Project #

OMB NO. 0930-0270
Expiration Date 03/31/2029

Child/Youth 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 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 at any time the crisis counselor feels the child or youth is exhibiting distress or they would benefit from referral to other services. It is recommended that the forms are administered during encounters where more than four event reactions or certain trauma-related risk categories are indicated (i.e., family, friend, or pet missing/dead, life was threatened, assisted with rescue, preexisting physical disability, injuries or physically harmed, witnessed death/injury, past substance use/mental health problem, past trauma).

Typically, child or youth 7 years or older can respond to the Assessment Questions themselves, though caregivers may support the child or youth's responses.

ENCOUNTER INFORMATION

Provider Name ☐ Provider # ☐

Date of Service (mm/dd/yyyy) ☐ County or Parish 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 a caregiver present during the visit? ☐ Yes ☐ No

Was the team lead or a supervisory staff member present during administration of this tool? ☐ Yes ☐ No

Who was the primary respondent for this tool? ☐ Child or youth ☐ Caregiver ☐ Both

LOCATION OF SERVICE

- ☐ 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 site (e.g., restaurant, mall, shopping center, store)
- ☐ public place/event (e.g., street, sidewalk, town square, fair, festival, sports)
- ☐ temporary home (including home of friend or family, group homes, shelters, apartments, trailers, and other dwellings)
  - ☐ IF TEMPORARY HOME: PLEASE CHECK THIS BOX IF ANY CHILDREN UNDER AGE 18 LIVE IN THIS HOME.
- ☐ permanent home
  - ☐ IF PERMANENT HOME: PLEASE CHECK THIS BOX IF ANY CHILDREN UNDER AGE 18 LIVE IN THIS HOME.
- ☐ phone counseling (outbound calls to participants lasting 15 minutes or longer)
- ☐ hotline, helpline, or crisis line (inbound calls from participants lasting 15 minutes or longer)
- ☐ medical center (e.g., doctor, dentist, hospital, mental health or substance use disorder treatment office)
- ☐ virtual (e.g., text line, online chat service, Zoom)
- ☐ other (specify in box) ☐

READ: Occasionally, we find it helpful to ask children, youth, or their caregivers a few specific questions about how the child or youth was affected by the disaster and how they are feeling now. May I ask you these questions? My questions are about various experiences you may have had due to the disaster.

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 un- or underemployment (self or household member)
- ☐ illness, injury, or physical harm (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)
- ☐ changed schools or learning format (e.g., virtual)
- ☐ prolonged separation from social network/family, physical isolation, or social distancing
- ☐ evacuated quickly with no time to prepare
- ☐ displaced 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
- ☐ disaster-caused food insecurity
- ☐ reduced or no access to reliable information/communication
- ☐ reduced or no access to reliable transportation

DEMOGRAPHIC INFORMATION

QUESTIONS TO BE READ

What is your age? (select one) ☐ preschool (0–5 years) ☐ child (6–11 years) ☐ adolescent (12–17 years)

Grade level in school ☐

Do you have a disability or other access or functional need? If so, 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.)

What is your sex? (select one) ☐ Male ☐ Female

What is the primary language spoken during this encounter? (select one)

☐ English ☐ Spanish ☐ Other (specify in box) ☐

What is your race/ethnicity? (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino
☐ Middle Eastern or North African ☐ Native Hawaiian or Pacific Islander ☐ White

RESPONSE OPTIONS

Prior to beginning the assessment, review the response options with the person who will be answering your questions. The options will assist the person in better understanding how often they are 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.

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 two times during the past month.

2

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

"Somewhat" means about one to two times each week during the past month.

3

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

"Quite a bit" means two to three 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

"Very much" means almost every day during the past month.

ASSESSMENT QUESTIONS

NOTE: Prior to the administration of the Child/Youth Assessment and Referral Tool, make sure that consent has been obtained from a caregiver for the child's or youth's participation. Children over the age of 7 may answer on their own behalf (with parental consent). For children 0-7, it is recommended that a caregiver be interviewed with the child present. When there are concerns about the ability of a child over the age of 7 to understand and accurately answer the questions, it is advisable for the caregiver to assist in answering the questions. Adolescents may not want to be interviewed in front of their parents. If a caregiver is present, ask the adolescent if he or she wishes to be interviewed alone. See your program manager or CCP Evaluation Guidance and Administration document for further details.

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				
	0	1	2	3	4
1. Do you have upsetting thoughts, pictures, or sounds of what happened come into your mind when you don't want them to?	☐	☐	☐	☐	☐
2. Do you try not to think about or have feelings about what happened?	☐	☐	☐	☐	☐
3. Do you feel alone even when you are around other people?	☐	☐	☐	☐	☐
4. Do you have trouble going to sleep, wake up often, or have trouble getting back to sleep?	☐	☐	☐	☐	☐
5. Do you find it harder to concentrate or pay attention to things than you usually do?	☐	☐	☐	☐	☐

COUNT THE NUMBER OF ENTRIES IN THE LAST TWO COLUMNS ABOVE THAT HAVE A SCORE OF 3 OR 4. IF TOTAL NUMBER IS 3 OR MORE, DISCUSS THE POSSIBILITY OF A REFERRAL FOR SERVICES.

TOTAL NUMBER ☐

REFERRAL (*select all that were communicated*)

- ☐ crisis counseling program services (e.g., group counseling, referral to 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; self-help or support groups, such as Alcoholics Anonymous or Narcotics Anonymous)
- ☐ FEMA-funded programs
- ☐ community services (e.g., 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 or youth? ☐ Yes ☐ No

Was the referral accepted by the 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 at any time the crisis counselor feels the child or youth is exhibiting distress or they would benefit from referral to other services. It is recommended that the forms are administered during encounters where more than four event reactions or certain trauma-related risk categories are indicated (i.e., family, friend, or pet missing/dead, life was threatened, assisted with rescue, preexisting physical disability, injuries or physically harmed, witnessed death/injury, past substance use/mental health problem, past trauma).

PROJECT #—FEMA disaster declaration number, e.g., State, Territory, or Tribe-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 child, youth, or caregiver indicate the child or youth 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 child, youth, or caregiver considers the child or youth 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, acquiredimmunodeficiency 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.

SEX—The sex the child, youth, or caregiver reports the child or youth being. 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/ethnicity does the person identify as being? SELECT ALL THAT APPLY.

ASSESSMENT QUESTIONS—SHOW THE RESPONSE OPTIONS 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 3 OR MORE, DISCUSS THE POSSIBILITY OF A REFERRAL FOR SERVICES.

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, youth, or caregiver 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 5 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 15E57B, Rockville, MD 20857