



**CEU MATRIX**  
THE INSTITUTE FOR ADDICTION & CRIMINAL JUSTICE STUDIES

# **SCREENING AND ASSESSMENT OF CLIENTS IN THE CRIMINAL JUSTICE SYSTEM**

## **2.75 Continuing Education Credits**

Asynchronous Distance Learning Course

*Content Level: Intermediate*

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— Maya Angelou

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## **ABOUT THE INSTRUCTOR**

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Kevin R. Scheel is a Masters prepared chemical dependency counselor with more than twenty-three years of experience in the human service field. He has served as the director of programs in the public sector as well as in private care facilities, both in the profit and not-for-profit arenas. He has been involved in the delivery of education services to the field since 1986 as an instructor at McLennan Community College in Waco, Texas, and as a private training consultant with Hazelden. Mr. Scheel is the author of “Alcohol: Chemistry & Culture,” as well as a series of education videotapes on the various drugs of abuse, published and marketed by WRS Group, Inc. He has also created a preparation and review manual that is currently in use by a variety of colleges and universities in Texas, designed to aid students preparing for their Texas chemical dependency credential.

While in Texas, Kevin served as the Texas Coordinator for the federally funded Project for Addiction Counselor Training (PACT) program. For this project Mr. Scheel designed a 270 curriculum for beginning counselors, delivering over 45,000 hours of classroom training to 415 minority students. As a result of his efforts, 268 of these students have gone on to obtain their credentials to practice chemical dependency counseling in Texas.

Kevin also served in the position as Coordinator for the Texas Addiction Training Center (currently the Texas Addition Technology Transfer Center), a federally funded project from the Center for Substance Abuse Treatment in Washington, D.C. In Texas this project worked with 8 major colleges and universities to increase the level of addiction education to the various disciplines offering counseling services to drug and alcohol affected clients.

## Screening and Assessment in Criminal Justice: Updated Prevalence Data and Emerging Challenges

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The screening and assessment framework this course provides — drawn from SAMHSA's TIP 44 — established protocols for identifying substance use disorders in criminal justice populations, selecting appropriate instruments, and addressing special population considerations. Since this course was published, three developments have reshaped the screening and assessment landscape: the transition from DSM-IV-TR to DSM-5, which collapsed the abuse-dependence distinction into a single substance use disorder spectrum; the emergence of fentanyl, which has created novel drug testing interpretation challenges; and the accumulation of large-scale prevalence data that updates the scope of substance use and co-occurring disorders in incarcerated populations.

The co-occurring disorder prevalence this course addresses through screening recommendations was quantified in a 2022 systematic review and meta-analysis of 50 studies involving nearly 25,000 incarcerated individuals, published in the *Lancet Public Health*. The analysis found that approximately half of incarcerated individuals diagnosed with a serious mental illness also had a co-occurring substance use disorder, and vice versa. Specifically, 3.5% had current non-affective psychosis with comorbid SUD, and 9.1% had current major depression with comorbid SUD. Individuals with psychosis showed 1.7 times higher likelihood of substance disorders, while those with depression had 1.6 times higher odds. The authors concluded that "consideration should be given to screening for dual disorders and implementing integrated and scalable treatments" (Baranyi et al., 2022). For the screening protocols this course describes, the Baranyi et al. meta-analysis establishes that screening for substance use in criminal justice settings without simultaneously screening for mental health conditions — or vice versa — will miss approximately half of the clinical picture. The 50% co-occurrence rate means that single-disorder screening protocols are inadequate by design.

The longitudinal trajectory of substance use disorder prevalence in criminal justice populations — which this course presents as a static snapshot — was documented in a 2022 study of 47,117 individuals admitted to Canadian provincial prisons between 2009 and 2017. The research revealed a concerning upward trend: co-occurring mental health and substance use disorders increased from 15% to 32% of admissions over the study period. Methamphetamine use disorder surged nearly fivefold from 6% to 29%, and heroin use disorder rose from 11% to 26%. The researchers concluded that "more treatment and efforts to address social and structural inequities" are essential to reduce incarceration among those with complex mental health needs (Butler et al., 2022). For the screening framework this course provides, the Butler et al. data means that the instruments and protocols selected for criminal justice screening must be recalibrated for a population whose substance use profile has changed dramatically. Screening tools validated on populations with primarily alcohol and cannabis use may not perform adequately in settings where methamphetamine and opioid use disorders have become predominant.

The magnitude of the screening gap between criminal justice and general populations was established in a 2022 French study comparing substance use patterns between 630 incarcerated men and 5,793 men from the general population. Alcohol use disorder was present in 33.8% of jail entrants compared to 8.7% in the general population. Drug use disorders affected 28.7% of incarcerated men compared to 5.0% of the general population. Opioid disorders were particularly elevated at 6.8% versus 0.4%. Among individuals with substance disorders, co-occurring anxiety and mood disorders were significantly more prevalent in the jail population, leading the researchers to recommend "systematic

assessment and treatment of psychiatric disorders in men entering jail" with diagnosed substance use disorders (Fovet et al., 2022). For the assessment depth this course recommends, the Fovet et al. data reinforces that brief screening is insufficient — the criminal justice population is not simply the general population that happened to commit crimes. It is a population with substance use disorder rates four to six times higher than the general population and co-occurring psychiatric conditions that compound treatment complexity.

The cultural and demographic dimensions of assessment — which this course addresses through its sections on racial and ethnic minorities and special populations — were examined in a 2024 Swedish registry study linking Addiction Severity Index assessment data with national incarceration records. The analysis found that immigrant background was positively associated with both pre- and post-assessment incarceration, with first-generation immigrants from the Global South experiencing longer incarceration periods even after accounting for substance use severity. The researchers concluded that "tailored interventions and support systems are vital to prevent re-entry into the criminal justice system" for these populations (Scarpa et al., 2024). For the assessment framework this course describes, the Scarpa et al. findings demonstrate that validated instruments like the ASI produce data that must be interpreted in cultural context. Assessment scores that appear similar across demographic groups may mask fundamentally different pathways to incarceration and different post-assessment trajectories that require culturally specific intervention planning.

The drug testing component of screening and assessment — which this course covers as a straightforward biological verification tool — has been complicated by the pharmacokinetics of fentanyl. A 2025 case report in the *Journal of Addiction Medicine* documented a patient receiving medication-assisted treatment for opioid use disorder whose urine drug tests remained positive for fentanyl for 95 days and its metabolite norfentanyl for 245 days after self-reported abstinence. The unpredictable clearance timeline created conflicts with both probation and child protective services, which interpreted continued positive tests as evidence of ongoing use (Celik et al., 2025). For the drug testing protocols this course describes, the fentanyl era has introduced a fundamental interpretation challenge: the assumption that a positive drug test indicates recent use — which underlies the entire drug testing framework in criminal justice settings — may not hold for fentanyl, whose metabolites can persist for months in individuals with high prior exposure. Screening and assessment protocols must now account for this pharmacokinetic reality or risk penalizing abstinent clients for biological persistence of a previously used substance.

# Screening and Assessment of Clients in the Criminal Justice System

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

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

This course addresses the issues relevant to screening and assessment and makes recommendations for the appropriate use of screening and assessment tools in specific settings within the criminal justice system. For information on how to use screening and assessment to match the offender to services and to identify an appropriate treatment plan, see the CCJP.com course entitled *“Treating Clients in the Criminal Justice System.”* More information on specific screening and assessment instruments is provided for you in Appendix A of this course.

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## Definitions of Terms

Information gathered during screening and assessment plays an important role in identifying offender needs and making appropriate referrals for services.

Throughout this course, the following definitions will be used for screening, assessment, and related terms in the criminal justice setting:

- *Screening*—A process for evaluating someone for the possible presence of a particular problem. The screening process does not necessarily identify what kind of problem the person might have or how serious it might be but determines whether or not further assessment is warranted. Screening does not typically include assignment of DSM-IV-TR (*Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision [American Psychiatric Association {APA} 2000]) diagnoses of alcohol or drug abuse or dependence and may only identify DSM-related problem areas. During the screening process staff members use instruments that are limited in focus, simple in format, quick to administer, and usually able to be administered by nonprofessional staff. There are seldom any legal or professional restraints on who can be trained to conduct a screening.
- *Assessment*—A process for defining the nature of a problem and developing specific treatment recommendations for addressing the problem. A basic *assessment* consists of gathering key information and engaging in a process with the client that enables the counselor to understand the client's readiness for change, problem areas, any diagnosis(es), disabilities, and strengths. The assessment process typically requires trained professionals to administer and interpret results, based on their experience and training. A clinical diagnosis has important legal ramifications since judges tend to rely on assessments to identify an offender's needs and risks, and to determine the offender's disposition.

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

- *Eligibility*- Does the offender meet the system's criteria for receiving treatment services? A quick screen, typically applicable in prisons and community corrections settings, can determine whether a person warrants assessment to determine if that person has a drug or alcohol problem.

- *Suitability*- Is the offender suitable for the type of program services that are available? An assessment can determine whether the offender is capable of benefiting from treatment or responding to a particular intervention. The question of suitability arises once it has been determined that offenders meet the eligibility criteria for receiving services.

In essence, screening and assessment vary based on the goals of the evaluation and the setting where they are used. For drug court and jail settings, a source for operational treatment and criminal justice definitions is the article "Guideline for Drug Courts on Screening and Assessment" (Peters and Peyton 1998).

## Common Myths About Screening and Assessment

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

- *Myth*: Screening and assessment are no better than intuition in detecting a person's need for treatment.
  - *Fact*: Objective screening and assessment measures can result in treatment that is better targeted to a client's needs, resulting in better outcomes.
- *Myth*: Only a single screening is needed to place people in different levels of treatment services.
  - *Fact*: Accurate evaluation requires a battery of assessment instruments that examine how substance use has affected all the domains of the client's life. When treatment options are severely limited, however, a basic screening may be sufficient to determine both eligibility and suitability for treatment.
- *Myth*: Untrained professionals can conduct screening and assessments.
  - *Fact*: Although some screenings can be administered and scored without significant training, placement decisions are greatly improved when they are made by professionally trained staff. This includes staff with relevant certification in substance abuse treatment, those with advanced professional degrees, and those with specialized training in the use of particular screening and assessment instruments. For those screening and assessment approaches that require an interview with the offender, specialized training is also needed in basic counseling techniques such as rapport building and reflective listening. Use of trained professional staff in the triage and placement process helps to minimize the number of inappropriate referrals for treatment.

- *Myth:* Screening and assessment are always compromised because you cannot trust self-report information from offenders.
    - *Fact:* Research generally validates the reliability, and to some degree, the validity of information obtained through self-reports. Collateral sources such as the offender's family and friends can improve the reliability of the information gathered (or "the full picture"). Offenders do supply a certain amount of misinformation in some settings to avoid unwanted consequences, however.
  - *Myth:* All screening and assessment instruments are equally effective.
    - *Fact:* Research shows significant variability in the reliability and validity of different instruments with different populations.
  - *Myth:* Because an instrument is widely used, it must be effective.
    - *Fact:* Many highly marketed and widely used instruments do not have a research base supporting the validity of their use. In fact, some of the widely marketed and used instruments have been shown to be less effective than those available in the public domain.
  - *Myth:* Screening and assessment should not examine the history of physical and sexual abuse and related trauma because this may aggravate the offender's level of stress and psychological instability, and staff may not be able to deal effectively with the consequences.
    - *Fact:* Screening and assessment of all forms of abuse is essential for both male and female offenders, because it is now recognized that the effects of trauma contribute to many mental disorders. Clinical outcomes are likely to be compromised if these abuse and trauma issues are not explored, and if strategies addressing these issues are not developed and integrated into treatment plans for mental and substance use disorders. However, it is important to emphasize that in screening for a history of trauma it can be damaging to ask the client to describe traumatic events in detail. To screen, it is important to limit questioning to very brief and general questions, such as "Have you ever experienced childhood physical abuse? Sexual abuse? A serious accident? Violence or the threat of it? Have there been experiences in your life that were so traumatic they left you unable to cope with day-to-day life?"
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## Screening Guidelines

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

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

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

### *Purpose of Screening*

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

**Figure 1: Screening Guidelines by Domain**

Domain	Information
<i>Substance Use</i>	<ul style="list-style-type: none"><li>• Substance use history</li><li>• Motivation and desire for treatment</li><li>• Severity and frequency of use</li><li>• Detoxification needs, acute intoxication</li><li>• Treatment history (e.g., number and type of episodes, outcomes)</li></ul>

<i>Criminal Involvement</i>	<ul style="list-style-type: none"> <li>• Criminal thinking</li> <li>• Current offense(s)</li> <li>• Prior charges</li> <li>• Prior convictions</li> <li>• Age at first offense</li> <li>• Type of offense(s)</li> <li>• Number of incarcerations</li> <li>• Prior successful completion of probation or parole drug use offenses</li> <li>• Prior involvement in diversionary programs</li> <li>• History of diagnosis of any personality disorder</li> </ul>
<hr/>	
<i>Health</i>	<ul style="list-style-type: none"> <li>• Intoxication, infectious disease (tuberculosis, hepatitis, sexually transmitted diseases, HIV status)</li> <li>• Pregnancy</li> <li>• General health</li> <li>• Acute conditions</li> </ul>
<hr/>	
<i>Mental Health</i>	<ul style="list-style-type: none"> <li>• Suicidality</li> <li>• History of treatment and prior diagnosis</li> <li>• Past diagnoses</li> <li>• Treatment outcome</li> <li>• Current and past medications</li> <li>• Acute symptoms</li> <li>• Psychopathy</li> </ul>
<hr/>	
<i>Special Considerations</i>	<ul style="list-style-type: none"> <li>• Educational level</li> <li>• Reading level/literacy</li> <li>• Language/cultural barriers</li> <li>• Physical disability</li> <li>• Developmental disability</li> <li>• Learning disability</li> <li>• Health and biomedical record</li> <li>• Housing</li> <li>• Dependents/family issues</li> <li>• History of abuse (victim and/or perpetrator), including trauma experienced as a result of physical and sexual abuse</li> </ul>
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Screening guidelines will vary by setting. A professional screening of an individual who has just been arrested will include different questions and require different information than a long-term prisoner being considered for parole. For a probationer, screening might be used to determine the appropriate level of supervision; a jail inmate may be screened to assess his or her suitability for treatment. Figure 2 highlights the different screening considerations for each setting.

**Figure 2: Screening Guidelines by Setting**

Setting	Purpose	Special Considerations
Jails	<ul style="list-style-type: none"> <li>• For early identification, if getting out of jail early</li> <li>• To determine eligibility for drug courts and pretrial diversion programs</li> <li>• For diversion to specialized mental health courts or programs focused on behavioral problems</li> <li>• To determine behavioral management problems and acute needs (including crisis intervention)</li> <li>• To identify suitability for placement in jail treatment programs</li> <li>• For classification to different housing units</li> </ul>	<p>Look for previous correctional substance abuse treatment, readiness for treatment, past institutional behavior problems, prior correctional treatment, and court orders.</p>

Prisons	<ul style="list-style-type: none"> <li>• To match time left to serve with time for receiving treatment or for custody level classification</li> <li>• To identify suitability for placement in prison treatment programs</li> </ul>	Look at prison record, treatment history (including treatment for issues other than substance abuse), and behavior.
Pretrial and Community Supervision	<ul style="list-style-type: none"> <li>• To determine the need for housing, transportation, employment, or economic benefits</li> <li>• To identify suitability for placement in community treatment programs</li> <li>• To assess for public safety risk and level of supervision needed, pursuant to consideration for placement in diversion programs</li> </ul>	Look for community or corrections records or collateral information (e.g., information from family members).

### *Selection of Screening Tools*

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

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

- Drug test results (from examination of hair, sweat, urinalysis, Breathalyzer®)

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

## **Assessment Guidelines**

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

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

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

The instruments and sources of information used during an assessment are determined by the purpose of the assessment. Jurisdictions may elect the quickest and most efficient approach to assess who goes into treatment. In other cases, the court may want the greatest amount of information available about an offender. In this case, in addition to police, corrections, and medical records, an assessment should include family and other collateral sources for historical information.

The following guidelines pertain to assessment protocols:

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

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

### ***Advice to the Counselor: Screening and Assessment***

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

## **Key Issues Related to Screening and Assessment**

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

### *Accuracy of Information*

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

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

Unless potential concerns related to the screening and assessment process are addressed directly, it is unlikely that screening and assessment results will provide an accurate picture of the offender's substance abuse problems and treatment needs. Offenders should be briefed in advance regarding who will have access to screening and assessment information and how the information will be used. Counselors and criminal justice professionals should also clearly indicate their own role in the information gathering process. It may also help to address myths regarding court-ordered or other mandated treatment and treatment program requirements, and to describe the benefits of participating in treatment. Counselors working in criminal justice settings should also be aware of issues related to confidentiality and informed consent in the context of screening and assessment (see CSAT 2004 and [www.hipaa.samhsa.gov](http://www.hipaa.samhsa.gov) ).

### *Continuity of Information*

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

Effective treatment programs require assessment and coordination between substance abuse treatment and criminal justice programs and an understanding of the goals of both systems. Coordination also leverages the scarce resources for substance abuse treatment (CSAT 1994a). 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 and procedural levels. In addition, cross-training can promote the use of screening and assessment results and can reduce duplication of efforts (CSAT 1994a).

### *Systemwide Information Sharing*

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

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

At each stage of the criminal justice process there can be individuals or agencies that do not support sharing of substance abuse screening and assessment information. These groups have legitimate concerns that need to be expressed, and they need to be brought into the decision-making process as full stakeholders. Jurisdictions that establish interagency agreements can preserve limited staff time and resources and help avoid unexpected resistance to systemwide sharing of screening and assessment information at any stage in the criminal justice process. See the text box below for examples of programs that have developed multilevel agreements for sharing information systemwide.

### **Examples of Multilevel Agreements for Systemwide Sharing of Information**

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

#### **Lane County, Oregon**

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

#### **High Intensity Drug Trafficking Areas Automated Tracking System**

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

### **Maricopa County, Arizona**

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

### **Orange County Probation Department**

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

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### *The Need to Rescreen and Reassess*

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

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

## ***Advice to the Counselor: The Need to Rescreen***

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

### *Timing of Screening and Assessment*

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

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

### *When Is a Formal Diagnosis Necessary?*

When identified with a diagnosis that will follow them throughout the system or even their lifetime (if entered into the criminal justice system's computer), people sometimes feel labeled and stigmatized. This is particularly true of diagnoses related to mental disorders. Because symptoms of mental disorders are often mimicked by recent drug or alcohol use, or withdrawal from these substances, it is particularly important to defer diagnosis until an adequate assessment period is provided under conditions of abstinence. A "people first" description such as "offender who uses drugs" is preferable to the label "drug user." Moreover, diagnostic classification can sometimes preclude offenders from receiving

needed services. For example, a mental disorder diagnosis can preclude access to substance abuse services. Likewise, a substance abuse diagnosis can preclude access to mental health services, resulting in no services being rendered. A substance abuse diagnosis can also limit an offender's access to certain work assignments or vocational training.

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

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

### *Drug Testing*

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

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

## **Areas to Address in Screening and Assessment**

This section describes the key areas that are important for effective screening and assessment.

### *Substance Abuse History*

Major topics covered during screening and assessment include observable signs and symptoms of alcohol or drug use, signs of acute drug or alcohol intoxication and withdrawal effects, drug tolerance effects, negative consequences associated with substance abuse, the self-reported history of substance abuse, age and pattern of first substance abuse, recent patterns of use, drug(s) of choice, and motivation for using substances. A full examination is made of the prior involvement in treatment, both in criminal justice and non-criminal-justice settings. Family history of substance abuse is also important, including current patterns of abuse by family members who have contact with the offender.

### Screening instruments

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

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

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

**Figure 3: Recommended Substance Abuse Screening Instruments**

Instrument	Purpose	Description
<b>Alcohol Dependence Scale (ADS)</b>	A 25-item instrument developed to screen for alcohol dependence symptoms; performs adequately in community and institutional settings	<ul style="list-style-type: none"> <li>The ADS (Skinner and Horn 1984) can be coupled with the ASI-Drug Use section to provide an effective screen for alcohol and drug use problems among offenders. For more information on the ADS, contact the Center for Addiction and Mental Health (formerly the Addiction Research Foundation) at (800) 661-1111. The ASI is reprinted in TIP 7, <i>Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System</i> (CSAT 1994e). As TIP 7 is currently out of print, information on ordering copies of the ASI can be found in Appendix C.</li> </ul>
<b>Simple Screening Instrument for Substance Abuse (SSI-SA)</b>	A 16-item screening instrument that examines symptoms of both alcohol and drug dependence	<ul style="list-style-type: none"> <li>An expert panel developed the SSI-SA as a tool for outreach workers. The SSI-SA, which can be administered without training, includes items related to alcohol and drug use, preoccupation and loss of control, adverse consequences of use, problem recognition, and tolerance and withdrawal effects. The SSI-SA is reproduced along with instructions in TIP 42, <i>Substance Abuse Treatment for Persons With Co-Occurring Disorders</i> (CSAT 2005c).</li> </ul>
<b>TCU Drug Screen (TCUDS)</b>	A 15-item substance abuse diagnostic screen	The TCU Drug Screen is completed by the offender and serves to quickly identify individuals who report heavy drug use or dependency (based on the DSM-IV-TR and the National Institute of Mental Health Diagnostic Interview Schedule) and who therefore might be eligible for treatment. For more information regarding the TCUDS and other related instruments go to <a href="http://www.ibr.tcu.edu">www.ibr.tcu.edu</a> .

Source: Peters et al. 2000.

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

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

### Assessment instruments

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

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

### *Detoxification Needs*

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

Safe withdrawal from substances such as stimulants, cocaine, hallucinogens, and inhalants can be achieved with psychological support, symptomatic treatment, and periodic reassessments by healthcare providers. Frequent clinical assessments, along with appropriate treatment adjustments, are also important since the intensity of withdrawal cannot always be predicted accurately (Federal Bureau of Prisons 2000). Some substances, such as alcohol, sedative-hypnotics, and anxiolytics, can produce dangerous withdrawal syndromes once physiological dependence has developed. Offenders who have severe and life-threatening symptoms of intoxication or withdrawal should be placed immediately under medical supervision. The Federal Bureau of Prisons (2000) recommends that "inmates presenting with alcohol intoxication should be presumed to have alcohol dependence until proven otherwise" (p. 8).

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

For more information on the signs and symptoms of intoxication and withdrawal and the treatment of individuals undergoing detoxification, see the forthcoming TIP *Detoxification and Substance Abuse Treatment* (CSAT in development a ). The *Federal Bureau of Prisons Clinical Practice Guidelines: Detoxification of Chemically Dependent Inmates, December, 2000* can be accessed online at [www.nicic.org/pubs/2000/016554.pdf](http://www.nicic.org/pubs/2000/016554.pdf).

### ***Advice to the Counselor: Screening for Detoxification***

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

### ***Physical Health Conditions***

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

### *Readiness for Treatment*

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

Readiness for treatment is not always clearly defined or apparent at the onset of treatment. Most clients do not volunteer for treatment and experience significant ambivalence about the process and level of commitment required. For years, treatment professionals and paraprofessionals believed that a person needed to "hit bottom" to be ready for change. Today, it is recognized that people can be ready for treatment without "hitting bottom" and that many people can receive benefits from treatment even if they are not completely ready. For example, motivational interviewing (MI) techniques (discussed in detail in the DLCAS.com course on *Motivational Change in Substance Abuse Treatment*) can be used to help clients resolve their ambivalence toward treatment and toward making changes in their lives. MI provides an empathic, supportive, and directive counseling style that attempts to persuade and guide the client toward change rather than to create motivation through confrontation of the client's substance abuse problems and labeling the client as an "addict."

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

An individual's readiness for change is one of the most important factors that substance abuse counselors and clinicians should examine during the screening and assessment process, and has been found to be predictive of treatment retention and other outcomes. Studies have shown that initial motivation for treatment influences enrollment in post-release treatment services (De Leon et

al. 2000; Simpson and Joe 1993). Several treatment interventions (e.g., MI, motivational enhancement therapy) (Miller and Rollnick 2002) have been developed to explore and enhance readiness for treatment. Many substance abuse programs in the criminal justice system include a "pretreatment," or "readiness" phase designed to address the needs of offenders not yet committed to recovery goals and ongoing involvement in treatment. This initial phase of treatment addresses offenders' goals, expectations, and motivation for change. This intervention helps identify offenders who are ready for more intensive treatment services that require full participation in activities designed to encourage changes in attitudes and behaviors.

Assessing readiness includes obtaining information about clients' awareness of a substance problem, their ability to acknowledge their need for help, their willingness to accept help, their perception of how others feel about their need for help, and whether they have taken steps to change on their own (Wanberg and Milkman 1998). Generally, clients can be considered "ready" for treatment if they want to abstain from substance abuse, see treatment as a means to become drug- or alcohol-free, and recognize the difficulty in abstaining from substance abuse without professional assistance (CSAT 1994a ). Figure 4 describes several brief instruments that can be used to assess readiness for treatment.

**Figure 4: Instruments for Evaluating Readiness for Treatment**

Instrument	Description
<b>The University of Rhode Island Change Assessment Scale (URICA)</b>	URICA was developed to assess stage of change. The instrument is known to be valid with different populations in a variety of settings. El-Bassel and colleagues have determined that URICA is useful, reliable, and valid among incarcerated women who use drugs (el-Bassel et al. 1998). The URICA and other similar instruments are reprinted in TIP 35, <i>Enhancing Motivation for Change in Substance Abuse Treatment</i> (CSAT 1999b ).
<b>The TCU Treatment Motivation Scales</b>	The TCU Treatment Motivation Scales can be used to track the stages of change in treatment motivation. For further information, go to <a href="http://www.ibr.tcu.edu">www.ibr.tcu.edu</a> .

**The Circumstances, Motivation, Readiness, and Suitability Scales (CMRS)**

The CMRS scales were designed to predict retention based on dynamic client factors related to seeking and remaining in treatment (DeLeon et al. 1994). The Circumstances scale is defined as the external pressure to engage and remain in treatment. The Motivation scale is defined as the internal pressure to change; the Readiness scale is defined as the perceived need for treatment; and the Suitability scale is defined as the individual's perception of the treatment modality or setting as appropriate for himself. A prison version has been developed. A revised version of the CMRS, the CMR, is also available. The CMR is copyrighted and can be obtained by contacting the National Development and Research Institute, Inc., 71 W. 23rd Street, 8th Floor, New York, New York 10010, or mail@ndri.org.

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**Stages of Change, Readiness, and Treatment Eagerness Scale (SOCRATES)**

SOCRATES includes items specifically focused on alcohol abuse and can be used as a starting point for discussion. A Spanish translation is available. The SOCRATES and other similar instruments are reprinted in TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999b).

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*Co-Occurring Disorders*

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

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

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

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

## **Steps for Assessing the Interactive Effects of Co-Occurring Disorders**

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1. Assess the significance of the substance use disorder. Obtain a chronological history describing the onset of mental disorder and substance abuse symptoms.
  - Determine whether mental disorder symptoms occur only in the context of substance abuse.
  - Determine whether ongoing abstinence leads to rapid and full resolution of mental disorder symptoms.
2. Determine the duration of the current period of abstinence.
  - If there has not been a 4–6 week period of abstinence, repeat assessment and diagnosis after such a period, depending on clinical judgment about the particular drug abuse history and the offender's physical status.
3. Reassess mental disorder symptoms at the end of 4–6 weeks of abstinence or at any time such symptoms appear or change.

4. If mental disorder symptoms are fully resolved, consider referral for traditional substance abuse treatment; if not, consider referral for mental health or specialized co-occurring disorders services.
  5. Provide ongoing reevaluation of the offender's mental disorder symptoms and progress in treatment.
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No single instrument can adequately screen for all mental and substance use disorders, particularly given the constraints of length, cost, and required training—but a combination of instruments can be used (Peters and Hills 1999). The choice of substance abuse screening instruments should be based on the purpose of the screening, ethnic or racial characteristics, language spoken, and gender (Broner et al. 2002). Figure 5 provides a list and description of instruments used to screen and assess for mental disorders.

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

### **Figure 5: Instruments for Screening and Assessing Mental Disorders**

<b>Instrument</b>	<b>Description</b>
<b>Beck Depression Inventory II (BD-II) (Beck et al. 1996)</b>	<ul style="list-style-type: none"> <li>• A 21 -item self-report of symptoms that screens for symptoms of depression.</li> <li>• Requires no significant training to administer.</li> <li>• Found to be the most effective instrument in detecting depression among individuals who abuse alcohol (Weiss and Mirin 1989).</li> <li>• Should not be used as a sole indicator of depression but in conjunction with other instruments (Weiss and Mirin 1989; Willenbring 1986).</li> </ul>

**Brief Symptom Inventory (BSI) (Derogatis 1975a)**

- A short form of the Symptom Checklist 90 - Revised (SCL-90-R).
- Comprising 53 items, including three global indices of psychopathology (General Severity Index, Positive Symptom Total, Positive Symptom Distress Index) and nine primary psychiatric symptom dimensions.
- Quick to administer and requires no significant training to administer.
- Only a 6th grade reading level is required.
- May be most useful as a general indicator of psychopathology (Boulet and Boss 1991).

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**General Behavior Inventory (GBI) (Depue and Klein 1988)**

- A 73-item self report instrument that examines mood disorders.
- Requires no significant training to administer.
- Differentiates between unipolar and bipolar depression.

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**Hamilton Depression Scale (HAM-D) (Hamilton 1960)**

- A 17-item scale completed by an interviewer based on self-report information.
- Examines several key elements of depression, including sleep disturbance, somatization, anxiety-depression, and apathy.
- Requires training to administer.

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**Mental Health Screening Form-III (MHSF-III) (Carroll and McGinley 2001)**

- Eighteen simple questions designed to screen for present or past symptoms of most of the main mental disorders.
  - A "rough" screening device and asks only one question for each disorder for which it attempts to screen.
  - Reproduced in TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005c).
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**Millon Clinical Multiaxial Inventory (MCMI-III) (Millon 1983; Millon et al. 1994)**

- A self report measure with several subscales.
- Useful in assessing Axis II (personality) disorders that may affect involvement in treatment.
- Includes the Drug Abuse Scale (DAS), an instrument designed to measure personality characteristics often associated with drug abuse (Calsyn and Saxon 1989).

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**Minnesota Multiphasic Personality Inventory (MMPI-2) (Butcher et al. 2001)**

- A self report measure with 567 items, 10 main clinical scales, and 10 supplementary scales.
- A restandardized version of the MMPI.
- Frequently used in correctional settings for classification and assignment to housing or inmate programs, and to predict an inmate's response to placement in a correctional setting.
- Useful in identifying characteristics of antisocial personality disorder.
- Designed to identify psychopathology and not to identify substance use disorders.

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**Personality Assessment Inventory (PAI) (Morey 1991)**

- A self-report measure with 344 items and 22 scales.
- Eleven clinical scales include separate measures of alcohol problems and drug problems.
- Five treatment scales are also provided in the PAI.

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**Referral Decision Scale (RDS) (Teplin and Swartz 1989)**

- A 14-item measure of mental disorder symptoms developed to identify mental health problems.
  - Developed and validated in a criminal justice setting.
  - Found to be useful in detecting the presence of major mental illness among jail inmates.
  - Requires no training to administer.
  - Self administered.
  - Examines only a few mental disorders (depression, bipolar disorder, schizophrenia).
-

**Symptom Checklist 90 - Revised (SCL-90-R) (Derogatis 1975b)**

- A 90-item, multidimensional self-report inventory designed to assess recently experienced physical and psychological distress.
  - Requires no training to administer.
  - Self-administered.
  - Short amount of time to administer.
  - Frequently used in criminal justice settings.
  - Covers a wide range of symptom dimensions that include somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism.
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***Advice to the Counselor: Screening for Co-Occurring Disorders***

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

Rates of trauma in men and women entering the criminal justice system are higher than are rates found in community samples. For example, Teplin et al. (1996) found that 34 percent of female jail inmates had PTSD. According to the DSM-IV-TR, trauma is defined by two characteristics:

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

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

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

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

Only trained counselors should inquire about abuse and trauma issues. The counselor should be prepared for how to respond to self-disclosed experiences related to physical and sexual abuse and how to provide referral for services. In most substance abuse settings, the goal of screening or an intake interview is not to compile detailed and comprehensive information regarding past trauma, but to identify that the offender has a history of trauma for purposes of treatment

planning, triage, and referral for more intensive services. As a result, counselors should be familiar with and have ready access to resources (e.g., counselors with mental health training, liaisons from women's shelters and treatment programs) to refer persons who wish to discuss their histories of trauma in more detail.

Although clinicians are sometimes concerned about addressing material that is potentially uncomfortable or even overwhelming for either the client or themselves, these adverse consequences are rarely experienced when these issues are raised by well-trained staff. In fact, offenders are typically relieved to talk frankly about their abuse and trauma experience, albeit in an appropriately limited fashion. In-depth discussion of the specific events surrounding traumatic experiences is typically conducted in follow-up individual or group treatment sessions that specifically address this topic area. Treatment for trauma issues progresses in stages, with early treatment goals focused on issues of ensuring safety in relationships, the place of residence, and in the workplace. Later work explores issues of recovery and reconciliation, if appropriate. This later work is frequently conducted by therapists with advanced degrees and in most cases is not appropriately addressed by paraprofessional staff.

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

Sample interview questions could include:

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

# Screening and Assessment of Abuse and Trauma History

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## Structured interview assessments

Trauma Assessment & Treatment Resource Book  
New York State Office of Mental Health's Trauma Initiative  
Design Center  
44 Holland Ave  
Albany, NY 12229  
Fax requests: (518) 473-2684

The Integrated Biopsychosocial Assessment that includes trauma history questions in an assessment form appropriate for a mental health or substance abuse setting. Available from:

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

## Self-report instruments

The Traumatic Antecedent Questionnaire (TAQ) (van der Kolk 1992). A widely used measure of lifetime experiences of trauma in 10 domains, i.e., physical, sexual, witnessing trauma, etc.

The Dissociative Experiences Scale (DES) (Bernstein and Putnam 1986). A self-report measure examining several domains of dissociative phenomena, often sequelae of trauma, i.e., amnesia, identity alterations, spontaneous trance states, etc.

The Clinician Administered PTSD Scale (CAPS) (Blake et al. 1998). A clinician-administered scale that provides an accurate diagnosis of PTSD.

The Trauma Symptom Inventory (TSI) (Briere 1995). A 100-item self-report instrument that evaluates symptoms in adults that may have arisen from childhood or adult traumatic experiences. Includes 10 clinical scales and 3 validity scales. An alternate version (TSI-A) includes no references to sexual issues. The companion Trauma Symptom Checklist 40 (Briere 1995; Briere and Runtz 1989) is a 40-item instrument that contains 6 sub-scales. Items are rated on a 4-point scale covering frequency over the past 2 months.

Posttraumatic Disorder Scale (PTDS) (Foa et al. 1993). Measures trauma history and specific symptoms associated with posttraumatic stress disorder.

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## **Advice to the Counselor: Screening for Trauma**

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

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

#### Psychopathy

One stable risk factor often found among offenders with substance use disorders is psychopathy and the closely related antisocial personality disorder defined in the DSM-IV classification system. Personality disorders are persistent and pervasive patterns of maladaptive behavior that are usually exhibited early in life. Historically, many terms have been used to describe personality disorders that involve criminogenic characteristics. Four closely linked terms are "sociopath" (and the trait of sociopathy), "antisocial personality" (and antisocial traits), "dissocial personality" (dissocial behavioral traits), and "psychopathic personality

disorder" (psychopathy or psychopathic traits). Whereas the first three formulations of criminogenic personality types focus on social deficits and mild emotional and cognitive problems resulting in impulsivity and poor school achievement, psychopathy focuses on primary and severe deficits in attachment and interpersonal bonding, lack of empathy for others' experiences, lack of remorse, and shallow emotional functioning. These relatively stable traits are thought to have a biological basis. As previously indicated, psychopathy is related to the DSM-IV antisocial personality disorder but represents a more extreme version of that disorder. Some would argue that psychopathy represents a distinct diagnostic group. From 40 to 60 percent of male prison inmates meet the criteria for antisocial personality disorder, whereas only 10 to 20 percent of male prison inmates meet the criteria for psychopathy (Hare et al. 1991).

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

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

Several other short self-report screening instruments for psychopathy have been developed but have yet to be fully validated with criminal justice populations. These include the Psychopathic Personality Inventory (Lilienfeld and Andrews 1996), the Psychopathy Q-Sort (Reise and Oliver 1994; Reise and Wink 1995), and the Levenson Self-Report Psychopathy Scale (Brinkley et al. 2001; Levenson et al. 1995). A number of other screening and assessment instruments examine personality features related, but not identical, to psychopathy (Zimmerman 2000), as described in Figure 6

## **Advice to the Counselor: Screening for Psychopathy**

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

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

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

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

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

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