NORTH CAROLINA COMMUNITY CHILD PROTECTION TEAM

2017 End of Year Report

Community Child Protection Teams
NC Advisory Board

Foreword

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

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. Dr. Joan Pennell and doctoral student Emily Lefebvre with the Center for Family and Community Engagement at North Carolina State University administered the survey, analyzed its results, and prepared this report.

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

Wanda Marino	NC CCPT Advisory Board Chair
Judith Ayers	Currituck County Department of Social Services
Molly Berkoff	Pediatrician
Cindy Bizzel	NC Administrative Office of the Courts/GAL
Wayne Black	NC Division of Social Services
George Bryan	Forsyth County
Carmelita Coleman	Independent Living Resources Inc.
Gail Cormier	NC Families United
Deborah Day	NC Social Services
Brenda Edwards	NC Department of Public Health
Sharon Hirsch	Prevent Child Abuse NC
Kathy Hitchcock	Child Fatality Review
Ann-Marie Hoo	Healing Place of Wake County
Tiffany Lee	Edgecombe County Social Services
Christy Nash	NC Social Services
Kristin O'Connor	NC Division of Social Services
Heather Skeens	NC Guilford County Social Services
Chaney Stokes	SaySo
Marvel Welch	NC Commission of Indian Affairs

Executive Summary

This is a time of change for Social Services in North Carolina and, in particular, for the child welfare system. The North Carolina General Assembly in 2017 mandated the establishment of the Social Services Regional Supervision and Collaboration Working Group (SSWG). The SSWG was charged with making recommendations on moving to regional supervision of Social Services. The intent is to improve the performance and responsiveness of Social Services. Furthermore, the state contracted with an outside organization, the SLI Center for the Support of Families, to evaluate and develop a plan for Social Services reform and specifically for child welfare reform. The child welfare plan is to encompass all aspects of child welfare delivery including prevention, in-home services, child fatality review, child placement, and workforce development.

The SSWG completed in March 2018 the Stage One Final Report, which delineates nine core supervisory functions distributed across the central, regional, and local levels. Community Child Protection Teams (CCPTs) can contribute to all the core functions, and three of the core functions stand out as ones to which CCPTs can play a strong role in improving the performance and responsiveness of child welfare. The first is disseminating best practices across Social Services and local agencies. The second is interagency coordination that includes local Social Services receiving assistance from other agencies. The third is quality improvement through using statewide data and performance dashboards of regional and local information. One of the tasks of the Center for the Support of Families is to create publically available dashboards to serve as report cards of state, regional, and local performance. These three core functions are in line with the role of CCPTs to identify gaps in services that families need within their communities. This report documents what CCPTs accomplished over 2017 to strengthen the performance and responsiveness of child welfare, and its findings and recommendations can assist with planning for child welfare reform.

This is a time of child welfare reform as the state moves toward regional supervision of Social Services. CCPTs can play a strong role in this reform effort by disseminating best practices, encouraging interagency coordination, and using data for continuous quality improvement.

The report summarizes the findings from the 2017 end-of-year survey of local CCPTs. This year 81 out of 101 CCPTs responded to the survey. The Eastern Band of the Cherokee Indians, with its recently established CCPT, participated in the survey for the first time, bringing the total possible respondents to 101. The survey inquired about the local teams' functioning and activities over the year and their ideas for improving the child welfare system. The North Carolina Community Child Protection Team (CCPT) Advisory Board used the survey results to make recommendations on improving the child welfare system to the North Carolina Division of Social Services (NC DSS). The membership of the Advisory Board included representatives from local CCPTs, community organizations, and family and youth partners.

NC DSS is expected to respond to the Advisory Board's recommendations in writing. The Advisory Board is responsible for distributing this report, including its recommendations to the local CCPTs. NC DSS will incorporate this report and the state's response into the Annual Progress and Services Report to the US Department of Health and Human Services,

Administration for Children and Families. The aim is to insure a system of local feedback, state-level review and recommendation, and county Social Services and NC DSS accountability. In other words, the process serves as a means of continuous quality improvement.

North Carolina General Statute §7B-1406 through 1413 mandates the establishment of local CCPTs in all 100 counties. CCPTs serve as North Carolina's means of meeting the requirement of the federal Child Abuse Prevention and Treatment Act (CAPTA) that each state establish citizen review panels to evaluate the child welfare system and advocate for improvements.

Local CCPTs are expected to review cases of child maltreatment, identify areas for systemic change, advocate for reforms and needed resources, offer public education, and report to their county board of social services and NC DSS on their work over the year. This survey assists local CCPTs with meeting their reporting requirements and can contribute to the statewide dialog on system reform.

2017 Recommendations

After reviewing the findings from the 2017 CCPT survey, the NC CCPT Advisory Board met on May 2, 2018 and approved a set of recommendations to be sent to NC DSS for response. In addition, the Advisory Board identified specific issues that emerged from the survey regarding information, resources, and supports requested by local CCPTs (see Appendix B).

The Advisory Board members agreed that they continued to support the four 2016 recommendations and further developed and updated these recommendations. The four recommendations for 2017 are as follows:

Recommendation 1—Ensure that children, youth, and families have the mental health services required for promoting child safety, child permanency, and child and family well-being through the following steps:

1. Work with state-level agencies and family-and-child associations to reach cross-system definitions of services, timelines, and response times;
2. Assist families in accessing needed mental health services, including providing subsidies for Medicaid-ineligible families (such as when children enter care), transportation especially in rural areas, and translation/interpretation for non-English-speaking families;
3. Provide training to Social Services and their community partners in assisting families in accessing appropriate services;
4. Promote education on what services are available within communities for families;
5. Compare the mental health services and their quality and accessibility that are covered by different Local Management Entity (LME)-Managed Care Organizations (MCOs) for children and youth in care and for their families;
6. Examine the cost-effectiveness of different mental health delivery mechanisms (e.g., teleconferencing);
7. Coordinate with state health officials implementing the North Carolina State Opioid Plan to ensure that addicted parents and caretakers receive the necessary mental health and substance abuse treatment and ongoing recovery supports and that children being impacted by the current drug epidemic receive trauma-informed counseling services; and

8. Identify strategies working well within our state to provide quality and accessible mental health services to families and disseminate these strategies statewide.

Recommendation 2—Strengthen the Capacity of Local CCPTs to Work with Social Services in Improving Child Welfare Services through the following steps:

1. Update the *2004 Reference Guide*, post the guide on the NC DSS website, and distribute the guide to county DSSs and local CCPT chairpersons;
2. Provide in-person and on-line training and technical assistance to local CCPTs on (a) CCPT responsibilities and processes, (b) case identification and review with particular attention to child maltreatment fatalities and near fatalities, (c) child welfare policies and procedures, (d) interagency collaboration, (e) diversity on teams, and (f) inclusion of family and youth partners on teams;
3. Assist local CCPTs with identifying resources for comprehensive medical evaluations, domestic violence, transportation, and other areas of child and family need;
4. Support local CCPTs in their work to educate communities and families about protective factors to prevent child abuse and neglect and to make local plans for prevention;
5. Promote discussion of policy recommendations proposed by local CCPTs and the NC CCPT Advisory Board;
6. Facilitate agreement on a template for the end-of-year report to county commissioners and the NC CCPT Advisory Board;
7. Support local teams in completing the end-of-year survey;
8. Offer particular assistance to local teams that are re-engaging in the work;
9. Support smaller counties in creating regional CCPT mechanisms that reflect their already shared membership and resources; and
10. Provide some funding to local CCPTs to better carry out their responsibilities.

Recommendation 3—Establish the NC Citizen Review Panel (CRP)/CCPT Advisory Board as the state body responsible for synthesizing and advocating for the local CCPT experiences and recommendations, identifying areas for child abuse prevention planning and improvements in the child welfare system, and serving as an asset to NC DSS in improving child welfare services through the following steps:

1. Implement the newly reconstituted Advisory Board as the NC Citizen Review Panel(CRP)/CCPT Advisory Board;
2. Work with the NC DSS CCPT consultant to facilitate communication among local teams, Advisory Board, and NC DSS;
3. Fund and participate in an annual retreat of the Advisory Board, local CCPTs, and NC DSS to support collaborative working relationship and engage in strategic planning;
4. Encourage linkages between the North Carolina Child Welfare Family Advisory Council and the NC CRP/CCPT Advisory Board;
5. Work with the NC CCPT Advisory Board in determining policy areas for study;
6. Work with the NC CCPT Advisory Board in synthesizing recommendations emerging from intensive child fatality reviews;
7. Ensure the collection of data from local CCPTs for planning purposes;

8. Provide child and family data needed for planning purposes by the NC CCPT Advisory Board and costs of policy recommendations; and
9. Facilitate the NC CCPT Advisory Board sharing findings and recommendations with state policy bodies.

Recommendation 4—Engage in planning on the long-term structure and processes for citizen review panels (CRPs) in the state through the following steps:

1. Request involvement in the state's child welfare reform efforts with a particular focus on the role of CCPTs and CRPs;
2. Continue to confer with the national technical assistant on CRP models and examine CRP models used in other states;
3. Engage local CCPTs in the planning process;
4. Develop a North Carolina model for CRP and consider as necessary, possible legislative changes;
5. Put in place necessary resources for implementing, evaluating, and improving the model; and
6. Ensure adequate notification and orientation of local teams and state bodies to the model.

2017 Survey

The 81 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 abuse services. More than four-fifths of the responding CCPTs stated that they were "an established team that meets regularly," while the others were in different stages of reorganizing. Over three-quarters of the CCPTs opted to combine with their local Child Fatality Prevention Team. Approximately half the surveys were completed by the chair or designee and the other half by the team as a whole or subunits of the team.

The 2017 survey inquired about the following five main questions:

1. Who takes part in the local CCPTs, and what supports or prevents participation?
2. Which cases do local CCPTs review, and how can the review process be improved?
3. What limits access to needed mental health, developmental disabilities, substance abuse, and domestic violence services, and what can be done to improve child welfare services?
4. What are local CCPTs' objectives, and to what extent do they achieve these objectives?
5. Which action steps do CCPTs support to accomplish the four 2016 Advisory Board recommendations?

Who participates in the local CCPTs, and what supports or prevents participation?

State law requires that local teams are composed of 11 members from specified agencies that work with children and child welfare. The 2017 survey results, as well as those in prior years, show that mandated members varied in their level of participation. DSS staff and mental health professionals were the most often present while the county boards of social services and the

district attorney were least often in attendance. Nevertheless, the majority of mandated members in nearly all categories were in attendance *frequently* or *very frequently*. This is fortunate because most (84%) of the responding CCPTs thought that representation by all the 11 mandated agencies was necessary for accomplishing their work.

County commissioners in over half the responding counties appointed additional members to their local CCPTs. These members came from mandated organizations and other public agencies and nonprofits or were community members or parents (e.g., foster/adoptive parent, parent of deceased child). Over one-quarter of the CCPTs said that they had a family or youth partner serving on their team. The teams used a range of strategies to engage family or youth partners: using networks to identify potential family or youth partner, utilizing members already in place to offer family perspectives, offering special and repeated invitations, orienting partners, and ensuring that partners felt included and validated.

Over half the responding teams identified important initiatives that they undertook with others in their community. Local collaborations made it possible to raise public awareness of child maltreatment, host community forums with school-age children and their parents, and sponsor joint trainings for service providers.

A small county, holding community forums for many years, reported, "This year was our most successful and focused on trauma treatment . . . and was attended by over 300 people."

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

In 2017, 62 (79.5%) of the 78 responding CCPTs reviewed between 1 and 26 cases, with a mean of 6.7 cases. All together these 62 teams reviewed 415 cases.

State statute requires that CCPTs review two types of cases: active cases and child maltreatment fatalities. Most (84%) responding CCPTs selected active cases for review. Child maltreatment fatality was given as a reason for case selection by 30% of CCPTs. The second most frequent reason for selecting cases was the caretaker's drug abuse, identified by 73% of the CCPTs. Compared with last year's survey, there was a somewhat larger number of CCPTs selecting cases for review because of parental opioid use. Other reasons given by over half the CCPTs were child safety, multiple agencies involved, domestic violence, stuck cases, and child and family well-being.

In reviewing cases, most CCPTs used reports from members and/or case managers, case files, and information on procedures and protocols of involved agencies. CCPTs identified what they needed to improve the case review process: standardization of procedures and forms, training and feedback from the state, better participation of mandated members as well as community and family partners, more timely receipt of medical examiners' reports, and clarification of the review process for CCPTs combined with Child Fatality Prevention Teams.

"Our CCPT has been conducting case reviews in the same format for many years. It would be helpful to receive guidance or information regarding 'best practices' for case reviews."

Last year, 27 (35%) out of the 77 responding CCPTs received information of child maltreatment fatality cases. In all, there were between 1 and 9 notifications of child maltreatment fatality cases, for a total of 84 notifications. When asked about their type of review, the teams identified different approaches that they used in response to the notifications. The most common type was a review by the combined CCPT and Child Fatality Prevention Team, used for 49 cases. NC DSS conducted intensive reviews or had these reviews pending for 43 cases. In 31 cases, the CCPT conducted the review or had the case scheduled for review.

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

Children, youth, and their parents or caregivers faced serious barriers to accessing needed services. Most CCPTs who reviewed cases in 2017 reported that children and youth needed access to mental health services. Most CCPTs also reviewed cases in which the parents or caregivers required access to mental health, substance abuse, 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 mental health, substance abuse, and domestic violence services.

Another way to view the findings is 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," CCPTs wanted to identify systemic barriers to families' accessing essential services. The most commonly cited barriers were transportation to services, limited services or no available services, and youth's having a dual diagnosis of mental health and substance abuse issues. The CCPTs commented on some family factors affecting service receipt such as refusing 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, lack of medical insurance or Medicaid, and policies preventing mental health and substance abuse service providers from being reimbursed.

Calling for better health coverage to prevent substance use, a CCPT gave a troubling example, "Two of the parents struggling with addiction were prescribed opioids for emergency dental treatment that could have been prevented if dental care was a regular part of their care."

Based on their case reviews, the CCPTs made a wide range of recommendations to improve child welfare services. Their top recommendations centered on six mutually-supportive areas:

- To increase service access by ensuring health insurance and quality and comprehensive services in families' home communities;

- To improve case assessment by having thorough medical evaluations and child protective services' assessments that address families' needs for a full array of services;
- To enhance community education and collaboration by educating community members and encouraging joint efforts that resolve child and family issues;
- To develop child protection services by making systemic changes and strengthening the workforce;
- To utilize case reviews by selecting challenging situations and identifying challenging factors; and
- To promote CCPT functioning by expanding membership and establishing funding for local initiatives.

A team advised that the state "include 'near fatalities' in the intensive review process."

What are local CCPTs' objectives, and to what extent do they achieve these objectives?

The 25 CCPTs that set objectives for their team for the most part achieved them. Their successes included assessing services, raising awareness, sharing information, and leveraging collaborations. Their challenges were lack of community resources and funding. CCPTs differed on whether they achieved their objectives of improving their case reviews and strengthening their teams. CCPTs credited their "great teamwork" in realizing these objectives while also identifying challenges concerning members' time, resources, and agreement on priorities.

Repeatedly the CCPTs credited their "great teamwork" for helping them realize their team's objectives.

Which action steps do CCPTs support to accomplish the four 2016 NC CCPT Advisory Board recommendations?

Last year, the NC CCPT Advisory Board made four recommendations to NC DSS for written response. These recommendations were based on the 2014, 2015, and 2016 CCPT surveys. Each recommendation was accompanied by six to eight action steps to accomplish them. The teams were asked to identify which action steps would help them achieve the recommendation.

2016 Recommendation 1: Ensure that children, youth, and families have the mental health services required for promoting child safety, child permanency, and child and family well-being

Most CCPTs supported taking action to ensure children, youth, and families' access to mental health services. They especially endorsed increasing awareness of available services, helping families access these services, providing training to professionals on service access, and reaching agreement on cross-system definitions of services to facilitate access.

One CCPT wrote, "Promote more of a focus on what is needed in a county within an LME/MCO than 'it is available within our LME/MCO catchment area.'"

2016 Recommendation 2: Strengthen the Capacity of Local CCPTs to Work with Social Services in Improving Child Welfare Services

The large majority of CCPTs wanted support in order to better carry out their work. This included education on protective factors and training and technical assistance on team functions, including having an updated CCPT reference guide.

2016 Recommendation 3: Establish the NC CCPT Advisory Board as the state body responsible for synthesizing and advocating for the local CCPT experiences and recommendations, identifying areas for child abuse prevention planning and improvements in the child welfare system, and serving as an asset to NC DSS in improving child welfare services

Two-thirds of the CCPTs endorsed the NC CCPT Advisory Board collecting data from local teams to facilitate planning. Over half wanted the role of the Board formalized in writing.

2016 Recommendation 4: Engage in planning on the long-term structure and processes for citizen review panels in the state

Most CCPTs wanted to be included in the planning for the long-term structure and processes for citizen review panels in the state. Over half endorsed having in place the necessary resources for carrying out, evaluating, and improving the model and ensuring adequate notification and orientation of local teams and state agencies about the model.

What further advice can you give on putting the four recommendations into action?

The CCPTs wanted to be included in planning and to have a good flow of information of local teams with the NC CCPT Advisory Board, NC DSS, and DSS Directors' Association. To carry out the recommendations, they recognized their need for funding and training and "enhanced collaborations" such as with LME/MCOs and courts. Some urged greater attention to local issues, pointing out that the four recommendations appeared "to be the responsibility of the state, rather than the local teams." Overall, the teams wanted to be valued, supported and oriented so that they could engage in wider discussions on their role within the state context.

Table of Contents

List of Tables

North Carolina Community Child Protection Teams (CCPT) 2017 End-of-Year Report

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

Introduction

This is a time of change for Social Services in North Carolina and, in particular, for the child welfare system. The North Carolina General Assembly in 2017 mandated the establishment of the Social Services Regional Supervision and Collaboration Working Group (SSWG). The SSWG was charged with making recommendations on moving to regional supervision of Social Services. The intent is to improve the performance and responsiveness of Social Services. Furthermore, the state contracted with an outside organization, the SLI Center for the Support of Families, to evaluate and develop a plan for Social Services reform and specifically for child welfare reform. The child welfare plan is to encompass all aspects of child welfare delivery including prevention, in-home services, child fatality review, child placement, and workforce development.

The SSWG completed in March 2018 the Stage One Final Report, which delineates nine core supervisory functions distributed across the central, regional, and local levels. Community Child Protection Teams (CCPTs) can contribute to all the core functions, and three of the core functions stand out as ones to which CCPTs can play a strong role in improving the performance and responsiveness of child welfare. The first is disseminating best practices across Social Services and local agencies. The second is interagency coordination that includes a local Social Services receiving assistance from other agencies. The third is quality improvement through using statewide data and performance dashboards of regional and local information. One of the tasks of the Center for the Support of Families is to create publically available dashboards to serve as report cards of state, regional, and local performance. These three core functions are in line with the role of CCPTs to identify gaps in services that families need with their communities. This report documents what CCPTs accomplished over 2017 to strengthen the performance and responsiveness of child welfare and its findings and recommendations can assist with planning for child welfare reform.

> ***This is a time of child welfare reform as the state moves toward regional supervision of Social Services. CCPTs can play a strong role in this reform effort by disseminating best practices, encouraging interagency coordination, and using data for continuous quality improvement.***

The report summarizes the findings from the 2017 end-of-year survey of local CCPTs. This year 81 out of 101 CCPTs responded to the survey. The Eastern Band of the Cherokee Indians, with its recently established CCPT, participated in the survey for the first time, bringing the total possible respondents to 101. The survey inquired about the local teams' functioning and activities over the year and their ideas for improving the child welfare system. The North Carolina Community Child Protection Team (CCPT)

Advisory Board (NC CCPT Advisory Board) used the survey results to make recommendations on improving the child welfare system to the North Carolina Division of Social Services (NC DSS). The membership of the Advisory Board included representatives from local CCPTs, community organizations, and family and youth partners.

NC DSS is expected to respond to the Advisory Board's recommendations in writing. The Advisory Board is responsible for distributing this report, including its recommendations to the local CCPTs. NC DSS will incorporate this report and the state's response into the Annual Progress and Services Report to the US Department of Health and Human Services, Administration for Children and Families. The aim is to insure a system of local feedback, state-level review and recommendation, and county Social Services and NC DSS accountability. In other words, the process serves as a means of continuous quality improvement.

North Carolina General Statute §7B-1406 through 1413 mandates the establishment of local CCPTs in all 100 counties. CCPTs serve as North Carolina's means of meeting the requirement of the federal Child Abuse Prevention and Treatment Act (CAPTA) that each state establish citizen review panels to evaluate the child welfare system and advocate for improvements.

Local CCPTs are expected to review cases of child maltreatment, identify areas for systemic change, advocate for reforms and needed resources, offer public education, and report to their county board of social services and NC DSS on their work over the year. This survey assists local CCPTs with meeting their reporting requirements and can contribute to the statewide dialog on system reform. Next we provide an overview of the work accomplished by the NC CCPT Advisory Board in fall 2017 and spring 2018 and then turn to the 2017 recommendations to NC DSS.

Achievements of the NC CCPT Advisory Board

Over the year, the NC CCPT Advisory Board accomplished a number of key steps toward strengthening the role of CCPTs in North Carolina. These included holding a November 2017 retreat with Dr. Blake Jones, a national Citizen Review Panel (CRP) technical consultant. The 23 participants included representatives from local CCPTs, NC DSS, community organizations, family and youth partners, and NC State University. At this retreat, Dr. Jones relayed how CRPs were functioning in other states, and the participants developed the Board's formal vision, mission, and values for CCPTs. The retreat also established four working subcommittees for strategic planning in the following areas: formalizing the Advisory Board structure, integrating family and youth partners into the Advisory Board, reviewing adherence to federal and state mandates for CCPTs/CRPs, and assessing local CCPT issues/concerns.

In the spring of 2018, results have already been produced in all four areas. The Advisory Board has drafted bylaws that formalize its purpose, membership, and structure. Family and youth partners serve as members of the Advisory Board. Additionally a method of liaison has been established between the NC CCPT Advisory Board and the NC Child Welfare Family Advisory Council, initiated in April 2018. Two faculty members from NC State University reported their findings from site visits with Citizen Review Panels in two other states and will be reporting their findings from conducting focus groups and interviews with local CCPTs. The 2017 end-of-year report is a means of sharing statewide developments in CCPTs and serving as a basis for making recommendations to NC DSS.

NC DSS is better positioned to implement the recommendations because during the year a CCPT consultant was hired. The consultant works with local CCPTs on how to carry out their roles. NC DSS is also working to expedite and strengthen child maltreatment fatality reviews at the state level.

2017 Recommendations

After reviewing the findings from the 2017 CCPT survey, the NC CCPT Advisory Board met on May 2, 2018, and approved a set of recommendations to be sent to NC DSS for response. In addition, the Advisory Board identified specific issues that emerged from the survey in regards to information, resources, and supports requested by local CCPTs (see Appendix B).

The Advisory Board members agreed that they continued to support the four 2016 recommendations and further developed and updated these recommendations. The four recommendations for 2017 are as follows:

Recommendation 1—Ensure that children, youth, and families have the mental health services required for promoting child safety, child permanency, and child and family well-being through the following steps:

1. Work with state-level agencies and family-and-child associations to reach cross-system definitions of services, timelines, and response times;
2. Assist families in accessing needed mental health services, including providing subsidies for Medicaid-ineligible families (such as when children enter care), transportation especially in rural areas, and translation/interpretation for non-English-speaking families;
3. Provide training to Social Services and their community partners in assisting families in accessing appropriate services;
4. Promote education on what services are available within communities for families;
5. Compare the mental health services and their quality and accessibility that are covered by different Local Management Entity (LME)-Managed Care Organizations (MCOs) for children and youth in care and for their families;
6. Examine the cost-effectiveness of different mental health delivery mechanisms (e.g., teleconferencing);
7. Coordinate with state health officials implementing the North Carolina State Opioid Plan to ensure that addicted parents and caretakers receive the necessary mental health and substance abuse treatment and ongoing recovery supports and that children being impacted by the current drug epidemic receive trauma-informed counseling services; and
8. Identify strategies working well within our state to provide quality and accessible mental health services to families and disseminate these strategies statewide.

Recommendation 2—Strengthen the Capacity of Local CCPTs to Work with Social Services in Improving Child Welfare Services through the following steps:

1. Update the *2004 Reference Guide*, post the guide on the NC DSS website, and distribute the guide to county DSSs and local CCPT chairpersons;
2. Provide in-person and on-line training and technical assistance to local CCPTs on (a) CCPT responsibilities and processes, (b) case identification and review with particular attention to child maltreatment fatalities and near fatalities, (c) child welfare policies and procedures, (d)

interagency collaboration, (e) diversity on teams, and (f) inclusion of family and youth partners on teams;
3. Assist local CCPTs with identifying resources for comprehensive medical evaluations, domestic violence, transportation, and other areas of child and family need;
4. Support local CCPTs in their work to educate communities and families about protective factors to prevent child abuse and neglect and to make local plans for prevention;
5. Promote discussion of policy recommendations proposed by local CCPTs and the NC CCPT Advisory Board;
6. Facilitate agreement on a template for the end-of-year report to county commissioners and the NC CCPT Advisory Board;
7. Support local teams in completing the end-of-year survey;
8. Offer particular assistance to local teams that are re-engaging in the work;
9. Support smaller counties in creating regional CCPT mechanisms that reflect their already shared membership and resources; and
10. Provide some funding to local CCPTs to better carry out their responsibilities.

Recommendation 3—Establish the NC Citizen Review Panel (CRP)/CCPT Advisory Board as the state body responsible for synthesizing and advocating for the local CCPT experiences and recommendations, identifying areas for child abuse prevention planning and improvements in the child welfare system, and serving as an asset to NC DSS in improving child welfare services through the following steps:

1. Implement the newly reconstituted Advisory Board as the NC Citizen Review Panel(CRP)/CCPT Advisory Board;
2. Work with the NC DSS CCPT consultant to facilitate communication among local teams, Advisory Board, and NC DSS;
3. Fund and participate in an annual retreat of the Advisory Board, local CCPTs, and NC DSS to support collaborative working relationship and engage in strategic planning;
4. Encourage linkages between the North Carolina Child Welfare Family Advisory Council and the NC CRP/CCPT Advisory Board;
5. Work with the NC CCPT Advisory Board in determining policy areas for study;
6. Work with the NC CCPT Advisory Board in synthesizing recommendations emerging from intensive child fatality reviews;
7. Ensure the collection of data from local CCPTs for planning purposes;
8. Provide child and family data needed for planning purposes by the NC CCPT Advisory Board and costs of policy recommendations; and
9. Facilitate the NC CCPT Advisory Board sharing findings and recommendations with state policy bodies.

Recommendation 4—Engage in planning on the long-term structure and processes for citizen review panels (CRPs) in the state through the following steps:

1. Request involvement in the state's child welfare reform efforts with a particular focus on the role of CCPTs and CRPs;

2. Continue to confer with the national technical assistant on CRP models and examine CRP models used in other states;
3. Engage local CCPTs in the planning process;
4. Develop a North Carolina model for CRP and consider as necessary, possible legislative changes;
5. Put in place necessary resources for implementing, evaluating, and improving the model; and
6. Ensure adequate notification and orientation of local teams and state bodies to the model.

2017 Survey

The North Carolina Community Child Protection Team (CCPT) Advisory Board was responsible for developing the survey content and synthesizing the experience of local CCPTs. On behalf of the Advisory Board, North Carolina State University administered the survey using the online platform Qualtrics, analyzed the results using SPSS, and drafted the report of findings. The North Carolina Division of Social Services (NC DSS) alerted county Social Services directors and local CCPT chairpersons about the survey and asked for their support and provided the university with the contact information for the chairpersons of the local CCPTs. The appendices in this report provide the survey's timeline (see Table A-1), more detail on the survey results, and a copy of the survey instrument (Appendix C). The survey protocol was approved by NC State University' Institutional Review Board for the Protection of Human Subjects in Research.

Responding CCPTs

The university distributed the survey to 100 county CCPTs as well as the Eastern Band of the Cherokee Indians, for a possible 101 respondents. The survey was completed in full by 79 CCPTs and partially by 2 CCPTs. A list of the counties of the 2017 responding CCPTs can be found in appended Table A-2.

The 2017 response rate of 81 CCPTs fell between those for the 2012 to 2016 surveys, which ranged from 71 to 87. The local teams came from all regions of the state and included counties of all population sizes. The response rates were 78% of the 51 small counties, 87% of the 39 medium counties, and 80% of the 10 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 abuse services. In 2017, there were seven LME/MCOs for the 100 counties. The survey included members from all LME/MCOs: Member county participation ranged from 65% to 100% (see Table A-4). The percentages of participating counties were higher for LME/MCOs with fewer members and lower for LME/MCOs with more members.

As seen in Table 1, the large majority (80%) of responding CCPTs characterized themselves as an "established team that meets regularly." The others stated that they had recently reorganized and were at various stages in terms of meeting. The CCPTs that did not characterize themselves as an established team that meets regularly included small through large counties.

Table 1 Number of CCPTs by Status of Establishment as a Team (N = 81)

Number of CCPTs by Status of Establishment as a Team, 2017

Status	Number of CCPTs	
We are an established team that meets regularly	65	(80.2%)
Our team recently reorganized, and we are having regular meetings	9	(11.1%)
Our team recently reorganized, but we have not had any regular meetings	2	(2.5%)
Our team was not operating, but we recently reorganized	4	(4.9%)
Other[a]	1	(1.3%)

[a] The CCPT did not specify this status.

CCPTs have the option of combining with their local Child Fatality Prevention Team (CFPT) or keeping the two teams separate. CFPTs are responsible for reviewing cases of child death where maltreatment is not suspected. CCPTs review active cases and child fatalities where death was caused by 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. At the time of the survey, 62 (78%) of the 80 responding counties opted to have combined teams, 17 (21%) had separate teams, and 1 (1%) combined the team when they met on the same month. The 78% in 2017 of combined team has risen somewhat from the 72% in 2015 and the 76% in 2016.

In summary, 81% of the local teams responded to the survey in 2017, a percentage that is in the mid-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. Over three-quarters of the CCPTs opted to combine with their local Child Fatality Prevention Team.

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 for input and review before your survey report 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 (41%), by the team as a whole (26%), or by a team subgroup (15%). The response “other” involved more than one team member. The teams were almost evenly split on whether one individual (51% chair or designee) or larger groupings (49% whole team or smaller group) developed the responses. The time period for completing the survey was approximately 2.5

months and spanned the winter holiday season, which may have limited the ability of some teams to meet to discuss their responses.

Table 2 Number of CCPTs by Who Completed the Survey (N = 81)

Number of CCPTs by Who Completed the Survey, 2017

Status	Number of CCPTs	
The CCPT chair on their own	33	(40.7%)
The CCPT team as a whole	21	(25.9%)
A subgroup of the CCPT team	12	(14.8%)
A designee of the CCPT chair on their own	8	(9.9%)
Other[a]	7	(8.6%)

[a]The "other" responses referred to two or more individuals involved in completing the survey: the chair with prior chair, co-chair, or team input.

In summary, the survey encouraged CCPT chairs to seek input from team members on their responses. Approximately half the surveys were completed by the chair or designee and the other half by the team as a whole or subunits of the team. The ability of teams to convene to develop their responses was likely limited by the survey being open for 2.5 months, including over the winter holidays.

Main Survey Questions

The 2017 survey inquired about the following five main questions:

1. Who takes part in the local CCPTs, and what supports or prevents participation?
2. Which cases do local CCPTs review, and how can the review process be improved?
3. What limits access to needed mental health, developmental disabilities, substance abuse, and domestic violence services, and what can be done to improve child welfare services?
4. What are local CCPTs' objectives, and to what extent do they achieve these objectives?
5. Which action steps do CCPTs support to accomplish the four 2016 Advisory Board recommendations?

Each of these four recommendations was accompanied by six to eight action steps. For last year's NC DSS response to the Advisory Board's four recommendations, go to this link. Following up on last year's recommendations, the 2017 survey asked local teams about whether they supported the action steps or proposed other steps to accomplish the recommendations.

This section summarizes the findings for each of these questions. The two unfinished surveys did not proceed beyond the first set of questions and did not answer the questions pertaining to the four main questions. This reduced the respondents to 79. All quotations in this report have been corrected for spelling and grammatical errors. Where available, survey findings from the 2016 survey are compared

with the 2017 findings to ascertain trends. These two surveys shared many of the same questions. The 2017 survey, however, included a number of new items particularly regarding the local teams' recommendations and objectives.

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

Mandated Members

State law requires that local teams are composed of 11 members from agencies that work with children and child welfare. Table 3 identifies these mandated CCPT members and their levels of participation on the team during 2017. The survey results indicate that mandated members varied in their level of participation. The two team members most likely to be *very frequently* in attendance were the DSS staff followed closely by the Mental Health professionals. On average, health care providers, public health directors, guardians ad litem, and DSS directors were *frequently* present. The team members whose average fell between *occasionally* and *frequently* present were the community action agency, law enforcement, and school superintendent. Those more likely to be *occasionally* present were the county board of social services and the district attorney. 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, district attorneys had the lowest average participation level but still had close to half (46%) their district attorneys taking part *frequently* or *very frequently.*

Table 3 Mandated CCPT Members and Reported Frequency of Participation

Mandated CCPT Members and Reported Frequency of Participation, 2017 (N=79)

Mandated Member	Never	Rarely	Occasionally	Frequently	Very Frequently	Mean (Median)
DSS Director	6	7	10	12	44	3.03
	(7.6%)	(8.9%)	(12.7%)	(15.2%)	(55.7%)	(4.00)
DSS Staff	1	0	1	4	73	3.87
	(1.3%)	(0.00%)	(1.3%)	(5.1%)	(92.47%)	(4.00)
Law Enforcement[a]	6	9	14	19	30	2.74
	(7.7%)	(11.5%)	(17.9%)	(24.4%)	(38.5%)	(3.00)
District Attorney	20	19	4	13	23	2.00
	(25.3%)	(24.1%)	(5.1%)	(16.5%)	(29.1%)	(2.00)
Community Action Agency Director or Designee[a]	7	7	11	17	36	2.87
	(9.0%)	(9.0%)	(14.1%)	(21.8%)	(46.2%)	(3.00)
School Superintendent	18	5	8	19	29	2.46
or Designee	(22.8%)	(6.3%)	(10.1%)	(24.1%)	(36.7%)	(3.00)
County Board of Social Services	13	12	11	21	22	2.34
	(16.5%)	(15.2%)	(13.9%)	(26.6%)	(27.8%)	(3.00)
Mental Health Professional	0	0	10	15	54	3.56
	(0.0%)	(0.0%)	(12.7%)	(19.0%)	(68.4%)	(4.00)
Guardian ad Litem Coordinator	3	5	13	19	39	3.09
or Designee	(3.8%)	(6.3%)	(16.5%)	(24.1%)	(49.4%)	(3.00)
Public Health Director	10	3	7	7	52	3.11
	(12.7%)	(3.8%)	(8.9%)	(8.9%)	(65.8%)	(4.00)
Health Care Provider	6	4	8	16	45	3.14
	(7.6%)	(5.1%)	(10.1%)	(20.3%)	(57.0%)	(4.00)

Note. 0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently
Counts are reported, with percentages out of 79 CCPTs in parentheses.
[a]One case missing.

The pattern of participation of mandated members remained relatively constant between 2016 and 2017. Table 4 shows that for both years, the ranked participation rates of the mandated members were almost identical. At the top in rank over the two years were DSS staff, mental health professionals, health care providers, and public health directors. The lower participation ranks for the two years were among district attorneys, county boards of social services, school superintendents, and law enforcement

Table 4 Mandated CCPT Members and Mean Rate and Rank of Participation

Mandated CCPT Members and Mean Rate and Rank of Participation, 2016 and 2017

Mandated Member	2016 (*N* = 86) Average (Rank)	2017 (*N* = 79) Average (Rank)
DSS Director	2.88 (5)	3.03 (6)
DSS Staff	3.78 (1)	3.87 (1)
Law Enforcement	2.70 (8)	2.74 (8)
District Attorney	1.89 (11)	2.00 (11)
Community Action Agency	2.87 (6.5)	2.87 (7)
School Superintendent	2.47 (9)	2.46 (9)
County Board of Social Services	2.06 (10)	2.34 (10)
Mental Health Professional	3.11 (2)	3.56 (2)
Guardian ad Litem	2.87 (6.5)	3.09 (5)
Public Health Director	2.98 (4)	3.11 (4)
Health Care Provider	2.99 (3)	3.14 (3)

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

Given that disparate levels of participation across the mandated members were reported on the 2016 survey (as well as from earlier surveys), the 2017 survey asked a new question: Are there statutorily required members that you feel might be unnecessary? Among the 78 respondents, 68 (84%) said *no* and 10 (12%) said *yes.* The survey permitted the *yes* respondents to identify one role that was not needed. At

least one would have indicated other roles if this had been possible and noted that several CCPT members duplicate each other and gave the example of the DSS director and staff. Out of the nine respondents, four checked district attorney and two checked community action agency. Three roles received one check each: school superintendent, county board of social services, and health care provider. Those who indicated that the district attorney (DA) was not a necessary, the CCPT respondent explained that the DA was usually unable to attend, not assigned to attend, or did not see children's issues as part of their role. One suggested that their team would be better served by having the DA available for consultation. Two commented that the community action agency in their community was not invested in CCPT, although one had recently reengaged with their team. Another CCPT said that the direct participation of the county board of social services was unnecessary because their DSS director had "great communication" with the board. As for the school superintendent, one CCPT wrote that school social workers, who directly worked with the students, filled this role.

In summary, state law requires that local teams are composed of 11 members from specified agencies that work with children and child welfare. The 2017 survey results, as well as those in prior years, show that mandated members varied in their level of participation. DSS staff and mental health professionals were the most often present while the county boards of social services and the district attorney were least often in attendance. Nevertheless, the majority of mandated members in nearly all categories were in attendance *frequently* or *very frequently*. This is fortunate because most (84%) of the responding CCPTs thought that representation by all the 11 mandated agencies was necessary for accomplishing their work.

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 78 responding CCPTs, 32 (41%) said that they did not have additional members while the other 46 (59%) had between 1 to 14 additional members. The average number of additional members was 2.5 for all respondents, and for those with at least one additional member, the average was 4.3. The survey provided space for the respondents to "list the organization/unit that additional members represent." On the survey, the respondents wrote in 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, military, and child developmental services. Still others were from nonprofits, including domestic violence, substance use, parenting education, and children's advocacy. Others identified were community members (e.g., retiree) or parents (e.g., foster/adoptive parent, parent of deceased child). According to state statute, the membership of the Child Fatality Prevention Teams is to include "a parent of a child who died before reaching the child's eighteenth birthday." Given that 78% of the CCPTs were combined with the local Child Fatality Prevention Team, it is likely that the parent representatives were intended to meet the statutory requirement of the Child Fatality Prevention Team.

In summary, county commissioners in over half the responding counties appointed additional members to their local CCPTs. These members came from mandated organizations and other public agencies and nonprofits or were community members or parents (e.g., foster/adoptive parent, parent of deceased child).

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 or Youth Partner Participation Rates

In response to the question on whether they had family or youth partners serving on their team, 23 (29%) out of 79 responding CCPTs said *yes* and 56 (71%) said *no.* The 2017 percentage of 29% responding *yes* is somewhat higher than in 2015 (21%, 19 out of 87) and 2016 (22%, 19 out of 86). Using the same scale as for the mandated members (see Table 3), the two previous surveys asked about the frequency of the participation of family or youth partners as a whole. The 2015 survey found that family or youth partners took part on average between *occasionally* and *frequently* (median of 2). The 2016 survey found a somewhat higher rate of participation and that family or youth partners took part on average *frequently* (median of 3).

Unlike the two previous surveys, the 2017 survey did not ask about family or youth partner participation levels in general and instead drilled down to six different categories of family or youth partners serving on the CCPTs (see Table 5 for the categories). Although the teams had the option of identifying other categories of family or youth partners, none did so. The teams who said they had a family or youth partner this year could, thus, identify if they had more than one partner on their team. Table 5 shows that the responding teams had a total of 33 family or youth partners, whose rates of participation ranged from *rarely* to *very frequently*. The most commonly represented category was biological parent who formed nearly half (16, 48%) of the family or youth partners. The midpoint of the biological parents' participation fell at *frequently.* The other five categories of partners were identified as serving on their teams by 2 to 5 CCPTs. Their rate of participation ranged from *rarely* to *very frequently*.

Table 5 Family or Youth Partners by Category and Reported Frequency of Participation

Family or Youth Partners by Category and Reported Frequency of Participation, 2017

Category	Never	Rarely	Occasionally	Frequently	Very Frequently	Number of CCPTs with Some Participation
Youth Partner	19	1	1	0	1	3
Biological Parent	6	0	4	6	6	16
Kinship Caregiver	19	1	0	1	0	2
Guardian	18	1	0	1	1	3
Foster Parent	16	1	2	0	2	5
Adoptive Parent	17	1	2	0	1	4
Total	**95**	**5**	**9**	**8**	**11**	**33**

Note. The sample size was 21 to 22 respondents for each category.

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. Out of the 79 responding teams, 23 (29%) said that they had a family or youth partners serving on their team. Among these CCPTs were a total of 33 family or youth partner members. Nearly half (16, 48%) of the partners were biological parents, whose participation rate centered around *frequently*. The other five categories of partners were 5 foster parents, 4 adoptive parents, 3 youth, 3 guardians, and 2 kinship caregivers. It is unclear whether the teams were identifying biological parents who served as members of the Child Fatality Prevention Teams. Future surveys will need to differentiate between Child Fatality Prevention Team members who are parents of a deceased child and CCPT members who are parents of a child in need of protection.

Strategies for Engaging Family or Youth Partners on the Team

The survey then asked the respondents to "list three strategies that your CCPT has successfully used to engage family and youth partners on your team." Among the 23 CCPTs who stated that they had family or youth partners, 16 replied to this question: 7 giving one strategy, 4 giving two strategies, and 5 giving three strategies. The CCPTs used five main strategies. First, they identified likely family or youth partners by "leveraging [the team's] connections in the community," raising awareness through "speaking engagements," using "recruitment through churches," or going through the "LINKS program to engage aged-out youth." Second, they tapped into pre-existing arrangements such as putting CCPT participation into the partner's "job duties," having a parent of a deceased child serve on both the Child Fatality Prevention Team and the CCPT, or having mandated members who were also "a kinship

caregiver, a foster parent, and an adoptive parent." Third, they carefully crafted how they extended the invitation: soliciting their participation more than once, using phone and/or email, having the invitation come from a senior agency representative, or rescheduling the meeting time to accommodate the partner. Fourth, they oriented partners by explaining the purpose of the CCPT and the partner's role on the team and after meetings, "de-briefing" the partner. Fifth, they emphasized how much they valued the partners' participation, responding in an "empathetic" manner to the parent, using "terminology that is clear and at a level all can understand," and "draw[ing] the parent into the discussion specifically from her perspective."

CCPTs identified likely family or youth partners by "leveraging [the team's] connections in the community," raising awareness through "speaking engagements," using "recruitment through churches," or going through the "LINKS program to engage aged-out youth."

In summary, the CCPTs used a range of strategies that built upon each other: using networks to identify potential family or youth partner, utilizing members already in place to offer family perspectives, offering special and repeated invitations, orienting partners, and ensuring that partners felt included and validated.

Factors Limiting the Participation of Family or Youth Partners

The participation of family or youth partners can be limited for two overarching reasons: (1) the partners may have their own reasons for not participating and (2) the local teams may have difficulty knowing how to engage these partners. The survey inquired about both sets of reasons. First, the survey asked the teams to "list three reasons that prevent some family or youth partners from taking part in your CCPT. This question sparked much discussion, with 62 (78.5%) of the 79 CCPTs writing in comments. Among the 62, 12 gave one reason, 19 gave two reasons, and 31 gave three reasons.

Many of the reasons were logistical: lack of transportation or reimbursement for travel; scheduling conflicts with work, school, or clubs; need for child care; or available family or youth partners in a small county already serving on other local collaborations. Other reasons related to the partners' motivation to participate because there was no payment for their time, their "lack of vested interest," or their not understanding the role of the CCPT or "unsure of the expectations." They thought that the partners might be "uncomfortable participating due to the topic" or "concerned about participating with the type of agencies at the table (i.e., law enforcement, DSS, juvenile services, mental health." They worried that partners might feel "blamed," "stigma," or a "fear of judgment." A deep-seated concern was emotionally overwhelming partners because of their "continuing grief," history of trauma, or "material discussed may be a trigger for youth." In response, a few teams stated that involving family or youth partners on CCPTs was not appropriate. One team explained, "We have concerns about including families and youth with our CCPT combined with our CFPT [Child Fatality Prevention Team]." Another team emphasized that "CCPT is NOT a CFT [child and family team] – inappropriate to include family & youth."

One team warned against involving family and youth partners, "CCPT is NOT a CFT [child and family team] – inappropriate to include family & youth."

Then, the survey asked the respondents to "list three reasons that prevent your CCPT from engaging some family or youth partners in your CCPT." This question led to much discussion. Among the 79

respondents, 61 (72%) commented. Out of 61 teams identifying why they were inhibited in engaging family or youth partners: 25 gave one reason, 19 gave two reasons, and 17 gave three reasons. As some respondents commented, the reasons that prevented them from engaging partners overlapped with those that prevented them from engaging family partners. These overlaps included the partners' other commitments (e.g., work and school), scheduling conflicts, lack of interest, transportation, child care, and no payment for their time. One team viewed the partners as having a "conflict of interest."

CCPTs identified quite a number of reasons related to the team rather than the family or youth partners. A frequently cited impediment pertained to recruitment: "unsure how to recruit [and] unsure who to recruit." A common concern was confidentiality: "unable to find that member who could protect confidentiality" or "small county, families identified in case review would likely be known to the youth," Some noted that the presence of the partners could inhibit the other team members: "concerns re: team members' transparency." Another matter was lack of understanding on how to involve the partners: "not knowing how to incorporate them into the meeting" and "limited information on how to . . . orient partners." Others recognized that they were not structured in a manner that would permit partners' participation: "CCPT not organized properly." One team recognized that involving partners required "a dedicated person appointed to ensure they are engaged."

Some CCPTs emphasized that they did not believe that family and youth partners should take part on CCPTs, especially when they were a combined team (CCPT and Child Fatality Prevention Team). In their view, child fatality reviews raised too many issues about maintaining confidentiality. One team pointed out that the Department of Health Services "expresses that they do not want [family or youth partners] there." Another team identified that it would be "difficult to engage those that are involved with Foster Care due to confidentiality." Others said that they were "not aware that youth or families were required to participate" on a CCPT. One CCPT simply responded, "N/A: our team does death reviews—youth are NOT invited."

A team explained at length, "In reviewing materials, we cannot find any information regarding the inclusion of youth partners. We have concerns regarding the benefits of including youth in this particular type of team given the case review content." A number of teams asked for more guidance: "need some technical assistance in recruiting," "need guidance on recruitment of family or youth partners," "would be apprehensive [including partners] with such outdated material/guide."

Nevertheless, a number of CCPTs were rethinking their approach and planning steps on how to include family or youth partners. One team considered "taking more initiative to reach out to family or youth partners" and "changing the meeting times." Another team responded, "We haven't tried but plan to in 2018—didn't know the process used by other CCPTs to select and contact family or youth partners."

Thinking ahead to recruiting family or youth partners, a team said, "We haven't tried but plan to in 2018—didn't know the process used by other CCPTs to select and contact family or youth partners."

In summary, CCPTs detailed at length the reasons preventing the participation of family or youth partners on their teams. Some of these reasons stemmed from the situation of the partners: logistical such as a lack of transportation or scheduling conflicts, motivational due to uncertainties about their role or lack of reimbursement, and emotional because of the sensitive topics discussed, especially when the CCPT was combined with the Child Fatality Prevention Team. In particular, they worried that the

partners might feel stigmatized or emotionally overwhelmed. CCPTs also identified reasons related to the team rather than family or youth partners. These included uncertainties about how to recruit the partners, maintain confidentiality, and involve partners on the team without inhibiting the discussion. CCPTs asked for more guidance on bringing family and youth partners onboard their teams.

Partnerships to Meet Community Needs

In addition to their own team meetings, the CCPTs engaged with other local groups to meet community needs. Two survey questions respectively asked about other organizations and other collaborations with which the CCPTs partnered. The first of these survey question was: "During 2017, did your CCPT partner with other organizations in the community to create programs or inform policy to meet an unmet community need?" Among the 79 responding teams, 42 (53%) answered that they did partner with other organizations and 37 (47%) said that they did not. A follow-up question was: "If yes, describe the most important of these initiatives to meet a community need." Demonstrating extensive local activism and justifiable pride in their accomplishments, the CCPTs described at length numerous initiatives.

These initiatives included raising public awareness of how to identify child abuse (including sexual abuse), strengthen protective factors, reach out for help from child welfare and health services, support healthy pregnancy, care for infants and young children, prevent teen suicide, stop human trafficking, and ensure fire-arm safety. A highly attended event in a small county during Stop Child Abuse month was providing informational bags to 1000 children to give to their parents about resources for mental health and domestic violence and providing educational games for the children on stopping child abuse. Another small county has held community forums for many years and reported, "This year was our most successful and focused on trauma treatment . . . and was attended by over 300 people."

A small county, holding community forums for many years, reported, "This year was our most successful and focused on trauma treatment . . . and was attended by over 300 people."

Frequent mention was made to securing or disposing of medications safely and to addressing the opioid crisis. For example, one team distributed information on opioids at local schools and held community informational forums. Another team "revamped data tracking effort to drill down on . . . data related to drug use/impact on children." In another initiative, the team partnered with NC Families United to "ensure a successful partnership between families and CCPT." One extensive initiative with the district court concerned allowing agencies to share information. This strengthened case reviews and made "meetings . . . much more productive, streamlined and outcomes focused."

One extensive initiative with the district court concerned allowing agencies to share information. This strengthened case reviews and made "meetings . . . much more productive, streamlined and outcomes focused."

The second related survey question was: "Besides the Child Fatality Prevention Team (CFPT), are you aware of any other county-level collaboration your CCPT is involved in?" Twenty-two CCPTs responded, among whom 5 identified 1 collaboration, 6 identified 2 collaborations, and 11 identified 3 collaborations. These collaborations were in support of the initiatives that the teams had already reported. Some CCPTs reported local collaborations that formed around issues such as opioid awareness and prevention; others referenced training efforts with schools, law enforcement, and other agencies;

and others pointed to collaboration with specific bodies such as county boards of commissioners and LME/MCOs.

In summary, over half the responding teams identified important initiatives that they undertook with others in their community. Local collaborations made it possible to raise public awareness of child maltreatment, host community forums with school-age children and their parents, and sponsor joint trainings for service providers.

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

According to state statute §7B-1406, CCPTs are to review:

a. Selected active cases in which children are being served by child protective services; and
b. 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, thus, the CCPT mandate is different from that of the Child Fatality Preventions Teams, who are responsible for reviewing child fatalities. State statute §7B-1401(1) defines 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. New to this year, the survey further asked about the recommendations that the teams made based on their case reviews and the objectives that they set for their teams.

Child Maltreatment Fatality Cases

The survey asked, "From January through December 2017, how many child maltreatment fatalities was your CCPT notified of?" Among the 77 responding CCPTs, 50 (65%) replied that they had received no notifications; the remaining 27 (35%) said that they had received between 1 to 9 notifications, with a mean at 3.11 (SD = 2.65). Across the 27 teams, there was a total of 84 notifications.

Next the CCPTs were asked about the type of review that these child maltreatment fatalities received. The teams were provided with nine types of reviews from which to select, and they had the option of writing in two other types of review. No team wrote in more than one additional type of review. As shown in Table 6, the most common type of review was a review conducted by a combined CCPT and Child Fatality Prevention team: 49 cases were reviewed in this manner, and these case reviews were reported by 14 CCPTs. The next two most frequent types were intensive reviews by NC DSS, with 22

cases pending review and 21 with reviews conducted. In fourth and fifth place were the 16 reviews conducted by the Child Fatality Prevention Team and 16 reviews conducted by the CCPT. Another 15 cases were pending review by the CCPT, meaning that the team had received notification of the case and had scheduled the case for review. In four cases, no review had been conducted. In one case the CCPT declined to conduct the review; and in another instance NC DSS was not notified about the case.

In summary, last year, 27 (35%) out of the 77 responding CCPTs received between 1 and 9 notifications of child maltreatment fatality cases, for a total of 84 notifications. When asked about their type of review, the teams identified different approaches. The most common type was a review by the combined CCPT and Child Fatality Prevention Team, used for 49 cases. NC DSS conducted intensive reviews or had these reviews pending for 43 cases. In 31 cases, the CCPT conducted the review or had the case scheduled for review.

Table 6 Number of Child Maltreatment Fatality Reviews by Type of Review

Number of Child Maltreatment Fatality Cases by Type of Review, 2017

Type of Review	Number of CCPTs	Sum of Cases	Minimum of Cases	Maximum of Cases	Mean of Cases	Standard Deviation
1. Combined CCPT and Child Fatality Prevention Team conducted case review	14	49	1	9	3.50	2.876
2. NC DSS conducted (intensive) state child fatality review pending	14	22	1	4	1.57	.938
3. NC DSS conducted (intensive) state child fatality review	18	21	1	2	1.17	.383
4. Child Fatality Prevention Team conducted case review	8	16	1	13	3.62	4.307
5. CCPT conducted case review	7	16	1	7	2.29	2.215
6. CCPT case review pending (CCPT notified, and case scheduled for review)	6	15	1	7	2.50	2.345
7. No case review conducted	2	4	1	3	2.00	1.414
8. CCPT declined to conduct case review	1	1	1	1	-	-
9. NC DSS not notified of case	1	1	1	1	-	-
Other type of case review[a]	2	5	2	3	2.50	.707

Note. A case may have more than one type of review; thus, the total of 150 for the sum of cases column cannot be equated with the number of cases reviewed, pending review, or not reviewed.

[a]The other identified types of case reviews included cases being scheduled, cases scheduled for review, internal DSS review, and combined NC DSS with CCPT, Child Fatality Prevention Team, and NC DSS professional staff.

Child Maltreatment Case Reviews

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 2017?" The survey instructions stated that combined CCPT and Child Fatality Prevention Teams should only include reviews "where the death was caused by abuse, neglect, or dependence and where the family had received DSS child welfare services within 12 months of the child's death."

In 2017, 62 (79.5%) of the 78 responding CCPTs reviewed between 1 and 26 cases, with a mean of 6.7 cases (SD = 5.19). All together these 62 teams reviewed 415 cases. The remaining 16 (20.5%) of the 78 responding CCPTs stated that they reviewed no cases. Three of these 16 teams had recently reorganized, and the other 13 met regularly; 14 of the 16 teams were combined CCPT and Child Fatality Prevention Teams.

Table 7 displays the median number of cases reviewed when organized by county size. Large counties reviewed the highest median of cases (7) as compared to small and medium counties.

Table 7 Number of Child Maltreatment Cases Reviewed by County Size

Number of Child Maltreatment Cases Reviewed by County Size, 2017, (N=78)[a]

Size of County	Number of CCPTs[a]	Median	Minimum-Maximum
Small	28	5.00	1-26
Medium	27	4.00	1-17
Large	7	8.00	4-24
Total	62	5.00	1-26

Note. Medians are reported here because they are less affected by outliers than means.

[a] Only CCPTs reporting one or more cases reviewed were included in analysis.

In summary, over 2017, 62 (79.5%) of the 78 responding CCPTs reviewed between 1 and 26 cases, with a mean of 6.7 cases. All together these 62 teams reviewed 415 cases.

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 two additional reasons. As shown in Table 8, the most common reason cited by 53 (84%) out of the 63 responding teams 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." It should be noted that at the time of the survey, NC DSS was seeking to catch up on the reviews of intensive child maltreatment fatalities and this push is likely to continue into the next year. Among the responding team, 19 (30%) stated that they selected for review child maltreatment fatalities. In addition to these statutory requirements, the CCPTs identified other selection criteria. Over half applied the criteria of child safety, multiple agencies involved, stuck cases, and child and family well-being. Compared with last year's survey, there was an uptick in the number of CCPTs selecting cases for review because of parental opioid use: 22 (34%) of the 64 respondents in 2016 to 26 (41%) of 63 respondents in 2017.

Twenty of the respondents added a selection criterion, and six of these provided two criteria. The additions included reasons related to the family such as "unsafe sleeping" and "missed appointments." The most common family reasons were substance-related concerns, young age of the children, or both (e.g., "substance affected infant"). One CCPT selected cases because of the intervention: "professionals not responding appropriately to abuse/neglect." Another CCPT's reason pertained to the nature of the situation, i.e., "complicated military cases." Some CCPTs noted that the cases were selected by Social Services: "DSS requesting guidance for case" or "DSS selected the cases with CCPT requested topics."

Table 8 Case Criteria Used by CCPTs for Selecting Child Maltreatment Cases for Review

Case Criteria Used by CCPTs for Selecting Child Maltreatment Cases for Review, 2017, (N=63)

Selection Criterion	Number of CCPTs	
Active Case	53	(84.1%)
Child Safety	44	(69.8%)
Multiple Agencies Involved	42	(66.7%)
Stuck Case	34	(54.0%)
Child and Family Well-Being	32	(50.8%)
Repeat Maltreatment	28	(44.4%)
Parent Opioid Use	26	(41.3%)
Court Involved	21	(33.3%)
Child Maltreatment Fatality	19	(30.2%)
Child Permanency	18	(28.6%)
Closed Case	6	(9.5%)
Other 1	20	(31.7%)
Other 2	6	(9.5%)

Note. The sample includes the 62 CCPTs that had at least one case review and 1 additional CCPT that answered these questions. Percentages in parentheses are out of the 63 valid responses.

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 9 lists these contributory factors and the number of CCPTs who used each factor in selecting cases for review. The two most common factors were caretaker's drug abuse cited by 45 (73%) CCPTs and household domestic violence cited by 37 (59.7%) CCPTs. Other factors used by over 40% of CCPTs pertained to the caretaker: emotionally disturbed, lack of child development knowledge, and alcohol abuse. Nearly one-third of respondents said that they selected cases because of the child's behavior or because of the household having inadequate housing.

Table 9 Contributory Factors for Children Being in Need of Protection Used by CCPTs for Selecting Child Maltreatment Cases for Review

Contributory Factors for Children Being in Need of Protection Used by CCPTs for Selecting Child Maltreatment Cases for Review, 2017, (N = 62)

Contributory Factor	Number of CCPTs	
Parent/Caregiver		
Drug Abuse	45	(72.6%)
Emotionally Disturbed	30	(48.4%)
Lack of Child Development Knowledge	29	(46.8%)
Alcohol Abuse	25	(40.3%)
Learning Disability	11	(17.7%)
Other Medical Condition	11	(17.7%)
Mental Retardation	6	(9.7%)
Visually or Hearing Impaired	3	(4.8%)
Children/Youth		
Behavior Problem	20	(32.3%)
Other Medical Condition	14	(22.6%)
Emotionally Disturbed	13	(21.0%)
Drug Problem	7	(11.3%)
Learning Disability	5	(8.1%)
Alcohol Problem	5	(8.1%)
Mental Retardation	2	(3.2%)
Physically Disabled	2	(3.2%)
Visually or Hearing Impaired	1	(1.6%)
Household		
Domestic Violence	37	(59.7%)
Inadequate Housing	20	(32.3%)
Financial Problem	16	(25.8%)
Public Assistance	12	(19.4%)

Note. Only 62 the CCPTs who reported conducting one or more case reviews were asked to answer the question on criteria used for selecting cases. Percentages in parentheses are out of 62 valid responses.

In summary, state statute requires that CCPTs review two types of cases: active cases and child maltreatment fatalities. Most (84%) responding CCPTs selected active cases for review. Child maltreatment fatality was given as a reason for case selection by 30% of CCPTs. The second most frequent reason for selecting cases was the caretaker's drug abuse, identified by 73% of the CCPTs. Compared with last year's survey, there was a somewhat larger number of CCPTs selecting cases for review because of parental opioid use. Other reasons given by over half the CCPTs were child safety, multiple agencies involved, domestic violence, stuck cases, and child and family well-being.

Process of Case Reviews

The CCPTs used different types of information to review the cases (see Table 10). Out of the 62 CCPTs who had reviewed cases, nearly all (98%) used reports from members and/or case managers, and most (85%) used case files. Close to two-thirds (63%) used information on procedures and protocols of involved agencies. These three types of information were the same primary sources as reported in the 2015 and 2016 surveys. Under half (44%) of the CCPTs reviewed child and family team meeting documentation. Less common sources of information were medical examiner's reports and individualized education plans. CCPTs also wrote in some other information source, including: medical and school, and members shared information from their own case records.

Table 10 Type of Information Used by CCPTs for Reviewing Cases

Type of Information Used by CCPTs for Reviewing Cases, 2017, (N=62)[a]

Type of Information	Number of CCPTs
Reports from Members and/or Case Managers	61 (98.39%)
Case Files	53 (85.48%)
Information on Procedures and Protocols of Involved Agencies	39 (62.90%)
Child and Family Team Meeting Documentation	27 (43.55%)
Medical Examiner's Report	14 (22.58%)
Individualized Education Plan	12 (19.35%)
Other	8 (12.90%)

Note. CCPTs could select all that apply.
[a]There were 62 valid cases. Only CCPTs who reported conducting one or more case reviews were asked to answer the question about type of information used.

Next the CCPTs were asked to share their views on what would help their CCPT carry out case reviews even better. Among the 63 respondents, 34 wrote in suggestions on how to improve their case reviews, and 6 stated they had nothing to add here because they believed they reviewed cases "very well as a team" or because they were "unsure" about what to propose. The most common recommendations concerned standardization of the process and increased guidance and training on completing case reviews. CCPTs wanted a "standardized checklist" or a "standardized reporting form" to ensure that they were addressing everything that they should. Others asked for "standardized criteria in what types of cases to review."

To support their case reviews, CCPTs requested more support from the state: "completing site visit and offering feedback" and "more training on the role and purpose of the CCPT." Elaborating on the need for more guidance, one CCPT wrote, "Our CCPT has been conducting case reviews in the same format for many years. It would be helpful to receive guidance or information regarding 'best practices' for case reviews."

"Our CCPT has been conducting case reviews in the same format for many years. It would be helpful to receive guidance or information regarding 'best practices' for case reviews."

Others highlighted the need for "committed members and attendance." They recognized that to conduct reviews well, they required "more consistent attendance of all members" and they identified other groups that needed to be present: "Housing Authority," "more community partners at the table," or "involving family/youth partners as well as Judge(s)."

They also wanted to be "to be better organized as a team." Ideas for reorganizing the process were "designating members to share cases on a rotating basis during each quarterly meeting," "case managers submitting cases for review on a regular basis," or "identifying the case to participants ahead of time so the respective members can gather information before the meeting," A repeated concern pertaining to child fatalities was having "more timely ME [medical examiner] reports" or "more timely submission of names of children at time of death." A related issue concerned combined teams and their need for "Updated guidelines": "Our local CCPT needs to refocus. The CCPT often takes the backseat to the CFPT [Child Fatality Prevention Team] agenda and during . . . meetings each agency has its own 'agenda' or purpose to address so . . . this causes the CCPT to be overlooked or just directly associated with DSS."

In summary, in reviewing cases, most CCPTs used reports from members and/or case managers, case files, and information on procedures and protocols of involved agencies. CCPTs identified what they needed to improve the case review process: standardization of procedures and forms, training and feedback from the state, better participation of mandated members as well as community and family partners, more timely receipt of medical examiners' reports, and clarification of the review process for CCPTs combined with Child Fatality Prevention Teams.

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

Limits on Access to Needed Services

A recurring concern of CCPTs is the families' limited access to needed services in mental health, developmental disabilities, substance abuse, and domestic violence (MH/DD/SA/DV). The 2014 through 2016 surveys inquired about whether the reviewed cases identified children and parents/caregivers lacking access to needed MH/DD/SA services. In all three past years, the lack of these three services was quite evident in the reviewed cases. The 2017 survey added access to DV services to the list of services. Because service access is affected by health insurance coverage, it should

be noted that 63 counties that responded to the service questions encompassed all seven Local Management Entity (LME)/Managed Care Organizations (MCOs). Each LME/MCO was represented by over half to all of their member counties.

The survey asked the CCPTs to identify how many cases reviewed in 2017 needed access to MH/DD/SA/DV services. Table 11 summarizes the findings first for the children and second for the parents or other caregivers. For children, the most needed service was mental health. Here 84% of the responding CCPTs identified this need for the children in a total of 193 cases. In regards to DD, SA, and DV services, 56% of the CCPTs stated these services were needed for the children; however, DV services were required by a combined 71 cases, which exceeds the numbers for DD (40 cases) and SA (50 cases).

For the parents or caregivers, the need for mental health and substance abuse services were the most prominent. Among the responding teams, 91% and 89% identified the need respectively for MH and SA services. The total number of reviewed cases were also highest with 216 of the reviewed cases requiring MH services and 208 requiring SA services. The need for DV services was cited by 76% of the teams, for a total of 104 cases. To a much lesser extent, CCPTs identified the need for DD services.

As noted previously, CCPTs commonly selected cases for review because of parental drug use, child safety, domestic violence, and child and family well-being (which includes mental health). These criteria would tilt the findings on reviewed cases toward the need for MH, SA, and DV services. Another way to view the findings is 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.

Table 11 Number of Reviewed Cases Requiring Access to MH/DD/S/DV Services

Number of Reviewed Cases Requiring Access to MH/DD/SA/DV Services, 2017 (N= 63)

	Number of CCPTs	Sum of Cases	Median of Cases
Children/Youth			
Mental Health	53 (84.1%)	193	2.00
Developmental Disabilities	35 (55.6%)	40	1.00
Substance Abuse	35 (55.6%)	50	0.00
Domestic Violence	35 (55.6%)	71	1.00
Parents/Caregivers			
Mental Health	57 (90.5%)	216	3.00
Developmental Disabilities	33 (52.4%)	37	0.00
Substance Abuse	56 (88.9%)	208	3.00

Domestic Violence	48 (76.2%)	104	1.50

Note. MH/DD/SA/DV=Mental Health, Developmental Disabilities, Substance Abuse, and Domestic Violence. The sample includes the 62 CCPTs that had at least one case review and 1 additional CCPT that answered these questions. The percentages in parentheses are out of the 63 valid responses. The median refers to the midpoint of the number of cases identified with limited access to services.

Next the survey asked, "Which of the following limitations prevented children, youth, and their parents or other caregivers from accessing needed MH/DD/SA/DV services?" As shown in Table 12, the two most frequently cited limitations were transportation to services (75% of CCPTs) and limited services or no available services (68% of CCPTs). Over two-fifths (41%) of CCPTs recognized that youth's having a dual diagnosis of MH and SA limited service access. Another common limitation, cited by 38% of CCPTs, was because of the community's lack of awareness about available services.

Among the responding teams, 17 CCPTs wrote in additional limitations. These primarily concerned systemic factors and to a far lesser extent, family reasons. Some CCPTs commented on families' "refusing service," "language and cultural barriers," and sense of "stigma around receiving services." One CCPT wrote about families' "lack of insight/desire to access services." It is quite likely that these identified family reasons reflected systemic barriers.

A frequently cited systemic factor concerned medical insurance or Medicaid. One CCPT observed that there was "no parent/caretaker medical insurance coverage to access substance abuse services." "Another pointed to the "loss of Medicaid for parents once their children are taken into custody." And a third identified the lack of coverage for "undocumented individuals." Another major systemic factor was the complexity of the system that made it difficult for families "navigating the MH/DD/SA/DV system." Barriers were also evident for service providers: "Too strict rules for some services that can be offered by MH/SA provider in order to get reimbursed." Other CCPTs identified that services did not align with family needs. A case in point is the lack of services for a "child with sexual behaviors/criminal charges/DJJ [Department of Juvenile Justice] involvement."

A CCPT identified that reimbursement policies were a barrier to service provision: "Too strict rules for some services that can be offered by MH/SA provider in order to get reimbursed."

Table 12 Number of CCPTs Reporting Limitations Preventing Children, Youth, and Their Parents or Other Caregivers Accessing Needed MH/DD/SA Services

Number of CCPTs Reporting Limitations Preventing Children, Youth, and Their Parents or Other Caregivers Accessing Needed MH/DD/SA/DV Services, 2017, (N = 63)

Limits on Access	Number of CCPTs
Limited Transportation to Services	47 (74.6%)
Limited Services or No Available Services	43 (68.3%)
Limited Services MH and SA for Youth with Dual Diagnosis	26 (41.3%)
Limited Community Knowledge About Available Services	24 (38.1%)
Limited Services MH and DD for Youth with Dual Diagnosis	16 (25.4%)
Limited Services MH and DV for Youth with Dual Diagnosis	16 (25.4%)
Limited Attendance MH/DD/SA/DV Providers at CFTs	12 (19.0%)
Limited Number of Experienced CFT Meeting Facilitators	6 (9.5%)
Other	17 (27.0%)

Note. MH/DD/SA/DV = Mental Health, Developmental Disabilities, Substance Abuse, and Domestic Violence. The sample includes the 62 CCPTs that had at least one case review and 1 additional CCPT that answered these questions. The percentages in parentheses are out of the 63 valid responses.

In summary, children, youth, and their parents or caregivers faced serious barriers to accessing needed services. Most CCPTs who reviewed cases in 2017 reported that children and youth needed access to mental health services. Most CCPTs also reviewed cases in which the parents or caregivers required access to mental health, substance abuse, or domestic violence services. As noted previously, CCPTs commonly selected cases for review because of parental drug use, child safety, domestic violence, and child and family well-being (which includes mental health). These criteria would tilt the findings on reviewed cases toward the need for MH, SA, and DV services. Another way to view the findings is 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. The most commonly cited barriers were transportation to services, limited services or no available services, and youth's having a dual diagnosis of mental health and substance abuse issues. The CCPTs commented on some family factors affecting service receipt such refusing 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, lack of medical insurance or Medicaid, and policies preventing MH/SA service providers from being reimbursed.

Recommendations for Improving Child Welfare Services

The case reviews identified multiple factors affecting service delivery and provided a foundation from which the CCPTs could formulate ways to improve child welfare delivery. CCPTs who reported conducting case reviews were asked, "Based on your 2017 case reviews, what were your team's top

three recommendations for improving child welfare services?" This question prompted extensive response, with only 5 out of 62 not offering a recommendation. Among the others, 7 gave one recommendation, 18 gave two, and 3 gave three. This made for a total of 139 recommendations. Their recommendations centered of six interconnected areas: service access, case assessment, community education and collaboration, child protection changes, case reviews, and CCPT functioning.

Service Access. The CCPTs repeatedly called for better access to substance abuse, mental health, domestic violence, and health services. They wanted quality, comprehensive, consistent, and coordinated services within families' home communities and transportation to appointments. They recognized that parents who had lost custody of their children required continuation of their Medicaid so that they could heal and reunify their families. Another concern was ensuring that undocumented individuals received essential services. They connected substance use to families' lack of income and resources combined with policies impeding needed care. Writing at length, a CCPT first recommended "less rigid rules" and better Medicaid coverage and then pointed out, "The majority of DSS cases involve poverty—inadequate housing, lack of transportation, job without a living salary, and health needs. For example, two of the parents struggling with addiction were prescribed opioids for emergency dental treatment that could have been prevented if dental care was a regular part of their care."

Calling for better health coverage to prevent substance use, a CCPT gave a troubling example, "Two of the parents struggling with addiction were prescribed opioids for emergency dental treatment that could have been prevented if dental care was a regular part of their care."

Case Assessment. In order that children and their families could access a full array of services, CCPTs underscored the necessity of comprehensive medical evaluations. This would also take close collaboration with hospitals by the Department of Public Health and DSS in such matters as maternal substance use during pregnancy. Child protective services' assessments, a team stressed, should go beyond "the area noted in the complaint." Another team urged "reorganization of the division to increase expertise on intake." Additionally, they wanted readier availability of case information as needed. For example, a CCPT advised, "CPS [child protective services] supervisors having access to state systems after hours in order to evaluate case specific information."

A CCPT advised child protective services' "supervisors having access to state systems after hours in order to evaluate case specific information."

Community Education and Collaboration. In order for services to be fully utilized, CCPTs urged enhancing community education and collaboration. A team recommended, "Increasing awareness in the community," and specifically referred to raising awareness in "schools for youth regarding suicide, alcohol, drugs, mental health issues, driver safety, etc." Knowing that child protection had to be a wider effort, a CCPT highlighted "outreach/training with local agencies on reporting cases." Another CCPT wanted "to get community leaders more involved with assisting the families in need of services." Two CCPTs pointed out how child and family teams (CFTs) could enhance collaboration: "inviting more Mental Health providers to CFTs" and "invit[ing] the Interfaith Refugee to CFTs."

Two CCPTs pointed out how child and family teams (CFTs) could enhance collaboration: "inviting more Mental Health providers to CFTs" and "invit[ing] the Interfaith Refugee to CFTs."

Child Protection Services. CCPTs recommended both systemic and workforce changes. They wanted the inclusion of more preventive services and "becoming more trauma focused and changing the infrastructure to do so." To improve the workforce, they stressed the need for raising the number of workers, "staff retention and recruitment efforts . . . and increased compensations," and workers' receiving "required and recommended training." They also urged better oversight to ensure "that social workers are making contact with family." Others pressed for expanding child placements and "financial compensation for kinship care providers."

CCPTs wanted child protection including more preventive services and "becoming more trauma focused and changing the infrastructure to do so."

Case Reviews. CCPTs emphasized the importance of their case reviews. One team explained, "We are committed to continued review of cases needing community support to address challenging factors." A team advised that the state "include 'near fatalities' in the intensive review process." Another team recommended a "low threshold for accepting cases with unexpected child death."

A team advised that the state "include 'near fatalities' in the intensive review process."

CCPT Functioning. They wanted "more partners on the team" and thought that social workers needed to be "involved in the CCPT's meeting." Another recommendation was "funding for CCPTs to develop local projects and initiatives."

Another recommendation was "funding for CCPTs to develop local projects and initiatives."

In summary, based on their case reviews, the CCPTs made a wide range of recommendations to improve child welfare services. Their top recommendations centered on six mutually-supportive areas:

- To increase service access by ensuring health insurance and quality and comprehensive services in families' home communities;
- To improve case assessment by having thorough medical evaluations and child protective services' assessments that address families' needs for a full array of services;
- To enhance community education and collaboration by educating community members and encouraging joint efforts that resolve child and family issues;
- To develop child protection services by making systemic changes and strengthening the workforce;
- To utilize case reviews by selecting challenging situations and identifying challenging factors; and
- To promote CCPT functioning by expanding membership and establishing funding for local initiatives.

What are local CCPTs' objectives, and to what extent do they achieve these objectives?

This year the survey asked a series of new questions about the CCPTs' objectives. First, they were asked, "Did your CCPT set objectives to complete over 2017?" Among the 63 responding CCPTs, 25

(40%) said *yes* and 38 said *no* (60%). All CCPTs who responded *yes* characterized themselves as an established team that met regularly.

Next, the 25 CCPTs who set objectives were asked, "List your CCPT's top three objectives for 2017. Then rate how successful your CCPT was in achieving these objectives." Table 13 summarizes the extent to which the CCPTs achieved their objectives on a four-point scale from *not at all*, *slightly*, *mostly*, and *completely.* In addition, they could select *too soon to rate.* Three CCPTs selected *too soon to rate* for one of their three objectives. All 25 CCPTs provided an Objective 1 with all stating that the objective was achieved to some extent. The median response was *mostly.* Nearly all (22) CCPTs identified an Objective 2, with the median at *completely.* An Objective 3 was identified by approximately two-third (16) of the CCPTs, and the median was *mostly.* When the ratings for the three objectives are combined, the median is *mostly.* In other words, the CCPTs overall saw themselves as successful in meeting their objectives for the year.

Table 13 Rating of CCPT Achievement of Objectives

Rating of CCPT Achievement of Objectives, 2017 (N =25)

	Number of CCPTs	Not at All	Slightly	Mostly	Completely	Median	Too Soon to Rate
Objective 1	25[a]	0	7	10	8	Mostly	1
Objective 2	22	1	3	5	13	Completely	1
Objective 3	16	1	3	5	7	Mostly	1
Total	**-**	**2**	**13**	**20**	**28**	**Mostly**	**3**

Note. The respondents were CCPTs who said that they had set objectives for 2017.
[a]One CCPT gave two ratings for Objective 1 (*mostly* and *too soon to rate*).

The objectives of the CCPTs for the most part aligned with their top recommendations for improving child welfare services as summarized in the previous section. CCPTs worked to improve access to mental health, substance use, and health services. They engaged medical examiners, provided public education and professional training, and worked collaboratively to protect children and improve family well-being. They sought to strengthen their case reviews and team functioning. Their success rate in achieving these objectives varied across the teams.

Objectives that some teams reported as *not at all* or *slightly* successful related particularly to improving access to services. One team rated themselves *not at* all succeeding in increasing mental health services. Another team reported *slightly* meeting their objective of "timely access to needed behavioral health and substance abuse services." And a third team saw themselves as *slightly* achieving the objective to "address the lack of mental health services to diagnose/treat juvenile sex offenders without health insurance coverage." Even *slightly* meeting these ambitious objectives is commendable.

A team rated themselves as *slightly* achieving the objective to "address the lack of mental health services to diagnose/treat juvenile sex offenders without health insurance coverage." Even *slightly* meeting this ambitious objective is commendable.

These same teams and others reported greater success in specific efforts to improve access. Their successes included assessing services, raising awareness, sharing information, and leveraging collaborations. For example, a team rated themselves as *completely* achieving the objectives to "continue evaluating the level of services/care and resources to meet the needs of families" and "bring awareness to the community of the effects of substance abuse in neonatal cases." Another team saw themselves as *completely* successful in getting a social worker for the school system.

A CCPT rated themselves as *completely* achieving the objectives to "continue evaluating the level of services/care and resources to meet the needs of families."

Many of the CCPT objectives related to improving their case reviews and strengthening their teams. The teams' self-ratings of success differed widely. Some reported struggling to "identify cases" for review and "topics of concern." Others reported greater success in increasing their case reviews. One team rated themselves as *completely* achieving their objectives to "revise the case presentation format to ensure consistency in information presented to the CCPT" and "develop a tool to collect case review data."

One team rated themselves as *completely* achieving their objective to "revise the case presentation format to ensure consistency in information presented to the CCPT."

Increasing membership and attendance were frequently cited by teams. Here some CCPTs gave themselves ratings of *slightly* and others ratings of *mostly* or *completely*. For instance, one team gave themselves a *mostly* in achieving the objective to "fill all CCPT vacancies," and another team stated that they were *completely* successful in meeting the objective to "engage the ME's [medical examiner's] office in attendance at CCPT."

Another team stated that they were *completely* successful in meeting the objective to "engage the ME's [medical examiner's] office in attendance at CCPT."

After asking the CCPTs to assess achievement of their objectives, the survey asked, "What helped you achieve your objectives? Twenty-two out of the 25 teams who set objectives described steps that helped them succeed. Repeatedly the CCPTs emphasized the "great teamwork," and they credited the members' "full participation and investment," their "strong partnerships," "buy in and support from administrators and community leaders," and "all agencies working together with the common goal of protecting children." They identified specific approaches that helped them succeed: "seeking input from team members," reaching "consensus," and "offering lunch." One CCPT advised "sending out regular email reminders and the agenda two weeks in advance" to develop members' investment in the team. Another strategy applied by a team was to assign "two different ad hoc committees and follow . . . up with reports from the committees at each meeting." In formulating achievable objectives, a CCPT "kept them simple and attainable and as a joint effort . . . with relevant programs that are already established and semi-funded and in need of the support."

Repeatedly the CCPTs emphasized that they achieved the objectives because of their "great teamwork."

The survey also asked, "What challenges did you face in achieving your objectives?" Sixteen CCPTs identified challenges. The primary ones were "time and resources" and "not all members agreed on priorities, which hindered CCPT's "follow up, follow through." Others pointed to the lack of resources in the community especially for behavioral health services and especially in small counties. A recurring challenge was low funding and "community/government commitment."

In summary, the 25 CCPTs that set objectives for their team for the most part achieved them. Their successes included assessing services, raising awareness, sharing information, and leveraging collaborations. Their challenges were limited community resources and funding. CCPT differed on whether they achieved their objectives of improving their case reviews and strengthening their teams. CCPTs credited their "great teamwork" in realizing these objectives while also identifying challenges concerning members' time, resources, and agreement on priorities.

Which action steps do CCPTs support to accomplish the four 2016 Advisory Board recommendations?

The NC CCPT Advisory Board at its June 19, 2017 meeting reached agreement on four recommendations to submit to NC DSS for written response. The recommendations were informed by three years of CCPT surveys administered in 2014, 2015, and 2016. These recommendations were:

1. Ensure that children, youth, and families have the mental health services required for promoting child safety, child permanency, and child and family well-being
2. Strengthen the capacity of local CCPTs to work with Social Services in improving child welfare services
3. Establish the NC CCPT Advisory Board as the state body responsible for synthesizing and advocating for the local CCPT experiences and recommendations, identifying areas for child abuse prevention planning and improvements in the child welfare system, and serving as an asset to NC DSS in improving child welfare services
4. Engage in planning on the long-term structure and processes for citizen review panels in the state

Each recommendation was accompanied by six to eight action steps to accomplish them. In order to assess the local teams support for the action steps, the 2017 CCPT survey asked for each recommendation, "Which of the following action steps does your CCPT support to accomplish [the recommendation]?" The respondents could check all with which they agreed and had the option of writing in additional steps.

2016 Recommendation 1: Ensure that children, youth, and families have the mental health services required for promoting child safety, child permanency, and child and family well-being

As previously and repeatedly documented in this report, the first 2016 recommendation aligned with the CCPTs' voiced concerns about the lack of accessible mental health services for children, youth, and

families served by child welfare. Table 14 summarizes which action steps the CCPTs supported for accomplishing this recommendation. The action step that received the most support pertained to increasing awareness of available services in the community; 80% of the CCPTs agreed. A close second in support was assisting families in accessing needed services, with 79% of the CCPTs agreeing. Over half the CCPTs concurred with offering training to Social Services and their partners in helping families connect to services and with reaching cross-system definitions on these services. Over two-fifths of the CCPTs gave their backing to identifying successful strategies in the state and disseminating them across the state. Another two-fifths of CCPTs wanted a comparison of the services covered by the different LME/MCOs. One CCPT wrote in, "Promote more of a focus on what is needed in a county within an LME/MCO than 'it is available within our LME/MCO catchment area.'" Another CCPT advised that the state "explore embedding clinical services within child welfare at the county department level." Not wanting to lose sight of substance abuse services, a third CCPT emphasized more treatment and education in this area.

One CCPT wrote in, "Promote more of a focus on what is needed in a county within an LME/MCO than . . . available within our LME/MCO catchment area."

Table 14 Support for 2016 Recommendation 1: Ensure that children, youth, and families have the mental health services required for promoting child safety, child permanency, and child and family well-being

Support for 2016 Recommendation 1: Ensure that children, youth, and families have the mental health services required for promoting child safety, child permanency, and child and family well-being, *2017, (N = 79)*

Action Step	Number of CCPTs Supporting the Action
Promote education on what services are available within communities for families	63 (79.7%)
Assist families in accessing needed mental health services, including providing subsidies for Medicaid-ineligible families (such as when children enter care), transportation especially in rural areas, and translation/interpretation for non-English-speaking families	62 (78.5%)
Provide training to Social Services and their community partners in assisting families in accessing appropriate services	45 (57.0%)
Work with state-level agencies and family-and-child associations to reach cross-system definitions of services, timelines, and response times	43 (54.4%)
Identify strategies working well within our state to provide quality and accessible mental health services to families and disseminate these strategies statewide	36 (45.6%)
Compare the mental health services and their quality and accessibility that covered by different Local Management Entity (LME)-Managed Care Organizations (MCOs) for children and youth in care and for their families	32 (40.5%)
Examine the cost-effectiveness of different mental health delivery mechanisms (e.g., teleconferencing)	18 (22.8%)
Other[a]	3 (3.8%)

Note. CCPTs could select all that apply.
[a]One CCPT provided two other steps.

In summary, most CCPTs supported taking action to ensure children, youth, and families' access to mental health services. They especially endorsed increasing awareness of available services, helping families access these services, providing training to professionals on service access, and reaching cross-system definitions of services to facilitate access.

2016 Recommendation 2: Strengthen the Capacity of Local CCPTs to Work with Social Services in Improving Child Welfare Services

Demonstrating a keen interest in preventative measures, most (79%) CCPTs wanted support for educating their families and communities about protective factors to prevent child maltreatment and for creating local plans for prevention (see Table 15). In order to better carry out CCPT functions, 71% of the teams asked for more training and technical assistance, and 57% asked for an updated CCPT reference guide. Three CCPTs wrote in additional steps. These included orientation and training for local teams and having "an annual retreat for all counties to share ideas and network."

Table 15 2016 Recommendation 2: Strengthen the capacity of local CCPTs to work with Social Services in improving child welfare services

2016 Recommendation 2: Strengthen the capacity of local CCPTs to work with Social Services in improving child welfare services, 2017 (N=79)

Action Step	Number of CCPTs Supporting the Action
Support local CCPTs in their work to educate communities and families about protective factors to prevent child abuse and neglect and to make local plans for prevention	62 (78.5%)
Provide in-person and on-line training and technical assistance to local CCPTs on (a) CCPT responsibilities and processes, (b) child welfare policies and procedures, (c) interagency collaboration, (d) diversity on teams, and (e) inclusion of family and youth partners on teams	56 (70.9%)
Update the *2004 Reference Guide*, post the guide on the NC DSS website, and distribute the guide to county DSSs and local CCPT chairpersons	45 (57.0%)
Facilitate agreement on a template for the end-of-year report to county commissioners and the NC CCPT Advisory Board	38 (48.1%)
Promote discussion of policy recommendations proposed by local CCPTs and the NC CCPT Advisory Board	37 (46.8%)
Support smaller counties in creating regional CCPT mechanisms that reflect their already shared membership and resources	30 (38.0%)
Other	4 (5.1%)

Note. CCPTs could select all that apply.

In summary, most CCPTs wanted support in order to better carry out their work. This included education of protective factors and training and technical assistance on team functions, including having an updated CCPT reference guide.

2016 Recommendation 3: Establish the NC CCPT Advisory Board as the state body responsible for synthesizing and advocating for the local CCPT experiences and recommendations, identifying areas for child abuse prevention planning and improvements in the child welfare system, and serving as an asset to NC DSS in improving child welfare services

As shown in Table 16, two-thirds (66%) of the CCPTs agreed that the NC CCPT Advisory Board should ensure collection of information from local teams to facilitate planning. Over half (57%) wanted the role of the Board formalized in writing. Half (51%) wanted a case review survey implemented across the state. In their written suggestions, CCPTs wanted greater clarity on the role of the Advisory Board and continuation of the reorganization of the Board. Another CCPT proposed, "Identify opportunities for collaboration with the Child Fatality Task Force as there are many combined teams statewide."

Table 16 2016 Recommendation 3: Establish the NC CCPT Advisory Board as the state body responsible for synthesizing and advocating for the local CCPT experiences and recommendations, identifying areas for child abuse prevention planning and improvements in the child welfare system, and serving as an asset to NC DSS in improving child welfare services, 2017

Support for 2016 Recommendation 3: Establish the NC CCPT Advisory Board as the state body responsible for synthesizing and advocating for the local CCPT experiences and recommendations, identifying areas for child abuse prevention planning and improvements in the child welfare system, and serving as an asset to NC DSS in improving child welfare services, 2017 (N = 79)

Action Step	Number of CCPTs	
Ensure the collection of data from local CCPTs for planning purposes	52	(65.8%)
Formalize in writing the role of the NC CCPT Advisory Board	45	(57.0%)
Implementing a case review survey across the state	40	(50.6%)
Support and participate in an annual retreat of the Advisory Board and NC DSS to support collaborative working relationship and engage in strategic planning	37	(46.8%)
Provide child and family data needed for planning purposes by the NC CCPT Advisory Board and costs of policy recommendations	36	(45.6%)
Facilitate the NC CCPT Advisory Board sharing findings and recommendations with state policy bodies	35	(44.3%
Work with the NC CCPT Advisory Board in determining policy areas for study	34	(43.0%)
Support and participate in an annual retreat of the Advisory Board and NC DSS to support collaborative working relationship and engage in strategic planning	28	(35.4%)
Other	4	(5.1%)

Note. CCPTs could select all that apply.

In summary, two-thirds of the CCPTs endorsed the NC CCPT Advisory Board collecting data from local teams to facilitate planning. Over half wanted the role of the Board formalized in writing.

2016 Recommendation 4: Engage in planning on the long-term structure and processes for citizen review panels in the state

The large majority (70%) of the CCPTs wanted to be included in the planning for the long-term structure and processes for citizen review panels in the state (see Table 17). Over half endorsed having in place the necessary resources for carrying out, evaluating, and improving the model and ensuring adequate notification and orientation of local teams and state agencies about the model. One team advised having the "appropriate members are on the team."

Table 17 2016 Recommendation 4: Engage in planning on the long-term structure and processes for citizen review panels in the state

Support for 2016 Recommendation 4: Engage in planning on the long-term structure and processes for citizen review panels in the state, 2017, (N = 79)

Action Step	Number of CCPTs Supporting the Action
Engage local CCPTs in the planning process	55 (69.6%)
Put in place necessary resources for implementing, evaluating, and improving the model	46 (58.2%)
Ensure adequate notification and orientation of local teams and state bodies to the model	43 (54.4%)
Develop a North Carolina model for CRP and consider as necessary, possible legislative changes	35 (44.3%)
Review with the NC CCPT Advisory Board different citizen review panel (CRP) models used in other states	32 (40.5%)
Support a meeting of the NC CCPT Advisory Board and NC DSS with the national technical assistant on CRP models	30 (38.0%)
Other	1 (1.3%)

Note. CCPTs could select all that apply.

In summary, most CCPTs wanted to be included in the planning for the long-term structure and processes for citizen review panels in the state. Over half endorsed having in place the necessary resources for carrying out, evaluating, and improving the model and ensuring adequate notification and orientation of local teams and state agencies about the model.

What further advice can you give on putting the four recommendations into action?

The survey then asked, "What further advice can you give us on putting the four recommendations into action?" Twenty-one CCPTs made suggestions, and one CCPT wrote, "Thank you for your survey." The often in-depth and extensive advice demonstrated the local team's commitment to the work. They wanted to be included in planning; to have a good flow of information of local teams with the NC CCPT Advisory Board, NC DSS, and NC Association of County Directors of Social Services; and to have resources (funding, training) for local teams. The teams further recognized the need for "enhanced collaborations" (e.g., LME/MCOs, courts) in order to implement the recommendations. Some urged greater attention to local issues, pointing out that the four recommendations appeared "to be the responsibility of the state, rather than the local teams." Overall, the teams wanted to be valued, supported, and oriented so that they could engage in wider discussions on their role within the state context. As one team articulated, "Bring together the local CCPTs and CFPTs (Child Fatality Prevention Teams) for orientation to their roles on the team and educate local teams to how and where the local

team fits into the overall functioning of the CCPT model for the state of North Carolina. The local team needs a wider frame of reference."

As one team articulated, "Bring together the local CCPTs and CFPTs (Child Fatality Prevention Teams) for orientation to their roles on the team and educate local teams to how and where the local team fits into the overall functioning of the CCPT model for the state of North Carolina. The local team needs a wider frame of reference."

Recommendations Based on 2017 Survey

After reviewing the findings from the 2017 CCPT survey, the NC CCPT Advisory Board met on May 2, 2018 and approved a set of recommendations to be sent to NC DSS for response. In addition, the Advisory Board identified specific issues that emerged from the survey regarding information, resources, and supports requested by local CCPTs (see Appendix B).

The Advisory Board members agreed that they continued to support the four 2016 recommendations and further developed and updated these recommendations. The four recommendations for 2017 are as follows:

Recommendation 1—Ensure that children, youth, and families have the mental health services required for promoting child safety, child permanency, and child and family well-being through the following steps:

1. Work with state-level agencies and family-and-child associations to reach cross-system definitions of services, timelines, and response times;
2. Assist families in accessing needed mental health services, including providing subsidies for Medicaid-ineligible families (such as when children enter care), transportation especially in rural areas, and translation/interpretation for non-English-speaking families;
3. Provide training to Social Services and their community partners in assisting families in accessing appropriate services;
4. Promote education on what services are available within communities for families;
5. Compare the mental health services and their quality and accessibility that are covered by different Local Management Entity (LME)-Managed Care Organizations (MCOs) for children and youth in care and for their families;
6. Examine the cost-effectiveness of different mental health delivery mechanisms (e.g., teleconferencing);
7. Coordinate with state health officials implementing the North Carolina State Opioid Plan to ensure that addicted parents and caretakers receive the necessary mental health and substance abuse treatment and ongoing recovery supports and that children being impacted by the current drug epidemic receive trauma-informed counseling services; and
8. Identify strategies working well within our state to provide quality and accessible mental health services to families and disseminate these strategies statewide.

Recommendation 2—Strengthen the Capacity of Local CCPTs to Work with Social Services in Improving Child Welfare Services through the following steps:

1. Update the *2004 Reference Guide*, post the guide on the NC DSS website, and distribute the guide to county DSSs and local CCPT chairpersons;
2. Provide in-person and on-line training and technical assistance to local CCPTs on (a) CCPT responsibilities and processes, (b) case identification and review with particular attention to child maltreatment fatalities and near fatalities, (c) child welfare policies and procedures, (d) interagency collaboration, (e) diversity on teams, and (f) inclusion of family and youth partners on teams;
3. Assist local CCPTs with identifying resources for comprehensive medical evaluations, domestic violence, transportation, and other areas of child and family need;
4. Support local CCPTs in their work to educate communities and families about protective factors to prevent child abuse and neglect and to make local plans for prevention;
5. Promote discussion of policy recommendations proposed by local CCPTs and the NC CCPT Advisory Board;
6. Facilitate agreement on a template for the end-of-year report to county commissioners and the NC CCPT Advisory Board;
7. Support local teams in completing the end-of-year survey;
8. Offer particular assistance to local teams that are re-engaging in the work;
9. Support smaller counties in creating regional CCPT mechanisms that reflect their already shared membership and resources; and
10. Provide some funding to local CCPTs to better carry out their responsibilities.

Recommendation 3—Establish the NC Citizen Review Panel (CRP)/CCPT Advisory Board as the state body responsible for synthesizing and advocating for the local CCPT experiences and recommendations, identifying areas for child abuse prevention planning and improvements in the child welfare system, and serving as an asset to NC DSS in improving child welfare services through the following steps:

1. Implement the newly reconstituted Advisory Board as the NC Citizen Review Panel(CRP)/CCPT Advisory Board;
2. Work with the NC DSS CCPT consultant to facilitate communication among local teams, Advisory Board, and NC DSS;
3. Fund and participate in an annual retreat of the Advisory Board, local CCPTs, and NC DSS to support collaborative working relationship and engage in strategic planning;
4. Encourage linkages between the North Carolina Child Welfare Family Advisory Council and the NC CRP/CCPT Advisory Board;
5. Work with the NC CCPT Advisory Board in determining policy areas for study;
6. Work with the NC CCPT Advisory Board in synthesizing recommendations emerging from intensive child fatality reviews;
7. Ensure the collection of data from local CCPTs for planning purposes;
8. Provide child and family data needed for planning purposes by the NC CCPT Advisory Board and costs of policy recommendations; and

9. Facilitate the NC CCPT Advisory Board sharing findings and recommendations with state policy bodies.

Recommendation 4—Engage in planning on the long-term structure and processes for citizen review panels (CRPs) in the state through the following steps:

1. Request involvement in the state's child welfare reform efforts with a particular focus on the role of CCPTs and CRPs;
2. Continue to confer with the national technical assistant on CRP models and examine CRP models used in other states;
3. Engage local CCPTs in the planning process;
4. Develop a North Carolina model for CRP and consider as necessary, possible legislative changes;
5. Put in place necessary resources for implementing, evaluating, and improving the model; and
6. Ensure adequate notification and orientation of local teams and state bodies to the model.

Appendices

Appendix A: Survey Process and Results

Table A-1 Timeline of CCPT Survey, 2017

Timeline of CCPT Survey, 2017

Date	Activity
July 31, 2017	NC CCPT Advisory Board established ad-hoc survey subcommittee to develop end-of-year survey
August 14, 2017	NC CCPT Advisory Board Survey Subcommittee specified items for the end-of-year survey
November 1, 2017	NC State University Institutional Review Board approved research protocols protecting participants
November 3, 2017	NC DSS sent letters to the County DSS Directors and to the CCPT Chairs to notify them about the survey
November 10 2017	NC State University Research CCPT Team distributed survey to CCPT Chairpersons or designees followed by weekly reminders to unfinished respondents
December 1, 2017	NC DSS reminded CCPT Chairs to complete the survey
January 31, 2018	Deadline for survey submission
February 6, 2018	Extended deadline for survey submission
April 18, 2018	NC CCPT Advisory Board reviewed survey findings

Table A-2 Counties of CCPTs Submitting Survey Report

Local CCPTs Submitting Survey Report, 2017

Participating Counties			
Alamance	Dare	Lincoln	Sampson
Allegheny	Davidson	Macon	Scotland
Anson	Durham	Madison	Stanly
Avery	Edgecombe	Martin	Stokes
Bertie	Franklin	Mecklenburg	Surry
Bladen	Gaston	Mitchell	Tyrrell
Brunswick	Gates	Montgomery	Union
Buncombe	Graham	Nash	Vance
Burke	Guilford	New Hanover	Washington
Cabarrus	Halifax	Northampton	Wake
Camden	Harnett	Onslow	Watauga
Carteret	Haywood	Orange	Wayne
Caswell	Henderson	Pamlico	Wilkes
Catawba	Hertford	Pasquotank	Wilson
Chatham	Hoke	Person	Yadkin
Cherokee	Hyde	Pitt	
Chowan	Iredell	Polk	
Clay	Jackson	Randolph	
Cleveland	Johnston	Richmond	
Columbus	Jones	Robeson	
Craven	Lee	Rockingham	
Cumberland	Lenoir	Rutherford	

Note. The survey was sent to 101 CCPTs of whom 81 responded. The respondents included the Eastern Band of the Cherokee Indians.

Table A-3 Responding CCPTs by County Population Size

Responding CCPTs by County Population Size, 2017, (N=81)

County Size	Total Counties	Total Responding Counties	Percent
Small	51	38	78.43%
Medium	39	34	87.18%
Large	10	8	80.00%

Note. The Eastern Band of the Cherokee Indians is not included on this cunty table.

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

LME/MCOs and Number of Member Counties Responding to Survey, 2017

LME/MCO	Number of Member Counties	Total Responding Counties	Percent
Alliance Behavioral Healthcare	4	4	100%
Cardinal Innovations Healthcare Solutions	20	15	75%
Eastpointe	11	9	82%
Partners Behavioral Health Management	8	8	100%
Sandhills Center	9	8	89%
Trillium Health Resources	25	21	84%
Vaya Health	23	15	65%
Total 7	100	80[a]	

Note. Member counties affiliated with a Local Management Entity (LME)/Managed Care Organization (MCO), as of March 24, 2018. See https://www.ncdhhs.gov/providers/lme-mco-directory

[a]Eastern Band of the Cherokee Indians not applicable.

Table A5 Organization of CCPTs and Child Fatality Prevention Teams (CFPTs) in Counties

Organization of CCPTs and Child Fatality Prevention Team (CFPTs) in Counties, 2016, (N=86)

CCPT/CFPT Organization	Number of Counties	Percent
Separate CCPT and CFPT	17	19.77%
Combined CCPT and CFPT	66	76.74%
Other	3	3.49%

Note. Missing data on one case. Selection of Other: "combined CCPT/CFPT in November 2016" and "just beginning CCPT."

Table A6 Type of Case Review Used for Child Maltreatment Fatalities

Type of Case Review Used for Child Maltreatment Fatalities, 2016, (N=19)

Type of Case Review	Number of Counties
Combined CCPT and Child Fatality Prevention Team conducted case review	9
Child Fatality Prevention Team conducted case review	1
NC DSS (Intensive) state child fatality review pending (case reported to NC DSS, and case scheduled for review	7
CCPT case review pending (CCPT received notification of case, and case scheduled for review)	0
CCPT conducted case review	1
No case review conducted	0
NC DSS conducted (intensive) state child fatality review	2
CCPT declined to conduct case review	0
NC DSS not notified of case	1
Other	4

Note. Of the 86 responding CCPTs, 54 indicated they had zero Child Maltreatment Fatality Reviews. Respondents could check all that apply. There were 19 valid cases.

Appendix B: Issues Emerging from Survey Responses

- Analyze and make contact with counties that did not respond and report result to Advisory Board
- Understand the issues of the two counties that reorganized but have not met yet
- Develop strategies for district attorney participation (or their designees)
- Develop strategies for school participation
- Understand the role of Community Action agencies on the local teams and decide whether they should continue to be a part
- Clarify our thinking on family and youth partners as part of local CCPTs
- Relay to local teams our thinking including the fact there is no statute requiring family and youth partners as part of local CCPTs
- Help local teams with suggestions on how to strategize on which cases to review
- Provide site visits to local teams and individual help with selecting cases
- Look at domestic violence services and have NC DSS working with domestic violence provide a fact sheet to local teams regarding resources.
- Need for insurance and Medicaid to cover substance abuse services
- Analyze transportation barriers and begin to help counties with this issue
- Analyze need for comprehensive medical evaluations
- Encourage trauma focused treatment
- Look at ways to help teams identify near fatality cases and review them

- Find ways for NC DSS to provide training to local DSS and partners on community service options
- Formalize role and structure of NC CCPT Advisory Board
- Have NC CCPT Advisory Board work more closely with child maltreatment fatalities
- Organize an annual retreat for local CCPTs
- Send timely information to local teams
- Provide some funding to teams

Appendix C: Copy of 2017 Survey

CCPT Survey 2017

Q1 **2017 Survey North Carolina Community Child Protection Teams Advisory Board**

We are asking that all Community Child Protection Teams (CCPTs) in North Carolina complete this 2017 survey. As the NC CCPT Advisory Board, we are responsible for conducting an end-of-year survey of local CCPTs and preparing a report to the North Carolina Division of Social Services (NC DSS). In the report, we summarize the information provided by the local CCPTs without identifying what individual teams said, and we make recommendations on how to improve public child welfare. NC DSS then writes a response to our report.

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

The survey responses are transmitted directly to the researcher, Dr. Joan Pennell, at North Carolina State University. This means that your responses are NOT transmitted to NC DSS or to the NC CCPT Advisory Board. Dr. Pennell and the other members of the research team (Dr. Jason Coupet, Dr. Maxine Thompson, Emily Lefebvre, Holly Benton, and Justine Chilton) 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.

Based on the 2016 CCPT survey data, the Advisory Board made four recommendations to the NC Division of Social Services:

1. **Ensure that children, youth, and families have the mental health services required for promoting child safety, child permanency, and child and family well-being**
2. **Strengthen the capacity of local CCPTs to work with Social Services in improving child welfare services**
3. **Establish the NC CCPT Advisory Board as the state body responsible for synthesizing local CCPT experiences and recommendations, identifying areas for further study and planning, and serving as an asset to NC DSS in improving child welfare services**
4. **Engage in planning on the long-term structure and processes for citizen review panels in the state**

This year's survey seeks your guidance on how to put these recommendations into action at the local and state levels.

Q2 Instructions: When completing this survey report, please remember the following:

1. This survey covers the work of your CCPT for the period January – December 2017.
2. Your survey responses must be submitted via Qualtrics survey– you should not submit paper copies to NC DSS or NC CCPT Advisory Board. As you work in your Qualtrics file, 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 for input and review before your survey report 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 20 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 CCPT Team at ccpt_survey@ncsu.edu.
7. Please complete and submit the survey in Qualtrics on or before **TBD**.

Q3 North Carolina State University INFORMED CONSENT FORM for RESEARCH

Title: Community Child Protection Team 2017 Survey Principal Investigator: Dr. Joan Pennell

What are some general things you should know about research studies?
You are being asked to take part in a research study. Your participation in this study is voluntary. You have the right to be a part of this study, to choose not to participate or to stop participating at any time without penalty. The purpose of research studies is to gain a better understanding of a certain topic or issue. You are not guaranteed any personal benefits from being in a study. Research studies also may pose risks to those that participate. In this consent form you will find specific details about the research in which you are being asked to participate. If you do not understand something in this form it is your right to ask the researcher for clarification

or more information. A copy of this consent form will be provided to you. If at any time you have questions about your participation, do not hesitate to contact the researcher named above.

What is the purpose of this study?

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

What will happen if you take part in the study?

If you agree to participate in this study, you will be asked to complete and submit the online survey. Filling out the survey will take about 20 minutes. In preparation for completing the survey, it is recommended that the local CCPT Chair meet with the team to discuss what responses to provide to the survey questions.

Risks

The local CCPTs are asked to identify by name their county or Qualla Boundary, and the responding CCPTs are listed in the end-of-year CCPT report that is shared with 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. Joan Pennell, and are not viewed by the

NC CCPT Advisory Board or by NC DSS. Before reporting the results, the researcher will combine responses and not link them to a specific CCPT.

Benefits

Your CCPT has the opportunity to contribute to improving public child welfare and protecting children from maltreatment.

Confidentiality

The information in the study records will be kept confidential to the full extent allowed by law. Data will be stored securely in a locked filing cabinet or under password protection. No reference will be made in oral or written reports that link your CCPT to specific survey responses.

Compensation

You will not receive anything for participating.

Q4 North Carolina State University INFORMED CONSENT FORM for RESEARCH

Title: Community Child Protection Team 2017 Survey Principal Investigator: Dr. Joan Pennell

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. Joan Pennell, 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 Deb Paxton, Regulatory Compliance Administrator at dapaxton@ncsu.edu or by phone at 1-919-515-4514.

Consent To Participate

"I have read and understand the above information. I have received a copy of this form. I agree to participate in

this study with the understanding that I may choose not to participate or to stop participating at any time without penalty or loss of benefits to which I am otherwise entitled."

- O **Yes**, you can now proceed to the next page.
- O **No**, please contact [TBD] at the NC Division of Social Services for technical assistance on completing the survey: email [TBD]@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.

Q5 **Select your CCPT from the list below.**

- ❍ Alamance
- ❍ Alexander
- ❍ Allegheny
- ❍ Anson
- ❍ Ashe
- ❍ Avery
- ❍ Beaufort
- ❍ Bertie
- ❍ Bladen
- ❍ Brunswick
- ❍ Buncombe
- ❍ Burke
- ❍ Cabarrus
- ❍ Caldwell
- ❍ Camden
- ❍ Carteret
- ❍ Caswell
- ❍ Catawba
- ❍ Chatham
- ❍ Cherokee
- ❍ Chowan
- ❍ Clay
- ❍ Cleveland
- ❍ Columbus
- ❍ Craven
- ❍ Cumberland
- ❍ Currituck
- ❍ Dare
- ❍ Davidson
- ❍ Davie
- ❍ Duplin
- ❍ Durham
- ❍ Eastern Band of Cherokee Nation (Qualla Boundary)
- ❍ Edgecombe

- Forsyth
- Franklin
- Gaston
- Gates
- Graham
- Granville
- Greene
- Guilford
- Halifax
- Harnett
- Haywood
- Henderson
- Hertford
- Hoke
- Hyde
- Iredell
- Jackson
- Johnston
- Jones
- Lee
- Lenoir
- Lincoln
- Macon
- Madison
- Martin
- McDowell
- Mecklenburg
- Mitchell
- Montgomery
- Moore
- Nash
- New Hanover
- Northampton
- Onslow
- Orange
- Pamlico
- Pasquotank
- Pender
- Perquimans
- Person
- Pitt
- Polk
- Randolph
- Richmond

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

Q6 Who completed this survey? (Please do not provide any identifying information)

- O The CCPT chair on their own
- O A designee of the CCPT chair on their own
- O The CCPT team as a whole
- O A subgroup of the CCPT team
- O Other _____

Q7 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?

- O Our team is not operating at all.
- O Our team was not operating, but we recently reorganized
- O Our team recently reorganized, but have not had any regular meetings
- O Our team recently reorganized and are having regular meetings
- O We are an established team that meets regularly.
- O Other _____

Q8 Some CCPTs combine their CCPT and Child Fatality Prevention Team (CFPT).

Which of the following applies to your CCPT?

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

Q9 CCPTs have members mandated by General Statute 7B-1406.

In 2017, 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

Q10 **Are there statutorily required team members that you feel might be unnecessary?**

- O Yes
- O No

Q11 **If you answered "yes" to the previous question, select who those mandated members are.**

- O DSS Director
- O DSS Staff
- O Law Enforcement
- O District Attorney
- O Community Action Agency
- O School Superintendent
- O County Board of Social Services
- O Mental Health Professional
- O Guardian ad Litem
- O Public Health Director
- O Health Care Provider

Q12 Please explain why they might be unnecessary.

_____

Q13 Besides mandated CCPT members, boards of county commissioners can appoint five additional members.

In 2017, how many additional members took part in your CCPT?

If zero, type 0. _____.

Q14 **List the organization/unit that additional members represent.**

Member 1 _____

Member 2 _____

Member 3 _____

Member 4 _____

Member 5 _____

Q15 **In 2016, did <u>family or youth partners</u> serve as members of your CCPT?**

o Yes
o No

Q16 **In 2017, how frequently did family or youth partners participate in your CCPT?**

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

Q17 List three strategies that your CCPT has successfully used to engage family and youth partners on your team.

- Strategy 1 _____
- Strategy 2 _____
- Strategy 3 _____

Q18 There are many reason why some family or youth partners might not participate in a CCPT. For example, family or youth partners may have limited transportation or feel apprehensive about taking part.

List three reasons that prevent some family or youth partners from taking part in your CCPT.

- Reason 1 _____
- Reason 2 _____
- Reason 3 _____

Q19 There are many reasons why a CCPT might have difficulty in keeping some family or youth partners engaged with their team. For example, CCPTs may not know how to recruit family or youth partners or support their involvement.

List three reasons that prevent your CCPT from engaging some family or youth partners in your CCPT.

- Reason 1 _____
- Reason 2 _____
- Reason 3 _____

Q20 **During 2017, did your CCPT partner with other organizations in the community to create programs or inform policy to meet an unmet community need?**

- Yes
- No

Q21 **If yes, describe the most important of these initiatives to meet a community need.**

_____

_____

Q22 **Besides the Child Fatality Prevention Team (CFPT), are you aware of any other county-level collaboration your CCPT is involved in?**

- Yes
- No

Q23 **If yes, describe the purpose of these collaborations.**

- O Collaboration 1 _____
- O Collaboration 2 _____
- O Collaboration 3 _____

Q24 **From January through December 2017, how many child maltreatment fatalities was your CCPT notified of?**

If zero, type in 0. _____

Child maltreatment fatalities are cases where the death was caused by abuse, neglect, or dependency and where the family had received Department of Social Services (DSS) child welfare services within 12 months of the child's death.

If you have questions about determining your number of cases of child maltreatment fatality, please contact Debra McHenry at the NC Division of Social Services for technical assistance: email debra.mchenry@dhhs.nc.gov or phone 919-527-6396.

Q25 **For these child maltreatment fatalities, state 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	_____
CCPT case review pending (CCPT received notification of case, and case scheduled for review)	_____
CCPT declined to conduct case review	_____
Child Fatality Prevention Team conducted case review	_____
NC DSS conducted (intensive) state child fatality review	_____
NC DSS (intensive) state child fatality review pending (case reported to NC DSS, and case scheduled for review)	_____

NC DSS not notified of case _____

No case review conducted _____

Other 1 _____

Other 2 _____

Q26 **What is the total number of cases of child maltreatment reviewed by your CCPT between January and December 2017?**

Include here both child maltreatment fatalities and other forms of child maltreatment**.**

If zero, type in 0. _____

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.

Q27 **Which of the following criteria did your CCPT use in 2017 for selecting cases for review?** Check all that apply. Please write in other criteria that you used.

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

Q28 **Which of the following** contributory factors **to children being in need of protection did you use in 2017 for selecting cases for review?**

- O Caretaker - Alcohol Abuse
- O Caretaker - Drug Abuse
- O Caretaker - Mental Retardation
- O Caretaker - Emotionally Disturbed
- O Caretaker - Visually or Hearing Impaired
- O Caretaker - Other Medical Condition
- O Caretaker - Learning Disability
- O Caretaker - Lack of Child Development Knowledge
- O Child - Alcohol Problem
- O Child - Drug Problem
- O Child - Mental Retardation
- O Child - Emotionally Disturbed
- O Child - Visually or Hearing Impaired
- O Child - Physically Disabled
- O Child - Behavior Problem
- O Child - Learning Disability

- O Child - Other Medical Condition
- O Household - Domestic Violence
- O Household - Inadequate Housing
- O Household - Financial Problem
- O Household - Public Assistance

Q29 **Which of the following types of information did you use in reviewing cases? Check all that apply.**

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

Q30 **What would help your CCPT carry out case reviews even better?**

Q31 **How many of the cases reviewed in 2017 were identified as having children and/or youth who needed <u>access</u> to the following services**

Mental Health (MH) _____

Developmental Disabilities (DD) _____

Substance Abuse (SA) _____

Domestic Violence (DV) _____

Q32 **How many of the cases reviewed in 2017 were identified as having parents or other caregivers who needed <u>access</u> to the following services:**

Mental Health (MH)	- _____ _
Developmental Disabilities (DD)	_____ _
Substance Abuse (SA)	_____ _
Domestic Violence (DV)	_____ _

Q33 **In 2017, which of the following limitations prevented children, youth, and their parents or other caregivers from accessing needed MH/DD/SA/DV services**. Check all that apply.

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

Q34 **Based on your 2017 case reviews, what were your team's top three recommendations for improving child welfare services?**

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

Q35 **Did your CCPT set objectives to complete over 2017?**

- O Yes
- O No

Q36 **List your CCPT's top three objectives for 2017. Then rate how successful your CCPT was in achieving these objectives.**

	Not at all (1)	Slightly (2)	Mostly (3)	Completely (4)	Too soon to rate (5)
Objective 1 _____	o	o	o	o	o
Objective 2	o	o	o	o	o
Objective 3	o	o	o	o	o

Q37 **What helped you achieve your objectives?**

_____

Q38 **What challenges did you face in achieving your objectives?**

_____

Q39 On the basis of 2016 survey, the NC CCPT Advisory Board made four recommendations to NC DSS.

Recommendation 1: Ensure that children, youth, and families have the mental health services required for promoting child safety, child permanency, and child and family well-being.

Which of the following action steps does your CCPT support to accomplish Recommendation 1? Check all that apply. You may have other steps to accomplish this recommendation. Please share these other steps.

- O Work with state-level agencies and family-and-child associations to reach cross-system definitions of services, timelines, and response times
- O Assist families in accessing needed mental health services, including providing subsidies for Medicaid-ineligible families (such as when children enter care), transportation especially in rural areas, and translation/interpretation for non-English-speaking families
- O Provide training to Social Services and their community partners in assisting families in accessing appropriate services
- O Promote education on what services are available within communities for families
- O Compare the mental health services and their quality and accessibility that covered by different Local Management Entity (LME)-Managed Care Organizations (MCOs) for children and youth in care and for their families
- O Examine the cost-effectiveness of different mental health delivery mechanisms (e.g., teleconferencing); and
- O Identify strategies working well within our state to provide quality and accessible mental health services to families and disseminate these strategies statewide
- O Other 1 _____
- O Other 2 _____

Q40 On the basis of the 2016 survey, the NC CCPT Advisory Board made four recommendations to NC DSS.

Recommendation 2: Strengthen the capacity of local CCPTs to work with Social Services in improving child welfare services.

Which of the following action steps does your CCPT support to accomplish Recommendation 2? Check all that apply. You may have other steps to accomplish this recommendation. Please share these other steps.

- O Update the 2004 CCPT Reference Guide, post the guide on the NC DSS website, and distribute the guide to county DSSs and local CCPT chairpersons
- O Provide in-person and on-line training and technical assistance to local CCPTs on (a) CCPT responsibilities and processes, (b) child welfare policies and procedures, (c) interagency collaboration, (d) diversity on teams, and (e) inclusion of family and youth partners on teams
- O Support local CCPTs in their work to educate communities and families about protective factors to prevent child abuse and neglect and to make local plans for prevention
- O Promote discussion of policy recommendations proposed by local CCPTs and the NC CCPT Advisory Board
- O Facilitate agreement on a template for the end-of-year report to county commissioners and the NC CCPT Advisory Board
- O Support smaller counties in creating regional CCPT mechanisms that reflect their already shared membership and resources
- O Other 1 _____
- O Other 2 _____

Q41 On the basis of the 2016 survey, the NC CCPT Advisory Board made four recommendations to NCDSS.

Recommendation 3: Establish the NC CCPT Advisory Board as the state body responsible for synthesizing and advocating for the local CCPT experiences and recommendations, identifying areas for child abuse prevention planning and improvements in the child welfare system, and serving as an asset to NC DSS in improving child welfare services.

Which of the following action steps does your CCPT support to accomplish Recommendation 3? Check all that apply. You may have other steps to accomplish this recommendation. Please share these other steps.

- O Formalize in writing the role of the NC CCPT Advisory Board
- O Designate a liaison between the Advisory Board and NC DSS
- O Support and participate in an annual retreat of the Advisory Board and NC DSS to support collaborative working relationship and engage in strategic planning
- O Work with the NC CCPT Advisory Board in determining policy areas for study
- O Encourage linkages between the North Carolina Child Welfare Family Advisory Council and the NC CCPT Advisory Board
- O Ensure the collection of data from local CCPTs for planning purposes
- O Provide child and family data needed for planning purposes by the NC CCPT Advisory Board and costs of policy recommendations
- O Facilitate the NC CCPT Advisory Board sharing findings and recommendations with state policy bodies
- O Other 1 _____
- O Other 2 _____

Q42 On the basis of the 2016 survey, the NC CCPT Advisory Board made four recommendations to NCDSS.

Recommendation 4: Engage in planning on the long-term structure and processes for citizen review panels in the state.

Which of the following action steps does your CCPT support to accomplish Recommendation 4? Check all that apply. You may have other steps to accomplish this recommendation. Please share these other steps.

- O Review with the NC CCPT Advisory Board different citizen review panel (CRP) models used in other states
- O Support a meeting of the NC CCPT Advisory Board and NC DSS with the national technical assistant on CRP models
- O Engage local CCPTs in the planning process
- O Develop a North Carolina model for CRP and consider as necessary, possible legislative changes
- O Put in place necessary resources for implementing, evaluating, and improving the model
- O Ensure adequate notification and orientation of local teams and state bodies to the model
- O Other 1 _____
- O Other 2 _____

Q43 **What further advice can you give us on putting the four recommendations into action?**

_____

_____

Q44 **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 2017 CCPT Survey.**

Thank you for taking the time to complete the 2017 CCPT Survey, your responses are appreciated. If you have questions about the survey and keeping a copy for your records, please contact ccpt_survey@ncsu.edu

Thank you for your participation!

The NC Community Child Protection Team Advisory Board

Wanda Marino (Chair)

Judith Ayers

Molly Berkoff

Cindy Bizzel

Wayne Black

George Bryan

Carmelita Coleman

Gail Cormier

Deborah Day

Lane Destro

Brenda Edwards

Sharon Hirsch

Kathy Hitchcock

Anne Marie Hoo

Tiffany Lee

Christy Nash

Kristin O'Connor

Heather Skeens

Chaney Stokes

Marvel Welch