Sunderland Youth Justice Liaison Diversion (YJLD) Health Screening Questionnaire

Young Person Details

TRAINING TOOL

Name:		Date:	Verbal Consent Tick if agreed ☐
Gender:	DOB:	Background checks Completed by:	
Address:		Tel No:	
Alleged Offence and date:		Arrest Outcome:	

Date Referred:	L&D Service Time:
L&D Declined:	Appointment Date:
Appointment Time:	Appointment: Booked Seen in Justice Setting Unknown
Screening Undertaken Date:	Assessment Undertaken Date:

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Many young people who come into contact with the Police have complex health and social difficulties. These include misusing alcohol and drugs, communication, education developmental and mental health problems. Many of those difficulties often go unrecognised by young people and people who are close to them.

Liaison and Diversion services seek to ensure that when young people become involved with the Police any vulnerabilities are identified and the young person is linked to appropriate treatment services. To ensure that best possible outcomes are achieved for young people Information about their needs can be provided to the Police and Courts to enable them to make decisions about charging, sentencing and post sentence services.

Completing this questionnaire will help identify any unmet health needs:

CONSENT TO SHARING INFORMATION

Date: …….

I give my permission for the YOS to gather and share information from relevant Professional services such as; Police, Health (this may include information from mental health/LD services including information on attendance/ appointments and plan of care), Education and Housing, to inform the assessment and intervention delivered by the YOS and other Professional services to prevent further offending.

Young Person Name: …….

Young Person Signature:……..

Parent/Carer Name …….

Parent/Carer Signature:……..

Please Note: this is a confidential document and should be returned to the Youth Offending Service Office @ 176 High Street West, Sunderland, SR1 1UP within 24 hours of completion.

Section 1: Physical Health

Tick Yes, No or Sometimes as appropriate for each question and include additional notes.	Yes	No	Sometimes
Are you registered with a Doctor? Name/details:			
Do you attend any regular health appointments? And/or attended CAMHS - past or present? Details:			
Do you have a physical disability? Details:			
Do you have any health conditions, such as diabetes, Asthma and allergies? Details:			
Are you taking any medicines? Details:			
Have you any problems with your teeth?			
Are you registered with a dentist?			
Have you lost or gained weight recently? Details i.e. Is this unexplained?			
Do you have any problems with your eyesight or your hearing? *Linked to School/Education* Details:			
Do you have any fits, faints or seizures? Detail:			
Do you smoke cigarettes? Detail:			
Are you currently in a relationship? *Depending on Age/Answer ask the following questions.*			
Do you know what is meant by safe sex?			
Do you know where to get condoms or the morning after pill from?			
Are you pregnant or could you be?			
Do you have any worries about your health and would you like to talk to someone in confidence about it? Details:			

Section 2: Substance Misuse

Tick Yes, No or Sometimes as appropriate for each question and include additional notes.	Yes	No	Sometimes
Does the Young Person appear to be under the influence of alcohol or substances Details:			
Do you ever drink alcohol?			
Have you drank any alcohol in the past month? Details (what, how much, frequency and when):			
Do you worry about the amount of alcohol you drink?			
Do your family or friends ever worry about the amount you drink?			
Have you ever used drugs?			
Have you used drugs in the past month? Details (what, how much, where, frequency, when, (what route – orally, injecting etc.):			
Have you ever been admitted to hospital due to drinking alcohol or using drugs? *Check CCM/Nurse* Details:			
Have you or your family ever sought help in relation to your alcohol or drug use? Details:			
Do you have any worries relating to alcohol or substance misuse you would like to speak to someone in confidence about? Details:			

Section 3: Mental Health

Tick Yes, No or Sometimes as appropriate for each question and include additional notes.	Yes	No	Sometimes
Have you ever had or have any problems with feeling sad or angry? Details:			
Do you, your family or friends – including school ever worry about you controlling your temper? Details:			
Have you any problems with eating or sleeping? Details:			
Do you feel like you are spending less time with friends and family and less time on doing things you enjoy? Details:			
Do you sometimes feel guilty about something that has happened even if it was not your fault? Details (include examples and physical symptoms):			
Do you worry about things over and over again (including worrying about things before they happen)? Details (include examples, times and frequency):			
Do you worry about things so much so that you can't relax? Details (include examples and physical symptoms):			
Do you sometimes dislike yourself or feel that everyone is better than you? *Perception of Self / Self Esteem* Details:			
Has or is there any time or anywhere that you don't feel safe? *Safeguarding / vm sexual exploitation* Details:			

Have you ever thought seriously about running away from home? *Sexual exploitation / vm* Details (context and frequency):			
Have there been any recent changes that have impacted upon your life and feelings? (i.e. bereavement or parental break up) Details:			
Do you hear voices that other people cannot hear, or see things that other people cannot see? Details:			
Have you ever thought about hurting yourself? Details (context, frequency and method):			
Do you find it difficult to sustain attention or concentrate? (i.e. feel restless especially when it is inappropriate) *School – lifestyle re play station* Details:			
Do you find it hard to sit still or do people keep telling you to stop fidgeting? Details:			
Has anything very frightening or awful or have you seen anything awful ever happen to you or your friends? Details (to include; do you have vivid memories, pervasive thoughts or flashbacks relating this):			
Do you have any worries relating to your emotions and feelings that you would like to speak to someone in confidence about? Details:			

Section 4: SLCN & Neurological Disability

Tick Yes, No or Sometimes as appropriate for each question and include additional notes.	Yes	No	Sometimes
Have professionals or family members expressed concerns that the young person may have social or communication difficulties? Details:			
Speech, Language and Communication Needs (SLCN):			
Does the young person have a stammer or get stuck on words when talking? Details:			
Does the young person often struggle / have difficulty thinking of the words they want to say? Details:			
Does the young person use simple vocabulary? Details:			
Is their speech difficult to understand? Details:			
Does the young person have difficulty remembering things people say? Details:			
Does the young person have difficulty following written instruction, or only follow part of them? Details:			
Does the young person have difficulty understanding the meaning of words? Details:			
Does the young person have difficulties using non-verbal communication? Details:			
Does the young person have difficulties showing emotions? Details:			
Learning Disability (LD):			

Does the young person struggle with schoolwork? (i.e. supported by a mentor or has difficulties with reading or writing) *School* Details:			
Does the young person have difficulties with time concepts? (i.e. telling the time, understanding what the day after tomorrow is and in placing events into context) Details:			
Does the young person need support with day-to-day tasks? (i.e. personal hygiene, getting dressed, using public transport) *School* Details:			
Does the young person have difficulties following conversations? (i.e. frequently goes off subject and is unable to paraphrase what has been discussed) Details:			
Autism Spectrum Disorder (ASD):			
Does the young person speak in a monotonous or unusual tone? *School / Parents /Observation* Details:			
Does the young person take things literally? (i.e. fails to understanding meaning of inference, jokes or sarcasm; black and white thinking) Details:			
Is the young person repetitive? (i.e. talks about the same thing over and over, fixated on a particular or narrow range of subjects; has little interest in what young people their age do) Details:			
Does the young person have limited understanding of different relationships and in understanding the thoughts/feelings of others? Details:			
Is the young person socially awkward and inappropriate, even when being polite? Details:			
Does the young person have difficulties initiating and / or maintaining friendships? Details:			
Is the young person inflexible? (i.e. have difficulties changing their mind) Details:			

Does the young person have more difficulty than others with changes in routine? Details:			
Acquired Brain Injury (ASI):			
Has the young person ever had a head injury that caused them to be knocked out, dazed or confused? Details (to include; has this happened on more than one occasion and has there been any change in their behaviour or memory since): *CCM / Nurse*			

Summary of Needs:

KEY:

Green – Verbal / Direct questions
Pink - Observation
Yellow – Third Party / Parent / Other Professional

Background Information

Children's Service's:
Children & Young People's Services (CYPS):
Education:
Family & Personal Relationships:
Police:
Plan