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Research Snippet

The Validity of Self-Reported Drug Use with Male Offenders

KEY WORDS: *Computerized Assessment of Substance Abuse, validity, self-report measures, Paulhus Deception Scale*

Impetus

The Computerized Assessment of Substance Abuse (CASA) is administered to male offenders upon reception into federal custody in Canada to determine the existence or severity of a substance abuse (SA) problem. Researchers have established the validity of the tests that comprise the CASA by comparing them to other measures of SA, such as other self-report measures[1], biological assays, official records, and accounts from friends/family (see Boland et al., 1998 for a review). With any self-report measure, it is valuable to conduct analyses that demonstrate the accuracy of the information presented.

The Paulhus Deception Scale (PDS; Paulhus, 1998) was included in the CASA as a measure of response bias. The PDS identifies four response profiles based on scores on the impression management (IM) and self-deceptive enhancement (SDE) scales:
(1) Reliable - aware of problems;
(2) Unreliable - aware of problems;
(3) Unreliable - self-deceiving;
(4) Unreliable - self-enhancing and self-deceiving.

Unreliable responders assessed with a SA problem are not as concerning as unreliable responders with no SA problem. Although some in the former group may have misrepresented their level of SA problem, if an offender is flagged as having any SA problem he will be assigned some level of treatment. Of more concern are unreliable responders who show no SA problem, as some in this group may have an undetected substance abuse problem and yet not receive a referral to treatment.

What we did

We explored associations between PDS responses and the presence of SA problems. The sample was comprised of 10,845 Canadian male federal offenders who completed the CASA between 2002 and 2009.

What we found

The results indicated that 63% of offenders were classified as reliable responders (#1 above), 11% were aware of problems, but unreliable (#2 above), 16% were self-deceiving and unreliable (#3 above), and 10% were self-enhancing, self-deceiving, and unreliable (#4 above). Of interest, 17% were classified as unreliable responders without a SA problem. Overall, 87% of reliable responders were classified as having a SA problem compared to 54% of unreliable responders. In line with this, 80% of reliable responders assessed with a SA problem acknowledged their SA problem compared to 57% of unreliable responders (Table 1).

Table 1: Percentages and frequencies of SA problem and recognition of SA problem.

	SA Problem		Recognize SA Problem[a]	
PDS Profile (N)	No	Yes	No	Yes
Reliable				
Aware of problem (6,817)	13%	87%	20%	80%
Unreliable				
Aware of Problem (1,150)	48%	52%	48%	52%
Self-Deceiving (1,752)	35%	65%	38%	62%
Self-Deceiving /Self-Enhancing (1,126)	61%	39%	52%	48%

[a] *Only those with identified SA problems responded to this question (N = 3,303).*

What it means

According to PDS responses, the majority of offenders provided reliable responses on the scales that comprise the CASA (ADS, DAST, and PRD), in line with Kunic and Grant's (2007) findings. This suggests that most offenders with a SA problem will be assigned to an appropriate treatment program.

Offenders assessed as unreliable responders may minimize their SA problems, possibly to appear publicly acceptable and/or in denial of a SA problem. However, assessments are never based on a single tool, but rely on multiple sources of information, so unreliable responders will most likely receive the appropriate level of SA treatment.

It is suggested that institutional staff consider PDS profile information when creating treatment plans. For example, since offenders scoring high on the SDE scale may be unaware of a SA problem, program staff should further assess these offenders for treatment readiness and motivation, to help determine their treatment needs. In contrast, offenders who score high on the IM scale may be trying to hide or minimize a SA problem. As such, staff may need to further assess offenders high on the IM scale, using methods other than self-report, such as accounts from friends/family. Offenders who score high on both the IM and SDE scales may benefit from a combination of strategies.

References

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[1] For example, the Alcohol Use Disorders Identification Test (Babor et al., 2001).