Mental And Behavioral Health

Overall Physical and Mental/Emotional Health

Note: Collect BOTH Parent-Self Report and either Child-Self Report or Parent Report About Child

Parent Self-Report

	Excellent	Very good	Good	Fair	Poor
In general, how is your physical health?	◯	◯	◯	◯	◯
In general, how is your mental or emotional health?	◯	◯	◯	◯	◯

Parent Report About Child

	Excellent	Very good	Good	Fair	Poor
In general, how is your childs physical health?	◯	◯	◯	◯	◯
In general, how is your childs mental or emotional health?	◯	◯	◯	◯	◯

Child Self-Report (Ages 8+)

	Excellent	Very good	Good	Fair	Poor
In general, how would you rate your physical health?	◯	◯	◯	◯	◯
In general, how would you rate your mental health, including your mood and your ability to think?	◯	◯	◯	◯	◯

Current Mental Health Symptoms

Tier 1: DSM-5 Cross-cutting Symptom Measure, PROMIS Depressive Symptoms, PROMIS Anxiety, PROMIS Fatigue

Tier 2: CRIES-8 Trauma, RCADS, PROMIS Pain Interference, Externalizing Symptoms

Additional Guidance: For younger children (Ages 1-5), the Working Group recommends using the PROMIS Early Childhood parent report measures for Anxiety, Anger/Irritability, Depressive Symptoms, Sleep Health, and Global Health found on HealthMeasures. PROMIS Early Childhood does not yet cover Fatigue or Pain Interference.

Organized below by:
1) Parent Report About Child (all measures except Trauma)
2) Child Self-Report

Parent Report About Child: Current Mental Health Symptoms
Tier 1: DSM-5 Cross-Cutting Symptom Measure (Ages 6-17)

The National Institute of Mental Health (NIMH) in consultation with the Wellcome Trust and other funders of mental health research has identified the DSM-5 Cross-Cutting Symptom Measure as part of a minimal list of data collection instruments that would be ideal for use by all mental health researchers conducting clinical research to facilitate and harmonize mental health data collection.

These measures have been selected using either the PhenX consensus process (https://www.phenxtoolkit.org/collections/view/1) or the International Consortium for Health Outcomes Measurement (ICHOM) (https://www.ichom.org/resource-library/category/condition-specific-resources/depression-anxiety/) with additional consideration for successful use of the measures in various countries.

During the past TWO (2) WEEKS, how much (or how often) has your child

	0-None Not at all	1-Slight Rare less than a day or two	2-Mild Several days	3-Moderate More than half the days	4-Severe Nearly every day
1. Complained of stomach aches, headaches, or other aches and pains?	○	○	○	○	○
2. Said he/she was worried about his/her health or about getting sick?	○	○	○	○	○

I. Somatic Symptoms - Highest Domain Score (clinician) _____

II.

	0-None Not at all	1-Slight Rare less than a day or two	2-Mild Several days	3-Moderate More than half the days	4-Severe Nearly every day
3. Had problems sleeping-that is, trouble falling asleep, staying asleep, or waking up too early?	○	○	○	○	○

II. Sleep Problems - Highest Domain Score (clinician) _____

III.

	0-None Not at all	1-Slight Rare less than a day or two	2-Mild Several days	3-Moderate More than half the days	4-Severe Nearly every day
4. Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	○	○	○	○	○

III. Inattention - Highest Domain Score (clinician) _____

IV.

	0-None Not at all	1-Slight Rare less than a day or two	2-Mild Several days	3-Moderate More than half the days	4-Severe Nearly every day
5. Had less fun doing things than he/she used to?	○	○	○	○	○
6. Seemed sad or depressed for several hours?	○	○	○	○	○

IV. Depression - Highest Domain Score (clinician) _____

V. & VI.

	0-None Not at all	1-Slight Rare less than a day or two	2-Mild Several days	3-Moderate More than half the days	4-Severe Nearly every day
7. Seemed more irritated or easily annoyed than usual?	○	○	○	○	○
8. Seemed angry or lost his/her temper?	○	○	○	○	○

V. Anger & VI. Irritability - Highest Domain Score (clinician) _____

VII.

	0-None Not at all	1-Slight Rare less than a day or two	2-Mild Several days	3-Moderate More than half the days	4-Severe Nearly every day
9. Started lots more projects than usual or did more risky things than usual?	○	○	○	○	○
10. Slept less than usual for him/her but still had lots of energy?	○	○	○	○	○

VII. Mania Highest - Domain Score (clinician) _____

VIII.

	0-None Not at all	1-Slight Rare less than a day or two	2-Mild Several days	3-Moderate More than half the days	4-Severe Nearly every day
11. Said he/she felt nervous, anxious, or scared?	○	○	○	○	○

12. Not been able to stop worrying?	○	○	○	○	○
13. Said he/she couldnt do things he/she wanted to or should have done, because they made him/her feel nervous?	○	○	○	○	○

VIII. Anxiety Highest - Domain Score (clinician) _____

IX.					
	0-None Not at all	1-Slight Rare less than a day or two	2-Mild Several days	3-Moderate More than half the days	4-Severe Nearly every day
14. Said that he/she heard voices - when there was no one there - speaking about him/her or telling him/her what to do or saying bad things to him/her?	○	○	○	○	○
15. Said that he/she had a vision when he/she was completely awake - that is, saw something or someone that no one else could see?	○	○	○	○	○

IX. Psychosis - Highest Domain Score (clinician) _____

X.					
	0-None Not at all	1-Slight Rare less than a day or two	2-Mild Several days	3-Moderate More than half the days	4-Severe Nearly every day
16. Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	○	○	○	○	○
17. Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	○	○	○	○	○

18. Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	◯	◯	◯	◯	◯
19. Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	◯	◯	◯	◯	◯

X. Repetitive Thoughts and Behaviors - Highest Domain Score (clinician) _____

XI. In the past TWO (2) WEEKS has your child

20. Had an alcoholic beverage (beer, wine, liquor, etc.)?	◯ Yes	◯ No	◯ Don't know
21. Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	◯ Yes	◯ No	◯ Don't know
22. Used drugs like marijuana, cocaine, or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	◯ Yes	◯ No	◯ Don't know
23. Used any medicine without a doctors prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	◯ Yes	◯ No	◯ Don't know

XI. Substance Use - Highest Domain Score (clinician) _____

XII.

24. In the past TWO (2) WEEKS has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	◯ Yes	◯ No	◯ Don't know
25. Has he/she EVER tried to kill himself/herself?	◯ Yes	◯ No	◯ Don't know

XII. Suicidal Ideation/ Suicide Attempts - Highest Domain Score (clinician) _____

Tier 2: After meeting thresholds

Domain	Domain Name	Threshold to guide further inquiry	DSM-5 Level 2 Cross-Cutting Symptom Measure available online
I.	Somatic Symptoms	Mild or greater	LEVEL 2—Somatic Symptom—Parent/Guardian of Child Age 6–17 (Patient Health Questionnaire 15 Somatic Symptom Severity (PHQ-15)
II.	Sleep Problems	Mild or greater	LEVEL 2—Sleep Disturbance—Parent/ Guardian of Child Age 6–17 (PROMIS—Sleep Disturbance—Short Form)[1]
III.	Inattention	Slight or greater	LEVEL 2—Inattention—Parent/Guardian of Child Age 6–17 (SNAP-IV)
IV.	Depression	Mild or greater	LEVEL 2—Depression—Parent/Guardian of Child Age 6–17 (PROMIS Emotional Distress—Depression—Parent Item Bank)
V.	Anger	Mild or greater	LEVEL 2—Anger—Parent/Guardian of Child Age 6–17 (PROMIS Emotional Distress—Calibrated Anger Measure—Parent)
VI.	Irritability	Mild or greater	LEVEL 2—Irritability—Parent/Guardian of Child Age 6–17 (Affective Reactivity Index)
VII.	Mania	Mild or greater	LEVEL 2—Mania—Parent/Guardian of Child Age 6–17 (adapted from the Altman Self-Rating Mania Scale)
VIII.	Anxiety	Mild or greater	LEVEL 2—Anxiety—Parent/Guardian of Child Age 6–17 (adapted from PROMIS Emotional Distress—Anxiety—Parent Item Bank)
IX.	Psychosis	Slight or greater	None
X.	Repetitive Thoughts and Behaviors	Mild or greater	None
XI.	Substance Use	Yes/ Don't Know	LEVEL 2—Substance Use—Parent/Guardian of Child Age 6–17 (adapted from the NIDA-modified ASSIST)/LEVEL 2—Substance Use—Child Age 11–17 (adapted from the NIDA-modified ASSIST)
XII.	Suicidal Ideation/ Suicide Attempts	Yes/ Don't Know	None

I. Somatic Symptoms

LEVEL 2 Somatic Symptom Parent/Guardian of Child Age 6-17 (Patient Health Questionnaire 15 Somatic Symptom Severity (PHQ-15)

During the past 7 days how much has your child been bothered by any of the following problems?

	Not bothered at all	Bothered a little	Bothered a lot
Stomach pain	○	○	○
Back pain	○	○	○
Pain in his or her arms, legs, or joints (knees, hips, etc.)	○	○	○
Headaches	○	○	○
Chest pain	○	○	○
Dizziness	○	○	○
Fainting spells	○	○	○
Feeling his or her heart pound or race	○	○	○
Shortness of breath	○	○	○

Constipation, loose bowels, or diarrhea	○	○	○
Nausea, gas, or indigestion	○	○	○
Feeling tired or having low energy	○	○	○
Trouble sleeping	○	○	○

Total/Partial Raw Score: _____

Prorated Score: (if 10 or more items answered) _____

II. Sleep Problems

LEVEL 2-Sleep Disturbance-Parent/ Guardian of Child Age 6-17 (PROMIS-Sleep Disturbance-Short Form)

Instructions to parent/guardian:

On the DSM-5 Level 1 cross-cutting questionnaire that you just completed you indicated that during the past 2 weeks your child receiving care has been bothered by problems sleeping-that is trouble falling asleep staying asleep or waking up too early at a mild or greater level of severity.

The questions below ask about these feelings in more detail and especially how often your child receiving care has been bothered by a list of symptoms during the past 7 days.

In the past 7 days

	Not at all	A little bit	Somewhat	Quite a bit	Very much
His/her sleep was restless.	○	○	○	○	○
He/She was satisfied with his/her sleep.	○	○	○	○	○
His/her sleep was refreshing.	○	○	○	○	○
He/she had difficulty falling asleep.	○	○	○	○	○

In the past 7 days

	Never	Rarely	Sometimes	Often	Always
He/she had trouble staying asleep.	○	○	○	○	○
He/she had trouble sleeping	○	○	○	○	○
He/she got enough sleep.	○	○	○	○	○

In the past 7 days

	Very poor	Poor	Fair	Good	Very good
His/her sleep quality was...	◯	◯	◯	◯	◯

Total/Partial Raw Score _____

Prorated Total Raw Score _____

III. Inattention

LEVEL 2 Inattention Parent/Guardian of Child Age 6-17 (SNAP-IV)

Instructions to parent/guardian:
On the DSM-5 Level 1 cross-cutting questionnaire that you just completed you indicated that during the past 2 weeks your child receiving care has been bothered by problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game at a slight or greater level of severity.

The questions below ask about these feelings in more detail and especially how often your child receiving care has been bothered by a list of symptoms during the past 7 days.

In the past 7 days my child

	Not at All	Just a Little	Quite a Bit	Very Much
1. Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.	◯	◯	◯	◯
2. Often has difficulty sustaining attention in tasks or play activities.	◯	◯	◯	◯
3. Often does not seem to listen when spoken to directly.	◯	◯	◯	◯
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties.	◯	◯	◯	◯
5. Often has difficulty organizing tasks and activities.	◯	◯	◯	◯
6. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g. schoolwork or homework).	◯	◯	◯	◯

7. Often loses things necessary for tasks or activities (e.g. toys, school assignments, pencils, books, or tools.)	○	○	○	○
8. Often is distracted by extraneous stimuli.	○	○	○	○

Total/Partial Raw Score: _____

Prorated Total Raw Score: (if 1-2 items left unanswered) _____

Average Total Score _____

IV. Depression

LEVEL 2 Depression Parent/Guardian of Child Age 6-17 (PROMIS Emotional Distress Depression Parent Item Bank)

Instructions to parent/guardian:

On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that during the past 2 weeks your child receiving care has been bothered by not finding interest or pleasure in doing things and/or seeming down, depressed, or hopeless at a mild or greater level of severity.

The questions below ask about these feelings in more detail and especially how often your child receiving care has been bothered by a list of symptoms during the past 7 days.

In the past 7 days, my child

	Never	Almost Never	Sometimes	Often	Almost Always
1. Could not stop feeling sad.	○	○	○	○	○
2. Felt alone.	○	○	○	○	○
3. Felt like he/she couldnt do anything right.	○	○	○	○	○
4. Felt lonely.	○	○	○	○	○
5. Felt sad.	○	○	○	○	○
6. Felt unhappy.	○	○	○	○	○
7. Thought that his/her life was bad.	○	○	○	○	○
8. Didnt care about anything.	○	○	○	○	○
9. Felt stressed.	○	○	○	○	○
10. Felt too sad to eat.	○	○	○	○	○
11.Wanted to be by himself/herself.	○	○	○	○	○

Total/Partial Raw Score: _____

V. Anger

Instructions to parent/guardian:

On the DSM-5 Level 1 cross-cutting questionnaire that you just completed you indicated that during the past 2 weeks your child receiving care has been bothered by seeming irritated or easily annoyed and/or seeming angry or lost his/her temper at a mild or greater level of severity.

The questions below ask about these feelings in more detail and especially how often your child receiving care has been bothered by a list of symptoms during the past 7 days.

In the past SEVEN (7) DAYS

	Never	Almost Never	Sometimes	Often	Almost Always
1. My child felt mad.	○	○	○	○	○
2. My child was so angry he/she felt like yelling at somebody.	○	○	○	○	○
3. My child was so angry he/she felt like throwing something.	○	○	○	○	○
4. My child felt upset.	○	○	○	○	○
5. When my child got mad, he/she stayed mad.	○	○	○	○	○

Total/Partial Raw Score: _____

Prorated Total Raw Score: _____

T-Score: _____

VI. Irritability

LEVEL 2 Irritability Parent/Guardian of Child Age 6-17 (Affective Reactivity Index)

Instructions to parent/guardian:

On the DSM-5 Level 1 cross-cutting questionnaire that you just completed you indicated that during the past 2 weeks your child receiving care has been bothered by seeming irritated or easily annoyed and/or seeming angry or lost his/her temper at a mild or greater level of severity.

The questions below ask about these feelings in more detail and especially how often your child receiving care has been bothered by a list of symptoms during the past 7 days.

In the last SEVEN (7) DAYS and compared to others of the same age how well does each of the following statements describe the behavior/feelings of your child?

Please try to answer all questions.

	Not True	Somewhat True	Certainly True

1. Is easily annoyed by others.	◯	◯	◯
2. Often loses his/her temper.	◯	◯	◯
3. Stays angry for a long time.	◯	◯	◯
4. Is angry most of the time.	◯	◯	◯
5. Gets angry frequently.	◯	◯	◯
6. Loses temper easily.	◯	◯	◯
7. Overall irritability causes him/her problems	◯	◯	◯

Total/Partial Raw Score: _____

Prorated Total Raw Score: (if 1 item is left unanswered) _____

VII. Mania

LEVEL 2 Mania Parent/Guardian of Child Age 6-17 (adapted from the Altman Self-Rating Mania Scale)

Instructions to parent/guardian:

On the DSM-5 Level 1 cross-cutting questionnaire you just completed you indicated that during the past 2 weeks your child receiving care has been bothered by sleeping less than usual but still have a lot of energy and/or only sleeping for a short time at night at a mild or greater level of severity.

The five statement groups or questions below ask about these feelings in more detail.

1. Please read each group of statements/question carefully.
2. Choose the one statement in each group that best describes the way your child has been feeling for the past week.
3. Check the box next to the number/statement selected.
4. Please note: The word occasionally when used here means once or twice; often means several times or more and frequently means most of the time.

Question 1

◯ He/she does not feel happier or more cheerful than usual.
◯ He/she occasionally feels happier or more cheerful than usual.
◯ He/she often feels happier or more cheerful than usual.
◯ He/she feels happier or more cheerful than usual most of the time.
◯ He/she feels happier or more cheerful than usual all of the time.

Question 2

◯ He/she does not feel more self-confident than usual.
◯ He/she occasionally feels more self-confident than usual.
◯ He/she often feels more self-confident than usual.
◯ He/she frequently feels more self-confident than usual.
◯ He/she feels extremely self-confident all of the time.

Question 3

◯ He/she does not need less sleep than usual.
◯ He/she occasionally needs less sleep than usual.
◯ He/she often needs less sleep than usual.
◯ He/she frequently needs less sleep than usual.
◯ He/she can go all day and all night without any sleep and still not feel tired.

Question 4

◯ He/she does not talk more than usual.
◯ He/she occasionally talks more than usual.
◯ He/she often talks more than usual.
◯ He/she frequently talks more than usual.
◯ He/she talks constantly and cannot be interrupted.

Question 5

◯ He/she has not been more active (either socially sexually at work home or school) than usual.
◯ He/she has occasionally been more active than usual.
◯ He/she has often been more active than usual.
◯ He/she has frequently been more active than usual.
◯ He/she is constantly more active or on the go all the time.

Total/Partial Raw Score: _____

Prorated Total Raw Score: (if 1 item is left unanswered) _____

VIII. Anxiety

LEVEL 2 - Anxiety - Parent/Guardian of Child Age 6-17 (adapted from PROMIS Emotional Distress-Anxiety-Parent Item Bank)

Instructions to parent/guardian:

On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that during the past 2 weeks your child receiving care has been bothered by feeling nervous, anxious, or scared, not being able to stop worrying, and/or couldn't do things he/she wanted to or should have done because they made him/her feel nervous at a mild or greater level of severity.

The questions below ask about these feelings in more detail and especially how often your child receiving care has been bothered by a list of symptoms during the past 7 days.

	Never	Almost Never	Sometimes	Often	Almost Always
Felt nervous.	◯	◯	◯	◯	◯
Felt scared.	◯	◯	◯	◯	◯
Felt worried.	◯	◯	◯	◯	◯

In the SEVEN (7) DAYS, my child said that he/she					
Felt like something awful might happen.	○	○	○	○	○
Worried when he/she was at home.	○	○	○	○	○
Got scared really easy.	○	○	○	○	○
Worried when he/she was away from home.	○	○	○	○	○
Worried about what could happen to him/her.	○	○	○	○	○
Worried when he/she went to bed at night.	○	○	○	○	○
Was afraid of going to school.	○	○	○	○	○

Total/Partial Raw Score _____

Prorated Total Raw Score _____

T-Score _____

XI. Substance Use

Instructions to parent/guardian:

On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that during the past 2 weeks your child receiving care has been bothered by having an alcoholic beverage; smoking a cigarette, a cigar, or pipe or used snuff or chewing tobacco; using drugs like marijuana, cocaine or crack, club drugs, hallucinogens, heroin, inhalants or solvents, or methamphetamine and/or using any medicine without a doctor's prescription.

The questions below ask about these feelings in more detail and especially how often your child receiving care has been bothered by a list of symptoms during the past two (2) weeks.

During the past TWO (2) WEEKS, about how often did your child...	Not at All	Less Than a Day or Two	Several Days	More Than Half the Days	Nearly Every Day
a. Have an acloholic beverage (beer, wine, liquor, etc.) ?	○	○	○	○	○
b. Have 4 or more drinks in a single day?	○	○	○	○	○
c. Smoke a cigarette, a cigar, or pipe or used snuff or chewing tobacco?	○	○	○	○	○

During the past TWO (2) WEEKS, about how often did your child use any of the following medicines without a doctor's prescription or in greater amounts or longer than prescribed?	Not at All	Less Than a Day or Two	Several Days	More Than Half the Days	Nearly Every Day
d. Painkillers (like Vicodin)	◯	◯	◯	◯	◯
e. Stimulants (like Ritalin, Adderall)	◯	◯	◯	◯	◯
f. Sedatives or tranquilizers (like sleeping pills or Valium)	◯	◯	◯	◯	◯

Or drugs like:	Not at All	Less Than a Day or Two	Several Days	More Than Half the Days	Nearly Every Day
g. Steroids	◯	◯	◯	◯	◯
h. Other medicines	◯	◯	◯	◯	◯
i. Marijuana	◯	◯	◯	◯	◯
j. Cocaine or crack	◯	◯	◯	◯	◯
k. Club drugs (like ecstasy)	◯	◯	◯	◯	◯
l. Hallucinogens (like LSD)	◯	◯	◯	◯	◯
m. Heroin	◯	◯	◯	◯	◯
n. Inhalants or solvents (like glue)	◯	◯	◯	◯	◯
o. Methamphetamine (like speed)	◯	◯	◯	◯	◯

Total/Partial Raw Score: _____

Prorated Total Raw Score: (If 1 item is left unanswered) _____

Additional Guidance: These CDEs include questions that can potentially identify respondents who are at risk of suicide. Investigators implementing this protocol should consult with their IRBs to develop a risk management plan specific to their study to ensure the safety of participants. Investigators should also ensure their studies are compliant with federal, state, and institutional regulations and policies and inform participants of limits of confidentiality when a participant endorses imminent risk of harm to self or others.

The following link provides additional information and guidelines for suicide-related research: https://www.nimh.nih.gov/funding/clinical-research/conducting-research-with-participants-at-elevated-risk-for-suicide-considerations-for-researchers.

Tier 1: Anxiety, Depression, Fatigue PROMIS scales (Parent Proxy Versions)

Due to early research demonstrating the presence of COVID-19/pandemic related mental health symptoms, anxiety, depressive symptoms and fatigue PROMIS measures were designated Tier 1 in addition to the DSM-5 screener.

Parent About Child:

PROMIS Anxiety

Age 1-5 (available not shown)
Age 5-17 (shown)

In the past 7 days

	Never	Almost Never	Sometimes	Often	Almost Always
My child felt nervous.	○	○	○	○	○
My child felt scared.	○	○	○	○	○
My child felt worried.	○	○	○	○	○
My child felt like something awful might happen.	○	○	○	○	○
My child worried when he/she was at home.	○	○	○	○	○
My child got scared really easy.	○	○	○	○	○
My child worried about what could happen to him/her.	○	○	○	○	○
My child worried when he/she went to bed at night.	○	○	○	○	○

PROMIS Depressive Symptoms

Age 1-5 (available not shown)
Age 5-17 (shown)

In the past 7 days

	Never	Almost Never	Sometimes	Often	Almost Always
My child could not stop feeling sad.	○	○	○	○	○
My child felt everything in his/her life went wrong.	○	○	○	○	○
My child felt like he/she couldn't do anything right.	○	○	○	○	○
My child felt lonely.	○	○	○	○	○
My child felt sad.	○	○	○	○	○
It was hard for my child to have fun.	○	○	○	○	○

PROMIS Fatigue

Age 5-17

	Never	Almost Never	Sometimes	Often	Almost Always
Being tired made it hard for my child to play or go out with friends as much as he/she would like.	○	○	○	○	○
My child felt weak.	○	○	○	○	○
My child got tired easily.	○	○	○	○	○
Being tired made it hard for my child to keep up with schoolwork.	○	○	○	○	○
My child had trouble finishing things because he/she was too tired.	○	○	○	○	○
My child had trouble starting things because he/she was too tired.	○	○	○	○	○
My child was so tired it was hard for him/her to pay attention.	○	○	○	○	○
My child was too tired to do sports or exercise.	○	○	○	○	○
My child was too tired to do things outside.	○	○	○	○	○
My child was too tired to enjoy the things he/she likes to do.	○	○	○	○	○

Tier 2: RCADS Anxiety and Depression Scale (Parent Report About Child)

Due to early research demonstrating the presence of COVID-19/pandemic related mental health symptoms, anxiety, and depression RCADS measures were designated Tier 2 in addition to the DSM-5 screener and Tier 1 PROMIS measures.

Please select the word that shows how often each of these things happens to your child. There are no right or wrong answers.

	Never	Sometimes	Often	Always
1. My child worries about things	○	○	○	○
2. My child feels sad or empty	○	○	○	○
3. When my child has a problem, he/she gets a funny feeling in his/her stomach	○	○	○	○
4. My child worries when he/she thinks he/she has done poorly at something	○	○	○	○

5. My child feels afraid of being alone at home	○	○	○	○
6. Nothing is much fun for my child anymore	○	○	○	○
7. My child feels scared when taking a test	○	○	○	○
8. My child worries when he/she thinks someone is angry with him/her	○	○	○	○
9. My child worries about being away from me	○	○	○	○
10. My child is bothered by bad or silly thoughts or pictures in his/her mind	○	○	○	○
11. My child has trouble sleeping	○	○	○	○
12. My child worries about doing badly at schoolwork	○	○	○	○
13. My child worries that something awful will happen to someone in the family	○	○	○	○
14. My child suddenly feels as if he/she can't breathe when there is no reason for this	○	○	○	○
15. My child has problems with his/her appetite	○	○	○	○
16. My child has to keep checking that he/she has done things right (like the switch is off, or the door is locked)	○	○	○	○
17. My child feels scared to sleep on his/her own	○	○	○	○
18. My child has trouble going to school in the mornings because of feeling nervous or afraid	○	○	○	○
19. My child has no energy for things	○	○	○	○
20. My child worries about looking foolish	○	○	○	○
21. My child is tired a lot	○	○	○	○
22. My child worries that bad things will happen to him/her	○	○	○	○

23. My child can't seem to get bad or silly thoughts out of his/her head	○	○	○	○

Tier 2: Pain, Cognitive Function

Pain Interference Parent Proxy

Age 8-17

In the past 7 days

	Never	Almost Never	Sometimes	Often	Almost Always
My child had trouble sleeping when he/she had pain.	○	○	○	○	○
My child felt angry when he/she had pain.	○	○	○	○	○
My child had trouble doing schoolwork when he/she had pain.	○	○	○	○	○
It was hard for my child to pay attention when he/she had pain.	○	○	○	○	○
It was hard for my child to run when he/she had pain.	○	○	○	○	○
It was hard for my child to walk one block when he/she had pain.	○	○	○	○	○
It was hard for my child to have fun when he/she had pain.	○	○	○	○	○
It was hard for my child to stay standing when he/she had pain.	○	○	○	○	○

Cognitive Function Parent Proxy

Age 8-17

In the past 4 weeks

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Your child has to use written lists more often than other people his/her age so he/she will not forget things	○	○	○	○	○
It is hard for your child to pay attention to one thing for more than 5-10 minutes	○	○	○	○	○

Your child has trouble keeping track of what he/she is doing if he/she gets interrupted	○	○	○	○	○
Your child has to read things several times to understand them	○	○	○	○	○
Your child forgets things easily	○	○	○	○	○
Your child has to work really hard to pay attention or he/she makes mistakes	○	○	○	○	○
Your child has trouble remembering to do things like school projects or chores	○	○	○	○	○

Tier 2: Externalizing Symptoms

While prioritized as a Tier 2 measure, this Working Group does not recommend specific measures since the most commonly used measures (Child Behavior Checklist and Strengths and Difficulties Questionnaire) require licensing. The Multidimensional Assessment Profile of Disruptive Behavior (MAP-DB), is available for use as well and does not require a license.

Child Self-Report: Current Mental Health Symptoms

Tier 1: DSM-5 Cross-Cutting Symptom Measure (Ages 11-17)

The National Institute of Mental Health (NIMH), in consultation with the Wellcome Trust and other funders of mental health research, has identified the DSM-5 Cross-Cutting Symptom Measure as part of a minimal list of data collection instruments that would be ideal for use by all mental health researchers conducting clinical research to facilitate and harmonize mental health data collection. These measures have been selected using either the PhenX consensus process (https://www.phenxtoolkit.org/collections/view/1) or the International Consortium for Health Outcomes Measurement (ICHOM) (https://www.ichom.org/resource-library/category/condition-specific-resources/depression-anxiety/) with additional consideration for successful use of the measures in various countries.

I.

	0 - None (Not at all)	1 - Slight (Rare less than a day or two)	2 - Mild (Several days)	3 - Moderate (More than half the days)	4 - Severe (Nearly every day)
1. Been bothered by stomach aches, headaches, or other aches and pains?	○	○	○	○	○
2. Worried about your health or about getting sick?	○	○	○	○	○

I. - Highest Domain Score (clinician) _____

II.

	0 - None (Not at all)	1 - Slight (Rare less than a day or two)	2 - Mild (Several days)	3 - Moderate (More than half the days)	4 - Severe (Nearly every day)
3. Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	○	○	○	○	○

II. - Highest Domain Score (clinician) _____

III.

	0 - None (Not at all)	1 - Slight (Rare less than a day or two)	2 - Mild (Several days)	3 - Moderate (More than half the days)	4 - Severe (Nearly every day)
4. Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	○	○	○	○	○

III. - Highest Domain Score (clinician) _____

IV.

	0 - None (Not at all)	1 - Slight (Rare less than a day or two)	2 - Mild (Several days)	3 - Moderate (More than half the days)	4 - Severe (Nearly every day)
5. Had less fun doing things than you used to?	○	○	○	○	○
6. Felt sad or depressed for several hours?	○	○	○	○	○

IV. - Highest Domain Score (clinician) _____

V. & VI.

	0 - None (Not at all)	1 - Slight (Rare less than a day or two)	2 - Mild (Several days)	3 - Moderate (More than half the days)	4 - Severe (Nearly every day)
7. Felt more irritated or easily annoyed than usual?	○	○	○	○	○
8. Felt angry or lost your temper?	○	○	○	○	○

V & VI. - Highest Domain Score (clinician) _____

VII.

	0 - None (Not at all)	1 - Slight (Rare less than a day or two)	2 - Mild (Several days)	3 - Moderate (More than half the days)	4 - Severe (Nearly every day)
9. Started lots more projects than usual or done more risky things than usual?	○	○	○	○	○
10. Slept less than usual but still had a lot of energy?	○	○	○	○	○

VII. - Highest Domain Score (clinician) _____

VIII.

	0 - None (Not at all)	1 - Slight (Rare less than a day or two)	2 - Mild (Several days)	3 - Moderate (More than half the days)	4 - Severe (Nearly every day)
11. Felt nervous, anxious, or scared?	○	○	○	○	○
12. Not been able to stop worrying?	○	○	○	○	○
13. Not been able to do things you wanted to or should have done, because they made you feel nervous?	○	○	○	○	○

VIII. - Highest Domain Score (clinician) _____

IX.

	0 - None (Not at all)	1 - Slight (Rare less than a day or two)	2 - Mild (Several days)	3 - Moderate (More than half the days)	4 - Severe (Nearly every day)
14. Heard voiceswhen there was no one there - speaking about you or telling you what to do or saying bad things to you?	○	○	○	○	○
15. Had visions when you were completely awake - that is, seen something or someone that no one else could see?	○	○	○	○	○

IX. - Highest Domain Score (clinician) _____

X.

	0 - None (Not at all)	1 - Slight (Rare less than a day or two)	2 - Mild (Several days)	3 - Moderate (More than half the days)	4 - Severe (Nearly every day)
16. Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	○	○	○	○	○
17. Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	○	○	○	○	○
18. Worried a lot about things you touched being dirty or having germs or being poisoned?	○	○	○	○	○
19. Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	○	○	○	○	○

X. - Highest Domain Score (clinician) _____

In the past TWO (2) WEEKS, have you

XI.

20. Had an alcoholic beverage (beer, wine, liquor, etc.)?	◯ Yes ◯ No
21. Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	◯ Yes ◯ No
22. Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	◯ Yes ◯ No
23. Used any medicine without a doctors prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	◯ Yes ◯ No

XII.

24. In the last 2 weeks, have you thought about killing yourself or committing suicide?	◯ Yes ◯ No
25. Have you EVER tried to kill yourself?	◯ Yes ◯ No

Tier 2: After meeting thresholds

Domain	Domain Name	Threshold to guide further inquiry	DSM-5 Level 2 Cross-Cutting Symptom Measure available online
I.	Somatic Symptoms	Mild or greater	LEVEL 2—Somatic Symptom—Child Age 11–17 (Patient Health Questionnaire Somatic Symptom Severity [PHQ-15])
II.	Sleep Problems	Mild or greater	LEVEL 2—Sleep Disturbance—Child Age 11-17 (PROMIS—Sleep Disturbance—Short Form)[1]
III.	Inattention	Slight or greater	None
IV.	Depression	Mild or greater	LEVEL 2—Depression—Child Age 11–17 (PROMIS Emotional Distress—Depression—Pediatric Item Bank)
V.	Anger	Mild or greater	LEVEL 2—Anger—Child Age 11–17 (PROMIS Emotional Distress—Calibrated Anger Measure—Pediatric)
VI.	Irritability	Mild or greater	LEVEL 2—Irritability—Child Age 11–17 (Affective Reactivity Index [ARI])
VII.	Mania	Mild or greater	LEVEL 2—Mania—Child Age 11–17 (Altman Self-Rating Mania Scale [ASRM])
VIII.	Anxiety	Mild or greater	LEVEL 2—Anxiety—Child Age 11–17 (PROMIS Emotional Distress—Anxiety—Pediatric Item Bank)
IX.	Psychosis	Slight or greater	None
X.	Repetitive Thoughts & Behaviors	Mild or greater	LEVEL 2—Repetitive Thoughts and Behaviors—Child 11–17 (adapted from the Children's Florida Obsessive-Compulsive Inventory [C-FOCI] Severity Scale)
XI.	Substance Use	Yes/ Don't Know	LEVEL 2—Substance Use—Child Age 11–17 (adapted from the NIDA-modified ASSIST)
XII.	Suicidal Ideation/ Suicide Attempts	Yes/ Don't Know	None

I. Somatic Symptoms

LEVEL 2-Somatic Symptom-Child Age 11-17 (Patient Health QuestionnaireSomatic Symptom Severity [PHQ-15])

During the past 4 weeks, how much have you been bothered by any of the following problems?

	Not bothered at all	Bothered a little	Bothered a lot
a. Stomach pain	○	○	○
b. Back pain	○	○	○
c. Pain in your arms, legs, or joints (knees, hips, etc.)	○	○	○
d. Menstrual cramps or other problems with your periods (women only)	○	○	○
e. Headaches	○	○	○
f. Chest pain	○	○	○
g. Dizziness	○	○	○
h. Fainting spells	○	○	○
i. Feeling your heart pound or race	○	○	○
j. Shortness of breath	○	○	○
k. Pain or problems during sexual intercourse	○	○	○
l. Constipation, loose bowels, or diarrhea	○	○	○
m. Nausea, gas, or indigestion	○	○	○
n. Feeling tired or having low energy	○	○	○
o. Trouble sleeping	○	○	○

II. Sleep Problems

LEVEL 2-Sleep Disturbance Child Age 11-17 (PROMIS-Sleep Disturbance-Short Form)

Instructions to the child: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that during the past 2 weeks you have been bothered by not being able to fall asleep or stay asleep or by waking up too early at a mild or greater level of severity.

The questions below ask about these feelings in more detail and especially how often you have been bothered by a list of symptoms during the past 7 days.

In the past 7 days

	Not at all	A little bit	Somewhat	Quite a bit	Very much
My sleep was restless.	○	○	○	○	○

	Not at all	A little bit	Somewhat	Quite a bit	Very much
I was satisfied with my sleep.	○	○	○	○	○
My sleep was refreshing.	○	○	○	○	○

	Not at all	A little bit	Somewhat	Quite a bit	Very much
I had difficulty falling asleep.	○	○	○	○	○

In the past 7 days

	Never	Rarely	Sometimes	Often	Always
I had trouble staying asleep.	○	○	○	○	○
I had trouble sleeping.	○	○	○	○	○

	Never	Rarely	Sometimes	Often	Always
I got enough sleep.	○	○	○	○	○

In the past 7 days

	Very poor	Poor	Fair	Good	Very good
My sleep quality was...	○	○	○	○	○

Total/Partial Raw Score _____

Prorated Total Raw Score _____

T-score _____

IV. Depression

LEVEL 2-Depression-Child Age 11-17 (PROMIS Emotional Distress-Depression-Pediatric Item Bank)

Instructions to the child: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that
during the past 2 weeks you have been bothered by having little interest or pleasure in doing things and/or feeling down, depressed, or hopeless at a mild or greater level of severity.

The questions below ask about these feelings in more detail and especially how often you have been bothered by a list of symptoms during the past 7 days.

In the past 7 days

	Never	Almost Never	Sometimes	Often	Almost Always
I could not stop feeling sad.	○	○	○	○	○
I felt alone.	○	○	○	○	○
I felt everything in my life went wrong.	○	○	○	○	○
I felt like I couldn't do anything right.	○	○	○	○	○
I felt lonely.	○	○	○	○	○
I felt sad.	○	○	○	○	○
I felt unhappy.	○	○	○	○	○
I thought that my life was bad.	○	○	○	○	○
Being sad made it hard for me to do things with my friends.	○	○	○	○	○
I didn't care about anything.	○	○	○	○	○
I felt stressed.	○	○	○	○	○
I felt too sad to eat.	○	○	○	○	○
I wanted to be by myself.	○	○	○	○	○
It was hard for me to have fun.	○	○	○	○	○

V. Anger

LEVEL 2-Anger-Child Age 11-17 (PROMIS Emotional Distress-Calibrated Anger Measure-Pediatric)

Instructions to the child:
On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that during the past 2 weeks you have been bothered by feeling irritated or easily annoyed and/or feeling angry or lost your temper at a mild or greater level of severity.

The questions below ask about these feelings in more detail and especially how often you have been bothered by a list of symptoms during the past 7 days.

In the past 7 days.

	Never	Almost Never	Sometimes	Often	Almost Always
I felt mad.	○	○	○	○	○
I was so angry I felt like throwing something.	○	○	○	○	○
I was so angry I felt like yelling at somebody.	○	○	○	○	○
When I got mad, I stayed mad.	○	○	○	○	○
I felt fed up.	○	○	○	○	○
I felt upset.	○	○	○	○	○

VI. Irritability

LEVEL 2 Irritability-Child Age 11-17 (Affective Reactivity Index)

Instructions to the child:
On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that during the past 2 weeks you have been bothered by feeling irritated or easily annoyed and/or feeling angry or lost your temper at a mild or greater level of severity.

The questions below ask about these feelings in more detail and especially how often you have been bothered by a list of symptoms during the past 7 days.

In the last SEVEN (7) DAYS and compared to others of the same age, how well does each of the following statements describe your behavior or feelings?

Am easily annoyed by others.

◯ Not True
◯ Somewhat True
◯ Certainly True

VII. Mania

LEVEL 2-Mania-Child Age 11-17 (Altman Self-Rating Mania Scale [ASRM])

Instructions to the child:
On the DSM-5 Level 1 cross-cutting questionnaire you just completed, you indicated that during the past 2 weeks you have been bothered by feeling so active that you couldn't settle down and/or finding that you didn't sleep a lot at night at a mild or greater level of severity. The five statement groups or questions below ask about these feelings in more detail.

1. Please read each group of statements/question carefully.
2. Choose the one statement in each group that best describes the way you have been feeling for the past week.
3. Check the box next to the number/statement selected.
4. Please note: The word occasionally, when used here means once or twice; often means several times or more and frequently means most of the time.

Question 1

◯ I do not feel happier or more cheerful than usual
◯ I occasionally feel happier or more cheerful than usual
◯ I often feel happier or more cheerful than usual
◯ I feel happier or more cheerful than usual most of the time
◯ I feel happier of more cheerful than usual all of the time

Question 2

◯ I do not feel more self-confident than usual
◯ I occasionally feel more self-confident than usual
◯ I often feel more self-confident than usual
◯ I frequently feel more self-confident than usual
◯ I feel extremely self-confident all of the time

Question 3

◯ I do not need less sleep than usual
◯ I occasionally need less sleep than usual
◯ I often need less sleep than usual
◯ I frequently need less sleep than usual
◯ I can go all day and all night without any sleep and still not feel tired

Question 4

◯ I do not talk more than usual.
◯ I occasionally talk more than usual
◯ I often talk more than usual
◯ I frequently talk more than usual
◯ I talk constantly and cannot be interrupted

Question 5

◯ I have not been more active (either socially, sexually, at work, home, or school) than usual
◯ I have occasionally been more active than usual
◯ I have often been more active than usual
◯ I have frequently been more active than usual
◯ I am constantly more active or on the go all the time

Total/Partial Raw Score: _____

Prorated Total Raw Score: (if 1 item left unanswered) _____

VIII. Anxiety

LEVEL 2-Anxiety-Child Age 11-17 (PROMIS Emotional Distress-Anxiety-Pediatric Item Bank)

Instructions to the child:
On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that during the past 2 weeks you have been bothered by feeling nervous, anxious, or scared, not being able to stop worrying and/or not being able to do things you wanted to or should have done because they made you feel nervous at a mild or greater level of severity.

The questions below ask about these feelings in more detail and especially how often you have been bothered by a list of symptoms during the past 7 days.

In the past 7 days

	Never	Almost Never	Sometimes	Often	Almost Always
I felt like something awful might happen.	◯	◯	◯	◯	◯
I felt nervous.	◯	◯	◯	◯	◯
I felt scared.	◯	◯	◯	◯	◯
I felt worried.	◯	◯	◯	◯	◯

I worried about what could happen to me.	◯	◯	◯	◯	◯
I worried when I went to bed at night.	◯	◯	◯	◯	◯
I got scared really easy.	◯	◯	◯	◯	◯
I was afraid of going to school.	◯	◯	◯	◯	◯
I was worried I might die.	◯	◯	◯	◯	◯
I woke up at night scared.	◯	◯	◯	◯	◯
I worried when I was at home.	◯	◯	◯	◯	◯
I worried when I was away from home.	◯	◯	◯	◯	◯
It was hard for me to relax.	◯	◯	◯	◯	◯

X. Repetitive Thoughts & Behaviors

LEVEL 2-Repetitive Thoughts and Behaviors-Child 11-17 (adapted from the Children's Florida Obsessive-Compulsive Inventory [C-FOCI] Severity Scale)

Instructions to the child:
On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that during the past 2 weeks you have been bothered by "thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else", "feeling the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off", "worrying a lot about things you touched being dirty or having germs or being poisoned", and/or "feeling you had to do things in a certain way, like counting or saying special things, to keep something bad from happening" at a mild or greater level of severity.

The questions below ask about these feelings in more detail and especially how often you have been bothered by a list of symptoms during the past 7 days.

During the past SEVEN (7) DAYS

1. On average, how much time is occupied by these thoughts or behaviors each day?

◯ 0-None
◯ 1-Mild (less than an hour a day)
◯ 2-Moderate (1 to 3 hours a day)
◯ 3-Severe (3 to 8 hours a day)
◯ 4-Extreme (more than 8 hours a day)

1. Clinician use - Item score

_____

2. How much do they bother you?

◯ 0-None
◯ 1-Mild (slightly upsetting)
◯ 2-Moderate (upsetting but still manageable)
◯ 3-Severe (very upsetting)
◯ 4-Extreme (overwhelming distress)

2. Clinician use - Item score

_____

3. How hard is it for you to control them?	◯ 0-None ◯ 1-Mild (usually able to control thoughts or behaviors) ◯ 2-Moderate (sometimes able to control thoughts or behaviors) ◯ 3-Severe (not usually able to control thoughts or behaviors) ◯ 4-Extreme (unable to control thoughts or behaviors)
3. Clinician use - Item score	_____
4. How much do they cause you to avoid doing things, going places or being with people?	◯ 0-None ◯ 1-Mild (occasionally avoids things) ◯ 2-Moderate (regularly avoids doing these things) ◯ 3-Severe (frequently avoids these things) ◯ 4-Extreme (nearly complete avoidance; can't leave the house)
4. Clinician use - Item score	_____
5. How much do they interfere with school, your social or family life, or your job?	◯ 0-None ◯ 1-Mild (slight interference) ◯ 2-Moderate (definite interference with functioning, but can still manage) ◯ 3-Severe (substantial interference) ◯ 4-Extreme (near-total interference)
5. Clinician use - Item score	_____
Total/Partial Raw Score	_____
Prorated Total Raw Score (if 1 item is left unanswered)	_____
Average Total Score	_____

XI. Substance Use

LEVEL 2 - Substance Use - Child Age 11-17 (adapted from the NIDA-modified ASSIST)

Instructions to the child:
On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that during the past 2 weeks you have been bothered by "having an alcoholic beverage"; "smoking a cigarette, a cigar, or pipe or used snuff or chewing tobacco"; "using drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)"; and/or "using any medicine ON YOUR OWN, that is, without a doctor's prescription, to get high or change the way you feel."

The questions below ask about these feelings in more detail and especially how often you have been bothered by a list of symptoms during the past two (2) weeks.

During the past TWO (2) weeks, about how often did you ...

	Not at All	Less Than a Day or Two	Several Days	More Than Half the Days	Nearly Every Day	Don't know
a. Have an alcoholic beverage (beer, wine, liquor, etc.)?	○	○	○	○	○	○
b. Have 4 or more drinks in a single day?	○	○	○	○	○	○
c. Smoke a cigarette, a cigar, or pipe or use snuff or chewing tobacco?	○	○	○	○	○	○

During the past TWO (2) weeks, about how often did you use any of the following medicines ON YOUR OWN, that is, without a doctor's prescription or in greater amounts or longer than prescribed?

	Not at All	Less Than a Day or Two	Several Days	More Than Half the Days	Nearly Every Day	Don't know
d. Painkillers (like Vicodin)	○	○	○	○	○	○
e. Stimulants (like Ritalin, Adderall)	○	○	○	○	○	○
f. Sedatives or tranquilizers (like sleeping pills or Valium)	○	○	○	○	○	○

Or drugs like:

	Not at All	Less Than a Day or Two	Several Days	More Than Half the Days	Nearly Every Day	Don't know
g. Steroids	○	○	○	○	○	○
h. Other medicines	○	○	○	○	○	○
i. Marijuana	○	○	○	○	○	○
j. Cocaine or crack	○	○	○	○	○	○
k. Club drugs (like ecstasy)	○	○	○	○	○	○
l. Hallucinogens (like LSD)	○	○	○	○	○	○
m. Heroin	○	○	○	○	○	○
n. Inhalants or solvents (like glue)	○	○	○	○	○	○
o. Methamphetamine (like speed)	○	○	○	○	○	○

Total/Partial Raw Score: _____

Total/Partial Raw Score: _____

Additional Guidance:
These CDEs include questions that can potentially identify respondents who are at risk of suicide. Investigators implementing this protocol should consult with their IRBs to develop a risk management plan specific to their study to ensure the safety of participants. Investigators should also ensure their studies are compliant with federal, state, and institutional regulations and policies and inform participants of limits of confidentiality when a participant endorses imminent risk of harm to self or others.

The following link provides additional information and guidelines for suicide-related research: https://www.nimh.nih.gov/funding/clinical-research/conducting-research-with-participants-at-elevated-risk-for-suicide-considerations-for-researchers.

Tier 1: Anxiety, Depression, Fatigue PROMIS scales Pediatric measures

Due to early research demonstrating the presence of COVID-19/pandemic related mental health symptoms, anxiety, depressive symptoms, and fatigue PROMIS measures were designated Tier 1 in addition to the DSM-5 screener.

	Never	Almost Never	Sometimes	Often	Almost Always
I felt like something awful might happen.	○	○	○	○	○
I felt nervous.	○	○	○	○	○
I felt scared.	○	○	○	○	○
I felt worried.	○	○	○	○	○
I worried when I was at home.	○	○	○	○	○
I got scared really easy.	○	○	○	○	○
I worried about what could happen to me.	○	○	○	○	○
I worried when I went to bed at night.	○	○	○	○	○

In the past 7 days

	Never	Almost Never	Sometimes	Often	Almost Always
I could not stop feeling sad.	○	○	○	○	○
I felt alone.	○	○	○	○	○
I felt everything in my life went wrong.	○	○	○	○	○
I felt like I couldn't do anything right.	○	○	○	○	○
I felt lonely.	○	○	○	○	○
I felt sad.	○	○	○	○	○
I felt unhappy.	○	○	○	○	○
It was hard for me to have fun.	○	○	○	○	○

In the past 7 days

	Never	Almost Never	Sometimes	Often	Almost Always
Being tired made it hard for me to keep up with my schoolwork.	○	○	○	○	○
Being tired made it hard for me to play or go out with my friends as much as I'd like.	○	○	○	○	○
I felt weak.	○	○	○	○	○
I got tired easily.	○	○	○	○	○
I had trouble finishing things because I was too tired.	○	○	○	○	○
I had trouble starting things because I was too tired.	○	○	○	○	○

I was so tired it was hard for me to pay attention.	○	○	○	○	○
I was too tired to do sports or exercise.	○	○	○	○	○
I was too tired to do things outside.	○	○	○	○	○
I was too tired to enjoy the things I like to do.	○	○	○	○	○

Tier 2: RCADS Anxiety and Depression Scale (Ages 8-18)

Due to early research demonstrating the presence of COVID-19/pandemic related mental health symptoms, anxiety, and depression RCADS measures were designated Tier 2 in addition to the DSM-5 screener and PROMIS Tier 1 measures.

Please select the word that shows how often each of these things happens to you. There are no right or wrong answers.

	Never	Sometimes	Often	Always
1. I worry about things	○	○	○	○
2. I feel sad or empty	○	○	○	○
3. When I have a problem, I get a funny feeling in my stomach	○	○	○	○
4. I worry when I think I have done poorly at something	○	○	○	○
5. I would feel afraid of being on my own at home	○	○	○	○
6. Nothing is much fun anymore	○	○	○	○
7. I feel scared when I have to take a test	○	○	○	○
8. I feel worried when I think someone is angry with me	○	○	○	○
9. I worry about being away from my parents	○	○	○	○
10. I get bothered by bad or silly thoughts or pictures in my mind	○	○	○	○
11. I have trouble sleeping	○	○	○	○
12. I worry that I will do badly at my schoolwork	○	○	○	○
13. I worry that something awful will happen to someone in my family	○	○	○	○

	Never	Sometimes	Often	Always
14. I suddenly feel as if I can't breathe when there is no reason for this	○	○	○	○
15. I have problems with my appetite	○	○	○	○
16. I have to keep checking that I have done things right (like the switch is off, or the door is locked)	○	○	○	○
17. I feel scared if I have to sleep on my own	○	○	○	○
18. I have trouble going to school in the mornings because I feel nervous or afraid	○	○	○	○
19. I have no energy for things	○	○	○	○
20. I worry I might look foolish	○	○	○	○
21. I am tired a lot	○	○	○	○
22. I worry that bad things will happen to me	○	○	○	○
23. I can't seem to get bad or silly thoughts out of my head	○	○	○	○
24. When I have a problem, my heart beats really fast	○	○	○	○

	Never	Sometimes	Often	Always
25. I cannot think clearly	○	○	○	○
26. I suddenly start to tremble or shake when there is no reason for this	○	○	○	○
27. I worry that something bad will happen to me	○	○	○	○
28. When I have a problem, I feel shaky	○	○	○	○
29. I feel worthless	○	○	○	○
30. I worry about making mistakes	○	○	○	○
31. I have to think of special thoughts (like numbers or words) to stop bad things from happening	○	○	○	○
32. I worry what other people think of me	○	○	○	○
33. I am afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	○	○	○	○

34. All of a sudden, I feel really scared for no reason at all	○	○	○	○
35. I worry about what is going to happen	○	○	○	○
36. I suddenly become dizzy or faint when there is no reason for this	○	○	○	○
37. I think about death	○	○	○	○

	Never	Sometimes	Often	Always
38. I feel afraid if I have to talk in front of my class	○	○	○	○
39. My heart suddenly starts to beat too quickly for no reason	○	○	○	○
40. I feel like I dont want to move	○	○	○	○
41. I worry that I will suddenly get a scared feeling when there is nothing to be afraid of	○	○	○	○
42. I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order)	○	○	○	○
43. I feel afraid that I will make a fool of myself in front of people	○	○	○	○
44. I have to do some things in just the right way to stop bad things from happening	○	○	○	○
45. I worry when I go to bed at night	○	○	○	○
46. I would feel scared if I had to stay away from home overnight	○	○	○	○
47. I feel restless	○	○	○	○

Tier 2

TRAUMA
Age 8-17

CRIES-8

Below is a list of comments made by people after stressful life events. Please tick each item showing how frequently these comments were true for you during the past seven days. If they did not occur during that time, please tick the 'not at all' box.

	Not at all	Rarely	Sometimes	Often

1. Do you think about it even when you don't mean to?	○	○	○	○
2. Do you try to remove it from your memory?	○	○	○	○
3. Do you have waves of strong feelings about it?	○	○	○	○
4. Do you stay away from reminders of it (e.g. places or situations)?	○	○	○	○
5. Do you try to talk about it?	○	○	○	○
6. Do pictures about it pop into your mind?	○	○	○	○
7. Do other things keep making you think about it?	○	○	○	○
8. Do you try not to think about it?	○	○	○	○

PROMIS Pain Interference

Age 8-17

In the past 7 days

	Never	Almost Never	Sometimes	Often	Almost Always
I felt angry when I had pain.	○	○	○	○	○
I had trouble doing schoolwork when I had pain.	○	○	○	○	○
I had trouble sleeping when I had pain.	○	○	○	○	○
It was hard for me to pay attention when I had pain.	○	○	○	○	○
It was hard for me to run when I had pain.	○	○	○	○	○
It was hard for me to walk one block when I had pain.	○	○	○	○	○
It was hard to have fun when I had pain.	○	○	○	○	○
It was hard to stay standing when I had pain.	○	○	○	○	○

PROMIS Cognitive Function

Age 8-17

In the past 4 weeks

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
I have to use written lists more often than other people my age so I will not forget things.	○	○	○	○	○
It is hard for me to pay attention to one thing for more than 5-10 minutes.	○	○	○	○	○
I have trouble keeping track of what I am doing if I get interrupted.	○	○	○	○	○
I have to read things several times to understand them.	○	○	○	○	○
I forget things easily.	○	○	○	○	○
I have to work really hard to pay attention or I make mistakes	○	○	○	○	○
I have trouble remembering to do things like school projects or chores	○	○	○	○	○

Tier 2: Externalizing Symptoms

While prioritized as a Tier 2 measure, this Working Group does not recommend specific measures since the most commonly used measures (Child Behavior Checklist and Strengths and Difficulties Questionnaire) require licensing. The Multidimensional Assessment Profile of Disruptive Behavior (MAP-DB), is available for use as well and does not require a license.