MRSS FAMILY DISCHARGE RECORD

This record should only be completed if a client and/or family was served beyond an initial crisis call (greater than 72 hours).

Please enter the Consumer ID for this client (confirm this matches exactly to the client's intake ID): _____

Please fill-in the client's county of residence: _____

Please fill-in the MRSS provider agency serving this client: _____

Name of the Data Entry staff member OR the person to whom questions about data entry should be directed (first and last name):

_____

Date of last service provided (Completed by MRSS team): _____

From the therapist's perspective, which issues were addressed with the family during their involvement with your MRSS program? (Selected all that apply)

__ Suicide-related thoughts or actions
__ Self-injury
__ Depression
__ Conduct/delinquency-related behaviors
__ Hyperactive and attention-related behaviors
__ Anxiety
__ Adjustment-related issues
__ Parenting Skills
__ School/Educational performance
__ Intellectual disabilities
__ Psychotic behaviors
__ Behavior consistent with Autism/ASD
__ High family stress levels
__ Foster care placement
__ Lack of family resources
__ Guardian/caregiver exhaustion
__ Guardian/caregiver mental health issue needs
__ Substance use, abuse, and drug dependency behaviors (caregiver)
__ Substance use, abuse, and drug dependency behaviors (youth)
__ Learning disabilities
__ Eating disorders (including anorexia, bulimia)
__ Sleeping problems
__ Current home unable to meet young adult's needs
__ Maltreatment (child abuse and neglect)
__ Behavioral concerns
__ Persistent noncompliance (when directed by caregivers/adults)
__ Attachment problems
__ Running away
__ Other reason(s) not listed above, please specify:
_____

Did the young adult/family:

Receive face to face de-escalation?	__ Yes	__ No	__ Don't know
Define the problem as a family?	__ Yes	__ No	__ Don't know
Learn and apply new problem-solving skills?	__ Yes	__ No	__ Don't know
Complete a safety plan?	__ Yes	__ No	__ Don't know
Review, monitor, and update a safety plan?	__ Yes	__ No	__ Don't know
Experience another crisis while in treatment?	__ Yes	__ No	__ Don't know
Assist in developing an individualized cross-system family plan?	__ Yes	__ No	__ Don't know

Did the young adult/family receive Youth Peer Support Services?

__ Yes __ No

If No,

If Youth Peer Support Services were not received, please indicate the reason why:

__ Youth Peer Support not available

__ Youth/Young Adult declined the service

__ Other _____

Did the young adult/family receive Parent Peer Support Services?

__ Yes __ No

If No,

If Parent Peer Support Services were not received, please indicate the reason why:

__ Parent Peer Support not available

__ Parent declined the service

__ Other _____

As a provider, how many times were the following services provided (Please do not include the attempts, only the completed contacts)

Face-to-face contacts with the family: _____

Telephone contacts with the family: _____

Collateral contacts were made with other agencies/individuals? _____

Was there a mental health or lethality assessment completed during this process?

__ Yes __ No

Was a facilitated System of Care MRSS Family Team planning meeting held (i.e. a planning meeting which involved more than the family and the family was present)?

__ Yes __ No

If Yes,

Who facilitated the System of Care planning meeting?

__ MRSS Staff __ Case Manager

__ Other agency employee __ Wraparound Facilitator

__ Other, please specify _____

Did the youth or young adult leave their home during involvement with MRSS

Psychiatric Hospitalization	__ Yes	__ No	__ Don't know
Psychiatric ER Visit	__ Yes	__ No	__ Don't know
Juvenile Detention Center	__ Yes	__ No	__ Don't know
Adult Jail	__ Yes	__ No	__ Don't know
Crisis Respite	__ Yes	__ No	__ Don't know
Residential Treatment Center/Crisis Stabilization Unit	__ Yes	__ No	__ Don't know
Group Home	__ Yes	__ No	__ Don't know
Foster Care/Therapeutic Foster Care	__ Yes	__ No	__ Don't know
Kinship Placement (includes relatives and non-relatives; may or may not involve a legal change in custody)	__ Yes	__ No	__ Don't know

Did the following occur during the youth or young adult's involvement with MRSS?

New unruly, delinquency, or if adult-criminal charges filed	__ Yes	__ No	__ Don't know
Law enforcement called (but no charges resulting)	__ Yes	__ No	__ Don't know
Probation violation	__ Yes	__ No	__ Don't know

Did the following occur during the youth or young adult's involvement with MRSS?

School suspension	__ Yes	__ No	__ Don't know	__ N/A (not enrolled)
School expulsion	__ Yes	__ No	__ Don't know	__ N/A (not enrolled)
Unexcused absences from school	__ Yes	__ No	__ Don't know	__ N/A (not enrolled)

Was the client referred to high-fidelity wraparound or service coordination?

__ Yes __ No

If the family was not referred to Wraparound/Service Coordination, why not?

__ Family/Young Adult was already being served by Wraparound/Service Coordination prior to referral to MRSS

__ Family/Youth Adult was already being served by a comparable planning process (i.e. Transition to Independence Program)

__ Family/Young Adult declined a referral to Wraparound/Service Coordination

__ MRSS clinician and family/young adult determined together that Wraparound/Service Coordination was not needed

__ Wraparound/Service Coordination had a waiting list

__ Wraparound/Service Coordination was unavailable

__ Other: _____

Referrals and Linkages (Please indicate the services and supports to which you referred the family and/or youth)
Direct Referral #1 (select one)

__ Substance Abuse Treatment
__ Residential Treatment/Crisis Stabilization Unit
__ Youth Support Group
__ Young Adult Peer Support
__ Job & Family Service Income Support/Financial Services
__ Transportation
__ Youth Mentoring
__ Parent Support Group
__ Parent Peer Support
__ Mental Health Therapy
__ Medication Management
__ Primary Care Physician/Physical Health Care Provider
__ Positive Recreation/Pro-social Activities
__ Parenting Classes/Coaching
__ Skill Development Group/Training
__ Adult Recovery Peer
__ Housing/Clothing/Food Support
__ Respite Care
__ Faith-based Supports
__ Natural Supports
__ Developmental Disabilities
__ Self-care activities
__ Veterans' Benefits
__ Employment Supports
__ Education Advocate
__ Mental Health Therapy
__ Transition to Independence Program
__ IHBT
__ Alternative School
__ Equestrian
__ Kinship Navigator
__ Case Management

Did these services from Referral #1 initiate prior to the MRSS closure?

__ Yes __ No

Referrals and Linkages (Please indicate the services and supports to which you referred the family and/or youth)
Direct Referral #2 (select one)

__ Substance Abuse Treatment
__ Residential Treatment/Crisis Stabilization Unit
__ Youth Support Group
__ Young Adult Peer Support
__ Job & Family Service Income Support/Financial Services
__ Transportation
__ Youth Mentoring
__ Parent Support Group
__ Parent Peer Support
__ Mental Health Therapy
__ Medication Management
__ Primary Care Physician/Physical Health Care Provider
__ Positive Recreation/Pro-social Activities
__ Parenting Classes/Coaching
__ Skill Development Group/Training
__ Adult Recovery Peer
__ Housing/Clothing/Food Support
__ Respite Care
__ Faith-based Supports
__ Natural Supports
__ Developmental Disabilities
__ Self-care activities
__ Veterans' Benefits
__ Employment Supports
__ Education Advocate
__ Mental Health Therapy
__ Transition to Independence Program
__ IHBT
__ Alternative School
__ Equestrian
__ Kinship Navigator
__ Case Management

Did these services from Referral #2 initiate prior to the MRSS closure?

__ Yes __ No

Referrals and Linkages (Please indicate the services and supports to which you referred the family and/or youth)
Direct Referral #3 (select one)

__ Substance Abuse Treatment
__ Residential Treatment/Crisis Stabilization Unit
__ Youth Support Group
__ Young Adult Peer Support
__ Job & Family Service Income Support/Financial Services
__ Transportation
__ Youth Mentoring
__ Parent Support Group
__ Parent Peer Support
__ Mental Health Therapy
__ Medication Management
__ Primary Care Physician/Physical Health Care Provider
__ Positive Recreation/Pro-social Activities
__ Parenting Classes/Coaching
__ Skill Development Group/Training
__ Adult Recovery Peer
__ Housing/Clothing/Food Support
__ Respite Care
__ Faith-based Supports
__ Natural Supports
__ Developmental Disabilities
__ Self-care activities
__ Veterans' Benefits
__ Employment Supports
__ Education Advocate
__ Mental Health Therapy
__ Transition to Independence Program
__ IHBT
__ Alternative School
__ Equestrian
__ Kinship Navigator
__ Case Management

Did these services from Referral #3 initiate prior to the MRSS closure?

__ Yes __ No

Were there any needed services or supports that were identified, but not available in the community?
If yes, please specify below:

_____

_____

Were there any referrals that were made that the family chose not to or was unable to engage with? (Incompleted Referrals)

__ Yes __ No

If Yes,

Please explain which services/supports and why the family chose not to or was unable to engage with them?

_____

_____

Please select NO, these questions were only for ENGAGE Cohort 1 to complete

Did the family answer the satisfaction questions?

__ Yes √ No *(Please leave the rest of the survey blank)*