

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	<input type="text"/>	Provider #	<input type="text"/>
Date of Service (mm/dd/yyyy)	<input type="text"/>	County or Parish of Service	<input type="text"/>
1st Employee #	<input type="text"/>	2nd Employee #	<input type="text"/>
		ZIP Code of Service	<input type="text"/>
<b>VISIT NUMBER</b>	<input type="checkbox"/> First visit	<input type="checkbox"/> Second visit	<input type="checkbox"/> Third visit
			<input type="checkbox"/> Fourth visit
			<input type="checkbox"/> Fifth visit or later
<b>DURATION</b>	<input type="checkbox"/> 15–29 minutes	<input type="checkbox"/> 30–44 minutes	<input type="checkbox"/> 45–59 minutes
			<input type="checkbox"/> 60 minutes or more

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

Was the team lead or a supervisory staff member 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 may have had in the disaster.

### LOCATION OF SERVICE (select one)

- |  |  |
|--|--|
| <input type="checkbox"/> school and child care (all ages through college)  | <input type="checkbox"/> temporary home (including home of friend or family, group homes, shelters, apartments, trailers, and other dwellings) |
| <input type="checkbox"/> community center (e.g., recreation club)  | <input type="checkbox"/> IF TEMPORARY HOME: PLEASE CHECK THIS BOX IF ANY CHILDREN UNDER AGE 18 LIVE IN THIS HOME.                              |
| <input type="checkbox"/> provider site/mental health agency (agency involved with the CCP)                               | <input type="checkbox"/> permanent home  |
| <input type="checkbox"/> workplace (workplace of the disaster survivor and/or first responder)                           | <input type="checkbox"/> IF PERMANENT HOME: PLEASE CHECK THIS BOX IF ANY CHILDREN UNDER AGE 18 LIVE IN THIS HOME.                              |
| <input type="checkbox"/> disaster recovery center (e.g., Federal Emergency Management Agency [FEMA], American Red Cross) | <input type="checkbox"/> phone counseling (outbound calls to participants lasting 15 minutes or longer)  |
| <input type="checkbox"/> place of worship (e.g., church, synagogue, mosque)  | <input type="checkbox"/> hotline, helpline, or crisis line (inbound calls from participants lasting 15 minutes or longer)                      |
| <input type="checkbox"/> retail site (e.g., restaurant, mall, shopping center, store)                                    | <input type="checkbox"/> medical center (e.g., doctor, dentist, hospital, mental health or substance use disorder treatment office)            |
| <input type="checkbox"/> public place/event (e.g., street, sidewalk, town square, fair, festival, sports)                | <input type="checkbox"/> virtual (e.g., text line, online chat service, Zoom)  |
|  | <input type="checkbox"/> other (specify in box) <input type="text"/>   |

### RISK CATEGORIES (select all that apply)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> family missing/dead  | <input type="checkbox"/> illness, injury, or physical harm (self or household member)                              | <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 member)  | <input type="checkbox"/> displace from home 1 week or more                                      |
| <input type="checkbox"/> pet 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"/> home damaged or destroyed                                  | <input type="checkbox"/> assisted with rescue/recovery (self or household member)                                  | <input type="checkbox"/> past substance use/mental health problem                               |
| <input type="checkbox"/> vehicle or major property loss                             | <input type="checkbox"/> changed schools or learning format (e.g., virtual)  | <input type="checkbox"/> preexisting physical disability  |
| <input type="checkbox"/> other financial loss                                       | <input type="checkbox"/> prolonged separation from social network/family, physical isolation, or social distancing | <input type="checkbox"/> past trauma  |
| <input type="checkbox"/> disaster un- or underemployment (self or household member) |  | <input type="checkbox"/> disaster-caused food insecurity  |
|   |  | <input type="checkbox"/> reduced or no access to reliable information/communication             |
|   |  | <input type="checkbox"/> reduced or no access to reliable transportation                        |

## 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 use disorder, etc.)

Gender  Male  Female  Transgender  None of these

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

Race/Ethnicity (select all that apply)

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

Did you move from another country to the United States in the past 5 years? (select one)  Yes  No

## RESPONSE CARD

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 PAST 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.

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<p>“Not at all” means never in the past month.</p>	<p>A “little bit” means about two times during the past month.</p>	<p>“Somewhat” means about one to two times each week during the past month.</p>	<p>“Quite a bit” means two to three times a week during the past month.</p>	<p>“Very much” means almost every day during the past month.</p>																																																																																																																																																																																																																		

## ASSESSMENT

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.

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

### QUESTIONS TO BE READ

### RESPONDENT ANSWERS

1. Do you get upset, afraid, or sad when something makes you think about the disaster?	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have bad dreams or nightmares about what happened?	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have upsetting thoughts or pictures that come into your mind about what happened?	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you try not to think about or talk about what happened?	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you stay away from places, people, or things that make you remember the disaster?	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have difficulty falling asleep or wake up often because of what happened?	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you feel jumpy or nervous?	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you find it harder to concentrate or pay attention to things than you usually do?	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you feel irritable or grouchy?	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## ASSESSMENT QUESTIONS (continued)

### QUESTIONS TO BE READ

### RESPONDENT ANSWERS

10. Do you feel sad, down, or depressed?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
11. Have you had more aches and pains, such as stomachaches or headaches?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
12. If in school: Do you find it harder to get your schoolwork done?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
13. Do you worry about something else bad happening to you/your family/your friends?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
14. Are you having a harder time getting along with family or your friends?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
15. Are you finding it harder to do or enjoy activities that you used to enjoy?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

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

16. Has your child been more clingy or worried about separation?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
17. Has your child been quieter and more withdrawn?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
18. Has your child talked repeatedly or asked questions about the disaster?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
19. Has your child's play been about the disaster?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
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 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

COUNT THE NUMBER OF ENTRIES IN THE LAST TWO 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:**

- 25. 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)

- |   |  |
|---|--|
| <input type="checkbox"/> other crisis counseling program services (e.g., group counseling, referral to a team leader, follow-up visit)<br><input type="checkbox"/> mental health services (e.g., professional, longer-term counseling, treatment, behavioral, or psychiatric services)<br><input type="checkbox"/> substance use services (e.g., professional, behavioral, or medical treatment or self-help groups, such as Alcoholics Anonymous or Narcotics Anonymous) | <input type="checkbox"/> community services (e.g., FEMA, loans, housing, employment, social services)<br><input type="checkbox"/> resources for those with disabilities or other access or functional needs<br><input type="checkbox"/> other (specify in box) <input style="width: 150px; border: 1px solid black;" type="text"/> |
|---|--|

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

**When To Use This Form:**

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 having an impact on 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 reactions to the disaster.

PROJECT #—FEMA disaster declaration number, e.g., State-XXXX. 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 issued by ODCES.

2nd EMPLOYEE #—Employee number issued by ODCES for your teammate during this encounter.

DATE OF SERVICE—The date of the encounter in the format mm/dd/yyyy, e.g., 01/01/2021.

COUNTY OR PARISH OF SERVICE—The county or parish 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 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.

PEOPLE 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, acquired immunodeficiency syndrome (AIDS), or multiple sclerosis (MS).
- Intellectual: includes a learning disability, birth defect, neurological disorder, developmental disability (e.g., Down syndrome), or traumatic brain injury.
- Mental health/substance use: includes psychiatric disorders, such as bipolar disorder, major depressive disorder, posttraumatic stress disorder (PTSD), schizophrenia, and substance use disorder.

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.

MOVED TO THE UNITED STATES IN THE PAST 5 YEARS—Indicate if any participant moved to the United States in the past 5 years from any country and for any reason. 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. COUNT THE NUMBER OF ENTRIES IN THE LAST TWO COLUMNS THAT HAVE A SCORE OF 3 OR 4. EACH ITEM WITH A SCORE OF 3 OR 4 COUNTS AS 1. IF THE TOTAL 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 of these questions (21–24), ask question 25 and indicate "yes" or "no" based on the individual's response. SELECT ONLY ONE.

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.

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

**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 Office of Management and Budget (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 Lane, Room 15E57A, Rockville, MD 20857.