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 ☐

1st Employee # ☐ 2nd 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)
- ☐ 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)
  - ☐ IF A TEMPORARY HOME: PLEASE CHECK THIS BOX IF ANY CHILDREN UNDER AGE 18 LIVE IN THIS HOME.
- ☐ permanent home
  - ☐ IF A TEMPORARY HOME: PLEASE CHECK THIS BOX IF ANY CHILDREN UNDER AGE 18 LIVE IN THIS HOME.
- ☐ phone counseling (15 minutes or longer)
  - ☐ IF HOTLINE, HELPLINE, or CRISIS LINE, please **check here.**
- ☐ medical center (e.g., doctor, dentist, hospital, mental health specialty center)
- ☐ other (specify in box) ☐

RISK CATEGORIES (select all that apply)

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

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, mental retardation, etc.) ☐ Mental Health/Substance Use (pyschiatric, substance dependence, etc.)

Sex ☐ Male ☐ Female

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

Ethnicity (select one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (select one or more) ☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Pacific Islander ☐ White

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.

0

S	M	T	W	T	F	S

"Not at all" means never in the past month.

1

S	M	T	W	T	F	S
		X				
					X	

A "little bit" means about 2 times per month.

2

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

"Somewhat" means about 1-2 times each week during the past month.

3

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

"Quite a bit" means 2-3 times a week during the past month.

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 chlid 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.

0 = not at all ☐ 1 = a little bit ☐ 2 = somewhat ☐ 3 = quite a bit ☐ 4 = very much ☐

QUESTIONS TO BE READ	RESPONDENT ANSWERS				
	0	1	2	3	4
1. Do you get upset, afraid, or sad when something makes you think about the disaster?	☐	☐	☐	☐	☐
2. Do you have bad dreams or nightmares about what happened?	☐	☐	☐	☐	☐
3. Do you have upsetting thoughts or pictures that come into your mind about what happened?	☐	☐	☐	☐	☐
4. Do you try not to think about or talk about what happened?	☐	☐	☐	☐	☐
5. Do you stay away from places, people, or things that make you remember the disaster?	☐	☐	☐	☐	☐
6. Do you have difficulty falling asleep or wake up often because of what happened?	☐	☐	☐	☐	☐
7. Do you feel jumpy or nervous?	☐	☐	☐	☐	☐
8. Do you find it harder to concentrate or pay attention to things than you usually do?	☐	☐	☐	☐	☐
9. Do you feel irritable or grouchy?	☐	☐	☐	☐	☐
10. Do you feel sad, down, or depressed?	☐	☐	☐	☐	☐
11. Have you had more aches and pains, such as stomachaches or headaches?	☐	☐	☐	☐	☐
12. If in school: Do you find it harder to get your schoolwork done?	☐	☐	☐	☐	☐
13. Do you worry about something else bad happening to you/your family/your friends?	☐	☐	☐	☐	☐
14. Are you having a harder time getting along with family or your friends?	☐	☐	☐	☐	☐
15. Are you finding it harder to do or enjoy activities that you used to enjoy?	☐	☐	☐	☐	☐

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-wedding, 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:

Have you had any thoughts or plans about either hurting or killing yourself?

☐ YES **IF YES, refer to 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."

☐ NO IF NO, continue.

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 vist 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 sto 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/yyy, 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 lond 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 than 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 retardation).
- Mental Health/Substance Use: Includes psychiatric disorders, such as bipolar disorder, depression, post-traumatic stress disorder (PTSD), schizophrenia, and substance dependence.

SEX—The sec 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 lanaguate that the person used (may include sign language). SELECT ONLY ONE.

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

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

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

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!