



# NC-TOPPS Mental Health and Substance Use Disorder

## Child (Ages 6-11)

## Initial 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>)

c. If *homeless*, please specify your child's 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)

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

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

- Yes  No

**17. How long has it been since your child 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

**18. How long has it been since your child last visited a dentist 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

**19. Would you say that in general your child's health is:**

- Excellent  Poor  
 Very good  Don't know/Not sure  
 Good  Refuse  
 Fair

**20. Now thinking about your child's physical health, which includes physical illness and injury, for how many days during the past 30 days was your child's physical health not good?**

- Number of days:    None  
 Don't know  
 Refused

**21. Now thinking about your child's mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your child's mental health not good?**

- Number of days:    None  
 Don't know  
 Refused

**22. During the past 30 days, for about how many days did poor physical or mental health keep your child from doing his/her usual activities, such as self-care, school work or recreation?**

- Number of days:    None  
 Don't know  
 Refused

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

- Never  A few times  More than a few times

**24. Has your child used tobacco/vaping products or alcohol?**

- Yes  No  Don't know

**25. Has your child used illicit drugs or other substances other than tobacco/vaping products and alcohol?**

- Yes  No  Don't know

**26. Does anyone who cares for your child ever smoke or vape (including in your home, car, or other places)?**

- Smoke  
 Vape  
 Neither

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

- Never → (skip to 28)  
 A few times  
 More than a few times  
 Deferred → (skip to 28)

b. In the past 7 days, has your child been hit, kicked, slapped, or otherwise physically hurt?

- Yes  No

**28. 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

**29. In the past 3 months, 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

**30. In your child's lifetime, has s/he ever attempted suicide?**

- Yes  No

**31. In the past 3 months, how often has your child had thoughts of suicide?**

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

**32. How many times has your child had a petition filed for any offense.... (enter zero, if none)**

- a. in the past month    
b. in the past year    
c. in their lifetime

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

- Yes  No

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### 34. 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

### 35. 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

### 36. How well has your child been doing in the following areas of his/her life in the past year?

- |                                    | 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. Did you receive a list or options, verbal or written, of places for your child 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

### 38. Was your child's first service in a time frame that met his/her needs?

- Yes  No

### 39. Does your child have a need for any of the following? (mark all that apply)

- Wheelchair/Mobility equipment or services  
 Equipment or services due to a physical disability  
 Equipment or services due to being deaf/hard of hearing  
 Sign language interpreter  
 Foreign language interpreter  
 Equipment or services due to being visually impaired  
 Child care  
 Other  
 None of the above/NA

### 40. Did your child and/or family have difficulty entering 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)

### 41. What help in any of the following areas is important to your child? (mark all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Educational improvement                 | <input type="checkbox"/> Medical Care            |
| <input type="checkbox"/> Housing (basic shelter or rent subsidy) | <input type="checkbox"/> Dental care             |
| <input type="checkbox"/> Transportation                          | <input type="checkbox"/> Legal issues            |
| <input type="checkbox"/> Food supply                             | <input type="checkbox"/> Volunteer opportunities |
| <input type="checkbox"/> Child Care                              | <input type="checkbox"/> None of the above       |

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

- Extremely Severe  Mild  
 Severe  Not present  
 Moderate

### 43. 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  Sometimes  
 All or most of the time  Rarely or never

**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:

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**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)
- Oppositional Defiant Disorder (313.81)
- Impulse Control Disorders (312.32, 312.33, 312.34)
- 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 B Personality Disorders (301.50, 301.7, 301.81, 301.83)
- Cluster C Personality Disorders (301.4, 301.6, 301.82)
- 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)