Screening and Assessing Substance-Abusing Offenders: Quantity and Quality

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THE CRIMINAL justice system continues to be overwhelmed by the number of offenders with substance abuse problems. The impact of the large number of substance-abusing offenders now is achieving attention in and out of the system. For example, a recent Bureau of Justice Statistics publication estimated that 36 percent of convicted offenders, under the jurisdiction of corrections agencies, were consuming alcohol at the time of the offense (Greenfeld, 1998). When the numbers for drugs are combined with the numbers for alcohol, the estimates appear to reach 80 percent to 90 percent of offenders who have serious substance abuse problems (Lipton, 1998).

In some correctional agencies, this large number of offenders is their single greatest challenge. For example, in some state correction systems, it is not unusual for the agency to be in-processing 3,000 to 4,000 offenders a month. Included in the offenders' general processing is usually a determination of the offender's involvement with alcohol and other drugs (AOD) or substance use disorders (SUDs). Some of the problems created by unprecedented numbers of offenders being processed through the system were foreseen. Lipton (1998) identifies "inadequate selection/diagnostic process to ensure that offenders selected for these programs are the ones likely to benefit from them" as being a critical problem amplified by the sheer number of offenders to be screened and assessed for substance abuse as they enter correctional facilities. (p. 23)

Clinical screening and assessment have been identified as two of the basic tasks and responsibilities (also known as core functions) of an addiction counselor (Curr. Review Committee, CSAT, 1995). In addition, the Center for Substance Abuse Treatment has provided for addiction counselors extensive technical publications with guidelines for screening and assessing substance-abusing offenders (Crowe & Reeves, 1994; Inciardi, 1994). Drawing on these valuable resources, some of the unique issues and challenges created by the large number of offenders needing screening and assessment will be identified in the discussion that follows. Understanding these issues and challenges clearly is important for correctional managers and program supervisors because a lack of screening and assessment procedures was one of the key factors where there have been problems with implementing substance abuse programs. (Austin, 1998).

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Screening

A clinical screening is an initial gathering and compiling of information to determine if an offender has a problem with AOD abuse and, if so, whether a comprehensive clinical assessment is warranted. Screening can be accomplished through a structured interview or instruments that are designed to get offenders to self-report information about their substance abuse. As Inciardi (1994) has stated, "Screening also filters out individuals who have medical, legal, or psychological problems that must be addressed before they can participate fully in treatment." In addition, screening may identify those offenders who would not profit from or be ready for treatment. The screening process is particularly critical because of the limited funds for subsequent assessment, which tends to be more expensive and time consuming than screening.

Interview vs. Self-Report

As the number of offenders entering criminal justice-based drug treatment programs increases, the ongoing debate about using interviews versus self-report measures has intensified. The first type of screening and assessment is referred to as a "structured counselor-client interview" and the second as a "self-administered assessment." The first type, with the benefit of providing an opportunity for the counselor to build rapport with the client, is clinically preferred. If a clinical interview is not possible, then a self-administered instrument, which requires less of the counselor's time, may be more appropriate. In addition, program administrators can get a better statistical profile of the population of offenders being screened with self-administered instruments. The question with self-report measures is whether they can be trusted to deliver as quality information as interviews do. As Broome, Knight, Joe, and Simpson (1996) report, "The few investigators who have compared interview-administered assessment and self-administered assessment with the same measure have found generally consistent agreement between the two assessment types."

Another major issue concerns the cost of screening. The per-unit cost of screening offenders is always an important budgetary concern, but when the cost reaches $3000 to $4000 a month, it becomes critical. Even a per-unit cost for instruments like the *Substance Abuse Subtle Screening Inventory* (SASSI), which costs about $1.50 an inmate, can be very expensive. Because of budgetary concerns, it becomes increasingly more important for substance abuse

programs to secure screening instruments that lie within the public domain with very low per-unit costs.

One such instrument currently in use is the *Texas Christian University Drug Dependence Screen* (TCUDDS). This instrument is consistent with the DSM-IV classifications for substance abuse and dependency. Since it falls within the public domain, it has a low per-unit cost. In addition, the TCUDDS is relatively brief and can be automated for ease of scoring. With the increasing number of offenders, the use of lengthy screening interviews becomes impractical, and an instrument of this type shows considerable promise for screening. Conversely, the high volume of offenders to be screened makes automated scanners and scoring programs very cost effective.

Accuracy

Most substance abuse programs obviously would prefer a screening instrument that only identified offenders who had serious substance abuse problems. Unfortunately, most instruments have psychometric properties that produce either over- or under-identification of substance abuse problems. When an instrument over-identifies substance abuse, it is termed a *false positive*. This means the screening instrument has indicated that the offender has a problem when, in reality, the offender does not. When an instrument under-identifies substance abuse, it is termed a *false negative*. This means the screening instrument has indicated that the offender does not have a problem when the offender actually does.

For typical substance abuse programs, the preferred outcome is to err on the side of false positive and reduce false negatives because it is important that individuals with substance abuse problems not be missed in the screening process (Nathan, 1996). Offenders who are over-identified can be eliminated from the program by the subsequent assessment process using more detailed diagnostic instruments.

The issue for agencies screening large numbers of offenders is one of consciously or unconsciously moving in the direction of false negative. Because of strained assessment and treatment resources, there is a greater advantage in screening instruments with *false negative* psychometric tendencies. In other words, it might be better to initially under-identify substance-abusing offenders and later conduct a document or criminal records check to see if a decision is warranted to override the initial screen. On the other hand, missing offenders with serious substance abuse problems would seem to be counter to the mission of the treatment programs and concerns for public safety. The challenge is to achieve a high level of screening accuracy.

Psychopathy

Recent research by Rice (1997) has emphasized the importance of screening offenders for psychopathy who may be potential candidates for placement in substance abuse therapeutic communities. Her research suggests that certain treatments, such as therapeutic communities, may actually increase the psychopath's future violence. It would follow that screening psychopathic tendencies is critical for successful placement in treatment programs.

Without getting into a detailed discussion of the theory and research on psychopathy, it is sufficient to say that it is a characteristic that is most difficult to screen in offender populations. At present, the most valid method of measuring psychopathy is the *Psychopathy Checklist-Revised* (PCL-R) (Hare, 1991). This 20-item checklist, designed for use in prison settings, provides a score that reflects the probability that an individual is a psychopath. Alterman, Cacciola, and Rutherford (1993) report that the PCL-R has high reliability and good validity in prisoner populations. In addition, most of the published work on the PCL-R has been on offender populations, but there is little evidence that this instrument is being used for screening large offender populations.

Another promising measure of psychopathy is the *Psychopathic Personality Inventory* (PPI) developed by Lilienfeld and Andrews (1996). The PPI is a 56-item, self-report inventory that provides a total score on psychopathy and factor scores on eight dimensions of psychopathy: Machiavellian egocentricity, social potency, cold-heartedness, carefree nonplanfulness, fearlessness, blame externalization, impulsive nonconformity, and stress immunity.

The strength of the PPI is that it is based more on psychopathic behavior than psychopathic personality, which is more consistent with DSM-IV diagnosis of antisocial personality disorder. The DSM-IV diagnosis emphasizes a history of criminal behaviors, so the PPI is more likely to identify the offender that substance abuse programs are concerned about.

The disadvantage of the PPI is that it was constructed for use with subjects in non-prison settings, having been developed on college student samples. This raises a critical question of generalizability: Can the psychopathic traits of college students be generalized to incarcerated samples? Until this concern is resolved, the PPI would seem to have limited value for screening psychopathy in substance-abusing offenders.

Assessment

Assessment involves a standardized set of procedures designed to:

- Establish baseline information on AOD dependence.
- Assess client readiness for counseling.
- Serve as treatment planning tools for counseling by identifying:
  1) the client's high-risk situations for AOD use and
  2) the client's coping strengths and weaknesses (Annis, Herie, & Watkin-Merek, 1996).

The assessment process is designed to gather detailed data in the social, behavioral, psychological, and physical areas of the offenders' functioning. In recent years, many assessment instruments have been developed to gather data on AOD abuse or SUDs in order to make decisions for placement or treatment planning. Reviews of instruments by Evans (1998), Murphy and Impara (1996), and Inciardi (1994) can be very

helpful in selecting the most appropriate instrument(s) for a particular program because each instrument tends to have specific psychometric strengths and weaknesses.

Currently, the most widely used assessment instrument is the *Addiction Severity Index* (ASI), but many other instruments are available (see Inciardi, TIP #7). The ASI is a structured interview that takes about an hour to complete by a counselor specifically trained in administering the instrument. In large offender populations, the ASI presents some critical issues as an assessment instrument. Software programs are available to enhance this process. First, the ASI is a lengthy interview that becomes too cumbersome for assessing 3,000 to 4,000 offenders a month. Inciardi (1994) indicates that a typical assessment "is conducted in a 2-3 hour procedure, although this can vary" (p. 15). The challenge for counselors conducting assessments in large populations, when we consider these guidelines, becomes mathematically apparent. A 2-hour assessment easily translates to over 2,000 hours a month in the assessment process if one-third of the original 3,000 are screened into the assessment process. One approach is to assess offenders after program placement when it also must be done for treatment planning. Offenders inappropriately screened into the program can be identified at this time.

Second, the staffing of specifically trained professionals is a major challenge for substance abuse assessment. To assess and diagnose substance abuse in offenders, the counselor must have not only general counseling skills, but also sufficient specialized professional training and clinical experience relative to this population (Inciardi, 1994; Evans, 1998). The individual conducting the assessment also must be able to communicate, particularly in writing, the assessment results and conclusions to the individual formulating a treatment plan. The retention of trained assessment personnel in substance abuse treatment programs becomes a challenge for program directors because these skilled personnel become highly desirable recruits for private health care organizations, which usually can pay higher salaries. With many assessments to conduct, as is the case in the large programs, the loss of assessment personnel becomes critical because of the number of offenders who are to be assessed each month.

Readiness Screening

Finally, several intriguing screening instruments are being tested in substance abuse programs to determine the offender's readiness, suitability, and amenability for treatment. Some of these are:

URICA. An offender is ready for treatment when the offender perceives and accepts that he or she is the problem and "owns" the problem. In coerced treatment settings, readiness traditionally has been a challenge for assessment personnel. According to Inciardi,

> Among clients mandated to treatment from the criminal justice system, it is unusual for a client to be genuinely enthusiastic about entering treatment. Most clients are not ready, do not want to be in treatment, and do not like it. (1994, p. 18)

Assessing readiness for treatment has been conceptualized as following several distinct stages of change that offenders may move through as they experience ambivalence about changing their addictive lifestyle. The issue of valuable treatment resources makes the assessment of readiness a primary focus of a comprehensive assessment process.

In order to measure treatment readiness, the *University of Rhode Island Change Assessment* scale (URICA) (Prochaska, Di Clemente, & Norcross, 1992), has been experimentally tested with offender populations. This is a self-report, paper-and-pencil questionnaire that classifies an offender on one of the five sequential stages of change: precontemplation, contemplation, preparation, action, and maintenance. Annis, Schober, and Kelly state that "[a]n important implication of the model, with its discrimination of different stages of change, is that a counselor should engage in a different set of counseling procedures depending on the readiness for change of the client" (1996, p. 153). The URICA shows promise in assessing offenders in their motivation for change so that those in the precontemplative stage, at least, can be matched to a different program for treatment, such as AOD education programs. Serin and Kennedy (1997) found that the URICA was not as useful with offender populations as with other clinical populations, but the sample in their study was quite small and limited to sex offenders. Other studies are under way with the URICA with much larger samples of substance abusing offenders.

CTRS. Traditionally, offenders have reported low readiness for treatment. This result has been attributed to minimalization, denial, and resistance. In the latter case, offenders who are resistant to treatment, who are identified as such, may well require pre-treatment intervention in order for the overall treatment program to be comprehensive and effective. We are not sure why offenders are resistant to treatment, but the question is certainly an important one.

An experimental attempt to identify offender's resistance to treatment, and answer why they are resistant, is represented by the *Correctional Treatment Resistance Scale* (CTRS) (Shearer, 1998). The CTRS measures an offender's response to seven factors: isolation, counselor distrust, compliance, low self-disclosure, cynicism, denial, and cultural issues. These factors are based on the theoretical work of Romig and Gruenke (1991) and Cullari (1996), who point out that overcoming resistance is critical if mental health services are to be effective in corrections. Data from the CTRS and research on the psychometric properties of the instrument currently are being established on offender populations in substance abuse treatment programs. This information can be valuable in addressing specific issues in pre-treatment consciousness raising and education programs.

Several instruments currently are being developed and evaluated that assess several important components of offender attitudinal factors. Research (e.g., Gendreau, Little, & Goggin, 1996) shows that these factors are important predictors of offender recidivism; however, there has been a lack of suitable assessment tools measuring these factors

such that treatment personnel have been reluctant to integrate these factors into treatment planning.

Criminal Sentiments Scale-Modified (CSS-M) and Pride in Delinquency Scale (PID). The CSS-M and PID are two measures of criminal attitudes in which the CSS-M examines offender attitudes toward offending behavior and the PID examines the criminal subculture component of criminal attitudes. Both scales have respectable reliability and validity (Simourd, 1997a). Also, they are relatively simple to administer, score, and interpret and can be used in assessment and program evaluation contexts. The *Criminal Expectancy Questionnaire* (CEQ; Simourd, 1996a) and *Offense Attitude Questionnaire* (OAQ; Simourd, 1996b) are also criminal attitude measures that assess more specific components of criminal cognitions. The CEQ is designed to measure the expectations offenders have about criminal behavior, whereas the OAQ examines the social psychological phenomenon consistent with the theory of reasoned action (Ajzen & Fishbein, 1980) within a criminal behavior context.

The *Self-Improvement Orientation Scheme* (SOS; Simourd, 1997b) is an interview-based instrument that assesses treatment amenability. The SOS is based on the clinical, behavioral, and attitudinal factors related to motivation for personal growth. The importance of their development is emphasized because of the rise in the number of offenders to be screened into treatment programs. It is important to identify those people who are not suitable for therapeutic intervention but, instead, need to be matched to a more appropriate intervention. Treatment matching seems to be the future of screening and assessment, and the development of these types of instruments is vital to accomplish this goal.

Conclusions

Screening and assessment is the beginning of the substance abuse treatment process. According to Chamberlain and Jew,

> Improper assessment and faulty diagnosis can lead counselors to create ineffective treatment plans, have inappropriate expectations for therapy, and instill the overall sense of frustration in the client and the therapist. One cannot treat what one does not recognize or understand. (1998, p. 97)

The large number of offenders entering the system, maintaining adequately trained substance abuse treatment personnel, and the cost and accuracy of screening have become major challenges. In addition, recent research has indicated the need for screening for psychopathy, criminal attitudes, and value systems. Several intriguing assessments, such as change readiness and treatment resistance, are currently being tested in substance abuse programs.

By identifying these issues and challenges, the critical elements of treatment can move forward so that: 1) appropriate offender-treatment matching is possible and; 2) scarce treatment resources can be used wisely by conducting careful assessments before designing and implementing treatment plans. With the large number of offenders entering the system, accurate screening and assessment increase cost effectiveness. In addition, offenders need an accurate picture of their substance use or abuse and how the behaviors relate to offense patterns. Specifically, the feedback of screening and assessment information can give the offender a more realistic estimation of the challenge and effort required to overcome addictions.

Finally, screening and assessing someone as drug or alcohol dependent can bring about serious consequences for that individual. When the screening and assessment is based on instruments that are self-report or brief interviews, the consequences can be devastating. As a result of this rather inexact science, substance abuse counselors ethically are obligated to exercise caution and be professionally certain about the critical issues in screening and assessment when using instruments that are designed to distinguish between those people whose use of substances raises the probability of criminal behavior and those whose substance use does not.

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