 August, 2019 Series No. 1

GUIDELINES AND PERSPECTIVES ON THE ESSENTIAL COMPONENTS OF STANDARDIZED AND EVIDENCED-BASED ASSESSMENT OF ALCOHOL AND OTHER DRUG USE PROBLEMS AND RELATED CONDITIONS IN ADULT POPULATIONS

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OVERVIEW

Most practitioners and agencies conduct an assessment and evaluation of individuals entering intervention and treatment services for alcohol and other drug problems and conditions related to these problems. However, these assessments vary in terms of the methods and procedures used and are not necessarily standardized across evaluators and agencies. The purpose of this paper, referred to hereafter as *Guide*, is to summarize some basic and essential components of effective standardized and evidence-based assessment programs for initial and in-depth evaluation of alcohol and other drug use problems and related conditions in adult populations – individuals 18 or older.

The assessment and evaluation process, particularly the one that is performed at intake into intervention or treatment services is often viewed as a required task and not as an integral and essential part of treatment and the change process. The purpose of treatment and intervention is to effect change. For changes to take place, those areas of change must be clearly identified by both by the client and the service provider. In essence, the assessment process is the beginning of the change process.

Depending on the population of clients being evaluated, assessment programs typically use standardized instruments and interview formats to identify five major areas of problems: AOD (alcohol and other drug) problems, mental health concerns, unresolved issues related to the developmental years, interpersonal and relationship adjustment problems, and legal and social non-conforming problems and patterns. The broad goal of standardized assessment is to identify the specific problem areas that need attention in intervention and treatment programs and to prevent returning to and the continuation of these problem conditions. The following perspectives will be addressed in this document:

- Data Sources for Assessment and Report Subjectivity
- Guidelines for Using Self-Report Instruments
- Multidimensional Assessment
- Levels of Assessment
- Assessment of Strengths
- The Convergent Validation Approach to Assessment
- Inclusion Criteria for AOD Problems in Initial Assessment
- Interpreting Error Risk
- Therapeutic and Correctional Evaluation Perspectives

DATA SOURCES FOR ASSESSMENT AND REPORT SUBJECTIVITY

There are two broad sources of data that are used in the initial and in the comprehensive and in-depth assessment process: other-report and self-report data.

Other-report data

Other-report data represent a broad catch of information most often collected separate from and independent of client self-report. These data include reports from family members, evaluation specialists, treatment professionals, and staff providing judicial supervision, laboratory results and official records. Typically, we sort the other-report data into three categories: Reports from individual third parties who have some familiarity with the client; Official documentation such as laboratory report or legal records; and the evaluator's ratings of the client across various problem areas.

Individual third party other-reports: Such data can be narrative in nature or can be structured into rating scales. Other-report or rater data are considered to be subjective data. In fact, these kinds of data are double-subjective. For example, the information given to the evaluator by the client is subjective. The evaluator's interpretation of the information is subjective. Thus, the final impression or ratings by the evaluator are double-subjective. In addition to being double-subjective, there are other problems with rater or other-report data. Different evaluators often do not agree on the presence or absence of a certain condition. The same evaluator on different occasions can reach different conclusions. The evaluator may not always be consistent in asking the same questions. The evaluator may be biased and make a judgment on the basis of only a few items or symptoms. Rater or other-report data *can* be made more objective when raters use standardized criteria to rate the information provided by either the client or collaterals.

Official documentation: These other-report sources include urine analysis test results, criminal records and records of past treatment, etc. On the surface, these other-reports would appear to be objective data. However, these data are also subject to error, distortion and misreporting. For example, official criminal records will often not fully disclose the extent or even the nature of the client's criminal history. A final charge or conviction may be quite different from the original charge following a plea-bargaining process. The official criminal record often does not reflect the extent of the client's involvement in criminal activity. Documentation of one DUI will not reveal the number of times a client has driven while intoxicated. One laboratory may report a 150 nanogram level of THC whereas another laboratory, using the same urine sample, may report a 70 nanogram level. Blood alcohol level results certainly vary across different laboratories using the same specimen. In spite of these problems with official documentation, this source of data is essential when assessing a client's condition and service or treatment needs.

Evaluator Ratings: Evaluators often use a rating instrument to rate the client across the various problem areas or conditions being evaluated. Some self-report instruments provide rating scales where the evaluator uses both other-report and the self-report results to make the ratings (e.g., ASUS-R, Wanberg 2019a). Using a rating scale that is structured and standardized along with the results of a self-report instrument provides a psychometric basis for utilizing the convergent validation approach to assessment, to be discussed below.

Self-report data

Self-report data are also subjective. However, self-report data become more objective and meaningful when they are based on psychometric principles. There are a number of ways the subjectivity of self-report data can be reduced and made more reliable and veridical (valid).

- When self-report information is collected in a standardized format. Every subject is asked the same questions and is provided with the same response options under a consistent and standardized structure.

- When using a multiple-variable measurement model several questions are used to measure a single construct. One area of evaluation, e.g., social benefit drinking, is measured by several questions. In this way, the risk of an error being made by asking only one question is reduced. The more valid aspects of a variety of questions, all of which are answered by the respondent, more accurately measure the particular area of evaluation. By summing up or adding across all of the questions, subjectivity can be reduced. This is the basis of psychological measurement (Horn, Wanberg, & Foster, 1990; Wanberg & Horn, 1983).

- Subjectivity of self-report is reduced when we use a client's peers as the normative basis upon which to interpret the client's results or scores. Thus, when comparing a defensive client's self-report with a group of his or her peers also thought to be defensive in self-disclosure, we gain a better understanding of the meaning of the client's score rankings.

- Finally, the subjectivity of self-report can be reduced when we develop trust and rapport with the client. This enhances the veridicality (the hypothetical valid or true picture) of self-disclosure.

GUIDELINES FOR USING SELF-REPORT ASSESSMENT INSTRUMENTS

There are a number of important guidelines and considerations that should be followed when using self-report psychometric methods or instruments.

1. Psychometric instruments demonstrate construct validity. It is important to distinguish between the **validity of a measure** and **the validity of the results of the measure of an individual subject**. The latter is seen as a good estimate of where the client is at the time of assessment and based on the level of defensiveness. It is an estimate of the client's "true" condition. Clients open to self-disclosure and in a more advanced stage of change provide a self-report that is a better estimate of their “true” condition.

2. The instrument instructions are read to the client. The most basic instructions prompt the respondent to: "answer each question as honestly as possible", "answer questions as to how you see yourself", "give only one answer to each question unless otherwise specified", "answer all questions", "the results will be treated within the confidentiality guidelines of the laws of your State and the Federal Guidelines of confidentiality", "the results will be used to help you and your service provider develop services most appropriate for you", and "the results of your assessment will be shared with you."

3. The methods of instrument administration are standardized. When the interview method is used to administer a self-report instrument, the questions and response choices should be read exactly as they are in the questionnaire booklet; the client should have a copy of the questionnaire booklet and read each question along with the evaluator. When possible, the client marks the answers on the survey booklet or answer sheet.

4. The reading level of clients is evaluated by asking them to read the first three or four questions.

5. The evaluator understands the instrument as to what it measures and whether it fits in with the evaluator's goals. A simple screening instrument should **only** be used to determine need for a differential intake assessment. An initial service plan and/or service referral is based on a differential assessment instrument. A simple screening instrument should not be used for initial differential assessment.

6. The instrument is appropriate for the group of clients being evaluated. It is most desirable and helpful to have a set of norms representing the client's peers and another representing a group involved in services for which the client is being evaluated. For example, when evaluating AOD use and problems with judicial clients, it is helpful for the instrument to be normed on the specific judicial population of which the client is a member (e.g., impaired drivers, probation, corrections). As well, it is also helpful when evaluating AOD problems, to have a normative group based on an AOD clinical treatment sample with which to compare the client’s AOD involvement and disruption scores.

7. When using computerized versions, the evaluator has knowledge of the instrument itself and not just what the automated assessment report says about any particular client. Computerized scoring and assessment algorithms may give a standardized interpretation of the results based on its norms from different samples, but will not provide the unique features and service needs of each individual client.

8. Clients should receive feedback as to how they compare with their peers, their level of defensiveness and how their results compare with the evaluator's estimate of the client's "true" condition. This feedback is an essential part of the treatment process (Winters, 2001) and supports the partnership model of assessment and treatment (Wanberg & Milkman, 1998, 2008).

MULTIDIMENSIONAL ASSESSMENT

Effective assessment recognizes that there is a general influence of a certain problem area on a person's life and within the problem area there are a wide variety of differences among people (2006, 2010, 2019a; Wanberg & Horn, 1987; Wanberg & Milkman, 1998; Wanberg & Milkman, 2010, 2014; Wanberg, Milkman & Timken, 2005). The general influence level of AOD assessment identifies the extent to which a client is involved in AOD use and a general measure of problems related to that use. Assessment of the general influence is usually the basis of initial assessment at intake into a service system.

The multidimensional level of assessment looks at the specific ways that individuals differ regarding AOD use. Individuals who have alcohol problems differ greatly. Some are solo drinkers and others drink at bars, some have physical problems from drinking and others do not, some drink continuous, and some periodic. Individuals differ with respect to involvement in different kinds of drugs, the extent of negative consequences or symptoms resulting from this involvement, and benefits derived from substance use. The disruptive results from AOD use for one individual may be in the area of performing social or employment roles. For another person, it may be problems and disruption in the psychophysical area of functioning. For another individual, AOD use may be having a serious disruptive influence on the management of anger and even violent behavior. Looking at the more specific influences and problem areas involves the application of a differential, in-depth and multidimensional assessment. Each of these different dimensions may need different treatment approaches and methods.

Multidimensional assessment also includes the evaluation of life-functioning domains that interact with AOD use and abuse. These include mental health issues, antisocial attitudes and behavior, degree of involvement in the criminal conduct and the criminal justice system, family and relationship concerns and problems, vocational and job concerns and problems, motivation for involvement in treatment, client self-perceived strengths, and level of defensiveness. Depending on the service or treatment setting, the assessment process may involve a medical-physical examination.

Although many initial assessment instruments focus on the extent of AOD involvement, some instruments used in the initial assessment provide a measure of multiple conditions related to AOD use. The more in-depth multidimensional assessment is usually done after the client has been admitted into a treatment program. Multidimensional assessment should include both self-report and other-report information. There are a number of self-report and other-report instruments that are available for multidimensional assessment.

LEVELS OF ASSESSMENT

It is helpful to view two levels of assessment: initial assessment, and in-depth assessment. Initial assessment is typically done at intake into a service system. “Screening” has been a common-place term to describe upfront assessment of individual entering a service-oriented and intervention system or programs. However, this *Guide* uses the concept of “initial assessment” which includes both simple screening and more in-depth initial differential assessment instruments. In-depth assessment is typically done in the specific treatment service program to which the client is referred.

Initial Assessment

The initial assessment process addresses general concerns. Does the person have an AOD problem? What is the extent of involvement in and the degree of disruption from AOD use? Are there mental health concerns? Are there problems related to social and legal non-conforming conduct? How resistive is the individual to disclosing these problems? What is the level of motivation and readiness to engage in intervention services? What kind of treatment referral resource might be appropriate? Information gained from addressing these questions provides a basis for an initial service and referral plan.

Objectives of Initial Assessment

Several specific objectives should be addressed at the initial assessment:

1. To provide opportunity for the client to disclose her or his AOD use history and related problem conditions – to give the client an opportunity to tell her/his story.

2. Acquire initial collateral information regarding the client's AOD history and related conditions.

3. Determine the level of defensiveness and degree of openness based on the observed discrepancy between the client's self-report and collateral reports regarding AOD use problems and related conditions.

4. Estimate the "true" condition of the client in the four core areas of initial assessment: AOD use and problems, indication of mental health concerns, history of social-legal non-conforming conduct, and motivation for change and treatment. For clients who indicate an extensive history of AOD use, an initial assessment of cognitive function may be indicated.

5. To develop an initial relapse prevention plan.

6. For judicial clients, conduct a recidivism risk assessment and develop an initial recidivism prevention plan.

7. Develop an initial service plan and match presenting problems with initial service referral resources.

8. To provide a baseline measure of problem conditions to compare with later assessments.

Methods for Initial Assessment

There are several assessment methods that are commonly used in the initial assessment process.

Self-Report: Initial simple or differential standardized self-report psychometric instruments

A self-report instrument based on sound standardized and psychometric principles is an essential component of an initial evidence-based assessment program for determining the presence of an AOD problem and problem conditions related to AOD use. Such instruments should provide a measure of not only AOD use and abuse, but also the two most critical conditions that interact with AOD use and that are relevant in determining the level and type of initial intervention services: brief assessment for mental health concerns, and past social-legal non-conforming problems particularly for judicial clients. Instruments used in initial assessment vary with respect to the degree of depth and the number of life-functioning domains that area evaluated. Some instruments measure only AOD use involvement and give a single score that provides a ranking of the individual in relationship to a normative group. Examples are the *Michigan Alcoholism Screening Test* (*MAST*) (Selzer, 1971), the *Simple Screening Inventory* (*SSI)* (CSAT, 1994), *Drug Abuse Screening Test (DAST)* (Addictions Research Foundation, 1982; Skinner, 1982), and the *Alcohol Use Questionnaire (AUQ)* (Horn, Skinner, Wanberg, & Foster, 1984). Typically, these instruments use a cut-off value to indicate AOD problems relative to a normative sample known to have a history of AOD problems and abuse.

Other instruments used in initial assessment provide a more in-depth and differential measurement of a number of important factors in addition to AOD problems. These measurements may include mental health adjustment, antisocial characteristics and behaviors, extent of involvement in the criminal justice system, motivation for treatment and level of defensiveness. Examples are: *Substance Abuse Subtle Screening Inventory – 4th Edition* (Miller, 2016) and the *Adult Substance Use Survey – Revised* (*ASUS-R*: Wanberg, 2019a). The differential initial assessment self-report instruments should address the three major areas AOD involvement and problems, social-legal non-conforming problems and history, and mental health concerns. For the area of recidivism risk assessment, the *Level of Supervision Inventory-Revised (LSI-R*: Andrews & Bonta, 2009) and the *Level of Service/Case Management Inventory (LS/CMI)* (Bonta, Andrews, & Wormith, 2004) are commonly used.

Self-report: Initial and brief psychosocial interview with client

An important source of information comes from the initial intake psychosocial interview. Although it is typical to do this at the time of intake into intervention and treatment services, at least a short interview with the client should be completed at the initial intake and cover the very essential areas of AOD use and abuse, mental health and psychological concerns, history of legal and social non-conforming problems and behavior, and motivation for engaging change services. This provides opportunity for the evaluator to at least briefly explore critical problem areas that are evident in the other sources of data (e.g., initial self-report psychometric instruments). It is recommended that the initial psychosocial interview be done after the self-report instruments are completed so that the results from these instruments can be used as guidelines in conducting the interview.

Other-report: Minimum symptom criteria

The minimum symptom criteria approach involves defining AOD problems in terms of a set of diagnostic criteria and requiring that a certain number of these criteria be met for inclusion into the category of AOD problems or a Substance Use Disorder (SUD). The evaluator rates the client across these specified inclusion or diagnostic criteria. Minimum symptom criteria are considered to be other-report or rater data and are considered to be double-subjective in nature. The most commonly used minimum symptom criteria screening approach in AOD assessment is the DSM-5 (American Psychiatric Association, 2013). The DSM-5 does provide "severity specifiers" for the evaluator to rate the client as Mild (2-3 symptoms) Moderate (4-5 symptoms) or Severe (6 or more symptoms). Also included are Course Specifiers of Early Remission and Sustained Remission and qualifiers that allow the diagnosis to indicate if there is a physiological dependence that involves evidence of tolerance or withdrawal symptoms. Diagnosis of a SUD can only be made by a qualified evaluator using all of the sources of information and the criteria for a SUD diagnosis as defined by the DSM-5.

Other-report: The relationship identifier (RI)

The presence of a relationship identifier (RI) (Wackwitz, Diesenhaus, & Foster, 1977; Wanberg & Milkman, 2008) is also helpful in determining whether an individual should be included in the category of having an AOD problem. The RI is a person who forges a link between life-role or negative-consequence disruptions and AOD use. The person who makes this connection is not the client. The RI concludes that behavior disruptions, domestic violence episodes, problems at work, or criminal conduct are linked to AOD use of drugs, although the major determinants of the behavior or psychological disruptions may be other than drug use. For example, there is an observed pattern of alcohol use and an observed pattern of other problem conditions. The RI links these together. The individual or client often accepts the RI's analysis and requests treatment. In the case of more resistive clients the RI may put pressure on the individual, or in the case where a judicial system is involved, require the individual to enter treatment.

Other-report: Evaluator ratings

Evaluator rating scales can be effective in estimating the degree of problems in certain areas at initial intake. Some self-report instruments include variables on which the evaluator rates the client across levels of AOD use problems (e.g., 2019a). Such ratings of the degree of mental health concerns and involvement in criminal history are helpful.

Cognitive Functioning at Initial Assessment

As noted, for clients with an extensive history of AOD use and abuse, a cognitive functioning assessment maybe warranted. This is usually a combination of both self-report and rater-report information. A commonly use cognitive function initial assessment tool is the *Mini-Mental State Examination (MMSE)* (M.F. Folstein, S.E. Folstein, & McHugh, 1975). Initial assessment in this area should be done by trained clinicians that can conduct a mental status examination and who are trained in using the MMSE or comparable instruments.

Negative Findings at Initial Assessment

Treatment agencies typically conduct an in-depth assessment for clients entering treatment services. However, in some settings such as those in the judicial system, if an AOD problem is not identified at initial assessment, the client may not be referred to treatment or to a more in-depth assessment process. In this case, as the client receives the intervention services and for judicial clients, supervision (probation or parole) continued assessment of the key service needs areas as described above is ongoing. Many systems including judicial have built-in services that can provide more in-depth assessment and services that address the major problem areas.

In-Depth Assessment

Attaining an initial fix on the potential and level of problem conditions addressed at initial assessment does not necessarily constitute an in-depth assessment of the different conditions associated AOD misuse or abuse and other psychosocial problems and concerns. The second level of evaluation explores the above questions that arose in the initial assessment at greater depth. This level gathers the necessary information with which to develop a comprehensive assessment and an understanding of the progress, process and existing condition of the individual's various problem areas in order to formulate a more comprehensive service plan and approach within the framework of expected outcomes.

Objectives of In-Depth Assessment

1. To provide a more in-depth opportunity for the client to disclose his or her AOD use history and to look at the different dimensions of AOD use problems - self-report data.

2. To gather more in-depth information from collateral sources regarding the client's overall history – other report data.

3. Reassess the client's level of defensiveness based on the observed discrepancy between what the client now reports in the in-depth assessment and what was reported in the initial assessment process. Has the level of willingness to self-disclose increased from that observed in the initial assessment?

4. Continue to estimate the "true" condition of the client relative to past and recent AOD use, level of mental health problems and motivation for change and treatment; and compare these findings with the initial assessment information.

5. Reassess the presenting problems and levels of severity with appropriate initial service referral resources and compare those with the results of the initial assessment and do a more in-depth assessment of the problem areas identified in the initial assessment process. For example, if a client indicated problems in the areas of mental health and psychological adjustment at initial assessment, then a more in-depth assessment should be conducted in this area. Problems in the area of cognitive-functioning should be further assessed in this in-depth phase of assessment.

6. Generate an in-depth service plan building on the initial service plan developed at initial assessment.

Two dimensions to In-depth and comprehensive assessment

There are two dimensions of in-depth and comprehensive assessment: broad perspective, and problem-specific focus. Both self-report and other-report data are used in addressing these two dimensions of assessment.

Broad-Based Assessment

The **broad-based** assessment will use both self-report and other-report assessment to look at all of the major categories of life-adjustment problems and concerns including a reassessment of the core areas addressed in initial assessment. These areas include:

- Unresolved issues related to the developmental years,
- Interpersonal and relationship adjustment problems including marital and family problems,
- AOD involvement and problems,
- Social-legal and criminal conduct problems and patterns including a reassessment of recidivism risk for judicial clients,
- Mental health and psychological adjustment concerns,
- Employment, job, and vocational development problems and needs,
- Self-report or other-report history of medical-physical problems (when available, conducted by medical staff),
- Reassessment of level of defensiveness and openness, and
- Motivation to change and to be involved in change-services.
- Assessment of strengths.

One option in conducting a broad-perspective assessment is to use the results from the more comprehensive and in-depth initial assessment instrument and then expand into the other areas of assessment such as interpersonal and relationship problems or mental health concerns. For example, the ASUS-R and the SASSI provide a rather comprehensive assessment of the area of AOD problems and concerns and social-legal non-conforming conduct. The results from that assessment may then be used in conjunction with the assessment of the other areas not addressed by instruments such as the ASUS-R or SASSI.

Another approach in conducting a broad-perspective assessment is to use an instrument that covers the above described areas of concerns that may need focus in intervention and treatment services. This would be a re-assessment of the areas of AOD problems, mental health concerns, and social-legal non-conforming problems and issues evaluated at initial assessment. This also gives the evaluator an opportunity to compare the initial assessment results with the results of the in-depth broad-perspective assessment.

Several self-report instruments are available for this type of assessment including the *Addictions Severity Index (ASI)* McClellan, Fureman, Pankh, & Bragg (1996) and the *Adult Self-Assessment Profile (AdSAP)* (Wanberg, 2010). Several personality inventories provided a more in-depth broad perspective view of personality and psychological assessment (e.g., *Minnesota Multiphasic Personality Inventory (MMPI)* Graham, 2011) and the *California Personality Inventory (CPI)* (Gough, 1987).

Problem-Specific Assessment

This dimension of assessment includes an in-depth focus on a specific area that is flagged in the broad-perspective assessment process which may include AOD abuse, mental health, relationship problems, vocational and employment concerns and criminal conduct and thinking. For example, collateral information regarding a history of mental health treatment, high-moderate to high scores on a self-report scale that measures mental health concerns, responding affirmative to questions pertaining to a history of self-harm attempts or current thinking and risk of self-harm or harm towards others in self-report instruments or in the psychosocial interview will trigger an in-depth assessment in this area. Such assessment may include use of instruments and an interview format that focus on several areas of mental health concerns including depression, anxiety, delusional thinking or perceptual distortions. There are a number of problem-specific self-report instruments that address these specific areas of mental health concerns. For example, the *Beck Depression Inventory (BDI)* (Beck, 2006) is widely used to gain a better understanding of the level and nature of an individual's depression.

Methods for In-depth Assessment

The methods used in the in-depth and comprehensive assessment build on those used in the initial assessment and will use more in-depth self-report and instruments and interview formats. This will include a more comprehensive psychosocial interview exploring at greater depths the various areas of life-functioning problems. There are a number of broad-perspective and problem-specific self-report instruments, some of which have been noted above.

ASSESSMENT OF STRENGTHS

During the early 1990s, a focus that gained momentum in the assessment of high-risk youth was the identification and evaluation of strengths (e.g., Bernard, 1991; Rapp, 1989; Ritter 1989; Wagnild & Collins, 2009; Jones-Smith, 2014; Allen, & Olson, 2015). Advocates in this area argued that clinical assessment focused only on the problem areas of adjustment and not enough on the direct measurement of strengths and resiliency. To address this concern, some AOD self-report instruments have included a strengths scale. (e.g. ASUS-R: Wanberg, 2019a). More extensive and comprehensive strength measures are also available (e.g., Simmons & Lehmann, 2013). Research has found that a strength-factor scale has statistically significant negative correlations with self-report scales that measure the following problem conditions (a, 2019b):

- AOD use involvement, disruption, and benefits,
- Involvement in social and legal non-conforming conduct and the judicial system,
- Mood, psychological and mental health adjustment concerns, and
- Overall global psychosocial and AOD problems.

Although this would indicate that problem-oriented measures will predict lower levels of self-reported strengths, it is important to provide the client with an opportunity to identify his/her areas of strengths and then to capitalize on these strength areas in intervention and treatment services. Using specific items as well as psychometric scales to identify levels and areas of strengths is recommended.

THE CONVERGENT VALIDATION APPROACH TO ASSESSMENT

The Convergent Validation (CV) approach (Wanberg & Milkman, 2008, 2010) is based on the classic study by Campbell & Fisk (1959) which demonstrated that the best methods in scientific inquiry and research is to use multiple methods and multiple sources of data to converge on reliable and valid outcomes in research. The assessment approach in this *Guide* advocates using multiple sources of data and multiple methods to arrive at the best estimate of a client's "true" condition. Several dimensions of this approach are summarized.

Assessment is a Process and is Ongoing

Self-report information should be viewed from two perspectives: the specific content of the data that we use in **estimating** the client's "true" condition; and the process of change in reporting this condition over time. The content of the data gathered at any particular point in time is relevant only as it is viewed within the process of self-report change. The results of any one point of assessment should never be taken as a fixed and final description of the client. Any point in assessment **only** provides us with an estimate of the client's condition and gives us guidelines for what might be the treatment needs at that point in time. From this perspective, the process of assessment is just as important as the content of assessment.

Valuing Client Self-Report

Many evaluators and workers in the field of AOD assessment and treatment tend to distrust the "so-called" validity of the client's self-report, particularly criminal justice clients. Evaluators are quick to conclude the client is "lying" or "into denial" when they think the client is not reporting his or her "true" condition. However, it is incongruous to ask clients to complete a self-report instrument and provide their best response as to how they see their condition and problems at this point in time and then conclude that they are "lying" or not telling the truth. We want to know how clients see themselves at any point in time and understand their degree of willingness to self-disclose. **Self-report data represent the client's perception of what is going on at the time of assessment and the willingness to report that perception**. Self-report is a baseline measure of the client's self-assessment in various areas of life-adjustment at a particular point in time and their willingness to disclose. If there is evidence that the client is not accurately reporting his or her "real condition," this should be viewed within the framework of defending the self, rather than denial. From this perspective, we see every self-report as valid. Determining how well the self-report estimates a client's "true" condition revolves around this baseline perception and the level of defensiveness related to reporting this perception. One of the most important questions at any point of assessment is the client's level of openness or defensiveness and how well the self-report explains what is going on with the client. The change process begins with the client's self-perception and willingness to disclose this self-perception

Within this framework of assessment, every self-report is considered to be valid. It is valid with respect to gaining an understanding of the client's attitude towards assessment and treatment and valid in that it represents the client's willingness to disclose his or her perception about the conditions being evaluated (e.g., AOD use and abuse) at the time of assessment. If there is evidence that the self-report is not congruent with collateral information and the client is defensive around self-disclosure, then the report is valid in that we have an estimate of the discrepancy between what the client reports and what the other-report data indicate. We may then conclude that our estimate of defensiveness and discrepancy is valid. Even "slap-dash" or random responding, given that the evaluator is aware that this was the client's response pattern, is a valid representation of where the client is at the time of assessment. This baseline understanding is essential and this is where the change process starts.

Maximizing Best Estimates: Utilizing Self-Report and Other-Report

However, within the convergent validation framework, self-report is only part of the process. Determining how well the client's self-report estimates the client's "true" condition requires that the evaluator utilizes other-report sources of information in the initial assessment. Yet, even self-report and other-report data together provide us only with an estimate of the "true" condition of the client. We never know what that "true" condition is: we only estimate it. We can hypothesize about this condition. Our data then can test that hypothesis. Yet, over time, our estimates become more representative of the client's "true" condition particularly as the client becomes less defensive and more open to self-disclosure.

If there is a discrepancy between the initial self-report and other sources of data (e.g., other-report), and if treatment is working, later self-reports will reflect a change in the reporting of this self-perception. The first indication of treatment efficacy is found in the client becoming more self-disclosing and open in treatment - or the change in the reporting of that self-perception. Re-assessment later in the intervention process should reveal changes that might be occurring in the disclosure of that perception.

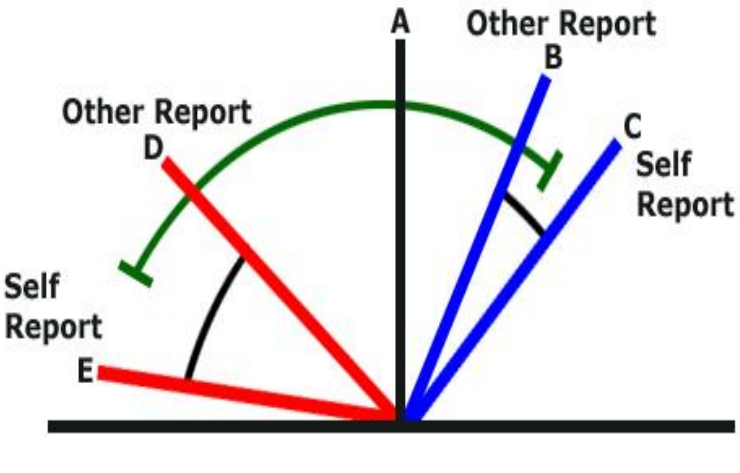
Figure 1 provides a graphic presentation of the convergent validation model. Vector A represents the “true” condition of the client with respect to AOD involvement and problems. The client represented by Vectors B and C shows the angle between B and C somewhat small. This indicates that the self-report information is close to the other-report information and both are close to vector A. A second client is represented by Vectors D and E with a larger angle between the self-report (Vector E) and the other-report information (Vector D). This configuration indicates that D-E client is more defensive and less self-disclosing. As well, the angle between Vectors D and E and Vector A (client’s hypothetical true condition) indicates that both the other-report and self-report are not as good of an estimate of the client’s “true” condition. An import task of the evaluator is to discern the level of defensiveness – discrepancy between the other-report and the self-report data. This discernment is where treatment begins.

The convergent validation model described above is based in part on a phenomenological view of personality. Reality is as we perceive it. We construct our own realities and form views of ourselves. Others construct their realities and form views of us. How we see ourselves and the world are important components of what we measure. For example, to one person, two beers a day may not be excessive. However, to the spouse whose father was "alcoholic," two beers a day may be perceived, not only as excessive, but threatening.

The convergent validation model, then, utilizes both self-report and other-report as valid representations of where the client is at the time of assessment. We are measuring the client's and the collaterals' current perceptions regarding the "true" condition of the client. This is, in fact, what we want to measure.

A self-report, psychometric instrument should not report results as being invalid, as do many self-report measures. Rather, the report of invalidity must be reinterpreted as indicating the discrepancy between sources of data, level of defensiveness and willingness on the part of the client to not only self-disclose, but to engage in intervention and treatment services.

Figure 1: The Convergent Validation Model



INCLUSION CRITERIA FOR AOD PROBLEMS IN INITIAL ASSESSMENT

One of the objectives of initial assessment is to determine whether the individual has an alcohol o other drug use problem. Usually this initial determination is unidimensional (Wanberg & Horn, 1987; Jacobson, 1989; Wanberg & Milkman, 1998, 2008, 2010). That is, the person either does or does not have the problem, and if so, at what level is the problem manifesting itself. There are three ways that we can define problems related to AOD use. These are briefly reviewed.

AOD Use Problem Occasion

A person who has experienced disruptive effects from AOD use can be considered as having had a problem from AOD use – or an AOD Use Problem Occasion. The disruptive effect may have been a one-time event or may have occurred several times over a longer period of time. Such an event or events may have been where an individual had too many drinks resulting in losing control over verbal behavior that is offensive to an intimate partner or family member and creating a problem in that relationship. Although quite rare, the one-time event may have been the person drove after having a few drinks and arrested for impaired driving. However, this is quite rare since research clearly shows that persons who have been arrested for impaired driving have driven numerous times when impaired but never arrested. Many, if not most, AOD users will have experienced at least once or twice, a problem from AOD use. This problem-occurrence is not seen as a pattern but when it does happen, the occurrence may be of such a nature that some formal intervention or reconciliation is needed or required as in the case of an impaired driving arrest.

AOD Use Problem Pattern

When problem events from AOD use become more than a one-time event or more than on occasion and becomes a pattern, then the person falls into the category of an AOD Use Problem Pattern. This is defined as a pattern of negative or life-disruptive consequence or consequences related to AOD use. This could involve a pattern of impaired driving whether or not it results in an impaired driving arrest, repeated hangovers that become life-disruptive that have an impact on normal life functioning, missing work, drug intoxication that leads to criminal conduct, using drugs to manage life problems that come from drug use, etc. The purpose of this definition is to have a category of AOD use problems that does not necessarily meet the criteria of a formal AOD or substance use clinical diagnosis as defined by the American Psychiatric Association's Diagnostic Statistical Manual – 5th (DSM-5) Edition (2013) yet provides a "red flag" to indicate that some formal intervention or treatment services may be needed to address the AOD use problem pattern.

AOD Use Clinical Diagnosis

Whereas this *Guide* uses the term AOD or drug use, the term "substance use" has the same meaning and is used in the DSM-5 or the World Health Organization's ICD-10 Classification of Mental and Behavioral Disorders (WHO, 2010) when rendering a formal diagnosis of a Substance Use Disorder (SUD). The DSM-5 defines a SUD as "a maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by two (or more) of 11 specific criteria occurring within a 12-month period". As noted, the AOD Use Problem category as defined above can be very useful in the case where the AOD use conditions do not meet two or more of the DSM-5 criteria.

These 11 criteria can be applied with a specific drug category, e.g., Alcohol Use Disorder. Using these criteria, the DSM-5 also provides three levels of severity: Mild, Moderate or Severe. As well, the DSM-5 provides an assessment of course specifiers: Early remission is defined as no criteria are met for 3 to 12 moths after having met the criteria for a SUD; and sustained remission defined as no criteria are met for 12 months or more after having met the criteria for a SUD.

INTERPRETING ERROR RISK

There are two kinds of errors that can be made when interpreting both self-report and other-report assessment data. The first is a *false negative* error which is made when it is concluded that there is no problem when in fact there is. The second is the *false-positive* error where it is concluded there is a problem when there is not.

The false-negative error (saying there is no problem when there is) is reduced when our instruments are *measurement-sensitive* or the instrument is able to provide a best-estimate of a certain condition that it is being measured in individuals who indeed have that condition. This error can also be reduced by making the criteria for inclusion less stringent or requiring fewer symptoms to say that there is a problem. When using a psychometric scale, this would involve decreasing the inclusion cutoff score so that more individuals are included that are estimated to have a substance use or other problems.

When we reduce the false negative risk or taking less of a risk of saying there is no problem where there is, then we may increase the risk of the false positive error. A false-positive error is concluding that there is a problem when there is not. This error can be reduced when our instruments have *measurement-specificity* or when the instrument designed to measure a certain condition is able to sort out those who do not have that condition from those who do. This error is also reduced when we set more stringent inclusion criteria. This may mean that we require more symptoms or a higher measurement cutoff value before we conclude that the individual may fit the problem category.

Determining the level of risk that we will assume may be based on economic considerations, client welfare, and client inconvenience. In medicine, to decrease the false negative risk may mean that patients may undergo more diagnostic procedures at a greater expense. However, increasing the false negative risk may result in not identifying some patients who have the medical disorder and thus may not receive further diagnostic procedures to fully diagnosis and provide treatment to address the disorder.

Most medical patients want to decrease the false negative risk or risk of saying there is no problem where there is, even though it means additional testing and expensive diagnostic procedures. Most patients want to be as sure as possible that they do not have the medical disorder for which they are being evaluated. In AOD and behavioral health assessment, where the presence of a disorder is most often not immediately life-threatening, this imposition may be unacceptable. A client who is diagnosed as having an Alcohol Use Disorder, but in fact, does not, may find this to be inconvenient and even adverse, particularly if the client is defensive against reporting such a condition.

One resolution to reducing both kinds of errors is to use multiple levels of assessment as described above: 1) initial and simple assessment or screening; 2) initial differential assessment, and 3) in-depth assessment. We set less stringent inclusion criteria which will decrease the false negative risk at the very basic and simple level of assessment to make sure that we avoid missing those that may have an AOD use or other problems that need to be addressed.

At the initial differential assessment level, the “net” should also be somewhat broad or the criteria still not real stringent to make sure that those with an AOD problem or other problem conditions are not missed since this is often the level of assessment where the client is either referred to an in-depth assessment or directly to treatment where an in-depth assessment is completed. Since the in-depth level of assessment is more thorough, those with a false positive (referred to treatment and an in-depth assessment but may not need treatment) can be sorted out and appropriate services can be developed for these clients such as an AOD education program. As well, this sorting out process will identify those with different problem levels and differentially assigned to the most appropriate treatment (or education) program.

In the case where clients are involved in ongoing supervision, as in the judicial system, risk of making false-negative errors at initial intake is not as crucial since clients are in an on-going monitoring process that includes evaluation for AOD problems. This provides a built-in fail-safe feature where during the on-going supervision

process, there is a greater probability of identifying those who do have an AOD problem and yet not identified as such in initial assessment. This will mean that probation and parole workers are trained to recognize symptoms and behaviors that indicate AOD involvement and problems in clients that were initially estimated to not have an AOD disorder or problem that needs formal treatment. Urine analysis (UA) monitoring during judicial supervision is part of this ongoing assessment process.

The risk of making false negative and false positive errors is also reduced when we use the convergent validation approach which uses multi-methods and multi-sources of information in the assessment process. We avoid depending only on the sensitivity and specificity of a particular method of assessment, but use all methods to formulate conclusions. This approach sees assessment as a process and not as only occurring at a single point in time. As noted, for judicial clients, assessment continues while the client is in judicial supervision and/or in treatment services.

The false negative error is critical since when this error is made (saying there is no problem when there is), we may fail to provide further assessment or intervention and treatment services for those who really need it. Failure to identify as clearly as possible various problems, whether it is in the area of AOD use, mental health concerns or criminal thinking and conduct, and concluding there is no problem when there is puts the client as well others and the community at risk.

Finally, best estimates are maximized when the client is engaged in the assessment process. This involves developing rapport and trust with the client to increase self-reporting that provides a better estimate of the client's "true" condition. As well, it also involves having the client become a partner in developing the service plan. This involves providing feedback to the client around the assessment findings, recommended services, and working towards a mutual decision as to service needs and approaches.

As stressed in this *Guide*, final conclusions at any given point in the assessment process are made only by the evaluator or clinician, preferably in partnership with the client and not a specific method or instrument. The results of any specific assessment method are never used as the sole source for making decisions. Using all of the available information – self-report and other-report - at a particular assessment point, **only the evaluator makes the final assessment of the client's condition and the service recommendation.**

THERAPEUTIC AND CORRECTIONAL EVALUATION PERSPECTIVES

Evaluators and clinicians working with judicial clients are confronted with meeting the needs and expectations of two parties: the client and the community. A standardized offender assessment (SOA) process is approached from two perspectives: the therapeutic or treatment; and the correctional. Effective SOA will integrate these two components.

Therapeutic Evaluation Perspective

The first perspective of SOA is to look at the agenda and goals of the client and the client's needs and expectations in the change process - even if that expectation or need is to make no changes or to not be involved in any formal change process program or effort. The therapeutic evaluation perspective begins with building trust and rapport with the client and with getting the client to tell his or her story. It begins with getting the client to self-disclose - at whatever level of probity this disclosure will occur.

Change starts with this disclosure process and is enhanced when the client receives therapeutic feedback resulting from the evaluation process. Change is enhanced through therapeutic confrontation - confronting the client with the client - with the client's own discrepancies, ambivalence, goals and agendas. Therapeutic evaluation is client-oriented and the change process is client-centered (Wanberg & Milkman, 2014). In therapeutic confrontation, the treatment message is: "I confront you with you, with your need and resistance to change, with your discrepancies."

Correctional Evaluation and Change Perspective

The second perspective of the SOA process is correctional and societal-centered. This dimension starts with the goals and agenda of society and the community representing society. It considers the sanctioning expectations of the community as these are expressed through the court and the legal system. Correctional evaluation gets the community to tell its story about the client to the evaluator. The source of this story involves arrest and conviction records, damage to the community and victims and the legal expectations, requirements and sanctions related to specific offending behavior. An important component of correctional or societal-centered assessment is to have clients provide a self-report of their understanding of the offenses for which they were convicted, their understanding of the court-ordered penalties, and required judicial supervision, and court-ordered treatment services.

Correctional change in judicial clients starts and occurs not only through their understanding of their judicial offenses and obligations, but also through hearing the community's story and concerns. It occurs through correctional confrontation - which is confronting the client with the community's expectations of change and sanctioning. Whereas therapeutic evaluation is client-centered, correctional evaluation is society-centered or sociocentric (Wanberg & Milkman, 2014). In correctional evaluation, the message is: "I confront you with what society and its official representatives are saying about you and their expectations of you. As an evaluator, I represent that expectation and I represent the sanctioning process that is basic to your change."

Integrating the Therapeutic and Correctional Perspectives and Services

The effective SOA evaluator will integrate the skills and knowledge of therapeutic and correctional approaches and considers the agenda of the client and the community. SOA and intervention assume the dual role of developing an environment of therapeutic change for the judicial client but also help the community to administer the judicial sentence and assure the safety of the community. Sound therapeutic and correctional evaluation skills and approaches are blended together in the assessment process and in the process of determining the therapeutic and correctional needs of the client. This integration goes beyond the assessment process. Research has clearly shown that punishment and sanctioning alone does not decrease the probability of recidivism. As noted above, studies show combining intervention and treatment along with sanctioning decreases the risk of recidivism (Andrews and Bonta, 2003; Bonta & Andrews, 2016). Although the importance and necessity of integrating these two components of assessment for judicial clients seems to be obvious, it is often overlooked or treated too lightly. Combining effective therapeutic and correctional assessment and intervention enhances the efficacy of the change process in judicial clients.

The Risk-Needs-Responsivity (RNR) Principle

An important guideline to follow in conducting a SOA is the principle of risk-needs-responsivity (RNR) developed by Andrews & Bonta (Andrews & Bonta, 2003; Bonta & Andrews, 2016) used in offender assessment and the principle of risk, resilience, and protective (RRP) factors developed for use in adolescent assessment (Botvin, 1983; Kandal, Simcha-Fagan & Davies, 1985; Newcomb, Maddahian & Bentler, 1986; Hawkins, Lisner & Catalano, 1985; Wanberg, 1992, 2015). RNR and RRP are very similar with the main difference being that in the latter, the component of risk represents all of the dimensions of core psychosocial adjustment problems of family disruption, school adjustment, AOD use and disruption, mental health adjustment along with the area of deviancy and legal non-conforming conduct whereas in the RNR model, the risk mainly refers to recidivism and the factors most associated with or predictive of recidivism..

Risk factors in the RNR model can include both static and dynamic factors, the former being factors that do not change (e.g., age, gender, history of problem behaviors) and the latter are more emergent and subject to change and can be either stable or fluctuating. Both are important in estimating risk of recidivism, the most important of which include antisocial thinking and conduct, prior criminal history and involvement in the judicial system, deviant associations and associates, mood and psychological adjustment, and involvement in AOD use and problems.

Needs, often referred to as criminogenic in judicial assessment, are difficult to separate from risk factors but are mainly identified as a focus of intervention since they can contribute to criminal and antisocial conduct. These become the main focus in intervention services since the theory is that if these are successfully addressed and mitigated, the risk of recidivism is reduced and the judicial client will be legally and socially responsible towards others and the community. The main focus of needs-assessment is in the areas of AOD use and abuse, mental health and psychological concerns, and social and legal non-conforming attitudes and conduct including involvement in the judicial system. Although it is difficult to differentiate between risk and need factors, risk factors provide a basis for identifying the level of judicial supervision and need factors identify the areas that need primary focus in intervention and treatment services. Although some have called the psychological and mood problems as non-criminogenic, the measurement of problems and dysfunction in this area have significant correlations with criminal conduct and substance abuse problems: 1) there is a significant positive correlation between mental health problems and criminal conduct; and 2) mental health problems increase the risk of AOD relapse and relapse increases the risk of recidivism.

The principal of responsivity refers to: 1) estimating the offender's potential response to treatment; 2) how well the intervention services address the offenders condition and needs; and 3) the offenders level of readiness and motivation for responding to these services which increases the potential for positive outcomes. In the initial assessment process, two factors in this area are important to identify: 1) level of motivation and readiness for services in the area of AOD problems and criminal conduct; and 2) level of openness to self-disclose or level of defensiveness. These factors are of particular importance in developing an initial service approach that is compatible with the judicial client's stage of change and readiness to respond to services (e.g., Connors, Donovan, & DiClemente, 2001; Wanberg & Milkman, 1998, 2008).
The recidivism risk factor in initial assessment is typically done through the use of a risk assessment instrument such as the *Level of Supervision Inventory-Revised (LSI-R)* (Andrews & Bonta, 2009) or *Level of Service/Case Management Inventory: An Offender Assessment System* (Andrews, Bonta, & Wormith, 2004). Initial assessment instruments are designed to address initial assessment needs factors in the RNR approach focusing on three core areas: 1) alcohol and other drug (AOD) involvement and problems; 2) social and legal non-conforming attitudes and conduct; and 3) mental health and mood adjustment concerns. This approach is also congruent with the RRP model used in adolescent assessment.

SOME FINAL COMMENTS AND CONCLUSIONS

The most effective method of assessment is to use all of the above methods and data sources in developing assessment information and making assessment decisions – the convergent validation approach. These methods include the main approaches to gather both self-report and other-report information around the client and can be used, even in brief or short forms, in the initial intake process. Too often, the evaluator will utilize only diagnostic criteria as described in the DSM-5 in making AOD assessment decisions. It is best not to rely only on formal diagnostic criteria for this purpose in that this may cause the individual doing the screening to make a large number of false negative errors with respect to determining services and treatment needs. .

Self-report instruments and data are essential components of an evidenced-based assessment program. The use of self-report differential assessment instruments are invaluable resources in providing guidelines for estimating client problem attitudes and behavior and making service placement decisions. Self-report data should be viewed as a valid representation of the client's willingness to self-disclose problem behavior, motivation and strengths at the time of initial assessment and that this disclosure represents one estimate of the "true" condition of the client at that specific assessment point in time. Research has shown that on average, self-report instruments provide a good estimate of the "true" condition of an individual respondent.

Self-report assessments are also important in terms of monitoring the client's change over the course of intervention and treatment beginning with initial assessment. One of the most important indicators of change is the increased degree to which the client is willing to self-disclose problem conditions. Gathering standardized and psychometric based self-report data at initial assessment provides a baseline understanding of the degree to which the client is open and self-disclosing and willingness to engage in change services, which in turn provides an

increased understanding of the individual client's problem condition and service needs. Involvement with and observation of the client during change-oriented services, and in the case of judicial clients, during judicial supervision, provides additional data and information about the client and provides the opportunity to make adjustments to the service plan according to data received from those observations. This will increase the probability of a positive outcome – preventing relapse and recidivism - and enhancing positive psychosocial adjustment.

The value of self-report data is always measured as it is used in conjunction with other-report data using the convergent validation approach. The self-report estimate of the client's "true" condition must be evaluated in relationship to an estimate of the client's "true" condition based on other-report information. This provides a good understanding of the willingness of the client to self-disclose, the level of resistance to self-disclosure, and the starting point of intervention and treatment services. Motivational enhancement programs should first be used with client's resistive to and defensive around self-disclosure. Placing such clients in regular treatment services, let alone in more intensive services, may be counter-productive.
Assessment is dynamic and is an ongoing process. It continues at every point of contact with the client by service providers – intervention and treatment staff and judicial supervisors (probation or parole) staff. The estimates of a client's condition and problems and service needs are valid for a particular point of assessment. As rapport and trust are developed with the client, and as the client becomes more self-disclosing, assessment of the client's condition and service needs will change and improve. Increased self-disclosure is one test of client progress. Thus, the process of assessment is just as important as the content and results of assessment.

Initial assessment instruments are designed to measure a client's perception of the three major core needs assessment areas: 1) AOD use and problems; 2) psychological and mental health concerns; and 3) social and legal non-conforming and criminal attitudes and conduct and involvement in the judicial system. They also measure the client's motivation and readiness for treatment services; and self-perceived level of strengths which are important components for assessing the area of service responsivity. In-depth assessment is typically done with clients at the time they enter a treatment agency or resource and involves two perspectives: 1) a broad-assessment perspective; and 2) a specific problem-focus.

The landscape of assessment changes significantly with judicial clients. Evaluators and clinicians working with judicial clients are confronted with meeting the needs and expectations of two parties: the client and the community. A standardized offender assessment (SOA) process is approached from two perspectives: the therapeutic or treatment; and the correctional. Effective SOA assessment will integrate these two components. The assessment of and service requirements for judicial clients must always consider the current perceptions and needs of the client and the agenda, sanctioning expectations, and safety of the community as these are expressed through the legal system.

Finally, **conclusions and decisions regarding assessment and referral services are never based on one source of data or information. Final assessments and referral recommendations are only made by the evaluator using all available sources of data and information.**

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