SCREENING FOR MENTAL DISORDER IN THE YOUTH JUSTICE SYSTEM

Supporting notes
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We would also like to thank the Bury and Birmingham Youth Offending teams, Rainsbrook STC, Werrington HMYOI and Orchard Lodge (LASU) who participated in both the piloting of this tool and the training package for this project.
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INTRODUCTION

The Youth Justice Board for England and Wales is committed to addressing the mental health needs of young people within the Youth Justice System. The Board commissioned The University of Manchester and Salford NHS Trust to develop a Child and Adolescent Mental Health Screening tool to be attached to the Youth Justice ASSET assessment form. This manual has been developed to support local training of Youth Justice staff in the use of the screening tool.

A comprehensive search of international literature and screening tools was performed which revealed a shortage of dedicated screening research in this area. It was concluded that the most practical approach would be to devise a two-stage screening process (described in section 3) with an initial short screening questionnaire completed by Youth Justice staff followed if necessary by an in-depth screening interview completed by Youth Justice health professionals. A parallel research study was undertaken to validate and ascertain the psychometric properties of the new tools.

The tools were evaluated in a variety of YOT and secure estate settings including the Bury and Birmingham Youth Offending teams, Rainsbrook STC, Werrington HMYOI and Orchard Lodge (LASU), and both research workers and youth justice workers performed the screening.

The new mental health Screening Questionnaire Interview for Adolescents (SQIfA) has the following overall psychometric properties for all domains in the first stage questionnaire:

- Sensitivity = 80%
- Specificity = 55%
- Positive Predictive Value = 61%

The detailed Screening Interview for Adolescents (SIFA) is a modified Salford Needs Assessment Interview (SNASA). This too has been extensively validated and its psychometric properties well documented (Kroll et al, 1999).

The psychometric properties of each tool are compatible with the aims of the project, which were to ensure young people with a disorder were not missed in the screening process and appropriate referrals were made to Child and Adolescent Mental Health (CAMH) Tier 1 to Tier 4 services. The Youth Justice Board will conduct an ongoing evaluation of the effectiveness of the new screening tools in the field following implementation.

More detailed descriptions of the screening tools can be found in the manual as follows:

- **Stage 1** - Screening Questionnaire Interview for Adolescents (SQIfA)
  Section 5 & Appendix C

- **Stage 2** - Screening Interview for Adolescents (SIFA)
  Section 6 & Appendix D
YJB Guidance notes
for the Mental Health Screening Tool

Screening Pathway
The Screening Pathway should be considered for all young people within the Youth Justice System (YJS) and action taken based on the following outcomes.

The Screening Pathway is intended to improve the identification of young people within the YJS who have mental health needs. It is important that these young people are supported by youth justice services to access the appropriate level of Child and Adolescent Mental Health Tier 2 to 4 services that they require. In any situation where it is clearly evident that a young person has mental health needs that require urgent assessment by specialist Child and Adolescent Mental Health Services, an immediate referral should be made to the appropriate local team. In these cases there is no requirement to complete the screening pathway before making a referral.

Where specialist assessment and treatment resources are not available to meet a young persons needs as identified by the screening pathway, and/or long waiting lists exist, the best possible alternative support package which should have already been considered, should be put in place while waiting for access to specialist CAMHS.

ASSET Tool
Section 9. Emotional and Mental Health
If a young person scores 2 or more in Section 9 of ASSET then SQIFA should be completed

<table>
<thead>
<tr>
<th>SQIFA</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 or 1</td>
<td>no problem in this area</td>
</tr>
<tr>
<td>2</td>
<td>consider repeating the questionnaire in 4-6 weeks or if circumstances change</td>
</tr>
<tr>
<td>3 or 4</td>
<td>possible problems, full screening interview SIFA should be carried out</td>
</tr>
</tbody>
</table>

Flow Charts A and B at the end of Appendix D give guidance to the next steps.

All decisions regarding action taken or decisions not to proceed with further screening and or referral, should be recorded on the young persons case file.

Consent
The Mental Health screening tools are attached to ASSET and form part of the wider assessment of a young persons needs.

It is important that each young person is given the opportunity to discuss all issues raised by the screening tools. It should be made clear to each young person that they are not required to disclose any information that they do not want to discuss during the screening interviews.
A young person can opt out of the SIFA interview at any time if they decide they do not want to participate. While it is preferable that the screening process is completed to enable the best decision on the most appropriate support package and/or referral to be made, in all cases the decision to put in place appropriate services is not dependant on a completed interview. The best interests of the young person should be paramount at all times during the screening process.

Confidentiality
- Clear statements need to be made about who has access to information and where information is recorded.
- Explain that information obtained will not be used against the young person in any way, and forms part of the health assessment as part of the multi-disciplinary assessments within the Yot or secure setting.
- Clarify that you are required to share information if a young person is at risk to themselves or others, or if they are at risk of abuse by others.
- Information may also need to be shared if the young person becomes subject to a formal assessment under the Mental Health Act.

Note: Guidance for Youth Offending Teams on Information Sharing, YJB Guidance Note 2 applies.

How to use the manual

This manual will be both a practical tool and reference point. It covers information on the mental health of young people, the screening process and considers referral to other agencies. It complements the accompanying training video, and mental health training days.

It is aimed at two groups of workers within the youth justice system.
- Firstly, workers from all backgrounds and disciplines, who have limited or no experience of mental illness, for which it will highlight key warning signs of illness and introduce the initial screening tool.
- Secondly, those who have an interest or some expertise in mental health difficulties who may wish to be trained in the interview based screening of mental health needs.

The following sections will address the issues raised in the screening process and look at basic warning signs and symptoms for common or important mental disorders. They will cover in detail both components of our 2 stage-screening programme.

The final but important section addresses the issue of what to do with the young people in whom you have identified a mental health need. It considers how you may appropriately use local resources and how you can best approach both statutory and voluntary services.

All professional codes of practice apply when undertaking the mental health screening tools. Responsibilities under the Children Act are of particular note. If an assessment indicates that the young person is at significant risk of harming themself or others then urgent psychiatric assessment is required. In circumstances when
abuse is revealed and or there is a risk of further abuse then this information needs to be shared with operational and team managers. All appropriate action to protect the young person under local child protection procedures should be followed.

*These processes need to be considered carefully as part of the preparation work before screening for mental health needs*
WHAT IS SCREENING?

Screening is an important strategy in the prevention and treatment of illness. In this manual screening aims to detect the early signs of mental illness.

Setting up your screening programme

Health screening programmes should aim to identify either common or severe and treatable illness within a given population. Research evidence has clearly demonstrated significant mental health difficulties among young people in contact with the youth justice system. However, it is important to carefully consider which specific areas of mental health need should be screened. All difficulties identified in the screening process must have proven and effective intervention strategies available. For this reason in this YJB screening tool we have selected 8 important and treatable mental health problems.

Before any screening begins it is important to spend time thinking through and developing guidelines on how your service could respond to a young person with each of the highlighted mental health areas. This process will involve accurate identification of local mental health services and a variety of both statutory and voluntary resources. The value of establishing links with other agencies before you start screening cannot be overemphasised. The next section in the manual covers this in greater detail.

Key point

- Before any screening takes place the most important steps to consider are what can be practically done for those who screen positive.
- It would be detrimental to both the young person and the service to start screening without having mechanisms in place to meet the needs of those with mental health problems.

Considerations when using a mental health screening tool

- Much illness arising from mental health problems comes from symptoms below the threshold for the diagnosis of disorder. This YJB tool focuses on mental health needs important in the young offending population and information gained will aid in appropriate intervention or referral.

- Psychiatric diagnoses can be of limited value in planning mental health services as they take no account of what treatments have been offered, whether they are appropriate and evidence-based, and whether the young person themselves perceives they have a problem. This screening tool has selected eight mental health areas of need in which interventions have been established and the motivation of the young person to access help and effectiveness of prior help received are assessed.

- Screening tools all have inaccuracies with a proportion of false positives detected and true positives missed. This tool has been validated to try and determine the optimal balance between the two within the aims of this screening process.
In this YJB mental health screening programme we are looking at
• Mental health in young people not criteria for disorder

*Lack of motivation can be a negative symptom which informs the assessment and need for treatment.*

**Why screen for mental illness?**

The main purpose of screening should be to identify those at high risk of developing mental illness or youngsters who have already developed the disorder. There may be other objectives. For example, screening may be incorporated into a programme to reduce the risk of outcomes important to the youth justice system such as violence and aggression. While the main reason for screening and treating mental disorders is humanitarian, interventions to reduce offending are likely to be more effective if criminogenic, sociobiological, psychiatric and psychological factors are addressed alongside other assessed risk factors. Tackling one factor in isolation to other problems will have limited impact on abating a young person's offending behaviour.

**Screening for mental disorders is not the same as assessing risk but can help determine risk eg. Paranoid disorders, common hallucinations and complex post traumatic stress disorder.**

**Issues in planning screening strategies in the youth justice system**

• When undertaking a screening programme it is important to develop links with a range of treatment resources.

• Ensure that screening does not stigmatise young people

• The purpose of screening is to detect reversible risk, not risk factors

• Some client groups are at higher risk of mental illness than others

• Mental health is not static but changes over time

**Any screening process needs to be carefully considered within the team before implementation.**

For further detailed information on screening tools and screening populations see appendix A.
THE MENTAL HEALTH SCREENING PROGRAMME

The previous section has raised general issues about the setting up of a mental health screening programme within the youth justice system. Here we describe the YJB mental health screening process and raise points to consider. In further sections of the manual we will describe the screening tools themselves in greater detail.

How screening for mental health fits into the youth justice system

The CAMHS tier model  (H.A.S document, Together We Stand)

Child and Adolescent Mental Health Services (CAMHS) is a term used to describe the range of services and professionals working in the field of young people’s mental health. In many areas services have been organised into 4 tiers, and services should be available for each level of need. The chart below sets out a model in which services could be organised. Workers within the youth justice system are included in the Tier 1 services.

<table>
<thead>
<tr>
<th>Tier 1</th>
<th>Primary Care Services including interventions by</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• GPs</td>
</tr>
<tr>
<td></td>
<td>• Health visitors</td>
</tr>
<tr>
<td></td>
<td>• School nurses</td>
</tr>
<tr>
<td></td>
<td>• Social services</td>
</tr>
<tr>
<td></td>
<td>• Voluntary agencies</td>
</tr>
<tr>
<td></td>
<td>• Teachers</td>
</tr>
<tr>
<td></td>
<td>• Residential social workers</td>
</tr>
<tr>
<td></td>
<td>• Juvenile justice workers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tier 2</th>
<th>Services from Uni-professional groups</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>which relate to each other, rather than within a team</td>
</tr>
<tr>
<td></td>
<td>• Clinical child psychologists</td>
</tr>
<tr>
<td></td>
<td>• Educational psychologists</td>
</tr>
<tr>
<td></td>
<td>• Paediatricans</td>
</tr>
<tr>
<td></td>
<td>• Child &amp; Adolescent psychiatrists</td>
</tr>
<tr>
<td></td>
<td>• Community psychiatric nurses</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tier 3</th>
<th>Specialist services for more complex and severe disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>usually a multidisciplinary team, which may consist of</td>
</tr>
<tr>
<td></td>
<td>• Child &amp; Adolescent Psychiatrists</td>
</tr>
<tr>
<td></td>
<td>• Social workers</td>
</tr>
<tr>
<td></td>
<td>• Clinical Psychologists</td>
</tr>
<tr>
<td></td>
<td>• Community psychiatric nurses</td>
</tr>
<tr>
<td></td>
<td>• Child psychotherapists</td>
</tr>
<tr>
<td></td>
<td>• Occupational therapists</td>
</tr>
<tr>
<td></td>
<td>• Art, music and drama therapists</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tier 4</th>
<th>Tertiary level services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>highly specialised services both as outpatients, day patients or in-patients for those with severe mental health difficulties. Often covering large geographical areas e.g.</td>
</tr>
<tr>
<td></td>
<td>• Adolescent in-patient units</td>
</tr>
<tr>
<td></td>
<td>• Secure forensic units</td>
</tr>
<tr>
<td></td>
<td>• Specialist outpatient teams</td>
</tr>
</tbody>
</table>

Key point

Mental health in young people is the responsibility of all professionals with whom they come into contact
Screening in the context of local resources

Before any screening process is performed careful thought and planning needs to be exercised within the team as to who will implement the screen and what should be done for those who screen positive.

Service mapping
At a local level initial groundwork will need to be done into discovering what local resources are available to meet the mental health needs of the young people with whom you are dealing. There will probably be a wealth of information and knowledge of what is locally available to young people within your own team. This will include both statutory health services, like general practitioners, or local child and adolescent, and adult mental health teams, as well as voluntary sector organisations.

Provision of health services is enormously variable nationwide and who has responsibility for obtaining and holding this information within each YOT or secure unit needs to be made clear to all workers. Clear mechanisms of accessing and sharing information with others need to be explicit to all within the team.

Statutory services

General Practitioners
Some young offenders have chaotic and transient lifestyles and are not registered with a General Practitioner: an initial step would be to encourage the young person to do this. Increasingly General Practitioners are developing sub specialities and there may be local doctors who have a particular skill or interests, e.g. in treating the homeless or those who abuse substances and alcohol. You may want to approach the local Primary Care Trust who can make you aware of what is available locally.

Child and Adolescent Mental Health Services (CAMHS)
Local child and adolescent mental health services (CAMHS) will vary in their composition, the age range they will see and how they except referrals.

A CAMHS team may consist of:
- Clinical psychologists
- Educational psychologists
- Psychiatrists
- Mental Health Practitioners
- Mental health nurses
- Psychotherapists
- Family therapists
- Speech and language therapists
- Occupational and art therapists
- Social workers

Sometimes there is a clear link/liaison between the juvenile justice services and CAMHS teams, with mechanisms to discuss worrying individuals and to make referrals. Often however, these mechanisms are unclear. Therefore, it is important to have a firm picture of the age range a service will provide for, clear procedures of referral and who may respond in an emergency.
Adolescent Mental health services
In a few areas there are separate specialist services for adolescents being developed and these are likely to increase in number over the coming years. Many of these services will attempt to address the difficulties and needs within this age groups and may bridge the transition to adult mental health care. Presently these services are few and far between.

Adolescent Forensic Services
There are at present only three regional specialist forensic adolescent services in the North West, North East and Midlands. The units do provide national coverage for assessments. Each service offers assessment of individuals with inpatient and outpatient treatments. Possible pathways to accessing such services will need to be explored with child and adolescent services locally. The best way to approach this is to open a dialogue with the local CAMHS team, preferably with a named point of contact.

*Your persistence in trying to establish communication will eventually pay off.*

Adult psychiatric services
For 16 and 17 year olds the local adult mental health or drugs and alcohol teams may be all that is available locally. Gaining accurate information about the services and resources offered and how they will accept referrals is worthwhile.

It can be frustrating trying to access mental health services at times of crisis and initial preparation may help to facilitate this when an emergency arises. Referral for the 16-18 year old age group can be particularly unclear as to whether it should be to the child or adult service and cases may have to be discussed individually. It would be worth periodically making contact with services to see if there have been any changes to local protocols.

*Forewarned is forarmed.*

Voluntary sector and non mental health services
For many young people with mental health issues voluntary services and organisations may be the most acceptable and/or appropriate first line response.

Gaining information on local services is important and rewarding groundwork to establishing a screening programme. This information may be obtained through local youth groups and schools, social and council services, and through national organisations, like Young MIND and the internet.

Services that can support young people’s mental health may include:
- Education
- Employment and training resources
- Housing associations and social supports
- Youth groups
- Sport and recreational organisations
- Local and national support groups
It is worth approaching these groups directly to obtain clear information on who they offer services to and the range and variety of support available. Familiarise yourself with initial contact procedures and ask for other local contacts they may know.

The range of services can be vast, from specialist drug and alcohol services to self harm groups, individual counselling services and structured activities. The value to young people of contact with others with similar problems and difficulties cannot be underestimated.

_Armed with the above information you are now ready to start screening._

**The YJB Mental Health Screening Programme**

The following section describes our 2-stage screening programme. Although we will give guidelines and suggestions within this manual, it is important that the process is tailored to meet your individual service’s needs and resources. The programme is designed to be flexible. Screening for mental health is a complex process. The programme has two stages. The initial screen aims to identify those young people who have a higher risk of mental health difficulties. The second stage interview attempts to identify these mental health needs.

**The 2-stage YJB mental health screening programme**

<table>
<thead>
<tr>
<th>Universal screening interview</th>
<th>Screen positive</th>
<th>Screen negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>completed on all young people within the youth justice system</td>
<td></td>
<td>consider repeating if concern or circumstances change</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Semi-structured interview by designated trained worker</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>screen positive</th>
<th>screen negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer to appropriate local service</td>
<td>Repeat interview In 4-6 weeks</td>
</tr>
</tbody>
</table>
The mental health Screening Questionnaire Interview for Adolescents (SQIfA)

- Designed to be a quick, broad questionnaire that screens for 8 common or important mental health problems in adolescence
- The screening questionnaire will be incorporated into the ASSET form and should be completed at first contact
- The questionnaire itself is a ‘stand alone’ tool to be used at times of key life events, stresses or change for the young person and in those who are thought to be at high risk
- Is repeatable as mental health needs change over time
- Those identified as screen positive go on to the 2nd stage screening interview

The mental health Screening Interview for Adolescents (SIIfA)

- A more detailed semi-structured interview designed to elicit symptoms of mental health problems in key areas
- Administered by an identified and trained juvenile justice worker
- Information gained will inform the next course of action
- It is repeatable as mental health needs change over time

Aims of the mental health screening programme

- To help in the identification of those who have symptoms of mental health difficulties that require further assessment and appropriate support and/or treatment.
- To be incorporated into an ongoing process of mental health surveillance within the youth justice system
- To identify accessibility issues for young people who require a range of local services.

Once a young offender is identified as at risk of mental health problems, the next step is to decide what may be appropriate to access in the context of your local services and resources.

Section 7 looks at how you may approach local services.

Key point

- Mental health is everyone’s responsibility
- Mental health surveillance is an ongoing process
- Mental health needs change over time
We cannot cover every aspect of mental disorder among young people. Our aim is to highlight key warning signs and presentations of the following mental health problems that are looked at in the screening tool:

- Depression
- Self harm
- Anxiety
- Reaction to experiences such as post traumatic disorder
- Substance misuse
- Attention deficit hyperactivity disorder
- Psychotic disorders

This list is not exhaustive but covers common or important presentations of mental illness in young people who offend. It is important that all workers within the youth justice system have some awareness of the warning signs of mental disorder. As with all screens, the YJB tool will not be perfect and a small proportion of those with difficulties will be missed.

Conduct disorder is a term used to denote a syndrome of core symptoms characterised by the persistent failure to control behaviour appropriately within socially defined rules. It has been excluded from the screening tool, as this classification is broad and often unhelpful in accessing appropriate support. Within the youth justice system the majority of individuals would meet the criteria for conduct disorder. However, a proportion will also have many wide-ranging mental health needs and presentations within the areas that have been covered by the YJB mental health screen.

**Adolescent development**

Adolescence is a time of great shifts biologically, socially and cognitively. Key changes are as follows

- Puberty reflects upsurges in hormones and alterations in sexual and aggressive behaviours.
- Development and maturation in thinking occurs but there is a wide variation amongst individuals with important consequences for social adaptation.
- Self-esteem tends to increase, but is threatened by a mismatch between physical and emotional development.
- Separation from parents occurs with formation of peer groups becoming predominant.
- A shift has to be made from accepting rules and boundaries to the development of self-imposed controls within a society.

The prevalence of many psychiatric disorders is roughly equal amongst boys and girls prior to puberty. During adolescence gender differences in rates of disorder are more pronounced

*These factors will all have an impact on how young people may present with mental health difficulties and need to be considered in making an assessment.*
Developmental, cultural and gender issues

Just as the developmental stages of adolescence have an impact when screening for mental health, developmental, cultural and gender factors need to be taken into account. For instance:

• Delays or disorders of development with difficulties in language and social communication and behavioural problems should always be considered. Many of these problems may present as symptoms of mental illness, and may also predispose the individual to mental health problems.

• Learning disabilities are often not recognised among young offenders. A learning difficulty may impact on the presentation of mental health symptoms as well as mimic some symptoms of illness.

• Cultural context is very important. Many cultures and languages have differing forms of expression for mental distress. These need to be carefully considered and recognised when trying to pinpoint mental health needs. It is important to remember that some behaviours that you may perceive as problematic or abnormal may be acceptable and appropriate within other cultures. All judgements about behaviours and beliefs need to be made within the young person’s own cultural background and information about this may need to be gathered from the family, community and mental health professionals working with the relevant cultural group.

• There are gender differences in the presentation and frequency of some mental health problems and an awareness of this will inform the screening process. For example, attention deficit hyperactivity disorder is four times more common in boys than girls.

Comorbidity

Comorbidity is the presence of two or more areas of mental health difficulty. This is very common in the young offending population and should always be borne in mind. Underlying symptoms may be masked by more tangible presentations, such as alcohol and substance misuse or aggressive behaviours.

When screening among young offenders it is important to enquire about all areas of difficulties. Anxiety, depression and traumatic experiences are commonly masked but potentially treatable disorders.

Risk & Resilience

When considering life experiences, why do some young people develop mental health problems while others with similar experiences and backgrounds do not? The consideration of risk and resilience attempt to answer this.
Risk factors for mental health problems in young people

<table>
<thead>
<tr>
<th>Individual</th>
<th>Family</th>
<th>Societal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exposure to trauma or stress</td>
<td>Hostile or rejecting relationships – emotional abuse</td>
<td>Economic deprivation</td>
</tr>
<tr>
<td>Bullying</td>
<td>Inconsistent parenting</td>
<td>Discrimination of any kind</td>
</tr>
<tr>
<td>Substance misuse</td>
<td>Physical and sexual abuse</td>
<td>Delinquent peer groups</td>
</tr>
<tr>
<td>Chronic health problems</td>
<td>Family history of mental illness</td>
<td></td>
</tr>
<tr>
<td>Being arrested</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication difficulties and developmental delay</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Certain factors are protective to the young person and may help them through, despite great adversity. This is resilience.

Resilience factors that foster good mental well-being

<table>
<thead>
<tr>
<th>Individual</th>
<th>Family</th>
<th>Societal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good self esteem and personal confidence</td>
<td>Members hold each other in high regard</td>
<td>High standard of living</td>
</tr>
<tr>
<td>Accomplishment and achievement</td>
<td>Positive role models</td>
<td>Supports within the community network</td>
</tr>
<tr>
<td>Problem solving skills</td>
<td>Appropriate support for individual development</td>
<td>Positive experiences outside the home</td>
</tr>
<tr>
<td>Adaptability to change</td>
<td>Consistent parenting and supervision</td>
<td></td>
</tr>
<tr>
<td>Clear &amp; appropriate supports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High intelligence</td>
<td></td>
<td></td>
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<tr>
<td>Having a skill or ability e.g. sports, music</td>
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</table>

Common causative factors in mental health problems

When considering the causal factors linked to the development of mental health difficulties within an individual, many common themes arise. In all of the problems we are screening for there is no one specific cause. Mental health difficulties are therefore multifactorial and highly variable from individual to individual.
Factors can be split into three broad categories as follows;

### Individual factors

<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategory</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genetic predisposition to a specific mental illness</td>
<td>Few specific genes have been identified as yet for mental disorders, a combination of genes and environment is more likely to be an explanatory factor</td>
<td></td>
</tr>
<tr>
<td>Psychological</td>
<td>Temperamental factors of an individual</td>
<td>Specific personality traits may be more predisposed to particular illnesses</td>
</tr>
<tr>
<td>Physical illness</td>
<td>Poor physical health, especially chronic or life threatening disorders, or any illness that effects the brain</td>
<td></td>
</tr>
<tr>
<td>Social</td>
<td>Social isolation and poor/no support networks</td>
<td></td>
</tr>
</tbody>
</table>

### Family factors

<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategory</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family history of mental health problems</td>
<td>A family history of any mental health problem, particularly amongst 1st degree relatives (parents &amp; siblings) will increase the chance of an individual developing a mental illness</td>
<td></td>
</tr>
<tr>
<td>Psychological factors</td>
<td>A family’s reaction to stress and their strategies to problem solving will impact on the individual</td>
<td></td>
</tr>
<tr>
<td>Family functioning</td>
<td>Emotional, physical and sexual abuse within a family increases the risk of mental health problems</td>
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<td></td>
<td>Poor family communication</td>
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<td></td>
<td>Family dysfunction and breakdown</td>
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### Environmental or social factors

<table>
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<tr>
<th>Category</th>
<th>Subcategory</th>
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<tr>
<td>Economic deprivation</td>
<td>Poor housing</td>
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<td></td>
<td>Unemployment</td>
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<td>Poor health care</td>
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<td>Criminality</td>
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<td>Social exclusion</td>
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<td>Loss of role within the community</td>
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<td>Poor support networks within the community</td>
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</table>

We will now look at the disorders in turn focusing on the key features in each.
Depression

Depression is common in young people who offend. Estimates vary between one in three and one in six of those with conduct disorder. The rates are higher with simultaneous alcohol or substance misuse.

There is no gender difference in rates of depression before puberty but among adolescents girls have higher rates than boys. However this may not be so marked if conduct disorder is also present. It is important to have a high index of suspicion of depressive disorder in young offenders. Many depressive symptoms may be misattributed to behavioural problems and can be difficult to uncover.

As well as identifying depressive symptoms, asking the young person about acts of self-harm and thoughts of suicide is crucial. Alcohol and substance misuse should also be assessed. Workers should be alert to the possibility of postnatal depression among young mothers and priority support will need to be given to those with a previous history of mental health difficulties. Monitoring of this at risk group of young women should be done in conjunction with local community midwives and health visitors.

Key symptoms of depression in young people include:

- Persistent low mood
- Irritability
- Altered sleep pattern
  - early morning wakening
  - insomnia or hypersomnia (over sleeping)
- Appetite disturbance
  - either decreased appetite or overeating
  - accompanying weight changes
- Loss of libido
- Feelings of hopelessness, helplessness, worthlessness or guilt
- Loss of self esteem
- Lack of enjoyment in life
- Withdrawal and isolation - from family and peers
- Alcohol and drug use

Suicidal ideation and thoughts of self-harm may be present in a depressive illness and are covered in a separate section. Occasionally in very severely depressed individuals the clarity of thinking is so impaired that their thoughts may become delusional in quality. In such cases, for example, the young person may become convinced they are seriously physically ill or that the world is about to end. Often in severe depressive episodes the individual’s ability to recognise their own illness is impaired.

Any young person who presents with persistent features of a depressive illness needs further assessment. The young person should be told of your concerns for them.
## Interventions for depressive symptoms

The treatment approach will vary according to the individual’s circumstances, the severity of illness and compliance issues. In broad terms strategies are:

<table>
<thead>
<tr>
<th>Psychological</th>
<th>Pharmacological</th>
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<tbody>
<tr>
<td>• Counselling</td>
<td>• Antidepressant drugs - used daily usually for 6-12 months</td>
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<tr>
<td>• Cognitive behavioural therapy</td>
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<tr>
<td>• Problem solving e.g. stopping bullying if this a causal factor</td>
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</table>

### Outcome in depression

Most depressive episodes will resolve and the individual will return to their prior level of functioning. A proportion of young people who have already experienced a depressive illness will go on to have further episodes. Past history of illness is an important risk factor. A very small proportion of young people will have a poor response to treatment and have chronic symptoms.

## Self harm and suicidality

Deliberate self-harm (DSH) has been defined by Morgan (1979), as ‘a deliberate non-fatal act, whether physical, drug overdose or poisoning, done in the knowledge that it was potentially harmful.’

**Self harm** is seen by the young person as a solution to a problem and often not an attempt at taking life. The act of self harm significantly raises the risk of an accidental suicide. Self harm is distinct from a deliberate suicide act.

**Suicide** refers to a conscious desire and act to end one's life. It is not invariably linked with mental disorder.

Deliberate self harm and suicidality are distinct phenomena and are not interchangeable terms.

Research has linked many common factors to suicide and DSH in young people. These include

- Family dysfunction and relationship difficulties
- Physical and sexual abuse
- Substance misuse
- Personal knowledge of DSH or suicide, among family/friends
- Significant life event e.g. bereavement, traumatic experience
- Custody
- School non-attendance and unemployment
- Economic deprivation and personal debt
- Serious physical illness
- Mental illness especially depression and schizophrenia

Males are at greater risk of completed suicide and tend to prefer more violent or high-risk methods. Females are at greater risk of repetitive self-harm.
Self Harm
Methods of self-harm also show gender and cultural variation. A young person’s choice of self-harm will vary with personal knowledge and prior exposure to acts of self-harm and depend on availability of methods.

Behaviours include
• **Drug overdose** - both prescribed and illicit
• **Laceration, self mutilation and foreign body insertion**
• **Self asphyxiation and hanging**
• **Drowning**
• **Electrocution**
• **Jumping** - from heights and in front of vehicles

Other possible self-harming behaviours include
• **Substance abuse**
• **Eating disorders**
• **High risk offending behaviours**
• **Promiscuity**

The key to identifying an act of self harm from one of attempted suicide is to understand the young person’s perception of the outcome from their self-harming behaviour and the degree of their suicidal intent.

In a young person the reasons for acts of self-harm are multiple. Some possible reasons are:
• To end their life
• A physical expression of their emotional state
• To externalise pain
• An act of self punishment or guilt
• To release tension
• A learned coping strategy or defence mechanism
• Wanting someone to care
• To exert some form of control, when everything else seems out of their control

Rarely, self-harming behaviours may be in response to psychotic symptoms.

All young people presenting with self-harm behaviours need careful and repeated assessment of risk. Anyone with a previous history of self-harm needs careful review at times of change or stress e.g. on entry into a secure unit.

Suicide
Attempted suicide among adolescents has increased steadily every year over the last decade. The UK has one of the highest attempted suicide rates in Europe. Completed suicide accounts for 18% of all deaths of young people (National Confidential Inquiry, 1997).

Methods of attempted suicide may be similar to those of deliberate self harm. However the young persons intention and their anticipated fatal outcome will make the distinction. A common mistake is to assess the level of a young person’s suicidality by your own awareness of the lethality of the method chosen.
The young people at greatest risk of completed suicide include the following groups of offenders:

- Males
- Those who are depressed
- Substance and alcohol abusers
- Those with a history of previous self-harm
- Unresolved problems or conflict

**Assessment**

It is important that clear information about suicidality and acts of self-harm is obtained. The best way to do this is to ask direct questions in a respectful and empathic way. Discussing thoughts and feelings around self-harm does not increase the likelihood of acts. Often young people find it a relief to discuss these painful feelings and find they are acknowledged in a non-judgemental fashion. The context of the self-harm and suicidal acts should always be explored and the possibility of mental disorder must always be considered.

**Important questions** to ask young people who have self harmed or attempted suicide would include:

- What has made them harm themselves? Why now?
- Do they still feel this way?
- What did they think would happen to them?
- Did they want to die? Do they still want to die?
- Do they still feel like harming themselves?
- Have they felt like this before?
- Have they had any previous help? From whom?
- Do they want help now?

*Any young person who remains suicidal with active plans for self harm needs urgent psychiatric assessment.*

**Interventions**

Interventions focus on the underlying reasons for the behaviour. Self-harm groups, many of which are in the voluntary sector may be a beneficial form of support for some young people.

**Anxiety**

Worries and fears are common among adolescents but the extent to which they impact on day-to-day living can be variable. Recent surveys suggest a prevalence of anxiety disorders of between 3-4% in adolescence. There is thought to be no significant difference between sexes.

Anxiety is common in families and may be related to adverse life events and threat. Personality factors and coping mechanisms are thought to play a part.

The most common anxiety disorder in young people is a generalised anxiety disorder. This tends to be pervasive across all situations and can have a
considerable impact on day-to-day functioning. Less common are specific phobias like social phobia (fear of social situations) and agoraphobia (fear of open spaces). The impact of a specific phobia will vary considerably on individuals, and lead to avoidance behaviours.

Panic disorder and post traumatic stress disorder are less common but important anxiety disorders and will also be considered.

**Key features of anxiety** include

- **Apprehension** - with fear and persistent worries about future misfortunes, feeling 'on edge', difficulties in concentrating
- **Muscular tension** - restless fidgeting, trembling and shaking, inability to relax and tension headaches
- **Autonomic nervous system over activity** - light headedness, sweating, increased heart rate and shortness of breath, dizziness, dry mouth, stomach churning and nausea
- **Sleep difficulties** - problems in getting off to sleep, interrupted sleep and fatigue on waking

Anxiety symptoms are often linked with other mental health problems in young people. These include

- **Concurrent depressive symptoms**
- **Self harm**
- **Substance misuse** e.g. young people may self medicate with cannabis

**Panic Disorder** is a specific form of anxiety that is characterised by

- Discrete episodes of panic without an obvious precipitant
- The individual often has a sudden overwhelming sense of fear, believing they may come to imminent harm
- Many of the symptoms of autonomic over activity

**Interventions for anxiety symptoms** will vary with the individual. As a general rule non-drug treatments are used initially. Psychological strategies focus on the individual recognising, understanding and gaining control of their anxiety symptoms. Techniques include

- Simple relaxation exercises
- Anxiety management courses
- Cognitive behavioural therapy

Rarely, in individuals unresponsive to psychological strategies, medication may be considered.
Post traumatic stress disorder

Post traumatic stress disorder is now well recognised in childhood and adolescence. As well as occurring after experiencing or witnessing disasters and extreme violence, it can also occur after physical and sexual abuse, life threatening illness and medical procedures. Many young people who offend may have been exposed to such violence and abuse within the family and community. It has been estimated that between 10-20% of all murders are witnessed by children. It is also important to consider that post traumatic symptoms may arise in a young person as a result of their own criminal activity.

Key features of PTSD include

- **Exposure to a traumatic event**, that lies outside normal experience and that would clearly cause suffering in almost anyone
- **Persistent re-experiencing** -
  - With recurrent flashbacks, nightmares and reliving of the episode
  - Psychological distress and bodily anxiety responses to cues that symbolise or resemble the trauma.
- **Persistent avoidance of places**, activities and cues related to trauma
- **Symptoms of hyper arousal** -
  - Hyper-vigilance, startle responses
  - Sleep disturbance
  - Dramatic outbursts of fear, panic or aggression
- **Psychosocial impairment** -
  - Impact on everyday living

However, most young people suffer from chronic PTSD rather than acute PTSD, often as a result of sexual, emotional and physical abuse.

Apparently similar traumas may have widely different effects between individuals. This may reflect differences in temperament, personality and problem solving ability. Family dysfunction, negative peer interactions and social disadvantage are likely to impair the young person’s resilience to stress.

Post traumatic symptoms in young people are often self medicated by alcohol and substance use, and should therefore be considered.

While it is important to recognise and treat PTSD symptoms, adequate account of the young person and family’s wide-ranging problems need to be taken and educational and social service involvement may play an important role.

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**Interventions**

**Interventions** may include psychological treatments and medication.

It is also essential to treat any co-existing difficulties such as depression and substance misuse.
Drug misuse

Experimentation with drugs is common in adolescence. In a survey of 15-16 year olds (Miller & Plant, 1996), 50% had reported some form of illicit drug use. It may be viewed as part of a normative lifestyle among certain cultures and peer groups and as such accepted. The substance of misuse will vary with regional availability and local preference, though most young people will start with cannabis. However, within certain classes of substance, occasional use can quickly spiral into frequent, problematic use or dependence. The impact on the individual, their family and society can be vast and offending behaviours may escalate to fund the habit. Other substances have immediate high risks: sniffing of glue and aerosols for example, can cause cardiac arrhythmias leading to sudden death.

Generally young people will fall into one of three classes of substance use
- Experimental users - with occasional use
- Sustained regular users - who will use in a set pattern
e.g. ecstasy at weekends only
- Substance misusers

Simple healthcare information about the risks and effects of substances is a good strategy in minimising risks of substance use in all young people. It is important that any information provided is factual as misinformation about the risks of substances is common and can lead to hazardous use. However, it is essential to identify those individuals who are dependent as withdrawal from certain substances, benzodiazepine drugs in particular, can have potentially fatal consequences, and need close medical supervision.

An assessment of drug usage must always include repeated evaluation of motivation to change, and interventions targeted accordingly.

Acute intoxication with substances can cause a young person to present with acute behavioural and emotional disturbance. There may be a reduction in the level of consciousness, e.g. in heroin use or a hyper arousal and over stimulated state, as occurs with amphetamines and cocaine. Both the ability to think clearly and memory may be impaired. The young person may be disorientated in time, place and person. Intoxication will resolve with time, however there may be serious complications and there is an increased risk of self-harm behaviours and danger to others. Acute intoxication can often mimic serious mental illness, like mania and psychosis and should always be considered in young people who are acutely aroused.

Harmful use is a pattern of use that is causing significant impairment, distress or damage to health. It is manifested by at least one of the following
- Recurrent substance use resulting in a failure to fulfil major role obligations at home, school or work
- Use in situations which are physically hazardous
- Recurrent substance related legal problems
- Persistent use despite recurrent social or interpersonal problems having origin in or caused/exacerbated by the effects of the substance

Dependence syndrome encompasses both psychological and physical elements. It can be for one class of drug or for a wider range of pharmacologically different substances. Physical dependence is evidenced by withdrawal effects on discontinuation of the substance. Dependence results in significant impairment and includes
• A repeated desire or compulsion to take the drug
• Persistence in drug use despite knowledge of its harmful effects
• A higher priority given to drug use than other activities and obligations
• Tolerance - requiring increased amounts of substance to obtain the desired effect
• Sometimes physical withdrawal - often the same (or similar) substance is used to relieve or avoid withdrawal

Identification of those who are physically dependent on a substance is essential to avoid serious complications of withdrawal e.g. fits.

### Intervention strategies in drug misuse

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<thead>
<tr>
<th>Interventions</th>
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<tbody>
<tr>
<td><strong>Intervention strategies in drug misuse</strong></td>
</tr>
<tr>
<td>• Any young person who is worried about their drug use and expresses the wish to reduce/stop their habit should be encouraged to seek help from a drug worker within the service or local voluntary or statutory services. Youth specific services should be used wherever possible.</td>
</tr>
<tr>
<td>• Evidence supports the view that even basic healthcare information can be effective in harm minimisation</td>
</tr>
<tr>
<td>• It should be remembered that often the motivation to stop using fluctuates depending on current circumstances and set backs should be anticipated</td>
</tr>
<tr>
<td>• <strong>Specialist services</strong> have a role in maintenance prescribing and detoxification regimes in those who are substance dependent</td>
</tr>
<tr>
<td>• A trusting and non-judgemental relationship with a young person has an important role in helping them maintain abstinence and reduce levels of use</td>
</tr>
</tbody>
</table>

### Alcohol misuse

Young people have always drunk alcohol, whether as a social activity within their peer group, acts of rebellion against parents or a learned coping strategy. For some young people, alcohol use will be seen as a normative lifestyle.

The pattern of alcohol usage varies among differing social and cultural groups, as does the perception of its effects compared to other psychoactive substances. Ease of availability, psychosocial adjustment, adult role models and genetic predisposition are all important variables. Alcohol use has an important link to crime and in particular acts of aggression and accidental death among young people.

### Dependence

It is rare for a young person to be physically dependent on alcohol. However, some older adolescents may have been drinking for some years, and if withdrawal symptoms are exhibited (shaking, tremulous, confusion and fits) medical advice should be sought. Individuals who are alcohol dependent would exhibit many of the features of substance dependence listed above.

Edwards & Gross, (1979) identified 7 criteria for alcohol dependence

• A stereotyped pattern of drinking
• Prominence of drink seeking behaviour over other activities
• An increased tolerance to alcohol effects
• Repeated withdrawal symptoms
• Relief of withdrawal by further drinking
• A compulsion to drink
• Reinstatement after abstinence

**Harmful misuse**
Many young people drink alcohol in binges, which is more problematic, and can place them at risk both of harm to themselves and to others. What constitutes a ‘binge’ is difficult to define but some authorities have suggested it is as low as 5 units of alcohol in one session. (One pint of lager=2 units). Elements of commonsense and judgement need to be made in the context of the young person’s environment and context. Acute alcohol poisoning can lead to death, often by asphyxiation by gastric contents. More commonly acute intoxication leads to disinhibition, altered emotional states and poor judgements, raising the young person’s risk of
• Harm to themselves
  • Accidents and deliberate self harm
• Harm to others
  • Aggression, violence & offending behaviours

**Alcohol & mental health problems**
In adolescents alcohol use has been linked with increased rates of
• Depression
• Anxiety
• Post traumatic stress disorder
• Completed suicide
These factors should always be considered in those who are drinking excessively.

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<th>Interventions</th>
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<tr>
<td>• Information about safe drinking practices is an important general strategy in helping to reduce risks.</td>
</tr>
<tr>
<td>• All young people who identify themselves as having an alcohol problem should be referred to alcohol and drugs workers available within the service or a young persons' substance misuse service. Support and encouragement to reduce alcohol intake are vital as motivation to change fluctuates.</td>
</tr>
<tr>
<td>• Individuals who are alcohol dependent should be referred to a specialist service for medical assessment</td>
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**Attention Deficit hyperactivity disorder**
Attention deficit disorder is estimated to effect between 1-4% of boys in the UK. The onset is in early childhood and males are four times more likely to be affected than females. Among all of the psychiatric disorders, problems with attention and over activity are the most heritable (i.e. most likely to run in families). Research has implicated specific genes in attention deficit hyperactivity disorder (ADHD).
Key features of ADHD include
• Impaired attention and distractibility
• Poor concentration
• Impulsivity
• Restlessness and overactivity

For the diagnosis to be made the features must be present in more than one situation (i.e. at home, in school, in the community) and impact on the young person’s functioning. These symptoms must have started before the age of 6 years.

It is common to have simultaneous educational and social problems. These may represent co-existing difficulties or deficits due to concentration and attention problems.

The most common co-existing conditions are;
• Conduct disorder
• Learning difficulties
• Epilepsy
• Pervasive developmental disorders.

Associated features in young people with ADHD include;
• Anti-social behaviours and difficulties in controlling temper
• Low self esteem
• Poor social skills
• Low frustration threshold
• Learning difficulties and specific delay in motor and language development (often clumsiness)

Interventions
After careful assessment including history and detailed exploration of symptoms, treatments may include;
• Educational strategies
• Psychological interventions
• Medication regimes, with regular monitoring

Psychotic illness
Psychotic illnesses in adolescence are rare, but are important because of their enormous impact on the individual. Research indicates that there is a higher prevalence of psychosis amongst young people in the youth justice system with the highest prevalence among those in Young Offenders Institutions; the figure could be as high as 10 percent.

Many of the initial symptoms of a psychotic episode can be non-specific behavioural changes which can be difficult to differentiate from adolescent behaviours. This can be even harder among young offenders who commonly present with hostile and ‘paranoid’ ideas towards others. However it is important to identify these individuals’ attributions as qualitatively different from the early symptoms of psychosis. This is not easy and many seasoned mental health professionals will get it wrong. Many young people who go on to develop a psychotic illness have a lifelong history of personality and developmental abnormalities, with delays in all aspects of functioning. The prodromal, early pre-illness, changes may represent a marked
change from baseline functioning, a worsening of existing problems, or simply a failure to develop expected skills.

Hearing voices can be a normal phenomenon for some adolescents, and the nature and quality of the voices need to be carefully assessed before a psychotic illness is diagnosed. Auditory hallucinations may well have other causes such as, intoxicated states or past abuse and occur in other mental health problems such as severe depression and personality disorders.

The individual’s developmental level and cultural issues can influence abnormal beliefs. All of these factors need to be carefully considered during an assessment.

There is an increased risk of substance abuse, depression and completed suicide in individuals with psychotic symptoms. Many young people with illness are using drugs to self medicate distressing symptoms.

**Key symptoms of a psychotic illness** include
- **Perceived interference with thoughts** - hearing your own thoughts spoken out aloud or believing others can place thoughts into or withdraw thoughts from you
- **Changes in the clarity and fluency of thoughts** making conversation sometimes difficult to follow
- **Delusions** - fixed false beliefs held despite evidence to the contrary and that are out of keeping with the individuals social and cultural context
- **Ideas that others can control your thoughts and actions**
- **Hallucinatory experiences** including voices and visions and false, persistent, perceptions in other sensory modalities including smell, touch and taste
- A significant and consistent **change in the overall quality of some aspects of personal behaviour**, this can be either
  - Acute with overexcitement, irritability, disinhibition and aggressive and acting out behaviours, or
  - Slow onset, with loss of interest, apathy, social withdrawal, poor self care and aimlessness

A diagnosis of psychosis is extremely difficult to make, even for experienced clinicians, particularly in the early stages of illness when changes in mental state may be very subtle.

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<tr>
<th>Interventions</th>
<th>Interventions split into three broad categories;</th>
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<td></td>
<td>Antipsychotic medications</td>
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<td></td>
<td>Psychological interventions working with both the individual and their families</td>
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<tr>
<td></td>
<td>Psychosocial strategies focusing on education and skills training</td>
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</table>

This is just a brief over view of the mental health problems we have incorporated into the screening process. Further information, leaflets and fact sheets, both for professionals and young people, can be obtained from some of the organisations listed in appendix B.
The screening programme developed for use within the youth justice system has been outlined in section 3.

This section focuses on the first step in the screening process, the screening questionnaire, which will be included in the ASSET form. The Screening Questionnaire Interview for Adolescents (SQIfA), when used as a stand-alone tool, is shown in appendix C.

### Key features of the YJB screening questionnaire

- To be completed on all young people within the youth justice system at first point of contact
- Designed for use by all youth workers
- Questions are incorporated into the ASSET form in parallel with the current mental health section
- Available for use as a stand alone mental health screening tool in ongoing mental health surveillance
- Designed to elicit warning signs of eight important mental health issues in young people
- Repeatable and flexible

When interviewing young people and asking questions about their mental health a degree of forethought and sensitivity is required. Following some basic principles may help in encouraging the young person to engage and respond openly.

### Basics of setting up the interview

- Set aside time specifically to administer the screen
- Consider the environment in which you will administer the questionnaire
  - a private space
  - quiet room with few distractions
  - be aware of safety issues, both for yourself and the young person
- Respect the young person’s privacy
- Explain the purpose of the interview and what happens to the information that is given
- Consider confidentiality issues and explain who may have access to the information obtained
The Screening Questionnaire Interview for Adolescents

The questionnaire is shown in full in appendix C. The questions are asked directly of the young person and cover the 8 mental health areas we have outlined in section 4. The questionnaire itself is divided into 3 sections: we will consider each separately.

Section A
This section focuses on the first 6 mental health areas, and 2 questions are asked of each area. All of the individual questions are scored according to the following responses:

- No = 0
- Sometimes = 1
- Yes, often = 2

Each of the 6 mental health areas total score is then calculated and noted. The questionnaire prompts you as to what your response should be to these scores as follows:

- 0/1 = no problem in this area
- 2 = consider repeating the questionnaire in 4-6 weeks or if circumstances change
- 3/4 = possible problems, full screening interview recommended

The self harm section is of important note - any young person with thoughts or plans to kill themselves or who has recently attempted self-harm should have the full interview.

Section B
In this section questions explore whether the young person has had previous mental health difficulties, previous input from professionals or treatment. Any yes response triggers a recommendation for the full screening interview (SIfA).

Section C
This section deals with the areas of attention deficit hyperactivity and psychotic symptoms. The scoring of these questions are based on your own and other people’s observations of the young person. These questions are not asked of the individual themselves. The scoring for this section is identical to section A.

Commonly asked Questions
When developing the SQIfA and talking to workers about questioning young people about their mental health, several common concerns have arisen.

Q Can talking about mental health issues, especially thoughts of self-harm and suicide, cause harm?
Talking about difficulties with an empathic listener is often a relief for many young people. There is no evidence that talking about self-esteem and thoughts of self-harm will precipitate suicidal behaviours. Often someone else acknowledging the young person’s feelings can have a therapeutic effect.
What happens when they won’t speak?
Often young people do not engage when they do not feel they are involved in a process. It is worth taking extra time to explain the purpose of the interview, how long it takes to complete and what happens to the information obtained. Sometimes the young person may need a little time and space. Explain that if they do not want to talk today then they will be offered the interview again.

What do I do if they become distressed or breakdown?
It is important to be sensitive and respect the young person’s feelings. Acknowledge that talking about thoughts and emotions can be painful. If a young person is extremely distressed, it is often best to take a break and offer to listen if they want to talk.

What if I think they are giving incorrect responses?
Avoid being too challenging or confrontational. Consider why they may be avoiding giving responses and try and address the cause. The questionnaire can always be repeated at a later date.

When scoring how do I differentiate between sometimes and often responses?
This requires a degree of judgement on the interviewer’s part. In general a “yes” or “often” response would indicate a symptom that is present at least 2-3 times a week e.g feeling sad every other day, or having flashbacks three times a week. Further exploratory questions may need to be asked to make this differentiation. For example, a young person may initially reply ‘sometimes’ to a question, but when asked how often may say ‘3-4 times a week’. In this example the response score should be a ‘yes’.

How do I score drug or alcohol use if I think it is within behavioural norms for that young person?
In the screening process we are trying to differentiate between young people who use drugs and do not see this as an issue and those for whom their substance use is harmful or dependent. The questions try and ascertain if there are signs of psychological or social or physical adverse consequences or dependence. Of course, all young people will benefit from health care information on alcohol and drugs.

Evaluation of the questionnaire

-What do I do now?
As discussed the screening questionnaire has several prompts included in its design to guide you on what to do next. The importance of using the tool in conjunction with all other information you have available cannot be over emphasised.

It is important to consider again the properties of a screening tool when considering the results of the screen (appendix A).

- Some young people who screen positive will not have mental illness (false positives)
- A proportion of those who screen negative will have mental health difficulties (false negatives)

No screening tool is perfect, but it allows us to identify those who may be more likely to have problems. In order to increase the accuracy of the screening process a second stage screening interview is required for those who screen positive.

After completing the screening questionnaire young people will fall into one of the 3 broad categories below.
Low concern
- All areas of the screener have been answered negatively

Advice
- No further screening is required
- Consider repeating at a later stage if the young person experiences a major life event, a change of circumstance or if you suspect a change in mental health

Remember - mental health surveillance is an ongoing process

Middle concern
- The young person has answered positively to some of the questions, but has not triggered a full interview in the prompt
- The young person has answered ‘no’ to questions but you have a strong suspicion some of the responses may be inaccurate and that mental health difficulties may be present
- The young person has entered a higher risk setting or had a significant crisis e.g. admission to a secure unit

It is important to alert all relevant workers of your concerns

Advice
- repeat the screener in a defined time period
  - we would suggest a routine of 4-6 weeks.

High concern
- The response to questions on the screener have triggered a positive score
- The screen is negative but the young person exhibits high risk symptoms or behaviours
- You have an extremely strong index of suspicion of mental health problems

Advice
- Refer for 2nd stage interview based screen

Section 7 will give some advice on how you may do this.

Key point
You need to consider all information available to you in the decision making process

Rarely your concerns may be so great for a young person, e.g. expressing active plans for suicide that you may need to refer directly to a mental health professional.

Key point
- A small number of those who screen negative will have mental health problems
- Trust your own instinct and judgement
- The programme is designed to be flexible
- When there are concerns discuss with the worker trained in the screening interview whether to proceed to the 2nd stage screen

Section 6

Section 7
THE MENTAL HEALTH SCREENING INTERVIEW FOR ADOLESCENTS (SIFA)

This is the second stage of the screening process. The interview is intended for use with the young people who have screened positive on the screening questionnaire or those who are of significant concern. The Screening Interview for Adolescents schedule is shown in appendix D.

Who does it?

It is anticipated that only key designated workers within a service will be trained in this part of the assessment. As the skill mix within services is highly variable this may vary from a CPN or CAMHS practitioner to a nurse with general training or a worker with a special interest in mental health. The nominated worker must have knowledge of the key warning signs of mental illness and feel confident in recognising and responding to these.

This section aims to cover the basics of semi-structured interviewing and issues raised here are highlighted in the training video. The degree of training for each worker will depend on past experience in working with mental health issues in young people but key points will serve as a reminder of good practice to all.

How do you do it?

Interviewing Techniques
A lot of research has been performed on how to get the most out of an interview. This may vary from basics like the structure of the room and allowing enough time to complete the task, to how questions may be structured. The following section highlights some important considerations.

Environment
The physical setting will undoubtedly affect the course of the interview. Comfort and privacy are essential. Rooms with multiple distractions and telephones ringing will lead to multiple breaks in the interview which impairs the free flow and discussion of sensitive issues. Try and avoid physical barriers to the interview - talking across a desk makes the interviewer seem distant and paternalistic.

Safety issues
Safety issues are paramount. Always tell colleagues where you are and who you are with. Be familiar with the layout of the room you are using, taking particular note of the exits. Always try and position yourself nearest to an exit route - you do not want to end up in a situation where you are trapped in a room. Trust your instincts - if you are beginning to feel uncomfortable or threatened by a young person, draw the interview to a close, get out of the room and seek help.

Interviewing styles and verbal skills
We all develop our own interviewing styles that often reflect our personality and confidence in this area. Research has been performed on how interviewers can optimise information obtained by the style of questioning adopted. In interviews the following categories of questions can be identified.
**Open questions** are those that allow the individual to provide a wide range of answers. They give the opportunity for the young person to provide a description of their behaviour or feelings.

E.g. *how are you feeling?*

**Closed questions** call for one of a limited set of responses, basically a yes-no answer, or a date, frequency, duration or other quite specific piece of information.

E.g. *do you feel depressed?*

Research on information gathering during interviews has shown that

- Most factual information was collected when a systematic approach using open questions was taken.
- Closed questions can be useful when trying to fill in gaps in the information provided in response to open questions or for clarification.
- If open questions are well considered a young person will often provide much of the needed information spontaneously. This avoids a barrage of closed questions which will appear to a young person to reflect the interviewer’s needs rather than their own.

**A leading question** is one that directly suggests its answer.

E.g. *‘I expect that made you feel angry, didn’t it?’*

These questions play no part in good interviewing as you cannot rely on information obtained in response. Suggestible individuals will feel pressure to comply and agree with the interviewer. An oppositional and defiant young person will seize the opportunity to demonstrate how wildly wrong the interviewer is while disregarding their actual feelings.

**A double question** asks about two things at the same time.

E.g. *‘When the police stopped you, were you worried or angry, or didn’t you care?’*

These questions often draw a yes-no response but leave the interviewer unclear what the answer refers to. The only way to be sure is to ask specific questions about worrying, anger and not caring. As such these double or multiple questions waste time.

**Multiple choice questions** are a form of closed questions that have a place when regular open and closed questioning has failed to provide an adequate answer. For example, when asking about the frequency of thoughts of self harm and the individual says ‘don’t know’ a question like:

*‘Is it every day, once a week or a couple of times a month?’* can be helpful.

However you need to consider the appropriate range of choices and further additional questions may need to be asked for clarification.

In all interviews it is best to use simple words and short sentences, constantly being alert for possible misunderstanding. The open question approach with its emphasis on getting the individual to describe their experiences and behaviour helps to ensure that both interviewer and interviewee are talking about the same thing. It is important to pick up on spontaneous comments and reflect back information given by the young person. This not only aids in clarification of issues but also enhances the individual’s sense of being listened to and understood.
E.g. ‘You mentioned you’ve not been sleeping, can you tell me more about that?’

This creates more of an open dialogue, where the young person is more likely to give honest responses and elaborate on difficulties.

**Sensitive issues**
When asking about sensitive or potentially embarrassing areas like suicidality and sexuality, a direct approach is favoured. Adolescents will pick up on the interviewers discomfort and are less likely to respond in an open and honest way if issues are broached with trepidation.

**Note taking**
In long interviews when gathering information it is good practice to make notes on key issues as you go along. Always explain to the young person that is what you are doing. This avoids note taking becoming overly intrusive. Recall following long interviews can be subject to much bias and important information can be lost or distorted if note taking is left until the interview is finished.

<table>
<thead>
<tr>
<th>Summary of good interviewing skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open questions</td>
</tr>
<tr>
<td>Clarification</td>
</tr>
<tr>
<td>Reflection</td>
</tr>
<tr>
<td>Sensitivity</td>
</tr>
<tr>
<td>Controlling the interview without being too directive</td>
</tr>
<tr>
<td>Making notes of key points as you go along</td>
</tr>
</tbody>
</table>

**Listening and non verbal skills**
When talking to young people about mental health difficulties, as well as sensitive techniques in asking questions, good listening skills will encourage open and honest replies.

Much research has been done in this area, but consistent themes arise

- Position yourself in the interview so you are turned towards the young person, conveying the message that you are engaged and interested in what they are saying
- Avoid sitting directly face to face, as this can be perceived as confrontational, an angle of 130-140 degrees is optimal
- Attend to your own body language: a relaxed open posture and non-verbal signals will facilitate communication
- Maintaining eye contact throughout the interview indicates attention and interest and allows you to pick up on non verbal cues
Consent and confidentiality

These are clearly important factors, when assessing for mental illness, which need to be discussed openly with the young person.

Issues of consent –
• The young person can choose not to be interviewed
• They should understand the nature and purpose of the interview
• The individual is free to withdraw consent at any time

Confidentiality-
• Clear statements need to be made about who has access to information and where information is recorded
• Explain that information obtained will not be used against the young person in any way and forms part of the health assessment as part of the multi-disciplinary assessments within the Yot or secure setting.
• Clarify that you are required to share information if a young person is at risk to themselves or others, or if they are at risk of abuse by others.
• Information may also need to be shared if the young person becomes subject to a formal assessment under the Mental Health Act.

Key points on interviewing
• Set aside enough time for the interview
• Environment
  • Comfortable, private and without distractions
  • Avoid barriers between you and the young person
• Safety issues
  • make sure you can get to an exit from the room if needed
  • let others know who you are with and where you are
• Introduce yourself and explain the procedure and purpose of the interview clearly
• Address consent & confidentiality
• Practice good interviewing and listening techniques

The section has focused on ideal interview scenarios. In reality interview rooms may not always be available and many young people in crisis may need to be interviewed in the community, at home or in police custody. In these difficult circumstances key principles of privacy, consent, confidentiality and safety should always be maintained.
The Screening Interview for Adolescents (SIfA)

The screening interview comprises the following sections:
- Alcohol misuse
- Substance misuse
- Depressed mood
- Deliberate self harm
- Anxiety symptoms
- Post traumatic stress
- Hallucinations, delusions and paranoid beliefs
- Hyperactivity

What are the aims of the interview?
The interview systematically looks for areas of mental health need in the young person by direct questioning. The interviewer then uses all information they have to rate symptoms in each problem area on a severity scale. The severity score for each section, in conjunction with the impact symptoms make on the young person and their willingness to accept help, will inform the decision making process. The interview aims to give a broad indication of the degree of mental health difficulties and makes suggestions on what next step may be appropriate.

There has to be a degree of flexibility in this process, depending on the availability of ‘in house’ programmes and supports within your own service, as well as local resources, in deciding what is the appropriate next step.

What is in the interview?
In this semi-structured interview format, key questions are provided for each mental health section. These prompts are for guidance and flexibility to suit the interviewer’s own style. The interviewer is expected to ask whatever questions are necessary to determine the presence or absence of a particular symptom. This approach ensures that all relevant material is covered. A strength of this style of interview is that a clinically based judgement of the presence of a symptom is made. It is up to the interviewer to decide whether a symptom is present, not the young person. Clearly this places increased demands on the interviewer, with an expectation of some broad knowledge of mental health issues and a degree of training.

How do I Rate the Interview?
Severity scales
These scales look at the impact that difficulties, present for the young person, have on their level of functioning. The interviewer objectively rates the severity scale for each section. The score is based on the response to the prompted questions in the interview in combination with all other information that may be available about the individual. At the end of each section a box reminds you of the key points to note for each problem area when making a decision.

The scores are divided into the following categories:
- No problem
- Mild problems
- Moderate problems
- Marked problems
- Severe problems

Each score in combination with the young person’s motivation to change will inform the decision making process. You are directed to possible actions by a flow chart at the end of each section.
Motivation to change
In all individuals when identifying mental health difficulties a key part of assessment would be to assess their motivation to change. The initial step in doing this in the interview is to ask if they perceive their own difficulties as a problem. It can be surprising how many young people haven’t thought of issues they may have in this way. Many interventions will only be effective if they are able to accept that they have difficulties.

The second area to consider is, if they were offered help would they accept it? Clearly many treatments that require active involvement from the young person would be impossible to provide if they do not wish this. Often young people will say maybe or appear ambivalent. In these circumstances it would be important to provide ongoing motivational work with the individual to help them move along the cycle of change, (motivational interviewing). It is important to remember that poor motivation can be a key symptom in many young people.

Current help offered
The final questions in each section look at interventions or supports the young person has had with each difficulty in the past.

This includes
• Informal help - from family, friends or support groups
• Formal help - from health professionals or from social care

For each, document who was involved, for how long and the outcome as perceived by the individual. All other agencies involved should be carefully documented.

What do I do next?
The information now obtained should highlight if there are areas of difficulties for the young person and their current motivation to address these problems. At the very end of each section a prompt will refer you to a flow chart that will guide you in the decision-making process.

In marked or severe problems the young person will require either further psychiatric assessment or specialist support. Rarely an emergency referral, for urgent psychiatric assessment, may be necessary.

In mild or moderate difficulties you may opt to continue ongoing mental health surveillance and support in combination with health care advice and motivational work. There may be expertise within your team you could access or you may choose to refer to other local statutory or non-statutory agencies.

Clearly the flow charts are suggestions for guidance only. How you decide you want to proceed will be influenced by what resources you have within your own service and what access you have to external agencies. This needs to be considered before screening begins.

What do I tell the Young Person?
When mental health needs have been identified it is important to give the young person clear information about your concerns and what you intend to do next. Reasons for referral to an external agency should be explained and a further opportunity for the young person to discuss their own concerns should be given.

Section 7 will consider referral to other services.
How to use information obtained from the screening tools

On completion of the screening questionnaire and interview you will have a record of whether there were any signs and symptoms of mental health difficulties present in a young person, at that point in time.

This is different to making a diagnosis of mental disorder.

In this section we will give some thoughts on how you may use this information to access other services and to incorporate it into a programme of ongoing mental health surveillance.

Screening process revisited

It is worth re-emphasising several points made earlier in the manual at this stage

- Screening for mental health should not be performed without thought and preparation as to what you will do with a positive result
- Be aware of what types and models of mental health services are available in your area before you begin - Service mapping

In this manual we do not want to be too prescriptive because of the huge variation in the availability, practice and models of services nationwide. The importance of developing communication and understanding of your local services cannot be overstated.

Here are some of our suggestions

Before screening
- Liaise with your local CAMHS and other organisations and try to establish clear links
- Go through the information and material you have on all resources in your area and decide who might be the most appropriate at dealing with each type of problem
- Agree with local organisations the best process of referral. Direct referrals may only be appropriate in emergencies, telephone discussion with a member of the team or writing a referral letter may be more appropriate

Making referrals

Telephone discussions
Some agencies will accept direct referrals over the telephone. It is worth having all information to hand before you make the telephone call. Jot down the key relevant points you wish to make to the referrer as well as basic demographic information:

- Name, address, date of birth and contact telephone number
• Nature of current difficulties as identified on mental health screen
• Past history of difficulties and any previous interventions
• Brief offending history and current contacts with the youth justice system

Having an awareness of information that you may be required to give about a young person will help you in putting your concerns across in a clear and confident manner. This is likely to enhance the chances of receiving a positive response to the referral.

If you have managed to develop contacts within a voluntary or CAMHS service they may initially wish you to discuss individuals cases, prior to making an official referral, in order to assess their suitability for the service or to discuss alternative management strategies. This process may be helpful for you in keeping up to date with what is available, and maintaining clear communication links with outside agencies.

Referral letters
Most CAMHS teams and adult psychiatric services will require information in the form of a referral letter. This will be in a similar format to a GP referral letter, highlighting key symptoms and concerns.

<table>
<thead>
<tr>
<th>Essential information to include in a referral letter</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A brief sentence on the presenting mental health complaints as identified by the screening tool</td>
</tr>
<tr>
<td>• History and background to presenting problems including key features of illness present</td>
</tr>
<tr>
<td>• Brief offending history and contact with the service</td>
</tr>
<tr>
<td>• History of alcohol or substance misuse</td>
</tr>
<tr>
<td>• Relevant family and social background including family history of mental health problems</td>
</tr>
<tr>
<td>• Previous interventions/treatment</td>
</tr>
<tr>
<td>• Results of the relevant parts of the screen</td>
</tr>
<tr>
<td>• What the young person was told about the referral</td>
</tr>
<tr>
<td>• Likely motivation for treatment</td>
</tr>
<tr>
<td>• Details of ongoing contacts within the youth justice system</td>
</tr>
</tbody>
</table>
Dr Buck  
Consultant Adolescent Psychiatrist  
Blurton CAMHS

Dear Dr Buck,

RE: Daryl Stipe  
D.O.B 20.01.1987  
14 Joshua Terrace  
Blurton

I would be grateful for your assessment of this 15 year old, who has been known to the youth offending team for the last 3 months following a car theft. He is keyworker initially raised concerns about his mental health and we have used our mental health screening interview to obtain the following information.

Daryl has felt low in mood for the last 8 weeks with occasional thoughts of self-harm.

At interview he has symptoms of poor sleep with early morning wakening, poor concentration and increased irritability. He is now isolating himself from social contacts and is no longer participating in the previous activities he used to enjoy.

Over the last few weeks his attendance at appointments has become increasingly erratic. He has expressed ideas of hopelessness and has occasional thoughts of self-harm. Daryl admits to one recent episode of cutting his arms but denied any active self-harm plans today.

Recently he has increased his alcohol intake. Daryl previously only drank at weekends with friends but is now drinking alone almost daily. He smokes cannabis intermittently but does not see this as a problem.

Daryl is currently living in a 10th floor council flat with his mother and 4-year-old sister. He has no contact with his natural father and his step-father has recently moved out following escalating domestic violence. Daryl has been excluded from school following an assault on a classmate and the educational welfare officer is trying to find an alternative placement.

Daryl has no previous history of mental health difficulties, however, his older brother committed suicide 3 years ago whilst on remand.

Daryl does feel his low mood and drinking are a problem and is willing to accept help. I have discussed my concerns about his mood with Daryl and he has agreed to a referral to your service. His keyworker will maintain contact weekly and we have asked a youth support worker to see him.

Yours sincerely

Peter Ryan  
Health Worker

See appendix E for further examples of referral letters
Making emergency referrals
Occasionally your concerns about the mental health of a young person may be so great that you may want to make a referral as an emergency.

Situations when this may arise will usually fall into one of two categories

• **The actively suicidal young person**
  In this situation the individual is expressing active plans with clear suicidal intent. There are no identifiable factors that may be put into place that may maintain the safety of that individual whilst an urgent assessment is organised.

• **The acutely disturbed individual**
  The young person's mental state is acutely aroused. They may be exhibiting bizarre, inappropriate or dangerous behaviours. There are clear concerns and symptoms of serious mental illness. The young person is in an environment where they are at risk of harm to themselves or to others.

In these situations an urgent mental state and risk assessment will need to be performed. Who does this will clearly depend on the local circumstance and what area of the Youth Justice System you are working in.

For **YOT services** our suggestion would be

• A telephone call to the local CAMHS or adult service, as appropriate, and discussion with the worker 'on-call' for emergencies. This may need to be followed up by a faxed referral letter.

• If these services are unavailable, you could contact the young person’s GP, clearly identifying the nature of your concerns. The GP may wish to make their own assessment or refer on appropriately.

• In extreme circumstances, when all other routes are impossible, taking the young person to the accident and emergency department, as a place of safety and to seek an urgent assessment.

Sometimes the young person may have little understanding of their difficulties and be unwilling to accept help. If you have significant concerns that they are severely depressed or have a psychotic illness then their judgement may be impaired. Efforts to get an assessment must still be made via the CAMHS or the local GP. In such circumstances assessments under the legal framework of the Mental Health or Children Act may be needed.

For **Institutional services** we would suggest

• An urgent referral to the medical service linked to the institution

• If there are links to a psychiatric service, an urgent telephone call expressing clearly the results of the screening tool and your concerns about safety. Ask for an emergency assessment at the earliest opportunity.

• Put in place the protocols within your service for continued monitoring of mental state e.g. 15 minute observations

• A clear mechanism of communication to all workers about the degree and nature of your concerns

These are suggestions. Modifications will need to be made to tailor your response, and develop appropriate guidelines for your own service.

**Key point**
Careful preparation and planning will reduce levels of anxiety for workers when making referrals at times of crisis.
A screening test is essentially a filter system to identify those who require further assessment. When devising a screening tool the following properties need to be considered:

**Sensitivity, specificity and positive predictive value**

The sensitivity and specificity of an assessment instrument gives a measure of its effectiveness. They are functions of the test and not of the tested individuals. In all screening tests a proportion of those who screen positive will be disease free and a proportion of those who have the disease will screen negative – e.g. in screening for cervical cancer, many women are identified but found not to have cancer on further testing. Unfortunately a small proportion of women will have a falsely negative smear test and will have cervical cancer.

- The **sensitivity** is a measure of the true positives
- The **specificity** of a test is a measure of the true negatives
- The **positive predictive value** of a test is the proportion of test positives that are true positives. This is never 100%.

A good screening test would ideally have both a high sensitivity and specificity. However, there is always a trade off between an acceptable level of sensitivity and the number of false positives the system can deal with. The screening project has aimed to identify the highest number of individuals with disorders without flooding the second stage of screening with unacceptably high numbers of false positives. This has been an important consideration in the development of this YJB tool.

**To what extent does screening for mental health needs satisfy the criteria for effectiveness?**

Wilson and Jungner’s screening criteria (1968) are a useful framework with which to assess the effectiveness of a screening method

**The disease**

- Is mental illness an important health problem?
- Is the natural history of the disease well understood?
- Is there a recognisable early test?

**The screen**

- Is there a suitable test?
- Is the test acceptable?
- At what intervals should screening be repeated?

**Follow up**

- Are there adequate facilities for the diagnoses and treatment of detected abnormalities?
- Is treatment at an early stage more beneficial than treatment started at a later stage?

**Ethics**

- Are the chances of physical and psychological harm less than the chances of benefit?
Economics
Can the cost be balanced against the benefits the service provides and against other opportunity costs and benefits?

In the development of a mental health-screening tool all of the above factors have been considered in detail. The YJB mental health screening process has been derived from a validated research assessment of mental health needs among young offenders (Kroll et al, 2002).

Why should we target young offenders for mental health screening?

One of the problems of universal interventions is that they generally offer only a small benefit to each participating individual. Sometimes this benefit is eliminated by a small risk coming from the intervention itself. In the young offending population we are already looking at a selected sample that we know have higher levels of mental health need than the general age matched population.

Advantages of selective screening and treatment programmes over universal strategies

- They target only vulnerable individuals so the dangers of harming people who are at low risk are reduced
- The intervention can then be matched to the special needs of the young person and his/her carers.

Advice that is targeted to the needs of the young person and their family is likely to enhance motivation more than advice that is not personally relevant.

Research evidence suggests that even severe mental health problems are often unrecognised in young people in contact with the youth justice system and that less than half of these cases ever get to see a mental health professional (Kataoka et al., 2001: Kroll et al., 2002) Earlier detection could lead to better outcomes – once established, many mental health problems are difficult to treat. For example, depression in adolescents often persists into adulthood (Harrington & Vostanis, 1995).

Issues to consider when screening for mental health difficulties

All screening programmes raise important ethical questions. Consider the following scenarios.

- If a patient goes to a doctor and asks for help, then the doctor does the best that he can for that patient. He is not responsible for defects in medical knowledge or in services for provision of care.

- However, if the practitioner decides to screen for a defined mental illness, then they should have evidence that they can change the outcome of that disease process in the majority of those that screen positive. They should also have adequate resources to treat the disorder they have screened for.

It is therefore important to have a set of criteria against which the effectiveness of an intervention for each area of need can be assessed. In screening for mental health prior planning and consideration of your response is essential. In all mental health screening careful explanation of the purpose of the screen and possible detrimental effects of the process e.g. negative effects of knowing you have a disorder, must be discussed with the individual. This allows them to give informed consent to the process.
CONTACTS OF USEFUL ORGANISATIONS AND SERVICES

The Mental Health Foundation
83 Victoria Street
London
SW1H 0HW
Tel: 020 7802 0300
e-mail: mhf@mentalhealth.org.uk
www.mentalhealth.org.uk

A national charity covering all aspects of mental illness.
Hold grants for community projects & research.
Provides fact sheets and other publications for the public.

Young Minds
102-108 Clerkenwell Road
London
EC1M 5SA
Tel: 020 7336 8445
Parents’ information service: 0800 018 2138
e-mail: enquiries@youngminds.org.uk
www.youngminds.org.uk

A national charity working to promote the mental health of all young people.
Provides a range of services
• Leaflets & resource sheets on mental health issues and the work of mental health professionals
• Booklets for young people
• Parents’ Information Service- a confidential telephone service providing information and advice on local & national services for anyone with concerns of mental health difficulties in a young person
• Seminars & training for people who work with young people
• A consultancy service for commissioners & purchasers of services
• Research

The Royal College of Psychiatrists
17 Belgrave Square
London
SW1X 8PG
Tel: 020 7235 2351 ext 146
e-mail: booksales@rcpsych.ac.uk
www.rcpsych.ac.uk

Produces a range of materials for both young people and their carers. The Mental Health and Growing Up Series contains 36 factsheets on a wide range of common mental health difficulties. The pack can be purchased from the address above. Factsheets are also available on the colleges website.
Youth Access
1a Taylors Yard
67 Alderbrook Road
London
SW12 8AD
Tel: 0208 772 9900 (9.00-17.00)
E-mail: admin@youthaccess.org.uk

A national organisation for youth information, advice and counselling agencies. They can put you in contact with your local agencies.

Childline
Tel: 0800 1111
www.childline.org

A free, confidential 24 hour helpline for children and young people. Offers a range of publications for young people and professionals.

The Samaritans
Tel: 08457 90 90 90
E-mail: jo@samaritans.org

A 24 hour service offering emotional support to anyone in crisis. Offers reports, leaflets and information packs by e-mailing communication@samaritans.org

Offers a resource pack for those working with young people

CRUSE (bereavement care)
Cruse House
126 Sheen Road
Richmond
Surrey
TW9 1UR
Tel: 0870 167 167 (helpline)
E-mail: info@crusebereavementcare.org.uk
www.crusebereavementcare.org.uk

A charity that offers support and practical information to anyone who has suffered bereavement. Has an extensive range of leaflets and books about bereavement, and specific information about bereavement in young people.

The National Schizophrenia Fellowship
Head Office
30 Tabernacle Street
London
EC2A 4DD
Advice Line: 020 8974 6814 open 10.00-15.00
Publications: 020 8547 3937
e-mail: advice@nsf.org.uk

Offers help to people with severe mental illness, not just schizophrenia, and their carers.
Depression Alliance
35 Westminster Bridge Road
London
Se1 7JB
Information line: 020 7633 0557
e-mail: hg@depressionalliance.org
www.depressionalliance.org

A charity offering help to people with depression, run by people who have experienced depression themselves.

The Manic Depression Fellowship
Castleworks
21 St George's Road
London
SE1 6ES
Tel: 020 7793 2600
e-mail: mdf@mdf.org.uk

Supports people with a diagnosis of manic depression and their families.

The Young People & Self Harm Information Resource
www.ncb.org.uk/selfharm

A website that provides information about initiatives in this area and resources for young people who self harm and professionals working with them.

SCODA (Standing Conference on Drug Abuse)
32-36 Loman Street
London
SE1 0EE
www.ncvo-vol.org.uk/scoda.html
E-mail: info@scoda.demon.co.uk

Can tell you about drug advice agencies in your area. Produces a training pack on drug misuse for primary care groups.

FRANK (previously National Drugs Helpline)
Tel: 0800 77 66 00
www.talktofrank.com

Offers confidential information about drug and solvent use. Trained advisors can offer support and information about local services. Leaflets available from the website.

www.trashed.co.uk
An interactive website for young people on drug issues.
**Alcohol Concern**  
Tel: 020 7922 8668 (Primary Care Information Service)  
www.alcoholconcern.org.uk  
A national agency on alcohol misuse. The website contains information and useful links. The Primary Care Information service is a resource to help workers treat and prevent alcohol misuse.

**www.wrecked.co.uk**  
An interactive website for young people interested in alcohol issues.

**ADHD Information Services**  
ADDISS  
PO Box 340  
Edgware  
Middlesex  
HA8 9HL  
Tel: 020 8906 9068  
E-mail info@addiss.co.uk  
www.addiss.co.uk  
Provides information and resources about Attention Deficit Hyperactivity disorder.
# THE MENTAL HEALTH SCREENING QUESTIONNAIRE INTERVIEW FOR ADOLESCENTS

**APPENDIX C**

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<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
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</table>

**Scoring System for Sections A & C**  
0 - No  | 1 - Sometimes  | 2 - Yes, often  

### SECTION A

**ALCOHOL USE**

- Do you think alcohol takes over your life and is out of control?  
- Do you feel depressed, angry or anxious if you are not drinking?  

**Drug Use**

- Do you think your drug use takes over your life and is out of control?  
- Does the thought of not using make you worried, angry or depressed?  

**Depression**

- Do you feel really miserable or sad?  
- Do you dislike yourself or your life?  

**Traumatic Experiences (PTSD)** e.g. serious accidents, abuse, assaults

- Do you have currently flashbacks of past upsetting events, which you can’t stop?  
- Do you have powerful memories of past upsetting events, which make you feel unwell, scared or angry?  

**Anxiety/Excessive Worry/Stress**

- Do you have panic attacks i.e. overwhelming fear, heart pounding, breathing fast and stomach churning?  
- Do you feel worried/scared for long periods of time?  

**Self Harm**

- Do you harm yourself e.g. cut yourself or take overdoses?  
- Do you think about harming or killing yourself?  

*If yes full interview*

**Recommendations**  
0/1 no problem  | 2 consider repeat  | 3 or 4 consider full interview
### SECTION B
More questions for the young person to answer (yes/no answers)

<table>
<thead>
<tr>
<th>Question</th>
<th>YES/NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever had treatment for any of the issues that we have just talked about (e.g., depression, PTSD, anxiety, drug/alcohol use, self-harm)?</td>
<td></td>
</tr>
<tr>
<td>Have you ever seen a GP/counsellor/therapist or other professional about any of these issues?</td>
<td></td>
</tr>
<tr>
<td>Have you ever taken tablets/medication related to your behaviour or how you were feeling?</td>
<td></td>
</tr>
</tbody>
</table>

Yes answers to any of these questions: consider full interview.

### SECTION C
The following questions are based upon your observations and other information that you may have obtained from a teacher/parent/person who knows the young person well.

#### ADHD/HYPERACTIVITY

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the young person have <strong>longstanding</strong> and <strong>severe</strong> overactivity and impulsive behaviours more than you would expect?</td>
<td></td>
</tr>
<tr>
<td>Does this overactivity and impulsive behaviour occur at all times and in all settings?</td>
<td></td>
</tr>
<tr>
<td>Total Score</td>
<td></td>
</tr>
</tbody>
</table>

#### PSYCHOTIC SYMPTOMS

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the young person appear unduly preoccupied/suspicious or frequently misinterpret situations?</td>
<td></td>
</tr>
<tr>
<td>Does the young person have odd behaviours or appear to respond to voices or see things that are not there?</td>
<td></td>
</tr>
<tr>
<td>Total Score</td>
<td></td>
</tr>
</tbody>
</table>

Total Score:
- 0/1 no problem
- 2 consider repeat
- 3 or 4 consider full interview

### 'NEXT STEP' INSTRUCTIONS

<table>
<thead>
<tr>
<th>Repeat</th>
<th>Full interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>repeat screening tool in 4-6 weeks or if a significant change or event occurs</td>
<td>referral to designated health worker for full interview</td>
</tr>
</tbody>
</table>

**Action Plan**

________________________

**Signed**

Users of this questionnaire should consult the Screening for Mental Disorder Manual.
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THE MENTAL HEALTH SCREENING INTERVIEW FOR ADOLESCENTS SfA

YOUNG PERSONS INTERVIEW

Developed for the Youth Justice Board by
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Child Psychiatry Department,
&
The Adolescent Forensic Unit,
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11 Carteret Street, London. SW1H 9DL
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
**Alcohol misuse**

These questions are designed to look at problematic alcohol misuse and any signs of alcohol dependence. Importantly they also are aimed at looking at the individual’s motivation to change and willingness to accept help.

Normal adolescent social experimentation with alcohol is not rated as a problem and a judgement has to be made in this context.

This section focuses on alcohol intake in the 2 months prior to interview. Key questions are looking at drinking patterns that have a detrimental effect on the individual’s physical or psychological state and impact on their level or ability to function. Judgements need to be made on what constitutes harmful use of alcohol in the young person’s own context.

Suggested responses to scores in this area will depend on what is available within local resources.

A young person with mild problems should be offered simple health care advice about safe drinking practices. All workers could do this.

Those with moderate to marked difficulties will certainly need information and advice, and this may come from a drug and alcohol worker within the team or a local service. Motivation to change is ever changing and needs to be considered.

Young people will severe physical and psychological dependence will need detailed assessment and medical input and may need to be seen within a specialised alcohol service.
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.
Substance misuse
Again the questions are designed to look at all substances of abuse including solvents and aerosols, prescribed medication and illegal substances. The aim is to identify individuals with problematic substance misuse and dependence and to assess their motivation to address these problems.

Response to the scoring on the severity scales will be dependent on local resources and access to services as well as the individual’s own desire to change. Many of the next step strategies will be similar to alcohol misuse.

All young people could be offered simple health care information about common substances of abuse.
Those with moderate difficulties will need information and advice on harm minimisation, and this may come from a drug and alcohol worker within the team or in other local services, dependent on motivation and what is offered locally.
Young people will severe physical and psychological dependence; whose drug use has a significant impact on their level of functioning will need detailed assessment. Referral to a specialised drug service may be appropriate.
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
Depressed mood
The questions ask about mood in the couple of months prior to the interview. It is important to try and obtain clear information on the severity of the mood change and the duration of this change. These are key components of the severity scale. Questions also try to elicit key life events that may have a negative impact on mood, whether the young person was able to make that association and how long low mood persisted.

Further questions consider whether the individual has any biological symptoms of depression; sleep and weight changes, poor concentration and poor energy and fatigue. It can sometimes be important to establish what has been normal behaviour for that individual, and whether these symptoms constitute a change from this norm.

Cognitive or thought processes are also questioned to give a clear picture of the young persons attitude to themselves, their environment and their future. We are trying to identify thoughts of hopelessness, worthlessness and guilt that are often associated with a depressive illness. It may be helpful for the young person to score themselves on a scale out of 10 in some areas e.g. 1 dislikes themselves the most, through to 10 likes themselves the most.

However, it is important to be aware that many individuals negative views about their own environment and future prospects may be grounded in reality. Again, judgements need to be made on whether this is part of a depressive state.

The young person’s ability to function at their previous level has to be considered, and impairment indicates a marked or severe problem that requires further assessment.

Thoughts of self-harm and suicide are asked in the next section.

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)

See flow chart A
Deliberate self-harm

In this section all forms of self-harming behaviour should be considered in the 2 month period prior to the interview. Common associated symptoms such as depression and anxiety should be rated in the respective section.

The section begins with direct questions on whether the young person has had thoughts of self-harm. It is important to try and ask about a wide range of self-harm behaviours many of which such as punching walls or high risk offending may not be recognised as such.

Asking a young person whether they have made plans or thought to kill themselves can be anxiety provoking. The best and safest approach is to ask direct questions in an empathic way. If suicidal thoughts are elicited clear, precise information about frequency, planning, motivation and exacerbating and protective factors need to be obtained. Current thoughts and motivation is extremely important, in planning how you may respond to the individual's needs in the most appropriate way.

Many individual's may use self-harm as a coping strategy and have little motivation to change and no other symptoms of psychiatric illness. Simple health care information and advice about the risks of their actions may be appropriate. Other young people may have more marked problems either in terms of their motivation and intent at the time of self-harm, which may have been a single episode, or in the repetitive or high risk nature of self harm.

All young people who have active motivation to harm themselves with full awareness of consequences will need close supervision and referral for urgent assessment.

It is good practice to have clear guidelines on such emergency referrals in place and agreed roles and responsibilities within the team.
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?

Answer 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).

See flow chart A
Anxiety symptoms

This section looks at symptoms of general anxiety, panic and specific phobias in the 2 month period prior to the interview. As well as asking questions about specific anxiety symptoms, it is vital to ask about the impact those symptoms may have on the individual's day-to-day functioning. Although the section focuses on generalised anxiety or panic, specific phobias or obsessional symptoms should also be noted.

Questions ask if the young person has worries and whether they are related to specific events. It is important to try and qualify whether the young person feels they have any control over their anxiety, and what they believe might happen to them when physical symptoms are present. Some young people may have developed their own strategies, whether adaptive or maladaptive to control symptoms. The impact worries and physical symptoms have on an individual will be the key marker of severity.

In marked problems symptoms are present more than 3 times a week and at times may feel difficult to control, impairing functioning from time to time. In young people who are severely affected, the symptoms are incapacitating, occur daily and impact on all areas of functioning, though not all symptoms have to be present.

In young people with mild symptoms a brief explanation of anxiety symptoms and reassurance may help them to maintain control. More marked and severe problems, which have a clear impact on the young person's life, need appropriate assessment for treatment, but motivation and engagement with this is 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
Post traumatic stress
In this section a lifetime history of an event or experience that was exceptionally frightening, stressful or life threatening is obtained. You may have to ask directly about exposure to violence whether direct or indirect, and make explicit that this may happen within the family. Serious assaults or being a direct witness to a serious illness or sudden death is included.

Asking whether others have hurt the young person in a physical or sexual way is extremely sensitive, and a great deal of tact is required. It is important to use language that you feel comfortable with.

Again some thought needs to be put in to how you would respond to a first disclosure of abuse before you start interviewing. A clear knowledge of the local protocol on child protection is essential and may reduce anxiety.

If the young person has identified a life history of a traumatic experience then you go onto the second part of the section that identifies symptoms of post traumatic stress within the 2 months prior to interview. Prompts require you to enquire about specific symptoms around reliving of the traumatic event that are painful and uncontrollable. Avoidance of cues or reminders of the traumatic event need to be asked about directly. The young person’s ability to concentrate, irritability and difficulties in sleeping need to be explored. How the individual perceives these difficulties and whether they affect daily functioning will be important in making a judgement on the severity score.

All individuals who are impaired and would like help should be considered for referral to an appropriate service.
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 misuse 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 been 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
**Hallucinations, delusions and paranoid beliefs**

In this section all information is rated in the 2 months prior to the interview. All odd and bizarre beliefs that are out of keeping with the young person’s social and cultural context and not based in reality should be rated. Any beliefs or hallucinations that occur only when under the influence of drugs or alcohol should not be rated here.

Hallucinatory experiences in all sensory modalities should be enquired about. If present in the young person then the nature and frequency of the experience, as well as the individual’s own perception should be clarified. It is important to differentiate between a hallucinatory experience and the flashbacks to past traumatic events that can occur in PTSD.

Sometimes a young person may react angrily to such enquires ‘I’m not mental’ – this is best dealt with by a simple explanation of what you are doing and that these questions are asked of everyone in the interview.

Trying to detect unusual thoughts or beliefs at interview can be difficult. It can be surprising when a direct question asking whether they have thoughts that are different to others is answered positively. It is important to clarify the nature and extent of unusual beliefs. Asking whether they have felt that someone or some force is able to control or interfere with their thoughts or actions is also important. Occasionally the individual may believe they have special powers.

‘Paranoia’ is a term used commonly in language, particularly within the young offenders group. This term may have slightly different meanings for individuals, ranging from feeling sensitive to others people’s comments to a firm belief that everyone is against you. If used it is important to understand what exactly the young person means. Direct questioning on whether they feel anyone is trying to harm or plot against them and evidence for this believe is sometimes more useful.

An assessment of how the young person’s daily functioning is affected by their thoughts, experiences and beliefs are important to mark severity. All young people with evidence of distressing hallucinatory experiences or delusional thinking, that impairs functioning should be referred for a full psychiatric assessment.
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
**Hyperactivity**

In this section although questions are asked of the young person, an informant such as a teacher, case worker or family member is required to clarify information obtained.

The individual’s activity levels are considered, and evidence of overactivity such as inability to sit for long periods, constant fidgeting and reduced sleep are looked for. Impulsivity is also a feature that is asked about, but the young person’s age and developmental level need to be taken into account. Inattention and distractible behaviours that result in some impairment of task completion or functioning are considered.

In scoring the severity scale the impact of symptoms on daily functioning, the persistence of difficulties across all settings, and the young person’s ability to control themselves will differentiate between moderate, marked and severe scores. To make these judgements information will need to be obtained from a wide variety of informants who know the young person well.
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

If no problem/ Mild problem

If moderate/ Marked problem

If severe problem

consider Q
Would you accept help?

if yes/ maybe

Refer to appropriate service

Consider motivational work with young person

if no

Go to next section

Go to next section
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

If no problem/ MILD problem

If moderate/ marked/severe problem

go to next section

Refer to appropriate psychiatric service for assessment
Anxiety & Substance misuse

Dear Dr Evans

Re Rebeka Shaw
44 Greystones
Sale

DoB 21.8.86

I would be grateful for your team’s assessment of this 15 year old girl who has some features of anxiety that are causing moderate impairment of her functioning.

We picked her up on our routine mental health screening questionnaire and she has had a positive outcome at a detailed mental health interview, with our health care worker.

Rebeka has described symptoms of apprehension and fear, difficulties in sleeping with nausea and tension headaches. The symptoms appear to date back to the time of a serious assault by a group of girls at her school last year. However she screened negative for post traumatic symptoms. Since the attack her attendance at school has been erratic, she only goes out to the shops on weekdays and she limits her activities to those at home.

She is known to our team following a series of shoplifting offences. Rebeka has no other criminal convictions. She is currently living with her mother who suffers with depression and her 9 year old sister, in a 4th floor housing association flat. Rebeka has recently started smoking cannabis, in an attempt to try and control her anxiety.

Rebeka admits that her anxiety is quite a problem but is happy with her current level of cannabis use. She is willing to accept help for her anxiety symptoms and is fully aware of the referral to CAMHS. She is continuing to attend her fortnightly appointments.

Yours sincerely

Jenny Mohindra
YOT worker
Hallucinations, Delusions & Paranoid Beliefs

Dr Williams
Adult Psychiatrist
Wincombe

Dear Dr Williams

Re: Adam Simons
D of B 12.09.85

Further to our telephone conversation thanks for agreeing to see this 17 year old who was recently admitted to the centre, following a conviction for aggravated robbery.

Adam has been exhibiting increasingly erratic behaviours, appears agitated and has been observed in conversation whilst alone in his room. Following an unprovoked assault on a young person yesterday he has been sedated with diazepam and is currently on the hospital wing. He has managed to have a few hours sleep.

Adam initially appeared to have settled following his sentence though tended to isolate himself, and at times appeared distracted. Over the last week he does not appear to have slept and has been writing in a diary throughout the night. He has also refused to eat food, and when questioned said the government were trying to poison him. He has not been attending to self-care despite prompts.

I interviewed him using our mental health screening tool two days ago because of concerns. On questioning he was extremely suspicious, and at times his conversation was difficult to follow. He appeared to have a delusional belief that he was a special agent and that was why he was imprisoned. He appeared preoccupied but denied hearing voices.

There is a family history of possible schizophrenia in a maternal aunt. Adam denies any substance misuse and has no other significant medical problems.

Thank you for your urgent opinion.

Yours sincerely

Bob Gerrard
REFERENCES


NHS Health Advisory Service (1995). Child and Adolescent Mental Health Services. Together We Stand. HMSO
