

EBP DISCHARGE ASSESSMENT PACKET

CBITS & BOUNCE BACK

English

Required Forms

1. Demographic Information:
Client Discharge Face Sheet
2. Child's Trauma Symptoms:
YCPC-Caregiver Report
3. Child's Behavior & Functioning:
Ohio- Caregiver Report
4. Satisfaction Questionnaire (caregiver or child)

Supplemental Assessments

Child Symptoms:

SMFQ (Child Depression Symptoms) – Child & Caregiver Report

PROMIS (Child Anxiety Symptoms) – Child & Caregiver Report

Caregiver Symptoms:

CESD-R (Caregiver Depression Symptoms)

PSS (Caregiver Stress Symptoms)

PCL-5 (Caregiver Trauma Symptoms)

Discharge Facesheet

! This symbol means the field is one of the minimum fields that must be filled out to save the record. No data will be saved unless these fields are completed.

* This symbol means the field is a required field in order to save the record as completed. Although you can save the record, the system does not consider the record to be completed unless ALL of these fields are completed.

Data Entry Person: Greyed-out fields are pulled in from the completed Client Face Sheet-Intake, so you won't have to enter them again here

Direct Service Provider User Information

Clinician First Name: !		Clinician Last Name: !	
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Child Information

Child First Initial: !		Child Last Initial :!	
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Child Identification Codes

Which EBP?	<input type="checkbox"/>	ARC	<input type="checkbox"/>	CBITS	<input type="checkbox"/>	Bounce Back	<input type="checkbox"/>	CPP
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Discharge Information

Discharge Date: * _____/_____/_____					
CGI: Considering your experience, how severe are the child's emotional, behavioral, and/or cognitive concerns at the time of discharge? (circle one):*	Normal Slightly Severe Mildly Severe Moderately Severe Markedly Severe Very Severe Among the most severe symptoms that any child may experience		CGI: Compared to the child's condition at intake, this child's condition is _____ (circle one): *	Very much improved Much improved Minimally improved No change Minimally worse Much worse Very much worse	
	<input type="checkbox"/>	Successfully completed selected EBP Model requirements-no more treatment needed		<input type="checkbox"/>	Referred for other EBP (outpatient) within agency

Discharge Reason: *	<input type="checkbox"/>	Successfully completed selected EBP Model requirements-continue with other treatment	<input type="checkbox"/>	Referred for other non-EBP (outpatient) within agency	<input type="checkbox"/>	Referred to other agency (outpatient)
	<input type="checkbox"/>	Family discontinued treatment	<input type="checkbox"/>	Referred to higher level of care	<input type="checkbox"/>	Assessment Only-no treatment needed
	Other (specify): _____					

System Involvement

Child/Family involved with DCF? *	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
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If child / family is involved with DCF, please complete ALL of the following questions:

DCF Case ID: (if available)			DCF Person Link ID: (if available)			
DCF Status: DCF Regional Office:	<input type="checkbox"/>	Child Protective Services – In-Home	<input type="checkbox"/>	Family with Service Needs – (FWSN) In-Home	<input type="checkbox"/>	Not DCF – On Probation
	<input type="checkbox"/>	Child Protective Services – Out of Home	<input type="checkbox"/>	Family with Service Needs (FWSN) Out of Home	<input type="checkbox"/>	Not DCF – Other Court Involved

Discharge Facesheet

	<input type="checkbox"/> Dual Commitment (JJ and Child Protective Services)	<input type="checkbox"/> Juvenile Justice (delinquency) commitment	<input type="checkbox"/>	Termination of Parental Rights
	<input type="checkbox"/> Family Assessment Response	<input type="checkbox"/> Not DCF	<input type="checkbox"/>	Voluntary Services Program
Youth involved with Juvenile Justice (JJ) System? *		<input type="checkbox"/> Yes	<input type="checkbox"/>	No
If youth is involved with JJ, please complete ALL of the following questions:				
CSSD Client ID: (if available)			CSSD Case ID: (if available)	
CSSD Case Type:		<input type="checkbox"/> Delinquency	<input type="checkbox"/>	Family with Service Needs (Status Offense)
CSSD Case Status:	<input type="checkbox"/> Administrative Supervision	<input type="checkbox"/> Juvenile probation	<input type="checkbox"/>	Restore Probation
	<input type="checkbox"/> Extended Probation	<input type="checkbox"/> Non-Judicial FWSN Family Service Agreement	<input type="checkbox"/>	Suspended Order
	<input type="checkbox"/> Interim Orders	<input type="checkbox"/> Non-Judicial Supervision (NJS)	<input type="checkbox"/>	Waived PDS - Probation
	<input type="checkbox"/> Judicial FWSN Supervision	<input type="checkbox"/> Non-Judicial Supervision Agreement	<input type="checkbox"/>	
Court District:				
Court Handling Decision:		<input type="checkbox"/> Judicial	<input type="checkbox"/>	Non-Judicial
Treatment Information: School				
Since the start of EBP treatment...				
Child's school attendance: *	<input type="checkbox"/> Good (few or no days missed)	<input type="checkbox"/> No School Attendance: Child Too Young for School	<input type="checkbox"/>	No School Attendance: Other
	<input type="checkbox"/> Fair (several days missed)	<input type="checkbox"/> No School Attendance: Child Suspended/Expelled from School	<input type="checkbox"/>	
	<input type="checkbox"/> Poor (many days missed)	<input type="checkbox"/> No School Attendance: Child Dropped Out of School	<input type="checkbox"/>	
Suspended or expelled: *		<input type="checkbox"/> Yes	<input type="checkbox"/>	No
IEP: * Does the child have an Individual Education Plan (special education)?		<input type="checkbox"/> Yes	<input type="checkbox"/>	No
Treatment Information: Legal				
Since the start of EBP treatment...				
Arrested: * Has the child been arrested since start of treatment?		<input type="checkbox"/> Yes	<input type="checkbox"/>	No
Detained or incarcerated: * Has the child been detained or incarcerated since start of treatment?		<input type="checkbox"/> Yes	<input type="checkbox"/>	No
Treatment Information: Medical				
Since the start of EBP treatment...				
Alcohol and/or drugs problems: *		<input type="checkbox"/> Yes	<input type="checkbox"/>	No
Evaluated in ER/ED for psychiatric issues: *		<input type="checkbox"/> Yes	<input type="checkbox"/>	No
Certified medically complex: *		<input type="checkbox"/> Yes	<input type="checkbox"/>	No

YCPC

Below is a list of symptoms that children can have after life-threatening events.

When you think of ALL the life-threatening traumatic events from the first page, circle the number below (0-4) that best describes how often the symptom has bothered you in the LAST 2 WEEKS.

0	1	2	3	4
Not at all	Once a week or less/ once in a while	2 to 4 times a week/ half the time	5 or more times a week/ almost always	Everyday

14. Does your child have intrusive memories of the trauma? Does s/he bring it up on his/her own? 0 1 2 3 4

15. Does your child re-enact the trauma in play with dolls or toys? This would be scenes that look just like the trauma. Or does s/he act it out by him/herself or with other kids? 0 1 2 3 4

16. Is your child having more nightmares since the trauma(s) occurred? 0 1 2 3 4

17. Did night terrors start or get worse after the trauma(s)? Night terrors are different from nightmares: in night terrors a child usually screams in their sleep, they don't wake up, and they don't remember it the next day. 0 1 2 3 4

18. Does your child act like the traumatic event is happening to him/her again, even when it isn't? This is where a child is acting like they are back in the traumatic event and aren't in touch with reality. This is a pretty obvious thing when it happens. 0 1 2 3 4

19. Since the trauma(s) has s/he had episodes when s/he seems to freeze? You may have tried to snap him/her out of it but s/he was unresponsive. 0 1 2 3 4

20. Does s/he get upset when exposed to reminders of the event(s)? 0 1 2 3 4

For example, a child who was in a car wreck might be nervous while riding in a car now. Or, a child who was in a hurricane might be nervous when it is raining. Or, a child who saw domestic violence might be nervous when other people argue. Or, a girl who was sexually abused might be nervous when someone touches her.

21. Does your child get physically distressed when exposed to reminders? Like heart racing, shaking hands, sweaty, short of breath, or sick to his/her stomach?" 0 1 2 3 4

Think of the same type of examples as in #20.

22. Does your child show persistent negative emotions (fear, guilt, sadness, shame, confusion) that are not triggered by exposure to reminders of the event as in #20? 0 1 2 3 4

PLEASE CONTINUE ON NEXT PAGE.....

0 Not at all	1 Once a week or less/ once in a while	2 2 to 4 times a week/ half the time	3 5 or more times a week/ almost always	4 Everyday
23. Does your child try to avoid people or conversations that might remind him/her of the trauma(s)? For example, if other people talk about what happened, does s/he walk away or change the topic?				
24. Does your child try to avoid things or places that remind him/her of the trauma(s)? For example, a child who was in a car wreck might try to avoid getting into a car. Or, a child who was in a flood might tell you not to drive over a bridge. Or, a child who saw domestic violence might be nervous to go in the house where it occurred. Or, a girl who was sexually abused might be nervous about going to bed because that's where she was abused before.				
25. Has s/he lost interest in doing things that s/he used to like to do since the trauma(s)?				
26. Since the trauma(s) has your child become more distant and withdrawn from family members, relatives, or friends?				
27. Since the trauma(s), does your child show a restricted range of positive emotions on his/her face compared to before?				
28. Has your child become more irritable, or had outbursts of anger, or developed extreme temper tantrums since the trauma(s)?				
29. Has s/he been more "on the alert" for bad things to happen? For example, does s/he look around for danger?				
30. Does your child startle more easily than before the trauma(s)? For example, if there's a loud noise or someone sneaks up behind him/her, does s/he jump or seem startled?				
31. Has your child had more trouble concentrating since the trauma(s)?				
32. Has s/he had a hard time falling asleep or staying asleep since the trauma(s)?				
33. Has your child become more physically aggressive since the trauma(s)? Like hitting, kicking, biting, or breaking things.				
34. Has s/he become more clingy to you since the trauma(s)?				

PLEASE CONTINUE ON NEXT PAGE.....

0	1	2	3	4
Not at all	Once a week or less/ once in a while	2 to 4 times a week/ half the time	5 or more times a week/ almost always	Everyday

35. Since the trauma(s), has your child lost previously acquired skills?
 For example, lost toilet training?
 Or, lost language skills?
 Or, lost motor skills working snaps, buttons, or zippers?

36. Since the trauma(s), has your child developed any new fears about things that don't seem related to the trauma(s)?
 What about going to the bathroom alone?
 Or, being afraid of the dark?

FUNCTIONAL IMPAIRMENT

Do the symptoms that you endorsed above get in the way of your child's ability to function in the following areas?

0	1	2	3	4
Hardly ever/ none	Some of the time	About half the days	More than half the days	Everyday

37. Do (symptoms) substantially "get in the way" of how s/he gets along with you, interfere in your relationship, or make you feel upset or annoyed? 0 1 2 3 4

38. Do these (symptoms) "get in the way" of how s/he gets along with brothers or sisters, and make them feel upset or annoyed? 0 1 2 3 4

39. Do these (symptoms) "get in the way" with the teacher or the class more than average? 0 1 2 3 4

40. Do (symptoms) "get in the way" of how s/he gets along with friends at all – at daycare, school, or in your neighborhood? 0 1 2 3 4

41. Do (symptoms) make it harder for you to take him/her out in public than it would be with an average child?"
 Is it harder to go out with your child to places like the grocery store?
 Or to a restaurant? 0 1 2 3 4

42. Do you think that these behaviors cause your child to feel upset? 0 1 2 3 4

version 12/9/13

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Client Initials: _____

Client ID: _____

Date of Completion: ____/____/____



P

Ohio Mental Health Consumer Outcomes System

Ohio Youth Problem and Functioning Scales (Caregiver: English)

Parent Rating – Short Form

	Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

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(Add ratings together) Total _____

January 2000 (Parent-1)

Response Scale for OHIO Problem Scale

0

1

2

3

4

5

Not at
all

Once or
twice

Several
times

Often

Most of
the time

All of
the time

Client Initials: _____

Client ID: _____

Date of Completion: ____/____/____

Ohio Youth Problem and Functioning Scales (Caregiver: English)

Parent Rating – Short Form continued

Instructions: Please rate the degree to which your child's problems affect his or her current ability in everyday activities. Consider your child's current level of functioning.	Extreme Troubles	Quite a Few Troubles	Some Troubles	OK	Doing Very Well
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

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January 2000 (Parent-2)

(Add ratings together) Total _____

Response Scale for OHIO Functioning Scale

0

1

2

3

4

Extreme Quite a few Some OK Doing
troubles troubles troubles very well

Client Initials: _____

Client ID: _____

Date of Completion: ___/___/___



Satisfaction Questionnaire

Youth Rating – OHIO SATISFACTION SCALE

Form Completed By: Caregiver Child Other: _____

Instructions: Please circle your response to each question.

1. How satisfied are you with the mental health services you have received so far?

1. Extremely satisfied
2. Moderately satisfied
3. Somewhat satisfied
4. Somewhat dissatisfied
5. Moderately dissatisfied
6. Extremely dissatisfied

2. How much are you included in deciding your treatment?

1. A great deal
2. Quite a bit
3. Moderately
4. Somewhat
5. A little
6. Not at all

3. Mental health workers involved in my case listen to me and know what I want.

1. A great deal
2. Quite a bit
3. Moderately
4. Somewhat
5. A little
6. Not at all

4. I have a lot of say about what happens in my treatment.

1. A great deal
2. Quite a bit
3. Moderately
4. Somewhat
5. A little
6. Not at all

Total: _____

Client Initials: _____

Client ID: _____

Date of Completion: ___/___/___



Satisfaction Questionnaire

P

Parent Rating –OHIO SATISFACTION SCALE (English)

Instructions: Please circle your response to each question.

1. How satisfied are you with the mental health services your child has received so far?

1. Extremely satisfied
2. Moderately satisfied
3. Somewhat satisfied
4. Somewhat dissatisfied
5. Moderately dissatisfied
6. Extremely dissatisfied

2. To what degree have you been included in the treatment planning process for your child?

1. A great deal
2. Quite a bit
3. Moderately
4. Somewhat
5. A little
6. Not at all

3. Mental health workers involved in my case listen to and value my ideas about treatment planning for my child.

1. A great deal
2. Quite a bit
3. Moderately
4. Somewhat
5. A little
6. Not at all

4. To what extent does your child's treatment plan include your ideas about your child's treatment needs?

1. A great deal
2. Quite a bit
3. Moderately
4. Somewhat
5. A little
6. Not at all

Total: _____