

Project #

Child/Youth Assessment and Referral Tool

OMB NO. 0930-0270
Expiration Date XX/XX/XXXX

The Crisis Counseling Assistance and Training Program (CCP) should have protocols or procedures in place for how a crisis counselor should respond if serious reactions are indicated while using this tool. Many CCPs have team leaders or other staff with a mental health background to administer this tool to ensure proper assessment and referral. All crisis counseling staff using this tool should have detailed training and guidance on use of the tool and when to make a referral for more intensive services. Prior to use of this tool, the CCP should have identified at least one organization or agency that is willing to accept referrals from the CCP for more intensive mental health or substance use intervention services.

Please use this tool as an interview guide.

- 1) with children receiving individual crisis counseling on the third and fifth occasions OR
- 2) with any child at any time if you suspect the child may be experiencing serious reactions to the disaster.

ENCOUNTER INFORMATION

Provider Name		Provider #	
Date of Service (mm/dd/yyyy)		County of Service	
1 st Employee #		2 nd Employee #	
ZIP Code of Service			

VISIT NUMBER ☐ First visit ☐ Second visit ☐ Third visit ☐ Fourth visit ☐ Fifth visit or later

DURATION ☐ 15 - 29 minutes ☐ 30 – 44 minutes ☐ 45 – 59 minutes ☐ 60 minutes or more

Was parent or caregiver present during the visit? ☐ Yes ☐ No

Was the team lead or supervisory staff present during administration of this tool? ☐ Yes ☐ No

READ: Occasionally, we find it helpful to ask children/adolescents or their parents/caregivers a few specific questions about how they were affected by the disaster and how they are feeling now. May I ask you these questions? My first questions are about various experiences you have had in the disaster.

LOCATION OF SERVICE (select one)

- | | |
|--|--|
| ☐ school and child care (all ages through college) | ☐ temporary home (including friend or family homes, group homes, shelters, apartments, trailers, and other dwellings) |
| ☐ community center (e.g., recreation club) | ☐ IF A TEMPORARY HOME: PLEASE CHECK THIS BOX IF ANY CHILDREN UNDER AGE 18 LIVE IN THIS HOME. |
| ☐ provider site/mental health agency (agency involved with the CCP) | ☐ permanent home |
| ☐ workplace (workplace of the disaster survivor and/or first responder) | ☐ IF A TEMPORARY HOME: PLEASE CHECK THIS BOX IF ANY CHILDREN UNDER AGE 18 LIVE IN THIS HOME. |
| ☐ disaster recovery center (e.g., Federal Emergency Management Agency [FEMA], American Red Cross) | ☐ phone counseling (15 minutes or longer) |
| ☐ place of worship (e.g., church, synagogue, mosque) | ☐ IF HOTLINE, HELPLINE, or CRISIS LINE, please check here . |
| ☐ retail (e.g., restaurant, mall, shopping center, store) | ☐ medical center (e.g., doctor, dentist, hospital, mental health specialty center) |
| ☐ public place/event (e.g., street, sidewalk, town square, fair, festival, sports) | ☐ other (specify in box) <input type="text"/> |

RISK CATEGORIES (select all that apply)

- | | | |
|---|---|---|
| ☐ family missing/dead | ☐ injured or physically harmed (self or household member) | ☐ evacuated quickly with no time to prepare |
| ☐ friend missing/dead | ☐ life was threatened (self or household member) | ☐ displace from home 1 week or more |
| ☐ pet missing/dead | ☐ witnessed death/injury (self or household member) | ☐ sheltered in place or sought shelter due to immediate threat of danger |
| ☐ home damaged or destroyed | ☐ assisted with rescue/recovery (self or household member) | ☐ past substance use/mental health problem |
| ☐ vehicle or major property loss | ☐ had to change schools (for children or youth) | ☐ preexisting physical disability |
| ☐ other financial loss | ☐ prolonged separation from family | ☐ past trauma |
| ☐ disaster unemployed (self or household member) | | |

DEMOGRAPHIC INFORMATION

Age (select one) ☐ preschool (0-5 years) ☐ child (6-11 years) ☐ adolescent (12-17 years) **Grade level in school**

If you have a disability or other access or functional need, indicate the type (select all that apply).

☐ Physical (mobility, visual, hearing, medical, etc.) ☐ Intellectual/Cognitive (learning disability, developmental delay, etc.) ☐ Mental Health/Substance Use (psychiatric, substance dependence, etc.)

Gender ☐ Male ☐ Female ☐ Transgender ☐ None of these

Primary language spoken during this encounter (select one) ☐ English ☐ Spanish ☐ Other

Race/Ethnicity (select one or more)

☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Hispanic/Latino

RESPONSE CARD (COUNSELOR COPY—GIVE THE LARGER VERSION TO CHILD/PARENT BEFORE ASSESSMENT)

Prior to beginning the assessment, please give the larger version of the response card to the child or parent who will be answering your questions. This card will assist the child or parent in better understanding how often the child is experiencing certain reactions.

Think about your thoughts, feelings, and behavior **DURING THE FIRST MONTH**. Use these frequency rating options to help answer how often the problem has happened in the past month. For each question choose **ONE** of the following responses.

1

3

4

S	M	T	W	T	F	S
X	X	X	X	X	X	X
X		X		X		X
	X		X	X	X	
X	X	X	X	X	X	X

“Very much” means almost every day.

ASSESSMENT QUESTIONS

INTRODUCTION: I want to talk to you about your (your child's) feelings and thoughts about the disaster and how much they are causing problems *now*. Think about your thoughts, feelings, and behavior **DURING THE PAST MONTH** (*please remind child/parent of this for each question*). Use the frequency rating options **on the previous page** and on the response card to help the child answer how often the problem has happened in the past month. For each question choose **ONE** of the following responses and check the appropriate box for that question.

4 = very much ☐

RESPONDENT ANSWERS

- [illegible]

ASSESSMENT QUESTIONS (continued)

ADDITIONAL QUESTIONS FOR PARENTS (required for parents of children ages 0-7; recommended for parents of all children and adolescents)

QUESTIONS TO BE READ

RESPONDENT ANSWERS

16. Has your child been more clingy or worried about separation?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
17. Has your child been more quiet and withdrawn?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
18. Has your child talked repeatedly or asked questions about the disaster?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
19. Has your child's play been about the disaster?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
20. Have you noticed changes in your child's behavior or development (e.g., bed-wetting, baby talk, fighting or risk-taking behavior, or decline in school performance)?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

COUNT THE NUMBER OF ENTRIES IN THE LAST 2 COLUMNS ABOVE THAT HAVE A SCORE OF 3 OR 4.
IF TOTAL NUMBER IS 4 OR MORE, DISCUSS THE POSSIBILITY OF A REFERRAL FOR SERVICES.

TOTAL NUMBER

FOR CHILDREN OVER THE AGE OF 10 OR IF YOU ARE CONCERNED ABOUT A YOUNGER CHILD, YOU MAY ASK:

21. In the past few weeks, have you wished you were dead?
☐ YES ☐ NO
22. In the past few weeks, have you felt that you or your family would be better off if you were dead?
☐ YES ☐ NO
23. In the past week, have you been having thoughts about killing yourself?
☐ YES ☐ NO
24. Have you ever tried to kill yourself?
☐ YES ☐ NO

If the patient answers "Yes" to any of the above, ask the following acuity question:

Are you having thoughts of killing yourself right now?
☐ YES ☐ NO

IF THE ANSWER TO ANY OF THE ITEMS ABOVE IS "YES," REFER FOR IMMEDIATE PSYCHIATRIC INTERVENTION. The CCP should have protocols or procedures in place for how a crisis counselor should respond or react if the response is "YES".

REFERRAL (select all that were communicated)

- | | |
|---|---|
| ☐ crisis counseling program services (e.g., group counseling, referral to a team leader, follow-up visit)

☐ mental health services (e.g., professional, longer-term counseling, treatment, behavioral, or psychiatric services)

☐ substance use services (e.g., professional, behavioral, or medical treatment or self-help groups, such as Alcoholics Anonymous or Narcotics Anonymous) | ☐ community services (e.g., FEMA, loans, housing, employment, social services)

☐ resources for those with disabilities, or other access or functional needs

☐ other (specify in box) |
|---|---|

Was the referral accepted by the child? ☐ YES ☐ NO

Was the referral accepted by the parent/caregiver? ☐ YES ☐ NO

INSTRUCTIONS: CHILD/YOUTH ASSESSMENT AND REFERRAL TOOL

It is recommended that this form be used with all children or youth who are intensive users of services. Intensive users are people who are participating in their third individual crisis counseling visit with any crisis counselor from the program or who continue to suffer severe distress that may be impacting their ability to perform routine daily activities. This form should be used as an interview guide (1) with children receiving individual crisis counseling on the third and fifth occasions OR (2) with any child at any time if you suspect the child may be experiencing serious reaction to the disaster.

PROJECT #—FEMA disaster declaration number, e.g., DR-XXX-State

PROVIDER NAME—The name of the program/agency.

PROVIDER #—The unique number under which your program/agency is providing services.

1st EMPLOYEE #—YOUR employee number.

2nd EMPLOYEE #—Employee number of your teammate during this encounter.

DATE OF SERVICE—The date of the encounter in the format mm/dd/yyyy, e.g., 01/01/2012.

COUNTY OF SERVICE—The county where the encounter occurred.

ZIP CODE OF SERVICE—The ZIP code of the location where the encounter occurred.

VISIT NUMBER—Is this the first, second, third, fourth, fifth, or later visit for this person to your program? All visits did not have to be with you. SELECT ONLY ONE.

DURATION—How long did your encounter last? SELECT ONLY ONE. If the encounter was under 15 minutes, record it on the Weekly Tally Sheet.

LOCATION OF SERVICE—Where did the encounter occur? SELECT ONLY ONE.

RISK CATEGORIES—These are factors that an individual may have experienced or may have present in his or her life that could increase his or her need for services. MORE THAN ONE CATEGORY MAY APPLY. SELECT ALL CATEGORIES THAT APPLY.

DEMOGRAPHIC INFORMATION:

AGE—What age does the person or his or her parent indicate he or she is? SELECT ONLY ONE.

GRADE LEVEL IN SCHOOL—Please enter the number, e.g., 4 = fourth grade.

PERSONS WITH DISABILITIES OR OTHER ACCESS OR FUNCTIONAL NEEDS—If the participant or his or her parent considers the participant to have a disability or an access or functional need, what type is indicated (physical, intellectual/cognitive, or mental health/substance use)? SELECT ALL THAT APPLY.

- Physical: Includes disorders that impair mobility, seeing, or hearing, as well as medical conditions, such as diabetes, lupus, Parkinson's, AIDS, or multiple sclerosis (MS).
- Intellectual: Includes a learning disability, birth defect, neurological disorder, developmental disability, or traumatic brain injury (e.g., Down syndrome).
- Mental Health/Substance Use: Includes psychiatric disorders, such as bipolar disorder, depression, post-traumatic stress disorder (PTSD), schizophrenia, and substance dependence.

GENDER—The gender the person reports him- or herself to be. SELECT ONLY ONE.

PRIMARY LANGUAGE SPOKEN DURING ENCOUNTER(S)—What language did you actually and primarily use to speak with this individual during the encounter? This may be different from the preferred language. If "OTHER" (not English or Spanish), fill in the other language that the person used (may include sign language). SELECT ONLY ONE.

RACE/ETHNICITY—What race does the person identify as being? SELECT ALL THAT APPLY.

REFERRALS—Based on your conversation with this individual, you may have referred him or her for other services. In the REFERRAL box, select all of the types of services to which you referred the person.

ASSESSMENT QUESTIONS—**GIVE THE RESPONSE CARD TO THE INDIVIDUAL.**

For each question, put a check mark in the appropriate box based on the individual's responses. COUNT THE NUMBER OF ENTRIES IN THE LAST 2 COLUMNS THAT HAVE A SCORE OF 3 OR 4. IF TOTAL NUMBER IS 4 OR MORE, DISCUSS THE POSSIBILITY OF A REFERRAL FOR SERVICES.

For questions 21-24, indicate "yes" or "no" based on the individual's responses. SELECT ONLY ONE.

If the child responds "yes" to any question 21-24, ask question 25 and indicate "yes" or "no" based on the individual's response. SELECT ONLY ONE.

REFERRALS ACCEPTED—This refers to whether or not the child or parent took the information you offered, not if they followed up on the referral. SELECT ONLY ONE.

Please submit the completed form to the designated person in your agency who will review the form.

Thank you for taking the time to complete this form accurately and fully!

Paperwork Reduction Act Statement This information is being collected to assist the Substance Abuse and Mental Health Services Administration (SAMHSA) with program monitoring of FEMA's Crisis Counseling Assistance and Training Program. Crisis counselors are required to complete this form following the delivery of crisis counseling services to disaster survivors (44 CFR 206.171 [F][3]). Information collected through this form will be used at an aggregate level to determine the reach, consistency, and quality of the Crisis Counseling Assistance and Training Program. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0270. Public reporting burden for this collection of information is estimated to average 15 minutes per assessment, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 5600 Fishers Ln, Room 15E57B, Rockville, MD 20857.