NORTH CAROLINA COMMUNITY CHILD PROTECTION TEAM

2020 End of Year Report

Community Child Protection Teams
NC Advisory Board

Foreword

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

The NC CCPT Advisory Board set the directions for the survey this year and reflected on its findings. Grounded on the experiences at the local level and the developments at the state level, the Advisory Board moved forward recommendations for improving child welfare in our state.

The NC Division of Social Services ensured that local teams were aware of the survey and strongly encouraged their participation. The Center for Family and Community Engagement at North Carolina State University, led by Dr. Sarah Desmarais and Dr. Kwesi Brookins, carried out the survey with Dr. Emily Smith, Dr. Joan Pennell, and research assistant Peyton Frye administering the survey, analyzing its results, and preparing this report.

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

George Bryan*	NC CCPT Advisory Board Chair
Karakahl Allen-Eckard	NCSU Center for Family and Community Engagement
Sharon Barlow*	Guilford County Department of Social Services
Molly Berkoff*	Medical Professional
Gina Brown*	Child Welfare Family Advisory Council
Christopher Carr*	Child Welfare Attorney
Carmelita Coleman*	Independent Living Resources Inc. - SAYSO
Deborah Day	NC Division of Social Services
Ellen Essick*	Department of Public Instruction
Peyton Frye	NCSU Center for Family and Community Engagement
Melissa Godwin	UNC Department of Public Health
Terri Grant	NC System of Care, NC DHHS
Carolyn Green*	Guardian Ad Litem
Kella Hatcher	NC Child Fatality Task Force
Amanda Hubbard	NC Division of Social Services
Virginia King	NC Division of Social Services
Pachovia Lovett	NC Department of Public Instruction
Debra McHenry	NC Division of Social Services
John Myhre*	County CCPT Board Member
Joan Pennell	NCSU Center for Family and Community Engagement
Terri Reichert	NC Division of Social Services
Paige Rosemond*	CCPT Board Chair
Starleen Scott Robbins*	Substance Use Expert
Megan Shanahan*	UNC Department of Public Health
Heather Skeens*	Guilford County Department of Social Services

Emily Smith	NCSU Center for Family and Community Engagement
Lynda Stephens	NC Division of Social Services
Kathy Stone	NC Division of Social Services
Bernetta Thigpen*	NC Council on Women
Cherie Watlington*	Independent Living Resources Inc. - SAYSO
Marvel Welch*	NC Commission of Indian Affairs
Barbara Young*	Child Welfare Family Advisory Council

*Denotes voting member. List subject to change through reporting period.

I. Executive Summary

A Challenging Year

Year 2020 was such a difficult year for children, families, and their communities. During this time, support was essential as the global coronavirus pandemic gained momentum and gravely affected health, education, employment, recreation, social and faith gatherings, and so many other vital aspects of our civil society. The impact was disproportionately felt by people of color, Indigenous, immigrant, and those living in congregate settings or in rural and other areas with fewer medical, economic, and technological resources (CDC, 2021).

The severity of COVID-19 was exacerbated by opioid overdoses, generating a syndemic of two deadly crises. Public health protocols were crucial to protecting life and wellbeing and compelled reimagining how to deliver public services. Under social distancing requirements, the federal government pushed distance forms of opioid-use treatment such as telemedicine and take-home medications, leading to innovations at a far more rapid pace than normal (Becker et al., 2021). Among those affected were Community Child Protection Teams (CCPTs), dedicated to helping Departments of Social Services improve their programs and engaging with local communities to raise awareness of children and their families' needs. The burden was also felt at the state level as public agencies sought to contain the fallout from the pandemic.

This report documents what we learned from the 2020 CCPT survey about the challenges faced in local communities and the strategies for meeting them. As the North Carolina Community Child Protection Team /Citizen Review Panel Advisory Board (NC CCPT/CRP Advisory Board), we wish to commend the 84 CCPTs who completed the survey, despite operating under the duress of a major public health crisis. These teams took the time to reflect on their work and envision ways to move forward in the new year.

The local CCPT experiences and perspectives inform the recommendations that the Advisory Board is proposing to the NC Department of Health and Human Services (DHHS) for strengthening child welfare. These recommendations, presented in this report, are sent to NC DHHS for response and action and are included in the state's plan to the US Administration for Children and Families.

The robustness of the recommendations is enhanced by the NC CCPT/CRP Advisory Board progress on orienting new members, widening its representation in programmatic areas, involving Family and Youth Partners, and keeping abreast of developments at the local and state levels affecting children and their families. Each year, the Advisory Board reviews and revises the CCPT survey and for 2020, added questions on the impact of COVID-19. The Advisory Board is also giving consideration to redesigning CCPT surveys so as to offer a better route for DHHS to respond directly to individual teams on the concerns and opportunities that they identify.

In 2020, The Advisory Board gathered information on two key policy areas: substance-affected infants and their Plans of Safe Care (POSC) and near fatalities of children who have been maltreated. The work on these two policy areas helps to move North Carolina toward the

formation of Citizen Review Panels (CRPs) that can offer an independent perspective on challenging issues affecting public child welfare across the state.

2020 NC CCPT Advisory Board Survey Summary

The 84 CCPTs who responded to the survey encompassed all state regions, county population sizes, and the seven LME/MCOs that provide mental health, developmental disabilities, and substance use services. More than four-fifths of the responding CCPTs stated that they were "an established team that meets regularly," while the others were in different stages of reorganizing. Four-fifths (80%) of the CCPTs opted to combine with their local Child Fatality Prevention Team (CFPT). Two-thirds (67%) of the surveys were completed by the chair or designee and a quarter (24%) by the team as a whole or subunits of the team.

The 2020 survey inquired about the following five main questions:

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

A. Respondent Characteristics

This year, 83% of the local teams responded to the survey in 2020, a percentage that is in the higher range for responses since 2012. The participating CCPTs encompassed all state regions, county population sizes, and the seven LME/MCOs that provide MH/DD/SA services. More than four-fifths of the responding CCPTs stated that they were "an established team that meets regularly," while the others were in different stages of reorganizing. Among the responding teams, 80% were combined with their local CFPT. Thus, overall CCPTs are sufficiently established to make significant contributions to child welfare. The trend toward combining CCPTs and CFPTs can contribute to state planning on consolidating reviews of child fatalities.

B. Survey Completers

The survey encouraged CCPT chairs to seek input from team members on their responses. The ability of teams to convene to develop their responses was likely limited by the survey being open during holiday months, although an extension was given to those who had not submitted a completed survey by the January 15th, 2020 deadline. Nevertheless, the majority of teams had more than one member completing the survey, thus, reflecting wider perspectives of the group.

C. What Difficulties does the Pandemic Pose to Team Operations

The pandemic affected the operations of most CCPT teams. The pandemic presented

three main challenges. First, they had to resort to online means of meeting. Not all members had access to the necessary technology, and teams were uncertain about how to meet virtually while safeguarding confidential case information. Second, teams were uncomfortable holding discussions without the usual face-to-face contact and networking. They especially were uneasy about discussing deaths online and had difficulty accessing and sharing records necessary for case reviews. They were also limited in carrying out community prevention activities. Third, members working on the frontline were simply unavailable because of increased work demands during the pandemic or because of members' exposure the virus.

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

State law requires that local CCPT teams are composed of 11 members from specified agencies that work with children and child welfare. Additionally, state law requires that combined CCPT/CFPT teams are composed of 16 members from specified agencies that work with children and child welfare as well as family partners. The 2020 survey results, as well as those in prior years, show that mandated members varied in their level of participation. DSS staff, mental health professionals, and healthcare providers were most often present while the county boards of social services, county medical examiner, the district court judge and attorney, and the parent of a child fatality victim (for combined CCPT/CFPTs) were least often in attendance. Nevertheless, in most categories, the majority of mandated members were in attendance frequently or very frequently. Thus, for the most part, the local teams had representation from a wide range of disciplines, necessary for addressing complex child welfare issues, with some notable exceptions.

E. Additional Members

County commissioners may appoint additional members to their local CCPTs, including organization and/or Family and Youth Partners. Of the 84 responding CCPTs, 48 reported additional organizational members and 9 reported additional Family or Youth Partner members. These members came from mandated organizations and other public agencies and nonprofits or were community members or parents (e.g., foster/adoptive parent, parent of deceased child). Thus, the appointments of county commissioners enlarged the perspectives brought to bear in the CCPTs' deliberations.

F. CCPT Operations

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

G. Family or Youth Partners

The survey asked if the CCPT included Family or Youth Partners. These are individuals who have received services or care for someone who has received services. Family and Youth

Partners are not mandated CCPT members, but their inclusion is encouraged. An exception for a combined team is a parent of a deceased child as long as the parent fits the definition of a family or youth partner. This year, 12% of respondents indicated that family or youth partners served on their CCPT or combined CCPT/CFPT, an increase from last year. The vast majority of CCPTs lacked family representation, which limited their capacity to bring youth and family perspectives to the table. This could inhibit their contributions to instituting safety organized practice in a family-centered manner.

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

In response to new questions this year, 9 (82%) out of 11 respondents indicated that they had invited Family or Youth partners to attend CCPT meetings but only 3 (27%) had requested resources or assistance from DSS to assist in Family Partner involvement. Additionally, outreach through community networks and using CCPT team members to offer Family Partner perspectives were the most commonly endorsed strategies among the 9 respondents, with 4 (44%) respondents endorsing each. This indicated that, although many CCPTs were struggling to increase Family Partner involvement, there are clear avenues for targeting Family Partner outreach and engagement, which may include promoting their requesting assistance from DSS.

I. Factors Limiting the Participation of Family or Youth Partners

CCPTs detailed at length the reasons preventing the participation of family or youth partners on their teams. In addition to the significant barriers posed by COVID-19, some of these reasons stemmed from the situation of the partners: logistical, such as an unavailability of transportation, scheduling conflicts, and lack of reimbursement for participation. However, overwhelmingly CCPTs identified reasons related to the team rather than family or youth partners. These included uncertainties about how to recruit partners and how to maintain confidentiality. CCPTs asked for more guidance on bringing Family and Youth Partners onboard their teams. Thus, CCPTs identified the training and resources they would need for engaging families on their teams.

J. Partnerships to Meet Community Needs

The pandemic deepened community needs while raising hurdles to carrying out local initiatives. Some initiatives were “cancelled” or “cut short” because of COVID-19, and others were adapted to meet pandemic challenges such resorting to virtual meetings with families. Nevertheless, nearly half partnered with other organizations in these community efforts. This year’s initiatives overlapped with those from last year, demonstrating continuity in areas of concern such as safe sleeping practices and teen suicide prevention. Communities were resourceful in securing partnerships and funding to implement their initiatives. Their partners were wide ranging and included public agencies, nonprofit organizations, faith communities, and businesses. This year, racial equity assumed a more prominent profile among the initiatives and led to partnerships beyond “traditional team members.” The collaboratives ensured that their findings and recommendations were communicated widely in their counties.

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

Over the past year, 27 (33%) respondents said that they had received between 1 to 11 notifications of child maltreatment fatality cases, for a total of 67 notifications. The majority of these notifications came from the CCPT's local DSS. Additionally, 9 (11%) respondents said that they had received between 1 and 6 notifications of child maltreatment near fatalities, for a total of 19 notifications. When asked about their type of review, the teams identified different approaches. The most common type of review was an intensive state child fatality review conducted by NC DSS and a combined CCPT/CFPT review. Thus, the cases of child maltreatment fatalities had different types of reviews, some in the county and others at the state level. What the survey did not identify is the reasons why the large majority of counties had no notification of child maltreatment fatalities. In addition, the survey did not ask about how many cases had multiple reviews and the benefits and costs of the different types of reviews and of having more than one review. And, most importantly the survey did not inquire about the impact of the reviews. This information would be helpful in planning ways to improve child maltreatment reviews in the state.

Because past surveys found that the majority of CCPTs did not receive notifications of child maltreatment fatalities, the 2020 survey inquired about what would facilitate the process. In response, teams explained that they had protocols already in place, did not have child maltreatment fatalities during the year, or had no issues with receiving notifications. Although the percentage of teams receiving notifications was lower in 2020 than in 2019, none of the CCPTs indicated that the pandemic affected notifications of child maltreatment fatalities.

The 2020 survey also inquired about what would facilitate notifications of child maltreatment near fatalities. Some CCPTs stated they had no issues with their being notified of near fatalities from child maltreatment, and many saw their protocols for child fatalities as applicable to near fatalities. Others offered principles to guide these notifications, including good communication and clarifying the responsible agencies. Given the newness of the near fatalities policy, teams more often expressed some confusion about the process or made recommendations for improving the process. Some wanted more clarification of the definition of near fatalities or training on near fatalities.

L. Child Maltreatment Case Reviews

Child maltreatment cases encompass both active cases and child fatalities and near fatalities where child abuse, neglect, or dependency is suspected. The survey did not ask respondents to state how many cases were active cases versus child fatalities, a distinction to inquire about in future CCPT surveys. In 2020, 70 (85%) of the 82 responding CCPTs reviewed 399 cases. As would be expected, larger counties reviewed more cases than smaller ones. Additionally, 65 of the cases reviewed were child maltreatment fatalities and one case was as a near fatality. Thus,

most CCPTs who responded to the survey carried out their mandated role of reviewing cases. However, 12 CCPTs did not indicate that they reviewed any cases. The survey did not specifically inquire about the reasons why some counties had not reviewed cases and what would have helped them fulfil this role.

a. Criteria for Selecting Cases for Review

State statute requires that CCPTs review two types of cases: active cases and child maltreatment fatalities. Most (66%) respondents selected active cases for review. Child maltreatment fatality was given as a reason for case selection by 24% of respondents. Whether local teams review all child maltreatment fatalities depends on the context (ex. if the CFPT does the review). The second most frequent criteria for selecting cases was both multiple agency involvement, and repeat maltreatment, both identified by 60% of respondents.

The teams also selected cases on the basis of factors contributing to children needing protection: The two most common factors were caretaker's drug use cited by 55 (66%) CCPTs and alcohol use cited by 41 (49%) CCPTs. Selection of cases because of parental opioid use decreased from 63% of respondents in 2019 to 42% in 2020. Three other factors used by over 40% of CCPTs pertained to lack of child development knowledge, child/youth behavioral problems, and household domestic violence. The range of issues identified indicates the CCPTs' concern about many areas affecting the families' lives. Thus, the teams had a comprehensive awareness of the challenges affecting the children and families in their communities.

The local teams figured out ways to operate during a pandemic but missed their in-person meetings. Team meetings were an important occasion for networking, information sharing, team building, and identifying community needs. CCPTs outlined ways that they could improve their review process: These included recruiting family and community representatives, having more consistent participation and structured meetings, and enhancing access to case information. They also recommended ways that DHHS could strengthen the review process, by expediting notifications of fatality cases, clarifying policies, and providing technical assistance and tools.

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

Children, youth, and their parents or caregivers faced serious barriers to accessing needed services. Most CCPTs who reviewed cases in 2020 reported that children and youth needed access to mental health services. Most CCPTs also reviewed cases in which the parents or caregivers required access to mental health or domestic violence services. As noted previously, CCPTs commonly selected cases for review because of parental drug use, child safety, domestic violence, and child and family well-being (which includes mental health). These criteria would

tilt the findings on reviewed cases toward the need for MH, SU, and DV services. CCPTs indicating that there were waiting lists for these services also speaks to this need. Additionally, CCPTs identified systemic barriers to families' accessing essential services. The most commonly cited barriers were limited services or no available services, transportation to services, limited community knowledge about available services, and youth having a dual diagnosis of mental health and developmental disability issues. The CCPTs commented on some family factors affecting service receipt such as parents' readiness to participate in services and language barriers. It is quite likely that these identified family reasons reflected systemic barriers such as the complexity of the health care system and challenges in finding services without having health insurance. Thus, the teams were well aware of multiple issues keeping children and families from much needed services. As stated in previous reports, the federal funding from the Family First Prevention Services Act may be able to assist them in securing prevention services in their communities.

N. Local CCPT Recommendations for Improving Child Welfare Services

The teams made a total of 297 recommendations to improve child welfare services, of which 165 recommendations addressed issues at the local level and another 132 addressed issues at the state level. The local recommendations included more services and resources in addressing substance use and mental health issues, infant and maternal health, family violence, affordable housing shortages, and immigrant needs. For their local child welfare, they advised more staffing, clarifying policy changes, and offering training, on topics such as racial equity in child welfare. At the state level, they wanted reforms to improve families' access to a full range of behavioral health services and resolution of cross-jurisdictional issues impeding this access. They proposed strategies to improve child welfare services from enhancing working conditions of caseworkers to changing regulations on youth transitions in care to altering methods of assessing and supporting families. The pandemic weighed on the CCPTs, and they recognized that addressing its impact required state-level intervention to ensure uniform standards, a fair distribution of resources, and adequate funding. Teams welcomed participation of state representatives to clarify policies, train members on their role, expedite case reviews, provide resources for community outreach, and respond to the CCPTs' recommendations.

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

A total of 34 teams set local objectives in 2020, for a grand total of 90 objectives. The objectives that they set for local action paralleled those that they recommended for improving child welfare services in their communities. Their local objectives fell into three main categories: public education and training, developing stronger programs, and improving team functioning. When asked to assess their achievement of their objectives, their ratings showed that they tended to have more success in achieving specific objectives that did not require outside resources. The onset of the pandemic frequently disrupted plans for accomplishing objectives, with the result

that teams were often less than successful or needed to change course. Despite the roadblocks mounted by the pandemic, teams found ways to persevere and identified four principal facilitators within their local communities: drawing on the strengths of team members, partnering with other organizations, following through on plans, and advocating for county supports and funding.

They also recognized the necessity of state-level support for systemic changes. They asked NCDSS for assistance in four areas: CCPT technical assistance, training, and networking; data sharing and evaluation; resources and funding; and system-level advocacy. Additionally, 30 teams laid out their need for further supports, often in richly detailed and contextualized statements. Some stated that they mostly needed the pandemic to be over in order to resume their normal operations. Many of the responses reiterated previously identified needs such as state guidance and funding and networking opportunities with other CCPTs. Teams wanted more outreach from the state, clarification of state expectations for teams, and understanding of their particular situations.

II. 2020 Recommendations

As summarized by the U.S. Children's Bureau, CRPs under CAPTA are intended to examine "the policies, procedures and practices of State and local child protection agencies" and make "recommendations to improve the CPS system at the State and local levels." In fulfilling this mandate, the NC CCPT/Citizen Review Panel Advisory Board used the extensive information and ideas from the current and earlier CCPT surveys to formulate the recommendations listed below. The Advisory Board met in two subcommittee meetings and then a meeting of the whole board to prepare and finalize the recommendations. The CCPTs identified a range of means for supporting their work. The Advisory Board was very cognizant that supports for CCPTs were all the more necessary in sfy 2021 as localities grappled with the effects of the coronavirus pandemic. Hence, a recommendation specific to these needs is proposed below for strengthening the work of the CCPTs.

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

RECOMMENDATION 1 – DEVELOP A PLAN FOR A RACIALLY EQUITABLE APPROACH TO CHILD WELFARE IN NORTH CAROLINA

State fiscal year 2020 has been characterized by a heightened national attention to social justice and racial equity. Efforts are being made at the federal, state, and local levels to acknowledge and address racial disparities in child welfare policy and practice. Leadership has been provided by Black, Brown, Indigenous, Immigrant, and Impoverished peoples and communities. The recommendations put forth in this report should be considered through the lens of racial equity and actions should reflect efforts toward a racially equitable approach to child welfare.

Local

1. *In SFY 2022,*
    a. Encourage child welfare staff, CCPTs, and other interested community members to discuss their responses on the end-of-year survey in regards to racially equitable child welfare in their community.
2. *In SFY 2023,*
    a. Support child welfare staff, CCPTs, and other interested community members, including family and youth, to participate in forums to raise awareness of racial equity issues in service delivery.[1]
3. *In SFY 2024,*
    a. Involve child welfare staff, CCPTs, and other interested community members, including family and youth, in assessing their commitment to action on developing a racially equitable approach to child welfare.

State

A. *In SFY 2022,*
    a. Support the Advisory Board in discussing racial equity, resources, and processes.

[1] Example: System of Care (SOC) *Building an Equitable Results-Based Organization.*

b. Support panels to engage Advisory Board members in defining racial equity in child welfare.
c. Host a statewide virtual conference to review possible models for racial equity in child welfare.
d. Support Advisory Board in review of end-of-year survey results on items related to a racially equitable approach to child welfare.
e. Respond to Advisory Board's recommendations on process for engaging local CPPTs, child welfare, and their community and family partners in discussion of the results.

B. In SFY 2023,

a. Assess commitment of state and local child welfare, CCPTs, and other community partners, including family and youth, to develop a plan for instituting a racially equitable approach to child welfare in North Carolina.
b. With sufficient commitment, funding, and a coordinating organization(s),
    i. Engage state and local child welfare and their community partners in identifying how racial inequities affect service delivery in one policy area (ex. testing, reporting, Plan of Safe Care, and home removals); and
    ii. Analyze the potential impact of current developments in federal and state policy on racially equitable service delivery in this one policy area.

C. *In SFY 2024, with Advisory Board*

a. Review process and content learning from sfy's 2022 and 2023.
b. Develop next steps re: racially equitable child welfare in North Carolina.

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

Background: Federal CAPTA 2016 legislation[2] requires health care providers involved in the delivery and care of infants identified as meeting 'substance affected' criteria to notify Child Welfare of the occurrence. The 'substance affected' criteria were to be developed by each state for three different required areas. North Carolina developed these criteria and implemented the updated policy and practice in 2017.[3] All such identified infants, under this legislation, must have a Plan of Safe Care developed to support the safety and well-being of the infant and the infant's family, regardless of imminent safety concerns.

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

Local

[2] https://www.congress.gov/114/plaws/publ198/PLAW-114publ198.pdf
[3] https://www.ncdhhs.gov/infant-plan-safe-care/place-of-delivery#affected_by_substance_abuse

1. *In SFY 2022, request review and recommendations on child welfare's POSC policies and forms by the NC Child Welfare Family Advisory Council and family violence organizations.*
2. *In SFY 2023, dedicate a county role/position to the complex and multilevel needs of families who are substance involved.*
    a. Develop understanding and expertise on the CAPTA 2016 Plan of Safe Care legislation[4] and the required cross collaboration implementation in North Carolina.
    b. Prioritize collaboration and communication with local partners in working with shared families experiencing child welfare involvement and substance use disorders, with 42 CFR part 2 compliant releases of information in place.
    c. Consider outreach and collaboration with community prenatal care providers to provide education on the Infant Plan of Safe Care and consider developing the POSC prenatally for those identified in treatment.
    d. Seek and develop 'in-house' expertise and familiarity with common issues related to substance use disorders and child welfare involvement, including medication for opioid use disorders during pregnancy and postpartum. Provide consultation to staff on these cases.[5]
    e. Prioritize referral and connection to substance use disorder professional for comprehensive clinical substance use disorder assessment when a case has been screened in for investigation/assessment and the parent/caregiver is not currently in treatment.
    f. Identify, with the assistance of LME_MCO, key local substance use disorder treatment agencies with whom county agency can develop an MOU/MOA to include facilitating timely substance use disorder assessments and communication back to county child welfare agency. MOU/MOA can include required participation of SUD agency staff in CCPT.
    g. Develop regular communication channels with the delivering hospitals and free-standing birth centers, to support education of the Plan of Safe Care notification requirements, including differentiation between 'notification' and 'report of child abuse or neglect', and aggregate data feedback related to their notifications. Provide guidance to these healthcare staff on what information is ideally provided when making a notification based on infant meeting 'substance affected' criteria. Guidance on timing of the notification from healthcare provider to child welfare is also needed. Review 42cfr Part 2 and provide training to healthcare providers involved in delivery and care of infant, on confidentiality requirements. Notifications (no clear indication of risk to the child) require consent to share information about substance use disorder treatment per federal regulation (42cfr part 2).

[4] https://ncsacw.samhsa.gov/topics/plans-of-safe-care-learning-modules.aspx
[5] https://ncpoep.org/key-messages/infant-care-providers/

h. Request that local DSSs and CCPTs review all screened-out notifications of infants identified as 'substance affected'. CMARC and SUD treatment providers are essential partners in this review.

State

1. *In SFY 2022, dedicate a state DSS position, with back up, to the complex and multilevel needs of families who are substance involved and the agencies that work with them to prevent harm and to support treatment and recovery.* [6]
   a. Develop understanding and expertise on the CAPTA 2016 Plan of Safe Care legislation and the historic and required cross collaboration implementation in North Carolina.
   b. Prioritize collaboration and transparency with state partners in working with shared families experiencing child welfare involvement and substance use disorders.
   c. Support regional and local child welfare agencies to develop in-house understanding, expertise and familiarity with common issues related to substance use disorders and child welfare involvement, including medication for opioid use disorders during pregnancy and postpartum. Provide consultation to staff on these cases.
2. *In SFY 2023, utilize NCDHHS Subject Matter Experts in developing and revising policies and procedures that relate to infants and children identified as impacted by family/caregivers substance use, including Infant Plan of Safe Care.*
   a. Review existing information provided by perinatal substance use providers, and develop a guidance document and expand educational outreach to all providers and care managers.

RECOMMENDATION 3 – SUPPORT THE DEVELOPMENT OF A STRATEGIC PLAN TO IMPROVE CROSS SYSTEM PARTNERSHIPS BETWEEN SYSTEMS OF CARE (SOC) AND CCPTS.

There are currently 75 System of Care (SOC) collaboratives that cover a total of 91 counties. Required functions of these Collaboratives include strengthening the Community Collaborative through developing the nine characteristics of a well-functioning collaborative (including an emphasis on cross-system collaboration); influence the development of broad evidence-based SOC behavioral health service array and practices consistent with System of Care values and principles; and support behavioral health workforce capacity building through the co-development and support of child and family team training and local system of coaching and monitoring of child and family team implementation. The following recommendations are designed to strengthen cross system collaboration, communication, and functioning.

Local

1. *In SFY 2022, provide structured support to local CCPTs in establishing cross systems communication and planning to accomplish the following:*
   a. CCPTs request via the local Systems of Care Coordinators presentations on:

[6] https://ncsacw.samhsa.gov/topics/plans-of-safe-care-learning-modules.aspx

i. the LME/MCO revised role in the local Behavioral Health (BH) and Intellectual and Developmental Disability (I/DD) service system in sfy 2022 (given the beginning of Standard Plans on July 1, 2021,
ii. their anticipated conversions and mergers into Tailored Plans come July 1, 2022, and
iii. the requirement of all contracted BH and I/DD providers to address social determinants of health and how this happens locally (including the use of NC 360).

b. CCPTs to request that Standard Plans make presentations on the Standard Plan's role and responsibility in the local Behavioral Health and Intellectual and Developmental Disability service delivery system as of July 1, 2021.
c. CCPTs to review cases to ascertain whether families have CFTs by more than one agency (e.g., SOC, Child Welfare), and if so identify the impact on families.

2. *In SFY 2022, provide structured support to local CCPTs in maintaining cross systems communication and planning to accomplish the following:*
   a. Local CCPTs work with LME/MCOs and Standard Plans to establish communication channels and develop formal protocols for the exchange of information between the systems when reviewing cases.
   b. CCPTs to present their work (including the End of Year CCPT Recommendations) to the local SOC Community Collaboratives (and other local child interagency groups). Request assistance (particularly from the local SOC Collaboratives) in increasing knowledge of local public agency resources and community-based resources and improving access for DSS-involved children.
   c. CCPTs to work with SOC Collaboratives to develop a service delivery flowchart that identifies specific areas where barriers to service for DSS-involved children surface. Then create a plan for workgroups to be established to brainstorm solutions to ease or remove those barriers.

State

1. *In SFY 2022, prioritize cross system communication to review, revise, and develop requested materials to facilitate cross system operations at the local level.*
   a. Collaborate with DMH/DD/SA and the Division of Health Benefits (DHB) to develop guidance sheets for CCPTs to use in understanding Standard Plans and Tailored Plans.
   b. Work with DMH/DD/SA to identify key commonalities and disparities between CFT models used in the state and improve the training curricula for each model.
   c. Develop a joint DSS and DMH/DD/SA statement emphasizing the importance of cross-system communication and collaboration to streamline the CFT meeting burden for families.
   d. Collaborate with DMH/DD/SA to develop a cross-system training on confidentiality requirements and guidance materials on what Child Welfare workers can request from LME/MCOs and Standard Plans and from individual BH providers.

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

State fiscal year 2020 has been characterized by substantial operational barriers due to COVID-19. Despite these barriers, CCPTs have adapted to carry out their mandated work. With the understanding that the pandemic presented tangible challenges to operation, CCPTs would benefit from additional communication and support from the Division. These recommendations include requests for updates on the state's progress in responses to *SFY* 2019 recommendations as well as requests for future support.

1. *Provide a review and update of the Division's response to the Advisory Board's recommendations from SFY 2019. The summarized update is then to be distributed to local teams for their review. Specific items for review include:*
    a. Within the context of the implementation of the NC Practice Model, NC DHHS/DSS plan to train the state and local child welfare workforce on essential functions, core activities, and practices standard that advance the assessment of risk and the potential of future harm.
    b. National Council on Crime and Delinquency review of tools, data, and policies, their recommendations, and the Division's response to those recommendations.
    c. Progress on establishing the structure of NC CFP system and implications for enrolling in the national database of case specific child deaths.
    d. Results of collaboration with UNC-CH School of Medicine, Child Medical Evaluation Program, NC Pediatric Society Committee on Child Abuse and Neglect, and other organizations to develop diagnostic criteria for healthcare providers to identify near fatalities.
    e. Results of NC DHHS/DSS review of NC's Child Fatality Prevention System targeting improving data collection systems, conducting Intensive Child Fatality Reviews, and expanding the Child Medical Evaluation Program.
    f. The funding of positions under the CME program located at UNC Chapel Hill School of Medicine in *SFY* 2021.
    g. The development of the T/TA Request Form.
    h. The efforts to redesign CRP and child fatality systems and associated implications for funding of CCPTs as recommended in *SFY* 2019.
    i. Request for staffing and/or consultants with the requisite expertise in policy, research, and community outreach for the CRP as recommended in *SFY* 2019.
2. *In SFY 2021, prioritize the development of a standard operating procedure (SOP) for CCPTs in anticipation of continued COVID-19 restrictions and normalization of telecommunication.*
    a. This SOP should include but is not limited to guidance on approved telecommunication platforms, policies on data sharing, policies and procedure on sharing of confidential information (e.g., medical, mental and behavioral health records), and meeting requirements.
    b. This SOP should consider the policies and procedures of partnering organizations and service providers.
    c. The SOP should be developed in collaboration with CCPT and other relevant organizations to facilitate point (b).

3. *In SFY 2022, dedicate a DSS position to the operational support of CCPTs. Historically, this position has proved exceedingly beneficial to facilitating optimal functioning of the teams and would play a critical role in enabling the implementation of the recommendations outlined in this report.*
4. *Beginning in SFY 2022, provide funding to local teams.*
    a. Allocate annual funding of $1,000 per team for operational and project support.
    b. Assist teams with understanding requirements on documenting the expenditure of the funds and assessing their local impact; and
    c. Ensure that the results of the funds are summarized, and a report provided to funding sources and the Advisory Board.
5. *Beginning in SFY 2022, ensure local teams receive supports that they request.*
    a. Ensure requested supports such as notification of grant opportunities, informational and material support for local planning efforts (ex., brochure on safe sleeping), and interceding with other state players (ex., courts); and
    b. Document these efforts, and report on them to the Advisory Board.
6. *Beginning in SFY 2022, foster exchanges of CCPTs from different locales.*
    a. Offer cross-county summits and other forums through online means to encourage robust exchanges and creative ideas for child welfare improvements.
    b. Identify topics for these exchanges with local teams and the Advisory Board.
    c. Capitalize on these forums to offer trainings and/or provide relevant updates and information.
7. *In SFY 2022, continue to explore changing the data-collection protocols to permit the researchers to share survey results with individual teams identified:*
    a. Review steps for moving from having de-identified data in reports to identifying the results by individual teams and providing the identifiable data to the NC CCPT/CRP Advisory Board, the Board's subcommittees (ex., CRPs), and NC DSS.
    b. Consult the Children's Committee of the NC Association of County Directors of Social Services (NCACDSS) and other pertinent bodies on these changes in survey procedure.
    c. Clarify changes to the contract with North Carolina State's Center for Family and Community Engagement that would allow for the identified data to be analyzed and reported on.
    d. Support using identified data to offer local CCPTs education and mutual support.

For previous year's NC DSS response to the Advisory Board's recommendations for improving child welfare services, go to this link. https://www.ncdhhs.gov/divisions/social-services/child-welfare-services/community-child-protection-teams

Table of Contents

North Carolina Community Child Protection Teams (CCPT)
2020 End-of-Year Report

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

I. Introduction

A Challenging Year

Year 2020 was such a difficult year for children, families, and their communities. During this time, support was essential as the global coronavirus pandemic gained momentum and gravely affected health, education, employment, recreation, social and faith gatherings, and so many other vital aspects of our civil society. The impact was disproportionately felt by people of color, Indigenous, immigrant, and those living in congregate settings or in rural and other areas with fewer medical, economic, and technological resources (CDC, 2021).

The severity of COVID-19 was exacerbated by opioid overdoses, generating a syndemic of two deadly crises. Public health protocols were crucial to protecting life and wellbeing and compelled reimagining how to deliver public services. Under social distancing requirements, the federal government pushed distance forms of opioid-use treatment such as telemedicine and take-home medications, leading to innovations at a far more rapid pace than normal (Becker et al., 2021).

Among those affected were Community Child Protection Teams (CCPTs), dedicated to helping Departments of Social Services improve their programs and engaging with local communities to raise awareness of children and their families' needs. The burden was also felt at the state level as public agencies sought to contain the fallout from the pandemic.

This report documents what we learned from the 2020 CCPT survey about the challenges faced in local communities and the strategies for meeting them. As the North Carolina Community Child Protection Team /Citizen Review Panel Advisory Board (NC CCPT/CRP Advisory Board), we wish to commend the 84 CCPTs who completed the survey, despite operating under the duress of a major public health crisis. These teams took the time to reflect on their work and envision ways to move forward in the new year.

The local CCPT experiences and perspectives inform the recommendations that the Advisory Board is proposing to the NC Department of Health and Human Services (DHHS) for strengthening child welfare. These recommendations, presented in this report, are sent to NC DHHS for response and action and are included in the state's plan to the US Administration for Children and Families.

The robustness of the recommendations is enhanced by the NC CCPT/CRP Advisory Board progress on orienting new members, widening its representation in programmatic areas,

involving Family and Youth Partners, and keeping abreast of developments at the local and state levels affecting children and their families. Each year, the Advisory Board reviews and revises the CCPT survey and, for 2020, added questions on the impact of COVID-19. The Advisory Board is also giving consideration to redesigning CCPT surveys so as to offer a better route for DHHS to respond directly to individual teams on the concerns and opportunities that they identify.

In 2020, The Advisory Board gathered information on two key policy areas: infants who are substance affected and their Plans of Safe Care (POSC) and near fatalities of children who have been maltreated. The work on these two policy areas helps to move North Carolina toward the formation of Citizen Review Panels (CRPs) that can offer an independent perspective on challenging issues affecting public child welfare across the state.

Focus Areas for Citizen Review Panels (CRPs)

In 2019. The Advisory Board identified focus areas for two CRPs: (1). Plan of Safe Care (POSC) for infants who are substance affected and their families and (2) near fatalities in situations of child maltreatment. These two topic areas were particularly timely in 2020. POSC was one way to respond to the syndemic of coronavirus and opioid use. Identifying near fatalities was a new area for workers and CCPTs, who needed more clarification on policies.

Establishment of the panels will assist the state in more fully implementing CRP requirements of the federal Child Abuse Prevention and Treatment Act (CAPTA). In undertaking this work, the CRPs will need the state to provide access to data and information on specific cases. The panels will draw upon the experience and insights of local CCPTs.

1) Infant Plan of Safe Care

CAPTA, as amended by the Comprehensive Addiction and Recovery Act (CARA) of 2016, stipulates that states provide services to infants who are substance affected and their parents/caregivers and other family members. Specifically, the Act requires:

> The development of a plan of safe care for the infant born and identified as being affected by . . . substance abuse[7] or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder . . . to ensure the safety and well-being of such infant following release from the care of healthcare providers, including through –
>
> (I) addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver; and

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

> (II) the development and implementation by the State of monitoring systems regarding the implementation of such plans to determine whether and in what manner local entities are providing, in accordance with State requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver. (US DHHS, ACF, 2017, p. 2).

The intent of the Act is to be supportive rather than punitive and to address exposure to both illegal and legal substances. The development of a plan of safe care is required whether the circumstances constitute child maltreatment or not under state law. Therefore, healthcare providers and/or child welfare are required to refer the family for services through the infant plan of safe care.

2) Near Fatalities

In addition to child fatalities, CAPTA Section 106 refers to “near fatalities” and requires states to provide public disclosures about cases where child maltreatment resulted in child fatalities or near fatalities. CAPTA defines a near fatality as "an act that, as certified by a physician, places the child in serious or critical condition." An example of a near fatality, provided by the US Children Bureau, is “if hospital records reflect that the child's condition is ‘serious’ or ‘critical’.” Comprehensive planning to prevent child fatalities requires systems sharing data that are of high quality and consistency (Commission to Eliminate Child Abuse and Neglect Fatalities, 2016). We turn now to the 2020 end-of-year survey, its findings, and recommendations to improve child welfare.

II. NC CCPT Advisory Board Survey Results

A. Respondent Characteristics

The university distributed the survey to 100 county CCPTs as well as the Eastern Band of the Cherokee Indians, for a possible 101 CCPTs. The survey was completed by 84 CCPTs, although response numbers may vary for certain survey items. A list of the counties of the 2020 responding CCPTs can be found in appended Table A-2.

The 2020 response rate of 84 CCPTs was in the higher range as compared with previous years (2012 to 2019) that ranged from 71 to 89. The local teams came from all regions of the state and included counties of all population sizes. The response rates were 43 (80%) of the 54 small counties, 30 (86%) of the 35 medium counties, and 11 (100%) of the 11 large counties (see appended Table A-3).

In the state of North Carolina, Local Management Entity (LME)/Managed Care Organizations (MCOs) are the agencies responsible for providing mental health, developmental disabilities, and substance use services. In 2020, there were seven LME/MCOs for the 100 counties. The survey included members from all LME/MCOs: Member county participation ranged from 75% to 100% (see Table A-4).

As seen in Table 1, the large majority (84%) of respondents characterized themselves as an "established team that meets regularly." The others stated that they had recently reorganized and were at various stages in terms of meeting. The CCPTs that did not characterize themselves as an established team that meets regularly included small through large counties.

Number of CCPTs by Status of Establishment as a Team, 2020 (N = 83)

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

Status	Number of CCPTs	
We are an established team that meets regularly	70	(84.3%)
Our team recently reorganized, and we are having regular meetings	5	(6%)
Our team recently reorganized, but we have not had any regular meetings.	2	(2.4%)
Our team was not operating, but we recently reorganized	1	(1.2%)
We are an established team that does not meet regularly	5	(6%)
Our team is not operating at all	0	(0%)

CCPTs have the option of combining with their local CFPT or keeping the two teams separate. CFPTs are responsible for reviewing cases of child death where maltreatment is not suspected. CCPTs review active cases and child fatalities where death was caused by abuse, neglect, or dependency and where the family had received NC DSS child welfare services within 12 months of the child's death. At the time of the survey, 66 (80%) of the 83 responding counties opted to have combined teams, and 16 (19%) had separate teams; one county indicated "Other" to

describe their team composition. The percentage of combined teams in prior years was 72% in 2015, 76% in 2016, 78% in 2017, 82% in 2018, and 78% in 2019.

In summary, 83% of the local teams responded to the survey in 2020, a percentage that is in the higher range for responses since 2012. The participating CCPTs encompassed all state regions, county population sizes, and the seven LME/MCOs that provide MH/DD/SU services. More than four-fifths of the responding CCPTs stated that they were "an established team that meets regularly," while the others were in different stages of reorganizing. Among the responding teams, 80% were combined with their local CFPT. Overall, CCPTs were sufficiently established to make significant contributions to child welfare. The trend toward combining CCPTs and CFPTs can contribute to state planning on consolidating child maltreatment fatalities.

B. Survey Completers

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

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

The survey asked, "Who completed this survey?" As shown in Table 2, the surveys were primarily completed by the chair on their own (55%), by the team as a whole (18%), or by a team subgroup (6%). The response "other" was selected by more than one team member. The teams were split on whether one individual (67% chair or designee) or larger groupings (24% whole team or smaller group) developed the responses. The time period available for completing the survey was extended to four months in acknowledgment of barriers to meeting face to face by CCPTs due to COVID-19.

Number of CCPTs by Who Completed the 2020 Survey (N = 84)

Table 2 Number of CCPTs by Who Completed the Survey

Status	Number of CCPTs	
The CCPT chair on their own	46	(54.8%)
The CCPT team as a whole	15	(17.9%)
A designee of the CCPT chair on their own	10	(11.9%)
A subgroup of the CCPT team	5	(6%)
Other	8	(9.5%)

In summary, the survey encouraged CCPT chairs to seek input from team members on their responses. The ability of teams to convene to develop their responses was likely limited by the survey being open during holiday months, although a lengthy extension was given to those who had not submitted a completed survey by the January 15th, 2020 deadline. Moreover, the pandemic prevented in-person meetings.

C. Main Survey Questions

The 2020 survey inquired about the following seven main questions:

1. What difficulties does the pandemic pose to team operations?
2. Who takes part in the local CCPTs, and what supports or prevents participation?
3. Which cases do local CCPTs review, and how can the review process be improved?
4. What limits access to needed mental health, developmental disabilities, substance use, and domestic violence services, and what can be done to improve child welfare services?
5. What do the teams recommend to improve child welfare services?
6. What are local CCPTs' objectives based on identified improvement needs, to what extent do they achieve these objectives, and what supports do they need to achieve their objectives?
7. What further support would help teams put their recommendations into action?

This section summarizes the findings for each of these seven questions. All quotations in this report have been corrected for spelling and grammatical errors. Where available, findings from the 2017, 2018, and 2019 surveys are compared with the 2020 findings to ascertain trends.

D. Pandemic and Team Operations

The survey asked CCPTs, "Has the pandemic affected your team's operation?" (See Appendix C). Most of the 84 teams, 71 (85%) acknowledged that the pandemic affected their operations, leaving a minority (13, 15%) responding that the pandemic did not have an impact. Overall, the survey responses did not appear to be affected by county size or by team status as a combined or separate CCPT and Child Fatality Prevention Teams (CFPT). However, responses were affected by the extent to which the team was established operationally.

As seen in Table 3, the 15 teams that did not experience an impact on their team operations, all characterized themselves as "an established team that meets regularly." Most CCPTs (55, 81%) that experienced some impact on their team functioning likewise were established teams meeting on a regular basis. The majority of the remaining teams had recently reorganized (8).

Effects of the Pandemic by CCPT Operational Status

Table 3 Effects of the Pandemic by CCPT Operational Status (N=83)

	Has the pandemic affected your team's operation?	
CCPT Operational Status	No	Yes
We are an established team that meets regularly	15 (100%)	55 (80.9%)
Our team recently reorganized, and we are having regular meetings	0 (0%)	5 (7.4%)
Our team recently reorganized, but we have not had any regular meetings.	0 (0%)	2 (2.9%)
Our team was not operating, but we recently reorganized	0 (0%)	1 (1.5%)
We are an established team that does not meet regularly	0 (0%)	5 (7.4%)

Note: One team did not indicate their status. Percentages out of total that indicated a specific response (i.e., 55, 80% of those who said "yes").

The second item related to COVID-19 asked, "What difficulties has your CCPT faced while trying to meet and complete your work?" This question sparked a lot of comment. All but five teams explained why the pandemic did or did not affect their operations. These five teams, not surprisingly, were all among those whose operations were not affected.

The other 10 teams without an impact explained that they switched to virtual meetings, followed a "HIPAA compliant Zoom for Healthcare," or managed to have all necessary members participating. A few in this group recognized that the pandemic kept them from meeting. For instance, one team stated that they "missed one monthly meeting early in pandemic, then adjusted to virtual meetings with no issue." Another team indicated that they held only one meeting in 2020 because of the pandemic.

The 69 CCPTs for whom the pandemic impeded their team operations faced three main challenges. These were meeting at a distance, maintaining member engagement, and dealing with the pandemic.

Meeting at a Distance. Teams cancelled in-person meetings especially at the outset of the pandemic, with some reconvening face to face during the fall. A barrier, though, to in-person meetings was the lack of space adequate for social distancing. Virtual formats made it possible to hold meetings but also posed technical challenges. Some members lacked access to technology, were unfamiliar with this medium, or were forced offline because of a cyber-attack. Teams were at first unsure whether they were allowed to meet virtually and if so, what platforms would be HIPAA compliant. For instance, a team experienced "initial confusion/different guidance from DHHS-DSS and DHHS-DPH about allowable formats in which to meet virtually." The online format made it difficult to share confidential records, and teams resorted to methods such as hand delivery of records.

Maintaining Member Engagement. Teams were uneasy collaborating via the internet and observed that "there seems to be less interaction among the team with the virtual meetings [and]

there has been consistent technical difficulties." Writing at length, a CCPT described members as "more hesitant to speak for fear of talking over someone else" and the format also made it harder for "members to effectively network and build strong professional relationships with their community partners." The subject matter in itself heightened the discomfort. A CCPT noted, "As a team, we have felt it is difficult to fully discuss death info among team members virtually." Another found it hard to hold "discussions regarding cases and in general [discussions were] a little more difficult virtually but improving." A combined CCPT/CFPT team "suspended meetings during the pandemic due to confidentiality concerns." Moreover, the closing of offices and staff working from home prevented accessing needed records for case reviews. The virus also limited the teams' capacity to carry out other responsibilities such as "prevention activities" and "community awareness events."

There seems to be less interaction among the team with the virtual meetings [and] there has been consistent technical difficulties.

Dealing with the Pandemic. Some team members were unable to take part during the pandemic. One CCPT explained, "There have been issues with members being available due to demands of their jobs due to COVID since most members are essential staff." For instance, a team noted, "The Chair is the Medical Director for our local health department and has been unable to lead the meeting for the last 2 months due to COVID vaccination rollout." Some members were unavailable because they were "quarantined or in isolation due to COVID."

In summary, the pandemic affected the operations of most CCPT teams. The pandemic presented three main challenges. First, they had to resort to online means of meeting. Not all members had access to the necessary technology, and teams were uncertain about how to meet virtually while safeguarding confidential case information. Second, teams were uncomfortable holding discussions without the usual face-to-face contact and networking. They especially were uneasy about discussing deaths online and had difficulty accessing and sharing records necessary for case reviews. They were also limited in carrying out community prevention activities. Third, members working on the frontline were simply unavailable because of increased work demands during the pandemic or because of members coming into contact with the virus.

1) Mandated Members

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

State law requires that local teams are composed of 11 members from agencies that work with children and child welfare. Table 4 identifies these mandated members for combined CCPTs and CFPTs. Table 5 identifies these mandated members for separate CCPTs and their levels of participation on the team during 2020. The survey results indicate that mandated members varied in their level of participation in both groups; however, patterns of participation were fairly consistent between the two groups. The two team members most likely to be very frequently in attendance for CCPT/CFPTs were the DSS staff followed closely by health care providers and mental health professionals. The same patterns of results were found among separate CCPTs in which DSS staff, followed closely by the mental health professionals and the health care providers, were reported to be in attendance *very frequently*. On average, health care providers, public health directors, guardian ad litems, and DSS directors were frequently present across

both groups. What needs to be kept in mind is that although participation rates varied across the mandated members, some mandated members in all categories participated frequently or very frequently. For instance, within the separate CCPT group, the School Superintendent had the lowest average participation level but still had (13%) taking part frequently and another 7% taking part very frequently. For CCPT/CFPTs, participation levels were much more variable across members. Most notably, the district court judge and the parent of child fatality victim had the lowest participation rates. Over half of district court judges (71%) and parents of child fatality victims (61%) never participated.

Mandated Members for Combined CCPT/CFPT and Reported Frequency of Participation, 2020 (N=62)

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

Mandated Member	Never	Rarely	Occasionally	Frequently	Very Frequently	Mean
DSS Director	5 (8.1%)	4 (6.5%)	7 (11.3%)	10 (16.1%)	36 (58.1%)	3.10
DSS Staff	3 (4.8%)	1 (1.6%)	0 (0%)	3 (4.8%)	55 (88.7%)	3.71
Law Enforcement	6 (9.7%)	5 (8.1%)	6 (9.7%)	17 (27.4%)	28 (45.2%)	2.90
District Attorney	16 (25.8%)	11 (17.7%)	10 (16.1%)	10 (16.1%)	15 (24.2%)	1.95
Community Action Agency Director or Designee	10 (16.1%)	6 9.7%)	11 (17.7%)	12 (19.4%)	23 (37.1%)	2.52
School Superintendent	12 (19.4%)	2 (3.2%)	12 (19.4%)	15 (24.2%)	21 (33.9%)	2.50
County Board of Social Services	20 (32.3%)	3 (4.8%)	10 (16.1%)	9 (14.5%)	20 (32.3%)	2.10
Mental Health Professional	5 (8.1%)	2 (3.2%)	4 (6.5%)	12 (19.4%)	39 (62.9%)	3.26
Guardian ad Litem Coordinator or Designee	9 (14.5%)	5 (8.1%)	2 (3.2%)	10 (16.1%)	36 (58.1%)	2.95
Public Health Director	10 (16.1%)	3 (4.8%)	4 (6.5%)	9 (14.5%)	36 (58.1%)	2.94
Health Care Provider	6 (9.7%)	3 (4.8%)	6 (9.7%)	8 (12.9%)	39 (62.9%)	3.15
District Court Judge	44 (71%)	4 (6.5%)	5 (8.1%)	5 (8.1%)	4 (6.5%)	.73

County Medical Examiner	30 (48.4%)	10 (16.1%)	3 (4.8%)	6 (9.7%)	13 (21%)	1.39
EMS Representative	14 (22.6%)	8 (12.9%)	11 (17.7%)	10 (16.1%)	19 (30.6%)	2.19
Local Child Care Facility	21 (33.9%)	6 (9.7%)	11 (17.7%)	12 (19.4%)	12 (19.4%)	1.81
Parent of Child Fatality Victim	38 (61.3%)	5 (8.1%)	4 (6.5%)	6 (9.7%)	9 (14.5%)	1.08

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

Mandated Members of Separate CCPT and Reported Frequency of Participation, 2020 (N=15)

Table 5 Mandated CCPT Members and Reported Frequency of Participation

Mandated Member	Never	Rarely	Occasionally	Frequently	Very Frequently	Mean
DSS Director	2 (13.3%)	2 (13.3%)	1 (6.7%)	4 (26.7%)	6 (40%)	2.67
DSS Staff	0 (0%)	0 (0%)	1 (6.7%)	3 (20%)	11 (73.3%)	3.67
Law Enforcement	1 (6.7%)	3 (20%)	3 (20%)	3 (20%)	5 (33.3%)	2.53
District Attorney	6 (40%)	3 (20%)	2 (13.3%)	0 (0%)	4 (26.7%)	1.53
Community Action Agency Director or Designee	5 (33.3%)	1 (6.7%)	0 (0%)	4 (26.7%)	5 (33.3%)	2.20
School Superintendent	7 (46.7%)	3 (20%)	2 (13.3%)	2 (13.3%)	1 (6.7%)	1.13
County Board of Social Services	4 (26.7%)	2 (13.3%)	1 (6.7%)	5 (33.3%)	3 (20%)	2.07
Mental Health Professional	1 (6.7%)	0 (0%)	2 (13.3%)	4 (26.7%)	8 (53.3%)	3.20
Guardian ad Litem Coordinator or Designee	2 (13.3%)	0 (0%)	3 (20%)	3 (20%)	7 (46.7%)	2.87
Public Health Director	5 (33.3%)	0 (0%)	3 (20%)	2 (13.3%)	5 (33.3%)	2.13
Health Care Provider	1	2	0	3	9	3.13

	(6.7%)	(13.3%)	(0%)	(20%)	(60%)

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

b. Mandated Member Participation by Mean Rate and Rank

In the 2020 survey, participation of mandated members was tracked for both CCPTs and CCPT/CFPTs. Table 6 shows that for all three years the ranked participation rates of the mandated members were almost identical. At the top in rank over the three years were DSS staff and mental health professionals and health care providers. For CCPTs, the lower participation ranks for this year included the school superintendent, district attorney, and county board of social services which is similar to last year's trend. District court judges, parent of child fatality victims, and county medical examiners were ranked lowest for participation among combined CCPT/CFPTs, continuing patterns from previous years.

Mandated Separate CCPT and Combined CCPT/CFPT Members and Mean Rate and Rank of Participation 2018, 2019, and 2020

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

Mandated Member	2018 CCPT (*N*=13) Average (Rank)	2018 CCPT/CFPT (*N*=73) Average (Rank)	2019 CCPT (*N*=13) Average (Rank)	2019 CCPT/CFPT (*N*=73) Average (Rank)	2020 CCPT (*N*=15) Average (Rank)	2020 CCPT/CFPT (*N*=62) Average (Rank)
DSS Director	3.69 (7)	3.25 (4)	3.88 (4)	3.16 (4)	2.67 (5)	3.10 (4)
DSS Staff	4.54 (1)	3.88 (1)	4.94 (1)	3.90 (1)	3.67 (1)	3.71 (1)
Law Enforcement	3.85 (6)	2.77 (7)	3.53 (7)	2.91 (7)	2.53 (6)	2.90 (7)
District Attorney	2.92 (10)	1.70 (13)	3.24 (9)	1.88 (13)	1.53 (10)	1.95 (12)
Community Action Agency	3.46 (9)	2.66 (8)	3.24 (10)	2.68 (8)	2.20 (7)	2.52 (8)
School Superintendent	3.54 (8)	2.36 (9)	3.41 (8)	2.24 (10)	1.13 (11.	2.50 (9)
County Board of Social Services	2.85 (11)	2.24 (11)	2.44 (11)	2.20 (12)	2.07 (9)	2.10 (11)
Mental Health Professional	4.46 (2)	3.30 (3)	4.59 (2)	3.44 (2)	3.20 (2)	3.26 (2)
Guardian ad Litem	3.92 (4)	3.03 (6)	3.94 (3)	3.07 (5)	2.87 (4)	2.95 (5)

Public Health Director	3.92 (3)	3.17 (5)	3.65 (6)	3.07 (6)	2.13 (8)	2.94 (6)
Health Care Provider	3.85 (5)	3.37 (2)	3.65 (5)	3.41 (3)	3.13 (3)	3.15 (3)
District Court Judge		.92 (16)		.94 (16)		.73 (16)
County Medical Examiner		1.47 (14)		1.28 (14)		1.39 (14)
EMS Representative		2.21 (12)		2.26 (9)		2.19 (10)
Local Child Care or Head Start Rep		2.29 (10)		2.21 (11)		1.81 (13)
Parent of Child Fatality Victim		1.06 (15)		1.09 (15)		1.08 (15)

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

In summary, state law requires that local CCPT teams are composed of 11 members from specified agencies that work with children and child welfare. Additionally, state law requires that combined CCPT/CFPT teams are composed of 16 members from specified agencies that work with children and child welfare as well as family partners. The 2020 survey results, as well as those in prior years, show that mandated members varied in their level of participation. DSS staff, mental health professionals, and healthcare providers were the most often present while the county boards of social services, county medical examiner, the district court judge and attorney, and the parent of a child fatality victim (for combined CCPT/CFPTs) were least often in attendance. Nevertheless, the majority of mandated members in most categories were in attendance frequently or very frequently. Thus, for the most part, the local teams had representation from a wide range of disciplines, necessary for addressing complex child welfare issues, with some notable exceptions.

E. Additional Members

Besides the state required members, the county commissioners can appoint additional members from the mandated agencies and from other community groups. Among the 84 survey responses, 48 CCPTs reported between 1 and 35 additional organizational members and 9 CCPTs reported between 1 and 2 additional Family or Youth Partner members. The survey provided space for the respondents to "list the organization/unit that additional members represent." Respondents indicated that the additional partners came from mandated organizations such as social services, mental health, law enforcement, public health, schools, and guardian ad litem. Other appointed members were based in public agencies such as courts, juvenile justice, and child developmental

services. Still others were from nonprofits, including domestic violence, substance use, parenting education, children's advocacy, and the community at large.

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

F. CCPT Operations

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

1) CCPT Meetings

The CCPTs were asked how well they prepare for meetings as a whole. The question on the survey read: "How well does your CCPT prepare for meetings?" Among the 84 respondents, 35 (42%) indicated that they prepare very well for meetings, and 32 (39%) prepare well. Of those that recently reorganized and met regularly, 60% and 20% prepared "well" or "very well" for meetings, respectively, none of the teams indicated that they did not prepare for meetings well. CCPT teams were asked how well they share information during meetings. Forty-nine (60%) of the respondents, indicated that they share information very well. Twenty-nine (35%) said that their team shares information well. When asked how well the team shared other resources 47 (58%) denoted very well, while 26 (32%) noted that they share other resources well. Sixty-three respondents listed at least one shared other resource, 42 listed a second shared resource, and 28 listed a third. CCPT teams identified key resources shared including community resources and events, educational resources, grant opportunities, meeting space, programs, and mental health resources.

2) Community Change

The CCPT teams were asked how well their team has effected changes in their community. Eleven (13%) of respondents indicated very well, 19 (23%) indicated well, 28 (34%) indicated moderately, 17 (21%) indicated marginally, and 8 (10%) indicated not at all with respect to how well their CCPT has effected changes in their community.

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

G. Family or Youth Partners

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

1) Family or Youth Partner Participation Rates

In response to the question on whether they had family or youth partners serving on their team, 10 (12%) out of 82 respondents said yes and 72 (87%) said no with one team not responding. The percentage of family or youth partner involvement is up from 2019 where 6 (7%) out of 89 respondents said yes and 79 (89%) said no. Family and Youth Partners engagement has been significantly lower in the last two years than in previous years, 2015 (21%, 19 out of 87), 2016 (22%, 19 out of 86), 2017 (29%, 23 out of 79), and 2018 (24%, 21 out of 88). This may be a function of more clearly defining Family and Youth Partners. Maintaining the structure from 2017, 2018, and 2019, the 2020 survey inquired about the six different categories of family or youth partners serving on the CCPTs (see Table 6 for the categories). The teams who said they had a family or youth partner this year could identify if they had more than one partner on their team. Table 6 shows rates of family or youth partners' participation. The most commonly represented category was biological parent which formed over two thirds (5, over 42%) of the family or youth partners. The other five categories' rate of participation ranged from occasionally to very frequently.

Family or Youth Partners by Category and Reported Frequency of Participation, 2020

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

Category	Never	Rarely	Occasionally	Frequently	Very Frequently	Total Participation of Partners
Youth Partner	9	0	0	0	1	1
Biological Parent	6	0	1	1	3	5
Kinship Caregiver	9	0	0	2	0	2
Guardian	8	0	0	0	1	1
Foster Parent	9	0	1	0	0	1
Adoptive Parent	8	0	1	1	0	2
Total	**49**	**0**	**3**	**4**	**5**	**12**

In summary, the survey asked if the CCPT included family or youth partners. These are individuals who have received services or care for someone who has received services. This year, 12% of respondents indicated that family or youth partners served on their CCPT or combined CCPT/CFPT, an increase from last year. The large majority of CCPTs lacked family

representation, which limited their capacity to bring youth and family perspectives to the table. This could inhibit their contributions to instituting the state's selected model of safety organized practice in a family-centered manner.

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

The survey then asked the respondents if "Family or Youth Partners were invited to attend CCPT meetings" and if they had "requested resources or assistance from DSS to assist in Family Partner involvement." Of the 11 respondents, 9 (82%) indicated that they had invited Family or Youth partners to attend CCPT meetings but only 3 (27%) had requested resources or assistance from DSS to assist in Family Partner involvement.

In previous years, CCPTs have been asked to provide a list of strategies to promote Family Partner engagement. In this year's survey, the research team identified common factors from past years and developed a checklist for response. The findings reveal that CCPTs had very few strategies that they leveraged to promote Family Partner engagement. Outreach through community networks and using CCPT team members to offer Family Partner perspectives were the most commonly endorsed among the 9 respondents, with 4 (44%) respondents endorsing each. Overall, this strategy appears to have resulted in a lack of robust data, indicating that trends in strategies to Family Partner participation may fluctuate significantly from year to year.

Strategies for Engaging Family or Youth Partners, 2020 (N=9)

Table 8 Strategies for Engaging Family or Youth Partners

Strategies for Engagement	Frequency (Percent)
Outreach through community networks to identify Family and Youth Partners	4 (44%)
Repeatedly extending invitations by multiple means (e.g., phone, email) to possible Family and Youth Partners	2 (22%)
Having a senior agency representative extend the invitation	1 (11%)
Putting CCPT membership into Family and Youth Partner's job description	1 (11%)
Explaining purpose of CCPTs in jargon-free and inviting language	3 (33%)
Describing the role of the Family and Youth Partners on the team	1 (11%)
Emphasizing the value that Family and Youth Partners bring to the team	3 (33%)
Providing information on opportunities available to participants (e.g., training)	0 (0%)
Rescheduling meeting times to accommodate Family and Youth Partners	1 (11%)
Preparing Family and Youth Partners for the meetings	2 (22%)
Drawing Family and Youth Partners into the meeting discussions	3 (33%)
Ensuring that discussions are in clear and understandable language for all participants	2 (22%)
Debriefing with Family and Youth Partners after meetings	2 (22%)
Using team members already on the CCPT to offer family perspectives	4 (44%)
Other	1 (11%)

In summary, these results indicated that, although many CCPTs were struggling to increase Family Partner involvement, there are clear avenues for promoting Family Partner outreach and engagement. These may include promoting requests for assistance from DSS and working with CCPT Technical Assistance to develop targeted strategies for recruitment and outreach.

I. Factors Limiting the Participation of Family or Youth Partners

In previous years, CCPTs have been asked to provide a list of factors they believe limit Family Partner engagement. In this year's survey, the research team identified common factors from past years and developed checklists for response. Although the respondents utilized the checklist for responding, the majority selected other, and entered a unique factor which limited Family Partner

participation in their CCPT. Among these qualitative responses common themes such as COVID-19 barriers, difficulty recruiting, problems identifying participants, confidentiality and statutory prohibition issues were reported by respondents.

Factors Preventing Family Partners from Participating, 2020 (N=79)

Table 9 Factors Preventing Family Partners from Participating

Preventative Factors	Frequency (Percent)
Lack of transportation	4 (5%)
Lack of childcare	0 (0%)
Lack of reimbursement for time	2 (3%)
Scheduling conflicts	1 (1%)
Other commitments (e.g., school, work)	14 (18%)
Uncertainty about role	20 (25%)
Other	38 (48%)

When asked "which of the following reasons prevented your CCPT from engaging some family or youth on your team?", 80 CCPTs responded to the checklist. Difficulty recruiting or identifying Family and Youth Partners was the most frequently cited barrier to Family Partner engagement. This is consistent with CCPTs limited reporting of strategies to engage Family Partners. Additionally, 15 respondents identified a unique factor preventing CCPTs from engaging Family Partners. These included COVID-19 as a barrier, case status preventing Family Partner engagement, and all of the above.

Factors Preventing CCPTs from Engaging Family Partners, 2020 (N=80)

Table 10 Factors Preventing CCPTs from Engaging Family Partners

Preventative Factors	Frequency (Percent)
Difficulty recruiting or identifying Family and Youth Partners	29 (36%)
Lack of resources to support participation (e.g., transportation, childcare, reimbursement for time)	8 (10%)
Sensitive nature of topics discussed	8 (10%)
Uncertainty about maintaining confidentiality	7 (9%)
Need for training on engaging Family and Youth Partners	8 (10%)
Lack of dedicated person to engage Family and Youth Partners	5 (6%)
Other	15 (18%)

Overall, this strategy appears to have resulted in a lack of robust data, indicating that trends in barrier to Family Partner participation fluctuate significantly from year to year. More likely, COVID-19 posed unique barriers that were not captured in this checklist.

In summary, CCPTs detailed at length the reasons preventing the participation of family or youth partners on their teams. In addition to the significant difficulties posed by COVID-19, some of these reasons stemmed from the situation of the partners: logistical, such as unavailability of transportation, scheduling conflicts, and lack of reimbursement. However, overwhelmingly CCPTs identified reasons related to the team rather than family or youth partners. These included uncertainties about how to recruit partners and how to maintain confidentiality. CCPTs asked for more guidance on bringing Family and Youth Partners onboard their teams. Thus, CCPTs identified the training and resources they would need for engaging families on their teams.

J. Partnerships to Meet Community Needs

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

Local Partnerships

The survey first asked: "During 2020, did your CCPT partner with other organizations in the community to create programs or inform policy to meet an unmet community need?" Among the 84 respondents, 39 (47%) answered yes that they did partner with other organizations and 44 (53%) responded no. Although the CCPTs were dealing with a pandemic, the percentages this year were similar to those in 2019 when 47% also said that they were partnering. Counties of all sizes were well represented among those partnering on community needs.

Local Initiatives

A follow-up question for those partnering was: "If yes, describe the most important of these initiatives to meet a community need." Out of the 39 teams, 36 provided information on these initiatives, some quite extensively.

This year, the local initiatives in which the 36 teams participated overlapped with those from last year, demonstrating continuity in areas of concern such as safe sleeping practices and teen suicide prevention. For instance, a mental health initiative focused on training for trauma screening of children. The CCPTs case reviews reinforced these efforts. A fatality review in one county led to a "safe sleeping policy which is utilized in Child Welfare cases and CC4C [Care Coordination for Children of substance-affected families] cases."

Some counties were able to continue their community prevention efforts. For example, one county presented "to local law enforcement agencies and the Highway Patrol on how to report child maltreatment including reviewing policy concerning caretakers who are impaired drivers." Another community had a "near fatality from a hot car incident. . . . [and] partnered with Safe Kids Coalition and promoted a hot cars event." A third county proudly reported success in

achieving a long-term goal of disengaging from a LME/MCO because of its "overall incompetence."

As noted previously, some teams, however, were unable to carry out community prevention work because of the pandemic. Their initiatives were "cancelled" or "cut short due to Covid." Others persisted, but not without challenges. In regard to one partnership to ensure training in schools for suicide prevention, the CCPT report that "COVID-19 has made this more difficult, however, the team is committed to making this a priority." Another CCPT "continues to umbrella the Early Intervention Team . . . to address truancy concerns for school aged children… . . [and] has faced new challenges with COVID."

Other initiatives could more readily be implemented during a pandemic such as creating a "QR code . . . . [that] pulls up a map of resources. . . . [and] provides a safe, informative, and engaging opportunity for our community." Some communities adapted their initiative for pandemic conditions. A case in point is a county that continued its sexual abuse prevention training "by having our trainers certified to do this virtually." Others moderated the expectations for their initiative during a pandemic. For example, one initiative to support youth who were substance affected reported that the pandemic increased the number of these youth in their county but "we still have had no deaths of youth and all had a Plan of Safe Care. We are still trying to work collaboratively to address difficulty for families adapting to virtual sessions."

Communities demonstrated their resourcefulness in securing supports and funding to implement their initiatives. Their partners were wide ranging and encompassed law enforcement, LME/MCOs, guardians ad litem, military bases, schools, courts, and businesses such as rental companies to reach "vacationing families who rent homes." Their grant activity included funding for trauma education, peer support to divert minor offences from the court system, and implementation of a family treatment court.

This year, racial equity assumed a more prominent profile among the initiatives. For example, one community secured "a health equity grant . . . to improve birth outcomes." Another team noted that equity efforts yielded new partnerships: The team promoted "racial equity . . . include[ing] infant mortality and youth on youth violence [and] solicited the support, resources, and engagement from community stakeholders and partners outside of our traditional team members."

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Sharing Findings and Recommendations

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

Among the 44 teams that responded no to involvement in local initiatives, 14 wrote in names of groups with whom they communicated findings and recommendations. These groups were the team members' organizations, county commissioners, county DSS board, county board of health, public health department, outside councils such as the juvenile justice prevention council, and training stakeholders.

Among the 39 teams currently involved in local initiatives, 33 specified groups with whom they shared findings and recommendations from local initiatives. The groups included those identified by the teams that responded no on involvement in local initiatives as well as some additional ones. For instance, one team wrote, "Mental Health Task Force and PSAC [public safety advisory committees] Committees, other community stakeholders i.e., hospital, mental health providers, domestic violence shelter, foster care organizations, church groups." Another CCPT elaborated on their system of communication, "Information . . . has been circulated through multiple community groups as well as to key agencies. Team members are actively involved in each of these and take information forward to other components that may work specifically with an area of need. Our court system, through judges, DA [district attorneys] and court administrators also disseminate information and bring back feedback."

Interagency Collaborations and CCPT's Role

The survey then drilled down further to interagency collaborations, "Are you aware of other county-level collaborations in which your CCPT was involved? The respondents were almost evenly split between those who said yes (41, 49%) and those who said no (42, 51%). Those responding yes included one-third (15) of CCPTs that did not identify partnering on local initiatives this year and two-thirds (26) of CCPTs that did identify currently partnering. Next the survey asked, "If yes, list the interagency group's name and describe your CCPT's role in each interagency group." Space was provided for writing in three different collaborations. With two exceptions, the teams, indicating that they were aware of other county-level collaboration, wrote in between one and three collaborations, for a total of 78 additional collaborations. Fourteen teams wrote in one collaboration, 11 wrote in two, and 14 wrote in three.

The additional interagency collaborations included early education, child advocacy, system of care, school justice, overdose prevention, and hospitals. Most did not identify the CCPT's role on the interagency collaboration. If their role was indicated, they referred to themselves as "committee member" or "participant."

In summary, the pandemic deepened community needs while raising hurdles to carrying out local initiatives. Some initiatives were "cancelled" or "cut short" because of COVID-19, and others were adapted to meet pandemic challenges such resorting to virtual meetings with families. Nevertheless, nearly half partnered with other organizations in these community efforts. This year's initiatives overlapped with those from last year, demonstrating continuity in areas of concern such as safe sleeping practices and teen suicide prevention. Communities were resourceful in securing partnerships and funding to implement their initiatives. Their partners were wide ranging and included public agencies, nonprofit organizations, faith communities, and businesses. This year, racial equity assumed a more prominent profile among the initiatives and

led to partnerships beyond "traditional team members." The collaboratives ensured that their findings and recommendations were communicated widely in their counties.

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

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

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

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

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

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

1) Child Maltreatment Fatality Cases

The survey asked, "From January through December 2020, how many notifications of child maltreatment fatalities were made by your local DSS and Public Health?" Among the 83 respondents, 56 (67%) replied that they had received no notifications from their local DSS; the remaining 27 (33%) said that they had received between 1 to 11 notifications, 1 county did not respond due to the operational status of the CCPT. Across the 27 respondents, there was a total of 67 notifications with a mean of 2.48 (SD = 2.38). Among the 83 respondents, 76 (91%) replied that they had received no notifications from Public Health; the remaining 7 (9%) said that they had received between 1 to 9 notifications, 1 county did not respond due to the operational status of the CCPT. Across the 7 respondents, there was a total of 23 notifications with a mean of 3.29 (SD = 2.81).

Additionally, this year's survey asked, "From January through December 2020, how many notifications of child maltreatment near fatalities were made by your local DSS and Public Health?" Among the 83 respondents, 74 (89%) replied that they had received no notifications from their local DSS; the remaining 9 (11%) said that they had received between 1 and 6 notifications, 1 county did not respond due to the operational status of the CCPT. Across the 9 respondents, there was a total of 19 notifications with a mean of 2.11 (SD = 1.69). Among the 83

respondents, 82 (99%) replied that they had received no notifications from Public Health; the remaining 1 (1%) said that they had received between 2 notifications, 1 county did not respond due to the operational status of the CCPT.

Next the CCPTs were asked about the type of review that these child maltreatment fatalities received. The teams were provided with three types of reviews from which to select, and they had the option of writing in other types of review. As shown in Table 7, the most common type of review was an intensive state child fatality review conducted by NC DSS and a combined CCPT/CFPT review: 53 and 37 cases were reviewed in each of these categories respectively, and these case reviews were reported by 15 and 13 CCPTs respectively.

In summary, last year, 27 (33%) respondents said that they had received between 1 to 11 notifications of child maltreatment fatality cases, for a total of 67 notifications. The majority of these notifications came from the CCPT's local DSS. Additionally, 9 (11%) respondents said that they had received between 1 and 6 notifications of child maltreatment near fatalities, for a total of 19 notifications. When asked about their type of review, the teams identified different approaches. The most common types of review were an intensive state child fatality review conducted by NC DSS and a combined CCPT/CFPT review. Thus, the cases of child maltreatment fatalities had different types of reviews, some in the county and others at the state level. However, the survey did not inquire about the impact of the reviews. This information would be helpful in planning ways to improve child maltreatment reviews in the state.

Number of Child Maltreatment Fatality Cases by Type of Review, 2020

Table 11 Number of Child Maltreatment Fatality Reviews by Type of Review

Type of Review	Number of CCPTs	Sum of Cases	Minimum of Cases	Maximum of Cases	Mean of Cases	SD of Cases
1. Combined CCPT and CFPT conducted case review	13	37	0	8	2.85	2.27
2. CCPT conducted case review	12	53	0	17	4.42	4.72
3. NC DSS conducted (intensive) state child fatality review	15	24	0	4	1.60	1.06
4. Other	4	5	0	2	1.25	.50

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

Notifications of Child Maltreatment Fatalities

Over the three most recent years, the percentages of CCPTs not receiving notifications of child maltreatment fatalities were 65% in 2017, 63% in 2018, and 54% in 2019. Given these results, the 2020 survey asked a new question: "What would facilitate your CCPT receiving notification of child maltreatment fatalities?" Among the 83 responding teams, 30 did not offer a strategy: They left the question blank, confirmed that they had no fatalities this year, explained that the

question was not applicable or unclear, or stated they were "unsure." The remaining 53 specified strategies for facilitating notifications.

Among the 53 specifying a facilitator, some confirmed that their team was "notified of all fatalities involving maltreatment." Others stated that they did not have any issues with notifications in 2020. For instance, one CCPT wrote, "There has not been any issues with the current process for notifications of child maltreatment fatalities." A second team observed, "They would be referred by either DSS, Medical Provider or community family referral." A third team reported, "We do not have a problem receiving notification through law enforcement." A fourth team found that they could become aware of child fatalities outside of the official route: "Notification by DSS (although team members may see on the news)."

Others noted that they already had protocols in place. For instance, a combined CCPT/CFPT team wrote, "Our CFPT is combined with CCPT and therefore, the case would be discussed." A number of teams expanded on their process. For instance, a CCPT described, "DSS would send an email notification to CCPT representative to be shared with all members of the team in order for information to be gathered from each prospective agency surrounding their involvement with the family in order to be shared and discussed with the group during CCPT meeting."

In their response, teams frequently did not indicate if protocols were already being followed and might simply list a notification source or a procedure. One combined CCPT/CFPT team described a situation in which they did not receive notification right away: "The State mandating that DHS contact CCPT chair at the time of a fatality. As of now, we find out a year later unless it is a difficult case which DHS opts to staff with CCPT because it is a difficult case. That is in the discretion of DHS though. They have no obligation to share anything with CCPT until we find out about the fatality in our quarterly reviews one year later."

What stands out in the written responses is that none of the CCPTs indicated that the pandemic affected notifications of child maltreatment fatalities. This finding is striking for two main reasons. First, the 2020 survey inquired not only about notifications from the local DSS but also from DPH, during a time of major public health concern. Second, if only DSS notifications are considered, the percentage of CCPTs not receiving notifications increased substantially from 54% in 2019 to 67.5% in 2020, though remaining only somewhat higher than in 2017 and 2018.

In summary, because past surveys found that the majority of CCPTs did not receive notifications of child maltreatment fatalities, the 2020 survey inquired about what would facilitate the process. In response, teams explained that they had protocols already in place, did not have child maltreatment fatalities during the year, or had no issues with receiving notifications. Although the percentage of teams receiving notifications was lower in 2020 than in 2019, none of the CCPTs indicated that the pandemic affected notifications of child maltreatment fatalities.

Facilitators of Notifications of Near Fatalities from Child Maltreatment

Given this was the first year in which CCPTs were asked to track the number of near fatalities resulting from child maltreatment, the survey asked, "What would facilitate your CCPT receiving notification of child maltreatment near fatalities? Out of 83 responding CCPTs, 29 (35%) did not offer a facilitator and 54 (65%) did. The figures for near fatalities are close to those identifying facilitators for child fatalities, as previously reported (30 vs. 53), and 77% of those not providing a facilitator for near fatalities notifications overlapped with those not providing a facilitator for child fatalities notifications. Similar to child fatalities, those not offering a facilitator of near fatalities notifications left the item blank, wrote not applicable, were uncertain about how to answer, or reported that their county had "no near fatalities" in 2020.

Some counties stated that there were no issues with the notifications. For instance, one team wrote, "The CCPT is notified of all severe explained and unexplained injuries and injurious environment cases." Other teams reported that they followed the same protocols for near fatalities as for child fatalities and referred to their prior responses for child fatalities. For example, a team responded, "Same as above," referring to the protocol for child fatality notifications that "The DSS Director and/or DSS Staff brings the case information to the CCPT Chair/following CCPT meeting in accordance to DSS/CPS Fatality policy."

Other teams said that they had worked out a protocol: "[County] DSS has agreed to send a copy of the near fatality notification to the chair of the CCPT." They also offered principles for a sound system of notifications:

- "Good communication and maintaining relationships between different partners."
- "An understanding of how these would be identified, and which agency would know."
- "Identification of a member to obtain and track the data from the appropriate source."

Teams varied in their views regarding the adequacy of state definition on near fatalities. Finding the state definition useful, a team wrote, "I think the recent guidance on the definition of near fatalities will help ensure that these get reported." Others requested more assistance regarding the definition:

- "More education on defining "near fatality" for all potential reporting parties."
- "I also believe the state needs to better define what constitutes "near fatality. Is that one with attempted murder charges or what?"

Some requested more training in their community or for themselves:

- "Education to the medical community about what they need to report"
- "Additional educational opportunities for community stakeholders/partners."
- "I am not sure if there is a requirement for our agency to track and notify those to the state. I would need further training if I am incorrect on that one."

One team recommended a change in policy: "The State should require near fatalities be reported to their office, in addition to fatalities, so the information can then be shared with the team."

In summary, some CCPTs stated they had no issues with their being notified of near fatalities from child maltreatment, and many saw their protocols for child fatalities as applicable to near

fatalities. Others offered principles to guide these notifications, including good communication and clarifying the responsible agencies. Given the newness of the near fatalities policy, teams more often expressed some confusion about the process or made recommendations for improving the process. Some wanted more clarification of the definition of near fatalities or training on near fatalities.

L. Child Maltreatment Case Reviews

Child maltreatment cases encompass both active cases and child fatalities and near fatalities where child abuse, neglect, or dependency is suspected.

a. Number of Cases Reviewed

The CCPTs were then asked, "What is the total number of cases of child maltreatment reviewed by your CCPT between January and December 2020?" In 2020, 70 (85%) of the 82 responding CCPTs reviewed between 1 and 20 cases, with a mean of 5.70 cases (SD = 4.62). All together these 70 teams reviewed 399 cases. The other 12 (15%) did not indicate they had reviewed cases in 2020. Table 12 displays the total number of cases reviewed when organized by county size. As county size increased so did the average number of cases per CCPT. Within each county-size group, especially for the largest counties, there was extensive variation in how many cases they reviewed.

Number of Child Maltreatment Cases Reviewed by County Size, 2020, (N=84)

Table 12 Number of Child Maltreatment Cases Reviewed by County Size

Size of County	Number of Respondents Reporting Cases	Number of Cases Reviewed	Mean	SD	Range
Small	41 (95%)	167	4.07	3.93	0-17
Medium	30 (100%)	147	4.90	5.12	0-20
Large	11 (100%)	85	7.73	5.59	1-20

Note: Number of responding counties and percent of total possible counties of a specific size. Large standard deviations indicate wide variability in number of cases reviewed. Standard Deviation (SD)

The 2020 survey asked participants a follow-up question to breakdown how many of the reviewed cases were child maltreatment fatalities or child maltreatment near fatalities. Nineteen CCPTs indicated that between 1 and 17 of these case reviews were child maltreatment fatalities for a total of 65 of the cases with a mean of 3.42 (SD= 3.73). Five CCPTs indicated that 1 of the case reviews was a child maltreatment near fatality for a total of 5 cases.

In summary, Child maltreatment cases encompass active cases and child fatalities and near fatalities where child abuse, neglect, or dependency is suspected. In 2020, 70 (85%) of the 82 responding CCPTs reviewed 399 cases. As would be expected, larger counties reviewed more cases than smaller ones. Additionally, 65 of the cases reviewed were child maltreatment fatalities and 5 cases were near fatalities. Thus, most CCPTs who responded to the survey carried out their mandated role of reviewing cases. Nevertheless, 12 CCPTs did not indicate that they reviewed any cases. The survey did not specifically inquire about the reasons why some counties had not reviewed cases and what would have helped them fulfil this role.

b. Criteria for Selecting Cases for Review

The survey asked about the criteria that the teams applied for selecting cases to review. The teams were provided a list of 11 criteria and could write in 2 additional reasons. As shown in Table 13, the most common reason cited by 55 (66%) out of the 83 respondents was that the case was active. This is in keeping with the expectation of state statute that CCPTs select "active cases in which children are being served by child protective services." Statute also charges the teams with reviewing "cases in which a child died as a result of suspected abuse or neglect." Among the respondents, 20 (24%) stated that they selected child maltreatment fatalities for review. In addition to these statutory requirements, the CCPTs identified other selection criteria. Along with active cases, the most frequently selected, at 50% or higher, were the criteria of stuck cases, repeat maltreatment, and multiple agency involvement. Compared with last year's survey, the number of CCPTs selecting cases for review because of parental opioid use decreased. Trends have historically increased: 22 (34%) of the 64 respondents in 2016 to 26 (41%) of 63 respondents in 2017 to 21 (24%) of respondents in 2018 to 45 (63%) in 2019 but decreased to 35 (42%) now in 2020. Twelve of the respondents added a selection criterion, and five of these provided two criteria. The additions included "mental health needs," "substance use," "domestic violence," "service needs for undocumented citizens" and "cases selected by DSS."

Case Criteria Used by CCPTs for Selecting Child Maltreatment Cases for Review, 2020, (N=83)

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

Selection Criterion	Number of CCPTs	
Active Case	55	(66.3%)
Multiple Agencies Involved	50	(60.2%)
Repeat Maltreatment	50	(60.2%)
Stuck Cases	45	(54.2%)
Child Safety	41	(49.4%)
Child and Family Well-Being	39	(47.0%)
Parent Opioid Use	35	(42.2%)
Court Involved	34	(41.0%)
Child Permanency	28	(33.7%)
Child Maltreatment Fatality	20	(24.1%)
Closed Case	10	(12.0%)
Other 1	11	(13.3%)
Other 2	5	(6.0%)

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

c. Contributory Factors to Intervention Necessity

Child Protective Services codes cases of substantiated maltreatment or family in need of services on factors contributing to the need for intervention. These contributory factors fall into three broad categories: caretaker, child, and household. Table 14 lists these contributory factors and the number of CCPTs who used each factor in selecting cases for review. The two most common factors were caretaker's drug use cited by 55 (66%) CCPTs and alcohol use cited by 41 (49%) CCPTs. Three other factors used by over 40% of CCPTs pertained to lack of child development

knowledge, child/youth behavioral problems, and household domestic violence. Alterations to the 2020 survey language included updating substance abuse to substance use and mental retardation to intellectual/developmental disability.

Contributory Factors for Children Being in Need of Protection Used by CCPTs for Selecting Child Maltreatment Cases for Review, 2020, (N = 83)

Table 14 Contributory Factors for Children Being in Need of Protection Used by CCPTs for Selecting Child Maltreatment Cases for Review

Contributory Factor	Number of CCPTs	
Parent/Caregiver		
Drug Use	55	(66.3%)
Alcohol Use	41	(49.4%)
Lack of Child Development Knowledge	37	(44.6%)
Emotionally Disturbed	24	(28.9%)
Intellectual/Developmental Disability	17	(20.5%)
Other Medical Condition	16	(19.3%)
Learning Disability	11	(14.5%)
Visually or Hearing Impaired	2	(2.4%)
Children/Youth		
Behavior Problem	42	(50.6%)
Emotionally Disturbed	29	(34.9%)
Drug Problem	23	(27.7%)
Other Medical Condition	22	(26.5%)
Intellectual/Developmental Disability	20	(24.1%)
Learning Disability	15	(18.1%)
Alcohol Problem	12	(14.5%)
Physically Disabled	5	(6.0%)
Visually or Hearing Impaired	3	(3.6%)
Household		
Domestic Violence	51	(61.4%)
Financial Problem	32	(38.6%)
Inadequate Housing	31	(37.3%)
Public Assistance	24	(28.9%)

In summary, state statute requires that CCPTs review two types of cases: active cases and child maltreatment fatalities. Most (66%) respondents selected active cases for review. Child maltreatment fatality was given as a reason for case selection by 24% of respondents. Whether local teams review all child maltreatment fatalities depends on the context (ex. if the CFPT does the review). The second most frequent criteria for selecting cases were multiple agency involvement and repeat maltreatment, both identified by 60% of respondents. The range of issues identified indicates the CCPTs' concern about many areas affecting the families' lives. The teams also selected cases on the basis of factors contributing to children needing protection: The two most common factors were caretaker's drug use cited by 55 (66%) CCPTs and alcohol use

cited by 41 (49%) CCPTs. Selection of cases because of parental opioid use decreased from 63% of respondents in 2019 to 42% in 2020. Three other factors used by over 40% of CCPTs pertained to lack of child development knowledge, child/youth behavioral problems, and household domestic violence. The range of issues identified indicates the CCPTs' concern about many areas affecting the families' lives. Thus, the teams had a comprehensive awareness of the challenges affecting the children and families in their communities.

2) Process of Case Reviews

The CCPTs used different types of information to review the cases (see Table 15). Out of the 83 respondents, 74% used reports from members and/or case managers, and 68% used case files. Over half (57%) used information on procedures and protocols of involved agencies. These three types of information were the same primary sources as reported in the 2015, 2016, 2017, 2018, and 2019 surveys, however reported use of these types of information is notably lower in 2020. This may have been a function of workers working remotely and not being able to access and share materials in the office. CCPTs also wrote in some other information sources, including social worker presentations and medical, school, police, and military records.

Type of Information Used by CCPTs for Reviewing Cases, 2020, (N=83)

Table 15 Type of Information Used by CCPTs for Reviewing Cases

Type of Information	Number of CCPTs
Reports from Members and/or Case Managers	61 (73.5%)
Case Files	56 (67.5%)
Information on Procedures and Protocols of Involved Agencies	47 (56.6%)
Child and Family Team Meeting Documentation	30 (36.1%)
Medical Examiner's Report	22 (26.5%)
Individualized Education Plan	20 (24.1%)
Other 1	8 (9.6%)
Other 2	3 (3.6%)

Ways to Improve Case Reviews

In 2020, the survey asked teams, "What would help your CCPT better carry out case reviews?" Among the 83 respondents, 43 (52%) provided a means of improving their review process and 40 (48%) did not. The methods offered in 2020 overlapped extensively with those in 2019 but included additional ones, particularly related to the pandemic.

Some teams responded that they were quite satisfied with their review process. They wrote about having a process that "works smoothly" or that the team was thorough "in the reviews." Others noted that the pandemic affected their process: "This year it has proven to be more difficult due to pandemic, but typically we are good about getting cases to review." Some reported that they were able to resume case reviews once they began convening virtually but looked forward to "being able to meet in person again."

Others noted areas for improvement that local teams could undertake:

- *Widening family and community participation*, by recruiting "a representative from the community that has had involvement with the services offered" in order to "bring a more comprehensive outlook to brainstorming and identifying the needs of the community."
- *More consistent participation*, especially "by Law Enforcement agencies and the Community Action agency."
- *Better structuring of meetings*, by having "a quarterly agenda item to submit," presentations of cases "from each agency on a rotating basis," and "developing a written format for presenting cases."
- *Greater access to case information*, especially from mental health on "details of services."
- *More supports for participation*, such as having "money that is actually earmarked for CCPT so that drinks and snack items can be provided."

Some improvements the local CCPTs observed needed to come from NC DHHS:

- *Timely access to cases for review*: "A policy which assigns us cases in real time as opposed to one year later in a fatality review. There is nothing that requires DHS to bring CCPT anything."
- *Virtual format approval*: "Policy from State level approving all virtual options for meetings to ensure confidentiality."
- *Uniform review process*: "A structured format that is used across the state."
- Technical assistance: "Formalized training." "Having a tool that we can enter data into from case reviews that would allow us to extract meaningful information would be really helpful. Excel is difficult with the complexity of the cases."
- *Supportive platform*: "An electronic management system for all CPS."

One team, dissatisfied with state-level support, nevertheless, worked out their own approach: "In our county, most of the time these necessary consults occur because we have good relationships with partnering agencies. People just call for help directly to the agency without needing to have a formalized CCPT review. We use CCPT more as a networking, information sharing, team building entity. We also look at community deficits in community services and attempt to meet those."

In summary, the local teams figured out ways to operate during a pandemic but missed their in-person meetings. Team meetings were an important occasion for networking, information sharing, team building, and identifying community needs. CPPTs outlined ways that they could improve their review process: These included recruiting family and community representatives, having more consistent participation and structured meetings, and enhancing access to case information. They also recommended ways that DHHS could strengthen the review process, by expediting notifications of fatality cases, clarifying policies, and providing technical assistance and tools.

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

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

The survey asked the CCPTs to identify how many cases reviewed in 2020 needed access to MH/DD/SU/DV services. Table 16 summarizes the findings first for the children and second for the parents or other caregivers. Here 56 of the respondents identified MH needs of children in a total of 202 cases. A total of 25 respondents identified SU service needs and 33 identified DV services needs for children; however, SU and DV services were required by 78 cases respectively, which exceeds the numbers for DV (70 cases) from 2019 but represents a decrease in SU cases from 2019 (132). This is consistent with the 2018 survey results that indicated that SU services were required for more cases (132 cases), than for DV (86 cases) and DD (40 cases). This year, DD services were needed by 30 of respondents for 36 cases, the same number of cases as 2019.

For the parents or caregivers, the need for mental health and domestic violence were the most prominent. Among the responding teams 56 identified the need for MH services and 47 identified a need for DV services. The total number of reviewed cases were also higher with 209 of the reviewed cases requiring MH services and 114 requiring DV services. The need for SU services was cited by 56 of the teams, for a total of 200 cases. The need for DD services was expressed by 16 CCPTs but with a significantly lower number of cases reviewed (25 cases).

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

Those respondents who indicated that they had reviewed cases where families needed access to substance use services were subsequently asked, "How many cases of substance affected newborns did you review in 2020?" and "How many of these had a Plan of Safe Care." Eleven CCPTs indicated that they reviewed cases of newborns who were substance affected, the sum of the cases reviewed was 31. Of these 11 CCPTs reporting that they reviewed cases of substance affected newborns, all of them responded to the follow-up question inquiring about Plans of Safe Care. All that reported reviewing a case of a substance affected newborn had a corresponding Plan of Safe Care (31 plans).

Number of Reviewed Cases Requiring Access to MH/DD/SU/DV Services, 2020 (N= 83)

Table 16 Number of Reviewed Cases Requiring Access to MH/DD/SU/DV Services

	Number of CCPTs	Sum of Cases	Mean	SD
Children/Youth				
Mental Health	83	202	2.43	2.54
Developmental Disabilities	83	36	0.78	0.43
Substance Use	83	78	.94	1.64
Domestic Violence	83	78	.94	1.69
Parents/Caregivers				
Mental Health	81	209	2.58	3.17
Developmental Disabilities	73	25	0.79	0.34
Substance Use	79	200	2.53	3.10
Domestic Violence	80	114	1.43	1.91

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

The 2020 survey asked, "Did any of these services have a waitlist?" To this, 13 respondents indicated there was a waitlist for MH services, 3 indicated there was a waitlist for DD services, 9 indicated there was a waitlist for SU services, and 7 indicated there was a waitlist for DV services. There were a total of 83 responses to this new survey item.

Next the survey asked, "Which of the following limitations prevented children, youth, and their parents or other caregivers from accessing needed MH/DD/SU/DV services?" As shown in Table 17, the two most frequently cited limitations were limited or no services (60% of respondents) and limited transportation to services (43% of respondents). Other common limitations, both cited by 33%, was the community's lack of awareness about available services and limited MH and DD services for youth with dual diagnosis. Respondents' recognition of limited services for youth with dual diagnosis as a limitation ranged from 18-33%. These trends are similar to previous year's findings.

Among the respondents, 14 wrote in additional limitations. These primarily concerned systemic factors and to a lesser extent, family reasons. Some respondents commented on "parent's willingness to seek services" and "parent's readiness to participate in services." Several limitations referenced language and cultural barriers. Others identified the lack of available services, particularly within the context of the pandemic.

Number of CCPTs Reporting Limitations Preventing Children, Youth, and Their Parents or Other Caregivers Accessing Needed MH/DD/SA/DV Services, 2020, (N = 83)

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

Limits on Access	Number of CCPTs
Limited Services or No Available Services	50 (60.2%)
Limited Transportation to Services	36 (43.4%)
Limited Community Knowledge About Available Services	27 (32.5%)
Limited Services MH and DD for Youth with Dual Diagnosis	27 (32.5%)
Limited Services MH and SA for Youth with Dual Diagnosis	25 (30.1%)
Limited Services MH and DV for Youth with Dual Diagnosis	15 (18.1%)
Limited Attendance MH/DD/SA/DV Providers at CFTs	15 (18.1%)
Limited Number of Experienced CFT Meeting Facilitators	5 (6.0%)
Other 1	17 (20.5%)
Other 2	5 (6.0%)

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

In summary, children, youth, and their parents or caregivers faced serious barriers to accessing needed services. Most CCPTs who reviewed cases in 2020 reported that children and youth needed access to mental health services. Most CCPTs also reviewed cases in which the parents or caregivers required access to mental health or domestic violence services. As noted previously, CCPTs commonly selected cases for review because of parental drug use, child safety, domestic violence, and child and family well-being (which includes mental health). These criteria would tilt the findings on reviewed cases toward the need for MH, SU, and DV services. CCPTs indicating that there were waiting lists for these services also speaks to this need. Additionally, CCPTs identified systemic barriers to families' accessing essential services. The most commonly cited barriers were limited services or no available services, transportation to services, limited community knowledge about available services, and youth having a dual diagnosis of mental health and developmental disability issues. The CCPTs commented on some family factors affecting service receipt such as parents' readiness to participate in services and language barriers. It is quite likely that these identified family reasons reflected systemic barriers such as the complexity of the health care system and challenges in finding services without having health insurance. Thus, the teams were well aware of multiple issues keeping children and families from much needed services. As stated in previous reports, the federal funding from the Family First Prevention Services Act may be able to assist them in securing prevention services in their communities.

N. Local CCPT Recommendations for Improving Child Welfare Services

Based on their 2020 case reviews, teams were asked to specify their three top recommendations for improving child welfare services at the local and state levels. As a group, CCPTs made 165 recommendations for the local level and another 132 recommendations for the state level, for a total of 297. The recommendations are compiled in Appendix C.

Out of 83 teams, 65 teams made recommendations for the local level, with 8 making one, 14 making two, and 43 making three, for a total of 165. This left 18 teams that did not offer recommendations. The number of recommendations at the state level (132) was lower than at the local level (165). When asked to specify state-level recommendations, far more teams declined (28 for state versus 18 for local). Among those giving state recommendations, 14 gave one, 5 gave 2, and 36 gave 3.

One team explained that they had not reviewed any cases this year and, therefore, were not positioned to make recommendations. In constructing future surveys, consideration should be given to removing the stipulation that teams make recommendations based on their case reviews. Although teams may not have conducted case reviews, they still have other community experience and knowledge on which to base proposals for improving child welfare services.

Recommendations for the Local Level

Substance Use and Mental Health Services. As in 2019, CCPTs called for more services and resources in addressing substance use and mental health. They insisted that their "Local Management Entity find . . . placements when needed," especially for "children with significant behavioral issues," and pushed for "better oversight and enforcement and standardization of MAT [medication-assisted treatment] programs." They urged "providing support for kinship providers [and] "navigating systems and managing the day-to-day care of children." Their emphasis was frontloading services, something teams fully recognized would require "state/federal funds" for prevention."

Infant and Maternal Health. They demonstrated particular concern for infant and maternal health. Their recommendations supported Plans of Safe Care for infants who were substance affected and their families. These included general services such as expanding "access to birth control and family planning," parent education on safe sleeping, and nurse home visitation. One team exclaimed, "Access to prenatal care!!!" Some explicitly called for "improved plans of safe care." A CCPT laid out the "need for better communication between hospital/OB provider and MAT clinic providers about a patient's postpartum MAT dosing."

Family Violence, Housing, and Immigrant Services. Teams gave close attention this past year to recommendations on family violence, housing, and immigrant services. Teams wanted more public education on "safe/healthy relationships," treatment for persons committing domestic violence, and "reopening a domestic violence shelter." Teams laid out in stark terms the housing crisis: "We need more affordable housing because these children have nowhere to live and we have tent cities." Recommendations for immigrant services covered: "Improve relationships with multicultural centers (ex. refugee centers) to ensure timely and accurate service provision to families" and "more financial resources for services for undocumented children."

We need more affordable housing because these children have nowhere to live and we have tent cities.

Local Child Welfare. In regard to their local DSS, they advised more staffing, clarifying policy changes, and training, including on "racial equity in child welfare." Within the county network of services, they pressed for more partnering. For example, "social workers will partner with

identified service provider facilitators to begin introduction of services with a warm hand off and allow for personal connection." Another partnership recommendation was: "Ensuring all involved agencies are working towards same goals with families and not having conflicting goals."

CCPT Functioning. They identified ways to improve their team functioning and particularly wanted to enhance their working relationships with local agencies. A CCPT wrote, "Cultivate better relationships with our school board as our superintendent refuses to attend our meetings. We have worked hard to cultivate that since the elections in November. We now have two school board members on our team." A year of meeting virtually appeared to affect how they approached making improvements. A case in point is one team that wanted to find "more creative ways to hold meetings virtually" and to boost their community outreach through "exploring ways to use social media and virtual avenues to share information with the public about child protection needs."

Recommendations for the State Level

System-Wide Intervention. The state-level recommendations were directed to action that counties could not undertake on their own. As one team simply put it, their county needed "funding, training, and resources" from the state. They knew that they could not advance systemic improvements in the community without more of an infusion of federal and state funding for local efforts such as domestic violence and homeless shelters and more broad-scale changes that only the state could approve. A prime example is teams exhorting the state to "accept federal Medicaid expansion," insure "access to Medicaid for children, parents and caregivers," and "increase parent's access to healthcare and insurance in order to access services to address their needs in order to prevent further maltreatment."

Cross-Jurisdiction Arrangements. Most cross-jurisdictional recommendations pertained to behavioral health services for families involved with child welfare. CCPTs urged that "NCDHHS and Mental Health MCO's work in partnership to allow families and DSS to receive authorization for higher level of mental health and substance use services when recommended." They recognized the need for "more user friendly and a diverse menu of services" to meet the mental health needs of parents and children, especially for "dependent and behaviorally challenging youth." Increasing and improving these services, they observed, would mean enlarging the pool of providers, especially to rural communities, and "more oversight/help from LMEs." To improve multi-agency work, they recommended "better data integration across various systems such as a universal EMR [electronic medical records]."

Child Welfare Services. Troubled by high turnover among child welfare workers, teams pressed for a number of reforms: decreasing caseloads given the complexity of family situations, hiring more staff, upgrading agency technology, and increasing training, including of trauma-informed resiliency to help staff deal with the effects of the work. Some teams proposed revisions to child welfare regulations. For instance, a major area of concern was preventing unnecessary transitions of children and youth in care. In response, a team urged "eliminating transition of children progressing in therapeutic [care]," and another team emphasized increasing "therapeutic foster homes in NC-with the requirement that before the child can be discharged for behavior it must be reviewed by the State for approval." Other recommendations would affect how families are assessed and supported: removing "parent substance use alone" as a criterion of determining

child maltreatment, "allocating DSS funds to follow families" to eradicate "poverty as a cause for maltreatment," implementing "a trauma informed child welfare system globally, including prevention services in every county department," and using "a practice model throughout Child Welfare."

Pandemic Response. The pandemic weighed on the CCPTs, and they recognized that addressing its impact required state-level intervention to ensure uniform standards, a fair distribution of resources, and adequate funding. In fact, one team spelled out three recommendations to respond the pandemic's impact:

- Get the teachers vaccinated ASAP so the kids can all go back to school.
- Access to healthcare (both physical and behavioral) for parents (i.e., parents still need Medicaid when their children are removed from their custody)
- Ensuring that new programs/initiatives are statewide and can be accessed across all counties (e.g., PPP [Paycheck Protection Program]).

Support for CCPT Teams. They welcomed the increased "participation of state representatives" to clarify policies and support team operations. They requested "more guidance" addressing infants who were substance affected, resources for providing preventative educational programs, and training for CCPT members, including on state expectations of teams. They appealed to the state to ensure "faster turn-around time" for case reviews of child fatalities and access of the Medical Examiner's Office to the child protection history for making "decisions to screen in or screen out a case." And they wanted the state to respond to the local teams' "expressed needs and recommendations."

In summary, the teams made a total of 297 recommendations to improve child welfare services, of which 165 recommendations addressed issues at the local level and another 132 addressed issues at the state level. The local recommendations included more services and resources in addressing substance use and mental health issues, infant and maternal health, family violence, affordable housing shortages, and immigrant needs. For their local child welfare, they advised more staffing, clarifying policy changes, and offering training, including on racial equity in child welfare. At the state level, they wanted reforms to improve families' access to a full range of behavioral health services and resolution of cross-jurisdictional issues impeding this access. They proposed strategies to improve child welfare services from enhancing working conditions of caseworkers to changing regulations on youth transitions in care to altering methods of assessing and supporting families. The pandemic weighed on the CCPTs, and they recognized that addressing its impact required state-level intervention to ensure uniform standards, a fair distribution of resources, and adequate funding. Teams welcomed participation of state representatives to clarify policies, train members on their role, expedite case reviews, provide resources for community outreach, and respond to the CCPTs' recommendations.

O. Local CCPT Objectives and Achievement of Objectives

This year the survey asked a series of questions about the CCPTs' local objectives based on identified improvement needs. First, they were asked, "Did your CCPT set local objectives based on identified improvement needs to complete over 2020?" Among the 82 respondents, 33 (41%) said yes and 49 said no (59%). Of the 34 teams that responded yes, one was recently reorganized

and having regular meetings, one was established but not meeting regularly, and 32 characterized themselves as an established team that met regularly.

Next, the 34 respondents who set objectives were asked, "List your CCPT's top three local objectives based on identified improvement needs for 2020. Then rate how successful your CCPT was in achieving these objectives." Table 18 summarizes the extent to which the CCPTs achieved their objectives on a five-point scale (0-4) from *not at all, slightly, moderately, mostly*, and *completely*, with the additional option of *too soon* to rate.

Rating of CCPT Achievement of Objectives, 2020

Table 18 Rating of CCPT Achievement of Objectives

	Number of CCPTs	Not at All	Slightly	Moderately	Mostly	Completely	Too Soon to Rate
Objective 1	34	2	10	5	5	6	6
Objective 2	33	1	9	6	5	6	6
Objective 3	23	1	3	5	6	4	4
Total	**-**	**4**	**22**	**16**	**16**	**16**	**16**

Note. Of the respondents were CCPTs who said that they had set objectives for 2020, not all provided success rating

Along with rating the achievement of their top three local objectives in 2020, CCPTs were asked to write in each of these objectives. Among the 83 responding teams, 55 (61.8%) did not write in an objective, and 34 (38.2%) wrote in at least one objective. Of the 34, 23 (68%) gave 3 objectives, 10 (97%) gave 2 objectives, and 1 (23.5%) gave 1 objective, for a total of 90 objectives listed. A rating of *slightly* was the most common response to how successful CCPTs were in achieving their objectives with 22 endorsements. A listing of their objectives and other qualitative responses can be found in Appendix C.

The objectives that they set for local action paralleled those that they recommended for improving child welfare services in their communities. Their local objectives fell into three main categories: public education and training, developing stronger programs, and improving team functioning.

Public Education and Training. They sought to build awareness of a number of topics, including domestic violence, family planning options, safe sleep, infants who were substance affected, and suicide prevention. In undertaking these efforts, they reached out to other local agencies as sponsors and partners.

Developing Stronger Programs. They assessed available resources to support families, created and distributed resources such as a "CPS child safety checklist," and advocated for resources such as "more CPS staff" and "having specific providers to come to the area to work with youth who abuse illicit substances."

Improving Team Functioning. They worked to increase their membership and engagement on the team and become "more efficient" such as by "merging their CCPT/CFPT" or developing ways to identify cases for review.

Their ratings showed that they tended to have more success in achieving specific objectives that did not require outside resources. For instance, they were completely successful in building "more awareness around substance-affected infants" and mostly successful in "adding more community agency representatives" to their team. Conversely, they were not at all successful in improving "access to housing" or "services for undocumented persons." Other efforts were in progress and were too soon to rate, such as reducing "baby roll over deaths."

Helps for Meeting Objectives

Next, CCPTs were asked, "What helped you achieve your local objectives to meet identified improvement needs." The onset of the pandemic frequently disrupted plans for achieving objectives, with the result that teams were often less than successful or needed to change course. For instance, one team set the objective to "work more collaboratively and cohesively as a combined CCPT/CFPT team." Preliminary work was carried out when the "chairpersons met at the beginning of 2020 to start the conversation but COVID interrupted and shifted the focus for 2020." The end result was that the objective was only slightly accomplished.

Despite the roadblocks mounted by the pandemic, teams found ways to persevere and identified four principal facilitators of their work: drawing on the strengths of team members, partnering with other organizations, following through on plans, and advocating for county supports and funding.

Drawing upon Strengths of Team Members: The teams recognized strengths internal to their teams or ones that they built up over the year. For instance, one team moderately met their objective to "assess local MH/SA/DV resources to meet the needs of families" because of the "knowledge and experience of team members." Another team mostly succeeded in "adding more community agency representatives to the CCPS" as "more persons were able to join the meetings because they moved from in-person to virtual."

Adding more community agency representatives to the CCPS" as "more persons were able to join the meetings because they moved from in-person to virtual.

*Partnering with Other Organizati*ons. Strategies for partnering included "inviting" participants, "using same language across multi-service agencies," getting "commitments by all agencies," or designating a "local lead agency to be the 'work horse' for the ideas." On team expanded upon how they *mostly* accomplished their objective of ensuring "accessible information on risk factors for children and families." They detailed key players and methods: "MDT [multidisciplinary team] reviews through CAC [Children's Advocacy Center]; school phone line for agencies to be able to share information and concerns brought up by students and others- data included on attendance at appointments (medical, MH treatment, education), and notifications to others who can follow up."

Following through on Plans. Once they had an approach in place, teams kept on track with the agreed plan or protocol. One multi-year effort was *completely* successful: "compiling data since 2018 on child deaths and causes of the death." Another *moderately* successful initiative of

"protecting SAI [substance affected infants]" ensured "referrals are made to home visitation services through PHD [Public Health Department]."

Advocating for County Supports and Funding. The teams recognized that additional resources from within their counties were essential to realizing their objectives, something often difficult to achieve in the short run. One team acknowledged that it was *too soon to tell* whether they would succeed in preventing "trafficking of youth," and sought to get their "Town and County Manager on board." Another team was *moderately* successful in their efforts on "staff retention" and reached out for the "support of County Administration to address salary for child welfare staff."

State Help for Local Objectives

Then, CCPTs were asked, "What can NC DSS do to help you achieve your local objectives to meet identified improvement needs? Teams were likely to ask for similar help from the state across multiple objectives. One team wrote, "Overall, with all three objectives having availability of training and quality technical assistance will be beneficial." Another team for two objectives wrote: "Work in collaboration with other agencies."

The type of state help requested fell mainly into four areas: CCPT technical assistance, training, and networking; data sharing and evaluation; resources and funding; and system-level advocacy.

CCPT Technical Assistance, Training, and Networking. They wanted the state to keep them "updated on state changes/issues" and to "provide support and guidance when the need arises." Teams frequently asked for more training for their members or community agencies, for example, "training for schools, healthcare providers, and law enforcement on how to report child maltreat and fatalities." Recognizing that teams would benefit from sharing with each other, they requested that NC DHHS "hold an annual conference for local CCPT members to attend or at least the chair and a representative from each team to attend to network, share ideas that will promote consistency across the state in regard to identifying needs and training on how to make more achievable recommendations."

Data Sharing and Evaluation. Less frequently cited were data sharing and program evaluation. One team proposed, "State initiatives on consolidation of reviews and data sharing." Another team asked for a "comprehensive data/program evaluation tracking over 5 years to determine positive changes/outcomes and identify continuing trends."

> *Comprehensive data/program evaluation tracking over 5 years to determine positive changes/outcomes and identify continuing trends.*

Resources and Funding. Teams wanted resources so that they could carry out local initiative on public awareness and professional training. These included, "More trainings/resources to educate the public; and "Funding for CCPT to sponsor and co-sponsor events in the community and to be more visible in the community. Without funding we are not able to implement ideas for improvement." They turned to the state to "share grant opportunities or increase funding for local teams" and "look into other funding resources for Public Health or DSS." Larger-scale initiatives, teams knew, could not proceed without state funding such as for prevention services,

family planning, “obesity initiatives,” and incentivizing “mental health providers to establish services in rural counties.”

System-Level Advocacy. They strongly urged the state to advocate for systemic reforms. These included: “Support increased funding to access to Prevention Services/Child Welfare Services /Family Planning”; “Advocate for increases in the array and funding of treatment services”; and “Medicaid transformation advocacy.”

In summary, 34 teams set local objectives in 2020, for a grand total of 90 objectives. The objectives that they set for local action paralleled those that they recommended for improving child welfare services in their communities. Their local objectives fell into three main categories: public education and training, developing stronger programs, and improving team functioning. When asked to assess their achievement of their objectives, their ratings showed that they tended to have more success in achieving specific objectives that did not require outside resources. The onset of the pandemic frequently disrupted plans for accomplishing objectives, with the result that teams were often less than successful or needed to change course. Despite the roadblocks mounted by the pandemic, teams found ways to persevere and identified four principal facilitators within their local communities: drawing on the strengths of team members, partnering with other organizations, following through on plans, and advocating for county supports and funding. They also recognized the necessity of state-level support for systemic changes. They asked NCDSS for assistance in four areas: CCPT technical assistance, training, and networking; data sharing and evaluation; resources and funding; and system-level advocacy.

1) Further Supports for Putting Recommendations into Action

The last survey question was: “What further support would help your team put your recommendations into action? Their responses are summarized in Appendix C. Out of the 84 teams, 30 wrote about what else they needed in support, and quite a number offered richly detailed and contextualized comments.

Rather than specifying needed supports, some teams simply said that they could resume their normal operations once the pandemic is under control. For example, one team explained, “The COVID pandemic halted the progress of the CCPT and efforts to move forward with establishing goals regarding recruitment of team members from families.”

Many of the responses reiterated previously identified needs such as for state guidance and funding. One team noted, “We are planning to make a technical assistance request regarding the inclusion of family partners, tracking data, and some general training on the roles of effective CCPT's.” Another team observed, “Funding is always an issue. Hearing from other counties what is working, successes they have had, strategies they have developed to implement local changes and more guidance from the state on how to help our community implement the changes. It would be nice if there was more contact between the state and the local CCPTs.”

A number of teams explained why their county required more supports. For instance, one team pointed out, “Our county is small and some of the things that would be helpful to a few folks in the county unfortunately can't be provided due to the cost to operate versus the number of folks who would actually use the services.” Deeply troubled by the inadequate care of children, another CCPT emphasized, “You can't ask for more funding enough. If you have enough staff to

do this job it would be great but when children are being kicked out of placement due to behaviors that leaves them in the local DSS all day (pandemic so there's no school) and all night (no placement because people want well behaved children). That leaves Social Worker's in the office all day not being able to get their other work done."

Our county is small and some of the things that would be helpful to a few folks in the county unfortunately can't be provided due to the cost to operate versus the number of folks who would actually use the services.

In their concluding remarks, a team reflected on the year and why they needed far greater clarity on state expectations for teams: "Our team has a very engaged, positive working relationship with one another. CCPT does not review specific cases unless we have a social worker who is stuck. That is not a State requirement. If you want us to do that, you need to make that a State requirement. We just call one another when we have an issue and get it fixed that way. We also review all of our fatalities, but we review them a year later when the State sends them to us. We would be happy to review them in real time, but that will require the State telling DHS that is a policy that they have to follow."

In summary, 30 teams laid out their need for further supports, often in richly detailed and contextualized statements. Some stated that they mostly needed the pandemic to be over to resume their normal operations. Many of the responses reiterated previously identified needs such as for state guidance and funding and networking opportunities with other CPPTs. Teams wanted more outreach from the state, clarification of state expectations for teams, and understanding of their situations.

2020 Recommendations of the NC CCPT/Citizen Review Panel Advisory Board

As summarized by the U.S. Children's Bureau, CRPs under CAPTA are intended to examine "the policies, procedures and practices of State and local child protection agencies" and make "recommendations to improve the CPS system at the State and local levels." In fulfilling this mandate, the NC CCPT/Citizen Review Panel Advisory Board used the extensive information and ideas from the current and earlier CCPT surveys to formulate the recommendations listed below. The Advisory Board met in two subcommittee meetings and then a meeting of the whole board to prepare and finalize the recommendations. The CCPTs identified a range of means for supporting their work. The Advisory Board was very cognizant that supports for CCPTs were all the more necessary in sfy 2021 as localities grappled with the effects of the coronavirus pandemic. Hence, a recommendation specific to these needs is proposed below for strengthening the work of the CCPTs.

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

RECOMMENDATION 1 – DEVELOP A PLAN FOR A RACIALLY EQUITABLE APPROACH TO CHILD WELFARE IN NORTH CAROLINA

State fiscal year 2020 has been characterized by a heightened national attention to social justice and racial equity. Efforts are being made at the federal, state, and local levels to acknowledge and address racial disparities in child welfare policy and practice. Leadership has been provided by Black, Brown, Indigenous, Immigrant, and Impoverished peoples and communities. The recommendations put forth in this report should be considered through the lens of racial equity and actions should reflect efforts toward a racially equitable approach to child welfare.

Local

4. *In SFY 2022,*
    a. Encourage child welfare staff, CCPTs, and other interested community members to discuss their responses on the end-of-year survey in regard to racially equitable child welfare in their community.
5. *In SFY 2023,*
    a. Support child welfare staff, CCPTs, and other interested community members, including family and youth, to participate in forums to raise awareness of racial equity issues in service delivery.[8]
6. *In SFY 2024,*
    a. Involve child welfare staff, CCPTs, and other interested community members, including family and youth, in assessing their commitment to action on developing a racially equitable approach to child welfare.

[8] Example: System of Care (SOC) *Building an Equitable Results-Based Organization.*

State

D. In SFY 2022,

a. Support the Advisory Board in discussing racial equity, resources, and processes.
b. Support panels to engage Advisory Board members in defining racial equity in child welfare.
c. Host a statewide virtual conference to review possible models for racial equity in child welfare.
d. Support Advisory Board in review of end-of-year survey results on items related to a racially equitable approach to child welfare.
e. Respond to Advisory Board's recommendations on process for engaging local CPPTs, child welfare, and their community and family partners in discussion of the results.

E. In SFY 2023,

a. Assess commitment of state and local child welfare, CCPTs, and other community partners, including family and youth, to develop a plan for instituting a racially equitable approach to child welfare in North Carolina.
b. With sufficient commitment, funding, and a coordinating organization(s),
    i. Engage state and local child welfare and their community partners in identifying how racial inequities affect service delivery in one policy area (ex. testing, reporting, Plan of Safe Care, and home removals); and
    ii. Analyze the potential impact of current developments in federal and state policy on racially equitable service delivery in this one policy area.

F. *In SFY 2024, with Advisory Board*

a. Review process and content learning from sfy's 2022 and 2023.
b. Develop next steps re: racially equitable child welfare in North Carolina.

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

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

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

[9] https://www.congress.gov/114/plaws/publ198/PLAW-114publ198.pdf
[10] https://www.ncdhhs.gov/infant-plan-safe-care/place-of-delivery#affected_by_substance_abuse

Local

3. *In SFY 2022, request review and recommendations on child welfare's POSC policies and forms by the NC Child Welfare Family Advisory Council and family violence organizations.*
4. *In SFY 2023, dedicate a county role/position to the complex and multilevel needs of families who are substance involved.*
    a. Develop understanding and expertise on the CAPTA 2016 Plan of Safe Care legislation[11] and the required cross collaboration implementation in North Carolina.
    b. Prioritize collaboration and communication with local partners in working with shared families experiencing child welfare involvement and substance use disorders, with 42 CFR part 2 compliant releases of information in place.
    c. Consider outreach and collaboration with community prenatal care providers to provide education on the Infant Plan of Safe Care and consider developing the POSC prenatally for those identified in treatment.
    d. Seek and develop 'in-house' expertise and familiarity with common issues related to substance use disorders and child welfare involvement, including medication for opioid use disorders during pregnancy and postpartum. Provide consultation to staff on these cases.[12]
    e. Prioritize referral and connection to substance use disorder professional for comprehensive clinical substance use disorder assessment when a case has been screened in for investigation/assessment and the parent/caregiver is not currently in treatment.
    f. Identify, with the assistance of LME_MCO, key local substance use disorder treatment agencies with whom county agency can develop an MOU/MOA to include facilitating timely substance use disorder assessments and communication back to county child welfare agency. MOU/MOA can include required participation of SUD agency staff in CCPT.
    g. Develop regular communication channels with the delivering hospitals and free-standing birth centers, to support education of the Plan of Safe Care notification requirements, including differentiation between 'notification' and 'report of child abuse or neglect', and aggregate data feedback related to their notifications. Provide guidance to these healthcare staff on what information is ideally provided when making a notification based on infant meeting 'substance affected' criteria. Guidance on timing of the notification from healthcare provider to child welfare is also needed. Review 42cfr Part 2 and provide training to healthcare providers involved in delivery and care of infant, on confidentiality requirements. Notifications (no clear indication of risk to the child) require consent to share information about substance use disorder treatment per federal regulation (42cfr part 2).

[11] https://ncsacw.samhsa.gov/topics/plans-of-safe-care-learning-modules.aspx
[12] https://ncpoep.org/key-messages/infant-care-providers/

h. Request that local DSSs and CCPTs review all screened-out notifications of infants identified as 'substance affected'. CMARC and SUD treatment providers are essential partners in this review.

State

3. *In SFY 2022, dedicate a state DSS position, with back up, to the complex and multilevel needs of families who are substance involved and the agencies that work with them to prevent harm and to support treatment and recovery*. [13]
   d. Develop understanding and expertise on the CAPTA 2016 Plan of Safe Care legislation and the historic and required cross collaboration implementation in North Carolina.
   e. Prioritize collaboration and transparency with state partners in working with shared families experiencing child welfare involvement and substance use disorders.
   f. Support regional and local child welfare agencies to develop in-house understanding, expertise and familiarity with common issues related to substance use disorders and child welfare involvement, including medication for opioid use disorders during pregnancy and postpartum. Provide consultation to staff on these cases.
4. *In SFY 2023, utilize NCDHHS Subject Matter Experts in developing and revising policies and procedures that relate to infants and children identified as impacted by family/caregivers substance use, including Infant Plan of Safe Care*.
   a. Review existing information provided by perinatal substance use providers, and develop a guidance document and expand educational outreach to all providers and care managers.

RECOMMENDATION 3 – SUPPORT THE DEVELOPMENT OF A STRATEGIC PLAN TO IMPROVE CROSS SYSTEM PARTNERSHIPS BETWEEN SYSTEMS OF CARE (SOC) AND CCPTS.

There are currently 75 System of Care (SOC) collaboratives that cover a total of 91 counties. Required functions of these Collaboratives include strengthening the Community Collaborative through developing the nine characteristics of a well-functioning collaborative (including an emphasis on cross-system collaboration); influence the development of broad evidence-based SOC behavioral health service array and practices consistent with System of Care values and principles; and support behavioral health workforce capacity building through the co-development and support of child and family team training and local system of coaching and monitoring of child and family team implementation. The following recommendations are designed to strengthen cross system collaboration, communication, and functioning.

Local

3. *In SFY 2022, provide structured support to local CCPTs in establishing cross systems communication and planning to accomplish the following:*
   a. CCPTs request via the local Systems of Care Coordinators presentations on:

[13] https://ncsacw.samhsa.gov/topics/plans-of-safe-care-learning-modules.aspx

i. the LME/MCO revised role in the local Behavioral Health (BH) and Intellectual and Developmental Disability (I/DD) service system in sfy 2022 (given the beginning of Standard Plans on July 1, 2021,
ii. their anticipated conversions and mergers into Tailored Plans come July 1, 2022, and
iii. the requirement of all contracted BH and I/DD providers to address social determinants of health and how this happens locally (including the use of NC 360).

b. CCPTs to request that Standard Plans make presentations on the Standard Plan's role and responsibility in the local Behavioral Health and Intellectual and Developmental Disability service delivery system as of July 1, 2021.
c. CCPTs to review cases to ascertain whether families have CFTs by more than one agency (e.g., SOC, Child Welfare), and if so identify the impact on families.

4. *In SFY 2022, provide structured support to local CCPTs in maintaining cross systems communication and planning to accomplish the following:*
    a. Local CCPTs work with LME/MCOs and Standard Plans to establish communication channels and develop formal protocols for the exchange of information between the systems when reviewing cases.
    b. CCPTs to present their work (including the End of Year CCPT Recommendations) to the local SOC Community Collaboratives (and other local child interagency groups). Request assistance (particularly from the local SOC Collaboratives) in increasing knowledge of local public agency resources and community-based resources and improving access for DSS-involved children.
    c. CCPTs to work with SOC Collaboratives to develop a service delivery flowchart that identifies specific areas where barriers to service for DSS-involved children surface. Then create a plan for workgroups to be established to brainstorm solutions to ease or remove those barriers.

State

2. *In SFY 2022, prioritize cross system communication to review, revise, and develop requested materials to facilitate cross system operations at the local level.*
    a. Collaborate with DMH/DD/SA and the Division of Health Benefits (DHB) to develop guidance sheets for CCPTs to use in understanding Standard Plans and Tailored Plans.
    b. Work with DMH/DD/SA to identify key commonalities and disparities between CFT models used in the state and improve the training curricula for each model.
    c. Develop a joint DSS and DMH/DD/SA statement emphasizing the importance of cross-system communication and collaboration to streamline the CFT meeting burden for families.
    d. Collaborate with DMH/DD/SA to develop a cross-system training on confidentiality requirements and guidance materials on what Child Welfare workers can request from LME/MCOs and Standard Plans and from individual BH providers.

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

State fiscal year 2020 has been characterized by substantial operational barriers due to COVID-19. Despite these barriers, CCPTs have adapted to carry out their mandated work. With the understanding that the pandemic presented tangible challenges to operation, CCPTs would benefit from additional communication and support from the Division. These recommendations include requests for updates on the state's progress in responses to *SFY* 2019 recommendations as well as requests for future support.

8. *Provide a review and update of the Division's response to the Advisory Board's recommendations from SFY 2019. The summarized update is then to be distributed to local teams for their review. Specific items for review include:*
    a. Within the context of the implementation of the NC Practice Model, NC DHHS/DSS plan to train the state and local child welfare workforce on essential functions, core activities, and practices standard that advance the assessment of risk and the potential of future harm.
    b. National Council on Crime and Delinquency review of tools, data, and policies, their recommendations, and the Division's response to those recommendations.
    c. Progress on establishing the structure of NC CFP system and implications for enrolling in the national database of case specific child deaths.
    d. Results of collaboration with UNC-CH School of Medicine, Child Medical Evaluation Program, NC Pediatric Society Committee on Child Abuse and Neglect, and other organizations to develop diagnostic criteria for healthcare providers to identify near fatalities.
    e. Results of NC DHHS/DSS review of NC's Child Fatality Prevention System targeting improving data collection systems, conducting Intensive Child Fatality Reviews, and expanding the Child Medical Evaluation Program.
    f. The funding of positions under the CME program located at UNC Chapel Hill School of Medicine in *SFY* 2021.
    g. The development of the T/TA Request Form.
    h. The efforts to redesign CRP and child fatality systems and associated implications for funding of CCPTs as recommended in *SFY* 2019.
    i. Request for staffing and/or consultants with the requisite expertise in policy, research, and community outreach for the CRP as recommended in sfy 2019.
9. *In SFY 2021, prioritize the development of a standard operating procedure (SOP) for CCPTs in anticipation of continued COVID-19 restrictions and normalization of telecommunication.*
    a. This SOP should include but is not limited to guidance on approved telecommunication platforms, policies on data sharing, policies and procedure on sharing of confidential information (e.g., medical, mental and behavioral health records), and meeting requirements.
    b. This SOP should consider the policies and procedures of partnering organizations and service providers.
    c. The SOP should be developed in collaboration with CCPT and other relevant organizations to facilitate point (b).

10. *In SFY 2022, dedicate a DSS position to the operational support of CCPTs. Historically, this position has proved exceedingly beneficial to facilitating optimal functioning of the teams and would play a critical role in enabling the implementation of the recommendations outlined in this report.*
11. *Beginning in SFY 2022, provide funding to local teams.*
    a. Allocate annual funding of $1,000 per team for operational and project support.
    b. Assist teams with understanding requirements on documenting the expenditure of the funds and assessing their local impact; and
    c. Ensure that the results of the funds are summarized, and a report provided to funding sources and the Advisory Board.
12. *Beginning in SFY 2022, ensure local teams receive supports that they request.*
    a. Ensure requested supports such as notification of grant opportunities, informational and material support for local planning efforts (ex., brochure on safe sleeping), and interceding with other state players (ex., courts); and
    b. Document these efforts, and report on them to the Advisory Board.
13. *Beginning in SFY 2022, foster exchanges of CCPTs from different locales.*
    a. Offer cross-county summits and other forums through online means to encourage robust exchanges and creative ideas for child welfare improvements.
    b. Identify topics for these exchanges with local teams and the Advisory Board.
    c. Capitalize on these forums to offer trainings and/or provide relevant updates and information.
14. *In SFY 2022, continue to explore changing the data-collection protocols to permit the researchers to share survey results with individual teams identified:*
    a. Review steps for moving from having de-identified data in reports to identifying the results by individual teams and providing the identifiable data to the NC CCPT/CRP Advisory Board, the Board's subcommittees (ex., CRPs), and NC DSS.
    b. Consult the Children's Committee of the NC Association of County Directors of Social Services (NCACDSS) and other pertinent bodies on these changes in survey procedure;
    c. Clarify changes to the contract with North Carolina State's Center for Family and Community Engagement that would allow for the identified data to be analyzed and reported on.
    d. Support using identified data to offer local CCPTs education and mutual support.

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

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Appendices
Appendix A: Survey Process and Results

Timeline of CCPT Survey, 2020

Table A-1 Timeline of CCPT Survey

Date	Activity
August 3, 2020	NC CCPT Advisory Board ad-hoc survey subcommittee developed end-of-year survey
August 27, 2020	NC CCPT Advisory Board finalized the survey
September 3, 2020	Survey materials sent to NC DSS for Approval
September 16, 2020	NC State University Institutional Review Board approved research protocols protecting participants
October 1, 2020	NC DSS sent letters to the County DSS Directors and to the CCPT Chairs to notify them about the survey
October 5, 2020	NC State University Research CCPT Team distributed survey to CCPT Chairpersons or designees followed by weekly reminders to unfinished respondents
January 4, 2021	NC DSS reminded CCPT Chairs to complete the survey
January 15, 2021	Deadline for survey submission
January 30, 2021	Extended deadline for survey submission
March 31, 2021	NC CCPT Advisory Board reviewed first draft of survey findings and report and created preliminary recommendations
April 12, 2021	The Advisory Board reviewed the initial draft of the report
May 3-4, 2021	Discussion groups were held to discuss content of the recommendations
May 10, 2021	The Advisory Board finalized and approved the recommendations
May 21, 2021	End of Year Report to NC DSS
TBD	Results of the survey to CCPT

Local CCPTs Submitting Survey Report, 2020

Table A-2 Counties of CCPTs Submitting Survey Report

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

Note. The survey was sent to 101 CCPTs of whom 84 responded.

Responding CCPTs by County Population Size, 2020, (N=84)

Table A-3 Responding CCPTs by County Population Size

County Size	Total Counties	Total Responding Counties	Percent
Small	54	43	80%
Medium	35	30	86%
Large	11	11	100%

LME/MCOs and Number of Member Counties Responding to Survey, 2020

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

LME/MCO	Number of Member Counties	Total Responding Counties	Percent
Alliance Behavioral Healthcare	4	3	75%
Cardinal Innovations Healthcare Solutions	20	19	95%
Eastpointe	10	8	80%
Partners Behavioral Health Management	9	9	100%
Sandhills Center	9	7	78%
Trillium Health Resources	25	19	76%
Vaya Health	23	19	83%
Total	100	84[a]	84%

Note. Member counties affiliated with a Local Management Entity (LME)/Managed Care Organization (MCO), as of March 24, 2018. See https://www.ncdhhs.gov/providers/lme-mco-directory. Eastern Band of Cherokee Nation not affiliated with an LME/MCO.

Organization of CCPTs and Child Fatality Prevention Team (CFPTs) in Counties, 2020, (N=83)

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

CCPT/CFPT Organization	Number of Counties	Percent
Separate CCPT and CFPT	16	19.3%
Combined CCPT and CFPT	66	79.5%
Other	1	1.2%

Appendix B: Cross-Year Comparisons

Table B-1. Child Maltreatment and Maltreatment Fatalities by Year

Year	Range of Notifications	Total Notifications	Total Cases Reviewed	Most Common Type of Review
2015	0-9 (F)	39 (F)	617	Combined CCPT and Child Fatality Prevention Team
2016	0-24 (F)	109 (F)	443	Combined CCPT and Child Fatality Prevention Team
2017	0-9 (F)	84 (F)	415	Combined CCPT and Child Fatality Prevention Team
2018	0-15 (F)	105 (F)	450	Combined CCPT and Child Fatality Prevention Team and intensive state child fatality review conducted by NC DSS
2019	0-14 (F)	85 (F)	436	NC DSS conducted intensive state child fatality review
2020	0-11 (F)	83 (F)	399	CCPT conducted case review

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

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

Year	Selection Criteria 1	Number of CCPTs (%)	Selection Criteria 2	Number of CCPTs (%)
2015 (*n*=73)	Active Case	64 (87%)	Multiple Agencies Involved	49 (67%)
2016 (*n*=64)	Active Case	47 (72%)	Multiple Agencies Involved	41 (63%)
2017 (*n*=63)	Active Case	53 (84%)	Child Safety	44 (70%)
2018 (*n*=88)	Active Case	48 (55%)	Multiple Agencies Involved	38 (44%)
2019 (*n*=89)	Active Case	61 (69%)	Child Safety	51 (57%)
2020 (*n*=83)	Active Case	55 (66%)	Multiple Agencies Involved; Repeat Maltreatment	50 (60%)

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

Type of Information	2015 (*n*=73)	2016 (*n*=65)	2017 (*n*=62)	2018 (*n*=88)	2019 (*n*=89)	2020 (*n*=83)
Reports from Members and/or Case Managers	71 (97%)	60 (92%)	61 (98%)	57 (65%)	67 (94%)	61 (74%)
Case Files	60 (82%)	49 (75%)	52 (85%)	56 (64%)	61 (86%)	56 (68%)
Information on Procedures and Protocols of Involved Agencies	44 (60%)	38 (58%)	39 (63%)	34 (39%)	47 (66%)	47 (57%)
Child and Family Team Meeting Documentation	28 (38%)	21 (32%)	27 (44%)	21 (24%)	30 (42%)	30 (36%)
Medical Examiner's Report	24 (33%)	18 (28%)	14 (23%)	21 (24%)	25 (35%)	22 (27%)
Individualized Education Plan	18 (25%)	16 (25%)	12 (19%)	6 (7%)	21 (30%)	20 (24%)
Other	8 (11%)	6 (9%)	8 (13%)	9 (10%)	10 (14%)	11 (14%)

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

Type of Information	2017		2018		2019		2020	
	Combined (*n*=61)	Separate (*n*= 16)	Combined (*n*=72)	Separate (*n*=13)	Combined (*n*=53)	Separate (*n*=16)	Combined (*n*=66)	Separate (*n*=16)
Reports from Members and/or Case Managers	45 (74%)	15 (94%)	45 (63%)	10 (77%)	50 (94%)	15 (94%)	47 (71%)	13 (81%)
Case Files	37 (61%)	14 (88%)	47 (65%)	7 (54%)	45 (85%)	14 (88%)	40 (61%)	15 (94%)
Information on Procedures and Protocols of Involved Agencies	29 (46%)	9 (56%)	25 (35%)	7 (54%)	37 (70%)	9 (56%)	25 (53%)	12 (75%)
Child and Family Team Meeting Documentation	20 (33%)	6 (38%)	18 (25%)	3 (23%)	23 (43%)	6 (38%)	22 (33%)	8 (50%)
Medical Examiner's Report	13 (21%)	1 (6%)	19 (26%)	1 (7%)	20 (38%)	4 (25%)	18 (27%)	4 (25%)
Individualized Education Plan	9 (15%)	3 (19%)	5 (7%)	1 (7%)	16 (30%)	5 (31%)	15 (23%)	5 (31%)
Other	5 (8%)	1 (6%)	8 (11%)	0 (0%)	8 (12%)	1 (6%)	8 (12%)	3 (19%)

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

CCPT/CFPT Organization	2014 (*n*=71)	2015 (*n*=87)	2016 (*n*=86)	2017 (*n*=80)	2018 (*n*=88)	2019 (*n*=89)	2020 (*n*=83)
Separate CCPT and CFPT	18 (25%)	23 (26%)	17 (20%)	17 (21%)	14 (15%)	17 (19%)	16 (19.3%)
Combined CCPT and CFPT	53 (75%)	63 (72%)	66 (77%)	62 (78%)	77 (83%)	66 (74%)	66 (79.5%)
Other	0 (0%)	1 (1%)	3 (3%)	1 (1%)	1 (1%)	2 (2%)	1 (1.2%)

Note: Number of counties (percent)

Table B-6. Mandated CCPT and CCPT/CFPT Members and Mean Rate and Rank of Participation, 2017, 2018, 2019, and 2020

	2017 Average (Rank)		2018 Average (Rank)		2019 Average (Rank)		2020 Average (Rank)	
Mandated Member	Combined (*n*=61)	Separate (*n*=16)	Combined (*n*=73)	Separate (*n*=13)	Combined (*n*=73)	Separate (*n*=13)	Combined (*n*=62)	Separate (*n*=15)
DSS Director	3.17 (4)	2.38 (9)	3.25 (4)	3.69 (7)	3.16 (4)	2.94 (4)	3.10 (4)	2.67 (5)
DSS Staff	3.90 (1)	3.75 (1)	3.88 (1)	4.54 (1)	3.90 (1)	3.94 (1)	3.71 (1)	3.67 (1)
Law Enforcement	2.82 (8)	2.53 (8)	2.77 (7)	3.85 (6)	2.91 (7)	2.76 (7)	2.90 (7)	2.53 (6)
District Attorney	1.93 (11)	2.31 (10)	1.70 (13)	2.92 (10)	1.88 (13)	2.53 (9)	1.95 (12)	1.53 (10)
Community Action Agency	2.83 (7)	3.00 (6)	2.66 (8)	3.46 (9)	2.68 (8)	2.47 (10)	2.52 (8)	2.20 (7)
School Superintendent	2.40 (9)	2.69 (7)	2.36 (9)	3.54 (8)	2.24 (10)	2.65 (8)	2.50 (9)	1.13 (11)
County Board of Social Services	2.35 (10)	2.19 (11)	2.24 (11)	2.85 (11)	2.20 (12)	1.94 (11)	2.10 (11)	2.07 (9)
Mental Health Professional	3.57 (2.	3.50 (2)	3.30 (3)	4.46 (2)	3.44 (2)	3.59 (2)	3.26 (2)	3.20 (2)
Guardian ad Litem	3.10 (6)	3.00 (5)	3.03 (6)	3.92 (4)	3.07 (5)	3.06 (3)	2.95 (5)	2.87 (4)

Public Health Director	3.17 (5)	3.06 (3)	3.17 (5)	3.92 (3)	3.07 (6)	2.88 (5)	2.94 (6)	2.13 (8)
Health Care Provider	3.23 (3)	3.00 (4)	3.37 (2)	3.85 (5)	3.41 (3)	2.82 (6)	3.15 (3)	3.13 (3)
District Court Judge			.92 (16)		.94 (16)		.73 (16)	
County Medical Examiner			1.47 (14)		1.28 (14)		1.39 (14)	
EMS Representative			2.21 (12)		2.26 (9)		2.19 (10)	
Local Child Care or Head Start Rep			2.29 (10)		2.21 (11)		1.81 (13)	
Parent of Child Fatality Victim			1.06 (15)		1.09 (15)		1.08 (15)	

Table B-7. Total County Participation by Year

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

CLEVELAND		x	x	x	x	x	x
COLUMBUS	x	x	x	x		x	x
CRAVEN	x	x	x	x	x	x	x
CUMBERLAND	x	x	x	x	x	x	x
CURRITUCK	x	x	x		x	x	x
DARE	x	x	x	x	x	x	x
DAVIDSON	x	x	x	x	x	x	x
DAVIE	x	x					
DUPLIN	x	x					x
DURHAM			x	x	x		x
EASTERN BAND OF CHEROKEE NATION (QUALLA BOUNDARY)				x		x	
EDGECOMBE	x	x	x	x	x	x	
FORSYTH		x	x		x	x	x
FRANKLIN	x	x		x	x	x	x
GASTON		x	x	x	x	x	x
GATES	x	x	x	x	x	x	x
GRAHAM		x	x	x	x	x	x
GRANVILLE			x		x	x	x
GREENE			x		x	x	
GUILFORD	x	x	x	x	x	x	x
HALIFAX	x	x	x	x	x	x	x
HARNETT	x	x	x	x	x	x	x

HAYWOOD		x	x	x	x	x	x
HENDERSON	x	x	x	x	x	x	x
HERTFORD	x	x	x	x	x	x	x
HOKE	x	x	x	x	x	x	x
HYDE	x	x	x	x	x	x	x
IREDELL	x	x	x	x	x	x	x
JACKSON	x	x	x	x	x	x	x
JOHNSTON	x	x	x	x			
JONES	x		x		x	x	x
LEE		x	x	x	x	x	
LENOIR	x	x	x	x	x	x	x
LINCOLN	x	x	x	x	x	x	x
MACON	x	x	x	x	x	x	x
MADISON	x			x	x	x	x
MARTIN	x	x	x	x	x	x	x
MCDOWELL			x		x		
MECKLENBURG		x	x	x	x	x	x
MITCHELL	x	x	x	x		x	
MONTGOMERY	x	x	x	x		x	x
MOORE		x				x	x
NASH	x	x	x	x	x	x	x
NEW HANOVER	x	x	x	x	x	x	x
NORTHAMPTON		x	x	x	x	x	

ONSLOW	x	x	x	x	x	x	x
ORANGE	x	x	x	x	x	x	x
PAMLICO		x		x			
PASQUOTANK	x	x	x	x	x	x	x
PENDER	x	x	x		x	x	x
PERQUIMANS		x			x	x	x
PERSON	x	x	x	x	x	x	x
PITT			x	x	x	x	
POLK	x	x	x	x	x	x	x
RANDOLPH	x	x	x	x	x	x	x
RICHMOND	x	x	x	x	x	x	x
ROBESON	x	x	x	x	x	x	x
ROCKINGHAM	x	x	x	x	x	x	x
ROWAN	x	x	x		x	x	x
RUTHERFORD	x	x	x	x	x	x	x
SAMPSON	x	x	x	x	x		x
SCOTLAND		x	x	x	x	x	x
STANLY	x	x	x	x	x	x	x
STOKES	x	x	x	x	x	x	x
SURRY		x	x	x	x	x	x
SWAIN	x	x	x		x	x	x
TRANSYLVANIA						x	x
TYRRELL			x	x	x	x	x

UNION		x	x	x	x	x	x
VANCE	x	x	x	x	x	x	x
WAKE		x	x	x	x	x	x
WARREN	x	x	x		x	x	x
WASHINGTON				x	x		
WATAUGA	x	x	x	x	x	x	x
WAYNE	x	x	x	x	x	x	x
WILKES	x		x	x	x	x	x
WILSON	x	x	x	x	x	x	x
YADKIN	x	x	x	x	x	x	x
YANCEY	x	x			x	x	x

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

Table B-8. Small County Participation by Year

COUNTY	2014	2015	2016	2017	2018	2019	2020
RESPONDENTS (%)	36 (71%)	42 (82%)	40 (78%)	38 (78%)	45 (83%)	46 (85%)	43 (80%)
ALEXANDER		x			x		x
ALLEGHANY	x	x	x	x	x	x	x
ANSON		x	x	x			
ASHE		x				x	x
AVERY	x	x	x	x	x	x	x
BEAUFORT	x					x	
BERTIE	x	x		x			x
BLADEN	x	x	x	x	x	x	x
CAMDEN	x	x	x	x	x	x	x
CASWELL	x	x	x	x	x	x	x
CHATHAM	x	x	x	x	x	x	x
CHEROKEE			x	x	x		x
CHOWAN	x	x	x	x	x	x	
CLAY	x	x	x	x	x	x	x
CURRITUCK	x	x	x		x	x	x
DARE	x	x	x	x	x	x	x
DAVIE	x	x					
GATES	x	x	x	x	x	x	x
GRAHAM		x	x	x	x	x	x
GRANVILLE			x		x	x	x
GREENE			x		x	x	
HERTFORD	x	x	x	x	x	x	x

HOKE	x	x	x	x	x	x	x
HYDE	x	x	x	x	x	x	x
JACKSON	x	x	x	x	x	x	x
JONES	x		x		x	x	x
LEE		x	x	x	x	x	
LENOIR	x	x	x	x	x	x	x
LINCOLN	x	x	x	x	x	x	x
MACON	x	x	x	x	x	x	x
MADISON	x			x	x	x	x
MARTIN	x	x	x	x	x	x	x
MCDOWELL			x		X		
MITCHELL	x	x	x	x		x	
MONTGOMERY	x	x	x	x		x	x
NORTHAMPTON		x	x	x	x	x	
PAMLICO		x		x			
PASQUOTANK	x	x	x	x	x	x	x
PENDER	x	x	x		x	x	x
PERQUIMANS		x			x	x	x
PERSON	x	x	x	x	x	x	x
POLK	x	x	x	x	x	x	x
RICHMOND	x	x	x	x	x	x	x
SCOTLAND		x	x	x	x	x	x
STANLY	x	x	x	x	x	x	x
STOKES	x	x	x	x	x	x	x
SWAIN	x	x	x		x	x	x
TRANSYLVANIA						x	x
TYRRELL			x	x	x	x	x

WARREN	x	x	x		x	x	x
WASHINGTON				x	x		
WATAUGA	x	x	x	x	x	x	x
YADKIN	x	x	x	x	x	x	x
YANCEY	x	x			x	x	x

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

Table B-9. Medium County Participation by Year

COUNTY	2014	2015	2016	2017	2018	2019	2020
RESPONDENTS (%)	30 (77%)	36 (92%)	36 (92%)	34 (87%)	32 (91%)	32 (91%)	30 (86%)
ALAMANCE	x	x	x	x	x	x	x
BRUNSWICK	x	x	x	x	x	x	
BURKE	x	x	x	x	x	x	x
CABARRUS	x	x	x	x	x	x	x
CALDWELL		x	x		x	x	
CARTERET		x	x	x	x	x	x
CLEVELAND		x	x	x	x	x	x
COLUMBUS	x	x	x	x		x	x
CRAVEN	x	x	x	x	x	x	x
DAVIDSON	x	x	x	x	x	x	x
DUPLIN	x	x					x
EDGECOMBE	x	x	x	x	x	x	
FRANKLIN	x	x		x	x	x	x
HALIFAX	x	x	x	x	x	x	x
HARNETT	x	x	x	x	x	x	x
HAYWOOD		x	x	x	x	x	x
HENDERSON	x	x	x	x	x	x	x
IREDELL	x	x	x	x	x	x	x
JOHNSTON	x	x	x	x		x	
MOORE		x				x	x
NASH	x	x	x	x	x	x	x
ONSLOW	x	x	x	x	x	x	x

ORANGE	x	x	x	x	x	x	x
PITT			x	x	x	x	
RANDOLPH	x	x	x	x	x	x	x
ROCKINGHAM	x	x	x	x	x	x	x
ROWAN	x	x	x		x	x	x
RUTHERFORD	x	x	x	x	x	x	x
SAMPSON	x	x	x	x	x		x
SURRY		x	x	x	x	x	x
UNION		x	x	x	x	x	x
VANCE	x	x	x	x	x	x	x
WAYNE	x	x	x	x	x	x	x
WILKES	x		x	x	x		x
WILSON	x	x	x	x	x	x	x

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

Table B-10. Large County Participation by Year

COUNTY	2014	2015	2016	2017	2018	2019	2020
RESPONDENTS (%)	5 (50%)	9 (90%)	10 (100%)	8 (80%)	11 (100%)	10 (91%)	11 (100%)
BUNCOMBE	x	x	x	x	x	x	x
CATAWBA	x	x	x	x	x	x	x
CUMBERLAND	x	x	x	x	x	x	x
DURHAM			x	x	x		x
FORSYTH		x	x		x	x	x
GASTON		x	x	x	x	x	x
GUILFORD	x	x	x	x	x	x	x
MECKLENBURG		x	x	x	x	x	x
NEW HANOVER	x	x	x	x	x	x	x
ROBESON	x	x	x	x	x	x	x
WAKE		x	x	x	x	x	x

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

Appendix C: Qualitative Responses

Difficulties faced completing work

Adjusting to virtual platform

We moved seamlessly to a virtual platform

We are currently scheduling regular meetings virtually.

Had to move meetings to virtual format

Meetings have changed over to ZOOM. Participants do not feel as engaged in the process over ZOOM and are more hesitant to comment. Prevention activities have been lessoned.

There seems to be less interaction among the team with the virtual meetings. There has been consistent technical difficulties.

We were not able to meet a for a couple of meetings but have been doing so now by Zoom.

meeting on-line

missed one monthly meeting early in pandemic, then adjusted to virtual meetings with no issue

We meet virtually instead of in person but that hasn't affected our ability to meet and discuss cases

We are meeting through a conference call.

Meetings were suspended March 20 - July 20. They resumed in August via conference call

Our team has moved to virtual meetings during the pandemic. Our team members have found that some services provided to our families have benefited from the ability to be virtual while other services have been more difficult to provide virtually.

Have met virtually for several meetings and had a few issues with technology.

Team has not been able to hold community awareness events.

We found it difficult to meet in person so we started meeting virtually. As a result of virtual meetings, we have seen an increase in engagement and participation from members.

During the pandemic we have been holding virtual CCPT Meetings, we have experienced less attendance & not as much conversation during the meetings from the attendees. One good thing is that we have been able to hold all bi-monthly meetings during the pandemic.

We have had meetings through Zoom as well as agencies are closed due to pandemic as resources are more difficult to achieve discussions regarding cases and in general are a little more difficult virtually but improving

Initially it was face-to-face meetings, but we have since been holding virtual meetings,

Meeting virtually. Many members have had to concentrate on COVID-19. DSS has had to adapt, and State did not provide last quarter data

As a team, we have felt it is difficult to fully discuss death info among team members virtually.

The team has moved to virtual meetings done on Zoom instead of in person meetings. This has a limiting effect on the meeting since members are more hesitant to speak for fear of talking over someone else. It also makes it more difficult for members to effectively network and build strong professional relationships with their community partners.

The meetings are held virtually.

We are able to meet virtually via Microsoft Teams, but the Chair is the Medical Director for our local health department and has been unable to lead the meeting for the last 2 months due to COVID-19 vaccination rollout.

Have had to meet via Zoom to meet the social distancing requirements.
At first, we had a hard time finding a platform to meet virtually that met HIPPA requirements.
just more difficult to communicate as we did in person and still getting used to the platform.
[County] had a cyber-attack in May 2020. Systems were down for about a month. As chair I was not able to connect with team members during that time.
We have begun holding meetings virtually instead of in person.
unable to meet, not everyone is able to meet virtually
By August 2020, we were able to meet through Microsoft Teams to securely discuss issues in our community.
We switched from in-person to virtual meetings.
Meeting virtually
Technical difficulties in trying to hold virtual meetings.
Having virtual meetings has presented challenges. We have battled technology issues. Also, some have been quarantined or in isolation due to COVID-19.
initial confusion/different guidance from DHHS-DSS and DHHS-DPH about allowable formats in which to meet virtually
We are meeting on protected Zoom. No documents are shared by email - hand delivery only.

COVID-19 Pandemic
A CCPT meeting was scheduled in April 2020, but it had to be postponed due to COVID-1919.
COVID-19 19 has impacted many individuals and families in being self-sufficient and this has, in turn, impacted our work with families.
We didn't meet in March or May due to pandemic.
pandemic
COVID-19 restrictions.
Two meetings were cancelled due to Pandemic Restrictions.
Also, there has been a lack of participation during the pandemic.
Only one meeting was able to be held in 2020 due to the pandemic and availability of members due to such.
We canceled our May 2020 meeting due to COVID-19.
Also, much of our staff has been frontline workers to the COVID-19 pandemic response.
team members affected by the pandemic

Attendance/Scheduling/Availability
We have had 3 of our meetings via conference call this year, June, September and December. This was not difficult, just a change in circumstances. Was difficult to not be able to see all of the team members.
We do not meet in person so had to work through confidentiality issues of meeting online and reviewing cases.
Initially we cancelled one meeting because it was scheduled soon after the pandemic closed in person meetings, and we were not yet prepared to host virtual meetings.
Low attendance at the meeting even with it being virtual
Availability of participants, equipment
Agency staff not being available- working from home; more difficult to access records; 4th quarter data on child deaths not available.
Getting everyone together during the pandemic since we are no longer meeting face-to-face.
We did miss one meeting.
We did cancel out May 2020 meeting.
Inconsistent attendance by a judge and medical examiner.
GETTING PEOPLE TO JOIN MEETINGS SCHEDULING MEETINGS
there have been issues with members being available due to demands of their jobs due to

COVID-19, since most members are essential staff.
we missed one of our quarterly meetings but were able to do the last one virtually
We did miss one of our meetings. We are now meeting regularly.
Team members serving the community are extremely busy at work.
everyone's schedule, having to find alternative ways to meet to accommodate everyone
using webex with low band width and being able to meet regularly
Getting all parties that need to be at the table to attend, participate, and provide valuable feedback.
Lack of Judicial Participation and difficulty with obtaining mental health records

Confidentiality/HIPPA concerns
Our meetings are combined with the Child Fatality Prevention Team and we suspended meetings during the pandemic due to confidentiality concerns.
Due to meeting with our CFPT, they were required to meet HIPPA requirements.
cannot discuss cases due to confidentiality

Lack of in-person meeting
Normal face-to-face meetings were halted in March 2020 but reconvened in August of this year.
limited access to one another, other obligations
No face-to-face meetings
Adequate meeting space to social distance has been a major issue.
Having in person meetings, workloads of agencies increasing, agency leaders not being in the physical offices
Social Distancing and scheduling zoom meetings
the ability to have a face-to-face meeting
Reluctance to meet via zoom instead of in person.
The pandemic lead to an inability to have face-to-face contact however meetings have consistently been held via teleconference.
Unable to have in-person meetings
Implementing Social distancing. Many are hesitant to meet, and others do not have the equipment for virtual meetings.
5/19/20 meeting was not held due to COVID-19 and the inability to social distance. A email meeting was held in June 2020.
Our team had suspended meeting for 4 months before resuming with zoom meetings.
virtual meetings only
Conducting face-to-face meeting
Not able to have face-to-face meeting and/or members not available for Zoom meetings.
We meet electronically.

Resources shared among CCPT members

Grant
Grant Opportunities
Grant information
Funding/Grants
[County] Coalition on Infant Mortality Grant
Grant options
Safety Makes Sense Grant
High Point Community Against Violence Grant
Grant ideas/notifications to meet identified needs

Financial
Financial resources
Funding resources for families
CARES Act Funding
Governmental Assistance
Food opportunities
State funding of $339
Financial opportunities for clients

Community
Future Community Events
[County] School Events
Community resources
Resources for Community Support
Community Resources and action plans
Outreach information
New Community Agencies/Organizations
School resources
Community initiatives
Community resources/organizations
Community Studies
Community programs
Community supports
Event and awareness event information
Upcoming events

Children
Water safety for children
Child Advocacy Center, Teen Trauma Support Group, Various Therapeutic Services
School-Suicide prevention grant
Car safety
[County] Partnership for Children
Child welfare information
Baby Boxes

Health and wellness
Mental health/substance abuse services
LME Mental Health
Health department
[County] Overdose Prevention Coalition
Mental health services
Drug Task Force Grants
New treatment providers
Public Health
Mental Health/VAYA
mental health resources
Man hours/staffing resources
Available resources/program lists
Substance abuse
Substance abuse counseling
Mental Health/Substance Abuse Providers
Health Department-family planning opportunities
Mental Health Resources

Education/Training
Educational Resources
Training Opportunities
Webinars/Training Opportunities
Educational Opportunities
Training
Learning opportunities (e.g., webinars)
Parenting class
Transportation Info
Training/public awareness/education
Resiliency Training
Knowledge/Education resources
Available trainings
Education

Family support
Christmas Assistance
Food Resources
Safe Sleep Pilot Program
Safe Sleep/Pack and Play
Childcare resources
COVID-19 Resources/Relief
Safe Spot
Support for Families
Pre-K
DSS-foster home licensing opportunities
Children Health Care Programs
IEP & 504 Plans
Crisis Assistance/Resources

Miscellaneous
State fatality Review Results and Recommendations
Military Resources
Expertise
Developmental
Programs for citizens
MDT
Advertising $
New County Resources
Opportunities
LIEAP

Collaborative ideas and plans
DHHS Eligibility Services
Agency specific resources
Advocacy
Legal changes
Invitations to community events
Housing
Workforce resources
Referrals
Direct services
Pack & Plays

Barriers to participation and family/youth partner engagement

COVID-19 Pandemic
COVID-19
We didn't focus on this particularly because of COVID-19
COVID-19 pandemic
Pandemic
Time constraints related to responding to the pandemic and keeping staff and families safe.

Recruitment difficulty
Difficulty identifying participants
Hesitancy about serving/ not enough slots available to invite to join the team
Lack of recruitment
The team is currently exploring and hopes to have a family or youth partner in 2021
Lack of initiative from members to recruit and invite to meetings
Being able to identify a family that is emotionally ready to be on the CCPT/CFPT.
Unable to be in community to recruit and address potential reasons
Have not recruited/identified
Could not get commitments for team members
No participants
Concern of confidentiality and difficulty identifying ones to participate.
We did not actively engage family and/or youth
Difficulty recruiting/engaging
Family interest is low
No invitation
Team did not invite them
Case discussions can trigger trauma; Additionally, it's hard to find youth that are emotionally Stable and mature enough to handle and discuss the serious subject matters.
Time & availability

Miscellaneous
Due to cases still being open in DSS or LE investigations this does not allow families to take part in CCPT
Statutory prohibition
We have a family member who participates 100% of the time.
Lack of transportation, lack of reimbursement, uncertainty about role - survey tool allowed for Only one selection at a time
Have not sought participation
Other commitments
Unable to check more than one all apply
The tool only will allow for one check even though it says otherwise- sensitive nature, need for training lack of dedicated person

Community needs

Child sleeping safety

We partnered with the Community Collaborative for Craven County Children, the Craven County Health Department and Carolina East Medical Center for the Safe Sleep Campaign. We also partnered with the health department to purchase car seats.
We partnered with many community agencies and non-profits to carry out the Embrace Recovery Rally.
Hot Car Display - large scale thermometer readout of internal car temps. even on overcast or relatively "cool" days
Safe Sleep initiative Child Abuse Prevention Plan
Discussions around safe sleep and sharing of an on-line training resource to become a safe sleep ambassador.
From a fatality involving an infant due to suffocation (infant sleeping in car carrier) the agency developed safe sleeping policy which is utilized in Child Welfare cases & CC4C cases to assure children are in safe sleeping situations.
Team members gave a presentation to local law enforcement agencies and the Highway Patrol on how to report child maltreatment including reviewing policy concerning caretakers who are impaired drivers and the necessity of reporting all vehicular child deaths.
[County] Safe Kids Coalition TASCO (Turning Adversity Into Success for Children in Onslow) Distribution of car seats and pack and plays Resiliency Training.
Provided grant money to community agencies to provide pack n plays and co-sleepers to address safe sleeping issues with families in need of baby bedding assistance.
A pediatrician on the CCPT partnered with UNC Maternal Health to pilot a Safe Sleep initiative in our county. This initiative was cut short due to COVID-19 and UNC not having the pilot program ready to launch.
Our community had a near fatality from a hot car incident. We partnered with Safe Kids Coalition and promoted a hot cars event in our community.

Mental health: Suicide, trauma
Teen Suicide
Our CCPT partnered with mental health and the school system to implement training in the school for suicide prevention for the area. COVID-19 has made this more difficult, however, the team is committed to making this a priority in the area.
identifying substance abuse services or mental health services within the county
The need for more help from mental health to find leveled placements for children with extreme behavioral issues was identified.
Worked closely with Mental Health Providers to help get the needs of the community met during this difficult time
Before the pandemic started, we were partnering with our local school system to create an essay contest for 8th graders to have an open discussion about suicide.
[County] DSS partnered with our local LME (Partners) to implement the Partnering for Excellence Initiative. PFE works to identify and refer children at risk due to trauma to mental health services by Gold Starred trauma clinicians. Children receive a trauma screen by the SW and if they screen positive for trauma; they are referred for a Trauma Informed Comprehensive Clinical Assessment (TICAA). This initiative was discussed during a CCPT meeting and community partners asked to join by selecting staff to attend the Trauma 101 trainings. Through the trainings, DSS has been able to identify and train trauma trainers from the school system, GAL and Partners.
Our community has been involved in a Trauma Informed Communities Grant

Miscellaneous
The team worked with the Medical Examiner's Office at the state and local level

to address identified issue of the ME's Office having lack of information when making decisions to screen in or screen out a case.
In 2020, our team continued to promote racial equity in a number of facets to include infant mortality and youth on youth violence. We solicited the support, resources, and engagement from community stakeholders and partners outside of our traditional team members.
Parenting Programs Social Supports Emergency Housing
Resiliency education
The CCPT partnered with community organizations and continues to umbrella the Early Intervention Team under the CCPT which continues to address truancy concerns for school aged children in the community and offer them resources to help meet family needs to ensure children are going to school. This initiative is ongoing and has faced new challenges with COVID-19.
The CCPT partnered with community organizations to umbrella the new TEAM LED/Peer Support program under the CCPT it is a grant funded program that was completed by the Health Department and Sheriff's Department. TEAM LED is a diversion program where law enforcement can choose to refer someone who is about to be arrested for minor crimes (theft, possession etc.) to a Peer Support Specialist instead of being charged and arrested. The program also allows for Community referrals to the Peer Support Specialist as well.
and also, a health equity grant (EMBRACE) to improve birth outcomes. Chatham County also was granted in October a large, three-year grant to implement a Family Treatment Court.
We were starting an initiative with our local CAC, N.E.E. D local action network, Domestic Violence Taskforce and Edgecombe-Nash LAN committee with some upcoming events however with COVID-19 everything was cancelled. We were not able to meet the goals in 2020. Collaboration with the local MDT to provide training for all County Schools, Presentations at the local community college, Collaboration and joint training with law enforcement
Note: each of these also addresses information for our military children and families as well. *Collaboration with School Health Advisory Council to address medical issues of children and ensure that needed equipment and supplies were accessible, even though the students were not in school (20 partner agencies-including CCPT members). *Reclaiming Futures supporting increased focus on Community Fellowship to identify natural helpers and partnerships for mentoring/training/support for families and youth. This initiative has helped the community redesign how RF cases are handled in court, lead treatment agency is looking at new services to engage and support families (SPARKS, KRAFT), all fellows are looking at risk factors for this population and how to ensure high risk youth are not lost in the system and protective factors are identified and in place. *Substance Affected Youth Team- although pandemic has impacted on this group and our numbers are up, we still have had no deaths of youth and all had a Plan of Safe Care. We are still trying to work collaboratively to address difficulty for families adapting to virtual sessions. *Our local CAC did not close during the pandemic and has modified services and remained accessible to do forensic interviews and provide advocacy services for families and on site or virtual treatment services. We have continued our MDT Case Reviews and CMEs, although not done as soon as we would like due to pandemic, are still done by our child maltreatment specialty physician. We are also continuing

Stewards of Children sexual abuse prevention training in the community by having our trainers certified to do this virtually.
Awareness, program integration, financial support.
Our team coordinated a joint meeting between the CCPT, the CFPT and court administrators to discuss concerns regarding Abuse, Neglect and Dependency Court. understanding and making suggestions for service delivery and partnership with MAT agencies.
Partnered with local rental companies to get the word about the Stick Around Don't Drown campaign targeted towards vacationing families who rent homes.
We worked hard to get rid of Cardinal Innovations and their overall incompetence. We are proud to be the first county to disengage.
Our CCPT/CFPT team is more of the "think tank" and we often "spin off" ideas/activities to our Safe Kids coalition. They are the work horse!
We created a resource QR code that we have available to the community. This QR code pulls up a map of the resources that we have in Scotland County. This provides a safe, informative, and engaging opportunity for our community to have the opportunity to what resources are available.
Partnered with the school and Law enforcement for Child Abuse Prevention and Bike Helmets for local children
The team is working with Boys and Girls Club of the Albemarle. The goal is for the county to have after school care within Tyrrell County.
Healthy outdoor activities for families and youth such as a skate park with other fun appropriate things to do.

Fatality Notification

Collaboration with government agencies
Having CCPT participation from the local medical community
[County] DSS has agreed to send a copy of the fatality notification to the chair of the CCPT.
Notification from the state, local law enforcement, and DSS.
DSS
Good communication and maintaining relationships between differing partners
Our Child Welfare would present these cases to the CCPT
All cases involving death are always discussed with the CCPT.
Local DSS, law enforcement, or Public Health
DSS staff would make the team aware
The health department informs of us fatality reviews
Reports from [County] DSS, Medical Providers, Law Enforcement, etc.
Continue information sharing across the agencies- promote process where reporting is centralized with designated point person
DSS and law enforcement presented the case.
An open or closed CPS, Law Enforcement or health care provider
Our DSS notifying them
DSS would bring the case to the CCPT team for review. Notification from hospital ER, EMS, law enforcement. Additional educational opportunities for community stakeholders/partners.
Deaths of children that CPS is working with or a fatality that is a result of child abuse or neglect.
Our CFPT is combined with CCPT and therefore, the case would be discussed.
DSS obtaining this information
The DSS Director and/or DSS Staff brings the case information to the CCPT

Chair/following CCPT meeting in accordance to DSS/CPS Fatality policy.
Death of a child involved with DSS
These would be received by DSS or other organizations represented on the team, such as law enforcement, and shared with the team.
DSS would send an email notification to CCPT representative to be shared with all members of the team in order for information to be gathered from each prospective agency surrounding their involvement with the family in order to be shared and discussed with the group during CCPT meeting.
DSS notification
DSS staff following policy and statutes.
Notification by DSS (although team members may see on the news)
we receive appropriate communications between all community partners
monthly report out by DSS
Jamie Pearson contacts CCPT chair
[Name] Chair; our Director [Name]; or our Program Manager [Name]
Myself, the CCPT chair, typically reports child maltreatment fatalities to the state.
They would be referred by either DSS, Medical Provider or community family referral
A CPS Assessment Supervisor would notify the chair
Child Fatality Team Chair
Our current protocol of receiving notification from the State.
CPS report
The State mandating that DHS contact CCPT chair at the time of a fatality. As of now, we find out a year later unless it is a difficult case which DHS opts to staff with CCPT because it is a difficult case. That is in the discretion of DHS though. They have no obligation to share anything with CCPT until we find out about the fatality in our quarterly reviews one year later.
Unsure of question?
CPS report which would be shared by CPS Program Manager during CCPT meeting at a closed session
The CCPT is notified of all fatalities involving maltreatment.
EMS, DSS, Law Enforcement
We operate jointly with CFPT so we staff fatalities as a team. We have had none this year.
All Scotland county fatalities are reported to the division of social services to determine if there is a facility review, results are reviewed with CCPT. CFPT reports on all fatalities to CCPT, which are joined together.
[County] DSS notifies the team when fatalities occur.
DSS notification
The quarterly reports come from the State
The CFT Coordinator would be notified about fatalities. DSS would receive a CPS report.

Miscellaneous
It is discussed at the quarterly meeting.
If a fatality were to occur due to abuse or neglect.
A case that has been open within 12 months of a child's death
Identification of a member to obtain and track the data from the appropriate source.
We already have a standard procedure by which this information is shared by our members
actual report

Near Fatality Notification

Collaboration with government agencies

[County] DSS has agreed to send a copy of the near fatality notification to the chair of the CCPT.
Good communication and maintaining relationships between differing partners
Notification from medical provider, law enforcement, and DSS.
The State should require near fatalities be reported to their office, in addition to fatalities, so the information can then be shared with the team.
DSS
Near fatalities where CPS is involved. Our Child Welfare unit would choose these cases to present to the group
All cases involving serious injury are always discussed with the CCPT.
CPS involvement and discussion at the quarterly meeting.
Capturing the data
DDS Staff would make the team aware
DSS or LE bringing this case to the team for review.
Reports from [County] DSS, Medical Providers, Law Enforcement, etc.
DSS presented the case.
An open or closed CPS, Law Enforcement and health care provider
Our DSS notifying them
DSS would bring the case to the CCPT team for review. Notification from hospital ER, EMS, law enforcement. Additional educational opportunities for community stakeholders/partners.
A CPS report and outcomes from a CPS investigation
DSS would bring the case before the CCPT to receive assistance in obtaining services for the family.
DSS obtaining this information
There would be received by DSS or other organizations represented on the team, such as law enforcement, and shared with the team.
The information regarding all child maltreatment that resulted in near fatalities would have to be identified by DSS and information shared with all CCPT team members.
A CPS Assessment Supervisor would notify the chair
DSS notification
We already have a standard procedure by which this information is shared by our members
DSS would provide a report
Actual reports
This information would come from DSS, but we have not encountered any yet.
I would be made aware as the CPS Supervisor and CCPT Chair.
Child Fatality Team Chair
Guilford County DSS provides that information
CPS report
CPS report which would be shared by CPS Program Manager during CCPT meeting at a closed session
The CCPT is notified of all severe explained and unexplained injuries and injurious environment cases.
EMS, DSS, Law Enforcement
Child Protective Services reports
All [county] fatalities are reported to the division of social services to determine if there is a facility review, results are reviewed with CCPT. CFPT reports on all fatalities to CCPT, which are joined together.
DSS notification
DSS presenting the case to the team.
DSS staff following policy and statutes.
Notification by DSS (although team members may see on news)
Jamie Pearson contacts CCPT chair
Reports from medical staff

Education on the term Near Fatality
Definition, protocols, policy, reporting expectations
Education to the medical community about what they need to report

More education on defining "near fatality" for all potential reporting parties
The same as above. I also believe the state needs to better define what constitutes a "near fatality." Is that one with attempted murder charges or what?
I think the recent guidance on the definition of near fatalities will help ensure that these get reported.

Miscellaneous
If such an incident were to occur due to abuse or neglect
Identification of a member to obtain and track the data from the appropriate source.
We receive appropriate communications between all community partners
An understanding of how these would be identified, and which agency would know
Again, I would just be notified of the case; however, I am not sure if there is a requirement for our agency to track and notify those to the state. I would need further training if I am incorrect on that one.

Improvements for case reviews

Training and guidelines
Training that would help with recommendations.
Training
More specific guidelines around what cases are to be reviewed
Updated guidelines
Training from the State Consultant
More trainings on how to appropriately and effectively have a CCPT meeting
Formalized training

Community resources
More information about the services in the community.
It would be helpful for our mental health liaison to be able to provide details of services that they've offered or provided to families during case reviews.
A barrier this past year has been timely access to information- correlated with program changes due to pandemic and staff working remotely and not having access to information at times
More organizational involvement and resources

Collaboration/Partnerships
Continue to encourage consistent participation during the scheduled reviews
If our area had more resources to connect families too.
More participation from all agencies.
Consistent participation from all members as well as training for all members
More participation by other agencies.
Consistent participation from certain sectors of the CCPT membership, better data integration across systems.
Increased attendance and participation by Law Enforcement agencies and the Community Action agency
In order for our CCPT to better carry out case reviews, recruitment of persons from the population/families served by our community partners should be made.
Having a representative from the community that has had involvement with the services offered by the various agencies can bring a more comprehensive outlook to brainstorming and identifying the needs of the community.
Strengthen collaborations with all members of the team
Ensuring all community partners are involved for input in order to have thorough case reviews
nothing
More community participates from other agencies.

A structure format that is used across the state
Better understanding on who should be involved and the overall goal of team.
complete help in everything

Time
More Time Designated for Reviews, Most Members have Multiple Responsibilities
More time for meetings. This is not possible due to the busy schedules of the CCPT members.

Limitations due to COVID-19
This year it has proven to be more difficult due to pandemic, but typically we are good about getting cases to review.
Not having a pandemic that threw us off our normal routine
If COVID-19 was not a factor
We are now able to meet virtually and have our second meeting scheduled in November
Policy from State level approving all virtual options for meetings to ensure confidentiality.
being able to meet in person again

Miscellaneous
Plan to include CFT documentation
Quarterly agenda item to submit and present cases from each agency on a rotating basis.
The CCPT team is thorough in the reviews
Money that is actually earmarked for CCPT so that drinks and snack items can be provided.
For DSS to send cases for us to review
Better direction from the State and a policy which assigns us cases in real time as opposed to one year later in a fatality review. There is nothing that requires DHS to bring CCPT anything. Additionally, in our county, most of the time these necessary consults occur because we have good relationships with partnering agencies. People just call for help directly to the agency without needing to have a formalized CCPT review. We use CCPT more as a networking, information sharing, team building entity. We also look at community deficits in community services and attempt to meet those.
CCPT will carry out reviews on as needed basis to avoid maltreatment
We are developing a written format for presenting cases and having discussions
The State implementing an electronic case management system for all CPS would be helpful.
Having a tool that we can enter data into from case reviews that would allow us to extract meaningful information would be really helpful. Excel is difficult with the complexity of the cases.

Limitations to accessing MH/DD/SA/DV services

COVID-19
COVID-19 impacted the already limited services
COVID-19 interfered with services.
COVID-19 pandemic
The pandemic impacted access, as many providers transitioned to telehealth services.
Health pandemic-COVID-19
Availability Due to COVID-19
Pandemic caused virtual services which could not provide all needed resources, ie., drug screening

Limited resources
Limited selection of providers
Local DV shelter closed
Limited Life Skill services for adults
Limited counseling services for young children
Limited virtual services

Limited access to technology for virtual sessions including CFTs
Homeless shelter has financial problems

Language & cultural barriers
Language barriers - dialect was different
Limited language access for immigrant families
Spanish speaking services
Limited culturally appropriate services for members of certain cultures

Unreceptiveness to families
Lack of interest in available services
Parent prevention of accessing
Parent's readiness to participate in services.

Miscellaneous
Medicaid/Insurance Issues
Problems navigating the service
Staffing issues

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

Adequate service provision
Increase number of mental health providers
Inadequate services I/DD Parents
Child Collaborative Services
Increase access to services
Substance abuse services
Better access to MH/SA services for adults with no insurance
More providers for MH services
Continue to promote quality substance use treatment
Increased and improved access to behavioral health services
Better access to mental health services and more providers
Better access to services in rural counties
Additional DV and Family Violence Services
Improve and expand access to birth control and family planning services
[county] Support implementation of Family Connects program.
Identifying local mental health providers
Accessing MH Services for parents and children, having the system be more user friendly and a diverse menu of services.
There's a lack of Public Housing for Low-Income Persons
Always need assistance with daycare for second shift
Assuring safe sleep for infants
Coordinated DV services
Better Community services
Continuing to front load services
Referrals for trauma focused therapy
More prevention services funded in part by state/federal funds.
Lack of mental health options in the county
More adequate placement options for children with significant behavioral issues
Continue to promote quality mental health treatment
Life skill development services are needed for adults
Work to get SA & MH providers in area
Additional MH services
Providers to offer tele-med support and counseling virtually during pandemic.
More trauma focused providers needed for adults
Lack of psychiatrists in county
Better oversight and enforcement and standardization of MAT programs
Prevention Services

Resources
Link families with resources
Reopening a domestic violence shelter
Increase the quality and number of SA/MH/DD resources
More funding
Housing

Transportation
Availability of transportation and other supportive services for families (e.g., parenting)
Knowledge and access of resources
Lack of available Foster Parents
Increase capacity of providers in DV and substance abuse
More providers for Substance Abuse for parents
Affordable and accessible housing
More facilities for needed for child placements
Additional resources to aid in staff retention
Resources for parents experiencing grief and loss
Identifying local trauma based focused therapist
We need more affordable housing because these children have no where to live and we have tent cities.
Resources
Supports for medically fragile children
Increase and maintain qualified CPS staff to meet policy requirements.
Continuing Peer Support Involvement in CFTs
More trauma informed service options at the local level, especially for adults
Improved accessibility of trauma informed services in the community
Improved plans of safe care
Referrals for psychological testing
Resource Management
Improved services to meet the mental health needs of children
More CPS Social Workers
More treatment options for youth sex offenders
Identify additional community resources and provide to local Child Welfare services
Having resources/services available in the community
Local Management Entity finding placements when needed
Affordable Housing
identifying local substance abuse providers
Financial Resources to pay for needed services
More and Improves Services
Mental Health Services to resume in school
More financial resources for services for undocumented children
Local Drug/Alcohol Treatment/Counseling - Lack of
always need transportation for second shift
Mental Health
Lack of methamphetamine substance abuse treatment
Funding
Follow through with bullying protocol.

Education and training
Ensuring the Community continues to be educated on the role of Child Welfare Services
Safe sleep resources and education for parents
Increasing awareness in the community.
Increase awareness and training around racial equity in child welfare.
Continue to complete trainings
Ensuring Training needs are available for staff and community partners.
Educate the public about child maltreatment awareness.
Trainings between social workers and law enforcement agencies on reporting abuse and neglect of children in the community.
Additional Training Needs
Training and Increasing DSS Staffing
Continue safe sleep education.
Advanced Training for CPS worker
Increase awareness of services
Increasing awareness in the schools regarding suicide, drugs, alcohol, driver safety, mental health issues, etc.
More community education about IPV
Improve community education/awareness regarding DV and substance abuse.
Education to health care provider and schools to make timely reports

Continue education and training for child welfare staff
Assuring that newly hired Child Welfare staff are properly trained and provided regular supervision
Co sleeping education
continue educating on child maltreatment amongst community agencies
Provide education on safe/healthy relationships
CPS Child Safety Checklist
TCDSS to have a SW certified to train foster families
Staff recruitment, training and retention.
Parenting education

Strengthening partnership/collaboration
Continue public awareness
Continue to work closely with stakeholders
Family involvement
Work with community stakeholders to create a community that thrives with multiple healthy, engaging and fun activities for youth
Increase communication with school personnel.
Improved collaboration between local DSS and Cardinal representative
More community partner involvement
Continue communication with community partners
Get rid of Cardinal Innovations as out LME/MCO and replace them with Partners.
Open communication between community partners
Need for better communication between hospital/OB provider and MAT clinic providers about a patient's postpartum MAT dosing
Improved cooperation between DSS and the Court System
Greater provider network
Encourage more participation by DSS with brining cases to present to CCPT
Continued Collaboration with other agencies
Improve relationships with multicultural centers (ex. refugee centers) to ensure timely and accurate service provision to families.
Continued partnerships with CAC for raising public awareness on maltreatment, access to forensic interviews and partnerships with military
family and youth to participate in meetings
Social workers will partner with identified service provider facilitators to begin introduction of services with a warm hand off and allow for personal connection.
Maintain collaboration with Mental Health Providers and Substance Abuse Providers
Continued communication between agencies to obtain services
Continued communication between all agencies that are providing services to families and children.
Increase communication with local medical providers.
Better coordinated services with hospital ER
Improve communication and process with SA treatment providers.
Cultivate better relationships with our school board as our superintendent refuses to attend our meetings. We have worked hard to cultivate that since the elections in November. We now have two school board members on our team.
strengthening communication between community agencies
greater collaboration form LME
Trying to engage all team members in our meetings.
Continue to strengthen relationships with law enforcement
Better communication between mental health providers and child welfare workers.
Streamlined process for local DSS receiving school EC records for client parents
Exploring ways to use social media and virtual avenues to share information with the public about child protection needs.

Ensuring all involved agencies are working towards same goals with families and not having conflicting goals.

Domestic violence support
Continue to promote domestic violence awareness
Domestic Violence Resources
Domestic discord/Relationship services
More programs for DV perpetrators
DV Treatment for perpetrators
Domestic Violence

Parental support
increase parenting class providers
parenting education on appropriate discipline methods
Provide education on prenatal substance use/abuse
Increase access to prenatal care!!!!
Providing support for kinship providers; support navigating systems and managing the day-to-day care of children.

Miscellaneous
Unlicensed day care check out before sending your child
Mandated Reporting
There were no 2020 case reviews
Meeting educational needs/truancy issues during COVID-19
Consistent meetings
MORES
Timely and consistent CPS reporting
Implementation of Family Treatment Court
Protocols for screening drownings
Keep Child Welfare Staff Up to Date on Changing in Policies.
Clearer laws around firearm security
Finding more creative ways to hold meetings virtually.
There were no 2020 case reviews
Substance Abuse
Recognize the essential role Child Welfare Workers
Continued community outreach
Raising Public Awareness
There were no 2020 case reviews

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

Mental health
More Availability for mental health services to children
Increasing access to mental health/substance abuse services for adults who have no insurance
More and easier access to MH services for children in care/ placements
Quality MH/SA oversight
More oversight/help from LME's
Improved efficiency of ICPC so children can be placed with family in a timely manner
Improvements to the mental health system
Increase providers available in communities to provide targeted mental health services such as parent-child interaction therapy.
Medicaid MH case management for children
Eliminating transition of children progressing in therapeutic
More mental health resources for county.
Accessing MH Services for parents and children, having the system be more user friendly and a diverse menu of services.
More access to funding for mental health services

Funding
More funding for resources to be given out as prevention to parents the local agencies and policy around safe sleep.
Funding
Money
Remove poverty as a cause for maltreatment by allocating DSS funds that follow families
More funding for prevention services.

Funding for local Community Child Protection Teams to provide preventive education programs
Financial resources
Prevention Services and Funding from the State
Accept federal Medicaid expansion
It is recommended that the state provide financial support to local DSS to hire more staff.
More funding for DV shelter
Continued Funding for services
more access to funding for substance abuse
Grant information
Funding for additional staff and training
More financial resources for undocumented children
For the state to provide more financial support to local DSS agencies to support technology upgrades.
Provide technical assistance and funding for county departments to develop their own clinical services in-house
Increase support/funding for preventative services
Statewide support - financially and practice-wise to implement a trauma informed child welfare system globally, including prevention services in every county department.
Increased funding for trauma services and trauma training Statewide as children are being traumatized in this pandemic.
More funding for CPS staff and funding for DV programs in the state

Substance abuse support
Support for improved substance use treatment
Parent substance use alone not considered maltreatment
Better support for substance abuse services in Co's

Education/Training
More trainings offered
Continued Training for Child Welfare Staff
Continued Trainings
State participation / training on the local level
Additional training for CCPT members
More training for judicial officials regarding child welfare issues
Virtual training accessibility and availability for child welfare staff
Provide training or training materials for local agencies
Increase access to training and development of new training.
Require/Provide Training for CCPT Members
State mandated training in certain areas such as working with families affected by drugs and alcohol
Additional training for Child Welfare staff
more guidance around substance affected infant
Education on human trafficking
CCPT training for local team
Training
Ensure all child welfare staff receive consistent, evidenced-based and trauma informed
Trainings
resiliency training to help manage the trauma they are exposed to during their work.
More trauma focused providers needed for adults
It is recommended that the state provide more guidance to the local teams about what types of virtual resources the local teams are allowed to use due to them being HIPPA compliant and confidential.
Pre/perinatal focus/education
ability to get staff certified to train foster families
Education of community partners on giving timely reports
Better understanding of what is required from local team.

Resources

Access to data in timely manner
Sharing information and resources
Provide better data integration across various systems such as a universal EMR
Functional electronic case management system so CPS workers can better review history
Increase capacity of providers.
Policy Specific Training for County Workers
More and easier access to SA services for parents
Medicaid expansion
A more financially stable homeless shelter
Ensuring that new programs/initiatives are statewide and can be accessed across all counties (e.g., PPP).
More community resources and groups for parents experiencing grief and loss and its impact
Increase mental health and substance abuse services
Support for local DSS and partner agencies during pandemic and impact on workers and quality of services (limited access to SA tests and interventions)
Transportation
Support for domestic violence awareness
Mental Health crisis - suicide and helping families deal with these issues with their kids.
Support expansion of substance abuse and mental health services
Encourage mental health professionals to rural areas
Standardized integrated health care Resources
Limited Resource Info for Cultural Diversity
Supports for CCPTs
Responding to the local team expressed needs and recommendations
Increase transportation
Improved system for data management
Access to Management Data

Children-specific support

Recruitment and Retention Plan for Child Welfare Staff
Increased support and collaborative efforts between child welfare and mental health in service to dependent and behaviorally challenging youth
Continue to reassess current policies within Child Welfare Services
Policy
Safe Sleep priority
More adequate placement resources for children
Get the teachers vaccinated ASAP so the kids can all go back to school.
Statewide safe sleep initiative and/or state level support for local initiatives
Education to Health Care providers to discuss safe sleep for infants

Health and wellness

Increase support/funding for trauma informed services
Insuring access to Medicaid for children, parents and caregivers
More and easier access to MH services for parents
Access to healthcare (both physical and behavioral) for parents (i.e., parents still need Medicaid when their children are removed from their custody)
Increase parent's access to healthcare and insurance in order to access services to address their needs in order to prevent further maltreatment
Support for improved mental health treatment
NCDHHS and Mental Health MCO's work in partnership to allow families and DSS to receive authorization for higher level of mental health and substance use services when recommended
address the lack of services for children with ASD
Obesity initiatives because all of weight gain we are seeing county wide from children

being home, on a computer, and eating processed foods all day.
Advocate for in-person intensive SA treatment
Increase in therapeutic foster homes in NC- with the requirement that before the child can be discharged for behavior it must be reviewed by the State for approval. Too many kids are having to move placements for the very behaviors that they were put into care for.
Encourage increase of psychiatrists

Miscellaneous
Family and youth participation
Address jurisdictional barriers/issues b/w states
Consistent practice model for CWS across all 100 counties.
Reduce the number of case load sizes
Implementation of a practice model throughout Child Welfare
Mandated state pharmacy reporting
Changing Policy
There were no 2020 case reviews
Easy Access to Bi-lingual Interpreters
Faster turnaround time related case reviews of child fatalities.
Provide local DSS with information on what resources are available on a state level
more regional support
There were no 2020 case reviews
Firearm securing
Greater oversight of MAT programs
NCDHHS and local DSS work in partnership to address the high turnover rate of child welfare social workers
Continued improvement to the NCFAST system to support the SWs practice.
DSS to ask for court intervention quicker
Decrease Caseloads for Child Welfare Staff Due to Complex and Demanding Cases
Additional state level staff available to help guide community driven committees like CCPT.
There were no 2020 case reviews
Ensuring Medical Examiner's Office has CPS history for making decisions to screen in or screen out a case
Increase participation of state representatives

Top three CCPT objectives based on improvement needs

Safe Sleep
Increase availability of safe sleep resources
Safe sleep prevention education
Assuring safe Sleep for Infants
Safe Sleep Ed
Safe Sleep Campaign on the local level
Decrease baby roll over deaths
Increase the number of car seats available
Enhanced Work with Families to Prevent Infant Sleep Related Deaths
Follow up on education of and implementation of safe sleep practices
Developed a sub-committee on safe sleep
Continued education efforts in Safe Sleep positioning for infants
Seek funding for portable cribs combined with safe sleep education

Substance use treatment/Substance-Affected Infants
Increase substance use recovery resources
Improve services for undocumented persons
Increase importance of prenatal care
Improved care of SAI
Substance affected Infants
Access to substance abuse services; maintain Substance Affected Infant Team
Having specific providers to come to the area to work with youth who abuse illicit substances
Protecting Substance Abuse affected Infants
Cessation Tobacco Specialist

Health and wellness services

Improve MH/DD services
Mental health services
Assess local MH/SA/DV resources to meet the needs of families.
Develop stronger child abuse and neglect prevention services
Promote suicide prevention
Strengthen array of behavioral health treatment that provides high quality, evidenced-based services
Improving mental health resources in the community
Focus Topic 2020: Mental Health Resources
Increase in Services

Training/Education
Training and Education
Ways to identify cases to bring to the CCPT for review
Education on farming accidents
Education/Training
Programs around grief and loss groups and educational materials

Public Awareness
Increasing awareness in the community.
Raising Public Awareness
Increase knowledge/awareness of family planning options
Community partners outreach
Continue public awareness
Increase community involvement in addressing youth on youth violence
Continued public education on available services
Identify opportunities to expand community knowledge of ACES. Maintain existing efforts toward a trauma informed child welfare system
Increasing awareness in the schools.
Increase knowledge of the effects of prenatal substance use
Continue promote substance abuse awareness
increase awareness re: driving infractions
Providing ongoing education in Suicide Prevention
Spreading information to the public
Child abuse awareness education with the public. Even though COVID-19 has hindered communication, staff continues to provide resource materials to family.
More awareness around substance abuse affected infant
Increase knowledge/provide education on health and safe relationships
Teen Suicide Prevention/ Ed
Educating service providers on the needs of citizens
Continue educating on child maltreatment amongst community agencies
Accessible information on risk factors for children and families

Collaboration/Participation
Collaboration with local agencies for services
Work more collaboratively and cohesively as a combined CCPT/CFPT team
Maintaining regular contact with schools regarding cases involving school-aged children
Improved participation
Increased participation/engagement from members
Improved comm. b/w agencies
Increase in membership
strengthening communication between community agencies
Collaboration with community resources to improve services.
Partner with community agencies to sponsor training and support awareness events surrounding domestic violence.
Continued Partnership w/ the local drug task force
Get an engaged school board
Collaborated with the school system
Partnerships with community partners
Work with the City of Concord and the Salvation Army to build a new shelter

Adding more community agency representatives to the CCPS

Miscellaneous
Better organization/format - implemented
Protective Factors framework
Team to collect data
Staff retention
More CPS staff
Fewer stuck cases
CPS Child Safety Checklist
Advocate for funding for prevention services on the state level, and on the local level to continue CRP Program after the grant ends.
Advocate for the firing of Cardinal Innovations
Public Housing
After School
Merge CCPT/CFPT to be more efficient
Better quality systemic recommendations
2020 Focus Topic: Teen Suicide Prevention
Trafficking of youth
Foster homes
Safe School Zones
Bring more expert speakers to team meetings
Improve access to housing

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

Collaboration and teamwork
Teamwork and staff dedication
Partnerships with other community agencies
Strong Partnerships
Coming together as a team-making each partner aware of the needs
Commitment from community partners to facilitate trainings
Community partnerships with substance abuse providers to increase virtual sessions as well as face-to-face contacts as indicated; timely access to crisis/detox when indicated; use of community support groups;
Commitment by DSS and others to Team for Substance Affected Infants, even though pandemic was a barrier
Knowledge and experience of team members.
Continuing community partners outreach
Collaboration among CCPT members/Drug Task Force Members
Teamwork
Inviting other organizations to get involve CCPT/CFPT
Inviting providers to share information regarding their services
Ongoing discussion and planning at the bi-monthly meetings
Local lead agency to be the "work horse" for the ideas
partnerships with other community agencies
Communication
Committed Community Partners
Continued collaboration with Housing Authority programs
Initiative of members to reach out to community partners
Commitment by all agencies (law enforcement, EMS, schools, hospitals, medical providers, OP providers to educate and continue to monitor safe sleep practices, including materials being available (including Pack and Plays, Baby Monitors); ensuring referrals are made to home visitation services through PHD, looking at model used with military families on Military Pregnancy Centering groups
Knowledge sharing/ collaboration
Using same language across multi-service agencies
Willingness of local agencies along with the CCPT to collaborate to address the issue.

Team member provided training to local agencies
Collaboration with the local schools
Regular and effective communication with community partners.
CCPT/CFPT
Meetings were held with local LE to figure out ways to strengthen communication and agency relationships
Ongoing discussions on safe sleep and granted community agencies funding to address safe sleep
Efforts from a PAC called Cabarrus Apple Cart and constant community engagement.
Expertise of local CCPT/CFPT
Inviting providers inside and outside of the county to CCPT
Partnership with UNC-CH Maternal Health Collaboration
Support of County Administration to address salary for child welfare staff
Funding from other levels to fund positions, keep staff stable to avoid burnout
MDT reviews through CAC; school phone line for agencies to be able to share information and concerns brought up by students and others- data included on attendance at appointments (medical, MH tx., education), and notifications to others who can follow up
Embrace Recovery Rally - community partnerships
More persons were able to join the meetings because they moved from in-person to virtual
Constant community engagement with the City and Salvation Army's fundraising efforts.
Department Heads involvement

Education/Training
Emailing trainings for team members to participate
A plan of safe care is developed, and staff are trained on safe sleep

Virtual platform
Access to virtual services, youth/MH First Aid training to school system
Meeting invitations are being mailed early and Zoom
Zoom
Meeting virtually

Working progress
Still a work in progress
Not met this objective yet, there needs to be more funding and less red tape for Medicaid Providers to provide services
This was not achieved
Due to the pandemic this goal was not really achieved
Chairpersons met at the beginning of 2020 to start the conversation, but COVID-19 interrupted and shifted focus for 2020

Advocacy
We need to do advocating with local legislators and county commissioners during budget preparation.
Constant advocacy with every elected official we had and providing data and anecdotal stories of Cardinal Innovations failures.
Advocacy

Funding
Trauma Informed Communities Grant Funding
Pasquotank was given the opportunity via Trillium LME/MCO to apply for a Co-Responder
Demonstration Pilot that would support rapid access to mental health services. The application to the RFP was submitted mid December 2020.
We need funding for CCPT to sponsor and co-sponsor events in the community and to be more visible in the community.
The awarding of the Family Treatment Court grant will allow for a substantial

increase in supports for parents who participate in this program.

Resources/Services
There has been some increase of the array of services
"Baby boxes" were purchased and donated by a community resource to DSS for reports involving infants without safe who were identified sleep
Distribution of pack and plays
Improvement with law enforcement and mental health attendance

Miscellaneous
Proactive completion of assessments.
Discussions were limited and topics were identified mid-year of 2020
advertising for more foster homes in the community
CC4C referrals are being made on all reports of substance abuse affected infants and guidance has been developed to assure continuance of agency collaboration
Town and County Manager on board
Clearer NCDHHS-DSS policy guidelines
Consistent process
Compiling data since 2018 on child deaths and causes of the death.

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

Funding
Share grant opportunities or increase funding for local teams
Provide technical assistance and funding for local efforts to address identified needs
More funding for food, advertisement, etc.
Look into other funding resources for Public Health or DSS
More funding, less red tape
Support increased funding to access to Prevention Services/Child Welfare Services /Family Planning
training assistance with engaging community with recommendations/media platforms, etc.
More detailed policy guidance on safe sleep of infants and updated safe sleeping webinars
available for support upon request
Funding for prevention programs within DSS.
Provide support and guidance when the need arises.
Prevention Services and funding from the State
Offer incentives to providers to specific services to counties
Funding
Continue and expand all initiatives at the State level- also funding for materials would be helpful (we received some special funds this year to help us get materials, but they are not continuation dollars)
Funding for CCPT to sponsor and co-sponsor events in the community and to be more visible in the community. Without funding we are not able to implement ideas for improvement.
Provide more financial resources to support safe sleep campaign
Fund obesity initiatives
Advocate for an increase in the array and funding of treatment services
Comprehensive data/program evaluation tracking over 5 years to determine positive changes/outcomes and identify continuing trends
Provide available updated materials or resources.
Provide additional funding for staff

Need funding for these positions. people don't realize it's not just the number of children in care that should be looked at but the time spent on these cases. You have a child with behavior problems who blows a placement that puts SW's in the office babysitting taking time away from their other cases, or a child who doesn't have daycare during a pandemic who has to be supervised at the local DSS. Those making these guidelines need to walk in the shoes of a social worker for a month to see what it's really like
Provide funding or resources for safe sleep of infants
Ongoing funding
Increase housing subsidy availability

Training
Training
Provide state developed training and materials that can be shared
Provide more training for CCPT members
Provide more financial resources
Overall, with all three objectives having availability of training and quality technical assistance will be beneficial.
More PowerPoint trainings
Offer training and technical support to staff annually on this topic
Provide training for schools, healthcare providers, and law enforcement on how to report child maltreat and fatalities
Support all schools to have a suicide prevention training
More trainings/resources to educate the public
Offer training to providers on how to best meet the needs of high-risk populations
Additional training
Offer SW to get certified virtually to be able to train foster families

Advocacy
Medicaid transformation advocacy
Continue to advocate for more supports for substance abuse assessments and treatment-Continue to Advocate

Collaboration and communication
Establish regular consultation between the state and the local CCPT
work in collaboration with other agencies
Continue to keep local teams updated on State changes/issues.
Continue to serve on the Housing Committee, etc.
Hold an annual conference for local CCPT members to attend or at least the chair and a representative from each team to attend to network, share ideas that will promote consistency across the state in regard to identifying needs and training on how to make more achievable recommendations
Work in collaboration with other agencies

Miscellaneous
Offer incentives for mental health providers to establish services in rural counties
more therapeutic foster home and more guidelines put in place for them
Respond to questions readily.
Maybe a site visit by the state to participate in local CCPT meetings.
Encourage Secretary Cohen to allow our county to leave Cardinal Innovations
State initiatives on consolidation of reviews and data sharing
Increase legal authority to have earlier intervention
Provide materials that could be given to citizens to spread the word about available resources
Increase eligibility for undocumented persons
Help with recruitment of CCPT members
Address the statewide affordable housing crisis

Further support that would help teams implement recommendations

Funding

Implementation budget

Funding is always an issue. Hearing from other counties what is working, successes they have had, strategies they have developed to implement local changes and more guidance from the state on how to help our community implement the changes. It would be nice if there was more contact between the state and the local CCPTs.

Additional community resources and funds.

increase state/local funding for initiatives

Financial support would make a big difference

You can't ask for more funding enough. If you have enough staff to do this job it would be great but when children are being kicked out of placement due to behaviors that leaves them in the local DSS all day (pandemic so there's no school) and all night (no placement because people want well behaved children). That leaves Social Workers in the office all day not being able to get their other work done. That leaves Social Workers in the office all night supervising a child sleep, not allowing them to return to the office during normal working hours to get their job done. You have SW's transporting children because foster parents are willing to do so(they should be treating this child as their own) If this isn't an expectation that you have of foster parents then let's get transportation workers in the local DSS to help eliminate that responsibility off of the SW so they can focus on the real issues of the family not transporting them. There's lots to be said about understaffed agencies and the burnout factor that it creates. A burnt-out SW does no good for a child in a crisis. We want to make sure that the SW is in the moment and alert of things that are going on, not walking around in a fog

Increase funding to local community agencies responsible for creating health and safety outcomes for children and families, creation of an universal EMR to ensure providers of physical/mental health have access to vital information needed to ensure successful outcomes, and address jurisdictional issues between counties in bordering states involving DSS and child protection.

Prevention efforts and funding from the State

Funding for the CCPT to use creatively to address local needs that are identified.

Funding from the Government

Funding for evidence-based practices.

Funding issues are always a barrier.

State participation

Someone from the state to become a part of our local CCPT.

Follow up and feedback from the State to indicate how concerns that have been shared from the local level are being addressed on the State level.

Limitations due to COVID-19

Ability to meet in person

Once we are able to have full participation without the barriers of the COVID-19 epidemic we can work on the recommendations.

Hopefully the impact of COVID-19 will not prevent us from meeting in the future to try to come up with ways to get around the barriers we face but Our county is small and some of the things that would be helpful to a few folks in the county unfortunately can't be provided due to the cost to operate verses the number of folks who would actually use the services.

The COVID-19 pandemic halted the progress of the CCPT and efforts to move

forward with establishing goals regarding recruitment of team members from families. This will be established at future meetings.

Resources

More providers in local community for mental health and substance abuse

More providers who can provide mental health. The biggest is trauma mental health counselors. So many children/youth/families that have experienced trauma. Sex offender treatment programs. We need a Child Advocacy/Sex Trafficking Center in Person County. Our goal for 2021 is to get a MDT together. We need your support. Any resources and information would help.

Need help with reorganizing and starting again

We are planning to make a technical assistance request regarding the inclusion of family partners, tracking data, and some general training on the roles of effective CCPT's.

Training

Training for all community partners to encourage active participation.

Training from the State Consultant.

I feel like an overall training for the processes of these meetings and how to get family/youth involved. I want to ensure that we are covering what we need to cover and think a training on state's expectations would be beneficial.

Training from State level.

We would like to see CCPT training offered by the state.

Virtual trainings would be beneficial

Miscellaneous

More dedicated time to do the work of the CCPT.

A few comments on the totality of this survey. Our team has a very engaged, positive working relationship with one another. CCPT does not review specific cases unless we have a social worker who is stuck. That is not a State requirement. If you want us to do that, you need to make that a State requirement. We just call one another when we have an issue and get it fixed that way. We also review all of our fatalities, but we review them a year later when the State sends them to us. We would be happy to review them in real time, but that will require the State telling DHS that is a policy that they have to follow.

Due to staff changes, we were unable to locate 2020 local objectives.

Learning how to advocate for needed services at the local and state level. An initiative was started by the CCPT team in 2019 working with Prevent Child Abuse about making a prevention plan and advocating for trauma informed services but this initiative fell off after the pandemic hit. Could re-visit this option with the team to talk about future of this initiative.

Implementing suggestions on consolidation of groups at the State level that will lead to a decrease in number of reviews; clearly delineating roles and implementing some of the recommendations on mandated training for all DSS agencies. Sharing information from the report from the Institute of Medicine workgroup

Policy clarifications and revisions and fostering a supportive approach to parents of substance abuse effected infants. The development of a standard of living plan within counties.

Appendix D: Copy of 2020 Survey

CCPT Survey 2020

2020 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 2020 survey. The NC CCPT Advisory Board is responsible for conducting an end-of-year survey of local CCPTs and preparing a report to the North Carolina Division of Social Services (DSS). In the report, the information provided by the local CCPTs is aggregated without identifying individual team responses and the NC CCPT Advisory Board makes recommendations on how to improve public child welfare. DSS then writes a response to the report.
The survey results assist local teams in preparing their annual reports to their county commissioners or tribal council and to DSS. You can choose whether to complete the survey and can decide which questions to answer. The one exception is that local teams will be asked to provide the name of their county or Qualla Boundary. This makes it possible to track which CCPTs completed the survey and to acknowledge the specific local CCPT in the annual report.

The survey responses are transmitted directly to the researcher, Dr. Sarah Desmarais, at North Carolina State University. This means that survey responses are NOT transmitted to DSS or to the NC CCPT Advisory Board. Dr. Sarah Desmarais and the other members of the research team Dr. Emily Smith and Dr. Joan Pennell will respect the confidentiality of local CCPTs and will NOT link individual responses to local CCPTs. De-identified findings may also be included in presentations, trainings, and publications. The 2017, 2018, and 2019 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 2020 Survey (6430)
Principal Investigator: Dr. Sarah Desmarais (919) 515-1723
What are some general things you should know about research studies?
You are being asked to take part in a research study. Your participation in this study is voluntary. You have the right to be a part of this study, to choose not to participate and to stop participating at any time without penalty. The purpose of this research study is to gain a better understanding of how to improve child welfare services across the state. We will do this through collecting survey data from local CCPTs regarding their functions and objectives.

You are not guaranteed any personal benefits from being in this study. Research studies also may pose risks to those who participate. You may want to participate in this research because CCPT has the opportunity to contribute to improving public child welfare and protecting children from maltreatment. You may not want to participate in this research because the responses of the local CCPT may identify that they made a particular answer.

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

What is the purpose of this study?

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

Am I eligible to be a participant in this study?

There will be approximately 101 number of participants in this study, representing all counties in North Carolina and Qualla Boundary. Chairpersons of the CCPT in each county and Qualla Boundary will be sent a survey.

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

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

What will happen if you take part in the study?

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

The total amount of time that you will be participating in this study is 20 minutes. In preparation for completing the survey, it is recommended that the local CCPT Chair meet with the team to discuss what responses to provide to the survey questions.

Risks and benefits

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

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

Right to withdraw your participation

You can stop participating in this study at any time for any reason. In order to stop your participation, please refrain from submitting the survey. If you choose to withdraw your consent and stop participating, you can expect that your survey responses will not be recorded.

Confidentiality

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

Compensation

You will not receive anything for participating.

What if you have questions about this study?

If you have questions at any time about the study or the procedures, you may contact the researcher, Dr. Sarah Desmarais, at Center for Family and Community Engagement, North Carolina State University, C.B. 8622, Raleigh, NC 27695-8622 or 919-513-0008.

What if you have questions about your rights as a research participant?

If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact the NC State IRB (institutional Review Board) Office via email at irb-director@ncsu.edu or via phone at 1.919.515.8754. An IRB office helps participants if they have any issues regarding research activities. You can also find out more information about research, why you would or would not want to be a research participant, questions to ask as a research participant, and more information about your rights by going to this website: http://go.ncsu.edu/research-participant

Consent to Participate

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

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

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

1. This survey covers the work of your CCPT for the period January – December 2020.
2. Your survey responses must be submitted online (via Qualtrics). Do not submit paper copies to DSS or NC CCPT Advisory Board. As you work in your survey, your work will save automatically, and you can go back to edit or review at any time before you submit.
3. You can print a blank copy of this survey to review with your team, and you will be able to print a copy of your completed survey report when you finish the survey.
4. Your team members should have the opportunity to provide input and review responses before your survey is submitted. Please schedule your CCPT meeting so that your team has sufficient time to discuss the team's responses to the survey.
5. In addition to the CCPT meeting time, set aside approximately 25 minutes for filling in the team's responses on the survey.
6. For questions about the survey and keeping a copy for your records, contact the Research Team at ccpt_survey@ncsu.edu.
7. Please complete and submit the survey online (via Qualtrics) on or before **January 15th, 2021.**

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
- Union
- Vance
- Wake
- Warren
- Washington
- Watauga
- Wayne
- 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

- Wilkes
- Wilson
- Yadkin
- Yancey

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

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

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

Has the pandemic affected your team's operation?
- Yes
- No

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

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

How often do subcommittees within your CCPT meet?
- We do not have subcommittees
- Annually
- Biannually
- Quarterly
- Bimonthly
- Monthly
- Other _____

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

Which of the following applies to your CCPT?

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

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

In 2020, how frequently did the following mandated members participate in your CCPT?

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

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

In 2020, how frequently did the following mandated members participate in your CCPT?

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

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

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

In 2020, how many additional members took part in your CCPT to include organizations, family and youth partners?
A family or youth partner is a youth or adult who has received services or is the caregiver/parent of someone who has received services, and who has firsthand experience with the child welfare system. If zero, type 0

- Organizations _____.
- Family and youth partners _____.

List the organization that additional members represent.

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

How well does your CCPT prepare for meetings?

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

How well does your CCPT share information during meets?

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

How well does your CCPT share other resources?

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

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

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

How well has your CCPT effected changes in your community?

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

In 2020, other than mandatory members, did <u>family or youth partners</u> serve as members of your CCPT? *A family or youth partner is a youth or adult who has received services or is the caregiver/parent of someone who has received services, and who has firsthand experience with the child welfare system.*

- Yes
- No

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

_____

In 2020, other than mandatory members, how frequently did family or youth partners participate in your CCPT?

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

In 2020, were family or youth partners invited to attend CCPT meetings?

- Yes
- No

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

- Yes
- No

In 2020, which of the following strategies did your CCPT use to successfully engage family and youth partners on your team? (The checklist below comes from CCPT survey responses in past years. Check all that apply and add your own.)

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

- Drawing family and youth partners into the meeting discussions
- Ensuring that discussions are in clear and understandable language for all participants
- Debriefing with family and youth partners after meetings
- Using team members already on the CCPT to offer family perspectives
- Other _____

In 2020, which of the following reasons prevented some family or youth from taking part in your CCPT? (The checklist below comes from CCPT survey responses in past years. Check all that apply and add your own.)

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

In 2020, which of the following reasons prevented your CCPT from engaging some family or youth on your team? (The checklist below comes from CCPT survey responses in past years. Check all that apply and add your own.)

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

During 2020, did your CCPT partner with other organizations in the community to create programs or inform policy to meet an unmet community need?

- Yes
- No

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

_____
_____

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

_____

Are you aware of other county-level collaboration your CCPT is involved in? (For example, the System of Care Community Collaborative, Juvenile Justice-Behavioral Health (JJSAMP) team, School Health Advisory Council, School Mental Health Committee, Local Interagency Council, and Smart Start Partnership.)

- Yes
- No

If yes, list the interagency group's name and describe your CCPT's role in each interagency group.

Collaboration 1 _____
Collaboration 2 _____
Collaboration 3 _____

From January through December 2020, how many notifications of child maltreatment fatalities were made by:
Child maltreatment fatalities are cases where the death was caused by abuse, neglect, or dependency and where the family had received Department of Social Services (DSS) child welfare services within 12 months of the child's death.

If zero, type in 0. _____
- Local DSS ___
- Public Health __

From January through December 2020, how many notifications of child maltreatment near fatalities were made by:
The NC Division of Social Services defines a near fatality as an act that a medical provider certifies placed the children in serious or critical condition as result of child maltreatment.

If zero, type in 0. _____
- Local DSS ___
- Public Health __

What would facilitate your CCPT receiving notification of child maltreatment fatalities?

_____

What would facilitate your CCPT receiving notification of child maltreatment near fatalities?

_____

Of the child maltreatment fatalities of which you were notified of by your local DSS, how many received the following types of review?
A case may have more than one type of review. This means that the total for all types of case reviews may be greater than your number of child maltreatment fatalities.

Combined CCPT and Child Fatality Prevention Team conducted case review _____

CCPT conducted case review _____

NC DSS conducted (intensive) state child fatality review _____

Other _____

What is the total number of cases of child maltreatment reviewed by your CCPT between January and December 2020?
- Number of cases reviewed _____
- No cases reviewed _____

How many were fatalities?

_____

How many were near fatalities?

_____

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

Which of the following criteria did your CCPT use in 2020 for selecting cases for review? Check all that apply. Please write in other criteria that you used.

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

Which of the following contributory factors to children being in need of protection did you use in 2020 for selecting cases for review? Check all that apply.
Terms such as alcohol use have been inserted as preferred identifiers but current terms on the child protection form are in parentheses. Definitions for these terms may be found in the NCANDS Child File Codebook

- Caregiver(taker) - Alcohol use (Abuse)
- Caregiver(taker) - Drug use (Abuse)
- Caregiver(taker) - Intellectual/Developmental Disability (Mental Retardation)
- Caregiver(taker) - Emotionally Disturbed
- Caregiver(taker) – Visually or Hearing Impaired
- Caregiver(taker) - Other Medical Condition
- Caregiver(taker) - Learning Disability
- Caregiver(taker) - Lack of Child Development Knowledge
- Child - Alcohol Problem
- Child - Drug Problem
- Child - Intellectual/Developmental Disability (Mental Retardation)
- Child - Emotionally Disturbed
- Child - Visually or Hearing Impaired
- Child - Physically Disabled
- Child - Behavior Problem
- Child - Learning Disability
- Child - Other Medical Condition
- Household - Domestic Violence
- Household - Inadequate Housing
- Household - Financial Problem
- Household - Public Assistance

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

- Reports from Members of the CCPT and/or Case Managers/Behavioral Health Care Coordinators/Care Managers
- Information on Procedures and Protocols of Involved Agencies
- Case Files
- Medical Examiner's Report
- Child and Family Team Meeting Documentation
- Individualized Education Plan
- Other 1 _____
- Other 2 _____

What would help your CCPT better carry out case reviews?

_____

How many of the cases reviewed in 2020 were identified as having children and/or youth who needed <u>access</u> to the following services

- Mental Health (MH) _____
- Developmental Disabilities (DD) _____
- Substance Use (SU)[14] _____
- Domestic Violence (DV) _____

How many cases of substance affected infants did you review in 2020? _____

How many of these had a Plan of Safe Care? _____
Plans of Safe Care do not end with a referral to Care Management for at-Risk Children.
Policy surrounding Substance Affected Infant and Plans of Safe Care are located in the child welfare manual: CPS Intake, Assessments and Cross Function.

How many of the cases reviewed in 2020 were identified as having parents or other caregivers who needed <u>access</u> to the following services:

- Mental Health (MH) _____
- Developmental Disabilities (DD) _____

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

- Substance Use (SU) _____
- Domestic Violence (DV) _____

Did any of these service have a waitlist?

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

In 2020, which of the following limitations prevented children, youth, and their parents or other caregivers from accessing needed MH/DD/SU/DV services. Check all that apply.

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

Based on your 2020 case reviews, what were your team's top three recommendations for improving child welfare services at the local level?

Recommendation 1 _____
Recommendation 2 _____
Recommendation 3 _____

Based on your 2020 case reviews, what were your team's top three recommendations for improving child welfare services at the state level?

Recommendation 1 _____
Recommendation 2 _____
Recommendation 3 _____

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

- Yes
- No

List your CCPT's top three local objectives based on identified improvement needs for 2020. Then rate how successful your CCPT was in achieving these objectives.

	Not at all	Slightly	Moderately	Mostly	Completely	Too soon to rate
Objective 1 _____	○	○	○	○	○	○
Objective 2 _____	○	○	○	○	○	○
Objective 3 _____	○	○	○	○	○	○

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

Objective 1 _____
Objective 2 _____
Objective 3 _____

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

Objective 1 _____
Objective 2 _____
Objective 3 _____

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

_____

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

Once you continue to the next page, you will be directed to a copy of your completed responses, and you may print the screen to have a record of your responses. Once you have reached the "completed responses" page, you have successfully submitted your 2020 CCPT Survey.
Thank you for taking the time to complete the 2020 CCPT Survey, your responses are appreciated.
If you have questions about the survey and keeping a copy for your records, please contact ccpt_survey@ncsu.edu

George Bryan (Chair)
Neesha Allen
Molly Berkoff
Gina Brown
Christopher Carr
Carmelita Coleman
Deborah Day
Ellen Essick
Terri Grant
Carolyn Green
Kella Hatcher
Sharon Hirsch
Debra McHenry
John Myhre
Joan Pennell
Terri Reichert
Paige Rosemone
Starleen Scott-Roberts
Heather Skeens
Meghan Shanahan
Emily Smith
Bernetta Thigpen
Marvel Andrea Welch
Ginger Wilder
Jaquia Wilson
Yvonne Winston
Barbara Young