI) is a 16-item "public domain" instrument

developed by the Center for Substance Abuse Treatment to assess alcohol and drug

dependency (Center for Substance Abuse Treatment, 1994). Peters et al. (2000) found that it had relatively high overall accuracy (82%), sensitivity (93%), specificity (73%), positive predictive value (75%), and negative predictive value (92%). It was particularly effective at identifying the largest number of inmates with drug use disorders, although 25% were misclassified as having drug problems. For agencies that are less concerned about sending someone to treatment who does not need it and more concerned about identifying the largest number of treatment eligible inmates, the SSI may prove useful.

TCUDS

The Texas Christian University Drug Screen (TCUDS; see appendix) was developed by researchers at the Institute of Behavioral Research at Texas Christian University (TCU) and has shown promise in meeting the substance abuse diagnostic needs of large correctional systems (Simpson et al., 1997). It has been used since 1993, originally as part of an earlier version of the instrument called the Brief Background Assessment (BBA). Revised twice since its earlier version as the BBA, the TCUDS includes 15 items that represent key clinical and diagnostic criteria for substance "dependence" as they appear in the Diagnostic and Statistical Manual (DSM; American Psychiatric Association, 1994) and the National Institute of Mental Health (NIMH) Diagnostic Interview Schedule (DIS; Robins, Helzer, Croughan, & Ratcliff, 1981). These criteria were adapted for use within criminal justice settings by rewording "clinical" language to be more appropriate for individuals with eighth-grade reading levels and by using a format that promotes reliable self-administration (Broome et al., 1996). The first part of the TCUDS includes a series of 10 questions about problems related to "drug use," and the second part addresses the frequency of specific drug use prior to prison as well as a self-assessment of one's readiness for substance abuse treatment. Based on the first 9 items of the TCUDS, a continuous composite score is computed that measures the level of an offender's drug use severity. Classification criteria for drug use "dependency" parallels the DSM protocol, based on any combination

of three "positive" responses out of the first 9 items. The remaining TCUDS items are designed to provide corroborative evidence of potential drug use problems, such as questions pertaining to prior drug treatment.

The TCUDS can be completed as part of an interview or self-administered, and prior research shows it elicits information that is highly consistent with other data sources (Broome et al., 1996). Based on the original version of the TCUDS, an article entitled "Evaluating the drug-abusing probationer: Clinical interview versus self-administered assessment" (Broome et al., 1996) compared probationer responses given under two types of administration--one using an interview format, and the other using self-administration–approximately 1 week apart. Overall, there were relatively few differences in item responses between the types of administration, supporting the use of the TCUDS as a self-administered instrument within correctional settings.

Results from the study conducted by Peters and his colleagues indicated that the TCUDS had one of the highest overall accuracy rates (82%; Peters et al., 2000). Furthermore, the TCUDS had high positive predictive value (92%) and specificity (92%). Measures of sensitivity (70%) and negative predictive value (78%) were comparable to the ADS/ASI, yet lower than the SSI. The TCUDS also had good test-retest reliability (.95).

As part of a grant funded by the National Institute of Justice, IBR researchers have been examining the application of the TCUDS within correctional settings more closely. Data include a sample of 18,384 TDCJ inmates (86% male, 14% female) who completed the TCUDS between January 1 and April 30, 1999. Results indicated that 30% of the sample scored at or above the cutoff score of "3". The scale's overall reliability was good (coefficient alpha = .89) and was nearly identical across race/ethnic and gender subgroups. Item-total correlations ranged from .37 and .58, and individual item positive (i.e., "Yes") responses ranged from 10% to 39%. Based on Item Response Theory analyses (Rasch, 1980), all 9 items contributed important and necessary

information toward the overall scale score, and the simple summative scoring scheme was found to be nearly as good as a statistically optimally weighted scoring algorithm (Knight, Hiller, Broome, & Simpson, 2000).

Conclusions

Short screening instruments, such as those mentioned in this chapter, can play an important role in the identification of offenders with drug problems. However, the usefulness of brief screens within correctional populations can vary considerably. Among the potential drug use screens, studies show that the TCUDS, ASI/ADS, and the SSI are highly reliable and valid, and are particularly useful in minimizing inappropriate referrals for more intensive treatment programs, such as in-prison therapeutic communities. In addition to the favorable research findings, the brevity of these screens makes them worthy of consideration for use, particularly for larger correctional settings.

Effective screening, however, is contingent on correctional agencies not only being able to identify correctly those offenders with drug problems, but also on being able to refer them to appropriate treatment services. In general, individuals with more severe problems require more intensive treatment (Simpson, Joe, Fletcher, Hubbard, & Anglin, 1999). Studies of intensive prison-based treatment programs have found that they are most effective for high-risk inmates--that is, those with more serious antisocial backgrounds (e.g., history of extensive drug use and criminality) (Knight et al., 1999). On the other hand, individuals with comparatively less serious problems are likely to benefit from a variety of treatment options, regardless of modality or level of intensity (Knight et al., 1999; Simpson et al., 1999). Providing intensive treatment to low-risk offenders (e.g., those not drug-dependent and who do not have a history of prior incarcerations), however, is likely to have a limited impact on reincarceration rates and may be wasting valuable taxpayer dollars and scarce treatment resources.

Given that research has demonstrated that community-based aftercare is an essential ingredient of a treatment protocol, referral decisions also need to consider the need for treatment services after an offender is incarcerated. For example, when compared to inmates with drug problems who did not receive treatment or who only completed a prison treatment program, inmates who completed both the prison-based and

aftercare treatment were significantly less likely to reoffend within 3 years of being released from prison (Knight et al., 1999; Martin et al., 1999; Wexler et al., 1999). Failure to provide adequate treatment after releasing offenders from corrections-based programs can undermine any positive changes that occurred during in-prison treatment and, consequently, severely limit the usefulness of an otherwise effective screening and referral protocol. Better tools and utilization strategies for drug use assessments are therefore crucial for matching needs and resources (Broome et al., 1996).

Because some offenders will fail to disclose drug problems on a drug screen, correctional staff may need to examine other sources of information such as biological test results and custodial records. For many correctional facilities (such as county jails), urine tests are administered shortly after arrest and positive results may indicate a need for treatment even when an inmate denies drug use. Urine samples are tested for targeted drugs, such as opiates and cocaine, and are processed typically "in-house" using an immunoassay process with a 2 to 3 day window of detection. Likewise, an indication of drug problems may be found in an offender's criminal record, such as having several arrests for possession of a controlled substance, or in the presentence investigation report that includes an inmate's confession needing help for drug problems. As with self-report measures, biological tests and criminal records also have limitations that need to be considered when making screening and referral decisions. For example, there are several drugs for which there are no biological tests available and, among potentially testable drugs, correctional officials often test for only a few types such as cocaine and opiates.

Overall, designing an effective and efficient screening and referral protocol requires careful attention to the factors outlined in this chapter. Not only must an instrument be selected that is best suited for a specific correctional environment, but a protocol for administering the screen so that offenders respond honestly also must be developed. In addition, referral decisions need to be based on available treatment options. Failure in any of these areas could undermine the entire screening and referral

process and result in offenders who do not need treatment being referred inappropriately to costly intensive programs, and those who do need treatment remaining untreated-- being released into the community with a high probability of reoffending and returning to prison.

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Appendix

Assessing Treatment Needs in Prison

TCU Drug Screen (TCUDS):

<u>Short</u> Assessment (2 pages) for--
- Drug Problems/Dependence
- Treatment History/Needs

- **Drug education**
- **step groups**
- **Brief interventions**
- **Residential TC**
- **Aftercare**

Appropriate Treatment Placement

Assessments

New inmates to state jails and prisons