

OPTIONAL MODULE 3: MENTAL HEALTH

(Modified Mini Screen)



FOR STAFF ONLY

UR Number: _____
Surname: _____
Given name: _____
Date of birth: _____
(Please fill in if no label available)

PURPOSE OF MODULE

To ascertain whether the client might be experiencing some possible undiagnosed mental health issues.

WHO CAN ADMINISTER THIS MODULE?

This is a clinician-administered module. If the client is under the influence of alcohol or drugs at the time of assessment this can affect results obtained in this module, and so it's best to administer this module at a later date.

INTRODUCTION FOR CLIENT

"Now I'm just going to ask you a few more questions about your mental health and wellbeing."

INSTRUCTIONS

1. For each question, please circle the response that best describes how your client has been feeling.
2. Total the number of "Yes" responses and compare to established cut-offs at the end of the module.
3. Consider intervention or referral to a mental health service if there is a moderate to high likelihood of mental illness. If item 4 is present, apply appropriate suicide risk measures.

		0	1
1	Have you been consistently depressed or down, most of the day, nearly every day for the past two weeks?	No	Yes
2	In the past two weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time?	No	Yes
3	Have you felt sad, low or depressed most of the time for the last two years?	No	Yes
4	In the past month, did you think that you would be better off dead or wish you were dead?	No	Yes
5	Have you ever had a period of time when you were feeling up, hyper or so full of energy or full of yourself that you got into trouble or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol.)	No	Yes
6	Have you ever been so irritable, grouchy or annoyed for several days, that you had arguments, verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or overreacted, compared to other people, even when you thought you were right to act this way?	No	Yes
7	Note: this question is in 2 parts. a) Have you had one or more occasions when you felt intensely anxious, frightened, uncomfortable or uneasy even when most people would not feel that way? <input type="checkbox"/> YES <input type="checkbox"/> NO b) If yes, did these intense feelings get to be their worst within 10 minutes? <input type="checkbox"/> YES <input type="checkbox"/> NO Interviewer: If the answer to BOTH a) and b) is YES, code the question YES. If the answer to either or both a) and b) is NO, code the question NO.	No	Yes
8	Do you feel anxious or uneasy in places or situations where you might have the panic-like symptoms we just spoke about? Or do you feel anxious or uneasy in situations where help might not be available or escape might be difficult? Examples include: Being in a crowd, standing in a line, being alone away from home or alone at home, crossing a bridge, travelling in a bus, train or car.	No	Yes
9	Have you worried excessively or been anxious about several things over the past 6 months? Interviewer: If NO to question 9, answer NO to question 10 and proceed to question 11.	No	Yes
10	Are these worries present most days?	No	Yes

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Clinician name: _____

Position: _____

Signature: _____

Date: _____

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11	In the past month, were you afraid or embarrassed when others were watching you, or when you were the focus of attention? Were you afraid of being humiliated? Examples include: speaking in public; eating in public or with others; writing while someone watches; being in social situations.	No	Yes
12	In the past month, have you been bothered by thoughts, impulses, or images that you couldn't get rid of that were unwanted, distasteful, inappropriate, intrusive or distressing? Examples include: Were you afraid that you would act on some impulse that would be really shocking? Did you worry a lot about being dirty, contaminated or having germs? Did you worry a lot about contaminating others, or that you would harm someone even though you didn't want to? Did you have any fears or superstitions that you would be responsible for things going wrong? Were you obsessed with sexual thoughts, images or impulses? Did you hoard or collect lots of things? Did you have religious practice obsessions?	No	Yes
13	In the past month, did you do something repeatedly without being able to resist doing it? Examples include: washing or cleaning excessively; counting or checking things over and over; repeating, collecting, or arranging; other superstitious rituals.	No	Yes
14	Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? Examples Include: serious accidents; sexual or physical assault; terrorist attack; being held hostage; kidnapping; fire; discovering a body; sudden death of someone close to you; war; natural disaster.	No	Yes
15	Have you re-experienced the awful event in a distressing way in the past month? Examples include: dreams; intense recollections; flashbacks; physical reactions.	No	Yes
16	Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you?	No	Yes
17	Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone's mind or hear what another person was thinking?	No	Yes
18	Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Or, have you ever felt that you were possessed?	No	Yes
19	Have you ever believed that you were being sent special messages through the TV, radio, or newspaper? Did you believe that someone you did not personally know was particularly interested in you?	No	Yes
20	Have your relatives or friends ever considered any of your beliefs strange or unusual?	No	Yes
21	Have you ever heard things other people couldn't hear, such as voices?	No	Yes
22	Have you ever had visions when you were awake or have you ever seen things other people couldn't see?	No	Yes
TOTAL YES RESPONSES			
<i>Likelihood of mental illness</i>			
Score of 0-5 = low			
Score of 6-9 = moderate			
Score of 10-22 = high			

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Signature:

Date: