ANNUAL REPORT OF THE

JUVENILE JUSTICE SUBSTANCE ABUSE MENTAL HEALTH PARTNERSHIPS (JJSAMHP)

2010-2011

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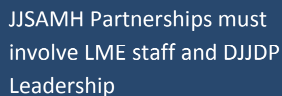
Section A: Overview of the Juvenile Justice Substance Abuse Mental Health Partnerships (JJSAMHP)

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:



- A Local Management Entity
- 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 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 DJJDP 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 2010-2011 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 (LMEs) involved with JJSAMHP and includes information on the Court Districts associated with each LME.
- **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 2010-2011.

Section B: Local Management Entity Involvement

As noted, JJSAMHP teams must involve the Local Management Entity. The role of the LME is to help to ensure that the principles of the JJSAMHP are facilitated through the local teams. The LME is also provided with funds to help support local team activities. There are 18 LMEs associated with JJSAMHP serving 72 counties. Within the LME's, there are 23 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 designation, please see **Appendix A. It is noted that many of these designations were changed in June, 2011.** Also, although there are 23 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)

JJSAMH Partnerships Across North Carolina

The 18 LMEs associated with JJSAMHP are as follows:

Alamance –Caswell Local Management Entity	**The Beacon Center**	**CenterPoint Human Services-3 major teams**	**Crossroads Behavioral Healthcare**
Cumberland County Mental Health Center	**The Durham Center**	**East Carolina Behavioral Health-2 major teams**	**Eastpointe**
Five County Mental Health Authority-2 major teams	**Guilford Center for Behavioral Health and Disability Services**	**Onslow Carteret Behavioral Healthcare Services**	**Orange-Person-Chatham MH/DD/SAS Authority-2 major teams**
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 LMEs include: Johnston, Mecklenburg, Pathways, and Smoky Mountain

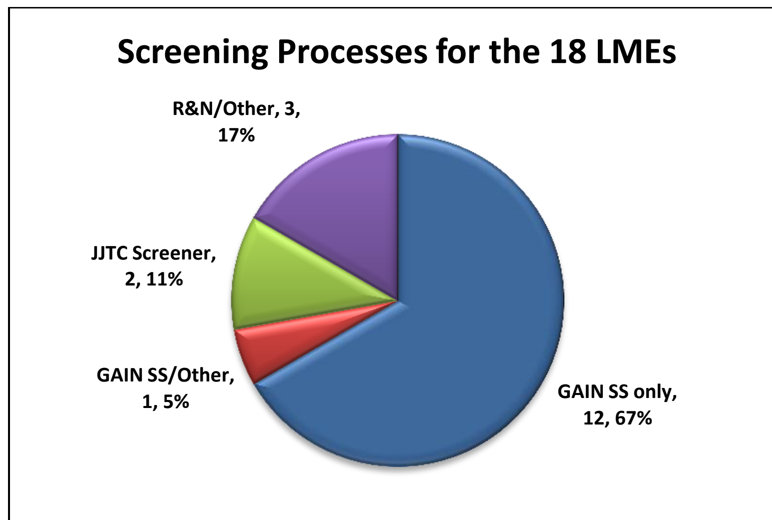
Section C: JJSAMHP SERVICE PROVISION DOMAINS

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/)

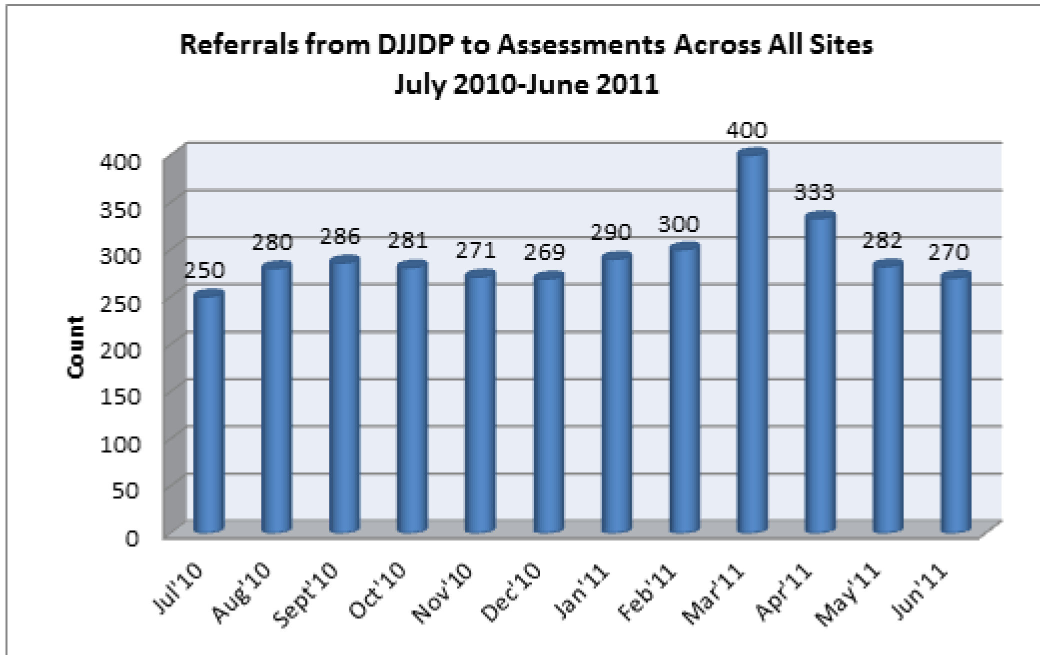
The RF six steps include a Coordinated Individualized Response of: 1) Initial Screening; 2) Initial Assessment and 3) Service Coordination and Community Directed Engagement plan for: 4) Initiation; 5) Engagement; and 6) Completion. Although all the JJSAMHP teams do not have to follow this model (there are six RF sites in NC), there are some overlapping concepts for JJSAMHP service domains. Please note these five domains below. It is noted that most of the team processes within each of the first four domains for each LME are outlined in the JJSAMHP Compendium of Services, which can be viewed online at: http://www.turninglivesaround.org/JJSAMHP%20Compendium%20of%20Services.pdf.

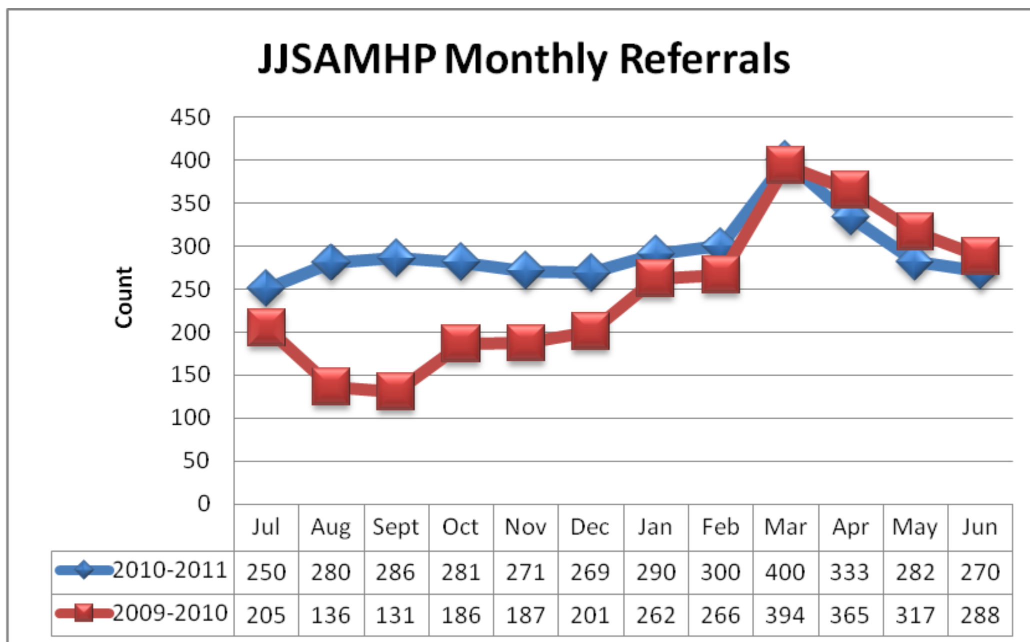
JJSAMHP Domain I: Screening and Referral

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. 95% of the JJJSAMHP teams identify a uniform screening process from DJJDP to a local provider. The different tools include the following: Global Appraisal of Individual Needs Short Screener (GAIN SS); Risk and Needs Assessment from DJJDP; 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 3,512 total referrals from DJJDP screening to local provider(s) for assessments from July, 2010 through June, 2011. This averages to 293 referrals per month. For the first half of the fiscal year (July through December), there were 1,637 referrals and for the second half of the fiscal year (January through June), there were 1,875 referrals. To determine the number of referrals for each LME across this time period, please see the section entitled "Local Team Processes." The following graphs represent the total referrals completed across all JJSAMHPs for 2010-2011 and then a comparison of this fiscal year with the previous fiscal year.

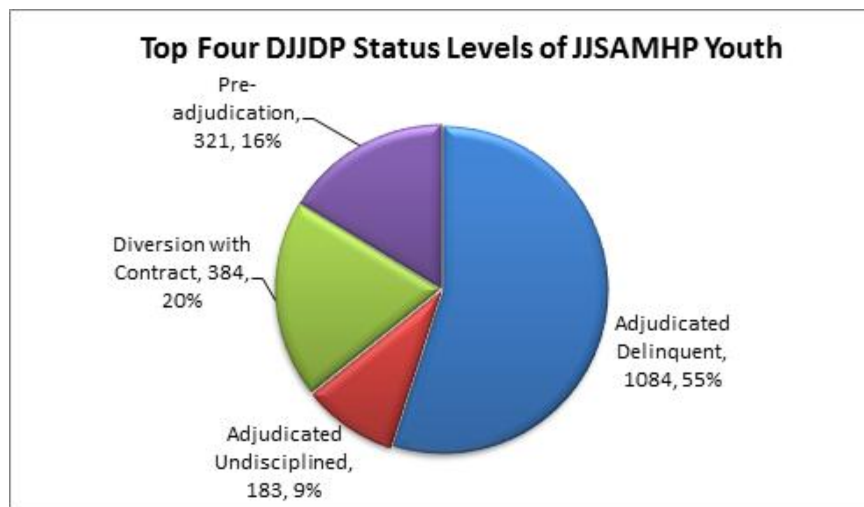




	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
2010-2011	250	280	286	281	271	269	290	300	400	333	282	270
2009-2010	205	136	131	186	187	201	262	266	394	365	317	288

DJJDP 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. Of those youth within those four categories, the majority were adjudicated delinquent, followed by diversion with contract, then pre-adjudication and adjudicated undisciplined. The information is in the following graph.

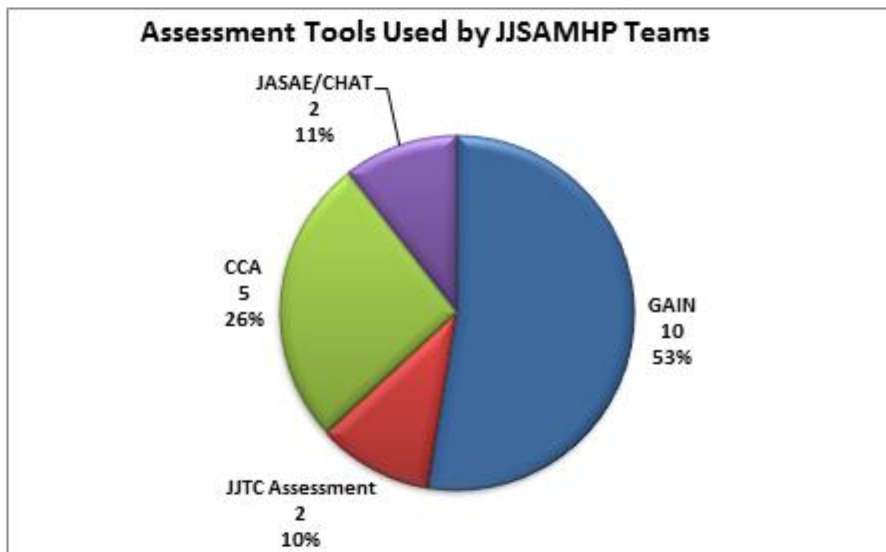


JJSAMHP Domain II: Assessment

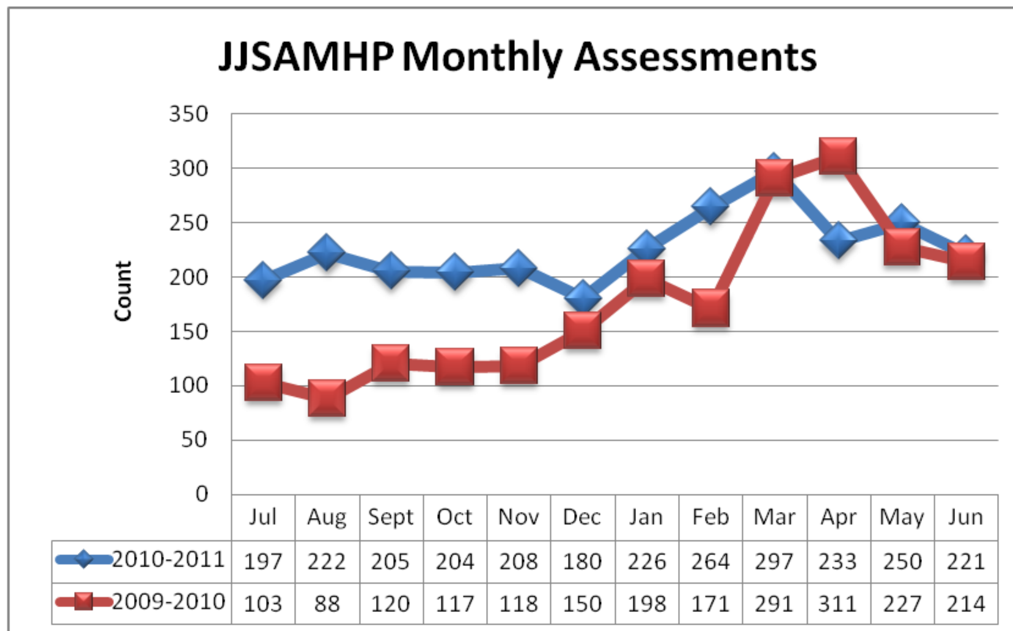
The second JJSAMHP domain is Assessment. The Assessment measure used by JJSAMHP teams must contain information to gather data on substance abuse and mental health challenges. According to Reclaiming Futures, a comprehensive assessment involves usage of a measure to ascertain a wide range of individual 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 another Evidence Based Assessment Tool such as the Global Appraisal of Individual Needs, the Juvenile Automated Substance Abuse Evaluation (JASAE) or the Comprehensive Health Assessment for Teens (CHAT).

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



Based on data submitted by the local teams, there were 2,707 assessments completed by partnering providers for the JJSAMHP during 2010-2011. This averages to 226 assessments per month. For the first half of the fiscal year (July through December) there were 1,216 assessments and for the second half of the fiscal year (January through June), there were 1,491 assessments. The assessments completed represent 74% of the referrals for the first half of the year and 80% of the referrals for the second half of the year. To determine the number of assessments for each LME across this time period, please see the section entitled "Local Team Processes." The following graphs represent the total assessments completed across all JJSAMHP for 2010-2011 and then a comparison of this fiscal year with the previous fiscal year.



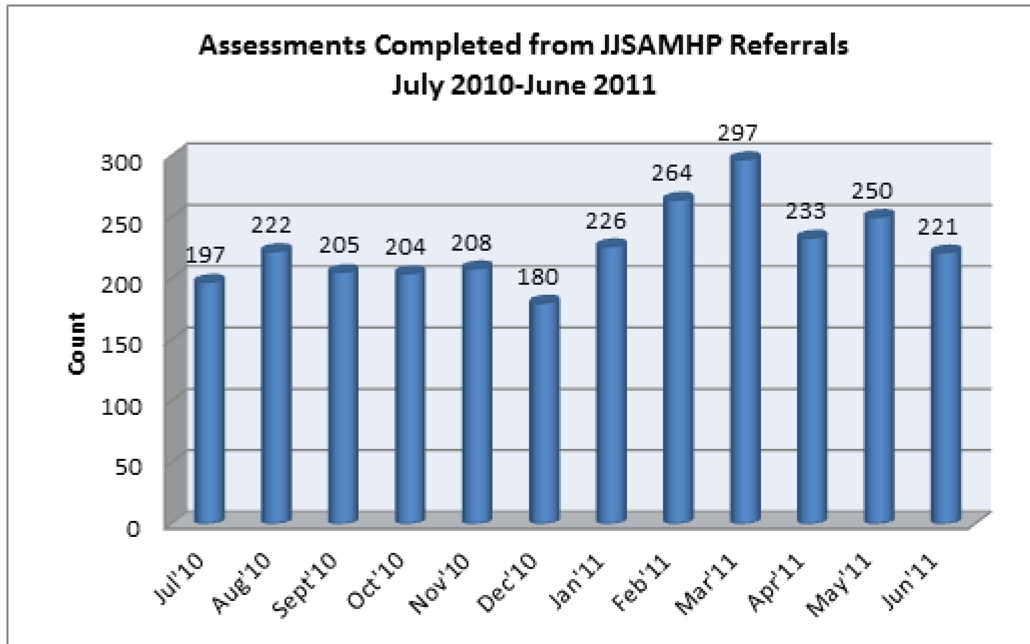
JJSAMHP Domain III: Engagement

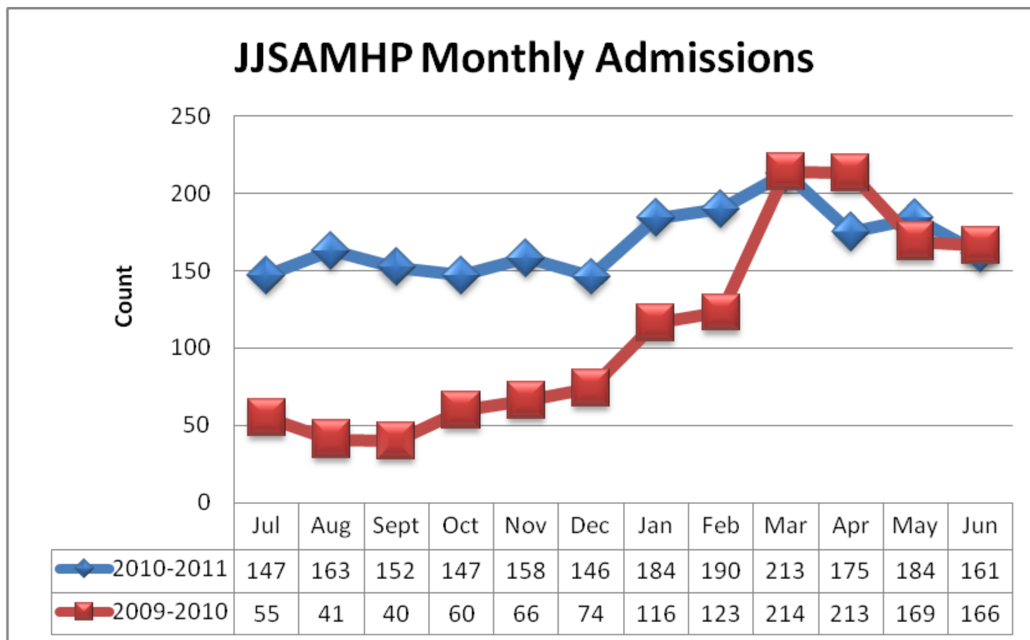
The third JJSAMHP domain is engagement –particularly utilizing System of Care Principles. Although engagement can entail various areas, including partnering with families, etc., the focus was ensuring admission to a partnering provider who agreed to include Child and Family Teams as part of the continuum of care.

100% of the teams cite regular usage of Child and Family Teams. 79% of the teams report having at least monthly (or more often) Child and Family Teams during the Service Provision process.

There were 2,020 admissions to JJSAMHP providers during 2010-2011. 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 may be some 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 913 admissions to local JJSAMHP providers and for the second half of the fiscal year (January through June), there were 1,107 admissions to JJSAMHP providers. To determine the number of admissions for each LME across this time period, please see the section entitled "Local Team Processes." The following graphs represent the total admissions to JJSAMHP partner providers for 2010-2011 and then a comparison of this fiscal year with the previous fiscal year.

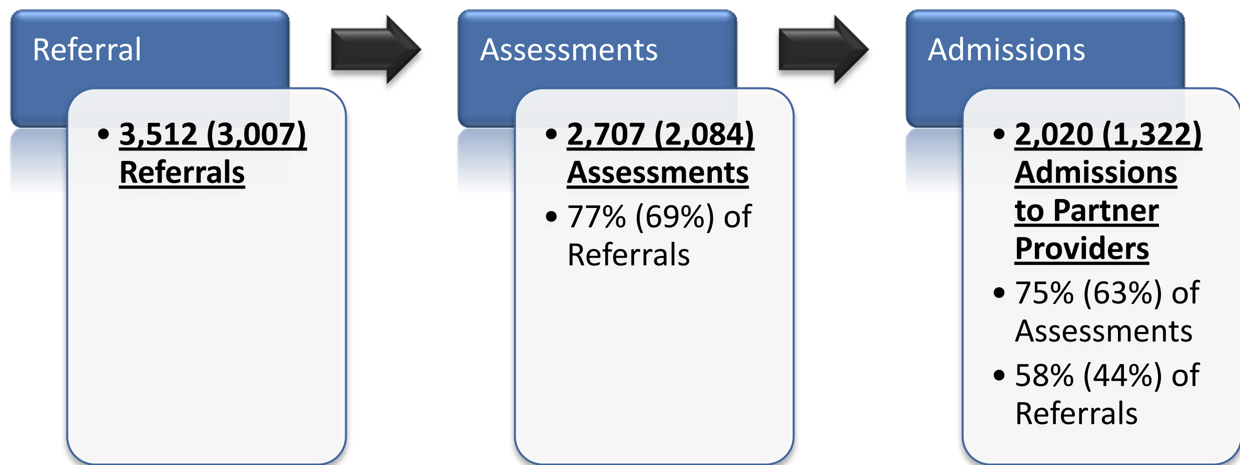




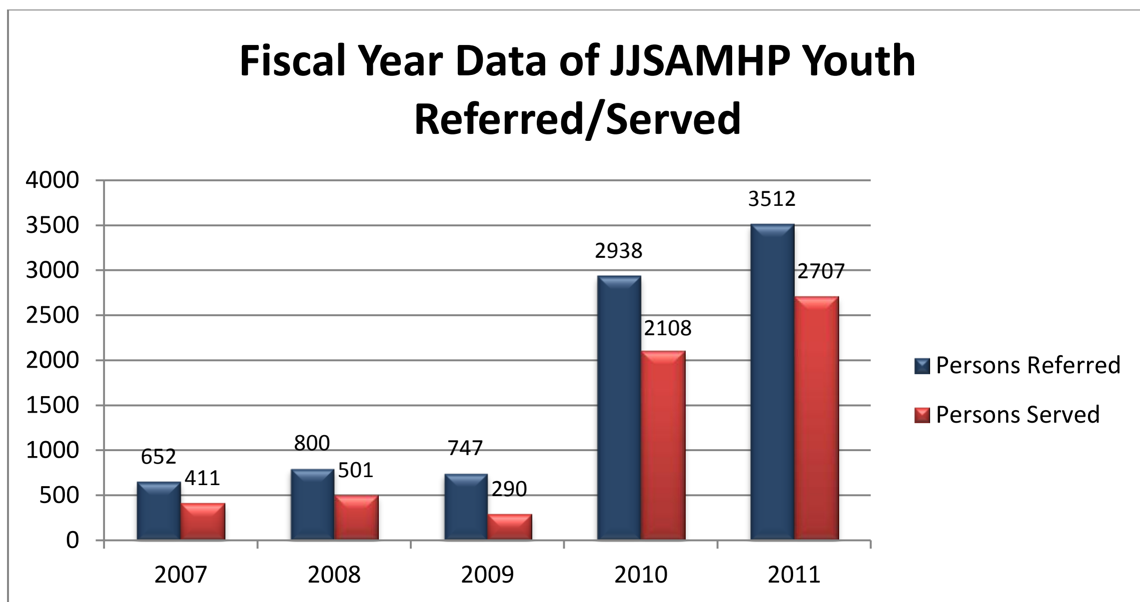
	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
2010-2011	147	163	152	147	158	146	184	190	213	175	184	161
2009-2010	55	41	40	60	66	74	116	123	214	213	169	166

Overall Process Numbers for JJSAMHP for 2010-2011

The next graphic outlines how many youth overall were reportedly referred by DJJDP into the JJSAMH Partnership, then assessed by JJSAMHP affiliated provider and then admitted to JJSAMHP affiliated provider (as a reminder, some youth are referred providers outside of the partnership for services based on their needs). **The numbers in parentheses represent the figures for 2009-2010 fiscal year.**

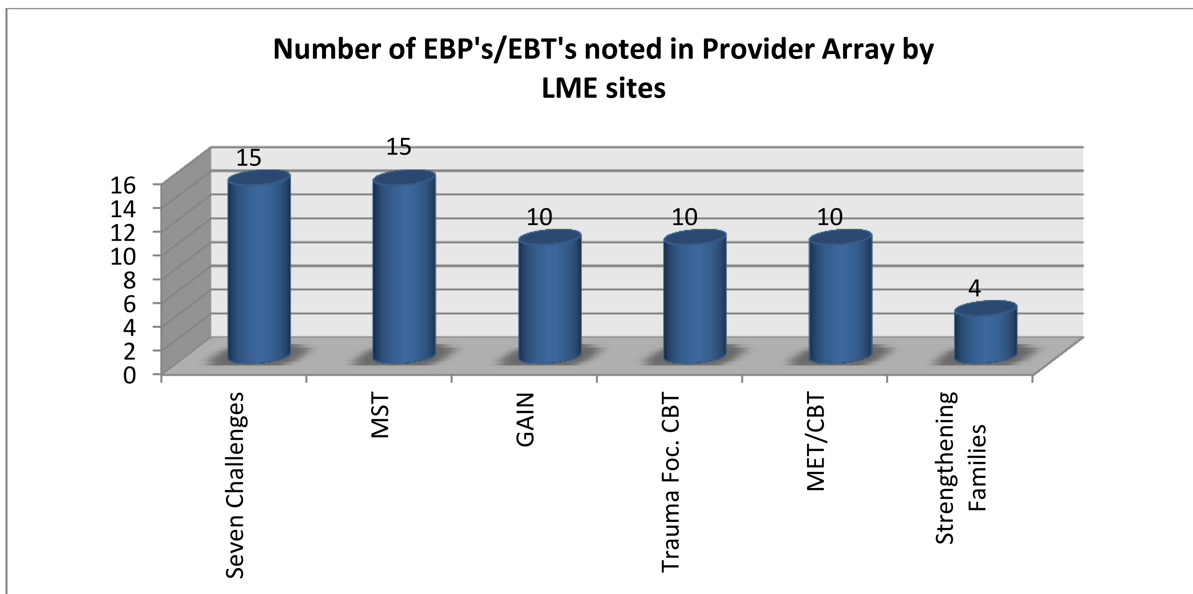


Additionally, there is data on the number of youth referred by DJJDP to a JJSAMHP provider (formerly MAJORS), and the number of youth who were admitted to a JJSAMHP provider for services. The next graphic outlines this information over the last five fiscal years. Notably, during Years 2007, 2008, 2009 (MAJORS), only substance abusing youth were being tracked and in 2010 and 2011 (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 endorsed 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). JCPC involvement is now mainly through DJJDP leadership and some of the JJSAMHP partners meeting with their JCPC teams. Many of the teams have cited sharing information about JJSAMHP with their local JCPC teams. There are other examples where JCPC funding provides for assessment partners or one of the treatment domains.

Domain	Percentage of JJSAMHP Teams
Inclusion of JCPC providers in the partnering for services	84%
Regularly update the work of the JCPC at team meetings	42%

Teams have partnered with other best practice youth development providers such as mentoring, leadership development, etc.	63%

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.

Section D: Activities and Accomplishments of JJSAMHP for Fiscal Year 2010-2011

This section outlines the overall Activities and Accomplishments of the JJSAMHP for the 2010-2011 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 increase awareness of 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. 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 during the first quarter of the fiscal year. One main activity was to determine the strengths and challenges of the JJSAMHP process for teams and for teams to do "cross work" to learn about each others' processes. From this activity, a report was generated and distributed to teams to share successes and challenging processes for JJSAMHP. Additionally, teams provided information about the type of training and technical assistance that they would request from JJSAMHP. The three Regional meetings were held on the following dates at following locations with number of individuals as noted:

      a. Statesville, Holiday Inn Statesville, November 9th-55 total participants
      b. Greenville, Hilton Greenville, November 16th -44 participants
      c. Sanford, Comfort Suites Sanford, November 17th-52 participants

2. The Spring Regional Meetings were planned in collaboration with state partners (including feedback from first meetings from participants) during the third quarter. The meetings were held in the fourth quarter. The theme for the meetings was "What Works in the Treatment of Juvenile Justice Involved Youth." One of the main highlights was presentation by Dr. Jean Steinberg of DJJDP on "What Works." An additional highlight was local team presentations on what works within local JJSAMHP processes. Additionally, there were presentations on using funding and data. The three Regional meetings were held on the following dates at following locations with number of individuals as noted:
   a. May 2nd-Durham at Millennium Hotel-68 participants
   b. May 4th-Greenville at the Greenville Hilton-45 participants
   c. May 11th-Hickory at the Crown Plaza Hotel-46 participants

B. The Compendium of Services is maintained as a resource document through work with local teams (specifically LME liaisons). 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. Also, there is provision of a "Snapshots" for state and regional level partners.

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 partners and the collection of North Carolina Treatment Outcomes and Program Performance System that is required by providers:

A. A new data process was introduced to teams using the Qualtrics system. This allowed local teams to generate a report of their data at the time of submission. This was tested this year and teams have reported that this system has been beneficial for accountability purposes. The main data points continue to be referrals, assessments, admissions, and discharges. UNCG worked with teams on the new data system and compliance/accuracy of data submissions. Reports were generated and provided to state level partners and local teams when requested. The survey questions are located in Appendix D.

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 worked on getting information out to teams about NC-TOPPS. There has been an increase in the number of NC-TOPPS submissions since last year -

Initials are up 178% and Episode Completions are up 259%. Teams were also presented their data a local team meetings and options for NC-TOPPS usage was presented at the Spring Regional Team meetings. Teams were shown how to access the new NC-TOPPS Outcomes At a Glance 2.0 for their area through the following link: http://152.1.166.29/ProviderQuery/Index.aspx . The NC-TOPPS forms are included in Appendix E. An example of data that is generated through NC-TOPPS is included in Appendix F-JJSAMHP Update.

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 82 site visits to teams from July, 2010 through June, 2011. 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. Beacon Center-July 1st 2. Orange Person Chatham-July 12th 3. Guilford Center (LME only) – July 14th 4. ECBH-July 19th 5. Southeastern Regional-July 20th 6. Southeastern Center-July 26th 7. Onslow Carteret-July 26th 8. Beacon Center-August 5th 9. Orange Person Chatham-August 13th 10. Southeastern Regional-August 17th 11. PBH-August 20th 12. Onslow Carteret-August 30th 13. Beacon Center-September 2nd 14. Eastpointe-	1. Beacon Center-October 7th 2. Eastpointe-October 7th 3. Orange Person Chatham-October 8th 4. Sandhills-October 11th 5. PBH-October 15th 6. Crossroads-October 18th 7. Guilford-October 19th 8. Five County-October 22nd 9. Southeastern Center-October 25th 10. Onslow Carteret-October 25th 11. Orange Person Chatham-October 27th 12. ECBH-Northeast-October 28th 13. Wake County-November 3rd	1. Eastpointe-January 6th 2. OPC-January 14th 3. PBH-January 14th 4. Southeastern Regional-January 18th 5. Five County-January 21st 6. Onslow Carteret-January 24th 7. ECBH Northeast-January 27th 8. ECBH-February 7th 9. Guilford Center-February 15th 10. Southeastern Regional-February 15th 11. Five County-February 18th 12. Alamance Caswell-February 25th 13. Southeastern Center-February 28th 14. Onslow Carteret-	1. ECBH-April 4th 2. Western Highlands-April 13th 3. Five County-April 15th 4. Guilford-April 19th 5. PBH-April 29th 6. Beacon Center-May 5th 7. Orange Person Chatham-May 13th 8. Five County-May 20th 9. Onslow Carteret-May 23rd 10. Southeastern Regional-May 31st 11. ECBH-June 6th 12. Crossroads-June 7th 13. CenterPoint-June 9th 14. Southeastern Regional-June 10th 15. Orange Person Chatham-June 10th 16. PBH-June 17th 17. Guilford-June 21st 18. ECBH Northeastern-

Type of Contact	*First Quarter*	*Second Quarter*	*Third Quarter*	*Fourth Quarter*
	September 2nd 15. Sandhills Center-September 2nd 16. Guilford Center (LME and Provider)-September 13th 17. CenterPoint Human Services-September 16th 18. PBH-September 17th 19. ECBH-September 20th 20. ECBH-Albemarle-September 23rd 21. Onslow Carteret-September 27th	14. Southeastern Center-November 22nd 15. Cumberland-November 23rd 16. Alamance Caswell-November 29th 17. Onslow Carteret-November 29th 18. Beacon Center-December 2nd 19. Western Highlands-December 9th 20. Onslow Carteret-December 20th 21. Southeastern Regional December 21st	February 28th 15. Eastpointe-March 3rd 16. Guilford Center-March 15th 17. Sandhills-March 15th 18. Southeastern Regional-March 15th 19. Durham-March 15th 20. ECBH Northeast-March 24th 21. Onslow Carteret-March 28th	June 23rd 19. Southeastern Regional-June 24th
Scheduled or planned phone technical assistance phone conferences or other Substantial Contact	Other assistance as follows (did not include routine emails, phone calls with questions, etc.): 1. OPC-Graduate student did research on parent videos that could be used on site and this was supplied to OPC-August 6th 2. Southeastern Center-phone conference with team-August 30th 3. Provide for Questions from the Field communication with Division and DJJDP liaisons 4. Sandhills requested additional information on assessments and this was provided along with links to other information-October 1st 5. November 11th-attendance at Wake County's collaborative JJSAMHP meeting 6. November 29th-Durham teleconference with LME rep. 7. Beacon Center-March 15th –liaison for vocational programming information request 8. Beacon Center Teleconference-April 7th			

B. Additionally, questions were asked at the Fall Regional Meetings on training and technical assistance needs of teams. The findings were used in setting up the Spring Regional meetings and for future meetings/ trainings. There were also trainings per request of teams or DJJDP. Below are JJSAMHP sponsored trainings.

Date	***Training Support Provided***	***Team members involved***
7/19/10	Completed requested training on HIPAA	7 ECBH team members
8/30/10	Completed GAIN SS training with JCC staff	10 court counseling staff
10/27/10	GAIN SS training with Rowan County Reclaiming Futures team (DJJDP and school personnel)	30 persons
3/31/11	Chatham Youth Development Center Trauma Informed Care training-Part 1	20 staff
4/26/11	Chatham YDC TIC training-Part 1	21 staff
4/27/11	Chatham YDC TIC training-Part 2	21 staff

5/12/11	Chatham YDC TIC training-Part 2	14 staff
	Training of Trainers for SOC	15 Individuals Participated/Completed SOC T**raining of Trainers** with consultant-Intentional Practices (Bibba Dobyns)
6/12-6/14	Family Partner Training	Trained 21 Family Partners in collaboration with North Carolina Families United

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

B. Every Evidence Based Practice facilitator that is noted in the EBP for Adolescent Substance Abuse Primer (see http://turninglivesaround.org/publications.html) were contacted during the first quarter to develop a menu document on costs for trainings in the EBT primer. This was updated and followed up through December 2010 and a Training Options document as completed in December 2010 and distributed to JJSAMHP teams (with costs, licensure requirements, etc. for training);

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 training for a female unit at a Youth Development Center.

Major Accomplishments from 2010-2011 Activities

A listing of Major Accomplishments from the Activities of JJSAMHP for fiscal year 2010-2011 is noted below:

- 82 Technical Assistance visits completed with local JJSAMHP teams during this period and seven substantial contacts for research and follow up (does not include routine email questions, phone calls, etc.)
- Facilitated 6 day long Regional Meetings based on DJJDP Areas with attendance noted above
- 15 Individuals Completed/Participated in SOC Training of Trainers with Intentional Practices-Bibba Dobyns
- Technical Assistance Protocol was developed and Modified and became "TA Snapshots" with distribution of Snapshots in December, 2010
- 12 Technical Assistance Reports provided during the year
- Created new data system in response to needs of data reporters/LMEs for immediate report generation after monthly data entry
- Provided data reports on: JJSAMHP teams, detention, MPGH, and data reporter activities
- Supported dissemination activities for NCTOPPs including presentations to local teams and at Regional Meetings and distribution of tables from data generated at DMHDDSAS, for local team usage
- Worked with NCFU to provide Family Partner training to 21 Family Partners that will work with JJSAMHP youth and families
- Provided 4 Trauma Informed Care Training dates at Chatham Youth Development Center
- Developed Training Options menu with costs, licensure requirements, etc. for local JJSAMHP teams in collaboration with all training providers
- Participated in and supported EBT activities including Seven Challenges training application reviews, support calls, listserve maintenance, GAIN SS training, GAIN overview training, and answering questions from local teams about Seven Challenges/GAIN
- Provided for 23 updated Cross Training manuals for individuals already trained as Trainers for SOC
- Supported 4 fidelity visits for Seven Challenges for JJSAMHP affiliated providers
- Developed web portal for Regional SA CASP program for local team usage
- Assisted with modifications to Detention Services including collection of data from each of the detention facilities
- Compendium of Services updated and maintained online
- Completion of Annual Report Document and PowerPoint with substantial input and feedback from state partners as well information from local teams and presentation of Annual Report information to DJJDP Deputy Director team
- Developed penetration rates documents for each LME area

Section E: LOCAL TEAM PROCESSES

This section outlines all of the local team processes within each of the local JJSAMHP sites by LME. 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 LMEs and which DJJDP youth are engaged for JJSAMHP. After this table, each LME main processes are outlined. More information can be obtained from the Compendium of Services at www.turninglivesaround.org.

LME	*Screening Measure*	*Assessment Measure*	*Adjudicated*	*Diversion with Contract*	*All Intakes*	*Pre-Adjudication*	*Other JJ involvement*	*Dedicated Assessor*
Alamance -Caswell	Risk & Needs Assessment	CCA	X	X				
Beacon Center	GAIN-SS	GAIN	X	X		X		
Center Point	GAIN-SS	GAIN	X	X		X		X
Crossroads	GAIN-SS	GAIN	X	X				
Cumberland	GAIN-SS	GAIN	X	X		X	Diversion Plan	
Durham Center	GAIN-SS	CCA	X	X				X
East Carolina Behavioral Health	GAIN-SS	GAIN/CCA	X	X	District 3B			
Eastpointe	GAIN-SS	GAIN	X	X		X		
Five County	GAIN-SS-4 County JJ TC Screener-Halifax	CHAT-4 County JJTC CCA-Halifax	X-District 6A	X District 6A	All intakes through DJJDP-District 9			
Guilford	GAIN-SS	GAIN			All intakes through DJJDP			
Onslow-Carteret	GAIN-SS	CCA	X	X				
Orange-Person-Chatham	GAIN-SS	Juvenile Automated Substance Abuse Evaluation			All intakes through DJJDP			
PBH	GAIN-SS	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 DJJDP			
Wake County	No measure-use JCERT process	CCA	X	X		X		X
Western Highlands	JJTC Screener	JJTC-CCA	X	X		X		

ALAMANCE CASWELL LOCAL MANAGEMENT ENTITY

Key Team Members:

Richard Bruton
System of Care Coordinator

Steve Fishel
Chief-District 15A

David Carter
Chief-District 9A

Trina Powell
Care Coordination Manager

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 DJJDP. 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.

2010-2011 Data

	July 2010	August 2010	September 2010	October 2010	November 2010	December 2010	January 2011	February 2011	March 2011	April 2011	May 2011	June 2011	Total	% of Ref.
Referrals	2	6	9	5	2	5	7	3	10	7	5	5	66	---
Assessments	2	4	3	4	3	2	5	2	3	2	1	0	21	47%
Admissions[1]	2	1	3	2	3	2	2	1	3	2	---	0	21	32%
Discharges	0	2	2	2	4	2	0	0	0	0	---	0	12	---

[1] 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
*Note that key team members changed at the end of the fiscal year in June (due to DJJDP staffing changes) and are not reflected on these pages to represent the team members for most of the year. The new staffing patterns for DJJDP are reflected in tables for the Chiefs following this section.

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 Chief-District 8	**Susan Meador** Pathways to Life	**Amy Watson** Pride in NC
Serafina Dowdy Easter Seals UCP NC & VA, Inc.	Restart Human Services	**Terri Proctor** District 7 Supervisor

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.). DJJDP 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 DJJDP staff and the Provider Agencies will be tracking the data and reporting it back to the LME staff.

2010-2011 Data

	July 2010	August 2010	September 2010	October 2010	November 2010	December 2010	January 2011	February 2011	March 2011	April 2011	May 2011	June 2011	Total	% of Ref.
Referrals	20	19	21	26	20	15	13	17	27	15	16	15	224	---
Assessments	19	16	18	13	19	15	13	13	27	13	16	11	193	86%
Admissions[1]	12	10	12	11	11	8	10	9	12	7	13	8	123	55%
Discharges	0	0	0	0	0	0	0	0	0	0	0	0	0	---

[1] 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

CENTERPOINT HUMAN SERVICES

Key Team Members

Denise Mannon
Provider Operations Manager

Ed Eklund
System of Care Coordinator

Rusty Slate
Chief-District 17

John Berry
Chief-District 21

Krista Hiatt
Chief-District 22

Amanda Vernon
Daymark Recovery Services

Sam Grey
Partnership for a Drug Free America

Ben Bentley
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 DJJDP 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-2010-2011 Data

	July 2010	August 2010	September 2010	October 2010	November 2010	December 2010	January 2011	February 2011	March 2011	April 2011	May 2011	June 2011	Total	% of Ref.
Referrals	11	6	8	0	16	10	15	7	11	6	14	4	108	----
Assessments	14	7	9	1	20	11	13	8	4	8	15	2	112	104%
Admissions[1]	8	4	3	1	8	6	3	6	1	3	10	1	54	50%
Discharges	3	4	9	2	2	0	1	3	1	0	0	2	27	----

CenterPoint-Rockingham-2010-2011 Data

	July 2010	August 2010	September 2010	October 2010	November 2010	December 2010	January 2011	February 2011	March 2011	April 2011	May 2011	June 2011	Total	% of Ref
Referrals	5	1	1	5	2	1	3	1	0	0	1	1	21	---
Assessments	2	2	2	2	3	3	0	2	2	0	0	0	18	86%
Admissions	2	2	2	2	---	3	0	0	1	0	0	0	12	57%
Discharges	2	0	---	0	3	0	0	1	3	0	0	0	9	---

[1] 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

CROSSROADS

Key Team Members:

Jackie Copeland
Director of Community Planning

Candice Moore
System of Care Coordinator

Kelly Johnson
System of Care Coordinator

Jim Harner
New River Behavioral Healthcare

Rusty Slate
District 17

Krista Hiatt
District 22

Bill Davis
District 23

Tonya Oakley
Easter Seals/UCP

Celeste Reed
Barium Springs Home for Children

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 mainly New River Behavioral Healthcare and then some to Barium Springs for Children or another assessment provider.

Assessment Process: New River utilizes the GAIN Core 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 GAIN is then shared with the family, treatment provider (s) and DJJDP 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.

2010-2011 Data

	July 2010	August 2010	September 2010	October 2010	November 2010	December 2010	January 2011	February 2011	March 2011	April 2011	May 2011	June 2011	Total	% of Ref.
Referrals	12	14	16	8	16	26	11	10	14	15	10	6	158	---
Assessments	13	11	12	8	5	14	16	21	9	17	10	9	145	92%
Admissions[1]	6	10	7	6	6	11	13	12	6	12	6	5	100	63%
Discharges	6	3	11	8	2	7	4	7	7	8	4	10	77	---

[1] 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

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

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.

2010-2011 Data

	July 2010	August 2010	September 2010	October 2010	November 2010	December 2010	January 2011	February 2011	March 2011	April 2011	May 2011	June 2011	Total	% of Ref.
Referrals	14	16	13	12	9	13	9	9	11	12	12	13	143	---
Assessments	12	14	14	10	11	11	8	8	8	12	6	11	125	87%
Admissions[1]	8	10	10	7	10	6	7	6	8	9	6	8	95	66%
Discharges	2	11	8	9	16	15	4	8	7	6	2	10	98	---

[1] 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

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

Donald Pinchback
Chief-District 14

Lisa Copley
Triumph

Jennifer McRant
BAART Community Health Care

Youth Villages
Elaine Gillaspie

Linda Hammock
Vision Quest Residential – Durham

Megan Poulas
Carolina Outreach

James Robinson
Easter Seals MST

Affiliated Counties: Durham

Screening Process: DJJDP 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 DJJDP 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 MAJORS Assessor and Child and Family team. CFT meetings should be held once per month and drive service decision for the youth and the family.

2010-2011 Data

	July 2010	August 2010	September 2010	October 2010	November 2010	December 2010	January 2011	February 2011	March 2011	April 2011	May 2011	June 2011	Total	% of Ref.
Referrals	11	16	11	7	9	4	15	11	7	15	15	8	129	---
Assessments	8	20	13	8	12	4	11	17	10	14	13	9	139	108%
Admissions[1]	10	11	13	7	10	4	10	13	10	13	11	7	119	92%
Discharges	20	7	37	7	2	10	6	11	17	8	7	31	163	---

[1] 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

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

EAST CAROLINA BEHAVIORAL HEALTH

Key Team Members*

Sadie Gurley
System of Care Coordinator

Nancy Cleghorn
System of Care CMH/SA Director

Sherri Ellington
Chief-District 1

Mark Leggett
Chief-District 2

Mary Mallard/Brian Stewart
Chiefs-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 1, 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 and District.

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

Treatment Process: For Districts 1, 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.

2010-2011 Data

ECBH- Beaufort

	July 2010	August 2010	September 2010	October 2010	November 2010	December 2010	January 2011	February 2011	March 2011	April 2011	May 2011	June 2011	Total	% of Ref
Referrals	1	1	0	0	0	0	2	2	0	1	---	1	8	---
Assessments	3	4	0	1	0	3	1	2	0	1	---	1	16	200%
Admissions[1]	3	4	0	1	0	0	0	0	0	0	---	0	8	100%
Discharges	0	0	0	0	2	0	0	0	0	0	---	0	2	---

[1] 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
*Note that key team members changed at the end of the fiscal year in June (due to DJJDP staffing changes) and are not reflected on these pages to represent the team members for most of the year. The new staffing patterns for DJJDP are reflected in tables for the Chiefs following this section.

ECBH – Craven/Pamlico

	July 2010	August 2010	September 2010	October 2010	November 2010	December 2010	January 2011	February 2011	March 2011	April 2011	May 2011	June 2011	Total	% of Ref.
Referrals	10	6	5	3	3	4	4	10	2	5	7	8	67	---
Assessments	8	3	4	2	1	2	1	4	1	1	4	5	36	54%
Admissions[1]	8	3	1	2	1	2	1	4	1	1	3	3	30	45%
Discharges	1	2	0	0	0	0	0	0	0	0	2	0	5	---

ECBH – Pitt

	July 2010	August 2010	September 2010	October 2010	November 2010	December 2010	January 2011	February 2011	March 2011	April 2011	May 2011	June 2011	Total	% of Ref.
Referrals	3	1	1	0	1	3	2	2	3	0	0	3	19	---
Assessments	3	1	1	0	1	0	1	0	3	1	0	2	13	68%
Admissions	3	1	1	0	1	0	3	0	3	0	0	2	14	74%
Discharges	0	0	0	0	0	0	0	2	4	0	0	0	6	---

[1] 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
*Note that key team members changed at the end of the fiscal year in June (due to DJJDP staffing changes) and are not reflected on these pages to represent the team members for most of the year. The new staffing patterns for DJJDP 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

Nancy Cleghorn
Care Coordinator Supervisor

Paula Johnson
System of Care Coordinator

Lora Vann
System of Care Coordinator

Tracey Webster
System of Care Coordinator

Sherri Ellington
Chief-District 1

Mark Leggett
Chief-District 2

Kim Huckoby
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.

2010-2011 Data

	July 2010	August 2010	September 2010	October 2010	November 2010	December 2010	January 2011	February 2011	March 2011	April 2011	May 2011	June 2011	Total	% of Ref.
Referrals	20	19	9	0	13	6	3	6	11	11	9	10	117	---
Assessments	6	8	6	0	5	4	---	6	5	5	5	3	53	45%
Admissions[1]	4	3	3	0	0	4	2	5	3	3	3	3	33	28%
Discharges	1	1	1	0	0	1	---	2	3	1	0	4	14	---

[1] 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

EASTPOINTE

Key Team Members

Suzanne Nix
Provider Relations

Phyllis Greene
System of Care Coordinator

Ken Jones
Director

Joe Testino
Chief-District 8

Don Neal
Waynesboro Family Clinic

Erinn Beekman
Precision Healthcare

Tom Savage
PORT Human Services

Affiliated Counties: Lenoir, Wayne

Screening Process: DJJDP 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 Precision Healthcare.

Assessment Process: A GAIN Initial or Core assessment is completed on each youth that is referred by DJJDP. Information from the assessment is shared with DJJDP 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.

2010-2011 Data

	July 2010	August 2010	September 2010	October 2010	November 2010	December 2010	January 2011	February 2011	March 2011	April 2011	May 2011	June 2011	Total	% of Ref.
Referrals	10	9	10	11	12	8	9	10	29	12	4	17	141	---
Assessments	8	8	12	11	6	4	10	7	13	16	12	7	114	81%
Admissions[1]	8	8	12	12	4	5	10	5	13	12	12	5	106	75%
Discharges	0	0	0	0	0	0	0	0	0	0	0	0	0	---

[1] 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

FIVE COUNTY

Key Team Members*

Glenn Field
Corporate Compliance/Project Manager

Marni Cahill
Service Management Director

Jim Kinnan
Quality Management Director

Jennifer Short
Chief-District 6A

Cynthia Yancey
Chief-District 9

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

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

Screening Process: Risk and Needs Assessment completed in Halifax and GAIN Short Screener used in four other counties. Juvenile Family Data Sheet and screening information is provided to Main Provider (BEARS And Family Preservation Services) by facsimile.

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

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 2010-2011 Data

	July 2010	August 2010	September 2010	October 2010	November 2010	December 2010	January 2011	February 2011	March 2011	April 2011	May 2011	June 2011	Total	% of Ref.
Referrals	3	5	11	4	1	3	6	8	20	7	4	0	72	---
Assessments	5	---	1	2	3	1	3	7	11	8	4	3	48	67%
Admissions[1]	3	5	1	1	3	1	3	7	8	6	9	1	48	67%
Discharges	0	0	0	1	2	1	1	1	0	2	3	1	12	---

Five County- Halifax 2010-2011 Data

	July 2010	August 2010	September 2010	October 2010	November 2010	December 2010	January 2011	February 2011	March 2011	April 2011	May 2011	June 2011	Total	% of Ref.
Referrals	2	5	6	0	7	4	10	13	14	10	5	1	77	---
Assessments	6	5	5	1	7	4	10	13	14	10	5	1	81	105%
Admissions	7	5	5	1	7	4	10	14	114	10	5	1	83	108%
Discharges	1	5	4	1	0	0	0	0	0	0	0	0	11	---

[1] 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
*Note that key team members changed at the end of the fiscal year in June (due to DJJDP staffing changes) and are not reflected on these pages to represent the team members for most of the year. The new staffing patterns for DJJDP are reflected in tables for the Chiefs following this section.

THE GUILFORD CENTER

Key Team Members

Joe Fortin
Substance Abuse Point of Contact

Steve Hess
Substance Abuse Contracts Administrator

Lisa Salo
System of Care Coordinator

Stan Clarkson
Chief-District 18

Quentin Leak
Alcohol and Drug Services

David Pate
Therapeutic Alternatives

Kristi Andrews
Youth Villages

Dortch Mann
Greenlight Counseling

Frances Browne
Youth Focus

Reclaiming Futures

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 or GAIN on DJJDP 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.

2010-2011 Data

	July 2010	August 2010	September 2010	October 2010	November 2010	December 2010	January 2011	February 2011	March 2011	April 2011	May 2011	June 2011	Total	% of Ref.
Referrals	13	22	35	34	22	25	25	33	45	32	32	17	335	---
Assessments	9	13	17	25	16	13	15	24	25	8	29	21	215	64%
Admissions[1]	2	6	14	23	11	10	12	18	17	6	25	16	160	48%
Discharges	7	9	0	1	0	1	0	3	0	7	2	2	32	---

[1] 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

ONSLOW-CARTERET

Key Team Members

Kathryn Hunsucker
System of Care Coordinator

Damon Wells
Provider Relations

Nicole Ferguson
Care Coordinator

Mary Mallard
Chief-District 3B

Tracy Arrington and Russell Turner
Chief/Supervisor-District 4

Joann Chavis
Carolina Psychological & Psychiatric Services

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

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.

2010-2011 Data

	July 2010	August 2010	September 2010	October 2010	November 2010	December 2010	January 2011	February 2011	March 2011	April 2011	May 2011	June 2011	Total	% of Ref.
Referrals	4	11	21	17	23	17	12	21	26	22	15	16	205	---
Assessments	0	7	6	4	16	12	6	11	14	10	22	14	122	60%
Admissions[1]	0	7	13	3	15	9	6	7	8	3	3	3	77	38%
Discharges	2	0	0	4	1	2	12	3	4	6	6	1	41	---

[1] 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

ORANGE-PERSON-CHATHAM

*Key Team Members**

Lisa Lackmann System of Care Coordinator	**Tom Velivil** Substance Abuse Liaison	**David Carter** Chief-District 9A
Peggy Hamlett Chief-District 15B	**Danielle Darkangelo** Easter Seals UPC, Inc.	**Russel Knop** Freedom House/Person County
Elaine Gillespie Youth Villages	**Ulaine Washington** Triumph	**Heidi Dohnert** Carolina Outreach

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 Moderate or High score on the GAIN, they are referred to the following: in Orange and Chatham counties they are referred to the OPC liaison and in Person County, they are referred to the School Care Coordinator.

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Assessment Process: If the youth has some indication of substance abuse issues based on the screening, then they will be administered the Juvenile Automated Substance Abuse evaluation. For youth with mental health issues, a standard assessment is completed. There are multiple providers in the area that provide assessments, including two that are GAIN trained and will utilize on case by case basis.

Treatment Process: Since youth are referred to agencies for assessment based on their screening, they will typically stay in services where they were assessed. Incentives are used with youth for attending the intake session, the 3rd session, and the 6th session to help in the engagement process.

2010-2011 Data

	July 2010	August 2010	September 2010	October 2010	November 2010	December 2010	January 2011	February 2011	March 2011	April 2011	May 2011	June 2011	Total	% of Ref.
Referrals	12	10	13	17	15	23	13	14	16	22	23	21	199	---
Assessments	7	12	4	8	10	11	10	10	13	15	17	13	130	65%
Admissions[1]	7	11	4	9	9	9	9	7	11	14	15	11	116	58%
Discharges	1	0	1	3	0	1	0	3	2	2	1	2	14	---

[1] 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

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

PBH

*Key Team Members**

Pam Burton
Regional MH/SA Care Coordination Manager

Tracy Threatt
Provider Relations

John Giampaolo
Provider Relations

Kelly Boling (Interim)
Chief-District 20B

Krista Hiatt
Chief-District 22

Emily Coltrane/Kecia Barnes/Scott Stoker
Chiefs-District 19

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

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

Screening Process: Court involved youth will receive a GAIN SS. Each DJJDP 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.

2010-2011 Data

	July 2010	August 2010	September 2010	October 2010	November 2010	December 2010	January 2011	February 2011	March 2011	April 2011	May 2011	June 2011	Total	% of Ref.
Referrals	6	6	21	14	9	3	13	11	11	12	9	2	117	---
Assessments	3	2	5	8	4	2	3	5	3	3	4	4	46	39%
Admissions[1]	3	3	3	5	3	3	5	4	3	2	1	3	38	32%
Discharges	1	4	0	1	0	2	2	0	0	0	1	3	14	---

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

THE SANDHILLS CENTER

*Key Team Members**

Lucy Dorsey
System of Care Coordinator

Gene McRay
Utilization Manager

Marsha Woodall
Chief-District 11

Randy Jones
Chief-District 16A

Kelly Boling (Interim)
Chief-District 20

Emily Coltrane
Chief-District 19B

La Vang
Daymark Recovery Services

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

Screening Process: All staff are training in GAIN Short Screener and refer different populations based on Districts.

Assessment Process: If a youth has substance abuse issues primary, they are referred to PRI 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 has monthly meetings to staff the youth who are referred to JJSAMHP services. Youth have Child and Family Team meetings based on need.

2010-2011 Data

	July 2010	August 2010	September 2010	October 2010	November 2010	December 2010	January 2011	February 2011	March 2011	April 2011	May 2011	June 2011	Total	% of Ref.
Referrals	47	41	25	51	34	44	39	41	48	39	37	32	478	---
Assessments	35	45	22	34	25	31	34	50	50	33	32	30	421	88%
Admissions[1]	23	26	16	31	25	31	34	50	50	33	33	30	382	80%
Discharges	7	15	4	23	0	0	3	5	23	18	39	5	142	---

[1] 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

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

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 DJJDP 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.

2010-2011 Data

	July 2010	August 2010	September 2010	October 2010	November 2010	December 2010	January 2011	February 2011	March 2011	April 2011	May 2011	June 2011	Total	% of Ref.
Referrals	15	18	21	23	22	18	20	25	23	17	7	16	225	---
Assessments*	14	7	9	21	15	23	13	20	25	9	13	8	177	79%
Admissions[1]	6	3	0	1	2	3	4	3	4	3	---	5	34	15%
Discharges	0	0	0	0	0	0	1	0	0	0	---	0	1	---

[1] 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

SOUTHEASTERN REGIONAL

Key Team Members*

Janine Britt
System of Care Coordinator

Jeanette Jordan-Huffman
Clinical Director

Olaf Thorson
Chief-District 13

Randy Jones
Chief-District 16A

Lance Britt
Chief-District 16B

Barden Grimes
Robeson Health Care Corporation

Heather Lynch
Youth Villages

Affiliated Counties: Bladen, Columbus, Robeson, Scotland

Screening Process: Screening is currently being done by provider, RHHC. The Provider screens each youth referred by the court counseling office and then does an assessment if the youth is screened into needing an assessment.

Assessment Process: RHHC staff complete a GAIN Initial on all youth that are screened to need this service. Based on the outcome, youth are then referred to RHHC if they have SA needs and to another provider for MH issues.

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

2010-2011 Data

	July 2010	August 2010	September 2010	October 2010	November 2010	December 2010	January 2011	February 2011	March 2011	April 2011	May 2011	June 2011	Total	% of Ref.
Referrals	5	4	1	12	4	2	10	3	5	25	7	3	81	---
Assessments	0	8	5	7	4	0	5	4	3	5	6	3	50	62%
Admissions[1]	4	0	1	8	1	0	3	0	0	1	0	0	18	22%
Discharges	5	1	6	4	1	1	2	0	0	3	0	0	23	---

[1] 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

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

WAKE COUNTY HUMAN SERVICES

*Key Team Members**

Beth Nelson
Substance Abuse Point of Contact

Greta Gill
System of Care Coordinator

Eric Johnson
Care Coordinator

Tim Montgomery
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 DJJDP already in services with a treatment provider, the DJJDP 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.

2010-2011 Data

	July 2010	August 2010	September 2010	October 2010	November 2010	December 2010	January 2011	February 2011	March 2011	April 2011	May 2011	June 2011	Total	% of Ref
Referrals	20	26	21	31	23	17	39	36	45	37	36	46	377	---
Assessments	16	17	29	22	16	7	37	21	38	29	24	45	301	80%
Admissions[12]	14	22	20	11	22	7	26	11	26	22	18	31	230	61%
Discharges	20	13	9	20	12	7	15	5	10	12	10	17	150	---

[1] 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
*Note that key team members changed at the end of the fiscal year in June (due to DJJDP staffing changes) and are not reflected on these pages to represent the team members for most of the year. The new staffing patterns for DJJDP are reflected in tables for the Chiefs following this section.

WESTERN HIGHLANDS

Key Team Members

Brenda Chapman
Substance Abuse Provider Specialist

Lisa Garland
Chief-District 24

Anthony Jones
Chief-District 28

Rodney Wesson
Chief-District 29

Danielle Arias
ARP Addiction, Recovery & Prevention

Jon McDuffie
Families Together, Inc.

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

Screening Process: The initial point of entry will be through the completion of a face-to-face screening by DJJ staff or a more comprehensive clinical assessment from the JJTC or JJ/SA/MHP provider as described above using a recognized and valid screening tool such as the GAIN Short Screen, SASSSI or other evidence based screening tool.

Assessment Process: A comprehensive clinical assessment will be completed by Families Together, the provider of first resort in the 24th and 29th districts. In the counties outside of the JJTC provider, ARP Phoenix will complete the comprehensive clinical assessment (CCA) which will provide 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 and appropriate, the service provider will make referrals for other family members.

Treatment Process: All services are provided in strength based, collaborative model following the system of care philosophy. Youth referred to ARP Phoenix either directly for DJJ or from Families Together will receive clinically appropriate services based on medical necessity and the level of care indicated by the comprehensive clinical assessment. ARP Phoenix provides a variety of services. When a clinically indicated service is not available within their service, ARP coordinates with other providers and levels of care as indicated. Youth referred to Families Together will receive an assessment, meet with Court Counselors and providers to develop a Treatment Contract and participate in blend of intervention services. Families Together has Intensive In-home team that includes a Certified Substance Counselor. For those youth in need of group treatment, youth will be referred to ARP Phoenix. In judicial districts where JJTC is involved, ARP Phoenix will support the JJTC provider as the provider of first resort to avoid duplication of services and support the JJTC service model.

2010-2011 Data

	July 2010	August 2010	September 2010	October 2010	November 2010	December 2010	January 2011	February 2011	March 2011	April 2011	May 2011	June 2011	Total	% of Ref.
Referrals	4	18	7	1	8	18	10	7	22	11	14	25	145	---
Assessments	4	8	8	12	6	3	11	9	16	13	12	19	121	83%
Admissions[1]	4	8	8	3	6	18	11	8	11	13	11	18	119	82%
Discharges	0	0	2	1	2	1	10	0	14	5	13	6	54	---

[1] 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

Appendix A-Chief Distribution by County AS OF SUMMER 2011 and LME Designation

District	*County*	*Chief Court Counselor*	*LME*
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	Eastpointe
4	Jones	TRACY WILLIAMS ARRINGTON	ECBH
4	Onslow	TRACY WILLIAMS ARRINGTON	Onslow Carteret
4	Sampson	TRACY WILLIAMS ARRINGTON	Eastpointe
5	New Hanover	ROBERT SPEIGHT	Southeastern Center
5	Pender	ROBERT SPEIGHT	Southeastern Center
6	Halifax	CLARENCE HIGH	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
7	Nash	MIKE WALSTON	Beacon
7	Wilson	MIKE WALSTON	Beacon

Appendix A-Chief Distribution by County AS OF SUMMER 2011 and LME Designation

District	*County*	*Chief Court Counselor*	*LME*
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	Five County
9	Granville	JENNIFER SHORT	Five County
9	Vance	JENNIFER SHORT	Five County
9	Warren	JENNIFER SHORT	Five County
9	Caswell	JENNIFER SHORT	Alamance Caswell as listed on map
9	Person	JENNIFER SHORT	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	TONYA GRIFFIS (INTERIM)	Durham
15	Alamance	PEGGY HAMLETT/SUPERVISOR STEVE FISHEL	Alamance Caswell as listed on map
15	Chatham	PEGGY HAMLETT	OPC
15	Orange	PEGGY HAMLETT	OPC
16	Hoke	LANCE BRITT	Sandhills
16	Scotland	LANCE BRITT	Southeastern Regional
16	Robeson	LANCE BRITT	Southeastern Regional
17	Rockingham	RUSTY SLATE	CenterPoint
17	Stokes	RUSTY SLATE	CenterPoint
17	Surry	RUSTY SLATE	Crossroads

Appendix A-Chief Distribution by County AS OF SUMMER 2011 and LME Designation

District	*County*	*Chief Court Counselor*	*LME*
18	Guilford	STAN CLARKSON	Guilford
19	Cabarrus	EMILY COLTRANE/SUPERVISOR RANDY JONES	Piedmont
19	Montgomery	EMILY COLTRANE	Sandhills
19	Moore	EMILY COLTRANE	Sandhills
19	Randolph	EMILY COLTRANE	Sandhills
19	Rowan	EMILY COLTRANE	Piedmont
20	Anson	KELLY BOLING (INTERIM)	Sandhills
20	Richmond	KELLY BOLING (INTERIM)	Sandhills
20	Stanly	KELLY BOLING (INTERIM)	Piedmont
20	Union	KELLY BOLING (INTERIM)	Piedmont
21	Forsyth	JOHN BERRY	CenterPoint
22	Alexander	KRISTA HIATT	Not JJSAMHP
22	Davidson	KRISTA HIATT	Piedmont
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
25	Caldwell	RONN ABERNATHY	Not JJSAMHP
25	Catawba	RONN ABERNATHY	Not JJSAMHP

Appendix A-Chief Distribution by County AS OF SUMMER 2011 and LME Designation

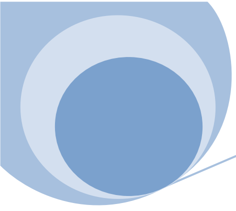
District	*County*	*Chief Court Counselor*	*LME*
26	Mecklenburg	LAURA McFERN	Not JJSAMHP
27	Gaston	CAROL McMANUS	Not JJSAMHP
27	Cleveland	CAROL McMANUS	Not JJSAMHP
27	Lincoln	CAROL McMANUS	Not JJSAMHP
28	Buncombe	ANTHONY JONES	Western Highlands
29	Henderson	RODNEY WESSON	Western Highlands
29	McDowell	RODNEY WESSON	Western Highlands
29	Polk	RODNEY WESSON	Western Highlands
29	Rutherford	RODNEY WESSON	Western Highlands
29	Transylvania	RODNEY WESSON	Western Highlands
30	Cherokee	CHUCK MALLONEE	Not JJSAMHP
30	Clay	CHUCK MALLONEE	Not JJSAMHP
30	Graham	CHUCK MALLONEE	Not JJSAMHP
30	Haywood	CHUCK MALLONEE	Not JJSAMHP
30	Jackson	CHUCK MALLONEE	Not JJSAMHP
30	Macon	CHUCK MALLONEE	Not JJSAMHP
30	Swain	CHUCK MALLONEE	Not JJSAMHP

APPENDIX B-FALL REGIONAL REPORT

JJSAMHP FALL REGIONAL MEETINGS

November, 2010

This document includes a summary of the JJSAMHP Regional Team meetings including individual and overall team impressions of the Regional Meetings-compiled and tabulated by UNCG staff and students.



Summary of Document Contents

Enclosed is the Overall Summary for the Regional Team Meetings held in November, 2010. The report was compiled by UNCG personnel Huaibo Xin, Sonja Frison, and Kelley Richardson. Other assistance was provided by Frederick Douglas and Claretta Witherspoon. The report is outlined in six different areas:

I. Meeting Locations
II. Meeting Participants
III. Meeting Agenda
IV. Individual Evaluations of Meeting
V. Overall Team Evaluations
VI. Strengths and Challenges Qualitative Review

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

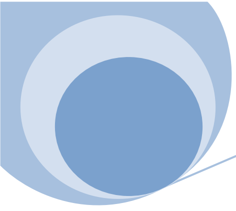
Western/Piedmont Areas	November 9th	Statesville	Holiday Inn Statesville
Eastern Area	November 16th	Greenville	Hilton Hotel Greenville
Central Area	November 17th	Sanford	Comfort Suites Sanford

II. Meeting Participants:

Overall, there were **118** Local Participants that attended the Regional Meetings across the state. There were **15** State/Regional/Contractor Participants that attended the Regional Meetings (some attended more than one and others attended all meetings). 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	12	9
DJJDP Local Representatives	14	13	11
Provider Representatives	14	9	19
Other Representatives	2	0	1
Total Local Participants	42	34	40
Total State/Regional	13	10	12
Total Participants	**55**	**44**	**52**



III. Meeting Agenda

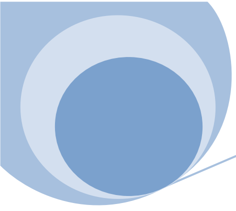
The overall agenda for each meeting is outlined below:

9:30am-3:00pm

9:30-9:45	**Welcome/Review of Service Domains** ❖ Paul Savery, DMHDDSAS ❖ Brad Bannister, DJJDP ❖ Sonja Frison, UNCG
9:45-10:45	**JCPC Partnerships** ❖ Jesse Riggs, DJJDP Area Consultant
10:45-11:00	**Break**
11:00-12:00	**What's Working Well Across Teams?** Cross Site Groups ❖ Claretta Witherspoon, UNCG
12:00-1:00	**Lunch Provided Onsite**
1:00-2:00	**What are Some of the Challenges?** Cross Site Groups ❖ Claretta Witherspoon, UNCG
2:00-3:00	**Team Goal Development/Feedback** Site Specific Groups ❖ UNCG

IV. Individual Evaluations of the Meeting

Overall, **94** local participants completed meeting evaluation forms. This is **80%** of the total 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 these key questions. 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 information shared during the meeting would be helpful. The individual responses from each participant are available upon request.



Overall Averages for Individual Evaluation 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 will be helpful.*	*The food was what I expected for this meeting.*	*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	3.65	3.57	3.14	3.46	3.14	3.49	3.34	3.40
Averages for Eastern	3.79	3.75	3.43	3.86	3.67	3.68	3.52	3.67
Averages for Central	3.72	2.90	3.42	3.55	3.45	3.52	3.45	3.43
Overall Averages for All Meetings	3.71	3.40	3.32	3.61	3.40	3.55	3.43	3.49
4=Strongly Agree, 3=Agree, 2=Disagree, 1=Strongly Disagree								

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.

1. ***My Favorite part of the meeting was….. (listed in order of most endorsed by 4 or more participants)***
   a. Cross Site Work-meeting other teams
   b. Working with the local team
   c. Group Work
   d. Coming up with Successes/Challenges
2. ***The meeting could be better by doing the following ……(listed in order of most endorsed by 4 or more participants)***
   a. More local team work time
   b. More space
   c. More cross site work time
   d. Less lecture
   e. Break out rooms

V. Team Evaluations

Each of the teams was asked questions about the regional team meetings and what they would like to see happen at these meetings if held in the future. 20 different teams provided responses to the questions on the team evaluation form. Notably, there were two teams from one LME at a meeting and another team that went to two different meetings, so the total number of teams came to 20. Also, one team answered the first question "no" and did not respond to any of the other questions. The overall results across the state and the breakdown by regions are presented below.

A. Does your team think having JJSAMHP cross-team meetings is helpful?

Overall, 80% (16) of the teams thought that having a cross-team meeting is helpful, 10% (2) thought having cross team meetings one was probably helpful with some modifications, and 10% (2) felt that having cross team meetings was not helpful. Teams offered some suggestions for overall improvement of having team meetings such as: time meeting with providers only, fewer lectures, some discussion of information between teams across the state, meeting for half days, having individual teams meet with their department heads at the state level, and finding a way to send out electronic updates of innovative strategies. The following table breaks down further percentages by each meeting location.

	Responses to helpfulness of having meetings by location		
	Yes	*No*	*Probably*
Western/Piedmont	**80% (4)**		20% (1)
Eastern	**71% (5)**	29% (2)	
Central	**88% (7)**		12% (1)

B. Please rank order the type of meeting format you would like to have for JJSAMHP cross-team meetings.

The second question asked of teams was for them to rank order the types of meetings they would like to have in the future. The choices for types of meeting are noted as follows:

1. Teleconferences
2. Webinars
3. Site Presentation-The sites (our teams) presenting information on specific topics of success/lessons learned
4. Team/System-Team building/group or team dynamics/system change practices
5. Topic Specific-Training or presentation on topics based on best practices/current research/evidence based practices
6. Other category

The following table represents the ranking from all teams and then broken down by the different meeting locations. It is noted that this was based on weighting of the overall responses. Overall, across the state, teams most wanted the sites to do presentations on specific topics of success/lessons learned and teams were least likely to choose teleconferences.

	Responses to types of meetings teams would like to have in the future			
	Overall State	*Western/Piedmont*	*Eastern*	*Central*
First Choice	**Site Presentations**	**Site Presentations**	**Site Presentations Team/System**	**Site Presentations**
Second Choice	Team/System	Team/System		Topics
Third Choice	Topic Specific	Topic Specific	Topic Specific	Team/System
Fourth Choice	Webinars	Webinars	Teleconference	Webinars
Fifth Choice	Teleconferences	Teleconferences	Webinars	Teleconference

Some of the other suggestions offered by the teams included the following: anything that brings us together, discussions of funding, meeting quarterly at various sites, having meetings regionally, and having multiple workshops.

C. *How many meetings would be helpful in a fiscal year?*

The teams were asked to respond to how many meetings they thought would be helpful to have in one fiscal year. The responses for the entire state and for each region are listed below. The most popular response was twice per year. The following table breaks down further percentages by each meeting location.

	Responses to frequency of team meetings		
	One Time a Year	*Two Times a Year*	*Three Times of Year*
State	11% (2)	**78% (15)**	11% (2)
Western/Piedmont		**100% (5)**	
Eastern		**100% (6)**	
Central	25% (2)	**50% (4)**	25% (2)

D. *Some teams would rather have one meeting across the entire state and other teams like the regional format. What is the consensus of your team?*

Teams were asked to note whether they thought it would be helpful to meet in one state level meeting or in the regional meetings as they have been set up. Most teams opted to continue with the regional meeting format. Some teams wrote in a request for one state/one regional meeting. The responses based on the overall state and the regions are noted in the table below.

	Responses to location of team meetings		
	1 State Meeting	*Regional Meetings*	*Other (Alternate State, Regional)*
State	11% (2)	**78% (15)**	11% (2)
Western/Piedmont		**80% (4)**	20% (1)
Eastern	17% (1)	**83% (5)**	
Central	12.5% (1)	**75% (6)**	12.5% (1)

E. <u>If there was topical training, what would you most like to see addressed?</u>

12 out of the 20 (60%) teams had time to answer the question of choosing the top four topics they would like to see in training. Teams were offered choices based on knowledge of experts in the state or near the state who could be contracted to provide best practice/evidence based practice training. Each of the responses was weighted based on the number of endorsements. The top choices are listed first along with points that were assigned to each top choice.

Possible Topic[1]	Total Points Endorsed
Working with Gang Involved Youth	22
Co-Occurring Disorders	10
Functional Strengths in the CFT Process	10
Resources for Keeping Youth in the Community	9
Juvenile Justice Crisis Planning	8
Developing a Sustainable Community Plan	8
Screening and Assessment	7
Working with Family Partners	6
Trauma Informed Care	6
Using Tools to Identify and Address Gaps in Services	5
Adolescence and the Adolescent Brain	4
Overview of Strengths Based Supervision	4
Overview of Data Systems Used by Similar Teams outside NC	4
Restorative Justice	3
Rapid Cycle Testing to Assess Goals	2
Recovery Oriented System of Care	2
Disproportionate Minority Contact	1

[1] The following topics were listed but not endorsed: Cultural Awareness, Youth Development Programming, Assisting Homeless Adolescents, Gender Responsive Issues, Peer to Peer Programming, Diversion and Re-Entry, Team Dynamics, HIPAA Issues tor Teams

VI. Strengths and Challenges Qualitative Review

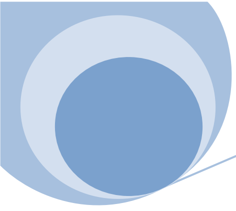
During each of the three regional meetings, teams were mixed based on LME, DJJDP, Provider groupings so that each "cross-site" group was made up of individuals who typically did not work together on a team. The purpose of this was two-fold. One, it was anticipated that this would allow for team members 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 what is working or challenges in their areas if they were in different groupings with others and not reliant on their regular "facilitators" of their local team.

This section outlines an overall summary of the most endorsed items across the three meetings in the five JJSAMHP domains (Screening/Referral, Assessment, Engagement, Evidence Based Treatments and JCPC). The overall queries were for "What is Working Well" and "What Are Some of the Challenges?" for JJSAMHP teams. The cross-site teams put their responses on flip chart paper and this was then transcribed into a WORD document. Huaibo Xin, graduate student, then did a qualitative review and categorization of the items that were most endorsed by teams. They were then listed in order of most endorsed categories. The following table lists the top response for each domain.

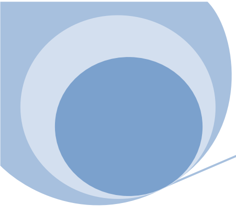
Domain	What is Working Well?	What are Challenges?
Screening/Referral	Implementation of Screening/Referral Process	Timeliness of Referrals
Assessments	Utilization of Standard Assessment Tools	Applicability of Standard Assessment Tools
Engagement	Utilization of Child and Family Teams	Participation in Child and Family Teams
Evidence Based Treatments	Utilization of Evidence Based Treatments/Practices	Cost of Evidence Based Treatment/Practices
JCPC Involvement	Utilization of JCPC Funding	JCPC Funding Limited

The following table outlines all the categorizations for each of the five domains as well as other categories that did not fit into the five domains. The first table lists endorsements for "What is Working Well?" and the second table lists endorsements for "What are Some of the Challenges?"

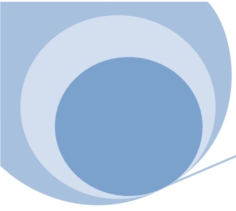
SERVICE DOMAINS	WHAT IS WORKING WELL?
Screening/Referral	1. **Implementation of Screening/Referral Process** (e.g., screening process is done, DJJDP screens referrals, barriers are reduced, increased JCC involvement) 2. **Utilization of Standard Screening Tools** (e.g., use of GAIN SS, GAIN SS in database, JCC trained in GAIN SS, use of CRAAFT) 3. **Staffing of Screening/Referral** (e.g., dedicated assessor works with screening team, good triage, identified provider in court)



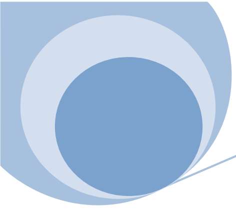
SERVICE DOMAINS	WHAT IS WORKING WELL?
	4. Establishment of Referral Process (e.g. dedicated slots for assessments, JCC can make appointments directly, referrals and assessments in one house, good contact person for referral process, consistent process) **5. Communication** (e.g., provider works well with DJJDP staff and quick referrals, positive communication/appointments, improved communication) **6. Adequacy of Screenings/Referrals** (e.g., receiving numerous referrals, adequate screening, referrals have increased) **7. Strengths of JJTC System** (quicker access, increased communication, defined roles)
Assessment	**1. Utilization of Standard Assessment Tools** (e.g., some sites expanding on use of evidence based assessment tools, over 50% of teams use valid and reliable assessment, use of GAIN is consistent, GAIN Quick and initial, use of ASAM) **2. Staffing of Assessment** (e.g., independent provider/neutral assessor, helpful to have one provider, independent assessor/locally housed, some staff completing assessment that does valid job of identifying services, reliable clinical staff completing assessments) **3. Efficiency of Assessment** (e.g., assessments are completed to determine need, assessments lead to referrals for services, referral can be made to agency completing assessment or provider of parent choice, receive assessments in same day, large number of youth assessed, mobility of assessment) **4. Comprehensiveness of Assessment** (e.g., Comprehensive Clinical Assessment being used including SASSI, some teams use comprehensive assessments, JJTC assessment is narrative and designed for court, not just a list of symptoms, includes co-occurring) **5. Accessibility of Assessment** (e.g., more accessible, assessor goes to YDC or detention) **6. Flexibility of Assessment Tools** (e.g., Clients administered GAIN and CCA when needed in some sites) **Time of Assessment** (e.g., improved assessment times)
Engagement	**1. Utilization of Child and Family Teams** (e.g., increased child and family teams, JJTC uses child and family team within 2 weeks and others within 30 days, CFT’s completed as required, use of family partners, all children get CFT’s in JJTC, attendance at CFT’s, treatment contracts developed with families within 30 days, handouts for families to understand process, CFT training is widespread, families being engaged in process, CFT training helps with engagement,, meetings at different locations)



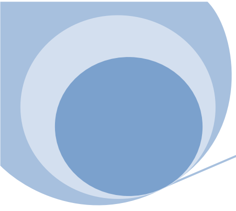
SERVICE DOMAINS	WHAT IS WORKING WELL?
	2. Utilization of System of Care Principles (e.g., use of SOC is fundamental and keeps everyone honest to family and collaborative approach, everyone is trained in SOC, SOC is being infused into the partnership, use of SOC principles, SOC coordinators are more involved and is a good resource, SOC coordinators involved with teams, good SOC teams and care review, accountability across the systems) **3. Communication** (e.g., monthly meetings with JCCs, providers, LME, improved communication, effective communication between providers and JCC, supervisor's meetings, increasing trust, reduces duplication of meetings/services) **4. Development of Collaboration** (e.g., natural helpers/support increased, community partners, improved collaboration, DJJDP and provider representation, QPs at DJJDP office to assist, community/child serving agency involvement) **5. Incentives** (e.g., offer incentives for enhanced services, incentives for parents and children, incentive programs) **6. Strengths of Child and Family Teams** (e.g. CFTs include school provider, family, there is increased role clarity and accountability, look at family as one entity, everyone is on the same page) **7. Support of Child and Family Teams** (e.g., CFTs are attended by DJJDP, active efforts to improve CFTs, support from judges, providing resources and supports to families that may have not been available before) **8. Support of System of Care Principles** (State/Division/Dept. support of SOC-single stream funding) **Transportation Access**
Evidence Based Treatment/Practice	**1. Utilization of Evidence Based Treatment/Practice** (e.g., GA IN, Seven Challenges, ACRA (community integration), Motivational Interviewing, MET/CBT, widespread use of EBTs, Cannabis Youth Treatment Series, Evidence Based Practices are being used, Fidelity to models, increased availability of MST, Training on Trauma/PTSD responsive treatment EBP availability, MST focus on DJJDP kids, Strengthening Families) **2. Effectiveness of Evidence Based Treatment/Practice** (MST/Seven Challenges is very practical for youth, MET/CBT is easy to engage youth and parents/guardians, going well in regard to the data supporting outcomes, better outcomes, they are working, improved outcomes-individual and provider, supports promising models, more effective, seeing positive outcomes, start to see change in clients who want to work) **3. Characteristics of Evidence Based Treatment/Practice** (e.g., consistent, quality, uniform-universal, provides defined-coordinated treatment path, service definition inclusion) **4. Support of Training**



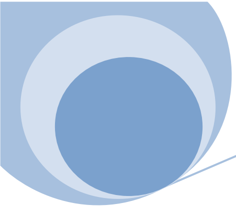
SERVICE DOMAINS	WHAT IS WORKING WELL?
	(e.g. funding for training)
JCPC	1. **Utilization of JCPC Funding** (e.g., JJSAMHP providers also receive JCPC funds consistently, JCPC funds used for Sex Offender Specific Evaluations and Sex Offender Treatment, JCPC funds SA counselor position, JCPC funds psychological/SA assessments, restorative justice funded through JCPC's, gang prevention, mediation, wrap around services, offender re-entry CORE and gang grant funding, transition beds for re-entry from YDCs, helps fund positions and programs, funding for evidence programs, funding therapist in school setting, funded programs are working well, some kids referred to JCPC programs when did not qualify for other services, fills gaps, teen court and restitution programs make it real, exposes children to opportunities they may not have had before, structured day reporting centers and SA treatment) 2. **JCPC Involvement** (e.g., LME has SOC reps working with JCPC, providers, LME and DJJDP involved with JCPCs, JCPC involvement is good, partnership building, advocates for training on local level, community collaborative, SOC coordinator involved in JCPC, restorative justice very involved, partnership represented in JCPC, JCPC works well with JJSAMHP team, creates awareness) 3. **Communication** (e.g., increased communication between JCPC programs, council members, and LME, networking, increased meetings)
Others	1. **Support** (e.g., grant facilitates barrier elimination, support from state and LME) 2. **Communication** (e.g., quarterly meetings, LME driven monthly meetings) 3. **Coordination** (e.g., coordination between treatment court and providers)



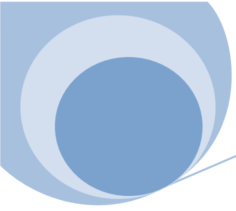
SERVICE DOMAINS	WHAT ARE SOME OF THE CHALLENGES?
Screening/Referral	1. **Timeliness of Referrals** (e.g., assessment backlog, prioritize assessment need, number of referrals creates timely assessment challenges, making timely referrals (high caseloads in some districts, lapse in time and creates delay in getting into treatment, lack of time, rules re: service exclusions-provider can't accept referrals if other treatment is in place) 2. **Fidelity of Screening/Referral** (e.g., youth are not always truthful, caregivers may influence answers, discomfort with DJJDP staff using screening tool screening tool underrepresenting problem due to timing of use of tool, accuracy of GAIN SS, subjectiveness of referrals) 3. **Acceptability of Screening/Referral** (e.g., client refusal to participate/disengaged, no shows, parent and juvenile not attending appointment, JCCs sending referral but providers not getting them, challenge when family is already getting services) 4. **Process/Follow-up of Referral** (e.g., making referral and no response coming back, process not going well) 5. **Staffing of Screening/Referral** (e.g., large geographical issues and time constraints-short staffed) **Consumer Choice** (e.g., with referral to one partnership provider, does consumer choice get compromised) **Interference in Screening/Referral** (e.g., judges ordering into programs and not services) **Data Collection** (e.g., data collection difficult-tracking GAIN SS and referrals) **Flexibility of Screening Tools** (limited flexibility with screening tool-clarify cutoffs) **Overlapping Areas** (e.g., court districts with greater than one LME and LMEs with more than one court district) **Utilization of Standard Screening Tools** (e.g., JCCs not all doing the GAIN SS) **Accessibility of Services** (e.g., transportation to the appointment) **Communication** (e.g., internal communication) **Consistency of Systems** (e.g., defining common ground across systems) **Balance of Utilization of Screening/Referral**



SERVICE DOMAINS	WHAT ARE SOME OF THE CHALLENGES?
	(e.g., balance public safety and clinical needs)
Assessment	1. **Applicability of Standard Assessment Tools** (e.g., GAIN I too time consuming and research oriented, GAIN capacity issues, cost of GAIN, underdiagnosis/overdiagnosis, GAIN too long and can't be reimbursed for full amount of time, impacts on relationship with clients, operationalizing the GAIN, length of assessments and interpretation, length of GAIN I, issues with time and travel and turnaround of GAIN, 2. **Acceptability of Assessment** (e.g., parent and juvenile not attending appointment, parent refusing services for consumer at times, no shows, engagement, family non-compliance, juveniles on the run, cancellations) 3. **Alternative of Standard Assessment Tools** (e.g., explore other EBP assessment tools, is GAIN always appropriate for serious MH issues only, using NC-TOPPS, confusion over whether GAIN or other assessment would be best, use of GAIN versus Comprehensive Clinical Assessment) 4. **Staffing of Assessment** (e.g., being GAIN trained/not enough people trained, ability of provider to cover large sparsely populated areas, concern of assessor not being independent, need for independent assessors, need for certified GAIN assessors, lack of trained GAIN assessors) 5. **Applicability of Assessment** (e.g., insurance will not pay for services, length of assessment, need for assessment tool to capture parent information or substance issues, duplication of assessments) 6. **Understanding of Standard Assessment Tools** (e.g., understanding where we are with assessment tools, education/public relations around GAIN and importance of GAIN instruments, defining screening tool versus full assessment for court counselors) 7. **Logistic Issues of Assessment** (e.g., billing issues-non Medicaid, locked, detained, YDC youth, referral discretion for DJJDP, can't bill Medicaid/Health Choice when juvenile is in detention/YDC-disruption in services) 8. **Decision-Making** (e.g., role confusion between treatment providers and DJJDP (JCCs don't agree with treatment recommendations, different in opinion over needed services, judges ordering treatment from bench) 9. **Follow-up of Assessment** (e.g., recommendations from assessor should be forwarded to appropriate program, feedback from assessment, lack of appropriate and timely feedback) 10. **Accessibility of Assessment** (e.g., transportation) 11. **Support of Assessment**



SERVICE DOMAINS	WHAT ARE SOME OF THE CHALLENGES?
	(e.g., evidence based practices without funding) **Data Collection** (e.g., tracking of assessments difficult) **Compatibility of Assessment** (e.g., jurisdiction/system differences) **Availability of Services** (e.g., lack of available services that are recommended **Continuum of Utilization of Standard Assessment Tools** (e.g., lack of consistency in use of the assessment tools)
Engagement	1. **Participation in Child and Family Teams** (e.g., family involvement-structuring system to decrease no shows, lack of family buy-in, child and family teams not following principles such as ground rules-facilitation-preparation, buy-in from family, disengaged families, lack of natural support at the table, parent involvement, no shows, parents feel some services are too intrusive and too demanding on parent's time, not having everyone at the table for CFT, getting all relevant parties to CFT/getting input for all, lack of consistent CFT-not inviting all involved, lack of family involvement "buying into treatment", engaging parents in a strengths focused way) 2. **Communication** (e.g., communication, communication about CFT meetings and services, lack of communication in order to form one agenda, working together when recommendations differ, resolving differences-respecting recommendations before going to court, cultural, lack of communication *Family may be sent to multiple providers "Bounced around"* 3. **Accessibility of Services** (e.g., family may be sent to multiple providers "bounced around", rural communities, transportation, work schedules, rural areas, time constraints) 4. **Applicability of Child and Family Team Meetings** (e.g., CFT meetings/when to have or not to have, CFT meeting is time consuming, issues with CFT meeting not being "family driven", issues with time for CFT meetings, only recently started doing CFT meetings) 5. **Development of Collaboration** (e.g., JJSAMHP/JJTC more collaborations, okay with JJTC but inconsistent with others, can always improve cross agency collaboration) 6. **Compliance of Child and Family Teams** (e.g., overall compliance with treatment providers, scheduling inconsistent, scheduling of CFT) 7. **Training of System of Care** (e.g., System of Care trainings are too long, SOC too long and not enough substance) 8. **Staffing** (e.g., lack of availability of quality service providers, single provider for partnership limits services to only those that provider has)



<table>
<tr><th>SERVICE DOMAINS</th><th>WHAT ARE SOME OF THE CHALLENGES?</th></tr>
<tr><td></td><td>9. Utilization of Systems of Care/Continuum
(e.g., System of Care Model: Schedules and commitment; SA continuum of care)

10. Historical Issues
(e.g., history of problems with MAJORS)

Funding Distribution
(e.g., fund family prevention programs that have Medicaid equivalent)

Training of Child and Family Teams
(e.g., continued need of training of CFTs)

Additional Services
(e.g., intervention/treatment options for parents that abuse substances)</td></tr>
<tr><td>Evidence Based Treatment/Practice</td><td>1. Cost of Evidence Based Treatment/Practice
(e.g., cost of EBTs, EBPs are expensive, expensive training and implementation, training and staff turnover, money costs for doing models, Seven Challenges materials too expensive, cost, private insurance not covering, costly, cost of materials, training, new staff, affordable training for staff)

2. Training
(e.g., training availability, availability of trainers, gaps in service for SA, no training for SA residential staff, requires new staff to be trained, certification/training, length of time to become certified, a lot of training, trainer availability)
3. Staffing
(e.g., high turnover of staff, training and staff turnover-money costs for doing models, lack of qualified personnel to implement programs, not enough professionals to do MST, more MST teams,, lack of licensed staff to implement services

4. Availability of Evidence Based Treatment/Practice
(e.g., age limits on GAIN and MST and limits who is served, rural geography/isolated by water is underserved, lack of SA services)

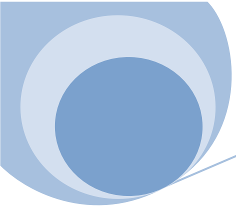
5. Acceptability of Evidence Based Treatment/Practice
(e.g., parents not always want provider within home-MST, parents feel some services are too intrusive and too demanding on parent’s time)

Consistency of Criteria
(e.g., constant change in mental health, requirements often changing)

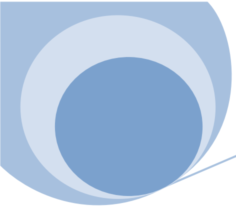
Applicability of Evidence Based Treatment/Practice
(e.g., hard to fit all evidence based programs within service definitions, maintain/fidelity)

6. Requirement of Evidence Based Treatment/Practice
(e.g., require diagnosis)

Alternative of Evidence Based Treatment/Practice
(e.g., who decides what an EBP (is)?</td></tr>
</table>



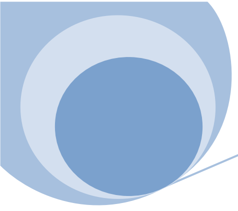
SERVICE DOMAINS	WHAT ARE SOME OF THE CHALLENGES?
	Communication (e.g., communication with Hispanic families) **Continuum** (e.g., continuum/CABHA) **Involvement of Child and Family** (e.g., lack of participation from child and family)
JCPC	**1. JCPC Funding Limited** (e.g., limited budgets, not enough funding, limited and dwindling funding, not traditionally funding prevention, same programs remain funded, funding difficulties, budget, lack of funding, JCPC not used as intended, involvement of non-profits, not enough programs) **2. Partnerships with JCPC** (e.g., more involvement from community in JCPC programs, not connected to partnership, no connectivity, lack of active collaboration) **3. Understanding of JCPC** (e.g., lack of complete understanding, lack of awareness) **4. Consistency** (e.g., different systems with different rules, consistency) **5. Vocational Programming-gap in services for Juveniles** **Staffing** (e.g., not enough programs and staff) **Complexity** (e.g., complexity of cases)
Others	**1. Funding Support** (e.g., stability of funds in changing MH system, funding for youth that don't fit traditional eligibility (not IPRS, not Medicaid), lack of funds to meet needs, lack of case management funding to effect wrap-around, inadequate state funding, inadequate reimbursement for services, funding spread too thin, program or funding stream? Services available by other providers but MAJORS money not available, budget cuts JCPC dollars and levels of care/facilities closing, funding (UCR, Non UCR) flexibility and hard to earn, working with DJJDP youth and there are too many non-billable services, understanding the funding stream, possibility of losing funding, Value Options) **2. Workforce** (e.g., lack of multi-lingual staff, workforce development, SA professional turnover, development-cost and time for training/retraining, bilingual providers needed, maintaining qualified employees, staff turnover, finding quality professionals, lack of diversity of staff, lack of appropriately licensed professionals (esp. in SA), safety in the community for JCCs, treatment providers, etc.) **3. Evaluation Needs** (e.g., standardized outcome evaluations, looking for same data, compliance vs.



SERVICE DOMAINS	WHAT ARE SOME OF THE CHALLENGES?
	participation-quantity versus quality, current program not following contract, need to revisit needs and match programs accordingly, data collection/databases need to work together, data gathering, holding departments/agencies accountable) *State mandates are unrealistic (CABHA, IIH)* *Length of time between behavior and consequences* 4. **Accessibility of Services** (e.g., lack of capacity/accessibility into high-end services-residential, lack of transportation, services for undocumented youth, at risk kids/family falling through the cracks, insufficient emphasis to connecting kids to services and meaningful activities and adults in the community-redefine fun) 5. **Communication** (e.g., poor implementation and communication has put project behind schedule, communication challenges, determining what data to collect-agency computers don't talk to each other, insufficient 6. **Consistency** (e.g., constant changing of state service definitions, training requirements, state mandates are unrealistic –CABHA/IIH) **Development of Collaboration** (JJSAMHP outside providers looking in and wanting to be a part of the partnership, need for continued collaboration at the state level-locally we make it work, client buy in and professional buy in) 7. **Transition** (overcoming bad experience with MAJORS-trusting new process, confusion surrounding the intersection of roles related to Partnership and Reclaiming Futures/JJTC) 8. **Priority of Services** (competing priorities, need to balance between too much competition or too few competition) **Documentation** (e.g., documentation requirements, amount of excessive paperwork associated with mental health services) 9. **CAHBA** (e.g. CAHBA) **Continuum of Services** (e.g., gaps in treatment continuum-residential)

What Are Some Ways that This Information Can Be Used?

1. State and Regional Level partners can review and provide feedback to teams based on priority of topics that are challenges or working well and also assist in planning processes at state level



2. Teams can review strengths to identify domains where they may have challenges and pilot test some of the ways other teams are succeeding in the same domain
3. Teams can look at challenges and cross check with own challenges and work with state and consultant partners on identifiable barriers and ways to address barriers
4. Teams can take some of challenges to other teams in area (JCPC's, SOC Collaborative) and look at methods of partnership to address some of funding, staffing, and other barriers
5. Teams can request information on liaisons for particular identified strengths and communicate with the other teams on how they are implementing a particular process, program, etc.-TA consultants are aware of team processes and can link, with approval, teams that would like to share information

APPENDIX C-SPRING REGIONAL REPORT

JJSAMHP REGIONAL MEETINGS

Spring, 2011

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

Summary of Document Contents

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

I. Meeting Locations
II. Meeting Participants
III. Meeting Agenda
IV. Individual Evaluations of Meeting

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,	May 2nd	Durham	Millennium Hotel
Eastern (DJJDP Area)	Beaufort, Camden, Carteret, Chowan, Craven, Currituck, Dare, Edgecombe, Gates, Greene, Halifax, Hyde, Jones, Lenoir, Martin, Nash, New Hanover, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Pitt, Tyrell, Washington, Wayne, Wilson	May 4th	Greenville	Hilton Hotel Greenville
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	May 11th	Hickory	Crowne Plaza

II. Meeting Participants:

Overall, there were **130** Local Participants who attended the Regional Meetings across the state (there were 118 in the Fall). There were 16 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	10	12	9
DJJDP Local Court Counseling Representatives	8	10	13
DJJDP Local YDC Representatives	4	7	8
Provider Representatives	13	9	25
Other Representatives	1	0	1
Total Local Participants	36	38	56
Total State/Regional	9	8	12
Total Participants	**45**	**46**	**68**

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-May 2nd

9:00-9:30 **Registration**
9:30-9:40 **Welcome & Introductions**
- *Robin Jenkins, DJJDP*

9:40-9:50 **Overall data for JJSAMHP**
- *Huaibo Xin, UNCG*

9:50-11:15 **What Works in the Treatment of Juvenile Justice Involved Youth**
- *Jean Steinberg, DJJDP*

11:15-11:25 **Break – Team set up for presentation**
11:25-12:00 **What Works in Treatment of Juvenile Justice Involved Youth – Local Team Presentation**
- *Wake*

12:00-1:00 **Lunch On Site**
1:00-1:30 **Using Data to Support What Works – NC-TOPPS**
- *Sonja Frison, UNCG*

1:30-2:30 **Utilizing Funding to Support What Works in Treatment of Juvenile Justice Involved Youth**
- *Paul Savery, DMHDDSAS*

2:30-3:20 **Applying "What Works" to our local situation – Local Team Break Out**
- *Brad Bannister, DJJDP*

3:20-3:30 **Evaluation**

Eastern Area-May 4th

9:00-9:30 **Registration**
9:30-9:40 **Welcome, Introductions & Announcements**
- *Claude Odom, DJJDP & Claretta Witherspoon, UNCG*

9:40-9:50 **Overall data for JJSAMHP**
- *Huaibo Xin, UNCG*

9:50-11:40 **What Works in the Treatment of Juvenile Justice Involved Youth**
- *Jean Steinberg, DJJDP*

10:30-10:40 **Break**
11:40-12:00 **Using Data to Support What Works – NC TOPPS**
- *Sonja Frison, UNCG*

12:00-1:00 **Lunch On Site**
1:00-2:10 **What Works in Treatment of Juvenile Justice Involved Youth – Local Team Presentations**
- *ECBH & Eastpointe*

2:10-2:50 **Utilizing Funding to Support What Works in the Treatment of Juvenile Justice Involved Youth**
- *Sonja Frison for Paul Savery*

2:50-3:20 **Applying "What Works" to our local situation – Local Team Break Out**
- *Brad Bannister, DJJDP*

3:20-3:30 **Evaluation**

Western/Piedmont-May 11th

9:00-9:30 **Registration**
9:30-9:45 **Welcome, Introductions & Announcements**
- *Tom Kilby and Karen McDonald, DJJDP & Claretta Witherspoon, UNCG*

9:45-9:55 **Overall data for JJSAMHP**
- *Huaibo Xin, UNCG*

9:55-11:45 **What Works in the Treatment of Juvenile Justice Involved Youth**
- *Jean Steinberg, DJJDP*

10:35-10:45 **Break**
11:45-12:15 **Using Data to Support What Works – NC TOPPS**
- *Sonja Frison, UNCG*

12:15-1:15 **Lunch On Site**
1:15-1:55 **What Works in Treatment of Juvenile Justice Involved Youth – Local Team Presentation**
- *Crossroads*

1:55-2:30 **Utilizing Funding to Support What Works in the Treatment of Juvenile Justice Involved Youth**
- *Paul Savery, DMHDDSAS*

2:30-3:20 **Applying "What Works" to our local situation – Local Team Break Out**
- *Brad Bannister, DJJDP*

3:15-3:30 **Evaluation**

V. *Individual Evaluations of the Meeting*

Overall, 102 local participants completed meeting evaluation forms. This is 78% 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. The individual responses from each participant are in a separate document.

Spring 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 will be 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	3.70	3.68	3.54	3.46	3.54	3.36	3.55
Averages for Eastern	3.96	3.82	3.46	3.50	3.61	3.43	3.63
Averages for Central	3.82	3.76	3.60	3.38	3.64	3.51	3.62
Overall Averages for All Meetings	3.83	3.75	3.54	3.44	3.60	3.45	3.60

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).

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

   a. Steinberg Presentation
   b. Local Team Presentations
   c. Local Team Breakout
   d. Everything/All
   e. Networking/Collaboration/Partners across levels for solution focused meeting
   f. Information shared/Information on YDC released youth
   g. Food
   h. Funding Presentation

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/Well Done/Keep up Good Work
b. Shorter Presentation/Less lecture
c. More information/More info on funding/More on YDC releases
d. More Breaks
e. Shorter Day
f. Warmer rooms

Appendix D-Monthly Report Survey

JJSAMHP Monthly Data Survey

1. What is the LME 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 2010

____ July 2010

____ August 2010

____ September 2010

____ October 2010

____ November 2010

____ December 2010

____ January 2011

____ February 2011

____ March 2011

____ April 2011

____ May 2011

____ June 2011

____ July 2011

____ August 2011

____ September 201

____ October 2011

____ November 2011

____ December 2011

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 DJJDP

____ Number of assessments completed during the month

____ Number of admissions to JJSAMHP providers during the month

____ Number of discharges from 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 DJJDP during the month

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

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

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

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

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

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

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

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

____ # of Intake youth referred by DJJDP during the month

____ # of other youth referred by DJJDP 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. For Female Adolescent SA individual: 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 ☐ Alaska Native
☐ White/Anglo/Caucasian ☐ Asian
☐ Multiracial ☐ Pacific Islander
☐ American Indian/Native American ☐ Other

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

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

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

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

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 **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

13. For K-12 only:

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. 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

Confidentiality of SA and MH consumer-identifying information is protected under Federal regulations 42 CFR Part 2 and HIPAA, 45 CFR Parts 160 and 164. Consumer-identifying information may be disclosed without the individual's consent to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) and to its authorized evaluation contractors under the audit or evaluation exception. Redisclosure of consumer-identifying information without the individual's consent is explicitly prohibited. Your questions may be directed to (919) 515-1310. Sponsored by the NC MH/DD/SAS.

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

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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
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)

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)

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NC-TOPPS Mental Health and Substance Abuse

Adolescent (Ages 12-17) Initial Interview

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

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

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

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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

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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

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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

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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, *where* 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, *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

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

30. *For Adolescent MH only individual*:
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 and 30)*

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

Substance	Past Month - 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)

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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

Confidentiality of SA and MH consumer-identifying information is protected under Federal regulations 42 CFR Part 2 and HIPAA, 45 CFR Parts 160 and 164. Consumer-identifying information may be disclosed without the individual's consent to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) and to its authorized evaluation contractors under the audit or evaluation exception. Redisclosure of consumer-identifying information without the individual's consent is explicitly prohibited. Your questions may be directed to (919) 515-1310. Sponsored by the NC MH/DD/SAS.

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

Confidentiality of SA and MH consumer-identifying information is protected under Federal regulations 42 CFR Part 2 and HIPAA, 45 CFR Parts 160 and 164. Consumer-identifying information may be disclosed without the individual's consent to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) and to its authorized evaluation contractors under the audit or evaluation exception. Redisclosure of consumer-identifying information without the individual's consent is explicitly prohibited. Your questions may be directed to (919) 515-1310. Sponsored by the NC MH/DD/SAS.

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-JJSAMHP UPDATE

JJSAMHP

THE JUVENILE JUSTICE SUBSTANCE ABUSE MENTAL HEALTH PARTNERSHIPS

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	470	715
Caucasian	499	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	20%	54%
Treatment Engagement	7%	26%
Family Issues	6%	19%
Scheduling Issues	7%	17%
Physically Hurt in Past 3 Months (A few times or more than a few times)	16%	27%