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Chapter 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 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.

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Chapter 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; 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 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.

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