RECLAIMING FUTURES
Communities helping teens overcome drugs, alcohol & crime

Dual Diagnosis Screening and Assessment For Youth in the Juvenile Justice System

By Kari Collins and Michelle Kilgore for the Reclaiming Futures National Program Office

Who are the youth we are serving? Recent research points out that most often the youth we serve are involved with multiple agencies, and are dealing with a variety of issues, and may have multiple diagnoses. Front line workers in most any agency will confirm this. Adolescence is a period when young people encounter multiple, complex, and challenging developmental tasks involving significant changes in biological, social, psychological, and environmental/societal domains. Therefore, knowing how to work with the youth we serve is imperative. We cannot work in isolation. We cannot only treat their mental health needs, singularly treat their substance use disorder, or work only within one setting when we know that youth spend their days involved in multiple agencies and environments. Youth found within juvenile justice may need to be assessed for trauma, mental health and substance abuse issues. Treatment providers must be prepared to work with the multiple agencies that a youth and their family may be involved with. Those that work with youth need to consistently help them apply the insights and gains made in treatment to their daily decisions, regardless of the setting where they find themselves.

No matter what discipline, practice or agency we come from, it is important for us to establish our information gathering processes and protocols to better recognize and respond to the possibility of co-occurring diagnosis (mental health and substance use disorders) and actively understand the youth and their families involvement across the child-serving system. One of the simplest ways to ensure correct identification of needs is for an adolescent program to become co-occurring capable. In other words, the program will have integrated and coordinated services for youth across systems and diagnosis.

> ***"The evolving concept of dual diagnosis capability refers to the notion that every agency/program providing behavioral health services must have a core capacity, defined through specific components of program infrastructure like policies, procedures, clinical practice instructions and standards, and clinician competencies and scopes of practice, to provide appropriate services to the individuals and families with co-occurring mental health and substance use issues who are already coming through its doors."***
>
> ***Minkoff and Cline***

It is important to youth and their families as well as providers, that a program is structured to be culturally sensitive, developmentally appropriate, and services are integrated and coordinated (see NIDA Guidelines) in order to achieve better outcomes. These strategies are also identified within an agency assessment called the Dual Diagnosis Capability in Youth Treatment (DDCYT) tool which can help programs assess their capability to provide integrated care to youth and their families. The DDCYT measures the co-occurring capability of child and adolescent services. Aligned with the Dual Diagnosis Capability in Addictions Treatment (DDCAT) Fidelity Scale for adult services, the DDCYT consists of seven dimensions and 45 benchmark items, rated on a scale of 1-Youth Services Only, to 3 – Dual Diagnosis

Capable, to 5 –Dual Diagnosis Enhanced. The instrument is designed to explore co-occurring disorder capability of a program (e.g., outpatient, home-based, juvenile justice, residential, school behavioral healthcare) that was established to serve the needs of children and adolescents. A toolkit and best practices addendum are being developed to 1) support the individualization of child and adolescent programs from adult programs, 2) assist the development of co-occurring disorder programs and services for children and adolescents and 3) impact organizational change processes. The toolkits and a manual for the use of the Dual Diagnosis Capability in Addictions Treatment (DDCAT) Fidelity Scale are in public domain and are made available through the Co-Occurring Disorders State Incentive Grant (COSIG) initiative and Dartmouth (http://ahsr.dartmouth.edu/html/ddcat.html#toolkits).

This information is intended to assist anyone who is interested in learning more, or who wishes to use the DDCAT to assess the dual diagnosis capability of addiction treatment services, and will also help those who wish to learn about and begin to use the DDCYT. Those that may benefit from these tools include state or regional authorities (such as single state agencies), treatment program administrators, clinicians, consumers, various treatment services and researchers. To request detailed information about and the use of the DDCYT, please contact Randi Tolliver, Director Illinois Co-Occurring Center for Excellence, 1207 W. Leland Ave 5Th Floor, Chicago, Illinois 60640 United States.

Screening and Assessment ensure that agencies across the system of care can begin to recognize and respond to youth with co-occurring needs. As those within the system begin to understand the statistics around the prevalence of co-occurring disorders, they are confronted with a compelling argument for ensuring thorough screening and assessment of youth for issues such as mental health, substance abuse, and trauma. Four million children and adolescents in this country suffer from serious mental health disorders that cause significant functional impairments at home, at school, and with peers.

Of children ages 9 to 17, 21 percent (or 1 in 5) have a diagnosable mental health or addictive disorder that cause at least minimal impairment. (Substance Abuse and Mental Health Services Administration (2011). Identifying mental health and substance use problems of children and adolescents: A guide for child-serving organizations (HHS Publication No. SMA 12-4670). Rockville, MD: Author.) Each year, more than 2 million children, youth, and young adults formally come into contact with the juvenile justice system, while millions more are at risk of involvement with the system for myriad reasons (Puzzanchera, 2009; Puzzanchera & Kang, 2010). Of those children, youth, and young adults, 65–70 percent have at least one diagnosable mental health need, and 20–25 percent have serious emotional issues (Shuffle & Cocozza, 2006; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Wasserman, McReynolds, Lucas, Fisher, & Santos, 2002).

Furthermore, it is important to understand what screening and assessment are and what they can provide. Each agency may have a myriad of screenings and assessments and needs to clearly define them so that when speaking with a brother/sister agency they can

minimize duplication and consider sharing important results. For instance, when speaking with a treatment provider the term assessment may mean several things such as a psychological assessment that has a prescribed battery of specific tests that may include personality testing and IQ testing; or it could mean a bio-psychosocial which is an information gathering process to aid in treatment planning and diagnosis; or a psychiatric assessment performed by a psychiatrist. A treatment provider that uses the word "assessment" amongst juvenile justice colleagues, without clarification, would many times be assumed to be assessing for risk to reoffend, or assessing for the level of risk within a community. Often times the words "screening" and "assessment" are used interchangeably. Clarify the difference between them in meetings, conversations, and even within agencies to ensure that people are using the appropriate terminology.

Three Guiding Principles for Adolescent Screening and Assessment

- ***Young people deserve effective, appropriate care***
- ***Young people have a right to privacy and to confidential handling of any and all information they provide***
- ***Program staff must consider cultural, racial, and gender concerns in all aspects of the screening and assessment process.***

TIP 3 Screening and Assessment of Alcohol and Other Drug Abusing Adolescents

Screening generally refers to a process to identify the presence, or lack thereof, of a potential problem that may require further attention. Screenings can and should be used with all, or at least a majority of all youth seen within an agency or organization. This enables earlier interventions to occur if needed. They are meant to be quick, and simply determine the need for further assessment. Screenings are not used to provide diagnoses or develop plans for treatment. Screenings often do not require specialized training in order to administer them. When discussing the possibility of implementing a screening instrument(s), it is important to do two things. 1) Identify the problem(s) that you wish to screen for, and 2) identify an empirically supported screening instrument that is reliable and valid in order to ensure the best results.

Although it is recommended to screen the entire population served by an agency, the screening process can be distilled to a certain population, or the instrument itself may be used only for a specific population. For example, a juvenile justice agency may wish to screen youth in their facilities specifically for trauma to better inform the need for an assessment and improved programming and treatment planning. You will find at the end of this document a list of screenings commonly used. For more resources and information see: http://www.integration.samhsa.gov/clinical-practice/screening-tools

Assessments are designed to gather more comprehensive and individualized information than a screening. In most cases, specific training will be required for a person administering the assessment. The "gathering of information" in an assessment can occur various ways, including interviews, self-reports, and obtaining collateral information. Often information in an assessment is gathered across multiple domains where the youth is involved, whereas a screening may only look at filtering out one or two "indicators". Assessments generally take more time to complete than a screening, and most often will ask for much

more detail. Assessments look at duration of problems, severity and functioning, and can be used to provide information to support diagnosis and treatment planning.

As with screening instruments, an agency should look for assessment instruments that are empirically based and that meet their assessment needs. Appropriate assessments help to determine the appropriate response with appropriate interventions. There are many different assessments that require varying degrees of training and costs including administration time and psychometric properties. Familiarize yourself with these when beginning to identify a tool you wish to use. At the end of this document is a listing of commonly used assessments. Additional resources and information can be found at the following web addresses:
http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf

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The following list provides general information on some of the types of instruments available and is provided to help you in your process of learning more about the choice and implementation of screening and assessment instruments.

Screenings

Instrument	Purpose	Norms	Format	Time (min.)	Training Needed	Scoring Time (min.)	Computer Scoring	Fee for Use
For Co-Occurring/Dual Diagnosis								
Global Appraisal of Individual Needs – Short Screener (GAIN-SS)	Screen for substance use problem and mental health severity and related problems	NA	20-items, interview	5	No	5	Yes	No
Massachusetts Youth Screening Inventory (2nd Ed)	Identify potential mental health needs or emotional disturbances, including alcohol or drug use, for youths aged 12-17 years old at any entry or transitional placement point in the juvenile justice system.	Yes	52-items,qx	10-15	No	3	Yes	Yes
Primarily screens for substance use, has some mental health measures								
Juvenile Automated Substance Abuse Evaluation (JASAE)	Multi-scale measure of substance involvement and related psychosocial factors	Yes	108-items	20	No	5	Yes	Yes
Problem Oriented Screening Instrument for Teenagers (POSIT)	Multi-screen for substance use problem severity and related problems	Yes	139-items, qx	20-25	No	10-15	Yes	No
Screens only for substance use								
CRAFFT	Screen for substance use problem severity	Yes	6-items, qx	5	No	2	No	No
Drug Abuse Screening Test-Adolescents (DAST-A)	Screen for drug use problem severity	Yes	27-items, qx	5	No	5	No	No
Personal Experience Screening Questionnaire (PESQ)	Screen for substance use problem severity	Yes	40-items, qx	10	No	5	No	Yes
Substance Abuse Subtle Screening Inventory-Adolescents (SASSI-A)	Screen for substance use problem severity and related problems	Yes	81-items, qx	10-15	No	5	Yes	Yes
Screens for Trauma								
Trauma Symptom Checklist for Children (TSCC)	The TSCC, the child version of the adult Trauma Symptom Inventory (Briere, 1995), evaluates acute and chronic Post traumatic symptomatology and other symptom clusters found in some children who have experienced traumatic events.	Yes	54-items, qx	10-20	Yes	10-20	NA	Yes

Assessments

Instrument	Purpose	Norms	Format	Time (min.)	Training Needed	Scoring Time (min.)	Computer Scoring	Fee for Use
For Co-Occurring/Dual Diagnosis								
Adolescent Self-Assessment Profile (ASAP)	Multi-scale measure of substance involvement and related psychosocial factors	Yes	225-items, qx	45-60	No	5	Yes	Yes
Global Appraisal of Individual Needs (GAIN)	Assess substance use, mental health and other life problems	NA	Semi-structured interview	45-90	Yes	15	Yes	Yes
Personal Experience Inventory (PEI)	Multi-scale measure of substance involvement and related psychosocial factors	Yes	276-items, qx	45-60	No	5	Yes	Yes
Teen Addiction Severity Index (T-ASI)	Assess substance use and other life problems	NA	Semi-structured interview	20-45	Yes	10	No	No
Primarily for substance use, has some mental health measures								
Adolescent Diagnostic Interview (ADI)	Assess DSM-IV substance use disorders and other life areas	NA	Structured interview	45	No	15-20	No	No
Comprehensive Adolescent Severity Inventory (CASI)	Assess substance use and other life problems	NA	Semi-structured interview	45-55	Yes	15	Yes	Yes (computer version)
Adolescent Self-Assessment Profile (ASAP)	Multi-scale measure of substance involvement and related psychosocial factors	Yes	225-items, qx	45-60	No	5	Yes	Yes
Primarily for mental health measures								
Diagnostic Interview for Children & Adoles. (DICA-R)	Assess DSM-IV child/adol. disorders	NA	Structured interview	45-60	Yes	10	Yes	Yes
Diagnostic Interview Schedule for Children (DISC-R)	Assess DSM-IV child/adol. disorders	NA	Structured interview	45-60	Yes	10	Yes	Yes
Structured Clinical Interview for the DSM (SCID)	Assess DSM-IV disorders	NA	Semi-structured interview	30-90	Yes	10-15	No	No
Teen Treatment Services Review (T-TSR)	Assess the type and number of program services	NA	Semi-structured interview	10-15	Yes	5	No	No
Service Gap & QA Assessment Tool								
Child and Adolescent Needs and Strengths (CANS) Mental Health (there is also a CANS juvenile justice, developmental disabilities)	The CANS is designed for use at two levels – for the individual child and family and for the system of care to point out service gaps. It can also be used as a quality assurance/monitoring tool.	Yes	47 – items, qx	10-30	Yes	10-30	NA	Free

References for Screening

CRAFFT

Knight, J., Sherritt, L., Harris, S.K., Gates, E., & Chang, G. (2003). Validity of brief alcohol screening tests among adolescents: A comparison of the AUDIT, POSIT, CAGE and CRAFFT. *Alcoholism: Clinical & Experimental Research, 27,* 67-73.

Drug Abuse Screening Test-Adolescents (DAST-A)

Martino, S., Grilo, C.M., & Fehon, D.C. (2000). The development of the drug abuse screening test for adolescents (DAST-A). *Addictive Behaviors, 25,* 57-70.

Global Appraisal of Individual Needs – Short Screener (GAIN-SS)

Dennis, M.L., Chan, Y-F., & Funk, R.R. (2006). Development and validation of the GAIN Short Screener (GAIN-SS) for psychopathology and crime/violence among adolescents and adults. American Journal on Addictions, 15, S80-91.

Juvenile Automated Substance Abuse Evaluation (JASAE)

Ellis, B.R. (1987). Clarkston, MI: ADE Incorporated.

Personal Experience Screening Questionnaire (PESQ)

Winters, K.C. (1992). Development of an adolescent alcohol and other drug abuse screening scale: Personal Experience Screening Questionnaire. *Addictive Behaviors*, *17*, 479-490.

Winters, K.C. (1992). Development of an adolescent alcohol and other drug abuse screening scale: Personal Experience Screening Questionnaire. *Addictive Behaviors*, *17*, 479-490.

Problem Oriented Screening Instrument for Teenagers (POSIT)

Rahdert, E. (Ed.) (1991). *The Adolescent Assessment/Referral System Manual*. Rockville, MD: U.S. Department of Health and Human Services, ADAMHA, National Institute on Drug Abuse, DHHS Pub. No. (ADM) 91-1735.

Latimer, W.W., Winters, K.C., & Stinchfield, R.D. (1997). Screening for drug abuse among adolescents in clinical and correctional settings using the Problem Oriented Screening Instrument for Teenagers. *American Journal of Drug and Alcohol Abuse, 23*, 79-98.

Substance Abuse Subtle Screening Inventory-Adolescents (SASSI-A)

Miller, G. (1985). *The Substance Abuse Subtle Screening Inventory-Adolescent Version*. Bloomington, IN: SASSI Institute.

Trauma Symptom Checklist

Briere, John, Psychological Trauma Program, USC Psychiatry, 2020 Zonal Avenue, Los Angeles, CA 90033

References for Assessments

Adolescent Diagnostic Interview (ADI)

Winters, K.C., & Henly, G.A. (1993). *Adolescent Diagnostic Interview Schedule and Manual*. Los Angeles: Western Psychological Services.

Winters, K.C., Stinchfield, R.D., & Fulkerson, J., & Henly, G.A. (1993). Measuring alcohol and cannabis use disorders in an adolescent clinical sample. *Psychology of Addictive Behaviors*, *7*, 185-196.

Comprehensive Adolescent Severity Inventory (CASI)

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

Diagnostic Interview for Children and Adolescents (DICA-R)

Welner, Z., Reich, W., herjanic, B., Jung, K., & Amado, K. (1987). Reliability, validity and parent-child agreement studies of the Diagnostic Interview for Children and Adolescents (DICA). *Journal of American Academy of Child Psychiatry, 26*, 649-653.

Diagnostic Interview Schedule for Children (DISC-R)

Shaffer, D., Fisher, P. & Dulcan, M. (1996). The NIMH Diagnostic Interview Schedule for Children (DISC 2.3): Description, acceptability, prevalence, and performance in the MECA study. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*, 865-877.

Shaffer, D., Schwab-Stone, M., Fisher, P., Cohen, P. et al. (1993). Revised version of the Diagnostic Interview Schedule for Children (DISC-R): Preparation, field testing, and acceptability. *Journal of the American Academy of Child and Adolescent Psychiatry, 32,* 643-650.

Global Appraisal of Individual Needs (GAIN)

Dennis, M.L. (1999). *Global Appraisal of Individual Needs (GAIN): Administration Guide for the GAIN and Related Measures*. Bloomington, Il: Lighthouse Publications

Buchan, B., Dennis, M. L., Tims, F., & Diamond, G. S. (in press). Marijuana use: Consistency and validity of self report, on-site testing & laboratory testing. *Addiction*.

Structured Clinical Interview for the DSM (SCID) – Substance Use Disorders Module

Martin, C.S., Pollock, N.K., Bukstein, O.G., & Lynch, K.G. (2000). Inter-rater reliability of the SCID alcohol and substance use disorders section among adolescents. *Drug and Alcohol Dependence, 59*, 173-176.

Spitzer, R., Williams, J., & Gibbon, B. (1987). *Instructions Manual for the Structured Clinical Interview for the DSM-III-R.* New York: New York State Psychiatric Institute.
Williams, J. B., Gibbon, M., First, M. B., Spitzer, R. L., Davies, M., Borus, J., Howes, M. J., Kane, J., Pope, H. G. Jr., Rounsaville, B., et al. (1992). The Structured Clinical Interview for DSM-III-R (SCID). II. Multisite test-retest reliability. *Archives of General Psychiatry*, *49*, 630-636.

Teen Addiction Severity Index (T-ASI)

Kaminer, Y., Bukstein, O. G., & Tarter T. E. (1991). The Teen Addiction Severity Index (T-ASI): Rationale and reliability. *International Journal of Addiction, 26,* 219-226.

Kaminer, Y., Wagner, E., Plummer, B., & Seifer, R. (1993). Validation of the Teen Addiction Severity Index (T-ASI): Preliminary findings. *American Journal on Addiction, 2,* 221-224.

Teen Treatment Services Review (T-TSR)

Kaminer, Y., Blitz, C., Burleson, J.A., & Sussman, J. (1998). The Teen Treatment Services Review (T-TSR). *Journal of Substance Abuse Treatment*, *15*, 291-300.

Adolescent Self-Assessment Profile (ASAP)

Wanberg, K. (1992). *Adolescent Self-Assessment Profile (ASAP).* Arvada, CO: Center for Addictions Research and Evaluation.

Personal Experience Inventory (PEI)

Winters, K. C., & Henly, G. A. (1989). *Personal Experience Inventory and Manual*. Los Angeles: Western Psychological Services.

Winters, K.C., Stinchfield, R.D., & Henly, G.A. (1996). Convergent and predictive validity of the Personal Experience Inventory. *Journal of Child and Adolescent Substance Abuse, 3*, 37-56.

CHILD AND ADOLESCENT NEEDS AND STRENGTHS – Lyons, John S, Praed Foundation

http://www.praedfoundation.org/About%20the%20CANS.html