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

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)