NORTH CAROLINA COMMUNITY CHILD PROTECTION TEAM

2016 End of Year Report

Community Child Protection Teams
NC Advisory Board

Foreword

This year, an impressive number of local Community Child Protection Teams (CCPTs) responded to the statewide online survey over a very short period. We appreciate the thoughtful responses of all 86 counties who participated.

The NC CCPT Advisory Board determined the foci of this year's survey with most questions maintained in their original format from the prior year's survey. The Advisory Board reviewed the survey findings and developed recommendations for improving child welfare in the state.

The support of the NC Division of Social Services was invaluable in ensuring completion of the survey. The Chief of Child Welfare, Kevin Kelley, reminded county directors of social services and local CCPT chairs of the vital role that the end-of-year survey plays in assessing the North Carolina child welfare system. NC DSS data analyst Lane Destro updated CCPT chairs contact lists so that as many chairs as possible could be contacted. Likewise, the NC CCPT Advisory Board chair, Michael Becketts[1], highlighted the importance of the survey through the Children's Services Committee of the NC Association of County Directors of Social Services.

The survey was administered by a multidisciplinary team at NC State University: Dr. Joan Pennell, a social worker with the Center for Family and Community Engagement; Dr. Jason Coupet with the Department of Public Administration; Dr. Maxine Thompson with the Department of Sociology and Anthropology; Sociology doctoral students Holly Benton and Josephine McKelvy; and Public Administration masters student Justine Chilton. This research team is working to formally understand CCPT coordination, family involvement, and cultural competency. As part of their research, they analyzed the data from this survey and prepared this report on behalf of the Advisory Council.

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

Michael Becketts	NC CCPT Advisory Board Chair[2]
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

[1] Mr. Becketts served as the State CCPT Advisory Board Chair until April 24, 2017 at which time he assumed the role of Assistant Secretary for Human Services for the North Carolina Department of Health and Human Services (NC DHHS).

[2] Mr. Becketts did not participate in the drafting or finalization of the recommendations; he assumed the role of NC DHHS Assistant Secretary for Human Services on April 24, 2017 which is prior to finalization of this report.

Carmelita Coleman	Independent Living Resources Inc.
Gail Cormier	NC Families United
Lane Destro	NC Division of Social Services
Brenda Edwards	NC Department of Public Health
Stephanie Francis	Interact of Wake County
Ryan Hill	NC Department of Health and Human Services
Sharon Hirsch	Prevent Child Abuse NC
Kathy Hitchcock	Child Fatality Review
Ann-Marie Hoo	Healing Place of Wake County
Lulu Jackson	Eastern Band of the Cherokee Indians
Trishanna Jones	NC Coalition Against Domestic Violence
Kevin Kelley	NC Division of Social Services
Rachel Larsen	NC Child Abuse Resource Prosecutor
Wanda Marino	New Hanover County Department of Social Services
Tilda Marshall	Edgecombe County Department of Social Services
Marcella Middleton	SaySo (Strong Able Youth Speaking Out)
Kristin O'Connor	NC Division of Social Services
Lou Parton	Polk County Department of Social Services
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Michelle Reines	NC Division of Social Services
Darrell Renfroe	NC Division of Social Services
Teresa Strom	NC Division of Social Services
Marvel Welch	NC Commission of Indian Affairs

Executive Summary

Community Child Protection Teams (CCPTs) are North Carolina's mechanism for citizen review to examine the extent to which child protection achieves its goals. Citizen review with broad community representation is mandated by the federal Child Abuse Prevention and Treatment Act (CAPTA). North Carolina General Statute §7B-1406 through 1413 defines the role and composition of CCPTs. Every county is expected to have its own local CCPT with representation from specific public agencies and community organizations, and county commissioners can increase CCPT representation by appointing additional members, including family partners.

Local CCPTs are charged to review cases served by child protection and on an annual basis to submit recommendations to their board of county commissioners and advocate for systemic improvements to child welfare. They may also carry out public education to support community efforts to assist children and their families. The local CCPTs are expected to provide an end-of-year report to the NC Division of Social Services.

At the state level, the NC CCPT Advisory Board conducts an end-of-year survey of local CCPTs in order to track their accomplishments, challenges, and recommendations to overcome systemic deficiencies. Based on the survey results, the Advisory Board prepares recommendations to NC DSS, who is expected to reply in writing to the recommendations. The Advisory Board's report and the state's response are incorporated into the Annual Progress and Services Report to the US Department of Health and Human Services, Administration for Children and Families. This process of local input, state-level recommendation, and NC DSS accountability are vital to continuous quality improvement and demonstrate the agency's responsiveness to the community.

2016 Recommendations

At the June 19th, 2017 meeting, the NC CCPT Advisory Board agreed upon the following set of recommendations for response by NC DSS. These recommendations are based on three years of survey results conducted in 2014, 2015, and 2016, as well as discussions of the Board over the year.

The first recommendation on mental health services reflects consistent concerns expressed by local CCPTs regarding the paramount need for these services in their communities. The other three recommendations pertain to the structure of CCPTs and likewise reflect survey results and discussions of the Advisory Board. These other three recommendations position CCPTs for working on substantive issues, including improving mental health services.

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 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); and
7. 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) child welfare policies and procedures, (c) interagency collaboration, (d) diversity on teams, and (e) inclusion of family and youth partners on teams;
3. 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;
4. Promote discussion of policy recommendations proposed by local CCPTs and the NC CCPT Advisory Board;
5. Facilitate agreement on a template for the end-of-year report to county commissioners and the NC CCPT Advisory Board; and
6. Support smaller counties in creating regional CCPT mechanisms that reflect their already shared membership and resources.

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 through the following steps:

1. Formalize in writing the role of the NC CCPT Advisory Board;
2. Designate a liaison between the Advisory Board and NC DSS;
3. Support and participate in an annual retreat of the Advisory Board 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 CCPT Advisory Board;
5. Work with the NC CCPT Advisory Board in determining policy areas for study;
6. Ensure the collection of data from local CCPTs for planning purposes;
7. Provide child and family data needed for planning purposes by the NC CCPT Advisory Board and costs of policy recommendations; and

8. 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 in the state through the following steps:

1. Review with the NC CCPT Advisory Board different citizen review panel (CRP) models used in other states;
2. Support a meeting of the NC CCPT Advisory Board and NC DSS with the national technical assistant on CRP models;
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.

2016 Survey

Based on the 2014 annual survey data, the NC CCPT Advisory Board made three recommendations to the NC Division of Social Services: (1) encourage common child and family team (CFT) practices in order to coordinate services for children, youth, and families; (2) strengthen the capacity of local CCPTs to work with Social Services in improving child welfare services; and (3) create and maintain a survey to track CCPT reviews of child protection cases.

The 2015 survey further supported these recommendations. This year's survey sought the guidance of the local CCPTs on how to put these recommendations into action. In addition to these recommendations, survey questions addressed the topic of who participates in local CCPTs, specifically looking at the participation of family members and other non-mandated members and their role on the team.

The 2016 annual survey questions changed slightly from the 2015 edition. The 2016 survey did not include questions from 2015 regarding peer mentoring and pilot programs. New questions for 2016 included: (1) a question asking CCPTs to list additional members who regularly attend meetings, other than those mandated by state statute; (2) a question about whether or not family or youth partners served as members of the CCPT and how frequently they participated; (3) an open ended question regarding how CCPTs carry out case reviews and what would help them to do so; and (4) an open ended question on how to best implement the three recommendations.

The 2016 survey addressed the following overarching questions:

1. Who participates in the local CCPTs?
2. How do the local CCPTs conduct their case reviews?
3. What limits access to needed mental health, developmental disabilities, and substance abuse (MH/DD/SA) services?
4. Which action steps do CCPTs support to accomplish the three 2014 recommendations?

The 2016 survey respondents included 86 of the 100 counties in North Carolina. This is nearly the same as the 2015 survey response rate of 87, although the participating counties varied from the previous year. This response rate was higher than that of earlier surveys which included 71 to 81 CCPTs. Participating counties covered all state regions and varied in population size. About 75% of responding CCPTs indicated that they operate as a combined CCPT and Child Fatality Prevention Team (CFPT). This percentage is similar to findings based on the 2015 and 2014 surveys. Finally, survey respondents included between 75 and 100% of the member counties in each of the eight Local Management Entity (LME)-Managed Care Organizations (MCOs) which provide MH/DD/SA services in those areas.

Who participates in the local CCPTs?

State statute directs the mandatory membership of CCPTs, drawing from various agencies in the county. However, representatives' participation varied broadly across the state. Department of Social Services (DSS) staff continued to participate in local CCPT meetings *very frequently*. Nearly half of all participating CCPTs also indicated that DSS directors attended *very frequently*, along with community action agencies, mental health professionals, public health directors, and health care providers. County boards of social services and district attorneys continued to participate less often than other members. Family or youth partners participated in 19 of the responding CCPTs.

One CCPT suggested, "It would be helpful to have more members at the table; this would make the discussion much richer."

How do the local CCPTs conduct their case reviews?

Annually, CCPTs are required to conduct reviews of active cases of child maltreatment and child fatalities in which abuse or neglect is suspected. Sixty-five of the 86 CCPTs who responded to the survey reported conducting case reviews in 2016. The median number of case reviews for those CCPTs conducting one or more case reviews was five. The majority of cases reviewed were due to reports from CCPT members or case managers, case files, or information on procedures and protocols of involved agencies. Of those who reviewed cases, 90% indicated drug abuse by a caretaker as a contributory factor used in selecting child maltreatment cases for review. Other common contributory factors included domestic violence in the household, alcohol abuse by the caretaker, or behavior problems with the child. All of these indicate the importance of access to MH/DD/SA services in the community.

One CCPT succinctly explained how they conduct case reviews, writing, "DSS social workers present the case and the team discusses strengths and weaknesses of the community to meet the needs of the children and families, looking for patterns from case to case that could be used to make recommendations for improving the community for children."

What limits access to needed mental health, developmental disabilities, and substance abuse (MH/DD/SA) services?

In the 2014 and 2015 surveys, CCPTs indicated that limited access to mental health, developmental disabilities and substance abuse (MH/DD/SA) services was a factor in the majority of their reviewed cases. In 2015, the need for mental health and substance abuse services was evident among member counties in all eight Local Management Entity (LME)-Managed Care Organizations (MCOs). This evidence was consistent with the results found in the 2016 survey. Some of the factors contributing to limited access to (MH/DD/SA) services in the most recent survey include lack of available services, limited transportation to services, and limited community knowledge about available services.

One CCPT wrote, "The mental health system is difficult to understand and navigate. There are situations where there is misinformation provided regarding availability of services. The staff who are the first responders don't seem to have the authority to offer anything beyond basic services."

What action steps do CCPTs support to accomplish the three 2014 recommendations?

Recommendation 1: Encourage common CFT (child and family team) practice in order to coordinate services for children, youth, and families

In this year's survey, over 70% percent of the responding CCPTs support two action steps for accomplishing the first recommendation. Respondents support (1) having an agreed-upon protocol for cross-system CFT meetings and (2) inviting family or youth partners to provide support to family members before, during, and after CFT meetings. More than 40% of the CCPTs also supported providing CCPTs with CFT documentation when reviewing cases, results similar to those found in the 2015 survey. More than 25% of respondents also support offering statewide or regional online forums to share successful strategies in holding cross-system CFTs or offering online trainings on CFT meetings to family members and/or resource families.

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

This recommendation aims to address the issue of infrequent participation by some mandated CCPT members. About 75% of survey respondents support sharing CCPT recommendations with bodies that can put them into action as a step towards realizing the second recommendation. Nearly two-thirds of responding CCPTs also supported (1) offering training to increase the participation of mandated CCPT members and (2) connecting CCPTs to related cross-system efforts. Other recommendations from CCPTs included inviting or appointing new members and updating training material to distribute to local teams.

Recommendation 3: Create and maintain a survey to track CCPT reviews of child protection cases

In regards to the third recommendation, more than 75% of the responding CCPTs indicated that they support working with CCPTs to identify necessary training and support for conducting a case review survey. A majority of respondents also support implementing the case review survey statewide (65%) and synthesizing findings from two years of statewide case review surveys and identifying areas for policy recommendations (58%). One CCPT also suggested using a standardized form to be submitted quarterly to the CCPT Advisory Board and North Carolina Department of Social Services.

Take Home Messages

Based on the current survey findings, the majority of CCPTs are operating according to state statute and working diligently to improve child welfare in North Carolina. The majority of responding teams operate as a combined CCPT and Child Fatality Protection Team (CFPT). Most teams surveyed have very frequent participation from many of their mandated members. Of those conducting one or more case review, CCPTs conduct a median of five case reviews per year and use a variety of sources to select cases for review. Criteria used to select cases continues to reflect the lack of access to mental health, developmental disability, and substance abuse services in the state.

CCPTs continue to make meaningful contributions in word and action regarding the 2014 recommendations. The recommendations, which center on child and family teams, working with social services agencies, and tracking case reviews, are all central to CCPTs' ability to be effective advocates for children. In regards to furthering these recommendations, survey responses indicate that most CCPTs support developing a protocol for CFT meetings, sharing CCPT recommendations with bodies that can put them into action, and working with CCPTs to identify necessary training and support for conducting a case review survey.

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North Carolina Community Child Protection Teams (CCPT) 2016 End-of-Year Report

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

Introduction

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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.

2016 Survey

This report describes the 2016 end-of-year (EOY) survey and summarizes the survey findings analyzed by the North Carolina State University Center for Family and Community Engagement CCPT Research Team. The appendices provide greater detail on the survey and its results and include a copy of the survey instrument.

Survey Focus and Development

The 2016 survey built upon the findings of the 2014 and 2015 CCPT surveys. The 2014 survey results led to the NC CCPT Advisory Board developing three recommendations for systemic change:

> (1) Encourage common child and family team (CFT) practices in order to coordinate services for children, youth, and families;
>
> (2) Strengthen the capacity of local CCPTs to work with social services in improving child welfare services; and
>
> (3) Create and maintain a survey to track CCPT reviews of child protection cases.

The 2015 survey gathered further evidence in support of each of the three recommendations.

In order to develop and disseminate the 2016 survey, the CCPT Research Team of NCSU's Center for Family and Community Engagement worked together with the NC CCPT Advisory Board and Dr. Lane Destro, Data Analyst at NC DHHS. Dr. Destro was instrumental in gathering the contact information of local CCPT county chairs. The CCPT Research Team used input from the Advisory Board to develop new survey questions and determine which questions from the previous survey to eliminate.

The content of the 2016 annual survey differed slightly from the 2015 survey. The 2016 survey included some new questions, but did not include questions from the previous year's survey regarding peer mentoring and pilot programs. New questions included: (1) a question asking CCPTs to list additional members who regularly attend meetings, besides those mandated by state statute; (2) a question about whether or not family or youth partners served as members of the CCPT and how frequently they participated; (3) an open ended question regarding how CCPTs carry out case reviews and what would help them to do so; and (4) an open ended question on how to best implement the three recommendations.

The 2016 survey addressed the following overarching questions:

1. Who participates in the local CCPTs?
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4. Which action steps do CCPTs support to accomplish the three 2014 recommendations?

The Advisory Board discussed the contents of the 2016 survey with the CCPT Research Team at the NC CCPT Advisory Board meeting held on January 19, 2017.

Survey Content and Participant Recruitment

Upon opening the online survey, respondents reviewed an explanation of the survey's purpose and terms of participation, instuctions for completing the survey, and the Informed Consent Form for Research. The consent form emphasized that participation was voluntary and that the CCPT Research Team would de-identify and aggregate responses before reporting findings, with the one exception being that researchers would list the local CCPTs by their county name or Qualla Boundary. Respondents had access to a copy of the Informed Consent Form to keep for their records. Before accessing the survey questions, respondents needed to consent to participate in the survey by selecting *yes* to continue. Alternatively, respondents could choose *no*, meaning they did not wish to participate in the survey. One responding county opened the link, but indicated they did not wish to participate. Additionally, in responding to the 2016 survey, one county chose to participate, but did not provide answers to any questions. Respondents received a copy of their completed survey upon submission. The North Carolina State University Institutional Review Board for the Use of Human Subjects in Research approved the survey protocol.

Survey questions addressed the following areas: whether or not the team was a combined CCPT/CFPT, the frequency of team member participation, the number of cases reviewed and the process for selecting cases, limitations to accessing MH/DD/SA services, and support for the action steps of each of the three 2014 recommendations. Appendix B provides a blank copy of the survey.

The CCPT Research Team used Qualtrics, a secure online survey platform, to distribute the survey and to provide regular reminders to teams that had not completed the survey. The CCPT chair of each county received one unique online link to the survey. Only one link was distributed per county via email to the CCPT chair. In the absence of a chairperson, the DSS director in that county received the unique link. NC Division of Social Services sent letters to CCPT chairpersons and county directors to encourage

participation in the survey. Participants also received survey completion reminders by email through Qualtrics as well as a notification by email regarding the extension of the survey completion deadline. A detailed timeline of the survey development, recruitment, and distribution can be found in Table A1. Throughout the survey process, members of the CCPT Research Team were accessible via email to address any technical issues CCPTs encountered while completing the survey.

Survey Respondents

The survey was distributed to 100 local CCPTs, of whom 86 completed the survey. This response rate was nearly the same as the response rate in 2015 of 87, but higher than the rates for 2012, 2013, and 2014 which ranged from 71 to 81 CCPTs. Although the response rate was almost the same as in 2015, the participating counties varied from the previous year. Four counties did not complete either the 2015 or the 2016 annual survey. See appended Table A2 for a list of the 2016 responding CCPTs.

As with previous years' surveys, CCPTs did not have the survey questions at the beginning of the calendar year. As a result, they were charged with the task of retroactively compiling their answers when the survey was distributed. In the past, teams indicated a preference for having a copy of the survey questions at the beginning of the year in order to track information for the EOY survey throughout the year. This would also be useful for many teams who use the survey to complete their annual reports to county commissioners. Before distributing the survey, a few CCPT chairs contacted the CCPT Research Team regarding the survey's dissemination timeline. This may be because this year's survey was distributed about a month later than previous years'. Despite the slight delay, overall participation was impressive and CCPTs' responses were insightful.

This year, as in 2014 and 2015, the majority of counties organized their teams as a combined CCPT and Child Fatality Prevention Team (CFPT). This means that counties elected to have a combined team that reviews both child maltreatment cases and child maltreatment fatality cases rather than separate these functions into two teams that meet independently. One reason counties might choose to combine teams is because CCPTs and CFPTs have many of the same mandated members. Because of this, it may be beneficial to participation to have only one meeting instead of two. Of the CCPTs who participated in the survey, 76% indicated that they have a combined CCPT and CFPT (see Table A5). This is slightly higher than the percentage of combined teams in 2015, which was 72%. In general, we can conclude that the pattern of combined CCPT and CFPT teams versus separate teams is continuing.

Responding CCPTs were mostly representative of North Carolina counties, covering all areas of the state and most counties in the three population size groups. Table A3 provides a breakdown of survey completion by county size. All counties with large population sizes responded to the survey. For small and medium counties, the response rates were 78.43% and 92.31% respectively.

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 2016, there were eight LME-MCOs for the 100 counties. Each LME-MCO was well represented in the survey, with member county participation ranging from 75 to 100% (see Table A4). Both Alliance Behavioral Healthcare (4 member counties) and Partners Behavioral Health Management (8 member counties) had 100% participation.

In sum, the survey respondents included CCPTs from 86 of the 100 counties in North Carolina and were representative of the state. Participating teams came from every state region and varied in population size. About 75% of CCPTs chose to have a combined CCPT and CFPT which conducted both child

maltreatment and child maltreatment fatality case reviews. Responding CCPTs also included between 75 and 100% of the member counties in each of the eight LME-MCOs that provide MH/DD/SA services.

Results

The 2016 survey was designed to address the following overarching questions:

1. Who participates in the local CCPTs?
2. How do the local CCPTs conduct their case reviews?
3. What limits access to needed MH/DD/SA services?
4. Which action steps do CCPTs support to accomplish the three 2014 recommendations?

This section summarizes the findings for each of these questions. All quotations in this report have been corrected for spelling and grammatical errors.

Who participates in the local CCPTs?

According to state law, CCPTs are required to have at least 11 members who represent various community agencies which interact with children and child welfare. Table 1 below lists the mandated CCPT members and their participation levels. The 2016 survey results suggest that like previous years, participation in CCPTs across North Carolina varied. Department of Social Services (DSS) staff seem to be the most likely to participate across the CCPTs surveyed. Eighty-eight percent of responding CCPTs indicated that DSS staff participated *very frequently*. This is similar to the result of the 2015 survey with 90% of responding CCPTs having DSS staff with very frequent participation. DSS directors, community action agencies, mental health professionals, public health directors, and health care providers also took part *very frequently* with at least 50% of responding CCPTs indicating such. On average, participation for all mandatory members other than DSS staff ranged from *rarely* to *frequently*. Some members participate at varying frequencies across the surveyed CCPTs. For example, while 26 surveyed CCPTs report that mandated members from County Board of Social Services never participate, 27 surveyed CCPTs report very frequent participation from this mandated member. District attorneys had the lowest average overall, with rare or occasional participation. It should be noted that despite this low average, 21 CCPTs out of the 86 surveyed indicated *very frequent* participation from district attorneys. This suggests that participation from mandated members, other than DSS staff, is inconsistent throughout the state.

Along with the mandated members, county commissioners are able to appoint additional members to CCPTs, and CCPTs can have more than one person serving in a mandated role. For example, a CCPT may have multiple school districts in their county, and therefore, have multiple school superintendents serving on the team. Of the 83 CCPTs responding to a question about extra members, 49 reported having additional members serving on the CCPT. The number of additional members ranged between 1 and 35, with a mean of 5.02 for these CCPTs. The additional non-mandated members represented diverse child and family services including non-profit organizations (e.g., United Way, Smart Start, Family Guidance Center, Children & Youth Partnership), advocacy groups/community representatives, parent or family members of a deceased child, legal services/judicial organizations (e.g. family court administrator, Department of Juvenile Justice, Juvenile Probation, Probation, and Parole), and health-related services (e.g., emergency medical services, local hospital and child maltreatment specialist, local

medical examiner). The survey did not ask about the frequency of participation for the additional members.

Table 1 Mandated CCPT Members and Reported Frequency of Participation

Mandated CCPT Members and Reported Frequency of Participation, 2016, (N=86)

Mandated Member	Never	Rarely	Occasionally	Frequently	Very Frequently	Mean (Median)
DSS Director[b]	14 (16.27%)	2 (2.33%)	10 (11.62%)	12 (13.95%)	46 (53.49%)	2.88 (4.00)
DSS Staff[a]	2 (2.33%)	0 (0.00%)	3 (3.49%)	4 (4.65%)	76 (88.37%)	3.78 (4.00)
Law Enforcement[b]	9 (10.47%)	8 (9.30%)	17 (19.77%)	15 (17.44%)	35 (40.70%)	2.70 (3.00)
District Attorney[c]	27 (31.40%)	9 (10.47%)	14 (16.28%)	12 (13.95%)	21 (24.42%)	1.89 (2.00)
Community Action Agency[b]	11 (12.79%)	7 (8.14%)	9 (10.47%)	12 (13.95%)	45 (52.33%)	2.87 (4.00)
School Superintendent[c]	19 (22.09%)	5 (5.81%)	10 (11.63%)	16 (18.60%)	33 (38.37%)	2.47 (3.00)
County Board of Social Services[c]	26 (30.23%)	9 (10.47%)	9 (10.47%)	12 (13.95%)	27 (31.39%)	2.06 (2.00)
Mental Health Professional[b]	5 (5.81%)	5 (5.81%)	11 (12.79%)	18 (20.93%)	45 (52.32%)	3.11 (4.00)
Guardian ad Litem[b]	10 (11.63%)	3 (3.49%)	15 (17.44%)	16 (18.60%)	40 (46.51%)	2.87 (3.00)
Public Health Director[b]	11 (12.79%)	6 (6.98%)	6 (6.98%)	12 (13.95%)	49 (56.98%)	2.98 (4.00)
Health Care Provider[b]	11 (12.79%)	4 (4.65%)	9 (10.47%)	11 (12.79%)	49 (56.98%)	2.99 (4.00)

Note. 0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently
Counts are reported, with percentages out of 86 CCPTs in parentheses.
[a]One case missing [b]Two cases missing [c]Three cases missing

In this year's survey, 19 CCPTs indicated that they had family or youth partners who participated in their meetings. This was the same number of CCPTs who had family or youth partner participation in the 2015 survey. The average number of these additional members was 3.05. The members tended to participate *very frequently*. Family or youth partner participation is listed by frequency in Table 2 below.

Table 2 Family or Youth Partner Participation in CCPTs

Family or Youth Partner Participation in CCPTs, 2016, (N=19)

	Never	Rarely	Occasionally	Frequently	Very Frequently	Mean (Median)
Family or Youth Partners	0	0	7 (36.8)	4 (21.1)	8 (42.1)	3.05 (3.00)

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

Of the CCPTs that did not have family or youth partners, approximately 51 provided information explaining why family and youth partners do not participate. Not being able to locate, identify, or recruit a family member to attend the meetings was the most common reason. Structural barriers also prohibited family participation including transportation issues, work conflicts, other conflicting obligations, and feeling apprehensive about participating due to grief or anxiety. A family and youth partner is not federally mandated, and CCPTs reported this as a reason for the lack of participation by family and youth partners. Finally, CCPTs expressed concern with confidentiality, but with less frequency than the other reasons provided.

In summary, state law specifies mandatory CCPT membership of various agencies, whose frequency of participation can be seen in Table 1. Similar to the findings in the 2015 survey, DDS staff participation is high. DSS directors, community action agencies, mental health professionals, public health directors, and health care providers also take part *very frequently*. However, other members participated inconsistently across CCPTs with district attorneys having the lowest participation overall. Among the 49 CCPTs reporting additional members, teams averaged about five additional members participating in their local CCPTs. Finally, 19 CCPTs indicated having family or youth partners on their teams with a median of three family or youth partners per team.

How do the local CCPTs conduct their case reviews?

State statute §7B-1406 charges CCPTs with undertaking reviews of:

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.

Because of the charge to focus on child maltreatment, CCPT reviews differ from those of the Child Fatality Preventions Teams, who are responsible for reviewing child fatalities. State statute §7B-1401(1) specifies that child fatalities are "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."

The number of expected case reviews is not stipulated in state statute. Nonetheless the statute requires CCPTs to meet at least four times each year. These meetings provide an opportunity to review cases.

According to the 2016 survey, 64 of the 86 responding CCPTs reported conducting at least one child maltreatment case review in 2016. Together, these CCPTs reviewed a total of 441 cases. A total of 19 CCPTs indicated that they reviewed zero cases. This is more than the 13 CCPTs reporting zero case reviews in the previous year. For CCPTs that reported reviewing one or more cases, the average number of case reviews was 6.89, with a median of five and a maximum number of reported case reviews of 36.

Table 3 displays the median number of cases reviewed, as well as the range, when organized by county size. Medium counties reported the widest range in the number of cases reviewed. Large counties, however, had the highest median number (7) of reviewed cases compared to other county sizes.

Table 3 Number of Child Maltreatment Cases Reviewed by County Size

Number of Child Maltreatment Cases Reviewed by County Size, 2016, (N=64)[a]

Size of County	Number of CCPTs[a]	Median	Range
Small	27	5.00	1-21
Medium	30	4.00	1-36
Large	7	7.00	1-24
Total	64	5.00	1-36

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. Nineteen CCPTs reported zero case reviews. Three missing cases.

In order to conduct case reviews, CCPTs used a variety of sources as illustrated in Table 4. Of the 65 CCPTs responding to this question, 92% used reports from members and/or case managers and 75% used case files to review cases. More than 50% also used information on procedures and protocols of involved agencies. These were the same primary sources of case reviews as reported in the 2015 survey. Some CCPTs reported using child and family team meeting documentation, medical examiner's reports, and individualized education plans. Written responses in the "other" category indicated that teams also use team member files, social worker's reports, and case plans.

Table 4 Type of Information Used by CCPTs for Reviewing Cases

Type of Information Used by CCPTs for Reviewing Cases, 2016, (N=65)[a]

Type of Information	Number of CCPTs
Reports from Members and/or Case Managers	60 (92.31%)
Case Files	49 (75.38%)
Information on Procedures and Protocols of Involved Agencies	38 (58.46%)
Child and Family Team Meeting Documentation	21 (32.31%)
Medical Examiner's Report	18 (27.69%)
Individualized Education Plan	16 (24.62%)
Other	6 (9.23%)

Note. CCPTs could select all that apply. Among the 86 CCPTs responding to the survey, 19 reviewed zero cases.
a There were 65 valid cases. Only CCPTs who reported conducting one or more case reviews responded to the question about type of information used. One CCPT answered this question although the respondent indicated reviewing zero cases in 2016. Percentages in parentheses are out of 65 valid responses.

This year's survey also identified the criteria that CCPTs used for selecting child maltreatment cases for review. The most common reasons for selecting cases for review are listed in Table 5 below. There were 64 valid responses to the survey question regarding what criteria CCPTs used to select cases. Responding CCPTs could make multiple selections for this question. The most common criteria used for selection included if the case was an active case, if multiple agencies were involved, if it was considered a stuck case, or if child safety was a concern. These reflect reasons for case reviews as reported in the 2015 survey, although more cases were reviewed in that year. Other common reasons for reviewing a case included if repeat maltreatment or child and family well-being were a concern. A new item this year was parent opioid use, which was checked by 34% of respondents. CCPT responses in the category of "other" included parental substance abuse, case selected by DSS, and medical issues.

Table 5 Case Criteria Used by CCPTs for Selecting Child Maltreatment Cases for Review

Case Criteria Used by CCPTs for Selecting Child Maltreatment Cases for Review, 2016, (N=64)

Selection Criterion	Number of CCPTs	
Active Case	47	(72.3%)
Multiple Agencies Involved	41	(63.1%)
Stuck Case	38	(58.5%)
Child Safety	38	(58.5%)
Repeat Maltreatment	29	(44.6%)
Child and Family Well-Being	27	(41.5%)
Court Involved	25	(38.5%)
Parent Opioid Use	22	(33.9%)
Child Maltreatment Fatality	18	(27.7%)
Child Permanency	16	(24.6%)
Closed Case	6	(9.2%)
Other	17	(26.2%)

Note. Only 64 CCPTs who reported conducting one or more case reviews responded to the question on criteria used for selecting cases. Among the 86 CCPTs, 19 CCPTs reviewed zero cases, and three CCPTs did not report the number of cases reviewed. Percentages in parentheses are out of the 64 valid responses.

Furthermore, CCPTs identified the most common contributory factors for children being in need of protection which they used in selecting maltreatment cases for review. CCPTs identified parent/caregiver, children/youth, and household factors. The results are illustrated in Table 6 below. The most common contributory factor was a parent or caregiver's drug abuse. Just over 90% of the 61 CCPTs who responded to this survey question considered caretaker drug abuse to be a contributory factor for children being in need of protection. More than 50% of responding teams also identified factors including; domestic violence in the household, alcohol abuse of a caretaker, lack of child development knowledge of a parent/caregiver, and child behavioral problems.

Table 6 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, 2016, (N = 61)

Contributory Factor	Number of CCPTs	
Parent/Caregiver		
Drug Abuse	55	(90.2%)
Alcohol Abuse	33	(54.1%)
Lack of Child Development Knowledge	31	(50.8%)
Emotionally Disturbed	26	(42.6%)
Learning Disability	10	(16.4%)
Other Medical Condition	8	(13.1%)
Mental Retardation	6	(9.8%)
Visually or Hearing Impaired	5	(8.2%)
Children/Youth		
Behavior Problem	33	(54.1%)
Emotionally Disturbed	20	(32.8%)
Other Medical Condition	16	(26.2%)
Learning Disability	13	(21.3%)
Drug Problem	11	(18.0%)
Alcohol Problem	8	(13.1%)
Mental Retardation	6	(9.8%)
Physically Disabled	4	(6.6%)
Visually or Hearing Impaired	4	(6.6%)
Household		
Domestic Violence	39	(63.9%)
Inadequate Housing	28	(45.9%)
Financial Problem	25	(41.0%)
Public Assistance	16	(26.2%)

Note. Only 64 CCPTs who reported conducting one or more case reviews responded to the question on criteria used for selecting cases. Among the 86 CCPTs, 19 CCPTs reviewed zero cases and three CCPTs did not report the number of cases reviewed. Percentages in parentheses are out of 61 valid responses.

In addition to reviewing cases of child maltreatment, CCPTs also conduct reviews of child maltreatment fatalities. In the 2016 survey, teams were directed to answer a question about how many child maltreatment fatalities they were notified of throughout the year and subsequently, how many of those cases they reviewed. Of the 82 CCPTs who responded to the question regarding child maltreatment fatality notifications, 28 indicated that they received one or more notifications. Those CCPTs that indicated receiving a notification were asked what type of case review was used. Of the 19 CCPTs that responded to this question, nearly half (9 CCPTs) reviewed them as a combined CCPT/CFPT. Most other CCPTs (7) reported that they had a NC DSS (Intensive) state child fatality review pending. Other less common methods of case review included the CFPT conducting the review alone, the CCPT conducting the review alone, or NC DSS conducting an intensive fatality review. These results can be seen in Table A6.

In 2016, CCPTs reported up to three responses as to how their team carried out case reviews. Feedback from the CCPTs highlights a general process in which either a DSS social worker, case manager, or CCPT chair identified and introduced cases for review to team members. Other team members/agencies are encouraged to present cases as well, but CCPTs did not report specific criteria for case selection. The chair sends the selected case record to team members. While there is no general order to the process, the common elements involved team discussion of case record information including family history, contributory factors, and family resource needs strengths. Team members identify the resources that their agency can bring to address the needs of the family, as well as gaps in the system or system deficiencies.

One CCPT responded, "We try to select cases that we are stuck on or have many systemic issues going on and systems involved. Our goal is to gather additional techniques or suggestions on assisting the family and parents to providing a safe home and/or meeting the needs of the children and how the systems can better work with the family/parents/children to ensure safety and well-being."

Critical feedback from CCPTs on how to improve the case review process included standardizing the case report protocol with instructions, training for CCPT members on the process, multidisciplinary data gathering, sharing and brainstorming for system issues, and including more members at the table to represent diverse stakeholders. Several CCPTs mentioned issues that might facilitate collaboration including sharing information on case reviews among stakeholders. In general, CCPTs would like to see more engagement by all stakeholders. Respondents noted additional barriers to an effective review process such as having an overload of responsibilities, including the overlap of CFPT work with CCPT work. CCPTs report prioritizing child fatality cases:

One such team wrote, "We are a combined team. Fatalities are the priority and take time which has interfered with the ability to review other cases. We have designated one month per quarter to review non-fatality cases and identify community gaps. The plan for the coming fiscal year is to increase the length of meetings to allow for greater discussion."

In summary, per state statute, CCPTs conduct reviews of active cases of child maltreatment and cases of child fatalities where abuse or neglect is suspected. According to this year's survey, 65 CCPTs of the 86 respondents conducted case reviews. Of those CCPTs, the median number of child maltreatment cases reviewed was five. Of the 19 CCPTs responding to the question regarding child maltreatment fatality reviews, most of them conducted the review as a combined CCPT/CFPT. Active cases and cases which involved multiple agencies were most commonly selected for review. Commonly CCPTs selected cases for review in which there was caretaker drug abuse or alcohol abuse, lack of child development knowledge, household domestic violence, and child behavior problems contributing to children being in need of protection. These factors point to the importance of access to MH/DD/SA services in a community, which will be discussed further in the next section.

What limits access to needed mental health, developmental disabilities, and substance abuse (MH/DD/SA) services?

In the 2014 and 2015 survey, CCPTs reported reviewing cases with a substantial need for mental health, developmental disabilities, and substance abuse (MH/DD/SA) services in their counties. However, access to these services was limited. This pattern continued in the 2016 survey and can be seen in Table 7 below. Table 7 presents the percentages of CCPTs in 2016 who reported conducting at least one case review and identified at least one of their cases as having limited access to MH/DD/SA services for children and youth and for parents or caregivers. This table also provides the median number of cases having limited access to each service.

For children and youth, the highest access need by far was for mental health services. Of the 64 CCPTs who reported reviewing one or more cases, nearly 80% reviewed cases that required access to mental health services for children and youth. For these CCPTs, the median number of cases identified was three. Around 30% of responding CCPTs who reported reviewing one or more cases also indicated that they reviewed cases requiring access to substance abuse and developmental disabilities services for children and youth. The median number of cases requiring access to these services for children and youth were one for substance abuse services and 1.5 for developmental disabilities services.

For parents or caregivers, the highest access needs were for mental health services and substance abuse services. Of those CCPTs reporting one or more cases reviews, nearly 83% indicated reviewing cases requiring access to mental health for parents or caregivers; the same percentage reported an access need to substance abuse services. The median number of reviewed cases with limited access to mental health services for parents or caregivers was three, while the median number of reviewed cases with limited access to substance abuse services was four. This suggests a substantial need for these services among parents and caregivers in North Carolina. The percentage of CCPTs who reviewed cases with limited access to developmental disability services for parents or caregivers was lower than for other services at 22%. The median number of reviewed cases with limited access to developmental disabilities services was one.

Table 7 Median Number of Reviewed Cases Requiring Access to MH/DD/SA Services

Median Number of Reviewed Cases Requiring Access to MH/DD/SA Services, 2016, (N=64)

	Number of CCPTs	Median Cases
Children/Youth		
Mental Health	51 (79.7%)	3.00
Substance Abuse	20 (31.3%)	1.00
Developmental Disabilities	22 (34.4%)	1.50
Parents/Caregivers		
Mental Health	53 (82.8%)	3.00
Substance Abuse	53 (82.8%)	4.00
Developmental Disabilities	14 (21.9%)	1.00

Note. MH/DD/SA = Mental Health, Developmental Disabilities, and Substance Abuse. The 2016 analysis only includes the 64 CCPTs (out of 86) who reported reviewing one or more cases. Percentage in parentheses are out of the 64 valid responses. The median refers to the midpoint of the number of cases identified with limited access to services.

CCPTs from all eight Local Management Entity (LME)-Managed Care Organizations (MCOs) in North Carolina were represented in the 2016 survey. CCPTs in these member counties identified a number of factors which limit access of children and youth and parents or caregivers to MH/DD/SA services. Table 8 summarizes these findings.

Similar to the findings in the 2015 survey, CCPTs frequently reported (1) limited services or no available services and (2) limited transportation to services as preventing children and families from accessing services. Of the 61 responding CCPTs, 84% identified limited or no available services compared to 80% in 2015, and 75% identified limited transportation compared to 70% in 2015. Other barriers included limited community knowledge about available services (39%), limited MH and SA services for youth with dual diagnosis (29%), and limited MH and DD services for youth with dual diagnosis (23%). There were 13 responses in the "other" category. Additional responses in the "other" category included minimal access to services for non-Medicaid children/families, lack of cultural connections, lack of adequately trained therapeutic foster homes, limited services for parents with dual diagnosis, and limited services for undocumented persons.

Table 8 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 Services, 2016, (N = 61)

Limits on Access	Number of CCPTs
Limited Services or No Available Services	51 (83.61%)
Limited Transportation to Services	46 (75.41%)
Limited Community Knowledge About Available Services	24 (39.34%)
Limited Services MH and SA for Youth with Dual Diagnosis	18 (29.51%)
Limited Services MH and DD for Youth with Dual Diagnosis	14 (22.95%)
Limited Attendance MH/DD/SA Providers at CFTs	13 (21.31%)
Limited Number of Experienced CFT Meeting Facilitators	7 (11.48%)
Other	13 (21.31%)

Note. MH/DD/SA = Mental Health, Developmental Disabilities, and Substance Abuse. Only CCPTs who reported conducting at least one case review were asked to answer the question. CCPTs could select all that apply. There were 61 valid cases. Percentages in parentheses are out of the 61 valid responses.

In summary, based on reviewed cases, CCPTs identified children and youth and parents or caregivers as requiring access to mental health, developmental disabilities, and substance abuse (MH/DD/SA) services. Of the CCPTs who reviewed at least one case in 2016, respondents cited the need for mental health services for both children and youth and parents or caregivers as being the greatest. Of counties who reviewed at least one case, the percentage requiring access to substance abuse services for parents or caregivers was equally high. Responding CCPTs cited factors limiting access to these services in their counties. The most common factors were limited services or no available services and limited transportation to services. These were the same findings in the 2015 survey. Other common factors included a lack of community knowledge about available services and limited services for youth with dual diagnosis.

One CCPT wrote, "The mental health system is difficult to understand and navigate. There are situations where there is misinformation provided about the availability of services. The staff who are the first responders don't seem to have the authority to offer anything beyond basic services."

Based on your 2016 case reviews, what were your team's top three recommendations for improving child welfare services?

In the 2016 survey, CCPTs provided recommendations for improvement in child protective services. Several themes emerged from the open ended responses: NC Division of Social Services (NC DSS) resources, county level resources, CCPT concerns, and family/client issues. This is a descriptive report of recommendations made by CCPTs.

NC DSS Resource Recommendations

CCPT recommendations focused on identifying ways in which NC DSS could facilitate CCPTs' responsiveness to communities. Financial support from NC DSS for CCPTs' agenda/meetings and for an intake worker position at DSS would allow CCPTs to be more visible in the community. Training and education recommendations would strengthen the capacity for CCPTs/CFPTs to respond to child welfare needs and increase agency participation. Training and education recommendations for staff and community partners included preparing a procedure for CPS reports and information gathering, a review of legal issues (e.g., laws) on case review with respect to other professionals, support for evidence-based practice models and the inclusion of parents/family members. Some recommendations suggested ways that NC DSS could facilitate collaboration among agencies. For example, educating community agencies on procedures and limitations at NC DSS regarding child abuse and neglect cases would clarify issues and assist agencies in working together. CCPTs request that DSS establish a procedure to address turnover, including burnout, among panel members, as well as outreach to include new community partners/agencies that provide assistance to families. Policy recommendations included the need for uniform identifiers to track a child(ren) who moves across county and/or state boundaries. This includes children and families connected with the military, in order to reciprocate or assist in providing services.

County Level Resource Recommendations

Community outreach to raise the level of knowledge and awareness about available child welfare and protective services can help promote prevention of child maltreatment and build community support. The county development of family resource centers with programming to reach high risk families is one such outreach effort. Public service announcements might provide public education around laws related to the safety and well-being of children and families including minimal housing standards, seat belt safety, home schooling regulations, and pool safety. There is also a need for financial and caregiver support for relatives who are legal guardians of children, as well as a need for additional resources to support an increase in the number of out-of- home placements for children coming into care. CCPT recommendations included the need to provide training to law enforcement regarding family/domestic violence and sex abuse cases.

CCPT Level Resources Recommendations

Education, training and collaboration were the most frequent recommendations to improve CCPT functioning. Recommendations focused on open communication, sharing of information between agencies (e.g., CPA, LE, schools), and collaboration between CCPT and the state. Turnover of members and infrequent attendance at meetings are barriers that interfere with collaboration. Education via webinars and a training manual on the case review process is recommended to help foster consistent case reviews. CCPTs recognized the value of child and family teams (CFT) by recommending increased use of CFTs in coordinating services. CCPTs also requested a facilitator for CFT meetings.

Family Level Recommendation

The family level recommendations made by CCPTs address providing education for parents on the risks associated with co-sleeping and improving safe child care, especially for those parents of children with special needs or disabilities. Comprehensive case management is recommended for families as well.

CCPTs also addressed the resource needs of families including affordable and available transportation to needed services, carbon monoxide detectors in homes, the loss of Medicaid when a child is removed from a home, and funding for low-income families not eligible for Medicaid and counseling services. CCPTs recommend developing a holistic assessment to address all aspects of child well-being and family functioning.

> ***One CCPT suggested, "Increase ease of accessing transportation services for families. Explore the possibility of providing taxi service to families with special needs children."***

Recommendations regarding mental health and substance abuse crossed all four levels – NCDSS, county, CCPT and family. In general, CCPTs recommended increasing access to mental health, developmental and substance abuse services for families by addressing insurance issues and availability of providers, in particular, behavioral health providers. CCPTs identified the need to develop effective strategies for working with parents who are addicted to drugs or other substances, especially in the case of newborns. There is also a need for early intervention and treatment programs for parents and funding for such programs. Programs that focus on trauma or trauma-based therapy are also recommended. Outreach programs to educate the community on opioid addiction problems and methamphetamine (meth) addiction are suggested for county consideration. NC DSS and/or county-level agencies might consider increasing the availability of suboxone and other medications used in treating opioids. There should also be some oversight to ensure that referrals for mental health services are appropriate based on the client's needs and that there is appropriate follow-up.

Which action steps do CCPTs support to accomplish the three 2014 recommendations?

In 2014, the NC CCPT Advisory Board made three recommendations to NC DSS on how to improve child welfare in the state: (1) encourage common CFT (child and family team) practices in order to coordinate services for children, youth, and families; (2) strengthen the capacity of local CCPTs to work with social services in improving child welfare services; and (3) create and maintain a survey to track CCPT reviews of child protection cases. These recommendations were developed based on the 2013 and 2014 CCPT annual survey as well as national studies of child welfare and citizen review panels. Each recommendation was accompanied by a series of critical action steps suggested for its implementation. These critical steps provided a framework for the 2015 and 2016 survey question regarding the three recommendations.

The goal of these survey questions was to assess local teams' level of support for the action steps. The survey asked respondents to indicate which action steps they supported and provided space to suggest other steps to accomplish the recommendation. Teams completing the survey could mark all action steps they supported for each recommendation. The following summary first explains the 2014 report's rationale for each recommendation and then summarizes the 2016 survey responses regarding each recommendation's action steps.

Recommendation 1: Encourage Common CFT Practices in order to Coordinate Services for Children, Youth, and Families

2014 Report Rationale for Recommendation

The 2014 end-of-year report provided the following rationale for the recommendation on child and family team meetings:

> The Advisory Board agreed that child and family teams (CFTs) are a common approach across child-and-family-serving systems and can coordinate an array of services at the family level. The capacity of CFTs, however, to provide coordination is limited by systemic factors that impede collaboration. In particular, agency differences in language, procedures, and training create barriers to using CFTs as a means of wrapping services around children, youth, and families. Overcoming these challenges is crucial because CFTs help to maintain family connections (Pennell et al. 2010; Wang et al., 2012), expedite and coordinate service access (Weigensberg, Barth, & Guo, 2009), and [as found in the 2014 CCPT survey], facilitate family/youth partners helping families navigate services. (CCPT Report 2014, p. 24)

2016 Survey Results

The survey results for the first recommendation regarding child and family teams (CFT) are displayed in Table 9 below. This table lists seven action steps towards achieving the first recommendation, the number of CCPTs who support each action step, and the corresponding percentage out of responding CCPTs. Having an agreed-upon protocol for cross-system CFT meetings (74%) and inviting family and youth partners to provide support to family members before, during, and after CFT meetings (73%) were the action steps with the highest level of support from the responding CCPTs. These were the same action steps that garnered the highest level of support in the 2015 survey. As previously noted, 19 CCPTs indicated in both 2015 and 2016 that they had family or youth partner participation on their teams.

A significant percentage of teams (44%) also supported providing CCPTs with CFT documentation, such as CFT participant lists or plans, when reviewing cases. Of the 64 teams who reviewed one or more cases in 2016, 21 responded that they currently use CFT documentation in their case reviews. Teams also support online offerings of forums, CFT training to family members and/or resource families, and CFT training to CCPTs. Profiling CFT successes on social media (while protecting family confidentiality) was the action step with the least amount of support.

Table 9 Support for Recommendation 1: Encourage common child and family team (CFT) practices in order to coordinate service for children, youth, and families

Support for Recommendation 1: Encourage common child and family team (CFT) practices in order to coordinate service for children, youth, and families, 2016, (N = 77)

Action Step	Number of CCPTs
Having an agreed-upon protocol for cross-system CFT meetings (e.g., who prepared family, who facilitates meetings, what information can be shared at meetings)	57 (74.0%)
Inviting family or youth partners to provide support to family members before, during, and after CFT meetings	56 (72.7%)
Providing CCPTs with any CFT documentation (e.g., CFT participant lists, CFT plans) when reviewing cases	34 (44.2%)
Offering statewide or regional CCPT online forums to share successes and strategies in holding cross-system CFTs	22 (28.6%)
Offering online CFT training to family members and/or resource families (foster or adoptive) on CFT meetings	21 (27.3%)
Offering to CCPTs online CFT training co-trained by family or youth partners	15 (19.5%)
Profiling CFT successes on social media (while protecting family confidentiality)	3 (3.9%)
Other	5 (6.5%)

Note. CCPTs could select all that apply. Percentages in parentheses are out of the 77 valid responses.

In summary, over 70% of CCPTs supported (1) having an agreed-upon protocol for cross system CFT meetings and (2) inviting family or youth partners to support family members throughout the CFT process. These steps were also the most widely supported in 2015. In both 2015 and 2016, 19 CCPTs indicated that they had family or youth partner participation on their teams. More than 40% of responding teams supported providing CCPTs with any CFT documentation when reviewing cases. Responding CCPTs also supported online forums, online CFT trainings for family members and/or resource families, and online CFT trainings for CCPTs.

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

2014 Report Rationale for Recommendation

The 2014 end-of-year report provided the following rationale for the recommendation on the capacity of local CCPTs to work with social services in improving child welfare services.

> In order to perform their role, CCPTs need to have a sense of cohesion as a team, have a good exchange of information with Social Services, and exert some degree of autonomy (Bryan, Jones, & Lawson, 2010). They, however, do *not* want to be left on their own. The child welfare system is highly complex and ever changing and that CCPTs need Social Services to provide

> education, resources, and guidance (Bryan, Collins-Camargo, & Jones, 2011). CCPTs can exert greater influence if they cooperatively engage with Social Services. To work with Social Services, they require frequent contact with administrators who can orient them to agency priorities, help them access data, give immediate feedback on recommendations, and affirm the value of citizen participation (Buckwalter, 2014). (CCPT Report 2014, p. 25)

2016 Survey Results

The six action steps to strengthen the capacity of local teams and the corresponding number of teams supporting each step are displayed in Table 10 below. All of the action steps had a significant amount of support. Each step had the support of between 43% and 74% of the CCPTs responding to these questions. Sharing CCPT recommendations with bodies that can put them into action, such as county directors' associations or state legislators, had the most support at 74%. Two other action steps, (1) offering training to increase the participation of mandated CCPT members and (2) connecting CCPTs to related cross-system efforts, also had the support of over 60% of the responding CCPTs. The second suggested step of offering training to mandated members corresponds with the survey results that many CCPTs have infrequent participation from certain members such as district attorneys.

Two other action steps had the support of more than 50% of responding CCPTs. These action steps were (1) using CCPT recommendations to structure child welfare plans such as the state's Child and Family Services Plan or the Program Improvement Plan to the US Children Bureau and (2) offering training to support the inclusion of family or youth partners as members of CCPTs. The final action step, ensuring feedback between NC DSS and CCPTs also had a significant amount of support (43%).

CCPTs also provided other suggestions in response to this survey question. A number of responses were related to providing training in some capacity to both new and established CCPT members. One CCPT suggested updating training materials and distributing them to local CCPTs. Another suggested ongoing training for CCPT members with specific training for chairpersons. A third training suggestion was to provide instruction regarding CCPT and CFPT statutory mandates.

Table 10 Recommendation 2: Strengthen the capacity of local CCPTs to work with Social Services in improving child welfare services

Recommendation 2: Strengthen the capacity of local CCPTs to work with Social Services in improving child welfare services, 2016, (N=77)

Action Step	Number of CCPTs Supporting the Action
Sharing CCPT recommendations with bodies that can put them into action (ex. county directors' association, state legislators)	57 (74.03%)
Offering training to increase the participation of mandated CCPT members	51 (66.23%)
Connecting CCPTs to related cross-system efforts (ex. system of care)	49 (63.64%)
Using CCPT recommendations to structure child welfare plans (ex. state's Child and Family Services Plan, Program Improvement Plan to the U.S. Children's Bureau)	40 (51.95%)
Offering training to support the inclusion of family or youth partners as members of CCPTs	40 (51.95%)
Ensuring feedback between NC DSS and CCPTs (ex. including senior NC DSS administrators on online forums)	33 (42.86%)
Other	7 (9.09%)

Note. CCPTs could select all that apply. There were 77 valid cases. Percentages in parentheses are out of the 77 valid responses.

In summary, the most strongly supported action step was to share CCPT recommendations with bodies that can put them into action. More than 60% of responding teams also supported (1) offering training to increase the participation of mandated CCPT members and (2) connecting CCPTs to related cross-system efforts. The action step related to offering training to increase member participation seeks to address the common experience among CCPTs that some mandated members participated infrequently in both 2015 and 2016. Substantial support was evident for all action steps regarding the second recommendation and CCPTs offered excellent suggestions in their written responses as well.

Recommendation 3: Create and Maintain a Survey to Track CCPT Reviews of Child Protection Cases

2014 Report Rationale for Recommendation

The 2014 end-of-year report provided the following rationale for the recommendation on maintaining a survey to track CCPT reviews of child protection cases.

> The CCPT Advisory Board agreed that NCDSS should establish a database for CCPT case reviews. They noted that most local CCPTs were already familiar with providing child fatality reviews to the NC Division of Public Health and, therefore, could extend this role to entering child protection reviews into a NC DSS database. The database is a means for collating the over 600 case reviews per year and generating reports regarding state and regional patterns in child maltreatment. These reports can encourage sharing within local CCPTs about child maltreatment and child fatalities, assist with the flow of information between local CCPTs and NCDSS on successes and challenges, inform policy recommendations, and identify whether instituting policy recommendations improve service delivery. Notably, research has found that case reviews of child protection fatalities and their findings and related system changes are associated with a decrease in child fatalities over time (Palusci, Yager, & Covington, 2010). (CCPT Report 2014, p. 26)

2016 Survey Results

There were three suggested action steps to accomplish the third recommendation. Table 11 summarizes the support for these three action steps. Of the 74 CCPTs who responded to the question regarding the third recommendation, the largest percentage (78%) supported working with CCPTs to identify necessary training and support for conducting a case review survey. This action step also received the most support in the 2015 survey. The other two action steps, (1) implementing a case review survey across the state and (2) synthesizing the findings from two years of statewide case review surveys and identifying areas for policy recommendations, also received a significant amount of support. In the written responses, one CCPT suggested using a standardized form to be submitted quarterly to the Advisory Board and North Carolina Department of Social Services and another proposed using a standard case review tool. These written responses reflect the suggestions made by teams in the previous year's survey.

Table 11 Support for Recommendation 3: Create and maintain a survey to track CCPT reviews of child protection cases

Support for Recommendation 3: Create and maintain a survey to track CCPT reviews of child protection cases, 2016, (N = 74)

Action Step	Number of CCPTs	
Identifying with CCPTs necessary training and supports for conducting the case review survey	58	(78.4%)
Implementing a case review survey across the state	48	(64.9%)
Synthesizing findings from 2 years of statewide case review surveys and identify areas for policy recommendations	40	(54.1%)
Other	4	(5.4%)

Note. CCPTs could select all that apply. Percentages in parentheses are out of the 74 valid responses.

In summary, the action step that received the most support (78%) from CCPTs to accomplish Recommendation 3 was to work with CCPTs to identify necessary training and support for conducting a case review survey. Implementing a case review survey across the state was also favored by 65% of responding CCPTs while synthesizing findings from case review surveys and identifying areas for policy recommendations was supported by 54%. All of these action steps had a substantial amount of support from responding CCPTs.

What do you think would help your CCPT complete a case review survey?

In the 2016 survey, CCPT members made suggestions as to factors that could help their team complete a case review survey. Of the 87 counties that completed the survey, only 40 provided a response to this question and most responses were brief. One clear need is training about the expectations for the case review survey and instructions on completing it. Having a standardized tool that is available throughout the year to collect data for the survey is recommended. Another recommendation is to collect the data on a quarterly basis rather than annually, or have access to the survey questions at the beginning of the calendar year under review. Implementing a tracking database to upload case review summaries on at least a quarterly basis or as needed is suggested. CCPT members recommend that NC DSS provide information on how the survey data are to be used, make the data available to the teams, provide feedback on the findings from the case review survey, and provide feedback on or assist in the implementation of child welfare recommendations made by CCPTs.

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

CCPTs recognize that NC DSS is in a better position to follow through on some of the recommendations, in part because NC DSS has a view of the larger, cross-country patterns. CCPTs are requesting clear and direct guidance from NC DSS on general policy and recommendations. CCPTs, in general, expressed dismay that information about the follow through on recommendations does not filter down from the state. This may be a result of not having a central person at NC DSS who would provide technical assistance to local CCPTs.

Periodic training with a review of the CCPT mission, purpose and case review criteria is necessary as members come and go. For example, a CCPT stated:

"Unless the CCPTS are working well with a clear understanding and focus, then we are no help in putting the recommendations into action.

Persons who volunteer to serve on CCPTs are often stretched to their limits as they often serve on other committees:

"Most are frontline workers who have been delegated to serve on the more formal teams. Because they are stretched they are often unable to attend all of these meetings unless the agenda or case discussion is specific to them."

CCPTs have also suggested it would beneficial to develop an alliance with legislators by educating them on CCPTs' mission, role and contribution to the State's child protection and welfare:

"[They] believe the State [DSS], possibly through the Director's Association, could do a better job of educating them about both CCPT/CFPT teams as well the issues that those groups see locally and at a statewide level."

Information and communication technology (ICT) offer ways to share information about trends in child welfare and community solutions in all 100 counties. Webinars, conference calls, and other ICT methods can contribute to county-wide access to information, queries and answers. CCPTs could be more effective with state funding and support. CCPTs are energetic and committed to their work and requesting an infusion of support, both tangible and nontangible, from the state.

Take Home Messages

Based on these survey findings, the majority of CCPTs are operating according to state statute and working diligently to improve child welfare in North Carolina. Also, most teams operate as a combined CCPT and Child Fatality Protection Team (CFPT). Most teams surveyed have very frequent participation from many of their mandated members. Although participation has continued to be an issue for some members, it has improved for others. CCPTs conduct a median of 6.9 case reviews per year and use a variety of sources to select cases for review. Criteria used to select cases continue to reflect the lack of access to mental health, developmental disability, and substance abuse services in the state.

CCPTs continue to make meaningful contributions in word and action regarding the 2014 recommendations. The recommendations, which center on child and family teams, working with social services agencies, and tracking case reviews, are all central to CCPTs' ability to be effective advocates for children. In regards to furthering these recommendations, survey responses indicate that most CCPTs support developing a protocol for CFT meetings, sharing CCPT recommendations with bodies that can put them into action, and working with CCPTs to identify necessary training and support for conducting a case review survey.

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Appendices

Appendix A: Survey Process and Results

Table A1 Timeline of CCPT Survey, 2016

Timeline of CCPT Survey, 2016

Date	Activity
January 19, 2017	NC CCPT Advisory Board specified items for the end-of-year survey
February 3, 2017	NC State University Institutional Review Board approved research protocols protecting participants
February 3, 2017	Lane Destro of NC DSS sent updated CCPT Chairpersons contact list to the CCPT Research Team
February 6, 2017	NC State University Research CCPT Team distributed survey to CCPT Chairpersons or designees with weekly reminders in February to unfinished respondents
February 15, 2017	Section Chief, Kevin Kelley, transmitted letter to County Directors, Child Welfare Staff
March 1, 2017	Original deadline for submission
March 8, 2017	Extended deadline for submission

Table A2 Counties of CCPTs Submitting Survey Report

Counties of CCPTs Submitting Survey Report, 2016

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

Note. The total is 86 CCPTs. One responding CCPT did not agree to complete the survey. The survey was sent to 100 CCPTs.

Table A3 Responding CCPTs by County Population Size

Responding CCPTs by County Population Size, 2016, (N=86)

County Size	Total Counties	Total Responding Counties	Percent
Small	51	40	78.43%
Medium	39	36	92.31%
Large	10	10	100%

Note. Missing data for one county.

Table A4 LME-MCOs and Number of Member Counties Responding to Survey

LME-MCOs and Number of Member Counties Responding to Survey, 2016

LME-MCO	Number of Member Counties	Total Responding Counties	Percent
Alliance Behavioral Healthcare	4	4	100%
Cardinal Innovations Healthcare	16	15	93.75%
CenterPoint Human Services	4	3	75%
Eastpointe	12	11	91.67%
Partners Behavioral Health Management	8	8	100%
Sandhills Center	9	8	88.89%
Smoky Mountain Center	23	18	78.26%
Trillium Health Resources	24	19	79.17%
Total 8	100	86	

Note. Member counties affiliated with a Local Management Entity (LME) - Managed Care Organization (MCO), as of July 1, 2015.

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: Copy of 2016 Survey

Q1 2016 Survey

North Carolina Community Child Protection Teams Advisory Board

We are asking that all Community Child Protection Teams (CCPTs) in North Carolina complete this 2016 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, Holly Benton, Justine Chilton, and Josephine McKelvy) 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 2014 CCPT survey data, the Advisory Board made three recommendations to the NC Division of Social Services, and these recommendations were further supported by the findings from the 2015 CCPT survey:

1. Encourage common child-and-family-team practices in order to coordinate services for children, youth, and families
2. Strengthen the capacity of local CCPTs to work with Social Services in improving child welfare services
3. Create and maintain a survey to track CCPT reviews of child protection cases.

This year's survey seeks your guidance on how to put these recommendations into action at the local and state levels. Please click the ">>" button below to continue.

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 2016.
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 hit 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_project@ncsu.edu or schedule a phone call at this link: http://goo.gl/p3ypoc
7. Please complete and submit the survey in Qualtrics on or before March 1, 2017.

Q3 North Carolina State University
INFORMED CONSENT FORM for RESEARCH
Title: Community Child Protection Team 2016 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 2016 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."

- ❍ Yes, you can now proceed to the next page.
- ❍ No, please contact Lane Destro at the NC Division of Social Services for technical assistance on completing the survey: email Lane.Destro@dhhs.nc.gov or phone 919-527-6297. Once your questions are answered and you wish to take the survey, email CCPT_project@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 Some CCPTs combine their CCPT and Child Fatality Prevention Team (CFPT). Which of the following applies to your CCPT?

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

Q7 CCPTs have members mandated by General Statute 7B-1406. In 2016, how frequently did the following mandated members participate in your CCPT?

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

Q8 Besides mandated CCPT members, boards of county commissioners can appoint five additional members. In 2016, how many additional members took part in your CCPT? If zero, type 0.

Q9 List the organization/unit that additional members represent.

- ❑ Member 1 _____
- ❑ Member 2 _____
- ❑ Member 3 _____
- ❑ Member 4 _____
- ❑ Member 5 _____

Q10 In 2016, did family or youth partners serve as members of your CCPT?

- ❍ Yes
- ❍ No

Q11 In 2016, how frequently did the family or youth partners participate in your CCPT?

	Never	Rarely	Occasionally	Frequently	Very Frequently
Family or Youth Partner	❍	❍	❍	❍	❍

Q12 List reasons that family members did not participate

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

Q13 From January through December 2016, 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 Lane Destro at the NC Division of Social Services for technical assistance: email Lane.Destro@dhhs.nc.gov or phone 919-527-6297.

Q14 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 can 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

Q15 What is the total number of cases of child maltreatment reviewed by your CCPT between January and December 2016? 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. If you have questions about determining your number of cases reviewed, please contact Lane Destro at the NC Division of Social Services for technical assistance: email Lane.Destro@dhhs.nc.gov or phone 919-527-6297.

Q16 Which of the following criteria did your CCPT use in 2016 for selecting cases for review? Check all that apply. Please write in other criteria that you used.

- ❑ Child Maltreatment Fatality
- ❑ Court Involved
- ❑ Multiple Agencies Involved
- ❑ Repeat Maltreatment
- ❑ Active Case
- ❑ Closed Case

- ❑ Stuck Case
- ❑ Child Safety
- ❑ Child Permanency
- ❑ Child and Family Well-being
- ❑ Parent Opioid Use
- ❑ Other 1 _____
- ❑ Other 2 _____

Q17 Which of the following contributory factors to children being in need of protection did you use in 2016 for selecting cases for review? Hold down control (Mac: Command), and click for all that apply.

- ❑ Caretaker - Alcohol Abuse
- ❑ Caretaker - Drug Abuse
- ❑ Caretaker - Mental Retardation
- ❑ Caretaker - Emotionally Disturbed
- ❑ Caretaker - Visually or Hearing Impaired
- ❑ Caretaker - Other Medical Condition
- ❑ Caretaker - Learning Disability
- ❑ Caretaker - Lack of Child Development Knowledge
- ❑ Child - Alcohol Problem
- ❑ Child - Drug Problem
- ❑ Child - Mental Retardation
- ❑ Child - Emotionally Disturbed
- ❑ Child - Visually or Hearing Impaired
- ❑ Child - Physically Disabled
- ❑ Child - Behavior Problem
- ❑ Child - Learning Disability
- ❑ Child - Other Medical Condition
- ❑ Household - Domestic Violence
- ❑ Household - Inadequate Housing
- ❑ Household - Financial Problem

- ❑ Household - Public Assistance

Q18 Which of the following types of information did you use in reviewing cases? Check all that apply.

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

Q19 How does your local CCPT carry out case reviews? What would help your CCPT carry out case reviews even better?

Q20 How many of the cases reviewed in 2016 were identified as having children and/or youth who needed access to the following services:

	Number of Cases
Mental Health (MH)	
Developmental Disabilities (DD)	
Substance Abuse (SA)	

Q21 How many of the cases reviewed in 2016 were identified as having parents or other caregivers who needed access to the following services:

	Number of Cases
Mental Health (MH)	
Developmental Disabilities (DD)	
Substance Abuse (SA)	

Q22 In 2016, which of the following limitations prevented children, youth, and their parents or other caregivers from accessing needed MH/DD/SA services. Check all that apply.

- ❑ Limited services or no available services
- ❑ Limited services for youth with dual diagnosis of mental health and substance use issues
- ❑ Limited services for youth with dual diagnosis of mental health and developmental disabilities

- ❑ Limited transportation to services
- ❑ Limited community knowledge about available services
- ❑ Limited number of experienced child and family team (CFT) meeting facilitators
- ❑ Limited attendance of MH/DD/SA providers at CFTs
- ❑ Other 1 _____
- ❑ Other 2 _____

Q23 Based on your 2016 case reviews, what were your team's top three recommendations for improving child welfare services?

Recommendation 1

Recommendation 2

Recommendation 3

Q24 On the basis of 2014 survey, the NC CCPT Advisory Board made three recommendations to NC DSS. Recommendation 1: Encourage common child and family team (CFT) practices in order to coordinate service for children, youth, and families. 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.

- ❑ Having an agreed-upon protocol for cross-system CFT meetings (ex. who prepares family, who facilitates meetings, what information can be shared at meetings)
- ❑ Inviting family or youth partners to provide support to family members before, during, and after CFT meetings.
- ❑ Providing CCPTs with any CFT documentation (e.g., CFT participant lists, CFT plans) when reviewing cases
- ❑ Profiling CFT successes on social media (while protecting family confidentiality)
- ❑ Offering to CCPTs online CFT training co-trained by family or youth partners.
- ❑ Offering statewide or regional CCPT online forums to share successes and strategies in holding cross-system CFTs
- ❑ Offering online training to family members and/or resource families (foster or adoptive) on CFT meetings
- ❑ Other 1 _____
- ❑ Other 2 _____

Q25 On the basis of the 2014 survey, the NC CCPT Advisory Board made three 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.

- ❑ Offering training to increase the participation of mandated CCPT members
- ❑ Offering training to support the inclusion of family or youth partners as members of CCPTs
- ❑ Connecting CCPTs to related cross-system efforts (ex. system of care)
- ❑ Ensuring feedback between NCDSS and CCPTs (ex. including senior NCDSS administrators on online forums)
- ❑ Sharing CCPT recommendations to bodies that can put them into action (ex. county directors' association, state legislators)
- ❑ Using CCPT recommendations to structure child welfare plans (ex. state's Child and Family Services Plan, Program Improvement Plan to the U.S. Children's Bureau
- ❑ Other 1 _____
- ❑ Other 2 _____

Q26 On the basis of last year's survey, the NC CCPT Advisory Board made three recommendations to NC DSS. Recommendation 3: Create and maintain a survey to track CCPT reviews of child protection cases. Currently CCPT reviews are not transmitted to NC DSS. This new survey instrument would collect information on CCPT case reviews more frequently. This information would be provided to NC DSS. 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.

- ❑ Identifying with CCPTs necessary training and supports for conducting the case review survey
- ❑ Implementing the case review survey across the state
- ❑ Synthesizing findings from two years of statewide case review surveys and Identifying areas for policy recommendations
- ❑ Other 1 _____
- ❑ Other 2 _____

Q27 What do you think would help your CCPT complete a case review survey?

Q28 What further advice can you give us on putting the three recommendations into action?

Q29 Once you hit "submit," you will be directed to a copy of your completed responses, and you can print the screen. If you have questions about the survey and keeping a copy for your records, please contact CCPT_project@ncsu.edu or schedule a phone call using this link: https://goo.gl/p3ypoc

Thanks for your participation! The NC Community Child Protection Team Advisory Board Michael Becketts (Chair)[3], Judith Ayers, Molly Berkoff, Cindy Bizzel, Wayne Black, George Bryan, Carmelita Coleman, Gail Cormier, Lane Destro, Brenda Edwards, Stephanie Francis, Ryan Hill, Sharon Hirsch, Anne Marie Hoo, Kevin Kelley, Wanda Marino, Tilda Marshall, Christy Nash, Kristin O'Connor, Michelle Reines, Darrell Renfroe, Adam Svolto, Adgenda Turner, Marvel Welch

[3] Until April 24, 2017