

Adult Assessment and Referral Tool

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 that proper assessment and referral is carried out. 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 abuse intervention services.

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 (it is recommended on the *third and fifth* encounter) OR
- (2) with any adult at any time if you suspect the adult may be experiencing serious reactions to the disaster.

Provider Name Provider Number

Date of Service (mm/dd/yyyy) County of Service

1st Employee # 2nd Employee #

LOCATION OF SERVICE (select one)

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

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 the team lead or supervisory staff present during administering this tool? Yes No

RISK CATEGORIES (select all that apply)

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

RISK CATEGORIES (select all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> family missing/dead | <input type="checkbox"/> injured or physically harmed (self or household) | <input type="checkbox"/> evacuated quickly with no time to prepare |
| <input type="checkbox"/> friend missing/dead | <input type="checkbox"/> life was threatened (self or household) | <input type="checkbox"/> prolonged separation from family |
| <input type="checkbox"/> pet missing/dead | <input type="checkbox"/> witnessed death/injury (self or household) | <input type="checkbox"/> displaced from home 1 week or more |
| <input type="checkbox"/> home damage | <input type="checkbox"/> assisted with rescue/recovery (self or household) | <input type="checkbox"/> past substance use/mental health problem |
| <input type="checkbox"/> vehicle or major property loss | <input type="checkbox"/> disaster unemployment (self or household) | <input type="checkbox"/> preexisting physical disability |
| <input type="checkbox"/> other financial loss | | <input type="checkbox"/> past trauma |

DEMOGRAPHIC INFORMATION

- | | | | | | | | |
|--|--|---|---|--|---|----------------------------------|--|
| Age (select one) | Do you have a disability, or other access or functional need? If so, indicate the type (select all that apply). | Primary language spoken during this encounter (select one) | Race (select all that apply) | | | | |
| | | | | <input type="checkbox"/> adult (18-39 years) | <input type="checkbox"/> Physical (mobility, visual, hearing, medical, etc.) | <input type="checkbox"/> English | <input type="checkbox"/> American Indian/Alaska Native |
| | | | | <input type="checkbox"/> adult (40-64 years) | <input type="checkbox"/> Intellectual/Cognitive (learning disability, mental retardation, etc.) | <input type="checkbox"/> Spanish | <input type="checkbox"/> Asian |
| <input type="checkbox"/> older adult (65 years or older) | <input type="checkbox"/> Mental Health/Substance Abuse (psychiatric, substance dependence, etc.) | <input type="checkbox"/> Other <input type="text"/> | <input type="checkbox"/> Black or African American | | | | |
| | Sex | Ethnicity (select one) | <input type="checkbox"/> Native Hawaiian/Pacific Islander | | | | |
| | <input type="checkbox"/> Male | <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> White | | | | |
| | <input type="checkbox"/> Female | <input type="checkbox"/> Not Hispanic or Latino | | | | | |

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 ANSWERS

- | | 1 | 2 | 3 | 4 | 5 |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. How much have you been bothered by unwanted memories, nightmares, or reminders of what happened? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. How much effort have you made to avoid thinking or talking about what happened or doing things that remind you of what happened? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. How much have you been bothered by poor sleep, poor concentration, jumpiness, irritability, or feeling watchful around you because of what happened? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. How down or depressed have you been because of what happened? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Has your ability to handle other stressful events or situations been harmed? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. How distressed or bothered are you about your reactions? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. How much have your reactions interfered with your ability to work or carry out your daily activities, such as housework or homework? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. How much have your reactions affected your relationships with your family or friends or interfered with your social, recreational, or community activities? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. How concerned have you been about your ability to overcome problems you may face without further assistance? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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. The CCP should have protocols or procedures in place for how a crisis counselor should respond or react if the response is "YES."

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 apply)

other crisis counseling program services (e.g., group counseling, referrals to a team leader, follow up visit)
Note the type of service for which you made the referral, not the site of service.

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 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)

Did the participant accept one or more of the referral(s)?

no

yes

**INSTRUCTIONS:
ADULT ASSESSMENT AND REFERRAL TOOL**

When to Use This Form:

It is recommended that this form be used with all adults 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 adults receiving individual crisis counseling on the third and fifth occasions 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 and Referral Tool.

PROJECT #—FEMA disaster declaration number, e.g., DR-XXXX-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 service occurred. **ZIP CODE OF SERVICE**—The zip code where the service occurred.

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

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.

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.** 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 that this instruction is not the same as for the Individual/Family 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 the individual these questions as needed. (Note that this instruction is not the same as for the Individual/Family 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— What age does the person indicate he or she is? **SELECT ONLY ONE.**

PERSONS WITH DISABILITIES—If the participant considers him- or herself to have a disability or access or functional need, what type does he or she indicate (physical, Intellectual, or mental health/substance abuse)? **SELECT ALL THAT APPLY.**

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

SEX—The sex the person reports to be. **SELECT ONLY ONE.**

PRIMARY LANGUAGE SPOKEN DURING ENCOUNTER(S)—Which 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 (this may include sign language). **SELECT ONLY ONE.**

ETHNICITY—Does this person self-identify as Hispanic/Latino? **SELECT ONLY ONE.**

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

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.

REFERRALS—In the **REFERRAL** box, select all of the types of services to which you referred the person. 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 fully!

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 Office of Management and Budget (OMB) control number. The OMB control number for this project is 0930-xxxx. Public reporting burden for this collection of information is estimated to average 15 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, MD 20857.