

South Carolina

Child and Adolescent

Policy Forum

Compiled by:

Pam Imm, Ph.D.
Evaluation Consultant
Tidwell & Associates

Date:

September 14, 2007

TABLE OF CONTENTS

BACKGROUND FOR THE SC CHILD AND ADOLESCENT POLICY FORUM.....	3
OVERVIEW OF THIS REPORT	4
EXECUTIVE SUMMARY	5
ROUNDTABLE DISCUSSION	7
RESULTS OF BREAKOUT SESSIONS	14
Directors/Agency Staff.....	14
Youth and Family Involvement and Cultural/Linguistic Competence.....	18
Screening Tool/Referral Protocol.....	23
Core Competencies/Evidence-Based Practice.....	26
HIGHLIGHTS OF EVALUATION SURVEY	29
NEXT STEPS	33
APPENDIX A- DETAILED SURVEY RESULTS.....	34

BACKGROUND FOR THE SOUTH CAROLINA CHILD AND ADOLESCENT POLICY FORUM

South Carolina is fortunate in that both the state substance abuse and mental health agencies received infrastructure grants from the Federal Substance Abuse and Mental Health Services Administration (SAMHSA) totaling approximately five million dollars. The South Carolina Department of Alcohol and Other Drug Abuse Services received a three-year infrastructure change grant referred to as Breaking Barriers (BB). The Department of Mental Health has a five-year infrastructure change grant known as Offering Assistance Stability Intensive Support (OASIS). The two grants have a shared strategic plan since the goals of both grants are similar.

These infrastructure grants are designed to promote lasting systems level changes that will improve access to treatment services for children and families. The collaboration between the two South Carolina agencies (e.g., South Carolina Alcohol and Other Drug Abuse Services and the South Carolina Department of Mental Health) is a model for how agencies can join forces to work together for infrastructure change and to collaboratively plan and implement an event like the South Carolina Child and Adolescent Policy Forum. There were many other agencies and organizations who worked as partners in planning this Policy Forum. The complete list of partners, as well as those participating in the BB/OASIS grants, is provided in the binders distributed at the Policy Forum.

South Carolina's Child and Adolescent Policy Forum was held on August 30, 2007, and was an opportunity to convene key leaders and stakeholders in order to discuss how the state can improve its infrastructure to enhance the services for youth and families. Key staff from BB/OASIS secured the participation of six South Carolina Agency Directors to participate as members of a Roundtable to facilitate discussion and meaningful dialogue about how to improve services for youth and their families. These Agency Directors included:

- Dr. Kathleen Hayes, Director, South Carolina Department of Social Services
- Mr. John Shackelford, Director, Continuum of Care, SC Governor's Office
- Mr. John Magill, Director, South Carolina Department of Mental Health
- Mr. W. Lee Catoe, Director, South Carolina Department of Alcohol and Other Drug Abuse Services
- Judge Byars Jr., Director, South Carolina Department of Juvenile Justice
- Ms. Lathran Woodard, Executive Director, South Carolina Primary Health Care Association

Additional representatives from community and local agencies invited to speak were:

- Mr. Charles Young, President, Behavioral Health Services Association of SC
- Ms. Diane Flashnick, Executive Director, Federation of Families of SC
- Dr. Michael Laughlin, Chairman, Faces And Voices of Recovery (FAVOR) SC

Ms. Cathy Finck, a consultant for the Substance Abuse and Mental Health Services Administration (SAMHSA), attended the Forum as a moderator for the day. There were two moderators/facilitators for each breakout session as well as scribes who transcribed notes that are included in this report. The four breakout sessions, the names of the moderators, and their scribes are provided below. Many of the moderators have been chairpersons or co-chairpersons of a BB/OASIS committee over the last two years, and all have been very involved in the processes of developing recommendations for improvement.

Name of Session	Moderators/Facilitators	Scribes
Roundtable Discussion of State Agency Directors	Cathy Finck	Pam Imm
Breakout Session for Agency Staff	Cathy Finck	Pam Imm
Breakout Session on Youth and Family Involvement	Jillian Lemay and Ashley Witt	Kathy Paget
Breakout Session on the Screening/Referral Processes	Felicity Myers and Barbara Hartt	Reenay Long and Karimah Ervin
Breakout Session on the Core Competencies/Evidence Based Practice	Vadonna Bartell and Louise Haynes	Wanda Pearson

OVERVIEW OF THIS REPORT

This report includes an Executive Summary as well as highlights of the Roundtable Discussion of the six State Agency Directors, results of four breakout sessions, and a summary of the quantitative and qualitative results obtained by an evaluation survey completed at the end of the day. The four breakout sessions provided an opportunity to discuss specific recommendations from the BB/OASIS committees that have been working together for two years and to gather input and ideas from additional stakeholders about the recommendations.

Approximately 200 people registered for the Policy Forum, and 151 actually attended the 6-hour event. Of the 151 participants, 96 (63%) completed a 3-page survey that included quantitative and qualitative questions about the process and content of the Policy Forum. The results of this survey are also included in this report as well as suggestions for next steps as BB and OASIS move forward with implementing recommendations and working more closely with those at the local level.

EXECUTIVE SUMMARY

This serves as the Executive Summary of the Policy Forum and includes Highlights of the Roundtable Discussion, each break out session, and the evaluation completed at the end of the day. The results of the South Carolina Child and Adolescent Policy Forum are quite positive based on observations, comments, and evaluation data¹.

Roundtable Discussion

The six Agency Directors recognized the importance of collaboration and effective coordination in order to improve the services for youth and families in South Carolina. There was general agreement that youth and families needed to be engaged at all levels, that effective programs/practices should be disseminated around the state, and that ensuring a skilled workforce should be a priority. The Directors signed a Joint Memorandum of Agreement that highlighted their commitment for working together and indicated that they desired to be an action-oriented group and not just another level of bureaucracy.

Breakout Sessions

The break out sessions varied in length and included a 2 hour session with agency/staff directors as well as shorter time periods with those interested in hearing the recommendations from the BB/OASIS committees about promoting family-driven, youth guided services, the screening and referral protocol, and the recommendations for integrating the core competencies and evidence-based practice into training opportunities. Results of all break out sessions are aggregated for this Executive Summary but the specific comments are included in the remaining sections of this report.

The participants reported that a great deal of local collaboration is already occurring and reported opportunities at the state and local levels. Barriers to collaboration included staff resistance given time constraints, how agencies are funded and required to report for accountability, and confidentiality regulations with the common interpretation being staff cannot talk to each other across agency lines. Several solutions to the barriers were generated and are included in this report. The agency staff, again, reported a great deal of opportunities for youth guided, and family driven care that currently exist at the state and local levels. Barriers to doing more included transportation, work schedules, cultural barriers, and the general definition of family driven, youth guided participation. Solutions included home visiting, the need for a shared language without acronyms, and providing peer mentors and bilingual workers. When the group discussed the idea of a common screening/referral tool, the group wondered if this was an “add on” to what they are already doing with screening and what incentives would there be for participation. The group mentioned that the common screening and referral tool would increase the identification of youth in need but indicated they would need a commitment from their agency directors. All participants were interested in improving core competencies of workers and were pleased about cross-training opportunities that will create new partnerships and improve adolescent services. It was suggested that institutions of higher learning become more involved and the need to attract a potential workforce was noted.

¹ Detailed results are included in this report.

Evaluation Survey Results

Participants were asked to complete their evaluation form at the end of the day. Approximately 63% (96 of the 151 participants) completed and returned an evaluation survey. The survey included quantitative and qualitative questions. The highlights of the data are provided below:

Quantitative Data: The majority of the survey respondents were white (60%) females (68%). Most of the respondents reported their job description to be manager/director (37.5%) or clinical administrator/manager (15.6%). When asked to provide information about their agency or affiliation, 58% reported working in state government and 20% indicated that they are affiliated with a substance abuse treatment program. Results to the Forum were generally positive. On the 10 quantitative questions, respondents could choose on a 1-5 Scale with “1” being the lowest score, “3” neutral, and “5” the highest score. The highest average score (4.54) was when the respondents were asked their level of agreement with the following statement: “This policy forum was well organized.” Participants also responded favorably (4.47) to “how satisfied are you with the quality of the materials distributed at this Forum. (See Appendix XX for a complete analyses of the results of each question).

Qualitative Data: The most frequent responses are provided below for the four questions asked on the evaluation survey. A more detailed analyses is included in the full report.

Question #1: What were the most important messages from the Roundtable Discussion with the State Agency Directors? (62% provided at least one response to this question)

- a. Agencies/and Directors seemed eager to collaborate/coordinate (32)
- b. The Memorandum of Agreement (MOA)/commitment to the process of improving services for families and youth in South Carolina (15)

Question #2: What about today’s Policy Forum was most useful? (65% provided at least one response to this question)

- a. Networking/bringing staff together/connections (20)
- b. Breakout sessions (18)

Question #3: What additional information do you need to maintain the momentum of the Breaking Barriers/OASIS projects? (40% provided at least one response to this question).

- a. Ongoing training/cross training for workers (12)
- b. Shared action plans, especially for collaborating to improve the involvement of youth and families (8)

Question #4: How could we improve our Policy Forum next year? (41% provided at least one response to this question).

- a. Increase family voices in the sessions/have a family track (8)
- b. Let us work together by region or county to move things along more quickly/share information (7)

Summary

The results of the Policy Forum are positive and suggest that the participants were well engaged in the process and had meaningful input and new ideas. The signing of the Joint

Memorandum of Agreement among the state Agency Directors was a significant event and represents each Director's commitment to develop a Joint Council on Adolescents including a joint strategic plan on adolescents, prioritize the principles of family driven and youth guided care, and examine existing funding streams in order to be most efficient in providing services to adolescents and their families. The Directors were clear that they do not want the Joint Council to be another level of bureaucracy but rather a true collaborative group that can produce meaningful results.

ROUNDTABLE DISCUSSION

Background for the Roundtable Discussion

The moderator of the roundtable discussion at the Forum, Cathy Finck, noted that shortly before the Forum, the South Carolina Directors received questions that pertained to the five SAMHSA strategic areas for the infrastructure change grants. The Directors were asked to provide short, one-minute answers to each of the five questions that pertain to the five key strategic areas. These strategic areas included interagency collaboration, evidence-based practice, workforce development, family involvement, and financing. The Directors were introduced in a particular order and their responses were always presented in that same order.

Format for this Report

Individual Questions and Responses Provided by the Agency Directors:

After each of the five questions listed, the responses from each of the Directors are presented. In many cases, actual verbatim responses are recorded; however, there are summaries of some responses since it was not possible to capture every word said by every Director.

QUESTION #1: Can you share an idea for addressing system barriers in South Carolina that hinder families having more easy access to treatment?

Dr. Hayes: I have noticed that there are silos across agencies, but also there are also silos for the children in the custody of the state that do not have parents advocating for them. These children are identified by name, and they are not getting the services they need because they are not viewed as a priority in our system. We need to engage parents and hope other agencies will do this as well. We need to place services for youth in the state's custody at a higher priority than we currently do. DSS is planning to cooperate more with DJJ. We have a great deal of collaboration at the local level in many areas; I am not sure how a common screening tool will help us improve collaboration.

Mr. Shackelford: Georgetown and Waccamaw are models for the state. In our agency, we are sometimes impeded by legislative mandates that do not allow us to serve certain types of youth. We have to go beyond that to improve our system. Two suggestions:

- 1) There are pockets in this state that do collaboration very well and are quite innovative; let's find where those pockets are and build on that.
- 2) We need to improve core competencies of staff. Many times the services lack quality because there is not a level of expertise available.

Mr. Magill: We have out stationed mental health workers in DSS and DJJ. We have school-based counselors in many of our schools, and we have seen results. We want to continue to build on that success and welcome partners who want to collaborate.

Mr. Catoe: There are many barriers to access and effective collaboration: cost, turf, etc. I would hope we could all agree on a "no wrong door" policy where families could be seen no matter which agency they initially access. I think a common screening tool will help us improve access.

Judge Byars: At DJJ, we are a penal system, a community in itself, a school district and touch about 25,000 youth every year. We need to break down the silos between our systems and look outside of our traditional agencies for assistance. For example, we found that the Youth Leadership Institute at Clemson University is working with youth at risk, and they help to train our staff. They set up training at the local level, and we send our people to Clemson as well.

Ms. Woodard: We are not a government agency and recognize that there are a lot of barriers in accessing services. This is an "us" problem; not an "us vs. them" problem; we are all in this together. Dealing with obstacles has to be done at the local level. Communities in SC are different, and we need to recognize these and capitalize on the resources that are out there. Communities have solutions to their problems more than government agencies do. Regulations and interpretations of laws are being used to keep us working in silos.

QUESTION #2 - How could having such a complete picture of SC services financing and utilization patterns assist in either improving infrastructure or increasing capacity (or both) for delivering effective adolescent services?

Dr. Hayes: Of course, we need to understand the full spectrum of funding. We also need to be concerned about determining our resources and programs that are evidence based. We need to locate where these are so we can replicate them.

Mr. Shackelford: Not only do we need to do a resource/financial mapping, we need to do a needs assessment. We need to look at service utilization patterns but we also need to determine if our types of services are doing really what our families need.

Mr. Magill: It is common sense that we need to do some resource/financial mapping. How the money is currently being spent is important to determine how we need to tweak it in order to be more efficient in our work.

Mr. Catoe: Not everything is always about money. We need to make sure that we do this resource mapping well, so we can avoid duplication.

Judge Byars: Several of us frequently get together after work, break bread, and talk with each other about what is going on in our agency. This is how I learned about the Bridge Program at DAODAS, and we are expanding the Bridge program. We have model programs that are out there, and it is time that we take the Bridge statewide and other programs like our intensive supervision program statewide.

Ms. Woodard: Having a resource/financial mapping process will be good but the question is: What do you do with the data after you get it? We have pockets of what works, we need to do things are sustainable or we actually end up doing a disservice to our families and communities.

QUESTION #3 - How could a SC Joint Council on Adolescent Services assist your agency/organization goals for how adolescent services are developed, delivered, evaluated and funded? And, can you share one or two priorities that such a “council” could accomplish in the next two years?

Dr. Hayes: We really need to consider what this might mean. Let’s do it right and not just more of the same. Let’s really look to where there are gaps in services, we need to find a way to make services available to all. Two recommendations:

- 1) The Joint Council could help us find the talent in the state in order to improve our services.
- 2) The Joint Council could help find a way to change the negative image that teens have in South Carolina.

Mr. Shackelford: The council could assess the needs and determine joint projects to do together and serve population that we are not serving now. We have a lot of neglected areas. This could also bring a lot of cross-training opportunities.

Mr. Magill: I am all for the Joint Council if it is not just talk. We also need to get buy-in and more involvement at the local level on the Council. The workforce issue is important, and we need to get participants at every level involved including the business and industry.

Mr. Catoe: The Joint Council has a potential for setting a new tone. It can potentially get us out of the government mode if we can also engage the private sector. I think education is important as well as recruitment of adolescents and families so we can plan with them rather for them.

Judge Byars: Coming together is good but if you come together in a strict sense, communication does not really happen. The Joint Council or any other group may need to do things differently like meet in the evenings, away from work (with distractions), and lots of opportunities for informal discussion. It will need to be the same folks so we don’t have to repeat information all the time; it should not be another level of bureaucracy.

Ms. Woodard: The Joint Council can help by setting the right example. Need to bring the physical and medical part into mental health and substance abuse treatment services. We need to deal with the mind, body, and spirit. We should look at how to integrate the health care system; collocation is a start. We can prioritize by being patient centered, and we must allow providers to talk to each other. This will not be easy, and it will be a big paradigm shift because we have regulations and policies that make it difficult to do this.

QUESTION #4 - What are some of the current ways your agency/ organization involves (or could involve) families and/or adolescents in the planning, delivery and/or evaluation of adolescent services? And, feel free to share examples of involving families (adults/youth) in the system's practice, program and/or policy areas.

Dr. Hayes: This is good practice. It is hard for a parent to navigate the system. I think about where is the path for the kids that are abused and neglected when frequently this is the result of parental behavior that involves mental health and/or substance abuse issues. We need to support foster families and adoptive families more. We have a teen council, known as GOAL, and they help inform our practice, and they have been clients in our system.

Mr. Shackelford: We are very committed to hearing the family voice. We host family forums throughout the state. Their input directly impacts our agency's policies and procedures. We do emphasize the need for family input at various levels, but we can improve in this area.

Mr. Magill: We have a state planning council that helps set priorities. This includes the fact that at least 51% of the council are families. This is not just an exercise we do, it really helps us to set our program priorities as well as budgets. If we are committed to a family driven, youth guided model, we need to start with doing this from the top.

Mr. Catoe: We have the Governor's Council and the Breaking Barriers grant that helps us involve families and communities. We do need to reach out more to be family driven and youth guided.

Judge Byars: Awhile ago, some of my key staff came to me and said that we needed to gather input from the "inmates" (our clients) about how to do things differently. I was not initially very supportive of this, but we got input from over 1000 people. This process and the results transformed our DJJ system. Our girls will have a residential treatment center that is furnished by volunteers. Through the Friends of Juvenile Justice Foundation, we are constructing a building that is now being built, and we will turn it over to the state as a place for youth and families to use for their needs. I am excited about this and amazed as I see the walls being built. We definitely need to have a process for listening to the community.

Ms. Woodard: From the community health center perspective, it is mandated that the majority of our governing board are patients who are receiving our care. Patients make the decisions about the direction of our health centers. These are community businesses. We have 20 corporations around the state and see almost 300,000 people a year. The patients are continuously giving input and are put in that role of making decisions.

QUESTION #5 - Can you share some ideas for how your agency/ organization could contribute to developing the SC workforce capacity for providing effective evidence-based adolescent services? (i.e., cross-training opportunities, suggestions for core competencies, implementing evidence-based practices, etc)

Dr. Hayes: We do not necessarily know that we have adequately trained staff in all areas. We need more cross training and joint leadership to promote this. We need to determine what the competencies are and then develop training systems for our workforce.

Mr. Shackelford: We have a strategic plan, and we recognize the need for core competencies for our staff. The skill levels of staff vary so much, and we need to join forces with other agencies and organizations to ensure that everyone has adequate training. There is a great deal of richness in our agencies that we can tap into. The Joint Council can help with this.

Mr. Magill: We serve about 33,000 kids and are in over 500 schools in SC. I like to think that our staff have the core competencies to serve adolescents. We have an educational/training division that helps to develop training modules for our staff. Perhaps I could be more involved in this and make sure that other agencies have access to our training modules.

Mr. Catoe: We have to ensure that we have a skilled workforce. DAODAS has the advantage of being in the Governor's Cabinet so we can talk among our agencies and work together. I think it will be to our advantage to get into the private sector to see how they could serve as resources in a variety of ways.

Judge Byars: The time for true collaboration is now. We know that one-day trainings are not effective if there is not follow up and monitoring. I have found that Clemson University is a great partner, and they offer a great training system. We are taking advantage of this and other agencies can as well. If you want to enhance community collaboration, sometimes it is important to go outside of the agency walls and consider strategies for true collaboration. At DJJ, there is an excitement about what we are doing, and we are not afraid of change.

Ms. Woodard: We need to have a work force that is effective. Our centers can serve as an incubator for training to help to identify outpatients that have not been identified previously who need services. We have had a relationship with ATOD in the past; and this helped us to increase our skills sets for our workers. We need to consider, who can we entice (workers) to get into this area. We have to have people in the pipeline since many of us will be retiring soon. The workforce issue is a big deal for us; for example the nursing shortage. How do we attract workers and more importantly retain them.

At this point, the Forum offered key community agencies that already provide input into the areas of substance abuse and mental health treatment an opportunity to share their perspectives and ideas for how access to services for youth and families could be improved. The presenters were:

Mr. Charles Young, President, Behavioral Health Services Association of SC
Ms. Diane Flashnick, Executive Director, Federation of Families of SC
Dr. Michael Laughlin, Chairman, Faces And Voices of Recovery (FAVOR) SC

Charles Young, Behavioral Health Services Association: The BHSA is an advocacy organization of the presidents of the 301 system and, we would like to highlight three areas/questions that we think are important.

1. Resource/financial mapping is a critical component: What is the best way to do it and what do we do with the information?
2. How do we increase the capacity of all locations to improve the quality of evidence-based practice and to determine the cost effectiveness of services?
3. We need to ensure that we have adequate prevention services including environmental changes, policy changes, and prevention services related to mental health and primary health care.

Diane Flashnick, Federation of Families of SC: The Federation is a grassroots family organization that advocates for family driven, youth guided services from the treatment level to the policy level. I have heard a lot of positives here in this initial session. My main question is: how would the agencies support buy in and the development of an organization like the Federation to integrate families into Boards so they can have input into policies?

Mike Laughlin, Faces And Voices of Recovery SC: Our chapter in Rock Hill started about seven years ago and there are a lot of chapters around the state. We want to tell people that recovery happens. We want to be involved and we are grateful that we have been invited and want to be at the table. I am learning new words like “silos” and “evidence-based.” I didn’t know what evidence-based meant but I realize that those in recovery are the evidence base. I would like to do a commercial that for support of a bill that we are supporting (H4059). This is the repeal of the alcohol exclusion law. Health care has recognized that if they identify alcohol and/or drug involvement in the accident/incident, then they do not get paid. This decreases the likelihood that the person will receive intervention and then it becomes a revolving door issue.

At this point, each agency head each signed a Joint Memorandum of Agreement that included the development of a Joint Council on Adolescents in order to prioritize issues of youth and families living in South Carolina. Ms. Long, the Principal Investigator of the Breaking Barriers grant, reported that the Joint Council on Adolescents is a major step toward sustainability of the two grant projects.

RESULTS OF BREAKOUT SESSIONS

Breakout Session for Directors/Agency Staff

Moderator: Cathy Finck

Scribe: Pam Imm

Attendance: Approximately 75 participants

The purpose of this break out session was to look at opportunities, barriers, and solutions for the five different strategic areas: collaboration, evidence-based practice, workforce development, family involvement, and financing. The session was two hours in length. After the break at the first hour (with collaboration and family involvement completed), it was decided that the remaining hour would focus on feedback about the use of a common screening tool as well as the strategies for integrating the core competencies into the variety of agencies.

The session began after the participants reported on what they expected in the session from the facilitator, themselves, and the other participants. The following lists are the comments from the participants in the areas of 1) interagency collaboration, 2) family involvement, 3) the use of a common screening tool, and 4) the integration of core competences.

1) Interagency Collaboration

Opportunities (local level):

- We have continued with the Youth Councils that were formed several Governor's ago by judicial district
- Co-location of services
- The Health Centers have family and youth workers on site (Charleston)
- We have local Boards in school systems and private/non profit groups
- There is a workforce Investment act in each county
- Local staffing that includes many agencies prior to youth going to court
- We have a one-stop shop in Barnwell
- Chesterfield has had a coordinating council/Marion county has an interagency collaboration group
- There is a great deal of interagency work going on and at the state level we have the infrastructure change grants as well as adolescent advisory councils at the state level (e.g., dept of education).

Opportunities (state level):

- The Federation is leading an initiative called the Shared Agenda
- Governor's Council at DAODAS
- Program Oversight Committee (initially led by DSS)
- Interagency agreements
- We share Board members
- We have sub-cabinet meetings within the Governor's Office

Barriers to Collaboration (state and local levels)

- Staff resistance to collaboration
- Staff consistency (turnover is high)
- Agency silos
- How agencies are funded and required to report for accountability
- Getting people to the table
- Lack of external competent facilitation
- Trust level
- Confidentiality regulations (a common interpretation is that we cannot talk to each other)

Solutions to the Barriers of Collaboration (communication)

- Website that has information about all agencies
- Web based client data system
- Combine mental health and substance abuse agencies
- Have a list of people to call for staff for referrals

Solutions to the Barriers of Collaboration (time/staffing)

- Allow staff time for collaboration
- Get true “buy in” from the top
- Collapse current collaboratives
- Develop standards for collaboration

2) Youth and Family Involvement

Opportunities (state and local levels):

- We have many community coalitions and community boards that include families and youth as meaningful participants
- National Association of Mental Illness has great representation from families
- The South Carolina Federation of Families
- Agency Boards of Youth and Families in schools and communities
- Parent Advisory Committees in treatment agencies
- Parent Teacher Associations
- Include parents/youth in every service case in the school
- We have regulations that families and youth be involved

Barriers (state and local levels):

- Transportation
- Work schedules for parents and youth
- The time of day when we schedule the meetings
- Training opportunities are not always customized for youth/families
- Cultural barriers

- Rigid methodology for recruitment (we cannot be reimbursed for particular types of recruitment because it does not fall into a certain category)
- The general definition of family involvement, youth guided (how do we know it is happening and/or can we label it?)

Solutions (state and local levels):

- Provide food, transportation, and child care
- Go to where the target group is (attend meetings, visit homes, etc.)
- Ask parents what they need in order to be involved
- Work on the language issues; we need a shared language that does not include a lot of acronyms
- Get a better understanding of what families bring to the table and capitalize on that.

Cultural barriers/solutions (state and local levels)

- The need for training among families and professionals
- Ensure that families are trainers
- Provide peer mentors
- We need to have bilingual workers
- The system of culture needs to change
- We should remove artificial barriers (forms on checklist that people don't understand)
- Change funding mechanisms

3) Screening/Referral Processes

Opportunities (state and local levels):

- We already have the example of forms and processes developed for the Co-SIG (Co-occurring disorders state infrastructure change) grant. The Co-SIG is for adults but we can use that to build our framework for youth
- Medicaid now provides funds for screening and brief intervention in medical facilities.
- With a wrap around system, clients will be less likely to fall through the cracks
- Where can this screening tool be implemented after a common release form is developed for youth and families?
 - School based (mental health counselors, guidance counselors)
 - DJJ intake
 - Guidance counselors at the schools
 - Primary health care
 - DSS foster care families

Barriers (state and local levels):

- Is this an “add on” for our already existing screening process?
- We will need training on this
- We will need agency buy in for us to do this

- We will need to consider the balance of resources: in some cases DMH is overbooked and ATOD does not have enough clients. How will we handle a potential influx of youth for both agencies?
- What incentives (e.g., money) are there for participation in the demonstration grant?

Solutions (state and local level):

- Need to agreement to be able to do this from the top of all agencies local and state
- Need to get the training on agency's training calendars soon
- We can involve other agencies (non profits) who could easily do the screening tool with their clients (e.g., Communities in Schools, etc).
- We could co-lead services in order to handle the traffic (youth and families who are identified in need of services). For example, a substance abuse and a mental health counselor could co-lead groups together.
- We have a 211 directory system that can be used by families and should be promoted

4) Core Competencies/Evidenced-Based Practice

Opportunities (state and local levels):

- Cross training opportunities and dissemination across the agencies
- We can share resources to do training
- It will help professionals develop a dual skill set for treatment
- It might create new partnerships
- It will improve adolescent services.

Barriers (state and local levels):

- Staff retention, we do not have a good incentive structure for workers
- Adequate staffing/lack of a workforce
- Low pay
- This will require staff time to be trained in all of these competencies
- Licensing regulations
- This will require a lot of ongoing quality supervision.

Solutions (state and local levels):

- Get institutions of higher learning on board as resources
- Do an assessment of our regulations; how can they be modified
- We need to do good PR to attract workers/recruit potential workforce
- Provide better training/ongoing supervision

Breakout Session for Family/Youth Involvement and Cultural/Linguistic Competence

Moderators: Jillian Lemay and Ashlee Witt
Scribe: Kathy Paget
Attendance: Approximately 68 participants

The purpose of this breakout session was to look at the opportunities, barriers, and solutions regarding family/youth involvement and cultural/linguistic competence within adolescent treatment services. The 35-minute breakout session occurred 3 different times throughout the afternoon of the Policy Forum. The sessions were broken down by region as follows: Upstate, Midlands and Pee Dee/Lowcountry.

In the beginning of the session, participants were given a copy of the *10 Guiding Principles of Family-Driven Care* compiled by the Federation of Families for Children's Mental Health. Each participant was asked to examine the 10 principles and to make note of the principles that they are currently achieving at their agency/organization or in their community. Participants were given the opportunity to report on the opportunities, barriers and solutions for each of the guiding principles. After this task was completed, the moderators lead a discussion around cultural and linguistic competence and treatment services. Participants were asked to report on the opportunities, barriers, and solutions regarding cultural and linguistic competence.

The following are a list of the comments from the participants in the areas of family and youth involvement and cultural competence.

1) Family and Youth Involvement

Opportunities (Upstate):

- Gateway Counseling Center (DAODAS) ensures that each client is participating in the making of their treatment plan. It is about meeting the client where he or she is.
- Greenville County DMH has been working for the last 5 years to implement the 10 Guiding Principles. "We are doing it now, but we could be doing it better."
- Greenwood County works collaboratively with Pro-Parents, a family support organization, by disseminating their support services to clients.
- Spartanburg Alcohol and Drug Abuse Commission holds meetings with the schools and offers free HIV testing.

Opportunities (Midlands):

- All foster children have a Guardian Ad Litem to advocate on their behalf (DSS).
- NAMI SC is developing an education program for youth with mental illness and their families.
- Families sign off on treatment plan for foster care and in-home treatment services (DSS).

- Lexington/Richland counties have a joint support group for youth with mental health, alcohol and other drug and/or co-occurring issues and their friends as well as siblings. It is offered at the same time as the parent support group to eliminate barriers such as transportation and child care (Federation of Families for Children's Mental Health SC).
- The Bridge Program allows staff to have flexible schedules in order to adapt to each individual family's needs.
- Families are already driving the process and professionals are helping them to get to where they need to go.
- The system has evolved over the last few decades to become more family centered.

Opportunities (*Pee Dee/ Lowcountry*):

- DMH has a peer support specialist working on the barrier of attendance.
- Georgetown Alcohol and Drug Commission has adolescents and their family assist with the design of their treatment plan.
- DMH has a comprehensive orientation process for parents of youth receiving treatment services.

Barriers (*Upstate*):

- Families tend to enter the system upset and frustrated ("ready to fight") because they have been given the "run around;" thus, leading to miscommunication because parents tend to be distressed during sessions.
- Terminology still conveys that the agency and provider are in charge.
- Lack of knowledge/information sharing of community resources available.

Barriers (*Midlands*):

- Parents do not have as much input in their child's treatment plan as they need to.
- There are different levels of family and youth involvement. Each agency/organization is on a different page.
- The language used can either drive families away or empower them.
- Some clinicians may feel threatened by the language "family-driven". There is a reason why professionals need to guide the planning.
- Encounter a major problem when families are in denial.
- Lack of knowledge/information sharing of community resources available.

Barriers (*Pee Dee/Lowcountry*):

- Do families really understand the information they are given?
- There is not an adolescent/youth component of NAMI and other support groups (i.e., AA, NA, etc).
- Lack of parent support groups and/or lack of knowledge of support groups for parents.
- Lack of knowledge/information sharing of community resources available.
- Youth and family involvement on advisory boards is not consistent.

Solutions (*Upstate*):

- Need more patient education with primary care and what each other agency has to offer.
- More support is needed from county offices (i.e., transportation, etc).
- Agencies and organizations need to empower parents, youth and families by using different terminology.
- Do not deliver services to families and youth while perceiving them as “passive recipients.” Rather, a treatment plan should be established that encourages families and youth to participate instead of “forcing” them.
- Greenville County DMH – Ensuring that each client has a family voice advocating on their behalf is “a matter of good practice.” Thus, develop strategies for identifying the surrogate family voice for each client.
- Group Homes need to play a stronger role in the treatment and support process.
- Strengthen community resource/ information sharing.

Solutions (*Midlands*):

- More training needs to be readily available to providers regarding family and youth involvement.
- Use language that gives families a “voice in the choice.”
- Parents/caregivers and siblings need their own support groups.
- Use language that relates to the partnership between professionals and families (i.e., family focused, etc). The word family-driven needs to be changed to accurately reflect the process.
- Families may not expect to make all the decisions; however, they just want to be included.
- Strengthen community resource/ information sharing.
- Increase outreach to the faith-based community.

Solutions (*Pee Dee/ Lowcountry*):

- Enhance caregiver education and orientation process.
- Strengthen the Federation of Families for Children’s Mental Health of SC in the Lowcountry and increase community resource/ information sharing.
- Be creative when developing strategies to involve youth and families on advisory boards.
- Create an adolescent model for NAMI, AA, NA, etc. and incorporate a parent component.

2) Cultural and Linguistic Competence

Opportunities (*Upstate*):

- The Community Medicine Foundation has interpreters/translators on staff and has created a manual for clients.
- Greenville MH offers their full program of services to the Hispanic/Latino population.
- The ability of all participants to recognize and understand the importance of providing culturally and linguistically competent treatment services to all clients.

Opportunities (*Midlands*):

- Department of Social Services and Department of Health and Environment Control currently offer an Interpreter Qualification Program for all bilingual, Spanish-speaking employees.
- The ability of all participants to recognize and understand the importance of providing culturally and linguistically competent treatment services to all clients.

Opportunities (*Pee Dee/ Lowcountry*):

- Georgetown AOD was awarded a grant to hire an individual to provide interpretation services in Spanish as well as to provide training to staff.
- DMH contracts with outside organizations to provide interpretation services to Limited English Proficiency clients.
- Shoreline offers a diversity training annually that is mandatory for all employees to complete.
- The ability of all participants to recognize and understand the importance of providing culturally and linguistically competent treatment services to all clients.

Barriers (Upstate):

- Lack of interpreters/translators on staff.
- Not using family members as a replacement.
- Training - maintaining the knowledge that family member expectations and roles vary across cultures as well as the definition of a family and the acceptable level of sharing personal information with a counselor and being able to identify these differences.
- Victims of domestic violence do not know where to go for services. The definition of abuse varies among cultures as well as the definition of substance abuse.

Barriers (*Midlands*):

- Cost of interpreters.
- Lack of interpreters/translators on staff.
- Limited training available - maintaining the knowledge that family member expectations and roles vary across cultures as well as the definition of a family and the acceptable level of sharing personal information with a counselor and being able to identify these differences.
- Is it the state or county's responsibility to develop a network pool of interpreters?

Barriers (*Pee Dee/ Lowcountry*):

- Limited training available - maintaining the knowledge that family member expectations and roles vary across cultures as well as the definition of a family and the acceptable level of sharing personal information with a counselor and being able to identify these differences.
- Lack of interpreters/translators on staff.
- Maintaining the knowledge that family member expectations and roles vary across cultures as well as the definition of a family and the acceptable level of sharing personal information with a counselor.
- Cost of interpreters – funding.

Solutions (Upstate):

- The development of Interpreter Qualification Program contract (DAODAS and DMH)
- More bilingual/multilingual employees need to be hired.
- Funding to support contracting with other organizations to provide interpretation/translation services.
- Offer more comprehensive trainings more often. Cultural Competence is much broader than language (i.e., how the family unit varies across and among cultures).
- Utilize Victim Advocates and shelters to support clients and their families.

Solutions (*Midlands*):

- Create a statewide network of interpreters.
- Funding to support contracting with other organizations to provide interpretation/translation services.

Solutions (*Pee Dee/ Lowcountry*):

- Hire bilingual/multilingual employees or contract out.
- Increase the amount of cultural and linguistic competency trainings.

Breakout Session for Screening Tool/Referral Protocol

Moderator: Barbara Hartt and Felicity Costin-Myers

Scribe: Reenaye Long

Attendance: Approximately 63 participants

The purpose of this break out session was to look at opportunities, barriers, and solutions for two areas: Screening Tool (Gain-SS) and the Referral Protocol.

1) Screening Tool (GAIN-SS)

Opportunities

- Screening Tool is being used for Substance Abuse, MH, and Behavioral problems.
- It is a common tool that will help identify adolescents across agencies.
- It enables an agency to share information on a client.
- This Screening Tool was piloted at COC, MHC, DJJ, and DAODAS Centers.
- The piloting process in these three agencies, will take up to two years.
- Mental Health system currently evaluating different assessment instruments.
- The GAIN has a lot of data on adolescent functioning.
- Other settings could utilize this instrument (Recovery Centers, Child Abuse Prevention and private organizations other than state agencies).
- It only takes five minutes to administer.
- It can be done online.
- Web-based electronic records will give agencies quick/readily access to info.
- The COSIG Model screens information on the web and different entities has access.
- New screening will be done only if last screening was greater than six months. It easier to keep up with client's over time.
- The pilot counties will be able to access "free training" about GAINS SS and other Best Practices

Barriers and Possible Solutions:

- The GAIN doesn't lend itself to MH System at this time as it does to the DAODAS system. *This aspect is still under development.*
- "If one agency wants to pilot, to what degree must collaboration already be in place?" Does the agency need to secure commitment of community agency partners first?" *This will be explained in the Demonstration site criteria.*
- The GAIN doesn't ask if the child was a victim of bullying. *Instrument is broken down into internalizing versus externalizing behavior.*
- Concerns about the reading level of the gain. "What are they going to do about kids who can't read regardless of their age?"

- You can read this tool to the client.
- “What are the criteria/scoring that triggers referral?” *The criteria/scoring are specified in the manual.*
- “What are the options for referral besides MH?” *Other options would include MOA agencies.*
- COSIG integrated web-based into other MIS -dual entry- takes away service time; difficult to enter data twice *Needs follow-up.*
- “What about the “family systems issue” on the front end?” These family dynamics impact youth. *This would be a part of the “assessment” for a later contact versus the initial screening. Early screening gets youth in services sooner.*
- “At group home level at DJJ, where will it be done (intake, evaluation center) and how will it get to their staff?” *Referral protocol addresses interagency information sharing vs. intra-agency coordination.*
- Instruments can be administered on-line, but a lot of agencies don’t have sufficient computer resources. *Will be addressed agency by agency.*
- Will need a common consent form that will allow for the sharing of information across agencies.
- What is the difficulty following up with families externally? *Referring entity has responsibility for coordinating care, not just let families fall between the cracks.*
- Not enough resources to serve kids already ID.
Give data for resource planning in terms of access to care.
When piloting, start small.
Don’t screen every kid in school.
Don’t overwhelm the system.
Can extrapolate data based upon targeted screening.
Joint voice- approach legislature for resources.
- Easy to administer and quick.
- Easy to understand by a child.
- Valid instrument/has been tested and researched.
- It’s a cheap tool for agencies with limited funds.
- Kid-friendly language.

2) Referral Protocol

Opportunities:

- Coordinated Care
- Informed Consent
- Roles/Responsibility
- COSIG Model is under development
- Based on MOA with DAODAS, MH, and VR
- COSIG screening tool on web, consent on web, and it can be emailed to other agencies

Barriers and Possible Solutions:

- “What about a screening tool for parents to explore follow up with child in the family unit?” *SASI (used by DJJ), Court-Ordered Parents, follow-up with churches*

Breakout Session on Core Competencies and Evidence—Based Practice

Moderators: VaDonna Bartell and Louise Haynes

Scribe: VaDonna Bartell and Louise Haynes

Attendance: Approximately 63 participants

1) Summary of discussion of the implementation of an initiative for the development of core counseling competencies

The Core Competencies document was reviewed with each group.

Across the breakout groups there was general consensus that developing counselor core competencies is a worthwhile goal to pursue. There was agreement on the need for training and clinical supervision to support the development of competencies.

Access to training was identified as a barrier. Counselor's participation in training is limited by the cost, through lost billable hours. Regardless of the agency, many counselors enter the field with minimal counseling skills. Many counselors receive their clinical training "on the job." A major factor in staff recruitment and retention is money – the ability to offer salaries that attract skilled counselors and retain counselors once they have skills and experience. The quality of supervision is a major factor in staff retention. Additionally, clinical supervision is considered an integral part of developing core competencies. True clinical supervision is a luxury in many treatment agencies.

Language in the core competency document should be modified to be more inclusive of mental health and other agency settings. As currently written, many of the competencies are specific to alcohol and drug treatment agencies.

There was recognition that core competencies can be developed only in those agencies for whom training and supervision is a priority. A shift in agency priorities may be required. This is particularly difficult in agencies struggling with a deficit finance situation.

Conducting in-house and or regional training was seen as a cost effective method of providing training. The current state-wide efforts (in the 301 system) to develop capacity for clinical supervision was seen as a positive direction. Local training events that include staff from all of the agencies serving adolescents could have a variety of advantages.

With modifications to fit particular agency needs, the core competencies document could be used in multiple agencies.

2) Summary of discussion of an initiative to improve the capacity for implementation of Evidence-Based Practices

Information was presented to clarify the meaning of Evidence-Based Practice and levels of evidence. Within treatment agencies there seems to be growing acceptance of the value of providing counseling that is based on an EBP model which has been shown to improve outcomes

for clients. There was consensus that the quality of the therapeutic relationship is a major factor in client engagement, retention and outcome.

Some of the barriers to implementation of evidence-based practices include resources for staff training, including many of the same issues discussed above for training on core competencies (i.e., staff time and billable hours).

It is challenging to identify population-specific EBP for adolescents.

Recruiting adolescent staff with basic counseling skills and adolescent treatment experience is difficult. Often counselors with little experience are hired, and they become overwhelmed because they do not have the skills to work with this difficult population. The use of ‘manualized’ therapies was identified as a helpful method of structuring therapy, especially for less experienced staff.

The importance of clinical supervision to support EBP and monitor fidelity was discussed.

Participants were asked what EBP they currently use. Some of the practices mentioned by attendees would meet only low-level evidence for effectiveness. Helping agencies choose practices that are practical and effective for their setting and population would be a helpful service.

In one breakout session, there were questions about the emphasis on adolescents versus children and families.

HIGHLIGHTS OF THE EVALUATION SURVEY

On August 30, 2007, The South Carolina Department of Alcohol and Other Drug Abuse Services and the Department of Mental Health, as the two lead agencies with SAMHSA grants, convened a South Carolina Child and Adolescent Policy Forum. Approximately 200 people from the state of South Carolina registered, and about 175 attended the conference held in Columbia, SC. The one-day Forum convened six state agency Directors and a variety of substance abuse treatment providers, mental health providers, and profit agencies to discuss issues impacting access to care for youth and families. The event included an Agency Directors' Roundtable as well as breakout sessions for those to hear the recommendations for improved collaboration, use of a common screen tool and referral protocol, strategies for promoting family-driven, youth-guided services, and the plan to integrate core competencies into the workforce.

Participants were asked to complete a three-page evaluation survey that was collected at the conclusion of the Forum. Ninety-six surveys were returned. The majority of the respondents were white (60%) females (68%). Most of the respondents reported their job description to be manager/director (37.5%) or clinical administrator/manager (15.6%). When asked to provide information about their agency or affiliation, 58% reported working in state government and 20% indicated that they are affiliated with a substance abuse treatment program. (Detailed data on all demographic information is provided in the full report (See Appendix A).

Results to the Policy Forum were generally positive. On the 10 quantitative questions, respondents could choose on a 1-5 Scale with "1" being the lowest score, "3" neutral, and "5" the highest score. The highest average score (4.54) was when the respondents were asked their level of agreement with the following statement, "this policy forum was well organized." Participants also responded favorably (4.47) to "how satisfied are you with the quality of the materials distributed at this Forum. (See Appendix A of this report for a complete analyses of the results for each quantitative question). The completed qualitative analyses are presented below.

Qualitative Analyses: Participants were asked to indicate which break out session they attended and if they believed the recommendations of the BB/OASIS committees working on the issue were clearly presented. The name of the break out session, the approximate total number attending, the percent that believed the recommendations were presented clearly, and the total number of respondents who answered the following question, "please list the suggestions that would assist in implementing the recommendations in your county" are listed in the chart below. Specific recommendations are also presented by each break out session.

Break Out Session	Approximate total number in attendance	Percent reporting that the recommendations were clearly presented	Number of respondents who provided input into the recommendations.
Family driven, youth guided	68	93%	28
Screening/referral protocol	63	93%	18
Core competencies/evidence-based practice	56	94%	13

Specific Results by Each Break Out Session: Each of the three break out sessions asked the attendees to provide input into the recommendations presented. The groups varied by size and quantity of feedback, but in general, it appears that the groups had meaningful input for “providing suggestions that would assist in implementing the recommendations in your county”. These data are provided below by break out session and the number in parenthesis indicates the amount of times this theme emerged in a response. Participants could provide more than one response but there had to be at least 3 responses in order to be listed as a common theme.

Family Driven-Youth Guided (N=28)

- Need to train all relevant staff on how to develop a collaborative approach to serving families/interagency staffings (9)
- Agencies need to cooperate more around this topic (5)
- We should develop an Advisory Council for the Joint Council in order to provide input and guidance (5)
- We need to ensure that the training plans are family driven (4)
- We need more staff to do this (3)

Screening/Referral Protocol (N=18)

- Need more specifics for how this would work with all of the agencies at the table together (4)
- Need more time built in for screening and assessment (4)
- Need a joint, common release form with all agencies (4)
- Need to build this into our training calendar for new employees (4)
- How can we extend this into nonprofits? (3)
- Need buy in from the top (3)
- Additional staff and funding (3)

Core competencies/Evidence-Based Practice(N=13)

- Need to ensure that the agencies/organizations know about the core competencies and are trained on them (6)
- Update us on tools, competencies, and other strategies for success (5)
- Help us prepare for the upcoming adolescents (5)
- Need additional staffing and funding (5)
- Need buy in from the top (3)
- Additional staff and funding (3)

Additional Qualitative Data Analyses: In order to gather additional qualitative evaluation data, the evaluation survey included four questions that all participants were asked to answer:

1. What were the most important messages from the Roundtable Discussion with the State Agency Directors?
2. What about today's Policy Forum was most useful?
3. What additional information do you need to maintain momentum in the Breaking Barriers/OASIS projects?
4. How could we improve our Policy Forum next year?

The data below highlight the responses for each of the questions through content analyses procedures. Content analyses is a qualitative method for analyzing data that includes grouping responses into themes or patterns in order to determine the frequency of each theme. For each of the four questions, we provide a number in parenthesis that is the frequency count for approximately how many people wrote in responses that were consistent with each theme. The respondents could provide more than one comment so the total number of responses in parenthesis does not always equal the total number of those who responded.

Question #1: What were the most important messages from the Roundtable Discussion with the State Agency Directors? (62% provided at least one response to this question)

- a. Agencies/and Directors seemed eager to collaborate/coordinate. (32)
- b. The Memorandum of Agreement (MOA)/commitment to the process of improving services for families and youth in South Carolina. (15)
- c. Agency Directors need to be organized and involved from the top. (10)
- d. Recognition that there is a great deal of existing collaboration being done at the local level; we want to see this collaboration at the state level and from the top. (10)
- e. It was awesome/very interesting. (10)
- f. Information on existing collaborations; how else would we know about other agencies are doing? (8)
- g. Several mentioned the need to move forward with being more collaborative and that Judge Byars seemed to have the most specific plans for how to do this. (6)
- h. There is too much planning and not enough action going on in our state. (6)

Question #2: What about today's Policy Forum was most useful? (65% provided at least one response to this question)

- a. Networking/bringing staff together/connections (20)
- b. Break out sessions (18)
- c. Agency Roundtable Discussion/next steps for agencies/organizations to collaborate (15)

- d. Memorandum of Agreement/commitment to move forward from the state and local perspective (10)
- e. Hearing more about the demonstration sites (8)
- f. Family presentation (4)

Question #3: What additional information do you need to maintain the momentum of the Breaking Barriers/OASIS projects? (40% provided at least one response to this question)

- a. Ongoing training/cross training for workers (12)
- b. Shared action plans, especially for collaborating to improve the involvement of youth and families (8)
- c. Updated information about the progress of the grants (8)
- d. Continued interaction/meetings/newsletter (7)
- e. Follow up information about the Forum's results (7)
- f. More information about the agencies involved in these two grants (7)
- g. Web-based or written correspondence on the next steps for moving forward (5)
- h. Why are other agencies like DOE, DDSN, Guardian Ad Litum not involved? (4)

Question #4: How could we improve our Policy Forum next year? (41% provided at least one response to this question)

- a. Increase family voices in the sessions/have a family track (8)
- b. Let us work together by region or county to move things along more quickly/share information (7)
- c. Are the treatment directors in alcohol and drug and mental health really committed? Many of them were not present by the end of the day (7)
- d. Room logistics (temperature, lights, could not hear the presenters, make this a 2-day training) (6)
- e. Break out sessions seemed to restate what was said at the Roundtable; make sure the presenters in the break out session are on the same page (4)
- f. Give a progress report to us about how the recommendations have made a difference in the lives of youth and families in South Carolina (4)

NEXT STEPS

The follow are offered as next steps based on this report and the current phase of project operations.

- 1) It should be determined how this report will be best disseminated. Clearly, people who attended are interested in these results; however, it is not likely that they will not read the entire 33 pages. On the other hand, the committee chairs as well as the State Directors may be interested in viewing the entire document.
- 2) Staff should thoroughly read through the document and make decisions and conduct appropriate follow-up.
- 3) The details of the demonstration sites need to be finalized and communicated back to the participants. It will be important to have all key agencies/members on board in order to encourage a high likelihood of success for the demonstration sites.
- 4) Determining how to infuse the core competencies into agency's training calendars as well as strategies necessary for individuals to be trained in the competencies (as well as receive supervision) will be important.
- 5) The groups need to remain committed to family-driven, youth-guided care among all committee activities and events. Progress on this should be regularly updated to the committees in a timely manner

Appendix A- Detailed Survey Results:

South Carolina Child and Adolescent Policy Forum

SURVEY RESPONSES

PLEASE CIRCLE ONE RESPONSE BASED ON YOUR OPINION.

	<u>Very Dissatisfied</u>	<u>Dissatisfied</u>	<u>Neutral</u>	<u>Satisfied</u>	<u>Very Satisfied</u>
1. How satisfied are you with the quality of the information/instruction from this Policy Forum?	0	1	9	44	40
2. How satisfied are you with the quality of the materials distributed at this Policy Forum?	0	0	6	38	50
3. Overall, how satisfied are you with your experience at this Policy Forum?	0	1	8	43	42

PLEASE INDICATE YOUR AGREEMENT WITH THESE STATEMENTS ABOUT TODAY'S POLICY FORUM.

	<u>Strongly Disagree</u>	<u>Disagree</u>	<u>Neutral</u>	<u>Agree</u>	<u>Strongly Agree</u>
4. This Policy Forum was well organized.	0	2	2	34	58
5. This Policy Forum was important in addressing gaps in substance abuse and mental health treatment services in South Carolina.	1	0	12	44	37
6. I expect to use the information gained from this Policy Forum.	1	2	14	47	32
7. I expect the information gained from this Policy Forum to benefit my clients.	2	0	24	38	30
8. The material presented in this Policy Forum will be useful to me in dealing with substance abuse/mental health treatment services for youth and families.	1	1	24	45	25
9. As a result of this Policy Forum, I have an agencies.	1	4	19	39	33
10. As a result of this Policy Forum, I have an understanding of how my agency can collaborate substance abuse/mental health services for youth and families in my county.	1	4	13	48	29

11. PLEASE INDICATE WHICH TITLE BEST DESCRIBES YOUR JOB (check only one):

- 1 Medical Director
- 1 Physician
- 3 Nurse
- 0 Physician's Assistant
- 36 Manager/Director
- 15 Clinical Administrator/Manager
- 6 Clinical Supervisor
- 3 Psychologist
- 6 Counselor
- 5 Social Worker
- 0 Federal Government Official
- 9 State Government Official
- 0 County Government Official
- 1 Researcher
- 10 Other

12. PLEASE INDICATE WHICH BEST DESCRIBES YOUR AGENCY OR AFFILIATION (check only one):

- 1 Federal Government
- 56 State Government
- 3 County Government
- 1 Local Government
- 19 Substance Abuse Treatment Program
- 2 University or other higher education institution
- 14 Other