NORTH CAROLINA COMMUNITY CHILD PROTECTION TEAM

2021 End of Year Report

Community Child Protection Teams
NC Advisory Board

Foreword

This report attests to the invaluable contributions that local Community Child Protection Teams (CCPTs) make in support of children, youth, and families across our state. The teams demonstrated a keen awareness of the issues facing families in their communities during the second year 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. Kwesi Brookins, carried out the survey with Dr. Emily Smith serving as project manager and Dr. Joan Pennell, Peyton Frye, and Helen Oluokun supporting data collection, analyzing results, and preparing this report.

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

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I. Executive Summary

Holding on Despite Challenges

In 2021, the Community Child Protection Teams (CCPTs) reported that the coronavirus pandemic continued to inflict a heavy toll on children, families, and their communities. The major difference between 2021 and the first year of the pandemic in 2020, though, was the exhaustion of service providers as they dealt with severe staff shortages and inadequate community services. CCPTs feared for the safety and well-being of the children who were isolated from school and other community support. Nevertheless, service providers demonstrated fortitude and ingenuity in overcoming challenges in supporting children and their families.

Each year, all CCPTs in North Carolina are asked to complete a survey regarding children and families served by child welfare in their communities. The survey documents local developments over the year, progress achieved, and areas for further action. Using the findings, the NC CCPT/Citizen Review Panel Advisory Board (hereafter CCPT Board) makes recommendations to the NC Department of Health and Human Services (NCDHHS) on ways to improve delivery of child welfare across the state. NCDHHS then responds to these recommendations and sets forth the steps they took to act upon the recommendations. The response is included in the state's progress report to the federal government. This process promotes quality improvement of child welfare services by having local experience inform state action, for which the state is accountable to the federal government.

A notable strength of CCPTs is their bringing multiple perspectives to identify local issues and develop strategies to safeguard children and their families. By law, CCPTs include representatives from different child-and-family-serving agencies and can bring on board others with relevant family and community experience. Accordingly, CCPTs are well positioned to address complex matters requiring a comprehensive understanding of the challenges faced by children, youth, and families in their communities. This collaboration develops a sense of collective responsibility and builds the momentum necessary for putting in place ways to resolve issues that are locally effective and racially equitable.

2021 NC CCPT Advisory Board Survey Summary

The 85 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 under three-quarters (72%) 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 under three-quarters (74%) of the CCPTs opted to combine with their local Child Fatality Prevention Team (CFPT). Two-thirds (60%) of the surveys were completed by the chair or designee and a quarter (12%) by the team as a whole. Other teams completed the survey with input from select team members or through other collaborative means.

The 2021 survey inquired about the following seven main questions:

1. What difficulties does the pandemic pose to team operations and to children and families in the community?
2. Who takes part in the local CCPTs, and what supports or prevents participation?
3. Which cases do local CCPTs review, and how can the review process be improved?
4. What limits access to needed mental health, developmental disabilities, substance use, and domestic violence services, and what can be done to improve child welfare services?
5. What local issues affect taking a racially equitable approach to child welfare?
6. What are local CCPTs' recommendations for improving child welfare services?
7. What are local CCPTs' objectives, and what helps them meet these objectives?

A. Respondent Characteristics

This year, 85 of the local teams responded to the survey in 2021, a number that is in the higher range for responses since 2012. The participating CCPTs encompassed all state regions, county population sizes, and the six LME/MCOs that provide MH/DD/SU services. Just under three-quarters (74%) of the responding CCPTs stated that they were "an established team that meets regularly," lower than in 2020 when 84% of the reporting counties identified themselves as an established team that meets regularly. The decrease is most likely due to continued adjustment to accommodate remote meetings and staffing shortages, but nevertheless, the CCPTs as a whole were sufficiently established to make significant contributions to child welfare. Among the responding teams, 74% were combined with their local CFPT. Although the percentage of combined teams slightly fell from the prior year, 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 14th, 2022 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 2021 survey inquired about the following seven main questions:

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3. Which cases do local CCPTs review, and how can the review process be improved?
4. What limits access to needed mental health, developmental disabilities, substance use, and domestic violence services, and what can be done to improve child welfare services?
5. What local issues affect taking a racially equitable approach to child welfare?
6. What are local CCPTs' recommendations for improving child welfare services?
7. What are local CCPTs' objectives, and what helps them meet these objectives?

D. Pandemic Impact on Team Operations and Families

By the second year of the pandemic, most CCPTs identified detrimental impacts on the functioning of their teams. There was extensive overlap in the responding teams for 2020 and 2021. As in the first year of the pandemic, teams struggled to meet, conduct case reviews, and reach out to the community. The main difference between the two years was their membership experiencing a much deeper level of exhaustion from prolonged staffing shortages and resulting in excessive workloads. The impact did not appear to be affected by county size or by team status as a combined or separate CCPT and Child Fatality Prevention Teams (CFPT). Responses, however, were affected by the extent to which the team was established operationally. The spill over into the lives of families was clearly evident. With added pressures from the pandemic, family situations had worsened and become more complex. Heavy worker turnover meant that new workers lacked guidance from more seasoned staff, and reduced community services meant that families were not receiving essential services to address aggravated mental health and substance use issues. CCPTs expressed concern that services were unable to assess and support families. In at least one instance, a child fatality was attributed to inadequate monitoring of a foster home. Risks were heightened by court backlogs and suspension of prosecutions against persons charged with crimes against children.

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 2021 survey results, as well as those in prior years, show that mandated members varied in their level of participation. DSS staff, mental health professionals, guardians ad litem, and DSS directors were the most often present while the county boards of social services, 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

County commissioners on over half the 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 Operations

CCPTs and combined CCPT/CFPTs who were established or recently re-established felt that they were preparing well for their regular meetings. Additionally, the majority indicated that they were sharing resources well and provided a number of additional shared resources they had accessed. The majority of respondents indicated that they only had a moderate to marginal impact in effecting change in their community. Thus, CCPTs created a working environment in which they shared information and resources; however, they recognized that their ability to make 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, 10% of respondents indicated that Family or Youth Partners served on their CCPT or combined CCPT/CFPT, a decrease 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. The Advisory Board is hopeful that the Division will engage with CCPTs to support county specific approaches to supporting Family Partner engagement.

I. Factors Limiting the Participation of Family or Youth Partners

CCPTs detailed at length the reasons preventing the participation of Family or Youth Partners on their teams. In addition to the significant difficulties posed by COVID-19, some of these reasons stemmed from the situation of the partners: logistical, such as unavailability of transportation, scheduling conflicts, and lack of reimbursement. However, overwhelmingly CCPTs identified reasons related to the team rather than Family or Youth Partners. These included uncertainties about how to recruit partners, how to maintain confidentiality, lack of time and resources to be allocated to Family Partner engagement strategies, and conflicts with current mandates and statutes. CCPTs asked for more guidance on bringing Family and Youth Partners onboard their teams. Thus, CCPTs identified the training and resources they would need for engaging families on their teams. The diversity in responses is indicative of a need for county specific support for Family Partner engagement.

J. Partnerships to Meet Community Needs

The pandemic deepened community needs while seeming to stall CCPTs from taking on new local initiatives. In the prior year, many CCPTs had to cut short their initiatives because of the pandemic, and this experience may have discouraged teams from taking on initiatives in 2021. Nevertheless, 25 out of the 80 CCPTs (31%), partnered with other organizations to pursue community efforts, initiatives, and communications. Their partners were wide-ranging and included public agencies, nonprofit organizations, faith communities, and businesses. This year, the diversity in partnerships and collaboration mirrored that of previous years extending beyond "traditional team members." The collaboratives ensured that their findings and recommendations were communicated widely in their counties.

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

Child maltreatment cases encompass active cases and child fatalities; active cases include near fatalities where child abuse, neglect, or dependency is suspected. In 2021, 80 (94%) of the 85 responding CCPTs reviewed 622 cases, although this may be inflated due to the inclusion of

preliminary case reviews from combined CCPT/CFPTs. The 622 cases included 471 active cases and 151 child fatalities. Among these cases were 79 infants who were affected by substances and only 5 cases of near fatalities. Large counties reviewed two to three times more cases on average than small or medium counties. Five CCPTs did not indicate that they reviewed any cases, possibly due to their status of not being an established team. 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. Child Maltreatment Case Reviews

State statute requires that CCPTs review two types of cases: active cases and child maltreatment fatalities. Most (86%) respondents selected active cases for review. Child maltreatment fatality was given as a reason for case selection by 33% 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 multiple agency involvement and repeat maltreatment, both identified by over 70% 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 59 (80%) CCPTs and caretaker's mental health need cited by 57 (77%) CCPTs. Four other factors used by over 50% of CCPTs pertained to caretaker's alcohol use, child/youth 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. Five CCPTs did not indicate that they reviewed any cases, possibly due to their status of not being an established team. 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.

The local teams figured out ways to operate during a pandemic but missed their in-person meetings. CPPTs outlined ways that they could improve their review process: These included recruiting family and community representatives, having more consistent participation, more consistent meetings, developing structure for meetings, and enhancing access to case information to facilitate a timely review process. They also recommended ways that DHHS could strengthen the review process, by expediting notifications of fatality cases, clarifying policies, roles, and expectations while also providing technical assistance and tracking tools.

L. 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 2021 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. With one exception, the majority of cases in each category received the needed service. Notably, the one exception was child trafficking. Nevertheless, substantial numbers in all categories did not receive required services, with the percentage ranging from 16-83%. 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 inadequate services for youth having a dual diagnosis of mental health and developmental disability issues. 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. 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.

M. Racial Equity in Addressing Local Needs

This year's survey explored local developments in regards to a racially equitable approach to child welfare. Most responding teams (74%) had not discussed issues of racial equity in child welfare over the year, and some stated that they were unaware of such issues locally. Others explained that the county had little diversity or that child protection did not determine cases based on race and ethnicity. A quarter (26%) of the responding teams described local issues of racial equity. They pointed to how systemic inequities in access to resources (e.g., housing, employment) led to reporting to child welfare. They placed weight on cross-county training to open up discussion of issues and possible solutions. Teams characterized racism as a public health issue and urged cultural humility to encourage continual learning. Most teams expressed interest in receiving training resources on a racially equitable approach to child welfare.

N. Local CCPT Recommendations for Improving Child Welfare Services

In developing recommendations to NCDHHS, the CCPT Board examined closely the recommendations emerging from the CCPTs to improve child welfare services at the local and state levels. The teams made 169 recommendations at the local level and 142 recommendations at the state level, for a total of 311 recommendations. Compared with 2020, this year's recommendations paid less attention to the pandemic and somewhat more attention to child fatalities. The teams' recommendations for the local level were especially directed to prevention strategies that could be achieved in their communities, such as raising awareness, forming partnerships, increasing service coordination, and advocating for resources. The teams recognized that state-level action was required to address the issues identified at the local level. For the state level, their recommendations were especially directed to matters that required state initiative, authorization, and resourcing. Their host of local and state recommendations

concentrated on five main areas: Accessible Resources and Culturally Responsive Services for Families, Expansion of Substance Use and Mental Health Services, Prevention Approach to Infant Safety, Strengthening Child Welfare, and Community-Engagement by CCPT Teams.

O. Local CCPT Objectives and Achievement of Objectives

Based on local needs, 40% of the responding teams set local objectives. The overall total of objectives was listed by counties was 76. Their objectives can be grouped into the same five areas as their recommendations. When asked to rate achievement of their objectives, the most common response was *moderately.* What especially helped them carry out their objectives were local relationships and resources. To achieve their objectives, they asked that NC DSS provide guidance, information, and funding; and they highlighted the necessity of system-wide changes to increase resources and services for children and their families. Looking ahead, the teams welcomed a new year in which they anticipated that their teams would no longer be struggling to deal with COVID.

II. 2021 Recommendations

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 two subcommittee meetings and then a meeting of the whole board to prepare and finalize the recommendations for action in 2023.

The first set of recommendations are steps for developing a racially and culturally equitable approach to child welfare in North Carolina. The second through fourth sets of recommendations drill down into what a racially and culturally equitable approach means for specific areas concerning child welfare.

In accordance with CAPTA, we propose the following for child protection at the local and state levels in 2023.

RECOMMENDATION 1 – DEVELOP A RACIALLY AND CULTURALLY EQUITABLE APPROACH TO CHILD WELFARE IN NORTH CAROLINA

Rationale. 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. This approach recognizes the historical and systemic racial/ethnic, cultural, social, economic, and ecological issues that have created a total environment that produces poor outcomes for families from a variety of marginalized groups and communities. In particular, researchers today have identified a number of factors affecting racial and ethnic disparities.[1] Racial and cultural racism increases the poverty of marginalized families and communities and increases their likelihood of child removals.[2] Community poverty, rather than individual family poverty, predicts the entry of Indigenous,[3] Black, Latinx, and White children into foster care; however, overall rates of child removals remain higher for Indigenous, Black, and Latinx children than White children.[4] A racially and culturally equitable approach seeks to

[1] Child Welfare Information Gateway. (2021). *Child welfare practice to address racial disproportionality and disparity*. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. https://www.childwelfare.gov/pubs/issue-briefs/racial-disproportionality/

[2] 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.

[3] North Carolina in 2017 was one of 15 US states that accounted for nearly all of the disproportionality in placement of American Indian/Alaskan Native (AI/AN) children. AI/AN children were 1.3% of NC children but were 2.4% of NC children in foster care. AI/AN have the highest rate of poverty among all racial groups in US. Cross, T. L. (2021). Racial disproportionality and disparities among American Indian and Alaska Native populations. In A. J. Dettlaff (Ed.). *Racial disproportionality and disparities in the child welfare system* (pp. 99-124). New York, NY: Springer. doi:10.1007/978-3-030-54314-3_4

[4] White-Wolfe, H. J., Charron-Chénier, R., & Denby-Brinson, R. (2021). Association between community-level material hardships and foster care entry by race/ethnicity. *Child Welfare, 99*(4), 105-136.

lessen disparities in child welfare interventions for children of different identities and backgrounds (e.g., rural/suburban/urban,[5] socio-economic status[6]).

CCPT Leadership. With support from local and state DSS, CCPTs are especially well positioned to exert leadership in developing a racially and culturally equitable approach to child welfare of relevance to their communities. They can encourage dialog among local child-and-family-serving agencies, families with lived experience, and other community groups. Such dialog is central to diversifying our understanding of and creating partnerships to increase racial and cultural responsiveness.[7]

Local

1) To support CCPTs and their community partners in creating a local plan for a racially and culturally equitable approach to child welfare by:
    a) Offering educational forums and materials on a racially and culturally equitable approach to child welfare, including a focus on populations of particular relevance to the community (e.g., low/medium/high-wealth, immigrant, military).
    b) Engaging people with lived experience from different racial and cultural communities to present at these forums and contribute to materials on racial and cultural responsiveness.
    c) Including diverse participants in these forums (e.g., service providers, families, system-of-care, local associations, faith communities, educational institutions, nonprofit foundations).
    d) Engaging CCPTs and their partners in defining their vision of a racially and culturally equitable approach to child welfare for local families and their communities, assessing what local assets or opportunities[8] (e.g., accessible resources, services, transportation) support this vision, setting objectives to achieve this vision, and identifying supports (e.g., education, policy, funding) required from outside the local community.
    e) Expediting cross-county and regional exchanges on steps for achieving a racially and culturally equitable approach and the successes of these steps.
2) To support CCPTs in increasing workers' capacity to relate to families from different backgrounds by:
    a) Conducting case reviews to identify organizational and systemic factors supporting a racially and culturally equitable approach to child welfare.

[5] For example, compared to children in more suburban and urban counties, children from rural counties are more likely to be substantiated for maltreatment but less likely to be placed outside their homes. 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

[6] Racist practices and policies impoverish marginalized families, and, even after taking poverty into account, racist bias leads to greater reporting, especially by medical personnel, of children of color with the same injuries as White children to child welfare. 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.

[7] A Texas study reported that a community engagement model reduced racial disproportionality and disparities. James, J., Baumann, D. J., Rodriguez, C., Craig, S., & Kathan, S. (2020). Creating comprehensive system reform to reduce racial disproportionality and disparities: The Texas community engagement model. In A. J. Dettlaff (Ed.). *Racial disproportionality and disparities in the child welfare system* (pp. 397-412). New York, NY: Springer. doi:10.1007/978-3-030-54314-3_4

[8] A useful map for identifying opportunities for counties across NC can be found at link.

b) Encouraging family-engagement strategies (e.g., Child & Family Team Meetings, Family Partners, youth focus groups) with marginalized groups.
c) Recommending sufficient exposure of workers to a critical mass of specific marginalized populations (e.g., African American, Indigenous, LGBTQ) on their workloads or rotating workers' caseloads to achieve this objective.[9]
d) Raising workers' awareness of assets in high-poverty or isolated racial and cultural communities.
e) Encouraging training to enhance workers' understanding that people in marginalized communities might manifest trauma histories or current trauma in uninviting ways and to increase the workers' skills in responding in a supportive, transparent, and trustworthy way.

State

1) To support DSSs in identifying and advancing systemic components that promote a racially and culturally equitable approach to child welfare.
2) To ensure that child protection decision-making tools distinguish parental neglect from systemic conditions outside parents' control.
3) To streamline Child and Family Teams to support cross-system work among child-serving systems in working with marginalized or isolated families.
4) To increase access to quality services (e.g., behavioral health) and concrete resources (e.g., food, housing) in high-poverty and isolated communities to lessen the impact of racial and cultural racism.
5) To support in next year's CCPT survey the inclusion of a definition of a racially and culturally equitable approach to child welfare that emphasizes strengths of families and communities.

RECOMMENDATION 2 – SUPPORT THE FAMILIES OF INFANTS IDENTIFIED AS 'SUBSTANCE AFFECTED,' INCLUDING THE PLAN OF SAFE CARE (POSC)

Rationale. Federal CAPTA 2016 legislation[10] requires health care providers involved in the delivery and care of infants identified as meeting 'substance affected' criteria to notify Child Welfare of the occurrence. The 'substance affected' criteria were to be developed by each state for three different required areas. North Carolina developed these criteria and implemented the updated policy and practice in 2017.[11] All such identified infants, under this legislation, must have a Plan of Safe Care developed to support the safety and well-being of the infant and the infant's family, regardless of imminent safety concerns.

Recommendations to support the families of infants identified as 'substance affected', including the Plan of Safe Care (POSC).

[9] Workers who work with a higher proportion of marginalized clientele understand better how to make equitable decisions. Fluke, J. D., Baumann, D. J., Dalgleish, L. I., & Kern, H. D. Racial disparities in child welfare: A decision-making ecology view. In A. J. Dettlaff (Ed.). *Racial disproportionality and disparities in the child welfare system* (pp. 339-352). New York, NY: Springer. doi:10.1007/978-3-030-54314-3_4

[10] https://www.congress.gov/114/plaws/publ198/PLAW-114publ198.pdf

[11] https://www.ncdhhs.gov/infant-plan-safe-care/place-of-delivery#affected_by_substance_abuse

Local

1) To request local cross systems training and technical assistance for child welfare's updated POSC policies and forms to support effective implementation.
2) To dedicate a county role/local position to the complex and multilevel needs of families who are child welfare and substance involved.
    a) Prioritizing collaboration and communication with local partners in working with shared families experiencing child welfare involvement and substance use disorders, with 42 CFR Part 2 compliant releases of information in place.
    b) Considering outreach and collaboration with community prenatal care providers to provide education on the Infant Plan of Safe Care.
    c) Seeking and developing 'in-house' expertise and familiarity with common issues related to substance use disorders and child welfare involvement, including medication for opioid use disorders during pregnancy and postpartum. Provide consultation to staff on these cases.
    d) Identifying, with the assistance of LME/MCO, key local substance use disorder treatment agencies with whom county agency can develop an MOU/MOA to include facilitating timely substance use disorder assessments and communication back to county child welfare agency. MOU/MOA can include required participation of SUD agency staff in CCPT.
    e) Developing regular communication channels with the delivering hospitals and free-standing birth centers, to support education of the Plan of Safe Care notification requirements, including differentiation between 'notification' and 'report of child abuse or neglect', and aggregate data feedback related to their notifications. Provide guidance to these healthcare staff on what information is ideally provided when making a notification based on infant meeting 'substance affected' criteria. Guidance on timing of the notification from healthcare provider to child welfare is also needed. Review 42 CFR Part 2 and provide training to healthcare providers involved in delivery and care of infant, on confidentiality requirements. Notifications (no clear indication of risk to the child) require consent to share information about substance use disorder treatment per federal regulation (42 CFR Part 2).
    f) Reviewing *de-identified* screened-out notifications of infants identified as 'substance affected' as a part of CCPT. CMARC and SUD treatment providers are essential partners in this review.

State

1) For state DSS, to maintain a focus on the following, in support of families who are substance involved:
    a) Prioritizing collaboration and transparency with state DHHS partners in working with shared families experiencing child welfare involvement and substance use disorders.
    b) Developing understanding of resources available through the LME/MCO to caregivers for substance use disorder treatment, when caregivers are not insured.
    c) Supporting regional and local child welfare agencies to develop in-house understanding, expertise and familiarity with common issues related to substance

use disorders and child welfare involvement, including medication for opioid use disorders during pregnancy and postpartum. Provide consultation to staff on these cases.

RECOMMENDATION 3 – SUPPORT COMMUNITIES IN PREVENTING NEAR FATALITIES DUE TO SUSPECTED ABUSE, NEGLECT, AND DEPENDENCY

Rationale. 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." Documenting alleged near fatalities in NC is a recent requirement for DSSs, beginning in July 2020, and CCPTs are only starting to conduct case reviews of near fatalities. Nationally, there have been difficulties in identifying near fatalities by child welfare, medical personnel, police, and other community groups.[12] Near fatal and fatal child physical abuse have extensive commonalities in terms of victim injuries and family risk factors, including a history of domestic violence[13] and mental health issues.[14] A major factor differentiating near fatal from fatal child maltreatment is readier access to quality health care rather than individual family risk factors.[15] Because child fatalities are rare events, individual risk factors should be used cautiously for prediction purposes. A stronger predictor is the general level of community poverty,[16] which affects the accessibility of health care for children and their families.[17] Rural communities particularly struggle to provide health service for Black and White residents.[18]

Local

1) To continue offering training and tip sheets on near fatalities to child welfare staff.
2) To make near fatalities training and information available to local CCPTs, family partners, health services, domestic violence organizations, system-of-care collaboratives, school personnel, judicial system, law enforcement, and others working with families.

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[12] 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

[13] 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

[14] 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

[15] 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

[16] 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

[17] 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

[18] 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

3) To facilitate training for CCPTs and other agencies (e.g., juvenile justice) on domestic violence and mental health when children are at risk of near fatal or fatal maltreatment.
4) To encourage CCPTs to leverage cross-system trainings to strengthen local partnerships to address near fatalities.
5) To provide training to CCPTs regarding case reviews of near fatalities and help them identify local cases and access medical records and other information necessary for these reviews.
6) To assist CCPTs conducting case reviews of near fatalities to identify community and systemic factors that heighten the risk of near fatalities, particularly for marginalized families, and impede timely access to life-saving health interventions.

State

1) To continue compiling and analyzing NC data on near fatalities to determine rates by counties and patterns in family and community profiles (e.g., race, ethnicity, indigeneity, poverty) and to compare cases of near-fatal child maltreatment with cases of fatal child maltreatment.
2) To analyze the manner of maltreatment near fatalities (e.g., unsafe sleeping, strangulation) by comparing cases of child maltreatment near fatalities with cases of child maltreatment fatalities and non-maltreatment fatalities.[19]
3) To identify systemic factors impeding the reporting of different types of maltreatment near fatalities.
4) To report findings and analyze their implications for practice and policy with county DSSs, CCPTs, CCPT Advisory Board, NC Child Welfare Family Advisory Council, NC Pediatric Society, and others.
5) To support the CCPT Advisory Board in preparing and disseminating a guide for local teams on reviewing cases of near fatalities, and to offer orientation on the guide to teams.
6) To clarify the roles of CCPTs and CFPTs in regard to reviewing cases of near fatal child maltreatment.
7) To combine reviews of child maltreatment near fatalities and domestic violence homicides to increase the identification of family violence in placing all family members at risk.[20] The Intensive Reviews conducted by NC DSS take a comprehensive look at near fatalities and, as appropriate, includes anti-domestic violence representatives.
8) To increase quick access to health care through use of dial-up services and other alternatives to private cars and mass transit.
9) To push for Medicaid expansion in order to provide quality and accessible health care for all NC families in rural, suburban, and urban settings.
10) To generate evidence-informed policy that promotes racial and cultural equity in addressing near fatalities.

RECOMMENDATION 4 – SUPPORT THE CAPACITY OF LOCAL CCPTS TO CARRY OUT THEIR WORK.

[19] The NC Division of Public Health reports annual findings on the manner and means of child fatalities. See link.
[20] 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

Rationale. NC statute mandates CCPTs in all counties and the involvement of key child-and-family-serving agencies with the flexibility to appoint others including family/youth and community partners. Thus, NC provides a strong basis for local input into improving the delivery of child welfare services. At the state level, the CCPT Board mirrors the composition of local CCPTs and offers a means of synthesizing statewide trends in child welfare, conducting analyses of policy and programming, and developing tools to assist local CCPTs. This comprehensive system of citizen review has much promise but also requires supports to strengthen the capacity of local CCPTs. The necessity of supports was especially evident in 2021, the second year of an exhausting pandemic, but is needed on an ongoing basis.

Local

1) To dedicate a NC DSS position to the operational support of CCPTs. Historically, this position has proved exceedingly beneficial to facilitating optimal functioning of the teams and would play a critical role in enabling the implementation of the recommendations outlined in this report. The assignment of one staff member to CAPTA and CCPTs is a valuable step in this direction.
2) To support CCPTs in developing ways to have their membership and discussions better reflect the racial and cultural diversity in their communities.
3) To assist CCPTs with strategies for the inclusion and retention of family and youth partners on teams. Consult with the NC Child Welfare Family Advisory Council on helpful approaches.
4) To foster exchanges of CCPTs from different locales.
    a) Offering cross-county summits and other forums through online means to encourage robust exchanges and creative ideas for child welfare improvements.
    b) Identifying topics for these exchanges with local teams and the CCPT Board.
    c) Capitalizing on these forums to offer trainings and/or provide relevant updates and information.
5) To offer technical assistance and training to local CCPTs, including on general changes to child welfare policy and programming and specific topics such as:
    a) Orienting teams to the guides on conducting case reviews and walking teams through the review steps with local cases. Emphasize the importance of identifying needed systemic changes.
    b) Writing recommendations for local initiatives and offering guidance, resources, and funding on implementing these recommendations.
6) To support the production and dissemination of the updated CCPT manual and provide orientations to CCPTs on the manual content.
7) To provide funding to local teams.
    a) Allocating annual funding of $1,000 per team for operational and project support;
    b) Assisting teams with understanding requirements on documenting the expenditure of the funds and assessing their local impact; and
    c) Ensuring that the results of the funds are summarized and a report provided to the funding sources and the CCPT Board.
8) To prepare local teams regarding impending changes to the end-of-year survey such as types of cases to review.
9) To provide targeted training to teams that identify areas on the end-of-year survey where they need support in fulfilling their role (e.g., engaging team members, conducting case

reviews, providing public education). This requires changing the survey protocols to permit identification of respondents to NC DSS and CCPT Board.

State

1) To keep the CCPT Board and local CCPTs informed over the year about the state's response to the Board's specific recommendations on improving child welfare and append addenda to the state's written response that detail steps taken.
2) To facilitate the change in survey protocols from de-identified to identified data, to engage key players (e.g., county DSS directors) in understanding and expediting this change, and to notify CCPTs of this change, help them take advantage of it, and respond to concerns about de-identification of their data

For previous year's NC DSS response to the Advisory Board's recommendations for improving child welfare services, go to this link.

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North Carolina Community Child Protection Teams (CCPT)

2021 End-of-Year Report

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

I. Introduction

Holding on Despite Challenges

In 2021, the Community Child Protection Teams (CCPTs) reported that the coronavirus pandemic continued to inflict a heavy toll on children, families, and their communities. The major difference between 2021 and the first year of the pandemic in 2020, though, was the exhaustion of service providers as they dealt with severe staff shortages and inadequate community services. CCPTs feared for the safety and wellbeing of the children who were isolated from school and other community supports. Nevertheless, service providers demonstrated fortitude and ingenuity in overcoming challenges to supporting children and their families.

Each year, all CCPTs in North Carolina are asked to complete a survey regarding children and families served by child welfare in their communities. The survey documents local developments over the year, progress achieved, and areas for further action. Using the findings, the NC CCPT/Citizen Review Panel Advisory Board (hereafter CCPT Board) makes recommendations to the NC Department of Health and Human Services on ways to improve delivery of child welfare across the state. NCDHHS then responds to these recommendations and sets forth the steps they took to act upon the recommendations. The response is included in the state's progress report to the federal government. This process promotes quality improvement of child welfare services by having local experience inform state action, for which the state is accountable to the federal government. CCPT survey reports and NCDHHS responses are posted at this link.

A notable strength of CCPTs is their bringing multiple perspectives to identify local issues and develop strategies to safeguard children and their families. By law, CCPTs include representatives from different child-and-family-serving agencies and can bring on board others with relevant family and community experience. Accordingly, CCPTs are well positioned to address complex matters requiring a comprehensive understanding of the challenges faced by children, youth, and families in their communities. This collaboration develops a sense of collective responsibility and builds the momentum necessary for putting in place ways to resolve issues that are locally effective and racially equitable.

Focus Areas

Two very complex family matters concern (1) infants affected by substances (drugs and alcohol)[21] and (2) children nearly dying of suspected maltreatment.[22] Both may have long-term, adverse consequences to children's development and require quick and coordinated intervention of the family, community, and service providers from different disciplines.

CCPTs have requested assistance in conducting case reviews of these two areas. To support the work of local teams, the CCPT Board formed two workgroups focused on creating guidance for CCPTs reviewing child welfare cases of prenatal substance exposure and near child fatalities, respectively. The reviews then serve as a basis for generating ways to assist families in these very difficult circumstances.

The guides adopt a social-ecological model[23] that views families within the context of their individual lives, relationships, communities, and broader society. This widened lens makes it possible to look at how to help families and promote collective responsibility to prevent future harm.

NC Division of Social Services introduced resources for local communities addressing these issues. This year NC DSS created eight new regional abuse medical specialist (RAMS) positions of which seven are to advise counties on serious injury cases and one is to advise counties on infants affected by substances. NC DSS developed guidance for child protection workers about plans of safe care (POSC) for infants affected by substances. NC DSS is preparing a companion piece on nighttime parenting and safe sleep.

Partnership Approach with Families and Communities

To work with families on prenatal substance exposure, near child fatalities, and other complex child welfare situations, NC DSS encourages a partnership approach. NC DSS has moved forward initiatives to support partnering with families: These include promoting a racially equitable approach, strengthening cross-system partnerships, and adopting the model of safety-organized practice.

Racial Equity. In last year's CCPT survey, some teams advised that training be offered on topics such as racial equity in child welfare. The CCPT Board recommended steps to increase awareness and action on issues of racial equity. NCDHHS' response outlined steps taken to

[21] Ingoldsby, E., Richards, T., Usher, K., Wang, K., Morehouse, E., Masters, L., & Kopiec, K. (2021). *Prenatal alcohol and other drug exposures in child welfare study: Final report*. Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. Available at https://www.acf.hhs.gov/sites/default/files/documents/cb/paode-in-cw-final-report-rev.pdf

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

[23] Jointly published by: Dahlberg LL, Krug EG. Violence: A global public health problem. (2002). In E. Krug, L. L. Dahlberg, J. A. Mercy, A. B. Zwi, & R. Lozano (Eds.), World report on violence and health (pp. 1-21). Geneva, Switzerland: World Health Organization; and Centers for Disease Control and Prevention. (2002). The Social-Ecological Model: A Framework for Prevention. Atlanta, GA: Author. Available at https://www.cdc.gov/violenceprevention/about/social-ecologicalmodel.html

advance racial equity. In particular, NC DSS focused on promoting racial diversity, equity, and inclusion within child welfare through dedicated staffing, training, and structuring assessment to be consistent across all client groups.

Cross-System Partnership. Last year, the CCPT Board recommended improving communication between local CCPTs and local Systems of Care (SOC) collaboratives, especially during Medicaid Transformation that will affect behavioral health coverage of families served by child welfare. Repeatedly, CCPT surveys have identified the need for better access to services. NC DSS has added new staffing to encourage information sharing across CCPTs and SOCs.

Safety Organized Practice. On the 2021 survey, some teams urged moving forward a state-wide practice model for public child welfare. North Carolina has adopted safety organized practice as its model and is training the child welfare workforce on this approach. Safety organized practice has three main components: (1) building strong relationships among child welfare, families, and community supports; (2) using critical thinking and decision-making tools to support consistent, accurate, and equitable assessment; and (3) developing collaborative plans between child welfare and families to enhance child safety and family well-being.

CCPT Advisory Board

The CCPT Board has carried out work in five main areas. First, the Board oversaw the local CCPT survey and, using the survey results, developed a set of recommendations to NCDHHS on improving public child welfare in North Carolina. Work has already commenced on preparing the 2022 survey. Second, as previously noted, the Board has worked on guidance for local teams on prenatal substance exposure and near fatalities due to suspected child maltreatment. The guide on infants who are substance affected has been disseminated to the chairs of the local CCPTs. The guide on near fatalities is in process. Third, the Board has begun work on revising a manual for CCPT teams. Fourth, the Board has kept abreast of current state and national trends affecting child welfare and citizen review panels. Fifth, the Board has appointed a vice-chair to provide leadership with the chair and has added members in order to enhance its range of expertise and deepen its understanding of issues faced by local CCPTs. Orientation has been provided to new Board members, and NC DSS designated one staff member, rather than rotating staff, to support the Board.

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 85 CCPTs, although response numbers may vary for certain survey items based on the operational status of counties and number of valid responses. A list of the counties of the 2021 responding CCPTs can be found in appended Table A-2.

The 2021 response rate of 85 CCPTs was in the higher range as compared with previous years (2012 to 2020) 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 41 (80%) of the 51 small counties, 34 (87%) of the 39 medium counties, and 10 (100%) of the 10 large counties (see appended Table A-3)[24].

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 2021, there were six LME/MCOs for the 100 counties. The survey included members from all LME/MCOs: Member county participation ranged from 73% to 100% (see Table A-4).

As seen in Table 1, the large majority (72%) of respondents characterized themselves as an "established team that meets regularly." This is 12 percentage points lower than in 2020 when 84% 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.

Number of CCPTs by Status of Establishment as a Team, 2021 (N = 85)

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

Status	Number of CCPTs	
We are an established team that meets regularly	61	(71.8%)
We are an established team that does not meet regularly	12	(14.1%)
Our team recently reorganized, and we are having regular meetings	4	(4.7%)
Our team was not operating, but we recently reorganized	3	(3.5%)
Our team recently reorganized, but we have not had any regular meetings.	2	2.4%
Our team is not operating at all	2	(2.4%)
Other	1	(1.2%)

[24] 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/

CCPTs have the option of combining with their local CFPT or keeping the two teams separate. CFPTs are responsible for reviewing cases of child death where maltreatment is not suspected. CCPTs review active cases and child fatalities where death was caused by 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 80 teams that were established or operating at some capacity, 59 (74%) of the counties opted to have combined teams, and 19 (24%) 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, and 80% in 2020.

In summary, 85 of the local teams responded to the survey in 2021, a number that is in the higher range for responses since 2012. The participating CCPTs encompassed all state regions, county population sizes, and the six LME/MCOs that provide MH/DD/SU services. Just under three-quarters (74%) of the responding CCPTs stated that they were "an established team that meets regularly," lower than in 2020 when 84% of the reporting counties identified themselves as an established team that meets regularly. The decrease is most likely due to continued adjustment to accommodate remote meetings and staffing shortages, but nevertheless, the CCPTs as a whole were sufficiently established to make significant contributions to child welfare. Among the responding teams, 74% were combined with their local CFPT. Although the percentage of combined teams slightly fell from the prior year, 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 (60%), by the team as a whole (12%). The response "other" was selected by 10 counties. Of these 10 counties, most indicated that the CCPT Chair completed the survey with input from specific team members such as the CFPT Chair, Program Managers, Review Coordinator, or simply other team members. The time period available for completing the survey was extended to three months in acknowledgment of delays in data provision from the state.

Number of CCPTs by Who Completed the 2021 Survey (N = 85)

Table 2 Number of CCPTs by Who Completed the Survey

Status	Number of CCPTs	
The CCPT chair on their own	51	(60%)
The CCPT team as a whole	10	(11.8%)
Other	10	(11.8%)
A designee of the CCPT chair on their own	8	(9.4%)
A subgroup of the CCPT team	6	(7.1%)

In summary, the survey encouraged CCPT chairs to seek input from team members on their responses. The ability of teams to convene to develop their responses was likely limited by the survey being open during holiday months, although a lengthy extension was given to those who had not submitted a completed survey by the January 14th, 2022 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 2021 survey inquired about the following seven main questions:

1. What difficulties does the pandemic pose to team operations and to families in the community?
2. Who takes part in the local CCPTs, and what supports or prevents participation?
3. Which cases do local CCPTs review, and how can the review process be improved?
4. What limits access to needed mental health, developmental disabilities, substance use, and domestic violence services, and what can be done to improve child welfare services?
5. What local issues affect taking a racially equitable approach to child welfare?
6. What are local CCPTs' recommendations for improving child welfare services?
7. What are local CCPTs' objectives, and what helps them meet these objectives?

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

D. Pandemic Impact on Team Operations and Families

The prior year's survey found that the first year of the coronavirus pandemic adversely affected the capacity of CCPTs to meet, review cases, and reach out to the community. This year's survey checked back to see how the teams were faring in the second year of the pandemic and, going a step further than the 2020 survey, inquired about the pandemic's impact on protecting children and supporting families involved with child welfare. There was extensive overlap in the responding teams for the two years. As shown in Table B-6, 79 teams completed the survey in both 2020 and 2021.

Impact on Team Operations

The large majority of CCPTs in 2021 reported that the coronavirus pandemic affected their team operations. Nevertheless, the percentage of those experiencing operational difficulties fell somewhat from 85% in 2020 to 77% in 2021. By the second year, teams had become more accustomed to meeting virtually or had developed other approaches such as hybrid meetings to accommodate differences in members' preferences and needs. Rural counties were more likely to have challenges with virtual formats because of their lack of broadband internet or cellular services.

Compared to the teams affected by the pandemic, those whose operations were unaffected were more likely to be an established team meeting regularly. The survey asked CCPTs, "Has the pandemic affected your team's operation?" (See Appendix C). Most of the 85 teams, 65 (77%) acknowledged that the pandemic affected their operations, leaving a minority (20, 23%) responding that the pandemic did not have an impact. Overall, the survey responses did not appear to be affected by county size or by team status as a combined or separate CCPT and Child Fatality Prevention Teams (CFPT). However, responses were affected by the extent to which the team was established operationally.

As seen in Table 3, the 20 teams that did not experience an impact on their team operations, all characterized themselves as "an established team" with 17 meeting regularly and 3 of them not meeting regularly. Most CCPTs (52%) that experienced some impact on their team functioning likewise were established teams meeting on a regular basis, a decrease from last year's 81%. The remaining teams that were impacted by the pandemic had recently reorganized (9) or were established but not meeting regularly.

Effects of the Pandemic by CCPT Operational Status (N=85)

Table 3 Effects of the Pandemic by CCPT Operational Status

	Has the pandemic affected your team's operation?	
CCPT Operational Status	No	Yes
We are an established team that meets regularly	17 (20%)	44 (51.8%)
We are an established team that does not meet regularly	3 (3.5%)	9 (10.6%)
Our team recently reorganized, and we are having regular meetings	0 (0%)	4 (4.7%)
Our team was not operating, but we recently reorganized	0 (0%)	3 (3.5%)
Our team recently reorganized, but we have not had any regular meetings.	0 (0%)	2 (2.4%)
Our team is not operating at all	0 (0%)	2 (2.4%)
Other	0 (0%)	1 (1.2%)

As was the case last year, the survey question about the pandemic's effect on team operations prompted extensive comment (see Appendix C). Out of the 65 teams responding *yes,* 64 described the impact. In some regards, their 2021 responses paralleled those in 2020. They

continued to struggle with holding meetings, having sufficient attendance, encouraging discussion at a distance, sharing confidential information for case reviews, and planning for community events.

This year, though, the tenor had shifted. Their words reflected a deep level of exhaustion after dealing with prolonged staffing shortages and excessive workloads, reduced community services that had already been inadequate, and their personal illness or illness in their own families.

The Health Department, DSS and School System are three of the biggest partners of our CCPT and we have been overwhelmed since March 2020 due to COVID.

CCPTs were keenly aware that reviewing cases was stymied by the capacity of their members to take part. As a result, they found it challenging to identify cases to review and to have "diversity on who presents cases." Their partners, likewise swamped by the demands of the pandemic, delayed providing necessary information, such as medical records and fatality reports.

Our meetings are triggered by release of fatality reports from Raleigh – they say these have been delayed due to COVID.

Impact on Children and Families

For those teams who had indicated that the pandemic affected their operations, a follow-up survey question delved further into the impact of the pandemic. The question asked them to "describe any barriers COVID-19 posed to facilitating the protection of children?" Again, the written responses were extensive (see Appendix C): Out of the 65 who had responded *yes* to the pandemic affecting team operations, 51 (78%) described the impact on families in their communities.

A minority of respondents voiced that their services were "still functioning normally." This group noted adhering to public health protocols to ensure safe visitation: completing visits "outside and at a distance," "use of video conferencing in lieu of face to face contact," and "wearing PPE" [personal protective equipment].

Some other counties, however, had difficulty following these protocols. For instance, one small county spoke of the "initial lack of distribution of PPE to non-public health staff (frontline social workers, economic services workers, etc.)." Another county pointed out that families also had their worries about contracting coronavirus and were reluctant to increase their exposure through home visits. The same concern applied to foster care when children were admitted while COVID positive.

The toll on workers was heavy. "Staff continued to facilitate the protection of children amidst the ongoing C19 pandemic; however, as it has continued, staff are fatigued and exhausted." One small county reported, "Covid-19 has wiped out the child welfare workforce. I have one of four workers on my blended in-home/assessment team." A medium-sized county found that "the rate of turnover increased exponentially, staffing was an issue when an area was infected. Staff in CPS have no means to work cases virtually." New staff in a large county were "faced with very

challenging families" and "could not always access co-worker or supervisor support." The "burnout and turnover" extended to "front workers," including "social workers, school personnel, and medical personnel."

> *Our team also saw an increase in CPS cases and within those, an increase in the severity/complexity of those cases. This, in turn, leads to staffing turnover and shortages.*

A major concern appearing across the responses was difficulty monitoring and assessing children's safety.[25] Some of the difficulties stemmed from workers' needing to protect themselves because of families having COVID. Counties also observed a "significant drop in reporting" as schools moved from in-person to virtual learning formats. As a result, one county reported that their "top reporter went from being teachers to cops." Not able to access children at school or in their homes, the fear was that COVID "secluded children often from a safe adult to tell" about their need for protection.

A frequently expressed concern was that COVID greatly reduced community support to children and their families. For instance, they noted a "severe need for child care facilities in the county" and "lack of domestic violence batterer services." As found in the general population, "parents have reported not accessing medical and other services because they are afraid of COVID." During this time, public transportation fell in some counties, further impeding service access. "Treatment for mental health, substance abuse . . . [became] much more difficult as appointments moved to virtual platforms" and waiting lists lengthened. Telehealth was not conducive to therapy with children, and families often could not avail of such services because of their lack of technology. Waiting lists lengthened and delayed appointments for "eight weeks to six months."

> *Internet service, WiFi and cell service are limited in our rural county, which made accessing virtual appointments more difficult.*

Over the year, the legal system also struggled. Courts stopped convening in-person early in the pandemic, and the move to online platforms did not help workers understand "court dynamics." Larger counties especially experienced large backlogs in child welfare court cases. In one county, "prosecutions stopped entirely during COVID" with the result that "persons charged with crimes against children have not been held accountable in a timely manner." Moreover, during the pandemic, "bail was set lower than previously, so persons charged with crimes against children were more likely to be out of custody during that time, which is concerning."

The most troubling observations concerned the pandemic's impact on children, youth, and their families. Virtual learning led to truancy, affecting children's learning and mental health. With families confined to the home, child-parent tensions escalated at the same time as external support declined. The pandemic "greatly affected mental health resources for youth and adults"

[25] According to the NC data management system, over 2020 and into early 2021, referrals fell from pre-pandemic levels for children considered at risk, but these declines were not as steep for substantiations, placements, and exits from care. 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 (v3.2). Retrieved May 10, 2022, from the University of North Carolina at Chapel Hill Jordan Institute for Families website. URL: http://ssw.unc.edu/ma/

and saw “an increase in substance use and decrease in services.” With added pressures, “some parents [became] more difficult to work with and that caused suspension of community services and resources that would keep their children safe.” The most chilling was the report that “DSS workers are not visiting foster children directly,” and this contributed to “at least one tragic death.”

In summary, by the second year of the pandemic, most CCPTs identified detrimental impacts on the functioning of their teams. There was extensive overlap in the responding teams for 2020 and 2021. As in the first year of the pandemic, teams struggled to meet, conduct case reviews, and reach out to the community. The main difference between the two years was their membership experiencing a much deeper level of exhaustion from prolonged staffing shortages and resulting in excessive workloads. The impact did not appear to be affected by county size or by team status as a combined or separate CCPT and Child Fatality Prevention Teams (CFPT). Responses, however, were affected by the extent to which the team was established operationally. The spill over into the lives of families was clearly evident. With added pressures from the pandemic, family situations had worsened and become more complex. Heavy worker turnover meant that new workers lacked guidance from more seasoned staff, and reduced community services meant that families were not receiving essential services to address aggravated mental health and substance use issues. CCPTs expressed concern that services were unable to assess and support families. In at least one instance, inadequate monitoring of a foster home contributed to a child fatality. Risks were heightened by court backlogs and suspension of prosecutions against persons charged with crimes against children.

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. Table 4 identifies these mandated members for combined CCPTs and CFPTs. Table 5 identifies these mandated members for separate CCPTs and their levels of participation on the team during 2021. 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 closely by the DSS Director, and health care providers and mental health professionals both being reported as the third most frequently in attendance. Among separate CCPTs, DSS staff was the most frequently reported attendee, followed by law enforcement and health care providers being reported as the second most frequent attendees, and mental health professionals as the third most frequent. On average, health care providers, mental health professionals, and guardians ad litem were frequently present across both groups. What needs to be kept in mind is that although participation rates varied across the mandated members, some mandated members in all categories participated frequently or very frequently. For instance, within the separate CCPT group, the School Superintendent had the lowest average participation level but still had 2% taking part frequently and another 6% taking part very frequently. For CCPT/CFPTs, participation levels were much more variable across members. Most notably, the district court judge and the parent of a child fatality victim had the lowest participation rates. Over half of district court judges (64%) and parents of child fatality victims (69%) never participated.

Mandated Members for Combined CCPT/CFPT and Reported Frequency of Participation, 2021 (N=61)

Table 4 Mandated CCPT/CFPT Members and Reported Frequency of Participation

Mandated Member	Never	Rarely	Occasionally	Frequently	Very Frequently	Mean
DSS Staff	3 (4.9%)	0 (0%)	1 (1.6%)	6 (9.8%)	51 (83.6%)	3.67
DSS Director	5 (8.2%)	3 (4.9%)	5 (8.2%)	10 (16.4%)	38 (63.1%)	3.20
Health Care Provider	3 (4.9%)	2 (3.3%)	9 (14.8%)	15 (24.6%)	32 (52.5%)	3.16
Mental Health Professional	5 (8.2%)	1 (1.6%)	5 (8.2%)	18 (29.5%)	32 (52.9%)	3.16
Health Care Provider	3 (4.9%)	2 (3.3%)	9 (14.8%)	15 (24.6%)	32 (52.5%)	3.16
Guardian ad Litem Coordinator or Designee	8 (13.1%)	3 (4.9%)	5 (8.2%)	16 (26.2%)	29 (47.5%)	2.90
Public Health Director	11 (18.3%)	0 (0%)	8 (13.3%)	13 (21.7%)	28 (46.7%)	2.78
Law Enforcement	6 (10%)	7 (11.7%)	8 (13.3%)	15 (25.0%)	24 (40%)	2.73
School Superintendent	10 (16.7%)	5 (8.3%)	6 (10.0%)	18 (30.0%)	21 (35.0%)	2.58
Community Action Agency Director or Designee	10 (16.4%)	8 13.1%)	10 (16.4%)	9 (14.8%)	24 (39.3%)	2.48
County Board of Social Services	17 (20.0%)	2 (43.3%)	8 (13.1%)	9 (14.8%)	25 (41.0%)	2.38
EMS Representative	17 (27.95)	9 (14.8%)	11 (18.0%)	9 (14.8%_	15 (24.6%)	1.93
Local Child Care Facility	18 (29.5%)	10 (16.4%)	11 (18.0%)	10 (16.4%)	12 (19.7%)	1.80
District Attorney	18 (29.5%)	12 (19.7%)	8 (13.1%)	12 (19.7%)	11 (18.0%)	1.77
County Medical Examiner	30 (50.0%)	9 (15.0%)	8 (13.3%)	3 (5.0%)	10 (16.7%)	1.23
Parent of Child Fatality Victim	36 (59.0%)	6 (9.8%)	9 (14.8%)	3 (4.9%)	7 (11.5%)	1.00
District Court Judge	39 (63.9%)	6 (9.8%)	3 (4.9%)	7 (11.5%)	6 (9.8%)	.93

Note. 0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently. Counts are reported, with percentages out of 61 CCPT/CFPTs in parentheses.

Mandated Members for Separate CCPT and Reported Frequency of Participation, 2021 (N=19)

Table 5 Mandated CCPT Members and Reported Frequency of Participation

Mandated Member	Never	Rarely	Occasionally	Frequently	Very Frequently	Mean
DSS Staff	0 (0%)	0 (0%)	2 (10.5%)	2 (10.5%)	15 (78/9%)	3.68
Mental Health Professional	0 (0%)	0 (0%)	3 (15.8%)	2 (10.5%)	14 (73.7%)	3.58
Guardian ad Litem Coordinator or Designee	4 (21.1%)	0 (0%)	2 (10.5%)	2 (10.5%0	11 (57.9%)	2.84
Law Enforcement	3 (15.8%)	1 (5.3%)	5 (26.3%)	1 (5.3%)	9 (47.4%)	2.63
DSS Director	1 (5.3%)	2 (10.5%)	6 (31.6%)	4 (21.1%)	6 (31.6%)	2.63
Community Action Agency Director or Designee	3 (15.8%)	1 (5.3%)	3 (15.8%)	6 (31.6%)	6 (31.6%)	2.58
Health Care Provider	4 (21.1%)	0 (0$)	7 (36.8%)	0 (0%)	8 (42.1%)	2.42
District Attorney	8 (42.1%)	1 (5.3%)	3 (15.8%)	3 (15.8%)	4 (21.1%)	1.68
Public Health Director	7 (36.8%)	1 (5.3%)	3 (15.8%)	0 (0%)	8 (42.1%)	2.05
County Board of Social Services	9 (47.4%)	1 (5.3%)	1 (5.3%)	2 (10.5%)	6 (31.6%)	1.74
School Superintendent	9 (50.0%)	0 (0%)	3 (16.7%)	1 (5.6%)	5 (2%)	1.61
County Board of Social Services	9 (47.4%)	1 (5.3%)	1 (5.3%)	2 (10.5%)	6 (31.6%)	1.74

Note. 0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently
Counts are reported, with percentages out of 19 CCPTs in parentheses.

b) Mandated Member Participation by Mean Rate and Rank

In the 2021 survey, participation of mandated members was tracked for both CCPTs and CCPT/CFPTs. Table 6 shows that for all three years the ranked participation rates of the mandated members were almost identical. At the top in rank over the three years were DSS staff and mental health professionals, however, this year for the combined teams, the DSS director was ranked second. 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. Parents of child fatality victims, county medical examiners, and district attorneys were ranked lowest for participation among combined CCPT/CFPTs, continuing patterns from previous years.

Mandated Separate CCPT and Combined CCPT/CFPT Members and Mean Rate and Rank of Participation 2019, 2020 and 2021

Table 6 Mandated CCPT and CCPT/CFPT Members and Mean Rate and Rank of Participation

Mandated Member	2019 CCPT (*N*=13) Average (Rank)	2019 CCPT/CFPT (*N*=73) Average (Rank)	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)
DSS Director	3.88 (4)	3.16 (4)	2.67 (5)	3.10 (4)	2.63 (4)	3.20 (2)
DSS Staff	4.94 (1)	3.90 (1)	3.67 (1)	3.71 (1)	3.68 (1)	3.67 (1)
Law Enforcement	3.53 (7)	2.91 (7)	2.53 (6)	2.90 (7)	2.63 (4)	2.73 (7)
District Attorney	3.24 (9)	1.88 (13)	1.53 (10)	1.95 (12)	1.68 (10)	1.77 (13)
Community Action Agency	3.24 (10)	2.68 (8)	2.20 (7)	2.52 (8)	2.58 (7)	2.48 (10)
School Superintendent	3.41 (8)	2.24 (10)	1.13 (11)	2.50 (9)	1.61 (11)	2.58 (8)
County Board of Social Services	2.44 (11)	2.20 (12)	2.07 (9)	2.10 (11)	1.74 (9)	2.38 (9)
Mental Health Professional	4.59 (2)	3.44 (2)	3.20 (2)	3.26 (2)	3.58 (2)	3.16 (3)
Guardian ad Litem	3.94 (3)	3.07 (5)	2.87 (4)	2.95 (5)	2.84 (3)	2.90 (5)
Public Health Director	3.65 (6)	3.07 (6)	2.13 (8)	2.94 (6)	2.05 (8)	2.78 (6)
Health Care Provider	3.65 (5)	3.41 (3)	3.13 (3)	3.15 (3)	2.42 (6)	3.16 (3)
District Court Judge		.94 (16)		.73 (16)		.93 (16)
County Medical Examiner		1.28 (14)		1.39 (14)		1.93 (14)
EMS Representative		2.26 (9)		2.19 (10)		1.93 (11)
Local Child Care or Head Start Rep		2.21 (11)		1.81 (13)		1.80 (12)
Parent of Child Fatality Victim		1.09 (15)		1.08 (15)		1.00 (15)

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

In summary, state law requires that local CCPT teams are composed of 11 members from specified agencies that work with children and child welfare. Additionally, state law requires that combined CCPT/CFPT teams are composed of 16 members from specified agencies that work with children and child welfare as well as Family Partners. The 2021 survey results, as well as those in prior years, show that mandated members varied in their level of participation. DSS staff, mental health professionals, guardians ad litem, and DSS directors were the most often present while the county boards of social services, 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 85 survey responses, 50 CCPTs reported between 1 and 20 additional organizational members and 13 CCPTs reported between 1 and 2 additional Family Partners and 3 counties reported 1-2 Youth Partner members. The survey provided space for the respondents to "list the organization/unit that additional members represent." Respondents listed a total of 162 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 courts, juvenile justice, and child developmental services. 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 Operations

By state statute, CCPTs are partially designed as information-sharing and policy-implementation groups. It is critical to understand whether or not CCPTs are operating to meet these goals.

1) CCPT Meetings

The CCPTs were asked how well they prepare for meetings as a whole. The question on the survey read: "How well does your CCPT prepare for meetings?" Among the 80 respondents, 34 (43%) indicated that they prepare very well for meetings, and 27 (34%) prepare well.
CCPT teams were asked how well they share information during meetings. Fifty (63%) of the respondents indicated that they share information very well. Twenty-one (26%) said that their team shares information well. CCPT teams identified key resources shared including: community resources and events, training and educational resources, grant opportunities,

meeting space, programs, and mental health resources. When asked to rate how well these resources were shared among members, the majority indicated they shared these resources well or very well (76%-80% across the three write-in options), however, some CCPTs indicated that they did not share these resources well at all (6%-26% across the three write-in options).

2) Community Change

The CCPT teams were asked how well their team has affected changes in their community. Ten (13%) of respondents indicated very well, 13 (17%) indicated well, 31 (39%) indicated moderately, 21 (27%) indicated marginally, and 4 (5%) 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 indicated that they were sharing resources well and provided a number of additional shared resources they had accessed. The majority of respondents indicated that they only had a moderate to marginal impact in effecting change in their community. Thus, CCPTs created a working environment in which they shared information and resources; however, they recognized that their ability to make changes was limited.

G. Family or Youth Partners

The survey also inquired specifically about Family or Youth Partners serving on the local teams. These are individuals who have received services or care for someone who has received services. Family and Youth Partners are not mandated CCPT members, but their inclusion is encouraged. An exception for a combined team is a parent of a deceased child as long as the parent fits the definition of a Family or Youth Partner.

1) Family or Youth Partner Participation Rates

In response to the question on whether they had Family or Youth Partners serving on their team, 8 (10%) out of 80 respondents said yes and 72 (90%) said no with five teams not responding. The percentage of Family or Youth Partner involvement is down slightly from 2020 where 10 (12%) out of 82 respondents said yes and 79 (89%) said no. In 2019, participation was 7% (6 out of 89). Family and Youth Partners engagement has been substantially lower in the last three years than in previous 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). Maintaining the questions from 2017, 2018, 2019, and 2020, the 2021 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. Several counties had multiple partners representing a single category, for example, one county reported 4 Biological Parents participating on their CCPT, and hence the number of Family and Youth Partners participating on CCPTs is 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 two-thirds (5, 66%) of the Family or Youth Partners. All categories' rates of participation ranged from never to very frequently.

Family or Youth Partners by Category and Reported Frequency of Participation, 2021

Table 7 Family or Youth Partners by Category and Reported Frequency of Participation

Category	Never	Rarely	Occasionally	Frequently	Very Frequently	Total Participation
Biological Parent	3	0	3	0	2	5
Kinship Caregiver	5	0	1	0	2	3
Adoptive Parent	4	0	1	0	2	3
Youth Partner	5	1	1	0	0	2
Guardian	6	0	1	0	0	1
Foster Parent	6	0	1	0	0	1
Other	6	0	0	0	0	0
Total	**35**	**1**	**8**	**0**	**6**	**15**

In summary, the survey asked if the CCPT included Family or Youth Partners. These are individuals who have received services or care for someone who has received services. This year, 10% of respondents indicated that Family or Youth Partners served on their CCPT or combined CCPT/CFPT, a decrease 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

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 8 respondents, 7 (83%) indicated that they had invited Family or Youth partners to attend CCPT meetings but only 4 (50%) 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 findings reveal that CCPTs had very few strategies that they leveraged to promote Family Partner engagement. Description of the role of the Family and Youth Partner and emphasis on the value the Family and Youth Partner role brings were the most commonly endorsed among the 7 respondents, with 4 (57%) respondents endorsing each. Overall, this strategy appears to have resulted in a lack of robust data, indicating that trends in strategies for Family Partner participation may fluctuate significantly from year to year.

Strategies for Engaging Family or Youth Partners, 2021 (N=7)

Table 8 Strategies for Engaging Family or Youth Partners

Strategies for Engagement	Frequency (Percent)
Emphasizing the value that Family and Youth Partners bring to the team	4 (57%)
Describing the role of the Family and Youth Partners on the team	4 (57%)
Repeatedly extending invitations by multiple means (e.g., phone, email) to possible Family and Youth Partners	3 (43%)
Having a senior agency representative extend the invitation	2 (29%)
Ensuring that discussions are in clear and understandable language for all participants	2 (29%)
Using team members already on the CCPT to offer family perspectives	1 (14%)
Rescheduling meeting times to accommodate Family and Youth Partners	1 (14%)
Providing information on opportunities available to participants (e.g., training)	1 (14%)
Preparing Family and Youth Partners for the meetings	1 (14%)
Outreach through community networks to identify Family and Youth Partners	1 (14%)
Explaining purpose of CCPTs in jargon-free and inviting language	1 (14%)
Drawing Family and Youth Partners into the meeting discussions	1 (14%)
Putting CCPT membership into Family and Youth Partner's job description	0 (0%)
Other	0 (0%)
Debriefing with Family and Youth Partners after meetings	0 (0%)

In summary, 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. The CCPT Board is hopeful that the Division will engage with CCPTs to support county specific approaches to supporting Family Partner engagement.

I. Factors Limiting the Participation of Family or Youth Partners

In previous years, CCPTs have been asked to provide a list of factors they believe limit Family Partner engagement. Although the respondents utilized the checklist for responding, the majority selected the category other and entered a unique factor which limited Family Partner participation in their CCPT. Among these qualitative responses, common themes such as COVID-19 barriers, lack of recruitment efforts, lack of commitment, problems identifying participants, confidentiality, and statutory prohibition issues were reported by respondents. These themes were similar to last year's results and should inform support provided to CCPTs to promote outreach and engagement strategies.

Factors Preventing Family Partners from Participating, 2021 (N=68)

Table 9 Factors Preventing Family Partners from Participating

Preventative Factors	Frequency (Percent)
Other	37 (54%)
Other commitments (e.g., school, work)	20 (29%)
Uncertainty about role	15 (22%)
Scheduling conflicts	14 (21%)
Lack of transportation	9 (13%)
Lack of reimbursement for time	8 (12%)
Lack of childcare	6 (9%)

Note. Percentages add up to more than 100 because counties could select multiple options.

When asked “which of the following reasons prevented your CCPT from engaging some family or youth on your team?” 76 CCPTs responded to at least one item on the checklist. Difficulty recruiting or identifying Family and Youth Partners was the most frequently cited barrier to Family Partner engagement. This is consistent with CCPTs limited reporting of strategies to engage Family Partners. Additionally, 11 respondents identified a unique factor preventing CCPTs from engaging Family Partners. These included, no efforts being made to do so, lack of meetings, managing priorities and mandates during COVID-19, case status preventing Family Partner engagement, and the perception that it is not permitted by statute.

Factors Preventing CCPTs from Engaging Family Partners, 2021 (N=76)

Table 10 Factors Preventing CCPTs from Engaging Family Partners

Preventative Factors	Frequency (Percent)
Difficulty recruiting or identifying Family and Youth Partners	37 (49%)
Sensitive nature of topics discussed	24 (32%)
Uncertainty about maintaining confidentiality	22 (29%)
Need for training on engaging Family and Youth Partners	22 (29%)
Lack of dedicated person to engage Family and Youth Partners	21 (28%)
Lack of resources to support participation (e.g., transportation, childcare, reimbursement for time)	18 (24%)
Other	11 (15%)

Note. Percentages add up to more than 100 because counties could select multiple options.

Overall, this strategy appears to have resulted in a lack of robust data, indicating that trends in barriers to Family Partner participation fluctuate significantly from year to year and are unique to each county and their respective cases, indicating a need for county specific approaches to supporting Family Partner engagement and participation.

In summary, CCPTs detailed at length the reasons preventing the participation of Family or Youth Partners on their teams. In addition to the significant difficulties posed by COVID-19, some of these reasons stemmed from the situation of the partners: logistical, such as unavailability of transportation, scheduling conflicts, and lack of reimbursement. However, overwhelmingly CCPTs identified reasons related to the team rather than Family or Youth Partners. These included uncertainties about how to recruit partners, how to maintain confidentiality, lack of time and resources to be allocated to Family Partner engagement strategies, and conflicts with current mandates and statutes. CCPTs asked for more guidance on bringing Family and Youth Partners onboard their teams. Thus, CCPTs identified the training and resources they would need for engaging families on their teams. The diversity in responses is indicative of a need for county specific support for Family Partner engagement.

J. Partnerships to Meet Community Needs

Besides their own teams, the CCPTs worked with other local groups to meet community needs. Survey questions on local initiatives and interagency collaborations were particularly timely this year. The pandemic increased community needs while impeding teams' capacity to carry out their functions, including community prevention efforts. Three survey questions inquired about local partners with whom the CCPT carried out initiatives and communicated about the findings from these initiatives, and another two asked about interagency collaborations and the CCPT's role in these groups.

Local Partnerships

The survey first asked: "During 2021, did your CCPT partner with other organizations in the community to create programs or inform policy to meet an unmet community need?" Among the

80 respondents, 25 (31%) answered *yes* that they did partner with other organizations and 55 (69%) responded *no*. Due to the continued impact of the pandemic, the percentages this year were lower than those in 2020 when 47% said that they were partnering. Counties of all sizes were well represented among those partnering on community needs.

A follow-up question for those partnering was: "If yes, describe the most important of these initiatives to meet a community need." Out of the 25 teams, only two provided information on these initiatives. This year one county engaged in a safe sleep initiative, and the other continued working towards initiatives from previous years with their Early Intervention Team and TEAM LED Diversion and Peer Support Program. The low rate of response in 2021 stands in stark contrast to the prior year, when 36 teams described their local initiative; however, many of these teams also identified that they had to cut short their initiative because of the impact of COVID. Their experience last year may have discouraged taking on initiatives in the second year of the pandemic.

Sharing Findings and Recommendations

A second follow-up question asked: "Who were the other organizations or groups at the local level, with whom you shared your CCPT's findings and recommendations resulting from the initiative?" Respondents included CCPTs that were involved or not involved in local initiatives this year.

Among the 55 teams that responded "no" to involvement in local initiatives, 10 wrote in names of groups with whom they communicated findings and recommendations. These groups were the team members' organizations, county commissioners, LME/MCO, county DSS board, county board of health, public health department, victim service agencies, juvenile justice, and the community at large.

Among the 25 teams currently involved in local initiatives, 24 specified groups with whom they shared findings and recommendations from local initiatives. For instance, one team wrote, "Police, Fire, EMS, Hospital, Obstetricians, Local Parent Groups, Specific Communities." Another CCPT elaborated on their system of communication and collaboration, "Local Hospital/Medical Professionals on CCPT/CFPT, developed additional screening tools to be used on all patients at the hospital to identify risk factors of substance use so they can be referred to DSS for plans of safe care."

In summary, the pandemic deepened community needs while seeming to stall CCPTs from taking on new local initiatives. In the prior year, many CCPTs had to cut short their initiatives because of the pandemic, and this experience may have discouraged teams from taking on initiatives in 2021. Nevertheless, 25 out of the 80 CCPTs (31%), partnered with other organizations to pursue community efforts, initiatives, and communications. Their partners were wide-ranging and included public agencies, nonprofit organizations, faith communities, and businesses. This year, the diversity in partnerships and collaboration mirrored that of previous years extending beyond "traditional team members." The collaboratives ensured that their findings and recommendations were communicated widely in their counties.

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

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

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

The expectation is that CCPTs examine cases of child maltreatment, and, accordingly, the CCPT mandate is different from that of the CFPTs, who are responsible for reviewing additional child fatalities. North Carolina General statute §7B-1401 (1. defines additional child fatalities as "any death of a child that did not result from suspected abuse or neglect and about which no report of abuse or neglect had been made to the county department of social services within the previous 12 months").

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

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

1) Child Maltreatment 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 cases (active cases) reviewed by your CCPT between January and December 2021?" Of the 80 responding counties, 66 (83%) reported having reviewed at least one active case, the number of cases reviewed ranged from 1-72, with a total of 471 cases being reviewed by counties in 2021. However, it should be noted that some combined CCPT/CFPT counties may have reported preliminary reviews in their survey responses that were not selected for full review based on relevant criteria. This may partially contribute to the increase in total cases reviewed from 2020 to 2021. Next year's survey will be adjusted to provide additional clarity regarding which cases to include in the count.

The survey then asked, "How many of these cases entailed Substance Affected Infants?" Of the 60 counties who indicated they reviewed at least one active case, 26 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 1-4, with a total of 47 active cases with a Substance Affected Infant being reviewed. Next the survey asked, "How many of the active cases entailed near fatality?" Of the 60 counties who indicated they reviewed at least one active case, only 5 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 5 counties was 1 for a total of 5 cases being reviewed that met these criteria. The low number of near fatalities reviewed may be a result of the lack of notification to teams about reviewing these types of cases and reflect the need for NC DSS and DSS directors to provide such notification.

Number of Child Maltreatment Reviews by Combined/Separate Status, 2021

Table 11 Number of Child Maltreatment 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	48	337	0	72	5.71	9.66
Active Cases Reviewed with SAI: CCPT/CFPT	17	31	0	4	0.53	1.08
Active Cases Reviewed with Near Fatality: CCPT/CFPT	1	1	0	1	0.02	0.13
Active Cases Reviewed: CCPT	17	134	0	16	7.05	4.49
Active Cases Reviewed with SAI: CCPT	9	16	0	3	0.84	1.07
Active Cases Reviewed with Near Fatality: CCPT	4	4	0	1	0.21	0.42

Note. A case may have more than one type of review. Standard Deviation (SD)

Table 12 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 but on average the large counties reviewed two or three times the number of cases than the small and medium size counties. Within each county-size group, especially for the largest counties, there was extensive variation in how many cases they reviewed.

Number of Child Maltreatment Cases Reviewed by County Size, 2021, (N=66)

Table 12 Number of Child Maltreatment Cases Reviewed by County Size

Size of County	Number of Respondents Reporting Cases	Number of Cases Reviewed	Mean	SD	Range
Small	29 (56.9%)	210	5.68	4.76	0-17
Medium	27 (67.5%)	129	3.91	3.77	0-16
Large	10 (100%)	138	13.80	20.57	4-72

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.

Maltreatment Fatalities

The 2021 survey then went on to ask, "In your county, does the CCPT conduct maltreatment fatality reviews separate from the intensive reviews?" Of the 79 CCPTs who responded to this question, 38 (48%) conducted maltreatment fatality reviews separate from Intensive reviews and 41 (52%) did not. As a follow up question, the CCPTs who responded *no* were asked, "Do you have a separate team that conducts these reviews?" Of the 41 CCPTs who responded *no*, 11 (27%) had a separate team that conducted these reviews and 29 (71%) did not, one team did not provide an answer to the follow up question.

Next the survey asked, "If your CCPT conducts fatality reviews outside of intensive reviews, how many met the criteria for a local review?" A total of 19 CCPTs indicated that at least one of their fatality reviews, outside of intensive reviews, met the criteria for a local review. The number of reviews meeting the criteria for a local review ranged from 1-72 with a total of 151 cases meeting the criteria. The survey then drilled down and asked CCPTs, "How many of the fatalities reviewed were Substance Affected Infants?" A total of 12 CCPTs indicated that at least one fatality case that was reviewed was a Substance Affected Infant. The number of cases that were reviewed with these criteria ranged from 1-5 with a total of 22 Substance Affected Infant fatality reviews conducted among the 12 CCPTs.

Reporting

The survey then sought to enquire 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 asked, "When an intensive review occurs, tell us how your local team handles the local review?" A total of 51 counties provided qualitative responses other than "not applicable." The responding CCPTs provided a range of responses indicating that the approaches vary 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 do 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. One team wrote, "When the ICFR is completed and the report received, the CCPT/CFPT reviews the document to identify strategies to address systems issues. We then

follow up on implementation of actions recommended and if there were positive results." Furthermore, CCPTs indicated that involvement from or communication with other organizations or persons outside of the team can either help or hinder the process and outcomes. For example, one CCPTs wrote, "The Department of Social Services provides pertinent case information to the community partners and an open discussion occurs to discuss solutions and resources that would benefit the case." While yet another indicated that "[an] Outside presentative tells us she is coming and we establish a team. We don't like it though because we don't feel anything useful is ever done with our findings and we feel that our findings are not always accurate because they are so influenced by facilitators." Overall, there was quite a range of responses to this new survey question 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.

Next the survey asked, "Were there any issues identified in the reporting process during your review?" Of the 50 CCPTs who responded, only 4 (8%) had issues with reporting and 46 (92%) did not, 35 CCPTs did not respond to this question. Finally, the survey asked, "In reviews of active or fatality cases did you identify any issues related to the report of Substance Affected Infants in accordance with the law?" Of the 76 CCPTs who responded, only 6 (8%) had issues reporting SAI and 70 (92%) did not; 9 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 2021, 80 (94%) of the 85 responding CCPTs reviewed 622 cases, although this may be inflated due to the inclusion of preliminary case reviews from combined CCPT/CFPTs. The 622 cases included 471 active cases and 151 child fatalities. Among these cases were 79 infants who were affected by substances and only 5 cases of near fatalities. Large counties reviewed two to three times more cases on average than small or medium counties. Five CCPTs did not indicate that they reviewed any cases, possibly due to their status of not being an established team. 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

The survey asked about the criteria that the teams applied for selecting cases to review. The teams were provided a list of 12 criteria and could write in two additional reasons. As shown in Table 13, the most common reason cited by 65 (86%) out of the 76 respondents was that the case was active. This is in keeping with the expectation of state statute that CCPTs select "active cases in which children are being served by child protective services." Statute also charges the teams with reviewing "cases in which a child died as a result of suspected abuse or neglect." Among the respondents, 25 (33%) stated that they selected child maltreatment fatalities for review. In addition to these statutory requirements, the CCPTs identified other selection criteria. Along with active cases, the most frequently selected, at 70% or higher, were the criteria of child safety, repeat maltreatment, and multiple agency involvement. Last year's survey asked about parent opioid use. This year's survey asked about parent substance use. The number of CCPTs selecting cases for review because of any types of parent substance use increased the responses from 42% for opioid use to 70% for the broader category of parent substance use. Fifty-one of the respondents added a selection criterion, and five of these provided two criteria. The additions

included “mental health needs,” “substance use,” “domestic violence,” “service needs for undocumented citizens,” and “cases selected by DSS.”

Case Criteria Used by CCPTs for Selecting Child Maltreatment Cases for Review, 2021, (N=76)

Table 13 Case Criteria Used by CCPTs for Selecting Child Maltreatment Cases for Review

Selection Criterion	Number of CCPTs	
Active Case	65	(85.5%)
Child Safety	60	(78.9%)
Multiple Agencies Involved	58	(76.3%)
Repeat Maltreatment	55	(72.4%)
Child and Family Well-Being	54	(69.7%)
Parent Substance Use	53	(69.7%)
Stuck Case	52	(68.4%)
Court Involved	42	(55.3%)
Child Permanency	36	(47.4%)
Other 1	34	(44.7%)
Child Maltreatment Fatality	25	(32.9%)
Other 2	17	(22.4%)
Closed Case	15	(19.7%)
Child Trafficking	13	(17.1%)

Note. The sample includes the 76 respondents that had at least one case review

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 14 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 59 (80%) CCPTs and emotionally disturbed state cited by 57 (77%) CCPTs. Four other factors used by over 50% of CCPTs pertained to caretaker’s alcohol use, 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, 2021, (N = 74)

Table 14 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	59	(79.7%)
Mental Health Need	57	(77.0%)
Alcohol Use	40	(54.1%)
Lack of Child Development Knowledge	34	(45.9%)
Intellectual/Developmental Disability	19	(25.7%)
Other Medical Condition	14	(18.9%)
Learning Disability	14	(18.9%)
Visually or Hearing Impaired	4	(5.4%)
Children/Youth		
Mental Health Need	53	(71.6%)
Behavior Problem	40	(54.1%)
Drug Problem	22	(29.7%)
Other Medical Condition	22	(29.7%)
Intellectual/Developmental Disability	16	(21.6%)
Learning Disability	15	(20.3%)
Alcohol Problem	12	(16.2%)
Physically Disabled	7	(9.5%)
Visually or Hearing Impaired	3	(4.1%)
Household		
Domestic Violence	48	(64.9%)
Inadequate Housing	37	(50.0%)
Financial Problem	30	(40.5%)
Public Assistance	30	(40.5%)

In summary, state statute requires that CCPTs review two types of cases: active cases and child maltreatment fatalities. Most (86%) respondents selected active cases for review. Child maltreatment fatality was given as a reason for case selection by 33% 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 multiple agency involvement and repeat maltreatment, both identified by over 70% 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 59 (80%) CCPTs and caretaker's mental health need cited by 57 (77%) CCPTs. Four other factors used by over 50% of CCPTs pertained

to caretaker's alcohol use, child/youth 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 15). Out of the 79 respondents, 87% used case files and 80% used reports from members and/or case managers. Over half (72%) 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 2020 surveys; however, reported use of these types of information is notably lower in 2020 but has risen based on this year's data. This may have been a function of workers working remotely and not being able to access and share materials in the office. CCPTs also wrote in some other information sources, including: social worker presentations and medical, school, police, and military records, similar to previous years.

Type of Information Used by CCPTs for Reviewing Cases, 2021, (N=79)

Table 15 Type of Information Used by CCPTs for Reviewing Cases

Type of Information	Number of CCPTs
Case Files	69 (87.3%)
Reports from Members and/or Case Managers/Behavioral Health Care Coordinators/Care Managers	63 (79.7%)
Information on Procedures and Protocols of Involved Agencies	57 (72.2%)
Child and Family Team Meeting Documentation	37 (46.8%)
Medical Examiner's Report	30 (38.0%)
Individualized Education Plan	26 (32.9%)
Other 1	25 (31.6%)
Other 2	13 (16.5%)

Ways to Improve Case Reviews

In 2021, the survey asked teams, "What would help your CCPT better carry out case reviews?" Among the 80 established teams, 49 (61%) provided a means of improving their review process and 31 (39%) did not. The methods offered in 2021 overlapped extensively with those in 2020 as the pandemic has continued to influence how the teams carry out case reviews.

Some teams responded that they were quite satisfied with their review process. They wrote about having a process that works, one CCPT said, "The team is good about sharing information, there are no suggestions for improvement" or that "The team feels case reviews are well coordinated and all members cooperate and participate." Others noted that the pandemic affected their process. Some reported that they were waiting to "get back in person" to resume their case reviews. Many of the themes were interconnected such as the need for "funds for a part time coordinator to track down information" due to the lack of communication and sharing of relevant information between agencies and offices. For example, one CCPT wrote "that the presenting

Social Workers don't have time to prepare their presentation because of other work duties." While another wrote, "Cases sometimes cannot be reviewed as the team is awaiting medical records." Their responses indicate the need for additional resources to track down this information if it is not being voluntarily shared in a timely manner. Many CCPTs also reported the need for more time to conduct case reviews and more involvement from participants, agencies, communities, and Family Partners.

Others noted areas for improvement that local teams could undertake:

- *Timely access to information,* including "timely receipt of cases to be reviewed from the state" as many CCPT are waiting for "DSS to present cases" to start conducting reviews.
- *Better structuring of meetings*, by having "a quarterly agenda item to submit," presentation of cases "from each agency on a rotating basis," and having "a standardized tool for collecting and compiling data."
- *More supports for conducting reviews,* such as "utilizing and learning CCPT policy" by having an "internal refresher with CCPT members and DSS CS staff to set case review expectations with a review of the CCPT purpose, duties and roles, and how case reviews guide advocacy and recommendations."

In summary, the local teams figured out ways to operate during a pandemic but missed their in-person meetings. CPPTs outlined ways that they could improve their review process: These included recruiting family and community representatives, having more consistent participation, more consistent meetings, developing structure for meetings, and enhancing access to case information to facilitate a timely review process. They also recommended ways that DHHS could strengthen the review process, by expediting notifications of fatality cases, clarifying policies, roles, and expectations while also providing technical assistance and tracking tools.

L. 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 2021 needed access to MH/DD/SU/DV/CT services. Table 16 summarizes the findings first for the children and second for the parents or other caregivers. Here, 54 of the respondents identified MH needs of children in a total of 243 cases. A total of 30 respondents identified SU service needs and 23 identified DV services needs for children; however, SU and DV services were required in 79 and 77 cases respectively. These numbers are on par with 2020 data which indicated a need for SU and DV services for 78 cases. I/DD services were needed for children in 33 cases. Child trafficking services were needed in 6 cases and were reported by 2 CCPTs.

The 2021 survey asked, "Did any of these services have a waitlist?" To this, 26 respondents indicated there was a waitlist for MH services, 6 indicated there was a waitlist for I/DD services, 7 indicated there was a waitlist for SU services, and 4 indicated there was a waitlist for DV

services, and 1 indicated there was a waitlist for CT services.

For the parents or caregivers, the need for mental health and domestic violence were the most prominent. Among the responding teams 61 identified the need for MH services and 45 identified a need for DV services. The total number of reviewed cases were also higher with 257 of the reviewed cases requiring MH services and 115 requiring DV services. The need for SU services was cited by 53 of the teams, for a total of 208 cases. The need for I/DD services was expressed by 12 CCPTs but with a significantly lower number of cases reviewed (19 cases). The 2021 survey asked, "Did any of these services have a waitlist?" To this, 22 respondents indicated there was a waitlist for MH services, 4 indicated there was a waitlist for I/DD services, 8 indicated there was a waitlist for SU services, and 6 indicated there was a waitlist for DV services. There was a total of 68 responses to this survey item.

Next the survey asked "How many of these cases received the needed services?" This comparison is reported in Table 16. Across all categories with one exception, the majority of cases received the needed services (17%-84%). Notably, the one exception was child trafficking, where only 1 out of 6 cases (17%) received the needed service. 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. For children, the need for child trafficking services was met for only 17% of the cases, however, mental health needs were met the most frequently in 84% of cases. For parents/caregivers, the need for substance use services was met the least frequently, in only 64% of cases, however, the need for intellectual/developmental disabilities services was met in 84% of cases. For cases where there was a child/youth need for substance use services, more cases were reported as receiving those needed services than the sum of cases reported. This is most likely due to input errors by responding CCPTs.

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, 2021 (N= 77)

Table 16 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	54	243	203 (83.5%)	3.16	6.10
Substance Use	30	79	48* (60.8%)	0.72	1.61
Domestic Violence	23	77	51 (66.2%)	1.03	2.62
Intellectual/Developmental Disabilities	19	33	25 (75.8%)	0.44	0.90
Child Trafficking	2	6	1 (16.7%)	0.08	0.59
Parents/Caregivers					
Mental Health	61	257	178 (69.3%)	3.34	6.11
Substance Use	53	208	134 (64.4%)	2.70	4.02
Domestic Violence	45	115	83 (72.2%)	1.51	1.82
Intellectual/Developmental Disabilities	12	19	16 (84.2%)	0.26	0.75

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. *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 7 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 17, the two most frequently cited limitations were limited or no services (64% of respondents) and limited transportation to services (58% of respondents). Other common reasons were limited MH and DD services for youth with dual diagnosis (43%) and the community's lack of awareness about available services (40%). Respondents' recognition of limited services for youth with dual diagnosis as a limitation ranged from 24-43%. These trends are similar to previous years' findings.

Among the respondents, 43 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 limitations referenced language and cultural barriers. Others identified the lack of available services, particularly within the context of the pandemic.

Number of CCPTs Reporting Limitations Preventing Children, Youth, and Their Parents or Other Caregivers Accessing Needed MH/DD/SA/DV Services, 2021, (N = 80)

Table 17 Number of CCPTs Reporting Limitations Preventing Children, Youth, and Their Parents or Other Caregivers Accessing Needed MH/DD/SA Services

Limits on Access	Number of CCPTs
Limited Services or No Available Services	51 (63.8%)
Limited Transportation to Services	46 (57.5%)
Limited Services MH and DD for Youth with Dual Diagnosis	34 (42.5%)
Limited Community Knowledge About Available Services	32 (40.0%)
Limited Services MH and SA for Youth with Dual Diagnosis	31 (38.8%)
Other 1	28 (35.0%)
Limited Services MH and DV for Youth with Dual Diagnosis	19 (23.8%)
Limited Attendance MH/DD/SA/DV Providers at CFTs	18 (22.5%)
Other 2	15 (18.8%)
Limited Number of Experienced CFT Meeting Facilitators	11 (13.8%)

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

In summary, children, youth, and their parents or caregivers faced serious barriers to accessing needed services. Most CCPTs who reviewed cases in 2021 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. With one exception, the majority of cases in each category received the needed service. Notably, the one exception was child trafficking. Nevertheless, substantial numbers in all categories did not receive required services, with the percentage ranging from 16-83% 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 inadequate services for youth having a dual diagnosis of mental health and developmental disability issues. 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. 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.

M. Racial Equity Issues in Addressing Local Needs

This year's survey explored local developments in regards to a racially equitable approach to child welfare. The survey defined racial equity as "*the condition when racial identity cannot be used to predict individual or group quality of life outcomes (e.g. wealth, income, employment, criminal justice, housing, health care, education).*" First, the survey asked, "Has your team discussed issues of racial equity in child welfare?" Among the 80 respondents, 59 (74%) checked *no* and 21 (26%) checked *yes.*

Next, the survey inquired, "What are some local issues in regards to child welfare taking a racially equitable approach?" Out of 85 teams, 22 (26%) described a local issue or issues and 63 (74%) did not (see Appendix C). Some who did not specify a local issue explained that their county had little diversity, for example, "We are predominantly a Caucasian county (96%+)." Others noted that "none were discussed this year" or they simply had "no meetings this year." Some responded that they were "not aware of any local issues at this time" or the matter did not apply to their local child welfare.

Child abuse does not see race or ethnicity when a case is called into our agency. Cases are not assigned or determined by race or ethnicity by our agency.

Among those describing an issue of racial equity, some pointed to concrete needs such as for transportation, housing, income, and employment. The lack of such resources could lead to involvement with the criminal legal system or, as another team explained, with child protection.

Disparities in child welfare start at CPS Intake, which families are or are not being reported to DSS. Systemic inequities impact families, and subsequently families that are impoverished and or have lack of access to resources are more likely to be reported to DSS.

Steps to improve child welfare delivery included "ensuring that our licensed foster homes are racially equitable" and "addressing the needs of Hispanic families—having bi-lingual staff available." Teams recognized the importance of having "a local awareness among community members" and "staff and placement providers being aware and educated about cultural identity."

CCPTs emphasized the importance of training for creating an environment attentive to racial equity, both on their team and within the wider community. One team explained, "Training opportunities for team members open conversations." Making use of local training, a team "practiced" multi-ethnic and cultural sensitivity training delivered in DSS.

A county provided a webinar series on service disproportionality for DSS and Health service providers. Another team stressed the importance of training aligned with a public health framework of racial equity and inclusion.

Our county recognized racism as a public health issue and has a Racial Equity & Inclusion Workgroup within county government that is providing educational opportunities for staff. Our Social Work Division also has a Racial Equity workgroup that has been doing the same.

Adopting a partnership-building strategy, a county detailed its work to enhance equitable delivery of services to the Latinx community.

Formed partnerships with local advocates and organizations, prepared materials in Spanish, attended Latina community festivals and distributed materials; Trained child welfare staff and other community organizations in culturally appropriate work with the Latinx community.

Acknowledging a "disproportionate number of minority children and families receiving CPS services" in the county, a CCPT spoke of the importance of adopting a posture of openness to learning from cultural communities.

Our team works to address issues with cultural humility and knowledge of racial inequities with an ongoing desire to learn more and apply knowledge better.

Questions on local issues were followed in the survey by asking, "Would you be interested in being provided resources to explore a racially equitable approach to child welfare?" Out of the 76 responses, 63 (83%) were *yes* and 13 (17%) were *no.* Five respondents added comments (see Appendix C). A CCPT characterized the type of training resource that could be useful, "Perhaps, from a neutral presenter." Another explained the reason for their interest, "Yes, because it could be useful for treatment planning especially since there is a teen suicide increase locally."

In summary, this year's survey explored local developments in regards to a racially equitable approach to child welfare. Most responding teams (74%) had not discussed issues of racial equity in child welfare over the year, and some stated that they were unaware of such issues locally. Others explained that the county had little diversity or that child protection did not determine cases based on race and ethnicity. A quarter (26%) of the responding teams described local issues of racial equity. They pointed to how systemic inequities in access to resources (e.g., housing, employment) led to reporting to child welfare. They placed weight on cross-county training to open up discussion of issues and possible solutions. Teams characterized racism as a public health issue and urged cultural humility to encourage continual learning. Most teams expressed interest in receiving training resources on a racially equitable approach to child welfare.

N. Local CCPT Recommendations for Improving Child Welfare Services

In developing recommendations to NCDHHS, the Advisory Board used all the survey sections and particularly examined closely the recommendations emerging from the CCPTs to improve child welfare services at the local and state levels. The survey asked the teams to ground their recommendations on their review of cases over the year and from this basis to identify their top three recommendations, respectively, for the local level and for the state level (see Appendix C). The teams made 169 recommendations at the local level and 142 recommendations at the state level, for a total of 311 recommendations.

Out of 85 teams, 73 teams made recommendations for the local level, with 12 making one, 9 making two, and 52 making three, for a total of 169. This left 12 teams that did not offer recommendations. The number of recommendations at the state level (142) was lower than at the local level (169). When asked to specify state-level recommendations, more teams declined (18

for state versus 12 for local). Among those giving state recommendations, 13 gave one, 6 gave 2, and 48 gave 3.

A benefit of grounding recommendations on the case reviews was that CCPTs proposed strategies to address situations that they had discussed as a team. A difficulty of having the recommendations based on cases is that teams without case reviews in 2021 may have refrained from offering their valuable suggestions for improvements to child welfare services. A few teams that had not reviewed cases made recommendations anyhow.

The 2021 recommendations overlapped with areas cited in the 2020 survey but with some divergences. Compared with 2020, this year's recommendations paid less attention to the pandemic and somewhat more attention to child fatalities.

Recommendations for the Local Level

The survey first asked, "Based on your 2021 case reviews, what were your team's top three recommendations for improving child welfare services at the local level?" Space was provided for writing in each of these top recommendations. The teams' recommendations for the local level were especially directed to prevention strategies that could be achieved in their communities, such as raising awareness, forming partnerships, increasing service coordination, and advocating for resources. Their host of recommendations concentrated on five main areas.

Accessible Resources and Culturally Responsive Services for Families. Teams recommended increasing "resources in the community to alleviate conditions that lead to DSS involvement." For instance, they urged "rapid rehousing" to stabilize families, "more after school options to reduce supervision reports," and "more local resources for DV." For families to avail of services, teams recommended "increasing the racial diversity" of professionals; offering "Spanish speaking services" for substance use, mental health, domestic violence, and educational support; and improving "child welfare staff and other community organizations' work with the Latinx community." An approach proposed by one county was to work with the "faith-based community" in developing "structured programs to support individuals and family members in recovery to promote navigation, engagement, and accountability."

Expansion of Substance Use and Mental Health Services. Team recognized the dire need for more behavioral services and recommended advocacy and coordination to extend services to more families. A team recommended "increasing the number of mental health professionals that provide evidence-informed child and family services related to trauma/PTSD and Intimate Partner Violence." One county partnered with their local LME-MCO provider to establish a process to support better communication between mental health providers and community partners to ensure families receive necessary services." Another team identified the necessity of "coordination of services between all providers during crises that could lead to out of home placement." Acting proactively, a team sought to "develop a sustainability plan for the Family Treatment Court."

Prevention Approach to Infant Safety. In general, CCPTs pushed for prevention strategies to safeguard infants. They advocated for increased "training to social work staff regarding plans of safe care and safe sleep for infants." A preventative approach was especially evident in their

campaigns to encourage safe sleeping practices. They sought to secure funds for baby cribs and "to saturate the community with safe infant sleep information and work to improve systems that serve infants' caregivers." One county used a collaboration of the "local hospital and DSS to educate parents about safe sleep." Another county proposed that "all county contracts require providers who work with families to undergo safe sleep training to better discuss safe sleep issues with families.

Strengthening Child Welfare. Teams emphasized more staffing, training, and program funding for their DSS. Deeply concerned about the availability and quality of child placements, they recommended more visits to children, creating a directory of placement resources, and "better local decision-making regarding placement resources in crisis and high need situations." They also recommended using child and family team meetings, which is a means of identifying kinship placements.

Community-Engagement by CCPT Teams. They thought of enhancing their team through CCPT training and extending their members to include family and youth and a representative from juvenile services. They saw their role as expanding partnerships in support of families, community education, and advocating for more resources and services to meet the needs of families. One proposed strategy was sharing their CCPT reports with the DSS board or county commissioners to raise awareness of community needs.

Recommendations for the State Level

Next, the survey asked, "Based on your 2021 case reviews, what were your team's top three recommendations for improving child welfare services at the state level?" Again, the teams had three places to write their recommendations. The teams recognized that state-level action was required to address the issues identified at the local level. For the state level, their recommendations were especially directed to matters that required state initiative, authorization, and resourcing. For instance, they turned to the state to ensure "non-conflicting state law and policy." For comparison purposes, their state-level recommendations can be grouped into the same five main areas as recommendations at the local level.

Accessible Resources and Culturally Responsive Services for Families. At the local level, CCPTs laid out ways to create more accessible resources and culturally responsive services. They had mapped out these strategies with others in the community. Not having the same conversations at the state level, their recommendations were understandably less detailed. Nevertheless, they hit on the same issues. They asked for more "access to resources to alleviate conditions that lead to DSS involvement," wanted "interpreter services" so that families could use services, and recognized that they needed "resources to address racial equity." Specific resources cited included "housing" and "affordable housing," "funding for transportation in rural areas," and "funding resources for undocumented individuals to obtain services."

Expansion of Substance Use and Mental Health Services. The CCPTs' recommendations to the state demonstrated their keen awareness that NCDHHS was pivotal to improving behavioral health services to children, youth, and their parents. Teams insisted that the state "re-examine policies related to substance use/misuse" and "update policies to reflect what is currently happening in the field. IE spread of fentanyl and impacts." Eligibility criteria for health insurance

were identified as a major block to families receiving essential services: They were concerned about "adults who have no insurance" or insurance such as Health Choice that few mental health providers accept. They advocated for ensuring that parents "maintain health coverage even when their children are removed from their care." They demanded that the state "identify solutions for children who are dually diagnosed but ineligible for behavioral health services due to a medical condition, e.g., diabetes." Recommendations included "increasing the number of mental health professionals that provide evidence-informed child and family services related to trauma/PTSD and intimate partner violence." They were concerned about "the lack of appropriate behavioral health care" that left children and youth "being cared for at DSS offices or hotels." They advised that NCDHHS "build network and placement capacity that meet the increasingly high-intensive behavioral needs of the youth served through child welfare to include those entering foster care" and were particularly concerned about "the need for violent youth to be able to quickly access the appropriate level of care."

Prevention Approach to Infant Safety. The teams made a series of recommendations to prevent further risks to infant safety. They asked for a "policy for the plan of safe care and co-sleeping" and increased "safe sleep resources." In regard to infants affected by substances, they requested "clear expectations" and "more guidance around POSC" [plan of safe care] to staff. They recognized how fatality reviews could prevent future risks and insisted on "being able to get autopsy reports and/or preliminary autopsy reports much quicker when there are living children still in the home." One team stressed the need to undertake research to "study the link between marijuana positive infants and fatalities."

Strengthening Child Welfare. Teams advocated for more funding to county DSS, especially for small counties. They wanted to ease the burden on child welfare by "decreasing the amount of forms" and moving away from "constant reviews" to a training model. Recognizing the secondary trauma experienced by staff, they wanted the state to "ensure all child welfare staff receive consistent evidenced-based, trauma-informed resiliency training. They urged that the state "make programs available statewide to better support families and prevent future child welfare involvement, e.g., PPP Home Visiting Programs.

Community-Engagement by CCPT Teams. They wanted the state to support their work by continuing to offer "updates and trainings" and provide "more trainings to CCPT members on making teams better and more effective." To strengthen their team, they asked "that a representative from Juvenile Services (Juvenile Court Counselor) be added to the mandated membership of the CCPT." Recognizing the importance of "preventive education programs," they requested "that the local CCPTs be provided funding to address issues identified by the team."

In summary, in developing recommendations to NCDHHS, the CCPT Board examined closely the recommendations emerging from the CCPTs to improve child welfare services at the local and state levels. The teams made 169 recommendations at the local level and 142 recommendations at the state level, for a total of 311 recommendations. Compared with 2020, this year's recommendations paid less attention to the pandemic and somewhat more attention to child fatalities. The teams' recommendations for the local level were especially directed to prevention strategies that could be achieved in their communities, such as raising awareness, forming partnerships, increasing service coordination, and advocating for resources. The teams

recognized that state-level action was required to address the issues identified at the local level. For the state level, their recommendations were especially directed to matters that required state initiative, authorization, and resourcing. Their host of local and state recommendations concentrated on five main areas: Accessible Resources and Culturally Responsive Services for Families, Expansion of Substance Use and Mental Health Services, Prevention Approach to Infant Safety, Strengthening Child Welfare, and Community-Engagement by CCPT Teams.

O. Local CCPT Objectives and Achievement of Objectives

By setting local objectives, CCPTs can direct their work toward meeting community needs. Similar to 2020, the survey asked, "Did your CCPT set local objectives based on identified improvement needs to complete over 2021?" The percentages of teams that checked *yes* in the two years were nearly identical: in 2020, 41% (33) of the 82 responding teams and in 2021, 40% (32) of the 80 responding teams. Of the 32 teams that responded *yes* in 2021, six were established but not meeting regularly, and 25 characterized themselves as an established team that met regularly. Of the 32, 20 (62.5%) gave 3 objectives, 4 (12.5%) gave 2 objectives, and 8 (25%) gave 1 objective, for a total of 76 objectives listed. A listing of their objectives and other qualitative responses can be found in Appendix C.

Identification and Rating of CCPT Achievement of Objectives, 2021

Next, the 32 respondents who set objectives were asked, "List your CCPT's top three local objectives based on identified improvement needs for 2021. Then rate how successful your CCPT was in achieving these objectives." Table 18 summarizes the extent to which the CCPTs achieved their objectives on a five-point scale (0-4) from *not at all, slightly, moderately, mostly,* and *completely,* with the additional option of *too soon* to rate. Among those rating their achievement of objectives, the most common response was *moderately,* somewhat higher than in 2020 when the most common response was *slightly.*

Rating of CCPT Achievement of Objectives, 2021

Table 18 Rating of CCPT Achievement of Objectives

	Number of CCPTs	Not at All	Slightly	Moderately	Mostly	Completely	Too Soon to Rate
Objective 1	32	5	0	12	5	8	2
Objective 2	24	2	6	8	4	1	3
Objective 3	20	2	3	7	5	2	1
Total	**80**	**9**	**9**	**27**	**14**	**11**	**6**

Note. Of the respondents were CCPTs who said that they had set objectives for 2021, not all provided success rating

Local Objectives

The objectives that they set for local action paralleled the five areas that they recommended for improving child welfare services in their communities: accessible resources and culturally

responsive services for families, expansion of substance use and mental health services, prevention approach to infant safety, strengthening child welfare, and community-engagement by CCPT teams. The ratings on their achievement of objectives indicate that as a group, they had some success in all areas but also were limited in meeting all their objectives in each area. The next two survey questions point to what CCPTs needed to achieve their objectives.

The first of these questions asked, "What helped you achieve your local objectives to meet identified improvement needs? Here, they emphasized the importance of local relationships and resources: "Knowledge and experience of team members," "current members reaching out to community partners and families," "strong community partnerships," and "funding from grant and local government."

The second question asked, "What can NC DSS do to help you achieve your local objectives to meet identified improvement needs?" The help that teams wanted from NC DSS were CCPT support such as policy updates, guidance, training, and funding for local initiatives; county DSS supports such as additional resources and streamlining procedures; and system-wide changes to increase resources and services for children and their families. A listing of their responses to these two questions can be found in Appendix C.

County Examples

Some examples below connect their objectives in each of the five areas to their ratings on achievement of their objectives and to related information provided by the teams.

Accessible Resources and Culturally Responsive Services for Families. In a small county, a CCPT observed that it had issues of racial equity and was dependent on resources outside the county to meet families' needs. Forging ahead, the county sought to increase local housing and shelter, not an easy objective and one that they had *not at all* met over the year. The CCPT was *slightly* successful in meeting a second objective of putting in place a domestic violence program for those causing the harm. While *not at all* successful in 2021 in establishing a local center for children who had suffered sexual and other forms of abuse, they were impressively resolute and remained committed to continuing the work on this initiative.

Expansion of Substance Use and Mental Health Services. In a medium size county, a team made two local recommendations centered on behavioral health: "increase the quality and number of SA/MH/DD resources" and "improve communication and process with SA treatment providers." In line with these recommendations, the team set the objective to "assess local MH/SA/DV resources to meet the needs of families" and rated itself as *moderately* achieving this objective. What helped the team meet the objective was the "knowledge and experience of team members." They asked that the state "provide support and guidance when the need arises."

Prevention Approach to Infant Safety. A CCPT in a medium size county recommended, "Continue efforts through local hospitals and DSS to educate parents about safe sleep." Then the team outlined clear and detailed steps to achieve their one objective to support safe sleeping: "Discussion with local hospital regarding educational efforts when children are born; CPS/DSS to continue to hand out information and assess sleeping conditions upon home visits; display information in the local DSS income maintenance areas; billboards in the community." While

they rated themselves as *not at all* realizing their multi-step objective, it is likely that their work is in progress.

Strengthening Child Welfare. The first objective of a team in a large county concerned child and family team meetings (CFTs): "identify resources available and accessible to conduct CFTs-promote agencies networking with each other to accomplish this." This work was in progress as they partnered with local training groups and universities and was *too soon to rate.* The team's first objective was a way of supporting their second objective to "decrease out of home placement/ shorten duration, by inclusion of natural and community supports along with formal services - strengths based." Large US studies have reported that family meetings support children living at home and finding kinship placements if needed[26]. The team rated the county as *mostly* accomplishing the second objective. What they found beneficial were "ensuring roles and responsibilities were clearly defined"; "listening to voice of all family members and their identified support network (faith based; other non-profits; advocacy groups; extended family and friends)"; and "providing access to needed material items that enhance quality of home life and safety." Increasing CFTs can reinforce the county in addressing what the team perceived as local issues with taking a racially equitable approach to child welfare.

Community-Engagement by CCPT Teams. A team in a small county had struggled over the year with the impact of COVID on "keeping members engaged through virtual meetings," something that was all the more challenging due to membership turnover. In response, the CCPT set one objective— "work more collaboratively and cohesively as a combined CCPT/CFPT"—and rated themselves as *mostly* realizing this objective. Helping the team at the local level to achieve their objective were the following: "building relationships among team members and working on the team membership," taking part in "CCPT training for the Chair (along with other DSS serving on the CCPT)," and partnering with their "CFPT on focus topics - suicide prevention & mental health resources for youth - billboard project and art design development in partnership with and 'thanks to' . . . their LME/MCO." From NC DSS, they made two requests for support in attaining their objective. The first was that the state "provide funding opportunities to support local team initiatives," and the second was that the state "consolidate the required reports, surveys and requested data and streamline through an automated collection throughout the year that would allow for teams to collect and consolidate this information in 'real time' versus after-the-fact."

Final comments

At the very end of the survey, teams had space to write in their reflections on the question, "What further support would help your team put your recommendations into action?" Half (43) of the CCPTs gave final comments (see Appendix C). Some reiterated the importance of assistance that they had already identified such as for training and funding for projects. A number wanted guidance on crafting and implementing their recommendations. For instance, a team requested, "Training and clarity on what these recommendations should look like." A second team wanted "just any recommendations on a local level on how the CCPT can carry out recommendations." Asking teams to make recommendations may have been especially daunting in a year in which they had struggled with fallout from the pandemic. One team observed,

[26] Allan, H., Rauktis, M. E., Pennell, J., Merkel-Holguin, L., & Crampton, D. (2021). Family meetings as system reform to address disproportionality and disparities. In A. J. Dettlaff (Ed.), *Racial disproportionality and disparities in the child welfare system* (pp. 309-338). New York, NY: Springer.

"COVID and staff turnover has created large barriers for the team" in carrying out its work. Looking ahead, another team anticipated, "Once we are able to have full participation without the barriers of COVID we can work in partnership on the recommendations."

In summary, based on local needs, 40% of the responding teams set local objectives. The overall total of objectives was listed by counties was 76. Their objectives can be grouped into the same five areas as their recommendations. When asked to rate achievement of their objectives, the most common response was *moderately.* What especially helped them carry out their objectives were local relationships and resources. To achieve their objectives, they asked that NC DSS provide guidance, information, and funding; and they highlighted the necessity of system-wide changes to increase resources and services for children and their families. Looking ahead, the teams welcomed a new year in which they anticipated that their teams would no longer be struggling to deal with COVID.

2021 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 two subcommittee meetings and then a meeting of the whole board to prepare and finalize the recommendations for action in 2023.

The first set of recommendations are steps for developing a racially and culturally equitable approach to child welfare in North Carolina. The second through fourth sets of recommendations drill down into what a racially and culturally equitable approach means for specific areas concerning child welfare.

In accordance with CAPTA, we propose the following for child protection at the local and state levels in 2023.

RECOMMENDATION 1 – DEVELOP A RACIALLY AND CULTURALLY EQUITABLE APPROACH TO CHILD WELFARE IN NORTH CAROLINA

Rationale. 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. This approach recognizes the historical and systemic racial/ethnic, cultural, social, economic, and ecological issues that have created a total environment that produces poor outcomes for families from a variety of marginalized groups and communities. In particular, researchers today have identified a number of factors impacting racial and ethnic disparities.[1] Racial and cultural racism increases the poverty of marginalized families and communities and increases their likelihood of child removals.[2] Community poverty, rather than individual family poverty, predicts the entry of Indigenous, Black, Latinx, and White children into foster care; however, overall rates of child removals remain higher for Indigenous, Black, and Latinx children than White children.[3] A racially and culturally equitable approach seeks to

[1] Child Welfare Information Gateway. (2021). *Child welfare practice to address racial disproportionality and disparity*. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. https://www.childwelfare.gov/pubs/issue-briefs/racial-disproportionality/

[2] 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.

[3] White-Wolfe, H. J., Charron-Chénier, R., & Denby-Brinson, R. (2021). Association between community-level material hardships and foster care entry by race/ethnicity. *Child Welfare*, *99*(4), 105-136.

lessen disparities in child welfare interventions for children of different identities and backgrounds (e.g., rural/suburban/urban,[4] socio-economic status[5]).

CCPT Leadership. With support from local and state DSS, CCPTs are especially well positioned to exert leadership in developing a racially and culturally equitable approach to child welfare of relevance to their communities. They can encourage dialog among local child-and-family-serving agencies, families with lived experience, and other community groups. Such dialog is central to diversifying our understanding of and creating partnerships to increase racial and cultural responsiveness.[6]

Local

1) To support CCPTs and their community partners in creating a local plan for a racially and culturally equitable approach to child welfare by:
    a) Offering educational forums and materials on a racially and culturally equitable approach to child welfare, including a focus on populations of particular relevance to the community (e.g., low/medium/high-wealth communities, immigrant, military).
    b) Engaging people with lived experience from different racial and cultural communities to present at these forums and contribute to materials on racial and cultural responsiveness.
    c) Including diverse participants in these forums (e.g., service providers, families, system-of-care, local associations, faith communities, educational institutions, nonprofit foundations).
    d) Engaging CCPTs and their partners in defining their vision of a racially and culturally equitable approach to child welfare for local families and their communities, assessing what local assets or opportunities[7] (e.g., accessible resources, services, transportation) support this vision, setting objectives to achieve this vision, and identifying supports (e.g., education, policy, funding) required from outside the local community.
    e) Expediting cross-county and regional exchanges on steps for achieving a racially and culturally equitable approach and the successes of these steps.

[4] For example, compared to children in more suburban and urban counties, children from rural counties are more likely to be substantiated for maltreatment but less likely to be placed outside their homes. 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

[5] Racist practices and policies impoverish marginalized families, and, even after taking poverty into account, racist bias leads to greater reporting, especially by medical personnel, of children of color with the same injuries as White children to child welfare. 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

[6] A Texas study reported that a community engagement model reduced racial disproportionality and disparities. James, J., Baumann, D. J., Rodriguez, C., Craig, S., & Kathan, S. (2020). Creating comprehensive system reform to reduce racial disproportionality and disparities: The Texas community engagement model. In A. J. Dettlaff (Ed.). *Racial disproportionality and disparities in the child welfare system* (pp. 397-412). New York, NY: Springer. doi:10.1007/978-3-030-54314-3_4

[7] A useful map for identifying opportunities for counties across NC can be found at link.

2) To support CCPTs in increasing workers' capacity to relate to families from different backgrounds by:
    a) Conducting case reviews to identify organizational and systemic factors supporting a racially and culturally equitable approach to child welfare.
    b) Encouraging family-engagement strategies (e.g., Child & Family Team Meetings, Family Partners, youth focus groups) with marginalized groups.
    c) Recommending sufficient exposure of workers to a critical mass of specific marginalized populations (e.g., African American, Indigenous, LGBTQ) on their workloads or rotating workers' caseloads to achieve this objective.[8]
    d) Raising workers' awareness of assets in high-poverty or isolated racial and cultural communities.
    e) Encouraging training to enhance workers' understanding that people in marginalized communities might manifest trauma histories or current trauma in uninviting ways and to increase the workers' skills in responding in a supportive, transparent, and trustworthy way.

State

1) To support DSSs in identifying and advancing systemic components that promote a racially and culturally equitable approach to child welfare.
2) To ensure that child protection decision-making tools distinguish parental neglect from systemic conditions outside parents' control.
3) To streamline Child and Family Teams to support cross-system work among child-serving systems in working with marginalized or isolated families.
4) To increase access to quality services (e.g., behavioral health) and concrete resources (e.g., food, housing) in high-poverty and isolated communities to lessen the impact of racial and cultural racism.
5) To support in next year's CCPT survey the inclusion of a definition of a racially and culturally equitable approach to child welfare that emphasizes strengths of families and communities.

RECOMMENDATION 2 – SUPPORT THE FAMILIES OF INFANTS IDENTIFIED AS 'SUBSTANCE AFFECTED,' INCLUDING THE PLAN OF SAFE CARE (POSC)

Rationale. Federal CAPTA 2016 legislation[9] requires health care providers involved in the delivery and care of infants identified as meeting 'substance affected' criteria to notify Child Welfare of the occurrence. The 'substance affected' criteria were to be developed by each state for three different required areas. North Carolina developed these criteria and implemented the updated policy and practice in 2017.[10] All such identified infants, under this legislation, must have a Plan of Safe Care developed to support the safety and well-being of the infant and the infant's family, regardless of imminent safety concerns.

[8] Workers who work with a higher proportion of marginalized clientele understand better how to make equitable decisions. Fluke, J. D., Baumann, D. J., Dalgleish, L. I., & Kern, H. D. Racial disparities in child welfare: A decision-making ecology view. In A. J. Dettlaff (Ed.). *Racial disproportionality and disparities in the child welfare system* (pp. 339-352). New York, NY: Springer. doi:10.1007/978-3-030-54314-3_4

[9] https://www.congress.gov/114/plaws/publ198/PLAW-114publ198.pdf

[10] https://www.ncdhhs.gov/infant-plan-safe-care/place-of-delivery#affected_by_substance_abuse

Recommendations to support the families of infants identified as 'substance affected', including the Plan of Safe Care (POSC).

Local

1) To request local cross systems training and technical assistance for child welfare's updated POSC policies and forms to support effective implementation.
2) To dedicate a county role/local position to the complex and multilevel needs of families who are child welfare and substance involved.
    a) Prioritizing collaboration and communication with local partners in working with shared families experiencing child welfare involvement and substance use disorders, with 42 CFR part 2 compliant releases of information in place.
    b) Considering outreach and collaboration with community prenatal care providers to provide education on the Infant Plan of Safe Care.
    c) Seeking and developing 'in-house' expertise and familiarity with common issues related to substance use disorders and child welfare involvement, including medication for opioid use disorders during pregnancy and postpartum. Provide consultation to staff on these cases.
    d) Identifying, with the assistance of LME/MCO, key local substance use disorder treatment agencies with whom county agency can develop an MOU/MOA to include facilitating timely substance use disorder assessments and communication back to county child welfare agency. MOU/MOA can include required participation of SUD agency staff in CCPT.
    e) Developing regular communication channels with the delivering hospitals and free-standing birth centers, to support education of the Plan of Safe Care notification requirements, including differentiation between 'notification' and 'report of child abuse or neglect', and aggregate data feedback related to their notifications. Provide guidance to these healthcare staff on what information is ideally provided when making a notification based on infant meeting 'substance affected' criteria. Guidance on timing of the notification from healthcare provider to child welfare is also needed. Review 42cfr Part 2 and provide training to healthcare providers involved in delivery and care of infant, on confidentiality requirements. Notifications (no clear indication of risk to the child) require consent to share information about substance use disorder treatment per federal regulation (42cfr part 2).
    f) Reviewing *de-identified* screened-out notifications of infants identified as 'substance affected' as a part of CCPT. CMARC and SUD treatment providers are essential partners in this review.

State

1) For state DSS, to maintain a focus on the following, in support of families who are substance involved:
    a) Prioritizing collaboration and transparency with state DHHS partners in working with shared families experiencing child welfare involvement and substance use disorders.

b) Developing understanding of resources available through the LME/MCO to caregivers for substance use disorder treatment, when caregivers are not insured.
c) Supporting regional and local child welfare agencies to develop in-house understanding, expertise and familiarity with common issues related to substance use disorders and child welfare involvement, including medication for opioid use disorders during pregnancy and postpartum. Provide consultation to staff on these cases.

RECOMMENDATION 3 – SUPPORT COMMUNITIES IN PREVENTING NEAR FATALITIES DUE TO SUSPECTED ABUSE, NEGLECT, AND DEPENDENCY

Rationale. 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." Documenting alleged near fatalities in NC is a recent requirement for DSSs, beginning in July 2020, and CCPTs are only starting to conduct case reviews of near fatalities. Nationally, there have been difficulties in identifying near fatalities by child welfare, medical personnel, police, and other community groups.[11] Near fatal and fatal child physical abuse have extensive commonalities in terms of victim injuries and family risk factors, including a history of domestic violence[12] and mental health issues.[13] A major factor differentiating near fatal from fatal child maltreatment is readier access to quality health care rather than individual family risk factors.[14] Because child fatalities are rare events, individual risk factors should be used cautiously for prediction purposes. A stronger predictor is the general level of community poverty,[15] which affects the accessibility of health care for children and their families.[16] Rural communities particularly struggle to provide health service for Black and White residents.[17]

Local

[11] 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
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1) To continue offering training and tip sheets on near fatalities to child welfare staff.
2) To make near fatalities training and information available to local CCPTs, family partners, health services, domestic violence organizations, system-of-care collaboratives, school personnel, judicial system, law enforcement, and others working with families.
3) To facilitate training for CCPTs and other agencies (e.g., juvenile justice) on domestic violence and mental health when children are at risk of near fatal or fatal maltreatment.
4) To encourage CCPTs to leverage cross-system trainings to strengthen local partnerships to address near fatalities.
5) To provide training to CCPTs regarding case reviews of near fatalities and help them identify local cases and access medical records and other information necessary for these reviews.
6) To assist CCPTs conducting case reviews of near fatalities to identify community and systemic factors that heighten the risk of near fatalities, particularly for minorized families, and impede timely access to life-saving health interventions.

State

1) To continue compiling and analyzing NC data on near fatalities to determine rates by counties and patterns in family and community profiles (e.g., race, ethnicity, indigeneity, poverty) and to compare cases of near-fatal child maltreatment with cases of fatal child maltreatment.
2) To analyze the manner of maltreatment near fatalities (e.g., unsafe sleeping, strangulation) by comparing cases of child maltreatment near fatalities with cases of child maltreatment fatalities and non-maltreatment fatalities.[18]
3) To identify systemic factors impeding the reporting of different types of maltreatment near fatalities.
4) To report findings and analyze their implications for practice and policy with county DSSs, CCPTs, CCPT Advisory Board, NC Child Welfare Family Advisory Council, NC Pediatric Society, and others.
5) To support the CCPT Advisory Board in preparing and disseminating a guide for local teams on reviewing cases of near fatalities, and to offer orientation on the guide to teams.
6) To clarify the roles of CCPTs and CFPTs in regard to reviewing cases of near fatal child maltreatment.
7) To combine reviews of child maltreatment near fatalities and domestic violence homicides to increase the identification of family violence in placing all family members at risk.[19]
8) To increase quick access to health care through use of dial-up services and other alternatives to private cars and mass transit.
9) To push for Medicaid expansion in order to provide quality and accessible health care for all NC families in rural, suburban, and urban settings.
10) To generate evidence-informed policy that promotes racial and cultural equity in addressing near fatalities.

[18] The NC Division of Public Health reports annual findings on the manner and means of child fatalities. See link.
[19] 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

RECOMMENDATION 4 – SUPPORT THE CAPACITY OF LOCAL CCPTS TO CARRY OUT THEIR WORK.

Rationale. NC statute mandates CCPTs in all counties and the involvement of key child-and-family-serving agencies with the flexibility to appoint others including family/youth and community partners. Thus, NC provides a strong basis for local input into improving the delivery of child welfare services. At the state level, the CCPT Board mirrors the composition of local CCPTs and offers a means of synthesizing statewide trends in child welfare, conducting analyses of policy and programming, and developing tools to assist local CCPTs. This comprehensive system of citizen review has much promise but also requires supports to strengthen the capacity of local CCPTs. The necessity of supports was especially evident in 2021, the second year of an exhausting pandemic, but is needed on an ongoing basis.

Local

1) To dedicate a NC DSS position to the operational support of CCPTs. Historically, this position has proved exceedingly beneficial to facilitating optimal functioning of the teams and would play a critical role in enabling the implementation of the recommendations outlined in this report. The assignment of one staff member to CAPTA and CCPTs is a valuable step in this direction.
2) To support CCPTs in developing ways to have their membership and discussions better reflect the racial and cultural diversity in their communities.
3) To assist CCPTs with strategies for the inclusion and retention of family and youth partners on teams. Consult with the NC Child Welfare Family Advisory Council on helpful approaches.
4) To foster exchanges of CCPTs from different locales.
    a) Offering cross-county summits and other forums through online means to encourage robust exchanges and creative ideas for child welfare improvements.
    b) Identifying topics for these exchanges with local teams and the CCPT Board.
    c) Capitalizing on these forums to offer trainings and/or provide relevant updates and information.
5) To offer technical assistance and training to local CCPTs, including on general changes to child welfare policy and programming and specific topics such as:
    a) Orienting teams to the guides on conducting case reviews and walking teams through the review steps with local cases. Emphasize the importance of identifying needed systemic changes.
    b) Writing recommendations for local initiatives and offering guidance, resources, and funding on implementing these recommendations.
6) To support the production and dissemination of the updated CCPT manual and provide orientations to CCPTs on the manual content.
7) To provide funding to local teams.
    a) Allocating annual funding of $1,000 per team for operational and project support.
    b) Assisting teams with understanding requirements on documenting the expenditure of the funds and assessing their local impact.

c) Ensuring that the results of the funds are summarized and a report provided to the funding sources and the CCPT Board.

8) To prepare local teams regarding impending changes to the end-of-year survey such as types of cases to review.
9) To provide targeted training to teams that identify areas on the end-of-year survey where they need support in fulfilling their role (e.g., engaging team members, conducting case reviews, providing public education). This requires changing the survey protocols to permit identification of respondents to NC DSS and CCPT Board.

State

1) To keep the CCPT Board and local CCPTs informed over the year about the state's response to the Board's specific recommendations on improving child welfare and append addenda to the state's written response that detail steps taken.
2) To facilitate the change in survey protocols from de-identified to identified data, to engage key players (e.g., county DSS directors) in understanding and expediting this change, and to notify CCPTs of this change, help them take advantage of it, and respond to concerns about de-identification of their data.

For previous year's NC DSS response to the Advisory Board's recommendations for improving child welfare services, go to this link. [20]

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Appendices
Appendix A: Survey Process and Results

Timeline of CCPT Survey, 2021

Table A-1 Timeline of CCPT Survey

Date	Activity
July 9, 2021	NC CCPT Advisory Board ad-hoc survey subcommittee developed end-of-year survey
July 12, 2021	NC CCPT Advisory Board finalized the survey
July 19, 2021	Survey materials sent to NC DSS for Approval
November 1, 2021	NC State University Institutional Review Board approved research protocols protecting participants
November 5, 2021	NC DSS sent letters to the County DSS Directors and to the CCPT Chairs to notify them about the survey
November 16, 2021	NC State University Research CCPT Team distributed survey to CCPT Chairpersons or designees followed by weekly reminders to unfinished respondents
January 3, 2022	NC DSS reminded CCPT Chairs to complete the survey
January 14, 2022	Deadline for survey submission
February 11, 2022	Extended deadline for survey submission
April 11, 2022	NC CCPT Advisory Board reviewed first draft of survey findings and report and created preliminary recommendations
April 12, 2022	The Advisory Board reviewed the initial draft of the report
April 14 & 22, 2022	Discussion groups were held to discuss content of the recommendations
May 9, 2022	The Advisory Board reviewed, finalized and approved the recommendations
May 16, 2022	End of Year Report to NC DSS
TBD	Results of the survey to CCPT

Local CCPTs Submitting Survey Report, 2021

Table A-2 Counties of CCPTs Submitting Survey Report

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

Note. The survey was sent to 101 CCPTs of whom 85 responded.

Responding CCPTs by County Population Size, 2021, (N=85)

Table A-3 Responding CCPTs by County Population Size

County Size	Total Counties	Total Responding Counties	Percent
Small	51	41	80%
Medium	39	34	87%
Large	10	10	100%

LME/MCOs and Number of Member Counties Responding to Survey, 2021

Table A-4 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	11	100%
Partners Behavioral Health Management	14	13	93%
Sandhills Center	11	8	73%
Trillium Health Resources	27	20	74%
Vaya Health	31	28	90%
Total	100	85[a]	85%

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=80)

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

CCPT/CFPT Organization	Number of Counties	Percent
Separate CCPT and CFPT	19	23.8%
Combined CCPT and CFPT	59	73.8%
Other	2	2.5%

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%)

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

Type of Information	2016 (*n*=65)	2017 (*n*=62)	2018 (*n*=88)	2019 (*n*=89)	2020 (*n*=83)	2021 (*n*=79)
Case Files	49 (75%)	52 (85%)	56 (64%)	61 (86%)	56 (68%)	69 (87%)
Reports from Members and/or Case Managers	60 (92%)	61 (98%)	57 (65%)	67 (94%)	61 (74%)	63 (80%)
Information on Procedures and Protocols of Involved Agencies	38 (58%)	39 (63%)	34 (39%)	47 (66%)	47 (57%)	57 (72%)
Child and Family Team Meeting Documentation	21 (32%)	27 (44%)	21 (24%)	30 (42%)	30 (36%)	37 (47%)
Medical Examiner's Report	18 (28%)	14 (23%)	21 (24%)	25 (35%)	22 (27%)	30 (38%)
Individualized Education Plan	16 (25%)	12 (19%)	6 (7%)	21 (30%)	20 (24%)	26 (33%)
Other	6 (9%)	8 (13%)	9 (10%)	10 (14%)	11 (14%)	11 (14%)

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

Type of Information	2018		2019		2020		2021	
	Combined (*n*=72)	Separate (*n*=13)	Combined (*n*=53)	Separate (*n*=16)	Combined (*n*=66)	Separate (*n*=16)	Combined (*n*=59)	Separate (*n*=19)
Case Files	47 (65%)	7 (54%)	45 (85%)	14 (88%)	40 (61%)	15 (94%)	50 (85%)	17 (89%)
Reports from Members and/or Case Managers	45 (63%)	10 (77%)	50 (94%)	15 (94%)	47 (71%)	13 (81%)	44 (75%)	17 (89%)
Information on Procedures and Protocols of Involved Agencies	25 (35%)	7 (54%)	37 (70%)	9 (56%)	25 (53%)	12 (75%)	40 (68%)	15 (79%)
Child and Family Team Meeting Documentation	18 (25%)	3 (23%)	23 (43%)	6 (38%)	22 (33%)	8 (50%)	27 (46%)	9 (47%)
Medical Examiner's Report	19 (26%)	1 (7%)	20 (38%)	4 (25%)	18 (27%)	4 (25%)	22 (37%)	8 (42%)
Individualized Education Plan	5 (7%)	1 (7%)	16 (30%)	5 (31%)	15 (23%)	5 (31%)	19 (32%)	7 (37%)
Other	8 (11%)	0 (0%)	8 (12%)	1 (6%)	8 (12%)	3 (19%)	16 (27%)	8 (42%)

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

CCPT/CFPT Organization	2015 (*n*=87)	2016 (*n*=86)	2017 (*n*=80)	2018 (*n*=88)	2019 (*n*=89)	2020 (*n*=83)	2021 (*n*=80)
Separate CCPT and CFPT	23 (26%)	17 (20%)	17 (21%)	14 (15%)	17 (19%)	16 (19.3%)	19 (23.8%)
Combined CCPT and CFPT	63 (72%)	66 (77%)	62 (78%)	77 (83%)	66 (74%)	66 (79.5%)	59 (73.8%)
Other	1 (1%)	3 (3%)	1 (1%)	1 (1%)	2 (2%)	1 (1.2%)	2 (2.5%)

Note: Number of counties (percent)

Table B-5. Mandated CCPT and CCPT/CFPT Members and Mean Rate and Rank of Participation, 2018, 2019, 2020, and 2021

	2018 Average (Rank)		2019 Average (Rank)		2020 Average (Rank)		2021 Average (Rank)	
Mandated Member	Combined (*n*=73)	Separate (*n*=13)	Combined (*n*=73)	Separate (*n*=13)	Combined (*n*=62)	Separate (*n*=15)	Combined (*n*=59)	Separate (*n*=19)
DSS Director	3.25 (4)	3.69 (7)	3.16 (4)	2.94 (4)	3.10 (4)	2.67 (5)	3.20 (2)	2.63 (4)
DSS Staff	3.88 (1)	4.54 (1)	3.90 (1)	3.94 (1)	3.71 (1)	3.67 (1)	3.67 (1)	3.68 (1)
Law Enforcement	2.77 (7)	3.85 (6)	2.91 (7)	2.76 (7)	2.90 (7)	2.53 (6)	2.73 (7)	2.63 (4)
District Attorney	1.70 (13)	2.92 (10)	1.88 (13)	2.53 (9)	1.95 (12)	1.53 (10)	1.77 (13)	1.68 (10)
Community Action Agency	2.66 (8)	3.46 (9)	2.68 (8)	2.47 (10)	2.52 (8)	2.20 (7)	2.48 (10)	2.58 (7)
School Superintendent	2.36 (9)	3.54 (8)	2.24 (10)	2.65 (8)	2.50 (9)	1.13 (11)	2.58 (8)	1.61 (11)
County Board of Social Services	2.24 (11)	2.85 (11)	2.20 (12)	1.94 (11)	2.10 (11)	2.07 (9)	2.38 (9)	1.74 (9)
Mental Health Professional	3.30 (3)	4.46 (2)	3.44 (2)	3.59 (2)	3.26 (2)	3.20 (2)	3.16 (3)	3.58 (2)
Guardian ad Litem	3.03 (6)	3.92 (4)	3.07 (5)	3.06 (3)	2.95 (5)	2.87 (4)	2.90 (5)	2.84 (3)
Public Health Director	3.17 (5)	3.92 (3)	3.07 (6)	2.88 (5)	2.94 (6)	2.13 (8)	2.78 (6)	2.05 (8)

Health Care Provider	3.37 (2)	3.85 (5)	3.41 (3)	2.82 (6)	3.15 (3)	3.13 (3)	3.16 (3)	2.42 (6)
District Court Judge	.92 (16)		.94 (16)		.73 (16)		.93 (16)	
County Medical Examiner	1.47 (14)		1.28 (14)		1.39 (14)		1.93 (14)	
EMS Representative	2.21 (12)		2.26 (9)		2.19 (10)		1.93 (11)	
Local Child Care or Head Start Rep	2.29 (10)		2.21 (11)		1.81 (13)		1.80 (12)	
Parent of Child Fatality Victim	1.06 (15)		1.09 (15)		1.08 (15)		1.00 (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)
Alamance	x	x	x	x	x	x	x	x
Alexander		x			x		x	x
Alleghany	x	x	x	x	x	x	x	x
Anson		x	x	x				
Ashe		x				x	x	x
Avery	x	x	x	x	x		x	x
Beaufort	x					x		
Bertie	x	x		x			x	
Bladen	x	x	x	x	x	x	x	x
Brunswick	x	x	x	x	x	x		x
Buncombe	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
Caldwell		x	x		x	x		x
Camden	x	x	x	x	x	x	x	x
Carteret		x	x	x	x	x	x	x
Caswell	x	x	x	x	x	x	x	x
Catawba	x	x	x	x	x	x	x	x
Chatham	x	x	x	x	x	x	x	x
Cherokee			x	x	x		x	
Chowan	x	x	x	x	x	x		
Clay	x	x	x	x	x	x	x	x

Cleveland		x	x	x	x	x	x	x
Columbus	x	x	x	x		x	x	x
Craven	x	x	x	x	x	x	x	x
Cumberland	x	x	x	x	x	x	x	x
Currituck	x	x	x		x	x	x	x
Dare	x	x	x	x	x	x	x	x
Davidson	x	x	x	x	x	x	x	x
Davie	x	x						x
Duplin	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
Forsyth		x	x		x	x	x	x
Franklin	x	x		x	x	x	x	x
Gaston		x	x	x	x	x	x	x
Gates	x	x	x	x	x	x	x	x
Graham		x	x	x	x	x	x	x
Granville			x		x	x	x	
Greene			x		x	x		x
Guilford	x	x	x	x	x	x	x	x
Halifax	x	x	x	x	x	x	x	x
Harnett	x	x	x	x	x	x	x	x
Haywood		x	x	x	x	x	x	x
Henderson	x	x	x	x	x	x	x	x

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

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

Table B-7. Small County Participation by Year

County	2014	2015	2016	2017	2018	2019	2020	2021
Respondents (%)	36 (71%)	42 (82%)	40 (78%)	38 (78%)	45 (83%)	46 (85%)	43 (80%)	41 (80%)
Alexander		x			x		x	x
Alleghany	x	x	x	x	x	x	x	x
Anson		x	x	x				
Ashe		x				x	x	x
Avery	x	x	x	x	x	x	x	x
Bertie	x	x		x			x	
Bladen	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
Chatham	x	x	x	x	x	x	x	x
Cherokee			x	x	x		x	
Chowan	x	x	x	x	x	x		
Clay	x	x	x	x	x	x	x	x
Currituck	x	x	x		x	x	x	x
Dare	x	x	x	x	x	x	x	x
Davie	x	x						x
Gates	x	x	x	x	x	x	x	x
Graham		x	x	x	x	x	x	x
Granville			x		x	x	x	
Greene			x		x	x		x
Hertford	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
Jackson	x	x	x	x	x	x	x	x
Jones	x		x		x	x	x	x
Lee		x	x	x	x	x		x
Lenoir	x	x	x	x	x	x	x	x
Lincoln	x	x	x	x	x	x	x	x
Macon	x	x	x	x	x	x	x	x
Madison	x			x	x	x	x	x
Martin	x	x	x	x	x	x	x	x
McDowell			x		X			
Mitchell	x	x	x	x		x		
Montgomery	x	x	x	x		x	x	x
Northampton		x	x	x	x	x		
Pamlico		x		x				
Pasquotank	x	x	x	x	x	x	x	x
Pender	x	x	x		x	x	x	x
Perquimans		x			x	x	x	x
Person	x	x	x	x	x	x	x	x
Polk	x	x	x	x	x	x	x	x
Richmond	x	x	x	x	x	x	x	
Stanly	x	x	x	x	x	x	x	x
Stokes	x	x	x	x	x	x	x	x
Swain	x	x	x		x	x	x	x
Transylvania						x	x	x
Tyrrell			x	x	x	x	x	x
Warren	x	x	x		x	x	x	
Washington				x	x			

Watauga	x	x	x	x	x	x	x	x
Yadkin	x	x	x	x	x	x	x	x
Yancey	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
Respondents (%)	30 (77%)	36 (92%)	36 (92%)	34 (87%)	32 (91%)	32 (91%)	30 (86%)	34 (87%)
Alamance	x	x	x	x	x	x	x	x
Beaufort	x					x		
Brunswick	x	x	x	x	x	x		x
Burke	x	x	x	x	x	x	x	
Cabarrus	x	x	x	x	x	x	x	x
Caldwell		x	x		x	x		x
Carteret		x	x	x	x	x	x	x
Cleveland		x	x	x	x	x	x	x
Columbus	x	x	x	x		x	x	x
Craven	x	x	x	x	x	x	x	x
Davidson	x	x	x	x	x	x	x	x
Duplin	x	x					x	x
Edgecombe	x	x	x	x	x	x		x
Franklin	x	x		x	x	x	x	x
Halifax	x	x	x	x	x	x	x	x
Harnett	x	x	x	x	x	x	x	x
Haywood		x	x	x	x	x	x	x
Henderson	x	x	x	x	x	x	x	x
Iredell	x	x	x	x	x	x	x	x
Johnston	x	x	x	x		x		
Moore		x				x	x	x
Nash	x	x	x	x	x	x	x	x

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

County	2014	2015	2016	2017	2018	2019	2020	2021
Respondents (%)	5 (50%)	9 (90%)	10 (100%)	8 (80%)	11 (100%)	10 (91%)	11 (100%)	10 (100%)
Buncombe	x	x	x	x	x	x	x	x
Catawba	x	x	x	x	x	x	x	x
Cumberland	x	x	x	x	x	x	x	x
Durham			x	x	x		x	x
Forsyth		x	x		x	x	x	x
Gaston		x	x	x	x	x	x	x
Guilford	x	x	x	x	x	x	x	x
Mecklenburg		x	x	x	x	x	x	x
New Hanover	x	x	x	x	x	x	x	x
Wake		x	x	x	x	x	x	x

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

Appendix C: Qualitative Responses
Difficulties faced completing work

Adjusting to Virtual Platforms

Additionally, we have experienced some technical difficulty as we continue to meet virtually.

agency staff changing to different positions within the agency or leaving the agency completely; timely access to records and documents; delays in cases being cleared for review by DA

All CCPT meeting in 2021 were held online via Zoom. The video format for these meeting has a limiting effect on how much interaction and discussion can be had between team members. Our team truly desires to get back to an in-person format as soon as possible.

blended virtual/in person to meet the requests of all members- it is difficult for the virtual participants to hear and participate in the discussions

Continue to meet virtually and have not been able to discuss any individual cases

Difficulty for staff to participate virtually at times

had to adjust meetings to meet through TEAMS/virtual and delay in return of requested medical records.

Had to meet virtually.

Having to meet virtually

In early part of this year we meet virtually not as many participated

Inability to meet in person lack of interest due to not being able to meet in person

It has been difficult discussing cases over Zoom due to the sensitive nature of some of the cases.

It has been difficult to collect feedback since we are not always face-to-face.

keeping members engaged through virtual meetings

Lack of secure technology to conduct virtual meetings

Meeting virtually, Lack of Broadband Internet Services in the County

Meetings have moved to virtual and mailings have been late; therefore, we did not meet 4 times this year

Moving to a secure virtual platform was initially a challenge but is working well for the team

No in-person meetings. All by phone.

Not being able to meet in person; we have to do everything virtually.

Not difficulties; however we are meeting virtually due to the pandemic

Our team has been operational, we have just switched to virtual meetings, which can be challenging for some.

Our team went to Zoom meetings rather than in person meeting to obtain the maximum number of attendees and to ensure safety of all members.

Some of the members could only attend virtual

Stakeholders reported not being able to see families and make traditional connections

Team is not satisfied at this time meeting virtual and finds communication more difficult.

Team members having trouble with technology to meet virtually.

Technology and ability to meet face to face

The team moved to virtual meetings early in the pandemic. Planning for events has been more difficult.

Virtual meetings have been held. One meeting did not have a quorum which rescheduled to next meeting. Fewer member attendance

Virtual Meetings have impacted the participation in Community Agencies.

Virtual meetings to reduce risk of exposure we are unable to meet in person but successfully meet via Microsoft Teams

We have continued to have CCPT Meetings via zoom
We have not been able to meet face to face
We have tried using Zoom however this is difficult and we just recently met in person
We meet virtually. Our attendance numbers have gone down.
We met virtually instead of in person and struggled with some technical difficulties.

COVID-19 Pandemic
At the beginning of the pandemic, it was difficult to hold meetings and since we have started back in April 2021, attendance of members and membership declined.
attendance due to Covid despite holding virtual meetings
COVID limiting face-to-face meetings and outreach
Covid restrictions
COVID restrictions and facilitation of meetings
COVID-19 prevented in-person meetings and made sharing confidential/sensitive materials difficult
Due to COVID meetings have had to be cancelled and as a Social Work Supervisor as chair of the CCPT is challenging due to the excessive workload due to COVID related changes.
During the pandemic, the attendance has decreased and some members do not want to meet face to face.
Everyone has been busy with Covid-19, people out of the office
For a while during the pandemic, most of the 2020 year and into 2021, we met virtually. We began to meet in person again during the 2021 year.
Member turnover and covid
Our meetings are triggered by release of fatality reports from Raleigh - they say these have been delayed due to COVID. Face to Face generally prompts more ideas and we have been virtual. The Health Dept which facilitates the meetings is currently overwhelmed with COVID response
Some of the members were out due to COVID for themselves or other family members.
Team members not being available to meet due to extra work because of COVID.
The Health Department, DSS and School System are three of the biggest partners of our CCPT and we have been overwhelmed since March 2020 due to COVID.
The pandemic has displaced some team members.
the pandemic lead to an inability to have face to face contact however meetings have consistently been held via teleconference.
These meetings are best done in person. Covid kept us from that.
we have had to meet virtually and CFPT has been able to meet
We have not been able to meet due to COVID due to the increase in numbers.

Attendance/Scheduling/Availability
Overall there was a lack of participation membership turnover made this more challenging
Meeting times where everyone can attend
Getting people to participate and be involved in the meeting
Lack of involvement from community partners
Availability of members and staffing issues at the Agency.
Ensuring everyone is able to participate in meetings due to the added responsibilities in their workplaces due to the pandemic. Most workplaces in which members work have been short staffed or have added duties.
We have been meeting virtually, attendance is difficult for members due to staffing challenges, having cases to review is always challenging and diversity on who presents cases.
Attendance. certain individuals that never show up to meetings that would be very useful in their participation. It is typically the same consistent agencies that are

represented. In addition, we have had to reschedule many times due to the nursing staff from the HD and schools being short staffed.
Staff illnesses staff shortages and being able to set up meetings when we all could meet while fully staffed
There has been difficulties obtaining medical records as well as a lack of participation from all members
Some of the members was swamp with work due to co-workers being out of work.

Miscellaneous
none (other than exhaustion, especially as Chair and Review Coordinator are intimately involved in public health COVID-19 response) -- we switched to virtual meetings (Microsoft Teams) in 2020 and continued them in 2021; they have gone well
We continued meeting in person as a combined CFPT/CCPT and this impacted attendance.
delays from ME office in obtaining information

COVID-19 Related Barriers

Lack of Face-Face Interactions
Lack of in-person meeting.
Inability to have court in person
This Team's Chairperson is a CPS investigator at DSS and the virus has created barriers including how we are able to communicate with families and gain access to their children because they have not been in school or we are unable to see them face to face and speak to them separately apart from their parents
Meetings are not the same. Same information is provided, but it is so difficult to meet by phone
Our outreach activities were hindered which would have reached children and their families.

Limited Support and Underreporting
Lack of available services/resources for families
visiting restrictions
A decrease in CPS reports because of isolation of children in homes
COVID-19 has resulted in agency variations in protecting children. For example, the use of video conferencing in lieu of face to face contact has been utilized to complete interviews with families with COVID and/or COVID exposure

DSS workers are not visiting foster children directly. this has resulted in at least one tragic death. Many children are not being reported because they are not in school.
Parents have reported not accessing medical and other services because they are afraid of COVID
Less in home and face to face contacts due to family members and staff exposure to known COVID patients
1) Virtual learning (which was case in 2020 and first part of 2021) led to less school contact with children and decreased reports to CPS, so unidentified child abuse/neglect; it also led to decreased social-emotional wellbeing of children, no home or face-to-face visits by early intervention specialists and CCNC care managers; community provider had decreased service opportunities, so downsized and have been struggling to scale back up to meet increased demand; child & family mental health waitlists are long, running 8 weeks to 6 months; prosecutions stopped entirely during COVID and now DA's office is digging out of backlog, so persons charged with crimes against children have not been held accountable in a timely manner; also, during pandemic, bail was set lower than previously, so persons charged with crimes against children were more likely to be out

of custody during that time, which is concerning.
Our CCPT identified that there was a negative impact on children during the beginning of 2021 when the schools were providing learning in the virtual format and not meeting physically with the students. This dissipated when students returned to in-person learning in August.
Under reporting of child maltreatment due to extended time of remote learning.
Increased waiting lists for mental health services, more mental health services being virtual, children not being in school decreases contact with children; children being at home causing more financial and emotional strain on the family. delays of appointments for CMEs specifically after children discharged from the hospital.
COVID 19 caused less face to face interaction with children and mandated reporters such as school personnel, medical personnel, neighbors, family members, etc. As a result, reports of suspected AND, went down.
COVID created several barriers impacting protection of children Initially [COUNTY NAME] experienced a significant drop in reporting presumably because children were in a virtual learning environment and it was difficult to assess situations that might warrant a report Childcare for working parents whose children are virtual learning has been a stressor for families and a contributing factor in child protection
Families had less access to home based and face to face support services eg therapy also raising the risk of child welfare involvement for families also struggling with other issues
COVID placed additional demands on an already stretched child welfare workforce which had impacts on the types of provided to child welfare involved families
Remote school attendance created barriers to seeing children for a variety of reasons. Children were not as easily accessible as to CPS, sometimes due to illness or identification as a close contact, and some families not answer the door to avoid contact with the department.
We have experienced delays to complete home visits due to Covid Exposures. There have been significant delay or lack of resources due to lasting effects of the pandemic. There is a severe need for Child Care facilities in the County due to increased demand of child care.
Treatment for mental health, substance abuse has been much more difficult as appointments moved to virtual platforms. Of course there was a delay in the transition. Appointments for physical health issues became more difficult to access as did public transportation.
Schools/Counselors and other entities may not be seeing children due to quarantine. [COUNTY NAME] County has overcome any barriers, but the most concerning was if the family who needed protection has Covid and workers had to ensure their own safety.
Lack of foster care placements lack of domestic violence batterer services
Mandated services were not going out and seeing children and families due to the pandemic which left an opportunity for increased abuse and neglect to occur secluded children from often a safe adult to tell
Parents were hesitant in allowing social workers into their home due to concerns of exposure to COVID.
Not having them in school was the biggest. Our top reporter went from being teachers to cops.
There was a decrease in reporting from the schools and law enforcements.
Some parents became more difficult to work with and that caused suspension of community services and resources that would keep their children safe. Agency didn't always have access to see children in the home due to parent not want DSS to

come in their home due to COVID.
Children no longer had that social outlet and place to feel safe to talk about maltreatment in the home. Maltreatment increased as a result of COVID.
Access to treatment services- some offered services primarily virtually and family could not do this; new staff within agencies who were faced with very challenging families, could not always access co-worker or supervisor support; differences in service delivery protocols between military and civilian community
Less oversight and involvement in the community
COVID-19 made the access to healthcare more difficult than it was under normal circumstance, in some cases. It prevented in-person service delivery or it delayed service delivery. COVID-19 also created the isolation of children some agencies and organizations that routinely observed/served them, such as a lack of in-person learning.
It has greatly affected mental health resources for youth and adults. We have seen an increase in substance use and decrease in services.
increased truancy due to virtual learning challenges, therapy through telehealth is difficult for children and increased mental health issues with children not being in school and schools not seeing children regularly and not being able to assess how children are doing.

Staff Personnel and Wellness
Testing/Vaccine availability; Safety and exposure concerns of children and staff who may engage with children to limit transmission
Safety impacts on our staff for possible Covid positive children brought into care.
Staff continued to facilitate the protection of children amidst the ongoing C19 pandemic; however, as it has continued, staff are fatigued and exhausted.
Limited Staff, Due to Staff exposure Child Welfare has continue to experience staff shortages. Workers remaining, continue to carry double the caseloads.
Our frontline workers (social workers, school personnel, medical personnel) are struggling with burnout and turnover. There is a backlog of A/N/D cases waiting to be heard due to the time court was shut down early in the pandemic.
Covid-19 has wiped out the child welfare workforce. I have one of four workers on my blended in-home/assessment team.
Workers leaving the agency for other opportunities, the inability to recruit appropriate qualified candidates for the open positions, health hazards for our staff.
the rate of turn over increased exponentially, staffing was an issue when an area was infected. Staff in CPS has no means to work cases virtually
workers exposed to Covid-19 and having to quarantine.
covid really made staffing shortage at times
Agency shutdown
Our team also saw an increase in CPS cases and within those, an increase in the severity/complexity of those cases. This, in turn, leads to staffing turnover and shortages.

Adjusting to Virtual Platform
Lack of attendance during virtual meetings
Internet service, WiFi and cell service are limited in our rural county which made accessing virtual appointments more difficult.
We had to improvise by wearing masks setting up zoom meetings etc
Some visits were not conducted face to face in person but virtually.
initial lack of distribution of PPE to non-public health staff (frontline social workers, economic services workers, etc.); on-going lack of cohesion in state responses to local

county needs due primarily to state employee teleworking
lack of WIFI to operate Zoom
Not all areas have strong internet coverage, thus some team members have difficulty connecting during the pandemic.
At beginning of the pandemic visits were completed virtually upon the states guidance.
At times in person face to face has had to be virtual due to either the child or caretakers being positive for COVID or exposed.

Miscellaneous
Court held by Webex did not give workers the adequate training they needed for court dynamics.

we have maintained all services during he pandemic
CPS is still functioning normally
Our team is still working during the pandemic-just not doing it in person. Our social workers have continued to see children in order to ensure safety-just wearing PPE, social distancing, etc...
COVID has impacted our service provision by making our jobs more challenging across all program areas
DSS still completed face to face visits to ensure safety Most visits were completed outside and at a distance

Resources shared among CCPT members

Community
board service between agencies
CAC
colocation between agencies
Community Activity Information
community assistance
Community Events
Community Events
community events
Community Resources
Community Resources
community resources
Community Resources
community resources
community resources for parent education
Community Supports
Future Community Events
Knowledge of Available community resources
New Community Agencies/Organizations
Outreach
Partners LME
Partners LME

Education/Training
available trainings
Car seat training
CPS Intake Presentation
Educational
Educational
Educational Resources
Events and/or Trainings
helpful trainings
learning opportunities (e.g., webinars)
Other Education
Parent training
substance classes
Training
Training opportunities
training opportunities
Training Opportunities
Training opportunities
Training Opportunities
Training Opportunities
Training Opportunities
Training Resources
Training/public awareness/education
TRAININGS
Trainings
Triple P Parenting

Financial
Advertising $
Financial

Financial resources
Financial Resources
financial resources
Financial Resources
financial resources
Financial resources
Financial resources
Financial Resources
Financial resources
Funding Opportunities
grant opportunities
grant opportunities
Grant Opportunities
grant opportunities
Grant Opportunities
Grant Opportunities
Grant opportunities
grant opportunities
Grant Opportunities
Grant opportunities
Grants
Safe Sleeping Funding Opportunities
several agencies partner together on grants
Team funds

Health and Wellness
Child Health Care Progress
Free Medicine Giveaway
medical information
Mental Health
Mental Health
mental health
MENTAL HEALTH REFERRALS/INFO
mental health resources
mental health services
Mental Health/Substance Abuse
mental health/substance abuse services
new providers
Referrals
Residential treatment provider resources
Vaya - Available mental health services
Womens Shelter

Advocacy
Juvenile court mediator

Updates and Announcements
Agency Announcements
Agency News
CFTF Info
Child Facility Changes
Invitation to share from other services at each meeting
legal changes
Legislative Updates
NCDHHS-DSS Policy updates
Policy Changes
Policy Updates
Program Updates
Resource Changes
upcoming events
We regularly share resources and upcoming changes etc

General Support
[Center Name] Center
[service provider] services in [County name] Co
Baby Boxes for safe sleep
COVID-19 Resources/Relief
Crisis Assistance/Resources
Donation for safe sleep from a local church
Housing
Juvenile Early Intervention/Crime Prevention
Licensed foster home additions
local agency resources
Parent support groups
Resources for Families
safe sleep
Service opportunities
Service Organizations
Service recommendations
Support for Families
Transportation Info
Transportation Resources
VOLT

Miscellaneous

Legislative Actions
Ryan's Law

School
SHARE RESOURCE/COLLABORATION
Statistical data
statistics

Barriers to participation and family/youth partner engagement

Recruitment Difficulties

Being unable to identify a family that is emotionally ready to be on the CCPT/CFPT
Could not get commitments for team members
Did not seek to involve for participation
Difficulty recruiting/engaging
Family was not identified.
Had the parent on the team who had a child die but had not explored further to identify/recruit another family and/or youth partner for 2021
Have Not Been Asked
Hesitancy about serving/ not enough slots available to invite to join the team
Identifying participants
identifying who to engage
Lack of effort to engage
lack of identified family and youth partners
lack of incentives
Lack of interest
lack of interest
Lack of interest from families
Lack of recruitment
lack of recruitment
lack of recruitment for participants
Managing priorities. We value parent and youth input and participation and have them participate regularly in our agency's Community advisory Council for grant funded programs.
never invited to join
No efforts made
No efforts made
No outreach
team did not identify them
Unable to reach
we didn't seek their participation

COVID-19 Pandemic

COVID
COVID
Covid
COVID
Covid
Difficulty meeting/communicating with individuals face to face and virtually
Team did not recruit family or youth; COVID
virtual platform
we didn't focus on this particularly because of Covid

Confidentiality/Appropriateness

Case discussions can trigger trauma. Additionally, it is hard to find youth that are emotionally stable and mature enough to handle and discuss the serious subject matters.
Confidentiality Concerns
Due to cases still being open in DSS or LE investigations this does not allow families to take part in CCPT
Due to cases still being open in DSS or LE investigations this does not allow families to take part in CCPT
Mandates from County and agencies related to the pandemic, etc. especially for face to face contact- also some we hoped to connect with have technology issues
The appropriateness of youths attending and the time of the meetings.
The Chair of our CFPT does have confidentiality concerns and we didn't offer remote meeting options during Covid
We feel they are not permitted by statute.
We feel they are not permitted by statute.

Miscellaneous

no meetings
no meetings
not addressed
Our CCPT did not meet
Our CCPT did not meet

List of Organization Collaborators

[COUNTY NAME] County Board of Commissioners, [COUNTY NAME] County Consolidated Human Services Board
[COUNTY NAME] County Gov't Staff
[COUNTY NAME] DSS Board
[COUNTY NAME] Forward, [COUNTY NAME] The[COUNTY NAME] Times,
[COUNTY NAME] County Partnership for Children
[COUNTY UNIVERSITY], Health Department, County government
Board of Commissioners & Board of Health
CC4C
CC4C addressing safe sleep, co-sleeping
Child Advocacy Center-Professional Advisory Council and MDT, Army Community Services
Care Review Committee, Reclaiming Futures Program, Behavioral Health Provider agencies
Community at large through FB information
County Commissioners
County Commissioners, Crossnore, Kiwanis
County EMS Schools
County Health and Human Services Board
Board of Commissioners CCPT member organizations
County Manager
DSS Staff County Commissioners Consolidated Human Services Board [Count Name] Safe
DSS, Law Enforcement, EMS, School System and District Health Department
DSS: "pack and plays/cribs" for new babies to discourage co-sleeping
Early Intervention Team- [County Name] County Schools
Health Department
Health Department, Schools, Medical Providers, CAC, Abuse Prevention and Guardian At Litems
Hospitality House, Domestic Violence Shelter
Information is often shared with the CFPT
Kids Coalition
Law enforcement Children's Advocacy Center and school system
local food/shelter pantry; domestic violence shelter; local CAC; local community action agencies
Local Hospital/Medical Professionals on CCPT/CFPT, developed additional screening tools to be used on all patients at the hospital to identify risk factors of substance use so they can be referred to DSS for plans of safe care
Local mental health & substance use providers
Local Mental Health Agencies, and the DA and Juvenile Justice. TEAM LED- [County Name]
[Center Name] Health Center, [County Name] County Sheriff's Office, and DA's office.
Local newspaper
Mental Health - Trillium
N/A
Police, Fire, EMS, Hospital, Obstetricians, Local Parent Groups, Specific Communities
System of Care,[COUNTY NAME] Public Library
Teen Suicide, Vaping in schools
The Board of Commissioners who fired Cardinal Innovations and led to them being fired by 10 other counties and disbanded by the Secretary.
Welcome Baby
YMCA of [COUNTY NAME] county
Youth Service Agencies

Intensive Review Process

Subcommittee formed

Independent of intensive review, although some members serve on the intensive review as well.
all documentation is reviewed
A team is recruited from our CCPT
CCPT will go into closed session and seek volunteers to serve as various members of the review Once review team is established all review members receive confidential copies of the record A review date is then established with state
The chair will identify keys members to participate and provide all required documents for review, well in advance of the review

CCPT requests volunteers to participate
Participants include those with and without case history Documents are sent securely to all prior to the review
We would pull an intensive review team together, composed of the required members. 1 representative from the local team is requested.
CCPT Chair organizes the review team and ensures records are gathered and distributed to the facilitator
A member serves on the intensive fatality review and brings the info of the findings back to the team
We have a CFPT Team who reviews fatalities in the community We also put together a Intensive Review Team with members from CCPT and CFPT when a review is needed for Child Welfare
Separate subcommittee developed for the review
DSS Director assembles review team to conduct an intensive review.

Whole Group Review
Everyone is notified prior to the meeting and asked to gather any information on the family for presentation
We discuss the case at the first CCPT meeting following the fatality. The CCPT chair sends out identifying information to the team members so they can prepare to discuss the case. We discuss the case at our meeting and then make recommendations if we come up with any.
Our local team proceeds with our local reviews per usual, minus the cases that are part of intensive review
This CCPT team staffs and reviews results of Intensive Fatality Review
We discuss it during our quarterly meeting and bring back progress or lack of progress of family to the next meeting. We also discuss policy and things that may or may not need to change and how we can work better together.
CCPT and CFPT members participate
Team members participate on the Fatality review
Collaboration with CFPT and CCPT
Each member gathers information from their respective agency.
The CCPT chair will inform our CCPT members of the findings and recommendations of the ICFR
All members are invited to attend in the intensive review participate in discussion and work collaboratively towards identifying service gaps and interventions to close those gaps
When the ICFR is completed and the report received, the CCPT/CFPT reviews the document to identify strategies to address systems issue. We then follow up on implementation of actions recommended and if there were positive results.
CCPT gathers the info
The local team is informed about fatalities and findings when applicable
Representatives from CCPT and CFPT are on the review team
We try to review the case during our quarterly meeting
These are staffed and discussed bi- monthly at the Child Fatality Prevention Team meetings
Gather the file and staff that were a part of the case
When an intensive review occurs, our team skips the local review but shares the finalized report from the state with the team.

Collaboration with Outside Agencies
Health department staff receives notification of case review. Case review is placed on the agenda for a meeting. Meetings are only scheduled if we have current cases. HD staff request full medical records for review. If medical records are received, meeting is scheduled. HD medical staff reviews medical records prior to meeting and provides summary of circumstances to the

group during meeting. All attendees are able to ask questions and recommendations, if any, are made as to if the death could have been prevented. If preventable, discussion/action on educating the community on preventable death discussion and what steps to get the information at to the community takes place.
Outside presentative tells us she is coming and we establish a team. We don't like it though because we don't feel anything useful is ever done with our findings and we feel that our findings are not always accurate because they are so influenced by facilitators.
The review is chaired by the local DSS agency and the outcome is shared with the CCPTCFPT committee
The Department of Social Services provides pertinent case information to the community partners and an open discussion occurs to discuss solutions and resources that would benefit the case.
This does not occur very often. The last time an intensive review occurred the local team had already reviewed the case. The CCPT team is kept informed about intensive reviews and their outcomes.
Staff from DSS invites CCPT members to participate on the review team and we share the final report with the whole team for discussion
We work with the State Child Fatality Team CCPT sends a representative

Miscellaneous
Fortunately our agency has not had to have an Intensive review in several years.
Unfortunately, we are going to have to have at least one this year, most likely two. It seems that the state has chosen to do reviews on these cases based on criteria that is not familiar to us, but we will go with what they are telling our agency. We also feel that they are asking for information on children that are not in the home (in one of the cases) that was not part of our investigation, nor part of our case, but we are having to request this information for this fatality review. Our agency is already short staffed and suffering from staff burnout and turnover. This will only exacerbate that.
We have not had one.
unfamiliar with process we have never had an intensive review that I am aware of
N/A for 2021 - would handle per policy
we have not had the opportunity to conduct an intensive review at this time.
we have not had any reviews other than our normal active case review

Local Review Problems

Communication amongst the different agencies. Sometimes we don't always reach out to each other for assistance and information to help assist the families.
Several members participate in the intensive review and once the state sends the final recommendations, it is shared with the team. We also discuss ways in which we can further assist with the outcomes.
we have not had any reviews other than our normal active case review
We were unable to review a case timely due to not receiving medical records. COVID made in person meetings difficult due to health department staff being unavailable.
Yes - hospital not reporting to DSS.We recommended update in training.

Improvements for Case Reviews

Uniform Data Collection

A standardized tool for collecting and compiling data

Having all counties use NCFast (statewide system) to give staff access to CPS records from other counties; Receiving fatalities to review in a timely manner from the State
Funds for a part time coordinator to track down information.
getting quicker autopsy reports
annual review of the state webinar and its materials and adopting the recommended process

Increase Participation/Collaboration
Regular attendance
Good participation and well rounded representation with input from service providers
Active Participation from Community Partners.
Add family partner piece, give team description of the case prior to scheduling meeting
Better participation
Member attendance
investigation information from other agencies due ongoing investigation & discussions with the District Attorney.
More community partners
More input for other agencies
More involved participants
More Law Enforcement Involvement and attendance
more participation
More participation from members. In particular LE partners. Timely sharing of information to include medical records. Cases sometimes cannot be reviewed as the team is awaiting medical records.
More participation with all team members
Continued communication with other agencies
ORGANIZATIONS CAN PRESENT CASES
For DSS to present cases
DJJ involvement at the meetings
If more services existed in the county, agencies could possibly connect people to services.
Input from community partners as well as bringing more cases to CCPT for review
Greater availability of law enforcement personnel to participate Review active cases
Picking more cases from other agencies than DSS; follow up on cases presented
Quarterly agenda item to submit and present cases from each agency on a rotating basis.

Education/Training
For members to be educated on NCDHHS state policy.
Internal refresher with CCPT members and DSS CS staff to set case review expectations with a review of the CCPT purpose, duties and roles and how case reviews guide advocacy and recommendations.
Provide additional trainings to CCPT on how to engage in prevention
Training
Training for members
recorded trainings that can be reviewed by the team at convenient times;
team education
Utilizing and learning CCPT Policy

Time
More time and staff to devote to the teams activities
More time for the professionals to focus on case reviews.
The biggest impediment to case reviews is that the presenting Social Workers don't have time to prepare their presentation because of other work duties.
Timely access to records. We had several cases that could not be reviewed due to pending criminal charges (not necessarily against the parents) and thus we could not move forward until clearance from DA's office.

Timely receipt of cases to be reviewed from the state.
timely reports from ME; case review selection criteria that is NOT universal (e.g., not all MV deaths need to be reviewed)

Miscellaneous
Referencing Individualized Education Plan when relevant
The team is good about sharing information, there are no suggestions for improvement.
To actually review cases for CCPT
Being able to meet in person
get back in person
CCPT will carry out reviews as needed to avoid maltreatment
Higher focus on system reform indicators and advocacy
Discussing possible referrals at sub-committee for full committee meetings.
Due to COVID, our team did not meet in 2020 and 2021.
EVERY 2 MONTHS WE HAVE A CASE PRESENTATION AND OTHER

Limitations to accessing MH/DD/SA/DV services

Unreceptiveness to families
Limited engagement by parents
Parents are not willing to participate.
parent lack of participation
Parents Unwilling to Participate
Family did not follow through with services
Parents unwillingness to seek services
Family Compliance
Parents not following through with services
Refusing to attend

Limited resources
limited Life Skill/Parenting services for adults
mental health with interpreter services
Lack of substance abuse programs for youth
Limited Medicaid for Parents
Limited number of providers
Limited Spanish speaking services
Lack of residential treatment programs for youth
Limited Enhanced Services
Limited Resources
Limited virtual services
Limited services for undocumented persons
HAD TO REFER SOME FAMILIES OUTSIDE THE COUNTY DUE TO LACK OF RESOURCES IN PERSON COUNTY
respite homes
providers losing therapist
Embedded Therapist
Limited access to technology for virtual sessions
Limited services for youth requiring higher level of mental health services (more than virtual individual therapy).
Providers having waitlist
DV shelter closed
Local Shelters for DV

Staffing
Due to staffing shortage in MH/SU, there were delays in accessing services.
Limited Staff
Vacant positions- staff working from home

Finance
Lack of medicaid or private insurance
Financial concerns
Lack of insurance/funding source
Parents lose Medicaid if children are taken into care

Miscellaneous
Fear of deportation due to immigration status
Misuse of community agencies
Parent Incarcerated/Moved Out of State
placements after hospitalizations
Team did not meet due to covid
Virtual mental health services lack efficacy.
COVID pandemic

Race Issues

Awareness/Training
acknowledging biases recognizing it as an issue

Staff and placement providers being aware and educated about cultural identity.
Team member awareness of the issue
Timely training and measuring competency of staff in understanding racial equity
Training opportunities for team members.
Open conversations.
training opportunities needed
Disproportionality consistent availability use of data more regular training opportunities have done a webinar series in this year for DSS and Health
The Department undergoes MEPPA
Training and Cultural Sensitivity Trainings that are practiced by the CCPT.
Local awareness among community members
Culture of the county and local DSS

Diversity
Lack of diversity
not a diverse population
We are located in a small predominantly white rural county where there is not a lot diversity.
We are predominantly a Caucasian county (96%+).

Separate Task Forces
Our county recognized racism as a public health issue and has a Racial Equity & Inclusion Workgroup w/in county government that is providing educational opportunities for staff. Our Social Work Division also has a Racial Equity workgroup that has been doing the same.
WE CURRENTLY HAVE A RACIAL EQUITY COMMITTEE IN PERSON COUNTY. WILL CONNECT WITH THE CHAIRPERSON OF THE COMMITTEE
In our county, there is a disproportionate number of minority children and families receiving CPS services. Our county has other committees dedicated to addressing the issue, but CPS addresses it in context of specific issues. Our team works to address issues with cultural humility and knowledge of racial inequities with an ongoing desire to learn more and apply knowledge better.

Equitable Resources
Providing equitable services to the Spanish speaking community. Formed partnerships with local advocates and organizations, prepared materials in Spanish, attended Latina community festivals and distributed materials; Trained child welfare staff and other community organizations in culturally appropriate work with the Latinx community
addressing the needs of Hispanic families-having bi-lingual staff available
Disparities in child welfare start at CPS Intake which families are or are not being reported to DSS Systemic inequities impact families and subsequently families that are impoverished and or have lack of access to resources are more likely to be reported to DSS
ensuring that our licensed foster homes are racially equitable
Resources available
Income, employment criminal justice and housing
Transportation housing
Disparities in reporting
Health Care and Income

Miscellaneous
Receiving reports
The team has not identified any issues.
This approach has not been discussed with the CCPT.
This is not a mission at this time.
Child abuse does not see race or ethnicity when a case is called into our agency Cases are not assigned or determined by race or ethnicity by our agency
Did not discuss
have not discussed and identified local issues regarding taking a racially equitable apporach to child welfare.

Race Resources

Our CCPT reviews social data regularly.
Perhaps, from a neutral presenter
The team is interested in being provided resources.
yes because it could be useful for treatment planning especially since there is a teen suicide increase locally
Yes Our agency is participating in an equity initiative

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

Adequate service provision

Mental Health Services
Mental health treatment
Increased mental health providers
Coordination with mental health services
Access to mental health and substance misuse services
[County Name] County CCPT members continue to advocate for additional mental health providers as well as residential providers in the county to provide consumers a choice.
Increasing racial diversity of mental health professionals providing child and family services
Better quality Mental Health/Substance abuse Services offered for adults
Increase the quality and number of SA/MH/DD resources
More SA and MH providers
more evidence based and trauma informed services
Increase access to quality, in person, trauma-informed mental health services
Continued collaboration with mental health, behavioral health, LME/MCO resources to serve families and children.
Increasing the number of mental health professionals that provide evidence-informed child and family services related to trauma/PTSD and Intimate Partner Violence
Timely access to quality in person SA &/or MH clinical services
Referrals for trauma focused therapy and psychological testing
More trauma informed service options at the local level for adults and children
Trauma screening assessment and treatment across systems
Address widespread drug addiction
Substance abuse treatment.
Substance Abuse Services
Substance Abuse for youth
more substance abuse treatment services
Admission to residential treatment programs
MAT structuring
Increased use of CFTs
Social workers to continue making appropriate referrals for services
Social Worker for just on-call duties
increase placement options
access to after hours child care
service providers
more services
Access to Services
Access to Spanish speaking services (SA, MH, parenting, DV, education support, etc)
Predictive analytics to promote early intervention and prevent early penetration into the child welfare system
Access to In-Home Parenting Programs for families with children older than 5.
Advancing prevention services
Supportive prevention services for at risk children
more after school options to reduce supervision reports
Continue plan of safe care/safe sleep

Resources

Type/Variety of Resources
Having Available Resources in the Community
Increase in community resources
Locating additional resources for families
Link families with resources
Additional supports and resources for parents of adolescents struggling with difficult behavioral, mental health, or juvenile justice issues
more local resources for DV
Resources for Mental health Services
Navigating the mental health system
Resources for Substance abuse Services
Access to Resources to alleviate conditions that lead to DSS involvement
Build directory of local resources of placement options that may include temporary resources (Diligent Recruitment & Retention Plan)
need for more resources
Access to and education of Resources
Financial Resources
Increase in pay to keep child welfare workers
Improving Child Welfare Staffing needs
Funding for DSS staff and programing
Mental Health resources and funds for those without insurance
fund Welcome Baby cribs
provide funding for safe sleep campaign
access to better transportation
Transportation services
transportation
Expanded public transportation for the community
Transportation
Transportation services for those in need who do not have Medicaid
Housing
Affordable, safe & accessible housing
Increase number of [County Name] County foster homes
Rapid rehousing
Affordable Housing
Establish a minimal housing standard for our county
Additional Housing resources within the community

Education and training
CCPT training
Continued training for CCPT members
Required Training for CCPT Members
increase self-awareness of CCPT
Provide education to local partners and community members regarding reporting requirements
Training available for all Stakeholders
Better local decision-making regarding placement resources in crisis and high need situations
increase awareness surrounding trafficking of youth
Educate the community as well as community partners
Strengthening public awareness through community education
Provide CCPT reports to DSS Board to enhance awareness of community needs.
increase awareness re: internet safety for youth
Community Education on Child Welfare Practices
Continue educating on child maltreatment amongst community agencies
Community education around healthy discipline, and relationships
Education of signs of abuse/neglect
More information provided in the school system about suicide prevention and discussion of ways to intervene
Increasing awareness in schools regarding suicide, drugs, alcohol, driver safety, and mental health issues.
Continue to educate health care and schools on the importance of making reports
Continued education and training for child welfare

Public awareness, education on risk factors for children; increasing knowledge on racial equity
Parenting instruction.
Provide quarterly reports to local health committee to increase awareness
Provide resource information to families
Increasing awareness in the community.
Saturate the community with safe infant sleep information and work to improve systems that serve infants' caregivers
public awareness on co-sleeping dangers
Safe Sleep awareness
Continue efforts through local hospital and DSS to educate parents about safe sleep
Increase training to social work staff regarding plans of safe care and safe sleep for infants
all county contracts require providers who work with families to undergo safe sleep training to gain the ability to discuss safe sleep issues with families

Strengthening partnership/collaboration
Continued communication with community partners
Continue open communication between community partners
Continue outreach to the community
MORE CONNECTION WITH THE COMMUNITY
COMMUNITY EVENTS
need for more community collaboration
Community Engagement
Continue open communication between community partners
Strengthening communication between community partners
Partnering with community agencies to ensure safety for children
Continue collaboration & improve communication
[County Name] County faith-based community develop structured programs to support individuals and family members in recovery to promote navigation, engagement, and accountability.
Continued communication between the partners of the CCPT.
Adding a representative from Juvenile Services to the local CCPT team.
Provide a quarterly report to the BOCC to enhance awareness.
Continue to partner with MDT and our local Child Advocacy Center.
Improve child welfare staff's and other community organizations' work with Latinx community
CHILD ADVOCACY CENTER IN OUR COUNTY
[County Name] County CCPT to partner with Vaya to establish a process to support better communication between mental health providers and community partners to ensure families receive necessary services.
Improve communication and process with SA treatment providers
Family Engagement
Bring family and youth into CCPT meetings
Family and youth participation
Get rid of Cardinal Innovations
Continue to partner with our local LME
work with LME/MCO for residential service needs for juveniles
Collaborate with Vaya to better serve children and youth in crisis so that they are not staying in emergency departments or the DSS office
Sharing of information and communication within the agency and with other agencies.
Address coordination of services between all providers during crises that could lead to out of home placement
Establish multidisciplinary teams to provide support earlier in process
personal visits with all children with DSS responsibility
Continue reunification efforts with families
Continuing to reach out to check on progress of child and situation.

Stop having State Law and Policy conflict with each
Strengthening of relationships with law enforcement
Continue to partner with our local law enforcement agencies.
More Military Involvement

Increasing Personnel
Additional Staff
Staffing
consistent staffing
Increase in number of child welfare workers
Continued Training for Child Welfare Staff
need for social work staff
Reduce number of cases per staff member
DSS stability
More one on one supervision between staff and supervisor.
Staff Retention
Increase and maintain qualified CPS staff to meet policy requirements.

Miscellaneous
Filing timely petition
Reviewing and discussing past history of families and having MDT meetings when we find out the family was involved with other agencies.
increase number of cases reviewed at CCPT
Assess reasons for not reporting and address DSS presenting cases
Make sure marijuana positive infants are reported
Make sure marijuana positive infants are followed
Develop a sustainability plan for the Family Treatment Court
Take a new look at Substance Use Policy
Permanency
Concerns about access to firearms
Our team did not meet

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

Mental health
Mental Health Services for Placement of Older Youth
Coordination with mental health services
Increase in state resources for mental health challenges with medicaid reform and access to mental health services
Increasing the number of mental health professionals that provide evidence-informed child and family services related to trauma/PTSD and Intimate Partner Violence
Increasing access to mental health/substance abuse services for adults who have no insurance
Increase access to mental health services for parents by ensuring they maintain health coverage even when their children are removed from their care
Restructuring of the MH system
Advocate for additional mental health providers as well as residential providers in the counties to provide consumers a choice
That NCDHHS and the Mental Health MCO's work in partnership to make sure that sufficient and appropriate outpatient substance abuse and mental health services for youth are available in the community, that mental health services specifically tailored to meet the needs of children who have been adopted or suffered serious loss be provided at the local level, and that incentives be provided to attract qualified trauma informed practitioners at the county level
Increased mental health and substance abuse services including interpreter services
Streamlined access to mental health and substance misuse services as well as strengthening the recovery community.

Funding

Funding
More funding and resources for child welfare to work with parents.
Better funding
more funding to small counties
Funding for transportation in rural areas
Funding to DSS for staffing & programing
Additional funds for additional staff
Funding for service provision of MH/SA/IDD services
The state must provide more funding for protection services.
More financial resources
Funding
that the local CCPT's be provided funding to address issues identified by the team, with preventive education programs.
The state must provide funding for prevention.
More funding for services
Expanded definition of candidacy to fund prevention services
Continued investment in prevention services
more funding
Increase Support/Funding for evidenced based in-home parenting programs
Local Engagement and Funding Opportunities
Funding for community education
Funding resources for undocumented individuals to obtain services
increase awareness of the need for funding
Increase funding for safe sleep issues

Education/Training

Accessibility and availability for increased child welfare staff training
Continue updates and trainings
Increase access to training and development of new training.
Offer needed CCPT training to counties
Required Training for CCPT Members
offer more thorough and frequent training of child welfare staff
More trainings to CCPT members on making teams better and more effective
public awareness on co-sleeping dangers
Training
Competency and Critical Thinking Training
MORE TRAININGS
more training
More training so there is consistency in policy across all counties
Training available for all Stakeholders
Trainings
more education on new Child welfare policies
More guidance around POSC to staff
Provide local agencies with information / resources available on a state level
Continued Training for Child Welfare Staff
Frequent training for the county level instead of constant reviews
Standardized Education among all State facilitated agencies
Ensure all child welfare staff receive consistent evidenced based trauma informed resiliency training to help manage trauma they are exposed to during their work
Required Training for CCPT Members
more education on new Child Welfare mandates
community outreach education

Resources

RESOURCES
More resources provided for all involved
Identifying Relative Placements
increase placement options
Build network and placement capacity that meet the increasingly high intensive behavioral needs of the youth served through child welfare to include those entering foster care
more oversight of therapeutic and IAFT foster homes and increase the number of these homes
Resources for high risk youth placements
Expand medicaid.

Advocacy and assistance for difficult to place children with therapeutic and residential needs within catchment areas
Housing
Affordable Housing
Sharing information and resources seamless service
Access to Resources to alleviate conditions that lead to DSS involvement
State child welfare case management system
Intake hotline
Prevention Services
access
support with resources
Resources to address racial equity

Children-specific support
Make sure marijuana positive infants are reported
Make sure marijuana positive infants are followed
he state needs to study the link between marijuana positive infants and fatalities.
Policy for plan of safe care and co- sleeping
Statewide child welfare case management
Increased education on infant safe sleep
continue education to health care providers to discuss safe sleep
Increase safe sleep resources
Clear expectations for Substance Affected Infants and plans of safe care
Address the problem of children and youth who are being cared for at DSS offices or hotels due to lack of appropriate behavioral health care
For NCDHHS and the Mental Health MCO's to work in partnership to provide enough additional residential treatment programs (PRTF and Level III) to meet the needs of youth with Substance abuse and mental health issues quickly when the need arises, that they address the need for violent youth to be able to quickly access the appropriate level of care, and that they work together to ensure that authorization is received for higher levels of care for teenage mental health and teenage substance abuse issues when recommended.
Being able to get autopsy reports and/or preliminary autopsy reports much quicker when there are living children still in the home.
When children die and are sent to the Medical Examiner for an autopsy, the medical examiner should always do a full body scan/x-ray of the deceased child to make sure there are no suspicious injuries.
Identify solutions for children who are dually diagnosed but ineligible for behavioral health services due to a medical condition eg diabetes
education on water safety for children

Health and wellness
Increasing access of patients with Health Choice to mental health providers (few accept that insurance)
Increase in the number of high-level placement providers
More services available for parents and children with dual diagnosis
Increase support/funding for trauma informed services
Trauma informed programming in all child serving systems
increase secure residential treatment and residential substance abuse treatment facilities for juveniles
Substance abuse Services
Provide more support for kinship care providers
Medicaid expansion
Make programs available statewide to better support families and prevent future child welfare involvement eg PPP Home Visiting Programs

Administrative Improvement
support with staffing
Would recommend a reduction of the case load assignment per DSS Social Worker.
Less regulation and paperwork

Decreasing the amount of forms within Child Welfare
Timely turnaround time for case reviews related to child fatality reviews
Timely access to data
Develop a team to streamline the process.
Reduction of number of cases per staff member
Advocate for a smoother process to share information across county lines between child welfare agencies
Continued improvement to the NCFAST system to support the SWs practice.
more support in all CW program areas
Continue to move toward a statewide child welfare information system to improve visibility of families as they move throughout the state

Policy
Policy
The state must be able to update policies to reflect what is currently happening in the field. IE spread of fentanyl and impacts.
Direct communication on policy changes.
Re-examine policies related to Substance Use/Misuse
Consistent & stable policies
Non-Conflicting State Law and Policy Legislation

Collaboration
That a representative from Juvenile Services (Juvenile Court Counselor) be added to the mandated membership of the CCPT
more collaboration
support with collaboration
Participation
Offer feedback from county workers not just management
Support and partner with local teams in their local efforts
monthly meeting and policy updates between community partners

Miscellaneous
Staff Turnover in Child Welfare
MAT compliance enforcement
Implementation of a practice model throughout Child Welfare
fewer intrusions
Ongoing support to agencies affected by the pandemic and impact on workers
Our team did not meet

Top three CCPT objectives based on improvement needs

General Resources
after school options
Assess local MH/SA/DV resources to meet the needs of families.
CHILD ADVOCACY CENTER
Having specific providers to come to the area to work with youth whom abuse illicit substances
Address drug addiction
Identify resources available and accessible to conduct CFTs- promote agencies networking with each other to accomplish this
Improve services to Latinx
Promote suicide prevention.
Opioids
Suicide Prevention
Youth on Youth Violence
DOMESTIC VIOLENCE PERPERTRATOR PROGRAMS
improving mental health resources in the community
Homelessness
HOUSING/SHELTER
Resource Development
Decrease out of home placement/ shorten duration, by inclusion of natural and community supports along with formal services - strengths based

Infant Resources
Increase importance of prenatal care
Infants Safe Sleeping
Prenatal care
More education regarding safe sleep
Safe sleep
safe sleep prevention for SAI education
Substance Affected Infants
Substance Affected Infants

Outreach and education on infant safe sleep
Provide safe sleep materials to local Oxford Houses
More awareness around substance abuse affected infants
address safe sleep
Decrease baby roll over deaths

Education/Awareness
Training
Combined Training for Staff
Educating service providers on the needs of citizens
Community Education
gun safety education to parents
education
Strengthening public awareness through community education
Continue educating on child maltreatment amongst community agencies
Continue public education on available services public training and education
Promoting education, identification of and awareness on risk factors for families and how community can become more involved;
Promote substance abuse awareness.
Training on CCPT
Water Safety Education
Community Awareness of issues
Increase community awareness
Child Abuse awareness within the community.

Community Collaboration/Participation
Strengthen community partnerships between agencies.
Strengthening communication between community partners
Increase representation from community members
Continue to locate and share any new community resources that families can utilize
Collaborated with the school system
Recruit more members
Community Engagement
Collaboration with community resources to improve services.
Increase membership
Case reviews from other providers other than DSS
Increase activities/partnerships to address needs of children and families- includes use of social media, community cafes, recreation and parks, etc.
Relationships
Discussion with local hospital regarding educational efforts when children are born; CPS/DSS to continue to hand out information and assess sleeping conditions upon home visits; display information in the local DSS income maintenance areas; billboards in the community
Ensure the community understands the role of Child Welfare
Local DSS Board RPTS
Work more collaboratively and cohesively as a combined CCPT/CFPT
Communication
Improve quality of CCPT meetings
Consistent meetings
Maintain meetings during the pandemic

Efficient Staffing
Additional Staff
Staff retention
Reduce number of cases per staff member
Social Worker for on-call only

Miscellaneous
Local health committee reports
Local BOCC reports
Increase CPS reporting by professionals
Racial Equity
Undocumented children

Things that helped CCPTs reach local objectives to meet identified improvement needs

Meeting Efficiency/Teamwork

brainstorming amongst team members & identifying potential options within the community

Inviting stakeholders to share information regarding services
Knowledge and experience of team members.
we structured agendas around this primary goal
Holding virtual meetings and in-person meetings were social distancing was observed.
Consistent CCPT Meeting, that consist of staffing cases with Child Welfare Staff
Building relationships among team members and working on the team membership.
Knowledge and experience of team members.
Multi-disciplinary commitment from team members
scheduled meetings in advance and completed some virtual
Committed team members
Encourage and promote case reviews
Sharing information and collaboration on reports
Communication and quick response

Community Collaboration
Sharing information with the public and other agencies
Strong community partnerships
Communication among Community Partners
Open communication with community partners
Partnership with local training groups (CAC-Professional Education and Training; AHEC; partnering with local universities)
substance abuse rally
Partnership with YMCA
Collaboration
Sharing information and collaboration on reports
Communication among Community Partners
Agencies assisting in providing info to the community, Pandemic did cause a change in how this occurred
Partnership at local level and with Faith Action International
Collaboration with DSS, local hospital and health department
Collaboration with local providers
regular communication with partners
Relationships established with local Oxford House manager
Agencies working together to provide training
Inviting providers to participate in CCPT meetings
Current members reaching out to community partners and families.
Commitment from all involved. Ensuring roles and responsibilities were clearly defined; listening to voice of all family members and their identified support network (faith based; other non-profits; advocacy groups; extended family and friends; reviewing lessons learned from some of our military partners; providing access to needed material items that enhance quality of home life and safety.
Medical Persons
Continuing to have a team of open minded community partners
Invited community partners
Creative collaboration and networking even though there were restrictions from the pandemic;
Communication among Community Partners
distributed informational brochures in community
Inviting more mental health and IFPS providers
Partnership with CFPT on focus topics - suicide prevention & mental health
resources for youth - billboard project and art design development in partnership with and 'thanks to' Trillium (LME/MCO)
Strong partnership with law enforcement and assistance from community organizations

Education/Awareness
VAYA - QPR training
Regular scheduled trainings and education

presentations to Law enforcement and hospital about CPS reporting
Education with community parterns
Participated in CCPT Training for Chair (along w/ other DSS staff serving on the CCPT) in October 2021.
Education of Health Providers and families
Training provided by community partners and the State
Sharing information
Sharing information and collaboration on reports
Billboards were purchased to raise awareness

Miscellaneous
Political support from local government
MASC
Changes instituted by CCDSS through their Models of Change initiative of CCDSS to support the Family First Preservation Act.
child fatality, high caseloads & increased extended duty
County administration increasing salaries for employees.
Increased staff assistance
celebrating successes
local fundraising
funding from grant and local government
MH
still a work in progress
still a work in progress
still a work in progress
child fatality
Have not achieved this goal
WE CURRENTLY WORKING ON GETTING A CAC IN OUR COUNTY
WE DO HAVE A SAFE HAVEN IN OUR COUNTY BUT NEED MORE

Ways the state can help local CCPTs achieve objectives to meet improvement needs

Funding
Additional funding to the counties
funding
funding
Provide funding opportunities to support local team initiatives
Provide support and guidance when the need arises.
More funding
Improve Funding local mandates
increased funding for positions
Financial support for programs/staffing.
Look into funding and grants with Public Health, DSS and state office
Improve Funding local mandates
Improve Funding local mandates
Increase funding access
increased funding
Increased funding for more staff.

Policy Update
Continue to update on State changes
Clarify policy expectations
change policy regarding caseload sizes
Updates on legislation that impact the CCPT and CFPT process

Services/Resources
Additional resources for Substance Abuse and MH Services
INCREASE MORE SERVICES OF MENTAL HEALTH FOR CHILDRE
Advocate for Medicaid expansion
Provide Comprehensive List of Resources List
Provide available updated materials or resources.
Increase eligibility for services for persons who are undocumented
TRAUMA THERAPIST
Resources for more providers.

Provide materials of available resources to be distributed to citizens
Increasing the number of landlords who accept Section 8/housing vouchers

Education/Training
More education on water safety for children continue to be available for trainings and questions
Train providers on meeting the needs of at risk and high risk populations
Train the team
Provide/develop mandatory training for child welfare staff
unknown
Training opportunities and provision of data Training
More education on undocumented children and human trafficking
Wider range of education topics for training
Provide support consistent training opportunities
Competency Training
Continue education on safe sleeping
General partnership training for law enforcement and DSS
MORE TRAININGS/RESOURCES
Provide Child Welfare Curriculum
Statewide efforts to educate professional organizations, such as physicians and therapists

Collaboration
Incentives for family/youth partners to join.
Partnership and collaboration with local law enforcement
Provide information on engaging Community Partners
Timely response to questions about partnerships
Provide suggestions on how to engage community partners
Partnership and collaboration with local MCO and other mental health provider

Miscellaneous
robust recruitment & retention policies;
Ensure we have adequate Child Welfare Staff so that we can continue to have staff to present cases with systematic barriers
Consolidate the required reports, surveys and requested data and streamline through an automated collection throughout the year that would allow for teams to collect and consolidate this information in 'real time' versus after-the-fact.
Enhance NC Safe Sleep capacity
Sharing results from other initiatives, not just in NC
Virtual meetings were held with schools, hospitals and Law enforcement
State materials to assist with setting up and maintaining virtual meetings.
Provide suggestions
Provide incentives to providers whom provide specific services to citizens

Further support that would help teams implement recommendations

Collaboration/Participation/Meeting Efficiency
A Planning meeting at the beginning of each year to set goals.
Continue to discuss and problem solve the recommendations and approval to move forward with strategies from leadership and upper management involvement.
Discuss previous recommendations at each meeting and provide updates throughout the year to keep goals at the fore-front
More participation from county managers
State member of CCPT.
Just any recommendations on a local level on how the CCPT can carry out recommendations. One suggestion as CCPT I would like to make this upcoming year is

to form a subcommittee regarding fire safety and prevention.
Participation
Offering of incentives to the CCPT members.
Ongoing support and collaboration- keeping us informed on policies and changes recommended at state and national level
Consistent and timely feedback from the state
Leadership, state presence
We did not set objectives but a goal would be to increase our membership
We are looking forward to being able to meet again in person.
We need to meet again in person

Additional Funding/Resources
Grant opportunities that contribute to the growth, safety, and protection of youth in rural communities.
Financial Support
Funding continues to be a need for all aspects of working to make improvements in the CCPT's efforts. CCPT members have limited availability due to the nature of the agencies they represent which are typically which are under resourced. The safety net systems (DSS, MH, SA, IDD) are under resourced to the point that their effectiveness is often limited.
Funding so that the local team could address identified issues locally. The lack of substance abuse and mental health services, both residential and community based, will likely need to be addressed by the legislature, the NCDHHS, and the MCO's.
Funding, support, and staff
money
increase funding
Increase in state/local funding to support initiatives
Additional MH and SA resources in the community.
more access to services
funding opportunities through grants and foundations that may be helpful
Continued technical support upon request; an updated CCPT user-friendly reference and/or guide for all members to include a video-graphic that exhibits examples of a well-formed and communicative, action-oriented team.
Prevention Efforts and Funding
Provide increase funding to local agencies and communities for additional services.
provide the chairperson with CCPT-specific guidance authored by the state
Some type of financial assistance to help the team with promoting child safety.

Training/Education
continued training and guidance
More comprehensive and engaging training for CCPT members
We need training on how CCPT is supposed to be conducted aside from meeting about cases.
I have helped fill in a CCPT chair when others have left the agency. I think that there should be more training as it relates to the role and requirements of CCPT with Program Managers, Supervisors, and Social Workers. There also needs to be training and information sent to community partners. With high turnover at most agencies, CCPT seems to fall through the cracks and is not utilized appropriately.
training to local child welfare agencies and service providers
Continued training.
Ongoing Training for CCPT Team Members
Better data collection tools more frequent training address the question of involvement of youth and family partners and how meetings could be triggering for youth in particular
Provide additional advanced training to CCPT on how to engage community resources in prevention, outreach to family and youth partners and to partner with

organizations to meet unmet community needs
State Training for CCPT Chairperson and Members
The state doing more research on the link between marijuana and cosleeping fatality. I assure you that one exists.
Training and clarity on what these recommendations should look like.
Training on what types of recommendations teams should make
TRAININGS/RESOURCES FOR OUR COUNTY
training

COVID Limitations
Our agency will have to rebuild a team for these reviews. COVID and staff turnover has created large barriers for the team.
The team continues to face challenges with COVID-19.
Once we are able to have full participation without the barriers of COVID we can work in partnership on the recommendations.
The team will be discussing additional goals for the upcoming year and will try to work around issues with the pandemic to achieve these goals.

Miscellaneous
In some respects perhaps the CFPT and CCPT are effective, maybe even helpful, but many are just feel good moments and another way to appear to be doing something. However it is disingenuous and hollow. Take this survey for example, you can't move on until all the boxes are checked Yes. It's dishonest data collection but this dishonest data is what is used to promote the use of these meetings. Makes it appear that we are collaborating with community agencies for the safety of children. I applaud those agencies that are excelling with their CFPT/CCPT but in some ways it is a waste of time.

Appendix D: Copy of 2021 Survey

CCPT Survey 2021
2021 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 2021 survey. The NC CCPT Advisory Board is responsible for conducting an end-of-year survey of local CCPTs and preparing a report to the North Carolina Division of Social Services (DSS). In the report, the information provided by the local CCPTs is aggregated without identifying individual team responses and the NC CCPT Advisory Board makes recommendations on how to improve public child welfare. DSS then writes a response to the report.

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

The survey responses are transmitted directly to the researcher, Dr. Emily Smith, at North Carolina State University. This means that survey responses are NOT transmitted to DSS or to the NC CCPT Advisory Board. Dr. Emily Smith and the other members of the research team, will respect the confidentiality of local CCPTs and will NOT link individual responses to local CCPTs. De-identified findings may also be included in presentations, trainings, and publications.

The 2017, 2018, 2019 and 2020 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 2021 Survey (6430)
Principal Investigator: Dr. Kwesi Brookins biadnow@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 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 the responses of the local CCPT may identify that they made a particular answer.

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 IRB 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.

Am I eligible to be a participant in this study?
There will be approximately 101 number of participants in this study, representing all counties in North Carolina and Qualla Boundary. Chairperson's of the CCPT in each county and 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 county's CCPT for the past year.

You cannot participate in this study if you are no longer a member of your county's 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 participating in this study is 20 minutes. In preparation for completing the survey, it is recommended that the local CCPT Chair meet with the team to discuss what responses to provide to the survey questions.

Risks 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 individual CCPT's survey responses are transmitted directly to the researcher, Dr. Emily Smith, and are not viewed by the NC CCPT Advisory Board or by DSS. Before reporting the results, the researcher will combine responses and not link them to a specific CCPT.

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. If you choose to withdraw your consent and stop participating you can expect that your survey responses will not be recorded.

Confidentiality
The information in the study records will be kept confidential to the full extent allowed by law. Data will be stored securely on an NC State 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. Emily Smith, at Center for Family and Community Engagement, North Carolina State University, ejlefebv@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 IRB (institutional Review Board) Office via email at irb-director@ncsu.edu or via phone at 1.919.515.8754. An 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 without penalty or loss of benefits to which I am otherwise entitled."

- **Yes**, you can now proceed to the next page.
- **No**, please contact Virginia King at the NC Division of Social Services for technical assistance on completing the survey: email DSS.CCPT@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 2021.

2. Your survey responses must be submitted online (via Qualtrics). Do not submit paper copies to 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.

7. Please complete and submit the survey online (via Qualtrics) on or before **January 14th, 2022**.

Select your CCPT from the list below.

- Alamance
- Alexander
- Allegheny
- Anson
- Ashe
- Avery
- Beaufort
- Bertie
- Bladen
- Brunswick
- Buncombe
- Burke
- Cabarrus
- Caldwell
- Camden
- Carteret
- Caswell
- Catawba
- Chatham
- Cherokee
- Chowan
- Clay
- Cleveland
- Columbus
- Craven
- Cumberland
- Currituck
- Dare
- Davidson
- Davie
- Duplin
- Durham
- Eastern Band of Cherokee Nation (Qualla Boundary)
- Edgecombe
- Forsyth
- Franklin
- Gaston
- Gates
- Graham
- Granville
- Greene
- Guilford
- Halifax
- Harnett
- Haywood
- Union
- Vance
- Henderson
- Hertford
- Hoke
- Hyde
- Iredell
- Jackson
- Johnston
- Jones
- Lee
- Lenoir
- Lincoln
- Macon
- Madison
- Martin
- McDowell
- Mecklenburg
- Mitchell
- Montgomery
- Moore
- Nash
- New Hanover
- Northampton
- Onslow
- Orange
- Pamlico
- Pasquotank
- Pender
- Perquimans
- Person
- Pitt
- Polk
- Randolph
- Richmond
- Robeson
- Rockingham
- Rowan
- Rutherford
- Sampson
- Scotland
- Stanly
- Stokes
- Surry
- Swain
- Transylvania
- Tyrrell

- Wake
- Warren
- Washington
- Watauga
- Wayne
- Wilkes
- Wilson
- Yadkin
- Yancey

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

- The CCPT chair
- A designee of the CCPT chair
- The CCPT team as a whole
- A subgroup of the CCPT team
- Other _____

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

Which of the following statements best characterizes your CCPT? *(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 _____

Has the pandemic affected your team's operation?

- Yes
- No

What difficulties has your CCPT faced while trying to meet and complete your work?

_____

Please describe any barriers COVID-19 posted to facilitation the protection of children? (This question is meant to be an open opportunity for your to highlight specific difficulties faced by your county)

_____

How often does your CCPT meet as a full team?

- Annually
- Biannually
- Quarterly

- Bimonthly
- Monthly
- Other

How often do subcommittees within your CCPT meet?

- We do not have subcommittees
- Annually
- Biannually
- Quarterly
- Bimonthly
- Monthly
- Other_____

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

Which of the following applies to your CCPT?

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

CCPTs have members mandated by General Statute 7B-1407.

In 2021, 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 2021, 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

For assistance communicating with and identifying mandated members to increase participation, please submit requests to DSS.CCPT@dhhs.nc.gov

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

In 2021, 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 _____

How well does your CCPT prepare for meetings?

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

How well does your CCPT share information during meetings?

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

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

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

How well has your CCPT effected changes in your community?

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

In 2021, 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

If family or youth partners did take part in your CCPT, how many of them had a dual role (for example, a mandated member meeting the definition of a family or youth partner)?

_____

In 2021, 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 2021, were family or youth partners invited to attend CCPT meetings?

- o Yes
- o No

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

- o Yes
- o No

In 2021, 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.)

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

In 2021, which of the following reasons prevented some family or youth from taking part in your CCPT? (The checklist below comes from CCPT survey responses in past years. Check all that apply and add your own.)

- o Lack of transportation
- o Lack of childcare
- o Lack of reimbursement for time
- o Scheduling conflicts
- o Other commitments (e.g., school, work)
- o Uncertainty about role
- o Other _____

In 2021, which of the following reasons prevented your CCPT from engaging some family or youth on your team? (The checklist below comes from CCPT survey responses in past years. Check all that apply and add your own.)

- o Difficulty recruiting or identifying family and youth partners
- o Lack of resources to support participation (e.g., transportation, childcare, reimbursement for time)
- o Sensitive nature of topics discussed
- o Uncertainty about maintaining confidentiality
- o Need for training on engaging family and youth partners
- o Lack of dedicated person to engage family and youth partners
- o Other _____

During 2021, did your CCPT partner with other organizations in the community to create programs or inform policy to meet an unmet community need?

- o Yes
- o No

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

_____

_____

Who were the other organizations or groups at the local level, with whom you shared your CCPT's findings and recommendations resulting from the initiative?

_____

What is the total number of cases (active cases) reviewed by your CCPT between January and December 2021?

Number of cases reviewed _____

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

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

*Fatalities: only include child fatality case reviews where the death was caused by abuse, neglect, or dependency **and** did not receive an intensive review.* (Intensive Review data will be collected from the State office, do not include these)

In your county, does the CCPT conduct maltreatment fatality reviews separate fromIntensive reviews?

- Yes
- No

If the answer is no, do you have a separate team that conducts these reviews?

- Yes
- No

If your CCPT conducts fatality reviews outside of Intensive Reviews, how many met the criteria for a local review?

How many of these did you conduct?

How many of the fatalities reviewed were Substance Affected Infants? *If zero, type 0.*

When an intensive review occurs, tell us how your local team handles the local review.

_____

_____

Were there any issues identified in the reporting process during your review?

- Yes
- No

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 2021 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 _____

Which of the following contributory factors to children being in need of protection did you use in 2021 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 (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 2021 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 (SU)[47] _____
- 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 (SU) _____
- 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 (SU) _____
- Domestic Violence (DV) _____
- Child Trafficking _____

How many of the cases reviewed in 2021 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 (SU) _____
- Domestic Violence (DV) _____

Please indicate if any of these services had a waitlist.

- Mental Health (MH) _____

[47] 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).

- Intellectual/Developmental Disabilities (I/DD) _____
- Substance Use (SU) _____
- Domestic Violence (DV) _____

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

- Mental Health (MH) _____
- Intellectual/Developmental Disabilities (I/DD) _____
- Substance Use (SU) _____
- Domestic Violence (DV) _____

In 2021, 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 number of experienced child and family team (CFT) meeting facilitators
- Limited attendance of MH/DD/SU/DV providers at CFTs
- Other 1 _____
- Other 2 _____

Please describe any barriers COVID-19 posed to facilitating the protection of children? (This question is meant to be an open opportunity for you to highlight specific difficulties faced by your county)

_____
_____

Racial Equity: *The condition when racial identity cannot be used to predict individual or group quality of life outcomes (e.g. wealth, income, employment, criminal justice, housing, health care, education).*

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

- Yes
- No

What are some local issues in regards to child welfare taking a racially equitable approach?

_____
_____

Would you be interested in being provided resources to explore a racially equitable approach to child welfare?

- Yes
- No

Based on your 2021 case reviews, what were your team's top three recommendations for improving child welfare services at the local level?

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

Based on your 2021 case reviews, what were your team's top three recommendations for improving child welfare services at the state level?

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

Did your CCPT set local objectives based on identified improvement needs to complete over 2020?

- Yes
- No

List your CCPT's top three local objectives based on identified improvement needs for 2021. Then rate how successful your CCPT was in achieving these objectives.

	Not at all	Slightly	Moderately	Mostly	Completely	Too soon
Objective 1 _____	o	o	o	o	o	o
Objective 2 _____	o	o	o	o	o	o
Objective 3 _____	o	o	o	o	o	o

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

- Objective 1 _____
- Objective 2 _____
- Objective 3_____

What can NC DSS do to help you achieve your local objectives to meet identified improvement needs?

- Objective 1_____
- Objective 2_____
- Objective 3_____

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

_____

_____

Please contact the DSS CCPT DSS.CCPT@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 2021 CCPT Survey.

Thank you for taking the time to complete the 2021 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.

George Bryan

Karakahl Allen-Eckard

Sharon Barlow

Molly Berkoff

Gina Brown

Carmelita Coleman

Deborah Day

Melissa Godwin

Terri Grant

Carolyn Green

Kella Hatcher

Virginia King

Pachovia Lovett

Debra McHenry

Helen Oluokun

Joan Pennell

Paige Rosemond

Starleen Scott-Robbins

Emily Smith

Lynda Stephens

Kathy Stone

Bernetta Thigpen

Cherie Watlington

Marvel Welch

Barbara Young