



**THE MENTAL HEALTH
SCREENING INTERVIEW
FOR ADOLESCENTS
SifA**

YOUNG PERSONS INTERVIEW

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1. Alcohol Misuse.

Consider all alcohol use here: Some social experimentation is normal in teenagers, do not rate as a problem.

In the last 2 months

Do you drink alcohol? What do you drink? Tell me about your drinking?

How many days a week do you drink? How much? How do you pay for it?

Does / has alcohol affected your daily life (stop you doing things)? Or got you into trouble? Have you missed things in the morning because you've had too much to drink the night before E.g. school, YOTs appointments?

Do you drink more than you plan to? Do you lose control? Do you drink alone?

Have you had blackouts / memory loss / hangovers / mood swings?

Have you done anything dangerous when drinking e.g. driving, climbing, taking risks, other dangerous behaviours, including fighting?

Have you tried to stop drinking? What happened? (Did you experience headaches, feel anxious or depressed, need to drink to make yourself feel better?)

Does the thought of not drinking make you angry, worried or depressed?

Do you need to drink more than double the amount to become drunk to the same level?

Do you plan your day around alcohol?

Motivation to change -

Does this bother you?

Ask or confirm to everyone.

(if not at all go to next section)

Not at all

A bit of a problem

A big problem

If help was on offer
would you consider it?

No

May be

Yes

Previous help

Do you think people have tried to help with this?

What help have you had from your family and friends?

What help have you had from professionals?

Severity score

1. No problem.
2. Mild problem, occasional heavy drinking, (e.g. once a week) but not affecting overall functioning at home, work or in education.
3. Moderate problem, excessive alcohol use, with moderate social consequences, such as problems in school or work as a result of alcohol use, loss of control of drinking, drinking excessively (most days of week or binge drinking twice a week), but no dependency symptoms (see 4).
4. Marked problem, psychological dependence on alcohol, with major social and recreational consequences, such as not attending school or giving up hobbies because of preoccupation with drinking and obtaining alcohol. Criminal behaviour associated with heavy alcohol intake or to obtain money to buy alcohol.
5. Severe problem, physical and psychological (as in 4) dependence. Person needs to drink more to become intoxicated, unsuccessful attempts to cut down; person may need to have a drink in morning to reduce withdrawal symptoms. Continued severe social, recreational and work/educational problems as a result of uncontrolled drinking.

See flow chart A

Name: _____

Date of Interview: _____

Interviewed by: _____

Notes

Severity Score =	1	2	3	4	5	<i>(please circle)</i>
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Action required

2. Substance Misuse.

Consider here substance misuse; e.g. all drugs including cannabis or solvent abuse.

In the last 2 months.

Do you use drugs? (Prompt for solvents, aerosols and drugs) Tell me about your use?

What drugs do you take? How do you take drugs? How many days a week do you use?
How much? How do you pay for it? Do you buy your own? Do you have your own dealer?
Do you use drugs on your own?

Do drugs affect your daily life (stop you doing things)? Have they got you into trouble?
Have you missed things in the morning because you've had too much the night before e.g.
school, YOTs appointments?

Do you use more than you plan to? Do you lose control and can't stop?
Do you ever use drugs to make you feel better?

Have you had blackouts / memory loss / bad come downs / mood swings?

Have you done anything dangerous whilst on drugs e.g. driving, climbing, taking
risks, other dangerous behaviour, including fighting?

Have you tried to stop taking drugs? What happened? (Did you experience
headaches, paranoia, feel anxious/depressed or need to take more drugs to make yourself feel
better)?

Does the thought of stopping using make you worried, angry or depressed?

Do you need to use more drugs now to get the same effects?

Do you plan your day around drug use?

Motivation to change -

Does this bother you?

Ask or confirm to everyone.

(if not at all go to next section)

Not at all

A bit of a problem

A big problem

If help was on offer
would you consider it?

No

May be

Yes

Previous help

Do you think people have tried to help with this?

What help have you had from your family and friends?

What help have you had from professionals?

Severity score

1. No problem.
2. Mild problem, occasional drug use (cannabis, recreational use, e.g. once a week) but not affecting overall functioning at home, work or in education.
3. Moderate problem, excessive drug use, with moderate social consequences, such as problems in school or work as a result of use, loss of control of drug usage, using excessively (most days of week), but no dependency symptoms (see 4).
4. Marked problem, psychological dependence on drugs, with major social and recreational consequences, such as not attending school or giving up hobbies because of preoccupation with drug using or obtaining drugs. Criminal behaviour associated with drug use or to obtain money to buy drugs.
5. Severe problem, physical and psychological (as in 4) dependence. Person needs to use more to obtain desired effect, unsuccessful attempts to cut down, person may need to have a use to reduce withdrawal symptoms. Continued severe social, recreational and work/educational problems as a result of uncontrolled drug use.

Name: _____

Date of Interview: _____

Interviewed by: _____

Notes

Severity Score = 1 2 3 4 5 (<i>please circle</i>)
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Action required

3. Depressed Mood.

Rate associated problems in appropriate sections, such as anxiety, PTSD, drug and alcohol misuse

Do not rate suicidal acts/ideas here, rate under section 4

In the last 2 months

How have you been feeling?

Any problem with feeling sad/down? How bad? How often? How long for?

Have you felt frustrated or wound up all of the time?

Do you ever feel like this for no reason?

Any problems with: - Losing interest in things? (e.g. friends, school, appearance, sport, hobbies)

Concentrating? (even on things you usually enjoy)

Feeling tired all the time?

Sleeping? (too much or too little, waking in the night)

Appetite? (gaining or losing a lot without trying to diet)

If YES to feeling sad, ask the following.

Do you know why you feel down? Is this due to things that have happened recently?

Do you feel bad about things that have happened in the past? Are these things actually your fault?

How do you feel about yourself as a person? (prompt marks out of 10)

Do you ever hate yourself? Or dislike yourself a lot?

Do you feel you are slowing down, physically or in your thoughts or speech?

Motivation

Does this bother you?

Not at all

A bit of a problem

A big problem

Would you want help for these symptoms

If not why not

No

May be

Yes

Previous help

Do you think people have tried to help with this?

What help have you had from your family and friends?

What help have you had from professionals?

Severity score

1. No problem.
2. Mild problem, gloomy or transient mood changes (1-3 days only) often associated with upsetting events (e.g. bullying, criticism, and/or being in trouble with others).
3. Moderate problem, definite depression and distress (5 or more days of the week), some thoughts of guilt, loss of self-esteem. May be irritable at home or school, or with peers.
4. Marked problem, as in 3. Inappropriate self-blame, slowing up physically or thoughts, some sleep problems, and weight change (up to half a stone, 4 kg, gain or loss)
5. Severe problem, as in 4, but very slowed, severe guilt, self-accusation, or critical thoughts. Obvious weight change and sleep problems, intense thoughts all of the time of sadness and worthlessness

See flow chart A

Name: _____

Date of Interview: _____

Interviewed by: _____

Notes

Severity Score = 1 2 3 4 5 <i>(please circle)</i>

Action required <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

4. Deliberate self-harm.

Consider deliberate self harm behaviour such as hitting self or self injury caused by cutting, overdoses, hanging, drowning, use of firearms.

Rate associated symptoms in respective areas, such as depression, anxiety, PTSD (sections 3, 5, 6)

In the last 2 months.

Have things ever got so bad that you have thought of hurting yourself e.g. after an argument, or when you're very angry, or when something bad has happened to you?

People hurt themselves in many different ways such as cutting, scratching, burning, banging head on walls, and punching walls. Have you ever tried this? How often?

Have you ever made plans or tried to kill or hurt yourself? How often? What happened? Did you want to kill yourself? Do you still feel like this?

Motivation to change -

Does this bother you?

Ask or confirm to everyone.

(if not at all go to next section)

Not at all

A bit of a problem

A big problem

If help was on offer would you consider it?

No

May be

Yes

Previous help

Do you think people have tried to help with this?

What help have you had from your family and friends?

What help have you had from professionals?

Severity score

1. No problem.
2. Mild problem, infrequent (once a fortnight) threats, gestures (obtaining pills, ligatures), worrying thoughts but no actual harm to self.
3. Moderate problems, infrequent (more than once a fortnight) threats, gestures (obtaining pills, ligatures), and some definite acts, but not life threatening, (e.g. superficial scratching or taking a few tablets).
4. Marked problem, e.g. a significant overdose or cutting episode, or an attempted hanging episode requiring medical attention. This might occur only once, or repetition is infrequent (2 episodes in 6 months)
5. Severe problem, repeated episodes of self harm usually life threatening and needing frequent medical intervention. Motivation to self harm persists in individual after life threatening episode.

See flow chart A

Name: _____

Date of Interview: _____

Interviewed by: _____

Notes

Severity Score =	1	2	3	4	5	<i>(please circle)</i>
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Action required

5. Anxiety symptoms

Consider here general anxiety and panic attacks.

Detail other specific worries e.g. social phobia, specific phobias or obsessional fears (checking rituals, fears of dirt or contamination) in a referral letter.

Rate worries associated with other problems, such as depression, PTSD or hallucinations, in appropriate area (sections 3, 6, 7)

In the last 2 months.

Do you ever worry a lot? Are you worried about anything at the moment?

How often? How much of the day?

Do you worry about things before they have happened?

Is there anything on your mind e.g. court appearances, school, your offence?

Are you so uptight that you can't relax even if you tried?

Can you stop worrying? Can you put it out of your mind?

Do you get headaches, stomach aches, aches and pains, feelings of restlessness?

Do you get easily tired, worn out, no energy, concentration problems or sleeping problems?

How often do these things occur?

Do you get panic attacks, heart racing, breathless, shaky, thoughts that something bad will happen, such as having some form of physical problem?

Do worries stop you from doing things, or interfere with how well you get on with your friends or family?

Motivation to change -

Does this bother you?

Ask or confirm to everyone.

(if not at all go to next section)

Not at all

A bit of a problem

A big problem

If help was on offer
would you consider it?

No

May be

Yes

Previous help

Do you think people have tried to help with this?

What help have you had from your family and friends?

What help have you had from professionals?

Severity score

1. No problem.
2. Minor problem. Worries appropriate to the situation, such as worries about future education, court appearance, parental ill health
3. Moderate problem, panic attacks at least once a month, with worries about having another one, or general anxiety at least three times a week. Person has some control of symptoms (panic or general anxiety) but needs prompting and reassurance.
4. Marked problems, symptoms frequently present (more than 3 times a week, panic attacks more than once a month), with great difficulty controlling symptoms, may be overwhelmed by panicky or anxious feelings leading to marked reduction in daily activities (school, work)
5. Severe problems, symptoms dominate overall function on most days of week, often incapacitating person. Loss of control of symptoms, with often symptoms such as problems sleeping, difficulty concentrating, restless and keyed up (person does not have to have all of these symptoms).

Name: _____

Date of Interview: _____

Interviewed by: _____

Notes

Severity Score = 1 2 3 4 5 *(please circle)*

Action required

6. Post traumatic stress problems

Consider events or situations that are exceptionally stressful, frightening or life threatening. Anxiety symptoms occur, but are related to the traumatic event.

Do not rate anxiety or depression symptoms unrelated to the event, rate in the appropriate sections 3 or 5.

Have any of these ever happened to you?

- Serious and frightening accident e.g. car accident? Have you been in a fire?
Have you been attacked or threatened? Have you been physically hurt in any way?
- Some young people have been hurt by others in different ways such as being hit, touched in a way that makes them feel uncomfortable or a sexual attack.
Has this ever happened to you?
- Have you ever seen family members being violent towards each other you been involved in violence within the family?
- Have you ever seen anybody being severely attacked or threatened?
Have you witnessed a sudden death/ suicide/ an overdose/ serious accident/ a heart attack?
- Any other distressing or very frightening experiences e.g. perpetrator or victim of crime?

If YES to one of the above then ask: In the last 2 months.

Do you think about this event a lot? Do you ever get images of the event, such as flashbacks / vivid memories? How often?

How does thinking about the event make you feel?

Do you have trouble sleeping, being irritable, or difficulty concentrating?

Have you had nightmares or bad dreams about the event?

Have you got upset if anything happened that reminded you of the event?

Do you avoid certain places or things that remind you of the event?

How does this affect your daily living? Can you control these things?

Motivation to change -

Does this bother you?

Ask or confirm to everyone.

(if not at all go to next section)

Not at all

A bit of a problem

A big problem

If help was on offer
would you consider it?

No

May be

Yes

Previous help

Do you think people have tried to help with this?

What help have you had from your family and friends?

What help have you had from professionals?

Severity score

1. No problem, no event, or no symptoms following a traumatic event.
2. Minor problem, some very mild symptoms, but person states that symptoms resolved or controllable
3. Moderate problem, definite symptoms in last month, but intermittent presence, and person has some control of symptoms if prompted or well motivated to control symptoms. Person avoids certain situations that remind them of event, have recurrent thoughts/nightmares or flashbacks, and have physical symptoms of anxiety associated with event (sleep, concentration, extra vigilant, very jumpy).
4. Marked problems, person often loses control and feels overwhelmed by symptoms, can get very tearful, angry or frightened. Significantly affects daily function at work/ home or school.
5. Severe problems, symptoms dominate daily function, often incapacitating and preoccupying person daily. Symptoms uncontrollable almost all of the time.

See flow chart A

Name: _____

Date of Interview: _____

Interviewed by: _____

Notes

Severity Score = 1 2 3 4 5 (<i>please circle</i>)

Action required

7. Hallucinations, delusions and paranoid beliefs.

Consider here odd or bizarre experiences, such as hallucinations - hearing own thoughts spoken out aloud, hearing voices talking to the person or about the person, seeing things, strong paranoid beliefs.

Do not rate beliefs based in reality e.g. real and immediate threats

Do not rate delusions associated with depression, rate under section 3.

Do not rate aggressive or destructive symptoms.

If symptoms are induced by drug or alcohol miss-use and are only present when intoxicated rate under 1 and/or 2. ,

Rate here if persistent beyond drug usage.

In the last 2 months.

Do you ever hear voices when you are alone? Have you seen things, or smelt things that others don't? What things? How often?

Do you have any unusual thoughts that other people don't seem to have? What?

Have you felt controlled by a force or power outside yourself, controlling your thoughts or actions?

Has anyone being plotting against you? How do you know?

Do you feel you have special powers? What?

Do these things affect your daily life? How do you feel about them e.g. distressing?

Motivation to change -

Does this bother you?

Ask or confirm to everyone.

(if not at all go to next section)

Not at all

A bit of a problem

A big problem

If help was on offer would you consider it?

No

May be

Yes

Previous help

Do you think people have tried to help with this?

What help have you had from your family and friends?

What help have you had from professionals?

Severity score

Base on all information available to you, not only from this interview.

1. No problem, no evidence of hallucinations or delusions.
2. Mild problem, mild paranoid beliefs not in keeping with reality, but little effect on daily function of person, or those in contact with person.
3. Moderate problem, definite paranoid thoughts and/or hallucinations, with mild to moderate distress to the person. As a result there is impaired functioning, such as some difficulty interacting with peers or adults because of symptoms.
4. Marked problem, preoccupation with paranoid thoughts and/or hallucinations, causing much distress to person, often odd and bizarre behaviour, and restriction of daily activities because of symptoms at least half of the week.
5. Serious problem, the person is seriously and adversely affected by delusions or hallucinations causing severe distress most days of the week. Behaviour towards others is obviously incoherent and bizarre. The person may be seen to be preoccupied and responding to hallucinations (voices or seeing things)

See flow chart B

Name: _____

Date of Interview: _____

Interviewed by: _____

Notes

Severity Score =	1	2	3	4	5	<i>(please circle)</i>
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Action required

8. Hyperactivity

Consider here hyperactivity, particularly hyperkinetic disorder. Include overactive behaviour associated with any cause such as severe attachment disorders, chaotic or abusive parenting hyperactivity associated with learning disability.

Do not rate here if symptoms are induced by drug or alcohol misuse and are only present when intoxicated rate under sections 1 and/or 2,

The following information needs to be gathered from a variety of informants who know the young person well. Do not use the young person's response to questions in isolation.

- Do you have any problems with paying attention? When is this?
Who are you with? What do other people say about this?
- Do you get told that you don't listen? Do people say that you talk too much?
- Do you have problems with doing things without thinking them through?
- Do you interrupt people?
(If at school, may involve interrupting the teacher constantly or talking over friends)
- Do you find it hard to sit still?
- Do you find it hard to complete an activity or task even if you are enjoying it (e.g. schoolwork or unable to sit and watch a video all the way through, or finish video game etc)
- Do you lose things constantly? Do people say you are forgetful?

Motivation to change -

Does this bother you?

Ask or confirm to everyone.

(if not at all go to next section)

Not at all

A bit of a problem

A big problem

If help was on offer
would you consider it?

No

May be

Yes

Previous help

Do you think people have tried to help with this?

What help have you had from your family and friends?

What help have you had from professionals?

Severity score

1. No problem.
2. Minor problem, overactive and easily distracted, but if prompted can control behaviour and sustain attention on task
3. Moderate problem, symptoms present mostly in large group settings such as mainstream class, or youth group. This leads to definite impaired functioning such as removal from class for brief periods, poor completion of work, inability to finish straightforward tasks such as short pieces of homework due to inattentiveness. When on own, symptoms can be controlled by prompting and young person can modify and partly control symptoms.
4. Marked problems, symptoms frequently present in all settings, group and on own. Symptoms have impact on others such as stress on carer, teacher and family members. Person mostly seems to have lost control of symptoms despite prompts and extra supervision.
5. Severe problems, symptoms dominate daily function, often incapacitating person (repeated loss of friends, education, work). Almost total loss of control of symptoms, unable to concentrate for even a few minutes, restless and on the go all the time. Major impact on others trying to help person.

See flow chart A

Name: _____

Date of Interview: _____

Interviewed by: _____

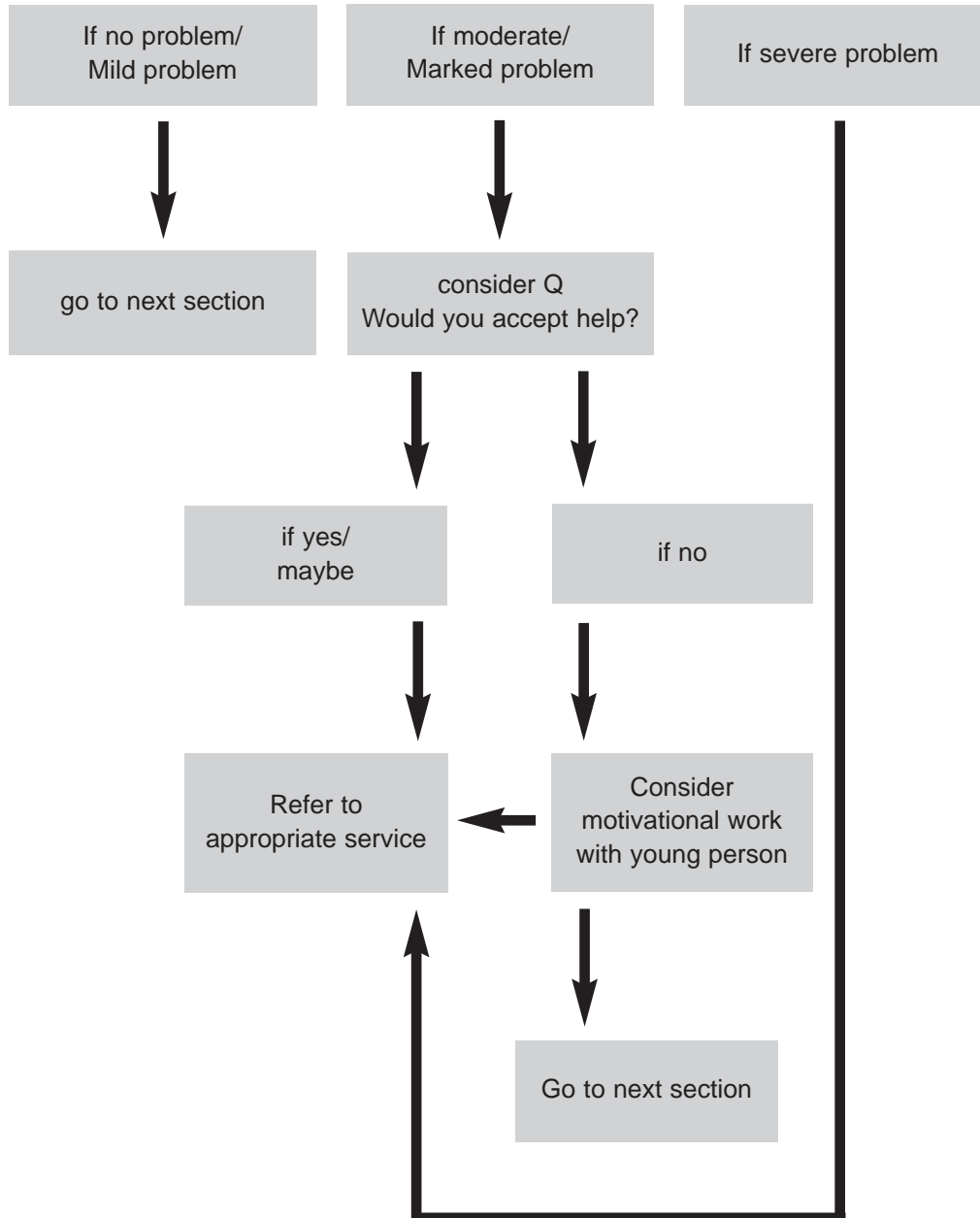
Notes

Severity Score =	1	2	3	4	5	<i>(please circle)</i>
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Action required

Flow chart A - Applies to sections 1-6 and 8

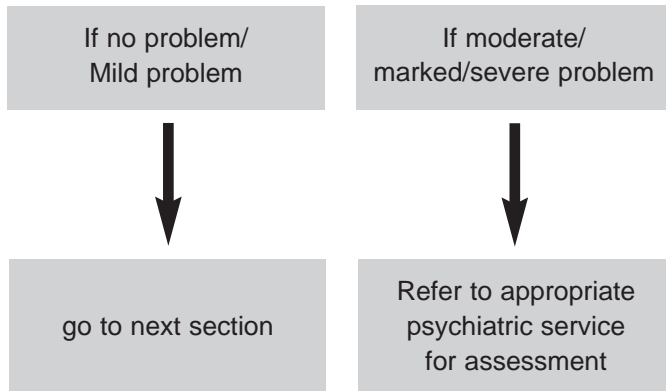
In making a judgement of severity consider responses at interview and all other sources of information available to you



Flow chart B - Applies to section 7

(Hallucinations, delusions & paranoid beliefs)

In making a judgement of severity consider responses at interview and all other sources of information available to you



Summary Sheet

Name: _____

Date of Interview: _____

Interviewed by: _____

1 Alcohol misuse
Problems identified _____

Severity score **1** **2** **3** **4** **5** *(please circle)*

2 Substance misuse
Problems identified _____

Severity score **1** **2** **3** **4** **5** *(please circle)*

3 Depressed mood
Problems identified _____

Severity score **1** **2** **3** **4** **5** *(please circle)*

4 Deliberate self harm
Problems identified _____

Severity score **1** **2** **3** **4** **5** *(please circle)*

5 Anxiety symptoms
Problems identified _____

Severity score **1** **2** **3** **4** **5** *(please circle)*

6 Post traumatic stress problems
Problems identified _____

Severity score **1** **2** **3** **4** **5** *(please circle)*

7 Hallucinations, delusions and paranoid beliefs
Problems identified _____

Severity score **1** **2** **3** **4** **5** *(please circle)*

8 Hyperactivity
Problems identified _____

Severity score **1** **2** **3** **4** **5** *(please circle)*

Gender and cultural issues

Action plan

Signature