

INTRODUCTION AND OVERVIEW OF THE *PACE* MONITOR

WHAT IS THE *PACE* MONITOR

The *PACE Monitor* is a comprehensive program for the screening, in-depth assessment and the evaluation of the progress and change of clients admitted to and proceeding through criminal conduct and substance abuse treatment programs. Although it is designed for the program *Criminal Conduct and Substance Abuse Treatment - Strategies for Self-Improvement and Change* (SSC: Wanberg & Milkman, 2006, 2008), it is a generic assessment and monitoring program that can be used in any treatment program for substance abusing offenders.

PACE is comprised of instruments and methods that evaluate critical life-situation and adjustment problems across a variety of domains that include substance abuse, mental health, criminal conduct, job productivity, relationship and family problems, and physical health concerns. It also measures client responsibility in the areas of motivation and defensiveness. It provides the mechanisms for the measurement of progress and change over the course of treatment and post-treatment outcome. *PACE* provides the mechanism and tools for both client and program evaluation.

WHO WOULD USE *PACE*

PACE can be used by a variety of personnel providing supervision and treatment services to judicial clients. **Effective use of *PACE* will require careful study of this *Handbook*.** It is recommended that agencies using *PACE* in part or in its entirety assign a lead evaluator to train and oversee its use. This could be the individual who supervises the overall evaluation process. This lead evaluator should have training and experience in offender assessment. When a lead evaluator is not available, individual judicial and treatment personnel will need to study the *PACE Monitor* and determine how it can be effectively used in their work with clients. We refer to the user of *PACE* in this *Handbook* as the provider, which may also represent the agency evaluator assigned to oversee its use.

HOW IS *PACE* TO BE USED

Due to the comprehensive nature of *PACE*, judicial and treatment agencies may not have the resources to implement its full program. Evaluators and providers may choose to use only portions of *PACE*. *PACE* is divided into parts or chunks that apply to different aspects of evaluation and may be conducted by different personnel. For example, *Part I* may be utilized by judicial evaluators at the level of screening clients into treatment services. *Part II*, the differential assessment component, may be utilized by clinical staff responsible for in-depth evaluation and developing the client's individual treatment plan. *Part III*, which measures treatment progress and change, may be used by the individual counselor working with clients. Thus, different individuals may be responsible for the implementation of different parts of *PACE*. A lead evaluator can provide the coordination and integration of its implementation.

OVERVIEW OF THIS HANDBOOK

This *Handbook* provides guidelines, instructions and instrumentation for the implementation of *PACE*. It includes the *PACE* instruments, a brief description of each instrument and its scales, instructions for scoring, and profiles that provide graphic results of the scale scores.

There are two sections of this *Handbook*. *Section I* is comprised of five parts and describes the various methods, procedures and instruments used in the *PACE Monitor*. This section also provides the scoring procedures for each of the instruments and brief descriptions of the instrument and instrument scales.

Section II provides the specific instruments that are used in *PACE*. The pages of these instruments are perforated so that they can be easily removed for copying.

In this *Introduction*, the five parts of *Section I* are briefly outlined. *Table 1* summarizes the instruments in each of these parts.

PART I describes intake and screening for clients entering treatment for substance abuse and criminal conduct, and specifically for *SSC*. As part of this screening, providers are asked to administer the *Adult Substance Use Survey - Revised* (ASUS-R: Wanberg, 2004a, 2009), the *Adult Self-Assessment Questionnaire* (AdSAQ: Wanberg & Milkman, 1993, 2008), and the *Treatment Assessment Questionnaire* (TAQ: Wanberg, 2009a). The provider or evaluator also completes the one page *Rating Current Status Scales* (RCSS: Wanberg, 2009b). Using the ASUS-R and other intake information, providers discern client appropriateness for admission to *SSC* or other programs for the substance abusing judicial client and to complete an initial treatment plan.

PART II provides guidelines and instruments for doing a differential and comprehensive assessment of clients that provide the basis for developing an individual treatment plan. For *SSC*, this information is also used to help clients complete the *Master Profile* (MP) and develop the *Master Assessment Plan* (MAP).

There are two *PACE* instruments that are used for this purpose: the *Adult Self-Assessment Profile* (AD-SAP: Wanberg, 1998a, 2009), a self-report instrument, which provides a differential assessment across the major problem conditions or risk areas traditionally evaluated by treatment programs; and the *Rating Adult Problems Scale* (RAPS: Wanberg, 1998b, 2009). RAPS is completed after the client has been interviewed and after completing the admission and intake instruments. The completed RAPS can serve as a psychosocial summary.

Since the cognitive-behavioral approach is the primary treatment platform for most treatment programs for substance abusing judicial clients, **Part II** also provides guidelines for completing a cognitive-behavioral assessment. This assessment identifies cognitive structures that lead to criminal conduct and substance abuse and are targets for change.

PART III provides guidelines and instruments for evaluating the progress and change of judicial clients. Forms for collecting program attending data are provided. Clients rate themselves and are rated

by providers as to their response to the program, and clients are readministered the TAQ. Guidelines for readministering the screening and assessment instruments are also provided.

PART IV describes the procedures for evaluating clients at phase and program closure. Most judicial treatment programs are conducted in phases. The *PACE Monitor* provides closure assessment for three different treatment phases.

At the end of *Phase I*, the client and provider review 14 specific skill and knowledge areas that are important for clients to grasp in order to successfully negotiate *Phases II* and *III* of *SSC*. For programs that do not have specific phases, this skills assessment can take place periodically during the program.

The *Program Closure Inventory* (PCI: Wanberg, 2009c) is administered at the end of the program. For clients who end their program involvement prematurely, the PCI should be administered at that terminal point.

PART V provides instruments and guidelines for longer term follow-up. This is beyond the scope of resources for most providers; however, some guidelines are provided to make this task feasible for most agencies.

THE CONVERGENT VALIDATION MODEL

The conceptual framework upon which *PACE* is constructed is the convergent validation model. This model is described in more detail in *Chapter 6 of Criminal Conduct and Substance Abuse Treatment - Strategies for Self-Improvement and Change, The Provider's Guide* (Wanberg & Milkman, 2008). It will be briefly summarized.

It is commonly believed by many workers and evaluators, particularly those working with judicial clients, that self-reports are not reliable and are often not to be trusted. Given that most would agree that both screening and comprehensive assessment are essential in the process of developing an effective treatment placement and plan for judicial clients, how do we approach assessment so as to resolve

the dilemma between this importance and the problem of self-report validity. Addressing this question is critical to the understanding and use of the *PACE Monitor* in evaluating the client's treatment needs and change.

The Components of Assessment

The convergent validation model is based on the concept that assessment is a continual process that has many components. The process begins with screening and continues through the assessment of treat-

T A B L E 1

Tasks and Instruments used in *PACE Monitor*

HANDBOOK PARTS	INSTRUMENTS
PART I: Differential screening and intake	<p>Adult Substance Use Survey - Revised (ASUS-R): Differential screening</p> <p>Personal Data Questionnaire (PDQ): Descriptive information</p> <p>Adult Self-Assessment Questionnaire (AdSAQ): Completed by client and measures motivation and readiness for treatment</p> <p>Treatment Assessment Questionnaire (TAQ): Completed by client at intake and describes the cognitive-behavioral status of clients (called Self-Evaluation Questionnaire (SEQ) in the <i>SSC Provider's Guide</i>)</p> <p>Rating Current Status Scales (RCSS): This is the provider's rating to be done at the same time as the TAQ</p>
PART II: Differential and comprehensive assessment	<p>Adult Self-Assessment Profile (ADSAP): Measures alcohol and other drug (AOD) use patterns and problems and other psychosocial problem areas and risk factors</p> <p>Rating Adult Problems Scale (RAPS): Evaluator's rating of client's AOD and other psychosocial problem areas</p> <p>Cognitive Assessment Guide (CAG): Identifies cognitive structures that lead to criminal conduct and substance abuse and are targets for change</p>
PART III: Progress and change during treatment	<p>Program Attendance Record (PAR): Measures client's program involvement</p> <p>Client Program Response - Client (CPR-C): Self-report that measures response to treatment every 4th session</p> <p>Client Program Response - Provider (CPR-P): Rates clients response to treatment every 4th session</p> <p>Treatment Assessment Questionnaire (TAQ): Completed by client every three months and/or at the end of each Phase of treatment</p> <p>Phase I Review Guide (Phase I-RG): Evaluates client's participation in program at end of <i>Phase I</i></p> <p>ASUS-R Re-Survey (optional): Completed by client after being in program six months and used to compare client's intake responses with six months post-admission responses</p> <p>AdSAQ Re-Survey (optional): Completed by client after being in program six months and used to compare client's intake motivation and readiness for treatment with six months post-admission responses</p>
PART IV: Treatment closure and immediate treatment outcome	<p>Program Closure Inventory - Client (PCI-C): By client when completing or terminating program</p> <p>Program Closure Inventory - Provider (PCI-P): By provider when client completes or ends program</p> <p>Treatment Assessment Questionnaire - TAQ: Completed at program closure unless last TAQ was given within two months of closure</p>
PART V: Treatment follow-up	<p>Follow-up Assessment Questionnaire (FAQ): Includes re-survey of TAQ and components of the ASUS-R and ADSAP at six months and one year (If resources are limited, recommend a random sample of clients be followed-up)</p> <p>Judicial Systems Survey (JSS): Guide to surveying the judicial system for recidivism information on clients</p>

ment outcome. This process has four major components. Over the assessment process, each component contributes information that converges on the estimate of a client's condition and changes in that condition.

- ▶ **Screening** discerns service referral placement and generates an initial treatment plan. It identifies the level of substance abuse and screens for other problem areas, e.g., mental health, criminal conduct.
- ▶ **Comprehensive or in-depth assessment** looks at distinct and multiple conditions that provide the basis for the development of a comprehensive treatment plan.
- ▶ **Treatment progress and change assessment** looks at the response to treatment, beginning with the initial assessment and continuing through the last contact made with clients.
- ▶ **Outcome assessment** includes: assessment done when the client finishes the formal treatment program; assessment at short-term outcome at three to six month post-discharge; and long-term outcome evaluation, or assessment at points one year or more post-discharge.

Objectives of the Convergent Validation Assessment Approach

Within the framework of collecting information to determine the specific service needs and targets for change of the judicial client, there are six objectives that guide the process of assessment.

- ▶ To provide clients with an opportunity to disclose information about themselves or to tell their story. This is essential and defines how clients see themselves at various points of assessment. At initial assessment, self-report provides a baseline of the client's perception of self and the willingness to self-disclose that perception. Subsequent self-reports can be compared with this initial baseline measure.
- ▶ To gather information from other individuals associated with the client or other sources of information. It provides opportunity for others to

tell their story about the client.

- ▶ To discern the level of openness or defensiveness of the client at the time of assessment by comparing the client's self-report with other-report data. As willingness to disclose increases, defensiveness decreases, and the motivation to engage in change is enhanced.
- ▶ Estimate the "true" condition of the client. We never know the client's "true" condition. We estimate this condition using self-report and other-report information. Our estimate is ongoing and converges on the client's "true" condition.
- ▶ To make a referral and placement that match the presenting problems with appropriate services. This matching is ongoing, and even after a client is in treatment for several months, continued assessment may reveal a new problem or condition that needs a new or different service.
- ▶ To evaluate progress and outcomes during treatment and post-treatment.

All of these objectives are viewed within the context of the partnership between the provider and client. The client is continually involved as a partner in determining the level of problems and services needed to address these problems.

Self-Report and Other-Report

The convergent validation model uses both self-report and other-report to understand the client's history, current situation and treatment needs. Self-report is viewed from two perspectives: the content of the data used in estimating the client's "true" condition; and the process of change of these conditions as they are reported over time. Data gathered at any particular point in time is relevant only as it is viewed within the process of change. Any point in testing only provides us with an estimate of the client's condition and gives us guidelines for treatment needs at that point in time. From this perspective, the process of assessment is just as important as the content of assessment.

When we see assessment as a process, we view all self-report data as a valid representation of where the

client is at a particular point in time. Self-report data are essential in that they provide a baseline measure of the client's willingness to disclose his or her problems or conditions at any point of assessment. It tells us the degree of openness to self-disclosure. The degree of validity of how well self-report data estimate the "true condition" of the client is directly related to the level of defensiveness. Thus, when looking at self-report data, we must first look at this level of defensiveness.

Self-report data tell us where to begin treatment. This is where the change process and intervention begins - with the client's self-perception, or the willingness to disclose information around that self-perception.

If self-report in the initial assessment does not accurately reflect what is going on in the client's life, based on other-report data, and if treatment is working, later self-reports will reflect a change in the disclosure of this self-perception. The first indication of treatment efficacy is found in the client's increase of self-disclosure and openness in treatment. Retesting should reveal any change occurring in this self-disclosure.

Within this model of assessment, *every self-report is seen as a valid representation* of the client's willingness to disclose perceptions about the conditions being evaluated at a particular point of assessment. 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 are valid. This discrepancy then becomes the basis for where we start treatment.

From this perspective, *a self-report is never invalid*. Report invalidity must always be interpreted 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. This approach prevents us from getting caught up in the question

of whether the client is "lying," "under-reporting," "denying," or "falsifying."

In summary, the convergent validation model uses all sources of information to converge on the most valid "estimate" of the client's condition in key areas of assessment. We can hypothesize about this condition. Our data then can test that hypothesis.

OVERVIEW OF INSTRUMENTS SCORING GUIDELINES

As the instruments used in *PACE* are discussed in their respective parts of this *Handbook*, their scoring procedures and brief description of their scales are presented. As well, a brief guide as to how the instrument and scales can be used in evaluating and assessing clients is also presented for each instrument.

Each instrument, along with its profile, is provided in *Section II: Instruments and Surveys Used in the PACE Monitor*. As noted, the pages of each instrument along with its respective profile are perforated so that the provider can easily remove them to make copies.

Scoring

For some instruments, scoring is done on the instrument itself and scores are placed in appropriate scoring boxes. Other instruments have answer sheets on which respondents mark their responses, and scoring boxes are provided on the answer sheet.

Rater Scales

Several instruments have rater scales that require the evaluator to rate the client across separate and independent rating scales. Other instruments are entirely comprised of rater variables. These components will be described for each respective instrument.

Plotting the Profile

Each instrument has its respective profile. For some instruments, the profile is on the instrument itself.

For other instruments, the profile is on a separate page or pages. Once the raw score scales have been calculated, they are recorded in the Raw Score column on the profile. The raw scores are then plotted in the proper row on the profile. This is done by marking the number in the row that corresponds to the raw score. If a raw score does not correspond to any of the listed numbers, the location of that score should be interpolated between the next lowest and next highest listed numbers.

UNDERSTANDING AND READING INSTRUMENT SCORES

The instruments in *PACE* use several different methods to interpret the meaning of their item and scale scores. Regardless of the method of interpreting scales, (e.g., normative sample, percent of total score) a high score on a scale indicates a higher quantitative measure of the particular characteristic, trait, pattern, or dimension the construct is measuring (e.g., AOD use disruption, psychological problems, strengths, motivation).

Item Interpretation

We refer to each question in any of the instruments and surveys as an item. One use of these instruments is to look at individual items in the instruments. Some are particularly important in understanding a particular client. We call these big-face valid items. For example, self-report items reflecting self-harm, harm to others, critical items measuring the serious direct and indirect effects of AOD use and abuse (e.g., seizures, delirium), and items measuring specific involvement in the judicial system should be attended to.

Face-Validity for Understanding the Meaning of a Scale

The meaning of a particular measure or scale is found in the content of the items of that scale. All of the scales of the instruments in *PACE* are face-valid with respect to the construct they measure. There are no subtle measures in these scales. Evaluators get what they see with respect to the meaning of items and should peruse the

items of each scale to understand its meaning. For example, the items in the ASUS-R DISRUPTION scale are obvious with respect to the specific symptoms and negative consequences they measure.

Standardized Scores Based on Normative or Reference Groups

The raw score of a particular test or scale also takes on meaning as we compare that score with the raw scores of a particular sample or group. We make this comparison by translating the raw score into a standardized or normative score.

Several instruments in *PACE* use the percentile rank as the standardized score. The percentile score indicates what percent of the reference or normative group that 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 75 percent in the reference or comparative group scored lower than that individual, and 25 percent of the reference group scored higher than that individual.

The percentile rank score can also be translated into a decile score or a quartile score. The decile score represents a range of 10 percentile scores. For a person with a decile of two, or a score that falls in the second decile range, 80% of the normative sample would score higher than that person, and 10% would score lower than that person.

The quartile score represents a range of 25 percentile scores. Thus, if a person scores in the second quartile range, this would indicate that at least 25 percent of the normative group falls below that person, and at least 50 percent of the normative group falls above that person's score. The decile and quartile scores take on value when we recognize that there is always measurement error in any score we might derive from a measure. The decile and quartile scores are not as precise as the percentile score, but they do allow us to build into the standard score the measurement error itself.

Four instruments in *PACE* use the percentile stan-

dard score. These are: ASUS-R, AdSAQ, ADSAP and the RAPS. Each of these instruments have profiles where the raw scores are located on a row to the right of the scale title. The percentile scores are located at the bottom of the profile and the decile scores located at the top of the profile. The normative groups for these four instruments are based on judicial samples. The norms will be briefly described when each of these instruments are discussed later in this *Handbook*.

Percent of Total Score - PTS

Some of the instruments in *PACE* specifically designed to measure change are not normed (e.g., TAQ, CPR-C, CPR-P). The standard score calculated for each scale of these instruments is the **percent of total score** (PTS). The purpose of the progress and change instruments in *PACE* is to evaluate the difference between surveys taken at different times for each individual. Thus, the PTS compares the individual with him/herself, rather than with a normative group. For example, if a scale is comprised of 10 items, and the total raw score for each item is 5, then the total score on that scale would be 50. The client's raw score on that scale is then converted to a PTS. If the respondent's total score is 40, then the PTS would be 80.

Since the main purpose of the progress and change scores is to compare results across various scale administrations, the PTS will give the provider an idea of change that is occurring across various measurements. This approach allows groups to be studied with respect to comparisons of mean raw scores across repeated measures. For example, the mean scores of a first and second measure of a particular scale in a *PACE* instrument for a group of 40 clients can be compared to determine whether there is a statistically significant difference across the repeated measures.

The percent total score (PTS) must not be used to indicate percent of change. That is, if a person has a PTS of 50 on the 1st survey and a PTS of 80 on the second survey, this should not be interpreted as a 30% improvement, as do some manuals of some in-

struments. It can be interpreted as a 30% change in the PTS and thus indicates there is a positive movement as to self-ratings or rater assessment. As data are collected on these *PACE* measurements and studies are done with respect to the statistical significance of changes in mean scores across repeated measures, then individual change scores can be evaluated relative to the statistical significance of group mean change scores.

If it has been established that the PTS change score of 30 does in fact represent a statistically significant change score for a baseline study group for that measure in a particular agency, then one could conclude that this PTS score for a particular individual does represent a statistically significant change when compared to that baseline group. That is, it could be concluded that an individual with a PTS change score of 30, when compared to the reference change group, does indicate a significant change in the particular area being assessed.

RESTRICTIVE USE

The *PACE Monitor* and its instruments is generic in that it can be adapted for all programs addressing the co-occurrence of criminal conduct and substance abuse. The paper-pencil versions of the *PACE* instruments can be used without cost when used in conjunction with *Criminal Conduct and Substance Abuse Treatment - Strategies for Self-Improvement and Change (SSC)*. A license agreement is required for such use (see Notice in front of this *Handbook*). Use of *PACE* and its instruments for the evaluation, assessment and progress and change monitoring of clients not in *SSC* requires a license agreement which includes an annual cost (see footnote 1).

RESOURCES FOR SPECIFIC INSTRUMENTS

For most of the *PACE* instruments, the provider will want to request the user's guides that give the full description of the instrument. It is highly recommended that the provider or counselor have access to the user's guides for the ASUS-R, ADSAP/RAPS and AdSAQ. Brief user's guides are also available for the *Treatment Assessment Questionnaire* (TAQ) and

for the *Client Program Response* (CPR). These guides provide information on instrument administration, scoring, description of scales, and psychometric properties of the instruments and their respective scales. Information regarding the access of these guides is found in footnote 1.

AGENCY LIMITATIONS AS TO THE USE OF PACE

Some agencies will be limited as to resources that can be devoted to the use of *PACE* for client assessment and program evaluation. As well, it is recognized that many agencies have their own screening, comprehensive assessment and progress evaluation procedures. Because of this, the provider or agency may elect to use only portions of the *PACE Monitor*.

AUTOMATED PACE: THE A-PACE MANAGER

The automated *PACE (A-PACE Monitor)* is available on a compact disc. The CD includes a PDF file for each instrument that can be used to print copies. Clients and providers complete the instruments on hard copy, and then results are entered into the computer.

The *A-PACE Monitor* scores each instrument, plots the profile, and shows profile comparisons over time. It can chart changes on individual clients and also provide aggregate change information across group, provider and agency. It can be used as a management information system for individual clients (e.g., client demographics, attendance), and for aggregate level reports for the group, provider and agency.

Providers may choose to use only portions of the *A-PACE* or the entire *A-PACE Monitor*. Information regarding the access of the *A-PACE* is found in footnote 2.

INTRODUCTION REVIEW

This introduction provides an overview of the *PACE Monitor* and a summary of the five parts of this *Handbook*. A summary of the convergent validation model and its various assessment components and

specific assessment objectives were presented. The convergent validation approach uses both self-report and other-report information in estimating the client's "true" clinical condition. The essentiality of self-report was stressed, and that every self-report is valid representation of where the client is with respect to the willingness to disclose his or her condition at that particular point in the assessment process. As the client becomes less defensive and more responsive to treatment, self-report becomes more valid with respect to estimating the clients "true" condition.

An overview of the *PACE* instrument's scoring guidelines was presented. Plotting the instrument profiles and a discussion of the two kinds of standardized approaches - percentile scores and percent of total score - used in reflecting the meaning of the scale scores in various instruments were discussed.

Limitations regarding the use of the *PACE Monitor* were outlined, including the restriction that *PACE* and its instruments are part of the overall *SSC* protocol and curriculum, and can be used without costs only with *SSC* clients. Use with non-*SSC* clients requires a contract (see footnote 1).

Information regarding the automated *PACE* was presented. As well, it was acknowledged that some agencies may not have the resources to use *PACE*, and that some agencies have their own screening and in-depth instruments and protocol.

1. Contact the Center for Addictions Research and Evaluation, P. O. Box 1975, Arvada, CO 80001-1975 or CARE@nilenet.com for information regarding the use of *PACE* or for acquiring User's Guides for the *ASUS-R*, *AdSAQ*, *AD-SAP/RAPS*, *CPR*, and *TAQ*. Also, information regarding these instruments may be found at: www.aodassess.com.
2. The *A-PACE Manager*, which includes the instruments and automated scoring will be available on compact disk in the Fall of 2010. Contact Diversion Services Inc., 4435 O Street, Suite 96, Lincoln, NE 68515 or by visiting www.aodassess.com/PACEMONITOR.