

The APA is offering a number of “emerging measures” for further research and clinical evaluation. These patient assessment measures were developed to be administered at the initial patient interview and to monitor treatment progress. They should be used in research and evaluation as potentially useful tools to enhance clinical decision-making and not as the sole basis for making a clinical diagnosis. Instructions, scoring information, and interpretation guidelines are provided; further background information can be found in DSM-5. The APA requests that clinicians and researchers provide further data on the instruments’ usefulness in characterizing patient status and improving patient care at <http://www.dsm5.org/Pages/Feedback-Form.aspx>.

**Measure:** LEVEL 2—Substance Use—Child Age 11–17 (adapted from the NIDA-Modified ASSIST)

**Rights granted:** This Instrument may be reproduced without permission by clinicians for use with their own patients.

**Rights holder:** National Institute on Drug Abuse (NIDA)

**To request permission for any other use beyond what is stipulated above, contact:** National Institute on Drug Abuse (NIDA)

## LEVEL 2—Substance Use—Child Age 11–17\*

\*Adapted from the NIDA-Modified ASSIST

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Sex:  Male  Female

Date: \_\_\_\_\_

**Instructions to the child:** On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you have been bothered by “having an alcoholic beverage”; “smoking a cigarette, a cigar, or pipe or used snuff or chewing tobacco”; “using drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)”; and/or “using any medicine ON YOUR OWN, that is, without a doctor’s prescription, to get high or change the way you feel.” The questions below ask about these feelings in more detail and especially how often you have been bothered by a list of symptoms **during the past two (2) weeks**. Please respond to each item by marking (✓ or x) one box per row.

|                                                                                                                                                                                                  |                                                                      |                            |                            |                            |                            |                            | Clinician Use |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|---------------|
|                                                                                                                                                                                                  |                                                                      | Not at All                 | Less Than a Day or Two     | Several Days               | More Than Half the Days    | Nearly Every Day           | Item Score    |
| During the past TWO (2) weeks, about how often did you ...                                                                                                                                       |                                                                      |                            |                            |                            |                            |                            |               |
| a.                                                                                                                                                                                               | Have an alcoholic beverage (beer, wine, liquor, etc.)?               | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |               |
| b.                                                                                                                                                                                               | Have 4 or more drinks in a single day?                               | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |               |
| c.                                                                                                                                                                                               | Smoke a cigarette, a cigar, or pipe or use snuff or chewing tobacco? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |               |
| During the past TWO (2) weeks, about how often did you use any of the following medicines ON YOUR OWN, that is, without a doctor’s prescription or in greater amounts or longer than prescribed? |                                                                      |                            |                            |                            |                            |                            |               |
| d.                                                                                                                                                                                               | Painkillers (like Vicodin)                                           | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |               |
| e.                                                                                                                                                                                               | Stimulants (like Ritalin, Adderall)                                  | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |               |
| f.                                                                                                                                                                                               | Sedatives or tranquilizers (like sleeping pills or Valium)           | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |               |
| <b>Or drugs like:</b>                                                                                                                                                                            |                                                                      |                            |                            |                            |                            |                            |               |
| g.                                                                                                                                                                                               | Steroids                                                             | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |               |
| h.                                                                                                                                                                                               | Other medicines                                                      | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |               |
| i.                                                                                                                                                                                               | Marijuana                                                            | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |               |
| j.                                                                                                                                                                                               | Cocaine or crack                                                     | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |               |
| k.                                                                                                                                                                                               | Club drugs (like ecstasy)                                            | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |               |
| l.                                                                                                                                                                                               | Hallucinogens (like LSD)                                             | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |               |
| m.                                                                                                                                                                                               | Heroin                                                               | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |               |
| n.                                                                                                                                                                                               | Inhalants or solvents (like glue)                                    | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |               |
| o.                                                                                                                                                                                               | Methamphetamine (like speed)                                         | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |               |

Courtesy of National Institute on Drug Abuse.

This Instrument may be reproduced without permission by clinicians for use with their own patients.

### **Instructions to Clinicians**

The DSM-5 Level 2—Substance Use—Child Age 11–17 is an adapted version of the NIDA-Modified ASSIST. The 15-item measure is used to assess the pure domain of alcohol, tobacco/nicotine, prescription medicine, and illicit substance use in children and adolescents. It is completed by the child prior to a visit with the clinician. Each item asks the child to rate the severity of his/her use of various substances **during the past 2 weeks.**

### **Scoring and Interpretation**

Each item on the measure is rated on a 5-point scale (i.e., 0=not at all; 1=less than a day or two; 2=several days; 3=more than half the days; 4=nearly every day). The clinician is asked to review the score of each item on the measure during the clinical interview and indicate the raw score for each item in the section provided for “Clinician Use.” Scores on the individual items should be interpreted independently because each item inquires about the use of a distinct substance. The rating of multiple items at scores greater than 0 indicates greater severity and complexity of substance use.

### **Frequency of Use**

To track change in the severity of the child’s use of alcohol, tobacco/nicotine, prescription or illicit substance over time, the measure be may completed at regular intervals as clinically indicated, depending on the stability of the child’s symptoms and treatment status. Consistently high scores on the measure may indicate significant and problematic areas for the child that might warrant further assessment, treatment, and follow-up. Your clinical judgment should guide your decision.