PROJECT # _____

Adult Assessment and Referral Tool

OMB NO. 0930-0270
Expiration Date 08/31/2025

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 adults who have received individual crisis counseling on two or more occasions before this visit (it is recommended on the *third* and *fifth* encounter) OR
2) with any adult at any time if you suspect the adult may be experiencing serious reactions to the disaster.

Provider Name _____ Provider Number _____

Date of Service (dd/mm/yyyy) _____ County or Parish of Service _____

1st Employee # _____ 2nd Employee # _____ Zip Code of Service _____

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 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) _____

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

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 problems
- ☐ 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

Age (select one) ☐ young adult (18–39 years) ☐ adult (40–64 years) ☐ older adult (65 years or older)

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.)

Gender (select one) ☐ 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/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Hispanic/Latino

Did you immigrate to the United States in the past 5 years? (select one) ☐ Yes ☐ No

ASSESSMENT QUESTIONS

GIVE RESPONSE CARD TO RECIPIENT.

READ: These questions are about the reactions you have experienced IN THE PAST MONTH. By reactions, I mean feelings or emotions or thoughts about the events. For each question choose one of the following responses from this card.

1 = not at all ☐ 2 = a little bit ☐ 3 = somewhat ☐ 4 = quite a bit ☐ 5 = very much ☐

QUESTIONS TO BE READ		RESPONDENT'S ANSWERS				
1.	How much have you been bothered by unwanted memories, nightmares, or reminders of what happened?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
2.	How much effort have you made to avoid thinking or talking about what happened or doing things that remind you of what happened?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
3.	To what extent have you lost enjoyment in things, kept your distance from people, or found it difficult to experience feelings because of what happened?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
4.	How much have you been bothered by poor sleep, poor concentration, jumpiness, irritability, or feeling watchful around you because of what happened?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
5.	How down or depressed have you been because of what happened?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
6.	Has your ability to handle other stressful events or situations been harmed?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
7.	Have your reactions interfered with how well you take care of your physical health? For example, are you eating poorly, not getting enough rest, smoking more, or finding that you have increased your use of alcohol or other substances?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
8.	How distressed or bothered are you about your reactions?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
9.	How much have your reactions interfered with your ability to work or carry out your daily activities, such as housework or homework?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
10.	How much have your reactions affected your relationships with your family or friends or interfered with your social, recreational, or community activities?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
11.	How concerned have you been about your ability to overcome problems you may face without further assistance?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
	NUMBER OF RESPONSES OF 4 OR 5 (this is recipient's score)					☐

12. In the past month, have you had thoughts about suicide? ☐ No ☐ Yes
13. Have you ever made a suicide attempt? ☐ No ☐ Yes
14. If yes to #12 or #13, Are you having thoughts of suicide right now? ☐ No ☐ Yes

REFERRAL INSTRUCTIONS

IF THE ANSWER TO ITEM #14 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."

IF THE ANSWER TO ITEM #14 IS "NO," CONTINUE:

IF SCORE IS 3 OR HIGHER, OR IF THE ANSWER TO ITEMS #12 OR #13 IS "YES," READ: FROM WHAT YOU HAVE TOLD ME, IT SEEMS THAT YOU MIGHT BENEFIT FROM PARTICIPATING IN ANOTHER SERVICE [DESCRIBE]. I WOULD LIKE TO REFER YOU TO:

_____.

IF SCORE IS BELOW 3, READ: FROM WHAT YOU HAVE TOLD ME, IT SEEMS THAT YOU ARE MANAGING YOUR REACTIONS. DOES THAT SEEM RIGHT TO YOU?

IF NO, READ: PERHAPS YOU WOULD BENEFIT FROM PARTICIPATING IN ANOTHER SERVICE [DESCRIBE]. I WOULD LIKE TO REFER YOU TO:

_____

IF YES, READ: WE SHOULD DECIDE UPON SPECIFIC GOALS FOR COUNSELING THAT WE CAN MEET TODAY OR WITHIN ANOTHER COUPLE OF VISITS.

REFERRAL (select all that apply)

- ☐ crisis counseling program services (e.g., group counseling, referral to teamleader, 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) ☐

Note the type of service for which you made the referral, not the site to which you made the referral.

Did the participant accept one or more of the referral(s)? ☐ No ☐ Yes *See "Referral Instructions" above.*

INSTRUCTIONS:

ADULT ASSESSMENT AND REFERRAL TOOL

When To Use This Form:

It is recommended that this form be used with all adults 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 adults receiving individual crisis counseling on the third and fifth occasions OR (2) with any adult at any time if you suspect the adult may be experiencing serious reactions to the disaster. Do not use this form with children; use the Child/Youth Assessment and Referral Tool.

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.

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 where the service occurred.

1st EMPLOYEE #—YOUR employee number issued by ODCES.

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

ZIP CODE OF SERVICE—The ZIP code where the service occurred.

LOCATION OF SERVICE—Where did the encounter occur? SELECT ONLY ONE.

VISIT NUMBER—Is this the first, second, third, fourth, or 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.

RISK CATEGORIES—These are factors that 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. The Adult Assessment and Referral Tool is an interview guide, and you may ask the individual whether or not he or she has experienced the listed factors. (Note that this instruction is not the same as for the Individual/Family Crisis Counseling Services Encounter Log.)

DEMOGRAPHIC INFORMATION—For each variable, SELECT ONLY ONE. The Adult Assessment and Referral Tool is an interview guide, and you may ask the individual these questions as needed. (Note that this instruction is not the same as for the Individual/Family Crisis Counseling Services Encounter Log.) For each question, read the options, and ask the individual to select the option or options that best describe(s) him or her.

AGE—What age does the person indicate he or she is? SELECT ONLY ONE.

PERSONS WITH DISABILITIES OR OTHER ACCESS OR FUNCTIONAL NEEDS—If the participant considers him- or herself to have a disability or access or functional need, what type does he or she indicate (physical, intellectual/cognitive, or mental health/substance use)? SELECT ALL THAT APPLY.

- Physical: includes disorders that impair mobility, seeing, and hearing, as well as medical conditions, such as diabetes, lupus, Parkinson's, acquired immunodeficiency syndrome (AIDS), and multiple sclerosis (MS).
- Intellectual/cognitive: includes a learning disability, birth defect, neurological disorder, developmental disability (e.g., Down syndrome), and 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 disorders.

GENDER—The gender the person reports being. SELECT ONLY ONE.

PRIMARY LANGUAGE SPOKEN DURING THIS ENCOUNTER—Which 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 (this may include sign language). SELECT ONLY ONE.

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

IMMIGRATED TO THE UNITED STATES IN THE PAST 5 YEARS—Indicate if any participant immigrated 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.
At the end of the 11 questions, COUNT the number of check marks in boxes 4 and 5. Each check mark counts as 1 point. This is the person's score.
For example, an individual who answered “quite a bit” on Questions 6 and 7 and “very much” on Question 11 and “somewhat” on Questions 1–5 and 8–10 would receive a score of 3.

REFERRALS—In the REFERRAL box, select all of the types of services to which you referred the person. If the service is not listed, please provide the type of service next to "other.”

Thank you for taking the time to complete this form accurately and fully!