EuroADAD, Developing a European version of "ASI for youths"

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Background:

The ADolescent Assessment Dialogue – ADAD, were originally developed by Alfred Friedman and Arlene Terras (1986ff) in Philadelphia USA under the name Adolescent Drug Abuse Diagnosis. It was modeled after the Addiction Severity Index with the specific focus on adolescents. In the end of the 90s the ADAD started to spread outside the USA and into Canada and Europe. In Europe, versions surfaced in Sweden, Greece and Switzerland, that all made their own translations and adaptations without any collaboration. Around 98-99 more interest concerning the ADAD came from countries such as the Netherlands, Belgium, Scotland, Germany, Norway, Finland etc. Some of the interest came from the network developed during the European research project, the IPTRP. This interest made the authors realize the need for a standardized European version of the instrument, in order to secure the quality and comparability of the instrument. Since the original ADAD had not been upgraded since 1987, this was also a possibility for the authors to use the experience that has been collected since then. The final construction of the European version can thereby also bee seen not only as a translation and an adaptation of the original instrument, but also as an upgrade. Friedman and Terras worked closely with a European group lead by David Öberg. This group is now also a part of the last year constituted "EuroADAD group" that consist of a coordination team and representatives for the national institutions that are responsible for the EuroADAD in their respective countries.

Problems and obstacles:

Introduction: When developing a cross-cultural version of the ADAD, there were primarily three types of problems which were necessary to address:

1. The heritage from the ASI: The general appearance and construction of the instrument was the same as the ASI, but the Areas are somewhat different as well as the individual items. The main differences concerning areas are that the ADAD had divided employment and Support into School and Work, the Family and Social were divided into two sections and the section of Legal problems was based on ASI-assessment of legal needs instead of a focus on criminality. As an instrument based on the ASI, some of the problems associated with the construction of this instrument were exported to the ADAD:

a: Client ratings: *Client rating of troubled and bothered.* The client rating of troubled and bothered should only be counted if the rating on this question is the same as the client rating of need of help. In reality, this means that the help rating is the only item of importance and that the instructions in this respect do not really make sense.

b: Severity ratings *Need for further treatment* has been a problematic concept since the explanations in ADAD and ASI are somewhat confusing when the interview is conducted in inpatient settings. Should the severity rating always be 0 if the client is interviewed within treatment and if so, how can the ratings provide useful information for the planning of treatment? *The description of the steps.* The steps are described as the degree of problems and in what extent treatment is necessary or not. The sense of this is

questionable since most interviewers logically connect problem severity with the level of treatment intensity and not whether treatment is necessary or not.

c: The interviewer items. As a part of the ASI/ADAD, the interviewer is asked to evaluate the psychological state of the client during the flow of the interview. Since both the lack of appropriate psychiatric competence and the inappropriateness of this "diagnostic" procedure during the interaction with the client are rules more than exceptions, this procedure is considered as a weakness of both instruments.

d: The focus on problems: Both the ADAD and the ASI are instruments which have a primary focus on problems. In the way the instructions initially were written, the interviewers normally concentrate on the negative information of the interview. Positive information and the absence of problems were often not taken in account in the ratings. This often generated too high severity ratings, which further was enhanced when computer generated summaries were used as a base for ratings.

2. The construction of the original ADAD. As opposed to the ASI, ADAD has not been revised in more than 15 years. At the same time, two decades of clinical use and several scientific studies in the U.S. have identified several items as either inconsequent, out of date, peripheral or of limited significance:

a: The name. Even though the original name "Adolescence Drug and Alcohol Diagnosis" implies the possibility of diagnosing alcohol and drug abuse, it is easy to misinterpret the name as providing diagnoses within all life areas.

b: Inconsistencies. The original instrument were inconsequent in the construction of the different areas. For example, the 30 day measure was not included or interpreted in the same way in all areas.

b: Areas. The original ADAD included the Area of "work". This Area has provided confusing results since the predictive value was absent. In order to be able to interpret the information from this area it was necessary to analyze questions in relation to the answers on other questions in a way that was almost impossible with larger data sets. In this area, the computation of composite scores was stopped since they did not provide any useful information.

3. To get beyond the cultural context. Early translations and adaptations of the different European versions of the ADAD included the problems of whether the understanding of items really covered the intentions of the original items. Since the instrument was not originally constructed for translations into other languages or intended for transferability to other cultures, the concepts were often culture specific. This phenomenon also resulted in country-specific and incomparable national adaptations.

Possibilities and solutions:

Introduction: The three types of problems with the original ADAD were addressed separately and in close collaboration with the American authors of the instrument.

1. **Solving ASI construction problems**.

a: Client ratings. The questions of *"troubled or bothered"* have been hard to interpret and of limited predictive value in statistical calculations. Furthermore, in reality, the item does not influence the severity rating, since the score on "*need for help*" always is the one to be considered. Hence, the questions of *"troubled or bothered"* have been excluded in the EuroADAD.

This simplifies both trainings and the rating of severity.

b: Severity ratings. The old descriptions of need for treatment in the severity ratings are easily interpreted as whether treatment is needed or not. The new definitions of the steps focus on a continuum from "no need for treatment/help" to "extreme need for treatment/help".

c: The interviewer items have generally been considered as a deviation from the structure of the ASI. Items concerning interviewer clinical judgement and the severity ratings at the end of each area disturbs the flow of the interview and can easily be misunderstood as a necessary task to perform during the interview. These questions are no longer a part of the EuroADAD-interview section.

d. The focus on problems. The ASI Feedback Form (AFF) is an integrated part of the EuroADAD. AFF concentrates on positive and negative aspects within every life-area, in order to lift forward strengths and the absence of problems when summarizing the interview and calculating the severity ratings.

2. The construction of the original ADAD.

a: The name. Since the instrument does not provide diagnoses in any of the areas, the original name ("Adolescence Drug and Alcohol Diagnosis"), was misleading. The acronym "ADAD" is now an abbreviation of The ADolescent Assessment Dialogue, to stress that this is an assessment in close dialogue with the client

b: Inconsistencies. The original instrument does not systematically use the 30-days measure in all life areas. This is now introduced into all areas for increased consistency of the EuroADAD.

c: The areas. Studies have concluded that the area of "work" does not contribute to predictive value of the instrument. Furthermore, "work" is seldom of general relevance for the population of clients assessed with ADAD. "Work" is now briefly addressed in the ADAD with the recommendation to complement the interview with the area of "Employment/support" from the ASI when relevant.

3. To get beyond the cultural context.

A great deal of developmental work has been focused on changes in the language of the interview items. The ambition has been to be more general, where the intention, not the exact phrasing of the question, has been in focus. This has been necessary in order to generate cross-cultural comparability and to facilitate translations from English. This work, more time-consuming than expected, has included close collaboration with the original authors, the European coordinator and the European representatives and field experts.

Conclusions and future directions:

The combination of the necessity to upgrade the instrument and close collaboration with the original authors has made a EU-version of ADAD possible, without loosing the intentions or structure of the original instrument. Years of clinical experience and several scientific studies as well as openness for the European perspective have generated a version which facilitates international studies, both across European language differences and across the Atlantic. The experiences from the revision of ADAD, especially concerning the heritage from the ASI, may be of importance for the continuous revisions of the Addiction Severity Index. Enhanced comparability between ADAD and ASI is of importance for clinical purposes and/or research needs when studying the same client from childhood to adulthood. Still, some questions of future revisions still prevail, both with the ADAD and the ASI: Protective factors, an increased focus on client strengths and abilities and comparability with versions outside Europe still are topics for the future. Hopefully, future revisions of ASI and ADAD will be more in mutual collaboration.

References:

Friedman, A., Öberg, D. & McMurphy, S. (1998) **Using the Adolescent Drug Abuse Diagnosis (ADAD) Instrument for Assessing a Newly Emerging Dependency Group: Adolescent Drug Abusers**. *ITPRP Newsletter - No. 4,* Maastricht University Press.

McLellan A T., Kushner, H., Metzger, D., Peters, R., Smith, I., Grissom, G., Pettinati, H. & Argeriou, M. (1992) **The fifth edition of the Addiction Severity Index**. *J. Subst. Abuse Treat., 9, 199-213.*

Öberg, D. Sallmén, B. & Haack, M.J. **The Adaptation of the Adolescent Drug Abuse Diagnosis (ADAD) to an International Context – the development of the euroADAD and the need for an Global Version.** Abstract, HOPE2000, Mumbay, India, November 2000.

Öberg, D., Terras A., Bergman H., Bolognini M., Friedman A. & Haack, M-J **The Development of a European version of the "Adolescent Drug Abuse Diagnosis" – the EuroADAD** Symposium; Abstract; Xth European Conference on Developmental Psychology. Uppsala, Augusti, 2001.