NORTH CAROLINA COMMUNITY CHILD PROTECTION TEAM

2022 End of Year Report

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 as they continued to experience effects of the COVID-19 pandemic 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. Chris Mayhorn, carried out the survey with Dr. Anna Abate serving as project manager and Dr. Emily Smith, Dr. Joan Pennell, Helen Oluokun and Alexis Briggs supporting data collection, analyzing results, and preparing this report.

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I. Executive Summary

Complex and Challenging. Year 2022 was a challenging year for children, youth, and families and for their child welfare workers, educators, and other service providers. In this year's survey, Community Child Protection Teams (CCPTs) identified the limitations placed by the pandemic on the capacity of child welfare to work with families. Their reports were backed by statewide child welfare data, which supported the conclusion:

> The pandemic had an unparalleled, widespread, and sustained impact on child welfare by decreasing maltreatment reports, substantiations, non-substantiated findings, entries and exits from foster care, which have yet to recover to pre-pandemic levels and instead are continuing or declining in early to mid-2022.

North Carolina was not alone, as seen in reports from other states to the U.S. Administration for Children and Families. By 2021, although the majority of states resumed in-person child welfare service, the data "show decreases that can *partly* be attributed to the continuing pandemic caused by COVID-19." The federal government points to the pandemic but not as the sole reason. Families' lives are complex and affected by multiple factors, something recognized by the CCPTs. In their survey responses, teams identified that children's development was affected by the long-term fallout from COVID-19 as well as by wide-ranging service limitations, economic constraints, and internet inaccessibility, especially in rural areas. Contrary to the North Carolina and national findings, these conditions would appear at first glance to increase, not decrease, child welfare interventions.

What are likely explanations for these continued decreases in child welfare involvement? One noteworthy factor is the load on child welfare, hampering intervention. The survey certainly documented concern about the capacity of Departments of Social Services (DSSs) to fulfill their mandate with chronic staff shortages, delayed court hearings, unavailable medical examiners' reports, and so forth. Moreover, other agencies, such as educational and medical services, often had reduced in-person contact with children and their families and, thus, fewer opportunities to identify and report children in need of protection. At the same time, CCPTs observed how agencies changed their practices such as using distance means of communication or holding child & family team meetings in the evening so that parents could take part. They projected a positive vision for families in their recommendations to improve child welfare and strengthen child protection as a community effort.

A focus on the social and environmental factors that promote health leads to another potential reason for the lower level of child welfare involvement. If families are treated in an equitable manner and their economic and social needs are being met, they have a greater capacity to care for their children and youth. Research on pandemic-related benefits reports improvements in the lives of children and their families. In particular, the 2021 expanded refundable child tax credit stabilized and increased family income through monthly checks and lifted many families out of poverty. The benefits were especially pronounced for Black, rural, large, and unmarried-mother households, including in North Carolina. While the expanded child tax credit was not renewed past 2021, other benefits lasted into 2023. These included the emergency (maximum) food and

nutrition supplements and the suspension of work requirements for able-bodied adults without dependents.

Offsetting the negative impact of ending these supports to families is a promising development, long sought by NCDHHS, county DSSs, and CCPTs—the passage of Medicaid Expansion. If incorporated into the state budget, Medicaid Expansion will offer health insurance to many low-income families across the state.

CCPTs identified many of these pandemic-related effects. Forming a multidisciplinary, statewide network, CCPTs are attuned to the needs of children, youth, and their families. By working together on teams and with the community, CCPTs are well placed to strengthen child protection collaborations responsive to local conditions. The annual survey was a means of tapping into their perspectives and the NC CCPT/Citizen Review Panel Advisory Board used their insights and experiences to generate recommendations to NCDHHS.

2022 NC CCPT Advisory Board Survey Summary

The 88 CCPTs who responded to the survey encompassed all state regions, county population sizes, and the six LME/MCOs that provide mental health, developmental disabilities, and substance use services. Just over three-quarters (78%) of the responding CCPTs stated that they were "an established team that meets regularly," while the others were in different stages of reorganizing. Again, just over three-quarters (76%) of the CCPTs opted to combine with their local Child Fatality Prevention Team (CFPT). Three-quarters (75%) of the surveys were completed by the chair or designee and a tenth (10%) by the team as a whole. Other teams completed the survey with input from select team members or through other collaborative means.

A. Respondent Characteristics

This year, 88 of the local teams responded to the survey in 2022, a number that is in the higher range for responses since 2012. The percentage of combined teams increased slightly from the prior year, indicating that the continued prevalence of combining CCPTs and CFPTs can contribute to state planning on consolidating child maltreatment fatalities.

B. Survey Completers

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 13th, 2023 deadline. Moreover, the pandemic continued to prevent in-person meetings and data from the state was delayed to the CCPTs which impacted their ability to respond to certain survey questions.

C. Main Survey Questions

The 2022 survey inquired about the following five main questions:

1. Who takes part in the local CCPTs, and what supports or prevents participation?
2. Which cases do local CCPTs review, and how can the review process be improved?
3. What limits access to needed mental health, developmental disabilities, substance use, and domestic violence services, and what can be done to improve child welfare services?

4. What local issues affect taking a racially and culturally equitable approach to child welfare?
5. What are local CCPTs' recommendations for improving child welfare policy and statute and strengthening child protection?

D. Team Meetings and Membership

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 2022 survey results, as well as those in prior years, show that mandated members varied in their level of participation. DSS staff, mental health professionals, health care providers, and DSS directors were the most often present while the county boards of social services, school superintendent, county medical examiner, the district court judge and attorney, and the parent of a child fatality victim (for combined CCPT/CFPTs) were least often in attendance. Nevertheless, the majority of mandated members in most 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, with some notable exceptions. When asked about the difficulties CCPTs faced while trying to meet and complete their work, many described difficulties related to attendance or participation at CCPT meetings, ongoing difficulties related to the COVID-19 pandemic (e.g., virtual meetings, delays), limited staffing, and lack of access or availability of resources and services.

E. Additional Members

County commissioners on 60% of responding surveys appointed additional organizational or Family Partner members to their local CCPTs. These members were Family or Youth Partners, as well as mandated organizations, other public agencies, and nonprofits. Thus, as in past years, the appointments of county commissioners played a key role in enlarging the perspectives brought to bear in the CCPTs' deliberations.

F. CCPT Team Operations

CCPTs and combined CCPT/CFPTs that were established or recently re-established felt that they were preparing well for their regular meetings. Additionally, the majority of respondents indicated that they only had a moderate to marginal impact in making desired change in their community. Thus, CCPTs created a working environment in which they shared information; however, they recognized that their ability to make desired changes was limited.

G. 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. This year, 12% of respondents indicated that Family or Youth Partners served on their CCPT or combined CCPT/CFPT, an increase from last year. 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 the state's selected model of safety organized practice in a family-centered manner.

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

State legislation does not mandate the involvement of Family Partners, and, as a result, teams may have reservations on adding members who are not specified in statute. Nevertheless, there are clear avenues for promoting Family Partner outreach and engagement. These may include promoting requests for assistance from DSS and working with CCPT Technical Assistance to develop targeted strategies for recruitment and outreach. In fact, 74% of respondents indicated that they had invited Family or Youth partners to attend CCPT meetings and 76% had requested resources or assistance from DSS to assist in Family Partner involvement, a significant increase from last year (2021).

I. Partnerships to Meet Community Needs

Among the 87 respondents, 50 (58%) answered *yes* that they did partner with other organizations and 37 (42%) responded *no*. Notably, the percentages this year were higher than those in 2021 and 2020 when 31% and 47%, respectively, said that they were partnering. Counties of all sizes were well represented among those partnering on community needs.

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

Child maltreatment cases encompass active cases and child fatalities; one type of active cases are near fatalities where child abuse, neglect, or dependency is suspected. In 2022, 72 (85%) of the 85 responding CCPTs reviewed 505 cases. The 505 cases included 482 active cases and 23 maltreatment fatality cases. Among these active cases were 48 infants who were affected by substances and 14 cases of near fatalities. Within each county-size group, especially for the small and medium counties, there was extensive variation in how many cases they reviewed; although, on average, all counties (regardless of size) reviewed the same number of cases. Further, regarding the counties' economic well-being, on average, Tier 3 counties (least distressed) reviewed a higher number of cases. Thirteen counties did not indicate that they reviewed any cases; notably, five of those CCPTs reported they were not an established team or had not met regularly. The survey did not specifically inquire about the reasons why some counties had not reviewed cases and what would have helped them fulfill this role.

1. CCPT Case Reviews

State statute requires that CCPTs review two types of cases: active cases and child maltreatment fatalities. Most (81%) respondents reviewed active cases. Child maltreatment fatality was given as a reason for case selection by 17% of respondents. Whether local teams review all child maltreatment fatalities depends on the context. For instance, teams select cases for review if there appear to be systemic factors affecting service delivery. The second most frequent criteria for selecting cases were stuck case, parent substance use, and multiple agency involvement, all identified by 55% or more of respondents. The range of issues identified indicates the CCPTs' concern about many areas affecting the families' lives. The teams also selected cases on the basis of factors contributing to children needing protection: The two most common factors were caretaker's drug use cited by 67 (76%) CCPTs and caretaker's mental health need cited by 59 (67%) CCPTs. Three other factors used by over 50% of CCPTs pertained to child/youth with mental health needs, child/youth behavioral problems, and household domestic violence. 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.

2. Process of Case Review

Overall, there was quite a range of responses to how local teams handle reviews providing an abundance of evidence indicating that CCPTs had varying approaches to conducting these types of reviews when the need arose. However, there appears to be room to provide additional guidance and support to CCPTs who feel that these processes are not running smoothly or having the intended impact. Thirteen CCPTs did not indicate that they reviewed any cases; however, the survey did not specifically inquire about the reasons why some counties had not reviewed cases and what would have helped them fulfill this role.

Those teams that emphasized their accomplishments all met regularly and, with one exception, had reviewed one or more active child maltreatment cases in 2022. They spoke of the benefits of being "an established and cohesive team" that is "well informed and has information regarding the cases reviewed." They also praised their capacity to "share information" and to do "a great job selecting cases." The teams that pointed out ways to improve their case reviews echoed these same themes regarding team participation and case selection and information. Additionally they emphasized the need for better structuring of the review process.

K. Reported Limits to Access to Needed Mental Health, Developmental Disabilities, Substance Use, and Domestic Violence Services and Suggestions for Improvement

Children, youth, and their parents or caregivers faced serious barriers to accessing needed services. Most CCPTs who reviewed cases in 2022 reported that children and youth needed access to mental health services. Most CCPTs also reviewed cases in which the parents or caregivers required access to mental health, substance use, or domestic violence services. Importantly, the majority of cases in each category received the needed service, with the percentage ranging from 50-90%. With the exception of child trafficking services, all needed service categories were reported as having a waitlist in at least one case. 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, SU, and DV services. CCPTs indicating that there were waiting lists for these services also speaks to this need. Additionally, CCPTs identified systemic barriers to families' accessing essential services. The most commonly cited barriers were limited services or no available services, lack of transportation to services, and limited community knowledge about services. The CCPTs commented on some family factors affecting service receipt such as parents' readiness to participate in services and on systemic factors such as language barriers, financial barriers, and service providers being understaffed or closed due to COVID-19. Additionally, a majority of respondents identified limited numbers of providers and a lack of training among the providers. It is quite likely that family and systemic barriers reflected the complexity of the healthcare 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. Perceived Barriers Related to the COVID-19 Pandemic

The COVID-19 pandemic has posed several barriers for team operations and families which include challenges with virtual/hybrid meetings, issues with attendance and participation, and limited resources for families. However, while many CCPTs described virtual meetings as a barrier, noting that in-person meetings were more beneficial (e.g., enabled better discussion), they also acknowledged the importance of and need for virtual meetings in order to accommodate differing schedules and improve meeting attendance. CCPTs noted various strategies to ensure families and team members were able to attend meetings, including providing the option of attending via telephone, providing transportation, and changing meeting times. CCPTs described a need for increased communication, collaboration, and partnership with other agencies and organizations in order to provide families with needed resources and services as soon as possible.

M. Racial Equity in Addressing Local Needs

Over two-thirds of responding teams had not discussed issues of equity in child welfare over the year. Nevertheless, teams identified challenges to racial and cultural equity posed by language and cultural barriers, lack of staff inclusivity, and imbalances in resources and services. They also specified strategies to address these challenges to equity. To overcome language and cultural barriers, they sought to increase language services and alleviate cultural hesitancies in accessing services. In response to the lack of staff inclusivity, CCPTs partnered with local service and community groups to identify training resources and build an inclusive service network. To address imbalances in resources and services, they worked on extending collaborative networks, developing alternative ways of meeting families' needs, and raising their own team's awareness of imbalances. To assist local teams in responding to equity issues, NC DSS distributed some resources over the year. The majority of teams reported that they had not received or did not use these resources, and some proposed strategies to increase their utilization. These proposals included: guidance from NC DSS on their use, distributing materials tailored to multi-disciplinary teams and focused on small steps rather than large-scale change, and having a designated administrative support to coordinate activities.

N. Local CCPT Recommendations for Improving Child Welfare Services

Based on their case reviews, CCPTs offered 509 recommendations on ways to improve child welfare policy and practice and community efforts on behalf of children, youth, and families. One set of recommendations formed a series of seven steps for enhancing the policy process: clarifying policy, refining policy, acknowledging disagreements and common ground, identifying recurring challenges, advocating for policy change, ensuring adequate resources and mutual accountability, and strengthening quality assurance through CCPTs. For each step, CCPTs provided quite specific proposals. For instance, in regards to clarifying policy, they stressed reducing confusion for families by simplifying child welfare language and forms and for workers by providing training in advance of the rollout of new policies. For the most part, teams appeared to agree on policy and practice. A striking difference, though, was whether to adopt a punitive or supportive approach to mothers who use substances. Underneath both positions was a shared concern about the widespread availability of addictive drugs and a firm commitment to preventing their use. On some recurring challenges such as accessing needed case information, teams felt stuck and could not resolve them on their own. In response, teams recommended better local coordination through an alert system to notify involved agencies of all child fatalities

or stronger advocacy on strengthening child welfare by educating elected officials and the public. Many of the proposed reforms required additional finances, personnel, and technology and vigilant oversight. With teams across the state, CCPTs are positioned to serve as a local system of quality assurance. To perform this role, they sought expanded membership, exchange of information with other teams, refresher training, and a CCPT/CFPT office at the state level to provide administrative support for the teams.

II. 2022 Recommendations

2022 Recommendations of the NC CCPT/Citizen Review Panel Advisory Board

As summarized by the U.S. Children's Bureau, Citizen Review Panels (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/CRP Advisory Board used the extensive information and ideas from the current and earlier CCPT surveys to formulate the recommendations listed below. The Advisory Board met in four subcommittee meetings and then a meeting of the whole board to prepare and finalize the recommendations for action in 2024.

Notably, there is no stand-alone recommendation to address racially and culturally equitable approaches to child welfare in North Carolina. Rather, recommendations to support racially equitable and culturally competent approaches to child welfare are embedded within each of the recommendations. This will allow for more context specific strategies to be developed and implemented.

In accordance with CAPTA, we propose the following for child protection at the local and state levels in 2024.

POLICY RECOMMENDATIONS

1. North Carolina should develop and disseminate a statewide evidence-based campaign promoting best practices for safe sleep.
    a. More specifically, North Carolina should develop a culturally competent dissemination plan to reach historically marginalized populations, to include translation to native languages.
2. North Carolina should examine existing child welfare policy and consider policy changes in order to provide kinship caregivers the same level of funding and other supports received by licensed resource parents.
3. To ensure an equitable approach to resources across counties throughout North Carolina, North Carolina should conduct a review of policy processes to ensure equity in resources and service access, provision, and quality across rural and urban communities.

PRACTICE RECOMMENDATIONS

1. North Carolina should continue to work on access to appropriate and trauma-informed mental/behavioral health and substance use prevention and intervention services including both residential/inpatient and outpatient options for children and families.
2. North Carolina Department of Health and Human Services (NCDHHS) should finalize and implement statewide child welfare record system in all counties.
3. North Carolina should continue to work toward uniformity in its intake process across counties.

RESOURCE and TRAINING RECOMMENDATIONS

1. North Carolina should increase funding to victim service agencies to assist with intervention and prevention services for adults, children, and teenagers.
2. The North Carolina Child Welfare Workload Study, which began June 12th and was designed to collect the necessary data for understanding the current workload demands on local child welfare staff, should continue in order to address the staffing and workload needed for adequately protecting children.
    a. Likewise, this study should examine the need for securing additional foster parents.
3. North Carolina should provide information and available resources to local agencies in order to improve access to affordable housing throughout the state.
4. Local DSS should support training for CCPTs on strategies for sustainably incorporating family partners on their teams.

Local DSS should facilitate training for CCPTs, child welfare workers, and other agencies (e.g., juvenile justice) on domestic violence and mental health.

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North Carolina Community Child Protection Teams (CCPT) 2022 End-of-Year Report

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

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[1] Child Welfare Caseload Trends (Quarterly Report: July 2022, page 9). In Duncan, D. F., Stewart, C. J., Vaughn, J. S., Guest, S., Rose, R. A., Malley, K., and Gwaltney, A. Y. (2018). *Management Assistance for Child Welfare, Work First, and Food & Nutrition Services in North Carolina* (V3.21). Retrieved March 23, 2023, from http://ssw.unc.edu/ma.

[2] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2023). *Child Maltreatment 2021*. Emphasis added to quotation from p. iv. Available from https://www.acf.hhs.gov/cb/data-research/child-maltreatment.

had reduced in-person contact with children and their families and, thus, fewer opportunities to identify and report children in need of protection. At the same time, CCPTs observed how agencies changed their practices such as using distance means of communication[3] or holding child & family team meetings in the evening so that parents could take part. They projected a positive vision for families in their recommendations to improve child welfare and strengthen child protection as a community effort.

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[3] A Texas study reported multiple benefits from telecommunication during a pandemic (e.g., keeping foster children in contact with family; increasing multidisciplinary discussion of children's health and other needs) and set forth principles for overcoming shortcomings of this approach. Loria, H., McLeigh, J., Wolfe, K., Conner, E., Smith, V., Greeley, C. S., & Keefe, R. J. (2023). Caring for children in foster and kinship care during a pandemic: Lessons learned and recommendations. *Journal of Public Child Welfare, 17*(1), 1-24. https://doi.org/10.1080/15548732.2021.1965065

[4] Hardy, B. L., Collyer, S. M., & Wimer, C. T. (2023, March). The antipoverty effects of the Expanded Child Tax Credit across states: Where were the historic reductions felt? Washington, DC: The Hamilton Project, Brookings Institution. Retrieved March 23, 2023, from https://www.hamiltonproject.org/assets/files/20230301_ES_THP_CTCbyState.pdf

[5] A study, conducted pre-onset of COVID-19, compared US states that reduced restrictions on supplemental nutrition assistance with those that did not. The states that reduced these restrictions had lower rates of child protection-investigated reports for suspected child maltreatment. Austin, A. E., Shanahan, M.E., Frank, M., Naumann, R. B., et al. (2023, published online). State expansion of Supplemental Nutrition Assistance Program eligibility and rates of child protective services-investigated reports. *JAMA Pediatrics*. doi:10.1001/jamapediatrics.2022.5348

CCPT Advisory Board

Over the year, the CCPT Board added to its members and provided an orientation. NC DSS kept the Board apprised on current developments in child welfare in North Carolina.

In response to requests from local teams, the CCPT Board concentrated this year on providing guidance to local teams in three main areas. First, continuing work from last year, the Board completed a draft of guidance on reviewing cases of near fatalities due to suspected child maltreatment. This draft was sent to NC DSS for approval and then dissemination to local teams. Second, to replace a now-dated CCPT manual, the Board has been preparing a new handbook with links to helpful resources, and its working committee has welcomed the wider participation of local team members. At the invitation of the NC Association of County Directors of Social Services, the Advisory Board provided a webinar overviewing CCPTs and its recording was made available for others to view. Third, the Advisory Board formed a committee, with leadership from the NC Child Welfare Family Advisory Council, to design and deliver webinars on ways to engage family partners on local teams. An introductory session was held (and recorded), and work is in progress on a follow-up session.

As in prior years, a major undertaking of the Board was developing the annual CCPT survey. A departure from past years was the decision to identify the respondents to certain questions at the request of NC DSS and the CCPT Board *only* for the purpose of enabling the CCPT Board to engage in outreach to teams to assist them in specific areas (e.g., conducting case reviews). For some survey questions, NC State University would not identify respondents to NC DSS and the CCPT Board (e.g., recommendations on improving child welfare). All public-facing reports would continue to keep confidential the identities of the teams providing the answers.

This end-of-year report, prepared by the University, served as a basis for the CCPT Board formulating recommendations to NC DSS. The Division had six months to respond in writing to these recommendations. End-of-year reports and state responses to them are available at this link.

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 by 88 CCPTs, although response numbers varied for certain survey items based on the operational status of counties and number of valid responses. A list of the counties of the 2022 responding CCPTs can be found in appended Table A-2.

The 2022 response rate of 88 CCPTs was in the higher range as compared with previous years (2012 to 2021) which ranged from 71 to 89. The local teams came from all regions of the state and included counties of all population sizes. The response rates were 45 (88%) of the 51 small counties, 34 (87%) of the 39 medium counties, and 9 (90%) of the 10 large counties (see appended Table A-3).[6]

The North Carolina Department of Commerce annually ranks the state's 100 counties based on economic well-being and assigns each a Tier designation. The 40 most distressed counties are designated as Tier 1, the next 40 as Tier 2 and the 20 least distressed as Tier 3.[7] The local teams came from all Tiers. The response rates for economic well-being were 34 (85%) of the 40 Tier 1 counties (most distressed), 37 (93%) of the 40 Tier 2 counties, and 17 (85%) of the 20 Tier 3 (least distressed) counties.

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 2022, there were six LME/MCOs for the 100 counties. The survey included members from all LME/MCOs: Member county participation ranged from 83% to 100% (see Table A-4).

As seen in Table 1, the large majority (78%) of respondents characterized themselves as an "established team that meets regularly." This is six percentage points higher than in 2021 when only 72% of the reporting counties identified themselves as an established team that meets regularly. The CCPTs that characterized themselves as in a state of reorganization or adjustment included small through large counties.

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[6] Duncan, D.F., Flair, K.A., Stewart, C.J., Guest, S., Rose, R.A., Malley, K.M.D., Reives, W. (2020). Management Assistance for Child Welfare, Work First, and Food & Nutrition Services in North Carolina. Retrieved [March, 2022], from the University of North Carolina at Chapel Hill Jordan Institute for Families website. URL: http://ssw.unc.edu/ma/

[7] County Distress Rankings (Tiers) | NC Commerce. (n.d.). Retrieved March 21, 2023, from https://www.commerce.nc.gov/grants-incentives/county-distress-rankings-tiers

Number of CCPTs by Status of Establishment as a Team, 2022 (N = 88)

Table 1 Number of CCPTs by Status of Establishment as a Team

Status	Number of CCPTs	
We are an established team that meets regularly	69	(78.4%)
Our team recently reorganized, and we are having regular meetings	8	(9.1%)
We are an established team that does not meet regularly	7	(8.0%)
Our team recently reorganized, but we have not had any regular meetings.	3	(3.4%)
Our team was not operating, but we recently reorganized	1	(1.1%)

CCPTs have the option of combining with their local Child Fatality Prevention Team (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 suspected abuse, neglect, or dependency and where the family had received NC DSS child welfare services within 12 months of the child's death. Of the 87 teams that were established or operating at some capacity, 67 (76%) of the counties opted to have combined teams, and 18 (20.5%) had separate teams; two counties indicated “Other” to describe their team composition. The percentage of combined teams in prior years was 72% in 2015, 76% in 2016, 78% in 2017, 82% in 2018, 78% in 2019, 80% in 2020, and 74% in 2021.

In summary, 88 of the local teams responded to the survey in 2022, a number that is in the higher range for responses since 2012. The participating CCPTs encompassed all state regions, county population sizes, economic well-being, and the six LME/MCOs that provided MH/DD/SU services. Over three-quarters (78%) of the responding CCPTs stated that they were “an established team that meets regularly,” higher than in 2021 when 72% of the reporting counties identified themselves as an established team that meets regularly. The increase is most likely due to a shift to more in-person meetings or an adjustment to remote meetings. Overall, the CCPTs as a whole were sufficiently established to make significant contributions to child welfare. Among the responding teams, 76% were combined with their local CFPT. The percentage of combined teams increased slightly from the prior year, indicating that the continued prevalence of 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 (64%) rather than by the team as a whole (10%). The response “other” was selected by 6 counties. Of these 6 counties, most indicated that the CCPT Chair completed the survey with input from specific team members such as the CFPT Chair, Review Coordinator, or simply other team members. The time period available for completing the survey was extended to two and a half months in order to account for meeting delays due to the various holidays. Additionally, data from the state was delayed to the CCPTs which may also impact their ability to respond to certain survey questions.

Number of CCPTs by Who Completed the 2022 Survey (N = 88)

Table 2 Number of CCPTs by Who Completed the Survey

Status	Number of CCPTs	
The CCPT chair on their own	56	(63.6%)
A designee of the CCPT chair on their own	10	(11.4%)
The CCPT team as a whole	9	(10.2%)
A subgroup of the CCPT team	7	(8.0%)
Other	6	(6.8%)

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 an extension was given to those who had not submitted a completed survey by the January 13th, 2023 deadline.

C. Main Survey Questions

The 2022 survey inquired about the following five main questions:

1. Who takes part in the local CCPTs, and what supports or prevents participation?
2. Which cases do local CCPTs review, and how can the review process be improved?
3. What limits access to needed mental health, developmental disabilities, substance use, and domestic violence services, and what can be done to improve child welfare services?
4. What local issues affect taking a racially and culturally equitable approach to child welfare?
5. What are local CCPTs’ recommendations for improving child welfare policy and statute and strengthening child protection?

This section summarizes the findings for each of these five questions. All quotations in this report have been corrected for spelling, grammatical errors, and identifying information has been redacted. Where available, findings from previous years are compared to this year’s survey results to ascertain trends.

D. Team Meetings and Membership

The prior year’s survey found that the first and second years of the coronavirus pandemic adversely affected the capacity of CCPTs to meet, review cases, and reach out to the community.

In contrast to the previous two years, this year's survey did not explicitly ask about the coronavirus pandemic's impact on the functioning of the CCPTs. Rather, the survey asked, more broadly, "What difficulties has your CCPT faced while trying to meet and complete your work?" Ninety-two (92%) CCPTs identified a difficulty. First, a majority of the CCPTs described difficulties related to attendance or participation at CCPT meetings. Specifically, some CCPTs described problems with attendance "from regular members" while other respondents noted difficulties with attendance "by other agencies." Additionally, other CCPTs described poor "family member attendance." One respondent noted there were difficulties related to "everyone being available at the same date and time" while another CCPT noted similar difficulty "having everyone needed at the table at every meeting." Second, many CCPTs described ongoing difficulties related to the COVID-19 pandemic. For instance, one CCPT reported they are "recovering from the work of COVID, staff shortages, and vacancies," and similarly, another CCPT noted challenges, "rebuilding post COVID." Other CCPTs commented on the format of meetings, stating that meetings continued to be virtual but noting "there is some lack of exchange because all is virtual." One CCPT commented on delays related to the pandemic, stating:

> As a combined CCPT/CFPT, CFPT case reviews take priority (which have been more than normal due to delays from COVID). Topics addressed during CFPT often coincide with CCPT; however, there is not much time left for additional case presentations/reviews for CCPT.

Third, several CCPTs described limited staffing and position vacancies, describing high rates of staff turnover. In particular, one CCPT wrote, "Our CCPT and CFPT are combined and we have experienced a great deal of turnover with staffing from the [COUNTY NAME] County Health Department." Similarly, another CCPT reported "vacancies in various organizations (turnover)" as a barrier to meeting and completing their work. Finally, some CCPTs commented on difficulties related to resources and services. For example, one CCPT commented that there are "not many resources available for housing and transportation" while another CCPT reported difficulties with "resources available to implement ideas and community changes."

In summary, when asked about the difficulties CCPTs faced while trying to meet and complete their work, many described difficulties related to attendance or participation at CCPT meetings, ongoing difficulties related to the COVID-19 pandemic (e.g., virtual meetings, delays), limited staffing, and lack of access or availability of resources and services.

1) Mandated Members

a) Participation by Mandated Members for Combined CCPT/CFPT and Separate CCPT

State law requires that local teams are composed of 11 members from agencies that work with children and child welfare. The CFPT requirements for membership do not apply to cases falling under CCPT jurisdiction under the law. Therefore, members such as district attorney, judge, and parent of a child fatality victim are not required to be present for reviews under CCPT statute. However, teams were asked to report their make-up in keeping with previous years. Next year's survey will adjust these questions in consideration of the statutory requirements.

Table 3 identifies these mandated members for combined CCPTs and CFPTs, with an asterisk identifying the members that are *not* mandated under a CCPT review. Table 4 identifies these mandated members for separate CCPTs and their levels of participation on the team during 2022. The survey results indicate that mandated members varied in their level of participation in both groups; however, patterns of participation were fairly consistent between the two groups. The two team members most likely to be *very frequently* in attendance for CCPT/CFPTs were the DSS staff, followed by mental health professionals; the DSS Director and health care providers were reported as the third and fourth most frequently in attendance. Among separate CCPTs, DSS staff was the most frequently reported mandated member in attendance, followed by mental health care providers and health care providers as the second and third most frequent attendees. On average, health care providers, mental health professionals, and guardians ad litem were frequently present across both groups. Notably, although participation rates varied across the mandated members, some mandated members in all categories participated *frequently* or *very frequently*. For instance, within the separate CCPT group, the District Attorney had the lowest average participation level but still had 6% taking part *frequently* and another 11% taking part *very frequently*.

Mandated Members for Combined CCPT/CFPT and Reported Frequency of Participation, 2022 (N=69)

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

Mandated Member	Never	Rarely	Occasionally	Frequently	Very Frequently	Mean
DSS Staff	0 (0%)	0 (0%)	0 (0%)	8 (11.6%)	61 (88.4%)	3.88
Mental Health Professional	6 (8.7%)	2 (2.9%)	11 (15.9%)	10 (14.5%)	40 (58.0%)	3.10
DSS Director	6 (8.7%)	2 (2.9%)	11 (15.9%)	12 (17.4%)	38 (55.1%)	3.07
Health Care Provider	6 (8.7%)	6 (8.7%)	6 (8.7%)	11 (15.9%)	40 (58.0%)	3.06
Public Health Director	8 (11.6%)	6 (8.7%)	6 (8.7%)	11 (15.9%)	38 (55.1%)	2.94
Law Enforcement	5 (7.2%)	9 (13.0%)	11 (15.9%)	17 (24.6%)	27 (39.1%)	2.75
Guardian ad Litem Coordinator or Designee	12 (17.4%)	3 (4.3%)	8 (11.6%)	13 (18.8%)	33 (47.8%)	2.75
Community Action Agency Director or Designee	17 (24.6%)	7 (10.1%)	9 (13.0%)	10 (14.5%)	26 (37.7%)	2.30
School Superintendent	19 (27.5%)	9 (13.0%)	7 (10.1%)	9 (13.0%)	25 (36.2%)	2.17
EMS Representative*	19 (27.5%)	9 (13.0%)	9 (13.0%)	11 (15.9%)	21 (30.4%)	2.09
County Board of Social Services	20 (29.0%)	6 (8.7%)	12 (17.4%)	11 (15.9%)	20 (29.0%)	2.07
Local Child Care Facility*	26 (37.7%)	9 (13.0%)	6 (8.7%)	10 (14.5%)	18 (26.1%)	1.78
District Attorney	25 (36.2%)	12 (17.4%)	9 (13.0%)	8 (11.6%)	15 (21.7%)	1.65
County Medical Examiner*	31 (45.6%)	10 (14.7%)	7 (10.3%)	9 (13.2%)	11 (16.2%)	1.40
Parent of Child Fatality Victim*	44 (63.8%)	7 (10.1%)	7 (10.1%)	3 (4.3%)	8 (11.6%)	.90
District Court Judge*	43 (62.3%)	8 (11.6%)	5 (7.2%)	8 (11.6%)	5 (7.2%)	.90

Note. 0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently. Counts are reported, with percentages out of 69 CCPT/CFPTs in parentheses.
*Members that are *not* mandated under a CCPT review

Mandated Members for Separate CCPT and Reported Frequency of Participation, 2022 (N=18)

Table 4 Mandated CCPT Members and Reported Frequency of Participation

Mandated Member	Never	Rarely	Occasionally	Frequently	Very Frequently	Mean
DSS Staff	0 (0%)	0 (0%)	0 (0%)	1 (5.6%)	17 (94.4%)	3.94
Mental Health Professional	2 (11.1%)	0 (0%)	5 (27.8%)	2 (11.1%)	9 (50.0%)	2.89
Health Care Provider	2 (11.1%)	2 (11.1%)	2 (11.1%)	4 (22.2%)	8 (44.4%)	2.78
DSS Director	2 (11.1%)	2 (11.1%)	4 (22.2%)	2 (11.1%)	8 (9.1%)	2.67
Guardian ad Litem Coordinator or Designee	5 (27.8%)	0 (0%)	4 (22.2%)	3 (16.7%)	6 (33.3%)	2.28
Law Enforcement	4 (22.2%)	0 (0%)	7 (38.9%)	3 (16.7%)	4 (22.2%)	2.17
Public Health Director	5 (27.8%)	3 (16.7%)	3 (16.7%)	2 (11.1%)	5 (27.8%)	1.94
Community Action Agency Director or Designee	5 (27.8%)	2 (11.1%)	5 (27.8%)	2 (11.1%)	4 (22.2%)	1.89
County Board of Social Services	7 (38.9%)	3 (16.7%)	2 (11.1%)	5 (27.8%)	1 (5.6%)	1.44
School Superintendent	9 (50.0%)	1 (5.6%)	3 (16.7%)	2 (11.1%)	3 (16.7%)	1.39
District Attorney	8 (44.4%)	5 (27.8%)	2 (11.1%)	1 (5.6%)	2 (11.1%)	1.11

Note. 0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently
Counts are reported, with percentages out of 18 CCPTs in parentheses.

b) *Mandated Member Participation by Mean Rate and Rank*

In the 2022 survey, participation of mandated members was tracked for both CCPTs and CCPT/CFPTs. Combined teams (CCPT/CFPTs) have an additional five members who represent specified agencies. Several members, including EMS, judges, medical examiners, local child care, and parents of a child fatality victim, are *not* required for CCPTs. However, as many CCPTs join with their CFPT to create combined teams, it is important to include the different compositions of teams.

Table 5 shows that for the last three years, the ranked participation rates of the mandated members were almost identical, with the number in parenthesis indicating the order of highest participation with one being the highest mean rate of participation. Despite the effects of the pandemic, the participation rates of mandated members remained relatively stable. At the top in rank over the last three years were DSS staff and mental health professionals. For CCPTs, the lower participation ranks for this year included the school superintendent, district attorney, and county board of social services which is similar to last year's rates.

Mandated Separate CCPT and Combined CCPT/CFPT Members and Mean Rate and Rank of Participation 2020, 2021, and 2022

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

Mandated Member	2020 CCPT (*N*=15) Average (Rank)	2020 CCPT/CFPT (*N*=62) Average (Rank)	2021 CCPT (*N*=19) Average (Rank)	2021 CCPT/CFPT (*N*=61) Average (Rank)	2022 CCPT (*N*=18) Average (Rank)	2022 CCPT/CFPT (*N*=69) Average (Rank)
DSS Director	2.67 (5)	3.10 (4)	2.63 (4)	3.20 (2)	2.67 (4)	3.07 (3)
DSS Staff	3.67 (1)	3.71 (1)	3.68 (1)	3.67 (1)	3.94 (1)	3.88 (1)
Law Enforcement	2.53 (6)	2.90 (7)	2.63 (4)	2.73 (7)	2.17 (6)	2.75 (6)
District Attorney	1.53 (10)	1.95 (12)	1.68 (10)	1.77 (13)	1.11 (11)	1.65 (13)
Community Action Agency	2.20 (7)	2.52 (8)	2.58 (7)	2.48 (10)	1.89 (8)	2.30 (8)
School Superintendent	1.13 (11)	2.50 (9)	1.61 (11)	2.58 (8)	1.39 (10)	2.17 (9)
County Board of Social Services	2.07 (9)	2.10 (11)	1.74 (9)	2.38 (9)	1.44 (9)	2.07 (11)
Mental Health Professional	3.20 (2)	3.26 (2)	3.58 (2)	3.16 (3)	2.89 (2)	3.10 (2)
Guardian ad Litem	2.87 (4)	2.95 (5)	2.84 (3)	2.90 (5)	2.28 (5)	2.75 (6)
Public Health Director	2.13 (8)	2.94 (6)	2.05 (8)	2.78 (6)	1.94 (7)	2.94 (5)
Health Care Provider	3.13 (3)	3.15 (3)	2.42 (6)	3.16 (3)	2.78 (3)	3.06 (4)
District Court Judge		.73 (16)		.93 (16)		.90 (15)
County Medical Examiner		1.39 (14)		1.93 (14)		1.40 (14)
EMS Representative		2.19 (10)		1.93 (11)		2.09 (10)
Local Child Care or Head Start Rep		1.81 (13)		1.80 (12)		1.78 (12)

Parent of Child Fatality Victim		1.08 (15)		1.00 (15)		.90 (15)

Note. 0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently. The last five categories in this table represent members who are not mandated members of CCPTs, rather these are members of CFPTs.

In summary, the 2022 survey results, as well as those in prior years, show that mandated members varied in their level of participation. DSS staff, mental health professionals, health care providers, and DSS directors were the most often present while the county boards of social services, school superintendent, county medical examiner, the district court judge and attorney, and the parent of a child fatality victim (for combined CCPT/CFPTs) were least often in attendance. Nevertheless, the majority of mandated members in most 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, with some notable exceptions.

E. Additional Members

Besides the state-required members, the county commissioners can appoint additional members from the mandated agencies and from other community groups. Among the 88 survey responses, 51 CCPTs reported between 1 and 22 additional organizational members and 9 CCPTs reported between 1 and 4 additional Family Partners and 2 counties reported 2 Youth Partner members. The survey provided space for the respondents to "list the organization/unit that additional members represent." Respondents listed a total of 159 organizations that the additional partners came from including LME/MCOs, and 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 juvenile justice. Still others were from nonprofits, including domestic violence, substance use, parenting education, children's advocacy, and the community at large.

In summary, county commissioners on over half the responding surveys appointed additional members to their local CCPTs. These members were Family or Youth Partners, as well as mandated organizations, other public agencies, and nonprofits. Thus, as in past years, the appointments of county commissioners played a key role in enlarging the perspectives brought to bear in the CCPTs' deliberations.

F. CCPT Team Operations

By state statute § 7B-1406, local CCPTs are charged to review cases served by child protection and on an annual basis to submit recommendations to their board of county commissioners and advocate for systemic improvements to child welfare. They may also carry out public education to support community efforts to assist children and their families. Local CCPTs are expected to provide an end-of-year report to the NC Division of Social Services. It is critical to understand whether or not CCPTs have the operational capacity to meet their goals.

1) CCPT Meetings

2) Community Change

The CCPT teams were asked how well their team has made desired changes in their community. Seven (8%) of respondents indicated very well, 21 (24%) indicated well, 24 (28%) indicated moderately, 29 (33%) indicated marginally, and 6 (7%) indicated not at all with respect to how well their CCPT has affected changes in their community.

In summary, CCPTs and combined CCPT/CFPTs that were established or recently re-established felt that they were preparing well for their regular meetings. Additionally, the majority of respondents indicated that they only had a moderate to marginal impact in making desired change in their community. Thus, CCPTs created a working environment in which they shared information; however, they recognized that their ability to make desired changes in the community was limited.

G. Family or Youth Partners

The survey also inquired specifically about Family or Youth Partners serving on the local teams. A Family or Youth Partner is a youth or adult who has received services or is the caregiver/parent of someone who has received services, and who has firsthand experience with the child welfare system. 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 (other than mandatory members), 10 (12%) out of 87 respondents said yes and 77 (88%) said no with one team not responding. The percentage of Family or Youth Partner involvement is similar to 2021 when 8 (10%) out of 80 said yes and 72 (90%) said no. In 2020, participation was 12% (10 out of 82), and in 2019, participation was 7% (6 out of 89). Family and Youth Partners engagement has been substantially lower in the most recent four years than in prior years: 2015 (21%, 19 out of 87), 2016 (22%, 19 out of 86), 2017 (29%, 23 out of 79), and 2018 (24%, 21 out of 88). This difference may be a result of how the survey defined Family and Youth Partners in earlier years; in other words, from 2015 to 2018, the survey did not distinguish between a non-child welfare-served parent of a deceased child and a Family or Youth Partner as defined in the 2019 to 2022 surveys. Maintaining the questions from 2017 through 2021, the 2022 survey inquired about the six different categories of Family or Youth Partners serving on the CCPTs (see Table 6 for the categories). The teams could identify if they had more than one partner on their team. For instance, nine CCPTs reported between one and four additional Family Partners and two CCPTs reported two Youth Partners. Therefore, the number of Family and Youth Partners participating on CCPTs may be higher than the number of CCPTs reporting Family and Youth Partner participation.

Table 6 shows rates of Family or Youth Partners' participation. The most commonly represented category was Biological Parent which formed over half (6, 60%) of the Family or Youth

Partners. A majority of categories' rates of participation ranged from *never* to *very frequently*; however, youth partners, guardians, and foster parents were all reported as *never*.

Family or Youth Partners by Category and Reported Frequency of Participation, 2022

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

Category	Never	Rarely	Occasionally	Frequently	Very Frequently	Total Participation
Biological Parent	3	1	2	1	2	6
Kinship Caregiver	8	0	1	0	1	2
Adoptive Parent	8	0	0	1	0	1
Youth Partner	9	0	0	0	0	0
Guardian	9	0	0	0	0	0
Foster Parent	9	0	0	0	0	0
Other	7	0	0	0	0	1*
Total	**53**	**1**	**3**	**2**	**3**	**10**

*1 CCPT listed "young adult 18-21" but did not indicate the frequency of participation

In summary, the survey asked if the CCPT included Family or Youth Partners. A family or youth partner is a youth or adult who has received services or is the caregiver/parent of someone who has received services, and who has firsthand experience with the child welfare system. This year, 12% of respondents indicated that Family or Youth Partners served on their CCPT or combined CCPT/CFPT, a similar finding to last year. The large majority of CCPTs lacked family representation, which limited their capacity to bring youth and family perspectives to the table; in fact, youth partners, guardians, and foster parents "never" participated. This could inhibit their contributions to instituting the state's selected model of safety organized practice in a family-centered manner.

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

The survey then asked the respondents if "Family or Youth Partners were invited to attend CCPT meetings" and if they had "requested resources or assistance from DSS to assist in Family Partner involvement." Of the 87 respondents, 65 (74%) indicated that they had invited Family or Youth partners to attend CCPT meetings and 67 (76%) had requested resources or assistance from DSS to assist in Family Partner involvement.

In previous years, CCPTs have been asked to provide a list of strategies to promote Family Partner engagement. In this year's survey, the research team identified common factors from past years and developed a checklist for response. The survey asked, "Which of the following strategies did your CCPT use to successfully engage family and youth partners on your team?"

The findings reveal that CCPTs had several strategies that they leveraged to promote Family Partner engagement. Using team members already on the CCPT to offer family perspectives and outreach through community networks to identify Family and Youth Partners were two of the most commonly endorsed among the 88 respondents. Overall, more respondents endorsed a greater variety in strategies for Family Participation than in previous years, suggesting the strategies may fluctuate from year to year. "Other" strategies were also highly endorsed. In describing "other" strategies used, CCPTs mentioned "using other CCPT members to assist in locating a family member for the CCPT" as well as "discussions among the team" and a "proposal for family partner expansion."

Strategies for Engaging Family or Youth Partners, 2022 (N=88)

Table 7 Endorsed Strategies for Engaging Family or Youth Partners

Strategies for Engagement	Frequency (Percent)
Using team members already on the CCPT to offer family perspectives	32 (36.4%)
Other	26 (29.5%)
Outreach through community networks to identify Family and Youth Partners	18 (20.5%)
Emphasizing the value that Family and Youth Partners bring to the team	14 (15.9%)
Describing the role of the Family and Youth Partners on the team	13 (14.8%)
Repeatedly extending invitations by multiple means (e.g., phone, email) to possible Family and Youth Partners	12 (13.6%)
Ensuring that discussions are in clear and understandable language for all participants	12 (13.6%)
Explaining purpose of CCPTs in jargon-free and inviting language	11 (12.5%)
Drawing Family and Youth Partners into the meeting discussions	8 (9.1%)
Providing information on opportunities available to participants (e.g., training)	7 (8%)
Debriefing with Family and Youth Partners after meetings	4 (4.5%)
Having a senior agency representative extend the invitation	3 (3.4%)
Rescheduling meeting times to accommodate Family and Youth Partners	3 (3.4%)
Preparing Family and Youth Partners for the meetings	3 (3.4%)
Putting CCPT membership into Family and Youth Partner's job description	1 (1.1%)

In summary, state legislation does not mandate the involvement of Family Partners on CCPTs, and, as a result, teams may have reservations on adding members who are not specified in statute. Nevertheless, there are clear avenues for promoting Family Partner outreach and

engagement. Interestingly, survey results suggest that CCPTs are engaging in outreach and inviting participation from Family Partners but other barriers might be contributing to lack of participation. TAs noted earlier, the CCPT Board this year has developed and delivered webinars to support local teams in engaging Family Partners.

I. Partnerships to Meet Community Needs

CCPTs are encouraged to work with other local groups to meet community needs.
This year, the survey asked: "During 2022, did your CCPT partner with other organizations in the community to create programs or inform policy to meet an unmet community need?" Among the 87 respondents, 50 (58%) answered *yes* that they did partner with other organizations and 37 (42%) responded *no*. Notably, the percentages this year were higher than those in 2021 and 2020 when 31% and 47%, respectively, said that they were partnering. Counties of all sizes were well represented among those partnering on community needs.

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 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) CCPT Case Reviews

Child maltreatment cases encompass both active cases and child fatalities. The active cases include near fatalities defined by NC General Statute § 7B-2902 as "a case in which a physician determines that a child is in serious or critical condition as the result of sickness or injury caused by suspected abuse, neglect, or maltreatment."

Active Cases

As occurred in previous years, this year's questions regarding child maltreatment fatality cases and near fatality cases had been extensively revised. This year's questions reflect an effort to be more specific in reporting and provide CCPTs with the opportunity to highlight difficulties they face in conducting cases review. This year's survey asked, "What is the total number of active cases reviewed by your CCPT between January and December 2022?" Of the 85 responding counties, 72 (85%) reported having reviewed at least one active case, the number of cases reviewed ranged from 1-41, with a total of 505 cases being reviewed by counties in 2022. Thus, 13 counties reported not reviewing any active cases.

The survey then asked, "How many of these cases entailed Substance Affected Infants?" Of the 72 counties who indicated they reviewed at least one active case, 28 reported instances where at least one of the active cases under review involved a Substance Affected Infant. The number of active cases reviewed that involved a Substance Affected Infant ranged from 1-6, with a total of 48 active cases with a Substance Affected Infant being reviewed. Next the survey asked, "How many of the active cases entailed near fatality?" Of the 72 counties who indicated they reviewed at least one active case, only 10 indicated that one of these cases involved a near fatality. The maximum number of active cases reviewed that involved a near fatality by any of the 10 counties was four, with one county reviewing four cases, one county reviewing two cases, and the remaining counties reviewing one case. The low number of near fatalities reviewed demonstrates the need to provide even more clarification to teams about the meaning of the term near fatality to aid in their identification of cases meeting the criteria for this type of case.

Number of Active Case Reviews by Combined/Separate Status, 2022

Table 8 Number of Active Case Reviews by Combined/Separate Status

Type of Review	Number of CCPTs	Sum of Cases	Minimum of Cases	Maximum of Cases	Mean	SD
Active Cases Reviewed: CCPT/ CFPT	55 (85%)*	393	1	41	7.15	8.11
Active Cases Reviewed with SAI: CCPT/CFPT	21	33	1	6	1.57	1.21
Active Cases Reviewed with Near Fatality: CCPT/CFPT	8	11	1	4	1.38	1.06
Active Cases Reviewed: CCPT	16 (89%)*	104	2	11	6.50	2.85
Active Cases Reviewed with SAI: CCPT	7	15	1	6	2.14	1.77
Active Cases	2	3	1	2	1.50	0.71

Reviewed with Near Fatality: CCPT						

Note. A case may have more than one type of review. The table does not include two counties who indicated "Other" to describe their team composition. Standard Deviation (SD)
*Percentage of responding combined CCPT/CFPTs and CCPTs that had reviewed at least one active case

Table 9 displays the total number of cases reviewed when organized by county size. Compared to the large and medium size counties, the small counties as a group reviewed the most cases, likely due to the larger number of small counties, but on average, all counties reviewed approximately the same number of cases. Within each county-size group, especially for the small and medium counties, there was extensive variation in how many cases they reviewed.

Number of Active Cases Reviewed by County Size, 2022, (N=85)

Table 9 Number of Active Cases Reviewed by County Size

Size of County	Number of Respondents Reporting Cases	Number of Cases Reviewed	Mean	SD	Range
Small	44 (86.3%)	260	5.91	6.97	0-41
Medium	32 (82.1%)	186	5.81	7.68	0-40
Large	9 (90%)	59	6.56	6.15	0-20

Note: Number of responding counties and percent of total possible counties of a specific size. Large standard deviations indicate wide variability in the number of cases reviewed. Standard Deviation (SD). Mean, Range, and Standard Deviation include responding counties that indicated zero cases were reviewed.

Table 10 displays the total number of cases reviewed when organized by Economic Well-Being Tier. Compared to the most and least distressed counties, the Tier 2 counties as a group reviewed the most cases. However, on average, Tier 3 counties (least distressed) reviewed a higher number of cases than the Tier 1 and Tier 2 counties, who reviewed approximately the same number of cases. Within each county-size group, especially for the Tier 1 and Tier 2 counties, there was extensive variation in how many cases they reviewed.

Number of Active Cases Reviewed by Economic Well-Being Tier, 2022, (N=85)

Table 10 Number of Active Cases Reviewed by Economic Well-Being Tier

Size of County	Number of Respondents Reporting Cases	Number of Cases Reviewed	Mean	SD	Range
Tier 1 (Most Distressed)	32 (80%)	168	5.25	7.37	0-40
Tier 2	36 (90%)	195	5.42	7.17	0-41
Tier 3 (Least Distressed)	17 (85%)	142	8.35	6.19	0-22

Note: Number of responding counties and percent of total possible counties of a specific tier. Large standard deviations indicate wide variability in the number of cases reviewed. Standard Deviation (SD). Mean, Range, and Standard Deviation include responding counties that indicated zero cases were reviewed.

Maltreatment Fatalities

The 2022 survey then went on to ask, "How many cases did your CCPT review that included maltreatment fatality factors?", and to avoid duplication in case counts included, the instruction to "not include those done through an Intensive Fatality Review." Of the 85 CCPTs who responded to this question, only 11 CCPTs indicated that they reviewed a case with maltreatment fatality factors. The number of cases reviewed that involved maltreatment fatality factors ranged from 1-7, with a total of 23 cases.

Next, the survey asked, "Of these fatalities reviewed, how many of these children had a history of identification as a Substance Affected Infants?" Of the CCPTS who had reviewed a case with maltreatment fatality factors, a total of 6 (55%) CCPTs indicated that at least one fatality case that was reviewed was a Substance Affected Infant. The number of cases that involved a Substance Affected Infant ranged from 1-2, with a total of 7 cases.

Reporting

The survey then inquired about reporting issues that the CCPTs may have encountered during the review process and how CCPTs generally go about conducting local reviews. First, the survey stated, "After an intensive review has occurred, describe how the findings and recommendations coming out of the review were typically communicated." A total of 48 counties provided qualitative responses other than "not applicable." The responding CCPTs provided a range of responses indicating that the approaches varied based on county specific resources, team composition, experience, and policy guidelines. Several CCPTs indicated that they had not had any intensive reviews, either this fiscal year or previously, or that they did not conduct these types of reviews at all. Additionally, several teams formed subcommittees or collaborated with their CFPT or other relevant partners to complete the case review. Further, many teams described communicating and discussing findings and recommendations during team meetings. For instance, one team wrote, "When Intensive Reviews occur, we present the findings at our CCPT meeting with all members. The findings are discussed with everyone, and if needed, recommendations are made to complete anything the review identified for our CCPT to do." Furthermore, CCPTs described involvement from or communication with other organizations or persons outside of the team can. One team wrote, "Following an email from the State, findings and recommendations were discussed with Child Welfare Staff and changes in practice were implemented." Similarly, another team wrote that "DSS is present at meetings and reports findings back to the staff."

Next, the survey asked, "After an intensive review has occurred, how does your CCPT typically identify action steps for working on the local recommendations?" A total of 43 CCPTs provided responses. Similar to the previous question, many CCPTs reported they formed subcommittees, collaborated with their CFPT or other relevant partners, or discussed action steps at their team meetings. For instance, one CCPT wrote:

> The Team reviews the recommendations outlined in the report. The Team then identifies how we will follow up on these, including who needs to be involved in what role. If there

> are already activities in the community that can have a positive impact, we evaluate whether they are being used and how to ensure the referrals and involvement for families.

Likewise, other teams reported discussing ways to reach the community, identifying additional needs, including for training, or working with collaborative partnerships to identify concerns and develop resources. Overall, there was a range of responses to these survey questions providing an abundance of evidence indicating that CCPTs had varying approaches to conducting these types of reviews when the need arose.

Finally, the survey asked, “In reviews of active or fatalities cases did you identify any issues related to the reporting of substance affected infants in accordance with the law?” Of the 82 CCPTs who responded, only 4 (5%) had issues with reporting and 78 (95%) did not; 6 CCPTs did not respond to this question.

In summary, child maltreatment cases encompass active cases and child fatalities; active cases include near fatalities where child abuse, neglect, or dependency is suspected. In 2022, 72 (85%) of the 85 responding CCPTs reviewed 505 active cases and 23 cases that included maltreatment fatality factors. Among these cases were 48 infants who were affected by substances and 14 near fatalities. Within each county-size group, especially for the small and medium counties, there was extensive variation in how many cases they reviewed; although, on average, all counties (regardless of size) reviewed the same number of cases. Further, regarding economic well-being, on average, Tier 3 counties (least distressed) reviewed a higher number of cases. Thirteen counties did not indicate that they reviewed cases; notably, five of those CCPTs reported they were not an established team or had not met regularly. The survey did not specifically inquire about the reasons why some counties had not reviewed cases and what would have helped them fulfill this role.

a) Criteria for Selecting Cases for Review

State statute requires that CCPTs choose “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.” Thus, the survey asked about the criteria that the teams and their DSS agency applied to their decision-making for which active cases are reviewed. The teams were provided a list of 12 criteria and could write in two additional reasons. As shown in Table 11, the most common reason cited by 63 (72%) out of the 88 respondents was that the case was active. Among the respondents, 15 (17%) stated that they selected child maltreatment fatalities for review. In addition to the statutory requirements, the CCPTs identified other selection criteria. Along with active cases, the most frequently selected, at 55% or higher, were the criteria of stuck case, parent substance use, and multiple agencies involved. Thirty-nine of the respondents added a selection criterion, and eleven of these provided two criteria. The additions included “lack of resource,” “homelessness,” “teen behavioral issues,” “child sexual abuse,” “mental health,” “language barriers,” “child under age one,” “domestic violence,” “undocumented children,” and “Health Department case.”

Case Criteria Used by CCPTs for Selecting Child Maltreatment Cases for Review, 2022, (N=88)

Table 11 Case Criteria Used by CCPTs for Selecting Child Maltreatment Cases for Review

Selection Criterion	Number of CCPTs	
Active Case	63	(71.6%)
Stuck Case	51	(58.0%)
Multiple Agencies Involved	50	(56.8%)
Parent Substance Use	49	(55.7%)
Repeat Maltreatment	46	(52.3%)
Child Safety	44	(50.0%)
Other 1	39	(44.3%)
Child and Family Well-Being	38	(43.2%)
Court Involved	30	(34.1%)
Child Permanency	27	(30.7%)
Child Maltreatment Fatality	15	(17.0%)
Other 2	11	(12.5%)
Closed Case	8	(9.1%)
Child Trafficking	7	(8.0%)

b) Contributory Factors to Intervention Necessity

Child Protective Services (CPS) 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 12 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 use cited by 67 (76%) CCPTs and caretaker's mental health need cited by 59 (67%) CCPTs. Three other factors used by over 50% of CCPTs pertained to child/youth with mental health needs, child/youth behavioral problems, and household domestic violence.

Contributory Factors for Children Being in Need of Protection Used by CCPTs for Selecting Child Maltreatment Cases for Review, 2022, (N = 88)

Table 12 Contributory Factors for Children Being in Need of Protection Used by CCPTs for Selecting Child Maltreatment Cases for Review

Contributory Factor	Number of CCPTs	
Parent/Caregiver		
Drug Use	67	(76.1%)
Mental Health Need	59	(67.0%)
Alcohol Use	42	(47.7%)
Lack of Child Development Knowledge	26	(29.5%)
Intellectual/Developmental Disability	18	(20.5%)
Other Medical Condition	11	(12.5%)
Learning Disability	9	(10.2%)
Visually or Hearing Impaired	5	(5.7%)
Children/Youth		
Behavior Problem	48	(54.5%)
Mental Health Need	44	(50.0%)
Other Medical Condition	22	(25.0%)
Drug Problem	21	(23.9%)
Intellectual/Developmental Disability	21	(23.9%)
Learning Disability	15	(17.0%)
Alcohol Problem	14	(15.9%)
Physically Disabled	11	(12.5%)
Visually or Hearing Impaired	6	(6.8%)
Household		
Domestic Violence	45	(51.1%)
Inadequate Housing	38	(43.2%)
Financial Problem	27	(30.7%)
Public Assistance	19	(21.6%)

In summary, state statute requires that CCPTs review two types of cases: active cases and child maltreatment fatalities. Most (81%) respondents selected active cases for review. Child maltreatment fatality was given as a reason for case selection by 17% of respondents. Whether local teams review all child maltreatment fatalities depends on the context. For instance, teams select cases for review if there appear to be systemic factors affecting service delivery. The second most frequent criteria for selecting cases were stuck case, parent substance use, and multiple agency involvement, all identified by 55% or more of respondents. The range of issues identified indicates the CCPTs' concern about many areas affecting the families' lives. The teams also selected cases on the basis of factors contributing to children needing protection: The two most common factors were caretaker's drug use cited by 67 (76%) CCPTs and caretaker's mental health need cited by 59 (67%) CCPTs. Three other factors used by over 50% of CCPTs pertained to child/youth with mental health needs, child/youth behavioral problems, and household domestic violence. 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.

2) Process of Case Reviews

The CCPTs used different types of information to review the cases (see Table 13). Out of the 88 respondents, 81% used reports from members and/or case managers and 80% used case files. Over half (53%) used information on procedures and protocols of involved agencies. These three types of information were the same primary sources as reported in the 2016 through 2021 surveys. CCPTs also wrote in some other information sources, including: social worker information, medical records, Department of Juvenile Justice records, forensic interviews, and mental health records, similar to previous years.

Type of Information Used by CCPTs for Reviewing Cases, 2022, (N=88)

Table 13 Type of Information Used by CCPTs for Reviewing Cases

Type of Information	Number of CCPTs
Reports from Members and/or Case Managers/Behavioral Health Care Coordinators/Care Managers	71 (80.7%)
Case Files	70 (79.5%)
Information on Procedures and Protocols of Involved Agencies	47 (53.4%)
Child and Family Team Meeting Documentation	29 (33.0%)
Medical Examiner's Report	27 (30.7%)
Other 1	26 (29.5%)
Individualized Education Plan	24 (27.3%)
Other 2	5 (5.7%)

Ways to Improve Case Reviews

The survey then turned to examining ways to enhance case reviews and asked, "What would help your CCPT better carry out case reviews?" Out of the 88 teams, 9 (10%) affirmed what they were doing well, 62 (71%) specified at least one means of strengthening their reviews, and 17 (19%) did not identify a means for improvement. The majority of teams in this last group, unlike the first two, came from counties that were small, faced economic distress, or both.

Those teams that emphasized their accomplishments all met regularly and, with one exception, had reviewed one or more active cases of child maltreatment in 2022. They spoke of the benefits of being "an established and cohesive team" that is "well informed and has information regarding the cases reviewed." They also praised their capacity to "share information" and to do "a great job selecting cases."

The teams that pointed out ways to improve their case reviews echoed these same themes regarding team participation and case selection and information. Additionally they emphasized the need for better structuring of the review process.

- *Team participation*: CCPTs stressed the need for “consistent participation by team members” “especially law enforcement & DA office.” They asked that agencies provide “better orientation and training . . . for staff they designate to be on the team.” Some wanted to understand how to include “community partners” and “youth or family partners in case reviews.” So that members could feel like the meetings are ”worth their time,” they highlighted the necessity of “active participation and engagement from multiple agencies,” “open communication among all team members,” and “more dedication from mandated members”

- *Case selection and information*: Some simply wanted cases to review. A recurring barrier in case reviews was receiving sufficient and timely information, particularly “reports from the Medical Examiner.” Teams urged “easier access to cross-state medical and CPS records and the ability to review cases with pending criminal charges.” An issue for combined teams was allocating time to CCPT cases given the need to review additional child fatalities. In response, one team proposed that they “schedule Interim/separate CCPT meetings for the primary purpose of reviewing cases,” and another team recommended designating “a co-chair who is dedicated to CCPT activities.”

- *Review structure*: Repeatedly teams asked for more training on “what is expected,” preparation of chairpersons, a “format” for case presentations, and a “review tool” so that they could select and process cases more efficiently and with attention to “race equity issues.” One team observed that having such a “tool” would make it possible to “compile data and information from case reviews that can be used at the local and state level to study trends and compare information to inform future efforts.”

In summary, the CCPTs used different types of information to review the cases and particularly drew upon reports from members and/or case managers, case files, and information on procedures and protocols of involved agencies. When asked what would help them better carry out case reviews, 10% affirmed what they were doing well, 71% specified at least one means of strengthening their reviews, and 19% did not identify a way to improve their reviews. Methods for improving case reviews included: strengthening team participation, accessing multiple forms of case information, and structuring the review process.

K. Reported Limits to Access to Needed Mental Health, Developmental Disabilities, Substance Use, and Domestic Violence Services and Suggestions for Improvement

A recurring concern of CCPTs was the families’ limited access to needed services in mental health, developmental disabilities, substance use, domestic violence, and child trafficking (MH/DD/SU/DV/CT).

The survey asked the CCPTs to identify how many cases reviewed in 2022 needed access to MH/DD/SU/DV/CT services. Table 14 summarizes the findings first for the children and second for the parents or other caregivers. Here, 65 of the respondents identified MH needs of children in a total of 248 cases. I/DD services were needed for children in 40 cases. These numbers are generally on par with 2021 data which indicated a need for MH services in a total of 243 cases,

and I/DD services were needed for children in 33 cases. Likewise, this year, child trafficking services were needed in 4 cases and reported by 3 CCPTs, and in 2021, 6 cases required services and were reported by 2 CCPTs. In contrast to 2021, there was a decrease in service needs for SU and DV services in 2022. This year, a total of 25 respondents identified SU service needs for 52 cases and 15 respondents identified DV services needs for children 41 cases; in 2021, SU and DV services were needed in 79 and 77 cases respectively.

Next, the 2022 survey asked, "Did any of these services have a waitlist?" For the child services, 38 respondents indicated there was a waitlist for MH services, 15 indicated there was a waitlist for I/DD services, 10 indicated there was a waitlist for SU services, and 4 indicated there was a waitlist for DV services; no respondents indicated a waitlist for CT services.

For the parents or caregivers, the need for mental health and substance use services were the most prominent. Among the responding teams 63 identified the need for MH services and 65 identified a need for SU services. The total number of reviewed cases were also higher with 255 of the reviewed cases requiring MH services and 234 requiring SU services. The need for DV services was cited by 40 of the teams, for a total of 92 cases. Notably, the need for DV services decreased since 2021; at that time, 115 cases needed services. The need for I/DD services was expressed by 9 CCPTs but with a significantly lower number of cases reviewed (20 cases).

Next, the 2022 survey asked, "Did any of these services have a waitlist?" To this, 23 respondents indicated there was a waitlist for MH services, 7 indicated there was a waitlist for I/DD services, 14 indicated there was a waitlist for SU services, and 5 indicated there was a waitlist for DV services.

Then the survey asked, "How many of these cases received the needed services?" This comparison is reported in Table 16. Across all categories, the majority of cases received the needed services (50%-90%). In each category, a substantial percentage of cases did receive the needed service, however, critical services were not received for all cases in any category. The children received needed services more often than the parents/caregivers. For children, the need for child trafficking services was met for only 50% of the cases, however, mental health needs were met the most frequently in 90% of cases. For parents/caregivers, the need for intellectual/developmental disabilities services was met the least frequently, in only 55% of cases, however, the need for mental health services was met in 75% of 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 SU, 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.

Number of Reviewed Cases Requiring Access and Receiving Services to MH/DD/SU/DV/CT Services, 2022 (N= 88)

Table 14 Number of Reviewed Cases Requiring Access and Receiving Services to MH/DD/SU/DV/CT Services

	Number of Reporting CCPTs*	Sum of Cases	Sum and Percentage of Services Received	Sum of Cases Mean	Sum of Cases SD
Children/Youth					
Mental Health	65	248	224 (90.3%)	3.82	3.84
Substance Use	25	52	36 (69.2%)	2.08	1.29
Domestic Violence	15	41	38 (92.7%)	2.73	1.49
Intellectual/Developmental Disabilities	25	40	34 (85.0%)	1.60	0.91
Child Trafficking	3	4	2 (50.0%)**	1.33	0.58
Parents/Caregivers					
Mental Health	63	255	191 (74.9%)	4.05	7.38
Substance Use	65	234	137 (58.5%)	3.60	4.50
Domestic Violence	40	92	51 (55.4%)	2.30	1.88
Intellectual/Developmental Disabilities	9	20	11 (55.0%)	2.22	2.22

Note. MH/DD/SU/DV=Mental Health, Developmental Disabilities, Substance Use, and Domestic Violence. Large standard deviations indicate wide variability in the number of cases reviewed requiring access to services.
*Number of reporting CCPTs who indicated 1 or more cases
**Several cases were pulled from analyses due to the number of cases where services were received being higher than the number of cases reported; this is most likely due to an input error from 2 responding counties.

Next the survey asked, “Which of the following limitations prevented children, youth, and their parents or other caregivers from accessing needed MH/DD/SU/DV services?” As shown in Table 15, the two most frequently cited barriers were limited or no services (60% of respondents) and lack of transportation to services (41% of respondents). Other common reasons were limitations in community knowledge about available services (30%) and MH and SA for youth with dual diagnosis (26%). Respondents’ recognition of inadequate services for youth with dual diagnosis ranged from 8-26%; these trends are a decrease from previous years’ findings.

Among the respondents, 32 wrote in additional limitations. These primarily concerned systemic factors and to a lesser extent, family reasons. Some respondents commented on “parent’s willingness to seek services” and “parent’s readiness to participate in services.” Several referenced language and cultural barriers. Others identified the lack of available services,

particularly within the context of the pandemic and "constant turnover" as well as a lack of services or residential placements for complex mental health needs for youth.

Number of CCPTs Reporting Limitations Preventing Children, Youth, and Their Parents or Other Caregivers Accessing Needed MH/DD/SA/DV Services, 2022, (N = 88)

Table 15 Number of CCPTs Reporting Limitations Preventing Children, Youth, and Their Parents or Other Caregivers Accessing Needed MH/DD/SA Services

Limits on Access	Numbers of CCPTs
Limited Transportation to Services	36 (40.9%)
Limited Services or No Available Services	53 (60.2%)
Other 1	32 (36.4%)
Limited Community Knowledge About Available Services	26 (29.5%)
Limited Services MH and SA for Youth with Dual Diagnosis	23 (26.1%)
Limited Services MH and DD for Youth with Dual Diagnosis	19 (21.6%)
Limited Participation of MH/DD/SA/DV Providers at CFTs	14 (15.9%)
Other 2	13 (14.8%)
Limited Services MH and DV for Youth with Dual Diagnosis	7 (8.0%)
Limited Number of Experienced CFT Meeting Facilitators	6 (6.8%)

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

Finally, the survey asked, "What barriers contributed to the limited participation of MH/DD/SU/DV providers at CFTs?" Among the 14 respondents who selected "limited participation of MH/DD/SU/DV providers at CFTs," 11 respondents provided a barrier. These barriers primarily consisted of restrictions and scheduling conflicts due to the pandemic. Additionally, a majority of respondents identified limited numbers of providers and a lack of training among the providers.

In summary, children, youth, and their parents or caregivers faced serious barriers to accessing needed services. Most CCPTs who reviewed cases in 2022 reported that children and youth needed access to mental health services. Most CCPTs also reviewed cases in which the parents or caregivers required access to mental health, substance use, or domestic violence services. Importantly, the majority of cases in each category received the needed service, with the percentage ranging from 50-90%. With the exception of child trafficking services, all needed service categories were reported as having a waitlist in at least one case. 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, SU, and DV services. CCPTs indicating that there were waiting lists for these services also spoke to this need. Additionally, CCPTs identified systemic barriers to families' accessing essential services. The most commonly cited barriers were limited services or no available services, lack of transportation to services, and limited community knowledge about services. The CCPTs commented on some family factors affecting service receipt such as parents' readiness to participate in services and on systemic factors such as language barriers, financial barriers, and service providers being understaffed or closed due to COVID-19. Additionally, a majority of respondents identified inadequate numbers of providers and a lack of training among the providers. It is quite likely that family and systemic barriers reflected the complexity of the healthcare 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. Perceived Barriers Related to the COVID-19 Pandemic

This year, CCPTs were asked, "Of the cases reviewed, what barriers did COVID-19 pose?" Thirty-eight (44.2%) CCPTs listed a barrier, indicating that the majority of CCPTs in 2022 found that the coronavirus pandemic posed a barrier in the case review process. Importantly, while the survey specifically asked about COVID-19 barriers *related to case reviews*, it appears that many respondents may have provided information about COVID-19 barriers more generally. Based on the cases reviewed, COVID-19 posed several barriers for both teams and families which included challenges with virtual/hybrid formats, issues with attendance and participation, and minimal resources for families.

Virtual and Hybrid Formats

Teams indicated that they were conducting meetings either virtually or in a hybrid format (meeting in person with an option for attendees to participate virtually). The virtual component of CCPT meetings was identified as a barrier. Lacking face-to-face interactions was provided by a participant as a reason that hybrid/remote format for meetings was not sufficient in comparison to in-person meetings: "You can't replace an in person meeting for these types of cases." Likewise, respondents noted that virtual meetings for client services were often challenging to families, who might lack access to reliable internet.

Attendance and Participation

In relation to the theme of virtual/hybrid format being a challenge to CCPT meetings, attendance and participation were stated as a barrier to conducting and scheduling CCPT team meetings for case reviews. . Attendance issues involved there being increased scheduling conflicts, absences due to illness, limited Internet access for virtual meetings, and discomfort meeting in person as a result of the risk associated with exposure to COVID-19. Participation issues included less discussion from meeting attendees in virtual team meetings. These challenges are expressed by the following participant, "Less discussion when done virtually, less attendance when done in person."

Limited Resources for Families

The COVID-19 pandemic has significantly impacted mental health and social services for family members. COVID-19 also led to an increase in mental health needs and a decrease in services, as well as long waitlists for services and the need for rescheduling appointments due to COVID-19 symptoms or exposure. Additionally, staff turnover with community stakeholders and difficulty maintaining community partner connections have been challenges. One member stated, "Part of the barriers with the pandemic have to do with staff turnover with community stakeholders and difficulty maintaining community partner connections."

Solutions to the Barriers

Next, the survey asked, "What creative solutions did your team identify to address those issues?" 42 (47.7%) CCPTs provided a solution. Interestingly, many of the solutions that the CCPTs identified were also listed as barriers. For example, in efforts to minimize the attendance and participation issues at CCPT meetings, a majority of the respondents indicated that they conducted meetings virtually. In order to combat the problems related to lack of internet access for families, one CCPT reported, "Parents use of public Wi-Fi and hotspots." Another CCPT noted:

> We continued to hold meetings in a manner that allowed for social distancing, as well as offering online attendance options for every meeting. This helped create security for team members and increased attendance rates due to safety and convenience.

Additionally, CCPTs noted they held meetings at different times to accommodate different schedules or provided transportation to the CCPT meeting locations.

Regarding staff turnover and limited resources for families, CCPTs described using a few different strategies. For instance, one CCPT noted that NC DSS staff "took a more active role in the CFPT process to help with staff turnover." A respondent described encouraging families to re-enroll in services that may have been stopped due to the COVID-19 pandemic. Other CCPTs reported that they increased communication and partnership between various agencies in order to provide families with needed resources and services sooner. Similarly, other teams noted they searched for additional resources in the community.

In summary, the COVID-19 pandemic posed several barriers for team operations and families which include challenges with virtual/hybrid meetings, issues with attendance and participation, and limited resources for families. While many CCPTs described virtual meetings as a barrier,

noting that in-person meetings were more beneficial (e.g., enabled better discussion), they acknowledged the need for virtual meetings in order to accommodate differing schedules and improve meeting attendance. CCPTs noted various strategies to ensure families and team members were able to attend meetings, including providing the option of attending via telephone, providing transportation, and changing meeting times. CCPTs described a need for increased communication, collaboration, and partnership with other agencies and organizations in order to provide families with necessary resources and services as soon as possible.

M. Racial and Cultural Equity Issues in Addressing Local Needs

This year's survey explored local developments in regards to a racially and culturally equitable approach to child welfare. The survey defined racial and cultural equity as "*responsive to and invests in families and their communities with the result that children remain safely at home and their families are respected and supported in making and carrying out decisions for the care and well-being of their children.*"

First, the survey asked, "Has your team discussed issues of racial and cultural equity in child welfare?" Among the 87 respondents, 59 (68%) checked *no* and 28 (32%) checked *yes*. Next, the survey inquired, "While conducting your case reviews, what were the issues identified by the team relating to racial and cultural equity?" Twenty-two (25%) specified one or more issues; among the 22, 20 had checked *yes* about discussing equity issues and 2 had not but offered issue(s). Teams identified challenges to racial and cultural equity posed by language and cultural barriers, lack of staff inclusivity, and imbalances in resources and services.

Language and Cultural Barriers

Language barriers were an issue for Spanish- and Arabic-speaking families. One team laid out the need for "medical and mental health providers that speak the language of those we serve and have culturally sound practices." Another CCPT recognized that in a "medically diabetic case, the mother did not know how to communicate with the provider."

Lack of Staff Inclusivity

CCPT members identified mindsets that staff and agencies may hold as well as lack of diversity of providers as challenges to racial and cultural equity. For example, one team stated that mental health providers have "common biases about a particular culture's behaviors and beliefs." Another team was concerned by the "lack of inclusivity of service providers." Concerns were raised about "uncomfortable" conversations with families from different racial and ethnic backgrounds and the need for "training to measure the competency of staff and agencies." Summing up the responses across many of the teams, a CCPT called for "trust, communication, non-bias opinions, everyone matters and deserves respect."

Imbalances in Resources and Services

CCPTs identified disparities in access to needed resources and services for families based on race, gender, and income. One team zeroed in on "bad housing areas and the racial imbalance." Another CCPT observed, "We have more citizens below the poverty line who do not seek medical care," and continuing, noted, "There are more illnesses related to specific race and gender." "A team insisted on "making sure the same services are offered and provided."

Turning from discussion to action steps, the survey asked, "What strategies did your team identify to address these issues?" Twenty-two (25%) teams outlined a strategy(ies) in response to these issues of racial and cultural inequity.

Addressing Language and Cultural Barriers

Teams sought to overcome these barriers by increasing language services and alleviating cultural hesitancies in accessing services. For instance, one team, identifying the "stigmas regarding MH services," proposed "access to MH providers who look like the clients being served" and, in general, "to normalize MH services." Another team sought to "diffuse communication barriers" by "wrapping a variety of services around the family." And a third team looked "for additional supports in translators/interpreters."

Addressing Lack of Staff Inclusivity

CCPTs partnered with local service and community groups to identify training resources and build an inclusive service network. For instance, to overcome "language barriers and common biases about a particular culture's behaviors and beliefs," a team sought out "training, partnerships with family-serving agencies, and Latinx community resources." Other teams advised, "Identifying providers that can work with different cultures" and "encouraging training resources" such as from the local Area Health Education Center and the Children's Advocacy Center.

Addressing Imbalances in Resources and Services

To address imbalances in resources and services, they worked on extending collaborative networks, developing alternative ways of meeting families' needs, and raising their own team's awareness of imbalances in distribution. Developing partnerships to overcome the lack of services to Hispanic families, a team reported that a "mental health community rep is discussing with a [local center] the need for additional resources." In order to assist lower-income families in accessing services, a team planned to work on "transportation issues" by promoting 'public transportation" and "virtual services." Examining their own attention to issues of "race and gender" in accessing medical care for "citizens below the poverty line," a team concluded, "We need to do a better job of tracking this issue." Another team noted the need for "a frank discussion" among their members and planned "to research racial and cultural equity."

Over 2022, NC DSS had distributed some resources to local teams to assist them in identifying and addressing equity issues. Checking on their use, the survey asked, "Are you currently utilizing the resources provided to your team to explore a racially and culturally equitable approach to child welfare?" Among the 85 responding teams, 48 (57%) said *no* and 37 (43%) said *yes.* Drilling down further, the survey asked, "If not, what would help your CCPT to use these and other resources that are provided?"

Among the teams checking *no,* some replied that they were "not familiar with this resource," requested that the state "provide the information again or explained that "these were not issues in the cases that were reviewed." Given reliance on distance formats during a pandemic, a team observed, "This needs to be a discussion. These discussions do not happen easily when virtual." Teams asked the state for more "guidance" and "reminders" on use of the materials and proposed various solutions to the issues faced by teams in using the resources.

Examining the content of the resources distributed, a team noted that one document pertaining to the Child & Family Services Review was "very DSS-centric" and its change actions required large scale resources. They advised, "Having information tailored to multi-disciplinary teams that can be focused on small steps to work toward stronger race/equity initiatives would be helpful." Other teams proposed staffing solutions to the issues faced by teams in using the resources. One CCPT suggested, "To have a designated person whose focus is on the CCPT." In agreement, another team elaborated on the necessary staffing: "Administrative funding and a dedicated administrative/office assistant . . . to be the primary point of contact . . . for distribution of information; coordination of training, workshops, informational meetings; data collection around case presentations/case reviews and minutes; and maintenance of all administrative duties in direct support of the CCPT."

In summary, this year's survey explored local developments in regards to a racially and culturally equitable approach to child welfare. Over two-thirds of responding teams had not discussed issues of equity in child welfare over the year. Nevertheless, teams identified challenges to racial and cultural equity posed by language and cultural barriers, lack of staff inclusivity, and imbalances in resources and services. They also specified strategies to address these challenges to equity. To overcome language and cultural barriers, they sought to increase language services and alleviate cultural hesitancies in accessing services. In response to the lack of staff inclusivity, CCPTs partnered with local service and community groups to identify training resources and build an inclusive service network. To address imbalances in resources and services, they worked on extending collaborative networks, developing alternative ways of meeting families' needs, and raising their own team's awareness of imbalances. To assist local teams in responding to equity issues, NC DSS distributed some resources over the year. The majority of teams reported that they had not received or did not use these resources, and some proposed strategies to increase their utilization. These proposals included: guidance from NC DSS on their use, distributing materials tailored to multi-disciplinary teams and focused on small steps rather than large-scale change, and having a designated administrative support to coordinate activities.

N. Local CCPT Recommendations for Improving Child Welfare Services

Number of CCPT Recommendations

Over the years, the survey has checked with CCPTs on ways in which to improve child welfare in their communities and at the state level. These CCPT recommendations have been reviewed closely by the CCPT Board in formulating recommendations to NCDSS on ways to enhance child welfare.

For the first time this year, the Board sought to hear CCPT recommendations on ways to strengthen (a) child welfare "as an agency with defined mandates and policies" and (b) child protection "as a community effort where everyone has a role." In each of these broad areas, the aim was for the survey to ask for local and state-level recommendations.

For the area on child welfare, the survey asked first: "Based on your 2022 case reviews, what were your team's top three recommendations for improving child welfare policies and statutory law at the local level?" In response, several teams pointed out that child welfare policies and statutory law were not made at the local level, and one commented that their case recommendations were not "related to Child Welfare local or state policies" and "were case specific determined by the family's circumstances." Others noted that they could not make recommendations because they had not reviewed cases during the year. As previously documented, 12 teams reviewed no cases in 2022. Summarized in the table below, among the 88 teams, 31 (35%) made no recommendation while 57 (65%) made between one to three recommendations. The total of recommendations at the local level was 152.

Second, the survey asked, "Based on your 2022 case reviews, what were your team's top three recommendations for improving child welfare policies and statutory law at the state level? In response, 32 (36%) made no recommendation while 56 (64%) made one or more recommendations, for a total of 142 at the state level. Combined the totals for the two questions equals 294 recommendations.

The paper version of the survey correctly asked about child protection as a community effort; however, the electronic version incorrectly repeated the questions about child welfare policies and statutory law. Some teams recognized this glitch in the e-survey and responded to the questions on the paper copy. Many teams pointed out that the e-survey only repeated the questions for the prior area on child welfare. Quite a number of CCPTs took the opportunity to reiterate or elaborate on recommendations set forth in response to the questions on child welfare. As shown in the table below, the number of recommendations dropped from a total of 294 for the first set of two questions to a total of 215 for the second set of two questions. Combined, the two sets of questions yielded 509 recommendations, although as noted, some were repeats of prior recommendations.

The analysis looked for recurring themes across all the recommendations as well as recommendations set forth in the survey's final section on additional information that teams chose to communicate. The result was a rich array of recommendations of utility to improving child welfare as an agency and encouraging child protection as a community effort.

Table 16 Number of CCPTs Providing Recommendations

	Zero Recommendations	One Recommendation	Two Recommendations	Three Recommendations
Welfare Local	31	7	5	45
Welfare State	32	8	10	38
Protect Local	40	10	6	32
Protect State	50	4	7	27
Total	**153**	**29**	**28**	**142**

Recommendations

In making their recommendations, teams demonstrated a keen awareness of local developments and pushed for policy and program changes that fit their experience. The analysis identified two main sets of recommendations. The first set was a series of steps for enhancing the policy process. The second set concerned enhancing services and reflected values for service delivery: adequate programming, equitable distribution, and family-centered approach.

Enhanced Policy Process. The teams' recommendations added up to a wealth of proposals for improving the policy process. They formed seven main steps: clarifying policy, refining policy, acknowledging disagreements and common ground, identifying recurring challenges, advocating for policy change, ensuring adequate resources and mutual accountability, and strengthening quality assurance through CCPTs.

Clarifying Policy. Frequently, CCPTs spoke of the need to clarify child welfare policy so that families, workers, and others in the community could better understand key terms and procedures. Teams recognized that agency policies and procedures were commonly incomprehensive and intimidating to families and proposed, "Simplified/family friendly Family Services Agreement and Safety Plans" and "Policies/laws with clear and concise guidance to families." Workers also needed an explanation of expectations. For example, a team asked for "policy outlining procedures for assessing recurrent maltreatment and additional reports." To lessen confusion, a team proposed that "DCDL [Dear County Director Letters] content to be included and written into the child welfare manual." They especially stressed that new policy initiatives, with Plan of Safe Care (POSC) as a notable example, required a "slower roll out" to leave time for educating workers and others in the community. In agreement, another team insisted, "Additional training for staff that is in the field. New policy and forms come out but no training." Continuing, this team observed, "This allows staff to understand the importance of POSC in all cases despite what the type of illegal substances used by the parent."

Refining Policy. Besides seeking clarification of policy, they sought better alignment of policy with community conditions. They requested greater state consultation with

counties on child welfare policies to ensure a "match" with "what is going on at the local level." The CCPTs pointed out places for improving policy and statute to support better practice. A team proposed an "expansion of statute with regards to sharing information in child welfare and provider cases." Another team recommended revising "child medical evaluation law" so that "the alleged perpetrator would not be the person who has to give consent for the child to be examined."

Acknowledging Disagreements and Common Ground. While the CCPTs' views often converged, there were some significant divergences. A striking difference was whether to address maternal substance use in a punitive or supportive manner. One team recommended, "When a Substance Affected Infant is born, there should be legal repercussions for the mother." In contrast, a second team suggested establishing "a think tank to plan for how to manage women who test positive for drugs at delivery in a non-punitive manner." Both teams shared the deeply held concern of a third team about "the increased number of cases that consist of substance use by a parent. Fentanyl, Meth, Heroin use as well as the misuse of prescription drugs." Teams looked for ways to stave off the necessity of more intrusive child welfare involvement. For example, a team pushed for consideration of "policies that allow funding and incentives for non-family members, kith/kin to provide crisis placement or short-term placements for families to work through challenges without long-term entry and custodial involvement of DSS. Another team proposed, "Expand/better integrate community resources to promote prevention plans and tools; early identification/access to needed services including shelter and alternative family living."

Identifying Recurring Challenges. For one team, a repeated challenge was the district attorney exercising the legally mandated authority to place holds on reviewing cases. Once the holds were eventually lifted, they found that "many, many of the staff [had] left . . . leav[ing] major gaps in knowledge of circumstances," crucial for carrying out the reviews. Another likewise experienced recurring problems in carrying out their work. This CCPT struggled with the "breakdown between the CME [child medical examination] policy/laws and providers. We had a near fatality and the hospital would not complete a SANE [Sexual Assault Nurse Examiner] exam so any evidence that may have been there was gone after the fact. Even with a court order, the hospital refused to complete the exam. This is an ongoing issue." Crossing county, state, or jurisdictional lines compounded difficulties in gaining access to requisite information. For example, a team felt stuck: "We are a military town and we struggle with the military's reluctance in sharing information on cases." These serious matters were not ones that teams could resolve on their own.

Advocating for Policy Change. Knowing that they could not single handedly effect some vital changes, CCPTs recommended that they form local alliances or ask the government to take action. To institute a coordinated response, teams looked to local organizing. For some this involved "increased communication between local DSS and providers about strengths and challenges about specific policies and mandates." Others adopted the strategy of putting in place systematic ways of working together. For example, a team proposed, "An alert system so that schools, hospitals, law enforcement, and other agencies involved in child welfare can be alerted and all child fatalities be fast tracked

with the state lab and the Medical Examiner's Office." Turning to political action, a team urged, "More involvement from elected officials to advocate for changes the public didn't agree with on a state level." To set this strategy into motion, this same team identified that "child welfare staff [needed] to educate the public, elected officials and other agencies about local laws and policies so they will understand child welfare limitations and policies. They could then advocate for changes."

Ensuring Adequate Resources and Accountability. Many of the proposed reforms required additional finances, personnel, and technology. Teams repeatedly recognized that chronic shortages and constant turnover in workers stymied work on behalf of children and families. Addressing these issues required "more CW staff" with reduced caseloads, "equitable pay," and provision of "resources to address secondary trauma at no cost to the employee." These reforms alone were insufficient unless other programs likewise grew. An area of concern was "ensuring that placement providers are available at the local level and that they meet the kid's needs" and that there is "a level of accountability - are services being billed to Medicaid provided?" Inadequate technology impeded the necessary exchange of information: "Sharing of data across counties - this is tedious and takes too much time when you are operating at times in crisis mode."

Strengthening Quality Assurance through CCPTs. North Carolina has an extensive network of CCPTs across the state. Their multidisciplinary case reviews, community engagement, and policy recommendations all position them well to serve as a local system of quality assurance. Such oversight promotes a system of responsive regulation that monitors, evaluates, and improves the policy process. In service of this aim, CCPTs proposed a number of recommendations. Some pertained to team membership. One team thought "family and youth participation" would enhance their work. Another wanted "a representative from the Dept. of Juvenile Justice (Juvenile Court Counselor) [as] a mandated member of the CCPT so that they don't take up an 'at large' spot." Teams also wanted greater communication with other teams and state DSS. One CCPT welcomed methods of sharing information among teams, including "a quarterly newsletter." Another team wrote, "The state would benefit from having a copy of the written report presented to our county commissioners attached to the survey." They wanted an "annual/refresher training" to assist chairs, and "policy reviews with the CCPT to assure the team (community members) understand policies and mandates." One team put forth a quite encompassing recommendation: "Create a standardized office of CCPT/CFPT at the State level to provide administrative support for the local teams."

Enhanced Services

Besides steps for enhancing the policy process, CCPTs proposed ways to ensure that services were adequate, equitable, and family-centered. These recommendations were firmly grounded on the CCPTs' reviews of cases.

Providing Adequate Programming. CCPTs were troubled by the insufficient services available to families. Summing up many of the recommendations of other teams, one CCPT outlined the necessity of "equitable and timely access to quality mental health, behavioral health, substance abuse, IDD services to include all levels of service (i.e.,

counseling, outpatient, inpatient, emergent, treatment that addresses the thoroughly assessed needs of the individual and families)." They wanted programming to start "pre-conception" to promote "maternal health" and to encompass other life stages. These included meeting placement needs of "youth with aggressive behaviors." To safeguard children's education, they advocated for "sensible and prudent homeschooling standards." To increase safety, they urged a "focus and education" on "infant safe sleep" and made other proposals, for example, "create laws similar to gun safety laws related to the safe storage of medication and illegal substances." Limited health coverage and service provision undercut efforts to meet children and families' needs. One team explained, "Medicaid reform is impacting and preventing families from receiving timely and available services. Policy needs to incorporate . . . mental health services being available and no restrictions with child welfare cases. Families should not have to wait until the provider is changed in order to get assistance."

Distributing Resources Equitably. Racial and rural/urban disparities and unfair selection practices of service providers undermined equitable coverage of families. Teams pressed for "bridging the gap in racial disparities," "protect[ing] undocumented children," "assisting communities in areas of culturally responsive services for families," and raising "awareness of nonconscious bias, diversity and inclusivity in the community, cultural/generational gaps." They were well aware of service differences between rural and urban counties. In response, one team requested, "CMARC [Care Management for At-Risk Children] resources be provided to small counties that don't have the financial backing to provide the service." Another team advocated, "Increas[ing] the funding opportunities for rural community resource providers to implement prevention programs that offer real supports to families." When making policy decisions, teams wanted the state to "receive input from all size counties"; "increase network capacity for emergency placements, ongoing placements, and treatment supported placements to serve children in the legal custody of ANY DSS agency"; and look "at barriers from state that could impact on funding available and development of needed resources in all counties- not just regional." Especially aggravating were selection practices making for unfair distribution of scarce resources: "There needs to be more Mental Health Providers in all areas in the local areas. They DO NOT NEED TO CHERRY PICK CHILDREN FOR PLACEMENTS." Another Team noted that "the state needs to enforce contracts with providers so they cannot cherry pick the clients they provide services to."

Encouraging a Family-Centered Approach. The CCPTs' recommendations emphasized helping families stay together, supporting families' informal networks, and promoting inclusive family decision-making. The intent was to "create and fund/sustain collaborative efforts to build/enhance/better integrate family-based services with lived experience, equity, and prevention principles." They identified the importance of child & family team meetings in making family decisions and pointed to the need for "local policies and incentives to enforce ongoing use of CFTs ensuring inclusion of relevant individuals and groups." Attention was given to reaching out to men who commit domestic violence by offering "batterer intervention programs." To sustain familial connections, teams put forth quite a range of recommendations that encompassed legal and financial assistance for families and their kin. For example, a team asked for "more legal assistance for families who want to pursue custody but do not have the financial

means." Another team recommended, "Incentivize family caregivers when caring for their own." A team explicated the reasoning behind this strategy: "Funding to keep families intact when they are serving as placement providers; flexible grant funding to support unanticipated needs. They are providing a safe placement for children which helps the child/youth and prevents entry into care; however, they face real financial struggles that impacts their quality of life and ability to provide basic needs." They recognized the challenges to kin providers and advised, "Expanding financial support of kinship care. For example, providing childcare subsidy to any kinship family regardless of employment status or assisting with board payments for kin going through licensure." Likewise, another team suggested that consideration be given to "policies that allow funding and incentives for non-family members, kith/kin to provide crisis placement or short-term placements for families to work through challenges without long-term entry and custodial involvement of DSS."

In summary, based on their case reviews, CCPTs offered 509 recommendations on ways to improve child welfare policy and practice and community efforts on behalf of children, youth, and families. One set of recommendations formed a series of seven steps for enhancing the policy process: clarifying policy, refining policy, acknowledging disagreements and common ground, identifying recurring challenges, advocating for policy change, ensuring adequate resources and mutual accountability, and strengthening quality assurance through CCPTs. For each step, CCPTs provided quite specific proposals. For instance, in regards to clarifying policy, they stressed reducing confusion for families by simplifying child welfare language and forms and for workers by providing training in advance of the rollout of new policies. For the most part, teams appeared to agree on policy and practice. A striking difference, though, was whether to adopt a punitive or supportive approach to mothers who use substances. Underneath both positions was a shared concern about the widespread availability of addictive drugs and a firm commitment to preventing their use. On some recurring challenges such as accessing needed case information, teams felt stuck and could not resolve them on their own. In response, teams recommended better local coordination through an alert system to notify involved agencies of all child fatalities or stronger advocacy on strengthening child welfare by educating elected officials and the public. Many of the proposed reforms required additional finances, personnel, and technology and vigilant oversight. With teams across the state, CCPTs were positioned to serve as a local system of quality assurance. To perform this role, they sought expanded membership, exchange of information with other teams, refresher training, and a CCPT/CFPT office at the state level to provide administrative support for the teams.

Besides steps for enhancing the policy process, CCPTs proposed ways to ensure that services were adequate, equitable, and family-centered. Troubled by the insufficient services available to families, CCPTs outlined a broad range of essential support for all family members. They recognized that limited health coverage and service provision undercut efforts to meet children, youth, and families' needs. They further identified that racial and rural/urban disparities and unfair selection practices of service providers undermined equitable coverage of families. They especially demanded that policy decisions include input from all size counties and that the state enforce contracts to prevent mental health providers from cherry picking children for placements. The CCPTs' recommendations emphasized a family-centered approach that helped families stay together, supported families' informal networks, and promoted inclusive family decision-making.

O. Additional Information

At the conclusion of the survey, CCPTs were provided a space in which to provide any additional information that they wished to communicate. Out of the 88 teams, 27 (31%) took advantage of the opportunity. Some expanded on policy and practice issues, and as previously noted, these were incorporated into the section on recommendations. Others gave updates on the progress or ongoing struggles of their team, relayed positive developments within their community, or clarified the reasons behind prior survey answers. A number praised the CCPT training provided by the state: "We appreciate the support and training from the State. . . . Thank you for all that you do."

2022 Recommendations of the NC CCPT/Citizen Review Panel Advisory Board

As summarized by the U.S. Children's Bureau, Citizen Review Panels (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/CRP Advisory Board used the extensive information and ideas from the current and earlier CCPT surveys to formulate the recommendations listed below. The Advisory Board met in four subcommittee meetings and then a meeting of the whole board to prepare and finalize the recommendations for action in 2024.

Notably, there is no stand-alone recommendation to address racially and culturally equitable approaches to child welfare in North Carolina. Rather, recommendations to support racially equitable and culturally competent approaches to child welfare are embedded within each of the recommendations. This will allow for more context specific strategies to be developed and implemented.

In accordance with CAPTA, we propose the following for child protection at the local and state levels in 2024.

POLICY RECOMMENDATIONS

1. North Carolina should develop and disseminate a statewide evidence-based campaign promoting best practices for safe sleep.
    a. More specifically, North Carolina should develop a culturally competent dissemination plan to reach historically marginalized populations, to include translation to native languages.
2. North Carolina should examine existing child welfare policy and consider policy changes in order to provide kinship caregivers the same level of funding and other supports received by licensed resource parents.
3. To ensure an equitable approach to resources across counties throughout North Carolina, North Carolina should conduct a review of policy processes to ensure equity in resources and service access, provision, and quality across rural and urban communities.

PRACTICE RECOMMENDATIONS

1. North Carolina should continue to work on access to appropriate and trauma-informed mental/behavioral health and substance use prevention and intervention services including both residential/inpatient and outpatient options for children and families.
2. North Carolina Department of Health and Human Services (NCDHHS) should finalize and implement statewide child welfare record system in all counties.
3. North Carolina should continue to work toward uniformity in its intake process across counties.

RESOURCE and TRAINING RECOMMENDATIONS

1. North Carolina should increase funding to victim service agencies to assist with intervention and prevention services for adults, children, and teenagers.

2. The North Carolina Child Welfare Workload Study, which began June 12th and was designed to collect the necessary data for understanding the current workload demands on local child welfare staff, should continue in order to address the staffing and workload needed for adequately protecting children.
    a. Likewise, this study should examine the need for securing additional foster parents.
3. North Carolina should provide information and available resources to local agencies in order to improve access to affordable housing throughout the state.
4. Local DSS should support training for CCPTs on strategies for sustainably incorporating family partners on their teams.

Local DSS should facilitate training for CCPTs, child welfare workers, and other agencies (e.g., juvenile justice) on domestic violence and mental health.

References

1) NC Child Welfare Manual. (2020, May). Purpose and philosophy, legal basis, and administration. Raleigh, NC: NCDHHS/DSS. https://policies.ncdhhs.gov/divisional/social-services/child-welfare/policy-manuals/modified-manual-1
2) Healthy Opportunities Pilots. NCDHHS. (n.d.). https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots
3) Notice of Proposed Rulemaking (NPRM) on Separate Licensing Standards for Relative or Kinship Foster Family Homes. (n.d.). The Administration for Children and Families. https://www.acf.hhs.gov/cb/policy-guidance/im2302
4) https://www.congress.gov/114/plaws/publ198/PLAW-114publ198.pdf
5) https://www.ncdhhs.gov/infant-plan-safe-care/place-of-delivery#affected_by_substance_abuse
6) Pierce, M. C., Kaczor, K., Acker, D., Webb, T., Brenzel, A., Lorenz, D. J., Young, A., & Thompson, R. (2017). History, injury, and psychosocial risk factor commonalities among cases of fatal and near-fatal physical child abuse. *Child Abuse & Neglect, 69*, 263-277. https://doi.org/10.1016/j.chiabu.2017.04.033
7) Adhia, A., Austin, S. B., Fitzmaurice, G. M., & Hemenway, D. (2019). The role of intimate partner violence in homicides of children aged 2–14 years. *American Journal of Preventive Medicine, 56*(1), 38-46. https://doi.org/10.1016/j.amepre.2018.08.028
8) Holland, K. M., Brown, S. V., Hall, J. E., & Logan, J. E. (2018). Circumstances preceding homicide-suicides involving child victims: A qualitative analysis. *Journal of Interpersonal Violence, 33*(3), 379-401. https://doi.org/10.1177/0886260515605124
9) Campbell, K. A., Wood, J. N., Lindberg, D. M., & Berger, R. P. (2021). A standardized definition of near-fatal child maltreatment: Results of a multidisciplinary Delphi process. *Child Abuse & Neglect, 112*, 104893. https://doi.org/10.1016/j.chiabu.2020.104893
10) Camasso, M. J., & Jagannathan, R. (2019). Conceptualizing and testing the vicious cycle in child protective services: The critical role played by child maltreatment fatalities. *Children and Youth Services Review, 103*, 178-189. https://doi.org/10.1016/j.childyouth.2019.05.024
11) Keenan, W., Tracey, S. M., Sanchez, C. E., & Kellogg, E. (Eds.). (2019). *Achieving behavioral health equity for children, families, and communities: Proceedings of a workshop*. The National Academies Press. https://doi.org/10.17226/25347
12) Cossman, J., James, W., & Wolf, J. K. (2017). The differential effects of rural health care access on race-specific mortality. *SSM - Population Health, 3*(C), 618-623. https://doi.org/10.1016/j.ssmph.2017.07.013
13) Maguire-Jack, K., Font, S. A., & Dillard, R. (2020). Child protective services decision-making: The role of children's race and county factors. *American Journal of Orthopsychiatry, 90*(1), 48-62. https://doi.org/10.1037/ort0000388
14) Dettlaff, A. J., Boyd, R., Merritt, D., Plummer, J. A., & Simon, J. D. (2021). Racial bias, poverty, and the notion of evidence. *Child Welfare, 99*(3), 61-89.
15) McCarroll, J. E., Fisher, J. E., Cozza, S. J., & Whalen, R. J. (2021). Child maltreatment fatality review: Purposes, processes, outcomes, and challenges. *Trauma, Violence, & Abuse*, *22*(5), 1032–1041. https://doi.org/10.1177/1524838019900559

16) Duncan, D. F., Stewart, C. J., Vaughn, J. S., Guest, S., Rose, R. A., Malley, K., and Gwaltney, A. Y. (2018). *Management Assistance for Child Welfare, Work First, and Food & Nutrition Services in North Carolina* (V3.21). Retrieved March 23, 2023, from http://ssw.unc.edu/ma.
17) U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2023).
18) https://www.acf.hhs.gov/cb/data-research/child-maltreatment.
19) Loria, H., McLeigh, J., Wolfe, K., Conner, E., Smith, V., Greeley, C. S., & Keefe, R. J. (2023). Caring for children in foster and kinship care during a pandemic: Lessons learned and recommendations. *Journal of Public Child Welfare, 17*(1), 1-24. https://doi.org/10.1080/15548732.2021.1965065
20) Hardy, B. L., Collyer, S. M., & Wimer, C. T. (2023, March). The antipoverty effects of the Expanded Child Tax Credit across states: Where were the historic reductions felt? Washington, DC: The Hamilton Project, Brookings Institution. https://www.hamiltonproject.org/assets/files/20230301_ES_THP_CTCbyState.pdf
21) Austin, A. E., Shanahan, M.E., Frank, M., Naumann, R. B., et al. (2023, published online). State expansion of Supplemental Nutrition Assistance Program eligibility and rates of child protective services-investigated reports. *JAMA Pediatrics*. doi:10.1001/jamapediatrics.2022.5348
22) County Distress Rankings (Tiers) | NC Commerce. (n.d.). Retrieved March 21, 2023, from https://www.commerce.nc.gov/grants-incentives/county-distress-rankings-tiers

Appendices

Appendix A: Survey Process and Results

Timeline of CCPT Survey, 2022

Table A-1 Timeline of CCPT Survey

Date	Activity
July 6, 2022	NC CCPT Advisory Board ad-hoc survey subcommittee developed end-of-year survey
July 19, 2022	Survey materials sent to NC DSS for approval
August 8, 2022	NC CCPT Advisory Board finalized the survey
September 9, 2022	Survey materials sent to NC State University Institutional Review Board
September 21, 2022	NC State University Institutional Review Board approved research protocols protecting participants
October 24, 2022	NC DSS sent letters to the County DSS Directors and to the CCPT Chairs to notify them about the survey
October 31, 2022	NC State University Research CCPT Team distributed survey to CCPT Chairpersons or designees followed by weekly reminders to unfinished respondents
January 10, 2023	NC DSS reminded CCPT Chairs to complete the survey
January 13, 2022	Deadline for survey submission
January 27, 202	Extended deadline for survey submission
April 3, 2023	NC CCPT Advisory Board reviewed first draft of survey findings and report and created preliminary recommendations
April 10, 2023	The Advisory Board reviewed the initial draft of the report
April 12 & 18, 2023 June 27, 2023 July 14, 2023	Discussion groups were held to discuss content of the recommendations
September 11, 2023	The Advisory Board reviewed, finalized and approved the recommendations
September 18, 2023	End of Year Report to NC DSS
TBD	Results of the survey to CCPT

Local CCPTs Submitting Survey Report, 2022

Table A-2 Counties of CCPTs Submitting Survey Report

Participating Counties			
Alamance	Duplin	Mecklenburg	Surry
Alexander	Edgecombe	Mitchell	Transylvania
Alleghany	Forsyth	Montgomery	Tyrrell
Ashe	Franklin	Moore	Union
Avery	Gaston	Nash	Vance
Bladen	Gates	New Hanover	Wake
Brunswick	Granville	Northampton	Warren
Buncombe	Greene	Onslow	Watauga
Burke	Guilford	Orange	Wayne
Cabarrus	Halifax	Pamlico	Wilkes
Carteret	Harnett	Pasquotank	Wilson
Caswell	Haywood	Pender	Yadkin
Catawba	Henderson	Perquimans	Yancey
Chatham	Hertford	Person	
Cherokee	Hyde	Polk	
Chowan	Iredell	Randolph	
Clay	Jackson	Richmond	
Cleveland	Johnston	Robeson	

Columbus	Jones	Rockingham		
Craven	Lee	Rowan		
Cumberland	Lenoir	Rutherford		
Currituck	Lincoln	Sampson		
Dare	Macon	Scotland		
Davidson	Madison	Stanly		
Davie	Martin	Stokes		

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

Responding CCPTs by County Population Size, 2022, (N=88)

Table A-3 Responding CCPTs by County Population Size

County Size	Total Counties		Total Responding Counties		Percent
Small	51		45		88%
Medium	39		34		87%
Large	10		9		90%

Responding CCPTs by County Economic Well-Being, 2022, (N=88)

Table A-4 Responding CCPTs by County Tier Type

County Size	Total Counties		Total Responding Counties		Percent
Tier I	40		34		85%
Tier II	40		37		93%
Tier III	20		17		85%

LME/MCOs and Number of Member Counties Responding to Survey, 2022

Table A-5 LME/MCOs and Number of Member Counties Responding to Survey

LME/MCO	Number of Member Counties	Total Responding Counties	Percent
Alliance Behavioral Healthcare	6	5	83%
Eastpointe	11	10	91%
Partners Behavioral Health Management	14	14	100%
Sandhills Center	11	9	82%
Trillium Health Resources	27	23	85%
Vaya Health	31	27	87%
Total	100	88[a]	88%

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.

Organization of CCPTs and Child Fatality Prevention Team (CFPTs) in Counties, 2021, (N=87)

Table A-6 Organization of CCPTs and Child Fatality Prevention Teams (CFPTs) in Counties

CCPT/CFPT Organization	Number of Counties	Percent
Separate CCPT and CFPT	18	20.7%
Combined CCPT and CFPT	67	77.0%
Other	2	2.3%

Appendix B: Cross-Year Comparison

Table B-1. Two Most Common Selection Criteria for Cases Reviewed by Year

Year	Selection Criteria 1	Number of CCPTs (%)	Selection Criteria 2	Number of CCPTs (%)
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%)
2020 (n=83)	Active Case	55 (66%)	Multiple Agencies Involved; Repeat Maltreatment	50 (60%)
2021 (n=76)	Active Case	65 (86%)	Child Safety	60 (79%)
2022 (n = 88)	Active Case	63 (72%)	Stuck Cases	51 (58%)

Table B-2. Type of Information Used by CCPTs for Reviewing Cases by Year

Type of Information	2017 (*n*=62)	2018 (*n*=88)	2019 (*n*=89)	2020 (*n*=83)	2021 (*n*=79)	2022 (*n*= 88)
Case Files	52 (85%)	56 (64%)	61 (86%)	56 (68%)	69 (87%)	70 (80%)
Reports from Members and/or Case Managers	61 (98%)	57 (65%)	67 (94%)	61 (74%)	63 (80%)	71 (81%)
Information on Procedures and Protocols of Involved Agencies	39 (63%)	34 (39%)	47 (66%)	47 (57%)	57 (72%)	47 (53%)
Child and Family Team Meeting Documentation	27 (44%)	21 (24%)	30 (42%)	30 (36%)	37 (47%)	29 (33%)
Medical Examiner's Report	14 (23%)	21 (24%)	25 (35%)	22 (27%)	30 (38%)	27 (31%)
Individualized Education Plan	12 (19%)	6 (7%)	21 (30%)	20 (24%)	26 (33%)	24 (27%)
Other	8 (13%)	9 (10%)	10 (14%)	11 (14%)	11 (14%)	28 (32%)

Table B-3. Type of Information Used by CCPTs and Combined CCPT/CFPTs for Reviewing Cases by Year

Type of Information	2019		2020		2021		2022	
	Combined (*n*=53)	Separate (*n*=16)	Combined (*n*=53)	Separate (*n*=16)	Combined (*n*=59)	Separate (*n*=19)	Combined (*n*=67)	Separate (*n*=18)
Case Files	45 (85%)	14 (88%)	45 (85%)	14 (88%)	50 (85%)	17 (89%)	54 (81%)	15 (83%)
Reports from Members and/or Case Managers	50 (94%)	15 (94%)	50 (94%)	15 (94%)	44 (75%)	17 (89%)	56 (84%)	14 (78%)
Information on Procedures and Protocols of Involved Agencies	37 (70%)	9 (56%)	37 (70%)	9 (56%)	40 (68%)	15 (79%)	37 (55%)	9 (50%)
Child and Family Team Meeting Documentation	23 (43%)	6 (38%)	23 (43%)	6 (38%)	27 (46%)	9 (47%)	23 (34%)	6 (33%)
Medical Examiner's Report	20 (38%)	4 (25%)	20 (38%)	4 (25%)	22 (37%)	8 (42%)	24 (36%)	3 (17%)
Individualized Education Plan	16 (30%)	5 (31%)	16 (30%)	5 (31%)	19 (32%)	7 (37%)	17 (25%)	7 (39%)
Other	8 (12%)	1 (6%)	8 (12%)	1 (6%)	16 (27%)	8 (42%)	20 (30%)	8 (44%)

Table B-4. Organization of CCPTs and Child Fatality Prevention Teams (CFPTs) by Year

CCPT/CFPT Organization	2016 (*n*=86)	2017 (*n*=80)	2018 (*n*=88)	2019 (*n*=89)	2020 (*n*=83)	2021 (*n*=80)	2022 (*n*=87)
Separate CCPT and CFPT	17 (20%)	17 (21%)	14 (15%)	17 (19%)	16 (19.3%)	19 (23.8%)	18 (20.7%)
Combined CCPT and CFPT	66 (77%)	62 (78%)	77 (83%)	66 (74%)	66 (79.5%)	59 (73.8%)	67 (77%)
Other	3 (3%)	1 (1%)	1 (1%)	2 (2%)	1 (1.2%)	2 (2.5%)	2 (2.3%)

Note: Number of counties (percent)

Table B-5. Mandated CCPT and CCPT/CFPT Members and Mean Rate and Rank of Participation, 2019, 2020, 2021 and 2022

	2019 Average (Rank)		2020 Average (Rank)		2021 Average (Rank)		2022 Average (Rank)	
Mandated Member	Combined (*n*=73)	Separate (*n*=13)	Combined (*n*=62)	Separate (*n*=15)	Combined (*n*=59)	Separate (*n*=19)	Combined (*n*=67)	Separate (*n*=18)
DSS Director	3.16 (4)	2.94 (4)	3.10 (4)	2.67 (5)	3.20 (2)	2.63 (4)	3.07 (3)	2.67 (4)
DSS Staff	3.90 (1)	3.94 (1)	3.71 (1)	3.67 (1)	3.67 (1)	3.68 (1)	3.88 (1)	3.94(1)
Law Enforcement	2.91 (7)	2.76 (7)	2.90 (7)	2.53 (6)	2.73 (7)	2.63 (4)	2.75 (6)	2.17 (6)
District Attorney	1.88 (13)	2.53 (9)	1.95 (12)	1.53 (10)	1.77 (13)	1.68 (10)	1.65 (13)	1.11(11)
Community Action Agency	2.68 (8)	2.47 (10)	2.52 (8)	2.20 (7)	2.48 (10)	2.58 (7)	2.30 (8)	1.89 (8)
School Superintendent	2.24 (10)	2.65 (8)	2.50 (9)	1.13 (11)	2.58 (8)	1.61 (11)	2.17 (9)	1.39 (10)
County Board of Social Services	2.20 (12)	1.94 (11)	2.10 (11)	2.07 (9)	2.38 (9)	1.74 (9)	2.07 (11)	1.44 (9)
Mental Health Professional	3.44 (2)	3.59 (2)	3.26 (2)	3.20 (2)	3.16 (3)	3.58 (2)	3.10 (2)	2.89 (2)
Guardian ad Litem	3.07 (5)	3.06 (3)	2.95 (5)	2.87 (4)	2.90 (5)	2.84 (3)	2.75 (6)	2.28 (5)
Public Health Director	3.07 (6)	2.88 (5)	2.94 (6)	2.13 (8)	2.78 (6)	2.05 (8)	2.94 (5)	1.94 (7)
Health Care Provider	3.41 (3)	2.82 (6)	3.15 (3)	3.13 (3)	3.16 (3)	2.42 (6)	3.06 (4)	2.78 (3)

District Court Judge	.94 (16)	.73 (16)	.93 (16)	.90 (15)
County Medical Examiner	1.28 (14)	1.39 (14)	1.93 (14)	1.40 (14)
EMS Representative	2.26 (9)	2.19 (10)	1.93 (11)	2.09 (10)
Local Child Care or Head Start Rep	2.21 (11)	1.81 (13)	1.80 (12)	1.78 (12)
Parent of Child Fatality Victim	1.09 (15)	1.08 (15)	1.00 (15)	.90 (15)

Table B-6. Total County Participation by Year

County	2014 (*n*=71)	2015 (*n*=87)	2016 (*n*=86)	2017 (*n*=81)	2018 (*n*=88)	2019 (*n*=89)	2020 (*n*=84)	2021 (*n*=85)	2022 *n*=88)
Alamance	x	x	x	x	x	x	x	x	x
Alexander		x			x		x	x	x
Alleghany	x	x	x	x	x	x	x	x	x
Anson		x	x	x					
Ashe		x				x	x	x	x
Avery	x	x	x	x	x		x	x	x
Beaufort	x					x			
Bertie	x	x		x			x		
Bladen	x	x	x	x	x	x	x	x	x
Brunswick	x	x	x	x	x	x		x	x
Buncombe	x	x	x	x	x	x	x	x	x
Burke	x	x	x	x	x	x	x	x	x
Cabarrus	x	x	x	x	x	x	x	x	x
Caldwell		x	x		x	x		x	
Camden	x	x	x	x	x	x	x	x	
Carteret		x	x	x	x	x	x	x	x
Caswell	x	x	x	x	x	x	x	x	x
Catawba	x	x	x	x	x	x	x	x	x
Chatham	x	x	x	x	x	x	x	x	x
Cherokee			x	x	x		x		x
Chowan	x	x	x	x	x	x			x
Clay	x	x	x	x	x	x	x	x	x

Cleveland		x	x	x	x	x	x	x	x
Columbus	x	x	x	x		x	x	x	x
Craven	x	x	x	x	x	x	x	x	x
Cumberland	x	x	x	x	x	x	x	x	x
Currituck	x	x	x		x	x	x	x	x
Dare	x	x	x	x	x	x	x	x	x
Davidson	x	x	x	x	x	x	x	x	x
Davie	x	x						x	x
Duplin	x	x					x	x	x
Durham			x	x	x		x	x	
Eastern Band of Cherokee Nation (Qualla Boundary)				x		x			
Edgecombe	x	x	x	x	x	x		x	x
Forsyth		x	x		x	x	x	x	x
Franklin	x	x		x	x	x	x	x	x
Gaston		x	x	x	x	x	x	x	x
Gates	x	x	x	x	x	x	x	x	x
Graham		x	x	x	x	x	x	x	
Granville			x		x	x	x		x
Greene			x		x	x		x	x
Guilford	x	x	x	x	x	x	x	x	x
Halifax	x	x	x	x	x	x	x	x	x
Harnett	x	x	x	x	x	x	x	x	x
Haywood		x	x	x	x	x	x	x	x

Henderson	x	x	x	x	x	x	x	x	x
Hertford	x	x	x	x	x	x	x	x	x
Hoke	x	x	x	x	x	x	x	x	
Hyde	x	x	x	x	x	x	x	x	x
Iredell	x	x	x	x	x	x	x	x	x
Jackson	x	x	x	x	x	x	x	x	x
Johnston	x	x	x	x					x
Jones	x		x		x	x	x	x	x
Lee		x	x	x	x	x		x	x
Lenoir	x	x	x	x	x	x	x	x	x
Lincoln	x	x	x	x	x	x	x	x	x
Macon	x	x	x	x	x	x	x	x	x
Madison	x			x	x	x	x	x	x
Martin	x	x	x	x	x	x	x	x	x
McDowell			x		x				
Mecklenburg		x	x	x	x	x	x	x	x
Mitchell	x	x	x	x		x			x
Montgomery	x	x	x	x		x	x	x	x
Moore		x				x	x	x	x
Nash	x	x	x	x	x	x	x	x	x
New Hanover	x	x	x	x	x	x	x	x	x
Northampton		x	x	x	x	x			x
Onslow	x	x	x	x	x	x	x	x	x
Orange	x	x	x	x	x	x	x	x	x
Pamlico		x		x					x

Pasquotank	x	x	x	x	x	x	x	x	x
Pender	x	x	x		x	x	x	x	x
Perquimans		x			x	x	x	x	x
Person	x	x	x	x	x	x	x	x	x
Pitt			x	x	x	x			
Polk	x	x	x	x	x	x	x	x	x
Randolph	x	x	x	x	x	x	x	x	x
Richmond	x	x	x	x	x	x	x		x
Robeson	x	x	x	x	x	x	x	x	x
Rockingham	x	x	x	x	x	x	x	x	x
Rowan	x	x	x		x	x	x	x	x
Rutherford	x	x	x	x	x	x	x	x	x
Sampson	x	x	x	x	x		x	x	x
Scotland		x	x	x	x	x	x	x	x
Stanly	x	x	x	x	x	x	x	x	x
Stokes	x	x	x	x	x	x	x	x	x
Surry		x	x	x	x	x	x	x	x
Swain	x	x	x		x	x	x	x	
Transylvania						x	x	x	x
Tyrrell			x	x	x	x	x	x	x
Union		x	x	x	x	x	x	x	x
Vance	x	x	x	x	x	x	x	x	x
Wake		x	x	x	x	x	x	x	x
Warren	x	x	x		x	x	x		x
Washington				x	x				

Watauga	x	x	x	x	x	x	x	x	x
Wayne	x	x	x	x	x	x	x	x	x
Wilkes	x		x	x	x	x	x	x	x
Wilson	x	x	x	x	x	x	x	x	x
Yadkin	x	x	x	x	x	x	x	x	x
Yancey	x	x			x	x	x	x	x

Table B-7. Small County Participation by Year

County	2014	2015	2016	2017	2018	2019	2020	2021	2022
Respondents (%)	36 (71%)	42 (82%)	40 (78%)	38 (78%)	45 (83%)	46 (85%)	43 (80%)	41 (80%)	45 (88%)
Alexander		x			x		x	x	x
Alleghany	x	x	x	x	x	x	x	x	x
Anson		x	x	x					
Ashe		x				x	x	x	x
Avery	x	x	x	x	x	x	x	x	x
Bertie	x	x		x			x		
Bladen	x	x	x	x	x	x	x	x	x
Camden	x	x	x	x	x	x	x	x	
Caswell	x	x	x	x	x	x	x	x	x
Chatham	x	x	x	x	x	x	x	x	x
Cherokee			x	x	x		x		x
Chowan	x	x	x	x	x	x			x
Clay	x	x	x	x	x	x	x	x	x
Currituck	x	x	x		x	x	x	x	x
Dare	x	x	x	x	x	x	x	x	x
Davie	x	x						x	x
Gates	x	x	x	x	x	x	x	x	x
Graham		x	x	x	x	x	x	x	
Granville			x		x	x	x		x
Greene			x		x	x		x	x
Hertford	x	x	x	x	x	x	x	x	x
Hoke	x	x	x	x	x	x	x	x	
Hyde	x	x	x	x	x	x	x	x	x
Jackson	x	x	x	x	x	x	x	x	x

Jones	x		x		x	x	x	x	x
Lee		x	x	x	x	x		x	x
Lenoir	x	x	x	x	x	x	x	x	x
Lincoln	x	x	x	x	x	x	x	x	x
Macon	x	x	x	x	x	x	x	x	x
Madison	x			x	x	x	x	x	x
Martin	x	x	x	x	x	x	x	x	x
McDowell			x		x				
Mitchell	x	x	x	x		x			x
Montgomery	x	x	x	x		x	x	x	x
Northampton		x	x	x	x	x			x
Pamlico		x		x					x
Pasquotank	x	x	x	x	x	x	x	x	x
Pender	x	x	x		x	x	x	x	x
Perquimans		x			x	x	x	x	x
Person	x	x	x	x	x	x	x	x	x
Polk	x	x	x	x	x	x	x	x	x
Richmond	x	x	x	x	x	x	x		x
Stanly	x	x	x	x	x	x	x	x	x
Stokes	x	x	x	x	x	x	x	x	x
Swain	x	x	x		x	x	x	x	
Transylvania						x	x	x	x
Tyrrell			x	x	x	x	x	x	x
Warren	x	x	x		x	x	x		x
Washington				x	x				
Watauga	x	x	x	x	x	x	x	x	x
Yadkin	x	x	x	x	x	x	x	x	x
Yancey	x	x			x	x	x	x	x

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

Table B-8. Medium County Participation by Year

County	2014	2015	2016	2017	2018	2019	2020	2021	2022
Respondents (%)	30 (77%)	36 (92%)	36 (92%)	34 (87%)	32 (91%)	32 (91%)	30 (86%)	34 (87%)	34 (87%)
Alamance	x	x	x	x	x	x	x	x	x
Beaufort	x					x			
Brunswick	x	x	x	x	x	x		x	x
Burke	x	x	x	x	x	x	x		x
Cabarrus	x	x	x	x	x	x	x	x	x
Caldwell		x	x		x	x		x	
Carteret		x	x	x	x	x	x	x	x
Cleveland		x	x	x	x	x	x	x	x
Columbus	x	x	x	x		x	x	x	x
Craven	x	x	x	x	x	x	x	x	x
Davidson	x	x	x	x	x	x	x	x	x
Duplin	x	x					x	x	x
Edgecombe	x	x	x	x	x	x		x	x
Franklin	x	x		x	x	x	x	x	x
Halifax	x	x	x	x	x	x	x	x	x
Harnett	x	x	x	x	x	x	x	x	x
Haywood		x	x	x	x	x	x	x	x
Henderson	x	x	x	x	x	x	x	x	x
Iredell	x	x	x	x	x	x	x	x	x
Johnston	x	x	x	x		x			x
Moore		x				x	x	x	x
Nash	x	x	x	x	x	x	x	x	x

Onslow	x	x	x	x	x	x	x	x	x
Orange	x	x	x	x	x	x	x	x	x
Pitt			x	x	x	x			
Randolph	x	x	x	x	x	x	x	x	x
Robeson	x	x	x	x	x	x	x	x	x
Rockingham	x	x	x	x	x	x	x	x	x
Rowan	x	x	x		x	x	x	x	x
Rutherford	x	x	x	x	x	x	x	x	x
Sampson	x	x	x	x	x		x	x	x
Scotland		x	x	x	x	x	x	x	x
Surry		x	x	x	x	x	x	x	x
Union		x	x	x	x	x	x	x	x
Vance	x	x	x	x	x	x	x	x	x
Wayne	x	x	x	x	x	x	x	x	x
Wilkes	x		x	x	x		x	x	x
Wilson	x	x	x	x	x	x	x	x	x

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

Table B-9. Large County Participation by Year

Appendix C: Qualitative Responses

Difficulties faced completing work

COVID-19 Pandemic:
Staff turnover and COVID
Covid and having to hold meeting virtually
Covid restrictions and staff turnover.
Our team continues to meet virtually due to Covid.
Rebuilding Post Covid
Covid issues/scheduling conflicts and getting medical records back timely

Attendance/Scheduling/Availability:
Due to workloads and day to day busy work, all members being present
Meeting face to face due to scheduling conflicts.
As a combined CCPT/CFPT, CFPT case reviews take priority (which have been more than normal due to delays from COVID).
Getting all Statutory required members to attend.
Everyone being available at the same date and time
Members are unable to attend regularly
Low attendance from team members
The only difficulty is not having every team member at meetings due to other conflicts such as (meetings, court, etc.)
attendance. most organizations and members are responsible for many more task after covid and lack of employees in general makes it harder for members to participate.
Schedule conflicts with community partners
Our team has continued to meet virtually since the COVID-19 pandemic.
Attendance is the biggest barrier, COVID-19 Pandemic, Virtual Meetings
Getting people to attend and participate. Particularly the individuals that need to participate.
Lack of participation by some members who are mandated members of the CCPT
COVID, the lack of staff or staff turnover
Getting all members to regularly participate - partly due to various demanding and conflicting schedules of parties
vacancies in various organizations (turnover), reluctance of anyone to assume the chair role
Lack of attendance by community partners
Family member attendance, low front-line staff supervisors have to present.
Getting all members to regularly participate - partly due to various demanding and conflicting schedules
Some members are not consistent with attending meetings
mandated team member attendance; resources available to implement ideas and community changes
Difficulties in getting a quorum
Moving from virtual to in-person meetings, participation from all agencies for meeting agendas.
There is some lack of exchange because all is virtual
Filling a couple vacant positions, however, all positions are now filled.
Getting people to the table. Getting appropriate feedback/help from others.

Miscellaneous:
Well, other than the pandemic, we are struggling with action. We have great ideas but lack of clear ownership and resources to carry them out has been a HUGE barrier. :-(We are also not managing data well so completing these reports, for example, is frustrating.
difficulty solving systemic issues relating to substance abuse and mental health placements for youth needing leveled care
Funding for CCPT is extremely limited to non existent.
DSS not bringing cases to the table
Limitations in the local resources available for referral for SW in Child Welfare/DSS; complexity of cases and issues faced by families of cases.
Buy in, investment, & commitment from community partners has been an ongoing challenge.
Issues obtaining medical records from hospitals and medical providers in other states. Obtaining CPS records from other states has also been a challenge.
Delayed death certificates

New Co-chairs and inconsistent participation from certain partners in the community
Identifying community mental health resources for the cases we discussed
Completing fatality reviews with limited information such as parent's DOB.
Work duties among all members has made it difficult to complete CCPT tasks as times.
Transitioning back to in person meetings from virtual.
Having a new team who handles the fatality reviews.
Not many resources available for housing and transportation

COVID-19 Related Barriers

Lack of Face-Face Interactions
You can't replace an in person meeting for these types of cases.
some families have a hard time with virtual intake appointments due to their work schedules or lack of internet service.
virtual did not work as well.
some agency representatives did not want to meet in person.
not being able to attend in person.
limited in person contact and/or access to virtual meetings.
Having face to face meetings.
Families were more resistant.
face-to-face contact.
Face to face interaction with parents and children.
Face to Face Contact with Mental Health Providers.
Rural Area-Virtual Communication Difficulty.
Early struggles in the year to connect, avoiding in-person meetings.

Limited Support and Underreporting
Long waitlists for services and if client is unable to attend due to COVID, having to wait months before getting a rescheduled appointment.
Limited resources for families appeared to be an issue.
Limited number of providers, clients having to complete services virtually.
Limited in person services.
Many mental health services are still being offered virtually - even to children. This presents a barrier to the effectiveness of the service.
increase in MH needs and decrease in services.
less attendance of participants due to sickness, unavailability of the resource provider, vacancies, turnover.
Isolation challenges – kids experienced education slide; rising psychological issues anxiety/depression; children unable to return to the classroom; increased homeschool?; school is serious about attendance/truancy; bottle neck from COVID-19 (services, court, waiting list); families recovering from strain (employment, etc.); custody increased – coparenting needs.

Staff Personnel and Wellness
Team members were out sick and/or felt uncomfortable meeting in person.
providers not meeting in person or staff turn-over due to COVID.
Part of the barriers with the pandemic have to do with staff turnover with community stakeholders and difficulty maintaining community partner connections.
Covid may have limited some of the partners from participating in person.
CFT was virtual and not as productive, home visit cancellation due to symptoms of COVID-19 from staff or family members and effects of COVID-19 on staff and families.

Adjusting to Virtual Platform
We met virtually or hybrid.
most visits were virtual.
Telehealth--limited staff--limitations of Wi-Fi Access.
Remote provision of services, staffing issues for providers, lack internet access for clients both service and hardware to access, poor internet service in the county.
I think overall some mental health/SUDS services are just being offered differently, ie...virtually/telephone.
At the beginning of the year CCPT meetings were held in a virtual format.

Miscellaneous
member attendance/flexibility to find meeting times for all individuals.
Less discussion when done virtually, less attendance when done in person.
Attendance/full participation.

Solutions to Address COVID-19 Barriers

Virtual Meetings
We did Zoom but got back in person ASAP.
virtual meetings
We continued to hold meetings in a manner that allowed for social distancing, as well as offering online attendance options for every meeting. This helped create security for team members and increased attendance rates due to safety and convenience.
Virtual meetings
Virtual Meetings have continued
None, During Covid we did have virtual meetings, and still offer that for members that cannot attend
virtual visits
Implemented virtual meetings
webex meeting
Still offer virtual meetings to those who prefer; most meet in-person.
discussion, PPE for staff, home visit and CFT held outside with family and continued virtual as needed.
We moved it from virtual to in person and are hoping to build numbers back up gradually.
Zoom
Virtual meetings

Technology and Remote Access:
School sent students home with hotspots and also allowed some parents to come into TCDSS agency to complete intake.
Parents use of public Wi-Fi and hotspots
Used WebEx and tele-conferenced people so they could attend CFTs.
Telehealth and virtual meetings outside visits
Telehealth was provided to most.
We make it available for team members to participate by telephone if they are not able to be in person.

Concerns and Challenges:
No issues due to COVID-19 were identified in 2022.
Encouraging families to re-enter services that may have been stopped due to Covid illness.
Team continues to express concern around the earlier impact of Covid on children and families - the isolation of children from friends/school/teachers/etc.; the stress this has created for children and families as they resume in-person activities; etc. Recognize the need for continued partnership and communication with one another (resource agencies) as we support children and families in the community.
Our team did not identify solutions to this issue.
Increase need for communication between agencies to discuss the urgent need for client to be seen sooner.
The barriers did not affect the team or the review.
In [COUNTY NAME] County there were several children's deaths by drowning. The team promoted swim lessons for the community and children in foster care.
Provided transportation to families to meet at locations other than DSS and held more evening CFT's when parents schedules conflicted.
Need for additional MH services in community for children and parents – more collaboration with Vaya; Family Centered Treatment SPARC - team members in DSS office. Community Awareness Services – GET SET newsletter, library, mailing lists for committees. DSS applies for endowment fund grant – smoke detectors; carbon monoxide; fire ext.

Collaboration and Communication:
searching for additional resources, use of school counselors/therapist
Developing a countywide strategic plan with the help of [UNIVERSIRTY NAME] to utilize evidenced based models to address the lifespan of individuals and families in [COUNTY NAME] County.
Thinking outside of the box--for example- utilizing the option of telephonic services for a father that works long daytime hours.
tried to encourage. Partners to send other representatives when possible.

We moved it from virtual to in person and are hoping to build numbers back up gradually.

Barriers to participation and family/youth partner engagement

Recruitment Difficulties
The lack of actual providers
limited providers in our rural county, provider chose not to attend or could not attend, not being invited

COVID-19 Pandemic
Covid Restricitions
COVID
COVID-19 restrictions, providers schedule conflict and staff changes.

Miscellaneous
Fee for service billing
Large Regional System and they cannot be at all meetings
Motivation; not well trained in CFT principles; facilitators of meetings not taking role as facilitator as key
coordination/communication/scheduling conflict
Limited resources
Providers are not able to bill for time spent attending CFT's

Strategies to engage family and youth partners

This does not apply to our team.
We did not engage family and youth partners on our team this year.
We did not actively seek involvement this past year
The family partner is member of our CCPT
Discussion among team regarding strategies to identify youth Partners
[COUNTY NAME] CCPT does not invite/engage family/youth partners (N/A)
Incorporating family and youth partners is a future goal for our team.
Used other CCPT members to assist in locating a family member for the CCPT.
No engagement due to confidentiality concerns
we were not successful at the time but are continuing our efforts
no strategies used
we did not engage family/youth partners other than the member that is mandated on our team
our team did not engage family or youth partners on our team this year
Proposal for family partner expansion
invite family partner to join team

List of Organization Collaborators

DJJ
DSS CPS Supervisor
Child Abuse Prevention Agency
LME
Family Services/Victim Services
School SW
REACH
DJJ
Victim Service Organization
SOC Community Coordinator
[DOMESTIC VIOLENCE CENTER]
[COUNTY NAME] County Family Violence Center
[COUNTY NAME] County Office/Legal
Mental Health [ORG NAME]
Juvenile Justice
Juvenile Justice, Rep (bilingual behavioral health provider)
CDSA
A.S.H.E./DV Victim Services
Smart Start
SOC
NC Cooperative Extension; [COUNTY NAME] Fire Department
LME/MCO
Court Adminstrator
Director [FOSTER CARE HOME]
Children’s Development Services Agency
Military
DJJ
Health Department
Guardian ad Lidum Coordinator
Division of Juvenile Justice
SAFE HAVEN OF [COUNTY NAME] COUNTY
System of Care Community Coordinator Trillium
Victim Services
Youth Services
County Health & Nutrition Center

LME/MCO System of Care Coordinator
System of Care Commuunity Coordinator
System of care community coordinator
Juvenile Justice Rep
Hospitality House
[UNIVERSITY NAME] Staff
Juvenile Crime Prevention Council (JCPC)
Nonprofit Organization
MCO
Public School Social Work Staff
LME/MCO
Department of Social Services
[COUNTY NAME] Community College
Pregnancy Care center
Juvenile Justice
MCO representative
Partners (LME/MCO)
2 school district reps
Domestic Violence Agency
[DOMESTIC VIOLENCE CENTER]
MH Provider
Cooperative Extension
Juvenile Justice
[COUNTY NAME] County Citizen Rep
School Counselor
Juvenile Justice
Depart. Of Juvenile Justice
Emergency Services
Local Children's Home Service Agency
Parent Rep
Daymark (behavioral health provider)
[NONPROFIT NAME]
Partnership For Children
VAYA/ALME
Child Advocacy Center – [CENTER NAME] Center
Retired Educator
[COUNTY NAME] County DHHS – Public Health & Social Services
Hospital
Child Advocacy Center
Juvenile Justice representation
Mountain Child Advocacy Center
Domestic Violence Agency
Families First
Law enforcement
Caring for Children
Victim Services
VAYA HEALTH
Sheriff Department
Private Child and Family Counseling Agency
Juvenile Justice Rep
Local Hospital Rep
Oasis
DJJ
[COUNTY NAME] County Partnership for children
Nonprofit Organization
LME
Public School Nurses
Victim Services
Health Department
Former Nurse and now private business owner
Child Care Agency rep
Hunger Relief (Esther's Heart)
Public Health Nursing Supervisor
Extra Law Enforcement
LME; East pointe
Appalachian Community Services
Partnership for Children
Local LME
Child Advocacy Center
CACNC
CDSA
Domestic Violence Shelter and Services
CAC
NC Highway Patrol; The Lighthouse Children's Advocacy Center
EIC
Child Pediatric Champion- Family Connects
Emergency Services
Project CARA (OB Clinic for pregnant persons with substance use disorder at Mountain Area Health Education Center
MH Managed Care Organization
County School Social Workers
DJJ Representative
[COUNTY NAME] CDSA
Family Advocacy Program – Military
County Office of Substance Abuse Recovery
Domestic Violence agency
Victim Service Org Rep
CDSA
LME/MCO
DACJJ
City Council Member
Child Developmental Service Agency Director
School Health
Partnership for Children
Sheriff's Office
Safe Kids Coalition Rep
Fire Dept.
Extra Medical
Be a Voice for Kids
MDT Member
Court System
Commissioner Appointment
[COUNTY NAME] County Victim Services
Communities in Schools
[TOWN NAME] Housing Authority
Resiliency Task Force
[NONPROFIT ORG]; Department of Juvenile Justice
Kintegra; Partners Behavioral Health Management
Health Dept
Military BH/FA/ACS

Child Maltreatment Specialist- AHEC
Community Partner
Juvenile Justice representation
Helpmate (Domestic Violence agency)
Community Care of NC (Care Management of Children)
Partnership for Children
County School SW
[COUNTY NAME] COUNTY SCHOOL SYSTEMS
GUARDIAN AD LITEM
Juvenile Justice
Fire Department
Children's Center of [COUNTY NAME]
County Office of Substance Abuse Recovery
Get Ready [COUNTY NAME]
Victim Services
Mental Health Providers
Mental Health Provider

Intensive Review Process

Subcommittee formed

For any concerns noted, we work together in subcommittees to develop and implement a plan.
Action steps assigned based on applicable department/agency.
Collaborative partnership to identify concerns and develop resources; assess common themes and similarities in cases reviewed.
For any concerns noted, we work together in subcommittees to develop and implement a plan.

Whole Group Review

In full team.
The Full committee discusses the recommendations of intensive team and endorses next steps.
The recommendations are discussed with the team. Recommendations are also discussed with the organizations in which they affect.
The recommendations are taken to the full team and to the relevant community partners. Action steps are identified through both processes.
The Team reviews the recommendations outlined in the report. The Team then identifies how we will follow up on these, including who needs to be involved in what role. If there are already activities in the community that can have a positive impact, we evaluate whether they are being used and how to ensure the referrals and involvement for families is occurring.
We discuss these as a group and come up with a plan.
During combined meetings with the local CFPT, members collaborate to create action steps. If outside resources are needed to make a recommendation, the review is tabled until the following meeting when members can review and approve of recommendations.
Draft report and report to full team.
Discuss at the CCPT meeting as a team.
The Full committee discusses the recommendations of intensive team and endorses next steps
The recommendations are taken to the full team and to the relevant community partners. Action steps are identified through both processes.
The Team reviews the recommendations outlined in the report. The Team then identifies how we will follow up on these, including who needs to be involved in what role.
During combined meetings with the local CFPT, members collaborate to create action steps.
We discuss these as a group and come up with a plan.
Discuss at the CCPT meeting as a team.
Draft report and report to full team.
We have discussed recommendations as a team and review the case quarterly for updates.
We just discuss the findings with the team.
Team together discusses strategies and makes recommendations.
Through discussions in meetings. Discuss recommendations as a team and develop action steps.
During the meeting through input of group.
We have discussed recommendations as a team and review the case quarterly for updates.
We just discuss the findings with the team.

Collaboration with Outside Agencies

Follow up with local community members to see if recommendations that were recommended actually happened.
The recommendations are discussed with the team. Recommendations are also discussed with the organizations in which they affect.

Communicate to specific programs what additional needs/trainings.
Collaborative partnership to identify concerns and develop resources; assess common themes and similarities in cases reviewed.
Review information from DHHS.
Discussion during CCPT and how county agencies are educating on SAI prevention.
The recommendations are also discussed with the organizations in which they affect.
Communicate to specific programs what additional needs/trainings.
Collaborative partnership to identify concerns and develop resources; assess common themes and similarities in cases reviewed.
Review information from DHHS.
Discussion during CCPT and how county agencies are educating on SAI prevention.

Miscellaneous
Recommendations are made for cases as they are presented during regular meetings if necessary.
No intensive reviews occurred in 2022 due to their not being any fatalities.
We will plan to use the report for action steps toward local recommendations.
Continue to look for ways to reach the community.
Yes.
Concerns or needs are identified.
Discuss what current resources are in place to address the issue and if not, then problem solve steps.
Action planning in meeting.
Following up with local community members to see if recommendations that were recommended actually happened.
Recommendations are made for cases as they are presented during regular meetings if necessary.
No intensive reviews occurred in 2022 due to their not being any fatalities.
Discuss and assign jobs to complete recommendations.
In 11/2022, we had our first intensive review in several years. No findings/recommendations have been received yet. In the past, the team reviews and discusses the local recommendations to identify action steps.
We will plan to use the report for action steps toward local recommendations.
continue to look for ways to reach the community.
Action steps assigned based on applicable department/agency.
If outside resources are needed to make a recommendation, the review is tabled until the following meeting when members can review and approve of recommendations.
By reviewing the recommendations from the Intensive Review.
Concerns or needs are identified.
Question and answer session.
action planning in meeting.

Case Selection

Child Issues
Child sexual abuse
child placement issues
Seeking other's ideas for children
Child characteristics: mental health; high acuity
For 2022 we did all Child Fatalities
child mental health services
undocumented children
Children under age one
Child Fatalities from DHHS
Truancy concerns
school issues

Abuse
Sexual abuse allegations
Domestic Violence
substance abuse
physical abuse

Mental Health
Lack of Mental Health Resource
Mental health Needs
Complex mental health needs - parent and child

Fatalities
We only review fatality cases. The protection piece stems from those themes and also themes of being a resident here. DHHS does not release active child protection cases to our team.
Near fatalities
Reviewed all fatalities

Referrals/Requests
any requested
An email would be sent to discuss cases for review
Cases referred to Reginal Abuse and Medical Specialists
Cases Needing Recommendations

Miscellaneous
Gaps in Services
Substantiated case
We used the memorandum submitted by the NC CFTF.
Cases that we are seeing the types of issues often
chronic issues/multiple reports
Not enough for court, but not enough to close
conflict of interest case for another county
lack of resource
Language Barriers
Health Department Cases
Lack of Resources
age of case
Homelessness
Substantiated or Services Needed cases

Information Used to Review Cases

Medical, Legal, and School Records
We review everything we can get our hands on with regards to Child Fatality cases.
Medical records
medical records
CME report
Medical records on other family members
Category 2: Social Services & Child Advocacy
DJJ Records
Criminal History
DJJ reports
Truancy records
School records
Mental Health records
Documentation

Children's Advocacy Center Involvement
Information for DJJ
SW Report to CCPT
forensic interview information from child advocacy center
Agency's information
Social Worker report out
SW presented case & completed Case Review form prior to share
ACS/FMBH
involvement in other agencys
SW information
Verbal report from the Social Worker assigned to the case
verbal case presentation and questions from the assigned caseworker

Miscellaneous
staff member notes and in-person presentations
Other team member information
Child's Needs
more frequent meeting attendance
Forensic Interview

Improvements for Case Reviews

Uniform Data Collection
review tool
better data
Having a tool to compile data and information from case reviews that can be used at the local and state level to study trends and compare information to inform future efforts.
More structured tool for diseminiation of information

Increase Participation/Collaboration
More community partners involvement when it comes down to case reviews.
Increased participation
We need to be diligent in getting more team members
Understanding how to include youth or family partners in case reviews in a way that is not traumatizing
More participation from team members
Continued open communication among all team members

More time being devoted to CCPT meetings and better participation
Participation of all mandated members.
Increased participation from mandated members.
Better buy in and attendance from community partners
Active participation and engagement from multiple agencies. Full attendance every meeting.
Increased member attendance
Having more community stake holders involved
get more people at the table and team members attending regularly
Increased participation from mandated members.
Better buy in and attendance from community partners
Active participation and engagement from multiple agencies. Full attendance every meeting.
Increased member attendance
more frequent meeting attendance
more attendance by community partners
Having more community stake holders involved
having more involvement with other organizations
Workers present to discuss the case.

Education/Training
Training from the state, especially around the issue of confidentiality. Some members wanted more information than they needed.
Tailored information for CCPT's wishing to evaluate race equity issues in their case reviews
Training and what is expected.
better orientation and training from agencies for staff they designate to be on the Team
more dedication from mandated members, additional cross training of agencies, family and youth representation on the team

Time and Resources
More time; adequate staff
Timely access across all agencies to needed information
More timely reports from the Medical Examiner.
getting all medical records more timely
Easier access to cross-state medical and CPS records and the ability to review cases with pending criminal charges.
quicker access to medical record documentation
more community resource options for mental health and substance use

Better Selection Guidelines
Maybe selecting cases w/ a specific goal in mind for what to gain from the team & state that goal prior to presenting the case so the team can be solution focused.
Members identifying cases for review
Guidance from State CCPT Coordinator with NCDSS in determining case selection process.
The Chair has depended on team members to bring or recommend cases and shared information about the process. In the coming yuear the Chair will coordinate with DSS leadership to identify and bring cases for review.
assure to follow policy criteria to select cases for review. assure all CCPT members attend especially law enforcement & DA office
For all agencies to provide cases to review to get different perspectives and types of cases other than CPS.
Request CW Supervisors to identify a case each quarter that meet criteria for review. Arrange for SW and SWS to present to the team and then rotate agenda items among the team.
More structure as to how to choose cases.
Specific guidelines on what criteria is needed to review cases

Miscellaneous
We do a great job with those because we are an established and a cohesive team.
Unsure
Need all to look for information before. We need more info on families to be shared prior to meetings so folks can check records
I am new in my position, and I am gaining more knowledge on the purpose of CCPT.
Team members are great to share information, there have been no issues with this.
Need to follow up with CCPT members to be better able to answer this question
Consistent participation by team members.
I don't know at this time
Regular attending team members prepare and participate for case reviews.
Easier access to information across county lines from all child serving systems.
Our CCPT is well informed and has information regarding cases reviewed.

if CPS would bring cases to the table
I believe we excel in this area.
Schedule Interim/separate CCPT meetings for the primary purpose of reviewing cases. As a combined team, CCPT case presentation, reviews and discussion does not receive the necessary time and attention since combined meetings focus on CFPT fatality reviews first.
more efficient processing of cases with pending criminal charges
Perhaps not having a combined team as we had very limited time in 2022 to devote to CCPT due to the number of fatalities that the CFPT was required to review. A co-chair who is dedicated to CCPT activities.
Chairperson better prepared
Continued and better communication with community partners and agency involvement
Our blended team reorganized in 2022 and started meeting again in April 2022 (we had a virtual training provided to us by the State. We met again in November 2022. We had to catch up on child fatality reviews. We will begin focusing on CCPT in 2023.
for members to feel like they are worth their time
We only reviewed 2 cases so just encouraging DSS and other agencies to present cases
Having cases to review
A review of what this is supposed to look like provided to the team.
For all agencies to provide cases to review to get different perspectives and types of cases other than CPS.
Complete information on the parents involved such as DOB so we are able to pull records.
Team members not trying to monopolize the entire time talking, giving others a chance to talk
Request CW Supervisors to identify a case each quarter that meet criteria for review. Arrange for SW and SWS to present to the team and then rotate agenda items among the team.
Funding
Change in the format in which it is presented.
Having more frequent case reviews in general
the team does a great job selecting cases
If more services existed within the county, possibly connect people to services.

Limitations to accessing MH/DD/SA/DV services

Unreceptiveness to families
Parents are not willing to participate.
Lack of motivation from clients to obtain and get to needed services.
lack of parent/family accountability.
Parent unwilling to participate in needed services.
Parent not ready to engage in services.
Family refusal.
Parents Unwilling to Participate.
Mother did not trust recommendation from provider even after being court ordered.
resistance to engage with services.

Limited resources
limited services for adults.
Limited Resources for Parents.
limited services for youth with complex behavioral health needs.
Limited availability of eating disorder services.
limited services for parents for DV.
Limited services for children/youth with Problematic Sexual Behaviors (PSB's).
Limited availability of transgender affirming placements for youth.
limited available resources.
Need for interpreters, language barriers.
Limited residential programs for children/youth with aggressive behaviors.
Long waiting times to access services which resulted in youth spending the night at DSS over 40 nights this year.
time restraints.
Extensive waitlist for services

Staffing
Constant turnover of service providers.
staff working from home and at times not being accessible for in-office or virtual services.

Finance
Financial issues
Insurance coverage or lack of

Miscellaneous
Covid.
facility denial.

Providers using technology for service delivery and families had no access.
services available; non-compliance.
Transportation Services.
Local Shelters for DV.
poor engagement.
Conflict with time classes offered and parents' work schedule.
Parent Incarcerated.

Issues Related to Racial and Cultural Equity

Awareness/Training
continued lack of training and ability to measure competency of staff and agencies.
Continued lack of training and ability to measure competency of staff and agencies.
Stigmas regarding MH services, access to MH providers who look like the clients being served.
We need better education regarding impaired parenting.
discussed services that the team was aware of.
We plan to research racial and cultural equity in the future.
We have discussed training in the area.
Self-awareness, education resources and guidance from community partners within the school system and mental health services that addresses equity and inclusion.
recommendations focused on inclusivity for families.
Continue to engage in training initiatives to address inequities through RMJJ and the hospital initiatives.
Educating the families that services and resources are available and providers as well as the agency are culturally competent and sensitive. Addressed concerns with family when they felt they were experiencing issues.

Diversity
Impaired parenting impacts all races.
concerns that service providers were uncomfortable having difficult conversations with a black family in the community.
a need for providers who speak Arabic.
Language barrier and common biases about a particular culture's behaviors and beliefs.
Language barriers with Spanish speaking families.
lack of resources for Hispanic families.
Stigmas regarding MH services, access to MH providers who look like the clients being served.
lack of inclusivity of service providers.
identifying providers that can work with different cultures.
Use interpreter line and staff fluent in Spanish.
Ensuring that we have medical and mental health providers that speak the language of those we serve and have culturally sound practices.
Look for additional supports in translators/interpreters.

Separate Task Forces
Training, partnerships with family-serving agencies, and Latinx community resources.
Partnerships; working with local AHEC to see how they can assist in the community; encouraging training resources of CAC to address topics in sponsored events.
ensuring community partners were identified.
mental health community rep is discussing with Sandhills Center as to need for additional resources.

Equitable Resources
Availability to services for Non-English speaking families.
access to services.
availability of resources.
Lower income, making sure same services are offered and provided.
Transportation issues (public transportation), virtual services.

Miscellaneous
This has particularly been discussed in regards to bad housing areas and the racial imbalance.
communication barriers.
Trust, Communication, non-bias opinions, everyone matters and deserves respect.
We need to do a better job of tracking this issue.
School RN & Social Worker attended appointments with the family.
transportation, community engagement, outreach.
Continue to normalize MH services.

Share information with each other.
discussed services that team was aware of.

Yes.
discussed training in the area.

Strategies to Address Issues Related to Racial and Cultural Equity

Education and Training
We need better education regarding impaired parenting.
We plan to research racial and cultural equity in the future.
We have discussed training in the area.
Partnerships; working with local AHEC to see how they can assist in the community; encouraging training resources of CAC to address topics in sponsored events.
Self awareness, education resources and guidance from community partners within the school system and mental health services that addresses equity and inclusion.
Continue to engage in training initiatives to address inequities through RMJJ and the hospital initiatives.
Educating the families that services and resources are available and providers as well as the agency are culturally competent and sensitive. Addressed concerns with family when they felt they were experiencing issues.

Community Engagement and Outreach
transportation, community engagement, outreach.
Partnerships; working with local AHEC to see how they can assist in the community; encouraging training resources of CAC to address topics in sponsored events.
ensuring community partners were identified.
mental health community rep is discussing with Sandhills Center as to need for additional resources.
recommendations focused on inclusivity for families.

Inclusivity and Equity
identifying providers that can work with different cultures.
Use interpreter line and staff fluent in Spanish.
Look for additional supports in translators/interpreters.
recommendations focused on inclusivity for families.

Miscellaneous
We need to do a better job of tracking this issue.
discussed services that team was aware of.
Share information with each other.

Top three recommendations for improving child welfare and protection services at the local level

Local DSS
Less discretion on policy at local level
Better education of local leaders/community on placement crisis of children with acute behaviors (including foster children)
Educating the community on CPS reporting
Involving outside agency training about child maltreatment
Better education of local leaders/community on placement crisis of children with acute behaviors (including foster children)
Ensuring that placement providers are available at the local level and that they meet the kid's needs
Review child welfare policies with CCPT Team to assure their understanding of policy
The need for “compliance petitions” when families are not following through with services
Making sure everyone has a clear understand of CW Policies
Review child welfare policies with CCPT Team to assure their understanding of policy

Resources
Making sure that community is aware of the resources in the community
Community resources for shareholders
County agencies assisting families with more financial assistance for food and gas

County agencies assisting families with more financial assistance for food and gas
Resources Available in the Community
provide local DSS with information on what resources are available on a state level
Recruiting more mental health providers to provide services in the local area
More Mental Health Providers at the local level that will provide appropriate services to children
Identify providers locally to address opioid dependency
Recruiting more mental health providers to provide services in the local area
Housing programs
Increase number of licensed foster homes
More options for placements for undisciplined youth
Continue to work to protect undocumented children
Affordable housing
Increase number of licensed foster homes
Access to affordable housing in the county
Affordable housing
Housing Issues
Increased access to safe and affordable housing
Increase number of licensed foster homes
Access to affordable housing in the county

Training/Education
Local education campaigns
Attend more trainings
Collaboration and cross training with agency stakeholders
Continued Training in Child Welfare
Continued Training in Child Welfare
Provide education on CPS reporting & referral sources for testing
Awareness of nonconscious bias, diversity and inclusivity in the community, cultural/generational gaps
Car seat safety and education
Child welfare staff to educate the public, elected officials and other agencies about local laws and policies so they will understand child welfare limitations and policies. They could then advocate for changes.
educating others in the community about child welfare and policies
More awareness about poison control
Provide education on CPS reporting & referral sources for testing
Trainings
Training for CCPT Members
Training for judges, attorneys, court officials
Continued education and training for child welfare
continue to educate child welfare staff on state level policy changes or changes in the law
offer education campaigns - water safety, safe sleep, animal safety education.
POSC additional training for staff that is in the field. New policy and forms come out but no training. This allows staff to understand the importance of POSC in all cases despite what the type of illegal substances used by the parent.
Continue to provide education and resources for social workers
Car Seat Installation Training/Education
Car seat knowledge and safety with families
Continued Training in Child Welfare
Collaboration and cross training with agency stakeholders
Educating the community on CPS reporting
Training and Education
Training for social workers on mental health first aid
More resources for parenting education
Effective recruitment, training and preservation of child welfare social workers
Increase knowledge on trafficking on all levels
requiring education after baby's birth prior to discharge
Effective recruitment and training for social workers
Provide adequate training to staff before implementation
Ensure staff are properly trained on the latest policies and procedures
Making sure everyone has a clear understanding of CW Policies
Golf cart safety
Car Seat Installation Training/Education
Bicycle Safety Education
Car seat knowledge and safety with families
Address lack of child development knowledge and belief in harsh discipline
Ensure staff are properly trained on the latest policies and procedures
Training for CCPT Members
Training for judges, attorneys, court officials

Safe Sleep
Education on Safe Sleep and learning about what other partners are doing
Educating staff on Safe Sleep Practices
Continued focus and education regarding infant safe sleep
PSA for Safe Sleep
Safe Sleep
Continue to educate safe sleep habits
safe sleeping
Continued infant safe sleep education
Educating staff on Safe Sleep Practices
Safe Sleep
Safe sleep education to be implemented in birthing/parenting classes

Substance Use/Substance Affected Infant
education for parents with substance use and improve early detection and referral to treatment
CPS to educate local hospitals to make timely reports on substance affected infant cases prior to the family being released from the hospital.

Communication
Continued communication with community partners
Communication with other agencies
Continue communication with LME/MCO
Strengthening communication between agencies
Community awareness
Communication between child welfare staff and other agencies involved
Increased knowledge of community resources

Collaboration
Better collaboration across counties when there is a conflict-of-interest case
Collaboration and cross training with agency stakeholders
Improved communication and collaboration between community partners
Community Stakeholder working together to ensure a safe community
Increase communication and community engagement that allows for shared learning, collaboration, partnership, and training
Better work relationship with Department of Juvenile Justice
Building stronger partnerships with community agencies
Collaboration and cross training with agency stakeholders
Community events and networking
Strengthening of relationships with law enforcement
Continue involving the school systems to best understand and support their efforts
Better involvement with DJJ that does not mean that DJJ dumps cases on DSS
Increase collaborative efforts to prevent truancy and holding parents/children accountable (court, DSS, school)
Outreach to primary care providers about making reports to DSS when there are concerns about weight or failure to gain weight
Better collaboration across counties when there is a conflict of interest case
Collaboration and cross training with agency stakeholders
Coming together as community agencies to see what can be done on the local level
Create and fund/sustain collaborative efforts to build/enhance/better integrate family-based services with lived experience, equity, and prevention principles
Community events and networking

Miscallenous
Continue reunification efforts with families
Family and youth participation
Bridging the gap in racial disparities
Roles of School Social Workers with families in need

Top three recommendations for improving child welfare and protection services at the state level

RESOURCES
Mental Health Services
Advocate for better access to Mental Health Services
Increase Mental Health Services

More community resources for mental health
Help with mental health treatment, availability
Access to better quality Mental Health/Substance Abuse Services offered for adults (especially with no insurance)
Access to mental health services
Better quality and better access to MH services for children and adults
Increased mental health and substance abuse services including interpreter services more community resources for mental health
More accessible mental health services
increase access to mental health services for parents by ensuring they maintain health coverage even when their children are removed from their care
more placement options for children in need of MH services
Therapeutic/Mental Health Placement
Access to mental health services
Better quality and better access to MH services for children and adults
Services for dual diagnosed youth (MH/SA, MH/Autism, MH/DD)
More accessible mental health service
Increase inpatient behavioral health facilities (in progress)
Increase the number for leveled care placements for all children (TFC, Group Home, PRTF)
Better support for placement of behaviorally challenging youth

Substance Use /Substance Affected Infant
Help with substance abuse treatment availability
Outreach regarding marijuana use during pregnancy
Substance Use
Access to better quality Mental Health/Substance Abuse Services offered for adults (especially with no insurance)
More community resources for substance use
Establish drug testing for families
Address need for more comprehensive and accessible substance abuse resources
more community resources for substance use
Access to needed services such as adult substance abuse and prenatal care
Address increasing drug addiction issues
Substance Use Disorders
Establish drug testing for families

Domestic Violence
There is a need for additional providers of services to address domestic violence, and for domestic violence services that are more effective than the ones currently available
Need to address batterer intervention programs for perpetrators of DV
DV treatment for victims and perpetrators
Need to address batterer intervention programs for perpetrators of DV

General Resources
ACE Score for children and caretakers included during assessment and ongoing service provision
concerns of facilities not accepting youth due to behaviors
Continue to promote kinship placements
72hr/30 day check at pediatrician – need psychological intake at timeframes to assess trauma
more resources
more statewide providers
more resources and funding
Access to Services

POLICIES
Mental Health Services
Address the mental health crisis facing children and youth
Advocate for better access to Mental Health Services
Advocate for better access to Mental Health Services

Substance Use /Substance Affected Infant
Address increasing drug addiction issues
Address increasing drug addiction issues
Universal screening for trauma/substance misuse/behavioral health with all pediatric practices

General
Resolving conflicting child welfare policy and statutory law
Need local policies and incentives to enforce ongoing use of CFTs ensuring inclusion of relevant individuals and groups
Create laws similar to gun safety laws related to the safe storage of medication and illegal substances
Medicaid Expansion

Policies that are written to give direct guidance
Resolving conflicting child welfare policy and statutory law
resolving State vs federal requirements
Create laws surrounding the requirement that children receive education related to abuse/neglect in developmentally appropriate ways (through school)
Continue with unit meetings to discuss policies
Communicate with DHHS any concerns with current policy or law that is identified during CCPT
Consistent implementation of policy from county to county
NCDHHS should finalize and implement statewide child welfare record system in all counties
continue to align NC Fast with policy/practice model
Development of an EMR
Create a standardized office of CCPT/CFPT at the State level to provide administrative support for the local teams
Increase network capacity for emergency placements, ongoing placements, and treatment supported placements to serve children in the legal custody of ANY DSS agency
Insuring that there is a very fast admission and placement process for placing youth with aggressive behaviors in appropriate residential settings
Create a standardized, timely process for sharing records between DSS agencies
Improvement to the LME/MCO
Centralized state Intake
A state system for foster care Medicaid

CAPACITY
Workforce
General staffing
Needing more workers
Reduce case load size for DSS investigators, work ratio too high
Funding for DSS staffing
Needing more funding for child welfare workers
Funding for additional staff for counties
Increase qualified staff and maintain
Workforce issues - recruitment and retention
Changes to the worker to caseload ratio
Recruitment and retention of well-qualified social workers

Mental Health Service personnel
More mental health providers
Identification of Mental Health Nurse
Mental health case managers
Collaboration with substance abuse and mental health professionals
Collaboration with substance abuse and mental health professionals
Mental health case managers
Increase LME/MCO providers in area for MH/SA
Increase LME/MCO providers in area for MH/SA
Increased availability of behavioral health services in Spanish
Increase quality mental health providers

Trainings/Education
General Trainings/Education
Additional face to face trainings
More Training
more trainings
Accessibility and availability of increased child welfare staff training
increase amount of trainings for staff
Mandatory safe sleep training and policy

Funding
General Funding
Financial assistance for service providers
Funding
Funding for evidence-based programs
Funding for local teams
More Funding
more support/funding for Improved access to In-Home Parenting Programs for families with children older than 5 years old
Funding for service resource development & expansion
More state funds available for services for families involved in child welfare sent to local level
Funding for Child Welfare for more services for families
Expanding financial support of kinship care
Funding for residential programs for aggressive youth
Funding
More funding
More Grants/ Funding for Housing

Substance Use
funding for a regional, on sight testing lab (drug lab)

State to provide financial assistance for counties to have parents receive drug testing

Appendix D: Copy of 2022 Survey

CCPT Survey 2022
2022 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 2022 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 (NC DSS). The state-level report is compiled from aggregated data without identifying individual team responses. This year, the Board and NC DSS will have access to individual county data which will allow for targeted support and communications to facilitate CCPTs' optimal functioning. The NC CCPT Advisory Board will make recommendations on how to improve public child welfare. NC DSS will write 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 their 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 participation of the specific local CCPT in the annual report. The survey responses are transmitted directly to the researcher, TBD, at North Carolina State University. De-identified findings may also be included in presentations, trainings, and publications.

The 2017 through 2021 Community Child Protection Team End of Year Reports including recommendations from the Advisory Board, are available through the links provided below.

Please follow this link to view past year's reports and responses.

North Carolina State University

INFORMED CONSENT FORM for RESEARCH

Title of Study: Community Child Protection Team 2022 Survey (6430)
Principal Investigator: Dr. Anna Abate acabate@ncsu.edu

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 and to stop participating at any time without penalty. The purpose of this research study is to gain a better understanding of how to improve child welfare services across the state. We will do this through collecting survey data from local CCPTs regarding their functions and objectives. You are not guaranteed any personal benefits from being in this study. Research studies also may pose risks to those who participate. You may want to participate in this research because your CCPT has the opportunity to contribute to improving public child welfare and protecting children from maltreatment. You may not want to participate in this research because NC DSS and the NC CCPT Board will be able to connect your team to some survey answers.

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(s) named above or the NC State University Institutional Review Board office (contact information is noted below).

What is the purpose of this study?
The purpose of the study is to assist 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. The survey results also assist in providing local CCPTs with individualized support.

Am I eligible to be a participant in this study?
There will be potentially 101 participants in this study, representing all counties in North Carolina and the Qualla Boundary. The chairpersons of the CCPT in each county or Qualla Boundary will be sent a survey.

In order to be a participant in this study you must have been an active member of your local CCPT for the past year.

You cannot participate in this study if you are no longer a member of your CCPT.

What will happen if you take part in the study?
If you agree to participate in this study, you will be asked to do all of the following: complete and submit the online survey.

The total amount of time that you will be filling in the survey is approximately 25 minutes. In preparation for filling in 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 and benefits
The local CCPTs are asked to identify by name their county or Qualla Boundary, and the responding CCPTs are listed in the end-of-year CCPT report that is shared with state and federal authorities and posted on a public website. In addition, the results may be shared in presentations, trainings, and publications. The responses of the local CCPT may identify that they made a particular answer. This risk is minimized because the NC CCPT Advisory Board and NC DSS will only use data identifying the local CCPT to inform what resources and support a particular CCPT might need to improve their functioning. The survey will indicate for which questions the Research Team will identify the local CCPT giving the response to the NC CCPT Advisory Board and NC DSS. All public facing reports will be in aggregate, which means that the responses of the individual CCPTs are combined together.

There are no direct benefits to your participation in the research. The indirect benefits are that your CCPT has the opportunity to contribute to improving public child welfare and protecting children from maltreatment.

Right to withdraw your participation
You can stop participating in this study at any time for any reason. In order to stop your participation, please refrain from submitting the survey. Any time before submitting the survey, you may choose to withdraw your consent and stop participating. If you choose to not submit your survey, results will not be included in analyses.

Confidentiality
The information in the study records will be kept confidential by the parties listed above to the full extent allowed by law. Data will be stored securely on an NC State University managed computer. Unless you give explicit permission to the contrary, no reference will be made in oral or written reports which could directly link you to the study. The responses of the local CCPT may indirectly identify that they made a particular answer due to other information shared with authorities.

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 itself or the procedures implemented in this study, you may contact the researcher, Dr. Anna Abate, at Center for Family and Community Engagement, North Carolina State University, at ccpt_survey@ncsu.edu.

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 the NC State University IRB (Institutional Review Board) Office via email at irb-director@ncsu.edu or via phone at 1.919.515.8754. The IRB office helps participants if they have any issues regarding research activities.

You can also find out more information about research, why you would or would not want to be a research participant, questions to ask as a research participant, and more information about your rights by going to this website: http://go.ncsu.edu/research-participant.

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 before submitting the survey without penalty or loss of benefits to which I am otherwise entitled."

- **Yes**, you can now proceed to the next page.
- **No**, please contact Jadie Baldwin-Hamm at the NC Division of Social Services for technical assistance on completing the survey: email jadie.baldwin@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.

Instructions: When completing this survey, please remember the following:

1. This survey covers the work of your CCPT for the period January – December 2022.

2. Your survey responses must be submitted online (via Qualtrics). Do not submit paper copies to NC DSS or NC CCPT Advisory Board. As you work in your survey, your work will save automatically, and you can go back to edit or review at any time before you submit.

3. 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.

4. 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.

5. In addition to the CCPT meeting time, set aside approximately 25 minutes for filling in the team's responses on the survey.

6. For questions about the survey and keeping a copy for your records, contact the Research Team at ccpt_survey@ncsu.edu.

Please complete and submit the survey online (via Qualtrics) on or before **January 13th, 2023**.

Note. The questions for which the Research Team will NOT provide the identity of the responding CCPT to the NC CCPT Advisory Board or NCDSS are shaded blue and have the caption "Confidential"

Select your CCPT from the list below.
(DROP DOWN LIST WILL BE PRESENTED IN THE ELECTRONIC VERSION)

Who completed this survey? (Please do not provide any identifying information) (*Confidential*)

- 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? *(Meetings include both in person and virtual formats)*

- 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 ____

What difficulties has your CCPT faced while trying to meet and complete your work? (*Confidential*)

____

How often does your CCPT meet as a full team?

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

If your team has subcommittees, 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-1407.

Within the last two years, has your CCPT moved from:

- A separate to combined team
- A combined to separate team
- We have not changed the format of our CCPT within the last two years

In 2022, 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

Only to be shown to those counties who indicated a combined CCPT/CFPT.

In 2022, 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 or 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 2022, how many additional members took part in your CCPT:

A family or youth partner is a youth or adult who has received services or is the caregiver/parent of someone who has received services, and who has firsthand experience with the child welfare system. If zero, type 0

- Organizations ____
- Family Partners ____
- Youth Partners. ____

List the organization that additional members represent. (System of Care Community Coordinator (LME/MCO), Other LME/MCO representation, Juvenile Justice representation, Victim Service organization, etc.)

Member 1 ____

Member 2 ____

Member 3 ____

Member 4 ____

Member 5 ____

In 2022, how well did your CCPT accomplish the following:

Prepare for meetings?

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

Share information during meetings?

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

Make desired changes in your community?

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

In 2022, other than mandatory members, did family or youth partners serve as members of your CCPT? *A family or youth partner is a youth or adult who has received services or is the caregiver/parent of someone who has received services, and who has firsthand experience with the child welfare system.*

- Yes
- No

In 2022, other than mandatory members, how frequently did family or youth partners participate in your CCPT?

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

In 2022, were family or youth partners invited to attend CCPT meetings?

- Yes
- No

Have you requested resources or assistance from DSS to assist in family partner involvement?

- Yes
- No

In 2022, which of the following strategies did your CCPT use to successfully engage family and youth partners on your team? (The checklist below comes from CCPT survey responses in past years. Check all that apply and add your own.)

- Outreach through community networks to identify family and youth partners
- Repeatedly extending invitations by multiple means (e.g., phone, email)) to possible family and youth partners
- Having a senior agency representative extend the invitation
- Putting CCPT membership into family or youth partner's job description
- Explaining purpose of CCPTs in jargon-free and inviting language
- Describing the role of the family and youth partners on the team
- Emphasizing the value that family and youth partners bring to the team
- Providing information on opportunities available to participants (e.g., training)
- Rescheduling meeting times to accommodate family and youth partners
- Preparing family and youth partners for the meetings
- Drawing family and youth partners into the meeting discussions
- Ensuring that discussions are in clear and understandable language for all participants
- Debriefing with family and youth partners after meetings
- Using team members already on the CCPT to offer family perspectives
- Other ____

During 2022, did your CCPT partner with other organizations in the community to create programs or inform policy to meet an unmet community need?

- Yes
- No

Active Cases

What is the total number of active cases reviewed by your CCPT between January and December 2022?

Number of cases reviewed ______

How many of these active cases entailed Substance Affected Infants[8]? ***If zero, type 0.***

---

[8] An infant identified as a "substance affected infant" (SAI) is defined by: (1) An infant has a positive urine, meconium or cord segment drug screen with confirmatory testing in the context of other clinical concerns as identified by current evaluation and management standard. (2)The infant's mother has had a medical evaluation, including history and physical, or behavioral health assessment indicative of an active substance use disorder, during the pregnancy or at time of birth. (3) An infant that manifests clinically relevant drug or alcohol withdrawal. (4) An infant affected by FASD with a diagnosis of Fetal Alcohol Syndrome (FAS), Partial FAS (PFAS), Neurobehavioral Disorder associated with Prenatal Alcohol Exposure (NDPAE), Alcohol-Related Birth Defects (ARBD), or Alcohol-Related Neurodevelopmental Disorder (ARND). (5) An infant has known prenatal alcohol exposure when there are clinical concerns for the infant per current evaluation and management standards.

____

How many of these active cases entailed a near fatality[9]? ***If zero, type 0.***

_____

Fatalities Cases

How many cases did your CCPT review that included maltreatment fatality factors? (Do not include those done through an Intensive Fatality Review).

_____

Of these fatalities reviewed, how many of these children had a history of identification as a Substance Affected Infants?

If zero, type 0.

_____

After an intensive review has occurred, describe how the findings and recommendations coming out of the review were typically communicated.

____

____

After an intensive review has occurred, how does your CCPT typically identify action steps for working on the local recommendations?

____

____

In reviews of active or fatalities cases did you identify any issues related to the reporting of substance affected infants in accordance with the law?

- Yes
- No

Which of the following criteria did your CCPT use in 2022 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 Substance Use
- Child Trafficking
- Other 1 ____
- Other 2 ____

[9] According to NC General Statute § 7B-2902, a child maltreatment near fatality is "a case in which a physician determines that a child is in serious or critical condition as the result of sickness or injury caused by suspected abuse, neglect, or maltreatment."

Which of the following contributory factors to children being in need of protection did you use in 2022 for selecting cases for review? Check all that apply.
Terms such as alcohol use have been inserted as preferred identifiers but current terms on the child protection form are in parentheses. Definitions for these terms may be found in the NCANDS Child File Codebook

- Caregiver(taker) - Alcohol use (Abuse)
- Caregiver(taker) - Drug use disorder (Abuse)
- Caregiver(taker) - Intellectual/Developmental Disability (Mental Retardation)
- Caregiver(taker) – Mental Health Need (Emotionally Disturbed)
- Caregiver(taker) – Visually or Hearing Impaired
- Caregiver(taker) - Other Medical Condition
- Caregiver(taker) - Learning Disability
- Caregiver(taker) - Lack of Child Development Knowledge
- Child - Alcohol Problem
- Child - Drug Problem
- Child - Intellectual/Developmental Disability (Mental Retardation)
- Child – Mental Health Need (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 of the CCPT and/or Case Managers/Behavioral Health Care Coordinators/Care 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 2022 were identified as having children and/or youth who needed access to the following services?

- Mental Health (MH) __________
- Intellectual/Developmental Disabilities (I/DD) __________
- Substance Use Disorder (SUD)[10] __________
- Domestic Violence (DV) __________
- Child Trafficking __________

Please indicate if any of these services had a waitlist.

- Mental Health (MH) __________
- Intellectual/Developmental Disabilities (I/DD) __________
- Substance Use Disorder (SUD) __________
- Domestic Violence (DV) __________
- Child Trafficking __________

Please indicate how many of these cases received the needed service.

- Mental Health (MH) __________
- Intellectual/Developmental Disabilities (I/DD) __________
- Substance Use Disorder (SUD) __________
- Domestic Violence (DV) __________
- Child Trafficking __________

How many of the cases reviewed in 2022 were identified as having parents or other caregivers who needed access to the following services?

- Mental Health (MH) __________
- Intellectual/Developmental Disabilities (I/DD) __________
- Substance Use Disorder (SUD) __________
- Domestic Violence (DV) __________

Please indicate if any of these services had a waitlist.

- Mental Health (MH) __________
- Intellectual/Developmental Disabilities (I/DD) __________
- Substance Use Disorder (SUD) __________
- Domestic Violence (DV) __________

Please indicate how many of these cases received the needed service.

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[10] Added as Footnote: 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).

- Mental Health (MH) __________
- Intellectual/Developmental Disabilities (I/DD) __________
- Substance Use Disorder (SUD) __________
- Domestic Violence (DV) __________

In 2022, which of the following limitations prevented children, youth, and their parents or other caregivers from accessing needed MH/DD/SU/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 participation of MH/DD/SUD/DV providers at CFTs
- Other 1 ____
- Other 2 ____

(If yes to "limited participation of MH/DD/SUD/DV providers at CFTs) What barriers contributed to the limited participation of MH/DD/SUD/DV providers at CFTs?

____

____

Of the cases reviewed, what barriers did COVID-19 pose?

____

____

What creative solutions did your team identify to address those issues?

____

____

Racial and Cultural Equity: *A racially and culturally equitable approach to child welfare is responsive to and invests in families and their communities with the result that children remain safely at home and their families are respected and supported in making and carrying out decisions for the care and well-being of their children.*

Has your team discussed issues of racial and cultural equity in child welfare?

- Yes
- No

While conducting your case reviews, what were the issues identified by the team relating to racial and cultural equity?

____

____

What strategies did your team identify to address these issues?

____

____

Are you currently utilizing the resources provided to your team to explore a racially and culturally equitable approach to child welfare?

- Yes
- No

If not, what would help your CCPT to use these and other resources that are provided?

____

____

NC DHHS: Child Welfare: An agency with defined mandates and policies

Based on your 2022 case reviews, what were your team's top three recommendations for improving child welfare policies and statutory law at the local level? (*Confidential*)

- Recommendation 1 ____
- Recommendation 2 ____
- Recommendation 3 ____

Based on your 2022 case reviews, what were your team's top three recommendations for improving child welfare policies and statutory law at the state level? (*Confidential*)

- Recommendation 1 ____
- Recommendation 2 ____
- Recommendation 3 ____

NC DHHS: Child Protection: A Community effort where everyone has a role

Based on your 2022 case reviews, what were your team's top three recommendations for improving child protection at the local level? (*Confidential*)

- Recommendation 1 ____
- Recommendation 2 ____
- Recommendation 3 ____

Based on your 2022 case reviews, what were your team's top three recommendations for improving child protection at the state level? (*Confidential*)

- Recommendation 1 ____
- Recommendation 2 ____
- Recommendation 3 ____

Please use this space to provide any additional information you would like to communicate.

____

____

Please contact Jadie Baldwin-Hamm jadie.baldwin@dhhs.nc.gov 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.

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 2022 CCPT Survey.

Thank you for taking the time to complete the 2022 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.

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