What is it?

Screening youth for substance abuse and mental health issues—especially in service delivery settings where children, adolescents and families present for assistance—involves identifying related needs and behaviours that affect these two areas. From this identification, further comprehensive individualized assessment and service planning can be conducted.

The definition of youth or adolescence is often ambiguous. For the purposes of this toolkit (and consistent with the definition found in Essentials of... Treating Youth Substance Abuse), adolescence constitutes the stage between later childhood (puberty) and early adulthood, typically accepted as the ages between 12 and 19 years. The terms adolescence and youth are used synonymously here.

Problematic youth substance abuse describes situations where the use of alcohol and/or psychoactive drugs negatively interferes with any area of an adolescent’s life. This may be seen in social areas such as school, work, family and friends. It can also be seen in personal areas of physical, mental, emotional and spiritual health and well-being.

Although varying classification systems are used in adolescent psychology/psychiatry, as compared to adults, mental health issues discussed here are consistent with the DSM-IV definition (i.e., clinically significant psychological or behavioural patterns in individuals that are associated with distress, disability or a significantly increased risk of suffering death, pain, disability or loss of freedom).

How does screening work?

The goal of screening is to accurately identify youth who will benefit from a complete assessment, at which time a determination of substance abuse and/or mental health disorders can be made and treatment plans developed. Some of the primary considerations when screening youth for substance abuse and mental health include:

1. **Staged process**
   Screening can be considered a two-staged process, involving a tentative identification of general problematic issues (i.e., brief screen for the possibility of any substance abuse or mental health disorder) and disorder-specific issues (i.e., longer screen for specific substance abuse or mental health disorders; CAMH, 2009). Screening raises ‘red flags’ about the possibility of problem areas; specific disorders can subsequently be confirmed via diagnostic assessments.

2. **Who should screen**
   Screening can be conducted by healthcare service delivery personnel (e.g., mental health or addictions professionals, pediatricians, family physicians, frontline workers), specialized school staff, vocational program workers and judicial organization members. Individuals associated with all at-risk youth should be able to briefly and generally screen for substance abuse and mental health disorders, whether the care setting is:
   - primary (e.g., schools, family physician offices);
   - secondary (e.g., community hospitals); or
   - tertiary (e.g., specialized mental health facilities).
3. **Attributes of screening instruments**

Screening tools need to be brief, straightforward and cost-effective enough to be comfortably, simply and efficiently administered, scored and understood by a wide range of professionals. They also need to be appropriate for—and useful in—screening youth. Determining the criteria of screening instruments involves paying attention to:

- particular agency mandates (e.g., specialized versus generic health and social services, identifying mental health disorders in a specialized substance use service);
- resources (e.g., staff skills in various topic areas); and
- purposes of screening results (e.g., improving staff decisions).

When selecting screening tools, critical factors are the target populations served (e.g., with respect to age, gender, socio-economic and cultural factors) and the instrument validity and reliability.

4. **Types of screening tools**

Some screening instruments identify substance abuse disorders but not other mental health disorders; some identify mental health disorders but not substance abuse disorders. Others, meanwhile, are dual-function. Below is a summary table of screening tools for youth. Selection of a particular screening instrument would be best determined by the aforementioned factors unique to each setting; for example, the younger the individual, the greater the requirement to employ instruments that can be completed by a parent.

**Summary of Screening Tools for Pre-Teens and Adolescents**

**Approximately Aged 12–19 (CAMH, 2009)**

<table>
<thead>
<tr>
<th>Mental Health but not Substance Abuse</th>
<th>Substance Abuse but not Mental Health</th>
<th>Both Substance Abuse and Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric Symptom Checklist (PSC); ages 4–16</td>
<td>CRAFFT; ages 14–18</td>
<td></td>
</tr>
<tr>
<td>Youth Outcome Questionnaire (Y-OQ-12); ages 4–17</td>
<td>RAFFT; ages 13–18</td>
<td></td>
</tr>
<tr>
<td>Child Behavior Checklist (CBCL); ages 6–18</td>
<td>Drug Acknowledgement Scale (ACK); ages 14–18</td>
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<tr>
<td>Strengths and Difficulties Questionnaire (SDQ); ages 11–16</td>
<td>Alcohol/Drug Problem Proneness Scale (PRO); ages 14–18</td>
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<tr>
<td>Youth Self-Report (YSR); ages 11-18</td>
<td>MacAndrew Alcoholism Scale-Revised (MAC-R); ages 14–18</td>
<td></td>
</tr>
<tr>
<td>Reporting Questionnaire for Children (RQC); ages 5–15</td>
<td>Detection of Alcohol and Drug problems in Adolescents (DEP-ADO); ages 14–19</td>
<td></td>
</tr>
<tr>
<td>General Health Questionnaire (GHQ); ages 11–15</td>
<td>Rutgers Alcohol Problem Index (RAPI); adolescents</td>
<td></td>
</tr>
</tbody>
</table>

**Implications for substance and allied professionals**

At any given time, 14 percent of Canadian youth are experiencing difficulties significant enough to meet criteria for a psychiatric disorder (substance abuse and mental health). Both substance abuse and mental health disorders have early onset and high co-morbidity.
And there are notable recurrences of mental health disorders, negative long-term consequences for youth, and substantial direct and indirect economic societal costs. Consequently, it is vital that there be a basic commitment across healthcare settings to screen adolescents for such problems. Moreover, it is critical to ensure that frontline individuals have the knowledge, skills, competencies and tools to screen youth for substance abuse and/or mental health difficulties.

With respect to screening youth, specific considerations are warranted. A developmental perspective is required (i.e., what’s ‘normal’ at one stage is not necessarily normal at another stage). Periodic screening may be beneficial during adolescence because substance abuse and mental health disorders vary at different life stages and these variations alter over time, with some emotional states or disorders discontinuing. It is important to consider youth motivation levels and their relationships with the screeners. It is also worth being sensitive to the potential risk of stigmatizing youth with substance abuse or mental health labels, as serious problems may not actually develop.

It is paramount to select screening tools that economically identify youth (i.e., those that most efficiently and effectively recognize general substance abuse and/or mental health problem areas in youth, and filter out youth without such issues). It is also crucial to examine screening stage, type(s) of disorders being screened, test development data (e.g., validity, reliability, norm sample, DSM-based model), agency/setting constraints, accessibility, cost and brevity of administration/scoring/interpretation.

Following a two-stage screening, the substance abuse and mental health workforce would ideally work with allied professionals to judiciously and efficiently apply assessment and treatment resources.

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References


Centre for Addiction and Mental Health. (2009). Screening for Concurrent Substance Use and Mental Health Problems in Youth.
