The Psychosocial Assessment

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Chapter 1: Introduction

A Psychosocial assessment, according to the Law Insider (n.d.) is a "series of evaluative measures designed to identify the behavioral and social factors involved in substance abuse and its symptoms, and is used in determination of placement and the development of treatment plan." It is comprehensive and holistic understanding of the patient's sociocultural background in order to develop a personalized, individual care plan (Caresearch, 2019).

Comment [TQ1]: 1. It is a series of evaluative measures designed to identify the behavioral and social factors involved in substance abuse and its symptoms, and is used in determination of placement and the development of treatment plan:
a**. Psychosocial assessment**
b. Trauma assessment
c. Physical assessment
d. Behavioral assessment

According to (York College, n.d.) there are three different sections in outlining psychosocial assessment which are as follows:

Basic Information:

- Identifying information
- Referral
- Presenting Problem
- Sources of Data
- General Description of client

Backgroundand Current Functioning

- Family background and composition
- Educational background
- Employment and vocational skills
- Religious/spiritual involvement

- **Physical functioning, health conditions, and medical background**
- Social, community, and recreational activities
- Basic life necessities
- Legal concerns
- Other environmental or psychosocial factors
- Client strengths, capacities, and resources

Comment [TQ2]: 2. The following are the sub-elements of basic information, EXCEPT:
a. Identifying information
b. Referral
c. Presenting Problem
d. Physical functioning, health conditions, and medical background

Impressions, Assessments, and Recommendations

- Clinical Summary, Impressions, and Assessments
- Goals and Recommendations

Section	Elements	Sub-Elements
Basic Information	Identifying information	• Client name • Gender • Birthdate • Age • Marital status • Race, ethnicity, and nationality • Language spoken • Socioeconomic status • Neighborhood where client lives (general community profilr) • Living arrangements (with whom does the client lives?)
	Referral	• Source (who referred the client to the agency?) • Nature of request • (Determine what type of assistance does the client need?)
	Presenting the Problem	• Describe the dilemma to which the client is being referred to for help • Include the following: length/duration of the problem; prior attempts to solve the existing problem; previous involvement with social agencies for assistance NOTE: If client is high-risk or is currently in crisis

		(abused, violent, suicidal, decompensating, drug abuse relapse), briefly describe his circumstances and offer risk assessment
	Data sources	• Determine the types of information being used for the assessment such as interviews, observations, previous records, consultations with collateral contacts, diagnostic test results (e.g. medical, psychological, educational, psychiatric, vocational) • Describe patient involvement during the process of collecting data: • Who was present during observations and interviews? • How many times were interviews conducted? What was the time duration of the whole process of information gathering?
Background and Current Functioning	Family background	• Nuclear family members and significant relationships; list members, ages, marriages, deaths, divorces. In addition, describe the focus of the relationship on marital and parental aspects as well as the strengths and difficulties (if necessary) • Origin of family: list the members, ages, location, deaths, divorces. Briefly describe all these relationships • History of substance abuse, legal and psychiatric problems among family members.
	Educational background	• Highest level of education • Degree/earned • Special school, talents, challenges, and goals
	Employment and vocational skills	• Occupational, work history, and current status whether client is employed, unemployed, part-time or full-time) • Special training/skills
	Religious and spiritual involvement	• Level of involvement with and support from religious community and/or spiritual practices and beliefs
	Physical functioning, health conditions, and medical background	• Physical development, general health, disabilities and current functioning • History of diseases, accidents, genetic predispositions, and prescription medications
	Psychological and	• History of mental health/psychiatric problems,

	psychiatric functioning	prescription medication, addictions such as alcohol and other drug use • History of neglect, mental, physical, and/or sexual abuse
	Social, community and recreational activities	• Social functioning (Are there any significant friendships, interpersonal relationships, support network?) • Use of community organizations or resources as a member, client or volunteer. • Hobbies, interests, or leisure
	Basic life necessities	• How is client functioning with respect to basic life necessities-food, housing, employment? • What entitlements does the client receive? • What assistance does client require?
	Legal concerns	Immigrant status, housing, marital issues, domestic violence, parole/probation, Driving-while-intoxicated (DWIs)
	Other environmental or psychosocial factors	Military service, sexuality issues
	Strengths and capacities	• How does the client cope when under pressure or difficult circumstances? • What are his/her strengths and problem-solving capacities? • What are his/her limitations to deal with the current problem/s?
Impressions, Assessments, and Recommendations	Clinical summary, impressions and assessments	3-5 sentence summary of: • The problem, need or concerns and the contributing factors to his current state/condition • Level or sense of urgency to the said problem • If secondary problems exists, please specify. Describe the clients' behavior or demeanor during the interview: • Give an overview of the client's mood, signs of anxiety or depression (if there is any), memory and speech problems, sense of reality, judgment or attitude towards a certain situation or difficulty. Take note of the client's service expectations

		Take note of the client's motivation for change and the probability to use the services offered
	Goals and recommendations	Identify goals as you move forward with client Recommendations in terms of the modality or the type of treatment to be used, and the duration of treatment (long-term or short-term) Next steps.

(York College, n.d.)

Importance of Clinical Documentation

The report content should be able to relay relevant and pertinent information about the client particularly his/her current state/condition because this data will be used as basis as the client moves forward with the services offered by the agency. In addition, this helps the social worker to process the information being given, resulting to a more detailed account of impression about the client and his or her situation.

What are Objective Facts and Subjective Impressions and the Difference

This table will delineate the difference between objective facts and subjective impressions:

Objective Facts	Subjective Impressions
• Actual words of client, his/her family members, and colleagues who are involved with the case. This may include the client's emotions and impression about his/her situation • Pertinent information about a client to colleagues for planning and purposes of referral • Pertinent information about a client to colleagues for case • Detailed account of "where the client is at" at a particular moment in time	• **These includes the social worker's beliefs, insights, hunches, guesses, inferences, speculations, about the client and his or her problem based on the facts established early on** • Statements that the social workers make about what he or she believes are the causal meanings/motivations of the remarks, actions, behavioral patterns, experiences, interaction, and feelings of the client

Comment [TQ3]: 3. The following are descriptions of objective facts, EXCEPT:
a. Actual words of client
b. Pertinent information about a client to colleagues for planning and purposes of referral
c. Pertinent information about a client to colleagues for case
d. These includes the social worker's beliefs, insights, hunches, guesses, inferences, speculations about the client

during service provision. • Gives the social worker an opportunity to write a detailed information and impression about the client	

(York College, n.d.)

To differentiate these two further there are action steps we need to take: One by ***making attributions***(clarify who said what) and two by ***framing claims*** (explicitly determine and write whether a statement is an objective fact or a subjective impression).

Examples of objective fact without qualification:

1. The client smiled as he spoke about his grandchild.
2. The client explained that he didn't want to hurt his son's feelings.

Examples of subjective impression with qualification:

1. The client ***seemed*** happy as he spoke about his grandchild.
2. Although the client did not expressly admit it, she ***appeared to be*** worried that he might have hurt his son's feelings.

Tentative Phrases

In psychosocial assessment, these phrases communicate to its readers that the statements are based on the inference, interpretation, hypothesis, or suggestion made by the social worker or the mental health workers performing the psychosocial assessment.

Examples:

It appears that It seems that	*It points to*
It may be the case that	*It suggests that*
The social worker wonders whether	***One might speculate that***

There is a hint of

One is struck by

It is worth wondering if

She might be

Perhaps ...

It leads one to question whether

It is like that

It is unlikely that

(York College, n.d.)

Comment [TQ4]: 4. Which of the following are tentative phrases that you can use to make inferences or interpretations?
a. One might speculate that
b. There is a hint of
c. One is struck by
d. All of the above

Inference:the act of passing from one proposition, statement, or judgment considered as true to another whose truth is believed to follow from that of the former (Merriam-Webster Dictionary, n.d.).

Interpretation:an explanation or opinion of what something means (Cambridge Dictionary, n.d.)

Suggestion: the process by which a physical or mental state is influenced by a thought or idea (Merriam-Webster Dictionary, n.d.)

Hypothesis: an idea or explanation for something that is based on known facts but has not yet been proved (Cambridge Dictionary, n.d.)

Coverage

- Does the report contain enough and relevant information that relates to, provides context on the current problem?
- Does the report contain a balance of information? Does it include client's strengths and weaknesses, objective facts and subjective impressions, and multiple data sources?

Prioritizing: Does the information highlights the key clinical issues for the client?

Decide what issues to include based on the level of importance and which sections should have more weight in the report.

The content flow should start from the most relevant, important, or urgent issues that the client is experiencing given his/her current situation.

To highlight and give priority to this sort of information, you have to present more material about the issue/area of client, present it first in a paragraph or section, and explicitly state its importance (York College, n.d.)

Informational Accuracy

It is vital to get report as accurate as possible. In order to do this, these three questions should be considered:

- Is the report material as truthfully and faithfully as the client, colleague, narrated during the assessment?
- Does the report accurately communicate what the client said, felt, or believed to the extent it was presented?

If not, what are the errors, and in what ways do these things mislead?

Treatment Plans and Goals

A **mental health treatment plan** is a written document that outlines the expectations for therapy. Depending on requirements of payment providers and the agency, the therapist's preferences and the severity of the presenting problem, the plan may be quite formalized or may simply be composed of loose handwritten notes. If an electronic record system is used by the agency, this may dictate the treatment plan format.

Comment [5]: 5. It is a written document that outlines the expectations for therapy:
a. Mental health treatment plans
b. Psychosocial assessment
c. Presenting problem
d. Time estimate

Nowadays, formalized treatment plans are required more frequently than in the past. However, no matter how loses or how formalized the treatment plan is, it's always subject to change during the progression of therapy.

The plan is based on needs identified during the initial assessment and diagnostic process. The process used to choose the level of care needed should be documented. Depending on the problem(s), treatment plans may include family information (Council of Juvenile Correctional Administrators, 2007).

A formal treatment plan generally consists of four or five parts--objectives and goals sometimes being combined:

1. **Presenting Problem**--A brief description of the most significant problem(s) to be addressed. Problems that are not urgent may be set aside for later treatment.
2. Goals of Therapy--An annotated list of both the overall and the interim goal(s) of therapy. Long-ranged goals may not need to be measurable (Utah Division of Substance Abuse and Mental Health, 2009).

Comment [TQ6]: 6. It is a brief description of the most significant problem(s) to be addressed:
a. Goals of therapy
b. Presenting problem
c. Objectives
d. Time estimate

3. Objectives--A list of measurable objectives showing what the client will do to reach a goal. Action verbs are used with identifiable outcomes such as frequency and quantity.
4. **Time Estimate**--A brief estimate of the length of time and/or number of sessions needed to reach each objective
5. Methods and Interventions--A short, annotated list of techniques that will be used by the therapist and/or the client to achieve the objectives

Comment [TQ7]: 7. A brief estimate of the length of time and/or number of sessions needed to reach each objective:
a. Goals of therapy
b. Presenting problem
c. Objectives
d. Time estimate

Often achieved via informally discussion the situation, the client should always be included in developing the treatment plan and this should be recorded in the record. Some therapists give the client a written copy of the treatment plan; others believe this can cause an unnatural feeling to the therapeutic relationship. However, a copy of the plan should always be given to a client who requests it (Fritscher, 2011).

In addition to the treatment plan itself, often kept in the record is a full descriptive summary that combines biopsychosocial information and a summary of key clinical issues; it functions as a connection between the treatment plan and the assessment. The narrative summary pinpoints diagnostic signs for any existing mental health problems, and includes both the reasons for the assessed level of care and any substitution for that level of care (Utah Division of Substance Abuse and Mental Health, 2009).

Progress

In many ways, psychotherapy is to a certain degree an unstructured process. This causes many clients who are experiencing guided self-discovery and behavioral change to ask themselves if therapy is helping. Repeated taking of a self-report questionnaire to track progress gives both client and therapists a chance to see what is improving from the client's perspective--the most important perspective.

Self-report data given via a formal assessment has often been used to:

- Add to the accuracy of clinical assessments
- Give a basis for treatment planning
- Provide an objective way to track treatment progress
- Use clinically proven guidelines to warn therapists to get stubborn cases back on track
- Aid in preventing hospitalizations through warning guidance
- Give referral sources some outcome-based information to link patients to therapists with a proven track record of giving outstanding treatment to clients with similar needs

An example of such a self-report assessment is the Patient Health Questionnaire (PHQ-9), an assessment for depression that is available online (PHQ-9, (1999). Like other most successful assessments of this sort, it's short (ten questions) with easy-to-answer questions (check the level that best suits: Not at all, Several days, More than half the days, Nearly every day). The validity of the test over time is also good.

These sorts of assessments, grouped under "behavior health outcome management" (BOHM), can be used every session to track progress. With real-time scoring and report generation (which can be done in a very few moments) both clinicians and clients receive excellent evaluation about the course of treatment and whether or not adjustments to the treatment plan should be made (Lambert, 2005).

Although it has not always been the case, some of the newer, more advanced assessments can reliably document improvement on a single domain more than 50% of the time and, with a multi-dimensional analysis, more than 90% of the time (Kraus, Seligman, and Jordan, 2005). With payers and purchasers alike looking for documentation of client improvement, you may want to research and evaluate applicable assessments.

According to the Core Battery Conference (CBC), a core assessment battery should address three distinct areas:

- Quality of life, or general distress
- Symptom clusters (e.g., anxiety, depression, mania, psychosis, etc.)
- Functional domains (e.g., work and social functioning)

Kraus, Seligman, and Jordan (2005) identified only one battery that met all of the criteria defined by CBC with a short questionnaire, the Treatment Outcome Package (TOP Toolkit). The free package includes assessments for children, adolescents, adults, and substance abuse, as well as a couple of assessments of client satisfaction and a wealth of other information (Behavioral Health Laboratories, 2011).

As clients proceed through therapy, progress and treatment plans are reviewed and assessed, and needed changes in the treatment plan are made to reflect the progress or lack thereof. In addition to the continual assessment of progress, the process includes:

- Comparing progress to criteria for continued service or discharge
- Determination of when the client can be treated at a different level of care or treatment approach based on resolution of problems and/or priorities

Treatment often ends when a frustrated client leaves prematurely. Following the procedures outlined above will hopefully reduce the number of times that happens.

Problems in Not Meeting Treatment Goals

Assessments aside, there will be clients who just can't seem to meet treatment goals. This seems especially true in cases involving substance abuse. The treatment plan should include reports of lack of response to treatment or meeting therapy goals, or if the client is disruptive in treatment. As you would expect, the treatment plan needs to be appropriately revised (Office of Alcoholism and Substance Abuse Services, 2010).

Significant Actions Taken and Outcome

The main point in again mentioning "significant actions taken and outcome" is to emphasize their importance in the psychotherapy notes. Sometimes it's helpful to gather them from the individual session notes and group them into a narrative. This can add perspective that will give good guidance as to where you should go next

Chapter 2: Adverse Childhood Experiences (ACEs)

Source: https://www.cdc.gov/violenceprevention/aces/fastfact.html

Adverse Childhood Experiences (ACEs) have a tremendous impact on future violence victimization and perpetration, and lifelong health and opportunity. Working together, we can help create neighborhoods, communities, and a world in which every child can thrive.

Learn more about preventing ACEs in your community by assuring safe, stable, nurturing relationships and environments.

Fast Facts

What are adverse childhood experiences?

Adverse childhood experiences, or ACEs, are potentially traumatic events that occur in childhood (0-17 years). For example:

- experiencing violence, abuse, or neglect
- witnessing violence in the home or community
- **having a family member attempt or die by suicide**

Also included are aspects of the child's environment that can undermine their sense of safety, stability, and bonding, such as growing up in a household with:

- substance use problems
- mental health problems
- instability due to parental separation or household members being in jail or prison

ACEs are linked to chronic health problems, mental illness, and substance use problems in adulthood. ACEs can also negatively impact education, job opportunities, and earning potential. However, ACEs can be prevented.

Please note the examples above are not meant to be a complete list of adverse experiences. There are many other traumatic experiences that could impact health and wellbeing.

Comment [TQ8]: 8. The following are adverse childhood experiences, EXCEPT?
a. Experiencing violence, abuse, or neglect
b. Witnessing violence in the home or community
c. Having a peaceful and loving family.
d. Substance use problems

How big is the problem?

ACEs are common. About 61% of adults surveyed across 25 states reported that they had experienced at least one type of ACE, and nearly 1 in 6 reported they had experienced four or more types of ACEs.

Preventing ACEs could potentially reduce a large number of health conditions. For example, up to 1.9 million cases of heart disease and 21 million cases of depression could have been potentially avoided by preventing ACEs.

Some children are at greater risk than others. Women and several racial/ethnic minority groups were at greater risk for having experienced 4 or more types of ACEs.

ACEs are costly. The economic and social costs to families, communities, and society totals hundreds of billions of dollars each year.

What are the consequences?

ACEs can have lasting, negative effects on health, well-being, as well as life opportunities such as education and job potential. These experiences can increase the risks of injury, sexually transmitted infections, maternal and child health problems (including teen pregnancy, pregnancy complications, and fetal death), involvement in sex trafficking, and a wide range of chronic diseases and leading causes of death such as cancer, diabetes, heart disease, and suicide.

ACEs and associated social determinants of health, such as living in under-resourced or racially segregated neighborhoods, frequently moving, and experiencing food insecurity, can cause toxic stress (extended or prolonged stress). Toxic stress from ACEs can change brain development and affect such things as attention, decision-making, learning, and response to stress.

Children growing up with toxic stress may have difficulty forming healthy and stable relationships. They may also have unstable work histories as adults and struggle with finances, jobs, and depression throughout life. These effects can also be passed on to their own children. Some children may face further exposure to toxic stress from

historical and ongoing traumas due to systemic racism or the impacts of poverty resulting from limited educational and economic opportunities.

How can we prevent adverse childhood experiences?

ACEs are preventable. There are a number of factors that may increase or decrease the risk of perpetrating and/or experiencing violence. To prevent ACEs, we must understand and address the factors that put people at risk for or protect them from violence.

Creating and sustaining safe, stable, nurturing relationships and environments for all children and families can prevent ACEs and help all children reach their full potential. CDC has produced a resource, Preventing Adverse Childhood Experiences (ACEs): Leveraging the Best Available Evidence, to help states and communities take advantage of the best available evidence to prevent ACEs. It features six strategies from the CDC Technical Packages to Prevent Violence.

Table 1.1 Preventing ACES

Strategy	Approach
Strengthen economic supports to families	• Strengthening household financial security • Family-friendly work policies
Promote social norms that protect against violence and adversity	• Public education campaigns • Legislative approaches to reduce corporal punishment • Bystander approaches • Men and boys as allies in prevention
Ensure a strong start for children	• Early childhood home visitation • High-quality child care • Preschool enrichment with family engagement
Teach skills	• Social-emotional learning • Safe dating and healthy relationship

Comment [TQ9]: 9. Which of the following statements best describes the "strengthen economic supports to families" preventive strategy/approach for Adverse Childhood Experiences (ACEs)?
a. Strengthening household financial security
b. Family-friend work policies
c. Promote social norms that protect against violence and adversity
d. Both A and B

Comment [TQ10]: 10. Which of the following statements best describes the "teach skills" preventive strategy/approach for Adverse Childhood Experiences (ACEs)?
a. Social-emotional learning
b. Safe dating and healthy relationship skill programs
c. Both A and B
d. Promote social norms that protect against violence and adversity

	skill programs • Parenting skills and family relationship approaches
Connect youth to caring adults and activities	• Mentoring programs • After-school programs
Intervene to lessen immediate and long-term harms	• Enhanced primary care • Victim-centered services • Treatment to lessen the harms of ACEs • Treatment to prevent problem behavior and future involvement in violence • Family-centered treatment for substance use disorders

Raising awareness of ACEs can help:

- Change how people think about the causes of ACEs and who could help prevent them.
- Shift the focus from individual responsibility to community solutions.
- Reduce stigma around seeking help with parenting challenges or for substance misuse, depression, or suicidal thoughts.
- Promote safe, stable, nurturing relationships and environments where children live, learn, and play.

Let's help all children reach their full potential and create neighborhoods, communities, and a world in which every child can thrive.

Risk and Protective Factors

Did you know that negative experiences in childhood and the teenage years may put children at risk for chronic health problems, mental illness, and substance use in

adulthood? These negative experiences are known as adverse childhood experiences (ACEs). ACEs are potentially traumatic experiences, such as neglect, experiencing or witnessing violence, and having a family member attempt or die by suicide, that occur in childhood (birth to 17) that can affect children for years and impact their life opportunities. Fortunately, we can prevent ACEs and we can educate parents, communities, and policymakers about how to help children grow up in a safe and stable environment.

This page explores risk factors (things that increase the likelihood of experiencing ACEs) and protective factors (things that protect people and decrease the possibility of experiencing ACEs). Individual, family, and community factors can affect the likelihood of these experiences, but they may or may not be direct causes of ACEs. Because ACEs include many different types of experiences, including abuse, neglect, household challenges, and other traumatic events that may occur outside the home such as bullying, teen dating violence, and witnessing community violence, there are many risk and protective factors that apply to the range of different ACEs. This page lists examples of the many common risk and protective factors that are related to multiple ACEs, but may not be related to all ACEs. This list is not meant to be exhaustive. It is also important to note that experiencing some ACEs can increase the risk of experiencing other ACEs. Although some risk and protective factors are at the individual and family level, no child or individual is at fault for the ACEs they experience.

Please note the term “caregiver” will be used throughout to refer to parents and those who care for children but may not be biological parents.

Risk Factors

Individual and Family Risk Factors

- Families experiencing caregiving challenges related to children with special needs (for example, disabilities, mental health issues, chronic physical illnesses)
- Children and youth who don’t feel close to their parents/caregivers and feel like they can’t talk to them about their feelings
- Youth who start dating early or engaging in sexual activity early

- Children and youth with few or no friends or with friends who engage in aggressive or delinquent behavior
- Families with caregivers who have a limited understanding of children's needs or development
- Families with caregivers who were abused or neglected as children
- Families with young caregivers or single parents
- Families with low income
- Families with adults with low levels of education
- Families experiencing high levels of parenting stress or economic stress
- Families with caregivers who use spanking and other forms of corporal punishment for discipline
- Families with inconsistent discipline and/or low levels of parental monitoring and supervision
- Families that are isolated from and not connected to other people (extended family, friends, neighbors)
- Families with high conflict and negative communication styles
- Families with attitudes accepting of or justifying violence or aggression

Community Risk Factors

- Communities with high rates of violence and crime
- Communities with high rates of poverty and limited educational and economic opportunities
- Communities with high unemployment rates
- Communities with easy access to drugs and alcohol
- Communities where neighbors don't know or look out for each other and there is low community involvement among residents

- Communities with few community activities for young people
- Communities with unstable housing and where residents move frequently
- Communities where families frequently experience food insecurity
- Communities with high levels of social and environmental disorder

Protective Factors

Individual and Family Protective Factors

- Families who create safe, stable, and nurturing relationships, meaning, children have a consistent family life where they are safe, taken care of, and supported
- Children who have positive friendships and peer networks
- Children who do well in school
- Children who have caring adults outside the family who serve as mentors/role models
- Families where caregivers can meet basic needs of food, shelter, and health services for children
- Families where caregivers have college degrees or higher
- Families where caregivers have steady employment
- Families with strong social support networks and positive relationships with the people around them
- Families where caregivers engage in parental monitoring, supervision, and consistent enforcement of rules
- Families where caregivers/adults work through conflicts peacefully
- Families where caregivers help children work through problems
- Families that engage in fun, positive activities together

- Families that encourage the importance of school for children

Community Protective Factors

- Communities where families have access to economic and financial help
- Communities where families have access to medical care and mental health services
- Communities with access to safe, stable housing
- Communities where families have access to nurturing and safe childcare
- Communities where families have access to high-quality preschool
- Communities where families have access to safe, engaging after school programs and activities
- Communities where adults have work opportunities with family-friendly policies
- Communities with strong partnerships between the community and business, health care, government, and other sectors
- Communities where residents feel connected to each other and are involved in the community
- Communities where violence is not tolerated or accepted

ACEs don't have a single cause, and they can take several different forms. Many factors contribute to ACEs, including personal traits and experiences, parents, the family environment, and the community itself. To prevent ACEs and protect children from neglect, abuse, and violence, it's essential to address each of these factors.

Help Youth At Risk for ACEs

Youth-serving and faith-based organizations, coaches, and caregivers can help prevent adverse childhood experiences (ACEs). Raising awareness of ACEs in communities about how to prevent these experiences can help children and youth grow up and thrive in a safe and stable environment.

What are ACEs?

Traumatic experiences in childhood and the teenage years may put children at risk for violence, chronic health problems, mental illness, and substance abuse in adulthood. These traumatic experiences are known as Adverse Childhood Experiences (ACEs). These experiences can affect children for years and impact their potential in life.

ACEs may take many forms, including:

- experiencing violence, abuse, or neglect
- witnessing violence in the home or community
- having a family member attempt or die by suicide

Also included are aspects of the child's environment that can undermine their sense of safety, stability, and bonding such as growing up in a household with:

- substance use problems
- mental health problems
- instability due to parental separation
- instability due to incarceration of a parent, sibling, or other members of the household

Raising Awareness of ACEs

The first step in helping young people at risk for ACEs is for everyone in our communities to gain a better understanding of these experiences. ACEs are far more common than many people realize. About 6 in 10 adults surveyed reported experiencing at least one ACE, and nearly 1 in 6 of them reported experiencing 4 or more different types of ACEs.

It is also important for people to understand the many long-term consequences of ACEs. ACEs put individuals at risk for chronic health problems, mental illness, and substance use problems in adulthood. For example, there is evidence that these childhood stresses can put people at risk for heart disease and depression later in life. ACEs can also negatively impact education and job opportunities.

Fortunately, educating youth-serving and faith-based organizations, coaches, and caregivers and raising awareness of ACEs in communities about how to prevent these experiences and how to help children and youth who have already experienced ACEs, can help children and youth grow up and thrive in a safe and stable environment.

How to Help Prevent ACEs

The good news is that ACEs are preventable. There are a number of strategies that involve people from all sectors of society that can prevent ACEs from happening in the first place and lessen the harmful effects of ACEs that have already occurred. The harmful effects of ACEs can affect everyone in our communities, and everyone can be helpful in preventing them. By keeping ACEs from occurring in the first place and taking quick action when an ACE happens, communities can help all children and youth reach their full potential.

Here are some ways to help prevent ACEs:

Strengthen Families' Financial Stability

Community organizations such as faith-based and youth-serving organizations can promote policies that support families facing financial problems or that help parents balance work and family responsibilities can reduce stress and make it easier for parents to meet children's basic needs. Examples include those:

- Policies that support employers offering paid time off to care for a newborn or family member
- Policies that provide families assistance with childcare costs and healthy nutrition
- Providing income or child tax credits for working families
- Offering flexible and consistent work schedules

Promote Social Norms that Protect Against Violence

Encourage community organizations such as youth-serving and faith-based organizations, coaches, and caregivers to promote non-violent attitudes, beliefs, and behaviors. Examples include:

- Supporting parents and positive parenting practices
- Encouraging people to speak up when they see violence

- Involving men and boys in prevention efforts
- Educating parents and caregivers that it's okay to ask for help

Help Kids Have a Good Start

Involved parents, strong preschool programs, and good quality childcare get children off on the right foot and help them succeed later in life. Youth-serving and faith-based organizations can contribute to this as well. Examples include:

- Getting caregivers involved in early learning programs
- Making sure that childcare facilities at the faith-based or youth-serving organization are licensed and accredited
- Helping improve access to affordable, high-quality childcare and preschool programs
- Offering in-home support and training in child health and development

Teach Healthy Relationship Skills

Children and caregivers alike can learn about how to create healthy relationships and manage their emotions. Teens while participating in faith-based organizations or youth-based organizations can learn about safe dating. Examples of ways to help include:

- Teaching children and youth how to handle conflict(s), negative feelings, and pressures from peers
- Offering programs that teach skills for developing healthy, non-violent dating and peer relationships
- Teaching healthy childrearing skills to parents
- Helping parents or caregivers learn ways to support their children and set a good example with their behaviors

Connect Youth with Caring Adults and Activities

Community organizations play a critical role in connecting young people with positive role models and providing activities to for young people to learn leadership and other new skills. Communities can help young people grow and succeed at school and in life.

Examples of ways organizations can connect youth to caring adults and activities include:

- Enrolling them in school or community mentoring programs
- Getting them involved in after-school activities
- Giving them opportunities to build confidence and practice leadership skills
- Offering a training opportunity in the arts, media, sports, science, or technology

Intervene to Lessen Immediate and Long-Term Harms

When ACEs occur, community organizations, can offer services and support to reduce the harms of ACEs and help break the cycle of adversity. Examples include:

- Learning more about ACEs and what kinds of support are available for kids, teens, and adults
- Offering medical, legal, housing, and other crisis intervention services as needed
- Providing therapy to reduce symptoms of depression, fear or anxiety, and behavior problems.
- Using family-centered treatment for substance misuse

Benefits of Preventing ACEs

Creating safe, stable, nurturing relationships and environments while youth are participating in faith-based organizations or youth-serving organizations can prevent ACEs and help all children and youth reach their full health and life potential. Some of the many benefits of preventing ACEs include:

- Healthier relationships
- Better performance in school
- Higher graduation rates
- Fewer mental health problems
- Less substance use

- Fewer behavior problems and less violence
- Fewer arrests for violent crimes
- Less burden and cost from violence for everyone

Everyone can play an important role in supporting a better future for kids, teens, and their families.

About the CDC-Kaiser ACE Study

The CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study is one of the largest investigations of childhood abuse and neglect and household challenges and later-life health and well-being.

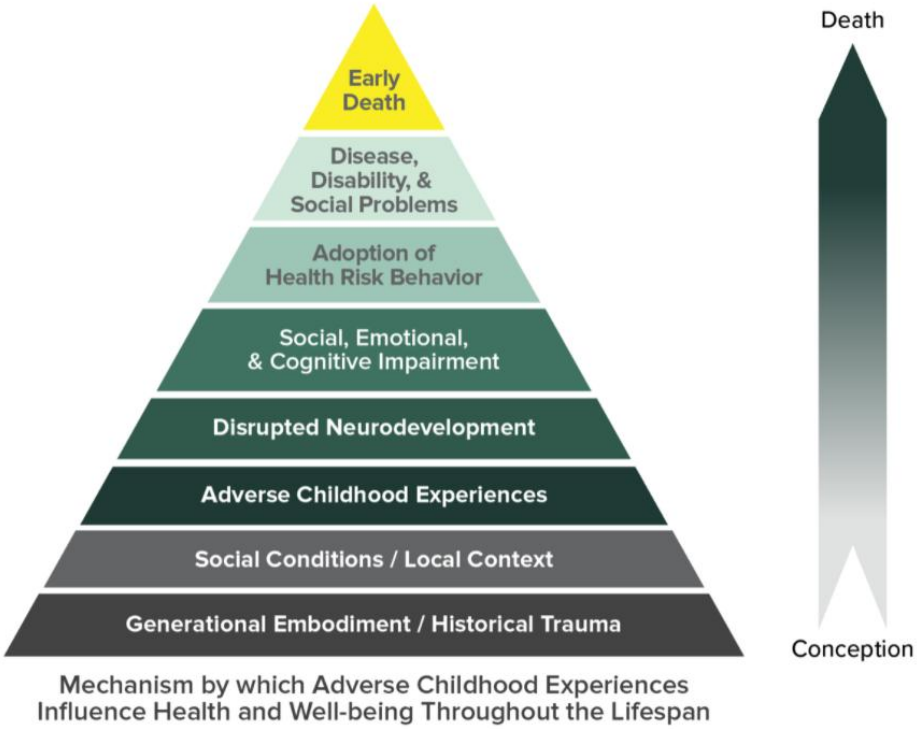
The original ACE Study was conducted at Kaiser Permanente from 1995 to 1997 with two waves of data collection. Over 17,000 Health Maintenance Organization members from Southern California receiving physical exams completed confidential surveys regarding their childhood experiences and current health status and behaviors.

More detailed information about the study can be found in the links below or in the article, "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adultsexternal icon,".

Please note: The original CDC-Kaiser dataset is not available to the public. Kaiser owns the data and data collection is ongoing (e.g., prescription drug use, medical status of original participants). However, there is an optional ACE Module on the Behavioral Risk Factor Surveillance System (BRFSS) that many states have administered. These data are available for download from BRFSS.

https://www.york.cuny.edu/wac/for-students/discipline-specific-infosheets/social-work-psychosocial-assessment-i.pdf

The ACE Pyramid



Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

Data and Statistics

Adverse Childhood Experiences (ACEs) are categorized into three groups: abuse, neglect, and household challenges. Each category is further divided into multiple subcategories. Participant demographic information is available by gender, race, age, and education. The prevalence of ACEs is organized by category.

ACEs Definitions

All ACE questions refer to the respondent's first 18 years of life.

- Abuse
    - **Emotional abuse:** A parent, stepparent, or adult living in your home swore at you, insulted you, put you down, or acted in a way that made you afraid that you might be physically hurt.

- **Physical abuse:** A parent, stepparent, or adult living in your home pushed, grabbed, slapped, threw something at you, or hit you so hard that you had marks or were injured.
- **Sexual abuse:** An adult, relative, family friend, or stranger who was at least 5 years older than you ever touched or fondled your body in a sexual way, made you touch his/her body in a sexual way, attempted to have any type of sexual intercourse with you.

- Household Challenges
  - **Mother treated violently:** Your mother or stepmother was pushed, grabbed, slapped, had something thrown at her, kicked, bitten, hit with a fist, hit with something hard, repeatedly hit for over at least a few minutes, or ever threatened or hurt by a knife or gun by your father (or stepfather) or mother's boyfriend.
  - **Substance abuse in the household:** A household member was a problem drinker or alcoholic or a household member used street drugs.
  - **Mental illness in the household:** A household member was depressed or mentally ill or a household member attempted suicide.
  - **Parental separation or divorce:** Your parents were ever separated or divorced.
  - **Incarcerated household member:** A household member went to prison.
- Neglect1
  - **Emotional neglect:** Someone in your family helped you feel important or special, you felt loved, people in your family looked out for each other and

felt close to each other, and your family was a source of strength and support.2

- **Physical neglect:** There was someone to take care of you, protect you, and take you to the doctor if you needed it[2], you didn't have enough to eat, your parents were too drunk or too high to take care of you, and you had to wear dirty clothes.

Participant Demographics

Demographic information is from the entire ACE study sample (n= 17, 337)

Demographic Information for CDC-Kaiser ACE Study Participants, Waves 1 and 2			
ACE Category	Women	Men	Total
	Percent (N= 9, 367)	Percent (N= 7,970)	Percent (N=17, 337)
ABUSE			
Emotional Abuse	13.1%	7.6%	10.6%
Physical Abuse	27%	29.9%	28.3%
Sexual Abuse	24.7%	16%	20.7%
HOUSEHOLD CHALLENGES			
Mother treated Violently	13.7%	11.5%	12.7%
Substance abuse	29.5%	23.8%	26.9%
Mental Illness	23.3%	14.8%	19.4%
Parental Separation or Divorce	24.5%	21.8%	23.3%
Incarcerated Household Member	5.2%	4.1%	4.7%
NEGLECT			
Emotional Neglect3	16.7%	12.4%	14.8%

Physical Neglect	9.2&	10.7%	9.9%

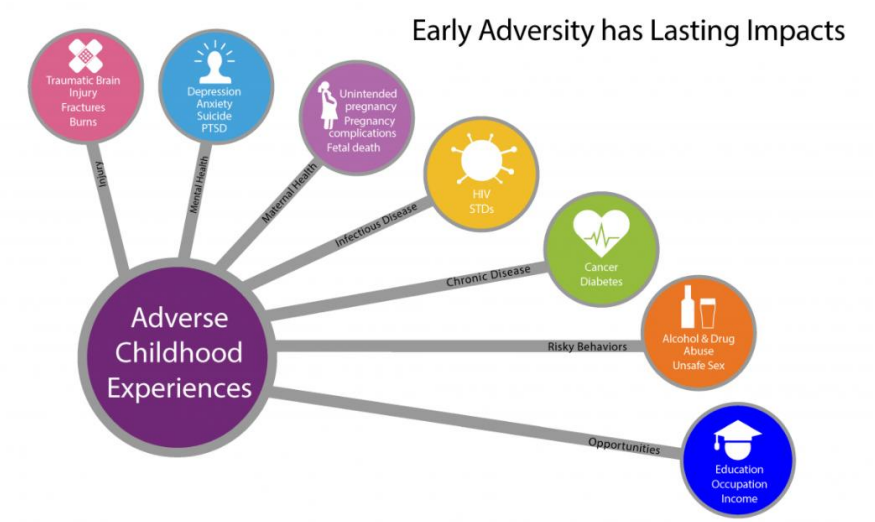
ACE Score Prevalence for CDC-Kaiser ACE Study Participants by Sex, Waves 1 and 2.			
Number of Adverse Childhood Experiences (ACE Score)	**Women Percent(N = 9,367)**	**Men Percent (N = 7,970)**	**Total Percent (N = 17,337)**
0	34.5%	38.0%	36.1%
1	24.5%	27.9%	26.0%
2	15.5%	16.4%	15.9%
3	10.3%	8.5%	9.5%
4 or more	15.2%	9.2%	12.5%

Major Findings

ACEs are common across all populations. Almost two-thirds of study participants reported at least one ACE, and more than one in five reported three or more ACEs.

Some populations are more vulnerable to experiencing ACEs because of the social and economic conditions in which they live, learn, work and play.

The ACE score is the total sum of the different categories of ACEs reported by participants. Study findings show a graded dose-response relationship between ACEs and negative health and well-being outcomes. In other words, as the number of ACEs increases so does the risk for negative outcomes.



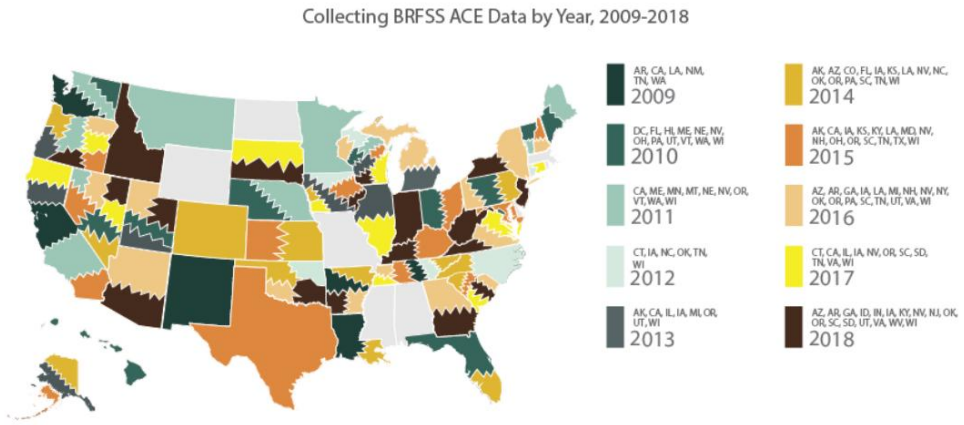
Behavioral Risk Factor Surveillance System ACE Data

Many states are collecting information about Adverse Childhood Experiences (ACEs) through the Behavioral Risk Factor Surveillance System (BRFSS). The **BRFSS** is an annual, state-based, random-digit-dial telephone survey that collects data from non-institutionalized U.S. adults regarding health conditions and risk factors. Since 2009, 48 states plus the District of Columbia have included ACE questions for at least one year on their survey.

Comment [TQ11]: 11. _____is an annual, state-based, random-digit-dial telephone survey that collects data from non-institutionalized U.S. adults regarding telephone survey that collects data from non-institutionalized U.S. adults regarding health conditions and risk factors.

a. Family Health Questionnaire
b. CANS
c. Behavioral Risk Factor Surveillance System
d. Telehealth

States Collecting BRFSS ACE Data by Year, 2009-2018.



Source: Centers for Disease Control and Prevention. *Behavioral Risk Factor Surveillance System Survey ACE Data, 2009-2018.* Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2019.

Data and Statistics

ACEs are categorized into two groups on the BRFSS ACE module: abuse and household challenges. Each category is divided into multiple subcategories. Neglect items were not added to the BRFSS ACE module until 2019.

States that have added the ACE module using their own resources are not required to report ACE data back to CDC BRFSS. To access states' ACE data please contact each state's BRFSS coordinator. A list of state coordinators can be found on the BRFSS state coordinators web page.

ACEs Definitions

All ACE questions refer to the respondent's first 18 years of life.

- Abuse4

- **Emotional abuse:** A parent or other adult in your home ever swore at you, insulted you, or put you down.
- **Physical abuse:** A parent or other adult in your home ever hit, beat, kicked or physically hurt you.
- **Sexual abuse:** An adult or person at least 5 years older ever touched you in a sexual way, or tried to make you touch their body in a sexual way, or attempted to have sex with you.

- Household Challenges
  - **Intimate partner violence:5** Parents or adults in home ever slapped, hit, kicked, punched or beat each other up.
  - **Substance abuse in the household:** A household member was a problem drinker or alcoholic or used street drugs or abused prescription medications.
  - **Mental illness in the household:** A household member was depressed or mentally ill or a household member attempted suicide.
  - **Parental separation or divorce:** Parents were ever separated or divorced.
  - **Incarcerated household member:** A household member went to prison.
- Neglect6
  - **Emotional neglect:** An adult in the household never or very seldom made you feel safe and protected.

- **Physical neglect:** An adult in the household never or very seldom tried hard to make sure your basic needs were met.

Participant Demographics

Demographic information reported below is for 23 states that included the ACE module on the 2011-2014 BRFSS (n=214,157).

Demographic Information for Participants Completing the 2011-2014 BRFSS ACE Module	
Demographic Information	**Percent (N = 214,157)**
Gender	
Female	51.5%
Male	48.5%
Race/Ethnicity	
White	68.1%
Black	8.4%
Other	6.3%
Multiracial	1.6%
Hispanic	15.6%
Age (years)	
18-24	12.3%
25-34	17.3%

35-44	16.5%
45-54	18.3%
55-64	16.2%
65+	19.4%
Educational Attainment	
Less than High School	13.8%
High School Diploma/GED	28.1%
Some College	32.6%
College Degree	25.5%

ACEs Prevalence

The prevalence estimates reported below are from 23 states that included the ACE module on the 2011-2014 BRFSS (n=214,157). Note: Reports and articles that use data from other years and/or other states may contain different estimates.

Prevalence of ACEs by Category for Participants Completing the ACE Module on the 2011-2014 BRFSS			
ACE Category	**Women**	**Men**	**Total**
	Percent	**Percent**	**Percent**
ABUSE			
Emotional Abuse	33.9%	34.9%	34.4%
Physical Abuse	17.5%	18.4%	17.9%
Sexual Abuse	16.3%	6.7%	11.6%
HOUSEHOLD CHALLENGES			

Prevalence of ACEs by Category for Participants Completing the ACE Module on the 2011-2014 BRFSS			
Intimate Partner Violence	18.2%	16.8%	17.5%
Substance Abuse	28.7%	26.3%	27.6%
Mental Illness	19.2%	13.7%	16.5%
Parental Separation or Divorce	27.8%	27.5%	27.6%
Incarcerated Household Member	7.3%	8.6%	7.9%

Major Findings

The prevalence of ACEs from the BRFSS data was similar to that of the original ACE Study. Almost two-thirds of surveyed adults reported at least one ACE and more than one in four reported three or more ACEs.

ACEs are common across all populations. Some populations are more vulnerable to experiencing ACEs because of the social and economic conditions in which they live, learn, work and play.

The ACE score is the total sum of the different categories of ACEs reported by participants. Study findings show a graded dose-response relationship between ACEs and negative health and well-being outcomes. In other words, as the number of ACEs increases so does the risk for negative health outcomes.

The Child and Adolescent Needs and Strengths (CANS) is a "*multiple purpose information integration tool that is designed to be the output of an assessment process. The purpose of the CANS Comprehensive is to accurately represent the shared vision of the child/youth serving system—children, youth, and families. As such, completion of the CANS Comprehensive is accomplished in order to allow for the effective communication of this shared vision for use at all levels of the system. Since its primary purpose is communication, the CANS Comprehensive is designed based on communication theory rather than the psychometric theories that have influenced most measurement development. There are six key principles of a communimetric measure*

Comment [TQ12]: 12. It is a multiple purpose information integration tool that is designed to be the output of an assessment process.
a. Family Health Questionnaire
b. Child and Adolescent Needs and Strengths
c. Behavioral Risk Factor Surveillance System
d. Telehealth

that apply to understanding the CANS Comprehensive". (John Praed Foundation, 2021).

In addition, the CANS aims to facilitate the connection between the assessment process and the unique and individualized rendering of service plans. It has six (6) key components which includes the following:

1. Items are selected based on relevance to planning.
2. Action levels for all items
3. Consider culture and development before establishing the action level
4. Agnostic as to etiology—descriptive, no cause and effect
5. About the child, not about the service. Rate needs when masked by interventions.
6. Specific ratings window (e.g. 30 days) can be over-ridden based on action levels

For more information about the CANS, please click on the following link: https://praedfoundation.org/tcom/tcom-tools/the-child-and-adolescent-needs-and-strengths-cans/

Part 2: Assessing Mental Health and Psychosocial Needs and Resources

Toolkit for humanitarian settings

Source:

https://apps.who.int/iris/bitstream/handle/10665/76796/9789241548533_eng.pdf;jsessionid=5A905DAFB246E7C83E8702717003D2D4?sequence=1

A quick guide to Identifying tools

Tool #	Title	Method	Why use this tool?	Page
For coordination and advocacy				
1	Who is Where, When, doing What (4Ws) in Mental health and psychosocial Support (MHPSS): summary of manual with activity codes	Interviews with agency programme managers	For coordination, through mapping what mental health and psychosocial supports are available.	30
2	WHO-UNHCR Assessment Schedule of Serious Symptoms in Humanitarian Settings (WASSS)	Part of a community household survey (representative sample)	For advocacy, by showing the prevalence of mental health problems in the community	34
3	Humanitarian Emergency Setting Perceived Needs Scale (HESPER)	Part of a community household survey (representative sample) Or exceptionally (in acute, major emergencies) as a convenience	For informing response, through collecting data on frequency of physical, social, and psychological perceived needs in the community	41

		sample		
For MHPSS through health services				
4	Checklist for site visit at institutions in humanitarian settings	Site visit and interviews with staff and patients	For protection and care for people with mental or neurological disabilities in institutions	42
5	Checklist for integrating mental health in primary health care (PHC) in humanitarian settings	Site visits and interviews with primary health care programme managers	For planning a mental health response in PHC	47
6	Neuropsychiatric component of Health Information System (HIS)	Clinical epidemiology using the HIS	For advocacy and for planning and monitoring a mental health response in PHC	53
7	Template to assess mental health systems formal resources in humanitarian settings	Review of documents and interviews with managers of services	For planning of (early) recovery and reconstruction, through knowing the formal resources in the regional/national mental health system	55
For MHPSS through different sectors, including through community support				
8	Checklist on obtaining general (non MHPSS specific) information from sector leads	Review of available documents	For summarizing general (non-MHPSS specific) information already known about the current humanitarian emergency (to avoid collecting data on issues that are already known)	59
9	Template for desk review of pre-existing	Literature review	For summarizing MHPSS information	60

	information relevant to MHPSS in the region/country		about this region/country already known before the current humanitarian emergency (to avoid collecting data on issues that are already known)	
10	Participatory statement: perceptions by general community members	Interviews with general community members (free listing with further questions)		63
11	Participatory assessment: perceptions by community members with in-depth knowledge of the community	Interviews with key informants or groups	For learning about local perspectives on problems and coping to develop an appropriate MHPSS response	70
12	Participatory assessment perceptions by severely affected people	Interviews with severely affected people (free listing with further questions)		74

Chapter 1: Introduction

1.1 How to use this toolkit?

This document provides an approach and a toolkit to help those designing and conducting an assessment of mental health and psychosocial needs and resources in major humanitarian crises. These could include major natural and human-made disasters and complex emergencies (for example armed conflicts). In general, assessments are aimed at:

- providing a broad understanding of the humanitarian situation;

- analysing people's problems and their ability to deal with them; and
- analysing resources to decide, in consultation with stakeholders, the nature of any response required.

Assessments are also helpful to start engagement with stakeholders, including governments, community stakeholders and national and international agencies.

The IASC (2007) Guidelines on Mental Health and Psychosocial Support in Emergency Settings suggest topics that should be covered in assessments of mental health and psychosocial issues. However, these guidelines do not offer guidance on how to collect the data or what information is typically needed for what health-sector actions. This document – written mainly for humanitarian actors in the health sector - is intended to help fill these gaps.

This document is rooted in two policy documents, the IASC Reference Group's (2010) Mental Health and Psychosocial Support in Humanitarian Emergencies: What Should Humanitarian Health Actors Know? and the Sphere Handbook's Standard on Mental Health (Sphere Project , 2011).

Page 7 (and the back cover) of this document provides a quick guide to identify tools and shows how the tools in this toolkit are linked to the main recommended health-sector actions in the area of mental health and psychosocial support (MHPSS).

Because of the broad scope of assessment topics, assessments should, as far as possible, be a coordinated effort. They greatly benefit from collaboration between partners. For guidance on coordinated assessments, see the work by the IASC Task Force on Needs Assessment (IASC NATF, 2011).

There is no 'one assessment that fits all'. This document is not a cookbook. Rather, it provides a toolkit and an approach to selecting the right tools. You should select a few tools and adapt them within each assessment project and specific situation, depending on what you want the assessment to achieve.

Assessment objectives depend on:

- what information is already available;
- the phase of the emergency; and
- the abilities, resources and interests of the assessment team.

The approach in this document – in line with recent interagency recommendations (IASC NATF 2011, IASC 2012) - covers collecting both primary data (new data) as well as secondary data (existing data).

1.2 Who should use the toolkit?

While this document is written primarily for public health agencies, many of the assessment tools presented are very relevant for staff working in other sectors. Health actors may work at any of the following different levels of the health system:

- in the community (for example at people's homes);
- in first-level and second-level health facilities (for example primary health care clinics, policlinics, general hospitals); and
- in tertiary care (for example mental hospitals).

As the social conditions that contribute to mental health and psychosocial problems occur across all sectors, approximately half of the tools in this document cover MHPSS assessment issues that are relevant to other sectors as well as the health sector.

This document assumes you know about mental health and psychosocial concepts as outlined in the IASC MHPSS Guidelines (2007). Although some explanations are given in the text, this document also assumes you have a basic knowledge of assessment techniques, for example, how to:

- conduct, analyse and report on semi-structured key informant interviews and group interviews;
- conduct, analyse and report on surveys; and
- manage the logistics of an assessment, budget, and train data collectors and so on.

Much of the rigour and quality of the assessment will depend on the abilities of the assessment team leader and their team. At a minimum, assessment team leaders should have previous experience in designing, conducting, analysing, and reporting on

qualitative and quantitative assessment methods in humanitarian settings. Team members should bring together good knowledge of:

- the socio-cultural context in which the humanitarian crisis takes place; and
- mental health issues and programming in humanitarian settings.

1.3 HOW WAS THE TOOLKIT DEVELOPED?

The toolkit was developed through an iterative process that involved consulting experts, holding multiple rounds of peer review, and pilot testing of various tools. Development started with a list of all the different assessment topics recommended in the IASC MHPSS Guidelines' Action Sheet on assessment. Possible questions (with defined assessment techniques and target respondents) on each of these topics were then entered into a large table. As much as possible, previously tested questions and tools were entered into the table. Subsequently, questions were grouped together across topics, according to assessment technique and type of respondent. Duplicate and superfluous questions were removed. Questions that had no obvious relationship to health-sector action were also removed. The grouped questions were then converted into assessment tools, each with an explicit objective that relates to one of the key actions listed in the revised Mental Health Standard of the 2011 Sphere Handbook. The IASC Reference Group on MHPSS reviewed a few tools involving assessment which crossed a number of sectors (Tools 1, 9, 10, 11) and this resulted in the Reference Group adopting these four tools.

1.4 CULTURE AND MENTAL HEALTH

Assessment coordinators will always be challenged to find a balance between obtaining: quick and practical information (through, for example, rapid assessments of main issues to start service delivery); and

- knowledge of the very complex socio-cultural reality (through, for example, in-depth ethnographic assessments).
- Unfortunately, there is no easy answer to achieving this balance.

Cultural dimensions of care in this toolkit are addressed in a number of ways, including:

- a template for literature reviews of the relevant social science and medical literature which apply to the specific context; and
- assessment tools that rapidly collect perspectives of local community members and other stakeholders with regard to mental health and psychosocial support.

It will be important to keep in mind that the tools in this toolkit generally provide rapid and superficial answers to complex questions. Information collected with these tools will require critical reflection and, where the situation evolves, further data collection.

Chapter 2: Overview of the assessment process

Assessing needs is a continuous process. Figure 2.1 below depicts this continuous process and outlines the different steps involved in assessing needs.

Before starting any assessments, it is crucial to coordinate with the relevant stakeholders, including, as appropriate, the government, sector leads, representatives of the target group, and other humanitarian actors. It is advisable to coordinate assessments (for example dividing topics or geographical areas between humanitarian agencies) for a number of reasons, including:

- to make efficient use of resources;
- to gain a more complete picture of needs;
- to avoid asking the same questions to the same participants.

If you are an agency from outside, you should try to coordinate assessments with local researchers and make use of existing government and university capabilities.

It is highly recommended that agencies planning to carry out coordinated MHPSS assessments apply the operational guidance on coordinated needs assessment by the IASC NATF, 2011.

The approach of this toolkit on mental health and psychosocial support needs and resources involves the following four types of data collection:

- Literature review (Tool 9).
- Collecting existing information from relevant stakeholders, including government (for example, Tools 7 and 8).
- Gathering new information through adding questions about psychosocial and mental health concerns to general health, nutrition, protection or other assessments done by non-MHPSS actors1 (for example, Tool 2 may be added to such assessments).
- Filling in any gaps in knowledge by collecting new information on mental health and psychosocial issues through specific MHPSS assessment including, for example, interviews and site visits, surveys, and group and key informant interviews (for example, Tool 11).

Figure 2.1 FLOW CHART OF NEEDS ASSESSMENT

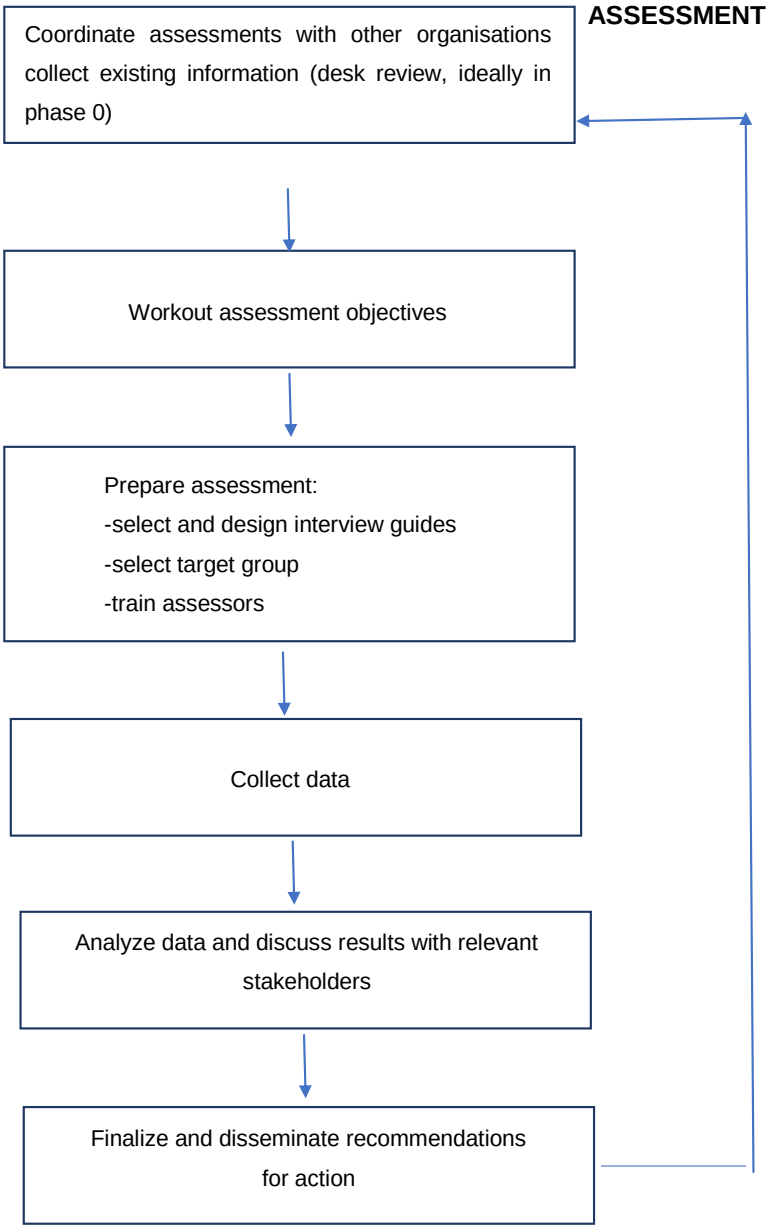


Table 2.1 GOOD PRACTICE PRINCIPLES FOR ASSESSMENT

1. Make sure to coordinate with relevant stakeholders (including, where possible, governments, NGOs, community and religious organizations, local universities and affected populations) and have them participate in designing the assessment; interpreting the results; and translating results into recommendations.

2. Include different sections of the affected population, paying attention to children, youth, women, men, elderly people and different cultural, religious and socio-economic groups.

3. **Design and analyse assessments with a focus on action, rather than on collecting information only**. Collecting too much data (that is, so much data that you cannot analyse it all or meaningfully use it) wastes resources and places unnecessary burdens on interviewees.

4. Attention to conflict, for example by maintaining impartiality and independence, considering possible tensions and not putting people at risk by asking questions.

5. Be aware that the assessment methodology and behaviour of the assessment team members are appropriate to the local culture.

6. Assess both needs and resources to increase the likelihood that any humanitarian response builds on the supports and resources that are already there.

7. Be aware of ethical principles, including respecting privacy, confidentiality, informed and voluntary participation, and the best interest of the interviewee (see section 3.3 on informed consent below).

8. Assessment teams should be trained in ethical principles and basic interviewing skills. They should be knowledgeable about the local context and balanced in terms of gender. Some of the team members should be themselves members of (or very familiar with) the local population. They should know about referral sources.

9. Data collection methods can include literature review, group interviews, key informant

Comment [TQ13]: 13. Which of the following is NOT a good practice principle for assessment?
a. Make sure to coordinate with relevant stakeholders
b. Pay attention to conflict by maintaining impartiality and independence
c. Be aware that the assessment methodology and behavior of the assessment team members are appropriate to the local culture.
d. Design and analyse assessments without focus on action, rather than on collecting information only,

interviews, observation and site visits.

10. Assessments should be timely so they are tailored to the phase of the humanitarian crisis, with more detailed assessments taking place in later phases.

Chapter 3: Assessment Methodology

3.1 Selecting assessment topics and tools from this toolkit

Assessments usually need to focus on a selected number of topics and tools. The quick guide on page 7 and the back cover of this document gives a list of potential key actions for health agencies in the area of mental health and psychosocial support. This list covers all but one of the key actions in the Sphere Handbook Mental Health Standard (Sphere Project, 2011).2 For each key action mentioned there are one or more assessment tools in this toolkit.

When selecting tools from this toolkit, it is important to keep the following in mind:

1. Develop a clear framework and objectives of your assessment. This will help you to prioritise the information you need and guide your selection of the tools.

2. Remember that time is short and resources are limited. Do not burden affected people unnecessarily; a study of already available information is crucial to minimise the topics for further assessment. There is no point in collecting the same information twice unless there is doubt whether existing information is up-to-date or of sufficient quality. Only collect information that can lead to humanitarian action.

3. There is rarely a need for in-depth information on all topics. The information needed depends on an agency's mandate and ability to act on the assessment. When assessments become too broad, it is difficult to collect, analyse and report good quality information.

4. Collaboration is helpful. When inter-agency (coordinated) assessments are done, the burden of doing assessments can be shared across agencies. Such assessments are recommended because they tend to be more credible, and they tend to support collaborative planning (IASC NATF, 2011). Agencies can divide topics and select a number of more specific topics according to their strengths.

5. Collecting information from different types of sources provides a bigger picture (cf. IASC NATF, 2011). This toolkit contains tools for the following sources.
    - Perceptions by interviewees of themselves (Tool 2, part A; Tool 12)
    - Perceptions by interviewees of others (Tool 2, part B, Tools 10, 11)
    - Perceptions by interviewees of themselves and others (Tool 3)
    - Health information system data (Tool 6)

- Services offered by agencies (Tools 1, 4, 5, 7) • Secondary data on an affected area as a whole (Tools 8, 9)

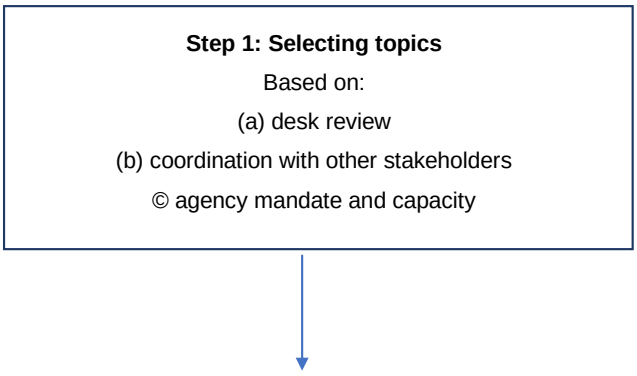
6. Plan to evaluate the validity of collected information. Choices for methodology should be based on:
   - available resources (skills, time, money); and
   - the decision to check the validity of findings by collecting related information in more than one way (triangulation).

   For example, you can compare data from the desk literature review with information obtained during a site visit and responses from communities about the need for care.

   This document sometimes provides more than one method to assess an issue, and you should select the methods most appropriate and feasible for you. Checking primary data (new data) with secondary data (existing data) is an efficient form of triangulation.

Figure 3.1 shows the process of choosing assessment topics and methodology. After selecting topics and methodology, you can estimate the time and human resources needed for your assessment. You can adapt the selected tools to the context and the purpose of the assessment. For a good example of how you can adapt and use the tools in this kit, see the IMC (2011) assessment in Libya.

Figure 3.1 Selecting Assessment Methodology



Step 2: Selecting assessment methodology

Based on:

(a) available time and resources

(b) decision to check the validity of findings by collecting data on the same concept in different ways (triangulation)

There is no strict 1:1 relationship between the phase of a crisis and the use of specific assessment tools. However, the following guidance may be given.

Within the international humanitarian response system, agencies increasingly discuss assessment in terms of four phases explained in Table 3.1.

Table 3.1 PHASES, TIME FRAMES AND THE AMOUNT OF ATTENTION PAID TO MENTAL HEALTH IN ASSESSMENTS OF MAJOR SUDDEN-ONSET CRISIS

Phases with examples of time frame after start of major sudden-onset crisis (as suggested by the IASC NATF (2011))	**Use of tools in this toolkit**
Phase 0 (before the sudden-onset crisis)	Conduct a desk review (Tool 9) and identify available services and actors (Tool 1). If resources are available, conduct an in-depth assessment focused on mental health and psychosocial wellbeing as it applies to the health sector (use any of the tools in this kit).
Phase 1 (for example, the first 72 hours of a sudden-onset crisis)	Initiate or update a desk review (Tool 9). Review projections on mental disorders based on knowledge of previous crises (for example, see Table 3.2).

Comment [TQ14]: 14. This phase involves reviewing of projections on mental disorders based on knowledge of previous crises:

a. Phase 0
b. Phase 1
c. Phase 2
d. Phase 3

	Set up an assessment of basic survival, protection and care of people in institutions (Tool 4).
Phase 2 (for example, the first two weeks of a sudden-onset crisis)	Include a few questions on mental health problems (for example, on care for people in institutions) as part of any Multi cluster/sector Initial Rapid Assessment (MIRA; IASC, 2012) and consider using the Humanitarian Emergency Setting Perceived Needs Scale (HESPER, Tool 3) in a convenience sample. Set up participatory assessments to develop mental health and psychosocial support (for example, Tools 10 to 12).
Phase 3(for example, weeks 3 and 4 after a sudden-onset crisis)	Include a subsection on mental and social aspects of health within general health assessments (for example, Tools 2, 4, 5, 6). Prepare in-depth assessment on mental health and psychosocial wellbeing (any of the tools in this kit).
Phase 4 (the remaining time)	Assess resources in the formal mental health system (Tool 7) to inform recovery activities. Conduct an in-depth assessment focused on mental health and psychosocial wellbeing (any of the tools in this kit).

Comment [TQ15]: 15. This phase includes a subsection on mental and social aspects of health within general health assessment:
a. Phase 0
b. Phase 1
c. Phase 2
d. Phase 3

With regard to these four phases, you should note the following:

- Although imperfect, this common language on the order of phases and tasks is useful for communicating and collaborative planning.

- The time frames in Table 3.1 above vary with the scale and severity of humanitarian crises and with the ability to respond.
- You need to complete, analyse and report rapidly on all assessments in phases 1 to 3 for them to be meaningful, because the situation on the ground can change quickly.
- In general the greater part of humanitarian assistance (including almost all support in complex emergencies) is provided in phase 4. • Most mental health assessments tend to take place in phase 4. • Where possible, you should avoid vertical (stand-alone) mental health assessments in phases 1 to 3. You should include them in multi- sector or health-sector assessments. • If an area has only recently opened after a longer time period (for example, because of security) you should start assessment in phase 1.

Most of the tools and questions covered in this document are for phase 4. Yet you can apply tools in earlier phases as part of multi-sector and health-sector assessments as follows:

- You can usually ask questions on perceived needs through the Humanitarian Emergency Setting Perceived Needs Scale (HESPER4 , Tool 3) in convenience samples as early as phase 2. At the time of writing, the HESPER questions are the base of the draft primary data collection questions in phase 2 of the IASC's Multi cluster/sector Initial Rapid Assessment (MIRA; IASC, 2012).5
- Tool 4 (on institutions) applies from the beginning of the emergency, because a key question is whether people in mental hospitals or other institutions (for example, old age homes, orphanages and prisons) have been forgotten or abandoned without access to clean water, food, physical health care or protection from violence and abuse. Given that people in mental hospitals are too often forgotten, advocacy is needed to make sure that any MIRA assessment automatically also occurs in institutions.
- You can add questions on serious symptoms of distress (see Tool 2) to population-based general health surveys (phase 3).

- You should add mental health categories (see Tool 6) to the health information system (HIS) (phase 3).

3.2 Estimating the prevalence of mental health problems

Attempts to estimate the prevalence of various mental disorders have been common. This document, however, does not cover surveys on the prevalence of mental disorders (that is, psychiatric epidemiology). Such surveys can be important for advocacy and academic value but, more often than not, are of limited practical value when designing a humanitarian response. Also, such surveys are very challenging to conduct in a meaningful manner in humanitarian settings. Surveys of mental disorders in humanitarian settings need to be accompanied by studies that validate the tool used to diagnose the disorders. Validating the tool ensures that there is a meaningful distinction between mental disorders and non-pathological psychological distress (see also IASC, 2007, page 45).

If you have to make a quick estimate on the prevalence of mental disorders, you can use existing WHO projections for a general indication of mental disorders in crisis-affected populations (see below in Table 3.2). However, you should acknowledge that this is only an estimate and that observed rates vary widely depending on the context and method of study.

In general, it is important to note the following:

- Both (a) **adversity (loss and potentially traumatic events) and (b) an insecure, unsupportive recovery environment** are associated with higher rates of mental disorder (Steel et al, 2009).
- Higher-quality studies (involving diagnostic tools, random samples and large sample sizes) are associated with lower rates of mental disorder (Steel et al, 2009).7
- Studies that do not take into account assessment of clinical significance or impaired functioning identify much higher rates of disorders (Breslau et al, 2007). This is generally the case for most studies involving self-report measures.

Comment [TQ16]: 16. Which of the following events are associated with higher rates of mental disorder?
a. Adversity (loss and potentially traumatic events)
b. An insecure unsupportive environment
c. Only A
d. Both a and b

Although the toolkit does not cover measuring mental disorders, it does cover surveys of serious mental health symptoms. Agencies are often interested in knowing, monitoring and reporting on such problems in a population, and this may be done relatively quickly without assessing mental disorders (see Tool 2). Experience with Tool 2 has shown that you can effectively use such surveys for making a case (advocacy) for more attention to mental health in humanitarian settings.

TABLE 3.2 WHO PROJECTIONS OF MENTAL DISORDERS IN ADULT POPULATIONS AFFECTED BY EMERGENCIES		
	Before the emergency: 12-month prevalence (median across countries and across level of exposure to adversity)	After the emergency: 12-month prevalence (median across countries and across level of exposure to adversity)
Severe disorder (for example, psychosis, severe depression, severely disabling form of anxiety disorder)	**2% to 3%**	3% to 4%
Mild or moderate mental disorder (for example, mild and moderate forms of depression and anxiety disorders, including mild and moderate PTSD)	10%	15% to 20%
Normal distress / other psychological reactions (no disorder)	No estimate	Large percentage

Comment [TQ17]: 17. Before the emergency (12-month prevalence), what is the population percentage of adults suffer from severe disorder?

a. 3% to 4%
b. 2% to 3%
c. 10%
d. 15% to 20%

3.3 Collecting qualitative and quantitative data

3.3.1 General guidance on collecting qualitative and quantitative data

General guidance on collecting qualitative and quantitative data is given below.

1. Informed consent: Assessments present a significant burden for those taking part. They take up important time and energy and may remind people of hardship, often in situations that are already challenging. It is very important that participants only join assessments on a voluntary basis and understand what you expect of them. In a humanitarian crisis this is often more difficult, because assessors often represent agencies that provide assistance. People may join assessments because they expect assistance from these agencies. It is important that you are completely honest with potential participants; if you are not sure whether assessment will be linked to action, you should make this clear. Such honesty includes keeping any promises you make for assistance. False promises undermine community participation and effective humanitarian assistance.
2. Interview setting: Where you conduct an interview can have a big influence on the results. You should, as far as possible, make sure that participants feel free to speak without being watched, interrupted by others, reminded of things they need to do, and so on. It is important to think through the logistics of where you will hold interviews, before the assessment team goes into specific assessment locations.
3. Language: Participants may discuss mental health and psychosocial problems in many ways. Mental disorders can easily be confused with normal distress, that is, being unhappy or upset. Local languages may or may not have words for this distinction (for example in Nepali a distinction is made between the heart-mind man and brain-mind dimaag, with problems in the man being less stigmatised). The same word may mean something different in different cultures. For example the word 'bored' in English refers to 'frustration' in some South Asian communities, and the word traumatized can have different meaning in different cultures. Also, different cultures will have different ways of distinguishing mental health problems from other problems. For example, problems that you may think

are interesting from a mental health point of view, may be experienced as supernatural problems by participants (for example hearing voices from evil spirits or fainting attacks). Sometimes lay language for mental disorders is stigmatising (for example, in English 'crazy' or 'has a screw loose'). You should choose words with great care so as not to stigmatise participants. It is crucial that you translate technical terms in any interviewing tools carefully, informed by the desk review or preliminary key informant interviews.

4. Attitude: An important aspect of interviewing rests in the way that the interviewer approaches participants, and is able to form a relationship of trust and rapport. This topic should be included in the training of the assessment team, for example through a brainstorm with all team members on essential characteristics for sensitive interviewing. These may include:
    - attitudes, for example: willingness to listen; openness towards other opinions; being non-judgmental; curiosity; flexibility; willingness to travel and work in different places at irregular times; and
    - skills, for example; active listening; ability to create an atmosphere of confidence; note-taking skills; ability to follow interviewing instructions; gaining interviewing experience through role play; and ability to think of alternative strategies if unexpected situations come up.
5. Bias: **Bias** refers to a systematic influence on the information that was not intended. For example, people may answer questions about how they are doing with strongly negative answers because they think this may help for them to get access to services. Or, people may not describe any negative emotions because they do not want to appear weak in the eyes of others. In addition, interviewers may be biased, which may influence responses. It is important that assessment teams reflect and report on how answers to questions may be biased.
6. **Recording verbatim data**: Many of the tools in this toolbox ask for specific information that can be recorded verbatim (that is, literally, as the words were spoken) on paper. Ideally, qualitative data is collected verbatim, and in most interview situations you can use tape recorders for this purpose. However, in humanitarian settings using a tape recorder may lead to security concerns or is

Comment [TQ18]: 18. This refers to a systematic influence on the information that was not intended:
a. Informed consent
b. Recording verbatim data
c. Bias
d. Storing data

Comment [TQ19]: 19. It asks specific information that can be recorded verbatim (that is, literally, as the words were spoken) on paper.
a. Informed consent
b. Recording verbatim data
c. Bias
d. Storing data

often just not feasible or appropriate. In situations where rapid information collection and analysis are crucial (for example phase 1 to 3), good note taking may be a good alternative to tape-recording.

7. Storing data: The information that you collect during an assessment (for example tape-recorded data, interview transcripts) provides the basis for recommendations for action and represents significant efforts and sacrifices by participants. So you should treat data with the utmost care and respect. You should take care that data: remains safe and secure (for example, from army personnel or camp leadership); is kept clean (for example in plastic sheets to protect it from humidity, food, dirt);
    - is systematically kept (for example in numbered boxes); and
    - is made anonymous to protect confidentiality. To achieve anonymity, the forms with data should only contain participant numbers, while you keep a list with corresponding names and numbers securely locked under the responsibility of the team leader.

3.3.2 Qualitative Assessments

Some of the tools in this toolbox concern collecting qualitative data, within a rapid appraisal format. The next sections are intended as a very short primer on the topic of collecting qualitative data. You can find more information in 'further reading' boxes.

3.3.2.1 Key informant interviews

Key informant interviews (a technique used in Tools 1, 4, 5, 9, 10, 11 and 12) are interviews with people that are considered to be in a good position to provide the information you need. For instance, if you are interested in local mourning rituals, you may consider religious leaders as key informants. Key informant interviews often involve repeated open-ended interviews with the same person.

There are a number of strengths associated with using key informant interviews, including:

- the possibility of examining topics in-depth by asking key informants to clarify information or explanations a number of times in a flexible manner;
- key informants may provide relatively easy access to a wealth of knowledge; and

- key informants often enjoy sharing their knowledge.

A limitation of using key informants is that information comes from a relatively small, select group of individuals. Also, you cannot assume that people who you select as key informants will actually have accurate knowledge of the issues you are assessing. It is not always easy to evaluate whether the opinions of these individuals are representative of the complete group of people that you are assessing. Also, interviewing key informants requires good interviewing skills, which might not always be readily available. One important limitation of using key informant interviews in emergencies is that analysing narrative data requires substantial skill and time.

3.3.2.2 Group interviews

Group interviews (a technique used in Tool 11) are meetings in which participants (often selected because they are similar in age, gender, profession, social status and so on) are asked to answer questions. When participants are encouraged to react to each other's comments and to expand each other's answers, they are called focus group interviews.

Comment [TQ20]: 20. This refers to meetings in which participants (often selected because they are similar in age, gender, profession, social status, and so on) are asked to answer questions.
a. Group Interviews
b. Recording verbatim data
c. Bias
d. Storing data

Group interviews are a good way to identify community opinions on issues and the different views held by different sub-groups. They are also useful to reach a larger number of people at the same time and to begin to identify the local language that people use to discuss things. The group is not expected to produce a consensus, as the assessors are looking for all points of view on a topic.

One of the main risks in group interviews is that a few people in the group may dominate the discussion (for example those with higher social standing), thus obscuring the different views of group members. When conducting group interviews it is important to:

- limit the group size to 8 to 12 participants; and
- keep group members as homogeneous (similar) as possible, especially regarding age and gender, so people are more likely to have the confidence to actively take part.

Also, the facilitation of a good group interview requires training on probing and group facilitation skills. In general, two people conduct group interviews with one person asking questions and steering the discussion, while the other person takes notes.

Group interviews are generally not appropriate for questions on very sensitive topics, when people may feel uncomfortable responding honestly in the presence of others. Finally, because different groups may have different answers to questions, you need to organise at least two group interviews for each topic to make sure you hear all opinions (saturation).

3.3.2.3 Free listing

Free listing (a technique used in Tools 10 and 12) involves asking an individual (often a general community member) to provide as many answers to a single question as possible. For instance, you can ask people to list the types of problems they have or the kind of coping methods they use. You can follow free listing by asking participants to prioritise or categorise their answers. From a free list, you can choose problems (for example, mental health and psychosocial problems) for further assessment through other types of assessment methods (for example individual or group interviews). Generally, it is easier to ask participants to discuss the experiences of others (for example about general members of their community) than their own experiences, especially in group settings. Free listing is often useful at the beginning of an assessment to get an overview of the types of problems and resources in a community.

Participative ranking (Ager, Stark & Potts, 2009) is similar to free listing. Participants are asked, generally in a group format, what types of problems they feel are present in a humanitarian setting. Then, participants are asked to identify objects to represent those problems (for example, a beer glass for alcohol use, a stone for domestic violence). Then, all the objects are placed in a line in order of importance (ranking). The whole process can then be repeated for resources (for example a book for supportive teachers, a tree branch for women groups). This method may have advantages when assessing relatively abstract concepts such as mental health and psychosocial problems.

The main advantage of free listing techniques is that they are relatively quick ways of collecting information on specific issues, and they can be done with a variety of informants (for example youth, men, women, people with disabilities). Also, results are much quicker and easier to analyse and compile compared with narrative data collected through open-ended questions from key informant interviews or focus groups. The disadvantages with these methods are that they generally provide less detailed information on the context. Another disadvantage is that these techniques depend highly on the exact phrasing of the question, which increases the risk of missing out on important information. Also, when you apply these techniques in a group, respondents may bias their responses towards what the other group members may want to hear. Nonetheless, these techniques are useful in acute emergencies, because they are able to provide valuable information in a very short time span.

3.3.2.4 Deciding on the number of participants in qualitative assessments

When carrying out qualitative assessments, you would mostly collect data until 'data saturation' takes place. Data saturation has occurred when the same responses are provided repeatedly. For instance, after fourteen semi-structured interviews, the last two or three interviews might not provide any new or different answers. When using qualitative techniques, it is usually not possible to determine beforehand how many people are needed. In practice, however, planning and budgeting are difficult without an estimate of the number of interviews you are going to conduct. We have provided these estimates in the introduction to the tools.

3.3.2.5 Analysing qualitative data

When collecting qualitative data, it is generally useful to do a preliminary data analysis while the collection is ongoing (for example, at the end of each data collection session). It can help to establish preliminary ideas and tighten the data collection plan accordingly (for example, filling gaps in knowledge on specific groups of participants, or changing the type of questions). Assessment team leaders should analyse at least some data while it is collected, to monitor the quality of data collection and the nature of the data as it comes in. This may best be done through daily meetings with the assessment team or by routinely technically debriefing local interviewers as they return from interviews.

These meetings should also function to monitor the wellbeing of assessment staff working in challenging circumstances. During these meetings, general themes arising from interviews may be discussed, and the data collection plans revised accordingly.

There are a variety of ways to analyse qualitative data. These range from sophisticated, time-consuming analyses aimed at constructing theories about social phenomena to simply grouping answers together and labelling them. For humanitarian purposes, grouping answers together and labelling them is often appropriate. For example the analyst reads the text and identifies themes. They then reread all responses to categorise text that relate to the themes. Ideally this is done by two independent analysts who compare results to reduce the risk of bias.

With regard to triangulation, it may happen that data from different sources on the same subject are inconsistent. Any such inconsistencies should be reported and discussed.

Chapter 4. Translating Assessment into Action

4.1 Drafting a report with recommendations

The main goal of an assessment is to provide recommendations for action. Generally, the more precise a recommendation, the more useful it is.

Recommendations for humanitarian activities should specify:

- who you are making the recommendation to;
- the target group;
- the problem targeted;
- the suggested intervention, or how the intervention may be developed together with the target population; and
- links with relevant guidance (for example specifying an action sheet from the IASC MHPSS guidelines).

When there are a number of recommendations, you should put them in order of priority. The report should communicate that actions should be carried out following rank order of priorities.

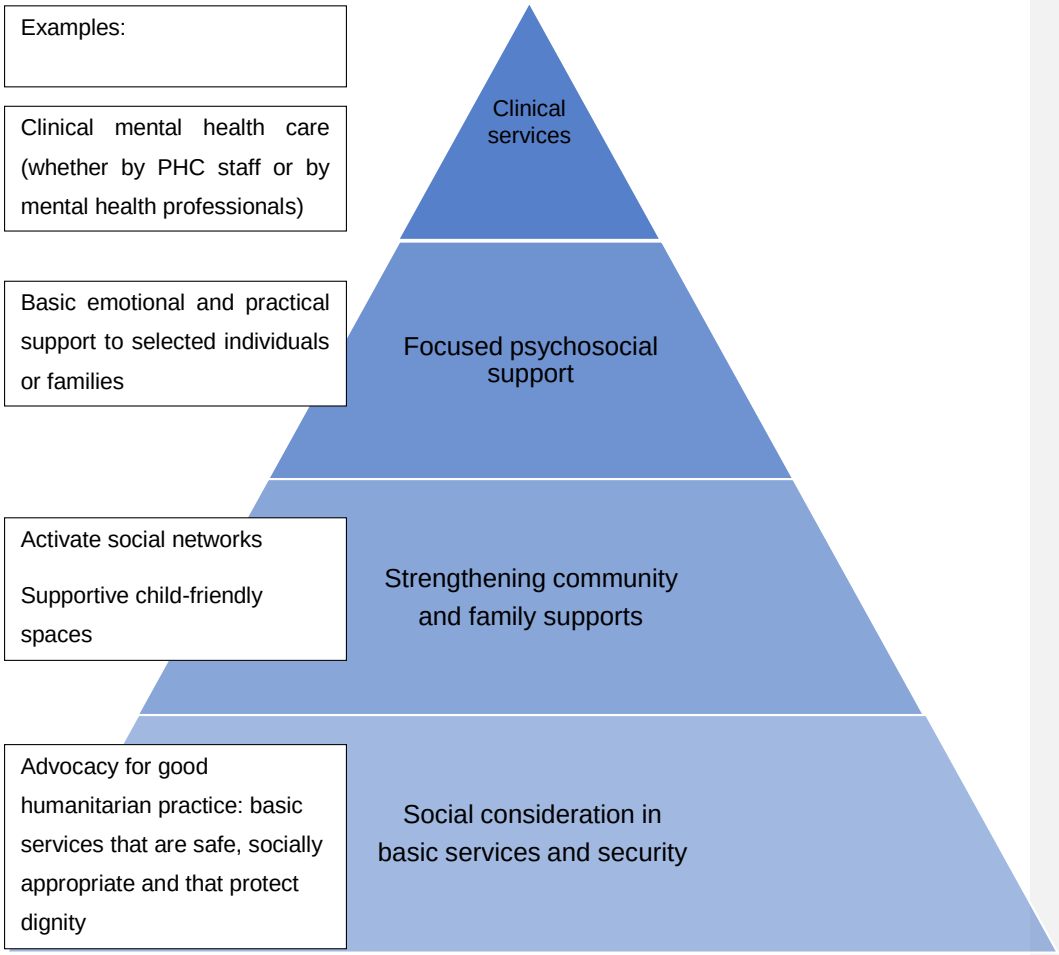
The report should be clear which recommendations are short term (that is, should be put in place immediately) and which recommendations are longer term.

As far as possible you should discuss ideas for recommendations with the target group before you put them on paper.

The IASC MHPSS guidelines recommend providing MHPSS in a multi-layered system of care. It can often be helpful to cross reference recommendations with the four layers of the IASC pyramid (for an example, see the Healthnet TPO (2009) assessment report on Afghanistan).

Figure 4.1 THE IASC PYRAMID (ADAPTED WITH PERMISSION)

Intervention pyramid



4.2 Communicating Recommendations

To make the most of any assessment, you should share recommendations with all relevant stakeholders. These include the government, the people you are targeting with the programs, and local communities, and other humanitarian and health actors. If you don't feed assessment information back to communities, you may possibly leave affected people feeling exploited. You can share recommendations with stakeholders by organising meetings to discuss the key findings. All assessment reports should include a summary in plain lay language to ensure that stakeholders can understand key findings along with the assessment's limitations and recommendations. Where possible,

you should accompany the assessment with a short power point presentation of this plain-language summary. Sharing the assessment report with relevant stakeholders is crucial to implementing humanitarian action in line with the best available information – maximising the positive impact of action while lowering the risk of unintentional harm. So, agencies should put their findings in the public domain and consider the following points.

1. Security risks. Security risks can occur when the assessment report identifies information that may put people at risk of harm. This situation is more likely to occur in assessments focusing on protection issues. For example, during interviews with key informants, participants may report information on human rights violations against their religious or ethnic group. In such situations, you should report the information to relevant trust-worthy protection bodies and you should not include it in the overall public reporting.
2. Agency competition.Agency competition for funding must not prevent dissemination of the main results and recommendations. Agencies should be able to use eachothers' assessment reports, and they should do this with proper acknowledgement of the agency that collected the information.
3. Sensitive information.An assessment may show that national or international agencies are delivering poor services and support. Whether it is appropriate to put such information in the public domain will depend on the situation. In any case, you should make all efforts to communicate the information in a constructive manner to the relevant agency. You should put all other findings of the assessment in the overall MHPSS needs assessment report which should go in the public domain.
4. Academic publication.Academic journals occasionally do not allow the publication of assessment reports that have already been disseminated widely (for example by posting on a website). However, this is not an acceptable reason to postpone disseminating at least a plain-language version of the report with the main results and recommendations.

Tool 1:WHO IS WHERE, WHEN, DOING WHAT (4WS) IN MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT: SUMMARY OF MANUAL WITH ACTIVITY CODES

Why use this tool: For coordination, through mapping what mental health and psychosocial supports are available
Method: Interviews with agency programme managers
Time needed: Depending on the scale of the crisis, approximately two weeks initially (needs regular updating)
Human resources needed: Two people

Background

- A Who is Where, When, doing What (4Ws) tool for MHPSS is useful for the following:

  (a) Providing a big picture of the size and nature of the response.

  (b) Identifying gaps in the response to enable coordinated action.

  (c) Enabling referral by making information available about who is where doing what.

  (d) Informing appeal processes (for example, the Consolidated Appeal Process, CAP). (e) Improving transparency and legitimacy of MHPSS through structured documentation. (f) Improving possibilities for reviewing patterns of practice and for drawing lessons for future response.

- This 4Ws tool is a software-based data system to map MHPSS activities in humanitarian settings across sectors.
- In many situations it may not be feasible for individuals to successfully collect the data. Collecting data from different agencies requires leverage and is best done by agencies (government, UN or NGOs) with coordination responsibilities.
- Data is collected through an Excel spreadsheet. The file needs to be completed by each organisation participating in the 4W exercise. The items to be completed for this sheet can be found in Table 1. This sheet refers to MHPSS activity codes displayed in Table 2.

- The relationship between the activity codes in Table 2 and the Action Sheets and Pyramid of the IASC Guidelines is described in an annex of the manual that comes with the 4Ws tool.
- You should read the whole manual carefully before using the tool. The manual describes suggested steps to implement the 4Ws tool for MHPSS including:

  (a) translating and adapting the 4Ws data collection spreadsheet for the local context;

  (b) contacting the government or the UN coordinating agency to obtain standard spelling and codes of geographical areas, specifying the boundaries of geographical areas;

  (c) deciding on the scope and strategy for data collection;

  (d) approaching agencies, collecting data and reviewing collected data;

  (e) reviewing collected data for major inconsistencies or errors, cleaning-up and merging data;

  (f) analysing data and preparing and disseminating a report on the results;

  (g) discussing identified gaps with stakeholders and deciding on improved programming; and

  (h) updating the data and reports.

- As mentioned, this 4Ws tool maps MHPSS across sectors. However, if you are interested only in mapping MHPSS within a specific sector, you should use a 4Ws tool that is sector specific. The 4Ws tool of the global health cluster is the IASC Global Health Cluster's (2009) Health Resources Availability Mapping (HeRAMS) system.

  (a) HeRAMS should be implemented by or under the health sector leadership (for example Ministry of Health, Health Cluster).

  (b) HeRAMS provides a health services checklist by level of care, by health sub-sectors, and for health facility/mobile clinic/community-based interventions at each point of delivery. There are specific mental health

checklist items under the community care, primary care and secondary and tertiary care levels.

(c) People who organize mental health assessments are usually not in the position to initiate HeRAMS. However, wherever HeRAMS is implemented, they should ensure that mental health services are recorded in HeRAMS, and use HeRAMS as a key source of relevant mental health services information.

Assessment Tools

TABLE 1 OF TOOL 1: ITEMS TO BE COMPLETED IN THE SECOND SHEET OF THE 4WS DATA COLLECTION SPREADSHEET
A. Date of providing or updating this information
B. Name of implementing agency
C. Name(s) of other organization(s) with whom this activity is done (in case of a joint activity)
D. Name of the focal point
E. Phone number of the focal point
F. Email address of the focal point
G. Region / district where the activity occurs
H. Town/ neighbourhood where the activity occurs
I. Government/ OCHA geographical code for the location
J. MHPSS activity code
K. MHPSS activity subcode
L. Description of the activity in one sentence (for subcode “Other” or for any other activity that is not clearly described by the subcode)
M. Target group(s) (specify age group(s) where relevant)
N. Number of people in target group directly supported in previous 30 days
O. This activity is (1) currently being implemented, (2) funded but not yet implemented, or (3) unfunded and not yet implemented
P. Start date for implementing the activity (for current activities, provide actual start date and not the originally proposed start date)
Q. End date (specify on what date committed funding to implement the activity ends)
Optional (The following 5 optional items give a better understanding of possible quality and volume of the services available but: may be too detailed for the first weeks or months of an acute major crisis.)
R. Number and type of MHPSS workers who do this activity (e.g., 4 community volunteers, 1 psychologist and 1 nurse)
S. Topic and length of non-university training on MHPSS (e.g. nurses received 1 day on psychological first aid)
T. (if applicable) Availability of the activity (e.g. child friendly space or clinic is open 40 hours/week)
U. Where is MHPSS provided? (people’s homes, clinic, public spaces etc.)
V. Do people have to pay to use these services/supports?

TABLE 2 OF TOOL 1. MHPSS ACTIVITY CODES AND SUBCODES		
• Read this first! • MHPSS stands for mental health and psychosocial support. • The list includes the most common activities that are conducted under the heading of MHPSS in large humanitarian crises. • The list is not exhaustive. You should use the category 'other (describe in column C of the data entry sheet)' to document activities not included in the list. • The list is descriptive rather than prescriptive. No judgement is passed whether included activities are appropriate or not. A number of the mentioned activities are or can be controversial. For guidance on recommended practices, see IASC (2007). • INSTRUCTION: FILL IN THE RELEVANT MHPSS ACTIVITY CODE (SEE COLUMN A BELOW) AND SUBCODE (SEE COLUMN B BELOW) IN COLUMNS A AND B OF THE DATA ENTRY SHEET. IF ONE WORKS BROADLY IN AN AREA, THEN CHOOSE THE SUBCODE 'OTHER'.		
	Column A: MHPSS activity code (4Ws)	**Column B: Examples of Interventions with subcodes. Record all that apply.**
Community-focused (targeted at communities or segments of	1. Disseminating information to the community at large.	1.1 Information on the current situation, relief efforts or available services in general 1.2 Raising awareness on mental health and psychosocial support (e.g., messages on positive coping or on available mental health services and psychosocial supports) 1.3 Other (describe in Column C of the data entry sheet)
	2. Facilitating conditions for community mobilisation, community organisation, community ownership or community control over emergency relief in general	2.1 Support for emergency relief that is initiated by the community 2.2 Support for communal spaces/meetings to discuss, problem-solve and plan action by members to respond to the emergency 2.3 Other (describe in Column C of the data entry sheet)
	3. Strengthening community and family support	3.1 Support for social support activities that are initiated by the community 3.2 Strengthening parenting/family supports 3.3 Facilitation of community supports to vulnerable people 3.4 Structured social activities (e.g. group activities) 3.5 Structured recreational or creative activities (do not include activities at child-friendly covered in 4.1) 3.6 Early childhood development (ECD) activities 3.7 Facilitation of conditions for indigenous traditional, spiritual or religious supports, including communal healing practices

		3.8 Other (describe in Column C of the data entry sheet)
	4. Safe spaces	4.1 Child-friendly spaces 4.2 Other (describe in Column of the data entry sheet)
	5. Psychosocial support in education.	5.1 Psychosocial support to teachers/ other personnel at schools/learning places 5.2 Psychosocial support to classes/groups of children at schools/learning places 5.3 Other (describe in Column C of the data entry sheet)
	6. Supporting including social/psychosocial considerations in protection, health services, nutrition, food aid, shelter, site, planning or water and sanitation	6.1 Orientation of or advocacy with aid workers/agencies on including social/ psychosocial considerations in programming (specify sector in column C of the data entry sheet) 6.2 Other (describe in column C of the data entry sheet)
Person-focused (targeted at identified people	7. (Person-focused) psychosocial work	7.1 Psychosocial first aid (PFA) 7.2 Linking vulnerable individuals/families to resources (e.g. health services, live like community resources etc.) and following up to see if support is provided. 7.3 Other (describe in Column C of the data entry sheet)
	8. Psychosocial intervention	8.1 Basic counselling for individuals (specific type in Column C of the data entry sheet) 8.2 Basic counselling for groups or families (specific type in Column C of the data entry sheet) 8.3 Interventions for alcohol/substance use problems (specific type in Column C of the data entry sheet) 8.4 Psychotherapy (specific type in Column C of the data entry sheet) 8.5 Individual or group psychological debriefing 8.6 Other (describe in Column C of the data entry sheet)
	9. Clinical management of mental disorders by nonspecialized health care providers (e.g. PHC, post-surgery wards)	9.1 Non-pharmacological management of mental disorder by nonspecialized health care providers (where possible specify type of support using categories 7 and 8) 9.2 Pharmacological management of mental disorder by nonspecialized health care providers 9.3 Action by community workers to identify and refer people with mental disorders and to follow-up on them to make sure adherence to clinical treatment 9.4 Other (describe in column C of the data entry sheet)

	10. Clinical management of mental disorders by specialized mental health care providers (e.g. psychiatrists, psychiatric nurses and psychologists working at PHC/general health facilities/mental health facilities)	10.1 Non-pharmacological management of mental disorder by specialized mental health care providers (where possible specify type of support using categories 7 and 8) 10.2 Pharmacological management of mental disorder by specialized health care 10.3 Inpatient mental health care 10.4 Other (describe in column C of the data entry sheet)
General	11. General activities to support MHPSS	11.1 Situation analyses/assessment 11.2 Monitoring/evaluation 11.3 Training / orienting (specify topic in column C of the data entry sheet) 11.4 Technical or clinical supervision 11.5 Psychosocial support for aid workers (describe type in column C of the data entry sheet) 11.6 Research 11.7 Other (describe in column C of the data entry sheet)

TOOL 2WHO-UNHCR ASSESSMENT SCHEDULE OF SERIOUS SYMPTOMS IN HUMANITARIAN SETTINGS (WASSS) (FIELD-TEST VERSION)
Why use this tool: For advocacy, by showing the prevalence of mental health problems in the community

Method: Part of a community household survey (representative sample)
Time needed: Two to three minutes for each interview covering part A of this tool, and five minutes for each interview covering part B
Human resources needed: interviewers, one analyst/report-writer

Background

Health surveys and surveillance in humanitarian crisis settings offer the opportunity to assess how common mental health problems are in the affected population. This short tool contains mental health questions that you could consider adding to general health surveys and surveillance in humanitarian crises. The tool is meant to be applied by humanitarian health actors and can be administered by lay interviewers without specific mental health expertise.

The purpose of this tool is to identify persons in priority need of mental health care. So, the selected questions are meant to identify people with symptoms of severe distress and impaired functioning. It is useful to identify these people:

- to describe to public health decision-makers the extent to which specific mental health problems are an issue (advocacy); and
- to potentially inform community mental health services whether an interviewee potentially has a mental disorder (screening).

The tool does not assess rates of mental disorders. Both mental disorders and transient (temporary) stress reactions are more likely to occur in humanitarian settings compared to settings not affected by crisis. Using interviews conducted by laypeople to distinguish between disorders and severe distress which is not a disorder is difficult in humanitarian settings (for example, interviews carried out by laypeople are unlikely to be able to distinguish between severe, normal grief and a depressive disorder in a recently bereaved person). So, tools used by laypeople (for example, the Self Report Questionnaire, WHO, 1994) can confuse and confound signs of normal distress and mental disorder in humanitarian settings (Bolton & Betancourt, 2004; IASC, 2007; Horwitz, 2007, Rodin & van Ommeren, 2009). This tool aims to side-step this challenge by measuring and reporting symptoms and impaired functioning - without giving a

specific diagnosis. Although many decision-makers and community mental health programs would prefer to have data on rates of (probable) mental disorders, data on rates of diverse symptoms of severe distress and functioning are less likely to be disputed and still offer useful descriptive information.

Overview

This tool is designed to be used with interviewees 18 years or older living in humanitarian settings. It is also designed to be used at least two weeks after the onset of a crisis.

The tool consists of two independent parts. Part A covers severe, common distress symptoms and impaired functioning in the respondent. Part B includes a broader range of symptoms - including symptoms of psychosis as well as epilepsy - in household members of the respondent. Note that the questions in Part B tend to measure more severe functional impairment than questions in Part A.

Analysis and reporting

As mentioned above, the questions in this tool assess the existence of symptoms of mental distress and functional impairment. Accordingly, you should report on symptoms and not levels of disorders. The easiest way to do this is by reporting percentages of people who responded above a pre-specified threshold on each of the questions. All people that answer ‘some of the time’, ‘most of the time’, and ‘all of the time’ may be grouped into a ‘positive (1)’ category and other responses as a ‘negative (0)’ category:

The resulting report would state that:

- X1% of respondents felt so afraid that nothing could calm them down most or all of the time in the last 2 weeks.
- X2% of respondents felt so angry that they felt out of control most or all of the time in the last 2 weeks.
- X3% of respondents felt so uninterested in things that they used to like that they did not want to do anything at all most or all of the time in the last 2 weeks.

- X4% of respondents felt so hopeless that they did not want to carry on living most or all of the time in the last 2 weeks.
- X5% of respondents felt so severely upset about the emergency/disaster/war or another event in their life, that they tried to avoid places, people, conversations or activities that reminded them of such event most or all of the time in the last 2 weeks.
- X6% of respondents felt unable to carry out essential activities for daily living because of feelings of fear, anger, fatigue, disinterest, hopelessness or upset most or all of the time in the last 2 weeks.

Source of questions

The phrasing of questions (for example, 'you feel so [emotion] that [consequence]') was inspired by the phrasing of some of the WHO World Mental Health Survey's subset of K6 questions (Kessler et al, 2002)10. This phrasing is helpful to ensure that the assessment focusses on relatively severe symptoms of distress.

The content of most questions in Part B was inspired by work on indicators of social risk in people with severe mental disorders in Timor Leste (Silove et al, 2004).

Administration

The average interview time for Part A (six questions) is estimated at two to three minutes. The average time for Part B (assuming an average household of five individuals) is estimated at five minutes.

Before using the tool, the interviewer should be trained in general interviewing techniques that are relevant to surveys in humanitarian settings, for example, how to behave ethically and how to probe and avoid introducing bias.

You should use your voice to emphasize all words highlighted in bold in the questions.

'IF NEC' means 'if necessary'. You should prompt the respondent with the response categories, using the truncated wording when specified, until the respondent has learned them well enough to respond without prompting.

'IF VOL' means 'if volunteered'. You should not read these responses out. If the respondent volunteers one of the specified responses, you should record it without additional probing.

Distress during the interview

Thinking about violent or other horrific events can cause people to become distressed. You should not ask details about these events. This is a fully structured tool and specifically designed not to ask for details. If the interviewee wants to talk about these events, you should allow them to do so to some extent, but do not ask them for more details. You should be patient and show that you are listening.

The interviewee may stop the interview at any time. If they ask to stop the interview, you should do this. The person does not need to give a reason for wanting to stop the interview. It is alright to continue with the interview if the person is a little upset and agrees to gently continue with the interview. However, if the person is getting very upset by a topic, you should close the interview booklet and be silent until he or she calms down. You could then say: "You seem very upset. Are you okay to continue the interview or would you prefer to stop?" At the end of the interview, the interviewee should be referred to the best available mental health and psychosocial support worker and you should inform your assessment team leader. Before a first interview you should receive a list of support organisations that you can give to interviewees.

PART A	**QUESTIONS TO AND ABOUT THE RESPONDENT. IT IS ASSUMED THAT ESSENTIAL INFORMATION ABOUT THE PERSON (FOR EXAMPLE, SEX, AGE AND SO ON) ARE ESTABLISHED EARLIER IN THE INTERVIEW**

A1. The next questions are about how **you** have been feeling during the **last two weeks**. About how often during the last two weeks did you feel **so afraid that nothing could calm you down** — would you say **all** of the time, **most** of the time, **some** of the time, **a little** of the time, or **none** of the time?

1. □ All of the time 2. □ Most of the time
3. □ All of the time 4. □A little of the time 5. □None of the time
8. □(IF VOL) Don't know 9. □(IF VOL) Refused

A2. About how often during the last two weeks did you feel **so angry that you felt out of control** — would you say **all** of the time, **most** of the time, **some** of the time, **a little** of the time, or **none** of the time?

1. □ All of the time 2. □ Most of the time
3. □ All of the time 4. □A little of the time 5. □None of the time
8. □(IF VOL) Don't know 9. □(IF VOL) Refused

A3. During the last two weeks, about how often did you feel **so uninterested in things that you used to like, that you did not want to do anything at all?** (IF NEC: **all** of the time, **most** of the time, **some** of the time, a **little** of the time, or **none** of the time?)

1. □ All of the time 2. □ Most of the time
3. □ All of the time 4. □A little of the time

5. □None of the time
8. □(IF VOL) Don't know 9. □(IF VOL) Refused

A4. During the last two weeks, about how often did you feel **so hopeless that you did not want to carry on living?** (IF NEC: **all** of the time, **most** of the time, **some** of the time, **a little** of the time, or **none** of the time?)

1. □ All of the time 2. □ Most of the time
3. □ All of the time 4. □A little of the time 5. □None of the time
8. □(IF VOL) Don't know 9. □(IF VOL) Refused

A5. You may have experienced one or more events that have been intensely upsetting to you, such as the recent emergency/disaster/war.12 During the last two weeks, about how often did you feel **so severely upset about the emergency/disaster/war or another event in your life, that you tried to avoid places, people, conversations or activities that reminded you of such event?** (IF NEC: **all** of the time, **most** of the time, **some** of the time, **a little** of the time, or **none** of the time?)

1. □ All of the time 2. □ Most of the time
3. □ All of the time 4. □A little of the time 5. □None of the time
8. □(IF VOL) Don't know 9. □(IF VOL) Refused

A6. The next question is about how these feelings of fear, anger, fatigue, disinterest, hopelessness or upset may have affected you during the last two weeks. During the last two weeks, about how often were you **unable to carry out essential activities for daily living because of these feelings?** (IF NEC: **all** of the time, **most** of the time, **some** of the time, a **little** of the time, or **none** of the time?)

1. □ All of the time 2. □ Most of the time
3. □ All of the time 4. □A little of the time 5. □None of the time
8. □(IF VOL) Don't know 9. □(IF VOL) Refused

PART B: (HOUSEHOLD ROSTER QUESTIONS): ONE FORM FOR EACH HOUSEHOLD											
	BoA	**BoB**	**B1**	**B2**	**B3**	**B4**	**B5**	**B6A**	**B6B**	**B7A**	**B7B**
			ASK THESE QUESTIONS ABOUT ALL HOUSEHOLD MEMBERS OLDER THAN 2 YEARS O					**ASK THESE QUESTIONS ABOUT ALL CHILD HOUSEHOLD MEMBERS BETWEEN 2 AND 12 YEARS O**		**ASK THESE QUESTIONS ABOUT ALL ADOLESCENT/ADULT HOUSEHOLD MEMBERS OLDER THEN 12 YEARS O**	
						Only ask this question if the response was yes to B3	Only ask this question if the response was yes to B3		Only ask this question if the response was yes to B6A		Only ask this question if the response was yes to B7A
Who else lives in your house hold right now? (only ask questions B1-B7 about house hold members older than 2)	**Age**	**Sex**	During the last 2 weeks, was s/he so distressed/ disturbed/ upset that s/he was **completely inactive or almost completely inactive, because of** any such feelings?	During the last 2 weeks, for how many days was s/he so distressed/ disturbed/ upset that s/ he was unable **to carry out essential activities** for daily living, **because** of any such feelings?	Is s/he acting in strange way or having fits/ convulsions / seizures?	Could you **describe** in a few words the **fits/ convulsions /seizures or the behaviour** that seems strange to you?	**When** did the strange behaviour start? **(Comment:** If date unknown, ask whether the behaviour started or increased after the recent emergency)	During the last 2 weeks, did s/he **urinate** at least two times in his/ her bed **during sleep?**	Did s/he have this problem one year ago?	During the last 2 weeks, did s/he **stop caring properly for his/her self** because s/ he is feeling distressed/ disturbed / upset?	During the last 2 weeks, did s/he **stop caring properly for children** s/he is responsible, because s/ he is feeling distressed/ disturbed/ upset?
1 = parent 2 = sibling 3 = child 4 = other relative 5 = non-relative	98= don't know 99=refused	1 = male 2 = female	1 = no 2 = yes 8 = don't know 9= refused	98= don't know 99= refused	1 = no 2 = yes 8= don't know 9= refused			1 = no 2 = yes 7 = not applicable 8= don't know 9= refused	1 = no 2 = yes 7 = not applicable 8= don't know 9= refused	1 = no 2 = yes 7 = not applicable 8= don't know 9= refused	1 = no 2 = yes 7 = not applicable 8= don't know 9= refused
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
etc											

TOOL 3: THE HUMANITARIAN EMERGENCY SETTINGS PERCEIVED NEEDS SCALE (HESPER)
Why use this instrument: For informing response, through collecting data on the frequency of physical, social, and psychological perceived needs in the community **Method:** Community household survey (representative sample) (early in emergencies you can also adapt this method in convenience samples with key informants) **Time needed:** 15 to 30 minutes for each interview **Human resources:** A HESPER community household survey needs one team leader, between four and eight interviewers and one interviewer supervisor

The HESPER scale provides a quick, scientifically robust way of assessing the **perceived serious needs**of people affected by large-scale humanitarian emergencies (Semrau et al, 2012). Perceived needs are needs which are felt or expressed by people themselves and are problem areas with which they would like help.

The scale assesses a wide range of social, psychological and physical problem areas. It helps quickly identify those broad problem areas with which the population is likely to want help. It needs to be followed by in-depth assessments to understand the expressed needs, and to decide what exact interventions and supports would be helpful. It is possible to disaggregate the results and provide population profiles according to gender, age groups, ethnicity, or other relevant subgroups. The scale focuses on needs as perceived by the adult population.

Perceived needs are assessed on the HESPER scale across 26 needs, which each include a short heading, as well as an accompanying question. Examples of needs include ‘Place to live in’ (“Do you have a serious problem because you do not have an adequate place to live in?”), ‘Education for your children’ (“Do you have a serious problem because your children are not in school, or are not getting a good enough education?”), and ‘Mental illness in your community’ (“Is there a serious problem in your community because people have a mental illness?”). Ratings are then made for each need according to whether:

- it is not being met (that is, it is a serious problem, as perceived by the respondent);
- it is not considered a need (that is, it is not a serious problem, as perceived by the respondent); or
- the respondent didn't answer (that is, declined, not known, or not applicable).

Respondents are also asked to name any unlisted additional needs that are not being met. Among needs that have been rated as unmet, respondents are asked to rank their three most serious problems.

Although the HESPER scale was developed for use in representative samples, you may also use it in convenience samples. This may be appropriate during the first few days or weeks of a large sudden onset crisis, when representative sampling may not be possible. You can use the scale in acute or chronic humanitarian settings, urban or rural settings, and in camps or communities.

The tool, together with an accompanying operations and training manual, is available at http://whqlibdoc.who.int/publications/2011/9789241548236_eng.pdf

TOOL 4: CHECKLIST FOR SITE VISITS AT INSTITUTIONS IN HUMANITARIAN SETTINGS
Why use this tool: For protection and care for people with mental or neurological disabilities in institutions **Method**: Site visit, interviews with staff and patients **Time needed**: Two hours (for initial impression) and two to three days (for a complete checklist) **Human resources needed:** Two people

Background

People with severe mental disorders and other mental and neurological disabilities (including those related to alcohol and other substance use) are at high risk of neglect in humanitarian settings, especially when they live in mental hospitals, social care homes or other institutions. This checklist is useful to collect information to plan humanitarian response to protect and provide basic care for people in institutions.

Your answers to the questions in this tool should be based on a walkabout around the institution and conversations with staff and, where feasible, residents themselves. To minimise bias, it is recommended that the assessment is carried out by two people who should have a different professional background.

When there are only a few hours available for assessing institutions (for example, this situation may arise during the first two weeks of a large sudden-onset emergency) the focus of assessment should be on:

(a) protection issues;

(b) basic survival needs; and

(c) (where relevant) the possibility of evacuation.

The checklist requires you to suggest recommended actions. It is essential that you indicate a time frame for these actions to ensure that the most urgent actions will be implemented first.

Notes

- The term ‘resident’ is used in the checklist to refer to people living in institutions.
- The QualityRights Tool (WHO, 2012) is the appropriate tool to be used in mental health facilities and social care homes in non-emergency, developmental settings. You should consider using this tool in chronic humanitarian emergencies whenever time and resources are available for an in-depth assessment.

General Information			
Name of Institution:		**Activities during visit:**	
Geographical Location:			
Interviewer:			
Date and time of visit:			
Length visit:			
Brief description of Institution (number of beds, general physical condition)			

1. STAFF AND RESIDENTS		
1.1 Number of staff who survived the disaster	Psychiatrists:	
	Doctors:	
	Nurses:	
	Psychologists:	
	Social workers:	
	Other staff:	
1.2 Number of staff who died due to crisis		
1.3 Number of staff who are (still) physically injured due to the crisis		
1.4 Number of staff not attending work during the previous week due to the crisis (for example, because of personal/ family needs)		
1.5 Number of residents who survived the crisis.	Total	
	Males:	
	Females:	
	Adult (18 to 65)	
	Elderly (over 65)	
	Adolescents (13 to 17)	
	Children (0 to 12)	
1.6 Number of residents who died due to the crisis		

1.7 Number of residents who are (still) physically injured due to the crisis		
1.8 Number of residents who have left the institution due to the crisis (for example they may have fled or been suddenly discharged)		
1.9 Number of residents with intellectual disabilities		

2. BASIC PHYSICAL NEEDS	
2.1 Are water and sanitation facilities adequate? (For example, is there access to clean drinking water, water points and soap)	Action needed: Yes □ No □ Not applicable/Don't know □ Resident views/ other comments:
2.2 Is hygiene and personal care adequate (including hygiene facilities and access to personal care items)	Action needed: Yes □ No □ Not applicable/Don't know □ Resident views/ other comments:
2.3 Are food and nutrition adequate? (For example, do residents receive 2 to 3 meals a day that contain adequate nutritional value?)	Action needed: Yes □ No □ Not applicable/Don't know □ Resident views/ other comments:
2.4 Are the residents' living and sleeping quarters adequate? (For example, are there enough mattresses, blankets, adequate shelter to protect from weather (heat/cold, rain, wind) and are their quarters clean enough?)	Action needed: Yes □ No □ Not applicable/Don't know □ Resident views/ other comments:
2.5 Is physical disease addressed? (Is physical health monitored and is there access to medical care and vaccinations?)	Action needed: Yes □ No □ Not applicable/Don't know □ Resident views/ other comments:
2.6 Are physical disability problems addressed? (For example, are facilities accessible and adequate social services	Action needed: Yes □ No □ Not applicable/Don't know □ Resident views/ other comments:

available to people with disabilities, and is there help and support from staff when needed such as when using bathroom facilities?)	

3. MENTAL HEALTH CARE	
3.1 Is each resident's mental health status regularly monitored?	Action needed: Yes □ No □ Not applicable/Don't know □
	Resident views/ other comments:
3.2 Are essential psychotropic medications available?	Action needed: Yes □ No □ Not applicable/Don't know □
	Resident views/ other comments:
3.3 Are non-pharmacological methods of care (psychosocial rehabilitation, occupational therapy and so on) used?	Action needed: Yes □ No □ Not applicable/Don't know □
	Resident views/ other comments:
3.4 What is current staff-resident ratio on the ward?	Action needed: Yes □ No □ Not applicable/Don't know □
	Resident views/ other comments:
3.5 Do residents have individual treatment files? (For example, files containing case notes which are kept confidentially?)	Action needed: Yes □ No □ Not applicable/Don't know □
	Resident views/ other comments:

4. PROTECTION ISSUES	
4.1 Do children receive care and protection? (For example, safe places to sleep and play, nutrition, stimulation and education?	Action needed: Yes □ No □ Not applicable/Don't know □
	Resident views/ other comments:

4.2 Are male and female residents housed separately? (For example, do they have separate quarters for sleeping, and separate latrines/toilets and washing facilities?)	Action needed: Yes □ No □ Not applicable/Don't know □
	Resident views/ other comments:
4.3 A re there any reports of, or have you witnessed, physical abuse such as beatings as a means of control?	Action needed: Yes □ No □ Not applicable/Don't know □
	Resident views/ other comments:
4.4 Are there any reports of sexual abuse?	Action needed: Yes □ No □ Not applicable/Don't know □
	Resident views/ other comments:
4.5 Are there any reports of, or have you witnessed, verbal abuse?	Action needed: Yes □ No □ Not applicable/Don't know □
	Resident views/ other comments:
4.6 Are any residents physically restrained?	Action needed: Yes □ No □ Not applicable/Don't know □
	Resident views/ other comments:
4.7 Are any residents locked up?	Action needed: Yes □ No □ Not applicable/Don't know □
	Resident views/ other comments:
4.8 Are residents neglected?	Action needed: Yes □ No □ Not applicable/Don't know □
	Resident views/ other comments:

5. EVACUATION	
5.1 Do evacuation plans exist?	Action needed: Yes □ No □ Not applicable/Don't know □
	Resident views/ other comments:
5.2 Are staff trained in carrying	Action needed: Yes □ No □ Not applicable/Don't know □

out evacuation plans?	Resident views/ other comments:

6. IMPACT OF CRISIS
Observations on impact of crisis:

7. RECOMMENDED ACTIONS	BY DATE:	BY WHOM:
7.1		
7.2		
7.3		
7.4		
7.5		
7.6		
7.7		
7.8		
7.9		
7.10		

Tool 5 CHECKLIST FOR INTEGRATING MENTAL HEALTH IN PRIMARY HEALTH CARE (PHC) IN HUMANITARIAN SETTINGS1
Why use this tool: For planning a mental health response in PHC **Method**: Site visit, interviews with PHC programme managers and staff **Time needed**: One hour for each facility **Human resources needed**: One interviewer

Background

Through an interview with clinic managers and staff (key informants), you assess to what extent important psychological and social considerations are and can be addressed in primary health care clinics.

You should integrate assessments of these indicators in general PHC assessments, where possible.

This tool focuses on PHC but it also applies to other general health care settings. The tool focuses on mental disorders but also covers epilepsy, a neurological condition.

For more extensive PHC checklists, please see:

- the International Medical Corps PHC Mental Health Integration Checklist (in preparation); and
- the WHO mhGAP situation analysis checklist (in preparation).

In the tool DK stands for Don't Know; NA stands for Not Applicable

Name/description of facility:	
Size of catchment area:	
Date:	
Interviewer:	
Visit Duration:	
Key informant 1: name, position, and phone	

number/email:	
Key informant 1: name, position, and phone number/email:	
Key informant 1: name, position, and phone number/email:	

1. HEALTH INFORMATION SYSTEMS INDICATORS	
1.1 Mental disorders are documented in the weekly morbidity report	Yes □ No □ DK □ NA □ Comment:
1.2 According to the health information system, in the last two weeks at this clinic, how many people were seen with the following conditions?	
1.2.1 depression	_____ DK/NA □ Comment:
1.2.2 epilepsy	_____ DK/NA □ Comment:
1.2.3 psychosis	_____ DK/NA □ Comment:
1.2.4 other mental health problem	_____ DK/NA □ Comment:

2. WORKER COMPETENCY INDICATORS	
2.1 Knowledge of available resources	
2.1.1 Health staff know the referral options to the mental health system. (For example, staff know the location, approximate costsand referral procedures for nearby mental health services.)	Yes □ No □ DK/NA □ Comment:
2.1.2 Health staff know available supports (for example, protection agencies/ networks, community/social	Yes □ No □ DK/NA □

services, community support systems, legal services) offering protection and/or social support for social problems such as domestic violence and rape.	Comment:
2.2 Within the last two years health staff have received training in:	
2.2.1 communication skills (for example, active listening, respectful attitude)	Yes □ No □ DK/NA □ Comment:
2.2.2 a basic problem-solving, counselling approach	Yes □ No □ DK/NA □ Comment:
2.2.3 offering basic support to people who are bereaved	Yes □ No □ DK/NA □ Comment:
2.2.4. offering psychological first aid (that is, basic psychological and social support for people recently exposed to potentially traumatic events)	Yes □ No □ DK/NA □ Comment:
2.3 At least one health care provider at each clinic is competent in identifying and clinically managing:	
2.3.1 depression	Yes □ No □ DK/NA □ Comment:
2.3.2 psychosis	Yes □ No □ DK/NA □ Comment:
2.3.3 epilepsy	Yes □ No □ DK/NA □ Comment:
2.3.4 developmental and behavioral disorders in children and adolescents	Yes □ No □ DK/NA □ Comment:
2.3.5 problems with alcohol use	Yes □ No □ DK/NA □ Comment:

2.3.6 problems with drug use	Yes □ No □ DK/NA □ Comment:
2.3.7 post-traumatic stress disorder	Yes □ No □ DK/NA □ Comment:
2.3.8 acute trauma-induced anxiety that is so severe that it limits basic functioning	Yes □ No □ DK/NA □ Comment:
2.3.9 self-harm/ suicide	Yes □ No □ DK/NA □ Comment:
2.3.10 medically unexplained somatic complaints	Yes □ No □ DK/NA □ Comment:
2.4 Specify what mental health training and clinical supervisions has been received by health staff in the last two years	
General physicians: Nurses: Other staff:	
2.5 What type of clinical supervision arrangements could practically be organised?	

3 PSYCHOTROPIC DRUGS		
Medicines	**Availability in the PHC clinic or nearby pharmacy in the previous two weeks**	**Specific types available (**examples)
3.1 Generic antidepressant medication	□ Always □ Sometimes □ Never	(amitriptyline, fluoxetine)
3.2 Generic anti-anxiety medication	□ Always □ Sometimes □ Never	(diazepam)
3.3 Generic anti-psychotic medication	□ Always □ Sometimes □ Never	(haloperidol, chlorpromazine, fluphenazine)

3.4 Generic anti-epileptic medication	□ Always □ Sometimes □ Never	(phenobarbital carbamazepine, diazepam inj, lorazepam inj, phenytoin, valproic acid)
3.5 Generic antiparkinsonian medicine for the management of side effects from antipsychotic medication.	□ Always □ Sometimes □ Never	(biperiden)

4. REFERRAL INDICATORS	
4.1 In the last two weeks PHC clinic received mental-health related referrals from:	
4.1.1 Mental health specialist care (secondary, tertiary, or private care)	□ Frequently □ Sometimes □ Never
4.1.2 Community health workers, other community workers, schools, social services and other community social supports, traditional/religious healers	□ Frequently □ Sometimes □ Never
4.2 In the last two weeks PHC clinic referred mental-health related referrals to:	
4.2.1 Mental health specialist care (secondary. Tertiary, or private care)	□ Frequently □ Sometimes □ Never
4.2.2. Community health workers, other community workers, schools, social services, and other community social supports, traditional/religious healers	□ Frequently □ Sometimes □ Never

5. STAFF AND THEIR WORKLOAD	
5.1 Approximate number of general physicians working at any given time in the clinic.	_____ DK/NA □ Comment:
5.2 Approximate number of general nurses working at any given time in the clinic	_____ DK/NA □ Comment:
5.3 Approximate number of other clinical staff (for example, health officers at any given time in the clinic	_____ DK/NA □ Comment:
5.4 Approximate number of patients (with any type of health problem) in the previous week in the clinic	_____ DK/NA □ Comment:
5.5 Approximate number of patients (with any type of health problem) seen by general physicians every hour	_____ DK/NA □ Comment:
5.6 Approximate number of patients (with any type of health problem) seen by general nurses every hour	_____ DK/NA □ Comment:
5.7 Approximate number of community health workers in the catchment area	_____ DK/NA □ Comment:

6. WHAT IS THE IMPACT OF THE EMERGENCY/HUMANITARIAN SITUATION ON THE FOLLOWING?	
6.1 Number of staff working at any given time at the facility	
6.2 Availability of psychotropic medicines	
6.3 Number of people seeking help for any health problem	
6.4 Number of people seeking help for any mental health problem	

7. SOCIAL INDICATORS	
7.1 Health care facility is in safe walking distance of affected community.	Yes □ No □ DK/NA □ Comment:
7.2 Further distance travelled by patients to access the health facility (in km)	
7.3 The clinic has at least one female health care provider	Yes □ No □ DK/NA □ Comment:
7.4 Each of the local languages is spoken by at least one clinic staff member	Yes □ No □ DK/NA □ Comment:
7.5 Procedures are in place to ensure that patients give consent before major medical procedures	Yes □ No □ DK/NA □ Comment:
7.6 Health care provision in organized in a way that respects privacy (for example, a curtain around consultancy area)	Yes □ No □ DK/NA □ Comment:
7.7 Information about the health status of people and potentially related life events (for example rape, torture) is treated confidentially	Yes □ No □ DK/NA □ Comment:
7.8 PHC care is affordable for all patients	Yes □ No □ DK/NA □ Comment:

8.1 ACCORDING TO THE KEY INFORMANTS, WHAT ARE THE THREE MAIN BARRIERS (WITH PROPOSED SOLUTIONS) TO IDENTIFYING AND MANAGING MENTAL DISORDERS IN PHC?	
Barrier	Solution
1	
2	
3	

8.2 ACCORDING TO THE ASSESSOR, WHAT ARE THE THREE MAIN BARRIERS (WITH PROPOSED SOLUTIONS) TO IDENTIFYING AND MANAGING MENTAL DISORDERS IN PHC?	
Barrier	Solution
1	
2	
3	

9 RECOMMENDED ACTIONS ACCORDING TO THEASSESSOR	BY DATE	BY WHOM
9.1		
9.2		
9.3		
9.4		
9.5		
9.6		
9.7		
9.8		

9.9		
9.10		

Tool 6NEUROPSYCHIATRIC COMPONENT OF THE HEALTH INFORMATION SYSTEM (HIS) 18
Why use this tool: For advocacy and for planning and monitoring a mental health response in primary health care (PHC) **Method:** Clinical epidemiology using the health information system (HIS) **Time needed**: Two weeks **Human resources needed:** One person

Background

- The PHC HIS must cover mental health. Indeed, one way to rapidly assess frequency of mental health problems and epilepsy is by analysing the HIS.
- The UNHCR HIS includes a 7-category neuropsychiatric component (displayed in Part A below). It is recommended you integrate these seven categories as soon as is possible in the HIS in humanitarian crises.
- Staff will need to be trained (two hours) – and initially supervised (for half a day) in using these categories properly.
- In the UNHCR HIS sex and age data are collected separately and for the following age groups (0 to 4; 5 to17, 18 to 60; over 60)
- Of note, in early days of some acute emergencies, public health decision-makers may not agree on adding 7 items to the HIS. In that situation, at the very least an item labelled “mental, neurological, or substance use problem” may be added to the health information system. Over time this item should then be replaced with the proposed 7 item HIS covered in this Too

Category (HIS)	**Number of seen in last**	**Proportion of people**	**2-week treated**

	two weeks	seeking help with this problem	prevalence
		Divide data in first column by the overall number of patients seen in last two weeks	Divide data in first column by the estimated number ofpeople in catchment area
1. Epilepsy/seizures			
2. Alcohol or other substance abuse			
3. Mental retardation/intellectual property			
4. Psychotic disorder			
5. Severe emotional disorder			
6. Other psychological complaint			
7. Medically unexplained somatic complaint			
Total (sum of 1 to 7)			

CASE DEFINITIONS: NEUROPSYCHIATRIC DISORDERS
1. Epilepsy/seizures A person with epilepsy has had at least two episodes of seizures not provoked by any apparent cause such as fever, infection, injury or alcohol withdrawal. These episodes are characterised by loss of consciousness with shaking of the limbs and sometimes associated with physical injuries, bowel/bladder incontinence and tongue biting.
2. Alcohol or other substance use disorder A person with this disorder seeks to consume alcohol (or other addictive substances) on a daily basis and has difficultiescontrolling how much they consume. Personal relationships, work performance and physical health often deteriorate. Theperson continues consuming alcohol (or other addictive substances) despite these problems.
3. Mental retardation/ intellectual disability The person has very low intelligence causing problems in daily living. As a child, this person is slow in learning to speak. As an adult, the person can work if tasks are simple. Rarely will this person be able to live independently or look after themself and/orchildren without support from others. When severe, the person may have difficulties speaking and

understanding others andmay require constant assistance.

4. Psychotic disorder

The person may hear or see things that are not there or strongly believe things that are not true. They may talk to themselves;their speech may be confused or incoherent and their appearance unusual. They may neglect themselves. Alternatively, they maygo through periods of being extremely happy, irritable, energetic, talkative, and reckless. The person's behaviour is considered"crazy"/highly bizarre by other people from the same culture.

5. Severe emotional disorder

This person's daily normal functioning is markedly impaired for more than two weeks due to overwhelming sadness/apathy orexaggerated, uncontrollable anxiety/fear, or both. Personal relationships, appetite, sleep and concentration are often affected.The person may be unable to initiate or maintain conversation. The person may complain of severe fatigue and be sociallywithdrawn, often staying in bed for much of the day. Suicidal thinking is common.

Inclusion criteria: Only apply this category if there is marked impairment in daily functioning.

CASE DEFINITIONS: OTHER PSYCHOLOGICAL OR MEDICALLY UNEXPLAINED COMPLAINTS OF CLINICAL CONCERN

6. Other psychological complaints

This category covers complaints related to emotions (for example, depressed mood, anxiety), thoughts (for example, ruminating,poor concentration) or behaviour (for example, inactivity, aggression). The person tends to be able to function in all or almostall day-to-day, normal activities. The complaint may be a symptom of a less severe emotional disorder or may represent normaldistress (that is, no disorder).

Inclusion criteria: Only apply this category if both of the following criteria apply:

- is requesting help for the complaint; and
- is not positive for any of the above five categories

7. Medically unexplained somatic complaints

The category covers any somatic/physical complaint that does not have an apparent organic cause.

Inclusion criteria: Only apply this category if all 3 of the following criteria apply:

- after conducting necessary physical examinations;
- if the person is not positive for any of the above six categories; and
- if the person is requesting help for the complaint.

TOOL 7 TEMPLATE TO ASSESS MENTAL HEALTH SYSTEM FORMAL RESOURCES IN HUMANITARIAN SETTINGS19
Why use this tool: For planning of (early) recovery/reconstruction, through knowing the formal resourcesin the regional/national mental health system **Method:** Review of documents, interviews with managers of services **Time needed:** Three to five days **Human resources needed:** One person

Background

Emergencies can be an opportunity for (re)forming nationally available and publicly accessible mental health systems (WHO, in press). An analysis of the formal health system provides essential information for (re)constructing the mental health system after emergencies.

Through consulting secondary information and filling gaps with mental health experts, this tool is intended to identify gaps in formal mental health services.

- Many of these variables (indicators) are adapted from WHO AIMS. For precise definitions of these indicators, see WHO-AIMS 2.2 http://www.who.int/mental_health/evidence/WHO-AIMS/en/
- Where possible, data should be collected by region and facility
- Where possible and relevant, data about patients should be disaggregated by gender and age (child up to18, adult 19 to 64, elderly over 65).
- Report data in aggregated format (across the affected area) when findings are not readily available in disaggregated format and when time for assessment is limited.

This information is also useful for any post-conflict needs assessment or post-disaster needs assessment that provide facts for large-scale fund-raising events for recovery after very large emergencies.

Sources of information

1. Data from:

- government
- MHPSS 4Ws (See Tool 1)
- WHO-AIMS reports on the country
- WHO Mental Health Atlas
- reports by health sector/cluster leads

2. Data from interviews with:

- government and NGO mental health services programme managers (or health services mangers if no specific mental health service managers exist)
- health cluster/sector coordinators
- facilitators of any (cross-cluster/sector) mental health and psychosocial support groups

Impact of the emergency

In the third column, indicate to what extent the emergency has had a negative impact on the functioning of the service.

1. FORMAL MENTAL HEALTH SERVICES IN THE (DEFINED) AREA		
1.1 Inpatient psychiatric facilities (both mental hospitals with acute and chronic patients, and acute inpatient wards at general hospital)		
Number of facilities		1. No emergency impact (services are fully functioning) □ 2. partially functioning (describe) □ 3. not functioning □
Number of beds		
Average number of inpatients a day in the previous month		
Number of psychiatrists		
Number of nurses		
Number of other professional staff (for example, physicians, psychologists, occupational therapists, social workers)		
Estimated % of inpatient units that have psychotropic medicines in each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, antiepileptic and anti-Parkinsonian) continuously available		
1.2 Outpatient psychiatric facilities (separate between public and private facilities)		
Number of facilities		1. No emergency impact (services are fully functioning) □ 2. partially functioning
Approximate number of people treated in previous month		
Number of psychiatrists		
Number of nurses		
Number of other professional staff (for example, physicians,		

psychologists, occupational therapists, social workers)		(describe) □
Number of other staff		
Estimated % of outpatient psychiatry facilities that have psychotropic medicinesin each therapeutic category (anti-psychotic, antidepressant, mood stabilizer,anxiolytic, antiepileptic and anti-Parkinsonian) continuously available		3. not functioning □
1.3 Other psychological treatment centres (for example NGO services)		
Number of centres		1. No emergency impact (services are fully functioning) □
Approximate number of people treated in previous month		
Number of psychiatrists		
Number of nurses		2. partially functioning (describe) □
Number of psychologists		
Number of social workers		
Number of other professional staff		3. not functioning □
Number of other staff		
1.4 Residential facilities and institutions that house people with sever neuropsychiatric disorders		
Number of centres		1. No emergency impact (services are fully functioning) □
Number of residents with severe mental disabilities		2. partially functioning (describe) □
Number of mental health staff		3. not functioning □
1.5 Other mental health facilities (for example drug and alcohol treatment facilities, homes for children with intellectual disabilities)		
Number of centres		1. No emergency impact (services are fully functioning) □
Approximate number of people treated in previous month		2. partially functioning (describe) □
Number of mental health and substance staff		3. not functioning □

2. MENTAL HEALTH IN GENERAL AND PRIMARY HEALTH CARE CLINICS		
2.1 General hospital, general medicine outpatient clinics (without specific focus on psychiatry)		
Number of clinics		1. No emergency impact

Approximate number of patients (with any type of health problem) seen in the previous week		(services are fully functioning) □
Approximate number of patients (with any type of health problem) seen by each physician every hour		2. partially functioning (describe) □
% of clinics that have psychotropic medicines in each therapeutic category continuously available		3. not functioning □
Approximate % of clinics with staff providing basic mental health care		
2.2 Primary health care clinics		
Number of clinics		1. No emergency impact (services are fully functioning) □
Approximate number of patients (with any type of health problem) seen in theprevious week in each clinic		2. partially functioning (describe) □
Approximate number of patients (with any type of health problem) seen by eachphysician/nurse every hour		3. not functioning □
% of clinics that have psychotropic medicines in each therapeutic categorycontinuously available		
Approximate % of clinics with staff providing basic mental health care		

3. COMMUNITY CARE (CARE BY COMMUNITY HEALTH WORKERS AND COMMUNITY MENTALHEALTH WORKERS OUTSIDE FACILITIES/ CLINICS)		
3.1 Community health workers		
Number		1. No emergency impact (services are fully functioning) □
Approximate number of people treated in previous month		2. partially functioning (describe) □
Number of mental health and substance staff		3. not functioning □
3.1 Community mental health workers (including community-based rehabilitation workers who work on mental health)		
Number		1. No emergency impact (services are fully functioning) □
Average population covered by each worker		2. partially functioning (describe) □
		3. not functioning □

TOOL 8 CHECKLIST ON OBTAINING GENERAL (NON-MHPSS SPECIFIC) INFORMATION FROM SECTOR LEADS
Why use this tool: For summarising general (non-MHPSS specific) information already known about the current humanitarian emergency (to avoid collecting more data on what is already known) **Method:** Review of available documents **Time needed:** One day **Human resources needed:** One person

Background

Basic physical needs, education and protection issues are key aspects of the context in which a mentalhealth and psychosocial response occurs. The assessment report should contain at least a paragraphdetailing these issues. This information should be available through agencies in the relevant clusters/sectors or on websites, and contacting the relevant lead agencies is likely the quickest way of obtainingkey information.

TYPE OF INFORMATION	SUGGESTED INFORMATION SOURCE	WHO TO CONTACT	INFORMATION RECEIVED
1. Population size	Government Overall UN coordinating agency		☐
2. Risks groups	Overall UN coordinating agency		☐
3. Size of risk groups	Overall UN coordinating agency		☐
4. Mortality	Overall UN coordinating agency Health cluster/ sector lead		☐
5. Threats to mortality	Overall UN coordinating agency Health cluster/ sector lead		☐
6. Access to basic needs: food	Nutrition and food security cluster/sector leads		☐
7. Access to basic needs: shelter	Emergency shelter cluster/sector lead		☐
8. Access to basic needs: water and sanitation	Water sanitation and hygiene (WASH) cluster/sector lead		☐
9. Access to basic needs: health care and existing mental health services	Health cluster/sector lead		☐

10. Access to education	Education cluster/sector lead		□
11. Human rights violations and protective frameworks	Protection cluster/sector lead		□
12.Social, political, religious, and economic structures and dynamics	Protection cluster/sector lead		□
13. Changes in the livelihood activities and daily community life	Nutrition cluster/ sector lead Camp coordination/ management cluster/ sector lead Protection cluster/ sector lead Emergency shelter cluster/ sector lead		□
14. Education and social services, and impact of crisis on these	Education cluster/sector lead Protection cluster/sector lead		□

TOOL 9 TEMPLATE FOR DESK REVIEW OF PRE-EXISTING INFORMATION RELEVANT TO MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN THE REGION/ COUNTRY21
Why use this tool: For summarising mental health and psychosocial support (MHPSS) information about this region/country already known before the current humanitarian emergency (to avoid collecting more data on what is already known) **Method:** Literature review **Time needed**: Seven to ten days **Human resources needed**: Two people

Background

The main part of this tool (part A) consists of a sample table of contents for a desk review.

The table of contents in part A of this tool outlines the major topics for which to summarise existing information, but you need to adapt these to each context. The extent to which you can cover each topic depends on the information available. Different information will be available and important in different humanitarian crises. **Generally,**

you can cover each line of the table of contents in one paragraph in the desk review.

Often, it will be useful to add to the collected information by interviewing national and international experts. Example questions to ask this group are included in part B which refers to primary data that you could collect to complement data identified through the desk review. If time allows, at least two local experts should read through the review before you finalise it.

You should use the tool flexibly to avoid unnecessary repetition in the resulting report. **It is essential that the report is highly readable by people without advanced academic training so you should avoid jargon and theory.** Where possible, the report should be edited into plain language.

The report should be shared electronically with everyone working on mental health and psychosocial support. And, where relevant, the report should be translated into key local languages.

For a guide on how to conduct literature reviews, see Galvan, J.L. (2006). Writing Literature Reviews: a Guide for Students of the Social and Behavioral and Sciences – 4th Edition. Pyrczak. For an example, see: http://www.who.int/mental_health/emergencies/culture_mental_health_haiti_eng.pdf

A. SAMPLE TABLE OF CONTENTS OF A LITERATURE REVIEW
1 Introduction
1.1 Rationale for the desk review (description of current/recent emergency)
1.2 Description of methodology used to collect existing information (including any library search terms you used)
2 General context
2.1 Geographical aspects (for example, climate, neighbouring countries)
2.2 Demographic aspects (for example, population size, age distribution, languages, education/ literacy, religious groups, ethnic
groups, migration patterns, groups especially at risk to suffer in humanitarian crises)
2.3 Historical aspects (for example, early history, colonisation, recent political history)

2.4 Political aspects (for example, organization of state/ government, distribution of power, contesting sub-groups or parties)
2.5 Religious aspects (for example, religious groups, important religious beliefs and practices, relationships between different
groups)
2.6 Economic aspects (for example Human Development Index, main livelihoods and sources of income, unemployment rate,
poverty, resources)
2.7 Gender and family aspects (for example, organisation of family life, traditional gender roles)
2.8 Cultural aspects (traditions, taboos, rituals)
2.9 General health aspects
2.9.1 Mortality, threats to mortality, and common diseases
2.9.2 Overview of structure of formal, general health system

3 Mental health and psychosocial context

3.1. Mental health and psychosocial problems and resources

3.1.1 Epidemiological studies of mental disorders and risk/protective factors conducted in the country, suicide rates

3.1.2 Local expressions (idioms) for distress and folk diagnoses, local concepts of trauma and loss

3.1.3 Explanatory models for mental and psychosocial problems

3.1.4 Concepts of the self/ person (for example relations between body, soul, spirit)

3.1.5 Major sources of distress (for example, poverty, child abuse, infertility)

3.1.6 Role of the formal and informal educational sector in psychosocial support

3.1.7 Role of the formal social sector (for example, social services) in psychosocial support

3.1.8 Role of the informal social sector (for example, community protection systems, neighbourhood systems, other
community resources) in psychosocial support

3.1.9 Role of the non-allopathic health system (including traditional health system) in mental health andpsychosocial
support

3.1.10 Help-seeking patterns (where people go for help and for what problems)

3.2 The mental health system

3.2.1 Mental health policy and legislative framework and leadership

3.2.2 Description of the formal mental health services (primary, secondary and tertiary care). Consider the relevant

Mental Health Atlas and WHO-AIMS reports among other sources to find out availability of mental health services,

mental health human resources, how mental health services are used, how accessible mental health services are

(for example distance, fee for service), and the quality of mental health services

3.2.3 Relative roles of government, private sector, NGOs, and traditional healers in providing mental health care

4 Humanitarian context

4.1 History of humanitarian emergencies in the country

4.2 Experiences with past humanitarian aid in general

4.3 Experiences with past humanitarian aid involving mental health and psychosocial support

5 Conclusion

5.1 Expected challenges and gaps in mental health and psychosocial support

5.2 Expected opportunities in mental health and psychosocial support

6 References

B. DATA TO BE COLLECTED THROUGH INTERVIEWS WITH CULTURAL AND MEDICAL EXPERTS, SOCIAL ANTHROPOLOGISTS, SOCIOLOGISTS, OTHER SOCIO-CULTURAL EXPERTS OR KEY INFORMANTS

Comment: This refers to primary data that you may collect to complement data identified though the desk review

What are the essential concerns, beliefs, and cultural issues that aid providers should be aware of when working on mental health and psychosocial support for [PROVIDE EXAMPLE TARGET GROUP, FOR EXAMPLE PEOPLE WHO SUFFERED LOSSES; FEMALE SURVIVORS OF SEXUAL VIOLENCE]? What actions should be avoided?

[PROBE IF NECESSARY] about the following.

- Local ways of describing emotional difficulties

- Existing resources to cope with emotional difficulties
- Local power structures (for example local hierarchies based on kinship, age, gender, knowledge of the supernatural)
- The political situation (for example issues of favouritism, corruption, instability)
- Interactions between different social groups (for example, ethnic and religious)
- Socially vulnerable or marginalized groups
- Former difficulties or bad experiences with aid agencies
- Gender relations
- Accepting services organised by people from outside the community
- Anything else that aid providers should know

TOOL 10 PARTICIPATORY ASSESSMENT: PERCEPTIONS BY GENERAL COMMUNITY MEMBERS

Why use this instrument: For learning about local perspectives on problems and coping in a participatory manner, to provide information for MHPSS response
Method: Interviews with general community members (free listing with further questions)
Time needed: One to two days
Human resources needed: Four people

Background

This tool is useful as a way to gain quick information from general community members living in a humanitarian setting.

This tool's first question involves free listing which is often useful in the beginning of an assessment to get an overview of the different types of problems and resources in a community. Free listing means asking an individual (often a general community member) to provide as many answers to a single question as possible. It can focus on a wide variety of topics. For instance, people can be asked to list the types of problems they have, what they do when they face problems, where they go for help and so on.

In the tool described below, the assessor uses free listing to ask respondents about what problems they have. The assessor then selects the type of problem of our interest (that is, mental health and psychosocial problems) for more in-depth assessment on

how the problem is seen to impact on daily functioning and how people may cope with it.

You can carry out free listing with individuals or in group settings. However, it is recommended doing it with individuals where feasible, because in a group people may influence each other's answers. It is recommended that you interview at least 10 to 15 people. It may be necessary to interview more than 15 people whenever additional interviews are likely to lead to relevant, new information.

Generally, it will be useful to ask these questions separately for women and men (and for children, youth and adults if this applies) and to check if there are differences.

Before using the tool, you should be trained in general interviewing techniques that are relevant to semi-structured interviews in humanitarian settings, for example, how to probe and avoid introducing bias.

Informed consent

It is important to obtain informed consent before doing any interviews. An example of how to do this is provided here.

Hello, my name is _____ and I work for _____. We have been working in ___ (area) to _____ (type of work) for ___ (period). Currently, we are talking to people who live in this area. Our aim is to know what kind of problems people in this area have, to decide how we can offer support. We cannot promise to give you support in exchange for this interview. We are here only to ask questions and learn from your experiences. You are free to take part or not.

If you do choose to be interviewed, I can assure you that your information will remain anonymous so no-one will know what you have told us. We cannot give you anything for taking part but we would greatly value your time and responses. Do you have any questions?

Would you like to be interviewed? 1. Yes

2. No

Interview

Step 1: Free listing

1.1 The interview starts by free listing on the following question to ask for all types of problems.

"What kind of problems do _____ [INSERT GROUP OF INTEREST] have because of the humanitarian situation? Please list as many problems that you can think of.''

Notes:

a) Groups of interest may include women in this community, men in this community, teenage girls in this community, young children in this community, etc.

b) When using free listing, you keep on encouraging the respondent to give more answers. For example after the respondent has listed a few problems and remains silent, you could ask:

"What other kind of problems do _____ [INSERT GROUP OF INTEREST] have because of the humanitarian situation? Please list as many problems that you can think of." The respondent may now list a few more problems. You would then continue with the question until the respondent gives no more answers.

c) After the list is completed, you should ask for a short description of each problem listed so that the following table can be completed.

TABLE 1. LIST OF PROBLEMS (OF ANY KIND)	
Problem	**Description**
1.1.1	
1.1.2	
1.1.3	
1.1.4	

1.1.5	
1.1.6	
1.1.7	
1.1.8	
1.1.9	
1.1.10	
1.1.11	
1.1.12	
1.1.13	
1.1.14	
1.1.15	
1.1.16	
1.1.17	
1.1.18	
1.1.19	
1.1.20	

1.2 You should then look at the responses to question 1.1 and follow the instructions below toselect mental health and psychosocial problems specifically.

Select those problems which are especially relevant from a mental health / psychosocial perspective, such

as:

(a) problems related to social relationships (domestic and community violence, child abuse, family

separation); and

(b) problems related to:

- feelings (for example feeling sad or fearful);
- thinking (for example worrying); or

- behaviour (for example drinking).

Copy these into Table 1.2 below and also in the first column of Tables 3.1 and 3.2 below.

TABLE 1.2 LIST OF MENTAL HEALTH/PSYCHOSOCIAL PROBLEMS
1.2.1
1.2.2
1.2.3
1.2.4
1.2.5
1.2.6
1.2.7
1.2.8
1.2.9
1.2.10

Step 2: Ranking

2.1 Find out from the respondent which mental health / psychosocial problems are perceived to be important and why.

"You mentioned a number of problems, including [RE AD OUT PROBLEMS NAMED IN 1.2 ABOVE]. Of these problems, which is the most important problem?" "Why?"

“Of these problems, which is the second most important problem?” “Why?”

“Of these problems, which is the third most important problem?” “Why?”

TABLE 2.1 TOP THREE PRIORITY PROBLEMS	
2.1.1	Problem:
	Explanation:
2.1.2	Problem:
	Explanation:
2.1.3	Problem:
	Explanation:

Step 3: Daily functioning and coping

3.1 Try to identify the impact of mental health / psychosocial problems on daily functioning by asking what tasks could be affected.

‘’Sometimes [NAME A PROBLEM FROM 1.2 ABOVE] may make it difficult for a person to perform their usual tasks. For example, things they do for themselves, their family or in their community. If a [INSERT GROUP OF INTEREST] suffers from [NAME AGAIN THE PROBLEM LISTED FROM 1.2 ABOVE], what kind of tasks will be difficult for them?’’

Report the answer in Table 3.1. Repeat the question for each of the problems mentioned in 1.2.

TABLE 3.1 IMPAIRMENT OF DAILY ACTIVITIES	
Repeat for each problem mentioned under 1.2	
Mental health/psychosocial problems (as listed in 1.2)	**Affected task**

1.2.1	3.1.1
1.2.2	3.1.2
1.2.3	3.1.3
1.2.4	3.1.4
1.2.5	3.1.5
1.2.6	3.1.6
1.2.7	3.1.7
1.2.8	3.1.8
1.2.9	3.1.9
1.2.10	3.1.10

3.2 Then try to identify how people cope with each of these mental health / psychosocial problems and whether this helps them.

''What kind of things do _____ [INSERT GROUP OF INTEREST] people do to deal with such problems? E.g., things they do by themselves, things they can do with their families or things they do with their communities?'' ''Does doing that help with the problem?''

Report the answer in Table 3.2. Repeat the question for each of the problems mentioned in 1.2

TABLE 3.2 COPING		
Repeat for each problem mentioned under 1.2		
Mental health/psychosocial problems (as listed in 1.2)	**Coping**	**Is the coping method helpful?**

1.2.1	3.2.1	Yes/No
1.2.2	3.2.2	Yes/No
1.2.3	3.2.3	Yes/No
1.2.4	3.2.4	Yes/No
1.2.5	3.2.5	Yes/No
1.2.6	3.2.6	Yes/No
1.2.7	3.2.7	Yes/No
1.2.8	3.2.8	Yes/No
1.2.9	3.2.9	Yes/No
1.2.10	3.2.10	Yes/No

TOOL 11 PARTICIPATORY ASSESSMENT: PERCEPTIONS BY COMMUNITY MEMBERS WITH IN-DEPTH KNOWLEDGE OF THE COMMUNITY
Why use this tool: For learning about local perspectives on problems and coping in a participatory manner, to provide information for MHPSS response **Method:** (Individual or group) key informant interviews **Human resources needed**: One person **Time needed**: Three days for collecting data (assuming the interviewer carries out four interviews a day) and three days for analysis and reporting

Background

This tool is especially useful as a way to gain more in-depth information after preliminary information has been obtained (see Tool 10)

This tool provides questions to use in **key informant or group interviews with community members who are expected to have in-depth knowledge of the**

affected community. These could be displacement camp committee members, local staff, religious leaders, traditional healers, women's association leaders, midwives, youth club leaders, school principals, school teachers, counsellors, and so on. You could also include young people.

Do not use all the questions from this tool. Choose those questions that are relevant to you. Remember that a common mistake in assessments is to ask too many questions that are not subsequently analysed, reported or otherwise used. So, do not ask more questions than are needed. Interviews should last no more than one hour. If an interview takes more than one hour, then it is generally better to make a second appointment at another time for a follow-up interview.

When adapting the questionnaire to the local context, **do not** change the sequence of the interview questions (e.g., first asking about problems in a subgroup of the population, then asking what people in this subgroup are doing already to address the problem, and ending with a question on what additional help may be needed) These interviews can be done with individuals or groups. However, it is recommended to do them with individuals where feasible, because individuals in a group may influence each other's answers. It is recommended to interview at least 10-15 people. It may be necessary to interview more than 15 people whenever additional interviews are likely to lead to relevant, new information.

Before using this tool, you should be trained in general interviewing techniques that are relevant to semi-structured interviews in humanitarian settings, for example, how to probe and avoid introducing bias. You should not ask highly sensitive questions that may put people (interviewee, interviewer, or other people) in danger. Depending on the context, these should be asked only during individual key informant interviews (for example questions about people at risk of human rights violations).

Remember it can be very relevant to interview traditional/ religious/ indigenous healers on local perceptions of mental health and available resources. A specific tool with questions to interview them is available upon request. That tool in particular is relevant to implementing IASC Guidelines Action 6.4 on potential collaboration with healers.

Informed consent

It is important to obtain informed consent before doing any interviews. An example of how to do this is provided here

Hello, my name is _____ and I work for _____. We have been working in ___ (area) to _____ (type of work) for ___ (period). Currently, we are talking to people who we believe know a lot about the people affected by this [NAME OF HUMANITARIAN CRISIS, FOR EXAMPLE FLOODS, EXPLOSION, ARMED CONFLICT]. In this interview I would like to ask you about various problems people in the community have. I would also like to ask how people deal with these problems, and if additional help may be needed.

Our aim is to learn from your knowledge and experience, so that we will be better able to provide support. We cannot promise to give you support in exchange for this interview. We are here only to ask questions and learn from your experiences. You are free to take part or not.

If you choose to be interviewed, I can assure you that your information will remain confidential. You are free not to take part. We cannot give you anything for taking part but I would greatly value your time and responses. Also, you can stop the interview at any time. Do you have any questions? Would you like to be interviewed?

1. Yes
2. No

A. SOURCES OF DISTRESS

First, I would like to ask you about problems in the community.

- What do people in your community believe has caused the current [NAME OF HUMANITARIAN CRISIS, FOR
- EXAMPLE FLOODS, EXPLOSION, ARMED CONFLICT]?
- According to community members, what are the consequences of the [NAME OF HUMANITARIAN CRISIS, FOR
- EXAMPLE FLOODS, EXPLOSION, ARMED CONFLICT]?

- According to community members, what will be further consequences of the [NAME OF HUMANITARIAN CRISIS,
- FOR EXAMPLE FLOODS, EXPLOSION, ARMED CONFLICT]?
- How has the [NAME OF HUMANITARIAN CRISIS, FOR EXAMPLE FLOODS, EXPLOSION, ARMED CONFLICT] affected
- daily community life?
- How has [NAME OF HUMANITARIAN CRISIS, FOR EXAMPLE FLOODS, EXPLOSION, ARMED CONFLICT] affected
- people's livelihood, activities/ work?
- How are people trying to rebuild and recover from this crisis?

B. RISK GROUPS

- Which people in your community are suffering the most from the current crisis. . . Who else? . . . and who else?

C. NATURE OF DISTRESS AND SUPPORT

C1. Now, I would like to ask a number of questions about children being upset/ distressed.
(COMMENT : You could repeat this question for boys and girls separately and for different age groups, for example, children under 6, children between 6 and 12, and adolescents from 13 to 18).

- How would an outsider recognise a child who is emotionally upset/ distressed by [NAME OF HUMANITARIAN
  CRISIS, FOR EXAMPLE FLOODS, EXPLOSION, ARMED CONFLICT]?
  a. What does the child look like?
  b. How do they behave?
  c. Are there different types of being upset? What are they?
  d. How can I tell the difference between [NAME ANSWER FROM C1]?
  In normal circumstances (before the recent emergency), what did community members usually do to reduce the
  upset/ distress of children?
- What are community members doing right now to reduce the upset/ distress of children?
- What else is being done right now to help children who are upset/ distressed?

- Where do children who are upset/ distressed seek help?
- What more could be done to help children who are upset / distressed?

C2. Now, I would like to ask a number of questions about women being upset/ distressed.

- How would an outsider recognize a woman who is emotionally upset/ distressed by the [NAME OF HUMANITARIAN CRISIS, FOR EXAMPLE FLOODS, EXPLOSION, ARMED CONFLICT]?
  a. What does she look like?
  b. How does she behave?
  c. Are there different types of being upset? What are they?
  d. How can I tell the difference between [NAME ANSWER FROM C2]?
- In normal circumstances (before the recent emergency), what did community members usually do for women to reduce upset/ distress?
- What are community members doing for each other right now to reduce women's upset/ distress? What else is being done right now to help women who are upset/ distressed? Where do women who are upset/ distressed seek help?
- What more could be done to help women who are upset / distressed?

C3. Now, I would like to ask a number of questions about men being upset/ distressed.

- How would an outsider recognize a man who is emotionally upset/ distressed by the [NAME OF HUMANITARIAN CRISIS, FOR EXAMPLE FLOODS, EXPLOSION, ARMED CONFLICT]?
- What does he look like?
- How does he behave?
- Are there different types of being upset? What are they?
- How can I tell the difference between [NAME ANSWER FROM C3]?
- In normal circumstances (before the recent emergency), what did community members usually do for men to reduce upset/ distress?
- What are community members doing for each other right now to reduce men's upset/ distress?
- What else is being done right now to help men who are upset/ distressed?
- Where do men who are upset/ distressed seek help?
- What more could be done to help men who are upset / distressed?

C4. Now, I also would like to ask about what happens when people die in your community.

- When someone in this community dies how do the family and friends express their

grief?

a. What are the first things to be done? Why?

b. How do other family/ friends/ community members express support?

c. What happens to the body?

d. What other things need to be done?

e. How long does mourning continue?

f. What happens if the body cannot be found/ identified?

- What happens if the process you described (for example, burial) cannot be done? • What are community members doing for each other right now to help bereaved families and friends?
- What else is being done right now to help people who are bereaved?
- Where do people who are bereaved seek help?
- What more could be done to help people who are bereaved?

C5. In all communities there are people with mental disorders. May I ask about them? (Comment: the word mental disorders may not be well-understood. Where needed, use an appropriate synonym that is understood.)

- Do you have people with mental disorders in the community?
- What kind of problems do they have?
- In general, what do community members think about people with mental disorders? How do they treat them?
- In normal circumstances (before the recent emergency), what did community members usually do to help people with mental disorders?
- What are community members doing right now to help people with mental disorders?
- What else is being done right now to help those with mental disorders?
- Where do people with mental disorders seek help?
- What more could be done to help people with mental disorders?

C6. In most communities there are people (men, women and children) who have been raped or sexually abused. May I ask about them? (COMMENT: additional questions may be phrased by replacing the word 'raped or sexually abused' with 'tortured' or with any other potentially traumatic event that is relevant.)

- If someone has been raped, what kind of problems may the person have?
- In general, what do community members think about people who have been raped? How do they treat them?
- In normal circumstances (before the recent emergency), what did community

members normally do to help those who have been raped?

- What are community members doing right now to help those who have been raped?
- What else is being done right now to help those who have been raped?
- Where do people who have been raped seek help?
- What more could be done to help those who have been raped?

C7. In most communities there are people who have problems with alcohol. May I ask about them? (COMMENT: depending on the context, the questions below may need to be asked also - or only - for drugs.)

- If someone frequently drinks a lot of alcohol, what kind of problems may happen in the family or community?
- If someone frequently drinks a lot of alcohol, what kind of problems may happen for him or her?
- In general, what do community members think of people who frequently drink a lot of alcohol? How do they treat them?
- In normal circumstances (before the recent emergency) what did community members normally do to reduce problems caused by alcohol?
- What are community members doing right now to reduce these problems?
- What else is being done right now to deal with these problems?
- Where do people seek help for these problems?
- What more could be done to reduce these problems?

TOOL 12 PARTICIPATORY ASSESSMENT: PERCEPTIONS BY SEVERELY AFFECTED PEOPLE25
Why use this tool: For learning about local perspectives on problems and coping in a participatory manner, to provide information for MHPSS response **Method:** Interviews with severely affected people (free listing with further questions) **Time needed**: Three to five days **Human resources needed**: Two people

This tool provides questions to be used in interviews with people who are severely affected by the humanitarian crisis, for example, because of direct exposure to major trauma or loss.

This tool is useful as a way to gain more in-depth information after preliminary information has been obtained from a desk review (see Tool 9), interviews with general community members (see Tool 10), or interviews with community members with in-depth knowledge of the affected community (see Tool 11). You can use this tool to triangulate data (that is, compare information from different sources).

This first question involves free listing. Free listing means asking an individual to provide as many answers to a single question as possible. It can focus on a wide variety of topics. For instance, you can ask people to list the types of problems they have, what they do when they face problems, where they go for help and so on.

In the example tool described below, you use free listing to ask respondents about what problems they have. You would then select the type of problem of interest (that is, mental health and psychosocial problems) for more in-depth assessment on support and coping.

You can carry out these interviews with individuals or groups. However, it is recommended you do them with individuals where feasible, because individuals in a

group may influence each other's answers. It is recommended that you interview at least 10 to 15 people. It may be necessary to interview more than 15 people whenever additional interviews are likely to lead to relevant, new information.

Before using the tool you should be trained in general interviewing techniques that are relevant to semi-structured interviews in humanitarian settings, for example, how to probe and avoid introducing bias.

You should not ask highly sensitive questions that may put people (interviewee, interviewer, or other people) in danger. Depending on the context, these should be asked only during individual key informant interviews (for example questions about people at risk of human rights violations).

Some questions contain probes; you should only use these if necessary (that is, when the respondent cannot think of a response after some time). It is not necessary to use each probe one-by-one; they are meant as examples to stimulate a fuller response.

Distress

Thinking about violent or other horrific events can cause people to become distressed. You should not probe about these events in detail. This tool is specifically designed not to need a great level of detail. If the interviewee wants to talk about these events, you should allow them to do so to some extent, but you should not ask them for more details as this is not the purpose of doing this assessment. In any case, you should be patient and show that you are listening.

The interviewee may stop the interview at any time. If they ask to stop the interview, you should do this. The person does not need to give a reason for wanting to stop the interview. It is alright to continue with the interview if the person is a little upset but agrees to continue. However, if the person is getting very upset by a topic, you should close the interview booklet and be silent until they calm down. You could then say: "You seem very upset. Are you okay to continue the interview or would you prefer to stop?" At the end of the interview, you should refer the interviewee to the best available

psychosocial support worker and you should inform the assessment team leader. Before a first interview you should receive a list of support organisations that you can give to interviewees.

Informed Consent

Hello, my name is _____ and I work for _____. We have been working in ___ (area) to _____ (type of work) for ___ (period). Currently, we are talking with people who live in this area. We would like to talk to you about what kind of problems you are experiencing because of the humanitarian situation, and how you have tried to deal with these.

Our aim is to learn from your knowledge and experience so that we will be better able to provide support. We cannot promise to give you support in exchange for this interview. We are here only to ask questions and learn from your experiences. You are free to take part or not. We will use this information to decide how best to support people in similar situations. If you do choose to be interviewed, I can assure you that your information will remain anonymous so no-one will know what you have said. We cannot give you anything for taking part, but we greatly value your time and responses. Do you have any questions? Would you like to be interviewed?

1. Yes
2. No

1. PSYCHOLOGICAL AND SOCIAL DISTRESS

Could you list the problems you are currently experiencing because of the humanitarian situation?

[WHEN THE PERSON STOPS LISTING PROBLEMS, YOU CAN PROBE WITH] What other problems are you currently experiencing because of the humanitarian situation?

[WHEN THE PERSON AGAIN STOPS LISTING PROBLEMS, PROBE WITH] What else? What other problems are you currently experiencing because of the humanitarian situation?

1.1	
1.2	
1.3	
1.4	
1.5	
1.6	
1.7	
1.8	
1.9	
1.10	
1.11	
1.12	
1.13	
1.14	
1.15	

Probe further for psychological and relational problems when the interviewee does not list any mental health or any social issues.

- Have you experienced problems in your relations with other people? If 'yes', what type of problems? [PROBE FURTHER IF NECESSARY. For example, do other people

stigmatize you or not give you support? Are you not as involved in community activities as you would like to be?]

- Have you been experiencing problems with your feelings? If 'yes', what type of problems? [PROBE FURTHER IF NECESSARY. For example, do you feel sad or angry or are you afraid?]
- Have you been experiencing problems with the way you think? If 'yes', what type of problems? [PROBE FURTHER IF NECESSARY. For example, do you have problems concentrating, are you thinking too much, are you forgetting things?]
- Have you been experiencing any problems with your behaviour? If 'yes', what type of problems? [PROBE FURTHER IF NECESSARY. For example, are you doing things because you are angry, are you doing things other people have found strange?]

2. SOCIAL SUPPORT AND COPING
I am especially interested in [INSERT ANY RELEVANT PSYCHOSOCIAL AND MENTAL HEALTH PROBLEMS MENTIONED ABOVE]. [FOR EACH PROBLEM OF INTEREST, ASK THE FOLLOWING QUESTIONS]
2.1 Could you tell me how [INSERT PROBLEM] affects your daily life?
2.2 Have you tried to find support for this problem?
2.3 Could you describe how you have tried to deal with this problem? What did you do first? And after that?
2.4 Have you received support from others in dealing with this problem?
2.5 Who gave you this support?
2.6 What kind of support did you get?
2.7 To what extent did this help to deal with the problem?
2.8 Do you feel you need additional support with this problem?

Case Study

Fezzik from the Princess Bride: A study in Development

I. Introduction

The purpose of this course is to trace the entertaining development of Fezzik, a fictional character based on the movie, "The Princess Bride" which was based on the novel, The Princess Bride by William Goldman (1973), which Goldman calls the "good parts version" of the novel with the same name by S. Morgenstern [Do you understand now? Anyway, get the book; you'll love it]. We will look at Fezzik's development in regards to physical maturation, cognitive development, psychosocial developmental tasks, and interpersonal relationships.

II. Physical Maturation

Fezzik's physical maturation is the most fascinating aspect of his development. Fezzik was the son of a Turkish mother and father, born sometime in the middle ages. Goldman states that "Turkish women are famous for the size of their babies," and Fezzik did not diminish their reputation. Normal babies weigh between 5 1/2 to 9 1/2 pounds at birth (Specht and Craig, 1982) and **lose three to four ounces immediately after**. This weight usually takes a good week to gain it back (Goldman, 1973).

According to Specht and Craig the genetic characteristics of height involves several gene or gene pairs that combine additively to create larger or smaller people with larger or smaller limbs (1982). For Fezzik, all of the genes must have added up perfectly to form largeness. At birth, Fezzik weighed fifteen pounds, large even for a Turkish baby. Fezzik did not lose weight either. Rather, Fezzik gained a full pound in his first afternoon.

Normal children double their birth weight at four months and triple it after one year (Specht and Craig, 1982). At a year old Fezzik weighed 85 pounds and looked like a young boy, except he was a little hairy. To continue with the information on Fezzik's physical growth, while in kindergarten he was the size of a normal man, and Goldman states that at nine he looked like he was twenty, but he was very clumsy and would fall down a lot. Fezzik was very aware of this clumsiness and that he was physically different than others. He continued to grow when at twenty he was estimated to be over seven feet tall and over four hundred pounds. All this growth can be based on genetics, it would appear. Even Fezzik seemed to understand this at one point saying, "I can't help being strong; it's not my fault. I don't even exercise."

In looking at the possible effects of Fezzik's physical maturation in his development, Leventhal and Dawson give us these insights:

> **"A child's general physical appearance is often the initial and most obvious basis for the development of environmental responses to him or her.** For the child emerging into the social world outside the family, responses to physical appearance may have substantial impact on other aspects of development (1982, p.33).

Comment [Q21]: 21. A child's _____ is often the initial and most obvious basis for the development of environmental responses to them.
a. amount of crying
b. smile
c. general physical appearance
d. foot size
e. response to verbal stimuli

> Furthermore:
>
> "Both clinical experience and some harder data attest to the fact that there can be a certain amount of psychological cost associated in childhood with being noticeably tall or short or slim or heavy. Children at the extremes of the distribution of the physical growth curve seem to show up disproportionately in psychiatric facilities (p. **36)."**

This directs us to Fezzik's development in other areas, all of which were more than likely affected by his size. The first of these areas is cognitive development.

III. Cognitive Maturation

Using Piaget's stages of cognitive development and other concepts from cognitive theory we can trace some of Fezzik's development. The big thing to remember in this task is Fezzik's age, and accordingly, is there any normal development that has gone awry, or is it age appropriate (Wenar, 1982) .

It would appear that Fezzik's sensorimotor schemes developed rather normally. This, I believe ties in to one of the risks Fezzik faced in his development; that of people expecting too much, too soon. This expectation could pressure him to move on or develop faster than he was capable, thus never fully completing the previous stage of development. Because of the information given about him later, it is assumed that he made it through the sensorimotor stage effectively. **This means, among other things, that he was able to establish object permanence; that an object can exist independent of him** (Specht and Craig, 1982)

Comment [Q22]: 22. Fezzik gaining "object permanence" means he was able to establish that:
a. some objects are to big to move
b. he doesn't have to move if he doesn't want to
c. an object can exist independent of him

At this stage Fezzik would also be able to somewhat organize and control his environment. His environment at this stage would also provide him with a good amount of environmental stimuli. This stimulus, which mainly comes from the primary caretaker at this stage, appears to have been abundant by the fact that Fezzik's parents were stated as caring for him very much (Specht and Craig, 1982).

As far as the Pre-operational stage it would appear that this is where Fezzik may have gotten stuck. He appears to have been able to accomplish some of the schemes necessary; imitation, symbolic play and language (Specht

and Craig, 1982). He liked to play rhyme games, either out loud with others or just in his own head by himself. He would do this even when others were angry with him.

At the age of five, Fezzik expressed symptoms of **solicitudophobia (fear of being alone)** (Thomlinson, 1984) when he told his parents that his vision of he

Since cognitive development is based on **having correct thoughts on what is observed**, Fezzik was definitely in danger in what he thought about others. In kindergarten, which is all the school Fezzik went to, Fezzik was as large as a grown man. At first the other children were afraid of Fezzik. As they found out that Fezzik was extremely passive, they would call him a bully and hit him over and over. Fezzik would just stand there until he would finally run home crying. He was then taken out of school, trained how to fight by his parents for three years, and then fought professionally for many years to come.

Because of this Fezzik may have seen the world as hostile and become overly aggressive toward other individuals. This combined with the postulate of Adler that when an individual has an exaggerated, intensified, unresolved, feeling of inferiority, he may have a "striving to express power over the environment, a goal of dominance over his fellows" (Adler, 1946, p.70). These circumstances would create high risk for Fezzik to develop an anti-social conduct disorder.

So Fezzik's cognitive development appears to have been limited. He appeared to have only one thing going for him in his environment, his

Comment [Q23]: 23. Fezzik's fear of being alone is referred to as:
a. solicitudophobia
b. alonephobia
c. greenlandphobia
d. isolophobia

Comment [Q24]: 24. Healthy cognitive development is manifested by:
a. eating nutritious food
b. an ability to play sports
c. having correct thoughts on what is observed

parents, but even they pulled him out of school and made him fight against his will to make money. This will be addressed further in Fezzik's psychosocial development.

IV. Psychosocial Development Tasks

In the fact that Fezzik's parents loved him and cared for him, it appeared he was able to develop a sense of trust in them. However, his fear of being alone may have seeds in this period of time. Maybe he mistrusted his parents, that they might abandon him. It would seem that he was able to handle some of the tasks of autonomy by exploring and mastering his environment, displaying initiative in that he was great at controlling his impulses, and developed a high moral standard. This was evident in that he insisted on the principle of sportsmanship when he fought.

The next stages are where Fezzik was at a higher risk of developing some psychopathology. **He did not look at his stature as an advantage, but a disadvantage**, because it made him different. Because of this attitude Fezzik struggled with inferiority. As mentioned, his parents **took him out of school**, and against his wishes, taught him how to fight. Fezzik's learning how to fight seemed to have two effects: The first was a sense of **role confusion**. He was placed in the role *of* the principle breadwinner for the family. He was nine years old and told to fight men. At the time of the first fight, when he refused to go into the ring, **his parents threatened him that they would leave him alone** forever if he did not fight. This could have caused a regression to struggling with his trust. Eventually fighting professionally became Fezzik's identity, especially after his parents

Comment [Q25]: 25. As he grew into latency age, Fezzik faced the risk of some psychopathologyas a result of:
a. Role confusion
b. Being insecure about his size
c. Being taken away from school socialization
d. Threats of abandonment from his parents
e. All of the above

died and he joined the circus to fight groups ofmen at a time. This he did in his adolescence.

So Fezzik struggled in the development of his psychosocial tasks. He was for the most part normal, although he never let go ofhis fear of being alone (Erickson's theoretical information for this section found in Corey, 1977).

v. Interpersonal Relationships

Fezzik created a strong attachment to his parents which would suggest the ability to form good, loving relationships with others. The caretaking of Fezzik appeared to be consistently and sensitively administered. He and his parents had a loving and trusting relationship until at the age of about six. At this time his parents showed a great insensitivity to Fezzik's feelings. They became selfish and abused their parental love by manipulating Fezzik as a tool to make money. This may have caused a contamination of the bond because of anxiety and possible anger (Wenar, 1982).

Also, according to Wenar, excessive self-control can be a risk. Fezzik would appear to have the excessiveness in that he would not defend himself against physical harm. This may have been a sign of neurosis (Wenar, 1982).

Fezzik's relations with his peers suffered greatly. Since peer relationships are based on similarities, Fezzik was out of luck. This lack of friendship could inhibit his transition from egocentrism to sharing,

mutuality, and concern for the other party.

At fifteen Fezzik experienced a rupture in his attachment bond when his parents died. Fezzik's social relationships then became those in the circus. This was "the time of his adolescence and groups at his time of development is the bridge to the future. This group also gave Fezzik a sense of belonging after his parents died. Then the circus fired him while they were in Greenland. His bridge to the future was severed, he knew nobody, and faced his greatest life time fear; he was all alone. Fezzik would be at a definite risk of suicide at such a time (Wenar, 1982).

Fezzik's social relationships put him at a high risk for psychopathology. His attachment bonds and social relationships combined to form this risk. .

VI. Conclusion

Fezzik's physical size contributed to all other parts of his development. He was at a high risk level to pathologies. He suffered some setbacks but was able to accomplish a lot considering them. A lot of this might be attributed to the initial attachment formed with his parents who may have given him the foundation to carry through the rest of his trials.

APPENDIX A

Study Questionnaires

The Family Health History and Health Appraisal questionnaires were used to collect information on child abuse and neglect, household challenges, and other socio-behavioral factors in the original CDC-Kaiser ACE Study.

Family Health History Questionnaire

Male Version

Question Number	Verbatim Question	Response categories andcomments
1	What is your birthdate?Month	
	Year_____	
1b	What state were you born in?State_____	enter two letter state codeDC=Districtof Columbia
	Iwas bornoutside the U.S.	1= boxchecked
2	Whatis yoursex?	1=male2=female
3a	Whatis your race?	1=asian 2=black 3=white 4=americanindian5=other 9=multiple boxes checked
3b	Are you of Mexican, Latino, orHispanicorigin?	1=yes2=no
4	Please check how far you've goneinschool.... (Chooseone)	1=Didn't go to high school2=Somehighschool 3=High school graduate or GED4=Some college or technical school5= 4 year college graduate9=Multipleboxeschecked

5	What is your current marital status?Areyounow...	1=married 2=not married, but living togetherwithapartner 3=widowed4=separated5=divorced6=nevermarried 9=multiple answers checked
6a	How many times have you beenmarried?	1=1 2=2 3=3 4=4 or more5=nevermarried 9=multiple boxes checked
6b	During what month and year wereyoufirstmarried? Month___	Range:1-12
	Year___	Range:10-96
	Nevermarried	1=never married
7a	Which of the following bestdescribesyouremploymentstatus?	1=full time (35 hours or more)2=part-time(1-34hours) 3=Not employed outside the home9=multipleitemschecked

7b	*If you are employed full time (35hoursperweekormore):* How many days of work did youmiss in the past 30 days due tostressorfeeling depressed?	Range:0-30
7c	How many days of work did youmissin thepast 30 daysdue topoor physical health?	Range:0-30
8	For most of your childhood, did yourfamilyowntheirhome?	1=yes2 =no
9a	During your childhood, how manytimes did you move residences,evenin thesametown? #oftimes_____	Range:0-999
9b	How long have you lived at yourcurrentresidence?	1=Less than 6 months2=Less than 1 year3=Less than 2 years4=2ormoreyears 9=Multiple boxes checked
10	How was your mother when youwereborn? Age_____	Range:0-99
11a	How much education does/did yourmotherhave?(Chooseone)	1=Didn't go to high school2=Somehighschool 3=High school graduate or GED4=Somecollegeortechnicalscho ol 5=4 year college degree graduate or

		higher9=Multipleboxeschecked
11b	How much education does/did yourfatherhave?(Chooseone)	1=Didn't go to high school2=Somehighschool 3=High school graduate or GED4=Some college or technical school5= 4 year college graduate or higher9=Multipleboxeschecked
12a	Have you smoked at least 100cigarettesin yourentire life?	1=yes2 =no
12b	How old were you when you beganto smoke cigarettes fairly regularly?Age__	Range:0-99
12c	Doyou smoke cigarettes now?	1=yes2 =no
12d	If yes, on average, about how manycigarettesaday doyou smoke? Number of cigarettes____	Range:0-99
13a	If you used to smoke cigarettes butdon't smoke now, about how manycigarettesa daydid yousmoke?	Range:00-99
13b	How old were you when you quit?Age_____	Range:00-99
14a	During your first 18 years of life didyourfathersmoke?	1=yes2 =no
14b	During your first 18 years of life didyourmothersmoke?	1=yes2 =no

15a	During the past month, about howmany days per week did youexercise for recreation or to keep inshape? _____daysper week	Range:0- 7
15b	During the past month, when youexercised for recreation or to keepin shape, how long did you usuallyexercise(minutes)? _____minutes	0=0 1=1-19 2=20-29 3=30-39 4=40-49 5=50-59 6=60or more
16a	How old were you when you hadyour first drink of alcohol other thanafewsips? Age_____	Range:00-99
	Neverdrank alcohol	1=Box Checked
	During each of the following ageintervals, what was your usualnumber of drinks of alcohol perweek?	
16b1	Age19-29	1=None 2=Less than 6 per wk3=7-13perwk 4=14 or more per wk9=multipleresponses

16b2	Age30-39	1=None 2=Less than 6 per wk3=7-13perwk 4=14 or more per wk9=multipleresponses
16b3	Age40-49	1=None 2=Less than 6 per wk3=7-13perwk 4=14 or more per wk9=multipleresponses
16b4	Age50 andolder	1=None 2=Less than 6 per wk3=7-13perwk 4=14 or more per wk9=multipleresponses
16c	During the past month, have youhad any beer, wine, wine coolers,cocktailsorliquor?	1=yes2=no
16d	During the past month, how manydays per week did you drink anyalcoholic beverages on average?	Range:0- 7
16e	On the days when you drank, abouthow many drinks per day did youhaveonaverage?	1=1 2=2 3=3 4=4or more

		5=didn’tdrink in past month
16f	Considering all types of alcoholicbeverages, how many times duringthe past month did you have 5 ormoredrinksonan occasion? Numberof times_____	Range:0-999
16g	During the past month, how manytimes have you driven when you’vehadperhapstoo muchto drink? Numberof times_____	Range:0-999
16h	During the past 30 days, how manytimes did you ride in a car or othervehicle driven by someone who hadbeendrinkingalcohol? Numberof times_____	Range:0-999
17	Have you ever had a problem withyouruseofalcohol?	1=yes2 =no
18	Have you ever considered yourselftobeanalcoholic?	1=yes2 =no
19a	During your first 18 years of life didyou live with anyone who was aproblemdrinkeror alcoholic?	1=yes2 =no
19b	*If“yes”checkall who were:*	
	father	1=ifboxed checked
	mother	1=ifboxed checked
	brothers	1=ifboxed checked
	otherrelative	1=ifboxed checked

	other non-relative	1=ifboxed checked
	sisters	1=ifboxed checked
20	Have you ever been married tosomeone (or lived with someone asif you were married) who was aproblemdrinkeroralcoholic?	1=yes2 =no
21a	Haveyou ever used street drugs?	1=yes2 =no
21b	If “yes” how old were you the firsttimeyouusedthem? Age_____	Range:0-99
21c	About how many times have youusedstreetdrugs?	0=0 1=1-2 2=3-10 3=11-25 4=26-99 5=100+ 9=multiple responses
21d	Have you ever had a problem withstreetdrugs?	1=yes2 =no
21e	Have you ever considered yourselftobeaddicted tostreetdrugs?	1=yes2 =no
21f	Have you ever injected streetdrugs?	1=yes2 =no
22	Have you ever been under the careof a psychologist, psychiatrist, ortherapist?	1=yes2 =no

23a	Has a doctor, nurse, or healthprofessional ever asked you aboutfamily or household problemsduringyourchildhood?	1=yes2 =no
23b	How many close friends or relativeswould help you with your emotionalproblems or feelings if you neededit?	1=none2 =one3=t wo 4=3 or more9=multiplerespon ses
	During your first 18 years of life,wasanyoneinyourhousehold...	
24	Did you live with anyone who usedstreetdrugs?	1=yes2 =no
25a	Were your parents ever separatedordivorced?	1=yes2 =no
25b	Did you ever live with astepfather?	1=yes2 =no
25c	Did you ever live with astepmother?	1=yes2 =no
26	Wereyou a fosterchild?	1=yes2 =no
27a	Did you ever run away from homeformorethanoneday?	1=yes2 =no
27b	Did your brothers or sisters runaway from home for more than oneday?	1=yes2 =no
28	Was anyone in your householddepressedormentallyi ll?	1=yes2 =no

29	Did anyone in your householdattempttocommitsuicide?	1=yes2 =no
30a	Did anyone in your household go toprison?	1=yes2 =no
30b	Did anyone in your household evercommitaseriouscrime?	1=yes2 =no
31a	What is the most you have everweighed? Weightin pounds_____	Range: 000-999
31b	How old were you then?age:___	Range:18-99
32a	Have you ever attempted to commitsuicide?	1=yes2 =no
32b	If “yes”, how old were you the firsttimeyouattemptedsuicide? Age_____	Range:1-99
32c	If “yes”, how old were you the lasttimeyouattemptedsuicide? Age_____	Range:1-99
32d	How many times have youattemptedsuicide? #oftimes_____	Range:01-99,
32e	Did any suicide attempt ever resultin an injury, poisoning, or overdosethat had to be treated by a doctor ornurse?	1=yes2 =no

	In order to get a more completepicture of the health of our patients,the next three questions are about<u>voluntary</u> sexual experiences.	
33a	How old were you the first time youhadsexualintercourse? Years_____	
	Never had intercourse	1=box checked
33b	With how many different partnershave you ever had sexualintercourse? Numberof partners_____	number of intercourse partners, lifetimeRange:0-999 .
33c	During the past year, with howmany different partners have youeverhadsexual intercourse? #of partners_____	number of intercourse partners, past yearRange:0-999
34a	Have you ever gotten someonepregnant? *If"Yes":*	1=yes2 =no
34b	How old were you the first time yougotsomeonepregnant? age:_____	Range:00-99
	Never got someone pregnant	1=box checked .
34c	What was the age of the youngestwomanyou evergot pregnant?	Range:00-99
	Never got someone pregnant	1=box checked
34d	Howold wereyou then?	Range:00-99

	Sometimes physical blows occurbetween parents.While you weregrowing up in your first 18 years oflife, how often did our father (orstepfather) or mother's boyfriend doany to these things to your mother(orstepmother)?	
35a	Push, grab, slap or throw somethingather?	1=never2=once, twice3=sometimes4=often5=veryoften 9=multiple responses
35b	Kick, bite, hit her with a fist, or hitherwithsomethinghard?	1=never2=once, twice3=sometimes4=often5=veryoften 9=multiple responses
35c	Repeatedly hit her over at least afewminutes?	1=never2=once, twice3=sometimes4=often5=veryoften 9=multiple responses
35d	Threaten her with a knife or gun, oruseaknifeor guntohurther?	1=never2=once, twice3=sometimes4=often5=veryoften 9=multiple responses

	Sometimes parents spank theirchildren as a form of discipline.While you were growing up duringyourfirst18yearsoflife:	
36a	Howoften were you spanked?	1=never2=onceortwice 3=a few times a year4=many times a year5=weekly or more9=multiplerespons es
36b	Howseverely were you spanked?	1=not hard2=a little hard3=mediu m4=quite hard5=veryhar d 9=multiple responses
36c	How old were you the last time yourememberbeingspanked? age:_____	Range:18-99
	While you were growing up, duringyour first 18 years of life, how truewere each of the followingstatements:	
37	Youdidn'thaveenoughtoeat?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru e 9=multiple responses

38	You knew there was someone totakecareofyouandprotectyou?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru e 9=multiple responses
39	People in your family called youthingslike“lazy”or “ugly”?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru e 9=multiple responses
40	Your parents were too drunk or hightotakecareofthefamily?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru e 9=multiple responses
41	There was someone in your familywho helped you feel important orspecial?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru e 9=multiple responses
42	Youhad to weardirty clothes?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru

		e 9=multiple responses
43	Youfelt loved?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru e 9=multiple responses
44	You thought your parents wishedyouhadneverbeen born?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru e 9=multiple responses
45	People in your family looked out foreachother?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru e 9=multiple responses
46	You felt that someone in your familyhatedyou?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru e 9=multiple responses

47	People in your family said hurtful orinsultingthingstoyou?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru e 9=multiple responses
48	People in your family felt close toeachother?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru e 9=multiple responses
49	You believe that you wereemotionallyabused?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru e 9=multiple responses
50	There was someone to take you tothedoctorifyouneeded it?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru e 9=multiple responses
51	Your family was a source ofstrengthandsupport?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru

		e 9=multiple responses
	Sometimes parents or other adultshurt children. While you weregrowing up, that is, during your first18 years of life, how often did aparent, step-parent, or adult living inyourhome:	
52a	Swear at you, insult you, or put youdown?	1=never2=once, twice3=sometimes4=often5=veryoften 9=multiple responses
52b	Threaten to hit you or throwsomethingatyou,butdidn'tdoit?	1=never2=once, twice3=sometimes4=often5=veryoften 9=multiple responses
52c	Actually push, grab, shove, slapyou,orthrowsomethingatyou?	1=never2=once, twice3=sometimes4=often5=veryoften 9=multiple responses
52d	Hit you so hard that you had marksorwereinjured?	1=never2=once, twice3=sometimes4=often5=veryoften

		9=multiple responses
52e	Act in a way that made you afraidthatyoumightbephysicallyhurt?	1=never2=once, twice3=sometimes4=often5=veryoften 9=multiple responses
	Some people, while growing up intheir first 18 years of life, had asexualexperience with<u>an adult orsomeone at least five years olderthan themselves.</u>Theseexperiences may have involved arelative family friend or stranger.During the first 18 years of life, didan adult or older relative, familyfriendorstrangerever:	
53a	Touch or fondle your body in asexualway? *If"Yes":*	1=yes2 =no
	The first time this happened, howoldwereyou? age:_____	Range:00-99
	The first time, did this happenagainstyourwishes?	1=yes2 =no
	The last time this happened, howoldwereyou? age:_____	Range:00-99

	About how many times did thishappentoyou? #times:_____	Range:00-99
	How many different people did thistoyou? #people_____	Range:00-99
	What was the sex of the person(s)whodidthis?	1=male2= female3=b oth 9=multiple responses
54a	Have you touch their body in asexualway? *If"Yes":*	1=yes2 =no
	The first time this happened, howoldwereyou? age:_____	Range:00-99
	The first time, did this happenagainstyourwishes?	1=yes2 =no
	The last time this happened, howoldwereyou? age:_____	Range:00-99
	About how many times did thishappentoyou? #times:_____	Range:00-99
	How many different people did thistoyou? #people:_____	Range:00-99

	What was the sex of the person(s)whodidthis?	1=male2= female3=b oth 9=multiple responses
55a	**Attempt** to have any type of sexualintercourse (oral, anal, or vaginal)withyou? *If"Yes":*	1=yes2 =no
	The first time this happened, howoldwereyou? age:_____	Range:00-99
	The first time, did this happenagainstyourwishes?	1=yes2 =no
	The last time this happened, howoldwereyou? age:_____	Range:00-99
	About how many times did thishappentoyou? #times:_____	Range:00-99
	How many different people did thistoyou? #people:_____	Range:00-99
	What was the sex of the person(s)whodidthis?	1=male2= female3=b oth 9=multiple responses

56a	**Actually have** any type of sexualintercourse with you (oral, anal, orvaginal)withyou? *If"Yes":*	1=yes2 =no
	The first time this happened, howoldwereyou? age:_____	Range:00-99
	The first time, did this happenagainstyourwishes?	1=yes2 =no
	The last time this happened, howoldwereyou? age:_____	Range:00-99
	About how many times did thishappentoyou? #times:_____	Range:00-99
	How many different people did thistoyou? #people:_____	Range:00-99
	What was the sex of the person(s)whodidthis?	1=male2= female3=b oth 9=multiple responses
	If you answered "No" to each of thelast 4 questions (54a-57a) aboutsexual experiences with olderpeople,pleaseskiptoquestion62 a.	

	Did any of these sexual experienceswith an adult or person at least 5yearsolderthanyou involve:	
57a	Arelative who livedin your home?	1=yes2 =no
57b	A non-relative who lived in yourhome?	1=yes2 =no
57c	A relative who didn't live in yourhome?	1=yes2 =no
57d	A family friend or person who youknew, and who didn't live in yourhome?	1=yes2 =no
57e	Astranger?	1=yes2 =no
57f	Someone who was supposed to betakingcareofyou?	1=yes2 =no
57g	Someone you trusted?	1=yes2 =no
	Did any of these sexual experiencesinvolve:	
58a	Trickery, verbal persuasion, orpressuretogetyoutoparticipate?	1=yes2 =no
58b	Beinggiven alcohol or drugs?	1=yes2 =no
58c	Threats to harm you if you didn'tparticipate?	1=yes2 =no
58d	Being physically forced oroverpowered to make youparticipate?	1=yes2 =no

59a	Have you ever told a doctor, nurse,or other health professional aboutthesesexualexperiences?	1=yes2 =no
59b	Has a therapist of counselor eversuggested to you that you weresexuallyabusedasa child?	1=yes2 =no
60	Do you think that you were sexuallyabusedasachild?	1=yes2 =no
	Apart from the other experiencesyou have already told us about,while you were growing up duringyourfirst18yearsof life:	
61a	Did a boy or group of boys aboutyour own age, ever force orthreaten you with harm in orderhavesexualcontact?	1=yes2 =no
61b	If yes did the contact involvesomeone touching your sexual partsortryingtohaveintercoursewithyou(oraloranal)?	1=yes2 =no
61c	If yes how many times did someonedothistoyou?	1=once2=twice3=3-5times 4=6-10times 5=more than 10 times9=multiple responses
61d	Did the contact involve a personactually having intercourse with you(vaginal,oraloranal)?	1=yes2 =no

61e	If yes how many times did someonedothis toyou?	1=once2=twice3=3-5times 4=6-10times 5=more than 10 times9=multiple responses
62a	***As an adult**, (age 19 or older) hasanyone ever physically forced orthreaten you to have sexualcontact?*	1=yes2=no
62b	If yes did the contact involvesomeone touching your sexual partsortryingtohaveintercoursewithyou(vaginal,oraloranal)?	1=yes2=no
62c	If yes how many times hassomeonedonethistoyou?	1=once2=twice3=3-5times 4=6-10times 5=more than 10 times9=multiple responses
62d	Did the contact involve a personactually having intercourse with you(vaginal,oraloranal)?	1=yes2=no
62e	If yes how many times did someonedothis toyou?	1=once2=twice3=3-5times 4=6-10times 5=more than 10 times9=multiple

		responses

Family Health History (FemaleVersion)

QuestionNumber	VerbatimQuestion	Response categoriesandcomments
1a	What was the month and yearofyourbirth? Month_____	
	Year_____	
1b	What state were you born in?State_____	enter two letter state codeDC=Districtof Columbia
	Iwas born outside the U.S.	1= box checked
2	Whatis your sex?	1=male2=female
3a	Whatis your race?	1=asian 2=black 3=white 4=americanindian5=other 9=multipleboxeschecked
3b	Are you of Mexican, Latino, orHispanicorigin?	1=yes2=no.

4	Please check how far you'vegoneinschool.... (Chooseone)	1=Didn't go to high school2=Some high school3=Highschoolgraduateorged 4=Some college ortechnicalschool 5=4 year college graduate9=Multiple boxeschecked
5	What is your current maritalstatus?Areyounow...	1=married 2=not married, but living togetherwithapartner 3=widowed4=separated5=divorced 6=nevermarried 9=multiple answers checked
6a	How many times have youbeenmarried?	1=1 2=2 3=3 4=4 or more5=nevermarried 9=multiple boxes checked
6b	During what month and yearwereyoufirstmarried? Month___	Range: 1-12
	Year___	Range:10-96
	Nevermarried	1=nevermarried

7a	Which of the following bestdescribes your employmentstatus?	1=full time (35 hours or more)2=part-time(1-34hours) 3=Not employed outside the home9=multipleitemschecked
	Ifyou arecurrently employed *outsidethehome:*	
7b	How many days of work didyou miss in the past 30 daysduetostressor feeling depressed?	Range: 0-30
7c	How many days of work didyoumissinthepast30days due to poor physical health?	Range: 0-30
8	For most of your childhood, didyourfamilyown theirhome?	1=yes2 =no
9a	During your childhood, howmany times did you moveresidences, even in the sametown? #of times_____	Range:00-99
10	How old was your motherwhenyouwerebor n? Age_____	
11a	How much education does/didyour mother have? (Chooseone)	1=Didn't go to high school2=Somehighschool 3=high school graduate or GED4=Some college or technical school5=College graduate or

		higher9=Multipleboxeschecked
11b	How much education does/didyour father have? (Chooseone)	1=Didn't go to high school2=Somehighschool 3=high school graduate or GED4=Some college or technical school5=Collegegraduateorhigher
12	Have you ever been pregnant? *Ifno skip toquestion 16*	1=yes2 =no
13a	Areyou pregnant now?	1=yes2 =no 3=don'tknow
13b	How many times have youbeenpregnant? Number_____	Range:00-99
13c	How many pregnanciesresulted in the birth of a child?Number:	Range:00-99
13d	How old were you the first timeyoubecamepregnant? age:_____	Range:00-99
13e	The first time you becamepregnant, how old was theperson who got you pregnant?age:	Range:00-99
13f	During what month and yeardid your first pregnancy	Range:01-12

	end?Month_	
	Year_____	Range:0-999
13g	How did your first pregnancyend?	1=live births2=stillbirth/miscarriage3=tubalorectopic pregnancy4=elective abortion5=other 9=multiple responses.
13h	When your first pregnancybegan, did you intend to getpregnant at that time in yourlife?	1=yes2 =no 3=didn'tcare
14	Were you ever pregnant asecondtime? *Ifno skip toquestion 16*	1=yes2 =no
15a	What month and year did yoursecond pregnancy end?month_	Range:01-12
15a	year_____	Range:00-99
15b	How did your secondpregnancyend?	1=live birth2=stillbirth/miscarriage3=tubalorectopic pregnancy4=elective abortion5=other 9=multipleresponses

15c	When your second pregnancybegan, did you intend to getpregnant at that time in yourlife?	1=yes2 =no 3=didn't care
16	*In order to get a morecomplete picture of the healthof our patients, the next threequestions are about voluntarysexualexperiences*. How old were you the first timeyouhad sexualintercourse? Age_____	
	Never hadintercourse	1=boxchecked
17	With how many differentpartners have you ever hadsexualintercourse? #of partners_____	number of intercourse partners,lifetime Range:0-999
18	During the past year, with howmany different partners haveyou ever had sexualintercourse? #of partners_____	number of intercourse partners, pastyear Range:0-999
19a	Have you smoked at least 100cigarettesin yourentire life?	1=yes2 =no
19b	How old were you when youbegan to smoke	Range: 0-99

	cigarettesfairlyregularly? age:_____	
20c	Doyou smoke cigarettes now?	1=yes2 =no
20d	If yes, on average, about howmany cigarettes a day do yousmoke? # cigarettes:_____	Range:0-99
21a	If you used to smoke cigarettesbut don't smoke now, abouthow many cigarettes a day didyousmoke? # cigarettes:_____	Range:00-99
21b	How old were you when youquit? Age_____	Range:00-99
22a	During your first 18 years of lifedidyourfathersmoke?	1=yes2 =no
22b	During your first 18 years of lifedidyourmothersmoke?	1=yes2 =no
23a	During the past month, abouthow many days per week didyou exercise for recreation ortokeepinshape?	Range:0 -7
23b	During the past month, whenyou exercised for recreation orto keep in shape, how long didyou usually exercise(minutes)?	0=0 1=1-19 2=20-29 3=30-39

	_____minutes	4=40-49 5=50-59 6=60 or more9=multiplerespon ses
24a	What is the most you haveeverweighed? Weight in pounds_____	Range:60-500
24b	How old were you then?age:___	Range:18-99
25a	How old were you when youhad your first drink of alcoholotherthanafewsips? age:_____	Range:00-99
	Neverdrank alcohol	1=Yes
	During each of the followingage intervals, what was yourusual number of drinks ofalcoholperweek?	
25b1	Age 19-29	1=None 2=Less than 6 per wk3=7-13perwk 4=14 or more per wk9=multipleresponse s
25b2	Age30-39	1=None 2=Less than 6 per wk3=7-13perwk

		4=14 or more per wk9=multipleresponses
QuestionNumber	Verbatim Question	Response categories andcomments
25b3	Age 40-49	1=None 2=Less than 6 per wk3=7-13perwk 4=14 or more per wk9=multipleresponses
25b4	Age50 and older	1=None 2=Less than 6 per wk3=7-13perwk 4=14 or more per wk9=multipleresponses
25c	During the past month, haveyou had any beer, wine, winecoolers,cocktails orliquor?	1=yes2 =no
25d	During the past month, howmany days per week did youdrink any alcoholic beveragesonaverage?	Range:-0 -7
25e	On the days when you drank,about how many drinks perdaydidyouhaveonaverage?	1=1 2=2 3=3 4=4or more 5=didn't drink in past

		month9=multipleresponses
25f	Considering all types ofalcoholic beverages, howmany times during the pastmonth did you have 5 or moredrinksonanoccasion? Number of times_____	Range:0-999
25g	During the past month, howmany times have you drivenwhen you've had perhaps toomuchtodrink? Numberof times_____	Range:0-999
25h	During the past 30 days, howmany times did you ride in acar or other vehicle driven bysomeone who had beendrinkingalcohol? Numberof times_____	Range:0-999 .
26	Have you ever had a problemwithyouruseof alcohol?	1=yes2 =no
27	Have you ever consideredyourselftobean alcoholic?	1=yes2 =no
28a	During your first 18 years of lifedid you live with anyone whowas a problem drinker oralcoholic?	1=yes2 =no
28b	If"yes" check all whowere:	

	father	1=if box checked
	mother	1=if box checked
	brothers	1=if boxed checked
	otherrelatives	1=if box checked
	othernon-relative	1=if box checked
	sisters	1=if box checked
29	Have you ever been married tosomeone (or lived withsomeone as if you weremarried) who was a problemdrinkeroralcoholic?	1=yes2 =no
30a	Have you ever used streetdrugs?	1=yes2 =no
30b	If “yes” how old were you thefirsttimeyouusedthem? Age_____	Range:0-99
30c	About how many times haveyouusedstreetdrugs?	0=0 1=1-2 2=3-10 3=11-25 4=26-99 5=100+ 9=multiple responses
30d	Have you ever had a problemwithstreetdrugs?	1=yes2 =no
30e	Have you ever consideredyourself to be addicted tostreetdrugs?	1=yes2 =no

30f	Have you ever injected streetdrugs?	1=yes2 =no
31	Have you ever been under thecare of a psychologist,psychiatrist,orthe rapist?	1=yes2 =no
32a	Has a doctor, nurse, or healthprofessional ever asked youabout family or householdproblems during yourchildhood?	1=yes2 =no .=noentry by respondent
32b	How many close friends orrelatives would you help youwith your emotional problemsorfeelingsifyouneed edit?	1=none2 =1 3=2 4=3or more
	During your first 18 years oflife, was anyone in yourhousehold...	
33	Did you live with anyone whousedstreetdrugs?	1=yes2 =no
34a	Were your parents everseparatedor divorced?	1=yes2 =no
34b	Did you ever live with astepfather?	1=yes2 =no
34c	Did you ever live with astepmother?	1=yes2 =no
35	Did you ever live in a fosterhome?	1=yes2 =no
36a	Did you ever run away	1=yes2

	fromhomeformorethanoneday?	=no
36b	Did your brothers or sisters runaway from home for more thanoneday?	1=yes2 =no
37	Was anyone in your householddepressedormentally ill?	1=yes2 =no
38	Did anyone in your householdattempttocommitsuicide?	1=yes2 =no
39a	Did anyone in your householdgotoprison?	1=yes2 =no
39b	Did anyone in your householdevercommit a serious crime?	1=yes2 =no
40a	Have you ever attempted tocommitsuicide?	1=yes2 =no
40b	If “yes”, how old were you thefirst time you attemptedsuicide? Age_____	Range:1-99
40c	If “yes”, how old were you thelast time you attemptedsuicide? Age_____	Range:1-99
40d	How many times have youattemptedsuicide? #of times_____	Range:01-99,
40e	Did any suicide attempt everresult in an injury, poisoning,	1=yes2 =no

	oroverdosethathadtobetreated bya doctoror nurse?	
	Sometimes physical blowsoccurbetween parents.Whileyou were growing up in yourfirst 18 years of life, how oftendidourfather(orstepfather) or mother's boyfriend do any tothese things to your mother (orstepmother)?	
41a	Push, grab, slap or throwsomethingather?	1=never2=onc e, twice3=someti mes4=often5= veryoften 9=multiple responses
41b	Kick, bite, hit her with a fist, orhither withsomething hard?	1=never2=onc e, twice3=someti mes4=often5= veryoften 9=multiple responses
41c	Repeatedly hit her over at leastafewminutes?	1=never2=onc e, twice3=someti mes4=often5= veryoften 9=multiple responses
41d	Threaten her with a knife orgun, or use a knife or gun tohurther?	1=never2=onc e, twice3=someti mes4=often5=

		veryoften 9=multipleresponses
	Sometimes parents spank theirchildren as a form of discipline.While you were growing upduringyourfirst18yearsoflife:	
42a	How often were you spanked?	1=never2=onceo rtwice 3=a few times a year4=many times a year5=weekly or more9=multiplerespon ses
42b	How severely were youspanked?	1=not hard2=a little hard3=mediu m4=quite hard5=veryhar d 9=multipleresponses
42c	How old were you the last timeyou remember being spanked?age:__	Range: 1-99
	While you were growing up,during your first 18 years oflife, how true were each of thefollowingstatements?.	

43	Youdidn'thaveenoughtoeat?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru e 9=multipleresponses
44	You knew there was someoneto take care of you and protectyou?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru e 9=multipleresponses
45	People in your family calledyouthingslike"lazy"or"ugly"?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru e 9=multiple responses
46	Your parents were too drunk orhightotakecareofthefamily?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru e 9=multiple responses
47	There was someone in yourfamily who helped you feelimportantorspecial?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru

		e 9=multipleresponses
48	Youhad to weardirty clothes?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru e 9=multipleresponses
49	Youfelt loved?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru e 9=multipleresponses
50	You thought your parentswished you had never beenborn?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru e 9=multipleresponses
51	People in your family lookedoutforeachother?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru e 9=multiple responses

52	You felt that someone in yourfamilyhatedyou?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru e 9=multiple responses
53	People in your family saidhurtful or insulting things toyou?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru e 9=multipleresponses
54	People in your family felt closetoeachother?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru e 9=multipleresponses
55	You believe that you wereemotionallyabused?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru e 9=multipleresponses
56	There was someone to takeyou to the doctor if you neededit?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru

		e 9=multipleresponses
57	Your family was a source ofstrengthandsupport?	1=never true2=rarely true3=sometimes true4=often true5=veryoftentru e 9=multiple responses
	Sometimes parents or otheradults hurt children. While youwere growing up, that is,during your first 18 years oflife, how often did a parent,step-parent, or adult living inyourhome:	
58a	Swear at you, insult you, or putyoudown?	1=never2=onc e, twice3=someti mes4=often5= veryoften 9=multiple responses
58b	Threaten to hit you or throwsomething at you, but didn't doit?	1=never2=onc e, twice3=someti mes4=often5= veryoften 9=multipleresponses
58c	Actually push, grab, shove,slap you, or throw somethingatyou?	1=never2=onc e, twice3=someti mes4=often5=

		veryoften 9=multipleresponses
58d	Hit you so hard that you hadmarksorwereinjured?	1=never2=onc e, twice3=someti mes4=often5= veryoften 9=multipleresponses
58e	Act in a way that made youafraid that you might bephysicallyhurt?	1=never2=onc e, twice3=someti mes4=often5= veryoften 9=multiple responses
	Somepeople,whilegrowingup in their first 18 years of life,had a sexual experience withan adult or someone at leastfive years older thanthemselves.Theseexperiencesmayhaveinvolved a relative family friendor stranger.During the first 18years of life, did an adult orolder relative, family friend orstrangerever:	
59a	Touch or fondle your body in asexualway? If"Yes"	1=yes2 =no

	The first time this happened,howoldwereyou? age:_____	Range:00-99
	The first time, did this happenagainstyourwishes?	1=yes2 =no
	The last time this happened,howoldwereyou? age:_____	Range:00-99
	About how many times did thishappentoyou? #times:_____	Range:00-99
	How many different people didthistoyou? #people:_____	Range:00-99
	What was the sex of theperson(s)who did this?	1=male2= female3=b oth 9=multiple responses
60a	Have you touch their body in asexualway? If"Yes":	1=yes2 =no
	The first time this happened,howoldwereyou? age:_____	Range:00-99
	The first time, did this happenagainstyourwishes?	1=yes2 =no
	The last time this	Range:00-99

	happened,howoldwereyou? age:_____	
	About how many times did thishappentoyou? #times:_____	Range:00-99
	How many different people didthistoyou? #people:_____	Range:00-99
	What was the sex of theperson(s)who did this?	1=male2= female3=b oth 9=multiple responses
61a	**Attempt** to have any type ofsexual intercourse (oral, anal,orvaginal)withyou? If"Yes":	1=yes2 =no
	The first time this happened,howoldwereyou? age:_____	Range:00-99
	The first time, did this happenagainstyourwishes?	1=yes2 =no
	The last time this happened,howoldwereyou? age:_____	Range:00-99
	About how many times did thishappentoyou? #times:_____	Range:00-99

	How many different people didthistoyou? #people:_____	Range:00-99
	What was the sex of theperson(s)who did this?	1=male2= female3=b oth 9=multipleresponses
62a	**Actually have** any typeofsexual intercourse with you(oral, anal, or vaginal) withyou? If"Yes":	1=yes2 =no
	The first time this happened,howoldwereyou? age:_____	Range:00-99
	The first time, did this happenagainstyourwishes?	1=yes2 =no
	The last time this happened,howoldwereyou? age:_____	Range:00-99
	About how many times did thishappentoyou? #times:_____	Range:00-99
	How many different people didthistoyou? #people:_____	Range:00-99
	What was the sex of theperson(s)who did	1=male2= female3=b

	this?	oth 9=multipleresponses
	Ifyouanswered"No" toeachof the last 4 questions (59a-62a) about sexualexperienceswith older persons, please skiptoquestion67a. *Mark all that apply. Did any ofthese sexual experiences withan adult or person at least 5yearsolder thanyou involve:*	
63a	A relative who lived in yourhome?	1=yes2 =no
63b	A non-relative who lived inyourhome?	1=yes2 =no
63c	A relative who didn't live inyourhome?	1=yes2 =no
63d	A family friend or person whoyou knew and who didn't live inyourhousehold?	1=yes2 =no
63e	A stranger?	1=yes2 =no9
63f	Someone who was supposedtobetakingcare ofyou?	1=yes2 =no
63g	Someone youtrusted?	1=yes2 =no

	Did any of these sexualexperiencesinvolve:	
64a	Trickery, verbal persuasion, orpressure to get you toparticipate?	1=yes2 =no
64b	Beinggiven alcohol or drugs?	1=yes2 =no
64c	Threats to harm you if youdidn'tparticipate?	1=yes2 =no
64d	Being physically forced oroverpowered to make youparticipate?	1=yes2 =no
65a	Have you ever told a doctor,nurse, or other healthprofessional about thesesexualexperiences?	1=yes2 =no
65b	Has a therapist of counselorever suggested to you that youwere sexually abused as achild?	1=yes2 =no
66	Do you think that you weresexuallyabusedasachild?	1=yes2 =no
	Apart from other sexualexperiences you have alreadytold us about, while you weregrowing up during your first 18yearsoflife	
67a	Did a boy or group of boysabout your own age ever forceorthreatentoharm youin	1=yes2 =no

	orderto have sexual contact?	
67b	If yes did the contact involvesomeone touching your sexualparts or trying to haveintercourse with you (oral,anal,vaginal)?	1=yes2 =no
67c	If yes how many times didsomeonedo thisto you?	1=once2=twi ce3=3- 5times 4=6-10times 5=more than 10 times9=multiple responses
67d	Did the contact involve aperson actually havingintercourse with you (oral,anal,vaginal)?	1=yes2 =no
67e	If yes how many times didsomeonedo thisto you?	1=once2=twi ce3=3- 5times 4=6-10times 5=more than 10 times9=multiple responses
68a	***As an adult****, (age 19 or older)did anyone ever force orthreaten you with harm in ordertohavesexualcontact?*	1=yes2 =no
68b	If yes did the contact involvesomeone touching your sexualparts or trying to	1=yes2 =no

	haveintercourse with you (oral,anal,vaginal)?	
68c	If yes how many times didsomeonedo thisto you?	1=once2=twice3=3-5times 4=6-10times 5=more than 10 times9=multiple responses
68d	Did the contact involve aperson actually havingintercourse with you (oral,anal,vaginal)?	1=yes2=no
68e	If yes how many times didsomeonedo thisto you?	1=once2=twice3=3-5times 4=6-10times5=more than10 times9=multiplerespo nses

Health Appraisal Questionnaire

Female Version

***Doyouhave*:**	
Frequent stuffy or waterynose,sneezing	1=yes2=no
An allergy to anymedications	1=yes2=no
Asthma or notice yourselfwheezing	1=yes2=no
Chronic bronchitis oremphysema	1=yes2=no
A frequent cough for anyreason	1=yes2=no
Shortnessofbreath	1=yes2=no
Haveyouever:	
Coughed up blood(coughednotvomited)	1=yes2=no
Been treated for TB orCoccidomycosis	1=yes2=n

(ValleyFever)	o
HadapositiveTBtest	1=yes2=no
Beenasmoker	1=yes2=no
Ifnowasmokerhow many cigarettes aday_____	
Hadlungcancer	1=yes2=no
Doyouchewtobacco	1=yes2=no
Have you ever had, oreverbeentoldyou have:	
Highbloodpressure	1=yes2=no
To take blood pressuremedicine	1=yes2=no
Aheartattack(coronary)	1=yes2=no
To take medicine to loweryourcholesterol	1=yes2=no
Doyouget:	
Pains orheavy pressureinyourchestwithexertion	1=yes2=no
Doyouusenitroglycerin	1=yes2=

	o
Episodes of fast heartbeatsorskippedbeats	1=yes2=no
Otherheartproblems	1=yes2=no
Nocturnallegcramps	1=yes2=no
Leg pains from rapid oruphillwalking,stairs	1=yes2=no
Doyouhave:	
Varicoseveins	1=yes2=no
Anyskinproblems	1=yes2=no
Areyoutroubledby:	
Abdominal (stomach)pains	1=yes2=no
Frequent indigestion orheartburn	1=yes2=no
Constipation	1=yes2=no
Frequent diarrhea, loosebowels	1=yes2=no
Has there been adefinitechange:	
In the pattern or regularityof your bowel movementsinthelastyear	1=yes2=no

Areyouavegetarian	1=yes2=no
Have you ever had, orbeentoldyouhave:	
Anulcer	1=yes2=no
Vomitedblood	1=yes2=no
Black tar-like bowelmovements	1=yes2=no
Gallstones, gallbladderproblems	1=yes2=no
Yellow jaundice, hepatitis,oranylivertrouble	1=yes2=no
Definite change in yourweightinrecentmonths	1=yes2=no
Areyoutroubledby:	
Frequentheadaches	1=yes2=no
Attacksofdizziness	1=yes2=no
Haveyouever	
Had seizures,convulsions,fits	1=yes2=no
Fainted or lostconsciousness for	1=yes2=no

noobviousreason	
Temporarily lost control ofahandorfoot(paralysis)	1=yes2=no
Had a stroke or “smallstroke”	1=yes2=no
Been temporarily unabletospeak	1=yes2=no
Areyoutroubledby:	
Frequentbackpain	1=yes2=no
Pain or swelling in yourjoints	1=yes2=no
Haveyouever:	
Brokenanybones	1=yes2=no
Frequently worried aboutbeingill	1=yes2=no
Been troubled as a resultof being more sensitivethanmostpeople	1=yes2=no
Had specialcircumstances in whichyoufindyourselfpanicked	1=yes2=no
Had reason to fear youranger getting out ofcontrol	1=yes2=no
Haveyouhad,ordoyo	

uhave:	
Any problems with youurinary tract (kidney,bladder)	1=yes2=no
Loss of control of youurine	1=yes2=no
Pain or burning when youurinate	1=yes2=no
Bloodin yourine	1=yes2=no
Trouble starting the flowofurine	1=yes2=no
Togetuprepeatedlyatnighttourinate	1=yes2=no
Vaginal bleeding betweenperiods	1=yes2=no
After menopause, anyvaginal bleedingwhatsoever	1=yes2=no
A noticable lump in yourbreast	1=yes2=no
Do breast self-examsregularly	1=yes2=no
Discharge from yournipples	1=yes2=no
Haveyoueverbeen treated for or told youhad:	
Anyvenerealdisease	1=yes2=n

	o
Diabetes	1=yes2=no
To take *medicine* fordiabetes	1=yes2=no
Thyroiddisease	1=yes2=no
Cancer	1=yes2=no
Have you ever had ordoyounowhave:	
Radiationtherapy	1=yes2=no
Trouble refusing requestsorsaying“No”	1=yes2=no
Hallucinations (seen,smelled, or heard thingsthatwerenotreallythere	1=yes2=no
Trouble falling asleep orstayingasleep	1=yes2=no
Tiredness, even after agoodnight’ssleep	1=yes2=no
Cryingspells	1=yes2=no
Depression or “feel downinthedumps”	1=yes2=no
Much trouble withnervousness	1=yes2=no

Doyou:	
Sometimes drink morethanisgoodforyou	1=yes2=no
Usestreetdrugs	1=yes2=no
Haveyouever:	
Beenraped,orsexuallymolestedasachild	1=yes2=no
Areyou:	
Currently sexually activewithapartner	1=yes2=no
Satisfiedwithyoursexlife	1=yes2=no
Concerned you are at riskforAIDS	1=yes2=no
Pleasetellus:	
In the past year, abouthow many visits to adoctorhaveyou made_____	.
How far have you gone inschool	.
Areyoumarried	1=yes2=no

How many times haveyoubeenmarried___	.
Are you now havingserious or disturbingproblems withyour:	
Marriage	1=yes2=no
Family	1=yes2=no
Drugusage	1=yes2=no
Job	1=yes2=no
Financialmatters	1=yes2=no
Have you ever hadcoronaryarterysurgery	1=yes2=no
Approximateyear	.
Did you have a bloodtransfusionbetween 1978 and1985	1=yes2=no
Do you feel you need anyimmunizations	1,2,.

Areyouretired	1=yes2 =no
Have members of yourfamily died before the ageof65?	1=yes2 =no
Are there diseases whicha number of familymembershavehad?	1=yes2 =no
Are there any unusualillnesses in your familyyoudidn'tlistpreviously?	1=yes2 =no
Has a parent, brother, orsister developed coronary(heart)diseasebefore age60?	1=yes2 =no
Do you have an identicaltwin?	1=yes2 =no
Please fill in the circle thatyou think best describesyour current state ofhealth	1=excellent2 =good3=fair4 =poor
Do you regularly use seatbeltsinacar?	1=yes2 =no
Please fill in the circle thatbestdescribesyourstresslevel:	1=high2=medium3=low

Yearoflastmammogram	
EXAMINATIONDATA	

Male Version

VerbatimQuestion	**Coding andcomments**
***Doyouhave*:**	
Frequent stuffy or waterynose,sneezing	1=yes2=no
An allergy to anymedications	1=yes2=no
Asthma or notice yourselfwheezing	1=yes2=no
Chronic bronchitis oremphysema	1=yes2=no
A frequent cough for anyreason	1=yes2=no
Shortnessofbreath	1=yes2=no
Haveyouever:	
Coughed up blood(coughednotvomited)	1=yes2=no

Been treated for TB orCoccidomycosis (ValleyFever)	1=yes2 =no
HadapositiveTBtest	1=yes2 =no
Beenasmoker	1=yes2 =no
Ifnowasmokerhow many cigarettes aday_____	
Hadlungcancer	1=yes2 =no
Doyouchewtobacco	1=yes2 =no
Haveyoueverhad,or ever been told youhave:	
Highbloodpressure	1=yes2 =no
To take blood pressuremedicine	1=yes2 =no
Aheartattack(coronary)	1=yes2 =no
To take medicine to loweryourcholesterol	1=yes2 =no
Doyouget:	
Pains orheavy pressureinyourchestwithexertion	1=yes2 =no

Doyouusenitroglycerin	1=yes2 =no
Episodes of fast heartbeatsorskippedbeats	1=yes2 =no
Otherheartproblems	1=yes2 =no
Nocturnallegcramps	1=yes2 =no
Leg pains from rapid oruphillwalking,stairs	1=yes2 =no
Doyouhave:	
Varicoseveins	1=yes2 =no
Anyskinproblems	1=yes2 =no
Areyoutroubledby:	
Abdominal (stomach)pains	1=yes2 =no
Frequent indigestion orheartburn	1=yes2 =no
Constipation	1=yes2 =no
Frequent diarrhea, loosebowels	1=yes2 =no
Has there been adefinitechange:	
In the pattern or regularityof your bowel	1=yes2 =no

movementsinthelastyear	
Areyoua vegetarian	1=yes2 =no
Have you ever had, orbeentoldyouhave:	
Anulcer	1=yes2 =no
Vomitedblood	1=yes2 =no
Black tar-like bowelmovements	1=yes2 =no
Gallstones, gallbladderproblems	1=yes2 =no
Yellow jaundice, hepatitis,oranylivertrouble	1=yes2 =no
Definite change in yourweightinrecentmonths	1=yes2 =no
Areyoutroubledby:	
Frequentheadaches	1=yes2 =no
Attacksofdizziness	1=yes2 =no
Haveyouever	
Had seizures,convulsions,fits	1=yes2 =no

Fainted or lostconsciousness for noobviousreason	1=yes2 =no
Temporarily lost control ofahandor foot(paralysis)	1=yes2 =no
Had a stroke or “smallstroke”	1=yes2 =no
Been temporarily unabletospeak	1=yes2 =no
Areyoutroubledby:	
Frequentbackpain	1=yes2 =no
Pain or swelling in yourjoints	1=yes2 =no
Haveyouever:	
Brokenanybones	1=yes2 =no
Frequently worried aboutbeingill	1=yes2 =no
Been troubled as a resultof being more sensitivethanmostpeople	1=yes2 =no
Had specialcircumstances in whichyoufindyourselfpanicked	1=yes2 =no
Had reason to fear youranger getting out ofcontrol	1=yes2 =no

Haveyouhad,ordoyouhave:	
Any problems with youurinary tract (kidney,bladder)	1=yes2=no
Loss of control of youurine	1=yes2=no
Pain or burning when youurinate	1=yes2=no
Bloodin youurine	1=yes2=no
Trouble starting the flowofurine	1=yes2=no
Togetuprepeatedlyatnighttourinate	1=yes2=no
Discharge from yournipples	1=yes2=no
Have you ever beentreatedfororortoldyou had:	
Anyvenerealdisease	1=yes2=no
Diabetes	1=yes2=no
To take *medicine* fordiabetes	1=yes2=no
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Cancer	1=yes2 =no
Have you ever had ordoyounowhave:	
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Much trouble withnervousness	1=yes2 =no
Doyou:	
Sometimes drink morethanisgoodforyou	1=yes2 =no
Usestreetdrugs	1=yes2 =no
Haveyouever:	

Beenraped,orsexuallymolestedasachild	1=yes2=no
Areyou:	
Currently sexually activewithapartner	1=yes2=no
Satisfiedwithyoursexlife	1=yes2=no
Concerned you are at riskforAIDS	1=yes2=no
Pleasetellus:	
In the past year, abouthow many visits to adoctorhaveyou made_____	.
How far have you gone inschool	.
Areyoumarried	1=yes2=no
How many times haveyoubeenmarried____	.
Are you now havingseriousordisturbing problemswithyour:	
Marriage	1=yes2=no
Family	1=yes2=no

Drugusage	1=yes2 =no
Job	1=yes2 =no
Financialmatters	1=yes2 =no
Have you ever hadcoronaryarterysurgery	1=yes2 =no
Approximateyear	Range:1-96 .
Did you have a bloodtransfusionbetween1978 and1985	1,2,.
Do you feel you need anyimmunizations	1,2,.
Areyouretired	1=yes2 =no
Have members of yourfamily died before the ageof65?	1=yes2 =no
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familyyoudidn’tlistpreviously?	
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