## Psychosocial assessment for refugees in reception phase – child and adolescent ages 6 to 18 (PAIR-C)

## Self-report version

You have experienced a big transition in life and perhaps many dramatic events. We know this can affect how you feel. Here are some questions about how you are doing and if you need help with anything. There are no right or wrong answers, just answer the best you can. If there's something that you don't want to answer, then that's also completely OK. Let us know if you have any questions while you are filling out the assessment. First, there will be a few questions about what you've experienced.

Contact details:       Age (years)       Gender:         Last name/First name:       Age (years)       Gender:         Date of Birth/ID number:       Telephone number for child/caregiver         Today's date:       Telephone number for child/caregiver         FAMILY       Yes       No         If yes, who?       If no, who is responsible for you?       Yes       No         Do you have parents or brothers and sisters who are not with you in Norway?       Yes       No       No         If yes, who?       Yes       No       No       No         Are you in contact with them?       Yes       No       No       No         Have you experienced anything else frightening, dangerous, violent or that was very stressful in another way?       No       No       No         Please describe here:        Yes       No       No       No         Have you experienced anything else frightening, dangerous, violent or that was very stressful in another way?       Yes       No         Please describe here:        Yes       No       No         Do you/your family have a permanent place or somewhere to live?       Yes       No         Do you get along with the people you live with?       Yes       No       No         Can you keep up/concentrate at school?<	Last name/First name: Age (years) Gender: Date of Birth/ID number: Today's date: Telephone number for child/caregiver FAMILY Did you come to Norway with anyone? Yes No									
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	4. Theu/exhaustion/lack of strength (not after exercise)		2	3	4					
	5 Feeling constantly scared or anxious *	1	2	3	Δ					
	6. Feeling tense or uneasy*	1	2	3	4					



7 Feelir	ng hopeless when you think about the future*	1	2	3	4
	ng down or sad *	1	2	3	4
	ied a lot about different things*	1	2	3	4
		•			
	POST-TRAUMATIC R	EACTIONS	**		
Now, we	e will talk about a list of problems that we can sometimes ex	perience afte	r we have had v	ery stressful	experiences. In
the <b>last</b>	2 weeks how often have you been bothered by:				
		Never	Sometimes	Often	Almost all the time
10. Bad	dreams that remind me of what happened	0	1	2	3
	ures of what happened in my head. It feels like it's ing again right now.	0	1	2	3
12. l try	not to think about what happened. Or to feel anything.	0	1	2	3
	y away from anything that reminds me of what happened	0	1	2	3
(people, places, things, situations or talking about it).					
	more careful than usual (checking who's around me)	0	1	2	3
15. l'm r	more shy	0	1	2	3
	SUBSTANCE	USE			
How oft	ten:	Never	Monthly	Weekly	Daily
16. c	do you drink alcohol?				
17. s	smoke hashish or use other drugs?				
18. t	take sleeping pills or something to help you sleep?				
19. If yes, have either you or someone else (a relative, friend, healthcare professional) been					Yes
concern	ned about your drug use or told you that you should reduce/s	stop using dru	ıgs?		
	OTHER PROBL	EMS			
20. Do you sometimes hear a voice that speaks to you clearly like I'm doing now, that other				No	Yes
people can't hear?					
20a. If yes: Does it bother you?			No	Yes	
21. Have you had thoughts about hurting yourself or others?				No	Yes
	e you hurt yourself or others in the last 14 days?			No	Yes
23. Have	e you had thoughts about taking your life in the last 14 days?			No	Yes

\* Goodman R 1997 \*\* Sachser et al. 2017