NORTH CAROLINA COMMUNITY CHILD PROTECTION TEAM

2014 End of Year Report

Community Child Protection Teams
NC Advisory Board

Forward

This year, the North Carolina Community Child Protection Team (CCPT) Advisory Board focused on a recurring issue faced by child welfare—the access of children and their families to mental health, substance abuse, and developmental disabilities services. We surveyed local CCPTs to learn about their experience with access to needed services and about their strategies for overcoming barriers to access.

We assumed that barriers to access can be overcome by developing a system of care in which youth and their families make and carry out plans in collaboration with their informal supports and formal services. At the family level, child and family teams are a means of putting system of care into action; at the system level, CCPTs are means of strengthening a system of care. Our survey questions asked about both family and community strategies.

We extend our appreciation to the 71 county CCPTs who completed the online survey. The survey and this report were prepared by Dr. Joan Pennell at NC State University, Center for Family and Community Engagement. She was assisted by Erika Brandt.

On the basis of the survey findings, we developed a series of recommendations on how to improve service access. Our conclusions were enriched by the expansion of the Advisory Board to encompass representation from youth and family partners and from different community organizations and public agencies. This expansion meant that our state-level board mirrored what we aim for in the membership of local CCPTs.

Respectfully submitted,

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Executive Summary

Community Child Protection Teams and Continuous Quality Improvement

North Carolina statute charges local Community Child Protection Teams (CCPTs) with reviewing child protection cases and identifying ways to improve child welfare in their communities. Local CCPTs report their findings both to their county commissioners and to the North Carolina Division of Social Services (NCDSS). On an annual basis, the North Carolina CCPT Advisory Board conducts an online survey of local CCPTs. Based on the survey data, the Advisory Board makes recommendations to NCDSS on how to better protect children and youth and support their families. NCDSS then provides a written response to the recommendations.

The CCPT report and the NCDSS 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 report is one of the requirements in the federal Child Abuse Prevention and Treatment Act (CAPTA). In 1997 North Carolina designed the Community Child Protection Team as its Citizen Review Panel with responsibility for this report. The purpose of Citizen Review panels is to provide opportunities for citizens to play an integral role in ensuring that states are meeting their goals of protecting children from maltreatment. The feedback loop promotes continuous quality improvement of child welfare.

Focus on System-of-Care Strategies to Improve Access to Mental Health, Substance Abuse, and Developmental Disabilities (MH/SA/DD) Services

This year, the North Carolina Community Child Protection Team (CCPT) Advisory Board decided to focus on a recurring and complex issue faced by child welfare across the state. This issue was the access of children, youth, and their families to mental health, substance abuse, and developmental disabilities (MH/SA/DD) services. The focus on service access was supported by the findings from last year's survey of local CCPTs. The 2013 survey found that lack of access to mental health services was the most frequently cited risk factor reported by CCPTs in reviewing case files. The second most cited risk factor was substance abuse. Along with concerns about domestic violence, these same issues were identified in earlier surveys.

The 2014 survey asked local CCPTs about their experience with access to needed services and about their strategies for overcoming barriers to access. The survey questions covered both family and systemic factors affecting access. The questions also inquired specifically about the extent to which child and family teams (CFTs) and community collaboration helped in overcoming barriers to access. Both of these strategies are seen as integral to building a system of care with and around children, youth, and families. CFTs include the family members as well as their informal networks and formal services in making and implementing plans. Collaborations are a way of building the community support necessary for safeguarding young people and their families.

Survey Participants

Out of the 100 local CCPTs, 71 completed the online survey. The CCPTs participating in the survey were relatively representative of North Carolina counties. They spanned from the Eastern to Western regions of the state and included counties with different population sizes. For each region of the state, a Local Management Entity (LME)-Managed Care Organization (MCO) develops, carries out, and monitors mental health, developmental disabilities, and substance abuse services. Each county is affiliated with one of the nine LMEs-MCOs. The LMEs-MCOs had between 50 to 83% of their member counties responding to the CCPT survey

Case Reviews Identified Need for Service Access

One of the responsibilities of CCPTs is to review cases of children in need of protection. In 2014, 80% of the CCPTs reported reviewing at least 1 case. The CCPTs reviewed on average 6 cases. Their reviews particularly identified the need for children, youth, and parents or caregivers to access Mental Health services.

System and Family Issues Keeping Children and Families from Accessing Needed MH/SA/DD Services

The CCPTs estimated the frequency with which different access problems occurred in their county. Both system and family barriers were prevalent across counties. Transportation challenges had the highest frequency of all access problems. Difficulties with the service network were common and included problems such as the unavailability of quality services and qualified providers. These systemic issues occurred among member counties of all nine LME-MCOs. Family issues such as the parents' lack of understanding about locating and arranging services also impeded access.

System-of-Care Strategies to Tackle MH/SA/DD Service Access Problems

The counties used a number of system-of-care strategies to tackle barriers to service access. These strategies included child and family teams, cross-system collaborations, and community education. Most counties did not have an automated case management system for child welfare; if they did have such a system, they were more likely to have a data-sharing agreement between Mental Health and Child Welfare. For the most part, counties did not utilize family and youth partners to assist families, and such partnerships were concentrated in a minority of counties. Nevertheless, counties were using a number of strategies to involve family and youth partners. The most common of these strategies was including them in a collaborative team, and the least common was providing a stipend.

Child and Family Teams (CFTs) Benefiting Children, Youth, and Parents

The CCPTs identified that child and family teams (CFTs) engaged families in planning on an informed basis and that CFTs expedited and coordinated service delivery. In addition, CCPTs expressed their views about the impact of CFTs on children and youth. On the basis of their experience, they indicated that CFTs sometimes keep foster children and youth's connected to their families and schools. These viewpoints need to be tested by longitudinal research. Nevertheless, the CCPTs' perceptions are supported by research in other parts of the country that engaging families in planning meetings expedites children's

return to their parents or placement with relatives (Washington, DC—Pennell et al., 2010; Texas—Wang et al., 2012).

CFTs Primarily Facilitated by Social Services and Secondarily by Mental or Behavioral Health

Child welfare cases requiring access to MH/SA/DD services were most often facilitated by Social Services and secondarily by Mental or Behavioral Health. All nine LME-MCOs had member counties in which Mental or Behavioral Health facilitated sometimes or often. Per LME-MCO, the percentage of member counties with Mental or Behavioral Health facilitating at least some of the time ranged from 60% to 100%.

CFT Attendance Varied Among Family Members and Among Involved Organizations

For CFTs related to MH/SA/DD service access, the most frequent family attendees were mothers with other family members, including the children/youth and fathers, present to a lesser extent. After Social Services, the two agencies represented the most frequently at the CFTs were Guardian ad Litem and Mental or Behavioral Health. Family and youth partners sometimes attended. For each LME-MCO, the percentage of member counties with Mental or Behavioral Health facilitating at least some of the time ranged from 70% to 100%. The impact of who is present and absent from meetings needs more study. A Cumberland County study matched school and child welfare data from 347 CFTs. The data analysis found that students were less likely to change placements if they were present at their CFT meeting and if a school official was present (Pennell & Rikard, 2013).

Family-level Strategies for Improving CFTs Prevalent but System-level Strategies Unevenly Applied

Counties across the board used family-level strategies to improve CFT meetings, but more counties could attend to preparing professionals, encouraging the participation of children and youth, and scheduling follow-up CFTs. The county's use of system-level strategies was quite uneven. Setting procedures and sharing information were common among the counties. Reimbursing Mental Health providers, however, stood out as an area for work in most counties. In their recommendations, local CCPTs emphasized increasing collaboration among partners, providing outreach and education to professionals and families, and seeking more financial assistance including to reimburse Mental Health providers.

Advisory Board Recommendations

TBD

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North Carolina Community Child Protection Teams (CCPT) 2014 End-of-Year Report

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

Introduction

North Carolina statute charges local Community Child Protection Teams (CCPTs) with reviewing child protection cases and identifying ways to improve child welfare in their communities. County Social Services directors are responsible for supporting these efforts of their local CCPTs. Local CCPTs report their findings both to their county commissioners and to the North Carolina Division of Social Services (NCDSS). On an annual basis, the North Carolina CCPT Advisory Board conducts an online survey of local CCPTs. Based on the survey data, the Advisory Board makes recommendations to NCDSS on how to better protect children and youth and support their families. NCDSS then provides a written response to the recommendations.

The CCPT report and the NCDSS 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 report is one of the requirements in the federal Child Abuse Prevention and Treatment Act (CAPTA). In 1997 North Carolina designed the Community Child Protection Team as its Citizen Review Panel with responsibility for this report. The purpose of Citizen Review panels is to provide opportunities for citizens to play an integral role in ensuring that states are meeting their goals of protecting children from maltreatment.

The entire CCPT feedback loop serves as a means of continuous quality improvement of child welfare in the state. More information about CCPTs is posted on the NCDSS website under Community Child Protection Teams, and the findings from prior CCPT reports and the NCDSS responses are included in the 2014 Annual Progress and Services Report

This year, the North Carolina Community Child Protection Team (CCPT) Advisory Board decided to focus on a recurring and complex issue faced by child welfare across the state. This issue was the access of children, youth, and their families to mental health, substance abuse, and developmental disabilities services. The focus on service access was supported by the findings from last year's survey of local CCPTs. The 2013 survey found that lack of access to mental health services was the most frequently cited risk factor reported by CCPTs in reviewing case files. The second most cited risk factor was substance abuse. Along with concerns about domestic violence, these same issues were identified in earlier surveys.

The 2014 survey asked local CCPTs about their experience with access to needed services and about their strategies for overcoming barriers to access. The survey questions covered both family and systemic factors affecting access. The questions also inquired specifically about the extent to which child and family teams (CFTs) and community collaboration helped in overcoming barriers to access. Both of these strategies are seen as integral to building a system of care with and around children, youth, and families. CFTs include the family members as well as their informal networks and formal services in making and implementing plans. Collaborations are a way of building the community support necessary for safeguarding young people and their families.

This report summarizes what was learned from the survey and presents a series of recommendations on how to improve the access of children, youth, and their families to needed services. In making its recommendations, the Advisory Board benefited from its recently expanded membership. The members included youth and family partners and different community organizations and public agencies. At the Board meeting in March 2015, each group brought its own distinctive perspectives to the deliberations.

The report begins by describing the development of the 2014 survey and patterns in survey participation. Next the key findings are reviewed. The report concludes with the Advisory Board's recommendations to NCDSS. The appendices provide additional detail on the survey results (Appendix A) and include a copy of the survey instrument (Appendix B).

2014 Survey

Survey Purpose, Focus, and Development

The purpose of the annual CCPT survey is to assess what issues affect child welfare delivery across the state and identify what strategies can be deployed to resolve these issues and improve child and family outcomes. The effectiveness and efficiency of the feedback process is increased if annual surveys are constructed on the basis of learning from prior surveys.

This year's survey built upon the foundation provided by the prior 2013 CCPT report of findings and recommendations. In particular, the 2014 survey followed up on the 2013 recommendations of the Advisory Board to connect CCPTs more closely with two reform efforts. The first reform was system of care that uses child and family teams (CFTs) to wrap unified supports and services around children and their families. The 2013 report identified that local CCPTs could better advance system of care if they had greater representation across disciplines and by family and youth partners.

The second reform was establishing a continuous quality improvement system that employs data to set goals and objectives and to monitor and strengthen service delivery. The Advisory Board recommended that in future years, one issue at a time be selected in order to permit concentrated study.

For the 2014 survey, the Advisory Board selected one topic: the lack of access of children, youth, and their families to needed mental health, substance abuse[1], and developmental disabilities services. The Advisory Board also agreed that the 2014 survey should explore the role of CFTs and community collaborations in improving access. Recognizing the complex and chronic nature of this issue, the Board envisioned continuing with the same focus into the 2015 survey.

The two overarching questions addressed by the 2014 survey were:

1. What are the barriers to access?
2. What are the means of overcoming these barriers?

To specify the meaning of key terms, the survey provided definitions posted in the glossary of the NC Division Mental Health, Developmental Disabilities, and Substance Abuse Services (MHDDSAS). The term access was defined as "the ability to get array of available treatments, services and supports needed." To identify potential problems with service access, the survey questions tapped into findings from two surveys previously conducted in the state: the Child and Adolescent Health Measurement Initiative and the Child and Adolescent Services Assessment.

Survey Content and Administration

The first page of the survey described its purpose to improve public child welfare and its basis in state and federal statutes. The second page gave instructions on how to complete the survey, and a blank copy of the survey was attached so that respondents could ask team members for their input on the questions. The third page outlined the terms and conditions of participation in the survey. It stressed that participation was voluntary and that answers would not be linked to individual CCPTs. If respondents consented to participate, they could then proceed to completing the survey questions.

Multiple choice or fill-in the blank survey questions covered the following: the respondent's county or reservation, the type of CCPT, the number and type of cases reviewed by the CCPT in 2014, the extent of specific problems in accessing needed services, strategies for overcoming service access problems, strategies for involving family or youth partners, data management systems for tracking child and family team (CFT) meetings, benefits of CFT meetings, organizations facilitating and attending CFT meetings, and system-level and family-level stratgies for improving CFT meetings. The last two questions were open-ended and asked about local challenges to holding CFT meetings and about recommendations for overcoming these challenges. See Appendix B for a blank copy of the survey.

To recruit participants, NCDSS did the following: (1) sent a memo to remind local Directors of Departments of Social Services and their Program Managers of Child Welfare of the upcoming annual CCPT survey and the requirement that they support completion of the survey, (2) sent an e-mail message to the Chairs of the CCPTs to ask them to complete the survey and provide them with the link to the survey, and

[1] The CCPT recognizes that the term "substance use" is preferable to "substance abuse" because the former is in keeping with a strengths-based approach and with the change in language incorporated by the DSM-5 of the America Psychiatric Association.

(3) sent an e-mail reminder and a follow-up email reminder to local CCPT Chairs whose teams had not yet submitted a survey to do so and to provide them with the link to the survey.

The online survey was administered in the software program Qualtrics. To safeguard confidentiality, the survey responses were transmitted directly to NC State University for analysis. This meant that NCDSS and the Advisory Board did not view responses linked to individual CCPTs. The survey protocols were approved by the NC State University's Institutional Review Board for the Use of Human Subjects in Research.

Survey Participants

Out of the 100 local CCPTs, 71 completed the online survey. See appended Table A1 for a list of these CCPTs (note that appended Tables begin with A). An additional two CCPTs later sent their responses directly to NCDSS and were not included in the data analyses. The CCPTs participating in the survey were relatively representative of North Carolina counties. They spanned from the Eastern to Western regions of the state, and in terms of population size, they included 36 of 51 (71%) small, 30 of 39 (77%) medium, and 5 of 10 (50%) large counties.

For each region of the state, a Local Management Entity (LME)-Managed Care Organization (MCO) develops, carries out, and monitors mental health, developmental disabilities, and substance abuse services. Each county is affiliated with one of the nine LMEs-MCOs. The LMEs-MCOs had between 50 to 83% of their member counties responding to the CCPT survey (see Table A2).

CCPTs have the option of whether to have one combined CCPT team conduct the reviews of both the child maltreatment cases and child fatalities cases or to separate these functions into two teams—a CCPT and Child Fatality Prevention Team (CFPT). Among the 71 responding CCPTs, 18 (25%) indicated they had separate CCPTs and CFPTs, and the other 53 (75%) had combined teams (see Table A3). Percentages for separate or combined teams found this year are similar to those reported on last year's CCPT survey.

Results

Case Reviews Identified Need for Service Access

On the survey, CCPTs were asked to state how many child welfare cases they had reviewed in 2014. The average number reported was 8 cases but with a wide range from 0 to an outlier with 108 cases (*SD* = 14.44). When the outlier is removed, as would be expected, the large counties on average reviewed the greatest number of cases. As seen in Table 2 below, the average numbers of reviewed cases reported are 6 for small counties, 6 for medium counties, and 12 for large counties.

Table 1

Number of Cases Reviewed in 2014, by County Size

Size of County	Number of CCPTs	Mean	Std. Dev.
Small	30	5.90	5.57
Medium	28	5.93	5.50
Large	5	11.60	16.64
Total	63	6.37	6.92

Note. Outlier with 108 cases removed.

The next set of survey questions asked about the number of reviewed cases in which the children or youth and the parents or caregivers needed access to mental health, substance abuse, or developmental disabilities (MH/SA/DD) services. It should be noted that five CCPTs reported cases with access difficulties without having reported the number of total cases reviewed. Once the questions on number of cases and number of cases with access difficulties are combined, 14 (19.7%) did not report any cases reviewed while 57 (80.3%) did report cases reviewed.

Among the 57 CCPTs reporting reviews of cases, most identified the need for access to at least some of these services. Table 2 below shows how many CCPTs reported the need for access to these services and the average number of cases requiring this access.
The highest reported need was for access to mental health services for both children (42 CCPTs) and parents (50 CCPTs). The second highest need for children was access to developmental disabilities services (36 CCPTs) and for parents was access to substance abuse services (47 CCPTs). The third level of need for children was to substance abuse services (20 CCPTs) and for parents was to developmental disabilities services (18 CCPTs).

Table 2

Number of Reviewed Cases for Children and/or Youth or Parents and/or Caregivers Served by Public Child Welfare and Requiring Access to MH/SA/DD Services

Services	Children/Youth			Parents/Caregivers		
	Number of CCPTs	Mean	Std. Dev.	Number of CCPTs	Mean	Std. Dev.
Mental Health	42	4.68	3.85	50	4.96	4.11
Substance Abuse	20	2.61	3.22	47	4.00	3.69
Developmental Disabilities	36	1.91	1.38	18	1.41	0.80

Note. Two outlier cases removed from analysis of means. The means only included CCPTs who identified at least one case requiring the service. MH/SA/DD = Mental Health, Substance Abuse, and Developmental Disabilities.

In summary, 80% of the CCPTs reported reviewing at least 1 case. On average, they reviewed 6 cases in 2014. Their reviews identified the need, especially, for children, youth, and parents or caregivers to access Mental Health services.

System and Family Issues Keeping Children and Families from Accessing Needed MH/SA/DD Services

The survey listed a series of reasons why children and families served by public child welfare might not be able to access needed mental health, substance abuse, and developmental disabilities services. The CCPTs were then asked to estimate the frequency with which these access problems occurred in their county on a scale of *never, rarely, sometimes,* or *often*.

The first set of questions asked about problems affecting children or youth's access to needed services. The results are summarized in Table 3. For all three problems the median, that is, the midpoint, is *sometimes.* The distribution of scores showed that coordination of care was somewhat more elevated as an issue than families not sharing in decision making or a lack of health insurance. Among the responding CCPTs, 49 (76.6%) identified coordination of care as a problem *sometimes* or *often.* In contrast, for the other two issues, the CCPTs identified them as affecting access *sometimes* or *often* at 39 (58.2%) for families not sharing in decision making and 36 (53.7%) for a lack of health insurance.

Table 3

Frequency of Problems Affecting Access to Needed MH/SA/DD Services for Children/Youth Served by Public Child Welfare

	Frequency				
Problem	Never	Rarely	Sometimes	Often	Mean
Had unmet needs for coordination of care	7	8	27	22	3.00
Lacked adequate health insurance	10	21	24	12	2.57
Had families who did not share in decision-making around issues important to their child's health	8	20	35	4	2.52

Note. The means are calculated with *low* = 1, *rarely* = 2, *sometimes* = 3, and *often* = 4. The median (the midpoint) for the frequency of all the problems was *sometimes* (3).

Further examination of the results found that these problems were generally not concentrated in any one LME-CMO. No LME-CMO had the majority of their responding CCPTs stating that lack of health insurance and not including families in decision making *often* happened. Regarding coordination of care, 8 out of 9 LME-CMOs did not have a majority of CCPTs responding that this problem *often* occurred. Because no LME-CMO had all its member counties responding, the results need to be treated with caution.

Next the CCPTs were asked how often 17 different problems affected access for child, youth, and their parents or caregivers served by public child welfare in their county. In addition, CCPTs could write in other problems. Table 4 shows that CCPTs as a whole experienced all the 17 listed problems with some noting other problems. Their mean responses were above *rarely* (2) on all these problems. Counting the number of problems occurring *sometimes* or *often* per county, individual counties identified having between 0 and 19 of the problems, with an average of 11.3 problems (*SD* = 4.23). As would be expected, the average number of problems increased with county size: 9.75 for small counties (*SD* = 4.51), 12.87 for medium counties (*SD* = 3.05), and 13.40 for large counties (*SD* = 4.78).

Table 4

Frequency of Other Problems Affecting Access to Needed MH/SA/DD Services for Children, Youth, and Their Parents or Caregivers Served by Public Child Welfare

Problem	Frequency				Mean	Total Responses
	Never	Rarely	Sometimes	Often		
Limited transportation to services	2	6	17	46	3.51	71
Lack of knowleadge of parents/caregivers about where to get services	2	5	40	23	3.20	70
Unavailability of quality services	5	11	23	31	3.14	70
Lack of knowledge of parents/caregivers about arranging services (e.g., making appointments)	2	9	41	18	3.07	70
Lack of time of parents/caregivers to take children to appointments	2	11	37	20	3.07	70
Lack of qualified providers who can be reimbursed for services	6	14	22	28	3.03	70
Infrequency of service provision	5	14	26	23	2.99	68
Lack of affordable services	3	19	27	21	2.94	70
Lack of affordable medications	3	22	28	17	2.84	70

Domestic violence keeping parents/caregivers from accessing services	6	12	38	12	2.82	68
Lack of support persons to accompany individuals to appointments	4	18	31	13	2.80	66
Refusal of children/youth to accept services	5	20	33	12	2.74	70
Lack of interpreters for non-English speakers	8	19	29	11	2.64	67
Reluctance of parents/caregivers to use services out of fear that they will be seen as unfit caregivers by Social Services	6	22	36	4	2.56	68
Embarrassment of parents/caregivers about using services in their cultural communities	7	23	30	4	2.48	64
Lack of interpreters for deaf individuals	13	21	18	6	2.29	58
Lack of information materials for low-literacy individuals	13	25	23	3	2.25	64
Other 1[a]	1	0	1	7	3.56	9
Other 2[b]	1	0	1	4	3.33	6

Note. The means are calculated with *low* = 1, *rarely* = 2, *sometimes* = 3, and *often* = 4.
[a]Problems included in "Other 1" category were: lack of nurse consultant in day care, lack of services for perpetrators of sexual abuse and domestic violence, lack of availability of services and funding for disabled children, lack of motivation to access services, therapeutic foster homes, lack of holistic trauma-informed services for parents/caregivers of maltreated children/youth, and parents/caregivers' refusal to access services.
[b]Problems included in "Other 2" category were: lack of mental health services in schools, lack of flexibility in services for substance abusers, high staff turnover of mental health and substance abuse providers, lack of significant consequence for failure to access services, and lack of mental health facility in the area.

The most commonly reported problem was limited transportation to services. Nearly two-thirds of the CCPTs stated that this problem *often* happened. The impact of transportation was the case across the board, without regard to the population size of the county. It should be noted that some "small" counties were geographically large compared to other counties. Transportation problems were likely exacerbated by the often reported lack of support persons to accompany parents to appointments.

Other problems frequently identified related to the service network. These included the unavailability of quality services, lack of qualified providers who could be reimbursed, infrequency of service provision, unaffordability of services, and unaffordability of medications. Using the option to write in other problems, the CCPTs primarily elaborated on barriers posed by the service system. A count of the five system problems listed found that they occurred *sometimes* or *often* in all nine LME-CMOs. For the individual LME-CMOs, their number averaged between 2.50 to 4.60 problems.

Other frequently cited problems pertained to the parents or caregivers: their lack of knowledge about where to get services or how to arrange services and their lack of time to take children to appointments. In addition, domestic violence kept parents from accessing services. CCPTs also identified that children or youth might refuse to accept services.

To a lesser extent, CCPTs indicated that parents might not reach out for services because of the lack of interpreters for non-English speaking individuals, fears that Social Services might see them as unfit parents, or embarrassment about accessing services in their cultural community. The problems with the lowest rated frequency concerned specific groups: individuals who were deaf or who had low-literacy skills.

In summary, both system and family barriers were prevalent across counties. Transportation challenges had the highest frequency of all access problems. Difficulties with the service network were common and included problems such as the unavailability of quality services and qualified providers. These systemic issues occurred among member counties of all nine LME-MCOs. Family issues such as the parents' lack of understanding about locating and arranging services also impeded access.

System-of-Care Strategies to Tackle MH/SA/DD Service Access Problems

Turning from problems to strategies, the survey asked the CCPTs to consider system-of-care approaches that had been used in their county to increase service access. On a list of 17 strategies, they were asked to respond if their county had used the strategy in 2014. Additionally, they could write in other strategies which had been applied. As summarized in Table 5, 11 out of the 17 listed strategies were used in more than half (over 36) of the counties according to the responding CCPTs.

A count of a possible 19 strategies (including the 2 other categories) found that individual CCPTs indicated that they had employed between 0 and 19 of the strategies, with an average of 9.90 (*SD* = 4.30). As counties increased in size, they tended to use more strategies, with the averages at 9.14 (*SD* = 4.54) for small, 10.03 (*SD* = 3.70) for medium, and 14.60 (*SD* = 3.21) for large counties.

Table 5

Use of Strategies for Helping Children/Youth and Parents/Caregivers Gain Access to Needed MH/SA/DD Services

Strategy	Use			Total Responses
	Yes	No	DK	
Child and family teams creating and implementing plans	63	5	1	69
Community presentations/forums	61	7	2	70
Workshops for resource parents (foster, therapeutic foster, kin, adoptive)	58	9	3	70
Joint training across the disciplines involved in child welfare	57	13	0	70
Joint meetings of LME/MCO and child welfare to address systemic issues	55	11	4	70
Development of multi-disciplinary teams to improve service delivery	53	16	1	70
Joint meetings of LME/MCO and child welfare to staff individual cases	52	16	2	70
Having Local Management Entity (LME) or Managed Care Organization (MCO) attend child welfare staff meetings	46	22	2	70
Posting resource information on a website	40	25	5	70
Joint development of protocols by LME/MCO and child welfare to improve service coordination	39	25	6	70
Joint development of protocols by LME/MCO and child welfare to increase access to services	37	28	5	70
Family workshops/cafés	28	34	7	69
Having a data sharing agreement between Social Services and Mental Health	27	38	5	70
Family/youth partner with experience of receiving services providing support to families	23	38	8	69
Family/youth partners with experience of receiving services helping families navigate access to services	20	42	7	69

Family/youth partners with experience of receiving services providing training	20	40	7	67
Having an automated case management system for child welfare	12	49	9	70
Other 1[a]	7	1	2	10
Other 2[b]	5	1	2	8

Note. DK = Don't Know.
[a]Responses included in "Other 1" category were: LINKS Program and Placement Social Workers assisting custody youth, In-Home Services Social Worker assisting youths within their families, and attending community meetings to discuss information regarding child welfare.
[b]Responses included in "Other 2" category were: youth mentoring, child advocacy partnering with mental health providers, providing education to multi-cultural service providers, outreach services, and critical case staffing.

The most commonly cited strategy for removing access barriers was child and family team (CFTs) meetings. This approach was checked *yes* by 63 out of 71 CCPTs. The finding is consistent with child welfare policy in North Carolina mandating the use of CFT meetings and different child-and-family-serving systems viewing CFTs as integral to coordinating a system of care. Nevertheless, attention needs to be paid to the minority of counties who were not using CFTs.

In second and third place were two educational strategies: community presentations and resource parent workshops. Both were used by over four-fifths of counties. Far fewer counties held family workshops or cafés, with this approach employed by under two-fifths of counties. Another fairly common educational strategy was posting information on websites.

A set of seven strategies referred explicitly to cross-system efforts between child welfare and mental health or other disciplines. These included joint training, meetings, teaming, case staffings, and protocol development. Each of these strategies was used by 37 to 57 counties. An eighth cross-system effort was far less common. This concerned having a data-sharing agreement between Social Services and Mental Health. Only 27 stated that they had such an agreement. For each LME-CMO, least one member county reported that they had a data-sharing agreement.

A count of the 8 cross-system strategies found that counties used between 0 and 8 of the strategies, with the average at 5.15 (*SD* = 2.48). The member counties of the LME-CMOs varied widely in their use of these strategies, ranging from an average of 3.30 up to 7.50 strategies. Again a reminder is in order that not all member counties for each LME-CMO completed the CCPT survey.

Among the 17 listed strategies, the least used was having an automated case management system. Only 12 CCPTs checked *yes* that they had such a system in their county; in contrast, 49 said *no,* 9 indicated *don't know,* and 1 did not respond. Whether or not a county Social Services has its automated system, implementation of a data-sharing agreement between Social Services and Mental Health does occur. In fact, as seen in Table 6, 16 counties had an agreement without their Social Services' having its automated system. Nevertheless, having this agreement is more likely when the county Social Services has an automated system in place. Among the 12 Social Services with an automated system, 8 also had a data-sharing

agreement with Mental Health while 3 did not have such an agreement (1 missing datum).

Table 6

Cross-Tabulation of Automated Case Management Systems and Data Sharing Agreements in Public Child Welfare Systems

		Existence of a data sharing agreement between Social Services and Mental Health		
		Yes	No	Total
Existence of an automated case management system for child welfare	Yes	8	3	11
	No	16	30	46
	Total	24	33	57

Note. 57 CCPTs provided data for both data-sharing agreement and automated system.

After the automated system, a set of three strategies stand out for their low utilization. These all refer to partnering with youth and families in overcoming access barriers. The survey provided the definition of family partners developed by NC Families United and adopted by the NC Collaborative for Children, Youth and Families: "a caregiver/parent of someone who has received services and therefore has firsthand experience within the child and family system, or who has gone through the system themselves." In addition, the survey inserted "youth partner with experience of receiving services."

The three strategies were about involving youth and family partners in supporting families, helping families navigate access to services, and providing training. Each of these strategies was used by under one-third of the counties. Moreover, use of all 3 partnering strategies was concentrated in a minority of counties: 7 counties used 1 strategy, 4 used 2 strategies, and 16 used 3 strategies.

A follow-up survey question looked further at strategies for involving family or youth partners. The question asked the CCPTs to identify which of six strategies supported involvement of family or youth partners in their county. In addition, they had space for writing in two strategies. As seen in Table 7 below, by far the most cited strategy was including family or youth partners in a collaborative team. The second most common was offering ongoing professional development. To a lesser extent, they cited reimbursement for expenses, mentoring by a family/youth partner, orientation to the work, and least of all, providing stipends. On average counties applied 2.24 of these 6 supportive strategies (*SD* = 1.64).

Table 7

Strategies Supporting Involvement of Family or Youth Partners

Strategy	Number	Percent
Inclusion in a collaborative team	57	80.28%
Ongoing professional development	34	47.89%
Reimbursement for expenses (e.g., travel, meals)	20	28.17%
Mentoring by other family/youth partners	19	26.76%
Orientation to the work	18	25.35%
Stipend for services provided	11	15.49%
Other[a]	3	4.23%

[a]Responses included in "Other" category were: Family Support Network offers ongoing training, none of the listed strategies used at this time, and no identified family/youth partners in county (recruiting).

In summary, the counties used a number of system-of-care strategies to tackle barriers to service access. These strategies included child and family teams, cross-system collaborations, and community education. Most counties did not have an automated case management system for child welfare; if they did have such a system, they were more likely to have a data-sharing agreement between Mental Health and Child Welfare. For the most part, counties did not utilize family and youth partners to assist families, and such partnerships were concentrated in a minority of counties. Nevertheless, counties were using a number of strategies to involve family and youth partners. The most common of these strategies was including them in a collaborative team, and the least common was providing a stipend.

Child and Family Teams Benefiting Children, Youth, and Parents

The next group of survey questions focused on child and family team (CFTs). First, the CCPTs were asked if their county Department of Social Services (DSS) had a system for tracking CFT meetings. Over half (39) responded *yes,* with another 6 noting that their DSS had a system in development (see Table A4). Most of those with a system were willing to ask their local DSS to share their system (see Table A5).

Then CCPTs were asked about the benefits of CFTs in their county for children, youth, parents, and/or caregivers who required access to Mental Health, Substance Abuse, or Developmental Disability Services. They were provided with a list of 17 potential positive results with space to add in two others. The CCPTs were asked to estimate the frequency with which these benefits occurred in their county on a scale of *never, rarely, sometimes,* or *often*.

As shown in Table 8 below, the CCPTs rated all benefits as happening for the most part between *sometimes* and *often.* Means for the benefits ranged from 2.83 to 3.72, and medians were all 3 (*sometimes*) or 4 (*high*).

Table 8

Frequency of CFT Benefits to Children/Youth and/or Parents/Caregivers Served by Public Child Welfare and Requiring Access to MH/SA/DD Services

Benefit	Frequency				Mean	Total Responses
	Never	Rarely	Sometimes	Often		
Increased the engagement of children/youth and their families in making a CFT plan	0	3	13	53	3.72	69
Increased the understanding of the involved professionals about a condition or functional difficulty	0	2	17	50	3.70	69
Increased the coordination of care among the involved service organizations	0	3	21	47	3.62	71
Increased the understanding of children/youth and their families about a condition or functional difficulty	0	2	24	44	3.60	70
Increased the sharing of resources among the involved service organizations	0	4	21	45	3.59	70
Maintained the connection to parents of children or youth placed in substitute care	0	4	24	38	3.52	66
Maintained the connection to kin of children/youth placed in substitute care	0	4	33	30	3.39	67
Increased the placement stability of children/youth in substitute care	0	6	33	26	3.31	65
Increased the completion rate of the services	0	8	30	26	3.28	64

Increased the school stability of children/youth in substitute care	0	9	30	26	3.26	65
Increased the quality of the services provided	0	7	36	23	3.24	66
Increased the resources made available to youth transitioning into adulthood	1	13	25	23	3.13	62
Reduced the time to referral for a service	0	9	42	16	3.10	67
Reduced the time from entry into substitute care to return home	0	12	33	16	3.07	61
Reduced the time from referral to enrollment in the service	0	11	37	14	3.05	62
Reduced the anxiety of children/youth placed in substitute care	0	16	31	13	2.95	60
Reduced aggressive behavior by children/youth placed in substitute care	0	20	30	10	2.83	60
Other 1[a]	0	0	0	4	4.00	4
Other 2[b]	0	0	1	3	3.75	4

Note. The means are calculated with *low* = 1, *rarely* = 2, *sometimes* = 3, and *often* = 4.
[a]Responses included in "Other 1" category were: increased informed safety networks playing active roles in keeping the child(ren) safe, maintained the connection to kin of children/youth placed in substitute care, created cohesion, and no children in care in 2014.
[b]Benefits included in "Other 2" category were: improved safety plans/goals to be behaviorally specific, built natural supports, and increased the sharing of resources among the involved service organizations.

Two top rated benefits related directly to developing a system of care: engaging children and families in planning and increasing coordination among service providers. These collaborative efforts were likely supported by three other frequent benefits: CFTs increasing the understanding of family members as well as involved professionals about a condition or functional difficulty and CFTs increasing sharing of resources among involved service organizations.

Other common positive results pertained to permanency: maintaining children and youth's connections to parents or to kin. In addition, CFTs were often viewed as supporting placement and school stability for children and youth in substitute care.

CCPTs identified other permanency benefits to a lesser extent. These were reducing time from entry into care to return home and making resources available for youth transitioning into adulthood.

A group of benefits which tended to occur *sometimes* related to service delivery. These were increasing service completion or quality of provided services and reducing time to service referral or time from referral to service enrollment.

Finally, the benefits which had the lowest number of responses and lowest means concerned CFTs mitigating the impact on children/youth of placement in substitute care. These benefits related to CFTs reducing the anxiety of the children and youth and their aggressive behavior.

In summary, the CCPTs identified that CFTs engaged families in planning on an informed basis and that CFTs expedited and coordinated service delivery. In addition, CCPTs expressed their views about the impact of CFTs on children and youth. On the basis of their experience, they indicated that CFTs sometimes keep foster children and youth's connected to their families and schools. These viewpoints need to be tested by longitudinal research. Nevertheless, the CCPTs' perceptions are supported by research in other parts of the country that engaging families in planning meetings expedites children's return to their parents or placement with relatives (Washington, DC—Pennell et al., 2010; Texas—Wang et al., 2012).

CFTs Primarily Facilitated by Social Services and Secondarily by Mental or Behavioral Health

The survey then inquired about the frequency with which different groups facilitated and attended child and family team (CFT) meetings. These were for CFT meetings convened for children, youth, or their parents or caregivers served by public child welfare and requiring access to MH/SA/DD services. For CFT meeting facilitators, 10 organizations were listed with space to write in two others.

Table 9 below summarizes the responses. Social Services was the organization that most *often* facilitated the CFT meetings for families whom they served. It should also be noted that Social Services had the most responses, that is, they gave a rating rather than indicating *don't know* or *not applicable* or leaving the item blank. Next were Mental or Behavioral Health services facilitators whose average frequency was closer to *sometimes.* Two child serving agencies—Schools and Juvenile Justice—facilitated CFTs on average between *rarely* and *sometimes.* For the remainder of organizations, they averaged between *never* and *rarely.*

Table 9

Frequency of Organizations' Facilitating CFT Meetings for Children/Youth and/or Parents/Caregivers Served by Public Child Welfare and Requiring Access to MH/SA/DD Services

Organization	Frequency				Mean	Total Responses
	Never	Rarely	Sometimes	Often		
Social Services	1	0	4	65	3.90	70
Mental or Behavioral Health	7	2	22	33	3.27	64
Schools	10	19	26	11	2.58	66
Juvenile Justice	14	13	20	11	2.48	58
Public Health	27	17	9	4	1.82	57
Domestic Violence	28	14	7	5	1.80	54
Child advocacy organization	26	11	9	6	1.90	52
Family advocacy organization	27	10	8	5	1.82	50
Faith organization	28	16	3	3	1.62	50
Cultural organization	32	11	2	2	1.45	47
Other 1[a]	2	0	2	4	3.00	8
Other 2[b]	2	0	0	1	2.00	3

Note. The means are calculated with *low* = 1, *rarely* = 2, *sometimes* = 3, and *often* = 4.
[a]Organizations included in "Other 1" category were: law enforcement, mediation center, LME/MCO, Guardian ad Litem program, Families First, and Access Care.
[b]Organizations included in "Other 2" category were: IDD and Substitute Care.

In summary, child welfare cases requiring access to (MH/SA/DD) services were most often facilitated by Social Services and secondarily by Mental or Behavioral Health. Further analysis found that all nine LME-MCOs had member counties in which Mental or Behavioral Health facilitated sometimes or often. The mean percentage for all the LME-MCO combined was 86% for at least sometimes, with data available for 64 of the 71 responding CCPTs. Per LME-MCO, the percentage of member counties with Mental or Behavioral Health facilitating at least some of the time ranged from 60% to 100%.

CFT Attendance Varied Among Family Members and Among Involved Organizations

CCPTs were asked about the frequency with which family members and organizations attended CFT meetings in their county. The meetings were convened for children, youth, and their families served by public child welfare and requiring access to MH/SA/DD services. Table 10 shows that Social Services and mothers were the most *often* in attendance. They were followed by other family, Guardians ad

Litem, fathers, children/youth, and Mental or Behavioral Health, all of whose average attendance fell between *sometimes* and *often.* Groups whose average attendance was around *sometimes,* included friends, Schools, family/youth partners, and Juvenile Justice. The remaining organizations were in attendance on average closer to *rarely.*

Table 10

Frequency of Attendance by Family Members and Organizations to CFT Meetings for Children/Youth and/or Parents/Caregivers Served by Public Child Welfare and Requiring MH/SA/DD Services

People/Organizations	Frequency				Mean	Total Responses
	Never	Rarely	Sometimes	Often		
Children/youth	1	5	23	39	3.47	68
Mothers	1	0	3	66	3.91	70
Fathers	1	3	21	44	3.57	69
Other family	1	1	22	45	3.61	69
Friends	2	6	38	23	3.19	69
Family/youth partners	8	7	23	22	2.98	60
Guardian ad Litem	1	3	21	46	3.58	71
Social Services	1	0	1	68	3.94	70
Mental or Behavioral Health	2	4	27	37	3.41	70
Schools	1	14	36	17	3.01	68
Juvenile Justice	6	14	31	16	2.85	67
Public Health	17	17	4	4	2.28	65
Domestic Violence	12	24	25	5	2.35	66
Child advocacy organization	14	18	18	4	2.22	54
Family advocacy organization	15	20	11	5	2.12	51
Faith organization	10	27	18	2	2.21	57
Cultural organization	20	25	4	0	1.67	49
Other 1[a]	1	0	3	3	3.14	7
Other 2[b]	1	0	2	2	3.00	5

Note. The means are calculated with *low* = 1, *rarely* = 2, *sometimes* = 3, and *often* = 4.
[a]Organizations included in "Other 1" category were: LME/MCO, attorneys, law enforcement, Access Care, and private child placement providers.
[b]Organizations included in "Other 2" category were: law enforcement, hospital Social Worker, Substitute Care, and licensed foster families.

In summary, for CFTs pertaining to MH/SA/DD service access, the most frequent family attendees were mothers with other family members, including the children/youth and fathers, present to a lesser extent. After Social Services, the two

agencies represented the most frequently at the CFTs were Guardian ad Litem and Mental or Behavioral Health. Family and youth partners sometimes attended. Further analysis determined that all nine LME-MCOs had member counties in which Mental or Behavioral Health attended sometimes or often. The mean percentage for all the LME-MCO combined was 91%, with data available for 70 of the 71 responding CCPTs. Per LME-MCO, the percentage of member counties with Mental or Behavioral Health facilitating at least some of the time ranged from 70% to 100%. The impact of who is present and absent from meetings needs more study. A Cumberland County study matched school and child welfare data from 347 CFTs. The data analysis found that students were less likely to change placements if they were present at their CFT meeting and if a school official was present (Pennell & Rikard, 2013).

Family-level Strategies for Improving CFTs Prevalent but System-level Strategies Unevenly Applied

Moving to ways of improving CFTs, the survey asked the CCPTs about system-level and family-level strategies that their counties had used in 2014. These strategies were employed with CFTs held for children, youth, and their parents or caregivers who were served by child welfare and required MH/SA/DD services. A list provided 12 strategies with space to write in 2 other strategies.

As seen in Table 11, the extent to which the 12 listed system-level strategies were used varied widely from a low of 5 counties to a high of 59 counties. Most counties used the strategies of having clear procedures for making referrals and making Mental Health and Social Services aware of each other's requirements for CFT meetings. A majority of counties shared information across systems or with families, monitored CFT delivery, and specified procedures for self-referrals. Approximately half the counties had CFT meetings jointly facilitated by Social Services and Mental Health, agreed upon procedures for cross-system CFTs, and sought feedback from CFT participants. Less than half of the counties offered training to families or across systems. And only a minority publicized CFT successes, and a very small minority of counties ensured that Mental Health providers were reimbursed for attending CFT meetings.

Table 11

Use of System-Level Strategies for Improving CFT Meetings for Children/Youth and/or Parents/Caregivers Served by Public Child Welfare and Requiring Access to MH/SA/DD Services

Strategies	Use		Total Responses
	Yes	No	
Making Mental Health and Social Services aware of each other's requirements for CFT meetings	59	8	67
Having clear procedures for making referrals to CFT meetings	59	11	70
Sharing information packages for family and professionals on CFT meetings	46	20	66
Using a tool to monitor delivery of CFT meetings	45	23	68
Having clear procedures for making self-referrals to CFT meetings	42	23	65
Having CFT meetings facilitated jointly by Social Services and Mental Health	38	29	67
Having an agreed-upon protocol for cross-system CFT meetings (e.g., who prepares families, who facilitates meetings, what information can be shared at meetings)	36	33	69
Seeking feedback from participants on how to improve CFT meetings	35	30	65
Offering training to family members and/or resource families on CFT meetings	22	43	65
Providing cross-system training on CFT meetings	19	44	63
Publicizing CFT meeting successes while maintaining family confidentiality	14	51	65
Ensuring that mental health providers are reimbursed for attending CFT meetings	5	62	67
Other 1[a]	3	0	3
Other 2[b]	2	0	2

[a]Strategies included in "Other 1" category were: strength-based/family-centered strategies, having neutral meeting sites, cross-training Prevention Staff to facilitate CFTs, and utilizing the Signs of Safety mapping process during meetings.
[b]Strategies included in "Other 2" category were: using a vehicle for TICCA recommendations (PFE) and utilizing electronic white boards to record mapping/safety plans and providing participants copies.

In contrast to system-level strategies, the family-level strategies were used almost uniformly across counties. As seen in Table 12, the number of counties applying a family-level strategy ranged from a low of 60 to a high of 69. Nearly all counties

agreed that they facilitated CFTs in which everyone felt that they could give input, felt respected, and developed a clear and agreed-upon plan. Although still quite prevalent, fewer counties prepared professionals for the meetings, asked children or youth how they wanted to participate in the meetings, or set a time to reconvene CFTs.

Table 12

Use of Family-Level Strategies for Improving CFT Meetings for Children/Youth and/or Parents/Caregivers Served by Public Child Welfare and Requiring Access to MH/SA/DD Services

Strategies	Use			Total Responses
	Yes	No	Unsure	
Facilitating CFT meetings in which everyone feels they can give input	69	0	1	70
Facilitating CFT meetings in which everyone feels respected	68	0	2	70
Developing a clear and agreed-upon CFT plan	68	1	1	70
Developing with families a clear purpose for convening CFT meetings	67	1	2	70
Explaining to families the CFT meeting process	67	1	2	70
Providing necessary information to support decision-making at CFT meetings	66	2	2	70
Encouraging families to select a support person for CFT meetings	66	0	4	70
Assessing the safety of CFT meeting participants and putting in place necessary safety measures	65	1	4	70
Making arrangements so families can attend CFT meetings (e.g., babysitting, transportation, time scheduling)	65	1	4	70
Asking families who they want at their CFT meeting	65	1	3	69
Setting ground rules with families for holding emotionally and physically safe CFT meetings	65	2	3	70
Monitoring and evaluating progress on implementing CFT plans	65	4	1	70
Setting a time to reconvene and revise CFT plans as needed	63	3	3	69
Asking children/youth how they want to participate in CFT meetings	61	4	5	70

Preparing professionals for CFT meetings	60	4	6	70
Other 1[a]	7	0	2	9
Other 2[b]	3	1	2	6

[a]Strategies included in "Other 1" category were: obtaining state funding to implement aforementioned strategies, being flexible with meeting locations to accommodate families, using a neutral facilitator, providing brochures to families, and encouraging families, professionals, and social supports to continue communicating after CFT meeting and to request follow-up meetings.
[b]Strategy included in "Other 2" category was: utilizing electronic white board to record plan as it is being developed and providing copies to participants.

In summary, counties across the board used family-level strategies to improve CFT meetings, but more counties could attend to preparing professionals, encouraging the participation of children and youth, and scheduling follow-up CFTs. The county's use of system-level strategies was quite uneven. Setting procedures and sharing information were common among the counties. Reimbursing Mental Health providers, however, stood out as an area for work in most counties.

At the conclusion of the survey, CCPTs had space to write in the main challenges faced in their counties to holding CFT meetings and their recommended strategies for overcoming these challenges. And most took this opportunity to record their views, 67 on challenges and 59 on recommendations. Their responses on challenges and recommendations are summarized respectively in Table A6 and Table A7. The most frequently cited challenges concerned scheduling meetings at times that worked for families and professionals, ensuring transportation and meeting sites for families, and involving Mental Health professionals. The recommendations emphasized increasing collaboration among partners, providing outreach and education to professionals and families, and seeking more financial assistance including to reimburse Mental Health providers.

Advisory Board Recommendations

TBD

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Appendices

Appendix A

Table A1

Counties Covered in Survey Report

Participating Counties			
Alamance	Cumberland	Johnston	Richmond
Alleghany	Currituck	Jones	Robeson
Avery	Dare	Lenoir	Rockingham
Beaufort	Davidson	Lincoln	Rowan
Bertie	Davie	Macon	Rutherford
Bladen	Duplin	Madison	Sampson
Brunswick	Edgecombe	Martin	Stanly
Buncombe	Franklin	Mitchell	Stokes
Burke	Gates	Montgomery	Swain
Cabarrus	Guilford	Nash	Vance
Camden	Halifax	New Hanover	Warren
Caswell	Harnett	Onslow	Watauga
Catawba	Henderson	Orange	Wayne
Chatham	Hertford	Pasquotank	Wilkes
Chowan	Hoke	Pender	Wilson
Clay	Hyde	Person	Yadkin
Columbus	Iredell	Polk	Yancey
Craven	Jackson	Randolph	

Table A2

LME-MCOs and Number of Member Counties[a] Responding to Survey

	LME-MCO	Number of Member Counties	Total Responding Counties	Percent
	Alliance Behavioral Healthcare	4	2	50%
	Cardinal Innovations Healthcare Solutions	16	13	81%
	CenterPoint Human Services	4	3	75%
	CoastalCare	5	4	80%
	East Carolina Behavioral Health	19	13	68%
	Eastpointe	12	10	83%
	Partners Behavioral Health Management	8	5	63%
	Sandhills Center	9	6	67%
	Smoky Mountain Center	23	15	65%
Total Numbers	9	100	71	

[a]Member counties affiliated with a Local Management Entity (LME)-Managed Care Organization (MCO), as of April 1, 2014

Table A3

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

CCPT/CFPT Organization	Number of Counties	Percent
Separate CCPT and CFPT	18	25.35%
Combined CCPT and CFPT	53	74.65%
Other	0	0%

Table A4

Existence of Systems for Tracking Child and Family Team (CFT) Meetings Held for Children/Youth and Families at Local Social Services

Existence of Tracking Systems	Frequency	Percent
Have a system in place	39	54.93%
Have a system in development	6	8.45%
Do not have a system	25	35.21%
Unsure	1	1.41%

Table A5

Willingness to Ask Local Social Services to Share CFT Tracking Systems

Willingness	Frequency	Percent
Yes	35	89.74%
No	4	10.26%

Table A6

Greatest Challenges Identified by Survey Participants in Holding Helpful CFT Meetings for Children/Youth and/or Parents/Caregivers Served by Public Child Welfare and Requiring Access to MH/SA/DD Services

Challenge	Frequency of Response
Scheduling, availability, or meeting time issues for families and professionals	31
Transportation or meeting location issues for families	23
Difficulty engaging/lack of participation by families[a]	15
Difficulty engaging/lack of participation by mental health professionals[b]	7
Difficulty engaging/lack of participation by other professional or community partners	8
Difficulty engaging/lack of participation by youth	2
Unwillingness of families to engage natural supports in meetings	5
Lack of effective or appropriate meeting facilitators	8
Lack of resources[c]	5
Communication and coordination issues[d]	4
Lack of effective or appropriate CFT training[e]	3
Difficulty tracking outcomes or success of meetings	1

[a]Especially prominent when parents have mental health or substance abuse issues
[b]This often occurs because mental health professionals cannot be reimbursed for meeting attendance
[c]E.g., resources for non-English speakers or sex offenders
[d]This includes cross-cultural communication
[e]E.g., SOC training for non-mental health professionals, lack of case management model within behavioral health systems

Table A7

Strategies Recommended by Survey Participants in Overcoming Challenges to Holding Helpful CFT Meetings

Strategy	Frequency of Response
Seek more financial assistance [a]	10
Increase collaboration and communication among partners [b]	13
Increase outreach/education on CFTs for professionals[c]	11
Increase outreach/education on CFTs for families[d]	10
Increase outreach/education on CFTs for other community partners	5
Increase youth engagement	2
Allow family and/or professional partners to participate in meetings by phone if they cannot attend in person	9
Provide transportation assistance to families	7
Prioritize family needs regarding meeting times and locations	5
Get trained meeting facilitators	5
Send out meeting reminders to family and professional partners	4
Establish more thorough protocols for ensuring CFTs operate effectively	3
Increase cultural and/or foster resources	2
Solicit feedback about effectiveness of CFTs and meetings	2

[a]E.g., reimbursing mental health professionals for meeting attendance, securing more state and local funding
[b]E.g., schedule CFT meetings further in advance to allow partners to make arrangements in order to attend, introduce the concept of CFTs to partners earlier
[c]This includes trainings on specific needs and scenarios
[d]This includes encouraging use of natural supports

Appendix B

2014 Survey
North Carolina Community Child Protection Team Advisory Board

As the NC Community Child Protection Team Advisory Board, we are asking that all Community Child Protection Teams (CCPTs) in North Carolina complete this survey. We are responsible for conducting an annual survey of local CCPTs and preparing a report to the North Carolina Division of Social Services (NCDSS). In the annual 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. Then NCDSS write a response to our report. Both our report and the NCDSS response are included in the state's Annual Progress and Services Report to the US Department of Health and Human Services, Administration for Children and Families.

This report is one of the requirements in the federal Child Abuse Prevention and Treatment Act (CAPTA). In 1997 North Carolina designated the Community Child Protection Team as its Citizen Review Panel with responsibility for this report. The purpose of Citizen Review panels is to provide opportunities for citizens to play an integral role in ensuring that states are meeting their goals of protecting children from maltreatment.

This survey assists you in preparing your annual reports to your county commissioners and to the NC Division of Social Services. 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 and reservation. This makes it possible to track who completed the survey and to acknowledge the name of your county or reservation 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 the NC Division of Social Services or to the NC CCPT Advisory Board. Dr. Pennell will respect the confidentiality of local CCPTs and will NOT link individual responses to local CCPTs. The one exception is that Dr. Pennell will provide the names of the county or reservation that submitted a survey to the NC CPPT Advisory Board. De-identified findings may also be included in presentations, trainings, and publications.

At our September 18, 2014 meeting, the NC CCPT Advisory Board decided to focus this year and next year on one issue: **access to mental health services** of children, youth, and their families served by public child welfare. We decided on this focus because in past surveys we have found that barriers to mental health care stand out as a major concern across the state. We also know that high percentages of children and youth in foster care have a behavioral health diagnosis.

Please click the ">>" button below to continue.

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

1. This survey covers the work of your CCPT for the period January – December 2014.
2. Your survey responses must be submitted via Qualtrics – you should not submit paper copies to NCDSS 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 the 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 our 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. Please complete and submit the survey in Qualtrics on or before **January 31, 2015.**

North Carolina State University
INFORMED CONSENT FORM for RESEARCH

Title: Community Child Protection Team 2014 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 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 reservation, and the responding counties and reservation are listed in the annual CCPT report which 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 NCDSS. Before reporting the results, the researcher will combine responses and not link them to a specific county or reservation.

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 which could link you to the study. You will NOT be asked to write your name on any study materials so that no one can match your identity to the answers that you provide.

Compensation

You will not receive anything for participating.

What if you have questions about this study?

If you have questions at any time about the study or the procedures, you may contact the researcher, Dr. 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 Terri Reichert at the NC Division of Social Services for technical assistance on completing the survey: email Terri.reichert@dhhs.nc.gov or phone 919-527-6406.

What county or reservation does this survey report cover?

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

Which of the following applies to your county or reservation?

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

What is the total number of cases reviewed by your CCPT between January and December 2014?

(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.)

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

	Number of Cases
Mental Health Services	
Substance Abuse Services	
Developmental Disabilities Services	

The problems listed below were identified in surveys completed by parents with special health care needs children in North Carolina. These problems can keep families from accessing needed mental health, substance abuse, or developmental disabilities services. Discuss with your local CCPT members their experience with these issues and together estimate how frequently these problems occur in your county or reservation.

In 2014, how often did these problems affect access to needed services for children and youth served by public child welfare in your county or reservation?

	Never	Rarely	Sometimes	Often	Don't Know
Did not currently have adequate health insurance	○	○	○	○	○
Had unmet needs for coordination of care	○	○	○	○	○
Had families who did not share in decision-making around issues important to their child's health	○	○	○	○	○

Other problems can keep families from accessing needed mental health, substance abuse, or developmental disabilities services. Discuss with your local CCPT members their experience with these issues and together estimate how frequently these problems occur in your county or reservation.

In 2014, how often did these problems affect access to needed services for children and youth served by public child welfare in your county or reservation?

	Never	Rarely	Sometimes	Often	Don't Know
Lack of qualified providers who can be reimbursed for services	○	○	○	○	○
Unavailability of quality services	○	○	○	○	○
Infrequency of service provision	○	○	○	○	○
Lack of affordable services	○	○	○	○	○
Lack of affordable medications	○	○	○	○	○
Limited transportation to services	○	○	○	○	○
Lack of interpreters to non-English speakers	○	○	○	○	○
Lack of interpreters for deaf individuals	○	○	○	○	○
Lack of information materials for low-literacy individuals	○	○	○	○	○
Lack of support persons to accompany individuals to appointments	○	○	○	○	○
Lack of knowledge of parents/caregivers about where to get services	○	○	○	○	○
Lack of knowledge of parents/caregivers about arranging services (e.g., making appointments)	○	○	○	○	○
Lack of time of parents/caregivers to take children to appointments	○	○	○	○	○
Refusal of children or youth to accept services	○	○	○	○	○
Embarrassment of parents/caregivers about using services in their cultural community	○	○	○	○	○
Domestic violence keeping parents/caregivers from accessing services	○	○	○	○	○

Reluctance of parents/caregivers to use services out of fear that they will be seen as unfit caregivers by Social Services	○	○	○	○	○
Other 1 _____	○	○	○	○	○
Other 2 _____	○	○	○	○	○

Think of children, youth, and their parents/caregivers in your county or reservation who are served by public child welfare and who require access to services for mental health, substance abuse, and/or developmental disabilities. Below is a list of possible strategies for helping them gain access to needed services. Be sure to include additional strategies under "Other". Your ideas on strategies will help others.

In 2014, did your county or reservation use this strategy?

	Yes	No	Don't Know
Community presentations/forums	○	○	○
Family workshops./cafés	○	○	○
Workshops for resource parents (foster, therapeutic foster, kin, adoptive)	○	○	○
Joint training across the disciplines involved in child welfare	○	○	○
Development of multi-disciplinary teams to improve service delivery	○	○	○
Posting resource information on a website	○	○	○
Having an automated case management system for child welfare	○	○	○
Having a data sharing agreement between Social Services and Mental Health	○	○	○
Having a Local Management Entity (LME) or Managed Care Organization (MCO) attend child welfare staff meetings	○	○	○
Joint meetings of LME/MCO and child welfare to address systemic issues	○	○	○
Joint meetings of LME/MCO and child welfare to staff individual cases	○	○	○
Joint development of protocols by LME/MCO and child welfare to increase access to services	○	○	○
Joint development of protocols by LME/MCO and child welfare to improve service coordination	○	○	○
Family Partner or youth partner with experience of receiving services providing support to families	○	○	○
Family Partner or youth partner with experience of receiving services helping families navigate access to services	○	○	○
Family or youth partners with experience of receiving services providing training	○	○	○
Child and family teams creating and implementing plans	○	○	○

Other 1		○	○	○
Other 2		○	○	○

Which of the following strategies support the involvement of family or youth partners in your county or reservation? Check all that apply.

- ☐ Inclusion in a collaborative team
- ☐ Orientation to the work
- ☐ Ongoing professional development
- ☐ Mentoring by other family or youth partners
- ☐ Reimbursement for expenses (e.g., travel, meals)
- ☐ Stipend for services provided
- ☐ Other 1
- ☐ Other 2

Does your local Social Services have a system for tracking child and family team (CFT) meetings held for children, youth, and families whom they serve?

- o No, don't have a system
- o Have a system in development
- o Yes, have a system
- o Don't know

Would you be willing to ask your local Social Services if they would share their CFT data tracking system with others?

- o Yes
- o No

Please ask your local Social Services to contact Terri Reichert about their CFT data tracking system:

Terri T. Reichert
NC Department of Health and Human Services
Child and Family Services Review Coordinator
Child Welfare Services Section – North Carolina Division of Social Services
820 South Boylan St.
Mail Service Center 2406
Raleigh, North Carolina 27699-2406
Email: Terri.reichert@dhhs.nc.gov
Phone: 919-527-6406

Think about how child and family teams (CFTs) can benefit children, youth, and/or their parents/caregivers who are served by public child welfare and who require access to services for mental health, substance abuse, or developmental disabilities.

In 2014, how often have CFTs resulted in the following benefits?

	Never	Rarely	Sometimes	Often	Don't Know
Increased the understanding of children, youth, and their families about a condition or functional difficulty	○	○	○	○	○
Increased the understanding of the involved professionals about a condition or functional difficulty	○	○	○	○	○
Increased the engagement of children, youth, and their families in making a CFT plan	○	○	○	○	○
Increased the coordination of care among the involved service organizations	○	○	○	○	○
Increased the sharing of resources among the involved service organizations	○	○	○	○	○
Reduces the time to referral for a service	○	○	○	○	○
Reduced the time from referral for a service	○	○	○	○	○
Reduced the time from referral to enrollment in the service	○	○	○	○	○
Increased the quality of the services provided	○	○	○	○	○
Increased the completion rate of the services	○	○	○	○	○
Maintained the connection to parents of children or youth placed in substitute care	○	○	○	○	○
Maintained the connection to kin of children or youth placed in substitute care	○	○	○	○	○
Reduced the anxiety of children or youth placed in substitute care	○	○	○	○	○

Reduced aggressive behavior of children or youth placed in substitute care	○	○	○	○	○
Increased the placement stability of children or youth in substitute care	○	○	○	○	○
Reduced the time from entry into substitute care to return home	○	○	○	○	○
Increased the resources mad available to youth transitioning into adulthood	○	○	○	○	○
Other 1	○	○	○	○	○

In 2014, how often in your county or reservation did the following organization facilitate CFT meetings for children, youth, and/or their parents/caregivers who were served by public child welfare and who required access to services for mental health, substance abuse, or developmental disabilities?

	Never	Rarely	Sometimes	Often	Don't Know	Not Applicable
Social Services	○	○	○	○	○	○
Mental or Behavioral Health	○	○	○	○	○	○
Schools	○	○	○	○	○	○
Juvenile Justice	○	○	○	○	○	○
Public Health	○	○	○	○	○	○
Domestic Violence	○	○	○	○	○	○
Child Advocacy Organization	○	○	○	○	○	○
Family Advocacy Organization	○	○	○	○	○	○
Faith Organization	○	○	○	○	○	○
Cultural Organization	○	○	○	○	○	○
Other 1	○	○	○	○	○	○
Other 2	○	○	○	○	○	○

In 2014, how often in your county or reservation did the following groups attend CFT meetings for children, youth, and/or their parents/caregivers who were served by public child welfare and who required access to services for mental health, substance abuse, or developmental disabilities?

	Never	Rarely	Sometimes	Often	Don't Know	Not Applicable
Children or Youth	○	○	○	○	○	○
Mothers	○	○	○	○	○	○
Fathers	○	○	○	○	○	○
Other Family	○	○	○	○	○	○
Friends	○	○	○	○	○	○
Family or Youth Partners	○	○	○	○	○	○
Guardian ad Litem	○	○	○	○	○	○
Social Services	○	○	○	○	○	○
Mental or Behavioral Health	○	○	○	○	○	○
Schools	○	○	○	○	○	○
Juvenile Justice	○	○	○	○	○	○
Public Health	○	○	○	○	○	○
Domestic Violence	○	○	○	○	○	○
Child Advocacy Organization	○	○	○	○	○	○
Family Advocacy Organization	○	○	○	○	○	○
Faith Organization	○	○	○	○	○	○
Cultural Organization	○	○	○	○	○	○
Other 1 _____	○	○	○	○	○	○
Other 2 _____	○	○	○	○	○	○

Below are possible system-level strategies for improving CFT meetings for children, youth, and/or their parents/caregivers who are served by public child welfare and who require access to services for mental health, substance abuse, or developmental disabilities. Include additional strategies so that others can learn from your experience.

In 2014, did your county or reservation use this strategy?

	Yes	No	Don't Know
Making Mental Health and Social Services aware of each other's requirements for CFT meetings	○	○	○
Having the CFT meetings facilitated jointly by Social Services and Mental Health	○	○	○
Having an agreed-upon protocol for cross-system CFT meetings (for example, who prepares family, who facilitates the meeting, what information can be shared at the meeting)	○	○	○
Sharing information packages for family and professionals on CFT meetings	○	○	○
Having clear procedures for making referrals to a CFT meeting	○	○	○
Having clear procedures for making self-referrals to a CFT meeting	○	○	○
Seeking feedback from participants on how to improve CFT meetings	○	○	○
Provide cross-system training on CFT meetings	○	○	○
Offering training to family members and/or resource families on CFT meetings	○	○	○
Using a tool to monitor delivery of CFT meetings	○	○	○
Ensuring that mental health providers are reimbursed for attending CFT meetings	○	○	○
Publicizing CFT meeting successes while maintaining family confidentiality	○	○	○
Other 1	○	○	○
Other 2	○	○	○

Below are possible family-level strategies for improving CFT meetings for children, youth, and/or their parents/caregivers who are served by public child welfare and who require access to services for mental health, substance abuse, or developmental disabilities. Include additional strategies so that others can learn from your experience.

In 2014, did your county or reservation use this strategy?

	Yes	No	Don't Know
Developing with the family a clear purpose for convening a CFT meeting	○	○	○
Explaining to family the CFT meeting process	○	○	○
Asking family who they want at their CFT meeting	○	○	○
Asking children and youth how they want to take part in a CFT meeting	○	○	○
Encouraging family to select a support person for a CFT meeting	○	○	○
Assessing the safety of CFT meeting participants and putting in place needed safety measures	○	○	○
Making arrangements so that family can attend a CFT meeting (for example, babysitting, transportation, time scheduling)	○	○	○
Preparing professionals for a CFT meeting	○	○	○
Setting with the family the ground rules for holding emotionally and physically safe CFT meetings	○	○	○
Providing necessary information to support decision making at the CFT meeting	○	○	○
Facilitating a CFT meeting in which everyone feels respected	○	○	○
Facilitating a CFT meeting in which everyone feels they can give input	○	○	○
Developing a clear and agreed-upon CFT plan	○	○	○
Monitoring and evaluating progress on implementing the CFT plan	○	○	○
Setting a time to reconvene to revise the CFT plan as needed	○	○	○
Other 1	○	○	○
Other 2	○	○	○

What are the main challenges in your county or reservation to holding CFT meetings that help children, youth, and/or their parents/caregivers who are served by public child welfare and who require access to services for mental health, substance abuse, or developmental disabilities?

What does your CCPT recommend as strategies for overcoming these challenges?

Once you hit "submit", you will be directed to a copy of your completed responses, and you can print the screen.

Thanks for your participation!
The NC Community Child Protection Team Advisory Board
Judith Ayers
Wayne Black
Natalie Brayboy
Terry Brubaker
Brenda Edqards
Sherri Glen
Joy Gossett
Libby Jones
Kevin Kelley
Wanda Marino
Tilda Marshall
Heather McAllister
Kimberly Nicholson
Kristin O'Connor
Lou Parton
Terri Reichert
Phillip Stonecipher
Gale Trevathan
Adgenda Turner
Rick Zechman