2019 End of Year Report

NORTH CAROLINA COMMUNITY CHILD PROTECTION TEAM

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 comprehensive child welfare reform with a focus on both prevention and treatment.

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, Dr. Emily Smith, and Dr. Joan Pennell with Dr. Sam Cacace 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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*Denotes voting member. "Non-voting members shall have no vote in the proceedings of the Board but are expected to participate in discussions pertaining to the business of the Board. They shall not hold office or serve as chairpersons of any committee."

I. Executive Summary

Community Child Protection Teams (CCPTs) and Citizen Review Panels (CRPs)

This year, the North Carolina Community Child Protection Team (CCPTs)/Citizen Review Panels (CRPs) Advisory Board took initial steps toward moving the work of CCPTs into a true CRP model. The Advisory Board identified two CRPs and is planning a third CRP. To reflect this change, the Advisory Board inserted "CRP" into its name. The panels will assist the state in more fully implementing CRP requirements of the federal Child Abuse Prevention and Treatment Act (CAPTA). The state's CRP system is intended to build upon the accomplishments of Community Child Protection Teams (CCPTs) in 100 counties and the Qualla Boundary.

In designing this model, the Advisory Board considered how the CRP model could be achieved given the state and federal structures and climate. In particular, the Advisory Board was aware that proposed state legislation could affect this work. This legislation was introduced as House Bill 825, and the language from House Bill 825 was then incorporated into the comprehensive budget bill, House Bill 966, which has not become law. This legislation directs the North Carolina Department of Health and Human Services (NCDHHS) to make a plan to consolidate the functions of the current four types of child death review teams (including local CCPTs and Child Fatality Prevention Teams) into local single or multi-county teams. It also directs NCDHHS to make a plan to discontinue the practice of using CCPTs as CRPs and to create a more effective framework for meeting requirements for federal CRPs. Although the legislation has not yet become law, DHHS is planning for these and other future changes as a means of strengthening the statewide Child Fatality Prevention System. This work being done by DHHS may impact the structure of CRPs in the future.

At the local level, CCPTs will continue to strengthen collaborations to advance the protection of children and youth and support of their families. The legislative authority for CCPTs derives from G.S. 7B-1406, and CCPTs are affected by other provisions in Article 14 of the North Carolina Juvenile Code that addresses the statewide Child Fatality Prevention System. The legislation on CCPTs became effective in 1993. North Carolina, since 1997, has identified CCPTs in federal reports as the state's mechanism for meeting the federally mandated CRP requirements under CAPTA. The federal act gives states the flexibility to use already existing entities as CRPs as long as they meet their federally mandated responsibilities. Although CCPTs technically meet the CRP requirements, North Carolina realizes that it is not meeting the full intent of the legislation.

The Advisory Board selected two practice areas for the CRPs to address: (1) Infant Plan of Safe Care and (2) Child Fatalities and Near Fatalities. In selecting these focus areas, the Board used information from prior CCPT surveys as well as federal and state developments in child welfare, including the emphasis on prevention services (e.g., mental health, substance use), early childhood, child fatalities and near fatalities, and practice improvement. As summarized in this report, similar areas of concern were expressed in the 2019 CCPT survey. We turn now to the 2019 end-of-year survey, its findings, and recommendations to improve child welfare.

II. 2019 NC CCPT Advisory Board Survey Summary

The 89 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 use 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). Over half (65%) of 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 2019 survey inquired about the following five main questions:

1. What are the barriers to team operations?
2. Who takes part in the local CCPTs, and what supports or prevents participation?
3. Which cases do local CCPTs review, and how can the review process be improved?
4. 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?
5. What are local CCPTs' objectives based on identified improvement needs, and to what extent do they achieve these objectives?
6. 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 2019 survey results, as well as those in prior years, show that mandated members varied in their level of participation. DSS staff, mental health professionals, and the Public Health Director were the most often present while the county boards of social services, community action agencies, 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*. 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 utilize. 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. **Barriers to Team Operations**

The survey asked teams to explain barriers, 38% of the 89 teams identified reasons. They were more likely to provide a reason if they characterized themselves as an established team meeting regularly. Fully operating teams, in all probability, had more opportunity to experience and, thus, identify barriers. If teams were a combined CCPT/CFPT, they also were more likely to describe barriers. Some combined CCPT/CFPTs referred to having an overwhelming number of complex cases to review and, as a result, they were unable to prioritize reviewing open child protection cases. In contrast, other teams were not receiving cases to review or the information they needed for the reviews. Commonly cited challenges to participation were scheduling meetings when all members could take part, inconsistent attendance of members with multiple demands on their time, absences of key members from the medical or legal fields, and difficulties in recruiting family partners. Some teams were adversely affected by staffing and leadership changes in key agencies. Especially disruptive factors were no funding for projects, conflict among members, unclear expectations from the state, and the magnitude of the issues that they were ill-equipped to handle locally. Going beyond explaining barriers, some teams mentioned strategies to overcome challenges such as holding meetings online or encouraging collaboration with other teams.

E. **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. Family and youth partners are not mandated CCPT members, but their inclusion is encouraged. An exception for a combined team is a parent of a deceased child as long as the parent fits the definition of a family or youth partner. Only 7% of respondents indicated that family or youth partners served on their CCPT or combined CCPT/CFPT. 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 contribution to instituting safety organized practice in a family-centered manner.

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

Only one team provided a strategy that they used to engage family and youth partners. This county identified likely family or youth partners through "word of mouth from community partners." The CCPTs and CCPT/CFPTs did not provide robust strategies for engaging family and youth partners as they have done in the past.

G. Factors Limiting the Participation of Family or Youth Partners

CCPTs detailed 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, and lack of reimbursement. 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.

H. 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, and sponsor joint trainings for service providers. Thus, through their initiatives, they demonstrated a keen understanding of the needs of families in their communities and their capacity to act on these areas of concern.

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

Last year, 37 (42%) out of the 89 responding CCPTs received between 1 and 14 notifications of child maltreatment fatality cases, for a total of 91 notifications. When asked about their type of review, the teams identified different approaches. The most common type was a review by the CCPT itself 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. This information would be helpful in planning ways to improve child maltreatment reviews in the state.

J. Child Maltreatment Case Reviews

Child maltreatment cases encompass both active cases and child fatalities where child abuse, neglect, or dependency is suspected. The survey did not ask respondents to state how many cases were active cases versus child maltreatment fatalities, a distinction to inquire about in future CCPT surveys. Over 2019, 68 (76%) of the 89 responding CCPTs reviewed cases of child maltreatment, with a total of 436 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.

a. Criteria for Selecting Cases for Review

State statute requires that CCPTs review two types of cases: active cases and child maltreatment fatalities. Most (86%) respondents selected active cases for review. Child maltreatment fatality was given as a reason for case selection by 35% of respondents. Whether local teams review all child maltreatment fatalities depends on the context (ex. if the CFPT does the review). The second most frequent criteria for selecting cases was child safety, identified by 72% 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.

State statute requires that CCPTs review two types of cases: active cases and child maltreatment fatalities. Most (86%) respondents selected active cases for review. Child maltreatment fatality was given as a reason for case selection by 35% of respondents. The second most frequent criterion for selecting cases was child safety, identified by 72% of the respondents. The teams also selected cases on the basis of factors contributing to children needing protection: The two most common were parental drug abuse (85%) and household domestic violence (68%). Selection of cases because of parental opioid use increased from 24% of respondents in 2018 to 63% in 2019. Six other factors used by over 40% of CCPTs pertained to child/youth behavior problems and other medical conditions, parent/caregiver alcohol abuse, lack of knowledge of child development, and emotional disturbance, or inadequate housing. 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. 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.

K. 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 2019 reported that children and youth needed access to substance use 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 having a dual diagnosis of mental health and substance use issues. The CCPTs commented on some family factors affecting service receipt such as citizenship and 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. As stated in previous reports, the federal funding from the Family First Prevention Services Act may be able to assist them in securing prevention services in their communities.

L. **Local CCPT Recommendations for Improving Child Welfare Services**

Local teams generated a total of 169 recommendations for improving child welfare services, and most gave more than one recommendation. The CCPTs' recommendations pertained to nine main strategies to address local and state issues. (1) Protecting infants and young children in regards to safe sleeping and substance-affected infants continued to be prominent in their recommendations. (2) As in prior years, they especially recognized the need for far more and improved substance use, mental health, and domestic violence services and (3) increasing the accessibility of these services whether through providing transportation, covering the uninsured, or offering services geared to Spanish-speaking populations. (4) They recognized that the need to raise public awareness of child maltreatment and particularly to educate youth about suicide, mental health, drugs, and other issues. (5) Their efforts would be stymied unless cross-system collaboration was enhanced through steps such as better reporting by health providers and an alternative being provided for forensic interviewing of children when the Child Advocacy Center interviewer was not available. (6) Given high turnover rates among child welfare staff, they pushed for enhanced training, recruitment, and retention. (7) They urged that the case management system be timely and accessible. (8) Many of their recommendations required policy clarifications or revisions. For instance, teams would continue to lack crucial planning information without changing laws on sharing information or expanding the meaning of caretakers. (9) They wanted local teams to have funding to implement public education and technical assistance and training to develop a better informed team.

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

Local objectives reflected the teams' recommendations, based on their case reviews, on improving child welfare services. The objectives that they set focused on matters that they could address in their communities rather than on state policy or funding changes. Their success in achieving their objectives varied extensively, with higher self-ratings mainly for concrete, time-limited, and measurable steps. They had slower momentum putting in place more, improved, and accessible services that relied on county, state, or national developments. An area of substantial progress was improving their team functioning. Many found that a partnering approach helped them achieve their objectives, and many wanted further support from the state. The state assistance that they were seeking related mainly to funding, notification of grant opportunities, clearer policy, training, access to drug records, support for local planning efforts, and interceding with other state players (e.g., courts). In moving forward, they met numerous challenges including changes in county leadership and partnering organizations. At the end of the survey, they made thoughtful comments on what further supports were needed that ranged from more state training to review of conflicting policies to reassessment of the role of CCPTs in a time when the state was changing its broader fatality system.

III. 2019 Recommendations

As summarized by the U.S. Children's Bureau, CRPs under CAPTA are intended to examine "the policies, procedures and practices of State and local child protection agencies" and make "recommendations to improve the CPS system at the State and local levels." In fulfilling this mandate, the NC CCPT/Citizen Review Panel Advisory Board used the extensive information and ideas from the 89 CCPT surveys, as well as earlier end-of-year CCPT reports, to formulate the first three recommendations listed below. In the 2019 survey, the CCPTs identified a range of means for supporting their work. The Advisory Board was very cognizant that supports for CCPTs are all the more necessary in sfy's 2020 and 2021 as localities grapple with the effects of the coronavirus pandemic. Hence, a separate set of two recommendations are proposed below for strengthening the work of the CCPTs.

In accordance with CAPTA, we propose the following for child protection at the state and local levels.

RECOMMENDATION 1 – IMPROVE ACCESS TO BEHAVIORAL HEALTH SERVICES OF CHILDREN, YOUTH, AND FAMILIES SERVED BY CHILD WELFARE

1. *Develop State Action Plan.* Undertake the following steps:
    a. Early in sfy 2021:
        i. Designate the NCDSS Family and Child Wellness Coordinator to facilitate the development of the action plan;
        ii. Consider whether to place development of the action plan for behavioral health access under the third CRP or some other entity and determine representatives to serve on the planning group;
        iii. Report the number of children, youth, and families requiring behavioral health services under Medicaid and compare them with numbers receiving these services whether through Medicaid or other funding streams over time;
        iv. Identify reasons why children, youth, and families served by child welfare do not receive behavioral health services; and
        v. Ensure representatives from NCDHHS, LME/MCO, MH/SU providers, Advisory Board, NC Child Welfare Family Advisory Council, and other involved bodies.
    b. In sfy 2021:
        i. Convene workgroup(s) on improving access to *MH/SU Services.*
        ii. Develop a written plan of collaboration in a memorandum of agreement that includes: goals, roles of signatories, action steps with timeline, monitoring, and reconvening in one year's time to assess progress and refine the collaboration plan.
2. *Enhance Accessibility of Services*. Explore in sfy 2021, the options to:
    a. Use telehealth to allow for physical distancing during a pandemic and afterwards and better access for rural communities, taking into account considerations such as security and privacy and availability of funding streams;
    b. Deliver services in the home, such as outpatient therapy, which can be more family friendly, as long as not prohibited by safety issues (ex., because of household domestic violence);

c. Encourage services to offer transportation resource to their program (ex., Uber, taxi, bus);
d. Increase parent access to health insurance, including in cases where children are residing outside the home; and
e. Facilitate health care of all families served by child welfare, including when the parents are undocumented.

3. *Consider New Methods of Service.* In sfy 2021:
    a. Encourage consideration by behavioral health services of new ways to treat trauma that are proving to be effective but may not be fully mainstream yet (ex., Neurofeedback, Eye Movement Desensitization and Reprocessing); and
    b. Support funding of these methods that are not currently covered by LME/MCOs.

RECOMMENDATION 2 –PROMOTE THE SAFETY OF VULNERABLE INFANTS

1. *Advance Safe Sleeping.* In sfy 2021, continue to work with the North Carolina Public Health Association (NCPHA) and partner with the UNC Center for Maternal & Infant Health to:
    a. Assess the need for safe infant sleep spaces across North Carolina; and
    b. Seek funding to provide portable cribs to families in need of this resource, combined with safe sleep education through Care Management for At-Risk Children (CMARC).
2. *Strengthen Plan of Safe Care (POSC) Approach for Substance Affected Infants.* In sfy 2021:
    a. Inform and clarify, for local Social Services and CCPTs, practices, policies, and procedures concerning POSC;
    b. Facilitate local DSSs having access to information required for making an informed POSC (ex. treatments planned and/or received by parents and infants, confidentiality issues regarding federally protected information on substance us):
    c. Request that local DSSs and CCPTs review all screened-out reports of substance affected infants;
    d. Continue to provide resources to local DSS on substance affected infants;
    e. Incentivize local DSS's to dedicate staff to manage substance affected infants in order to increase timely access to needed services; and
    f. Foster a supportive rather than penalizing approach to the parents of substance affected infants.
3. *Support the Citizen Review Panel (CRP) on POSC.* In sfy 2021, facilitate the efforts of the CRP:
    a. Designate a NCDHHS liaison to work with the panel;
    b. Ensure staffing and/or consultants with the requisite expertise in policy, research, and community outreach for the panel;
    c. Connect the panel to local, state, and national groups working on POSC;

d. Expedite the panel's access to needed materials (ex., case files, literature reviews, policy statements) for conducting their work; and
e. Assist the panel with disseminating their reports and seeking public input on the action plan.

RECOMMENDATION 3 – ENHANCE IDENTIFICATION AND PREVENTION OF CHILD MALTREATMENT FATALITIES AND NEAR FATALITIES

1. *Collaborate on Ensuring that Involved Parties in North Carolina Are Prepared for Passage of the Child Death Review Framework.* In sfy 2021:
    a. Facilitate advance notification about impending changes to Courts, Medical Examiners, Law Enforcement, Public Health, Child Welfare, Child Prevention Fatality Teams, CCPTs, and other involved parties;
    b. Clarify roles and responsibilities of different groups within the child death review framework;
    c. Encourage participation in the technical assistance and training for identification and prevention of child fatalities; and
    d. Support North Carolina's inclusion in and use of the national databank of case-specific child deaths.
2. *Ensure Accurate Reporting of Child Near Fatalities.* In sfy 2021:
    a. Operationalize the definition of near fatalities by specifying procedures for local DSSs and their communities to identify case-specific near fatalities;
    b. Set forth policies and procedures for reporting near fatalities to state DSS; and
    c. Make recommendations to local teams on identifying and reviewing child near fatalities.
3. *Identify and Address Challenges in Reporting Case Reviews.*
    a. In August 2020, provide information to the Advisory Board on the best way for the calendar-year 2020 CCPT survey to ask for the number of notifications of child maltreatment fatalities and near fatalities and for the number of reviews of active cases versus child maltreatment fatalities;
    b. In January 2021, to assist with interpreting survey results, provide the Advisory Board with the number of notifications of child maltreatment fatalities and near fatalities in the 2020 calendar year; and
    c. In sfy 2021, use the results from the 2020 survey to check and improve the state's procedures for obtaining accurate and complete reports of child maltreatment fatalities and near fatalities.
4. *Support the Citizen Review Panel (CRP) on Child Fatalities and Near Fatalities.* In sfy's 2020 and 2021, facilitate the efforts of the CRP:
    a. Designate a NCDHHS liaison to work with the panel;
    b. Ensure staffing and/or consultants with the requisite expertise in policy, research, and community outreach for the panel;
    c. Connect the panel to local, state, and national groups working on near fatalities;
    d. Expedite the panel's access to needed materials (ex., case files, literature reviews, policy statements) for conducting their work; and

e. Assist the panel with disseminating their reports and seeking public input on the action plan.

Based on the 2019 and earlier CCPT surveys, we propose the following to enhance the functioning of CCPTs.

RECOMMENDATION 4 – IMPROVE CASE REVIEWS BY CCPTS

1. *Offer Training and Technical Support on Conducting Case Reviews.* In sfy 2021:
    a. Engage participants through co-training on case reviews by community and family partners;
    b. Assist teams during CCPT coordinator's visits (in person and/or through distance means) in the following areas: defining the cases they would like to review, writing down the procedure for the local teams, and checking on and supporting their progress;
    c. Involve local teams in creating a 15-minute webinar on conducting reviews of active cases (including near fatalities) and child maltreatment fatalities, cover confidentiality requirements which are the same for all members (whether agency, community, or family), and disseminate the webinar by September 2020; and
    d. Seek participant feedback on all training and technical support, and document responses to share with the Advisory Board.
2. *Increase Local Teams' Access to Information Necessary for Complete Case Reviews.* In sfy 2021:
    a. Provide clarifications on policies regarding such matters as family reunification and definition of caretakers; and
    b. Where feasible, facilitate sharing confidential information (ex. drug use).

RECOMMENDATION 5 – SUPPORT THE CAPACITY OF LOCAL TEAMS TO CARRY OUT THEIR WORK

1. *Enlarge the Formally Required Members on Local Teams.*
    a. Encourage the state legislature in sfy 2021 to add to team membership: (1) a Juvenile Justice representative (which would parallel the membership on the NC Child Fatality Task Force in House Bill 825 and the pending state budget bill), (2) community action agencies or community non-governmental organization providing prevention-focused services (this change requires altering the language on community partners), (3) family partners (two per team) with lived experience in the child welfare system, (4) military liaison in counties with high military populations, and (5) tribal representative as nominated by the NC Commission of Indian Affairs;
    b. Seek guidance in sfy 2021 from relevant bodies on these membership expansions and the best ways to proceed with them (ex., Military Family Support Centers, NC Child Welfare Family Advisory Council); and
    c. Reference sections of this report in sfy 2021 to make the case to legislators of the reasons for formally enlarging the teams' membership.
2. *Extend, Enrich, and Make Accessible State Training of Local Teams.*

a. Beginning in sfy 2021, facilitate the CCPT Consultant's annually visiting (in person and/or distance) 50% of CCPT teams;
b. Over sfy's 2021 and 2022, use the findings in this report and further consultations with Advisory Board members and local teams to design, test, refine, format for on-demand delivery, and provide ongoing support for 12 online webinars or other learning opportunities for all 101 teams;
c. Create by October 2020 as part of the overall webinars, a 10-minute webinar on engaging the entire local team in completing the survey as a group, encourage teams to view the webinar in November 2020 and document their local procedure for a group response on the survey, and encourage teams at end of the survey completion to assess their performance by February 2021;
d. Enrich these trainings by using a co-training model of family and community partners to identify topics, examine wording and its impact on families, and deliver trainings, and ensure payment of family trainers for their work; and
e. Seek participant feedback to keep the trainings relevant to local teams.

3. *Provide Funding to Local Teams.* Beginning in sfy 2022,
    a. Allocate annual funding of $1,000 per team for operational and project support;
    b. Assist teams with understanding requirements on documenting the expenditure of the funds and assessing their local impact; and
    c. Ensure that the results of the funds are summarized and a report provided to funding sources and the Advisory Board.
4. *Ensure Local Teams Receive Supports that They Request.* Beginning in sfy 2021:
    a. Ensure requested supports such as notification of grant opportunities, informational and material support for local planning efforts (ex., brochure on safe sleeping), and interceding with other state players (ex., courts); and
    b. Document these efforts, and report on them to the Advisory Board.
5. *Foster Exchanges of CCPTs from Different Locales.* Beginning in sfy 2021,
    a. Offer cross-county summits and other forums through online means to encourage robust exchanges and creative ideas for child welfare improvements.
    b. Identify topics for these exchanges with local teams and the Advisory Board.
6. *Explore for Calendar Year 2021 CCPT Survey, Changing the Data-Collection Protocols to Permit the Researchers to Share Survey Results with Individual Teams Identified.* In sfy 2021:
    a. Review steps for moving from having de-identified data in reports to identifying the results by individual teams and providing the identifiable data to the NC CCPT/CRP Advisory Board, the Board's subcommittees (ex., CRPs), and NC DSS;
    b. Consult the Children's Committee of the NC Association of County Directors of Social Services (NCACDSS) and other pertinent bodies on these changes in survey procedure;
    c. Support inquiries to the Institutional Review Board for the Protection of Human Subjects (IRB) on moving from current procedures which only allow sharing de-identified by individual teams and about the likely timeline for receiving approval for this change; and
    d. Support using identified data to offer local CCPTs education and mutual support.

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

I. Introduction

A. Community Child Protection Teams (CCPTs) and Citizen Review Panels (CRPs)

This year, the North Carolina Community Child Protection Team (CCPTs)/Citizen Review Panels (CRPs) Advisory Board took initial steps toward moving the work of CCPTs into a true CRP model. The Advisory Board identified two CRPs and is planning a third CRP. To reflect this change, the Advisory Board inserted "CRP" into its name. The panels will assist the state in more fully implementing CRP requirements of the federal Child Abuse Prevention and Treatment Act (CAPTA). The state's CRP system is intended to build upon the accomplishments of Community Child Protection Teams (CCPTs) in 100 counties and the Qualla Boundary.

In designing this model, the Advisory Board considered how the CRP model could be realized given the state and federal structures and climate. In particular, the Advisory Board was aware that proposed state legislation could affect this work. This legislation was introduced as House Bill 825, and the language from House Bill 825 was then incorporated into the comprehensive budget bill, House Bill 966, which has not become law. This legislation directs the North Carolina Department of Health and Human Services (NCDHHS) to make a plan to consolidate the functions of the current four types of child death review teams (including local CCPTs and Child Fatality Prevention Teams) into local single or multi-county teams. It also directs NCDHHS to make a plan to discontinue the practice of using CCPTs as CRPs and to create a more effective framework for meeting requirements for federal CRPs. Although the legislation has not yet become law, DHHS is planning for these and other future changes as a means of strengthening the statewide Child Fatality Prevention System. This work being done by DHHS may impact the structure of CRPs in the future.

At the local level, CCPTs will continue to strengthen collaborations to advance the protection of children and youth and support of their families. The legislative authority for CCPTs derives from G.S. 7B-1406, and CCPTs are affected by other provisions in Article 14 of the North Carolina Juvenile Code that addresses the statewide Child Fatality Prevention System. The legislation on CCPTs became effective in 1993. North Carolina, since 1997, has identified CCPTs in federal reports as the state's mechanism for meeting the federally mandated CRP requirements under CAPTA. The federal act gives states the flexibility to use already existing entities as CRPs as long as they meet their federally mandated responsibilities. Although CCPTs

technically meet the CRP requirements, North Carolina realizes that it is not meeting the full intent of the legislation.

As specified by CAPTA, North Carolina must have at least three CRPs mandated to evaluate child protection at the system level and offer recommendations for its improvement. Within six months of receiving the recommendations, the state is required to respond in writing. At a minimum, each CRP is expected to:

- Convene on a quarterly basis;
- Have volunteers with the requisite expertise for carrying out the work;
  Ensure broad representation of the community, which may include adults who were formerly maltreated as children;
- Review cases that may include child fatalities and near fatalities;
- Access confidential information, as necessary;
- Ensure public outreach and comment; and
- Report each year on the CRP work. (Child Welfare Information Gateway)

These expectations are meant to support the state and local child welfare accountable for public child protection. A national survey of 378 panel members found that most (82.7%) agreed that their CRP "can be an effective advocate" for the public child welfare system (Miller, Collins-Camargo, Jones, & Niu, 2017, p. 356). This same survey, however, found that less than two-thirds (65.5%) agreed that "in general, CRPs have a positive impact" on the child welfare system and only a quarter (25.6%) agreed that "in general, citizens have the knowledge to evaluate" public child welfare (Miller et al., 2017, p. 356). If CRPs are to carry out their work, they need orientation, training, and support; solid partnerships with state and local child welfare; and a clear exchange of information between state CRPs and local CCPTs.

In order to build in needed supports for CRPs and CCPTs, the NC CCPT/CRP Advisory Board formally increased its meeting schedule from a quarterly to monthly basis, with a plan to schedule separate meetings for the three CRPs workgroups. The Advisory Board oversaw the statewide CCPT survey, advised the NCDSS CCPT consultant on supporting local teams, and served on statewide child welfare planning committees, such as the Child and Family Services Plan Design teams. Additionally, the Board took steps to form the CRPs.

B. **Structure and Supports for NC Citizen Review Panels**

The plan is for the Advisory Board to use the CRPs' findings, along with the CCPT survey data, to make recommendations to the state on improving child welfare practice. The Advisory Board recognizes that public child welfare is in a time of transition in North Carolina and that changes to the child welfare system may affect the design of CRPs in the future.

Over the year, the Board expanded its membership to reflect better the composition of local CCPTs and to secure additional members to inform the transition to a CRP model. Members were recruited or are being recruited from such areas as local CCPTs, county Social Services boards, family partners, public health, pharmacology, substance use, domestic violence, law, public instruction, and disabilities. In preparation, new member will receive a training

PowerPoint and an orientation manual for Board members that covers CCPT roles and responsibilities, NC legislation, and Board and CRP workgroups. The end-of-year CCPT survey and its report facilitate an exchange of information between the state-level panels and the local teams and to develop recommendations grounded on child welfare developments from across the state.

C. **Functions and Focus Areas of North Carolina Citizen Review Panels**

As noted previously, CAPTA requires North Carolina to have three CRPs, and the NC CCPT/CRP Advisory Board has already formed two panels and a third is in the planning stage. In regard to specific focus areas, the functions of the CRPs are to:

- Review policies, procedures, and practices of state and local agencies;
- As appropriate, examine specific cases to determine the extent to which state and local child welfare systems are effectively discharging their child protection responsibilities;
- Provide for public outreach and comment to assess the impact of current procedures and practices upon children and families in the community; and

Prepare an annual report on its work and recommendations for improving child welfare, and make this report available to the public. In undertaking this work, the CRPs will need access to state data and information on specific cases, and the state is expected to ensure access as necessary. The panels are not responsible for advising on specific cases. With oversight from the Advisory Board, the CRPs develop their own agenda and schedule of work.

In selecting focus areas, the Advisory Board used information from prior CCPT surveys as well as federal and state developments in child welfare, including the emphasis on prevention services (e.g., mental health, substance use), early childhood, child fatalities and near fatalities, and practice improvement. As summarized in this report, similar areas of concern were expressed in the 2019 CCPT survey.

The Advisory Board selected a practice area for each of the formed CRPs:

1. Infant Plan of Safe Care[1]

[1] The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published in 2013, by the American Psychiatric Association (APA) provides criteria to be used by clinicians as they evaluate and diagnose different mental health conditions. Previous editions of the DSM identified two separate categories of substance-related and addictive disorders, "substance abuse" and "substance dependence". The current diagnostic manual combines these disorders into one, "substance use disorders" (SUDs). SUDs have criteria that provide a gradation of severity (mild, moderate and severe) within each diagnostic category. (*Diagnostic and statistical manual of mental disorders* (5 ed.). Arlington, VA: American Psychiatric Association. 2013. p. 483. ISBN 978-0-89042-554-1) Although this change was made in the DSM 5, the term substance abuse is still utilized when referring to certain titles, services or other areas that require general statute, policy or rule revisions to change the language. Substance use disorder is generally utilized to identify a diagnosis or service to treat for someone with a substance use diagnosis (i.e. substance use disorder treatment).

CAPTA, as amended by the Comprehensive Addiction and Recovery Act (CARA) of 2016, stipulates that states provide services to substance-affected infants and their parents/caregivers and other family members. The Act reflects concern across the country about the impact of substances, including opioids, and this concern has been repeatedly voiced by CCPTs in their end-of-year surveys. Specifically, the Act requires:

> The development of a plan of safe care for the infant born and identified as being affected by . . . substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder . . . to ensure the safety and well-being of such infant following release from the care of healthcare providers, including through –
>
> > (I) addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver; and
> >
> > (II) the development and implementation by the State of monitoring systems regarding the implementation of such plans to determine whether and in what manner local entities are providing, in accordance with State requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver. (US DHHS, ACF, 2017, p. 2)

The intent of the Act is to be supportive rather than punitive and to address exposure to both illegal and legal substances. The development of a plan of safe care is required whether the circumstances constitute child maltreatment or not 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.

2. Child Fatalities and Near Fatalities

CCPTs have a long track record of reviewing cases of child maltreatment fatalities, and Child Fatality Prevention Teams (CFPTs) or combined CFPT/CCPTs review additional child fatalities[2] where child maltreatment is not suspected. In addition to child fatalities, CAPTA Section 106 refers to “near fatalities” and requires states to provide public disclosures about cases where child maltreatment resulted in child fatalities or near fatalities. CAPTA defines a near fatality as "an act that, as certified by a physician, places the child in serious or critical condition." An example of a near fatality, provided by the US Children Bureau, is “if hospital records reflect that the child's condition is ‘serious’ or ‘critical’.” Comprehensive planning to prevent child

[2] North Carolina General statute §7B-1401(1) defines additional 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.”

fatalities requires systems sharing data that are of high quality and consistency (Commission to Eliminate Child Abuse and Neglect Fatalities, 2016).

We turn now to the 2019 end-of-year survey, its findings, and recommendations to improve child welfare.

II. 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 89 CCPTs. A list of the counties of the 2019 responding CCPTs can be found in appended Table A-2.

The 2019 response rate of 89 CCPTs was the highest to date with previous years ranging from 71 to 88 from 2012 to 2018. 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, 94% of the 35 medium counties, and 91% 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 use services. In 2019, there were seven LME/MCOs for the 100 counties. The survey included members from all LME/MCOs: Member county participation ranged from 75% to 100% (see Table A-4).

As seen in Table 1, the large majority (81%) 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 = 89)**
Number of CCPTs by Status of Establishment as a Team, 2019

Status	Number of CCPTs	
We are an established team that meets regularly	72	(80.9%)
Our team recently reorganized, and we are having regular meetings	6	(6.7%)
Our team was not operating, but we recently reorganized	2	(2.2%)
We are an established team that does not meet regularly	6	(6.7%)
Our team is not operating at all	3	(3.4%)

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, 66 (78%) of the 89 responding counties opted to have combined teams, and 17 (20%) had separate teams; two counties indicated "Other" describing their team composition. The percentage of combined teams in prior years was 72% in 2015, 76% in 2016, 78% in 2017, and 82% in 2018.

In summary, 89% of the local teams responded to the survey in 2019, 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 80% 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 (57%), by the team as a whole (14%), or by a team subgroup (12%). The response "other" was selected by more than one team member. The teams were split on whether one individual (65% chair or designee) or larger groupings (26% 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 = 89)
Number of CCPTs by Who Completed the Survey

Status	Number of CCPTs	
The CCPT chair on their own	51	(57.3%)
The CCPT team as a whole	12	(13.5%)
A subgroup of the CCPT team	11	(12.4%)
A designee of the CCPT chair on their own	7	(7.9%)
Other	8	(9.0%)

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 during holiday months, although a lengthy extension was given to those who had not submitted a completed survey by the January 15thth, 2020 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 2019 survey inquired about the following six main questions:

1. What are the barriers to team operations?
2. Who takes part in the local CCPTs, and what supports or prevents participation?
3. Which cases do local CCPTs review, and how can the review process be improved?

4. 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?
5. What are local CCPTs' objectives based on identified improvement needs, and to what extent do they achieve these objectives?
6. 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 identify barriers to team operations, list their top three local objectives based on identified improvement needs, and 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, findings from the 2017 and 2018 surveys are compared with the 2019 findings to ascertain trends.

D. Barriers to Team Operations

The survey asked CCPTs to "please explain what barriers your CCPT is facing." (See Appendix C). Among the 89 respondents, 55 (62%) did not offer an explanation of barriers or stated they had no barriers, and the remaining 34 (38%) described barriers. County size and frequency of meeting as a full team had limited impact on whether a team provided an explanation. Two factors appeared to elevate the likelihood that a team would provide an explanation: being an established team that met regularly or being a combined CCPT/CFPT. Teams providing a reason characterized themselves almost all the time (97%) as an established team meeting regularly; the one exception was a team that was not in operation at all. In contrast, those teams that did not offer a reason referred to themselves 71% of the time as an established team convening regularly. It is plausible to surmise that a fully operating team would have more opportunity to identify barriers. If a team was a combined CCPT/CFPT, they cited a reason 88% of time, while those not providing a reason were a combined team 71% of the time. The written comments of the teams identified the challenges to participation faced by the teams generally and why some combined teams would face greater barriers.

Frequently, the comments referenced the lack of consistent participation among the team members, problems in recruiting or retaining participants, multiple demands on participants' time, and scheduling meetings to suit all attendees. Some CCPTs sought to increase participation by meeting more often or holding some meetings via the web. Challenges in securing family representation were voiced by four CCPTs. For example, a combined team wrote, "Difficulty engaging a parent/client participant," and a separate CCPT team acknowledged problems in "filling positions for youth and parent on the Team." Others were concerned about the low or no involvement from the medical and legal fields.

Team participation for some was adversely affected by staffing and leadership changes in key agencies. Especially disruptive factors were no funding for projects, conflict among members,

unclear expectations from the state, and the magnitude of the issues that they were ill-equipped to handle locally. For instance, one team explained that the "majority of issues we face are issues that cannot be handled on a community level, but are those on a broader level." Writing at length, a second team identified conflictual relationships within a complex state context:

> *The biggest problem we often face is political in nature. All CCPT's should constantly have the best interests of the child at the forefront of all that we do. Sometimes, it is difficult to honor that when partners are in conflict about what the best interests of a child are. It often appears that the conflict within partnerships surrounds conflicts within North Carolina State Statutes.*

The CCPT, quoted above, identified team conflict stemming from the seemingly mandatory federal policy on reunification expectations, and requested help from the state on enhancing the team's capacity "to take constructive criticism with the goal of improving practice."

Six teams raised concerns specifically related to reviewing cases or securing sufficient information for carrying out their work. Teams were not receiving cases to review or lacked sufficient information for doing so: "We continue to have the barrier of team members not submitting cases for bi-monthly review." A team from a county with a military base observed, "Sometimes, we may experience difficulty when attempting to collect pertinent information and/or records from our military affiliates." The volume of work was a major issue in reviewing cases, especially for large counties with combined teams. One such team reported a "backlog of intensive fatality reviews to complete along with other responsibilities of our blended team." Another team found, "As a combined CCPT/CFPT with many complex fatalities to review last year, we only had time to review 2 DSS open cases." Based in a large county, a combined team analyzed the impact of the state's response on their team functioning: "Our team has struggled to receive important data from the state regarding fatality and child protection trends, responses to our recommendations, and the relevance of much of our reporting. This threatens to reduce engagement of crucial team members." One strategy that this county has employed to manage this situation is to "welcome collaboration and feedback with other county CCPTs to reduce duplication of efforts."

In summary, when asked to explain barriers, 38% of the 89 teams identified reasons. They were more likely to provide a reason if they characterized themselves as an established team meeting regularly. Fully operating teams, in all probability, had more opportunity to experience and, thus, identify barriers. If teams were a combined CCPT/CFPT, they also were more likely to describe barriers. Some combined CCPT/CFPTs referred to having an overwhelming number of complex cases to review and, as a result, they were unable to prioritize reviewing open child protection cases. In contrast, other teams were not receiving cases to review or the information they needed for the reviews. Commonly cited challenges to participation were scheduling meetings when all members could take part, inconsistent attendance of members with multiple demands on their time, absences of key members from the medical or legal fields, and difficulties in recruiting family partners. Some teams were adversely affected by staffing and leadership changes in key agencies. Especially disruptive factors were no funding for projects, conflict among members, unclear expectations from the state, and the magnitude of the issues that they were ill-equipped to handle locally. Going beyond explaining barriers, some teams mentioned strategies to

overcome challenges such as holding meetings online or encouraging collaboration with other teams.

E. 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 2019. 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 and the Public Health director. 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, the County Board of Social Services had the lowest average participation level but still had over a quarter (13%) 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 (54%) and parents of child fatality victims (54%) *never* participated.

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

Mandated CCPT/CFPT Members and Reported Frequency of Participation, 2019 (N=66)

Mandated Member	Never	Rarely	Occasionally	Frequently	Very Frequently	Mean
DSS Director	4 (5.9%)	5 (7.4%)	7 (10.3%)	12 (17.6%)	40 (58.8%)	3.16
DSS Staff	0 (0%)	1 (1.5%)	1 (1.5%)	2 (2.9%)	64 (94.1%)	3.90
Law Enforcement	4 (5.9%)	5 (7.4%)	12 (17.6%)	19 (27.9%)	28 (41.2%)	2.91
District Attorney	17 (25%)	15 (22.1%)	9 (13.2%)	13 (19.1%)	14 (20.6%)	1.88
Community Action Agency Director or Designee	8 (11.8%)	6 (8.8%)	14 (20.6%)	12 (17.6%)	28 (41.2%)	2.68

School Superintendent	16 (23.5%)	8 (11.8%)	6 (8.8%)	20 (29.4%)	18 (26.5%)	2.24
County Board of Social Services	16 (24.2%)	10 (15.2%)	8 (12.1%)	9 (13.6%)	23 (34.8%)	2.20
Mental Health Professional	3 (4.4%)	1 (1.5%)	5 (7.4%)	13 (19.1%)	46 (67.6%)	3.44
Guardian ad Litem Coordinator or Designee	5 (7.4%)	5 (7.4%)	8 (11.8%)	12 (17.6%)	38 (55.9%)	3.07
Public Health Director	8 (11.8%)	3 (4.4%)	6 (8.8%)	10 (14.7%)	41 (60.3%)	3.07
Health Care Provider	3 (4.4%)	2 (2.9%)	5 (7.4%)	12 (17.6%)	46 (67.6%)	3.41
District Court Judge	37 (54.4%)	13 (19.1%)	6 (8.8%)	9 (13.2%)	3 (4.4%)	.94
County Medical Examiner	35 (51.5%)	8 (11.8%)	7 (10.3%)	7 (10.3%)	11 (16.2%)	1.28
EMS Representative	15 (22.1%)	4 (5.9%)	18 (26.5%)	10 (14.7%)	21 (30.9%)	2.26
Local Child Care Facility	14 (20.6%)	6 (8.8%)	17 (25%)	14 (20.6%)	17 (25%)	2.21
Parent of Child Fatality Victim	36 (53.7%)	11 (16.4%)	6 (9.0%)	6 (9.0%)	8 (11.9%)	1.09

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, 2019 (N=17)

Mandated Member	Never	Rarely	Occasionally	Frequently	Very Frequently	Mean
DSS Director	2 (11.1%)	2 (11.1%)	1 (5.6%)	3 (16.7%)	10 (55.6%)	3.00
DSS Staff	0 (0%)	0 (0%)	0 (0%)	1 (5.9%)	16 (94.1%)	3.94
Law Enforcement	1 (5.9%)	3 (17.6%)	3 (17.6%)	2 (11.8%)	8 (47.1%)	3.53
District Attorney	4 (23.5%)	1 (5.9%)	2 (11.8%)	2 (11.8%)	8 (47.1%)	3.24

Community Action Agency Director or Designee	3 (17.6%)	1 (5.9%)	4 (23.5%)	3 (17.6%)	6 (35.3%)	3.24
School Superintendent or Designee	4 (23.5%)	0 (0%)	2 (11.8%)	3 (17.6%)	8 (47.1%)	2.70
County Board of Social Services	5 (31.3%)	3 (18.8%)	1 (6.3%)	2 (12.5%)	5 (31.3%)	2.44
Mental Health Professional	0 (0%)	0 (0%)	1 (5.9%)	5 (29.4%)	11 (64.7%)	3.58
Guardian ad Litem Coordinator or Designee	1 (5.9%)	1 (5.9%)	2 (11.8%)	5 (29.4%)	8 (47.1%)	3.06
Public Health Director	4 (23.5%)	0 (0%)	1 (5.9%)	1 (5.9%)	11 (64.7%)	2.88
Health Care Provider	3 (17.6%)	0 (0%)	2 (11.8%)	4 (23.5%)	8 (47.1%)	2.82

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 2019 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 and mental health professionals. This year, guardian ad litem was ranked third replacing health care provider from 2018 and DSS Director was ranked fourth, consistent with the 2018 ranking. For CCPTs, the lower participation ranks for this year included county board of social services and district attorneys following last year's trend, however, this year, community action agency was listed among the top three. District court judge, parent of child fatality victim, and county medical examiners were ranked lowest for participation among combined CCPT/CFPTs, continuing last year's pattern.

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, 2018, and 2019

Mandated Member	2017 CCPT (*N* = 79) Average (Rank)	2018 CCPT (*N* = 13) Average (Rank)	2018 CCPT/CFPT (*N* = 73) Average (Rank)	2019 CCPT (*N* = 13) Average (Rank)	2019 CCPT/CFPT (*N* = 73) Average (Rank)
DSS Director	3.03 (6)	3.69 (7)	3.25 (4)	3.88 (4)	3.16 (4)

DSS Staff	3.87 (1)	4.54 (1)	3.88 (1)	4.94 (1)	3.90 (1)
Law Enforcement	2.74 (8)	3.85 (6)	2.77 (7)	3.53 (7)	2.91 (7)
District Attorney	2.00 (11)	2.92 (10)	1.70 (13)	3.24 (9)	1.88 (13)
Community Action Agency	2.87 (7)	3.46 (9)	2.66 (8)	3.24 (10)	2.68 (8)
School Superintendent	2.46 (9)	3.54 (8)	2.36 (9)	3.41 (8)	2.24 (10)
County Board of Social Services	2.34 (10)	2.85 (11)	2.24 (11)	2.44 (11)	2.20 (12)
Mental Health Professional	3.56 (2)	4.46 (2)	3.30 (3)	4.59 (2)	3.44 (2)
Guardian ad Litem	3.09 (5)	3.92 (4)	3.03 (6)	3.94 (3)	3.07 (5)
Public Health Director	3.11 (4)	3.92 (3)	3.17 (5)	3.65 (6)	3.07 (6)
Health Care Provider	3.14 (3)	3.85 (5)	3.37 (2)	3.65 (5)	3.41 (3)
District Court Judge			.92 (16)		.94 (16)
County Medical Examiner			1.47 (14)		1.28 (14)
EMS Representative			2.21 (12)		2.26 (9)
Local Child Care or Head Start Rep			2.29 (10)		2.21 (11)
Parent of Child Fatality Victim			1.06 (15)		1.09 (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 2019 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, community action agency, and the district attorney (for CCPTs), and the district court judge, the parent of a child fatality victim, and medical examiner (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*. 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 89 survey responses, 38 (45%) said that they did not have additional members while the other 47 (55%) had between 1 to 14 additional members, 4 counties gave no information. The survey provided space for the respondents to "list the organization/unit that additional members represent." Respondents indicated 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, 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.

F. 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 89 respondents, 33 (37%) indicated that they prepare *very well* for meetings, and 30 (34%) prepare *well*. Of the established teams that met regularly, 35% and 39% of those that recently reorganized and met regularly prepared "well" or "very well" for meetings, respectively, none of the teams indicated that they did not prepare for meetings well.

CCPT teams were asked how well they share information during meetings. Fifty-three, 60% of the respondents, indicated that they share information very well. Twenty-five (28%) said that their team share information *well.* When asked how well the team shared other resources 49 (55%) denoted *very well,* while 28 (32%) noted that they share other resources *well.* Sixty-four respondents listed at least one shared other resource, 52 listed a second shared resource, and 25 listed a third. CCPT teams identified key resources shared including: community resources and events, 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. Twelve (14%) of respondents indicated *very well*, 14 (16%) indicated *well*, 32 (36%) indicated *moderately*, 19 (21%) indicated *marginally*, and 7 (8%) indicated *not at all* with respect to how well their CCPT has effected changes in their community.

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.

G. 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. Family and youth partners are not mandated CCPT members, but their inclusion is encouraged. An exception for a combined team is a parent of a deceased child as long as the parent fits the definition of a family or youth partner.

1. Family or Youth Partner Participation Rates

In response to the question on whether they had family or youth partners serving on their team, 6 (7%) out of 89 respondents said *yes* and 79 (89%) said *no*. The percentage of family or youth partner involvement is down from 2018 where 21 (24%) out of 88 respondents said *yes* and 66 (76%) said *no.* This year's family and youth partner engagement has decreased from 2015 (21%, 19 out of 87), 2016 (22%, 19 out of 86) and lower than 2017 (29%, 23 out of 79). Maintaining the structure from 2017 and 2018, the 2019 survey inquired about the six different categories of family or youth partners serving on the CCPTs (see Table 6 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 rates of family or youth partners' participation. The most commonly represented category was biological parent which formed half (4, over 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, 2019

Category	Never	Rarely	Occasionally	Frequently	Very Frequently	Total Participation of Partners
Youth Partner	6	0	0	0	0	0
Biological Parent	2	0	1	0	3	4
Kinship Caregiver	6	0	0	0	0	0
Guardian	6	0	0	0	0	0
Foster Parent	5	0	1	0	0	1
Adoptive Parent	4	0	1	0	1	2
Total	**29**	**0**	**3**	**0**	**4**	**7**

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 7% of respondents indicated that family or youth partners served on their CCPT or combined CCPT/CFPT, a significant decrease from previous years. It is unclear whether the teams were identifying biological parents who served as members of the Child Fatality Prevention Teams. 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 contributions 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 six respondents who stated that they had family or youth partners, one replied to this question. This county identified likely family or youth partners through "word of mouth from community partners." In summary, the CCPTs and CCPT/CFPTs did not provide robust strategies for engaging family and youth partners as they have done in the past.

H. 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 75 (84%) of the 89 respondents writing in comments. Among the 75, 37 gave one reason, 20 gave two reasons, and 17 gave three reasons.

A vast majority of the reasons were logistical: lack of transportation or reimbursement for travel and the times of meetings conflicting 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 89 respondents, 62 (70%) commented with valid responses, four responses were eliminated due to "N/A" content. Out of 62 respondents identifying why they were inhibited in engaging family or youth partners: 34 provided one out of the three possible reasons, 16 provided two out of the three possible reasons, and 10 provided all three reasons. These reasons included conflicting commitments (e.g., work and school), scheduling conflicts, transportation, child care, and no payment for their time, not knowing how to recruit partners, 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 were "uncertain of the best way to recruit family or 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, and lack of reimbursement. 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.

I. 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 questions was: "During 2019, did your CCPT partner with other organizations in the community to create programs or inform policy to meet an unmet community need?" Among the 89 respondents, 42 (47%) answered that they did partner with other organizations and 43 (48%) did not. A follow-up question was: "If yes, describe the most important of these initiatives to meet a community need." Of the 42 that responded, 41 provided information on these initiatives. Demonstrating extensive local activism and justifiable pride in their accomplishments, the CCPTs described at length numerous initiatives.

These initiatives included raising public awareness around substance use (e.g., education on opioid addiction and vaping), strengthen protective factors through education on healthy parenting practices such as safe sleeping, and raising public awareness of how to identify child abuse (including sexual abuse). Many teams hosted or facilitated events such as walks and runs, community fundraisers, and community viewings of educational films and other materials. These events aimed to raise awareness to support healthy pregnancy, care for infants and young

children, prevent teen suicide, prevent domestic violence, safe use of electronics, and to ensure firearm safety.

The second related survey question was: "Are you aware of any other county-level collaboration your CCPT is involved in?" Nineteen responded yes, among whom 5 identified one collaboration, six identified two collaborations, and 8 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 and human trafficking awareness and prevention; others referenced educational efforts with schools, law enforcement, and other agencies.

In summary, just under 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, 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.

J. 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 additional child fatalities. North Carolina General statute §7B-1401(1) defines additional 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 2019, how many notifications of child maltreatment fatalities were made by your local DSS?" Among the 89 respondents, 48 (54%) replied that they had received no notifications; the remaining 37 (42%) said that they had

received between 1 to 14 notifications, 4 counties did not respond due to the operational status of the CCPT. Across the 37 respondents, there was a total of 91 notifications with a mean of 2.5 (SD = 2.10).

Next the CCPTs were asked about the type of review that these child maltreatment fatalities received. The teams were provided with six 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 an review conducted by a CCPT as well as intensive state child fatality reviews conducted by NC DSS: 47 and 30 cases were reviewed in each of these categories respectively, and these case reviews were reported by 25 and 31 CCPTs respectively.

In summary, last year, 37 (42%) out of the 89 responding CCPTs received between 1 and 14 notifications of child maltreatment fatality cases, for a total of 91 notifications. When asked about their type of review, the teams identified different approaches. The most common type was a review by the CCPT itself 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. 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, 2019

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	27	17	0	5	.63	1.08
2. Number of child maltreatment fatality cases that had a review conducted	27	22	0	5	.81	1.30
3. NC DSS conducted (intensive) state child fatality review	31	30	0	5	.97	1.20
4. CFPT conducted case review	23	11	0	3	.48	.79
5. CCPT conducted case review	25	47	0	35	1.88	6.93
6. CCPT/CFPT conducted case review and DSS conducted intensive case review	24	10	0	3	.42	.78

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

2. Child Maltreatment Case Reviews

Child maltreatment cases encompass both active cases and child fatalities where child abuse, neglect, or dependency is suspected. The survey did not ask respondents to state how many cases were active cases versus child fatalities, a distinction to inquire about in future CCPT surveys.

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 2019?" 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 2019, 68 (76%) of the 89 responding CCPTs reviewed between 1 and 26 cases, with a mean of 5.13 cases (SD = 5.33). All together these 68 teams reviewed 436 cases. The other 21 (24%) did not indicate they had reviewed cases in 2019. 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=89)

Size of County	Number of Respondents Reporting Cases	Number of Cases Reviewed	Mean	SD	Range
Small	30 (55%)	172	4.10	3.79	0-15
Medium	31 (89%)	162	4.91	4.97	0-26
Large	7 (64%)	102	10.20	8.85	0-24

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

In summary, Child maltreatment cases encompass both active cases and child fatalities where child abuse, neglect, or dependency is suspected. The survey did not ask respondents to state how many cases were active cases versus child fatalities, a distinction to inquire about in future CCPT surveys. Over 2019, 68 (76%) of the 89 responding CCPTs reviewed cases of child maltreatment, with a total of 436 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. Nevertheless, 21 CCPTs did not indicate that they reviewed any cases. The survey did not specifically inquire 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 2 additional reasons. As shown in Table 9, the most common reason cited by 61 (86%) out of the 89 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, 25 (35%) stated that they selected child maltreatment fatalities for review. In addition to these statutory requirements, the CCPTs identified other selection criteria. In addition to active cases, the most frequently selected, at 50% or higher, were criteria of child safety, multiple agency involvement, repeat maltreatment, stuck cases, child and family well-being, and parent opioid use. Compared with last year's survey, the number of CCPTs selecting cases for review because of parental opioid use increased significantly: 22 (34%) of the 64 respondents in 2016 to 26 (41%) of 63 respondents in 2017 to 21 (24%) of respondents in 2018 to 45 (63%) now in 2019. Twenty of the respondents added a selection criterion, and four of these provided two criteria. The additions included "mental health," "substance abuse," "substance affected infant" "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, 2019, (N=89)

Selection Criterion	Number of CCPTs	
Active Case	61	(85.9%)
Child Safety	51	(71.8%)
Multiple Agencies Involved	50	(70.4%)
Repeat Maltreatment	49	(69.0%)
Stuck Cases	48	(67.6%)
Child and Family Well-Being	47	(66.2%)
Parent Opioid Use	45	(63.4%)
Court Involved	35	(49.3%)
Child Permanency	29	(40.8%)
Child Maltreatment Fatality	25	(35.2%)
Closed Case	10	(14.1%)
Other 1	17	(23.9%)
Other 2	5	(7.0%)

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 60 (85%) CCPTs and household domestic violence

cited by 48 (68%) CCPTs. Six other factors used by over 40% of CCPTs pertained to child/youth behavior problems and other medical conditions, parent/caregiver alcohol abuse, lack of knowledge of child development, and emotional disturbance, or 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, 2019, (N = 89)

Contributory Factor	Number of CCPTs	
Parent/Caregiver		
Drug Abuse	60	(84.5%)
Alcohol Abuse	35	(49.3%)
Lack of Child Development Knowledge	35	(49.3%)
Emotionally Disturbed	30	(42.3%)
Other Medical Condition	16	(22.5%)
Mental Retardation	13	(18.3%)
Learning Disability	13	(18.3%)
Visually or Hearing Impaired	8	(11.3%)
Children/Youth		
Other Medical Condition	32	(45.1%)
Behavior Problem	30	(42.3%)
Emotionally Disturbed	24	(33.8%)
Drug Problem	13	(18.3%)
Learning Disability	12	(16.9%)
Physically Disabled	12	(16.9%)
Alcohol Problem	10	(14.1%)
Mental Retardation	9	(12.7%)
Visually or Hearing Impaired	8	(11.3%)
Household		
Domestic Violence	48	(67.6%)
Inadequate Housing	33	(46.5%)
Financial Problem	26	(36.6%)
Public Assistance	22	(31.0%)

In summary, state statute requires that CCPTs review two types of cases: active cases and child maltreatment fatalities. Most (86%) respondents selected active cases for review. Child maltreatment fatality was given as a reason for case selection by 35% of respondents. The second most frequent criterion for selecting cases was child safety, identified by 72% of the respondents. The teams also selected cases on the basis of factors contributing to children needing protection: The two most common were parental drug abuse (85%) and household domestic violence (68%). Selection of cases because of parental opioid use increased from 24% of respondents in 2018 to 63% in 2019. Six other factors used by over 40% of CCPTs pertained to child/youth behavior problems and other medical conditions, parent/caregiver alcohol abuse, lack of knowledge of child development, and emotional disturbance, or inadequate housing. 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. 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 89 respondents, 94% used reports from members and/or case managers, and 90% used case files. Over to two-thirds (66%) 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, 2017, and 2018 surveys, however reported use of these types of information is notably higher in 2019. 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, 2019, (N=89)

Type of Information	Number of CCPTs
Reports from Members and/or Case Managers	67 (94.4%)
Case Files	61 (85.9%)
Information on Procedures and Protocols of Involved Agencies	47 (66.2%)
Child and Family Team Meeting Documentation	30 (42.3%)
Medical Examiner's Report	25 (35.2%)
Individualized Education Plan	21 (29.6%)
Other 1	10 (14.1%)
Other 2	2 (2.8%)

Note. CCPTs could select all that apply.

The survey asked, "What would help your CCPT better carry out case reviews?" Among the 89 respondents, 35 (40%) provided a way to improve their case reviews and the remaining 52 (60%) either did not comment or said that no improvements were necessary. The analysis examined possible factors decreasing the likelihood of offering a method for improving case reviews.

Interestingly, the following factors appeared to have little association with offering a method:

- *CCPT chair completing the survey on their own*: In other words, having a one-person response did not seem to affect the likelihood of citing ways to improve case reviews.
- *Structure of team as a separate or combined CCPT/CFPT*: Overall, the team's structure did not affect identifying a method. Nevertheless, two combined teams in large counties that cited their workload as a barrier to their operations also commented on ways to improve their reviews.

- *Team functioning*. The survey had three items related to teams functioning: the team prepared well for meetings, the team shared information well, or the team shared other resources well. The average responses on how a team characterized their functioning did not generally seem to influence whether a method was identified to improve the case review process.

Some factors decreased the likelihood of commenting on an improvement method. As compared with those CCPTs providing an improvement method, CCPTs that did not give a method were more often small counties (61.5% vs. 34%), had fewer notifications of child maltreatment fatalities (Mean[SD]: 0.80[1.34] vs. 1.46[2.79]), and had fewer reviewed cases (Mean[SD]: 4.46[4.20] vs. 6.09[6.58]. These patterns make sense in that small counties on average did not have as many fatality notifications or reviewed child maltreatment cases as medium or large counties (see Tables 8).

Another factor that correlated with commenting on ways to improve case reviews was explaining a barrier that the team was facing to its operations. Those teams that had written in a barrier were more likely to offer a method for improving case reviews than those that did not (51% vs. 33%). As previously summarized, some of the identified barriers related explicitly to the case review process. The CCPTs' methods for improving case reviews fell into seven main areas.

The first area for improvement pertained to the number of cases to review. The low number of cases was voiced by both smaller and larger counties that only reviewed one child maltreatment case in 2019. Conversely, a county with 14 child fatality notifications and 24 child maltreatment reviews struggled to complete their work in a timely manner.

Second, teams recognized that they needed to improve their selection of cases. Proposals for enhancing case selection included: having "defined criteria for selection of cases based on community needs" or having "other team members picking cases to be reviewed (not just DSS)." In the same vein, a different team noted that "DSS selects cases" and thought "it would be beneficial if other agencies led the discussion or brought case/trends from various agencies." To improve their review process, a team undertook "planning designated reviews around specific service needs in 2020."

To improve their review process, a team undertook "planning designated reviews around specific service needs in 2020."

Third, CCPTs knew that they needed better preparation for case reviews. One team wanted, "Advance knowledge by [team] members of families to be reviewed"; another identified that it was necessary to have "additional prep work by partner agencies"; and yet another team proposed, "Make a standing agenda item for preparing and facilitating for cases to be presented by CW SWs [child welfare social workers]."

Fourth, CCPTs identified the need for better participation at meetings. This might entail "participating agencies [having] more free time to attend" or greater involvement of key agencies such as child protection staff, local schools, and guardians ad litem. A team was stymied by the lack of partnership with providers of medication assisted treatment (MAT). Another team was taking steps to involve the local housing authority" by "inviting them to our monthly case

reviews." Still another team in a small county and with "sporadic attendance" said that they would benefit from having "dedicated state funding without local match for a regional facilitator."

Fifth, teams required better access to information necessary for conducting the case reviews. For instance, a CCPT wrote about having "contact in a timely manner with medical personnel treating the families being treated regarding complex medical issues." A different team advocated for a "centralized case management system" and "electronic records." A third team said that it would be helpful "if our mental health liaison was legally able to share information in regards to services offered and received by the case family members."

Sixth, CCPTs sought more guidance on the review process from the state: In particular, they were asking for technical assistance, training, and a protocol manual. For instance, one team wrote, "I am not aware of any training opportunities in more than five years"; another team wanted, "Guidance on what those reviews within CCPT need to look like"; and yet another team asked for "more guidance from state to CCPT Chair (like a handbook)."

Seventh, teams reflected on their own processes and ways to strengthen them. A CCPT with quite conflicting views among their membership challenged themselves to better understand "each other's policies, procedures, boundaries, and limitations." Another team challenged themselves to "being more intentional about making systematic recommendations following case reviews."

A CCPT with quite conflicting views among their membership challenged themselves to better understand "each other's policies, procedures, boundaries, and limitations."

In summary, among the 89 respondents, 35 (40%) provided a way to improve their case reviews and the remaining 52 (60%) either did not comment or said that they did not need to make improvements. The areas for improvement fell into seven main areas. The first area for improvement pertained to having too few or too many cases to review. Second, teams recognized that they needed to improve their selection of cases so that they fit with community needs or expand those picking cases beyond Social Services.

To improve their review process, a team undertook "planning designated reviews around specific service needs in 2020."

Third, CCPTs knew that they needed better preparation for case reviews by having information in advance of meetings and having better preparation by partner agencies. Fourth, CCPTs identified the need for better participation at meetings. This might involve better attendance by key members and involvement of specific groups, including medication assisted treatment (MAT) providers and housing authorities. Fifth, teams required better and timelier access to information necessary for conducting the case reviews such as on medical and mental health treatments. Sixth, CCPTs sought more guidance on the review process from the state: In particular, they were asking for technical assistance, training, and a protocol manual. Seventh, teams challenged themselves to strengthen their review process. A CCPT with quite conflicting views among their membership challenged themselves to better understand "each other's

policies, procedures, boundaries, and limitations." Another team challenged themselves to "being more intentional about making systematic recommendations following case reviews."

A CCPT with quite conflicting views among their membership challenged themselves to better understand "each other's policies, procedures, boundaries, and limitations.

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: assistance with too few or too many cases for review, improving the selection process to meet community needs, and better sharing of information with partners before meetings. Thus, over a third of teams recognize the complexities of the barriers that they face in reviewing cases and have identified areas for improvement.

K. 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 2019 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 80% of the respondents identified this need for the children in a total of 217 cases. In regards to DD, SA, and DV services, 80% of the respondents stated these services were needed for the children; however, SA services were required by a combined 80 cases, which exceeds the numbers for DD (36 cases) and DV (70 cases). This is consistent with the 2018 survey results that indicated that SA services were required for more cases (132 cases), than for DV (86 cases) and DD (40 cases).

For the parents or caregivers, the need for mental health and substance abuse services were the most prominent. Among the responding teams, 79% identified the need for MH services and 78% identified a need for SA services. The total number of reviewed cases were also higher with 267 of the reviewed cases requiring MH services and 244 requiring SA services. The need for DV services was cited by 72% of the teams, for a total of 130 cases. CCPTs identified the need for DD services at a rate of 64% but with a significantly lower number of cases reviewed (10 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. As noted in previous years, the findings indicate 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.

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 2019?" 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 46. Of these 12 CCPTs reporting reviewing cases of substance affected newborns, all of them responded to the follow up question inquiring about Plans of Safe Care. All that reported reviewing a case of a substance affected newborn had a corresponding Plan of Safe Care (12 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, 2019 (N= 89)

	Number of CCPTs	Sum of Cases	Mean	SD
Children/Youth				
Mental Health	71 (80%)	217	3.06	2.80
Developmental Disabilities	71 (80%)	36	0.51	0.84
Substance Abuse	71 (80%)	80	1.13	1.74
Domestic Violence	71 (80%)	70	.99	1.70
Parents/Caregivers				
Mental Health	70 (79%)	267	3.81	3.23
Developmental Disabilities	57 (64%)	10	0.18	0.73
Substance Abuse	69 (78%)	244	3.54	3.02
Domestic Violence	64 (72%)	130	2.03	1.92

Note. MH/DD/SA/DV=Mental Health, Developmental Disabilities, Substance Abuse, and Domestic Violence. Large standard deviations indicate wide variability in the 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 (77% of respondents) and limited transportation to services (71% of respondents). Another common limitation, cited by 47%, 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 25-38%. These trends are similar to previous year's findings.

Among the respondents, 14 wrote in additional limitations. These primarily concerned systemic factors and to a lesser extent, family reasons. Some respondents commented on families' "parent's willingness to seek services" and "parent's readiness to participate in services". Many limitations referenced families who were undocumented and as a result were "ineligible for

Medicaid services." Others identified the lack of "coordination between community providers" and a "lack of available translators at mental health centers."

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, 2019, (N = 89)

Limits on Access	Number of CCPTs
Limited Services or No Available Services	65 (76.5%)
Limited Transportation to Services	60 (70.6%)
Limited Community Knowledge About Available Services	40 (47.1%)
Limited Services MH and SA for Youth with Dual Diagnosis	32 (37.6%)
Limited Services MH and DD for Youth with Dual Diagnosis	32 (37.6%)
Limited Services MH and DV for Youth with Dual Diagnosis	21 (24.7%)
Limited Attendance MH/DD/SA/DV Providers at CFTs	20 (23.5%)
Limited Number of Experienced CFT Meeting Facilitators	12 (14.1%)
Other 1	14 (16.5%)
Other 2	2 (2.4%)

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 2019 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 having a dual diagnosis of mental health and substance abuse issues. The CCPTs commented on some family factors affecting service receipt such as citizenship and language barriers. It is quite likely that these identified family reasons reflected systemic barriers such as the complexity of the health care system and challenges in finding services without having health insurance. Thus, the teams were well aware of multiple issues keeping children and families from much needed services. As stated in previous reports, the federal funding from the Family First Prevention Services Act may be able to assist them in securing prevention services in their communities.

L. Local CCPT Recommendations for Improving Child Welfare Services

Local teams generated a total of 169 recommendations for improving child welfare services. They responded at length to the question, "Based on your 2019 case reviews, what were your team's top three recommendations for improving child welfare services?" Space was provided for writing in three recommendations, and many teams availed themselves of the opportunity to propose more than one recommendation. Among the 89 teams, 40 (44.9%) gave three

recommendations, 20 (22.5%) gave two, 9 (10.1%) gave one, and 20 (22.5%) gave none. Among the 20 CCPTs giving no recommendation, 4 left blank the survey item asking for their number of reviewed cases, 6 stated that they did not review cases, and the remaining 10 reviewed an average of 5 cases. All those giving one, two, or three recommendations reviewed cases and had on average somewhat over five reviewed cases. A list of all their recommendations can be found in Appendix C.

The CCPTs' recommendations pertained to nine main strategies to address local and state issues:

1. *Early Childhood Protection.* The teams continued to express concern about safe sleeping and substance-affected infants and the necessity of parent education. Their recommendations included: "Review all screen-out substance-affected reports," "medicine guidelines for sick children age 5 and under," and "public awareness of co-sleeping and child fatality rates."

2. *More and Improved Services.* As in prior years, the teams especially recognized that they needed far more and stronger substance use, mental health, and domestic violence services. Their recommendations included: "More available trauma focused mental health services," "Medication Assisted Treatment for Opioid Use Disorder [in which] the selected provider must offer a counseling component," and offering "affordable domestic violence services for perpetrators."

3. *Better Access to Services.* The teams further recognized that families not only needed more services but ones that they could access. They were well aware of the need to provide transportation. They were particularly sensitive to the needs of immigrants and urged "local mental health . . . provide translator services for Hispanic clients," "establishing and strengthening relationships with multicultural centers (e.g., refugee centers)," and "more community financial resources to help undocumented families with medical needs."

4. *Raising Public Awareness.* The teams were keenly cognizant of the need for increasing awareness of child maltreatment across their communities and particularly zeroed in on students: "Increase awareness in schools for youth regarding suicide, alcohol, drugs, MH issues, driver safety, etc." and "education to teens on how to report suicide thoughts of friends."

5. *Enhancing Collaboration across Systems.* To help systems work together better, teams proposed reaching out to crucial partners such as the county's managed care organization ("invite MCO . . . to come to meeting"), ensuring CPS reporting by "EMS & Hospital . . . for any child death with siblings," providing alternative service when "CAC [Child Advocacy Center] when trained county [forensic] interviewer is not available,"

6. *Training and Increasing DSS Staffing.* They frequently mentioned the necessity of enhancing training given poor retention rates *(*"Training for CPS Staff – 100% turnover in 2019"), pushed for "supporting child welfare re: recruitment and retention," and advocated that "money for DSS from state should be in ratio with caseload sizes."

7. *Access to Management Data.* Local teams recognized that efforts to protect children were stymied unless child welfare and their community partners had access to data on which to base their planning. They wanted a "Case Management/Documentation automation system or

program that allows for units to interface in 'real time' and allows for counties in NC to do the same."

8. *Changing Policy.* Many of their recommendations required policy clarification or revision. For instance, teams would continue to lack crucial planning information without "changing the Mental Health law about sharing information." They wanted trainings "to be more policy driven . . . [with] improved communication down to the county level." Policies that they singled out for revision included the "federal government . . . revis[ing] the reunification procedures that appear like they are almost mandatory," moving to "public mental health instead of private mental health," and revising the "Definition of Caretaker to be expanded and [a] more modern definition of family," Legislation that has expanded the definition of caretaker is *An Act to Protect Children from Sexual Abuse and to Strengthen and Modernize Sexual Assault Laws,* S. L. 2019-245 (S199). G.S. 7B-101(3) enlarges the definition of caretaker beyond relatives to non-relatives and defines caretaker as "an adult entrusted with the juvenile's care."

9. *Supports for CCPTs.* They wanted local teams to have funding, technical assistance, and training. Their recommendations included: "Funding for CCPTs to use towards public education," "more consistent contact, support and TA from state," "required training for CCPT members," and "increased understanding among the public and team members of the pros and cons of Methadone and Suboxone drug treatment programs."

In summary, local teams generated a total of 169 recommendations for improving child welfare services, and most gave more than one recommendation. The CCPTs' recommendations pertained to nine main strategies to address local and state issues. (1) Protecting infants and young children in regards to safe sleeping and substance-affected infants continued to be prominent in their recommendations. (2) As in prior years, they especially recognized the need for far more and improved substance use, mental health, and domestic violence services and (3) increasing the accessibility of these services whether through providing transportation, covering the uninsured, or offering services geared to Spanish-speaking populations. (4) They recognized that the need to raise public awareness of child maltreatment and particularly to educate youth about suicide, mental health, drugs, and other issues. (5) Their efforts would be stymied unless cross-system collaboration was enhanced through steps such as better reporting by health providers and an alternative being provided for forensic interviewing of children when the Child Advocacy Center interviewer was not available. (6) Given high turnover rates among child welfare staff, they pushed for enhanced training, recruitment, and retention. (7) They urged that the case management system be timely and accessible. (8) Many of their recommendations required policy clarifications or revisions. For instance, teams would continue to lack crucial planning information without changing laws on sharing information or expanding the meaning of caretakers. (9) They wanted local teams to have funding to implement public education and technical assistance and training to develop a better informed team.

M. 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 2019?" Among the 89 respondents, 34 (38%)

said yes and 51 said no (57%). Of the 34 teams that responded yes, four were recently reorganized and having regular meetings, four were established but not meeting regularly, and 26 characterized themselves as an established team that met regularly.

Next, the 34 respondents who set objectives were asked, "List your CCPT's top three local objectives based on identified improvement needs for 2019. 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 (0-4) from *not at all, slightly, moderately, mostly*, and *completely*, with the additional option of *too soon to rate*.

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	34	3	6	8	6	8	3
Objective 2	26	3	4	5	3	9	2
Objective 3	17	0	6	5	3	2	1
Total	**-**	**6**	**16**	**18**	**12**	**19**	**6**

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

Along with rating the achievement of their top three local objectives in 2019, CCPTs were asked to write in each of these objectives. Among the 83 responding teams, 55 (61.8%) did not write in an objective, and 34 (38.2%) wrote in at least one objective. Of the 34, 17 (50.0%) gave 3 objectives, 9 (26.5%) gave 2 objectives, and 8 (23.5%) gave 1 objective, for a total of 77 objectives listed. The ratings of *mostly* or *completely* achieving their objectives declined as they listed more objectives: For the first objective, 51%; for the second, 46.1%; and for the third, 29.4%. A listing of their objectives and other qualitative responses can be found in Appendix C.

Many of the local objectives fit with the teams' recommendations on improving child welfare services. These recommendations were grounded on their case reviews. Quite reasonably, the objectives that they set for themselves focused on matters that they could address in their communities rather than on state policy or funding changes such as accessing data management systems or increasing DSS staffing. Their success in achieving their objectives varied extensively, with higher self-ratings mainly for concrete, time-limited, and measurable steps. For instance regarding early childhood protection, counties gave themselves a rating of *mostly* or *completely* for setting forth "medication guidelines for children age 5 and under," "providing Pack-n-Plays (Cribs)," and "strengthen[ing] safe sleep initiatives."

They had slower momentum putting in place more, improved, and accessible services that relied on county, state, or national developments. For instance, some were stymied in their efforts to

"bring . . . more service specific providers to the area to work with substance abusing youth," "increase access to affordable housing," and "improve access to services for undocumented persons." Though, others made progress such as on the "availability of SA/MH providers" and "continued public education on available services."

Raising public awareness of child maltreatment was something on which a number of CCPTs could take pride: "Partner with community agencies to sponsor training and support awareness events surrounding domestic violence" and "educating service providers on the needs of citizens." They also improved collaboration with other community groups: "Outreach to law enforcement, hospital, and emergency services" and "improved communication between agencies."

An area in which some CCPTs made substantial progress related to the functioning of their team: "Education/Training for CCPT members," "review cases utilizing protective factors overlay," "update protocols for military case reviews," and "at each meeting have a follow-up report on all cases presented." Others, however, continued to struggle to "refer more cases to CCPT"; "recruit youth, family members, foster family and medical providers"; or secure "better attendance of health care professionals" even when they sought to "move the meeting to the hospital."

1. Helps for Meeting Objectives

Next for each local objective, CCPTs were asked**, "**What helped you achieve your local objectives to meet identified improvement needs? The CCPTs wrote in a total of 56 ways of achieving their local objectives (see Appendix C). This total is somewhat lower than the 77 for their listed objectives. They left blank the "help" space for 19 objectives or, on 2 occasions, noted that an objective was no longer applicable. It is quite possible that some teams felt that they had already specified what helped or would help in their earlier responses.

The statements on what helped reflected the objectives that the teams were seeking to achieve. For instance, the county that had only *slightly* achieved its objective of "bringing more service specific providers to the area to work with substance abusing youth" noted that they were taking action steps: "researching and inviting providers to the table to discuss their services." A rural county specified the objectives of increasing access to mental health and substance use services and rated their momentum toward achieving these objectives as modest. Nevertheless, they had local partnerships assisting them in working on enhancing these services: "Assistance from mental health partners and the school" and "having a mental health partner at the meetings to relay the needs to the LME." Likewise, using a partnering approach, an urban county concerned about low-income housing "continued collaboration with housing authority to increase access to FUP [family unification program] vouchers for CPS/CWS involved families."

2. State Help for Local Objectives

Then for the local objectives, CCPTs were asked, "What can NC DSS do to help you achieve your local objectives to meet identified improvement needs? The teams provided a total of 55 ways in which NC DSS could assist them in achieving their local objectives (see Appendix C). They distinguished between objectives where the state could be of help and where the objectives required local input only. The state assistance that they were seeking related mainly to funding

(for projects, services, and workers); notification of grant opportunities; clearer policy; training; access to drug records; support for local planning efforts; and interceding with other state players (e.g., courts). For instance, a county found that helping them work toward an objective of "developed a subcommittee on safe sleeping" was that "our CFPT/CCPT members continued to notice a trend in infants dying in unsafe sleep environments." They, however, also recognized that they needed significant state assistance:

> *Provide more financial resources to support safe sleep campaigns (educational materials). NCDSS need to address the verbiage of the wording SIDS and "other ill defined" [terms] when mentioning the cause of death to educate the public that the real issue is a child placed in an unsafe sleep environment.*

3. Challenges in Achieving Local Objectives

The teams were asked, "What challenges did you face in achieving your local objectives to meet identified improvement needs? In response, 28 CCPTs listed between one and three challenges, for a total of 60 (see Appendix C). Some of the challenges were logistical such as "time commitment constraints with regular job." Other hurdles were connecting the county to service providers: "LME cannot find providers with staff willing to travel to the county to provide the service." And if the county secured staffing, they found over and over that "no one stays long enough." Other challenges resulted from changes in local leadership and community partnerships: "new director" and "turnover with personnel facilitating initiative." The need for funding was repeatedly raised by teams. And finally, some of the challenges related to team functioning: "The team has not been able to recruit the needed members to meet our objective" and "having other agencies outside of DSS bring cases to review."

4. Further Supports for Putting Recommendations into Action

The question on challenges was followed by the last survey question, "What further support would help your team put your recommendations into action? Thirty-four CCPTs responded, often at length (see Appendix C). These identified supports followed up earlier raised concerns and recommendations. They pertained to having "state sponsored training" for CCPTs, "access to more essential services," "more providers who can provide substance abuse treatment services," and "grant money to support after school care." Speaking on many of these issues and others, a CCPT asked for "more providers, reduction in eligibility criteria, more staffing (capacity), funding, daycare options, more community involvement/support, case management system, family planning options, and transportation."

Other CCPTs called for re-assessment of the responsibilities of their teams: "The role of CCPTs in the community should be reexamined in conjunction with broader fatality system changes" and urged regular communication from the state to local teams. Another asked for communication on "what is being done at the state level regarding recommendations received from CCPT/CFPT teams." They also pushed for review of policies that impacted child welfare:

"They need to look at the legislative level and see how the laws are contradictory within itself as that creates a lot of tension between agencies which create distrust and prohibit child welfare globally."

In summary, the local objectives reflected the teams' recommendations, based on their case reviews, on improving child welfare services. The objectives that they set focused on matters that they could address in their communities rather than on state policy or funding changes. Their success in achieving their objectives varied extensively, with higher self-ratings mainly for concrete, time-limited, and measurable steps. They had slower momentum putting in place more, improved, and accessible services that relied on county, state, or national developments. An area of substantial progress was improving their team functioning. Many found that a partnering approach helped them achieve their objectives, and many wanted further support from the state. The state assistance that they were seeking related mainly to funding, notification of grant opportunities, clearer policy, training, access to drug records, support for local planning efforts, and interceding with other state players (e.g., courts). In moving forward, they met numerous challenges including changes in county leadership and partnering organizations. At the end of the survey, they made thoughtful comments on what further supports were needed that ranged from more state training to review of conflicting policies to reassessment of the role of CCPTs in a time when the state was changing its broader fatality system.

II. 2019 Recommendations of the NC CCPT/Citizen Review Panel Advisory Board

As summarized by the U.S. Children's Bureau, CRPs under CAPTA are intended to examine "the policies, procedures and practices of State and local child protection agencies" and make "recommendations to improve the CPS system at the State and local levels." In fulfilling this mandate, the NC CCPT/Citizen Review Panel Advisory Board used the extensive information and ideas from the 89 CCPT surveys, as well as earlier end-of-year CCPT reports, to formulate the first three recommendations listed below. In the 2019 survey, the CCPTs identified a range of means for supporting their work. The Advisory Board was very cognizant that supports for CCPTs are all the more necessary in sfy's 2020 and 2021 as localities grapple with the effects of the coronavirus pandemic. Hence, a separate set of two recommendations are proposed below for strengthening the work of the CCPTs.

In accordance with CAPTA, we propose the following for child protection at the state and local levels.

RECOMMENDATION 1 – IMPROVE ACCESS TO BEHAVIORAL HEALTH SERVICES OF CHILDREN, YOUTH, AND FAMILIES SERVED BY CHILD WELFARE

1. *Develop State Action Plan.* Undertake the following steps:
    a. Early in sfy 2021:
        i. Designate the NCDSS Family and Child Wellness Coordinator to facilitate the development of the action plan;
        ii. Consider whether to place development of the action plan for behavioral health access under the third CRP or some other entity and determine representatives to serve on the planning group;

iii. Report the number of children, youth, and families requiring behavioral health services under Medicaid and compare them with numbers receiving these services whether through Medicaid or other funding streams over time;
iv. Identify reasons why children, youth, and families served by child welfare do not receive behavioral health services; and
v. Ensure representatives from NCDHHS, LME/MCO, MH/SU providers, Advisory Board, NC Child Welfare Family Advisory Council, and other involved bodies.

b. In sfy 2021:
i. Convene workgroup(s) on improving access to *MH/SU Services.*
ii. Develop a written plan of collaboration in a memorandum of agreement that includes: goals, roles of signatories, action steps with timeline, monitoring, and reconvening in one year's time to assess progress and refine the collaboration plan.

2. *Enhance Accessibility of Services*. Explore in sfy 2021, the options to:
   a. Use telehealth to allow for physical distancing during a pandemic and afterwards and better access for rural communities, taking into account considerations such as security and privacy and availability of funding streams;
   b. Deliver services in the home, such as outpatient therapy, which can be more family friendly, as long as not prohibited by safety issues (ex., because of household domestic violence);
   c. Encourage services to offer transportation resource to their program (ex., Uber, taxi, bus);
   d. Increase parent access to health insurance, including in cases where children are residing outside the home; and
   e. Facilitate health care of all families served by child welfare, including when the parents are undocumented.
3. *Consider New Methods of Service.* In sfy 2021:
   a. Encourage consideration by behavioral health services of new ways to treat trauma that are proving to be effective but may not be fully mainstream yet (ex., Neurofeedback, Eye Movement Desensitization and Reprocessing); and
   b. Support funding of these methods that are not currently covered by LME/MCOs.

RECOMMENDATION 2 –PROMOTE THE SAFETY OF VULNERABLE INFANTS

1. *Advance Safe Sleeping.* In sfy 2021, continue to work with the North Carolina Public Health Association (NCPHA) and partner with the UNC Center for Maternal & Infant Health to:
   a. Assess the need for safe infant sleep spaces across North Carolina; and
   b. Seek funding to provide portable cribs to families in need of this resource, combined with safe sleep education through Care Management for At-Risk Children (CMARC).
2. *Strengthen Plan of Safe Care (POSC) Approach for Substance Affected Infants.* In sfy 2021:

a. Inform and clarify, for local Social Services and CCPTs, practices, policies, and procedures concerning POSC;
b. Facilitate local DSSs having access to information required for making an informed POSC (ex. treatments planned and/or received by parents and infants, confidentiality issues regarding federally protected information on substance us):
c. Request that local DSSs and CCPTs review all screened-out reports of substance affected infants;
d. Continue to provide resources to local DSS on substance affected infants;
e. Incentivize local DSS's to dedicate staff to manage substance affected infants in order to increase timely access to needed services; and
f. Foster a supportive rather than penalizing approach to the parents of substance affected infants.

3. *Support the Citizen Review Panel (CRP) on POSC.* In sfy 2021, facilitate the efforts of the CRP:
    a. Designate a NCDHHS liaison to work with the panel;
    b. Ensure staffing and/or consultants with the requisite expertise in policy, research, and community outreach for the panel;
    c. Connect the panel to local, state, and national groups working on POSC;
    d. Expedite the panel's access to needed materials (ex., case files, literature reviews, policy statements) for conducting their work; and
    e. Assist the panel with disseminating their reports and seeking public input on the action plan.

RECOMMENDATION 3 – ENHANCE IDENTIFICATION AND PREVENTION OF CHILD MALTREATMENT FATALITIES AND NEAR FATALITIES

1. *Collaborate on Ensuring that Involved Parties in North Carolina Are Prepared for Passage of the Child Death Review Framework.* In sfy 2021:
    a. Facilitate advance notification about impending changes to Courts, Medical Examiners, Law Enforcement, Public Health, Child Welfare, Child Prevention Fatality Teams, CCPTs, and other involved parties;
    b. Clarify roles and responsibilities of different groups within the child death review framework;
    c. Encourage participation in the technical assistance and training for identification and prevention of child fatalities; and
    d. Support North Carolina's inclusion in and use of the national databank of case-specific child deaths.
2. *Ensure Accurate Reporting of Child Near Fatalities.* In sfy 2021:
    a. Operationalize the definition of near fatalities by specifying procedures for local DSSs and their communities to identify case-specific near fatalities;
    b. Set forth policies and procedures for reporting near fatalities to state DSS; and
    c. Make recommendations to local teams on identifying and reviewing child near fatalities.

3. *Identify and Address Challenges in Reporting Case Reviews.*
    a. In August 2020, provide information to the Advisory Board on the best way for the calendar-year 2020 CCPT survey to ask for the number of notifications of child maltreatment fatalities and near fatalities and for the number of reviews of active cases versus child maltreatment fatalities;
    b. In January 2021, to assist with interpreting survey results, provide the Advisory Board with the number of notifications of child maltreatment fatalities and near fatalities in the 2020 calendar year; and
    c. In sfy 2021, use the results from the 2020 survey to check and improve the state's procedures for obtaining accurate and complete reports of child maltreatment fatalities and near fatalities.
4. *Support the Citizen Review Panel (CRP) on Child Fatalities and Near Fatalities.* In sfy's 2020 and 2021, facilitate the efforts of the CRP:
    a. Designate a NCDHHS liaison to work with the panel;
    b. Ensure staffing and/or consultants with the requisite expertise in policy, research, and community outreach for the panel;
    c. Connect the panel to local, state, and national groups working on near fatalities;
    d. Expedite the panel's access to needed materials (ex., case files, literature reviews, policy statements) for conducting their work; and
    e. Assist the panel with disseminating their reports and seeking public input on the action plan.

Based on the 2019 and earlier CCPT surveys, we propose the following to enhance the functioning of CCPTs.

RECOMMENDATION 4 – IMPROVE CASE REVIEWS BY CCPTS

1. *Offer Training and Technical Support on Conducting Case Reviews.* In sfy 2021:
    a. Engage participants through co-training on case reviews by community and family partners;
    b. Assist teams during CCPT coordinator's visits (in person and/or through distance means) in the following areas: defining the cases they would like to review, writing down the procedure for the local teams, and checking on and supporting their progress;
    c. Involve local teams in creating a 15-minute webinar on conducting reviews of active cases (including near fatalities) and child maltreatment fatalities, cover confidentiality requirements which are the same for all members (whether agency, community, or family), and disseminate the webinar by September 2020; and
    d. Seek participant feedback on all training and technical support, and document responses to share with the Advisory Board.
2. *Increase Local Teams' Access to Information Necessary for Complete Case Reviews.* In sfy 2021:
    a. Provide clarifications on policies regarding such matters as family reunification and definition of caretakers; and
    b. Where feasible, facilitate sharing confidential information (ex. drug use).

RECOMMENDATION 5 – SUPPORT THE CAPACITY OF LOCAL TEAMS TO CARRY OUT THEIR WORK

1. *Enlarge the Formally Required Members on Local Teams.*
    a. Encourage the state legislature in sfy 2021 to add to team membership: (1) a Juvenile Justice representative (which would parallel the membership on the NC Child Fatality Task Force in House Bill 825 and the pending state budget bill), (2) community action agencies or community non-governmental organization providing prevention-focused services (this change requires altering the language on community partners), (3) family partners (two per team) with lived experience in the child welfare system, (4) military liaison in counties with high military populations, and (5) tribal representative as nominated by the NC Commission of Indian Affairs;
    b. Seek guidance in sfy 2021 from relevant bodies on these membership expansions and the best ways to proceed with them (ex., Military Family Support Centers, NC Child Welfare Family Advisory Council); and
    c. Reference sections of this report in sfy 2021 to make the case to legislators of the reasons for formally enlarging the teams' membership.
2. *Extend, Enrich, and Make Accessible State Training of Local Teams.*
    a. Beginning in sfy 2021, facilitate the CCPT Consultant's annually visiting (in person and/or distance) 50% of CCPT teams;
    b. Over sfy's 2021 and 2022, use the findings in this report and further consultations with Advisory Board members and local teams to design, test, refine, format for on-demand delivery, and provide ongoing support for 12 online webinars or other learning opportunities for all 101 teams;
    c. Create by October 2020 as part of the overall webinars, a 10-minute webinar on engaging the entire local team in completing the survey as a group, encourage teams to view the webinar in November 2020 and document their local procedure for a group response on the survey, and encourage teams at end of the survey completion to assess their performance by February 2021;
    d. Enrich these trainings by using a co-training model of family and community partners to identify topics, examine wording and its impact on families, and deliver trainings, and ensure payment of family trainers for their work; and
    e. Seek participant feedback to keep the trainings relevant to local teams.
3. *Provide Funding to Local Teams.* Beginning in sfy 2022,
    a. Allocate annual funding of $1,000 per team for operational and project support;
    b. Assist teams with understanding requirements on documenting the expenditure of the funds and assessing their local impact; and
    c. Ensure that the results of the funds are summarized and a report provided to funding sources and the Advisory Board.
4. *Ensure Local Teams Receive Supports that They Request.* Beginning in sfy 2021:
    a. Ensure requested supports such as notification of grant opportunities, informational and material support for local planning efforts (ex., brochure on safe sleeping), and interceding with other state players (ex., courts); and

    b. Document these efforts, and report on them to the Advisory Board.
5. *Foster Exchanges of CCPTs from Different Locales.* Beginning in sfy 2021,
    a. Offer cross-county summits and other forums through online means to encourage robust exchanges and creative ideas for child welfare improvements.
    b. Identify topics for these exchanges with local teams and the Advisory Board.
6. *Explore for Calendar Year 2021 CCPT Survey, Changing the Data-Collection Protocols to Permit the Researchers to Share Survey Results with Individual Teams Identified.* In sfy 2021:
    a. Review steps for moving from having de-identified data in reports to identifying the results by individual teams and providing the identifiable data to the NC CCPT/CRP Advisory Board, the Board's subcommittees (ex., CRPs), and NC DSS;
    b. Consult the Children's Committee of the NC Association of County Directors of Social Services (NCACDSS) and other pertinent bodies on these changes in survey procedure;
    c. Support inquiries to the Institutional Review Board for the Protection of Human Subjects (IRB) on moving from current procedures which only allow sharing de-identified by individual teams and about the likely timeline for receiving approval for this change; and
    d. Support using identified data to offer local CCPTs education and mutual support.

References

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Appendices
Appendix A: Survey Process and Results

Table A-1 Timeline of CCPT Survey, 2019
Timeline of CCPT Survey, 2019

Date	Activity
August 19, 2019	NC CCPT Advisory Board ad-hoc survey subcommittee developed end-of-year survey
September 16, 2019	NC CCPT Advisory Board finalized the survey
September 20th, 2019	Survey materials sent to NC DSS for Approval
November 4, 2019	NC State University Institutional Review Board approved research protocols protecting participants
November 25, 2019	NC DSS sent letters to the County DSS Directors and to the CCPT Chairs to notify them about the survey
November 26, 2019	NC State University Research CCPT Team distributed survey to CCPT Chairpersons or designees followed by weekly reminders to unfinished respondents
January 7, 2020	NC DSS reminded CCPT Chairs to complete the survey
January 15, 2020	Deadline for survey submission
January 30, 2020	Extended deadline for survey submission
March 30, 2020	NC CCPT Advisory Board reviewed first draft of survey findings and report and created preliminary recommendations
April 13, 2020	The Advisory Board reviewed recommendations.
May 11, 2020	The Advisory Board finalized and approved the recommendations.
May 15, 2020	End of Year Report to NC DSS
TBD	Results of the survey to CCPTs

Table A-2 Counties of CCPTs Submitting Survey Report

Local CCPTs Submitting Survey Report, 2019

Participating Counties			
Alamance	Davidson	Macon	Scotland
Allegheny	Eastern Band of Cherokee Indians	Madison	Stanly
Ashe	Edgecombe	Mecklenburg	Stoke
Avery	Forsyth	Mitchell	Swain
Beaufort	Franklin	Montgomery	Transylvania
Bladen	Gaston	Moore	Tyrrell
Brunswick	Gates	Nash	Union
Buncombe	Graham	New	Vance
Burke	Granville	Hanover	Wake
Cabarrus	Green	Northampton	Warren
Caldwell	Guilford	Onslow	Watauga
Camden	Halifax	Orange	Wayne
Carteret	Harnett	Pasquotank	Wilkes
Caswell	Haywood	Pender	Wilson
Catawba	Henderson	Perquimans	Yadkin
Chatham	Hertford	Person	Yancey
Chowan	Hoke	Pitt	
Clay	Hyde	Polk	
Cleveland	Iredell	Randolph	
Columbus	Jackson	Richmond	
Craven	Jones	Robeson	
Cumberland	Lee	Rockingham	
Currituck	Lenoir	Rowan	
Dare	Lincoln	Rutherford	

Note. The survey was sent to 101 CCPTs of whom 89 responded.

Table A-3 Responding CCPTs by County Population Size
Responding CCPTs by County Population Size, 2019, (N=89)

County Size	Total Counties	Total Responding Counties	Percent
Small	54	46	83%
Medium	35	32	94%
Large	11	10	90%

Table A-4 LME/MCOs and Number of Member Counties Responding to Survey
LME/MCOs and Number of Member Counties Responding to Survey, 2019

LME/MCO		Number of Member Counties	Total Responding Counties	Percent
Alliance Behavioral Healthcare		4	3	75%
Cardinal Innovations Healthcare Solutions		20	19	95%
Eastpointe		11	9	82%
Partners Behavioral Health Management		8	8	100%
Sandhills Center		9	8	89%
Trillium Health Resources		25	21	84%
Vaya Health		23	20	87%
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. Eastern Band of Cherokee Nation not affiliated with an LME/MCO.

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, 2019, (N=89)

CCPT/CFPT Organization	Number of Counties	Percent
Separate CCPT and CFPT	17	20%
Combined CCPT and CFPT	66	77.6%
Other	2	2.4%

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
2019	0-14 (F)	85 (F)	436	NC DSS conducted intensive state child fatality review

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%)
2019 (*n*=89)	Active Case	61 (69%)	Child Safety	51 (57%)

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)	2019 (*n*=89)
Reports from Members and/or Case Managers	71 (97%)	60 (92%)	61 (98%)	57 (65%)	67 (94%)
Case Files	60 (82%)	49 (75%)	52 (85%)	56 (64%)	61 (86%)
Information on Procedures and Protocols of Involved Agencies	44 (60%)	38 (58%)	39 (63%)	34 (39%)	47 (66%)
Child and Family Team Meeting Documentation	28 (38%)	21 (32%)	27 (44%)	21 (24%)	30 (42%)
Medical Examiner's Report	24 (33%)	18 (28%)	14 (23%)	21 (24%)	25 (35%)
Individualized Education Plan	18 (25%)	16 (25%)	12 (19%)	6 (7%)	21 (30%)
Other	8 (11%)	6 (9%)	8 (13%)	9 (10%)	10 (14%)

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

	2017		2018		2019	
Type of Information	Combined (*n*=61)	Separate (*n*= 16)	Combined (*n*=72)	Separate (*n*=13)	Combined (*n*=53)	Separate (*n*=16)
Reports from Members and/or Case Managers	45 (74%)	15 (94%)	45 (63%)	10 (77%)	50 (94%)	15 (94%)
Case Files	37 (61%)	14 (88%)	47 (65%)	7 (54%)	45 (85%)	14 (88%)
Information on Procedures and Protocols of Involved Agencies	29 (46%)	9 (56%)	25 (35%)	7 (54%)	37 (70%)	9 (56%)
Child and Family Team Meeting Documentation	20 (33%)	6 (38%)	18 (25%)	3 (23%)	23 (43%)	6 (38%)
Medical Examiner's Report	13 (21%)	1 (6%)	19 (26%)	1 (7%)	20 (38%)	4 (25%)

Individualized Education Plan	9 (15%)	3 (19%)	5 (7%)	1 (7%)	16 (30%)	5 (31%)
Other	5 (8%)	1 (6%)	8 (11%)	0 (0%)	8 (12%)	1 (6%)

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)	2019 (*n*=89)
Separate CCPT and CFPT	18 (25%)	23 (26%)	17 (20%)	17 (21%)	14 (15%)	17 (19%)
Combined CCPT and CFPT	53 (75%)	63 (72%)	66 (77%)	62 (78%)	77 (83%)	66 (74%)
Other	0 (0%)	1 (1%)	3 (3%)	1 (1%)	1 (1%)	2 (2%)

Note: Number of counties (percent)

Table B-6. Mandated CCPT and CCPT/CFPT Members and Mean Rate and Rank of Participation, 2017, 2018, and 2019

	2017 Average (Rank)		2018 Average (Rank)		2019 Average (Rank)	
Mandated Member	Combined (*n*=61)	Separate (*n*=16)	Combined (*n* = 73)	Separate (*n*=13)	Combined (*n* = 73)	Separate (*n*=13)
DSS Director	3.17 (4)	2.38 (9)	3.25 (4)	3.69 (7)	3.16 (4)	2.94 (4)
DSS Staff	3.90 (1)	3.75 (1)	3.88 (1)	4.54 (1)	3.90 (1)	3.94 (1)
Law Enforcement	2.82 (8)	2.53 (8)	2.77 (7)	3.85 (6)	2.91 (7)	2.76 (7)
District Attorney	1.93 (11)	2.31 (10)	1.70 (13)	2.92 (10)	1.88 (13)	2.53 (9)
Community Action Agency	2.83 (7)	3.00 (6)	2.66 (8)	3.46 (9)	2.68 (8)	2.47 (10)
School Superintendent	2.40 (9)	2.69 (7)	2.36 (9)	3.54 (8)	2.24 (10)	2.65 (8)
County Board of Social Services	2.35 (10)	2.19 (11)	2.24 (11)	2.85 (11)	2.20 (12)	1.94 (11)
Mental Health Professional	3.57 (2)	3.50 (2)	3.30 (3)	4.46 (2)	3.44 (2)	3.59 (2)
Guardian ad Litem	3.10 (6)	3.00 (5)	3.03 (6)	3.92 (4)	3.07 (5)	3.06 (3)
Public Health Director	3.17 (5)	3.06 (3)	3.17 (5)	3.92 (3)	3.07 (6)	2.88 (5)

Health Care Provider	3.23 (3)	3.00 (4)	3.37 (2)	3.85 (5)	3.41 (3)	2.82 (6)
District Court Judge			.92 (16)		.94 (16)	
County Medical Examiner			1.47 (14)		1.28 (14)	
EMS Representative			2.21 (12)		2.26 (9)	
Local Child Care or Head Start Rep			2.29 (10)		2.21 (11)	
Parent of Child Fatality Victim			1.06 (15)		1.09 (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)	2019 (*N*=89)
Alamance	x	x	x	x	x	x
Alexander		x			x	
Alleghany	x	x	x	x	x	x
Anson		x	x	x		
Ashe		x				x
Avery	x	x	x	x	x	
Beaufort	x					x
Bertie	x	x		x		
Bladen	x	x	x	x	x	x
Brunswick	x	x	x	x	x	x
Buncombe	x	x	x	x	x	x
Burke	x	x	x	x	x	x
Cabarrus	x	x	x	x	x	x
Caldwell		x	x		x	x
Camden	x	x	x	x	x	x
Carteret		x	x	x	x	x
Caswell	x	x	x	x	x	x
Catawba	x	x	x	x	x	x
Chatham	x	x	x	x	x	x
Cherokee			x	x	x	
Chowan	x	x	x	x	x	x
Clay	x	x	x	x	x	x
Cleveland		x	x	x	x	x
Columbus	x	x	x	x		x
Craven	x	x	x	x	x	x
Cumberland	x	x	x	x	x	x
Currituck	x	x	x		x	x
Dare	x	x	x	x	x	x
Davidson	x	x	x	x	x	x
Davie	x	x				
Duplin	x	x				
Durham			x	x	x	
Eastern Band of Cherokee Nation (Qualla Boundary)				x		x

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

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

Table B-8. Small County Participation by Year

County	2014	2015	2016	2017	2018	2019
Respondents (%)	36 (71%)	42 (82%)	40 (78%)	38 (78%)	45 (83%)	46 (85%)
Alexander		x			x	
Alleghany	x	x	x	x	x	x
Anson		x	x	x		
Ashe		x				x
Avery	x	x	x	x	x	x
Beaufort	x					x
Bertie	x	x		x		
Bladen	x	x	x	x	x	x
Camden	x	x	x	x	x	x
Caswell	x	x	x	x	x	x
Chatham	x	x	x	x	x	x
Cherokee			x	x	x	
Chowan	x	x	x	x	x	x
Clay	x	x	x	x	x	x
Currituck	x	x	x		x	x
Dare	x	x	x	x	x	x
Davie	x	x				
Gates	x	x	x	x	x	x
Graham		x	x	x	x	x
Granville			x		x	x
Greene			x		x	x
Hertford	x	x	x	x	x	x
Hoke	x	x	x	x	x	x
Hyde	x	x	x	x	x	x
Jackson	x	x	x	x	x	x
Jones	x		x		x	x
Lee		x	x	x	x	x
Lenoir	x	x	x	x	x	x
Lincoln	x	x	x	x	x	x
Macon	x	x	x	x	x	x
Madison	x			x	x	x
Martin	x	x	x	x	x	x
McDowell			x		X	
Mitchell	x	x	x	x		x
Montgomery	x	x	x	x		x
Northampton		x	x	x	x	x
Pamlico		x		x		
Pasquotank	x	x	x	x	x	x
Pender	x	x	x		x	x

PERQUIMANS		x			x	x
PERSON	x	x	x	x	x	x
POLK	x	x	x	x	x	x
RICHMOND	x	x	x	x	x	x
SCOTLAND		x	x	x	x	x
STANLY	x	x	x	x	x	x
STOKES	x	x	x	x	x	x
SWAIN	x	x	x		x	x
TRANSYLVANIA						x
TYRRELL			x	x	x	x
WARREN	x	x	x		x	x
WASHINGTON				x	x	
WATAUGA	x	x	x	x	x	x
YADKIN	x	x	x	x	x	x
YANCEY	x	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	2019
RESPONDENTS (%)	30 (77%)	36 (92%)	36 (92%)	34 (87%)	32 (91%)	32 (91%)
ALAMANCE	x	x	x	x	x	x
BRUNSWICK	x	x	x	x	x	x
BURKE	x	x	x	x	x	x
CABARRUS	x	x	x	x	x	x
CALDWELL		x	x		x	x
CARTERET		x	x	x	x	x
CLEVELAND		x	x	x	x	x
COLUMBUS	x	x	x	x		x
CRAVEN	x	x	x	x	x	x
DAVIDSON	x	x	x	x	x	x
DUPLIN	x	x				
EDGECOMBE	x	x	x	x	x	x
FRANKLIN	x	x		x	x	x
HALIFAX	x	x	x	x	x	x
HARNETT	x	x	x	x	x	x
HAYWOOD		x	x	x	x	x
HENDERSON	x	x	x	x	x	x
IREDELL	x	x	x	x	x	x
JOHNSTON	x	x	x	x		x
MOORE		x				x
NASH	x	x	x	x	x	x
ONSLOW	x	x	x	x	x	x
ORANGE	x	x	x	x	x	x
PITT			x	x	x	x
RANDOLPH	x	x	x	x	x	x
ROCKINGHAM	x	x	x	x	x	x
ROWAN	x	x	x		x	x
RUTHERFORD	x	x	x	x	x	x
SAMPSON	x	x	x	x	x	
SURRY		x	x	x	x	x
UNION		x	x	x	x	x
VANCE	x	x	x	x	x	x
WAYNE	x	x	x	x	x	x
WILKES	x		x	x	x	
WILSON	x	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	2019
RESPONDENTS (%)	5 (50%)	9 (90%)	10 (100%)	8 (80%)	11 (100%)	10 (91%)
BUNCOMBE	x	x	x	x	x	x
CATAWBA	x	x	x	x	x	x
CUMBERLAND	x	x	x	x	x	x
DURHAM			x	x	x	
FORSYTH		x	x		x	x
GASTON		x	x	x	x	x
GUILFORD	x	x	x	x	x	x
MECKLENBURG		x	x	x	x	x
NEW HANOVER	x	x	x	x	x	x
ROBESON	x	x	x	x	x	x
WAKE		x	x	x	x	x

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

Appendix C: Qualitative Responses

Barriers to Team Operation Participation

Participation

The biggest barrier we face is lack of participation. We are missing several key people at the table.

The barriers that we are facing is that we cannot get any Law enforcement, Judges, Community people and Guardian Ad Litem.

Sporadic attendance from some team members

Participation from all members at quarterly meetings

Parent participation (parent of a deceased child)

Trying to find a day and time that suits all participants in order to have good attendance at each meeting.

Time and attendance as so many of our members serve on multiple boards/meetings and are also delivering the services. Just cannot be everywhere all of the time.

Team members are all employed and time commitment is challenging to attend meetings and implement recommendations from case & fatality reviews

Maintaining consistent involved members

Loss of participant in medical field

Leadership changes within our local agency.

Inconsistent attendance by a judge and medical examiner.

Getting community partnership without local MAT agencies.

Getting all Members to the table may sometimes be difficult. Which in turn may cause a meeting to be bi-monthly (every other month)

Filling positions for youth and parent on the Team

Distance between team members. All members can't attend each meeting due to living in different areas of the state. Some meetings are held via web

Participation (continued)

Difficulty engaging a parent/client participant.

Consistent participation from required members

Consistent attendance and participation of some community partners

Attendance and identifying community partners to participate.

Attendance from community partners

It has been difficult to recruit and retain parent members

Representation from all agencies

We welcome collaboration and feedback with other county CCPTs to reduce duplication of efforts.

Funding

Not having funding to assist us with projects.

Funding is limited as well.

Funding for projects

Preparation

We continue to have the barrier of team members not submitting cases for bi-monthly review.

Our CCPT has an issue reviewing cases as no one brings cases into the meetings to discuss.

Information Access

Sometimes, we may experience difficulty when attempting to collect pertinent information and/or records from our military affiliates.

Our team has struggled to receive important data from the state regarding fatality and child protection trends, responses to our recommendations, and the relevance of much of our reporting. This threatens to

reduce engagement of crucial team members.

Policy and Practice
The biggest problem we often face is political in nature. All CCPT's should constantly have the best interests of the child at the forefront of all that we do. Sometimes, it is difficult to honor that when partners are in conflict about what the best interests of a child are. It often appears that the conflict within partnerships surrounds conflicts within North Carolina State Statutes.

Majority of issues we face are issues that cannot be handled on a community level, but are those on a broader level
Clarity on state expectations of the CCPT team.

Case Load
Backlog of intensive fatality reviews to complete along with other responsibilities of our blended team. Continued staffing and organizational changes in key agencies.
As a combined CCPT/CFPT with many complex fatalities to review last year, we only had time to review 2 DSS open cases.

Top Three Objectives Based on Identified Improvement Needs

Recruitment

Recruitment efforts
Recruit youth, family members, foster family, and medical provider
Recruit family/children partners for CCPT

Training

Education/Training for CCPT members.
Resiliency Training
Complete CCPT training requirements.

Service Availability and Quality

Improved MH/DD Services
Availability of SA/MH providers
Mental Health Services

Education/Promoting Awareness/Public Knowledge

...Shared community education events
Educating community partners
Continued public education on available services
Educating service providers on the needs citizens
Public awareness
Education awareness walk
"Fall in the Park"
Parenting

Access to Services

Continue to discuss barriers to accessing services
Access to MH svcs.
Improve access to services for undocumented persons

Systemic Resources

After hours transportation.
Housing Issues.
After School Care.
After hours daycare
Increase access to affordable housing

Resources

Resources
Resources for extra-curricular activities/support groups
Providing Pack-n-Plays (Cribs)
Free or at cost car seats

Communication and Collaboration

Outreach to Law Enforcement, hospital, and emergency services
Collaboration
Improved communication between agencies
Communication gaps
Partner with community agencies to sponsor training and support awareness events
Collaborate with community partners to bring awareness and education on Child Abuse
Partnership with team members to assist with P4 NCF transition
Collaborated with the local school system to address teen suicide through education and public information
Adding more community agency representatives to the CCPT
Access MH/SA/DV client information timely and consistently
Support the creation of community initiatives as defined by the community
Identify new services available to the community

Engagement

Invite more member
Improve participation
Members coming more regularly
Move meeting to the hospital for better attendance of health care professionals

Vaping and E-Cig Use
Vaping - E-Cigarettes
Teen Vaping & E-Cig Use among Teens - parental awareness and teen awareness of effects

Safe Sleeping
Continue to discuss/educate on safe sleep
Decrease co-sleeping deaths
Developed a sub-committee on safe sleep
Strengthen Safe Sleep initiatives
Safe sleeping

Prevention and Early Intervention
Suicide prevention
Prevention during the month of April
Advocate for funding for prevention on the state level and on the local level to continue CRP

Planning and Continuity
Planning re: Child Abuse Prevention Plan
Program after the grant ends

Infant/Toddler Needs
Medication guidelines for children age 5 and under

General Safety
Seat belt check
Pool safety and children
access

Substance Use
Opioid Awareness/education
Opioid crisis in our community
Bringing more service specific providers to the area to work with substance abusing youth
Access to SU svcs
Continue to discuss/educate on the Opioid Epidemic

Administrative Concerns
At each meeting have a follow-up report on all cases presented
Update protocols for military case reviews
start MDT meetings
Turnover
Fewer stuck cases
Rejuvenate the CCPT local team

Identification, Review, and Referral of Cases
Review cases utilizing protective factors overlay
Refer more cases to CCPTs
Ways to identify cases to bring to the CCPT for review
Identify child protection needs as they arise and act quickly upon them

Trauma
Ongoing focus on use of ACEs in all agencies
Promote Trauma/Resiliency

Factors that Assist Teams Achieve their Objectives

Collaboration

Collaboration
Our continued collaboration with local agencies
Solid sharing of information regarding case concerns
Collaboration with the CFPT and ARHS to identify presenter, arrange workshop and share information
Community partners support
Collaborative meetings and media provided on community channel
Partnering with Trillium
advocate[ing] to school board for Youth Mental Health First Aid in school system
Partnerships within SOAR
collaboration with community
Willingness of local agencies to collaborate to address issues
Continued collaboration with Housing Authority to increases access to FUP vouchers for CPS/CWS involved families
Collaboration between Community Partners
Assistance from MH partner and the school
New provider in the community; provider located in DSS completing QSAP
Networking
Partnership
Input from medical providers and CPS staff who serve on CCPT
Partnership with bilingual services providers
We are in the process of brainstorming ideas to recruit new members from key agencies inviting providers inside and outside the county to CCPT

Education/Distributing Information

Use of course "Child Development and the Effects of Trauma"

Funding

Funding for CCPT to sponsor and co-sponsor events in the community and to be more visible in the community
Fundraising/friendraising
Grant, partnerships

Communication

CCPT team members sharing information with the public on safe sleep
Expanded community and agency presentations and discussions on video "Resilience" Discussing gaps in services and some of the group members finding ways to provide helpful services
Dialogue/Feedback/communication
Informing mental health providers of needs in the community
Researching and inviting providers to the table to discuss their services
Ongoing discussion about the opioid epidemic
Having a MH partner at the meetings to relay the needs to the LME.

Training

The state provided a training on CCPT at our Agency and this counted as one of our quarterly meetings
Ongoing training on and access to services available to military families
Inclusion of fathers in all training on safe sleep
In April, hosted a mini-CCPT training conducted by CCPT state consultant with members

Participating in county wide events to distribute information
Presentations for the CCPT by experts in the field of concern

Forms developed to address co-sleeping and supervision to hand out to families
Assessment by all agencies on appropriate use of Pack N Plays (for safe sleep environment for children- not storage).

Staff Performance and New Hiring
Team members
Knowledge and experience of team members
The team working together towards one goal
Community DSS Technician position - trained in parenting
Medical DSS Board Member recruited retired pediatrician for the team
Our CFPT/CCPT members continued to notice a trend in infants dying in unsafe sleep environments

Meetings
Recent goals set in December's meeting
Regular meetings re: Child Abuse Prevention Plan
Chose a head and team for MDT meetings

Engagement
Attendance
Attendance by relevant agency staff in bi-monthly clinical case staffings within the military system
Community engagement
An improvement with mental health attendance
Each member contributed to inviting new members.

Administrative Improvements
Sending out invitations timely
Earlier invites, reminders and scheduling
Chair provided case follow-ups for all members
Sent out notices of cases being reviewed in advance
Adding Hospitality House to CCPT
Clearer guidelines to follow from the NCDHHS-DSS

How NC DSS can assist in CCPTs Achieving Local Objectives

Funding
Funding for educational materials
Funding for Prevention Programs within DSS
More funds to provide car seats
Providing funding source for rural counties.
Funding to increase services
Funding for marketing.
Funding for CCPT to sponsor and co-sponsor events in the community and to be more visible in the community
Without funding we are not able to implement ideas for improvement
Allocate additional funds to support MH services in rural communities.

Education/Sharing Information
Increased education to all SW's and community providers regarding Safe Sleep
Provide knowledge of grant opportunities to provide extra-curricular activities

Training
Training; support
Continue to provide these trainings in the area annually
More trainings

Provide More Resources
Provide any available updated materials or resources
Provide uniform materials that could be provided to citizens to help get the word out about available resources
Access to medicaid or other funding sources for undocumented persons.
Medicaid expansion, budget approval, improved oversight for Medicaid providers
Provide Resources

Training cont.
Trainings on CCPT
Assist with any training necessary to restarting our team

Additional training opportunities
Require training to all state agency to properly identify child abuse and neglect and how to properly complete a child welfare referral
Offer training to providers on how to best meet the needs of high risk populations

Education/Distributing Information
Share information on how ACEs is being incorporate[d] in State protocols and other agencies/counties

Advocacy
Lobby the legislature to allow CPS SW's access to the Controlled Substance Abuse Reporting System
Advocacy

Participation/Engagement
Participate in community education
Attend CCPT meeting

Provide more financial resources to s.
Increase housing subsidy availability
Continue to provide resources and recommendations.
Offer incentives to providers to specific services to counties
Implementing a way for local DSS to access client's drug treatment records.

Accessibility

Chair set aside time to send out notices and follow-ups
Be accessible to local team if needs arise
...Be available as partners

Increasing Staff/Staff Changes

Hire LCSWs for local DSSs to work with at risk children and children in foster care

Policy Guidance, Clarification, and Updating

Continue to provide policy guidance
Update CCPT handbook
Help clarify policies and procedures that work with mental health policy
Incorporate information noted above into statewide initiative Court system to be more efficient with scheduling judges

Communication and Collaboration

Clearer policy to other state agencies
Meet with new leadership to discuss moving forward
…Take constructive criticism with the goal of improving practice.
Provide continued support in communities allowing community partners to see support from NC DSS
Collaborate with other teams

Challenges to Achieving Local Objectives

Funding
Funding
Originally lack of funds, but grants help
Lack of funding
Financial support for Safe Sleep campaign
Lack of funding could promote more education and awareness with funding for CCPT members not being regular

Limited Time
Time Restraints
Time commitments
Time constraints to plan and organize special events to address recommendations
Member availability and participation - finding the time!
Time commitment constraints with regular job availability and time
Potential members work schedule/work load

Limited Resources
Limited resources available in the community
Transportation
Resources
Lack of eligibility and resources
Access to training on Safe Sleep in rural areas
Gaps in services due to policy restrictions remain problematic

Staff Transition/Turnover/Limitations
Transition of staff
No one stays long enough
New director
Turnover by providers
Turnover with personnel facilitating initiative
Turnover in DSS staff
Staff turnover
Inconsistent leadership
Meeting fatigue

Trouble with Collaboration/Communication
Changes in roles with community partnership
Having other agencies outside of DSS bring cases to review
State support
SWs remembering that they can make referrals to have case heard at CCP

Inability to Access Information
Obtained information from LE and Hospital staff
Inability to access necessary information

Lack of Participation/Response/Interest
Lack of Response
Inconsistent attendance of certain team members
Lack of interest from the public to participate in events
Extended recover efforts from natural disasters, families still displaced from housing project suspended and county opted to not participate
Attendance from some agencies
Lack of participation from agencies
Lack of commitment from providers to stay in the area once services begin here
Attendance

Lack of Awareness/Ability to Recruit
Need for more widespread awareness
The team has not been able to recruit the needed members to meet our objective
LME cannot find providers with staff willing to travel to the county to provide the service

Ongoing, Time Intensive Goal

Increased capacity for MH/DD services
continues to be an enormous task
Sustainability of progress made in achieving set goals
Ongoing goal that will take time to achieve

Further Support Requested to put Recommendations in Action

Funding

Increased State and local funding
Funding
Financial support to implement a safe sleep campaign
Financial support and readily available materials to offer to the community
Community support/funding
Additional state funding to offset local dollars for child welfare positions
Grant money to support after school care
Increased funding sources
...Adequate funding for services can be problematic
Funding for resources and to provide more educational training for CPS workers
Medicaid expansion and increased state funding for MH/DD/SA and housing subsidies

More Resources/Access to Resources

More providers, reduction eligibility criteria, staffing.., funding, daycare options,...community involvement/support, case mgt. system, family planning options, transportation continued training
Access to more essential services
Prevention resources available for community education
There should be resources (staff, materials, technical assistance, immigrants) to help CCPTs implement recommendations because all team participants are volunteering their time and resources
A focus by state officials (appointed and elected) on lack of services related to substance use, poverty, and mental health

Training

Trainings for staff retention
Technical assistance and training from the state
Any kind of training, facilitation of exchange of information among teams, and technical assistance would be helpful
Having more providers in [county name removed] county who can provide substance abuse treatment services training
Continued trainings by the state. training on CCPT would be helpful
State sponsored training
We would like to see a CCPT training offered by the State; there was a training offered this year for CFPT members by the State which was informative and helpful
Training
Trainings on CCPT
Have the team member to attend the annual review team training held by the state

Support/Guidance

Continued support as needed or requested
Assistance with understanding the role and expectations of CCPT in the community
State guidance in sharing information regarding MAT programs
Ongoing support from the State- sharing of information across teams on regular basis
Continued support of all team members
Support from the state

Increased Participation/Engagement

Have better attendance from mandated member

Consist support from community partners would be helpful
More participation from agencies
Invite
Commissioner Chair to meeting to discuss
Continue to educate members and community

Policy/Legislative Changes and Advocacy

They need to look at the legislative level and see how the laws are contradictory within itself as that creates a lot of the tension between agencies which create distrust and prohibit child welfare globally

Appendix D: Copy of 2019 Survey

CCPT Survey 2019
2019 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 2019 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. Sarah Desmarais and the other members of the research team (Emily Smith, Dr. Joan Pennell, , 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.

The 2017 and 2018 Community Child Protection Team End of Year Reports including recommendations from the Advisory Board, are available through the links provided below.

2017 Report

2017 Response

2018 Report

North Carolina State University

INFORMED CONSENT FORM for RESEARCH

Title: Community Child Protection Team 2019 Survey

Principal Investigator: Dr. Sarah Desmarais

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 NC DSS 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

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 irb-director@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."

- o Yes, you can now proceed to the next page.
- o No, please contact [TBD] 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
- Union
- Vance
- Wake
- 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

- 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

Please explain what barriers your CCPT is facing?

_____

How often does your CCPT meet as a full team?

- Annually
- Biannually
- Quarterly
- Bimonthly
- Monthly
- Other

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 2019, how frequently did the following mandated members participate in your CCPT?

DSS Director	Never	Rarely	Occasionally	Frequently	Very Frequently
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 2019, how frequently did the following mandated members participate in your CCPT?

	Never	Rarely	Occasionally	Frequently	Very Frequently
DSS Director	o	o	o	o	o

DSS Staff	o	o	o	o	o
Law Enforcement	o	o	o	o	o
District Attorney	o	o	o	o	o
Community Action Agency	o	o	o	o	o
School Superintendent	o	o	o	o	o
County Board of Social Services	o	o	o	o	o
Mental Health Professional	o	o	o	o	o
Guardian ad Litem	o	o	o	o	o
Public Health Director	o	o	o	o	o
Health Care Provider	o	o	o	o	o
District Court Judge	o	o	o	o	o
County Medical Examiner	o	o	o	o	o
Emergency Medical Services (EMS) Representative	o	o	o	o	o
Local Child Care Facility/Head Start Representative	o	o	o	o	o

Parent of Child Fatality Victim	o	o	o	o	o

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

In 2019, 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
o	o	o	o	o

How well does your CCPT share information during meets?

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

How well does your CCPT share other resources?

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

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	o	o	o	o	o
Resource 2	o	o	o	o	o
Resource 3	o	o	o	o	o

How well has your CCPT effected changes in your community?

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

In 2019, other than mandatory members, did <u>family or youth partners</u> serve as members of your CCPT?

Yes

No

In 2019, other than mandatory members, 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 2019, 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 2019, 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 2019?

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 2019 for selecting cases for review? Check all that apply. Please write in other criteria that you used.

Child Maltreatment Fatality

Court Involved

Multiple Agencies Involved

Repeat Maltreatment

Active Case

Closed Case

Stuck Case

Child Safety

Child Permanency

Child and Family Well-being

Parent Opioid Use

Other 1

Other 2

Which of the following contributory factors to children being in need of protection did you use in 2019 for selecting cases for review? Check all that apply

Caretaker - Alcohol Abuse

Caretaker - Drug Abuse

Caretaker - Mental Retardation

Caretaker - Emotionally Disturbed

Caretaker - Visually or Hearing Impaired

Caretaker - Other Medical Condition

Caretaker - Learning Disability

Caretaker - Lack of Child Development Knowledge

Child - Alcohol Problem

Child - Drug Problem

Child - Mental Retardation

Child - Emotionally Disturbed

Child - Visually or Hearing Impaired

Child - Physically Disabled

Child - Behavior Problem

Child - Learning Disability

Child - Other Medical Condition

Household - Domestic Violence

Household - Inadequate Housing

Household - Financial Problem

Household - Public Assistance

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

Reports from Members and/or Case Managers

Information on Procedures and Protocols of Involved Agencies

Case Files

Medical Examiner's Report

Child and Family Team Meeting Documentation

Individualized Education Plan

Other 1 _____

Other 2

What would help your CCPT better carry out case reviews?

How many of the cases reviewed in 2019 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 infants did you review in 2019? _____

How many of these had a Plan of Safe Care? _____

How many of the cases reviewed in 2019 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 2019, 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.

Limited services or no available services

Limited services for youth with dual diagnosis of mental health and substance use issues

Limited services or youth with dual diagnosis of mental health and developmental disabilities

Limited services for youth with dual diagnosis of mental health and domestic violence

Limited transportation to services

Limited community knowledge about available services

Limited number of experienced child and family team (CFT) meeting facilitators

Limited attendance of MH/DD/SA/DV providers at CFTs

Other 1 _____

Other 2

Based on your 2019 case reviews, what were your team's top three recommendations for improving child welfare services?

Recommendation 1

Recommendation 2

Recommendation 3

Did your CCPT set local objectives based on identified improvement needs to complete over 2019?

Yes

No

List your CCPT's top three local objectives based on identified improvement needs for 2019. Then rate how successful your CCPT was in achieving these objectives.

	Not at all	Slightly	Moderately	Mostly	Completely	Too soon to rate
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 NC DSS 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?_____

_____

Please contact the CCPT Consultant for technical support with regards to training, community engagement, active and fatality case review concerns, and any other local team guidance your team may need. Melanie.Meeks@dhhs.nc.gov

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 2019 CCPT Survey.

Thank you for taking the time to complete the 2019 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

George Bryan (Chair)
Molly Berkoff
Gina Brown
Carmelita Coleman
Deborah Day
Sharon Hirsch
Melanie Meeks
Marcella Middleton
Joan Pennell
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