Published in final edited form as:
J Child Adolesc Subst Abuse. 2010 January ; 19(1): 33–47. doi:10.1080/10678280903400578.

An In-Depth Survey of the Screening and Assessment Practices of Highly Regarded Adolescent Substance Abuse Treatment Programs

JEREMY GANS,
Drug Strategies, Washington, DC, USA

MATHEA FALCO,
Drug Strategies, Washington, DC; Department of Public Health, Weill Cornell Medical College, New York, NY, USA

BRUCE R. SCHACKMAN, and
Department of Public Health, Weill Cornell Medical College, New York, NY, USA

KEN C. WINTERS
University of Minnesota, Minneapolis, MN, USA; Treatment Research Institute, Philadelphia, PA, USA

Abstract

Aims—To examine the quality of screening and assessment practices at some of the most highly regarded adolescent substance use treatment programs in the United States.

Methods—Between March and September 2005, telephone surveys were administered to directors of highly regarded programs. Several different publications and databases were then used to measure the quality of the screening and assessment instruments described by programs.

Results—For the 120 programs responding, 77 distinctly named instruments developed by outside sources were used at some point in the screening and assessment process, and the majority of programs also used instruments developed in-house. Fewer than half of these instruments were mentioned in the Substance Use Screening & Assessment Instruments Database. We were able to confirm that 87% of the instruments developed by others have a published manual, and 74% have been described in an article appearing in a peer-reviewed publication. Sixty-two percent were designed to be used with adolescents or adults and adolescents, while 19% were designed for adults only.

Conclusion—Although adolescent substance abuse treatment programs recognized the importance of screening and assessment, the quality of such practices varied significantly. A large number of different tools were used by some of the most highly regarded programs in the country, and many used questionnaires developed in-house that may not have had high standards of reliability and

Address correspondence to Mathea Falco, President, Drug Strategies, 1616 P Street, NW Suite 220, Washington, DC 20009, USA. dspolicy@gmail.com.

validity. Furthermore, numerous programs were using assessment instruments that were not uniquely designed for adolescents. Encouraging the adoption of standardized assessment practices would help those involved in treatment to evaluate programs and to understand the assessment process.

Keywords

adolescent substance abuse; screening; assessment; treatment

Substance abuse by adolescents continues to present a serious problem in the United States. According to a recent national survey, 27% of twelfth-graders reported having tried an illicit drug other than marijuana, 33% used marijuana within the year prior to the survey, and 28% admitted to binge drinking within the previous two weeks (National Institute on Drug Abuse [NIDA], 2005). Many adolescents need treatment (Drug Strategies, 2003), and experts agree that adolescent programs need to be designed specifically for the needs of youths rather than simple modifications of adult programs. Teenagers present different patterns of substance use, have unique developmental and social issues, and a higher prevalence of co-occurring disorders. Adolescent treatment programs must address the variety of factors that affect the adolescent's life, including education, family, recreation, peers, juvenile court, probation, and mental and physical health (Drug Strategies, 2003; Muck et al., 2001).

The first step in finding the appropriate kind of help for an adolescent with substance abuse problems is an initial screening followed by an in-depth assessment of the adolescent's presenting symptoms and needs. Treatment experts agree that programs should use standard screening and assessment instruments, which have been rigorously evaluated for reliability and validity (Drug Strategies, 2003). Such tools are designed to explore a variety of possible problem areas, including substance use, physical and mental health, educational or vocational status, family and peer relationships, and delinquency. A comprehensive assessment should examine medical, psychiatric, and family status, so that the many interrelated factors that affect the teenager's life are addressed in the treatment plan. When properly designed and administered, assessment can identify the nature and severity of drug use to determine what level of treatment is appropriate, and distinguish between problem drug users and those who are already dependent. We are not aware of any legislative mandates or state reporting requirements that could account for differences in screening and assessment practices among programs.

In a previous study conducted in 2001, we surveyed personnel from 144 highly regarded adolescent substance use treatment programs to evaluate the quality of services (Brannigan, Schackman, Falco, & Millman, 2004). Our results found substantial variation in program performance, including screening and assessment of clients. To further examine screening and assessment procedures in-depth, we conducted follow-up surveys of directors of the programs that had participated in our earlier study. Questions regarding assessment procedures were more detailed in the follow-up surveys than in the original study.

METHODS

Survey

The original sample for the 2001 study was composed of 144 adolescent substance abuse programs. In the 2001 study, an advisory panel of 22 experts on adolescent substance abuse treatment was assembled, including 10 leading researchers, 9 practitioners from nationally recognized treatment programs, and 3 senior federal policymakers. These program names and the list of experts are provided in *Treating Teens* (Drug Strategies, 2003). We asked panel members to recommend names of programs to which they would refer family or friends. In addition, programs were identified by mailing a request to alcohol and drug abuse agencies in

all 50 U.S. states as well as several national organizations and federal agencies, asking each agency to identify five adolescent treatment programs that they considered exemplary. We excluded programs that treated adolescents and adults together as well as programs located at mental health institutions. After accounting for duplicate recommendations and excluding those programs that treated adults and adolescents in the same facility, this process identified a total of 144 highly regarded programs nationally. Additional information regarding the methodology of program selection has been previously described (Brannigan et al., 2004).

At the time of this follow-up study, 138 programs were still in operation (6 of the original 144 had closed). Three surveys were administered to each program between March and September 2005: an in-depth telephone survey for program directors, and two telephone or written surveys for clinical and finance directors. In this paper we report on findings related to screening and assessment derived from responses to the telephone survey of program directors. The interviews were conducted by two researchers who utilized the same survey implementation software that immediately recorded responses. The software used was the Questionnaire Development System (QDS), from Nova Research Company in Bethesda, MD. No inter-rater reliability checks were done. Programs that were not reached were called back several times, and mailed two follow-up letters requesting their participation.

Program directors were asked in the telephone surveys whether their program conducted a screening or assessment of the client at three different stages: before or shortly after entering the program; a reassessment during the course of treatment (beyond a routine update of the treatment plan); and shortly before leaving the program. We also asked whether the program conducted an assessment of the family as well as a separate mental health assessment. For each type of assessment, we then asked the program director to identify the instruments or other assessment methods used, including: an assessment tool developed in-house; an assessment tool developed by others (and the name of the tool); a structured, clinical interview; or a non-structured or nonclinical interview. Programs were not asked to specify whether the interviews used materials developed in-house or developed by others.

We recorded verbatim the names of all assessment tools developed by others that programs reported using. Twenty-two of the programs reported using one or more instruments that were unclear to the researcher, because they were incomplete, uncertain, or misspelled. In total, these 22 programs used 40 unclear instruments. We were able to re-contact 17 of the 22 programs that reported using at least one of these questionnaires to clarify the name or description of these instruments.

We used several different approaches to measure the quality of these instruments. We determined whether the instruments are mentioned in the University of Washington's Substance Use Screening & Assessment Instruments Database, which is a collection of information on 322 screening and assessment instruments. Among those instruments mentioned we determined whether the database indicates that they were "widely used and have proven reliability and validity" (Seattle, WA; Alcohol and Drug Abuse Institute, 2006). We also determined whether the instruments were mentioned in a recently published guide to assessing alcohol use for clinicians and researchers (Winters, 2003). In addition, we examined whether the instruments had either a published manual or a description in a peer-reviewed journal article. To do this, we consulted Ovid Technologies,a Inc.'s Health and Psychosocial Instruments (2006a) and Mental Measurements Yearbook Database (2006b), *Assessing Alcohol Problems* (Allen & Wilson, 2003), the *Treatment Improvement Protocol* series (Winters, 1999), and Google. Finally, using these sources we determined whether the instruments were originally designed for adolescents, adults, or both.

RESULTS

Survey Response Rate

We received an 87% response rate (120 programs of the 138 still in operation) to the program director survey. Program characteristics for the 120 respondents have been reported elsewhere (Schackman et al., 2007).

Screening and Assessment Methods

Table 1 shows the number of programs using a tool developed by others or a structured clinical interview alone or in combination with other tools by type of assessment. All but one of the 120 programs conducted some sort of screening or assessment of the client before or shortly after entry into treatment. At this stage, 93 programs (78%) used a screening or assessment tool developed by others; 106 programs (88%) conducted a structured clinical interview. Either before or shortly after clients entered into treatment, 43 programs (36%) conducted a non-structured or nonclinical interview with the client, and 82 programs (68%) used a screening or assessment tool developed in-house. Only 5 of the 120 programs did not conduct a reassessment of the client during the course of treatment, beyond a routine update of the treatment plan. To reassess the client, 65 programs (54%) used a screening or assessment tool developed by others to reassess the client; 45 programs (38%) used a non-structured or non-clinical interview, and 58 programs (48%) used a tool developed in-house.

Only 8 of the 120 programs did not conduct an assessment of the client shortly before leaving the program. At this stage, 43 programs (36%) used a screening or assessment tool developed by others. Forty-six programs (38%) used a non-structured or nonclinical interview with the clients shortly after they exited the program, and 62 (52%) used a tool developed in-house.

Few programs exclusively used questionnaires developed in-house to assess clients. Five programs used only in-house questionnaires to assess clients before or shortly after they entered the program. Six programs used only in-house questionnaires to reassess clients at some point during treatment, and nine programs used only in-house questionnaires to assess clients shortly before leaving the program.

An even smaller number of programs exclusively used in-house questionnaires and non-structured or nonclinical interviews to assess clients: one program before or shortly after clients entered, three programs to reassess clients, and six programs shortly before clients exited.

Screening and Assessment Instruments Used

The 120 programs in our sample used 77 distinctly named instruments developed by outside sources at some point in the screening and assessment process. Table 2 shows the questionnaires developed by others that were most frequently used by programs. The complete list of tools developed by others is in the Appendix.

The most widely used externally developed tool for these assessments is the Substance Abuse Subtle Screening Inventory (SASSI) (Reynolds, 1987), which 29 programs reported using at some point during the screening and/or assessment process. Twenty-one programs reported using American Society of Addiction Medicine (ASAM) (American Society of Medicine, 2001) guidelines. Unlike other tools we assessed, the ASAM guidelines do not provide a specific instrument for assessment. However, we decided to include ASAM because it is a resource used by many of the programs that participated in the survey and used by them as a screening or assessment tool. The other tools used by more than 10 programs are Minnesota Multiphasic Personal Inventory (MMPI/MMPIA) (13 programs) (Butcher, Graham, Williams, & Ben-Porath, 1990), Beck Depression Inventory (BDI) (12 programs) (Beck, Ward,

Mendelson, Mock, & Erbaugh, 1961), and Global Appraisal of Individual Needs (GAIN/GAIN-I/GAIN-Q) (12 programs) (Dennis, 1999).

Before or shortly after the adolescent entered treatment, more programs used the SASSI than any other tool (27 programs), while 15 programs used ASAM criteria, 11 programs used some form of the GAIN, 9 programs used the ASI, 6 programs used the Michigan Alcoholism Screening Test (MAST) (Selzer, 1971), 5 programs used the MMPI, and 5 programs used the Comprehensive Addiction Severity Inventory (CASI) (Meyers, McLellan, Jaeger, & Pettinati, 1995). The most popular tool for reassessment was ASAM guidelines (15 programs), which was the only one that more than 10 programs used. The next most widely used reassessment tools were the GAIN (seven programs), SASSI (six programs) and BDI (six programs). The only tool used by at least 10 programs shortly before clients left the program was ASAM guidelines.

Fewer than half of the instruments used by programs (29 out of the 77) were mentioned in the University of Washington's Substance Use Screening & Assessment Instruments Database, which is a collection of information on 322 screening and assessment instruments (2006). Of these 29 instruments, 12 were marked as measures that were "widely used and have proven reliability and validity." A chapter on adolescent assessment (Winters, 2003) that was included in NIAAA's recent handbook on assessing alcohol problems (Allen & Colombus, 2003) reviewed 13 of the 77 instruments.

We were able to confirm that 67 of the instruments (87%) had a published manual, and 57 instruments (74%) had been described in an article appearing in a peer-reviewed publication. Seven of the instruments were state-required tools. For the remaining instruments, a "no" signifies that we were able to confirm that the instrument had not been tested in a published manual or peer-reviewed article, while an "unknown" signified that we were unable to confirm the existence of a published manual or any peer-reviewed citations for the instrument (see Appendix).

Forty-eight of the tools (62%) were designed to be used with adolescents or adults and adolescents, while 15 instruments (19%) were designed for adults only. For the remaining 16 instruments (21%), we were unable to find any data about the target populations. Six programs were exclusively using instruments that were designed for adults only.

Assessment of the Family and Mental Health

Almost all (115) of the 120 programs reported conducting an assessment of the adolescent's family. Fifty programs (53%) used a non-structured or non-clinical interview to assess the family, and 67 (70%) used a tool developed in-house. Eighty-nine programs used a screening or assessment tool developed by others or a structured, clinical interview. In contrast, 58 programs used either a screening or assessment tool developed in-house or a non-structured or nonclinical instrument.

Almost all (112) of the 120 programs reported that they used a separate mental health instrument during the screening and assessment process. Thirty-four programs (36%) used a non-structured or nonclinical interview as a separate mental health instrument, and 46 (48%) used a tool developed in-house. Eighty-nine programs used a screening or assessment tool developed by others or a structured, clinical interview, while 40 programs used either a screening or assessment tool developed in-house or a non-structured or nonclinical instrument.

The most popular instruments used to assess mental health that were developed by others were MMPI/MMPIA (nine programs), the BDI (seven programs) and the Modified MINI Screen

(MMS)/MINI Kid/Modified Mini Mental State Exam (MMMSE) (four programs) (Teng & Chui, 1987).

DISCUSSION

Not since the Owen and Nyberg study (1981) has an investigation examined the screening and assessment practices of a large national sample of adolescent treatment programs that are highly regarded by experts in the field. Several positive findings emerged from this study. First, very few programs exclusively used questionnaires developed in-house. In addition, almost all programs conducted an assessment at each of the stages we described, including reassessment during treatment and assessment of the adolescent's mental health.

However, assessment practices among the 120 programs in our study varied widely. A large proportion of programs (68%) were using questionnaires that were developed in-house before or shortly after clients entered the program. A number of the tools developed by others are of questionable reliability and validity.

In addition, the number of instruments currently used overall is high. While some programs used only one or two instruments throughout treatment, others used more than 10 different instruments to screen and assess clients. No single instrument or group of instruments dominated assessment practices, suggesting that each treatment program had its own way of assessing clients. A fairly large number of programs stated that they used ASAM guidelines to assess clients, but since ASAM guidelines can be applied in a variety of ways, we could not be sure how each program was interpreting and assessing these criteria in practice. Furthermore, no single instrument was used by more than two programs to assess the family, suggesting that a lack of well-known or well-regarded family assessment instruments.

In addition, numerous tools used by the adolescent substance abuse treatment programs in our study were not developed specifically for adolescents. Six programs were using only instruments designed exclusively for adults. Adolescents and adults have distinct developmental and mental health needs that must be taken into account by the assessment instruments used (Drug Strategies, 2003).

Our study had several limitations. We did not ask program directors to clarify between screening and assessment practices. Therefore, we did not know if instruments were being used for an initial screening to determine suitability for treatment or for a more comprehensive assessment used in designing a treatment plan. In addition, we did not ask if programs conducted a more comprehensive assessment of clients after they were admitted to the program. We also had no information on the training of the personnel who conducted the assessments. The research was intended to provide a descriptive portrait of the state of screening and assessment practices among a select group of adolescent drug treatment programs, rather than a statistical analysis of these programs. The reasons why a program chooses specific assessment instruments are worthy of further study.

We also did not have programs distinguish between interviews (either clinical or non-clinical) developed in-house and those developed by others. This limited our ability to interpret data from programs that conducted interviews instead of using pen-and-paper questionnaires.

CONCLUSION

Our study provided evidence that although adolescent substance abuse treatment programs recognized the importance of assessment in the treatment process, the quality of assessment practices varied significantly among programs. A large number of different screening and assessment tools were being used by some of the most highly regarded programs in the country,

and many used questionnaires developed in-house that may not have high standards of reliability and validity.

Although experts agreed that assessment of adolescent substance users should be designed specifically for adolescents (Drug Strategies, 2003), we found that numerous programs were using assessment instruments that were not uniquely designed for adolescents, and several programs were not using any tools specifically designed for youths. This finding suggested that many of the most highly regarded treatment programs in the country were not adequately assessing adolescent clients.

Encouraging the adoption of standardized assessment practices would help parents, youths, and others involved in treatment to evaluate programs and to understand the assessment process. State agencies, accreditation organizations, and treatment providers can all take steps to adopt screening and assessment instruments with proven reliability and validity that can be used at various stages of treatment. Accurate screening and assessment of the adolescent client, the family, and mental health issues are essential in developing and guiding successful strategies throughout the course of treatment. Our study demonstrated that the quality of screening and assessment, even among leading programs nationwide, is not yet consistent and often falls short of widely acknowledged best practices in the field.

Acknowledgments

The authors wish to acknowledge the contributions of Erick G. Rojas, Chris Russell, and Laura Burnett. This research was supported by a grant from the Robert Wood Johnson Foundation. The funding agreement ensured the authors' independence in designing the study, interpreting the data, and writing and publishing the report.

References

Allen, J.; Colombus, M., editors. Assessing alcohol problems: A guide for clinicians and researchers. 2. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism; 2003.

Allen, JP.; Wilson, VB. Assessing alcohol problems: A guide for clinicians and researchers. National Institute on Alcohol Abuse and Alcoholism; 2003. Retrieved September 1, 2006, from http://pubs.niaaa.nih.gov/publications/Assesing%20Alcohol/index.htm

American Society of Medicine. Patient placement criteria, revised. Chevy Chase, MD: American Society of Addiction Medicine; 2001.

Beck AT, Ward CH, Mendelson M, Mock J, Erbaugh J. An inventory for measuring depression. Archives of General Psychiatry 1961;4:561–571. [PubMed: 13688369]

Brannigan R, Schackman BR, Falco M, Millman RB. The quality of highly regarded adolescent substance abuse treatment programs: Results of an in-depth national survey. Archives of Pediatrics and Adolescent Medicine 2004;158:904–909. [PubMed: 15351757]

Butcher, JN.; Graham, JR.; Williams, CL.; Ben-Porath, YS. Development and use of the MMPI-2 content scales. Minneapolis, MN: University of Minnesota Press; 1990.

Dennis, M. Global appraisal of individual needs (GAIN): Administration guide for the GAIN and related measures. Chestnut Health Systems; 1999. Retrieved October 31, 2006, from www.chestnut.org/li/gain/gadm1299.pdf

Drug Strategies. Treating teens: A guide to adolescent drug programs. Washington, DC: Author; 2003.

Jesness, CF. The Jesness inventory. North Tonawanda, NY: Multi-Health Systems; 1991. (rev. ed.)

Kansas Social and Rehabilitative Services, Alcohol and Drug Abuse Services. Kansas client placement criteria. Topeka, KS: Author; 1995.

Meyers K, McLellan AT, Jaeger JL, Pettinati HM. The development of the comprehensive addiction severity index for adolescents (CASI-A): An interview for assessing the multiple problems of adolescents. Journal of Substance Abuse Treatment 1995;12:181–193. [PubMed: 7474026]

Millon, T. Millon Clinical Multiaxial Inventory (MCMI). Minneapolis, MN: National Computer Systems; 1983.

Millon, T.; Millon, C.; Davis, RD. Millon Adolescent Clinical Inventory. Minneapolis, MN: NCS Pearson; 1993.

Muck R, Zempolich KA, Titus JC, Fishman M, Godley MD, Schwebel R. An overview of the effectiveness of adolescent substance abuse treatment models. Youth Society 2001;33:143–168.

National Institute on Drug Abuse. University of Michigan, Institute for Social Research. Monitoring the future, national survey results on drug use. Bethesda, MD: National Institute on Drug Abuse, U.S. Dept. of Health and Human Services, National Institutes of Health; 2005.

Ohio Department of Mental Health. SOQIC user manual. Columbus, OH: Author; 2004.

Ovid Technologies, Inc. Ovid health and psychosocial instruments. 2006a. Retrieved September 1, 2006, from www.ovid.com

Ovid Technologies, Inc. SilverPlatter mental measurements yearbook database. 2006b. Retrieved September 1, 2006, from http://ovidsp.ovid.com/

Owen PL, Nyberg LR. Assessing alcohol and drug problems among adolescents: Current practices. Journal of Drug Education 1981;13(3):249–254.

Reynolds, WM. Reynolds Adolescent Depression Scale professional manual. Odessa, FL: PAR/ Psychological Assessment Resources; 1987.

Schackman BR, Rojas EG, Gans J, Falco M, Millman RB. Does higher cost mean better quality? Evidence from highly-regarded adolescent drug treatment programs. Substance Abuse Treatment, Prevention, and Policy 2007;2(23):1–6.

Substance use screening & assessment instruments database. Seattle, WA: Alcohol and Drug Abuse Institute, University Washington; 2006. Retrieved September 1, 2006, from http://adai.washington.edu/instruments

Selzer ML. The Michigan alcoholism screening test: The quest for a new diagnostic instrument. American Journal of Psychiatry 1971;127:1653–1658. [PubMed: 5565851]

Teng EL, Chui HC. The Modified Mini-Mental State (3MS) examination. Journal of Clinical Psychiatry 1987;48:314–318. [PubMed: 3611032]

Winters, KC. Vol. 31. Department of Health and Human Services; 1999. Screening and assessing adolescents for substances use disorders treatment improvement protocol (TIP). Retrieved September 1, 2006, from www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.54841

Winters, KC. Screening and assessing youth for drug involvement. In: Allen, J.; Colombus, M., editors. Assessing alcohol problems: A guide for clinicians and researchers. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism; 2003. p. 101-124.

TABLE 1

Number of Programs Using Assessment Tools at Each Stage (of 120 Total Programs)

Action	Before or shortly after entry	Reassessment	Shortly before exit
Conduct some sort of screening or assessment on the client	119 programs	115 programs	112 programs
Do not conduct screening or assessment of the client	1 program	5 programs	8 programs
Use a tool developed by others and/or a structured clinical interview	113 programs	97 programs	86 programs
Use both a tool developed by others and other tools	90 programs	56 programs	37 programs
Use a tool developed by others only	3 programs	9 programs	6 programs
Total number of programs using a tool developed by others	*93 programs*	*65 programs*	*43 programs*
Use both a structured clinical interview and other tools	103 programs	68 programs	55 programs
Use a structured clinical interview only	3 programs	12 programs	19 programs
Total number of programs using a structured clinical interview	*106 programs*	*80 programs*	*74 programs*
Use both a tool developed by others and a structured clinical interview	86 programs	48 programs	34 programs
Use a screening or assessment tool developed in-house	82 programs	58 programs	62 programs
Use a non-structured or nonclinical interview	43 programs	45 programs	46 programs

Note. “Other tools” include screening or assessment tools developed in-house and non-structured or non-clinical interviews.

TABLE 2

Number of Programs Using Most Frequently[a] Used Instruments Developed by Others at Each Stage (of 120 Total Programs)

Name of instrument	Total number of programs using instrument	Number of programs using instrument before or shortly after entry	Number of programs using instrument for reassessment during the course of treatment	Number of programs using instrument shortly before client exits
Substance Abuse Subtle Screening Inventory (SASSI) (60)[b,c,d]	29	27	6	2
American Society of Addiction Medicine (ASAM) Placement Criteria (15)	21	15	15	10
Minnesota Multiphasic Personal Inventory (MMPI/MMPIA) (46)	13	5	5	3
Beck Depression Inventory (BDI) (17) [c,d]	12		6	
Global Appraisal of Individual needs (GAIN/GAIN-I/GAIN-Q) (36)[b,c,d]	12	11	7	3
Addiction Severity Index (ASI/Teen-ASI) (16)[b,c,d]	8	8	3	2
Child Behavior Checklist (CBCL) (25)	6		6	
Michigan Alcoholism Screening Test (MAST) (42)[c]	6	6		
Comprehensive Addiction Severity Index (CASI) (24)[b,c]	5	5		2

[a] Table includes instruments used in one of the three above stages of assessment by at least five programs.

[b] Mentioned by Ken Winters in his article in *Assessing Alcohol Problems: A Guide for Clinicians and Researchers* (2003).

[c] Mentioned in University of Washington's Substance Use Screening & Assessment Instruments Database (2006).

[d] Marked in University of Washington's Substance Use Screening & Assessment Instruments Database (2006) as "widely used and have proven reliability and validity." Reliability is measured by inter-rater (or joint), test-retest (or stability), and internal (or internal consistency). Validity is measured by construct, content, discriminate (convergent or divergent) and face validity. See http://lib.adai.washington.edu/instruments/glossary.htm.

Appendix

Instruments Developed by Others Used by Highly Regarded Adolescent Substance Abuse Programs*

Tool name	Published manual	Peer reviewed	Age demographic
ADIS	Yes	Yes	Adolescents
Adolescent Drug Abuse Diagnosis (ADAD)	Yes	Yes	Adolescents
Adolescent Self Assessment Profile II (ASAP)	Yes	Yes	Adolescents
Alabama Psychosocial Assessment Tool	No – training conducted by state	No	Adults and Adolescents
American Society of Addiction Medicine (ASAM) placement criteria	Yes	Unknown	Adults and Adolescents
Addiction Severity Index (ASI)/Teen ASI (TASI)	Yes	Yes	Adolescents
Alcohol Use Disorders Identification Test	Yes	Yes	Adults
Beck Depression Inventory (BDI)	Yes	Yes	Adults and Adolescents
Behavioral Emotional Rating Scale (BERS)	Yes	Yes	Adolescents
Stanford Binet Intelligence Skills	Yes	Yes	Adults and Adolescents
Brief Symptom Inventory (BSI)	Yes	Yes	Adults
Burns Anxiety Inventory	Yes	Yes	Adults
CAGE questionnaire	Yes	Yes	Adults and Adolescents
Caroll Depression Inventory	Yes	Yes	Adults
Comprehensive Addiction Severity Inventory (CASI)	Yes	Yes	Adolescents
Child Behavior Checklist (CBCL)	Yes	Yes	Adolescents
Child and Adolescent Functional Assessment Scale (CAFAS)	Yes	Yes	Adolescents
Child Michigan Alcoholism Screening Test (MAST)	Yes	Yes	Adults and Adolescents
CATS developed by Phoenix House	Yes	No	Adults and Adolescents
Conners' Rating Scales	Yes	Yes	Adolescents
Drug Abuse Screening Test (DAST-20)	Yes	Yes	Adults
Diagnostic Interview Schedule for Children (DISC)	Yes	Yes	Adolescents
Diagnostic and Statistical Manual (DSM-IV-R)	Yes	Yes	Unknown
Family Adaptation and Cohesion Scales (FACES III)	Yes	Yes	Adults and Adolescents
Family Assessment Measures (FAM/ FAM 3)	Yes	Yes	Adults and Adolescents
Family Assessment Scale	Unknown	Unknown	Unknown
Family Environment Scale	Yes	Yes	Adults and Adolescents
Form 90	Yes	Yes	Adults and Adolescents
Global Appraisal of Individual Needs (GAIN/GAIN-I/GAIN-Q)	Yes	Yes	Adults and Adolescents
Hazelden Youth 40 Questionnaire	Unknown	Unknown	Unknown
House Tree Person (H-T-P)	Yes	Yes	Adolescents

Tool name	Published manual	Peer reviewed	Age demographic
HEADSS for Adolescents	Yes	Unknown	Adolescents
Individual Addiction Profile	Unknown	Unknown	Unknown
Jesness Inventory (JI)	Yes	Yes	Adults and Adolescents
Kansas Client Placement Criteria	Yes	No	Adults and Adolescents
Millon Adolescent Clinical Inventory (MACI)	Yes	Yes	Adolescents
MAJORS Assessment System (MAS)	No	No	Adolescents
Michigan Alcoholism Screening Test (MAST)	Yes	Yes	Adults and Adolescents
Massachusetts Youth Screening Instrument (MAYSI II/MAYSI)	Yes	Yes	Adolescents
Millon Clinical Multiaxial Inventory (MCMI)	Yes	Yes	Adults
Mental Health Screening Form III developed by Project Return Foundation Inc.	Yes	Unknown	Adults
Minnesota Multiphasic Personal Inventory (MMPI/MMPIA)	Yes	Yes	Adults (Separate children's version available)
Modified MINI Screen (MMS)/ Modified Mini Mental State Exam (MMMSE)	Yes	Yes	Adults
MINI Kid	Yes	Yes	Adolescents
OASIS Comprehensive Psychosocial	Yes	No	Unknown
ODADAS Level of Care/ODADAS	Yes	No	Adults and Adolescents
Practical Adolescent Dual Diagnostic Interview (PADDI)	Yes	Yes	Adolescents
Parent Adolescent Communication Scale	Yes	Yes	Adolescents and Parents
Parenting Scale	Yes	Yes	Adolescents
Parenting Stress Index	Yes	Yes	Parents of Adolescents
Personal Experience Inventory (PEI)	Yes	Yes	Adolescents
Personality Assessment Inventory	Yes	Yes	Adults
PREPARE-ENRICH	Yes	Yes	Adults
Problem Oriented Screening Instrument for Teenagers (POSIT)	Yes	Yes	Adolescents
Psychiatric Research Interview for Substance and Mental Disorders (PRISM)	Yes	Yes	Adults
Problem Situation Inventory (PSI)	Yes	Yes	Adults
Readiness Ruler	Yes	Yes	N/a
RELATE	Yes	Yes	Adults
Reynolds Adolescent Depression Scale (RADS)	Yes	Yes	Adolescents
Salt Lake County MIS Form	Unknown	Unknown	Unknown
SAPI	Unknown	Unknown	Unknown
Substance Abuse Subtle Screening Inventory (SASSI)	Yes	Yes	Adults and Adolescents
SBSL90	Unknown	Unknown	Unknown
Self Image Profile	Yes	Yes	Adolescents

Tool name	Published manual	Peer reviewed	Age demographic
Service Utilization Form	Yes	Yes	Unknown
Stages of Change Readiness and Treatment Eagerness Scale - Socrates Screening Inventory	Yes	Yes	Adults
Solutions for Ohio's Quality Improvement and Compliance (SOQIC)	Yes	No	Unknown
Symptom Checklist-90 (SCL90-R)	Yes	Yes	Adults and Adolescents
Test of Adult Basic Education Measure (TABE)	Yes	Yes	Adults
University of Rhode Island Chance Assessment (URICA)	Yes	Yes	Adults
Value Options 27-pg Comprehensive Review	Yes	Unknown	Adults and Adolescents
Wexler Reading Assessment Tool	Unknown	Unknown	Unknown
Wisconsin Uniform Placement Criteria (UPC)	Yes	Unknown	Unknown
Woodcock Johnson	Yes	Yes	Adolescents and Adults
Wide Range Achievement Test (WRAT)	Yes	Yes	Adults and Adolescents
Youth Outcome Questionnaire (YOQ)	Yes	Yes	Adolescents
Youth Self-Report (YSR)	Yes	Yes	Adolescents

* References upon request.