Project

Child/Youth Assessment and Referral Tool

OMB NO. 0930-0270 Expiration Date 09/30/2018

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						
1 st Employee #	2 nd Em	ployee #	ZIP Code of Service					
VISIT NUMBER	☐ First visit ☐ Second vis	it	☐ Fourth visit ☐ Fifth visit or later					
DURATION	☐ 15 - 29 minutes ☐ 30 – 44 mir	nutes 45 – 59 minutes	60 minutes or more					
Was parent or caregiver prese	ent during the visit?							
Was the team lead or supervis	sory staff present during administration of th	is tool?						
	it helpful to ask children/adolescents or their lling now. May I ask you these questions? M		questions about how they were affected by the experiences you have had in the disaster.					
	LOCATION O	F SERVICE (select one)						
school and child care (all			friend or family homes, group homes, shelters, ther dwellings)					
community center (e.g., re	ecreation club)		RY HOME: PLEASE CHECK THIS BOX IF ANY DER AGE 18 LIVE IN THIS HOME.					
provider site/mental health	h agency (agency involved with the CCP)	permanent home						
workplace (workplace of t	the disaster survivor and/or first responder)		RY HOME: PLEASE CHECK THIS BOX IF ANY DER AGE 18 LIVE IN THIS HOME.					
	disaster recovery center (e.g., Federal Emergency Management Agency [FEMA], American Red Cross)							
place of worship (e.g., chu	urch, synagogue, mosque)	☐ IF HOTLINE, HE	LPLINE, or CRISIS LINE, please check here.					
retail (e.g., restaurant, ma	all, shopping center, store)	medical center (e.g., doctor	r, dentist, hospital, mental health specialty center)					
public place/event (e.g., s sports)	street, sidewalk, town square, fair, festival,	other (specify in box)						
	RISK CATEGO	RIES (select all that apply)						
family missing/dead		ed (self or household member)	evacuated quickly with no time to prepare					
friend missing/dead	☐ life was threatened (self or	household member)	displace from home 1 week or more					
pet missing/dead	witnessed death/injury (sel	If or household member)	sheltered in place or sought shelter due to immediate threat of danger					
home damaged or destroy	yed assisted with rescue/recov	ery (self or household member)	past substance use/mental health problem					
vehicle or major property	loss	r children or youth)	preexisting physical disability					
other financial loss	prolonged separation from	family	past trauma					
disaster unemployed (self	f or household member)							
	2540.02							
		APHIC INFORMATION						
Age (select one)	_ , , , _	. , , —	ent (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)								
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								
1.000 (00.001 0.100 0.1.100) - Annonoun malativilatina rativo - Notari - Biatri of Annonoun - Mativo nawaliativi atinio islander - Willie								

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.

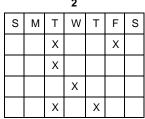
Think about your thoughts, feelings, and behavior **DURING THE FIRST MONTH**. Use these frequency rating options to help answer how often the problem has happened in the past month. For each question choose **ONE** of the following responses.

S M T W T F S

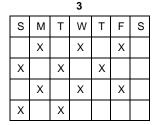
"Not at all" means never in the past month.

			1			
S	М	Т	W	Т	F	S
		Χ				
					Χ	

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



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



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

			4			
S	М	Т	W	Т	F	S
Χ	Χ	Χ	X	Χ	Χ	Χ
Χ		Χ		Χ		Χ
	Χ		X	Χ	Χ	
Χ	Χ	Χ	Χ	Χ	Χ	Χ

"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.

	$0 = \text{not at all } \square$	1 = a little bit	$2 = somewhat \square$	$3 = \text{quite a bit } \square$	ite a bit 4 = very muc			ry much	ı 🗆
QUESTIONS TO BE READ RESPONDENT ANSWERS									RS
1.	Do you get upset, afraid, or	sad when something makes	you think about the disaster?		0	1	2	3	4
2.	Do you have bad dreams or	nightmares about what hap	pened?		0	1	2	3	4
3.	Do you have upsetting thou	ghts or pictures that come in	to your mind about what happened?		0	1	2	3	4
4.	Do you try not to think abou	t or talk about what happene	d?		0	1	2	3	4
5.	Do you stay away from place	es, people, or things that ma	ke you remember the disaster?		0	1	2	3	4
6.	Do you have difficulty falling	g asleep or wake up often bed	cause of what happened?		0	1	2	3	4
7.	Do you feel jumpy or nervou	us?			0	1	2	3	4
8.	Do you find it harder to cond	centrate or pay attention to the	nings than you usually do?		0	1	2	3	4
9.	Do you feel irritable or ground	chy?			0	1	2	3	4
10.	Do you feel sad, down, or d	epressed?			0	1	2	3	4
11.	Have you had more aches a	and pains, such as stomacha	ches or headaches?		0	1	2	3	4
12.	If in school: Do you find it ha	arder to get your schoolwork	done?		0	1	2	3	4
13.	Do you worry about someth	ing else bad happening to yo	ou/your family/your friends?		0	1	2	3	4
14.	Are you having a harder tim	e getting along with family or	your friends?		0	1	2	3	4
15.	Are you finding it harder to o	do or enjoy activities that you	used to enjoy?		0	1	2	3	4

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		RE	SPON	DENT A	NSWE	RS
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?				2	3	4
18. Has your child talked repeatedly or asked questions about the disast	er?	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 or risk-taking behavior, or decline in school performance)?	e.g., bed-wedding, baby talk, fighting	0	1	2	3	4
COUNT THE NUMBER OF ENTRIES IN THE LAST 2 COLUMNS ABOVE THA IF TOTAL NUMBER IS 4 OR MORE, DISCUSS THE POSSIBILITY OF A REFE		TC	OTAL NU	JMBER		
FOR CHILDREN OVER THE AGE OF 10 OR IF YOU ARE CONCERNED ABO	OUT A YOUNGER CHILD, YOU MAY AS	K:				
Have you had any thoughts or plans about either hurting or killing yourself?						
YES IF YES, refer to immediate psychiatric intervention. THE CCP respond or react if the response is "YES."	should have protocols or procedures in pl	ace for h	now a cri	isis coun	selor sh	ould
☐ NO IF NO, continue.						
REFERRAL (select all t	hat were communicated)					
						-1
 crisis counseling program services (e.g., group counseling, referral to a team leader, follow-up visit) 	community services (e.g., FEMA, lesservices)	oans, no	using, e	mpioyme	∍nt, soci	aı
 mental health services (e.g., professional, longer-term counseling, treatment, behavioral, or psychiatric services) 	resources for those with disabilities	s, or othe	er access	s or func	tional ne	∍eds
substance use services (e.g., professional, behavioral, or medical treatment or self-help groups, such as Alcoholics Anonymous or Narcotics Anonymous)	other (specify in box)					
Was the referral accepted by the child? $\ \square$ YES $\ \square$ NO	Was the referral accepted by the parer	nt/caregiv	ver?	YES)
INSTRUCTIONS: CHILD/YOUTH AS	SSESSMENT AND REFERRAL TOOL					
It is recommended that this form be used with all children or youth who are intensive use counseling vist with any crisis counselor from the program or who continue to suffer severe d used as an interview guide (1) with children receiving individual crisis counseling on the experiencing serious is	istress that may be impacting their ability to perf	form routin	ne daily a	ctivities.	This form	should b
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.						
	2 nd EMPLOYEE #—Employee number of your to	eammate	during th	is encoun	ter.	
DATE OF SERVICE—The date of the encounter in the format mm/dd/yyy, e.g., 01/01/2012.						
	ZIP CODE OF SERVICE—The ZIP code of the				r occurre	d.
VISIT NUMBER—Is this the first, second, third, fourth, fifth, or later visit for this person to you	•		ONLY C	NE.		
DURATION—How lond did your encounter last? SELECT ONLY ONE. If the encounter was u	under to minutes, record it on the Weekly Tally	oneet.				
LOCATION OF SERVICE—Where did the encounter occur? SELECT ONLY ONE. RISK CATEGORIES—These are factors than an individual may have experienced or may ha CATEGORY MAY APPLY. SELECT ALL CATEGORIES THAT APPLY.	eve present in his or her life that could increase h	nis or her	need for	services.	MORE TI	AN ON
DEMOGRAPHIC INFORMATION:						
AGE—What age does the person or his or her parent indicate he or she is? SELECT O	NLY 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 language 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.