ANNUAL REPORT OF THE

JUVENILE JUSTICE SUBSTANCE ABUSE MENTAL HEALTH PARTNERSHIPS (JJSAMHP)

2011-2012

NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services

DEPARTMENT OF PUBLIC SAFETY

THE UNIVERSITY of NORTH CAROLINA GREENSBORO
Center for Youth, Family and Community Partnerships

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Section A: Overview of the Juvenile Justice Substance Abuse Mental Health Partnerships (JJSAMHP)

The Juvenile Justice Substance Abuse Mental Health Partnerships (JJSAMHP) are local teams across North Carolina working together to deliver effective, family-centered services and supports for juvenile justice-involved youth with substance abuse and/or mental health challenges. The partnerships require an organized, person-centered system that operates under the following System of Care principles:

- Family Driven & Youth Guided
- Child & Family Team Based
- Natural Supports
- Collaboration
- Community Based
- Culturally & Linguistically Competent
- Individualized
- Strengths Based
- Persistence
- Outcomes and Data Based Driven

The Partners can include any individual/agency in the community that wants to help address these issues but at a minimum, includes:

JJSAMH Partnerships must involve LME/MCO staff and DJJ Leadership

- A Local Management Entity/Managed Care Organization
- Local Court District Leadership
- Local Provider (s)
- Coordination with Juvenile Crime Prevention Councils

The Partnerships work together to ensure the following for juvenile justice involved youth:

- Completion of comprehensive substance abuse and mental health clinical assessments by appropriately licensed substance abuse and mental health treatment professionals
- Provision of evidence-based treatment options to youth referred for substance abuse, mental health and co-occurring disorders by appropriately licensed and qualified mental health professionals;
- Use of the Child and Family Team Process
- Involvement of Juvenile Crime Prevention Councils in programming

Additionally, the JJSAMHP teams are requested to problem solve about the following domains:

- Usage of funding such as Medicaid, Health Choice, Comprehensive Treatment Service Program, Child Mental Health and Child Substance Abuse in collaboration with their LME/MCO financial liaisons
- Utilize methods/practices for engaging youth and families
- Increase accessibility of services including offering after hour or non-traditional service provision times
- Providing for choice for families in service locations including at DJJ office, in homes, in the community
- Establishing a relationship amongst providers to develop a service array
- Work on decision making about processes for out of home placements
- Assist in training staff on Evidence Based Treatments and Evidence Based Practices

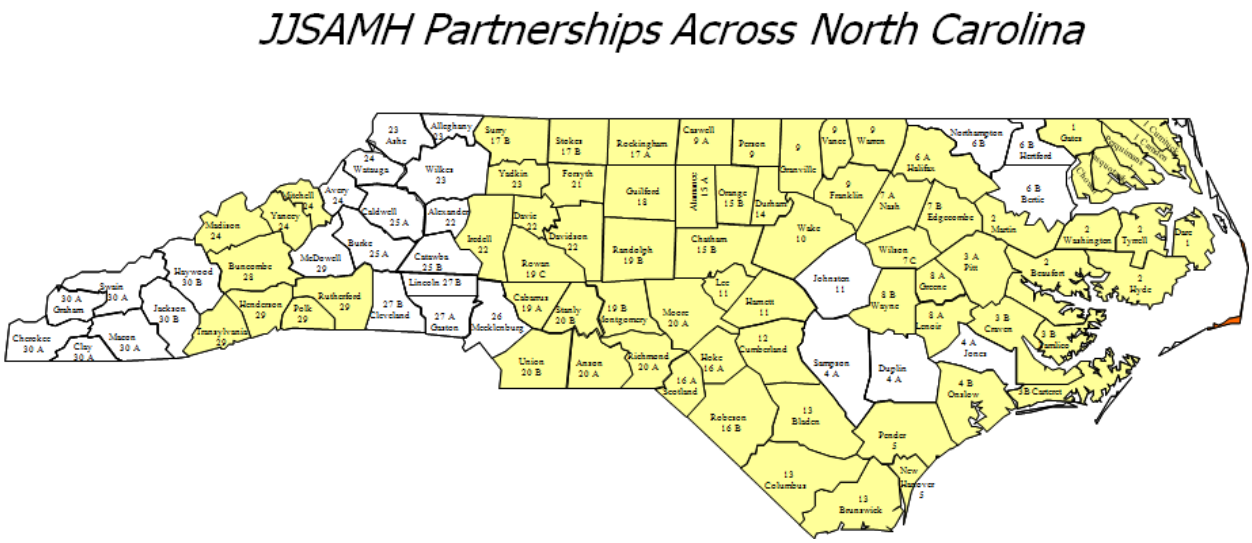
This Annual Report provides information about the JJSAMHP 2011-2012 fiscal year. Although no report can capture every detail of a statewide initiative, the purpose of this document is to provide the main highlights and overall information about JJSAMHP. It is divided up in the following sections:

- **Section A** is this overview of the document.
- **Section B** outlines the Local Management Entities (LME)/Managed Care Organizations (MCOs) involved with JJSAMHP and includes information on the Court Districts associated with each LME/MCO.
- **Section C** outlines the JJSAMHP Service Domains that are expected to be addressed by each JJSAMHP local team. This section also includes overall statistics for the JJSAMHP across all sites.
- **Section D** outlines Activities and the Accomplishments of the overall JJSAMHP.
- **Section E** details the local JJSAMHP processes including screening, assessment, and treatment for each local team as reported at the end of the fiscal year 2011-2012.

Section B: Local Management Entity/Managed Care Organization Involvement

As noted, JJSAMHP teams must involve the Local Management Entity/Managed Care Organization. The role of the LME/MCO is to help to ensure that the principles of the JJSAMHP are facilitated through the local teams. The LME/MCO is also provided with funds to help support local team activities. There are 15 LME/MCOs associated with JJSAMHP serving 72 counties. **It is noted that many of these designations were changed in July, 2012.** Within the LME/MCO's, there are 20 locally driven teams that work to address juvenile justice involved youth and family needs. For a listing of how each county is distributed by Chief Court Counselor and LME/MCO designation, please see **Appendix A.** Also, although there are 20 locally driven teams, there may be Court Districts within each team that have different processes. For example, there may be one Court District that completes a GAIN Short Screener on each youth and another Court District (within the same team) that utilizes another screening tool. Therefore, when describing team processes, there may be fluctuations in the numbers based on these processes within teams. The local partnership counties involved in JJSAMHP are graphically represented below.

Figure 1-Juvenile Justice Substance Abuse Mental Health Partnerships (Counties in Yellow)



The major teams associated with JJSAMHP are as follows (with their 2011-2012 nomenclature):

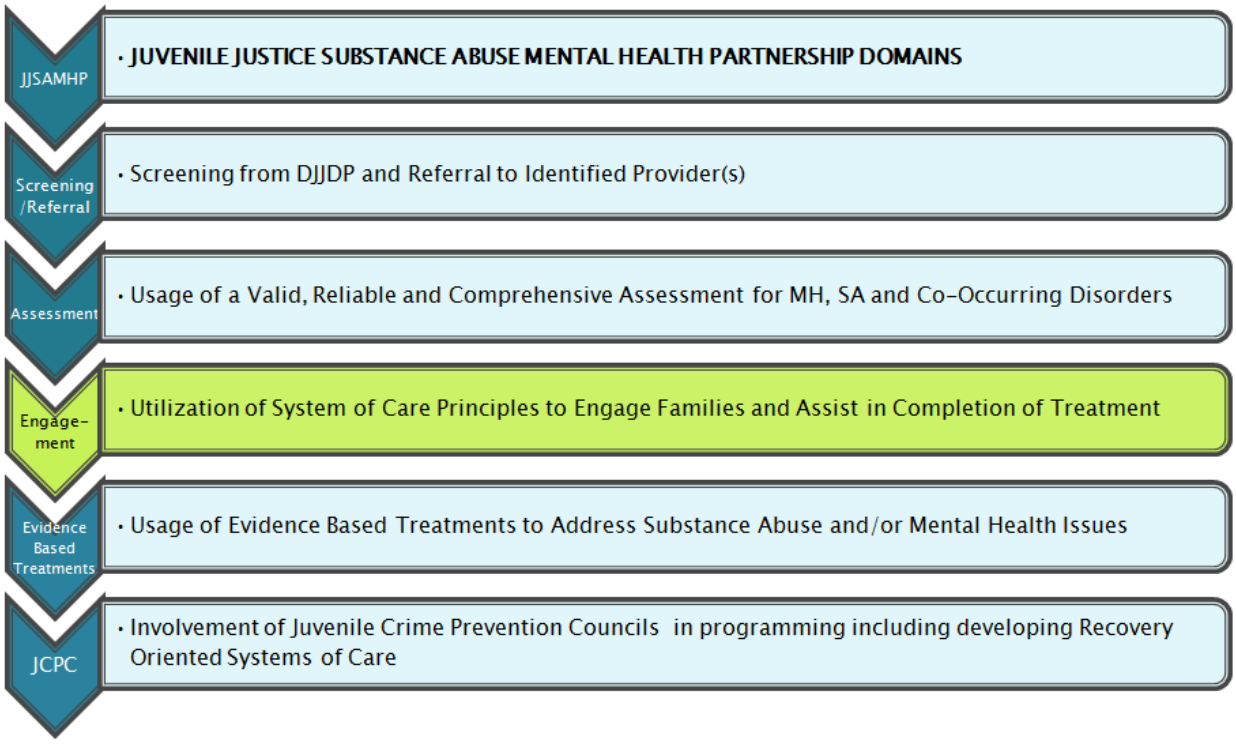
The Beacon Center	**CenterPoint Human Services**	**Crossroads Behavioral Healthcare**	**Cumberland County Mental Health Center**
The Durham Center	**East Carolina Behavioral Health-2 major teams**	**Eastpointe**	**Guilford Center for Behavioral Health and Disability Services**
Onslow Carteret Behavioral Healthcare Services	**PBH-AC area**	**PBH-Five County Area (2 teams)**	**PBH-OPC area**
PBH	**Sandhills Center for MH/DD/SAS**	**Southeastern Center for MH/DD/SAS**	**Southeastern Regional MH/DD/SAS Services**
	Wake County Human Services	**Western Highlands Network**	

Non JJSAMHP LME/MCOs include: Johnston, Mecklenburg, Pathways, and Smoky Mountain

Section C: JJSAMHP SERVICE PROVISION DOMAINS

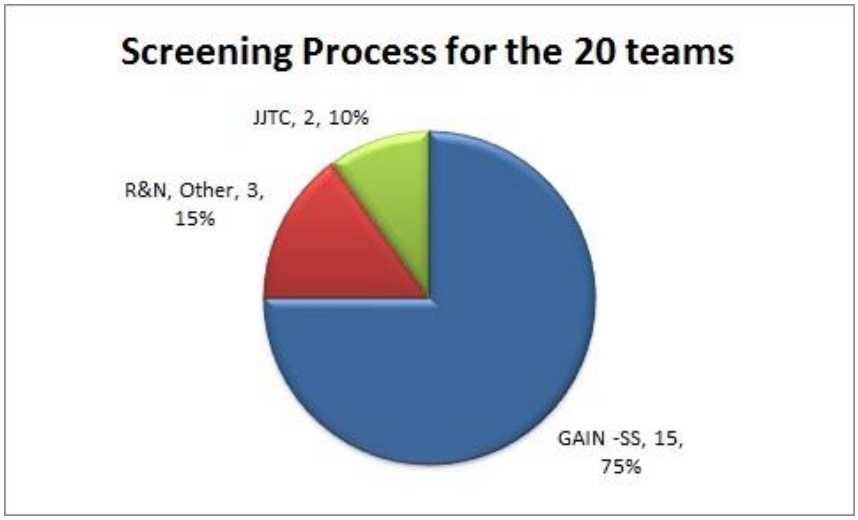
Although local teams define service provision within their area, there are five domains that are expected to have some uniformity to ensure that youth engage in services based on best practices. These five domains are: Screening, Assessment, Engagement, Evidence Based Treatment, and involvement with Juvenile Crime Prevention Councils. Most of these overall domains are represented by a national initiative, Reclaiming Futures (RF). Reclaiming Futures "helps teenagers caught in cycle of drugs, alcohol and crime. The project began in 2001 with $21 million form Robert Wood Johnson Foundation (RWJF) for 10 pilot sites to create a six-step model that promotes new standards of care and opportunities in juvenile justice" (http://www.reclaimingfutures.org/blog/)

The RF six steps include a Coordinated Individualized Response of: 1) Initial Screening; 2) Initial Assessment and 3) Service Coordination and Community Directed Engagement plan for: 4) Initiation; 5) Engagement; and 6) Completion. Although all of the JJSAMHP teams do not have to follow this model (there are six RF sites in NC), the concepts are complementary to JJSAMHP service domains. Please note these five domains below. It is noted that the section that is highlighted in green was changed during this fiscal year to emphasize the impact the use of System of Care principles can have on treatment completion. It is also noted that most of the team processes within each of the first four domains for each LME/MCO are outlined in the JJSAMHP Compendium of Services, which can be viewed online at: http://turninglivesaround.org/docs/JJSAMHP_Compendium_of_Services2012.pdf.

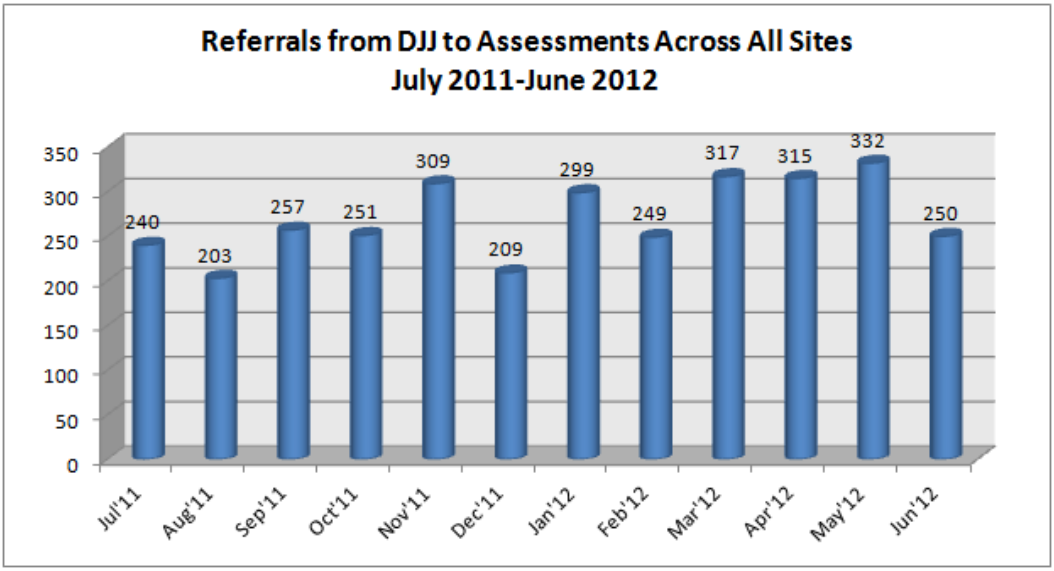


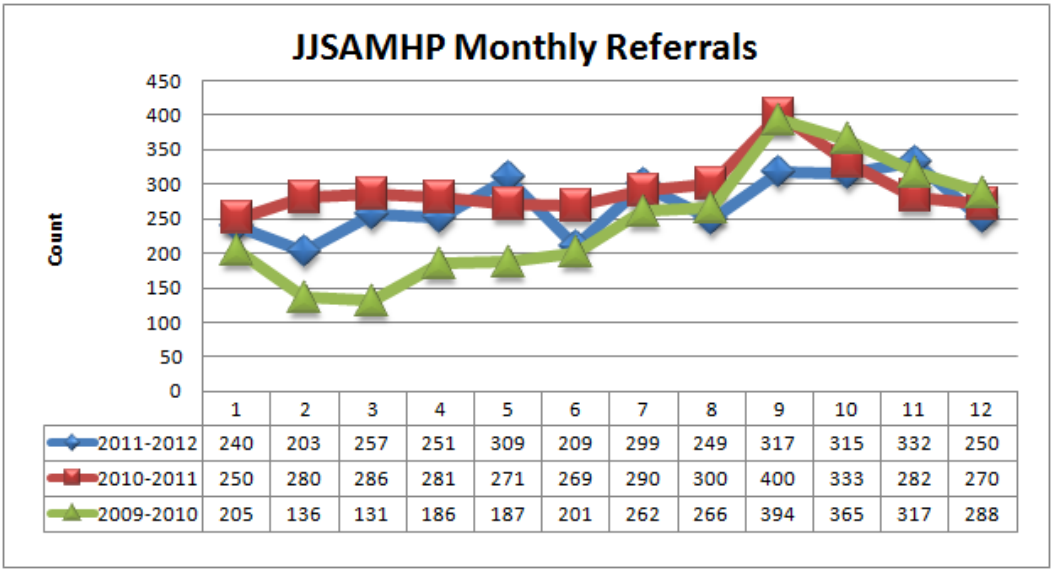
JJSAMHP Domain I: Screening and Referral

The first domain is Screening and Referral. According to Reclaiming Futures, screening involves usage of a reputable tool to identify youth who potentially have a substance abuse problem. In the case of JJSAMHP, the tool should also be able to detect possible mental health challenges. 100% of the JJSAMHP teams identify a uniform screening process from DJJ to a local provider. The different tools include the following: Global Appraisal of Individual Needs Short Screener (GAIN SS); Risk and Needs Assessment from DJJ; and the Juvenile Justice Treatment Continuum (JJTC) Screener. The following chart outlines the most frequently cited screening tools used by teams:



Based on data submitted by the local teams, there were 3,231 total referrals from DJJ screening to local provider(s) for assessments from July, 2011 through June, 2012. This averages to 269 referrals per month. For the first half of the fiscal year (July through December), there were 1,469 referrals and for the second half of the fiscal year (January through June), there were 1,762 referrals. To determine the number of referrals for each LME/MCO across this time period, please see the section entitled "Local Team Processes." The following graphs represent the total referrals completed across all JJSAMHPs for 2011-2012 and then a comparison of this fiscal year with the two previous fiscal years.

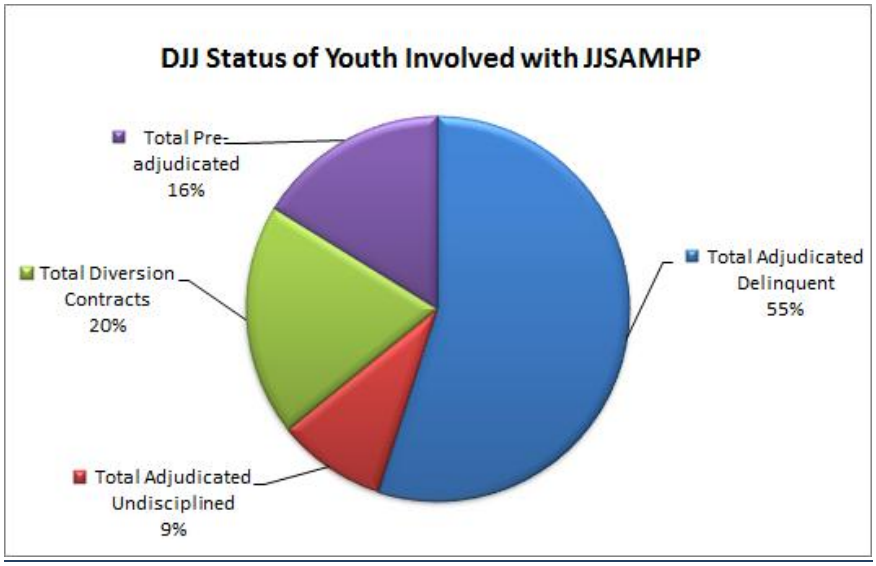




	1	2	3	4	5	6	7	8	9	10	11	12
2011-2012	240	203	257	251	309	209	299	249	317	315	332	250
2010-2011	250	280	286	281	271	269	290	300	400	333	282	270
2009-2010	205	136	131	186	187	201	262	266	394	365	317	288

DJJ Categories for Youth Involved with JJSAMHP

There are four main domains of information captured on type of youth involved in JJSAMHP: Adjudicated Delinquent, Adjudicated Undisciplined, Diversion with Contract, and Pre-Adjudication (there are very few youth in other DJJ categories). Of those youth within the four main categories, the majority were adjudicated delinquent, followed by diversion with contract, then adjudicated undisciplined and then pre-adjudication. The information is in the following graph.

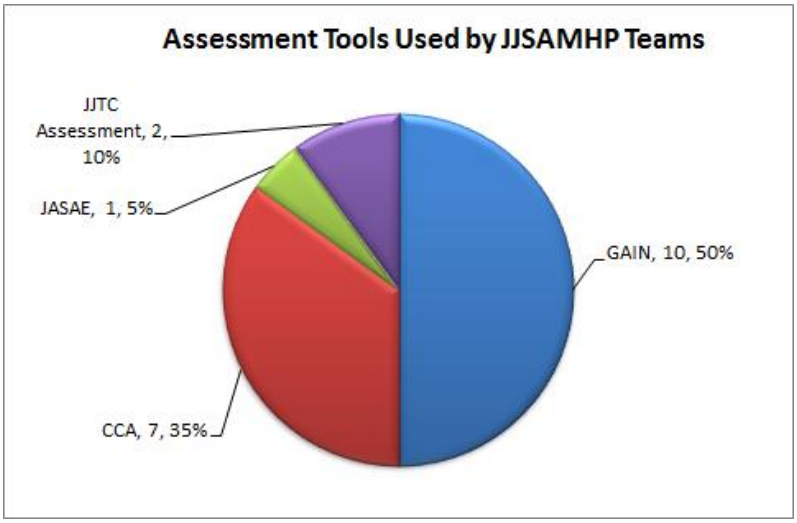


JJSAMHP Domain II: Assessment

The second JJSAMHP domain is Assessment. The Assessment tool used by JJSAMHP teams must gather information on substance abuse and mental health challenges. According to Reclaiming Futures, a comprehensive assessment involves usage of a tool to ascertain a wide range of individual and family risk factors, service needs, as well as the youth's strengths and assets.

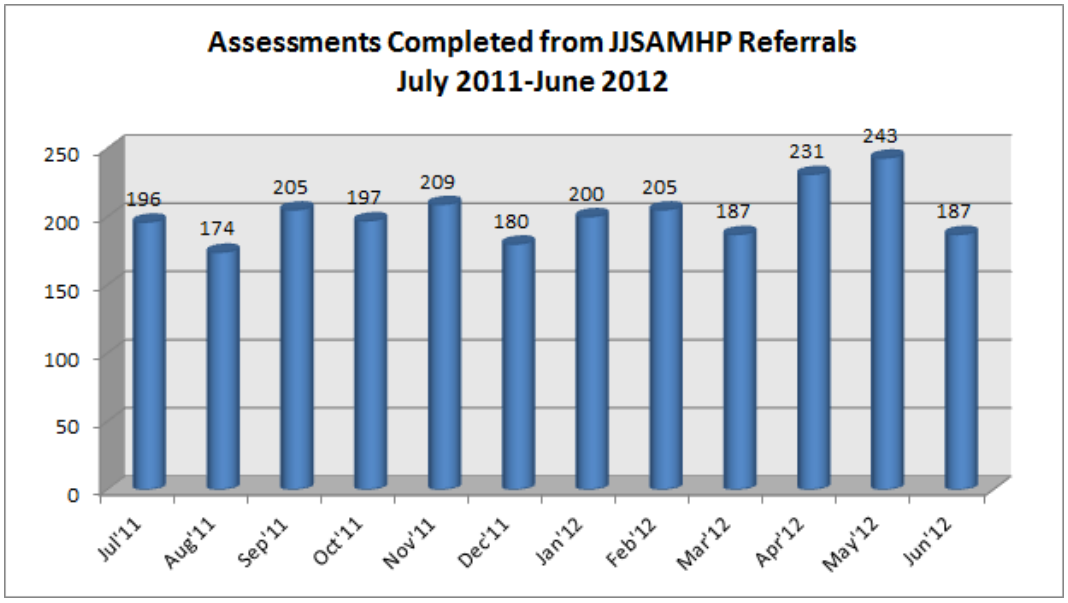
100% of the JJJSAMHP teams identify an assessment process that involves using either a Provider based assessment tool (Comprehensive Clinical Assessment) or an Evidence Based Assessment Tool such as the Global Appraisal of Individual Needs or the Juvenile Automated Substance Abuse Evaluation (JASAE).

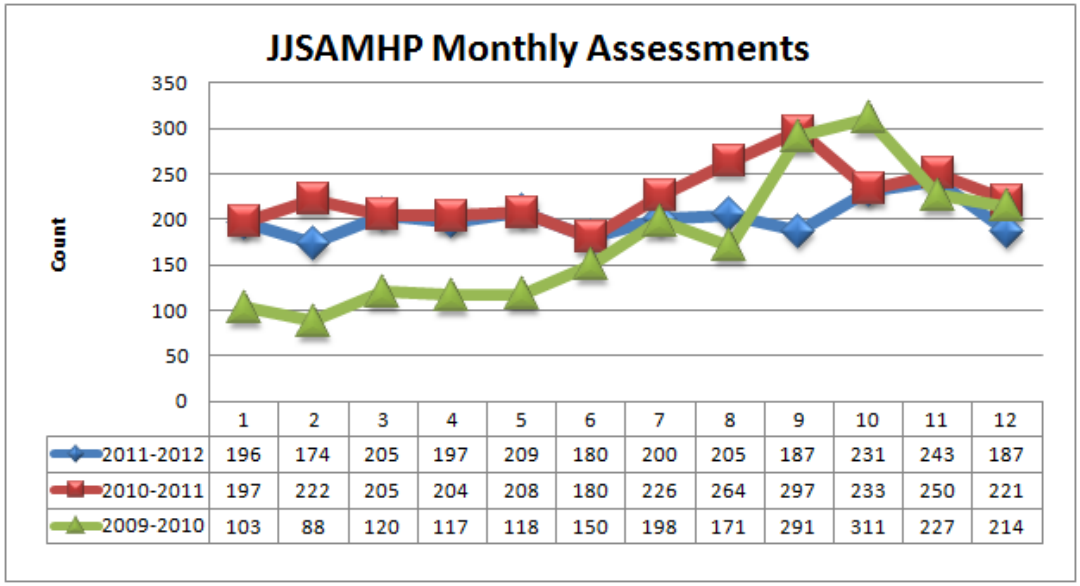
Four of the sites utilize a dedicated assessment clinician or a clinician that is mainly housed at DJJ. The following chart outlines the most frequently cited assessment tools used by teams:



Based on data submitted by the local teams, there were 2,414 assessments completed by partnering providers for the JJSAMHP during 2011-2012. This averages to 201 assessments per month. For the first

half of the fiscal year (July through December) there were 1,161 assessments and for the second half of the fiscal year (January through June), there were 1,253 assessments. The assessments completed represent 79% of the referrals for the first half of the year and 71% of the referrals for the second half of the year. To determine the number of assessments for each LME/MCO across this time period, please see the section entitled "Local Team Processes." The following graphs represent the total assessments completed across all JJSAMHP for 2011-2012 and then a comparison of this fiscal year with the previous fiscal years.

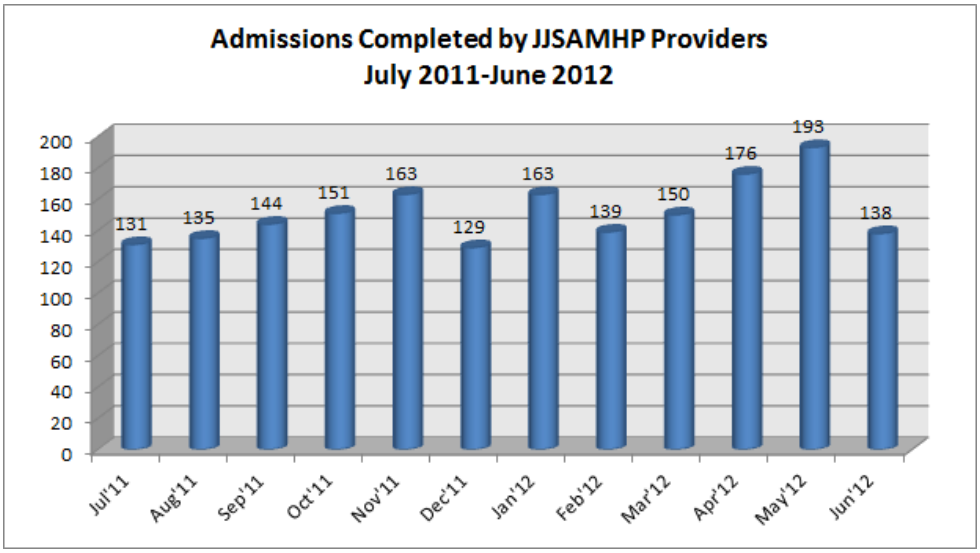


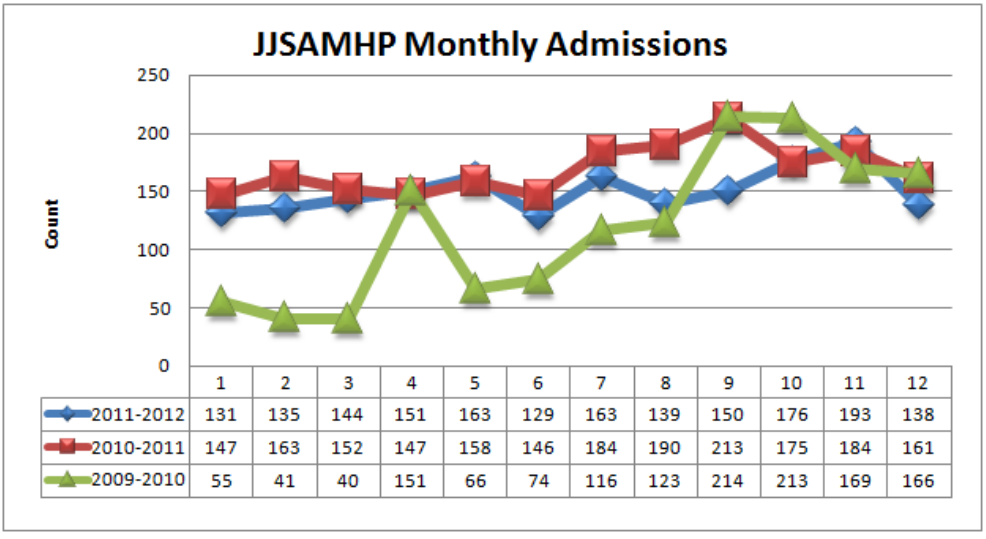


	1	2	3	4	5	6	7	8	9	10	11	12
2011-2012	196	174	205	197	209	180	200	205	187	231	243	187
2010-2011	197	222	205	204	208	180	226	264	297	233	250	221
2009-2010	103	88	120	117	118	150	198	171	291	311	227	214

JJSAMHP Domain III: Engagement

The third JJSAMHP domain is engagement –particularly utilizing System of Care Principles. Although engagement can entail various areas, including partnering with families, etc., the focus was ensuring admission to a partnering provider who agreed to include Child and Family Teams as part of the continuum of care. 100% of the teams cite regular usage of Child and Family Teams. There were 1,812 admissions to JJSAMHP providers during 2011-2012. It is noted that several of the teams do not have the capability to track when referring youth outside of the partnering provider array, so there are likely youth who are referred to another provider but not captured in these numbers since it is based on admissions by partnering providers. For the first half of the fiscal year (July through December) there were 853 admissions to local JJSAMHP providers and for the second half of the fiscal year (January through June), there were 959 admissions to JJSAMHP providers. To determine the number of admissions for each LME/MCO across this time period, please see the section entitled "Local Team Processes." The following graphs represent the total admissions to JJSAMHP partner providers for 2011-2012 and then a comparison of this fiscal year with the previous fiscal years.

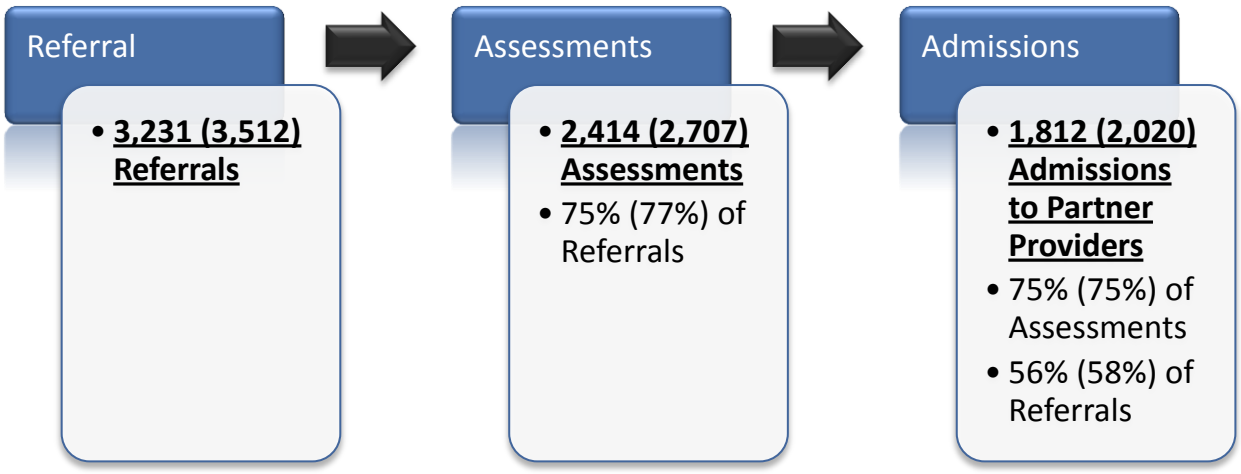




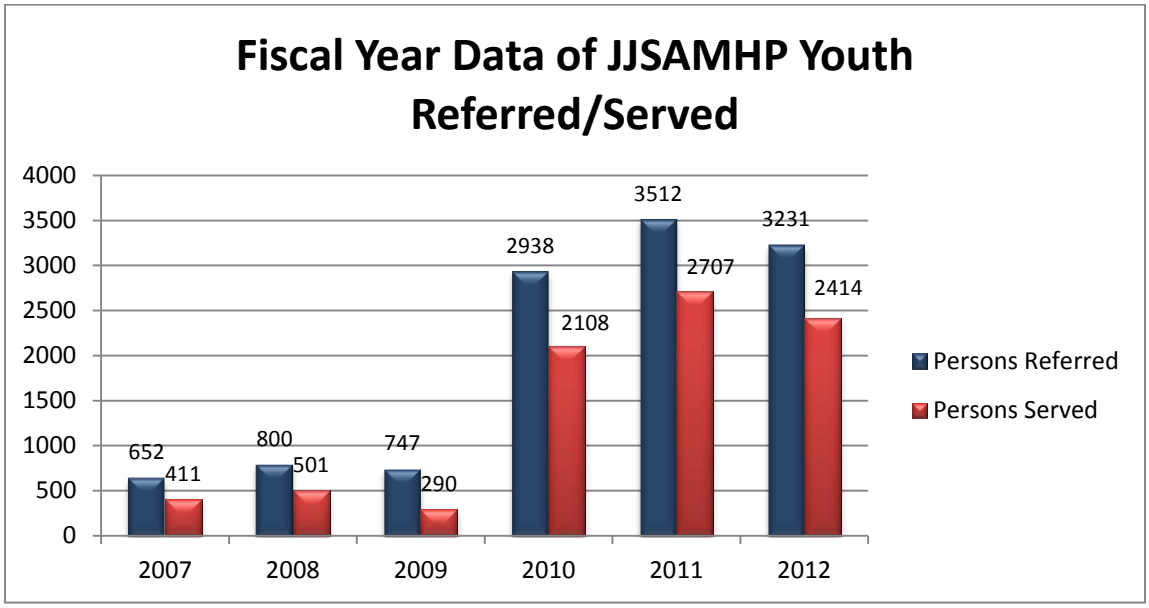
	1	2	3	4	5	6	7	8	9	10	11	12
2011-2012	131	135	144	151	163	129	163	139	150	176	193	138
2010-2011	147	163	152	147	158	146	184	190	213	175	184	161
2009-2010	55	41	40	151	66	74	116	123	214	213	169	166

Overall Process Numbers for JJSAMHP for 2011-2012

The next graphic outlines how many youth overall were referred by DJJ into the JJSAMH Partnership, then assessed by a JJSAMHP affiliated provider and then admitted to a JJSAMHP affiliated provider (as a reminder, some youth are referred to providers outside of the partnership for services based on their needs). The overall numbers are slightly lower than last year but still higher than fiscal year 2009-2010. It is noted that during this year, the Department of Juvenile Justice and Delinquency Prevention became the Division of Juvenile Justice under the Department of Public Safety. Additionally, there were significant activities, including LME mergers, in preparation for implementing the 1915 b/c Medicaid Waiver. One of the consequences was significant LME staffing changes across the state. Given this shift within the two major partners, the teams appeared to maintain progress in getting youth and their families into services. Additionally, during this transition year, each team was able to develop engagement goals (see Spring Regional Report in Appendix C) for the 2012-2013 fiscal year. **The numbers in parentheses represent the figures for 2010-2011 fiscal year.**

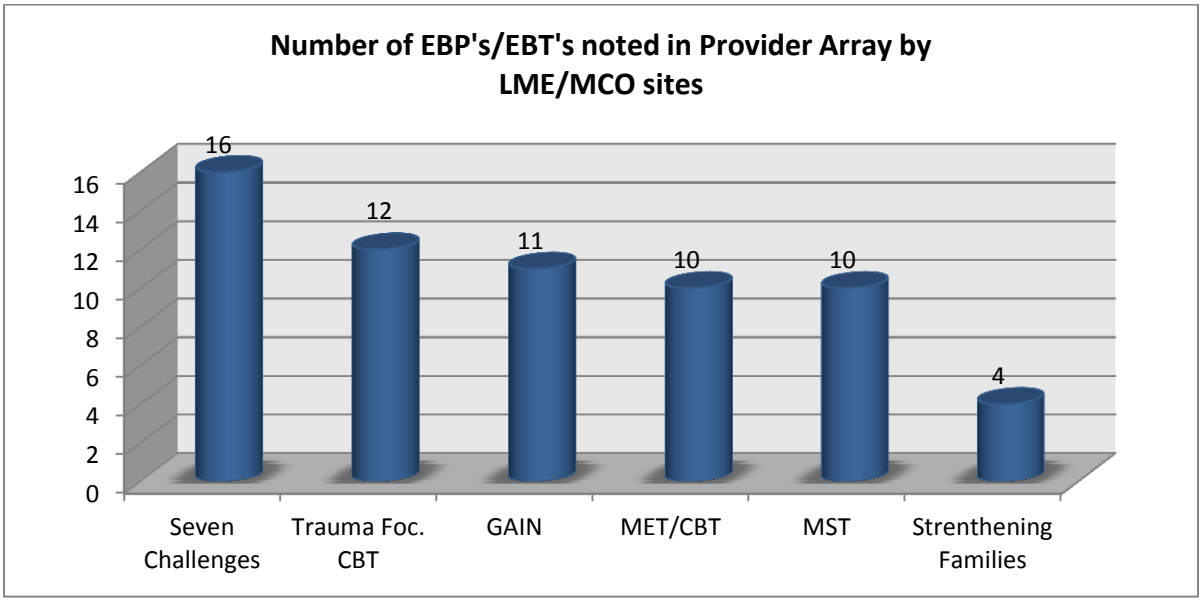


Additionally, there is data on the number of youth referred by DJJ to a JJSAMHP provider (formerly MAJORS), and the number of youth who were admitted to a JJSAMHP provider for services. The next graphic outlines this information over the last five fiscal years. Notably, during Years 2007, 2008, 2009 (MAJORS), only substance abusing youth were being tracked and in 2010, 2011, and 2012 (JJSAMHP), youth with mental health issues were also tracked.



JJSAMHP Domain IV: Evidence Based Practices/Evidence Based Treatments

The fourth domain is usage of Evidence Based Practices/Treatments. All teams cite having providers that use evidence based treatments within their service array. The most commonly used EBT's/EBP's are in the chart below (only those with 3 or more sites are listed). This information is provided by the teams but this is not a check into the actual fidelity of the treatment/practice. The Evidence Based Practices/Treatments include: Seven Challenges, Multisystemic Therapy (MST), Global Appraisal of Individual Needs (GAIN), Trauma Focused Cognitive Behavioral Therapy, Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET/CBT), and Strengthening Families. GAIN is an Evidence Based Assessment; Seven Challenges, MST, Trauma Focused CBT, and MET/CBT are Evidence Based Treatments; and Strengthening Families is an Evidence Based Prevention program. For more information on these EBP's/EBT's, please refer to: http://turninglivesaround.org/publications.html.



JJSAMHP Domain V: JCPC Involvement-Developing Recovery Oriented Systems of Care and Ensuring "Beyond Treatment" Activities

The last domain involves inclusion of Juvenile Crime Prevention Council (JCPC) programming, particularly with respect to Recovery Oriented Systems of Care (ROSC).

ROSC is defined as the following:

> *Recovery-oriented systems of care are designed to support individuals seeking to overcome substance use disorders across the lifespan. Participants at the Summit declared, "There will be no wrong door to recovery" and also recognized that recovery-oriented systems of care need to provide "genuine, free and independent choice" (SAMHSA, 2004) among an array of treatment and recovery support options. Services should optimally be provided in flexible, unbundled packages that evolve over time to meet the changing needs of recovering individuals. (USDHHS, 2009)*

For the purposes of JJSAMHP, the focus is to build upon treatment services to address the needs of not only youth with substance abuse issues, but also youth with mental health issues as well. This is described by Reclaiming Futures as "Beyond Treatment" and entails involvement in other community based activities such as mentoring and leadership development to address the holistic needs of the youth and their families as recovery often includes natural supports and helps that can only be provided by the community. DJJ leadership is involved with both JJSAMHP and the local JCPC team.

Section D: Activities and Accomplishments of JJSAMHP for Fiscal Year 2011-2012

This section outlines the overall Activities and Accomplishments of the JJSAMHP for the 2011-2012 Fiscal Year. This will be detailed in four (4) areas that helped shape the review of activities: 1) Strengthen Partnerships, Communication, and Information Sharing; 2) Improve Data Reporting; 3) Provide Support for Training and Technical Assistance; 4) Provide Support for Usage of Evidence Based Practices/Evidence Based Treatments/Best Practices. Each of these areas is outlined below, followed by a listing of major accomplishments of JJSAMHP:

1. Strengthen Partnerships, Communication and Information Sharing

One of the goals of this fiscal year was to continue support for partnerships' provision of services for JJSAMHP youth, and provide opportunities for teams to share their local processes. Local teams meet at varying frequencies from quarterly to every week (for clinical staffing). This information can be found in the Compendium of Services. Additionally, the state level partnership meets regularly to review and discuss the initiative and processes and to obtain and provide feedback. Additionally, the focus was to increase communication and sharing of information between state level and local partners to assist in providing support to local teams. The main activities are highlighted below that helped towards achieving this goal:

A. One of the main activities was to continue to educate teams on funding opportunities for services for JJSAMHP youth and the different types of funding available to ensure service delivery. This was accomplished through Regional Meetings, communications from DMHDDSAS, emails, phone calls, etc. The goal was to communicate that if any youth needed services, there shouldn't be a barrier for them to receive those services. Additionally, teams were encouraged to use funding to provide support for gaps in service delivery such as necessary training and support.
B. Another main activity for JJSAMHP during this fiscal year was provision of Regional Meetings based on the needs of the teams and to increase collaboration amongst the teams at the meetings. Both Regional meetings this year focused on Engagement and educating teams on ways to engage youth and to ensure service provision. The Fall Regional Meeting Report is included in Appendix B, and the Spring Regional Meeting Report is included in Appendix C.
    1. The Fall Regional Meetings were planned in collaboration with state partners, Young Adult Advocates, and Family Partners during the first quarter of the fiscal year. One main activity was involvement of Young Adult Advocates in a Powerpoint/Panel Session. The Young Adult Advocates then met with individual groups and led discussions around engagement and System of Care Issues. Teams received information about effective ways to partner with young adults to increase engagement. The three Regional meetings were held on the following dates at the following locations with number of individuals as noted:
        a. Fayetteville, Holiday Inn Bordeaux, November 2nd -60 total participants

b. Hickory, Crowne Plaza Hickory, November 7th -45 participants
c. Greenville, Hilton Greenville, November 9th-78 participants

2. The Spring Regional Meetings were planned in collaboration with state and regional partners and during the third quarter. The meetings were held in the fourth quarter. The theme for the meetings was "Creating an Effective System of Care for Juvenile Justice Involved Youth." One of the main highlights was presentations on Care Coordination from various LME/MCO staff (as the state moves toward managed care). Additionally, there was dissemination of information on partnerships and Lessons Learned and engaging youth in residential settings. The other main highlight was that teams presented on their goals for the next fiscal year on ways they would better engage youth and their families. These goals are included in the Spring Regional Meeting report. The three Regional meetings were held on the following dates at following locations with number of individuals as noted:
   a. May 1st-Durham at Millennium Hotel-60 participants
   b. May 3rd- Hickory at the Crown Plaza Hotel-55 participants
   c. May 16th-Greenville at the Greenville Hilton-60 participants

B. The Compendium of Services is maintained as a resource document through work with local teams (specifically LME/MCO liaisons). This year, it was helpful to involve a Family Partner in maintaining information from LME/MCO liaisons. This allows for individuals to see various roles that Family Partners can play in working with JJSAMHP teams. It outlines the key team partners, juvenile justice youth served, services provided, referral, assessment, and treatment processes. The link to the Compendium is located at http://www.turninglivesaround.org/JJSAMHP%20Compendium%20of%20Services.pdf.

C. Continued updating of JJSAMHP website, including a new portal for Substance Abuse Residential beds. The website is www.turninglivesaround.org.

D. Provision of monthly updated Technical Assistance (TA) document that is provided to state and regional level partners to ensure better understanding of type of work being completed by sites. Each TA on-site visit and each substantial contact (such as teleconferences or research requests) is noted in a TA Document.

2. Improve Data Reporting

This second area for the fiscal year was to improve already existing data reporting mechanisms to help increase the ability to describe local and state processes. This includes two forms of data: the monthly report that is required by the Division of LME/MCO partners and the collection of North Carolina Treatment Outcomes and Program Performance System that is required by providers:

A. The teams continued to use the data system that was introduced last year, Qualtrics, through UNCG. This allowed local teams to generate a report of their data at the time of submission. The main data points continue to be referrals, assessments, and admissions. UNCG worked with teams on the data system and compliance/accuracy of data submissions. This includes training new liaisons since there were many staff changes through the year. Reports were generated and provided to state level partners and local teams when requested. The survey questions are

located in Appendix D. It is noted that at the end of 2011-2012 fiscal year, the data for detention was changed to reflect extensive training during the year in Evidence Based practices.

B. The second domain was collection/distribution of NC-TOPPS data. This is to assist in providing more information about quality and treatment provided to youth who are admitted to services. JJSAMHP state partners and UNCG provided mid-and end-year information out to teams about NC-TOPPS data. Teams were also presented their data a local team meetings and options for NC-TOPPS usage was presented at the Spring Regional Team meetings. The NC-TOPPS forms are included in Appendix E. Additionally; teams were given information such as is outlined in Appendix F which looks at NC-TOPPS information and treatment completion and Educational outcomes.

C. One additional area that was worked on was obtaining university (UNCG) and Division (DMHDDSAS) approval to utilize individual, de-identified, NC-TOPPS data. The UNCG researchers applied for these two approvals and achieved them by the end of the fiscal year. The focus in 2012-2013 will be to utilize this data to generate more helpful updates for the local JJSAMHP teams, Regional, and state partners.

3. Provide Support for Training and Technical Assistance

A. Technical Assistance. Another activity of the JJSAMHP was to provide technical assistance directly to local teams. The state level partners requested that teams be visited at least two times during the year. There were a total of 83 site visits to teams from July, 2011 through June, 2012. These visits helped to identify barriers at the local team level and possible solutions/information from state level partners, information sharing on evidence based practices, and sharing of other team's processes as ways to address barriers and encouragement of usage of funds to support processes. There were numerous emails and short phone calls that are not documented here but this was also provided to teams, particularly around evidence based treatment questions, data collection, or general JJSAMHP processes.

The following visits were completed by UNCG or UNCG contractors:

Type of Contact	*First Quarter*	*Second Quarter*	*Third Quarter*	*Fourth Quarter*
On-Site Visits	1. ECBH-July 11th 2. Eastpointe-July 14th 3. Five County-July 15th 4. Southeastern Regional-July 15th 5. Guilford-August 16th 6. Five County-August 19th 7. Alamance Caswell-August 23rd 8. Five County Halifax-August 24th	1. ECBH-October 3rd 2. Five County-October 6th 3. Sandhills-October 17th 4. Guilford-October 18th 5. Five County-October 21st 6. Onslow Carteret-October 24th 7. ECBH Northeast-October 27th	1. PBH-January 6th 2. Sandhills-January 9th 3. ECBH-January 10th 4. Guilford-January 17th 5. PBH-OPC-January 20th 6. Onslow Carteret-January 23rd 7. Beacon-February 2nd 8. PBH-February 3rd 9. ECBH-February 6th 10. Durham-February 8th	1. ECBH-April 2nd 2. Durham-April 16th 3. Guilford Center-April 17th 4. Onslow Carteret-April 23rd 5. Wake-April 27th 6. ECBH-NE-April 27th 7. PBH-Five County-April 30th 8. PBH-Piedmont-May 4th

Type of Contact	*First Quarter*	*Second Quarter*	*Third Quarter*	*Fourth Quarter*
	9. Orange Person Chatham-August 25th 10. Beacon Center-September 1st 11. ECBH-September 6th 12. Western Highlands-September 9th 13. Five County-September 16th 14. Piedmont Behavioral Health-September 16th 15. Southeastern Center-September 26th 16. Onslow Carteret-September 26th 17. Five County Halifax-September 28th 18. Southeastern Regional- September 30th	8. Onslow Carteret-October 28th 9. Crossroads-November 1st 10. Eastpointe-November 3rd 11. Beacon-November 3rd 12. Five County-November 18th 13. District 9 Community Forum attendance-November 21st 14. Durham-December 1st 15. Alamance Caswell-December 2nd 16. Southeastern Regional-December 2nd 17. PBH-December 2nd 18. District 8 Community Forum-December 9th 19. Guilford-December 12th	11. CenterPoint-February 10th 12. PBH-OPC February 17th 13. Guilford-February 21st 14. Southeastern Regional-February 21st 15. Onslow Carteret-February 27th 16. ECBH-March 5th 17. Sandhills-March 5th 18. Western Highlands-March 15th 19. PBH-OPC-March 16th 20. Southeastern Center-March 19th 21. Guilford-March 20th 22. Southeastern Regional-March 20th 23. ECBH NE-March 23rd 24. Onslow Carteret-March 26th 25. Beacon-March 27th 26. PBH-Five County-March 29th	9. ECBH-May 7th 10. Sandhills-May 15th 11. SER-May 17th 12. PBH-OPC-May 18th 13. PBH-AC-May 18th 14. Guilford Center Drug Court Team meeting-May 23rd 15. PBH-Five County-May 23rd 16. Durham-June 7th 17. ECBH-June 11th 18. PBH-OPC-June 15th 19. PBH-Five County-June 19th 20. Guilford Center-June 19th
Scheduled or planned phone technical assistance phone conferences or other Substantial Contact	1. August 16th-PBH-call on changes in data processes and update on information about JJSAMHP and role 2. Onslow Carteret team meeting by phone-August 22nd 3. Onslow Carteret-Multiple dates around 10/25/11-Consulted with State level System of Care Coordinator, and with direct residential liaisons about Onslow Carteret juvenile justice involved youth with multiple (medical, substance abuse, and mental health) challenges. Obtained liaison information and passed to team and made phone calls to help find placement for youth 4. Western Highlands-Responded to information about GAIN SS and provided information to Chief in the area about usage of GAIN SS-12/14/11 5. NC-TOPPs State team meeting September 16th 6. Guilford-January 27-Attended DJJ Forum at Request of Chief 7. Guilford-January 31-provided drug court research at request of provider and team 8. Southeastern Regional-February 2-phone conference with SER LME/MCO reps and Paul Savery about expectations for JJSAMHP 9. Southeastern Center-February 16th –phone call with JCC supervisor about needs for JJSAMHP within their county 10. Guilford-March 9th- Conference call with LME/MCO rep about need for coordination for JJSAMHP team and description of JJSAMHP needs 11. Eastpointe-March 14th and after-discussion with team and planning for day long trauma training 12. PBH-Five County-March 19th and beyond-phone calls with Chief and PBH liaison about needs 13. CenterPoint-June 8th-meeting with new liaison 14. CenterPoint-week of June 11th-significant calls, emails about restructuring of JJSAMHP in area 1. PBH-Five County-June 2012-Assisted in finding out information through Chestnut and GAIN trainers for team to get GAIN training set up locally			

B. Additionally, there was focus again on increasing capacity for Evidence Based Assessments and Treatments. This included training detention, residential, and community providers on the Global Appraisal of Individual Needs and Seven Challenges. This also included training detention staff on using the Brief Challenges-which is designed for settings such as detention. North Carolina was one of the first sites to use this intervention from the Evidence Based Treatment Program-Seven Challenges. Additionally, staff were trained on Trauma Informed care and recognizing trauma's impact on mental health and substance abuse outcomes. Lastly, training was also provided to Juvenile Court Counselors on the GAIN Short Screener.

Training	Brief Description of Trainings	Number of Participants Attending Trainings
7/14/11	Chatham YDC training Part 1 and Part 2	1. 15 Youth Development Center staff; at Chatham YDC in Siler City
9/19/11	Trauma Informed Care training for Five County Collaborative	2. 20 Community Collaborative members at Aycock Recreation in Henderson, NC
9/22-9/23/11	Training at the Central Area DJJDP Conference-Training on Mental Health issues for juvenile justice involved youth	3. 70 DJJ staff and community collaborators
October, 2011-November 2011	Training of Young Adult Partners for participation in regional meetings-multiple dates	4. 7 young adults at CYFCP at UNCG
	Fall Regional Meetings on Engagement Issues	5. Fayetteville-Holiday Inn Bordeaux(28 local)-November 2nd 6. Hickory, Crowne Plaza Hickory (44 local)-November 7th 7. Greenville, Hilton Greenville (57 local) November 9th 8. 24 State, Regional and contractor representatives could attend more than one meeting
11/15-11/16	GAIN Assessment Training	9. 12 Behavioral Health clinicians; at UNCG
11/17/11	GAIN Short Screener training for Court Counseling staff	10. 16 Juvenile Court Counseling staff, District 19; Asheboro, NC
12/5-12/6	GAIN Assessment Training	11. 6 Behavioral Health clinicians and one supervisor audit; at UNCG
2/16/12	Provided training on Advocating for youth with behavioral health issues in school settings-Durham County clinical and guidance staff	12. 70 school staff ; in Durham

Training	Brief Description of Trainings	Number of Participants Attending Trainings
3/21-3/23	Coordinated Seven Challenges Initial Training at Bryan Park Conference Center-lunch and location provided	13. 54 SA clinicians at Bryan Park, Greensboro, NC
May 1st, May 3rd, and May 16th	Regional Meetings-training on Creating an Effective System of Care	14. May 1st-Central DJJ Area-Millennium Hotel (Durham)-49 local participants 15. May 3rd-Western/Piedmont DJJ Area-Crowne Plaza (Hickory)-43 local participants 16. May 16th-Eastern DJJ Area-Greenville Hilton (Greenville)-48 local participants 17. 19 State or Regional level participants attended at least one of the three meetings
May 10th	Training on Effective Providers for Victimized Children (APA training)	18. 19 Behavioral Health clinicians; at Eastpointe LME, Kinston, NC
May 22-24	Facilitated Training for Seven Challenges-Leader training	19. 18 SA clinicians; at UNCG, Greensboro, NC
May-June, 2012	Facilitated contracts and resource allocation and initial training session for Brief Challenges training for Detention SAS clinicians in coordination with Seven Challenges administration	20. 9 SA clinicians; at various locations in NC-training by teleconference with Seven Challenges
June 27	Training for Juvenile Court Counselors in District 9 on GAIN Short Screener	21. 14 Juvenile Court Counseling staff; at Aycock Recreation Center, Henderson, NC
June 29	Training for Juvenile Court Counselors on GAIN Short Screener	22. 23 Juvenile Court Counseling staff; at Wake County Division of Juvenile Justice Office, Raleigh, NC

4. Provide Support for Usage of Evidence Based Practices/Evidence Based Treatments and Best Practices

The goal is to encourage and support teams in the utilization of evidence based practices/evidence based treatments and opportunities for teams to increase their ability to provide more effective services to juvenile justice involved youth and their families. This entailed the following activities (See training section for actual support provided for training by JJSAMHP).

A. See table above for EBP training including strengthening EBP usage in for detention clinicians;

B. Provision of Overview/Awareness training on EBT's and usage of the GAIN as requested;

C. Provided support to teams on Seven Challenges and GAIN related issues;

D. Provision of training based on previously identified needs including Trauma Informed Care for partners per request.

Major Accomplishments from 2011-2012 Activities

A listing of Major Accomplishments from the Activities of JJSAMHP for fiscal year 2011-2012 is noted below:

- 83 Technical Assistance visits completed with local JJSAMHP teams during this period and twelve (12) substantial contacts for research and follow up (does not include routine email questions, phone calls, etc.)
- Provision of 11 Technical Assistance Reports on visits to local JJSAMHP teams (one month period there were no visits)
- Participation in 21 state level team meetings or teleconferences
- Contracting twice per year for Regional meetings in 3 locations across the state: included facilitation of meeting location, dates, agenda, speakers, registration, and documentation for the meetings: Key themes of the meetings were Engagement (Fall) and Creating an Effective System of Care (Spring)-There were 153 participants in the Fall Regional meetings and 159 participants in the Spring Regional meetings
- Collected monthly data and distribution to state and regional partners monthly and throughout the year to local partners; distributed MPGH and detention data to key state partners
- Developed 2 NC-TOPPS updates and distributed to partnerships
- Reformatted NC-TOPPS data for easier review and distributed to state, regional, and local partners per state team's request
- Participated in NC-TOPPS Task Force
- Responded to NC-TOPPS queries from local teams
- Obtained approval from UNCG IRB and DHHS to obtain de-identified individual level data.
- Sent out emails from the state per request of team
- Updated the SA Residential census weekly from 8 facilities and uploaded on the JJSAMHP website
- Updated Compendium per LME/MCO liaisons requests and requested changes to Compendium to fiscal year-received half of teams changes and other teams wanted to wait until MCO transitions were completed
- Provided Trauma Informed Care Training to 15 Chatham Youth Development Center Staff (Part 1 and Part 2)
  Provided Trauma Informed Care Training to 20 Five County Collaborative members
- Provided training on behavioral health issues to 70 DJJ staff and their community collaborators at Area meeting
- Provided training on Behavioral Health Issues in Juvenile Justice to 70 counseling/social work staff in Durham County Public Schools
- Provided training to 19 behavioral health clinicians in Effective Providers for Child Victims of Violence in Eastpointe area
- Worked with SA state Coordinator and Seven Challenges in developing plan to facilitate Seven Challenges and Brief Challenges training and developed RFA, provided for review of applications, and selected applicants for different levels of training (by committee)
- Facilitated training for Seven Challenges Initial training on March 21-23 in Greensboro for 54 SA clinicians (including CEUs)
- Provided training for 18 SA clinicians (including CEUs) for Seven Challenges Leaders at UNCG on May 22-24th
- Facilitated contracting, resource allocation, and initial training for 9 Detention SAS clinicians in Brief Challenges

- Served as liaison for GAIN and Seven Challenges (Regional Leader) issues and concerns
- Completed GAIN Short Screener Training for a total of 53 JCC staff during the year
- Finalized Residential Substance Abuse Brochure including printing of 1,000 brochures with over half going to SA residential locations and others to partners at meetings
- Assisted in completion of Detention Substance Abuse Services guide
- Provided monthly training information on SA listserve and online
- Provided training to 7 Young Adult Partners in preparation for meetings and working with teams
- Supervised graduate student who completed draft Engagement toolkit and present Toolkit poster at Regional meetings in Spring (toolkit is under revision)

*Section E: LOCAL TEAM PROCESSES * indicates team will have name change in 2012-2013*

This section outlines all of the local team processes within each of the local JJSAMHP sites by LME/MCO. As a reminder, there are some sites where there is more than one team, and even differentiation within team based on Court District preferences. The following table provides a general overview of Screening and Assessment processes for each of the LME/MCOs and which DJJ youth are engaged for JJSAMHP. After this table, each LME/MCO main processes are outlined. More information can be obtained from the Compendium of Services at www.turninglivesaround.org.

LME/MCO	*Screening Measure*	*Assessment Measure*	*Adjudicated*	*Diversion with Contract*	*All Intakes*	*Pre-Adjudication*	*Dedicated Assessor*
Beacon Center*	GAIN-SS	GAIN	X	X	X	X	
Center Point	GAIN-SS	GAIN	X	X	X	X	X
Crossroads*	GAIN-SS	CCS	X	X	X		
Cumberland*	GAIN-SS	GAIN	X	X		X	
Durham Center*	GAIN-SS	CCA	X	X			X
East Carolina Behavioral Health	GAIN-SS	GAIN/CCA	X	X			
Eastpointe	GAIN-SS	GAIN	X	X	X	X	
Guilford*	GAIN-SS	CCA			All intakes through DJJ	X	
Onslow-Carteret*	GAIN-SS	CCA	X	X			
PBH*	GAIN-SS	GAIN	X	X		X	
PBH-Alamance – Caswell Area*	Risk & Needs Assessment	CCA	X	X			
PBH-Five County*	GAIN-SS-4 County JJ TC Screener-Halifax	GAIN-4 County JJTC CCA-Halifax	X-District 6	X District 6	All intakes through DJJ-District 9		
PBH-Orange-Person-Chatham*	GAIN-SS	Juvenile Automated Substance Abuse Evaluation/GAIN	X	X		X	
Sandhills	GAIN-SS	GAIN	Varies by District by all adjudicated				
Southeastern Center*	GAIN-SS and MAYSI	CCA-Psychologist Assessment through JCPC	X	X		X	X
Southeastern Regional*	Risk & Needs Assessment	GAIN			All intakes through DJJ		
Wake County*	No measure-use JCERT process	CCA	X	X		X	X
Western Highlands	GAIN-SS	GAIN	X	X		X	

*THE BEACON CENTER**

Key Team Members**

Tiffany Purdy
System of Care Coordinator

Brooke Futrell
System of Care Coordinator

Mike Walston
Chief-District 7

Joe Testino (until June, 2012)**
Chief-District 8

Terri Proctor
District 7 Supervisor

Amy Watson
Pride in NC

Serafina Dowdy
Easter Seals UCP NC & VA, Inc.

Susan Meador
Pathways to Life

Affiliated Counties: Edgecombe, Greene, Nash, Wilson

Screening Process: Juvenile Court Counselors use the GAIN-SS on any court involved youth (complaint filed, diversion, probation, court supervision, PRS). Any youth who scores in Moderate or High range is referred to the Assessment Provider (A New Horizons, Inc.). DJJ also supplies the juvenile data sheet to the Assessment Provider.

Assessment Process: The provider completes the GAIN assessment. Following recommendations for services the consumer/guardian has the option to receive services from the provider performing the assessment or choose another provider in the network.

Treatment Process: The Provider Agencies will confirm initial appointment with family. They will conduct Child and Family Team meetings and hold one every 30 days for the youth. Information about treatment will be provided monthly to DJJ staff and the Provider Agencies will be tracking the data and reporting it back to the LME/MCO staff.

2011-2012 Data

	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011	January 2012	February 2012	March 2012	April 2012	May 2012	June 2012	Total	% of Ref.
Referrals	20	19	25	16	15	13	13	8	17	12	9	11	178	---
Assessments	15	15	18	9	14	7	12	4	9	6	8	9	126	71%
Admissions[1]	15	13	19	8	14	6	11	2	7	4	6	6	111	62%
Discharges	0	0	---	---	---	---	---	---	---	---	---	---	---	---

[1] Note that these admissions are to JJSAMHP Providers only and does not include other agencies that work with youth but do not provide data

*Name reflects 2011-2012 nomenclature and is changed for 2012-2013 fiscal year; **DJJ also had staffing changes in June, 2012

CENTERPOINT HUMAN SERVICES

Key Team Members*

Kathi Perkins*
Network Development Specialist

Bibba Dobyns*
Network Development Manager

Rusty Slate
Chief-District 17

Stan Clarkson
Chief-District 21

Krista Hiatt
Chief-District 22

Amanda Vernon
Daymark Recovery Services

Sam Gray
Partnership for a Drug Free America

Cheryl Goldberg
The Children's Home

Affiliated Counties: Davie, Forsyth, Rockingham, Stokes

Other JJ Initiatives Reclaiming Futures

Screening Process: All youth who come into the court office are screened using the GAIN-SS. If a youth scores 5 or higher on the GAIN-SS (or indicates high risk such as endorsing suicidal thoughts), they will be sent to the JJSAMHP funded counselor housed in DJJ for an assessment.

Assessment Process: The JJSAMHP funded counselor meets with the juvenile and their family and conducts a GAIN-Quick or schedules a GAIN I, as needed and asks additional questions. Based on their responses, the youth may immediately be referred for services. The JJSAMHP funded counselor works to have an appointment in the family's hands when they leave the courthouse.

Treatment Process: Services are provided by three main Providers unless there is a need that the provider cannot address and the youth and their family are then referred to an outside provider.

CenterPoint Forsyth/Stokes/Davie-2011-2012 Data

	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011	January 2012	February 2012	March 2012	April 2012	May 2012	June 2012	Total	% of Ref.
Referrals	5	4	4	3	6	5	8	10	16	22	9	4	96	---
Assessments	4	4	4	4	5	3	6	6	9	7	10	3	65	68%
Admissions[2]	1	1	2	1	4	2	2	4	5	5	8	1	36	38%
Discharges	3	0	---	---	---	---	---	---	---	---	---	---	---	---

CenterPoint-Rockingham-2011-2012 Data

	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011	January 2012	February 2012	March 2012	April 2012	May 2012	June 2012	Total	% of Ref.
Referrals	4	2	3	0	2	3	0	2	4	6	0	0	26	---
Assessments	3	3	2	0	0	0	1	0	1	8	4	0	22	85%
Admissions	1	3	2	0	0	0	1	0	1	8	4	3	23	88%
Discharges	2	0	---	---	---	---	---	---	---	---	---	---	---	---

[2] Note that these admissions are to JJSAMHP Providers only and does not include other agencies that work with youth but do not provide data; * New team members at end of the fiscal year

*CROSSROADS**

Key Team Members**

Candice Moore**	**Tara Conrad**	**Rusty Slate**
System of Care Coordinator	Director of Community Planning	District 17
Krista Hiatt	**Bill Davis**	**Tonya Oakley**
District 22	District 23	Easter Seals/UCP
Ron Baczurik	**Celeste Reed**	**George Edmonds**
Daymark Recovery Services	Barium Springs Home for Children	Youth Villages

Affiliated Counties: Iredell, Surry, Yadkin

Other JJ Initiatives Reclaiming Futures
Juvenile Justice Treatment Continuum

Screening Process: Intake Counselors utilize the GAIN Short Screener on any youth that is adjudicated and on youth with diversion contract. The results are forwarded to any of the four providers according to location and district.

Assessment Process: All four providers utilize the Comprehensive Clinical Assessment for their assessments and has a team of licensed professionals and qualified professionals that work together to complete the assessment process. The information from the assessment is then shared with the family, treatment provider (s) and DJJ staff to help in directing and organizing the Child and Family Team. The youth and their family can be referred to anyone in a network of providers in the area.

Treatment Process: Youth are referred to services based on their needs and as outlined in their Child and Family Team. Child and Family Teams are held at least one time a month or more often based on the needs of the youth and their family. The teams also work to include a family partner for each family that can advocate and assist in engagement processes for the families.

2011-2012 Data

	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011	January 2012	February 2012	March 2012	April 2012	May 2012	June 2012	Total	% of Ref.
Referrals	3	3	12	3	4	2	4	0	2	3	6	2	44	---
Assessments	4	6	3	7	4	2	2	2	2	3	4	7	46	105%
Admissions[3]	4	4	2	4	4	2	2	1	1	3	4	7	38	86%
Discharges	4	5	---	---	---	---	---	---	---	---	---	---	---	---

[3] Note that these admissions are to JJSAMHP Providers only and does not include other agencies that work with youth but do not provide data

*Name reflects 2011-2012 nomenclature and is changed for 2012-2013 fiscal year; **New team leader at end of fiscal year

*CUMBERLAND**

Key Team Members

Debbie Jenkins
Local MH Administrator

Sharon Glover
System of Care Coordinator

Claretta Johnson
Substance Abuse Liaison

Michael Strickland
Chief-District 12

Mark Stang
Reclaiming Futures

Yvonne Smith
Cumberland CommuniCare

Affiliated Counties: Cumberland

Other JJ Initiatives Reclaiming Futures

Screening Process: Any court involved youth are screened by the court counseling staff with the GAIN SS and are referred if there is possible indication of substance abuse. Youth are then referred to Cumberland CommuniCare.

Assessment Process: Each youth will receive an assessment using the GAIN Initial and also will receive a urine test. If youth has a DSM-IV diagnosis for substance abuse or substance dependence, they are then admitted into JJSAMHP services.

Treatment Process: Treatment is holistic, with family and community based supports to "wrap" services around juveniles in ways to reduce/eliminate substance use and avoid future legal consequences. Services are generally provided through Cumberland CommuniCare unless the youth needs something outside of their service array.

2011-2012 Data

	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011	January 2012	February 2012	March 2012	April 2012	May 2012	June 2012	Total	% of Ref.
Referrals	10	13	14	12	18	8	9	12	16	7	12	16	147	---
Assessments	6	13	10	6	11	16	7	13	19	6	7	14	128	87%
Admissions[4]	6	10	10	6	10	12	7	11	11	6	6	12	107	73%
Discharges	4	8	---	---	---	---	---	---	---	---	---	---	---	---

[4] Note that these admissions are to JJSAMHP Providers only and does not include other agencies that work with youth but do not provide data

*Name reflects 2011-2012 nomenclature and is changed for 2012-2013 fiscal year

*THE DURHAM CENTER**

*Key Team Members***

Peter Baker**
Substance Abuse Point of Contact

Nancy Kent**
System of Care Coordinator

Lena Klumper
Director of Quality Management

Calvin Vaughan
Chief-District 14

Heidi Donhert
Carolina Outreach

Jennifer McRant
Criminal Justice Resource Center

Bobbie Hopf
Youth Villages

Tanesha McCauley
Vision Quest Residential – Durham

James Robinson
Easter Seals MST

Affiliated Counties: Durham

Screening Process: DJJ office uses the GAIN Short Screener for Adjudicated Delinquent, Adjudicated Undisciplined, and Diversion contract youth. This information is passed on to a full time assessor.

Assessment Process: An assessor, being funded by JJSAMHP, conducts all the assessments at DJJ office. The assessor is employed by an adult provider, which helps eliminate pressure to refer to services within the agency.

Treatment Process: The family selects from Best Practice services based on recommendation of JJSAMHP Assessor and Child and Family team. CFT meetings should be held once per month and drive service decision for the youth and the family.

2011-2012 Data

	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011	January 2012	February 2012	March 2012	April 2012	May 2012	June 2012	Total	% of Ref.
Referrals	19	19	13	10	16	12	14	11	13	18	12	10	167	---
Assessments	17	13	11	13	14	11	13	18	9	21	7	10	157	94%
Admissions[5]	7	11	11	12	13	10	13	18	9	20	7	9	140	84%
Discharges	31	2	---	---	---	---	---	---	---	---	---	---	---	---

[5] Note that these admissions are to JJSAMHP Providers only and does not include other agencies that work with youth but do not provide data

*Name reflects 2011-2012 nomenclature and is changed for 2012-2013 fiscal year; **Transitioned from team at end of fiscal year

EAST CAROLINA BEHAVIORAL HEALTH-SOUTHERN AREA

Key Team Members

Keith Letchworth
System of Care Coordinator

Amy Bryant
System of Care Coordinator

Mark Leggett/Bill Batchelor
Chief/Supervisor*-District 2

Mary Mallard/Brian Stewart
Chief/Supervisor-District 3

Tracy Williams Arrington/ Russell Turner
Chief/Supervisor-District 4

Jennifer Hardee/Debbie Sudekum
PORT Human Services

Affiliated Counties: Beaufort, Craven, Jones, Pamlico, Pitt

Screening Process: Districts 2, and 3 use the GAIN-SS and the Risks and Needs Assessment to determine which youth need to be referred to JJSAMHP. District 4 uses the Risk and Needs Assessment.

Assessment Process: All Districts use the GAIN on youth referred to the JJSAMHP team.

Treatment Process: For Districts 2, 3, and 4, treatment is based on the decision in the CFT, youth are then referred either to the Assessment Provider or a partner providing agency. Child and Family teams will be held monthly or more frequently for youth.

2011-2012 Data

ECBH- Beaufort

	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011	January 2012	February 2012	March 2012	April 2012	May 2012	June 2012	Total	% of Ref.
Referrals	2	0	0	2	0	0	4	1	1	1	2	2	15	---
Assessments	0	0	0	2	0	0	0	2	1	2	2	1	10	67%
Admissions[6]	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Discharges	3	0	---	---	---	---	---	---	---	---	---	---	---	---

[6] Note that these admissions are to JJSAMHP Providers only and does not include other agencies that work with youth but do not provide data

ECBH – Craven/Pamlico

	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011	January 2012	February 2012	March 2012	April 2012	May 2012	June 2012	Total	% of Ref.
Referrals	6	3	6	5	4	0	5	7	5	11	11	1	64	---
Assessments	2	1	3	4	5	2	3	7	0	4	3	3	37	58%
Admissions[7]	0	1	2	2	3	0	0	3	0	1	1	0	13	20%
Discharges	0	0	---	---	---	---	---	---	---	---	---	---	---	---

ECBH – Pitt

	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011	January 2012	February 2012	March 2012	April 2012	May 2012	June 2012	Total	% of Ref.
Referrals	1	0	0	0	1	2	1	0	0	0	0	2	7	---
Assessments	2	0	0	0	1	1	0	0	0	0	0	1	5	71%
Admissions	2	0	0	0	1	1	0	0	0	0	0	1	5	71%
Discharges	0	0	---	---	---	---	---	---	---	---	---	---	0	---

[7] Note that these admissions are to JJSAMHP Providers only and does not include other agencies that work with youth but do not provide data

*Note that key team members changed at the end of the fiscal year in June (due to DJJ staffing changes) and are not reflected on these pages to represent the team members for most of the year. The new staffing patterns for DJJ are reflected in tables for the Chiefs following this section.

EAST CAROLINA BEHAVIORAL HEALTH-NORTHEAST AREA

Key Team Members

Sarah Massey
System of Care Coordinator

Tracey Webster
System of Care Coordinator

Sherri Ellington
Chief-District 1

Mark Leggett
Chief-District 2

Kim Huckoby/Garrett Taylor
Uplift Foundation

Affiliated Counties: Camden, Chowan, Currituck, Dare, Hyde, Martin, Pasquotank, Perquimans, Tyrrell, Washington

Screening Process: Juvenile Court Counselors use the GAIN-SS District 1-Diversion Contract and Adjudication and for District 2-Diversion, Pre-Adjudication, Adjudication, and PRS. Court Counselors complete a referral sheet on any youth who scores in the Moderate or High range. Family members must sign a consent form in order to participate. Then, a referral is faxed to the Assessment Provider Uplift Foundation.

Assessment Process: The GAIN-I is being used by Uplift, who is certified in administration of the GAIN. After the assessment is completed, a Child and Family Team is held.

Treatment Process: The Assessment provider will refer families to services based on the CFT meeting to either their agency or to another agency in the community.

2011-2012 Data

	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011	January 2012	February 2012	March 2012	April 2012	May 2012	June 2012	Total	% of Ref.
Referrals	---	4	4	12	7	5		5	3	3	5	12	60	---
Assessments	---	3	4	7	4	5		5	3	3	4	9	47	78%
Admissions[8]	---	2	3	5	3	4		4	3	2	3	7	36	60%
Discharges	---	---	---	---	0	---		---	---	---	---	---	---	---

[8] Note that these admissions are to JJSAMHP Providers only and does not include other agencies that work with youth but do not provide data

EASTPOINTE

*Key Team Members**

Suzanne Nix-until June, 2012**
Provider Relations

Phyllis Greene-until June, 2012**
System of Care Coordinator

Ken Jones
Director

Joe Testino-until June, 2012**
Chief-District 8

Don Neal
Waynesboro Family Clinic

Family First Support Center
Howard Calhoun

Donna Ramsey
Precision Healthcare

Tom Savage
PORT Human Services

Affiliated Counties: Lenoir, Wayne

Screening Process: Staff utilize the GAIN Short Screener and youth with a Moderate or High Score are referred to one of three assessment Providers: Waynesboro Family Clinic, PORT Human Services, and Family First Support Center.

Assessment Process: A GAIN Initial or Core assessment is completed on each youth that is referred by JJSAMHP. Information from the assessment is shared with JJSAMHP staff and used for Child and Family team process. The youth and family are encouraged to participate in recommended services where they have been assessed by a partner provider. Should other services be needed or youth and family prefer another provider, client choice is allowed.

Treatment Process: A Child and Family Team is held for each youth after their assessment is completed. Child and Family teams are then held once per month or more often if needed and decisions about treatment are made in collaboration with the family.

2011-2012 Data

	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011	January 2012	February 2012	March 2012	April 2012	May 2012	June 2012	Total	% of Ref.
Referrals	14	6	12	16	21	11	19	16	14	11	11	12	163	---
Assessments	13	11	6	12	15	16	8	21	11	15	8	11	147	90%
Admissions[9]	9	10	6	10	13	13	8	17	14	15	8	10	133	82%
Discharges	0	0	---	---	---	---	---	---	---	---	---	---	0	---

[9] Note that these admissions are to JJSAMHP Providers only and does not include other agencies that work with youth but do not provide data; ** Note that there were some key team member changes at the end of the fiscal year

*THE GUILFORD CENTER**

Key Team Members

Tamra Mell
Best Practice Specialist

Carmen Graves
Chief-District 18

Lisa Salo
System of Care Coordinator

Lylan Wingfield
Youth Focus

Quentin Leak
Alcohol and Drug Services

Maxine Hammonds
Court Counselor Supervisor

Dannette McCain
Reclaiming Futures Director

Carri Munns
Specialty Courts Manager

Lawrence Bass
Court Counselor Supervisor

Joe Fortin
RF Community Fellow

David Pate
Therapeutic Alternatives

Affiliated Counties: Guilford

Screening Process: The Juvenile Court Counselors screen all adjudicated youth and youth with diversion contracts using the GAIN SS. Any youth with moderate or high scores on any subscale (except CJ score) are referred to Youth Focus for an assessment. Consent for referral is obtained on each youth.

Assessment Process: Youth Focus completes a Comprehensive Clinical Assessment on DJJ referred youth.

Treatment Process: Youth Focus will lead the initial Child and Family Team meeting. Based on assessment results and Child and Family Team recommendations, youth are referred for services either to Youth Focus or to another partnering agency in the community.

2011-2012 Data

	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011	January 2012	February 2012	March 2012	April 2012	May 2012	June 2012	Total	% of Ref.
Referrals	18	13	20	10	24	18	13	17	24	10	28	10	205	---
Assessments	15	13	12	12	12	19	11	9	12	10	14	10	149	73%
Admissions[10]	12	13	11	12	9	14	10	7	10	7	13	7	125	61%
Discharges	0	2	---	---	---	---	---	---	---	---	---	---	---	---

[10] Note that these admissions are to JJSAMHP Providers only and does not include other agencies that work with youth but do not provide data

*ONSLOW-CARTERET**

Key Team Members**

Kathryn Hunsucker (until June, 2012)**
System of Care Coordinator

Lisa Moncrief (until June, 2012)**
Provider Relations*

Tracy Arrington and Russell Turner
Chief/Supervisor-District 4

Mary Mallard
Chief-District 3

*See Compendium of Services for a listing of Partnering Provider Agencies at www.turninglivesaround.org

Joann Chavis**
Carolina Psychological & Psychiatric Services

Affiliated Counties Carteret, Onslow

Screening Process: Intake Counselors utilize the brief GAIN. DJJ staff will determine if a potential mental health or substance abuse problem exist. DJJ staff will refer consumer to Carolina Psychological and Psychiatric Services if follow-up support and services are indicated.

Assessment Process: The Carolina Psychological Health Services clinician will meet with the youth and family to receive a full assessment utilizing a standardized, evidenced based best practice tool such as the GAIN to identify and clarify the reason for referral, the presenting challenges, available resources, strengths of the consumer and family, areas of needed improvement, services consumer is eligible for, and services recommended.

Treatment Process: In cases where enhanced services are recommended for youth, youth services are based on the system of care model and the Child and Family Team (CFT) serves to guide services and treatment. After the Assessment with specific treatment recommendations, a CFT will be held to develop the Person Centered Plan that will drive the recommended services. In addition to the recommended paid services, natural supports and resources will be identified and incorporated into the plan.

2011-2012 Data

	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011	January 2012	February 2012	March 2012	April 2012	May 2012	June 2012	Total	% of Ref.
Referrals	5	8	8	13	9	7	16	20	19	11	13	17	146	---
Assessments	6	4	5	6	8	6	4	18	7	15	9	9	97	66%
Admissions[11]	1	1	0	3	0	6	4	14	6	14	8	9	66	45%
Discharges	---	4	---	---	---	---	---	---	---	---	---	---	---	---

[11] Note that these admissions are to JJSAMHP Providers only and does not include other agencies that work with youth but do not provide data; *Name reflects 2011-2012 nomenclature and is changed for 2012-2013 fiscal year; **Note that there were key staff changes during this fiscal year

*PBH-Alamance Caswell Area**

Key Team Members

Fran Harvey
System of Care Coordinator

Sonya Carter
Care Coordination Manager

Jennifer Short (until June, 2012)**
Chief-District 9

Peggy Hamlett
Chief-District 15

Anthony Hanes/Chris Porsenna
TASK, Inc.

Affiliated Counties: Alamance, Caswell

Screening Process: Youth are screened by court counseling staff and they currently use the Risk and Needs Assessment to determine which youth to refer for an assessment. Youth will be referred to TASK Inc.

Assessment Process: TASK completes a Comprehensive Clinical Assessment on each youth referred from DJJ. Youth who have SA issues are mainly referred to TASK and youth with MH issues will have a choice of various providers in the community.

Treatment Process: Each youth will have a Child and Family Team that will help design and guide treatment options. The Child and Family Team meets at least monthly for each youth and other child serving agencies as well as family advocates are actively recruited to be part of the treatment process for each youth.

2011-2012 Data

	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011	January 2012	February 2012	March 2012	April 2012	May 2012	June 2012	Total	% of Ref.
Referrals	0	3	7	1	6	1	1	4	13	3	7	1	47	---
Assessments	5	0	4	5	1	1	0	4	2	3	5	1	31	66%
Admissions[12]	5	2	4	5	1	1	0	3	2	2	4	1	30	64%
Discharges	3	3	---	---	---	---	---	---	---	---	---	---	---	---

[12] Note that these admissions are to JJSAMHP Providers only and does not include other agencies that work with youth but do not provide data: *Name reflects 2011-2012 nomenclature and is changed for 2012-2013 fiscal year; **Note that DJJ had staff changes at the end of the fiscal year

*PBH-FIVE COUNTY COC**

Key Team Members

Lynette Fuller
System of Care Coordinator

Marni Cahill
MH/SA Care Coordination Manager

Charles Quint
Network Manager

Clarence High
Chief-District 6

Jennifer Short –Until June, 2012/**
David Carter
Chief/Supervisor-District 9

Stephanie Slaughter
Family Preservation Services

Natasha Holley
Integrated Family Services

Bobbie Hopf
Youth Villages

Serafina Dowdy
Easter Seals

Dana Greenway
Triumph

Affiliated Counties: Franklin, Granville, Halifax, Vance, Warren

Screening Process: The Risk and Needs Assessment is completed in Halifax and GAIN Short Screener is used in the four other counties. Juvenile Family Data Sheet and screening information is provided to all providers except Integrated Family Services, by facsimile.

Assessment Process: District 6 uses a Comprehensive Clinical Assessment modeled after the JJTC Assessment and Global Appraisal of Individual Needs used in 4 other counties (District 9).

Treatment Process: Families are provided services through Integrated Family Services and Family Preservation Services unless there is a service not within these provider's arrays. If a child is receiving an enhanced benefit, child and family team meetings are to occur every 30 days in Halifax County. High priority cases are staffed weekly and non-high priority cases are staffed at least once per month. In 4 Counties, Child and Family teams are held as needed.

Five County- Four County 2011-2012 Data

	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011	January 2012	February 2012	March 2012	April 2012	May 2012	June 2012	Total	% of Ref.
Referrals	11	4	6	18	21	11	10	10	14	14	10	7	136	---
Assessments	3	2	6	7	1	1	5	5	5	5	7	4	51	38%
Admissions[13]	0	2	5	5	1	0	6	4	4	4	5	3	39	29%
Discharges	0	1	---	---	---	---	---	---	---	---	---	---	---	---

Five County- Halifax 2011-2012 Data

	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011	January 2012	February 2012	March 2012	April 2012	May 2012	June 2012	Total	% of Ref.
Referrals	3	3	3	2			6	5	3	11	9	8	53	---
Assessments	0	1	2	2			2	4	0	9	13	6	39	74%
Admissions	0	1	2	2			2	4	0	9	13	8	41	77%
Discharges	0	0	---	---			---	---	---	---	---	---	---	---

[13] Note that these admissions are to JJSAMHP Partnering Providers only and does not include other agencies that work with youth but do not provide data

*Name reflects 2011-2012 nomenclature and is changed for 2012-2013 fiscal year; **Note that key team members changed at the end of the fiscal year

*PBH-ORANGE-PERSON-CHATHAM COC**

Key Team Members

Lisa Lackmann
System of Care Coordinator

Anne Levin
DJJ/PBH Liaison

Jennifer Short (until June, 2012)/**
David Carter
Chief/Supervisor-District 9

Peggy Hamlett
Chief-District 15

Beth Barwick
Easter Seals UPC, Inc.

Russel Knop/Tania Peterson
Freedom House

Bobbie Hopf
Youth Villages

Ulaine Washington
Triumph

Diane Norblad
Carolina Outreach

Karen Brooks
Securing Resources for Consumers

Laura Conaty
Center for Behavioral Healthcare

Rick Rawitz
Institute for Family Centered Services

Affiliated Counties: Chatham, Orange, Person

Screening Process: All youth who come to the court counseling office for intakes receive the GAIN SS. If the youth has a red flag on the GAIN SS or on the Risk and Needs Assessment, he/she is referred to the OPC/DJJ Liaison.

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Assessment Process: DJJ Providers use the JASAE and the UCLA PTSD RI assessment tools for all youth referred by DJJ. Providers can use the GAIN I if they have staff certified in its use.

Treatment Process: Services will be offered based on the assessments. Youth receiving enhanced services will have monthly Child and Family Teams which will coordinate their plans using a strength-based approach.

2011-2012 Data

	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011	January 2012	February 2012	March 2012	April 2012	May 2012	June 2012	Total	% of Ref.
Referrals	15	12	9	22	20	18	23	12	14	20	41	31	237	---
Assessments	12	12	8	16	15	10	18	7	11	14	32	20	175	74%
Admissions[14]	9	10	7	14	13	8	14	6	10	9	27	15	142	60%
Discharges	0	0	---	---	---	---	---	---	---	---	---	---	--	---

[14] Note that these admissions are to JJSAMHP Providers only and does not include other agencies that work with youth but do not provide data

*Name reflects 2011-2012 nomenclature and is changed for 2012-2013 fiscal year; **Note that DJJ had staff changes at the end of the fiscal year

*PBH-Piedmont COC**

Key Team Members**

Pam Burton (until May, 2012)**
Regional MH/SA Care Coordination Manager

Tracy Threatt (until May 2012)**
Provider Relations

Laurie Whitson
System of Care Coordinator

Deidre Webb
MHSA Care Coordination Manager

Krista Hiatt
Chief-District 22

Emily Coltrane
Chief-District 19

Kelly Boling (Interim)
Chief-District 20

Mackie Johnson
RHA

Jean Tillman
Daymark Recovery Services

LaRuth Brooks
Youth Villages

Tim Tilley
Family Services of Davidson

Dr. Arlana Sims
Sims Consulting and Clinical Services

Greg Yousey
Carolina Counseling and Consulting, LLC

Affiliated Counties: Cabarrus, Davidson, Rowan, Stanly, Union

Screening Process: Court involved youth will receive a GAIN SS. Each DJJ will identify which youth will receive this screening based on their current structure and individual district/county needs. Based on the outcome of the GAIN SS the Court Counselor will offer child/family provider choice and make referral to one of the Partnership providers for GAIN-I assessment.

Assessment Process: The Partnership clinician will complete a full GAIN assessment and make clinically appropriate recommendations. The assessing clinician will offer the consumer/family provider choice and make referrals to identified service and chosen partnership provider.

Treatment Process: The treating provider will serve as the Clinical Home for the referred youth. The Clinical Home is responsible for coordination and facilitation of Child and Family Team meetings. Children receiving enhanced services have monthly CFT meetings.

2011-2012 Data

	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011	January 2012	February 2012	March 2012	April 2012	May 2012	June 2012	Total	% of Ref.
Referrals	1	2	9	3	18	13	21	20	19	47	37	29	219	---
Assessments	0	2	7	2	11	9	10	9	4	12	13	10	89	41%
Admissions[15]	0	1	2	2	8	5	12	5	4	7	9	5	60	27%
Discharges	---	---	---	---	---	---	---	---	---	---	---	---	---	---

[15] Note that these admissions are to JJSAMHP Providers only and does not include other agencies that work with youth but do not provide data

*Name reflects 2011-2012 nomenclature and is changed for 2012-2013 fiscal year; **Note that there were changes in staffing during this fiscal year

THE SANDHILLS CENTER

Key Team Members

Lucy Dorsey
System of Care Coordinator

Gene McRay
Customer Services Director

Marsha Woodall
Chief-District 11

Lance Britt
Chief-District 16

Kelly Boling (Interim)
Chief-District 20

Emily Coltrane
Chief-District 19

La Vang/Jerry Earnhart
Daymark Recovery Services

Affiliated Counties: Anson, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond

Screening Process: DJJ

Assessment Process: If a youth has substance abuse issues primary, they are referred to Daymark Recovery for an assessment and they utilize the GAIN. If the youth has MH issues in screening, then they are referred to Daymark or another provider in the area.

Treatment Process: Each county's DJJ office has monthly meetings with Daymark to staff the youth who are referred to JJSAMHP services. Youth have Child and Family Team meetings monthly which are led by their service provider.

2011-2012 Data

	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011	January 2012	February 2012	March 2012	April 2012	May 2012	June 2012	Total	% of Ref.
Referrals	45	40	42	38	48	26	32	31	57	38	47	29	473	---
Assessments	34	23	32	32	39	26	28	27	40	31	38	22	372	79%
Admissions[16]	34	28	36	36	44	27	30	27	41	32	40	8	383	81%
Discharges	14	17	---	---	---	---	---	---	---	---	---	---	---	---

[16] Note that these admissions are to JJSAMHP Providers only and does not include other agencies that work with youth but do not provide data

*SOUTHEASTERN CENTER**

Key Team Members

Amy Horgan
System of Care Coordinator

Jessica Dosher
Substance Abuse Point of Contact

Susan Hanson
Clinical Director

Robert Speight
Chief-District 5

Olaf Thorsen
Chief-District 13

*See Compendium of Services for a listing of Partnering Provider Agencies at www.turninglivesaround.org

Affiliated Counties: New Hanover, Pender, Brunswick

Screening Process: The local DJJ office will use the GAIN SS and MAYSI to determine which youth are to be referred for an assessment.

Assessment Process: The assessments are conducted by a psychologist on staff at the juvenile court district.

Treatment Process: Youth with substance abuse issues are referred to PORT Human Services and youth with predominantly MH issues as well as SA issues are referred to Coastal Horizons for treatment. Assessments that recommend family work are referred to Youth Villages for MST & school concerns are referred to Physician's Alliance for Day Treatment.

2011-2012 Data

	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011	January 2012	February 2012	March 2012	April 2012	May 2012	June 2012	Total	% of Ref.
Referrals	19	7	11	15	14	12	16	13	20	21	22	13	183	---
Assessments*	17	13	30	9	14	14	11	14	11	18	22	13	186	102%
Admissions[17]	3	1	---	2	2	4	1	0	---	--	3	1	17	9%
Discharges	0	0	---	---	---	---	---	---	---	---	---	---	---	---

[17] Note that these admissions are to JJSAMHP Providers only and does not include other agencies that work with youth but do not provide data; *Name reflects 2011-2012 nomenclature and is changed for 2012-2013 fiscal year

*SOUTHEASTERN REGIONAL**

Key Team Members**

Tammy Oxendine
Care Coordination/System of Care Supervisor

Gary Allen (until June, 2012)**
Provider Relations

Olaf Thorson
Chief-District 13

Barden Grimes**
Robeson Health Care Corporation (until April, 2012)

Lance Britt
Chief-District 16

Greg Worthington
Supervisor-District 13

Advantage Behavioral
Barry Graham

Allied Behavioral
Larry Crib/Marie Tutwiler

Holistic Services
Carolyn Floyd-Robinson

Primary Health Choice
Alice Hunt

Saguaro Group (Community Innovations)
Ivan Pride/Martha Locklear

Affiliated Counties: Bladen, Columbus, Robeson, Scotland

Screening Process: Juvenile Court Counselors complete the Risk and Needs Assessment for any court involved youth (complaint filed, diversion, probation, court supervision, PRS). Any youth determined to be eligible for a referral; guardian will be assisted in contacting the LME/MCO Call Center to choose a partnership provider. DJJ will forward the Risk and Needs assessment results to the chosen the Provider Agencies.

Assessment Process: The provider completes the GAIN assessment. Following recommendations for services the consumer/guardian has the option to receive services from the provider performing the assessment or choose another provider in the network.

Treatment Process: Each youth has a Child and Family Team and all youth in residential care have a monthly Child and Family Team meeting.

2011-2012 Data

	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011	January 2012	February 2012	March 2012	April 2012	May 2012	June 2012	Total	% of Ref.
Referrals	9	7	11	3	7	10	18	5	0	0	3	0	73	---
Assessments	4	5	5	4	2	2	8	2	2	0	3	0	37	51%
Admissions[18]	0	1	1	0	0	0	4	0	0	0	3	0	9	12%
Discharges	2	1	---	---	---	---	---	---	---	---	---	---	---	---

[18] Note that these admissions are to JJSAMHP Providers only and does not include other agencies that work with youth but do not provide data

*Name reflects 2011-2012 nomenclature and is changed for 2012-2013 fiscal year; **Note that key team members changed at the end of the fiscal year

*WAKE COUNTY HUMAN SERVICES**

*Key Team Members***

Beth Nelson (until June, 2012)**
Substance Abuse Point of Contact

Greta Gill (until June, 2012)**
System of Care Coordinator

Eric Johnson
Care Coordinator

Donald Pinchback
Chief-District 10

*See Compendium of Services for a listing of Partnering Provider Agencies at www.turninglivesaround.org

Affiliated Counties: Wake

Screening Process: Screenings are conducted on any court involved youth (diversion contracts and more involved) who are not already receiving treatment services. The youth and families are referred for evaluations by juvenile court counselors based on identified screening indicators that reflect a need for assessment and possible treatment services. If a youth comes to the attention of DJJ already in services with a treatment provider, the DJJ Court Counselor reviews the PCP with provider and family to determine if the current level of care is appropriate. If the youth is not connected to treatment services, a referral is made to the Juvenile Court Evaluation and Referral Team (JCERT) for a comprehensive MH/SA evaluation.

Assessment Process: JCERT is made up of 1.25 FTE licensed clinicians who complete a single, comprehensive, individualized clinical evaluation process to assess mental health and substance abuse issues, determine eligibility for available funding sources, make recommendations, and link the juvenile court involved youth and their families to appropriate mental health and substance abuse services and supports.

Treatment Process: The comprehensive and individualized evaluation process yields better outcomes for youth and families through objective matching of youth to appropriate services and supports based on professional assessment recommendations and consumer choice. Once the youth and families engage with a treatment provider, a Child and Family Team is initiated to develop and monitor a person centered plan (PCP). The Child and Family Teams meet monthly, as well as any time there is an urgent need to review/revise the PCP.

2011-2012 Data

	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011	January 2012	February 2012	March 2012	April 2012	May 2012	June 2012	Total	% of Ref.
Referrals	20	23	30	32	21	17	48	27	33	35	26	23	335	---
Assessments	24	22	25	28	19	19	33	15	19	28	18	14	264	79%
Admissions[1920]	15	14	12	18	9	6	19	0	12	17	10	16	148	44%
Discharges	16	---	---	---	---	---	---	---	---	---	---	---	---	---

[19] Note that these admissions are to JJSAMHP Partnering Providers only and does not include other agencies that work with youth but do not provide data

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WESTERN HIGHLANDS

Key Team Members

Brenda Chapman
Substance Abuse Provider Specialist

Donald Reuss
Director of Provider Relations

Lisa Garland
Chief-District 24

Rodney Wesson
Chief-District 29

Anthony Jones (until Summer, 2012)
Chief-District 28

Bill Westel/Jon McDuffie
Mentor Network/Families Together

Danielle Arias
RHA/ARP

Youth Villages
George Edmonds

Vern Eleazer
Swain Recovery Center

Affiliated Counties: Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania, Yancey

Screening Process: The initial point of entry is through the completion of a face-to-face screening by DJJ court counselor utilizing the GAIN Short Screen. Individuals who score positive on this instrument or who have other factors indicating possible substance abuse/co-occurring disorders are referred for a comprehensive clinical assessment utilizing the full GAIN. Additionally a urine drug screen will be conducted on all youth who are referred for a mental health assessment to determine need for more in-depth substance abuse assessment.

Assessment Process: A comprehensive clinical assessment utilizing the GAIN full screen is completed by Families Together, the and provides the clinical basis for the development of the Person Centered Plan (PCP), establishes medical necessity for services and recommends a Level of Care using ASAM Patient Placement Criteria (ASAM-PPC) . When indicated,, the service provider makes referrals or provides resources for other family members

Treatment Process: Treatment Services are determined through a comprehensive assessment process and must meet medical necessity as determined by the provider and the LME/MCO. Services may include outpatient individual or group therapy, multi- family therapy, intensive in-home, MST, or residential services, as well as referral for prevention services. Some services, such as intensive in-home, may be limited in some areas due to current availability in all counties (we are in the process of developing service continuum capacity in all counties). A System of Care approach is utilized throughout the treatment process.

2011-2012 Data

	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011	January 2012	February 2012	March 2012	April 2012	May 2012	June 2012	Total	% of Ref.
Referrals	10	8	8	15	27	20	13	13	10	11	12	10	157	---
Assessments	10	8	8	10	14	15	13	13	10	11	12	10	134	85%
Admissions[21]	7	6	7	4	11	12	13	9	10	11	11	9	110	70%
Discharges	3	5	---	---	---	---	---	---	---	---	---	---	---	---

[21] Note that these admissions are to JJSAMHP Providers only and does not include other agencies that work with youth but do not provide data

Appendix A-Chief Distribution by County AS OF JUNE 2012 and LME/MCO Designation			
District	*County*	*Chief Court Counselor*	*LME/MCO*
1	Camden	SHARON ELLINGTON	ECBH-Northeast
1	Chowan	SHARON ELLINGTON	ECBH-Northeast
1	Currituck	SHARON ELLINGTON	ECBH-Northeast
1	Dare	SHARON ELLINGTON	ECBH-Northeast
1	Gates	SHARON ELLINGTON	ECBH-Northeast
1	Pasquotank	SHARON ELLINGTON	ECBH-Northeast
1	Perquimans	SHARON ELLINGTON	ECBH-Northeast
2	Beaufort	MARK LEGGETT/SUPERVISOR BILL BATCHELOR	ECBH
2	Hyde	MARK LEGGETT	ECBH-Northeast
2	Martin	MARK LEGGETT	ECBH-Northeast
2	Tyrrell	MARK LEGGETT	ECBH-Northeast
2	Washington	MARK LEGGETT	ECBH-Northeast
3	Pitt	MARY MALLARD/ SUPERVISOR BRIAN STEWART	ECBH
3	Carteret	MARY MALLARD	Onslow Carteret
3	Craven	MARY MALLARD	ECBH
3	Pamlico	MARY MALLARD	ECBH
4	Duplin	TRACY WILLIAMS ARRINGTON/SUPERVISOR RUSSELL TURNER	Not JJSAMHP
4	Jones	TRACY WILLIAMS ARRINGTON	ECBH
4	Onslow	TRACY WILLIAMS ARRINGTON	Onslow Carteret
4	Sampson	TRACY WILLIAMS ARRINGTON	Not JJSAMHP
5	New Hanover	ROBERT SPEIGHT	Southeastern Center
5	Pender	ROBERT SPEIGHT	Southeastern Center
6	Halifax	CLARENCE HIGH	PBH-Five County
6	Bertie	CLARENCE HIGH	Not JJSAMHP
6	Hertford	CLARENCE HIGH	Not JJSAMHP
6	Northampton	CLARENCE HIGH	Not JJSAMHP
7	Edgecombe	MIKE WALSTON/SUPERVISOR TERRI PROCTOR	Beacon

Appendix A-Chief Distribution by County AS OF JUNE 2012 and LME/MCO Designation			
District	*County*	*Chief Court Counselor*	*LME/MCO*
7	Nash	MIKE WALSTON	Beacon
7	Wilson	MIKE WALSTON	Beacon
8	Greene	JOE TESTINO/SUPERVISOR JERRY BURNS	Beacon
8	Lenoir	JOE TESTINO	Eastpointe
8	Wayne	JOE TESTINO	Eastpointe
9	Franklin	JENNIFER SHORT/ SUPERVISOR DAVID CARTER	PBH-Five County
9	Granville	JENNIFER SHORT	PBH-Five County
9	Vance	JENNIFER SHORT	PBH-Five County
9	Warren	JENNIFER SHORT	PBH-Five County
9	Caswell	JENNIFER SHORT	PBH-AC area
9	Person	JENNIFER SHORT	PBH-OPC
10	Wake	DONALD PINCHBACK	Wake
11	Harnett	MARSHA WOODALL	Sandhills
11	Johnston	MARSHA WOODALL	Not JJSAMHP
11	Lee	MARSHA WOODALL	Sandhills
12	Cumberland	MIKE STRICKLAND	Cumberland
13	Bladen	OLAF THORSEN	Southeastern Regional
13	Brunswick	OLAF THORSEN	Southeastern Center
13	Columbus	OLAF THORSEN	Southeastern Regional
14	Durham	CALVIN VAUGHAN	Durham
15	Alamance	PEGGY HAMLETT/SUPERVISOR STEVE FISHEL	PBH-AC area
15	Chatham	PEGGY HAMLETT	PBH-OPC
15	Orange	PEGGY HAMLETT	PBH-OPC
16	Hoke	LANCE BRITT	Sandhills
16	Scotland	LANCE BRITT	Southeastern Regional
16	Robeson	LANCE BRITT	Southeastern Regional
17	Rockingham	RUSTY SLATE	CenterPoint

Appendix A-Chief Distribution by County AS OF JUNE 2012 and LME/MCO Designation			
District	***County***	***Chief Court Counselor***	***LME/MCO***
17	Stokes	RUSTY SLATE	CenterPoint
17	Surry	RUSTY SLATE	Crossroads
18	Guilford	CARMEN GRAVES	Guilford
19	Cabarrus	EMILY COLTRANE/SUPERVISOR RANDY JONES	PBH
19	Montgomery	EMILY COLTRANE	Sandhills
19	Moore	EMILY COLTRANE	Sandhills
19	Randolph	EMILY COLTRANE	Sandhills
19	Rowan	EMILY COLTRANE	PBH
20	Anson	KELLY BOLING (INTERIM)	Sandhills
20	Richmond	KELLY BOLING (INTERIM)	Sandhills
20	Stanly	KELLY BOLING (INTERIM)	PBH
20	Union	KELLY BOLING (INTERIM)	PBH
21	Forsyth	STAN CLARKSON	CenterPoint
22	Alexander	KRISTA HIATT	Not JJSAMHP
22	Davidson	KRISTA HIATT	PBH
22	Davie	KRISTA HIATT	CenterPoint
22	Iredell	KRISTA HIATT	Crossroads
23	Alleghany	BILL DAVIS	Not JJSAMHP
23	Ashe	BILL DAVIS	Not JJSAMHP
23	Wilkes	BILL DAVIS	Not JJSAMHP
23	Yadkin	BILL DAVIS	Crossroads
24	Avery	LISA GARLAND	Not JJSAMHP
24	Madison	LISA GARLAND	Western Highlands
24	Mitchell	LISA GARLAND	Western Highlands
24	Watauga	LISA GARLAND	Not JJSAMHP
24	Yancey	LISA GARLAND	Western Highlands
25	Burke	RONN ABERNATHY	Not JJSAMHP

Appendix A-Chief Distribution by County AS OF JUNE 2012 and LME/MCO Designation			
District	***County***	***Chief Court Counselor***	***LME/MCO***
25	Caldwell	RONN ABERNATHY	Not JJSAMHP
25	Catawba	RONN ABERNATHY	Not JJSAMHP
26	Mecklenburg	LAURA McFERN	Not JJSAMHP
27	Gaston	CAROL McMANUS	Not JJSAMHP
27	Cleveland	CAROL McMANUS	Not JJSAMHP
27	Lincoln	CAROL McMANUS	Not JJSAMHP
28	Buncombe	ANTHONY JONES	Western Highlands
29	Henderson	RODNEY WESSON	Western Highlands
29	McDowell	RODNEY WESSON	Western Highlands
29	Polk	RODNEY WESSON	Western Highlands
29	Rutherford	RODNEY WESSON	Western Highlands
29	Transylvania	RODNEY WESSON	Western Highlands
30	Cherokee	DIANNE WHITMAN	Not JJSAMHP
30	Clay	DIANNE WHITMAN	Not JJSAMHP
30	Graham	DIANNE WHITMAN	Not JJSAMHP
30	Haywood	DIANNE WHITMAN	Not JJSAMHP
30	Jackson	DIANNE WHITMAN	Not JJSAMHP
30	Macon	DIANNE WHITMAN	Not JJSAMHP
30	Swain	DIANNE WHITMAN	Not JJSAMHP

APPENDIX B-FALL REGIONAL REPORT

JJSAMHP Fall 2011 Regional Meetings

This document includes a summary of the JJSAMHP Fall Regional Team meetings including individual impressions of the Regional Meetings-compiled and tabulated by the UNCG Center for Youth, Family and Community Partnerships

Summary of Document Contents

Enclosed is the Overall Summary for the Regional Team Meetings held in November, 2011. The report is outlined in four different areas:

I. Meeting Locations
II. Meeting Participants
III. Meeting Agenda
IV. Individual Evaluations of Meeting
V. Local Team Meetings Engagement Responses

I. Meeting Locations: Regional Meetings were held in the following locations based on DJJDP Areas:

Area	*Counties*	*Date*	*City*	*Location*
Central (DJJDP Area)	Alamance, Bladen, Brunswick, Caswell, Chatham, Columbus, Cumberland, Durham, Franklin, Granville, Harnett, Hoke, Lee, Orange, Person, Robeson, Scotland, Vance, Wake, Warren,	Nov 2nd	Fayetteville	Holiday Inn Bordeaux
Western/Piedmont (DJJDP Areas)	Anson, Buncombe, Cabarrus, Davidson, Davie, Forsyth, Guilford, Henderson, Iredell, Madison, Mitchell, Montgomery, Moore, Polk, Randolph, Richmond, Rockingham, Rowan, Rutherford, Stanly, Stokes, Surry, Transylvania, Union, Yadkin, Yancey	Nov 7th	Hickory	Crowne Plaza Hickory
Eastern (DJJDP Area)	Beaufort, Bertie, Camden, Carteret, Chowan, Craven, Currituck, Dare, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Jones, Lenoir, Martin, Nash, New Hanover, Northhampton, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Pitt, Tyrell, Washington, Wayne, Wilson	Nov 9th	Greenville	Greenville Hilton

II. Meeting Participants:

Overall, there were **129** **Local** Participants who attended the Regional Meetings across the state (there were 130 in the Spring). There were24 State/Regional/Contractor Participants who attended the Regional Meetings (some attended more than one meeting so they are only counted one time). The breakdown of the types of personnel that attended each meeting is indicated below and a listing of each person who attended each meeting is available upon request:

Participants in Regional Meetings

	Western/Piedmont	Eastern	Central
LME Representatives	12	8	13
DJJDP Local Court Counseling Representatives	9	16	11
Provider Representatives	7	30	18
Other Representatives	0	3	2
Total Local Participants	28	57	44
Total State/Regional	17	21	16
Total Participants	**45**	**78**	**60**

III. Meeting Agenda

The overall agenda for each meeting varied and was changed after the first meeting in the Central Area and all three are located below.

Central Area-November 2nd

9:00-9:30 Registration
9:30-9:45 Welcome & Introductions
- *Maxine Evans Armwood*

9:45-9:55 What is Engagement?
9:55-11:10 Young Adult Panel on Engagement/Questions
- *Young Adult Advocates/Family Advocates*

11:10-11:25 Break and Movement to Assigned Tables
11:25-12:30 Engagement of Juvenile Justice Involved Youth -Cross Team
- *Young Adult Advocates/Family Advocates*

12:30-1:30 Lunch On Site
1:30-1:50 Review of Engagement Tools
1:50-3:00 Local Team Breakout and Reporting Back/Questions
3:00-3:15 Evaluation and Wrap Up

Western/Piedmont Region-November 7th

9:00-9:30 Registration
9:30-9:40 Welcome & Introductions
- *Tom Kilby*

9:40-9:50 What is Engagement?
9:50-10:50 Young Adult Panel on Engagement/Questions
- *Young Adult Advocates/Family Advocates*

10:50-11:05 Break and Movement to Assigned Tables
11:05-12:10 Engagement of Juvenile Justice Involved Youth -Cross Team
- *Young Adult Advocates/Family Advocates*

12:10-1:10 Lunch On Site
1:10-1:30 State Level Update
1:30-2:00 Western Highlands Presentation
2:00-3:10 Local Team Break Outs and Reporting Back
3:10-3:30 Evaluation and Wrap Up

Eastern Area- November 9th

9:00-9:30 Registration
9:30-9:45 Welcome & Introductions
- *Claude Odom*

9:45-9:55 What is Engagement?
9:55-10:55 Young Adult Panel on Engagement/Questions
- *Young Adult Advocates/Family Advocates*

10:55-11:05 Break and Movement to Assigned Tables
11:05-12:05 Engagement of Juvenile Justice Involved Youth -Cross Team
- *Young Adult Advocates/Family Advocates*

12:05-1:05 Lunch On Site
1:05-1:20 State Level Update
1:20-1:50 Five County Halifax Area Presentation
1:50-2:00 Review of Engagement Tools
2:00-2:30 Beacon Center Area Presentation
2:30-3:20 Local Team Breakout
3:20-3:30 Evaluation and Wrap Up

IV. Individual Evaluations of the Meeting

Overall, 74 local participants completed meeting evaluation forms. This is 57**%** of the total local meeting participants. The participants were asked questions about meeting location, registration, helpfulness of meeting, meeting pace and organization and qualitative questions about what they liked most or would improve about the meeting. The following table includes the overall evaluations across the three sites for the key questions that were asked of meeting participants. The ratings were as follows: **Strongly Agree=4, Agree=3, Disagree= 2, and Strongly Disagree=1**. Overall, the highest rated response was for ease of registration and the lowest rated response was the meeting will be helpful to our local team planning process. The individual responses from each participant are in a separate document.

Fall Regional Meeting-Individual Responses							
Questions asked of Participants	*It was easy to register for this meeting*	*The location was appropriate for this meeting.*	*The information shared during the meeting was helpful.*	*The pace of the meeting was appropriate- not too fast or too slow*	*The meeting was well organized/*	*The meeting will be helpful to our local team planning process*	*Overall Averages*
Averages for Western/Piedmont	3.88	3.75	3.5	3.44	3.5	3.38	3.57
Averages for Eastern	3.77	3.86	3.66	3.63	3.69	3.63	3.70
Averages for Central	3.96	3.39	3.61	3.57	3.57	3.59	3.61
Overall Averages for All Meetings	3.85	3.69	3.61	3.57	3.61	3.56	3.65

<u>Additionally, the following questions were asked in a qualitative form on the individual forms:</u>

1. My favorite part of the meeting was_____
2. The meeting could be better by doing the following _____

What follows is a listing of the responses to the two questions based on categorizing the responses and then ranking based on most endorsed).

A. <u>My Favorite part of the meeting was….. (listed in order of most endorsed by 3 or more participants)</u>

a. Youth Presentations
b. Provider presentations/Beacon Center Presentation
c. Breakout Sessions
d. Hearing from others/Collaboration/Local Area Discussions
e. Other: DJJDP/ Topic of Engagement

B. <u>The meeting could be better by doing the following (listed in order of most endorsed by 3 or more participants)</u>

a. Nothing/ N/A
b. Well Done/Good format/Very informative
c. More breaks
d. More time for local breakout/providers/presentation

V. Local Team Meeting Engagement Responses

During each of the three regional meetings, teams were mixed based on LME, DJJDP, Provider groupings so that each "cross-team" group was made up of individuals who typically did not work together on a team. The purpose of this was two-fold. One, it was anticipated that this would allow for team members to hear of some of the processes and activities of other teams. Second, it was anticipated that team members would be more open to discuss in their areas if they were in different groupings with others and not reliant on their regular "facilitators" of their local team. These cross team groups were facilitated by a young adult advocate and/or a family partner. The purpose of this was to create a dialogue with team members about youth engagement and processes of youth engagement.

The next table outline overall summaries for the items that were endorsed at each of the different Regional Meetings (Central, Western/Piedmont, Eastern). The cross-site teams put their responses on flip chart paper and this was then transcribed into a Word document. Graduate student Delta Adams then reviewed these responses and put into the following tables. The five questions were asked of each of the cross team groups:

1. Share some examples of programs in your community that are Youth-Guided and Family Driven.
2. Describe youth engagement activities/approaches to getting youth involved into treatment that has been successful in your community.
3. What are some examples of how youth are involved in decision making in your community?
4. When are Child and Family Teams (CFT) meetings being used in your community? What are successes you know of as result of effective CFTs in your community? What are suggestions you would offer other communities to have successful and effective CFTs?
5. Tell some actions that you think would impact on youth engagement into treatment services- even if they are not currently being used.

Central Area Responses for Youth Engagement

1. *Share some examples of programs in your community that are Youth-Guided and Family Driven.*

Programs

- Teens Making a Change (3)- (Cumberland, Robeson)
- 2nd Round Boxing (2)- (Wake)
- Teen Court (2)
- Say So (2)-(Durham)
- Art Camp- (Cumberland)
- Let Me Explain- (Wake)
- Haven House Services- (Wake)
- Dream Center-(Columbus)
- Consumer Family Advisory Council
- Child and Family Teams
- Community Rec Programs
- Parent advocacy on planning boards
- Question Y-SAP Prevention
- Peer to peer mentoring
- SAMSHA-monies for transitional youth
- Youth as own "targeted case manager"
- Family Advocate @ residential setting
- Project Build- (Durham)
- Proud Program- (Durham)
- Transitional Living Program- (Durham)
- Church groups
- Music Program- (Wake)
- Rites of Passage
- Parenting of Adolescence
- YMCA
- Upward Bound
- Big Brothers/ Big Sisters
- 4-H
- Girls Empowerment- (Wake)
- Youth Empowerment Center- (Guilford)
- Boys & Girls Club Family Intervention Programs

Services

- Intensive In-Home (3)
- Multisystemic Therapy (2)
- Outpatient Therapy
- Assertive Comm. Treatment
- Integrated Dual Dig Treatment
- Service-Day Treatment- (Robeson, Bladen)

2. *Describe youth engagement activities/approaches to getting youth involved into treatment that has been successful in your community.*

- Juvenile Crime Prevention Councils (3)- (Harnett, Lee)
- 2nd Round Boxing (2)- (Wake)
- Corral (2)- (Wake)
- Rewards/Incentives (2)
- Collaboration
- Faith community
- Identify natural supports
- Celebrate successes
- Exercise as an outlet
- Advocate for activities- clearinghouse for resources (resources that are free)
- System of care coordinator- consistency w/job description-not all coordinators are as knowledgeable of resources
- Positive Attitude- (Alamance)
- Engagement Hardship…need improvement
- 4-H
- Other organizations
- Utilizing youth/family as a whole to get youth engagement
- Problems w/parents for youth: lack of knowledge, don't want some in their home
- Let Me Explain
- Haven House
- Ligo Dojo
- LGBT
- PROUD
- Project BUILD
- Youth/Parent representative at the

Central Area Responses for Youth Engagement	
• Child and Family Teams • Child and Family Support Teams • School SW • School Nurses • Participation • Music program • ET- (Wake) • Hope through Horses- (Cumberland, Robeson) • See-Saw- (Durham) • Pray- (Guilford)	Collaborative • Youth & Parent involvement in planning • Use youth who are engaged to reach out to other youth • Striving to include youth in child/family teams • Use of internet/social media to inform & involve youth • Audio/video rather than print media • Food • Transportation
3. What are some examples of how youth are involved in decision making in your community?	
• Juvenile Crime Prevention Councils (4)- (Alamance) • Teen Court (3) • Child and Family Teams (2) • Consumer Advisory Comm. • TMAC • (Youth get school credit for participating in these activities) • Get stipends • Foster Friends of NC • Youth Advisory Council • SEEDS- (Durham) • Mayor's Office- (Durham) • Proposal for Guilford County • Youth committee • PROUD Girls Group	• 4-H • Haven House • LINKS • Youth involvement in Community Collaboratives & other advisory groups • Community youth forum/summits • Youth & Parent representatives on boards should have relevant "experience" to the concerns addressed by that board • More MTL conferences should be provided about youth issues for youth • Involving youth in presenting their needs for grant funding requests
4. When are Child and Family Teams (CFT) meetings being used in your community? What are successes you know of as result of effective CFTs in your community? What are suggestions you would offer other communities to have successful and effective CFTs?	
• Monthly/ every 30 days (2) • As Often as is needed • Better family involvement • Youth voices are heard • Who is the "family"? • Youth engagement tips: incentives/rewards • For therapists: Good training/supervision • MI/ enhancement • Family choice of providers • When youth are attempting to live independently • Used to help foster creativity & individuality • Successful outcomes: avoiding "pre-	• Sharing info. • Input • Include child & family in the conversation • Remain focused on goals/needs • Make sure the youth understand everyone's roles • Feedback surveys are important • Commitment & consistency is a big part to success • Big help and PALA challenge to get active in the community and get a certificate from the president!!

Central Area Responses for Youth Engagement	
meetings" to keep service family-oriented • Going into meetings without presumptions • Family-driven meetings & agendas • CFTs- sometimes underutilized, process can be improved • Success- family involved in CFT's • Collaboration • Connected to appropriate resources/placements • Appropriate diagnosis	
5. Tell some actions that you think would impact on youth engagement into treatment services-even if they are not currently being used.	
• Listening to our kids • "Checking" in with kids emotionally • Encouraging our kids to maintain their motivation • Respect • More outreach • Fill the gaps • address changing needs • Listening • support • One-Stop Shop- More accessibility	

Western/Piedmont Areas Responses for Youth Engagement

1. Share some examples of programs in your community that are Youth-Guided and Family Driven.

Programs

- Teen Court (4)- (Winston-Salem, Asheville, Cabarrus, Western Highlands, Buncombe, Gaston, Shelby, Rowan)
- LINKS (4)-(Guilford, Crossroads, Statewide)
- Juvenile Crime Prevention Councils (3)
- Say-So (2) –(Durham & Across)
- Youth Villages (2)- (Guilford)
- North Carolina Families United (2)
- Consumer Input
- Speak Out
- Youth Advisory Council
- Parent/ Teen Together Classes
- Links- (Guilford)
- NC Reach- (Guilford)
- ETV- (Guilford)
- Text for Teens
- Transition Program- (Winston-Salem)
- Family Partners – (Crossroads, Centre Point)
- Parent Advisory Council- (Surry)
- Autism Support Groups- (Across State)
- FCT – (Asheville)
- Youth Move- (Greensboro)
- Consumer Family Advisory Council – (PBH)
- Youth Empowerment Services-(Asheville, Wilmington)
- Volunteers/employed- (Crossroads)
- Mentoring- (Crossroads)
- Support groups- (Crossroads)
- Parent perspective included in decision-making processes- (Crossroads)
- Gas cards- (Crossroads)
- Flex funds- (Crossroads)
- Family training- (Crossroads)
- Restorative justice- (Western Highlands)
- Multi-family group- (Western Highlands)
- Parent component in collaborative- (Western Highlands)
- Parent training- (Western Highlands)
- UNC Mentoring/Partnership- (Guilford)
- Urban Ministries- (Guilford)
- BOTSO- (Guilford)
- Youth Focus ACT together- (Guilford)
-
- Org:
  - Teaches youth independent living skills
  - Manage & budget monies
  - Grocery store
  - Shopping
  - Summer trip (educational)
  - SAT fees
  - Waivers
- Reclaiming Futures
- Child and Family Teams
- Boy Scouts/ Girl Scouts
- Church youth programs
- 4-H
- Children's Home Society
- Leadership Development
- Family Partner Initiatives
- Parent advocacy on planning boards

Services

- Intensive In Home- (Asheville)

2. Describe youth engagement activities/approaches to getting youth involved into treatment that has been successful in your community.

- Mentoring Services (3)-(Stanly & Universal)
- Juvenile Crime Prevention Councils (2)-(Western Highlands)
- System of Care (2)-(Universal)
- In home services
- Case-management like tasks:
  - Research options (e.g. internet)
  - Presentation of services
  - Educate about options

Western/Piedmont Areas Responses for Youth Engagement

- Reclaiming Futures
- Second Chances
- "Fire Escape"
- School-Based Treatment Services
- Primary health care settings
- Good Fellows/Goodwill- (Stanly)
- YWCA/YMCA- (Stanly)
- Davie Cty. Program- (Stanly)
- The CIPT Program-(Stanly)
- Adolescent Treatment Court-(Catawba)
- Family Partners
- Youth Empowerment Center- (Greensboro)
- Juvenile Justice Treatment Continuum- (Crossroads, Western Highlands)
- Early College- (Crossroads)
- Strategize in staffing- (Western Highlands)
- Pray program- (Guilford)
- UNC Charlotte/NC Families United leadership summer series- (Guilford)
- Upward bound- (Guilford)
- Child and Family Team meeting- (Universal)
- Convenient times & location- (Universal)
- Flex funds- (Universal)
- Stipends- (Universal)
- Strength-based- (Universal)
- Leadership opportunities- (Universal)
- Person Centered Plan- (Universal)
- Services that come to home- (Universal)
- Youth Day-Youth Conference- music, games, workshops
- Power Cross
- Say So
- SRC/Foster Parents- athletics- (Buncombe)
- Girl Power
    - Ask about goals/desires/ dreams
    - Link to peers with similar interests
    - Advocate for interests expressed
    - Use interests as part of treatment
    - Include youth in service delivery, decision-making, advocacy efforts
    - Make sure youth have a voice
    - Youth as peer educators in mass media
- Incentives
- Appropriate activities
- Motivational Interviewing
- Real World- (Surry)
- Texting
- Facebook
- Flex schedules
- Transportation
- Diversity with therapists
- Meeting basic family needs

3. *What are some examples of how youth are involved in decision making in your community?*

- Child and Family Teams (4)
- Juvenile Crime Prevention Councils (3)
- Teen Court (3)- (Western, Guilford)
- System of Care (2)
- Youth Move
- Care Review
- Person Centered Plan
- Court Supervision Plan
- High Point Human Relations Commission- (Guilford)
- Transition Training

Western/Piedmont Areas Responses for Youth Engagement

- Student council
- School surveys
- Right to vote at 18
- Participation in campaigns
- North Carolina Families United (Powerful Youth Families United)
- Treatment Planning

4. When are Child and Family Teams (CFT) meetings being used in your community? What are successes you know of as result of effective CFTs in your community? What are suggestions you would offer other communities to have successful and effective CFTs?

- When:
  - Emergencies (3)
  - Monthly (3)
  - Changes in treatment (2)
  - Placement changes
  - Change in supervision
  - Drug court
  - Juvenile Justice Treatment Continuum
  - Treatment Expeditor
  - At IEP meetings- (Western, Crossroads)
  - Across systems- (Western, Crossroads)
  - All child-serving agencies- (Western, Crossroads)
  - At parent's request
  - School
  - Home
  - Drive goals of treatment/treatment progress
  - Review of goals
  - Getting key players involved w/family & child
  - Gain more support before presenting to care review
  - Initial engagement of care
  - Need of signature
  - Authorizations for funding
- Successes:
  - Reduction of out of home placements/detention
  - Family support
  - Identification of resources
  - Identification of gaps in services
  - Collaborative way of transcending organizational barriers
  - Address cultural competencies
  - Development of partnerships
  - Surveys to evaluate
- Suggestions:
  - Transitions beyond treatment
  - More surveys to evaluate
  - Better use of incentives
  - Do what is working in the success stories
  - Ensure fidelity in Child and Family Team
  - Buy-into philosophy
  - Drives
  - Staffing turnovers
  - Mary make sure a Family Partner is available in community (Smoky Mountain)
  - Share the responsibility
  - Strengthen families to drive the meetings eventually
  - Meet more frequently (quality over quantity)
  - System of Care
  - Child and Family Team training
  - Transportation
  - Have <u>all</u> involved at the Child and Family Team
  - *Follow up*/ *communication*
  - Family/child voice
  - Less duplication of services

<table>
<tr><th colspan="2">Western/Piedmont Areas Responses for Youth Engagement</th></tr>
<tr><td colspan="2">

Family partner involvement
Incentives
Increased communication
Terrance's example w/ IEP mtg/CFTM- (Crossroads)
Level 3/Level 4 Group Home transitions- (Crossroads)
SIP- (Western)
Care review teams- (Crossroads)
Court Improvement Project- (Crossroads)
Treatment contract- (Crossroads, Western)
POT/Drug- (Buncombe)
Families/youth more engaged in treatment when done properly
Goal achievement
Youth determine who to include
More participation with assistance to access (e.g. trans.)
Flexible schedules (Nontraditional hours)
Appropriate level of care
Natural supports
Better family involvement

</td></tr>
<tr><td colspan="2">5. Tell some actions that you think would impact on youth engagement into treatment services-even if they are not currently being used.</td></tr>
<tr><td>

Mentoring (2)
Surveys (2)
Ability to get proper medication
Payer resource issues
Respect
Training for community partners
Resources for PR
Consistency
Listen to them
Proper diagnosis
Enlist people who have a "heart" to work w/youth

</td><td>

Getting to know youth/ family by factoring in special time
Does an informal initial intro to family- (Buncombe)
Need to become more outside the box engagement
Relationship engagements
Funding
Functional Family Therapy
Trust
Motivational Interviewing
Teen Centered marketing-Facebook
Natural resources
Attrition-turnover, retention of staff
WRAP- for providers to retain
Focus group w/students
Community Resource Guides
Youth Forums
Youth Advocate
Peer support
Support groups
Incentives

</td></tr>
</table>

Eastern Area Responses for Youth Engagement	
1. Share some examples of programs in your community that are Youth-Guided and Family Driven.	
Programs • Teen Court (6)- (Statewide) • Youth Move (3)- (Guilford) • Peer Mediation (2)- (Brunswick, HC) • C.F.T/C.F.S.T (2) • North Carolina Families United (2) • Youth Council (2) • System of Care (2) • Teens Making a Change • Consumer Family Advisory Council • National Alliance on Mental Illness • Mothers Against Drunk Driving and Students Against Destructive Decisions • Presidential Active Lifestyle Achievement Challenge • LINKS • DJJDP • E.B.P. • Girls Inc. • Police Athletic league- (Nash, Edgecombe) • Juvenile Crime Prevention Council • Independent living skills for children in foster care • Friends and families • Brothers Giving Back • Most Men Most Men • Functional Family Therapy • Connect 4 • Strengthening Families • F.U.N. • T.C.M • Resolve It Together • Multifamily Group- (Bertie, NHC, HC, Halifax)	Services • Intensive In Home (5)- (Statewide) • Multisystemic Therapy (5)- (Statewide) • Case Management – (Statewide) • Pride SAAT • Family Therapy • Individual therapy • Day Treatment • Substance Abuse Treatment • Peer Mediation (2)- (Brunswick, HC)

Eastern Area Responses for Youth Engagement

2. Describe youth engagement activities/approaches to getting youth involved into treatment that has been successful in your community.

- Incentives (3)
- Church (Edge/Loft) (3)
- Assertive Engagement (2)
- Motivational Interviewing (2)
- Juvenile Justice Treatment Continuum (2)
- Group Therapy (2)
- Multisystemic Therapy (Stalking)
- Agency educating Families
- MAMA-Mothers against Methamphetamine
- Intensive In Home
- Evidence Based Practices
- Seven Challenges
- Peer Group
- Individual therapy
- Contingency management
- Pro-Social Activities
- Community-driven services
- Boys & Girls Club
- YMCA
- EPIC Center – (Craven, Lenoir)
- Links- (Statewide)
- TL- (Wake, Durham, Guilford)
- Changing Lives Together Initiative- (Beacon)
- Substance Abuse Prevention Helps Everyone- (Craven)
- YES – (Craven)
- Community support
- Real World Event
- Teens in Transition
- High Appraisal
- S.A./A.I. groups
- S.A Coalition
- Restitution- (Brunswick & Statewide)
- Child & family support- (Brunswick, Martin, Bertie, Wayne, Greene)
- Vocational Rehabilitation- (Nash & Statewide)
- WIA-Monies
- Most Men Most Men- (HC)
- Success Academy- (HC)
- Partnerships w Juvenile Justice
- Person Centered Plan
- Global Appraisal of Individual Needs
- Child and Family Teams

3. What are some examples of how youth are involved in decision making in your community?

- Teen Court (5)
- Juvenile Crime Prevention Councils (4)- (Camden)
- Child and Family Teams (4)
- Youth Council/Student Councils (3)
- Youth Commercial-Media
- Youth Groups (church)
- School clubs
- School leadership programs- (Pasquotank)
- Substance Abuse Prevention Helps Everyone
- Mental health treatment teams
- Initial home visit leading to informed decisions
- Person centered plans
- S.A. Coalition
- Student Government
- Treatment
- Seven Challenges
- Person Centered Planning

Eastern Area Responses for Youth Engagement

4. When are Child and Family Teams (CFT) meetings being used in your community? What are successes you know of as result of effective CFTs in your community? What are suggestions you would offer other communities to have successful and effective CFTs?

Frequency

- Monthly (6)
- Emergency/Crisis (4)
- Out of Home Placements (2)
- anytime a major decision is made
- sometime more often
- whenever child needed

Successes:

- Ensure quality of care (2)
- Resolve conflict
- Delineates roles/ responsibilities
- Identifies advancement/ barriers
- Opportunity to discuss goal
- Building relationship
- Engagement
- Positive CFT
- Out of Home Placements
- Families get appropriate services
- Advocating for families
- Including more partnerships
- Helps identify progress
- Helps identify and clarify desired outcomes
- Assists in identifying positive family supports
- Families assume responsibility
- Diminished use of services/Engaged in treatment
- Nothing done w/out me!!!
- Child reunification w/family
- Interagency cooperation

Suggestions:

- Family/child active participant in the process (3)
- Incentive (2)
- Positive attitude (building up/ not tearing down) (2)
- Introduction of new members to team
- CFT meetings that is inclusive of full treatment array.
- Mediation Process
- Follow state/federal requirements/ regulations
- Add all ecologically based stakeholder presence @ the table
- Align desired outcomes across all stakeholders
- Be clinically relevant
- Follow system of care principles/training
- Have an independent facilitator
- Involve everyone in child's life (doctor, teacher)
- Change location of CFT
- Use simple language
- Allow families to elaborate on their strengths
- More utilization & training
- Effective facilitation

5. Tell some actions that you think would impact on youth engagement into treatment services-even if they are not currently being used.

- Have voice in process (4)
- Social/Recreational activities (3)
- Transportation (3)
- Incentives (3)
- Support (3)
- Marketing-enticements focused on youth (2)
- Petty Cash Account- utilize as needed for youth program development
- Person Centered Plan
- PALA Challenge
- Increasing decision making program models that engage youth to make better decisions
- Eliminate non-compliance and No-shows from vocabulary
- Be more strength based
- Flexible scheduling
- Avoid power struggle (collaborate)
- More groups
- Focused on problem at moment
- Keep material informative/relevant
- Be non-judgmental
- Incentive
- Certificates/ Celebration
- Acknowledgement

Eastern Area Responses for Youth Engagement	
• Seven Challenges • LINKS • Food • Sustainable/ generalizable • Family accountable/responsible • DO a CFT: child focused, every input, realistic, increase participation, convenient for child, transportation, empathy, kid's direction he/she wants to go, feeling supported, Listen	• Hearing from others (stories) • Expansion of Peer Specialist • Train GAL • Educate network

APPENDIX C-SPRING REGIONAL REPORT

JJSAMHP Spring 2012 Regional Meetings and Fiscal Year 2012-2013 Team Engagement Goals

This document includes a summary of the JJSAMHP Spring Regional Team meetings including individual impressions of the Regional Meetings-compiled and tabulated by the UNCG Center for Youth, Family and Community Partnerships. Additionally, this includes reporting information on Accomplishments and Lessons Learned and overall Team Engagement goals for Fiscal Year 2012-2013.

Summary of Document Contents

Enclosed is the Overall Summary for the Regional Team Meetings in May, 2012. The report is outlined in four different areas:

I. Meeting Locations
II. Meeting Participants
III. Meeting Agenda
IV. Individual Evaluations of Meeting
V. Accomplishments and Lessons Learned
VI. Team Goals on Engagement

I. Meeting Locations: Regional Meetings were held in the following locations based on DJJ Areas:

Area	*Counties*	*Date*	*City*	*Location*
Central (DJJ Area)	Alamance, Bladen, Brunswick, Caswell, Chatham, Columbus, Cumberland, Durham, Franklin, Granville, Harnett, Hoke, Lee, Orange, Person, Robeson, Scotland, Vance, Wake, Warren,	May 1st	Durham	Millennium Hotel Durham
Western/Piedmont (DJJ Areas)	Anson, Buncombe, Cabarrus, Davidson, Davie, Forsyth, Guilford, Henderson, Iredell, Madison, Mitchell, Montgomery, Moore, Polk, Randolph, Richmond, Rockingham, Rowan, Rutherford, Stanly, Stokes, Surry, Transylvania, Union, Yadkin, Yancey	May 3rd	Hickory	Crowne Plaza Hickory
Eastern (DJJ Area)	Beaufort, Bertie, Camden, Carteret, Chowan, Craven, Currituck, Dare, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Jones, Lenoir, Martin, Nash, New Hanover, Northampton, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Pitt, Tyrell, Washington, Wayne, Wilson	May 16th	Greenville	Greenville Hilton

II. Meeting Participants:

Overall, there were **<u>140</u> Local** Participants who attended the Regional Meetings across the state (there were 129 in the Fall). There were 19 State/Regional/Contractor Participants who attended the Regional Meetings (some attended more than one meeting so they are only counted one time) giving a total of 159 individuals. The breakdown of the types of personnel that attended each meeting is indicated below and a listing of each person who attended each meeting is available upon request:

Participants in Regional Meetings

	Central	Western/Piedmont	Eastern
LME Representatives	15	16	13
DJJ Local Court Counseling Representatives	12	11	15
Provider Representatives	21	15	20
Other Representatives	1	1	0
Total Local Participants	49	43	48
Total State/Regional	11	12	12
Total Participants	**60**	**55**	**60**

III. Meeting Agenda

The agendas for each of the three meetings are below:

Central-May 1st

9:00-9:30	Registration
9:30-9:45	Welcome & Introductions ➢ *Maxine Evans Armwood, DPS*
9:45-9:55	Announcements
9:55-10:50	Ensuring Appropriate Level of Care and Creating Effective Partnerships in a MCO Environment ➢ *Pam Burton, PBH*
10:50-11:05	Break
11:05-11:20	Effective Systems Change and a National Model ➢ *Jessica Jones, DPS*
11:20-11:30	Sandhills Team Update
11:35-11:45	Cumberland Team Update
11:50-12:00	PBH-Five County Area Team Update
12:00-1:00	Lunch On Site
1:00-1:30	Effective Transitions for Youth with Substance Abuse Residential Needs ➢ *Paul Savery, DMHDDSAS and TaNesha McAuley, VisionQuest*
1:30-1:40	Southeastern Regional Team Update
1:45-1:55	Durham Team Update
1:55-2:05	Break
2:05-2:15	PBH-AC Area Team Update
2:20-2:30	Wake Team Update
2:35-2:45	PBH-OPC Area Team Update
2:45-3:30	Local Team Break Outs (What Can We Take Home?) and Evaluation

Western/Piedmont-May 3rd

9:00-9:30	Registration
9:30-9:45	Welcome & Introductions ➢ *Tom Kilby and Chuck Mallonee, DPS-DJJ Area Administrators*
9:45-9:50	Announcements
9:50-11:00	Ensuring an Appropriate Level of Care for Juvenile Justice Involved Youth ➢ *Pam Burton, PBH* ➢ *Brad Owen, Western Highlands*
11:00-11:15	Break
11:15-11:45	JJSAMHP-Creating Effective Partnerships in a MCO Environment ➢ *Pam Burton, PBH*
11:45-12:00	Effective Systems Change and a National Model ➢ *Jessica Jones, DPS*
12:00-1:00	Lunch On Site
1:00-1:30	Effective Transitions for Youth with Substance Abuse Residential Needs ➢ *Paul Savery, DMHDDSAS and Lylan Wingfield, Youth Focus, Jeff Matkins, Swain Recovery, Ben Bentley, The Children's Home*
1:30-1:45	Crossroads Team Update
1:45-2:00	Western Highlands Team Update
2:00-2:10	Brief Break
2:10-2:25	Guilford Team Update
2:25-2:40	PBH Team Update
2:40-2:55	CenterPoint Team Update
2:55-3:30	Local Team Break Outs (What Can We Take Home?) and Evaluation

Eastern Area- May 16th

9:00-9:30	Registration

9:30-9:45 Welcome & Introductions
- *Joe Testino, DPS-DJJ Area Administrator*

9:45-9:50 Announcements

9:50-11:00 Ensuring an Appropriate Level of Care for Juvenile Justice Involved Youth
- *Pam Burton, PBH*
- *Nancy Cleghorn and Rob Heubel, ECBH*

11:00-11:15 Break

11:15-11:45 JJSAMHP-Creating Effective Partnerships in a MCO Environment
- *Pam Burton, PBH*

11:45-12:00 Effective Systems Change and a National Model
- *Jessica Jones, DPS*

12:00-1:00 Lunch On Site

1:00-1:30 Effective Transitions for Youth with Substance Abuse Residential Needs
- *Paul Savery, DMHDDSAS and Jennifer Hardee, PORT Human Services*

1:30-1:45 Onslow Carteret Team Update

1:45-2:00 Beacon Team Update

2:00-2:10 Brief Break

2:10-2:25 Eastpointe Team Update

2:25-2:40 ECBH Northeast Update

2:40-2:55 ECBH Lower Team Update

2:55-3:30 Local Team Break Outs (What Can We Take Home?) and Evaluation

IV. Individual Evaluations of the Meeting

Overall, 94 local participants completed meeting evaluation forms. This is 67**%** of the total local meeting participants. The participants were asked questions about meeting location, registration, helpfulness of meeting, meeting pace and organization and qualitative questions about what they liked most or would improve about the meeting. The following table includes the overall evaluations across the three sites for the key questions that were asked of meeting participants. The ratings were as follows: **Strongly Agree=4, Agree=3, Disagree= 2, and Strongly Disagree=1**. Overall, the highest rated response was for ease of registration and the lowest rated response was the pace of the meeting was appropriate-not too fast or too slow.

Fall Regional Meeting-Individual Responses							
Questions asked of Participants	*It was easy to register for this meeting*	*The location was appropriate for this meeting.*	*The information shared during the meeting was helpful.*	*The pace of the meeting was appropriate-not too fast or too slow*	*The meeting was well organized/*	*The meeting will be helpful to our local team planning process*	*Overall Averages*
Averages for Central	3.89	3.83	3.66	3.31	3.63	3.59	3.64
Averages for Western/Piedmont	3.81	3.63	3.58	3.56	3.59	3.67	3.67
Averages for Eastern	3.81	3.77	3.29	3.39	3.58	3.40	3.55
Overall Averages for All Meetings	3.84	3.75	3.51	3.41	3.60	3.55	3.61

Additionally, the following questions were asked in a qualitative form on the individual forms:

1. My favorite part of the meeting was_____

2. The meeting could be better by doing the following _____

What follows is a listing of the responses to the two questions based on categorizing the responses and then ranking based on most endorsed).

Central Meeting-Durham-5/1/12

A. ***My Favorite part of the meeting was….. (listed in order of most endorsed by 2 or more participants)***

a. Lessons Learned/Team Updates
b. Pam Burton's presentation(s)
c. Networking

B. ***The meeting could be better by doing the following (listed in order of most endorsed by 2 or more participants)***

a. Change format of local team updates (time limit/goal specific)
b. Nothing

Western/Piedmont Meeting-Hickory- 5/3/12

C. ***My Favorite part of the meeting was….. (listed in order of most endorsed by 2 or more participants)***

a. Care Coordination and Presentations (Pam Burton and Brad Owens)
b. Open Dialogue and Group discussions
c. Local team updates
d. Networking

D. ***The meeting could be better by doing the following (listed in order of most endorsed by 2 or more participants)***

a. Nothing
b. More open and facilitated conversations

Eastern Meeting-Greenville-5/16/12

E. ***My Favorite part of the meeting was….. (listed in order of most endorsed by 2 or more participants)***

a. Local Team Updates
b. Care Coordination and Presentations (Pam Burton, Nancy Cleghorn, and Rob Heubel)
c. Lessons Learned (Pam Burton)
d. Residential CASP presentation
e. Everything

F. ***<u>The meeting could be better by doing the following (listed in order of most endorsed by 2 or more participants)</u>***

a. Too Cold

b. More local information on Care Coordination

V. Accomplishments and Lessons Learned Themes

Each team was presented with a document in March, 2012 in which they were asked to outline Accomplishments and Lessons Learned during their previous three years of implementation under the Juvenile Justice Substance Abuse Mental Health Partnerships What follows is table where teams have shared this information and then categorized based on what teams outlined. As a reminder, the JJSAMHP domains are as follows:

Screening and Referral

Expectation is that each team has a defined protocol for referrals from DJJ to an identified provider(s).

Assessment

Expectation is that each team uses a valid and reliable comprehensive assessment for substance abuse, mental health and co-occurring disorders that is administered by appropriately credentialed professionals.

Engagement/Treatment Completion

Expectation is that each team uses System of Care principles to engage families and assist in completion of treatment.

Evidence Based Treatments

Expectation is that each team will utilize evidence based treatments for substance abuse and/or mental health.

Juvenile Crime Prevention Council Involvement

Expectation is that each team will utilize Juvenile Crime Prevention Councils in particular to address Recovery Oriented Systems of Care.

Additionally, some teams outlined what would be classified as Network/Systems issues. Lastly, there is a category of “other” where teams outlined Accomplishments or Lessons Learned that did not fit into other categories.

Domain	Accomplishments	Lessons Learned
Screening	▪ Use of Global Appraisal of Individual Needs (GAIN)-Short Screener****** ▪ Decrease in time from referral to follow up*** ▪ The Assessment position and the LME court liaison position are both housed in DJJ offices or Assessor is collocated at DJJ** ▪ DJJ referred more youth with mental health issues** ▪ Development of protocol for screening and assessment and outlined expectations of each team member* ▪ JCC scheduling of assessments while clients in the office*	▪ Referrals need to be followed up by not only provider but JCC staff as well (regular meetings are necessary for follow up)* ▪ Having staff member that can track referrals into services necessary* ▪ Need more defined protocol for screening youth and will use GAIN Short Screener* ▪ Use of GAIN Short Screener designated benchmark was not inclusive of all youth needing assessments-JCCs can make referrals even if youth are not always forthcoming* ▪ Diverted youth are now formally assessed*
Valid and Reliable and Comprehensive Assessment	▪ Use of GAIN and/or GAIN training****** ▪ Increase in percentage of youth assessed** ▪ GAIN Local Trainers in Network ▪ *Set up regular assessment times in rural county in conjunction with DJJ schedule* ▪ Elimination of independent assessor to allow youth quicker and easier access to services* ▪ Maintenance of 95% show rate for assessments, most of which occur within 7 days* ▪ Over 80% of all children referred by DJJ had received intake appointment within 14 days*	▪ Lengthy intake processes with provider agencies is a challenge for engaging families into treatment*

Domain	*Accomplishments*	*Lessons Learned*
Engagement and System of Care	• Working with Family Partner on JJSAMH team** • Use of Assertive Engagement definition ** • Use of contingency management** • Completion of Child and Family Teams with all youth who receive an assessment with provider** • Treatment sustained through SOC principles-increased communication with all parties** • Attendance of provider at court during hearings* • Team able to work out transportation for youth in rural county* • Involvement of school in timeliness of assessments* • Ability to maintain SOC regardless of numerous changes across multiple systems* • LME liaison arranges CFT's, gets consumer to appropriate treatment modality and understands SOC processes* • Monthly CFTs have increased* • More youth receive care coordination services from LME/DJJ liaison including multiple care coordination events*	• CFT meetings must occur regularly and include all team members* • Parental substance abuse a major barrier* • If goal is engagement, it is important to have family member whose child has been a consumer of services at the table sharing ideas and experiences* • All team members (LME/MCO, DJJ, providers, families) should be involved in treatment decision making* • Saturday groups to meet needs of youth and families* • Implementing System of Care in multi-rural counties is a challenge* • Youth need to feel comfortable around adults and be open and honest without consequences or don't need to be rushed* • Treatment expeditor position is invaluable in case coordination * • Could use more support in the initial engagement and follow up (work done with local university interns) * • Could benefit for more Hispanic service options for treatment* • Youth sometimes complete probation before treatment-need transition planning* • More informal supports need to attend CFT meetings and participate in their plans* • Families having multiple new people in their lives is a challenge for engaging families into treatment*

Domain	Accomplishments	Lessons Learned
Evidence Based Treatments/Practices	• Use of and training in Seven Challenges******* • Use and Training in Motivational Interviewing (Including DJJ partners)***** • Providers trained in Trauma Focused CBT*** • Providers trained in Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)* • Providers trained in Seeking Safety* • Use of Adolescent Community Reinforcement Approach (A-CRA)* • A-CRA trained supervisor* • MINT (Motivational Interviewing) trainer in lead provider*	• Staff turnover and being able to maintain usage of EBTs* • Staff turnover is best addressed with in-house leaders and trainers in evidence based tools* • Need to update on which providers are using which EBTs* • Child and Family Teams need to focus more on strengths and be more family and youth friendly*
Juvenile Crime Prevention Council (JCPC) Involvement	• Full involvement of JCPC programming and quarterly meetings for JCPC programs to educate all frontline staff of activities* • JCPC programs use GAIN-SS*	• The complementary nature of JJSAMHP and JCPC cannot be understated-to assure continuity of care across services, the objectives of one cannot be considered in isolation from the other* • JCPC programming screening has identified more MH youth than SA youth
Overall system/Network	• Increased collaboration, communication, and problem solving among partners** • Increased tracking of youth and families in the mh/sa system** • Use of multi-provider network after having single provider** • Reduction of court involvement for youth who are getting assessments and CFT meetings early* • Quarterly or other frequency meetings held focused on education, training, and relationship building of all frontline staff*	• Need for clear concise and ongoing communication*** • Need to expand the partnership to include more than one provider** • Need for more effective data tracking system such as collecting information on youth not in the JJSAMHP provider network or those participating in pro-social activities** • Partnership must function as a team in order to be successful** • Need to change and discuss processes* • LME/MCO needs to take leadership in meetings* • Need to maintain LME liaison, JJSAMH assessor, and DJJ under same roof* • Having smaller/stronger network with array of services*

Domain	Accomplishments	Lessons Learned
	• Strong relationship between systems* • Provider network use of coversheets to track information back on youth after referral* • Communicating more effectively by having individual meetings with each provider agency every 60 days in network and having point of contact in agency* • Monthly progress reports completed on each youth* • Provider can meet need of DJJ offices by providing range of services (assessment, treatment, and monitoring) and communicate with DJJ-MOA developed that identified roles and responsibilities*	• Need organized strategy for referral and follow up* • Need for clear roles and responsibilities of team members* • Need effective tool for tracking of youth and families* • For successful programs, have to be willing to compromise with other organizations* • Team recognized the importance of carefully selecting provider who has capacity to provide array of services in large catchment area* • Need to have meetings with frontline staff to find out how things are going* • Partnerships with multiple districts should address differences in accessing and providing services* • Must adapt services and "Do best you can within the systems you operate under"* • Significant changes in staffing will require retraining on protocols and procedures in all agencies (DJJ, LME/MCO and providers)* • Team learned importance of carefully reviewing referral/documentation processes and timeline reporting to refine MOA expectations* • The Reclaiming Futures Project Director is involved in the JJSAMHP team*
Other	• Youth Treatment Court/Drug Treatment Court* • Several LCAS or other licensed staff involved* • Teen Court usage* • Proving outpatient services in rural county* • Judge mandate of treatment and supported through case reviews*	• Availability of licensed SA clinicians in rural areas is a challenge* • Loss of Youth Treatment Court was great because increased accountability-will work to build accountability within current system* • Drug Court needs to be every 2 weeks* • Drug Court needs JCC that has intensive caseload level due to needs of youth in court*

VI. Local Team Engagement Goals for Fiscal Year 2012-2013

Lastly, each team was requested to develop goals for the Fiscal Year 2012-13 around engaging youth and their families and to present these goals at the Regional Meeting in May 2012. Each team then was to submit these goals to DMHDDSAS. The table below provides the two required goals and one optional goal (for teams that utilized this) that were submitted. Please note that the LME team names included in the document were based on Fiscal Year 2011-2012 nomenclature and do not reflect changes to names on July 1, 2012.

LME Team Name (Fiscal Year 2011-2012)	Goal # 1 (and example of characteristic activity to meet goal)	Goal # 2 (and example of characteristic activity to meet goal)	Optional Goal # 3 (and example of characteristic activity to meet goal)
PBH-Alamance Caswell	Increase Treatment Completion Rate from 33% to 45% (e.g., implement survey to assess barriers to families engaging in treatment)	Increase availability of evidence based practices (e.g., prioritize available funding to provide training based on needs)	Expand family support and education to promote engagement (e.g., seek input from parent representative)
Beacon Center	Use funding to support a Local GAIN trainer	Decrease no shows by using 60 day individual meetings with providers and including JCC staff and direct care staff	Finding ways to engage youth and their families in the treatment process (e.g., finding out barriers to engagement and treatment compliance and addressing these barriers as soon as possible)
CenterPoint	Increase treatment completion rate from 38 to 50 by increasing communication between treatment providers and DJJ and by increasing partnerships between families, providers, and DJJ (e.g., every first treatment session is being organized as a Child and Family Team meeting with invitations to DJJ and LME)	Increase treatment compliance through usage of EBPs such as Seven Challenges and Motivational Interviewing	Track all juvenile court involved youth referred to JJSAMHP contracted providers

LME Team Name (Fiscal Year 2011-2012)	Goal # 1 (and example of characteristic activity to meet goal)	Goal # 2 (and example of characteristic activity to meet goal)	Optional Goal # 3 (and example of characteristic activity to meet goal)
Crossroads	Service engagement and coordination shall be completed through a Child and Family Team meeting that will be scheduled within 30 days of Juvenile Justice intake 80% of the time (e.g., Targeted Case Manager/Care Coordinator shall convene the Child and Family Team meeting within 30 days of the completion of the Juvenile Justice intake meeting)	In regards to engagement and treatment, recommendations and options discussed during the Child and Family Team Meetings shall include more than one MH/SA treatment service option, at least one parent enrichment service and at least one youth pro-social service 100% of the time	
Cumberland	Increase treatment completion rate by 10% by developing a data tracking process to incorporate outcomes for youth who are referred for more intensive services into the JJSAMHP reporting protocols	To decrease recidivism and/or relapse by 10% by developing a process to track recidivism rates for youth who have been involved in the JJSAMHP program by Initially developing a baseline of youth who maintain progress made and those who either relapse following completion of treatment and/or have more involvement in the juvenile court	
Durham	Ensure at least 55% of youth involved with juvenile justice system engage in at least 4 treatment sessions in 45 days (e.g., compare locally paid claims data compiled by the MCO Quality Management department)	Increase treatment completion of youth to 41% according to data in NC-TOPPS (e.g., keep active CFT meeting status information)	

LME Team Name (Fiscal Year 2011-2012)	Goal # 1 (and example of characteristic activity to meet goal)	Goal # 2 (and example of characteristic activity to meet goal)	Optional Goal # 3 (and example of characteristic activity to meet goal)
Eastpointe	Increase Eastpointe treatment completion rate by providing JJSAMHP awareness and NC-TOPPS training, as it pertains to DJJ involved youth being served, to all youth serving agencies in Eastpointe catchment area (e.g., will assist providers in accurately identifying juvenile justice involved youth and ensuring treatment completion is documented in NC TOPPS system)	Increase Eastpointe treatment completion rate by requiring JJSAMHP providers in Lenoir and Wayne County to utilize Contingency Management techniques in their treatment approaches for DJJ involved youth	
ECBH	Provide incentives for families to keep appointments especially for initial assessment, (develop plan for providing incentives-e.g., gift cards for gas and groceries- involving partnership provider, JCCs and other providers where warranted)	Providers in all judicial districts will be educated about services and supports needed by youth and their families, the process of working with the juvenile justice system, expectations for the delivery of services and desired outcomes (e.g., have Partnership meetings in each District and invite providers in those districts to participate in educational sessions)	Ensure that a child transitioning from a secure facility can receive the necessary and appropriate assessments and services prior to release from the secure facility (develop an Alternative Service Definition for utilizing Assertive Engagement funds)
ECBH Northeast	Increase referrals and treatment for youth involved in JJ system by attending District 2 staff meetings, increased community collaborative attendance by Partnership staff, and completing assessment on all referrals as reported by DJJ, parent, child and provider staff	Increase formal and oral communication between the Partnership regarding the status of at-risk youth involved in the JJ system to at least monthly utilizing the Monthly progress report for youth and family progress	Increase treatment completion for youth involved in the JJ system by implementation of closure treatment team with mandatory JCC participation and/or referral to lower level of care

LME Team Name (Fiscal Year 2011-2012)	Goal # 1 (and example of characteristic activity to meet goal)	Goal # 2 (and example of characteristic activity to meet goal)	Optional Goal # 3 (and example of characteristic activity to meet goal)
PBH-Five County	The goal for 2012-2013 will be to increase the treatment completion rate from 50% to 52% by providing improved collaboration and accountability of service provision to youth and families involved with JJSAMHP. (Contact the DJJ referral source for any no-show or cancellation)	Identified partners will have at least 1 staff member complete all required components to receive GAIN certification and SOC training by December 2012.	To improve data tracking through PBH CI system by adding a drop down box on the Tar to flag JJSAMH consumers, which will enable reports to be run with data specific to the JJSAMH population.
Guilford	The goal for 2012-2013 will be to increase the treatment completion rate to 52% by making a plan to monitor CFT attendance and problem solving attendance by both formal and informal supports (e.g., team will develop a CFT tracking document including some information on barriers to CFT attendance)	Team will work on identifying funding sources for incentives for participation in treatment services (e.g., team will attend Contingency Management training offered throughout the state)	

LME Team Name (Fiscal Year 2011-2012)	Goal # 1 (and example of characteristic activity to meet goal)	Goal # 2 (and example of characteristic activity to meet goal)	Optional Goal # 3 (and example of characteristic activity to meet goal)
PBH-OPC	Team will increase treatment completion rate to 31% by revising MOA and improving compliance with the MOA between providers, OPC/PBH, and DJJ (e.g., team members will complete a monthly progress report on each DJJ child served and use those progress reports in team meetings)	Team will increase the number of DJJ involved youth who receive 4 successful contacts within their first 45 days of referral from DJJ (e.g., each agency involved with DJJ initiative will try at least 2 strategies that are considered promising practices for improving engagement-ex. include reminder calls for appointments, follow-up with family after no show, contracting for attendance, problem solving at first call about barriers to attending appointment, using motivational interviewing to attend the first appointment)	
Onslow Carteret	Team will use strategies to increase compliance to treatment (e.g., offer community service credit hours for attending Youth Empowerment and SA groups or percentage for attending individual/family therapy)	Team will use strategies to increase engagement of families (e.g., will offer incentives for attending treatment)	

LME Team Name (Fiscal Year 2011-2012)	Goal # 1 (and example of characteristic activity to meet goal)	Goal # 2 (and example of characteristic activity to meet goal)	Optional Goal # 3 (and example of characteristic activity to meet goal)
PBH	Increase overall treatment completion rate from 58.97 to 70% (e.g., look at JJSAMHP model and show one of processes/activities to track attendance through engagement)	Increase capacity for Psychological Evaluations and Sex Offender assessments and shift these costs off of JCPC onto the MH system (e.g., involve Network and Finance personnel and work on identifying a rate that can incentive some of the current barriers a provider experiences)	
Sandhills	Increase treatment completion rate to 39.5% by addressing the barrier of lack of parent investment in youth's treatment by improving parent MH/SA knowledge and confidence in treatment (e.g., encourage parents to participate in the Sandhills Center Family Support Program support groups)	Increase treatment completion rates by examining NC-TOPPS data for DJJ youth who did not complete treatment (e.g., DJJ will determine if a pattern exists that affects treatment completion rates such as do youth terminate treatment once probation ends regardless of where they are in the treatment process)	
Southeastern Center			
Southeastern Regional	Team will increase treatment completion rate to 25% (e.g., using the GAIN to identify needs of consumers in order to coordinate appropriate treatment interventions and service providers to provide needed services)	JJSAMHP providers will initiate four consumer contacts within 45 days of provider agency receiving referral (e.g., JJSAMHP team will meet to identify and monitor adherence to goal and address barriers to accomplishing the goals)	

LME Team Name (Fiscal Year 2011-2012)	Goal # 1 (and example of characteristic activity to meet goal)	Goal # 2 (and example of characteristic activity to meet goal)	Optional Goal # 3 (and example of characteristic activity to meet goal)
Wake	Increase treatment completion rate (according to NC-TOPPS data) of youth involved in juvenile justice from 46% to 52% using Medicaid and IPRS paid claims (e.g., providers will improve initial education regarding treatment process to families)	At least 71% of youth will have an assessment appointment available within 14 days of referral; 63% will attend 2 treatment contacts within 14 days, and 55% will attend 4 treatment contacts within 45 days of referral using same data as in Goal 1 (e.g., increase number of staff on Juvenile Court Evaluation Team including Spanish speaking clinician and JCC's follow up with family the day before the assessment appointment)	Determine baseline number of youth involved in juvenile justice who engage in treatment service through a JCPC program and/or engage in a JCPC program as part of a treatment aftercare program (e.g., add item to monthly report that asks about number of JDD youth referred to or involved in JCPC programs)
Western Highlands	Improve initial treatment engagement rates -percentage to be determined through initial baseline study (e.g., if clients do not show for initial appointment, responsible clinician will immediately report the "no show" to the JCC who will follow up with the client/family)	Improve treatment completion rates (e.g., pilot contingency management approach in Buncombe, Henderson, and Transylvania counties)	Increase evidence based practice knowledge and skills of court counselors and clinical staff through initial training for new staff and ongoing training for all staff (e.g., determine which JCCs and clinical staff have not been trained in Motivational Interviewing and provide training to these individuals by October 1, 2012)

Appendix D-Monthly Report

JJSAMHP Monthly Data Survey

1. What is the LME/MCO Associated with this Report?

____ Alamance Caswell

____ Beacon Center

____ CenterPoint-Forsyth/Stokes/Davie

____ CenterPoint-Rockingham

____ Crossroads

____ Cumberland

____ Durham

____ Eastpointe

____ ECBH-Beaufort

____ ECBH-Northampton/Hertford/Bertie

____ ECBH-Pitt

____ Five County-Halifax

____ Five County-Four County

____ Guilford Center

____ Mecklenburg

____ OPC

____ Pathways

____ PBH

____ Onslow-Carteret

____ Sandhills

____ Smoky Mountain

____ Southeastern Center

____ Southeastern Regional

____ Wake

____ Western Highlands

2. As data reporter, what is your name?

_____

3. What is your agency name?

_____

4. What is your title?

_____

5. What is your email address?

_____

6. What are the counties associated with this report?

_____

_____

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7. What is the date of this report?

Month _____

Day _____

Year _____

8. For which month are you reporting this data?

____ June 2011

____ July 2011

____ August 2011

____ September 2011

____ October 2011

____ November 2011

____ December 2011

____ January 2012

____ February 2012

____ March 2012

____ April 2012

____ May 2012

____ June 2012

9. JJSAMHP Only-Please put in the total number of youth who participate in the following activities during the month of this report.

____ Number of youth referred from DJJ

____ Number of assessments completed during the month

____ Number of admissions to JJSAMHP providers during the month

10. Please describe the type of juvenile-justice involvement for JJSAMHP admissions during the reporting moth (total account for admissions only).

____ # of Consultation youth referred by DJJ during the month

____ # of Diversion with Contract youth referred by DJJ during the month

____ # of Diversion without Contract youth referred by DJJ during the month

____ # of Pre-Adjudication youth referred by DJJ during the month

____ # of Adjudicated Delinquent youth referred by DJJ during the month

____ # of Adjudicated Undisciplined youth referred by DJJ during the month

____ # of Commitment status youth referred by DJJ during the month

____ # of Post-Release Supervision youth referred by DJJ during the month

____ # of youth with closed cases referred by DJJ during the month

____ # of Intake youth referred by DJJ during the month

____ # of other youth referred by DJJ during the month

DETENTION ONLY

1. DETENTION CENTER ONLY DATA –for this current report month (please leave blank if you are not required by the Division to report these activities):

____ # of referrals for the month

____ # of screenings for the month

____ # of SA assessments for the month

____ # youth in individual SA treatment for the month

____ # of youth with SA contact discharged during the month

____ # of groups conducted for the month

____ # in-service trainings for Detention Center staff

____ # of case supports (include follow-up referrals, arranging for SA and continuity and follow through after release from Detention Center)

2. Other Detention Center Activities for the current reporting month (please leave blank if you are not required by the Division to report these activities):

Name of Activity _____

Total number of youth involved in activity _____

Name of Activity _____

Total number of youth involved in activity _____

Name of Activity _____

Total number of youth involved in activity _____

Name of Activity _____

Total number of youth involved in activity _____

MULTIPURPOSE GROUP HOME ONLY

1. MULTIPURPOSE GROUP HOME ONLY DATA –for this current report month (please leave blank if you are not required by the Division to report these activities):

____ # of referrals for the month

____ # of screenings for the month

____ # of SA assessments for the month

____ # youth in individual SA treatment for the month

____ # of youth with SA contact discharged during the month

____ # of groups conducted for the month

____ # in-service trainings for Multipurpose Group Home Center staff

____ # of case supports (include follow-up referrals, arranging for SA and continuity and follow through after release from Multipurpose Group Home)

2. Other Multipurpose Group Home Activities for the current reporting month (please leave blank if you are not required by the Division to report these activities):

Name of Activity _____

Total number of youth involved in activity _____

Name of Activity _____

Total number of youth involved in activity _____

Name of Activity _____

Total number of youth involved in activity _____

Name of Activity _____

Total number of youth involved in activity _____

APPENDIX E-NORTH CAROLINA-TREATMENT OUTCOMES AND PROGRAM PERFORMANCE SYSTEM (NC-TOPPS) FORMS

NC-TOPPS Mental Health and Substance Abuse

Adolescent (Ages 12-17) Initial Interview

Use this form for backup only. *Do not mail.* Enter data into web-based system (http://www.ncdhhs.gov/mhddsas/nc-topps)

QP First Initial & Last Name

I certify that I am the QP who has conducted and completed this interview.

Sign: _____ ***Date:*** _____

LME Assigned Consumer Record Number

First three letters of consumer's last name: (If female, use consumer's maiden name)

First letter of consumer's first name:

Please provide the following information about the individual:

1. Date of Birth

/ /

2. County of Residence:

_____

3. Gender

☐ Male ☐ Female

4. Please select the appropriate age/disability category(ies) for which the individual will be receiving services and supports. *(mark all that apply)*

☐ Adolescent Mental Health, age 12-17

☐ Adolescent Substance Abuse, age 12-17

b. *If both Mental Health and Substance Abuse,* is the treatment at this time mainly provided by a...

- ☐ qualified professional in substance abuse
- ☐ qualified professional in mental health
- ☐ both

5. Assessments of Functioning

a. Current Global Assessment of Functioning (GAF) Score

6. Please indicate the DSM-IV TR diagnostic classification(s) for this individual. *(See Attachment I)*

7. <u>For Female Adolescent SA individual:</u>
Is this consumer being admitted to a specialty program for maternal, pregnant, perinatal, or post-partum?

☐ Y ☐ N

Begin Interview

8. Are you of Hispanic, Latino, or Spanish origin?

☐ Y ☐ N

9. Which of these groups best describes you?

- ☐ African American/Black
- ☐ White/Anglo/Caucasian
- ☐ Multiracial
- ☐ American Indian/Native American
- ☐ Alaska Native
- ☐ Asian
- ☐ Pacific Islander
- ☐ Other

10. What kind of health/medical insurance do you have? *(mark all that apply)*

- ☐ None
- ☐ Private insurance/health plan
- ☐ TRICARE/Military Coverage
- ☐ Health Choice
- ☐ Medicaid
- ☐ Medicare
- ☐ Other
- ☐ Unknown

11. What is the highest grade you completed or degree you received in school?

- ☐ Grade K, 1, 2, 3, 4, or 5
- ☐ Grade 6, 7, or 8
- ☐ Grade 9, 10, 11, or 12 (no diploma)
- ☐ HS diploma/GED
- ☐ Some college or technical/vocational school
- ☐ 2-year college/assoc. degree
- ☐ 4-year college degree
- ☐ Graduate work, no degree
- ☐ Professional degree or more

12. Are you currently enrolled in school or courses that satisfy requirements for a certification, diploma or degree? (Enrolled includes school breaks, suspensions, and expulsions)

☐ Y ☐ N → *(skip to 13)*

b. If **<u>yes</u>**, what programs are you currently enrolled in for credit? *(mark all that apply)*

- ☐ Alternative Learning Program (ALP) - at-risk students outside standard classroom
- ☐ Academic schools (K-12)
- ☐ Technical/Vocational school
- ☐ College
- ☐ GED Program, Adult literacy

13. <u>For K-12 only</u>:

a. What grade are you currently in?

b. For your most recent reporting period, what grades did you get most of the time? *(mark only one)*

☐ A's ☐ B's ☐ C's ☐ D's ☐ F's ☐ School does not use traditional grading system

c. *If school does not use traditional grading system,* for your most recent reporting period, did you pass or fail most of the time?

☐ Pass ☐ Fail

14. <u>For K-12 only</u>: In the past 3 months, how many days of school have you missed due to...

a. Expulsion_____

b. Out-of-school suspension_____

c. Truancy_____

d. Are you currently expelled from regular school?

☐ Y ☐ N

NC-TOPPS Mental Health and Substance Abuse

Adolescent (Ages 12-17) Initial Interview

Use this form for backup only. *Do not mail*. Enter data into web-based system. (http://www.ncdhs.gov/mhddsas/nc-topps)

15. In the past 3 months, what best describes your employment status? *(mark only one)*

☐ Full-time work (working 35 hours or more a week)
☐ Part-time work (working less than 35 hours a week)
☐ Unemployed (seeking work or on layoff from a job)
☐ Not in labor force (not seeking work)

16. In the past 3 months, how often have your problems interfered with work, school, or other daily activities?
☐ Never ☐ A few times ☐ More than a few times

17. In the past year, how many times have you moved residences?
☐☐ → *(enter zero, if none and skip to 19)*

b. What was the reason(s) for your most recent move? *(mark all that apply)*
☐ Moved closer to family/friends
☐ Moved to nicer or safer location
☐ Needed more supervision or supports
☐ Moved to location with more independence, better access to activities and/or services
☐ Could no longer afford previous location or evicted

18. In the past 3 months, where did you live most of the time?
☐ Homeless → *(skip to b)*
☐ Temporary housing → *(skip to 19)*
☐ In a family setting (private or foster home) → *(skip to 19)*
☐ Residential program → *(skip to c)*
☐ Facility/institution → *(skip to 19)*
☐ Other → *(skip to19)*

b. *If homeless*, please specify your living situation most of the time in the past 3 months.
☐ Sheltered (homeless shelter or domestic violence shelter)
☐ Unsheltered (on the street, in a car, camp)

c. *If residential program*, please specify the type of residential program you lived in most of the time in the past 3 months.
☐ Therapeutic foster home
☐ Level III group home
☐ Level IV group home
☐ State-operated residential treatment center
☐ Substance abuse residential treatment facility
☐ Halfway house (for Adolescent SA individual)

19. Was this living arrangement in your home community?
☐ Y ☐ N

20. In the past 3 months, who did you live with most of the time? *(mark all that apply)*
☐ Lived alone
☐ Spouse/partner
☐ Child(ren)
☐ Mother/Stepmother
☐ Father/Stepfather
☐ Grandmother
☐ Grandfather
☐ Foster family
☐ Sibling(s)
☐ Other relative(s)
☐ Guardian
☐ Friend(s)/roommate(s)
☐ Other

21. How long has it been since you last visited a physical health care provider for a routine check up?
☐ Never
☐ Within the past year
☐ Within the past 2 years
☐ Within the past 5 years
☐ More than 5 years ago

22. Females only: Are you currently pregnant?
☐ Y
☐ N *(skip to 23)*
☐ Unsure *(skip to 23)*

b. How many weeks have you been pregnant? ☐☐
c. Have you been referred to prenatal care? ☐ Y ☐ N
d. Are you receiving prenatal care? ☐ Y ☐ N

23. For Female Adolescent SA individual:
Do you have children? ☐ Y ☐ N → *(skip to 24)*

b. Do you have legal custody of all, some, or none of your children?
☐ All → *(skip to e)* ☐ Some ☐ None

c. Does DSS have legal custody of all, some, or none of your children? ☐ All ☐ Some ☐ None

d. Are you currently seeking legal custody of all, some or none of your children? ☐ All ☐ Some ☐ None

e. Are all, some, or none of the children in your legal custody receiving preventive and primary health care?
☐ All ☐ Some ☐ None ☐ NA (no children in legal custody)

f. How many of the children in your legal custody have been screened for mental health and/or substance abuse prevention or treatment services? ☐ All ☐ Some ☐ None ☐ NA

g. In the past year, have you been investigated by DSS for child abuse or neglect? ☐ Y ☐ N → *(skip to 24)*

g-2. Was the investigation due to an infant testing positive on a drug screen? ☐ Y ☐ N ☐ NA

h. Was your admission to treatment required by Child Welfare Services of DSS? ☐ Y ☐ N

24. In the past 3 months, how often did you participate in ...

a. extracurricular activities?
☐ Never ☐ A few times ☐ More than a few times

b. recovery-related support or self-help groups?
☐ Never → *(skip to 25)* ☐ A few times ☐ More than a few times

c. In the past month, how many times did you attend recovery-related support or self-help groups?
☐ 1-3 times (less than once per week)
☐ 4-7 times (about once per week)
☐ 8-15 times (2 or 3 times per week)
☐ 16-30 times (4 or more times per week)
☐ some attendance, but frequency unknown

Version 07/01/2010

NC-TOPPS Mental Health and Substance Abuse

Adolescent (Ages 12-17) Initial Interview

Use this form for backup only. *Do not mail*. Enter data into web-based system. (http://www.ncdhs.gov/mhddsas/nc-topps)

25. For Adolescent MH only individual:
Have you ever used tobacco or alcohol?
☐ Y ☐ N

26. For Adolescent MH only individual:
Have you ever used illicit drugs or other substances?
☐ Y ☐ N → *(skip to 28 if 'No' is answered on both questions 25 and 26)*

27. Please mark the frequency of use for each substance in the past 12 months and past month.

Substance	Past 12 Months - Frequency of Use					Past Month - Frequency of Use				
	Not Used	1-3 times monthly	1-2 times weekly	3-6 times weekly	Daily	Not Used	1-3 times monthly	1-2 times weekly	3-6 times weekly	Daily
Tobacco use *(any tobacco products)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heavy alcohol use *(>=5(4) drinks per sitting)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Less than heavy alcohol use	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Marijuana or hashish use	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cocaine or crack use	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heroin use	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other opiates/opioids	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other drug use ☐☐ (enter code from list below)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Other Drug Codes

5=Non-prescription Methadone	10=Other Amphetamine	14=Barbiturate	22=OxyContin (Oxycodone)
7=PCP	11=Other Stimulant	15=Other Sedative or Hypnotic	29=Ecstasy (MDMA)
8=Other Hallucinogen	12=Benzodiazepine	16=Inhalant	
9=Methamphetamine	13=Other Tranquilizer	17=Over-the-Counter	

28. For Adolescent SA individual:
If ever, when is the last time you used a needle to get any drug injected under your skin, into a muscle, or into a vein for nonmedical reasons?
☐ Never
☐ Within the past 3 months
☐ Within the past year
☐ More than a year ago
☐ Deferred

29. In the past 3 months, how often have you been hit, kicked, slapped, or otherwise physically hurt?
☐ Never
☐ A few times
☐ More than a few times
☐ Deferred

30. In the past 3 months, how often have you hit, kicked, slapped, or otherwise physically hurt someone?
☐ Never
☐ A few times
☐ More than a few times
☐ Deferred

31. In the past 3 months, how often have you tried to hurt yourself or cause yourself pain on purpose (such as cut, burned, or bruised self)?
☐ Never ☐ A few times ☐ More than a few times

32. In your lifetime, have you ever attempted suicide?
☐ Y ☐ N

33. In the past 3 months, how often have you had thoughts of suicide?
☐ Never ☐ A few times ☐ More than a few times

34. For Adolescent SA individual:
In your lifetime, how many times have you been arrested or had a petition filed for adjudication for any offense including DWI? ☐☐ *(enter zero, if none)*

35. For Adolescent MH individual:
In the past year, how many times have you been arrested or had a petition filed for adjudication for any offense including DWI? ☐☐ *(enter zero, if none)*

36. In the past month, how many times have you been in trouble with the law? ☐☐
(enter zero, if none and skip to 39)

NC-TOPPS Mental Health and Substance Abuse

Adolescent (Ages 12-17) Initial Interview

Use this form for backup only. *Do not mail*. Enter data into web-based system. (http://www.ncdhs.gov/mhddsas/nc-topps)

37. In the past month, how many times have you been arrested or had a petition filed for adjudication for any offense including DWI? *(excluding traffic violations)*

☐☐ *(enter zero, if none)*

38. Do you have a Court Counselor or are you under the supervision of the criminal justice system (adult or juvenile)?

☐ Y ☐ N

39. For Adolescent SA individual:
In the 3 months prior to your current admission, how many weeks were you enrolled in substance abuse treatment (not including detox)? ☐☐ *(enter zero, if none)*

40. In the past 3 months, have you...

a. had **telephone** contacts to an emergency crisis facility?
☐ Y ☐ N

b. had **visits** to a hospital emergency room?
☐ Y ☐ N

c. spent **nights** in a medical/surgical hospital? *(excluding birth delivery)*
☐ Y ☐ N

d. spent **nights** homeless? (sheltered or unsheltered)
☐ Y ☐ N

e. spent **nights** in detention, jail, or prison? (adult or juvenile system)
☐ Y ☐ N

41. How many active, stable relationship(s) with adult(s) who serve as positive role models do you have? *(i.e., member of clergy, neighbor, family member, coach)*

☐ None ☐ 1 or 2 ☐ 3 or more

42. How supportive do you think your family and/or friends will be of your treatment and recovery efforts?

☐ Not supportive
☐ Somewhat supportive
☐ Very supportive
☐ No family/friends

43. How well have you been doing in the following areas of your life in the past year?

	Excellent	Good	Fair	Poor
a. Emotional well-being	☐	☐	☐	☐
b. Physical health	☐	☐	☐	☐
c. Relationships with family or significant others	☐	☐	☐	☐

44. Did you receive a list or options, verbal or written, of places to receive services?

☐ Yes, I received a list or options
☐ No, I came here on my own
☐ No, nobody gave me a list or options

45. Was your first service in a time frame that met your needs?

☐ Y ☐ N

46. Did you have difficulty entering treatment because of problems with... *(mark all that apply)*

☐ No difficulties prevented you from entering treatment
☐ Active mental health symptoms (anxiety or fear, agoraphobia, paranoia, hallucinations)
☐ Active substance abuse symptoms (addiction, relapse)
☐ Physical health problems (severe illness, hospitalization)
☐ Family or guardian issues (controlling spouse, family illness, child or elder care, domestic violence, parent/guardian cooperation)
☐ Treatment offered did not meet needs (availability of appropriate services, type of treatment wanted by consumer not available, favorite therapist quit, etc.)
☐ Engagement issues (AWOL, doesn't think s/he has a problem, denial, runaway, oversleeps)
☐ Cost or financial reasons (no money for cab, treatment cost)
☐ Stigma/Embarrassment
☐ Treatment/Authorization access issues (insurance problems, waiting list, paperwork problems, red tape, lost Medicaid card, IPRS target populations, Value Options, referral issues, citizenship, etc.)
☐ Language or communication issues (foreign language issues, lack of interpreter, etc.)
☐ Legal reason (incarceration, arrest)
☐ Transportation/Distance to provider
☐ Scheduling issues (work or school conflicts, appointment times not workable, no phone)

47. What help in any of the following areas is important to you? *(mark all that apply)*

☐ Educational improvement ☐ Child care
☐ Finding or keeping a job ☐ Medical care
☐ Housing ☐ Legal issues
☐ Transportation

48. In the past month, how would you describe your mental health symptoms?

☐ Extremely Severe ☐ Mild
☐ Severe ☐ Not present
☐ Moderate

For Data Entry User (DEU) only:

This printable interview form must be signed by the QP who completed the interview for this consumer.

Does this printable interview form have the QP's signature (see page 1)? ☐ Y ☐ N

NOTE: This entire signed printable interview form must be placed in the consumer's record.

End of interview

Enter data into web-based system:
http://www.ncdhhs.gov/mhddsas/nc-topps
Do not mail this form

Attachment I:
DSM-IV TR Diagnostic Classifications

Childhood Disorders

- ☐ Learning Disorders (315.00, 315.10, 315.20, 315.90)
- ☐ Motor skills disorders (315.40)
- ☐ Communication disorders (307.00, 307.90, 315.31, 315.39)
- ☐ Childhood disorders-other (307.30, 309.21, 313.23, 313.89, 313.90)
- ☐ Mental Retardation (317, 318.00, 318.10, 318.20, 319)
- ☐ Autism and pervasive development (299.00, 299.10, 299.80)
- ☐ Attention deficit disorder (314.xx, 314.90)
- ☐ Conduct disorder (312.80)
- ☐ Disruptive behavior (312.90)
- ☐ Oppositional defiant disorder (313.81)

Substance-Related Disorders

- ☐ Alcohol abuse (305.00)
- ☐ Alcohol dependence (303.90)
- ☐ Drug abuse (305.20, 305.30, 305.40, 305.50, 305.60, 305.70, 305.90)
- ☐ Drug dependence (304.00, 304.10, 304.20, 304.30, 304.40, 304.50, 304.60, 304.80, 304.90)

Schizophrenia and Other Psychotic Disorders

- ☐ Schizophrenia and other psychotic disorders (293.xx, 295.xx, 297.10, 297.30, 298.80, 298.90)

Mood Disorders

- ☐ Dysthymia (300.40)
- ☐ Bipolar disorder (296.xx)
- ☐ Major depression (296.xx)

Anxiety Disorders

- ☐ Anxiety disorders (other than PTSD) (293.89, 300.00, 300.01, 300.02, 300.21, 300.22, 300.23, 300.29, 300.30, 308.30)
- ☐ Posttraumatic Stress Disorder (PTSD) (309.81)

Adjustment Disorders

- ☐ Adjustment disorders (309.xx)

Personality, Impulse Control, and Identity Disorders

- ☐ Personality disorders (301.00, 301.20, 301.22, 301.40, 301.50, 301.60, 301.70, 301.81, 301.82, 301.83, 301.90)
- ☐ Impulse control disorders (312.31, 312.32, 312.33, 312.34, 312.39)
- ☐ Sexual and gender identity disorders (302.xx, 306.51, 607.84, 608.89, 625.00, 625.80)

Delerium, Dementia, & Other Cognitive Disorders

- ☐ Delirium, dementia, and other cognitive disorders (290.xx, 290.10, 293.00, 294.10, 294.80, 294.90, 780.09)

Disorders Due to Medical Condition and Medications

- ☐ Mental disorders due to medical condition (306, 316)
- ☐ Medication induced disorders (332.10, 333.10, 333.70, 333.82, 333.90, 333.92, 333.99, 995.2)

Somatoform, Eating, Sleeping & Factitious Disorders

- ☐ Somatoform, eating, sleeping, and factitious disorders (300.xx, 300.11, 300.70, 300.81, 307.xx)

Dissociative Disorders

- ☐ Dissociative disorders (300.12, 300.13, 300.14, 300.15, 300.60)

Other Disorders

- ☐ Other mental disorders (Codes not listed above)
- ☐ Other clinical issues (V-codes)

NC-TOPPS Mental Health and Substance Abuse

Adolescent (Ages 12-17) Episode Completion Interview

Use this form for backup only. *Do not mail.* Enter data into web-based system (http://www.ncdhhs.gov/mhddsas/nc-topps)

QP First Initial & Last Name

I certify that I am the QP who has conducted and completed this interview.

Sign: _____ ***Date:*** _____

LME Assigned Consumer Record Number

First three letters of consumer's last name: (If female, use consumer's maiden name)

First letter of consumer's first name:

Please provide the following information about the individual:

1. Date of Birth ☐☐ / ☐☐ / ☐☐

2. Gender

☐ Male ☐ Female

3. Please select the appropriate age/disability category(ies) for which the individual is receiving services and supports.
(mark all that apply)

☐ Adolescent Mental Health, age 12-17

☐ Adolescent Substance Abuse, age 12-17

b. *If both Mental Health and Substance Abuse*, is the treatment at this time mainly provided by a...

☐ qualified professional in substance abuse
☐ qualified professional in mental health
☐ both

4. Individual County of Residence:

_____

5. Please indicate reason for Episode Completion:
(mark only one)

☐ Completed treatment
☐ Discharged at program initiative
☐ Refused treatment
☐ Did not return as scheduled within 60 days
☐ Changed to service not required for NC-TOPPS
☐ Moved out of area or changed to different LME
☐ Incarcerated
☐ Institutionalized
☐ Died

Reminder: If Episode Completion reason is 'Did not return as scheduled within 60 days' or 'Died,' answer questions based on the last time period when the consumer was in active treatment.

6. Assessments of Functioning

a. Was the Global Assessment of Functioning (GAF) score updated in the past 3 months or since the last interview?

☐ Y ☐ N → *(skip to 7)*

b. Current Global Assessment of Functioning Score: ☐☐

7. Please indicate the DSM-IV TR diagnostic classification(s) for this individual. *(See Attachment I)*

8. <u>For Female Adolescent SA individual:</u>
Is this consumer enrolled in a specialty program for maternal, pregnant, perinatal, or post-partum? ☐ Y ☐ N

If Episode Completion reason is 'Consumer did not return as scheduled within 60 days' or 'Died,' answer 9.

9. How many weeks ago was the consumer last seen for treatment?

☐ Past week
☐ 2-4 weeks ago
☐ 5-8 weeks ago
☐ More than 8 weeks ago

10. Since the last interview, the consumer has attended scheduled treatment sessions...

☐ Rarely or never
☐ Sometimes
☐ All or most of the time

11. <u>For Adolescent SA individual</u>:
Number of drug tests conducted and number positive in the past 3 months: *(Do not count if Positive for Methadone Only)*

a. Number Conducted ☐☐ *(enter zero, if none and skip to 12)*

b. Number Positive ☐☐ *(enter zero, if none and skip to 12)*

c. How often did each substance appear for all drug tests conducted?

Alcohol	THC	Opiates	Benzo.
☐☐	☐☐	☐☐	☐☐

Cocaine	Amphetamines	Barbiturates
☐☐	☐☐	☐☐

12. Since the individual started services for this episode of treatment, which of the following areas has the individual received help?
(mark all that apply)

☐ Educational improvement
☐ Finding or keeping a job
☐ Housing (basic shelter or rent subsidy)
☐ Transportation
☐ Child care
☐ Medical care
☐ Screening/Treatment referral for HIV/TB/HEP
☐ Legal issues

NC-TOPPS Mental Health and Substance Abuse

Adolescent (Ages 12-17) Episode Completion Interview

Use this form for backup only. *Do not mail.* Enter data into web-based system. (http://www.ncdhs.gov/mhddsas/nc-topps)

13. In the past 3 months, has the individual's family, guardian, or significant other been involved in any contact with staff concerning any of the following? *(mark all that apply)*

- ☐ Treatment services
- ☐ Person-centered planning
- ☐ None of the above

Section II: Complete items 14-35 using information from the individual's interview (preferred) or consumer record

14. How are the next section's items being gathered? *(mark all that apply)*

- ☐ In-person interview (preferred)
- ☐ Telephone interview
- ☐ Clinical record/notes

15. Do you ever have difficulty participating in treatment because of problems with... *(mark all that apply)*

- ☐ No difficulties prevented you from entering treatment
- ☐ Active mental health symptoms (anxiety or fear, agoraphobia, paranoia, hallucinations)
- ☐ Active substance abuse symptoms (addiction, relapse)
- ☐ Physical health problems (severe illness, hospitalization)
- ☐ Family or guardian issues (controlling spouse, family illness, child or elder care, domestic violence, parent/guardian cooperation)
- ☐ Treatment offered did not meet needs (availability of appropriate services, type of treatment wanted by consumer not available, favorite therapist quit, etc.)
- ☐ Engagement issues (AWOL, doesn't think s/he has a problem, denial, runaway, oversleeps)
- ☐ Cost or financial reasons (no money for cab, treatment cost)
- ☐ Stigma/Embarrassment
- ☐ Treatment/Authorization access issues (insurance problems, waiting list, paperwork problems, red tape, lost Medicaid card, IPRS target populations, Value Options, referral issues, citizenship, etc.)
- ☐ Language or communication issues (foreign language issues, lack of interpreter, etc.)
- ☐ Legal reason (incarceration, arrest)
- ☐ Transportation/Distance to provider
- ☐ Scheduling issues (work or school conflicts, appointment times not workable, no phone)

16. Are you currently enrolled in school or courses that satisfy requirements for a certification, diploma or degree? (Enrolled includes school breaks, suspensions, and expulsions)

☐ Y ☐ N → *(skip to 17)*

b. If **yes**, what programs are you currently enrolled in for credit? *(mark all that apply)*

- ☐ Alternative Learning Program (ALP) - at-risk students outside standard classroom
- ☐ Academic schools (K-12)
- ☐ Technical/Vocational school
- ☐ College
- ☐ GED Program, Adult literacy

17. For K-12 only:

a. What grade are you currently in? ☐☐

b. Since beginning treatment, your school attendance has...

☐ improved ☐ stayed the same ☐ gotten worse

c. For your most recent reporting period, what grades did you get most of the time? *(mark only one)*

☐ A's ☐ B's ☐ C's ☐ D's ☐ F's ☐ School does not use traditional grading system

d. *If school does not use traditional grading system*, for your most recent reporting period, did you pass or fail most of the time? ☐ Pass ☐ Fail

18. For K-12 only: In the past 3 months, how many days of school have you missed due to...

a. Expulsion ☐☐

b. Out-of-school suspension ☐☐

c. Truancy ☐☐

d. Are you currently expelled from regular school? ☐ Y ☐ N

19. What best describes your current employment status? *(mark only one)*

- ☐ Full-time work (working 35 hours or more a week)
- ☐ Part-time work (working less than 35 hours a week)
- ☐ Unemployed (seeking work or on layoff from a job)
- ☐ Not in labor force (not seeking work)

20. In the past 3 months, how often did you participate in ...

a. extracurricular activities?

☐ Never ☐ A few times ☐ More than a few times

b. recovery-related support or self-help groups?

☐ Never → *(skip to 21)* ☐ A few times ☐ More than a few times

c. In the past month, how many times did you attend recovery-related support or self-help groups?

- ☐ 1-3 times (less than once per week)
- ☐ 4-7 times (about once per week)
- ☐ 8-15 times (2 or 3 times per week)
- ☐ 16-30 times (4 or more times per week)
- ☐ some attendance, but frequency unknown

NC-TOPPS Mental Health and Substance Abuse

Adolescent (Ages 12-17) Episode Completion Interview

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21. In the past 3 months, how often have your problems interfered with work, school, or other daily activities?
☐ Never ☐ A few times ☐ More than a few times

22. In the past month, how would you describe your mental health symptoms?
☐ Extremely severe ☐ Severe ☐ Moderate ☐ Mild ☐ Not present

23. In the past month, if you have a current prescription for psychotropic medications, how often have you taken this medication as prescribed?
☐ No prescription
☐ All or most of the time
☐ Sometimes
☐ Rarely or never

24. In the past 3 months, how many times have you moved residences? ☐☐ *(enter zero, if none and skip to 25)*

If Episode Completion reason is 'Consumer did not return as scheduled within 60 days' or 'Died,' skip 24b.

b. What was the reason(s) for your most recent move? *(mark all that apply)*
☐ Moved closer to family/friends
☐ Moved to nicer or safer location
☐ Needed more supervision or supports
☐ Moved to location with more independence, better access to activities and/or services
☐ Could no longer afford previous location or evicted

25. Currently, <u>where</u> do you live?
☐ Homeless → *(skip to b)*
☐ Temporary housing → *(skip to 26)*
☐ In a family setting (private or foster home) → *(skip to 26)*
☐ Residential program → *(skip to c)*
☐ Facility/institution → *(skip to 26)*
☐ Other → *(skip to 26)*

If Episode Completion reason is 'Consumer did not return as scheduled within 60 days' or 'Died,' skip 25band 25c.

b. *If homeless*, please specify your living situation currently.
☐ Sheltered (homeless shelter or domestic violence shelter)
☐ Unsheltered (on the street, in a car, camp)

c. *If residential program*, please specify the type of residential program you currently live in.
☐ Therapeutic foster home
☐ Level III group home
☐ Level IV group home
☐ State-operated residential treatment center
☐ Substance abuse residential treatment facility
☐ Halfway house (for Adolescent SA individual)

26. Was this living arrangement in your home community?
☐ Y ☐ N

27. In the past 3 months, have you received any residential services outside of your home community?
☐ Y ☐ N

If Episode Completion reason is 'Consumer did not return as scheduled within 60 days' or 'Died,' skip 28.

28. In the past 3 months, <u>who</u> did you live with most of the time? *(mark all that apply)*
☐ Lived alone
☐ Spouse/partner
☐ Child(ren)
☐ Mother/Stepmother
☐ Father/Stepfather
☐ Grandmother
☐ Grandfather
☐ Foster family
☐ Sibling(s)
☐ Other relative(s)
☐ Guardian
☐ Friend(s)/roommate(s)
☐ Other

29. <u>For Adolescent MH only individual</u>:
In the past 3 months, have you used tobacco or alcohol?
☐ Y ☐ N

30. <u>For Adolescent MH only individual</u>:
In the past 3 months, have you used illicit drugs or other substances?
☐ Y ☐ N → *(skip to 32 if 'No' is answered on both questions 29 <u>and</u> 30)*

31. Please mark the frequency of use for each substance in the past month.

Substance	Past <u>Month</u> - Frequency of Use				
	Not Used	1-3 times monthly	1-2 times weekly	3-6 times weekly	Daily
Tobacco use (any tobacco products)	☐	☐	☐	☐	☐
Heavy alcohol use (>=5(4) drinks per sitting)	☐	☐	☐	☐	☐
Less than heavy alcohol use	☐	☐	☐	☐	☐
Marijuana or hashish use	☐	☐	☐	☐	☐
Cocaine or crack use	☐	☐	☐	☐	☐
Heroin use	☐	☐	☐	☐	☐
Other opiates/opioids	☐	☐	☐	☐	☐
Other Drug Use ☐☐ (enter code from list below)	☐	☐	☐	☐	☐

Other Drug Codes

5=Non-prescription Methadone
7=PCP
8=Other Hallucinogen
9=Methamphetamine
10=Other Amphetamine
11=Other Stimulant
12=Benzodiazepine
13=Other Tranquilizer
14=Barbiturate
15=Other Sedative or Hypnotic
16=Inhalant
17=Over-the-Counter
22=OxyContin (Oxycodone)
29=Ecstasy (MDMA)

NC-TOPPS Mental Health and Substance Abuse

Adolescent (Ages 12-17) Episode Completion Interview

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32. In the past month, how many times have you been in trouble with the law? ☐☐
(enter zero, if none and skip to 34)

33. In the past month, how many times have you been arrested or had a petition filed for adjudication for any offense including DWI? ☐☐
(enter zero, if none)

34. Do you have a Court Counselor or are you under the supervision of the crimal justice system (adult or juvenile)?
☐ Y ☐ N

35. For Female Adolescent SA individual only: Do you have children?
☐ Y ☐ N → *(skip to 36)*

b. Since the last interview, have you... *(mark all that apply)*
- ☐ Gained legal custody of child(ren)
- ☐ Lost legal custody of child(ren)
- ☐ Begun seeking legal custody of child(ren)
- ☐ Stopped seeking legal custody of child(ren)
- ☐ Continued seeking legal custody of child(ren)
- ☐ New baby born - removed from legal custody
- ☐ None of the above

c. Are all, some, or none of the children in your legal custody receiving preventive and primary health care?
☐ All ☐ Some ☐ None ☐ NA (no children in legal custody)

d. Since the last interview, have your parental rights been terminated from all, some, or none of your children?
☐ All ☐ Some ☐ None

e. Since the last interview, have you been investigated by DSS for child abuse or neglect? ☐ Y ☐ N → *(skip to g)*

f. Was the investigation due to an infant testing positive on a drug screen? ☐ Y ☐ N ☐ NA

g. How many of the children in your legal custody have been screened for mental health and/or substance abuse prevention or treatment services?
☐ All ☐ Some ☐ None ☐ NA (no children in legal custody)

Section III: This next section includes questions which are important in determining consumer outcomes. These questions require that they be asked directly to the individual either in-person or by telephone.

36. Is the individual present for an in-person or telephone interview or have you directly gathered information from the individual within the past two weeks?
- ☐ Y - Complete items 37-51
- ☐ N - Stop here

37. Females only: Are you currently pregnant?
☐ Y ☐ N *(skip to 38)* ☐ Unsure *(skip to 38)*

b. How many weeks have you been pregnant? ☐☐

c. Have you been referred to prenatal care? ☐ Y ☐ N

d. Are you receiving prenatal care? ☐ Y ☐ N

38. Females only: Have you given birth in the past year?
☐ Y ☐ N→ *(skip to 39)*

b. For Adolescent SA individual:
How long ago did you give birth?
- ☐ Less than 3 months ago
- ☐ 3 to 6 months ago
- ☐ 7 to 12 months ago

c. Did you receive prenatal care during pregnancy? ☐ Y ☐ N

d. For Adolescent SA individual:
What was the # of weeks gestation? ☐☐

e. For Adolescent SA individual:
What was the birth weight? ☐☐ pounds ☐☐ ounces

f. How would you describe the baby's current health?
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Baby is deceased → *(skip to 39)*
- ☐ Baby is not in birth mother's custody → *(skip to 39)*

g. Is the baby receiving regular Well Baby/Health Check services? ☐ Y ☐ N

39. Since the last interview, have you visited a physical health care provider for a routine check up?
☐ Y ☐ N

40. How many active, stable relationship(s) with adult(s) who serve as positive role models do you have? *(i.e., member of clergy, neighbor, family member, coach)*
☐ None ☐ 1 or 2 ☐ 3 or more

41. For Adolescent SA individual:
In the past month, if you have a sponsor, how often have you had contact with him or her?
- ☐ Don't have a sponsor
- ☐ Never
- ☐ A few times
- ☐ More than a few times

42. How supportive has your family and/or friends been of your treatment and recovery efforts?
- ☐ Not supportive
- ☐ Somewhat supportive
- ☐ Very supportive
- ☐ No family/friends

NC-TOPPS Mental Health and Substance Abuse

Adolescent (Ages 12-17) Episode Completion Interview

Use this form for backup only. *Do not mail.* Enter data into web-based system. (http://www.ncdhs.gov/mhddsas/nc-topps)

43. For Adolescent SA individual:
In the past 3 months, have you used a needle to get any drug injected under your skin, into a muscle, or into a vein for nonmedical reasons? ☐ Y ☐ N

44. In the past 3 months, how often have you been hit, kicked, slapped, or otherwise physically hurt?
☐ Never ☐ A few times ☐ More than a few times

45. In the past 3 months, how often have you hit, kicked, slapped, or otherwise physically hurt someone?
☐ Never ☐ A few times ☐ More than a few times

46. Since the last interview, how often have you tried to hurt yourself or cause yourself pain on purpose (such as cut, burned, or bruised self)?
☐ Never ☐ A few times ☐ More than a few times

47. Since the last interview, how often have you had thoughts of suicide?
☐ Never ☐ A few times ☐ More than a few times

48. Since the last interview, have you attempted suicide?
☐ Y ☐ N

49. In the past 3 months, how well have you been doing in the following areas of your life?

	Excellent	Good	Fair	Poor
a. Emotional well-being	☐	☐	☐	☐
b. Physical health	☐	☐	☐	☐
c. Relationships with family or significant others	☐	☐	☐	☐

50. In the past 3 months, have you...
a. had **telephone** contacts to an emergency crisis facility?
☐ Y ☐ N
b. had **visits** to a hospital emergency room?
☐ Y ☐ N
c. spent **nights** in a medical/surgical hospital? *(excluding birth delivery)*
☐ Y ☐ N
d. spent **nights** homeless? (sheltered or unsheltered)
☐ Y ☐ N
e. spent **nights** in detention, jail, or prison? (adult or juvenile system)
☐ Y ☐ N

51. How helpful have the program services been in...
a. improving the quality of your life?
☐ Not helpful ☐ Somewhat helpful ☐ Very helpful ☐ NA
b. decreasing your symptoms?
☐ Not helpful ☐ Somewhat helpful ☐ Very helpful ☐ NA
c. increasing your hope about the future?
☐ Not helpful ☐ Somewhat helpful ☐ Very helpful ☐ NA
d. increasing your control over your life?
☐ Not helpful ☐ Somewhat helpful ☐ Very helpful ☐ NA
e. improving your educational status?
☐ Not helpful ☐ Somewhat helpful ☐ Very helpful ☐ NA

For Data Entry User (DEU) only:
This printable interview form must be signed by the QP who completed the interview for this consumer.

Does this printable interview form have the QP's signature (see page 1)? ☐ Y ☐ N

NOTE: This entire signed printable interview form must be placed in the consumer's record.

End of interview

Enter data into web-based system:
http://www.ncdhhs.gov/mhddsas/nc-topps

Do not mail this form

Attachment I:
DSM-IV TR Diagnostic Classifications

Childhood Disorders

- ☐ Learning Disorders (315.00, 315.10, 315.20, 315.90)
- ☐ Motor skills disorders (315.40)
- ☐ Communication disorders (307.00, 307.90, 315.31, 315.39)
- ☐ Childhood disorders-other (307.30, 309.21, 313.23, 313.89, 313.90)
- ☐ Mental Retardation (317, 318.00, 318.10, 318.20, 319)
- ☐ Autism and pervasive development (299.00, 299.10, 299.80)
- ☐ Attention deficit disorder (314.xx, 314.90)
- ☐ Conduct disorder (312.80)
- ☐ Disruptive behavior (312.90)
- ☐ Oppositional defiant disorder (313.81)

Substance-Related Disorders

- ☐ Alcohol abuse (305.00)
- ☐ Alcohol dependence (303.90)
- ☐ Drug abuse (305.20, 305.30, 305.40, 305.50, 305.60, 305.70, 305.90)
- ☐ Drug dependence (304.00, 304.10, 304.20, 304.30, 304.40, 304.50, 304.60, 304.80, 304.90)

Schizophrenia and Other Psychotic Disorders

- ☐ Schizophrenia and other psychotic disorders (293.xx, 295.xx, 297.10, 297.30, 298.80, 298.90)

Mood Disorders

- ☐ Dysthymia (300.40)
- ☐ Bipolar disorder (296.xx)
- ☐ Major depression (296.xx)

Anxiety Disorders

- ☐ Anxiety disorders (other than PTSD) (293.89, 300.00, 300.01, 300.02, 300.21, 300.22, 300.23, 300.29, 300.30, 308.30)
- ☐ Posttraumatic Stress Disorder (PTSD) (309.81)

Adjustment Disorders

- ☐ Adjustment disorders (309.xx)

Personality, Impulse Control, and Identity Disorders

- ☐ Personality disorders (301.00, 301.20, 301.22, 301.40, 301.50, 301.60, 301.70, 301.81, 301.82, 301.83, 301.90)
- ☐ Impulse control disorders (312.31, 312.32, 312.33, 312.34, 312.39)
- ☐ Sexual and gender identity disorders (302.xx, 306.51, 607.84, 608.89, 625.00, 625.80)

Delerium, Dementia, & Other Cognitive Disorders

- ☐ Delirium, dementia, and other cognitive disorders (290.xx, 290.10, 293.00, 294.10, 294.80, 294.90, 780.09)

Disorders Due to Medical Condition and Medications

- ☐ Mental disorders due to medical condition (306, 316)
- ☐ Medication induced disorders (332.10, 333.10, 333.70, 333.82, 333.90, 333.92, 333.99, 995.2)

Somatoform, Eating, Sleeping & Factitious Disorders

- ☐ Somatoform, eating, sleeping, and factitious disorders (300.xx, 300.11, 300.70, 300.81, 307.xx)

Dissociative Disorders

- ☐ Dissociative disorders (300.12, 300.13, 300.14, 300.15, 300.60)

Other Disorders

- ☐ Other mental disorders (Codes not listed above)
- ☐ Other clinical issues (V-codes)

APPENDIX F (NC-TOPPS Updates for JJSAMHP teams)

JJSAMHP UPDATE

Comparing JJSAMHP Youth Who Complete Treatment and Those Who Do Not

This data update looks at two groups of JJSAMHP Treatment Consumers responding to the NC-TOPPS Episode Completion Interview during 2010-2011. It compares those youth who completed treatment (47%) and those who did not complete treatment (53%). Some key variables are outlined below.

- Demographics. Analyses reveal that African American youth are significantly less likely to complete treatment than Caucasian youth.
- Parent/Family Contact. Youth who do not complete treatment are more likely to have no parent/family contact with staff than those who do complete treatment.
- Treatment Attendance. Treatment attendance strongly differentiates between those who complete treatment and those who do not (73% versus 26%).
- Substance Use. For youth who report substance use, 35% of completers reported past month marijuana use versus 51% of non-completers.
- Mental Health Symptoms. Youth not completing treatment were more likely to report moderate to severe/extremely severe mental health symptoms when compared to those who complete treatment.
- Participation in Extra-curricular Activities. Treatment completers participated in extra-curricular activities at about 2 times the rate of treatment non-completers.
- Problems Interfere with Daily Life. Youth who did not complete treatment were two times more likely to report problems interfering with daily life than youth who did complete treatment.
- Barriers. More than half of the youth who did not complete treatment had a barrier to attending treatment. Treatment engagement was the most common barrier among those who did not complete treatment.
- Physically Hurt. Youth who do not complete treatment reported more often being physically hurt in the past three months when compared to youth who did complete treatment.

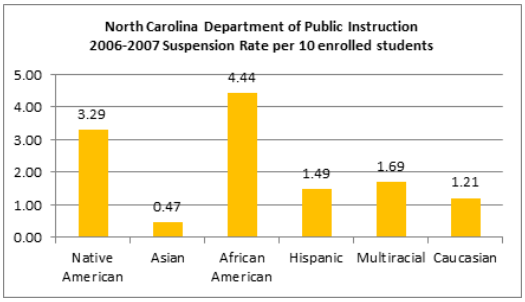
	Completed Treatment	***Did Not Complete Treatment***
Number responding	N= 892	N=1,019
Race (top two groups) African American Caucasian	 470 499	 715 447
Parent/Family Contact with Treatment Staff	84%	67%
Attended Most or All Treatment Sessions	73%	26%
Substance Use, past month Marijuana Use	35%	51%
Mental Health Symptoms, past month Moderate to Severe/Extremely Severe	38%	69%
Youth participation in Extra-curricular activities	21%	11%
Problems Interfere with Daily Life more than a few times	20%	47%
Barriers to Treatment Any Barrier Treatment Engagement Family Issues Scheduling Issues	 20% 7% 6% 7%	 54% 26% 19% 17%
Physically Hurt in Past 3 Months (A few times or more than a few times)	16%	27%

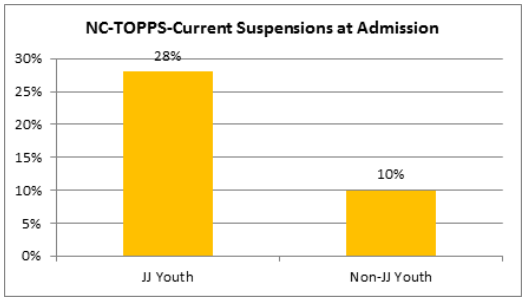
Educational Outcomes and Juvenile Justice Involved Youth

The Juvenile Justice Substance Abuse and Mental Health Partnerships

A recent study in the state of Texas examined school discipline and found the following [1]:

- 60% of students who had entered the 7th grade between the years of 2000-2003 had received an in school suspension, out of school suspension or expulsion by their 12th grade year;
- Many of the removals from the classroom were not mandated by school code but were at the discretion of school personnel. In fact, only 3% of the expulsions were mandatory or based on "zero tolerance" type policies;
- Disciplinary actions were related to adverse educational outcomes and increased involvement in the juvenile justice system;
- African American youth and youth with mental illnesses were disproportionately disciplined for discretionary reasons;
- Even when looking at schools with similar economic and demographic profiles, the use of disciplinary practices varied and showed that many actions were based on where the student attended school.



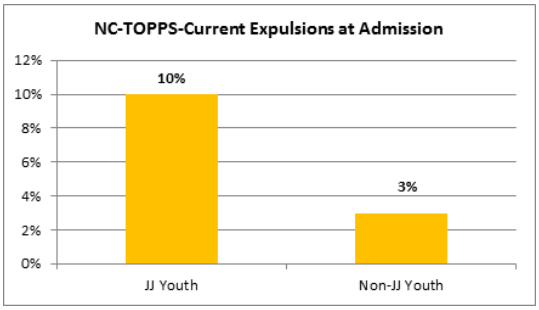


In North Carolina, data from NC-TOPPS and North Carolina Department of Public Instruction outline the following:

- African American and Native American Youth have higher suspension rates than any other group of youth;
- Juvenile justice involved youth have almost three times as many suspensions when compared to non-JJ youth at admission to treatment;
- Similarly, JJ involved youth have more than three times as many expulsions when compared to non-JJ youth at admission to treatment.

The Justice Center Study director (Texas) noted that "We hope these findings strengthen efforts underway in Texas to improve outcomes for students, and help other states' policymakers in examining school discipline practices so that they can enhance students' academic performance and reduce juvenile justice system involvement"

As their study found, local policies and practices also dictated to a large extent the nature of disciplinary actions, regardless of other factors. Therefore, local stakeholders can have a significant impact on advocating for the needs of youth and making alternative plans to address their needs.



NC -TOPPS is the North Carolina Treatment Outcomes Program and Performance System that is used to collect data on consumers engaged in behavioral health services.

[1]Fabelo et al. (2011). Breaking Schools' Rules: A Statewide Study of How School Discipline Relates to Students' Success and Juvenile Justice Involvement: Council of State Governments Justice Center.