

Screening and Assessing Adolescents for Substance Use Disorders

Treatment Improvement Protocol (TIP) Series

31



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31

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration

1 Choke Cherry Road
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What Is a TIP?

Treatment Improvement Protocols (TIPs) are developed by the Substance Abuse and Mental Health Services

Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). Each TIP involves the development of topic-specific best-practice guidelines for the prevention and treatment of substance use and mental disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts of various forms of treatment and prevention. TIPs are distributed to facilities and individuals across the country.

Published TIPs can be accessed via the Internet at <http://kap.samhsa.gov>.

Although each consensus-based TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that behavioral health is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. If research supports a particular approach, citations are provided.

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Foreword

The Treatment Improvement Protocol (TIP) series fulfills the Substance Abuse and Mental Health Services Administration's (SAMHSA's) mission to improve prevention and treatment of substance use and mental disorders by providing best practices guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses their particular area of expertise until

they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

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Executive Summary and Recommendations

In recognition of the importance of developing reliable, valid, and clinically useful instruments as well as procedures for screening adolescents for substance use disorders, the Center for Substance Abuse Treatment (CSAT) in 1992 convened a Panel of experienced researchers and clinicians who work with troubled youths and their families. A year later, CSAT convened another Panel that examined substance use disorder treatment for adolescents and outlined state-of-the-art treatment guidelines. Two Treatment Improvement Protocols (TIPs 3 and 4) were developed from these efforts. Given the continued significance of assessment and treatment of adolescents' substance use, CSAT convened another Panel in 1997 to update both of the earlier TIPs. This TIP should be viewed as a companion volume to TIP 32, *Treatment of Adolescents With Substance Use Disorders* (CSAT, 1999), which updates TIP 4.

The original Panel on adolescent substance use screening and assessment had two goals. The first was to discuss the problems of adolescent substance use disorders from the viewpoints of the Panel Members, who come from a wide spectrum of backgrounds and specialty areas. The emphasis was on practical clinical procedures to help treatment providers improve care. A second goal for the Panel was to review, from a practical perspective, available instruments, procedures, and measures for

assessing adolescent substance use in various settings, including rehabilitation, that could be used easily by clinicians and other workers in the field. The Revision Panel preserved the original goals but also incorporated new research, updated summaries of previously listed instruments, and added recently developed tools.

This TIP incorporates the deliberations of the 1992 Consensus Panel and the 1997 Revision Panel. It concentrates on the strategies, procedures, and instruments that are appropriate for the initial detection of substance-using adolescents, the comprehensive assessment of their problems, and subsequent treatment planning. Although the TIP summarizes many instruments, it does not endorse any screening or assessment tools.

The purposes of the TIP are several:

1. To provide general guidelines for evaluating, developing, and administering screenings and assessment instruments and processes for those who screen and assess young people for substance use disorders
2. To inform a wide range of people whose work brings them in contact with adolescents in problem situations (e.g., teachers, guidance counselors, school nurses, police probation officers, coaches, and family service workers) about the processes, methods, and tools available to

screen for potential substance use problems in adolescents

3. To discuss strategies and accepted techniques that can be used by treatment personnel to detect related problems in the adolescent's life, including problems with family and peers, and psychiatric issues, and to see that these problems are dealt with during the primary intervention for a substance use disorder
4. To outline a screening and assessment system designed to identify those youths with potential substance use problems in various settings

Adolescents differ from adults physiologically and emotionally and are covered by different laws and social services. This revised TIP is designed to help juvenile justice, health and human service, and substance use disorder treatment personnel better identify, screen, and assess people 11 to 21 years old who may be experiencing substance-related problems. The TIP details warning signs of substance use disorders among adolescents, when to screen, when to assess, what domains besides substance use to assess, and how to involve the family and other collaterals. Also covered are the legal issues of screening and assessing teenagers, including confidentiality, duty to warn, and how to communicate with other agencies. The TIP also includes a chapter specifically for those working in the juvenile justice system who want to improve their screening and assessment procedures. Appendix A lists the citations referred to throughout this TIP and relevant to the instrument summaries. Appendix B provides up-to-date summaries of instruments relevant for screening and comprehensively assessing substance-abusing adolescents. Appendix C contains excerpts from "Drug Testing of Juvenile Detainees," a publication prepared by the American Correctional Association and the Institute for Behavior and Health, Inc., under a

grant from the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice.

The following summary is excerpted from the main text, in which references to the research appear. To avoid sexism and awkward sentence construction, the TIP alternates between "he" and "she" in generic examples.

Introduction

The purpose of screening is to identify adolescents who need a more comprehensive assessment for substance use disorders. It does so by uncovering "red flags," or indicators of serious substance-related problems among adolescents. As such, it covers the general areas in a client's life that pertain to substance use without making an involved diagnosis. The Consensus Panel recommends that all adolescents who exhibit signs of substance use receive appropriate, valid, and sensitive screening.

Selection of screening and assessment instruments for use with adolescents should be guided by several factors: (1) reliability and validity of the tool, (2) its appropriateness to an adolescent population, (3) the type of settings in which the instrument was developed, and (4) the intended purpose of the instrument. The Panel recommends that screening and assessment cover multiple domains pertaining to the individual and his environment, and that the process involve more than one method and source.

Important features of screening and assessment instruments include

- High test-retest reliability
- Evidence of convergent validity (i.e., the instrument is strongly correlated with other instruments that purport to measure similar constructs)
- Demonstrated ability to predict relevant criteria, such as school performance,

performance in treatment, and substance use relapse

- Availability of normative data for representative samples based on, for example, age, race, gender, and different types of settings (e.g., school, detention center, and drug clinic)
- The ability to measure meaningful behavioral and attitude changes over time

When assessing family members, certain principles should be kept in mind:

- Adolescents may define family in nontraditional ways. Treatment providers should allow adolescents to identify and acknowledge the people they would describe as “family,” even though they may not live with the adolescent.
- The law and society may define family in ways that differ from the actual experiences of substance-abusing youth.
- Cultural and ethnic differences in family structures should be respected.
- Although an adolescent may be initially identified as having a substance use disorder, she may be a victim of family discord. The treatment provider should be aware that the core problem may reside outside the adolescent and that the young person’s problems are a symptom of this environmental distress.

Screening

Health service providers, juvenile justice workers, educators, and other professionals who work with adolescents at risk should be able to screen and refer for further assessment. Community organizations (e.g., schools, health care delivery systems, the judiciary, vocational rehabilitation, religious organizations) and individuals associated with adolescents at risk must be also able to screen and detect possible substance use. Thus, many health and judicial

professionals should have screening expertise, including school counselors, street youth workers, probation officers, and pediatricians. For adolescents at high risk for a substance use disorder, a negative screening result should be followed up with a re-evaluation, perhaps after 6 months.

Juvenile justice systems should screen all adolescents at the time of arrest or detention, including “status offenders” who are not normally screened. Given the high correlation between psychological difficulty and substance use disorders, all teens receiving mental health assessment should also be systematically screened. Within other service delivery systems, runaway youth (e.g., at shelters), teens entering the child welfare system, teens who dropped out of school (e.g., in vocational/job corps programs), and other high-risk populations (e.g., special education students) should also be screened.

Adolescents who present with substantial behavioral changes or emergency medical services for trauma, or who suddenly begin experiencing medical problems such as accidents, injury, or gastrointestinal disturbance should also be screened. In addition, schools should screen youth who show increased oppositional behavior, significant changes in grade point average, and a great number of unexcused school absences. Because of the close connection between substance use and HIV, workers dealing with youth should receive adequate training on HIV/AIDS prevention, education, and referral, including confidentiality issues.

The screening process should last no more than 30 minutes—ideally, 10–15 minutes—and the instrument should be simple enough that a wide range of health professionals can administer it. It should focus on the adolescent’s substance use severity (primarily consumption patterns) and a core group of associated factors such as legal problems, mental

health status, educational functioning, and living situation. The content of the test must be appropriate for clients from a variety of background and cultural experiences, and for clients of differing age and experience. The Panel strongly recommends that structured or semistructured interviews be used in this field, since unstructured interviews pose special administrative problems that contribute to measurement error. Interviews should not be performed with parents present. When using paper-and-pencil questionnaires, the screener should have the client read aloud the instructions that accompany the test to ensure that the client understands what is expected of her and to judge whether the client's reading ability is appropriate for the testing situation.

There is no definitive rule as to how many uncovered red flags indicate a need for a comprehensive assessment. Many screening questionnaires provide empirically validated cut scores to assist with this decision. Nevertheless, any time there are several red flags or a few that appear to be meaningful, the screener should refer the adolescent for a comprehensive assessment.

Drug monitoring is a useful adjunct to screening and should be conducted at an appropriate point during screening and in a manner consistent with accepted standards and guidelines. Laboratories certified by the National Institute on Drug Abuse are available in most communities and are equipped to provide agencies with the necessary training in collecting urine and blood samples. Drug testing should always be conducted with the knowledge and consent of the adolescent. Testers should always report the results of testing to a youth and discuss their implications.

If time permits, the person conducting the screening should also get information from another source such as parents, family members, or case workers to get a more complete picture.

It is wise to collect the information when the youth is not present in the interview room and to tell the parents that what they say may be shared with the adolescent in the summary of the screening.

The Consensus Panel recommends that everyone who works with youth in a community use the same screening instruments. One way to accomplish this would be for schools, child welfare agencies, human service agencies, and juvenile justice systems to establish an areawide coordinating committee for adolescent screening and assessment. The committee could review and select reliable, standardized screening and assessment tools so that all agencies serving the local adolescents and their families will use the same standardized measures. The committee could also establish consistent referral criteria and a communitywide definition of "high risk" for substance use disorders.

The Consensus Panel also recommends a communitywide interagency mechanism for coordination of screening, management of information systems, and training of screeners and other relevant professionals. Any such mechanism would have to conform to confidentiality regulations.

It is also advisable, if possible, for local communities to collect their own norms on the standardized instruments. It is important for local agencies to keep databases on local drug testing results for the particular purposes of needs assessment. This information can also be shared with other community facilities, but only if any information identifying the client is stripped.

Screeners must be especially careful when stating and storing information. To avoid labeling, they should report facts only, not opinions, and give only the information that is necessary to meet the client's treatment needs.

Assessment

The comprehensive assessment, which is based on initial screening results, has several purposes:

1. To accurately identify those youth who need treatment
2. To further evaluate if a substance use disorder exists, and if so, to determine its severity including whether a substance use disorder exists based on formal criteria (e.g., *Diagnostic and Statistical Manual of Mental Disorders-IV*)
3. To permit the evaluator to learn more about the nature, correlates, and consequences of the youth's substance-using behavior
4. To ensure that additional related problems not flagged in the screening process are identified (e.g., problems in medical status, psychological status, nutrition, social functioning, family relations, educational performance, delinquent behavior)
5. To examine the extent to which the youth's family (as defined in the introduction to this volume) can be involved not only in comprehensive assessment, but also in possible subsequent interventions
6. To identify specific strengths of the adolescent (e.g., coping skills) that can be used in developing an appropriate treatment plan
7. To develop a written report that
 - ◆ Identifies the severity of the substance use disorder
 - ◆ Identifies factors that contribute to or are related to the substance use disorder
 - ◆ Identifies a corrective plan of action to address these problem areas
 - ◆ Details an interim plan to ensure that the treatment plan is implemented and monitored to its conclusion
 - ◆ Makes recommendations for referral to agencies or services

- ◆ Describes how resources and services of multiple agencies can best be coordinated and integrated

In addition, the assessment begins a process of responding creatively to the youth's denial and resistance and can be seen as an initial phase of the youth's treatment experience.

The assessor should be a well-trained professional experienced with adolescent substance use issues, such as a psychologist or mental health professional, school counselor, social worker, or substance abuse counselor. One individual should take the lead in the assessment process, especially with respect to gathering, summarizing, and interpreting the assessment data. An assessor not licensed to make mental health diagnoses should refer an adolescent in apparent need of a formal mental health workup to an appropriate professional.

The assessment should be conducted in an office or other site where the adolescent can feel comfortable, private, and secure.

To arrive at an accurate picture of the adolescent's problems, the following domains should be assessed:

- Strengths or resiliency factors, including self-esteem, family, religiosity, other community supports, coping skills, and motivation for treatment.
- History of use of substances, including over-the-counter and prescription drugs (including Ritalin), tobacco, caffeine, and alcohol. The history notes age of first use, frequency, length, pattern of use, and mode of ingestion, as well as treatment history.
- Medical health history and physical examination (noting, for example, previous illnesses, infectious diseases, medical trauma, pregnancies, and sexually transmitted diseases). An adolescent's HIV risk behavior status (e.g., does he inject drugs or practice unsafe sex?) should be assessed as well. A

full sexual history, including sexual abuse and sexual orientation, should be taken.

- Developmental issues, including influences of traumatic events, such as physical or sexual abuse and other threats to safety (e.g., pressure from gang members to participate in drug trafficking).
- Mental health history, with a focus on depression, suicidal ideation or attempts, attention deficit disorders, oppositional defiance and conduct disorders, and anxiety disorders, as well as details about prior evaluation and treatment for mental health problems. Also assess the disability status of the individual young person.
- Family history, including the parents' and/or guardians' history of substance use, mental and physical health problems, chronic illnesses, incarceration or illegal activity, child management concerns, and the family's cultural, racial, and socioeconomic background and degree of acculturation. The description of the home environment should note substandard housing, homelessness, proportion of time the young person spends in shelters or on the streets, and any pattern of running away from home. Issues regarding the youth's history of child abuse or neglect, involvement with the child welfare agency, and foster care placements are also key considerations. The family's strengths should also be noted as they will be important in intervention efforts.
- School history, including academic performance and behavior, learning-related problems, extracurricular activities, and attendance problems. Has the child been assessed with a learning disability, or perhaps received special education services at some time in his educational career?
- Vocational history, including paid and volunteer work.

- Peer relationships, interpersonal skills, gang involvement, and neighborhood environment.
- Juvenile justice involvement and delinquency, including types and incidence of behavior and attitudes toward that behavior.
- Social service agency program involvement, child welfare involvement (number and duration of foster home placements), and residential treatment.
- Leisure activities, including recreational activities, hobbies, interests, and any aspirations associated with them.

It is critical to form a therapeutic alliance with the family to the fullest extent possible and to involve the family in the assessment process. If there is evidence that the adolescent is being abused at home, the family should still be questioned about the adolescent's substance use. Providers must, however, report child abuse (see Chapter 4).

The use of well-designed questionnaires and interviews can yield an accurate, realistic understanding of the teenager and the problems she is experiencing. Assessment instruments must have both validity and reliability.

Of great importance to the user is the author's description of how the instrument is to be administered, scored, and interpreted. Specific statements should include

- The purpose or aim of the test
- For whom the test is and is not appropriate
- Whether the test can be administered in a group or only on an individual basis
- Whether it can be self-administered or if it must be given by an examiner
- Whether training is required for the assessor and, if so, what kind, how much, and how and where it can be obtained
- Where the test can be obtained and what it costs

Once selected, the tests should be administered and scored in the manner recommended by the authors; no substitutions should be made for any test items and no items should be eliminated or modified. For structured interviews, the interview format and item wording should be strictly followed.

After the information from the different sources (interview, observation, specialized testing) has been assembled, the assessor writes a report of what he has learned about the adolescent in terms that can be understood by all concerned, including the adolescent. The report should deal with such issues as (1) the way the adolescent processes information most effectively and how this will affect treatment, (2) how the adolescent's past experiences will affect her reaction to certain treatment interventions, (3) specific treatment placement recommendations and justifications, and (4) counselor recommendations.

Assessment instruments should be selected on the basis of their purpose, content, administration, time required for completion, training needed by the assessor, how the instrument can be obtained, its cost, and persons to contact for further guidance. The two most important criteria in the evaluation of any measurement instrument are reliability and validity.

Legal Issues

Programs that specialize, in whole or in part, in providing treatment, counseling, and/or assessment and referral services for adolescents with substance use disorders must comply with the Federal confidentiality regulations (42 C.F.R. § 2.12(e)).

Information that is protected by the Federal confidentiality regulations may always be disclosed after the adolescent has signed a proper consent form. (Parental consent must

also be obtained in some States.) The regulations also permit disclosure without the adolescent's consent in situations such as medical emergencies, child abuse reports, program evaluations, and communications among staff.

Any disclosure made with written client consent must be accompanied by a written statement that the information disclosed is protected by Federal law and that the person receiving the information cannot make any further disclosure of such information unless permitted by the regulations (§2.32).

When a program that screens, assesses, or treats adolescents asks a school, doctor, or parent to verify information it has obtained from the adolescent, it is making a client-identifying disclosure that the adolescent has sought its services. The Federal regulations generally prohibit this kind of disclosure unless the adolescent consents.

Programs may not communicate with the parents of an adolescent unless they get the adolescent's written consent. The Federal regulations contain an exception permitting a program director to communicate with an adolescent's parents without her consent when

1. The adolescent is applying for services
2. The program director believes that the adolescent, because of an extreme substance use disorder or a medical condition, does not have the capacity to decide rationally whether to consent to the notification of her guardians
3. The program director believes the disclosure is necessary to cope with a substantial threat to the life or well-being of the adolescent or someone else

Other exceptions to the Federal confidentiality rules prohibiting disclosure regarding adolescents seeking or receiving substance use disorder services are

- Information that does not reveal the client as having a substance use disorder
- Information ordered by the court after a hearing
- Medical emergencies
- Information regarding crimes on program premises or against program personnel
- Information shared with an outside agency that provides service
- Information discussed among people within the program
- Information disclosed to researchers, auditors, and evaluators with appropriate Institutional Review Board review and approval to ensure the protection of program participants

Juvenile Justice Settings

Many adolescents entering the juvenile justice system (JJS) have substance use disorders. Many also have experienced or are experiencing

- Physical or sexual abuse
- Psychological and emotional problems
- Poor performance in school
- Family difficulties, which may include mental health problems, parental neglect, foster care placement, family involvement in criminal activity, and a history of substance use disorders by other family members, including current use, with or without the adolescent present
- Gang-related violence and involvement with drug sales, as well as other antisocial characteristics (e.g., vandalism)
- Living in neighborhoods where economic hardship, lack of employment opportunities, inadequate housing, and other factors related to poverty and low income have led to communitywide despair and hopelessness among adults as well as youth

The depth of the problems calls for a more holistic approach to the juvenile offender rather

than the typical focus on individual crime episodes. A primary goal of substance use screening and assessment among juvenile offenders is to prevent their further involvement in the JJS. Thus screening and assessment should be repeated at different stages in the system (intake, preadjudication, and postadjudication) to detect changes over time in the pattern of substance use, related problem behaviors, and the need for services.

All juveniles entering a juvenile justice facility should receive an initial screening, risk assessment, and followup assessment, as indicated. Initial screening should be conducted within 24 hours of entry to the agency or facility. Screening and assessment activities may need to be completed over the course of several days for juveniles who are intoxicated, show symptoms of mental illness, are experiencing significant stress related to arrest or incarceration, or are not honestly disclosing information during an initial interview. Alternative screening and assessment measures should be developed to accommodate the needs of juveniles with limited reading skills and with physical disabilities.

When conducting screenings and assessments to determine patterns of use, programs should be aware of the youth's confinement status prior to testing. Periods of preassessment incarceration (e.g., pretrial detention) may skew results of recent use surveys. In recognition of the importance of early detection and intervention, rules for deciding how to interpret the results of initial screening should be designed to be overinclusive in identifying adolescents who may have substance use problems. In other words, it is better to identify more adolescents as having substance use problems than to be overly cautious and miss some.

Screening, assessment, and interviews should be conducted in a private room where the teenager feels safe and comfortable. The use

of holding cells to conduct screening and assessment is *not* recommended.

All juvenile justice staff providing screening or assessment services should be trained in the following areas:

- Cultural sensitivity and competence
- Legal and ethical issues
- Administration, scoring, and interpretation of instruments
- Determination of reading abilities
- Interviewing techniques
- Report writing
- Interpersonal communication
- Counseling techniques
- Management of critical incidents
- Working collaboratively with the treatment community

Substance Use Disorders And the Adolescent's Development

A person's entire life is shaped in late adolescence and early adulthood. Developmental tasks associated with this period include dating, marriage, child bearing and rearing, establishing a career, and building rewarding social connections. Younger adolescents are taking the first steps on this path

by separating from their parents, developing a moral code, and aligning themselves with different segments of their community.

Although some experimentation is normal, sustained use of substances will likely interfere with the demands and roles of adolescence and make it more difficult to negotiate the transitions from early adolescence to late adolescence to young adulthood. Because substance use changes the way people approach and experience interactions, the adolescent's psychological and social development are compromised, as is the formation of a strong self-identity.

To help teenagers who have substance use disorders, the problem must first be identified. The members of both Consensus Panels for this TIP believe that health professionals, educators, and others who come into regular contact with adolescents have the obligation to use appropriate, effective, and respectful means to identify potential substance use problems among adolescents. Screening and assessment procedures must be followed by sensitive, direct treatment and interventions as indicated by the test results. This TIP offers practical guidance to accomplish these goals, supported by the research and the extensive clinical experience of the two Consensus Panels.

1 Introduction

Since the 1960s, the rate of substance use by adolescents has waxed and waned: It is currently on the rise. In the early to mid-1990s, the percentage of 8th graders who reported using illicit drugs (that is, drugs illegal for Americans of all ages) within the past year almost doubled, from 11.3 percent in 1991 to 21.4 percent in 1995 (National Institute on Drug Abuse [NIDA], 1996). Drug use by high school students also has risen steadily since 1992; 33 percent of 10th graders and 39 percent of 12th graders reported the use of an illicit drug within the last 12 months (NIDA, 1996).

The frequency of the problem may mask its seriousness: Substance use can disrupt the young person's ability to adequately meet developmental tasks (Baumrind and Moselle, 1985; Newcomb and Bentler, 1989) and impair identity development, a central theme of adolescence. Sustained drug use will likely interfere with the demands and roles of late adolescence and early adulthood, including reaching achievement in dating, marriage, bearing and raising children, establishing a career, and building personally rewarding social connections (Havighurst, 1972). Thus, it stands to reason that the substance-using youth will find it more difficult to negotiate the demands of transition from early adolescence to late adolescence to young adulthood. An adolescent who has not attained development is likely to enter his 20s woefully unprepared for the demands of adult life (Baumrind and Moselle, 1985).

Some of the costs are emotional: Any substance use tends to interfere with a youth's ability to cope with feelings that are a necessary component of his developmental tasks. For example, instead of saying "I feel depressed" or "I feel anxious," an adolescent who is masking her emotions might say "I feel like a beer" or "I feel like a joint" and never know she is having a typical emotion. A great deal is at stake intellectually as well. Abstract thinking, propositional logic (the ability to form hypotheses and consider possible solutions), and metacognition (the ability to think about the thought process itself) are essential abilities that develop during the adolescent years—abilities blunted by alcohol and drug use.

To be treated, the problem must be found. Treatment providers, school nurses, pediatricians, and others who come in contact with teenagers need reliable and valid assessment instruments and procedures to

- Identify potential substance users
- Assess the full spectrum of treatment problems
- Plan appropriate interventions
- Involve the youth's family, as defined below, in all aspects of intervention
- Evaluate the effectiveness of the interventions that are actually used
- Assess substance use problems in the context of the youth's overall development

Screening and assessment are not neutral or passive procedures. Used intelligently, they can provide vital information, thus contributing to effective care. Used in a careless or unprofessional manner, there is the potential for significant harm to the very individuals who need help.

In the discussions that follow, adolescents' rights to privacy and confidentiality and the needs of parents to stay informed about their child's health are emphasized repeatedly to underscore the need for professional and sensitive handling of information on adolescents at each step of the assessment process.

Program staff must understand the impact that culture, race, and gender can have on screening and assessment. Multiethnic and multicultural programs are essential in today's society. People involved in the assessment process must be aware of how their own culture and ethnic background and their life experiences affect the assessment process. Also, before using screening and assessment tools, the assessor should review the instrument's user's manual to ensure that the instrument has been validated on adolescents with a wide range of demographic characteristics. Furthermore, when assessing youth with unique backgrounds, it is recommended that the assessor review the instrument's content so that possible gaps in content coverage can be addressed with supplemental information (e.g., most tests will not provide measures that accommodate an adolescent with a physical disability). Similarly, some screening instruments and procedures are normed for older adolescents, not for children from 11 to 14 years old.

Terms Used in This TIP

The adolescent. This volume uses the broadest possible definition of an adolescent—namely, an individual 11 to 21 years of age. This definition

captures the great majority of the physical changes associated with adolescence and the maturing of a child into an adult. The emotional and behavioral transitional stages that have traditionally been associated with the teenage years (e.g., dating to marriage, sexual experimentation to childbearing and parenting, dependent to independent living, and school to work) have changed. In today's society, the adolescent's actual age or physical stage of development does not always correspond with the emotional or behavioral situations of his life. It is no longer unusual to see sexually active 11- to 13-year-olds, 15- to 17-year-olds living independently from their parents, 14- to 18-year-olds responsible for a family, or conversely, 25-year-olds living with their parents.

The diversity of physical, emotional, and behavioral stages among adolescents makes substance use disorder screening, assessment, and treatment planning for this group of individuals especially challenging. The discussions in this TIP assume that adolescents of different ages may have very similar types of problems and treatment needs; on the other hand, adolescents of the same age may be at very different stages of development.

It is obvious that alcohol use in a 13-year-old has much more significance and demands a more aggressive intervention than the same amount or frequency of alcohol use in a 19-year-old. Similarly, the types and quality of relationships that an adolescent experiences with family, school, work, and peers will vary significantly.

The family. The family is a key element in all aspects of screening, assessing, and treating adolescents for substance use disorders (Liddle and Dakof, 1995). However, before assessors involve families in the assessment process, they must reconsider the traditional definition of family (that is, a mother, father, and children all living together). Traditional definitions of family are no longer applicable for many

Figure 1-1
Family Members

Family can include

- Biological or adoptive parents, grandparents, aunts, uncles
- Brothers and sisters (including half-siblings)
- Current foster parent(s)
- Former foster parent(s)
- Other children placed in current or previous foster homes
- A relative or close friend of a foster parent
- An incarcerated biological or adoptive parent
- An adult, perhaps a teacher or social worker, who is close to the youth
- Other members of the traditional “extended” family

members of society. For example, a family may consist of other relatives and adults who may be helping to raise the child (see Figure 1-1). An expanded definition of family may help the assessor identify individuals who can support the screening and assessment process, and assist the young person as well.

As assessors seek to define the family, they should bear certain principles in mind:

- The law and society may define family in ways that differ from the actual experiences of substance-using youth.
- Adolescents may define family in nontraditional ways. Treatment providers should allow adolescents to identify and acknowledge the people they would describe as “family,” even though they may not live with the adolescent. For example, family members may include the extended family, foster parents, or an adult who is close to the youth.

Whether its make-up is traditional or not, the family’s function continues to be much as it has always been: to meet family members’ physical, emotional, financial, spiritual, and cultural needs. Another characteristic of a family is a sense of duty and obligation, so family members provide for needs that range from food and

shelter and emotional support, to helping the youth develop values and cultural traditions. Such nurturing is essential to a child’s development, and the multiplicity of family types should not prevent treatment staff from understanding and addressing failures in family roles.

The importance of family involvement throughout the assessment process is discussed in this volume. Assessors should receive training in theories and concerns about “family systems” (Szapocznik et al., 1988). It should be kept in mind, however, that despite the importance of family involvement in assessing troubled youth, agencies are often frustrated by the lack of available resources needed to adequately include the family in the process. In addition, abused adolescents should be protected from abusing parents. So although family involvement in screening and assessment, as well as in treatment, is usually highly recommended, it is not always feasible.

Substance abuse. What is meant by substance abuse? A vast amount of literature discusses the problem severity continuum of “using” drugs and the abusive and dependent problems that arise from excessive substance use (American Psychiatric Association, 1994). However, these distinctions often do not

consider the special case of adolescents (Martin et al., 1995; Winters et al., in press). The term abuse is often used to refer to any use by adolescents because any use of substances is illegal. In addition, given the rapid physiological changes that occur during adolescence, some experts argue that use of any substance contributes to the “abuse” of a developing body and personality.

In this volume, however, we emphasize the more traditional definitions of abuse and its related concept of dependence. That is, abuse is defined as use of psychoactive substances that increases risk of harmful and hazardous consequences; dependence is defined as a pattern of compulsive seeking and using of substances despite the presence of severe personal and negative consequences. Thus, the Revision Panel, like its predecessor, focused on the identification and referral of adolescents who are showing either substance abuse or dependence characteristics as defined by criteria in the current Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (APA, 1994) criteria and for whom health care or social service resources are warranted.

In addition, the Panel recognizes the importance of new advances in conceptualizing adolescent substance involvement that are more developmentally germane to young people. An excellent example of recent progress along these lines is the Diagnostic and Statistical Manual for Primary Care, which views adolescent substance use disorders along a continuum of severity, which extends from experimentation with drug use through problematic use to disorders of abuse and dependence (American Academy of Pediatrics, 1996).

Screening and assessment. Screening and assessment constitute a two-step process to determine the existence and extent of a substance use problem. Screening is a process that identifies people at risk for the “disease” or disorder (National Institute on Alcohol Abuse

and Alcoholism, 1990). As such, screening refers to a brief procedure used to determine the probability of the presence of a problem, substantiate that there is a reason for concern, or identify the need for further evaluation. In a general population, screening for substance abuse and dependency would focus on determining the presence or absence of the disorder, whereas for a population already identified at risk, the screening process would be concerned with measuring the severity of the problem and determining need for a comprehensive assessment.

Comprehensive assessment determines the nature and complexity of the individual’s problems. There are at least five objectives for conducting appropriate and comprehensive assessments of persons with substance abuse or dependence problems (Substance Abuse and Mental Health Services Administration, 1994):

1. To identify those who are experiencing problems related to substance abuse and/or have progressed to the stage of dependence
2. To assess the full spectrum of problems for which treatment may be needed
3. To plan appropriate interventions
4. To involve appropriate family members or significant others, as needed, in the individual’s treatment
5. To evaluate the effectiveness of interventions implemented

It is beyond the scope of this TIP to address the evaluation of treatment effectiveness. This domain includes assessing treatment process (e.g., treatment involvement) and posttreatment functioning. Interested readers are directed to TIP 14, Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment (Center for Substance Abuse Treatment [CSAT], 1995), for more information about this topic.

Intervention. The term *intervention* refers to a spectrum of responses to reduce or ameliorate

the problem behaviors under consideration. Among the least intrusive but often effective interventions are conversations between an adolescent and a concerned parent, teacher, physician, or friend. More formalized interventions include prevention programs (aimed at preventing drug use onset), early intervention programs (aimed at intervening before the substance use becomes problematic), and intensive treatment programs (typically directed at stopping current use and maintaining abstinence).

Perhaps the most common interventions are treatment efforts that may take place in outpatient, partial hospital, or residential settings (including correctional facilities). “Partial hospitalization” is a term used to refer to the provision of daytime care with clients returning home overnight. Treatment options are discussed fully in the TIP 32, *Treatment of Adolescents With Substance Use Disorders* (CSAT, 1999).

A special set of interventions occurs within the juvenile justice system (JJS) and includes arrests, probation, and detention. A primary purpose of these interventions is to interrupt the course of illegal and antisocial behaviors, many of which are associated with substance use. Ideally, detention incorporates a treatment protocol to facilitate rehabilitation.

Because of the special circumstances surrounding JJS interventions and the large number of adolescents identified and processed within that system, this volume includes a description of tools that were developed and validated for use with juvenile justice adolescents; Chapter 5 is devoted to the discussion of JJS assessment procedures for substance use disorders.

Assessment Model

It is useful to understand the coverage of this TIP by considering a multiple assessment model

(see Chapter 3). The three components of the model—content, methods, and sources—each pertain to specific evaluation goals. The *content* domain refers to the important clinical variables of adolescent substance use and related problems. For the most part, evaluation of adolescent substance use disorders should address four primary factors: substance use disorder severity, predisposing and perpetuating risk factors, coexisting psychiatric disorders, and response distortions, such as faking good and faking bad tendencies. This perspective assumes that substance use disorders are usually accompanied by other problems in an adolescent’s life, such as school performance, peer and family adjustment, medical problems, and crime (Jessor and Jessor, 1977).

The second component of the model refers to the methods used to measure the content. Naturally, there are numerous ways to gain information about substance use. This TIP emphasizes available instruments using the method of self-report questionnaires and interviews. However, direct observation and laboratory testing are also relevant assessment methods to consider.

Finally, several *information sources* may be relevant when evaluating an individual’s substance use disorder. In addition to the client, other informants include parents, teachers, peers, employers, and significant others. (Of course, collateral sources cannot be contacted for information without the adolescent’s written consent.) Written reports and records from schools, previous treatment experiences, and juvenile courts also contain information that may be relevant to the adolescent’s substance use problems. The Consensus Panel agrees with the conventional wisdom that assessors must use multiple sources in conjunction with a client report because relying on any one source may lead to an underestimate or overestimate of the problem (Weissman et al., 1987). Nevertheless,

it is important that the diverse information collected across sources is coherently incorporated into a diagnostic picture. Failure to do so may result in a treatment referral that is irrelevant for the client. Also, assessors need to evaluate the relative validity of the information from different sources and should not assume that the client's self-report is necessarily less valid than other information sources. While there is clearly some evidence to the contrary (e.g., Stinchfield, 1997), several instruments have documented the validity of adolescent self-report of drug involvement (see Winters, 1994).

Figure 1-2 summarizes the application of the three-component assessment model at the screening and comprehensive assessment levels. This application recognizes that the screening evaluation will focus primarily on substance use disorder severity and target a few key psychosocial variables (e.g., psychiatric status). Furthermore, screening should be limited to a short questionnaire and a brief interview and may rely solely on the client and parent as sources of information. However, a comprehensive assessment is intended to address substance use problem severity in great depth, as well as adequately cover the wide range of multiple problems that accompany these problems. This process should employ multiple methods and multiple sources.

Selection of Screening And Assessment Instruments

Selection of screening and assessment instruments intended for use with adolescents must be guided by several factors: (1) evidence for reliability and validity, (2) the adolescent population(s) for which the instrument was developed and normed, (3) the type of settings in which the instrument was developed, and (4) the intended purpose of the instrument.

Important features of screening and assessment instruments include

- High test-retest reliability: Are there similar results when the test is given again to the same youth after a brief interval (for instance, 1 week)?
- Evidence of convergent validity with other instruments attempting to measure the same construct: Is there a strong relationship between the results obtained from this instrument and the results obtained from other instruments designed to look at the same kind of problem (e.g., substance use disorder severity)?
- Demonstrated ability to measure outcomes that correspond to criterion or standard for comparison: Has the test proven over time that it has helped to predict specific behaviors (e.g., performance in treatment) or clinical decisions (e.g., diagnostic decisions) in the same or similar populations?
- Availability of normative data for representative groups defined by age, race, gender, and type of settings: Has research shown evidence of a test's reliability and validity among different populations of young people (e.g., boys, girls) and in different kinds of settings (e.g., school, treatment programs)?
- Sensitivity of the instrument to measure meaningful behavioral changes over time: Is there evidence that the tool reliably measures the changes in a young person's behavior and related thinking?

In addition to the above criteria, it is important to consider these features: The instrument should be relatively easy to administer and not burdensome in length; a detailed user's manual and appropriate scoring materials need to be available; and the cost of the materials for administering and scoring the instrument should not be excessive. See Chapter 3 for more on evaluating instruments.

Figure 1-2
Screening and Assessment

Level	Content	Methods	Sources
Screening	■ Substance use disorder severity, plus ◆ Home life ◆ Psychiatric status ◆ School status	■ Short questionnaire ■ Brief interviews	■ Client ■ Parent(s)
Comprehensive Assessment	■ Substance use disorder severity, plus ◆ Home life ◆ Delinquency ◆ Physical/sexual abuse ◆ Medical status ◆ Learning status ◆ Indepth psychiatric status ◆ Environmental risks ◆ Environmental assets/strengths ◆ Sexual behavior ◆ Developmental status ◆ Leisure and recreation ◆ Family dynamics	■ Standardized questionnaire ■ Structured interviews ■ Laboratory tests ■ Direct observation ■ Diagnostic tests	■ Client ■ Parent(s) ■ Archival records ■ Significant others

Substance use disorders invariably ripple out into other areas of a person's life, and this is especially true with young people who are developing emotionally, intellectually, and physically. Although this volume focuses on assessing the individual youth's problems as a

foundation for treatment, programs involved with adolescent substance use disorders should also be a part of efforts to address the fundamental community and societal problems that contribute to adolescents' substance use disorders.

2 Preliminary Screening of Adolescents

The Consensus Panel recommends that all adolescents who exhibit signs of substance use receive appropriate, valid, and sensitive screening. Health service providers, juvenile justice workers, educators, and other professionals who work with adolescents at risk should be able to screen and refer for further assessment.

When screening turns up “red flags” that indicate that the adolescent may have a substance use disorder, the youth should be referred for a comprehensive assessment (Winters, 1994). For adolescents at high risk for substance use disorders, a negative screening result should be followed up with a re-evaluation, perhaps after 6 months. In recognition of the importance of early detection and intervention, it is appropriate to be inclusive when screening youth for substance use problems. The goal of screening is to identify accurately youth who will benefit from a full and complete assessment, at which time a determination of a substance use disorder can be made and recommendations for intervention developed.

Of course, just because an adolescent shows warning signs of substance use, this does not confirm that he has a problem severe enough to warrant a formal diagnosis or referral to intensive drug treatment. Some adolescents’ substance involvement is temporary (Newcomb and Bentler, 1989), and most young substance

users do not develop serious problems as they get older (Shedler and Block, 1990). Thus, professionals conducting screenings for substance use disorders must also be sensitive to the potential danger of stigmatizing the youth with a label of a substance abuse or substance dependence diagnosis or as having a “disease.”

Screening

Screening determines the need for a comprehensive assessment; it does not establish definitive information about diagnosis and possible treatment needs. The process should take no longer than 30 minutes and ideally will be shorter. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), the hallmarks of a screening program are (1) its ability to be administered in about 10–15 minutes and (2) its broad applicability across diverse populations (SAMHSA, 1994). A screen should be simple enough that a wide range of health professionals can administer it. It should focus on the adolescent’s substance use severity (primarily consumption patterns) and a core group of associated factors such as legal problems, mental health status, educational functioning, and living situation. The client’s awareness of her problem, her thoughts on it, and her motivation for changing her behavior should also be solicited.

During a 30-minute screening, there may be enough time to gather information from both the adolescent and a parent or guardian and to administer a brief standardized screening questionnaire to supplement the interview. A 10- to 15-minute screening process would involve the adolescent and one method of data collection (either brief questionnaire or structured interview). The shorter screening procedure may be the only feasible strategy in facilities that must process large numbers of at-risk youth and where staff is overburdened with other tasks. Some believe that behavioral histories obtained using interactive computer software are more accurate than those done by interview or written survey, but other experts debate this (Turner et al., 1998).

Who Should Screen

Community organizations (e.g., schools, health care delivery systems, the judiciary, vocational rehabilitation, religious organizations) and individuals associated with adolescents at risk must be able to screen and detect substance use. Thus many health and judicial professionals should have screening expertise, including school counselors, street youth workers, probation officers, and pediatricians.

Who Should Be Screened

Obviously, juvenile justice systems should screen all adolescents at the time of arrest or detention. "Status offenders" do not go through these processes, but they should also be screened. Adolescent offenders clearly form an at-risk population, and the base rate of substance use is sufficiently high among them to justify universal screening (Dembo et al., 1993a). Given the high correlation between psychological difficulty and substance use disorders, all teens receiving mental health assessment should also be systematically screened. Within other service delivery systems, runaway youth (e.g., at shelters), teens entering

the child welfare system, teens who dropped out of school (e.g., in vocational/job corps programs), and other high risk populations (e.g., special education students) should also be screened.

Adolescents who present with substantial behavioral changes or emergency medical services for trauma, or who suddenly begin experiencing medical problems such as accidents, injury, or gastrointestinal disturbance should also be screened. In addition, schools should screen youth who show increased oppositional behavior, significant changes in grade point average, and a great number of unexcused school absences.

Components of the Screening Process

Naturally, an appropriate screening procedure must consider several variables pertaining to the client, such as age, ethnicity, culture, gender, sexual orientation, socioeconomic status, and literacy level. Before using standardized interviews and questionnaires, it is incumbent on the assessor to review the instrument manual to gauge how sensitive it is to differences in adolescents' backgrounds. For example, many instruments will have different norms for boys and girls and for younger and older children. Collecting normative data for representative populations of different cultural groups can confuse the assessment of substance use disorders among individuals across cultural groups. If the norm for a particular group is high substance use, high substance use will "score" as normal when compared with a standardization sample made up exclusively of members of that group. What is important is that the content of the test is appropriate for clients from a variety of backgrounds and cultural experiences. Responses to potentially culture-insensitive items should be reviewed with the individual for clarification.

There are three primary components to preliminary screening: (1) content domains, (2) screening methods, and (3) information sources.

Content

The screening procedure focuses on empirically verified “red flags,” or indicators of serious substance-related problems among adolescents (Rahdert, 1991). The indicators tend to fall into two broad categories: those that indicate substance use problem severity and those that are psychosocial factors. While more research is needed to validate red flags of adolescent substance use disorders, a growing body of empirical literature identifies salient markers. Figure 2-1 provides a list of such markers prepared by the Panel. There is no definitive rule as to how many uncovered red flags dictate a referral for a comprehensive assessment. Many screening questionnaires provide empirically validated cut scores to assist with this decision. Nevertheless, any time there are several red flags or a few that appear to be meaningful, it is advisable to refer the adolescent for a comprehensive assessment.

HIV/AIDS risk behaviors

Current public health concerns require that screenings for substance use disorders place a high priority on the issue of substance use as a contributor to risky sexual activity and to other HIV/AIDS risk behaviors (Leigh and Stall, 1993). According to the Youth Risk Behavior Survey, in 1995 over half of students in grades 9–12 had already engaged in sexual intercourse. Almost one-fifth reported that they had more than four sex partners, and only half of all sexually active high schoolers reported using a condom the last time they had intercourse. Drug use also appears to encourage risky sexual behavior: One-fourth of the sexually active students said they used substances the last time they had intercourse (Centers for Disease Control and Prevention, 1998; Jainchill et al., in press).

This issue highlights the importance that workers dealing with youth receive adequate training on HIV/AIDS prevention, education, and referral. Because confidentiality is essential in this area, agencies and service providers

Figure 2-1
Indicators for Assessment

Substance Use Disorder-Related

- Use of substances during childhood or early teenage years
- Substance use before or during school
- Peer involvement in substance use
- Daily use of one or more substances

Psychosocial

- Physical or sexual abuse
- Parental substance abuse (including driving under the influence/driving while intoxicated)
- Sudden downturns in school performance or attendance
- Peer involvement in serious crime
- Marked change in physical health
- Involvement in serious delinquency or crimes
- HIV high-risk activities (e.g., intravenous drug use, sex with intravenous drug user)
- Indicators of serious psychological problems (e.g., suicidal ideation, severe depression)

should have clear policies and procedures for recording, providing, and disclosing information on HIV counseling and testing. State laws vary concerning the confidentiality rights of youth and the right of parents to know about the HIV status of their child. Thus, it is important that local policies and procedures be consistent with State regulations. If a program receives funds from Federal sources, it may have to consider Federal laws as well.

Screening methods

Interviews and questionnaires

A model screening instrument is short, simple, and appropriate to the youth's age. The instrument should give the "big picture" of the youth's situation, not a lot of specific, detailed information. However, the instrument should be of sufficient scope to cover the "red flag" areas of substance use disorders and psychosocial functioning noted above. The tool should not require sophisticated knowledge in test administration or interpretation; it must have high utility for a broad range of professionals and paraprofessionals.

The most commonly used screening method is the interview. Not only is a screening interview an efficient means to gathering information on the essential red flags, it also offers an opportunity to observe the client's nonverbal behaviors and to gauge his verbal skills.

When structured screening interviews are used, it is important that the interviewer follow the administration structure provided in the interview booklet. Unstructured interviews pose special administration problems that contribute to measurement error. The Panel strongly recommends that structured or semistructured interviews be used in this field. Interviews should not be performed with parents present.

When using paper-and-pencil questionnaires, administration procedures

should have the client read aloud the instructions that accompany the test to ensure that the client understands what is expected of him and to judge whether the client's reading ability is appropriate for the testing situation.

The Consensus Panel and Revision Panel reviewed available screening instruments for adolescent substance use (see Appendix B). Many of these screening instruments can be administered in 15 minutes and require only a few more minutes to score. Others ("mid-range screeners" such as Dembo's Prototype Screening/Triage Form) are quite lengthy and will require more administration, training, and scoring time (Dembo et al., 1990a).

Furthermore, the group of screening tools varies considerably in how many red flags each tool covers. The Problem-Oriented Screening Instrument for Teenagers (POSIT), recently developed by the National Institute on Drug Abuse (NIDA) (Rahdert, 1991), covers 10 domains, while others are quite narrow in scope. Naturally, choosing a screening tool requires other considerations, including cost (some are not public domain) and its long-range value for agencies wanting to develop clinical databases. The reader is encouraged to contact the authors of instruments to obtain additional information about their applicability and utility.

Drug monitoring

Laboratory methods to monitor substance use can be conducted in the preliminary screening to supplement information gathered through screening tools and additional sources. Drug testing is an important addition to most screens and assessments; it is particularly useful at intake to juvenile assessment centers, other juvenile detention facilities, and crisis stabilization units. Drug monitoring should be conducted at an appropriate point during screening and in a manner consistent with accepted standards and guidelines. NIDA-certified laboratories are generally available in

most communities and are equipped to provide agencies with the necessary training in collecting urine and blood samples.

Drug testing should always be conducted with the knowledge and consent of the adolescent. Surreptitious testing (e.g., asking for a sample for “medical” reasons and then testing it for drugs) is never advisable. Assessors should always report the results of testing to a youth and discuss their implications. Drawbacks to drug testing include the fact that lab tests yield a narrow range of information. Severity of use and the consequences of that use cannot be obtained from testing for the presence of drugs in urine and blood. Since adolescents may adulterate or replace their urine sample, collection should probably be observed. Appendix C provides additional information about laboratory testing procedures.

Other sources of information

Although it is a luxury in most screening situations, supplemental and corroborative information is useful during a screening evaluation. In most instances, obtaining it will involve interviewing a knowledgeable parent or guardian. Other logical sources at this level may be other family members, or the youth’s caseworker, probation officer, or teacher. Getting information from other sources helps the assessor guard against developing an incorrect picture based solely on the young person’s self-report. There is evidence that knowledgeable parents generally provide valid information about their child’s “externalizing” problems, such as conduct problems, delinquency, and attention deficits, while they provide less valid and corroborating information with respect to the child’s “internalizing” concerns, such as mood distress and self-view (Ivens and Rehm, 1988). Parents also can report on signs of use such as paper bags with inhalable substances in them, beer cans in a car, or drug-seeking behaviors such as stealing money from family members. Clinical

wisdom suggests that parents’ knowledge of their child’s substance use is probably based on observation of its consequences (e.g., physical effects of intoxication).

After getting the teenager’s consent, the assessor should also collect information about family life, including substance use behaviors and attitudes in the home, and whether physical, sexual, or emotional abuse is present. It is wise to collect the information when the youth is not present in the interview room and to tell the parents that what they say may be shared with the adolescent in the summary of the screening.

The Need for Community Coordination

At-risk behavior among youth is often viewed solely as a disciplinary problem rather than a signal that intervention is needed. Community-based training and community involvement in the screening process can go a long way toward enhancing effective community responses to substance-using adolescents. The Consensus Panel recommends that everyone who works with youth use the same instruments. One way to accomplish this would be for schools, child welfare agencies, human service agencies, and juvenile justice systems to establish an areawide coordinating committee for adolescent screening and assessment. The committee could review and select reliable, standardized screening and assessment tools from among the instruments presented in Appendix B so that all agencies serving the local adolescents and their families will use the same standardized measures. The use of these measures can be refined from feedback gained from focus groups.

When substance use disorder treatment, mental health, and related service providers and other community agencies specifically designed to serve at-risk youth agree to use the same screening instruments and follow similar

procedures, the community is most able to apply consistent referral criteria. This process can be facilitated by communities agreeing on definitions of "high-risk" behavior for their particular community and thresholds for referring young persons for additional comprehensive assessment and treatment. If possible, local communities should ascertain the instruments' reliability and validity for that community. It is also important for local agencies to maintain their own databases on local drug testing results for the particular purposes of need assessment. For example, it helps to have data on the frequencies of abuse of various drugs and to document what are the most prevalent problems that coexist with the substance use disorder.

Administrative considerations regarding preliminary screening include cost, ease of use, flexibility of use in different settings among different populations, analyses of screening data, and preparation of relevant reports. To address these considerations, agencies throughout the community or local area must coordinate their screening policies. A communitywide interagency mechanism should be put in place to coordinate and implement screening, management of information systems (MIS), and training of screeners and other relevant professionals. Any such mechanism would have to conform to confidentiality regulations (see below).

The establishment of an areawide coordinating body for screening and assessing adolescents for substance use disorders could greatly facilitate administrative effectiveness on all levels. Such centers can coordinate intake, screening, referral, and MIS activities. The Treatment Alternatives for Safe Communities (TASC) program offers one example of effective interagency collaboration. TASC programs have been successful in identifying a large number of offenders in need of substance use disorder services (Cook, 1992). The TASC evaluation

conducted in 1976 stated that various programs had achieved success in identifying a large number of offenders who qualified for TASC services and that self-reports, urinalysis, and referrals from lawyers and judges seemed to increase client flow (Toborg et al., 1976). This type of structured case management between the criminal justice and treatment systems has facilitated the traditional goals of each system.

Funding for grassroots training and implementation is necessary to support communitywide collaboration. Training should take place within a particular agency, among different agencies, and areawide. These efforts will help to identify the service providers most likely to conduct preliminary screening (such as protective service and intake workers, guidance counselors, and nurses). Training should focus on the advantages and cautions when using standardized measures (e.g., advantage of reducing error associated with subjective judgment versus inherent limitation of tests to address the unique situation of an individual).

After client-identifying information has been stripped, screening results can be made available to a large repository that can track data through on-line computer and database systems. A number-identifying system is one way to share data and yet ensure confidentiality. MIS tracking based on compiled data can provide information critical to future planning. (Some communities will not have the resources to conduct these efforts.) Electronic case reporting and instrument scoring are easing the inevitable move to paperless recordkeeping and electronic data communication, and they provide aggregate data for population descriptions, internal accountability, and reports to funding and licensing agencies. In addition, aggregate case data can sometimes persuade funding and governmental agencies responsible for resource allocation that a serious need exists for expanded local resources for adolescents.

How information is stated and stored in the files is critical, especially in today's world of computerized recordkeeping. Computerization of records greatly complicates efforts to ensure security. Once a file is created, it can "follow" a client for the rest of her life. Wording can lead to misinterpretation, creating future problems. Labeling of the adolescent must be avoided. One way to avoid labeling is to report facts, not opinions, and only information that is necessary for meeting the client's treatment needs. (For a brief discussion of some of the issues computerization raises, see TIP 23, *Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing* [CSAT, 1996], pp. 52–53.)

Protocols developed by community agencies to govern screening and assessment must be

clear about consent and patient notice, confidentiality and privacy, State and Federal regulations (including those regarding child abuse reporting), and duty-to-warn requirements. Programs must establish and follow guidelines on confidentiality and privacy, including policies for administrative procedures and training. In other words, confidentiality and privacy must be highlighted as priorities in every aspect of the program. Training must be provided so that protocols and instruments are clearly understood. Interviewers must remind clients in a clear, realistic, and understandable manner about their rights concerning informed consent and privacy. See Chapter 4 for a more detailed discussion of confidentiality and other legal concerns.

3 Comprehensive Assessment of Adolescents for Referral and Treatment

Comprehensive assessment follows a positive screening for a substance use disorder and may lead to long-term intervention efforts such as treatment. Screening procedures identify that a youth may have a significant substance use problem. The comprehensive assessment confirms the presence of a problem and helps illuminate other problems connected with the adolescent's substance use disorder. Comprehensive information can be used to develop an appropriate set of interventions.

The comprehensive assessment has several purposes:

1. To document in more detail the presence, nature, and complexity of substance use reported during a screening, including whether the adolescent meets diagnostic criteria for abuse or dependence
2. To determine the specific treatment needs of the client if substance abuse or substance dependence is confirmed, so that limited resources are not misdirected
3. To permit the evaluator to learn more about the nature, correlates, and consequences of the youth's substance-using behavior
4. To ensure that related problems not flagged in the screening process (e.g., problems in medical status, psychological status, social

functioning, family relations, educational performance, delinquent behavior) are identified

5. To examine the extent to which the youth's family (as defined earlier) can be involved not only in comprehensive assessment but also in possible subsequent interventions
6. To identify specific strengths of the adolescent, family, and other social supports (e.g., coping skills) that can be used in developing an appropriate treatment plan (financial information is relevant here as well)
7. To develop a written report that
 - ◆ Identifies and accurately diagnoses the severity of the use
 - ◆ Identifies factors that contribute to or are related to the substance use disorder
 - ◆ Identifies a corrective treatment plan to address these problem areas
 - ◆ Details a plan to ensure that the treatment plan is implemented and monitored to its conclusion
 - ◆ Makes recommendations for referral to agencies or services

In addition, the assessment begins a process of responding creatively to the youth's denial and resistance and can be seen as an initial

phase of the treatment experience. Although an adolescent who has been referred for a substance use disorder assessment is likely to have a substance use problem, a counselor should not presuppose the presence of a problem. Assessment must go to the depth necessary to rule out the possibility of a substance use disorder. If a substance use disorder cannot be excluded from consideration, then the probe should continue.

The Assessor

The assessor should be a well-trained professional experienced with adolescent substance use issues, such as a psychologist or mental health professional, school counselor, social worker, or a substance abuse counselor. The assessor might work in private practice, a public clinic, a nonprofit organization, or a juvenile justice setting. Naturally, the assessor should have sufficient training in psychological assessment, use of standardized measures, developmental psychology, and substance use disorders. The assessor should also be familiar with the local slang terms for particular drugs.

It is advisable for one individual to take the lead in the assessment process, especially for gathering, summarizing, and interpreting the assessment data. If the responsibility is spread out, the adolescent may “fall through the cracks,” or tasks may be duplicated unnecessarily. The process of coordinating the activities of different people and agencies working with a young person can be difficult and often creates interagency turf problems. These potential tensions can be reduced if all involved agencies are clear about expectations and responsibilities.

The skill level of the assessor should be appropriate to the tasks required by the assessment process and the particular training needed to use the specific instruments. For

example, an unlicensed but trained technician may administer an objective assessment instrument such as one summarized in Appendix B, the results of which may need to be interpreted and confirmed by a licensed professional. Many diagnostic interviews need to be administered by a licensed professional because advanced training in descriptive psychopathology is required to assess the complexity of behavioral and mental disorders. However, many standardized and highly structured instruments to assess psychiatric disorders can now be administered by lay personnel with appropriate training and scored by a computer.

Note that the training, education, accreditation, sensitivity, and skill level of the assessor can limit the scope and outcome of the assessment. For example, an assessor not licensed to make mental health diagnoses should refer an adolescent who needs a formal mental health workup to an appropriate professional. Professional qualification of an assessor may affect eligibility for reimbursement for the assessment and, in some cases, authorization for treatment.

The assessor should not be a passive link in the chain from assessment to treatment. By accepting responsibility for the assessment of an adolescent and her family, the assessor also accepts responsibility for assisting in the treatment planning process. Linkages with various local agencies and programs should be established to guarantee that the adolescent will be properly transferred from assessment to the recommended referral or service agency and receive the services she needs.

To ensure that the youth obtains needed services, the assessor sometimes must become the young person’s advocate. This often includes overcoming challenges in the treatment referral process and in obtaining needed

services. The barriers include limited family financial resources, a shortage of slots in treatment programs, agency turf issues, and lack of appropriate services for specific treatment needs. These issues can be addressed by community networking, comprehensive case management, interagency communication and collaboration, and systematic data gathering to document adolescent treatment needs.

Setting

The assessment should be conducted in an office or other site where confidentiality can be ensured and where the adolescent can feel comfortable, private, and secure. The validity of information provided by the youth may depend on the setting (especially if the setting is seen by the youth as adversarial or threatening), the level of trust between the adolescent and the assessor, and the adolescent's understanding of the potential use and audience for the information he is about to divulge.

If the adolescent feels that he will be overheard by others in the assessor's office or that providing information will result in punishment, he is unlikely to tell the full truth. If an interview is conducted in a detention center, the juvenile should be assured that no one in authority at the center can overhear the interview. Screening and assessment should not take place in a cell (see Chapter 5).

If other people, such as the youth's family, are involved in the assessment process, the assessor should determine the order of the interviewing process. For example, it may be advisable to first interview the young person in private, then the parent(s) in private, then with the group as a whole, being sure to tell each person that no information given in confidence will be shared with the entire group unless prior permission is granted. This strategy will maximize comfort and confidentiality.

The Multiple Assessment Approach

As described in Chapter 1, the Panel recommends the use of the multiple assessment approach whereby different content issues are measured with methods from several sources. Because no single factor causes substance use disorders, and given that its effects extend to multiple areas of a youth's life (Children's Defense Fund, 1991), it is necessary to measure a wide range of personal and environmental factors.

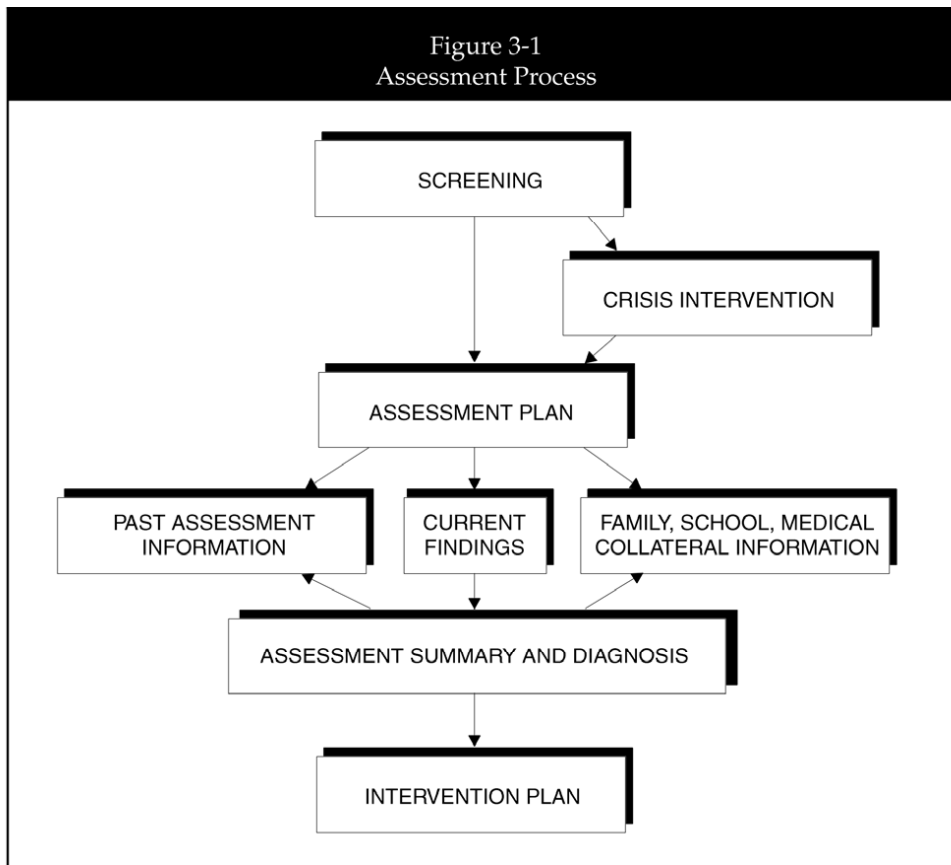
Furthermore, the measurement challenges require that the assessor evaluate substance use disorders using multiple strategies and several sources of information (Winters, 1990). Thus, assessors should collect information through interview, observation, and specialized testing (discussed in detail below), and attempt, with the adolescent's consent, to gather information from well-informed parents, other family members (e.g., siblings), and adults and peers important to the youth. Of course, the evaluation needs to be conducted according to local, State, and Federal laws and guidelines regarding confidentiality and child abuse reporting (see Chapter 4). See Figure 3-1 for a schematic representation of the multiple assessment approach.

Content Domains To Be Assessed

Listed below are the domains that should be assessed in order to arrive at an accurate picture of the adolescent's problems. The comprehensive instruments reviewed in Appendix B measure them or subsets of them.

- History of use of substances, including over-the-counter and prescription drugs, tobacco, and inhalants—the history notes age of first use; frequency, length, and pattern of use;

Figure 3-1
Assessment Process



mode of ingestion; treatment history; and signs and symptoms of substance use disorders, including loss of control, preoccupation, and social and legal consequences

- Strengths and resources to build on, including self-esteem, family, other community supports, coping skills, and motivation for treatment
- Medical health history and physical examination, noting, for example, previous illnesses, ulcers or other gastrointestinal symptoms, chronic fatigue, recurring fever or weight loss, nutritional status, recurrent nosebleeds, infectious diseases, medical trauma, and pregnancies

- Sexual history, including sexual orientation, sexual activity, sexual abuse, sexually transmitted diseases (STDs), and STD/HIV risk behavior status (e.g., past or present use of injecting drugs, past or present practice of unsafe sex, selling sex for drugs or food)
- Developmental issues, including possible presence of attention deficit disorders, learning problems, and influences of traumatic events (such as physical or sexual abuse)
- Mental health history, with a focus on depression, suicidal ideation or attempts, attention-deficit disorders, anxiety disorders, and behavioral disorders, as well as details

about prior evaluation and treatment for mental health problems.

- Family history, including the parents', guardians', and extended family's history of substance use, mental and physical health problems and treatment, chronic illnesses, incarceration or illegal activity, child management concerns, and the family's ethnic and socioeconomic background and degree of acculturation (The description of the home environment should note substandard housing, homelessness, proportion of time the young person spends in shelters or on the streets, and any pattern of running away from home. Issues regarding the youth's history of child abuse or neglect, involvement with the child welfare agency, and foster care placements are also key considerations. The family's strengths should be noted as they will be important in intervention efforts.)
- School history, including academic and behavioral performance, and attendance problems
- Vocational history, including paid and volunteer work
- Peer relationships, interpersonal skills, gang involvement, and neighborhood environment
- Juvenile justice involvement and delinquency, including types and incidence of behavior and attitudes toward that behavior
- Social service agency program involvement, child welfare agency involvement (number and duration of foster home placements), and residential treatment
- Leisure-time activities, including recreational activities, hobbies, and interests

Involvement of Other Sources

The adolescent's family is an important factor in the adolescent's involvement in and treatment for substance use disorders. Therefore, it is

critical to form a therapeutic alliance with the family to the fullest extent possible and to involve the family in the assessment process. If there is evidence that the adolescent is being abused at home, the family should still be questioned about the matter. It is important to pursue what is known about possible abuse from the parents, even the abusing parent, as well as other family members (e.g., siblings). Of course, the reporting requirements for professionals regarding evidence of abuse must be disclosed to each individual being interviewed (see Chapter 4 for details).

The assessment should not be considered complete until there has been time to assess the traditionally defined family and others identified by the court as legal custodians who can speak for the best interests of the adolescent, as well as the family that is defined by the young person. The assessor must determine who the "family" is as perceived by the adolescent and by legal considerations (that is, the person or entity able to legally represent the interests of the adolescent).

The assessment of an entire family requires a specific set of skills in addition to those needed to assess an individual (Szapocznik et al., 1988). Such assessments require people who are highly skilled and trained to interpret family dynamics, strengths, weaknesses, and social support systems. Assessors must also be able to identify key family structures and interrelationship patterns in which the adolescent's substance use disorder is enmeshed. It is also essential for the assessor to elicit previous treatment experiences, as well as previous attempts by the family to address the substance use problem and to ascertain the family's feelings about the adolescent. Do the family's responses to questions about this indicate the desire to help the adolescent, or do they suggest that the family sees the adolescent as "the problem?" These responses are useful in determining how

to best proceed in working with the adolescent and the family.

Of course, the absence of a traditional family can be a barrier for adolescents seeking treatment. At-risk adolescents may be homeless or on the verge of homelessness. Some youth may go from shelter to shelter and have no address. In some States, a minor cannot gain access to any services unless an adult signs for her. Potential assistance can be obtained by initiating procedures to help the adolescent achieve emancipation or become a temporary ward of the State.

Key sources other than family members include adult friends, school officials, surrogate parent advocates in school-related issues, court officials, Court Appointed Special Advocates, social service workers (especially when the youth has been involved with the child welfare system), previous treatment providers, and previous assessors. Contacting these additional sources of information, with the client's consent, may be necessary to support or supplement the information that the adolescent provides in the comprehensive assessment.

Assessment Instruments

The Panel emphasized the importance of two methods for use when assessing adolescent substance use disorders: self-report questionnaires, and structured and unstructured interviews. (Laboratory testing, described in detail in Appendix C, is considered more relevant to the screening procedure.)

The use of well-designed questionnaires and interviews can yield an accurate, realistic understanding of the teenager and the problems he is experiencing. The information derived can also provide important insights into the young person's motivation and readiness to make use of and benefit from treatment.

Appendix B describes recommended instruments and their purpose, content,

administration, time required for completion, training needed by the assessor, how to obtain them, their cost, and persons to contact for further guidance. All the instruments met the two most important criteria in the evaluation of any measurement instrument: reliability and validity. It is important to briefly discuss these psychometric concepts.

Reliability

Reliability refers to the relative freedom of a measure from error. One indicator of favorable reliability in a test is high consistency of item responses. Two types of consistency are involved: internal consistency and temporal stability. Internal consistency represents the expectation that the client's responses to various items are congruent to each other. For example, if the response to one question is that drugs are used "daily," it would be consistent for the client to say, in response to another question, that he uses drugs frequently. Temporal or "test-retest" consistency is based on repeated use of the measurement and refers to how the person's responses compare over a short time period, that is, from day to day or even from week to week. Thus, if the instrument is administered a second time to the individual shortly after the initial administration and the results for the two occasions correlate highly with each other, then evidence for the instrument's "test-retest" consistency is demonstrated.

Validity

Validity refers to the extent or degree to which the assessment instrument measures what it is intended to measure. Of course, a test can be valid only to the degree that it is reliable—a result with a wide amount of error cannot measure exactly what it is intended to measure. Good reliability, however, does not guarantee validity. Descriptions of assessment

instruments often mention four kinds of validity.

One is *content (or face) validity*. This is, based on logical reasoning, the extent to which the test items are judged, “on the face of it,” to deal with information, questions, or problems related to the stated objectives of the test. Content validity is often assessed by developing in advance a table of specifications that describes all the domains and characteristics that should be included in a test, and then having experienced judges rate their content relevance. A drug abuse test might gather evidence for face validity by obtaining ratings of relevance of test items from experts in the field. Some effective tests eschew content validity because they seek items whose content cannot be recognized by the subjects.

Concurrent or criterion validity is the extent to which the results of an instrument are statistically consistent with a measure intended to address the same trait or domain. The concurrent validity of a test being developed can be measured by comparing it to an already established test. For example, the Wechsler Adult Intelligence Scale has been demonstrated to be effective in assessing the thinking, memory, and learning capabilities of adults, and it has established validity as a test of intelligence. If a group of researchers developed another instrument, such as one that requires a person to solve linguistic and graphic puzzles, they might administer the two tests to a group of adults. The group would have evidence that the new test reflects intelligence if each individual scored at about the same level on both tests. That is, there would be evidence that the new test measures the same construct of intelligence that is measured by the Wechsler test by virtue of it concurring with the validity evidence associated with the established scale.

Predictive validity deals with the effectiveness with which an assessment instrument predicts how people will function or behave in the

future. Thus, a criminality instrument could be used on a group of people to predict whether they will actually become criminals. In this regard, they would be followed for several years after completing the questionnaire and checked for evidence of criminality. The instrument would be considered to have predictive validity if a high correlation (for example, a correlation of .50 or higher) was determined between the results on the instrument and the later incidence of illegal behavior.

A complex type of validity is *construct validity*. This refers to whether the results derived from a test are consistent with and reflect the underlying theoretical notion it is intended to measure. This can be determined by assessing the extent to which the results obtained are in line with what the theory claims. For example, the developer of an assessment instrument may theorize that people who are likely to commit crimes are without clear-cut values of honesty, social conformity, or sympathy for other people and are not thoughtful about their actions. The developer then organizes a questionnaire containing items related to these traits. The questionnaire is administered to a group of known criminals and to a group known not to be criminals. When the questionnaires are scored, construct validity is present if the criminals and noncriminals are successfully distinguished from each other to a statistically significant degree.

Validity evidence can be reported in the form of correlations. Generally, validity coefficients tend to be lower than reliability coefficients. They may range between .30 and .80 or even higher, depending on whether they refer to concurrent validity (in which case coefficients tend to be higher) or to predictive validity (in which case coefficients tend to be lower). Also, as the complexity of what is being evaluated is great, as in the assessment of personality makeup, the validity coefficients are likely to be lower. Another form of reporting validity

evidence is with between-group difference tests. The user of the instrument should examine the data available on validity to determine whether they represent the type of validity that fits the purposes for which the test is to be used.

Other Test Features

Norms, which are provided by the author of an assessment instrument, represent the scores or results that the types of people who are to be assessed by the instrument tend to obtain. No psychological instrument is useful for all people. Therefore, the author of the instrument reports the types of individuals for whom its use is appropriate. This report should refer to such client characteristics as the age, sex, ethnicity, educational achievement, socioeconomic level, and medical and psychological status of the population on which the original measurements were made.

Norms are often provided as tables that show how the scores are distributed for key characteristics, such as the sex or age of the population. The central tendency, or the average, of the scores is shown, along with the range from highest to lowest scores. These normative tables can be very useful to the counselor in determining the extent to which a client's functioning is within normal or abnormal limits. Often, as a test is used more extensively, norms are expanded, and the instrument becomes appropriate for increasingly larger and differing types of client populations.

Conditions for administration of any test or assessment instrument should be clearly spelled out in a manual prepared by the author of the instrument. The manual for the instrument should describe how the test was constructed and should report available information on its reliability, validity, and norms. It should also describe the content and structure of the instrument, as well as how it relates to similar instruments.

Of great importance to the user is the author's description of how the instrument is to be administered, scored, and interpreted. Specific statements should include

1. The purpose or aim of the test
2. For whom the test is and is not appropriate
3. Whether the test can be administered in a group or only on an individual basis
4. Whether it can be self-administered or if it must be given by an examiner
5. Whether training is required for the assessor, and, if so, what kind, how much, and how and where it can be obtained
6. Where the test can be obtained and what it costs

Consideration of the above practical issues and of the conditions for administration should enable program staff to select the instruments that are most applicable and useful for its program and clients. Once selected, the tests should be administered in the manner recommended by the authors. No substitutions should be made for any test items and no items should be eliminated or modified. For structured interviews, the interview format and item wording should be strictly followed. If this rule is not followed, the results obtained from the test cannot legitimately be interpreted in terms of the norms provided in the test manual. Changing the test in any way makes it, in effect, a different test, so that the reliability, validity, and norms reported for the test no longer apply, thus making it difficult to know how to interpret the results. However, not all assessment tools are tests. The more descriptive instruments may have more flexibility in terms of adaptation to the individual and the situation.

Written Report

Depending on the setting, the assessor should prepare a detailed report based on information

gathered using assessment instruments and personal observation. The complexity of adolescence requires that the individual being assessed never be reduced to a test score. A child's range of strengths and problems can best be evaluated with both quantitative and qualitative procedures. The aim is to assess the

strengths and competence, as well as the limitations, of the child (see Figure 3-2). After the information from the different sources has been assembled, the assessor writes a report of what he has learned about the adolescent in terms that can be understood by all concerned, including the adolescent. The written report

Figure 3-2
The Written Report

The written report should identify

- The conditions/environment at the time of assessment
- The severity of the substance involvement
- Youth's conceptualization of reasons for substance use
- Factors that contribute or relate to the substance involvement
- Diagnosis as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, fourth ed.
- History of treatment services, including drug treatment and mental health treatment
- A corrective action plan to address problem areas
- A detailed plan to ensure that the treatment plan is
 - ◆ Mindful of the adolescent's expressed views and desires in his own words
 - ◆ Implemented
 - ◆ Monitored to its conclusion

The written report should be careful to

- Not reduce a youth to a test score or label
- Emphasize the youth's strengths as well as problems
- Capture the range of issues, strengths, and concerns
- Integrate previous workups when they indicate progression of symptoms and problems
- Not include opinions and descriptions from previous reports without thought and research (remember that the report can follow the youth for years)

The written report should be distributed

- In compliance with the confidentiality requirements of 42 C.F.R.
- Only with the signed approval of the adolescent (and, in some States, of the parent or guardian), as described in Federal or State laws

The report should

- Serve as a basis for linking youths with needed services
- Specify treatment placement recommendations
- Recommend posttreatment support services

The report should be written so that it can be understood by the adolescent and all parties concerned.

captures the adolescent's range of problems, strengths, and sources of support, as well as those of the youth's family.

To maintain continuity with previous workups and interventions, to make efficient use of all information available, and to spare the adolescent (and the party paying for the assessment) unnecessary duplication of effort, the assessor should be actively involved in determining if organized, accurate information on the adolescent already exists. When appropriate, that information should be integrated into the current written report. In particular, historical information can provide an indication of the progression of symptoms and problem severity. However, the assessor's report, along with providing immediate direction for treatment and other interventions, has the potential to follow the young person for years and be a central factor in shaping decisions about the adolescent. Therefore, it is important not to include opinions and descriptions from previous reports unless that information is currently accurate. The report should deal with such issues as (1) the way the adolescent processes information most effectively and how this will affect treatment, (2) how the adolescent's past experiences will affect his reaction to certain treatment interventions,

(3) specific treatment placement recommendations and justifications, and (4) counselor recommendations. As the field has many different levels of professionals, it is important that these reports be written with specific treatment recommendations that can be understood by all.

The report should be distributed on a need-to-know basis to those service providers who will be working with the adolescent. Adolescents and their parents or guardians often request reports or assessment findings. One practice is to write the report to the parents of a youth under 18 years of age and directly to the young adult if he is over 18, with a copy to the parents who may be paying for the assessment. However, in keeping with the requirements regarding confidentiality, information often cannot be released without the young person's approval and signature on the proper consent forms. Refer to Chapter 4 for further elaboration on the laws regarding release of information.

The report should specify recommendations for treatment placement and posttreatment support services, although the latter issue may require knowledge of treatment progress. The report should also contain a plan for use by a case manager or other responsible party for monitoring services provided to the youth.

4 Legal Issues in the Screening And Assessment of Adolescents

by Margaret K. Brooks, Esq.¹

Staff of substance use disorder treatment programs serving adolescents need to be aware of legal issues that affect program operation. Of top concern among these issues is confidentiality: the protection of the adolescent's right to privacy.

For example, staff members of a program that assesses adolescents and tries to place them in appropriate treatment are often interested in seeking information from other sources, such as parents and schools, about the adolescents they screen. How can the program approach these sources and, at the same time, protect the adolescents' right to privacy? Can the program contact a parent or guardian without the adolescent's consent? If the adolescent tells program staff that she has been abused, can the program report it? If the adolescent is threatening harm to herself or another, can the program call the authorities? Are there special rules regarding confidentiality for programs operating in the juvenile justice system or for child welfare programs?

This chapter will attempt to answer these questions over five sections. First is an overview of the Federal law protecting a youth's right to privacy when seeking or receiving treatment services for substance use disorders. Next is a detailed discussion of the rules regarding the

use of consent forms to get a youth's permission to release information about his seeking or receiving substance use disorder services. The third reviews the rules for communicating with others about various issues concerning a youth who is involved with treatment services (including rules for communicating with parents, guardians, and other sources; reporting child abuse; warning others of an adolescent's threats to harm; and special rules for use within the juvenile justice system). The next section discusses a number of exceptions to the general rules preventing disclosure of information, such as medical emergencies. The chapter ends with a few additional points concerning a youth's right to confidential services and the need for programs to obtain legal assistance.

Federal Law Protects Youths' Right to Privacy

Federal law and a set of regulations guarantee the strict confidentiality of information about persons—including adolescents—receiving substance use prevention and substance use disorder treatment services. The legal citations for these laws and regulations are 42 U.S.C. §290dd-2 as well as 42 Code of Federal Regulations (C.F.R.) Part 2.

These laws and regulations are designed to protect clients' privacy rights in order to attract people into treatment. The regulations restrict communications more tightly in many instances than, for example, either the doctor–client or the attorney–client privilege. Violating the regulations is punishable by a fine of up to \$500 for a first offense and up to \$5,000 for each subsequent offense (§2.4).²

Some may view these Federal regulations governing communication about the adolescent and protecting clients' privacy rights as an irritation or a barrier to achieving program goals. However, most of the nettlesome problems that may crop up under the regulations can easily be avoided through planning ahead. Familiarity with the regulations' requirements will assist communication. It can also reduce confidentiality-related conflicts among the program, client, and an outside agency so that they occur only in a few relatively rare situations.

What Types of Programs Are Covered by the Regulations?

Any program that specializes, in whole or in part, in providing treatment, counseling, and/or assessment and referral services for adolescents with substance use disorders must comply with the Federal confidentiality regulations (42 C.F.R. §2.12(e)). Although the Federal regulations apply only to programs that receive Federal assistance, this includes indirect forms of Federal aid such as tax-exempt status or State or local government funding coming (in whole or in part) from the Federal government.

Coverage under the Federal regulations does not depend on how a program labels its services. Calling itself a "prevention program" does not excuse a program from adhering to the confidentiality rules. It is the kind of services, not the label, that determines whether the program must comply with the Federal law.

The General Rule: Overview of Federal Confidentiality Laws

The Federal confidentiality laws and regulations protect any information about an adolescent if the adolescent has applied for or received any treatment related to her substance use disorder or referral services from a program that is covered under the laws. Services applied for or received can include assessment, diagnosis, individual counseling, group counseling, treatment, or referral for treatment.³ The restrictions on disclosure (the act of making information known to another) apply to any information that would identify the adolescent as having a substance use disorder either directly or by implication. The general rule applies from the time the adolescent makes an appointment, and it also applies to former clients. The rule applies whether or not the person making an inquiry already has the information, has other ways of getting it, has some form of official status, is authorized by State law, or comes armed with a subpoena or search warrant.

When May Confidential Information Be Shared With Others?

Information that is protected by the Federal confidentiality regulations may always be disclosed after the adolescent has signed a proper consent form. (As explained below, parental consent must also be obtained in some States.) The regulations also permit disclosure without the adolescent's consent in several situations, including medical emergencies, child abuse reports, program evaluations, and communications among staff.

The most commonly used exception to the general rules prohibiting disclosure is for a program to obtain the adolescent's consent. The regulations' requirements regarding consent are strict and somewhat unusual and must be carefully followed.

Consent To Disclose Information

Most disclosures are permissible if an adolescent has signed a valid consent form that has not expired or been revoked (§2.31).⁴ A proper consent form must be in writing and must contain *each* of the items specified in §2.31:

1. The name or general description of the program(s) making the disclosure
2. The name or title of the individual or organization that will receive the disclosure
3. The name of the client who is the subject of the disclosure
4. The purpose or need for the disclosure
5. How much and what kind of information will be disclosed
6. A statement that the client may revoke (take back) the consent at any time, except to the extent that the program has already acted on it
7. The date, event, or condition upon which the consent expires if not previously revoked
8. The signature of the client (and, in some States, his parent)
9. The date on which the consent is signed (§2.31(a))

A general medical release form, or any consent form that does not contain all of the elements listed above, is not acceptable. (See sample consent form in Figure 4-1.) A number of items on this list deserve further explanation and are discussed under the subheadings below: the purpose of the disclosure and how much and what kind of information will be disclosed, the youth's right to revoke the consent statement, expiration of the consent form, the adolescent's signature and parental consent, required notice against rereleasing information, and agency use of the consent form.

The Purpose of the Disclosure and What Information Will Be Disclosed

These two items are closely related. All disclosures, and especially those made pursuant to a consent form, must be limited to information that is necessary to accomplish the need or purpose for the disclosure (§2.13(a)). It would be improper to disclose everything in an adolescent's file if the recipient of the information needs only one specific piece of information.

In completing a consent form, it is important to determine the purpose or need for the communication of information. Once this has been identified, it is easier to determine how much and what kind of information will be disclosed, tailoring it to what is essential to accomplish the need or purpose that has been identified.

As an illustration, if an adolescent needs to have her participation in counseling verified in order to be excused from school early, the purpose of the disclosure would be "to verify treatment status so that the school will permit early release," and the amount and kind of information to be disclosed would be "time and dates of appointments." The disclosure would then be limited to a statement that "Susan Jones (the client) is receiving counseling at XYZ Program on Tuesday afternoons at 2 p.m."

Youth's Right To Revoke Consent

The adolescent may revoke consent at any time, and the consent form must include a statement to this effect. Revocation need not be in writing. If a program has already made a disclosure prior to the revocation, the program has acted in reliance on the consent—in other words, the program was relying on the consent form when it made the disclosure. Therefore, the program

Figure 4-1
Sample Consent Form

Consent for the Release of Confidential Information

I, _____, authorize XYZ Clinic to receive
(name of client or participant)

from/disclose to _____

(name of person and organization)

for the purpose of _____

(need for disclosure)

the following information _____

(nature of the disclosure)

I understand that my records are protected under the Federal and State confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically on _____ unless otherwise specified below. (date, condition, or event)

Other expiration specifications:

Date executed

Signature of client

Signature of parent or guardian, where required

is not required to try to retrieve the information it has already disclosed.

The regulations state that “acting in reliance” includes the provision of services while relying on the consent form to permit disclosures to a

third party payor. (Third party payors are health insurance companies, Medicaid, or any party that pays the bills other than the client’s family or the treatment agency.) Thus, a program can bill the third party payor for

services provided before the consent was revoked. However, a program that continues to provide services after a client has revoked a consent authorizing disclosure to a third party payor does so at its own financial risk.

Expiration of Consent Form

The form must also contain a date, event, or condition on which it will expire if not previously revoked. A consent must last “no longer than reasonably necessary to serve the purpose for which it is given” (§2.31(a)(9)). If the purpose of the disclosure can be expected to be accomplished in 5 or 10 days, it is better to fill in that amount of time rather than a longer period.

This is better than the practice of having all consent forms within an agency expire in 60 to 90 days. When uniform expiration dates are used, agencies can find themselves in a situation where there is a need for disclosure, but the client’s consent form has expired. This means at the least that the client must come to the agency again to sign a consent form. At worst, the client has left or is unavailable, and the agency will not be able to make the disclosure.

The consent form does not have to contain a specific expiration date, but may instead specify an event or condition. For example, if an adolescent has been placed on probation at school on the condition that he attend counseling at the program, a consent form should be used that does not expire until the completion of the probation period. Or, if an adolescent is being referred to a specialist for a single appointment, the consent form should stipulate that consent will expire after he has seen that doctor.

The Signature of the Adolescent And Parental Consent

The adolescent must always sign the consent form in order for a program to release

information even to her parent or guardian. The program must get the parent’s signature in addition to the adolescent’s signature only if the program is required by State law to obtain parental permission before providing treatment to the adolescent (§2.14). (“Parent” includes parent, guardian, or other person legally responsible for the minor.)

In other words, if State law does not require the program to get parental consent in order to provide services to the adolescent, then parental consent is not required to make disclosures (§2.14(b)). If State law requires parental consent to provide services to the adolescent, then parental consent is required to make any disclosures. The program must always obtain the adolescent’s consent for disclosures, and cannot rely on the parent’s signature alone.

There is one very limited exception to this rule, which is discussed below in the section, “Communicating With Parents or Guardians.”

Required Notice Against Redisclosing Information

Once the consent form has been properly completed, there remains one last formal requirement. Any disclosure made with written client consent must be accompanied by a written statement that the information disclosed is protected by Federal law and that the person receiving the information cannot make any further disclosure of such information unless permitted by the regulations (§2.32). This statement, not the consent form itself, should be delivered and explained to the recipient of the information at the time of disclosure or earlier.

The prohibition on redisclosure is clear and strict. Those who receive the notice are prohibited from rereleasing information except as permitted by the regulations. (Of course, an adolescent may sign a consent form authorizing such a redisclosure.)

Note on Agency Use of Consent Forms

The fact that an adolescent has signed a proper consent form authorizing the release of information does not force a program to make the proposed disclosure, unless the program has also received a subpoena or court order (§2.3(b)(1); 2.61(a)(b)). The program's only obligation is to refuse to honor a consent that is expired, deficient, or otherwise known to be revoked, false, or incorrect (§2.31(c)).

In most cases, the decision whether to make a disclosure pursuant to a consent form is up to the program to decide unless State law requires or prohibits disclosure once consent is given. In general, it is best to follow this rule: Disclose only what is necessary, for only as long as is necessary, keeping in mind the purpose for requesting the desired information.

Communicating With Others About Adolescents

Now that the rules regarding consent are clear, attention can turn to the other questions introduced at the beginning of this chapter:

- How can programs seek information from collateral sources about adolescents they are screening?
- How can programs communicate with parents?
- Can programs report child abuse?
- Do programs have a duty to warn others of threats by adolescents, and if so, how do they communicate the warning?
- Are there special rules for adolescents who are involved in the juvenile justice system?

Seeking Information From Collateral Sources

Making an inquiry of schools, doctors, and other health care providers might, at first glance, seem

to pose no risk to an adolescent's right to confidentiality. But it does.

When a program that screens, assesses, or treats adolescents asks a school, doctor, or parent to verify information it has obtained from the adolescent, it is making a client-identifying disclosure that the adolescent has sought its services. In other words, when program staff seek information from other sources, they are letting these sources know that the youth has asked for substance use disorder services. The Federal regulations generally prohibit this kind of disclosure unless the adolescent consents.

How then is a screening or assessment program to proceed? The easiest way is to get the adolescent's consent to contact the school or health care facility.

Another method involves the program's asking the client to sign a consent form that permits it to make a disclosure for purposes of seeking information from collateral sources to any one of a number of entities or persons listed on the consent form. Note that this combination form must still include "the name or title of the individual or name of the organization" for each collateral source the program may contact. Whichever method the program chooses, it must use the consent form required by the regulations, not a general medical release form.

Communicating With Parents or Guardians

As noted above, programs may not communicate with the parents of an adolescent unless they get the adolescent's written consent.

In getting the adolescent's consent, the program should discuss with the adolescent whether she (and the program) wants the program to be able to confer with the adolescent's parents or guardians. Program staff should also talk to the youth about whether such discussions or meetings with the parent or guardian should occur just once or on a regular

basis. This decision will affect how the program fills out the consent form.

If a program counselor and the adolescent jointly decide they want the counselor to confer with the parent or guardian only once, such as to obtain collateral information, the purpose of the disclosure (which must be stated on the consent form) would be “to obtain information from Mary’s parents in order to assist in the screening (or assessment) process.” The kind of information to be disclosed (which must also be stated on the consent form) would be “Mary’s application for services.” The expiration date should be keyed to the date by which the counselor thinks screening or assessment will have been completed.

If the program and Mary decide they want the program’s counselor to be free to talk to Mary’s parents or guardians over a longer period of time, the program would fill out the consent form differently. The purpose of the disclosure would be “to provide periodic reports to Mary’s parents” and the kind of information to be disclosed would be “Mary’s progress in treatment.” The expiration of this kind of open-ended consent form might be set at the date the program and Mary foresee her counseling ending or even “when Mary’s participation in the program ends.” (However, Mary can revoke the consent any time she wishes to.)

What if Mary refuses to consent? Since the Federal confidentiality regulations forbid disclosures without Mary’s consent, the program cannot confer with her parents.

One special situation deserves mention. The Federal regulations contain an exception permitting a program director to communicate with a minor’s parents when the following conditions are met:

1. An adolescent has applied for services.
2. The program director believes that the adolescent, because of an extreme substance use disorder or a medical condition, does not

have the capacity to decide rationally whether to consent to the notification of his guardians.

3. The program director believes the disclosure is necessary to cope with a substantial threat to the life or well-being of the adolescent or someone else.

Thus, if an adolescent applies for services in a State where parental consent is required to provide services but the adolescent applying for services refuses to consent to the program’s notifying his parents or guardians, the regulations permit the program to contact a parent without his consent only if those two conditions are met. Otherwise, the program must explain to the adolescent that while he has the right to refuse to consent to any communication with a parent, the program can provide no services without such communication and parental consent (§2.14(d)).⁵

Section 2.14(d) applies only to applicants for services. It does not apply to minors who are already clients. Thus, programs cannot contact parents of clients without consent even if the programs are concerned about the behavior of the children.

Reporting Child Abuse and Neglect

All 50 States and the District of Columbia have statutes requiring reporting when there is reasonable cause to believe or suspect child abuse or neglect. While many State statutes are similar, each has different rules about what kinds of conditions must be reported, who must report, and when and how reports must be made.

Most States now require not only physicians but also educators and social service workers to report child abuse. Most States require an immediate oral (spoken) report, and many now have toll-free numbers to facilitate reporting. (Half of the States require that both oral and written reports be made.) All States extend immunity from prosecution to persons reporting

child abuse and neglect. Most States provide penalties for failure to report.

Program staff will often need some form of training to review the State's child abuse and neglect laws and to clearly explain what the terms "abuse" and "neglect" really mean according to the law. A lay person's—or a professional's—idea of child neglect may differ greatly from the legal definition. For example, a child living with a parent involved in extensive alcohol or drug use, perhaps surrounded by a culture of drugs and alcohol, is often not considered to be "abused" or "neglected" unless certain additional conditions are met. Such legal definitions may go against the grain of what some staff members consider to be in the best interest of the child, but these are safeguards that have developed over time to protect the child, the parent, and the family unit.

Because of the variation in State law, programs should consult an attorney familiar with State law to ensure that their reporting practices are in compliance.⁶ Since many State statutes require that staff report instances of abuse to administrators, who are then required to make an official report, programs should establish reporting protocols to bring suspected child abuse to the attention of program administrators. Administrators, in turn, should shoulder the responsibility to make the required reports. However, some States require that an individual aware of child neglect or abuse must report the situation directly to the child protection authority. Alerting the situation to an administrator alone does not exempt the individual from making the report.

The Federal confidentiality regulations permit programs to comply with State laws that require the reporting of child abuse and neglect. However, this exception to the general rule prohibiting disclosure of any information about a client applies only to initial reports of child abuse or neglect. Programs may not respond to followup requests for information or to

subpoenas for additional information, even if the records are sought for use in civil or criminal proceedings resulting from the program's initial report. The only situation in which a program may respond to requests for followup information is when the adolescent consents or the appropriate court issues an order under subpart E of the regulations.

There are clinical considerations as well. There is a need, on the one hand, to guarantee the immediate safety of the adolescent or other children in the home and to comply with the legal reporting requirements of child abuse. On the other hand, assessors need to be sensitive to the potential strain on the trust between assessor and youth that may arise from initiating a report of suspected child abuse. Assessors must handle their obligations with sensitivity.

Duty To Warn

For most treatment professionals, the issue of reporting a patient's threat to harm another or commit a crime is a troubling one. Many professionals believe that they have an ethical, professional, or moral obligation to prevent a crime when they are in a position to do so, particularly when the crime is a serious one.

There has been a developing trend in the law to require psychiatrists and other therapists to take "reasonable steps" to protect an intended victim when they learn that a patient presents a "serious danger of violence to another." This trend started with the case of *Tarasoff v. Regents of the University of California*, 17 Cal.3d 425 (1976). In that case, the California Supreme Court held a psychologist liable for monetary damages because he failed to warn a potential victim that his patient threatened to, and then did, kill. The court ruled that if a psychologist knows that a patient poses a serious risk of violence to a particular person, the psychologist has a duty "to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other

steps are reasonably necessary under the circumstances.”

While the Tarasoff ruling, strictly speaking, applies only in California, courts and legislatures in other States have adopted Tarasoff’s reasoning to hold therapists liable for monetary damages when they have failed to warn someone threatened by a patient. In most instances, liability is limited to situations where a patient threatens violence to a specific identifiable victim; liability does not usually apply where a patient makes a general threat without identifying the intended target.

If an adolescent’s counselor thinks she poses a serious risk of violence to someone, there are at least two—and sometimes three—questions that need to be answered:

- Does a State statute or court decision impose a duty to warn in this particular situation?
- Even if there is no State legal requirement that the program warn an intended victim or the police, does the counselor feel a moral obligation to warn someone?

The first question can only be answered by an attorney familiar with the law in the State in which the program operates. If the answer to the first question is “no,” it is advisable to discuss the second question with a knowledgeable lawyer, too.

- If the answer to question 1 or 2 is “yes,” how can the program warn the victim or someone able to take preventive action without violating the Federal confidentiality regulations?

The problem is that there is a conflict between the Federal confidentiality requirements and the “duty to warn” imposed by States that have adopted the Tarasoff rule. Simply put, the Federal confidentiality law and regulations appear to prohibit the type of disclosure that the Tarasoff rule requires. Moreover, the Federal regulations make it clear that Federal law overrides any State law that

conflicts with the regulations (§2.20). In the only case, as of this writing, that addresses this conflict between Federal and State law (*Hansenie v. United States*, 541 F. Supp. 999 (D. Md. 1982)), the court ruled that the Federal confidentiality law prohibited any report.

When an adolescent makes a threat to harm himself or another and the program is confronted with conflicting moral and legal obligations, it can proceed in one of the following ways:

- The program can go to court and request a court order authorizing the disclosure. The program must take care that the court abides by the requirements of the Federal confidentiality regulations (discussed below in detail).
- The program can make a disclosure that does not identify the adolescent who has threatened to harm another as a patient. This can be accomplished either by making an anonymous report or—for a program that is part of a larger nonsubstance use disorder treatment facility—by making the report in the larger facility’s name. For example, a counselor employed by a drug program that is part of a mental health facility could phone the police or the potential target of an attack, identify herself as “a counselor at the New City Mental Health Clinic” and explain the risk. This would convey the vital information without identifying the adolescent as someone in treatment for a substance use disorder. Counselors at free-standing alcohol or drug programs cannot give the name of the program. (The “nonpatient-identifying disclosure” exception is discussed more fully below.)
- If the adolescent has been mandated into treatment by the criminal justice system (CJS) or the juvenile justice system (JJS), the program can make a report to the mandating CJS or JJS agency, so long as it has a CJS consent form signed by the adolescent that

has been worded broadly enough to allow this sort of information to be disclosed. (For a discussion of the criminal justice system consent form, see the next section.) The CJS or JJS agency can then act on the information to avert harm to the adolescent or the potential victim. However, the regulations limit what the justice agency can do with the information. Section 2.35(d) states that anyone receiving information pursuant to a criminal justice system consent “may redisclose and use it only to carry out that person’s official duties with regard to the patient’s conditional release or other action in connection with which the consent was given.” Thus, the referring justice agency can use the disclosure to revoke the adolescent’s conditional release or probation or parole. If the justice agency wants to warn the victim or notify another law enforcement agency of the threat, it must be careful that it does not mention that the source of the tip was someone at a substance use disorder treatment program or that the adolescent making the threat is in treatment for a substance use disorder. However, the disclosure most likely cannot be used to prosecute the adolescent for a separate offense (such as making the threat). The only way to prosecute an adolescent based on information obtained from a program is to obtain a special court order in accordance with §2.65 of the regulations (discussed below).

- The program can make a report to medical personnel if the threat presents a medical emergency that poses an immediate threat to the health of any individual and requires medical intervention. (See the discussion of the medical emergency exception below.)
- The program can obtain the patient’s consent. This may be unlikely, unless the patient is suicidal.

If none of these options is practical, and a counselor believes there is a clear and imminent danger to an adolescent patient or another identified person, it is probably wiser to err on the side of making an effective report about the danger to the authorities or to the threatened individual.

While each case presents different questions, it is doubtful that any prosecution (or successful civil lawsuit) under the confidentiality regulations would be brought against a counselor who warned about potential violence when he believed in good faith that there was real danger to a particular individual. On the other hand, a civil lawsuit for failure to warn may well result if the threat is actually carried out. In any event, the counselor should at least try to make the warning in a manner that does not identify the individual as having a substance use disorder.

“Duty to warn” issues represent an area in which staff training, as well as a staff review process, may be helpful. For example, a troubled youth may engage in verbal threats as a way of “blowing off steam.” Such threats may be the adolescent’s cry for additional support services. Program training and discussions can help staff sort out what should be done in each particular situation.

Adolescents in the Juvenile Justice System

Programs screening and assessing adolescents who are involved in the JJS (such as family court or juvenile court) must also follow the confidentiality rules that generally apply to treatment programs. However, some special rules apply when an adolescent comes for screening or assessment as an official condition of probation, sentence, dismissal of charges, release from detention, or other disposition of any criminal proceeding.

A consent form (or court order) is still required before any disclosure can be made about an adolescent who is the subject of JJS referral.⁷ However, the rules concerning the length of time that a consent is valid and the process for revoking the consent are different (§2.35). Specifically, the regulations require that the following factors be considered in determining how long the consent involving an adolescent who is the subject of a criminal justice system referral will remain in effect:

- The anticipated duration of treatment
- The type of criminal proceeding in which the juvenile is involved
- The need for treatment information in dealing with the proceeding
- When the final disposition will occur
- Anything else the client, program, or juvenile justice agency believes is relevant

These rules allow programs to continue to use a traditional expiration condition for a consent form that once was the only one allowed—“when there is a substantial change in the client’s justice system status.” This formulation appears to work well. A substantial change in status occurs whenever the adolescent moves from one phase of the JJS to the next. For example, if an adolescent is on probation, there would be a change in JJS status when the probation ends, either by successful completion or revocation. Thus, the program could provide an assessment or periodic reports to the probation officer monitoring the adolescent and could even testify at a probation revocation hearing if it so desired, since no change in criminal justice status would occur until after that hearing.

As for the revocability of the consent (the rules under which the youth can take back his consent), the regulations provide that the consent form can state that consent cannot be revoked until a certain specified date or condition occurs. The regulations permit the JJS

consent form to be irrevocable so that an adolescent who has agreed to enter treatment in lieu of prosecution or punishment cannot then prevent the court probation department or other agency from monitoring her progress. Note that although a JJS consent may be made irrevocable for a specified period of time, its irrevocability must end no later than the final disposition of the criminal proceeding. Thereafter, the client may freely revoke consent.

Other Exceptions to the General Rule

Other exceptions to the Federal confidentiality rules prohibiting disclosure regarding youth seeking or receiving services for a substance use disorder are

- Disclosures that do not reveal the fact that the client has a substance use disorder
- Disclosure authorized by court order
- Disclosures made during medical emergencies
- Disclosure of information regarding a crime on program premises or against program personnel
- Disclosures to an outside agency that provides services to the program
- Disclosures to other staff within the program
- Disclosures to researchers, auditors, and evaluators with appropriate institutional review to ensure the protection of program participants

Communications That Do Not Disclose “Client-Identifying” Information

Federal regulations permit programs to disclose information about an adolescent if the program reveals no client-identifying information.

“Client-identifying” information is information that identifies someone as having a substance use disorder. Thus, a program may disclose

information about an adolescent if that information does not identify him as having a substance use disorder or support anyone else's identification of the adolescent as such.

There are two basic ways a program may make a disclosure that does not identify a client. The first way is obvious: A program can report aggregate data about its population (summing up information that gives an overview of the clients served in the program) or some portion of its populations. Thus, for example, a program could tell a newspaper that, in the last 6 months, it screened 43 adolescent clients—10 female and 33 male.

The second way is trickier: A program can communicate information about an adolescent in a way that does not reveal the adolescent's status as a substance use disorder client (§2.12(a)(i)). For example, a program that provides services to adolescents with other problems or illnesses as well as substance use disorders may disclose information about a particular client as long as the fact that the client has a substance use disorder is not revealed. An even more specific example: A program that is part of a general hospital could have a counselor call the police about a threat an adolescent made, so long as the counselor does not disclose that the adolescent has a substance use problem or is a client of the treatment program.

Programs that provide only substance use disorder services cannot disclose information that identifies a client under this exception, since letting someone know a counselor is calling from the "XYZ Treatment Program" will automatically identify the adolescent as someone in the program. However, a freestanding program can sometimes make "anonymous" disclosures, that is, disclosures that do not mention the name of the program or otherwise reveal the adolescent's status as having a substance use disorder.

Court-Ordered Disclosures

A State or Federal court may issue an order that will permit a program to make a disclosure about an adolescent that would otherwise be forbidden. A court may issue one of these authorizing orders, however, only after it follows certain special procedures and makes particular determinations required by the regulations. *A subpoena, search warrant, or arrest warrant, even when signed by a judge, is not sufficient, standing alone, to require or even to permit a program to disclose information* (§2.61).⁸

Before a court can issue an order authorizing a disclosure about a youth that is otherwise forbidden, the program and any adolescents whose records are sought must be given notice of the application for the order and some opportunity to make an oral or written statement to the court. Generally, the application and any court order must use fictitious names for any known adolescent, not the real name of a particular youth. All court proceedings in connection with the application must remain confidential unless the adolescent requests otherwise (§§2.64(a), (b), 2.65, 2.66).

Before issuing an authorizing order, the court must find that there is "good cause" for the disclosure. A court can find "good cause" only if it determines that the public interest and the need for disclosure outweigh any negative effect that the disclosure will have on the client or the doctor-client or counselor-client relationship and the effectiveness of the program's treatment services. Before it may issue an order, the court must also find that other ways of obtaining the information are not available or would be ineffective (§2.64(d)).⁹ The judge may examine the records before making a decision (§2.64(c)).

There are also limits on the scope of the disclosure that a court may authorize, even when it finds good cause. The disclosure must be limited to information essential to fulfill the

purpose of the order, and it must be restricted to those persons who need the information for that purpose. The court should also take any other steps that are necessary to protect the adolescent's confidentiality, including sealing court records from public scrutiny (§2.64(e)).

The court may order disclosure of "confidential communications" by an adolescent to the program only if the disclosure:

- Is necessary to protect against a threat to life or of serious bodily injury
- Is necessary to investigate or prosecute an extremely serious crime (including child abuse)
- Is in connection with a proceeding at which the adolescent has already presented evidence concerning confidential communications (for example, "I told my counselor ...") (§2.63)¹⁰

Medical Emergencies

A program may make disclosures to public or private medical personnel "who have a need for information about [an adolescent] for the purpose of treating a condition which poses an immediate threat to the health" of the adolescent or any other individual. The regulations define "medical emergency" as a situation that poses an immediate threat to health and requires immediate medical intervention (§2.51).

The medical emergency exception permits disclosure only to medical personnel. This means that the exception cannot be used as the basis for a disclosure to the police or other nonmedical personnel, including parents.

Under this exception, however, a program could notify a private physician or school nurse about a suicidal adolescent so that medical intervention can be arranged. The physician or nurse could, in turn, notify the adolescent's parents, so long as no mention is made of the adolescent's substance use disorder. Whenever

a disclosure is made to cope with a medical emergency, the program must document all of the following in the adolescent's records:

- The name and affiliation of the recipient of the information
- The name of the individual making the disclosure
- The date and time of the disclosure
- The nature of the emergency

Crimes on Program Premises or Against Program Personnel

When an adolescent patient has committed or threatens to commit a crime on program premises or against program personnel, the regulations permit the program to report the crime to a law enforcement agency or to seek its assistance. In such a situation, without any special authorization, the program can disclose the circumstances of the incident, including the suspect's name, address, last known whereabouts, and status as a patient at the program (§2.12(c)(5)).

Drugs brought into the program by patients.

One crime that an adolescent might well commit on program premises is drug possession—bringing drugs into the program either on his person or (if the program is residential) in his luggage. When a program finds drugs on a patient or in a patient's personal property, what should it do? Should the program call the police? And what should it do with the drugs?

The answer to the first question has already been discussed above in the section dealing with reporting criminal activity. Generally, State law does not require programs to make such a report. As for the second question, State regulations often govern how a program may dispose of drugs, sometimes requiring that they be flushed down a toilet. Programs should check with their Single State Agency if they are unsure about State mandates.

Qualified Service Organization Agreements (QSOAs)

If a program routinely needs to share certain information with an outside agency that provides services to the program, it can enter into what is known as a qualified service organization agreement (QSOA).

A QSOA is a written agreement between a program and a person providing services to the program, in which that person

1. Acknowledges that in receiving, storing, processing, or otherwise dealing with any client records from the program she is fully bound by the Federal confidentiality regulations
2. Promises that, if necessary, she will resist in judicial proceedings any efforts to obtain access to client records except as permitted by these regulations (§§2.11, 2.12(c)(4))

A sample QSOA is provided in Figure 4-2.

A QSOA should be used only when an agency or official outside the program is providing a service to the program itself. An example is when laboratory analyses or data processing are performed for the program by an outside agency.

A QSOA is not a substitute for individual consent in other situations. Disclosures under a QSOA must be limited to information that is needed by others so that the program can function effectively. A QSOA may not be used between different programs providing substance use disorder treatment and other services.

Internal Program Communications

The Federal regulations permit some information to be disclosed to individuals within the same program.

The restrictions on disclosure in these regulations do not apply to communications of information among personnel having a need for the information in connection with their duties that arise out of the provision of

diagnosis, treatment, or referral for treatment of substance abuse if the communications are (i) within a program or (ii) between a program and an entity that has direct administrative control over that program (§2.12(c)(3)).

In other words, staff members who have access to client records because they work for or administratively direct the program—including full- or part-time employees and unpaid volunteers—may consult among themselves or otherwise share information if their substance use disorder work so requires (§2.12(c)(3)).

A question that frequently arises is whether this exception allows a program that assesses or treats adolescents and that is part of a larger entity—such as a school—to share confidential information with others who are not part of the assessment or treatment unit itself. The answer to this question is among the most complicated in this area. In brief, there are circumstances under which the assessment unit can share information with other units. However, before such an internal communication system is set up within a large institution, it is essential that an expert in the area be consulted for assistance.

Research, Audit, or Evaluation

The confidentiality regulations also permit programs to disclose client-identifying information to researchers, auditors, and evaluators without client consent, provided certain safeguards are met (§§2.52, 2.53).¹¹

Other Rules About Confidentiality

Client Notice and Access to Records

The Federal confidentiality regulations require programs to notify clients of their right to confidentiality and to give them a written summary of the regulations' requirements. The notice and summary should be handed to adolescents when they begin participating in the

Figure 4-2
Qualified Service Organization Agreement

XYZ Service Center ("the Center") and the _____

(name of the program)

("the Program") hereby enter into a qualified service organization agreement, whereby the Center agrees to provide _____

(nature of services to be provided)

Furthermore, the Center:

(1) acknowledges that in receiving, storing, processing, or otherwise dealing with any information from the Program about the clients in the Program, it is fully bound by the provisions of the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 C.F.R. Part 2; and

(2) undertakes to resist in judicial proceedings any effort to obtain access to information pertaining to clients otherwise than as expressly provided for in the Federal Confidentiality Regulations, 42 C.F.R. Part 2.

Executed this ___ day of _____, 19_____

_____ President XYZ Service Center [address]	_____ Program Director [Name of the Program] [address]
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program or soon thereafter (§2.22(a)). The regulations contain a sample notice.

Programs can use their own judgment to decide when to permit adolescents to view or obtain copies of their records, unless State law allows clients or students the right of access to records. The Federal regulations do not require programs to obtain written consent from clients before permitting them to see their own records.

Security of Records

The Federal regulations require programs to keep written records in a secure room, a locked file cabinet, a safe, or other similar container.¹²

The program should establish written procedures that regulate access to and use of adolescents' records. Either the program director or a single staff person should be

designated to process inquiries and requests for information (§2.16).

A Final Note

Drug abuse treatment programs should try to find a lawyer familiar with local laws affecting their problems.

As has already been mentioned, State law governs many concerns relating to screening and assessing adolescents. A practicing lawyer with an expertise in adolescent substance use and abuse concerns is the best source for advice on such issues. Moreover, when it comes to certain issues, the law is still developing. For example, programs' "duty to warn" of clients' threats to harm others is constantly changing as courts in different States consider cases brought against a variety of different kinds of care providers. Programs trying to decide how to handle such a situation need up-to-the minute advice on their legal responsibilities.

Endnotes

1. This chapter was written for the Consensus Panel by Margaret K. Brooks, Esq., Montclair, New Jersey.
2. Citations in the form "§2..." refer to specific sections of 42 Code of Federal Regulations (C.F.R.) Part 2.
3. Only adolescents who have "applied for or received" services from a program are protected. If an adolescent has not yet been evaluated or counseled by a program and has not herself sought help from the program, the program is free to discuss the adolescent's substance use disorders with others. But, from the time the adolescent applies for services or the program first conducts an evaluation or begins to counsel the youth, the Federal regulations govern.
4. Note, however, that no information that is obtained from a program (even if the patient consents) may be used in a criminal

investigation or prosecution of a patient unless a court order has been issued under the special circumstances set forth in §2.65. 42 U.S.C. §290dd-3(c), ee-3(c); 42 C.F.R. §12(a),(d).

5. In States where parental consent is not required for treatment, the regulations permit a program to withhold services if the minor will not authorize a disclosure that the program needs in order to obtain financial reimbursement for that minor's treatment. The regulations add a warning, however, that such action might violate a State or local law (§2.14(b)).
6. If an attorney is not immediately available, and someone wants information about child abuse and neglect rules within a particular State, contact the social service or child welfare agency for that area. Nationally, the Child Welfare League of America (CWLA) can also be contacted at (202) 638-2952. (Federal definitions of these terms appear in the Child Abuse Prevention and Treatment Act (CAPTA), 42 U.S.C. §5106g; available on the Internet at <http://www.calib.com/nccanch/pubs/whatis.htm>.)
7. Although the rules concerning criminal justice system consent probably apply to proceedings in juvenile court involving acts that, if committed by an adult, would be a crime, there appear to be no cases on point. It is less likely that the special criminal justice system consent rules would apply when an adolescent is adjudicated (found to be) in need of special supervision (e.g., "persons in need of supervision"), but not guilty of a criminal act.
8. For an explanation about how to deal with subpoenas and search and arrest warrants, see Confidentiality: A Guide to the Federal Laws and Regulations published in 1995 by the Legal Action Center, 153 Waverly Place, New York, NY 10014.

9. However, if the information is being sought to investigate or prosecute a patient for a crime, only the program need be notified (§2.65). And if the information is sought to investigate or prosecute the program, no prior notice at all is required (§2.66).
10. If the purpose of seeking the court order is to obtain authorization to disclose information in order to investigate or prosecute a patient for a crime, the court must also find that: (1) the crime involved is extremely serious, such as an act causing or threatening to cause death or serious injury; (2) the records sought are likely to contain information of significance to the investigation or prosecution; (3) there is no other practical way to obtain the information; and (4) the public interest in disclosure outweighs any actual or potential harm to the patient, the doctor-patient relationship, and the ability of the program to provide services to other patients. When law enforcement personnel seek the order, the court must also find that the program had an opportunity to be represented by independent counsel ("counsel" is an appointed lawyer). If the program is a governmental entity, it *must* be represented by counsel (§2.65(d)).
11. For a more complete explanation of the requirements of §2.52 and 2.53, see TIP 14, *Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment*, pp. 58-59 (CSAT, 1995a).
12. Staff in juvenile detention facilities, who work in institutions where resources are sometimes stretched to the limit, may experience problems with having access to equipment that can be locked. However, procedures must be worked out that follow the intention of the regulations as closely as possible.

5 Screening and Assessment of Adolescents in Juvenile Justice Settings

It is estimated that up to 250,000 adolescents who enter the juvenile justice system (JJS) in the United States each year have a diagnosable substance use disorder. The percentage of juveniles with such disorders, among groups of delinquents that were studied, ranged from 19 percent to 67 percent (Dembo et al., 1993b, 1990b; Dembo and Associates, 1990).

The screening and assessment of adolescents, especially in the JJS setting, is a complex task. A growing body of literature indicates that adolescents entering the JJS have multiple problems in addition to substance use (Dembo et al., 1993b), which the evaluator must be alert to, including

- Physical or sexual abuse
- Psychological and emotional problems
- Poor performance in school
- Family difficulties, which may include mental health problems, parental neglect, foster care placement, involvement in criminal activity, and a history of substance use by family members, including current use, with or without the adolescent present
- Gang-related violence and involvement with drug sales, as well as other antisocial characteristics (e.g., vandalism)
- Living in neighborhoods where economic hardship, lack of employment opportunities,

inadequate housing, and other factors related to poverty and low income have led to communitywide despair and hopelessness among adults as well as youth (Botvin et al., 1997; Schinke et al., 1997; Brinson, 1995; Davis et al., 1996; Dubrow and Garbarino, 1989; Duncan, 1996)

These interrelated problems have usually developed over several years, and may not have been detected during previous contacts of the youth with social service agency staff, school counselors, or law enforcement personnel. As a result, problems are often quite severe by the time an adolescent enters the JJS. The scope and severity of these psychosocial problems place juvenile offenders at significant risk for return to substance use and for further delinquent behavior. The depth of the problems produces unique challenges for staff providing screening and assessment in the juvenile justice system. Thus, a primary goal of substance use screening and assessment among juvenile offenders is to prevent their further involvement in the JJS.

The JJS traditionally has maintained an episodic interest in these individuals. The typical focus has been on the behaviors and activities that immediately preceded the adolescent's current involvement in the system, without an examination of the history of

psychosocial problems contributing to his substance use and delinquent behavior. Individual monitoring of adolescents entering the juvenile justice system frequently ends at the completion of supervision. No further tracking is provided to make sure the adolescent receives services that might help to remedy key problem areas. These service and monitoring gaps are associated with severe lack of funding in the JJS. Fortunately, recent trends suggest that funding shortages may not be as acute as they were in the past. Juvenile drug courts are becoming more accepted in the JJS; they provide an opportune environment to address many needs of substance-using delinquent adolescents. Also, youth charged with minor offenses are being processed with diversion programs. Such programs optimize the opportunity to intervene early and prevent continued delinquency and drug abuse. Diversion programs are well-suited to screening for substance use disorders and referring to the appropriate community agency for followup assessment and treatment. For more information on diversion programs, refer to TIP 21, *Combining Alcohol and Other Drug Abuse Treatment With Diversion for Juveniles in the Justice System* (CSAT, 1995b).

An excellent example of the diversion model is the Juvenile Assessment Center (JAC) in Hillsborough County, Florida (Dembo et al., 1993b). The core components of the JAC include a detailed screening of several problem areas followed by an indepth assessment where indicated, a determination of the level and type of services needed for each problem area that was identified, and an assignment to a case manager to ensure appropriate referrals to community service providers.

Screening and assessment activities within the JJS must be (1) provided at the earliest possible point in the youth's contact with the JJS in order to identify adolescents who are at risk for further involvement in substance use and serious delinquent behavior; (2) repeated at

different stages in the system (intake, preadjudication, and postadjudication) to detect changes over time in the pattern of substance use, related problem behaviors, and the need for services; and (3) be multimodal and comprehensive so that several methods and sources are used to measure the range of the young person's physical, emotional, and environmental circumstances. When conducting screenings and assessments to determine patterns of use, programs should be aware of the youth's confinement status prior to testing. Periods of preassessment incarceration, (e.g., pretrial detention), may skew results of recent use surveys. An assessment taken soon after incarceration, when access to substances is limited, may provide inaccurate information about the adolescent's abstinence or use, potentially resulting in a false negative.

In general, the depth of the screening or assessment provided at a given point in the JJS should be determined by (1) the type of dispositional decision being considered (e.g., conditional release or commitment) and (2) the likelihood of further involvement in the juvenile justice system. A high priority should be established for screening and assessment with adolescents who are unlikely to be referred further within the JJS, in order to identify immediate needs for community services outside the system.

Screening and Assessment Protocols

The following discussion reviews general principles pertaining to screening and assessment protocols implemented in juvenile justice settings. The purpose of the various types of screening and assessment are presented, as well as important content areas to be probed. (The reader will find summaries of screening and assessment tools in Appendix B.)

Figure 5-1
Types of Screening/Assessment

Initial Screening.	Risk Assessment	Drug Testing/Urinalysis	Psychosocial Assessment	Comprehensive Assessment
Purposes				
To determine emergency needs with respect to supervision, medical, and psychological treatment.	To evaluate suicide potential, whether youth will be detained, level of custody/restrictiveness, likelihood of further delinquency or substance use, or degree of compliance with community supervision.	To determine the recent use of substances for detection, monitoring, and supervision.	Refers to both psychological and social/environmental aspects of a youth's life.	To clarify factors related to onset of problems, describe history and development of problems, assess problem severity, draw diagnostic/treatment implications.
Domains Probed				
■ Acute intoxication/withdrawal and need for detoxification ■ Suicide risk ■ Potential for violent behavior ■ Other immediate medical or psychological needs	■ Demographic variables ■ Offense severity and evidence of substance use ■ Delinquency history, severity of past offenses, disposition of prior charges, prior violations of supervision, escape/absconding, and past involvement in community diversion programs ■ Current legal status ■ Substance use disorder history ■ Psychological functioning and motivation ■ Any mitigating or aggravating factors	■ Use of alcohol, amphetamines, barbiturates, cocaine, cannabinoids, opiates, PCP, other illicit drugs (e.g., steroids)	■ Demographic and personal history information ■ Substance use disorder history ■ History of delinquent and aggressive behavior ■ Medical status ■ Psychological/emotional status ■ Family relationships ■ Peer relationships/social skills ■ Educational status ■ Vocational status ■ Evidence of physical or sexual abuse ■ Specialized substance use disorder screening ■ Detailed personal, family, and peer history of involvement in the juvenile or adult justice systems¹	■ Substance use history, diagnosis of dependence and coexisting disorders² ■ Delinquent and aggressive behavior ■ Medical status ■ Psychological and emotional status ■ Family relationships ■ Peer relationships and social skills ■ Educational status ■ Vocational status ■ Physical or sexual abuse ■ Other markers of disturbed functioning (e.g., fire-setting, cruelty to animals).³

¹ The following areas should be addressed within the specialized use screening protocol: (1) motivation to participate in treatment; (2) recognition of a substance problem; (3) substance history, including types and modes of substance abuse, quantity and frequency of use, and patterns of recent use; (4) HIV risk behaviors associated with substance abuse; (5) current substance problem severity and intensity, diagnosis of chemical dependency, and level of treatment services required; (6) the association between substance use disorders and delinquent behavior (offenses committed while under the influence of substances, and offenses committed to obtain substances); (7) prior involvement in substance use disorder treatment, including the type and location of services, and responses to treatment.

² A diagnosis of coexisting disorders (also known as "dual diagnosis") refers to a situation in which a person has been diagnosed as having a mental health problem in addition to a substance use disorder.

³ Other markers of disturbed functioning may include: (1) history of running away from home and truancy; (2) evidence of stealing, property destruction, and breaking into others' homes; (3) physical cruelty to others, confrontation of crime victims, and use of weapons; (4) initiation of fights and forcible sexual activity with others; and (5) other cognitive and psychological markers (e.g., low frustration tolerance, low self-esteem, irritability, poor modulation of or ability to handle anger).

Screening and Assessment at Key Points

Procedures need to be developed to ensure that the results of screening and assessment follow the adolescent through successive stages of the JJS. Figure 5-1 is a matrix that describes the purpose of each of the five types of screening or assessment: preliminary screening, risk assessment, drug testing/urinalysis, psychosocial assessment, and comprehensive assessment. For each type, the matrix indicates the domains that the screening or assessment is designed to probe. Again, the adolescent must sign a consent form prior to the assessment process so that her rights to privacy, issues of mandatory reporting of abuse, disclosure of information, and duty to warn are clarified (see Chapter 4).

Whenever possible, results of preadjudication screening and assessment should include a checklist or other means to identify a juvenile's relevant problem areas. Results should also define specific services needed and alternative types of services available in the community to assist judges, probation officers, and others working with the juvenile to develop a disposition plan. Those screening and assessment instruments that assist in this process by readily identifying problem areas and levels of problem severity should be selected. Consultation should be provided to the juvenile court in interpreting results from various assessment protocols that are reviewed at the time of disposition.

It may be useful for juvenile justice and clinical staff from community social service agencies to collaborate in developing procedures for triage and referral. Staff from community agencies should be encouraged to "reach in" to detention and other secure facilities to assist in developing and implementing individualized aftercare plans for juvenile offenders. For example, community agency staff, acting in a

case management model, can be particularly useful in clarifying admission criteria for various community treatment programs and can help to secure family involvement in aftercare services and link juveniles to a range of other services. Likewise, JJS staff should also be encouraged to "reach out" to facilitate adequate community involvement.

Juvenile justice agencies should develop procedures to guide referral decisions for substance use disorder assessment, mental health assessment, and other relevant community services. Decision rules guiding referrals for further assessment should include the development of threshold criteria (e.g., behavioral markers and test scores) for referral and should reflect:

- The severity of the problem
- The capabilities of community agencies to provide comprehensive assessment or related services
- Available resources for community assessment services

In recognition of the importance of early detection and intervention, rules for deciding how to interpret the results of initial screening should be designed to be overinclusive in identifying adolescents who may have substance use disorders. It is better to identify more adolescents as having substance use disorders than to be overly cautious and miss some. Rules for deciding how to interpret the results of psychosocial assessment may be more conservative in consideration of the limited resources available for providing further comprehensive assessment.

In some areas, screening and assessment units have been successfully implemented in detention centers to identify adolescents with substance use disorders and mental health problems. The detention setting offers a good opportunity to identify adolescents at high risk for further delinquent behavior and substance

use. Resources permitting, the period of juvenile detention can be used constructively to provide initial screening, risk assessment, psychosocial assessment, or more comprehensive assessment.

Preliminary steps in developing a screening and assessment unit within detention centers include meetings with community agencies to review the goals of the unit and an updated review of available referral services. Community service providers can also be invited to visit the detention facility.

Preliminary meetings with external agencies can be designed to develop a community referral network for substance-involved juveniles. In addition, negotiations may need to take place within various levels of the bureaucracies that oversee the detention center to persuade authorities that a screening and assessment unit for substance use disorders is needed, perhaps entailing the allocation of additional resources. (Such lobbying may be formal or informal in nature, to include meetings and reports documenting the need.) Community service providers may be enlisted to support such efforts as well.

Centralized intake and referral units in the community provide an alternative to specialized screening and assessment units developed in detention centers as a setting for early identification of high-risk adolescents in the JJS. Within a centralized intake unit, comprehensive information is compiled regarding the adolescent's mental health, substance use, medical, educational, and other social service needs. Centralized intake units rely on collaboration among law enforcement and social service agencies to conduct evaluations of youth and to make referrals for community services. Any sharing of substance use information, however, must comply with Federal confidentiality regulations.

Implementing Screening and Assessment Protocols

All juveniles entering a juvenile justice facility should receive an initial screening, risk assessment, and followup assessment, as indicated. Figure 5-2 provides juvenile justice protocols for implementing screening and assessment. Initial screening should be conducted within 24 hours of entry to the agency or facility. Screening and assessment activities may need to be completed over the course of several days for juveniles who are intoxicated, show symptoms of mental illness, are experiencing significant stress related to arrest or incarceration, or are not honestly disclosing information during an initial interview. Self-administered instruments should be designed to reflect the reading level and cultural background of the juvenile population. Alternative screening and assessment measures should be developed to accommodate the needs of juveniles with limited reading skills or with physical disabilities.

As discussed in Chapter 1, data should be collected from different sources; besides self-report, these sources include (with the adolescent's consent) knowledgeable parent(s)/guardians, other individuals who may be familiar with the juvenile, and laboratory tests (see Appendix C for further discussion on laboratory testing).

Results of screening and assessment should describe the various sources of the information obtained and should indicate how the different sources of information contributed to findings and recommendations. The use of screening and assessment instruments should be supplemented by individual interviews. Individual interviews are particularly important in clarifying responses and gathering additional information related to suicidal behavior, recent

substance use, and mental health symptoms. Screening, assessment, and interviews should be conducted in a private room where the youth feels safe and comfortable. The use of holding cells to conduct screening and assessment is *not* recommended.

In recording events leading up to the most recent offense, staff conducting screening and assessment interviews should note the social context of delinquent behavior, including substance use, peer involvement, and relevant psychosocial stressors. Similarly, the juvenile's perceptions of reasons for initiating and continuing to use substances should be elicited. Interviews should also note the juvenile's perceptions and attitudes about (1) the screening or assessment process, (2) the interviewer, (3) the juvenile justice setting in which the

interview is conducted, and (4) the accuracy of information provided by the youth or by the interviewer regarding the youth.

The interviewer should evaluate the adolescent's reading level (if necessary) and other factors that may influence the quality of screening and assessment results (for example, effects of immediate intoxication, mental health symptoms, and motivation).

Juvenile justice staffing patterns should be developed to reflect the flow of referrals for screening or assessment. Assignment of juvenile justice staff exclusively to screening and assessment activities encourages burnout and tends to restrict the diversity of the work experience and involvement in other aspects of the juvenile justice program. Juvenile justice staff members are also frequently overburdened

Figure 5-2

Juvenile Justice Protocols To Implement Screening and Assessment

- Initial screening should be done within 24 hours of entry.
- Full assessment should be done within several days of entry.
- Use of holding cells for screening and assessment is not recommended.
- Screening and assessment should follow many of the same guidelines used for youth in the community, such as
 - ◆ The collection of data from different sources
 - ◆ The careful selection of the instrument used
- The setting in which the interview is conducted is especially important in JJS settings and should be clearly noted in the written record.
- Juvenile justice staff should not be exclusively assigned to screening and assessment, as it encourages burnout.
- Protocols must be implemented to flag potential suicides.
- Protocols are needed to guide JJS staff in responding to critical problems that may arise during screening and assessment, such as
 - ◆ ☐ Reported physical or sexual abuse
 - ◆ ☐ Suicide threats
 - ◆ ☐ Violent or aggressive behavior
 - ◆ ☐ HIV-related concerns
 - ◆ ☐ Symptoms of withdrawal or acute intoxication
- Quality assurance monitoring of screening and assessment records should be completed at regular intervals.
- Staff must receive adequate training in key areas to handle adolescent-related situations.

with large numbers of daily screenings and assessments. Thus, if resources are available, screening and assessment services perhaps should be contracted out to community-based organizations.

Evaluation and Quality Management Monitoring

Screening and assessment often provide an important contribution to program evaluation activities. For example, this information is useful in describing characteristics of juvenile populations served at various stages of the system, emerging trends in drug use, HIV risk behaviors, and physical or sexual abuse. The information may assist in the following activities:

- Documenting the need for additional community services for juvenile offenders
- Identifying existing screening and assessment instruments that need modification
- Evaluating changes over time in mental health status, substance use, or other areas of functioning
- Identifying signals or situations that can help to predict disciplinary incidents within juvenile facilities or trigger relapse or recidivism following release from juvenile custody
- Supporting the need for ongoing screening and assessment activities within juvenile settings
- Identifying breakdowns in multiagency service coordination

When conducting an outcome evaluation that assesses an adolescent's behavior after he completes treatment, programs should be aware of the problems posed under the Federal confidentiality regulations. For a discussion of the issues and a more complete explanation of the requirements of §§2.52 and 2.53, 42 C.F.R.,

Part 2, see TIP 14, Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment (CSAT, 1995a).

Screening and assessment information may also contribute to reports developed for facility or agency administrators describing patterns of juvenile admissions, severity of substance use or other problems, and services needs. Both criterion-based tests (in which the instrument measures an established criterion, like a diagnosis) and norm-based tests (in which a normal range of responses for youth in various settings has been identified) are useful in assisting evaluation efforts.

All juvenile justice facilities and programs must develop policies and procedures for responding to critical issues that may arise during a screening or assessment interview. These issues include reported physical or sexual abuse, suicide threats, HIV status, aggressive behavior, and symptoms of acute intoxication or withdrawal. Staff should be trained in methods of responding to these issues and in documenting responses.

Quality management activities should include examination of the accuracy and comprehensiveness of screening and assessment records, methods used to obtain information, staff responses to critical issues identified during screening and assessment, and the use of screening and assessment information in developing referral decisions. Whenever possible, screening and assessment interviews should be periodically observed by someone within the program and followed with a debriefing so that ratings and referral decisions can be compared and reviewed.

Staff Training

All juvenile justice staff providing screening or assessment services should be trained in the following areas:

- Cultural sensitivity and competence
- Legal and ethical issues
- Administration, scoring, and interpretation of instruments
- Determination of reading abilities
- Interviewing techniques
- Report writing
- Interpersonal communication
- Counseling techniques
- Management of critical incidents
- Working collaboratively with the treatment community

Staff should also receive training in implementing policies and procedures related to screening and assessment. Juvenile justice staff assigned to administer screening and assessment protocols should observe interviews conducted by other staff and should have regular opportunities to debrief following difficult screenings or assessment interviews and to discuss problems encountered in the use of various test instruments.

Staff conducting screening or assessment at intake to the juvenile justice system should be trained to recognize causes and symptoms of stress and to develop an awareness of the potential impact of stress on test and interview

results. Staff should also be alerted to the potential for overestimating the need for intensive treatment services based on results of an initial interview without the addition of collateral supporting information. Program procedures and training efforts should be designed to encourage staff to postpone more comprehensive screening or assessment if evidence of significant stress or acute intoxication or withdrawal is observed. Staff should also receive training on issues surrounding adolescents in juvenile justice facilities and HIV infection.

Juvenile justice staff should receive training in maintaining the confidentiality of screening and assessment information and in guidelines for reporting information. All staff involved in screening and assessment should understand the key issues related to informed consent, which include mandatory reporting of child abuse or neglect, disclosure of information to parents or guardians, courts, attorneys, or other agencies, and duty to warn. Staff may need training in issues related to the duty to warn, in order to effectively respond to situations involving a juvenile's threat to harm a potential victim (see Chapter 4).

Appendix A

Bibliography

- Achenbach, T.M. *Manual for the Youth Self-Report and 1991 Profile*. Burlington, VT: University of Vermont Department of Psychiatry, 1991.
- Achenbach, T.M., and Edelbrock, C.S. Behavioral problems and competencies reported by parents of normal and disturbed children aged 4-16. *Monographs of the Society for Research in Child Development* 46(1, Serial No. 88), 1981.
- American Academy of Pediatrics. *The Classification of Child and Adolescent Mental Diagnoses in Primary Care: Diagnostic and Statistical Manual for Primary Care (DSM-PC) Child and Adolescent Version*. Elk Grove Village, IL: American Academy of Pediatrics, 1996.
- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (DSM-IV). Washington, DC: American Psychiatric Association, 1994.
- Baumrind, D., and Moselle, K.A. A developmental perspective on adolescent drug abuse. *Advances in Alcohol and Substance Abuse* 4:41-67, 1985.
- Beck, A.T., and Ward, J. Beck Depression Inventory (BDI). In: *Depression: Causes and Treatment*. Philadelphia, PA: University of Pennsylvania Press, 1972.
- Benishek, L.A. *A Summary of Adolescent Substance Abuse Assessment Instruments*. East Lansing, MI: Michigan State University, 1989.
- Boleloucky, Z., and Horvath, M. SCL-90 rating scale: First experience with the Czech version in healthy male scientific workers. *Archives of Nervous Disorders* 16(2):115-116, 1974.
- Botvin, G.J.; Baker, E.; Dusenbury, L.; Tortu, S.; and Botvin, E.M. Preventing adolescent drug abuse through a multimodal cognitive-behavioral approach: Results of a 3-year study. *Journal of Consulting and Clinical Psychology* 58(4):437-446, 1990.
- Botvin, G.J.; Epstein, J.A.; Baker, E.; Diaz, T.; and Williams, I.W. School based drug abuse prevention with inner city minority youth. *Journal of Child and Adolescent Substance Abuse* 6(1):5-19, 1997.
- Brayfield, A.H., and Rothe, H.F. An index of job satisfaction. *Journal of Applied Psychology* 35:307-311, 1951.
- Brinson, J.A. Group work for adolescent substance users: Some issues and recommendations. *Journal of Child and Adolescent Substance Abuse* 4(2):49-60, 1995.
- Brodman, K.; Erdman, A.; Lorge, I.; and Wolff, H. The Cornell Medical Index: An adjunct to medical interview. *Journal of the American Medical Association* 140:530-534, 1949.

- Carroll, K.M.; Rounsaville, M.D.; and Gawin, F.H. A comparative trial of psychotherapies for ambulatory cocaine abusers: Relapse prevention and interpersonal psychotherapy. *American Journal on Drug and Alcohol Abuse* 17(3):229-247, 1991.
- Center for Substance Abuse Treatment. *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Disease*. Treatment Improvement Protocol (TIP) Series, Number 11. HHS Publication No. (SMA) 24-2094. Washington, DC: U.S. Government Printing Office, 1994.
- Center for Substance Abuse Treatment. *Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment*. Treatment Improvement Protocol (TIP) Series, Number 14. HHS Pub. No. (SMA) 95-3031. Washington, DC: U.S. Government Printing Office, 1995a.
- Center for Substance Abuse Treatment. *Combining Alcohol and Other Drug Abuse Treatment With Diversion for Juveniles in the Justice System*. Treatment Improvement Protocol (TIP) Series, Number 21. HHS Pub. No. (SMA) 95-3051. Washington, DC: U.S. Government Printing Office, 1995b.
- Center for Substance Abuse Treatment. *Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing*. Treatment Improvement Protocol (TIP) Series, Number 23. HHS Publication No. (SMA) 96-3113. Washington, DC: U.S. Government Printing Office, 1996.
- Center for Substance Abuse Treatment. *Treatment of Adolescents With Substance Use Disorders*. Treatment Improvement Protocol (TIP) Series, Number 31. HHS Pub. No. (SMA) 99-3283. Washington, DC: U.S. Government Printing Office, 1999.
- Centers for Disease Control and Prevention. <http://www.cdc.gov/nccdphp/dash/yrbs/ov.htm> [Accessed April 6, 1998].
- Children's Defense Fund. *The Adolescent and Young Adult Fact Book*. Washington, DC: Children's Defense Fund, 1991.
- Conoley, J.C., and Impara, J.C., eds. *The Twelfth Mental Measurements Yearbook*. Lincoln, NE: The Buros Institute of Mental Measurements, 1995.
- Conoley, J.C., and Kramer, J.J., eds. *The Tenth Mental Measurements Yearbook*. Lincoln, NE: The Buros Institute of Mental Measurements, 1989.
- Cook, F. TASC: Case management models linking criminal justice and treatment. In: Ashery, R.S., ed. *Progress and Issues in Case Management*. NIDA Research Monograph Series, Number 127. HHS Pub. No. (ADM) 92-1946. Rockville, MD: National Institute on Drug Abuse, 1992. pp. 368-382.
- Costello, A.; Edelbrock, C.; Dulcan, M.; Kalas, R.; and Klaric, S. "Final Report to NIMH on the Diagnostic Interview Schedule for Children." Unpublished manuscript. 1984.
- Davis, A.R., and Ware, J.E. *Measuring Health Insurance Experiment (R-2711-HHS)*. Santa Monica, CA: Rand Corporation, 1984.
- Davis, N.; Moss, H.; Kirisci, L.; and Tarter, R. Neighborhood crime rates among drug abusing and nondrug abusing families. *Journal of Child and Adolescent Substance Abuse* 5(4):1-14, 1996.
- Dembo, R., and Associates. *Prototype Screening/Triage Form for Juvenile Detention Centers*. Tampa, FL: Department of Criminology, University of South Florida, 1990.

- Dembo, R., and Shern, D. Relative deviance and the process(es) of drug involvement among inner city youths. *The International Journal of the Addictions* 17(8):1973-1999, 1983.
- Dembo, R.; Williams, L.; Fagan, J.; and Schmeidler, J. The relationships of substance abuse and other delinquency over time in a sample of juvenile detainees. *Criminal Behavior and Mental Health* 3:158-179, 1993a.
- Dembo, R.; Williams, L.; and Schmeidler, J. Addressing the problems of substance abuse in juvenile corrections. In: Inciardi, J.A., ed. *Drug Treatment in Criminal Justice Settings*. Newbury Park, CA: Sage, 1993b.
- Dembo, R.; Williams, L.; Wish, E.D.; Berry, E.; Getreu, A.; Washburn, M.; and Schmeidler, J. Examination of the relationships among drug use, emotional/psychological problems, and crime among youths entering a juvenile detention center. *International Journal of the Addictions* 25(11):1301-1340, 1990a.
- Dembo, R.; Williams, L.; Wish, E.D.; Schmeidler, J. *Urine Testing of Detained Juveniles to Identify High-Risk Youth*. Washington, DC: U.S. Department of Justice, 1990b.
- Derogatis, L.R. *SCL-90 Administration, Scoring and Procedures Manual*. Baltimore, MD: Johns Hopkins University School of Medicine, 1977.
- Derogatis, L.R., and Melisaratos, N. The Brief Symptom Inventory: An introductory report. *Psychological Medicine* 13:595-605, 1983.
- Derogatis, L.R., and Cleary, P. Confirmation of the dimensional structure of the SCL-90: A study in construct validation. *Journal of Clinical Psychology* 33(4):981-989, 1977a.
- Derogatis, L.R., and Cleary, P. Factorial invariance across gender for the primary symptom dimensions of the SCL-90. *British Journal of Social Clinical Psychology* 16:347-356, 1977b.
- Derogatis, L.R.; Rickels, K.; and Rock, A. The SCL-90 and the MMPI: A step in the validation of a new self-report scale. *British Journal of Social Clinical Psychology* 128:280-289, 1976.
- Dubrow, N., and Garbarino, J. Living in the war zone: Mothers and young children in a public housing development. *Child Welfare* 58:3-20, 1989.
- Duncan, D.F. Problems associated with three commonly used drugs: A survey of secondary school students. *Psychology of Addictive Behavior* 5(2):1-5, 1992.
- Duncan, D.F. Growing up under the gun: Children and adolescents coping with violent neighborhoods. *Journal of Primary Prevention* 16(4):343-356, 1996.
- Edwards, D.W.; Yarvis, R.M.; Mueller, D.P.; Zingale, H.C.; and Wagman, W.J. Test-taking and the stability of adjustment scales. *Evaluation Quarterly* 2(2):275-291, 1978.
- Elliott, D.S.; Huizinga, D.; and Ageton, S.S. *Explaining Delinquency and Drug Use*. Beverly Hills, CA: Sage Publications, 1985.
- Epstein, J.L., and McPartland, J.M. In: Epstein, J.L., and McPartland, J.M., eds. *Manual for the Quality of School Life Scale*. Boston: Houghton Mifflin, 1978.
- Eysenck, H.J. *The Maudsley Personality Inventory*. London: University of London Press, 1959.
- Farrow, J.A.; Smith, W.R.; and Hurst, M.D. *Adolescent drug and alcohol assessment instruments in current use: A critical comparison*. Seattle, WA: Department of Pediatrics, University of Washington, 1993.
- Fournier, D.G.; Olson, D.H.; and Druckman, J.M. Assessing marital and premarital relationships: The PREPARE-ENRICH Inventories. In: Filsinger, E.E., ed., *Marital and Family Assessment*. Beverly Hills, CA: Sage Publications, 1983.

- Fowers, B.J., and Olson, D.H. Predicting marital success with PREPARE: A predictive validity study. *Journal of Marriage and Family Therapy* 12:403-413, 1986.
- Friedman, C.J., and Friedman, A.S. Drugs and delinquency. *Drug Use in America: Problem in Perspective* 1:398-487. The technical papers on the Second Report of National Commission on Marijuana and Drug Abuse, Washington, DC: U.S. Government Printing Office, 1973.
- Furberg, C.D., and Elinson, J. In: Furberg, C.D. and Elinson, J., eds. *Assessment of Quality of Life in Clinical Trials of Cardiovascular Disease*. NY: Le Jacq Publishing, 1984. pp. 184-188.
- Gavin, D.R.; Ross, H.E.; and Skinner, H.A. Diagnostic validity of the drug abuse screening test in the assessment of DSM-III drug disorders. *British Journal of Addiction* 84:301-307, 1989.
- Gawin, F.H., and Kleber, H.D. Cocaine abuse treatment. *Archives of General Psychiatry* 44:903-909, 1984.
- Glantz, M., and Pickens, R. *Vulnerability to Drug Abuse*. Washington, DC: American Psychological Association, 1992.
- Goffman, T.J. *The Presentation of Self in Everyday Life*. Garden City, NY: Doubleday, 1959.
- Gunderson, E.K.; Russell, J.W.; and Nail, R.L. A drug involvement scale for classification of drug abusers. *Journal of Community Psychology* 1:399-403, 1973.
- Hagbord, W.J. The Revised Problem Behavior Checklist and severely emotionally disturbed adolescents: Relationship to intelligence, academic achievement, and sociometric ratings. *Journal of Abnormal Child Psychology* 18:47-53, 1990.
- Harrell, T.H.; Honaker, L.M.; and Davis, E. Cognitive and behavioral dimensions of dysfunction in alcohol and polydrug abusers. *Journal of Substance Abuse* 3:415-426, 1991.
- Hater, J.J., and Simpson, D.D. "The PMES Information Form on Family, Friends, and Self: A Report on Scale Construction." Report to Drug Abuse Prevention Division (DAPD), and the Texas Department of Community Affairs (TDCA), 1981.
- Havighurst, R. J. *Developmental Tasks and Education*, 3rd ed. New York: David McKay, 1972.
- Hedlund, J.L., and Vieweg, M.S. The Michigan Alcoholism Screening Test (MAST): A comprehensive review. *The Journal of Operational Psychiatry* 15:55-65, 1984.
- Henly, G.A., and Winters, K.C. Development of problem severity scales for the assessment of adolescent alcohol and drug abuse. *The International Journal of the Addictions* 23:65-85, 1988.
- Henly, G.A., and Winters, K.C. Development of psychosocial scales for the assessment of adolescent alcohol and drug involvement. *The International Journal of the Addictions* 24:973-1001, 1989.
- Hubbard, R. *The Washington, D.C. Diagnostic, Referral, Data, and Data Management Unit*. Research Triangle Park, NC: Research Triangle Institute, 1991.
- Impara, J.C., and Plake, B.S., eds. *The Thirteenth Mental Measurements Yearbook*. Lincoln, NE: The Buros Institute of Mental Measurements, 1998.
- Inwald, R.E.; Brobst, M.A.; and Morissey, R.F. Identifying and predicting adolescent behavioral problems by using a new profile. *Juvenile Justice Digest* 14(3), 1986.

- Ivens, C., and Rehm, L.P. Assessment of childhood depression: Correspondence between reports by child, mother, and father. *Journal of the American Academy of Child and Adolescent Psychiatry* 6:738-741, 1988.
- Jacob, T., and Tennenbaum, D. Family Assessment Methods. In: Rutter, M.; Tuma, H.; and Lann, I., eds. *Assessment and Diagnosis of Child and Adolescent Psychopathology*. NY: Guilford Press, 1987.
- Jainchill, N.; Yagelka, J.; and DeLeon, G. Adolescent admissions to residential drug treatment: HIV risk behaviors pre-and post-treatment. *Psychology of Addictive Behaviors*, in press.
- Jastak, S.F., and Wilkinson, G.S. *Wide Range Achievement Test-Level I and II*, rev. ed. Wilmington, DE: Jastak Associates, 1984.
- Jenkins, W.O.; Witherspoon, A.D.; DeVine, M.D.; deValera, E.R.; Muller, J.B.; Barton, M.C.; and McKee, J.M. *The Post-Prison Analysis of Criminal Behavior and Longitudinal Followup Evaluation of Institutional Treatment*. Rehabilitation Research Foundation, #RRF-910-2-74, Manpower Administration. Tuscaloosa, AL: Behavior Science Press, 1974.
- Jessor, R., and Jessor, S. *Problem Behavior and Psychosocial Development: A Longitudinal Study of Youth*. NY: Academic Press, 1977.
- Kramer, J.J., and Conoley, J.C., eds. *The Eleventh Mental Measurements Yearbook*. Lincoln, NE: The Buros Institute of Mental Measurements, 1992.
- Krug, S.E., and Laughlin, J.E. *IPAT Depression Scale*. Savoy, IL: Institute for Personality and Ability Testing, 1976.
- Labouvie, E. Alcohol and marijuana use in adolescent stress. *International Journal of the Addictions* 21(3):333-345, 1986.
- Leccese, M., and Waldron, H.B. Assessing adolescent substance abuse: A critique of current measurement instruments. *Journal of Substance Abuse Treatment* 11:553-563, 1994.
- Leigh, B.C., and Stall, R. Substance use and risky sexual behavior for exposure to HIV. Issues in methodology, interpretation, and prevention. *American Psychologist* 48(10):1035-1045, 1993.
- Liddle, H.A., and Dakof, G.A. Family-based treatment for adolescent drug use: State of the science. In: Rahdert, E., and Czechowicz, D., eds. *Adolescent Drug Abuse: Clinical Assessment and Therapeutic Interventions*. Rockville, MD: National Institute on Drug Abuse, 1995. pp. 218-254.
- Manson, M.P., and Huba, G.J. *The Manson Evaluation Manual*. Los Angeles: Western Psychological Services, 1987.
- Martin, C.S.; Kaczynski, N.A.; Maisto, S.A.; Bukstein, O.M.; and Moss, H.B. Patterns of DSM-IV alcohol abuse and dependence symptoms in adolescent drinkers. *Journal of Studies on Alcohol* 56:672-680, 1995.
- McCubbin, H.; Larson, A.; and Olsen, D.H. (1982). (F-Copes) Family coping strategies. In: Olsen, D.H.; McCubbin, H.I.; Barnes, H.; Larson, A.; Muxen, M.; and Wilson, M., eds. *Family Inventories: Inventories Used in a National Survey of Families Across the Family Life Cycle*. St. Paul, MN: Family Social Science, University of Minnesota, 1989. pp. 101-119.
- McLellan, A.T.; Luborsky, L.; Woody, G.E.; and O'Brien, C.P. An improved diagnostic evaluation instrument for substance abuse clients: The Addiction Severity Index. *The Journal of Nervous and Mental Disease* 168(1):26-33, 1980.

- Moore, R.A. The diagnosis of alcoholism in a psychiatric hospital: A trial of the Michigan Alcohol Screening Test (MAST). *American Journal of Psychiatry* 128(12):115-119, 1972.
- Moos, R.H. *Combined Preliminary Manual for the Family, Work, and Group Environment Scales*. Palo Alto, CA: Consulting Psychologists Press, 1974.
- Moos, R.H. Conceptual and empirical approaches to developing family-based assessment procedures: Resolving the case of the family environment scale. *Family Process* 29:199-208, 1990.
- Moos, R.H., and Moos, B.S. *Family Environment Scale: Manual*. Palo Alto, CA: Consulting Psychologists Press, 1981.
- Moss, F.A.; Hung, T.; and Omwake, K. *Social Intelligence Test*. Montreal, CA: Institute of Psychological Research, Inc., 1990.
- National Commission on Correctional Health Care (NCCHC). *Standards for Health Services in Juvenile Detention and Confinement Facilities*. Chicago: NCCHC, 1992.
- National Highway Traffic Safety Administration. *Assessment of Classification Instruments Designed To Detect Alcohol Abuse*. Washington, DC: National Highway Traffic Safety Administration, 1988.
- National Institute on Alcohol Abuse and Alcoholism. Screening for alcoholism. *Alcohol Alert* 8(PH285):1-4, 1990.
- National Institute on Alcohol Abuse and Alcoholism. *Assessing Alcohol Problems: A Guide for Clinicians and Researchers*. NIAAA Treatment Handbook Series, Number 4. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism, 1995.
- National Institute on Drug Abuse. *Evaluation Instruments for Drug Abuse Adolescents and Adults*. Rockville, MD: National Institute on Drug Abuse, 1992.
- National Institute on Drug Abuse. *Monitoring the Future Study*. Rockville, MD: National Institute on Drug Abuse, 1996.
- Newcomb, M.D., and Bentler, P.M. Substance use and abuse among children and teenagers. *American Psychologist* 44:242-248, 1989.
- Oetting, E.R., and Beauvais, F. Common elements in youth drug abuse: Peer cluster and other psychological factors. In: Peele, S., ed. *Visions of Addiction: Major Contemporary Perspectives on Addiction and Alcoholism*. Lexington, MA: Lexington Books, 1987. pp. 142-161.
- Oetting, E.R., and Beauvais, F. Adolescent drug use: Findings of national and local surveys. *Journal of Consulting and Clinical Psychology* 58(4):385-394, 1990.
- Oetting, E.R.; Beauvais, F.; Edwards, R.; and Waters, M. *The Drug and Alcohol Assessment System*. Fort Collins, CO: Rocky Mountain Behavioral Sciences Institute, 1984.
- Olson, D.H.; McCubbin, H.I.; Barnes, H.; Larsen, A.; Muxen, M.; and Wilson, M. *Family Inventories: Inventories Used in a National Survey of Families Across the Family Life Cycle*. St. Paul, MN: Family Social Science, University of Minnesota, 1982.
- Orvaschel, H.; Puig-Antich, J.; Chambers, W.; Tabrizi, M.A.; and Johnson, R. Retrospective assessment of prepuberty major depression with the Kiddie-SADS-E. *Journal of the American Academy of Child Psychiatry* 21:392-397, 1982.
- Rahdert, E.R., ed. *The Adolescent Assessment/Referral System Manual*. HHS Publication No. (ADM) 91-1735. Rockville, MD: U.S. Department of Health and Human Services, ADAMHA, National Institute on Drug Abuse, 1991.

- Rogers, R., and Cashel, M.L. Evaluation of adolescent offenders with substance abuse: Validation of the SASSI with conduct-disordered youth. *Criminal Justice and Behavior*, in press.
- Rosenberg, M. *Society and the Adolescent Self-Image*. Princeton, NJ: Princeton University Press, 1965.
- Reich, W.; Welner, Z.; Taibleson, C.; and Kram, L. *The DICA-R Training Manual*. St. Louis, MO: Washington University School of Medicine, 1990.
- Ridley, T.D., and Kordinak, S.T. Reliability and validity of the Quantitative Inventory of Alcohol Disorders (QIAD) and the veracity of self-report by alcoholics. *American Journal of Drug and Alcohol Abuse* 14(2):263-292, 1988.
- Riskind, J.H.; Beck, A.T.; Berchick, R.; Brown, G.; and Steer, R.A. Taking the measure of anxiety and depression: Validation of the reconstructed Hamilton Rating Scale. *Journal of Nervous and Mental Diseases* 175:474-479, 1987.
- Rounsaville, B.J.; Weissman, M.M.; Wilber, C.; and Kleber, H.D. Identifying alcoholism in treated opiate addicts. *American Journal of Psychiatry* 140:764-766, 1983.
- Russell, C.S. "The systems approach to family study." Unpublished manuscript, Kansas State University, 1977.
- Schinka, J.A. *Health Problems Checklist*. Odessa, FL: Psychological Assessment Resources, 1984.
- Schinke, S.; Cole, K.; Diaz, T.; and Botvin, G.J. Developing and implementing interventions in community settings. *Journal of Child and Adolescent Substance Abuse* 6(3):49-63, 1997.
- Schuessler, K.F. *Measuring Social Life Feelings*. San Francisco: Jossey-Bass, 1982.
- Shedler, J., and Block, J. Adolescent drug use and psychological health. *American Psychologist* 45:612-630, 1990.
- Simpson, D.D. *Drug Abuse Treatment for AIDS-Risks Reduction (DATAR): Forms Manual*. Fort Worth, TX: Institute of Behavioral Research, Texas Christian University, 1990.
- Simpson, D.D., and McBride, A.A. *Hispanic Journal of Behavioral Sciences*. Newbury Park, CA: Sage Publications, 1991.
- Skinner, H. Self-report instrument for family assessment. In: Jacob, T., ed. *Family Intervention and Psychopathology: Theories, Methods, and Findings*. NY: Plenum, 1987.
- Skinner, H.A., and Sheu, W.J. Reliability of alcohol use indices: The lifetime drinking history and the MAST. *Journal of Alcohol Studies* 43:1157-1170, 1982.
- Skinner, H.; Steinhauer, P.; and Santo-Barbara, J. The family assessment measure. *Canadian Journal of Community Mental Health* 2:91-105, 1983.
- Spanier, G.B. Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and the Family* 38:15-28, 1976.
- Spanier, G.B., and Thompson, L.A. A confirmatory analysis of the Dyadic Adjust scale. *Journal of Marriage and the Family* 44:731-738, 1982.
- Spitzer, R.L., and Williams, J.B. *Structured Clinical Interview for DSM-III-R*. New York: Biometrics Research Department, New York State Psychiatric Institute, 1987.
- Spitzer, R.L.; Williams, J.B.; Gibbon, M.; and First, M.B. *Structured Clinical Interview for DSM-III-R*. Washington, DC: The American Psychiatric Press, 1990.

- Stinchfield, R.D. Reliability of adolescent self-reported pretreatment alcohol and other drug use. *Substance Use and Misuse* 32:425-434, 1997.
- Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment. *Treatment for alcohol and other drug abuse: Opportunities for coordination*. HHS Publication No. (SMA) 94-2075. Rockville MD: Substance Abuse and Mental Health Services Administration, 1994.
- Swaim, R.C.; Oetting, E.R.; Edwards, R.W.; and Beauvais, F. Links from emotional distress to adolescent drug use: A path model. *Journal of Consulting and Clinical Psychology* 57(2):227-231, 1989.
- Szapocznik, J.; Perez-Vidal, A.; Brickman, A.L.; Foote, F.H.; Santisteban, D.; Hervis, O.; and Kurtines, W. Engaging adolescent drug abusers and their families in treatment: A strategic structural systems approach. *Journal of Consulting and Clinical Psychology* 56(4):552-557, 1988.
- Tarter, R.E. Evaluation and treatment of adolescent substance abuse: A decision tree method. *American Journal of Drug Alcohol Abuse* 16(1 and 2):1-46, 1990.
- Toborg, M.A.; Levin, D.R.; Milkman, R.H.; and Center, L.J. *Treatment Alternatives to Street Crime: (TASC) Projects: National Evaluation Program, Phase I Summary Report*. Washington, DC: National Institute of Law Enforcement and Criminal Justice, 1976.
- Turner, C.F.; Ku, L.; Rogers, S.M.; Lindberg, L.D.; Pleck, J.H.; and Sonenstein, F.L. Adolescent sexual behavior, drug use, and violence: increased reporting with computer survey technology. *Science* 280(5365):867-873, 1998.
- Ware, J.E. Scales for measuring general health perceptions. *Health Services Research* 11(4):396-415, 1976.
- Ware, J.E. General Health Rating Index. In: Wenger, N.K.; Mattson, M.E.; Furberg, C.D.; and Elinson, J., eds. *Assessment of Quality of Life in Clinical Trials of Cardiovascular Disease*. NY: Le Jacq Publishing, 1984. pp. 184-188.
- Ware J.E.; Manning, W.G.; Duan, N.; Wells, K.B.; and Newhouse, J.P. Health status and the use of outpatient mental health services. *American Psychologist* 39(10):1090-1100, 1984.
- Weissman, M.M.; Wickramaratne, P.; Warner, V.; John, K.; Prusoff, B.; Merikangas, K.; and Gammon, D. Assessing psychiatric disorders in children: Discrepancies between mothers' and children's reports. *Archives of General Psychiatry* 44:747-753, 1987.
- Welner, Z.; Reich, W.; Herjanic, B.; Jung, K.; and Amado, K. Reliability, validity, and parent-child agreement studies of the Diagnostic Interview for Children and Adolescents (DICA). *Journal of American Academic Child Psychiatry* 26:649-653, 1987.
- Winters, K.C. The need for improved assessment of adolescent substance involvement. *Journal of Drug Issues* 20(3):487-502, 1990.
- Winters, K.C. *Assessment of Adolescent Alcohol and Other Drug Abuse: A Handbook*. Los Angeles, CA: Western Psychological Services, 1994.
- Winters, K.C., and Henly, G.A. *Personal Experience Inventory Test and Manual*. Los Angeles, CA: Western Psychological Services, 1989.
- Winters, K.C.; Latimer, W.W.; Stinchfield, R.D. DSM-IV criteria for adolescent alcohol and cannabis use disorders. *Journal of Studies on Alcohol*, in press.

Witherspoon, A.D.; deValera, E.K.; and Jenkins, W.O. *The Law Encounter Severity Scale (LESS): A Criterion for Criminal Behavior and Recidivism*. Rehabilitation Research Foundation, Grant No. 21-01-73-38, Manpower Administration. Tuscaloosa, AL: Behavior Science Press, 1973.

Appendix B

Instrument Summaries

Appendix B summarizes recommended instruments and fundamental information about each one: purpose, content, administration, time required for completion, training needed by the assessor, how the instrument can be obtained, its cost, and persons to contact for further guidance. Some of the instrument summaries are updates of those that appeared in the original TIP 3, and others are new instruments that the Revision Panel identified. Most measures included were developed specifically for young people, and all have established reliability and validity. Full citations to the *Mental Measurements Yearbook* and Lecesse and Waldron, 1994, appear in Appendix A.

Part I

Summary of Screening Instruments for Substance-Using Adolescents

Title of Instrument:	Adolescent Drinking Index (ADI)
Introduction:	ADI is a 24-item rating scale that quickly assesses alcohol use disorders in adolescents.
Developer/ Address:	Adele V. Harrell, Ph.D. Philip W. Wirtz, Ph.D.
Inquiries:	Psychological Assessment Resources, Inc. Post Office Box 998 Odessa, FL 33556 (800) 331-8378
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.
Type of Assessment:	ADI can be administered to individuals or groups.
Life Areas/Problems Assessed:	Alcohol use disorders in adolescents
Reading Level:	5th grade
Completion Time:	5 minutes
Credentials/Training:	Minimum of a bachelor's degree in psychology or a closely related field and relevant coursework or training in the interpretation of psychological tests and measurement at an accredited university or college
Scoring Procedures:	On the bottom page of the two-part carbonless answer sheet, the user sums the appropriate values to calculate raw scores. The raw scores are then converted into <i>T</i> scores through the use of tables and plotted on the profile sheet.
Scoring Time:	Approximately 10 minutes
Access and Source of Psychometrics:	Psychological Assessment Resources, Inc. See address above

Pricing Information: \$59.00 per introductory kit (includes manual and 25 test booklets)
\$22.00 per professional manual only
\$40.00 per set of test booklets (25 each)

Reviewed in: *Mental Measurements Yearbook*, 12th ed., and Leccese and Waldron, 1994

Title of Instrument:	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).
Developer/Address:	D. Paul Moberg, Ph.D. Center for Health Policy and Program Evaluation University of Wisconsin at Madison 2710 Marshall Ct. Madison, WI 53705-2279 (608) 263-1304 dpmoberg@facstaff.wisc.edu
Inquiries:	D. Paul Moberg, Ph.D. See address above
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.
Type of Assessment:	Paper and pencil questionnaire for self-administration by adolescents. It can be used in groups or individually. While there are nominally 12 items, the "check all that apply" nature of many of the questions in fact yields answers to 53 discrete questions.
Life Areas/Problems Assessed:	As scored, ADIS should be interpreted as a unidimensional operational measure of drug involvement. The items making up the scale cover drug use frequency and recency, perceived reasons for use, social context of use, effects of use in multiple life areas, and self- and others' appraisal of the subject's drug use.
Reading Level:	Not ascertained
Completion Time:	4-5 minutes
Credentials/Training:	No specific requirement

Scoring Procedures:	Additive scoring by adding the weights to highest positive answer to each of 12 items. Optional drug use grid (item 13) can also be scored as an index of multiple drug use.
Scoring Time:	2-3 minutes
Related Tests:	The Adolescent Alcohol Involvement Scale (AAIS), developed by John Mayer and William Filstead, is a parallel instrument measuring alcohol involvement. For more information on AAIS, see Mayer, J., and Filstead, W.J. The Adolescent Alcohol Involvement Scale. An instrument for measuring adolescents' use and misuse of alcohol. <i>Journal of Studies on Alcohol</i> 40:291-300, 1979. Moberg, D.P. Identifying adolescents with alcohol problems. A field test of the Adolescent Alcohol Involvement Scale. <i>Journal of Studies on Alcohol</i> 93:408-417, 1983.
Access and Psychometrics:	ADIS is in the public domain. The complete scale and source of scoring details are available in Moberg, D.P., and Hahn, L. The adolescent drug involvement scale. <i>Journal of Adolescent Chemical Dependency</i> 2(1):75-88, 1991. Note: This journal has been renamed <i>Journal of Child and Adolescent Substance Abuse</i>.
Pricing Information:	Not applicable

Title of Instrument:	Drug and Alcohol Problem (DAP) Quick Screen, pencil/paper test
Introduction:	This is a 30-item test with four key items.
Developer / Address:	Richard H. Schwartz, M.D. 410 Maple Avenue West Vienna, VA 22180 (703) 338-2244
Purpose:	Rapid in-office test for adolescent substance use problems. Sixteen salient questions and four critical questions.
Type of Assessment:	Assesses substance use relationships with parents and parents' use of alcohol, tobacco, and other substances. Contains questions on depression and suicide.
Life Areas/Problems Assessed:	Substance use disorders and behavior patterns
Reading Level:	6th grade
Completion Time:	10 minutes
Scoring Procedures:	Scores of greater than 6 correlate with "red flags" for drug/alcohol use
Scoring Time:	A few minutes
Access and Source of Psychometrics:	Schwartz, R.H., and Wirth, P.W. Potential substance abuse detection among adolescent patients. Using the Drug and Alcohol Problem (DAP) Quick Screen, a 30-item questionnaire. <i>Clinical Pediatrics</i> 29:38-43, 1990
Reviewed in:	Leccese and Waldron, 1994

Title of Instrument:	Drug Use Screening Inventory-Revised (DUSI-R)
Introduction:	DUSI-R is a 159-item instrument that documents the level of involvement with a variety of drugs and quantifies severity of consequences associated with drug use. The profile identifies and prioritizes intervention needs and provides an informative and facile method of monitoring treatment course and aftercare. The DUSI-R is a self-administered instrument. A Spanish version is available.
Developer/Address:	Ralph E. Tarter, Ph.D. Department of Psychiatry University of Pittsburgh School of Medicine 3811 O'Hara Street Pittsburgh, PA 15213 (412) 624-1070
Inquiries:	Ralph E. Tarter, Ph.D. See address above
Purpose:	To comprehensively evaluate adolescents and adults who are suspected of using drugs; to identify or "flag" problem areas; to quantitatively monitor treatment progress and outcome; and to estimate likelihood of drug use disorder diagnosis
Type of Assessment:	A decision-tree approach is used: The information acquired from the DUSI-R should be viewed as implicative and not definitive in that the findings should generate hypotheses regarding the areas requiring comprehensive diagnostic evaluation by using other instruments. DUSI-R is structured and formatted for self-administration using paper and pencil or computer. It can also be group-administered.
Life Areas/Problems Assessed:	■ Substance use behavior ■ Behavior patterns ■ Health status ■ Psychiatric disorder ■ Social skill ■ Family system ■ School work ■ Peer relationship ■ Leisure ■ Recreation
Reading Level:	5th grade

Completion Time:	20 to 40 minutes (depending on the subject)
Credentials:	Available to drug counselors and other qualified users
Training:	Usual standards for administration of educational and psychological tests and questionnaires. Since the DUSI-R is self-administered and instructions are provided, no training program is essential for either administering or scoring of the instrument.
Scoring Procedures:	First, the Lie Scale score is tabulated to determine validity of the response to the questionnaire. Next, the "Absolute Problem Density" score is obtained for each of domains 1–10, indicating the severity of problem. The "Relative Problem Density" score is then calculated to indicate the severity of problems in each domain relative to the severity of overall problems. The "Summary Problem Index" represents the overall severity of problems from the total universe of DUSI problems. This index or summary score indicates the absolute severity of problems of all types without reference to particular problem areas. Two graphical profiles are constructed based on the absolute and relative problem density scores. Scoring can be done manually or by computer.
Scoring Time:	15–20 minutes
General Commentary:	The adolescent and adult versions are homologous, thereby enabling tracking of individuals on the same dimensions over time. The "Relative Problem Density" score enables ranking of the relative severity of problem types across the 10 domains and thus is an aid to developing an individualized treatment plan. An adult version of DUSI is available.
Access:	Dave Gorney The Gordian Group P.O. Box 1587 Hartsville, SC 29950 (843) 383-2201 http://www.dusi.com
Source of Psychometrics:	Kirisci, L.; Mezzich, A.; and Tarter, R. Norms and sensitivity of the adolescent version of the Drug Use Screening Inventory. <i>Addictive Behaviors</i> 20:149–157, 1995.
Pricing Information:	\$2.00 each for DUSI paper questionnaires; call for price of DUSI software for computer administration and scoring. DUSI is copyrighted.
Reviewed in:	Leccese and Waldron, 1994

Title of Instrument:	Personal Experience Screening Questionnaire (PESQ)
Introduction:	PESQ is a 40-item questionnaire that screens for the need for further assessment of drug use disorders. It provides a “red or green flag problem” severity score and a brief overview of psychosocial problems, drug use frequency, and faking tendencies.
Developer/Address:	Ken Winters, Ph.D. Center for Adolescent Substance Abuse Department of Psychiatry University of Minnesota Box 393, Mayo Building Minneapolis, MN 55455 (612) 626-2879 winte001@tc.umn.edu
Inquiries:	Ken Winters, Ph.D. See address above Tony Gerard, Ph.D. Senior Project Director Western Psychological Services 12031 Wilshire Boulevard Los Angeles, CA 90025 (310) 478-2061
Purpose:	To provide at a screening level an indication of the need for a comprehensive drug use evaluation and to briefly screen for select psychosocial problems and faking good and faking bad tendencies.
Type of Assessment:	Fixed-format self-report questionnaire
Life Areas/Problems Assessed:	■ Drug use problem severity (18 items) ■ Psychosocial problem (8 items) ■ Drug use frequency and onset (6 items) ■ Faking tendencies (8 items)
Reading Level:	4th grade
Completion Time:	10 minutes
Credentials/Training:	PESQ is appropriate for use by a range of health professionals.
Scoring Procedures:	Hand scoring instructions are provided in the questionnaire booklet.

Scoring Time:	3 minutes
General Commentary:	PESQ should not be used as a replacement for a comprehensive assessment.
Access:	Order from Western Psychological Services (see “Inquiries”). PESQ is copyrighted.
Source of Psychometrics:	Winters, K.C. <i>The Personal Experience Screening Questionnaire Manual</i> . Los Angeles, CA: Western Psychological Services, 1991. Winters, K.C. Development of an adolescent substance abuse screening questionnaire. <i>Addictive Behaviors</i> 17:479-490, 1992.
Pricing Information:	\$70.00 per PESQ Kit (including manual and 25 tests) \$42.50 per manual \$25.20-\$29.50 per package of 25 test forms (cost depends on size of order)
Reviewed in:	<i>Mental Measurements Yearbook</i> , 12th ed., and Leccese and Waldron, 1994

Title of Instrument:	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.
Developer/Address:	National Institute on Drug Abuse (NIDA), National Institutes of Health
Inquiries:	Elizabeth Rahdert, Ph.D. National Institute on Drug Abuse National Institutes of Health 5600 Fishers Lane, Room 10A-10 Rockville, MD 20857 (301) 443-0107
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.
Type of Assessment:	POSIT is a self-administered 139-item "yes/no" screening questionnaire.
Life Areas/Problems Assessed:	■ Substance use and abuse ■ Physical health ■ Mental health ■ Family relations ■ Peer relations ■ Educational status (i.e., learning disabilities/disorders) ■ Vocational status ■ Social skills ■ Leisure/recreation ■ Aggressive behavior/delinquency
Reading Level:	5th grade

Completion Time:	20-30 minutes
Credentials/Training:	No special qualifications are necessary to administer POSIT and POSIT followup questionnaires as their formats are very clear and straightforward.
Scoring Procedures:	Two scoring systems are available, the original system presented in the Adolescent Assessment-Referral System (AARS) manual and the newer scoring system available from NIDA. The original scoring system includes "red flag" items and one expert-based cut-off score that indicates either a high or low risk for each of the 10 problem areas. In contrast, the newer scoring system does not consider red flag items but includes two empirically based cut-off scores that indicate low, medium, or high risk for each of the 10 problem areas. In the newer system, the total raw score for each problem determines the level of risk for that area.
Scoring Time:	Two seconds for computerized scoring; 2-5 minutes when using the scoring templates placed over the paper and pencil versions of the POSIT and POSIT followup questionnaires
General Commentary:	POSIT and POSIT followup questionnaires are brief, easy to use, and specific to the problems and concerns of adolescents. They are not diagnostic instruments and require additional tests for full assessment. Some literacy is required.
Related Tests:	Each problem area identified on POSIT is addressed indepth by one or more of the assessment tools listed in the Comprehensive Assessment Battery (CAB). The POSIT questionnaire and the CAB are available in the Adolescent Assessment/Referral System Manual.
Access and Source of Psychometrics:	To obtain a copy of the POSIT, call Dr. Rahdert (see "Inquiries" above) or order the Adolescent Assessment-Referral System Manual, Stock #BKD-59, through National Clearinghouse for Alcohol and Drug Information P.O. Box 2345 Rockville, MD 20847-2345 (800) 729-6686

To obtain the computerized POSIT and POSIT followup, contact the following for pricing information on the currently available computer software:

PowerTrain, Inc.
8201 Corporate Drive
Suite 1080
Landover, MD 20785
(301) 731-0900

Reviewed in:

Leccese and Waldron, 1994

Title of Instrument:	Rutgers Alcohol Problem Index (RAPI)
Introduction:	RAPI is a 23-item self-administered screening tool for assessing adolescent problem drinking. It was developed to create a conceptually sound, unidimensional, relatively brief, and easily administered instrument to assess problem drinking in adolescence. Its empirical development involved factor analyses conducted of test-retest data on frequencies of a total of 53 symptoms and/or consequences of alcohol use, as reported by a nonclinical sample of 1308 males and females. The resulting 23-item scale has a reliability of .92 and a 3-year stability coefficient of .40 for the total sample. The advantages of this short, self-administered screening tool are its ease of administration and its standardization, which make it possible to compare problem drinking scores across groups. Please note, however, that RAPI is only a measure of adolescent drinking problems, and additional information about intensity of use, motivations for use, and contexts of use is desirable when conducting a full assessment of problem drinking.
Developer/Address:	Helene Raskin White, Ph.D. Erich Labouvie, Ph.D. Center of Alcohol Studies Rutgers University P.O. Box 969 Piscataway, NJ 08855-0969 (732) 445-3579
Inquiries:	Helene Raskin White, Ph.D. See address above
Purpose:	To screen for adolescent drinking problems
Type of Assessment:	Self-administered paper and pencil instrument. Respondents simply circle the number that corresponds to the number of times they have experienced each problem. Items can also be read aloud by an interviewer to clients with reading difficulties or it can be used as a springboard for a discussion of problems related to the client's alcohol use.
Life Areas/Problems Assessed:	Negative consequences of drinking
Reading Level:	7th grade
Completion Time:	10 minutes or less

Credentials/Training:	There is no training required for the administrator.
Scoring Procedures:	The coded numbers (0-4) are added together across items to form a scale ranging from 0 to 69. It can be normed on any sample. In a clinical sample (age 14 to 18) means ranged from 21 to 25 and in a nonclinical sample (age 15 to 18) means ranged from 4 to 8 depending upon age and sex. (Please note that in these analyses items were coded 0-3 with the last two categories combined.) The time frame for responses can be made smaller (e.g., last year or last 6 months rather than last 3 years).
Scoring Time:	3 minutes
General Commentary:	RAPI is appropriate for use in clinical and nonclinical samples of adolescents and young adults. It has been validated on a clinical sample of male and female adolescents aged 14 to 18 years from a treatment program for youth with substance use disorders and on a household sample of 1,308 male and female adolescents aged 12 to 21 years. RAPI can be used to assess the level of problem drinking among adolescents and young adults. It can also be part of a clinical interview in which the clinician addresses each problem related to drinking with the client and uses the results to discuss life disruptions due to drinking and denial of problems. Clinicians may find shorter time frames (e.g., last year or last 6 months) more useful than the last 3-year time frame which was used. RAPI can also be used as an interval scale of problem drinking in research studies.
Access:	Helene Raskin White, Ph.D. See address above (The developers request that persons who use RAPI send them their age/sex norms as well as a description of their sample.)
Pricing Information:	It is free, and there is no copyright.
Reviewed in:	Leccese and Waldron, 1994

Title of Instrument:	Teen Addiction Severity Index (T-ASI)
Introduction:	This is a relatively brief assessment instrument developed for use when an adolescent is being admitted to inpatient care for substance use-related problems.
Developer:	The Adolescent Drug Abuse and Psychiatric Treatment Program Division of Child and Adolescent Psychiatry Western Psychiatric Institute and Clinic 2811 O'Hara Street Pittsburgh, PA 15213
Editors:	Yifrah Kaminer, M.D. Oscar Bukstein, M.D. Ralph Tarter, Ph.D.
Inquiries:	Western Psychiatric Institute See address above Yifrah Kaminer, M.D. 263 Farmington Ave. University of Connecticut Health Center Farmington, CT 06030-2103 (860) 679-4344 (860) 679-4077 (fax)
Purpose:	The purpose of this instrument is to provide basic information on an adolescent prior to entry into inpatient care for substance use-related problems.
Type of Assessment:	Objective face-to-face interview combined with opportunity for assessor to offer comments, confidence ratings (indicating whether the information may be distorted), and severity ratings (indicating how severe the assessor believes is the need for treatment or counseling).
Life Areas/Problems Assessed:	▪ Chemical use ▪ School status ▪ employment/support ▪ Family relationships ▪ Peer/social relationships ▪ Legal status (involvement with criminal justice program) ▪ Psychiatric status ▪ Contact list for additional information

The questions asked for each area are fewer in number than many other instruments described in this document.

Reading Level: Not applicable

Credentials/Training: Assessors will require training in interviewing troubled youth with substance use problems.

General Commentary: T-ASI is an interview instrument providing baseline information on adolescents prior to entering inpatient care for substance use disorders. Information is collected in the following eight areas: (1) demographic, (2) chemical use, including consequences of use and treatment experiences, (3) school status, (4) employment/support status, (5) family relationships, including physical abuse and sexual abuse, (6) peer/social relationships, (7) legal status, and (8) psychiatric status, including treatment experiences. At the end of topic areas 2 through 8, space is provided for assessor's comments, a problem severity rating, and "confidence ratings" (assessor's ratings regarding subject's misrepresentation or inability to understand the questions).

Reviewed in: Leccese and Waldron, 1994

Part II

**Summary of Comprehensive Assessment Instruments for
Substance-Using Adolescents**

Title of Instrument:	Adolescent Drug Abuse Diagnosis (ADAD)
Introduction:	ADAD is a 150-item instrument for structured interviewer administration that produces a comprehensive evaluation of the client and provides a 10-point severity rating for each of nine life problem areas. Composite scores to measure client behavioral change in each problem area during and after treatment can be calculated. Only 83 items of the 150 ADAD items are used for measuring change: posttest, followup tracking in an evaluation of clients after treatment, and evaluation of treatment outcome. These 83 items are circled on the ADAD form.
Developer/Address:	Alfred S. Friedman, Ph.D., and Arlene Terras (Utada), M.Ed. Belmont Center for Comprehensive Treatment 4081 Ford Road Philadelphia, PA 19131 (215) 877-6408 (215) 879-2443 (fax)
Inquiries:	Alfred S. Friedman, Ph.D., and Arlene Terras, M.Ed. See address above
Purpose:	To assess substance use and other life problems, to assist with treatment planning, and to assess changes in life problem areas and severity over time
Type of Assessment:	Structured interview
Life Areas/Problems Assessed:	■ Medical ■ School ■ Employment ■ Social relations ■ Family and background relationships ■ Psychological ■ Legal ■ Alcohol use ■ Drug use
Checklists:	A special feature of ADAD is three problem checklists in the medical, school, and family sections. These lists, which require only a yes or no response from the adolescent, enable the interviewer to gather a considerable amount of information from the youth in an easy and efficient manner. The items on the problem checklists were selected

from longer lists of items of an open-ended instrument that had been administered to several different populations of adolescent substance users. The items that were found to predict treatment outcome to the most significant degree were selected for inclusion in the ADAD.

Reading Level: Not applicable; a staff person interviews the client.

Completion Time: 45-55 minutes

Credentials/Training: A 1-day training session is recommended. As an alternate minimal training method, a training videotape is available at a cost of \$25.00. Technical assistance for this training procedure is available at no cost by telephone.

The videotape shows an actual ADAD interview which can be used as (1) a simple model for the administration of the instrument, and (2) a means of developing proficiency with assigning severity ratings (by comparing the trainee's severity ratings with those of the trainer).

Scoring Procedures: Each life problem area is scored for problem severity on a 10-point scale. Collectively, these scores are referred to as the Interviewer Severity Ratings and comprise a comprehensive adolescent life problem profile.

The interviewer's ratings usually reflect the judgment of the severity of the problems based on the historical perspective of the client's behavior and life conditions over a period of time that is longer than the most recent 30-day period covered by the items that are included in the formulas for deriving the composite scores.

Mathematically derived composite scores (based on a formula for weighting selected item scores) can be used to assess changes in problem severity over time. These scores are independent of both the interviewer's clinical judgment of the "severity" of each life problem area, as well as the adolescent client's problem severity and treatment need self-ratings.

Scoring Time: Less than 10 minutes

General Commentary: Although ADAD was originally developed for use with adolescents in substance use disorder treatment settings, it has proved useful as a general assessment tool for adolescents in school settings, youth social service agencies, mental health facilities, and facilities and programs within the criminal justice system. Formal ADAD training sessions have

been provided to intake workers, drug counselors, and therapists in 12 States. It has also been translated into French, Swedish, and Greek.

A computerized version for administration of ADAD, which has been developed by the Target Cities Research Project at the University of Akron in Akron, Ohio, is now available on disk. This software version of ADAD provides a narrative summary of the data collected from each individual client that is intended to facilitate report writing and treatment planning.

Normative Information:

The standardization sample consists of 1,042 clients admitted to six outpatient programs ($n=683$), three residential, nonhospital programs ($n=157$), and three hospital programs ($n=202$). Some of the demographics of this standardization sample are

- Mean age: 15.6 years
- Sex distribution: 73 percent male, 27 percent female
- Race distribution: 53 percent white, 25 percent African-American, 20 percent Hispanic, and 2 percent other
- Mean school grade completed: 8.1

There were an insignificant number of Native Americans in the standardization sample; therefore, ADAD may not be appropriate for use with Native Americans.

Psychometrics:

Good two-year rater interrater reliability ($r=0.85-0.97$) was demonstrated for the interviewers' severity ratings of the nine life problem areas. Good test-retest reliability was shown for interviewer severity ratings (r between .83 and .96) and for the composite scores (r between .91 and .99), except for the employment of life problems area ($r=.71$). Adequate concurrent (external) validity (r between .43 and .67) was established for all but two life problem areas (by correlating with scores obtained on other previously validated instruments that purported to measure the same life problem area). The exceptions were the medical and social relations life problem areas; obtained correlations were lower.

Access:

From developers (see above for address)

Pricing Information:

\$15.00 per instruction manual
 \$25.00 per training videotape
 \$40.00 per computerized version of the ADAD with a manual for installing and using software

ADAD is in the public domain. In response to inquiries about ADAD, the following items are sent free of charge: a copy of ADAD instrument;

a copy of the original journal paper about the ADAD which describes its development, its psychometric properties, and its normative sample; a letter that provides additional information about the ADAD and a price list.

Reviewed in:

Leccese and Waldron, 1994

Title of Instrument:	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.
Developer/ Address:	Ken Winters, Ph.D. Center for Adolescent Substance Abuse Department of Psychiatry University of Minnesota Box 393, Mayo Building Minneapolis, MN 55455 (612) 626-2879 winte001@tc.umn.edu George Henly, Ph.D. Department of Counseling University of North Dakota Box 8262 University Station Grand Forks, ND 58202
Inquiries:	Ken Winters, Ph.D. See address above Tony Gerard, Ph.D. Senior Project Director Western Psychological Services 12031 Wilshire Boulevard Los Angeles, CA 90025 (310) 478-2061
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
Type of Assessment:	Structured interview
Life Areas/Problems Assessed:	■ Substance use diagnostic criteria (DSM-III-R and DSM-IV) ■ Demographics ■ Psychosocial stressors

- Level of functioning; screening for other disorders
- Screening for memory/orientation

Completion Time:	30-90 minutes
Credentials/Training:	ADI is available to “qualified professional users” as defined by the ethical standards of the American Psychological Association.
Scoring Procedures:	Hand-scoring instructions are provided in the booklet.
Scoring Time:	10-15 minutes
General Commentary:	ADI provides diagnostic coverage for all the major psychoactive substances.
Access:	Order from Western Psychological Services (see “Inquiries”). ADI is copyrighted.
Pricing Information:	\$75.00 per ADI kit (including manual and five administration booklets) \$45.00 per ADI manual \$29.90-\$32.00 per package of five administration booklets (cost depends on size of order)
Source of Psychometrics:	Winters, K.C., and Henly, G.A. <i>Adolescent Diagnostic Interview Manual</i> . Los Angeles: Western Psychological Services, 1993. Winters, K.C.; Stinchfield, R.D.; Henly, G.A.; and Fulkerson, J. Measuring alcohol and cannabis use disorders in an adolescent clinical sample. <i>Psychology of Addictive Disorders</i> 7:185-196, 1993. Winters, K.C.; Latimer, W.W.; and Stinchfield, R.D. DSM-IV criteria for adolescent alcohol and cannabis use disorders. <i>Journal of Studies on Alcohol</i> , in press.
Reviewed in:	<i>Mental Measurements Yearbook</i> , 12th ed., and Leccese and Waldron, 1994

Title of Instrument:	Adolescent Self-Assessment Profile (ASAP)
Introduction:	ASAP is a 225-item self-report instrument comprising 20 basic scales and 15 supplemental scales that provides primary order and broad scale measurement of (1) six major risk-resiliency factors; (2) assessment of drug use benefits, involvement, and disruption; and (3) degree of drug use involvement in nine drug use categories. The core common factor structure of ASAP is based on the six primary risk-resiliency factors identified in the literature—family, mental health, school adjustment, peer influence, deviancy, and drug use symptoms—and has been validated across independent samples.
Developer:	Kenneth Wanberg, Ph.D. Center for Addictions Research and Evaluation 5460 Ward Road Suite 140 Arvada, CO 80002 (303) 421-1261 (303) 467-1985 (fax)
Inquiries:	Kenneth Wanberg, Ph.D. See address above
Purpose:	To provide a differential assessment of the adolescent's psychosocial adjustment and substance use involvement, benefits, and disruption to provide a basis for differential treatment planning. Can be used for, during, and after treatment assessment to determine changes in perception of the adolescent's psychosocial and substance use problems.
Type of Assessment:	ASAP is a self-report instrument that may be either self-administered or administered through an interview structure. It provides a broad-based assessment of the major risk factors and an indepth assessment of involvement in substance use. It is composed of broad scales that measure the general areas of psychosocial adjustment and substance use and primary scales that provide more specific measurements of family and mental health problems and drug use benefits and drug use disruption.
Life Areas/Problems Assessed:	■ Family adjustment ■ Mental health symptoms ■ Negative peer influence ■ School adjustment ■ Deviancy and conduct problems ■ Substance use comprising the following measures:

	◆ Attitude toward drug use ◆ Drug use exposure and extent (number of drugs) ◆ Involvement in nine drug categories (alcohol, marijuana, amphetamines, cocaine, inhalants, hallucinogens, heroin, pain killers, and tranquilizers and sedatives) ◆ Substance use symptoms and disruption ◆ Substance use benefits ◆ Substance dependence (based on DSM-IV criteria)
Reading Level:	6th to 7th grade
Credentials and Training:	Certified addictions counselors, psychologists, social workers, physicians, licensed professional counselors
Completion Time:	Self-administered, 25-50 minutes depending on client reading level, degree of involvement in different drugs, and degree of psychosocial problems
Scoring Procedures:	All items are grouped by scoring domain, and thus hand scoring is easy and quick. Raw scores are converted into decile and percentile scores through a user-friendly profile. Several reference or normative groups are available, including adolescents admitted to both rural and urban outpatient treatment centers ($n=3,500$), juvenile justice probation clients, ($n=1,500$) and committed juvenile offenders ($n=1,200$). Computer administration and scoring is available.
Scoring Time:	5 to 10 minutes including plotting profile. Automated scoring version is currently being developed.
General Commentary:	ASAP was developed using multivariate methods and procedures. Factor patterns of the 20 broad and 15 primary scales have been replicated across a variety of samples. All scales have good to excellent reliabilities. ASAP manual provides good evidence of content and construct validity. Several scales of ASAP can be used to test for treatment outcome through a repeated measures model. Scales can be interpreted from both a risk- and strength-based perspective.
Access:	Center for Addictions Research and Evaluation 5460 Ward Road Suite 140 Arvada, CO 80002

Pricing Information: ASAP is distributed on the basis of restricted-license use. Original material (test booklet, answer sheets, profiles) and a manual are provided to the user. Cost is as follows:

\$50.00 for fewer than 100 administrations per year

\$100.00 for 100 to 299 administrations per year

\$200.00 for 300 to 500 administrations per year

More than 500 administrations per year negotiated with distributor

Reviewed in: Leccese and Waldron, 1994

Title of Instrument:	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.
Developer/Address:	E.R. Oetting, Ph.D. Ruth W. Edwards, Ph.D. Fred Beauvais, Ph.D. Rocky Mountain Behavioral Science Institute, Inc. (RMBSI) 419 Canyon Avenue, Suite 316 Fort Collins, CO 80521
Inquiries:	Patricia Waters, Director of Professional Services RMBSI, Inc. See address above (800) 447-6354
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.
Type of Assessment:	Self-report, paper and pencil
Life Areas/Problems Assessed:	Children's Form (4th-6th grade) drug survey: ■ Drug and alcohol prevalence (5 classes of substances) ■ Lifetime, annual, last-30-day use ■ Peer encouragement and sanctions ■ School adjustment ■ Family sanctions and caring Adolescent Form (6th-12th grade) drug survey: ■ Drug and alcohol prevalence (21 classes of substances) ■ Lifetime, annual, last-30-day use ■ Peer and family encouragement and sanctions ■ Drug use consequences

- Location of drug use
- High-risk drug behaviors
- Perceived harm and availability
- Future intent

Prevention Planning Survey (available only as a supplement to the Adolescent ADAS):

- School adjustment
- Family adjustment
- Peer relationships
- Violence and victimization
- Gang involvement
- Emotional adjustment/distress
- Prevention program involvement

Completion Time:	30 to 50 minutes depending on whether inserts are used
Credentials/Training:	Instructions are provided for classroom teachers (or others selected to administer the survey) and students. No additional training required.
Scoring Procedures:	Surveys are returned to RMBSI for scanning and data analysis. RMBSI prepares complete reports for each participating school or district including an executive summary, detailed report, press release, overhead transparencies, and a presentation script. Supplementary reports are prepared when survey inserts are used.
Scoring Time:	RMBSI ships reports to schools approximately 30 days after receipt of completed questionnaires.
General Commentary:	The experience of RMBSI is that the data are most useful at the local level when provided on an individual school basis. A special feature of the ADAS is the development of a typology of nine "styles" of drug use based on various combinations of types of drugs. These styles are hierarchically listed in order of decreasing severity of drug involvement. ADAS has been thoroughly tested on over 1 million students, including substantial numbers of minority students, and has excellent psychometric properties.
Access:	Patricia Waters See address above

Pricing Information: \$75-\$200 per report; \$0.80 to \$1.10 per survey form depending on the volume of the order. Each customer is billed for each completed survey form and for each report requested. Call for details.

Reviewed in: *Mental Measurements Yearbook*, 12th ed.

Title of Instrument:	The Chemical Dependency Assessment Profile (CDAP)
Introduction:	CDAP is a 232-item, multiple-choice and true-false self-report instrument to assess substance abuse and dependency problems. The 11 dimensions measured include quantity/frequency of use, physiological symptoms, situational stressors, antisocial behaviors, interpersonal problems, affective dysfunction, attitude toward treatment, degree of life impact, and three "use expectancies" (that is, the client's expectation that use of the substance reduces tension, facilitates socialization, or enhances mood).
Developer/Address:	Psychologistics, Inc. 268 N. Babcock St., Suite B-1 Melbourne, FL 32935
Inquiries:	See address above
Purpose:	The questionnaire covers chemical use history, patterns of use, reinforcement dimensions of use, perception of situational stressors, and attitudes about treatment, self-concept, and interpersonal relations.
Type of Assessment:	A structured self-report inventory that obtains detailed information useful for treatment and planning.
Life Areas/Problems Assessed:	Chemical use history, patterns of use, reinforcement dimensions of use, perception of situational stressors, attitudes toward treatment, self-concept, interpersonal relations
Reading Level:	9th grade
Completion Time:	40 minutes
Scoring Procedures:	Not applicable
Scoring Time:	Not applicable
General Commentary:	Report generates descriptive information; subscale scores are computer generated.
Access:	Psychologistics, Inc. See address above
Pricing Information:	\$20.00 for a package of 20 forms. \$295.00 for Windows or Macintosh software for report generation.

Title of Instrument:	Comprehensive Adolescent Severity Inventory (CASI)
Introduction:	This instrument is designed to measure 10 life issues in an adolescent's life, including substance use severity.
Inquiries:	Alicia Webb Center for Studies of Addiction VA Medical Center University and Woodland Building 7 Philadelphia, PA 19104 (215) 823-4674 awebb@mail.med.upenn.edu
Purpose:	To provide a comprehensive, indepth assessment of the severity of an adolescent's substance use and other related areas
Type of Assessment:	Includes objective face-to-face interview combined with urine drug screen results and observations from the assessor. (After each area is assessed, there is space for comments as well as "confidence ratings": the degree to which the assessor believes the information may be distorted.)
Life Areas/Problems Assessed:	General screening overview (including urine drug screen results). Indepth assessment of the following areas: ■ Education ■ Substance use ■ Use of free time (time not spent in school, includes employment and sources for financial support) ■ Leisure activities ■ Peer relationships (including sexual activity) ■ Family relationships ■ Psychiatric status
Reading Level:	Not applicable. A staff person interviews the client.
Credentials/Training:	Training in interviewing troubled youth with substance use problems
General Commentary:	CASI is a general screening interview (including Breathalyzer™ and urine drug test results), providing an indepth assessment of the severity of an adolescent's substance use and related problems. Information is collected in 10 areas: (1) psychological, (2) significant life changes, (3) educational experiences and plans, (4) substance use, effects of use, and treatment experiences, (5) use of free time, including employment and sources of financial support, (6) leisure activities, (7) peer relationships,

including sexual activity and related diseases, (8) family history and relationships including physical and sexual abuse, (9) legal history, and (10) psychiatric status, including treatment experiences. At the end of topic areas 3 through 10, space is provided for assessor's comments and "confidence ratings" (assessor's ratings regarding subject's misrepresentation or inability to understand the questions). Preliminary psychometric data are available on the CASI.

Source of Psychometrics: Meyers, K.; McLellan, A.T.; Jaeger, J.L.; and Pettinati, A. The development of the Comprehensive Addiction Severity Index for Adolescents (CASI-A): An interview for assessing multiple problems of adolescents. *Journal of Substance Abuse Treatment* 12:181-193, 1995.

Title of Instrument:	Hilson Adolescent Profile (HAP)
Introduction:	HAP consists of 310 “true or false” items grouped into 16 separate scales. The contents of these 16 scales correspond to characteristics found in psychiatric diagnostic categories. The HAP directly questions adolescents and documents their admitted behaviors rather than infer those behaviors from statistically or theoretically derived personality indicators.
Developer/ Address:	Robin E. Inwald, Ph.D. Hilson Research, Inc. P.O. Box 150239 82-28 Abingdon Road Kew Gardens, NY 11415 (800) 926-2258
Inquiries:	Robin E. Inwald, Ph.D. See address above
Purpose:	HAP is a behaviorally oriented assessment measure geared for use by professionals who work with troubled youth. This instrument was designed as a screening tool to assess the presence and extent of adolescent behavior patterns and problems. In short, the purpose of HAP is to help mental health practitioners, school personnel, and administrators in the juvenile justice system identify adolescents at risk.
Type of Assessment:	HAP is a “true or false” inventory that can be administered individually or in a group setting. Questions are printed in the HAP test booklet, and responses should be made on the computer-readable answer sheets provided. It is appropriate for individuals between 9 and 19 years of age. Information is provided on how the adolescent scored in relation to clinical patients, juvenile offenders, and adolescent students.
Life Areas/Problems Assessed:	■ Alcohol use ■ Drug use ■ Educational adjustment difficulties ■ Law/society violations ■ Frustration tolerance ■ Antisocial/risk-taking ■ Rigidity/obsessiveness ■ Interpersonal/assertiveness difficulties ■ Home life conflicts ■ Social/sexual adjustments ■ Health concerns

- Anxiety/phobic avoidance
- Depression/suicide potential
- Suspicious temperament
- Unusual responses
- Guarded responses

Reading Level:	5th grade
Completion Time:	Approximately 45 minutes
Credentials/Training:	HAP is appropriate for use by psychologists, school administrators, adolescent counselors, etc. Trained Hilson Research staff members are available to all users when there are questions regarding test administration or interpretation of any Hilson test.
Scoring Procedures:	HAP is completely computer scored, eliminating the type of accidental errors that are often the result of hand-scoring and allowing a much greater quantity of information to be provided to the test user. An important advantage of the HAP computer scoring system is the ability to store all test data for later retrieval, rescoring, and/or analysis.
Scoring Time:	Three scoring services currently are available for HAP. It can be scored online using Hilson Research remote system software (2-3 second online scoring time per test), by the Hilson Research fax service (same day processing), or by the Hilson Research mail-in service (same day processing).
Related Tests:	The Inwald Survey 2-Adolescent Version (IS2-A) is used to aid in the identification of adolescents who may disregard rules and/or societal norms. IS2-A focuses on characteristics that have been associated with antisocial/violent behavior patterns. Some of the IS2-A scales are for alcohol use, drug use, unlawful behavior, lack of responsibility, and disciplinary difficulties. The Hilson Adolescent Profile-Version S (HAP-S) is a shortened version of HAP containing seven original HAP scales. HAP-S was developed to identify adolescent emotional adjustment difficulties, depression and/or suicidal tendencies, homelife conflicts, and other behavioral patterns. The Hilson Adolescent Profile-Version D (HAP-D) is a hand-scored inventory that can help identify adolescents who are depressed and/or at risk for suicide attempts. It also can be used to assess antisocial behaviors and to diagnose conduct disorders.

The Hilson Parent/Guardian Inventory (HPGI) assesses a parent/caregiver's attitudes/behaviors toward his or her children. HPGI can be used alone or in conjunction with the above-mentioned Hilson Research tests for adolescents. When used with other Hilson tests, HPGI can provide a comprehensive view of family difficulties, parental attitudes, and the child's behavioral problems.

Pricing Information: \$7.50-\$12.00 each per test using Hilson Research remote system software (research rates are available for some Hilson Research tests)
\$15.00 per test using the Hilson Research fax service
\$15.00-\$21.50 per test using mail-in scoring
\$2.00 per reusable test booklet and \$0.25-\$0.30 per answer sheet

Reviewed in: *Mental Measurements Yearbook*, 11th ed.

Title of Instrument:	Juvenile Automated Substance Abuse Evaluation (JASAE)
Introduction:	JASAE is a computer-assisted substance use disorder screening/assessment instrument that consists of the following: ▪ Self-report JASAE survey containing 108 items ▪ Copyrighted JASAE program that performs a computer-assisted evaluation of each client's responses ▪ Print-out of JASAE report for each client evaluated ▪ Accumulation of an ongoing database for clients evaluated using JASAE
Developer:	Bryan R. Ellis, President ADE Incorporated P.O. Box 660 Clarkston, MI 48347
Inquiries:	Carol Pummill Marketing Representative See address above (248) 625-7200 adeinc@mail.tir.com http://www.adeincorp.com
Purpose:	Based on adolescent norms, JASAE evaluates alcohol and drug use/abuse by juveniles, generally between the ages of 12 and 18. It also examines respondent attitude and life stress issues to determine if, and to what degree, problems exist in these areas.
Type of Assessment:	Modeling the techniques and procedures of the personal interview process, the JASAE goal is to arrive at the most effective intervention to bring about the needed behavior change. In its recommendations, JASAE provides a suggested DSM-IV classification and a suggested referral based on American Society of Addiction Medicine guidelines.
Life Areas/Problems Assessed:	Patterns of substance use/abuse, including drug of first and second choice, and when these drugs were last used. Also measures attitude and life stress issues pertinent to age and life situations of adolescent population.
Reading Level:	5th grade
Completion Time:	20 minutes
Credentials:	Available to substance abuse counselors and other qualified users

Training:	Demonstration materials, including a JASAE Reference Guide that discusses scores produced on JASAE, are provided at no charge. Group training sessions for statewide usage and other high volume users can be arranged. Telephone support is provided to customers via a toll-free telephone number.
Scoring Procedures:	Client responses to JASAE Survey are entered into the JASAE software. A JASAE Report can be printed on site immediately.
Scoring Time:	Manual entry of client responses through computer keyboard takes 3-5 minutes. For high volume users, optical scanners can be used for data entry.
General Commentary:	Ideally, JASAE is used as a tool in conjunction with a brief followup interview. However, when time and personnel constraints require it, JASAE can be used for making quick first referrals. JASAE is used by mental health agencies, courts, school systems, student assistance programs, and treatment agencies (public and private).
Related Tests:	The following programs are available for use in conjunction with JASAE: ■ For clients who have been evaluated using JASAE, ADE's Tracking Program monitors participation and progress in intervention programs. ■ JASAE Outcome Program can be used periodically throughout intervention to measure effectiveness of intervention from client's perspective. ■ JASAE TAB is a simple crosstab data analysis program designed specifically for use with the database which accumulates as JASAE evaluations are processed.
Access:	ADE Incorporated See address above JASAE is copyrighted.
Pricing Information:	\$4.50 per evaluation. No start-up costs. Minimum order is 12 evaluations. \$10.00 each for English and Spanish Audio Tapes of the JASAE Survey JASAE is provided on computer disk for use on disk or for installation. Compatible with DOS (3.3 or higher), Windows 3.1, and Windows 95.

Title of Instrument:	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.
Developer/Address:	Ken Winters, Ph.D. Center for Adolescent Substance Abuse Department of Psychiatry Box 393, Mayo Building University of Minnesota Minneapolis, MN 55455 (612) 626-2879 winte001@tc.umn.edu George Henly, Ph.D. Department of Counseling University of North Dakota Box 8262 University Station Grand Forks, ND 58202
Inquiries:	Ken Winters, Ph.D. See address above Tony Gerard, Ph.D. Senior Project Director Western Psychological Services 12031 Wilshire Blvd. Los Angeles, CA 90025 (310) 478-2061

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
Type of Assessment:	Fixed-format self-report questionnaire
Life Areas/Problems Assessed:	Part I (129 items): The CIPS section includes items on alcohol as well as drug use and problems; it provides problem severity scores for each of five “basic” scales and five “clinical” scales and a history of drug use frequency. There are also three “Validity Indices” in CIPS: (1) infrequent responses, (2) defensiveness, and (3) pattern misfit. Part II (147 items): the PS section of PEI includes: ■ Eight personal risk or personal adjustment scales ■ Four family and peer environmental risk scales ■ Six problem screens including eating disorder, sexual abuse, physical abuse, suicide risk, psychiatric referral ■ Two validity indices
Reading Level:	6th grade
Completion Time:	45–60 minutes
Credentials/Training:	Since PEI is self-administered and instructions are provided, a formal training program is not essential. PEI is available to “qualified professional users” as defined by the ethical standards of the American Psychological Association. Training workshops are offered by Ken Winters, coauthor of PEI (612-626-2879).
Scoring Procedures:	Western Psychological Services (WPS) provides IBM compatible Windows software for on-site scoring, mail-in service, or fax-in service. The score report from WPS includes the profile of standardized scores obtained by the client and an interpretation narrative.

Scoring Time:	Mail-in service turnaround time is the same working day after receipt of materials; fax-in service turnaround is within a few hours after receipt of materials. Turnaround time of the PC software is virtually instantaneous.
General Commentary:	Provides a list of critical items that suggest areas in need of immediate attention by the treatment provider and summarizes treatment indicators. Additional data collected by the authors indicate that the scales appear to be reliable and valid for African American, Hispanic, Asian American, and American Indians.
Access:	Order from Western Psychological Services (see "inquiries"). PEI is copyrighted.
Source of Psychometrics:	Winters, K.C.; and Henly, G.A. <i>The Personal Experience Inventory Manual</i>. Los Angeles, CA: Western Psychological Services, 1989. Winters, K.C.; Stinchfield, R.D.; and Henly, G.A. Further validation of new scales measuring adolescent alcohol and other drug abuse. <i>Journal of Studies on Alcohol</i> 54:534-541, 1993. Guthmann, D.R., and Brenna, D.C. The Personal Experience Inventory: An assessment of the instrument's validity among a delinquent population in Washington State. <i>Journal of Adolescent Chemical Dependency</i> 1(2):15-24, 1990. Winters K.C.; Stinchfield R.; and Henly R.A.. Convergent and predictive validity of scales measuring adolescent substance abuse. <i>Journal of Child and Adolescent Substance Abuse</i> 5(3):37-55, 1996.
Pricing Information:	\$145.00 per PEI kit (including Manual and 5 WPS Test Report forms) \$47.50 per PEI manual \$9.96-\$21.00 per PEI test depending on size of order and scoring method
Reviewed in:	<i>Mental Measurements Yearbook</i> , 11th and 13th eds., and Leccese and Waldron, 1994

Title:	Prototype Screening/Triage Form for Juvenile Detention Centers
Introduction:	This instrument gathers information both objectively and subjectively in a number of areas to establish a juvenile's risk and service needs in each information area. The information is based, in part, on the assessor's clinical judgment.
Developer:	Richard Dembo, Ph.D., and Associates
Inquiries:	Dr. Richard Dembo Department of Criminology, SOC 107 University of South Florida 4202 E. Fowler Avenue Tampa, FL 33620 (813) 931-3345
Purpose:	To assess a juvenile's overall risk and needs within juvenile detention facilities
Type of Assessment:	Face-to-face interview, with multiple choice and open-ended questions
Life Areas/Problems Assessed:	■ Admission and demographic ■ Education and employment ■ Home/living situation ■ Other personal information ■ Substance use ■ Sexual abuse history ■ Physical abuse history ■ Family history ■ Psychological/medical history ■ Mental health information
Reading Level:	Not applicable
Credentials/Training:	Skilled interviewers whose training includes role playing, mock interviews, and rapport-building techniques
Completion Time:	45 minutes
Scoring:	Scoring can take up to 20 minutes depending on problem areas identified
General Commentary:	This form, consisting of subjective and objective questions, collects demographic and reason-for-admission information on juvenile detainees, and obtains information on their status and functioning in 10

areas: (1) education/employment, (2) home/living situation, (3) other personal information (e.g., religious practice, gang membership), (4) substance use, (5) sexual abuse history, (6) physical abuse history, (7) family history, (8) psychological/medical history, (9) mental health information, and (10) legal history.

Title of Instrument:	The Texas Christian University Prevention Intervention Management and Evaluation System (TCU/PMES)
Introduction:	TCU/PMES forms include three instruments (related to substance use problems) for administration in a structured interview shortly after admission to treatment and at followup. It “provides information considered theoretically significant for adolescent drug use and related problems.”
Developer/ Address:	D. Dwayne Simpson, Ph.D., Director Institute of Behavioral Research Texas Christian University TCU Box 298740 Fort Worth, TX 76129 (817) 921-7226 (817) 921-7290 FAX http://www.ibr.tcu.edu
Inquiries:	D. Dwayne Simpson, Ph.D. See address above
Purpose:	To assess substance abuse and other life problems of adolescent clients, to assist in planning treatment, and to provide followup assessment and evaluation data on treatment outcome
Type of Assessment:	TCU/PMES consists of three main parts: the Client Intake form (CIF), the Family, Friends, and Self (FFS) Assessment form, and the Client Followup (CFU) interview. The information derived is integrated to plan the treatment and determine the appropriate level of care for the client. In the structured interview format, the questions are read verbatim to the client.
Life Areas/Problems Assessed:	CIF includes 55 questions covering the following areas: ■ Client-identifying demographics ■ The referral source and process ■ Socioeconomic and family background ■ School problems, legal status and problems, substance use history ■ A checklist for the interviewer to indicate in which of ten problem areas the client needs help CFU interview includes 94 items that cover similar areas.

The 60-item FFS Assessment form includes the following three parts:

- The Family Relations Scale (22 items), measuring three different parts:
 - ◆ Warmth ($\alpha=.91$)
 - ◆ Control ($\alpha=.74$)
 - ◆ Conflict ($\alpha=.77$)
- The Peer Activity Scale (23 items), measuring four dimensions
 - ◆ Peer activity level ($\alpha=.82$)
 - ◆ Peers in trouble ($\alpha=.86$)
 - ◆ Peers' familiarity with parents ($\alpha=.77$)
 - ◆ Peers' conventional involvement ($\alpha=.73$)

Only the first dimension refers to the client's own activity with peers; the other three refer to the number of close friends involved in each type of activity or problem.

- The Self Scale (15 items) measures three dimensions of the client's psychological status
 - ◆ Self-esteem ($\alpha=.75$)
 - ◆ Environment ($\alpha=.82$)
 - ◆ School satisfaction ($\alpha=.79$)

Reading Level: 6th grade

Completion Time: Approximately 1 hour for intake and followup interviews and 15 minutes for FFS

Credentials/Training: Since TCU/PMES forms are self-administered and contain instructions, no user manual and no specific training program are required by personnel qualified to administer such instruments. While a brief training period of several hours' duration is advisable, it is not essential for adequately qualified personnel (such as drug counselors).

Scoring Procedures: Each item of the FFS form is constructed in a Likert-type format in which the client is asked to indicate the degree to which, or the frequency with which, the particular behavior or attitude occurred.

By totaling item scores, separate scores are derived for the life areas assessed. The scoring instructions are available, together with TCU/PMES questionnaire forms, including all items and factors (see pricing information below).

Scoring Time: 10-15 minutes

General Commentary:	A strength of TCU/PMES is that the score obtained for an individual client can be compared to the scores obtained by the normative sample. A relative weakness of the TCU/PMES is that it has not as yet had quite the indepth psychometric development for establishing test-retest reliability and validity that some other instruments for assessing adolescent substance users have had. Some assessors may like the fact that, compared to some of the other instruments, TCU/PMES is not as long and complicated, and the items are relatively simple and easy to understand.
Access:	See pricing information. TCU/PMES is not copyrighted and permission to photocopy is granted without special permission.
Pricing Information:	\$5.00 per copy of the full set of PMES forms (for printing and mailing) Several TCU data collection instruments are available, without charge, from the Internet web site for the Institute of Behavioral Research at TCU (http:// www.ibr.tcu.edu). These instruments include the PMES FFS, referred to as the "TCU Adolescent Assessment" forms on the Internet. Scoring procedures and psychometric references are also included.

Part III

Adolescent Measurement Instruments for General Functioning Domains

Delinquency/Illegal Behavior Domain

Title of Instrument:	Supervision Risk/Classification Instrument
Introduction:	This instrument is used throughout Florida to assess the risk and needs of juveniles involved with the criminal justice system.
Developer:	Florida Department of Health and Rehabilitative Services
Inquiries:	Stephen Ray, Program Administrator Florida Department of Juvenile Justice Department of Children and Families Alcohol, Drug, Mental Health Program 2737 Centerview Drive Tallahassee, FL 32399-3100 (850) 487-9818
Purpose:	This instrument is designed for use within government agencies to classify the risks, service needs, and appropriate levels of commitment for youth involved with the criminal justice system. The instrument also includes an attachment used to reclassify youth on community control or furlough supervision. Reclassification is to be done every 60 days or whenever there are significant changes in a youth's supervision (e.g., additional law violations). Instrument is intended to be filled out by case managers.
Type of Assessment:	This assessment is completed by the case manager through the rating of risks within particular categories. There is no need for the youth to be present when the instrument is filled out. However, the instrument requires the case manager to be knowledgeable about the youth's situation.
Life Areas/Problems Assessed:	■ Section I—Identifying data ■ Section II—Risk Assessment (most serious illegal offense, prior history of illegal offenses, other factors) ■ Section III—Needs Assessment (assessing the needs in regard to family relationships, parental dysfunction, peer relationships, significant adult relationships, education, employment, developmental disabilities, health and hygiene, mental health, and substance abuse) Notes "mitigating factors" (e.g., successful completion of program) and "aggravating factors" (e.g., youth has a felony violation), which should

be taken into account when deciding the youth's appropriate level of commitment.

Reading Level: Not applicable

Credentials/Training: The assessor needs minimal training in how to score the instrument and evaluate the youth's behavior and/or records. This instrument does not require interviewing skills.

Scoring: Each response to be made by the assessor is designated with a point. The points for each response appear directly on the form (e.g., one violent felony offense gets 17 points, one prior misdemeanor gets one point). The total risk score is added up, as is the total needs score. The scores are then used to make placement recommendations regarding the youth's status.

General Commentary: This instrument is completed by the case manager of a youth involved in the juvenile justice system. It is designed for use in recommending a level of program structure and commitment for the youth. Reclassification is to be completed every 60 days or whenever there is a significant change in the youth's supervision status (e.g., a new law violation). Information included in the form covers the following topic areas:

- Identifying data of youth and case manager
- Risk assessment (instant offense, prior legal history, other scoring factors [e.g., previous technical violations of supervision, history of escape/absconding, substance use involvement]), consideration of mitigating factors (e.g., no new referrals, successful program completion) and aggravating factors (youth has a felony law violation, returned to supervision status from absconder status)
- Needs assessment (family relationships, parental dysfunctions [including a history of abuse/neglect], peer relationships, significant adult relationships, educational problems, employment experiences, developmental disabilities, physical health and hygiene, mental health, and substance use)

Family Domain

Title:	Family Assessment Measure (FAM-III)
Introduction:	Provides a multilevel (within family) assessment of family functioning
Developer:	Harvey A. Skinner, Ph.D. Paul D. Steinhaues, M.D. Jack Santa-Barbara, Ph.D. Multi-Health Systems 908 Niagara Falls Blvd. North Tonawanda, NY 14120-2060 (416) 424-1700 (416) 424-1736 FAX http://www.mhs.com
Inquiries:	Jerry Smith, Marketing Manager Multi-Health Systems See address above (800) 456-3003
Purpose:	FAM-III provides a new dimension in work with families because it measures family strengths and weaknesses. FAM-III is based on the Process Model of Family Functioning and can be completed by preadolescent, adolescent, and adult family members.
Type of Assessment:	Two types of profiles are available for FAM. FAM-III Colorplot™ of Family Perceptions is color coded and can be used to present results to clients in an easy-to-understand way. The Progress Colorplot™ is specifically designed for displaying changes in family functioning over time.
Life Areas:	A unique feature of FAM-III is its ability to provide a multilevel (within-family) assessment of family functioning across seven universal clinical parameters: task accomplishment; role performance; communication; affective expression; involvement; control; values and norms. Also included are two performance (or validity) scales: social desirability and defensiveness.
Reading Level:	Not applicable
Completion Time:	20-60 minutes

Access:	Multi-Health Systems See address above
Pricing Information:	\$125.00 for Brief FAM Starter Kit (includes FAM-III Manual, 25 Brief FAM General Scale QuikScore™ Forms, 25 Brief FAM Dyadic Scale QuikScore™ Forms, 25 Self-Rating Scale QuikScore™ Forms, and 15 Progress ColorPlot™)

Title of Instrument:	Family-Crisis Oriented Personal Evaluation Scales (F-COPES)
Introduction:	This instrument features 30 coping behavior items that focus on the two levels of interaction outlined in the Resiliency Model: (1) Individual to family system, or the ways a family internally handles difficulties and problems between its members, and (2) family to social environment, or the ways in which the family externally handles problems or demands that emerge outside its boundaries but affect the family unit and its members. It was hypothesized that families operating with more coping behaviors focused on both levels of interaction will adapt to stressful situations more successfully.
Developer:	Developed by H.I. McCubbin, D. Olson, and A. Larsen.
Purpose:	To identify problem solving and behavioral strategies utilized by families in difficult or problematic situations
Type of Assessment:	Self-report survey questionnaire
Life Areas/Problems Assessed:	The five subscales or dimensions assessed by F-COPES are ■ Acquiring social support ■ Reframing the problem ■ Seeking spiritual support ■ Mobilizing family to acquire and accept help ■ Using passive appraisal techniques to cope with difficulties
Reading Level:	6th grade
Credentials and Training:	None necessary to administer or fill out the questionnaire
Completion Time:	15-20 minutes
Scoring Procedures:	Response to items are on a 5-point scale ranging from “strongly disagree” (1) to “strongly agree” (5). The scores for each item are simply summed for all items in a subscale to obtain a scale score, or for all items to obtain a total score.
Scoring Time:	5 minutes
Related Tests:	There are also a young adult version (Young Adult-Coping Orientation for Problem Experiences) and an adolescent version of this instrument (Adolescent-Coping Orientation for Problem Experiences).

- Access: Permission to use the instrument is obtained by purchasing the book:
Family Assessment, Resiliency Coping and Adaptation: Inventories for Research and Practice by McCubbin, H.I., A. I. Thompson, and M.A. McCubbin (1996) The book is available from

The University Book Store
711 State Street
Madison, WI 53703
(800) 993-2665 x344
(608) 257-9479 FAX
info@univbkstr.com
- Inquiries: Family Stress, Coping and Health Project
University of Wisconsin-Madison
School of Human Ecology
1300 Linden Drive
Madison, WI 53706
(608) 262-5712
(608) 265-4969 FAX
manual@macc.wisc.edu
http://sohe.wisc.edu/CfFS/CfFS_main.html
- Pricing Information: \$65.00 for the manual for scoring the instrument as well as 27 other scales developed by the project (*Family Assessment, Resiliency Coping and Adaptation: Inventories for Research and Practice*). This book is a 900+ page hardcover, and the purchase price includes permission to use the instruments.

HIV/AIDS Risk Domain

The instruments recommended in this document do not include detailed assessment of HIV / AIDS risk behavior. Because applicants for drug abuse treatment who are intravenous (IV) drug users or who engage in certain types of sexual behavior are particularly at risk for the HIV infection and subsequently for AIDS, administration of an HIV / AIDS risk behavior questionnaire is recommended as a supplement to one of the comprehensive alcohol or drug problem screening instruments. The Revision Panel recommends an instrument developed by the National Institute on Drug Abuse (NIDA), the Risk Behavior Assessment Questionnaire (RBA). The RBA sections are sexual activity, sex for money / drugs, sex-related diseases, health status, and IV and needle use behavior. The RBA instrument is available from the Community Research Branch of NIDA, 301-443-6720, 5600 Fishers Lane, Rockville, Maryland 20857.

Medical and Physical Health Domain

Title of Instrument:	General Health Rating Index (GHRI)
Introduction:	A summary measure of self-evaluated health constructed from 22 items in the Health Perceptions Questionnaire
Developer:	John E. Ware, Jr., Ph.D. NEMCH-345 750 Washington Street Boston, MA 02111 (617) 636-8098 (617) 636-3229 (fax) Jware@qmetric.com
Inquiries:	John E. Ware, Jr., Ph.D. Same as above
Purpose:	A general health outcome measure that represents perceptions of current and future health as well as health worry
Type of Assessment:	Self-evaluated standardized questions and categorical ratings
Life Areas/Problems Assessed:	■ Current health ■ Health outlook ■ Health worry
Reading Level:	6th grade
Completion Time:	3–5 minutes
Credentials/Training:	None needed.
Scoring Procedures:	Favorably scored (0-100)
General:	A sensitive measure of perceived health status and outcome and a good predictor of health care utilization and costs
Related Tests:	A 5-item short form of GHRI, referred to as the GH scale, is included in the SF-36 Health Survey
Access:	Published in numerous articles and books
Pricing Information:	Free

Mental Health Domain

Title of Instrument:	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.
Developer/Address:	Wendy Reich, Ph.D. Division of Child Psychiatry Washington University School of Medicine 40 N. Kings Highway, Suite #4 St. Louis, MO 63108 (314) 286-2263 (314) 286-2265 (fax) Wendyr@twins/wustl/edu
Inquiries:	Same as above
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.
Type of Assessment:	Either paper and pencil or computer. The computerized version can be self-administered unless the adolescent has difficulty reading. Parent versions which ask about the adolescent are also used.
Life Areas/Problems Assessed:	In addition to the above, the interview begins with an overview of the child's functioning at school with friends and in after school activities. Toward the end of the interview there is a section on common psychosocial problems. The parent interview contains prenatal, perinatal, and early childhood development sections.
Reading Level:	The computer interview is at the 4th grade level.

Completion Time:	1 to 1½ hours unless the adolescent has excessive psychopathology
Credentials/Training:	Available to medical professionals and qualified researchers
General Commentary:	Although the questions are written out for the interviewer in a typical structured format, the instrument includes features of the semi-structured interviews (such as probes) to be used when the subject does not appear to understand the question or gives a vague response. The interviewer is also allowed to give examples and collect examples from the respondent. There is a DICA-A for interviewing the adolescent respondent and a version for interviewing the parent about the adolescent. Of course, interviews with or about adolescents who manifest a great deal of psychopathology will take longer. Psychometric data on DICA show good test-retest reliability (Welner et al., 1987; Reich et al., unpublished data, 1997; Reich et al., unpublished data, 1998). DICA is also available in a computerized version. Adolescents are able to self administer the instrument or have it administered to them.
Related Tests:	Children's Semi-structured Interview for the Genetics of Alcohol (CSSIGA). Based on DICA but with an even more detailed substance abuse section. Some psychiatric diagnoses are omitted.
Access:	Wendy Reich, Ph.D. See address above
Source of Psychometrics:	Welner, Z.; Reich, W.; Herjanic, B.; Jung, K.; and Amado, K. Reliability, validity, and parent-child agreement studies of the Diagnostic Interview for Children and Adolescents (DICA). <i>Journal of American Academic Child Psychiatry</i> 26:649-653, 1987.

Title of Instrument:	Revised Behavior Problem Checklist
Introduction:	This is a simple checklist that can be used by anyone.
Developers:	Herbert C. Quay, Ph.D. University of Miami Donald R. Peterson, Ph.D. Rutgers University
Purpose:	This instrument offers a simple checklist of potential problem behaviors to be filled out by parent, guardian, or anyone who is knowledgeable about the youth.
Type of Assessment:	A two-page checklist of problem behaviors. The person filling out the form is to indicate the extent to which the behavior is mild, severe, etc.
Life Areas/Problems Assessed:	Checklist includes behaviors indicating potential problems with self-esteem, peer and family relationships, and school performance.
Reading Level:	8th grade or below
Credentials/Training:	No training is necessary.
Completion Time:	5–10 minutes at most
General Commentary:	This form is a simple checklist, to be completed by a parent, guardian, or anyone who is knowledgeable about the youth, regarding potential problem behaviors. The instrument collects information in six problem areas: (1) conduct disorder, (2) socialized aggression, (3) attention problems, (4) anxiety or withdrawal, (5) psychotic behavior, and (6) motor excess.
Reviewed in:	<i>Mental Measurements Yearbook</i> , 11th ed.

Title of Instrument:	Youth Self-Report (YSR)
Introduction:	This is a 112-item instrument for adolescents (11 to 18 years of age) to report their competencies and problems. It obtains an adolescent's own views of self-functioning. It yields two competency scale scores (activities and social relationships), eight syndrome scores, plus internalizing, externalizing, and total problems scores for both genders. For males there is an additional syndrome, self-destructive identity problems. The syndrome scores are ■ Anxious/depressed ■ Withdrawn ■ Somatic complaints ■ Social problems ■ Attention problems ■ Thought disorders ■ Delinquency ■ Aggressive behavior
Developer/ Address:	T.M. Achenbach, Ph.D. Department of Psychiatry University of Vermont 1 South Prospect Street Burlington, VT 05401-3456
Inquiries:	ChildBehavior Checklist (802) 656-8313 (802) 656-2602 (fax) checklist@uvm.edu website: http://checklist.uvm.edu
Purpose:	To assess behavioral and emotional problems and competencies
Type of Assessment:	Self-report
Life Areas/Problems Assessed:	YSR takes about 15 to 20 minutes to complete and requires a 5th grade reading ability. YSR has been found to correctly classify 83 percent of a sample of 1,054 referred and 1,054 non-referred ("normal") children according to Achenbach, 1991. The subscales of YSR that might appear to be most relevant for assessment of drug-using adolescents are "delinquent" and "aggressive." These two problem scales, together with the "social" competence scale, can add to the evaluation of an adolescent's social lifestyle problem area. The remaining seven problem scales of YSR can add to the evaluation of the psychological problem area of the adolescent client.

Reading Level:	5th grade
Completion Time:	15 to 20 minutes
Credentials/Training:	Self-administered, but users should have knowledge of standardized assessment at master's level
Scoring Procedures:	Hand, computer machine readable, or client entry
Scoring Time:	10 minutes by hand, 4 minutes by computer
Related Tests:	Child Behavior Checklist, Teacher Report Forms; Semistructured Clinical Interview for Children and Adolescents
Access:	T.M. Achenbach, Ph.D. See address above
Pricing Information:	\$10.00 for 25 YSR forms \$25.00 for the manual (221 pages) \$220.00 for IBM and Apple II computer scoring programs (optional)
Reviewed in:	<i>Mental Measurements Yearbook</i> , 13th ed.

School Domain (Achievement)

Title of Instrument:	Wide Range Achievement Test 3rd Edition (WRAT-3)
Introduction:	This is a well-standardized test that is widely used with children, adolescents, and adults for a quick evaluation of reading, spelling, and arithmetic skills and performance. Two alternate versions of the test are available (blue and tan forms).
Developer:	Judith McWatters, Director Wide Range, Inc. 15 Ashley Place, Suite 1A Wilmington, DE 19804 (800) 221-9728 (302) 652-1644 (fax)
Inquiries:	Judith McWatters, Director See address above
Purpose:	WRAT-3 can be used as pre- and posttest or combined for a more comprehensive test. Items on the two versions are comparable in item difficulty and content but contain different items.
Type of Assessment:	Scholastic skills
Reading Level:	Age 5
Completion Time:	20 to 30 minutes
Scoring Procedures:	Norms are based on national, stratified sample. The manual contains grade equivalents, standard scores, and percentile ranks.
Scoring Time:	The test can be scored by hand or computer.
Access:	Judith McWatters, Director Wide Range, Inc. See address above
Pricing Information:	\$38.00 for the manual (administration and scoring) \$25.00 for test forms (package/25) \$12.00 for reading/spelling plastic cards for the administration of the reading and spelling tests

\$18.00 for profile forms (package/25)
\$110.00 for starter set (including each of the above)
\$99.00 for computer scoring software

Reviewed in: *Mental Measurements Yearbook*, 12th ed.

Appendix C

Drug Identification and Testing in The Juvenile Justice System

This appendix on laboratory testing is an excerpt from *Drug Identification and Testing in the Juvenile Justice System*, by Ann H. Crowe, American Probation and Parole Association, and Shay Bilchik, Administrator, Office of Juvenile Justice and Delinquency Prevention. Published by the Office of Justice Programs, U.S. Department of Justice in May 1998.

Drug Recognition Techniques

Drug recognition techniques were developed originally by the Los Angeles Police Department to help law enforcement officers identify drug-impaired motorists in a traffic arrest situation. The Orange County, California, Probation Department later applied and adapted the techniques for use in community corrections settings, using their findings to expand the period for detecting illicit drug use.

Drug recognition techniques are systematic and standardized evaluation techniques for detecting signs and symptoms of substance abuse. All the areas evaluated are observable physical reactions to specific types of drugs. Three key elements in the process are

- Verifying that the person's physical responses deviate from normal
- Ruling out a cause that is not drug related
- Using diagnostic procedures to determine the category or combination of substances that are likely to cause the impairment

A skilled practitioner can determine, with a high degree of accuracy, whether a youth has used some substances recently. Drug recognition techniques include the identification of the category of chemical substances ingested, although it is not possible to identify specific drugs within a classification. These techniques can determine whether a youth currently is under the influence of substances or has used a particular drug or combination of drugs within 72 hours of ingestion. However, it is not possible to determine the amount of the substance consumed.

Using drug recognition techniques is cost efficient because they often can eliminate the need for costly urinalysis by screening out those youth who do not show symptoms of current or recent substance use. This does not mean these youth have not used illicit drugs; however, if the

symptoms are not apparent through drug recognition techniques, it is unlikely there is a sufficient quantity of most drugs, or their metabolites, left in the body for urinalysis to produce a positive test result. (Marijuana and PCP may be exceptions, as low levels sometimes can be detected through urinalysis for as long as 3 to 4 weeks.) Initial training for staff to become proficient in using these techniques can be costly, but once the staff are trained, ongoing expenses are minimal.

Use of drug recognition techniques provides immediate results with which to confront youth. These techniques are minimally intrusive in detecting illicit drug use, compared with the collection of body fluids required for urinalysis. The process is systematic and standardized, reducing the possibility of bias or error by trained staff.

Not all categories of drugs are equally detectable using drug recognition techniques, and the specific drugs ingested cannot be determined. Thus, the techniques used alone may not be conclusive in determining the exact substance used or in detecting the effects of illicit drugs that have minimal influence on the physical responses measured by the techniques. There are 12 steps in the drug recognition process:

- Drug history
- Breath alcohol test
- Divided-attention psychophysical tests
- Medical questions and initial observations
- Examination for muscle rigidity
- Examination for injection sites
- Examination of vital signs
- Darkroom examination
- Examination of the eyes
- Youth's statements and additional observations by staff
- Opinions of the evaluator
- Toxicological examination

It is imperative that practitioners be well trained in using these techniques and that each step be followed precisely to preserve the credibility and integrity of the drug recognition process.

Chemical Testing

Chemical testing is the most physically intrusive and the most expensive of the three methods of identifying illicit drug use; however, it is also the most accurate. Several scientific methods are available for detecting illicit drug use in individuals, including urinalysis, blood analysis, hair analysis, and saliva tests. However, saliva and breath analysis for alcohol and urinalysis for drugs other than alcohol are the methods currently recommended because they are reliable and relatively inexpensive compared with other methods of chemical testing.

Immunoassay tests generally are used for initial tests, and they are considered reliable for detecting the presence of illicit drugs in a person's system. These tests depend on naturally occurring reactions between antibodies and antigens. A specific antibody can be produced to react with a particular antigen, such as a drug. A "tag" is chemically attached to a sample of the illicit drug to be detected.

Immunoassay procedures vary primarily in the tag used to produce the reaction. The following immunoassay methods of urinalysis have been developed. Often, the type of tag used to produce the chemical reaction is reflected in the name of the test:

- Radioimmunoassay (RIA)
- Latex agglutination immunoassay (LAIA)
- Enzyme immunoassay (EIA)
- Fluorescence polarization immunoassay (FPIA)
- Kinetic interaction of microparticles in solution (KIMS)
- Ascent multi-immunoassay (AMIA)

During an immunoassay process, the reagent (the tagged drug), the urine, and the antibody are combined. The tagged drug and the untagged drug (if present in the urine) compete for binding sites with the antibody. If a sufficient concentration of drug is in the urine, little of the tagged drug can bind with the antibody. The results will indicate the amount of tagged drug that either was or was not bound with the antibody. These results are compared with a sample containing a known amount of a drug to determine whether the urine contained a measurable amount of the substance.

Immunoassay tests provide qualitative results that indicate the presence or absence of a chemical relative to a certain cutoff level. However, except for the RIA method used primarily by the military, which provides quantitative results, they cannot indicate the actual amount of the illicit drug in the system or when it was ingested.

Chromatography methods of urinalysis extract the drug from the urine in a concentrated form. This is then processed by laboratory instruments using heat or liquids, causing the drug metabolites to separate. These methodologies include gas chromatography/mass spectrometry (GC/MS), gas chromatography (GC), and high-performance liquid chromatography (HPLC). They are the only other procedures providing a quantitative reading of the level of drugs in one's system. GC/MS is considered the "gold standard" of urinalysis testing, and although it is the most expensive, it is often used to confirm positive results of initial tests. Thin-layer chromatography (TLC) was one of the earliest methods developed, but it has been found to be extremely unreliable and is not recommended for use in the criminal or juvenile justice system (Bureau of Justice Assistance, 1990).

Breath analysis is the most commonly used and most cost-effective method of detecting

levels of alcohol intoxication. Because alcohol evaporates quickly from urine, urinalysis generally is not used to test for alcohol.

The cutoff level is the amount of drug or metabolite that must be in the specimen for a test to show a positive result. A positive test indicates the amount of drug present is above the cutoff level; negative results show there is no drug or the amount is below the cutoff level. The cutoff level is usually measured in nanograms per milliliter (ng/ml), and recommended cutoff levels for illicit drug categories have been developed by the Division of Workplace Programs, Center for Substance Abuse Prevention (CSAP) (see table below). Cutoff levels for confirmation tests are generally set lower than those for initial tests (see table on the following page). Agencies are encouraged to establish cutoff levels consistent with those recommended by the U.S. Department of Health and Human Services (HHS) guidelines (Substance Abuse and Mental Health Services Administration, 1994), as they are more likely to

be accepted by courts if the results of drug tests are challenged.

It is important that agencies conducting urinalysis have well-defined policies and procedures for doing so. Following are some issues that should be considered in developing policies. The documents listed in the references and suggested readings section of this Summary are sources of additional information on these topics.

Frequency of testing

Staff and monetary resources can be wasted if tests are conducted more often than necessary. However, testing should occur with sufficient frequency to ensure there is a reasonable opportunity to detect youth who are using illicit drugs. Policies should establish minimum frequencies for testing (e.g., once per week, three times per month). These should be flexible enough that personnel could test any youth if circumstances so dictated. For example, a youth whose behavior seems erratic might be tested

Recommended Cutoff Levels for Initial Tests

Cannabinoids*	50 ng/ml
Cocaine*	300 ng/ml
Opiates*	300 ng/ml
Amphetamines/Methamphetamines*	1,000 ng/ml
PCP*	25 ng/ml
Benzodiazepines**	100 ng/ml
Barbiturates**	300 ng/ml
Methadone**	300 ng/ml
*U.S. Department of Health and Human Services Mandatory Guidelines for Testing Levels. **Cutoff levels for these drugs are not included in the HHS. guidelines because they may be legally prescribed. The cutoff levels cited are those recommended by the scientific community. Sources: <i>Federal Register</i> 59(11):29922. American Probation and Parole Association. <i>Drug Testing Guidelines and Practices for Juvenile Probation and Parole Agencies</i>. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, 1992.	

Recommended Cutoff Levels for Confirmation Tests	
Cannabinoids*	15 ng/ml
Cocaine*	150 ng/ml
Opiates*	300 ng/ml
Amphetamines/ Methamphetamines*	500 ng/ml
PCP*	25 ng/ml
Benzodiazepines**	250 ng/ml
Barbiturates**	250 ng/ml
Methadone**	250 ng/ml
*U.S. Department of Health and Human Services Mandatory Guidelines for Testing Levels. **Cutoff levels for these drugs are not included in the HHS guidelines because they may be legally prescribed. The cutoff levels cited are those recommended by the scientific community. Sources: <i>Federal Register</i> 59(11):29922. American Probation and Parole Association. <i>Drug Testing Guidelines and Practices for Juvenile Probation and Parole Agencies</i>. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, 1992.	

before the next random test time occurs. Because different drugs of abuse stay in the body for varying lengths of time, ranging from a few hours to several days (see table on following page), it is helpful to know the youth's drug(s) of choice to decide how often he or she should be tested. Many programs test youth initially and periodically during their time in the program for a broad range of illicit drugs, but most of the time they test only for those substances the youth has been known to use. Another factor to consider is the youth's progress in the program. Initially, testing may be performed much more often, with testing frequency being reduced for youth whose results are consistently negative. A response to the youth should always be made following testing, whether the results are positive or negative. A realistic appraisal of staff tasks also is important. Thus, caseloads and other responsibilities of staff must be considered when deciding how often to test.

Some agencies conduct testing at set times, while others advise youth that they are subject

to testing at any time. Scheduling tests can help staff members organize their tasks and time efficiently. However, when juveniles know they will be tested at certain times, they may learn to schedule their substance abuse accordingly to avoid detection. Therefore, random testing is generally recommended.

Observed specimen collection

To avoid the possibility of specimens being adulterated or otherwise tampered with, urination should be observed by a staff member who is the same sex as the youth. There are two ways youth may attempt to taint a urine sample: by ingesting something before giving the sample or by adding something to the specimen after it leaves the body. Examples of substances youth might try to ingest before a drug test include large quantities of water, acidic liquids (such as lime or lemon juice or vinegar), diuretics, pectin, and oriental tea. Water, bleach, toilet bowl cleaner, and soap are examples of substances youth might try to add to a specimen during or after urination. Most of these substances will

Approximate Duration of Detectability of Selected Drugs*	
Drug	Duration of Drug Detectability
Alcohol	Very short**
Amphetamine	2–4 days
Methamphetamine	2–4 days
Barbiturates	
• Most types	2–4 days
• Phenobarbital	Up to 30 days
Benzodiazepines	Up to 30 days
Cocaine metabolites	12–72 hours
Methadone	2–4 days
Opiates (heroin, codeine, morphine)	2–4 days
Cannabinoids (marijuana)	
• Casual use	2–7 days
• Chronic use	Up to 30 days
Phencyclidine (PCP)	
• Casual use	2–7 days
• Chronic use	Up to 30 days
*These provide only general guidelines. Many variables should be considered in interpreting duration of detectability. These include drug metabolism and half-life, the youth's physical condition, the youth's fluid balance and state of hydration, and the route and frequency of ingestion. **The period of detection depends on the amount consumed. Approximately 1 ounce of alcohol is excreted per hour. Source: Division of Workplace Programs, Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.	

not affect the accuracy of most drug tests unless the amount of drug remaining in the youth's system is already very close to the cutoff level. Test manufacturers also have taken steps to design tests that detect adulterants or ensure specimens are brought to the proper pH level before they are analyzed. Another ploy some youth might use if not supervised is to substitute a specimen they have taken earlier or one from another individual. A substitution should be easily detectable by the temperature of the sample; some collection cups now have temperature strips to ensure the sample is consistent with body temperature. Youth also might make a sample useless by punching a

hole in the collection cup. Because of all these possibilities, it is recommended that collection of specimens be observed to rule out any potential for adulteration, switching of samples, or tampering with collection cups.

Chain of custody

There must be a record of the whereabouts and persons handling the urine specimen and test results at all times. This includes documentation of the specimen collection; handling, storage, transportation, and testing; and dissemination of results. All drug-testing specimens, supplies, and equipment should be kept in a locked storage area.

Onsite testing or contracting for services

There are both instruments and field kits that can be used by agency personnel to conduct initial immunoassay tests. If used according to manufacturer's directions, these provide accurate qualitative results. However, it is also possible to contract with a laboratory to analyze the specimens collected from youth. Volume of testing, staff time, training level for processing tests, the time required to obtain results, and the availability of laboratories will be factors to consider in selecting either onsite or laboratory services. Some programs use a combination of onsite and laboratory testing. For example, they may conduct initial tests onsite and, if necessary, send positive tests to a laboratory for confirmation. Using commercial laboratories, health departments, and forensics laboratories might be explored.

Safety measures

One aspect of safety includes procedures for handling and testing urine specimens. There are no known cases of transmission of HIV through laboratory contact with urine. However, it is wise for personnel to take standard precautions when handling urine to protect themselves from any potential disease transmission. Safety procedures should include wearing rubber gloves, lab coats, and goggles.

Safety measures also should be employed to protect the specimens. Therefore, rules should include no smoking, eating, or drinking in the area where specimens are stored or handled. No food should be in the same refrigerator with specimens.

Safety concerns also should be related to the youth in the program. Staff should be trained to identify the possible withdrawal symptoms or side effects of chemical use that might endanger a youth's health and safety. Some substances may lead to erratic behavior that could endanger the youth or others. Staff should know how to intervene appropriately if these are noticed. If

youth have injected drugs, it may be important for them to receive counseling and testing for HIV/AIDS and other blood-borne infections.

Finally, safety also refers to the development of guidelines for staff and youth when revealing positive results to juveniles. When working with potentially violent youth, staff should be trained to use designated procedures in case of an emergency.

Quality assurance and quality control

Steps should be taken by agency personnel or laboratories to document the accuracy and reliability of the testing program regularly. Without such measures, the program may be subject to legal liability issues.

Report of results

Onsite noninstrument tests will yield virtually instant results. However, onsite instrument and laboratory testing procedures will take longer. For youth, timely responses to their behavior are important. The type of agency and the way results will be used also will affect how soon results may be needed. For detention programs, results may be needed before the youth goes to court. Thus, the ACA/IBH project recommends "[s]pecimen collection should take place during the intake process, and testing should occur before the pre-hearing or within 48 hours of detention" (American Correctional Association/Institute for Behavior and Health, 1995, p. 4). Initial information also is needed for case planning. The American Probation and Parole Association Guidelines state the turnaround time for receiving a report of results "should be 72 hours or less from the time the specimen reaches the laboratory until the results are received by agency personnel" (APPA, 1992, p. 49).

Confirmation

A positive result may be confirmed in three ways: a statement of admission by the youth, a second test using the same methodology, or a

second test using a different methodology. For legal proceedings, especially if a youth's freedom may be limited, a second test using a different methodology may be necessary. Confirmation by GC/MS is required in some jurisdictions because it is the most accurate test. If results are going to be used for treatment planning or for internal program procedures, the other methods of confirmation may be acceptable.

Responding to results

Unless a response follows every test administered, youth may receive an unintended message that drug testing is simply procedural and does not have much impact. Chemical testing, assessments, and drug recognition techniques are tools available to juvenile justice agencies and practitioners to identify and monitor substance abuse among youth. The most critical element of any program is how the results are used to intervene with the youth.

References

- American Correctional Association/Institute for Behavior and Health, Inc. *Testing Juvenile Detainees for Illegal Drug Use*. Final report. Laurel, MD: American Correctional Association, 1995.
- American Probation and Parole Association. *Drug Testing Guidelines and Practices for Juvenile Probation and Parole Agencies*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, 1992.
- Bureau of Justice Assistance. *A Comparison of Urinalysis Technologies for Drug Testing in Criminal Justice*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance, 1990.
- Substance Abuse and Mental Health Services Administration. Mandatory guidelines for Federal workplace drug testing programs. *Federal Register* 59(110):29921-29922, 1994.

Appendix D

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- TIP 2** *Pregnant, Substance-Using Women* **BKD107**
- TIP 5** *Improving Treatment for Drug-Exposed Infants* **BKD110**
- TIP 6** *Screening for Infectious Diseases Among Substance Abusers* **BKD131**
- TIP 11** *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* **BKD143**
- TIP 13** *The Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders* **BKD161**
- TIP 14** *Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment* **BKD162**
- TIP 16** *Alcohol and Other Drug Screening of Hospitalized Trauma Patients* **BKD164**
- TIP 18** *The Tuberculosis Epidemic: Legal and Ethical Issues for Alcohol and Other Drug Abuse Treatment Providers* **BKD173**
- TIP 21** *Combining Alcohol and Other Drug Abuse Treatment With Diversion for Juveniles in the Justice System* **SMA 08-4073**
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- TIP 39** *Substance Abuse Treatment and Family Therapy* **SMA 12-4219**
- TIP 40** *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction* **SMA 07-3939**
- TIP 41** *Substance Abuse Treatment: Group Therapy* **SMA 09-3991**
- TIP 42** *Substance Abuse Treatment for Persons With Co-Occurring Disorders* **SMA 08-3992**
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- TIP 46** *Substance Abuse: Administrative Issues in Outpatient Treatment* **SMA 06-4151**
- TIP 47** *Substance Abuse: Clinical Issues in Outpatient Treatment* **SMA 06-4182**
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