Assessment Instruments Summary

The American Drug and Alcohol Survey (ADAS)

Introduction: ADAS is a self-report inventory of drug use and related behaviors that is administered in school classrooms. Two versions of ADAS are available: the Children's Form (4th-6th grade) and the Adolescent Form (6th-12th grade). In addition, supplemental inserts are available for the 6th-12th grade version. One of these provides an indepth measure of tobacco use, and the other assesses a variety of factors relevant to planning and evaluating prevention programs.

Purpose: ADAS is used by schools and school districts to assess the levels of substance use among their students. The results are used to create community awareness of the magnitude of drug use among youth, to assist in targeting prevention efforts toward existing local drug use patterns, to evaluate prevention program effectiveness, and to serve as a needs assessment in seeking prevention resources.

Adolescent Drinking Index (ADI)

Introduction: ADI is a 24-item rating scale that quickly assesses alcohol use disorders in adolescents.

Purpose: ADI quickly assesses alcohol use in adolescents with psychological, emotional, or behavioral problems. It also identifies adolescents who need further alcohol evaluation or treatment. ADI defines the type of drinking problem and can help develop treatment plans and recommendations.

The ADI (Harrell & Wirtz, 1989) is a 24-item self-administered test that examines adolescent drinking. It does so by measuring psychological, physical, and social symptoms as well as loss of control. This test is written at a fifth grade reading level. The results of this test provide a single score as well as two subscale scores. The subscale scores include, self-medicating drinking and rebellious drinking. These two scales are intended as research scales. The reliability of the ADI is good. Results are shown to be consistent and accurate (coefficient alpha, .93-.95) in measuring the severity of adolescent drinking problems. Studies show a moderate correlation with alcohol consumption as well as significant differences between groups with different levels of alcohol problem severity. In addition, there was a hit rate of 82% in classification accuracy of the ADI (Harrell & Wirtz, 1989). This means that 82% of the time, when a drinking problem was identified using this scale, the test was accurate in classifying the drinking as a problem and the test accurately determined the level of severity of the drinking problem.

Adolescent Diagnostic Interview (ADI)

Introduction: ADI is a structured interview designed to assess DSM-III-R and DSM-IV criteria for substance use disorders. It also measures several domains of level of functioning including peers, opposite sex relationships, school behavior and performances, home behavior, and life stress events. ADI also screens for several coexisting mental/behavioral disorders, and it screens for memory and orientation problems.

Purpose: To provide diagnostic and level of functioning information for adolescents suspected of drug use and to screen for mental/behavioral problems that often accompany adolescent drug use.
Adolescent Drug Involvement Scale (ADIS)

**Introduction:** ADIS is a 12-item research and evaluation tool developed as a brief measure of the level of drug involvement in adolescents. The scale is an adaptation of Mayer and Filstead's Adolescent Alcohol Involvement Scale (AAIS).

**Purpose:** To provide a brief paper and pencil screen which assesses level of adolescent use of drugs other than alcohol. Higher scale scores represent higher levels of drug involvement. Intended as a research instrument and/or a screening tool, it has not been validated as a clinical measure. Positive results when used for screening should be followed with an independent clinical assessment process.

Moberg and Hahn (1991) modified the AAIS (described above) to address drug use problem severity. The ADIS is a 13-item questionnaire written at an eighth grade reading level. This scale correlates (.72) with drug use frequency and (.75) with independent rating by clinical staff. When matched up with the frequency of drug use and the ratings that clinical staff gave, the scale correlates with their findings, therefore providing evidence of the validity of this test.

Comprehensive Adolescent Severity Inventory (CASI)

**Introduction:** This instrument is designed to measure 10 life issues in an adolescent's life, including substance use severity.

**Purpose:** To provide a comprehensive, indepth assessment of the severity of an adolescent's substance use and other related areas.

Diagnostic Interview for Children and Adolescents (DICA)

**Introduction:** The adolescent version of this instrument (DICA-R-A), for youth ages 13-18) assesses 19 DSM-IV psychiatric disorders. It features an extremely detailed substance abuse section.

**Purpose:** The Diagnostic Interview for Children and Adolescents (DICA) is a structured interview for children between the ages of 6 and 12 and adolescents. The adolescent version (DICA-R-A) rules out or establishes DSM-IV psychiatric diagnoses for youth from 13 to 18 years of age. (The DSM-IV criteria are currently the most widely utilized systematic method for establishing psychiatric diagnoses.) DICA-R-A is a "lifetime" interview with questions that refer to the entire life span of the subject and determine whether the adolescent has ever had any of one or more of 19 psychiatric conditions. However, certain sections deemed difficult to ask only on a lifetime basis are assessed in both present and past. An extremely detailed section on alcohol and other substance abuse is included.

Personal Experience Inventory (PEI)

**Introduction:** This is a comprehensive assessment instrument that covers all substances and related problems. PEI consists of two parts, the Chemical Involvement Problem Severity (CIPS) section and the Psychosocial (PS) section. It provides a list of critical items that suggests areas in need of immediate attention by the treatment provider and summarizes problems relevant for planning the level of treatment intervention. The test also contains five validity indicators to measure faking to appear good or bad.
PEI is part of a three-tool assessment system, the Minnesota Chemical Dependency Adolescent Assessment Package (MCDAAP). MCDAAP also includes a structured diagnostic interview, the Adolescent Diagnostic Interview, and a brief screening tool, the Personal Experience Screening Questionnaire. As an assessment system, MCDAAP is intended to assist with screening, evaluation, and treatment planning.

**Purpose:**
- To assess the extent of psychological and behavioral issues with alcohol and drug problems
- To assess psychosocial risk factors believed to be associated with teenage substance involvement
- To evaluate response bias or invalid responding
- To screen for the presence of problems other than substance abuse, such as school problems, family problems, and psychiatric disorders
- To aid in determining the appropriateness of inpatient or drug outpatient treatment

The PEI is a 276-item, multi-scale questionnaire that measures chemical involvement problem severity (10 scales), psychosocial risk (or protective) factors (12 scales), and the tendency for subjects to distort responses (5 scales). Supplemental problem screens measure eating disorders, suicide potential, physical/sexual abuse, and parental history of drug abuse. The scoring program provides a computerized report that includes narratives and standardized scores for each scale, as well as other clinical information. Extensive normative and psychometric data (including test-retest reliability and convergent and predictive validity) are available (Miters & Henly, 1989; Winters, Stinchfield & Henly, 1996).

### Problem Oriented Screening Instrument for Teenagers (POSIT)

**Introduction:** POSIT was developed by a panel of expert clinicians as part of a more extensive assessment and referral system for use with adolescents ages 12-19 years (Rahdert, 1991). POSIT was designed to identify problems and potential treatment or service needs in 10 areas, including substance abuse, mental and physical health, and social relations. Related is the POSIT followup questionnaire that was derived from items on POSIT to screen for potential change in 7 out of the 10 problem areas represented on POSIT.

**Purpose:** POSIT is a screening tool designed to identify potential problem areas that require further indepth assessment. Depending on the results of the indepth assessment, early therapeutic intervention or treatment and related services may be necessary. POSIT can be utilized by school personnel, juvenile and family court personnel, medical and mental health care providers, and staff in substance use disorder treatment programs. When used in conjunction with POSIT, the POSIT followup questionnaire can be used as a measure of change or an outcome measure. This 139-item self-administered yes/no instrument is part of the Adolescent Assessment and Referral System developed by the National Institute on Drug Abuse (Randert, 1991). It addresses 10 functional adolescent problem areas: substance use, physical health, mental health, family relations, peer relationships, educational status, vocational status, social skills, leisure and recreation, and aggressive behavior/delinquency. The need for further assessment has been determined by cut scores that have been established rationally, or confirmed with documented proof providing procedures (Latimer, Winters, & Stinchfield, 1997). Convergent and discriminating data for the POSIT have been reported by several investigators (Dembo, Schmeidler, Borden, Chin Sue, & Manning, 1997; McLaney et al., 1994).
Substance Abuse Subtle Screening Inventory (SASSI)
Millers (1985) 81-item adolescent version of the SASSI shows scores for several scales. Those scales are: face valid alcohol, face valid other drug, obvious attributes, subtle attributes, and defensiveness. The validity of this test is proven by its high correlation with the MMPI cut scores for chemical dependency and the SASSI's high correspondence with diagnosis of substance use disorder at Intake (Risberg, Stevens, & Graybill, 1995).

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