



**A Compendium of Tools for the Assessment of the  
Mental Health and Psychosocial Wellbeing of Children  
in the Context of Humanitarian Emergencies**

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The details provided are based upon information interpreted from a diverse range of sources. The authors welcome correspondence correcting any factual errors regarding specific measures. Information is provided to orient readers to the potential utility of particular measures. Before using any measure, readers are encouraged to consult the sources indicated to verify key information.

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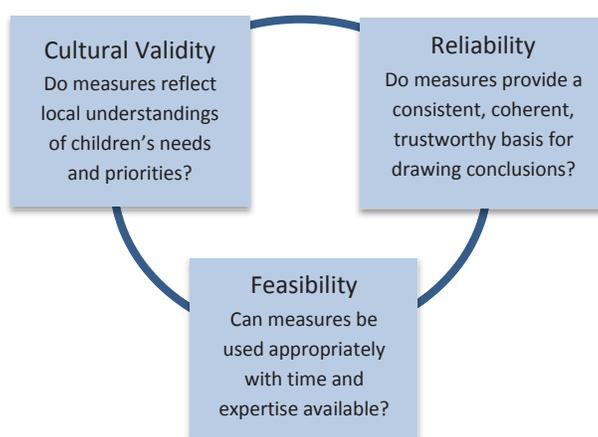
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(Cover photo: Alastair Ager)

## Introduction

Selecting a measurement strategy for the assessment of the mental health and psychosocial wellbeing of children in humanitarian emergencies requires careful consideration of a number of issues. This compendium lists 48 measures and approaches that have been used in such contexts, and provides details of each to assist in their selection. A decision-making guide – in the form of a flow chart – is provided at the end of the compendium to assist the process of matching the measurement approach to context and requirements.

Whatever approach is selected, consideration needs to be given to the issues of cultural validity, reliability and feasibility. Cultural validity means that the concepts and ideas being asked about make sense to people in that context and relate to local concerns and priorities. While certain types of mental health issue may be seen across a broad range of settings – such as anxiety, or depression – the specific way they are manifest can be heavily shaped by local understandings and social mores. This variation is perhaps greater still when focusing on broader indicators of children's well-being. Signs that a child is 'doing well' can be understood very differently in different contexts. For this reason, it is widely acknowledged that measures of mental health and psychological wellbeing – amongst children or any other group – need to clearly reflect the understanding of health and well-being in the setting where there are being used. It is best when this is confirmed by evidence that those whose scores on a measure indicate major needs are also those identified - by lay or professional judgment - as the most needy (technically referred to as 'criterion validity').



Reliability focuses on whether measures provide a consistent, coherent, trustworthy basis for drawing conclusions. It is not just a question of selecting a few relevant indicators. The development of a reliable measure involves careful adjustment of the wording of items (to remove ambiguities and inconsistencies of interpretation) and the addition and deletion of items (dropping those which the pattern of responses suggests doesn't 'fit' with the others; bringing in new ones that strengthen the internal consistency between items). Most established mental health and psychosocial measures will have gone through such processes, and documentation will normally include reports of their statistical reliability. However, given the strong cultural influences on understanding of such concepts, a measure that proves reliable in one setting may

not prove so in another. Good reliability is crucial in evaluation studies, where sensitivity to change over time is required. Using an unreliable measure may mean there is so much 'noise' in data collected that important changes are not detected.

In terms of feasibility, humanitarian settings present many constraints with respect to measurement. Principal amongst these are the timescale within which assessments need to be completed to be of value for baseline purposes and the limited human resource capacity that can be mobilized in support of data collection. In terms of timing, measures need to be feasible both in terms of the length of time administering an assessment takes with an interviewee and in terms of the overall window of time within which data collection must be completed for operational reasons. With regards to human resource requirements, humanitarian settings are generally marked by a severe shortage of technical skills, due both to a combination of weak pre-existing capacities, disruption of existing work structures and, frequently, competition between non-government agencies regarding people with advanced technical skills in such areas as assessment and evaluation. Measures that require engagement of a mental health professional or social worker, for example, may in principle be suitable for the assessment of affected children's needs affected, but not feasibly implemented in the circumstances. Most assessments are likely to have to rely on completion by locally-recruited enumerators, using focused training to strengthen capacities required for data collection.

This compendium seeks to assist the navigation of these challenges. There is wide concern that adoption of reliable measurement instruments by a skilled external research team for a short period risks an 'extractive' form of data collection wildly disconnected from local priorities and concerns (that is, fails to establish cultural validity). Equally hazardous, however, are strategies that engage in valuable participative work in communities, but fail to pay attention to establishing the reliability of findings in a robust manner. Further, a measure may be culturally valid and reliable, but the length of time and technical support required for its use may make it unfeasible to implement in many humanitarian contexts, particularly those involving rapid onset emergencies.

The decision-making guide suggests the questions that need to be asked to identify a tool or approach suited to a particular circumstance.

1. Answer the prompt questions to the left of the diagram to identify the required focus (assessing individuals to guide specific interventions; assessing overall group- or population-level needs; or structuring relevant participatory activities); the required scope (e.g. whether the measure is suited to assess mental health, broader psychosocial wellbeing, or both); and the age range of children concerned.
2. Drawing upon the details tabulated in the Index, list the pool of potential measures suited to your answers.
3. Review the details for each measurement tool or approach in this pool.
4. Select a promising measure from the list and follow through the questions indicated for the 'Using or Adapting Existing Measure Route', repeating this loop as many times as necessary to identify a valid, reliable and feasible measure for use.
5. Consider the prompts for the 'Developing Local Measure Route' to identify an alternative or complementary strategy.

## Contents

Arab Youth Mental Health Scale **(AYMH)**  
 “Are We Making a Difference?”  
 Brief Ethnographic Interviewing  
 Child Behavior Checklist **(CBCL)**  
 Child Behavior Inventory **(CBI)**  
 Child Functioning Impairment Rating Scale  
 Child Led Indicators  
 Child Post-Traumatic Stress Disorder Symptom Scale **(CPSS)**  
 Child Post-Traumatic Stress Reaction Index **(CPTSD-RI)**  
 Child Protection Rapid Assessment **(CPRA)**  
 Child Psychosocial Distress Screener **(CPDS)**  
 Childhood War Trauma Questionnaire **(CWTQ)**  
 Children’s Depression Inventory **(CDI)**  
 Children’s Hope Scale **(CHS)**  
 Composite International Diagnostic Interview **(CIDI)**  
 Depression Self-Rating Scale **(DSRS)**  
 Design, Implementation, Monitoring and Evaluation Model **(DIME)**  
 Developmental Assets Profile **(DAP)**  
 Diagnostic Interview Schedule for Children **(DISC)**  
 Family Connectedness Scale **(FCS)**  
 General Health Questionnaire **(GHQ)**  
 Global Assessment of Psychosocial Disability **(GAPD)**  
 Harvard Trauma Questionnaire **(HTQ)**  
 Hopkins Symptom Checklist –25/37A **(HSCL-25/37A)**  
 Humanitarian Emergency Settings Perceived Needs Scale **(HESPER)**  
 International Organization for Migration’s Psychosocial Tools  
 Impact of Event Scale **(IES)**  
 Kiddie Schedule for Affective Disorders and Schizophrenia for School-Aged Children **(K-SADS)**  
 Mini International Neuropsychiatric Interview for Children and Adolescents **(MINI KID)**  
 Mood and Feelings Questionnaire **(MFQ)**  
 Multidimensional Anxiety Scale for Children **(MASC)**  
 Nipissing District Developmental Screen **(NDDS)**  
 Orphans and Vulnerable Children Wellbeing Tool **(OWT)**  
 Participatory Ranking Methodology **(PRM)**  
 Participatory Rapid Appraisal **(PRA)**  
 Pediatric Emotional Distress Scale **(PEDS)**  
 Post-Traumatic Stress Symptoms in Children **(PTSS-C)**  
 Psychological Screening for Young Children Aged 3-6 **(PSYCa3-6)**  
 Rapid Assessment of Mental Health Needs of Refugees, Displaced and Other Populations Affected by Conflict and Post-Conflict Situation **(RAMH)**  
 Revised Children’s Manifest Anxiety Scale **(RCMAS)**  
 Rosenberg Self-Esteem Scale **(RSES)**  
 Screen for Childhood Anxiety Related Emotional Disorders **(SCARED)**  
 Self-Reporting Questionnaire **(SRQ)**  
 Strengths and Difficulties Questionnaire **(SDQ)**  
 UCLA PTSD Reaction Index **(UCLA PTSD-RI)**  
 War Events Questionnaire **(WEQ)**  
 Who is Where, When, Doing What? **(4Ws)**

## Arab Youth Mental Health Scale

### Overview/Description

A 21-item tool used to assess common mental health disorders in children aged 10-14 years. The tool is usually administered through a structured questionnaire by a trained interviewer. The scale has a recall period of one-week and ranges from scores of 21 to 63, with a higher score suggestive of poorer mental health. Possible responses include: Rarely, Sometimes, and Always.

### Suitable for Assessment of:

Depression and anxiety symptoms among children aged 10 to 14 years. The tool was initially developed for use in Lebanon and is available in English and Arabic, upon request.

### Examples of Use

Makhoul, J., Nakkash, R., El Hajj, T., Abdulrahim, S., Kanj, M., Mahfoud, Z., & Afifi, R. (2011). Development and Validation of the Arab Youth Mental Health Scale. *Community Mental Health Journal*, 47, 331–340.

Mahfoud, Z., Abdulrahim, S., Badaro Taha, M., Harpham, T., El Hajj, T., Makhoul, J., ...Afifi, R. (2011). Validation of the Arab Youth Mental Health scale as a screening tool for depression/anxiety in Lebanese children. *Child and Adolescent Psychiatry and Mental Health*, 5(9).

### Restrictions on Use

None noted.

### Available from:

Mahfoud, Z., Abdulrahim, S., Badaro Taha, M., Harpham, T., El Hajj, T., Makhoul, J., ...Afifi, R. (2011). Validation of the Arab Youth Mental Health scale as a screening tool for depression/anxiety in Lebanese children. *Child and Adolescent Psychiatry and Mental Health*, 5(9).

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## “Are We Making a Difference?”

### Overview/Description

A set of qualitative, participatory evaluation tools for monitoring and measuring the impact of psychosocial support programs for children. The tools consist of a series of leader-facilitated group activities (approximately one to two hours in duration) that are based on the following indicators: emotional self-awareness, independence, self-regard/self-worth, social networks, empathy, integration into the community, flexibility, problem-solving, contribution to own basic needs, normalization, skills and knowledge, happiness vs. depression, and optimism and future orientation. Program staff must first decide which of the pre-defined indicators it wishes to measure and then select tools/activities that match selected indicator(s). Each indicator contains three to eight activities, many of which involve group discussions and/or asking the children to draw. Selected children are invited to participate, given an explanation of the purpose of the activities, and then asked for informed consent. Activity groups consist of six to ten children, who should be divided by age groups (i.e. ages 6-10, 11-13, and 14-18). The activities both help children to recognize, understand and express their feelings, and assist staff of psychosocial programs in determining if programs are meeting pre-determined objectives.

### Suitable for Assessment of:

The psychosocial and emotional awareness of children aged 6-18 years. In addition, it allows for the ongoing evaluation of psychosocial program impacts. Activities do not require the use of an outside facilitator, and/or a professional mental health clinician, but rather, can be facilitated by trained program staff. However, group activities should consist of one facilitator, who is solely responsible for facilitating, and a recorder, who documents participant discussions, during the activity. Activities must be facilitated in a quiet and private setting, either indoors or outdoors. The tool has been used in various parts of Africa, but would be suited to many contexts.

### Examples of Use

Evans, R. (2011). ‘We are managing our own lives...’: Life transitions and care in sibling-headed households affected by AIDS in Tanzania and Uganda. *Area*, 43(4), 384-396.

### Restrictions on Use

Informed and ongoing consent of children required for participation. All program staff must maintain confidentiality of children’s personally identifiable information (i.e. name, birth date, etc.) when writing reports of evaluation findings. Group facilitators should refrain from asking numerous questions about sad topics, and exercise caution in using leading questions (i.e. ‘So that made you unhappy?’). Staff should start discussions with lighter, less emotionally charged topics and later move to more difficult topics.

The manual is only available to people who have undergone in-depth training and paid \$24 USD for a paper copy, or \$16 for an electronic copy.

### Available from:

REPSSI: [www.repssi.org](http://www.repssi.org) as:

Are we making a difference? Participatory evaluation tools for monitoring and measuring the impact of psychosocial support programmes for children aged 6 to 18.

## Brief Ethnographic Interviewing

### Overview/Description

An assessment approach that uses brief semi-structured interviews to develop locally relevant indicators. In a semi-structured interview, a central question is asked and discussed, from which themes and assessment data are derived. Following interviews, data is sorted, given thematic names, and eventually molded into assessment indicators by a group of researchers. Once a set of indicators is developed, it will need to first be piloted to test for accuracy in assessing intended areas of MHPSS. Although Brief Ethnographic Interviews can be used singularly, they are encouraged to be used in conjunction with other assessment approaches, such as focus groups and key informant interviews. Each interview takes about 15 minutes to complete.

### Suitable for Assessment of:

Psychosocial and mental wellbeing of children. This assessment approach is valuable both for developing new assessment measures, and/or adapting existing measures to local contexts so that indicators are reflective of local expressions and beliefs regarding psychosocial and mental health.

### Examples of Use

Bolton, P., & Tang, A. M. (2004). Using ethnographic methods in the selection of post-disaster, mental health interventions. *Prehospital and Disaster Medicine, 19*(1), 97-101.

Rasmussen, A., Katoni, B., Keller, A. S., & Wilkinson, J. (2011). Posttraumatic idioms of distress among Darfur refugees: hozun and majnun. *Transcultural Psychiatry, 48*(4), 392-415.

### Restrictions on Use

It is important that interview questions be brief, and attempt to elicit information about real people known to interviewees. Although no requirement is made for the number of people who should be interviewed, it is recommended that at least 150 to 250 responses for each sub-population be collected. Interviewers should not paraphrase or re-word interview questions; interview questions should be asked exactly as stated. Although no set number is given for how many indicators should be developed, it is recommended to start with a smaller number, and if needed, work up to a larger number.

### Available from:

The Center for Victims of Torture:

<http://www.cvt.org/sites/cvt.org/files/attachments/u8/downloads/Brief%20Ethnographic%20Interviewing%20Manual.pdf>

## The Child Behavior Checklist (CBCL)

### Overview/Description

A tool used to screen for abnormal behavior and emotions in children. Part of the Achenbach System of Empirically Based Assessment—a comprehensive approach to studying children's behavior—the CBCL comprises two versions—the Preschool Checklist (CBCL/1½-5), for use with children between the ages of 18 months and 5 years; and the School-age Checklist (CBCL/6-18), for children aged 6 to 18 years. It also contains two forms—the Teacher's Report Form (TRF), administered to a child's teachers; and the Youth Self Report (YSR), completed by children aged 11 to 18. Apart from the TRF and YSR, a child's parent, family member, or caregiver completes both the Preschool and School-age Checklists. The Preschool Checklist contains 100 items, and the School-Age Checklist contains 120 items. In both checklists, statements about a child's behaviors are provided, with response options scored on a three point scale—Not true (0), Somewhat or Sometimes true (1), Very true or Often true (2). Two open-ended items are included at the end of a questionnaire for a respondent to report any other worrisome behavior. A total score can be derived for the tool, as well as for various behavioral syndromes—Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Social Problem, Thought Problems, Attention Problems, Rule-Breaking Behavior, and Aggressive Behavior; and DSM IV categories—Affective Problems, Anxiety Problems, Somatic Problems, Attention Deficit/Hyperactivity Problems, Oppositional Defiant Problems, and Conduct Problem. Although the CBCL does not require administration by a clinician, someone with at least a graduate-level degree—that included coursework in standardized assessments—should administer it. The tool requires approximately 15 minutes for administration.

### Suitable for Assessment of:

Current problematic behavior, or over the past six months, in children between the ages of 18 months and 18 years. The CBCL can be used for a variety of purposes—epidemiological and other research studies, clinical assessments, and monitoring interventions over time. The CBCL has been used in numerous multicultural settings, and is available in over 90 languages.

### Examples of Use

Mollica, R. F., Poole, C., Son, L., Murray, C. C., & Tor, S. (1997). Effects of war trauma on Cambodian refugee adolescents' functional health and mental health status. *Journal of the American Academy of Child & Adolescent Psychiatry, 36*(8), 1098-1106.

Allwood, M. A., Bell-Dolan, D., & Husain, S. A. (2002). Children's trauma and adjustment reactions to violent and nonviolent war experiences. *Journal of the American Academy of Child & Adolescent Psychiatry, 41*(4), 450-457.

Rousseau, C., & Drapeau, A. (2003). Are Refugee Children an At-Risk Group? A Longitudinal Study of Cambodian Adolescents. *Journal of Refugee Studies, 16*(1), 67-81.

Najarian, L. M., Goenjian, A. K., Pelcovitz, D., Mandel, F., & Najarian, B. (1996). Relocation after a disaster: posttraumatic stress disorder in Armenia after the earthquake. *Journal of the American Academy of Child & Adolescent Psychiatry, 35*(3), 374-383.

### Restrictions on Use

CBCL documents are available for use and download from the ASEBA website; however, they should not be modified in any way, and if copied or distributed, should adhere to ASEBA's copyright and trademark policies outlined on its website. CBCL questionnaires and associated products are available for a fee ranging from \$9 USD to \$2,000 USD.

### Available from:

Achenbach System of Empirically Based Assessment: <http://www.aseba.org/>

## Child Behavior Inventory (CBI)

### Overview/Description

A 42-item, behavioral screening tool that measures children's behavioral symptoms and adaptations. Modified from numerous other child behavioral measurements, the CBI is available in two versions—CBI-A (for parents and/or caretakers) and CBI-C (for children). Both versions can either be self-administered or administered as a structured interview; however, CBI-C can only be administered to children between the ages of 10 and 16, while the CBI-A can be administered to parents and caretakers of children between the ages of 5 and 16. When possible, administration in an interview format is advisable, especially when administering the questionnaire directly to children, as this method tends to yield better results. The questionnaire contains 25 items that inquire about behavioral symptoms—aggression (9 items), depression (10 items), and anxiety (6 items)—and 17 items measuring behavioral adaptations—prosocial behavior (9 items) and planful behavior (8 items). The CBI response options are based on a 4-point scale: Never (0), Rarely (1), Sometimes (2), and Always (3). Sub-scale scores are first tallied (i.e. a score for aggression, depression, anxiety, prosocial behavior, and planful behavior) and added together to derive an overall CBI score.

### Suitable for Assessment of:

Behavioral symptoms and adaptations in children between the ages of 5 and 16 years, especially those exposed to armed conflict over the past six months. Available in English and Arabic. Has been used for assessment of impact of war in Lebanon and Kuwait.

### Examples of Use

Macksoud, M. S., & Aber, J. L. (1996). The war experiences and psychosocial development of children in Lebanon. *Child Development*, 67(1), 70-88.

Ager, A. & Loughry, M. (2004). Psychology and Humanitarian Assistance. *Journal of Humanitarian Assistance*: <http://sites.tufts.edu/jha/archives/80>

### Restrictions on Use

Prior to administration in any new country and/or cultural context, the CBI should first be test piloted to ensure local relevancy of each questionnaire item.

### Available from:

Macksoud S. M., Aber, L., Dyregrov, A., & Raundalen, M. (1990). *Child Behavior Inventory: Project on children and war*. New York: Columbia University, Center for the Study of Human Rights.

## Child Functioning Impairment Rating Scale

### Overview/Description

A culturally adaptable assessment tool that measures daily functioning levels of children living in low- and middle-income countries. Due to both a lack of mental health resources, and a dearth of appropriate psychometric tools specific to low- and middle-income countries (LAMIC), the Child Functioning Impairment Rating Scale was developed as a tool that could be easily adapted for use across various LAMIC contexts. The pilot scale, designed and implemented in Indonesia, consists of 11-items that assess various social and ecological indicators of functional impairment in Indonesian children—individual activities (4 items), family activities (2 items), peer activities (2 items), school functioning (2 items), and one open item. Questions were developed following a series of mixed-methods data collection efforts that consisted of participant observations, two-week diary entries of daily activities by a sample of school children, and focus group discussions. The finalized questionnaire, scaled on a 4-point scale—None (1), A Little (2), Moderate (3), and Often Can't do Activity (4)—was scored from 0 to 44, with higher scores indicative of higher levels of impairment. The pilot tool provides a foundational basis on which to develop similar, context-specific impairment rating scales.

### Suitable for Assessment of:

Daily functioning of children living in LAMIC, and who have been affected by political violence. Data collected from assessments can be used to inform program directions and/or development, as well as policy and research decisions. The tool was designed in Indonesia, but can be adapted to other contexts.

### Examples of Use

Tol, W. A., Komproe, I. H., Susanty, D., Jordans, M. D., Macy, R. D., & De Jong, J. M. (2008). School-Based Mental Health Intervention for Children Affected by Political Violence in Indonesia: A Cluster Randomized Trial. *JAMA*, 300(6), 655-662. <http://jama.jamanetwork.com/article.aspx?articleid=182378>

Kohrt, B. A., Jordans, M. D., Tol, W. A., Speckman, R. A., Maharjan, S. M., Worthman, C. M., & Komproe, I. H. (2008). Comparison of Mental Health Between Former Child Soldiers and Children Never Conscripted by Armed Groups in Nepal. *JAMA*, 300(6), 691-702. <http://jama.jamanetwork.com/article.aspx?articleid=182377>

### Restrictions on Use

For the piloted scale, questionnaires administered to both children and parents demonstrated low correlation. Consequently, in future adaptations of this method, it is recommended that only child-administered questionnaires be developed. This scale only provides impairment measurements, and is not suitable for deriving data on specific mental conditions and/or deficits. Additionally, this scale did not account for gender-specific indicators, but if desired, this could be an area of exploration for future studies and scale developments.

### Available from:

Tol, W. A., Komproe, I. H., Jordans, M. D., Susanty, D. & De Jong, J. M. (2001). Developing a function impairment measure for children affected by political violence: a mixed methods approach in Indonesia. *International Journal of Quality in Health Care*, 23(4), 375-383. <http://intqhc.oxfordjournals.org/content/23/4/375.full>

## Child Led Indicators

### Overview/Description

A multi-step, participatory process in which children develop their own culturally grounded concepts on psychosocial wellbeing, desired outcomes, and indicators as a way of monitoring psychosocial programming outcomes. Developed by the Transcultural Psychosocial Organization (TPO) Nepal, the process is centered on empowering children to be actively involved in finding solutions to their own problems, largely as a way of engendering local buy-in and sustainability. While the process of involving local children is specific to each context, the general areas in which their participation is valuable are not—providing specific insights and experiences about their lived experiences; offering insight into what constitutes wellbeing within their socio-cultural contexts; and their knowledge of resources available to them in their communities. From these areas of knowledge and insight, psychosocial programming can occur. With psychosocial programming comes the development of program indicators, which are also informed by participating children. The multi-step process begins with a drawing exercise, in which selected children are asked to draw their *heartmind*, a Nepali symbol for emotion and memory, in which children are to depict both their positive and negative feelings. In subgroups, children are then asked by a facilitator to choose the most pressing issues confronting their lives today (sometimes gleaned from looking at their *heartminds*), and collectively share their answers with the group. Next, children are asked to think through (or draw) the cause and effect analysis of their main psychosocial problem—how the problem affects their lives, both now and in the future. This is followed by an analysis of objectives, in which children can positively describe their future situation, as though their main problem has been resolved. In this activity, children are asked to turn their ‘problems’ into positive ‘objectives’ that are both realistic and achievable. Afterwards, children are involved in resource mapping, in which they identify resources that will be both beneficial to their wellbeing and available in their communities. Children then list activities that they think will help them achieve their desired objectives. Finally, children design indicators that will help them measure their success in fulfilling originally determined objectives, and which will serve as indicators for program monitoring and evaluation.

### Suitable for Assessment of:

Initial and ongoing evaluation of psychosocial programming. It allows for children’s participation throughout the process—needs assessment, planning, implementation, monitoring and evaluation—and helps children identify their most pressing psychosocial needs.

### Examples of Use

Ben-Arieh, A. (2008). The child indicators movement: past, present, and future. *Child Indicators Research*, 1(1), 3-16.

### Restrictions on Use

Children may propose objectives that are not obtainable given the limited resources of their communities, a funding agency/organization, etc. It is important to balance logistical and budgetary realities with the sometimes-lofty ambitions of children participating in activities. While it is important to honor the programming ideas volunteered by children, it is also important for adults to determine just how practical and feasible these ideas truly are, and to discontinue ideas that make little practical sense. Participation in the process is not in and of itself a proxy for psychosocial wellbeing; participation can impose unnecessary stressors that need to be constantly monitored and attended to.

### Available from:

Karki, R., Kohrt, B. A., & Jordans, M. J. (2009). Child Led Indicators: pilot testing a child participation tool for psychosocial support programmes for formal child soldiers in Nepal. *Intervention*, 7(2), 92-109.

<http://www.ourmediaourselves.com/archives/72pdf/Karki.pdf>

## Child Post-Traumatic Stress Disorder Symptom Scale (CPSS)

### Overview/Description

A 24-item tool used to assess for, and/or diagnose, Post-Traumatic Stress Disorder in children. Adapted from the adult screening tool, the Posttraumatic Diagnostic Scale (PDS), the CPSS comprises two parts—Part One, patterned after DSM-IV criteria; and Part Two, assesses functional impairments resulting from symptoms recognized in Part One. Part One, consisting of 17 items, addresses symptom frequency—how often a child has been bothered by a particular problem over the past two weeks. Response options for this section include: Not at All (0), Once a Week or Less/Once in a While (1), Two to Four Times a Week/Half the Time (2), and Five or More Times a Week/Almost Always (3). The total score for this section ranges from 0 to 51, with higher scores indicative of PTSD. In Part Two, children are asked seven questions about functional impairment due to symptoms discussed in Part One. Response options for this section are: Absent (0) or Present (1). The total score for this section ranges from 0 to 7, with higher scores indicative of greater functional impairment. If desired, it is also possible to calculate sub-scale scores for re-experiencing, avoidance, and hyper-arousal. The CPSS, which can be self-administered or administered by an interviewer, takes about 10-20 minutes to administer.

### Suitable for Assessment of:

PTSD and symptom severity in children between the ages of 8 and 18 years. The tool is available in English and Spanish. While the tool has primarily been used in developed, non-humanitarian contexts, it has been implemented in humanitarian settings in Asia and South America.

### Examples of Use

Balaban, V. (2006). Psychological assessment of children in disasters and emergencies. *Disasters*, 30(2), 178-198.

Tol, W. A, Komproe, I. H., Jordans, M. D., Susanty, D., & De Jong, J. M. (2001). Developing a function impairment measure for children affected by political violence: a mixed methods approach in Indonesia. *International Journal for Quality in Health Care*, 23(4), 375-383 <http://intqhc.oxfordjournals.org/content/23/4/375.full>

Tol, W. A, Komproe, I. H., Jordans, M. D., Vallipuram, A., Sipsma, H., Sivayokan, S., & Macy, R. D. (2012). Outcomes and moderators of a preventive school-based mental health intervention for children affected by war in Sri Lanka: a cluster randomized trial. *World Psychiatry*, 11(2), 114–122. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3363388/>

### Restrictions on Use

The CPSS is available free of charge.

### Available from:

American Academy of Child & Adolescent Psychiatry:

[http://www.aacap.org/App\\_Themes/AACAP/docs/resource\\_centers/resources/misc/child\\_ptsd\\_symptom\\_scale.pdf](http://www.aacap.org/App_Themes/AACAP/docs/resource_centers/resources/misc/child_ptsd_symptom_scale.pdf)

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## Child Post-Traumatic Stress Reaction Index (CPTSD-RI)

### Overview/Description

A 20-item, self-report measure that screens for post-traumatic stress reactions in children exposed to various forms of trauma. Based on the frequency of symptom occurrences, each item ranges in score from 0 (None) to 4 (Most of the Time). The questionnaire has a total score of 80, with scores ranked according to the severity of reported PTSD symptoms and/or reactions—Doubtful (0-11) Mild (12-24), Moderate (25-39), Severe (40-59), and Very severe (60-80). The tool takes about 15-20 minutes to administer.

### Suitable for Assessment of:

Post-traumatic stress reactions in children between the ages of 6 to 16 years, who have been exposed to various types of traumatic events (i.e. war, earthquake, hurricane, mass-shootings, etc.). Most appropriate for use after disasters and emergencies. The questionnaire is has been used in a variety of emergency contexts.

### Examples of Use

Ovuga, E., & Larroque, C. (2012). Post Traumatic Stress Disorder – Northern Uganda Clinical Perspective. In E. Ovuga (Ed.) *Post Traumatic Stress Orders in a Global Context*. <http://cdn.intechopen.com/pdfs/26611/InTech-Post-traumatic-stress-disorder-a-northern-uganda-clinical-perspective.pdf>

Altawil, M., Nel, P. W., Asker, A., Samara, M., & Harrold, D. (2008). The effects of chronic war trauma among Palestinian children. In M. Parsons (Ed.) *Children: The invisible victims of war- An interdisciplinary study*. Peterborough-England: DSM Technical Publications Ltd. <http://en.ptcgaza.com/files/2011/05/Chapter-in-Book1-The-effects-of-Chronic-Trauma-in-Palestine.pdf>

Thabet, A., & Vostanis, P. Post-traumatic Stress Reactions in Children of War. *Journal of Child Psychology and Psychiatry*, 3, 385–391. [http://www.nctsn.net/nctsn\\_assets/Articles/84.pdf](http://www.nctsn.net/nctsn_assets/Articles/84.pdf)

### Restrictions on Use

The tool is not intended for diagnostic uses, only for screening purposes.

### Available from:

Pynoos, R., Frederick, C., Nader, K., Arroyo, W., Steinberg, A., Eth, S.,...Fairbanks, L. (1987). Life threat and post-traumatic stress in school-age children. *JAMA - Archives General Psychiatry*, 44(12), 1057–1063.

## Child Protection Rapid Assessment (CPRA)

### Overview/Description

Allows for a rapid, inter-agency assessment of Child Protection needs and existing local resources following the onset of an emergency. It is recommended for use within three to four weeks following the onset of an emergency. When possible, it should be used in conjunction with other coordinated Protection Rapid Assessments. Works best when conducted as a collaborative and coordinated effort among all Child Protection members, including governments. When possible, a lead organization should be selected to organize and spearhead group efforts, and a Child Protection Rapid Assessment Task Force (CPRATF) formed to manage the assessment process. Different communities are chosen through a structured purposive sampling—a sampling process in which information is collected in select communities to estimate the needs of an entire population. The CPRA covers all major child protection issues, including psychosocial distress, but does not explore them in depth. It allows for a broad estimate of the situation to guide quick planning and action. Desk review, key informant interviews, and direct observations are used for collecting data. Information collected from each community is compiled into a single 'site report' which forms the basis of the analysis. The accompanying excel-based data management tool allows for timely analysis of data, using descriptive analysis techniques, and produces basic graphs and tables. As part of the methodology, it is recommended that an interpretation workshop is organized upon initial analysis of the data, involving child protection actors. There is potential for extracting questions addressing psychosocial concerns for use within other surveys.

### Suitable for Assessment of:

Initial child protection needs of a community in the aftermath of an emergency, including psychosocial concerns. Data collected from CPRA helps inform CP programs in short- and medium-term. It is particularly beneficial in determining the scale of needs and protection risks, response priorities, any gaps in information, execution of response activities (including building upon any existing resources), and engagement of various stakeholders (i.e. governments and rebel groups). It is appropriate for any and all post-emergency settings, can be adapted to meet local contexts, and adjusted to accommodate any changes in initial selections in data collection sites and/or methodologies.

### Examples of Use

Metzler, J., Savage, K., Vojta, M., Yamano, M., Schafer, A. & Ager, A. (2013). Evaluation of Child Friendly Spaces: Ethiopia Field Study Summary Report. <http://mhpss.net/wp-content/uploads/group-documents/78/1364821269-20130315WV-CUCFSEthiopiaFieldStudySummaryReport-1.pdf>

Child Protection Working Group. (2013). Interagency Child Protection Rapid Assessment Summary Report Hajjah Governorate: Yemen. Global Protection Cluster. <http://cpwg.net/assessment-topics/yemen/>

### Restrictions on Use

Because of CPRA's reliance on purposive sampling, assessment findings are not representative of the total population. It is imperative that principles of 'do no harm' and 'best interest of the child' be strictly adhered to throughout the CPRA process. A well-trained interviewer must ask sensitive questions flagged in the CPRA Toolkit. In the absence of highly competent interviewers, children should not be interviewed within this methodology. A minimum of three key informants should be interviewed at each site: at least two must work directly with children (i.e. teacher, community care giver, etc.), and at least one should hold a position of authority in the community (i.e. tribal leader, camp manager, etc.). Although required qualifications for assessors are emergency-specific, all assessors, regardless of context, must be knowledgeable in the local language(s), be able to clearly express themselves, and have experience working responsibly in communities.

### Available from:

Global Protection Cluster: Child Protection (2012). Child Protection Rapid Assessment: A Short Guide. <http://cpwg.net/assessment-topics/cpra-toolkit/>

## Child Psychosocial Distress Screener (CPDS)

### Overview/Description

An assessment tool that aids in preliminary detection and determination of the level of psychosocial distress, and any potential need for specialized services and/or treatment, in children. CPDS uses broad, non-specific questions relating to one of three factors—distress, resilience, and school—and can be administered by non-specialists. It contains seven items, the first four of which are answered by the child, and the final three by a teacher of the child. Possible response options include: Never/Not at all/Irregular, Sometimes/A little/Some absence, and Often/A lot/Regular. Pictorial representations of empty, half-full, and full-glasses are used to help children with providing correctly intended responses to each question. Each question response is worth 0-2 points (14 total possible points for the entire CPDS), with higher overall scores indicative of higher levels of psychosocial distress in the past month. For three of the items, 'probes', relating to the child's own experiences and memories of past events, are used. Information for probes is gleaned through focus group discussions held with parents, teachers, and children prior to administration of questionnaires. In these focus group discussions, participants are queried about local and/or personal examples of aversive events (Question 1.1 on CPDS) and manifestation(s) of distress and other worrisome behaviors (Questions 1.3 and 2.1). Responses are listed and ranked, with the most frequently mentioned responses selected for use as probes. In addition to the pre-administration focus groups, it is strongly encouraged to conduct pre-administration briefings with parents, teachers, and children to discuss screening procedures, project objectives, and the consent process. Also, it is acceptable for the questionnaire to be administered orally to illiterate children.

### Suitable for Assessment of:

Psychosocial distress in large populations of children living in conflicted-affected communities, and who are between the ages of 8 and 14 years. The questionnaire specifically assesses for psychosocial distress over the last month, and has been used primarily in low- and middle-income countries (LAMIC) affected by conflict.

### Examples of Use

Jordans, M. J., Komproe, I. H., Tol, W. A., & De Jong, J. T. (2009). Screening for psychosocial distress amongst war-affected children: cross-cultural construct validity of the CPDS. *Journal of Child Psychology and Psychiatry*, 50(4), 514-523.

Tol, W. A., Komproe, I. H., Jordans, M. D., Vallipuram, A., Sipsma, H., Sivayokan, S., & Macy, R. D. (2012). Outcomes and moderators of a preventive school-based mental health intervention for children affected by war in Sri Lanka: a cluster randomized trial. *World Psychiatry*, 11(2), 114-122.

### Restrictions on Use

The CPDS can be used freely as long as appropriate attributions and acknowledgements are made. Many of the questions contained in the CPDS tool are context-specific; consequently, the CPDS should undergo a validation process prior to commencement of its use in each new site. Final versions should first be translated from English into the local language(s); back-translated using several bi-lingual professionals; reviewed by a bi-lingual mental health specialist; undergo a blind back-translation by a psychologist who is unexposed to the original version; go through a comparison of the back-translated version with the original, English version; and finally, administered via a test-run in a school.

### Available from:

Jordans, M. J., Komproe, I. H., Ventevogel, P., Tol, W. A., & De Jong, J. T. (2012). The Child Psychosocial Distress Screener (CPDS). Measurement Instrument Database for the Social Science.

[http://www.midss.ie/sites/www.midss.ie/files/child\\_psychosocial\\_distress\\_screener\\_cpds\\_v2010.pdf](http://www.midss.ie/sites/www.midss.ie/files/child_psychosocial_distress_screener_cpds_v2010.pdf)

## Childhood War Trauma Questionnaire (CWTQ)

### Overview/Description

A tool used to assess children's war-related experiences. It has two versions—CWTQ-C (for children) and CWTQ-A (for parents and caretakers). Both versions can either be self-administered or administered by an interviewer, although data reliability is greater when administered by an interviewer. The CWTQ contains 25 items and comprises two sections: Section One inquires about demographic details such as age, gender, and place of residency; Section Two asks detailed questions relating to a child's direct and indirect experiences and exposures to war. Section Two asks about 45 different types of war-related traumas, separated according to the following categorizations—Separation, Victim of Violent Acts, Involvement in Hostilities, Displacement, Bereavement, Exposure to Shelling or Combat, Witness Violent Acts, Physical Injuries, Emigration, and Extreme Deprivation.

### Suitable for Assessment of:

War exposures and experiences in children aged 3 to 16 years. The CWTQ-C is for administration to children between the ages of 10 and 16 years, and the CWTQ-A is to be administered to parents/caretakers of children between the ages of 3 and 16 years. The CWTQ helps to define the number and types of trauma related to war, which can be used to guide research and intervention programs.

### Examples of Use

Smith, P., Perrin, S., Yule, W., & Rabe-Hesketh, S. (2001). War exposure and maternal reactions in the psychological adjustment of children from Bosnia-Herzegovina. *Journal of Child Psychology and Psychiatry*, 42(3), 395-404.

Geltman, P. L., Augustyn, M., Barnett, E. D., Klass, P. E., & Groves, B. M. (2000). War trauma experience and behavioral screening of Bosnian refugee children resettled in Massachusetts. *Journal of Developmental & Behavioral Pediatrics*, 21(4), 255-261.

Macksoud, M. S., & Aber, J. L. (1996). The war experiences and psychosocial development of children in Lebanon. *Child Development*, 67(1), 70-88.

Macksoud, M. S. (1992). Assessing War Trauma in Children: A Case Study of Lebanese Children. *Journal of Refugee Studies*, 5(1), 1-15.

### Restrictions on Use

None noted.

### Available from:

Children and War Foundation: <http://www.childrenandwar.org/wp-content/uploads/2009/03/Childhood-war-trauma-questionnaire.pdf>

## Children's Depression Inventory (CDI)

### Overview/Description

A 27-item, self-report tool used to assess symptoms and severity of depression in children. The CDI questionnaire, which can be administered individually or in a group setting, poses various statements relating to mood, interpersonal problems, ineffectiveness, lack of energy, and negative symptoms, to which respondents are to select three that best describe their thoughts and feelings over the past two weeks. Apart from the primary CDI, administered directly to children, the CDI exists in other versions—CDI-S, a 10-item, condensed version of the tool that allows for rapid screening; the CDI-P, for administration to parents, and based on behavior observed at home; and CDI-T, given to teachers, who report on observed behaviors at school and in social settings. The tool is scored from 0 to 54, with scores above 19 indicative of depression. The CDI, which takes about 15 minutes to administer (10 minutes for CDI-S), is available both in paper and computerized-formats.

### Suitable for Assessment of:

Depressive symptoms over the past two weeks in children between the ages of 7 and 16 years. The tool is helpful in determining treatment needs, and when used in combination with other tools, is effective for evaluating programs and interventions. The CDI is available in over 15 languages—English, French, Spanish, Italian, Japanese, Norwegian, Russian, Ukrainian, Afrikaans, Dutch, German, Hebrew, Hungarian, Lithuanian, Swedish, Polish, and Turkish.

### Examples of Use

Ajdukovic, M. A. (1998). Impact of displacement on the psychological wellbeing of refugee children. *International Review of Psychiatry*, 10(3), 186-195.

Morgos, D., Worden, J. W., & Gupta, L. (2007). Psychosocial effects of war experiences among displaced children in southern Darfur. *OMEGA--Journal of Death and Dying*, 56(3), 229-253.

### Restrictions on Use

The CDI is a screening tool, and thus, should not be used for diagnostic purposes. The tool is available for use following a payment ranging from \$82-170 USD, which includes the CDI manual and 25 screening and scoring forms.

### Available from:

Kovacs M. (1985). The Children's Depression Inventory (CDI). *Psychopharmacology Bulletin*. 21, 995-998.

Kovacs M. (1992). *Children's Depression Inventory Manual*. North Tonawanda, NY: Multi-Health Systems, Inc.

Multi-Health Systems: [www.mhs.com](http://www.mhs.com)

## Children's Hope Scale (CHS)

### Overview/Description

A self-report questionnaire that contains six items measuring a child's self-perception and level of belief about personal goal-attainment. The tool is based on two fundamental components of hope—agency and pathways. Agency refers to a child's ability to initiate and sustain goal-directed activities, and pathways indicate a child's capacity to carry out goals. The premise is that with more positive emotions come higher levels of hope, self-esteem, and goal-directed behavior; whereas, more negative emotional states tend to indicate reduced levels of hope, self-esteem, and goal-directed behavior. Question responses are scored from one through six—None of the Time (1), A Little of the Time (2), Some of the Time (3), A Lot of the Time (4), Most of the Time (5), and All of the Time (6). The higher the score, the higher the child's level of hope and goal-directed behavior. The questionnaire takes, on average, four minutes to complete. There is also a modified parent-report version available for use.

### Suitable for Assessment of:

Hopeful thinking, perceptions of self-worth, emotional wellbeing, motivation, and resiliency of individual children aged 8 to 16 years. While not a requirement, the tool can be used to measure short-term and long-term levels of hope in individual children with acute and/or chronic physical and/or mental health problems. The questionnaire is available in English and Chinese, with Spanish and Portuguese versions in the validation stages.

### Examples of Use

Tol, W. A., Komproe, I. H., Susanty, D., Jordans, M. J., Macy, R. D., & De Jong, J. T. (2008). School-based mental health intervention for children affected by political violence in Indonesia. *JAMA*, *300*(6), 655-662.

Khamis, V. (2013). The Mediating Effects of Child Strengths and Hopes on Academic Achievement for Palestinian Children Exposed to Armed Conflict. *International Journal of School & Educational Psychology*, *1*(2), 112-121

### Restrictions on Use

The tool is available free of charge. Both agency and pathways questions should be used together whenever administering a test, as this provides the most complete and accurate picture of a child's level of hopeful, goal-directed thinking.

### Available from:

Snyder, C. R., Hoza, B., Pelham, W. E., Rapoff, M., Ware, L., Danovsky, M.,...Stahl, K. J. (1996) The Development of the Child Hope Scale. *Journal of Pediatric Psychology*, *22*(3), 399-421.

<http://jpepsy.oxfordjournals.org/content/22/3/399.full.pdf>

## Composite International Diagnostic Interview (CIDI)

### Overview/Description

A comprehensive tool designed by the World Health Organization (WHO) to assess for psychiatric disorders (as defined in ICD-10 and DSM-IV) and associated risk factors, consequences, and treatment interventions. The CIDI consists of a series of structured modules that screen for somatoform disorders, anxiety, depression, mania, schizophrenia, eating disorders, impairments in cognition, and substance use disorders. The CIDI is a highly complex tool that requires advanced knowledge, both in its administration procedures and its scope of clinical pathologies; however, with proper training, it can be administered by interviewers who are non-clinicians. The CIDI allows for great variability in its administration. The questionnaire begins with a series of screening questions about the child's general health, before delving into disorder-specific questions. Depending on the scope and aims of an assessment, the CIDI can be administered in its entirety, or broken up and given in sections (i.e. the screening section and the depression module, etc.). However, it is important that the screening section always be included in any administration of the CIDI. The CIDI consists of a Short and a Long version. The Short version, averaging 45 minutes in administration time, helps to significantly reduce unnecessary financial and time costs compared with the Long version, which averages two hours in administration time. The Long version must be given to those who meet criteria for a mental disorder; it is up to the study organizer to determine whether or not to administer the Long version to those not meeting criteria for a mental disorder. The CIDI questionnaire and scoring algorithm are available in paper (PAPI) and computerized (CAPI) formats, and are updated regularly due to continual revisions in ICD and DSM criteria. Worldwide, CIDI training centers are available to provide expert training and technical assistance with the tool. Trainings last from 3-5 days and are available in Arabic, Chinese, Dutch, English, and Spanish.

### Suitable for Assessment of:

Mental disorders, detailed in ICD-10 and DSM-IV, occurring over the last 12 months and/or lifetime in children aged 16-17 years. Although the tool was primarily designed for use in epidemiological studies, CIDI can be used for a variety of individual- and societal-level purposes—to measure the prevalence, severity, and burden of mental disorders; mental health infrastructure; and accessibility to, and use of, mental health services, including pharmacological and non-pharmacological treatment methods. The CIDI has historically been used in a variety of cultural settings for both clinical and research purposes. New additions to the CIDI include assessments of chronic, medical conditions; the WHO Disability Assessment Schedule, which assesses for impairments, disabilities, and/or handicaps; assessment of any services used; history of childhood adversities; and a more detailed demographic section. The CIDI is available in over 24 languages, some of which include regional versions of a particular language (i.e. Dutch from the Netherlands and Dutch from Belgium).

### Examples of Use

Elbert, T., Schauer, M., Schauer, E., Huschka, B., Hirth, M., & Neuner, F. (2009). Trauma-related impairment in children—a survey in Sri Lankan provinces affected by armed conflict. *Child Abuse & Neglect*, 33(4), 238-246.

World Mental Health Survey Initiative (Harvard): <http://www.hcp.med.harvard.edu/wmh/>

### Restrictions on Use

The CIDI is copyrighted by the WHO; consequently, attendance at a CIDI training event, or training by a CIDI representative at a place of an organizer's choosing, is a requisite for full- or partial-use of the CIDI. In addition, a user must first purchase a license for administration, and if applicable, a translated copy of the CIDI. License costs are determined by country distributors at the local level, who can be contacted for country-specific price quotes.

### Available from:

The World Health Organization (WHO) Composite International Diagnostic Interview (CIDI):  
<http://www.hcp.med.harvard.edu/wmhcid/index.php>

## Depression Self-Rating Scale (DSRS)

### Overview/Description

An 18-item, self-rating tool to screen for depressive symptoms and exposure to environmental stressors. Children should complete the questionnaire independently, but if a child demonstrates or expresses difficulty in reading the items, a clinician may assist by reading items aloud. All items in the tool contain positive and negative "I" statements (i.e. "I feel like crying"), to which children answer with one of three responses—Mostly, Sometimes, or Never—depending on their personal experiences and feelings relating to the scenarios described. When items describe positive, non-depressive scenarios, (i.e. "I look forward to things as much as I used to"), responses are scored—Mostly (0), Sometimes (1), and Never (2). When items depict depressive symptoms (i.e. "I have bad dreams"), responses are scored—Mostly (2), Sometimes (1), and Never (0). The total possible score on the questionnaire is 36, with a total of 15 or more indicative of mental stress and/or disorder, and the need for diagnostic follow-up. The tool takes about five minutes to complete.

### Suitable for Assessment of:

Depressive symptoms in the past week in children aged 8 to 14 years. The DSRS is available in Arabic, Chinese, Dari, English, Italian, Japanese, Khmer, Norwegian, and Pashto.

### Examples of Use

Tol, W. A., Komproe, I. H., Susanty, D., Jordans, M. D., Macy, R. D., & De Jong, J. M. (2008). School-Based Mental Health Intervention for Children Affected by Political Violence in Indonesia: A Cluster Randomized Trial. *JAMA*, 300(6), 655-662. <http://jama.jamanetwork.com/article.aspx?articleid=182378>

Panter-Brick, C., Goodman, A., Tol, W., & Eggerman, M. (2011). Mental Health and Childhood Adversities: A Longitudinal Study in Kabul, Afghanistan. *Journal of the American Academy of Child and Adolescent Psychiatry*, 50(4), 349-363. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3069303/>

Fazel, M., Reed, R. V., Panter-Brick, C., & Stein, A. (2012). Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors. *The Lancet*, 379(9812), 266-282.

### Restrictions on Use

If a child requires items to be read aloud by a clinician, ensure that the clinician reads questions in a neutral tone so that the child is not influenced in his/her response choice.

### Available from:

Children and War Foundation: <http://www.childrenandwar.org/measures/depression-self-rating-scale-for-children-birleson/>

## Design, Implementation, Monitoring and Evaluation Model (DIME)

### Overview/Description

The DIME model is a process developed and used by the Applied Mental Health Research Group at Johns Hopkins University since 2000. The model seeks to combine evidence-based programming with rigorous monitoring and impact evaluation. It demonstrates the potential of using qualitative, participative research to inform the development of quantitative measures of mental health and psychosocial well-being. A manual is available which specifies the key steps specified by the DIME model. These steps are: (1) Qualitative assessment to identify and describe priority mental health and psychosocial problems; (2) Development of draft instruments to assess priority mental health and psychosocial problems; (3) Validation of draft instrument(s); (4) Conduct baseline prevalence surveys; (5) Program planning; (6) Development of interventions to address the identified mental health and psychosocial problems; (7) Implementation and monitoring; (8) Intervention evaluation. DIME is thus an approach to program development not just an approach to assessment and evaluation. However, there is potential to use aspects of the approach without committing to the whole DIME cycle.

### Suitable for Assessment of:

Local understandings and prioritization of mental health and psychosocial well-being issues, and the effectiveness of programming in addressing these. Given the time required to effectively identify issues through qualitative fieldwork, and follow through with other stages of the process, the approach is generally not suitable for use in rapid-onset emergencies unless there has been prior engagement with the context. Although the approach has widely been used with respect to issues of adult trauma, anxiety and depression, DIME methodology has also been adopted for studies of family and social cohesion and general psychosocial well-being.

### Examples of Use

Jordans M. J., Tol W. A., Susanty D., Ntamatumba P., Luitel N. P., Komproe I. H., & De Jong J. T. (2013). Implementation of a mental health care package for children in areas of armed conflict: a case study from Burundi, Indonesia, Nepal, Sri Lanka, and Sudan. *PLoS Med*, 10(1).

Bass, J., Pudyal, B., Tol, W., Murray, L., Nadison, M., & Bolton, P. (2012). A controlled trial of problem-solving counseling for war-affected adults in Aceh, Indonesia. *Social Psychiatry and Psychiatric Epidemiology*, 47(2), 279-291.

Betancourt, T., Bass, J., Borisova, I., Neugebauer, R., Speelman, L., Onyango, G., & Bolton, P. (2009). Measuring local instrument validity and reliability: A field-based example from northern Uganda. *Social Psychiatry and Psychiatric Epidemiology*, 44(8), 685-92.

### Restrictions on Use

The DIME approach requires significant skilled capacity for assessment, development, validation and evaluation aspects of the work. Activities are thoroughly documented in the online modules available, but are likely to require external technical support for effective implementation. The Applied Mental Health Research Group at Johns Hopkins has provided such assistance to wide range of humanitarian organizations, including World Vision, War Child Holland, International Medical Corps, and International Rescue Committee.

### Available from:

DIME Program Research Model (JHSPH): [http://www.jhsph.edu/research/centers-and-institutes/center-for-refugee-and-disaster-response/response\\_service/AMHR/dime/](http://www.jhsph.edu/research/centers-and-institutes/center-for-refugee-and-disaster-response/response_service/AMHR/dime/)

## Developmental Assets Profile (DAP)

### Overview/Description

A self-report, questionnaire consisting of 58 items that measure “developmental assets”, a set of skills, experiences, relationships, and behaviors found to facilitate formative growth and development in youth, and that are indicative of later success in adulthood. It has been found that the more developmental assets youth have, or acquire, the more likely their chances for success in school, and in leading happy, healthy and productive lives. DAP assesses eight internal and external categories of developmental assets: support (how caring parents, teachers, and neighbors are in a youth’s life); empowerment (a youth’s perceived sense of safety, value and appreciation at school and home); boundaries and expectations (a youth’s perception of how much he/she must abide by boundaries set at home, school and in the community); constructive use of time (the level of extra-curricular involvement partaken by a youth); commitment to learning (how motivated a youth is in completing school work and in seeking new information and/or skills); positive values (the level of personal and community responsibility exercised by a youth); social competencies (how well a youth engages in social relationships, adapts to change, and expresses himself/herself to others); and positive identity (a youth’s sense of self-worth). In addition, DAP includes five contextual areas—personal, social, school, family, and community. The tool contains the following four response options: Not at All or Rarely; Somewhat or Sometimes; Very or Often; Extremely or Almost Always. On average, the DAP takes approximately ten minutes to complete. When used in combination with data on school attendance, achievement and other measurable factors, DAP can provide a more complete picture of youths’ well-being, as well as inform strategies and programs to prepare them for later successes in such spheres as higher education, professional careers, and civic duties.

### Suitable for Assessment of:

Internal strengths and external supports that influence youths’ success in life, including school. Used previously for youths between the ages of 10 and 18 years. The DAP assesses positive internal feelings and external actions expressed by youth in the home, school and or community setting in the last three months. The DAP is available in English, Spanish, and “selected other languages”.

### Examples of Use

Scales, P. C. (2011). Youth developmental assets in global perspective: Results from international adaptations of the Developmental Assets Profile. *Child Indicators Research*, 4, 619–645.

Scales, P. C., Benson, P. L., Dershem, L., Fraher, K., Makkonen, R., Nazneen, S.,...Titus, S. (2013). Building developmental assets to empower adolescent girls in rural Bangladesh: Evaluation of Project 'Kishoree Kontha'. *Journal of Research on Adolescence*, 23(1), 171–184.

### Restrictions on Use

The Search Institute charges a one-time fee of \$150 USD for activation costs, and an additional \$2 USD per youth for pre- and post-tests. All DAP users must strictly adhere to the Search Institute’s guidelines on professional responsibilities for appropriate conduct in the collection, storing, and use of respondents’ data. These include: maintaining ethical research practices, such as following strict confidentiality practices and obtaining informed consent, including parental; understanding and correctly administering the questionnaire; creating appropriate and comfortable conditions for youth to complete questionnaires; reporting survey results to youth, parents, and other involved parties; and not altering the questionnaire in any way, and/or authorizing its use by outside organizations without the Search Institute’s permission.

### Available from:

Search Institute DAP Survey: <http://www.search-institute.org/survey-services/surveys/DAP>

## Diagnostic Interview Schedule for Children (DISC)

### Overview/Description

A tool that consists of a structured interview to assess for and diagnose a broad spectrum of psychiatric disorders in children. The DISC has been revised on numerous occasions to reflect new research on psychiatric pathology, and to coincide with updates to the DSM and ICD classification systems. Trained, non-clinicians can administer older versions—DISC-I, DISC-R, DISC-2.1, and DISC-2.3—as well as the newest version—DISC-IV. All versions contain two different forms, DISC-Y, for administration to children aged 9 to 17 years; and DISC-P, for administration to parents and/or caretakers of children aged 6 to 17 years. The DISC-P contains a few more questions than the DISC-Y; otherwise, the two forms are similar in composition. The original version of the tool, DISC-I, followed DSM-III criteria and focused largely on environmental (i.e. school and home), rather than pathological, domains. The subsequent version, DISC-R, minimized the use of open-ended questions and disorders requiring observations for diagnoses, and added a section to chart time. Shortly after, the DISC-2.1 was introduced, which included more robust psychometrics—assessments of treatment history, age at initial onset of symptoms, and impairments precipitated by a current episode. This was followed by the DISC-2.3, which reduced the length and complexity of questions, and permitted diagnoses of disorders based on symptom criteria. The latest version, DISC-IV, follows DSM-IV and ICD-10 criteria, contains over 30 psychiatric diagnoses commonly seen in youth, allows for information discrimination of initial and present onset of symptoms, inquires about impairments related to symptoms and/or disorders, uses more concisely-worded questions, and has all but eliminated open-ended questions. Answer responses to the DISC-IV are: Yes, No, Somewhat, and Sometimes. The questionnaire is arranged into different modules, which query demographic information, as well as information specific to various disorders—Anxiety, Mood, Disruptive, Substance use, Schizophrenia, and Miscellaneous disorders. The DISC-IV consists of 2,930 items (some of which are asked of all respondents and others only asked of respondents who provide clinically significant responses), and takes about 70 minutes to administer to parents/caregivers, and 90 to 120 minutes to administer to children.

### Suitable for Assessment of:

Psychiatric disorders occurring over the past four weeks to one year in children aged 6 to 17 years. The tool's use is primarily intended for epidemiological studies; however, it can be used in clinical settings, both as a diagnostic or research tool, and/or for community public health prevention efforts. The DISC is available in English and Spanish.

### Examples of Use

Abdeen, Z., Qasrawi, R., Nabil, S., & Shaheen, M. (2008). Psychological reactions to Israeli occupation: Findings from the national study of school-based screening in Palestine. *International Journal of Behavioral Development, 32*(4), 290-297.

### Restrictions on Use

The DISC is available to the public, but with the following costs associated: \$2,000 USD (per project) for projects under the auspices of the U.S. Department of Health and Human Services, \$700 USD (per project) for public health professionals and non-funded researchers, \$150 USD (per project) for students and educators, and \$900 USD (per facility/project) for clinical and commercial uses.

### Available from:

Shaffer, D., Fisher, P., Lucas, C., Dulcan, M., & Schwab-Stone, M. (2000). NIMH Diagnostic Interview Schedule for Children, Version IV (NIMH DISC-IV): description, differences from previous versions, and reliability of some common diagnoses. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*, 28-38.

## Family Connectedness Scale (FCS)

### Overview/Description

A scale that measures an adolescent's sense of family connectedness, defined by his/her perception of interpersonal relations with, closeness to, and respect from family. Adapted from previous research undertaken by social scientists in the U.S. pertaining to family and school connectedness in youth, the FCS follows the premise that enhanced social supports and positive perceptions of family relationships in adolescents are protective against various psychosocial risk factors, including emotional distress, depression, and suicidality. The tool consists of 12 items and is scored on a 3-point scale—Very/Often, Somewhat/Sometimes, Not at all/Almost Never. Higher scores indicate increased family connectedness, and lower scores are indicative of decreased family connectedness.

### Suitable for Assessment of:

Environmental and social resources that influence, either positively or negatively, the psychosocial wellbeing and resiliency in adolescents who are considered vulnerable, and/or have been exposed to a traumatic event or humanitarian emergency. The FCS is particularly geared towards population-level identification of, and targeted interventions for, adolescents who report low family connectedness and social supports.

### Examples of Use

Betancourt, T. S., Salhi, C., Buka, S., Leaning, J., Dunn, G., & Earls, F. (2012). Connectedness, social support and internalizing emotional and behavioural problems in adolescents displaced by the Chechen conflict. *Disasters*, 36(4), 635-655.

### Restrictions on Use

Prior to administration of the scale, always ask a respondent to define his/her family, as many youth do not live with their traditional families and assuming such could produce inaccuracies in data results. Always maintain strict respondent confidentiality and privacy.

### Available from:

Betancourt, T.S. (2004). Connectedness, Social Support and Mental Health in Adolescents Displaced by the War in Chechnya (Working Paper). [http://web.mit.edu/cis/www/migration/pubs/rrwp/22\\_connectedness.pdf](http://web.mit.edu/cis/www/migration/pubs/rrwp/22_connectedness.pdf)

Annan, J. (2007). Self-appraisal, social support, and connectedness as protective factors for youth associated with fighting forces in northern Uganda. ProQuest.

## General Health Questionnaire (GHQ)

### Overview/Description

A self-report screening tool used to assess for a variety of current mental disturbances. The questionnaire was originally developed as a 60-item tool (GHQ-60), but has since been revised into shorter versions—GHQ-30, GHQ-28, GHQ-20, and GHQ-12. All versions of the questionnaire ask about a respondent's current behavior and functioning abilities, and if there have been any recent changes in either. The GHQ-60 contains all original questions, which focus on both physical and mental disturbances; the GHQ-30 excludes questions about somatic symptoms; the GHQ-28 inquires about severe depression (7 items), somatic symptoms (7 items), social dysfunction (7 items), and anxiety/insomnia (7 items); and the shortest version, the GHQ-12, facilitates a rapid screening (about 2 minutes) for various mental disturbances. The GHQ-28 allows for scoring of each domain of disturbance, as well as an overall score. The GHQ-60, GHQ-28 and GHQ-12 only produce total scores. The questionnaires' response options are on a 4-point scale—Better/Healthier than Normal, Same as Usual, Worse/More than Usual, Much Worse/More than Usual—and can be scored according to a variety of scale values—GHQ (0-0-1-1), Likert (0-1-2-3), Modified Likert (0-0-1-2), and C-GHQ (0-0-1-1 or 0-1-1-1). The tool takes from 2-10 minutes to administer, depending on the version chosen.

### Suitable for Assessment of:

Current, minor (non-psychotic) mental disturbances. Designed for use with adults, the tool is considered valid for use with adolescents but NOT younger children. The GHQ is especially beneficial in conducting community mental health assessments in general populations, and can be administered repeatedly to the same respondents to measure changes over time. Additionally, it is helpful in informing further interventions—research, programmatic, community, and/or clinical. The GHQ-60 is ideal for thorough assessments of mental disturbances. The GHQ-12 is an ideal tool to use in situations where time is limited, and/or when literacy levels are low in populations being assessed. The tool is available in approximately 36 languages, and has been used extensively in a variety of international contexts.

### Examples of Use

Singh, B., & Raphael, B. (1981). Postdisaster morbidity of the bereaved: A possible role for preventive psychiatry? *The Journal of Nervous and Mental Disease*, 169(4), 203-212.

De Jong, J. P., Scholte, W. F., Koeter, M. W., & Hart, A. A. (2000). The prevalence of mental health problems in Rwandan and Burundese refugee camps. *Acta Psychiatrica Scandinavica*, 102, 171-177.  
<http://msf.openrepository.com/msf/bitstream/10144/18112/2/deJong.pdf>

De Jong, K., Prosser, S., & Ford, N. (2005). Addressing Psychosocial Needs in the Aftermath of the Tsunami. *PLoS Med*, 2(6). <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.0020179>

### Restrictions on Use

The GHQ is available for a variable fee. All versions of the questionnaire should not be copied or modified without approval from the distributor, GL Assessment. As noted above, although the GHQ has been used previously with adolescents, it is NOT recommended for use with children.

### Available from:

GL Assessment: <http://www.gl-assessment.co.uk/>

## Global Assessment of Psychosocial Disability (GAPD)

### Overview/Description

A global assessment tool that measures impairments in psychosocial functioning due to an underlying psychiatric disorder. The GAPD is based on Axis VI of the ICD-10, which addresses deficits in functioning at home, school, work (if employed), and with peers due to a psychiatric disorder, or a disorder of psychological origin, and/or mental retardation. The GAPD does not assess individual symptoms, but instead, evaluates a child's overall psychological, social, and occupational levels of functioning. The overall score for GAPD is between 0 and 8, with a higher score reflective of a higher degree of disability. The composite score values and corresponding psychosocial functioning levels are as follows: Superior/Good Social Functioning (0), Moderate Social Functioning (1), Slight Social Disability (2), Moderate Social Disability (3), Serious Social Disability (4), Serious and Pervasive Social Disability (5), Unable to Function in Most Areas (6), Gross and Pervasive Social Disability (7), and Profound and Pervasive Social Disability (8). In general, a score of two is commonly used as the cut-off between clinical cases and non-cases (i.e. scores of 2 to 8= cases, and 0-2= non-cases).

### Suitable for Assessment of:

Mental disorders causing functional and social deficits over the past three months in children aged 4 to 18 years. The GAPD is primarily intended for use in populations with psychiatric disorders, although it can also be used in healthy populations. The GAPD is useful for research purposes, as well as evaluating programmatic and/or clinical treatment outcomes. Use in humanitarian contexts not widespread, but reported use in Nepal for purposes of cross-validation of other measures.

### Examples of Use

Kohrt, B. A., Jordans, M. J., Tol, W. A., Speckman, R. A., Maharjan, S. M., Worthman, C. M., & Komproe, I. H. (2008). Comparison of mental health between former child soldiers and children never conscripted by armed groups in Nepal. *JAMA*, *300*(6), 691-702.

Kohrt, B. A., Jordans, M. J., Tol, W. A., Luitel, N. P., Maharjan, S. M., & Upadhaya, N. (2011). Validation of cross-cultural child mental health and psychosocial research instruments: adapting the Depression Self-Rating Scale and Child PTSD Symptom Scale in Nepal. *BMC Psychiatry*, *11*(1), 127.

### Restrictions on Use

Generally requires clinical judgments that may be made only by professional staff with appropriate training.

### Available from:

Schorre B. E., & Vandvik, I. H. (2004). Global assessment of psychosocial functioning in child and adolescent psychiatry: a review of three unidimensional scales (CGAS, GAF, GAPD). *European Child & Adolescent Psychiatry*, *13*(5), 273-286.

## Harvard Trauma Questionnaire (HTQ)

### Overview/Description

A questionnaire that explores traumatic events and symptoms associated with traumatic events. HTQ contains four parts, each part focusing on different aspects of a person's relationship with trauma. In the original version of HTQ, available in Vietnamese, Cambodian, and Laotian, questions address trauma specific to Southeast Asian refugees. Part I consists of 17 possible traumatic events, to which respondents are to answer with one or more of the following—Experienced, Witnessed, Heard about it, or No. In the later version of the HTQ, available in Japanese, Bosnian, and Croatian, Part I contains 46 to 82 traumatic event scenarios, with available response choices reduced to Yes/No only. In both versions of the HTQ, Part II asks respondents to provide a subjective, open-ended narrative of the most traumatic event ever experienced. Part III inquires about head injuries, with the question further expanded upon in the Bosnian and Croatian versions, and eliminated from the Japanese version. Part IV of the original version explores trauma symptoms, with the first 16 items drawn from the DSM III-R/DSM-IV criteria for post-traumatic stress disorder (PTSD) and the remaining 14 developed by the Harvard Program in Refugee Trauma to reflect symptoms specific to refugee trauma. In later versions of HTQ, Part IV of the Japanese version contains the original 30 items, in addition to seven items specific to Japanese culture and language. The Bosnian and Croatian versions for Part IV preserve the original 16 items from the DSM III-R/DSM-IV for PTSD, but contain 24 items that inquire about one's perception of and/or ability to function on a day-to-day basis.

### Suitable for Assessment of:

Experiences of trauma and the psychological symptoms related to trauma, including PTSD, in individuals and populations, especially those who have been displaced and/or subjected to mass-conflict. The HTQ was first developed in English, Vietnamese, Cambodian, Laotian, Croatian, Bosnian, and Japanese, but now exists in 35 languages. Developed for use with adult populations, but adopted for studies of adolescents frequently. Some reports include use with children as young as 7 years of age, but 11 is a more conservative threshold.

### Examples of Use

Bolton, P., & Betancourt, T. S. (2004). Mental Health in Postwar Afghanistan. *JAMA*, 292(5), 636-628.

<http://jama.jamanetwork.com/article.aspx?articleid=199182>

Tang, S. S., & Fox, S. H. (2001). Traumatic experiences and the mental health of Senegalese refugees. *The Journal of Nervous and Mental Disease*, 189(8), 507-512.

Goldin, S., Levin, L., Persson, L. Å., & Hägglöf, B. (2003). Child war trauma: A comparison of clinician, parent and child assessments. *Nordic Journal of Psychiatry*, 57(3), 173-183.

### Restrictions on Use

Questionnaires are to be administered by health care professionals who are either mental health specialists or under the supervision of a mental health specialist. The questionnaire should not be used as a self-report tool.

### Available from:

Harvard Program on Refugee Trauma: <http://hpert-cambridge.org/screening/harvard-trauma-questionnaire/>

## Hopkins Symptom Checklist – 25/37A (HSCL-25/37A)

### Overview/Description

A screening tool that assesses mental wellbeing based on five symptom dimensions—somatization, obsessive-compulsion, interpersonal sensitivity, anxiety, and depression. It is comprised of various versions, ranging from 90 to 10 items (i.e. HSCL-90, -71, -64, -58, -35, -31, -25, -20, and -10), and scaled based on four categories of responses: Not at All (1), A Little (2), Quite a Bit (3), and Extremely (4). Originally developed as a self-report tool, over time and in contexts where illiteracy predominates, HSC has been adapted for use as an interviewer administered tool. HSCL can be used for various purposes: research; epidemiological studies; clinical screening in medical and psychiatric patients, and in “healthy” populations; to measure clinical change; and to monitor and evaluate effectiveness of interventions. The HSCL-25 consists of 25 items that are broken down into two sub-scales: 10 items for assessment of anxiety and 15 items that screen for depression.

### Suitable for Assessment of:

Symptomatic presence and/or report of somatization, obsessive-compulsion, interpersonal sensitivity, anxiety, and depression over the last month. HSCL-25 is often used for screening for anxiety and depression in individuals who have experienced torture and/or trauma. HSCL-37A, a modification of HSCL-25, is used in adolescents, especially those who have experienced trauma. It also assesses for internalizing and externalizing behaviors, and emotional distress. The HSCL-25 has been widely used in developing countries, and is available in English, Bosnian, Cambodian, Croatian, Japanese, Laotian, and Vietnamese.

### Examples of Use

Mels, C., Derluyn, I., Broekaert, E., & Rosseel, Y. (2010). Community-based cross-cultural adaptation of mental health measures in emergency settings: validating the IES-R and HSCL-37A in Eastern Democratic Republic of Congo. *Social Psychiatry and Psychiatric Epidemiology*, 45(9), 899-910.

Syed, H., Zachrisson, H., Dalgard, O., Dalen, I., & Ahlberg, N. (2008). Concordance between Hopkins Symptom Checklist (HSCL-10) and Pakistan Anxiety and Depression Questionnaire (PADQ), in a rural self-motivated population in Pakistan. *BMC Psychiatry*, 8(1), 59.

Mollica, R. F., McInnes, K., Sarajlić, N., Lavelle, J., Sarajlić, I., & Massagli, M. P. (1999) Disability Associated With Psychiatric Comorbidity and Health Status in Bosnian Refugees Living in Croatia. *JAMA*, 282(5), 433-439.

<http://jama.jamanetwork.com/article.aspx?articleid=191006>

### Restrictions on Use

The HSCL-25 is available on CD-ROM from the Harvard Program in Refugee Trauma for: \$300 USD (for institutions), \$150 USD (for individuals), and \$75 USD for students, not including shipping and handling, and includes the Harvard Trauma Questionnaire and a 300-page manual.

### Available from:

Harvard Program on Refugee Trauma: <http://hprt-cambridge.org/screening/hopkins-symptom-checklist/>

## The Humanitarian Emergency Settings Perceived Needs Scale (HESPER)

### Overview/Description

A 26-item tool used to rapidly assess perceived serious needs of populations affected by large-scale humanitarian emergencies. Developed by the World Health Organization (WHO), the HESPER combines elements of survey research (i.e. sampling) and participatory methods for assessing needs. Respondents for surveys are first chosen either through convenience sampling (anyone who is accessible to the interviewer) or representative sampling (a random selection of people from a sampled population who accurately reflect the entire make-up of that population). Although representative sampling is the preferred sampling method for HESPER, it is not always a feasible option (especially in emergency contexts), in which case, convenience sampling is appropriate. Once a sampling method and sample size are decided upon, respondents can be recruited and interviewed. The 26 “need” items are read by the interviewer and answered by the respondent with the following rating options: Serious Problem (1)—identified as a serious problem by the respondent; No Serious Problem (0)—not identified as a serious problem by the respondent; or No Answer (9)—no answer provided, answer declined, not applicable, etc. After answering the 26 items, a respondent is then asked to list his/her three most serious perceived needs, as well as identify any other perceived needs not covered in the 26 items. Use of the tool does not require extensive training, as much of the general information can be learned through reading its user’s manual; however, it is important that interviewers have a few days of formal training and, at a minimum, have 12 years of education, familiarity with the local culture and context, and comfort interacting with diverse groups of people. Although children are not directly included in interviews (HESPAR respondents should be at least 18 years old), adult respondents can provide valuable information about children living in their homes or communities. The tool allows for considerable flexibility and adaptations to local and cultural contexts, and requires about 15-30 minutes (per interview) to administer.

### Suitable for Assessment of:

The primary social, psychological, and physical needs expressed by people (18 years or older) who have been affected by human and/or natural disasters. The expressed perceived needs could be a direct result of the emergency (i.e. physical injury sustained in a flood), could be indirectly related to the emergency (i.e. anxiety related to displacement from the flood), or have existed prior to the emergency (i.e. alcohol dependence). The tool is appropriate for needs assessments in a variety of humanitarian contexts—urban/rural, short-term/long-term, and developed/under-developed nations. Monitoring of affected communities’ needs over time can also be facilitated through the employment of convenience sampling in the early-stages of an emergency, and representative sampling in the late stages. Additionally, the HESPER can be used for case management purposes in situations where delivery of mental health services is already underway. The tool is available in English, French, Spanish, Arabic, Nepali, and French/Haitian Creole.

### Examples of Use

Manzoor, A. (2012). The Humanitarian Emergency Settings Perceived Needs Scale (HESPER). *International Review of Public Administration*, 17(2), 171-173.

### Restrictions on Use

The HESPER is available free of charge; however, anyone wishing to alter it in any way must first contact the WHO for permission. Convenience sampling is not always representative of a population's expressed needs, and consequently, should be analyzed and utilized accordingly. Finally, it is integral that informed consent be obtained prior to initiation of any research activities, and privacy and confidentiality of all information provided by respondents be maintained at all times.

### Available from:

World Health Organization & King’s College London (2011). *The Humanitarian Emergency Settings Perceived Needs Scale (HESPER): Manual with Scale*. Geneva: World Health Organization.  
[http://whqlibdoc.who.int/publications/2011/9789241548236\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9789241548236_eng.pdf)

## I DEAL

### Overview/Description

A toolkit produced by War Child Holland, which provides modules and interactive training exercises to use with children (aged 11-15) and youth (aged 16-20) in conflict settings as a way to improve their life skills and resiliency. The six thematic modules include: 1) Identity and Assessment, 2) Dealing with Emotions, 3) Peer Relations, 4) Relationships with Adults, 5) Conflict and Peace, and 6) The Future. Each module consists of between two to five 90-minute sessions that are designed to build upon one another. Sessions within each module engage in a combination of different activities including drama, visual arts, games and group discussions. These are designed so that participants can explore important issues in their current lives and learn how to better cope with these. Home assignments are integrated into the sessions encouraging participants to practice new skills and strategies outside of the program. Sessions should be facilitated by two trained facilitators and conducted with a group of children who can participate in the modules together. The I DEAL curriculum is also developing additional modules tailored at specific groups. These are: BIG DEAL (addresses gender relations, rights and responsibilities, and leadership with young people aged 16-20), PARENTS DEAL (aims to establish supportive environment for parents and caregivers to address the challenges they face in raising children), TEACHERS DEAL (assists teachers in creating a safe school environment), and SHE DEALS (addresses concerns of girls and young mothers under 20 years old).

### Suitable for Assessment of:

Implementation is specifically intended for children and youth aged 11 to 20 who have been exposed to conflict. Modules and sessions are available in English, Spanish, French, and Arabic.

### Examples of Use

Claessens, L., & de Graaff, D. Who know best? Children do!: How children evaluate the effects of a War Child programme. War Child. [http://www.warchildholland.org/sites/default/files/bijlagen/node\\_489/23-2013/warchild\\_ppi\\_report\\_2011.pdf](http://www.warchildholland.org/sites/default/files/bijlagen/node_489/23-2013/warchild_ppi_report_2011.pdf)

### Restrictions on Use

This toolkit is not designed as an assessment tool of psychosocial wellbeing *per se* but provides interactive exercises that are potentially relevant to such assessment. The facilitation of these modules requires two trained facilitators in the methodology of the I DEAL program.

### Available from:

War Child Holland: <http://www.warchildlearning.org/ideal>

## International Organization for Migration's Psychosocial Tools

### Overview/Description

A manual comprising various population-level psychosocial assessment tools used globally by the International Organization for Migration (IOM). In its methodological approach, the IOM tools incorporate aspects of other psychosocial assessment measures, namely the Rapid Appraisal Procedure (RAP), which relies on a variety of measurement strategies—literature reviews, informant interviews, focus group interviews, field-level observations, and individual and family interviews—to glean insight into populations' needs. The IOM tools consist of two distinct questionnaires—a Questionnaire for International and National Stakeholders, which identifies psychosocial needs and responses by key international and national organizations; and a Questionnaire for Local Stakeholders and Key Members of the Displaced Population, which queries the needs expressed by affected populations and their coping strategies, and/or desired post-emergency services. In addition to the two questionnaires, there are other tools: a Qualitative Household Questionnaire, which focuses on an emergency's psychosocial effect on households, particularly children; A Scheme for Psychosocial Wellbeing, which studies the emotional experiences of displacement in terms of housing, employment, school, and social life; and Distress Indicators, which aim to identify common psychosocial-related symptoms and/or areas of dysfunction seen in affected families and communities. For all IOM tools, a conversational approach to interviewing is emphasized, rather than asking direct questions. Additionally, non-verbal communication and body language, both from the respondent and people in his/her family, are valuable pieces for analyses. A minimum of 30 interviews should be completed to have enough data to derive meaningful information.

### Suitable for Assessment of:

Psychosocial deficits/needs, and existing family/community resources and capacities in populations beset by an active emergency, or that are in the early recovery stages of a disaster. The tools are particularly attuned to those who are currently displaced, or who have recently returned from a displacement. Additionally, they allow for significant community participation and feedback; are well suited to qualitative, rapid assessments; permit considerable flexibility in application and interpretation; and help inform intervention decisions. The tools have been used by various humanitarian organizations throughout Africa and the Middle East.

### Examples of Use

Salem-Pickartz, J. (2009). Iraqi refugees in Jordan research their own living conditions: 'we only have our faith and families to hold on to'. *Intervention*, 7(1), 34-49.

Lacroix, M., & Al-Qdah, T. (2012). Iraqi refugees in Jordan: lessons for practice with refugees internationally. *European Journal of Social Work*, 15(2), 223-239.

### Restrictions on Use

Due to the nature of the toolkit, it should be used sparingly in generating quantitative analyses. Graduate-level professionals, fluent in English, comfortable working in stressful, unpredictable environments, and who are known by the affected population(s) should administer questionnaires. Respondents selected for interviews should be integrally involved with the affected community, either as a direct member or an indirect participant (i.e. aid worker). People who are directly involved in the provision of material aid are prohibited from conducting interviews, and interviewees who are directly receiving humanitarian assistance should be excluded from the sample design process. Interviewers must communicate to interviewees the purpose of the study, that no direct care or services will be provided, and that all disclosed information will remain anonymous. Questionnaires containing gray-shaded question boxes indicate those questions that should not be asked directly of interviewees.

### Available from:

Psychosocial Needs Assessment in Emergency Displacement, Early Recovery, and Return: IOM Tools:  
<http://www.iom.int/jahia/webdav/shared/shared/mainsite/activities/health/mental-health/Psychosocial-Needs-Assessment-Emergency-Displacement-Early-Recovery-Return-IOM-Tools.pdf>

## Impact of Event Scale (IES)

### Overview/Description

A self-report tool that measures stress reactions to a traumatic life event. IES consists of 15 items, which are grouped and scored based on two sub-categories—intrusion and avoidance. When filling out the questionnaire, a child is directed to first write at the top of the page the specific life event to be used for questionnaire responses, and the date of its occurrence. The child is then asked to recall whether or not he/she experienced each of the 15 items in the last week. If the child is able to recall an item, the frequency—Rarely, Sometimes, and Often—and intensity—Mild, Moderate, or Severe—are measured. A revised IES scale, called IES-R, was developed shortly after the introduction of the IES, and is similar to the IES but contains 22 items (8 avoidance and 8 intrusion items) and an additional hyper-arousal sub-category (6 items). In both scales, the following response options are used: Not at All (0), A Little Bit (1), Moderately (2), Quite a Bit (3), and Extremely (4). IES yields a total score from 0 to 60, and IES-R a score from 0 to 88. Higher scores are more indicative of increased stress reactions. It is also possible to calculate sub-scale scores for intrusion, avoidance, and hyper-arousal. Although IES was not originally designed as a tool for children, it has been used successfully on several occasions with children. The Children's Impact of Event Scale 8 (CRIES-8, and also called IES-8), containing eight of the most child-pertinent items from the IES, was developed to reflect differences between adults and children in responding to trauma. Modeled after the IES, CRIES-8 consists of four items measuring intrusion and four items measuring avoidance. Another child-specific IES scale that expands on the CRIES-8 is the Children's Impact of Event Scale 13 (CRIES-13). In CRIES-13, the same eight items relating to intrusion and avoidance from CRIES-8 are present, plus five items measuring arousal. CRIES-8 and -13 are measured and scored by the following responses: Not at All (0), Rarely (1), Sometimes (3), and Often (5). All of the scales can be administered in group settings.

### Suitable for Assessment of:

Recent (in the past week) distress due to a traumatic life event. IES, while not designed for use with children, has been used with children from eight years of age and above. The CRIES-8 and -13 are to be used with children who are eight years and older. IES scales can be administered repeatedly, and are often used to monitor individuals and populations affected by trauma over time. All scales are particularly beneficial in screening for PTSD, and are appropriate for use by people of differing cultural, economic, and educational backgrounds. IES is available in English, Spanish, French, Chinese, Japanese, and German. CRIES-8 is available in 19 languages, and CRIES-13, in 25 languages.

### Examples of Use

Allwood, M. A., Bell-Dolan, D., & Husain, S. A. (2002). Children's Trauma and Adjustment Reactions to Violent and Nonviolent War Experiences. *Journal of the American Academy of Child and Adolescent Psychiatry*, 41(40), 450-457. [http://www.nctsn.org/nctsn\\_assets/Articles/48.pdf](http://www.nctsn.org/nctsn_assets/Articles/48.pdf)

Bromet E. J., Goldgaber, D., Carlson, G., Panina, N., Golovakha, E., Gluzman, S., ...Schwartz, J. E. (2000). Children's Well-being 11 Years After the Chernobyl Catastrophe. *JAMA - Archives of General Psychiatry*, 57(6), 563-571. <http://archpsyc.jamanetwork.com/article.aspx?articleid=481617>

### Restrictions on Use

All versions of IES require respondents to have conscious awareness of their traumatic experiences. If respondents are unaware of their traumatic experiences, it is unlikely the IES scales will accurately measure levels of distress. IES scales are not diagnostic tools and should not be used as such. Information about IES scales is freely available to the public; however, distribution is limited to qualified mental health professionals and researchers. The authors of CRIES-8 and -13 request that anyone using the tools send results to them so that further improvements to the tool can be made. The IES-R is an effective tool to use with children who have experienced specific and discrete traumas, but its usefulness is limited in instances where children have experienced multiple and/or ongoing traumas.

### Available from:

Horowitz, M. J., Wilner, M. & Alvarez, W. (1979). Impact of Events Scale: A measure of subjective stress. *Psychosomatic Medicine*, 41 (3), 209-218. (IES)

## Kiddie Schedule for Affective Disorders and Schizophrenia for School-Aged Children (K-SADS)

### Overview/Description

A comprehensive, semi-structured interview tool used to assess and diagnose a variety of psychiatric disorders found in children. The K-SADS was developed from an adult instrument, the Schedule for Affective Disorders and Schizophrenia (SADS). In its lifetime, it has undergone several revisions in order to reflect periodic recapitulations in DSM diagnostic criteria. The original tool coincides with the K-SADS-P (Present Episode Version), which assesses current psychopathology, and comprises four sections of disorder domains— affective, anxiety, conduct, and psychosis. The K-SADS-PL (Present and Lifetime version) is the newest version and assesses for a wider range of Axis I psychiatric disorders, both current and past. It is arranged into six sections: the Introductory Interview, the Diagnostic Screening Interview, the Supplement Completion Checklist, the Diagnostic Supplements, the Summary Lifetime Diagnosis Checklist, and the Children's Global Assessment Scale ratings. The last four sections are completed only when indicated by respondents' answers in the Diagnostic Screening Interview. Overall scores and diagnostic decisions are determined after combining a variety of data—children's self-reports, parents' reports of observable behavior, and summary ratings (parent, child, school, etc.). Because of its complexity and need for clinical judgment, the tool requires administration by a clinical professional, who can re-word questions or probe for further clarification, when required. The K-SADS is administered to both children and parents, and requires about 75 minutes for administration (per respondent). Overall scores and diagnostic decisions are determined after combining a variety of data—children's self-reports, parents' reports of observable behavior, and summary ratings (parent, child, school, etc.).

### Suitable for Assessment of:

Current and past episodes of psychiatric disorders, including present and lifetime PTSD, in children between the ages of 6 to 18 years. The tool's use is most applicable to research settings; however, it can be used for diagnosing disorders in clinical settings. It has primarily been used in developed countries, and non-humanitarian settings.

### Examples of Use

Kohrt, B. A., Jordans, M. J., Tol, W. A., Speckman, R. A., Maharjan, S. M., Worthman, C. M., & Komproe, I. H. (2008). Comparison of mental health between former child soldiers and children never conscripted by armed groups in Nepal. *JAMA*, 300(6), 691-702.

Mollica, R. F., Guerra, R., Bhasin, R., & Lavelle, J. (2004). Book of Best Practices: Trauma and the Role of Mental Health in Post-Conflict Recovery. Project 1 Billion. <http://siteresources.worldbank.org/DISABILITY/Resources/280658-1172610662358/Proj1Billion.pdf#page=41>

### Restrictions on Use

Although the K-SADS is a copyrighted instrument, it is available free of charge to those who intend to use it for clinical purposes with a non-profit institution, and/or for an IRB-approved research study. Those who wish to use the tool for commercial use, purposes of redistribution, and/or plan to make modifications must first obtain written authorization from Dr. Joan Kaufman. The Diagnostic Supplements should be administered in the order they occurred (i.e. if a child experienced anxiety prior to depression, the Anxiety Supplement should be completed before the Depression Supplement). When disorders occurred concurrently, the disorder that appears to have had the greater effect on the other is completed first. When administering the tool to adolescents, interviewers should first interview the adolescent prior to the parent; with younger children, an interviewer should first interview the parent before the child.

### Available from:

Kaufman, J., Chambers, W., Puig-Antich, J., Birmaher, B., Rao, U., & Ryan, N.D. (1996). *Kiddie-SADS—Present and Lifetime Version*. Pittsburgh, PA: University of Pittsburgh. <http://psychiatry.pitt.edu/research/tools-research/assessment-instruments>

## Mini International Neuropsychiatric Interview for Children and Adolescents (MINI KID)

### Overview/Description

A tool that uses a structured clinical interview to assess for, and diagnose, DSM-IV Axis I mental disorders. Modeled after the Mini International Neuropsychiatry Interview (MINI), a diagnostic tool for adults, the MINI KID comprises 24 mental disorders, each containing its own set of disorder-specific questions, to which children provide Yes or No responses. Several of the disorders contain one to three initial questions that screen a child for that particular disorder. If the child answers "No" to the screening questions, the administrator can skip forward to the following disorder's questions. The tool requires approximately 15 minutes to administer.

### Suitable for Assessment of:

A broad range of DSM-IV Axis I mental disorders, such as anxiety/mood/psychotic/substance abuse disorders, in children aged 6 to 17 years. The MINI KID's use is particularly beneficial in the rapid screening of subjects for clinical trials, epidemiological studies, and for monitoring outcomes in non-clinical settings. The tool is available in 30 languages, and has been used widely in various developed, developing, humanitarian, and non-humanitarian contexts.

### Examples of Use

Behrendt, A. (2008). Associated with the Fighting Forces in Liberia: a Cross Section Study in Lofa Country. <http://www.healthnettpo.org/files/706/study-report-liberia.pdf>

### Restrictions on Use

The MINI KID is available (both in paper and computerized formats) after completing a permission form for Dr. Sheehan, and providing payment of \$5 USD (per administration). Any downloading of materials is strictly forbidden without first obtaining Dr. Sheehan's authorization. Any studies or publications using the MINI KID must provide proper attribution to its authors.

### Available from:

Sheehan, D.V., Sheehan, K.H., Shytle, R.D., Janavs, J., Bannon, Y., Rogers, J.E., ...Wilkinson, B. (2010). Reliability and validity of the Mini International Neuropsychiatric Interview for Children and Adolescents (MINI-KID). *Journal of Clinical Psychiatry*, 71(3), 313-326

Medical Outcome Systems: <https://medical-outcomes.com/index/minifororganizations>

## Mood and Feelings Questionnaire (MFQ)

### Overview/Description

A 33-item, self-report questionnaire that screens for symptoms of depression and loneliness (based on DSM-III-R criteria for depression). The MFQ consists of several short phrases describing feelings or actions, to which respondents answer—True (2), Sometimes True (1), or Not True (0). A shorter, 13-item subscale, called the Short Mood and Feelings Questionnaire (SMFQ), focuses on affective and cognitive symptoms. Both the MFQ and SMFQ contain child and parent-report forms, and require approximately 5-10 minutes to administer. The parent-report form for the MFQ consists of 34-items.

### Suitable for Assessment of:

Depressive symptoms over the past two weeks in children aged 8 to 18 years. The tool is helpful in identifying children at risk for depression in a community setting, and for guiding program interventions. The tool is available in English, and has primarily been used in developed, non-humanitarian settings.

### Examples of Use

Reed, R. V., Fazel, M., Jones, L., Panter-Brick, C., & Stein, A. (2012). Mental health of displaced and refugee children resettled in low-income and middle-income countries: risk and protective factors. *The Lancet*, 379(9812), 250-265.

Abdelmonium, A., & Anwar, M. (2009). Post-traumatic stress disorder in a school in Darfur, Western Sudan. *Published by The Sudan Medical Association*, 45(1).

Rhew, I. C., Simpson, K., Tracy, M., Lymp, J., McCauley, E., Tsuang, D., & Vander Stoep, A. (2010). Criterion Validity of the Short Mood and Feelings Questionnaire and one- and two-item depression screens in young adolescents. *Child and Adolescent Psychiatry and Mental Health*, 4(8).

### Restrictions on Use

Both the MFQ and SMFQ are available for downloading free of charge; however, proper citation of authors must be included in any publications. The MFQ does not have any prescribed cut-off points for scoring. This is something that can be determined based on the intended use of the tool.

### Available from:

Duke University Center for Development Epidemiology: <http://devepi.duhs.duke.edu/mfq.html>

## Multidimensional Anxiety Scale for Children (MASC)

### Overview/Description

A self-report tool used to assess for symptoms of anxiety in children. The MASC is available in two forms—MASC (the full version) and MASC-10 (the short version). The MASC consists of 39 items spread across various domains—Harm Avoidance, Social Anxiety, Physical Symptoms, Anxiety Disorders, Separation/Panic, Total Anxiety Index, and Inconsistency Index. The Inconsistency Index helps to recognize any reporting mistakes and errors, and the Total Anxiety Index identifies respondents whose anxiety scores warrant further clinical follow-up. The primary MASC scales—Harm Avoidance, Social Anxiety, Physical Symptoms, and Separation/Panic—can be further broken down into sub-scales—Somatic Symptoms, Tense Symptoms, Perfectionism, Anxious Coping, Humiliation Fears, and Performance Fears. Due to its comprehensiveness, the MASC is most appropriate for initial screenings. The MASC-10, which contains ten items exclusively measuring anxiety, allows for a rapid screening for anxiety symptoms, and is meant as a tool for monitoring progress over time. Questionnaire responses for both MASC versions are scored on a 4-point scale, ranging from “Never True About Me” (0) to “Often True About Me” (3). The tool should be administered by a clinician, or trained professional. Administration times for the MASC average about five minutes for the MASC-10 and 15 minutes for the full-version MASC.

### Suitable for Assessment of:

The range and severity of anxiety symptoms in children between the ages of 8 and 19 years. The MASC can be used to assess for the presence of anxiety, and as a follow-up tool for monitoring changes and/or treatment progress in someone already identified as having anxiety. The tool is available in 15 languages, and if desired, may be translated into other languages by contacting MHS' Translations Department. To date, its use has primarily been relegated to developed, non-humanitarian settings.

### Examples of Use

Balaban, V. (2006). Psychological assessment of children in disasters and emergencies. *Disasters*, 30(2), 178-198.

### Restrictions on Use

The MASC is available for a fee ranging from \$60-205 USD.

### Available from:

March, J.S. (1997). Multidimensional Anxiety Scale for Children (MASC). MHS, Inc.  
<http://downloads.mhs.com/masc/masc-brochure.pdf>

## Nipissing District Developmental Screen (NDDS)

### Overview/Description

A developmental screening tool to aid in the early detection of, and if needed, intervention for developmental delays in infants and children up to six years of age. Comprising one page of Yes/No questions that are completed by a child's parent, caregiver, or health care professional, either at home or during a child wellness visit, the NDDS evaluates a child's developmental health based on the following areas: vision, hearing, speech, language, fine and gross motor skills, cognition, social skills, emotional skills, and self-help skills. These skills are monitored and tracked at various intervals over a child's first six years of life, with assessments occurring most frequently in the first three years of life. Each assessment interval has a corresponding one-page NDDS questionnaire, which includes various activities parents or caregivers can implement with their child to improve developmental areas. Any "No" responses are to be addressed with a child's health care professional. Assessment visits also coincide with a child's immunization schedule, which allows parents/caregivers and health care providers to coordinate both activities in one visit. The tool, which includes illustrations, activities to reinforce or augment positive developmental activities, and color-coding based on ages, is not scored.

### Suitable for Assessment of:

Developmental delays or disorders in infants and children up to six years of age. Assessments are conducted at thirteen key developmental periods: 1 & 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 30 months, 3 years, 4 years, 5 years, and 6 years. The frequent assessments facilitate numerous interactions with, and continual, prevention-focused monitoring of a child's development by a health care provider. The tool is available in English, French, Spanish, Vietnamese, and Chinese, and has primarily been used in developed, non-humanitarian settings.

### Examples of Use

Benzies, K., Tough, S., Edwards, N., Mychasiuk, R., & Donnelly, C. (2010). Aboriginal Children and Their Caregivers Living with Low Income: Outcomes from Two-Generation Preschool Program. *Journal of Child and Family Studies*, 20(3), 311-318. <http://link.springer.com/article/10.1007/s10826-010-9394-3/fulltext.html>

### Restrictions on Use

The NDDS is available free of charge for residents of Ontario, Canada; otherwise, NDDS charges a user-fee varying from \$8 (one pad of 50 sheets) to \$100 (13 pads of 50 sheets). All screening questionnaires must contain the NDDS trademark logo, and can only be copied for archival purposes (i.e. to copy and give to a child's health care professional). Items marked with an asterisk indicate culturally influenced questions that may erroneously indicate developmental delays when, in reality, delays are due to differences in cultural experiences. The NDDS should be used merely as a screening tool, not as a substitute for regular child wellness visits with a health care professional. Users of the NDDS should keep in mind that all children develop differently and not necessarily according to the developmental schedules assigned to their age groups. Consequently, a child's health care provider should properly assess any developmental abnormalities detected through the NDDS. If a child's age at the time of assessment is between screening ages (i.e. child is 4.5 years-old), the younger screening questionnaire should be used (i.e. the form for four year-olds). Although not intended, the NDDS does contain some cultural, economic, and geographic biases that users should be conscious of when working with diverse populations.

### Available from:

Nipissing District Developmental Screen: <http://www.ndds.ca/usa.html>

## Orphans and Vulnerable Children Wellbeing Tool (OWT)

### Overview/Description

A rapid, self-report tool designed and implemented by Catholic Relief Services (CRS) to measure the perceived wellbeing of orphans and vulnerable children (OVC), and to bolster efforts and effective responses to child friendly programs. The tool, consisting of 36 statements, is administered orally, and is based on ten key domains—nutrition/food security, shelter/environment, protection, family, health, spirituality, mental health, education, economic opportunities, and community cohesion. During administration, a youth is asked to report how often each of the 36 statements applies to him/her, with the following response options: None of the Time, Some of the Time, or All of the Time. The total possible score is between 10 (low level of wellbeing) and 30 (high level of wellbeing). On average, the tool takes 15-20 minutes to complete.

### Suitable for Assessment of:

How well an orphaned and/or vulnerable child living in a resource-poor environment is doing from his/her own perspective. The OWT is used in youth aged 13-18 years, can be administered repeatedly, is adaptable to many contexts and cultures, and is primarily intended to provide program outcome data for program managers. Because of its allowance for repeated measurements, the OWT is helpful in monitoring trends, and evaluating programs and interventions over time. It also allows for identification of patterns of OVC wellbeing within projects. It is intended as a tool for rapid assessment of needs, and can help inform program managers and project beneficiaries of the need for more in-depth assessments, and/or interventions. The OWT is available in English, Luo, Swahili (Kenyan and Tanzanian), Chichewa, Amharic, and Haitian Creole. It has been used primarily in African settings.

### Examples of Use

CRS. Active Listening: Youth Participation in M&E of OVS wellbeing in Botswana.

[http://www.crsprogramquality.org/storage/pubs/hivaidis/iacpubs/ovc/OWT\\_Botswana.pdf](http://www.crsprogramquality.org/storage/pubs/hivaidis/iacpubs/ovc/OWT_Botswana.pdf)

CRS. A tool for assessing changes in OVC wellbeing over time: Longitudinal data from a child's perspective.

<http://www.crsprogramquality.org/storage/pubs/hivaidis/iacpubs/ovc/KenyaOWThandout.pdf>

CRS. Using mobile phones to support OVC in Tanzania.

[http://www.crsprogramquality.org/storage/pubs/hivaidis/Mobile\\_Research\\_Brief\\_Fact\\_sheet.pdf](http://www.crsprogramquality.org/storage/pubs/hivaidis/Mobile_Research_Brief_Fact_sheet.pdf)

### Restrictions on Use

The OWT is available free of charge, but CRS requests that its use be appropriately cited in any written reports and/or presentations. Adaptation of the OWT to local contexts and cultures is strongly encouraged by CRS as long as adaptations follow a proper validation process. A feedback loop needs to be established so that findings from collected data are disseminated back to populations in the communities where assessments occurred. The tool should not be used for in-depth, individual assessments. For all youth interviewed, informed consent must be obtained and confidentiality maintained throughout OWT's use. To ensure correct translation of the tool, back-translations by an independent translator (someone other than the person(s) who provided the original translation) must occur. The OWT is intended for oral administration. If written, self-administration is desired, a rigorous assessment of youths' literacy levels must first occur. During an interview, interviewers should follow and read all directions verbatim, never changing words and/or providing interpretations of concepts. Before implementing the OWT, it is important to first determine if the domains in the tool are culturally relevant to the local context so that accurate data can be derived.

### Available from:

Catholic Relief Services (CRS). (2009) Orphans and Vulnerable Children Wellbeing Tool:

<http://www.crsprogramquality.org/storage/pubs/hivaidis/OWTguide.pdf>

## Participatory Ranking Methodology (PRM)

### Overview/Description

A rapid, mixed-methods (quantitative and qualitative) assessment tool that allows community members and project stakeholders to communicate their needs and to identify local resources. Data collection comes from group exercises, in which various community members are gathered in an open-forum that is systematic and controlled, and collectively asked to provide their opinions on various community needs-based questions. Information comes from one primary question (“framing question”) that is asked in a group setting by a PRM facilitator. It is imperative that questions be created to allow for detailed responses from group participants. More than one question may be asked of a group, but efforts should be made to delineate each question into separate exercises. Although participation is at the individual level, questions posed should elicit responses about the community, not the individual. Two people are required for conducting a group exercise—a note taker and a facilitator. Group activities follow a P-R-M sequencing method: P= Pile (the facilitator poses a question to the group, the group provides responses; themes are recognized and given representative objects; objects are then placed in a pile); R= Ranking (through group consensus, objects, or issues, are ranked by importance); M=Meaning (understanding of the meaning of each theme is sought throughout the exercise). One group exercise lasts roughly 30 minutes. PRM produces information that can be readily processed and analyzed. Ideally, in each community assessed, individuals chosen for group participation should be recruited and selected based on the following three broad categorical affiliations—community leaders, prominent community groups, and community groupings such as age, gender, ethnicity, etc. Depending on the setting, group exercises can occur both indoors and outdoors, although group facilitators should always be conscious of outsiders listening or peering in (especially in more public venues).

### Suitable for Assessment of:

A community's needs and experiences in a humanitarian emergency. PRM also allows for comparisons to be derived across communities, as well as to categorize, determine frequencies of, and rankings for specified issues. Assessment usually occurs in communities affected by an emergency, but if this proves impossible, sampling (either random or purposive) of accessible communities can also be done. The tool is flexible, can be adapted to any context, and has primarily been used in humanitarian emergencies occurring in Africa and Asia.

### Examples of Use

Stark, L., Ager, A., Wessells, M., & Boothby, N. (2009). Developing culturally relevant indicators of reintegration for girls formerly associated with armed groups, in Sierra Leone using a participative ranking methodology. *Intervention*, 7(1), 4-16.

Stark, L., Bancroft, C., Cholid, S., Sustikarini, A., & Meliala, A. (2012). A qualitative study of community-based child protection mechanisms in Aceh, Indonesia. *Vulnerable Children and Youth Studies*, 7(3), 228-236.

Fund, P. (2011). Evaluation of UNFPA's Provision of Dignity Kits in Humanitarian and Post-Crisis Settings.

### Restrictions on Use

PRM is not to be used in assessing individual needs. When recruiting participants for group exercises, it is important to clearly and thoroughly explain to them the purpose of the PRM exercise, that they are under no obligation to participate, and that no compensation will be provided for their help.

### Available from:

Ager, A., Stark, L., Sparling, T., & Ager, W. (2011). Rapid Appraisal in Humanitarian Emergencies Using Participatory Ranking Methodology (PRM). Program on Forced Migration and Health, Columbia University.  
<http://www.cpcnetwork.org/participative-ranking-methodology.php>

## Participatory Rapid Appraisal (PRA)

### Overview/Description

An assessment approach that allows communities to give voice to their psychosocial needs, and to play an active part in identifying solutions. The PRA approach, which relies heavily on oral communication for conducting needs assessments, is generally qualitative in nature, and comprises a variety of tools, techniques, and activities that facilitate community membership and participation. Prior to commencement of assessment activities, the aims, goals, and logistics of a project, including distribution of labor, should be outlined and decided upon by implementing parties. Shortly after, sites for community assessments are chosen. Once sites are identified, specific details of PRA assessments are further discussed and finalized, including any necessary trainings, budgetary proposals, and/or applications for site approvals. With site details finalized, field assessments are conducted using selected PRA approaches. Over time, sites are continually re-visited to gather more information and complete any missing data collection activities. Findings are then shared with communities, national and international governments, and any participating agencies. Because the PRA approach allows for abundant use of creativity, improvisation, and flexibility in designing and implementing assessments, it is rare to find uniformity in its application.

### Suitable for Assessment of:

The psychosocial needs of populations, particularly those living in more impoverished, rural, and socially marginalized settings. The PRA approach is particularly useful in settings where large-scale assessments are logistically or politically impossible, or have never before been done. The approach can provide baseline, introductory data that can inform larger-scale, more technically focused assessment methods, and/or supplement quantitative data. Findings from PRA assessments are generally used for research, and/or project development and monitoring purposes.

### Examples of Use

Chatty, D., Crivello, G., & Hundt, G. L. (2005). Theoretical and methodological challenges of studying refugee children in the Middle East and North Africa: young Palestinian, Afghan and Sahrawi refugees. *Journal of Refugee Studies*, 18(4), 387-409.

Hart, J., Galappatti, A., Boyden, J., Armstrong, M. (2007). Participatory tools for evaluating psychosocial work with children in areas of armed conflict: a pilot in eastern Sri Lanka, *Intervention*, 5(1), 41-60.

<http://www.ourmediaourselves.com/archives/51pdf/hart.pdf>

### Restrictions on Use

When utilizing the PRA approach, it is important to actively engage with communities at all stages of the PRA process. When possible, allow community members to do the majority of the talking. This should help facilitate a more harmonious relationship between communities and researchers, as well as greater community ownership of any projects. It is not advisable to use PRA for single, brief participatory encounters because it is an approach that is better suited for data collection over a longer period of time. This facilitates greater respect of and engagement with communities, and ultimately allows for capturing of data that is more representative.

### Available from:

Robinson, L. (2002). Participatory Rural Appraisal: A Brief Introduction. *International Association of Facilitators*.

[http://www.iaf-world.org/Libraries/IAF\\_Journals/Participatory\\_Rural\\_Appraisal.sflb.ashx](http://www.iaf-world.org/Libraries/IAF_Journals/Participatory_Rural_Appraisal.sflb.ashx)

## Pediatric Emotional Distress Scale (PEDS)

### Overview/Description

A 21-item, rapid behavioral screening tool that is completed by parents and/or caregivers of children who have had recent exposure to a traumatic and/or stressful event. The tool's items consist of 17 general behavioral questions, grouped into three domains—anxious/withdrawn, fearful, and acting out—and four questions specific to trauma exposure, and focused either on play or talk. Question responses are scored on a 4-point scale, based on symptom applicability and frequency—Almost Never (1), Sometimes (2), Often (3), and Very Often (4). The PEDS averages about seven minutes to administer.

### Suitable for Assessment of:

Behavioral problems, anxiety, and/or altered mood states in the past month in children aged 2 to 10 years, and who have been exposed to trauma. The PEDS is available in English and Spanish.

### Examples of Use

Balaban, V. (2006). Psychological assessment of children in disasters and emergencies. *Disasters*, 30(2), 178-198.

### Restrictions on Use

The PEDS is available free of charge. It is a screening tool and should not be used for diagnostic purposes.

### Available from:

Saylor, C. F., Swenson, C. C., Reynolds, S. S., & Taylor, M. (1999). The Pediatric Emotional Distress Scale: A brief screening measure for young children exposed to traumatic events. *Journal of Clinical Child Psychology*, 28(1), 70-81.

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## Post Traumatic Stress Symptoms in Children (PTSS-C)

### Overview/Description

A 30-item tool used to assess for and diagnose PTSD in children affected by various forms of trauma. The tool's first 17 items are dedicated to PTSD (based on DSM criteria), while the remaining 13 questions focus on child-specific stress reactions to trauma that are unrelated to PTSD (i.e. hyperactivity). Moreover, the DSM-based items (1-17) are grouped according to the classic triad of diagnostic PTSD symptoms—re-experiencing (items 1-4), avoidance (items 5-11), and hyper-arousal (items 12-17). All items contain Yes (1) or No (0) response options. A diagnosis of PTSD is warranted when a child answers "Yes" to at least one item relating to re-experiencing, three avoidance items, and two items of hyper-arousal. The tool is administered via a semi-structured interview and averages approximately 30 minutes for administration. Interviewers should have experience working with children, and undergo a short training on the PTSS-C prior to conducting interviews.

### Suitable for Assessment of:

Behavioral symptoms, either related or unrelated to PTSD, over the past month in children exposed to various forms of trauma, disaster, and violence.

### Examples of Use

Balaban, V. (2006). Psychological assessment of children in disasters and emergencies. *Disasters*, 30(2), 178-198.

Balaban, V. F., Steinberg, A. M., Brymer, M. J., Layne, C. M., Jones, R. T., & Fairbank, J. A. (2005). Screening and assessment for children's psychosocial needs following war and terrorism. *NATO Security Through Science Series E Human AND Societal Dynamics*, 4, 121.

Ahmad, A., von Knorring, A. L., & Sundelin-Wahlsten, V. (2008). Traumatic experiences and post-traumatic stress disorder in Kurdistanian children and their parents in homeland and exile: An epidemiological approach. *Nordic Journal of Psychiatry*, 62(6), 457-463.

### Restrictions on Use

None reported.

### Available from:

Ahmad, A., Sundelin-Wahlsten, V., Sofi, M. A., Qahar, J. A., von Knorring, A. L. (2001) Reliability and validity of a child-specific cross-cultural instrument for assessing posttraumatic stress disorder. *European Child & Adolescent Psychiatry*, 9(4), 285-94.

## Psychological Screening for Young Children aged 3 to 6 (PSYCa 3-6)

### Overview/Description

A rapid screening tool to assess for and determine a general level of psychological distress in young children exposed to crisis situations. The PSYCa 3-6 is often administered by non-specialists, who interview a child's parent and/or caregiver, and when indicated, refer the child to a specialist. The PSYCa 3-6, originally developed in French for use with refugees in Macedonia, contains 40 items, and has the following response options—Never/Not at All (0), Sometimes/A Few Times (1), and Often/Frequently/Always (2). The tool has a total score value of 80, with higher scores indicative of increased levels of distress. An adapted and validated PSYCa 3-6a version is available in Hausa, and contains 22-items, with a possible total score from 0 to 44. In both the original and adapted versions, items address depression, phobia, anxiety, regression, psychosomatic complaints, and post-traumatic stress disorder (PTSD).

### Suitable for Assessment of:

Psychological distress in children affected by humanitarian crises, and who are between the ages of 3 and 6 years. The PSYCa 3-6 is available in English, French, and Hausa.

### Examples of Use

Mouchenik Y. E. (2001). Evaluer les troubles psychologiques post-traumatiques chez les enfants de moins de six ans. A propos d'une étude réalisée à Débar (Macédoine). *L'autre, Cliniques, cultures et sociétés*, 2:359-366.

Marquer, C., Barry, C., Mouchenik, Y., Hustache, S., Djibo, D., Manzo, M.L., ...Moro, M. (2012). A rapid screening tool for psychological distress in children 3-6 years old: results of a validation study. *BMC Psychiatry*, 12(1), 170.

### Restrictions on Use

If a non-mental health specialist will administer the PSYCa 3-6, it is important to first pilot the tool with all administrators so that standardization of administration procedures can be ensured. Because the PSYCa 3-6 is a preliminary tool to determine whether or not children's levels of distress warrant further evaluation by a mental health specialist, it should not be used in contexts where mental health services are unavailable.

### Available from:

Marquer, C., Barry, C., Mouchenik, Y., Hustache, S., Djibo, D., Manzo, M.L., ...Moro, M. (2012). A rapid screening tool for psychological distress in children 3-6 years old: results of a validation study. *BMC Psychiatry*, 12(1), 170.

<http://www.biomedcentral.com/1471-244X/12/170>

## The Rapid Assessment of Mental Health Needs of Refugees, Displaced and Other Populations Affected by Conflict and Post-Conflict Situations (RAMH)

### Overview/Description

A qualitative, multi-sector tool used to rapidly assess the psychosocial needs and resources of individuals, families, and populations fleeing various forms of conflict and persecution. Developed by the World Health Organization (WHO) and various partnering entities, the RAMH's scope of practice cuts across various levels of focus and units of measurement. The tool, a combination of direct data collection and information gathered through discussions with governmental- and non-governmental officials, is appropriate for use in the earliest phases of an emergency. Prior to deployment into any emergency setting, RAMH assessment teams should first research affected populations, the nature of the conflict(s), and other helpful background information. Consisting of seven sections, the RAMH inquires about access to food, water, and education; the nature of the conflict and those affected by it; exposure to violence; pre- and post-conflict population characteristics; mental health resources; and recommendations for future community-based, mental health programming. Questionnaire items contain four response columns—Refugees (Yes), Refugees (No), Host Population (Yes), and Host Population (No)—in which assessors check applicable responses to questions about refugees and the host population(s). While the RAMH is flexible in its requirements for team members' credentials and professional backgrounds, it is important that, at a minimum, team members possess knowledge and skills in emergencies and refugee mental health. A RAMH assessment process averages 7 to 10 days.

### Suitable for Assessment of:

Psychosocial needs of refugees, forcibly displaced persons, and other populations dislocated from their homes due to various forms of human conflict and socio-political marginalization. While the tool is specifically geared for conducting needs assessments in emergent phases of humanitarian emergencies, when information is limited and difficult to obtain, it can also be used in post-conflict situations, when intermittent bouts of instability persist. Through its utilization of a complex assessment process, which compiles psychosocial data on multiple human and geographical levels (i.e. individual, family, and rural or urban community), the RAMH facilitates a diverse appraisal of needs.

### Examples of Use

Katz, C. L. (2011). Needs Assessment. *Disaster Psychiatry: Readiness, Evaluation, and Treatment*, 49.

Song, S., & Shaheen, M. (2013). Assessing the impact of violence and war on youth in low-and middle-income countries. In *Child & Youth Care Forum* (pp. 1-9). Springer US.

### Restrictions on Use

The RAMH should not be used in isolation; a more comprehensive assessment process that builds upon the RAMH assessment should always follow it. To maintain the objectivity of a RAMH assessment, it is imperative that assessment members remain impartial, unbiased, uninfluenced, and independent during all assessment processes. Because a RAMH assessment is disseminated to various actors within national and international sectors, it is important to keep post-assessment write-ups simple, clear, and non-technical so that findings and recommendations can be understood by those unfamiliar with mental health terminology. At least one mental health professional should be part of a RAMH assessment team.

### Available from:

Petevi, M., Revel, J. P., & Jacobs, G. A. (2011). *Rapid Assessment of Mental Health Needs of Refugees, Displaced and Other Populations Affected by Conflict and Post-Conflict Situations: A community-oriented assessment*. Geneva: World Health Organization. <http://www.who.int/hac/techguidance/pht/7405.pdf>

## Revised Children's Manifest Anxiety Scale (RCMAS)

### Overview/Description

A 37-item, self-report tool used to measure the level and nature of generalized anxiety in children. The RCMAS, informally referred to as the 'What I Think and Feel' scale, was originally adapted from the Children's Manifest Anxiety Scale (CMAS) in order to allow for a wider and more accurate measurement of anxiety. Items contained in the RCMAS—primarily "I" sentences—describe various feelings or experiences a child may have. Response options are binary—"Yes", if the statement is applicable to a child's current feelings or experiences; or "No", if it is non-applicable. Twenty-eight of the items directly correlate with anxiety, and are arranged and scored based on sub-indicators of anxiety—physiological symptoms (10 items), obsessive thoughts and/or worries (11 items), and social disturbances (7 items). The final nine items, called "Lie" items, are meant to detect any incorrect reports (i.e. a child who purposefully denies a symptom of anxiety when he/she is knowingly aware of its existence). A total cumulative score can be derived for the RCMAS, as well as for the four sub-scales—Physiological Anxiety, Worry/Oversensitivity, Social Concerns/Concentration, and Lie. The higher the score received, the greater the likelihood for anxiety, or the possibility that the child has lied in his/her responses. The tool takes about 10 to 15 minutes to administer, and can be administered in individual or group settings by clinicians, teachers, and/or researchers.

### Suitable for Assessment of:

Anxiety in children between the ages of 6 to 19 years. The RCMAS is used in multiple settings and contexts to assess and/or diagnose anxiety—clinically for evaluation of anxiety and/or treatment effectiveness, programmatically to monitor intervention needs and/or effectiveness, and for research purposes. The tool has been used widely in developed and developing countries, as well as in humanitarian and non-humanitarian contexts.

### Examples of Use

Smith, P., Perrin, S., Yule, W., Hacam, B., & Stuvland, R. (2002). War exposure among children from Bosnia-Herzegovina: psychological adjustment in a community sample. *Journal of Traumatic Stress, 15*(2), 147-156.

Bromet E. J., Goldgaber, D., Carlson, G., Panina, N., Golovakha, E., Gluzman, S., ...Schwartz, J. E. (2000). Children's Well-being 11 Years After the Chernobyl Catastrophe. *JAMA - Archives of General Psychiatry, 57*(6), 563-571.

### Restrictions on Use

While the tool is applicable for self-administration, younger and/or less literate children should be administered the questionnaire orally.

### Available from:

Reynolds, C. R., & Richmond, B. O. (1985). Revised Children's Manifest Anxiety Scale. RCMAS Manual. Los Angeles: Western Psychological Services.

## The Rosenberg Self-Esteem Scale (RSES)

### Overview/Description

A 10-item, self-report questionnaire that measures the level of children's self-esteem. The RSES inquires about children's current feelings, using "I" statements (i.e. "I feel I have a number of good qualities..."). The items consist of five positively and five negatively worded scenarios. All ten items are answered on a 4-point scale—Strongly Agree (3), Agree (2), Disagree (1), and Strongly Disagree (0). Total possible scores range from 0 to 30, with higher scores indicative of higher levels of self-esteem. A score between 15 and 25 is considered normal, and a score below 15 is suggestive of low self-esteem. If desired, the 4-point response scale can be changed to varying point allotments (i.e. 5- or 7-point scales) that provide more response options and higher overall score totals.

### Suitable for Assessment of:

Self-esteem levels in children of various cultural and ethnic backgrounds. The RSES has been used in numerous countries and cross-cultural settings, and is available in 28 languages.

### Examples of Use

Rousseau, C., Drapeau, A., & Rahimi, S. (2003). The complexity of trauma response: a 4-year follow-up of adolescent Cambodian refugees. *Child Abuse & Neglect*, 27(11), 1277-1290.

Amone-P'Olak, K., Jones, P. B., Abbott, R., Meiser-Stedman, R., Ovuga, E., & Croudace, T. J. (2013). Cohort profile: mental health following extreme trauma in northern Ugandan cohort of War-Affected Youth Study (the WAYS Study). *SpringerPlus*, 2(300). <http://www.springerplus.com/content/pdf/2193-1801-2-300.pdf>

Behrendt, A. (2008). Associated with the Fighting Forces in Liberia: a Cross Section Study in Lofa Country. <http://www.healthnettpo.org/files/706/study-report-liberia.pdf>

### Restrictions on Use

While the tool is available free of charge to anyone involved in educational and/or research pursuits, those wanting to use it should first inform the Rosenberg family and the University of Maryland's Sociology Department at:

The Morris Rosenberg Foundation  
c/o Department of Sociology  
University of Maryland  
2112 Art/Soc Building  
College Park, MD 20742-1315  
USA

Copies of any publication materials involving use of the RSES should also be sent to the University of Maryland's Sociology Department, and include proper citation of the RSES in the Reference/Bibliography section.

### Available from:

Rosenberg Self-Esteem Scale: <http://www.yorku.ca/rokada/psycstest/rosenbrg.pdf>

## Screen for Childhood Anxiety Related Emotional Disorders (SCARED)

### Overview/Description

A self-report screening tool that assesses for a variety of anxiety disorders in children. The SCARED comprises 41 items that measure the severity of anxiety-related symptoms (based on DSM-IV criteria), and is scored on a 3-point scale—Not True/Hardly Ever True (0), Sometimes True (1), and True/Often True (2). The questionnaire is administered by a clinician to children and their parent(s), and requires approximately 10 minutes to administer.

### Suitable for Assessment of:

Anxiety disorders—general anxiety, separation anxiety, panic disorder, social phobia, and school phobias—over the past three months in children aged 8 to 18 years. The tool is available in English, Chinese, Arabic, French, German, Italian, Portuguese, and Spanish. The SCARED has been used widely in developed and developing countries, as well as in humanitarian and non-humanitarian contexts.

### Examples of Use

Kohrt, B. A., Jordans, M. J., Tol, W. A., Speckman, R. A., Maharjan, S. M., Worthman, C. M., & Komproe, I. H. (2008). Comparison of mental health between former child soldiers and children never conscripted by armed groups in Nepal. *JAMA*, *300*(6), 691-702.

Jordans, M. J. D., Komproe, I. H., Tol, W. A., Nsereko, J., & de Jong, J. T. (2013). Treatment Processes of Counseling for Children in South Sudan: A Multiple n= 1 Design. *Community Mental Health Journal*, 1-14.

### Restrictions on Use

The tool can be downloaded from the Internet, and is available for use free of charge.

### Available from:

University of Pittsburgh, Department of Psychiatry: <http://www.psychiatry.pitt.edu/research/tools-research/assessment-instruments>

## Self-Reporting Questionnaire (SRQ)

### Overview/Description

A screening tool designed by the World Health Organization (WHO) to assesses for common mental disorders in primary health care, and/or community settings. SRQ consists of 20 short, Yes/No questions that inquire about the presence of anxiety, depression, and psychosomatic symptoms during the past month. It originally comprised 25 questions, twenty of which assessed neurosis, four assessed psychosis, and one explored convulsions; however, it was later shortened to 20 items (SRQ-20) pertaining exclusively to neurosis. An SRQ-24 exists, which still contains the original 20 questions about neurosis and four questions about psychosis, but it is not as commonly used as the SRQ-20. The maximum total score for SRQ-20 is 20, with a "Yes" response indicating symptom presence, and "No", the absence of a symptom. The SRQ can be self-administered, but in settings where there are high levels of illiteracy, an interviewer should administer it.

### Suitable for Assessment of:

Psychiatric and neurotic disorders existing in primary health care, and/or community settings. The SRQ contains other versions to aid in assessment of substance abuse disorders and epilepsy, and is also a helpful tool for research purposes. The SRQ is adaptable to many different cultures, and is available in English, Afrikaans, Amharic, Arabic, Bahasa Malaysia, Bengali, Filipino, French, Italian, Hindi, Kiswahili, Njanja, Portuguese, Shona, Siswati, Somali, South Sotho, and Spanish. The Spanish version also contains five items about abnormal alcohol use. Developed for adults, but widely used with adolescents.

### Examples of Use

Tuan, T., Harpham, T., & Huong, N. T. (2004). Validity and Reliability of the Self-Reporting Questionnaire 20 Items in Vietnam. *Hong Kong Journal of Psychiatry*, 14(3), 15-18. [http://easap.asia/journal\\_file/0403\\_v14n3\\_15-18\\_VValidity.pdf](http://easap.asia/journal_file/0403_v14n3_15-18_VValidity.pdf)

Al-Subaie, A., Mohammed, K., & Al-Malik, T. (1998). The Arabic Self-Reporting Questionnaire (SRQ) as a Psychiatric Screening Instrument in Medical Patients. *Annals of Saudi Medicine*, 18(4), 308-310. <http://www.kfshrc.edu.sa/annals/articles/184/97-360.pdf>

### Restrictions on Use

To keep results consistent within one study, it is important to use the SRQ either as a self-administered or an interviewer-administered tool, but not to mix application procedures within a single study. If it is decided to use interviewers for administration of the tool, it is vital that uniform procedures, including reading of questionnaire directions and how to address questions posed by respondents during actual interviews, are followed for all subjects and all interviewers. The SRQ should be piloted at all new sites before actual data collection commences, especially when administered by interviewers, so that consistency is maintained.

### Available from:

World Health Organization. (1994). A User's Guide to the Self Reporting Questionnaire (SRQ). Geneva: Division of Mental Health, World Health Organization. [http://whqlibdoc.who.int/hq/1994/WHO\\_MNH\\_PSF\\_94.8.pdf](http://whqlibdoc.who.int/hq/1994/WHO_MNH_PSF_94.8.pdf)

## Strengths and Difficulties Questionnaire (SDQ)

### Overview/Description

A screening tool that measures behavior in children over the last month to six months. The SDQ is available in various versions---a One-Sided, Informant-Rated version for parents and teachers, which is completed by parents and teachers of children aged 4 to 16 years; a One-Sided, Informant-Rated Parent and Teacher version for completion by parents and teachers of children aged 3 to 4 years (identical to the parent/teacher version for 4 to 16 year-olds except for three age-modified questions); and a One-Sided, Self-Rated version for adolescents aged 11 to 16 years. Each version consists of 25 items that measure positive and negative attributes based on five sub-scales—Emotional (5 items), Conduct (5 items), Hyperactivity/Inattention (5 items), Peer Relationship Problems, and Prosocial Behavior. Double-sided SDQ versions are also available in all of the One-Sided versions. The Double-Sided SDQ versions consist of a front side containing the primary 25 questions, but also contain a backside, called an Impact Supplement, that allows for further elaboration of behavior. Additionally, there is a Follow-up version of the SDQ, which includes the original 25 items and the Impact Supplement, but also two extra questions that inquire about treatment effectiveness. Contrary to the other SDQ versions, which measure a child's behavior over the past six months and/or the current school year, the Follow-up version only assesses behavior over the past month. Response options for the 25 items on all versions are based on a 3-point scale—Not True, Somewhat True, and Certainly True. Response options for the Impact Supplement for all versions are—Not at All (0), Only a Little (0), Quite a Lot (1), and A Great Deal (2). Impact Scores range from 0 to 10, with scores of two or more considered abnormal. The five sub-scales generate an overall SDQ score, which ranges from 0 to 40, with scores between 20 and 40 indicative of abnormal behavior. Individual scores for each of the five sub-scales can also be calculated.

### Suitable for Assessment of:

Behavioral problems in children aged 3-17 years. The SDQ is especially beneficial for conducting initial screenings for behavioral problems (prior to an assessment by a health care provider), measuring intervention effectiveness, and for various research purposes (i.e. epidemiological and social research studies). The SDQ is available in over 70 languages; however, not all versions are available in every language. The tool has been used widely in developed and developing countries, and in humanitarian and non-humanitarian settings.

### Examples of Use

Du, Y., Kou, J., & Coghill, D. (2008). The validity, reliability and normative scores of the parent, teacher and self report versions of the Strengths and Difficulties Questionnaire in China. *Child and Adolescent Psychiatry and Mental Health*, 2(8). <http://pubmedcentralcanada.ca/pmcc/articles/PMC2409296/>

Panter-Brick, C., Goodman, A., & Eggerman, M. (2011). Mental Health and Childhood Adversities: A Longitudinal Study in Kabul, Afghanistan. *Journal of the American Academy of Child and Adolescent Psychiatry*, 50(4), 349-363. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3069303/>

Bolton, P., Bass, J., Betancourt, T., Speelman, L., Onyango, G., Clougherty, K., ...Verdeli, H. (2007). Interventions for Depression Symptoms Among Adolescent Survivors of War and Displacement in Northern Uganda. *JAMA*, 298(5), 519-527. <http://jama.jamanetwork.com/article.aspx?articleid=208211>

Tol, W. A., Komproe, I. H., Jordans, M., Vallipuram, A., Sipsma, H., Sivayokan, S., ...De Jong, J. T. (2012). Outcomes and moderators of a preventative school-based mental health intervention for children affected by war in Sri Lanka: a cluster randomized trial. *World Psychiatry*, 11(2): 114-122. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3363388/>

### Restrictions on Use

SDQ questionnaires are copyrighted and cannot be modified in any way. Paper versions can be used without charge, as long they are used by a non-profit organization that does not charge families. Use of the SDQ in an electronic format is not authorized.

### Available from:

SDQ: [www.sdqinfo.com](http://www.sdqinfo.com)

## UCLA PTSD Reaction Index (UCLA PTSD-RI)

### Overview/Description

A tool for conducting in-depth assessments of trauma-induced psychological reactions, especially PTSD, in school-aged children and adolescents. Administration criteria for the tool are rather flexible—it can be administered in a self-report format, either individually or in a group setting, or orally by an interviewer. The tool, adapted from the Child Post-Traumatic Stress Disorder Reaction Index (CPTSD-RI) exists in three versions—Child (ages 6 to 12 years), Adolescent (13 years or older), and Parent's Report. All three versions of the UCLA PTSD-RI are comprised of questions corresponding to the DSM-IV's criteria for PTSD. The Child version consists of 20 items, and the Adolescent and Adult versions contain 22 items. All versions of the questionnaire are divided into three parts: Parts I, II, and III. Part I addresses a child's traumatic experience (Criterion A1 for PTSD from the DSM-IV). Part II, containing Yes/No response options, assesses cognitive and emotional reactions to the distressing event (Criterion A2 for PTSD from the DSM-IV). Part III delves into the frequency of PTSD symptoms in the past month, based on the classic PTSD triad of behavioral disturbances—avoidance, intrusion, and arousal (PTSD Criterion B, C, and D from the DSM-IV). Response options for items are—None of the Time (0), Some of the Time (1), Much of the Time (2), and Most of the Time (4). Two additional items address fear of recurrence and guilt related to trauma. Responses can be used to calculate a total score, and/or subscale values. The tool takes about 20-30 minutes to administer, and can be administered repeatedly.

### Suitable for Assessment of:

Trauma exposure and PTSD presence in children and adolescents aged 6 to 18 years, particularly following catastrophic disasters and violent conflicts. The tool provides information at the individual- and population-level, and produces integral data for mental health recovery responses and intervention strategies. Because it can be administered more than once, it is also beneficial for continuous assessments. The tool is adaptable to many different cultural settings, humanitarian contexts, traumatic experiences, and age groups, and is available in 16 languages.

### Examples of Use

Balaban, V. (2006). Psychological assessment of children in disasters and emergencies. *Disasters*, 30(2), 178-198.

Catani, C., Kohiladevy, M., Ruf, M., Schauer, E., Elbert, T., & Neuner, F. (2009). Treating children traumatized by war and tsunami: A comparison between exposure therapy and meditation-relaxation in North-East Sri Lanka. *BMC Psychiatry*, 9(22). <http://www.biomedcentral.com/1471-244X/9/22>

O'Callaghan, P., McMullen, J., Shannon, C., Rafferty, H., & Black, A. (2013). A Randomized Controlled Trial of Trauma-Focused Cognitive Behavioral Therapy for Sexually Exploited, War-Affected Congolese Girls. *Journal of the American Academy of Child and Adolescent Psychiatry*, 52(4), 359-369. [http://www.jaacap.com/article/S0890-8567\(13\)00075-0/abstract](http://www.jaacap.com/article/S0890-8567(13)00075-0/abstract)

Abdeen, Z., Qasrawi, R., Nabil, S., & Shaheen, M. (2008). Psychological reactions to Israeli occupation: Findings from the national study of school-based screening in Palestine. *International Journal of Behavioral Development*, 32(4), 290-297.

### Restrictions on Use

The UCLA PTSD-RI tool is not a diagnostic tool and should not be used as such. The tool should be administered by people with previous experience conducting psychiatric testing, and who have reviewed the UCLA PTSD-RI training manual or video. The tool is copyrighted, and thus, only available after contacting UCLA and paying a fee.

### Available from:

Steinberg A. M., Brymer M. J., Kim S., Ghosh C., Ostrowski S.A., Gulley K., ... Pynoos, R. S. (2013). Psychometric properties of the UCLA PTSD Reaction Index: Part 1, *Journal of Traumatic Stress*, 26(1), 1-9.

## War Events Questionnaire (WEQ)

### Overview/Description

A measurement tool that assesses the degree of war exposure in children. The tool aims to differentiate itself from others by providing an individualized objective and subjective assessment of war exposure outcomes in populations exposed to the same war. The WEQ addresses a variety of war events common to all wars, regardless of context or location, and is divided into two parts: Part One, which contains four items and asks about the frequency of exposure to various war events (i.e. physical injury and building damage), both in the respondent and anyone “very close” to the respondent (i.e. family member, neighbor, friend, etc.); Part Two, which is optional, contains six items that assess the level of perceived stress to various events resulting from a war (i.e. water shortage, electricity outages, displacement, etc.). Also in Part Two, the respondent rates his/her perception of stress to the events that he/she reported exposure to in Part One. This is rated from one (“War Event had No Effect”) to 10 (“War Event was Very Dreadful”). In Part One, up to five blank spaces are available for the respondent to answer questions about the occurrence of each event, meaning that in some respondents it is possible that they will have been exposed, and/or a “very close” person will have been exposed multiple times to an event, and will require a report on each occurrence of the same event. Each question contains its own response codes and numerical response values, allowing for independent measurements for each exposure event. The scores in Part Two are not cumulative. The entire scale is scored from 0 to 10,000, with higher numbers indicative of higher levels of exposure to war events and perceived stress resulting from these events. The WEQ should be administered by interviewers who, while not requiring a clinical or professional degree, have received detailed training on the tool prior to administration.

### Suitable for Assessment of:

Individual reactions to war exposure, including the witnessing of various war events, in children. The WEQ also measures the frequency and severity of exposure to various events common to wartime, and children’s perceived stress levels to these events. The tool was developed in Lebanon, but is considered adaptable to other cultural and humanitarian contexts.

### Examples of Use

Karam, E., Fayyad, J., Karam, A. N., Tabet, C. C., Melhem, N., Mneimneh, Z., & Dimassi, H. (2008). Effectiveness and specificity of a classroom-based group intervention in children and adolescents exposed to war in Lebanon. *World Psychiatry*, 7(2), 103-109. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2430518/>

### Restrictions on Use

The development of WEQ was in the context of a long running civil war in Lebanon. Although the WEQ should be adaptable to wars occurring in other parts of the world, some of the events measured in the questionnaire, and their numerical scores, may require revisions to better capture local contexts of war.

### Available from:

Karam, E. G., Al-Atrash, R., Saliba, S., Melhem, N., & Howard, D. (1999). The War Events Questionnaire. *Social Psychiatry and Psychiatric Epidemiology*, 34(5), 265-274.

## Who is Where, When, Doing What? (4Ws)

### Overview/Description

An inter-agency tool used in the aftermath of humanitarian crises to assess and coordinate various mental health and psychosocial response efforts. The tool is intended for use by mental health and psychosocial support agencies—NGO, governmental, and intergovernmental—rather than individuals, and is operated through an Excel spreadsheet file, where various pieces of data about each participating agencies' mental health and psychosocial activities are entered and used for evaluating response actions. Information entered into the data file comes from interviews with representatives of participating agencies, and consists of short-sentence responses, numerical values, or activity codes. The activity codes, found in the tool's manual, reflect common activities undertaken after an emergency situation, and are divided by: community activities, activities for identified cases, and general activities. The initial use of the tool averages about two weeks in duration, and requires periodic updates.

### Suitable for Assessment of:

Mental health and psychosocial support activities conducted in post-humanitarian crises by various humanitarian agencies. The tool helps inform agencies of specific details relating to existing mental health and psychosocial support efforts (the who, what, when, and where), to recognize any gaps or deficiencies in existing activities and resources, and to coordinate response actions across sectors and agencies. The tool's manual is available in English; however, the tool can be translated into other languages. It has been used in Jordan, Haiti, Nepal, Libya, and Syria.

### Examples of Use

Fayyad, K., & Poudyal, B. (2009). Piloting of 4Ws Tool to Map MHPSS Activities in Jordan: Final Report. <http://mhps.net/wp-content/uploads/group-documents/167/1341491881-finalreport4WsJordan-1.pdf>

O'Connell, R., Poudyal, B., Streel, E., Bahgat, F., Tol, W., & Ventevogel, P. (2012). Who is Where, When doing What: mapping services for mental health and psychosocial support in emergencies. *Intervention*, 10(2), 171-176. [http://www.ourmediaourselves.com/archives/102pdf/O'Connell\\_2012\\_Intervention\\_10-2.pdf](http://www.ourmediaourselves.com/archives/102pdf/O'Connell_2012_Intervention_10-2.pdf)

Fitzgerald, C., Elkaied, A., & Weissbecker, I. (2012). Mapping of mental health and psychosocial support in post conflict Libya. *Intervention*, 10(2), 188-200. <https://www.bc.edu/content/dam/files/schools/gssw/pdf/07GsswAlumna2012.pdf>

### Restrictions on Use

Activities coded in the 4Ws are specific to mental health and psychosocial support. Activities that do not have a basis in mental health and psychosocial support should not be included in this tool's mapping activities. Users of the 4Ws are advised to adapt the tool to the local context(s) and language(s). While 4Ws is useful for measuring the types of mental health and psychosocial support activities available, it does not allow for an assessment of the quality of existing activities.

### Available from:

Inter-Agency Standing Committee (IASC) Reference Group on Mental Health and Psychosocial Support in Emergency Settings. (2012). Who is Where, When, doing What (4Ws) in Mental Health and Psychosocial Support. Geneva: Division of Mental Health, World Health Organization [http://www.who.int/mental\\_health/publications/iasc\\_4ws/en/index.html](http://www.who.int/mental_health/publications/iasc_4ws/en/index.html)

## Index of Measures

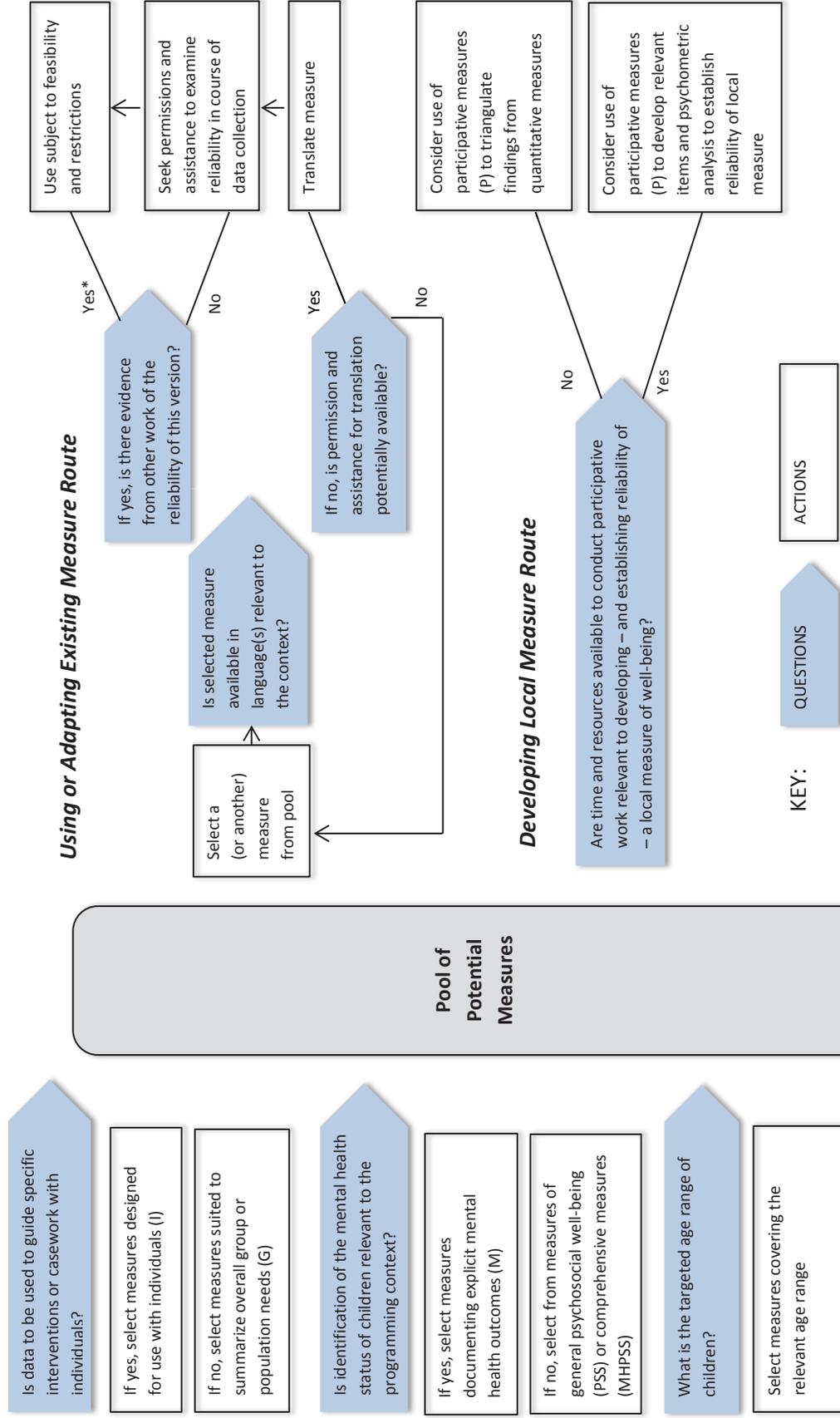
NAME	SCOPE	AGES (yrs)	FOCUS	NOTES ON CONTEXT & LANGUAGE AVAILABILITY
Arab Youth Mental Health Scale (p.4)	MH	10-14	I/G	Developed in Lebanon and available in Arabic and English
Are We Making a Difference? (p.5)	PSS	6-18	P	Has been used widely in Africa but is suited to varied contexts
Brief Ethnographic Interviewing (p.6)	MHPSS	All	P	Provides insight into cultural understandings in varied contexts
Child Behavior Checklist (p.7)	MHPSS	1 ½-18	I/G	Available in over 90 languages; cannot adapt
Child Behavior Inventory (p.8)	MHPSS	5-16	I/G	Available in English and Arabic versions
Child Functioning Impairment Rating Scale (p.9)	PSS	Not specified	I/G	Developed in Indonesia using method suited to varied contexts
Child Led Indicators (p.10)	PSS	Not specified	P	Piloted in Nepal but suited to wide range of settings
Child Post-Traumatic Stress Disorder Symptom Scale (p.11)	MH	8-18	I/G	Available in English and Spanish; used in Latin America & Asia
Child Post-Traumatic Stress Reaction Index (p.12)	MH	6-16	G	Wide use in crisis contexts – available in multiple languages
Child Protection Rapid Assessment (p.13)	PSS	6-18	G	Available in many languages including Arabic, Swahili & Bahasa; caregiver reports for younger children
Child Psychosocial Distress Screener (p.14)	PSS	8-14	G	Wide use in - and adaptability for - humanitarian contexts
Childhood War Trauma Questionnaire (p.15)	MHPSS	3-16	I/G	Reports of use in Lebanon and Bosnia-Herzegovina
Children's Depression Inventory (p.16)	MH	7-16	I/G	Available in English, French, Spanish, Italian, Japanese, Norwegian, Russian, Ukrainian, Afrikaans, Dutch, German, Hebrew, Hungarian, Lithuanian, Swedish, Polish, & Turkish
Children's Hope Scale (p.17)	PSS	8-16	I/G	Available in English and Chinese, with Spanish and Portuguese versions in the validation stages
Composite International Diagnostic Interview (p.18)	MH	16-17	I	Available in over 24 languages, including regional variations
Depression Self-Rating Scale (p.19)	MH	8-14	I/G	Available in Arabic, Chinese, Dari, English, Italian, Japanese, Khmer, Norwegian, and Pashto
Design, Implementation, Monitoring and Evaluation Model (p.20)	MHPSS	All	G	Represents a method for developing measures in any context
Developmental Assets Profile (p.21)	PSS	10-18	I/G	Available in English, Spanish and 18 other languages
Diagnostic Interview Schedule for Children (p.22)	MH	6-17	I/G	Available in English and Spanish
Family Connectedness Scale (p.23)	PSS	Adolescents	I/G	Reported use in Uganda and Chechnya
General Health Questionnaire (p.24)	MHPSS	Adolescents	I/G	Available in 36 languages including Czech, Afrikaans and Spanish
Global Assessment of Psychosocial Disability (p.25)	MHPSS	4-18	I	Reported use in Nepal
Harvard Trauma Questionnaire (p.26)	MH	7+	I/G	Available in 35 languages, including English, Vietnamese, Cambodian, Laotian, Croatian, Bosnian, and Japanese
Hopkins Symptom Checklist (p.27)	MH	Adolescents and above	I/G	Available in English, Bosnian, Cambodian, Croatian, Japanese, Laotian, and Vietnamese
Humanitarian Emergency Settings Perceived Needs Scale (p.28)	PSS	18+	G	Available in English, French, Spanish, Arabic, Nepali, and French/Haitian Creole
I DEAL (p.29)	PSS	11-20	P	Available in English, Spanish, French and Arabic
International Organization for Migration's Psychosocial Tools (p.30)	PSS	Not specified	P	The tool has been used in Iraq, Lebanon, Jordan and Kenya
Impact of Event Scale (p.31)	MH	8+	I/G	Available in English, Spanish, French, Chinese, Japanese, and German. CRIES-8 is available in 19 languages, and CRIES-13, in 25 languages

Kiddie Schedule for Affective Disorders and Schizophrenia for School-Aged Children (p.32)	MH	6-18	I/G	The tool has been used in developed countries and non-humanitarian settings
Mini International Neuropsychiatric Interview for Children and Adolescents (p.33)	MH	6-17	I/G	Available in 30 languages and has been used widely in various developed, developing, humanitarian, and non-humanitarian contexts
Mood and Feelings Questionnaire (p.34)	MH	8-18	I/G	Has primarily been used in developed, non-humanitarian settings but reported use in Darfur
Multidimensional Anxiety Scale for Children (p.35)	MH	8-19	I/G	Available in 15 languages - may be translated into other languages by contacting MHS' Translations Department
Nipissing District Developmental Screen (p.36)	MHPSS	0-6	I	Available in English, French, Spanish, Vietnamese, and Chinese, and has primarily been used in developed, non-humanitarian settings
Orphans and Vulnerable Children Wellbeing Tool (p.37)	MHPSS	13-18	I/G	Available in English, Luo, Swahili (Kenyan and Tanzanian), Chichewa, Amharic, and Haitian Creole
Participatory Ranking Methodology (p.38)	PSS	6-18	P	Method that can be adopted in widely differing cultures and contexts
Participatory Rapid Appraisal (p.39)	PSS	Not specified	P	The method has been used in many settings across the world
Pediatric Emotional Distress Scale (p.40)	MHPSS	2-10	I/G	Available in English and Spanish
Post-Traumatic Stress Symptoms in Children (p.41)	MH	6-18	I/G	Reports of use in Kurdistan (Iraq-Turkey border)
Psychological Screening for Young Children Aged 3-6 (p.42)	MH	3-6	I	Available in French, English, and Hausa
Rapid Assessment of Mental Health Needs of Refugees, Displaced & Other Populations Affected by Conflict & Post-Conflict Situations (p.43)	MHPSS	Not specified	G	Assessment methodology developed for use in broad range of humanitarian contexts
Revised Children's Manifest Anxiety Scale (p.44)	MH	6-19	I/G	Reported use in Bosnia, Central Asia and Indonesia
Rosenberg Self-Esteem Scale (p.45)	PSS	Not specified	I/G	Available in 28 languages
Screen for Childhood Anxiety Related Emotional Disorders (p.46)	MH	8-18	I/G	Available in English, Chinese, Arabic, French, German, Italian, Portuguese, and Spanish
Self-Reporting Questionnaire (p.47)	MH	Adolescents+	I/G	Available in English, Afrikaans, Amharic, Arabic, Bahasa Malaysia, Bengali, Filipino, French, Italian, Hindi, Kiswahili, Njanja, Portuguese, Shona, Siswati, Somali, South Sotho, and Spanish
Strengths and Difficulties Questionnaire (p.48)	MHPSS	3-17	I/G	Available in over 70 languages – widely used in humanitarian and non-humanitarian settings
UCLA PTSD Reaction Index (p.49)	MH	6-18	I/G	Available in 16 languages
War Events Questionnaire (p.50)	MHPSS	Not specified	I	Developed in Lebanon, but potential for contextual and cultural adaptation
Who is Where, When, Doing What? (p.51)	MHPSS	Not specified	P	Manual is available in English only, but 4W tool has been translated into many other languages; reported use in Jordan, Haiti, Nepal, Libya, and Syria

Scope: MH=mental health; PSS=psychosocial wellbeing; MHPSS=both mental health and psychosocial wellbeing

Focus: I=individual profile; G=group or population needs; P=participatory activities

## Decision-Making Guide for the Selection of Measures



*\*If an evaluation is planned, pay particular attention to evidence of the sensitivity of the measure to change over time; if the goal is a needs assessment, evidence of the criterion validity of the measure (it fitting with professional or lay judgments of mental health and psychosocial wellbeing) is particularly important.*