COST

The cost of the alcohol and drug evaluation is established by the provider. It is the responsibility of the defendant to pay for the evaluation. However, providers must offer alcohol and drug evaluations at a reduced fee to defendants who can prove inability to pay the full cost according to established program standards.

REGULATIONS

Providers that conduct DUI evaluations for the Court or the Office of the Secretary of State are licensed and regulated by the Illinois Department of Human Services, Division of Alcoholism and Substance Abuse. Professional evaluators working in these programs must meet standards prescribed by the Department. Programs are inspected and must conform to applicable Department Rules and Regulations in order to maintain licensure.

COMPLAINTS

The Department has statutory authority to investigate providers who conduct alcohol and drug evaluations for DUI defendants. Questions or complaints regarding DUI services rendered should be directed to:

Illinois Department of Human Services
Division of Alcoholism and Substance Abuse
Licensing and Certification
401 South Clinton Street, Second Floor
Chicago, Illinois 60607
312-814-3840

If you have any questions about alcohol or other drugs, call:

Illinois Department of Human Services
Division of Alcoholism and Substance Abuse
1-866-213-0548 (toll-free Voice)
1-866-843-7344 (toll-free TTY)

If you have questions about Illinois Department of Human Services (IDHS) programs or services please call or visit your local Family Community Resource Center (FCRC). We will answer your questions. If you do not know where your FCRC is or if you are unable to go there, you may call the automated helpline 24 hours a day at:

1-800-843-6154
1-800-447-6404 (TTY)

You may speak to a representative between:
8:00 a.m. - 5:30 p.m.
Monday - Friday (except state holidays)

Visit our website at:
www.dhs.state.il.us

IDHS
Illinois Department of Human Services

DHS 4499 (R-02-14) DHS/DASA DUI Processes and Evaluations
Printed by the Authority of the State of Illinois.
200 copies P.O.#14-1086

State of Illinois
Department of Human Services

DUI Processes and Evaluations

IDHS
Illinois Department of Human Services

Office of the Clerk of the Circuit Court
DuPage County, Illinois

Thank you for using **Dupage County Circuit Court Clerk's Case Inquiry and Payment System**
Your case has been successfully processed.
Your payment of $229.50 ($225.00 Balance Due + $4.50 Convenience Fee) against the original amount of $225.00 for case number **2018DT000020** has been accepted.
Your billing approval code is . Your billing ID is **100524369487** It is the Defendant's responsibility to keep the Circuit Clerk's Office informed of his/her current address.
We will return court notices,bond refunds,driver's licenses, and other deposited documents to the address listed on your complaint.
If this is not your current address, it is your responsibility to update the Circuit Clerk's Office with your new address.
You can call the Circuit Clerk's office at (630-407-8600) with your new address. Have your Case Number and complaint number available when you call.

Click here to return to the main page Click here to view the Return Policy

Transaction Details

Defendant Details		**Billing Details**	
Defendant Name	[redacted]	Payor Name	[redacted]
Case Number	**2018DT000020**	Address	[redacted]
Payment Date	2/1/2018	City	[redacted]
Issuing Agency	LO	State	IL
		Zip	60451
		Card Number	**********0523
		Email	PROBATION.DUI.CASHREG@DUPAGECO.ORG
		Amount	DUI Eval Fee $ 225.00 Total Amount : $229.50

Print this Page

If you have questions, or you are experiencing technical difficulties, please Click here to contact us.

DUI EVALUATION REFERRAL FORM

Incarcerated ☐ Initial DUI Evaluation ☐ Re-Evaluation ☐ SOS Update ☐

Date:_____ Court Date:_____

Case #:_____ Court Room:_____

Most Recent DUI Arrest Date: _____ Arresting Agency: _____

Name: _____

LAST FIRST MIDDLE NAME

A.K.A/Maiden: _____

Address: _____

_____

Cell Phone: _____ Email address: _____

Date of Birth: _____ Male ☐ Female ☐

Race: Asian/Pacific Islander ☐ Black ☐ Indian ☐ White ☐ Hispanic ☐ Other ☐

Driver's License Number: _____ State: _____

Social Security Number: _____

Language: _____

Attorney Name: _____

Attorney's Phone Number: _____

Office Use Only

Fee Assessment Added: ☐

Appointment Date & Time: _____ *Assigned Evaluator:* _____

*Appointment Set On:*_____ *Appointment Set by:*_____

(Date) *(Initials)*

Interpreter Needed: _____ *Email Requested:* _____

PLEASE INITIAL EACH LINE BELOW STATING YOU HAVE READ AND UNDERSTAND THE FOLLOWING POLICIES:

_____ $250 PAYMENT: for cost of evaluation: WE DO NOT ACCEPT CASH. Acceptable forms of payment are: Money Order, Personal Check (with valid photo I.D.), Credit/Debit Card (with valid photo I.D.) *Please note: credit/debit cards will be charged a $5 processing fee. Payment for SOS Update MUST be paid in full at the time of the appointment.

_____ 24- HOUR CANCELLATION POLICY: You MUST give a 24 hour notice of cancellation or you will be charged a $50 Penalty Fee that must be paid before re-scheduling.

_____ $50 PENALTY FEE: for any missed appointments, less than 24-hour cancellations, alcohol/drug impairment, failure to bring an interpreter if necessary, and/or non-payment for a SOS Update. The DUI Evaluation Unit reserves the right to cancel your appointment at their discretion for any of the above or related occurrences.

_____ ALCOHOL/DRUG FREE POLICY: You are not to arrive under the influence of any drugs or alcohol. If you are suspected to be under the influence, the DUI Evaluation Unit reserves the right to terminate your appointment at the cost of a $50 Penalty Fee.

_____ INDIGENT REQUIREMENTS: Refer to the back of the yellow information sheet to see what documents are required to apply for a reduced fee amount. Applying for reduced fee does not guarantee you will be approved. Reduced fee will not be approved without sufficient documentation.

_____ TEXT MESSAGE REMINDER: I authorize and understand that I will be given a text message reminder of my DUI evaluation appointment at least 48 hours in advance.

_____ CONFIRMATION OF APPOINTMENT DATE AND TIME

_____ INTERPRETER REQUIREMENT (if necessary): The DUI Evaluation Unit will provide you a court appointed interpreter at no cost. You may not bring your own personal or professional interpreters.

FOR SOS UPDATES ONLY:

_____ CORROBORATOR REQUIREMENT: You must bring a friend or family member to the evaluation with you to be interviewed on your behalf. This portion usually takes about 10-15 minutes.

_____ ALL TREATMENT VERIFICATION: You must bring any/all treatment verification or completion documents for your SOS Update. Without required documentation, the SOS Update cannot be completed, and you are subject to a $50 Penalty Fee for rescheduling.

DATE: _____

JB Pritzker, *Governor*

Illinois Department of Human Services

Grace B. Hou, *Secretary-designate*

100 South Grand Avenue East • Springfield, Illinois 62762
401 South Clinton Street • Chicago, Illinois 60607

INFORMED CONSENT

In order to obtain an Alcohol and Drug Evaluation for the Circuit Court or the Office of the Secretary of State, I agree to provide the following information:

- A copy of my driving abstract or a written summary of my driving history obtained from the Office of the Secretary of State;
- The written results of any chemical testing or documentation of refusal of such testing that occurred after my arrest for driving under the influence of alcohol and/or other drugs (DUI); and
- Alcohol and drug use history from first use to present.

I also attest to the fact that I have not undergone any other alcohol and drug evaluation as a result of my DUI arrest or if I have, I agree to provide a copy of all such evaluations, if completed and/or the name and address of such program(s). I also give my consent for this program to obtain information from any program(s) where I previously began and/or completed any alcohol and drug evaluation relative to my arrest for DUI. I have read the Department of Human Services brochure entitled "DUI Processes and Evaluations" explaining the alcohol and drug evaluation procedure. I understand that I have the right to withdraw from this evaluation process at any time, refuse the completed alcohol and drug evaluation or seek a second opinion by obtaining another evaluation. I further understand that any information I do provide can be released to the Circuit Court, the Office of the Secretary of State or the Department of Human Services upon request. If I do not complete the evaluation or do not return to sign and obtain my copy of the evaluation within 30 days of its completion date, notice will be sent to the Circuit Court or the Office of the Secretary of State along with any relevant information pertaining to my involvement with this program.

_____ _____

Offender Signature *Date*

_____ _____

Parent/Guardian Signature (If offender is under age 18) *Date*

Witnessed:

_____ _____

Signature *Date*

IF CONSENT IS NOT GIVEN, PLEASE INDICATE THAT YOU HAVE READ THIS FORM BY INITIALING ON THIS LINE. _____

18th Judicial Circuit – Department of Probation & Court Services

DUI Evaluation Unit

CLIENT'S RIGHTS STATEMENT

All clients seeking a DUI Evaluation will have the following rights:

1) Access to services will not be denied on the basis of race, religion, ethnicity, disability, sexual orientation or HIV Status;
2) All services will be provided in the least restrictive environment available;
3) The confidentiality of clinical records and information is governed by the Confidentiality of Alcohol and Drug Abuse Patient Records regulations 42 CFR 2 (1987) of the alcohol, Drug Abuse, Mental Healthy Administration of the Public Health Service of the United States Department of Health and Human Services effective August 10, 1987, which is incorporated herein by reference, and Article 30 of the Act [20 ILCS 301/Art. 30], unless otherwise authorized by appropriate court order. Clinical records and information are also protected by 730 ILCS 110/12 (4);
4) Access to services on a nondiscriminatory basis as specified in the American's with Disabilities Act of 1990 (42 USC 12101);
5) All services offered will be available regardless of the defendant's source(s) of financial support;
6) The defendant has the right to refuse treatment, or any specific treatment procedure, and a right to be informed of the consequences resulting from a refusal of treatment, or of a treatment procedure;
7) A Description of the route of appeal or grievance procedure shall be made when the defendant disagrees with the facility's decision, policies or procedures;
8) The confidentiality regarding a request for and/or signed consent to do HIV antibody test; a defendant's HIV antibody or AIDS status; the fact that the defendant has been tested for HIV antibodies, and/or the result of an HIV antibody test, whether negative, or positive or inconclusive; and or in pre-teste and or post-test counseling will be protected the AID's Act and AID's Code;

Client's signature: _____ Date: _____

Evaluator's signature: _____ Date: _____

18th Judicial Circuit – Department of Probation & Court Services

DUI Evaluation Unit

CONSENT FOR SERVICE and CORROBORATOR RELEASE FORM

Client's Name: _____ Case Number: _____

I consent to receive a DUI Evaluation from the DuPage County Probation & Court Service's DUI Evaluation Unit.

I also authorize DuPage County Probation & Court Services to obtain information from a corroborator I appoint for the purposes of a DUI Evaluation. On this date, I have given my permission to _____ *(name & relationship to defendant)* to speak on my behalf with the DUI evaluator.

Defendant's signature: _____ Date: _____

Evaluator's signature: _____ Date: _____

JB Pritzker, *Governor*

Illinois Department of Human Services

Grace B. Hou, *Secretary-designate*

100 South Grand Avenue East • Springfield, Illinois 62762
401 South Clinton Street • Chicago, Illinois 60607

REFERRAL LIST VERIFICATION FORM

I have been shown a listing of licensed DUI and/or substance abuse treatment programs. I understand that I may seek any necessary services at the program of my choice.

_____ _____

Offender Signature *Date*

_____ _____

Evaluator Signature *Date*

LAW ENFORCEMENT SWORN REPORT

Circuit Court, DuPage County, 18th Municipal District 5595

Case Number

DUI TRAFFIC CITATION NO. (11-501A1)	DUI TRAFFIC CITATION NO. (11-501A2)
18040200 88	18040200 88
11-401 Citation No.	**DUI TRAFFIC CITATION NO. (OTHER)**
	18040200 88

Name _____ R
Last First Middle

e-FILED
AUG 23 2018 02:07 PM
CLERK OF THE
18TH JUDICIAL CIRCUIT
DUPAGE COUNTY, ILLINOIS

☐ CDL holder

Driver's License Number _____ State IL

Chris Kachmarbas

Street Address Schaumburg, Illinois

City & State

Wheaton / DuPage

City and/or County of Arrest

Arrest Date 04 / 02 / 18 2:48 a.m.
Month Day Year Time

M / 12-17- /
Sex Date of Birth

Central Dupage Hospital
Place of Refusal or Location of Test(s)

Notice of Summary Suspension/ Revocation Given On 8 / 9 / 2018
Month Day Year

Refusal or Test Date 04 / 02 / 18 / 2:48 a.m. p.m.
Month Day Year Time

The suspension/revocation shall take effect on the 46th day following issuance of this notice. Subsequent to an arrest for violating Section 11-501 of the Illinois Vehicle Code, or similar provision of a local ordinance or Section 11-401 of the Illinois Vehicle Code, you are hereby notified that on the date shown above, you were asked to submit to a chemical test(s) to determine the alcohol, other drug(s), intoxicating compound(s), or any combination thereof, content of your breath, blood, urine or other bodily substance and warned of the consequences pursuant to Section 11-501.1 of the Illinois Vehicle Code. You have the right to a hearing to contest your suspension/revocation. You must file a petition to rescind your suspension/revocation within 90 days of this notice.

☐ Because you refused to submit to or failed to complete testing, **your driving privileges will be suspended for a minimum of 12 months.***

☒ Because you submitted to testing conducted pursuant to Section 11-501.2, which disclosed:

☒ an alcohol concentration of .141, which is .08 or more; or ☐ a delta-9-tetrahydrocannabinol concentration of either 5 nanograms or more of whole blood or 10 nanograms or more of other bodily substance

☒ any amount of a drug, substance or intoxicating compound resulting from the unlawful use or consumption of a controlled substance as listed in the Illinois Controlled Substances Act; an intoxicating compound as listed in the Use of Intoxicating Compounds Act; or methamphetamine as listed in the Methamphetamine Control and Community Protection Act; **your driving privileges will be suspended for a minimum of 6 months.***

☐ Because you refused to submit to or failed to complete testing and you were involved in a motor vehicle crash that caused Type A personal injury or death to another, **your driving privileges will be revoked for a minimum of 12 months.**

☐ Because you are a CDL holder and you submitted to testing conducted pursuant to 11-501.2 which disclosed any amount of a drug, substance or compound resulting from the unlawful use or consumption of cannabis as covered by the Cannabis Control Act your CDL privileges will be disqualified for a minimum of 12 months.

Driver's license surrendered? ☐ Yes ☒ No; Reason: Pending lab results

Driver's license valid at time of arrest? ☒ Yes (Sign receipt) ☐ No (Void receipt)

I have complied with Section 11-501.1 of the Illinois Vehicle Code by having reasonable grounds to believe the arrestee was in violation of Section 11-501 or a similar provision of a local ordinance, or Section 11-401: (Explain)

Defendant involved in single MV accident roll-over (substantial damage) with little to no recollection of how the event occurred. Defendant admitted to using Xanax, Cannabis and Drinking alcohol. PBT showed .144. Blunt cannabis emitting from breath. Impairment on HGN.

Pursuant to Section 11-501.1 of the Illinois Vehicle Code I have:

☐ Served immediate Notice of Summary Suspension/Revocation of driving privileges on the above-named person.

☒ Given Notice of Summary Suspension/Revocation of driving privileges to the above-named person by depositing in the U.S. mail said notice in a prepaid postage envelope addressed to said person at the address as shown on the Uniform Traffic Ticket.

Under penalties as provided by law pursuant to Section 1-109 of the Illinois Code of Civil Procedure, the undersigned certifies that the statements set forth in this instrument are true and correct.

Signature of Arresting Officer #008 (LUNDY) ID Number

Wheaton Police Department Date 8 / 9 / 18
Law Enforcement Agency Month Day Year

EDWD DNNDHD
956163

POLICE OFFICER - SEND TO COURT OF VENUE

JULY 2016 – DSD DC 35.28

LAW ENFORCEMENT SWORN REPORT

Circuit Court, Dupage County, 18th Municipal District

Case Number

DUI TRAFFIC CITATION NO. (11-501A1)	DUI TRAFFIC CITATION NO.
11-401 Citation No.	DUI TRAFFIC CITATION NO. (SR)

Name _____ (Last) _____ (First) _____ (Middle)

☐ CDL holder.

Driver's License Number	State
[illegible]	Illinois

_____ (Street Address)

_____ (City & State)

M / 07-29-67 / _____ (Sex / Date of Birth)

Notice of Summary Suspension/ Revocation Given On 01 / 14 / [illegible] (Month / Day / Year)

Hinsdale (City and/or County of Arrest)

Arrest Date 01 / 14 / 20[illegible] 4:43 a.m. (p.m.) (Month / Day / Year / Time)

Hinsdale Hospital (Place of Refusal or Location of Test(s))

Refusal or Test Date 01 / 14 / [illegible] 5:45 a.m. (p.m.) (Month / Day / Year / Time)

The suspension/revocation shall take effect on the 46th day following issuance of this notice. Subsequent to an arrest for violating Section 11-501 of the Illinois Vehicle Code, or similar provision of a local ordinance or Section 11-401 of the Illinois Vehicle Code, you are hereby notified that on the date shown above, you were asked to submit to a chemical test(s) to determine the alcohol, other drug(s), intoxicating compound(s), or any combination thereof, content of your breath, blood, urine or other bodily substance and warned of the consequences pursuant to Section 11-501.1 of the Illinois Vehicle Code. You have the right to a hearing to contest your suspension/revocation. You must file a petition to rescind your suspension/revocation within 90 days of this notice.

☒ Because you refused to submit to or failed to complete testing, **your driving privileges will be suspended for a minimum of 12 months.***

☐ Because you submitted to testing conducted pursuant to Section 11-501.2, which disclosed:

- ☐ an alcohol concentration of _____, which is .08 or more; or ☐ a delta-9-tetrahydrocannabinol concentration of either 5 nanograms or more of whole blood or 10 nanograms or more of other bodily substance
- ☐ any amount of a drug, substance or intoxicating compound resulting from the unlawful use or consumption of a controlled substance as listed in the Illinois Controlled Substances Act; an intoxicating compound as listed in the Use of Intoxicating Compounds Act; or methamphetamine as listed in the Methamphetamine Control and Community Protection Act; **your driving privileges will be suspended for a minimum of 6 months.***

☐ Because you refused to submit to or failed to complete testing and you were involved in a motor vehicle crash that caused Type A personal injury or death to another, **your driving privileges will be revoked for a minimum of 12 months.**

☐ Because you are a CDL holder and you submitted to testing conducted pursuant to 11-501.2 which disclosed any amount of a drug, substance or compound resulting from the unlawful use or consumption of cannabis as covered by the Cannabis Control Act your CDL privileges will be disqualified for a minimum of 12 months.

Driver's license surrendered? ☒ Yes ☐ No; Reason: _____

Driver's license valid at time of arrest? ☒ Yes (Sign receipt) ☐ No (Void receipt)

I have complied with Section 11-501.1 of the Illinois Vehicle Code by having reasonable grounds to believe the arrestee was in violation of Section 11-501 or a similar provision of a local ordinance, or Section 11-401: (Explain)

Passed out in vehicle, strong smell alcoholic beverages, urinated on self, Illegal transportation open alcohol.

Pursuant to Section 11-501.1 of the Illinois Vehicle Code I have:

☒ Served immediate Notice of Summary Suspension/Revocation of driving privileges on the above-named person.

☐ Given Notice of Summary Suspension/Revocation of driving privileges to the above-named person by depositing in the U.S. mail said notice in a prepaid postage envelope addressed to said person at the address as shown on the Uniform Traffic Ticket.

Under penalties as provided by law pursuant to Section 1-109 of the Illinois Code of Civil Procedure, the undersigned certifies that the statements set forth in this instrument are true and correct.

_____ (Signature of Arresting Officer) 6 (ID Number)

Hinsdale PD (Law Enforcement Agency) Date 01 / 14 / [illegible] (Month / Day / Year)

034425

Intox EC/IR-II
Subject Test

BLOOMINGDALE
POLICE DEPARTMENT
Serial Number: 011859
Test Number: 851
Test Date: 12/01/20
Test Time: 10:07 CST
Operator Name: JAFFE
Operator ID: 116
Subject Name

Subject D.O.B.: 12/08/1996
Subject Sex: Male
Drivers License Number

Drivers License State: IL
Arresting Officer: JAFFE
Arresting Officer ID: 116
Arresting Department
BLOOMINGDALE PD
County Name: DUPAGE
Citation Number:
System Check: Passed

Test	g/210L	Time
BLK	.000	10:09
SUBJ	.092	10:10

Test Status: Success

Operator Signature

Intox EC/IR-II
Scheduled
Certification

BLOOMINGDALE
POLICE DEPARTMENT
Serial Number: 011859
Test Number: 850
Test Date: 12/01/20
Test Time: 07:00 CST
Dry Gas Target: .078
Lot Number
AG809502 T029
Exp Date: 04/05/2020
System Check: Passed

Test	g/210L	Time
BLK	.000	07:01
CHK	.078	07:01
BLK	.000	07:03
CHK	.078	07:03

Test Status: Success

Intox EC/IR-II
Subject Test

GLEN ELLYN
POLICE DEPARTMENT
Serial Number: 012861
Test Number: 692
Test Date: 01/24/20
Test Time: 21:20 CST
Operator Name: BOOTON
Operator ID: 10
Subject Name

Subject D.O.B.: 09/18/1975
Subject Sex: Male
Drivers License Number

Drivers License State: IL
Arresting Officer: BOOTON
Arresting Officer ID: 10
Arresting Department
GLEN ELLYN
County Name: DUPAGE
Citation Number:
System Check: Passed

Test	g/210L	Time
BLK	.000	21:22
SUBJ	.***	21:23

Test Status: Test refused

Operator Signature

==========

Intox EC/IR-II
Scheduled
Certification

GLEN ELLYN
POLICE DEPARTMENT
Serial Number: 012861
Test Number: 681
Test Date: 01/01/20
Test Time: 07:00 CST
Dry Gas Target: .079
Lot Number: AG805201-020
Exp Date: 02/21/2020
System Check: Passed

Test	g/210L	Time
BLK	.000	07:01
CHK	.078	07:01
BLK	.000	07:03
CHK	.078	07:03

Test Status: Success

ILLINOIS STATE POLICE
Division of Forensic Services
Forensic Science Center at Chicago
1941 West Roosevelt Road
Chicago, Illinois 60608-1229
(312) 433-8000 (Voice) * 1-(800) 255-3323 (TDD)

Bruce Rauner
Governor

Leo P. Schmitz
Director

July 23, 2018

LABORATORY REPORT

Lundy, Tamra
WHEATON PD
900 WEST LIBERTY DRIVE
WHEATON, IL 60187

Laboratory Case #C18-
Agency Case #
SUPPLEMENTAL REPORT

OFFENSE Driving Under the Influence
SUSPECT

The following evidence was received by the Forensic Science Center at Chicago on April 10, 2018:

EXHIBIT	DESCRIPTION	FINDINGS
1B	Two bottles of urine	Alprazolam detected. Tetrahydrocannabinol (THC) metabolite detected.

This supplemental report only includes the results from additional analysis performed at the request of Ofc. Tamra Lundy of the Wheaton Police Department. For the initial test results please refer to the laboratory report dated 18 June 2018.

Drug analysis was limited to the following classes: Barbiturates, Benzodiazepines, and THC metabolite. Note: Testing is not all inclusive and does not include synthetic cannabinoids. Should additional testing be required, please contact the laboratory.

Section 5-9-1.9 of the Unified Code of Corrections (730ILCS) authorizes a criminal laboratory analysis fee of $150.00 to be imposed for persons adjudged guilty of an offense in violation of Section 11-501 of the Illinois Vehicle Code.

Any analysis conducted is accredited under the laboratory's ISO/IEC 17025 accreditation issued by ANSI-ASQ National Accreditation Board (ANAB). Refer to certificate #AT-1697 and associated Scope of Accreditation.

Respectfully submitted,

8/1/18

DISTRIBUTION
SUBMITTING OFFICER
PROPERTY CONTROL OFFICER
PROSECUTOR
LC#504

Henry Luis Rentas
Forensic Scientist

ILLINOIS STATE POLICE

Division of Forensic Services
Forensic Science Center at Chicago
1941 West Roosevelt Road
Chicago, Illinois 60608-1229
(312) 433-8000 (Voice) * 1-(800) 255-3323 (TDD)

Bruce Rauner
Governor

Leo P. Schmitz
Director

June 18, 2018

LABORATORY REPORT

Lundy, Tamra
WHEATON PD
900 WEST LIBERTY DRIVE
WHEATON, IL 60187

Laboratory Case #C18-
Agency Case # 3

OFFENSE Driving Under the Influence
SUSPECT

The following evidence was received by the Forensic Science Center at Chicago on April 10, 2018:

EXHIBIT	DESCRIPTION	FINDINGS
1A	Two tubes of blood	Ethanol 0.141 g/dL.
1B	Two bottles of urine	Not analyzed.

Note: Analysis has been limited to volatiles only. Should additional testing be required, please contact the Forensic Science Center at Chicago at (312) 433-8000.

Volatile analysis of this case is limited to the following: ethanol, methanol, acetone, isopropanol, and toluene.

Section 5-9-1.9 of the Unified Code of Corrections (730ILCS) authorizes a criminal laboratory analysis fee of $150.00 to be imposed for persons adjudged guilty of an offense in violation of Section 11-501 of the Illinois Vehicle Code.

Any analysis conducted is accredited under the laboratory's ISO/IEC 17025 accreditation issued by ANSI-ASQ National Accreditation Board (ANAB). Refer to certificate #AT-1697 and associated Scope of Accreditation.

Respectfully submitted,

Henry Luis Rentas
Forensic Scientist

Submitting Officer

Property Control Officer

Prosecutor

ILLINOIS STATE POLICE
Division of Forensic Services

Rod R. Blagojevich
Governor

Larry G. Trent
Director

November 8, 2007

Assistant State's Attorney Janetta Sanks
Office of the DuPage County State's Attorney
503 North County Farm Road
Wheaton, IL 60187

Dear ASA Sanks;

I am writing this in response to your request for a conversion of the serum alcohol level into a whole blood alcohol level of [redacted]. The following are the results of those calculations.

The serum alcohol level provided is 257 mg/dL of ethanol, or 0.257 grams of ethanol in 100 milliliters (1 deciliter) of serum. Conversion from the serum to whole blood is accomplished using the following equation based on the guidelines in 20 Illinois Administrative Code, Chapter II, Part 1286:

$$BAC = SAC/1.18$$

Where: BAC = Blood Alcohol Concentration
SAC = Serum Alcohol Concentration
1.18 = Correction factor used for conversion

BAC = 0.257 g/dL (ethanol in serum)/1.18 (serum/whole blood)
= 0.217 g/dL (ethanol in whole blood)

The ratio is based on the difference in water content between whole blood and serum. Alcohol distributes throughout the body relative to the water content of the various tissues and fluids. The concentration of water in serum is approximately 18% higher than whole blood. This is reflected in the alcohol concentrations of these two fluids by the fact that serum will have an alcohol concentration approximately 18% higher than whole blood.

Conclusions:

Therefore, it is my conclusion, based on the calculations shown, that [redacted] blood alcohol concentration was approximately 0.217 g/dL. This opinion is based on the data provided for this case, data published in scientific literature, and on the calculation outlined above.

Should you have any further questions, feel free to contact me at (312) 433-8000 ext. 2051.

Sincerely,

A. Karl Larsen, Jr., Ph.D.
Toxicology Technical Leader
Forensic Science Center at Chicago

Forensic Sciences Command • Forensic Science Center at Chicago
1941 West Roosevelt Road • Chicago, IL 60608-1229
(312) 433-8000 (voice) • 1 (800) 255-3323 (TDD)
www.illinois.gov • www.isp.state.il.us

State of Illinois
Department of Human Services

Alcohol and Drug Evaluation Uniform Report

PART 1. OFFENDER INFORMATION

Offender Name: _____
LAST FIRST MI

IL Driver's License Number or State ID: _____

Other Valid Driver's License Number: _____
NUMBER STATE

Home Address: _____

City: _____ State: _____ Zip Code: _____

County of Residence: _____ Citizenship: _____

Phone Number: _____ / _____ / _____
HOME WORK/extension CELL

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female
MM/DD/YYYY

Race(s):
☐ American Indian/Alaskan Native
☐ Asian
☐ Black/African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Unknown

Hispanic Origin: _____ Primary Language: _____

Religion: _____ Interpreter Services: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

Education Level:
☐ Under 7 yrs.
☐ Junior H.S.
☐ High School/GED
☐ Some college, no degree
☐ Associate's Degree
☐ Bachelor's Degree
☐ Master's Degree, or higher

Employment Status: ☐ Full-time ☐ Part time ☐ Unemployed ☐ Disabled ☐ Retired ☐ Student

Occupation: _____

Annual Household Income: _____ Number of Dependents (including self): _____

Physical or Mental Disability: _____

Emergency Contact Person: _____ Contact Phone Number: _____

VETERAN: ☐ ***YES*** ☐ ***NO*** ***BRANCH:*** _____ ***ACTIVE:*** ☐ ***YES*** ☐ ***NO***

STOP HERE

PART 2. CURRENT DUI ARREST INFORMATION

2.1 Referral Source: ☐ COURT ☐ SOS ☐ ATTORNEY ☐ SELF ☐ OTHER

2.2 Evaluation Begin Date: _____ 2.3 Evaluation End Date: _____

2.4 Date of Arrest: _____ 2.5 Time of Arrest: _____ **AM / PM**

2.6 County of Arrest: _____ 2.7 Blood-Alcohol Concentration (BAC): _____

2.8 Results of Blood and/or Urine:

_____

_____

_____

_____

_____

2.9 Specify up to five mood altering substances (alcohol/drugs) consumed which led to this DUI arrest (in order of most to least).

_____ _____ _____ _____ _____

01-Alcohol (beer/wine/liquor)	08-Dilaudid (Rx/Non-Rx)	15-Methamphetamine
02-Amphetamines	09-Hallucinogens (Peyote, LSD, etc.)	16- Non-Rx Methadone
03-Barbiturates	10-Hashish	17- Non-Barbiturate Sedatives
04-Base cocaine	11-Heroin	18- Other
05-Benzodiazepines	12-Inhalents	19- Other Opioids
06-Cocaine	13-Karachi	20- Over-the counter
07-Crack	14-Marijuana	21- PCP

2.10 Specify the amount and time frame in which the alcohol and/or drugs were consumed which let to this DUI arrest.

_____

_____

_____

_____

_____

2.11 Does the Blood-Alcohol Concentration (BAC) for the current arrest correlate with the offender's reported consumption? Yes or No. If no, please explain.

_____

_____

_____

_____

PART 3. ALCOHOL AND DRUG RELATED LEGAL & DRIVING HISTORY

3.1 Prior DUI dispositions (list chronologically, from first arrest to most recent, and include out-of-state arrests):

Date of Arrest	Date of Conviction or Court Supervision	BAC

(Additional dispositions should be listed in an addendum to the Uniform Report)

3.2 Prior statutory summary or implied consent suspensions (may have same arrest date of DUIs listed above):

Date of Arrest	Effective Date of Suspension	BAC

(Additional dispositions should be listed in an addendum to the Uniform Report)

3.3 Prior reckless driving convictions reduced from DUI (may have same arrest date of summary of suspensions listed above):

Date of Arrest	Date of Conviction	BAC

(Additional dispositions should be listed in an addendum to the Uniform Report)

3.4 Other prior alcohol and/or drug related driving dispositions by type and date of arrest as reported by the offender and/or indicated on the driving record (including out-of-state dispositions).

Zero Tolerance		Illegal Transportations	
Date of Arrest	Effective Date	Date of Arrest	Date of Conviction

3.5 Describe any discrepancies between information reported by the offender and information on the driving record.

PART 4. SIGNIFICANT ALCOHOL/DRUG USE HISTORY

TYPE OF DRUG	AGE OF ONSET	AGE OF FIRST INTOXICATION	AGE OF REGULAR USE	YEAR OF LAST USE
Alcohol				
~~Caffeine~~				
Cannabis				
Hallucinogens (PCP and other hallucinogens)				
Inhalants				
Opioids				
Sedatives / Hypnotics / Anxiolytics				
Stimulants (amphetamine type, cocaine, and other stimulants)				
Tobacco				
Other (or unknown) substances: _____				

4.1 Chronological History Narrative:

4.2 Review any prescription or over-the-counter medication the offender is currently taking that has the potential for abuse. List the medication, what it is used for, and how long it has been taken. Report whether the offender has ever abused medications and whether he/she has ever illegally obtained prescription medication.

PART 4. SIGNIFICANT ALCOHOL/DRUG USE HISTORY

4.3 Specify any immediate family member(s) with a history of alcoholism, alcohol abuse, drug addiction/abuse, or any other problems related to any substance abuse. State whether the family member is in frequent contact with the offender and whether he/she is still using any substance.

4.4 Specify any immediate peer group member(s) with a history of alcoholism, alcohol abuse, drug addiction/abuse, or any other problems related to any substance abuse. State whether the peer group member is in frequent contact with the offender and whether he/she is still using any substance.

4.5 List all dates, locations, and charges for which the offender has been arrested where substance use, possession, or delivery was a primary or contributing factor (including out-of-state dispositions).

4.6 Identify the significant other and summarize the information obtained in the interview.

4.7 Provide the names, locations, and dates of any treatment programs reported by the offender.

4.8 Provide the names of any self-help or sobriety-based support group participation reported by the offender and the dates of involvement.

PART 4. SIGNIFICANT ALCOHOL/DRUG USE HISTORY

4.9 Has substance use/abuse negatively impacted the client's major life areas?

Impairments

Family

Marriage or significant other relationships

Legal status

Socially

Vocational/work

Economic status

Physically/Health

PART 5. OBJECTIVE TEST INFORMATION

5.1 Mortimer/Filkins Score: **NOT APPLICABLE** Category: **NOT APPLICABLE**

5.2 ASUDS-RI Risk Level:

- ☐ 1 = Minimal
- ☐ 2 = Moderate
- ☐ 3 = Significant
- ☐ 4 = High

5.3 Driver Risk Inventory (DRI) Scales and Risk Ranges:

Validity Scale:	☐ LOW	☐ MEDIUM	☐ PROBLEM	☐ SEVERE PROBLEM
Alcohol Scale:	☐ LOW	☐ MEDIUM	☐ PROBLEM	☐ SEVERE PROBLEM
Driver Risk:	☐ LOW	☐ MEDIUM	☐ PROBLEM	☐ SEVERE PROBLEM
Drugs Scale:	☐ LOW	☐ MEDIUM	☐ PROBLEM	☐ SEVERE PROBLEM
Stress Coping Abilities Scale:	☐ LOW	☐ MEDIUM	☐ PROBLEM	☐ SEVERE PROBLEM

PART 6. CRITERIA FOR SUBSTANCE USE DISORDER

6.1 Identify any Substance Use Disorder criteria occurring any time in the same 12-month period. This may be done using the offender's current presentation or a past episode for which the offender is currently assessed as being in remission.

IMPAIRED CONTROL:

☐ Alcohol or drugs are taken in larger amounts or over a longer period than intended.

☐ There is a persistent desire or unsuccessful efforts to cut down or control alcohol or drug use.

☐ A great deal of time is spent in activities necessary to obtain, use, or recover from its effects of alcohol or drug use.

☐ Craving, or a strong desire or urge to use alcohol or drugs.

SOCIAL IMPAIRMENT:

☐ Recurrent alcohol or drug use resulting in a failure to fulfill major role obligations at work, school, or home.

☐ Continued alcohol or drug use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol or drugs.

☐ Important social, occupational, or recreational activities are given up or reduced because of alcohol or drug use.

RISKY USE:

☐ Recurrent alcohol or drug use in situations in which it is physically hazardous.

☐ Alcohol or drug use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol or drugs.

PHARMACOLOGICAL:

☐ Tolerance—either a need for markedly increased amounts of alcohol or drug to achieve intoxication or the desired effect, or a markedly diminished effect with continued use of the same amount of alcohol or drug.

☐ Withdrawal—as manifested by either the characteristic withdrawal syndrome for the substance or the same or closely-related substance is taken to relieve or avoid withdrawals.

6.2 If the offender meets Substance Use Disorder criteria based on a past episode and is now assessed as being in remission, identify and describe the course specifier that reflects the offender's current status.

Current status:

☐ In early remission
☐ In sustained remission
☐ Not Applicable
☐ On maintenance therapy
☐ In controlled environment

6.3 Has the offender ever met Substance Use Disorder criteria by prior history but is now considered recovered (no current Substance Use Disorders)? If yes, please explain when the criteria were met and why it is not clinically significant for the purposes of risk assessment. The explanation must include the length of time since the last episode, the total duration of the episode, and any need for continued evaluation or monitoring.

_____

_____

_____

_____

_____

_____

PART 7. OFFENDER BEHAVIOR

7.1 Were the offender's behavior and responses consistent, reliable, and non-evasive?

_____

_____

_____

_____

7.2 Identify indications of any significant physical, emotional/mental health, or psychiatric disorders.

_____

_____

_____

_____

7.3 Identify any special assistance provided to the offender in order to complete the evaluation.

_____

_____

_____

_____

7.4 Where was the offender interview conducted?

☐ Licensed Site ☐ Non-Licensed Site, specify site: _____

7.5 Is this a second opinion evaluation?

☐ Yes ☐ No If yes, explain: _____

7.6 What modality was this DUI Evaluation completed?

☐ Face-to-face ☐ Telehealth, explain: _____

PART 8. CLASSIFICATION

8.1 Classification: ☐ Minimal ☐ Moderate ☐ Significant ☐ High

8.2 Discuss how corroborative information from both the interview and the objective test either correlates or does not correlate with the information obtained from the DUI alcohol/drug offender.

_____

_____

_____

_____

PART 9. MINIMAL REQUIRED INTERVENTION

9.1 Intervention: ☐ Minimal (10) ☐ Moderate (10/12) ☐ Significant (10/20) ☐ High (75)

9.2 The offender was referred as follows:

All clients of the 18th Judicial Circuit DUI Evaluation Unit receive a comprehensive DHS/DASA Treatment Providers list.

Illinois Driver Risk Inventory-2

Name: Mr. John Smith
Age: 35 Sex: Male
Date of Birth: 01/12/1979
Race: Caucasian
Marital Status: Single

CONFIDENTAIL REPORT

Last Four Digits of SSN: 1234
Education: H.S. Graduate
DRI-2 DATE: 08/26/2016

Driver Risk Inventory-2 (DRI-2) results are confidential and should be considered working hypotheses. No decision should be based solely upon DRI-2 results. The DRI-2 is to be used in conjunction with experienced staff judgment.

Mandatory Minimum DUI Risk

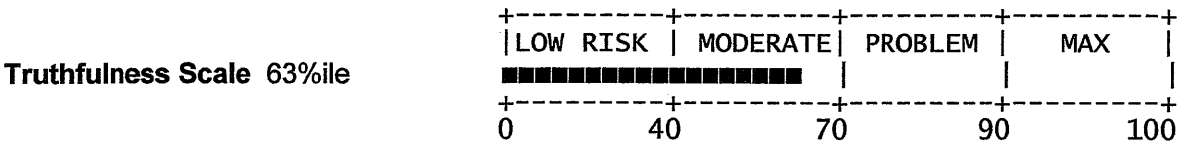
Significant (Problem) Risk

Mr. John Smith's Illinois Mandatory Minimum DUI Risk Classification is in the **Significant (Problem) Risk** range, which is characterized by one prior DUI conviction, or a prior court ordered supervision for DUI, or a prior statutory summary suspension, or a prior reckless driving conviction reduced from DUI. Conversely, a BAC of .20 or higher as a result of Mr. Smith's most current DUI arrest, and/or two to three DSM-5 Substance Use Disorder symptoms meet the Significant Risk criterion. In summary, Mr. Smith's Illinois Mandatory Minimum DUI risk range is the Significant (Problem) Risk range.

Different Measures

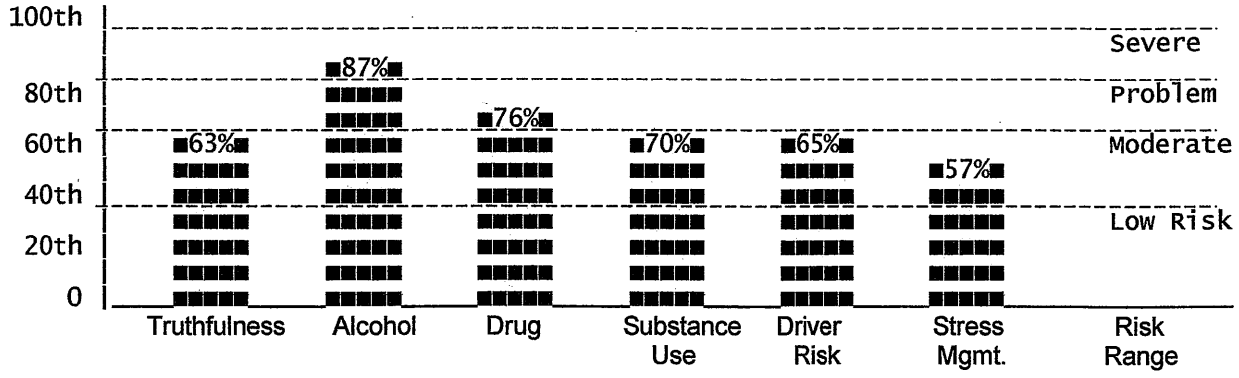
Illinois' Mandatory Minimum DUI Risk Classification uses court-related data and DSM-5 Substance Use Disorder criteria to classify DUI risk. While the Substance Use Disorder scale consists of admissions to eleven DSM-5 questions, the Alcohol and Drug Scales focus on client opinions regarding their drinking and drug use. That said, different measures may produce different results. **Illinois mandatory minimums take precedence.**

Illinois Driver Risk Inventory-2 (DRI-2) Profile



Mr. John Smith's Truthfulness Scale score is in the **moderate risk** (40 to 69th percentile) range. This is an accurate Driver Risk Inventory-2 (DRI-2) profile and all DRI-2 scale scores are accurate. Nevertheless, Mr. Smith tends to be cautious when answering DRI-2 questions. This may be situation specific and related to why he is being evaluated. However, there is a fine line between cautiousness and recalcitrance or evasiveness. Consequently, the evidence based DRI-2 Truthfulness Scale score helps answer truthfulness-related questions. That said, Mr. Smith's Truthfulness Scale score is within the acceptable range and all of his DRI-2 scale scores are accurate.

DRI-2 Profile



ADDITIONAL INFORMATION PROVIDED BY CLIENT

Date of Present DUI Arrest	08/29/2017	Driver's License Suspended/Revoked?	No
Reason for Arrest	Alcohol	Arrest Reduced to Careless/Reckless Driving?	No
Additional DUI Offenses Pending?	No	Lifetime alcohol-related (not DUI) arrests	1
BAC at Time of Current Arrest	.014	Lifetime drug-related (not DUI) arrests	0
Refused Breath/Blood Test in Current DUI?	No	Lifetime At-Fault Motor Vehicle Accidents	0
Lifetime DUI Arrests	2	Lifetime Traffic Violations (Tickets)	3

Scale Score Paragraphs

All seven Illinois DRI-2 scale-related paragraphs explain when problems exist and what each attained scale score means. It should be understood that the **Illinois Mandatory Minimum DUI risk range has priority and takes precedence.** Nevertheless, when problems exist, risk-related recommendations are offered.

Substance Use Disorder: PROBLEM

In the DSM-5, alcohol and drug use are combined under the caption "Substance Use Disorder." That said, DSM-5 postulates eleven (11) substance use severity criteria. A client's (offender's) substance use severity is then determined by the number of the eleven severity criteria the client admits too. Mr. Smith admits to **four or five** of the eleven severity criteria, which is classified **problem** substance use. The DSM-5 **problem** classification is equivalent to a Driver Risk Inventory-2 (DRI-2) **problem risk** (70 to 89th percentile) Alcohol Scale or Drug Scale score. Mr. Smith's DSM-5 Substance Use Disorder score is in the **problem risk** range (four or five admissions).

Alcohol Scale: PROBLEM **SCORE: 87%**

Mr. John Smith's Alcohol Scale score is in the **problem** (70 to 89th percentile) range. An established pattern of alcohol (beer, wine or liquor) abuse is indicated. Recommendations: A minimum level of treatment, consideration should be given to outpatient chemical dependency treatment for people with drinking problems. Participation in self-help or mutual-help (e.g., AA or RR) meetings might augment, but not replace treatment. Without treatment, Mr. Smith's drinking problem will likely worsen. Should Mr. Smith relapse, his optimum level of care would likely increase to "intensive outpatient treatment." Mr. Smith would benefit from help with his drinking problem.

Drug Scale: PROBLEM **SCORE: 70%**

Mr. John Smith's Drug Scale score is in the **problem** (70 to 89th percentile) range. Problem risk scorers have drug (prescription and/or nonprescription) involvement that warrants intervention and/or treatment. Review Mr. Smith's answer to the "recovering" question (#84). If recovering, how long? Recommendations: consider outpatient (individual or group) counseling augmented (not replaced) by Narcotics Anonymous (NA) or Cocaine Anonymous (CA) meetings. Review other DRI-2 scale scores for co-occurring disorders. Should Mr. Smith relapse, his optimum level of care would likely increase to "intensive outpatient treatment."

Driver Risk: MODERATE **SCORE: 65%**

Mr. John Smith's Driver Risk Scale score is in the **moderate** risk (40 to 69th percentile) range. Some indicators of inattentive driving are present, but an established pattern of irresponsible driving is not present. *Mr. Smith* may only be a driving risk after using alcohol (beer, wine or liquor) or drugs (prescription and/or nonprescription). Prudent assessors will check out the other Driver Risk Inventory-2 (DRI-2) scales that can directly contribute to *Mr. Smith's* driving risk, e.g., Truthfulness Scale, Alcohol Scale, Drug Scale, Substance Use Scale and the Stress Management Scale. Any elevated (70th percentile and higher) scale scores would contribute to driver risk. On its own merits, *Mr. Smith's* Driver Risk Scale indicates he is a safe driver.

Stress Management Scale: MODERATE **SCORE: 57%**

Mr. John Smith's Stress Management Scale score is in the **moderate** (40 to 69th percentile) range. Stress management issues are becoming apparent. If left unattended these potential issues or concerns could worsen. Recommendations: a "brief intervention" might be considered. Brief interventions range from 15 to 30 minutes of direct face-to-face staff-client (offender) discussion, they can be a valuable intervention for clients with early stage stress-related problems. There are also many good self-help stress management books that help readers recognize their stress, reframe it and positively manage it. They also discuss stress reduction techniques like relaxing body parts, deep breathing exercises, meditation, etc. Another alternative is enrollment in a stress management class. Stress-related issues are emerging.

Significant Items. The following self-report responses represent areas that may help in understanding the respondent's situation and status.

Alcohol

2. Concerned about my drinking.
6. Drinking has caused serious problems.
9. Often drinks more than intended.
11. Feels guilty about drinking.

Drug

17. Family member said get help.
22. Been treated for drug prblm.
31. Had drug abuse problem.

Substance Use Disorder

65. Almost all activities substance-related.
69. Persistent cravings and strong urges.
71. Continue using despite knowing causes prblms.
77. Cannot reduce or cut down.

Driver Risk

3. I usually drive fast.
7. I am quick tempered.
14. Use cell phone while driving.

Comments/Recommendations:_____

Use back of this page, if necessary

STAFF MEMBER SIGNATURE **DATE**

IL DRI-2 RESPONSES

1 - 50 TFFFTFFFFF FFFFFFFFTF TFTFFFTFTF FTFTFTFTFT FFTFTFFFFT
51 - 100 FFFFFFFFFF TFFFFFFTFF FTT4444114 4444444444 1411414144
101 - 113 1144141141 144

ADULT SUBSTANCE USE AND DRIVING SURVEY - REVISED FOR ILLINOIS (ASUDS-RI)
Authors: Kenneth W. Wanberg and David S. Timken

CLIENT INFORMATION

Name: Teddy Trouble **DOB:** 12/06/1986 **Age:** 20 **Gender:** Male **Ethnicity:** Anglo-American White **Marital Status:** Never married	**Assess Date:** 04/09/2019 **Client ID:** 0001 **Evaluator:** rjk **Agency Name:** Don't Drive DUI	**Arrest BAC:** .149 **Failed Blood/Urine Test:** No **Prior DWI/DUI Convictions:** 0 **Prior DWI/DUI Education Hrs:** 0 **No. AOD OP Treatment Sessions:** 8 **No. AOD Inpatient Days:** 0

DRUG AND ALCOHOL USE HISTORY

Drug Category	Times in lifetime	Times last 12 months	Age Last Use	Drug Category	Times in lifetime	Times last 12 months	Age Last Use
Alcohol Drunk	More than 50 times	11-25 times	20	Heroin	Never Used	Never Used	N/A
Marijuana	More than 50 times	26-50 times	20	Other Opiate	Never Used	Never Used	N/A
Cocaine	Never Used	Never Used	N/A	Sedatives	Never Used	Never Used	N/A
Amphetamines	Never Used	Never Used	N/A	Tranquilizers	Never Used	Never Used	N/A
Hallucinogens	One to 10 times	Never Used	18	Cigarettes	Up to a pack a day		
Inhalants	Never Used	Never Used	N/A				

CRITICAL ITEMS

- Drove a few times when had too much to drink
- Passed out often when drinking
- Not recall what did when drinking twice
- Blackouts 1-3 times
- Physically violent 4-6 times
- Passed out 1-3 times
- Committed a crime 4-6 times
- Charged with impaired driving 1-2 times
- Arrested and charged with crime 1-2 times
- Convicted of a crime 1-2 times
- Violent behavior sometimes
- Have problems sleeping a lot of the time
- For sure, want to make changes in use of alcohol or other drugs
- Most likely want to stop using or continue not to use alcohol

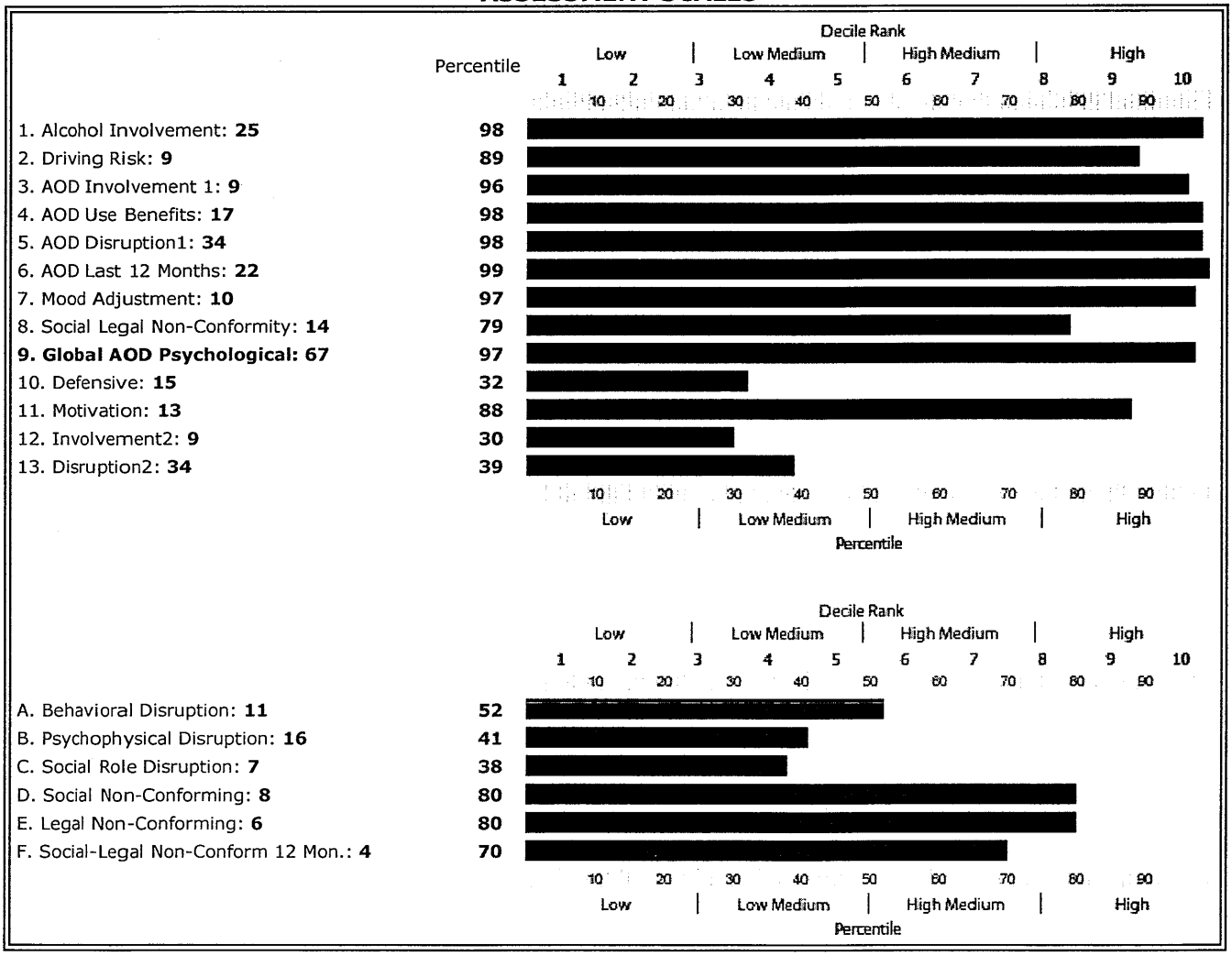
SUGGESTED SERVICE LEVEL BENEFITS OR GUIDELINES

Level	Suggested Service Level Benefit	Weighted
4	Client could benefit from a basic alcohol-drug / DUI risk education program plus an extended-enhanced alcohol/drug treatment program followed with an aftercare plan.	13

ASSESSMENT SUMMARY

- Fairly open around driving risk behavior; may benefit from driving risk education
- High level of past alcohol involvement with very strong indication of a past disruptive pattern of alcohol problems.
- Low-moderate defensiveness quite open to self-disclosure.
- Moderate to high levels of mood and psychological distress. Consider mental health assessment if collateral information supports this.
- Moderate to high past AOD involvement based on drugs (drugs include alcohol) listed in the survey.
- Reports very significant AOD involvement in last 12 months.
- Past AOD negative outcomes or consequences to indicate past moderate disruptive effects and problems with possible Substance Abuse Disorder.
- Indicates low to moderate history of social-legal non-conforming.
- Indicates moderate to high motivation and desire for change and reluctant to get help for AOD problems.
- Overall history of psychosocial and AOD problems and disruption is very high.

ASSESSMENT SCALES



*AOD = alcohol or other drugs

Information in the ASUDS-RI summary is based on the client's self-report. It is dependent on his or her ability to validly respond to the questions. It represents the individual's perception of self regarding alcohol and other drug use, driving attitudes and behaviors, concerns about self, relationship with the community, legal history, and willingness to be involved in the change process. This information should be used only in conjunction with information from all other sources when making referral, education or treatment recommendations. No one piece of information from this or any other source should be used solely to make such decisions. When possible, it is helpful to engage the client in a partnership when making referral and treatment recommendations and decisions. The final referral and treatment recommendations are always made by the evaluator.

Client Signature:_____ Date:_____

Answer Sheet

Questions are based on user entry; 1 = A, 2 = B, 3 = C, 4 = D, 5 = E, 6 = F

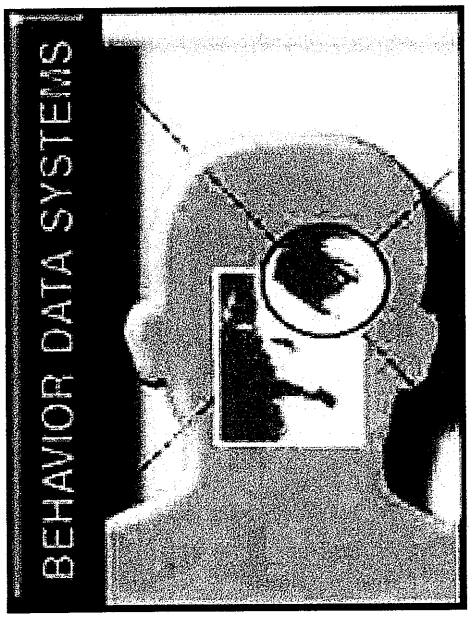
1. **3** | 2. **3** | 3. **2** | 4. **4** | 5. **4** | 6. **2** | 7. **4** | 8. **2** | 9. **3** | 10. **3** | 11. **3** | 12. **3** | 13. **2** | 14. **2** | 15. **2** | 16. **1** | 17. **2** | 18. **1** | 19. **1** | 20. **2** | 21. **1** | 22. **2** | 23. **2** | 24. **4** | 25. **1** | 26. **5** | 26a. **3** | 26b. **20** | 27. **5** | 27a. **4** | 27b. **20** | 28. **1** | 28a. **1** | 28b. **N/A** | 29. **1** | 29a. **1** | 29b. **N/A** | 30. **2** | 30a. **1** | 30b. **18** | 31. **1** | 31a. **1** | 31b. **N/A** | 32. **1** | 32a. **1** | 32b. **N/A** | 33. **1** | 33a. **1** | 33b. **N/A** | 34. **1** | 34a. **1** | 34b. **N/A** | 35. **1** | 35a. **1** | 35b. **N/A** | 36. **4** | 37. **4** | 38. **3** | 39. **2** | 40. **2** | 41. **1** | 42. **2** | 43. **2** | 44. **2** | 45. **2** | 45a. **1** | 46. **3** | 46a. **1** | 47. **4** | 47a. **2** | 48. **2** | 48a. **1** | 49. **1** | 49a. **1** | 50. **5** | 50a. **3** | 51. **1** | 51a. **1** | 52. **1** | 52a. **1** | 53. **1** | 53a. **1** | 54. **1** | 54a. **1** | 55. **1** | 55a. **1** | 56. **1** | 56a. **1** | 57. **5** | 57a. **3** | 58. **5** | 58a. **4** | 59. **5** | 59a. **3** | 60. **5** | 60a. **5** | 61. **2** | 61a. **1** | 62. **5** | 62a. **3** | 63. **3** | 63a. **2** | 64. **1** | 64a. **1** | 65. **2** | 66. **2** | 67. **2** | 68. **1** | 69. **4** | 70. **1** | 71. **3** | 72. **2** | 73. **2** | 74. **2** | 75. **3** | 76. **2** | 77. **3** | 78. **3** | 79. **1** | 80. **2** | 81. **2** | 82. **1** | 83. **2** | 84. **2** | 85. **1** | 86. **2** | 87. **2** | 88. **1** | 89. **2** | 89a. **2** | 90. **2** | 90a. **2** | 91. **2** | 91a. **1** | 92. **1** | 92a. **1** | 93. **2** | 93a. **1** | 94. **1** | 94a. **1** | 95. **2** | 95a. **2** | 96. **2** | 96a. **2** | 97. **1** | 97a. **1** | 98. **1** | 98a. **1** | 99. **1** | 99a. **1** | 100. **1** | 100a. **1** | 101. **1** | 101a. **1** | 102. **1** | 102a. **1** | 103. **2** | 103a. **1** | 104. **1** | 104a. **1** | 105. **3** | 105a. **1** | 106. **1** | 106a. **1** | 107. **4** | 108. **3** | 109. **2** | 110. **2** | 111. **4** | 112. **3** | 113. **2** |

CLIENT NAME/CASE NUMBER:

DATE:	CASE NOTES:

IL DRI-2

DRIVER RISK INVENTORY-2



Training Manual

Courtesy of Behavior Data Systems, Ltd. and its subsidiaries
Risk & Needs Assessment, Inc.
and Professional Online Testing Solutions, Inc.

E-mail: info@bdsltd.com

www.bdsltd.com
www.online-testing.com

Table of Contents

Preface

All major DUI assessment instruments and tests were evaluated by the U.S. Department of Transportation, National Highway Traffic Safety Administration (NHTSA). In a two-year NHTSA study reported in DOT HS 807 475. As you know, NHTSA is the highest federal authority in the DUI/DWI field. As reported in Government Technology (Vol. 3, No. 5, May 1990), **NHTSA concluded that the Driver Risk Inventory was the best DUI/DWI test.**

"This instrument (DRI-2) appears to be by far the most carefully constructed from a psychometric standpoint...Reliability is well established and validity is based on the instrument's relationship to other established measures." (NHTSA, DOT HS 807 475)

"In settings where it has been adopted as the primary screening instrument for processing convicted drunk drivers, substance abuse counselors have reported that it (DRI-2) improves the quality of their decisions while making their task less time-intensive." (NHTSA, DOT HS 807 475)

By merging the latest in psychometrics with computer technology, the DRI-2 accurately assesses client behavior and identifies client risk, as well as need. DUI staff members can now objectively gather a vast amount of relevant information, identify client problems and formulate specific intervention and treatment strategies.

The DRI-2 is a self-report test that is completed by the client. There are no forms or questionnaires to be completed by the staff. DRI-2's are scored and interpreted by the computer, which generates printed DRI-2 reports on-site within 2½ minutes of test data (answers) entry. These reports eliminate the need for tedious, time consuming and error prone hand scoring. Staff report writing, substantiation of decision making and record keeping needs are met with DRI-2 reports.

Product Description

The **Driver Risk Inventory (DRI-2)** is a brief, easily administered and automated (computer scored and interpreted) test specifically designed for DUI/DWI offender risk assessment and screening.

Within minutes of test completion, the DRI-2 can generate a comprehensive report presenting six empirically based measures (scales), explaining attained risk levels and making specific recommendations. DRI-2 reports also summarize multiple choice questions, set forth "significant items" and provide space for staff recommendations.

The DRI-2 is a test designed specifically for use with convicted DUI and DWI offenders. It has 113 items (questions), and can be completed in 20 to 25 minutes. Reports can be printed on-site within 2½ minutes of test data (answers) input. The DRI-2 has been researched and normed on the DUI/DWI offender population.

DRI-2 tests are now also available over our Internet testing platform at **www.online-testing.com**.

Tests can be given directly on the computer screen or in paper-pencil test booklet format. Regardless of how the tests are administered, all tests are computer scored on-site, and reports are available within 2½ minutes of test completion.

Staff report writing, substantiation of decision-making and record keeping needs are met with these reports. The DRI-2 is to be used in conjunction with experienced staff judgment. Today, we acknowledge the growing role of automation **and** the importance of evaluator experience and judgment.

Present, Past or Future Tense

Clients should answer questions as the questions are stated -- in present tense, past tense or future tense. Questions are to be answered literally as they are presented. There are no trick questions. If an item wants to know about the past, it will be stated in past tense. If the item inquires about the present, it will be stated in present tense. And, if an item asks about the future, it will be stated in future tense. Just answer each question as it is stated.

Seven Measures

The DRI-2 includes six (6) empirically-based measures (scales):

1. TRUTHFULNESS SCALE: The Truthfulness Scale is a measure of how truthful the client was while completing the DRI-2. This scale identifies self-protective, recalcitrant and guarded people who minimize or even conceal information.

2. ALCOHOL SCALE: The Alcohol Scale is a measure of the client's alcohol proneness and alcohol-related problems. DUI risk evaluation and screening programs are based on the concept of an objective, reliable and valid measure of alcohol proneness and abuse. Alcohol refers to beer, wine or liquor.

3. DRUG SCALE: The Drug Scale is an independent measure of the client's drug abuse proneness and drug-related problems. Without a Drug Scale, many drug (marijuana, cocaine, crack, barbiturates, amphetamines, heroin, etc.) abusers would remain undetected.

4. DRIVER RISK SCALE: The Driver Risk Scale is a measure of the client's driver risk, independent of their involvement with alcohol or other drugs. This scale is helpful in detecting the abstaining, yet irresponsibly aggressive driver.

5. STRESS MANAGEMENT SCALE: The Stress Management Scale is a measure of the client's ability to handle or cope with their stress. Severely impaired stress coping abilities are indicative of other identifiable emotional and mental health problems.

6. SUBSTANCE USE DISORDER SCALE: DSM-5 Substance Use Disorder **severity** is based upon the number of the 11 DSM-5 symptom criteria endorsed. When "none or one" of the 11 symptom criteria is endorsed (admissions), the DUI offender **Does not meet substance use disorder criteria.** When "two or three" symptom criteria are endorsed, the DUI offender's substance use disorder severity is classified as **Moderate. Problem** severity is identified by the endorsement of "four or five" of the 11 symptom criteria. A **severe** substance use disorder is identified by the presence of **six or more** of the 11 symptoms.

7. ILLINOIS MANDATORY MINIMUMS: The Illinois Department of Human Services, Division of Alcohol and Substance Abuse has mandatory minimums when it comes to assigning a DUI Risk Classification, i.e., Minimal Risk, Moderate Risk, Significant Risk or High Risk.

Why Use DRI-2 Scales

The Driver Risk Inventory (DRI-2) scales (Truthfulness, Alcohol, Drug, Driver Risk and Stress Management) were developed specifically and exclusively for DUI/DWI offender assessment. Each of these scales measure the severity of use of the substance it represents. The Diagnostic & Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) Substance Use Disorder classification was incorporated into the DRI-2 because it is widely accepted by clinicians and recognized by the courts. Each of the DRI-2 scales measures the severity of use of the substance it represents. As a general rule, the more specific or focused an assessment scale is, the more accurate its findings. And precise

"problem severity" measurement makes accurate "problem severity-treatment intensity" matching possible.

In contrast, DSM-5 disorders (classifications) were developed for clinical diagnosis and are treatment oriented. The DSM-5, its Substance Use Scale and other DSM-5 classifications are not designed for, nor standardized on DUI/DWI offenders. Moreover, the DSM-5 Substance Use Disorder Scale includes both alcohol and drug use in the same scale. One of the major criticisms of the DSM-5 is its lack of evidence-based peer review research.

Reasons for developing and using the DRI-2 and its Alcohol Scale and Drug Scale are many and include the need for an Alcohol Scale and Drug Scale that are designed for, researched on and standardized on DUI/DWI offenders. The DRI-2 and its six scales are standardized on DUI/DWI offenders. The DSM-5 and its scales or disorders are not. Generalizing from chemical dependency and alcohol/drug treatment patients to DUI/DWI offenders is tenuous, at best.

Professional reliability, validity and accuracy standards for tests, scales, domains and classifications systems must be met. Extensive DRI-2 peer review research is set forth at www.BDS-Research.com. Each DRI-2 scale has been extensively researched and standardized on the DUI/DWI offender population. The lack of DSM-5 DUI/DWI offender research was cited earlier.

DRI-2 scales use a short-term time referent (here-and-now or recent past). In contrast, the DSM-5 uses longer term and even lifetime time referents. DUI/DWI offenders represent present day driver risk. Once identified, driver risk must be resolved if the DUI/DWI offender is to drive safely in the future. It should be noted that DRI-2 recommendations constitute a practical approach to matching problem severity and treatment intensity.

In summary, the Driver Risk Inventory (DRI-2) and its scales have been designed specifically for DUI/DWI offender assessment. The DRI-2 has been researched and standardized on over 1½ million DUI/DWI offenders. Evidence-based peer review research is extensive and has demonstrated impressive reliability, validity and accuracy. The Alcohol and Drug Scales are focused entirely upon the substance each represents. There is no confusion or blending of substances. The time frame is the "here-and-now" not last year. And the DRI-2 is available 24/7.

DIMENSIONAL & CATEGORICAL MEASURES

Kessler (2002, 2008) advocates using both "dimensional" and "categorical" measures in the same test. Dimensional measures use recent time frames (e.g., the past year, last month, or now) to measure the severity of alcohol and/or drug use. In contrast, categorical measures gather long term or lifetime occurrence information to help with treatment planning. DRI-2 Alcohol and Drug Scales are "dimensional" whereas DSM-5 uses both. Even so, DSM-5's categorically-based measures can produce seemingly dissimilar results. For example, you could have a DRI-2 Alcohol or Drug Scale score in one severity range (e.g., low risk) and a DSM-5 Substance Use Disorder classification in another severity range (e.g., moderate risk). Contributing factors to these different severity classifications includes: dimensional versus categorical measurement; the DSM-5's Substance Use Disorder category incorporates both alcohol and drugs, whereas the DRI-2 independently assesses alcohol and drugs; DSM-5 expunged or deleted the term "abuse," while the DRI-2 continues to use it; and severity scale classification methodology differs. To sum up, DRI-2 Alcohol and Drug Scales enable matching of problem severity with treatment intensity, whereas DSM-5 substance Use Disorder results can guide treatment planning.

Illinois Mandatory Minimums

Located at the top of the Illinois report the Mandatory Minimum paragraph reports the client's status according to Illinois requirements.

- **MINIMAL RISK:** *No prior conviction or court ordered supervision for DUI, no prior statutory summary suspension, and no prior reckless driving conviction reduced from DUI; AND a BAC of less than .15 as a result of the most current arrest for DUI; AND no other symptoms of a Substance Use Disorder.*

- **MODERATE RISK:** *No prior conviction or court ordered supervision for DUI, no prior statutory summary suspension, and no prior reckless driving conviction reduced from DUI; AND a BAC of .15 to .19 or a refusal of chemical testing as a result of the most current arrest for DUI; AND/OR at most one symptom of a Substance Use Disorder.*

- **SIGNIFICANT RISK:** *One prior conviction or court ordered supervision for DUI, or one prior statutory summary suspension, or one prior reckless driving conviction reduced from DUI; AND/OR a BAC of .20 or higher as a result of the most current arrest from DUI; AND/OR two or three symptoms of a Substance Use Disorder.*

- **HIGH RISK:** *Four or more symptoms of a Substance Use Disorder (regardless of the driving record); AND/OR within the ten year period prior to the date of the most current (third of subsequent) arrest, any combination of two prior convictions or court ordered supervisions for DUI, or prior statutory summary suspensions, or prior reckless driving convictions reduced from DUI, resulting from separate incidents.*

Alcohol Scale automatically defaults to PROBLEM as a result of a prior DUI, the same if the client's BAC was .20 or higher.

Risk Level Classification

Each DRI-2 scale score is classified in terms of its severity or the risk it represents. These risk level classifications are calculated individually for five of the six empirically based scales. The Substance Use Disorder classification scale, consequently it is not scored as the other five DRI-2 scales.

Risk Level Classification

PERCENTILE RANGE	RISK RANGE
0 to 39th percentile	Low Risk
40 to 69th percentile	Medium Risk
70 to 89th percentile	**Problem Risk**
90 to 100th percentile	**Severe Problem**

A person who does not presently engage in alcohol or other drug abuse may score above zero, but would score in the low risk range. In addition, an elevated score (above the 70th percentile) on the Alcohol or Drug Scale could be obtained by a recovering alcoholic or drug abuser, consequently the client should be asked if he or she is recovering, and if recovering, they would be asked "how long have they been abstaining" from alcohol or other drug use. **Question #84 asks if the client is a recovering alcoholic, drug abuser or both. The client's answer to this question is printed in the DRI-2 report on page 3 under the Significant Items section.**

Staff Should Not Take the DRI-2

Sometimes a staff member wants to simulate the client taking the DRI-2. It is strongly recommended that staff members do **not** take the DRI-2. **The DRI-2 is not standardized on staff.** In any case, staff members do not have the same mental set as a client. Staff members would likely invalidate, distort or otherwise compromise their DRI-2 profile.

Significant Items

Significant Items represent self-admissions or important self-report responses. Significant Items are printed on page 3 of the DRI-2 report for the **Alcohol** and **Drugs** Scales. Significant Items augment scale scores and sometimes provide a more complete understanding of the client. They are provided for reference, and do not by themselves determine the respondent's scale score. For example**, a person could have a high scale score and few significant items**. Significant Items permit comparison of the client's beliefs and attitude with their objective scale scores.

When no significant items are answered in a negative direction, the following statement is printed under that scale heading: "No significant items were reported for this scale."

Evaluator's Recommendations

In some instances, the evaluator will have an observation or recommendation that differs from the DRI-2 report. **This is OK!** The evaluator may obtain important information from another source (offender, relative, records, etc.) which influences their recommendations. In these situations, it is recommended that the evaluator document in writing this additional source in the space provided for "Comments" in the DRI-2 report.

Unique DRI-2 Features

The Driver Risk Inventory (DRI-2) has been researched and normed on the DUI offender population. The DRI-2's expanding database enables it to incorporate many unique features. **Each of these unique DRI-2 features is solidly based upon extensive DRI-2 research.** Perhaps of equal importance is the fact that this database research is ongoing in nature.

Expanding Database

The copyrighted DRI-2 software was designed with the capability of **"saving"** the data from each test in a confidential (no names) manner for ongoing research and analysis. No client names appear in DRI-2 research or annual program summary reports. Users are encouraged to use the Delete Names option when a client's has completed their program. When data is downloaded into the DRI-2 database for subsequent analysis, client names are removed. **The expanding DRI-2 database is statistically analyzed each year.** This feature represents a unique advantage of the DRI-2. The database ensures ongoing research, the benefits of which are made available to the DRI-2 user at no additional cost. As the DRI-2 database continues to grow, new and exciting research discoveries and innovative software remedies are implemented. Gender (male/female) differences have already been identified (and remedies developed) by this procedure.

Truthfulness Scale

Self-report tests and interviews are subject to the danger of respondents not telling the truth. An important advance in testing is the inclusion of the Truthfulness Scale, which measures how honest the client is while completing the test. It would be naive to believe that all people taking tests always answer questions truthfully. The Truthfulness Scale identifies self-protective and guarded people who attempt to deny, minimize or even conceal information. This feature is of special importance in court-related settings, since the outcome of a person's test results could affect their level of supervision, the nature of intervention and their life situation. **The Truthfulness Scale identifies attempts to fake or underreport problems and concerns.**

Validity

Definition: Within the context of assessment, **validity** is a general term for accuracy of measurement. Valid test results are essentially free from error. They are accurate. In contrast, invalidity refers to distortion of test results due to the client's attitude and test taking behaviors. Invalidity may be due to guardedness, denial, faking, reading things into questions, emotional instability, reading impairments, etc. An invalid test means test results are distorted and not accurate.

When reviewing a DRI-2 report, staff members should check the Truthfulness Scale score. If the Truthfulness Scale score is below the 89th percentile, the test results are valid and accurate. Truthfulness Scale scores between the 70th and 89th percentile are likely valid, but should be interpreted cautiously. Truthfulness Scale scores above the 90th percentile are invalid. The "problem" (70 to 89th percentile) risk scale scores are truth-corrected to insure accuracy. Truthfulness Scale scores below the 70th percentile are accurate and scale scores above the 90th percentile are too distorted to be truth-corrected.

Alcohol Scale

The Alcohol Scale measures a client's alcohol proneness and alcohol-related problems. This is an important area of inquiry when evaluating alcohol abuse and predicting driver risk. Similarly, alcohol-related arrests are important when predicting driver risk.

Discriminant validity of the Alcohol Scale is demonstrated by the fact that no other DRI-2 scale correlates significantly with alcohol-related arrests. Only the Alcohol Scale correlates significantly with alcohol-related arrests.

Driver Risk Scale

The Driver Risk Scale correlates significantly with the number of DUI arrests. This relationship has been discussed earlier under the title "Total Number of DUI Arrests." Discriminant validity is demonstrated by the fact that no other DRI-2 scale correlates significantly with the number of traffic violations or the number of at-fault accidents. Only the Driver Risk Scale correlates significantly with traffic violations and at-fault accidents.

As noted by the National Highway Traffic Safety Administration (NHTSA, DOT HS 807 475), "One of the scales (the Driver Risk Scale) is designed to detect irresponsible driving and provides an assessment for driver risk, a particularly useful feature for evaluating the DUI offender that does not exist in any other instrument we reviewed."

Drug Scale

Discriminant validity of the Drug Scale is determined by the fact that no other DRI-2 scale correlates significantly with "other drug-related arrests." Drugs refer to marijuana, cocaine, crack, LSD, ecstasy, barbiturates, amphetamines, heroin, etc.

The Drug Scale measures a client's drug proneness and drug-related problems. This is becoming an increasingly important area of inquiry when evaluating drug abuse and DUI risk. Similarly, drug-related arrests are important when predicting driver risk.

BAC

For maximum screening effectiveness, test results and arrest records should be used jointly. Thus, when driver history and court-related information are available, they are included in the DRI-2 scoring methodology. Yet, when this information is not available, the DRI-2 is still scored. This flexibility in

data acquisition and scoring procedures results in even more comprehensive and accurate DUI screening and assessment.

Discriminant validity of the Alcohol Scale is demonstrated by the fact that no other DRI-2 scale correlates significantly with the Blood Alcohol Level (BAL) obtained at time of arrest. Only the Alcohol Scale correlates significantly with the BAL.

Substance Use Disorder Classification Scale

The Driver Risk Inventory-2 (DRI-2) incorporates two methods, classification and dimensional scaling, for assessing substance use severity. The DRI-2 employs separate Alcohol and Drug Scales each focusing independently and exclusively on alcohol or drug use. The DSM-5 on the other hand, blends alcohol and drugs use in its Substance Use Disorder classification. DRI-2 scales use short-term time referents like recently or now; whereas the DSM-5 uses longer term or even lifetime referents. The DRI-2 scales use percentile scores to measure risk severity. The DSM-5 classifies risk using endorsement of 11 criteria/symptoms, classifying substance use problems as mild, moderate and severe. Researchers (Kessler, 2002; Kline, 2009) advocate using both types of measurement methods in one test.

Stress Management Scale

The Stress Management Scale correlates significantly (.001 level of significance) in predicted directions with the following MMPI scales: Psychopathic Deviate (Pd), Psychasthenia (Pt), Anxiety (A), Manifest Anxiety (MAS), Ego Strength (ES), Social Responsibility (RE), Social Alienation (PD 4A), Social Alienation (SCIA), Social Maladjustment (SOC), Authority Conflict (AUT), Manifest Hostility (HOS), Suspiciousness/Mistrust (TSC-III), Resentment/Aggression (TSC-V) and Tension/Worry (TSC-VII). Stress exacerbates other symptoms of emotional problems. A high risk (90 to 100th percentile) Stress Management score is indicative of markedly impaired stress coping abilities and very likely reflects identifiable emotional and mental health problems.

DRI-2 Reports

DRI-2 reports are designed to meet the needs of DUI risk evaluation and screening programs. The standard three-page DRI-2 report concisely summarizes test data in an accurate and easily understood manner. **Staff needs for report writing, substantiation of decision making, and record keeping are all met with DRI-2 reports.** DRI-2 reports can be individualized to be in compliance with each state and agency's needs. Recommendations desired in one city or state may not be appropriate in another.

Oral Instructions

It is now clear that DUI offenders in court-related settings minimize their alcohol and other drug-related problems. They also substantially under-report their alcohol and other drug use. However, the oral instructions to the offender before they begin taking the DRI-2 are important. A straightforward approach is recommended. For example:

"This test contains a truthfulness measure to determine how cooperative and truthful you are while completing it. Please answer all of the questions honestly. It is also important that you do not read anything into the questions that is not there. Your court records may be checked to verify the accuracy of your answers. Just answer each question truthfully"

Giving the client an example, often helps them understand. The example that you use will be influenced by your client population, experience and intent. It should be individualized to your situation and needs. The following example is presented for clarification as to how an example might be included in your oral instructions to the client:

Last week a client told me while taking the MMPI that he could not answer this true-false question, 'I am attracted to members of the opposite sex.' When asked why, the client replied, "If I answer True, you will think I am a sex maniac. If I answer False, you will think I am a homosexual." I told the client that "this test item does not ask you about being a sex maniac or a homosexual. It simply asked if you are attracted to members of the opposite sex. When you interpreted it to refer to sex maniacs or homosexuals, you were answering a different question. Do not read anything into these questions that isn't there, because if you do, you will invalidate the test and may have to take it over. Simply answer the questions True or False. There are no trick questions or hidden meanings. If you misinterpret or change the questions in the test, you will invalidate the test."

A few minutes of oral instructions can put the client at ease while providing structure and clarifying client expectations. Such procedures can greatly reduce your invalidity ratio, while making the assessment procedure more acceptable to the client. Some agencies type out oral instructions for the staff so that they can have them as a ready reference.

Test Data Input Verification

This procedure allows the person that is inputting the test data from the answer sheet to verify the accuracy of their data input. In brief, the test data is input twice, and any inconsistencies between the first and second data entry are highlighted until corrected. When the first and second data entries match (or are the same), you may continue. This data verification feature is optional.

Delete Client Names

You have the option to delete client names. This is optional. **If you want to use this option, remember that once you delete the client name -- they are gone and cannot be retrieved.** We recommend you use this option. Deleting client names does not delete demographic information or test data. It only deletes client names when you use this option. **This option is provided for you to protect client confidentiality. This "name deletion" procedure insures confidentiality and compliance with HIPAA (federal regulation 45 C.F.R. 164.501) requirements.**

Control of DRI-2 Reports

The standard DRI-2 report is designed for DUI evaluator and court-related use. It is not recommended that the DRI-2 report be given to the DUI offender. It is not recommended that the offender takes any DRI-2 materials, including the report out of the office. **Do not give the DRI-2 report to the DUI offender to read or take out of your office.** Nor should the client remove any DRI-2 materials from the office.

Check Answer Sheet for Completeness

Check the client's answer sheet for completeness when it is turned in and before the client leaves. No items should be skipped and both true and false should not be answered for the same question. In these instances the clients should be informed that each question must be answered in accordance with the instructions, and be given the opportunity to correct or complete their answer sheet. **Skipped answers are scored by the computer in the deviant direction since it is assumed that these items were omitted to avoid providing a "negative" response.**

Staff should verify the information provided by the client on the answer sheet. The information concerning DUI's, BAC and other court history may be used in the DRI-2 report to establish minimum scores. Staff should be aware that "Total number of DUI arrests" includes DUI's reduced to reckless driving.

DRI-2 Interpretation

There are several levels of DRI-2 interpretation ranging from viewing the DRI-2 as a self-report to interpreting scale elevations and scale interrelationships. The following table is a starting point for interpreting DRI-2 scale scores.

SCALE RANGES

Risk Category	Risk Range Percentile	Total Percentage
Low Risk	0 - 39%	39%
Medium Risk	40 - 69%	30%
Problem Risk	**70 - 89%**	**20%**
Severe Problem	**90 - 100%**	**11%**

Referring to the above table, a problem is not identified until a scale score is at the 70th percentile or higher. **Elevated scale scores** refer to percentile scores that are at or above the 70th percentile. **Severe problems** are identified by scale scores at or above the 90th percentile. Severe problems represent the highest 11 percent of DUI/DWI offenders evaluated with the DRI-2. The DRI-2 has been normed on over one and a half million DUI/DWI offenders. And this normative sample continues to expand with each DRI-2 test that is administered.

Scale Interpretation

1. Truthfulness Scale: measures how truthful the DUI/DWI offender was while completing the test. It identifies guarded and defensive people who attempt to fake good. Truthfulness Scale scores at or below the 89th percentile mean that all DRI-2 scale scores are accurate. **When the DRI-2 Truthfulness Scale score is in the 70 to 89th percentile range other DRI-2 scale scores are accurate because they have been Truth-Corrected.** In contrast, when the Truthfulness Scale score is at or above the 90th percentile this means that all DRI-2 scales are inaccurate (invalid) because the DUI/DWI offender was overly guarded, read things into test items that aren't there, was minimizing problems, or was caught faking answers. If not consciously deceptive, offenders with elevated Truthfulness Scale scores are uncooperative (likely in a passive-aggressive manner), fail to understand test items or have a need to appear in a good light. **Truthfulness Scale scores at or below the 89th percentile mean that all other DRI-2 scale scores are accurate.** One of the first things to check when reviewing a DRI-2 report is the Truthfulness Scale score.

2. Alcohol Scale: measures alcohol use and the severity of abuse. Alcohol refers to beer, wine and other liquors. An elevated (70 to 89th percentile) Alcohol Scale score is indicative of an emerging drinking problem. An Alcohol Scale score in the severe problem (90 to 100th percentile) range identifies established and serious drinking problems. Elevated Alcohol Scale scores do not occur by chance.

A history of alcohol problems (e.g., alcohol-related arrests, DUI/DWI convictions, etc.) could result in an abstainer (current non-drinker) attaining a low to medium risk scale score. Consequently safeguards have been built into the DRI-2 to identify "recovering alcoholics." For example, the offender's self-reported court history is summarized on the first page of the DRI-2 report. **The DUI/DWI offender's answer to the "recovering alcoholic" question (item 84) is printed on page 3 of the DRI-2 report.** In addition, elevated Alcohol Scale paragraphs caution staff to establish if the offender is a recovering alcoholic. If recovering, how long? Obviously the DUI/DWI offender was arrested for a DUI or DWI.

Severely elevated Alcohol and Drugs Scale scores indicate polysubstance abuse, and the highest score usually identifies the offender's substance of choice.

Scores in the severe problem (90 to 100th percentile) range are a malignant prognostic sign. Elevated Alcohol Scale, Drugs Scale and Driver Risk Scale scores identify a particularly dangerous driver. Here you have a person with poor driving skills who is even further impaired when drinking or using drugs.

In intervention and treatment settings the offender's DRI-2 Alcohol Scale score can help staff work through offender denial. More people accept objective standardized assessment results as opposed to someone's subjective opinion. This is especially true when it is explained that the DRI-2 has been given to over one and a half million DUI/DWI offenders and that elevated scores do not occur by chance. The Alcohol Scale can be interpreted independently or in combination with other DRI-2 scales.

3. Drugs Scale: measures drug use and severity of drug abuse. Drugs refer to marijuana, ice, crack, cocaine, ecstasy, amphetamines, barbiturates and heroin. An elevated (70 to 89th percentile) Drugs Scale score identifies emerging drug problems. A Drugs Scale score in the severe problem (90 to 100th percentile) range identifies established drug problems and drug abuse.

A history of drug-related problems (e.g., drug-related arrests, prior DUI/DWI convictions, drug treatment, etc.) could result in an abstainer (current non-user) attaining a low to medium risk Drug Scale score. For this reason precautions have been built into the DRI-2 to insure correct identification of "recovering" drug abusers. Many of these precautions are similar to those discussed in the above Alcohol Scale description. **And the DUI/DWI offender's answer to the "recovering drug abuser" question (item 84) is printed on page 3 of the DRI-2 report.**

Concurrently elevated Drugs and Alcohol Scale scores are indications of polysubstance abuse, and the highest score reflects the offender's substance of choice. Very dangerous drivers are identified when both the Drugs Scale and the Driver Risk Scale are elevated. Any Drugs Scale score in the severe problem (90 to 100th percentile) range should be taken seriously. The Drugs Scale can be interpreted independently or in combination with other DRI-2 scales.

4. Substance Use Disorder Scale: Substance use disorders span a wide variety of problems arising from substance use, and cover 11 different criteria:

1. Taking the substance in larger amounts or for longer than the you meant to
2. Wanting to cut down or stop using the substance but not managing to
3. Spending a lot of time getting, using, or recovering from use of the substance
4. Cravings and urges to use the substance
5. Not managing to do what you should at work, home or school, because of substance use
6. Continuing to use, even when it causes problems in relationships
7. Giving up important social, occupational or recreational activities because of substance use
8. Using substances again and again, even when it puts the you in danger
9. Continuing to use, even when the you know you have a physical or psychological problem that could have been caused or made worse by the substance

10. Needing more of the substance to get the effect you want (tolerance)

11. Development of withdrawal symptoms, which can be relieved by taking more of the substance.

The DSM 5 allows assessors to specify how severe the substance use disorder is, depending on how many symptoms are identified. Two or three symptoms indicate a mild substance use disorder, four or five symptoms indicate a moderate substance use disorder, and six or more symptoms indicate a severe substance use disorder.

The American Society of Addiction Medicine (ASAM) states there can be exceptions to DSM classifications -- and these exceptions are made according to the **severity** of a person's substance abuse. The severity of a person's substance abuse determines their recommended level of intervention and/or treatment.

In summary, the Alcohol and Drugs Scales measure **severity** of substance (alcohol and other drugs) abuse, whereas the Substance Use Disorder Scale **classifies** people as no problem, mild, moderate or severe substance use disorder.

5. Driver Risk Scale: measures driving risk, e.g., aggressive, irresponsible or careless drivers. This scale is independent of the Alcohol, Drugs and Substance Abuse/ Dependency Scales. Some people are simply poor drivers. Elevated (70 to 89th percentile) Driver Risk Scale scores identify problem prone drivers that would benefit from a driver improvement program. **Severe problem (90 to 100th percentile) scorers are simply dangerous drivers.** These are high probability accident prone drivers. When the Driver Risk Scale and the Alcohol Scale and/or Drugs Scale are elevated a person's poor driving abilities are further impaired by substance use or abuse. According to the National Highway Traffic Safety Administration (NHTSA), which is the highest federal authority in the DUI/DWI field - the DRI-2 is the only major DUI/DWI test that measures driver risk. Consequently, other tests do not identify abstaining (non-drinking and non-drug use) dangerous drivers.

The Driver Risk Scale provides considerable insight into offender driving behavior and it is overlooked by other DUI/DWI tests. The Driver Risk Scale can be interpreted independently or in combination with the DRI-2 Alcohol Scale, Drugs Scale and Stress Management Scale.

6. Stress Management Scale: measures the DUI/DWI offender's ability to cope effectively with stress, tension and pressure. How well a person manages stress affects their driving safety. A Stress Management Scale score in the elevated (e.g., problem risk) range provides considerable insight into co-determinants while suggesting possible intervention programs like stress management. An offender scoring in the severe problem (90 to 100th percentile) range should be referred to a mental health specialist for further evaluation, diagnosis and a treatment plan.

We know that stress exacerbates emotional and mental health problems. The Stress Management Scale is a non-introversive way to screen for established (diagnosable) mental health problems. Stress coping problems can have a direct impact on a person's driving.

A particularly unstable and perilous driving situation involves an elevated Stress Management Scale with an elevated Alcohol Scale, Drugs Scale or Driver Risk Scale. Poor driving abilities along with substance abuse in an emotionally reactive person who doesn't handle stress well operationally defines a dangerous driver. **The higher the elevation of these scales -- the worse the prognosis.** The Stress Management Scale can be interpreted independently or in combination with other DRI-2 scales.

7. Illinois Mandatory Minimums: The Illinois Department of Human Services, Division of Alcohol and Substance Abuse has mandatory minimums when it comes to assigning a DUI Risk Classification, i.e., Minimal Risk, Moderate Risk, Significant Risk or High Risk.

- MINIMAL RISK: *No prior conviction or court ordered supervision for DUI, no prior statutory summary suspension, and no prior reckless driving conviction reduced from DUI; AND a BAC of less than .15 as a result of the most current arrest for DUI; AND no other symptoms of a Substance Use Disorder.*

- MODERATE RISK: *No prior conviction or court ordered supervision for DUI, no prior statutory summary suspension, and no prior reckless driving conviction reduced from DUI; AND a BAC of .15 to .19 or a refusal of chemical testing as a result of the most current arrest for DUI; AND/OR at most one symptom of a Substance Use Disorder.*

- SIGNIFICANT RISK: *One prior conviction or court ordered supervision for DUI, or one prior statutory summary suspension, or one prior reckless driving conviction reduced from DUI; AND/OR a BAC of .20 or higher as a result of the most current arrest from DUI; AND/OR two or three symptoms of a Substance Use Disorder.*

- HIGH RISK: *Four or more symptoms of a Substance Use Disorder (regardless of the driving record); AND/OR within the ten year period prior to the date of the most current (third of subsequent) arrest, any combination of two prior convictions or court ordered supervisions for DUI, or prior statutory summary suspensions, or prior reckless driving convictions reduced from DUI, resulting from separate incidents.*

The Alcohol Scale automatically defaults to PROBLEM as a result of a prior DUI, the same if the client's BAC was .20 or higher.

In conclusion, it was noted that several levels of DRI-2 interpretation are possible. They range from viewing the DRI-2 as a self-report to interpreting scale elevations and interrelationships. Staff can then put a DUI offender's DRI-2 findings within the context of the offenders driving situation.

Retest

Driver Risk Inventory (DRI-2) tests results are invalidated (not accurate, often due to problem minimization, denial and untruthful answers) when the DRI-2 Truthfulness Scale is at or above the 90th percentile. When this occurs, it is recommended that the client be given the opportunity to be retested. The retest interval is determined by the assessor's opinion of the client's attitude, behavior, emotional and mental state. Retesting can occur immediately or several days or weeks later.

Prior to retesting, the test administrator should review the DRI-2 retest instructions with the client. A straightforward approach is recommended. For example,

> *Please answer all questions truthfully. It is important that you do not read anything into a question that isn't there. Last week, while completing another test, a client involved in a custody case said, "I cannot answer this question true or false." The question was "There are times when I worry about my court case or the charges made against me." When asked why not, the client replied, "If I answer true, you'll tell the judge that I am guilty because I'm worried; if I answer false you'll tell the judge that I don't care and I'll never get my kids."*

I told the client, "This test item doesn't ask you about your guilt or caring for your kids. The question simply asked if you are worried about your court case. When you interpreted the question to refer to your guilt or innocence, you were answering a different question. ***Do not read anything into these questions that isn't there****, because if you do you will invalidate the test. Simply answer the question as instructed, (i.e., True or False). There are no trick questions or hidden meanings. If you misinterpret or change the questions you will invalidate the test.*

A few minutes of oral instructions, can put the client at ease while providing structure and clarifying the client's expectations. Do not tell the client they were lying – you will never win that argument. Note the above example reframes the issue from denial, problem minimization and noncompliance to reading questions correctly.

That said, nobody wants an invalid test. That is why problem tests (tests whose truth-corrected scores are in the problem risk range) are "truth-corrected" so test results are accurate and usable. Truthfulness Scale scores at or below the 89th percentile are accurate. **Truthfulness Scale scores at or above the 90th percentile are inaccurate due to client denial or attempts to fake good.**

If this was a retest, this person may not be "testable" at this time. However, an alternative approach includes using the Human Voice Audio program. Human Voice Audio is an automated computer presentation in which the questions are verbally read to the client (in English, Spanish, etc.) while simultaneously being presented on the computer monitor (screen). The Human Voice Audio program is available to you free or at no additional cost. More information on the Human Voice Audio program can be provided upon request. Our email address is info@bdsltd.com and our toll free number is 1 (800) 231-2401.

Database

A database of client information and test data is very useful. It makes possible ongoing cost-effective research and also provides the capability to summarize results for administrative, budgeting and planning purposes. **Behavior Data Systems' copyrighted built-in expanding database provides both a research and program summary capability.** Copyrighted software "saves" the test data from each test that is administered in a confidential (no names) manner.

These same databases provide a cost effective means by which testing programs can be summarized--again in a confidential (no names) manner. Annual summary reports describe the population that was tested. Population statistics, demographics, emerging trends and much more can be provided in these reports on an annual basis.

When prompted your secret code is "y"

www.online-testing.com

How to Login

With your Username and Password you are now ready to login and begin testing. To login, click the LOGIN button in the upper right corner.

Type in your username and password (both are case sensitive). Below these box, click on the Login button, this takes you to your account page. On your first visit to this page you will see that you have 1 test credit in your account. We give you one free test credit to enable you to familiarize yourself with our tests and our website.

Click on the "Continue" button or the "Account Summary" button to go to your Account Summary Page.

The Account Summary Page shows Account History, Test Credits Used and Test Credits Available.

There is a drop down box to show the list of available tests and a link to print test booklets and answer sheets.

How to Administer a Test

Before you proceed, please be aware that there are ***two test administration options described.***

1. Paper/Pencil Test Administration (Data Entry Method)

The first option is to print the test booklet and answer sheet, both of which are available in English and Spanish. The client then answers the questions on the answer sheet in pencil. The paper-pencil test administration option allows you to test in groups which can save considerable time. Some evaluators do not want to tie up their computers administering tests and prefer paper-pencil testing. When testing is completed the answer sheet data is entered online and a report is generated.

If the paper-pencil method is selected, click on the "Print Test Booklets" link on the screen and print the test booklet and answer sheet; both are available in English, Spanish and other languages.

2. On Screen Online (Internet) Test Administration

The second option is online (on the screen) test administration. This allows the client to sit at the computer and answer the test questions on the screen. Regardless of how tests are administered, all tests are scored and reports generated and printed while online.

Click on the name of the test to be administered. This takes you to the Main Menu page for the test selected.

How to Score a Test and Print a Report

When you have selected your preferred method of test administration click either "Administer Test to Client" (in which case the client would enter his/her answers on the screen), or "Enter Test from Answer Sheet" (client will use the paper/pencil method).

The next screen will be "Client Information" (name, age, sex, education etc.). When you have completed this information, click the "Information Correct" button which will take you to the "Court History" page. Depending on the test you have chosen some tests have a court history section, some do not. Each screen allows the option to choose "Cancel" or "Information Correct" to proceed.

After completing Court History, the next screen is for client answers to the test questions. If the client has used the on-screen method, the questions and answers will be displayed to the client on the screen. If the paper/pencil method was used to test the client, you may enter the answer sheet data at your convenience by typing 1 for true, 2 for false, etc. For multiple choice questions, enter 1, 2, 3 or 4.

Again, this screen allows the option to choose "Cancel" or "Information Correct." If "Information Correct" is chosen the option is still available to cancel or abort the entry and not charge the account. At the end of the test a notice will appear alerting you that one test credit is about to be used. To save the test record to the database, click "Yes." To cancel or discard the test entry, click "No." ***When "Yes" is selected, your account will then be charged 1 test credit.***

Highlight the client's name and click on the "Supervisor Options" button to proceed to that client's supervisor options page. Here you can print the report, verify the answer sheet data entered and delete the client's name. The default page that appears is the Print Report page. To print the report, click the "Continue" button. To verify the data entered or delete the client's name, click on the appropriate tab at the top and follow the instructions.

In summary, procedures are designed to be concise, easily followed and swiftly executed, so that they will not detract from test administration.

When prompted your secret code is "y"

How to Verify Data Entry

The Verify Data Input procedure allows you to enter the answers a second time for any particular client. This feature insures that the responses are input into the computer correctly.

From the main menu, select the client's name and then click on the "Supervisor Options" button. This will take you to the Supervisor Options page. Click on the tab labeled "Verify Data Entry" and then click on the "Continue" button. You will now be presented with the answer grid so that you can re-input the answers.

As you input each answer, the computer will verify that it matches the answer you originally entered. If it does, the computer will automatically move on to the next response. However, if the answer you input does not match the original answer, you will be immediately alerted to the discrepancy between the two responses via a message box.

The message box will notify you as to which answer did not match the original input. The message box will display what the current answer is and what the original response was.

At this point you should review the answer sheet to verify what the correct response to that particular question is. You will then click "OK" if the answer input this second time is correct and the computer will accept this response and move on to the next answer.

If, after reviewing the answer sheet, you discover that you have erroneously input the wrong answer, click the "Cancel" button and the computer will allow you to enter the response again.

Continue with these steps until all answers have been input. Using this feature insures the accuracy of the data input.

How to Delete Client Names

This procedure allows the user to delete the client's name from the test record. Use this option to protect client confidentiality once you are done with the test record.

From the main menu, select the client' name and then click on the "Supervisor Options" button. This will take you to the Supervisor Options page. Click on the tab labeled, "Delete Client Name" and then click on the "Continue" button. You will be given the opportunity to cancel this procedure at this time. USE WITH CAUTION! Once the name has been deleted it CANNOT be restored. When you are absolutely

certain that you are ready to proceed, click on the "Continue" button. That's all there is to it. The name will be deleted from the record and you will be returned to the main menu. Notice that the name you just deleted is no longer visible in the client list.

Live Support Chat

Throughout our site, after you have logged in, you will find "Live Support" buttons. Clicking on these buttons will open a "Live Support" chat window that puts you in touch with an Online-Testing.com technical support staff member.

Support staff is available for these "Live Support" sessions between the hours of 8:00 a.m. and 4:00 p.m. Mountain Standard Time, Monday through Friday. If you need to leave your computer during the chat session, you can return within 24 hours and resume your online conversation.

TECHNICAL SUPPORT

If you have any questions Professional Online Testing Solutions, Inc. is only a telephone call away. Our telephone number is **(800) 231-2401**, fax **(602) 266-8227**, and E-mail **info@online-testing.com**. Our offices are open 8:00 a.m. to 4:00 p.m. Mountain Standard Time, Monday through Friday.

Illinois Driver Risk Inventory-2

Name: Mr. John Smith
Age: 35 Sex: Male
Date of Birth: 01/12/1979
Race: Caucasian
Marital Status: Single

CONFIDENTAIL REPORT

Last Four Digits of SSN: 1234
Education: H.S. Graduate
DRI-2 DATE: 08/26/2016

Driver Risk Inventory-2 (DRI-2) results are confidential and should be considered working hypotheses. No decision should be based solely upon DRI-2 results. The DRI-2 is to be used in conjunction with experienced staff judgment.

Mandatory Minimum DUI Risk

Significant (Problem) Risk

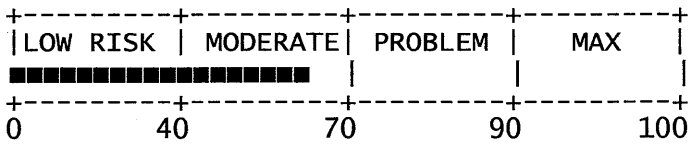
Mr. John Smith's Illinois Mandatory Minimum DUI Risk Classification is in the **Significant (Problem) Risk** range, which is characterized by one prior DUI conviction, or a prior court ordered supervision for DUI, or a prior statutory summary suspension, or a prior reckless driving conviction reduced from DUI. Conversely, a BAC of .20 or higher as a result of Mr. Smith's most current DUI arrest, and/or two to three DSM-5 Substance Use Disorder symptoms meet the Significant Risk criterion. In summary, Mr. Smith's Illinois Mandatory Minimum DUI risk range is the Significant (Problem) Risk range.

Different Measures

Illinois' Mandatory Minimum DUI Risk Classification uses court-related data and DSM-5 Substance Use Disorder criteria to classify DUI risk. While the Substance Use Disorder scale consists of admissions to eleven DSM-5 questions, the Alcohol and Drug Scales focus on client opinions regarding their drinking and drug use. That said, different measures may produce different results. **Illinois mandatory minimums take precedence.**

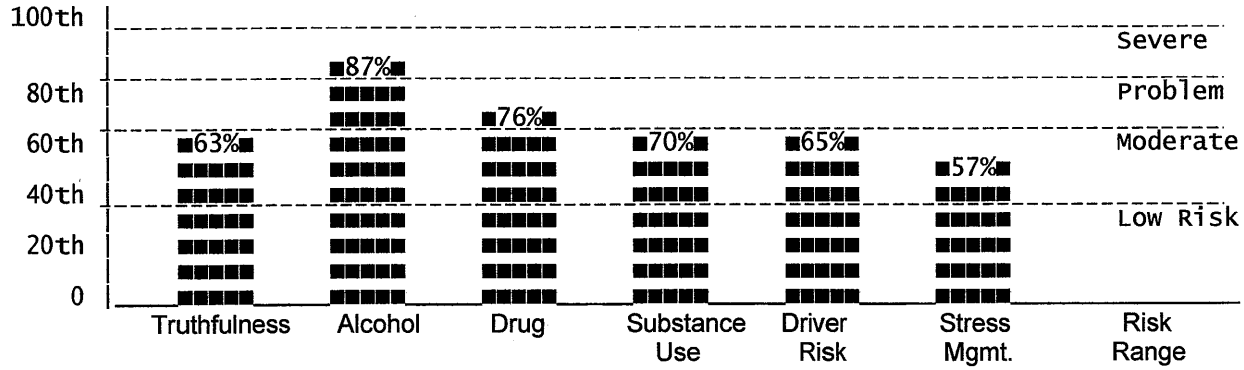
Illinois Driver Risk Inventory-2 (DRI-2) Profile

Truthfulness Scale 63%ile



Mr. John Smith's Truthfulness Scale score is in the **moderate risk** (40 to 69th percentile) range. This is an accurate Driver Risk Inventory-2 (DRI-2) profile and all DRI-2 scale scores are accurate. Nevertheless, Mr. Smith tends to be cautious when answering DRI-2 questions. This may be situation specific and related to why he is being evaluated. However, there is a fine line between cautiousness and recalcitrance or evasiveness. Consequently, the evidence based DRI-2 Truthfulness Scale score helps answer truthfulness-related questions. That said, Mr. Smith's Truthfulness Scale score is within the acceptable range and all of his DRI-2 scale scores are accurate.

DRI-2 Profile



ADDITIONAL INFORMATION PROVIDED BY CLIENT

Date of Present DUI Arrest	08/29/2017	Driver's License Suspended/Revoked?	No
Reason for Arrest	Alcohol	Arrest Reduced to Careless/Reckless Driving?	No
Additional DUI Offenses Pending?	No	Lifetime alcohol-related (not DUI) arrests	1
BAC at Time of Current Arrest	.014	Lifetime drug-related (not DUI) arrests	0
Refused Breath/Blood Test in Current DUI?	No	Lifetime At-Fault Motor Vehicle Accidents	0
Lifetime DUI Arrests	2	Lifetime Traffic Violations (Tickets)	3

Scale Score Paragraphs

All seven Illinois DRI-2 scale-related paragraphs explain when problems exist and what each attained scale score means. It should be understood that the **Illinois Mandatory Minimum DUI risk range has priority and takes precedence.** Nevertheless, when problems exist, risk-related recommendations are offered.

Substance Use Disorder: PROBLEM

In the DSM-5, alcohol and drug use are combined under the caption "Substance Use Disorder." That said, DSM-5 postulates eleven (11) substance use severity criteria. A client's (offender's) substance use severity is then determined by the number of the eleven severity criteria the client admits too. Mr. Smith admits to **four or five** of the eleven severity criteria, which is classified **problem** substance use. The DSM-5 **problem** classification is equivalent to a Driver Risk Inventory-2 (DRI-2) **problem risk** (70 to 89th percentile) Alcohol Scale or Drug Scale score. Mr. Smith's DSM-5 Substance Use Disorder score is in the **problem risk** range (four or five admissions).

Alcohol Scale: PROBLEM **SCORE: 87%**

Mr. John Smith's Alcohol Scale score is in the **problem** (70 to 89th percentile) range. An established pattern of alcohol (beer, wine or liquor) abuse is indicated. Recommendations: A minimum level of treatment, consideration should be given to outpatient chemical dependency treatment for people with drinking problems. Participation in self-help or mutual-help (e.g., AA or RR) meetings might augment, but not replace treatment. Without treatment, Mr. Smith's drinking problem will likely worsen. Should Mr. Smith relapse, his optimum level of care would likely increase to "intensive outpatient treatment." Mr. Smith would benefit from help with his drinking problem.

Drug Scale: PROBLEM **SCORE: 70%**

Mr. John Smith's Drug Scale score is in the **problem** (70 to 89th percentile) range. Problem risk scorers have drug (prescription and/or nonprescription) involvement that warrants intervention and/or treatment. Review Mr. Smith's answer to the "recovering" question (#84). If recovering, how long? Recommendations: consider outpatient (individual or group) counseling augmented (not replaced) by Narcotics Anonymous (NA) or Cocaine Anonymous (CA) meetings. Review other DRI-2 scale scores for co-occurring disorders. Should Mr. Smith relapse, his optimum level of care would likely increase to "intensive outpatient treatment."

Driver Risk: MODERATE **SCORE: 65%**

Mr. John Smith's Driver Risk Scale score is in the **moderate** risk (40 to 69th percentile) range. Some indicators of inattentive driving are present, but an established pattern of irresponsible driving is not present. *Mr. Smith* may only be a driving risk after using alcohol (beer, wine or liquor) or drugs (prescription and/or nonprescription). Prudent assessors will check out the other Driver Risk Inventory-2 (DRI-2) scales that can directly contribute to *Mr. Smith's* driving risk, e.g., Truthfulness Scale, Alcohol Scale, Drug Scale, Substance Use Scale and the Stress Management Scale. Any elevated (70th percentile and higher) scale scores would contribute to driver risk. On its own merits, *Mr. Smith's* Driver Risk Scale indicates he is a safe driver.

Stress Management Scale: MODERATE **SCORE: 57%**

Mr. John Smith's Stress Management Scale score is in the **moderate** (40 to 69th percentile) range. Stress management issues are becoming apparent. If left unattended these potential issues or concerns could worsen. Recommendations: a "brief intervention" might be considered. Brief interventions range from 15 to 30 minutes of direct face-to-face staff-client (offender) discussion, they can be a valuable intervention for clients with early stage stress-related problems. There are also many good self-help stress management books that help readers recognize their stress, reframe it and positively manage it. They also discuss stress reduction techniques like relaxing body parts, deep breathing exercises, meditation, etc. Another alternative is enrollment in a stress management class. Stress-related issues are emerging.

Significant Items. The following self-report responses represent areas that may help in understanding the respondent's situation and status.

Alcohol

2. Concerned about my drinking.
6. Drinking has caused serious problems.
9. Often drinks more than intended.
11. Feels guilty about drinking.

Drug

17. Family member said get help.
22. Been treated for drug prblm.
31. Had drug abuse problem.

Substance Use Disorder

65. Almost all activities substance-related.
69. Persistent cravings and strong urges.
71. Continue using despite knowing causes prblms.
77. Cannot reduce or cut down.

Driver Risk

3. I usually drive fast.
7. I am quick tempered.
14. Use cell phone while driving.

Comments/Recommendations:_____

_____

_____

_____

_____

_____

Use back of this page, if necessary

_____ _____

STAFF MEMBER SIGNATURE **DATE**

IL DRI-2 RESPONSES

1 - 50 TFFFTFFFFF FFFFFFFFTF TFTFFFTFTF FTFTFTFTFT FFTFTFFFFT
51 - 100 FFFFFFFFFF TFFFFFFTFF FTT4444114 4444444444 1411414144
101 - 113 1144141141 144

IL DRI-2

Instructions
We realize this is a difficult time for you. Nevertheless, we need more information so we can better understand your situation.

All questions in this questionnaire should be answered. Do not skip any questions. Your cooperation is appreciated.

The term "substance use" refers to alcohol and drugs.

Anticipate approximately 20 ± minutes to complete this questionnaire.

You may begin.

Section 1
The statements in this section are to be answered true or false. If a statement is **true**, put an **X** under **T** for **True** on your answer sheet. If a statement is **false**, put an **X** under **F** for **False** on your answer sheet.

1. There have been times when I have been irritated and frustrated by other drivers.
2. I am concerned about my drinking.
3. I am an impatient person and usually drive fast.
4. I have used drugs more than I should.
5. There are times when I get very angry.
6. My drinking has caused serious family and social problems for me.
7. I am quick tempered and need to learn how to control it.
8. There have been times when I have felt guilty about my use of drugs.
9. I often drink more or use more drugs than I intended.
10. There are times when I really worry about myself and my happiness.
11. There are times when I feel guilty about my drinking.
12. I can be easily annoyed or angered while driving.
13. I am concerned about my drug use.
14. I have used my cell phone while driving.
15. My drinking is more than just a little or minor problem.
16. When I get frustrated and annoyed at another driver I tend to "fly off the handle" and curse or swear at them.
17. A family member has told me I should get help for my drug use.
18. I spend a lot of time using alcohol and/or drugs and recovering from their effects.
19. There have been times when I have driven after drinking.
20. I attend Alcoholics Anonymous (AA) meetings because of my drinking.
21. Even though I wasn't caught, I have made mistakes while driving that were my fault.
22. I have been treated for a drug problem.
23. I know I shouldn't, but there have been times when I have been jealous of others' success.
24. Once I begin drinking, it often seems as if I cannot stop.
25. I get angry quickly.
26. My repeated substance (alcohol/drug) use has resulted in my failing to fulfill important duties and responsibilities at home, school or work.
27. I get upset when others criticize or blame me.
28. I have had two or more memory losses (blackouts) after drinking heavily.
29. There are times when I get really frustrated and angry.
30. I admit I am often an aggressive driver.

31. I have had a drug abuse problem in the past.
32. I don't consider myself a fast or aggressive driver, but at some point I do exceed the speed limit almost every time I drive.
33. I continue to drink despite family arguments about my drinking.
34. I regret some of the things I have said or done when I was angry or mad.
35. To be honest, I am a fast and aggressive driver.
36. There are times when I am concerned that others may think badly of me.
37. I go to Narcotics Anonymous (NA) or Cocaine Anonymous (CA) meetings because of my drug use.
38. I do not always tell the whole truth when asked about my personal life.
39. I continue my substance (alcohol/drugs) use despite the recurrent social and interpersonal problems this causes.
40. There are times when I am really down, depressed and discouraged.
41. I am a recovering alcoholic.
42. When I am angry or mad I become verbally abusive and shout or swear a lot.
43. It bothers me when I am overlooked or ignored by people I know.
44. I have given up or reduced important social, occupational or recreational activities because of my substance (alcohol/drug) use or abuse.
45. There are times when I am very unhappy.
46. I have admitted to a family member that I have a drinking problem.
47. Two or more of the following apply to me (answer true or false on your answer sheet):
    a. I have driven without proper insurance.
    b. My driver's license has been suspended or revoked.
    c. I use my cell phone while driving.
    d. I have had three or more speeding tickets in the last ten years.
    e. I have caused two or more at-fault accidents.
48. My use of drugs has threatened my happiness and success in life.
49. Even though I am aware of the harmful effects of repeated substance use, I continue to drink and/or use non-prescription drugs.
50. Sometimes I get angry and upset at myself.
51. I have had to use much more alcohol and/or drugs to get the same effect I used to.
52. I have missed school or work because of my drinking.
53. I have lied about my use of drugs – either saying I use less than I really do, or hiding the fact that I use drugs at all.
54. I am a careless, inattentive or indifferent driver.
55. People tell me I lose control over little problems and minor frustrations.
56. I have been treated for a drinking problem.
57. I have admitted to a close family member that I have a drug problem.
58. I often take substances (alcohol/drugs) in larger amounts or over a longer period than I intended.
59. I use and sometimes abuse drugs.
60. I send and receive text messages while driving.
61. I have done things when angry or mad that I later regretted.
62. I am in counseling or treatment for my drinking problem.
63. To be honest, I drive too fast.
64. I continue to use drugs despite family arguments about my drug use.
65. Almost all of my normal daily activities are associated with (or affected by) my substance use and abuse.
66. Drinking has interfered with my happiness and success in life.

67. I have a drug problem.

68. There are times when I really worry about myself and my future.

69. Within the last year I have had persistent cravings and strong urges for my alcohol and/or drug use.

70. Because of my drug use I have given up or quit social functions, work and/or recreational activities.

71. I continue using substances (alcohol/drugs) even though I know they cause physical and psychological problems for me.

72. I have a drinking problem.

73. There have been times when I knew I should not drive – but did.

Section 2

The statements in this section describe you or your situation. Put an **X** under the number **(1, 2, 3 or 4)** on your answer sheet that is most accurate for you.

74. Rate your "driving" on a ten point scale. One represents a "poor" driver-rating whereas ten represents a "good" driver-rating I rate myself as:
    1. A poor (rate 1 or 2) driver.
    2. An adequate (rate 3, 4 or 5) driver.
    3. A below average (rate 6, 7 or 8) driver.
    4. A good (rate 9 or 10) driver.

75. My drinking is:
    1. A serious problem.
    2. A moderate problem.
    3. A mild problem.
    4. Not a problem.

76. My drug use is:
    1. A serious problem.
    2. A moderate problem.
    3. A mild problem.
    4. Not a problem.

77. I have tried but I cannot:
    1. Reduce, cut down or control my use of alcohol and/or drugs.
    2. Stop using alcohol and/or drugs.
    3. Both 1 and 2.
    4. None of the above.

78. Rate your drinking on a ten point scale. One represents "no problem," whereas ten represents a "severe drinking problem." I rate my drinking as:
    1. No problem (rate 1 or 2).
    2. Mild alcohol use (rate 3, 4 or 5).
    3. A drinking problem (rate 6, 7 or 8).
    4. A severe drinking problem (rate 9 or 10).

79. Rate your drug use on a ten point scale. One represents "no drug use problem," whereas ten represents a "severe drug abuse" problem. I rate my drug use as:
    1. No drug use problem (rate 1 or 2).
    2. Mild drug use problem (rate 3, 4 or 5).
    3. A drug abuse problem (rate 6, 7 or 8).
    4. A severe drug abuse problem (rate 9 or 10).

80. Within the last year I have had intense urges or cravings for my substance of choice:
    1. In settings where I had used the substance.
    2. Randomly, at different times and places.
    3. Both 1 and 2.
    4. None of the above.

81. How would you describe your desire to get alcohol treatment or help?
    1. I want help.
    2. I may need help.
    3. Maybe, not sure.
    4. No need.

82. My repeated substance (alcohol/drug) use has resulted in:
    1. Absences or poor performance in school or work due to alcohol and/or drug use.
    2. Neglecting my household duties or responsibilities.
    3. Both 1 and 2.
    4. None of the above.

83. I have continued alcohol and/or drug use despite persistent and recurrent:
    1. Social and/or interpersonal problems
    2. Arguments or fights with my family or significant other about my substance use.
    3. Both 1 and 2.
    4. None of the above.

84. Recovering means have a substance (alcohol/ drug) abuse problem, but not drinking or using drugs anymore. I am a recovering:
    1. Alcoholic.
    2. Drug abuser.
    3. Both 1 and 2.
    4. None of the above.

85. I have repeatedly used alcohol or drugs:
    1. In physically hazardous or dangerous situations like swimming, boating, driving or skiing.
    2. Before driving or operating machinery.
    3. Both 1 and 2.
    4. None of the above.

86. How would you describe your desire to get drug treatment or help?
    1. I want help.
    2. I may need help.
    3. Maybe, not sure.
    4. No need.

87. I have noticed within the last year:
    1. I use a lot more alcohol and/or drugs to get intoxicated or high.
    2. I do not get intoxicated or high when I use the same amount of alcohol or drugs that I used to use.
    3. Both 1 and 2.
    4. None of the above.

88. I have had withdrawal symptoms like trouble sleeping, tremors, sweating, nausea, vomiting, headaches, etc.:
    1. After reducing my alcohol/drug use.
    2. When I stopped my alcohol/drug use.
    3. Both 1 and 2.
    4. None of the above.

89. How many different drug treatment programs have you been enrolled in?
    1. One.
    2. Two or three.
    3. Four or more.
    4. None.

Section 3

Rate each statement as it applies to you **now**. Put an **X** on your answer sheet under the number that you select for your answer. Use the following rating scale.

1. Rare or Never	**3.** Often
2. Sometimes	**4.** Very Often or Always

90. Positive Attitude / Outlook
91. Anxious / Worried / Fearful
92. Satisfied with Self / Like Self
93. Nervous / Unable to Relax
94. Impulsive / Spontaneous
95. Financially Stable / Responsible
96. Dissatisfied with Life
97. Able to Handle Life's Problems
98. Insomnia / Trouble Sleeping
99. Careful / Considerate Driver
100. Enthusiastic / Involved in Life
101. Fatigued / Tired / Sluggish
102. Angry / Hostile with Others
103. Work / Job Satisfaction
104. Tension / Stress / Pressure
105. Trust My Own Judgment
106. Depressed / Discouraged
107. Rebellious / Unruly / Defiant
108. Content with Life / Satisfied
109. Lonely / Unhappy
110. Careless / Inconsiderate Driver
111. Patient / Tolerant / Understanding
112. Emotionally Upset / Crying
113. Express My Feelings Comfortably

When finished turn in your questionnaire and answer sheet.

Thank you for your cooperation.

IL DRI-2

Answer Sheet

Accurately Complete the Following Information

Name: _____ _____ _____
First Name Middle Initial Last Name

Age: _____ Date of Birth: ____ / ____ / ____
Month Day Year

Sex: M ☐, F ☐ Education (Highest Grade Completed): _____

Ethnicity (Race): _____

Marital Status: _____
Single, Married, Divorced, Separated, Widowed

Last Four Digits of Your SSN: _ _ _ _

Today's Date: ____ / ____ / ____
Month Day Year

INSTRUCTIONS: If the answer is none, put in a zero, if the item does not apply to you put in an "N". If the BAC is refused enter "R". If there is no BAC enter "N" otherwise enter an attained three digit BAC level number.

1. Date of your present DUI/DWI: _____ / _____ / _____
2. Do you have other or additional DUI/DWI offenses pending? ..... Y___ N___
3. Primary / underlying reason for your present DUI/DWI (select one):
   - Alcohol ☐
   - Marijuana (pot) ☐
   - Drugs ☐
   - Substance abuse ☐
   - Zero Tolerance ☐
   - Impaired due to other substances ☐
4. Blood Alcohol Content (BAC) level at time of DWI arrest: .___
5. Did you refuse a breath/blood test? ..... Y___ N___
6. Number of DUI/DWI arrests in your lifetime (include current arrest): ..... _____
7. Is your driver's license suspended or revoked? ..... Y___ N___
8. Was your current arrest reduced to careless or reckless driving? ..... Y___ N___
9. Number of alcohol-related (not DUI/DWI) arrests in your lifetime: ..... _____
10. Number of drug-related (not DUI/DWI) arrests in your lifetime: ..... _____
11. Number of at-fault motor vehicle accidents in your lifetime: _____
12. Total number of traffic violations (tickets) in your lifetime: _____

Section 1

If a statement is True, put an **X** under **T** for **True**. If a statement is False, put an **X** under **F** for **False**.

	T	F		T	F
1.	___	___	29.	___	___
2.	___	___	30.	___	___
3.	___	___	31.	___	___
4.	___	___	32.	___	___
5.	___	___	33.	___	___
6.	___	___	34.	___	___
7.	___	___	35.	___	___
8.	___	___	36.	___	___
9.	___	___	37.	___	___
10.	___	___	38.	___	___
11.	___	___	39.	___	___
12.	___	___	40.	___	___
13.	___	___	41.	___	___
14.	___	___	42.	___	___
15.	___	___	43.	___	___
16.	___	___	44.	___	___
17.	___	___	45.	___	___
18.	___	___	46.	___	___
19.	___	___	47.	___	___
20.	___	___	48.	___	___
21.	___	___	49.	___	___
22.	___	___	50.	___	___
23.	___	___	51.	___	___
24.	___	___	52.	___	___
25.	___	___	53.	___	___
26.	___	___	54.	___	___
27.	___	___	55.	___	___
28.	___	___	56.	___	___

Section 1, continued

	T	F		T	F
57.	____	____	65.	____	____
58.	____	____	66.	____	____
59.	____	____	67.	____	____
60.	____	____	68.	____	____
61.	____	____	69.	____	____
62.	____	____	70.	____	____
63.	____	____	71.	____	____
64.	____	____	72.	____	____
			73.	____	____

Section 2

Put an X under the number (1, 2, 3 or 4) that is accurate for you.

	1	2	3	4
74.	____	____	____	____
75.	____	____	____	____
76.	____	____	____	____
77.	____	____	____	____
78.	____	____	____	____
79.	____	____	____	____
80.	____	____	____	____
81.	____	____	____	____
82.	____	____	____	____
83.	____	____	____	____
84.	____	____	____	____
85.	____	____	____	____
86.	____	____	____	____
87.	____	____	____	____
88.	____	____	____	____
89.	____	____	____	____

Section 3

Put an **X** under the number (**1, 2, 3** or **4**) that describes you best. Use the following rating scale to select your answers.

1= Rare or Never	**3= Often**
2= Sometimes	**4= Very Often or Always**

	1	2	3	4
90.	____	____	____	____
91.	____	____	____	____
92.	____	____	____	____
93.	____	____	____	____
94.	____	____	____	____
95.	____	____	____	____
96.	____	____	____	____
97.	____	____	____	____
98.	____	____	____	____
99.	____	____	____	____
100.	____	____	____	____
101.	____	____	____	____
102.	____	____	____	____
103.	____	____	____	____
104.	____	____	____	____
105.	____	____	____	____
106.	____	____	____	____
107.	____	____	____	____
108.	____	____	____	____
109.	____	____	____	____
110.	____	____	____	____
111.	____	____	____	____
112.	____	____	____	____
113.	____	____	____	____

When finished turn in your questionnaire and answer sheet.

Thank you for your cooperation.

ADULT SUBSTANCE USE AND DRIVING SURVEY

REVISED FOR ILLINOIS

ASUDS - RI

Survey Booklet

Authors:

Kenneth W. Wanberg and David S. Timken

CARE

CENTER FOR ADDICTIONS RESEARCH AND EVALUATION

P.O. Box 1975
Arvada, Colorado 80001-1975

Adult Substance Use and Driving Survey (Revised for Illinois) - ASUDS-RI

Instructions

Answer each question in this booklet as to how you see yourself. Choose the answer that best fits you. Give careful thought to your answers. It is important that you answer each question as accurately as you can.

Please give an answer to every question.

Mark only one answer for each question.

Please read the instructions that are provided for the different parts of this survey. In some parts, you are asked to give answers as to how they apply to your life time and then as to how they apply during the last 12 months that you have been in the community.

Carefully read each question and each possible answer before making your choice.

You are asked to mark your answers on this survey booklet.

If you have any questions, ask the person who is giving you this survey.

Your answers will be treated as confidential according to the laws of your state and the Federal confidentiality laws and within the guidelines of the consent you have provided to your agency for the release of confidential information about you. Before you start to answer the questions, please complete the following information..

☐ ☐

Name: TEDDY TROUBLE	Date: 10|02|07	Agency: DPC	
Date of Birth: 12|06|1986	Age: 20	☒ Male	☐ Female
Ethnic Group:	☐ African American ☐ Asian American ☐ Native American	☒ Anglo-American White ☐ Hispanic American	
Marital Status:	☒ Never Married ☐ Separated	☐ Married ☐ Divorced	☐ Remarried ☐ Widowed

ADULT SUBSTANCE USE AND DRIVING SURVEY - REVISED FOR ILLINOIS (ASUDS-RI)

Please circle the letter by the answer to each question that best fits how you see yourself

1. Did you drink* (alcohol) to have fun or to be happy?
   a. No.
   b. Sometimes.
   c. Often.
   d. Very often.

2. Did you drink to relax socially?
   a. No.
   b. Sometimes.
   c. Often.
   d. Very often.

3. Did you take a drink or two to relieve yourself of worries?
   a. Never.
   b. Sometimes.
   c. Often.
   d. Very often.

4. Have you had a bad headache because of having too much to drink?
   a. No.
   b. One or two times.
   c. Three or four times.
   d. Five or more times.

5. How many times have you been drunk?
   a. Never.
   b. Once or twice.
   c. Several times.
   d. Many times.

6. Have you been "half with it" at work or called in sick because you had too much to drink?
   a. No.
   b. One time.
   c. Two or three times.
   d. Four or more times.

7. Have you ever been unable to think or concentrate clearly after drinking?
   a. No.
   b. One time.
   c. Two or three times.
   d. Four or more times.

8. Did you drink when feeling down and depressed?
   a. Never.
   b. Sometimes.
   c. Often.
   d. Very often.

* Drink (or drinking) refers to the use of alcoholic beverages.

9. Did you ever drive an automobile knowing you had too much to drink?
   a. No.
   b. One time.
   c. A few times.
   d. Many times.

10. Have you ever passed out as a result of drinking?
    a. No.
    b. Once.
    c. Two or three times.
    d. Four or five times or more.

11. Have you ever felt down in the dumps after drinking?
    a. No.
    b. One time.
    c. A couple of times.
    d. Several times.

12. Have you ever been unable to recall what you did when you were drinking?
    a. No.
    b. One time.
    c. Two times.
    d. Three or more times.

13. Did you drink to relieve stress?
    a. No.
    b. Sometimes.
    c. Often.
    d. Very often. 1 [35]

14. I exceed the speed limit if road conditions are safe.
    a. Never.
    b. Seldom.
    c. Often.
    d. Very often.

15. I have found myself driving fast without realizing it.
    a. Never.
    b. Seldom.
    c. Often.
    d. Very often.

16. When other drivers do stupid things, I lose my temper.
    a. Never.
    b. Seldom.
    c. Often.
    d. Very often.

17. I drive fast and take my chances of getting caught.
    a. Never.
    b. Sometimes.
    c. Often.
    d. Very often.

18. High speed driving gives me a sense of power.
    a. Never.
    b. Very seldom.
    c. Sometimes.
    d. Often.

19. I have taken a risk when driving just because I felt like it.
    a. Never.
    b. Very seldom.
    c. Sometimes.
    d. Often.

20. I swear out loud or cuss under my breath at other drivers.
    a. Never.
    b. Seldom.
    c. Often.
    d. Very often.

21. I have outrun other drivers.
    a. Never.
    b. Very seldom.
    c. Sometimes.
    d. Often.

22. I pass other drivers when not in a hurry.
    a. Never.
    b. Seldom.
    c. Often.
    d. Very often.

23. I am a driver who likes to stay ahead of or out in front of traffic.
    a. Never.
    b. Sometimes I do.
    c. Often.
    d. Very often.

24. I have tried to beat a red light.
    a. Never.
    b. Sometimes.
    c. Often.
    d. Very often.

25. I dodge and weave through traffic.
    a. Never.
    b. Seldom.
    c. Often.
    d. Very often. 2 [ ]

For the list of drugs below, circle the letter for the answer that best fits you. For alcohol, it is the number of times in your lifetime you have been intoxicated. For all other drugs, it is the number of times in your lifetime that you have used the drug. On the right side of the page opposite the drug, indicate the number of times in the last 12 months in the community, that you have been intoxicated on alcohol or you have used the other drugs. Circle "a" if you did not use alcohol or the other drugs in the past 12 months. Circle "b" if you were intoxicated on alcohol or used the other drugs from one to 10 times, etc.. Then for each drug that you have used in your lifetime, put your age you last used that drug.

	Total Number of Times in Lifetime						
	Never used	One to 10 times	11-25 times	26-50 times	More than 50 times	Times used in the last 12 months	Age last used
26. Number of times intoxicated or drunk on alcohol (beer, wine, hard liquor, mixed drinks).	a	b	c	d	(e)	a b (c) d e	20
27. **Marijuana** (pot, hashish, hash, THC, dope, etc.).	a	b	c	d	(e)	a b (c) d e	20
28. **Cocaine** (coke, snow, crack, rock, blow, etc.).	(a)	b	c	d	e	(a) b c d e	—
29. **Amphetamines/methamphetamine/stimulants** (meth, ice, crystal, speed, uppers, stimulants, diet pills, black beauties, bennies, white crosses, Dexedrine, Desoxyn, and other stimulants used for nonmedical reasons such as Ritalin, Adderall, etc.).	(a)	b	c	d	e	(a) b c d e	—
30. **Hallucinogens** (LSD, acid, peyote, mushrooms, PCP, angel dust, ecstasy, ketamine, etc.).	a	(b)	c	d	e	(a) b c d e	18
31. **Inhalants** (rush, gasoline, paint, glue, nitrous oxide, poppers, snappers, etc.).	(a)	b	c	d	e	(a) b c d e	—
32. **Heroin** (horse, H, smack, junk, etc.).	(a)	b	c	d	e	(a) b c d e	—
33. **Other opiates** or pain killers used for nonmedical reasons (codeine, opium, morphine, Percodan, Dilaudid, Demerol, Methadone, Oxycodone, Oxycontin, Vicodin, Darvon, etc.).	(a)	b	c	d	e	(a) b c d e	—
34. **Barbituates/sedatives** used for nonmedical reasons (Seconal, Nembutal, Amytal, Phenobarbital, Dalmane, quaaludes, placidyl, sleeping medicines, blues, reds, yellows, ludes, etc.).	(a)	b	c	d	e	(a) b c d e	—
35. **Tranquilizers** use for nonmedical reasons (Librium, Valium, Ativan, Xanax, Serax, Miltown, Equanil, Halcion, meprobamates, etc.).	(a)	b	c	d	e	(a) b c d e	—
						3 ☐	

36. As to your use of **cigarettes (tobacco).**	Never smoked	Do not smoke now	Up to half pack a day	Up to a pack a day	Up to two packs a day	More than two packs a day
	a	b	c	(d)	e	f

Have you used alcohol or other drugs for any of the following reasons? Circle the letter for the answer that best fits you.

	No	Sometimes	Often	Very often	
37. To have fun and relax?	a	b	c	(d)	
38. To relieve stress and tension?	a	b	(c)	d	
39. To feel less depressed?	a	(b)	c	d	
40. To be less shy?	a	(b)	c	d	
41. To be able to express myself better?	(a)	b	c	d	
42. To relieve your worries and troubles?	a	(b)	c	d	
43. To forget your problems?	a	(b)	c	d	
44. To calm yourself down?	a	(b)	c	d	4 ☐

As a result of using alcohol or any of the other drugs on page 4, indicate how often any of the following have happened to you in your lifetime. Then, for each of the following statements, in the column on the right side of the page, indicate how many times it has happened to you in the last 12 months in the community. Circle an "a" if it did not happen to you, circle a "b" if it happened to you 1-3 times, circle a "c" if it happened to you 4-6 times, circle a "d" if it happened to you 7-10 times and circle an "e" if it happened more than 10 times.

	Total Number of Times in Lifetime					Number of times in the last 12 months
	Never	1-3 times	4-6 times	7-10 times	More than 10 times	
45. Had a blackout (forgot what you did but were still awake).	a	b	c	d	e	a b c d e
46. Became physically violent.	a	b	c	d	e	a b c d e
47. Staggered and stumbled around.	a	b	c	d	e	a b c d e
48. Passed out (became unconcious).	a	b	c	d	e	a b c d e
49. Tried to take your own life.	a	b	c	d	e	a b c d e
50. Became physically sick or nauseated.	a	b	c	d	e	a b c d e
51. Saw or heard things not there.	a	b	c	d	e	a b c d e
52. Became mentally confused.	a	b	c	d	e	a b c d e
53. Thought people were out to get you or wanted to cause you harm.	a	b	c	d	e	a b c d e
54. Had physical shakes or tremors.	a	b	c	d	e	a b c d e
55. Had a seizure or a convulsion.	a	b	c	d	e	a b c d e
56. Had rapid or fast heart beat.	a	b	c	d	e	a b c d e
57. Became very anxious, nervous and tense.	a	b	c	d	e	a b c d e
58. Became feverish, hot or sweaty.	a	b	c	d	e	a b c d e
59. Did not eat or sleep.	a	b	c	d	e	a b c d e
60. Were weak, tired and fatigued.	a	b	c	d	e	a b c d e
61. Unable to go to work or school.	a	b	c	d	e	a b c d e
62. Neglected your family.	a	b	c	d	e	a b c d e
63. Broke the law or committed a crime.	a	b	c	d	e	a b c d e
64. Could not pay your bills.	a	b	c	d	e	a b c d e
	A[ ]	B[ ]	C[ ]		5[ ]	6[ ]

For the following questions, please choose the answer that best fits you.	Hardly at all	Yes sometimes	Yes A lot	Yes, all the time
65. Have you felt down and depressed?	a	b	c	d
66. Have you been nervous and tense?	a	b	c	d
67. Have you been irritated and angry?	a	b	c	d
68. Have your moods been up and down - from very happy to very depressed?	a	b	c	d
69. Do you tend to worry about things?	a	b	c	d
70. Have you felt like not wanting to live or taking your own life?	a	b	c	d
71. Have you had problems sleeping?	a	b	c	d
72. Have you had thoughts that upset or disturb you?	a	b	c	d
73. Have you been discouraged about your future?	a	b	c	d

7[ ]

Please circle the letter for the answer for each question that best fits you.

	No never	Hardly at all	A few times	Yes a lot
74. Have you ever gotten angry at someone?	a	b	c	d
75. Have you lied about something or not told the truth?	a	b	c	d
76. Do you ever find yourself unhappy?	a	b	c	d
77. Have you felt frustrated about a job?	a	b	c	d
78. Do you hold things in and not tell others what you think or feel?	a	b	c	d
79. Have you been unkind or rude to someone?	a	b	c	d
80. Have you ever cried about someone or something?	a	b	c	d

10☐

Please circle the letter for the answer for each question that best fits you.

	Never	1-2 times	3-4 times	5 or more times
81. When I was in my teen years, I got into trouble with the law.	a	b	c	d
82. I was suspended or expelled from school when I was a child or teenager.	a	b	c	d
83. I have been in fights or brawls.	a	b	c	d
84. I have been charged with driving while impaired or under the influence of alcohol or other drugs.	a	b	c	d

	Not true	Somewhat true	Usually true	Always true
85. I have had trouble because I don't follow the rules.	a	b	c	d
86. I don't like police officers.	a	b	c	d
87. There are too many laws in society.	a	b	c	d
88. It is all right to break the law if it doesn't hurt anyone.	a	b	c	d

Please answer these questions as to how they apply to you during your lifetime and during the last 12 months in the community. Circle the letter for the answer of your choice.

During Your Lifetime

	None	1-2 times	3-4 times	5 or more times	During the last 12 months
89. Number of times I have received a ticket for a driving violation (speeding, driving without a license, running a red light, etc.).	a	b	c	d	a b c d

During Your Lifetime

	No never	Sometimes	A lot	Most of the time	During the last 12 months
90. When in the community, I have spent time with people who have been in trouble with the law.	a	b	c	d	a b c d
91. My friends and/or family get into trouble with the law.	a	b	c	d	a b c d
92. When I have broken the law, I have been high or under the influence of alcohol or other drugs.	a	b	c	d	a b c d
93 When I have committed a crime, I knew that I was involved in criminal behavior.	a	b	c	d	a b c d

D☐

Please answer these questions as to how they apply to you during your lifetime and during the last 12 months in the community. Circle the letter for the answer of your choice.

	During Your Lifetime				
	None	1-2 times	3-4 times	5 or more times	During the last 12 months
94. As an adult, I have been in trouble with the law other than while driving a motor vehicle.	(a)	b	c	d	(a) b c d
95. Number of times that I have been arrested and charge with a crime.	a	(b)	c	d	a (b) c d
96. Number of times that I have been convicted of a crime (misdemeanor or felony).	a	(b)	c	d	a (b) c d
97. Number of times my probation or parole has been revoked (circle "a" if never been on parole or probation).	(a)	b	c	d	(a) b c d
98. Number of times I have been arrested for a crime committed against a person (such as robbery, burglary, assault, rape, manslaughter, murder).	(a)	b	c	d	(a) b c d
99. Number of times I have been arrested for a domestic violence related offense.	(a)	b	c	d	(a) b c d

Please answer these questions as to how they apply to you during your lifetime and during the last 12 months. Circle the letter for the answer of your choice.

	During Your Lifetime					
	Never	1-6 months	7-12 months	1-3 years	4 or more years	During the last 12 months
100. Total amount of time I have spent on probation.	(a)	b	c	d	e	(a) b c
101. Total amount of time I have spent on parole.	(a)	b	c	d	e	(a) b c
102. Total amount of time I have spent in jail or prison.	(a)	b	c	d	e	(a) b c

	During Your Lifetime				
	No Never	Sometimes	Often	Very often	During the last 12 months
103. I have been violent in my behavior or actions.	a	(b)	c	d	(a) b c d

Please answer these questions as to how they apply to you during your lifetime and during the last 12 months in the community. Circle the letter for the answer of your choice.

	Total Number of Times in Lifetime					
	Never	One time	Two times	Three times	4 or more times	Number of times in last 12 months
104 Number of times I have been sentenced for a crime to county jail.	(a)	b	c	d	e	(a) b c d e
105. Number of times I have been sentenced for a crime for which I have been on probation or conditional discharge or conditional supervision.	a	b	(c)	d	e	(a) b c d e
106. Number of times I have been sentenced for a crime to state or federal prison.	(a)	b	c	d	e	(a) b c d e

8☐ E☐ F☐

Please answer the following questions as to how you see yourself at this time.

	No not at all	Yes maybe	Yes most likely	Yes for sure
107. Have you felt a need to make changes in your use of alcohol or other drugs?	a	b	c	(d)
108. Do you want to *stop using alcohol; or to continue not using alcohol?*	a	b	(c)	d
109. Do you want to *stop using other drugs; or continue not using other drugs?*	a	(b)	c	d
110. Have you felt a need to have help with problems having to do with alcohol use?	a	(b)	c	d
111. Have you felt a need to have help with problems with the use of other drugs?	a	b	c	(d)
112. Is it important for you to make changes around the use of alcohol or other drugs?	a	b	(c)	d
113. Would you be willing to come to *(or continue in)* a program where people get help for alcohol or other drug use problems?	a	(b)	c	d

11☐

ADULT SUBSTANCE USE AND DRIVING SURVEY - REVISED FOR ILLINOIS (ASUDS-RI)

Authors: Kenneth W. Wanberg and David S. Timken

CLIENT INFORMATION

Name: Teddy Trouble **DOB:** 12/06/1986 **Age:** 20 **Gender:** Male **Ethnicity:** Anglo-American White **Marital Status:** Never married	**Assess Date:** 04/09/2019 **Client ID:** 0001 **Evaluator:** rjk **Agency Name:** Don't Drive DUI	**Arrest BAC:** .149 **Failed Blood/Urine Test:** No **Prior DWI/DUI Convictions:** 0 **Prior DWI/DUI Education Hrs:** 0 **No. AOD OP Treatment Sessions:** 8 **No. AOD Inpatient Days:** 0

DRUG AND ALCOHOL USE HISTORY

Drug Category	Times in lifetime	Times last 12 months	Age Last Use	Drug Category	Times in lifetime	Times last 12 months	Age Last Use
Alcohol Drunk	More than 50 times	11-25 times	20	Heroin	Never Used	Never Used	N/A
Marijuana	More than 50 times	26-50 times	20	Other Opiate	Never Used	Never Used	N/A
Cocaine	Never Used	Never Used	N/A	Sedatives	Never Used	Never Used	N/A
Amphetamines	Never Used	Never Used	N/A	Tranquilizers	Never Used	Never Used	N/A
Hallucinogens	One to 10 times	Never Used	18	Cigarettes	Up to a pack a day		
Inhalants	Never Used	Never Used	N/A				

CRITICAL ITEMS

- Drove a few times when had too much to drink
- Passed out often when drinking
- Not recall what did when drinking twice
- Blackouts 1-3 times
- Physically violent 4-6 times
- Passed out 1-3 times
- Committed a crime 4-6 times
- Charged with impaired driving 1-2 times
- Arrested and charged with crime 1-2 times
- Convicted of a crime 1-2 times
- Violent behavior sometimes
- Have problems sleeping a lot of the time
- For sure, want to make changes in use of alcohol or other drugs
- Most likely want to stop using or continue not to use alcohol

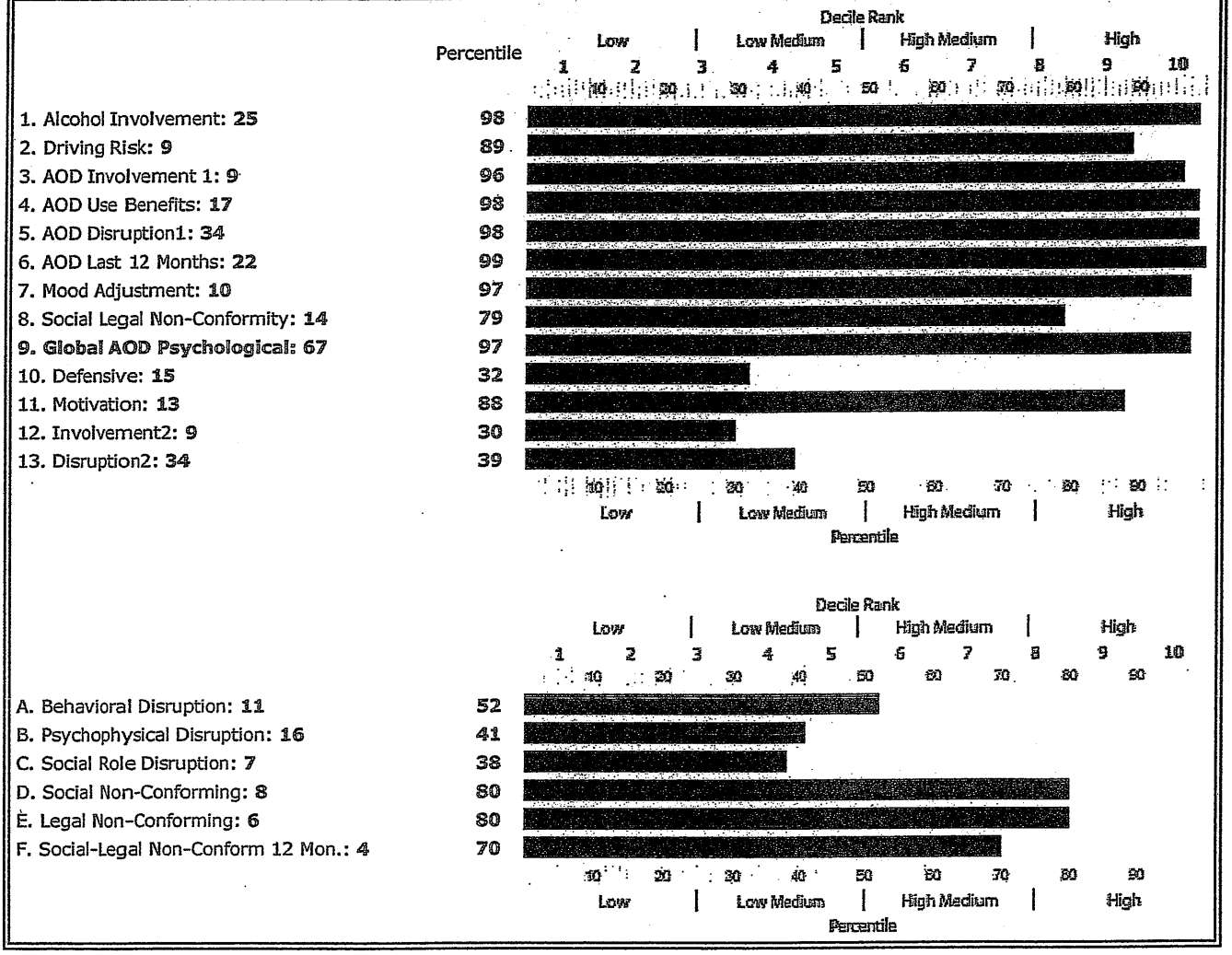
SUGGESTED SERVICE LEVEL BENEFITS OR GUIDELINES

Level	Suggested Service Level Benefit	Weighted
4	Client could benefit from a basic alcohol-drug / DUI risk education program plus an extended-enhanced alcohol/drug treatment program followed with an aftercare plan.	13

ASSESSMENT SUMMARY

- Fairly open around driving risk behavior; may benefit from driving risk education
- High level of past alcohol involvement with very strong indication of a past disruptive pattern of alcohol problems.
- Low-moderate defensiveness quite open to self-disclosure.
- Moderate to high levels of mood and psychological distress. Consider mental health assessment if collateral information supports this.
- Moderate to high past AOD involvement based on drugs (drugs include alcohol) listed in the survey.
- Reports very significant AOD involvement in last 12 months.
- Past AOD negative outcomes or consequences to indicate past moderate disruptive effects and problems with possible Substance Abuse Disorder.
- Indicates low to moderate history of social-legal non-conforming.
- Indicates moderate to high motivation and desire for change and reluctant to get help for AOD problems.
- Overall history of psychosocial and AOD problems and disruption is very high.

ASSESSMENT SCALES



*AOD = alcohol or other drugs

Information in the ASUDS-RI summary is based on the client's self-report. It is dependent on his or her ability to validly respond to the questions. It represents the individual's perception of self regarding alcohol and other drug use, driving attitudes and behaviors, concerns about self, relationship with the community, legal history, and willingness to be involved in the change process. This information should be used only in conjunction with information from all other sources when making referral, education or treatment recommendations. No one piece of information from this or any other source should be used solely to make such decisions. When possible, it is helpful to engage the client in a partnership when making referral and treatment recommendations and decisions. The final referral and treatment recommendations are always made by the evaluator.

Client Signature:_____ Date:_____

Answer Sheet

Questions are based on user entry; 1 = A, 2 = B, 3 = C, 4 = D, 5 = E, 6 = F

1. 3 | 2. 3 | 3. 2 | 4. 4 | 5. 4 | 6. 2 | 7. 4 | 8. 2 | 9. 3 | 10. 3 | 11. 3 | 12. 3 | 13. 2 | 14. 2 | 15. 2 | 16. 1 | 17. 2 | 18. 1 | 19. 1 | 20. 2 | 21. 1 | 22. 2 | 23. 2 | 24. 4 | 25. 1 | 26. 5 | 26a. 3 | 26b. 20 | 27. 5 | 27a. 4 | 27b. 20 | 28. 1 | 28a. 1 | 28b. N/A | 29. 1 | 29a. 1 | 29b. N/A | 30. 2 | 30a. 1 | 30b. 18 | 31. 1 | 31a. 1 | 31b. N/A | 32. 1 | 32a. 1 | 32b. N/A | 33. 1 | 33a. 1 | 33b. N/A | 34. 1 | 34a. 1 | 34b. N/A | 35. 1 | 35a. 1 | 35b. N/A | 36. 4 | 37. 4 | 38. 3 | 39. 2 | 40. 2 | 41. 1 | 42. 2 | 43. 2 | 44. 2 | 45. 2 | 45a. 1 | 46. 3 | 46a. 1 | 47. 4 | 47a. 2 | 48. 2 | 48a. 1 | 49. 1 | 49a. 1 | 50. 5 | 50a. 3 | 51. 1 | 51a. 1 | 52. 1 | 52a. 1 | 53. 1 | 53a. 1 | 54. 1 | 54a. 1 | 55. 1 | 55a. 1 | 56. 1 | 56a. 1 | 57. 5 | 57a. 3 | 58. 5 | 58a. 4 | 59. 5 | 59a. 3 | 60. 5 | 60a. 5 | 61. 2 | 61a. 1 | 62. 5 | 62a. 3 | 63. 3 | 63a. 2 | 64. 1 | 64a. 1 | 65. 2 | 66. 2 | 67. 2 | 68. 1 | 69. 4 | 70. 1 | 71. 3 | 72. 2 | 73. 2 | 74. 2 | 75. 3 | 76. 2 | 77. 3 | 78. 3 | 79. 1 | 80. 2 | 81. 2 | 82. 1 | 83. 2 | 84. 2 | 85. 1 | 86. 2 | 87. 2 | 88. 1 | 89. 2 | 89a. 2 | 90. 2 | 90a. 2 | 91. 2 | 91a. 1 | 92. 1 | 92a. 1 | 93. 2 | 93a. 1 | 94. 1 | 94a. 1 | 95. 2 | 95a. 2 | 96. 2 | 96a. 2 | 97. 1 | 97a. 1 | 98. 1 | 98a. 1 | 99. 1 | 99a. 1 | 100. 1 | 100a. 1 | 101. 1 | 101a. 1 | 102. 1 | 102a. 1 | 103. 2 | 103a. 1 | 104. 1 | 104a. 1 | 105. 3 | 105a. 1 | 106. 1 | 106a. 1 | 107. 4 | 108. 3 | 109. 2 | 110. 2 | 111. 4 | 112. 3 | 113. 2 |

USER'S GUIDE

ADULT SUBSTANCE USE AND DRIVING SURVEY

REVISED (ILLINOIS)

ASUDS-RI

Kenneth W. Wanberg and David S. Timken

CARE

CENTER FOR ADDICTIONS RESEARCH AND EVALUATION

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Kenneth W. Wanberg and David S. Timken

P. O. Box 1975
Arvada, Colorado 80001-1975

303-421-1261

care@nilenet.com

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PURPOSE OF THIS USER'S GUIDE

It is common practice for judicial jurisdictions in the United States to have programs to provide screening and initial evaluations of impaired driving offenders' substance abuse problems and to determine their needs for further assessment and type of services. These programs typically use standardized testing and interview formats to identify substance use severity level and treatment referral needs. Considering the annual rate of 17,400 alcohol-involved traffic fatalities accounting or 41 percent of all traffic fatalities, 3,000,000 annual victims of alcohol and other drug (AOD) related accidents, and 110 billion dollars in annual costs of AOD related crashes (Cogen & Larkin, 1999; NHTSA, 2003; Wanberg, Milkman & Timken, 2005), the goal of these programs is to prevent recidivism through early identification and intervention of problem drinkers.

Many psychometric instruments have been used for screening and initial assessment of alcohol involvement and problems with DWI offenders (see Wanberg, Milkman & Timken, 2005 for comprehensive review of instruments used for assessing alcohol problems). Instruments used to screen for alcohol problems among substance impaired driving offenders vary with respect to the degree of depth desired in the screening process and the number of life-functioning domains that are the focus of screening. Some instruments measure only alcohol or other drug (AOD) use involvement and give a single score that provides a ranking of the individual in relationship to a normative group such as the Michigan Alcoholism Screening Test - MAST (Selzer, 1971). Often, these single-scale instruments are based on only five or six items, and only a cut-off value is given that indicates AOD problems with normative distributions such as the Simple Screening Inventory - SSI (CSAT, 1994).

Other driving offender screening instruments provide a more in-depth and differential measurement of a number of important factors in addition to AOD problems. These measurements include mental health adjustment, driving risk, a low-level measurement of alcohol involvement, antisocial characteristics, motivation for treatment and level of defensiveness. The *Adult Substance Use and Driving Survey* (*ASUDS*: Wanberg & Timken, 1998) and its revision, the *Adult Substance Use and Driving Survey-Revised* (*ASUDS-R*: Wanberg & Timken, 2006) provide a broader base measurement of life-adjustment problems.

The purpose of this *User's Guide* is to provide a description of and guidelines for the use of the *Adult Substance Use and Driving Survey-Revised Illinois* (*ASUDS-RI*). The *ASUDS-RI* is a slight modification of the *ASUDS* (Wanberg & Timken, 1998) and the *ASUDS-R* (Wanberg & Timken, 2006) and is designed to meet the more specific needs of the Illinois impaired driving assessment program. The *ASUDS* and the *ASUDS-R* were developed from scales utilized in several instruments and questionnaires developed by the authors and their associates (Wanberg, 1992, 1994, 1997; Wanberg & Horn, 1989, 1991; and Horn, Wanberg & Foster, 1990; Wanberg & Timken, 1991, 2004).

Although, as noted, there is a slight difference between the *ASUDS-R* and the *ASUDS-RI*, these differences will be briefly summarized:

- The *ASUDS-R* STRENGTHS scale is not included in the *ASUDS-RI*;
- Whereas the SOCIAL-NONCONFORMING and LEGAL-NONCONFORMING scales are included in the Basic Scales list of the *ASUDS-R*, these two scales are combined into one broad scale for the Basic Scales list in the *ASUDS-RI*, and included as separate scales in the Supplemental Scales list of the *ASUDS-RI*;
- The *ASUDS-R* does not include the broad SOCIAL-LEGAL Scale, whereas, as noted above, this is included as a basic scale in the *ASUDS-RI*.
- Whereas the *ASUDS-R* uses a six month time frame for recent AOD involvement and disruptions, the *ASUDS-RI* uses a 12 month time frame.

The purpose of the *ASUDS-RI* is to provide a differential screening assessment of the driving while impaired (DWI) offender in the areas of substance use and abuse, alcohol involvement and other areas of life-adjustment problems and problem behaviors. It is the self-report component of a convergent validation assessment approach where the evaluator uses all sources of information in evaluating the service needs of the DWI offender.

OVERVIEW OF 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 occurs a wide variety of differences among people (Wanberg & Horn, 1987; Wanberg & Milkman, 1998; Wanberg et al., 2005). For example, alcohol has a general influence on the life of the alcohol dependent individual. Yet, 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; some periodic, etc.

Assessment, then, should consider these two levels of evaluation: 1) the general effect of a certain problem area, e.g., AOD abuse, criminal conduct; and 2) the specific ways that these problem areas affect the person's life. Assessment of the general influence is usually the basis of screening. Looking at the more specific influences and problem areas involves the application of a differential, in-depth and multidimensional assessment. This differential and in-depth assessment is usually done after the client has been admitted into a treatment program (see Wanberg, Milkman & Timken, 2005 for a more complete discussion of these two levels of assessment).

The first level of assessment, or screening, utilizes inclusion criteria to address several important questions: Does the person have an AOD problem? What is the extent of involvement in and the degree of disruption from drugs? Is the individual appropriate for treatment referral? If so, is the person motivated for help? What kind of service referral resources might be appropriate? Jacobson's (1989) concepts of detection and assessment would fall into this screening or first level of evaluation. Miller et al. (1995), Cooney, Kadden, & Steinberg (2005) and Wanberg and associates (Wanberg & Milkman, 1998; Wanberg et al., 2005) also identify this as screening.

Deciding whether the individual is to be included into the category of alcohol or other drug misuse does not mean that one has obtained a valid description of the different conditions associated with AOD misuse or abuse. The second level of evaluation identifies the distinct conditions associated with the disorder or problem. This level provides the necessary information with which to develop a comprehensive understanding of the progress, process and existing condition of the individual in order to formulate a treatment plan and approach within the framework of expected outcomes. Whereas Jacobson (1989) calls this level of evaluation diagnosis, Wanberg and associates identify this level as in-depth differential assessment.

A CONVERGENT VALIDATION MODEL FOR SCREENING AND ASSESSMENT

Objectives of Screening and Assessment

There are five specific objectives of screening and assessment:

1. To provide opportunity for clients to disclose their AOD use history, or "tell their story";

2. To give opportunity to collateral sources to "tell their story" as to how they see the client's AOD history;

3. To determine the level of defensiveness based on the observed discrepancy between the client's reported perception of his or her AOD use and the collateral reports regarding that use;

4. Estimate the "true" or veridical condition of the client relative to past and recent AOD use, level of mental health problems and motivation for change and treatment; and

5. Match presenting problems and levels of severity with appropriate service referral resources.

Data Sources for Assessment and Report Subjectivity

In achieving the above stated screening and assessment goals, the evaluator has two sources of data: other-report and self-report data.

Other Report Data:

Other report data represent a broad catch of information considered to be collateral to the self-report of the client. These data sources included reports from: probation officer, family members, evaluation specialists, treatment professionals, laboratory results and official records. Typically, we sort the other-report data into two categories: reports from individual third parties who have some familiarity with the client; and official documentation such as laboratory report or legal records.

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 making the final impression or rating of the evaluator double-subjective.

In addition to being double-subjective, there are other problems with rater or individual 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 include urine analysis results, criminal records and records of past treatment. On the surface, these other-reports appear to be objective data. Yet, they are also subject to error, distortion and misreporting. Official records will often not fully disclose the extent or even the nature of the client's criminal history. A final charge or conviction following a plea-bargaining process may be quite different from the original charge. The official criminal record never reflects the extent of involvement in criminal activity. Documentation of one DUI conviction 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 treatment needs.

Self-Report Data:

Self-report data are also subjective. However, Self-report data become more objective and meaningful when they are based on the principles of psychological measurement (see Horn, Wanberg & Foster, 1990; Wanberg & Horn, 1983). There are a number of ways the subjectivity of self-report data can be reduce and made more reliable and veridical (valid).

Self-report data are made more objective when the information is collected in a standardized format. In this respect, every subject is asked the same questions and is provided with the same response options under a consistent and standardized structure.

Self-report data become more objective when we use a multiple variable measurement model. 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 most psychological measurement (Horn, Wanberg & Foster, 1990; Wanberg & Horn, 1983).

Third, we reduce the subjectivity of self-report 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 that client. This certainly enhances the veridicality (the hypothetical valid or true picture of the client) of self-disclosure.

Valuing Client Self-Disclosure When Discerning Veridicality

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 testing should never be taken as a fixed and final description of the client. Any point in testing **only** provides us with an estimate of the client's condition and gives us guidelines for service needs at that point in time. From this perspective, the process of assessment is just as important as the content of assessment.

Many evaluators and workers in AOD assessment and treatment tend to distrust the "so-called" validity of the client's self-report, particularly DWI clients. Evaluators are quick to conclude the judicial client is "lying" or "into denial" when they conclude the client is not reporting his or her "true" condition. However, when we see assessment as a process, we view all self-report as a valid representation of where the client is at a particular point in time. If we think the client is not accurately reporting his or her "real condition," we should view this within the framework of defending the self, rather than denial.

Within this perspective, we view self-report data as the client's willingness to provide his or her perception of what is going on at the time of testing. The value of self-report is that it is a baseline measure of this willingness to report problems at the time of testing. The discernment of the validity or veridicality of the self-report revolves around this baseline perception and the level of defensiveness related to reporting this perception. What we are discerning, first and foremost, is the client's level of defensiveness and then the veridicality of the client's self-report as to what is going on with the client. This discernment is part of the overall task of the evaluator.

Discerning the veridicality of the self-report requires that the evaluator utilizes other-report sources of information in screening. Self-report and other-report data 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. Over time, our estimate of the "true condition" becomes more veridical. We gather more data; the client becomes less defensive and more open to self-disclosure.

Neither self-report nor other-report alone will allow us to determine the veridicality of the self-report. Self-report *is an essential component* of the assessment process since it represents the client's present willingness to report what he or she perceives to be going on. This is where the change process begins - with the client's self-perception, or the willingness to disclose this self-perception. If, in the initial assessment, the self-report is not veridical with 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. Retesting later in the intervention process should reveal any changes that might be occurring in the disclose of that perception.

Within the framework of this concept of interpreting self-report, every client self-report is considered to be valid. Even slap-dash or random responding, given that the evaluator is aware that this was the response pattern utilized, is valid with respect to gaining an understanding of the client's attitude towards assessment and treatment. If we view all self-reports as 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 testing, then we conclude that this is a valid representation of that disclosed perception. If we have evidence that the self-report is not veridical with collateral information, and the client is highly defensive around self-disclosure, then the report is valid in the sense that we have an estimate of the discrepancy between what the client says is going on and what the other-reports indicate. We may then conclude that our estimate of defensiveness and discrepancy is valid. This defensiveness and discrepancy become the basis for starting treatment.

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.

Basis for the Convergent Validation Model

The convergent validation model described above is based on Campbell and Fiske's (1959) classic convergent and discriminant multitrait-multimethod matrix approach. It is grounded in *phenomenology* and *constuctivism* (see Delia, O'Keefe, & O'Keefe, 1982; Mahoney, 1995; Neimeyer, 2000). These views hold that reality is as we perceive it and we approach the world through the process of interpretation. We construct our own realities and form views of ourselves. These interpretive constructs or "schemes" (Kelly, 1971) help us make sense of and determine how we see ourselves and the world. These constructs, or cognitive organizations, are important components of what we measure. Others also construct their realities and form views of us, using interpretive schemes and constructs. These are also important components of what we measure in assessment.

The interpretation of how we view ourselves and others is influenced by our life experiences. 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.

However, there are common schemes and constructs that determine how we see maladaptive or problem behaviors, e.g., AOD use behavioral disruptions. These are constructed by those who view these problem behaviors from a scientific and measurement perspective. These constructs have construct validity, e.g., have measurement reliability, are invariant across independent samples, can predict outcomes. Using these constructs and schemes, we develop psychometric instruments to measure them. Yet, an individual's response to these structured measures, e.g., *ASUDS-R* DISRUPTION scale, is based on self-interpretation and construction of reality at the time of testing. It is the self-disclosure of this view that we want to measure, no matter how it might differ from how other's view the individual fitting the construct. Most important, this view changes in relationship to current experiences, e.g., learning and understanding the realities of the negative (or positive) consequences of certain behavioral patterns.

Assessment, then, is the process of measuring how individuals see themselves in relationship to constructs that putatively define conditions of life-adjustment that are adaptive and maladaptive. It is assumed that these constructs have validity with respect to predicting outcome, e.g., a person who reports a lot of signs or symptoms of a certain condition is observed to demonstrate, by society's standards, poor adjustment. The goal is to start where individuals see themselves as fitting those constructs, to discern the discrepancy

between that view and the estimated "true" condition, increase the individuals' awareness and acceptance of that estimate, and help them make changes so as to reduce maladaptive behaviors and increase adaptive responses and outcomes.

Change is first noted in how the self-report over time converges with the estimate of the "true" condition. With many clients, the initial self-report is a good estimate of that "true" condition. Implementation of change includes both: 1) increasing this convergence through increasing the veridicality of the client's self-disclosing of his or her "true" condition; and 2) providing effective services (education and treatment) to change thinking and behavior so as to prevent future problem behavior (relapse and recidivism).

MULTIDIMENSIONAL AND DIFFERENTIAL SCREENING

Screening instruments used in AOD assessment are usually structured to measure whether or not an individual has a substance abuse problem. However, it is usually helpful to go beyond this single task of screening to measure other relevant conditions related to AOD use. This represents a multidimensional or differential approach to screening. For example, within the domain of AOD assessment, screening will measure the extent to which individuals are involved in various kinds of drugs and the extent of negative consequences or symptoms resulting from this involvement.

Other domains of assessment are also relevant for screening. These include mental health issues, motivation for involvement in treatment and level of defensiveness. These are some of the most important areas of evaluation at the screening level.

INCLUSION CRITERIA FOR AOD SCREENING AND ASSESSMENT

Clinical screening "is a preliminary gathering and sorting of information used to determine if an individual has a problem with AOD abuse, and if so, whether a detailed clinical assessment is appropriate" (Center for Substance Abuse Treatment, 1994, p. 5). The screening level of evaluation is almost always unidimensional (Wanberg & Horn, 1987; Jacobson, 1989; Wanberg & Milkman, 1998). That is, the goal is to determine whether the individual has a condition indicating drug abuse, drug dependence, alcoholism, a drug use problem, an alcohol use problem, etc. Several screening approaches have been developed to meet the objective of determining whether an individual is to be included in the category of having an AOD problem and needing treating services. These will be briefly reviewed.

Other Report Data - Minimum Symptom Criteria

The minimal 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, abuse or dependence. The evaluator rates the client across specified inclusion or diagnostic criteria. Minimum symptom criteria are considered to be other-report or rater data and are subjective data. The most commonly used minimum screening approach in AOD assessment is based on the criteria defining Substance Abuse or Substance Dependence as outlined in the *Diagnostic and Statistical Manual of Mental Disorders 4th ed.* (American Psychiatric Association, 1994) and its text revision (American Psychiatric Association, 2000).

Other Report Assessment - The Impaired-Control Cycle

The concept of impaired control and the impaired-control cycle (Wanberg, 1974, 1990; Wanberg & Milkman, 1998; Wanberg, Milkman & Timken, 2005; Wanberg & Milkman, 2008) can be useful in identifying the presence of an AOD problem. Impaired control occurs when notable negative consequences result from drug use (loss of job, physical problems, relationship, marital problems, etc.). The cycle begins when drugs are used to solve problems that result from their use and continues when the individual continues to use drugs to solve the problems that come from drug use.

If we define a drug use problem on the basis of the occurrence of negative consequences resulting from drug use, then all persons who experience a disruptive effect from using drugs meet the criteria for inclusion in the drug use problem group. This would include the drug user arrested for possession, the adolescent arrested for alcohol possession or the adult arrested for impaired driving. Clinical judgment of whether a person fits the impaired controlled cycle is considered to be other-report or rater data.

Other-Report Assessment - The Relationship Identifier (RI)

The presence of a relationship identifier (RI) (Wackwitz, Diesenhaus & Foster, 1977; Wanberg & Milkman, 1998) 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 disruptions and AOD use. Often, the person who makes this connection is not the user. The RI concludes that the undesirable behaviors of the drug user are a direct consequence of the use of drugs (although the major determinants of the life-role disruptions may be other than drug use). There is a pattern of drug use (e.g., use resulting in an impaired driving offense) and disruptions in life role functions (e.g., legal problems, school failure); the RI links these together. The user often accepts the RI's analysis and requests treatment. In the case of more resistive clients, the RI pressures or even forces (e.g., the court) the individual into treatment.

Self-Report - Self-selection

Self-selection is also an important inclusion criterion. The client admits to having AOD use problems and selects him/herself into the category of having such problems. Self-selection is enhanced when the individual experiences some emotional concern about the disruptive quality of drug use. In the case of the impaired driving offender, if treatment is to have some impact, the client has to move towards some degree of openness for and acceptance of treatment. This represents self-selection.

Self-Report - Standardized Psychometric Approaches

Given the fact that self-report data are subjective, and that such subjectivity can be reduced by applying the principles of psychometric measurements, standardized psychometric approaches are important sources for discerning the presence of an AOD problem. We have noted that there are a variety of screening devises that have been used to determine whether an individual falls into the category of AOD use problems.

The *Adult Substance Use and Driving Survey-Revised Illinois* (*ASUDS-RI*) provides measures of not only AOD use and abuse, but also measures conditions outside of the domain of AOD use that are relevant in determining the level and type of treatment services that might be needed.

Maximizing Veridicality in Assessment: Integrating Self-report and Other-Report

The most effective method of assessment is to use both sources of data in making treatment referral and clinical judgements. We have concluded that self-report is essential in getting the baseline perception of the client and developing a starting point in treatment. Yet, collateral information is also important in the assessment process.

Thus, it is recommended that all of the above methods be used when determining whether a client does in fact have a need for AOD intervention and treatment. Too often, the evaluator will utilize only diagnostic criteria as described in the *Diagnostic Statistical Manual* 4th ed. (DSM-IV) revised (American Psychiatric Association, 1994; 2000) in making this inclusion decision. 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. This kind of error occurs when the evaluator concludes that the individual does not have an AOD use problem when in fact such a problem does exist. A strict application of formal diagnostic criteria as defined in the DSM-IV increases the number of false negatives at the screening level of evaluation.

INTERPRETING ERROR RISK

There are two kinds of errors that we define when interpreting both self-report and other-report assessment data. The first is a *false negative* which is made when it is concluded that there is no problem when in fact there is (Type 1 error in statistics). This error is reduced when our instruments are *test-sensitive* or the test will identify a certain condition that it is attempting to measure in individuals who indeed have that condition. This error can be avoided by making the criteria for inclusion less stringent. When using a psychometric scale, we lower the inclusion cutoff score so that we will include more individuals who show symptoms. The false negative is a critical error, since it may cause us to fail to provide assessment or services for those who really need it.

When we reduce the false negative risk, we increase the risk of the *false positive* error. This is concluding that there is a problem when there is not (a statistical type 2 error). This error can be reduced when our instruments have *test-specificity* or when the test designed to measure a certain condition is able to sort 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 cutoff value before we conclude that the individual fits 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 lower the false negative risk may mean that more patients will receive an expensive diagnostic procedure. However, raising the false negative risk may result in patients who have the medical disorder not receiving the necessary diagnostic procedure to confirm diagnosis.

Most medical patients are willing to decreases the false negative risk, even thought it means additional testing and expensive diagnostic procedures when it is not necessary. In AOD and behavioral health assessment, where the presence of a disorder is most often not life-threatening, this imposition may be unacceptable. A client who is diagnosed as having *Alcohol Dependence,* but in fact, does not have it, may find this to be inconvenient and even adverse.

One resolution to this dilemma is to use multiple levels of assessment: preliminary and differential screening; and in-depth assessment. We set criteria that will decrease the risk of a false negative at the level of initial or preliminary screening, and then increase the criteria at the differential level of screening where the decision for further assessment or service referral is usually made. The "net" is initially large which increases the catch, and where the cost of assessment is less. At the differential screening, the criteria can be made more stringent, since the risk of false negatives was decreased at the initial screening. If proper screening is done at the preliminary and differential levels, the risk of false positives is minimized.

The risk of making false negative and false positive errors is also reduced when we use the multimethod or convergent validation approach. We avoid depending on the sensitivity and specificity of a particular method of assessment, but allow all methods to formulate conclusions. This approach sees assessment as a process and not as occurring at a single point in time. Assessment continues while the client is in judicial supervision and in treatment services. As we stress in this *User's Guide*, conclusions at any given point in the assessment process is made by the evaluator or clinician and not a specific method or instrument.

GUIDELINES FOR USING 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 should demonstrate construct validity, discussed later in this *User's Guide*. It is important to distinguish between the **validity of a test** and **the validity of the results of the testing of an individual subject.** The former is based on studies that support the understanding, utility and meaning of a test or scale. The latter is seen as a valid representation of where the client is at the time of testing 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 will provide a more veridical view of their "true condition."

2. The test instructions should be 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 counselor or case manager develop services most appropriate for you"; and "the results of your testing will be shared with you."

3. The methods of test administration should be 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 test booklet; the client should have a copy of the test booklet and read each question along with the evaluator. When possible, the client marks the answers on the answer sheet.

4. Evaluate reading level by asking clients to read the first three or four questions.

5. The evaluator should understand what the test measures and whether it fits in with the evaluator's goals. A simple screening instrument should **only** be used to determine need for differential screening. Screening for treatment referral should be done with a differential screening instrument. A screening instrument should not be used for comprehensive assessment.

6. The test norms should be appropriate for the group of clients being evaluated. With some samples, it is 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 judicial clients, it is helpful for the test to be normed on judicial clients; and a clinical sample with which to assess the client's scores regarding need for treatment.

7. When using computerized scoring, the evaluator should have knowledge of the test itself, and not just what the interpretive report says about any particular client. Computerized scoring may give a standardized interpretation of the test, based on its norms, but will not provided the more idiosyncratic nuances of the results 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 treatment (Wanberg & Milkman, 1998, 2008).

INTEGRATING THE EDUCATION-TREATMENT AND CORRECTIONAL EVALUATION

Evaluators and clinicians working with DWI offenders are confronted with meeting the needs and expectations of two parties: the client and the community. The DWI evaluation process has two components: education-treatment (ET); and the correctional. Effective DWI assessment must integrate these two components.

Education-Therapeutic Evaluation

The first component of DWI evaluation is to determine the ET needs of the client (therapeutic and treatment are used synonymously). DWI education and treatment start with the client. They consider the agenda and goals of the client, 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. The ET evaluation component begins with building trust and rapport with the client and with getting the client to tell his or her story. It begins with self-disclosure - at whatever level of probity this disclosure occurs.

Change starts with this disclosure process and is enhanced when the client receives feedback on information received in the evaluation process. Change is further enhanced through therapeutic confrontation - confronting the client with the client - with the client's own discrepancies and ambivalence, with the client's goals and agendas. ET evaluation is client-oriented and the healing process is client-centered. In therapeutic confrontation, the treatment message is: "I confront you with you, with your need and resistance to change, with your discrepancies."

Correctional Evaluation

The second component of DWI evaluation is correctional. This dimension starts with the goals and agenda of society and the community representing that 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. This story involves legal records, arrest BAC, damage to the community and victims, and the legal expectations, requirement and sanctions related to specific offending behavior.

Correctional change occurs through the client 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 ET is client-centered, correctional evaluation is society-centered. 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."

The effective DWI evaluator will blend together the skills and knowledge of education-treatment and correctional evaluation and intervention. The DWI evaluator considers the agenda of the client and the community. DWI evaluation and intervention assumes the dual role of developing an environment of therapeutic change but also helps the community administer the judicial sentence. Sound ET and correctional evaluation skills are blended together in the assessment process and in the process of determining the therapeutic and correctional needs of the client.

OVERVIEW OF THE ASUDS-RI

The *ASUDS-RI* provides a psychometric approach to screening individuals charged with or convicted of driving while impaired or under the influence of alcohol or other drugs (AOD). It is a self-report survey comprised of 113 standardized self-report questions appropriate for use with Driving While Impaired (DWI) offenders 16 years or older. The *ASUDS-RI* is provided in the Appendix of this *User's Guide*.

ADMINISTRATION OF THE ASUDS-RI

Basic Instructions

First, read to the client, or have the client read, the brief instructions on page 2 of the *ASUDS-RI Survey Booklet*. Then, ask the client to complete the personal data information. The issue of confidentiality should be dealt with at the time the instructions are reviewed.

Clients are then instructed to complete the *ASUDS-RI* based on the period of time of AOD use, since many clients discontinue AOD use once they have received an DWI charge. Clients should also be asked to respond to the questions based on lifetime experiences, except for the specific portions of the survey where the client is asked to answer the questions based on a 12 months month time-frame. Here are the special instructions for the 12 month set of questions.

- For questions 26 through 35 and 45 through 64, it is the last 12 months spent in the community. Some evaluators also use the 12 months prior to their last arrest, if that arrest was recent, e.g., within the last two or three months, which is acceptable. If clients were incarcerated up to the time

of evaluation, it should be the last 12 months prior to incarceration.

- Clients are asked to answer the "last 12 months" legal items 89 through 99 and 104 through 106 in relationship to the last 12 months they have been in the community.

- For questions 100 through 102, which measures legal status, they should use the last 12 months prior to evaluation, whether or not whey were in the community.

Ask clients to give their honest and best response to all questions, to answer each question and provide only one answer to each question. Make it clear that the purpose of the evaluation is to assess the needs of clients in order to provide the best possible resources to prevent future impaired driving conduct and AOD related problems. Make it clear to the client how the information provided on the *ASUDS-RI* will be used and that formal releases must be obtained from the client before information is release to a third party.

Methods of Administration

Three methods can be used in administering the *ASUDS-RI*: the *interview method*; *self-administered paper-pencil method (PPM)*; or *self-administered computer method (CM)*.

The *interview method* is recommended for clients who are unable to read the questions and for clients who are very resistive and unmotivated. When using the *interview method*, both the interviewer and client should have a copy of the survey booklet, the interviewer then reads the introduction heading for the first section of the *ASUDS-RI*, and then proceeds to read each item separately, with the client following along with the interviewer. The response choices should be read for each of the items, or for a sufficient number of the items in each section so that the interviewer is confident that the client understands clearly the response choices. Note that the instructions and response choices differ for each section of the *ASUDS-RI*. The survey booklet can be marked by either the client or interviewer, or the interviewer can enter the client's response into the computer during the interview process.

When the *self-administered paper-pencil method (PPM)* method is used, the evaluator should be sure the client can read the survey items. To test reading level, have the client read a sampling of survey items. The *self-administered PPM* is appropriate for clients who present with some degree of cooperativeness and willingness to take part in the evaluation. The self-administered PPM can be used on about 90 percent of DWI offenders. Thus, the interview-administered method must be used on about 10 percent of the DWI offenders because of resistance to cooperate or for clients who may not have the necessary reading skills to negotiate the items.

When the *self-administered computer method (CM)* method is used, the evaluator should be sure the client can read the survey items and navigated through the various computer screens to complete the survey. A brief period of instructions will be required to teach the client to navigate through the survey. The *self-administered CM* is appropriate for clients who present with some degree of cooperativeness and willingness to take part in the evaluation. The CM can also be used during the interview-administered method; or data can be entered from the client's PPM hard copy.

Checking for Invalid Responding and Response Inconsistency

The evaluator should check the completed test booklet to make sure all items have been answered and that only one answer is given to each question. Check for missing and multiple responses. Check for random or slap-dash responding such as an oval circle around all of the "a" responses, indicating that each individual item may not have been carefully addressed. This kind of responding will indicate that the individual was marking the test items without much thought. Yet, the discovery of this kind of responding is important assessment information. When the computer-administered method is used, the computer will automatically prevent duplicate responses or check for the failure to answer a particular question.

SCORING THE ASUDS-RI AND DEVELOPING THE PROFILE

Calculating the Raw Scale Scores

The questions measuring the respective *ASUDS-RI* scales are grouped together so as to make the scoring user-friendly. *Table 1* provides the scoring procedures for the *ASUDS-RI* basic scales and *Table 2* for the supplemental scales. It provides the name of each scale, the items comprising each scale and the scoring item weights. Except for the items in the DEFENSIVE scale, all items are scored: a=0, b=1, c=2, d=3 and e=4. The Items on the DEFENSIVE scale are scored as follows: a=3, b=2, c=1 and d=0.

Test Scoring Boxes in *Survey Booklet*

A scoring box with the number for the respective scales is provided in the *Survey Booklet*. When scoring, sum across each item in the scale, using *Tables 1* and *2* as scoring guides. There is an alpha designation and box for each of the six supplemental scales. For example, for BEHAVIORAL DISRUPTION, items 45 through 50 are scored, and the raw score is then put in box "A" under the response choices for item 64.

The DEFENSIVE items follow the MOOD ADJUSTMENT items in the *Survey*, yet the DEFENSIVE SCALE is designated as number 10 on the profile. This is because the DEFENSIVE items are similar to the MOOD ADJUSTMENT items, and should be clustered after those items in the *Survey*.

On the profile, the AOD and other problem behavior scales (scales 1 through 9) are presented first, and logically followed by DEFENSIVE and MOTIVATION, which are scales that measure attitudes toward self-disclosure and change. This allows the evaluator to view the problem behavior issues before assessing attitudes towards survey-taking and involvement in change and intervention services.

Plotting the Profile and Reading Standard Scores

After scoring each scale and recording the raw scores in the test booklet, transfer the scores to the *DWI Offender Profile, Figure 1*. Plot the raw scores in the proper row on the profile, using an X or by drawing a line up to the raw score. The evaluator may find that a client has a raw score on a scale that is not found on the row of that respective scale. For example, for the scale GLOBAL AOD-PSYCHSOCIAL, in the 10th decile range, there are only two raw scores: 44 and 199. This means that only 10 percent of the sample had a raw score in that range. If a client results in a score of 50 on that scale, just mark the location of that score between 42 and 179.

Three Standardized Scores

There are three standard scores which can be used: the approximate percentile score; the decile score (percentile score ranges of 10) and the quartile score (percentile score ranges of 25) All three indicate how a score on a particular scale ranks with a specified reference or normative group or sample.

Percentile scores indicate what percent of the normative group falls below and above a particular individual's raw scale score. If an individual has a percentile score of 75 on an arithmetic test, this would mean that this person scores higher than 75 percent in his normative or reference group. It also means that he scores lower than 25 percent in the reference group. The approximate percentile score for a subject is found on the profile by following the column in which the raw score is plotted downward to the bottom row labeled Percentile. The numbers range from one through 99, one indicating the first percentile and 99 indicating the 99th percentile. The percentile score for a particular raw score must be approximated.

Decile scores are determined by following the column in which the raw score is plotted upward to the top row labeled Decile Rank. A decile score ranges from one to ten percentile points. For example, the raw score of 5 on DISRUPTION1 on the *ASUDS-RI* results in a decile score of 8 (approximate percentile score of 72) indicating the client scores higher than 70 percent and lower than 20 percent of his driving offender

peers on a scale that measures disruptive symptoms associated with AOD use.

Quartile scores are given a descriptive label of "low", "low-medium," "high-medium," or "high." Each of these categories or quartiles represents a score range of 25 percentile points. The descriptive labels, however, take on meaning only in relationship to a specific normative group. For a group of clients, such as represented by the DWI sample, that has low-bound expressions of AOD use and abuse problems, raw scores that represent the "high" range may actually represent a "low" or "low-medium" range in a more severely AOD disrupted sample. This issue will be further discussed below.

It is recommended that the decile standard score is used over the percentile score, or that if percentile scores are used, the evaluator always refers to that score as an **approximate percentile score**. Because of the standard error of measurement of behavioral science measures such as those represented by the *ASUDS-RI* scales, an exact standard score is never determined. Thus, less precise standard score measures are suggested, such as the decile rank or the quartile score or rank.

Interpreting Standardized Scores for DWI Offenders

The normative sample for the *ASUDS-RI* is a group of impaired driving offenders being evaluated for appropriate services at pre-sentencing at several probation jurisdictions within the State of Illinois. DWI offenders are generally defensive, and they generally have lower levels of AOD involvement and problem behaviors compared with non-DWI judicial clients, or AOD clients not in the judicial system.

The level of defensiveness **and** the lower bound AOD problems of DWI clients result in the distributions on some scales, particularly those related to AOD use and abuse, to be positively skewed. That is, most clients will have low raw scores. For example, the *ASUDS-RI* profile in *Figure 1* indicates that, for the AOD USE BENEFITS scale, over half of the DWI clients had raw scores of zero through two. The scores pile up on the low end of the range of scores.

Thus, when interpreting an individual's raw score on these scales, the evaluator must keep in mind that the score is being compared to a group that generally reports or actually has low levels of involvement in AOD abuse or other problem behaviors.

For example, using the *DWI Offender Profile, Figure 1*, it can be noted that approximately 60 percent of the Illinois DWI normative group have a raw score of two or less on DISRUPTION1; and only 10 percent of the DWI sample has a raw score of 13 or higher. A raw score of five or less would indicate a low level reporting of disruptive symptoms associated with AOD use, yet when the profile is plotted using the DWI normative group, it presents in the high range. When the raw score of five is viewed for DISRUPTION2, which is normed on a clinical group of AOD clients, approximately 90 percent of the group have a raw score greater than five. Thus, when using standardized scores to interpret the findings, the evaluator needs to keep in mind the magnitude of the client's raw score that is used to generate the standardized score as well as the normative sample being used to interpret that score. For example, the endorsement of a "b" response for three items in DRIVING RISK amounts to a raw score of three, which seems quite low, considering some of the items in the scale, yet results in an approximate percentile score of 42 (higher than 42 percent of the DWI normative sample).

Thus, because of the positively skewed distributions of DWI populations on some scales, we often use the scale's raw score to interpret the findings. Again, as noted above, sometimes we refer to a raw score range on a particular scale as being low, yet that raw score may fall in the high-medium range with respect to the standardized score based on the Illinois DWI offender group. For example a raw score of 10 on DISRUPTION1 is considered low with respect to measuring AOD symptoms and problems for a clinical group. Yet, when the Illinois DWI normative sample is used to convert it to a standardized percentile or decile score, it falls in the high range. Both standardized and raw scores, then, are utilized in interpreting and understanding a client's profile.

Table 1
ASUDS-RI Scoring Procedures For Basic Scales

ASUDS SCALE	ITEMS IN EACH SCALE	SCORING WEIGHTS
1. ALCOHOL INVOLVEMENT	1-13	a=0,b=1,c=2,d=3
2. DRIVING RISK	14 to 25	a=0,b=1,c=2,d=3
3. AOD+ INVOLVEMENT1	26-35	a=0,b=1,c=2,d=3,e=4
4. AOD+ USE BENEFITS	1-3, 8, 13, 37-44	a=0,b=1,c=2,d=3
5. AOD+ DISRUPTION1	45-64	a=0,b=1,c=2,d=3,e=4
6. AOD+ LAST 12 MONTHS	26-35, 45-64 (12 month col.)	a=0,b=1,c=2,d=3,e=4
7. MOOD ADJUSTMENT	65-73	a=0,b=1,c=2,d=3
8. SOCIAL-LEGAL NON-CON	81-106	a=0,b=1,c=2,d=3,e=4
9. GLOBAL AOD PSYCHOSOCIAL	Sum scales: 3, 5, 7, 8	Total raw score
10. DEFENSIVE	9, 74 to 80, 84	a=3,b=2,c=1,d=0
11. MOTIVATION	107-113	a=0,b=1,c=2,d=3
12. INVOLVEMENT2*	26-35	a=0,b=1,c=2,d=3,e=4
13. DISRUPTION2*	45-64	a=0,b=1,c=2,d=3,e=4

\+ AOD = Alcohol and Other Drugs

* These scales are normed on a clinical sample of AOD clients in an intensive outpatient program or in an AOD residential treatment program

Table 2
ASUDS-RI Scoring Procedures For Supplemental Scales

ASUDS SCALE	ITEMS IN EACH SCALE	SCORING WEIGHTS
A. BEHAVIORAL DISRUPTION*	45-50	a=0,b=1,c=2,d=3, e=4
B. PSYCHPHYS DISRUPTION*	51-60	a=0,b=1,c=2,d=3,e=4
C. SOCIAL ROLE DISRUPTION*	61-64	a=0,b=1,c=2,d=3,e=4
D. SOCIAL NON-CONFORM	81-92	a=0,b=1,c=2,d=3
E. LEGAL NON-CONFORM	93-106	a=0,b=1,c=2,d=3,e=4
F. SOCIAL-LEGAL 12 MONTHS	89-106	a=0,b=1,c=2,d=3,e=4

* These scales are normed on a clinical sample of AOD clients in an intensive outpatient program or in an AOD residential treatment program

Figure 1
ASUDS-RI Profile

NAME:	DATE	AGE:	GENDER: [ ] F [ ] M	CASE NO.

ASUDS-R SUMMARY PROFILE- BASIC SCALES

SCALE NAME	RAW SCORE	Low			Low-medium			High-medium			High		
		1	2	3	4	5	6	7	8	9	10		
1. ALCOHOL INVOLVE		0	1	2	3	4	5 6	7	8 9 10	11 12 14	15 19 39		
2. DRIVING RISK		0	1	2	3	4	5	6	7 8 9	10 12 36			
3. AOD+ INVOLVEMENT1		0		1		2		3	4	5	6 9 40		
4. AOD+ USE BENEFITS		0		1		2		3	4 5	6 7 8	9 12 39		
5. AOD+ DISRUPTION1		0		1		2	3	4	5 6 7	8 9 12	13 19 80		
6. AOD+ LAST 12 MONTH		0		1		2		3	4	5 6 7	8 11 99		
7. MOOD ADJUSTMENT		0		1		2		3	4	5 6	7 9 27		
8. SOCIAL-LEGAL NON		0 1	2 3	4	5	6 7	8 9	10 11	12 13 14	15 17 19	20 26 84		
9. GLOBAL AOD-PSCHSOC		0 2 3 4	5 6 8	9 10	11 12 13	14 15 16	17 18 19	20 21 24	25 28 30	31 35 43	44 199		
10. DEFENSIVE		0 4 8 11	12 13	14	15 16	17	18	19	20	21 22	23 24 27		
11. MOTIVATION		0		1 2	3	4 5	6	7 8	9 10 11	12 13 14	15 17 21		
12.*AOD INVOLVEMENT2		1 2 3	4 5	6 7 8 9	10 11 12	13 15 16	17 18 19	20 22 23	24 25 26	27 30 32	33 36 40		
13.*AOD DISRUPTION2		0 1 3 5	6 11 15	16 21 26	27 30 34	35 38 41	42 45 47	48 50 53	54 57 59	60 63 65	66 70 80		
		1	10	20	30	40	50	60	70	80	90	99	
NORMED ON DUI GROUP (N=984)		* INPT/IOP NORMS (N=669)					PERCENTILE						

ASUDS-R SUMMARY PROFILE- SUPPLEMENTAL SCALES

SCALE NAME	RAW SCORE	Low			Low-medium			High-medium			High		
		1	2	3	4	5	6	7	8	9	10		
A.*BEHAVIORAL DISRUPT		0 1	2 3	4 5	6 7 8	9 10	11 12	13 14 15	16 17	18 19	20 21 24		
B.*PSCHOPHYS DISRUPT		0	1 2 4 6	7 9 11	12 14 15	16 17 19	20 21 23	24 25 26	27 28 30	31 32 33	34 35 40		
C.*SOCIAL ROLE DISRUPT		0	1	2 3 4	5 6 7	8 9	10 11	12 13	14	15	16		
D. SOCIAL NON-CONFORM		0	1	2	3	4	5	6	7 8	9 10	11 13 36		
E. LEGAL NON-CONFORM		0		1		2		3 4	5 6	6 8 9	10 14 48		
F. SOCIAL-LEGAL 12 MO.		0		1	2	3		4	5	6 7	8 9 48		
		1	10	20	30	40	50	60	70	80	90	99	
* INPT/IOP NORMS (N=669)							PERCENTILE						

+AOD (ALCOHOL AND OTHER DRUGS)

Authors: Kenneth W. Wanberg and David S. Timken

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DESCRIPTION OF THE *ASUDS-RI* BASIC SCALES

Each scale of the *ASUDS-RI* will be introduced and summarized to provide the most salient features of the scale. These descriptions may be used when explaining the results of the *ASUDS-RI*. Again, it is important to keep in mind that both the raw scores and the standardized scores should be used when explaining the results of a particular scale for a specific client. As noted above, a relative low raw score on DISRUPTION1 may reflect a high standardized score for a DWI normative group, but reflect a relatively low standardized score for a clinical group.

As well, it is best to interpret the meaning of a particular scale in relationship to the results on other scales, e.g., a configural approach to profile interpretation to be discussed below. For example, a low score on DISRUPTION should always be viewed in relationship to the client's score on DEFENSIVE. A low DISRUPTION and low DEFENSIVE has different meaning than low DISRUPTION and a very high DEFENSIVE SCORE.

Scale 1: ALCOHOL INVOLVEMENT

This scale has good variance. Raw scores in the first and second decile range (raw score of zero through 2) will, for many clients, indicate a high degree of defensiveness. The following will help the evaluator interpret this scale.

- Measures the extent of involvement in alcohol use, but not necessarily, alcohol abuse.
- Measures a low level of alcohol use patterns and problems, and many items can be endorsed by the average drinker with no alcohol use problems.
- It is a subtle or oblique measure of alcohol involvement that is a reliable and valid measure of the client's involvement in alcohol use, and to some extent, abuse.
- Average drinkers often have raw scores in the one to 10 range. Defensive DWI clients will resist providing affirmative responses to items that the average drinker will endorse.
- Used to determine the degree of defensiveness of a client. Includes an item that directly assesses defensiveness: "Did you ever drive an automobile knowing that you had too much to drink?"

Scale 2: DRIVING RISK

The DRIVING RISK scale represents the general risk scale of the *Driving Assessment Survey* (*DAS*: Wanberg & Timken, 1991, 2004). Most DWI offenders are quite guarded on this scale and 80 percent have raw scores of six or less. This defensiveness is based on the awareness that if one discloses driving habits that are considered to be of danger to others, they may lose the privilege of driving. It is suggested that clients be retested on this scale after they have been in intervention services for awhile, with retesting only for the purpose of giving them feedback on their change in willingness to self-disclose. Invariably, their scores will increase when there is no threat to loss of driving privileges. The following statements help the evaluator interpret this scale.

- Represents the general driving risk scale of the DAS and made up of items measuring driving risk and driving hazard.
- Clients tend to be defensive on this scale since they will perceive the endorsement of too many of these items as a threat to their driving privilege.
- Retesting on this scale will show increase of scores once treatment has begun and the client is less defensive and more open to self-disclosure.

Scale 3:INVOLVEMENT1

Around 30 to 40 percent of DWI offenders will report using substances other than alcohol. A raw score of eight or above may indicate a history of multiple-substance use. Raw scores of 12 or above are strong indications of a history of polydrug use.

- Provides a measure of the lifetime involvement in the 10 major drug categories that are described in the literature.

- Monodrug users, e.g., use only alcohol, will appear to have lower scores relative to their percentile ranking, but may in fact be very involved in their drug. For example, a monodrug user with a raw score of three, or endorsing "26 to 50 times used," will have a percentile score of approximately 69 (using the DWI normative sample). That is in the high-medium range, yet their involvement in that single drug is quite high.

- Many clients who report a history of multiple-drug use will not have had recent use of many or all of these drugs other than alcohol. Thus, the "age of last use" variable is important in understanding the client's recent use pattern.

Scale 4: AOD USE BENEFITS

Most DWI offenders have low raw scores on this scale. This is particularly true for the Illinois normative group. DWI clients are guarded with respect to reporting AOD use for purposes of enhancing positive outcomes or reducing stress or unpleasant events and emotions. Forty percent of DWI offenders will report not using alcohol or other drugs for psychosocial benefits. Yet, it is clear that most AOD users will use alcohol or other drugs to enhance pleasure or reduce unpleasant emotions and experiences. A raw score of 15 or higher would suggest psychological dependency on substances.

- Measures degree to which the client reports using alcohol or other drugs (AOD) for social and psychological benefits.

- Provides good indication whether the client is using alcohol or other drugs to manage depression, anxiety, to feel good, or to be more sociable.

- Forty to fifty percent of DWI offenders report not using alcohol or other drugs for these purposes. About 20 percent report significant AOD use for psychosocial benefits.

Scale 5: DISRUPTION1

Over 70 percent of the Illinois sample report low raw scores on this scale - raw score less five. Raw scores from 16 to 40 may indicate *Substance Abuse;* 37 to 47 suggests *Substance Dependence,* and raw scores of 48 or above strongly suggests *Substance Dependence.* These are not precise cutoff values, and some clients with raw scores lower than 16 will indicate substance abuse; and some with scores lower than 37 will indicate substance dependence.

- A broad measure of problems and negative consequences due to AOD use.

- Identified in the multivariate studies by Wanberg and associates of adult AOD users.

- Focus is on the measurement of disruptive signs and symptoms in relationship to drugs in general, and not any specific drug or drug category.

- High scores indicate AOD related loss of control over behavior, disruption of psychological and physiological functioning, and disruption of social role responsibilities, e.g., home, work, school.

Scale 6: AOD INVOLVEMENT LAST 12 MONTHS

Scores in the column "used in the past 12 months" will provide a picture of recent use and are used to score the AOD LAST 12 MONTH scale. As discussed earlier, clients answer the "last 12 months" questions based on their last 12 months in the community. However, as noted earlier, DWI offenders often enter a "shape-up" phase of change following arrest, and will stop AOD use for a short period of time. Thus, some evaluators also stipulate that the 12 month period should be prior to their DWI arrest, if that arrest was as recent as two to three months prior to their evaluation. For most clients, the 12 months in the community prior to their evaluation, which could include a couple of "shape-up" months, is acceptable.

For clients whose prosecutory process has been delayed, which could be up to one or two years, this does pose a problem with respect to getting a good recent measure of AOD use and problems if the 12 months prior to arrest guideline is used. These clients will have gone through the "shape-up" period. Thus, for these clients, evaluators may want to use the 12 month period prior to their evaluation and not add the stipulation prior to their DWI arrest.

The "prior to arrest" instruction is also relevant for clients who were incarcerated following arrest. Some may remain incarcerated up to the time that they are evaluated. Thus, for most of these clients, the "prior to arrest" guideline will incorporate the "prior to incarceration" circumstance.

A very small number of clients will have been in and out of incarceration over the last year or two, and it may be difficult for them to find a recent period in the community that comes close to 12 months. For these clients, the period does not have to be an exact 12 months.

DWI clients tend to be quite guarded against disclosing recent use. Over 80 percent of the Illinois offender sample have low raw scores on this scale (raw score less than five). Just under 70 percent have a raw score of three or less, e.g., an endorsement of a response "b" on three items, or a response "d" on one item, etc.

- Measures extent of involvement and disruption from AOD use in past 12 months.
- Variance will be low since there is a tendency to be defensive around recent use. Lifetime measures are the best predictors of relapse and future problems from AOD use, mainly because of the increased variance of lifetime measures (versus much lower variance of 12 month measures).

Scale 7: MOOD DISRUPTION - PSYCHOLOGICAL PROBLEMS

Most DWI offenders will indicate having minimal if any mood adjustment or mental health problems. About 20 percent will report significant to serious psychological problems. Raw scores of 9 to 13 suggests that the client may need further mental health assessment.

- Measures a single dimension of psychological and emotional adjustment issues.
- High score indicates depression, worry, anxiety, irritability, anger, feelings of not wanting to live, and being unable to control emotions and acting out behavior.
- Because of the reluctance on the part of DWI offenders to endorse items that indicate mood or psychological problems at initial evaluation, it is suggested that those clients who are suspected of having mood or psychological adjustment problems be retested on this scale or on a scale comparable to MOOD DISRUPTION. An effective DWI education and treatment program will have clients engage in self-evaluation of psychosocial issues and problems during program involvement.
- Correlations of this scale with external criterion measures indicate that it has good sensitivity to identifying individuals with mood adjustment problems who are open to self-disclosure.

Scale 8: SOCIAL-LEGAL NON-CONFORMING

This is a broad measure of rebellious, antisocial behavior and attitudes, and involvement in antilegal or criminal conduct. These two areas are broken out into two supplemental scales: SOCIAL NON-CONFORMING; and LEGAL NON-CONFORMING, discussed below. SOCIAL-LEGAL NON-CONFORMING has several important features.

- Has both static and dynamic items. The dynamic items measuring aggressive behavior and rebellious attitudes and association with antisocial peers and friends. An example of a dynamic variable is item 101: "spend time with persons who have been in trouble with the law." Static items measure prior involvement in antilegal and criminal conduct, either in youth or adulthood.

- Not to be construed as a measure of an antisocial personality disorder per se, but does represent the antisocial personality pattern.

- Scores in the decile range of eight or higher indicate antisocial patterns and character pathology, but also indicates openness to self-disclosure and low defensiveness.

- Item 84, "I have been charged with driving under the influence of alcohol or other drugs," provides a check for overall *ASUDS-RI* response veracity.

Scale 9: GLOBAL AOD-PSYCHOSOCIAL

An effective way to determine the overall or global problems or disruption of a client is to look at all of the salient psychosocial areas that are part of problem behavior. These include AOD involvement and disruption, social and legal non-conforming problems and behaviors, and mental health problems.

- GLOBAL is comprised of the sum of the four scales: INVOLVEMENT, DISRUPTION, SOCIAL-LEGAL NON-CONFORMING, and MOOD.

- Provides a global and overall measure of the degree to which the client is indicating life-functioning AOD and psychosocial problems.

Scale 10: DEFENSIVE

DWI offenders are defensive and guarded around self-disclosure of problem attitudes and behaviors (Cavaiola & Wuth, 2002; Wanberg, Milkman & Timken, 2005). From two to five percent report that they have never knowingly driven while impaired and have never been cited for DWI. A 9th and 10th decile normative score is seen as very defensive, and clients in this range may be having difficulty openly reporting AOD or other life-adjustment problems that are good estimates of the their "true" condition. Scores in the 2nd to 6th decile range are most desirable. Scores in the 7th to 8th decile range are acceptable. Very low defensiveness, e.g., zero to one raw score, may indicate any number of possibilities, including difficulty in setting limits on self-disclosure, setting appropriate social-behavioral boundaries, a "cry for help," or a genuine degree of honesty and openness.

- Provides a measure of the degree to which the client is able to divulge personal and sensitive information on the *ASUDS-RI*.

- Comprised of statements to which almost all individuals can give a yes answer, even though it may be at a "Hardly at all" level of response. Almost every individual has gotten angry, felt unhappy, not told the truth, felt frustrated about the job and not told others what he or she was feeling inside.

- Also represents a measure of social desirability.

Scale 11: MOTIVATION

The score ranges on this scale can be used to identify the relative stages of change a client might be in, using Prochaska and associates (DiClemente, 2003; Prochaska, 1999; Prochaska & DiClemente, 1992) contemplative-preparation-action-maintenance stages of change; or Wanberg and Milkman's (1998, 2008; Wanberg, Milkman & Timken, 2005) challenge-commitment-ownership stages of change. Scores in the low normative range would indicate the contemplative or challenge stages. Low-medium to high-medium standard score ranges would indicate the preparation and action or commitment stages of change. And, those in the high range would indicate the action and maintenance or the commitment-ownership stages.

It is important to note, that retesting these clients after being in intervention services for six months will indicate a decrease in scores. That is because clients who have had education and treatment services will report a lower need for and willingness to be involved in these services.

- A reliable measure of the degree to which the client is motivated to seek help to make life changes, to seek help for AOD problems and to stop or to continue to not use alcohol or other drugs.

- A low score on MOTIVATION, DEFENSIVE and DISRUPTION may simply indicate the client's AOD use and problems are truly in the low range and that a high level of treatment services are not needed. This kind of profile should be corroborated with collateral data.

Scales 12 and 13: INVOLVEMENT2 and DISRUPTION2

Several large clinical samples, clients who were in intensive outpatient or residential care, were administered the *ASUDS-RI* DISRUPTION AND INVOLVEMENT scales. This provides a basis upon which to compare a DWI client's raw score on these two scales with a sample of DWI peers and a clinical sample.

- Items in these two scales are the same as in INVOLVEMENT1 and DISRUPTION1.

- INVOLVEMENT2 and DISRUPTION2 are normed on a sample of clients treated in public intensive outpatient or residential care facilities for alcohol and other drug abuse.

- Provides the evaluator with an option of comparing the client's raw score with a DWI normative group and with a group that evinces relatively severe AOD abuse problems.

DESCRIPTION OF THE *ASUDS-RI* SUPPLEMENTAL SCALES

Six supplemental scales have been developed to provide a more in-depth differential screening for DWI offenders. *Scales A through C* are subscales of the items in the DISRUPTION scale. Those 21 items have been subjected to factor analytic procedures across several samples to determine if there are reliable DISRUPTION common factors. Three such factors have been found (Horn & Wanberg, 1969; Horn, Wanberg & Foster, 1990; Wanberg, 1992; Wanberg, 2004). These scales can be utilized in determining a client's specific types of AOD disruptive syndromes. The scales are normed on the clinical sample used to norm DISRUPTION2.

Scales D and E provide a differential measurement of *Scale 8*, the SOCIAL-LEGAL NON-CONFORMING measure. *Scale F* provides a 12 month measure on the items in the SOCIAL-LEGAL NON-CONFORMING scale. Each of these scales will be discussed.

Scale A: BEHAVIORAL CONTROL DISRUPTION

This scale was derived from a reliable common factor in the DISRUPTION scale. It is important to remember that this scale is normed on a clinical sample of AOD clients in intensive outpatient care or inpatient residential care.

- This scale measures behavioral control-loss and disruptions under AOD influence, e.g., passing out, stumbling and staggering under influence, getting physically violent, making a suicide attempt and loss of control of the amount or quantity of use, e.g., blackouts, getting physically sick.

- This is an important scale in that individuals with high scores (decile range of 8 through 10) may be at risk of harm to self or others when intoxicated or under AOD influence. Such individuals should be carefully informed of this risk when they are under AOD influence and that for this kind of pattern, total abstinence from drug use is recommended. Such individuals tend to be periodic or binge drinkers or drug users. Even moderate ranged scores (raw score of nine through 15) may portend problems in loss of control over behavior when under AOD influence.

Scale B: PSYCHOPHYSICAL DISRUPTION

This scale was also derived from a reliable common factor in the DISRUPTION scale. It is normed on a clinical sample of AOD clients in intensive outpatient care or inpatient residential care.

- Measures degree to which clients have experienced psychophysical symptoms associated with AOD intoxication or withdrawal. High scores (decile range of seven or higher) suggest high risk for occurrence of these symptoms with future use.

- This syndrome can be life-threatening. High scores indicate past substance dependence and portend the need for medical management in cases where future excessive and protracted drinking or other drug use episodes might occur. Clients with high scores should be informed of this risk.

- Scores in the 5th or 6th decile range or higher could indicate past substance dependence and portend future significant psychophysical problems related to the direct or withdrawal effects of AOD use where future AOD use episodes might occur.

Scale C: SOCIAL ROLE DISRUPTION

This is the third scale derived from a common factoring of the items in the DISRUPTION scale. It is normed on a clinical sample of AOD clients in intensive outpatient care or inpatient residential care. It is a narrow but reliable scale.

- This scale indicates the degree to which an individual's AOD use has disrupted normal and expected social roles, e.g., job, obeying the law, family and financial responsibilities.

- High scores on this scale can be associated with depression and discouragement and suggest a need for life-management skills training in the areas of employment and family.

Scale D: SOCIAL NON-CONFORMING

This scale, normed on the Illinois DWI sample, represents a rather general measure of antisocial attitudes and behaviors. Individuals with significant to high antisocial characteristics are often seen as **not** amenable to intervention and treatment. Yet cognitive-behavioral approaches within a structured format and integrating sanctioning with the therapeutic approach, can be very effective with many antisocial clients. Also, individuals with high scores on this scale will be open and self-disclosing, features that are well correlated with a positive treatment response. Thus, this scale represents a two-edged sword. High scores indicate amenability to treatment; yet high scores will also indicate antisocial patterns and character pathology which are often resistant to treatment involvement and change.

- Is a measure of past and current rebellious and even antisocial behavior and attitudes.

- Has static items measuring involvement in anti-legal behavior, both in adolescence and adulthood, behavioral acting out in adolescence.

- Also has dynamic items measuring aggressive behavior and rebellious attitudes. Has both static and dynamic items.

- Represents antisocial personality features, but not necessarily the antisocial personality disorder as measured by the DSM-IV (American Psychological Association, 1994, 2000).

Scale E: LEGAL NON-CONFORMING

Being antisocial does not necessarily mean the person engages in criminal conduct. There are antisocial non-criminal patterns. But, some antisocial patterns involve criminal conduct. This scale, normed on the Illinois DWI sample, provides a reliable measure of involvement in criminal thinking, criminal associates and criminal conduct. Most DWI offenders will have low scores on this scale. For example, 50 percent of the Illinois DWI sample have a score of zero or one on this scale. The utility of this scale is that of identifying DWI offenders who have a noteworthy to significant history of legal non-conforming behavior. Raw scores of six to eight would suggest a noteworthy antilegal history. Raw scores of nine or above (10th decile range) would suggest significant history of antilegal involvement. A high score on *Scale 8*, SOCIAL NON-CONFORMING and a high score on *Scale 9* will be indicating significant problems and history of both antisocial and antilegal problems.

- Provides a measure of the history of involvement in the adult criminal justice system: history of arrests, convictions, time on probation and parole and time spent in jail or prison.

- About 70% will have a low raw score on this scale (four or less). A few clients will score in the high range. Tenth decile scores on both *Scales D and E* would indicate significant problems and history of both antisocial and antilegal problems and may suggest a lifestyle pattern of social-legal non-conformity.

- The items on this scale are mainly static variables, measuring a history of antilegal involvement in contrast to the SOCIAL-NON-CONFORMING scale which has a number of dynamic variables.

Scale F: SOCIAL-LEGAL NON-CONFORMING 12 MONTHS

As discussed earlier, special instructions are given for these questions. In summary: clients are asked to answer the "last 12 months" legal items 89 through 99 and 104 through 106 in relationship to the last 12 months they have been in the community; for questions 100 through 102, which measures legal status, they should use the last 12 months prior to evaluation, whether or not whey were in the community.

- Measures recent legal problems.

- Over 70 percent of Illinois sample of DWI offenders will score very low on this scale (raw score of four or less). Raw scores above five would suggest the client has had noteworthy if not significant involvement in social-legal non-conformity in the 12 months prior to their evaluation.

- Only 10 percent of the Illinois DWI sample have a raw score of eight or more. Clients with scores in the 10th decile range on *Scales D through F* may indicate a lifestyle pattern of social-legal non-conformity.

UTILIZATION OF INVOLVEMENT2 AND DISRUPTION2

As noted above, these scales are normed on a clinical sample comprised of inpatient and intensive outpatient AOD clients. These scales are best used for clients with scores in the medium-high range on DISRUPTION1

and INVOLVEMENT1, since it will give the evaluator a good idea how the client compares with a clinical sample. Here are some examples.

- A client with raw score of six on INVOLVEMENT1 has a standardized percentile score of approximately 90 when compared with the pre-sentenced Illinois DWI normative group; and, has a percentile score of 25 when compared with the clinical group.

- A client with a raw score of 12 on DISRUPTION1 will have an approximate percentile score of 89 when compared with the DWI sample, and an approximate percentile score of 17 when compared with the clinical sample.

For clients with raw scores of 4 or more on INVOLVEMENT1 and a raw score of 6 or more on DISRUPTION1, the evaluator will want to use the INVOLVEMENT2 and DISRUPTION2 profiles in order to get a good clinical picture of the client's AOD involvement and disruption.

UTILIZATION OF THE *ASUDS-RI* SCALES IN ASSESSING SERVICE NEEDS

The information provided below is based on both standardized and raw scores of the *ASUDS-RI* scales. This information should be used only as guidelines in helping evaluators discern levels of severity and service recommendations. They are never used alone to make final decisions as to treatment referral or intervention and treatment recommendations. Final assessment and referral decisions are made by the evaluator who uses all sources of information including self-report and other-report data. *Table 3* provides a summary of the key areas discussed below.

Assessing Defensiveness and Report Veracity

Once the testing is complete and all of the collateral information reviewed, the first step is to determine the degree of defensiveness of the client and veracity of the client's individual report. The level of defensiveness will provide an idea of where to start treatment and the referral needs of the client. A highly defensive client will probably need a motivational enhancement program so as to increase the probability of a positive response to education and treatment. As well, the degree of defensiveness will tell us how confident we are in making judgements about how the self-report reflects the actual or "true" condition of the client. Here are some guidelines in discerning defensiveness and report veridicality.

First, in discerning the client's level of defensiveness and the veridicality of the client's *ASUDS-RI* self-report in estimating the "true" condition of the client, we use the convergent validation model and compare the other-report data with the results of the *ASUDS-RI* scales, particularly INVOLVEMENT1 and DISRUPTION1. If the record indicates the client has had several DWI arrests or convictions, "possession" charges, or other AOD related convictions, and the client's scores are low or "zero" on INVOLVEMENT1 and DISRUPTION1, we can suspect there is a high level of defensiveness and that the client's self-report is not a good representation of the client's "true" AOD use history. However, it is a valid representation of where the client is at the point of testing and the client's willingness to self-disclosure around AOD use.

Second, we then use the DEFENSIVE scale to discern level of defensiveness. Clients who fall in the sixth to eighth decile range are indicating moderate levels of defensiveness against self-disclosure. A person in the ninth and 10th decile range is being very defensive and most likely, is not giving a self-report that is veridical to the client's "true" condition. A person with a raw score of 27 (answer's "no" to all of the items in DEFENSIVE) is extremely defensive or may not be in touch with some of his or her own emotions and thoughts. It could also mean that the client is answering "no" to all of the *ASUDS-RI* items. This can be verified through a visual scan of the test. The first row in *Table 3* provides score ranges and indications for extreme defensiveness based on the DEFENSIVE scale.

Third, in addition to the DEFENSIVE scale, *ASUDS-RI* item data can be used to determine level of defensiveness. The response veracity and veridical representation of the client's "true" condition should

be seriously questioned for DWI clients who answer "no" to question 9, "did you ever drive an automobile knowing that you had too much to drink?" and "never" to question 86, "have been charged with driving under the influence of alcohol or other drugs."

When there is concern about issues of the veracity and veridicality of the client's self-report based on the above sources of information, or based on what appears to be a slap-dash or random responding to the test, the client should be given information about these findings and therapeutic counseling skills should be used in confronting the matter. If, indeed, there is evidence of AOD problems in the client's life that the client is unable, for whatever reason, to disclose, it is recommended that the client be placed in a motivational enhancement group so as develop rapport and trust with the client and to enhance openness and self-disclosure and subsequently, self-awareness.

Assessing Mood Adjustment and Mental Health Issues

The second row of *Table 3* provides guidelines in assessing mental health and mood adjustment concerns. A MOOD raw score of nine to 13 would suggest a need for a referral for a mental health evaluation. Scores greater than 13 is stronger indication of this need. Certainly, some clients will score low to moderate (raw score of less than nine) on MOOD, and yet have either past or current mood and psychological adjustment problems. Again, collateral information as well as interview data are extremely important in determining the clients need for a mental health evaluation or services.

A score of "b" on item 70 indicates the client has had some thoughts of self-harm or suicide. Scores of "c" or "d" would clearly raise concern and indicate a need for a mental health assessment. Also, scores of "b" or above on item 49 would trigger consideration for a mental health referral.

Motivational Enhancement Needs

Row 3 of *Table 3* provides guidelines for enhancing motivational enhancement services. High DEFENSIVE and low MOTIVATION scores along with low or zero scores on ALCOHOL INVOLVEMENT, DRIVING RISK, AOD DISRUPTION and INVOLVEMENT would suggest a need for a motivational enhancement approach. When this type of profile is added to collateral data indicating prior DWIs or a high arrest BAC or collateral reports of AOD problems, strong defensiveness against self-disclosure and resistance to the change process and treatment are indicated.

Inclusion Into AOD Problem Category

Determining whether clients have had a history of AOD use problems is a broader question than discerning whether they fall in the *Substance Abuse* or *Substance Dependence* diagnostic classification of the DSM IV (American Psychiatric Association, 1994, 2000). The INVOLVEMENT and DISRUPTION scales can provide some guidelines in this area. Row four of *Table 3* provides a summary of these guidelines.

Monodrug users with a raw score of three or four on INVOLVEMENT, or persons with a history of multiple substances with a score in the range of six to eight would indicate a history of AOD involvement indicating need for AOD education and treatment. Scores in this range or above for persons with drug-related offenses point to even more of a concern with respect to the degree of AOD involvement.

DISRUPTION scores of four to seven indicates noteworthy reporting of AOD problems and indicates a need for AOD education and possibly treatment. DISRUPTION raw scores 8 to 15 indicates a self-report of significant negative consequences, puts the person into the problem use range, and indicates need for treatment. DISRUPTION scores 16 or greater puts the person at greater risk for substance abuse and substance dependence problems and a clear need for AOD treatment.

Using both the INVOLVEMENT and DISRUPTION scales provide a better picture of whether the person has AOD use problems. Using the clinical normative sample, an INVOLVEMENT2 score in the third decile and

a DISRUPTION2 score in the third decile range or above clearly puts the person in the AOD problem-use range and need for AOD education and basic AOD treatment.

Using several *ASUDS-RI* scales in a configural analysis is also an effective method to assess level of severity and treatment needs. The configural analysis approach is discussed below.

The above raw score and standard score ranges on INVOLVEMENT and DISRUPTION are only guidelines. Some DWI clients will have very low scores (e.g., raw score of two or three), either due to defensiveness in self-disclosure or other circumstances not indicated on the *ASUDS-RI*, yet need to have treatment services, . Furthermore, it is a standard guideline in the field of AOD intervention that any individual who is in the judicial system because of impaired driving must have a basic AOD education program. Some will argue that such involvement will also trigger a definite need for treatment.

Guidelines indicating Substance Abuse and Substance Dependence

Table 3, row 5, provides some guidelines for using the DISRUPTION raw score in discerning possible *Substance Abuse* (SA) and *Substance Dependence* (SD), as defined by the DSM-IV Revised (American Psychiatric Association, 1994, 2000). The authors have done several studies comparing the DISRUPTION scale with external criterion ratings of SA or SD. These results indicate that DISRUPTION raw scores in the range of 22 to 36 indicate SA. Raw scores from 37 to around 47 is stronger indication of SA and possible SD. Scores higher than 47 on DISRUPTION is a stronger indication of SD. Scores of 60 or above provide very strong indication of SD.

These DISRUPTION raw scores are used only as guidelines to indicate possible SA or SD. **The cutoff guidelines are conservative and minimizes the risk of a false positive but increases the risk of a false negative.** Some if not many DWI clients will be diagnosed by clinicians as having *Substance Abuse* or *Substance Dependence* and have raw scores on DISRUPTION below the above identified cutoff ranges.

Scores on a psychometric instrument are only used as guidelines for making placement and service recommendations. As has been stressed in this *User's Guide*, an instrument never makes a final diagnostic decision or referral recommendation. Those determinations are only made by the evaluator.

Guidelines for Determining Need for Enhanced Treatment

Row 6 of *Table 3* provides some guidelines for suggesting a need for enhanced treatment services. Enhanced services include: enhanced outpatient (3 to 8 hours a week); intensive outpatient (9 or more hours a week); intensive residential treatment (IRT); and therapeutic community (TC). The evaluator is encouraged to use the American Society of Addiction Medicine (ASAM: 2001) for guidelines regarding referral for treatment level evaluation.

Table 4 provides rationale guidelines for determining what kind of enhanced treatment might be appropriate for the client. The evaluator checks those items that apply to the client. The nature of those items checked and the number of checks would indicate that the client might need an enhancement of treatment support and intensity.

Determining Service Needs for Clients AOD-Free for a Protracted Period of Time

How do we determine service needs for clients who have high-medium to high scores on INVOLVEMENT and DISRUPTION and who have been AOD-free for the past year or two or more? If there is evidence that such clients are stable in their abstinence, and relapse is unlikely, then it is suggested that they not be referred to the same treatment that would be appropriate for clients with the same scores but who have not had a significant period of abstinence. However, lifetime measures are better predictors of future AOD problems, than say last six or 12 month measures, since they have greater measurement variance and higher correlations with criterion variables that measure AOD abuse problems.

Table 3
Assessing Specific Needs

ASSESSMENT AREAS	SCORE RANGES AND INDICATIONS
Extreme defensiveness	• 23-27 on DEFENSIVENESS • DEFENSIVENESS in 9th or 10th Decile range indicates that DISRUPTION and INVOLVEMENT may be under-reported • Scores of zero to 2 on ALCOHOL INVOLVEMENT; zero ("a") response on items 9 and 84
Mood adjustment and mental health problems	• MOOD of 9-13: consider mental health evaluation • MOOD score > 13: strongly recommend mental health evaluation • MOOD scores greater than 20 increases the strength of this recommendation • Scores of "b" or above on item 49; and "c" or above on item 70 trigger further mental health assessment
Motivational enhancement services and group	• High defensiveness and low scores on AOD use scales suggest need for motivational enhancement group • Very low or zero scores on ALCOHOL INVOLVEMENT, DRIVING RISK, AOD INVOLVEMENT, and AOD DISRUPTION with other-report data indicting more than one DWI arrest, high BAC at arrest, and other reports of AOD problems
Inclusion into AOD problem category	• INVOLVEMENT score of 3 or 4 for monodrug and 6 to 8 for multiple substance users suggest a need for AOD education and treatment • DISRUPTION scores in range of 4 to 7 indicate AOD problems and need for AOD education modality and possibly treatment • DISRUPTION scores 8 to 15 indicate a self-report of significant negative consequences, puts the person into the problem use range, and indicates need for treatment • DISRUPTION scores 16 or greater puts the person at greater risk for substance abuse problems and higher need for AOD treatment. • Using the clinical normative sample, an INVOLVEMENT2 score and DISRUPTION2 score in the third decile range clearly puts the person in the AOD problem-use range and need for treatment.
Substance Abuse and Substance Dependence Disorder	• DISRUPTION raw score range 22-36: indicates Substance Abuse • DISRUPTION raw score range 37-47: strong indication of Substance Abuse and some indication of Substance Dependence • DISRUPTION raw score 48 or higher: much stronger indication of Substance Dependence • DISRUPTION scores of 60 or above is very strong indication of Substance Dependence Disorder
Need of enhanced treatment for AOD abuse and dependence	• Look for biomarkers as defined by American Society of Addiction Medicine (ASAM, 2001) • Decile scores of 8-10 on AOD INVOLVEMENT2 and AOD DISRUPTION2 (clinical norms) are strong markers for more intensive outpatient treatment or residential structured care

Table 4
Rationale for Supporting Enhanced Treatment Services

RATIONALE	CHECK	RATIONALE	CHECK
High risk relapse/recidivism		Homeless/poor living conditions	
Prior criminal behavior		Minimal family/peer support	
Serious antisocial behavior		Family/peers are antisocial	
Prior probation/parole		Family/peers into AOD abuse	
Prior AOD offense		Danger to self or others	
Prior AOD education/treatment		Need structured care	
Severe AOD problem		Failed to complete treatment	
Low motivation to change		Poor socialization	
Serious medical problems		Risk of victimization	
Serious psych/behavior problems		Lack of impulse control	

Individuals with a period of abstinence and who have high INVOLVEMENT and DISRUPTION scores are at greater risk for relapse than persons who have the same period of abstinence and who have low lifetime scores on these scales. Thus, for protective and preventive purposes, clients with medium to high INVOLVEMENT and DISRUPTIVE scores would need more supportive and preventive services. Again, the evaluator uses all sources of information in making referral decisions for these special cases.

Guidelines for Determining Level of AOD Severity and Service Referral

There are several ways that the severity level and treatment needs of clients can be assessed.

Individual Scale Interpretation

The scores on individual scales can be assessed to determine the degree of severity and level of treatment need. We have provided some guidelines in the discussion of the individual scales above.

Configural Analysis

Another method for using the *ASUDS-RI* scales for assessing level of severity and treatment need is the configural analysis approach. For example, a client with low scores on DEFENSIVE, DISRUPTION1, INVOLVEMENT1 and MOTIVATION may in fact be low in AOD problems. Conversely, a client low on MOTIVATION, high on DEFENSIVE, low on DISRUPTION1 and moderate on ANTISOCIAL may in fact have a significant AOD use pattern but is resisting disclosure of such a pattern. A client with a high DISRUPTION1 and MOOD ADJUSTMENT, low to moderate DEFENSIVE, moderate to high MOTIVATION and low to moderate ANTISOCIAL may be a good candidate for more intensive treatment and is, in fact, stating that as a need.

Combined Weighted Scores of ASUDS-RI Scales

Another approach to assessing severity and services needs is to generate a weighted score from the *ASUDS-RI* scales that measure problem behavior related to DWI conduct. The following *ASUDS-RI* scales are selected in this model: ALCOHOL INVOLVEMENT, DRIVING RISK, INVOLVEMENT1, and DISRUPTION1.

As well, *ASUDS-RI* variable 84, "I have been charged with driving while impaired or under the influence of alcohol or other drugs" was also factored into the weighted score. This variable factors in the self-report of having been charged with impaired driving or driving under the influence of alcohol or other drugs. For the Illinois sample (N=984), about 30 percent reported never being charged with impaired driving; about 65 percent reported being charged 1 to 2 times; and 4.8 percent reported being charged three or more times.

Table 5 provides the raw scale score range and the corresponding weighted score for these four scales and variable 84. *Table 6* provides a suggested service guideline table that indicates, based on the weighted scores, the client might benefit from and be appropriate for the identified services.

The services described in *Table 6* are patterned closely after the Illinois Uniform Reporting placement categories developed by the Illinois Department of Human Services, Office of Alcoholism and Substance Abuse. They are also in line with commonly designated service placements for impaired driving offenders (see Wanberg, Milkman & Timken, 2005).

As has been stressed in this *Guide*, the suggested intervention benefits provided in *Table 6* are to be used only as guidelines. **Referral decisions are never made solely on the results or weighted score based on the scales of the *ASUDS-RI* or any other psychometric instrument survey.**

Using the ASUDS-RI Guidelines in Conjunction with the Illinois Standardized Assessment Model

The Illinois Department of Human Services has generated a standardized assessment model for determining placement based on: arrest BAC; prior DUI disposition; prior statutory DUI; prior AOD treatment; and diagnosis of Substance Abuse or a diagnosis of Substance Dependence based on the DSM-IV diagnostic criteria. *Table 7* provides a description of these service categories. The *ASUDS-RI* weighted scoring guidelines described in *Tables 5* and *6* can be used in conjunction with the formal and standardized model used by the Illinois Department of Human Services in Table 7.

Evaluating for Special Service Needs

Evaluators should also discern services that clients might need other than AOD/DWI education or treatment. Evaluators should have knowledge of services DWI clients often need and knowledge of where these services can be accessed. *Table 8* provides a list of some of the most common of these services. This table can be used as a checklist by the evaluator in completing the assessment process.

AUTOMATED ASUDS-RI

The Automated *ASUDS-RI* provides the evaluator with two options for administration: Client self-administration; and evaluator input of data from the paper-pencil form completed by the client. Administration time for the client is the same. The automated *ASUDS-RI* provides an **automated profile printout** of the *ASUDS-RI DWI Offender Profile*.

The automated *ASUDS-RI* provides a summary of client personal data information such as gender, age, ethnicity, BAC at arrest, prior DWI convictions, and prior DWI education and treatment. It also provides a summary of the extent of lifetime use of drugs in the 10 drug categories, age of last use of drugs in these categories, and times used during the last 12 months in the community.

The automated version also gives a list of the **critical items** endorsed by clients, such as: Item 49, "tried to take your own life 1-3 times during AOD use or AOD withdrawal"; Item 46, "became physically violent as a result of AOD use", etc. It also provides a **summary Assessment** based on the *ASUDS-RI* profile and endorsement of specific items. Example: "Indicates history of multiple substance use." Finally, it provides four possible **levels of suggested service level benefits** or guidelines based on the weighted scores in *Table 5* and the guideline descriptions in *Table 6*.

Table 5
Converting *ASUDS-RI* Scale Raw Scores to Weighted Scores

ASUDS-RI SCALE	SCALE SCORE RANGE	WEIGHTED SCORE
ALCOHOL INVOLVE	0	0
ALCOHOL INVOLVE	1 - 4	1
ALCOHOL INVOLVE	5 - 9	2
ALCOHOL INVOLVE	10 - 13	3
ALCOHOL INVOLVE	14 - 39	4
DRIVING RISK	0	0
DRIVING RISK	1 - 4	1
DRIVING RISK	5 - 10	2
DRIVING RISK	11 - 18	3
DRIVING RISK	19 - 36	4
INVOLVEMENT	0	0
INVOLVEMENT	1 - 4	1
INVOLVEMENT	5 - 9	2
INVOLVEMENT	10 - 20	3
INVOLVEMENT	21 - 40	4
DISRUPTION	0	0
DISRUPTION	1 - 4	1
DISRUPTION	5 - 11	2
DISRUPTION	12 - 20	3
DISRUPTION	21 - 80	4
ASUDS-RI VAR 84*	0	0
ASUDS-RI VAR 84	1	1
ASUDS-RI VAR 84	2	2
ASUDS-RI VAR 84	3	3

* Based on scoring Variable 84 as: a=0, b=1, c=2 and d=3

Table 6
Suggested Interventions DWI Offenders Might Benefit From Based on Weighted Scores in Table 5

Level	Suggested Service	Weighted
1	AOD/DWI Basic Education (10-12 hours)	0 - 4
2	AOD/DWI Basic Education (10-12 hours) plus short-term (10-15 hours) of Intervention Services	5 - 6
3	AOD/DWI Basic Education plus regular OP AOD treatment (minimum 20 hours)	7 - 10
4	Extended and enhanced AOD treatment with continuing care (could include intensive outpatient, residential care)	11 - 18

Table 7
Illinois Uniform Reporting Placement Categories Developed By the Illinois Department of Human Services, Office of Alcoholism and Substance Abuse.

Service Level	Description of Intervention Services
1	Minimal Risk: Completion of a minimum of 10 hours of DUI Risk Education
2	Moderate Risk: Completion of minimum 10 hours DUI Risk Education and minimum of 12 hours early intervention and active participation in continuing care plan after discharge
3	Significant Risk: Minimum 10 hours DUI Risk Education and minimum 20 hours substance abuse treatment and active participation in continuing care plan after discharge
4	High Risk: Minimum 75 hours substance abuse treatment and after discharge, active participation in continuing care plan

Table 8
Checklist for Recommending Specialized Services

Description of Specific Treatment Services	Recommend
1. Motivational enhancement group due to defensiveness of client	
2. Driving risk and AOD education	
3. Standard outpatient AOD treatment	
4. More intense outpatient treatment/	
5. Structured treatment, e.g., residential care	
6. Enhanced relapse prevention services	
7. Mental health evaluation referral	
8. Offender and antisocial enhanced treatment	
9. Family and/or marital counseling and services	
11. Healthy life-style counseling	

ASUDS-RI NORMATIVE GROUP

The normative sample for the Illinois version of the *ASUDS-R* is comprised of 984 DWI offenders being processed through selected county jurisdictions in the State of Illinois and tested at pre-sentencing. *Table 9* provides a summary of demographic, descriptive and AOD related variables for this sample. The average age is 31.58 (standard deviation of 10.78).

Table 9
Descriptive and Demographic Summary of the Illinois Normative Sample: N = 984 Unless Otherwise Specified in Legend Below

VARIABLE	PERCENT	VARIABLE	PERCENT	VARIABLE	PERCENT
Male	73.1	Never mar.	63.1	No Income*	9.7
Female	29.9	Married	17.2	1K-10K	12.7
Age 17-20	10.3	Remarried	.5	10.1K-25K	26.2
Age 21-30	45.4	Separated	3.6	25.1K-40K	19.9
Age 31-40	21.1	Divorced	15.0	40.1K-80K	20.9
Age 41-50	16.5	Widowed	.7	> 80K	10.6
Age 51 +	6.7	Em. full X	69.7	BAC 0-04**	6.3
African-Am	8.4	Em. part X	10.0	BAC 05-10	14.3
Anglo	78.4	Unemployed	15.0	BAC 11-15	39.6
Hispanic	9.0	Student	4.1	BAC 16-20	28.6
Native Am	1.6	Retired	.6	BAC 21-25	8.8
Asian Am	2.6	Other	.6	BAC > 25	2.5
No SA Dx	73.0	No Pri DUI	78.2	REF. BAC	34.3
SA Dx	27.0	Pri DUI	21.8	ILLINOIS CLASSIFICATION+	
No SD Dx	86.2	No Pri Tx	75.9	Min. risk	22.2
SD Dx	13.8	Prior Tx	24.1	Mod. risk	29.4
No Pr. Rec	99.1	No Ot. Pri	79.5	Sig. risk	33.4
Prior Rec	.9	Other Pri	20.5	High risk	15.0

SA Dx= Substance Abuse Diagnosis; SD Dx=Substance Dependence Diagnosis
No Pr. Rec = no prior reckless driving conviction reduced from DUI
Em. full X = employed full time; Em. part X = employed part time
No Pri DUI = No prior DUI; Pri DUI = prior DUI
No Pri Tx = no prior treatment; Prior Tx = prior treatment
No Ot. Pri = No other prior alcohol or other drug related driving convictions
* Income: K = $1,000
** BAC at time of arrest; percent based on N=651 who submitted to BAC testing
\+ Min. = minimum; Mod. = moderate; Sig. = significant

ASUDS-RI CONSTRUCT VALIDITY

Construct validity "refers to all the evidence, and sound theory derived from evidence, that can be brought to bear in the interpretation of the measurements of a scale" (Horn, Wanberg, & Foster, 1990, p. 30). Cronbach (1986) sees all evidence pertaining to validity as parts of construct validity, which includes all forms of validity as traditionally described - criterion, predictive, content, concurrent, relevancy validity.

Thus, construct validation involves all information that renders understanding to the meaning, value and purpose of the test or the scales of a test. This includes all of the psychometric properties of the test that support expected measurement: internal consistency and test-retest reliability; raw score distributions and skew; and correlations among the scales within a test.

Construct validity also includes support of hypotheses around what the test is supposed to measure. For example, the validity of the construct DISRUPTION is demonstrated if it has a significant correlation with an external criterion that also measures AOD negative consequences and disruptive symptoms. If it is expected that one sample will have higher scores on certain scales than another sample because of inherent differences between the two samples, significant mean scores differences in the expected directions is evidence of construct validity, e.g., individuals with prior DWIs have higher scores on the ASUDS-RI scales than those with no prior DWIs.

Although there is a tendency to separate reliability from validity, it is more helpful to see reliability as one component of construct validity. Historically, reliability is often seen as separate from validity because we can have numerical indexes for assessing reliability and there are no such indexes for validity (Bowers & Courtright, 1984, p. 118). Ghiselli noted some time ago, "...construct validity is determined and evaluated by a subjective process of judgment; and the degree of validity cannot be expressed by any single quantitative index such as a validity coefficient but must be given in verbal terms" (1964, p. 350).

However, if we say that validity is the ability of a test to measure what we want it to measure and that it involves all information that renders understanding to the meaning, value and purpose of the test or scale, then reliability (whether it is internal consistency or test-retest) is an essential component of that information. It certainly renders value to the test.

Thus, different components of construct validity can be given a coefficient, e.g., internal consistency reliability, skew coefficients, correlations among variables, that help to make judgments about the construct validity of a test or scale. Therefore, in evaluating the construct validity of various scales and tests, we use numerical indexes.

This *User's Guide* also uses the idea of consistency validation (or measurement invariance) in evaluating the construct validity of the *ASUDS-R* and *ASUDS-RI* scales. Consistency validation refers to whether the findings or results are consistent or stable across different cohort groups or samples. Is a non-significant correlation of an *ASUDS-R* scale with an specific external variable consistently found across different samples or cohort groups? Consistency validation can be applied to different types of construct validation, e.g, predictive, concurrent, criterion, relevancy.

Numerous construct validity studies have been conducted on the *ASUDS-RI* scales, which are reported in the User's Guides for the following instruments: *Adult Substance Use Survey (ASUS*: Wanberg, 1997); the *Adult Substance Use Survey-Revised (ASUS-R:* Wanberg, 2006); and the *Adult Substance Use and Driving Survey* (*ASUDS*: Wanberg & Timken, 1998). The reader is referred to those *Guides* for this information.

In this guide, some of the important results of the construct validity studies done on the *ASUDS-RI* and the *ASUDS-R* scales will be summarized. Because all of the scales in the original *ASUDS*, the original *ASUS*, and the current *ASUDS-R* are included in the *ASUDS-RI*, except for the STRENGTHS scale, some of the results from the construct validation studies done on those instruments will be included in this User's Guide. These studies are relevant for, and add measurably to, the construct validation of the *ASUDS-RI* scales.

Psychometric Attributes of the *ASUDS-RI* Scales

Two different Illinois *ASUDS-RI* samples have been collected. We combined these to generate the normative sample of 984 impaired driving offenders. However, to test the replicability of the internal consistency reliabilities and the means and standard deviations of the *ASUDS-RI* scales, these statistics are given for both of these samples. *Table 10* provides these psychometric properties for the initial Illinois Study group and *Table 11* for the second group.

All internal consistency reliabilities (ICRs) are in optimal range. The *ASUDS-RI* scale ICRs are very consistent with findings of studies numerous non-DWI and DWI samples. The ICRs are also provided for the INVOLVEMENT2 and DISRUPTION2 scales and the three subscales of the DISRUPTION scale for the clinical sample. As can be noted, ICRs are in optimal range for these scales based on the clinical sample.

The mean scale scores on the two samples were compared. Three of the basic scales indicated significant different mean scores, as noted in *Table 11*. At the .05 level of statistical confidence, the second Illinois sample had higher mean scores on AOD USE BENEFITS and SOCIAL-LEGAL; and at the 01 level of confidence, a higher mean score on MOTIVATION and the supplemental scale LEGAL-NONCONFORMING. The first sample had a higher mean score on AOD LAST 12 MONTHS at the .05 level of confidence. These finding suggest that clients in the second sample may be more involved in the judicial system and may be more motivated for services and for change. However, across most scales, the two samples were very similar.

As well, the positively skewed distributions of the INVOLVEMENT and DISRUPTION scales as well as other scales of the *ASUDS-RI* found in the Illinois sample were consistently found in other samples tested with the scales of the *ASUDS-RI*.

Content Validity

Content validity has to do with measurement purpose. Items in each of the *ASUDS-RI* scales were evaluated to determine whether they did contribute logically and content-wise to the measurement of a construct. Perusal of the *ASUDS-RI* scales will indicate that the items are face-valid, direct and straightforward with respect to their measurement purpose and objective. Several experts in the field have also reviewed the scales for their content validity.

One objective was to measure the specific drugs that the client, historically and recently, has used. The INVOLVEMENT scale meets this expectation. Another objective was to gain some idea of the extent to which a client may be experiencing disruptions from AOD use. The DISRUPTION scale items are a measurement of the symptoms resulting from AOD use.

The benefits and expectations from AOD use are an important component of the cognitive approach to changing AOD use patterns (Marlatt, 1985; Marlatt & Witkiewiz, 2005). Changing these expectations is an important component of cognitive restructuring in AOD treatment. Perusal of the items in BENEFITS will indicate that they meet the purpose of this measurement objective.

Perusal of the items in SOCIAL-LEGAL NONCONFORMITY will indicate their content validity with respect to measuring antisocial attitudes and behaviors and an past involvement in antilegal behaviors. Face and content validity are apparent in the items of MOOD with respect to their measurement of recent or current emotional and mental health disruptions. The same content validity expectations are found the items measuring MOTIVATION.

More importantly, the *ASUDS-RI* scales as a whole represent a content-valid approach to differential screening for the most salient areas that may need to be addressed in education and treatment services. Those areas include: AOD involvement and disruption; mental health issues; antisocial and antilegal attitudes and behaviors; self-disclosure and defensiveness; and motivation for change.

Table 10
Psychometric Attributes of *ASUDS-RI* Scales for **Sample 1**: Number of Questions in Scale (ITEMS), Number of Subjects (N), Means, Standard Deviation (SD), Internal Consistency Reliabilities (ICR) (Cronbach's Alpha), Squared Multiple Correlations (SMR), and Percent Unique Variance (PUV)

BASIC SCALES	ITEMS	N	Mean	SD	ICR	SMR	PUV
1. ALCOHOL INVOLVEMENT	13	476	6.98	6.16	.89	.72	.17
2. DRIVING RISK	12	476	5.08	4.16	.86	.49	.37
3. INVOLVEMENT1	10	472	3.18	3.48	.76	.66	.10
4. AOD USE BENEFITS	13	470	3.30	4.61	.91	.69	.22
5. DISRUPTION1	20	465	4.93	8.01	.90	.71	.19
6 AOD 12 MONTHS	30	270	4.16	6.93	.90		
7. MOOD ADJUSTMENT	9	475	3.10	3.35	.87	.59	.28
8. SOCIAL-LEGAL	26	411	9.28	7.69	.88	.43	.45
9. GLOBAL	4	398	20.60	17.88	.74		
10. DEFENSIVE	9	472	17.52	4.31	.80	.56	.24
11. MOTIVATION	7	406	5.73	5.27	.81	.31	.50
12. INVOLVEMENT2*	10	669	17.32	10.66	.86		
13. DISRUPTION2*	20	669	39.16	21.71	.94		

SUPPLEMENTAL SCALES	ITEMS	N	Mean	SD	ICR
A. BEHAVIORAL DISRUPT*	6	669	11.00	6.71	.88
B. PSYCHOPHYSICAL DISRUPT*	10	669	19.17	11.68	.91
C. SOCIAL ROLE DISRUPTION*	4	669	9.19	5.63	.87
D. SOCIAL NON-CONFORMING	12	465	5.57	3.88	.76
E. LEGAL NON-CONFORMING	14	425	3.73	4.90	.86
F. SOCIAL-LEGAL 12 MONTHS	18	240	3.63	2.36	.70

* Normed on 669 Inpatient or Intensive Outpatient AOD clients

Table 11
Psychometric Attributes of *ASUDS-RI* Scales for Sample 2: Number of Questions in Scale (ITEMS), Number of Subjects (N), Means, Standard Deviation (SD), Internal Consistency Reliabilities (ICR) (Cronbach's Alpha) Squared Multiple Correlations (SMR), and Percent Unique Variance (PUV)

BASIC SCALES	ITEMS	N	Mean	SD	ICR	SMR	PUV
1. ALCOHOL INVOLVEMENT	13	496	7.04	6.12	.88	.80	.08
2. DRIVING RISK	12	497	4.62	3.70	.83	.41	.40
3. INVOLVEMENT1	10	492	3.09	2.93	.72	.51	.19
4. AOD USE BENEFITS+	13	493	4.05	5.08	.92	.71	.21
5. DISRUPTION1	20	492	5.48	7.69	.89	.69	.20
6 AOD 12 MONTHS++	30	494	3.47	4.01	.83		
7. MOOD ADJUSTMENT	9	496	3.16	3.28	.84	.54	.30
8. SOCIAL-LEGAL+	26	495	10.56	8.89	.90	.35	.55
9. GLOBAL	4	481	22.23	17.88	.79		
10. DEFENSIVE	9	497	17.47	4.39	.81	.63	.18
11. MOTIVATION+++	7	496	7.32	5.41	.81	.20	.61
12. INVOLVEMENT2*	10	669	17.32	10.66	.86		
13. DISRUPTION2*	20	669	39.16	21.71	.94		

SUPPLEMENTAL SCALES	ITEMS	N	Mean	SD	ICR
A. BEHAVIORAL DISRUPT*	6	669	11.00	6.71	.88
B. PSYCHOPHYSICAL DISRUPT*	10	669	19.17	11.68	.91
C. SOCIAL ROLE DISRUPTION*	4	669	9.19	5.63	.87
D. SOCIAL NON-CONFORMING	12	497	5.99	3.84	.76
E. LEGAL NON-CONFORMING+++	14	495	4.61	5.88	.89
F. SOCIAL-LEGAL 12 MONTHS	18	495	3.45	3.25	.77

\+ Illinois sample 2 mean score higher than sample 1, $p < .05$
++ Illinois sample 1 mean score higher than sample 2, $p < .05$
+++ Illinois sample 2 mean score higher than sample 1, $p < .01$

* Normed on 669 Inpatient or Intensive Outpatient AOD clients

Scale Independence

There are two methods to evaluate scale independence. One is to look at the percent of variance of any one scale that is separate from any other scale. The second method is to evaluate what percent of variance that each scale measures that is not measured by all of the other scales combined. We use these two methods to evaluate the independence of the *ASUDS-RI* scales.

Correlations Between Scales

First, the correlations between scales will indicate the degree to which a scale is separate and unique from other individual scales. *Table 12* provides the correlations among the 11 basic *ASUS-RI* scales, using the total Illinois normative sample.

In order to keep scale independence as low as possible, it is desirable to not have item overlap - items are used only once for measurement. In the ASUDS-RI scales, there is some item overlap. Five items from the ALCOHOL INVOLVEMENT scale are used in the AOD USE BENEFITS SCALE. And, one item from the ALCOHOL INVOLVEMENT scale and one item from the SOCIAL-LEGAL NONCONFORMING scale is used in the DEFENSIVE scale. Thus, we would expect that the correlation between ALCOHOL and BENEFITS scales and the correlation between the ALCOHOL and DEFENSIVE, and between the SOCIAL-LEGAL and DEFENSIVE, to somewhat higher than random expectation since covariances are slightly increased by this overlap. Also, we would expect GLOBAL, which is a higher-order scale, to have high correlations with INVOLVEMENT, DISRUPTION, MOOD and SOCIAL-LEGAL since GLOBAL is based on the sum of these four scales. We would also expect the INVOLVEMENT and DISRUPTION scales to have higher correlations with the AOD 12 MONTHS scale since the latter is comprised of the same items as the two former scales.

The goal with respect to independence is to have each scale measuring at least 45 percent of variance not measured by any other individual scale among those scales that are not logically or operationally dependent. The first nine scales listed in *Table 12* are those that have non-overlapping items (except for minimal overlap among ALCOHOL, BENEFITS, SOCIAL-LEGAL, and DEFENSIVE). The GLOBAL and AOD 12 MONTHS scales are listed last, since we would expect them to have high correlations with those scales since they are not operationally independent scales and have 100 percent overlap of items, as outlined above.

All correlations meet our desirable 45 percent independence other than the AOD USE BENEFITS scale, which has only 40 percent unique variance with respect to its correlation with ALCOHOL INVOLVE ($r = .78$). To calculate the percent of variance or measurement that two variables have in common, the correlation coefficient is squared. Thus, the square of .78 is .61 or these two scales have about 60 percent variance in common. This high correlation between ALCOHOL and AOD BENEFITS is found in all of the DWI samples that have been studied (consistency validity). The intercorrelations found among the *ASUDS-RI* normative sample are consistent with those found in the study of both non-DWI and DWI samples.

Percent Unique Variance of Scales

The second and more powerful method for evaluating scale independence is to determine what percent variance does any scale measure independent of all other scales combined; or what percent of variance that is measured by any one scale is not measured by all of the other scales combined. If, for example, a scale has zero PUV (percent unique variance), it makes little sense to use that scale, since what it tells us is also revealed in the other measurement constructs.

The squared multiple correlations (SMR) provides us with this information. The SMR indicates the variance a scale has in common with a best-weighted linear combination of the other scales. If a SMR is large for a particular scale, then much of what is measured by that scale is measured by all of the other scales combined. To get an accurate measure of what any scale truly measures that is independent of other scales, it is necessary to subtract the ICR (internal consistency reliability) from the SMR. The ICR represents the true score measurement variance of a scale and indicates how well the items of a factor correlates with

a common (centroid) factor. The SMR indicates how well the scale correlates with the weighted combination of all of the other scales.

By subtracting the ICR from the SMR, we get a measure of the percent of unique variance (PUV) for each scale and what is not measured by all of the other scales combined. Our goal is to have each scale measure at least 10% (.10) unique variance; or each scale has the potential of contributing something unique to prediction and understanding. This 10% is a rule of thumb, but is reasonable with respect to what we want a scale to do (Horn et al., 1990). We hypothesized that the PUVs for the primary scales in the original ASUDS would exceed this 10% rule.

Because there is some item overlap (operational dependence) between ALCOHOL INVOLVEMENT and AOD BENEFITS, and ALCOHOL INVOLVEMENT and DEFENSIVE, we can anticipate that ALCOHOL INVOLVEMENT will, overall, have less percent unique variance. And, because AOD INVOLVEMENT and DISRUPTION have high correlations with each other and with other scales, particularly those related to AOD use and abuse, we expect those scales to have lower PUVs. Note also, that the AOD 12 MONTHS, and GLOBAL were left out of the calculations since these scales use the same items that are in AOD INVOLVEMENT, DISRUPTION, SOCIAL-LEGAL, and MOOD, and thus, are operationally dependent.

As can be noted in *Tables 10* and *11*, the PUVs well exceed our expected minimum of 10% independence except for ALCOHOL INVOLVEMENT in Sample 2, which has a PUV of eight (.08). In Sample 1, all have very good PUVs, except INVOLVEMENT which has a PUV of 10. The rest of the scales have very good PUV levels. In Sample 2, all have good to very good PUVs except for ALCOHOL INVOLVEMENT, which is lower than our rule of thumb, but acceptable. Although it was expected that this scale would have low PUV values, it does meet our 10 percent rule of thumb in Sample 1. The scales with the highest unique variances are: DRIVING RISK, SOCIAL-LEGAL, MOOD and MOTIVATION. These are scales that measure problem behaviors outside the domain of AOD use and abuse. The level of independence of these scales support their relevancy in the assessment of impaired driving offenders.

Table 12
Intercorrelations Among *ASUS-RI* Scales (Decimal Points Omitted)

SCALE	1	2	3	4	5	6	7	8	9	10	11
1. ALCOHOL INV.											
2. DRIVING RISK	53										
3. AOD INVOLVE	55	43									
4. AOD BENEFITS	78	37	49								
5. DISRUPTION	71	42	67	64							
6. MOOD	56	43	42	58	55						
7. SOCIAL-LEGAL	38	33	51	35	39	32					
8. DEFENSIVE	-61	-56	-41	-51	-51	-64	-42				
9. MOTIVATE	33	09	25	35	35	26	32	-27			
10. GLOBAL	69	50	79	64	84	65	79	-61	39		
11. AOD ONEYEAR	51	28	47	54	66	46	21	-36	26	55	

Positive Manifold Among Scales

Studies by Wanberg and associates (e.g., Wanberg, 1992; Horn & Wanberg, 1969, 1970; Wanberg & Horn, 1970; 1987; Wanberg, Horn & Foster, 1977) have demonstrated that factor analyses of items measuring AOD patterns and problems invariably produce a positive manifold among factor scales. That is, a high score on one scale will tend to predict high scores on other scales. In part, this may be due to instrument variance (Horn, Wanberg & Adams, 1982) and in part due to the nature of self-reporting of perceived problems of self. More importantly, this positive manifold may be due to a common factor of life problems found among clients referred for AOD assessment and evaluation. Studies by Wanberg and associates have clearly supported this finding. It was hypothesized that this finding would also replicate in the intercorrelations among the *ASUDS-RI* scales. Results in *Table 12* clearly supports this hunch.

This positive manifold phenomenon in the *ASUDS-RI* as well as in every prior study of the *ASUS, ASUS-R, ASUDS* and *ASUDS-R* scales, as well as studies conducted on the *Alcohol Use Inventory* (Horn, Wanberg & Foster, 1990) lends consistency validation to the *ASUDS-RI* scales.

Relationship Between Defensiveness and Problem Disclosure

It is noted in *Table 12* that DEFENSIVE has negative correlations with the other 11 scales. DEFENSIVE is scored so that a high score indicates defensiveness and a low score indicates willingness to disclose what might be interpreted as psychosocial problems.

The negative correlations between DEFENSIVE and the other scales was hypothesized. It would be expected that non-defensive individuals will be more willing to disclose personal and sensitive information, particularly pertaining to AOD use and emotional and psychological problems. Results in *Table 12* provide evidence supporting this hypothesis. This finding is replicated in every *ASUS, ASUS-R, ASUDS* and *ASUDS-R* study sample. That is, high scores on DEFENSIVE predict low scores on all problem-oriented scales. Support of this hypothesis provides not only predictive validity for the DEFENSIVE scale, but also provides support for consistency validity of the *ASUDS-RI* scales. Lapham, Wanberg, Timken and Barton (1996) found the same phenomenon among DUI clients using a different screening instrument.

One interpretation of these findings is that individuals who are willing to self-disclose AOD use patterns and symptoms, mental health symptoms and antisocial attitudes and behavior are on the average much less defensive and more candid in their reporting. Individuals with high scores on DEFENSIVE are more self-protective and guarded.

What is even more important is that *Tables 15* and *16* below, which provides correlations between the *ASUDS-RI* and external criterion measures, show that the correlations between DEFENSIVE and the collateral variables are all significant and negative except for BAC. This measurement invariance across samples provides a powerful example of consistency validity of a specific scale.

Although it was concluded that persons with high defensiveness are less self-disclosing and less forthcoming with information, and clients with low defensive scores are more self-disclosing, it was not necessarily assumed that high defensiveness did in fact indicated fewer AOD and psychosocial problems. Yet, persons with high scores on DEFENSIVE consistently scored lower on these scales (as well as criterion scales that were measured completely independent of the *ASUDS-R* scales). So, what does this mean? We look at the data to address this question.

Offenders who are high defensive also tend to have fewer DWI priors, tend not to have a diagnosis of abuse or dependence, are placed in a lower Risk Class, have lower scores on the Mortimer-Filkins scale, etc., as revealed in *Tables 15* and *16*. Most important about these finding is that these correlations are with external criterion variables, totally independent from the measurement of DEFENSIVE. When the variables correlating with DEFENSIVE are within the same instrument, we could explain the finding to instrument variance and straightforward defensiveness. But when these correlations are with external variables, it

makes us realize that high defensiveness may in fact portend lower levels of psychosocial problems. Thus, these results would suggest that clients, on the average, with lower DEFENSIVE scores do indeed have greater levels of AOD and psychosocial disruption; and conversely, DWI offenders with higher defensive scores tend to have lower levels of AOD and psychosocial disruption.

Perspective Validity

Some correlates of the *ASUDS-R* scales may not provide information that validates what the scale in fact does measure, but does provide information which helps to better understand the overall instrument and the meaning of individual scales. Horn, Wanberg & Foster (1990) have called this form of construct validity perspective validity. Correlations with age, gender, ethnicity, and marital status have this characteristic. Cronbach (1986) has referred to this as *weak-program construct validity*. The strength of such validity measures, however, depends upon whether the results of these relationships support hypotheses generated about the constructs themselves, and, more importantly, whether these relationships are consistently found across various samples (consistency validity).

Four perspective validity variables were evaluated with respect to their correlations with the *ASUDS-RI* scales: age, ethnicity, marital status, and gender.

Age

Past studies of the relation of age to the *ASUDS-R* scales indicate, that for the most part, age has been relatively independent of these scales. That is, most correlations between age and the *ASUDS-R* scales are statistically non-significant. Or, when statistically significant correlations are found with perspective variables, they are usually low. The same hypothesis was proposed for the *ASUDS-RI* scales. Only two scales showed significant correlations with age: older DWI clients have higher scores on ALCOHOL INVOLVEMENT ($r = .11$, $p < .001$) and on AOD BENEFITS ($r = .08$, $p < .01$). This finding indicates that different norms are not needed for different age groups. The finding is also consistent with other studies and lends consistency validity to the *ASUDS-RI* scales.

Ethnicity

Prior studies also indicated that ethnicity is relatively independent of the *ASUS-R and ASUDS-R* scales. This finding was also supported in the study of the *ASUDS-RI* scales. All scales had non-significant correlations with the perspective variables except for the following: African American clients had lower scores on ALCOHOL INVOLVEMENT than Anglos or Hispanics ($r = -.11$, $p < .001$), lower scores on DRIVING RISK ($r = ,.09$, $p < .01$) and higher scores on the SOCIAL-LEGAL scale ($r = .16$, $p < .001$); Anglos reported lower scores on the SOCIAL-LEGAL scale ($r = -.13$, $p < .001$) and lower scores on MOTIVATION ($r = .11$, $p < .001$); and Hispanics had higher scores on MOTIVATION ($r = .08$, $P < .01$). Given these few significant correlations, it is safe to say that these findings support the expectation that the ASUDS-R scale scores would be relatively independent of ethnicity.

Marital Status

Based on prior ASUS-R and ASUDS-R studies, it was hypothesized that the correlations between the *ASUDS-RI* scales and **marital status** would be relatively nonsignificant. Correlations between marital status of single and married revealed no significant correlations at the .001 level of confidence. At the .01 level, the only significant correlations were: single DWI clients scored higher on the SOCIAL-LEGAL scale ($r = .10$, $p < .01$); and married DWI clients scored lower on that scale ($r = .10$, $p < .01$), lower on AOD INVOLVEMENT ($r = .09$, $p < .01$) and lower on GLOBAL ($r = .09$, $p < .01$). These significant findings are as expected and are consistent with studies performed on numerous other samples using these scales. What is more important is that marital status is relatively independence of the *ASUDS-RI* scales, also consistent with studies.

Gender

The literature is rich with information indicating that women in treatment in general have different treatment needs than men, particularly, within judicial populations. Wanberg and Milkman have provided extensive review of these findings (Milkman, Wanberg, & Gagliardi, 2008) and provide some of the foundations and sources for these needs.

An important source of information regarding male-female differences and identify specific needs of female offenders was a study by Wanberg (2006) using 11 different samples, including three impaired driving samples, that compared 18,841 male offenders with 5,640 female offenders across seven *ASUDS-R* scales. Only those scales that were available across all 11 samples were used in the study. For example, the ALCOHOL and DRIVING RISK, are not in the original ASUDS or ASUS which were used to test the non-DWI judicial samples.

Table 13 provides the results from this study, and *Table 14* summarizes the sample sources. The first eight samples are non-DWI adult offenders. Samples 9, 10, and 11 in *Table 10* are DWI samples, with Sample 11 being the Illinois normative sample.

The cells in *Table 13* with the dashed lines (--) indicate that data was not available for those scales. A NS indicates no statistically significant difference between males and females. F1 and F2 indicates females scored significantly higher than males on the scale; M1 and M2 indicates males scored significantly higher on the scale.

Although this study is important with respect to giving guidelines for the treatment of women in corrections, including women DWI offenders, relevant to this current paper, these findings provide further support for the construct validity of the *ASUDS-R* scales included in the study. The findings also provide evidence of consistency validation of the *ASUDS-R* scales. Most of the findings in this study, summarized briefly, support the general findings in the literature.

- **Ratio of male offenders to female offenders.** *Table 2* shows that Female offenders represent: 25.7 percent of the pre-sentenced probation group;, 19.5 percent of the post-sentenced probation group; 12.9 percent of the incarcerated offenders; and 20 to 27 percent of DWI offenders (the Illinois sample is somewhat higher than other DWI samples).

- **Antisocial and criminal conduct.** *Table 13* clearly shows that, across all 11 samples, on the average, males report higher levels of antisocial attitudes and behaviors. This finding is well supported in the literature.

- **Psychological, mental health problems and mood adjustment.** Across all 11 samples, female offenders score higher than men on the psychological and mood adjustment scale.

- **General drug involvement.** Male and female offenders do not differ with respect to the extent of general AOD involvement across nine of the 11 samples. The two exceptions are DWI samples. This scale measures the extent of AOD use across 10 basis drug use categories. High scores indicate polydrug involvement. This does not support some studies in literature suggesting female offenders are more apt than males to be involved in multiple drug use.

- **Extent of drug disruption and symptoms.** Female offenders reported greater disruption and symptoms related to AOD use across eight of the 11 samples. The two pre-sentenced evaluation driving while impaired (DWI) samples indicated no difference, but sample B, the post-sentenced evaluation group, indicated females score higher. Thus, even though there is no consistent gender differentiation across the general INVOLVEMENT scale, there is consistency with respect to female offenders reporting having greater life disruptions resulting from AOD use. This would suggest that female offenders may have more psychophysical problems associated with AOD use.

- **Level of defensiveness.** Male offenders, across 10 of the 11 samples had a higher score on DEFENSIVE. One could conclude that because women are more open to reporting undesirable symptoms in general, accounting for their scoring higher on the DISRUPTION and PSYCH PROBLEMS scales. However, evidence in *Table 13* argues against this interpretation in that males score higher on self-report antisocial attitudes and behavior, and that there is no difference on the INVOLVEMENT scale between the two groups. Although not shown in *Table 13*, males report greater involvement in marijuana and alcohol. If males were more defensive in endorsing self-report items, then we would expect them to be defensive across all of the ASUS scales, which was not the case. This differential effect supports validity of the findings.

From these findings, there is support for the concept that pre-sentenced evaluations will tend to generate lower levels of scale score variance, and lower levels of psychosocial problem-reporting. In part, we could attribute this to pre-sentenced individuals being more defensive, however, some of the arguments provided above mitigate against this conclusion. What is most plausible, is that there is a greater percent of clients in the pre-sentenced group that actually do have lower levels of problems, and these clients are screened out, in a variety of ways, and do not end up in the post-sentenced group. Generally, those ending up in post-sentence evaluation are those who have been screened for psychosocial and AOD problems. Support for this conclusion is found in the comparison of pre- and post-sentenced group across the *ASUDS-R* scales.

The findings around gender provide substantive guidelines as to how treatment needs to be adjusted for the female offender, including those in the DWI populations. This would include greater concentration on psychological and mood adjustment problems and greater attention to psychophysical manifestations of AOD use and abuse (See Milkman et al., 2008, for a more detailed summary of the specific treatment needs of women in the DWI and corrections system.

The findings in *Table 13* provide another cogent piece of the construct validation puzzle of the *ASUDS-R* and *ASUDS-RI* scales. There is robust consistency of measurement results relative to gender similarities and differences across 11 samples of over 24,000 subjects. This provides evidence of consistency validity or measurement invariance of the *ASUDS-R* scales and the expected directions of gender differences.

Table 13
Comparison of Male and Female Offenders Across the Scales in the *ASUS, ASUS-R, ASUDS, ASUDS-R,* and *ASUDS-RI*

SCALES	1	2	3	4	5	6	7	8	9	10	11
AOD INVOLVE	NS	NS	NS	NS	F2	NS	NS	NS	M1	NS	NS
AOD DISRUPT	F1	F2	F2	F2	F1	F1	NS	F1	NS	F2	NS
SOCIAL NONCON	M1	M1	M1	M1	M1	M1	M1	M1	M1	M1	M1
MOOD	F1	F1	F1	F1	F1	F1	F1	F1	F1	F1	F2
DEFENSIVE	M1	M1	M1	M1	M1	M1	M1	M2	M1	M1	NS
MOTIVATION	NS	NS	NS	NS	NS	--	--	--	NS	NS	NS
GLOBAL	NS	NS	NS	NS	F1	F1	NS	F1	NS	F2	NS

NS = Statistically non-significant
F1 = Females score higher with probability < .009
F2 = Females score higher with probability < .05
M1 = Males score higher with probability < .009
M2 = Males score higher with probability < .05

Table 14
Descriptions and Distributions by Gender for Samples in Table 13: Total N=24,481

Table 1 Sample No.	Description of Sample	Total N	Percent Female	Percent Male
1	State A: Probation pre-sentence	4,000	73.4	26.6
2	State A: Probation pre-sentence	4,000	73.5	26.5
3	County A: Probation pre-sentence	1,183	74.8	25.2
4	State B: Probation post-sentence	1,383	80.4	19.6
5	State C: Probation pre-sentence	2,604	75.6	24.4
6	State D: Probation pre-sentence	2,070	76.2	23.8
7	State D: Probation pre-sentence	2,079	76.6	23.4
8	State D: DOC - incarceration	2,739	87.5	12.5
9	SAMPLE A: DWI	2,340	79.0	21.0
10	SAMPLE B: DWI	1,099	78.9	21.1
11	SAMPLE C: ILLINOIS DWI	984	73.0	27.0

Criterion and Predictive Validity

Cattell (1957) has referred to criterion validity as relevancy: how relevant is the information provided by a scale for making an inference one desires to make? Criterion validity also indicates predictive validity, e.g., a certain scale predicts prior DWI arrest; predicts independent decisions made by the evaluator; or predicts a future event such as DWI recidivism.

The criterion variables should be operationally independent (OI) and removed as far as possible from the predictors or measures being validated. OI increases the cogency of validating hypotheses. OI is achieved when a criterion measure is taken by an instrument separate from the scales being validated or when taken at a different time from those being validated. OI is achieved when the criterion variable uses a different measurement model, e.g., the measure to be validated is self-report and the criterion is other report such as collateral ratings, BAC, criminal record, etc. It is expected that the strength of the covariation will be reduced in direct proportion to the degree of independence of the criterion and predictors. We would expect to find higher correlations between DISRUPTION and comparable measures of AOD disruption than between DISRUPTION and BAC, the latter being very removed from the *ASUDS-RI* self-report scales.

One question is whether the criterion measures are reliable and valid? Often it is safe to suspect that this is not the case. For example, how do we know that the treatment placement ratings made by evaluators are any more valid than those made by a self-report instrument? If operationally independent variables putatively measure the same construct as the measures being validated, then a significant positive correlation with the criterion provides evidence of construct (criterion) validity.

This section looks at a number of studies of the correlates between the *ASUDS-RI* scales and independent criterion measures that provide evidence of criterion (construct) validity of the *ASUDS-RI* scales, using a variety of DWI and non-DWI samples. These studies are based on the original *ASUDS* and *ASUS*, the *ASUDS-R* and *ASUS-R*, and the *ASUDS-RI*. As mentioned previously, the *ASUDS-RI* is a slight variation from the *ASUDS-R*.

Correlations with External Criterion Variables in Illinois Sample

Table 15 provides the correlations between collateral or external criterion variables and the scales of the *ASUDS-RI* for the total normative sample (N=984). There is distinct operational independence between the collateral variables on the *Uniform Reporting Form* and the *ASUDS-RI* scales. *Table 15* provides rich information as to the construct validity of the *ASUDS-RI* scales. Only a few of the covariations in *Table 15* will be discussed. Both individual correlations and regression analyses were used to evaluate and interpret the data and findings.

First, as predicted, the ALCOHOL, DISRUPTION, INVOLVEMENT and SOCIAL-LEGAL scales are strong individual predictors of DSM-IV (American Psychiatric Association, 1994, 2000) *Substance Dependence*. However, the GLOBAL scale, which is a sum of the INVOLVEMENT, DISRUPTION, SOCIAL-LEGAL and MOOD scales, is the best individual predictor of *Substance Dependence* (r=.62).

It is recalled that GLOBAL is a measure of AOD disruption plus other psychosocial problems, e.g., mood and social-legal problems. Thus, the strong correlation between GLOBAL and DSM-IV *Substance Dependence* suggests that the latter construct is made up of more than just substance dependence criteria but also it most likely measures a generic psychosocial problems component This conclusion is supported by the fact that DISRUPTION, which is basically comprised of AOD symptoms and DISRUPTION has a lower and GLOBAL a higher correlation with *Substance Dependence*. This conclusion is further supported by the robust correlations of *Substance Dependence* with MOOD and SOCIAL-LEGAL NON-CONFORMITY. A regression analysis that included the seven clinical scales of the *ASUDS-RI* (ALCOHOL, DRIVING RISK, INVOLVEMENT, DISRUPTION, SOCIAL-LEGAL, BENEFITS and MOOD) accounted 44 percent (MR (Multiple R)=.66) of the variance in predicting *Substance Dependence*.

Second, the best individual predictors of prior DWI behavior are the ALCOHOL and GLOBAL scales. A regression analysis indicated that the seven clinical scales accounted for 21 percent (MR=.46) of the variance in predicting a prior impaired driving disposition.

Third, the best individual predictors of prior treatment are ALCOHOL, DISRUPTION, SOCIAL-LEGAL and GLOBAL. A regression analysis indicates that SOCIAL, ALCOHOL, and DRIVING RISK are the best predictors of prior treatment, accounting for 45 percent of the variance.

Fourth, all of the *ASUDS-RI* scales, except for DRIVING RISK, are good individual predictors of assigned intervention or risk class levels (minimum, moderate, significant and high) in the Illinois system. Regression analysis that included the seven *ASUDS-RI* clinical scales accounted for 33 percent of the variance in predicting treatment classification (MR=.57.5). When the five variables used in the ASUDS-RI weighted system for determining placement guidelines (ALCOHOL, AOD INVOLVE, DISRUPT, and Variable 84) are used as predictors, 27 percent (MR=51.1) of the variance is accounted for. It is important to note that these predictors are basically accounting for the placement variance that is determined by AOD problems and disruption. As will be seen later, many other variables contribute to the variance of placement decisions made by evaluators.

A rather robust finding from the individual correlations is that social-legal nonconformity (including driving risk) is a good predictor of prior impaired driving, substance dependence, prior treatment, and treatment classification. When social-legal non-conformity is coupled with disruptive AOD use patterns and mood adjustment problems, it is clear that psychosocial and AOD problems combined are good predictors of DWI behavior, and most likely, DWI recidivism. This supports the basic approach to DWI education and treatment developed by Wanberg, Milkman and Timken (2005) - that to prevent DWI recidivism, a multidimensional intervention approach must be taken that addresses the many factors that contribute to impaired driving behavior, including antisocial behaviors and attitudes, psychosocial and relationship adjustment problems, AOD abuse and addiction, and an emphasis on building a strong sense of prosociality and moral responsibility in the community.

Table 15
Correlations Between *ASUDS-RI* Scales and Collateral Data in *Uniform Reporting Form* For Sample of 984 (All Variables Are Operationally Independent of the *ASUDS-RI* Scales)

ASUDS-RI SCALES	BAC	PRIOR	ABUSE	DEPEN	PR.TX	TXCL	M.FIL	TYPE
1. ALCOHOL	.24	.29	.38	.50	.28	.40	.56	.47
2. DRIVING RISK	.02	.10	.19	.24	.11	.16	.34	.28
3. AOD INVOLVE	.02	.17	.37	.46	.24	.37	.53	.38
4. AOD BENEFITS	.14	.22	.37	.50	.25	.38	.50	.43
5. AOD DISRUPT	.16	.21	.40	.50	.30	.39	.55	.44
7. MOOD ADJUST	.15	.15	.28	.42	.17	.33	.49	.46
8. SOCIAL-LEGAL	.00	.35	.46	.53	.40	.48	.61	.45
9. GLOBAL	.11	.31	.51	.62	.40	.52	.68	.54
10. DEFENSIVE	-.14	-.23	-.29	-.39	-.21	-.32	-.37	-.35
11. MOTIVATION	.10	.24	.38	.44	.29	.40	.45	.41

Correlations .10 to .13 $P < .01$ Correlations .14 or greater $P < .001$

BAC: Blood Alcohol Concentration
PRIOR: Prior Impaired driving disposition
ABUSE: Diagnosis of Substance Abuse
DEPEN: Diagnosis of Substance Dependence
PR.TX: Prior Treatment
TXCL: Illinois treatment classification or risk level
M.FIL: Mortimer/Filkins total score
TYPE: MF type: 1 = social drinker; 2 = presumptive problem drinker; 3 = problem drinker

It is important to note that in behavioral science research, accounting for 25 to 30 percent of the variance of a criterion variable by five or less predictor variables is good. This is because there are so may external factors that contribute to the variance of any one criterion measure. For example, in determining a final intervention placement for a DWI client, any number of unaccounted for and uncontrolled variables contribute to the final placement decision, e.g., the mood of the evaluator, the personality characteristics and attitude of the client, the time of day, the nature of the DWI offense, to mention only few.

Correlations With Criterion Variables Using Other Samples

A number of studies have been conducted on samples other than the Illinois normative group to cross-validate the *ASUDS-R/ASUDS-RI* scales with external criterion variables that are measuring similar constructs. These studies addressed the question: "Do the scales measure what they are supposed to measure?"

Table 16 provides the results from these analyses. One important focus is to determine the criterion validity of the *ASUDS-RI/ASUDS-R* scales that measure AOD involvement and negative consequences and symptoms. Strong correlations with external criterion variables that putatively measure AOD involvement and problems would certainly support the construct validity of the *ASUDS-R/ASUDS-RI* scales.

Table 16
Correlations of ASUDS-R Scales with Criterion Scales Measuring Substance Use Involvement and Problems: MF (Mortimer-Filkins); SSI (Simple Screening Inventory); ADS (Alcohol Dependence Scale); DAST (Drug Abuse Screening Test); LSI-D (Level of Supervision Inventory-Drug Scale); LSI-C (Level of Supervision Inventory-Crime Scale); DWI = impaired driving samples; and N-DWI = judicial samples mostly non-DWI)

ASUDS-R SCALES	MF N=358 DWI	SSI N=589 N-DWI	ADS N=673 N-DWI	DAST N=673 N-DWI	LSI-D N=1385 N-DWI	LSI-C N=1385 N-DWI
1. ALCOHOL INVOLVE	.41*	---	---	---	---	---
2. DRIVING RISK	.23*	---	---	---	---	---
3. AOD INVOLVE	.33*	.43*	.43*	.62*	.61*	.32*
4. AOD BENEFITS	.32*	.59*	---	---	---	---
5. AOD DISRUPT	.36*	.55*	.63*	.65*	.59*	.28*
6. AOD 6 MONTHS	.29*	.39*	---	---	.57*	.37*
7. MOOD ADJUST	.39*	.43*	.26*	.31*	.31*	.19*
8. SOCIAL NON-C	.44*	.36*	.41*	.32*	.45*	.50*
9. LEGAL NON-C	.41*	.44*	---	---	---	---
10. LEGAL NC 6 MO	.25*	.33*	---	---	---	---
11. GLOBAL	.49*	.56*	.60*	.68*	.63*	.36*
12. DEFENSIVE	-.31*	-.44*	-.29*	-.27*	-.31*	-.21*
13. MOTIVATION	.32*	.56*	---		.65*	.35*

* $p < .001$

The *Mortimer-Filkins* (MF: Mortimer & Filkins, 1971) is a 56 item screening test with only eight items pertaining to alcohol use. The *Simple Screening Instrument* (SSI: Center for Substance Abuse Treatment, 1994) is a 16 item AOD screening instrument. *The Alcohol Dependence Scale* (ADS: Horn, Skinner, Wanberg & Foster, 1984) is a 21 item alcohol disruption screening instrument that is the Disruption scale of the *Alcohol Use inventory* (Horn, Wanberg, & Foster, 1990). The *Drug Abuse Screening Test* (DAST: Skinner, 1982) is a 20 item instrument designed to screen for AOD problems and involvement The nine item LSI-D is the drug subscale and the 10 item LSI-C is the crime subscale of the *Level of Service Inventory - Revised* (LSI-R: Andrews & Bonta, 1995).

The important foci are the correlations between the criterion measures and the *ASUDS-R* scales of ALCOHOL, AOD INVOLVE, AOD DISRUPTION, AOD 6 MONTHS, and GLOBAL. As is seen in *Table 16*, all of the correlations are robust and of significant magnitude. Of particular note is the correlation of AOD DISRUPTION of .55, .63 and .65 with the SSI, ADS and DAST respectively. Comparable correlations are found between AOD INVOLVEMENT and the three criterion measures. These correlations approach acceptable internal consistency reliability levels. Also important is the comparable magnitude of the correlations of these criterion measures with the GLOBAL scale. GLOBAL represents a robust broad measure of AOD and psychosocial disruption and problems.

The *Mortimer-Filkins*, used for screening AOD problems, has only eight items pertaining to drinking. It is more of a measure of overall-psychosocial adjustment problems, verified by the .49 correlation with GLOBAL. When comparing the correlations between the Mortimer-Filkins and the *ASUDS-RI/ASUDS-R* and the correlations between the other scales measuring AOD involvement/problems (e.g., DAST, ADS, SSI) and the *ASUDS-RI/ASUDS-R* scales (see *Tables 15* and *16)*, the Mortimer-Filkins does not appear to be as good of measure of AOD disruption or involvement as are other criterion measures in those tables.

Predicting Treatment Class From Both ASUDS-RI Scales and External Criterion Measures

When looking at the correlations of the *ASUDS-RI/ASUDS-R* scales with treatment classification decisions made by evaluators (see the above section, ***Correlations with External Criterion Variables in Illinois Sample***), we found that using only the AOD and driving risks scales, we could account for about 27 to 30 percent of the variances of evaluator placement classifications. The percent of variance accounted for increased to 33 percent when seven of the *ASUDS-RI/ASUDS-R* were used. In essence, what we are accounting for are the client characteristics that are determined mainly by AOD use, but also other psychosocial problems. Yet we know that other factors contribute to the decision making process of evaluators. For example, the Illinois evaluators take in account a broad array of information pertaining to impaired driving, much of which is based on clinical impressions other than quantitative measurement.

In order to evaluate what other variables might account for the variance that contributes to the evaluator-determined treatment classification/risk level placement, using the Illinois normative group, we added the external criterion variables of BAC, prior impaired driving, and prior treatment to the five *ASUDS-RI* scales of ALCOHOL, DRIVING RISK, AOD INVOLVEMENT, SOCIAL-LEGAL NONCONFORMITY, and AOD DISRUPTION in the regression equation. These eight variables accounted for 50 percent of the variance in predicting treatment class (MR=.71).

Yet, there are other variables that evaluators use in discerning placement class and risk level, e.g., substance abuse and substance dependence diagnosis. When the regression equation includes

- the seven clinical scales and Variable 84 (endorsing past DWI arrest) of the *ASUDS-RI/ASUDS-RI*, and
- BAC, substance abuse diagnosis, substance dependence diagnosis, prior DWI disposition, and prior treatment,

these combined variables account for 73 percent of the variance predicting the Illinois treatment level or risk class. This more realistically accounts for much of the information that evaluators use in placing DWI clients in one of the four risk classes (as defined in *Table 7*.

Certainly, the 73 percent variance based on the 13 variables, and the 50 percent based on the five ASUDS-RI scales and BAC, prior disposition, and prior treatment, is a very significant (and impressive) percent of variance accounted for in predicting a criterion variable. Yet, it does demonstrate that there is still noteworthy variance left unaccounted for that must be attributed to other variables and conditions related to the client or the evaluation process, as discussed earlier.

The above findings reinforce two important points made in this *User's Guide*:

- That although the scales of the ASUDS-R can provide guidelines for service placement, evaluators should use them only in conjunction with other information when making final service placement decisions; and
- that all of the information available to the evaluator must be used to make these kinds of determinations, as indicated in the 73 percent variance accounted for when adding just five external criterion measures.

Comparisons of Pre-Sentenced with Post-Sentenced Samples Across ASUDS-R Scales

We hypothesized that DWI clients evaluated at post-sentence would be more self-disclosing, less defensive, and more apt to have more AOD and psychosocial problems than the pre-sentence group. Two separate studies were conducted comparing pre- and post-sentenced clients. The first compared a large group of impaired drivers (N=2,286) tested before sentencing with a large group tested after sentencing (N=1088) across the 10 original *ASUDS* scales (Wanberg & Timken, 1998). These original 10 scales are represented by **Scales 1-3, 5-7, 9-11, and Scale D** of the *ASUDS-RI* in *Figure 1*. The results are provided in *Table 17*. In that table, Scale 8, SOCIAL NON-CONFORMING is the same as Scale D in the *ASUDS-RI*. The post-sentenced group scored statistically significantly higher on all of the eight problem behavior scales and significantly lower on DEFENSIVE. The mean score on MOTIVATION did not differ significantly.

Table 17: Comparing Pre-Sentenced Clients (N=2286) with Post-Sentenced Clients (N=1088) Across the *ASUDS-R* Scales

ASUDS-R SCALE DESCRIPTION	PRE-SENTENCED		POST-SENTENCED		t Value * P < .001
	Mean	SD	Mean	SD	
1. ALCOHOL INVOLVE	8.28	6.24	12.59	8.12	15.46*
2. DRIVING RISK	4.11	3.27	5.58	4.25	10.12*
3. ADO INVOIVEMENT	3.89	3.95	5.98	5.67	11.03*
5. AOD DISRUPTION	5.81	8.45	10.36	13.08	10.15*
6. AOD 6 MONTHS	2.78	4.40	3.95	6.34	5.53*
7. MOOD DISRUPT	4.24	4.20	6.26	5.12	11.06*
8. SOCIAL NON-CON	6.72	4.04	7.89	4.74	6.95*
11. GLOBAL DISRUPT	20.19	16.59	30.21	24.03	11.42*
12. DEFENSIVE	14.94	3.62	11.63	4.10	22.56*
13. MOTIVATION	8.20	5.64	7.98	5.87	1.03
Age at Evaluation	33.15	11.60	35.11	11.77	4.57*
Gender (female=2; male=1)	1.21	.41	1.21	.41	.09

A second study compared the first Illinois pre-sentenced group (N=480), with the post-sentencing group in the first study above (N=-1088). The findings were the same. It is clear that DWI clients evaluated at post-sentencing are less defensive, more apt to report problem behaviors, and based on some of the construct validation findings, represent a group with higher levels of AOD and psychosocial problems.

Comparing Group With No Prior DWI With Group Having One Or More DWIs

Three samples were used to study the differences between impaired drivers with no prior DWIs and those with one or more priors. Two groups, the Illinois sample (*Table 18*) and a large group from a Western state (*Table 19*) represent impaired drivers evaluated at pre-sentencing. The third group from an Eastern state (*Table 20*) was evaluated at post-sentencing (same group as represented in *Table 17*). In this latter group, of the 1,088 clients, only 720 had data on the prior DWI variable. Because of this amount of missing data, findings may not be as reliable. Results of this study are found in *Tables 18* through *20*.

Table 18: Comparing Group With No Prior DWI With Group Having One Or More DWIs Across *ASUDS-RI/ASUDS-R)* Scales - Illinois Normative Group (Pre-sentenced)

ASUDS-R/ASUDS-RI SCALE DESCRIPTION	NO PRI (N=756)		PRIORS (N=210)		t Value * P < .007 ** P < .001
	Mean	SD	Mean	SD	
1. ALCOHOL INVOLVE	6.11	5.19	10.24	7.97	7.09**
2. DRIVING RISK	4.61	3.69	5.65	4.64	2.99*
3. AOD INVOLVEMENT	2.83	2.75	4.22	4.33	4.38**
4. AOD BENEFITS	3.18	4.13	5.52	6.63	4.85**
5. AOD DISRUPTION	4.36	6.48	8.17	10.95	4.80**
6. AOD 12 MONTHS	3.60	5.17	4.34	5.48	1.57
7. MOOD DISRUPT	2.91	3.05	3.94	4.06	3.42**
8. SOCIAL-LEGAL NON	8.51	7.24	15.29	10.04	8.85**
9. GLOBAL	18.53	15.00	31.97	24.11	7.29**
10. DEFENSIVE	17.98	4.15	15.74	4.63	6.30**
11. MOTIVATION	6.02	5.05	8.78	6.11	5.74**
D. SOCIAL NON-CON	5.25	3.61	7.78	4.16	7.91**
E. LEGAL NON-CON	3.31	4.75	7.39	6.61	8.22
Age at Evaluation	30.47	10.82	35.77	9.62	6.91**
Gender	1.29	.45	1.20	.40	2.71*

NO PRI = No prior DWIs (same for *Tables 19* and *20*)
PRIORS = One or more prior DWIs (same for *Tables 19* and *20*)
Gender: Female is scored 2 and male scored 1 (same for *Tables 19* and *20*)

The hypotheses tested were: clients in the pre-sentencing group with prior DWIs would score higher on most if not all of the ASUDS-R scales, particularly for those scales measuring AOD involvement and disruption, social-legal non-conformity, and mood disruption - or that this group would have higher levels of psychosocial and AOD problems; that these differences would not be as robust, and with some scales, vanish, with the post-sentencing group; the repeat offenders would be more motivated for services; and that they would be less defensive. It was expected that priors would be older and have significantly fewer women. *Tables 18* through *20* provide the findings from these analyses.

Results provide strong support for the above stated hypotheses. For the Illinois pre-sentencing sample (*Table 18*), the prior DWI group scored higher on all of the *ASUDS-RI/ASUDS-R)* Scales except for the AOD 12 MONTHS scale, which was probably due to its restricted measurement variance of that scale. For the second pre-sentencing group (*Table 19*), the prior DWI group scored higher on all of the *ASUDS-RI/ASUDS-R)* scales except for DRIVING RISK. The mean score difference on DEFENSIVE was also lower.

With respect to the post-sentencing group, as expected, the mean score differences were not as large, although the prior DWI group scored higher (at a lower confidence level) on all the scales except for DRIVING RISK, AOD INVOLVEMENT, AOD 6 MONTHS, and GLOBAL. As discussed earlier, the post-sentencing group represents clients who reflect higher levels of AOD and psychosocial problems and the no-priors and prior DWI groups at post-sentencing are more similar than at pre-sentencing. Many of the impaired driving offenders with lower levels of AOD and psychosocial problems have been screening before they get to post-sentencing, e.g., those with lower BACs, those who do not fit the substance abuse or substance dependence classifications, etc. Although the differences are not as robust in the post-sentencing group, the differences do clearly exist.

Other important findings help us understand how the two groups differ. Across all three study groups, prior DWI clients reflect higher levels of motivation and readiness for treatment. This is consistent with other findings that those with more AOD problems are more motivated for intervention services. There are statistically significant fewer women in the prior DWI group: Illinois sample, 29 percent in the no-priors versus 20 percent in the priors; in the Western state pre-sentencing sample, 23 percent in the no-prior group versus 13 percent in the prior; and for the Eastern state sample, 23 percent in the no-prior versus 10 percent in the prior sample. Based on these findings, women are almost twice as likely **not** to re-offend as men.

One of the mixed findings was the scores on DEFENSIVE. For the Illinois pre-sentencing sample, the priors had significantly lower scores on DEFENSIVE. However, in the Western state pre-sentencing sample, priors had higher DEFENSIVE scores. And, for the post-sentencing group, no-priors and priors did not differ on the DEFENSIVE scale. One explanation for this finding is that the Western state group had only 13 percent women in the prior DWI group and 23 percent were men. A robust finding in these construct validation studies is that men score higher than women on DEFENSIVE. Thus a group with a significantly lower number of women would most likely have higher DEFENSIVE scores. The no-difference finding on DEFENSIVE with the post-sentencing group would be expected for reasons described above.

The findings that priors scored higher on AOD and psychosocial problems in the pre-sentencing group, and for the most part, in the post-sentencing group provide cogent support for the construct validity of the *ASUDS-RI/ASUDS-R* scales.

Comparing *ASUDS-RI* Weighted Scores Assignment With Illinois Placement/Risk Classification Assignment

The distribution of the weighted scores in *Tables 5* and *6* above were calculated for the Illinois normative sample. Column 3 of *Table 21* provides a summary of that distribution. The distribution of the assigned service classification based on the Illinois placement criteria (*Table 7*) is provided in column 4 of *Table 21*. The distribution is very similar. Cross-tabulation statistics indicated the following:

- Of the 202 clients placed in Level 1 by the Illinois placement criteria, 70 percent had an *ASUDS-RI* weighted score of 1 or 2, and only 6, or three percent, had a *ASUDS-RI* weighted score of four;

- Of the 131 clients placed in Level 4 by the Illinois criteria, 83 percent were placed in Level 3 or 4 by the *ASUDS-RI* weighted system and 6 or 4.2 percent were placed in Level 1 by the *ASUDS-RI* criteria;

- Of the 216 clients placed Level 1 by the *ASUDS-RI*, only 6 or 2.8 percent were placed in Level 4 by the Illinois system and 70 percent were placed in Levels 1 and 2 by the Illinois criteria;

- Of the 112 clients placed in Level 4 by the *ASUDS-RI* weight criteria, only 6 or 5.4 percent were placed in Level 1 by the Illinois system and just over 88 percent were placed in Levels 3 and 4 by the Illinois criteria.

Table 19: Comparing No Prior DWI With One Or More Prior DWIs Across *ASUDS-R* (Pre-Sentenced)

ASUDS SCALE DESCRIPTION	NO PRI (N=1648)		PRIORS (N=880)		t Value: ** P <.001 * P <.01
	Mean	SD	Mean	SD	
1. ALCOHOL INVOLVE	7.02	5.15	10.11	7.15	11.19**
2. DRIVING RISK	3.98	3.25	4.00	3.30	.18
3. AOD INVOLVEMENT	3.19	3.29	4.63	4.65	8.05**
5. AOD DISRUPTION	4.56	6.35	7.38	10.76	6.84**
6. AOD 6 MONTHS	2.50	3.47	3.00	5.51	2.44*
7. MOOD DISRUPT	3.86	3.78	4.74	4.63	4.69**
9. GLOBAL	17.50	13.34	23.68	20.28	7.29**
10. DEFENSIVE	15.00	3.66	15.48	3.72	3.01*
11. MOTIVATION	7.54	5.40	10.16	5.97	10.09**
D. SOCIAL NON-CON	6.04	3.79	7.53	4.25	8.38**
Age at Evaluation	30.89	11.28	36.68	10.59	12.80**
Gender	1.23	.42	1.13	.34	5.94**

Table 20: Comparing No Prior DWI With One Or More Priors Across *ASUDS-RI* (Post-Sentenced)

ASUDS-R SCALE DESCRIPTION	NO PRI (N=1604)		PRIORS (N=851)		t Value: ** P <.001 * P <.05
	Mean	SD	Mean	SD	
1. ALCOHOL INVOLVE	12.51	8.13	14.46	8.83	2.48*
2. DRIVING RISK	5.61	4.17	5.99	4.54	.92
3. AOD INVOLVEMENT	5.91	5.48	6.97	6.91	1.99*
5. AOD DISRUPTION	9.94	12.82	12.64	15.79	2.13*
6. AOD 6 MONTHS	4.27	7.10	4.31	5.54	.07
7. MOOD DISRUPT	6.10	5.25	7.11	5.57	2.00*
9. GLOBAL	29.73	24.33	34.23	26.08	1.82
10. DEFENSIVE	11.71	4.20	11.03	4.15	1.83
11. MOTIVATION	7.59	5.81	9.87	6.16	4.00**
D. SOCIAL NON-CON	7.70	4.61	8.81	5.22	2.36*
Age at Evaluation	34.44	11.95	38.82	9.23	4.87**
Gender	1.23	.42	1.10	.30	4.25**

Table 21
Comparison of *ASUDS-RI* Weight Score Assignment With Illinois Risk Classification Assignment (N=984)

Level	Service	ASUDS-RI Percent	Illinois Percent
1	Basic Education	23.8	22.2
2	Basic Education plus Intervention	32.9	29.8
3	Basic Education plus min.treatment	31.0	33.6
4	Extended treatment with continuing care	12.3	14.4

We can conclude that these are relatively good matches. However, the *ASUDS-RI* criteria is more conservative in placing clients than the Illinois placement criteria. Or, the Illinois system is more apt to place clients at a higher level than the *ASUDS-RI* weighted system. These results again point to the importance of using all of the information available by the evaluator in making placement decisions, and not just the *ASUDS-RI* placement criteria.

SUMMARY

The *ASUDS-RI* is designed to gain the client's self-report of his or her perception of important areas of life functioning, including AOD use and abuse, mental health concerns, attitudes and behaviors that run counter to the expectations of society and the community, and motivation and readiness for education and treatment services. This *User's Guide* provides basic information around administering, scoring and interpreting the *ASUDS-RI* scales. There are some important issues to keep in mind when using an instrument in the genre of the *ASUDS-RI*.

First, the *ASUDS-RI* is a differential screening instrument designed to provide direction and guidelines for the evaluator in making decisions around the service needs of DWI offenders. It is not intended to serve as an in-depth look at the client. The in-depth assessment is done after the client has been placed in a specific education or treatment facility.

Second, the *ASUDS-RI* represents the client's best ability to self-disclose around life-adjustment issues and problem behaviors. Even though the client may know that the self-report is not veridical with what is going on in his or her life, it is a valid representation of where the client is with respect to willingness to self-disclose at the time of assessment. It is where we start services - with the client's self-disclosure of that perception. This is crucial to placement and service needs planning. The **process** of screening is just as important as the **content** of screening. If the client becomes more self-disclosing as services progress, then intervention and treatment is being effective.

Third, self-report instruments are an essential and necessary component of the assessment process. The raison d'etre of any self-report screening instrument is to provide guidelines for decision making. However, any viable assessment must integrate the findings from self-report with the findings of other-report data, using the convergent validation model. Assessment conclusions and placement decisions of DWI offenders must be based on all sources of information and always consider the current perceptions, agenda and needs of the client as well as the agenda and sanctioning expectations of the community as these are expressed through the legal system. Collateral data, official records, other clinical information and placement criteria such as those developed by the *American Society of Addiction Medicine* (2001) should be used in conjunction with the *ASUDS-RI* scales and the above defined collateral variables in making service referral decisions. Findings reported in this *User's Guide* from the construct validation studies conducted on the *ASUDS-RI* scales point to the importance of utilizing all information when making both supervision and treatment recommendations and decisions with the client.

Fourth, even though our understanding of where the client is guides us in developing a referral plan, we know that it is not only the client's needs that determine service placement. The evaluator also keeps in mind the agenda and expectations of society and the community. Both agendas - the therapeutic and the correctional - guide the work and decisions of the DWI evaluator.

Fifth, although the *ASUDS-RI* can be used to provide suggested service level placement guidelines, the value of the *ASUDS-RI* is much greater than this single utility. Effective use of the *ASUDS-RI* scales can help both evaluators, judicial supervisors, and treatment personnel generate an initial supervision and service delivery plan and provided ongoing guidance in supervision and treatment. For example, clients with high scores on DISRUPTION and INVOLVEMENT may need more concentrated judicial supervision since such clients are at higher risk for relapse and, consequently, recidivism, since there is a strong interaction between these two potential outcomes. Clients who are highly defensive will need more reflective-supportive supervision approaches initially, using strong motivational counseling methods.

Sixth, the *ASUDS-RI* scales also help clients organize their perceptions of their AOD use and other psychosocial problems and provides a structure around which clients can be given feedback as to the areas of change and self-improvement that they need to address.

Finally, effort should be made to work in partnership with the client regarding intervention planning, referral decisions and service recommendations. Clients who are informed about the information upon which referral decisions are being made and who feel they are part of the decision making process are less resistive to services and perform better in DWI education and treatment.

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APPENDIX

ADULT SUBSTANCE USE AND DRIVING SURVEY

REVISED (ILLINOIS)

ASUDS - RI

ADULT SUBSTANCE USE AND DRIVING SURVEY

REVISED FOR ILLINOIS

ASUDS - RI

Survey Booklet

Authors:

Kenneth W. Wanberg and David S. Timken

CARE

CENTER FOR ADDICTIONS RESEARCH AND EVALUATION

P.O. Box 1975
Arvada, Colorado 80001-1975

Adult Substance Use and Driving Survey (Revised for Illinois) - ASUDS-RI

Instructions

Answer each question in this booklet as to how you see yourself. Choose the answer that best fits you. Give careful thought to your answers. It is important that you answer each question as accurately as you can.

Please give an answer to every question.

Mark only one answer for each question.

Please read the instructions that are provided for the different parts of this survey. In some parts, you are asked to give answers as to how they apply to your life time and then as to how they apply during the last 12 months that you have been in the community.

Carefully read each question and each possible answer before making your choice.

You are asked to mark your answers on this survey booklet.

If you have any questions, ask the person who is giving you this survey.

Your answers will be treated as confidential according to the laws of your state and the Federal confidentiality laws and within the guidelines of the consent you have provided to your agency for the release of confidential information about you. Before you start to answer the questions, please complete the following information..

☐ ☐

Name:		Date:	Agency:
Date of Birth:		Age:	☐ Male ☐ Female
Ethnic Group:	☐ African American ☐ Asian American ☐ Native American	☐ Anglo-American White ☐ Hispanic American	
Marital Status:	☐ Never Married ☐ Separated	☐ Married ☐ Divorced	☐ Remarried ☐ Widowed

ADULT SUBSTANCE USE AND DRIVING SURVEY - REVISED FOR ILLINOIS (ASUDS-RI)

Please circle the letter by the answer to each question that best fits how you see yourself

1. Did you drink* (alcohol) to have fun or to be happy?
   a. No.
   b. Sometimes.
   c. Often.
   d. Very often.

2. Did you drink to relax socially?
   a. No.
   b. Sometimes.
   c. Often.
   d. Very often.

3. Did you take a drink or two to relieve yourself of worries?
   a. Never.
   b. Sometimes.
   c. Often.
   d. Very often.

4. Have you had a bad headache because of having too much to drink?
   a. No.
   b. One or two times.
   c. Three or four times.
   d. Five or more times.

5. How many times have you been drunk?
   a. Never.
   b. Once or twice.
   c. Several times.
   d. Many times.

6. Have you been "half with it" at work or called in sick because you had too much to drink?
   a. No.
   b. One time.
   c. Two or three times.
   d. Four or more times.

7. Have you ever been unable to think or concentrate clearly after drinking?
   a. No.
   b. One time.
   c. Two or three times.
   d. Four or more times.

8. Did you drink when feeling down and depressed?
   a. Never.
   b. Sometimes.
   c. Often.
   d. Very often.

* Drink (or drinking) refers to the use of alcoholic beverages.

9. Did you ever drive an automobile knowing you had too much to drink?
   a. No.
   b. One time.
   c. A few times.
   d. Many times.

10. Have you ever passed out as a result of drinking?
    a. No.
    b. Once.
    c. Two or three times.
    d. Four or five times or more.

11. Have you ever felt down in the dumps after drinking?
    a. No.
    b. One time.
    c. A couple of times.
    d. Several times.

12. Have you ever been unable to recall what you did when you were drinking?
    a. No.
    b. One time.
    c. Two times.
    d. Three or more times.

13. Did you drink to relieve stress?
    a. No.
    b. Sometimes.
    c. Often.
    d. Very often. 1☐

14. I exceed the speed limit if road conditions are safe.
    a. Never.
    b. Seldom.
    c. Often.
    d. Very often.

15. I have found myself driving fast without realizing it.
    a. Never.
    b. Seldom.
    c. Often.
    d. Very often.

16. When other drivers do stupid things, I lose my temper.
    a. Never.
    b. Seldom.
    c. Often.
    d. Very often.

17. I drive fast and take my chances of getting caught.
    a. Never.
    b. Sometimes.
    c. Often.
    d. Very often.

18. High speed driving gives me a sense of power.
    a. Never.
    b. Very seldom.
    c. Sometimes.
    d. Often.

19. I have taken a risk when driving just because I felt like it.
    a. Never.
    b. Very seldom.
    c. Sometimes.
    d. Often.

20. I swear out loud or cuss under my breath at other drivers.
    a. Never.
    b. Seldom.
    c. Often.
    d. Very often.

21. I have outrun other drivers.
    a. Never.
    b. Very seldom.
    c. Sometimes.
    d. Often.

22. I pass other drivers when not in a hurry.
    a. Never.
    b. Seldom.
    c. Often.
    d. Very often.

23. I am a driver who likes to stay ahead of or out in front of traffic.
    a. Never.
    b. Sometimes I do.
    c. Often.
    d. Very often.

24. I have tried to beat a red light.
    a. Never.
    b. Sometimes.
    c. Often.
    d. Very often.

25. I dodge and weave through traffic.
    a. Never.
    b. Seldom.
    c. Often.
    d. Very often. 2☐

For the list of drugs below, circle the letter for the answer that best fits you. For alcohol, it is the number of times in your lifetime you have been intoxicated. For all other drugs, it is the number of times in your lifetime that you have used the drug. On the right side of the page opposite the drug, indicate the number of times in the last 12 months in the community, that you have been intoxicated on alcohol or you have used the other drugs. Circle "a" if you did not use alcohol or the other drugs in the past 12 months. Circle "b" if you were intoxicated on alcohol or used the other drugs from one to 10 times, etc.. Then for each drug that you have used in your lifetime, put your age you last used that drug.

	Total Number of Times in Lifetime						
	Never used	One to 10 times	11-25 times	26-50 times	More than 50 times	Times used in the last 12 months	Age last used
26. Number of times intoxicated or drunk on alcohol (beer, wine, hard liquor, mixed drinks).	a	b	c	d	e	a b c d e	____
27. **Marijuana** (pot, hashish, hash, THC, dope, etc.).	a	b	c	d	e	a b c d e	____
28. **Cocaine** (coke, snow, crack, rock, blow, etc.).	a	b	c	d	e	a b c d e	____
29. **Amphetamines/methamphetamine/stimulants** (meth, ice, crystal, speed, uppers, stimulants, diet pills, black beauties, bennies, white crosses, Dexedrine, Desoxyn, and other stimulants used for nonmedical reasons such as Ritalin, Adderall, etc.).	a	b	c	d	e	a b c d e	____
30. **Hallucinogens** (LSD, acid, peyote, mushrooms, PCP, angel dust, ecstasy, ketamine, etc.).	a	b	c	d	e	a b c d e	____
31. **Inhalants** (rush, gasoline, paint, glue, nitrous oxide, poppers, snappers, etc.).	a	b	c	d	e	a b c d e	____
32. **Heroin** (horse, H, smack, junk, etc.).	a	b	c	d	e	a b c d e	____
33. **Other opiates** or pain killers used for nonmedical reasons (codeine, opium, morphine, Percodan, Dilaudid, Demerol, Methadone, Oxycodone, Oxycontin, Vicodin, Darvon, etc.).	a	b	c	d	e	a b c d e	____
34. **Barbituates/sedatives** used for nonmedical reasons (Seconal, Nembutal, Amytal, Phenobarbital, Dalmane, quaaludes, placidyl, sleeping medicines, blues, reds, yellows, ludes, etc.).	a	b	c	d	e	a b c d e	____
35. **Tranquilizers** use for nonmedical reasons (Librium, Valium, Ativan, Xanax, Serax, Miltown, Equanil, Halcion, meprobamates, etc.).	a	b	c	d	e	a b c d e	____
						3 ☐	

36. As to your use of **cigarettes (tobacco).**	Never smoked	Do not smoke now	Up to half pack a day	Up to a pack a day	Up to two packs a day	More than two packs a day
	a	b	c	d	e	f

Have you used alcohol or other drugs for any of the following reasons? Circle the letter for the answer that best fits you.

	No	Sometimes	Often	Very often	
37. To have fun and relax?	a	b	c	d	
38. To relieve stress and tension?	a	b	c	d	
39. To feel less depressed?	a	b	c	d	
40. To be less shy?	a	b	c	d	
41. To be able to express myself better?	a	b	c	d	
42. To relieve your worries and troubles?	a	b	c	d	
43. To forget your problems?	a	b	c	d	
44. To calm yourself down?	a	b	c	d	4 ☐

As a result of using alcohol or any of the other drugs on page 4, indicate how often any of the following have happened to you in your lifetime. Then, for each of the following statements, in the column on the right side of the page, indicate how many times it has happened to you in the last 12 months in the community. Circle an "a" if it did not happen to you, circle a "b" if it happened to you 1-3 times, circle a "c" if it happened to you 4-6 times, circle a "d" if it happened to you 7-10 times and circle an "e" if it happened more than 10 times.

	Total Number of Times in Lifetime					
	Never	1-3 times	4-6 times	7-10 times	More than 10 times	Number of times in the last 12 months
45. Had a blackout (forgot what you did but were still awake).	a	b	c	d	e	a b c d e
46. Became physically violent.	a	b	c	d	e	a b c d e
47. Staggered and stumbled around.	a	b	c	d	e	a b c d e
48. Passed out (became unconcious).	a	b	c	d	e	a b c d e
49. Tried to take your own life.	a	b	c	d	e	a b c d e
50. Became physically sick or nauseated.	a	b	c	d	e	a b c d e
51. Saw or heard things not there.	a	b	c	d	e	a b c d e
52. Became mentally confused.	a	b	c	d	e	a b c d e
53. Thought people were out to get you or wanted to cause you harm.	a	b	c	d	e	a b c d e
54. Had physical shakes or tremors.	a	b	c	d	e	a b c d e
55. Had a seizure or a convulsion.	a	b	c	d	e	a b c d e
56. Had rapid or fast heart beat.	a	b	c	d	e	a b c d e
57. Became very anxious, nervous and tense.	a	b	c	d	e	a b c d e
58. Became feverish, hot or sweaty.	a	b	c	d	e	a b c d e
59. Did not eat or sleep.	a	b	c	d	e	a b c d e
60. Were weak, tired and fatigued.	a	b	c	d	e	a b c d e
61. Unable to go to work or school.	a	b	c	d	e	a b c d e
62. Neglected your family.	a	b	c	d	e	a b c d e
63. Broke the law or committed a crime.	a	b	c	d	e	a b c d e
64. Could not pay your bills.	a	b	c	d	e	a b c d e
	A[ ]	B[ ]	C[ ]		5[ ]	6[ ]

For the following questions, please choose the answer that best fits you.	Hardly at all	Yes sometimes	Yes A lot	Yes, all the time
65. Have you felt down and depressed?	a	b	c	d
66. Have you been nervous and tense?	a	b	c	d
67. Have you been irritated and angry?	a	b	c	d
68. Have your moods been up and down - from very happy to very depressed?	a	b	c	d
69. Do you tend to worry about things?	a	b	c	d
70. Have you felt like not wanting to live or taking your own life?	a	b	c	d
71. Have you had problems sleeping?	a	b	c	d
72. Have you had thoughts that upset or disturb you?	a	b	c	d
73. Have you been discouraged about your future?	a	b	c	d

7[ ]

Please circle the letter for the answer for each question that best fits you.

	No never	Hardly at all	A few times	Yes a lot
74. Have you ever gotten angry at someone?	a	b	c	d
75. Have you lied about something or not told the truth?	a	b	c	d
76. Do you ever find yourself unhappy?	a	b	c	d
77. Have you felt frustrated about a job?	a	b	c	d
78. Do you hold things in and not tell others what you think or feel?	a	b	c	d
79. Have you been unkind or rude to someone?	a	b	c	d
80. Have you ever cried about someone or something?	a	b	c	d

10 ☐

Please circle the letter for the answer for each question that best fits you.

	Never	1-2 times	3-4 times	5 or more times
81. When I was in my teen years, I got into trouble with the law.	a	b	c	d
82. I was suspended or expelled from school when I was a child or teenager.	a	b	c	d
83. I have been in fights or brawls.	a	b	c	d
84. I have been charged with driving while impaired or under the influence of alcohol or other drugs.	a	b	c	d

	Not true	Somewhat true	Usually true	Always true
85. I have had trouble because I don't follow the rules.	a	b	c	d
86. I don't like police officers.	a	b	c	d
87. There are too many laws in society.	a	b	c	d
88. It is all right to break the law if it doesn't hurt anyone.	a	b	c	d

Please answer these questions as to how they apply to you during your lifetime and during the last 12 months in the community. Circle the letter for the answer of your choice.

	During Your Lifetime				
	None	1-2 times	3-4 times	5 or more times	During the last 12 months
89. Number of times I have received a ticket for a driving violation (speeding, driving without a license, running a red light, etc.).	a	b	c	d	a b c d

	During Your Lifetime				
	No never	Sometimes	A lot	Most of the time	During the last 12 months
90. When in the community, I have spent time with people who have been in trouble with the law.	a	b	c	d	a b c d
91. My friends and/or family get into trouble with the law.	a	b	c	d	a b c d
92. When I have broken the law, I have been high or under the influence of alcohol or other drugs.	a	b	c	d	a b c d
				D ☐	
93 When I have committed a crime, I knew that I was involved in criminal behavior.	a	b	c	d	a b c d

Please answer these questions as to how they apply to you during your lifetime and during the last 12 months in the community. Circle the letter for the answer of your choice.

	During Your Lifetime				
	None	1-2 times	3-4 times	5 or more times	During the last 12 months
94. As an adult, I have been in trouble with the law other than while driving a motor vehicle.	a	b	c	d	a b c d
95. Number of times that I have been arrested and charge with a crime.	a	b	c	d	a b c d
96. Number of times that I have been convicted of a crime (misdemeanor or felony).	a	b	c	d	a b c d
97. Number of times my probation or parole has been revoked (circle "a" if never been on parole or probation).	a	b	c	d	a b c d
98. Number of times I have been arrested for a crime committed against a person (such as robbery, burglary, assault, rape, manslaughter, murder).	a	b	c	d	a b c d
99. Number of times I have been arrested for a domestic violence related offense.	a	b	c	d	a b c d

Please answer these questions as to how they apply to you during your lifetime and during the last 12 months. Circle the letter for the answer of your choice.

	During Your Lifetime					
	Never	1-6 months	7-12 months	1-3 years	4 or more years	During the last 12 months
100. Total amount of time I have spent on probation.	a	b	c	d	e	a b c
101. Total amount of time I have spent on parole.	a	b	c	d	e	a b c
102. Total amount of time I have spent in jail or prison.	a	b	c	d	e	a b c

	During Your Lifetime				
	No Never	Sometimes	Often	Very often	During the last 12 months
103. I have been violent in my behavior or actions.	a	b	c	d	a b c d

Please answer these questions as to how they apply to you during your lifetime and during the last 12 months in the community. Circle the letter for the answer of your choice.

	Total Number of Times in Lifetime					
	Never	One time	Two times	Three times	4 or more times	Number of times in last 12 months
104 Number of times I have been sentenced for a crime to county jail.	a	b	c	d	e	a b c d e
105. Number of times I have been sentenced for a crime for which I have been on probation or conditional discharge or conditional supervision.	a	b	c	d	e	a b c d e
106. Number of times I have been sentenced for a crime to state or federal prison.	a	b	c	d	e	a b c d e

8 ☐ E ☐ F ☐

Please answer the following questions as to how you see yourself at this time.

	No not at all	Yes maybe	Yes most likely	Yes for sure
107. Have you felt a need to make changes in your use of alcohol or other drugs?	a	b	c	d
108. Do you want to *stop using alcohol; or to continue not using alcohol?*	a	b	c	d
109. Do you want to *stop using other drugs; or continue not using other drugs?*	a	b	c	d
110. Have you felt a need to have help with problems having to do with alcohol use?	a	b	c	d
111. Have you felt a need to have help with problems with the use of other drugs?	a	b	c	d
112. Is it important for you to make changes around the use of alcohol or other drugs?	a	b	c	d
113. Would you be willing to come to *(or continue in)* a program where people get help for alcohol or other drug use problems?	a	b	c	d

11 ☐