

## Psychosocial screening for asylum seeking or refugee children and youth (6-18 years):

### Interview version

Interviewer (read): People who have left their homes following war commonly need some help to manage in a new country. I will now ask some questions about your situation and well-being, so that we can figure out if you need any help or support at the moment. There are no right or wrong answers, just answer the questions as well as you can. If there is something you do not want to answer, that is fine. Tell me if you have any questions or comments along the way. *(if an option)* Do you prefer that we talk about this alone or together with (caregiver)?

#### BACKGROUND

Contact information:

Surname/First name:	Age (years)	Sex:
Date of birth/ ID number:		
Today's date:	Phone nr. child/caregiver	

#### FAMILY

Did you arrive in Norway together with someone?	Yes	No
If yes, who?	If no, what is your living situation and who takes care of you?	
Do you have parents or siblings who are not here in Norway with you?	Yes	No
If yes, who?		
Are you in contact with them?	Yes	No
Has someone in your family, or any close friends, been killed in the war or during your travels from home to arrival in Norway?	Yes	No
If yes, who?		

#### EVERYDAY LIFE

Do you /your family have a permanent place to live now?	Yes	No
Have you started school here in Norway?	Yes	No
Do you follow digital lessons from the school you attended before leaving your country of origin?	Yes	No

#### FUNCTION

	Completely	Partially	Not really
Do you get along with the people you live with?			
Can you manage to concentrate at school?			
Do you have someone to talk to or play with except the people you live with?			

#### COMMON PROBLEMS

Interviewer (read): Below is a list of some common health problems. During the past 2 weeks, how much have you been bothered by any of the following problems? *(Instructions for interviewer: Help the child relate to the time period in question, if needed.)*

	Not at all	A little bit	Quite a bit	Very much
Bothered by headaches?	1	2	3	4
Bothered by pain (ie. stomachache, pain in neck/shoulders/chest/back/arm/ legs)?	1	2	3	4
Trouble sleeping?	1	2	3	4

Feeling tired or having low energy?	1	2	3	4
<b>Calculate average</b>	<b>≤2</b>		<b>&gt;2</b>	
Bothered by fear or anxiousness?	1	2	3	4
Feeling tense or uneasy?	1	2	3	4
Feeling of hopelessness (about the future)?	1	2	3	4
Sadness?	1	2	3	4
Been worried about different things?	1	2	3	4
<b>Calculate average</b>	<b>≤2</b>		<b>&gt;2</b>	

**POSTTRAUMATIC REACTIONS**

*Interviewer (read):* Stressful or scary events happen to lots of people. If you have had such experiences how often have you had associated thoughts, feelings or problems in the last two weeks

	Never	Sometimes	Often	Almost always
Bad dreams reminding me of what happened	0	1	2	3
Pictures in my head of what happened. Feels like it is happening right now.	0	1	2	3
Trying not to think about what happened. Or to not have feelings about it.	0	1	2	3
Staying away from anything that reminds me of what happened (people, places, things, situations, talks).	0	1	2	3
Being overly careful (checking to see who is around me)	0	1	2	3
Being jumpy	0	1	2	3
<b>Sum up all the answers</b>				<b>&gt;7</b>

**Questions about SUBSTANCE USE should be asked to all children 10 years or older, and to younger children on indication**

	Never/ Seldom	Weekly	(Almost ) Daily
How often do you drink alcohol?		<16 years	
How often do you smoke weed/marijuana or do other drugs?			
How often do you use sleep medicine or sedative drugs?			
Has a relative or friend, doctor, nurse, or someone else been worried or told you that you need to stop drinking alcohol, using drugs or medication?		No	Yes

**INDICATION OF SEVERE MENTAL DISORDERS**

*Instructions: If the child scores yellow on symptoms above and shows functional decline, ask the following questions:*

Do you sometimes hear a voice that others cannot hear, and that is just as loud as my voice is right now?	No	Yes
If yes: Is it distressing?	No	Yes
Have you thought of harming yourself or others?	No	Yes
Have you harmed yourself or others during the last two weeks?	No	Yes

Have you had thoughts of taking your own life during the last two weeks?		No	Yes
<b>OVERALL ASSESSMENT (CHECK FOR CORRECT MEASURES)</b>			
<b>No need for measures now</b> <input type="checkbox"/>	<b>Need for help, but not acute</b> <input type="checkbox"/>	<b>Need for acute assessment/treatment and follow-up</b> <input type="checkbox"/>	
Adequate psychosocial state and functioning	Unaccompanied minor Significant mental distress, functional decline or difficulties in the family (e.g. mental disorder/substance abuse in parents)	Active psychosis Suicidality Signs of life-threatening condition, serious illness/injury or current violence/abuse/neglect.	
Provide child and caregiver with information about normal reactions, rights to care and who to contact if needed.	In need for close follow-up and assistance: Recommended follow-up within 1-2 weeks	Acute consultation with emergency services/physician on call for assessment.	
<b>CONTACT INFORMATION TO THE ASSESSOR</b>			
Name and workplace of assessor		Phone nr. assessor:	
If the child/family has a contact person in the municipality			
Who is the contact person?		Phone nr. contact person:	