Cohort V Counselor Follow-up Questionnaire

OMB No. 0930-0274
Expiration Date: XXXX

FORM A: COUNSELOR INFORMATION

To be completed once by each counselor who makes follow-up calls.

Center: Click here to enter text.____ (Will be replaced by ID #)

Counselor's Name or Initials: Click here to enter text. (Will be replaced by ID #)

Today's Date: Click here to enter text.

1. How long have you worked as a telephone crisis worker? (Check one and give details)
   - ☐ Less than 1 year – Number of months Click here to enter text.
   - ☐ 1 year or more – Number of years:Click here to enter text.
2. How long have you been conducting follow-up calls? (Check one and give details)
   - ☐ Less than 1 year – Number of months: Click here to enter text.
   - ☐ 1 year or more – Number of years: Click here to enter text.
3. What is your employment status at your center? (check all that apply)
   - ☐ Paid employee
   - ☐ Volunteer
   - ☐ Trainer/Supervisor
4. How many hours per week on average do you work at your center? Click here to enter text.
5. What is your highest level of education? (check one)
   - ☐ Less than high school
   - ☐ High school graduate or GED
   - ☐ Some college or technical school
   - ☐ College graduate
   - ☐ Graduate school (e.g., M.S., M.S.W., Ph.D., M.D.)
6. Are you a licensed clinician / licensed mental health professional?
   - ☐ Yes
   - ☐ No
7. Have you completed training in ASIST (Applied Suicide Intervention Skills Training)?
   - ☐ Yes
   - ☐ No
8. Have you completed training in Safety Planning protocols (other than ASIST)?
   - ☐ Yes
   - ☐ No

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FORM B: CLIENT INFORMATION & FOLLOW-UP CALL LOG

ID: _____
(for Columbia use only)

Instructions:

This form is to be filled out for each eligible client referred by an ED, hospital or mental health agency to your center's follow-up program. Submit form to evaluation team when your center closes the case.

When you save this document, please use the following convention for naming your file: Your Center's referral Date (MMDDYY), underscore, Last four digits of client's primary telephone number provided to your center for follow-up, underscore, initials of the counselor submitting the form. The complete file name should look like this: 091911_1234_ABL.doc (for example).

1. **Center:**_____(Will be replaced by ID#)
2. **Client's Initials:**_____(Will be replaced by ID#)
3. **Last 4 digits** of client's primary phone number provided for follow-up: _____
4. **Has this client accepted follow-up from your center before?**
   - ☐ Check here if this client has been enrolled in your center's follow-up before (i.e., the client's previous case was closed, Form B was sent, and the case is now being reopened)

I. CIRCUMSTANCES OF REFERRAL FOR FOLLOW-UP

5. **Referral Source:**
   - ☐ Emergency department; Name of hospital: _____
   - ☐ Inpatient unit; Name of hospital: _____
   - ☐ Other: _____
6. **Date of Referral for Follow-up:**_____
7. **Why was this client offered follow-up?** (check all that apply)
   - ☐ Suicidal ideation within 48 hours of referral
   - ☐ Moderate to high suicide risk
   - ☐ Suicide attempt within past week
   - ☐ Absence of buffers
   - ☐ Client not engaged in treatment
   - ☐ Other:_____

II. CLIENT'S DEMOGRAPHICS

8. Gender: ☐ Male ☐ Female ☐ Other: _____ ☐ Don't know

9. Age: (in years):_____ ☐ Don't know

10. Ethnicity: ☐ Hispanic ☐ Not Hispanic

11. Race (Select all that apply):

- ❑ American Indian/Alaska Native
- ❑ Asian
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ Black or African American
- ❑ White
- ❑ Don't Know

12. Ever Served in US Military? ☐ Yes ☐ No ☐ Don't know

If Yes, check all that apply: ☐ Current military service ☐ Active Duty

☐ Veteran ☐ Reservist ☐ National Guard ☐ Don't know

Served in combat zone or on peacekeeping mission? ☐ Yes ☐ No ☐ Don't know

If Yes, where and when? _____

13. Employment Status (check all that apply)

☐ Employed Full Time	☐ Homemaker	
☐ Employed Part Time	☐ Retired	
☐ Unemployed	☐ On Disability	☐ Don't know

14. Household Composition (check all that apply)

☐ Spouse/Partner	☐ Other Family Member(s)	☐ Homeless
☐ Children	☐ Non-Family Member(s)	☐ Don't know
☐ Parents	☐ Lives Alone	

15. Does client have medical insurance? ☐ Yes ☐ No ☐ Don't know

III. BASELINE SUICIDE RISK & INTERVENTION

These questions are about the client's status at the time of the ED/hospital visit which triggered the client's referral for follow-up.

16. Client's Risk Profile At Baseline Crisis Contact *(if known)*

	Y	N	DK		Y	N	DK
Suicidal ideation?	☐	☐	☐	Current substance abuse?	☐	☐	☐
Specific suicide plan?	☐	☐	☐	Prior substance abuse?	☐	☐	☐
Means available?	☐	☐	☐	Social supports?	☐	☐	☐
Expressed intent to die?	☐	☐	☐	Other buffers?	☐	☐	☐
Preparatory behavior?	☐	☐	☐	Current outpatient† mh/sa tx?	☐	☐	☐
Attempt in progress?	☐	☐	☐	Prior outpatient† mh/sa tx?	☐	☐	☐
Prior suicide attempt(s)?	☐*	☐	☐	Prior inpatient mh/sa tx?	☐**	☐	☐
*If yes, how many? _____			☐	**If yes, how many times? _____			☐
*How recent? _____			☐	Prior ED use for mh/sa issue?	☐**	☐	☐
				**If yes, how many times? _____			☐

†Include outpatient psychotherapy/counseling, and/or psychotropic medication prescribed by a psychiatrist or primary care physician.

17. Overall Assessment of Client's Suicide Risk at Baseline: (choose one)

☐ Low ☐ Moderate ☐ High ☐ Imminent or Near Term Risk ☐ DK

18. Source of Information on Client's Baseline Risk Status (please check the primary source)

- ☐ Information provided by referring hospital
- ☐ Information obtained from client at hospital by center staff
- ☐ Information obtained retrospectively from client at follow-up contact
- ☐ N/A – Information on baseline risk status unavailable

19. Referrals Made at Baseline (ED/hospital visit) (check all that apply)

- ☐ New outpatient mh/sa service(s):_____
- ☐ Referred back to client's own current/prior mh/sa service(s):_____
- ☐ Other/related service(s):_____ ☐ No referrals ☐ Don't know

NOTE: Pages 4-6 apply only to cases where one or more clinical follow-up contacts was completed. For cases <u>not successfully reached</u> for follow-up, skip to page 7.

IV. CASE SUMMARY/FOLLOW-UP CONTACT LOG

20. Please complete one entry below for each completed clinical follow-up contact.*****

	Date of completed follow-up contact*****:	Type of contact				Duration of contact (in minutes):	Primary activity or activities**						
		Phone	Chat	Text	Face-to-Face		DC	PS	RA	SC	SP	TP	OT
1	_____	☐	☐	☐	☐	_____	☐	☐	☐	☐	☐	☐	☐
2	_____	☐	☐	☐	☐	_____	☐	☐	☐	☐	☐	☐	☐
3	_____	☐	☐	☐	☐	_____	☐	☐	☐	☐	☐	☐	☐
4	_____	☐	☐	☐	☐	_____	☐	☐	☐	☐	☐	☐	☐
5	_____	☐	☐	☐	☐	_____	☐	☐	☐	☐	☐	☐	☐
6	_____	☐	☐	☐	☐	_____	☐	☐	☐	☐	☐	☐	☐
7	_____	☐	☐	☐	☐	_____	☐	☐	☐	☐	☐	☐	☐
8	_____	☐	☐	☐	☐	_____	☐	☐	☐	☐	☐	☐	☐
9	_____	☐	☐	☐	☐	_____	☐	☐	☐	☐	☐	☐	☐
10	_____	☐	☐	☐	☐	_____	☐	☐	☐	☐	☐	☐	☐
11	_____	☐	☐	☐	☐	_____	☐	☐	☐	☐	☐	☐	☐
12	_____	☐	☐	☐	☐	_____	☐	☐	☐	☐	☐	☐	☐

***** Do not include contacts with no clinical content, e.g., when client was busy and rescheduled the contact for another time. Do not include outreach efforts with no client participation, such as voicemails left, or texts that were sent but not responded to.

****** DC: de-escalating crisis; PS: problem-solving; RA: risk assessment; SC: supportive contact; SP: safety planning; TP: treatment promotion; OT: other. If OT is checked, please give details:

21. How many counselors completed clinical follow-up contacts in this case? _____

22. Please give initials of each counselor who completed a clinical follow-up contact in this case:

_____(initials will be replaced with ID#s)

23. Did a counselor who met the client face-to-face at the hospital also complete one or more follow-up contacts with clinical content?

☐ Yes ☐ No ☐ N/A

24. How many *non*-clinical follow-up contacts were completed with this client? _____

i.e., contacts when client was busy and rescheduled, or voicemails left, or text messages sent but not responded to (NOTE: these contacts are NOT included in contact log above)

V. DURING FOLLOW-UP (FROM REFERRAL TO LAST FOLLOW-UP CONTACT)

25. Risk Profile During Follow-up

Were any of these present at any point while your center was following this client?

	Y	N	DK		Y	N	DK
Suicidal ideation?	☐	☐	☐	Imminent/near term risk?	☐	☐	☐
Specific suicide plan?	☐	☐	☐	Preparatory behavior?	☐	☐	☐
Means available?	☐	☐	☐	Suicide attempt(s)?	☐	☐	☐
Expressed intent to die?	☐	☐	☐	Current substance abuse?	☐	☐	☐

26. Emergency Rescue During Follow-up

Was emergency rescue initiated at any point during follow-up with this client? ☐ Yes* ☐ No

*If yes : Rescue was initiated: ☐ with client's consent ☐ without client's consent

Was client admitted to the hospital as a result of this rescue? ☐ Yes ☐ No ☐ DK

27. Referrals Made During Follow-up:

☐ New outpatient mh/sa service(s): _____

☐ Referred back to client's own current/prior mh/sa service(s): _____

☐ Other/related service(s): _____

☐ No referrals during follow-up

28. Service Use/Treatment Engagement During Follow-up:

Please check all services the client made use of while your center was following him/her:

☐ Emergency Department visit for mh/sa issue

☐ Hospital admission/inpatient treatment for mh/sa issue

☐ Outpatient mh/sa service(s): _____

If yes:***** ☐ New (your referral) ☐ New (other) ☐ Pre-existing

☐ Other/related service(s): _____

If yes:***** ☐ New (your referral) ☐ New (other) ☐ Pre-existing

☐ No service use during follow-up

☐ Don't know

***** "NEW" = a new provider seen since referral for follow-up; "Pre-existing" = a provider the client was already seeing or had already seen before referral for follow-up.

VI. LAST FOLLOW-UP CONTACT

29. Service Use/Treatment Engagement at Last Follow-up Contact

Please check all services the client was engaged with (in ongoing treatment) when follow-up ended:

☐ Inpatient mh/sa facility

☐ Outpatient mh/sa service(s): _____

If yes:***** ☐ New (your referral) ☐ New (other) ☐ Pre-existing

☐ Other/related service(s): _____

If yes:***** ☐ New (your referral) ☐ New (other) ☐ Pre-existing

☐ No service use

☐ Don't know

***** "NEW" = a new provider seen since referral for follow-up; "Pre-existing" = a provider the client was already seeing or had already seen before referral for follow-up

30. Risk Profile at Last Follow-up Contact:

	Y	N	DK		Y	N	DK
Suicidal ideation?	☐	☐	☐				
Specific suicide plan?	☐	☐	☐	Current substance abuse?	☐	☐	☐
Means available?	☐	☐	☐	Social supports?	☐	☐	☐
Expressed intent to die?	☐	☐	☐	Other buffers?	☐	☐	☐

31. Overall Assessment of Client's Suicide Risk at Last Follow-up Contact: (choose one)

☐ Low ☐ Moderate ☐ High ☐ Imminent/Near Term Risk

32. To what extent were your center's goals for follow-up accomplished with this client?

☐ A lot ☐ A little ☐ Not at all

VII. CLOSURE

33. Please give the date the case was closed: _____

34. Please give the reason(s) for closing this case: (check all that apply)

- ☐ Client could not be reached, or could no longer be reached*
  - *If yes, please give number of unsuccessful tries before closing: _____
  - ☐ Caller's phone disconnected/no longer working
- ☐ Client declined follow-up, or declined further follow-up
- ☐ Client uncooperative/unengaged with goals of follow-up (e.g., unwilling to enter treatment)
- ☐ Client is engaged in MH/SA treatment (if yes, choose one option below)
  - ☐ NEW treatment since referral for follow-up
  - ☐ Treatment engagement pre-existed follow-up
- ☐ Client is well-supported by other (informal) resources (if yes, choose one below)
  - ☐ NEW connectedness with informal supports since referral for follow-up
  - ☐ Current level of informal support pre-existed follow-up
- ☐ Client has a safety plan and is likely to use it
- ☐ Client's trigger situation(s) have been addressed/resolved
- ☐ Client no longer in crisis
- ☐ Planned length of time allotted for follow-up has gone by
- ☐ Planned number of follow-up calls has been made
- ☐ Other reason: _____

35. This form was submitted by _____ (counselor initials) **on** _____(date: MM/DD/YY).

36. Comments: