

# NYS OMH/OASAS Task Force on Co-occurring Disorders

Subcommittee on Youth and Adolescents  
Final Report  
March 2009

The Subcommittee on Youth and Adolescents was charged with making recommendations to improve the care of youth, adolescents and young adults in NYS who have a co-occurring disorder, with a primary focus on youth ages 10-24\* involved in OMH State Operated Programs and in OASAS and OMH State Certified Programs. The subcommittee's work builds on the principles of "The Children's Plan: Improving the Social and Emotional Well Being of New York's Children and Their Families" (October 2008), by providing recommendations for clinical and systems integration, and regulatory and fiscal changes. Fundamental to the work of the Subcommittee was the importance of shared decision making for youth and their families.

## **Rationale and Importance of the Work of the Youth Subcommittee**

Research has shown that the prevalence of co-occurring mental health and substance use disorders in youth is very high, with disruptive behavior disorders most common, followed by anxiety and mood disorders. These psychiatric disorders worsen substance use disorders and impede their treatment, resulting in poorer outcome of the substance use treatment. The reverse is true also - substance use disorders worsen adolescent mental health disorders and complicate their treatment.

Mental health and substance use disorders, singly and together, create enormous personal and social burden. Individuals with these problems, both adults and adolescents, when treated, are generally in mental health and chemical dependency settings, but often times they also are found in family courts, juvenile detention facilities, OCFS residential facilities, jails or prisons, depending on their age.

There is a general consensus stated by the American Academy of Child and Adolescent Psychiatry's Practice Parameter for the Assessment and Treatment of Children and Adolescents with Substance Use Disorders (2005) that the optimal treatment approach for adolescents with mental health disorders and co-morbid substance use disorders is integrated treatment for both problems - rather than concurrent (in different settings) or consecutive treatment for each. We also know that early identification is important to the successful treatment and outcome of these disorders.

For these reasons, the early identification, assessment and integrated treatment of youth with co-occurring disorders is crucial to help prevent and diminish the incidence and severity of these problems in youth, with their attendant personal, familial and social consequences, and to help prevent their continuation into adulthood.

## **Background and Process**

The subcommittee first met on July 16, 2008. Commissioner Hogan (OMH) and Commissioner Carpenter-Palumbo (OASAS) indicated they sought a limited number of recommendations that were meaningful and doable, and that "stretched" existing service systems in ways that fostered service integration. Drs. Lloyd Sederer (OMH Medical Director) and Frank McCorry (OASAS, Director of NYS Operations), co-chairs of the COD Task Force, described the work of the adult COD Task Force, especially screening, assessment and evidence-based practices, along with

methods for achieving regulatory and fiscal improvements. The Youth Subcommittee was encouraged to build on this work whenever possible and establishes short-term (less than one year) goals.

A second subcommittee meeting was held on August 5, 2008. The scope of work was finalized and the following four workgroups established: 1.Clinical; 2.Systems, fiscal and regulatory; 3.Youth and families, and 4.Accountability and data. During September and October the workgroups met and developed a series of recommendations based on principles that underlie the adult task force efforts, including the importance of evidence to support recommendations for screening, assessment and treatment.

### **Basic principles specific to youth and adolescents:**

1. Children are not “little adults”; they have different physical, psychological, social, emotional and developmental needs. Services for youth and families should be designed specifically for them and not merely “downsized” or “added to” adult services.
2. Community supports and family interventions are essential in working with youth. Whenever possible, these services should take place in the youth’s natural environment.
3. Children and families should be partners in formulating clinical service plans as well as clinical policies and services that impact their lives.
4. A well functioning system of care is needed for youth involved with numerous agencies and providers to achieve optimal outcomes. These values and approaches to a system of care are expressed in the Child and Adolescent Service System Program (CASSP) and have been expanded on in the NYS Children’s Plan (October, 2008), which reflects the goals of providing coordinated, collaborative services to youth and their families or caregivers.

### **Summary of Recommendations of the Four Workgroups comprising the Subcommittee on Youth and Adolescents:**

Each workgroup made specific recommendations that are noted below. Together, these recommendations comprise the recommendations of the Youth Subcommittee.

#### **1. Clinical Workgroup:**

The clinical workgroup supported the transformation design developed by the Adult COD Task Force for screening, assessment and evidence based practices. The full Report of the Clinical Workgroup of the Youth Subcommittee is contained in Appendix A, with detailed approaches to screening, assessment and treatment related to youth. The recommendations of the clinical workgroup are:

**Recommendation 1.** All youth being evaluated for mental health disorders should be screened for substance use problems and all youth being evaluated for substance use disorders should be screened for mental health problems using appropriate screening tool(s). Those who screen positive for these problems should have subsequent assessment using appropriate interview and/or assessment tools.

The subcommittee recommends:

- For screening of alcohol and substance abuse in mental health settings:
  - The CRAFFT

- The Global Appraisal of Individual Needs (screening version) (GAIN-SS)
- The Problem Oriented Screening Instrument for Teenagers (POSIT)
- For screening of mental health problems in alcohol and substance use settings:
  - The Child Behavior Checklist (CBCL) and associated Youth Self Report (YSR)
  - The Pediatric Symptom Checklist (PSC)

The subcommittee did not recommend a specific assessment instrument in either mental health or alcohol and drug abuse treatment settings, but did emphasize the importance of thorough assessment using appropriate interview techniques for youth and parents/caregivers.

Diagnoses should be made using the Diagnostic and Statistical Manual of Mental Disorders (DSM) framework. For those wishing to supplement the interview in the assessment process using a more structured format, the full GAIN or the Mini International Neuropsychiatric Interview for Children (Kids MINI) might be considered. This information is summarized in Table 1.

Implementation of evidence-based screening and assessment in mental health, alcohol and drug abuse treatment agencies and all other settings employing these procedures should include adequate training, supervision, and follow-up on the administration, scoring, and interpretation of the particular instruments used.

**Recommendation 2.** Screening should occur not only in outpatient clinics, but in all hospital, residential, day treatment and other settings or programs operated or certified by OMH or OASAS, e.g. psychiatric hospitals; residential treatment facilities; residential treatment centers.

**Recommendation 3.** Screening also should be part of ongoing services provided by other appropriate agencies and professionals serving youth in other environments, e.g. Department of Health clinics; physician offices, public schools; child welfare and foster care agencies schools and programs for youth with mental retardation and developmental disorders, probation offices, OCFS residential facilities and juvenile detention facilities.

**Recommendation 4.** Screening for both mental health disorders and substance use disorders should be repeated during transition periods in the youth's life, with changes in types or levels of care, or as needed based on the clinician's judgment.

**Recommendation 5.** Families and caregivers should be involved in the screening, assessment and treatment process in all cases unless there are compelling reasons to the contrary. Clinicians should be trained in techniques to better engage youth and families in the screening, assessment and treatment process.

**Recommendation 6.** Evidence based or evidence supported treatments should be the mainstays of treatment for youth with co-occurring disorders, although research is limited in this area. Based on available evidence, we recommend the treatment approaches noted in Table 2. Additional descriptions of these treatments are contained in Appendix A, Report of the Clinical Workgroup of the Youth Subcommittee.

**Recommendation 7.** As envisioned in the NYS Children's Plan (October, 2008), ongoing collaboration between OMH and OASAS regarding youth with co-occurring disorders should be broadened to include collaboration among all state agencies serving youth.

**Recommendation 8.** Agencies and individual providers across child-serving agencies should be provided with training and guidance on how to obtain services for youth with co-occurring disorders.

## **2. Systems/fiscal and regulatory workgroup**

This work group reviewed recommendations related to systems, fiscal and regulatory issues developed by the adult COD Task Force. A basic tenet of the work group's efforts was that fiscal policy should follow from clinical priorities and service delivery needs. The youth workgroup recommended:

*Recommendation 1:* Adopt and apply the recommendations of the Adult COD Task Force to the service delivery needs of youth and adolescents.

*Recommendation 2:* Establish a uniform regulatory and fiscal structure, including a common language, for service delivery to youth in both OASAS and OMH settings. Funding for services involving collateral contacts should be available in both OASAS and OMH.

*Recommendation 3:* Investigate existing local/county models that foster cross-system coordination of treatment and support services for COD youth to serve as models for coordinated service delivery.

*Recommendation 4:* Longer term or "stretch" goals:

- a. Investigate foundation or other sources of grant funding to develop integrated models of treatment for adolescents with co-occurring disorders, in conjunction with counties and local communities.
- b. Establish a mechanism to review residential need capacity across youth serving systems of care.
- c. Establish a mechanism to allocate funding from residential to community services when appropriate.
- d. Establish models of braided or blended funding that support the values and principles identified throughout this document.

## **3. Youth and family workgroup:**

Building on the recommendations of the Children's Plan, this workgroup recommended:

*Recommendation 1:* OASAS and OMH commit to establish an interagency workgroup that includes other state agencies, to advocate for the engagement of youth and families in treatment planning and in broader policy issues. Practice guidelines should be established around family involvement in the service delivery needs of youth with COD.

*Recommendation 2:* OASAS and OMH commit to an interagency effort, that includes other state agencies, in support of continuing education to maintain and increase competencies of providers and staff regarding family support, engagement and models of parent education.

*Recommendation 3:* The commissioners of OMH and OASAS convene a work group to evaluate and plan for service delivery needs of transitional age youth, who are defined as youth

between the ages of 18 and 24 years. Housing options for youth with COD who are “aging out” of children and youth services, but who are not ready to live independently, is one example of the this group’s needs.

**4. Accountability and data workgroup:**

*Recommendation 1:* OMH and OASAS should identify common data and outcome elements across systems for planning, clinical and research efforts.

*Recommendation 2:* OMH and OASAS should create a workgroup specifically to oversee the merging and use of common data and to identify areas for evaluation that could guide decision-making on adolescent co-occurring disorders.

**Summary:**

The Subcommittee on Youth and Adolescents followed and built on the work and recommendations of the Adult OMH/OASAS COD Task Force. There were four workgroups: clinical; systems/fiscal and regulatory; youth and family; and accountability and data. Clinical work with youth requires differentiating their screening, assessment, and treatment needs from those of adults. Clinicians and state agency personnel must recognize and support the diverse types of family groupings that exist today, as well as the inclusion of parents, caregivers and youth in decision making regarding their treatment and programs. In light of the limited evidence base to date for youth with COD, the subcommittee urges developing means to gather meaningful data and study outcome of youth treated in OMH and OASAS programs.

Table 1: Recommended Screening Instruments and Assessment Approaches\*

Screening Instruments and Assessment Approaches for Adolescents with Mental Health or Substance Use Disorders	
Screening Instruments	
For Mental Health Disorders	For Substance Use Disorders
<ul style="list-style-type: none"> <li>• Child Behavior Checklist (CBCL)-completed by parents. An associated Youth Self Report (YSR) is completed by the adolescent;</li> <li>• Pediatric Symptom Checklist (PSC)-completed by parents. An associated youth self-report (Y-PSC) is completed by the adolescent.</li> </ul>	<ul style="list-style-type: none"> <li>• CRAFFT-completed by the adolescent;</li> <li>• Global Appraisal of Individual Needs (screening version) (GAIN-SS)-completed by the adolescent;</li> <li>• Problem Oriented Screening Instrument for Teenagers (POSIT)-completed by the adolescent. An associated Problem Oriented Screening Instrument for Parents (POSIP) may be completed by the parent(s).</li> </ul>
Assessment Approaches	

No specific assessment instrument is recommended. Youth oriented interview procedures should be used. Other informants should be included. Diagnoses should be made by clinicians trained and experienced in the 5 Axis DSM classification approach.

Those wishing a structured approach as a supplement to the interview might use either the Global Appraisal of Individual Needs (complete version) (GAIN) that is administered to the adolescent or the Mini International Neuropsychiatric Interview for Children (Kids MINI) that also is administered to the adolescent directly. Both of these instruments have mental health as well as substance abuse components.

\*The instruments and approaches recommended are appropriate in a variety of settings and does not need to be limited to mental health and/or substance abuse treatment programs.

Table 2: Evidenced Based Psychotherapies for Youth with Co-Occurring Disorders

<b>Treatment Approach</b>	<b>Evidence Base present for:</b>
Cognitive Behavior Therapy (CBT)	Mental health and substance use disorders
Contingency Management	Mental health and substance use disorders
Dialectical Behavior Therapy (DBT)	Mental health disorders
Motivational Interviewing	Mental health and substance use disorders
Family/ Caregiver Therapies	Mental health and substance use disorders
Functional Family Therapy	Mental health and substance use disorders
Brief Strategic Family Therapy	Substance use disorders
Multidimensional Family Therapy	Substance use disorders
Multisystemic Therapy (MST)	Mental health and substance use disorders

## Appendix A: **Clinical Subcommittee Report**

### **Introduction**

The clinical workgroup met on two occasions. The group focused on the following areas:

1. Screening for co-occurring disorders
2. Assessment of co-occurring disorders
3. Empirically based or empirically grounded treatment approaches that are likely to be useful in treating mental health disorders and/or substance use disorders.

The efforts of the clinical workgroup followed closely on the work of the adult component of the OMH/OASAS task force. While there are specific screening and assessment tools and treatment approaches that are different for adults and youth (as discussed below), the overall principles, with some modifications and needed emphases, that are described in the OMH and OASAS

Guidance Document (July 31, 2008) are appropriate to the consideration of screening, assessment and treatment of youth and adolescents also.

This report provides a rationale and purpose for screening in youth, guiding principles and important practices in the screening and assessment of youth, specifically recommended screening and assessment instruments, and empirically based or empirically grounded treatment approaches to be considered for youth with co-occurring disorders.

### **Rationale and Purpose of Screening and Early Intervention for Youth with Co-Occurring Disorders**

Research has shown that the prevalence of co-occurring mental health and substance use disorders in youth is very high, with disruptive behavior disorders most common, followed by anxiety and mood disorders. These psychiatric disorders worsen substance use disorders and impede their treatment, resulting in poorer outcome of the substance use treatment. The reverse is true also - substance use disorders worsen adolescent mental health disorders and complicate their treatment.

Mental health and substance use disorders, singly and together, create enormous personal and social burden. Individuals with these problems, both adults and adolescents, are generally in mental health and chemical dependency settings when they are treated, but often times they also are found in juvenile detention facilities or jails and prisons, depending on their age.

There is a well established long term trajectory for many youth who initially present with attention deficit hyperactivity disorder in early childhood and then develop oppositional defiant disorder and conduct disorder in adolescence, the latter often associated with substance use disorders. This pattern frequently continues into adulthood with the development of more severe substance use disorders, antisocial personality disorder, and other psychiatric disorders, such as depression, that is common in both adolescents and adults with substance use disorders.

There is a general consensus stated by the American Academy of Child and Adolescent Psychiatry's Practice Parameter for the Assessment and Treatment of Children and Adolescents with Substance Use Disorders (2005) that the optimal treatment approach for adolescents with mental health disorders and co-morbid substance use disorders is integrated treatment for both problems - rather than concurrent (in different settings) or consecutive treatment for each.

Early identification, assessment and integrated treatment of youth with co-occurring disorders therefore is crucial to help prevent and diminish the incidence and severity of these problems in youth, with their attendant personal, familial and social consequences, and to help prevent their continuation into adulthood.

### **Guiding Principles and illustrative practices:**

The following provides a number of general principles that should be emphasized in the screening, assessment and treatment process of youth with co-occurring disorders and their families. Specific practices are provided to illustrate these principles.

*Principle 1:* Cultural and attitudinal changes are needed to achieve coordinated, integrated approaches to screening, assessment and treatment of adolescents with co-occurring disorders. Service delivery must not be fragmented between mental health and substance abuse/dependence systems. Both systems should learn from one another and work to integrate appropriate approaches for the youth and family that are served, regardless of where the youth is treated.

*Principle 2:* Adolescents, as well as their families and caregivers, need to be positively engaged in order for reliable and accurate screening, assessment and treatment to be accomplished. Practices to achieve these goals include:

- A. The display of empathy, and a person-centered approach that reflects the clinician's appreciation of racial, ethnic, cultural, sexual orientation, gender identity and/or other group designations or differences among youth.
- B. Reflective listening, non judgmental attitude, patience are required for sensitive exploration of issues with the youth and his or her family/caregiver.
- C. Evidence-based engagement practices should be used to encourage parents/caregivers to participate in treatment.

*Principle 3:* Screening, assessment and treatment should not occur in a mechanical, minimalist or rote fashion. Adequacy in any of these endeavors may require additional information that is provided by parents or other informants. Practices to achieve these goals include:

- A. Youth and their families should be made to feel welcome regardless of the route through which they enter the service delivery system.
- B. The screening, assessment and treatment should be seen as safe and inviting through the eyes of the youth and his or her family/caregiver.

*Principle 4:* Screening, assessment and treatment of the youth and family must take into account the context of their lives and the frequent changes and upheaval that sometimes are present. Youth and their families may be involved with numerous social and care giving individuals and systems, such as health care, social service, juvenile justice, mental health, chemical dependency, education. Families may be intact, fragmented, reconstituted, or non existent.

*Principle 5:* Youth with co-occurring disorders and their families often present with complex personal and family issues and difficulties. Assessment must be multifaceted and mindful of the importance of identifying both strengths and problem areas. Practices include:

- A. Obtaining information from multiple sources, including therapists, teachers, and social service personnel.
- B. Obtaining a history of out of home placement and social service involvement, with a focus on child abuse and neglect, and parenting practices
- C. Obtaining a history of family mental health problems, addiction and recovery
- D. Obtaining a history of school achievements and problems, discipline issues, cognitive strengths and learning difficulties
- E. Obtaining a history of recreational, community, faith based, and peer related activities, such as sports, hobbies, clubs, church related groups,.
- F. Obtaining a history of trauma, abuse, neglect, victimization, violence in the home or community.

*Principle 6:* Screening should not be considered a one time activity, but should be repeated during transition periods in the youth's life, with changes in types or levels of care, or as needed based on the clinician's judgment.

A practice supporting this principle is that the results of screening and assessment should be part of the agency record that, with permission, is shared with new providers used by the adolescent and his or her caregiver.

*Principle 7:* Screening, assessment and treatment should be done by those with specific training and experience with these procedures, knowledge of their rationale and intended purposes. Practices supporting this principle include:

- A. Establishing training and competencies for providers in screening, assessment and treatment approaches that are empirically based. Providing specific training on the instruments that are to be used. Providing training and supervision on youth centered approaches to treatment.

### **Specific screening and assessment instruments**

Both the screening and assessment instruments used with children and youth differ from those used with adults. Choosing a particular screening or assessment instrument should be based on a number of factors, including: psychometric properties of the instrument; ease of administration and scoring; clinician familiarity with the tool; acceptability by the client; cost; availability in the public or private domain; and time involved to administer and score.

Another important point is that screening and assessment instruments do not necessarily form distinct groups. Depending on the construction, an instrument may be considered for screening but also provide information that is part of an assessment. Choosing the right instrument depends on the purposes for which it is used.

A good source for more complete information about screening and assessment instruments for youth can be found in the US Department of Health and Human Services SAMHSA's National Clearinghouse for Alcohol and Drug Information publication: Screening and Assessing Adolescents for Substance Use Disorders. Treatment Improvement Protocol TIP (Series 31).available at <http://ncadi.samhsa.gov/govpubs/BKD306/31k.aspx>. It is important to note that due to literacy levels many instruments may need to be administered orally if youth does not have the reading level to perform this independently.

All youth being evaluated for mental health disorders should be screened for substance use problems and all youth being evaluated for substance use disorders should be screened for mental health problems using appropriate screening tool(s). Those who screen positive for these problems should have subsequent assessment using appropriate interview and/or assessment tools. The subcommittee recommends:

- Screening Instruments for Substance Use Disorders
  - The CRAFFT
  - The Global Appraisal of Individual Needs (screening version) (GAIN-SS)
  - The Problem Oriented Screening Instrument for Teenagers (POSIT)

- Screening Instruments for Mental Health Disorders
  - The Child Behavior Checklist (CBCL) and associated Youth Self Report (YSR)
  - The Pediatric Symptom Checklist (PSC)

The subcommittee did not recommend a specific assessment instrument in either mental health or alcohol and drug abuse treatment settings, but did emphasize the importance of thorough assessment using appropriate interview techniques for youth and parents/caregivers. Diagnoses should be made using the Diagnostic and Statistical Manual of Mental Disorders (DSM) framework. For those wishing to supplement the interview in the assessment process using a more structured format, the full GAIN or the Mini International Neuropsychiatric Interview for Children (Kids MINI) might be considered. This information is summarized in Table 1.

Implementation of evidence-based screening and assessment in mental health, alcohol and substance abuse treatment agencies and all other settings, should include training, supervision, and follow-up on the administration, scoring, and interpretation of the instrument selected..

**Specific Instruments:** Descriptions of the instruments noted above follow.

***Child Behavior Checklist (CBCL) and Youth Self Report (YSR)***

The Child Behavior Checklist for ages 6-18 years (CBCL 6-18) that is completed by parent(s) and the Youth Self-Report (YSR) that is completed by youth aged 11-18 years initially were developed by T. Achenbach. These are instruments that can be completed in a relatively brief period. They are normed by age and sex, and identify behavior problems across several domains, such as anxiety, depression, and conduct problems. These narrower band problem areas can be considered within broader internalizing and externalizing behavioral dimensions. The CBCL and YSR provide information on specific behavioral or emotional problems along a dimensional rather than categorical approach. They have been used very widely in clinical and research settings and psychometric properties have been extensively studied. Scoring is by hand or by computer program. The CBCL and YSR are not in the public domain; there is a fee to purchase the manual, scoring material and forms. <http://www.aseba.org/> Psychological Assessment Resources, Inc.

***Pediatric Symptom Checklist (PSC)***

The PSC is a 35 item psychosocial screening instrument completed by parents that was developed by M.S. Jellinek and J.M. Murphy to facilitate the recognition of emotional, behavioral and cognitive difficulties in youth aged 4-16 years. There also is a youth self report (Y-PSC) that can be used in adolescents aged 11 years and up. Parents and youth (depending on the version used) complete a one page questionnaire that is nearly identical and includes a broad range of children's emotional and behavioral problems. Cut off scores that correspond to clinical ranges have been derived. Positive scores on the PSC or the Y-PSC indicate that further evaluation by a qualified health or mental health professional is indicated. The PSC was developed to be completed as part of routine primary health visits. The instrument is free and can be downloaded from the website. [http://www.massgeneral.org/allpsych/psc/psc\\_home.htm](http://www.massgeneral.org/allpsych/psc/psc_home.htm)

## **CRAFFT**

The CRAFFT is a very brief, self administered screening test for adolescents that are intended to determine whether alcohol or drug problems exist. It was developed at the Center for Adolescent Substance Abuse Research, Children's Hospital, and Boston. The CRAFFT consists of 6 items that are formulated in a yes/no fashion. Questions address alcohol and drug related issues such as whether the informant has ever gotten into trouble (the "T" in CRAFFT) while using alcohol or drugs. The CRAFFT was developed for use in primary care settings. A score of 2 or higher (out of a possible 6, i.e. one point for each question) is optimal to identify youth who may have alcohol or drug problems. In a study from a hospital based adolescent clinic, approximately one quarter of the youth had a score of 2 or higher. Permission for use is required, but there is no fee to use the instrument. The CRAFFT has been disseminated for use in the Child and Family Clinic Plus program of the NYS Office of Mental Health. Further information can be obtained from the Center for Adolescent Substance Abuse Research, Children's Hospital Boston. See: <http://www.ceasar-boston.org/> and <http://www.ceasar-boston.org/clinicians/crafft.php>

## ***Global Appraisal of Individual Needs (GAIN) and the Global Appraisal of Individual Needs-Short Screener (GAIN-SS)***

The GAIN is a series of measures (screen, standardized biopsychosocial intake assessment battery, follow-up assessment battery) designed to integrate research and clinical assessment for people with substance abuse or other behavioral health problems. The GAIN asks the adolescent about symptoms derived from DSM-IV-TR that are then used to develop a dimensional symptom picture or a categorical diagnostic impression in four areas: internalizing, externalizing, substance use disorders and crime/violence. The full GAIN requires 1-2 hours of patient/staff time to complete. It is designed to measure the recency, breadth, and frequency of problems and service utilization related to substance use (including diagnosis and course, treatment motivation, and relapse potential), physical health, risk/protective involvement, mental health, environment and vocational situation. The GAIN's substance problem index (SPI) provides a dimensional measure of problem severity for the participant's lifetime, past year, and past month; It can also be used to measure change over time and to categorize participants (based on report) in terms of abuse, dependence, and course specifiers. Supplemental questions can be used to break out problems/diagnosis by substance. Those using the GAIN must be trained and certified in its use. There is a collateral report section in the full GAIN that can be used to gather information from parents or other sources, but this is not a complete parent interview.

The need for a short screening instrument that can be used widely in different settings and in which there might be limited time and resources resulted in the development of the GAIN-Short Screener (GAIN SS). This scale consists of 20 items and can be completed in 5 minutes. Training needs are minimal. The GAIN SS is self or staff administered. Like the full GAIN, the GAIN SS provides a measure of overall severity and addresses symptoms in the four dimensions of internalizing, externalizing, substance use disorders and crime/violence problems. Correlations with the item scales of the full GAIN are good. See [http://www.chestnut.org/LI/GAIN/GAIN\\_Overview\\_120706.pdf](http://www.chestnut.org/LI/GAIN/GAIN_Overview_120706.pdf). Chestnut Health Systems

**Problem Oriented Screening Instrument for Teenagers (POSIT)**

The POSIT is a self administered screening instrument for adolescents that has 139 items developed in a yes/no format. It was designed to identify potential problem areas that require further more in depth assessment. The POSIT assesses problems in 10 domains: substance use and abuse, physical health, mental health, family relations, peer relations, educational status, vocational status, social skills, leisure/recreation and aggressive behavior/delinquency. The scale can be completed in about 20-30 minutes. The POSIT can be used in a variety of settings. Scoring is by computerized program or through use of scoring templates placed over pencil and paper versions. The POSIT is not copyrighted and is free. An associated Problem Oriented Screening Instrument for Parents (POSIP) is the parental version of the POSIT. The POSIP queries parents on items derived from five areas of the POSIT. Used in association with the POSIT, results on the POSIP may indicate different perceptions or reporting of symptoms between the parents or between the parent and youth. See: <http://eib.emcdda.europa.eu/html.cfm/index4439EN.html>.

**Mini International Neuropsychiatric Interview for Children**

The Mini-International Neuropsychiatric Interview for children (MINI-KID) is a structured diagnostic interview designed to be used with youth and to meet the need for a short but accurate psychiatric interview for mental health and alcohol and drug abuse. It assesses the presence of numerous DSM IV psychiatric diagnoses and the risk of suicide. There also is a MINI-KID-P that is a parent rated. A screening version also is available. See: Sheehan DV et al (1998), Journal of Clinical Psychiatry 59 Suppl 20:22-33. Paper version free with permission from David. V.Sheehan M.D., M.B.A.

Table 1: Recommended Screening Instruments and Assessment Approaches\*

Screening Instruments and Assessment Approaches for Adolescents with Mental Health or Substance Use Disorders	
<b>Screening Instruments</b>	
For Mental Health Disorders	For Substance Use Disorders
<ul style="list-style-type: none"> <li>• Child Behavior Checklist (CBCL)-completed by parents. An associated Youth Self Report (YSR) is completed by the adolescent;</li> <li>• Pediatric Symptom Checklist (PSC)-completed by parents. An associated youth self-report (Y-PSC) is completed by the adolescent.</li> </ul>	<ul style="list-style-type: none"> <li>• CRAFFT-completed by the adolescent;</li> <li>• Global Appraisal of Individual Needs (screening version) (GAIN-SS)-completed by the adolescent;</li> <li>• Problem Oriented Screening Instrument for Teenagers (POSIT)-completed by the adolescent. An associated Problem Oriented Screening Instrument for Parents (POSIP) may be completed by the parent(s).</li> </ul>
<b>Assessment Approaches</b>	

No specific assessment instrument is recommended. Youth oriented interview procedures should be used. Other informants should be included. Diagnoses should be made by clinicians trained and experienced in the 5 Axis DSM classification approach.

Those wishing a structured approach as a supplement to the interview might use either the Global Appraisal of Individual Needs (complete version) (GAIN) that is administered to the adolescent or the Mini International Neuropsychiatric Interview for Children (Kids MINI) that also is administered to the adolescent directly. Both of these instruments have mental health as well as substance abuse components.

\*The instruments and approaches recommended are appropriate in a variety of settings and does not need to be limited to mental health and/or substance abuse treatment programs.

### **Evidence-Based and Evidence-Linked Treatments**

Evidence-based treatments ideally follow from screening and assessment that has identified and provided a comprehensive understanding of the problems faced by the youth and family/caregiver. The OMH/OASAS COD task force has reviewed evidence-based treatments for adults and identified several evidence-based and evidence-linked practices recommended for adoption at OMH and OASAS clinics. These are noted in the Commissioners' letter of June, 2008: [http://www.omh.state.ny.us/omhweb/news/colleague\\_ltr\\_june2008.html](http://www.omh.state.ny.us/omhweb/news/colleague_ltr_june2008.html)

At present there are few treatments that have good evidentiary bases for treating both mental disorders and substance abuse in adolescents. There are a growing number of evidenced-based treatments for adolescents, however. These treatments generally have been studied in adolescents with mental health disorders or in adolescents with substance abuse; only a small number have been studied in adolescents with both mental health and substance use disorders. Therefore, our recommendations often are based on the judgment that a treatment with empirical support for one disorder should be considered in the treatment of other co-occurring mental or substance use disorders (depending on type), but this needs further study.

Medication is another issue that often is raised in treating youth with co-occurring disorders. There are no approved medications for substance use disorders in adolescents. There is a more substantial empirical literature on the use of medications for many mental disorders affecting youth (e.g., depressive disorder, anxiety disorders, and ADHD). The decision to use medication for adolescents with co-existing substance use and mental health disorders often rests on clinical judgment whether the pharmacological treatment of the mental disorder will not be accompanied by abuse of the medication that is given. A list of various treatments for adolescents with substance abuse disorders can be found through the University of Washington's Alcohol and Drug Abuse Institute's report "Evidence-Based Practices for Treating Substance Use Disorders: Matrix of Interventions." <http://adai.washington.edu/ebp/matrix.pdf>

Urine toxicology for drug use is a component of chemical dependency treatment programs, and at times can be considered in screening efforts also. It is not a treatment in itself, but forms part of an overall treatment approach that is well recognized in chemical dependency settings, and

should be considered too in mental health settings when treating youth with co-occurring disorders.

Mutual and peer support groups are approaches that have a wealth of tradition and support. This category includes 12-step programs such as Alcoholics Anonymous and Narcotics Anonymous for youth with addiction and with co-occurring disorders, Al-Anon for family/caregiver members of youth with co-occurring disorders, and Alateen for adolescents who have a family member/caregiver with alcoholism.

There are several treatment approaches that have some empirical support in youth with mental disorders and in youth with substance use disorders. Several of these treatment programs are likely to be applicable for use in adolescents with both mental disorders and substance abuse. Generally, these approaches involve clinical work with the family/caregiver (as well as the adolescent) and at times with other systems (e.g. schools). The treatments the workgroup recommends for consideration are listed below. Table 2 indicates whether the treatment approach has been studied in mental health, substance abuse/dependence settings or in both.

**Cognitive Behavioral Therapy (CBT)** is a form of psychotherapy that emphasizes the important role of thinking in how we feel and what we do. Versions of CBTs have been developed and applied in mood, anxiety, and disruptive behavior disorders and substance use disorders in adolescents. Cognitive behavioral therapies are based on the hypothesis that since thoughts cause a person's maladaptive feelings and behaviors, changing thought patterns should result in changes in feelings and behaviors. Therapy sessions are structured, directive and intended to be educational. Specific techniques dealing with how to address maladaptive thought patterns are provided. Therapy typically is short term.

**Contingency Management** approaches are treatment strategies utilizing reinforcement of desired goals or behavior with rewards such as vouchers or coupons. Increasingly used in the mental health or substance abuse fields, clients are rewarded or penalized for their behaviors, such as attendance, compliance or adherence to program rules and regulations or their treatment plans.

**Dialectical Behavioral Therapy (DBT)** is an approach used in treating patients who have a variety of symptoms and behaviors. DBT emphasizes behavioral theory, dialectics, cognitive therapy, and mindfulness. It has been employed in many patient groups, including adolescents who have with mood disorders and/or problems with mood regulation.

**Motivational Interviewing (MI)** refers to a counseling approach that is a client-centered, semi-directive method of engaging intrinsic motivation to change behavior by developing discrepancy and exploring and resolving ambivalence within the client.

**Family/Caregiver Therapies** include a number of approaches to family/caregiver intervention for substance abuse treatment that have common goals including: providing psycho education about substance use disorders and assisting parents and family/caregivers to initiate and maintain efforts to encourage the adolescent into appropriate treatment and achieve abstinence. Assisting parents and family/caregivers to establish or reestablish structure with consistent limit-setting and careful monitoring of the adolescent's activities and behavior, improving

communication among family/caregiver members, and getting other family/caregiver members into treatment and/or support programs are components of these programs.

**Functional Family Therapy** is a family/caregiver-based prevention and intervention program that has been applied successfully in a variety of situations to assist youth and their families.

**Brief Strategic Family Therapy** uses treatment methods that are both strategic (i.e., problem focused and pragmatic) and time limited.

**Multidimensional Family Therapy** is a comprehensive, flexible, family based treatment program for substance abusing adolescents and for youth with other types of behavioral difficulties also. It targets risk factors and processes that have produced problem behaviors. MDFT intervenes systemically to help individuals and families develop approaches to address the problems they have. MDFT intervenes on multiple levels and across various systems that affect the youth and family.

**Multi systemic Therapy (MST)** was developed to address the therapeutic needs of severe juvenile offenders and their families. MST is based on the premise that antisocial behavior in youth is multidetermined and linked to characteristics in the youth, family, peer, school and community. MST works to reduce risk factors by building youth and family/caregiver strengths (protective factors) on a highly individualized basis. Parental empowerment is stressed. MST uses other forms of therapies as needed, including CBT, behavior therapy and more practical solution oriented family therapies. Interventions are delivered within the home or community during a highly intense, time limited period.

Table 2: Evidenced Based Psychotherapies for Youth with Co-Occurring Disorders

<b>Treatment Approach</b>	<b>Evidence Base present for:</b>
Cognitive Behavior Therapy (CBT)	Mental health and substance use disorders
Contingency Management	Mental health and substance use disorders
Dialectical Behavior Therapy (DBT)	Mental health disorders
Motivational Interviewing	Mental health and substance use disorders
Family/ Caregiver Therapies	Mental health and substance use disorders
Functional Family Therapy	Mental health and substance use disorders
Brief Strategic Family Therapy	Substance use disorders
Multidimensional Family Therapy	Substance use disorders
Multisystemic Therapy (MST)	Mental health and substance use disorders

**Summary:**

The efforts of the clinical workgroup of the subcommittee on youth and adolescents followed on the findings and recommendations of the adult oriented clinical component of the OMH/OASAS task force on co-occurring disorders. Much of the work of that task force is appropriate to considerations with youth and families. This workgroup emphasized principles and practices that are specific to youth and families. It provided specific recommendations for screening and assessment of youth with co-occurring disorders. Numerous treatment approaches also were offered. The evidence base for most treatments in youth with co-

occurring disorders is not strong, and clinical judgment must be considered in choosing among various treatments.