NORTH CAROLINA COMMUNITY CHILD PROTECTION TEAM

2018 End of Year Report

Community Child Protection Teams
NC Advisory Board

Foreword

This report attests to the invaluable contributions that local Community Child Protection Teams (CCPTs) make in support of children, youth, and families across our state. The teams demonstrated a keen awareness of the issues facing families in their communities and offered thoughtful commentary on how to enhance the performance and responsiveness of child welfare. They also pointed out what resources CCPTs need in order to build robust local teamwork to safeguard children and families. Their insights and efforts will be vital to instituting an effective system of regional supervision of Social Services and comprehensive child welfare reform.

The NC CCPT Advisory Board set the directions for the survey this year and reflected on its findings. Grounded on the experiences at the local level and the developments at the state level, the Advisory Board moved forward recommendations for improving child welfare in our state. The NC Division of Social Services ensured that local teams were aware of the survey and strongly encouraged their participation. The Center for Family and Community Engagement at North Carolina State University, led by Dr. Sarah Desmarais and doctoral student Emily Smith, with Drs. Sam Cacace, Joan Pennell, and Jason Coupet, and graduate student Courtney Wade, administered the survey, analyzed its results, and prepared this report.

The report and its recommendations for improving child welfare in North Carolina are respectfully submitted by,

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I. Executive Summary

A. Introduction

Community Child Protection Teams (CCPTs) are local collaborations founded on the principle that protecting children and youth and supporting their families requires community-wide prevention and intervention strategies. CCPTs plan how to put this principle of community responsibility into action locally. Based in all 100 counties and the Qualla Boundary, CCPTs over the years have reviewed active cases of child maltreatment and child maltreatment fatalities and have called for integrated efforts across their communities that strengthen families so that they can nurture their youngsters.

As documented in this end-of-year report and prior reports, CCPTs have repeatedly emphasized that families need access to mental health, substance use, domestic violence, and disability services as well as affordable health care, housing, and transportation. CCPTs are rightly proud of their efforts to educate their communities about what children and their families need to overcome adversity and to thrive.

With solid community representation, CCPTs bring a comprehensive understanding of the needs of children and families in their work to educate the public, review cases, and identify ways to improve child welfare delivery. These interdisciplinary teams assume all the more importance as the federal Family First Prevention Services Act seeks to redirect child welfare efforts and funding toward prevention services and as the state's Early Childhood Action Plan seeks to support healthy early childhood development. The federal and state initiatives offer possibilities for preventing child maltreatment from occurring. With long-term experience conducting case reviews, CCPTs can offer insights on how best to consolidate the review process at the local and state levels. CCPTs' ready grasp of local service delivery means that they can provide help and feedback to child welfare in its initiation of a collaborative practice model called safety organized practice. These contributions of CCPTs and possible barriers to these contributions are addressed in this report summarizing the findings from the 2018 end-of-year survey of local CCPTs.

This year 88 out of 101 CCPTs responded to the survey. The survey inquired about the local teams' functioning and activities over the year and their ideas for improving the child welfare system. The North Carolina Community Child Protection Team Advisory Board used the survey results to make recommendations on improving the child welfare system to the North Carolina Division of Social Services (NC DSS). The membership of the Advisory Board included representatives from local CCPTs, community organizations, and family and youth partners.

II. 2018 NC CCPT Advisory Board Survey Summary

The 88 CCPTs who responded to the survey encompassed all state regions, county population sizes, and the seven LME/MCOs that provide mental health, developmental disabilities, and substance abuse services. More than four-fifths of the responding CCPTs stated that they were "an established team that meets regularly," while the others were in different stages of reorganizing. Over three-quarters of the CCPTs opted to combine with their local Child Fatality Prevention Team (CFPT). Approximately half the surveys were completed by the chair or designee and the other half by the team as a whole or subunits of the team.

The 2018 survey inquired about the following five main questions:

1. Who takes part in the local CCPTs, and what supports or prevents participation?
2. Which cases do local CCPTs review, and how can the review process be improved?
3. What limits access to needed mental health, developmental disabilities, substance abuse, and domestic violence services, and what can be done to improve child welfare services?
4. What are local CCPTs' objectives based on identified improvement needs, and to what extent do they achieve these objectives?
5. What would help CCPTs achieve their local objectives based on identified improvement needs?

A. Who participates in the local CCPTs? And what supports or prevents participation?

State law requires that local CCPT teams are composed of 11 members from specified agencies that work with children and child welfare. Additionally, state law requires that combined CCPT/CFPT teams are composed of 16 members from specified agencies that work with children and child welfare as well as family partners. The 2018 survey results, as well as those in prior years, show that mandated members varied in their level of participation. DSS staff, health care providers, and mental health professionals were the most often present while the county boards of social services, the district attorney (for CCPTs), and the district court judge, the parent of a child fatality victim (for combined CCPT/CFPTs) were least often in attendance. Nevertheless, the majority of mandated members in nearly all categories were in attendance *frequently* or *very frequently.* This is fortunate because most (83%) of the survey respondents thought that representation by all the 11-16 mandated agencies was necessary for accomplishing their work. Thus, for the most part, the local teams had representation from a wide range of disciplines, necessary for addressing complex child welfare issues.

B. Additional Members

County commissioners on over half the responding surveys appointed additional members to their local CCPTs. These members came from mandated organizations and other public agencies and nonprofits or were community members or parents (e.g., foster/adoptive parent, parent of deceased child). Thus, the appointments of county commissioners enlarged the perspectives brought to bear in the CCPTs' deliberations.

C. CCPT Operations

CCPTs and combined CCPT/CFPTs who are established or recently re-established feel that they are preparing well for their regular meetings. Additionally, the majority indicate that they are sharing resources well and provided a number of additional shared resources they have accessed. The majority of respondents indicated that they only have a moderate to marginal impact in effecting change in their community. Thus, CCPTs have created a working environment in which they share information and resources; however, they recognized that their ability to make changes is limited.

D. Family or Youth Partners

The survey asked if the CCPT included Family or Youth Partners. These are individuals who have received services or care for someone who has received services. Only 24% of respondents indicated that family or youth partners served on their CCPT or combined CCPT/CFPT. It is unclear whether the teams were identifying biological parents who served as members of the CFPTs. Future surveys will need to differentiate between CFPT members who are parents of a deceased child and CCPT members who are parents of a child in need of protection. Thus, the large majority of CCPTs lacked family representation, which limited their capacity to bring youth and family perspectives to the table. This could inhibit their contributing to instituting safety organized practice in a family-centered manner.

E. Strategies for Engaging Family or Youth Partners on the Team

CCPTs used a range of strategies that built upon each other. Especially apparent were two basic approaches: using networks to identify potential Family or Youth Partner as well as utilizing members already in place to offer family perspectives, and extending repeated invitations which included information on benefits of participation and inclusive terminology.

F. Factors Limiting the Participation of Family or Youth Partners

CCPTs detailed at length the reasons preventing the participation of Family or Youth Partners on their teams. Some of these reasons stemmed from the situation of the partners: logistical, such as a lack of transportation or scheduling conflicts, lack of reimbursement; and emotional, because of the sensitive topics discussed, especially when the CCPT was combined with the CFPT. CCPTs also identified reasons related to the team rather than Family or Youth partners. These included uncertainties about how to recruit the Family or Youth Partners and how to maintain confidentiality. CCPTs asked for more guidance on bringing Family and Youth Partners onboard their teams. Thus, CCPTs identified the training and resources they would need for engaging families on their teams.

G. Partnerships to Meet Community Needs

Over half the respondents identified important initiatives that they undertook with others in their community. Local collaborations made it possible to raise public awareness of child maltreatment, host community forums with school-age children and their parents, and sponsor joint trainings for service providers. Thus, through their initiatives demonstrated a keen understanding of the needs of families in their communities and their capacity to act on these areas of concern.

H. Which cases do local CCPTs review, and how can the review process be improved?

Last year, 33 (38%) out of the 88 responding CCPTs received between one and 15 notifications of child maltreatment fatality cases, for a total of 105 notifications. When asked about their type of review, the teams identified different approaches. The most common type was a review by the combined CCPT and NC DSS intensive state reviews. Thus, the cases of child maltreatment fatalities had different types of reviews, some in the county and others at the state level. What the survey did not identify is the reasons why the large majority of counties had no notification of child maltreatment fatalities. In addition, the survey did not ask about how many cases had multiple reviews and the benefits and costs of the different types of reviews and of having more than one review. And, most importantly the survey did not inquire about the impact of the reviews. All this information would be helpful in planning ways to improve child maltreatment reviews in the state.

I. Child Maltreatment Case Reviews

Over 2018, 63 (72%) of the 88 responding CCPTs reviewed cases of child maltreatment, with a total of 450 cases reviewed. As would be expected, larger counties reviewed more cases than smaller ones. Thus, most CCPTs who responded to the survey carried out their mandated role of reviewing cases. What the survey did not specifically inquire about were the reasons why some counties had not reviewed cases and what would have helped them fulfil this role.

a. Criteria for Selecting Cases for Review

State statute requires that CCPTs review two types of cases: active cases and child maltreatment fatalities. Most (55%) respondents selected active cases for review. Child maltreatment fatality was given as a reason for case selection by 23% of respondents. The second most frequent criteria for selecting cases was a multiple agency involvement, identified by 43% of the respondents. The range of issues identified indicates the CCPTs' concern about many areas affecting the families' lives. Thus, the teams had a comprehensive awareness of the challenges affecting the children and families in their communities.

J. What limits access to needed mental health, developmental disabilities, substance abuse, and domestic violence services, and what can be done to improve child welfare services?

Children, youth, and their parents or caregivers faced serious barriers to accessing needed services. Most CCPTs who reviewed cases in 2018 reported that children and youth needed access to substance abuse services. Most CCPTs also reviewed cases in which the parents or caregivers required access to mental health or domestic violence services. As noted previously, CCPTs commonly selected cases for review because of parental drug use, child safety, domestic violence, and child and family well-being (which includes mental health). These criteria would tilt the findings on reviewed cases toward the need for MH, SA, and DV services. Additionally, CCPTs identified systemic barriers to families' accessing essential services. The most commonly cited barriers were limited services or no available services, transportation to services, and youth's having a dual diagnosis of mental health and substance abuse issues. The CCPTs commented on some family factors affecting service receipt such as language barriers. It is quite likely that these identified family reasons reflected systemic barriers such as the complexity of the health care system and lack of medical insurance or Medicaid. Thus, the teams were well aware of multiple issues keeping children and families from much needed services. The federal

funding from the Family First Prevention Services Act may be able to assist them in securing prevention services in their communities.

K. Local CCPT Recommendations for Improving Child Welfare Services

The CCPTs were quite forthcoming in proposing ways to improve child welfare services. Even more than past years, they focused on two early childhood issues--unsafe sleeping and substance-affected infants. They offered concrete strategies for child welfare integrating support of safe sleeping across all stages of their casework, and they laid out a series of steps for getting better and more timely substance and mental health treatment to families. They further specified the supports and services that parents, or caregivers, would need in order to care for their children. These included emotional and practical support for parents and kinship caregivers, better law enforcement practices to protect parents abused by their partner, improved service access for rural counties, and removal of roadblocks to MH/SA/DD/DV services, particularly as related to Medicaid coverage. They identified the need for community groups to collaborate better, including better sharing of critical information between health care providers. In regard to DSS, they focused on improving the child welfare workforce and case management. They recognized serious understaffing in offices, emphasized streamlining of protocols, and urged replacing the ineffective statewide case management system.

L. Local CCPT Objectives and the Extent to Which They Achieved These Objectives

The objectives largely reflected the early childhood recommendations on safe sleeping and substance-affected infants, supporting parents, increasing service access, strengthening local collaboration, and improving child welfare casework. They realized their objectives with the support of strong local collaborations and state-level protocols and resources. Additionally, the CCPTs recognized that they needed to strengthen how they worked as a team. They set objectives on expanding their membership, becoming more inclusive of community and family partners, enhancing participation, and improving their case review processes. They welcomed the state-level CCPT training and asked for even more in the future.

III. 2018 Recommendations

The NC CCPT/Citizen Review Panel Advisory Board used the extensive information and ideas from the 88 CCPT surveys to make the recommendations listed below. We recognize that some of the recommendations will require action at the local level, others by NC DHHS, and still others by the legislature. The Advisory Board will identify which recommendations require action at what level and convey this to NC DSS.

Recommendation 1—Support achievement of the 10 goals of the Early Childhood Action Plan through the following steps:

1. Encourage safe sleeping in all stages of child welfare work with families, including financial support of safe and stable places for children to sleep
2. Continue to provide resources to counties on substance-affected infants
3. Use a supportive rather than penalizing approach to the parents of substance-affected infants
4. Clarify the expectations concerning an Infant Plan of Safe Care

5. Dedicate staff at DSS to manage substance-affected infants in order to increase timely access to needed services

Recommendation 2—Support parents/caregivers in parenting through the following steps:

1. Offer a universal statewide hotline for parents and caregivers
2. Train and mentor parents/caregivers in parenting
3. Build in concrete supports for parents, including extending hours of daycare services and offering transportation
4. Increase access to MH/SA/DD/DV services for families, including expanding Medicaid
5. Create an effective statewide case management system
6. Enhance child welfare services by increasing DSS staffing and reducing paperwork demands so that social workers can focus on work with families
7. Raise awareness of poverty as a community issue

Recommendation 3—Improve community collaboration through the following steps:

1. Assist abused parents through offering one-stop service centers and training law enforcement on legalities of no-contact orders
2. Facilitate sharing of critical patient healthcare information

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North Carolina Community Child Protection Teams (CCPT) 2018 End-of-Year Report

North Carolina CCPT Advisory Board
Submitted to the North Carolina Division of Social Services

I. Introduction

A. Contributions of Community Child Protection Teams (CCPTs)

Community Child Protection Teams (CCPTs) are local collaborations founded on the principle that protecting children and youth and supporting their families requires community-wide prevention and intervention strategies. CCPTs plan how to put this principle of community responsibility into action locally. Based in all 100 counties and the Qualla Boundary, CCPTs over the years have reviewed active cases of child maltreatment and child maltreatment fatalities and have called for integrated efforts across their communities that strengthen families so that they can nurture their youngsters.

As documented in this end-of-year report and prior reports, CCPTs have repeatedly emphasized that families need access to mental health, substance use, domestic violence, and disability services as well as affordable health care, housing, and transportation. CCPTs are rightly proud of their efforts to educate their communities about what children and their families need to overcome adversity and to thrive.

1. Support of Federal and State Policy Initiatives

a. Family First Prevention Services Act

The collaborative approach of CCPTs can support national and state initiatives to partner public and private groups that wrap resources around children, youth, and their families. At the national level, the 2018 Family First Prevention Services Act frees up federal Title IV-E funds for prevention services to strengthen families so that children and youth do not face removal from their homes, schools, and communities or so that they can exit care to families or with resources to live on their own. In particular, the Family First legislation facilitates families' access to substance use and mental health services and parenting education. CCPTs have the local knowledge to identify where and how to avail of the federal funding for critical prevention services.

b. Early Childhood Action Plan

Likewise, within North Carolina, state plans urge collaborative efforts. A prime example is the 2019 North Carolina Early Childhood Action Plan that the NC Department of Health and Human Services (DHHS), with an executive order from the Governor, created with 350plus stakeholders from a wide range of sectors. The plan sets forth principles for children, ages 0 to 8 years, to "get a healthy start and develop

their full potential in safe and nurturing families, schools and communities" (p. 10). With this larger vision, child safety, permanency, and wellbeing are not addressed in isolation by child protection services but instead by instituting a comprehensive plan to support children's positive development. CCPTs know their community resources and can plan together how to achieve the outcomes proposed in the Early Childhood Action Plan.

One of the 10 goals of the Early Childhood Action Plan is "safe and nurturing relationships" for young children (p. 24), and under this goal, the Plan sets targets for reducing child maltreatment. In creating its new Child and Family Services Plan, North Carolina Division of Social Services (NC DSS) will include metrics on reducing the rate of child maltreatment in the state that local CCPTs can use in assessing progress within their own counties. Most troubling are fatalities caused by child maltreatment, and currently the state is considering ways of consolidating the review process.

2. Support of Child Maltreatment Fatality Review

As documented in this report, North Carolina has multiple levels of child maltreatment fatality reviews that can be cumbersome and time consuming. Nevertheless, a benefit of North Carolina's approach is that it brings to bear cross-disciplinary perspectives in death reviews and can identify the complex factors leading to children's deaths rather than signaling out the failing of one worker, office, or policy. This approach can lessen a risk-averse reaction and instead create a collaborative learning environment that takes a systemic view of what causes human error in investigations (Dekker, 2017). Comprehensive planning to prevent child fatalities requires systems sharing data that are of high quality and consistency (Commission to Eliminate Child Abuse and Neglect Fatalities, 2016). This CCPT report sheds light on the extent to which CCPTs share information and resources in tackling how to keep children with safe and nurturing parents or caregivers.

3. Support of Evidence-Based Practice Models: Safety Organized Practice

North Carolina Child Welfare is instituting a practice model, called safety organized practice. CCPTs have much to offer in facilitating the model's implementation. Safety organized practice builds upon strengths-based, family-centered approaches that are mutually supportive of each other and need to be used together. These approaches include: (a) solution-focused treatment of partnering with families to address everyday challenges (Berg & Kelly, 2000), (b) the signs of safety approach of creating positive relationships with families and identifying indicators of children's safety alongside those for risk (Turnell & Edwards, 1997), and (c) child and family engagement in decision making to widen the circle of culturally-responsive supports around families (Pennell & Anderson, 2005). Evaluation of each of these three contributors to safety organized practice points to the necessity for close monitoring at the local level to ensure fidelity to their practices and to identify and remove barriers to their implementation.

Solution based casework operationalizes solution-focused treatment in child welfare. This casework model has demonstrated effectiveness in achieving the federally-stipulated

outcomes of safety, permanency, and wellbeing *as long as* its components are applied across all stages of the work with families (Antle et al., 2012). The available evidence on signs of safety does not establish that the approach is more successful than practice as usual in decreasing the need for out-of-home placements (Reekers et al., 2018; Sheehan et al., 2018). These inconclusive results may well be a function of the level of support for a practice innovation throughout the child welfare agency and from partner organizations (Ribroek, Strating, & Juijsman, 2017; Salveron et al., 2015).

Research on child and family engagement in case planning and decision making has promising findings on reducing out-of-home care (Lambert, 2017), including with Latinx and African American children (Sheets et al., 2009). These benefits, however, increase if the referral is made early in a case (HDHS, 2012) and the jurisdiction has policy and legislation mandating that families be offered a family meeting (Pennell, Edwards, & Burford, 2010). In other words, safety organizing practice has much potential, but clear and collaborative local guidance is required to make it work. CCPT case reviews are a means not only of monitoring implementation but figuring out ways to enhance implementation.

Another means of enhancing implementation of safety organized practice is engaging with family and youth partners who have experience of child welfare services. At the state level and in three pilot counties (Richmond, Durham, and Forsyth), family advisory councils offer advice on creating family-friendly practices and policies for child welfare. Moreover, some CCPTs, as the survey found, have family partners on their teams. Including family partners is not only a way of learning from their perspectives but of learning how to partner with them.

In summary, with solid community representation, CCPTs bring a comprehensive understanding of the needs of children and families in their work to educate the public, review cases, and identify ways to improve child welfare delivery. These interdisciplinary teams assume all the more importance as the federal Family First Prevention Services Act seeks to redirect child welfare efforts and funding toward prevention services and as the state's Early Childhood Action Plan seeks to support healthy early childhood development. The federal and state initiatives offer possibilities for preventing child maltreatment from occurring. With long-term experience conducting case reviews, CCPTs can offer insights on how best to consolidate the review process at the local and state levels. CCPTs' ready grasp of local service delivery means that they can provide help and feedback to child welfare in its initiation of a collaborative practice model called safety organized practice. These contributions of CCPTs and possible barriers to these contributions are addressed in this report summarizing the findings from the 2018 end-of-year survey of local CCPTs.

B. **Contributions of the NC CCPT Advisory Board**

Over the past year, the Advisory Board accomplished a number of key steps toward strengthening the role of CCPTs in North Carolina. The work groups of the Advisory Board

focused on supporting local CCPT teams, solidifying the Board's role and membership, constructing the end-of-year survey, and preparing recommendations to NC DSS based on the 2018 survey results. The Board provided guidance on NC DSS's training and support of local CCPTs and through family and youth partners, remained linked to the NC Child Welfare Family Advisory Council. Additionally, the Advisory Board examined proposed changes to the North Carolina child welfare system, including heightened emphasis on prevention services in line with the federal Family First Prevention and Services Act and the Governor's NC Early Childhood Action Plan, consolidation of the child fatality review system, and adoption of the practice model of safety organized practice.

II. 2018 NC CCPT Advisory Board Survey Overview

The Advisory Board was responsible for developing the survey content and synthesizing the experience of local CCPTs. On behalf of the Advisory Board, North Carolina State University administered the survey using the online platform Qualtrics, analyzed the results using SPSS, and drafted the report of findings. NC DSS alerted county Social Services directors and local CCPT chairpersons about the survey and asked for their support and provided the university with the contact information for the chairpersons of the local CCPTs. The appendices in this report provide the survey's timeline (see Table A-1), more detail on the survey results, and a copy of the survey instrument (Appendix C). The survey protocol was approved by the NC State University' Institutional Review Board for the Protection of Human Subjects in Research.

A. 2018 NC CCPT Advisory Board Recommendations

The Advisory Board was provided with the survey report and developed recommendations at the meeting on May 15, 2019, for consideration and response by NC DSS. A summary of the survey data and Advisory Board recommendations were compiled to create the NC CCPT End-of-Year Report.

B. NC CCPT End-of-Year Report

Among 101 CCPTs, 88 responded to the survey. The survey inquired about the local teams' functioning and activities over the year and their ideas for improving the child welfare system. The NC CCPT Advisory Board used the survey results to make recommendations on improving the child welfare system to the NC DSS. The membership of the Advisory Board included representatives from local CCPTs, community organizations, and Family and Youth partners.

NC DSS is expected to respond to the Advisory Board's recommendations in writing. The Advisory Board is responsible for distributing this report, including its recommendations to the local CCPTs. NC DSS will incorporate this report and the state's response into the Annual Progress and Services Report to the US Department of Health and Human Services, Administration for Children and Families. The aim is to insure a system of local feedback, state-level review and recommendation, and county Social Services and NC DSS accountability. In other words, the process serves as a means of continuous quality improvement.

North Carolina General Statute §7B-1406 through 1413 mandates the establishment of local CCPTs in all 100 counties. CCPTs serve as North Carolina's means of meeting the requirement of the federal Child Abuse Prevention and Treatment Act (CAPTA) that each state establish citizen review panels to evaluate the child welfare system and advocate for improvements. Local CCPTs are expected to review cases of child maltreatment, identify areas for systemic change, advocate for reforms and needed resources, offer public education, and report to their county board of social services and NC DSS on their work over the year. This survey assists local CCPTs with meeting their reporting requirements and can contribute to the statewide dialog on system reform. Next we provide an overview of the work accomplished by the NC CCPT Advisory Board in fall 2018 and spring 2019 and then turn to the 2018 recommendations to NC DSS.

III. NC CCPT Advisory Board Survey Results

A. **Respondent Characteristics**

The university distributed the survey to 100 county CCPTs as well as the Eastern Band of the Cherokee Indians, for a possible 101 CCPTs. The survey was completed in full by 88 CCPTs. A list of the counties of the 2018 responding CCPTs can be found in appended Table A-2.

The 2018 response rate of 88 CCPTs was the highest to date with previous years ranging from 71 to 87 from 2012 to 2017. The local teams came from all regions of the state and included counties of all population sizes. The response rates were 86% of the 54 small counties, 90% of the 35 medium counties, and 90% of the 11 large counties (see appendix Table A-3).

In the state of North Carolina, Local Management Entity (LME)/Managed Care Organizations (MCOs) are the agencies responsible for providing mental health, developmental disabilities, and substance abuse services. In 2018, there were seven LME/MCOs for the 100 counties. The survey included members from all LME/MCOs: Member county participation ranged from 65% to 100% (see Table A-4).

As seen in Table 1, the large majority (83%) of respondents characterized themselves as an "established team that meets regularly." The others stated that they had recently reorganized and were at various stages in terms of meeting. The CCPTs that did not characterize themselves as an established team that meets regularly included small through large counties.

Table 1 Number of CCPTs by Status of Establishment as a Team **(N = 88)**
Number of CCPTs by Status of Establishment as a Team, 2018

Status	Number of CCPTs	
We are an established team that meets regularly	72	(83%)
Our team recently reorganized, and we are having regular meetings	12	(14%)
Our team recently reorganized, but we have not had any regular meetings	1	(1%)
Our team was not operating, but we recently reorganized	1	(1%)
We are an established team that does not meet	1	(1%)

CCPTs have the option of combining with their local CFPT or keeping the two teams separate. CFPTs are responsible for reviewing cases of child death where maltreatment is not suspected. CCPTs review active cases and child fatalities where death was caused by abuse, neglect, or dependency and where the family had received NC DSS child welfare services within 12 months of the child's death. At the time of the survey, 72 (82%) of the 88 responding counties opted to have combined teams, and 13 (15%) had separate teams. The 82% in 2018 of combined team has risen somewhat from the 72% in 2015, 76% in 2016, and 78% in 2017.

In summary, 88% of the local teams responded to the survey in 2018, a percentage that is in the high-range for responses since 2012. The participating CCPTs encompassed all state

regions, county population sizes, and the seven LME/MCOs that provide MH/DD/SA services. More than four-fifths of the responding CCPTs stated that they were "an established team that meets regularly," while the others were in different stages of reorganizing. Among the responding teams, nearly 90% were combined with their local CFPT. Thus, overall CCPTs are sufficiently established to make significant contributions to child welfare. The trend toward combining CCPTs and CFPTs can contribute to state planning on consolidating child maltreatment fatalities.

B. **Survey Completers**

To encourage wider input by the local CCPT membership, the survey instructions stated:

- You can print a blank copy of this survey to review with your team, and you will be able to print a copy of your completed survey report when you finish the survey.
- Your team members should have the opportunity to provide input and review responses before your survey is submitted. Please schedule your CCPT meeting so that your team has sufficient time to discuss the team's responses to the survey.

The survey asked, "Who completed this survey?" As shown in Table 2, the surveys were primarily completed by the chair on their own (36%), by the team as a whole (28%), or by a team subgroup (15%). The response "other" involved more than one team member. The teams were split on whether one individual (42% chair or designee) or larger groupings (58% whole team or smaller group) developed the responses. The time period available for completing the survey was approximately two months.

Table 2 Number of CCPTs by Who Completed the Survey (N = 88)
Number of CCPTs by Who Completed the Survey, 2018

Status	Number of CCPTs	
The CCPT chair on their own	31	(36%)
The CCPT team as a whole	24	(28%)
A subgroup of the CCPT team	13	(15%)
A designee of the CCPT chair on their own	5	(6%)
Other	14	(16%)

In summary, the survey encouraged CCPT chairs to seek input from team members on their responses. The ability of teams to convene to develop their responses was likely limited by the survey being open for 2 months, although a lengthy extension was given to those who had submitted a completed survey by the February 28th, 2019 deadline. Nevertheless, the majority of teams had more than one member completing the survey, thus, reflecting wider perspectives of the group.

C. **Main Survey Questions**

The 2018 survey inquired about the following five main questions:

1. Who takes part in the local CCPTs, and what supports or prevents participation?
2. Which cases do local CCPTs review, and how can the review process be improved?

3. What limits access to needed mental health, developmental disabilities, substance abuse, and domestic violence services, and what can be done to improve child welfare services?
4. What are local CCPTs' objectives based on identified improvement needs, and to what extent do they achieve these objectives?
5. What further support do CCPTs need to help them achieve their local objectives?

In previous years, CCPTs were asked to identify which action steps they supported to achieve the four recommendations set forth by the Advisory Board. For previous year's NC DSS response to the Advisory Board's four recommendations, go to this link. This year, CCPTs were asked to list their top three local objectives based on identified improvement needs and to identify factors that both help and hinder achieving the objectives. CCPTs were also asked to identify what the state could do to help them achieve their local objectives and what additional support they required.

This section summarizes the findings for each of these questions. All quotations in this report have been corrected for spelling and grammatical errors. Where available, survey findings from the 2017 survey are compared with the 2018 findings to ascertain trends. These two surveys shared many of the same questions. The 2018 survey, however, included a number of new items particularly regarding the local teams' recommendations and objectives.

D. Who participates in the local CCPTs? And what supports or prevents participation?

1. Mandated Members

a. Participation by Mandated CCPT and Combined CCPT/CFPT Members

State law requires that local teams are composed of 11 members from agencies that work with children and child welfare. Table 3 identifies these mandated members for combined CCPTs and CFPTs. Table 4 identifies these mandated CCPT members and their levels of participation on the team during 2018. The survey results indicate that mandated members varied in their level of participation with both groups; however, patterns of participation were fairly consistent between groups. The two team members most likely to be *very frequently* in attendance for CCPTs were the DSS staff followed closely by the Mental Health professionals. The two team members most likely to be *very frequently* in attendance for CCPT/CFPTs were the DSS staff followed closely by Health Care providers and Mental Health professionals. On average, health care providers, public health directors, guardians ad litem, and DSS directors were *frequently* present across both groups. What needs to be kept in mind is that although participation rates varied across the mandated members, some mandated members in all categories participated *frequently* or *very frequently.* For instance, within the CCPT group, community action agencies had the lowest average participation level but still had over a quarter (31%) of their community action agencies taking part *frequently* and another 31% taking part *very frequently.* For CCPT/CFPTs, participation levels were much more variable across members. Most notably, the district court judge and parent of child fatality victim had the lowest participation rates. Over half of district court judges (62%) and parents of child fatality victims (56%) *never* participated.

Table 3 Mandated CCPT/CFPT Members and Reported Frequency of Participation

Mandated CCPT/CFPT Members and Reported Frequency of Participation, 2018 (N=73)

Mandated Member	Never	Rarely	Occasionally	Frequently	Very Frequently	Mean
DSS Director	4 (6%)	2 (3%)	10 (14%)	13 (18%)	44 (60%)	3.25
DSS Staff	0 (0%)	0 (0%)	1 (1%)	7 (10%)	65 (89%)	3.88
Law Enforcement	0 (0%)	15 (21%)	14 (19%)	17 (23%)	27 (37%)	2.77
District Attorney	25 (34%)	8 (11%)	15 (21%)	14 (19%)	11 (15%)	1.70
Community Action Agency Director or Designee	9 (12%)	6 (8%)	14 (19%)	16 (22%)	28 (38%)	2.66
School Superintendent	15 (21%)	9 (12%)	6 (8%)	21 (29%)	22 (30%)	2.36
County Board of Social Services	15 (21%)	11 (16%)	10 (14%)	12 (17%)	23 (32%)	2.24
Mental Health Professional	3 (4%)	3 (4%)	7 (10%)	16 (22%)	44 (60%)	3.30
Guardian ad Litem Coordinator or Designee	5 (7%)	5 (7%)	10 (14%)	15 (21%)	37 (51%)	3.03
Public Health Director	6 (8%)	4 (6%)	4 (6%)	16 (22%)	42 (58%)	3.17
Health Care Provider	3 (4%)	3 (4%)	4 (6%)	16 (23%)	45 (63%)	3.37
District Court Judge	44 (62%)	6 (9%)	10 (14%)	5 (7%)	6 (9%)	.92
County Medical Examiner	35 (49%)	6 (8%)	8 (11%)	8 11%)	15 (21%)	1.47
EMS Representative	14 (19%)	10 (14%)	17 (24%)	9 (13%)	22 (31%)	2.21
Local Child Care Facility	14 (19%)	11 (15%)	11 (15%)	12 (17%)	24 (33%)	2.29
Parent of Child Fatality Victim	40 (56%)	11 (15%)	7 (10%)	5 (7%)	9 (13%)	1.06

Note. 0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently
Counts are reported, with percentages out of 73 CCPT/CFPTs in parentheses.

Table 4 Mandated CCPT Members and Reported Frequency of Participation
Mandated CCPT Members and Reported Frequency of Participation, 2018 (N=13)

Mandated Member	Never	Rarely	Occasionally	Frequently	Very Frequently	Mean
DSS Director	2 (15%)	1 (8%)	1 (8%)	1 (8%)	9 (62%)	3.69
DSS Staff	1 (8%)	0 (0%)	0 (0%)	1 (7%)	11 (85%)	4.54
Law Enforcement	1 (8%)	1 (8%)	2 (15%)	2 (15%)	7 (54%)	3.85
District Attorney	5 (39%)	0 (0%)	0 (0%)	2 (15%)	6 (46%)	2.92
Community Action Agency Director or Designee	2 (15%)	0 (0%)	3 (23%)	4 (31%)	4 (31%)	3.46
School Superintendent or Designee	3 (23%)	0 (0%)	0 (0%)	4 (31%)	6 (46%)	3.54
County Board of Social Services	5 (39%)	0 (0%)	1 (8%)	1 (8%)	6 (46%)	2.85
Mental Health Professional	1 (7%)	0 (0%)	0 (0%)	2 (15%)	10 (77%)	4.46
Guardian ad Litem Coordinator or Designee	2 (15%)	0 (0%)	1 (8%)	2 (15%)	8 (62%)	3.92
Public Health Director	2 (15%)	0 (0%)	1 8%)	2 (15%)	8 (62%)	3.92
Health Care Provider	1 (8%)	1 (8%)	3 (23%)	0 (0%)	8 (62%)	3.85

Note. 0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently
Counts are reported, with percentages out of 13 CCPTs in parentheses.

b. Mandated Member Participation by Mean Rate and Rank

In the 2018 survey participation of mandated members was tracked for both CCPTs and CCPT/CFPTs. Table 5 shows that for both years the ranked participation rates of the mandated members were almost identical. At the top in rank over the two years were

DSS staff, mental health professionals, health care providers, and public health directors. The lower participation ranks for the two years were among district attorneys, county boards of social services and district court judges and county medical examiners, these last two being specific to combined CCPT/CFPTs.

Given that disparate levels of participation across the mandated members were reported on the 2016 survey (as well as from earlier surveys), the 2017 survey asked a new question which remained in the 2018 survey: Are there statutorily required members that you feel might be unnecessary? Among the 88 respondents, 71 (83%) said *no* and 15 (17%) said *yes.* The survey permitted the *yes* respondents to identify one role that was not needed. Seven respondents indicated that the district court judge was not needed in attendance followed by the county medical examiner, both of which are specific to combined CCPT/CFPTs. Three respondents indicated that the district attorney was also unneeded. Common themes arose when respondents explained why certain members were unnecessary. These included, unavailability or difficulty scheduling, overlap in roles certain members were engaged in, especially in rural counties, or a lack of understanding what the local needs are.

Table 5 Mandated CCPT and CCPT/CFPT Members and Mean Rate and Rank of Participation
Mandated CCPT and CCPT/CFPT Members and Mean Rate and Rank of Participation, 2017 and 2018

Mandated Member	2017 (N = 79) Average (Rank)	2018 CCPT (N = 13) Average (Rank)	2018 CCPT/CFPT (N = 73) Average (Rank)
DSS Director	3.03 (6)	3.69 (7)	3.25 (4)
DSS Staff	3.87 (1)	4.54 (1)	3.88 (1)
Law Enforcement	2.74 (8)	3.85 (6)	2.77 (7)
District Attorney	2.00 (11)	2.92 (10)	1.70 (13)
Community Action Agency	2.87 (7)	3.46 (9)	2.66 (8)
School Superintendent	2.46 (9)	3.54 (8)	2.36 (9)
County Board of Social Services	2.34 (10)	2.85 (11)	2.24 (11)
Mental Health Professional	3.56 (2)	4.46 (2)	3.30 (3)

Guardian ad Litem	3.09 (5)	3.92 (4)	3.03 (6)
Public Health Director	3.11 (4)	3.92 (3)	3.17 (5)
Health Care Provider	3.14 (3)	3.85 (5)	3.37 (2)
District Court Judge			.92 (16)
County Medical Examiner			1.47 (14)
EMS Representative			2.21 (12)
Local Child Care or Head Start Rep			2.29 (10)
Parent of Child Fatality Victim			1.06 (15)

Note. 0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently

In summary, state law requires that local CCPT teams are composed of 11 members from specified agencies that work with children and child welfare. Additionally, state law requires that combined CCPT/CFPT teams are composed of 16 members from specified agencies that work with children and child welfare as well as family partners. The 2018 survey results, as well as those in prior years, show that mandated members varied in their level of participation. DSS staff, health care providers, and mental health professionals were the most often present while the county boards of social services, the district attorney (for CCPTs), and the district court judge, the parent of a child fatality victim (for combined CCPT/CFPTs) were least often in attendance. Nevertheless, the majority of mandated members in nearly all categories were in attendance *frequently* or *very frequently.* This is fortunate because most (83%) of the survey respondents thought that representation by all the 11-16 mandated agencies was necessary for accomplishing their work. Thus, for the most part, the local teams had representation from a wide range of disciplines, necessary for addressing complex child welfare issues.

2. Additional Members

Besides the state required members, the county commissioners can appoint additional members from the mandated agencies and from other community groups. Among the 88 survey responses, 47 (53%) said that they did not have additional members while the other 41 (47%) had between 1 to 8 additional members. The survey provided space for

the respondents to "list the organization/unit that additional members represent." On the survey, the respondents wrote in that the additional partners came from mandated organizations such as social services, mental health, law enforcement, public health, schools, and guardian ad litem. Other appointed members were based in public agencies such as courts, juvenile justice, military, and child developmental services. Still others were from nonprofits, including domestic violence, substance use, parenting education, and children's advocacy.

In summary, county commissioners on over half the responding surveys appointed additional members to their local CCPTs. These members came from mandated organizations and other public agencies and nonprofits or were community members or parents (e.g., foster/adoptive parent, parent of deceased child). Thus, the appointments of county commissioners enlarged the perspectives brought to bear in the CCPTs' deliberations.

E. CCPT Operations

By state statute, CCPTs are partially designed as information-sharing and policy-implementation groups. It is critical to understand if CCPTs are operating to meet these goals.

1. CCPT Meetings

The CCPTs were asked how well they prepare for meetings as a whole. The question on the survey read: "How well does your CCPT prepare for meetings?" Among the 88 respondents, 30 (35%) indicated that they prepare *very well* for meetings, and 34 (39%) prepare *well.* Of the established teams that met regularly, 77% and 59% of those that recently reorganized and met regularly prepared "well" or "very well" for meetings, respectively.

CCPT teams were asked how well they share information during meetings. Forty-nine, 57% of the respondents, indicated that they share information very well. Thirty-four (40%) said that their team share information *well.* When asked how well the team shared other resources 45 (52%) denoted *very well,* while 29 (34%) noted that they share other resources *well.* Sixty respondents listed at least one shared other resource, 39 listed a second shared resource, and 22 listed a third. CCPT teams identified key resources shared including: community resources, educational resources, grant opportunities, meeting space, programs, and mental health resources.

2. Community Change

The CCPT teams were asked how well their team has effected changes in their community. Five (6%) of respondents indicated *very well,* 20 (23%) indicated *well,* 34 (40%) indicated *moderately,* 22 (26%) indicated *marginally,* and 5 (6%) indicated *not at all* with respect to how well their CCPT has effected changes in their community. Of the seven that indicated *not at all* for effecting community change, none listed other shared resources.

In summary, CCPTs and combined CCPT/CFPTs who are established or recently re-established feel that they are preparing well for their regular meetings. Additionally, the majority indicate that they are sharing resources well and provided a number of additional shared resources they have accessed. The majority of respondents indicated that they only have a moderate to marginal impact in effecting change in their community. Thus, CCPTs have created a working environment in which they share information and resources; however, they recognized that their ability to make changes is limited.

F. Family or Youth Partners

The survey also inquired specifically about family or youth partners serving on the local teams. These are individuals who have received services or care for someone who has received services.

1. Family or Youth Partner Participation Rates

In response to the question on whether they had family or youth partners serving on their team, 21 (24%) out of 88 respondents said *yes* and 66 (76%) said *no.* The 2018 percentage of *yes* responses is somewhat higher than in 2015 (21%, 19 out of 87), the same as 2016 (22%, 19 out of 86) and lower than 2017 (29%, 23 out of 79). Maintaining the structure from 2017, the 2018 survey inquired about the six different categories of family or youth partners serving on the CCPTs (see Table for the categories). The teams who said they had a family or youth partner this year could identify if they had more than one partner on their team. Table 6 shows that the respondents had a total of 28 family or youth partners, whose rates of participation ranged from *rarely* to *very frequently*. The most commonly represented category was biological parent which formed half (14, 50%) of the family or youth partners. The other five categories' rate of participation ranged from *rarely* to *very frequently*.

Table 6 Family or Youth Partners by Category and Reported Frequency of Participation
Family or Youth Partners by Category and Reported Frequency of Participation, 2018

Category	Never	Rarely	Occasionally	Frequently	Very Frequently	Number of CCPTs with Some Participation
Youth Partner	14	1	0	2	0	3
Biological Parent	6	5	2	1	6	14
Kinship Caregiver	15	2	0	0	0	2
Guardian	16	1	0	0	0	1
Foster Parent	14	3	0	0	1	4
Adoptive Parent	13	2	1	1	0	4
Total	**78**	**14**	**3**	**4**	**7**	**28**

In summary, the survey asked if the CCPT included family or youth partners. These are individuals who have received services or care for someone who has received services. Only 24% of respondents indicated that family or youth partners served on their CCPT or combined CCPT/CFPT. It is unclear whether the teams were identifying biological parents who served as members of the Child Fatality Prevention Teams. Future surveys will need to differentiate between Child Fatality Prevention Team members who are parents of a deceased child and CCPT members who are parents of a child in need of protection. Thus, the large majority of CCPTs lacked family representation, which limited their capacity to bring youth and family perspectives to the table. This could inhibit their contributing to instituting safety organized practice in a family-centered manner.

2. Strategies for Engaging Family or Youth Partners on the Team

The survey then asked the respondents to "list three strategies that your CCPT has successfully used to engage family and youth partners on your team." Among the 21 respondents who stated that they had family or youth partners, 10 replied to this question: seven providing only one of the three possible strategies, one providing two out of the three possible strategies, and two providing all three strategies. The CCPTs and combined CCPT/CFPTs used two main strategies. First, they identified likely family or youth partners by conducting "outreach to team members with connections to desired [partners]" and "networking between surviving family members to engage others." Second was continuously extending invitations to the community. Important components of this process were "explaining [the] purpose for quarterly meetings" and providing information regarding participation such as opportunities for "training" and "orientation" as well as discussing the impact of participation and using inclusive terminology. In

summary, the CCPTs used a range of strategies that built upon each other. Especially apparent were two basic approaches: using networks to identify potential family or youth partner as well as utilizing members already in place to offer family perspectives, and extending repeated invitations which included information on benefits of participation and inclusive terminology.

3. Factors Limiting the Participation of Family or Youth Partners

The participation of family or youth partners can be limited for two overarching reasons: (a) the partners may have their own reasons for not participating and (b) the local teams may have difficulty knowing how to engage these partners. The survey inquired about both sets of reasons. First, the survey asked the teams to "list three reasons that prevent some family or youth partners from taking part in your CCPT." This question sparked much discussion, with 69 (78%) of the 88 respondents writing in comments. Among the 69, 34 gave one reason, 19 gave two reasons, and 16 gave three reasons.

A vast majority of the reasons were logistical: lack of transportation or reimbursement for travel and scheduling conflicts with work, school, or clubs; need for child care. Other reasons related to the sensitive nature of topics discussion as well as issues maintaining confidentiality.

Then, the survey asked the respondents to "list three reasons that prevent your CCPT from engaging some family or youth partners in your CCPT." This question led to much discussion. Among the 88 respondents, 60 (68%) commented with valid responses, three responses were eliminated due to "N/A" content. Out of 60 respondents identifying why they were inhibited in engaging family or youth partners: 36 provided one out of the three possible reasons, 13 provided two out of the three possible reasons, and 11 provided all three reasons. As some respondents commented, the reasons that prevented them from engaging mandated participants overlapped with those that prevented them from engaging family partners. These overlaps included the partners' other commitments (e.g., work and school), scheduling conflicts, transportation, child care, and no payment for their time, and concerns about discussing sensitive topics as well as maintaining confidentiality. The most common barrier that CCPTs identified was difficulty recruiting youth and family partners. CCPTs indicated that they "lacked a dedicated person appointed to ensure engagement" and simply "having limited skill in engaging and recruiting family and youth partners."

In summary, CCPTs detailed at length the reasons preventing the participation of family or youth partners on their teams. Some of these reasons stemmed from the situation of the partners: logistical, such as a lack of transportation or scheduling conflicts, lack of reimbursement, and emotional because of the sensitive topics discussed, especially when the CCPT was combined with the Child Fatality Prevention Team. CCPTs also identified reasons related to the team rather than family or youth partners. These included uncertainties about how to recruit partners and how to maintain confidentiality. CCPTs asked for more guidance on bringing family and youth partners onboard their teams. Thus, CCPTs identified the training and resources they would need for engaging families on their teams.

G. **Partnerships to Meet Community Needs**

In addition to their own team meetings, the CCPTs engaged with other local groups to meet community needs. Two survey questions respectively asked about other organizations and other collaborations with which the CCPTs partnered. The first of these survey question was: "During 2018, did your CCPT partner with other organizations in the community to create programs or inform policy to meet an unmet community need?" Among the 88 respondents, 43 (49%) answered that they did partner with other organizations and 44 (51%) did not. A follow-up question was: "If yes, describe the most important of these initiatives to meet a community need." Demonstrating extensive local activism and justifiable pride in their accomplishments, the CCPTs described at length numerous initiatives.

These initiatives included raising public awareness of how to identify child abuse (including sexual abuse), strengthen protective factors through education on healthy parenting practices such as safe sleeping. Many teams hosted or facilitated events such as walks and runs, community fundraisers, and community viewings of educational films. These events aimed to raise awareness to support healthy pregnancy, care for infants and young children, prevent teen suicide, stop human trafficking, prevent domestic violence, and ensure firearm safety.
The second related survey question was: "Are you aware of any other county-level collaboration your CCPT is involved in?" Twenty responded yes, among whom 11 identified one collaboration, two identified two collaborations, and seven identified three collaborations. These collaborations were in support of the initiatives that the teams had already reported. Some CCPTs reported local collaborations that formed around issues such as opioid awareness and prevention; others referenced educational efforts with schools, law enforcement, and other agencies.

In summary, over half the respondents identified important initiatives that they undertook with others in their community. Local collaborations made it possible to raise public awareness of child maltreatment, host community forums with school-age children and their parents, and sponsor joint trainings for service providers. Thus, through their initiatives demonstrated a keen understanding of the needs of families in their communities and their capacity to act on these areas of concern.

H. **Which cases do local CCPTs review, and how can the review process be improved?**

According to North Carolina General Statute §7B-1406, CCPTs are to review:

a. Selected active cases in which children are being served by child protective services;
b. and cases in which a child died as a result of suspected abuse or neglect, and
    1. A report of abuse or neglect has been made about the child or the child's family to the county department of social services within the previous 12 months, or
    2. The child or the child's family was a recipient of child protective services within the previous 12 months.

The expectation is that CCPTs examine cases of child maltreatment, and, accordingly, the CCPT mandate is different from that of the CFPTs, who are responsible for reviewing child fatalities. North Carolina General statute §7B-1401(1) defines child fatalities as "any death of a child that did not result from suspected abuse or neglect and about which no report of abuse

or neglect had been made to the county department of social services within the previous 12 months."

State statute does not stipulate how many cases CCPTs must review in a calendar year. Statute does specify that CCPTs must meet a minimum of four times per year. During these meetings, the teams may opt to review cases.

The survey posed a series of questions about the CCPTs' case reviews. These concerned child maltreatment fatalities, active cases of child maltreatment, criteria for selecting cases, information used in case reviews, and service needs of the cases.

1. Child Maltreatment Fatality Cases

The survey asked, "From January through December 2018, how many notifications of child maltreatment fatalities were made by your local DSS?" Among the 88 respondents, 55 (63%) replied that they had received no notifications; the remaining 33 (38%) said that they had received between 1 to 15 notifications. Across the 33 respondents, there was a total of 105 notifications with a mean of 5.23 (SD = 7.44).

Next the CCPTs were asked about the type of review that these child maltreatment fatalities received. The teams were provided with nine types of reviews from which to select, and they had the option of writing in two other types of review. As shown in Table 7, the most common type of review was a review conducted by a combined CCPT and CFPT as well as an intensive state child fatality review conducted by NC DSS: 41 cases were reviewed in each of these categories, and these case reviews were reported by 20 and 26 CCPTs respectively. The next two most frequent types were reviews by CFPTs, with 18 cases reviewed. Another 13 cases were reviewed by CCPTs and 7 were reviewed both by CCPT/CFPTs and then by DSS in intensive case review. A total of 18 cases were reviewed by CFPTs.

In summary, last year, 33 (38%) out of the 88 responding CCPTs received between 1 and 15 notifications of child maltreatment fatality cases, for a total of 105 notifications. When asked about their type of review, the teams identified different approaches. The most common type was a review by the combined CCPT and NC DSS intensive state reviews. Thus, the cases of child maltreatment fatalities had different types of reviews, some in the county and others at the state level. What the survey did not identify is the reasons why the large majority of counties had no notification of child maltreatment fatalities. In addition, the survey did not ask about how many cases had multiple reviews and the benefits and costs of the different types of reviews and of having more than one review. And, most importantly the survey did not inquire about the impact of the reviews. All this information would be helpful in planning ways to improve child maltreatment reviews in the state.

Table 7 Number of Child Maltreatment Fatality Reviews by Type of Review

Number of Child Maltreatment Fatality Cases by Type of Review, 2018

Type of Review	Number of CCPTs	Sum of Cases	Minimum of Cases	Maximum of Cases	Mean of Cases	Standard Deviation
1. Combined CCPT and CFPT conducted case review	20	41	0	15	2.05	3.65
2. Number of child maltreatment fatality cases that had a review conducted	18	25	0	5	1.39	1.50
3. NC DSS conducted (intensive) state child fatality review	26	41	0	5	1.58	1.63
4. CFPT conducted case review	19	18	0	5	.95	1.35
5. CCPT conducted case review	17	13	0	5	.76	1.39
6. CCPT/CFPT conducted case review and DSS conducted intensive case review	17	7	0	2	.41	.62

Note. A case may have more than one type of review

2. Child Maltreatment Case Reviews

a. Number of Cases Reviewed

The CCPTs were then asked, "What is the total number of cases of child maltreatment reviewed by your CCPT between January and December 2018?" The survey instructions stated that combined CCPT and Child Fatality Prevention Teams should only include reviews "where the death was caused by abuse, neglect, or dependency and where the family had received DSS child welfare services within 12 months of the child's death."

In 2018, 63 (72%) of the 88 responding CCPTs reviewed between 1 and 45 cases, with a mean of 5.23 cases (SD = 7.44). All together these 63 teams reviewed 450 cases. Table 8 displays the total number of cases reviewed when organized by county size. As county size increased so did the average number of cases per CCPT. Within each county-size group, especially for the largest counties, there was extensive variation in how many cases they reviewed.

Table 8 Number of Child Maltreatment Cases Reviewed by County Size
Number of Child Maltreatment Cases Reviewed by County Size, 2018, (N=88)

Size of County	Number of Respondents	Number of Cases Reviewed	Mean	SD	Range
Small	43	186	4.33	5.45	0-30
Medium	32	141	4.41	6.73	0-35
Large	11	123	11.18	12.67	1-45

Note: Large standard deviations indicate wide variability in number of cases reviewed.

In summary, over 2018, 63 (72%) of the 88 responding CCPTs reviewed cases of child maltreatment, with a total of 450 cases reviewed. As would be expected, larger counties reviewed more cases than smaller ones. Thus, most CCPTs who responded to the survey carried out their mandated role of reviewing cases. What the survey did not specifically inquire about were the reasons why some counties had not reviewed cases and what would have helped them fulfil this role.

b. Criteria for Selecting Cases for Review

The survey asked about the criteria that the teams applied for selecting cases to review. The teams were provided a list of 11 criteria and could write in two additional reasons. As shown in Table 9, the most common reason cited by 48 (55%) out of the 88 respondents was that the case was active. This is in keeping with the expectation of state statute that CCPTs select "active cases in which children are being served by child protective services." Statute also charges the teams with reviewing "cases in which a child died as a result of suspected abuse or neglect." Among the respondents, 20 (23%) stated that they selected for review child maltreatment fatalities. In addition to these statutory requirements, the CCPTs identified other selection criteria. Most frequently selected, at 30% or higher, were criteria of stuck cases, multiple agencies involvement, and repeat maltreatment. Compared with last year's survey, the number of CCPTs selecting cases for review because of parental opioid use decreased slightly: 22 (34%) of the 64 respondents in 2016 to 26 (41%) of 63 respondents in 2017 to 21 (24%) of respondents in 2018. Seventeen of the respondents added a selection criterion, and four of these provided two criteria. The additions included "unsafe sleeping," "high risk of harm," "substantiated for services needed," and multiple or other agency involvement.

Table 9 Case Criteria Used by CCPTs for Selecting Child Maltreatment Cases for Review

Case Criteria Used by CCPTs for Selecting Child Maltreatment Cases for Review, 2018, (N=88)

Selection Criterion	Number of CCPTs	
Active Case	48	(55%)
Multiple Agencies Involved	38	(43%)
Stuck Cases	37	(42%)
Repeat Maltreatment	31	(35%)
Parent Opioid Use	21	(24%)
Child and Family Well-Being	20	(23%)
Child Maltreatment Fatality	20	(23%)
Court Involved	19	(22%)
Child Permanency	11	(13%)
Closed Case	7	(8%)
Other 1	16	(18%)

Note. The sample includes the 63 respondents that had at least one case review

c. Contributory Factors to Intervention Necessity

Child Protective Services codes cases of substantiated maltreatment or family in need of services on factors contributing to the need for intervention. These contributory factors fall into three broad categories: caretaker, child, and household. Table 10 lists these contributory factors and the number of CCPTs who used each factor in selecting cases for review. The two most common factors were caretaker's drug abuse cited by 58 (66%) CCPTs and household domestic violence cited by 44 (50%) CCPTs. Other factors used by over 25% of CCPTs pertained to child/youth behavior problems, parent/caregiver emotional disturbance and alcohol abuse, and inadequate housing.

Table 10 Contributory Factors for Children Being in Need of Protection Used by CCPTs for Selecting Child Maltreatment Cases for Review

Contributory Factors for Children Being in Need of Protection Used by CCPTs for Selecting Child Maltreatment Cases for Review, 2018, (N = 88)

Contributory Factor	Number of CCPTs	
Parent/Caregiver		
Drug Abuse	58	(66%)
Alcohol Abuse	26	(30%)
Emotionally Disturbed	24	(27%)
Lack of Child Development Knowledge	21	(24%)
Mental Retardation	7	(8%)
Learning Disability	6	(7%)
Other Medical Condition	6	(7%)
Visually or Hearing Impaired	0	(0%)
Children/Youth		
Behavior Problem	36	(41%)
Other Medical Condition	16	(18%)
Drug Problem	15	(17%)
Emotionally Disturbed	14	(16%)
Learning Disability	7	(8%)
Physically Disabled	6	(7%)
Alcohol Problem	5	(6%)
Mental Retardation	4	(5%)
Visually or Hearing Impaired	1	(1%)
Household		
Domestic Violence	44	(50%)
Inadequate Housing	26	(30%)
Financial Problem	18	(21%)
Public Assistance	13	(15%)

In summary, state statute requires that CCPTs review two types of cases: active cases and child maltreatment fatalities. Most (55%) respondents selected active cases for review. Child maltreatment fatality was given as a reason for case selection by 23% of respondents. The second most frequent criteria for selecting cases was a multiple agency involvement, identified by 43% of the respondents. The range of issues identified indicates the CCPTs' concern about many areas affecting the families' lives. Thus, the teams had a comprehensive awareness of the challenges affecting the children and families in their communities.

3. Process of Case Reviews

The CCPTs used different types of information to review the cases (see Table 11). Out of the 88 respondents, 65% used reports from members and/or case managers, and 64% used case files. Close to two-thirds (39%) used information on procedures and protocols of involved agencies. These three types of information were the same primary sources as reported in the 2015, 2016, and 2017 surveys. CCPTs also wrote in some other information sources, including: medical, school, police, and military records as well as information from their own case records.

Table 11 Type of Information Used by CCPTs for Reviewing Cases
Type of Information Used by CCPTs for Reviewing Cases, 2018, (N=88)

Type of Information	Number of CCPTs
Reports from Members and/or Case Managers	57 (65%)
Case Files	56 (64%)
Information on Procedures and Protocols of Involved Agencies	34 (39%)
Child and Family Team Meeting Documentation	21 (24%)
Medical Examiner's Report	21 (24%)
Individualized Education Plan	6 (7%)
Other	9 (10%)

Note. CCPTs could select all that apply.

Next the CCPTs were asked to share their views on what would help their team carry out case reviews even better. Among the 88 respondents, 32 wrote in suggestions on how to improve their case reviews, and eight stated they were "unsure" or "N/A". The most common recommendations were access to information and records as well as increased participation and attendance. In addition to the need for records, there was an emphasis on the need for timely sharing of information, especially across agencies. CCPTs also expressed a desire for a "standardized checklist" or a "structure for case presentation" to ensure that they were addressing everything that they should.

In summary, in reviewing cases, most CCPTs used reports from members and/or case managers, case files, and information on procedures and protocols of involved agencies. CCPTs identified what they needed to improve the case review process: increased record sharing in a timely manner, better participation of mandated members as well as community and family partners, standardization of procedures and forms, and

clarification of the review process. Thus, the recommendations of the CCPTs are in line with those at the national level for improving child maltreatment reviews (Commission to Eliminate Child Abuse and Neglect Fatalities, 2016).

I. Reported Limits to Access to Needed Mental Health, Developmental Disabilities, Substance Abuse, And Domestic Violence Services And Suggestions for Improvement of Child Welfare Services

1. Limits on Access to Needed Services

A recurring concern of CCPTs is the families' limited access to needed services in mental health, developmental disabilities, substance abuse, and domestic violence (MH/DD/SA/DV).

The survey asked the CCPTs to identify how many cases reviewed in 2018 needed access to MH/DD/SA/DV services. Table 12 summarizes the findings first for the children and second for the parents or other caregivers. For children, the most needed service was mental health. Here 75% of the respondents identified this need for the children in a total of 200 cases. In regards to DD, SA, and DV services, 75% of the respondents stated these services were needed for the children; however, SA services were required by a combined 132 cases, which exceeds the numbers for DD (40 cases) and DV (86 cases). This reflects a shift from the 2017 survey results which indicated that DV services were required at a higher level than SA and DD services.

For the parents or caregivers, the need for mental health and substance abuse services were the most prominent. Among the responding teams, 72% identified the need for both SA and MH services. The total number of reviewed cases were also highest with 285 of the reviewed cases requiring SA services and 242 requiring MH services. The need for DV services was cited by 66% of the teams, for a total of 152 cases. CCPTs identified the need for DD services at a rate of 66% but with a significantly lower number of cases reviewed (21 cases).

As noted previously, CCPTs commonly selected cases for review because of parental drug use, child safety, domestic violence, and child and family well-being (which includes mental health). These criteria would tilt the findings on reviewed cases toward the need for SA, MH, and DV services. Another way to view the findings is that the CCPT members were well aware of these issues across the families that they served and recognized the complexity of these situations, often entailing the involvement of multiple agencies. Rather than being "stuck," they wanted to identify systemic barriers to families' accessing essential services.

In 2018, two new items were added to provide insight into more specific types of cases that were reviewed by CCPTs across the state. Those respondents who indicated that they had reviewed cases where families needed access to substance abuse services were subsequently asked, "How many cases of substance affected newborns did you review in 2018?" and "How many of these had a Plan of Safe Care". Twelve CCPTs indicated that they reviewed cases of substance affected newborns, the sum of the cases reviewed was

45. Of these 12 CCPTs reporting reviewing cases of substance affected newborns, 11 of them responded to the follow up question inquiring about Plans of Safe Care. All but three reported reviewed case of a substance affected newborn had a corresponding Plan of Safe Care (42 plans).

Table 12 Number of Reviewed Cases Requiring Access to MH/DD/S/DV Services
Number of Reviewed Cases Requiring Access to MH/DD/SA/DV Services, 2018 (N= 88)

	Number of CCPTs	Sum of Cases	Mean	SD
Children/Youth				
Mental Health	66 (75%)	200	3.03	3.74
Developmental Disabilities	66 (75%)	40	0.61	1.07
Substance Abuse	66 (75%)	132	2.00	4.96
Domestic Violence	66 (75%)	86	1.30	3.30
Parents/Caregivers				
Mental Health	63 (72%)	242	3.84	4.27
Developmental Disabilities	57 (65%)	21	0.37	0.85
Substance Abuse	63 (72%)	285	4.52	6.33
Domestic Violence	58 (66%)	152	2.62	3.57

Note. MH/DD/SA/DV=Mental Health, Developmental Disabilities, Substance Abuse, and Domestic Violence. Large standard deviations indicate wide variability in number of cases reviewed requiring access to services.

Next the survey asked, "Which of the following limitations prevented children, youth, and their parents or other caregivers from accessing needed MH/DD/SA/DV services?" As shown in Table 13, the two most frequently cited limitations were limited or no services (75% of respondents) and limited transportation to services (66% of respondents). Another common limitation, cited by 46%, was because of the community's lack of awareness about available services. Respondents' recognition of limited services for youth with dual diagnosis as a limitation ranged from 22-40%.

Among the respondents, 16 wrote in additional limitations. These primarily concerned systemic factors and to a lesser extent, family reasons. Some respondents commented on families' "willingness to participate in programs that are offered" as well as language and cultural barriers. A frequently cited systemic factor concerned medical insurance or Medicaid. One CCPT observed that there was "parents without Medicaid or insurance [have] to pay for needed treatment or care". This is especially true for undocumented families who are ineligible for Medicaid. " Others identified the lack of "after hour care" as a barrier to accessing needed MH/DD/SA/DV services.

Table 13 Number of CCPTs Reporting Limitations Preventing Children, Youth, and Their Parents or Other Caregivers Accessing Needed MH/DD/SA Services
Number of CCPTs Reporting Limitations Preventing Children, Youth, and

Their Parents or Other Caregivers Accessing Needed MH/DD/SA/DV Services, 2018, (N = 88)

Limits on Access	Number of CCPTs
Limited Services or No Available Services	66 (75%)
Limited Transportation to Services	58 (66%)
Limited Community Knowledge About Available Services	40 (46%)
Limited Services MH and SA for Youth with Dual Diagnosis	35 (40%)
Limited Services MH and DD for Youth with Dual Diagnosis	27 (31%)
Limited Services MH and DV for Youth with Dual Diagnosis	19 (22%)
Limited Attendance MH/DD/SA/DV Providers at CFTs	11 (13%)
Limited Number of Experienced CFT Meeting Facilitators	5 (5%)
Other	17 (19%)

Note. MH/DD/SA/DV = Mental Health, Developmental Disabilities, Substance Abuse, and Domestic Violence.

In summary, children, youth, and their parents or caregivers faced serious barriers to accessing needed services. Most CCPTs who reviewed cases in 2018 reported that children and youth needed access to substance abuse services. Most CCPTs also reviewed cases in which the parents or caregivers required access to mental health or domestic violence services. As noted previously, CCPTs commonly selected cases for review because of parental drug use, child safety, domestic violence, and child and family well-being (which includes mental health). These criteria would tilt the findings on reviewed cases toward the need for MH, SA, and DV services. Additionally, CCPTs identified systemic barriers to families' accessing essential services. The most commonly cited barriers were limited services or no available services, transportation to services, and youth's having a dual diagnosis of mental health and substance abuse issues. The CCPTs commented on some family factors affecting service receipt such as language barriers. It is quite likely that these identified family reasons reflected systemic barriers such as the complexity of the health care system and lack of medical insurance or Medicaid. Thus, the teams were well aware of multiple issues keeping children and families from much needed services. The federal funding from the Family First Prevention Services Act may be able to assist them in securing prevention services in their communities.

IV. Recommendations for Improving Child Welfare Services

Given their keen understanding of local issues, the CCPTs were well primed to answer the survey question, "Based on your 2018 case reviews, what were your team's top three recommendations for improving child welfare services?" They provided a total of 170 recommendations. These recommendations came from 67 (76%) out of the 88 CCPTs. Among the 67 CCPTs who made a recommendation, 44 made three, 15 made two, and 8 made one. Their recommendations reflected many of those raised in the 2017 survey but this year appeared to give even greater paramountcy to early childhood.

A. Early Childhood

The recommendations on early childhood fell mainly into two areas of concern—unsafe sleeping and substance-affected infants. Both are related to infant fatalities and can be addressed by prevention and intervention (Commission to Eliminate Child Abuse and Neglect Fatalities, 2016). The proposed ways of promoting safe sleeping went beyond education on the dangers of co-sleeping to creating safe sleeping environments for babies. The teams recognized the impact of poverty on families' capacity to offer safe and stable places for their children to sleep. For instance, one team pointed out the need for "more resources to give parents something for children to sleep in safely." The teams urged that child welfare support safe sleeping in all stages of work with families, and they articulated concrete proposals on how to accomplish this. Writing at length, one CCPT advised, "Enhance all safe sleep outreach activities - provide Pack N Plays, books pamphlets, door hangers, etc. with safe sleep messages on them so that social workers can use these materials at screening/intake and then each time they are in the home or delivering services."

CCPTs set the goal that "safe sleeping information has been incorporated into all child welfare practices."

Concerns about safe sleeping were related those about substance-affected infants. One county advised, "Target high risk populations with a focus on substance abusing parents when educating on safe sleep." Another county, likewise concerned about safe sleeping practices, pointed out problems with the "overuse of prescription drugs when caring for infants." Both these counties made recommendations on improving how fatalities are handled. The first one advised, "alternate protocols as to not disturb a fatality scene," and the second one concluded that the "medical examiner was needed at the death scene."

Every year, surveyed CCPTs have identified concerns about substance-exposed infants. The salience of the issue in 2018 reflected national alarm about the increase in the use of substances, including opioids, and the passage of the Comprehensive Addiction and Recovery Act (CARA) of 2016 that mandates states to offer services to the infant, parents/caregivers, and other family members. The intent is to be supportive rather penalizing and to cover exposure to illegal and legal substances. The development of a plan of safe care is required whether or not the circumstances constitute child maltreatment under state law. Therefore, healthcare providers and/or child welfare are required to refer the family for services through the infant plan of safe care.

On the 2018 survey, CCPTs recommended "better perinatal and infant care" and raising community "awareness around the opioid crisis as it affects pregnant women and infants." Meeting the families' needs were fraught with difficulties. One team recommended, "All follow up appointments after discharge of substance affected infants not being kept should be reported as neglect." In order for child welfare workers to "get services in place that are evidence based for working with substance using and abusing parents," a CCPT pointed out, "workers need training on these methodologies." Families also require, a team stressed, "quality MH/SA services in the home" and "SA/MH providers sharing information with child welfare consistently and in a timely manner." A related CCPT recommendation concerned child fatality reviews: A team called for "system wide regulation of the MAT [medication-assisted treatment] programs—in particular how methadone use is related to child fatality among treated parents." Another team emphasized, "The use of differing drug screening methods for parents dependent upon the circumstances of their drug use." Given the complexity of working with substance-affected infants and their families, a CCPT proposed, "Dedicate staff at DSS to manage the substance affected babies so that the process includes timely access to needed MH/SA/DV services."

A CCPT proposed, "Dedicate staff at DSS to manage the substance affected babies so that the process includes timely access to needed MH/SA/DV services."

The teams were also keenly cognizant of the issues faced by school-age children and adolescents. Likewise these age groups needed "timely" assessments and "experienced mental health professionals who specialize in working with children and teenagers." Such specialization was seen, in particular, as necessary for children with dual diagnoses and for teens around suicide, alcohol, drugs, mental health, and driver safety.

B. Parent/Caregiver Supports and Services

The teams devoted much attention to methods for bringing more supports and resources to the children's parents or caregivers, especially as they cared for children with mental health and substance use disorders. The CCPTs recognized that the caregivers needed to receive care, or as one team simply stated, "Parenting to all parents." This could mean offering a "universal statewide hotline number" or supporting "extended family members raising children in foster care." It also meant changing community perceptions of families by "developing a trauma informed community" and raising "awareness of poverty as a community issue."

One team called for "Parenting to all parents."

They wanted to support parents in learning how to parent. This could be in form of parent education such as "Triple P Level IV and V parenting classes" or providing a "facility that will house both parent and child to help train and mentor parents." Additionally they enumerated ways to build in concrete supports that parents needed: "better access to daycare services after hours," education about "informal networks of child care providers," or encouraging the "use of the transportation authority" that is "less than full cost or free if on Medicaid."

Another concern was that parents, particularly mothers, be safe from domestic violence so that they are not hindered in parenting their children. The teams urged "resources for DV" and "one stop family justice centers" for survivors. To assist the abused parent, they called for training of law enforcement on the legalities of no-contact orders and on "when is it appropriate and safe for a victim to press charges."

Especially problematic was helping parents to access services when they lived in a small or rural county. These could be addressed, in part, by locating services outside the county or improving "community awareness of tele-psychiatry services." A more detailed proposal was made by one CCPT in a small county for funding a local family resource center that would "provide ongoing prevention and child advocacy services" as well as developing within the county treatment services to counter the "growing substance abuse problems that are usually present in the substantiated cases of child abuse and neglect."

As highlighted previously in this report, teams were gravely concerned about the roadblocks to families accessing much needed MH/SA/DD/DV services. In their recommendations, they repeatedly called for expanding Medicaid or redesigning its policies. For instance, one team stressed the need to "change Medicaid rules so parents who have lost custody and working toward regaining it will not be cut off from treatment due to funding." They wanted "more long term SA treatment beds which are affordable and closer to home." They pushed for "improved access to services for non US citizens."

One team stressed the need to "change Medicaid rules so parents who have lost custody and working toward regaining it will not be cut off from treatment due to funding."

C. Community Collaboration

In their recommendations, CCPTs emphasized enhancing the capacity of the different community groups to work together. This included "improve[d] communication among involved agencies," "partnering with each other for community awareness activities," aligning their efforts with the Department of Juvenile Justice, and "collaboration with the court system and judicial players." A troubling issue, a CCPT observed, was that "critical patient healthcare information is not being shared between medical providers causing a delay in sharing health information." In order for child welfare to engage better with the community, they recommended that the "child welfare team become more visible in community events."

D. Child Welfare Functioning

The CCPTs made numerous recommendations on developing the child welfare workforce and on improving case management. They recognized that child welfare needed "more positions," "increased financing for CW staff," "staff retention and recruitment efforts," and "reduction of non-essential mandated requirements for social workers." In order for caseworkers to carry out their responsibilities, the teams advised: "less 'paper work' for DSS workers so more time can be spent doing their jobs with families and cases," having for "in-home services . . . a structured documentation instrument much like the DSS-5010," and "specialized training" including on how "to interpret LE [law enforcement] records." Between counties, they wanted better "collaboration between county administered social service agencies when protective services were being transferred across county lines." One quite emphatic CCPT pushed "funding for and implementation of an effective and purposely built (i.e., NOT NC FAST) statewide case management system."

In summary, the CCPTs were quite forthcoming in proposing ways to improve child welfare services. Even more than past years, they focused on two early childhood issues--unsafe sleeping and substance-affected infants. They offered concrete strategies for child welfare integrating support of safe sleeping across all stages of their casework, and they laid out a series of steps for getting better and more timely substance and mental health treatment to families. They further specified the supports and services that parents or caregivers would need in order to care for their children. These included emotional and practical support for parents and kinship caregivers, better law enforcement practices to protect parents abused by their partner, improved service access for rural counties, and removal of roadblocks to MH/SA/DD/DV services, particularly as related to Medicaid coverage. They identified the need for community groups to collaborate better, including better sharing of critical information between health care providers. In regards to DSS, they focused on improving the child welfare workforce and case management. They recognized serious understaffing in offices, emphasized streamlining of protocols, and urged replacing the ineffective statewide case management system.

E. Local CCPT Objectives and Achievement of Objectives

This year the survey asked a series of new questions about the CCPTs' local objectives based on identified improvement needs. First, they were asked, "Did your CCPT set local objectives based on identified improvement needs to complete over 2018?" Among the 88 respondents, 28 (34%) said *yes* and 57 said *no* (66%). Twenty-two who responded *yes* characterized themselves as an established team that met regularly.

Next, the 28 respondents who set objectives were asked, "List your CCPT's top three local objectives based on identified improvement needs for 2018. Then rate how successful your CCPT was in achieving these objectives." Table 14 summarizes the extent to which the CCPTs achieved their objectives on a five-point scale (0-5) from *not at all, slightly, moderately, mostly, completely, and too soon to rate.* All 28 CCPTs provided an Objective 1, 25 identified an Objective 2, and 18 identified an Objective 3. However, not all provided success ratings for achieving their listed objectives. The CCPTs overall saw themselves as somewhat successful in meeting their objectives for the year.

Table 14 Rating of CCPT Achievement of Objectives

Rating of CCPT Achievement of Objectives, 2018 (N =28)

	Number of CCPTs	Not at All	Slightly	Moderately	Mostly	Completely	Too Soon to Rate
Objective 1	28	4	3	4	6	7	4
Objective 2	21	0	7	4	2	3	5
Objective 3	17	0	5	6	4	1	1
Total	**-**	**4**	**15**	**13**	**12**	**10**	**10**

Note. The respondents were CCPTs who said that they had set objectives for 2018, not all provided success ratings.

The CCPTs not only made recommendations on what was needed to improve child welfare services but set objectives for themselves based on what they had identified needing improvement. For instance, the CCPT, that recommended local access to Triple P parenting classes, set this as an objective for their community, and by year's end, they could check off meeting this objective *completely*. Another team recommended "incorporating ACEs study and factors into conducting assessments and being more trauma-informed," and made this recommendation into a local objective, one that they *slightly* achieved. Many of the CCPTs recognized that they had set ambitious objectives, requiring long-term effort, and stated that it was *too soon to rate* their achievement. To reach their objectives, CCPTs turned to community partners. For instance, one county "collaborated with the local school system to address the issue of teen suicide through education and public information" and achieved this objective completely.

The objectives largely reflected the early childhood recommendations on safe sleeping and substance-affected infants, supporting parents, increasing service access, strengthening local collaboration, and improving child welfare casework. For instance, the county, wanting better collaboration between DSSs on case transfers, rated themselves as *moderately* successful in putting this into effect. Often they reframed recommendations into objectives that could be achieved at the county level. Another county, that had recommended freeing DSS workers from excessive paperwork so that they could spend more time with families, set as their objective to "support DSS in request for an intake worker rather than rotation of staff" and rated themselves as *completely* realizing this objective. Counties that made broad recommendation narrowed their objectives to be more feasible and measurable. For instance, a CCPT recommended "educate public of services available" and specified objectives of holding two community forums, one on opioid addiction and the other on domestic violence, both of which they *moderately* accomplished.

The CCPTs recognized that if they were to work toward improving child welfare, they needed to strengthen themselves as a team. They set objectives of increasing their membership, enhancing participation, and deepening case reviews. Teams were in different

stages of meeting their objectives. For instance, one CCPT scored themselves as only *slightly* increasing their membership and team participation while a second CCPT scored themselves as *completely* increasing participation. Another county recognized that so far they were only *slightly* successful in having a Social Services Board member serve on their team, but still persevering, this county aimed next year to "seek out a member of the Department of Juvenile Justice to serve on the team." An area that CCPTs identified for improvement was including community and family on their teams. One team stated that they had *slightly* realized their objective of community/family engagement, and another likewise said that they had *slightly* achieve their objective to "work to have youth and family attendance."

To improve their performance, teams set the objective of meeting on a "bi-monthly" basis, an objective that was *too soon to rate;* another CCPT provided training for their members, an objective that was *mostly* fulfilled; and a different CCPT wrote that they *mostly* achieved the objective to "structure meetings based on the info we need to gather to report to the state." In order to improve case reviews, one CCPT sought "ways to identify cases to review during the CCPT meetings," an objective *too soon to rate.* A different CCPT *mostly* accomplished the objective to "begin to incorporate ACEs information into reviews," and this same county *completely* met the objective to "fully integrate military reviews into team reviews and increase utilization of resources for service and non-service family members to reduce risk factors."

F. Supports for and Challenges in Achieving Local Objectives

The survey asked CCPTs to identify what helped them achieve their local objectives, what could the state do to help them meet their local objectives, what challenges did they face in realizing their objectives, and what further support would help the team put their recommendations into action. In meeting their local objectives, CCPTs touted the benefits of local collaborations and state-level support. Repeatedly, they stressed that they could not have achieved their objectives without collaboration from other local agencies and county commissioners. For instance, a county that *completely* realized its objective of "human trafficking awareness" applauded the "strong" support from their district attorney, sheriff, and county commissioners. Another benefited from collaboration with Prevent Child Abuse NC on resilience screening. A county with a strong military presence were helped by an "agreement with military senior leadership and commitment from all aspects of the military and partner agencies."

Much appreciated were the protocols and resources from the state on substance-affected infants. One team praised "DSS implementing a protocol for all parents with newborns that are NAS [neonatal abstinence syndrome]." Another pointed to the helpfulness of "statistics and state education [being] made available regarding safe sleep being the leading factor in state-reviewed child fatalities." They were assisted by the "continued focus at the state level on ACEs and education on data." A challenge, though, was having the funding to cover safe sleep publicity. One CCPT asked the state to "provide more financial resources to support safe sleep campaigns," and another requested "funding to purchase pack-n-plays."

Another pointed to the helpfulness of "statistics and state education [being] made available regarding safe sleep being the leading factor in state-reviewed child fatalities."

In terms of strengthening their teams, CCPTs commended the training that NC DSS and NC DPH offered to their team. Writing at length, a team noted, "Our team continues to make progress and has new goals for the upcoming year. The state seems to have more resources to support CCPTs now, and we hope to use those resources." A number stated that they were looking forward to receiving the updated CCPT manual. In the future, they wanted the state to provide "more trainings on how to engage community partners and families," "yearly CCPT presentations from the state representative at local CCPT meetings," "more consistent and hands-on local support by providing training, educating members and by providing frequent updates from a State," and "training, outreach and support from the State including sharing information from other CCPTs to promote learning from each other."

"Our team continues to make progress and has new goals for the upcoming year. The state seems to have more resources to support CCPTs now, and we hope to use those resources."

Challenges that they faced in achieving their objectives included Hurricane Florence, limited local training (especially in western counties) and the cost of AHEC training, minimal local services, sharing a local Community Action Agency with an adjacent county, families resistant to changing their unsafe sleeping practices, and in one case, "parents being told by other entities that co sleeping is bonding." They were deeply troubled by families' lack of access to Medicaid. They appealed to NC DHHS to "increase state funding for MH/DD and substance abuse services and housing." They stressed the need for NC DSS to free staff from being "bombarded with change and paperwork." They recognized that some challenges were beyond the purview of NC DHHS. For instance, a county pointed out that "many DSS cases reviewed [were] held up because not enough judges to hear them [and] judges rotate, so often when a case is continued"; a second emphasized difficulties in "convinc[ing] providers to locate in our area"; a third highlighted "political fears that raising taxes for services will lose them support"; and a fourth acknowledged that sharing healthcare information would need to be "addressed through HIPAA."

In summary, the objectives largely reflected the early childhood recommendations on safe sleeping and substance-affected infants, supporting parents, increasing service access, strengthening local collaboration, and improving child welfare casework. They realized their objectives with the support of strong local collaborations and state-level protocols and resources. Additionally, the CCPTs recognized that they needed to strengthen how they worked as a team. They set objectives on expanding their membership, becoming more inclusive of community and family partners, enhancing participation, and improving their case review processes. They welcomed the state-level CCPT training and asked for even more in the future.

V. 2018 Recommendations of the NC CCPT/Citizen Review Panel Advisory Board

A subcommittee of the NC CCPT/Citizen Review Panel Advisory Board reviewed this 2018 survey report, and at the May 15, 2019 meeting developed recommendations for consideration and response by the NC Division of Social Services (NC DSS). These recommendations were approved by the full Advisory Board on June 10th and transmitted to NC DSS along with this survey report. Below, the Board first reflects on progress by NC DSS in meeting the Board's recommendations from last year (2017) and then presents a set of recommendations based on the 2018 survey results.

Progress on the 2017 Recommendations

The NC CCPT/Citizen Review Panel Advisory Board wishes to commend NC DSS for taking positive steps toward meeting their recommendations from 2017. The first recommendation pertained to ensuring mental health services for children, youth, and families served by child welfare. The Board supports NC DSS's efforts to access federal Title IV-E funds through the 2018 *Family First Prevention Services Act.* The Board further endorses the NC Department of Health and Human Services' (NC DHHS) efforts to reform Medicaid and extend the coverage of foster youth and families served by child welfare. As reported in the 2018 survey, however, much more needs to be done to meet this first recommendation.

The second recommendation last year was about strengthening the capacity of local CCPTs to work with DSS in improving child welfare services. Here notable strides have been made. In particular, the establishment of a state-level CCPT consultant has paid good dividends. As summarized in this report, the local CCPTs welcomed the training and information provided by the CCPT consultant and are requesting continuation of this assistance as well as an updated CCPT manual. In addition, NC DSS funded the Child Fatality Prevention Summit that was attended by 201 participants, including CCPT members. Nearly 90% of those completing the evaluation form rated the Summit a success in "increasing the effectiveness of local teams to implement prevention strategies and changes in their own communities to prevent future child deaths and maltreatment."

The third recommendation concerned the work of this Advisory Board. NC DSS supported the Board by designating the CCPT coordinator as the liaison between the Board and NC DSS, encouraging local DSSs to complete the end-of-year survey, and supporting family and youth representation on the Board. Additionally, NC DSS funded NC State University to support the Board by conducting and analyzing the 2018 survey and assisting the Board with reporting the results.

The fourth recommendation was for NC DSS to engage with the Board in planning for the long-term structure and processes of citizen review panels in North Carolina. This recommendation was put on hold while the state is considering ways to consolidate child fatality prevention

reviews, as proposed in House Bill 825, Strengthen Child Fatality Prevention System. This bill includes the provision of "discontinuing . . . using . . . Community Child Protection Teams as citizen review panels to fulfill the requirements of the federal Child Abuse Prevention and Treatment Act."

Recommendations Based on 2018 Survey Results

The NC CCPT/Citizen Review Panel Advisory Board used the extensive information and ideas from the 88 CCPT surveys to make the recommendations listed below. We recognize that some of the recommendations will require action at the local level, others by NC DHHS, and still others by the legislature. The Advisory Board will identify which recommendations require action at what level and convey this to NC DSS.

Recommendation 1—Support achievement of the 10 goals of the Early Childhood Action Plan through the following steps:

1. Encourage safe sleeping in all stages of child welfare work with families, including financial support of safe and stable places for children to sleep
2. Continue to provide resources to counties on substance-affected infants
3. Use a supportive rather than penalizing approach to the parents of substance-affected infants
4. Clarify the expectations concerning an Infant Plan of Safe Care
5. Dedicate staff at DSS to manage substance-affected infants in order to increase timely access to needed services

Recommendation 2—Support parents/caregivers in parenting through the following steps:

1. Offer a universal statewide hotline for parents and caregivers
2. Train and mentor parents/caregivers in parenting
3. Build in concrete supports for parents, including extending hours of daycare services and offering transportation
4. Increase access to MH/SA/DD/DV services for families, including expanding Medicaid
5. Create an effective statewide case management system
6. Enhance child welfare services by increasing DSS staffing and reducing paperwork demands so that social workers can focus on work with families
7. Raise awareness of poverty as a community issue

Recommendation 3—Improve community collaboration through the following steps:

1. Assist abused parents through offering one-stop service centers and training law enforcement on legalities of no-contact orders
2. Facilitate sharing of critical patient healthcare information
3. Enhance local coordination of resources by encouraging expansion of the number of communities that are creating Community Based Child Abuse Prevention Plans

4. Encourage partnering on community awareness activities, including having the child welfare staff more visible at events

Recommendation 4—Strengthen local CCPTs as a team through the following steps:

1. Add to team membership: (a) a Juvenile Justice representative (which would parallel the membership on the NC Child Fatality Task Force in House Bill 825), (b) community action agencies or community non-governmental organization providing prevention-focused services (this change requires altering the language on community partners, (c) family partner who was previously on child welfare caseload and adult in age, and (d) military liaison in counties with high military populations
2. Ensure training for CCPTs in conducting case reviews, encouraging the participation of members, engaging family and youth partners (with training for family and youth partners), and incorporating ACEs perspectives and protective factors
3. Offer cross-county summits and other forums to encourage robust exchanges and creative ideas for child welfare improvements
4. Continue to support and fund a statewide CCPT survey under the NC CCPT/Citizen Review Panel Advisory Board in order to synthesize and disseminate local CCPTs' recommendations for improving child welfare and to assist local CCPTs in their reporting requirements to board of county commissioners

Recommendation 5—Engage in planning on the long-term structure and processes for citizen review panels as specified in the Child Abuse Prevention and Treatment Act through the following steps:

1. Define and communicate a process to publicly report on NC DSS's progress to address the identified recommendations
2. Request that NC DHHS involve the NC CCPT/Citizen Review Panel Advisory Board in planning for citizen review in the state

References

Antle, B. F., Christensen, D. N., van Zyl, M. A., & Barbee, A. P. (2012). The impact of the Solution Based Casework (SBC) practice model on federal outcomes in public child welfare. *Child Abuse & Neglect, 36*, 342–353. doi:10.1016/j.chiabu.2011.10.009

Berg, I. K., & Kelly, S. (2000). *Building solutions in child protective services*. London: W. W. Norton.

Commission to Eliminate Child Abuse and Neglect Fatalities. (2016). *Within our reach: A national strategy to eliminate child abuse and neglect fatalities* . Washington, DC: Government Printing Office. Available at: http://www.acf.hhs.gov/programs/cb/resource/cecanf-final-report

Dekker, S. (2017). *The field guide to human error investigations.* London, United Kingdom: Routledge. doi:10.4324/9781315202778

Hawai‘i Department of Human Services. (HDHS, 2012). *Family connections Hawai‘i: Final report.* Honolulu, HI: Author. Retrieved from, http://www.familyfinding.org/assets/files/Family%20Connections%20Hawaii%20Final%20Report%2012-31-2012.pdf

Lambert, M. C., Johnson, L. E., & Wang, E. W. (2017). The impact of family group decision-making on preventing removals. *Children and Youth Services Review, 78*, 89-92. doi:10.1016/j.childyouth.2017.05.005

Pennell, J., & Anderson, G. (Eds.). (2005). *Widening the circle: The practice and evaluation of family group conferencing with children, youths, and their families.* Washington, DC: NASW Press.

Pennell, J., Edwards, M., & Burford, G. (2010). Expedited family group engagement and child permanency. *Children and Youth Services Review, 32*, 1012-1019. doi: 10.1016/j.childyouth.2010.03.029

Rijbroek, B., Strating, M. M. H., & Huijsman, R. (2017). Implementation of a solution based approach for child protection: A Professionals' perspective. *Children and Youth Services Review, 82,* 337-346. doi:10.1016/j.childyouth.2017.09.024

Sheehan, L., Forrester, D., Kemp, A., O'Donnell, C., Addis, S., Nurmatov, U., Brand, S. L., & El-Banna, A. (2018). Signs of safety: Findings from a mixed-methods systematic review focused on reducing the need for children to be in care. Cardiff, United Kingdom: What Works Centre for Children's Social Care. Retrieved April 30, 2019, from https://assets.ctfassets.net/7swdj0fkojyi/2d9bU5LbiYQIUkiMy4MkMC/d1dd7ba5b7bc457880e3fdfed631570a/SoS_systematic_review_GD_Edit_v3.pdf

Salveron, M., Bromfield, L., Kirika, C., Simmons, J., Murphy, T., & Turnell, A. (2015). 'Changing the way we do child protection': The implementation of signs of safety® within the Western Australia Department for Child Protection and Family Support. *Children and Youth Services Review, 48*, 126-139. doi.org/10.1016/j.childyouth.2014.11.011

Sheets, J., Wittenstrom, K., Fong, R., James, J., Tecci, M., Baumann, D. J., & Rodriguez, C. (2009). Evidence-based practice in family group decision-making for Anglo, African American and Hispanic families. *Children and Youth Services Review, 31,* 1187-1191. doi:10.1016/j.childyouth.2009.08.003

Turnell, A., & Edwards, S. (1997). Aspiring to partnership: The signs of safety approach to child protection. *Child Abuse Review, 6*(3), 179-190

Appendices

Appendix A: Survey Process and Results

Table A-1 Timeline of CCPT Survey, 2018
Timeline of CCPT Survey, 2018

Date	Activity
August 13, 2018	NC CCPT Advisory Board established ad-hoc survey subcommittee to develop end-of-year survey
September 26, 2018	NC CCPT Advisory Board Survey Subcommittee specified items for the end-of-year survey
November 16, 2018	NC State University Institutional Review Board approved research protocols protecting participants
December 31, 2018	NC DSS sent letters to the County DSS Directors and to the CCPT Chairs to notify them about the survey
January 7, 2019	NC State University Research CCPT Team distributed survey to CCPT Chairpersons or designees followed by weekly reminders to unfinished respondents
February 19, 2019	NC DSS reminded CCPT Chairs to complete the survey
February 28, 2019	Deadline for survey submission
March 15, 2019	Extended deadline for survey submission
May 15, 2019	NC CCPT Advisory Board reviewed survey findings

Table A-2 Counties of CCPTs Submitting Survey Report

Local CCPTs Submitting Survey Report, 2018

Participating Counties			
Alamance	Durham	Madison	Stokes
Alexander	Edgecombe	Martin	Surry
Allegheny	Forsyth	McDowell	Swain
Avery	Franklin	Mecklenburg	Tyrrell
Bladen	Gaston	Nash	Union
Brunswick	Gates	New Hanover	Vance
Buncombe	Graham	Northampton	Wake
Burke	Granville	Onslow	Warren
Cabarrus	Greene	Orange	Washington
Caldwell	Guilford	Pasquotank	Watauga
Camden	Halifax	Pender	Wayne
Carteret	Harnett	Perquimans	Wilkes
Caswell	Haywood	Person	Wilson
Catawba	Henderson	Pitt	Yadkin
Chatham	Hertford	Polk	Yancey
Cherokee	Hoke	Randolph	
Chowan	Hyde	Richmond	
Clay	Iredell	Robeson	
Cleveland	Jackson	Rockingham	
Craven	Jones	Rowan	
Cumberland	Lee	Rutherford	
Currituck	Lenoir	Sampson	
Dare	Lincoln	Scotland	
Davidson	Macon	Stanly	

Note. The survey was sent to 101 CCPTs of whom 88 responded.

Table A-3 Responding CCPTs by County Population Size
Responding CCPTs by County Population Size, 2018, (N=88)

County Size	Total Counties	Total Responding Counties	Percent
Small	54	45	83%
Medium	35	32	91%
Large	11	11	100%

Table A-4 LME/MCOs and Number of Member Counties Responding to Survey
LME/MCOs and Number of Member Counties Responding to Survey, 2018

LME/MCO		Number of Member Counties	Total Responding Counties	Percent
Alliance Behavioral Healthcare		4	4	100%
Cardinal Innovations Healthcare Solutions		20	19	95%
Eastpointe		11	10	91%
Partners Behavioral Health Management		8	8	100%
Sandhills Center		9	6	66%
Trillium Health Resources		25	20	80%
Vaya Health		23	21	91%
Total	7	100	88[a]	

Note. Member counties affiliated with a Local Management Entity (LME)/Managed Care Organization (MCO), as of March 24, 2018. See https://www.ncdhhs.gov/providers/lme-mco-directory

Table A-5 Organization of CCPTs and Child Fatality Prevention Teams (CFPTs) in Counties

Organization of CCPTs and Child Fatality Prevention Team (CFPTs) in Counties, 2018, (N=88)

CCPT/CFPT Organization	Number of Counties	Percent
Separate CCPT and CFPT	14	15%
Combined CCPT and CFPT	77	83%
Other	1	1%

Appendix B: Cross-Year Comparisons

Table B-1 Child Maltreatment and Maltreatment Fatalities by Year

Year	Range of Notifications	Total Notifications	Total Cases Reviewed	Most Common Type of Review
2015	0-9 (F)	39 (F)	617	Combined CCPT and Child Fatality Prevention Team
2016	0-24 (F)	109 (F)	443	Combined CCPT and Child Fatality Prevention Team
2017	0-9 (F)	84 (F)	415	Combined CCPT and Child Fatality Prevention Team
2018	0-15 (F)	105 (F)	450	Combined CCPT and Child Fatality Prevention Team and intensive state child fatality review conducted by NC DSS

Note: Total reviews does not mean just maltreatment fatalities. F = specific to child maltreatment fatalities

Table B-2 Two Most Common Selection Criteria for Cases Reviewed by Year

Year	Selection Criteria 1	Number of CCPTs (%)	Selection Criteria 2	Number of CCPTs (%)
2015 (*n*=73)	Active Case	64 (87%)	Multiple Agencies Involved	49 (67%)
2016 (*n*=64)	Active Case	47 (72%)	Multiple Agencies Involved	41 (63%)
2017 (*n*=63)	Active Case	53 (84%)	Child Safety	44 (70%)
2018 (*n*=88)	Active Case	48 (55%)	Multiple Agencies Involved	38 (44%)

Table B-3 Type of Information Used by CCPTs for Reviewing Cases by Year

Type of Information	2015 (*n*=73)	2016 (*n*=65)	2017 (*n*=62)	2018 (*n*=88)
Reports from Members and/or Case Managers	71 (97%)	60 (92%)	61 (98%)	57 (65%)
Case Files	60 (82%)	49 (75%)	52 (85%)	56 (64%)
Information on Procedures and Protocols of Involved Agencies	44 (60%)	38 (58%)	39 (63%)	34 (39%)
Child and Family Team Meeting Documentation	28 (38%)	21 (32%)	27 (44%)	21 (24%)
Medical Examiner's Report	24 (33%)	18 (28%)	14 (23%)	21 (24%)
Individualized Education Plan	18 (25%)	16 (25%)	12 (19%)	6 (7%)
Other	8 (11%)	6 (9%)	8 (13%)	9 (10%)

Table B-4 Type of Information Used by CCPTs and Combined CCPT/CFPTs for Reviewing Cases by Year

	2017		2018	
Type of Information	Combined (*n*=61)	Separate (*n*= 16)	Combined (*n*=72)	Separate (*n*=13)
Reports from Members and/or Case Managers	45 (74%)	15 (94%)	45 (63%)	10 (77%)
Case Files	37 (61%)	14 (88%)	47 (65%)	7 (54%)
Information on Procedures and Protocols of Involved Agencies	29 (46%)	9 (56%)	25 (35%)	7 (54%)
Child and Family Team Meeting Documentation	20 (33%)	6 (38%)	18 (25%)	3 (23%)
Medical Examiner's Report	13 (21%)	1 (6%)	19 (26%)	1 (7%)
Individualized Education Plan	9 (15%)	3 (19%)	5 (7%)	1 (7%)
Other	5 (8%)	1 (6%)	8 (11%)	0 (0%)

Table B-5 Organization of CCPTs and Child Fatality Prevention Teams (CFPTs) by Year

CCPT/CFPT Organization	2014 (*n*=71)	2015 (*n*=87)	2016 (*n*=86)	2017 (*n*=80)	2018 (*n*=88)
Separate CCPT and CFPT	18 (25%)	23 (26%)	17 (20%)	17 (21%)	14 (15%)
Combined CCPT and CFPT	53 (75%)	63 (72%)	66 (77%)	62 (78%)	77 (83%)
Other	0 (0%)	1 (1%)	3 (3%)	1 (1%)	1 (1%)

Note: Number of counties (percent)

Table B-6 Mandated CCPT and CCPT/CFPT Members and Mean Rate and Rank of Participation, 2017 and 2018

	2017 Average (Rank)		2018 Average (Rank)	
Mandated Member	Combined (*n*=61)	Separate (*n*=16)	Combined (*n* = 73)	Separate (*n*=13)
DSS Director	3.17 (4)	2.38 (9)	3.25 (4)	3.69 (7)
DSS Staff	3.90 (1)	3.75 (1)	3.88 (1)	4.54 (1)
Law Enforcement	2.82 (8)	2.53 (8)	2.77 (7)	3.85 (6)
District Attorney	1.93 (11)	2.31 (10)	1.70 (13)	2.92 (10)
Community Action Agency	2.83 (7)	3.00 (6)	2.66 (8)	3.46 (9)
School Superintendent	2.40 (9)	2.69 (7)	2.36 (9)	3.54 (8)
County Board of Social Services	2.35 (10)	2.19 (11)	2.24 (11)	2.85 (11)
Mental Health Professional	3.57 (2)	3.50 (2)	3.30 (3)	4.46 (2)
Guardian ad Litem	3.10 (6)	3.00 (5)	3.03 (6)	3.92 (4)
Public Health Director	3.17 (5)	3.06 (3)	3.17 (5)	3.92 (3)
Health Care Provider	3.23 (3)	3.00 (4)	3.37 (2)	3.85 (5)

District Court Judge	.92 (16)
County Medical Examiner	1.47 (14)
EMS Representative	2.21 (12)
Local Child Care or Head Start Rep	2.29 (10)
Parent of Child Fatality Victim	1.06 (15)

Table B-7 Total County Participation by Year

County	2014 (*N*=71)	2015 (*N*=87)	2016 (*N*=86)	2017 (*N*=81)	2018 (*N*=88)
Alamance	x	x	x	x	x
Alexander		x			x
Alleghany	x	x	x	x	x
Anson		x	x	x	
Ashe		x			
Avery	x	x	x	x	x
Beaufort	x				
Bertie	x	x		x	
Bladen	x	x	x	x	x
Brunswick	x	x	x	x	x
Buncombe	x	x	x	x	x
Burke	x	x	x	x	x
Cabarrus	x	x	x	x	x
Caldwell		x	x		x
Camden	x	x	x	x	x
Carteret		x	x	x	x
Caswell	x	x	x	x	x
Catawba	x	x	x	x	x
Chatham	x	x	x	x	x
Cherokee			x	x	x
Chowan	x	x	x	x	x
Clay	x	x	x	x	x
Cleveland		x	x	x	x
Columbus	x	x	x	x	
Craven	x	x	x	x	x
Cumberland	x	x	x	x	x
Currituck	x	x	x		x
Dare	x	x	x	x	x
Davidson	x	x	x	x	x
Davie	x	x			
Duplin	x	x			
Durham			x	x	x
Eastern Band of Cherokee Nation (Qualla Boundary)				x	
Edgecombe	x	x	x	x	x

FORSYTH		x	x		x
FRANKLIN	x	x		x	x
GASTON		x	x	x	x
GATES	x	x	x	x	x
GRAHAM		x	x	x	x
GRANVILLE			x		x
GREENE			x		x
GUILFORD	x	x	x	x	x
HALIFAX	x	x	x	x	x
HARNETT	x	x	x	x	x
HAYWOOD		x	x	x	x
HENDERSON	x	x	x	x	x
HERTFORD	x	x	x	x	x
HOKE	x	x	x	x	x
HYDE	x	x	x	x	x
IREDELL	x	x	x	x	x
JACKSON	x	x	x	x	x
JOHNSTON	x	x	x	x	
JONES	x		x		x
LEE		x	x	x	x
LENOIR	x	x	x	x	x
LINCOLN	x	x	x	x	x
MACON	x	x	x	x	x
MADISON	x			x	x
MARTIN	x	x	x	x	x
MCDOWELL			x		x
MECKLENBURG		x	x	x	x
MITCHELL	x	x	x	x	
MONTGOMERY	x	x	x	x	
MOORE		x			
NASH	x	x	x	x	x
NEW HANOVER	x	x	x	x	x
NORTHAMPTON		x	x	x	x
ONSLOW	x	x	x	x	x
ORANGE	x	x	x	x	x
PAMLICO		x		x	
PASQUOTANK	x	x	x	x	x
PENDER	x	x	x		x
PERQUIMANS		x			x
PERSON	x	x	x	x	x
PITT			x	x	x
POLK	x	x	x	x	x
RANDOLPH	x	x	x	x	x

RICHMOND	x	x	x	x	x
ROBESON	x	x	x	x	x
ROCKINGHAM	x	x	x	x	x
ROWAN	x	x	x		x
RUTHERFORD	x	x	x	x	x
SAMPSON	x	x	x	x	x
SCOTLAND		x	x	x	x
STANLY	x	x	x	x	x
STOKES	x	x	x	x	x
SURRY		x	x	x	x
SWAIN	x	x	x		x
TRANSYLVANIA					
TYRRELL			x	x	x
UNION		x	x	x	x
VANCE	x	x	x	x	x
WAKE		x	x	x	x
WARREN	x	x	x		x
WASHINGTON				x	x
WATAUGA	x	x	x	x	x
WAYNE	x	x	x	x	x
WILKES	x		x	x	x
WILSON	x	x	x	x	x
YADKIN	x	x	x	x	x
YANCEY	x	x			x

Table B-8 Small County Participation by Year

County	2014	2015	2016	2017	2018
Respondents (%)	36 (71%)	42 (82%)	40 (78%)	38 (78%)	45 (83%)
Alexander		x			x
Alleghany	x	x	x	x	x
Anson		x	x	x	
Ashe		x			
Avery	x	x	x	x	x
Beaufort	x				
Bertie	x	x		x	
Bladen	x	x	x	x	x
Camden	x	x	x	x	x
Caswell	x	x	x	x	x
Chatham	x	x	x	x	x
Cherokee			x	x	x
Chowan	x	x	x	x	x
Clay	x	x	x	x	x
Currituck	x	x	x		x
Dare	x	x	x	x	x
Davie	x	x			
Gates	x	x	x	x	x
Graham		x	x	x	x
Granville			x		x
Greene			x		x
Hertford	x	x	x	x	x
Hoke	x	x	x	x	x
Hyde	x	x	x	x	x
Jackson	x	x	x	x	x
Jones	x		x		x
Lee		x	x	x	x
Lenoir	x	x	x	x	x
Lincoln	x	x	x	x	x
Macon	x	x	x	x	x
Madison	x			x	x
Martin	x	x	x	x	x
McDowell			x		X
Mitchell	x	x	x	x	
Montgomery	x	x	x	x	
Northampton		x	x	x	x
Pamlico		x		x	
Pasquotank	x	x	x	x	x
Pender	x	x	x		x

PERQUIMANS		x			x
PERSON	x	x	x	x	x
POLK	x	x	x	x	x
RICHMOND	x	x	x	x	x
SCOTLAND		x	x	x	x
STANLY	x	x	x	x	x
STOKES	x	x	x	x	x
SWAIN	x	x	x		x
TRANSYLVANIA					
TYRRELL			x	x	x
WARREN	x	x	x		x
WASHINGTON				x	x
WATAUGA	x	x	x	x	x
YADKIN	x	x	x	x	x
YANCEY	x	x			x

Note: Distribution of county size has changed over this time period

Table B-9 Medium County Participation by Year

County	2014	2015	2016	2017	2018
Respondents (%)	30 (77%)	36 (92%)	36 (92%)	34 (87%)	32 (91%)
Alamance	x	x	x	x	x
Brunswick	x	x	x	x	x
Burke	x	x	x	x	x
Cabarrus	x	x	x	x	x
Caldwell		x	x		x
Carteret		x	x	x	x
Cleveland		x	x	x	x
Columbus	x	x	x	x	
Craven	x	x	x	x	x
Davidson	x	x	x	x	x
Duplin	x	x			
Edgecombe	x	x	x	x	x
Franklin	x	x		x	x
Halifax	x	x	x	x	x
Harnett	x	x	x	x	x
Haywood		x	x	x	x
Henderson	x	x	x	x	x
Iredell	x	x	x	x	x
Johnston	x	x	x	x	
Moore		x			
Nash	x	x	x	x	x
Onslow	x	x	x	x	x
Orange	x	x	x	x	x
Pitt			x	x	x
Randolph	x	x	x	x	x
Rockingham	x	x	x	x	x
Rowan	x	x	x		x
Rutherford	x	x	x	x	x
Sampson	x	x	x	x	x
Surry		x	x	x	x
Union		x	x	x	x
Vance	x	x	x	x	x
Wayne	x	x	x	x	x
Wilkes	x		x	x	x
Wilson	x	x	x	x	x

Note: Distribution of county size has changed over this time period

Table B-10 Large County Participation by Year

County	2014	2015	2016	2017	2018
Respondents (%)	5 (50%)	9 (90%)	10 (100%)	8 (80%)	11 (100%)
Buncombe	x	x	x	x	x
Catawba	x	x	x	x	x
Cumberland	x	x	x	x	x
Durham			x	x	x
Forsyth		x	x		x
Gaston		x	x	x	x
Guilford	x	x	x	x	x
Mecklenburg		x	x	x	x
New Hanover	x	x	x	x	x
Robeson	x	x	x	x	x
Wake		x	x	x	x

Note: Distribution of county size has changed over this time period

Appendix C: Copy of 2018 Survey

2018 Survey North Carolina Community Child Protection Teams Advisory Board

The NC CCPT Advisory Board is asking that all Community Child Protection Teams (CCPTs) in North Carolina complete this 2018 survey. The NC CCPT Advisory Board is responsible for conducting an end-of-year survey of local CCPTs and preparing a report to the North Carolina Division of Social Services (DSS). In the report, the information provided by the local CCPTs is aggregated without identifying individual team responses and the NC CCPT Advisory Board makes recommendations on how to improve public child welfare. DSS then writes a response to the report.

The survey results assist local teams in preparing their annual reports to their county commissioners or tribal council and to DSS. You can choose whether to complete the survey and can decide which questions to answer. The one exception is that local teams will be asked to provide the name of their county or Qualla Boundary. This makes it possible to track which CCPTs completed the survey and to acknowledge the specific local CCPT in the annual report.

The survey responses are transmitted directly to the researcher, Dr. Sarah Desmarais, at North Carolina State University. This means that survey responses are NOT transmitted to DSS or to the NC CCPT Advisory Board. Dr. Desmarais and the other members of the research team (Dr. Joan Pennell, Dr. Jason Coupet, Emily Lefebvre, Krista Kenney, and Dr. Samantha Cacace) will respect the confidentiality of local CCPTs and will NOT link individual responses to local CCPTs. De-identified findings may also be included in presentations, trainings, and publications.

Based on the 2017 CCPT survey data, the Advisory Board made four recommendations to DSS:

1. Ensure that children, youth, and families have the mental health services required for promoting child safety, child permanency, and child and family wellbeing
2. Strengthen the Capacity of Local CCPTs to Work with Social Services in Improving Child Welfare Services
3. Establish the NC Citizen Review Panel (CRP)/CCPT Advisory Board as the state body responsible for synthesizing and advocating for the local CCPT experiences and recommendations, identifying areas for child abuse prevention planning and improvements in the child welfare system, and serving as an asset to NC DSS in improving child welfare services
4. Engage in planning on the long-term structure and processes for citizen review panels (CRPs) in the state

This year's survey seeks guidance on how to put these recommendations into action at the local and state levels.

What are some general things you should know about research studies?
You are being asked to take part in a research study. Your participation in this study is voluntary. You have the right to be a part of this study, to choose not to participate or to stop participating at any time without penalty. The purpose of research studies is to gain a better

understanding of a certain topic or issue. You are not guaranteed any personal benefits from being in a study. Research studies also may pose risks to those that participate. In this consent form you will find specific details about the research in which you are being asked to participate. If you do not understand something in this form it is your right to ask the researcher for clarification or more information. A copy of this consent form will be provided to you. If at any time you have questions about your participation, do not hesitate to contact the researcher named above.

What is the purpose of this study?
This survey assists local CCPTs in preparing the annual reports to their county commissioners or tribal council and to the NC Division of Social Services. The North Carolina CCPT Advisory Board uses the survey results to prepare recommendations to the North Carolina Division of Social Services on improving public child welfare.

What will happen if you take part in the study?
If you agree to participate in this study, you will be asked to complete and submit the online survey. Filling out the survey will take about 20 minutes. In preparation for completing the survey, it is recommended that the local CCPT Chair meet with the team to discuss what responses to provide to the survey questions.

Risks
The local CCPTs are asked to identify by name their county or Qualla Boundary, and the responding CCPTs are listed in the end-of-year CCPT report that is shared with state and federal authorities and posted on a public website. In addition, the results may be shared in presentations, trainings, and publications. The responses of the local CCPT may identify that they made a particular answer. This risk is minimized because the individual CCPT's survey responses are transmitted directly to the researcher, Dr. Sarah Desmarais, and are not viewed by the NC CCPT Advisory Board or by DSS. Before reporting the results, the researcher will combine responses and not link them to a specific CCPT.

Benefits
While you will not directly benefit from participating, your CCPT has the opportunity to contribute to improving public child welfare and protecting children from maltreatment.

Confidentiality
The information in the study records will be kept confidential to the full extent allowed by law. Data will be stored securely in a locked filing cabinet or under password protection. No reference will be made in oral or written reports that link your CCPT to specific survey responses.

Compensation
You will not receive anything for participating.

What if you have questions about this study?
If you have questions at any time about the study or the procedures, you may contact the researcher, Dr. Sarah Desmarais, at Center for Family and Community Engagement,

North Carolina State University, C.B. 8622, Raleigh, NC 27695-8622 or 919-513-0008.

What if you have questions about your rights as a research participant? If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Jennie Ofstein, Regulatory Compliance Administrator at irbdirector@ncsu or by phone at 1-919-515-4514.

Consent To Participate

"I have read and understand the above information. I have received a copy of this form. I agree to participate in this study with the understanding that I may choose not to participate or to stop participating at any time without penalty or loss of benefits to which I am otherwise entitled."

Yes, you can now proceed to the next page.
No, please contact Melanie Meeks at the NC Division of Social Services for technical assistance on completing the survey: email Melanie.Meeks@dhhs.nc.gov. Once your questions are answered and you wish to take the survey, email ccpt_survey@ncsu.edu to receive a new link to the survey.

Select your CCPT from the list below.

- Alamance
- Alexander
- Allegheny
- Anson
- Ashe
- Avery
- Beaufort
- Bertie
- Bladen
- Brunswick
- Buncombe
- Burke
- Cabarrus
- Caldwell
- Camden
- Carteret
- Caswell
- Catawba
- Chatham
- Cherokee
- Chowan
- Clay
- Cleveland
- Columbus
- Craven
- Cumberland
- Currituck
- Dare
- Davidson

- Davie
- Duplin
- Durham
- Eastern Band of Cherokee Nation (Qualla Boundary)
- Edgecombe
- Forsyth
- Franklin
- Gaston
- Gates
- Graham
- Granville
- Greene
- Guilford
- Halifax
- Harnett
- Haywood
- Henderson
- Hertford
- Hoke
- Hyde
- Iredell
- Jackson
- Johnston
- Jones
- Lee
- Lenoir
- Lincoln
- Macon
- Madison
- Martin
- McDowell
- Mecklenburg
- Mitchell
- Montgomery
- Moore
- Nash
- New Hanover
- Northampton
- Onslow
- Orange
- Pamlico
- Pasquotank
- Pender
- Perquimans
- Person
- Pitt
- Polk
- Randolph
- Richmond
- Robeson
- Rockingham

- Rowan
- Rutherford
- Sampson
- Scotland
- Stanly
- Stokes
- Surry
- Swain
- Transylvania
- Tyrrell
- Union
- Vance
- Wake
- Warren
- Washington
- Watauga
- Wayne
- Wilkes
- Wilson
- Yadkin
- Yancey

Who completed this survey? (Please do not provide any identifying information)
- The CCPT chair
- A designee of the CCPT chair
- The CCPT team as a whole
- A subgroup of the CCPT team
- Other _____

By state statute all counties are expected to have a CCPT. Some CCPTs are well established while others are just getting started or are starting up again.

Which of the following statements best characterizes your CCPT?
- Our team is not operating at all.
- Our team was not operating, but we recently reorganized
- Our team recently reorganized, but have not had any regular meetings
- We are an established team that does not meet regularly
- Our team recently reorganized and are having regular meetings
- We are an established team that meets regularly.
- Other _____

Add question. How often does your CCPT meet as a full team?
- Annually
- Biannually
- Quarterly
- Bimonthly
- Monthly
- Other

Q How often do subcommittees within your CCPT meet?

- "We do not have subcommittees"
- Annually
- Biannually
- Quarterly
- Bimonthly
- Monthly
- Other

Some CCPTs combine their CCPT and Child Fatality Prevention Team (CFPT).

Which of the following applies to your CCPT?

- Separate CCPT and CFPT
- Combined CCPT and CFPT
- Other _____

CCPTs have members mandated by General Statute 7B-1406.

In 2018, how frequently did the following mandated members participate in your CCPT?

	Never	Rarely	Occasionally	Frequently	Very Frequently
DSS Director	○	○	○	○	○
DSS Staff	○	○	○	○	○
Law Enforcement	○	○	○	○	○
District Attorney	○	○	○	○	○
Community Action Agency	○	○	○	○	○
School Superintendent	○	○	○	○	○
County Board of Social Services	○	○	○	○	○
Mental Health Professional	○	○	○	○	○
Guardian ad Litem	○	○	○	○	○
Public Health Director	○	○	○	○	○
Health Care Provider	○	○	○	○	○

Only to be shown to those counties who indicated a combined CCPT/CFPT.
In 2018, how frequently did the following mandated members participate in your CCPT?

	Never	Rarely	Occasionally	Frequently	Very Frequently
DSS Director	○	○	○	○	○
DSS Staff	○	○	○	○	○
Law Enforcement	○	○	○	○	○
District Attorney	○	○	○	○	○

Community Action Agency	○	○	○	○	○
School Superintendent	○	○	○	○	○
County Board of Social Services	○	○	○	○	○
Mental Health Professional	○	○	○	○	○
Guardian ad Litem	○	○	○	○	○
Public Health Director	○	○	○	○	○
Health Care Provider	○	○	○	○	○
District Court Judge	○	○	○	○	○
County Medical Examiner	○	○	○	○	○
Emergency Medical Services (EMS) Representative	○	○	○	○	○
Local Child Care Facility/Head Start Representative	○	○	○	○	○
Parent of Child Fatality Victim	○	○	○	○	○

Are there statutorily required team members that you feel might be unnecessary?

- ○ Yes
- ○ No

If you answered "yes" to the previous question, select who those mandated members are.

- ○ DSS Director
- ○ DSS Staff
- ○ Law Enforcement
- ○ District Attorney

- Community Action Agency
- School Superintendent
- County Board of Social Services
- Mental Health Professional
- Guardian ad Litem
- Public Health Director
- Health Care Provider
- District Court Judge
- County Medical Examiner (EMS) Representative
- Local Child Care Facility or Head Start Representative
- Parent of Child Fatality Victim
- (the following are only applicable if you indicated a combined CCPT/CFPT)

Please explain why you feel they might be unnecessary.

_____

Besides mandated CCPT members, boards of county commissioners can appoint five additional members.

In 2018, how many additional members took part in your CCPT to include organizations, family and youth partners?

If zero, type 0. _____.

List the organization that additional members represent.

Member 1 _____
Member 2 _____
Member 3 _____
Member 4 _____
Member 5 _____

How well does your CCPT prepare for meeting?

Not at all	Marginally	Moderately	Well	Very well
○	○	○	○	○

How well does your CCPT share information during meets?

Not at all	Marginally	Moderately	Well	Very well
○	○	○	○	○

How well does your CCPT share other resources?

Not at all	Marginally	Moderately	Well	Very well
○	○	○	○	○

Other than information, please list other resources shared among CCPT members and how well they are shared (e.g., financial resources, grant opportunities, ect.)

	Not at all	Marginally	Moderately	Well	Very well
Resource 1	○	○	○	○	○
Resource 2	○	○	○	○	○
Resource 3	○	○	○	○	○

How well has your CCPT effected changes in your community?

Not at all	Marginally	Moderately	Well	Very well
○	○	○	○	○

In 2018, did <u>family or youth partners</u> serve as members of your CCPT?

- ○ Yes
- ○ No

In 2018, how frequently did family or youth partners participate in your CCPT?

	Never	Rarely	Occasionally	Frequently	Very Frequently
Youth partner	○	○	○	○	○
Biological parent	○	○	○	○	○
Kinship caregiver	○	○	○	○	○
Guardian	○	○	○	○	○
Foster parent	○	○	○	○	○
Adoptive parent	○	○	○	○	○
Other	○	○	○	○	○

List strategies that your CCPT has successfully used to engage family and youth partners on your team.

- ○ Strategy 1 _____
- ○ Strategy 2 _____
- ○ Strategy 3 _____

There are many reasons why some family or youth partners might not participate in a CCPT. For example, family or youth partners may have limited transportation or feel apprehensive about taking part.

List reasons that prevent some family or youth partners from taking part in your CCPT.

- ○ Reason 1 _____
- ○ Reason 2 _____
- ○ Reason 3 _____

There are many reasons why a CCPT might have difficulty in keeping some family or youth partners engaged with their team. For example, CCPTs may not know how to recruit family or youth partners or support their involvement.

List reasons that prevent your CCPT from engaging some family or youth partners in your CCPT.

- ○ Reason 1 _____
- ○ Reason 2 _____
- ○ Reason 3 _____

During 2018, did your CCPT partner with other organizations in the community to create programs or inform policy to meet an unmet community need?

- Yes
- No

If yes, describe the most important of these initiatives to meet a community need.

_____
_____

Are you aware of any other county-level collaboration your CCPT is involved in?

- Yes
- No

If yes, describe the purpose of these collaborations.

- Collaboration 1 _____
- Collaboration 2 _____
- Collaboration 3 _____

From January through December 2018, how many notifications of child maltreatment fatalities were made by your local DSS?

If zero, type in 0. _____

Child maltreatment fatalities are cases where the death was caused by abuse, neglect, or dependency and where the family had received Department of Social Services (DSS) child welfare services within 12 months of the child's death.

Of the child maltreatment fatalities that you were notified of by your local DSS, how many received the following types of review?

A case may have more than one type of review. This means that the total for all types of case reviews may be greater than your number of child maltreatment fatalities.

Combined CCPT and Child Fatality Prevention Team conducted case review	_____
CCPT conducted case review	_____
Number of child maltreatment fatality cases that had a review conducted	_____
Child Fatality Prevention Team conducted case review	_____
NC DSS conducted (intensive) state child fatality review	_____

What is the total number of cases of child maltreatment reviewed by your CCPT between January and December 2018?

Include here both child maltreatment fatalities and other forms of child maltreatment**.**

Number of cases reviewed _____
No cases reviewed _____

If you are a combined CCPT and Child Fatality Prevention Team, this CCPT survey report should only

include child fatality case reviews where the death was caused by abuse, neglect, or dependency and where the family had received DSS child welfare services within 12 months of the child's death. Any other child fatality cases that were reviewed by a combined team should be included on the Child Fatality Prevention Team report.

Which of the following criteria did your CCPT use in 2018 for selecting cases for review? Check all that apply. Please write in other criteria that you used.

- o Child Maltreatment Fatality
- o Court Involved
- o Multiple Agencies Involved
- o Repeat Maltreatment
- o Active Case
- o Closed Case
- o Stuck Case
- o Child Safety
- o Child Permanency
- o Child and Family Well-being
- o Parent Opioid Use
- o Other 1 _____
- o Other 2 _____

Which of the following contributory factors to children being in need of protection did you use in 2018 for selecting cases for review? Check all that apply

- o Caretaker - Alcohol Abuse
- o Caretaker - Drug Abuse
- o Caretaker - Mental Retardation
- o Caretaker - Emotionally Disturbed
- o Caretaker - Visually or Hearing Impaired
- o Caretaker - Other Medical Condition
- o Caretaker - Learning Disability
- o Caretaker - Lack of Child Development Knowledge
- o Child - Alcohol Problem
- o Child - Drug Problem
- o Child - Mental Retardation
- o Child - Emotionally Disturbed
- o Child - Visually or Hearing Impaired
- o Child - Physically Disabled
- o Child - Behavior Problem
- o Child - Learning Disability
- o Child - Other Medical Condition
- o Household - Domestic Violence
- o Household - Inadequate Housing
- o Household - Financial Problem
- o Household - Public Assistance

Which of the following types of information did you use in reviewing cases? Check all that apply

- o Reports from Members and/or Case Managers
- o Information on Procedures and Protocols of Involved Agencies
- o Case Files
- o Medical Examiner's Report

- o Child and Family Team Meeting Documentation
- o Individualized Education Plan
- o Other 1 _____
- o Other 2 _____

What would help your CCPT better carry out case reviews?

How many of the cases reviewed in 2018 were identified as having children and/or youth who needed <u>access</u> to the following services

Mental Health (MH) _____

Developmental Disabilities (DD) _____

Substance Abuse (SA) _____

Domestic Violence (DV) _____

How many cases of substance affected newborns did you review in 2018? _____
How many of these had a Plan of Safe Care? _____

How many of the cases reviewed in 2018 were identified as having parents or other caregivers who needed <u>access</u> to the following services:

Mental Health (MH) _____

Developmental Disabilities (DD) _____

Substance Abuse (SA) _____

Domestic Violence (DV) _____

In 2018, which of the following limitations prevented children, youth, and their parents or other caregivers from accessing needed MH/DD/SA/DV services. Check all that apply.

- o Limited services or no available services
- o Limited services for youth with dual diagnosis of mental health and substance use issues
- o Limited services or youth with dual diagnosis of mental health and developmental disabilities
- o Limited services for youth with dual diagnosis of mental health and domestic violence
- o Limited transportation to services
- o Limited community knowledge about available services
- o Limited number of experienced child and family team (CFT) meeting facilitators
- o Limited attendance of MH/DD/SA/DV providers at CFTs
- o Other 1 _____
- o Other 2 _____

Based on your 2018 case reviews, what were your team's top three recommendations for improving child welfare services?

- o Recommendation 1 _____
- o Recommendation 2 _____
- o Recommendation 3 _____

Did your CCPT set local objectives based on identified improvement needs to complete over 2018?

- ○ Yes
- ○ No

List your CCPT's top three local objectives based on identified improvement needs for 2018. Then rate how successful your CCPT was in achieving these objectives.

	Not at all (0)	Slightly (1)	Moderately (2)	Mostly (3)	Completely (4)	Too soon to rate (5)
Objective 1 _____	○	○	○	○	○	○
Objective 2 _____	○	○	○	○	○	○
Objective 3 _____	○	○	○	○	○	○

What helped you achieve your local objectives to meet identified improvement needs?

Objective 1_____
Objective 2_____
Objective 3_____

What can the state do to help you achieve your local objectives to meet identified improvement needs?

Objective 1_____
Objective 2_____
Objective 3_____

What challenges did you face in achieving your local objectives to meet identified improvement needs?

Objective 1_____
Objective 2_____
Objective 3_____

What further support would help your team put your recommendations into action?_____
_____

Once you continue to the next page, you will be directed to a copy of your completed responses, and you may print the screen to have a record of your responses. Once you have reached the "completed responses" page, you have successfully submitted your 2018 CCPT Survey.

Thank you for taking the time to complete the 2018 CCPT Survey, your responses are appreciated. If you have questions about the survey and keeping a copy for your records, please contact ccpt_survey@ncsu.edu

Thank you for your participation!

The NC Community Child Protection Team Advisory Board

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