Methodologies and Tools for Measuring the Mental Health and Psychosocial Wellbeing of Children in Humanitarian Contexts

Report of a Mapping Exercise for the Child Protection Working Group (CPWG) and Mental Health & Psychosocial Support (MHPSS) Reference Group

Alastair Ager, Sarah Robinson and Janna Metzler

Columbia University, Columbia Group for Children in Adversity & the CPC Learning Network

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1. CONTEXT AND BACKGROUND

Addressing children's MHPSS needs is an established priority in humanitarian emergencies

Exposure to conflict and natural disasters poses significant risks to the mental health and psychosocial wellbeing of affected populations. Children and adolescents are particularly vulnerable given that humanitarian emergencies often disrupt the very social institutions, community resources, economic livelihoods, and infrastructural supports that children depend on for normal growth and development. Although children can be remarkably resilient and adaptive to change in their environments, such disruption of the social fabric commonly warrants the mobilization of interventions addressing mental health and psychosocial support to further facilitate recovery and growth (Loughrey & Eyber, 2003; Boothby, Wessells & Strang, 2006; Hunter, 2012)

The need for mental health and psychosocial support (MHPSS) services for children in contexts of humanitarian crises is now widely accepted. In recent years, increasingly more attention has been placed on ensuring MHPSS provision is included as a basic component of all humanitarian response efforts. Children, because of their unique vulnerabilities and responses to environmental emergencies, factor prominently in these efforts to better address mental health and psychosocial challenges.

In 2007, the Inter-Agency Standing Committee (IASC), representing United Nations (UN) and non-UN international humanitarian organizations, convened a consultative process on the minimum standards of mental health and psychosocial support all organizations should adhere to during humanitarian emergencies. The guidance developed through this consultation, the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007)*, represented a call to action for more professional standards and practices in emergency settings. The guidelines recognize the pervasive and destructive nature of unaddressed, or under-addressed, mental health and psychosocial needs due to humanitarian crises and advise collaboration across sectors and agencies in coordinating MHPSS support endeavors.

Although a major focus of the IASC guidelines is upon actions that can be anticipated to be of relevance across diverse humanitarian contexts, a consistent emphasis across recommended actions is appraisal of needs and capacities that can inform response. While there has been significant advance in the availability of tools to support such appraisals (e.g. WHO & UNHCR, 2012), the assessment of mental health and psychosocial wellbeing – particularly of children – has remained a particular challenge. Such assessment is relevant both to the determination of the goals and nature of interventions and to the subsequent judgment of their impact.

Measuring children's mental health and psychosocial wellbeing is crucial

The Assessment & Measurement Task Force of the Child Protection Working Group (CPWG) and the Mental Health and Psychosocial Support Reference Group (MHPSS RG) have both recognised that while mental health and psychosocial wellbeing may be a 'hard to measure' issue in the context of humanitarian emergencies, its documentation is crucial for the development of practice.

The CPWG sees such developments as critical in establishing evidence-based programming within the child protection sector in line with the standards detailed in the *Minimum Standards on Child Protection in Humanitarian Action* (CPWG, 2012). The MHPSS RG similarly sees that the development of a monitoring and evaluation framework to accompany the IASC guidelines is vital if M&E practice in the sector is to be significantly strengthened. Mapping the current repertoire of tools and approaches available for measuring children's psychosocial wellbeing is a key step in providing practical recommendations to practitioners to guide the development of initial assessments and ongoing monitoring and evaluation tools in humanitarian settings.

Ongoing monitoring and evaluation may help reveal programmatic areas that require modification, and in some cases, the discontinuation of programming. An absence of impact assessments has the potential to perpetuate established programing approaches that provide little to no benefit to their beneficiaries and potentially drain local and international resources (Betancourt & Williams, 2008). A recent review highlighted the large gap between current MHPSS practices and knowledge of the effectiveness of interventions (Tol et al., 2011). The review found that evaluation research has tended to develop the most robust evidence-base for interventions that are infrequently implemented, with fewer rigorous studies focused on the interventions most commonly adopted. The review's authors recommend increased efforts in operational research to further strengthen capacity of practitioners to conduct evaluation as part of ongoing program efforts, particularly around tool identification, development, and field administration.

The *Inter-Agency Guide to the Evaluation of Psychosocial Programming in Humanitarian Emergencies* (UNICEF, 2011) represents current understandings of good practice in strengthening assessment and evaluation by agencies within the context of routine program implementation. The guide presents a comprehensive framework for assessment and evaluation, and endorses an approach to psychosocial support that promotes the routine identification of indicators within the domains of emotional wellbeing, social wellbeing and skills and knowledge. However, it does not review in detail specific tools and measures related to assessment with respect to these domains. Nor does it address the assessment of mental health, which – through the influence of the IASC guidelines – is increasingly acknowledged as key component of an integrated field of mental health and psychosocial support.

The importance of measurement is not only related to the issue of evaluation. Programming decisions continue to often be based upon assumed MHPSS needs (often on the basis of judgments by external actors) or, at best, somewhat superficial initial assessment exercises rather than upon structured baseline assessments (Ager et al., 2011; Marquer et al., 2012). Lack of clarity in the assessment of needs puts at risk the beneficial impact of programs on their intended populations, and increases the likelihood of wasting crucial human and financial resources on ineffective programs. In contrast, effective assessment measures inform practitioners of the specific nature of children's MHPSS needs so that suitable programming can be appropriately focused, enhancing accountability to both beneficiaries and donors.

Key challenges are the cultural validity, reliability and feasibility of measures

What makes the mental health and psychosocial wellbeing of children in humanitarian emergencies such a 'hard to measure' issue, rather than just a matter of choosing relevant indicators? There appear to be three factors contributing to this (see Figure 1).
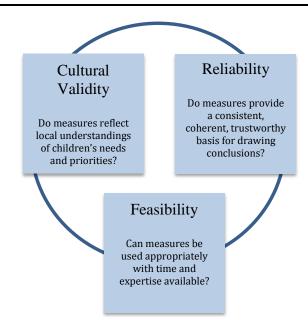
The challenge of cultural validity
There is a well-established literature documenting how culture heavily influences the manner in which mental health problems are presented (Patel, 1999). While certain types of mental health issue may be seen across a broad range of contexts – such as anxiety or depression – the specific way they are manifest can be heavily shaped by local understandings and social mores. This variation is perhaps greater still when focusing on broader indicators of children's wellbeing. Signs that a child is 'doing well' can be understood very differently in different settings; a number of studies have documented marked variation in locally derived indicators of child wellbeing (Stark et al., 2009). For this reason, it is widely acknowledged that measures of mental health and psychological wellbeing – amongst children or any other group – need to clearly reflect the understanding of health and wellbeing in the setting where they are being used. This is generally referred to as 'cultural validity': the concepts and ideas being asked about make sense to people in that context and relate to local concerns and priorities. It is best when this is confirmed by evidence that those whose scores on a measure indicate major needs are also those identified - by lay or professional judgment - as the most needy (technically referred to as 'criterion validity').

The challenge of reliability
It is generally recognized that to conclude something meaningful about a child's wellbeing we will have to ask a number of questions. But how many questions? Are these clearly and consistently understood by those who are answering them? Do they fit together in a meaningful way so that responses can be combined together and confidently used to represent an aspect of the child's wellbeing? These concerns touch upon matters of validity, but the central focus is reliability: does the measure give us a consistent, coherent, trustworthy picture of what we want to be asking about? This is a key focus of the field of psychometrics, which generally involves several stages of

not only adjusting the wording of items (to remove ambiguities and inconsistencies of interpretation) but also the addition and deletion of items (dropping those which the pattern of responses suggests doesn't 'fit' with the other; bringing in new ones that strengthen the internal consistency between items). Most established mental health and psychosocial measures will have gone through such processes, and documentation will normally include reports of their statistical reliability. However, given the strong cultural influences on understanding of such concepts, a measure that proves reliable in one setting may not prove so in another. Good reliability is crucial in evaluation studies, where sensitivity to change over time is required. Using an unreliable measure may mean there is so much 'noise' in data collected that important changes are not detected.

Figure 1: The three key challenges making measurement of mental health and psychosocial wellbeing of children in humanitarian settings a 'hard to measure' issue.

Cultural Validity

Do measures reflect local understandings of children's needs and priorities?

Reliability

Do measures provide a consistent, coherent, trustworthy basis for drawing conclusions?

Feasibility

Can measures be used appropriately with time and expertise available?

The challenge of feasibility

Humanitarian settings present many constraints with respect to measurement. Principal amongst these are the timescale within which assessments need to be completed to be of value for baseline purposes and the limited human resource capacity that can be mobilized in support of data collection. In terms of timing, measures need to be feasible both in terms of the length of time administering an assessment takes with an interviewee and in terms of the overall window of time within which data collection must be completed for operational reasons. With regards to human resource requirements, humanitarian settings are generally marked by a severe shortage of technical skills, due both to a combination of weak pre-existing capacities, disruption of existing work structures and, frequently, competition between non-government agencies regarding people with advanced technical skills in such areas as assessment and evaluation. Measures that require

engagement of a mental health professional or social worker, for example, may in principle be suitable for the assessment of affected children's needs, but not feasibly implemented in the circumstances. Most assessments are likely to have to rely on completion by locally-recruited enumerators, using focused training to strengthen capacities required for data collection.

Each of these issues in their own right represents a significant challenge to measurement, but it is in combination that they genuinely contrive to make children's mental health and psychosocial wellbeing in humanitarian contexts truly 'hard to measure'. For example, there is wide concern that adoption of reliable measurement instruments by a skilled external research team for a short period (which addresses the second and third challenges) risks an 'extractive' form of data collection (Wessells, 2009) wildly disconnected from local priorities and concerns (that is, fails to establish cultural validity). Equally hazardous, however, are strategies that engage in valuable participative work in communities (including directly with children) in a manner that addresses the first and third challenges, but fail to pay attention to establishing the reliability of findings in a robust manner (UNICEF, 2011). This risks data being meaningless or, worse, misleading. Finally, there are – as noted later - a number of strategies emerging that reflect due attention to the challenges of both cultural validity and reliability. However, the length of time and technical support required to implement them makes them appear unfeasible to implement in many humanitarian contexts, particularly those involving rapid onset emergencies. Developing capacity for the measurement of the mental health and psychosocial wellbeing of children in humanitarian emergencies must mean identifying strategies that address all three of these challenges

Programming increasingly encourages an integrated understanding of MHPSS issues

In the 1990s psychosocial work in the field of humanitarianism was 'characterised by a lack of consensus on goals, strategy and best practice' (PWG, 2002). There was especial divergence between those focusing on treatment of mental disorders, particularly post-traumatic stress disorder, and those addressing broader community wellbeing, for which the reestablishment of local coping capacities were seen as key. However, beginning at the turn of the century, there was increasing evidence of more integrated understandings, with a number of initiatives seeking to formulate a common framework for interventions.

These initiatives culminated in the presentation of the intervention pyramid used in the formulation of the IASC guidelines (2007). This identifies the potential relevance of basic services and security (level 1), community and family supports (level 2), focused supports (level 3) and more specialized services (level 4); while noting the expectation of proportionally fewer within the population requiring support with each step 'up' the pyramid.

The identification of symptoms associated with mental health problems is, in these terms, most likely of relevance for informing interventions at level 3, with identification of clinical disorder

(typically through a level of symptom reports associated with high risk for formal diagnosis) relevant to level 4 interventions. Appraisal of broader psychosocial wellbeing – typically interpreted as assets and capacities with respect to emotional wellbeing, social wellbeing, and relevant skills and knowledge – would typically be seen as relevant to informing interventions at levels 1 and 2.

In practice, however, this locating of mental health interventions and broader psychosocial supports on a continuum has served to unite the conceptualization of MHPSS as a coherent field of work. Interventions are of varying emphasis depending upon need, priorities and context, but share a common framing. The measurement of MHPSS would usefully accommodate this convergence. That is, while there will be instances where measurement should appropriately focus on potential mental health symptoms - and others where a more generic, assets-based understanding of wellbeing should be the focus – the continuity of these elements within a child's experience may usefully be recognized.

2. THE MAPPING PROCESS

A mapping exercise was conducted in August and September of 2013 to document existing assessment approaches to children's mental health and psychosocial wellbeing in the context of humanitarian emergencies. Given the goal of informing routine assessment, monitoring and evaluation practice, the focus was not on 'bespoke' measures developed for one particular setting, but rather tools and approaches that had been used in at least two contexts, and for which there was therefore some evidence of generalizability. For the purposes of this mapping exercise, mental health and psychosocial support was defined using the IASC definition: "any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorder" (2007, p. 1); 'children' were defined as persons between the ages of birth and 18; 'humanitarian contexts' included conflicts, man-made disasters, and/or natural disasters; and 'psychosocial wellbeing' was taken to encompass emotional wellbeing, social wellbeing, and relevant skills and knowledge, as defined within inter-agency guidelines (UNICEF, 2011).

The principal basis of mapping was a systematic review of published literature using the computer-based search engines and electronic resources: ProQuest, PubMed, PsychInfo, JSTOR, and Google Scholar. Search terms used for preliminary capture of material comprised: 'psychosocial', 'assessment', 'humanitarian', 'children', 'wellbeing', and 'well-being'. This identified 3,570 papers in which various measurement tools and approaches were documented. Titles and abstracts of these papers were reviewed with respect to specified exclusion criteria. Given the goals of the study (and the constraints on the analysis in terms of time and resources) these specified the exclusion of material where:
- the tool or approach was not focused on children;

- the tool or approach reported upon was a basis for psychosocial intervention rather than a form of assessment, monitoring, or evaluation;
- the tool or approach was not employed in assessment of children in humanitarian situations, but in high-income countries where children previously exposed to humanitarian crisis had resettled (e.g. United States, Europe, Australia, etc.);
- reported use of the tool or approach was limited to a single instance or setting;
- no details of any consideration of validation of the tool or approach was reported; or
- no material regarding the tool or approach was available in English.

This resulted in identification of 106 resources, for which full reports were obtained. These documents were then reviewed to confirm that the tools and approaches they referenced met the stated inclusion criteria. This frequently required secondary computer searchers to confirm details of the tool or approach and its contexts of use. This resulted in the confirmation of 46 tools and approaches as meeting inclusion criteria (see Table 1).

To complement the computer search, professional networks were also utilized to elicit potential material. Web-postings and emails requesting details of those tools or methodologies used to assess psychosocial wellbeing in children in humanitarian settings were made through the CPWG, the MHPSS, and Child Protection in Crisis (CPC) networks. Such consultations identified a number of tools, but only two meeting inclusion criteria had not already been identified by computer search. The analysis that follows is, thus, based on the 48 resources meeting specified inclusion criteria.

Key details of these tools and approaches were then extracted and entered into a reference table, utilizing a standardized template. These details included the scope of the tool or measure (e.g. whether the measure is suited to assess mental health, broader psychosocial wellbeing, or both); specified age ranges for its use; its focus (assessing individuals to guide specific interventions; assessing overall group- or population-level needs; or structuring relevant participatory activities); language availability and/or adaptability; examples of its use; restrictions on use; and details of where to obtain further information. The resulting compilation of tools and approaches is available in the supplement to this report: *A Compendium of Tools and Methods for Assessment of the Mental Health and Psychosocial Wellbeing of Children in Humanitarian Emergencies*.

There was wide variation in the amount and accessibility of data available for the completion of the reference table. For some tools and approaches considerable information, and studies evidencing their use in humanitarian contexts, was available. For others, information was fragmented and, at times, contradictory. In such circumstances, details were completed as comprehensively as information allowed. In many instances, there was a large amount of information available in relation to a tool's use in high-income countries (HICs), and/or in non-humanitarian settings, but

Table 1: Tools and Approaches Identified By the Mapping Exercise

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

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

Scope: MH=mental health; PSS=psychosocial wellbeing; MHPSS=both mental health and psychosocial wellbeing
Focus: I=individual profile; G=group or population needs; P=participatory activities

far less regarding use in settings of greatest interest to this exercise: humanitarian situations, typically in the low- and middle-income countries (LMICs).

Finally, there were two documents identified which, although not meeting this review's specific inclusion criteria, are highlighted here as of significant broader relevance to those working on MHPSS issues with children in humanitarian contexts. Both are publications by the World Health Organization (WHO): *Assessing Mental Health and Psychosocial Needs and Resources,* and *Mental Health and Psychosocial Support in Humanitarian Emergencies: What Should Humanitarian Health Actors Know?* The former provides useful assessment strategies and guidance on psychosocial assessments, particularly on the mechanics of conducting population- and system-level assessments to inform sector-level planning and interventions. While its content is helpful in determining ways to elicit information on relevant MHPSS topics, it does not provide specific measures for assessing psychosocial wellbeing of children *per se*. However, it does include participatory techniques that may help in developing measures for assessment, monitoring and evaluation of psychosocial wellbeing. *Mental Health and Psychosocial Support in Humanitarian Emergencies: What Should Humanitarian Health Actors Know* provides an overview of the fundamentals of MHPSS in emergency situations, and is primarily geared towards humanitarian actors working in non-MHPSS health sectors as a way for them to incorporate MHPSS into their sectors.

3. CURRENT MEASUREMENT TOOLS AND APPROACHES: EMERGING THEMES

The 48 psychosocial measurement tools meeting inclusion criteria were subject to detailed review. The focus was to identify recurrent themes characterizing the materials and reflect on the apparent 'state-of-the-art' of assessment of children's mental health and psychosocial wellbeing suggested by this material. Four such themes were identified: the wide, varied array of measures available; the failure to frame measures with respect to a comprehensive understanding of MHPSS; the current reliance on HIC-originated measures; and the complexities of determining age-appropriateness and the use of self- versus parental-report.

There is a wide, varied array of measures available for use in humanitarian settings

Although, given its constraints and emphasis, the mapping exercise has clearly not identified ALL tools and approaches potentially available for use in the measurement of children's mental health and psychosocial wellbeing, it is apparent that a very wide range of tools have been used in such contexts. They are not just numerous, but vary widely on many dimensions. Some measures are focused on specific clinical disorders, some on a wider range of mental health issues, many on broader issues of psychosocial wellbeing, including assets and capacities. Some measures are relatively long, comprehensive assessments focused on providing a profile of an individual child with respect to a range of issues, commonly represented by distinct 'sub-scales'. Others are

relatively short measures providing a single aggregate score as a broad measure of a child's current wellbeing, suited for screening purposes or assessing typical levels of wellbeing across a large group or population. Some are focused on younger children, some on older children, others on adolescents and youth. Some are available in multiple languages, some in very few. Some are freely open to translation, others have specified processes for negotiating translation and use, and others are generally not available for translation other than by the originators of the measure. Some have well established data regarding their validity and reliability others provide little guidance on such issues. Some represent measures to be used as part of a structured survey or interview, others specify participative processes to gain more qualitative insights from children and their communities (either in their own right or as a precursor to developing a quantitative measure reflecting local understandings).

Although there are in principle a large number of tools and approaches from which to choose, in practice the requirements of the programming context and setting significantly narrow the options. The *Compendium of Tools and Methods for Assessment of the Mental Health and Psychosocial Wellbeing of Children in Humanitarian Emergencies* accompanying this report seeks to provide the core information regarding each measure identified in the mapping exercise to assist in such selection. A Decision-Making Guide for the Selection of Measures (see Figure 2) is also provided to assist in this process.

Measures are generally not framed with respect to the comprehensive approach to MHPSS needs adopted by the IASC Guidelines

A consequence of the broad array and diversity of existing measures is the risk of fragmented and inconsistent approaches to measurement. In reports of the use of measures the rationale for selecting one particular tool rather than another was rarely articulated. There is, as indicated by Table 1, significant overlap in the scope, focus and age range of many measures. And yet a measure well-suited to measuring a child's general social and emotional wellbeing may clearly be ill-suited to identifying specific symptoms suggestive of a mental disorder.

There appear to be two broad strategies to deal with this complex situation, both of which involve linking measurement to the broader framing of MHPSS supports and interventions within the IASC Guidelines. One seeks identification or development of a measure that spans the breadth of MHPSS concerns reflected in the guidelines. In practice, this means a tool which captures information relevant to the (need for or effectiveness of) provision of specialized interventions for mental disorders AND information on emotional wellbeing, social wellbeing and relevant skills and knowledge (relevant for non-specialized interventions) AND information on broader psychosocial capacities and assets (relevant to family and community supports and, potentially, basic services). There is no single measure available, at present, which spans MHPSS needs so broadly, though there are some, such as the SDQ and CBCL, which approximate this range.

The other strategy is to encourage framing of specific measures with respect to specific levels of the IASC pyramid or, more accurately, with respect to the needs and capacities that need to be assessed to direct provision at that level. In practice, this likely means identifying measures which (i) identify or screen for specific mental disorders, (ii) assess symptoms of distress (without reference to specific mental disorders), (iii) measure emotional wellbeing and social wellbeing and related prosocial behaviour, and (iv) document skills, knowledge, assets and capacities supportive of functioning. As noted earlier, the overlap between categories 'pegged' to levels of the IASC intervention pyramid is considerable, and these categories need to be seen as reflecting a continuum between specific disorders and general capacities. In practical terms, it may, therefore, be best to follow the coarser categorization of measures as having a mental health (MH), psychosocial (PSS) or comprehensive (MHPSS) focus as used in Table 1.

Whatever the approach, the aim would be for choices of measures to reflect the broader framing of MHPSS needs as reflected in the IASC framework. This may mean complementary measures being selected so that, together, the measures ensure that both issues of mental ill-health and broader psychosocial wellbeing are being addressed. Or it may mean more explicitly acknowledging that addressing concerns about a minority of children who may be experiencing severe mental health issues (or, alternatively, that addressing broader issues of psychosocial wellbeing within the community) is NOT within the scope of the assessment and/or programming by a particular agency. Either way, it would involve using the integrated framing of MHPSS as a basis for coherent measurement strategies.

With increasing encouragement for inter-agency coordination in both assessment and intervention, we should also recognize that – with such an integrated approach - different agencies may take the lead on different issues. The IASC framework provides a potential basis for coherent planning of comprehensive intervention AND assessment. Time constraints and limited resources, typical to most humanitarian emergencies, impose significant pressures to rapidly identify children's MHPSS needs. Such pressures work against the more comprehensive coverage of mental health and wider psychosocial wellbeing, and of individual, familial and community levels of analysis, encouraged above. However, inter-agency collaboration provides some promise as a means of securing such analysis.

There remains a heavy reliance on measures originated in high-income countries but examples of the development of local measures are emerging

Figure 2 – A Decision-Making Guide for the Selection of Measures – indicates that in reflecting on choices related to the tools and approaches identified through the mapping exercise there are essentially two major 'routes' followed. The first involves using or adapting an existing measure and, as implied, there are two 'branches' of this route: direct use of an existing measure, or

adapting an existing measure (through translation and/or broader revision of items to match the particular context). Direct use of an existing measure is often most attractive in terms of feasibility and, most likely, in the established reliability of the measure. However, as discussed previously, the cultural validity of such a measure may be questionable and, without evidence of its validity in that context, a process of adaptation will often be required. For example, HIC-originated measures that talk of access to computer games, going to the cinema or, more subtly, ask about self-esteem, may be poorly suited to settings where such activities or sensibilities are unfamiliar.

Processes of adaptation, however, need to tread a difficult line between being true to the intentions of the existing measure and making adjustments to ensure it is meaningful in a new setting. Translation and back-translation of the tool may be seen as a minimum requirement; broader field-testing to avoid any ambiguities of expression and meaning will usually be required. With such adjustments, the existing data on reliability of the measure is generally no longer relevant, and so additional testing to check for internal consistency of the tool with the changes made, will usually be warranted. Such adjustment requires significant technical expertise and, in many instances, permissions and collaboration with the originators of the tool.

These challenges presented by adaptation suggest that the second route, developing a local measure, might usefully be explored more frequently. This approach may be demanding of expertise and time that is not available in some humanitarian settings. However, a number of examples of such work are now emerging (e.g. Child Functioning Impairment Rating Scale), and participatory approaches supportive of such developments (e.g. Brief Ethnographic Interviewing, the DIME Model, PRM) are increasingly available. This strategy not only results in a measure suited to a specific humanitarian context but also adds to the pool of existing measures. Having more tools originated in LMIC settings, suited for direct use in similar context or with lesser requirements for adaptation, reduces the risk of measurement reflecting an inappropriately HIC frame.

Determining age-appropriateness and the appropriateness of self- versus parental-report presents additional complexities

Many of the measures identified are targeted to a specific age-group, or else have different versions of the tool available for different age ranges. Clearly this is an important reflection of seeking to ensure that measures are not only culturally appropriate (as discussed above) but also developmentally appropriate. However, as can be readily noted from Table 2, the way that age-bands are specified varies widely. It appears that children in the range 6 to 12 years are the group best catered for in terms of available measures. There appear less options for measurement of mental health and psychosocial wellbeing in younger (pre-school-age children) and also in adolescents.

A number of measures have age ranges 'up to 18', but it is unclear in such circumstances if the nature of questions fully reflects the experiences, aspirations and circumstances of youth in many humanitarian settings (where work and household responsibilities may be significant, for example). There are indications of more participative approaches targeted at this age group (e.g. Are We Making A Difference?) but there is scope for more structured measures directly addressing the need and priorities of children in this older age range.

The lack of measures for younger children is troubling, especially with early childhood education and related activities often having a prominent place in humanitarian response. There are clear challenges in assessing wellbeing at such ages, and parental report measures are generally seen as appropriate in this age group. There appears scope, however, for the development of more simple observational checklists that may be useful in determining needs and evaluating programs for pre-school age children.

There appears to be wide variation in practices regarding the place of parental reports on the mental health and psychosocial wellbeing of children. Some measures, such as the DAP, take the position that parents (and other caregivers) cannot be assumed to have reliable insight into the psychosocial wellbeing of children in their care, and proscribe the use of parent/caregiver reports as a 'proxy' for children's wellbeing. Other measures, such as the CPRA, take the view that direct engagement with children regarding issues of psychosocial wellbeing represents a potential risk in humanitarian settings (notably because of the vulnerability of children in such circumstances and the likelihood that interviewers are not experienced in interviews with children) and mandates data collection through adults only.

4. RECOMMENDATIONS

It was noted earlier how the measurement of the mental health and psychosocial wellbeing of children in the context humanitarian emergencies presents very particular challenges (focused on the issues of cultural validity, reliability and feasibility). Based on this mapping work it is clear that there are a large number of tools and approaches available for selection when seeking to put together an appropriate assessment or evaluation strategy. However, practice appears fragmented, incoherent with a more integrated framing of MHPSS issues, unduly reliant on HIC-originated measures and less well served to address the specific needs of pre-school children and adolescent youth. The increased commitment to measurement by donors and implementing agencies and the wealth of continuing innovation with respect to measurement reflected through the course of the mapping exercise provide significant opportunities to address these challenges, however. The following recommendations are made on the basis of the preceding analysis:

1. Development of a clear framework guiding selection of tools and approaches with respect to current MHPSS guidance

The emergence of increasingly integrated understandings of MHPSS needs in humanitarian settings – spanning response at multiple levels – provides a potential basis for structuring a measurement strategy more coherently and comprehensively. Figure 2 seeks to provide some basis for selection of tools and approaches on the basis of scope, focus and age-range. In future work by the CPWG and MHPSS RG it will be appropriate to build upon such efforts, providing practical guidance to assist in selection from the plethora of tools available, and to do so with respect to an overall framing of intervention needs (and thus assessment and evaluation requirements) regarding mental health and psychosocial wellbeing. This may involve identification of measures relevant to specific levels of the IASC MHPSS pyramid.

2. Development of inter-agency field-friendly guidance on the development of local measures

There is promising practice in the deployment of approaches that facilitate qualitative and quantitative work required for the development of local measures that demonstrate both cultural validity and statistical reliability. Time and the technical expertise required to support such work comprise the major barrier to the wider use of this strategy. However, it would appear feasible to develop documentation (and associated training packages) that would address these barriers, reducing the time required for each stage of this process and lessening reliance on external expertise. This would make development of local measures a more feasible option in many humanitarian settings (and, as a by-product) would also lead to an increased pool of LMIC originated measures for potential adoption or revision elsewhere.

3. Exploration of (a) identification or (b) development of one or more 'generic' MHPSS measures suited for widespread use

Although development of local measures is an important strategy for the field to extend, there will remain many contexts where selection (with some potential adaptation) of an existing measure will remain the most feasible strategy given a range of contextual factors. Acknowledging this, there are two potential strategies to facilitate availability of a tool (or tools) that could serve as a 'generic' measure of MHPSS across varied settings, and thus provide greater comparability and consistency of measurement.

(a) One strategy is to identify a current measure that approximates this function and seek to address wider barriers to its broader use. To take an illustrative example, the SDQ provides a measure of social and emotional difficulties and prosocial behavior that has been widely used. Its scope, focus and age range all support its use across a range of contexts. The two
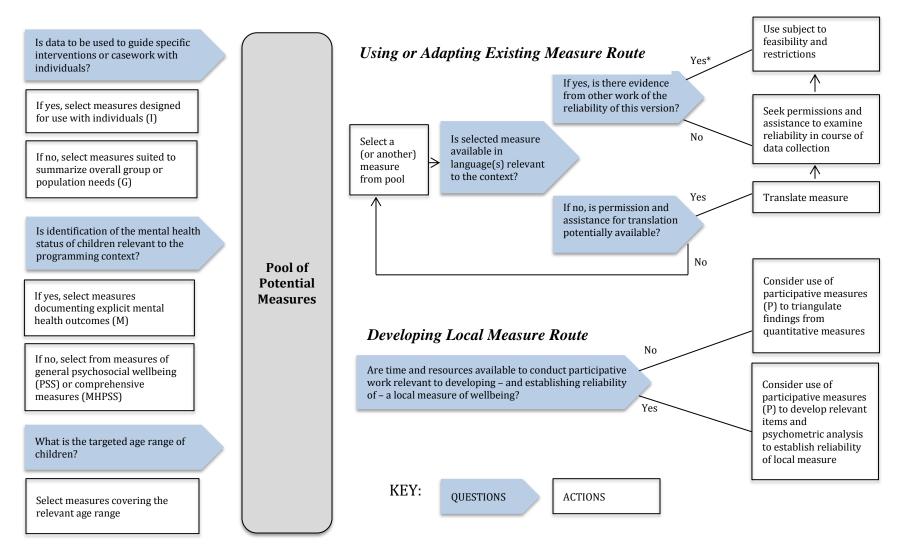
major barriers to its adoption as a 'generic' tool are its language availability and copyright restrictions (appropriately imposed to make sure that rigorous contextualization processes guarantee the cultural validity and reliability of all translations). With inter-agency support there may be the opportunity to negotiate an agreement with the originators of such a tool to fund a prioritized list of translations and validation exercises.

(b) A second strategy would be to develop a generic MHPSS measure suited for widespread use and easy local contextualization 'from scratch', drawing upon the expertise of research groups engaged with the CPWG and MHPSS RG. This would be a major undertaking, and the previous strategy may be a more cost-effective option in the shorter term. However, if such agreements could not be forged, the expertise and reach of agencies engaged with the CPWG and MHPSS RG is such that there would be strong capacity potentially available for (i) specifying the core structure and coverage of such a measure and (ii) refining and validating it through field research in multiple settings.

4. Documentation and promotion of mixed method approaches to assessment and evaluation, integrating use of robust quantitative measures with participative methods engaging children and youth

The emphasis on use of robust quantitative measures should not be at the expense of qualitative, participative approaches that can valuably triangulate findings and provide an opportunity for engaging the voice of children and youth. The mapping exercise has identified a broad range of qualitative, participative methods (Are We Making a Difference?, Child Led Indicators, I Deal, PRM etc.) However, there are relatively few examples of documentation that integrates such methods with survey approaches. RAMH, IOM's Toolkit, CPRA, however, all provide examples of assessment methodologies that lend themselves to incorporating quantitative and qualitative data sources. It would be useful if brief reports documenting the deployment of mixed methods in a particular humanitarian setting were disseminated, promoting the complementary role of different data sources in providing a more comprehensive view of children's mental health and psychosocial wellbeing.

Figure 2: Decision-Making Guide for the Selection of Measures

Is data to be used to guide specific interventions or casework with individuals?

If yes, select measures designed for use with individuals (I)

If no, select measures suited to summarize overall group or population needs (G)

Is identification of the mental health status of children relevant to the programming context?

If yes, select measures documenting explicit mental health outcomes (M)

If no, select from measures of general psychosocial wellbeing (PSS) or comprehensive measures (MHPSS)

What is the targeted age range of children?

Select measures covering the relevant age range

Pool of Potential Measures

Using or Adapting Existing Measure Route

Select a (or another) measure from pool

Is selected measure available in language(s) relevant to the context?

If yes, is there evidence from other work of the reliability of this version?

Yes*

If no, is permission and assistance for translation potentially available?

No

Yes

No

Use subject to feasibility and restrictions

Seek permissions and assistance to examine reliability in course of data collection

Translate measure

Developing Local Measure Route

Are time and resources available to conduct participative work relevant to developing – and establishing reliability of – a local measure of wellbeing?

No

Yes

Consider use of participative measures (P) to triangulate findings from quantitative measures

Consider use of participative measures (P) to develop relevant items and psychometric analysis to establish reliability of local measure

KEY: QUESTIONS ACTIONS

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

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