Project

OMB NO. 0930-0270
Expiration Date xx/xx/xxxx

Adult Assessment & Referral Tool

Please use this tool as an interview guide

(1) with adults who have received individual crisis counseling on two or more occasions before this visit
OR
(2) with any adult at any time if you suspect the adult may be experiencing serious reactions to the disaster.

Provider Name | Provider # | Employee #

Date of Service (mm/dd/yyyy) | County Code of Service | Zip Code of Service

CHARACTERISTICS of ENCOUNTER

LOCATION of SERVICE (select one)

- ☐ school & child care (all ages through college)
- ☐ community center (e.g., government, recreation, social services)
- ☐ provider site (agency involved with CCP)
- ☐ workplace (e.g., office workers, public safety)
- ☐ disaster recovery center (e.g., FEMA, Red Cross)
- ☐ place of worship (e.g., church, synagogue, mosque)
- ☐ retail (e.g., restaurant, mall, shopping center, store)
- ☐ home (temporary or permanent; including friend or family homes; group homes; including houses, apartments, trailers, and other dwellings)
  - ☐ IF HOME: PLEASE CHECK THIS BOX IF ANY CHILDREN < AGE 18 LIVE IN THIS HOME.
- ☐ phone counseling (15 minutes or longer, including "hot-lines" & "life-lines")
- ☐ medical center (e.g., doctor, dentist, hospital, mental health specialty)
- ☐ public place/event (e.g., street, sidewalk, town square, fair, festival, sports)
- ☐ other (specify in box) >

VISIT NUMBER

☐ 1st visit ☐ 2nd visit ☐ 3rd visit ☐ 4th visit ☐ 5th visit or more

DURATION

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

RISK CATEGORIES (select all that apply)

- ☐ family member missing or dead
- ☐ friend missing or dead
- ☐ pet missing or dead
- ☐ home damaged or destroyed
- ☐ vehicle or major property loss
- ☐ other financial loss
- ☐ injured or physically harmed (self or household)
- ☐ life was threatened (self or household)
- ☐ witnessed death/injury (self or household)
- ☐ assisted with rescue/recovery (self or household)
- ☐ disaster unemployed (self or household)
- ☐ evacuated quickly with no time to prepare
- ☐ prolonged separation from family
- ☐ displaced from home 1 week or more
- ☐ past substance use/mental health problem
- ☐ pre-existing physical disability
- ☐ past trauma

DEMOGRAPHIC INFORMATION

Age (select one)

- ☐ adult (18-39)
- ☐ adult (40-64)
- ☐ adult (65+)

Sex (select one)

- ☐ male
- ☐ female

Race (select one or more)

- ☐ American Indian / Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian / Pacific Islander
- ☐ White

Ethnicity (select one)

- ☐ Hispanic or Latino
- ☐ not Hispanic or Latino

Primary Language of Contact (select one)

- ☐ English
- ☐ Spanish
- ☐ other (specify in box)>

PLEASE CONTINUE ON PAGE 2 (ON BACK)

Adult Assessment & Referral Tool page 2: ASSESSMENT QUESTIONS

GIVE RESPONSE CARD TO RECIPIENT

READ: These questions are about the reactions you have experienced IN THE PAST MONTH. By reactions, I mean feelings or emotions or thoughts about the events. For each question choose one of the following responses from this card.

1, not at all ☐ 2, a little bit ☐ 3, somewhat ☐ 4, quite a bit ☐ 5, very much ☐

QUESTIONS TO BE READ	RESPONDENT'S ANSWER				
	1	2	3	4	5
1. How much have you been bothered by unwanted memories, nightmares, or reminders of what happened?	☐	☐	☐	☐	☐
2. How much effort have you made to avoid thinking or talking about what happened or doing things that remind you of what happened?	☐	☐	☐	☐	☐
3. To what extent have you lost enjoyment in things, kept your distance from people, or found it difficult to experience feelings because of what happened?	☐	☐	☐	☐	☐
4. How much have you been bothered by poor sleep, poor concentration, jumpiness, irritability or feeling watchful around you because of what happened?	☐	☐	☐	☐	☐
5. How down or depressed have you been because of what happened?	☐	☐	☐	☐	☐
6. Has your ability to handle other stressful events or situations been harmed?	☐	☐	☐	☐	☐
7. Have your reactions interfered with how well you take care of your physical health? For example, are you eating poorly, not getting enough rest, smoking more, or finding that you have increased your use of alcohol or other substances?	☐	☐	☐	☐	☐
8. How distressed or bothered are you about your reactions?	☐	☐	☐	☐	☐
9. How much have your reactions interfered with your ability to work or carry out your daily activities, such as housework or homework?	☐	☐	☐	☐	☐
10. How much have your reactions affected your relationships with your family or friends or interfered with your social, recreational, or community activities?	☐	☐	☐	☐	☐
11. How concerned have you been about your ability to overcome problems you may face without further assistance?	☐	☐	☐	☐	☐

NUMBER OF RESPONSES OF 4 OR 5 (this is recipient's score)>>>> ☐

12. I also need to ask: Is there any possibility that you might hurt or kill yourself? ☐ no ☐ yes

REFERRAL INSTRUCTIONS

IF THE ANSWER TO ITEM #12 IS "YES," REFER FOR IMMEDIATE PSYCHIATRIC INTERVENTION.
IF THE ANSWER TO ITEM #12 IS "NO," CONTINUE:
IF SCORE IS 3 OR HIGHER, READ:
FROM WHAT YOU HAVE TOLD ME, IT SEEMS THAT YOU MIGHT BENEFIT FROM PARTICIPATING IN ANOTHER SERVICE [DESCRIBE]. I WOULD LIKE TO REFER YOU TO _____.
IF SCORE IS BELOW 3, READ:
FROM WHAT YOU HAVE TOLD ME, IT SEEMS THAT YOU ARE MANAGING YOUR REACTIONS. DOES THAT SEEM RIGHT TO YOU?
IF NO, READ: PERHAPS YOU WOULD BENEFIT FROM PARTICIPATING IN ANOTHER SERVICE [DESCRIBE]. I WOULD LIKE TO REFER YOU TO _____.
IF YES, READ: WE SHOULD DECIDE UPON SPECIFIC GOALS FOR COUNSELING THAT WE CAN MEET TODAY OR WITHIN ANOTHER COUPLE OF VISITS.

REFERRAL (select all that were communicated)

☐ other crisis counseling program services (e.g., group counseling, team leader, follow-up)

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

☐ substance abuse services (e.g., professional, behavioral, or medical treatment or self-help groups, such as AA or NA)

☐ community services (e.g. FEMA loans, housing, employment, social services)

☐ other (specify in box)> ☐

Note what the referral was for not where it was made to.

Did the participant accept one or more of the referral(s)? ☐ no ☐ yes

INSTRUCTIONS:
ADULT ASSESSMENT & REFERRAL TOOL

When to Use This Form:

This form is used as an interview guide (1) with adults who have received individual crisis counseling on two or more occasions before this visit OR (2) with any adult at any time if you suspect the adult may be experiencing serious reactions to the disaster. Do not use this form with children; use the Child Assessment & Referral Tool.

PROVIDER NAME - The name of the program/agency.
PROVIDER # - The unique number your program/agency is providing services under.
EMPLOYEE # - YOUR employee number.
DATE OF SERVICE - The date of the encounter in the format MM/DD/YYYY, e.g., 01/01/2008.
COUNTY CODE OF SERVICE - The 3 digit FIPS code for the county where the service occurred.
ZIP CODE OF SERVICE - The zip code of the location where the service occurred.
LOCATION OF SERVICE - Where did you provide the service? SELECT ONLY ONE.

VISIT NUMBER - Based on your conversation with the individual, is this the 1st, 2nd, 3rd, 4th, 5th or more 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 < 15 minutes, record it on the Weekly Tally.

RISK CATEGORIES - These are factors that an individual may have experienced or may have present in their life that could increase their need for services. MORE THAN ONE CATEGORY MAY APPLY. SELECT ALL CATEGORIES THAT APPLY. The Adult Assessment and Referral Tool is an interview guide, and you may ask the individual whether or not he or she has experienced the listed factors. (Note this instruction is not the same as for the Individual Crisis Counseling Services Encounter Log.)

DEMOGRAPHIC INFORMATION - For each variable, SELECT ONLY ONE. The Adult Assessment and Referral Tool is an interview guide, and you may ask ask the individual these questions, as needed. (Note this instruction is not the same as for the Individual Crisis Counseling Services Encounter Log.) For each question, read the options, and ask the individual to select the option or options that best describes him or her.

AGE - SELECT ONLY ONE.
SEX - SELECT ONLY ONE
RACE - SELECT ALL THAT APPLY.
ETHNICITY - SELECT ONLY ONE.
PRIMARY LANGUAGE OF CONTACT - What language did you actually and primarily use to speak with this individual during the encounter? This may be different than the preferred language. If “OTHER” (not English or Spanish), fill in the other language. SELECT ONLY ONE.

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.
At the end of the 11 questions, COUNT the number of check marks in boxes 4 and 5. This is the person's score. For example, an individual who answered "quite a bit" on Questions 6 and 7 and "very much" on Question 11 and "somewhat" on Questions 1-5 and 8-10 would receive a score of 3.

The assessment questions come from the Sprint-E © and are used with permission. See the Evaluation Manual for documentation of reliability and validity.

REFERRALS - In the REFERRAL box, select all of the types of services you referred the person to. If the service is not listed, please provide the type of service next to “OTHER SERVICES.”

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 completely!

Public Burden Statement: 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 20 minutes per encounter per year, 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, 1 Choke Cherry Road, Room 7-1044, Rockville, Maryland, 20857.