

# NC-TOPPS Mental Health and Substance Use Disorder

## Child (Ages 6-11)

## Episode Completion Interview

Use this form for backup only. **Do not mail.** Enter data into web-based system:

(<http://www.ncdhhs.gov/providers/provider-info/mental-health/nc-treatment-outcomes-and-program-performance-system>)

QP First Initial & Last Name

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

QP Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please provide the following consumer information:

LME-MCO Assigned Consumer Record Number:

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Consumer Date of Birth:

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Consumer Gender:

Male  Female

First three letters of consumer's last name:

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First letter of consumer's first name:

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Consumer County of Residence: \_\_\_\_\_

CNDS ID Number

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Medicaid ID Number (optional)

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Medicaid County of Residence: \_\_\_\_\_

Provider Internal Consumer Record Number (optional)

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Local Area Code (Reporting Unit Number) (optional)

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Please select the appropriate age/disability category(ies) for which the individual has received services and supports.

Child Mental Health, age 6-11

Discharge Date (date of last paid service for this episode of care):

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### Begin Interview

1. Please select all services the consumer has received for this episode of care. (See Attachment I)

2. 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 → (skip to end of interview)
- Changed to service not required for NC-TOPPS
- Moved out of area or changed to different LME-MCO
- Incarcerated
- Institutionalized
- Died → (skip to end of interview)
- Other

3. Please indicate the DSM-5 diagnostic classification(s) for this individual. (See Attachment I)

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

All or most of the time  Sometimes  Rarely or never

5. 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
  - Housing (basic shelter or rent subsidy)
  - Transportation
  - Food supply
  - Child care
  - Medical care
  - Dental care
  - Screening/Treatment referral for HIV/TB/HEP
  - Legal issues
  - Volunteer opportunities
  - None of the above
- b. If food supply, how helpful have the program services been in supplying food as needed?
- Not helpful  Somewhat helpful  Very helpful  NA

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

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

### Section II: Complete items 7-26 using information from the individual's interview (preferred) or consumer record

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

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

8. Does your child and/or family ever have difficulty participating in treatment because of problems with... (mark all that apply)

- No difficulties prevented your child from entering treatment
- Active mental health symptoms (anxiety or fear, agoraphobia, paranoia, hallucinations)
- Active substance use disorder 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/Discrimination (race, gender, sexual orientation)
- Treatment/Authorization access issues (insurance problems, waiting list, paperwork problems, red tape, lost Medicaid card, referral issues, citizenship, etc.)
- Being deaf/hard of hearing
- Language or communication issues (foreign language issues, lack of interpreter, etc.)
- Legal reasons (incarceration, arrest)
- Transportation/Distance to provider
- Scheduling issues (work or school conflicts, appointment times not workable, no phone)
- Lack of stable housing
- Personal safety (domestic violence, intimidation or punishment)

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**9. Is your child currently enrolled in school or courses that satisfy requirements for a certification, diploma or degree?** (Enrolled includes school breaks, suspensions, and expulsions)

Yes  No → (skip to 10)

b. What program(s) is your child currently enrolled in for credit? (mark all that apply)

- Alternative Learning Program (ALP)/School  
 Academic schools (K-12)  
 Private Home School by parents/guardians  
 Homebound Instruction by public/private school  
 Incarceration/Detention/Youth Development Centers  
 Other

**10. Does your child have an Individualized Education Program (IEP) (program or plan for special education and related services)?**

Yes  No

**11. What grade is your child currently in?**

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**12. Since beginning treatment, your child's school attendance has...**

improved  stayed the same  gotten worse

**13. For your child's most recent reporting period, what grades did s/he 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

b. If school does not use traditional grading system, for your child's most recent reporting period, did s/he pass or fail most of the time?

Pass  Fail

**14. In the past 3 months, has your child been...**

a. suspended from school?  Yes  No

b. expelled from school?  Yes  No

**15. In the past 3 months, how often did your child participate in extracurricular activities?**

Never  A few times  More than a few times

**16. In the past 3 months, how often have your child's problems interfered with play, school, or other daily activities?**

Never  A few times  More than a few times

**17. In the past month, how would you describe your child's mental health symptoms?**

Extremely severe

Severe

Moderate

Mild

Not present

**18. In the past month, if your child has a current prescription for psychotropic medications, how often has your child taken this medication as prescribed?**

No prescription

All or most of the time

Sometimes

Rarely or never

**19. In the past 3 months, how many times has your child moved residences?**

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(enter zero, if none)

**20. Currently, where does your child live?**

In a family setting (private or foster home) → (skip to 21)

Residential program (group home, PRTF) → (answer b)

Institutional setting (hospital or detention center/jail) → (skip to 21)

Homeless → (answer c)

Temporary housing → (answer d)

b. If residential program, please specify the type of residential program your child currently lives in.

Therapeutic foster home

Level III group home

Level IV group home

State-operated residential treatment center

Psychiatric Residential Treatment Facility (PRTF)

Other

c. If homeless, please specify your child's living situation currently.

Sheltered (homeless shelter or domestic violence shelter)

Unsheltered (on the street, in a car, camp)

d. If temporary housing, please specify your child's living situation most of the time in the past 3 months.

Unstable housing with frequent moves to and from relative's/friend's homes

Hotel/motel

**21. Was this living arrangement in your child's home community?**

Yes  No

**22. In the past 3 months, has your child received any residential services outside of his/her home community?**

Yes  No

**23. In the past 3 months, has your child used tobacco or alcohol?**

Yes  No  Don't know

**24. In the past 3 months, has your child used illicit drugs or other substances other than tobacco and alcohol?**

Yes  No  Don't know

**25. In the past month, how many times has your child had a petition filed for any offense?**

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(enter zero, if none)

**26. Does your child have a Court Counselor or is your child currently under the supervision of the juvenile justice system?**

Yes  No

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

**27. Is the respondent present for an in-person or telephone interview or have you directly gathered information from the respondent within the past two weeks?**

Yes - Complete items 28-38

No - Stop here

**28. Since the last interview, has your child visited a physical health care provider for a routine check up?**

Yes  No

**29. Since the last interview, has your child visited a dentist for a routine check up?**

Yes  No

**30. Other than yourself, how many active, stable relationship(s) with adult(s) who serve as positive role models does your child have? (i.e., member of clergy, neighbor, family member, coach)**

None  1 or 2  3 or more

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**31. In the past 3 months, how often has your child been hit, kicked, slapped, or otherwise physically hurt?**

Never  A few times  More than a few times  Deferred

**32. In the past 3 months, how often has your child hit, kicked, slapped, or otherwise physically hurt someone?**

Never  A few times  More than a few times  Deferred

**33. Since the last interview, how often has your child tried to hurt him/herself or cause him/herself pain on purpose (such as cut, burned, or bruised self)?**

Never  A few times  More than a few times

**34. Since the last interview, how often has your child had thoughts of suicide?**

Never  
 A few times  
 More than a few times  
 Don't know

**35. Since the last interview, has your child attempted suicide?**

Yes  No

**36. In the past 3 months, how well has your child been doing in the following areas of his/her life?**

	Excellent	Good	Fair	Poor
a. Emotional well-being	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Physical health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Relationships with family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Living/Housing situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**37. In the past 3 months, has your child...**

- a. had **contacts** with an emergency crisis provider?  
 Yes  No
- b. had **visits** to a hospital emergency room?  
 Yes  No
- c. spent **nights** in a medical/surgical hospital? (excluding birth delivery)  
 Yes  No
- d. spent **nights** in a psychiatric inpatient hospital?  
 Yes  No
- e. spent **nights** homeless? (sheltered or unsheltered)  
 Yes  No
- f. spent **nights** in detention, jail, or prison? (adult or juvenile system)  
 Yes  No

**38. How helpful have the program services been in...**

- a. improving the quality of your child's life?  
 Not helpful  Somewhat helpful  Very helpful  NA
- b. decreasing your child's symptoms?  
 Not helpful  Somewhat helpful  Very helpful  NA
- c. increasing your child's hope about the future?  
 Not helpful  Somewhat helpful  Very helpful  NA
- d. increasing your child's control over his/her life?  
 Not helpful  Somewhat helpful  Very helpful  NA
- e. improving your child's 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)?  Yes  No

**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/providers/provider-info/mental-health/nc-treatment-outcomes-and-program-performance-system>**

**Do not mail this form**

# Attachment I: NC-TOPPS Services

## Community Based Services

- Intensive In-Home Services (IIH) - H2022
- Multisystemic Therapy Services (MST) - H2033

## Facility Based Day Services

- Mental Health - Partial Hospitalization - H0035
- Child and Adolescent Day Treatment - H2012 HA

## Residential Services

- Behavioral Health - Long Term Residential - H0019
- Residential Treatment - Level II - Program Type (Therapeutic Behavioral Services) - H2020
- Psychiatric Residential Treatment Facility - YA230
- Group Living - High - YP780

## Therapeutic Foster Care Services

- Residential Treatment - Level II - Family Type (Foster Care Therapeutic Child) - S5145

## Other Services

**Service Code:** \_\_\_\_\_ **Service Description:** \_\_\_\_\_

# Attachment II: DSM-5 Diagnostic Classifications

## Neurodevelopmental Disorders

- Learning Disorders (315.00, 315.1, 315.2)
- Communication Disorders (307.9, 315.35, 315.39)
- Intellectual Disabilities (315.8, 317, 318.0, 318.1, 318.2, 319)
- Motor and Tic Disorders (307.20, 307.21, 307.22, 307.23, 307.3, 315.4)
- Autism Spectrum Disorder (299.00)
- Attention-Deficit/Hyperactivity Disorder (314.00, 314.01)
- Other Neurodevelopmental Disorders (315.8, 315.9)

## Substance-Related and Addictive Disorders

- Alcohol-Related Disorders (303.90, 305.00)
- (Other) Drug-Related Disorders (304.00, 304.10, 304.20, 304.30, 304.40, 304.50, 304.60, 305.20, 305.30, 305.40, 305.50, 305.60, 305.70, 305.90)
- Gambling Disorder (312.31)

## Schizophrenia Spectrum and Other Psychotic Disorders

- Schizophrenia and Other Psychotic Disorders (293.81, 293.82, 293.89, 295.40, 295.70, 295.90, 297.1, 298.8, 298.9)

## Bipolar and Related Disorders

- Bipolar I Disorder (296.40, 296.41, 296.42, 296.43, 296.44, 296.45, 296.46, 296.50, 296.51, 296.52, 296.53, 296.54, 296.55, 296.56, 296.7)
- Bipolar II Disorder (296.89)
- Cyclothymic Disorder (301.13)

## Depressive Disorders

- Major Depressive Disorder (296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.26, 296.30, 296.31, 296.32, 296.33, 296.34, 296.35, 296.36)
- Persistent Depressive Disorder (Dysthymia) (300.4)
- Other Depressive Disorders (296.99, 311, 625.4)

## Anxiety Disorders

- Anxiety Disorders (300.00, 300.01, 300.02, 300.09, 300.22, 300.23, 300.29, 309.21, 312.23)

## Obsessive-Compulsive and Related Disorders

- Obsessive-Compulsive and Other Related Disorders (300.3, 300.7, 312.39, 698.4)

## Trauma- and Stressor-Related Disorders

- Posttraumatic Stress Disorder (PTSD) (309.81)
- Adjustment Disorders (309.0, 309.24, 309.28, 309.3, 309.4)
- Other Trauma- and Stressor-Related Disorders (308.3, 309.89, 309.9, 313.89)

## Dissociative Disorders

- Dissociative disorders (300.12, 300.13, 300.14, 300.15, 300.6)

## Disruptive, Impulse-Control, and Conduct Disorders

- Conduct Disorder (312.81, 312.82, 312.89)
- Impulse Control Disorders (312.32, 312.33, 312.34)
- Oppositional Defiant Disorder (313.81)
- Other Disruptive Behavior Disorders (312.89, 312.9)

## Gender Dysphoria Disorders

- Gender Dysphoria Disorders (302.6, 302.85)

## Neurocognitive Disorders

- Delirium Disorders (292.81, 293.0, 780.09)
- Major and Mild Neurocognitive Disorders (290.40, 294.10, 294.11, 331.83, 331.9, 799.59)

## Personality Disorders

- Cluster A Personality Disorders (301.0, 301.20, 301.22)
- Cluster C Personality Disorders (301.4, 301.6, 301.82)
- Cluster B Personality Disorders (301.50, 301.7, 301.81, 301.83)
- Other Personality Disorders (301.89, 301.9)

## Feeding and Eating Disorders

- Anorexia Nervosa (307.1)
- Other Feeding and Eating Disorders (307.50, 307.51, 307.52, 307.53, 307.59)

## Other Disorders

- Somatic Symptom and Related Disorders (300.11, 300.19, 300.7, 300.82, 300.89, 316)
- Elimination Disorders (307.6, 307.7, 787.60, 788.30, 788.39)
- Sexual Dysfunction Disorders (302.70, 302.71, 302.72, 302.73, 302.74, 302.75, 302.76, 302.79)
- Sleep-Wake Disorders (307.45, 307.46, 307.47, 327.21, 327.23, 327.24, 327.25, 327.26, 327.42, 333.94, 347.00, 347.01, 780.52, 780.54, 780.57, 780.59, 786.04)
- Paraphilic Disorders (302.2, 302.3, 302.4, 302.81, 302.82, 302.83, 302.84, 302.89, 302.9)
- Other Conditions That May Be a Focus of Clinical Attention (V-codes, 999.xx)
- Other Mental Disorders and Conditions (any codes not listed above)