NORTH CAROLINA COMMUNITY CHILD PROTECTION TEAM

2024 End of Year Report

Community Child Protection Teams
NC Advisory Board

Foreword

This report attests to the invaluable contributions that local Community Child Protection Teams (CCPTs) make in support of children, youth, and families across our state. The teams demonstrated a keen awareness of the issues facing families in their communities and offered thoughtful commentary on how to enhance the performance and responsiveness of child welfare. They also pointed out what resources CCPTs need in order to build robust local teamwork to safeguard children and families. Their insights and efforts will be vital to instituting an effective system of 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. 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 (CFACE) at North Carolina State University, led by Dr. Christopher B. Mayhorn, carried out the survey with Dr. Anna Abate serving as program manager and Helen Oluokun supporting data collection, analyzing results, and preparing this report.

Executive Summary

The report delves into the comprehensive assessment of Child Community Protection Teams (CCPTs) in North Carolina, focusing on their efforts to enhance child welfare at both local and state levels. Through an extensive survey conducted at the end of 2024, CCPTs were queried on various aspects of their operations, including local activities, positive changes observed, recommendations for improvement, and utilization of resources provided by the North Carolina Department of Social Services (NC DSS). The survey gathered insights on strategies devised to address gaps in services, enhance collaboration, improve policies and procedures, and promote community awareness. Additionally, it examined the involvement of Family or Youth Partners within CCPT teams, highlighting challenges and opportunities for their engagement. The findings underscore the importance of continuous evaluation and improvement to safeguard the well-being of children and families across North Carolina.

2024 NC CCPT Survey Summary

Main Survey Questions
The 2024 survey inquired about the following six main questions:

1. Who takes part in the local CCPTs, and what supports or prevents participation?
2. Which cases do local CCPTs review, and how can the review process be improved?
3. How do the local CCPTs enhance maltreatment prevention in their communities?
4. What recommendations do CCPTs have to help prevent or ameliorate child abuse and neglect?
5. What policies, procedures, or practices do CCPTs identify as in need of enhancement in the child protection system?
6. What technical assistance needs do the CCPTs have?

This report has been divided into three main sections: CCPT operations, Citizen Review Panel (CRP) function, and technical assistance needs, to best organize the information gained in response to these six broad questions.

A. CCPT Operations

In summary, 78 of the local teams responded to the survey in 2024. The participating CCPTs encompassed all state regions, county population sizes, economic well-being, and the four Local Management Entities (LMEs)/Managed Care Organizations (MCOs) that provided mental health, developmental disabilities, and substance use services. Eighty percent of the responding CCPTs stated that they were “an established team that meets regularly,” lower than in 2023 when 85% of the reporting counties identified themselves as an established team that meets regularly. Overall, the CCPTs as a whole were sufficiently established to make significant contributions to child welfare. Among the responding teams, 83% were combined with their local Child Fatality Prevention Team (CFPT). The percentage of combined teams increased from the prior year, indicating that the continued prevalence of combining CCPTs and CFPTs can contribute to state

planning on consolidating child maltreatment fatalities. Within the last two years, 94% of teams have maintained their team format.

B. CRP Function

a) Maltreatment Prevention

CCPTs have been actively engaged in enhancing maltreatment prevention within their local communities through various activities, collaborations, and education initiatives. Approximately 65% of CCPT teams reviewed active cases to enhance maltreatment prevention, while 52 teams reported positive changes noticed in their communities because of CCPT operations. These changes were driven by maltreatment prevention through community education. Collaborative efforts with agencies such as the Department of Juvenile Justice and local law enforcement, community outreach activities, and partnerships with organizations such as the Firearm Safety Coalition have contributed to positive changes in community welfare. Furthermore, improved collaboration among stakeholders has led to more efficient assessments and the implementation of services, facilitating prompt interventions to support vulnerable children and families. Collectively, these factors have contributed to a more cohesive and responsive community dedicated to safeguarding the well-being of its youngest members.

b) CCPT Case Reviews

Child maltreatment cases encompass active cases and child fatalities; active cases include near fatalities where child abuse, neglect, or dependency is suspected. In 2024, 55 (71%) of the 78 responding CCPTs reviewed 301 active cases and 31 fatality cases that were suspected to have resulted from abuse or neglect. Among the active cases were 22 infants who were affected by substances and 15 near fatalities. Within each county-size group, there was extensive variation in how many cases they reviewed; smaller counties as a group reviewed the most cases. Further, regarding economic well-being, on average, Tier 2 counties (middle distressed) reviewed a higher number of cases. Thirteen counties did not indicate that they reviewed case. 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.

c) Case Review Trends and Recommendations

A total of 72 counties provided qualitative responses. The responding CCPTs identified trends in systemic issues and service gaps that need to be addressed to improve child welfare outcomes in their communities. The major findings noted by respondents included correlations between child safety, substance misuse, mental health difficulties, domestic violence, and child maltreatment cases. Several CCPTs indicated limited access to resources addressing the previously mentioned issues as the contributing factors to child welfare issues. Further, many teams noted challenges with language and cultural barriers as an overarching trend when reviewing cases.

CCPTs offered a comprehensive array of recommendations for preventing and addressing child abuse and neglect in their communities. These recommendations stem from their case reviews and observations and span various domains, including mental health and substance use disorder treatment services, community collaboration and support, education and assistance for families, policy reforms and funding allocations, and professional development and training. CCPTs stressed the importance of advocating for increased access to mental health services, and better

public education initiatives. They also emphasized sustained collaboration with community partners, utilization of resources for essential services, increased education for families, and policy changes to enhance access to services and funding for evidence-based programs. Additionally, CCPTs underscored the need for ongoing professional development and training for healthcare providers, social workers, and other professionals to address various issues, including mandatory reporting protocols and trauma-focused therapy.

d) Reported Services and Resources for Children and/or youth and Parents or other Caregivers

The top three ranked services needed for both parents/ caregivers and children were Mental Health (MH) services, followed by Substance Use Disorder (SUD) services, then Domestic Violence (DV) services. Sixty percent of the responding teams listed MH services for children as the most needed service. Fifty-one percent of the responding teams listed MH services for parents as the most needed service.

e) Reported Limits to Access to Needed Mental Health, Developmental Disabilities, Substance Use Treatment, and Domestic Violence Services and Suggestions for Improvement

The most cited barriers were limited services or no available services, lack of transportation to services, limited service for youth with dual diagnosis of mental health and developmental disabilities/substance use issues, and limited finances. The CCPTs commented on some family factors affecting service receipt, such as parents' readiness to participate in services. It is quite likely that family and systemic barriers reflect the complexity of the healthcare system and the 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.

CCPTs developed strategies to address identified gaps in services and resources, as reported by sixty teams. These strategies focus on collaboration and stakeholder engagement, with efforts directed towards working closely with mental health and substance use disorder treatment providers, county commissioners, and local management entities/managed care organizations (LMEs/MCOs) to advocate for additional funding and improve access to care through resource sharing. Additionally, CCPTs demonstrated the multifaceted approach—focusing on building partnerships, outreach and education, resource advocacy, systemic change, and development of new programs—to bridge service gaps and enhance resource availability for families and children.

f) Review of Local Level Policies, Procedures, or Practices

The survey sought insights on enhancing the local child protection system, particularly focusing on policies, procedures, and practices at the local level. Identified areas for improvement in local policies include enhancing protocols for substance-affected infants, safe sleep practices, and mandatory reporting, as well as reviewing CPS procedures and parental rights. Local procedures emphasized continuous support for children without immediate placement, adherence to state procedures, timely court hearings, and thorough safety assessments. Practices needing enhancement encompassed child placement options, training for parents with substance use disorders, and community education on various topics. Despite these challenges, nearly 50% of CCPTs highlighted successful practices, including effective collaboration among agencies,

implementation of new support programs for families, ongoing education and training, and proactive communication with relevant entities for child safety.

g) Review of State Level Policies, Procedures, or Practices

They survey sought insights on enhancing the state-level child protection system, eliciting a wealth of suggestions spanning policies, procedures, and practices. Proposed enhancements in state policies encompass streamlining documentation, enhancing data collection and sharing, addressing substance use comprehensively, and improving mental health support services for children and youths within the child welfare system. Teams advocated for updated standardized templates, improved inter-county communication, robust policies regarding substance use, and adequate mental and behavioral support for children. State procedure enhancements were recommended to include a more efficient system for reporting abuse, swifter responses for ensuring child safety and placement if possible, ongoing communication among stakeholders, and standardized procedures and training to clarify any policy updates or best practices. State practice enhancements aimed to strengthen preventive services, improve training for DSS staff and community partners, and provide state support to local agencies. One-third of CCPTs noted successful state practices such as RAM initiatives improving access to mental health resources, implementation of Plan of Safe Care policies ensuring infant safety, effective CPS screening policies, and robust collaboration policies facilitating comprehensive decision-making processes within the child welfare system.

h) Local CCPT Recommendations for Improving Child Welfare Services

The survey elicited 122 recommendations from 78 CCPT teams, reflecting a comprehensive approach to enhancing child welfare at both the agency and community levels. Teams emphasized the importance of education, funding, collaboration, and training in preventing child abuse and neglect. These recommendations were categorized into two main sets: Enhanced System and Capacity, and Enhanced Services. Under Enhanced System and Capacity, teams proposed steps including training and education and advocating for policy and practice change. Recommendations for Enhanced Services focused on ensuring adequate and equitable services, with an emphasis on funding support and improving services and resources. Teams highlighted the need for more child welfare staff, increased funding for CCPT initiatives, expanded prevention services, additional resources for mental health and substance abuse, and transparent communication between state and county departments. These recommendations underscored a commitment to improving the child welfare system and promoting the well-being of children and families across North Carolina.

C. Technical Assistance

a) Awareness of Trends and Performance

Among the 72 respondents, 45 (63%) stated that their team discussed or had been educated about Child Welfare trends in North Carolina and the Nation, and 37 (51%) reported that their team was aware of how NC performed in the Federal reviews. Drilling down further, the survey asked, “Is your team aware of your county’s performance on the CFSR?” Forty-one (53%) respondents said no, and 31 (40%) respondents said yes; six (8%) teams did not respond.

b) Assistance and Training Needs

The survey revealed that a significant portion of CCPT teams in North Carolina did not fully utilize training and support provided by NCDSS, with only 37% indicating they had done so. Moreover, the majority of teams rarely or never requested resources or assistance from NCDSS, suggesting a potential underutilization of available support. To address this, the survey sought to identify areas where teams would benefit most from resources, with training identified as the top priority. Additionally, teams expressed interest in training topics ranging from child safety practices to community engagement, highlighting the diverse needs across different areas of expertise within the teams. Overall, the survey underscored the importance of leveraging available resources and training opportunities to enhance the efficiency and effectiveness of maltreatment case reviews conducted by CCPT teams in North Carolina.

c) Racial Equity in Addressing Local Needs

This year's survey explored local developments that emphasized racially and culturally equitable approach to child welfare. Almost two-thirds of responding teams had not discussed issues of equity in child welfare over the year. Nevertheless, teams identified challenges to racial and cultural equity posed by language and cultural barriers and imbalances in reporting, resources, and services. They also specified strategies to address these challenges to equity. To overcome language and cultural barriers, they sought to increase language services and alleviate cultural hesitancies in accessing services. To address imbalances in resources and services, they worked on extending collaborative networks, developing alternative ways of meeting families' needs, and raising their own team's awareness of imbalances.

d) Family or Youth Partners

The survey examined the involvement of Family or Youth Partners in local CCPT teams, emphasizing their role as individuals with firsthand experience in the child welfare system. Despite encouragement for their inclusion, only 11% of respondents reported having Family or Youth Partners on their teams, a slight increase from last year. NC DSS offered resources and training to support the engagement of individuals with lived experience, but only 15% of teams utilized these offerings, potentially contributing to limited participation. While state legislation does not mandate Family Partner involvement, there are opportunities to promote outreach and engagement to enhance the diversity and effectiveness of CCPT teams.

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North Carolina Community Child Protection Teams (CCPT) 2024 End-of-Year Report

Submitted to the North Carolina Division of Social Services

I. Introduction

The federal Child Abuse Prevention and Treatment Act (CAPTA) mandates that each state maintain Citizen Review Panels (CRPs) to assess the effectiveness of child protection efforts in accordance with the CAPTA State Plan, review child welfare agency policies and practices, and investigate child fatalities and near-fatalities. In North Carolina, the Department of Health and Human Services (DHHS), Division of Social Services (NC DSS) oversees CRPs, currently represented by Community Child Protection Teams (CCPTs), interdisciplinary groups established in 1991 to address child abuse and neglect. These teams review active cases to identify system deficiencies, providing a community-wide approach to child protection. Furthermore, NCDSS is responsible for coordinating CRPs, ensuring compliance with federal mandates. Recent legislation, effective October 2024 (NC SL 2024-134), will restructure CRPs under NC DHHS by January 2025, aiming to enhance child protection efforts statewide. This restructuring aims to strengthen the effectiveness of CRPs in identifying and addressing gaps in the child protection system, thereby safeguarding vulnerable children more effectively.

This report provides a comprehensive examination of CCPTs in North Carolina, drawing on insights gathered from the 2024 survey. With the active participation of 78 local teams, this study offers a detailed examination of the operational dynamics, challenges, and recommendations presented by CCPTs across the state. Through six main inquiries, the report examines the diverse activities and initiatives undertaken by CCPTs to safeguard the welfare of children and families, providing valuable insights into the efficacy of current practices and areas for improvement.

Participation patterns and team dynamics are scrutinized, revealing trends in CCPT engagement and operational efficiency. From the prevalence of established teams to the nuances of combined CCPT and Child Fatality Prevention Teams (CFPT), the report sheds light on the organizational structures that underpin effective child protection efforts at the local level. Moreover, the survey provides valuable insights into the collaborative landscape, highlighting the pivotal role of community partnerships, stakeholder engagement, and inter-agency collaboration in bolstering child welfare outcomes.

The report further highlights the core functions of CCPTs, including case reviews and efforts to prevent maltreatment. Through qualitative analysis and thematic exploration, it uncovers trends, challenges, and innovations in these critical areas, offering actionable recommendations to enhance child protection strategies. Additionally, the report underscores the importance of equity, inclusivity, and continuous evaluation in addressing systemic disparities and fostering resilient communities dedicated to safeguarding the well-being of their youngest members. By synthesizing the insights and experiences of CCPTs across North Carolina, this report aims to drive meaningful change and promote the well-being of children and families throughout the state.

This end-of-year report, prepared by North Carolina State University, draws directly on the extensive qualitative and quantitative data collected through the 2024 CCPT survey, as well as the state's formal response to the 2023 CCPT recommendations. Unlike prior years, recommendations were not developed through a separate stakeholder meeting process but were instead formulated by synthesizing county-level survey input, prior survey findings, and state feedback. This approach ensures that the recommendations reflect both the voices of local teams and the broader system-level context provided by NC DSS. Table A-1 provides the process and timeline for the CCPT survey and report.

. End-of-year reports and state responses to them are available at this link.

II. NC CCPT Advisory Board Survey Results

Main Survey Questions

The 2024 survey inquired about the following six main questions:

1. Who takes part in the local CCPTs, and what supports or prevents participation?
2. Which cases do local CCPTs review, and how can the review process be improved?
3. How do the local CCPTs enhance maltreatment prevention in their communities?
4. What recommendations do CCPTs have to help prevent or ameliorate child abuse and neglect?
5. What policies, procedures, or practices do CCPTs identify as in need of enhancement in the child protection system?
6. What technical assistance needs do the CCPTs have?

This report has been divided into three main sections—CCPT operations, Citizen Review Panel (CRP) function, and technical assistance needs—to best organize the information gained in response to these six broad questions.

A. CCPT Operations

a) Respondent Characteristics

The university distributed the survey to 100 county CCPTs, as well as to the Eastern Band of the Cherokee Indians, for a total of 101 CCPTs. The survey was completed by 78 CCPTs, although response numbers varied for certain survey items based on the operational status of counties and number of valid responses. A list of the counties of the 2024 responding CCPTs can be found in the appended Table A-2.

The 2024 response rate of 78 CCPTs was lower than that of 2023 (80) but fell within the typical response rate compared with previous years (2012-2023), which ranged from 71 to 89. The local teams came from all regions of the state and included counties of all population sizes. Specifically, the response rates were 46 (90%) of the 51 small counties, 25 (64%) of the 39 medium counties, and 7 (70%) of the 10 large counties (see appended Table A-3).[1]

The North Carolina Department of Commerce annually ranks the state's 100 counties based on economic well-being and assigns each a Tier designation. The 40 most distressed counties are designated as Tier 1, the next 40 as Tier 2, and the 20 least distressed as Tier 3.[2] The local teams came from all Tier designations. The response rates for economic well-being were 28 (70%) of the 40 Tier 1 counties (the most distressed), 35 (88%) of the 40 Tier 2 counties, and 15 (75%) of the 20 Tier 3 counties (the least distressed) (see appended Table A-4).

In the state of North Carolina, Local Management Entities (LMEs)/Managed Care Organizations (MCOs) are the agencies responsible for providing mental health, developmental disabilities, and substance use treatment services for those who are uninsured. In 2024, the state consolidated the six LMEs/MCOs into four for the 100 counties. The survey included members from all LMEs/MCOs, with member county participation ranging from 71% to 81% (see Table A-5).

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.

Specifically, the survey asked, "Who completed this survey?" As shown in Table 1, the surveys were primarily completed by the chair independently (64%) rather than by the team as a whole (1%). The response "other" was selected by ten counties. Of these ten counties, most indicated that the CCPT Chair completed the survey with input from specific team members, such as the

[1] Duncan, D.F., Flair, K.A., Stewart, C.J., Guest, S., Rose, R.A., Malley, K.M.D., Reives, W. (2020).

[2] County Distress Rankings (Tiers) | NC Commerce. (n.d.). Retrieved May 5, 2025, https://www.commerce.nc.gov/grants-incentives/county-distress-rankings-tiers#TierRankingbyCounty-495

Co-Chair, Review Coordinator, or simply other team members. The time period available for completing the survey was extended to three and a half months to account for meeting delays due to the various holidays and structural adjustments.

Number of CCPTs by Who Completed the 2024 Survey (N = 78)

Table 1. Number of CCPTs by Those Who Completed the Survey

Status	Number of CCPTs	
The CCPT chair on their own	50	(64.1%)
A designee of the CCPT chair on their own	14	(17.9%)
The CCPT team as a whole	1	(1.3%)
A subgroup of the CCPT team	3	(3.8%)
Other	10	(12.8%)

In summary, the survey encouraged CCPT chairs to seek input from team members regarding their responses. The ability of teams to convene to develop their responses was likely limited by the survey being open during holiday months, although an extension was given until March 28, 2025, to those who had not yet submitted a completed survey by the original February 14, 2025 deadline.

c) Team Meetings and Membership

As seen in Table 2, the large majority (80%) of respondents characterized themselves as an "established team that meets regularly." This is five percentage points lower than in 2023, when 85% 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 to large counties.

Number of CCPTs by Status of Establishment as a Team, 2024 (N = 78)

Table 2. Number of CCPTs by Status of Establishment as a Team

Status	Number of CCPTs	
We are an established team that meets regularly	62	(79.5.0%)
Our team recently reorganized, and we are having regular meetings	6	(7.7%)
We are an established team that does not meet regularly	9	(11.5%)
Other	1	(1.3%)
Our team was not operating, but we recently reorganized	0	(0%)
Our team recently reorganized, but we have not had any regular meetings.	0	(0%)

CCPTs have the option of combining with their local Child Fatality Prevention Team (CFPT) or keeping the two teams separate. CFPTs are responsible for reviewing cases of child death where maltreatment is not suspected. CCPTs review active cases and child fatalities where death was caused by suspected abuse, neglect, or dependency, and where the family had received NC DSS

child welfare services within 12 months of the child's death. Of the 78 teams established or operating at some capacity, 65 (83%) of the counties had combined teams, and 12 (15%) had separate teams; one county indicated "Other" to describe its team composition. The percentage of combined teams in prior years has remained relatively stable, ranging from 72% to 82%.

This year's survey also included an additional question to investigate the changes in CCPT/CFPT structure. The survey broadly asked, "Within the last two years has your CPPT moved from a separate to combined team, a combined to separate, or we did not change the format?" Seventy-three counties (94%) have maintained the same format, whereas five counties (6%) have moved from a separate to a combined format. No team moved from a combined to a separate format in the last two years.

d) CCPT Operations Summary

In summary, 78 of the local teams responded to the survey in 2024. The participating CCPTs encompassed all state regions, county population sizes, economic well-being, and the four LME/MCOs that provided MH/DD/SU services. Eighty percent of the responding CCPTs stated that they were "an established team that meets regularly," lower than in 2023, when 85% of the reporting counties identified themselves as an established team that meets regularly. Overall, the CCPTs collectively were sufficiently established to make significant contributions to child welfare. Among the responding teams, 83% were combined with their local CFPT. The percentage of combined teams increased from the prior year, indicating that the continued prevalence of combining CCPTs and CFPTs can contribute to state planning on consolidating child maltreatment fatalities. Within the last two years, 94% of teams have maintained their team format.

B. CRP Function

As CCPTs, state statutes require that teams meet on a regular basis:

1) to identify gaps and deficiencies in community resources which have an impact on the incidence of abuse, neglect, or dependency
2) to advocate for system improvements and needed resources where gaps and deficiencies exist in the child protection system
3) to promote collaboration between agencies in the creation or improvement of resources for children because of their review of selected cases; and
4) to inform the county commissioners about actions needed to prevent or ameliorate child abuse, neglect, or dependency.

a) Maltreatment Prevention

This year's survey posed a series of questions about the CCPTs' efforts to enhance maltreatment prevention within their local communities. First, the survey asked, "What local activities has your team done to enhance maltreatment prevention in your community?" These local activities included education, collaboration, and review of active and near-fatalities cases, among other activities. As shown in Table 3, approximately 65% of CCPT teams reviewed active cases to enhance maltreatment prevention. Next, the survey asked teams, "What positive changes has

your community seen based on your CCPT operations?" Fifty-two CCPT teams shared the positive changes they had noticed in their communities.

Number of local activities used for maltreatment prevention

Table 3. Number of local activities used for maltreatment prevention

Local Activity	Number of CCPTs	
Review of Open/Active Cases	51	(65.4%)
Collaboration	50	(64.1%)
Education	42	(53.8%)
Review of Near Fatalities	16	(20.5%)
Other	11	(14.1%)

CCPTs were then given the opportunity to provide additional information about the types of education they offer. A total of 43 counties provided qualitative responses. The themes for maltreatment prevention through community education encompass four main areas:

1. **Public Education and Awareness**: Focusing on increasing awareness and promoting safety across various areas. These include campaigns on proper gun storage, safe sleep, mental health support, and illicit drug safety through billboards, flyers, and community events. One team wrote, "[we] provided information and resources on stress management and how to provide care for children with special needs." Another team engaged in "Positive Parenting Program Promotion to families involved with DSS, as well as the general public who are caring for children."

2. **Training and Technical Education**: Conducting comprehensive training and educational initiatives aimed at enhancing safety and awareness. Teams, "provided safe sleep training for DSS workers, medical professionals, civic groups, and community partners." While others trained law enforcement, social workers, and medical providers on toxic substances, fentanyl, and drug safety.

3. **Policy and System Education**: Educating major stakeholders about policy and procedure changes at various levels of government to create a safer environment for children and families, ensuring that laws and regulations support maltreatment prevention efforts. One team noted that they reviewed "policy in regard to truancy and what steps the educational system needs to take in order for DSS to screen reports in based on educational neglect." While another team communicated changes "about legislative/policy changes throughout the year. For example, the Unlicensed Kinship Reimbursement Program; updates about the Regional Abuse and Medical Specialist (RAMS) Program; NCPALS Access Line; changes to the CCPT Program becoming a local Child Fatality Prevention Team […]."

4. **Collaboration and Community Outreach**: Engaging in cross-agency and community collaboration to enhance maltreatment prevention and community safety. Teams shared brought in guest speakers from local agencies to educate their CCPT teams and

community on services, resources, and safety initiatives. Efforts focused on improving coordination, referral processes, and resource dissemination through updated QR codes and outreach. Additionally, Community resources were promoted via social media, events, and partnerships. One team "[…] obtained educational materials for swimming safety. We provided these materials to local pool stores and distributed them to families during community events where we had a booth."

Subsequently, CCPT teams were asked to provide information about the local collaborations within their communities. The community collaboration efforts encompass a wide range of activities aimed at improving communication, resource sharing, and service coordination across multiple agencies and community partners. These include formal conferences, regular cross-sector meetings, and multi-disciplinary teams involving law enforcement, health services, schools, child advocacy centers, and nonprofits ("Collaborating with various agencies, including Department of Juvenile Justice, local law enforcement, mental health agencies, etc., to identify areas of neglect or abuse."). Teams organize community outreach events such as safety campaigns, parent support activities, and educational trainings on topics like safe sleep, substance use, and child abuse prevention ("Partnered with several community groups, Aspire, DSS, Vaya, Out Reach Ministries, [local non-profit name] to sponsor the Community awareness Event we host in April."). Overall, these collaborative efforts foster stronger partnerships, improved access to resources, and coordinated approaches to ensuring child and family safety.

Lastly, CCPT teams were asked to discuss the positive changes they had observed in their communities. Collectively, the responses provided highlight the positive changes brought about by CCPT's collaborative efforts in addressing child welfare concerns and promoting the well-being of families in the community. Based on the positive changes observed in the community because of CCPT operations, five themes emerge:

1. **Child Safety**: Focusing on practices such as safe sleep and car safety helps to protect children from potential harm and accidents. One team wrote, "Citizen have become more knowledgeable of local resources, safe sleep is being utilized due to the education on the dangers of co-sleeping." Another team "purchased car seats and booster seats for the community." Several teams noted a decrease in unsafe sleeping incidents.

2. **Collaboration and Community Engagement**: This has been achieved through the collaborative sharing of information and the establishment of strong relationships among team members and various agencies. Increased collaboration has been established with key agencies, including local LMEs/MCOs, local child advocacy centers, and universities. These partnerships have established more effective communication channels, enabling a deeper understanding of the available services and resources. Overall, collaboration among community agencies has improved working relationships and enhanced the effectiveness of child welfare initiatives.

3. **Community Awareness and Resource**: Community awareness has led to increased education and training sessions on critical topics like child maltreatment, safe sleep, and access to local resources. Counties provided space for Mental Health Providers to educate the community. Moreover, there has been a notable increase in awareness levels among

various stakeholders, including community members, medical professionals, schools, law enforcement, and the courts. As a result, community members are becoming more educated on issues that pose risks to children, fostering a proactive approach to preventing and addressing child maltreatment challenges.

4. **Team Development and Morale:** CCPT teams noted an overall boost in morale because of strengthened relationships and rapport building. Teams have gained a better understanding of available services and identified gaps within the county. Opportunities for community partners to meet, discuss cases, and share practices have helped improve collaboration, enhance resource sharing, and strengthen overall efforts to support families and children.

5. **Reduction in Negative Outcomes:** Teams noted a reduction in negative outcomes related to child welfare, marked by a decrease in reports/cases of child maltreatment and a significant reduction in sleep-related infant deaths and unsafe sleeping fatalities. This positive trend can be attributed to improved communication and initiatives promoting safe sleep practices. The increased availability of resources, such as pack n' plays and gun safes, further equipped families with tools to enhance child safety.

In summary, CCPTs and their respective communities are proactively addressing child welfare issues. Through community education and strategic collaboration, significant positive outcomes have been achieved in health, safety, and child welfare. Enhanced education efforts have increased awareness about safe sleep practices, car seat safety, and the dangers of co-sleeping, contributing to a decrease in unsafe sleep incidents and deaths. Collaboration among agencies, law enforcement, schools, medical providers, and community partners has fostered stronger communication, facilitated better resource sharing, and led to more coordinated efforts to protect children and support families. These collaborative initiatives have not only expanded access to services, such as mental health resources and community programs, but also improved morale among partners, who now have clearer connections and a better understanding of the services available. Collectively, these factors have contributed to a more cohesive and responsive community dedicated to safeguarding the well-being of its youngest members.

b) CCPT Case Reviews

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

a. Selected active cases where children are being served by child protective services;
b. and cases in which a child died because 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 received 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 Statutes §7B-1401 defines additional child fatalities as “any death of a child that did not result from suspected abuse or neglect and about which no report of

abuse or neglect had been made to the county department of social services within the previous 12 months." State statute does not stipulate how many cases CCPTs must review in a calendar year. However, the 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, information used in case reviews, and service needs of the cases.

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."

(1) Active Cases

As occurred in previous years, this year's questions regarding child maltreatment fatality cases and near fatality cases have been extensively revised. This year's survey asked, "What is the total number of active cases in which abuse, neglect, or dependency was found did your CCPT review between January and December 2024?" Of the 78 responding counties, 55 (71%) reported having reviewed at least one active case. Overall, the number of cases reviewed ranged from 1-24, with a total of 301 cases being reviewed by counties in 2024. Thus, 23 counties reported not reviewing any active cases.

The survey then asked, "How many of these cases entailed Substance Affected Infants?" Of the 55 counties that indicated that they reviewed at least one active case, 15 counties 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 to 3, with a total of 22 active cases with a Substance-Affected Infant being reviewed.

Next, the survey asked, "How many of the active cases entailed near fatality?" Of the 55 counties that indicated they reviewed at least one active case, only nine 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 nine counties was four, with one county reviewing three cases, three counties reviewing two cases, and the remaining five counties reviewing one case. The low number of near fatalities reviewed highlights the need for further clarification of the term 'near fatality' to aid teams in identifying cases that meet the criteria for this type of case.

Number of Active Case Reviews, 2024

Table 4. Number of Active Case Reviews

Type of Review	Number of CCPTs	Sum of Cases	Minimum of Cases	Maximum of Cases	Mean	SD
Active Cases Reviewed:	55 (71%)	301	1	24	3.86	4.27
Active Cases Reviewed	15	22	1	3	0.400	0.74

with SAI						
Active Cases Reviewed with Near Fatality	9	15	1	4	0.19	0.63

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

Table 5 displays the total number of cases reviewed when organized by county size. Compared to the large and medium-sized counties, the small counties reviewed the most cases, likely due to the larger number of small counties. Within each county-size group, there was considerable variation in the number of cases they reviewed.

Number of Active Cases Reviewed by County Size, 2024, (N=55)

Table 5. Number of Active Cases Reviewed by County Size

Size of County	Number of Respondents Reporting Cases	Number of Cases Reviewed	Mean	SD	Range
Small	32 (69.57%)	179	3.89	4.83	1-24
Medium	19 (76.00%)	97	3.88	3.27	1-10
Large	4 (57.14%)	25	3.57	3.95	1-10

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

Table 6 displays the total number of cases reviewed when organized by Economic Well-Being Tier. The mid-level distressed counties reviewed the most cases collectively. Within each county-size group, particularly for Tier 1 and Tier 2 counties, there was considerable variation in the number of cases each county reviewed.

Number of Active Cases Reviewed by Economic Well-Being Tier, 2024, (N=55)

Table 6. Number of Active Cases Reviewed by Economic Well-Being Tier

Size of County	Number of Respondents Reporting Cases	Number of Cases Reviewed	Mean	SD	Range
Tier 1 (Most Distressed)	17 (42.50%)	103	3.68	3.95	1-15
Tier 2	28 (70.00%)	137	3.91	4.52	1-24
Tier 3	10 (50%)	61	4.07	4.51	1-16

(Least Distressed)

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

(2) Fatalities

The 2024 survey then went on to ask, "How many cases in which the fatality was suspected to have resulted from abuse or neglect did your team review?" To avoid duplication in case counts included, the instruction to "not include those done through an Intensive Fatality Review" was also included. Of the 78 CCPTs who responded to this question, only 13 CCPTs indicated that they reviewed a fatality case suspected of having resulted from abuse or neglect. The number of fatality cases reviewed that were suspected to have resulted from abuse or neglect ranged from 1 to 10, with a total of 31 cases.

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 2024, 55 (71%) of the 78 responding CCPTs reviewed 301 active cases and 31 fatality cases that were suspected to have resulted from abuse or neglect. Among the active cases were 15 infants who were identified as substance-affected and nine near fatalities. Within each county-size group, there was extensive variation in the number of cases they reviewed; smaller counties, as a group, reviewed the most cases. Further, regarding economic well-being, on average, Tier 3 counties (least distressed) reviewed a lower number of cases. Twenty-three counties did not indicate that they reviewed cases. 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.

c) Case Review Trends and Recommendations

(1) Case Review Trends

The survey then inquired about case trends CCPTs generally observed when conducting local reviews. First, the survey stated, "What were the overarching trends, findings, or conclusions your team identified when reviewing active or fatal cases in which abuse, neglect, or dependency was found? Please be specific when describing (i.e., include the *who*, *what*, *when*, and *where*)." A total of 72 counties provided qualitative responses. The significant findings noted by respondents included correlations between child safety, substance misuse, mental health difficulties, domestic violence, language and cultural barriers, and child maltreatment cases. Several CCPTs indicated limited access to resources addressing the previously mentioned issues and unstandardized reporting protocols across agencies as contributing factors to child welfare issues. One team wrote, "Lack of Standardized Information Sharing Across Schools, child welfare agencies, and law enforcement face barriers in accessing critical student information due to the absence of a universal policy requiring public, charter, and private schools to release records. This inconsistency prevents timely intervention for children at risk due to abuse, neglect, or mental health concerns. Delays in information-sharing hinder coordinated responses, leading to gaps in child safety and well-being."

(2) Case Review Recommendations

Next, the survey asked, "Based on these trends, findings, or conclusions, what were your team's recommendations to help prevent or ameliorate child abuse or neglect? Please be specific when providing the recommendation that your team made (i.e., include the *who*, *what*, *when*, and *where*)." A total of 56 CCPTs provided recommendations. The recommendations provided by teams reflected a comprehensive approach to addressing various issues related to mental health, substance use, child welfare, community collaboration, advocacy, and professional development.

Teams recommended the following based on their case reviews:

I. **Information Sharing and Communication:** Teams emphasized the importance of enhancing communication and collaboration among schools, child welfare, law enforcement, medical providers, and community agencies. This involves sharing critical student information, particularly regarding substance exposure and trafficking, to enable prompt response. Regular meetings with medical examiners, law enforcement, and child welfare professionals are necessary to review and refine policies and procedures, reducing the need for multiple interviews and streamlining efforts. Teams also proposed that more education on safe sleep practices, substance abuse, and domestic violence for families with infants and young children be provided. Additionally, teams suggested using CFPT funds to streamline information through billboards and educational campaigns on various child welfare topics, aiming to raise public awareness.

II. **Parent Education to Promote Prevention:** Teams recommended the expansion of proactive outreach to families at key developmental stages, including hospital discharge and well-child visits, to promote safety, substance exposure awareness, and mental health. Teams emphasized the need for focused education efforts aimed at informing parents about safe sleep practices, storing weapons safely, supervision, water safety, and recognizing signs of abuse. Moreover, promoting parenting classes and community-based programs helps prevent neglect and abuse, while ongoing development of evidence-based substance use and mental health treatments addresses underlying issues. Lastly, providing culturally sensitive education about immigration concerns and fostering supportive networks for ESL families to help support the diverse families within the welfare system.

III. **Safety and Risk Reduction:** Teams prompted an increased implementation of comprehensive measures to protect children from harm, including promoting firearm safety through safe storage practices, gun locks, and lock boxes. Teams discussed the need for training around safe sleep, substance use, and fentanyl awareness. Several teams advocated for safer, structured placements that meet children's behavioral and developmental needs, alongside emphasizing supervision and monitoring in high-risk environments involving weapons or substances. Additionally, teams noted that early intervention strategies, such as Family Recovery Courts and specialized placement supports, were vital in

addressing challenging behaviors and preventing future safety risks for vulnerable children.

IV. **Service and Resource Accessibility:** The CCPT teams emphasized the need to increase access to vital mental health, substance abuse, and family counseling services, particularly by improving transportation and community support (translation services) for ESL and rural populations. Strengthening partnerships with providers who offer trauma-informed and attachment-based therapies is crucial, along with facilitating access to pediatric dental care, early intervention programs, and comprehensive wraparound services. Additionally, collaborative efforts to secure funding and enhance systems are essential to expanding service availability and reducing barriers to treatment and safe placement for children and families in need.

V. **System and Policy Development:** Teams advocated for policy changes and funding primarily focused on improving screening tools for human trafficking risk, mental/behavioral health services, and substance exposure. Additional recommendations were made for state and local agencies to allocate funds for evidence-based programs, training for gun safety, co-sleeping, mandatory reporting of child abuse, and residential care and treatment programs.

d) Reported Services and Resources for Children and/ or youth and Parents or other Caregivers

This year's survey asked the CCPTs to rank the need for specific services or resources for both children and/or youth and parent/caregiver from most needed to least needed. Figure 1 summarizes the findings for the children, and Figure 2 summarizes the findings for the parents or other caregivers. The top three ranked services needed for children were Mental Health (MH) services, followed by Substance Use Disorder (SUD) services, then Domestic Violence (DV) services, and Intellectual Disabilities (I/DD) services. Sixty percent of the responding teams listed MH services for children as the most needed service. The least ranked services included Child Trafficking services, Language and Literacy Skills, and Other services (including transportation, parent education, and STD education).

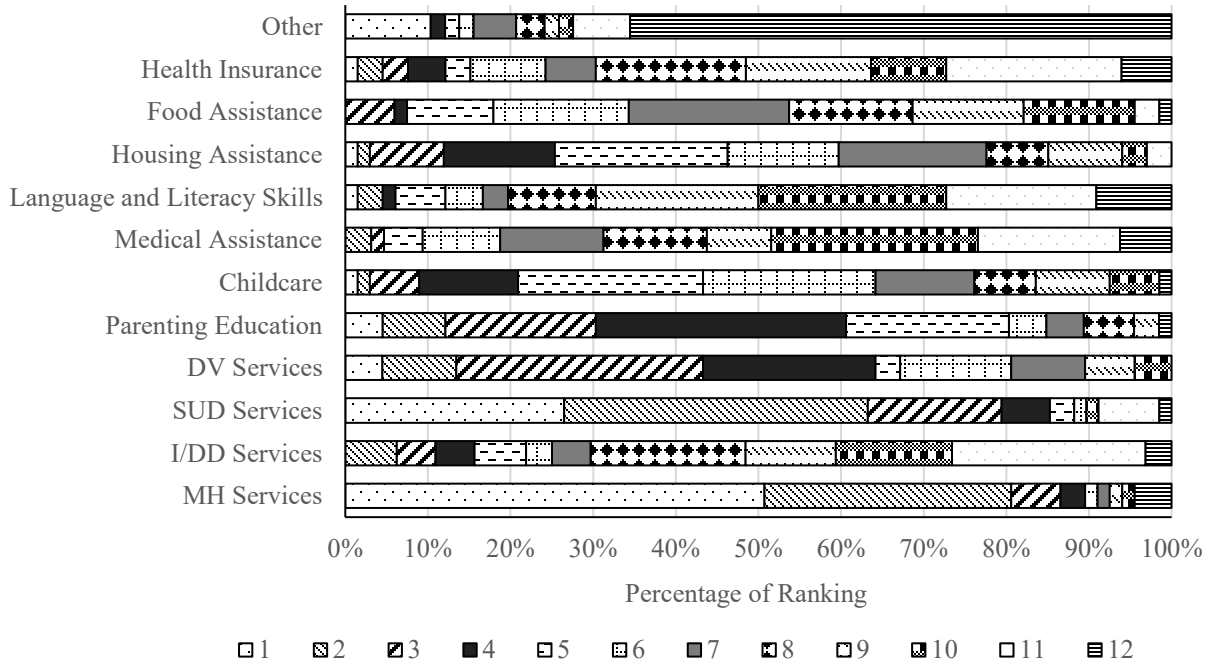
Similar to the ranking of services needed for children, the top three ranked services needed for parents were Mental Health (MH) services, followed by Substance Use Disorder (SUD) services, then Domestic Violence (DV) services. Fifty-one percent of the responding teams listed MH services for parents as the most needed service. The least ranked services included Intellectual/Developmental Disabilities (I/DD) services, Health Insurance, and Other services (including transportation and financial support).

Ranking of Reported Services and Resources for Children and/or Youth (N= 68)

Figure 1. Ranking of Reported Services and Resources for Children and/or Youth

Ranking of Reported Services and Resources for Parents or Other Caregivers (N= 68)

Figure 2. Ranking of Reported Services and Resources for Parents or Other Caregivers



e) 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 the services needed. The survey asked, "In 2024, which of the following limitations prevented children, youth, and their parents or other caregivers from accessing needed services. Check all that apply." As seen in Table 7, the most cited barriers were limited services or no available services, lack of transportation to services, limited service for youth with dual diagnosis of mental health and developmental disabilities/substance use issues, and limited finances. The CCPTs commented on some family factors affecting service receipt, such as parents' readiness to participate in services. Family and systemic barriers likely reflected the complexity of the healthcare system and the challenges of finding services without health insurance. Thus, the teams were well aware of multiple issues that prevented children and families from accessing much-needed services.

Number of Limitations to Accessing Needed Services

Table 7. Number of limitations to accessing needed services

Limitation	Number of CCPTs	
Limited Service or no Available Service	64	(82.1%)
Limited transportation to services	53	(67.9%)
Limited services or youth with dual diagnosis of mental health and developmental disabilities	40	(51.3%)
Limited services for youth with dual diagnosis of mental health and substance use issues	34	(43.6%)
Limited finances	34	(43.6%)
Limited community knowledge about available services	34	(43.6%)
Limited participation of MH/DD/SUD/DV providers at CFTs	31	(39.7%)
Limited child care	27	(34.6%)
Language Barrier	27	(34.6%)
Limited access to healthcare/no health insurance	21	(26.9%)
Limited services for youth with dual diagnosis of mental health and domestic violence	20	(25.6%)
Other 1	5	(6.4%)
Other 2	3	(3.8%)

In response to the limitations identified by teams, the survey asked CCPTs, "What strategies did your local team develop from the reviews to address any of these gaps in services and resources?" Fifty-eight teams provided details regarding the strategies devised to close the service gap in their respective counties. These strategies were grouped into several themes, which are discussed below.

1. **Enhancing Service Coordination and Interagency Collaboration**: Teams actively focused on enhancing service coordination and interagency collaboration through regular meetings to share updates on community services and address barriers. They reestablished involvement with the Juvenile Justice and CFPT to strengthen oversight and response. Ongoing communication among team members ensures a coordinated approach to service needs, with collaboration extending to family services, such as ABA therapy and caregiver education, as well as with LME/MCO agencies, hospitals, and healthcare providers to optimize resource utilization. Teams also participated in local and statewide advocacy efforts, including the Mental Health Task Force, working with partners such as Smart Start, hospitals, and the health department to host community events and develop referral networks, all aimed at improving access to resources and coordination for families and children.

2. **Increasing Community Outreach and Education**: CCPT teams utilized outreach strategies to increase awareness and access to community resources by distributing bilingual flyers, informational videos, and educational materials such as lockboxes, gunlocks, and safe sleep resources in waiting areas, churches, pediatric offices, and at community events. They engaged families directly through outreach efforts at various community gatherings to inform them about available services, including transportation options like CARTS and Medicaid transit. Additionally, the teams expanded after-school programs and partnered with organizations like 4-H to boost youth engagement. To better serve diverse populations, they addressed language barriers by collaborating with Spanish-speaking community members and healthcare providers, ensuring that more families were informed and supported in accessing critical services for mental health, substance abuse, childcare, and transportation.

3. **Resource Development and Funding Advocacy**: Strategies involved advocating for increased financial support from state and local governments to enhance services related to mental health, transportation, childcare, and family support. When existing facilities were limited or closed, teams sought alternative services. They explored grant-funded opportunities to expand resources, including ESL classes with childcare and liaison services for non-English speakers. They also researched and utilized resources from surrounding counties to fill service gaps, continuously advocating for systemic changes to improve access, such as expanding transportation and childcare slots, despite persistent systemic limitations.

4. **Addressing Systemic and System-Level Barriers:** CCPT teams recognized that many barriers, such as transportation and limited agency resources, are systemic issues beyond their immediate control. They actively highlighted challenges related to the availability and hours of treatment facilities, as well as the difficulties faced by employment-striving parents in accessing services. The teams engaged in ongoing discussions about these

systemic gaps and challenges at policy levels, advocating for broader solutions to improve overall service availability and accessibility within the community.

f) Review of Local Level Policies, Procedures, or Practices

This year, the survey requested information about ways to enhance the child protection system at the local level. The survey asked: "During active or fatal maltreatment reviews (active cases in which abuse, neglect, or dependency is found or fatalities suspected to have resulted from child abuse or neglect), what *policies, procedures, or practices* at the LOCAL LEVEL did you identify as in need of enhancement in the child protection system?"

Local Policies: Generally, teams provided a variety of policies that may improve the effectiveness and outcomes of child welfare practices. CCPT teams identified several existing policies that require enhancement to strengthen the child protection system, including amendments to bicycle laws and updates to the Child and Family Team (CFT) practices. They emphasized the need for improved training on handling interviews of children involved in sexual abuse cases, ensuring that forensic interviews are conducted by properly trained professionals rather than untrained police officers. Additionally, there is a call for increased awareness and clarity around reporting suspected abuse, neglect, or dependency, and for better communication with the DA and law enforcement regarding these cases. The teams highlighted the need for increased mental health funding and for agencies to stay well-informed about available county resources to support families effectively. Recognizing that poverty is not synonymous with abuse, they stressed the importance of aiding impoverished families to prevent unnecessary system involvement. They also underscored the necessity for expanded substance use intervention and improved access to knowledge about abuse, neglect, or dependency, along with updates to the NC Child Welfare Manual to align policies with current needs better.

Local Procedures: Teams identified several local procedures within the child protection system that require enhancement, including ensuring strict adherence to policies during investigations and promoting community-based support programs. They emphasized the importance of developing a collaborative framework for establishing a Child Advocacy Center (CAC), streamlining the process of generating letters in NCFAST, and enhancing access to medical and dental providers, particularly for specialized Level 3 placements. Proper supervision management was highlighted as crucial, alongside increasing agency education on available resources to assist families better. They recommended expanding data sharing among agencies to enhance knowledge and coordinate support more effectively, with referrals being more efficiently funneled to additional services.

Local Practices: The practices that needed further enhancement included ensuring all agencies are well-informed about available resources and actively sharing this information with their clients. The need for improving notifications to DSS, particularly from law enforcement regarding substance use and domestic violence issues, was noted. There's a recognized need to increase public awareness through education on helmet safety, reflective gear, and firearm safety, alongside exploring harm reduction models and integrating them into case planning. Enhancing collaboration among agencies, including the use of the CAC model for joint assessments of child sexual and physical abuse, was also noted as critical. The teams emphasized

the importance of strengthening supervisory guidance, ensuring strict adherence to protocols, accurate documentation, and making informed decisions about custody petitions and temporary safety placements. Additionally, addressing challenges in engaging families with serious substance use disorders and improving communication and coordination among child welfare staff and community resources were seen as vital improvements.

Teams were then asked to discuss, "What policies, procedures, and practices of the LOCAL child protection system did you find worked well?" Forty-four percent of the CCPTs noted the things that worked well locally. Overall, teams discussed many policies, procedures, and practices that contributed to the overall effectiveness and efficiency of local child welfare initiatives in the community. These enhancements included strong communication and collaboration among agencies, community partners, schools, law enforcement, hospitals, and organizations like Safe Kids. Adherence to policies, procedures, and the Policy Manual, along with the use of tools such as RAMS and supervision guidance sheets, helped ensure consistent and accountable practice. Regular CCPT/CFPT meetings, community-based programs such as parenting classes, and early engagement with courts for placements and kin support all contributed to effective case management. Teams also emphasized the importance of distributing safe sleep materials through hospitals and community events, utilizing multidisciplinary teams, and leveraging local leadership and stakeholder engagement—all of which foster a collaborative environment that promotes child safety and well-being.

g) Review of State Level Policies, Procedures, or Practices

Next, the survey asked CCPT teams how to enhance the child protection system at the state level. Like local enhancements, teams provided ample suggestions to strengthen child welfare across policies, procedures, and practices.

State Policies: CCPT teams identified several NC State policies that require enhancement to strengthen the child protection system. These include clarifying and making policies more precise, particularly regarding assessments, substance-affected infants, and the use of the Maltreatment Screening Tool to ensure consistency. They highlighted challenges in case decision-making where there are no living children or caretakers, especially involving substance use during delivery and related medical records, emphasizing the need for clear guidance on these complex cases. There is a call for increased support for kinship care, including partial payments, and for developing services tailored to youth with significant behavioral, mental health, and substance use needs, supported by expansion of Medicaid and school mental health services. The teams also recommend implementing statewide policies requiring all schools to cooperate in child fatality investigations, mandating human trafficking screening across agencies, and strengthening firearm storage policies, including accountability for pharmaceutical companies in youth suicides related to medication. The current policies are perceived as insufficient or ambiguous, resulting in inconsistent interpretations and practices at local levels, which highlights the need for clearer, standardized procedures across the state to ensure more uniform and effective child welfare responses.

State Procedures: Teams suggested that state procedure enhancements should include the establishment of a statewide child suicide prevention program to track and support at-risk

children and their siblings. Teams also noted that procedures requiring pediatricians to screen for postpartum depression and assess mother-child bonding during well-checks should be put in place. They emphasized the need for more precise guidance on assessment tools, standards for Temporary Safety Plans (TSPs), and consistent application of policies, especially regarding substance-affected infants, with some families not receiving adequate guidance after policy changes. There's also concern about the limited availability of Level 3 placements for older children, as well as the variability in outcomes for truancy charges and parental cooperation. Additionally, teams emphasized the importance of expanding preventive services to reduce families' entry into child protective systems, advocating for full state funding of these services, and addressing the state's limited capacity to intervene in conflict-of-interest cases across counties. Finally, promoting safety measures such as helmets and reflective gear was noted as an important youth safety initiative.

State Practices: CCPT teams identified several NC state practices that require enhancement to support child protection efforts better. These include improving tools and processes for assessing the safety of children and determining appropriate Temporary Safety Plans (TSPs), as well as expanding community-based treatment options, such as telehealth, to increase access to services. Teams noted the need for ongoing peer and state-level consultation to align new system developments with existing policies, and for clear messaging and education around risk reduction—particularly regarding co-sleeping and fentanyl exposure. Additional priorities include filing obstruction/interference petitions, increasing access to firearm safety resources, and promoting public education through billboards, especially on bicycle laws. Challenges such as hospital discharge criteria for youth recommended for Private Residential Treatment Facilities (PRTF), inconsistent local interpretations affecting accountability, and a lack of clear guidance for families with illegal status were also identified. Teams called for more specialized training for staff, particularly around domestic violence, substance use, and working with non-county residents, as well as policy tweaks to make Substance-Affected Infant (SAI) screening more inclusive and adequately identify at-risk children. Overall, there is a need for increased state funding for all services, as well as for well-educated social workers to navigate evolving policies effectively.

Subsequently, teams were asked to discuss, "What policies, procedures, and practices of the STATE child protection system did you find worked well?" Approximately one-third of the CCPTs shared what went well. For instance, several counties have noted that RAMs (Regional Access and Mobilization Projects) initiatives have successfully improved access to mental health resources and services within their communities. The multidisciplinary team (MDT) approach for case reviews—involving CPS, law enforcement, and healthcare providers—has been particularly strong in reviewing serious cases such as abuse, neglect, or fatalities. The revision of the Substance Affected Infant (SAI) policy, along with improved intake screening, community referral processes, and timely follow-up with fatality reports, has enhanced case management. Additionally, ongoing improvements by the NC DHHS in policies, technology, and public assistance programs—including Medicaid support for health and dental care, as well as support for kinship care—have contributed positively. Policies such as the new DUI classifications, including Physical Abuse, and the Cross-Function Topics Guide have been helpful for interpretation and decision-making.

h) CCPT Recommendations for Improving Child Welfare Services

Number of CCPT Recommendations

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

The survey asked: "Based on your 2024 case reviews, what do you wish North Carolina DSS did differently to help support your CCPT to carry out its mandated function? Please provide your top three recommendations for improving the prevention of child abuse, neglect, or dependency. In writing your recommendations, please be clear and specific (i.e., what specifically needs to be changed?) Please consider policy changes, program needs, or resources." Across 78 CCPT teams, a total of 122 recommendations were provided. Each county provided a range of zero to three recommendations.

The analysis sought recurring themes across all the recommendations and additional information outlined in the survey's final section. The result was a rich array of recommendations that could enhance child welfare within the agency and foster child protection as a community effort.

Recommendations

In making their recommendations, teams demonstrated a keen awareness of local developments and pushed for policy and program changes that fit their experience. These recommendations cover a wide range of areas and emphasize the importance of education, funding, collaboration, and training in preventing child abuse and neglect. The analysis identified two main sets of recommendations. The first set was a series of steps for Enhanced System and Capacity. The second set focused on improving services and reflected the values of service delivery.

Enhanced System and Capacity. The teams' recommendations added to a wealth of proposals for improving the child welfare system and capacity. They formed three main steps: training and education, community awareness and collaboration, and advocating for policy and practice change.

> *Training and Education.* Suggestions from CCPTs included hands-on support at CCPT meetings and ongoing training from the state. Recommendations also involve training on the expectations of CCPT and training for members on specific topics, such as trauma-informed practices, advocacy efforts, and legislative updates. One team proposed that "the state should provide ongoing, mandatory training for CCPT and CFPT members, ensuring they understand their responsibilities, how to analyze data effectively, and best practices in child fatality prevention." In addition to supporting CCPT members, teams emphasize the importance of educating the local community on various topics related to child welfare.

Advocating for Policy and Practice Change. Knowing that they could not single-handedly affect some vital changes, CCPTs recommended that they form local alliances or ask the government to act. To institute a coordinated response, teams looked to local organizing. Recommendations included improving and clarifying policies related to child assessments, fatality reviews, and children with high placement needs, including policy tweaks for substance-affected infants. Suggestions also involve strengthening laws addressing domestic violence, repeat offenders, and youth criminal behaviors. One team specifically suggests "state [to] facilitate stronger cross-agency partnerships by requiring regular joint meetings between public health agencies."

Enhanced Services. In addition to steps to improve the system and capacity, CCPTs proposed ways to ensure that services were adequate and equitable. These recommendations were firmly grounded in the CCPTs' reviews of cases.

Funding Support. CCPTs were concerned about the limited services available to families. Teams repeatedly recognized that chronic shortages and constant turnover among workers hindered their work on behalf of children and families. Addressing these issues required "more child welfare staff." Many recommendations emphasize the need for funding to support CCPT initiatives, expand prevention services, provide more resources for mental health and substance abuse, and offer financial assistance for educational materials and prevention programs. These reforms alone were insufficient unless other programs likewise grew. Suggestions also include funding the DSS for staffing and programming, providing funding for prevention programs, and increasing financial resources for smaller counties.

Improving Services and Resources. Suggestions involve developing community resources such as domestic violence shelters, interpreter services, and safe sleep materials, especially for rural and non-English speaking families. Recommendations also include enhancing support for displaced children with mental health issues, increasing access to mental health services, and promoting transparent communication between state and county departments. In response, one team recommended that "NCDHHS and Mental Health MCOs work in partnership to provide residential treatment programs for quickly and safely providing services to youth with aggressive or serious criminal behaviors."

C. Technical Assistance

a) Awareness of Trends and Performance

This year's survey inquired about the team's general understanding of Child Welfare trends both within the state and across the country. Specifically, the survey asked questions about the team's performance in federal reviews. Among the 72 respondents, 45 (63%) stated that their team had discussed or been educated about Child Welfare trends in North Carolina and the Nation, and 37 (51%) reported that their team was aware of how NC performed in federal reviews. Drilling down further, the survey asked, "Is your team aware of your county's performance on the CFSR?" 41 (53%) respondents said *no,* and 31 *(*40%*)* respondents said *yes;* six (8%) teams did not respond.

b) Assistance and Training Needs

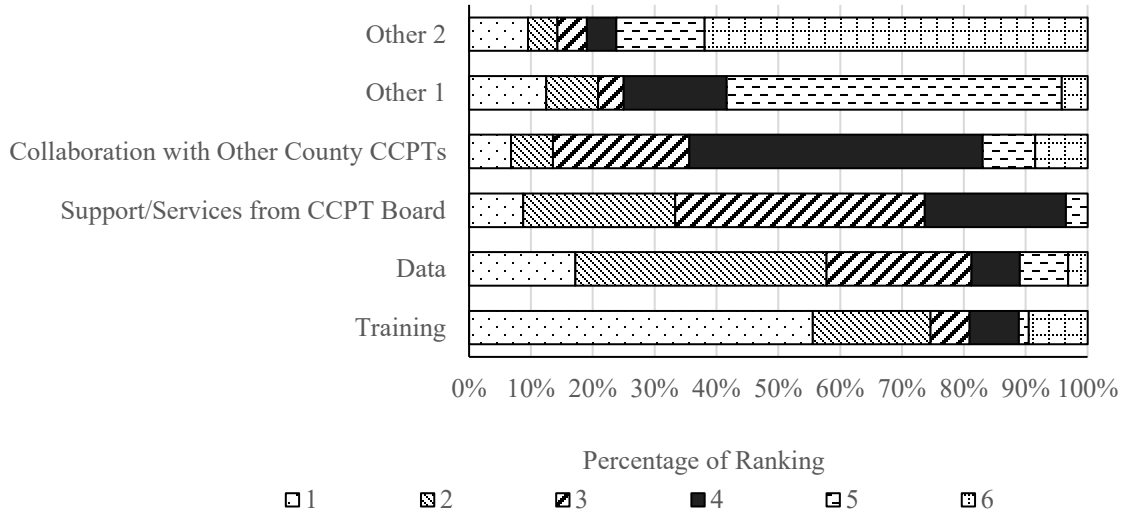
In 2024, NC DSS distributed resources to local teams to help them enhance their team functions. Checking on their use, the survey asked, “Did your team utilize any training and support provided by NCDSS to enhance your team’s function?” Among the 78 responding teams, 42 (54%) responded 'no', 29 (37%) responded 'yes', and seven (9%) did not respond. Subsequently, the survey asked, “How often has your team requested resources or assistance from NCDSS to enhance your team’s function?” Nearly two-thirds (44) of the teams *rarely* or *never* requested resources for NCDSS. Twenty-four (33%) of the teams *occasionally* requested resources, and four (6%) teams *frequently* or *very frequently* requested assistance.

To encourage increased use of NCDSS-provided resources, the 2024 survey asked teams to rank resources that would help them conduct maltreatment case reviews more efficiently. Figure 3 provides the ranking for each need. Overall, training was ranked as the highest anticipated area of need, followed by data and support from the CCPT board. Other needs, such as state support, education on case reviews, and funding for CCPT participation, were ranked the lowest.

In addition to ranking anticipated needs, the survey asked teams to identify the training topics they would benefit from. Generally, CCPT teams noted that they can benefit from training sessions covering various topics next year. The topics include cultural competency, trauma-informed practices, mental health awareness, substance use education, guidance on state requirements related to CCPT roles and processes, training on reporting procedures and case reviews, and sessions on community engagement and collaboration involving mandatory stakeholders.

Ranking of Needed Resources for CCPTs (N= 76)

Figure 3. Needed Resources for CCPTs



c) Racial Equity in Addressing Local Needs

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

First, the survey asked, "Has your team discussed issues of racial and cultural equity in child welfare?" Among the 72 respondents, 45 (63%) selected 'no', and 27 (37%) selected 'yes'. Next, the survey inquired, "While conducting your case reviews, what were the issues identified by the team relating to racial and cultural equity?" Eighteen (23%) specified one or more issues. Teams identified racial and cultural equity challenges posed by language and cultural barriers, as well as imbalances in reporting, allocation of resources, and provision of services.

Cultural and Language Barriers

Responding teams highlighted ongoing challenges, including language barriers, limited English proficiency, and cultural differences, that hinder effective communication, engagement, and trust between families and service providers. These issues include the need for more bilingual workers, culturally sensitive messaging—particularly around topics such as co-sleeping—and targeted community outreach to enhance awareness, screening, and access among diverse populations.

Imbalances in Reporting, Resources, and Services

Families living in poverty, including undocumented and non-English speaking populations, often face significant barriers to accessing care, resources, and Medicaid or insurance coverage, compounded by transportation issues and limited community intervention sites. These barriers lead to disparities in prenatal and child health services, with overrepresentation of certain racial groups, such as Black and Hispanic families, due to social determinants and cultural norms. One team zeroed in on "over representation of brown and black mothers being reported due to Marijuana use and child testing positive or not; other social and behavioral determents amongst brown and black families that cause them to be reported more frequently or impact healthy pregnancies." Another CCPT observed, "lack of services available to parents that are not legal, increasing lack of trust with parents willing to communicate and work with DSS."

Turning from discussion to action steps, the survey asked, "What strategies did your team identify to address these issues?" Twenty-two (32%) teams outlined a strategy (or strategies) in response to these issues of racial and cultural inequity.

Teams focused on educating both staff and families about culturally sensitive practices, including discussions on co-sleeping risks, available treatment options, and the importance of providing uniform services regardless of a family's background. They emphasized the need for ongoing community education, cross-cultural training, and engagement at community events to

raise awareness about available resources. Several teams utilized interpreters and other language services within the community to support their families. Another team "attended non-English speaking community events to make sure service information is available." Teams sought out funding and community partnerships to help uninsured and undocumented individuals, aiming to eliminate barriers related to language, culture, and financial constraints, all while promoting a more inclusive, informed approach to family and child welfare.

In summary, this year's survey explored local developments regarding a racially and culturally equitable approach to child welfare. Almost two-thirds of responding teams had not discussed issues of equity in child welfare over the year. Nevertheless, teams identified challenges to racial and cultural equity posed by language and cultural barriers, as well as imbalances in reporting, resources, and services. They also specified strategies to address these challenges to equity. To overcome language and cultural barriers, they sought to increase language services and alleviate cultural hesitancies in accessing services. To address imbalances in resources and services, they focused on extending collaborative networks, developing alternative ways to meet families' needs, and raising their own team's awareness of these imbalances.

d) Family or Youth Partners

The survey also inquired specifically about Family or Youth Partners serving on the local teams. A Family or Youth Partner is a youth or adult who has received services or is the caregiver/parent of someone who has received services and who has firsthand experience with the child welfare system. Family and Youth Partners are not mandated CCPT members, but their inclusion is encouraged. An exception for a combined team is the parent of a deceased child, as long as the parent fits the definition of a Family or Youth Partner.

Overall, only eight (11%) of the 72 respondents indicated they had a Family or Youth Partners serving on their team (other than mandatory members). The percentage of Family or Youth Partner involvement is slightly higher than that of 2023, when seven (9%) out of 76 respondents indicated they had a Family or Youth Partner serving on their team. In 2022, participation was 12% (10 out of 87), in 2021, participation was 10% (10 out of 80); in 2020, participation was 12% (10 out of 82), and in 2019, participation was 7% (6 out of 89). Family and Youth Partners engagement has been substantially lower in the most recent five years than in prior years: 2015 (21%, 19 out of 87), 2016 (22%, 19 out of 86), 2017 (29%, 23 out of 79), and 2018 (24%, 21 out of 88). This difference may be a result of how the survey defined 'Family and Youth Partners' in earlier years; in other words, from 2015 to 2018, the survey did not distinguish between a non-child welfare-served parent of a deceased child and a Family or Youth Partner as defined in the surveys from 2019 to 2024.

To assist local teams in increasing Family or Youth Partner engagement, NC DSS offered resources, training, and support related to engaging individuals with lived experience. Eleven (15%) out of 72 respondents indicated that their team had utilized some of the training and support offered. The limited usage of the NC DSS provided resources may contribute to the limited Family or Youth Partner participation discussed above.

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

e) Additional Information

At the conclusion of the survey, CCPTs were provided with a space to provide any additional information they wished to communicate. Out of the 80 teams, 10 (13%) took advantage of the opportunity. Some gave updates on the progress or ongoing struggles of their team, relayed positive developments within their community, or noted the need for clarification on prior survey questions.

2024 Recommendations of the NC CCPTs

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 North Carolina, this mandate is carried out through a partnership between NC DSS and North Carolina State University. Drawing on extensive qualitative and quantitative data from the 2024 CCPT survey—along with insights from prior surveys and state feedback—this report presents a set of recommendations designed to strengthen the prevention of child abuse, neglect, and dependency across the state.

The 2024 CCPT survey findings highlight opportunities for improvement across several key areas: training and support, public education and awareness, funding and resource development, interagency collaboration, and systemic communication. Counties underscored the need for ongoing training and technical assistance, stronger public awareness campaigns, sustainable funding to support prevention efforts, expanded placement and treatment options for high-acuity youth, and more structured collaboration between state agencies and local partners. Together, these recommendations emphasize the central role of education, funding, collaboration, and training in building stronger child protection systems.

Equity is embedded throughout these recommendations. While not presented as a stand-alone category, racially equitable and culturally competent approaches are intentionally woven across all areas of focus. This allows for the development of strategies that are both context-specific and responsive to the diverse needs of North Carolina's communities. Counties consistently identified barriers such as language and literacy challenges, limited English proficiency, shortages of bilingual staff, and cultural differences in parenting practices (e.g., co-sleeping). They also expressed concern about the overrepresentation of families of color in child welfare reporting. To address these disparities, counties emphasized the need for translation of forms and materials, interpreter access, culturally tailored harm-reduction messaging, and equitable distribution of resources across rural and urban communities.

Recent legislation, NC SL 2023-134, established the new Office of Child Fatality Prevention (OCFP) under the Department of Public Health. Effective July 2025, CCPTs will transition into Local Teams under this structure, with a focus on greater transparency and collaboration through formalized information and data sharing between Local Teams and CRPs. NC DSS is currently in the process of contracting with an agency to research and develop three CRP teams for North Carolina. This agency will be responsible for ensuring CRPs are implemented in alignment with CAPTA and the NC CAPTA Plan, including recommendations for regional composition, membership, recruitment, and training, with a commitment to broad and diverse representation across the state. The agency will also consolidate data and recommendations into an annual report to NC DSS and provide ongoing communication with the DHHS Liaison, the OCFP Liaison, and county directors.

The 2023 State Response affirmed that CCPT recommendations are integrated into the state's Child and Family Services Plan (CFSP) and Annual Progress and Services Report (APSR),

ensuring that local input informs statewide strategy. The response highlighted ongoing commitments to public awareness campaigns, improved data systems (such as PATH NC), and systemic improvements, while also noting that many recommendations must be weighed against available resources and implementation capacity.

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

POLICY RECOMMENDATIONS

1. North Carolina could continue to strengthen public awareness campaigns to educate communities about child safety practices (e.g., safe sleep, car seat safety, substance safety, and firearm safety). Campaigns may be enhanced through public service announcements featuring local leaders (judges, sheriffs, law enforcement, DSS directors, etc.).
2. To support equitable service access and quality across rural and urban communities, North Carolina may consider systematic reviews of policy and funding distribution. Equity efforts should continue to include cultural and racial considerations, with strategies adaptable to local community contexts.
3. As CRPs are restructured under NC SL 2023-134, North Carolina may wish to clarify expectations for CCPT/CFPT members, including defining roles, setting reasonable standards for member attendance, and determining how data and outcomes are shared back with teams.

PRACTICE RECOMMENDATIONS

1. North Carolina should continue expanding access to trauma-informed mental/behavioral health and substance use services, including both inpatient and outpatient supports. Consideration could also be given to additional placement resources for children with high needs, with attention to cultural and linguistic accessibility. North Carolina could continue efforts to strengthen state-local data sharing. Building on initiatives like PATH NC, teams would benefit from access to more timely data on child maltreatment and fatalities. Improving data systems can support local reviews, planning, and prevention strategies.
2. North Carolina could continue working toward the implementation of a statewide child welfare practice model across all 100 counties to ensure greater consistency. Prompt and consistent fatality reviews would further strengthen prevention efforts, with guidance and technical assistance provided by the new State Office of Child Fatality Prevention.
3. North Carolina may explore opportunities to encourage collaboration between state and local agencies, including DSS, public health, law enforcement, juvenile justice, courts, and the medical examiner's office. Regular joint meetings and shared protocols could help ensure smoother coordination.
4. North Carolina could consider expanding preventive and supportive services for families showing early signs of crisis. Options might include in-home parenting programs, family preservation services, or co-located treatment options, with attention to both Medicaid and private insurance coverage.

RESOURCES and TRAINING RECOMMENDATIONS

1. The state may wish to provide ongoing training opportunities for CCPT/CFPT members, covering topics such as confidentiality, policy updates, legislative developments, fatality prevention, data analysis, and advocacy strategies. Training could include:
    a. Orientation for new members and periodic refreshers
    b. Accessible online learning modules
    c. In-person, hands-on opportunities at the state level
    d. Specialized training for magistrates, law enforcement, and juvenile justice partners
    e. Support for addressing secondary traumatic stress among child welfare workers
2. North Carolina could explore ways to enhance placement availability for children with high needs. Consideration may also be given to expanding housing support for families, improving access to therapy during school hours, and increasing provider networks for trauma-focused care and autism supports.
3. Where feasible, North Carolina may look to identify or develop dedicated funding streams for CCPT/CFPTs to support their work. Such funding could help with case reviews, community outreach, public awareness campaigns, and prevention programs (e.g., safe sleep initiatives, lock boxes, smoke detectors, newsletters).
4. The state may consider reintroducing a CCPT newsletter to share updates, policy guidance, and examples of best practices. An online hub or centralized location for counties to exchange ideas could also be valuable. Recruitment and awareness materials would further strengthen CCPT membership and public visibility.

References

1) NC Child Welfare Manual. (2020, May). Purpose and philosophy, legal basis, and administration. Raleigh, NC: NCDHHS/DSS. https://policies.ncdhhs.gov/divisional/social-services/child-welfare/policy-manuals/modified-manual-1
2) Healthy Opportunities Pilots. NCDHHS. (n.d.). https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots
3) https://www.congress.gov/114/plaws/publ198/PLAW-114publ198.pdf
4) https://www.ncdhhs.gov/infant-plan-safe-care/place-of-delivery
5) 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
6) 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
7) 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
8) 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
9) 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
10) 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.
11) 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
12) Duncan, D. F., Stewart, C. J., Vaughn, J. S., Guest, S., Rose, R. A., Malley, K., and Gwaltney, A. Y. (2018). *Management Assistance for Child Welfare, Work First, and Food & Nutrition Services in North Carolina* (V3.21). Retrieved March 23, 2024, from http://ssw.unc.edu/ma.
13) U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2024).
14) https://www.acf.hhs.gov/cb/data-research/child-maltreatment.
15) Austin, A. E., Shanahan, M.E., Frank, M., Naumann, R. B., et al. (2024, published online). State expansion of Supplemental Nutrition Assistance Program eligibility and rates of child protective services-investigated reports. *JAMA Pediatrics*. doi:10.1001/jamapediatrics. 2024.5348
16) County Distress Rankings (Tiers) | NC Commerce. (n.d.). Retrieved March 11, 2024, from https://www.commerce.nc.gov/grants-incentives/county-distress-rankings-tier

Appendices

Appendix A: Survey Process and Results

Timeline of CCPT Survey, 2024

Table A-1 Timeline of CCPT Survey

Date	Activity
September 7, 2024	Survey materials sent to NC DSS for approval
September 11, 2024	Survey materials sent to the NC State University Institutional Review Board
September 9, 2024	NC State University Institutional Review Board approved research protocols protecting participants
December 17, 2024	NC DSS sent letters to the County DSS Directors and to the CCPT Chairs to notify them about the survey
December 20, 2024	NC State University Research CCPT Team distributed surveys to CCPT Chairpersons or designees followed by weekly reminders to unfinished respondents
January 6, 2025	NC DSS reminded CCPT Chairs to complete the survey
February 14, 2025	Deadline for survey submission
March 28, 2024	Extended deadline for survey submission
TBD	End of Year Report to NC DSS and the Advisory Board
TBD	Results of the survey to CCPTs

Table A-2 Counties of CCPTs Submitting Survey Report

Participating Counties			
Alamance	Franklin	Orange	Yancey
Allegheny	Gaston	Pamlico	
Ashe	Gates	Pasquotank	
Avery	Granville	Pender	
Beaufort	Guilford	Perquimans	
Bertie	Halifax	Polk	
Buncombe	Harnett	Randolph	
Cabarrus	Haywood	Richmond	
Caldwell	Hoke	Robeson	
Camden	Hyde	Rockingham	
Carteret	Iredell	Rowan	
Caswell	Jackson	Rutherford	
Catawba	Jones	Scotland	
Chatham	Lee	Stanly	
Cherokee	Lenoir	Stokes	
Chowan	Lincoln	Surry	
Clay	Macon	Transylvania	

Craven	Madison	Tyrrell		
Cumberland	Martin	Union		
Currituck	McDowell	Wake		
Dare	Mitchell	Warren		
Davie	Montgomery	Washington		
Duplin	Moore	Watauga		
Durham	Nash	Wayne		
Edgecombe	Northampton	Wilkes		
Forsyth	Onslow	Yadkin		

Note: The survey was sent to 101 CCPTs of whom 78 responded.

Responding CCPTs by County Population Size, 2024, (N=78)

Table A-3 Responding CCPTs by County Population Size

County Size	Total Counties		Total Responding Counties		Percent
Small	51		46		90%
Medium	39		25		64%
Large	10		7		70%

Responding CCPTs by County Economic Well-Being, 2024, (N=78)

Table A-4 Responding CCPTs by County Tier Type

County Size	Total Counties		Total Responding Counties		Percent
Tier I	40		28		70%
Tier II	40		35		88%
Tier III	20		15		75%

LME/MCOs and Number of Member Counties Responding to Survey, 2024

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

LME/MCO	Number of Member Counties	Total Responding Counties	Percent
Alliance Behavioral Healthcare	7	5	71%
Partners Behavioral Health Management	15	12	80%
Trillium Health Resources	46	35	76%
Vaya Health	32	26	81%
Total	100	78	78%

Note: Member counties affiliated with a Local Management Entity (LME)/Managed Care Organization (MCO), as of February 01, 2024. 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, 2024, (N=78)

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

CCPT/CFPT Organization	Number of Counties	Percent
Separate CCPT and CFPT	12	15.4%
Combined CCPT and CFPT	65	83.3%
Other	1	1.3%

Appendix B: Cross-Year Comparison

Organization of CCPTs and Child Fatality Prevention Teams (CFPTs) by Year

Table B-1. Organization of CCPTs and Child Fatality Prevention Teams (CFPTs) by Year

CCPT/ CFPT Organization	2017 (*n*=80)	2018 (*n*=88)	2019 (*n*=89)	2020 (*n*=83)	2021 (*n*=80)	2022 (*n*=87)	2023 *(n=79)*	*2024 (n=78)*
Separate CCPT and CFPT	17 (21%)	14 (15%)	17 (19%)	16 (19.3%)	19 (23.8%)	18 (20.7%)	17 (21.5%)	12 (15.4%)
Combined CCPT and CFPT	62 (78%)	77 (83%)	66 (74%)	66 (79.5%)	59 (73.8%)	67 (77%)	59 (74.7%)	65 (83.3%)
Other	3 (3%)							1 (1.3%)

Note: Number of counties (percent)

Table B-2. Total County Participation by Year

	2014 (*n*=71)	2015 (*n*=87)	2016 (*n*=86)	2017 (*n*=81)	2018 (*n*=88)	2019 (*n*=89)	2020 (*n*=84)	2021 (*n*=85)	2022 *(n*=88)	2023 *(n=80)*	2024 (n=78)
Alamance	x	x	x	x	x	x	x	x	x	x	
Alexander		x			x		x	x	x		x
Alleghany	x	x	x	x	x	x	x	x	x		x
Anson		x	x	x							
Ashe		x				x	x	x	x	x	x
Avery	x	x	x	x	x		x	x	x	x	x
Beaufort	x					x				x	x
Bertie	x	x		x			x			x	x
Bladen	x	x	x	x	x	x	x	x	x	x	
Brunswick	x	x	x	x	x	x		x	x	x	
Buncombe	x	x	x	x	x	x	x	x	x	x	x
Burke	x	x	x	x	x	x	x	x	x	x	
Cabarrus	x	x	x	x	x	x	x	x	x	x	x

Caldwell		x	x		x	x		x			x
Camden	x	x	x	x	x	x	x	x		x	x
Carteret		x	x	x	x	x	x	x	x	x	x
Caswell	x	x	x	x	x	x	x	x	x	x	x
Catawba	x	x	x	x	x	x	x	x	x	x	x
Chatham	x	x	x	x	x	x	x	x	x	x	x
Cherokee			x	x	x		x		x	x	x
Chowan	x	x	x	x	x	x			x	x	x
Clay	x	x	x	x	x	x	x	x	x	x	x
Cleveland		x	x	x	x	x	x	x	x	x	
Columbus	x	x	x	x		x	x	x	x		
Craven	x	x	x	x	x	x	x	x	x	x	x
Cumberland	x	x	x	x	x	x	x	x	x	x	x
Currituck	x	x	x		x	x	x	x	x	x	x
Dare	x	x	x	x	x	x	x	x	x	x	x
Davidson	x	x	x	x	x	x	x	x	x		
Davie	x	x						x	x	x	x
Duplin	x	x					x	x	x		x
Durham			x	x	x		x	x			x
Eastern Band of Cherokee Nation (Qualla Boundary)				x		x					
Edgecombe	x	x	x	x	x	x		x	x	x	x
Forsyth		x	x		x	x	x	x	x	x	x
Franklin	x	x		x	x	x	x	x	x	x	x

Gaston		x	x	x	x	x	x	x	x	x	x
Gates	x	x	x	x	x	x	x	x	x	x	x
Graham		x	x	x	x	x	x	x			
Granville			x		x	x	x		x	x	x
Greene			x		x	x		x	x		
Guilford	x	x	x	x	x	x	x	x	x		x
Halifax	x	x	x	x	x	x	x	x	x	x	x
Harnett	x	x	x	x	x	x	x	x	x	x	x
Haywood		x	x	x	x	x	x	x	x	x	x
Henderson	x	x	x	x	x	x	x	x	x	x	
Hertford	x	x	x	x	x	x	x	x	x	x	
Hoke	x	x	x	x	x	x	x	x		x	x
Hyde	x	x	x	x	x	x	x	x	x	x	
Iredell	x	x	x	x	x	x	x	x	x	x	x
Jackson	x	x	x	x	x	x	x	x	x	x	x
Johnston	x	x	x	x					x		
Jones	x		x		x	x	x	x	x	x	x
Lee		x	x	x	x	x		x	x	x	x
Lenoir	x	x	x	x	x	x	x	x	x		x
Lincoln	x	x	x	x	x	x	x	x	x	x	x
Macon	x	x	x	x	x	x	x	x	x	x	x
Madison	x			x	x	x	x	x	x	x	x
Martin	x	x	x	x	x	x	x	x	x	x	x
McDowell			x		x					x	x
Mecklenburg		x	x	x	x	x	x	x	x		

Mitchell	x	x	x	x		x			x	x	x
Montgomery	x	x	x	x		x	x	x	x	x	x
Moore		x				x	x	x	x	x	x
Nash	x	x	x	x	x	x	x	x	x		x
New Hanover	x	x	x	x	x	x	x	x	x	x	
Northampton		x	x	x	x	x			x	x	x
Onslow	x	x	x	x	x	x	x	x	x		x
Orange	x	x	x	x	x	x	x	x	x	x	x
Pamlico		x		x					x	x	x
Pasquotank	x	x	x	x	x	x	x	x	x	x	x
Pender	x	x	x		x	x	x	x	x	x	x
Perquimans		x			x	x	x	x	x	x	x
Person	x	x	x	x	x	x	x	x	x	x	
Pitt			x	x	x	x				x	
Polk	x	x	x	x	x	x	x	x	x	x	x
Randolph	x	x	x	x	x	x	x	x	x	x	x
Richmond	x	x	x	x	x	x	x		x	x	x
Robeson	x	x	x	x	x	x	x	x	x	x	x
Rockingham	x	x	x	x	x	x	x	x	x	x	x
Rowan	x	x	x		x	x	x	x	x	x	x
Rutherford	x	x	x	x	x	x	x	x	x	x	x
Sampson	x	x	x	x	x		x	x	x	x	
Scotland		x	x	x	x	x	x	x	x	x	x
Stanly	x	x	x	x	x	x	x	x	x	x	x
Stokes	x	x	x	x	x	x	x	x	x	x	x

Surry		x	x	x	x	x	x	x	x	x	x
Swain	x	x	x		x	x	x	x			
Transylvania						x	x	x	x	x	x
Tyrrell			x	x	x	x	x	x	x	x	x
Union		x	x	x	x	x	x	x	x	x	x
Vance	x	x	x	x	x	x	x	x	x		
Wake		x	x	x	x	x	x	x	x	x	x
Warren	x	x	x		x	x	x		x	x	x
Washington				x	x					x	x
Watauga	x	x	x	x	x	x	x	x	x	x	x
Wayne	x	x	x	x	x	x	x	x	x	x	x
Wilkes	x		x	x	x	x	x	x	x	x	x
Wilson	x	x	x	x	x	x	x	x	x		
Yadkin	x	x	x	x	x	x	x	x	x	x	x
Yancey	x	x			x	x	x	x	x		x

Table B-3. Small County Participation by Year

County	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Respondents (%)	36 (71%)	42 (82%)	40 (78%)	38 (78%)	45 (83%)	46 (85%)	43 (80%)	41 (80%)	45 (88%)	47 (92%)	46 (90%)
Alexander		x			x		x	x	x		x
Alleghany	x	x	x	x	x	x	x	x	x		x
Anson		x	x	x							
Ashe		x				x	x	x	x	x	x
Avery	x	x	x	x	x	x	x	x	x	x	x
Bertie	x	x		x			x			x	x
Bladen	x	x	x	x	x	x	x	x	x	x	
Camden	x	x	x	x	x	x	x	x		x	x
Caswell	x	x	x	x	x	x	x	x	x	x	x
Chatham	x	x	x	x	x	x	x	x	x	x	x
Cherokee			x	x	x		x		x	x	x
Chowan	x	x	x	x	x	x			x	x	x
Clay	x	x	x	x	x	x	x	x	x	x	x
Currituck	x	x	x		x	x	x	x	x	x	x
Dare	x	x	x	x	x	x	x	x	x	x	x
Davie	x	x						x	x	x	x
Gates	x	x	x	x	x	x	x	x	x	x	x
Graham		x	x	x	x	x	x	x			
Granville			x		x	x	x		x	x	x
Greene			x		x	x		x	x		
Hertford	x	x	x	x	x	x	x	x	x	x	
Hoke	x	x	x	x	x	x	x	x		x	
Hyde	x	x	x	x	x	x	x	x	x	x	

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

Watauga	x	x	x	x	x	x	x	x	x	x	x
Yadkin	x	x	x	x	x	x	x	x	x	x	x
Yancey	x	x			x	x	x	x	x		x

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

Table B-4. Medium County Participation by Year

County	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**
Respondents (%)	30 (77%)	36 (92%)	36 (92%)	34 (87%)	32 (91%)	32 (91%)	30 (86%)	34 (87%)	34 (87%)	26 (67%)	25 (64%)
Alamance	x	x	x	x	x	x	x	x	x	x	
Beaufort	x					x				x	x
Brunswick	x	x	x	x	x	x		x	x	x	
Burke	x	x	x	x	x	x	x		x	x	
Cabarrus	x	x	x	x	x	x	x	x	x	x	x
Caldwell		x	x		x	x		x			x
Carteret		x	x	x	x	x	x	x	x	x	x
Cleveland		x	x	x	x	x	x	x	x	x	
Columbus	x	x	x	x		x	x	x	x		
Craven	x	x	x	x	x	x	x	x	x	x	x
Davidson	x	x	x	x	x	x	x	x	x		
Duplin	x	x					x	x	x		x
Edgecombe	x	x	x	x	x	x		x	x	x	x
Franklin	x	x		x	x	x	x	x	x	x	x
Halifax	x	x	x	x	x	x	x	x	x	x	x
Harnett	x	x	x	x	x	x	x	x	x	x	x
Haywood		x	x	x	x	x	x	x	x	x	x
Henderson	x	x	x	x	x	x	x	x	x	x	

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

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

Table B-5. Large County Participation by Year

County	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Respondents (%)	5 (50%)	9 (90%)	10 (100%)	8 (80%)	11 (100%)	10 (91%)	11 (100%)	10 (100%)	9 (90%)	7 (70%)	7 (70%)
Buncombe	x	x	x	x	x	x	x	x	x	x	x
Catawba	x	x	x	x	x	x	x	x	x	x	x
Cumberland	x	x	x	x	x	x	x	x	x	x	x
Durham			x	x	x		x	x			x
Forsyth		x	x		x	x	x	x	x	x	x
Gaston		x	x	x	x	x	x	x	x	x	
Guilford	x	x	x	x	x	x	x	x	x		x
Mecklenburg		x	x	x	x	x	x	x	x		
New Hanover	x	x	x	x	x	x	x	x	x	x	
Wake		x	x	x	x	x	x	x	x	x	x

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

Appendix C: Qualitative Responses

Community Education

Public Education and Awareness

[County Name] County Board of County Commissioner provided funding to support a safe sleep campaign/education.
Awareness of proper gun storage; suicide prevention
billboards done around safe sleep, flyer and education
Bullying education from local law enforcement
Child abuse prevention education as well as firearm and water safety education for the community.
Child Protective Services recognizing and reporting maltreatment was provided to each elementary and middle school in [County Name] County as well as to [High School Name] High School staff.
Enhanced Parenting Education - One-on-one parenting support is provided to families, particularly those with developmental delays or special needs, who may not benefit as much from traditional classroom settings. This individualized approach ensures more effective learning and engagement, tailored to the family's specific needs. Father Engagement Enhancements - The program has strengthened efforts to involve fathers and paternal relatives in the lives of their children. Father engagement is a critical protective factor in child safety and well-being. Involved fathers contribute to a child's emotional development, stability, and can help mitigate risks associated with child maltreatment. The initiative ensures that paternal family members are included in planning, support, and permanency discussions.
Flyers created for THC Gummies, how to properly secure or store medications and illicit drugs in the home to prevent accidental ingestions. DV education and information distributed during office visits and flyers created and displayed in human services agencies.
Positive Parenting Program Promotion to families involved with DSS as well as the general public who are caring for children
Provided child abuse, neglect and dependency information to the community (handouts)
Providing information and resources on stress management and how to provide care for children with special needs. Public Health to follow up with local providers on parents reporting depression. Provided training to law enforcement and social workers on fentanyl use. Purchased fentanyl testing strips to provide education on the dangers of drugs on content of drugs.
This past year we obtained educational materials for swimming safety. We provided these materials to local pool stores and distributed them to families during community events where we had a booth.

Training and Technical Education

Audited a fatality in our agency in 2024 and provided the results to the Child Welfare team
Car seat safety Classes at Senior Centers and on-site demonstrations at Walmart
DSS, Aspire, CCPT sponsored Education to have trainings: Mental Health First Aide, Community Resource Activities, Sponsored the Child Abuse Awareness event and brought in vendors from all areas to help educate the community
Education on child abuse, neglect, and dependency to the public, law enforcement, and the school system.
Education was provided on the roles of different community stakeholders and child welfare policies
I (CCPT chair) provided education on recognizing the signs of child abuse and neglect to a large group of educators.

Policy and System Education
Presentation of annual CCPT and CFPT reports to the combined team, Board of Commissioners, Board of Health and DSS Board. Also DSS Director gave an educational presentation to the team on the CFSR. The team co-chairs presented on legislative changes to local teams.
Recognizing/Reporting; Outreach re: public assistance services
Safe Sleep
Safe Sleep - local events such as the Latinx Festival, Cheerwine Festival
Safe Sleep (various groups) and SUD (various)
safe sleep and parenting to clients and families
Safe Sleep Training to DSS Social Workers, Medical Professionals, Civic Groups, etc.
Safe Sleep, Car Seat Safety education to the community.
Safe Sleep, monthly webinars on different topics, Gun safety, Mental Health
Safe Sleep, Opioid Crisis Information/Training. Both topics were discussed by the CCPT and training was provided to the CPS staff.
The CCPT team membership was updated about legislative/policy changes throughout the year. For example, the Unlicensed Kinship Reimbursement Program; updates about the Regional Abuse and Medical Specialist (RAMS) Program; NCPALS Access Line; changes to the CCPT Program becoming a local Child Fatality Prevention Team; March 2024 -- social worker appreciation month; April 2024 -- Child Abuse Prevention Month; NCDHHS Policy Manuals, Appendices, Forms, and Notices can be found at https://policies.ncdhhs.gov/; Redesigned Pre-Service Training for newly hired social work staff; May 2024 -- National Foster Care Month; June 2024 -- National Reunification Month and Fatherhood Awareness Month; the Child Welfare Information System (CWIS) was renamed Path (Partnership and Technology Hub) NC; September 9-13, 2024 -- Child Welfare Workers Appreciation Week; 2024-2025 Memorandum of Understanding between with the [County Name] County DSS and [County Name] County Schools; and November 2024 -- Adoption Awareness Month.
The intake process to educational professionals and medical providers
training on roll over deaths
Variety of parenting skills, lists of local mental health, medical and dental resources.
We have educated the community on safe sleep
We reviewed policy in regard to truancy and what steps the educational system needs to take for DSS to screen reports based on educational neglect. We discussed barriers around UDS and SA/MH Ax.
We sent out training videos to multiple people that we were adding to our team as education about what we do.

Collaboration and Community Outreach
Community Resources - Smart Start
Education is provided ongoing throughout the year on different community resources to members of the team and other community partners. Different CCPT members will present resources to the team and there are times when speakers are invited to the team to share about their programs/resources.
Our team has contributed to education of the community in numerous ways. We have participated in gun locks and medication lock boxes collaboratively. We had multiple meetings about train safety following a fatality. We have also done ongoing safe sleep education with multiple community partners following fatality.
Presentations by local providers regarding behavior intervention
Shared prevention and cross-system collaboration best practices with team members, participant agencies, and other

community partners. Also where feasible, identified and shared barriers and facilitators to effective maltreatment prevention -- along with identified gaps in services/supports with relevant policymakers. Law Enforcement partners conducted education sessions in the school system related to gun violence prevention. CC4C offered (offers) ongoing education about pre-natal care.
[County Name] County partner agencies continue to offer/support home visiting services and nurse practitioner supports for eligible families.
Team has had guest speakers at the quarterly meetings to discuss services for families in the community. Continued updating our county QR code with resources to families in the community, and during the meetings DSS cases have been discussed to identify any gaps in services.
We offer educational resources across the county to help individuals access the support they need. Multiple different partnerships come together in our meetings to share information and ideas.

Community Collaboration

[County Name] County Child Advocacy Center Child abuse prevention classes, County Safe Kid on with Certified car seat teaches
[County Name] County's CCPT maintains strong collaboration with child and family serving organizations located in [County Name] County including our Child Advocacy Center, our Community Action Agency, and other child/family serving groups such as SAFE Kids. Collaboration is recognized as a critical element for success among/within each of these groups. For example, our Child Advocacy Center hosts a strong and well-defined Multi-Disciplinary Team (MDT) that also includes several members of the CCPT. This collaboration is critical in helping all agencies understand their role in assisting with any given child/family being discussed at the MDT. Roles and responsibilities can be defined within each agency so the child/family is served without duplication or gaps in services.
2nd Annual 34th Judicial District Welfare Conference that included the GAL Program and other DSS agencies within the district. The purpose of the conference was to devise ways to communicate better and to break communication barriers between agencies.
As a team we have all been working closely together to observe some of the community resource gaps in the community and how we in general can combat some of those barriers. Western Youth Network for example is wanting to establish better therapeutic programs that will go to the schools and offer therapy during school hours. These therapy sessions would be centered around children who are in foster care or have traumatic events in their lives. between team members about services in our community.
CCPT has worked to collaborate with Trillium in attempts to find additional resources for families discussed at CCPT meetings. Trillium has been a great asset to the team!
CFPT
Collaborated with local LE due to there being a gap in time of reports being received from them in cases. For example, domestic violence cases happening sometimes a month or so before a report is made to DSS.
Collaborated with other organizations in the community to have a child safety expo
Collaboration on behavioral health service planning.
collaboration on drug involved families
Collaboration with child advocacy center and Safe Kids.
Collaboration with school member and law enforcement.

Collaboration with schools, LME/MCO, law enforcement, and DSS staff
Collaboration with the local Health Department, Hospital and Social Services to provide education on Safe Sleeping practices at local events.
Community Partners that are part of the CCPT/CFPT often collaborate with each other to brainstorm and meet unmet needs of cases/families that are staffed at the meeting this includes collaborating to connect with local mental health agencies, food pantries, [church name], the Health Department, DSS Eligibility programs and crisis assistance, and many other community organizations.
Continued partnership with agencies within our community to allow for better communication, stronger partnerships, and better understanding of resources available.
Discuss issues trends, review fatalities
DSS, Health Dept, Law Enforcement, Mental Health - we all work together with the same clients and we can all share this valuable information within our agencies and in the community.
Due to the variety of team members on this team, we are able to more closely collaborate with one another. Also, when staffing the cases, we are able to make connections to resources outside of the representative of the Team. This allows us to locate and connect families to agencies that are providing needed services. Sometimes this leads to new partnerships.
Health Department, Law Enforcement, School System, Mental Health, Judicial, Health Dept; Community prevention events
Held a training to include multiple community partners such as law enforcement, social workers and public health to provide education on drug education with a specific focus on fentanyl and fentanyl use. Partnered with NC STATE in 2023 to provide training and continued collaboration and training around working with parent(s) who are using fentanyl.
I think as a team we just collaborate in general. We discuss community resources and things that might can help families if the social workers are not familiar with something out there.
Implementation of DJJ Court Liaison - A Family Support Social Worker is partnered with the Department of Juvenile Justice (DJJ) to work directly with families involved in the juvenile court system. This early intervention strategy helps address family needs and prevent children from entering foster care. Neighborhood Network Partnerships The program collaborates with elementary schools to identify and support families in need. By working closely with schools, the team can provide early resources, build trust, and reduce the risk of maltreatment through community-based support systems.
Invited local providers, Welcome Baby and Equity Before Birth to share information about their services. Some members attended the Black Maternal Health Conference in Durham.
Law Enforcement , Local Hospitals
Law enforcement, drug court, school system, health dept. etc.
Local community agencies and churches, local county agencies, local schools, local law enforcement agencies, etc.
Local law enforcement, the local hospital, the CAC, DSS and mental health providers collaborate regularly. This helps communication and trust.
Mental Health provider through the health department to discuss services for families with limited income and transportation issues
Our local LME/MCO, Partners Behavioral Health, [County Name] Health Alliance, Safe Kids, The [County Name] Partnership for Children, the City of [city name], Atrium Health, and parents of newborns through CMARC and DHS

Our team is made up of numerous entities, from DSS, LE, Child Advocacy Center, Mental Health, Medical Providers and School System. That collaboration is important to make sure we are all on the same page with issues within our community.
Our team members share information, training opportunities amongst each other and have allowed the other agencies involved an opportunity to share what they do.
Our team values cross-agency, and community partner collaboration. We share opportunities for skill/knowledge improvement (webinars, local or virtual opportunities), peer-related activities that could benefit partners, basically anything that serves as a chance to improve communication, collaboration, and cooperation between team/agency members or others. We also share system-related factors, findings, policy issues involving maltreatment causes and prevention with partners and interested stakeholders.
Example agencies receiving or interacting with these processes include DSS, local pediatricians, family physicians, allied health professional, military partners, law enforcement, courts/court officials and staff, behavioral health practitioners and the LME/MCO, and other community-related nonprofit agencies. [County Name] County Health Dept provides a "baby store" and holds events such as community baby assistance, information and service fairs, and various clinics. DSS provides "pack-n-plays", car seats, etc. to promote safe sleep and proper child transportation skills. Our Military partners conduct a broad array of on-base and community events dealing with family support services, health needs, and related topics.
Partnered with several community groups, Aspire, DSS, Vaya, Out Reach Ministries, Step to Hopes to sponsor the Community awareness Event we host in April.
Rootle Bus Tour Event for Sp. Needs families; Community Baby Shower event including info tables, car seat checkpoints, post partum support services, etc.
safe sleep activities, collaboration around gaps, issues with children without placement
Safe Sleep, NC UNC Center for Maternal and Infant Health and the [County Name] County Drug Endangered Task Force
Several members are also on the Safe Kids Riverbend which seeks to identify risk factors that affect health and wellness of the community.
Sharing information from one department/entity to another about possible resources available for families within the community. Also collaborating to support and promote Prevent Child Abuse Prevention Month in April. We put out signage and pinwheels across the county in varies locations
The team collaborated on "stuck" child welfare cases to brainstorm solutions and a path forward.
United Way, LME/MCO, Safe Kids [County Name]
Vaya - System of Care
Water Safety - Hospitals, YMCA, [County Name] County GEMS; Safe Sleep - State Level
We collaborate with Law enforcement, CAC, Schools.
We collaborated with law enforcement and our state consult rep.
We have partnered with various agencies like Law Enforcement and Child advocacy centers within the county to provide enhanced resources and support for individuals in need.
worked cooperative extension in the past and housing authority for parenting classes
Working alongside health care providers to learn about Narcan use for emergencies with our client.

Positive Change

Child Safety

Agencies are working together more to try and keep children safe.
Car Seat Safety/safe sleeping
More emphasis placed on ensuring the Plan of Safe Care is implemented on each case for SAI . Additional internal required training for all SW on SAI
Providing safe sleep arrangements for families who do not have them or cannot afford them.
purchased car seats and booster seats for the community

Collaboration and Community Engagement

Better communication and collaboration with community partners
Better education about the practices of each agency from members of the team
Building local partnerships and connections
Citizen have become more knowledgeable of local resources, safe sleep is being utilized due to the education on the dangers of co-sleeping
Collaborating with law enforcement, district attorney office, school and medical services.
Collaborative efforts to increase child protection
Community partners coming together to strategize for solutions and resources.
Community partners communicate and work well together, as necessary to help families.
Continued collaboration
Greater interagency cooperation
Increased collaboration and understanding between community partners when it comes to each community partners role.
Increased community collaboration, increased services available
Increased Community Events
increased partnerships among organizations
More active collaboration with varying community agencies.
Opportunity to get together with community partners and discuss cases and practices to help strengthen our practices.
Our CCPT is pulling people from lots of different agencies. We are able to collaborate with each other to provide better services and referrals to the community.
Our CCPT/CFPT continues to umbrella the Early Intervention Team and this has been successful in helping improve the truancy rate in Clay County. CCPT/CFPT has increased knowledge amongst community partners about available resources/services in the community to help families in crisis.
Professionals have a network of experts to reach out to who are willing to meet/discuss complexities in cases. Most medical and school providers are willing to come to the table to share relevant info regarding family involvement and discuss through efforts that work at engaging family.
the community stays acclimated to all available resources through interaction with other community providers and resources.
The primary benefit of the CCPT-CFPT in our community is that it serves as a convening for leadership in the community to review the challenges faced by families served by the child welfare system. The ability to impact large scale societal problems on the local level is minimal but case reviews shine a light on both the hard work that goes into supporting families by all of the service providers (including child welfare) and the number of difficult problems that families face.
Working together as a team has allowed each agency to understand more about the roles we each play in the community and the services available.

Community Awareness and Resource

ATV Awareness
Communities are reaching out to us and asking questions. CCPT is bridging a lot of the gaps we see in the community.

Communities became more educated on various services in the community and informed
County offers space for Mental Health Providers, Increased community education /training, development of CAC, CCPT is very involved in the April Child Abuse Event that is held with numerous community providers, organizations not historically involved in child protections attend the event and provided information.
Education and community outreach about child maltreatment.
Expanded afterschool program
Finally getting it established after two years of not being active.
greater empathy toward parent roll over deaths
Identifying other resources
Improved morale among CCPT partners who know who to call and have relationships with individuals who can assist them with identifiable needs like gun locks and drug lock boxes.
increase in community awareness of needs with local children and families
Increased awareness of community resources, better collaboration, and advocacy for needed services.
Individual members have developed a better understanding of service arrays and service gaps areas within the county. Members indicate they are beginning to see synthesis among all of the organizations and specialized meetings such as Community Health Assessments.
relationship building and collaboration, resource sharing
Relationship building, information sharing regarding up-to-date resources and programs.
same page

Team Development and Morale

Team membership awareness of community needs has been enhanced in the hope that information spreads throughout the community.
The team works diligently to serve all clients and provide them with all the resources that are available.
There is a heightened awareness concerning Safe Sleep and the Opioid epidemic in our area.
We have been able to offer additional services and assistance to several families we have served.
We have more diverse members, community members, we have more participation from the DA's office, law enforcement, and a judge.

Reduction in Negative Outcomes

A decrease in safe sleep related deaths.
Anecdotally, we are seeing fewer unsafe sleep events. We've also noted (earlier) improved guidance and tools for workers stemming from case reviews and team discussions.
We have had less safe sleep incidents

Miscellaneous

It's difficult to say because in our field, we don't know if it's working. We only know if it's not.
Unable to measure. This is my first time completing this survey and I will look out for this the next time around.
Unaware of any change

Case Recommendations

Information Sharing and Communication

Improved Information Sharing Between Schools and Agencies Schools should be required to share critical student information when requested by child welfare agencies or law enforcement. This would help ensure timely intervention and support for children at risk of abuse or neglect. A statewide policy mandating cooperation from public, charter, and private schools would eliminate inconsistencies and prevent critical information from being withheld.
Open communication with law enforcement in order to prevent a child from having to be interviewed multiple times.
Recommended improved communication of risk factors and conditions around the children/families reviewed to all involved (caretakers, medical providers, family members) to reinforce the supervision and risk mitigation that agencies and teams/staff can attend to looking into the future. This is especially pertinent re: safe weapons storage and use, safe sleep, monitoring and supervising children in higher risk environments.

Parent Education to Promote Prevention

Based on the above, we focus heavily on parent education and prevention of impaired parenting. Our CCPT partners speak to the hospital, actively engage our locate pediatric practices, provide education via CMARC, and we even have a SUN (Substance Use Network) Project which provides counseling, and prenatal care to addicted mothers in hopes of helping them give birth to health infants, retain custody of those infants, and effectively parent those infants.
continue to educate parents on safe sleep/co-sleeping, and how their substance use impacts their ability to safely parent their child. Make referrals to parenting program.
Continuing to educate the public, providing literature (reviewing with the parent/caregiver).
Expanded Parental Education at Key Medical Touchpoints New and experienced mothers should receive enhanced education on child safety, substance exposure risks, and mental health at hospital discharge and during newborn well-checks with primary care providers (PCPs). This education should continue through well-child visits, adolescence, and during prenatal and postpartum care to ensure ongoing support.
Parenting classes, Education on recognition

Safety and Risk Reduction

Addressing and observing safe sleep in the homes.
Convened a Safe Sleep Committee and explored avenues to increase community awareness around safe sleep. Explored evidence-based harm reduction models for safe sleep and developed materials (door hangers) and placed in high-risk communities. Requested further studies on harm reduction models for safe sleep and substance use particularly around fentanyl.
Recommended more qualitative studies on telehealth.
education on co-sleeping, development of better evidence-based substance use treatment programs.
Education within the community, committee members ensure each agency has flyers on both co-sleeping and car seat safety
Firearm Safety and Secure Storage Initiatives Families known to have firearms should receive direct recommendations for safe storage practices. Mandated gun safes or lock boxes as a standard practice would reduce the risk of accidental shootings and suicides among children and adolescents. Strengthening gun control measures for households with children would further enhance safety.
For the improper supervision case, the team recommended an assessment for mom and In-Home care for the child. For the alleged sex trafficking case, DSS worked with the

school to figure out the best educational plan and Partners LME worked with mom to secure adequate housing.
In the cases of substance exposure, education was provided to the parent and caretakers regarding how to prevent this from happening again. How/where to store the substances if they feel they must bring it into the home or car. For the domestic violence incident, the mother and father both lost their lives so there were no services that could be provided. We chose to spread awareness regarding the negative impacts of parental substance use and domestic violence.
Increase education; utilize funding for gun locks
Medication Safe
More involvement with children, supervisor of children and knowledge of their behaviors and seeking treatment and education on handling the behaviors. Continued education of the effects of substance use and the ability to provide care.
Parents need to supervise their children while in the bathtub. Parents need to make informed choices on who they allow to provide care to their children. CFPT will do water safety education again as they do before summer. Our team members will look for any handouts that can be provided to parents about choosing appropriate people to provide care to children. Our team members will try to locate educational material to provide to families on the safe storage of harmful substances to prevent children from having access.
Recognize that parents are going to co-sleep and help provide education to reduce the risk rather than the messaging to cease co-sleeping all together. Educate about the risk of fentanyl exposure for children.
Recommended public awareness campaigns around safe gun storage and responsible weapons use. Recommended improved outreach and education around childcare needs, supported housing needs, and other various social determinants of health impacting the families we've considered in our work. Our hospital, DSS, and Health Dept partners provide (provided) ongoing education in multiple formats (English, Spanish) re: an array of topics related to these issues. Each team member receives information and supplies to use in their agencies and community efforts to reduce identified challenges. We use funds to purchase pack-n-plays, car seats, and other supplies to distribute where needed. Gun safety pamphlets, coloring books were purchased and distributed throughout agencies and event. Gun lock were also purchased and distributed. Our team continues to recommend closer monitoring once children are identified by LE or DSS to better meet needs of children- at times, risk conditions are identified, and children are screened or in various levels of care; however, effective monitoring strategies with periodic data and more intensive case reviews may prevent future problems. These recommendations involved all team members at various times during the year.
Started a Family Recovery Court in our county for child welfare involved families. Continued strong focus on unsafe sleep education. Strong support for a "dead baby" campaign to shock public in understanding the serious consequences of unsafe sleep.
Stepped up unsafe sleep initiatives, as well as starting work on water safety due to the drowning and near drowning deaths in the county
The team currently continues to work on recommendations to positively impact substance abuse within the county that will hopefully reach families involved with CPS and prevent future child abuse or neglect as it relates to substance abuse. The [County name] County Opioid Outreach Program has begun to take referrals.

To be better at educating about safe sleep
Trainings were held to educate the team as well as community partners on the dangers of co-sleeping.
used CFPT funds for billboard on safe sleep, education
We were to collaborate with a community agency to get gun locks. DSS social workers were able to pass these out to families they were working with. We are also able to have these to hand out at community events.

Service and Resource Accessibility

A Trillium representative came to DSS and discussed eligibility for services and gave helpful handouts. Also, a local pediatrician on the CCPT emailed out helpful information concerning available services to CCPT members which was in turn, sent out via email to CPS staff.
Advocate for easy access and availability of mental health resources.
advocating for increased mental health services
Better awareness of Services for Mental Health, better reporting of Substance Abuse and domestic violence
Community partners to consider providing ESL classes while also providing childcare and non-traditional hours like at night. [County Name] County to provide a more robust transportation system that operates like a traditional bus system with specific stops and schedules. The school system to provide early intervention and additional support to children of ESL families such as handouts and information to parents in their native language. Community partners to be more diligent in assessing and evaluating needs of ESL families including interpretation services, cultural differences, etc.… Education for community partners about immigration and deportation, fears of ESL families, etc.… - how to build a better network for ESL families. Vaya to provide a continuum of ACT services and long-term mental health services available in the community. CCPT collaborate with Project CARA to increase community education about services available. CCPT advocate f
Connecting individuals to resources to help provide early intervention
Coordinate with our MCO about service providers who can assist with the identified needs, partner with Home Builders and assisting families in the home to address children and parents' behaviors
Education, mental health and substance abuse referrals
Enhanced Support for Children of Deceased Parents When a biological parent has passed away, medical providers should initiate a structured support system to monitor the child's emotional and mental well-being. This should include follow-up visits and resource referrals to ensure they receive necessary emotional and psychological support.
Exploring relative placements if needed, discussing treatment options and/or why perpetrators are resistant to treatment. What treatment is available.
For dental providers, the team recommended compiling a list of available pediatric dental providers and specialists. Almost all providers are an hour away and the specialists are two to three hours away. For childcare, the team recommended continuing to explore the issue with local providers and CYP.
For the last case, DSS followed up with In-Reach, [City Name] Autism Services, Autism Services of North Carolina, Autism Speaks, Autism Support, resources and other advocacy groups. RHA Health Services, NC Start, Easter Seals UCP North Carolina, Work Together NC and the [County name] County Medicaid Department. In sum, the team provided information on services, additional treatment options and resources in the community.

For those parents to seek out and participate in available resources sooner to eliminate or minimize situations
provide education at each contact
quicker identification of drug involved cases and more treatment options
services help
Several recommendations were given to increase accessibility to substance treatment, however, this is a resource that is limited in our community.
Team suggested substance and mental health therapy/counseling for parents. Child care was suggested for children who are not public school age.
The county and community need more resources in regard to services. Respite services, parenting services, etc. Also, a way to engage families more in the community and have opportunities to connect with local services that we do have. Care givers need training on how to work with children with mental health or difficult behavioral issues.
Placements that provide wraparound services are not located close by, for instances when mothers need recovery while parenting, etc.
The Department & Community to collaborate on identifying and applying resources.
The social worker will provide the needed transportation for the families to attend the needed resources/providers that are located in another county. The social worker provided guidance and encouragement to the parent so that they understand the need for them to be compliant with services such as mental health assessments, parenting classes or substance use assessments.
The team talked about how the schools have flyers about numbers to call for mental health that would be accessible to children and parents.
The team wants to continue to make the community aware of all needs and resources that are available and advocate strongly for more stable employment opportunities and housing.
There needs to be more access to mental health services within the community. There needs to be more resources for people with substance abuse concerns.
This child has been removed from the home. There was discussion about trying to frontload services from the beginning of cases. The recommendation was to continue to look for placement that can manage his behaviors.
try to front load services in assessment phase, encourage substance abuse assessments and identify what the parent feels they are able to do as far as recommended treatment, provide resources as possible to assist parents in obtaining treatment
Vaya will continue to advocate for providers in [County Name] County that provide trauma informed community services and attachment informed services such as, PCIT – parent child interaction therapy. Vaya to advocate for more level 3 placements closer to [County Name] County and the need for structured placement resources to support IEP testing process. ([DSS staff] will follow up on who could provide training)
we need to find ways to better educate the community.
We want to continue to push for more substance abuse and mental health treatment options and additional access for the community. The numbers are overwhelmingly high as these being the root causes of children being removed from their home for neglect or abuse.

System and Policy Development

Development of a Human Trafficking Screening Tool Mandated standardized, accessible screening tool should be used by juvenile justice, child welfare, schools, and

law enforcement agencies to identify children at risk of human trafficking. This tool should be integrated into assessments for youth exhibiting high-risk sexual behaviors to improve early identification and intervention.
Funding needs to help access services for: sexual offenders and those that are not documented. Funding for Mental Health Services, Funding for family counseling, Funding for Substance Abuse. Parents with Severe needs are not being met.
Have backup plans for critical staffing issues (reaching out for temp workers in advance) and ensure proper training of staff and supervisors.
Mandatory reporter training for Highway Patrol due to children being in the vehicle when DUI are given. Also, newborns testing positive for fentanyl and the need for threshold levels of was this in-utero exposure or medication received during delivery.
Our team found that when an individual faces a language barrier, it can be challenging to connect with the right person to assist the family while they're in a medical facility. We also discovered in one case that there was a need for a medical expert's opinion, and CPS needs additional support to assess certain situations.

Provide system of Care education about navigating placement and appropriate clinical recommendations for community partners, clinicians, and social workers. Increase DSS and CCNC partnership to identify providers involved. Increase collaboration between schools and DSS related to truancy cases. Administrative of Courts to provide resident interpreter (state certified) available in court on a specified date each month. Community partners to consider grant funded opportunities to provide liaison in [County Name] court system for ESL clients about the next steps in court to ensure understanding and prevent delays.
seek court intervention without requesting immediate custody/foster care to order services and/or legally sanction placement/ protect through a legally secure plan
The team recommended that DSS staff review and consider changes to processes/protocols and staff trainings (if not already done) around when to consider petitioning for custody and when to consider ending a temporary safety provider.
To try to set up a meeting with Medical Examiners, Law enforcement, and discuss Policy and Procedures of Child Welfare.

Service Strategies

Enhancing Service Coordination and Interagency Collaboration

[County Name] County has developed a Mental Health Task Force to address some of the gaps addressed above. This regularly held meeting allow MH/DD/SAS providers to come together and share updates on how they, individually, are addressing the gaps. Child and family serving organizations and community members are invited to attend to share updates on how access barriers may be impacting them or the individuals whom they serve.
[County Name] County Schools has expanded the afterschool program to allow middle school children to attend. The school has also partnered with 4-H program which allows children to have more opportunities to engage in arts and crafts.
Caseworkers worked to ensure that transportation to local services was not an issue and local free public transportation could be used when necessary. The team worked to increase participation of MD/DD/SUD participants. Our local DV

shelter shut down. However, an alternative service was secured.
Collaborated with LME/MCO, and other community partners to identify providers and services, and DSS provided follow up.
Collaboration with community partners collaboration with external agencies to begin providing services for [County name] County residents
Continue to reach out to other surrounding agencies that provide the service
Continue to share resources with the committee, add new members that can help in this process.
Continue to work with different departments and entities to get the word out and promote available resources in the community by sharing handouts at churches, pediatricians, child care facilities. Etc.
Continue working with community partners in working with families.
Continuous communication and collaboration with team members for services needed/available. Team coordinator met with Highlights Healthcare to discuss services available to families in the community. They provide ABA therapy to autistic children and provide education to caregivers.
discuss new initiatives that each agency is implementing to address the needs
Discuss services available in the area that families can participate in
Discussed lack of providers in the area and the constant change in
LME/MCOs. Discussed lack of resources for children in the country illegally and how to appropriately meet their needs.
Discussion of available services or new services to the area. Having a member of our local LME on the team to see what services are needed.
DSS utilizes Language Line for interpretation services. We received a resource list and shared with staff regarding community resources for mental health, substance abuse, child care, and transportation.
Each year, we discuss and work on increasing efforts to enhance cross-partner and cross-agency networking, to further analyze the impacts and barriers associated with several of these barriers.
In addition, we have hired a behavioral health clinician that is working with families in the community that do not have access to mental health or behavioral health services or just need direction on where to go.
Increased Collaboration with Juvenile Justice and Child Fatality Prevention Teams (CFPT) Status: The Nurse Review Coordinator initiated outreach to the Department of Juvenile Justice (DJJ) to reestablish involvement with CFPT 4. Development of a Standardized Suicide Response Status: Discussions have started within CFPT to create a structured workflow for Wake County agencies following suspected suicides
make referrals to resources, make concerns know to community organizations and meeting with administration
Our team does make families aware of available services in the community. The schools are taken by knowledge of how to access the services. Also, with our local MCO we make the lack of services known in community meetings.
Reaching out to all providers who offered the needed services, transportation and childcare to allow clients to have access to services
reaching out to neighboring counties for services for families. Increase more involvement in Child and Family Team Meetings, provide education.
Referrals for specific evaluation/assessment or treatment services for children or their parents; Follow up with DJJ if a child continues to miss school in the coming school year; Referral to the Post Overdose Response Team (PORT); Connect a parent

with a pharmacy that delivers; Seek assistance from animal control; Connect family with charities in the community; Identify summer programs, camps, bible schools, etc. that children can participate in; Monitor computer and internet use of children; Assist family in identifying funding sources (insurance) for services; Obtaining records from treatment facilities or other county/state DSS's;
Referred to other counties for services. Seek out resources from surrounding counties and research additional in-county resources.
Speaking with LME provider (Trillium) about workarounds for self-pay clients.
Status: Outreach by the Maternal and Child Health (MCH) manager to WakeMed's postpartum unit has begun to enhance discharge education on safe sleep practices.
The agencies can think outside of the box and research services more to be able to educate families more.
The team has worked with the Spanish speaking community and health care providers, Medicaid, etc. to make sure the Spanish population know of services
The team shared resources with each other and educated each other on what is available so that each agency is able to share this information with their clients.
The use of informational videos playing in the lobby of DSS, the Health Dept and local pediatrician waiting areas. The videos are in Spanish and English and give information concerning local services for families with children.
These gaps are complex and issues that would be difficult for a local CCPT to close. We cannot create transportation services or add child care slots. We also cannot add services in the community. We do work on increasing the community knowledge through each agency working outreach events and sharing information interagency.
To educate the team about where those gaps may be to advocate for the needed for any needed services, to share knowledge about services/resources accessible to the community to increase knowledge and referrals to these services.
Utilizing the LME/MCO to seek resources to provide services.
We discussed utilization of resources and to continue working with Vaya.
work closely together to identify community resources to meet the family/children's needs and partnered with the local smart start/children's alliance and hospital/health dept to host a community baby shower.
Worked together to come up with referral sources in the community.

Increasing Community Outreach and Education

ach to community and making resources available
Advertising campaigns to increase community awareness about available services
Child abuse prevention materials were provided at community events. Written materials, lockboxes, and gunlocks were provided.
Continue to advocate for the community in getting safe treatment options. Advocating to community partners to find suitable solutions for those that have limited or no service options available.
Continue to educate and advocate for community needs and services.
Continue to educate parents on the needed services and continue to be an advocator to the State and the MH providers informing them of the needed services for families in our county.
continue to educate the community
Continue with our Booths at local events and flyers in the schools
Educated on community transportation resources.

Educating families about CARTS and other Medicaid transportation resources, linking families with Case Management services
Education and promotion of resources available; and Local Resource Guide
Have a list of pediatric dentists and specialists available for parents. Educate them on transportation options. Work with other community partners on child care.
In the small county, it is known that there are limited resources. The agencies represented in the team would brain storm what services that they did offer that could help the families along with if there was any other resources outside of the county but still close by that would assist the need of the family. The team would address the issue, like lack of employment and see if a local agency could help the family with employment through supportive employment. The team would also suggest other ideas like further evaluations or known people in the community that could assist with the issue.
Invited speakers from the community to share with the team resources they offer, e.g., safe sleep resources (pack-n-plays, cribs, car seats, clothing, parenting education) and doulas as there's an increased use in [County Name]. Team Members researched/shared information about harm reduction models for safe sleep. Public Health invited the Public Health Administrator to share the 2023 [County Name] Community Health Assessment.
School-Based Suicide Prevention and Mental Health Awareness. Status: Some discussions have started within [County Name] to encourage schools to integrate mental health discussions, suicide prevention initiatives, and drug/alcohol education programs. However, there is no indication that a structured program has been fully implemented.
The County has a community resource listing that we post and distribute that provide education on available resources

Resource Development and Funding Advocacy

Advocacy efforts for increased services attempting to locate funding
Education, advocacy, outreach, grant writing
Gathering lists of resources for medical, mental and dental health. Providing updates about community group staff
Invite community resources to the awareness event to help educate on the needs of the community.
Our county is actively building a mental heath facility which will include beds for children and we have employed the services of a Ph. D to run said facility. We take mental health very seriously.
Resource Needs: Additional mental health professionals, school counselors, and peer-led program facilitators are needed to ensure effective implementation.
Resource Needs: Expanded funding to provide a wider range of secure storage options, along with more educational effort
Resource Needs: More funding for caseworkers, law enforcement collaboration, and outreach programs.
Local team members continue to advocate for service improvement.
Resource Needs: More resources to develop guidelines, additional crisis response teams, and dedicated personnel for follow-up services.
Resource Needs: More trained educators, standardized educational materials, and ongoing funding for outreach efforts.
Strengthened Postpartum Education and Safe Sleep Initiatives

Addressing Systemic and System-Level Barriers

Administrative of Courts to provide resident interpreter (state certified) available in court

on a specified date each month. Community partners to consider grant funded opportunities to provide liaison in [County Name] court system for ESL clients about the next steps in court to ensure understanding and prevent delays. Community partners to consider providing ESL classes while also providing childcare and non-traditional hours like at night. [County Name] County to provide a more robust transportation system that operates like a traditional bus system with specific stops and schedules. The school system to provide early intervention and additional support to children of ESL families such as handouts and information to parents in their native language. Community partners to be more diligent in assessing and evaluating needs of ESL families including interpretation services, cultural differences, etc… Education for community partners about immigration and deportation, fears of ESL families, etc… - how to build a better network for ESL families. Vaya to provide a continuum of ACT services and long-term mental health services available in the community.

Expansion of Community Safety Initiatives. Status: The initiative to conduct regular check-ins with families in low-income neighborhoods with high police call volumes has been discussed. Firearm Safety and Secure Storage Measures -Status: Lockboxes are currently provided for some firearms, but they do not accommodate larger guns such as shotguns.

Increased funding from the State and Local governments. In the annual report to the county commissioners, the needs listed above were presented to show the need of the citizens.

participate in local teams, advocate at the state level and with legislatures

These issues still exist. Daymark is currently closed which is where we do our UDS/ MA&SA Ax and the other facilities do not accept random drug screens. The hours Daymark was accepting walk-ins were from 9:30-2:30 again limits those services for parents who are striving work.

While we did not create new strategies this year, we annually advocate for increased access to local public transportation and affordable child care, housing, and basic family supports; stepped up referral information to partner agencies; highlighted policy and "systems" issues for further review and improvement to key agency leaders; shared various priority findings with policymakers; offered public education in various settings and events as previously noted; and drilled down into specific questions with review team members to learn more and suggest future opportunities to reduce barriers. Most of the identified factors are systemic and our team has limited impact relative to changing them.

Local Policy

Bicycle Laws

CFT

How to handle interviews of children of child sexual abuse/How to trained forensic interviews trained and not have untrained police officers conduct the interviews increased awareness of reporting

Informing the DA and local LE of suspected A/N/D

Mental health funding

NC Child Welfare Manual (Fatality)

Practice-agencies need to stay informed on what is available in the county to help families

recognizing that poverty is not abuse and aiding families in poverty to keep them out of the system

substance use intervention

To give agencies more access to knowledge of abuse, neglect, or dependency

(Local) Mandatory safe sleep training for all child welfare staff and foster parents.

Local Procedure

Act according to policy/ investigation
community based support programs
Development of the collaborative for the development of a CAC
Generating a letter in NCFAST
Limited medical dental providers available in the community. Lack of available level 3 placements for an 8-year-old.
Management ensuring the proper supervision is taking place.
More education to agencies about what is available to assist families
Offer data sharing among agencies for enhanced knowledge of the programs needed for families
referrals get funneled for additional support and resources
reviewed child born 34 weeks and death due to birth defects.
smoother collaboration
The agencies struggle with what information can be given to another agency.
Wearing a helmet

Local Practice

Agencies will be knowledgeable of available resources and share this information with their clients
Assess Safety of other children and find TSP
Better notifications to DSS especially from LE in regard to Substance use and DV issues
Education on helmets and reflective gear for bike riding. Blinking lights for riding at night. Handouts from NC Safe Kids
Enhanced Collaboration among agencies
Ensuring safe sleep is observed, discussed, and addressed at every home visit.
Getting engagement from parents who have serious substance use disorders has been challenging for the child welfare program and the Department of Social Services is exploring resources for this as state training is extremely limited and often unavailable.
Getting in touch with Hwy Patrol regarding reports that involve them
Gun Safety Measures – Improve access to firearm safety resources for families.
How to incorporate Harm Reduction Model in case planning.
I think our agency could strengthen our CFT's to include more family and service providers
Informing by telephone and letter
Making sure Child Welfare staff and Supervisors are aware of resources in the community, so they can share with families.
need a way to compel some families to treatment
Providing education to families and the community.
public awareness, collaboration between agencies
The agencies be able to collaborate better and communicate effectively.
the creation of a prevention team
Use the CAC model for interviews/joint assessments of child sexual abuse and physical abuse
We focused heavily on the need for supervisors to improve supervisory guidance, following protocols, and accurately documenting case activities and findings
when to consider petitioning for custody and when to end a temporary safety provider

Well Local

Agencies are trying to communicate necessary information to each other in trying to keep children safe.
All policies, procedures and practices worked well.
Always following the Policy Manual, Using RAMS when needed, working with the community as a whole during the investigation while gathering information.
buy in from local county officials
CCPT/CFPT Meetings
Collaboration among agencies and community partners.
Collaboration between agencies
Contacting collaterals and using agencies involved with families as collaterals
CPS staffing bringing "stuck" cases to the CCPT for suggestions and recommendations has been very helpful.
Determining actions and recommendations for systems issues. Utilizing time to brainstorm ideas and resources with Child Welfare worker, supervisor and program manager.
Development of the CAC for the community. Trainings for Health Department and DSS.
Ensuring that practice encompasses all policies and procedures.
Excellent local collaboration with the multi-disciplinary team
Keeping a master updated listed of available resources in the community to share with families when needed
Local trainings on Narcan. Monthly meeting with community partners regarding Opioids-Rockingham Recovers
Meeting with the other community partners works well. The partnership with the school allows collaboration between the children, parents and DSS.
Open dialogue between community partners.
EMS provided lockboxes and gun locks for community education events.
Our team is very collaborative and open in sharing resources, ideas, and having productive discussions about how best to serve the families in these complex situations. The team has developed good working relationships and we take a holistic approach.
Policy for visits
Print outs through NC Safe Kids and talking with law enforcement
Referrals to law enforcement and DA - we have a good relationship with our community partners.
Regular review of safe sleep with families, including secondhand smoke and its risks.
Strong collaboration and critical communication among everyone involved with a family. Meeting and sharing of policy and procedure from a child protection standpoint with local hospital nursing/medical staff. Continuing to disseminate safe sleep material via hospitals to caretakers at discharge and in local doctor offices.
Successful implementation of community-based family support programs, such as parenting classes. Partnership with local hospitals, LE, and the schools
Supervisory guidance tolls and social worker guidance sheets were created and/or revised to provide clearer directives, and to help workers improve accountability for procedural actions. These were specifically focusing on safety assessments, TSPs, safe sleep assessments and interventions, and all cases involving substance use/abuse.
Through the Team's efforts, DSS staff and external partners have clearer understanding and directions around policies, practices, procedures, and expectations.
SW connected with dental service in a neighboring county to expedite services after referral from another dentist. SW connected child with educational, dental, health care, mental health, and eye care after

coming into custody. School – proactive with truancy charges, help child with emotional regulation in the school, communicated with mom about requesting IEP meeting, IEP meeting occurred in a timely manner and it was positive. Care Management Support through Vaya Relationships between providers/community partners allowed services to be expedited CARE coalition has lock boxes for families

The ability to collaborate with local resources gather their feedback in hopes of ensuring children and families are safe within the community.

The agencies do work together to find services and provide services for the families. Locally the DSS and other agencies have partnered to provide safe sleep for infants.

There is interest and engagement from almost all CCPT_CFPT Partners as well as local leadership including the Boards of Health and Social Services and Board of County Commissioners. There is a strong partnership with Safe Kids Chatham which has led to distribution of items to enhance child safety including gun locks, baby gates, and medication lock boxes.

use of the court system in the early stages of a case to legally secure placements and support kin

Virtual team meetings were held as scheduled

We did not identify any.

We have a prevention team within DHS that works to provide wrap-around services for families that have been identifies

State Policy

Assessment

Assessments

Bicycle Laws

changes to the State drug policy

Clear and precise policies

DHHS - making a case decision with no living children or caretakers can be challenging.

Guidance on cases with Substance Affected Infants that involve parents who test positive for Fentanyl and medical records report this could be due to the mother's epidural during delivery.

implement a practice model

increased support of kinship care and providing partial payments to kin

Medicaid Expansion, School mental health services

NC Child Welfare Manual

Policies are need to help develop services for youth with significant needs - behavioral, mental health, and substance use.

State funding all services

Statewide Policy on School Information Sharing – Require all public/charter/private schools to cooperate in child fatality investigations. Mandatory Human Trafficking Screening – Implement a standard screening tool across agencies. Firearm Storage Policy – Strengthen requirements for safe storage of all firearms, including large shotguns. Pharmaceutical Company Accountability – Consider policies holding pharmaceutical companies accountable for youth suicides linked to medications. Standardized Post-Adoption Follow-Up – Mandate follow-up services for adopted children.

Substance Affected Infant Policy that changed is now not inclusive enough for DSS agencies to screen in reports on all substance affected infants.

The use of the Maltreatment Screening Tool There are often interpretation differences at the local levels involving state and local

policies. These interpretation differences can lead to ambiguity, different procedures and practices, and inconsistent worker outcomes.

TSP

State Procedure

Act according to policy/ investigation
Child Suicide Prevention Program – Implement a statewide system for tracking and supporting at-risk children and siblings of suicide victims. Postpartum Depression Screening & Intervention – Require pediatricians to assess mother-child bonding during well-checks.
Consulting with the tool when making assessment decisions
Determining appropriateness of standards of TSP's
Follow the changes to the State drug policy
Great support from the State level whenever there are critical staffing shortages.
increase the number of available trainings intervention protocols, licensing mental health providers

Lack of level 3 placements available 8-year-old. Different outcomes for truancy charges for parents.
Once policy changed in how Substance Affected Infant policies are screened, some families are not receiving needed guidance and assistance.
Parents not allowing DSS into the home.
Preventative Services for families that could benefit and may cause less families to enter the need for child protective services
State funding all services
The state lacks the ability to intervene when other counties will not accept conflict of interest cases.
Wearing Helmets and other reflective Gear

State Practice

Assess Safety of other children and find TSP community bases treatment options, telehealth
Consulting among peers and state due to the policy being
continue discussion of new system how it will align to policy changes
Create messaging to address risk reduction in co-sleeping. Continued education about the risk of fentanyl exposure with children.
File an Obstruction/ Interference Petition
Gun Safety Measures – Improve access to firearm safety resources for families.
Have Billboards that have education on the importance of following bicycle laws
Hospital discharge criteria for youth recommended for PRTF and none available
Local interpretations by workers, supervisors that sometimes affect efficiency, effectiveness, and accountability

More training and guidance when dealing with families here illegally. More training to DSS and partners around DV and Substance Use and its impacts on Children and Families
Our agency has asked previously and would continue to ask for specific guidance on approving TSP's (criminal, CPS history) what is or is not appropriate across the board. Not just county to county.
specialized training for new staff
State funding all services
The SAI policy needs to be tweaked again to make is more inclusive of children that are born exposed to substances. There are cases were babies are born with serious drugs in their system but the report is screened out (by policy) because the child is not showing symptoms of withdrawal and their parents are acting appropriately in caring for them.
well educated social workers on State police

Well State

Assess for Safety first and make sure that any other children are place in a safe environment/
Assessment policy
CCPT/CFPT Reviews
Designated forms for completion are easy to complete.
Development of RAMS
DUI's being changed to Physical Abuse in NC DHHS Policy
Ensuring that practice encompasses all policies and procedures.
It was recognized that the NCDHHS-DSS is making continued improvements with state policies, and enhanced technology, to improve child welfare in the State of NC.
Medicaid allowed child to get back into health and dental Care needs met quickly.
New financial support to kinship families (this was in place locally prior to this legislative change).
One of the strongest procedures is the multidisciplinary team (MDT) approach used by county-level Child Protective Services (CPS), law enforcement, and healthcare providers to review serious cases of abuse, neglect, or child fatalities. Human trafficking screening tool for CW
public assistance programs
Revision of the Substance Affected Infant Policy
Screening process, timeframes for assessment, community resources such as referral process for CMARC, how to respond based on the screening process.
support of kinship care
The CCPT had no active or fatal maltreatment cases to review
The Cross Function Topics Guide in policy has been a tremendous help to staff and administration while interpreting policy and seeking guidance. Also, the addition of unlicensed kinship providers has greatly improved the success of permanency for foster children.
The monthly meetings have assisted with training and answering questions
The overall changes to the drug policy go hand in hand with the impaired parenting educational goals of our community.
The policies, procedure, and practices are there to be followed and would have been effective if it were able to be followed in the case in mind.
The requirement to interview household members and victim children alone in a global assessment model.
There is a growing need for appropriate placement options.
Truancy screening criteria for CPS intake
When fatality intake forms are sent, communications are quickly received which activates needed follow-up with State and local partners. Intensive reviews are going well, more timely, and informative.

Recommendations

Training and Education

Better education about child abuse and neglect
Bring back the newsletter with helpful information
Continue to educate parents on resources available to help when they are in crisis.
Consistent and regular New CCPT Member Training
Educating and meeting with the Magistrates
Educating and speaking with Juvenile Justice
Educating Law Enforcement
Education
Education about the new system
Enhance and expand training to the child welfare workforce, including addressing the impacts of secondary traumatic stress. Child

welfare workers should have timely access to training and leave training believing that it was a good use of their time.
Hands On Training- State Level
increase number of available trainings
Increase training for CCPT members
More general and specific training on CCPT
More training opportunities
Need state level training on requirements.
Provide more opportunities for trainings and refreshers.
provide more trainings for CCPT members
Provide training & education to the team
Provide training for CCPT
Provide training on confidentiality and information needed to conduct CCPT
Providing additional in-person training
Regular Training and Technical Assistance
The state should provide ongoing, mandatory training for CCPT and CFPT members, ensuring they understand their responsibilities, how to analyze data effectively, and best practices in child fatality prevention. Additionally, state-led technical assistance could support counties in addressing challenges and developing local action plans.
Technical assistance and trainings from the state
There needs to be more training and feedback on obtaining other resources
There needs to be online learning opportunities for members of the local Community Child Protection Teams.
train in advocacy efforts the teams could utilize
training and support at local level
Training as a team would be helpful.
Training for CCPT Team
Training for CCPT/CFPT members. Updated.
training for members
Training options to enhance learning on identified issues

<u>Community Awareness and Collaboration</u>

A cultural attitude of collaboration between all community partners which begins at the State level wherein CCPT and CFPT are viewed as a resource and a support for all community partners (similar to a Chamber of Commerce for business owners but for child welfare)
Increase awareness of mental health issues with [County Name] County citizens.
Increase awareness of substance abuse in the community.
more awareness
Strengthen Interagency Collaboration with sharing of protocols

<u>Advocating for Policy and Practice Change</u>

A way to hold required members accountable for attendance to meetings.
Additional funding for local CFPT's
Be specific - if CFPT is absorbing CCPT then let's be clear re: CCPT expectations going forward.
better communication between community partners and workers
Close the gap between what DJJ can do to address children's behaviors and what ends up falling on DSS to manage due to child's high needs.
Enhanced ideas or talking points
Faster turnaround for death review cases to be able to see trends and focus on prevention
Greater support during times of staffing crisis.
Interpretation and regular reviews of policies and practices
Lower caseloads for CPS workers

more assistance in obtaining CCPT members
Perform Intensive Fatality Reviews when indicated and in a timely manner (our team reviewed a case that should have had a state-led intensive review but it ended up being delayed, scheduled, and then canceled due to staffing issues)
policy and laws
Preventive Services to families identified that may be approaching concerns
Provide a little more instruction on what a review should look like
provide examples of best practice that other teams are implementing
Providing support and compassion, recognizing fatalities sometimes happen regardless of diligent efforts towards prevention.
PSA - with local elected officials (Chief Judge, Sheriff, Police Chief, DA, Chief of Fire Department, DSS Director, HD Director etc.) - script that could be used. Covering topics such as safe sleep, care seats, DV, drug use, smoke detectors, lock boxes, etc.
Recruitment materials/informational material for public knowledge of the CCPT
Require coordination and accountability across the DHHS divisions including DSS, DHSR, and DMH/DD/SUD/, and DHB to ensure that the behavioral health needs of children and youth are met as evidenced by a reduction in boarding in Emergency Departments, DSS Offices, and other inappropriate placement settings. While [County Name] County has been fortunate to have minimal problems with children/youth boarding in inappropriate placements, it often requires an extensive amount of time and resources to identify placements for children with significant behavioral health needs.
staff support
State advocation for better Mental Health
Strengthen state-local data surveillance and reporting systems. Infant and child morbidity/mortality data lag at least a year. Also, the fragmented DSS maltreatment reporting systems need substantial improvement as it is very difficult to get recent or real-time data useful for team reviews, planning, and strategic activity prioritization.
Stricter laws on perpetrators of domestic violence that are repeat offenders - these often result in fatalities.
The abuse definition/screening tools should include a specific category for children who have access to harmful substances and ingest them.
The efficiency of medical examiner in the timely release of autopsy reports specifically for children
The state can facilitate stronger cross-agency partnerships by requiring regular joint meetings between public health agencies.
There are several other meetings (e.g., multidisciplinary team meetings) that our county's DSS staff facilitate with community partners related to review of cases of child abuse, neglect, and dependency that likely do a better job carrying out the role of a CCPT. The state should look at expanding what can count as a CCPT. As a combined team in a county with nearly 30 child fatalities a year and many becoming more complicated due to youth mental health & substance use issues, we have a hard time getting through our required fatality reviews, let alone finding time to conduct CCPT reviews.

Funding Support
Additional funding for local CFPT's

Consider advocating for more local CCPT funding to purchase safety and public awareness supplies and resources.
Fund actual prevention programs before a family is in need of protective services.
funding
Funding
Funding CCPT to be more involved and relevant during community outreach events
Funding for prevention programs and education. Campaign to highlight states definition of safe discipline
Funding Services for MH/SA/IDD
Funding to DSS for Staffing and programing
Increased Funding and Resource Allocation – Many local teams struggle with limited funding for staffing, data collection, and program implementation. The state could allocate dedicated funding streams to ensure local teams have the necessary resources to conduct thorough case reviews, implement prevention strategies, and engage in community outreach
more funding
More funding for community outreach
More funding to purchase materials
More money to provide PSA on TV, in newspapers.
NC DSS should provide local CCPTs money to assist in providing educational opportunities and materials to families to try and prevent further abuse and/or neglect.
Need funding to help purchase safe sleep for infants in need.
Seek increased funding and improvements for behavioral health/mental health/substance use/IDD services and care coordination-case management. We have many gaps in these areas, especially for children and youth.

Improving Services and Resources

[county name] continues to need a domestic violence shelter
access to better quality Mental Health/Substance Abuse Services offered for adults (especially with no insurance)
Accountability with LME/MCO for finding leveled placements for children with clinical recommendations for such
Adequate safe housing is consistently a challenge for parents involved with the child welfare system, especially when they do not have extended family support. Identify specialized housing vouchers or other resources that could make available housing support for parents who are at risk of losing custody or are working toward reunification and housing is an identified need for the family.
Advocate for more Spanish-speaking providers or increase the availability of interpreters and/or translation services.
Advocate more for better mental health services in the community.
Advocate more for DV, Prevention, Substance and housing resources.
Advocate more for local placement options in our county.
Accessible resources
Enhance the number of providers for mental health, substance abuse, and peer support services. Grow the roster of providers trained in evidence-based treatment modalities for caretakers and children.
Enhancement and expansion of options for youth with high levels of placement needs.
Ensure a standardized program for parents before discharge at hospital (Military Hospitals included) which focus on supervision, car seat safety, and safe sleep.
improved access to In-Home Parenting Programs for families with children older than 5 years old
To support families we need a place that will accept random drug screens at any time. Example Lap Corp through the hospitals

Increase co-located treatment for families (inpatient treatment for families). Not just for women and children (include fathers).
increase providers in the community to prevent delays in services
Increase resources in the community as they are scarce in certain areas.
Lack of appropriate placements for children, especially those with high acuity (i.e., behaviors/mental health needs)
More accessible placement options
More available trauma focused mental health services
More domestic violence resources
More IDD resources
more marketing on safe sleep
more mental health services for families
more resources
More resources for families but it's understandable why there aren't more as funds are limited to all agencies
More resources for rural counties
more resources to lock firearms
More services for parents with private insurance
NCDHHS and Mental Health MCO's work in partnership to provide enough additional residential treatment programs (Level III and PRTF) for youth with Mental Health and Substance Abuse issues so that youth can be quickly admitted to appropriate levels of care when the need arises
NCDHHS and Mental Health MCO's work in partnership to provide residential treatment programs for quickly and safely providing services to youth with aggressive or serious criminal behaviors;
Need more available resources to offer mental health and substance abuse treatments.
Offer caregivers and childcare providers strategies to strengthen Autism Spectrum Disorder supportive practices.
online hub or forums to allow counties to share ideas or projects with each other
Provide incentives to recruit and train qualified Trauma Informed practitioners at the county and state level
Provide services to prevent those gaps. Example we are currently struggling with getting Intensive Family Preservation services.
resources
Resources
Trauma based services
We need therapy services for children during regular school hours through the school system.
we struggle to meet all mandated services when we have no staff

Technical Training Topics

Accessing available data - what state/local/national data is available to the team.
Any training that would improve teams outcomes.
Anything you suggest
Better understanding about natural causes of deaths.
CCPT - Clarification with the primary focus on CFPT
CCPT Advisory Board Functions
CCPT board training
CCPT recruitment materials
changes in system
Child Death trends in NC
Clarification of State Policy with the new changes with local team reviews.
community outreach
Cultural Competency
data
Early intervention for Mental Health
Effects of substance abuse on mental health.
Forming Recommendations
General Education for CCPT Participation
How does your CCPT operate. Who is at the table.

How teams should look with the new law
How the new "Local Teams" should conduct fatality reviews in cases that would have previously had a 2-day state-led intensive review
How to conduct a meeting
how to do intensive reviews of CPS cases
How to effectively run a CCPT
How to effectively run a CCPT meeting
How to get the most out of CCPT
How to get the most out of our CCPT meetings
How to obtain better attendance and improve engagement
how to review cases
marijuana impacted parenting (rather than opioids)
Mental Health Awareness
Near fatalities
Near Fatality cases
obtaining members for CCPT and training on CCPT meetings
Ongoing best practices in the case review process -- how might they be strengthened and utilized for proactive system improvements
Outline for case reviews
Overview/refresher training
Placement Options
Process and structure for conducing local team meetings
Resources
Resources in small/rural counties
Show us work that is being done in others areas that you all feel demonstrates the function of a local CCPT
Skills of communication and collaboration
State requirements related to CCPT
State to discuss new structure for local team and new processes with examples.
The organization of meetings and training on recommendations for cases
Training about the new system
Training identifying methods/best practices to address systemic issues such as increasing safe and affordable housing; lack of mental health providers; etc.
Training on how to properly run a CCPT
Meeting for new staff
Training on providing activities and recommendations on cases reviewed
Training on the role of the chair for new "local team"
Trauma Focused practices
Trauma-Informed; Poverty vs. Neglect; At-Risk vs. Intentional neglect/maltreatment trends
Trends and leading causes of child fatalities in our Region (Region 1)
Trends in NC child fatalities.
Ways to strengthen/improve development, alignment, and use of data for CCPT strategic planning and protocol development/use
What can and cannot be discussed during CCPT
which cases to review

Racial/Ethnic Challenges

Language and Cultural Barriers

cultural barriers
Discussed issues with our Spanish speaking families having access to care and resources.
Lack of access to services in part due to language barriers, funding/access for Medicaid, Market Place insurance
lack of services available to parents that are not legal, increasing lack of trust with parents willing to communicate and work with DSS
Language barriers; we try to be culturally sensitive in all that we do.
Limited English Proficiency LEP

Literacy/language barriers
Needs for children who are in US illegally
Non English speaking parents
The team has discussed issues with the multi-cultural populations in our state, barriers to language and cultural differences
There has been discussion about cultural differences related to co-sleeping. This led to the need to develop messaging specific to risk-reduction rather than messaging that condemns co-sleeping altogether.
There is a large population of non-English speaking individuals in our County who are unaware of services available to them
We have discussed engagement and connecting to culturally appropriate services

Imbalance in Reporting, Resources and Services

Access to resources
Access to services
Needs for many more bilingual workers, community support personnel, judicial staff, Law Enforcement, etc. Lack of focused community intervention locations/sites where public education (bilingual, multi-lingual) can be effectively delivered, and families screened and/or identified for prevention services. Women in poverty lack access to pre-natal care. This is usually due to barriers such as transportation.
over representation of brown and black mothers being reported due to Marijuana use and child testing positive or not; other social and behavioral determents amongst brown and black families that cause them to be reported more frequently or impact healthy pregnancies.
Some families struggle with poverty yet can meet their children's needs and can live without certain things people take for granted.
Some issues identified by our team involved the lack of resources for the Hispanic population that we serve and the barrier between the cultures.

Racial/Ethnic Strategies

Continued education and access to medical care. [Couty Name] has advocated for Medicaid Expansion and look forward to seeing the positive impact it will have on families and children.
Discussing different services, treatment options, and involve the community
Discussing the need to provide the same services to all citizens with the same amount of effort.
Discussion of co-sleeping risks at each CPS home visit.
Group discussion
Have an open mind with families when assisting with their families' issues.
Identified the resources for uninsured, Spanish speaking individuals. Communicate these resources in all public access areas and when working with families in attempt to reduce access to services.
increase knowledge by communicating with families through interpreters willingness to provide resources and safety for children rather than legal status
Information/forms in several languages would be helpful. Not all of the DSS forms are in other languages other than English.
Issues were identified during case reviews.
Locating interpreters for the non English speaking parent
possible training on different cultures to the community
Reviewed protocols and access to the language line
Sought out other resources to help support the financial need for payment/funding to

support a specific service needed by an undocumented individual.
The CCPT had no cases to review, however client centered services were discussed (i.e. home visits, flexible schedules to accommodate working families)
To continue to explain the process of child welfare in NC and help educate
we have a diverse team
We have attended non-English speaking community events to make sure service information is available
We made sure that we had Arabic and Urdu translations for co-sleeping at our hospital.

Additional Information

Clarification re: CCPT for 2025.
In the questions above, does the phrase "any training and support offered by DSS concerning the engagement of individuals with lived experience" refer to NC DHHS - Division of Social Services? If not, have local depts. of social services received information on how to offer this training and support?
It is unclear what immediate above question is asking. I'm not sure if this is NCDSS or the local DSS. I presume it is NCDSS. If that is correct, I would like more information on what that means.
It's difficult enough for us to get the mandated members to come and participate.
Not aware of any training about engaging an individual with lived experience.
This is something that I would like to discuss further with the team in 2025!
we continue to build capacity in our CCPT,
We deeply appreciate our relationship with State partners, and the supports provided by them. We learn a great deal from the webinars, procedural updates, and other communications so encourage them as often as possible. We need ongoing education around best practices, effective procedures, protocols for collaborative prevention and intervention, etc. and do not have staff or funding to generate some of this on our own.
We have a partner who serves on the CWFAC
We have had several conversations about having family and youth partners on our committees. We just have not found the right person(s) to be added to the committee.

Appendix D: Copy of 2024 Survey

CCPT Survey 2024
2024 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 2024 survey. The NC CCPT Advisory Board is responsible for conducting an end-of-year survey of local CCPTs and preparing a report to the North Carolina Division of Social Services (NC DSS). The state-level report is compiled from aggregated data without identifying individual team responses. This year, the Board and NC DSS will have access to individual county data which will allow for targeted support and communications to facilitate CCPTs' optimal functioning. The NC CCPT Advisory Board will make recommendations on how to improve public child welfare. NC DSS will write a response to the report.

The survey results assist local teams in preparing their annual reports to their county commissioners or tribal council and to their DSS. You can choose whether to complete the survey and can decide which questions to answer. The one exception is that local teams will be asked to provide the name of their county or Qualla Boundary. This makes it possible to track which CCPTs completed the survey and to acknowledge the participation of the specific local CCPT in the annual report. The survey responses are transmitted directly to the researcher, TBD, at North Carolina State University. De-identified findings may also be included in presentations, trainings, and publications.

The 2017 through 2022 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 2024 Survey (6430)
Principal Investigator: Dr. Anna Abate; acabate@ncsu.edu
What are some general things you should know about research studies?

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

In this consent form you will find specific details about the research in which you are being asked to participate. If you do not understand something in this form it is your right to ask the researcher for clarification or more information. A copy of this consent form will be provided to you. If at any time you have questions about your participation, do not hesitate to contact the researcher(s) named above or the NC State University Institutional Review Board office (contact information is noted below).

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

Am I eligible to be a participant in this study?
There will be potentially 101 participants in this study, representing all counties in North Carolina and the Qualla Boundary. The chairpersons of the CCPT in each county or Qualla Boundary will be sent a survey.
In order to be a participant in this study you must have been an active member of your local CCPT for the past year.
You cannot participate in this study if you are no longer a member of your CCPT.

What will happen if you take part in the study?
If you agree to participate in this study, you will be asked to do all of the following: complete and submit the online survey.
The total amount of time that you will be filling in the survey is approximately 25 minutes. In preparation for filling in the survey, it is recommended that the local CCPT Chair meet with the team to discuss what responses to provide to the survey questions.

Risks and benefits
The local CCPTs are asked to identify by name their county or Qualla Boundary, and the responding CCPTs are listed in the end-of-year CCPT report that is shared with state and federal authorities and posted on a public website. In addition, the results may be shared in presentations, trainings, and publications. The responses of the local CCPT may identify that they made a particular answer. This risk is minimized because the NC CCPT Advisory Board and NC DSS will only use data identifying the local CCPT to inform what resources and support a particular CCPT might need to improve their functioning. The survey will indicate for which questions the Research Team will identify the local CCPT giving the response to the NC CCPT Advisory Board and NC DSS. All public facing reports will be in aggregate, which means that the responses of the individual CCPTs are combined together.
There are no direct benefits to your participation in the research. The indirect benefits are that your CCPT has the opportunity to contribute to improving public child welfare and protecting children from maltreatment.

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

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

Compensation
You will not receive anything for participating.

What if you have questions about this study?
If you have questions at any time about the study itself or the procedures implemented in this study, you may contact the researcher, TBD, at Center for Family and Community Engagement, North Carolina State University, TBD.

What if you have questions about your rights as a research participant?
If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact the NC State University IRB (Institutional Review Board) Office via email at irb-director@ncsu.edu or via phone at 1.919.515.8754. The IRB office helps participants if they have any issues regarding research activities.

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

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

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

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

1. This survey covers the work of your CCPT for the period January – December 2024.

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

3. You can print a blank copy of this survey to review with your team, and you will be able to print a copy of your completed survey report when you finish the survey.
4. Your team members should have the opportunity to provide input and review responses before your survey is submitted. Please schedule your CCPT meeting so that your team has sufficient time to discuss the team's responses to the survey.
5. In addition to the CCPT meeting time, set aside approximately 25 minutes for filling in the team's responses on the survey.
6. For questions about the survey and keeping a copy for your records, contact the Research Team at ccpt_survey@ncsu.edu.
7. Please complete and submit the survey online (via Qualtrics) on or before **TBD**.

Note. The Research Team WILL provide 1) a list of CCPTs who completed the survey and 2) the corresponding data from the TA section (in blue) of this survey to the NC CCPT Advisory Board or NCDSS

Select your CCPT from the list below.

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

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

CCPT Operation

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.

Reminder: CCPTs review active cases in which abuse, neglect, or dependency is found and are responsible for 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."

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 _____

How often does your CCPT meet as a full team?

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

If your team has subcommittees, how often do subcommittees within your CCPT meet?

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

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

Which of the following applies to your CCPT?

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

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

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

CRP Function

Citizen Review Panels (CRPs) are charged with evaluating the extent to which the state is effectively fulfilling its child protection responsibilities in accordance with the CAPTA State Plan; examining the policies, practices, and procedures of the state and county child welfare agencies; reviewing child fatalities and near fatalities; and examining other criteria important to ensuring the protection of children. In the state of North Carolina, CCPTs are designated as CRPs.

As CCPTs, state statue require that teams meet together on a regular basis:

1. *to identify gaps and deficiencies in community resources which have impact on the incidence of abuse, neglect, or dependency*
2. *to advocate for system improvements and needed resources where gaps and deficiencies exist in the child protection system*
3. *to promote collaboration between agencies in the creation or improvement of resources for children as a result of their review of selected cases; and*
4. *to inform the county commissioners about actions needed to prevent or ameliorate child abuse, neglect, or dependency.*

What local activities has your team done to enhance maltreatment[3] prevention in your community? Check all that apply.

[3] Maltreatment includes abuse, neglect, and dependency.

- Education [*if selected, "Please provide more information on the education provided, including what topic and to whom"]*
- Collaboration [*if selected, "Please provide more information on the collaboration, including with whom the team collaborated and why"]*
- Reviewed maltreatment open or active cases (that were not near fatalities)
- Reviewed maltreatment near fatalities[4]
- Other _____

[If "reviewed maltreatment open or active cases" is selected] **What is the total number of <u>active cases</u> in which abuse, neglect, or dependency was found did your CCPT review between January and December 2024?**

Number of cases reviewed _____

How many of these <u>active cases</u> entailed Substance Affected Infants[5]? ***If zero, type 0.***

____

[*If "reviewed maltreatment near fatalities" is selected*] How many of these <u>active cases</u> entailed a near-fatality that did not result in a death/fatality? ***If zero, type 0.***

____

How many fatality cases in which the fatality was suspected to have resulted from abuse or neglect did your team review? (Do not include those done through an Intensive Fatality Review)

_____

What were the overarching trends, findings, or conclusions your team identified when reviewing active or fatal cases in which abuse, neglect, or dependency was found? Please be specific when describing (i.e., include the *who*, *what*, *when*, and *where*).

_____

_____

Based on these trends, findings, or conclusions, what were your team's recommendations to help prevent or ameliorate child abuse, neglect, or dependency? Please be specific when

[4] 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."

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

providing the recommendation that your team made (i.e., include the *who*, *what*, *when*, and *where*)

_____

_____

Based on the cases your team reviewed in 2024, please rank the need of these services or resources for <u>children and/or youth</u> from MOST NEEDED to LEAST NEEDED.

- Mental Health (MH) services
- Intellectual/Developmental Disabilities (I/DD) services
- Substance Use Disorder (SUD) services
- Domestic Violence (DV) services
- Child Trafficking services
- Medical Assistance (Visual/Hearing Impairment/Physical Disability) services
- Language and Literacy Skills
- Housing Assistance
- Food Assistance
- Health Insurance
- Other _____

Based on the cases your team reviewed in 2024, please rank the need of these services or resources for <u>parents or other caregivers</u> from MOST NEEDED to LEAST NEEDED.

- Mental Health (MH) services
- Intellectual/Developmental Disabilities (I/DD) services
- Substance Use Disorder (SUD) services
- Domestic Violence (DV) services
- Parenting Education/Childhood Developmental Knowledge
- Childcare
- Medical Assistance (Visual/hearing Impairment/Physical Disability)
- Language and Literacy Skills
- Housing Assistance
- Food Assistance
- Health Insurance
- Other _____

In 2024, which of the following limitations prevented children, youth, and their parents or other caregivers from accessing needed services. Check all that apply.

- Language barriers
- Limited services or no available services
- Limited services for youth with dual diagnosis of mental health and substance use issues
- Limited services or youth with dual diagnosis of mental health and developmental disabilities
- Limited services for youth with dual diagnosis of mental health and domestic violence
- Limited transportation to services
- Limited community knowledge about available services
- Limited participation of MH/DD/SUD/DV providers at CFTs
- Limited child care
- Limited access to healthcare/no health insurance
- Limited finances

- Other 1 _____
- Other 2 _____

What strategies did your team develop to address any of these gaps in services and resources?

_____

_____

During active or fatal maltreatment reviews (active cases in which abuse, neglect, or dependency is found or fatalities suspected to have resulted from child abuse or neglect), what *policies, procedures, or practices* at the LOCAL LEVEL did you identify as in need of enhancement in the child protection system[6]?

- Policy _____
- Procedure _____
- Practice _____

During active or fatal maltreatment reviews (active cases in which abuse, neglect, or dependency is found or fatalities suspected to have resulted from child abuse or neglect), what policies, procedures, or practices at the STATE LEVEL did you identify as in need of enhancement in the child protection system?

- Policy _____
- Procedure _____
- Practice _____

What STATE level policies, procedures, and practices did you find worked well?

_____

_____

What policies, procedures, and practices of the LOCAL child protection system did you find worked well?

_____

_____

What positive changes has your community seen based on your CCPT operations?

_____

Based on your 2024 case reviews, what do you wish North Carolina did differently to help support your CCPT to carry out its mandated function? Please provide your top three recommendations for improving prevention of child abuse, neglect, or dependency. In writing your recommendations, please be clear and specific (i.e., what specifically needs to be changed?) Please consider policy changes, program needs, or resources.

---

6 A collaborative community (local entities: schools, courts, MHS, etc.) effort where everyone has a role in ensuring a child's protection.

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

Technical Assistance [NOT CONFIDENTIAL]

Have your team discussed or been educated about the Child Welfare trends in NC and the Nation?

- Yes
- No

Is your team aware of how NC has performed in Federal reviews (i.e., CFSR)?

- Yes
- No

Is your team aware of your county's performance on the CFSR?

- Yes
- No

How often has your team requested resources or assistance from NCDSS to enhance your team's function?

Never	Rarely	Occasionally	Frequently	Very Frequently
o	o	o	o	o

Did your team utilize any training and support provided by NCDSS to enhance your team's function?

- Yes
- No

What would help your CCPT better carry out child maltreatment case reviews? Please rank the areas of anticipated needs (regarding child maltreatment) for the next calendar.

- Training
- Data
- Support/resources from CCPT Advisory Board
- [Enter another option]
- [Enter another option]
- [Enter another option]

Please help us plan training for this next year by identifying specific topics your team would benefit from. One topic requested; additional appreciated. If none, please write "none."

_____

_____

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

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

- Yes
- No

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

_____

_____

What strategies did your team identify to address these issues?

_____

_____

In 2024, other than mandatory members, did family or youth partners serve as members of your CCPT? This does not include the mandatory CFPT parent, if meeting as a combined team.

- Yes
- No

Did your team utilize any training and support offered by DSS concerning the engagement of individuals with lived experience?

- Yes
- No

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

_____

_____