

**Phase 1 Final Report**

**Child Welfare Preliminary Reform Plan**

***State of North Carolina  
Office of State Budget and Management (OSBM) with  
Department of Health and Human Services (DHHS)***

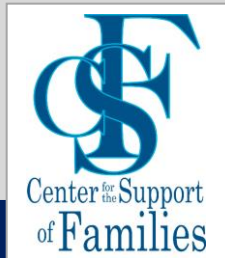
**August 31, 2018**

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## EXECUTIVE SUMMARY

The Center for the Support of Families (CSF) was awarded the third-party contract on March 1, 2018, to work with North Carolina on its critical Social Services and Child Welfare reform. CSF has endeavored to complete an extraordinary amount of work in a brief period of time, and this Preliminary Plan and its recommendations should be understood with that in mind. Phase 2 of this project is intended to be a time to work with the General Assembly, state leaders, county leaders, and stakeholders to finalize these recommendations and to begin to provide oversight and monitoring of immediate implementation of those recommendations not requiring legislation or appropriations. The final Social Services Reform Plan and the Child Welfare Reform Plan, due February 28, 2019, will close out Phase 2. Phase 3 provides for continued oversight and monitoring of the implementation activities.

This North Carolina Child Welfare Preliminary Reform Plan provides information about current performance and system dynamics, findings, and preliminary recommendations. A companion report, the North Carolina Social Services Preliminary Reform Plan, is presented as a separate volume. While the two reports address specific findings and recommendations, they are intended to be read in sequence, beginning with the Social Services Preliminary Reform Plan, since it addresses organization, staffing, and management of the delivery of services in all programs. This Child Welfare Preliminary Reform Plan follows, with specific policy and practice recommendations to improve the delivery of child welfare services.

These reports and the actions needed to implement the recommendations are but one part of a dynamic and complex program improvement process being undertaken by the North Carolina General Assembly, the Department of Health and Human Services, the 100 county Departments of Social Services, the Social Services Working Group (SSWG), and related state and county departments serving citizens of North Carolina. These reforms include Medicaid transformation, development and initial implementation of Memoranda of Understanding (MOU) with specific performance measures, planning for the Family First Prevention Services Act (FFPSA), and an ongoing assessment of data systems. The delivery of this Preliminary Report marks the end of Phase 1 and reflects our in-depth analysis and development of preliminary recommendations.

North Carolina is unique in that the state recognizes the need for significant change in management of the delivery of social services and provision of child welfare services to families and children. Indeed, this type of assessment and program improvement planning is most often undertaken based on significant findings of program deficiencies from federal or state oversight entities – or even court action, as has been the case in many child welfare reforms. It is significant that there is real focus at every level of the system for improvement and commitment to work to make changes to better serve citizens. Through focus groups, individual interviews, and site visits, we encountered leaders, line staff, and stakeholders who clearly are passionate about the work, willing to face challenges, and excited to explore new ways of doing business and work collaboratively to improve outcomes for the state’s most vulnerable citizens. This willingness to address challenges honestly and build on strengths is evident, even as state and county staff work under the stress of dealing with complex societal problems, such as the expanding opioid crisis, coupled with staffing shortages and budget reductions.

SL 2017-41 makes clear that “transforming the child welfare system to better ensure safety, permanency, and well-being of children and families is the right thing to do.”<sup>1</sup> The legislation cited two recent reviews – the federal Child and Family Services Review (CFSR) and the North Carolina Statewide Child Protective Services Evaluation of the State’s Child Protective Services (CPS) – that “identified troubling gaps and flaws in North Carolina’s child welfare system that are allowing too many ... vulnerable children and fragile families to fall through the cracks.”<sup>2</sup> Although North Carolina’s CFSR scores on the seven outcomes in its 2015 CFSR were slightly better than the average scores of other states, the state’s performance had slipped significantly from the previous CFSR in 2007.

Section § 2.1.(b) of the law requires the state to contract with a third-party organization to develop a child welfare reform plan that, at a minimum, makes recommendations in these areas.

- ◆ Child Protective Services (CPS), including the system for receiving reports and investigating allegations of child abuse, neglect, or dependency.
- ◆ Preventive and In-Home Services that provide struggling families with needed supports and treatment to prevent removal of the children from the home.
- ◆ Child fatality oversight, including a review of the existing structure, communication, and effectiveness of the Community Child Protection Teams, the Child Fatality Prevention Team, and use of Citizen Review Panels. Oversight shall also include identification of systemic problems in the Child Welfare system that may increase risk of harm or death to a child and implementation of timely and appropriate systemic reforms following a child fatality.
- ◆ Placement of children in foster care and other out-of-home settings.
- ◆ Services provided to children, youth, and parents involved with Child Welfare to achieve reunification of families.
- ◆ Efforts to achieve permanency for children either through reunification with family, legal guardianship or custody, or adoption.
- ◆ Provision of health care, mental health, and educational services to children and families involved with the Child Welfare system.
- ◆ Services provided to older youth in foster care and to those who have aged out of foster care.
- ◆ Strategies to ensure well-trained and adequately compensated staff to improve performance and reduce turnover.
- ◆ Practice and implementation, including ensuring a statewide, trauma-informed, culturally competent, family-centered practice framework.<sup>3</sup>

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<sup>1</sup> S.L. 2017-41 (HB630)

<sup>2</sup> *Ibid.*

<sup>3</sup> Section § 2.1.(b) required some additional practice and implementation recommendations related to how North Carolina could: 1) incorporate more evidence-based practices, including evidence-informed prevention services designed to reduce the number of children entering foster care; 2) specify expectations regarding professional development, training, and performance standards; 3) eliminate unnecessary barriers to licensing foster care and therapeutic foster care families to ensure an adequate supply of qualified families; 4) improve provider and foster

This Preliminary Reform Plan is the culmination of the Center for the Support of Families' (CSF) work to date on the North Carolina Child Welfare Reform Plan project and contains the methodology used; the current structure, dynamics, and performance of the Child Welfare system; specific findings; and preliminary recommendations for improvement.

### ***Methodology***

CSF first developed eight primary research questions designed to focus on the areas identified in SL 2017-41. As detailed in Chapter 1, CSF completed the following activities to assess rapidly North Carolina's child welfare system in these areas, while engaging participants and stakeholders in the development of preliminary findings and recommendations. All findings are based on these data sources and are identified specifically in Chapter 3. Preliminary recommendations are based on these findings, a review of best practices, and of the evidence that is available.

### **Systemic Factors**

- ◆ Reviewed North Carolina's Juvenile Code, online child welfare policy manual, and the modified policy manual scheduled to be disseminated statewide in September 2018.
- ◆ Reviewed multiple reports made available by the state and counties including the 2015 CFSR final report and the state's Program Improvement Plan.
- ◆ Researched best practices nationally and in North Carolina.

### **Quantitative Data Reports**

- ◆ Reviewed and analyzed administrative data regarding North Carolina's performance, available through the UNC Management Assistance website, state DHHS, and the Children's Bureau.
- ◆ Reviewed data specifically requested from DHHS.

### **Existing State Case Record Reviews**

- ◆ Reviewed extensive data from recent state-led case record reviews assessing county compliance with policy and guidance, for services provided to children and families.

### **Interviews, Focus Groups, and Site Visits**

- ◆ Conducted multiple interviews with state Department of Health and Human Services, Division of Social Services, and child welfare officials.
- ◆ Conducted multiple focus groups and interviews across the state with county child welfare staff, stakeholders and partners, and youth and families receiving services.
- ◆ Conducted site visits at individual county offices.

### **Electronic Surveys**

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parent feedback loops; 5) perform time use and salary surveys; 6) promote relationship-building across agencies and providers; 7) implement supports for adoptive families; 8) maintain sibling groups; and 9) develop a statewide, standardized functional protocol for case planning, service referrals, enhancing executive-level decision-making related to resource allocation and system reform efforts.



- ◆ Reviewed data collected from three surveys: one for foster care workers, one for CPS workers, and another for state office child welfare employees.

### **Participation in Meetings and Conferences**

- ◆ Attended multiple meetings and conferences including meetings of the Social Services Working Group (SSWG); the North Carolina Association of County Directors of Social Services (NCACDSS); the April Child Fatality Prevention Summit, the April meeting with the Children’s Bureau to review state progress; a meeting of the DHHS leadership team; and a meeting with DHHS leaders and stakeholders to discuss the Family First Prevention Services Act (FFPSA).

### **Theory of Change Session**

- ◆ Facilitated a two-day theory of change session in Durham on July 9 and 10 with state and county child welfare leaders to review preliminary findings and participate in developing a logical set of recommendations to accomplish a shared vision of change.

### ***Current Child Welfare System in North Carolina***

In an average month, county Departments of Social Services (DSS) throughout North Carolina receive just over 11,000 reports of suspected child abuse, neglect, or dependency.<sup>4</sup> Approximately 7,000 or 65 percent of those reports are screened-in as meeting legal criteria to be accepted for a CPS investigative or family assessment.<sup>5</sup> Those numbers translated to statewide annual totals of 133,771 CPS reports screened and 87,336 accepted in 2017.<sup>6</sup> While the total number of reports accepted for CPS assessment has recently been relatively stable, the proportion assigned to the more formal investigative assessment track has decreased slightly in the past five years (15,981 to 13,658), while the proportion of reports assigned to the family assessment track has increased slightly (50,105 to 51,504).<sup>7</sup>

The number of families open to CPS In-Home Services – the goal of which is to help families in which maltreatment has occurred remain safely together – has decreased from 4,760 families in January 2015 to 4,118 families in November 2017.<sup>8</sup> The number of children entering foster care for the first time each year has risen from 5,252 children in State Fiscal Year 2014 to 5,707 children in SFY 2017.<sup>9</sup> North Carolina does not meet federal standards for achieving permanency quickly for new enterers into foster care, though the state does meet federal permanency measures for children who have been in foster care for longer periods of time.<sup>10</sup>

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<sup>4</sup> 2017 Master Child Welfare Workforce Data Book

<sup>5</sup> Ibid.

<sup>6</sup> Ibid.

<sup>7</sup> Duncan, D.F., Kum, H.C., Flair, K.A., Stewart, C.J., Vaughn, J.S., Guest, S., Rose, R.A., Malley, K.M.D. and Gwaltney, A.Y.(2018).Management Assistance for Child Welfare, Work First, and Food & Nutrition Services in North Carolina (v3.2).

Retrieved [4/17/18], from the University of North Carolina at Chapel Hill Jordan Institute for Families website.

URL: <http://ssw.unc.edu/ma/>

<sup>8</sup> 2017 Master Child Welfare Workforce Data Book

<sup>9</sup> Duncan, D.F., Kum, H.C., Flair, K.A., Stewart, C.J., Vaughn, J.S., Guest, S., Rose, R.A., Malley, K.M.D. and Gwaltney, A.Y.(2018).Management Assistance for Child Welfare, Work First, and Food & Nutrition Services in North Carolina (v3.2). Retrieved [6/30/18], from the University of North Carolina at Chapel Hill Jordan Institute for Families website. URL: <http://ssw.unc.edu/ma/>.

<sup>10</sup> Ibid.

North Carolina's rate of re-entry into foster care continues to be lower than the national federal standard.<sup>11</sup>

These dynamics, coupled with the complex societal problems mentioned above, have contributed to a child welfare system with an increasing number of children in foster care. On June 30, 2015, North Carolina had 10,288 children in foster care. On June 30, 2017, the number of children in care had risen to 11,113.<sup>12</sup>

### *Findings*

In a state-supervised, county-administered child welfare system, variation exists in how individual counties deliver services and work with children and families. Some of the differences reflect the variation in county populations, economics, and available resources. In addition, each county has its own strengths and challenges. Many counties are engaging in best practices tailored to address their county's specific needs. As such, the findings in this report may apply to counties to differing degrees. Conversely, many of the recommendations in this report identify the state as the primary responsible entity because of this variation – broad-scale system improvement in all one hundred counties will require state leadership and a state office that is equipped to lead.

It is important to note that the findings related to Prevention and In-Home Services; Child Protective Services; Placement into Foster Care, Reunification and Permanency Services; Health, Mental Health, and Educational Services; and Services for Older Youth are generally focused on the counties, rather than the state, because our primary focus was to understand the experiences of children and families in North Carolina at the case practice level. Findings in the other areas are more balanced between the state and counties due to the broader focus of our inquiry, particularly in the Preliminary Social Services Reform Plan.

Each area of practice below begins with the primary research question and some key findings.

#### *Child Protective Services*

Are children and their household members who come to the attention of the child welfare system through reports of maltreatment receiving a response that ensures children are safe from immediate threats to their health safety and future risk of harm?

- ◆ Children and families in North Carolina who come to the attention of the child welfare system through a report of maltreatment are not consistently receiving a response that ensures the immediate safety of children and protects them from risk of future harm.
- ◆ The majority of CPS caseworkers indicated they meet regularly with their supervisors to staff cases and that their supervisors are always available, knowledgeable, and provide guidance.
- ◆ Substantial variation exists among individual counties in the frequency with which they screen-out reports of child abuse or neglect.

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<sup>11</sup> Ibid.

<sup>12</sup> Ibid.

- ◆ Only about 70 percent of CPS assessments (investigative and family) are being completed within 45 days, and caseworkers indicate that meeting this timeline is difficult.
- ◆ New information uncovered in CPS assessments is not consistently followed-up on or integrated into ongoing safety assessments.

### *Prevention and In-Home Services*

Are children and their household family members who are in open CPS In-Home Services cases receiving services that ensure children are protected from immediate threats to their health, safety, and future risk of harm?

- ◆ Children and parents receiving In-Home Services are not being consistently served and supported in a way that ensures child health, safety, and protects against future risk of harm.
- ◆ The lack of consistent, quality face-to-face contact with children and parents in In-Home Services cases impacts state performance in being able to assess accurately and respond to matters of risk and safety.
- ◆ The array, availability, and quality of services to children and families varies across the state.
- ◆ Public funding for mental health and substance abuse services for uninsured parents is very limited. Staff cited transportation challenges, families' refusal to participate, followed by issues such as extended waitlists, a lack of providers in the area, and providers not accepting Medicaid as additional reasons services are not received.

### *Child Fatality Reviews*

Are findings from North Carolina's fatality reviews being used effectively to take actions to prevent other fatalities and improve the health and safety of children?

- ◆ Together with state and county stakeholders, North Carolina has begun a process to review and strengthen its child fatality review system.
- ◆ The State Child Fatality Prevention Task Force is active and many of its recommendations to improve child safety have been adopted by the legislature.
- ◆ Findings from state-led intensive reviews, local team reviews, and internal agency reviews are more likely to lead to local than state action to prevent other fatalities and improve the health and safety of children than state actions.
- ◆ North Carolina fatality review processes include recommended practices such as taking a comprehensive, multi-disciplinary approach that engages the community in efforts to keep children safe.
- ◆ North Carolina has an unusual number of review processes and a more complicated system than other states.
- ◆ The state-led intensive fatality review team recently resolved a large backlog. It is time to revisit how the state and local teams work together.
- ◆ Review processes have engaged communities in fatality prevention and led to local and statewide public information campaigns designed to improve child safety.

### *Placement into Foster Care*

Are reasonable efforts made to support families prior to removing children and effective efforts made after removal to promote stable placements?

- ◆ North Carolina has a lower rate of children entering foster care than most states. However, room for improvement exists in efforts to safely preserve families and ensure placement stability of children in foster care.
- ◆ North Carolina meets the federal 95 percent standard of seeing every child in foster care face-to-face every month.
- ◆ Efforts are needed to locate and engage relatives earlier in the case planning process to mitigate child and family trauma and promote placement stability.

### *Reunification Services*

Are children in foster care, their families, and caregivers receiving trauma-informed services and supports that facilitate timely reunification?

- ◆ Children in North Carolina, as well as their families and caregivers, are not receiving the appropriate level of trauma-informed services and supports to facilitate timely reunification.
- ◆ North Carolina's foster care re-entry rate is low compared to other states.
- ◆ Monthly caseworker face-to-face contact with parents is not occurring with required frequency.
- ◆ In the majority of cases, state program monitors found that initial Child and Family Team (CFTs) meetings were not held within 30 days of removal and did not appropriately involve the child.

### *Permanency Services*

Are children and youth in foster care receiving trauma-informed services and supports that facilitate timely permanency?

- ◆ Children and youth in foster care in North Carolina are not receiving an appropriate level of trauma-informed services and supports to facilitate timely permanency.
- ◆ Foster care caseworkers feel supported by their supervisor.
- ◆ Supportive services are generally in place at the time of case closure.
- ◆ Timeliness of selecting permanency goals and making concerted efforts to achieve permanency are both areas needing improvement.
- ◆ Children in foster care are not consistently given the opportunity for input at court hearings.
- ◆ Children and parents are not consistently engaged in the development of case plans.
- ◆ Termination of Parental Rights (TPR) petitions are not being filed timely.
- ◆ Only 56 percent of foster care workers responding to CSF's survey reported looking diligently for relatives throughout the life of a case.

- ◆ Challenges to permanency include a lack of court time and differing perspectives on what is best for children between the court system and county departments of social services.
- ◆ Most relatives and kin providing placements for children in foster care do not complete the licensure process and, therefore, do not receive the financial support available to them through a foster parent board payment.

### ***Health, Mental Health, and Educational Services***

Are the needs of children in foster care being appropriately assessed, including exploring the history of trauma, and services being provided to address those needs and achieve case goals?

- ◆ Some appropriate services do exist to address the needs of children being served in foster care, but significant barriers remain for these services to be provided timely and appropriately to achieve case goals.
- ◆ About three-quarters of youth receive annual well-child checkups.
- ◆ Parents are not consistently provided with the opportunity to participate in medical appointments with their children in foster care.
- ◆ Too many barriers exist to the timely provision of needed mental health services for children in foster care in North Carolina.
- ◆ DSS has some consistent trauma-informed practices occurring in some counties. Triple P and Project Broadcast are being implemented in multiple counties with some success.

### ***Services to Older Youth***

Are older youth in foster care being prepared for adulthood?

- ◆ Older youth served in foster care are not consistently being prepared for adulthood.
- ◆ Youth report favorable engagement through LINKS but report less engagement in other key meetings and planning sessions and have mixed opinions about involvement in Child and Family Team (CFT) meetings.
- ◆ Older youth in foster care report a need for more resources, especially in smaller counties.
- ◆ While there is evidence that some youth are being supported in building relationships, relatives are not being regularly assessed for placement or involvement in the young person's life.

### ***Preliminary Recommendations***

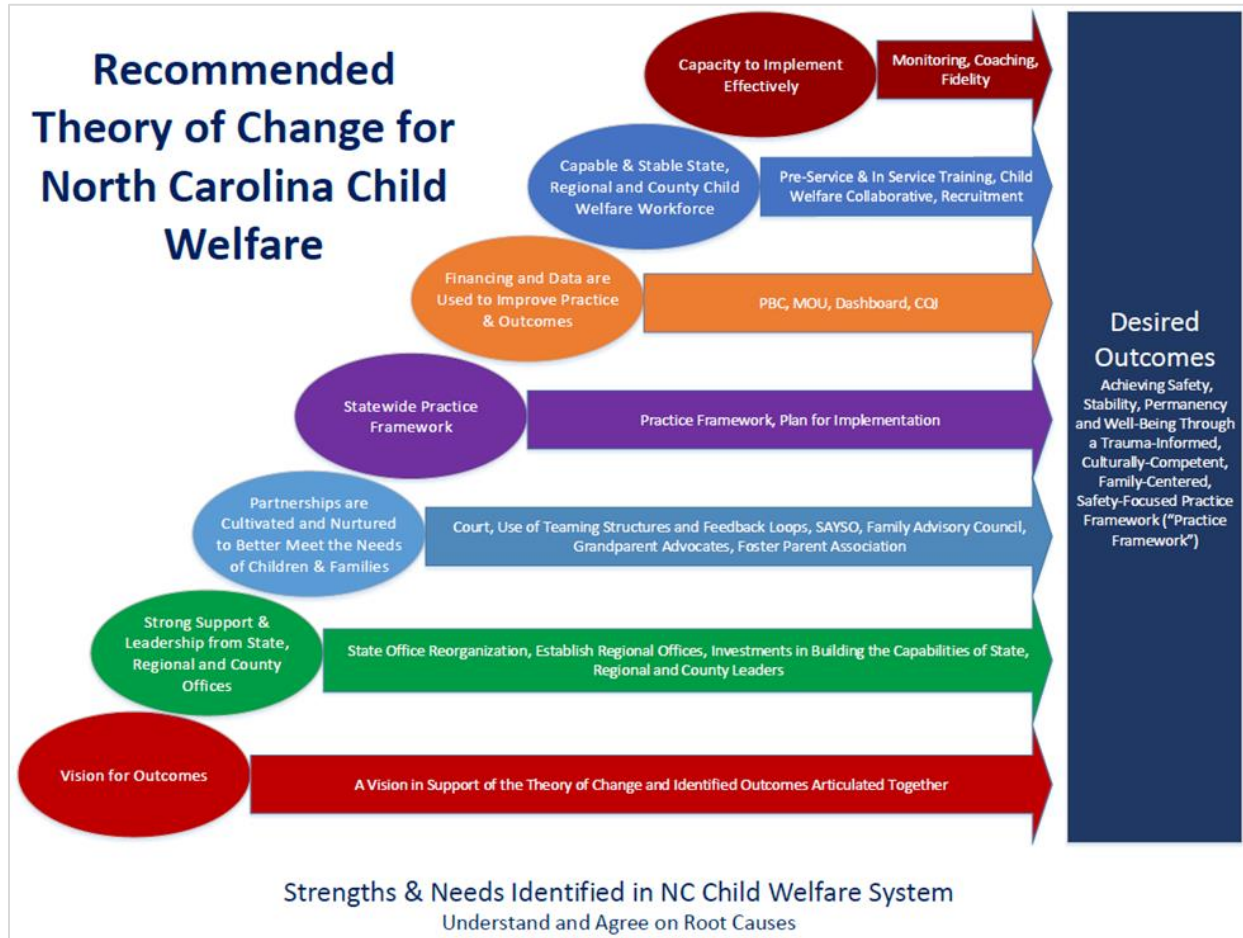
Creating a child welfare system in North Carolina that is experienced by children and families in all 100 counties as being culturally-competent, trauma-informed, family-centered, and safety-focused will require a shift in organizational and system culture and mindset. It will also require a reliance upon proven and effective approaches to implementation. The theory of change session held in Durham was a step in this direction. A draft theory of change was developed and refined during this two-day session on July 9 and 10. To promote more candid, open dialogue, CSF, with input from the Office of State Budget and Management (OSBM), made the determination that this session would be a small, internal meeting of public, state, and county

child welfare leaders. CSF understands the critical importance of bringing families and child welfare leaders, stakeholders, advocates and other contributors into the process, and proposes that be a next step in Phase 2 of this project.

The recommendations described here reflect ideas and input from the theory of change session and from information gathered from our assessment, which included input from hundreds of DHHS employees, county Department of Social Services employees, and stakeholders. A review of best practices in child welfare also informed these recommendations. In addition, CSF carefully reviewed recent reports and recommendations including: 1) the Child Welfare Strategic Plan, S.L. 2016-94, Section § 12C.1. (b); 2) Report to the Joint Legislative Oversight Committee on Health and Human Services by the North Carolina Department of Health and Human Services; 3) the North Carolina Child and Family Services Review (CFSR) Program Improvement Plan (PIP); and 4) the PCG study, which was also required by Section § 12C.1.(f) of N.C. Session Law 2014-100.

It should be noted that the U.S. Congress has set forth a path for all child welfare systems to place more focus on prevention and intervention to keep children safely with families through the Family First Prevention Services Act (FFPSA), beginning as early as October 2019. North Carolina is poised to jumpstart this process through implementation of its new vision and practice framework. These recommendations have been crafted to align and incorporate readiness activities identified as part of North Carolina's effort to prepare for the implementation of the FFPSA. This process should help inform the prevention plan the state will be required to submit to the U.S. Department of Health and Human Services and the notification the state will be giving about a timeline for opting into the FFPSA before November 9, 2018.

Figure 1: Recommended Theory of Change for North Carolina Child Welfare



The following preliminary recommendations are offered for consideration. They are not listed in order of priority, but instead they correlate directly with the draft theory of change, which frames the basic conditions that would need to exist within North Carolina’s Child Welfare system to address identified findings and improve desired outcomes over time. The basic conditions are listed below.

- ◆ Vision for outcomes.
- ◆ Strong support and leadership from Central Office, regional office, and county offices.
- ◆ Partnerships are cultivated and nurtured to better meet the needs of children and families.
- ◆ Statewide practice framework.
- ◆ Financing and data are used to improve practice and outcomes.
- ◆ Capable and stable state, regional, and county child welfare workforce.
- ◆ Capacity to implement effectively.

The recommendations to develop and create each of the basic conditions for the draft theory of change are listed in order as depicted in the *Key for Recommendations* below, based on a

preliminary implementation timeline: short-term recommendations that can be implemented before the end of Phase 2 (February 28, 2019); mid-term recommendations that can be implemented before the end of Phase 3; and then long-term recommendations to be implemented beyond Phase 3. Although multiple entities (e.g. DHHS, General Assembly, County Departments of Social Services, Administrative Office of the Courts) will need to work together to implement almost every recommendation, we have listed the primary entity that has much of the responsibility for the specific recommendation. Some specific steps will need to be taken in earlier phases to prepare for the implementation of certain recommendations in the mid-term or longer-term timeframes.

**Key for Recommendations**

<i>Short-term = can be implemented before February 28, 2019 (Phase 2)</i>
<i>Mid-term = to be implemented after March 1, 2019 (Phase 3)</i>
<i>Long-term = to be implemented beyond Phase 3</i>
<i>Legislature</i>
<i>DHHS</i>
<i>Counties</i>
<i>Core Implementation Team (CIT)</i>

Specific recommendations in the preliminary plan include the following.

**Vision for Outcomes**

1.	Recruit and hire one person with implementation experience and expertise to create a core, representative implementation team to guide the implementation of these recommendations.	DHHS
	<i>Short-term</i>	
2.	Convene a broad group of stakeholders to more fully develop a vision for improving outcomes in North Carolina – starting with the theory of change and identified outcomes developed in partnership with CSF on July 9 and 10 in Durham, North Carolina.	CIT
	<i>Short-term</i>	
3.	Ensure that the articulated vision supports a parallel process for shifting the culture of the workplace to provide culturally-competent, trauma-informed, family-centered, and safety-focused environments to support social services staff at the county, regional, and Central Office levels.	CIT
	<i>Short-term</i>	



4.	Develop and implement a communication plan to help ensure leaders at all levels and a broad group of stakeholders are receiving and providing needed information related to North Carolina's vision for outcomes.	CIT
	Short-term	

*Strong Support and Leadership from State, Regional, and County Offices*

5.	Create five new high-level positions in the state Division of Social Services at competitive salaries and then advertise, recruit, and select candidates qualified to lead.	DHHS
	Short-term	

6.	Ensure competitive salaries for Central Office Division of Social Services Child Welfare Section employees and prospective employees. See Social Services Preliminary Reform Plan.	DHHS
	Mid-term	

7.	Reorganize the Central Office Division of Social Services Child Welfare Section to align with the regional offices established under S.L. 2017-41.	DHHS
	Mid-Term	

8.	Create a centralized hotline for reports of all suspected abuse or neglect in North Carolina.	DHHS
	Long-term	

9.	Ensure each regional office is equipped with relevant child welfare programmatic and coaching expertise.	DHHS
	Long-term	

*Partnerships Are Cultivated and Nurtured to Better Meet the Needs of Children and Families*

10.	External stakeholders need to be engaged on a regular and ongoing basis as North Carolina develops a culturally-competent, trauma-informed, family-centered, and safety-focused child welfare system.	CIT
	Short-term	

11.	Engage, collaborate and coordinate with courts to address and remedy existing barriers, while creating buy-in for the new vision and jointly tracking key outcomes for children, youth, and families.	Short-term	DHHS
12.	Strengthen partnership between the state Division of Social Services and the Divisions of Medical Assistance and MH/DD/SAS to make sure behavioral health services are available to parents and ensure appropriate placements for children in foster care.	Short-term	DHHS
13.	Finalize the criteria for readiness to implement the Family First Prevention Services Act.	Short-term	DHHS
14.	Engage, collaborate and coordinate with birth families, youth, relatives, fictive kin, and foster parents to improve outcomes and effectively implement system reforms.	Mid-term	DHHS

*Statewide Practice Framework*

15.	The state and CSF should begin immediately to further explore the fit and feasibility of adapting and effectively implementing Safety Organized Practice (SOP) as the comprehensive statewide practice framework to create consistency in child welfare practice that is trauma-informed, culturally-competent, family-centered, and safety-focused throughout North Carolina.	Short-term	DHHS/CIT
16.	Include in the practice framework an expedited licensure process for foster parents, relative, and kin caregivers that has been streamlined.	Short-term	DHHS/CIT
17.	Include in the practice framework specific expectations related to the engagement of birth families in the planning processes and provision of services provided to their children while in foster care.	Short-term	DHHS/CIT

18.	Include in the practice framework the specific support that older youth in foster care need.	DHHS/CIT
<i>Short-term</i>		
19.	Include in the practice framework a specific approach to child and family teams or CFTs to align with a family-centered, culturally-competent, trauma-informed, safety-focused child welfare system.	DHHS/CIT
<i>Short-term</i>		
20.	Include in the practice framework the SDM process and tools as may be needed.	DHHS/CIT
<i>Short-term</i>		
21.	Assess Project Broadcast or review assessments that have been done to understand the extent to which it has been implemented and its impact on children and families.	DHHS
<i>Mid-term</i>		
22.	Create border agreements to ensure children can be with their relatives in neighboring states as soon as possible.	DHHS
<i>Mid-term</i>		
23.	Provide funding for more robust In-Home Services.	DHHS
<i>Mid-term</i>		
24.	Take concrete steps to increase the number and percent children in foster care placed with relatives and kin caregivers, the percent of those kin who are licensed, and the numbers of children exiting to their care.	DHHS
<i>Mid-term</i>		

*Financing and Data Are Used to Improve Practice and Outcomes*

25.	Develop a communication strategy at the state and local level that clearly expresses the expectation that staff rely on properly produced data evidence.	CIT
	Short-term	

26.	Train county, regional, and statewide staff in the proper use of administrative data to support program monitoring and decision-making.	DHHS
	Mid-term	

27.	Offer ongoing training to staff on data entry and data extraction.	DHHS
	Mid-term	

28.	Conduct an analysis of how state and county child welfare contract for services and make recommendations on how to maximize the effectiveness of contracting to achieve child and family outcomes.	DHHS
	Mid-term	

29.	Review and strengthen statewide protocols and procedures on how information is entered into the system and streamline methodologies to ensure data accuracy and consistency for identified variables that will be used in reports.	DHHS
	Short-term	

30.	Continue to develop and regularly disseminate standard reports on basic information about the child welfare population.	DHHS
	Mid-term	

31.	Create an analytic data file, that can be periodically updated, that links NC FAST data with data from the legacy system.	DHHS
	Mid-term	

32.	Adopt outcome measures aligned with a safety-focused, family-centered, trauma-informed, culturally-competent system.	DHHS/CIT
	Short-term	

33.	Make investments in existing qualitative case review processes since they are so essential to monitoring and supporting efforts towards improving case practice and outcomes for children and families.	DHHS/Cty DSS
	Mid-term	

34.	Track progress on identified outcomes based on individual county performance in recent years.	DHHS/Cty DSS
	Long-term	

35.	Conduct an analysis of the financing structure of the Child Welfare system and make recommendations of how to maximize federal dollars, including tying performance to financing in order to support improvements.	DHHS
	Long-term	

*Capable and Stable State, Regional and County Child Welfare Workforce*

36.	Take concrete steps to reduce paperwork and streamline requirements (create a stop-doing list) to increase the time caseworkers have available to work with families.	DHHS/Cty DSS
	Short-term	

37.	Consider strategies for organizing staffing or workloads to allow more intensive effort during the first 30-days of foster care.	DHHS/Cty DSS
	Mid-term	

38.	Changes are necessary to allow CPS assessors, CPS In-Home caseworkers, and foster care caseworkers to meet job expectations when caseloads are at standard levels.	DHHS
	Long-term	

39.	Pre-service training needs to be redesigned to better prepare a workforce, the majority of whom are coming to child welfare without a social work degree.	DHHS
	Short-term	

40.	Training should be integrated into a larger strategy for professional development and a diverse, representative design team should be charged with co-creating an approach for designing and developing learning programs (preparation, training, coaching, transfer of learning and support) as opposed to stand-alone training modules.	Short-term	DHHS

41.	Make necessary revisions to existing university contracts for training and professional development to align with the newly developed learning program.	Mid-term	DHHS

42.	A process for continuous evaluation and revisions of learning programs should be integrated into professional development to determine what is needed, how well it is working, and to make improvements.	Mid-term	DHHS

43.	The state needs to develop a recruitment and retention strategy for child welfare caseworkers that includes positive and realistic messaging about child welfare caseworkers and the role of child welfare supporting children and families.	Mid-term	DHHS

44.	The Child Welfare Collaborative should be revived and retooled so that it benefits all counties, not just those neighboring state universities with collaborative programs.	Mid-term	DHHS

45.	Strategies should be implemented to retain child welfare caseworkers.	Short-term	DHHS

*Capacity to Implement Effectively*

46.	Create a teaming structure for statewide decision-making that will provide input and feedback loops from key stakeholders that will also allow for nimble and efficient decision-making at the state level.	Short-term	CIT

*Child Fatality Reviews*

47.	CSF endorses the process that the state Child Fatality Prevention Task, with the full involvement of DHHS, is taking to work with participants and stakeholders of the child fatality review and prevention system to: <ul style="list-style-type: none"> <li>▪ Simplify the structure and processes of the system.</li> <li>▪ Improve the use the data.</li> <li>▪ Improve support of and collaboration between review teams.</li> </ul>	DHHS
<i>Mid-term</i>		
48.	Consider consolidating state-level responsibility for child fatality reviews within a single entity of DHHS to create a central point of accountability for review processes and to simplify review reporting and feedback expectations.	DHHS
<i>Mid-term</i>		
49.	Consolidate into a single review the state-led intensive and local team reviews required when children brought to the attention of the Child Welfare system within the previous 12 months die of suspected abuse or neglect.	DHHS
<i>Mid-term</i>		
50.	Continue to explore options for streamlining local team structure with input from local teams.	DHHS
<i>Mid-term</i>		

*Next Steps*

CSF recommends the immediate creation of a small, representative core implementation team to be identified and charged with the responsibility for taking these recommendations to the next level – sorting them in priority order, making them actionable and identifying the resources needed to support and implement them. We also recommend that DHHS recruit and select one person to be devoted to this full-time, to lead this team and manage the implementation of these recommendations and the improvement effort overall.

This core implementation team would be responsible for strategically sequencing and operationalizing these recommendations, using the evidence that is available about effective approaches to broad-scale implementation, including a focus on readiness, goals, and activities. This team would be responsible for creating a well-defined teaming structure to regularly engage a broader group of stakeholders in the implementation process.

Working with DHHS and the counties, we will also develop implementation plans for those recommendations DHHS decides to pursue. The final reports, due by February 28, 2019, will document progress on the short-term recommendations, and will include implementation plans for the mid- and long-term recommendations. Implementation plans will also specify the intended outcomes tied to each recommendation, along with how improvement can be measured.

As noted earlier in this Executive Summary, North Carolina's leadership is to be applauded for its decision to pursue the systemic changes needed to improve outcomes for its most vulnerable citizens. State and county social services professionals alike show their commitment to providing the best services they can, on a daily basis. We believe the preliminary recommendations detailed in this report will help North Carolina sequence, prioritize, and order improvement activities and over time improve everyday practice with families and the outcomes experienced by children and families in North Carolina. We look forward to continuing our work with state and county staff to implement agreed upon recommendations effectively.



## I. METHODOLOGY

Given the size and scope of the assessment requested by North Carolina, CSF developed eight primary research questions designed to focus on:

- ◆ Assessments of children coming to the attention of the Department of Health and Human Services (DHHS)/Department of Social Services (DSS) to ensure children are safe from immediate threats to their health, safety, and future risk of harm;
- ◆ Services provided to children and families to ensure children are protected from immediate threats to their health, safety, and future risk of harm;
- ◆ Seeking to understand the extent to which findings from North Carolina’s fatality reviews are being used effectively to take actions to prevent other fatalities and improve the health and safety of children;
- ◆ Reasonable efforts to prevent custody and the placement process;
- ◆ Services to support and promote reunification;
- ◆ Services to support and promote permanency;
- ◆ Physical health, mental health, educational, and development needs identified and met; and
- ◆ Preparing young persons for adulthood.

The eight primary research questions are outlined below. Not included are the specific sub-questions for each of these primary research questions. These sub-questions are listed and answered in the detailed findings in Chapter 3.

<p><b><u>Primary Research Question:</u></b></p>	<p><i>Are children and their household members who come to the attention of the child welfare system through reports of maltreatment receiving a response that ensures children are safe from immediate threats to their health safety and future risk of harm?</i></p>
<p><b><u>Primary Research Question:</u></b></p>	<p><i>Are children and their household family members who are in open CPS in-home services cases receiving services that ensure children are protected from immediate threats to their health, safety and future risk of harm?</i></p>
<p><b><u>Primary Research Question:</u></b></p>	<p><i>Are the findings from North Carolina’s fatality reviews being used effectively to take actions to prevent other fatalities and improve the health and safety of children?</i></p>

<b><u>Primary Research Question:</u></b>	<i>Are reasonable efforts made to support families prior to removing children and effective efforts made after removal to promote stable placements?</i>
<b><u>Primary Research Question:</u></b>	<i>Are children and youth in foster care, their families, and caregivers receiving trauma-informed services and supports that facilitate family reunification?</i>
<b><u>Primary Research Question:</u></b>	<i>Are children and youth in foster care receiving trauma-informed services and supports that facilitate timely permanency?</i>
<b><u>Primary Research Question:</u></b>	<i>Are the needs of children and youth in foster care being appropriately assessed, including exploring the history of trauma, and services being provided to address those needs and achieve case goals?</i>
<b><u>Primary Research Question:</u></b>	<i>Are older youth in foster care in being prepared for adulthood?</i>

To answer these questions, CSF gathered information from multiple sources, first relying on available state information then gathering data with our own data collection methods. We summarize below the primary sources of information CSF used to answer these research questions and sub-questions.

### ***A. Review of Systemic Factors***

CSF conducted an extensive review of North Carolina policies and statutes, as well as a review of emerging best practices in North Carolina and throughout the United States.

#### **Policy**

As North Carolina was utilizing two separate policy manuals at the time of this review, CSF staff reviewed both the existing policy manual, which is used by 90 counties, and the new modified policy manual, which was being piloted by 10 counties and was then to be rolled out statewide in September 2018. The focus of this review was on policy relevant to the research questions and sub-questions. This analysis was provided in our monthly report on April 30.

#### **Statutes**

CSF utilized one of its national experts to conduct the review of pertinent North Carolina statutes. The review of statutes looked at the Juvenile Code related to the research questions and sub-questions. This analysis was provided in our monthly report on April 30.

### **North Carolina Best Practices**

Through the review of other systemic factors, meetings with state stakeholders, as well as the review of North Carolina materials provided, CSF identified emerging best practices currently implemented or in the process of being implemented in specific counties in North Carolina or statewide. The practices identified were limited to those that aligned with the research questions and sub-questions, and were identified based on their merit, grounding in research, or alignment with similar nationally recognized practices or principles.

### **National Best Practices**

Through the review of other systemic factors, CSF staff identified recognized best practices nationwide in the field of child welfare, specifically aligned with the research questions and sub-questions.

### ***B. Review of Quantitative Data Reports***

To understand how North Carolina is performing based on national standards, as well as other key child welfare standards, CSF first reviewed publicly-available data to get a baseline understanding of performance and available data. This included results from Round 3 of the Children and Family Services Review, Children’s Bureau child maltreatment reports, the data reports available on the UNC Jordan Institute Management Information website relevant to child welfare, and other recent research reports that provide some statistics on North Carolina performance. CSF and our data partner, Westat, held an initial meeting with North Carolina information system leads to determine what data could be provided to the team for additional quantitative analysis and then followed up with a more specific data request. Although there are some limitations in the quantitative data available in North Carolina, which are described in more detail in Chapter 4, DHHS’s Division of Social Services moved quickly to produce the data requested and to provide these data to our team using a secure server.

### ***C. Review of Existing State Case Reviews***

North Carolina currently utilizes two case review processes. First, they are using the Children’s Bureau Onsite Review Instrument (OSRI), the same instrument used for the federal CFSR. Second, they are using the Program Monitoring tool, an instrument they developed and tailored to the programs, practices, and processes of North Carolina.

### **OSRI**

North Carolina participated in Round 3 of the CFSR in 2015, using the OSRI instrument on an ongoing basis to monitor performance of counties as compared to the federal measures. CSF was provided with the results of these case review activities, which are included within this report. Here are a few factors to keep in mind regarding these data. First, the methodology with which counties are selected for review, or the number of cases selected in each county to be reviewed, does not seem to be uniform or proportional based on the size of the county. Second, the number of cases presented are not representative of the state and cannot be extrapolated as such.

## **Program Monitoring**

The Program Monitoring instrument is divided into five separate tools: Foster Care, In-Home, Assessment, Screen-Ins, and Screen-Outs. CSF was provided the Program Monitoring case review results for 2016 and 2017, though limited the analysis to the case review results from 2017. For each instrument, the data was provided in two Microsoft Excel spreadsheets. One for all case reviews conducted between January and June, and the other for all case reviews conducted between July and December. Through conversations with the Program Monitoring staff, CSF learned that questions in the instruments had been refined, clarified, expanded, or deleted to align with policy and practice expectations between the first half of the year and the second. To be able to analyze a full year of data, CSF first conducted a question-by-question analysis to make sure that questions had not been modified, or if they had, that they had not been modified significantly so as to impact the integrity of the data by merging the results. If the questions had been altered significantly or if new questions were added or old questions were deleted, they were not included in the full-year analysis. CSF then used Excel to merge the data from the two spreadsheets. To mirror the levels of analysis being conducted with the quantitative data, CSF organized the results in both a statewide analysis, and one divided between the large, medium, and small county categories.<sup>13</sup>

### ***D. Interviews, Focus Groups, Site Visits***

To provide more insight and context to the quantitative data, and most importantly to get the voice and experience of the counties operating the child welfare system, CSF focused a large portion of the information collection activities on conducting county-level interviews and focus groups, as well as conducting two site visits.

County child welfare foster care caseworkers and their supervisors, county child welfare CPS caseworkers and their supervisors, former foster youth, relative caregivers, birth parents, foster parents, educators, judges and other court personnel, child placing agencies, and other key stakeholders participated in these focus groups in three representative locations in North Carolina. These locations were selected based on geography, level of economic distress per the North Carolina Department of Commerce Tier system, and population size.

The focus groups in the central part of North Carolina were held May 15 and 16 in Guilford County. We invited Caswell, Chatham, Guilford, Moore, Randolph, and Yadkin Counties to participate. To accommodate some stakeholders and staff who were unable to make it to Guilford County at the allotted times, CSF staff traveled, at the request of two counties, to Chatham County and Caswell County to conduct additional interviews.

The focus groups in the eastern part of North Carolina were held May 22 and 23 in Carteret County. We invited Beaufort, Carteret, Craven, Hyde, Jones, and Pender Counties to participate. Due to Hyde County having court on of the days of the focus group, its representatives nominated Perquimans County to attend the focus groups on that day in their stead. To accommodate some stakeholders who were unable to make it to Carteret County at the allotted

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<sup>13</sup> Throughout this report, we compare counties using the UNC management assistance website categorization of ten large counties with a total child population of about 1,000,000, 39 medium counties with a child population of 950,000, and 51 small counties with a child population of about 300,000.

times, CSF staff traveled, at the request of Beaufort County, to conduct additional interviews with youth in a LINKS group and foster parents. In addition, given that Jones County was unable to send any staff due to its small size, separate phone interviews were conducted with Jones County workers, supervisor, and county director on May 30.

The focus groups in the western part of North Carolina were held May 30, 31, and June 1 in Rutherford County. We invited Buncombe, Burke, Haywood, Jackson, McDowell, and Rutherford Counties to participate. Due to technological difficulties with the conference call line, separate interviews were held with the foster care caseworkers in Jackson County. In addition, CSF conducted a separate interview with the leadership in Buncombe County.

CSF developed focus group and interview protocols for each group conducted. The questions were determined based on an analysis of gaps of information in the available quantitative data to be able to answer the research questions and sub-questions adequately.

### **Site Visits**

At the request of the counties themselves, and in order to get a better sense of the operations and practices specific to counties, CSF conducted two half-day site visits. The first site visit was held in Orange County on May 18, and the second site visit was held in Wilson County on May 25. As part of the site visits, county staff showed the CSF team their office space, and presented the work being done in the county, what was working well, and where they had concerns.

### ***E. Electronic Surveys***

To supplement the feedback CSF received from counties during the focus groups in the different areas of the state, and based on the invaluable information CSF learned through the focus group process, CSF developed three surveys: one for CPS workers, one for foster care workers, and one for Central Office child welfare section employees. The survey instruments were developed using [www.SurveyMethods.com](http://www.SurveyMethods.com). Links to the CPS and Foster Care worker surveys were distributed to DSS county directors to give to their staff on June 5, and they had two weeks to complete them, with one reminder email being sent. There were 360 respondents to the CPS workers survey and 211 respondents to the Foster Care workers survey.<sup>14</sup> Qualitative comments that were provided in the surveys were coded and grouped together by frequency of theme highlighted in the comments.

The Central Office staff survey was distributed to 131 Child Welfare Section employees using [www.SurveyMethods.com](http://www.SurveyMethods.com) on June 22, and staff had one week to respond. There were 66 respondents to the Central Office survey, which is a 50 percent response rate.

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<sup>14</sup> These two surveys instructed that they be completed by caseworkers and not others in the agency, but based on a few of the comments, it is clear that some supervisors and therapists also completed the surveys. The primary questions that could be impacted by this are the questions about supervision. It is not possible to provide an exact response rate for these surveys because they were to be distributed by county directors and we do not know how many county directors did so.

### *F. Participation in Meetings and Conferences*

In addition to the interviews, focus groups, and site visits that CSF scheduled in the counties with staff and stakeholders to better understand child welfare practice in the counties and the strengths and barriers they face, CSF was invited to participate in additional meetings and conferences from the beginning of the contract in March 2018 at both county and state levels. CSF learned further about issues facing the North Carolina child welfare system as the result of participation in these meetings, observations about which are incorporated throughout the report. Below is a list of some of those meetings and conferences we attended.

- ◆ March 19 and 20 – Meeting with State DHHS Leadership.
- ◆ April 9 and 10 – Child Fatality Summit: A member of the CSF team attended the Child Fatality Summit.
- ◆ April 12 – North Carolina Association of County Social Services Directors (NCACDSS) Greensboro Meeting: This meeting was for urban county directors as well as child welfare directors.
- ◆ April 23 – CFSP Meeting: A member of the CSF team attended the CFSP meeting.
- ◆ April 24 – PIP Meeting: A member of the CSF team attended the PIP meeting to learn more about where the state was in the PIP process.
- ◆ April 25 – Blowing Rock Focus Group: CSF team members conducted a focus group at the NCACDSS directors’ annual retreat.
- ◆ May 9 and 10 – NCACDSS Focus Group in Raleigh: CSF held focus groups with child welfare directors on May 9, and DSS executive directors on May 10.
- ◆ May 11 – Central Office Meeting with Child Welfare Division: CSF team members attended the regular child welfare division staff meeting where progress was reported across the different areas, as well as conducted a short focus group with Central Office staff.
- ◆ May 14 – Meeting with SSWG facilitators from UNC School of Government and the DHHS Secretary and her leadership team.
- ◆ May 17 – Modified Policy Rollout Meeting: A member of the CSF team attended the first day of the modified policy rollout meeting in Lincolnton, NC, which focused on the modified policy changes related to Intake, Assessment, and In-Home in Child Protective Services.
- ◆ May 24 – NCACDSS Eastern Meeting: CSF conducted focus groups as part of the larger meeting of Eastern DSS directors, which was attended by both directors and program staff.
- ◆ June 5 – FFPSA Stakeholder Meetings: There was a morning session attended by hundreds of child welfare stakeholders statewide, and two CSF team members were present. Two CSF team members facilitated an afternoon session focused on implementation in North Carolina with smaller group of stakeholders. The purpose of the meeting was to learn more about the Family First Act, and how it could be implemented in North Carolina.
- ◆ June 13 – Social Services Commission Meeting: Two CSF team members gave a presentation to during this June meeting.

- ◆ June 14 – Family Advisory Council Meeting: Two CSF team members met with the members of the Family Advisory Council and asked prepared questions.
- ◆ June 14 – Interview with Lisa Cauley: Two CSF team members conducted this interview via Adobe Connect.
- ◆ June 15 – Meeting with the Duke Endowment: CSF conducted an interview with two project officers from the Duke Endowment, Tamika Williams and Phil Redmond.
- ◆ June 15 – Meeting with the Administrative Office of the Courts: CSF met with the AOC to discuss the Court Improvement Project, the data being used to improve practice, and the partnership between the judiciary and child welfare.
- ◆ June 25 – Third Sector Meeting on Adoption Promotion: CSF participated in this meeting to learn more about North Carolina’s effort to use data and financing to promote adoptions.
- ◆ July 2 – Interview with Kristin O’Connor: Two CSF team members conducted this interview by telephone.

In addition, CSF set up an email address, which was distributed at meetings at the county and state level for people to email any feedback, questions, or concerns that they were not able to share, or did not feel comfortable sharing in the sessions CSF attended. This feedback is also incorporated throughout the document.

### ***G. Facilitation of the Theory of Change Session***

CSF facilitated a session on July 9 and 10 in Durham, North Carolina to solicit ideas and input for this report. Just over 30 state DHHS/DSS child welfare and county DSS leaders worked with our team from CSF and national experts to:

- ◆ Explore and respond to data and information gathered about the child welfare system in North Carolina;
- ◆ Understand the evidence for creating a trauma-informed, culturally-competent, family-centered, safety-focused child welfare system;
- ◆ Connect with DSS colleagues from across North Carolina;
- ◆ Incorporate the voices of children, youth, birth parents, relative caregivers, and foster parents into strategic directions for North Carolina’s reform plan;
- ◆ Consider a draft North Carolina theory of change; and
- ◆ Provide insight regarding some of the key components of North Carolina’s draft theory of change that will impact CSF recommendations.

Participants were chosen based on recommendations from the North Carolina Association of County Social Services Directors (NCACDSS) and the leadership within the state DHHS/DSS.

## II. CURRENT CHILD WELFARE SYSTEM IN NORTH CAROLINA

North Carolina has a state-supervised, county-operated child welfare system. The state DSS is responsible for developing policy and for providing training, technical assistance, and supervision to county departments of social services (or consolidated departments of human services) that provide statutorily-required child welfare services to children and families. The state has 100 counties that vary in population from less than 10,000 to more than 1,000,000 people. Throughout this report, we compare counties using the University of North Carolina (UNC) Management Assistance website categorization of ten large counties with a total child population of about 1,000,000; 39 medium counties with a total child population of 950,000; and 51 small counties with a total child population of about 300,000. This system of categorizing counties also is currently used by state office's program monitoring team.

North Carolina has made significant efforts over the last decade to improve child welfare practice. These efforts have included policy changes to reflect emerging best practices in the field, initiatives such as Project Broadcast and Triple P to provide services to children and families that are trauma-informed, holistic, and evidence-supported, and a host of other changes. However, despite such promising initiatives, North Carolina faces continued challenges in some areas of effectively serving children and their families and ensuring their safety, permanence, and well-being, revealed through recent program reviews and tragedies involving children who had come to the attention of the child welfare system. As CSF began its assessment, DHHS and county DSS continued to engage in ongoing efforts to respond to the challenges and make system improvements.

CSF's recommendations to improve child welfare practice and child and family outcomes in North Carolina are made in the context of: 1) the organizations and entities that impact everyday practice and outcomes; and 2) recent system dynamics.

### *A. Organizations and Entities that Impact Practice and Outcomes*

#### **DHHS/DSS Central Office**

The North Carolina Department of Health and Human Services (DHHS) is a large cabinet-level state department with 30 divisions and offices that fall into four broad service areas: health, human services, administrative, and support functions. The divisions of Social Services, Aging and Adult Services, and Early Childhood and Education are within the human services program area, while Public Health and Mental Health, Developmental Disabilities, and Substance Abuse (MH/DD/SA) services are among the divisions within the health area.

Within DHHS, the Division of Social Services is primarily responsible for providing supervision and support to the 100 county departments of social services that provide child welfare services. Major functions of DSS related to provision of child welfare services include:



1. Child welfare policy development.
2. Technical assistance to counties, including answering county questions about policy and its application.
3. In-person and online training, including pre-service training, to county child welfare staff.
4. Liaison with and accountability to the federal Administration of Children and Families.
5. Performance and compliance monitoring of county child welfare programs or CQI.
6. Approving licenses of county and private agency foster homes and therapeutic homes.
7. Providing mechanisms for counties to pull down federal and state funding for child welfare services.
8. Directly contracting with private vendors for services that support child welfare outcomes, including prevention services and intensive family preservation services.
9. Providing timely information to the 100 counties about changes in law, policy, and funding.
10. Guidance to counties on coordinating service efforts.

House Bill 630, passed by the legislature in 2017 (S.L. 2017-41), strives to strengthen DHHS's supervision of the counties by requiring written agreements with provisions for corrective action and state intervention and by requiring the development of regional supervision of counties.

### **DSS County Offices and Governments**

Each of North Carolina's 100 counties operates its own child welfare program within its own department of social services. Counties in North Carolina are governed by county commissions that appoint county managers and raise funds primarily through property taxes. Counties vary in population from over 1,000,000 (Wake and Mecklenburg) to under 10,000 (Terrell, Hyde, Graham, and Jones). Counties have the option of combining their social services and health departments into a consolidated human services department and have several options for creating a governing board of social services or human services. Most county DSS and Human Services directors report directly to their governing boards.

Each county child welfare program is responsible for:

- ◆ Screening reports of suspected child abuse, neglect, and dependency, using a structured intake process.
- ◆ Providing assessments of reports using a multiple-response system to assess safety and the need for ongoing CPS services.
- ◆ Providing CPS In-Home Services for children found to be maltreated if there is ongoing risk and the children can be safely maintained in the home.
- ◆ Providing case management for foster care and adoption services for maltreated children who cannot safely remain in their homes.

The majority of counties also license and supervise some of the foster homes where children are placed. DSS Central Office employees in Black Mountain, North Carolina, are responsible for reviewing and approving licensure materials.

### **The Court System, Including the Judiciary, Attorneys, and the Guardian Ad Litem Offices**

North Carolina's 100 counties are apportioned into 43 judicial districts. A DSS director or director's designee can petition the district court alleging that a juvenile is abused, neglected, or dependent and requesting court intervention. Although the majority of petitions request custody of the juvenile (and a petition is required for a county to take custody of a juvenile), counties also have the option of requesting court intervention to compel parents' cooperation with a CPS assessment or critically-needed services. Parties to court hearings are the county, parents (represented if needed by court-appointed attorneys), and the guardian ad litem (appointed by the court to represent the interests of the juvenile). The guardian ad litem program is operated by the state Administrative Office of the Courts or AOC. Each judicial district has a guardian ad litem administrator who recruits and trains volunteers who are represented by a guardian ad litem attorney in hearings.

North Carolina's juvenile code outlines a series of required court hearings and timeframes beginning with a seven-day hearing, proceeding through adjudication and disposition, permanency-planning hearings, and if necessary, termination of parental rights hearings. At each hearing, the court makes findings and issues orders based on information and recommendations put forward by the parties.

### **The MH/DD/SAS System, Including the LME/MCOs and Private and Not-For Profit Providers**

North Carolina's Mental Health, Developmental Disability, and Substance Abuse system has undergone rapid change over the past 15 to 20 years with additional changes anticipated as part of the state vision for Medicaid reform. Prior to mental health reform efforts, a system of 42 local area programs provided direct MH/DD/SA services; in several steps, the local programs consolidated and transformed into seven regional Local Management Entities/Managed Care Organizations (LME/MCOs) that are responsible for assessing their catchment area's needs, developing networks of private vendors, and authorizing services based on medical necessity criteria. As will be detailed in Chapter 3, many county departments of social services report that accessing services for both children and parents has become more difficult. DHHS's current vision is to integrate behavioral health into physical health as part of a statewide Medicaid reform plan. However, individuals with complex behavioral health needs (possibly including foster children) may have physical health services integrated into a tailored behavioral health services plan.

### **Private Child Placing Agencies**

In North Carolina, both county departments of social services and private placing agencies can recruit, train, license, and supervise foster homes and receive a board rate for the families and an administrative rate to cover the costs of recruitment, training, licensure, and supervision. Most county agencies choose to license foster homes within their county but also place some children in privately-licensed homes. A few counties use privately-licensed homes almost exclusively.

Additionally, many private placing agencies operate therapeutic home programs, for which they receive the foster care board rate plus a larger daily Medicaid treatment rate. Some private placing agencies also operate congregate care facilities that bill board rates established for their facility. The board rates received by private placing agencies are funded by a combination of federal, county, and state funds. Some of the private placing agencies also provide other services in addition to placements, for which they receive reimbursement under state contracts described below. In North Carolina, responsibility for case management of children in foster care placed with private agencies remains with the counties.

### **Agencies Providing Services on State Contracts**

The state DSS office also maintains contracts with a number of private and not-for-profit vendors for services, such as:

- ◆ Intensive family preservation;
- ◆ Adoption promotion;
- ◆ Post-adoption support;
- ◆ Prevention services;
- ◆ Multi-systemic therapy and transitional living services;
- ◆ Family support;
- ◆ Training and coaching in trauma-focused, evidence-supported treatments; and
- ◆ Child medical and forensic evaluations.

State contracts are funded with federal, special state, or foundation funds. Some contracts are bid on competitively (i.e., family preservation), while others are structured to incentivize outcomes (i.e., adoption promotion).

### **Private Philanthropy**

Private philanthropy in North Carolina provides funding and expertise to help individual counties and the state engage in innovative or evidence-supported practices to improve outcomes for children and families. Foundations offer assistance to the state and counties for planning and provide expert consultation to the state and counties on promising initiatives and national trends. Casey Family Programs, Annie E. Casey, and the Duke Endowment are among the philanthropic organizations that have been active in supporting both the Central Office and individual counties in North Carolina.

### **Colleges and Universities**

North Carolina is home to a large, highly-rated public university system and well-known private colleges and universities. The state Division of Social Services and also some county departments of social services have partnered with universities in several notable ways over the years including:

- ◆ The North Carolina Child Welfare Education Collaborative, a program that prepares MSW and BSW students specifically for careers in child welfare and operates in multiple public universities throughout the state. Graduates of the program have satisfied North Carolina's

pre-service training requirements. Significant financial assistance offered to students in exchange for a county child welfare employment service commitment has been phased out in recent years.

- ◆ The state has significant financial contracts with both UNC and North Carolina State University (NC State) for development of training, including online training modules.
- ◆ NC State is currently helping the state develop its Family Advisory Council.
- ◆ DHHS and county departments have occasionally collaborated with universities on program evaluation and child welfare related research.

### **Public Health**

North Carolina DHHS has a Public Health division, and each county in North Carolina operates a health department. Public Health in North Carolina has several primary prevention initiatives related to child abuse and neglect, including nurse-family partnership programs.

In recent years, the North Carolina Legislature explicitly allowed county departments of social services and of health to form combined county human services agencies, and a number of counties have chosen that option. Public Health is a natural partner with social services in efforts to support parents, reduce child maltreatment, and reduce child fatalities.

### **The North Carolina Legislature**

The North Carolina legislature is responsible for passing laws that govern, and budgets that partially fund child welfare in North Carolina. Members of the legislature take an active interest in child welfare and serve on a number of committees that provide oversight and support to child welfare issues. S.L. 2017-41, in addition to commissioning social services and child welfare reform plans; requires the state to regionalize supervision of county departments of social services; increases accountability of counties to the state; creates a social services working group and child welfare transformation council; and includes specific measures to improve child safety in reunifications, shorten the appeals process for termination of parental rights decisions, facilitate therapeutic home licensing, and establish a pilot project to help foster youth get driver's licenses.

### ***B. Recent Child Welfare System Dynamics***

Data from North Carolina staffing reports in *Figure 12* in Chapter 3 indicate the overall proportion of screened-in and accepted child abuse and neglect reports have stayed relatively constant over the past three years, with an average of more than 11,000 reports being received per month and approximately 7,000 reports or 65 percent of those reports having been accepted.

North Carolina's Multiple Response System (MRS) allows CPS assessments to be assigned to one of two tracks. All reports of abuse and specified reports of neglect must be assigned to the investigative track; most reports of neglect are assigned to a family assessment track that is designed to be less threatening and more positively engaging for families. Over the past five fiscal years, the number of completed CPS investigative assessments has decreased from 15,981 to 13,658, while the number of completed CPS family assessments has increased from 50,105 to 51,504 (see *Figures 8 and 9* in Chapter 3). The percentage of CPS investigative assessments resulting in a positive finding of maltreatment has remained relatively constant (varied between 26% and 28%) with the vast majority of positive findings being for neglect.

The percentage of family assessments with positive findings of maltreatment has remained around 17 percent during the same time period. *Services needed*, which means maltreatment was found and the family was referred to CPS In-Home Services, was the finding in 10 percent of these family assessments in FY 2017. *Services provided, no longer needed*, the other family assessment finding that indicates maltreatment was found, was the decision in another seven percent of family assessments.

The number of open CPS In-Home Services cases has decreased over the past three years, as shown in *Figure 18* in Chapter 3. Data from the North Carolina 2017 Master Child Welfare Workforce Data Book show the number of families receiving CPS In-Home services on the last day of each month decreasing from 4,760 in January 2015 to 4,118 in November 2017. The decrease may be due to fewer families being referred for these services, a decrease in the length of time these cases are open, or a combination of both.

Initial entry-level cohort data indicate an increasing number of children entered foster care for the first time in North Carolina in recent years.

**Figure 2: Children Entering Foster Care for First Time in North Carolina, SFY 2014-2017**

		Age 0-5		Age 6-12		Age 13-17		Missing DOB		Total
		#	%	#	%	#	%	#	%	
<b>Large</b>	SFY 14	1000	50.8%	548	27.9%	417	21.2%	3	0.2%	1968
	SFY 15	1049	52.7%	527	26.5%	411	20.7%	2	0.1%	1989
	SFY 16	1074	56.3%	503	26.4%	330	17.3%	1	0.1%	1908
	SFY 17	1038	53.2%	530	27.1%	376	19.3%	9	0.5%	1953
<b>Medium</b>	SFY 14	1269	55.0%	615	26.6%	423	18.3%	2	0.1%	2309
	SFY 15	1207	52.9%	693	30.4%	378	16.6%	3	0.1%	2281
	SFY 16	1294	53.6%	719	29.8%	400	16.6%	1	0.0%	2414
	SFY 17	1444	54.2%	817	30.7%	401	15.0%	4	0.2%	2666
<b>Small</b>	SFY 14	512	52.5%	286	29.3%	177	18.2%	0	0.0%	975
	SFY 15	518	53.8%	255	26.5%	189	19.6%	1	0.1%	963
	SFY 16	522	50.4%	324	31.3%	188	18.2%	1	0.1%	1035
	SFY 17	601	55.2%	307	28.2%	179	16.4%	2	0.2%	1089
<b>Statewide</b>	SFY 14	2781	53.0%	1449	27.6%	1017	19.4%	5	0.1%	5252
	SFY 15	2774	53.0%	1475	28.2%	978	18.7%	6	0.1%	5233
	SFY 16	2890	54.0%	1546	28.9%	918	17.1%	3	0.1%	5357
	SFY 17	3083	54.0%	1654	29.0%	956	16.8%	15	0.3%	5708

Source: Retrieved on June 30, 2018 from the University of North Carolina at Chapel Hill Jordan Institute for Families website.  
 URL: <http://ssw.unc.edu/ma><sup>15</sup>

*Figure 3* below compares the entry rate per 1,000 children in the large, medium, and small counties. As can be seen, the rate of entry per 1,000 children into foster care is lowest in the large counties, higher in the medium counties, and highest in the small counties. A slightly higher percentage of these children are male.

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<sup>15</sup> Ibid.

**Figure 3: Rate of Children Entering Foster Care Per 1,000 Children in Population by County Size**

		Rate of Placement
<b>Large</b>	SFY 12	1.67
	SFY 13	1.71
	SFY 14	1.94
	SFY 15	1.94
	SFY 16	1.85
<b>Medium</b>	SFY 12	2.16
	SFY 13	2.29
	SFY 14	2.42
	SFY 15	2.40
	SFY 16	2.54
<b>Small</b>	SFY 12	2.54
	SFY 13	2.81
	SFY 14	3.11
	SFY 15	3.11
	SFY 16	3.36

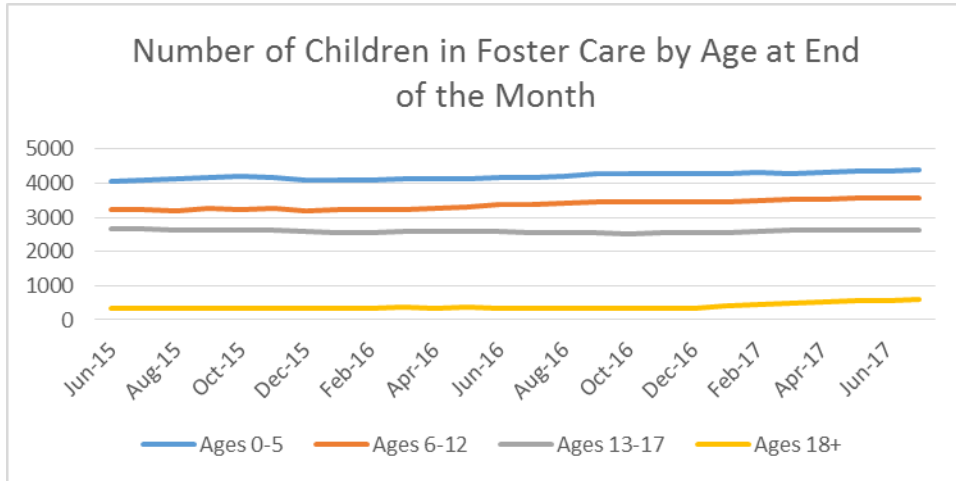
Source: Retrieved on June 30, 2018 from the University of North Carolina at Chapel Hill Jordan Institute for Families website. URL: <http://ssw.unc.edu/ma/><sup>16</sup>

The next three figures focus on caseload counts at the end of the month for the last three years. Caseload counts combine the dynamics of entry and time in care to provide a representation of system dynamics at a point in time. These data indicate that the number of children in foster care at the end of each month has increased over the last three years, particularly in the last year. On June 30, 2015, there were 10,288 children in foster care; the next year on that same date there were 10,439 children in foster care; and then on June 30, 2017, there were 11,113.

*Figure 4* shows the number of children in foster care by age. Children under the age of six represent the largest age group in foster care, followed by children six to 12, and then children 13 to 18. The numbers of children under six and six to 12 have increased in recent years, while the number of teenagers has been fairly stable. While older youth ages 18 and up make up a much smaller percentage of the children in care in North Carolina, the increase in their numbers the past 18 months indicates more youth are opting to remain in care to take advantage of North Carolina’s new foster care 18-21 program.

<sup>16</sup> Ibid.

**Figure 4: Number of Children in Foster Care by Age**

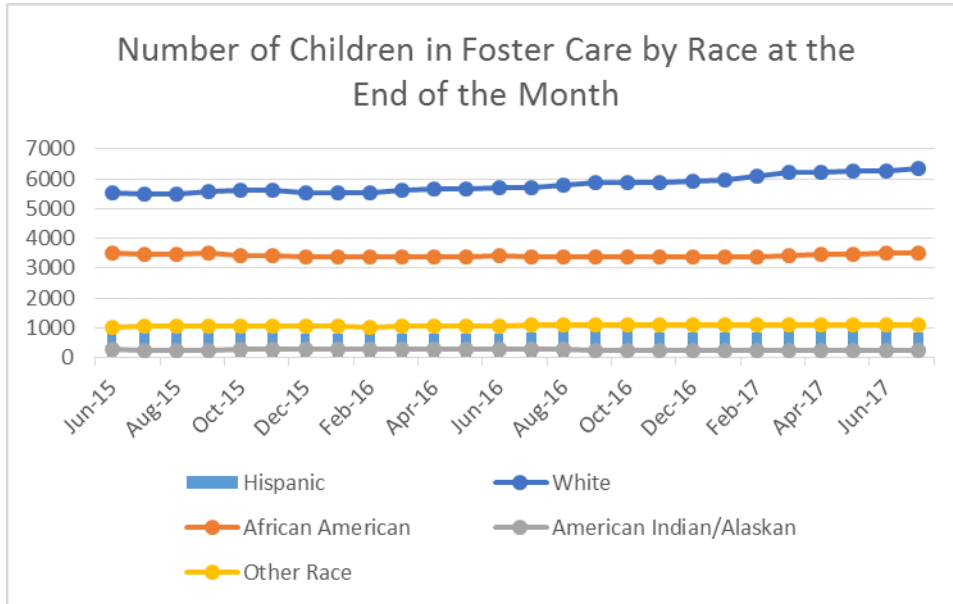


Source: Retrieved on June 30, 2018 from the University of North Carolina at Chapel Hill Jordan Institute for Families website. URL: <http://ssw.unc.edu/ma/><sup>17</sup>

Figure 5 below shows the number of children in custody at the end of the month over the last three years by race. The lines connecting dots represent the numbers of children by race, and the teal bars represent the numbers of children of all races with Hispanic origin. The numbers of children in foster care for all races and Hispanic designations have remained relatively consistent over the last three years, with the exception of those children identified as white, whose numbers have gradually increased. The recent trend has reduced the degree to which African American children are over-represented in foster care compared to white children in North Carolina. According to the 2010 census, 65.04 percent of North Carolina’s children are white and 26.43 percent are black.

<sup>17</sup> Ibid.

**Figure 5: Number of Children in Foster Care by Race and Hispanic Designation**



Source: Retrieved on July \*, 2018 from the University of North Carolina at Chapel Hill Jordan Institute for Families website.

URL: <http://ssw.unc.edu/ma/><sup>18</sup>

Note: Hispanic designation is a duplicate count across all races

As previously noted, the number of children entering foster care in North Carolina has increased in recent years. The proportion of children initially placed with relative caregivers has increased, while those placed in traditional foster home settings has decreased. The number of children and youth initially placed in a group home spiked in SFY 2016, however, has since decreased again and is closer in line with previous trends. This is highlighted in *Figure 6* below.

<sup>18</sup> Ibid.



**Figure 6: Initial Placements for Children Entering Foster Care**

	July 2012- June 2013	July 2013- June 2014	July 2014- June 2015	July 2015- June 2016	July 2016- June 2017
<b>Number of Children</b>	<b>4807</b>	<b>5252</b>	<b>5233</b>	<b>5355</b>	<b>5707</b>
Own Home	149	139	107	132	145
Relative	1557	1684	1733	1971	2049
Foster Home	1956	2147	2098	1929	2094
Group Home	321	301	325	416	349
Hospital	199	205	277	247	311
Emergency Shelter	100	97	73	78	77
Court Approved	192	342	302	330	381
Therapeutic Home	172	136	134	96	125
Jail/Detention	43	57	39	31	37
Runaway	19	31	46	35	32
DACJJ Residential Facility	14	8	8	9	14
Other	3	9	4	3	1
Missing Data	82	96	87	78	92
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
Own Home	3%	3%	2%	2.5%	2.5%
Relative	32%	32%	33%	37%	36%
Foster Home	41%	41%	40%	36%	37%
Group Home	7%	6%	6%	8%	6%
Hospital	4%	4%	5%	5%	5.5%
Emergency Shelter	2%	2%	1.5%	1.5%	1.5%
Court Approved	4%	6.5%	6%	6%	7%
Therapeutic Home	3.5%	2.5%	2.5%	2%	2%
Jail/Detention	1%	1%	1%	.5%	.6%
Runaway	0.5%	0.5%	1%	0.5%	0.5%
DACJJ Residential Facility	0.3%	0.15%	0.15%	0.17%	0.25%
Other	.06%	.017%	0.08%	0.06%	0.02%
Missing Data	1.5%	2%	1.5%	1.5%	1.5%

Source: Retrieved on April 19, 2018 from the University of North Carolina at Chapel Hill Jordan Institute for Families website.  
 URL: <http://ssw.unc.edu/ma/>.<sup>19</sup>

Figure 7 below shows that the percentage of children experiencing just one placement in their first year in care has increased slightly to 43 percent while the number of children experiencing two placements in their first year has decreased slightly over the past five years. The percentages of children with higher numbers of placements in the first year are similar to five years ago, with 18 percent of children experiencing four or more placements in their first year.

<sup>19</sup> Ibid.

**Figure 7: Placement Stability in the First Year of Foster Care**

Number of Placements	July 2012- June 2013	July 2013- June 2014	July 2014- June 2015	July 2015- June 2016	July 2016- June 2017
Total Number of Children	4807	5252	5233	5355	5707
1 Placement	1923	2037	2077	2211	2447
2 Placements	1293	1313	1376	1223	1320
3 Placements	600	723	665	692	747
4 or More Placements	853	1028	987	1095	1039
No Countable Placements	138	151	128	134	154
<b>Total</b>	100%	100%	100%	100%	100%
1 Placement	40%	39%	40%	41%	43%
2 Placements	27%	25%	26%	23%	23%
3 Placements	12%	13.5%	13%	13%	13%
4 or More Placements	18%	19.5%	19%	20.5%	18%
No Countable Placements	3%	3%	2.5%	2.5%	3%

Source: Retrieved on April 19, 2018 from the University of North Carolina at Chapel Hill Jordan Institute for Families website.

URL: <http://ssw.unc.edu/ma/>

Note: Data for SFY 2017 is censored

The percentage of children achieving permanency within 12 months of entering foster care in North Carolina has remained relatively constant (31-32%) over the past three fiscal years and is below the Round III CFSR national standard of 40.5 percent. Children from smaller and medium size counties are more likely to experience timely permanency than those from larger counties.

Permanency within 12 months for North Carolina children who have been in foster care between 12 and 23 months is slightly higher (45%) than the CSFR national standard of 43.6 percent, with children in small and medium sized counties somewhat more likely to achieve permanence in this timeframe than those from larger size counties. The state’s performance on achieving permanence within a year for children who have already been in custody for two or more years has consistently exceeded the national Round III CFSR performance standard of 30.3 percent and is currently just over 37 percent (more detailed data are available in Chapter 3, Section F).

Finally, North Carolina’s rate of re-entry into foster care has consistently been much lower than the national Round III CFSR standard of 8.3 percent, with large, medium, and small counties all having very low rates of re-entry into care (see Chapter 3, Section E).

When looking at rates of entry into foster care, time to permanency, and re-entry into foster care for small, medium, and large counties in North Carolina, a pattern emerges. Children in smaller counties, compared to larger counties, are more likely to: 1) enter foster care in the first place; 2) stay less time in care before leaving for a permanent home; and 3) re-enter foster care after leaving for permanency.

### III. DETAILED FINDINGS

#### A. Child Protective Services (CPS)

##### Overview

###### **CPS Intake**

North Carolina is a universal reporting state, meaning all persons with reason to suspect that a child is abused, neglected, or dependent are required to report that information to their county department of social services. North Carolina does not have a centralized state report hotline; all 100 county departments of social services are responsible for accepting, screening, and responding to reports on a 24/7 basis. Reports are most frequently received by telephone, and counties are required to follow a structured intake protocol to determine:

- ◆ Whether to accept the report for assessment;
- ◆ The child’s county of residence, which determines the county with lead responsibility for conducting the assessment;
- ◆ The required response time (72 hours, 24 hours, or immediate); and
- ◆ The appropriate assessment track (investigative assessment or family assessment).

North Carolina implemented a structured intake protocol after the state Supreme Court ruled *In Re Stumbo* on July 16, 2003 that CPS does not have authority to begin a CPS investigation unless the information alleged in a report, if true, would satisfy the definitions of child abuse, neglect, or dependency in North Carolina statutes. The court opinion further stated that conduct meeting the definition of neglect was either severe or dangerous conduct, or a pattern of conduct potentially or actually causing injury to the juvenile. Consistent with the ruling, North Carolina policy allows counties to consider their own agency history to assess whether a pattern of conduct exists but forbids counties from gathering any information from outside sources before making a screening decision. The structured intake protocol includes questions to ask reporters and tools for making screening decisions.

###### **CPS Investigative and Family Assessments**

North Carolina is one of many states that has adopted a differential response approach on the theory that CPS will be more successful protecting children and strengthening families if it tailors its response to the type of report. North Carolina’s Multiple Response System (MRS) is a two-track approach.

1. A traditional investigative assessment track *must* be used for reports classified as abuse and special categories of reports classified as neglect (e.g., reports involving a foster child or a hospitalized child), should be used for reports of “serious neglect,” and may be used for other reports of neglect judged likely to benefit from that approach. Investigative assessments prioritize determining whether allegations of maltreatment occurred. They are often conducted together with law enforcement because the maltreatment allegations are more likely also to be criminal offenses. Children may be interviewed at the beginning of the

investigative assessment before parents are notified. The case decision in the investigative track is to substantiate or unsubstantiate that maltreatment occurred, and positive findings specify which perpetrator(s) committed which type(s) of maltreatment against which child(ren) in the household. The names of persons determined to have perpetrated abuse or serious neglect go on a responsible individuals list (RIL) that can be used to screen persons for certain jobs working with children and to be foster or adoptive parents.

2. A family assessment track *may* be used for most reports classified as neglect. Family assessments are intended to be less threatening and to positively engage parents in services that will help them safely care for their children. A family assessment typically begins with a call to a parent to set up an initial interview and has a greater emphasis on assessing a family's strengths and needs jointly with the family and connecting the family to services. A family assessment can result in one of four case decisions:
  - a. **Services needed:** means neglect or dependency was found and future risk is high enough to require involuntary ongoing CPS services.
  - b. **Services recommended:** means CPS made well-being recommendations, but did not find safety or future risk issues meriting ongoing involvement with the family.
  - c. **Services not recommended:** means CPS did not find safety or future risk issues meriting ongoing involvement with the family.
  - d. **Services provided, no longer needed:** means neglect or dependency was found and risk was high enough to require ongoing CPS services, but successful services were provided during the assessment and CPS is ending its involvement with the family.

No perpetrator is named in the case decision for a family assessment, and adults in a family found in need of services do not have their names placed on the RIL.

According to administrative data below on case decisions, North Carolina used family assessments to complete 79 percent of CPS assessments in FY 2017. Although this is a higher percentage than in most states, North Carolina's family assessments include many elements of a traditional investigative response. In North Carolina, both the investigative and family track require:

- ◆ Reports to meet statutory definitions of child maltreatment;
- ◆ CPS to have face-to-face contact with all children in the household within the timeframe established for the assessment (the new modified manual requires each child to be seen individually in both approaches).
- ◆ CPS to have face-to-face contact with all parents or caretaking adults in the household on the same day as the children are first seen.
- ◆ The assessment worker to use the same structured decision-making (SDM) tools including a safety assessment at initiation and a safety plan when safety issues are identified.
- ◆ CPS to conduct checks of criminal records, the Central Registry, and the agency's own CPS records.
- ◆ CPS to have ongoing contacts with the children and parents throughout the course of the assessment and to contact collaterals named by the family.

- ◆ Caseloads to be no greater than ten open assessments per caseworker and five caseworkers per supervisor.
- ◆ Ongoing supervisory review including two-person decision making on safety plans and case decisions.

Both assessment tracks allow CPS to refer families to mandatory CPS In-Home Services and to petition the juvenile court for custody or other intervention either during the assessment or subsequently during the provision of in-home services. In both tracks, all children living in a household are considered potential victim children and are included in the assessment. CPS can switch tracks after an assessment begins if it believes the other track would be more appropriate based on what has been found.

CPS assessments often require cooperation across county lines. The county responsible for conducting a CPS assessment may need to request assistance from another county for multiple reasons such as:

- ◆ A child's parents do not both live in the same county.
- ◆ A child or parent is temporarily staying in another county.
- ◆ A parent proposes an adult living in another county as a safety resource.

Additionally, CPS assessments that present a conflict of interest for a county (e.g., a report involving a foster child, DSS employee, or county official), must be completed by another county after the home county initiates. Data from the 2017 staffing survey indicated that counties assisted other counties on an average of 906 CPS assessments a month, suggesting that about 10 percent of CPS assessments require cooperation between the county primarily responsible and at least one other county.

*Figure 8* shows case decision totals for investigative assessments for five fiscal years ending in SFY 2017. The percentage of CPS investigative assessments ending with a substantiation that maltreatment occurred varied between 26 and 28 percent during the five-year period. The majority of substantiations (between 72% and 75%) were for neglect. When an investigative assessment determines that maltreatment has occurred, the county can refer the family for CPS In-Home Services or petition for custody if necessary for safety. Counties also have the option of closing the case if they determine the risk of future maltreatment is low.

**Figure 8: CPS Investigative Assessment Findings**

CPS Investigative Assessment							
	Substantiated				Unsubstantiated	Total	Percent Substantiated
	Abuse and Neglect	Abuse	Neglect	Dependency			
July 2012-June 2013	473	488	3,140	132	11,748	15,981	26.5%
July 2013-June 2014	528	466	3,331	133	11,310	15,768	28.3%
July 2014-June 2015	475	514	3,240	129	11,557	15,915	27.4%
July 2015-June 2016	485	407	2,757	175	10,155	13,979	27.4%
July 2016-June 2017	491	384	2,570	119	10,094	13,658	26.1%

Duncan, D.F., Kum, H.C., Flair, K.A., Stewart, C.J., Vaughn, J.S., Guest, S., Rose, R.A., Malley, K.M.D. and Gwaltney, A.Y.(2018).Management Assistance for Child Welfare, Work First, and Food & Nutrition Services in North Carolina (v3.2). Retrieved [4/17/18], from the University of North Carolina at Chapel Hill Jordan Institute for Families website. URL: <http://ssw.unc.edu/ma/>

Figure 9 below presents findings for family assessments for five fiscal years ending in 2017.

**Figure 9: CPS Family Assessments 2012 to 2017**

	CPS Family Assessment								Total
	Services Needed		Services Provided, No Longer Needed		Services Recommended		Services Not Recommended		
	#	%	#	%	#	%	#	%	
July 2012-June 2013	4,651	9.3%	3,695	7.4%	17,505	34.9%	24,254	48.4%	50,105
July 2013-June 2014	5,009	10.0%	3,483	7.0%	17,957	36.0%	23,462	47.0%	49,911
July 2014-June 2015	4,972	9.9%	3,549	7.1%	17,980	35.8%	23,787	47.3%	50,288
July 2015-June 2016	5,211	10.2%	3,889	7.6%	17,912	35.1%	24,012	47.1%	51,024
July 2016-June 2017	5,041	9.8%	3,735	7.3%	17,122	33.2%	25,606	49.7%	51,504

Duncan, D.F., Kum, H.C., Flair, K.A., Stewart, C.J., Vaughn, J.S., Guest, S., Rose, R.A., Malley, K.M.D. and Gwaltney, A.Y.(2018).Management Assistance for Child Welfare, Work First, and Food & Nutrition Services in North Carolina (v3.2). Retrieved [4/17/18], from the University of North Carolina at Chapel Hill Jordan Institute for Families website. URL: <http://ssw.unc.edu/ma/>

In SFY 2017, CPS found *services needed* and referred families to CPS In-Home Services in 5,041 of the 51,504 (10%) family assessments. Although CPS ended its involvement with the family at the completion of the remaining 90 percent of family assessments, efforts were made during a substantial number of those assessments efforts to connect families to services. In slightly over one-third of family assessments (17,122 of the 51,504), the finding was *services recommended*, meaning families were encouraged, but not required to participate in community-

based services, either because no maltreatment was found or because the risk level was low. In about 7 percent of family assessments, CPS found *services provided, no longer needed*, meaning that maltreatment was found but that services provided during the assessment had reduced the risk so that ongoing services were no longer necessary.

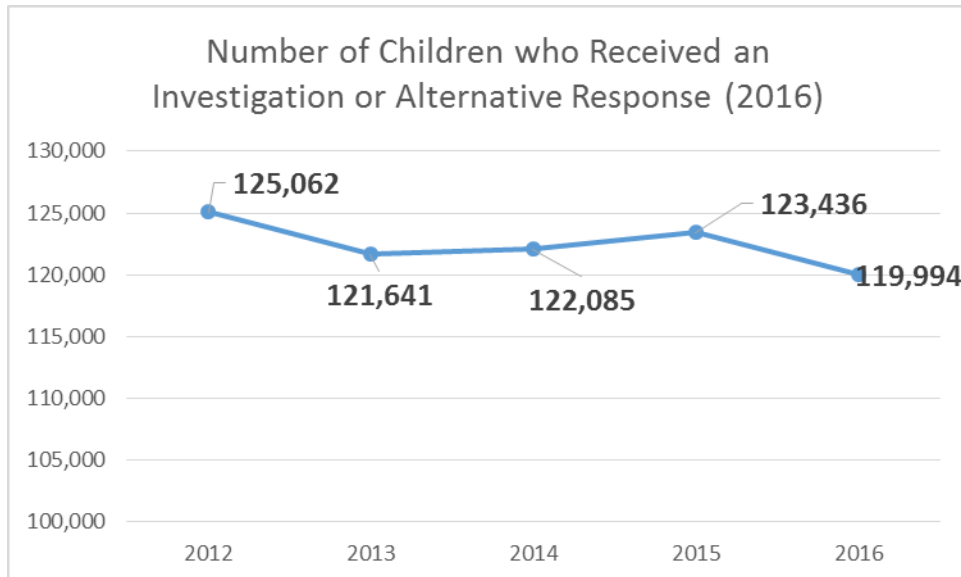
Figure 10 below shows that the percentage of CPS assessments completed as family assessments increased from 76 to 79 percent between 2002 and 2017.

**Figure 10: CPS Investigative and Family Assessment Totals 2012 to 2017**

	Investigative Assessments	Family Assessments
July 2012-June 2013	15,981 24%	50,105 76%
July 2013-June 2014	15,768 24%	49,911 76%
July 2014-June 2015	15,915 24%	50,288 76%
July 2015-June 2016	13,979 22%	51,024 78%
July 2016-June 2017	13,658 21%	51,504 79%

Figure 11 below shows the unique number of children in North Carolina each year who were involved in a CPS investigative or family assessment that was completed and reported to the Children’s Bureau from 2012 to 2016.

**Figure 11: Child Maltreatment Reports, Children’s Bureau**



Source: Children’s Bureau. Child Maltreatment Report 2016. Administration for Children and Families. US DHHS. Retrieved from: <https://www.acf.hhs.gov/sites/default/files/cb/cm2016.pdf>

About 120,000 were included in completed assessments in 2016, slightly fewer than 2012. The number involved is greater than the number of completed CPS assessments because a CPS

assessment includes all children in the household. Children included in more than one completed CPS assessment in a year are only counted once for that year in the figure above.

**Sources of Information**

- ◆ Administrative Data:
  - UNC Management Assistance website
  - County Child Welfare Staffing Workbook Data
  - NC Legacy Data
  - Child Maltreatment Report 2016 Children’s Bureau
- ◆ Case Review Data:
  - Program Monitoring Review Data
  - OSRI Data
- ◆ Focus Groups:
  - Intake staff
  - CPS workers
  - CPS supervisors
- ◆ Surveys:
  - CPS Survey

**Detailed Findings**

<p><b><u>Primary Research Question:</u></b> (CPS)</p>	<p><i>Are children and their household members who come to the attention of the child welfare system through reports of maltreatment receiving a response that ensures children are safe from immediate threats to their health safety and future risk of harm?</i></p>
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Data that was gathered and analyzed as part of the assessment process suggests that children and families in North Carolina who come to the attention of the child welfare system through a report of maltreatment are not consistently receiving a response that ensures the immediate safety of children and protects them risk of future harm. In reaching this conclusion, CSF examined whether:

- ◆ Maltreatment reports are being screened appropriately;
- ◆ CPS assessments are being initiated and completed timely;
- ◆ Safety and risk are being appropriately assessed and addressed during the assessment; and
- ◆ Supervision is occurring during the assessment process.

While examples of positive CPS practices were observed and we were impressed by the dedication and skill of the professionals with whom we spoke, key safety- and risk-related practices required by policy are not being performed consistently.



CPS is required to use a structured intake process to screen reports of suspected maltreatment before beginning a CPS assessment to determine whether the information, if true, would constitute child abuse, neglect, or dependency under North Carolina law. The statewide average rate of screening in CPS reports at Intake has remained relatively stable in recent years at approximately 65 percent. The Central Office program monitoring team reviews of CPS intakes found that decisions to screen-in and screen-out reports were appropriate over 90 percent of the time. More troubling, however, is that counties appear to differ substantially in how they interpret law and policy regarding what constitutes a CPS report that should be accepted. CSF also inquired about whether all attempts to make CPS reports are received. County staff who participated in focus groups stated that it is sometimes a challenge to answer all calls as they come in. These persons expressed their belief that they successfully return every call that is missed, although there is no additional data available from the state or counties to be able to truly examine this particular issue.

When a report of maltreatment is screened-in for assessment, CPS is required to initiate the report by interviewing all children in the household face-to-face on the same day and within timeframes (72 hours, 24 hours, or immediately) based on the type of report and safety-related circumstances. Case review findings indicate that CPS successfully initiates reports within required timeframes in only about 70 percent of CPS assessments. When cases were not initiated timely, reasons were documented only 25 percent of the time. Case review data also found that CPS assessments are completed within the expected timeframe of 45 days less than 70 percent of the time, with justifications for keeping the assessment longer present about half the time. Results from CPS focus groups and survey data indicate that many staff find meeting the 45-day timeframe for completing assessments to be difficult, with some citing high caseloads, the need to “frontload” services, or being held up by additional requirements, such as Child Medical Exams (CMEs), Child and Family Evaluations (CFEs), and other evaluation or record requests.

Case review data also found that counties consistently complete required safety assessments when they initiate an assessment and that the safety agreements that are developed appear to support the safety of the child. Reviews by the state program monitoring team found, however, that safety assessments are not being consistently updated as new information is revealed nor are required criminal record checks and Central Registry checks on adults living in safety resource homes consistently completed or followed-up on. Perhaps most importantly, case review data suggests that ongoing face-to-face contact with children, parents, and other caregivers, which is a critical casework practice in ensuring the safety of children during the course of an assessment, is only occurring as required approximately 75 percent of the time.

The essential role of the supervisor in overseeing and supporting the critical front-end work with children and families cannot be overstated. Case review data shows that supervisors are generally signing off on the various CPS assessment documents. Encouragingly, CPS workers who responded to a CSF survey overwhelmingly indicated that they have regular interactions with their supervisors regarding their assigned cases and that they find their supervisors to be available, knowledgeable, and there to provide them with needed guidance.

An assessment of North Carolina’s performance conducting CPS assessments must be made in the context of information from the child welfare staffing survey that shows CPS assessment is the program area with the greatest staffing shortages in North Carolina and consistent feedback from counties that current requirements cannot be achieved even when caseload levels are at state standards. This issue is discussed in greater depth in section on workforce later in this Chapter and in the recommendations.

**Sub-Question 1:** *How many reports are made each year to the child abuse hotline? How many of these are screened-in or -out? How many are abandoned?*

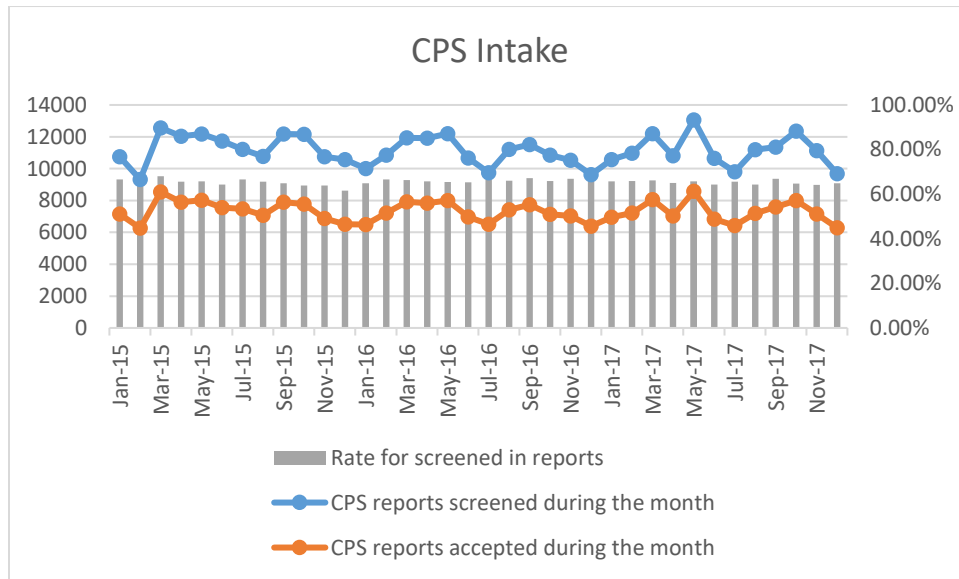
To assess the extent to which reports to the child abuse hotline are being screened-in, -out or abandoned, CSF analyzed data from the Child Welfare staffing workbook, 2017 Program Monitoring Reviews, focus groups with county Intake staff from across the state, and statewide data from a CPS survey conducted by CSF in June 2018.

Figure 12 below represents data on intakes from the Child Welfare staffing workbook and shows the number of reports received statewide, the number accepted, and the percentage accepted over time.

**Key Findings:** *Reports made to the hotline each year:*

- In 2017, counties received 133,771 CPS reports, an average of 11,148 per month.
- The statewide average rate of screened in reports has remained near 65% and been relatively steady over the past three years.
- In focus groups, county staff expressed their belief that that very few calls are abandoned.

**Figure 12: CPS Intake**



Source: North Carolina 2017 Master Child Welfare Workforce Data Book

Over the past three years, an average of over 11,000 reports have been received per month, with an average of just over 7,000 reports being accepted. In 2017, a total of 133,771 reports were received and 87,336 reports were accepted. The statewide average rate of screening-in reports has remained near 65 percent and has been relatively steady. The chart also shows the seasonal

variation in the number of reports with the highest numbers of reports received in the spring and when school goes back into session in the fall. Fewer reports tend to be received during December and January and during summer months, when most schools are not in session. The state standard is for an Intake worker to be able to handle 100 calls a month. Focus groups with county Intake staff indicate that calls are time-consuming, can take up to two hours to complete, and that they are not able to answer each and every call at the time it is received. However, Intake workers felt that they successfully returned almost every call, using caller ID when necessary if a caller did not leave a message. In that sense, most workers agreed that no calls are abandoned.

Figure 13 below shows the sources of accepted CPS reports. As the chart indicates, law enforcement and courts, educational personnel, medical personnel, and human services workers all were significant sources of accepted reports. Assuming anonymous reporters are unlikely to be professionals, almost a third of the reports came from non-professional sources, including relatives, non-relatives, parents, and victim children.

**Figure 13: CPS Reports accepted for Assessment by Referral Source**

	July 2012- June 2013	July 2013- June 2014	July 2014- June 2015	July 2015- June 2016	July 2016- June 2017
<b>Anonymous</b>	7,624	7,165	6,579	6,177	5,665
<b>Care Provider</b>	703	592	562	402	507
<b>Educational Personnel</b>	11,702	11,386	12,316	11,706	12,003
<b>Law Enf./Court Personnel</b>	12,597	12,877	13,206	13,891	13,757
<b>Medical Personnel</b>	8,037	8,737	8,634	9,323	9,849
<b>Relative</b>	6,563	6,469	6,318	6,093	6,183
<b>Non-Relative</b>	6,565	6,482	6,559	5,959	6,172
<b>Human Services</b>	9,053	9,111	9,051	8,676	8,099
<b>Victim</b>	263	193	189	183	210
<b>Parental</b>	4,266	4,115	3,991	3,768	3,713

Duncan, D.F., Kum, H.C., Flair, K.A., Stewart, C.J., Vaughn, J.S., Guest, S., Rose, R.A., Malley, K.M.D. and Gwaltney, A.Y. (2018). Management Assistance for Child Welfare, Work First, and Food & Nutrition Services in North Carolina (v3.2). Retrieved [4/17/18], from the University of North Carolina at Chapel Hill Jordan Institute for Families website. URL: <http://ssw.unc.edu/ma/>

**Sub-Question 2: Were reports screened-in or -out for investigation and assessment appropriately and in accordance with DHHS policy?**

Overall, results from the state’s Program Monitoring team reviews suggest that counties are following DHHS policy on intakes reasonably well. In the course of conducting 2017 reviews, the team determined that reports were screened-in appropriately in 95 percent of the 700 reviewed reports that were screened-in by counties, and 92 percent in more than 100 reports that were screened-out.

Data on reviews of screened-in reports statewide and by county size are presented below.

<b>2017 NC Program Monitoring Review Data</b>				
<b>Select Questions – CPS Assessment Protocol</b>				
Screen-Ins	State	Large	Medium	Small
Was the report screened appropriately according to policy?	95.27% (664/697)	100% (50/50)	95.59% (217/227)	94.52% (397/420)
Was there a two-level review?	96.70% (674/697)	98% (49/50)	97.80% (222/227)	95.95% (403/420)
Was the most appropriate assessment track assigned?	91.38% (689/754)	94.23% (49/52)	93% (226/243)	90.20% (414/459)
Was the response time appropriate to the allegations?	90.85% (685/754)	92.31% (48/52)	93.42% (227/243)	89.32% (410/459)

Data on reviews of 117 reports that were screened-out is presented in the table below.

<b>2017 NC Program Monitoring Review Data</b>				
<b>Select Questions – CPS Assessment Protocol</b>				
Screen-Outs	State	Large	Medium	Small
Was the report screened appropriately according to policy?	92.31% (108/117)	100% (15/15)	86.67% (52/60)	97.62% (41/42)
Was there a two-level review?	95.73% (116/117)	100% (15/15)	100% (60/60)	88.10% (37/42)
Is there justification on the report or attached to it as to why the report did not meet the criteria for acceptance?	95.73% (116/117)	100% (15/15)	98.33% (59/60)	90.48% (38/42)
Does the justification explain why or how the allegations did not meet the criteria for abuse, neglect, and dependency; or otherwise provide a rationale for screening the report out?	86.61% (97/112)	100% (15/15)	76.27% (45/59)	97.37% (37/38)

Reviewers agreed with decisions to screen-out reports in 92 percent of cases reviewed, meaning there was agreement that screened-out reports did not meet legal criteria to be accepted for CPS assessment. Focus groups with Intake staff indicated that if a case is screened-in, it is unlikely to be reversed, adding that, when necessary, they will call a reporter back to request additional information. Participants talked about the fear of “not knowing” and therefore erring on the side of safety. When asked about the advantages and disadvantages of having each county handle its own intake versus having a centralized state hotline, participants generally supported a county-based intake process, citing the advantages of being on a local level, knowing who the callers are, and having a rapport with local stakeholders. Participants also, however, acknowledged that a centralized intake process might improve consistency in screening decisions and that it might also take some of the pressure off of counties, especially those that are understaffed.

CPS survey results (*see below*) suggest CPS assessment workers disagree more frequently than the program monitors with intake decisions to screen-in reports.

*To what extent do you ever disagree with the screening decision made by Intake?*

	Number	Percent
Usually Disagree	5	1.5%
Often Disagree	50	14.7%
Sometimes Disagree	170	50.0%
Rarely Disagree	96	28.2%
Never Disagree	19	5.6%
<b>Total</b>	<b>340</b>	<b>100%</b>

**Key Findings:** Screen-ins/outs of reports in accordance with DHHS policy:

- Program Monitoring Review data suggest that counties are generally following policy as it relates to screening-in and -out reports appropriately.
- CPS survey results suggest that CPS assessment workers disagree more frequently than the program monitors with intake decisions to screen-in reports.
- Data confirms that substantial variation exists among individual counties in the frequency with which they screen-out CPS reports.

The primary reason given by survey respondents for disagreeing with the screening decision is that the intake should have been screened-out (77%), followed by feeling the screening decisions should have been assigned a longer response time.

State leadership indicated in an interview that counties are not consistent with each other in how they screen reports in or out. Consistent with this concern, the chart below, using data from the 2017 Child Welfare staffing survey, shows significant variation across counties in the percentages of CPS reports that are screened-out.

Screen-Out Percentages	< 20%	20-30%	30-40%	40-50%	>50%
Number of Counties	2	29	41	22	6

The following chart suggests county size is not a significant predictor for the percentage of reports that are screened-out.

	Range of Rate of Screen-Out	Average Rate of Screen-Out
Small Counties	15.9%-63.64%	36.52%
Medium Counties	20.14%-53.33%	34.15%
Large Counties	21.45%-49.93%	33.87%

Although the average rate of screening-out reports statewide is 35 percent, the data confirms that substantial variation exists among individual counties in the frequency with which they screen-out CPS reports.

**Sub-Question 3:** *Are investigations initiated and completed in a timeframe that is in accordance with DHHS policy?*

**Timely Initiation:** Initiation of a CPS assessment is defined as having initial face-to-face contact with all children in the household. Initiation is considered timely if it occurs within the response time after receiving the report set by Intake and required by policy. To assess timeliness of initiation, CSF reviewed North Carolina’s performance on Round III of the CFSR, subsequent reviews by state and county teams using the CFSR’s On Site Review Instrument (OSRI), results of 2017 Program Monitoring Reviews conducted in 41 counties, and statewide administrative data based on county submissions to the state.

An estimate of timeliness of initiation can be made using administrative data based on the form that CPS assessment workers submit after completing an assessment that includes the date of the report, the type of maltreatment reported, and the date of initiation. The estimate of timeliness using administrative data is based on whether abuse reports are initiated within one calendar day and neglect reports are initiated within three calendar days. The data provides only an estimate for two reasons:

- ◆ Response times are measured in hours, whereas the administrative data only includes calendar dates. For example, if an abuse report received in the morning was initiated in the evening the next day, the actual response time would be longer than the 24-hour limit.
- ◆ Policy requires CPS Intake to set response timeframes that may be shorter than 24 hours for abuse and 72 hours for neglect if specific safety related factors are present in the report. Shorter response times set by Intake are not included in administrative data.

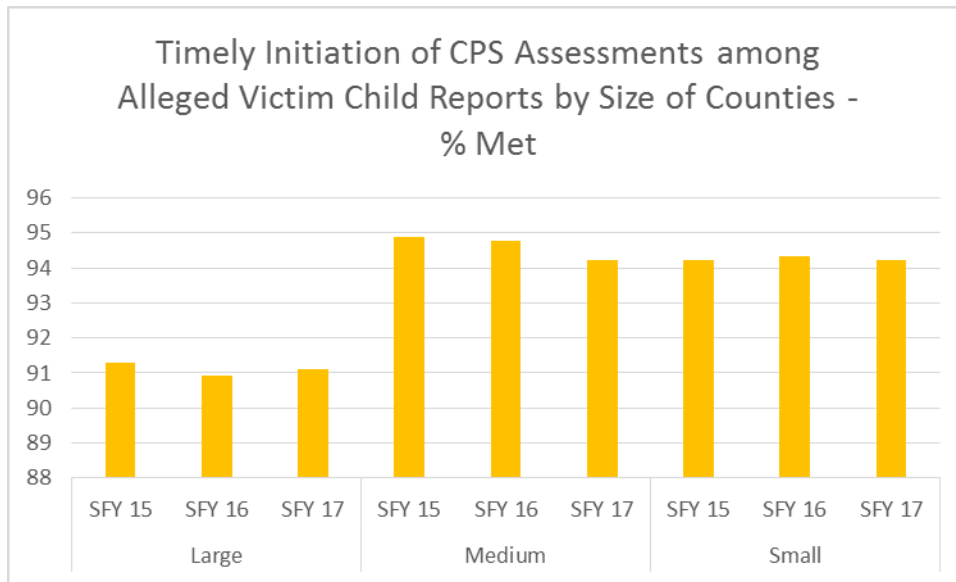
For the two reasons listed above, the administrative data is likely to overestimate the percentage of cases that are initiated within timeframes.

The chart below shows the estimate from administrative data of the percentage of assessments that meet timeframes for initiation in large, medium and small counties over the past three years.

**Key Findings: Timely Initiation**

- Administrative data provides a rough estimate that approximately 92% to 94% of CPS assessments are initiated within timeframes.
- More precise assessment data from reviews of CPS records suggest much lower rates of meeting initiation timeframes.
- Reasons for not making timely initial face-to-face contact with victim children and diligent efforts to do so are not documented consistently.

**Figure 14: Timely Initiation of CPS Assessment Among Alleged Victim Child Reports by Size of Counties (% Met)**



Source: TimelyInitiationData14-15.csv, TimelyInitiationData15-16.csv, and TimelyInitiationData16-17.csv

\* A SFY cohort is defined based on a maltreatment report date.

\*\* An alleged victim child can be reported *with different report dates* more than once within SFY; therefore, the unit of analysis in the table is a child-assessment.

\*\*\* The policy-mandated initiation standards vary by the type reported. The standard for Abuse is 1 day (24hr) and for Neglect it is 3 days (72hr).

*Denominator:* # of unique reports (different report dates) during the SFY of interest

*Numerator:* # of investigative assessments initiated within policy-recommended standards.

On average, the administrative data suggest medium and small counties are meeting initiation timeframes on average 94 percent of the time and large counties are meeting timeframes about 91 percent of the time.

Data from the CFSR On Site Review Instrument (OSRI) and the Program Monitoring team provide a more conservative and probably more accurate measure of timeliness of initiation because the reviewers are able to see the actual timeframes that were set and the number of hours between the report and the initiation, rather than the number of days. The determination of when the initiation takes place is also different. The administrative data is based on the CPS assessment worker’s data entry. The OSRI and Program Monitoring determination are based primarily on documentation in the record that all children in the household were seen on the same day and within the timeframe. OSRIs conducted by DHHS in 2017-2018 (as of 7/2/18) indicate that initiation was timely in only 67 percent of 33 applicable cases, which is substantially lower than the administrative data estimates.

Data collected from Program Monitoring Reviews of 773 CPS assessments that were conducted in 41 counties in 2017 reflect the following.

<b>2017 NC Program Monitoring Review Data</b>				
<b>Select Questions – CPS Assessment Protocol</b>				
<b>CPS Assessment Initiation</b>	<b>State</b>	<b>Large</b>	<b>Medium</b>	<b>Small</b>
Were all the victim children seen and interviewed within the response timeframes?	76.71% (593/773)	79.03% (49/62)	82.48% (226/274)	72.77% (318/437)
If not, was there documentation as to why not and diligent efforts to see the child(ren)?	24.86% (44/177)	38.46% (5/13)	35.42% (17/48)	18.97% (22/116)
Were all the parents or primary caretakers who reside in the home with the children seen and interviewed the same day as the children?	76.25% (578/758)	73.08% (38/52)	82.66% (224/271)	72.64% (316/435)
If all parents/primary caretakers who reside in the home with the child(ren) were not seen and interviewed on the same day as the child(ren), is there documentation as to why not and diligent efforts made to contact them?	35.96% (64/178)	71.43% (10/14)	34.04% (16/47)	32.48% (38/117)
Were all other non-primary caretaker adults in the children’s home seen and interviewed within 7 days?	71.02% (174/245)	75% (12/16)	80.22% (73/91)	64.49% (89/138)
If other non-primary caretaker adults were not seen and interviewed within 7 days, was there documentation as to why not and diligent efforts made to see and interview them?	17.39% (12/69)	33.33% (1/3)	11.11% (2/18)	18.75% (9/48)

Program monitoring data indicate that assessments were initiated timely in 77 percent of the cases reviewed, meaning all children in the household were interviewed on the same day within the required timeframe. For those cases where initiation was not timely, reviewers found documentation in the case file as to why initiation was not timely and also supported diligent efforts made by the worker to see the children in accordance with policy in only 25 percent of applicable cases. The data, based on a large sample of assessments, suggest that counties either initiated in a timely way or documented diligent efforts to do so 82 percent of the time.

The program monitoring team found similar rates of interviewing the parents or primary caretakers on the same day as the child and of interviewing all other non-primary caretaker adults in the household with seven days.

When CPS workers were surveyed about which type of CPS assessment, Family, or Investigative, is more likely to be initiated timely, the majority (69%) indicated there was no difference, with 20 percent indicating that investigation assessments were more likely to be initiated timely.



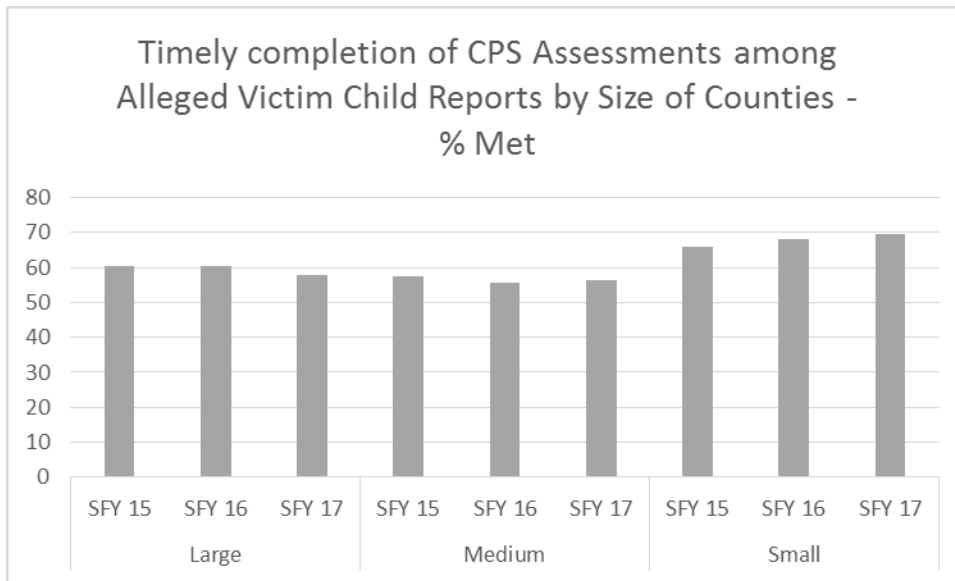
**Timely Completion:** During most of 2017, state policy called for investigative assessments to be completed within 30 days and family assessments to be completed in 45 days, the difference originating in a desire to give family assessments more time to connect families to services. The modified policy manual scheduled to be effective in September 2018 sets 45 days as the timeframe for completing both types of assessments, with counties able to extend an assessment with appropriate written justification.

Administrative data on timely completion of CPS assessments is based on the days from the date of the report to the date of the case decision.

**Key Findings: Timely Completions:**

- Administrative data suggest 70% of assessments are completed within 45 days.
- Documentation of justifications for extensions was present in approximately half of cases reviewed per Program Monitoring Review data.
- CPS staff participating in focus groups indicated meeting the 45 day timeframe is difficult.

**Figure 15: Timely Completion of CPS Assessment Among Alleged Victim Child Reports by Size of Counties (% Met)**



Source: TimelyCompletionData14-15.csv, TimelyCompletionData15-16.csv, and TimelyCompletionData16-17.csv

\* A SFY cohort is defined based on a maltreatment report date.

\*\* An alleged victim child can be reported with different report dates more than once within SFY; therefore, the unit of analysis in the table is a child-report.

*Denominator:* # of unique reports (different report dates) during the SFY of interest

*Numerator:* # of investigative assessments completed within 45 days.

The administrative data indicates that just under 70 percent of CPS assessments were completed within timeframes, with small counties being perhaps slightly more likely to complete assessments within timeframes. Data from the 2017 Program Monitoring Reviews on the timeliness of completion of CPS assessments also finds just under 70 percent of assessments were completed within 45 days.

2017 NC Program Monitoring Review Data				
Select Questions – CPS Assessment Protocol				
CPS Assessment Completion	State	Large	Medium	Small
Was the assessment completed within 45 days?	68.26% (471/690)	59.65% (34/57)	70.78% (172/243)	67.95% (265/390)
If the assessment exceeded 45 days, was there documentation to justify the delay?	47.95% (105/219)	57.17% (12/23)	53.52% (38/71)	44% (55/125)
Was the written justification reasonable to justify the delay?	58.18% (64/110)	50% (7/14)	47.37% (18/38)	67.24% (39/58)

The program monitoring data indicates that 68 percent of investigative and family assessments statewide were completed within 45 days.

Policy allows counties to extend a CPS assessment past the timeframes with a justification of why extra time is needed. According to the program monitoring data, counties documented justifications for extending assessments in approximately half of the assessments reviewed that exceeded completion timeframes, with 58 percent of the justifications deemed to be reasonable.

CPS workers who participated in focus groups indicated that completing investigations in 45 days is difficult and that it helps when Intake is able to gather a lot of information upfront. Some staff also noted high caseloads and attempting to “frontload” services creates challenges to meeting the 45-day timeline. CPS survey results suggest that a primary issue specifically impacting the timely completion of Investigation assessments is that they are often held up by additional requirements, such as Child Medical Exams (CMEs), Child and Family Evaluations (CFEs), and other evaluation or record requests.

***Sub-Question 4:*** Do North Carolina’s Structured Decision-Making Tools adequately address safety, risk, and protective factors for all children in the household?

North Carolina uses Structured Decision-Making (SDM) tools to assess current safety, risk of future harm, and family strengths and needs and to make CPS Assessment case decisions. Additionally, North Carolina uses a SEEMAPS approach to assess strengths and needs and help identify options for services. The SDM tools provide clearly defined and consistently applied decision-making criteria and have been evaluated in large scale studies in California, Minnesota, and Michigan. The North Carolina DSS policies that support the use of these SDMs are likewise very clear and specify practice expectations, including timeliness and quality. The tools represent a clear effort to assure that issues of safety, risk, and protective factors are addressed in the provision of Child Welfare services in North Carolina.

**Key Findings: Quality of NC Risk and Safety Assessment Tools:**

- Structured Decision-Making (SDM) tools currently being utilized in North Carolina are in keeping with national best practices although the risk assessment is no longer current. The state office is exploring options for how to proceed.
- Current North Carolina DSS policies provide clear guidelines in expectations for the application of SDM tools in work with in-home service cases.

The tools being utilized in North Carolina that are described below are first completed during the CPS assessment process.

- ◆ **Safety Assessment (DSS-5231):** This is a structured safety assessment form that must be completed at the following times during a CPS assessment:
  - ◆ Initiation and completion.
  - ◆ Whenever new allegations are received or safety issues emerge.
  - ◆ Prior to removing or returning a child to a home.

Caseworkers rate whether any of 16 serious threats to safety are present. If not, the children are rated as “safe.” If one or more of these safety factors are present, the caseworker must consider whether one or more of six listed safety interventions is adequate to provide protection. If so, the children are rated as “safe with a plan.” If not, the rating is “unsafe” and the child should be removed. When children are rated safe with a plan, a section must be filled out specifying the plan and key people’s roles. The parents, safety resources, caseworker, and supervisor all must sign the plan.

- ◆ **Family Risk Assessment of Abuse / Neglect (DSS-5230):** This tool produces an estimate of whether the risk of future abuse or future neglect is high, moderate, or low based on the presence or absence of risk factors, such as the type and history of reports, age of children, parenting issues, and presence of substance abuse. This tool must be completed before a CPS case decision is made and it is an important element in determining whether families will be referred for ongoing CPS services. *The version of this instrument in use in North Carolina is out-of-date, and the tool’s developer no longer considers the version in use in North Carolina to be supported by the most recent validation studies.* The state office is aware of this and is exploring options for how to proceed. Another limitation is that the scale leaves no room for responses that are not absolute, or that require discussion/explanations.
- ◆ **Family Assessment of Strengths and Needs (DSS – 5229) (FASN):** This tool assesses family strengths and needs during the CPS assessment and it is also used to prepare the family for the CFT meeting process and as a basis for service planning.
- ◆ **Case Decision Summary/Initial Family Services Agreement (DSS-5228):** This tool is used by the assessment worker and supervisor to structure the inclusion of safety, risk, and protective factors into the case decision for the CPS assessment, to document and present a rationale for the case decision, and to identify behaviors, goals, and activities for the family services agreement.

**Sub-Question 5: Is safety appropriately assessed and are safety threats identified (and responded to) during initial contacts and throughout the investigative process?**

Appropriate assessment of safety and response to threats to safety during a CPS assessment have multiple elements, including not only the adequacy of the safety assessment tool but also the quality of the information gathered, the adequacy of the safety plan and interventions, and the sufficiency of ongoing contacts and monitoring.

Data collected from Program Monitoring Reviews of CPS assessments that were conducted in 2017 that are relevant to safety is highlighted in the table below.

**Key Findings: Assessment of safety**

- Initial safety assessments are timely (92%).
- Initial safety agreements are adequate to ensure safety (86%).
- New information results in a new safety assessment (67%).
- Criminal background and Central Registry checks are not consistently completed for safety resource homes
- Sufficient face-to-face contacts occur with children (74%).

2017 NC Program Monitoring Review Data				
Select Questions – CPS Assessment Protocol				
Assessment of Child Safety	State	Large	Medium	Small
Was a safety assessment completed for the initial report?	98.07% (713/727)	96.77% (60/62)	93.68% (237/253)	97.40% (412/423)
Was the safety assessment completed at the time of initiation?	92.39% (692/749)	95% (57/60)	90.91% (240/264)	92.94% (395/425)
Did the social worker include the parents/primary caretakers in developing the safety agreement?	90.20% (635/704)	93.33% (56/60)	88.14% (223/253)	91.05% (356/391)
Does the information documented on the safety assessment correlate with the information obtained from the interviews and observations?	88.03% (647/735)	95% (57/60)	89.37% (227/254)	86.22% (363/421)
Was the safety agreement adequate to ensure safety?	86.04% (598/695)	91.38% (53/58)	86.22% (219/254)	85.12% (326/383)
If new information was uncovered by the social worker during the assessment or the situation changed, was a new safety assessment and agreement completed as new concerns arose?	67.32% (103/153)	66.67% (8/12)	64% (32/50)	69.23% (63/91)
Was an Initial Safety Provider Assessment filled out completely and in the record?	63.92% (62/97)	66.67% (4/6)	76.19% (32/42)	53.06% (26/49)
Was the Initial Safety Provider Assessment completed prior to the child(ren) being placed in the home of the TSP?	48.89% (44/90)	33.33% (2/6)	65.79% (25/38)	36.96% (17/46)
Were criminal record checks completed on all adults and children 16 and older in the TSP's home?	71.88% (69/96)	100% (6/6)	80.95% (34/42)	60.42% (29/48)
Were Central Registry checks completed on all adults living in the Safety Resource's home?	62.50% (60/96)	66.67% (4/6)	76.19% (32/42)	50% (24/48)

2017 NC Program Monitoring Review Data				
<i>Select Questions – CPS Assessment Protocol</i>				
After initiation, were ongoing face to face contacts made with victim child(ren)?	73.96% (514/695)	74.47% (35/47)	74.49% (184/247)	73.57% (203/338)
If not, was there documentation as to why not and diligent efforts made?	7.18% (13/181)	16.67% (2/12)	6.35% (4/63)	6.60% (7/106)

Program Monitoring Review data suggests that the state does a good job overall with conducting Initial Safety Assessments (98%), completing them in a timely manner (92%), and developing safety agreements that support child safety (86%).

Other Program Monitoring Review data related to ensuring the safety of children suggest room for improvement, such as updating safety assessments when new information was found during an assessment (67%) and completion of timely Initial Safety Provider Assessments (64%), required criminal record checks (72%) and Central Registry checks on adults living in safety resource homes (62.5%). The practice of conducting ongoing face-to-face contacts throughout the CPS assessment process also indicates an area needing improvement. Contacts with victim children were found to be occurring in only 74 percent of the cases reviewed, and in only 7 percent of the cases was there documentation as to why the contacts were not occurring or that diligent efforts were being made to see the children where contacts were not occurring. Ongoing contacts with mothers (73%), fathers (64%), other caretakers (69%) residing in the home and temporary safety providers (79%) were also not occurring in keeping with policy, with little documentation to indicate that diligent efforts were being made. Performance in regard to collateral contacts, an important source of child safety and risk-related information, ranged from contacts with collaterals identified by parents/caretakers (83%) and professional agency collaterals involved with the family (84%), to collaterals identified in the Intake report (72%) and with the reporter (62%).

When CPS workers were asked in focus groups about their use of SDM tools in assessing child safety, most indicated they rely both on the tool and their own judgement, but that the tool is particularly helpful in dictating the frequency of family contact. Some workers shared that the safety assessment process takes longer and that families are therefore more receptive to the risk assessment process. Conversely, some noted that assessing safety is easier “because it is happening in the present, while risk is a ‘could be.’” CPS supervisors provided mixed reviews of SDM tools, with some saying the categories listed on the form covered most everything while others indicated the tool was not very logical in terms of its flow and how the work is done. Some supervisors also noted finding more mistakes in the use of the safety assessments versus risk assessments, that workers overuse the category of “other” in the safety assessment, and that there was not enough guidance on how and when as supervisors they should override safety assessment determinations.

CPS survey respondents overwhelming indicated they are usually or almost always confident that the case decision accurately reflects the family’s situation.

**Sub-Question 6: Is risk of future harm appropriately assessed and identified?**

CSF was informed by staff from several counties and the department that the structured decision-making tool North Carolina has been using to assess the risk of future harm is out-of-date and does not include upgrades that the tool developer, National Council on Crime and Delinquency (NCCD) Research Center, has made since North Carolina adopted the tools. CSF has been informed that the version of the tool North Carolina is using is no longer considered valid by the NCCD.

To further understand how well caseworkers are assessing a child’s risk of harm, CSF analyzed results of the 2017 Program Monitoring Reviews. Specific areas of focus included not only the extent to which key agency procedural requirements were met (i.e. conducting criminal background checks), but also whether the caseworker reviewed and integrated the information obtained from such checks into the larger risk assessment process. Also, just as ongoing face-to-face contact by the caseworker with the child victims, parents, and caregivers is critical to ensuring child safety during the course of the CPS assessment, it plays an equally important role in the ability of the agency to adequately assess the risk of future harm to the children.

Program Monitoring Review data indicates that Central Registry checks were conducted in 79 percent of cases and criminal record checks were conducted on adults and children 16 years and older in the household (85%) prior to making a case decision. There was also documentation that the assigned caseworker generally reviewed the results of such checks as well as any previous child welfare records involving the family (84%). A notable finding is that in only 62 percent of applicable cases where relevant information was found through the various record checks was there documentation of follow-up conversations by the caseworker with collaterals in order to gather additional information.

Finally, as previously noted under sub-question 4, the frequency of the caseworker’s contact with the children, parents, and other caregivers during the course of CPS assessments in North Carolina is an area in need of improvement. Social work contacts impact both the ability to ensure immediate child safety as well as to assess the child’s future risk of harm.

**Key Findings:**

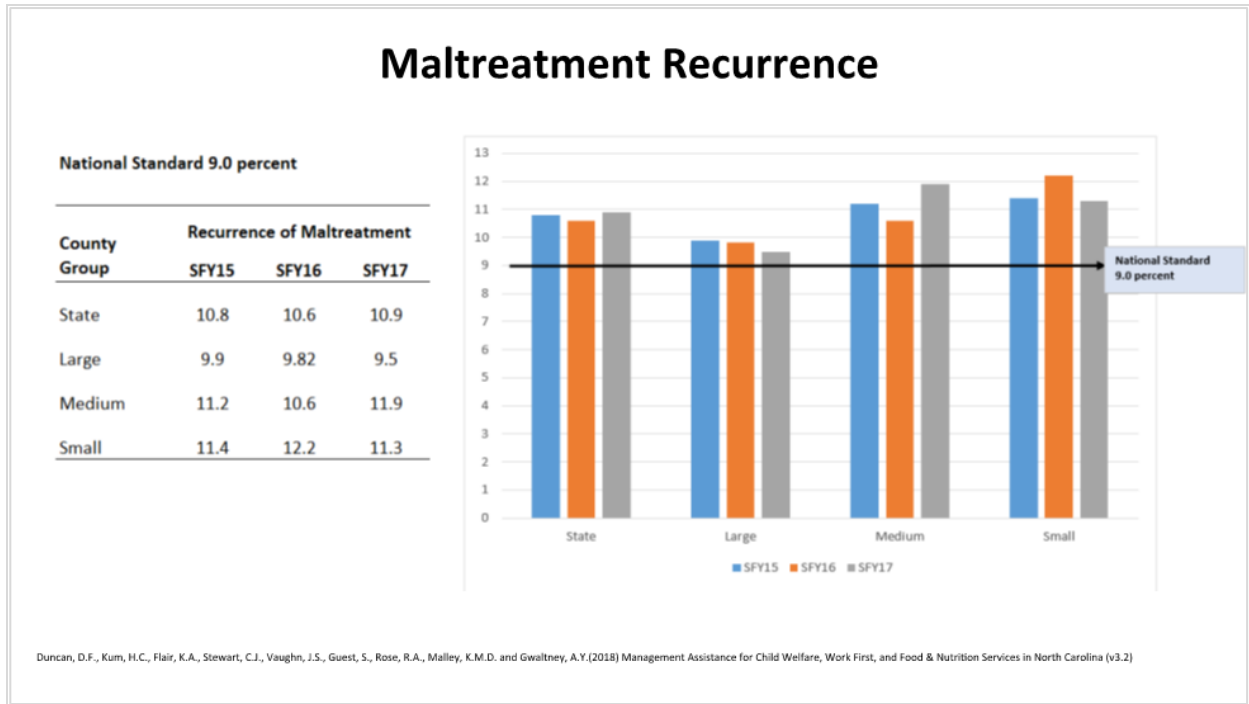
- Staff report the structured decision-making tool NC uses to assess risk is out of date.
- Checks of criminal background and CPS history of adult household members are being conducted but the results are not consistently followed up on.
- Ongoing face-to-face contacts with victim children, parents and caretakers are not reliably occurring in accordance with policy.

<b>2017 NC Program Monitoring Review Data</b>				
<b>Select Questions – CPS Assessment Protocol</b>				
<b>Assessment of Risk</b>	<b>State</b>	<b>Large</b>	<b>Medium</b>	<b>Small</b>
Was a Central Registry check conducted regarding the child(ren) and parent/caretaker CPS history prior to case decision?	78.62% (548/697)	95.74% (45/47)	89.92% (223/248)	69.65% (280/402)
Is there evidence on the 5,010 or specifically stated in the case narratives that the social worker reviewed this history?	83.13% (557/670)	83.72% (36/43)	92.89% (222/239)	77.06% (299/388)
Were criminal record checks conducted on all adults and all children 16 years and older, living in the home prior to case decision?	85.45% (593/694)	91.49% (43/47)	87.85% (217/247)	83.25% (333/400)
Is there evidence, on the 5,010 or specifically stated in the case narratives, the social worker reviewed these criminal record checks?	84.59% (571/695)	86.36% (38/44)	91.77% (223/243)	79.90% (310/388)
Is there evidence, on the 5,010 or specifically stated in the case narratives, that previous agency Child Welfare records were reviewed?	83.77% (506/604)	78.05% (32/41)	91.20% (197/216)	79.83% (277/347)
If information was found in record checks, were there follow-up conversations or collaterals made to gather more information?	62.02% (227/366)	58.06% (18/31)	65.87% (83/126)	60.29% (126/209)
Did the information documented in the record support the information about ongoing risk, safety, and health of the child(ren) on the Family Risk Assessment, Family Assessment of Strengths and Needs, and Case Decision Summary?	81.35% (567/697)	80.85% (38/47)	81.53% (203/249)	81.30% (326/401)

When CPS workers were asked in focus groups which was harder to assess (safety or risk), most liked using the risk assessment tool, noting it “keeps the bias out,” but also suggested the tool felt somewhat generic and needed more flexibility.

CFSR Round 3 data regarding the recurrence of maltreatment during a 12-month period indicates this is a long-standing challenge for North Carolina, with some variance based on the size of the county. The most recent data, however, suggests an encouraging (downward/decreasing) trend for this performance indicator.

Figure 16: CFSR Round 3 Measure: Recurrence of Maltreatment



Small and medium counties have higher instances of repeat maltreatment than larger counties according to the CFSR measure. However, the table below, developed from the Legacy data system extract, might explain.

Figure 17: Investigated Reports by Type of Finding by County Size Group and State Fiscal Year (Exclusive: Most Severe Finding) Point in Time

State Fiscal Year	Abuse and Neglect		Abuse		Neglect		Dependency		Services Needed		Services Provided, No Longer Needed		Services Recommended		Unsubstantiated		Services Not Recommended		Total
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	
<b>State Totals</b>																			
SFY 2017	755	1%	584	1%	2,980	4%	200	0.3%	7,314	11%	3,819	5%	18,824	27%	9,802	14%	25,193	36%	69,471
SFY 2016	822	1%	554	1%	3,326	5%	238	0.3%	7,594	11%	3,960	6%	19,798	28%	10,361	15%	24,348	34%	71,001
SFY 2015	742	1%	690	1%	3,869	5%	216	0.3%	7,108	10%	3,653	5%	19,502	27%	12,132	17%	23,648	33%	71,560
<b>Large County Group</b>																			
SFY 2017	268	1%	170	0.6%	951	3%	53	0.2%	2,770	9%	1,668	6%	11,279	39%	4,084	14%	8,045	27%	29,288
SFY 2016	318	1%	167	0.6%	996	3%	73	0.2%	2,756	9%	1,495	5%	12,323	42%	4,082	14%	7,363	25%	29,573
SFY 2015	244	1%	229	1%	1,197	4%	63	0.2%	2,458	8%	1,035	4%	12,036	41%	4,622	16%	7,626	26%	29,510



**North Carolina Child Welfare Preliminary Reform Plan**

State Fiscal Year	Abuse and Neglect		Abuse		Neglect		Dependency		Services Needed		Services Provided, No Longer Needed		Services Recommended		Unsubstantiated		Services Not Recommended		Total
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	
<b>Medium County Group</b>																			
SFY 2017	370	1%	294	1%	1410	5%	94	0.3%	3,381	11%	1,622	5%	5,297	18%	4,332	14%	13,321	44%	30,121
SFY 2016	366	1%	264	1%	1612	5%	111	0.4%	3,605	12%	1,685	5%	5,480	18%	4,602	15%	13,337	43%	31,062
SFY 2015	357	1%	334	1%	1849	6%	106	0.3%	3477	11%	1,849	6%	5,635	18%	5,483	17%	12,500	40%	31,590
<b>Small County Group</b>																			
SFY 2017	117	1%	120	1%	619	6%	53	0.5%	1,163	12%	529	5%	2,248	22%	1,386	14%	3,827	38%	10,062
SFY 2016	138	1%	123	1%	718	7%	54	0.5%	1,233	12%	780	8%	1,995	19%	1,677	16%	3,648	35%	10,366
SFY 2015	141	1%	127	1%	823	8%	47	0.4%	1,173	11%	769	7%	1,831	18%	2,027	19%	3,522	34%	10,460

Two patterns emerge from the data. The first is that small and medium counties are somewhat more likely than large counties to substantiate maltreatment in CPS investigative assessments and to find *services needed* in family assessments. The second pattern relates to negative findings in family assessments. Large counties are more likely to find *services recommended* and less likely to find *services not recommended* than medium and small counties. The fact that small and medium counties are more likely to make a finding that maltreatment has in fact occurred than large counties makes small and medium counties also more likely to have a finding of recurrence of maltreatment than large counties.

**Sub-Question 7: Is there evidence of supervisory oversight of caseworker practices?**

North Carolina policy establishes expectations for extensive supervisory oversight of all Child Welfare cases, sets the supervisor-worker ratio at one supervisor to five workers, and requires that most key decisions in a child welfare case to be two-level decisions of the worker together with the supervisor. As part of its program improvement plan, North Carolina has included increased expectations for supervisory involvement in every case throughout child welfare services. The modified manual scheduled to be effective in September 2018 details the frequency with which each case must be staffed with a supervisor (twice monthly), what must be covered in the supervisory conference, and when two-level decision making must be conducted.

**Key Findings:**

- Required supervisory signatures are usually present on CPS assessment documents. Twice monthly supervision –scheduled to become a requirement in September 2018 –was documented in 56% of assessments.
- The majority of CPS worker survey respondents indicated they meet regularly with their supervisor to staff cases and that their supervisor is always available, knowledgeable and provides guidance.

To assess whether supervisory oversight of CPS assessments was adequate, CSF analyzed results of the 2017 Program Monitoring Reviews and data from focus groups that were conducted by CSF in April and May 2018.

Program Monitoring Reviews found consistent evidence of supervision via the presence of supervisory signatures on assessment forms (i.e. Assessment, Family Risk Assessment) as well as Case Decision Summaries and Initial Case Plans. In cases where the CPS assessment track (investigative or family assessment) was changed during the course of the assessment, documentation of clear reasons for the change and supervisory approval was present in only 48 percent of applicable cases. Documentation of case-specific supervisory consultation during the CPS assessment process at least twice monthly was evident in 56 percent of the 685 assessments reviewed. However, this is a new requirement in the modified policy manual that was not effective in most North Carolina counties in 2017 when the program monitoring took place.

<b>2017 NC Program Monitoring Review Data</b>				
<b>Select Questions – CPS Assessment Protocol</b>				
<b>Supervisory Oversight</b>	<b>State</b>	<b>Large</b>	<b>Medium</b>	<b>Small</b>
Was there documentation of the social worker and supervisor making the two-level case decision in the narrative, case summary, or a staffing note?	91.15% (628/689)	85.96% (49/57)	92.18% (224/243)	91/26% (355/389)
Did the supervisor review, sign and date each safety assessment within 24 hours?	80.03% (589/736)	80% (48/60)	73.20% (183/250)	84.04% (358/426)
Was the Initial Safety Assessment form signed by the TSP, social worker, and supervisor?	66.67% (60/90)	66.67% (4/6)	73.17% (30/41)	60.47% (26/43)
Was there documentation of case specific supervisory consultation during the assessment at least twice monthly?	56.35% (386/685)	68.09% (32/47)	52.24% (128/245)	57.51% (226/393)

<b>2017 NC Program Monitoring Review Data</b>				
<b>Select Questions – CPS Assessment Protocol</b>				
Was the Family Risk Assessment signed and dated by the social worker and supervisor?	94.12% (624/663)	95.74% (45/47)	96.17% (226/235)	92.65% (353/381)
Was the Case Decision Summary/Initial Case Plan signed and dated by the social worker and supervisor on the date of case decision?	90.75% (608/670)	88.89% (48/54)	93.64% (221/236)	89.21% (339/380)
If the assessment response was changed during the assessment, was it done with supervisory approval and reasons clearly documented?	48.05% (37/77)	37.50% (3/8)	41.38% (12/29)	55% (22/40)

The majority of CPS workers who responded to the CSF survey indicated they staff cases regularly with their supervisor and that their supervisor is always available, knowledgeable, and provides guidance.

CPS supervisors who participated in focus groups indicated caseload size was a primary challenge in their work – i.e., too many requirements, more complicated cases, not enough time, resources, or staff. They indicated the following when asked what they needed in order to do their jobs well:

- ◆ Access to better training.
- ◆ Being fully staffed, access to quality applicants, retention of staff, having an assistant.
- ◆ Access to state level staff who can answer questions, give clear direction, and provide clarification of expectations between federal and state government regulations.
- ◆ More group meetings with peers to share/discuss issues.
- ◆ More assistance from attorneys and other judicial staff regarding legal paperwork, understanding policy changes.

## ***B. Preventive and CPS In-Home Services***

### **Overview**

#### ***North Carolina Prevention Practices and Services***

<b><i>Primary Prevention</i></b>
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Primary prevention strategies are typically directed at large populations of people and are intended to promote strengths and prevent problems from occurring in the first place. Providers of primary prevention include public and private nonprofit organizations, agencies, schools, and qualified individuals. Multiple other primary prevention efforts to reduce child maltreatment and improve child safety have been implemented with state or philanthropic funds within DHHS including its public health division and by individual counties such as:

- ◆ Intensive home visiting programs, such as the Nurse Family partnership.
- ◆ Parent education programs, such as Triple P.
- ◆ Public awareness programs to promote safe sleep or to prepare parents for parents for the stress of crying infants.

DHHS, through DSS, implements the Children’s Trust Fund, which was established by the legislature to support this priority across the state. State statute 7B-1300 provides the framework and regulations for the operation of the Children’s Trust Fund. In addition to private contributions, grants, and gifts, the Children’s Trust Fund is funded by a portion of the marriage license fee and a portion of the special license fee. Current grantees include Buncombe County Department of Social Services, Catawba County Department of Social Services, Easter Seals UCP NC and VA, and Orange County Partnership for Young Children.

**Secondary Prevention**

Secondary prevention strategies are typically implemented when problems are in their early stages to prevent their full development. Secondary prevention services provided by county DSS offices in North Carolina are often called Family Support Services, and are voluntary for families. Counties are not legally mandated to provide family support services, and their availability varies significantly from county to county. Counties that provide family support services typically provide an assessment of a family’s needs, often make home visits, and make a plan with the family to connect them to services within DSS or the community. Referrals to family support services can come from the community, from a family itself, or from CPS after a CPS assessment in which a family is not referred to mandatory ongoing CPS services. Participation in these services is voluntary for families.

Another secondary prevention strategy offered by DSS occurs within CPS assessments, especially family assessments, with families who are not found to need ongoing involuntary services from CPS. A goal of North Carolina’s multiple response system is to more effectively engage families reported to CPS in services that will strengthen the family and reduce the likelihood of difficulties in the family progressing to child maltreatment. Each county is responsible for developing partnerships with service providers in the community to make appropriate referrals to meet the specific needs of families on a voluntary basis.

**Tertiary Prevention (Intervention):  
CPS In-Home Services**

Tertiary prevention strategies are typically used when a problem already exists in an effort to ameliorate the problem and to prevent the problem from becoming more severe and having more serious consequences. CPS In-Home services are an example of tertiary prevention.

In North Carolina, families are referred to CPS In-Home services when a CPS investigative or family assessment has found maltreatment, immediate removal from the home is not required, but the risk of further maltreatment is assessed to be moderate or high. The goals of North Carolina’s CPS In-Home Services are:

- ◆ To maintain the safety of children;
- ◆ To strengthen the family's capacity to protect and nurture its children; and
- ◆ To maintain children in their own families.

The modified policy manual scheduled to be implemented in September 2018 requires safety and risk assessment to be ongoing throughout the provision of CPS In-Home Services. Children substantiated as maltreated or found in need of services and their parents or primary caretakers must be seen face-to-face at least twice a month and a minimum of seven days apart; caseworkers must contact at least two collaterals each month; make face-to-face contact with any non-victim child(ren) and any other household members at least once a month. At least one contact per month with each child must be in the home and allow observation of interaction with parents. In cases rated high risk, a third face-to-face contact per month with the children and parents is required. The following must occur during each contact:

- ◆ An assessment of child safety and risk of maltreatment;
- ◆ A review of the Family Services Agreement (Initial or In-Home);
- ◆ An inquiry regarding child and family well-being needs; and
- ◆ An individual interview with each child, separate from the parent/caretaker.

The Family Strengths/Needs Assessment creates the foundation for the Family Service Agreement that is developed in partnership between the family and the DSS caseworker and approved by the supervisor. During the CPS Assessment and at every contact, the Child and Family Team (CFT) process is discussed to identify supports for the family. These CFT meetings are designed to be family-led, youth-guided, and agency-supported. The family service agreements are completed in the CFT Meeting. For high risk cases, a facilitator leads the meeting, while the DSS caseworker leads all other cases. DSS policy addresses expectations for CFT meetings extensively. For In-Home Services cases, the CFT is to occur within 30 days of the substantiation of the CPS Assessment, quarterly, during critical decision points, when cases are "stuck," and prior to case closure, if the family decides they want one.

To have maximum impact, the Family Services Agreement focuses on behavioral change or conditions affecting the child's present safety or risk of future harm. Objectives are developed, and activities clearly planned. DSS monitors progress on the stated objectives throughout the life of the In-Home Services case. In order to do this effectively, state policy indicates that caseworkers should have no more than 10 families with open In-Home Services cases. Moreover, each supervisor should have no more than five caseworkers for whom he or she provides coaching, guidance, and mentoring.

During CPS In-Home Services, DSS must petition for court involvement if safety issues require immediate removal, or the family is unwilling to accept services critically required to keep the family intact. Court involvement can range from ordering a family to comply with services to removal of a child from the home.

North Carolina is in the process of assessing its readiness to opt into the Family First Prevention Services Act (FFPSA) in October 2019. This federal legislation will provide additional federal resources to support prevention services and efforts to keep families together.

There are many current strengths in the North Carolina system upon which to build a robust prevention program under the FFPSA. There is universal stakeholder interest in child welfare and well-being and there are strong public-private partnerships. This is evidenced by an existing system of care and framework with other agencies and the state's commitment to raise the age of juvenile justice from 16 to 18 through recent legislation. Philanthropic organizations such as the Duke Endowment continue to provide resources and technical assistance to support best practices across the state. The state is also rich in resources, such as university expertise in implementation science and service providers who are already accredited. Moreover, compared to other states, North Carolina has a moderate number of children in congregate care. It is a primary goal of the FFPSA to reduce the use of congregate care. According to a report issued by the Children's Bureau in 2015,<sup>20</sup> the state of North Carolina was just under the national average for the 2008 cohort of children experiencing congregate care who were age 12 and younger at the time of entering congregate care. At 30 percent, North Carolina ranked 23 among the 50 states. Thus, the transition to FFPSA will be less difficult.

The FFPSA provides an opportunity to better support a safety-focused, trauma-informed, family-centered practice model through creation of more robust services aimed at helping families keep children safely at home. This report recommends the creation of a statewide practice framework to be implemented in each of the 100 counties. This framework will need to balance child safety with family empowerment. Moreover, some counties have already established practice models. Thus, creating buy-in and utilization of strong implementation science will be vital toward this effort.

Strengthening the workforce is an area of challenge across the state. While the ability to recruit and retain caseworkers and supervisors varies greatly across the counties, creating and sustaining a strong workforce with the capacity to implement a new practice model while shifting the agency culture to FFPSA needs attention statewide. Likewise, there is a need to increase recruitment and retention of family foster homes and develop a full array of supports for relative caregivers who are not licensed.

North Carolina is currently undergoing several large-scale system changes, including a Medicaid transformation that will take effect in 2019. This will add an additional layer of complexity to the existing complications with mental health systems and services. Health care provider involvement will continue increasing and DSS will need to build its internal capacity and knowledge of these systems to build effective collaborative partnerships. Another large-scale system change involves increasing the age of juvenile justice authority from age 16 to age 18. While this is an asset that reflects the state's understanding of adolescent development, it is unclear how this will impact the judicial system and its court dockets. In focus groups and

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<sup>20</sup> DHHS, Children's Bureau, *A National Look at the Use of Congregate Care in Child Welfare*. Retrieved from [https://www.acf.hhs.gov/sites/default/files/cb/cbcongregatecare\\_brief.pdf](https://www.acf.hhs.gov/sites/default/files/cb/cbcongregatecare_brief.pdf) 7/15/18.

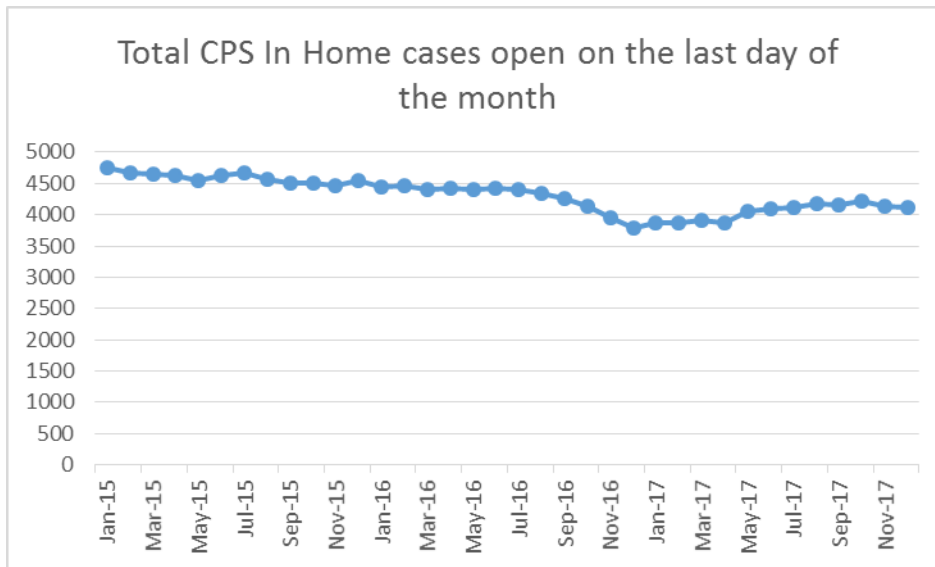
interviews DSS caseworkers and supervisors expressed a desire and need for more court time to move cases to permanency.

Finally, FFPSA is the largest shift in federal regulation of child welfare practice in decades. There will be substantial changes to child welfare financing, new resources made available, and new restrictions for federal reimbursements. This will require local, regional, and state level buy-in and acceptance of a new way of working and engaging families. Statewide data collection capacity and performance-based contracting will need to be developed to provide oversight of the system and meet the new federal requirements. The legislature will also need to consider allocation of more funds for state match.

### **Prevention and In-Home Services Trends**

The number of families in CPS In-Home cases has gone down over the years. The graph below, from the North Carolina 2017 Master Child Welfare Workforce Data Book, shows the number of open CPS In-Home cases on the last day of each month from January 2015 to November 2017.

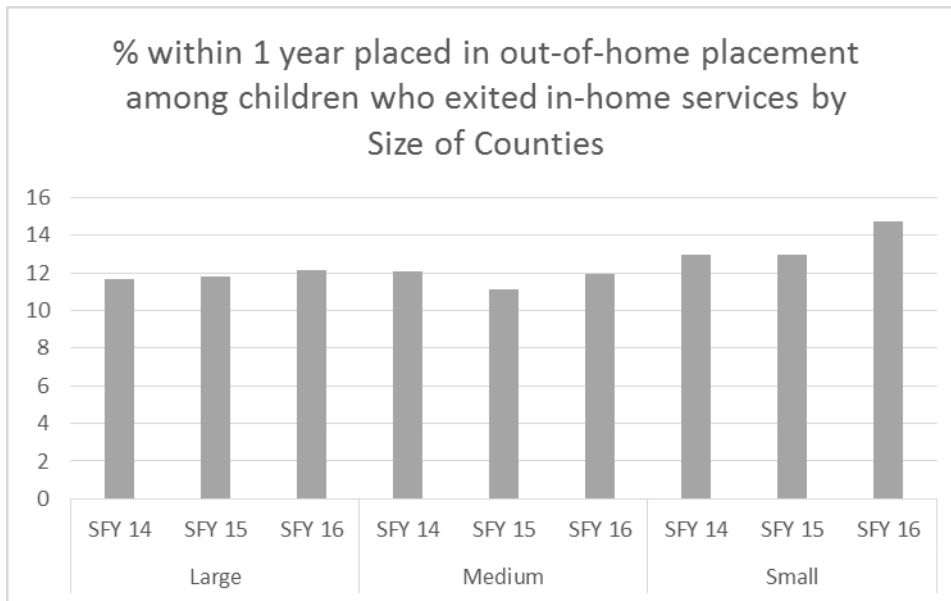
**Figure 18: Total CPS In-Home Cases Open on the Last Day of the Month**



The number of open CPS In-Home cases has decreased from 4,760 in January 2015 to 4,118 in November 2017, with the lowest month being December 2016 with 3,790 open cases. It is too soon to determine if the slight increase after December 2016 represents the end of the downward trend or is related to seasonal variations in reports received or other factors.

Rates of being placed in foster care within one year of exiting CPS In-Home Services ranged from 11 percent to almost 15 percent between SFY 2015 and 2017. Large and medium counties have comparable rates of out-of-home placement within one year of exiting In-Home Services, both of which have remained relatively constant, whereas small counties have a higher rate, which has steadily increased since SFY 2015.

**Figure 19: Percentage Within One Year Placed in Out-of-Home Placement Among Children Who Exited In-Home Services, by Size of Counties**



Source: For # children who received and exited in-home services: ExitsIH13-14.xlsx, ExitsIH13-14.xlsx, and ExitsIH13-14.xlsx. For # FC entry: IHtoFC\_13-14IHExits.xlsx, IHtoFC\_14-15IHExits.xlsx, and IHtoFC\_15-16IHExits.xlsx  
 Denominator: # of unique children who existed 3 or more days of in-home services during the given SFY; 'unique' means that a child (a unique SIS id) is counted once no matter how many in-home service episodes during the given SFY.  
 Numerator: of children in the denominator, # placed in out-of-home placement within 1 year of their in-home service exit.

**Sources of Information**

- ◆ Administrative Data:
  - UNC Management Assistance website.
  - NC Legacy Data.
  - County Child Welfare Staffing Workbook Data.
- ◆ Case Review Data:
  - Program Monitoring Review Data.
  - OSRI Data.
- ◆ Meetings attended with state and county staff:
  - Most Impacted Counties Meeting (4/12/18).
  - Modified Policy Training (5/17/18).
  - FFPSA Meeting (6/5/18).
- ◆ Focus Groups/Interviews:
  - CPS In-Home workers.
  - CPS supervisors Foster Care workers.
  - Interviews with Parents.
- ◆ Surveys:
  - CPS Surveys.
  - Foster Care Supervisors.



**Detailed Findings**

<p><b><u>Primary Research Question:</u></b></p>	<p><i>Are children and their household family members who are in open CPS In-Home Services cases receiving services that ensure the children are protected from immediate threats to their health, safety, and future risk of harm?</i></p>
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Taking into consideration all of the information that was collected and analyzed, CSF determined that children and parents of In-Home Services cases are not being consistently served and supported in a way that ensures child health, safety, and protects against future risk of harm. While there is evidence that some core child welfare policies and practices are happening as envisioned in North Carolina in working with In-Home families, the lack of available services or supports to meet the needs of families impacts the state’s ability to effectively serve this vulnerable population.

DSS staff do a good job of engaging mothers and fathers in the development of the Family Services Agreement (FSA). While Program Monitoring Reviews indicate that over 90 percent of parents were involved in this process, only 51 percent of children and youth participated in CFTs and the development of the FSA. This was confirmed during focus groups with youth, who indicated that they did not get notices for CFT and did not know how decisions were made in their cases. Some DSS staff indicate that in an attempt to mitigate trauma, they are hesitant to involve youth in what are sometimes contentious conversations. This may reveal a greater need for more trauma-informed training and more direct feedback loops from youth. The LINKS program and Strong Able Youth Speaking Out (SAYSO) are existing vehicles for enhancing engagement with youth.

During the assessment and engagement process, DSS staff are expected to identify risks as well as protective factors and well-being needs for families. While risks are being adequately addressed in FSAs and CFTs, protective factors and well-being needs are only identified and addressed 65 percent of the time for mothers, 56 percent for fathers, and 55 percent for children based on the cases that were reviewed as part of the program monitoring process. With limited information gathered during the assessment process, it is difficult for DSS to provide the right services specifically designed to meet the needs of each family member.

Even if risks, well-being needs, and protective factors are identified, and the right types of services are identified, the availability and accessibility of services to meet those needs and factors varies greatly from county to county. In surveys, staff identified Substance Abuse and Mental Health services as the most commonly-needed services, followed by parenting-related services, and individual therapy. Staff also indicated in surveys that transportation limitations and family refusal to participate are the biggest hurdles to provision of services. Other identified hurdles included extended waitlists, a lack of providers in the area, and providers who do not accept Medicaid. The behavioral health system in North Carolina has transformed from a system of local mental health centers into a regional managed care system with services provided by private vendors. The Duke Endowment has provided resources and assistance to facilitate a collaborative effort between DHHS and the Department of the North Carolina Institute of Medicine. Leaders from the seven managed care organizations and county DSS directors

convened to improve communication, collaboration, and outcomes for children and families served by DSS and Behavioral Health, as well as adults served by Adult Protective Services and Guardianship services. Together, the groups developed strategies to improve timely access to existing services, including:

- ◆ Cross-training of DSS and Local Managing Entity (LME)/ Managed Care Organization (MCO) staff;
- ◆ Establishing contact people to resolve problems;
- ◆ Creating trauma-informed systems of care; and
- ◆ Integrating behavioral health strategies into traditional foster care.

Follow-up and implementation of these strategies, as the state further transforms its behavioral health and Medicaid systems, may increase the quality, accessibility, and availability of services for families involved in DSS In-Home Services. However, DSS will also need to focus on continued engagement, follow-up, and reassessment of families to ensure that service provision is effective. Although DSS staff reported in focus groups that they stay in regular contact with service providers, case record reviews suggest FSAs are not being consistently updated every three months in accordance with DSS policy.

Detailed information pertaining to each of the eight sub-questions used to help CSF answer the primary research questions is provided below.

***Sub-Question 1: Are counties completing the North Carolina safety and risk assessments during CPS In-Home Services at the times and in the manner required by policy?***

In assessing North Carolina practices in this area, CSF took into consideration evidence of workers' use of the afore noted SDM tools as well as consistent quality face-to-face worker contacts between the worker and child and family, in their home environment whenever possible and appropriate, as a means towards assessing risk and ensuring child safety with in-home service cases.

***Application of SDM Tools***

Program Monitoring Review data indicate that SDM tools are not consistently completed in keeping with DHHS policy. The Risk Reassessment tool is more likely to be completed as required at FSA updates (74%) and within 30 days of case closure (81%) than when significant changes occur in a family (50%). The Strengths and Needs Assessment was found to be completed as required at FSA updates and within 30 days prior to case closure in approximately 75 percent of the cases reviewed.

***Key Findings: Implementation of child safety and risk using SDM tools:***

- Formal risk and safety assessment tools are generally utilized per agency policy however practices could be strengthened.
- Staff surveyed feel SDM tools are “very” or “usually” accurate in reflecting the safety, risk and protective factors in families they work with.
- The lack of consistent, quality face-to-face contact with children and parents of in-home service cases impacts state performance in being able to accurately assess and respond to matters of risk and safety.

<b>2017 NC Program Monitoring Review Data</b>				
<b>Select Questions – In-Home Services Protocol</b>				
Safety and Risk Assessments completed per policy and with accuracy	State	Large Counties	Medium Counties	Small Counties
Was the Risk-Reassessment (DSS-5226) completed:	74.42%	66.67%	78.40%	70.43%
▪ At FSA updates	(224/301)	(16/24)	(127/162)	(81/115)
▪ When there was significant change in the family	53.63%	57.89%	55.68%	50%
	(96/179)	(11/19)	(49/88)	(36/72)
▪ Within 30 days prior to case closure?	80.90%	78.95%	88%	72.50%
	(161/199)	(15/19)	(88/100)	(58/80)
Was the Family Assessment of Strengths and Needs (DSS-5229) completed:	74.10%	72%	77.44%	69.83%
▪ At FSA updates?	(226/305)	(18/25)	(127/164)	(81/116)
▪ Within 30 days prior to case closure?	74.49%	63.16%	82.47%	67.50%
	(146/196)	(12/19)	(80/97)	(54/80)

CSF administered a survey to CPS Assessment and CPS In-Home Services workers. Questions and feedback from In-Home Services workers specific to the use of SDM tools in North Carolina included:

*To what extent do you feel the Structure Decision Making (SDM) tools accurately reflect the safety, risk, and protective factors in the cases you see?*

	Number	Percent
<b>Very Accurate</b>	48	15.2%
<b>Usually Accurate</b>	155	49.1%
<b>Somewhat Accurate</b>	94	29.7%
<b>Not Very Accurate</b>	19	6.0%
<b>Total</b>	<b>316</b>	<b>100%</b>

*Which tool is least likely to accurately assess the safety, risk, or protective factors in cases you see?*

	Number	Percent
<b>Risk Assessment</b>	86	27.4%
<b>Safety Assessment</b>	36	11.5%
<b>Strengths and Needs Assessment</b>	67	21.3%
<b>NA - They are all accurate</b>	125	39.8%
<b>Total</b>	<b>316</b>	<b>100%</b>

Respondents were also provided the opportunity to share additional feedback in the form of comments regarding the use of SDM tools in their work with children and families. While some staff offered positive comments such as “the tools are all accurate,” “they are “useful,” and “important,” the vast majority of comments reflected staff sentiments regarding the challenges in using SDM tools and clustered around themes such as:

- ◆ Risk Assessment score doesn’t reflect current situation (history, age, etc.).
- ◆ Strengths and Needs is broad, out-of-date, limited, too subjective.

- ◆ Strengths and Needs are useless in helping determine if families are safe.
- ◆ Risk Assessments should vary on a case-by-case basis, should be based on current situation, not history.
- ◆ Strengths and Needs is pointless, done at end, scores constantly change.
- ◆ Safety Assessment is completed when little is known about the family.
- ◆ Risk Assessments are not individual to the family, abstract.
- ◆ Safety Assessment is too long.
- ◆ Strengths and Needs are not consistent, easily manipulated/skewed, inaccurate reflection of family, factors inaccurate.

Focus groups with CPS staff indicated they use SDM tools as well as their own judgement when it comes to assessing child safety. Some said that assessing safety is easier because it is happening in the present, while risk is a ‘could be’ however most indicated both that the safety and risk assessment tools are equal in terms of the level of difficulty, and that “45 days” is a challenge given caseload sizes and that they often feel vulnerable in terms of making the right decisions.

***Quality Face-to-Face Worker Contacts with Children and Families***

Results from 2017 Program Monitoring Reviews suggest that both victim and non-victim children residing in the household on In-Home Services cases are not being seen in accordance with agency policy and with enough frequency in order to adequately assess risk and ensure child safety. Data indicates that approximately 60 percent of child victims are being seen face-to-face by their workers at least twice per month (or more as needed based on the assigned risk rating) and even less for non-child victims (50%) based on the applicable cases that were reviewed. On a more positive note, data suggests that monthly home visits are being completed in the home where children primarily reside in 86 percent of the cases reviewed.

During focus groups with CPS caseworkers and supervisors, some staff indicated that engagement is a challenge due to workloads. Several counties indicated that engagement with families seems to be more successful with In-Home Services cases, in which they could schedule the regular contacts and manage their workloads more effectively.

<b>2017 NC Program Monitoring Review Data</b>				
<b><i>Select Questions – In-Home Services Protocol</i></b>				
<b>In-Home Services Worker Face to Face Worker Contacts</b>	<b>State</b>	<b>Large Counties</b>	<b>Medium Counties</b>	<b>Small Counties</b>
Was a minimum of twice monthly (more as needed) face-to-face contacts with individuals according to policy based on risk rating?				
▪ Victim child(ren) in household	59.63% (257/431)	52.94% (18/34)	58.37% (136/233)	62.80% (103/164)
▪ Non-victim children	50% (18/36)	80% (4/5)	53.85% (7/13)	38.89% (7/18)

<b>2017 NC Program Monitoring Review Data</b>				
<b>Select Questions – In-Home Services Protocol</b>				
<b>In-Home Services Worker Face to Face Worker Contacts</b>	<b>State</b>	<b>Large Counties</b>	<b>Medium Counties</b>	<b>Small Counties</b>
▪ Mother (in household)	59.65% (238/399)	57.58% (19/33)	58.82% (130/221)	61.38% (89/145)
▪ Father (in household)	47.95% (105/219)	50% (11/22)	46.49% (53/114)	49.40% (41/83)
▪ Other caretaker	50.48% (53/105)	33.33% (2/6)	63.83% (30/47)	40.38% (21/52)
▪ TSP Provider 1	70.69 (82/116)	60% (3/5)	76.47% (52/68)	62.79% (27/43)
▪ TPS Provider 2	58.33% (35/60)	100% (2/2)	58.33% (21/36)	54.55% (12/22)
Was there contact with all non-resident parents monthly?	33.09% (89/269)	25% (3/12)	35.53% (54/152)	30.48% (32/105)
Were there a minimum of two different collateral contacts each month?	67.52% (289/428)	61.29% (19/31)	70.94% (166/234)	63.80% (104/163)
Were there home visits completed inside the home where the child(ren) primarily resides at least monthly?	86.30% (359/416)	83.87% (26/31)	86.43% (191/221)	86.59% (142/164)
Were home visits completed inside the home of an involved non-resident parent, where the child(ren) visit, at least quarterly?	58.87% (73/124)	30% (3/10)	63.41% (51/82)	56.25% (18/32)
Was a visit made to the family within 7 days of the case decision?	75.24% (313/416)	80.49% (33/41)	80.65% (175/217)	66.46% (105/158)
Was a joint visit made to the family with both the transferring and receiving social worker?	57.65% (211/366)	51.28% (20/39)	59.33% (124/209)	56.78% (67/118)

It is also worth noting that North Carolina’s 2017-2018 OSRI reviews rated Item 3, which focuses on agency efforts to conduct Initial and Ongoing Risk and Safety Assessments, as a strength in only 31 percent of the 32 applicable In-Home cases reviewed. OSRI findings for North Carolina in the area of worker visits with children and parents was also evaluated in terms of the frequency and quality of worker face-to-face contacts with both children and parents. Item 14 (worker visits with children) was rated a strength in 50 percent of the 32 applicable In-Home cases while Item 15 (worker visits with parents) was rated a strength in 44 percent of cases reviewed, making this critical case practice area an area in need of improvement.

An important distinction between ratings on worker visits in the two review processes is that the Program Monitoring review questions are more focused on the frequency of visits while the OSRI is focused on both the frequency and quality of the contacts. The OSRI has the added benefit of incorporating information received through the use of case specific stakeholder interviews.

***Sub-Question 2: Are identified safety and risk factors addressed, monitored, and followed up on appropriately in CPS In-Home Services?***

In the Summary of Performance section of North’s Carolina’s *Round 3 CFSR Final Report*, the Children’s Bureau states that concerns identified in CPS In-Home cases “related to premature case closures when safety concerns were present. Within the In-Home sample, some cases were closed before assessing safety or offering services. The case review also revealed that cases were closed without addressing the presenting problem and the reason for agency involvement. The Children’s Bureau encourages North Carolina to examine its practices surrounding case closure to improve safety outcomes for children.”

As previously noted, the 2017-2018 OSRI reviews found Item 3, which relates to both the assessment and appropriate follow-up of safety and risk, to be a strength in only 31 percent of In-Home cases reviewed, suggesting that safety and risk management are a persistent practice challenge for North Carolina in working with In-Home families.

Program Monitoring Reviews in 2017 shown in the table below are slightly more encouraging, but they suggest North Carolina still has room for improvement in appropriately addressing safety and risk factors before closing CPS In-Home Services.

<b>2017 NC Program Monitoring Review Data</b>				
<b>Select Questions – In-Home Services Protocol</b>				
<b>Prevention and In-Home Services</b>				
Is policy regarding the assessment of safety, risk, child well-being, and protective capacity prior to closing the case adequate and is it being followed?				
<b>Data Indicators</b>	<b>State</b>	<b>Large Counties</b> 2/10 reviewed	<b>Medium Counties</b> 14/39 reviewed	<b>Small Counties</b> 20/51 reviewed
Did the closing summary outline why the child is no longer at risk of maltreatment or foster care?	72.62% (122/168)	50% (6/12)	74.47% (70/94)	74.19% (46/62)
Did closing SDM tools support the decision to close the case?	74.85% (125/167)	58.33% (7/12)	74.47% (70/94)	78.69% (48/61)

Program monitoring data in the table below suggests policy requiring making a new CPS report to address new allegations that arise within CPS In-Home Services needs to be followed more consistently.

<b>2017 NC Program Monitoring Review Data</b>				
<b>Select Questions – In-Home Services Protocol</b>				
<b>Identified safety and risk factors are addressed, monitored and followed up on appropriately</b>	<b>State</b>	<b>Large Counties</b>	<b>Medium Counties</b>	<b>Small Counties</b>
If the social worker received new allegations of abuse/neglect/dependency, was a CPS report made?	75.76% (75/99)	90.91% (10/11)	81.82% (45/55)	60.61% (20/33)

Once safety and risk factors are identified, DSS must address those factors, monitor them, and follow up on them appropriately. This is a vital component of the work to assist families in

achieving lasting and sustainable permanency. During focus groups, some caseworkers shared that they focus on strengths and then needs, and that follow-up works best when there is a transfer meeting from the assessment with the caseworkers and the family. 2017 Program Monitoring Review findings indicate that counties perform reasonably well in terms of making CPS reports once a new allegation of abuse or neglect is received, at 76 percent. Large and medium counties performed slightly better in this area than smaller counties. As previously noted, however, 2017-2018 OSRI results for Item 3 as it relates to risk and safety management, which includes not only the assessment of safety and risk, but also the appropriate follow-up to ensure child safety, found this to be a persistent practice challenge for North Carolina in working with in-home families.

CPS caseworkers were also asked in focus groups about how they monitor and follow up on safety threats and risk factors in their work on In-Home cases. Some shared that they look for strengths and then needs, and then connect families to resources. They also indicated that the process works best when a transition meeting takes place around the assessment between the worker and the family. One county shared they have been staffing a lot more with the legal department when feeling vulnerable about decision.

***Sub-Question 3: Are family members engaged in decision-making and service plan development?***

As previously discussed, the Child and Family Team (CFT) meeting process is a key component toward successfully engaging families, assessing their strengths and needs and developing and completing a Family Service Agreement. Policy expectations and requirements for CFTs are clear. Performance in this area, however, varies based on findings from Program Monitoring Reviews and information obtained via focus groups.

Program Monitoring Reviews of CPS In-Home cases conducted in 2017 found that mothers (95%) and fathers (91%) living in the home participated in the development of the FSA; however, these same reviews indicated that only 51 percent of children and youth participated in CFTs and in the development of the FSA.

***Key Findings: Engaging family members in decision-making and service plan development:***

- Staff do a good job engaging mothers and fathers residing in the home in the development of their FSA.
- Children are much less likely to be engaged in the development of their FSA or to participate in CFTs.
- Initial and ongoing CFTs are not consistently held per agency policy.

This is consistent with focus groups with youth, who revealed that they did not always get notice of these meetings. Some adult professionals interviewed expressed a level of discomfort in having children and youth involved in this aspect of the process because they felt it would increase the trauma that they were already experiencing from the alleged abuse or neglect.

Results from North Carolina’s 2017-2018 OSRIs suggests that child and family engagement in the case planning process (Item 13) is an area in need of improvement with only 38 percent of 32 applicable CPS In-Home Services cases rated as a strength.

At a system level, the North Carolina State Family Advisory Council is made up of foster parents, birth parents, relative caregivers, and youth who have experienced the child welfare system. This council is in its early stages and is being staffed by DSS and university partners. Engagement with this group and the development of similar advisory councils at the local level may help to mitigate misconceptions like this that impact practice. Likewise, engagement with such stakeholders can highlight good practice that needs to be replicated and sustained. Some birth parents indicated that they received appropriate services in a timely manner that they were treated with respect, and it made a big difference for their families. While this was true for some of the birth families involved in focus groups, Program Monitoring review data indicates that only 68 percent of families had their CFTs within 30 days of a case decision, and 58 percent had ongoing CFTs every 90 days in accordance with DSS policy.

<b>2017 NC Program Monitoring Review Data</b>				
<b>Select Questions – In-Home Services Protocol</b>				
<b>Family engagement in decision-making and service plan development</b>	<b>State</b>	<b>Large Counties</b>	<b>Medium Counties</b>	<b>Small Counties</b>
Were CFTs held according to policy:	67.83%	54.76%	73.57%	63.13%
▪ Initial CFT within 30 days of case decision	(291/429)	(23/42)	(167/227)	(101/160)
▪ Ongoing CFTs every 90 days	57.68%	36%	66.26%	49.52%
(169/293)	(9/17)	(108/163)	(52/105)	
▪ CFT’s when there was a change in family Circumstances	47.88%	25%	55.42%	43.94%
(79/165)	(4/16)	(46/83)	(29/66)	
▪ Did children participate in CFTs?	51.08%	42.86%	58.97%	40.59%
(142/278)	(9/21)	(92/156)	(41/101)	
Did the mother (residing in the home) participate in the development of the FSA?	95.34%	97.5%	96.48%	92.91%
(389/408)	(39/40)	(219/227)	(131/141)	
Was the FSA regularly reviewed with the mother?	76.41%	63.16%	76.96%	79.39%
(285/373)	(24/38)	(157/204)	(104/131)	
Did the father (residing in the home) participate in the development of the FSA?	90.09%	80.77%	91.23%	91.46%
(200/222)	(21/26)	(104/114)	(75/82)	
Was the FSA regularly reviewed with the father?	69.90%	42.86%	70.30%	77.03%
(137/196)	(9/21)	(71/101)	(57/74)	
Did the other custodian/guardian/caretaker and non-resident parents participate in the development of the FSA?	58.56%	66.67%	72%	44.23%
(65/111)	(6/9)	(36/50)	(23/52)	
Did the child(ren) in the home participate in the development of the FSA?	51.09%	56%	57.14%	40.21%
(141/276)	(14/25)	(88/154)	(39/97)	
Did the Temporary Service Provider participate in the development of the FSA?	58.33%	50%	69.69%	43.59%
(63/108)	(2/4)	(44/65)	(17/39)	



**Sub-Question 4:** *Is information regarding risk and protective factors incorporated in the Family Service Plan and are safety issues specifically addressed in the FSA?*

North Carolina has multiple policy and practice expectations for staff regarding the identification of protective factors and incorporating them into the Family Service Plan. This asset-driven approach is research-based and enables families to build upon their strengths as they work toward the goals in their Family Service Agreements. However, during focus groups with supervisors, several noted that safety and risk factors are being incorporated into the service plans more often than protective factors.

**Key Findings:** *Incorporating information regarding risk, safety and protective factors into Family Service Plan:*

- FSAs do not consistently identify well-being needs for the mother, father and child but do address needs identified in the CPS assessment.

Program Monitoring Reviews in 2017 found that well-being needs were identified in FSAs in only 65 percent of reviewed records for mothers and only 56 percent of reviewed records for fathers and were updated and addressed in only 55 percent of FSAs for children. In contrast, program monitors found that FSAs addressed needs identified in the CPS assessment nearly 90 percent of the time for mothers, 82 percent of the time for fathers, and 84 percent of the time for children. As the state moves toward implementation of FFPSA, shifting to a system built upon the protective factors of families will be essential.

2017 NC Program Monitoring Review Data				
<i>Select Questions – In-Home Services Protocol</i>				
Appropriate integration of relevant risk, protective factors, and safety issues information incorporated into and addressed in service plan	State	Large Counties	Medium Counties 14/39 reviewed	Small Counties 20/51 reviewed
Were well-being needs for the Mother (residing in the home) identified in the FSA?	65.13% (254/390)	50% (20/40)	64.35% (139/216)	70.90% (95/134)
Were well-being needs for the father (residing in the home) identified in the FSA?	56.37% (115/204)	36% (9/25)	58.65% (61/104)	60% (45/75)
Were well-being needs for the child(ren) updated and addressed in each FSA?	55.15% (166/301)	57.14% (16/28)	57.23% (95/166)	51.40% (55/107)
Did the FSA address needs identified in the DSS 5228 or 5010 (Case Decision Summary/Initial Family Services Agreement), and 5229 (Assessment of Strengths and Needs) for the mother (residing in-home)?	88.83% (358/403)	74.36% (29/39)	91.52% (205/224)	88.57% (124/140)
Did the FSA address needs identified in the DSS 5228 or 5010 (Case Decision Summary/Initial Family Services Agreement), and 5229 (Assessment of Strengths and Needs) for the father (residing in-home)?	82.08% (174/212)	68% (17/25)	88/79% (95/107)	77.5% (62/80)
Did the FSA address needs identified in the DSS 5228 or 5010 (Case Decision Summary/Initial Family Services Agreement), and 5229 (Assessment of Strengths and Needs) for the custodian/guardian/caretaker (residing in-home)?	60.87% (42/69)	33.33% (2/6)	83.87% (26/31)	43.75% (14/32)

<b>2017 NC Program Monitoring Review Data</b>				
<b>Select Questions – In-Home Services Protocol</b>				
Appropriate integration of relevant risk, protective factors, and safety issues information incorporated into and addressed in service plan	State	Large Counties	Medium Counties 14/39 reviewed	Small Counties 20/51 reviewed
Did the FSA address needs identified in the DSS 5228 or 5010 (Case Decision Summary/Initial Family Services Agreement), and 5229 (Assessment of Strengths and Needs) for the child(ren)?	84.15% (292/347)	96.97% (32/33)	82.97% (151/182)	82.58% (109/132)
Was the FSA focused on the child as the client, the goals focused on child safety and activities that impact the goal (mother – residing in-home)?	68.64% (278/405)	65% (26/40)	73.33% (165/225)	62.14 (87/140)
Was the FSA focused on the child as the client, the goals focused on child safety and activities that impact the goal (father – residing in-home)?	65.09% (138/212)	58.33% (14/24)	71.30% (77/108)	58.75% (47/80)
Was the FSA focused on the child as the client, the goals focused on child safety and activities that impact the goal (custodian/guardian/caretaker – residing in-home)?	61.90% (39/63)	60% (3/5)	82.76% (24/29)	41.38% (12/29)

**Sub-Question 5:** *How is the service array and availability for families receiving In-Home Services? Are services monitored and adjusted as needed based on progress or lack of progress or changes in the family’s situation?*

Two somewhat distinct issues are included in this sub-question:

- ◆ General service array and availability for families receiving In-Home Services; and
- ◆ The extent to which counties work closely with In-Home families to monitor and adjust services based on progress being made and as family needs and dynamics change over time.

The issues are not completely distinct because service availability and quality impact families’ progress and counties’ ability to monitor and adjust services.

To address this research question, CSF considered data obtained from focus groups, surveys, and available reports and also analyzed available administrative, program monitoring, and OSRI data.

**Service Array and Availability**

Service array and availability vary greatly from county to county. For example, many county departments of social services provide direct services like parent training, but others do not. A few county DSS employ mental health therapists, but most do not. Counties also vary substantially in the kinds of services available from community providers, with more prosperous and more densely populated counties providing more services. The availability of services directly impacts the ability of DSS to assist families through In-Home Services. With the growing need for substance abuse and mental health treatment, the gaps in services in small rural counties create seemingly insurmountable hurdles for families. In interviews and focus groups, caseworkers and supervisors in these communities indicated that they often must send clients to

larger neighboring counties and that transportation becomes an additional barrier. Counties also report barriers accessing behavioral health services outside the regional provider network of the local managing entity/managed care organization (LME/MCO) responsible for their county. This can be a problem, for example, when a child is placed with a relative in another county or when a desired service is located in a neighboring county covered by a different LME/MCO.

The quality of services also varies greatly from county to county. Some focus group participants lamented that services seemed too “cookie cutter” and did not address the specific behavior changes that families were endeavoring to achieve. The lack of child care, housing, employment, and other basic needs in small communities exacerbate the situations for families. At the same time, staff in these communities expressed that they know their families well and they do whatever it takes to assist them. Likewise, youth, parents, foster parents, and relatives also expressed that the staff in small counties are highly accessible, return text messages within minutes, and respond on weekends and holidays.

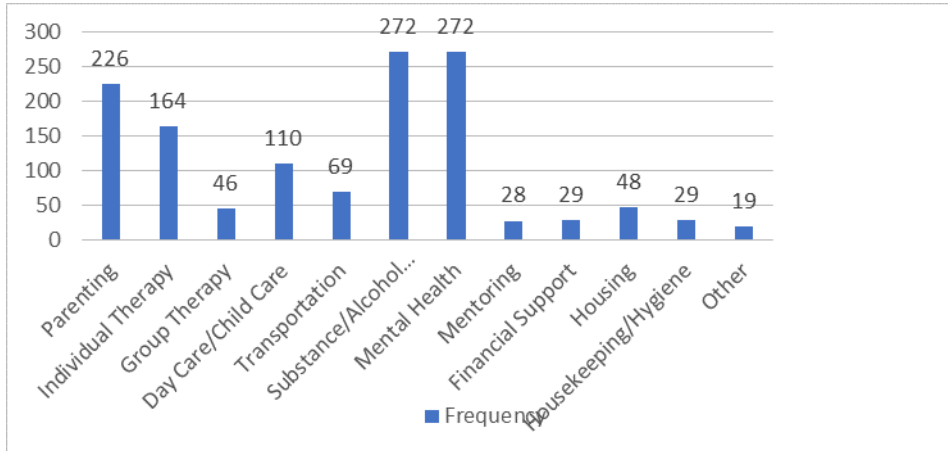
The state also contracts directly with private vendors for some services that are important to families receiving in-home services. The most notable of these contracts is for regional providers of intensive family preservation services based on the evidence supported Homebuilder model, in which workers provide intensive, time-limited services to very small caseloads for about six weeks in an effort to support families in safely preventing removals into foster care. This service is available statewide but has limited slots because it is so intensive.

***Key Findings: Service Array/Availability and Service Monitoring/Adjustment:***

- The array, availability and quality of services varies across the state.
- Public funding for mental health and substance abuse services for uninsured parents is very limited.
- In surveys, staff reported substance abuse and mental health services are the most common services provided, followed by parent training.
- Staff cited transportation challenges, and families’ refusal to participate, followed by issues such as extended wait lists, a lack of providers in the area and providers not accepting Medicaid as common reasons services are not received.
- Challenges were found regarding the monitoring and adjusting of services. Staff report they stay in regular contact with service providers. Case record reviews suggest FSA’s are not being updated every three months per policy.

CPS staff who participated in a survey administered by CSF responded as follows when asked, “What services are most frequently provided to families receiving CPS In-Home Services? Identify the most common three.”\*

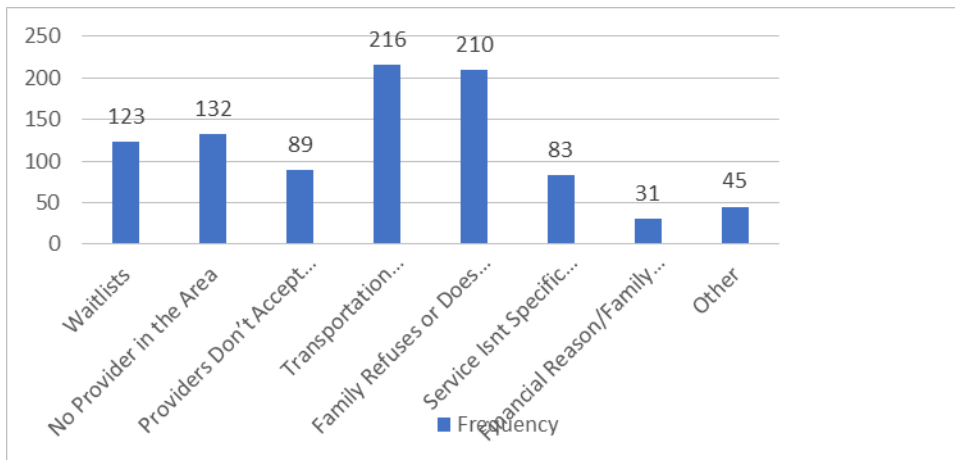
**\*Figure 20: CPS Staff Survey Responses: What Services Are Most Frequently Provided to Families Receiving CPS In-Home Services?**



Survey results indicate that both Substance Abuse and Mental Health services were the most frequently provided, followed by parenting related services and individual therapy.

Participants were also asked to respond to the question: “If services are not being provided and needs of families are therefore not being met, what are the three most common reasons as to why?”\*

**\*Figure 21: CPS Staff Survey Responses: If Services Not Being Provided, Why?**



Respondents identified that transportation challenges and families’ refusal to participate were the most prevalent reasons for services to in-home families not being provided. This was followed by issues such as extended wait lists, a lack of providers in the area and providers not accepting Medicaid.

**Services Monitored and Adjusted**

Data from 2017 Program Monitoring Reviews provide insight into county DSS efforts to work closely with families to monitor service provision effectively and to make adjustments as necessary that ensure the services are meeting the needs of the family towards goal achievement. Performance monitoring data in the table below indicates FSAs were updated every three months in accordance with policy for mothers in 67 percent and fathers in 63 percent of the cases reviewed. Documentation of a rationale for why the FSAs were not updated or for worker efforts to make FSA updates was found in only 22 percent of the cases in which FSAs were not updated timely. Similarly, there was little documentation to suggest that parental well-being needs were being updated and addressed at each required FSA update. Child well-being needs were updated and addressed at each FSA update in just over half of the cases reviewed.

2017 NC Program Monitoring Review Data				
<i>Select Questions – In-Home Services Protocol</i>				
Monitoring and adjustment of services	State	Large Counties	Medium Counties	Small Counties
Was the FSA formally updated for the Mother (residing in home) when there were significant changes and at least every three months?	66.89% (200/299)	60.71% (17/28)	70.41% (119/169)	62.75% (64/102)
If not, was there documentation of diligent efforts to engage Mother or rationale for continuing the previous FSA?	22% (22/100)	33% (5/15)	25% (12/48)	13.51% (5/37)
Were well-being needs updated and addressed for Mother at each FSA update?	52.82% (150/284)	65.52% (19/29)	52.56% (82/156)	49.49% (49/99)
Was the FSA formally updated for the Father (residing in home) when there were significant changes and at least every three months?	63.13% (101/160)	41.81% (7/17)	71.76% (61/85)	56.90% (33/58)
If not, was there documentation of diligent efforts to engage Father or rationale for continuing the previous FSA?	22.03% (13/59)	10% (1/10)	33.33% (8/24)	16% (4/25)
Were well-being needs updated and addressed for Father at each FSA update?	44.52% (69/155)	36.84% (7/19)	47.50% (38/80)	42.86% (24/56)
Were well-being needs updated and addressed for the child(ren) at each FSA update?	55.15% (166/301)	57.14% (16/28)	57.23% (95/166)	51.40% (55/107)

Close communication and collaboration with service providers is essential in ensuring that the type of service being provided and level of intensity (i.e., frequency) aligns with the child and family’s needs over time and in keeping with family dynamics and progress made.

CPS In-Home caseworkers participating in the CSF survey reported a high level of engagement with providers, with 28 percent reporting on average that they communicated with providers at least monthly, 34 percent reporting bi-weekly contact, and 25 percent reporting communication weekly or more than weekly.

	<b>Number</b>	<b>Percent</b>
<b>More than Weekly</b>	18	5.9%
<b>Weekly</b>	57	18.7%
<b>Bi-Weekly</b>	104	34.1%
<b>Monthly</b>	85	27.9%
<b>Less than Once a Month</b>	13	4.3%
<b>Never</b>	28	9.1%
<b>Total</b>	<b>305</b>	<b>100%</b>

Survey participants were also asked to what extent they felt that those services (i.e., therapy, parenting, formal assessments, etc.) being provided are inadequate or need to be adjusted to meet the needs of the children and or family. The majority of participants (45.5%) responded that services needed to be adjusted “sometimes,” while others responded “usually” (11%) or “often” (29%). This suggests there are overall service array issues across the state as well as a need for services that are more readily customized to the unique needs of in-home families.

***Sub-Question 6: Is children’s well-being (including health and education) appropriately addressed through assessment, case planning, and service delivery?***

Focus group participants indicated there is good access to health care services for children, but services can be difficult for parents to access. In contrast, mental health services are more challenging to access, especially in smaller counties. Data from 2017 Program Monitoring Reviews suggest the well-being of children being served as part of in-home services cases is being appropriately documented as part of Strengths and Needs Assessments in 66 percent of cases reviewed. Results from North Carolina’s 2017-2018 OSRIs indicated that meeting children’s educational needs (Item 16) as part of in-home cases was rated a strength in 63 percent of 16 applicable cases. Results for meeting child physical health (67% of 18 applicable cases) and mental health/behavioral needs (71% of 21 applicable cases) were rated slightly higher, but still an area needing improvement.

***Key Findings: Assessment of child well-being (including health and education)***

- Staff report that health care services are available for children but not always easily accessible for parents.
- Well-being needs of children of in-home cases are not being consistently documented in the Strengths and Needs Assessment.
- Meeting children’s physical health, mental/behavioral health, and educational needs in CPS in-home cases is an area in need of improvement.

**2017 NC Program Monitoring Review Data**

**Select Questions – In-Home Services Protocol**

Addressing children’s well-being needs (including health and education) through assessment, case planning and service delivery	<b>State</b>	<b>Large Counties</b>	<b>Medium Counties</b>	<b>Small Counties</b>
Were child well-being needs (physical health, education, mental health), or lack of needs, documented in the well-being section of the Strengths and Needs Assessment?	65.85% (216/328)	55.56% (15/27)	61.27% (106/173)	74.22% (95/128)

**Sub-Question 7:** *Is policy regarding assessment of safety, risk, child well-being, and protective capacity prior to closing the case adequate and is it being followed?*

As previously mentioned, addressing safety issues prior to closing in-home cases was highlighted as an area of concern in North Carolina’s 2015 CFSR report. Subsequent case reviews have found continued room for improvement. Results of 2017 Program Monitoring Reviews suggest that key agency closing procedures were being followed in an average of 70 percent of cases reviewed. Sending closure letters to non-resident parents was a specific weakness.

CPS In-Home services caseworkers who participated in the CSF survey were asked to describe the factors that enter into their determination that an in-home case can be safely closed. The top five responses were:

- ◆ Risk is reduced.
- ◆ Family exhibits behavioral changes.
- ◆ No remaining safety concerns.
- ◆ The goals of the service plan were met/completed.
- ◆ Family followed through with recommended services.

**Key Findings:** *Assessment of child safety, risk, and well-being, and parental protective capacities prior to case closure:*

- Key agency closing procedures are generally being followed based on Program Monitoring review findings.
- Documentation from SDM tools that support the decision to close in-home cases in 75% of cases reviewed.
- The practice of sending timely case closure letters to involved non-resident parents is an area in need of improvement.

2017 NC Program Monitoring Review Data				
<i>Select Questions – In-Home Services Protocol</i>				
Assessment of safety, risk, child well-being, and protective capacities prior to case closure	State	Large Counties	Medium Counties	Small Counties
Did the closing summary outline why the child is no longer at risk of maltreatment or foster care?	72.62% (122/168)	50% (6/12)	74.47% (70/94)	74.19% (46/62)
Did closing SDM tools support the decision to close the case?	74.85% (125/167)	58.33% (7/12)	74.47% (70/94)	78.69% (48/61)
If this is not the first time the family has received CPS In-Home Services, was there a closing CFT with the family?	69.70% (46/66)	60% (3/5)	75% (30/40)	61.90% (13/21)
Was a closure letter sent to the family (parents in household) within 7 days of the decision?	76.30% (132/173)	57.14% (8/14)	80% (76/95)	75% (48/64)
Was a closure letter sent to the family (involved non-resident parent) within 7 days of the decision?	45% (36/80)	0% (0/2)	48.21% (27/56)	40.91% (9/22)

**Sub-Question 8:** *Is supervisory involvement and oversight of these processes adequate?*

Results of surveys conducted with CPS In-Home Services staff revealed that virtually all feel somewhat or very supported by their supervisor in their work.

*To what extent do you feel supported by your supervisor during In-Home cases?*

	Number	Percent
Very Supported	174	64.7%
Somewhat Supported	79	29.4%
Not Particularly Supported	9	3.3%
Not Supported at All	7	2.6%
<b>Total</b>	<b>269</b>	<b>100%</b>

**Key Findings:** *Supervisory involvement and oversight on In-Home family service cases:*

- Caseworkers serving in-home families feel supported by their supervisor.
- Supervisors are doing a good job of signing off on most required documents in the case file.

When asked to provide details as to how they feel supported, the top responses included:

- ◆ I feel supported by my supervisor.
- ◆ My supervisor provides guidance, is helpful
- ◆ We do regular staffings
- ◆ My supervisor is available
- ◆ My supervisor is hands on (calls, visits, paperwork meetings, etc.)

Program Monitoring review data indicate that supervisory involvement and oversight is documented through co-signing SDM tools in about 90 percent of cases reviewed. Documentation of case specific supervisory consultation at least twice monthly was found in fewer than half of reviewed cases, but this new requirement in the modified policy manual had not yet been implemented in most counties when the cases were reviewed.

<b>2017 NC Program Monitoring Review Data</b>				
<b>Select Questions – In-Home Services Protocol</b>				
Supervisory involvement and oversight of In-Home Services	State	Large Counties	Medium Counties	Small Counties
Were Risk Re-Assessments (DSS-5226) signed and dated by the social worker and supervisor?	91.46% (289/316)	88.89% (24/27)	93.45% (157/168)	89.26% (108/121)
Were Strengths and Needs Assessments (DSS-5229) signed and dated by the social worker and supervisor?	89.93% (268/298)	84% (21/25)	92.45% (147/159)	87.72% (100/114)
Did the FSA include signatures of the supervisor?	91.51% (399/436)	88.10% (37/42)	91.10% (215/236)	93.04% (147/158)
Was there documentation of case specific supervisory consultation during the case at least twice monthly?	45.64% (199/436)	54.76% (23/42)	44.83% (104/232)	44.44% (72/162)
If the case was identified as high risk at the time of any CFT's, was a facilitator used according to policy?	74.54% (202/271)	70.59% (12/17)	80.39% (123/153)	66.34% (67/101)



2017 NC Program Monitoring Review Data				
<i>Select Questions – In-Home Services Protocol</i>				
Supervisory involvement and oversight of In-Home Services	State	Large Counties	Medium Counties	Small Counties
If initiated during the provision of CPS In-Home Services, was the Initial Safety Provider Assessment form signed by the TSP, social worker, and supervisor?	62.26% (33/553)	66.67% (2/3)	63.33% (19/30)	60% (12/20)
The disposition decision included the supervisor or supervisor designee.	79.62% (168/211)	70% (14/20)	81.55% (84/103)	79.55% (70/88)

### ***C. Child Fatality Oversight***

Together with state and county stakeholders, North Carolina has begun a process to review and strengthen its child fatality review and prevention system with a goal of assuring that fatality reviews lead to actions to improve child safety and health. A description of that process is included in the description of the system below.

#### **Overview**

North Carolina has multiple teams and processes to review fatalities at the local and state level involving the social services and public health systems. The teams and processes have complex relationships with each other.

#### ***Local Teams***

N.C.G.S 7B-1406 requires the creation of local Community Child Protection Teams (CCPTs) in all 100 counties with representatives from public and private entities that provide services to children and families including social services, public health, the health care and mental health professions, law enforcement, the legal system, the education system. The local teams must review:

- ◆ Active child welfare cases.
- ◆ Child fatalities suspected to be the result of abuse or neglect *and* in which the child or child’s family was reported to CPS or open to child welfare services within the previous 12 months.

The statute gives CCPTs the option of also reviewing additional fatalities and being a joint CCPT/Child Fatality Prevention Team (CFPT). About three quarters of counties choose to combine the teams, with one-quarter of counties choosing to operate a separate CFPT. The combined teams must have an additional five specified community representatives. Both teams or the joint team are required to make reports of findings and recommendations for system improvements to the local county board of commissioners. The local teams also report on cases reviewed, together or separately, to the CCPT consultant in the state DSS office and the CFPT coordinator in division of public health. Additionally, child welfare policy has established CCPTs as the citizen review panels (CRPs) for public child welfare agencies required by the federal Child Abuse Prevention and Treatment Act (CAPTA). A State CCPT/CRP Advisory Board provides guidance to the local CCPTs and makes an annual report to the state Division of Social Services.

### ***Other Child Welfare Fatality Review Processes***

- ◆ In 2017 the Central DSS Office began conducting a review, within seven days, whenever a child dies while in open foster care or CPS In-Home Services cases, using sections of the Child and Family Services Review (CFSR) On Site Review Instrument (OSRI). This review assesses the county's adherence to policy and expected practice.
- ◆ The Child Fatality Review Team within the Central DSS Office leads an intensive local review of the same maltreatment related fatalities known to child welfare that local CCPTs are required to review. Required participants in the state-led intensive review include representatives from:
  - the county DSS;
  - the county Community Child Protection Team (CCPT);
  - the county Child Fatality Prevention Team (CFPT);
  - law enforcement;
  - the medical profession; and
  - a prevention service.

Findings and recommendations are intended to stimulate system improvements and can be made public. The state fatality review coordinator also reports back to local teams on the intensive review findings.

- ◆ County DSS directors are required by N.C.G.S. 7B-2902 to disclose information to the public within five working days of receiving a request when a person is charged criminally with a child fatality or near fatality. The information, which must first be reviewed by the district attorney, includes confirmation of all CPS reports received, actions taken, and services rendered, and a description of the most recent CPS investigation.
- ◆ Some county DSS conduct internal reviews of fatalities according to their own protocols to assure appropriate service response to other household members and to immediately assess operational issues within their agency.

### ***Other State Level Components of the Child Fatality Prevention System***

- ◆ N.C.G.S. 7B-1404 creates a State Child Fatality Prevention Team composed of the directors of multiple state agencies to be chaired by the Chief State Medical Examiner. The State Fatality Prevention Team is responsible for reviewing all deaths of children attributed to abuse or neglect or of children who had been reported to CPS at any time in their lives. The State Child Fatality Prevention Team is also responsible for reviewing findings and recommendations from local team reviews of other fatalities and working with team coordinators to implement recommended system improvements. Finally, the team is responsible for reporting to the State Child Fatality Task Force on recommendations for changes to any law, rule, and policy that would promote the safety and well-being of children.
- ◆ N.C.G.S. 7B-1402 creates a 35-member State Child Fatality Prevention Task Force that includes directors of multiple state agencies, 10 members of the general assembly, and stakeholders appointed by the legislative leadership or the governor. The task force receives

reports and recommendations from the State Child Fatality Prevention Team and makes reports and recommendations to the legislature and governor.

A two-day summit was hosted in April 2018 by the Child Fatality Prevention Task Force and that brought together representatives of all components of North Carolina’s child fatality system described above. CSF attended this summit, which included sessions about how the current elements of the system are intended to function; strengths, weaknesses, findings, and accomplishments of the system and its components; health and wellbeing initiatives relevant to the system; and national best practices in fatality review and prevention. The two diagrams below were distributed by the leaders of the State Child Fatality Prevention Task Force. The leaders explained that the diagrams illustrate the complexity of the current structure, process and feedback loops in the system.

Figure 22: North Carolina Child Fatality Prevention System Structure

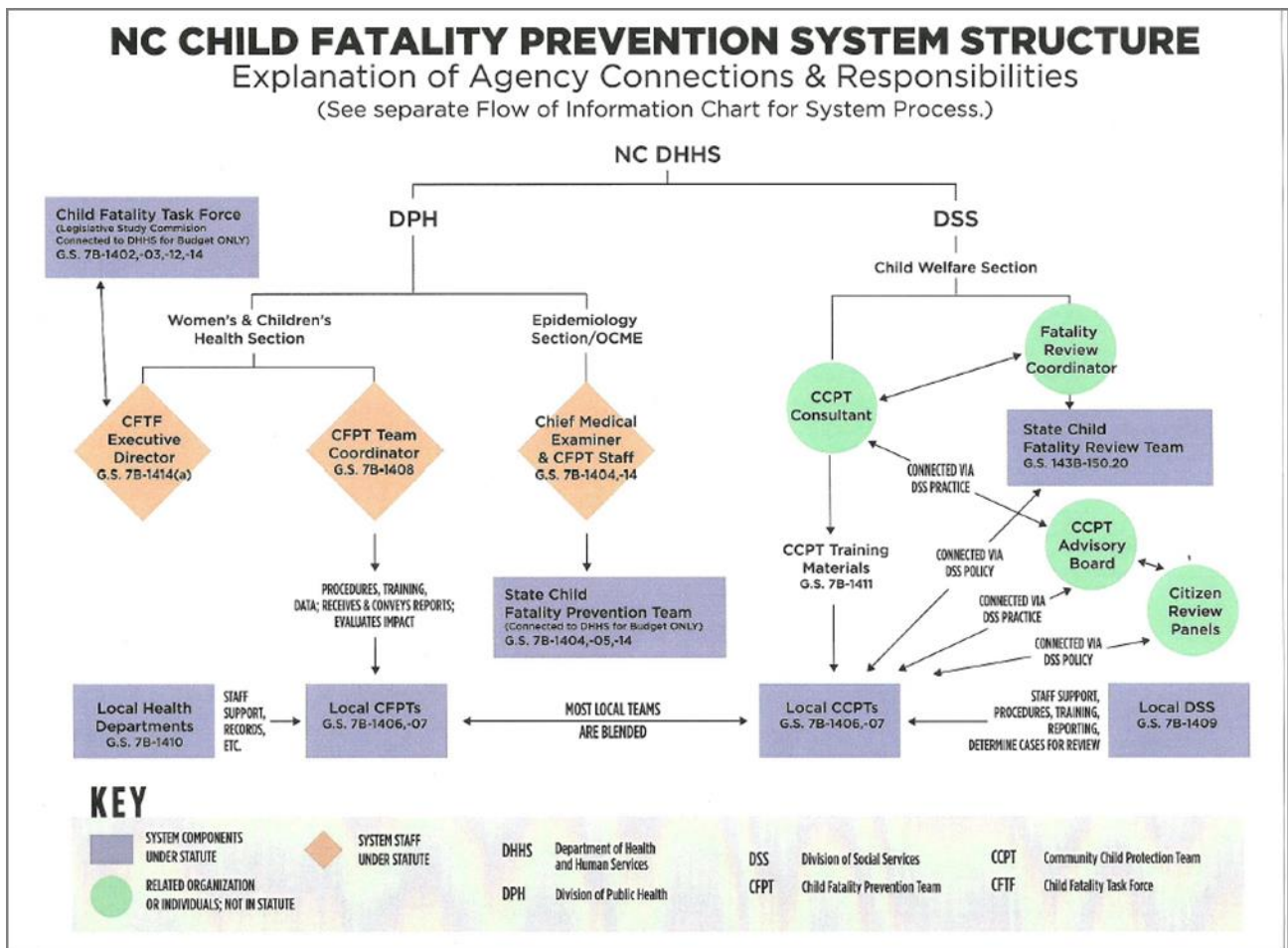
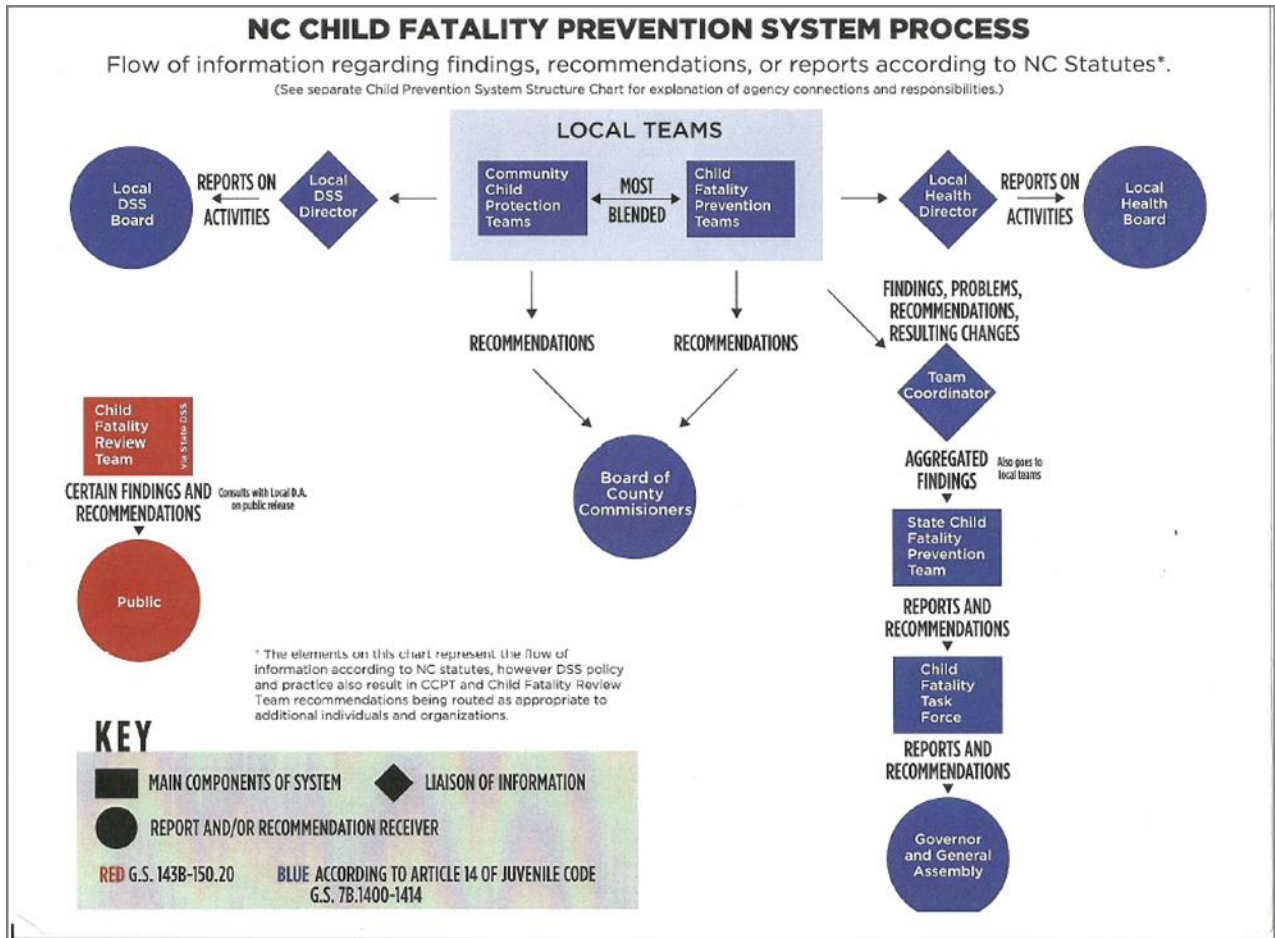


Figure 23: North Carolina Child Fatality Prevention System Process



On August 17, 2018 the Child Fatality Task Force hosted a smaller follow-up meeting of Child Fatality Prevention stakeholders. The meeting, facilitated by two national experts, focused on generating ideas to improve the fatality system structure, and participants were encouraged not to be constrained in their thinking by the current structure. The task force also is planning to convene groups to consider how to improve the use of data from fatality reviews and how best to provide support to review processes.

**Sources of Information**

- ◆ N.C.G.S. 7B-1400.
- ◆ NC DSS Family Services Manual. Volume I: Children’s Services; Chapter VIII: Child Protective Services.
- ◆ Meetings Attended:
  - 2018 NC Child Fatality Prevention System Summit, April 9-10, McKimmon Center, Raleigh. Materials at <https://www.surveygizmo.com/s3/4250682/NC-Child-Fatality-Task-Force-Summit-2018>
  - CFP Structure Stakeholder Meeting, August 17, Raleigh

- ◆ Focus Groups and interviews.
- ◆ Reports Reviewed:
  - Reports of State-Led Fatality Reviews.
  - Annual Report of the NC Child Fatality Task Force to the Governor and General Assembly, May 2018.  
<https://www.ncleg.net/DocumentSites/Committees/NCCFTF/Reports%20and%20Data/Annual%20Reports/CFTF%202018%20Annual%20Report.pdf>
  - 2016 Report on the Status of Child Death Reviews in the United States, National Center for Fatality Review and Prevention (CFRP) (from summit website).
  - Within our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities. Commission to Eliminate Child Abuse and Neglect Fatalities. Final Report, 2016, available at [https://www.acf.hhs.gov/sites/default/files/cb/cecanf\\_final\\_report.pdf](https://www.acf.hhs.gov/sites/default/files/cb/cecanf_final_report.pdf)
  - NC Maltreatment Reviews, Debra McHenry. April 2018 NC Child Fatality Prevention Summit.

**Detailed Findings**

<b><u>Primary Research Question:</u></b>	<i>Are the findings from North Carolina’s fatality reviews being used effectively to take actions to prevent other fatalities and improve the health and safety of children?</i>
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The 2018 Child Fatality Task Force Annual Report provides a list of legislation that has been passed that was recommended or supported by the task force since its inception in 1991. Listed legislative accomplishments include:

- ◆ Child Protection funding including funding for CPS workers, intensive family prevention services, CPS In-Home Services workers, and the child medical evaluation program.
- ◆ Child abuse prevention funding including home visiting programs and safe sleep awareness programs.
- ◆ Multiple efforts to reduce motor vehicle fatalities, including child passenger safety laws and graduated driver’s license laws.
- ◆ Multiple efforts to reduce fatalities from other types of accidents, including smoke and carbon monoxide detector and bicycle helmet laws.
- ◆ Funding for efforts to reduce infant mortality.

Findings from state-led intensive reviews, local team reviews, and internal agency reviews are more likely to lead to local than state action to prevent other fatalities and improve the health and safety of children than state actions. This conclusion is based on:

- ◆ The very general nature of findings and recommendations made from the state intensive review team process.
- ◆ The current lack of a systematized approach to aggregating and analyzing the rich information gathered in the state led reviews to inform conclusions about specific changes in

how child welfare or other systems operate that might better protect children and support families.

- ◆ The relatively sparse flow of information from local teams to the state about findings and recommendations.

The CFPT/CCPT process, the state-led intensive team process, and the State Child Fatality Prevention Team and task force all engage the broader community in conversations on how better to protect children, enhance their wellbeing, and support families.

A couple ways of organizing data that might help the state DSS consider actions to reduce fatalities and improve well-being were not found in the reports reviewed. For example, data could be organized to group:

- ◆ Deaths believed to be related to child abuse or neglect (irrespective of whether child welfare had involvement in the previous 12 months).
- ◆ Deaths with relevant family history of child welfare involvement prior to the death.

***Sub-Question 1:*** How does North Carolina’s child fatality review protocol for conducting comprehensive multidisciplinary reviews when children known to the child welfare system die from suspected child abuse or neglect compare with protocols in other states?

In its 2016 report on the status of child death reviews in the United States, the National Center for Fatality Review and Prevention (CFRP) reports more than 1,350 state and local fatality review teams are operating in the United States, with at least one team in every state. The CFRP reports that the Health Department is the lead state agency for fatality review in the majority of states, with the Social Services being the second most frequent lead agency. When the Health Department is the lead agency, the types of deaths reviewed tend to be broader. Only a minority of states include serious injury cases in their reviews, though this was a recommendation of the 2016 final report of the President’s Commission to Eliminate Child Abuse and Neglect Fatalities. Among the majority of states that have local teams, some, like Georgia, have a team in every county; others, like Texas, allow counties to join into regional teams.

***Key Findings: Protocol Comparison with Other States***

- North Carolina fatality review processes include recommended practices such as taking a comprehensive, multi-disciplinary approach that engages the community in efforts to keep children safe.
- North Carolina appears to have an unusual number of review processes.

The CFRP recommends the following operating principles of child death review.

- ◆ The death of a child is a community responsibility.
- ◆ A child’s death is a sentinel event that should urge communities to identify other children at risk for illness or injury.
- ◆ A death review requires multidisciplinary participation from the community.
- ◆ A review of case information should be comprehensive and broad.

- ◆ A review should lead to an understanding of risk factors.
- ◆ A review should focus on prevention and should lead to effective recommendations and actions to prevent deaths and to keep children healthy, safe, and protected.

North Carolina's fatality review protocols generally incorporate the principles recommended by the CFRP. The local teams, state-led intensive review process, State Fatality Prevention Team, and State Fatality Prevention Task Force all have broad representation from human services, education, law enforcement, and legal agencies, and multiple disciplines; and their reviews underline the message that child deaths are sentinel events and their prevention is a community responsibility. The reviews are comprehensive and broad in scope and seek to lead both to a better understanding of risk factors and system recommendations for prevention.

North Carolina is unusual in the total number of different review processes arising out of the social services and public health systems. A national expert at the August 17 stakeholder meeting told participants North Carolina has, without question, the most complicated system of any state.

***Sub-Question 2: Is North Carolina following its protocol?***

The North Carolina Child Fatality Team and Child Fatality Task Force are active teams that make data and information about trends in the demographics of children who die and the causes of their deaths available to the legislature and prevention partners. In 2016, the Office of the Medical Examiner and the NC Fatality Prevention Team reviewed 511 of 1,360 infant and child deaths, including all deaths that were due to homicide, suicide, accidents, and deaths of undetermined causes, along with some natural deaths. The State Child Fatality Task Force had a total of nine committee and three full task force meetings in 2017 and organized a summit held in April 2018 that was attended by 200 people from all elements of the state's child fatality prevention system. The state

teams make recommendations annually for legislative changes and policy initiatives to reduce fatalities. Local teams appear to be active in the vast majority of counties, though a DHHS official reports the highest number of required annual reports received was 85 of 100. Interviews and focus groups suggest some variability exists in functioning of local CCPTs and CFPTs and that recruiting and retaining full active membership is a challenge. A leader of the state CCPT/CRP advisory board expressed concern that combined local teams (CFPT/CCPT) often focus on the CFPT function of reviewing fatalities at the expense of the CCPT/CRP function of reviewing active DSS cases. A focus group participant reported this phenomena occurred in her county until a separate CCPT was established. For several years, the State Child Welfare Fatality Review team had backlogs of fatalities awaiting state-led intensive reviews, resulting in reviews often not occurring until a year or two after children died. This backlog was largely cleared up in late 2017 and early 2018, and the state now has a goal of conducting intensive reviews within six months except in those cases for which a county district attorney requests the review be delayed.

***Key Findings: Is North Carolina Following its Protocol?***

- The state Child Fatality Team and Child Fatality Task force are both very active.
- Local teams are active in most counties, with some variability in functioning.
- The state-led intensive fatality review team recently resolved a large backlog.

***Sub-Question 3:*** *Do the reports from North Carolina’s fatality reviews individually and collectively lead to a better understanding of how and why children are dying?*

Reports from the State Child Fatality Prevention Team and Child Fatality Prevention Task Force provide detailed pictures of the causes of child death in North Carolina and the age and demographics of children who die from the various causes. The 2018 annual report from the Child Fatality Prevention Task Force includes a report on child death data compiled by the North Carolina Division of Public Health in conjunction with the State Center for Health Statistics that additionally provides information on trends over time. The reports show, for example that the majority of the 1,360 children who died in 2016 were infants with perinatal conditions, birth defects, or illnesses. However, the report also includes information about the almost 200 children dying from motor vehicle and other types of accidents, 51 children dying from homicide, and 44 dying from suicide. To more reliably assess trends in subcategories with lower incidences of fatalities, the report compares death rates by causes in five-year periods (2007-2011 and 2012-2016).

***Key Findings:***

**Reports Lead to a Better Understanding of Why Children Are Dying**

- Reports provide excellent information on causes of death and the demographics of children who die.
- The rich information gathered in intensive state led and local reviews is not being aggregated

Decreases were found in deaths among older youth from motor vehicle and other accidents and among children of all ages from poisoning; increases were found in infant homicides and suicides for children of all ages. An advantage to studying serious injuries resulting from maltreatment, as recommended by the 2016 President’s Commission, is that the greater numbers of children suffering serious injuries allows better tracking of trends and the effectiveness of interventions. A challenge is that data on serious injuries resulting from maltreatment are not currently being consistently and reliably tracked.

A report from the State DSS Child Fatality Review Team provided data from FY 2015 and FY 2016 on 51 reviews of children whose deaths were suspected to be the result of maltreatment and whose families had been served by or reported to child welfare in the previous 12 months. The most common causes of death were unsafe infant sleep practices (15, average age two months), homicide (11, average age 23 months), and suicide (11, average age 15). The report includes risk factors and recommendation highlights.

A strength of the state-led intensive review process is that it gathers rich and detailed information about the circumstances leading up to child deaths and the services received or not received from child welfare and other community entities. This information is available to the review team and by extension to the members of the local team and the county child welfare agency. A weakness is that this information is not being systematically aggregated to better understand patterns in actions or inactions of child welfare agencies or other community providers in child deaths across the state. Confidentiality protections preclude child specific information from being included in the reviews’ publicly available reports and, as of the April fatality summit, the rich information in the reviews was not being systematically aggregated and analyzed. DHHS officials at the summit signaled a desire to move in that direction.



***Sub-Question 4:*** *What is the relationship between reviews conducted as part of the State child fatality review protocol and reviews conducted by local community child protection teams, and how well do those processes work together?*

Local CCPTs or joint CCPT/CFPTs typically meet between four and 12 times a year and often conduct their reviews prior to the state led intensive review, especially when the state has had long review backlogs. It is common for state-led intensive reviews to recruit multiple members of the local CFPT/CCPTs to be on the state-led review team. After the state intensive review is completed, a report is made back to the local CCPT or joint CCPT/CFPT. The state-led review is acknowledged to be much more detailed than the local review. With the state fatality review team having eliminated its backlog and poised to complete prompt reviews, how the process by which the state and local teams review fatalities that meet criteria for intensive state review can be revisited.

***Key Findings: Relationship between state and county processes***

- With the backlog in state-led intensive reviews resolved, it is time to revisit how the state and local teams work together
- Input from local teams to the state team and task force can be strengthened.

The number of fatalities that meet criteria each year for the state-led intensive fatality review is relatively small. It was noted at the April Child Fatality Prevention summit that a great many of the “other fatalities” reviewed by the local CFPT and joint CCPT/CFPTs are found to have families with histories of involvement with child welfare and/or to involve maltreatment.

At the April Child Fatality Prevention summit, the Child Fatality Task Force chair reported the task force receives relatively few recommendations and reports from local CCPT/CFPT teams.

***Sub-Question 5:*** *Does the review process increase public awareness and advocacy for issues that affect the health and safety of children in North Carolina?*

- ◆ Local CCPT reviews and state-led intensive reviews raise awareness for the community representatives who participate.
- ◆ We learned of examples of information from local team reviews being used for local public information campaigns. For example, public health educators in Carteret County used information from its local teams to inform public awareness campaigns about safe sleep, hot cars, and rip currents.
- ◆ Reports of the state-led intensive reviews are vaguely written to avoid disclosing client specific information and unlikely to lead to awareness or advocacy.

***Key Findings: Does Process Increase Public Awareness?***

- The local team process raises awareness for participants
- Review processes have led to both local and statewide public information campaigns to improve child safety.

- ◆ Disclosures by DSS directors released pursuant to 7B-2902 sometimes include a great deal of information about fatalities and may be reported on extensively in the media.
- ◆ The Child Fatality Task Force and the Child Fatality Prevention Team actively seek to raise public awareness through information campaigns and actively advocate for legislation and administrative changes. The active involvement of legislators and governmental leaders on the Child Fatality Prevention Task Force greatly increases the effectiveness of the task force's advocacy and public awareness efforts.

## *D. Placement of Children in Foster Care and Other Out-of-Home Settings*

### **Overview**

Law and policy concerning protective services in North Carolina regard taking legal custody of a child away from parents or guardians as an extreme step that is justified only when the child is in imminent danger of serious harm and no other reasonable means is available to protect the child.

In North Carolina, children typically are placed in foster care and other out-of-home settings by social services after the director or his/her designee petitions the district court alleging the child has been abused, neglected, or dependent and requesting non-secure custody. The county director has authority to petition the court and request non-secure custody of a child any time during a CPS investigative or family assessment or the provision of CPS In-Home services. N.C.G.S 7B-502 gives any district court judge the authority to issue a non-secure custody order and allows the chief district court judge to delegate that authority to others through administrative order. Judicial districts in North Carolina have adopted different protocols to assure that petitions requesting non-secure custody are responded to rapidly in order to protect children. Additionally, N.C.G.S 7B-500 gives both law enforcement officers and social services workers the authority to take children into temporary custody for up to 12 hours (24 hours on a holiday or weekend) in emergency situations if waiting for a custody order for non-secure custody would endanger the child. If a custody order is not secured within the time frame, the child must be returned.

North Carolina's CPS policy is intended both to assure that the safety of children is accurately assessed and monitored during CPS assessments and that safety plans are considered and implemented when children can be protected without being removed from their parents or guardians' care. Safety plans often include the family receiving services and being monitored by DSS. The most restrictive type of plan involves giving the parent or guardian the option of choosing a safety provider (who must be assessed and approved by DSS) with whom the child will live for a temporary period while the parent retains custody while DSS continues its assessment and/or the family works to ameliorate the safety issue. Policy balances efforts to prevent legal removal of children with concerns about ensuring parental consent and parents' due process by setting timeframes for when DSS must petition for court involvement if it believes children are not safe to return home.

Child and Family Team (CFT) meetings play a significant role in DSS policy for assuring that children and families and supports of their choosing are involved in decisions about whether children need to be removed their home. CPS is required to hold a CFT meeting whenever

considering removing a child or requiring a family to choose a safety provider to avoid removal. When safety considerations do not allow a meeting to be held before a child is placed with a safety provider or enter-secure custody with DSS, the meeting is to be held immediately afterward.

A small percentage of children enter the placement and custody authority of a department of social services by court order without the director or designee petitioning for custody. This typically happens in one of two ways:

- ◆ DSS petitions the court alleging a child has been abused or neglected without also petitioning for custody and the court determines to give non-custody to DSS. This can happen when DSS petitions requesting court assistance in ordering a family to participate in critical services or to assure due process when a child has remained with a safety provider.
- ◆ A judge in another court (e.g., juvenile delinquency court or domestic court), based on evidence heard in that court, orders a child directly into the custody of DSS. This practice is more prevalent in some judicial districts than others.

When placing children who enter non-secure custody, DSS – in compliance with the federal Fostering Connections act – is required to give first preference to relatives who are assessed as able to provide a safe placement for the children. Other placement options include licensed foster homes or other homes authorized by law, DSS operated facilities, and any other home approved by the court. DSS policy further states that “any child removed from his or her home shall be placed in the least restrictive, most family-like setting in which special needs may be met, within close proximity to his or her family and with relatives when appropriate.” The policy manual guides caseworkers to focus on matching the child’s strengths and needs with any potential placement options. Policy also requires siblings to be placed together when possible and addresses the additional trauma that children may experience when separated. Policy emphasizes the importance of a single, stable placement while a child is in care.

A hearing on the need for continued non-secure custody must be held within seven days. For the child to remain in custody, the court must find a reasonable factual basis that information in the petition that the child was abused, neglected, or dependent is true and that no other reasonable means are available to protect the child. After the first non-secure custody hearing, the statutes require a clearly specified series of hearings in which DSS, in order to maintain custody, must demonstrate diligent efforts to notify relatives in compliance with the federal Fostering Connections act, demonstrate reasonable efforts to make custody no longer necessary, and present facts that support a finding that it is “contrary to the welfare of the child to remain in the home.” DSS policy articulates clear expectations that in addition to relatives, caseworkers shall consider non-relatives, fictive kin, and persons with legal custody of a sibling. Caseworkers must also consider if it is in the best interest of a child to remain in the community of their residence and there are legal prohibitions to discriminatory placements practices based on race, ethnicity, gender, or religion.

The federal government recognizes only one Native American tribe in North Carolina, the Eastern Band of Cherokee Indians. Families in this tribe have additional protections under the Indian Child Welfare Act (ICWA) of 1978. Under ICWA, DSS must put forth intensive services,

“active efforts,” to prevent abuse and neglect and keep children in their homes and when necessary to remove them, ensure that they remain in their communities through tribal relative searches. In addition to this tribe, the state of North Carolina recognizes seven additional tribes throughout the state. Although the federal Indian Child Welfare Act (ICWA) does not apply to all children and families from state-recognized tribes, current state law and policy encourage partnership between child welfare agencies and state-recognized tribes.

Once in foster care or out-of-home placement, N.C.G.S. 7B-501.1 allows DSS to arrange and consent for routine and emergency health and dental care. Mental health services and any non-routine medical care or care requiring informed consent must also be consented to by the child’s parent or guardian, or ordered by a judge after a hearing if the parent and DSS disagree.

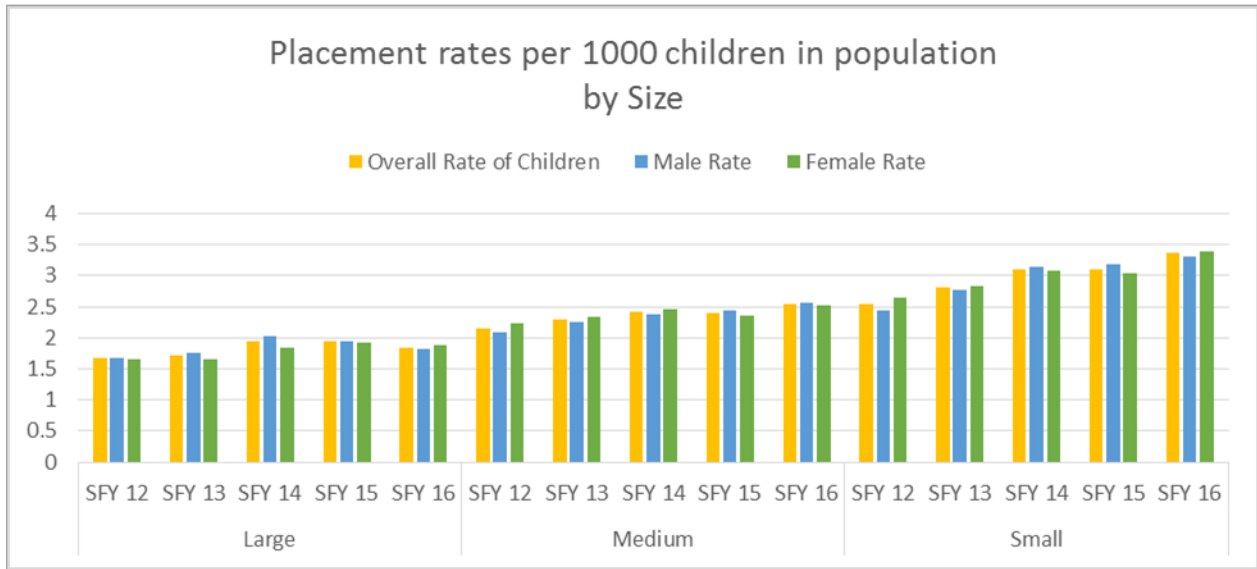
### **Placement of Children into Foster Care – Trends**

Effectively preventing placement of children into foster care depends on many factors, including:

- ◆ The ability of DSS staff to appropriately assess the strengths and needs of a family as well as any safety risks of all children in the home;
- ◆ The ability of DSS staff to effectively engage families and assist families in identifying relatives, kin, and fictive kin to support the family and serve as safety resources if needed;
- ◆ The ability to adequately identify appropriate services and intervention strategies that build upon a family’s protective factors and will lead to sustainable behavioral changes needed to address their challenges; and
- ◆ The availability and accessibility of community-based resources and services that are effective and targeted to meet the needs of families.

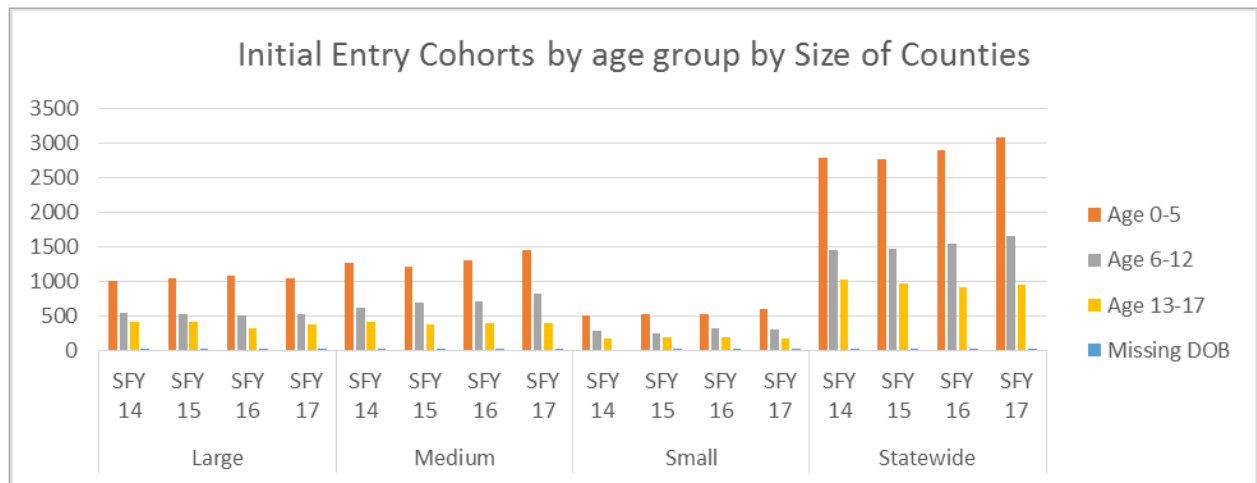
Two data points that can be analyzed to determine the effectiveness of these reasonable efforts to prevent removal is the rate of entry into foster care compared to other states and the trend of entries into foster care. As discussed previously, North Carolina’s rate of entry into foster care is lower than in most states. However, as is true in many states, the number of children entering foster care has been slightly increasing over the past five years. This is true for small, medium, and large counties.

**Figure 24: Placement Rates per 1,000 Children in Population by Size**



Source: Retrieved on June 30, 2018 from the University of North Carolina at Chapel Hill Jordan Institute for Families website. URL: <http://ssw.unc.edu/ma/>

**Figure 25: Initial Entry Cohorts by Age Group, by Size of Counties**

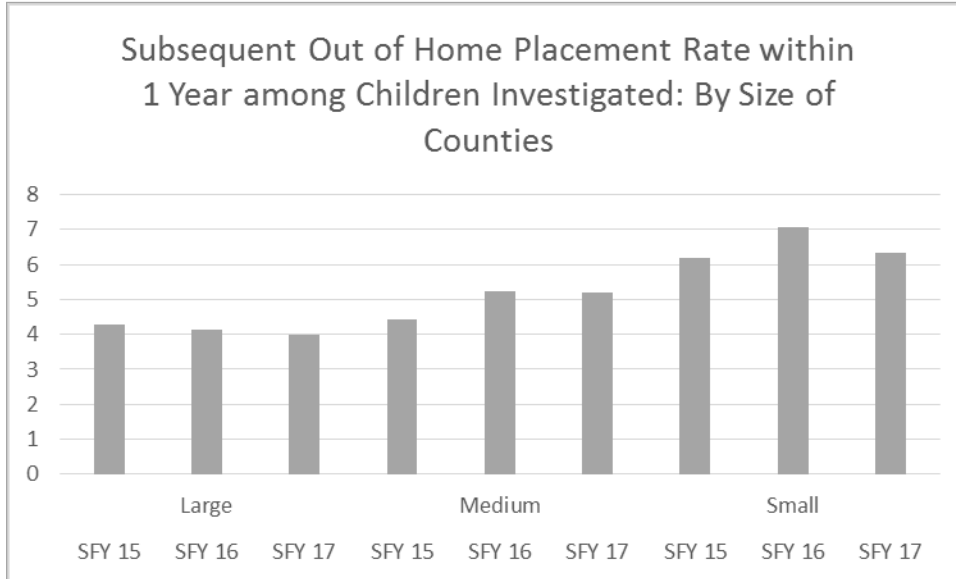


Source: Retrieved on June 30, 2018 from the University of North Carolina at Chapel Hill Jordan Institute for Families website. URL: <http://ssw.unc.edu/ma/>

Throughout a CPS assessment or the provision of CPS In-Home Services, CPS caseworkers and supervisors are responsible for assessing safety and for making reasonable efforts to prevent children from entering care (except in situations in which imminent threats to safety make it so no efforts are reasonable). During a CPS assessment, workers are encouraged to frontload services when possible to address safety and reduce risk. When maltreatment is found and the risk of future harm is assessed as moderate or high, families are referred to CPS In-Home Services whenever safety allows. The types of services and intervention provided vary greatly from county to county. The philosophy that undergirds this area of practice is that with effective intervention, DSS can prevent some families from entering foster care.

Figure 26 presents out-of-home placement rates within one year among children involved in a CPS assessment.

**Figure 26: Subsequent Out-of-Home Placement Rate Within One Year Among Children Investigated, by Size of Counties**



Source: Retrieved on June 30, 2018 from the University of North Carolina at Chapel Hill Jordan Institute for Families website. URL: <http://ssw.unc.edu/ma/>

Determining whether effective services are being delivered is difficult to analyze. External factors such as the availability of services play a role. What can be analyzed and what is defined in North Carolina is whether DSS used “reasonable efforts” to provide services to prevent removal. G.S. 7B-101(18) defines reasonable efforts as follows:

The diligent use of preventive or reunification services by a department of social services when a juvenile’s remaining at home or returning home is consistent with achieving a safe, permanent home for the juvenile within a reasonable period of time. If a court of competent jurisdiction determines that the juvenile is not to be returned home, then reasonable efforts means the diligent and timely use of permanency planning services by a department of social services to develop and implement a permanent plan for the juvenile.

**Sources of Information**

- ◆ Administrative Data:
  - UNC Management Assistance website.
  - NC Legacy Data.
  - County Child Welfare Staffing Workbook Data.
- ◆ Case Review Data:
  - Program Monitoring Review Data.
  - OSRI Data.

- ◆ Meetings Attended with State and County Staff:
  - Most Impacted Counties Meeting (4/12/18).
  - FFPSA Meeting (6/5/18).
- ◆ Focus Groups/Interviews:
  - CPS In-Home workers.
  - CPS supervisors.
  - Foster Care workers.
  - Foster Care supervisors Interviews with Parents.
  - Foster Parents.
  - Youth.
- ◆ Surveys:
  - CPS Surveys.
  - Foster Care Supervisors and managers.

## Detailed Findings

<p><b><u>Primary Research Question:</u></b></p>	<p><i>Are reasonable efforts made to support families prior to removing children and effective efforts made after removal to promote stable placements?</i></p>
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Administrative data from the Children’s Bureau suggests North Carolina performs well compared to other states in avoiding taking children unnecessarily, but other data gathered and analyzed as part of the assessment process suggests that North Carolina has room for improvement in many of its efforts to preserve families and to ensure placement stability of children in care. To reach this conclusion, CSF examined the use of North Carolina’s structured decision-making tools in mitigating safety threats and preventing unnecessary removals, the use of stabilization services in addressing child safety and preventing unnecessary removals, and also whether efforts are made to ensure placement stability and reduce trauma for children who are placed in foster care. While CSF observed some examples of positive safety- and placement-related practices, there were other practices and services identified that not were being delivered with consistency and in accordance with state policy.

North Carolina uses structured decision-making tools. The North Carolina Safety Assessment is structured to prompt workers to consider each of six safety interventions prior to making a decision that a child is unsafe and must be removed from the home and to list specific behaviors that must be addressed and who will be responsible. The Family Assessment of Strengths and Needs is designed to identify strengths to build on and needs to address in the Family Services Agreement (FSA).

CSF observed that DSS does make attempts to prevent unnecessary child removals during CPS assessments and while providing CPS In-Home Services; however, service availability and accessibility vary widely across counties. The practice of frontloading services during CPS assessments in an effort to provide stability to families and prevent removal was evident, but it appears to vary by county size, with small and medium size counties frontloading services more

frequently than larger counties. Focus group feedback indicated there are challenges in providing services to stabilize families when services are not available within a family member's LME/MCO service area.

Once children enter foster care, CSF looked at DSS efforts to assure that children have safe, stable placements. CSF found that DSS is meeting the federal 95 percent standard of having a face-to-face visit every month with every foster child. Caseworkers are doing a good job visiting with children in their placements and following up with caregivers as a means toward stabilizing placement and mitigating trauma. OSRI reviews, which looked more rigorously at both the frequency and quality of visits with foster children, identified areas for improvement. Greater efforts are also needed to locate and engage relatives earlier in the case planning process to mitigate child and family trauma and promote placement stability. Data indicates that children are frequently not able to be placed with their siblings in care and must change schools upon entering care or when experiencing placement changes. Caseworkers who participated in focus groups cited a need for additional placement resources and better access to the types of services to meet child needs. Foster parents indicated they would like more training opportunities to help them better understand trauma, as well as access to mentor-foster-parents for additional support.

***Sub-Question 1:*** *Do North Carolina's structured decision-making tools appropriately address factors that might mitigate safety threats and prevent unnecessary removals such as parental protective factors and risk factors for the children including the type and history of abuse/neglect and availability of appropriate services? To what extent are safety, risk, and protective factors incorporated into the Family Services Agreement?*

North Carolina's structured decision making (SDM) tools are described and discussed in sub-question 4 of the Key Findings on Child Protective Services. The tools are comprehensive and represent an effort to integrate strengths and parental protective factors with safety and risk when decisions about whether children need to be removed are made.

The North Carolina Safety Assessment, which must be completed at specified times during a CPS assessment and the provision of CPS In-Home Services, prompts workers to consider six possible safety interventions before concluding that a child is unsafe and must be removed. Those interventions are:

- ◆ Monitoring and/or use of direct services by county child welfare agency.
- ◆ Use family, neighbors, or other individuals in the community in the development and implementation of a safety agreement.
- ◆ Use community agencies or services.

***Key Findings:*** *Quality of SDM tools as it relates to mitigating threats and preventing unnecessary removals*

- SDM tools in use in North Carolina are thorough and cover every aspect of protective factors, risk factors and safety threats.
- Focus groups with Foster Care workers and supervisors suggest there is overall support for the FSA however some raised concerns regarding the subjective nature of the questions and scoring.
- Review data indicates FSA's included a focus on child safety in only 50% of cases reviewed.



- ◆ The alleged perpetrator will leave or has left the home – either voluntarily or in response to legal action.
- ◆ A protective caretaker will move or has moved to a safe environment with the child(ren) and there are no restrictions on protective caretaker’s access to the child(ren).
  - Identification of a Temporary Safety Provider by the parent with the social worker monitoring.
  - A Temporary Safety Provider will move into the family home.
  - The child(ren) will reside in the home of a Temporary Safety Provider.

The form further prompts workers to list the specific behaviors that make a child unsafe, the actions needed to protect the child, and who is responsible for taking them.

The North Carolina Family Assessment of Strengths and Needs (FASN) is optional during a CPS assessment, but it must be completed when a family is referred to CPS In-Home Services prior to the completion of the Family Services Agreement (FSA). The FASN structures workers to rate both caretakers and children on a variety of factors and, based on those ratings, to list the family’s strengths and needs as well as well-being needs in the domains of education, health, and mental health. The tool is designed to help identify needs to address, and strengths to build on in the FSA.

Program Monitoring results related to the incorporation of safety, risk and protective factors into the FSA during CPS In-Home Services cases are presented in detail and discussed under sub-question 4 in the Preventive and In-Home Services section. Overall, program monitoring found that the FSA addressed needs identified in the CPS assessment and the FASN for the mother 89 percent and for the father 82 percent of the time. The program monitoring found the FSA was used to identify well-being needs of the parents with less consistency.

In focus groups with caseworkers and supervisors across the state, most noted that they liked the new Family Assessment of Strengths and Needs (FASN) because all the information is now in one place and the language in the tool is less vague. Others observed that placing an emphasis on strengths and not just needs and problems has made engagement with families more successful and Child and Family Team Meetings are more meaningful. Noted challenges with the FSA involved the subjective nature of the questions and scoring. In focus groups with family members, concerns were raised about assumptions being made based on gender or ethnicity. Caseworkers and supervisors must make deliberate efforts to prevent personal and cultural biases from impacting the scoring process during the FASN.

***Sub-Question 2:*** *Are stabilization services provided to address the safety and well-being needs of children, parents and family household members to prevent removal and keep families together?*

DSS must demonstrate reasonable efforts to prevent removal of children by providing stabilization services to the family (or show that no efforts are reasonable and consistent with safety). This is required by federal regulations, state statutes and DSS policy. District Court judges must make a finding as to DSS efforts at the non-secure custody hearing. For Native American children from the Eastern Band of Cherokees, DSS must show “active efforts” meaning intensive services to keep families together.

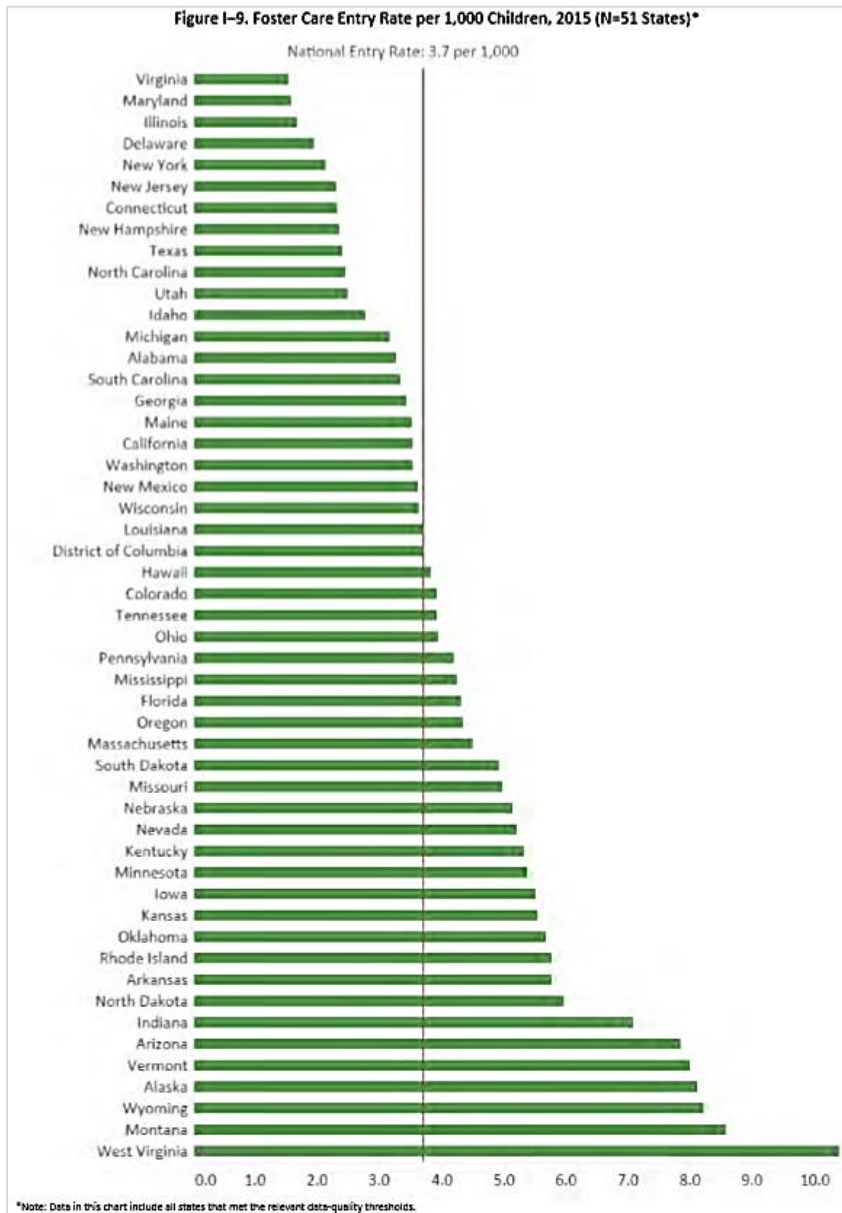
Avoiding unnecessary removals of children is critical to avoid traumatization of both children and families when a removal is not truly required for a child’s immediate safety. Two key elements to avoiding unnecessary removals are appropriate assessment strategies (sub-question 1) and stabilization services (sub-question 2). One indicator of the overall success of avoiding unnecessary removals is to look at a state’s foster care entry rate and compare it to other states.

The chart below is taken from the most recent Child Welfare Outcomes Report to Congress from the Children’s Bureau. It shows that North Carolina’s annual foster care entry rate per 1000 children in 2015 was the tenth lowest among all the states and significantly below the national rate of 3.7 children per 1,000.

***Key Findings:*** *Provision of stabilization services to address child safety and family well-being needs to prevent removal*

- North Carolina has a lower rate of removing children into foster care than the majority of states.
- Availability and accessibility of services to prevent removals varies widely from county to county
- Small and medium counties document frontloading services in assessments more frequently than larger counties.
- Challenges exist accessing behavioral health services to prevent removal.

Figure 27: Foster Care Entry Rate per 1,000 Children, 2015 (National)



Source: Children’s Bureau. Child Welfare Outcomes 2015: Report to Congress. Administration of Children and Families. US DHHS. Retrieved from: <https://www.acf.hhs.gov/sites/default/files/cb/cwo2015.pdf>

Stabilization services in North Carolina come from three primary sources:

- ◆ Services provided directly by counties during a CPS assessment or CPS In-Home Services;
- ◆ Intensive family preservation services provided through by private providers through a state contract; and
- ◆ Other services accessed by DSS from community providers.

While policy and law are clear, practice varies greatly from county to county across North Carolina. Data from 2017 Program Monitoring Reviews indicate that small counties

outperformed medium and large counties in frontloading services to families during the assessment (73%). This metric appeared especially challenging for large counties (44%), although the sample of reviewed cases was small. This seemingly contradicts the fact that larger counties have more resources and services that are available and accessible. However, during focus group sessions, birth families, youth, and staff expressed a family-like setting in small county DSS offices. They revealed that in small counties, the staff members know the families and are intimately aware of services in a way that may not be as possible in larger jurisdictions.

However, Program Monitoring reviewers judged that CFT meetings were held when warranted in only 34 percent of assessments. Counties did much better completing the FASN when a decision was made to place a child in foster care or other out-of-home placement (93%). In large counties, the FASN was completed in these circumstances for all 23 cases reviewed.

During focus groups, DSS staff expressed a belief that a great deal of services are provided to prevent removal. Some expressed that this was sometimes to the detriment of the children who may be continuing to experience trauma. DSS petitions to the court without requesting custody were reported to have mixed results. Such petitions represent an attempt to galvanize court oversight as an incentive for families to comply with service agreements and prevent removal. However, some staff felt that it increased risk and took even more time having to negotiate time on court dockets.

It is unclear from data when counties are providing services directly and when they are referring families to services. For children who enter care from families receiving In-Home Services, there is more evidence of contact with the agency on a regular basis and some levels of service provision. During focus groups, several counties, particularly small counties, indicated that they have no services. Most need to send clients to larger counties, and transportation becomes a challenge. In addition, when children enter care, most parents who have Medicaid lose their eligibility, and they do not have the resources to pay for services. A common theme across the state was a need for more services to address substance abuse, mental health, and child care needs. Other perceived needs for services included: domestic violence, employment, parenting for teens, home cleanliness, transportation, tailored therapy (trauma, CBT, etc.), anger management, housing, and more classes specifically tailored for men.

In focus groups and interviews, many of the larger county DSS staff identified excellent services available, including job skills programs, church-run parenting programs, family preservation, helping parents with a criminal history find a job, therapy, transportation, and family crisis centers. The disparity of accessible services from county to county has been exacerbated by the regionalization of the Local Management Entities/Managed Care Organizations (LME/MCOs), which have assigned catchment areas. Some LMEs offer more or different types of services. Focus group participants revealed that it is difficult to access services that are not available through the LME/MCO that serves their county, even if those services are available in counties served by another LME/MCO. The North Carolina State Medicaid and Health Choice program is also undergoing a major transformation from fee-for-service to managed care in 2019, and current plans call for moving toward a statewide, rather than regional, behavioral health plan.

<b>2017 NC Program Monitoring Review Data</b>				
<b>Select Questions – CPS Assessment Protocol</b>				
	<b>State</b>	<b>Large Counties</b>	<b>Medium Counties</b>	<b>Small Counties</b>
Provision of stabilization services to address child safety and family well-being needs to prevent removal				
If services were needed or recommended, were any services frontloaded to the family during the assessment?	67.82% (215/317)	44% (11/25)	64.66% (75/116)	73.30% (129/176)
Was a CFT held during the assessment, if it was warranted?	34.24% (63/184)	60% (6/10)	34.29% (24/70)	31.73% (33/104)
If the case was transferred to CPS In-Home Services or Foster Care, was there a discussion with the family regarding CFT's?	36.57% (98/268)	30.77% (4/13)	38.71% (36/93)	39.19% (58/148)
If there was a decision to transfer to CPS In-Home Services or Foster Care, a Family Assessment of Strengths and Needs (FASN) was completed.	92.88% (261/281)	100% (23/23)	92.23% (95/103)	92.26% (143/155)

***Sub-Question 3: If children are placed in foster care, are sufficient efforts made to ensure placement stability to reduce trauma?***

In order to reduce trauma for children in foster care or other out-of-home placements, DSS strives to reduce the number and frequency of placement disruptions.

Caseworker face-to-face visits with children in their placements is a critical element of assuring a child has a safe, stable placement. The federal government requires states to report on monthly visitation and to meet an annual standard of conducting at least 95 percent of the required monthly face-to-face visits with foster children, at least half of which must be in the child's placement. A chart in the Children's Bureau's 2015 Child Welfare Outcomes Report to Congress shows that North Carolina was slightly below the 95 percent standard for conducting monthly face-to-face visits with foster children; a state DSS official has informed CSF that North Carolina has subsequently met the 95 percent requirement. The 2015 Report to Congress shows that about 88 percent of monthly visits in North Carolina were at a child's placement, easily exceeding the requirement that at least 50 percent.

North Carolina also conducts more rigorous and detailed assessments of caseworker visits with children through its Program Monitoring and OSRI Reviews. The Program Monitoring Reviews have a more exacting standard of whether a child was seen every month during a six-month period of review. North Carolina's program monitors found monthly visits occurred in 468 of 531 reviewed cases (88%). Item 14 of the OSRI examines not only at whether visits occur with sufficient frequency (which can be more than once a month if deemed necessary), but also assesses whether visits are of adequate quality (sufficient length, include a private interview with the child, and include discussion of issues pertinent to the child's needs). For an OSRI review to rate visitation as a strength in a record, both the frequency and quality of visits must be assessed to be sufficient throughout the period under review. In 2018, item 14 was rated as a strength in 19 of 31 reviewed foster care cases (61%).

Studies consistently find that kinship placements are more stable than non-kinship placements.<sup>21</sup> Recruiting from a child's existing network of family members and supports is another method to ensure important connections are maintained for children in foster care and that the trauma of entering foster care is reduced. When asked about the causes of placement instability during focus groups; responses from DSS caseworkers included:

- ◆ Children's behaviors and lack of timely access to mental health;
- ◆ Poor treatment of foster parents;
- ◆ Not enough therapeutic placements for children;
- ◆ Inability to respond to the needs of foster parents in a timely manner; and
- ◆ Lack of resources and funding for relative placements.

In North Carolina, policy suggests that CFTs should be held when appropriate prior to removing children into custody and that relatives, kin, or other safety resources should be involved and considered for placement. Program Monitoring Review findings suggest that staff involved kin and/or safety resources with planning and decision making in 67 percent of the cases reviewed with large and medium counties (77% and 73% respectively) performing better than smaller counties (58%). CFTs were only held prior to custody in just over 25 percent of the cases reviewed across the state.

Some youth in focus groups expressed a desire for DSS to put forth more efforts to locate and engage relatives early in the process. Relatives who participated in focus groups revealed that they did not feel engaged by DSS. Some described a heavy-handed approach of engagement in which DSS caseworkers said children would enter foster care if the relatives did not take them for placement. Relatives also noted that communication with DSS was hampered due to the

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<sup>21</sup> Beeman, S.K, Kim, H. Bullerdick, S.K. (2000). Kinship family foster care: A methodological and substantive synthesis of research. *Children and Youth Services Review*, 22 (1) (2000), 37-54.  
Benedict, M. I., Zuravin, S., & Stallings, R. Y. (1996). Adult functioning of children who lived in kin versus nonrelative family foster homes. *Child Welfare*, 75(5), 529-549.  
Berrick, J. D., Barth, R. P., & Needell, B. (1994). A comparison of kinship foster homes and foster family homes: Implications for kinship foster care as family preservation. *Children and Youth Services Review*, 16(1-2), 33-63. doi:10.1016/0190-7409(94)90015-9  
Cuddeback, G. S. (2004). Kinship family foster care: A methodological and substantive synthesis of research. *Children and Youth Services Review*, 26(7), 623-639. doi:10.1016/j.childyouth.2004.04.014  
Goerge, R. M. (1990). The reunification process in substitute care. *Social Service Review*, 64(3), 422-457. doi:10.1086/603780  
Iglehart, A. P. (1994). Kinship foster care: Placement, service, and outcome issues. *Children and Youth Services Review*, 16(1-2), 107-122. [http://dx.doi.org/10.1016/0190-7409\(94\)90018-3](http://dx.doi.org/10.1016/0190-7409(94)90018-3)  
Koh, E. (2010). Permanency outcomes of children in kinship and non-kinship foster care: Testing the external validity of kinship effects. *Children and Youth Services Review*, 32(3), 389-398. doi:10.1016/j.childyouth.2009.10.010  
Testa, M. F. (2002;2001;). Kinship care and permanency. *Journal of Social Service Research*, 28(1), 25-43. doi:10.1300/J079v28n01\_02  
Webster, D., Barth, R. P., & Needell, B. (2000). Placement stability for children in out-of-home care: A longitudinal analysis. *Child Welfare*, 79(5), 614-632.  
Winokur, M. A., Crawford, G. A., Longobardi, R. C., & Valentine, D. P. (2018). Matched comparison of children in kinship care and foster care on child welfare outcomes. *Families in Society*, 89(3), 338-346. doi:10.1606/1044-3894.3759

turnover of staff within DSS. One kin shared as an example having three GALs and two workers in 16 months. Program Monitoring Review data supported focus group feedback in this area, with only 60 percent of cases reviewed having documentation that the child and family were appropriately prepared for placement prior to the physical removal of the child.

Another strategy devised by North Carolina DSS to mitigate trauma for children ages 12-17 entering care is a booklet entitled, *Understanding Foster Care – A Handbook for Youth*. Data from 2017 Program Monitoring Reviews indicate that only 20 percent of these children received the booklet. With such little usage, this strategy needs to be evaluated for availability, effectiveness, and staff understanding and buy-in.

According to the National Resource Center for Permanency and Family Connections, frequent changes in caseworkers, judges, and legal representation also interfere with child well-being and achievement of a permanent home. There are stages inherent to the system along the continuum of a case in which the caseworker will change, and in North Carolina a new caseworker is usually assigned when a child enters foster care. Program monitoring looked at whether the former and new worker made joint visits to children, caretakers, and removal parents to ease the transition and found this was rarely done. This is not, however, a requirement of North Carolina policy. It is worth highlighting that during focus groups, youth indicated that they had positive relationships with their caseworkers, especially those youth involved in the LINKS program.

Visiting with children in their placements and following up with caregivers is another important aspect of stabilizing placements and mitigating trauma. All counties are doing a good job of making face-to-face contact with children within seven days of (initial) placement (80.5%) and making contact with the (initial) placement resource within seven days of placement (84%). DSS policy provides numerous provisions that stress the importance of maintaining as many connections for children in foster care as possible. Program Monitoring Review data indicates that siblings were placed together in 63 percent of the cases reviewed. Less than half of placements allowed children to remain in their same schools, with only 47 percent of applicable cases containing documentation as to whether a school change was in the child's best interest. One youth interviewed indicated that he was able to remain in his school in spite of five placement changes and having to board the school bus every day as early as 5:00 a.m. On a

**Key Findings:** *Efforts made to ensure placement stability to reduce trauma:*

- North Carolina meets the federal 95% standard of seeing every foster child face-to-face every month.
- Efforts are needed to locate and engage relatives earlier in the case planning process to mitigate child and family trauma and to promote placement stability.
- Caseworkers are doing a good job visiting with children in their placements and following up with caregivers as a means toward stabilizing placements and mitigating trauma.
- Children are frequently not able to be placed with their siblings and must change schools upon entering care or when experiencing placement changes.
- Caseworkers cite a need for additional placements and better access to the types of services to meet child needs.
- Foster parents would like more training opportunities in order to better understand trauma and access to mentor foster parents for added support.

positive note, 92 percent of the cases reviewed documented that children were able to engage in “normal childhood activities.”

In focus groups with foster care caseworkers, the following barriers to placement stability were noted:

- ◆ Behavior of children and lack of timely access to mental health services, sometimes due to lengthy waitlists.
- ◆ Not enough placements to meet the number and needs of children in care.
- ◆ Poor treatment and untimely response to needs of foster parents.
- ◆ Relatives and kin not given the same levels of support as foster parents

Making sure that foster parents and relative placements are prepared and supported is also a vital component to placement stability. When asked about training and preparation, foster parent participants noted the following:

- ◆ Some felt prepared with the training and some did not;
- ◆ Some counties utilize foster parents as co-trainers for all sessions and youth in foster care and other stakeholders for panel discussions to provide real-life scenarios;
- ◆ Some counties have developed Facebook pages to provide peer support and additional resources;
- ◆ Some foster parents expressed a need to “overhaul” the MAPP training to include more on trauma;
- ◆ Respondents requested more training and in-service training opportunities to better understand trauma;
- ◆ Suggestions were made to add mentor foster parents for added support;
- ◆ Shared parenting is stressed; however, foster parents suggested structured times for parent-to-parent interaction without the child’s presence;
- ◆ More information should be provided to caregivers prior to placing children; and
- ◆ No amount of training can prepare you for the emotional aspect of caretaking.

Finally, OSRIs conducted by DHHS in 2017-2018 rated Item 4 (Stability of Foster Care Placement), which focuses on the number of placement settings experienced by the child, the appropriateness, and necessity of any placement changes and the stability of the child’s current placement, as a strength in 68 percent of the 40 cases reviewed.



**North Carolina Child Welfare Preliminary Reform Plan**

<b>2017 NC Program Monitoring Review Data</b>				
<b>Select Questions – Foster Care Protocol</b>				
<b>Efforts to ensure placement stability to reduce trauma</b>	<b>State</b>	<b>Large Counties</b> 3/10 reviewed	<b>Medium Counties</b> 16/39 reviewed	<b>Small Counties</b> 27/51 reviewed
Were kin and/or safety resource involved with planning and decision making (pre-placement)?	66.74% (307/460)	77.05% (47/61)	73.3% (140/191)	57.69% (120/208)
Was a CFT held prior to custody?	25.52% (122/478)	40.98% (25/61)	21.9% (46/210)	24.64% (51/207)
Were the child and family appropriately prepared for the placement prior to the physical move of the child or in the case of an emergency removal is there documentation of as soon as possible after the move?	60.47% (283/468)	61.02% (36/59)	64.65% (128/198)	56.4% (119/211)
Was the child entering foster care, ages 12-17, provided “Understanding Foster Care – A handbook for Youth?”	20% (32/160)	9.09% (2/22)	17.46% (11/63)	25.33% (19/75)
Was a joint visit made to the child and caregivers with the sending and receiving social workers?	27.49% (124/451)	8.06% (5/62)	33.66% (68/202)	27.27% (51/187)
Was a joint visit made to the following with the sending and receiving social workers?				
▪ Mother	22.09% (95/430)	10% (6/60)	25.77% (50/194)	22.16% (39/176)
▪ Father	15.73% (59/375)	13.73% (7/51)	17.65% (30/170)	14.29% (22/154)
▪ Other removal caregiver	18.92% (21/111)	0% (0/16)	23.81% (10/42)	20.75% (11/53)
Did the (initial) placement allow the child to:				
▪ Remain in the same school?	47.54% (135/184)	40.63% 13/32	50.91% (56/110)	46.48% (66/142)
▪ If the child’s school changed, is there documentation as to why it is in the child’s best interest?	46.53% (67/144)	41.18% (7/17)	51.92% (27/52)	44% (33/75)
▪ Be placed with siblings?	63.48% (186/293)	66.67% (24/36)	69.57% (96/138)	55.46% (66/119)
▪ Participate in faith of choice?	35.44% (118/333)	20% (10/50)	41.22% (54/131)	35.53% (54/152)
▪ Maintain therapeutic contacts?	76.65% (197/257)	70% (21/30)	76.85% (83/108)	78.15% (93/119)
▪ Engage in “normal childhood activities?”	92.05% (405/440)	91.67% (44/48)	94.33% (183/194)	89.9% (178/198)
▪ Continue to participate in activities from prior to placement?	72.04% (219/304)	79.41% (27/34)	74.62% (97/130)	67.86% (95/140)
Was a face to face contact made to the child within 7 days of (initial) placement?	80.5% (417/518)	73.13% (49/67)	82.43% (183/222)	80.79% (185/229)
Was contact made with the (initial) placement resource within 7 days of placement?	83.53% (431/516)	80.60% (54/67)	83.78% (186/222)	84.14% (191/227)
Was there a shared parenting meeting between the parent and placement resource within 7 days of custody?	11.2% (54/482)	9.23% (6/65)	8.21% (17/207)	14.76% (31/210)
▪ If not, was there documentation as to why?	18.87% (80/424)	12.28% (7/57)	16.84% (32/190)	23.16% (41/177)
▪ Was this an appropriate justification?	72.55% (74/102)	87.5% (7/8)	75% (27/36)	68.97% (40/58)

## *E. Services to Children, Youth, and Families to Achieve Reunification*

### **Overview**

Reunification with the parent(s) or primary caretaker(s) from whom children were removed is almost always the initial primary plan when children enter foster care in North Carolina. The new modified policy manual, scheduled to be implemented in September 2018, requires counties to attempt to achieve reunification within 12 months. Counties are, however, required to continue working on reunification as the primary or secondary plan until the court makes written findings that reunification efforts are futile or inconsistent with a child's needs for a safe, permanent home.

State policy on removal of children attempts to set the stage for reunification efforts. A Child and Family Team meeting is supposed to be held prior to removal to engage parents and their supports in the decision of whether removal is necessary. Policy also attempts to reduce the trauma of removal by requiring that families be prepared for removal with clear explanations about why children are being removed, what to expect when children are placed, and what needs to occur for children to be returned.

Upon entry into foster care, a new caseworker is typically assigned to provide case management for both the removed children and the parents, and policy calls for work to begin quickly toward reunification. Within seven days of removal, the modified policy calls for the worker to have a face-to-face meeting with the parents and initial visitation or family time between parents and children. An initial shared parenting meeting – in which birth parents have the opportunity to meet with the placement provider and offer information about their children – is to occur within 14 days.<sup>22</sup> A Child and Family Team (CFT) meeting – in which parents, children, and their chosen supports are full participants – must be held within 30 days of removal to develop the family service agreement detailing services and changes to accomplish reunification. A CFT meeting to update the plan is required within 90 days of removal, and ongoing CFT meetings are required every 90 days. Parents are also expected to be given the opportunity to have an ongoing active role in medical and other services to their children.

Counties are required to have monthly face-to-face contacts with parents while working towards reunification, with at least half of contacts taking place in the parents' residence. Services to parents that address the issues that resulted in removal must be provided or arranged. Some services (e.g., parenting training, supervising visits) are provided directly by many counties while most counties refer parents to outside providers for services related to mental health, substance abuse, or domestic violence. Counties are required to prepare families and assess their readiness for reunification. Limited funding from the state is available for intensive family reunification services. Rylan's Law requires counties to observe two home visits prior to recommending reunification. Some counties and some courts employ extended trial home visits while the county retains custody and continues to monitor. Child Welfare services to families end when legal custody is returned to parents, though parents may choose to continue to participate voluntarily in community services.

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<sup>22</sup> The modified manual extended this timeframe from one week to two weeks.

When a county petitions for custody of child in North Carolina, the juvenile court assumes jurisdiction and holds a series of statutorily required hearings at which the court determines or orders:

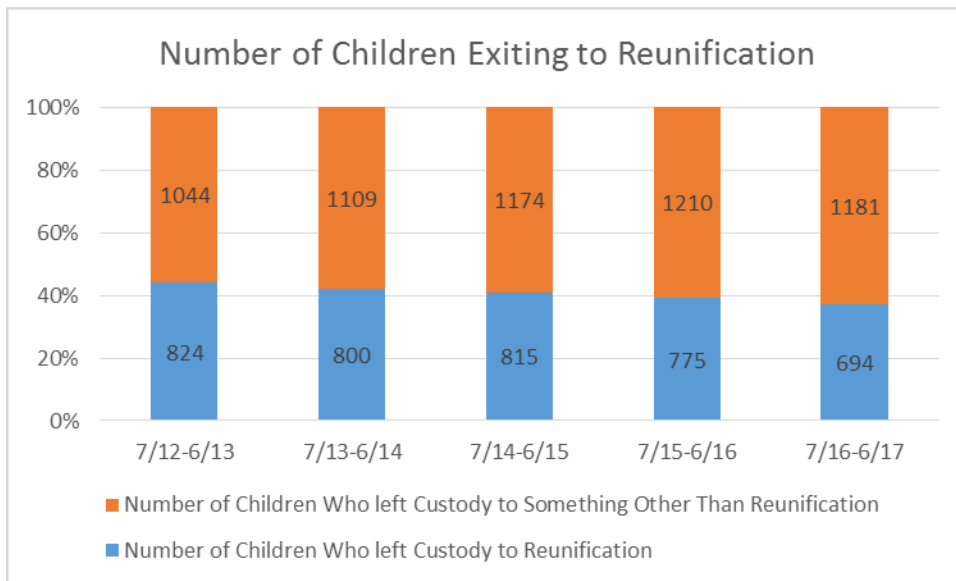
- ◆ Whether non-secure custody (foster care) was and continues to be required and whether reasonable efforts to prevent non-secure custody were made and are ongoing.
- ◆ Whether the child was abused, neglected, or dependent.
- ◆ Services that the county must provide and the parents must complete.
- ◆ Visitation between parents and children.
- ◆ The child’s permanency plan.
- ◆ Whether the family is ready for reunification.

The parties to the court hearings are the county, the parents, and a court-appointed guardian ad litem to make recommendations in the best interests of the children. Some court districts have court improvement (CIP) projects that include “Day One” conferences to expedite the work of reunification.

**Reunification Trends**

Figure 28 below shows that the percentage of children leaving foster care in North Carolina who are reunified with the parent(s) or primary caretaker(s) from whom they were removed declined steadily in the past five years, from 44 percent to 37 percent. It also indicates that the proportion and number of children exiting custody to reunification has decreased slightly in the last five years.

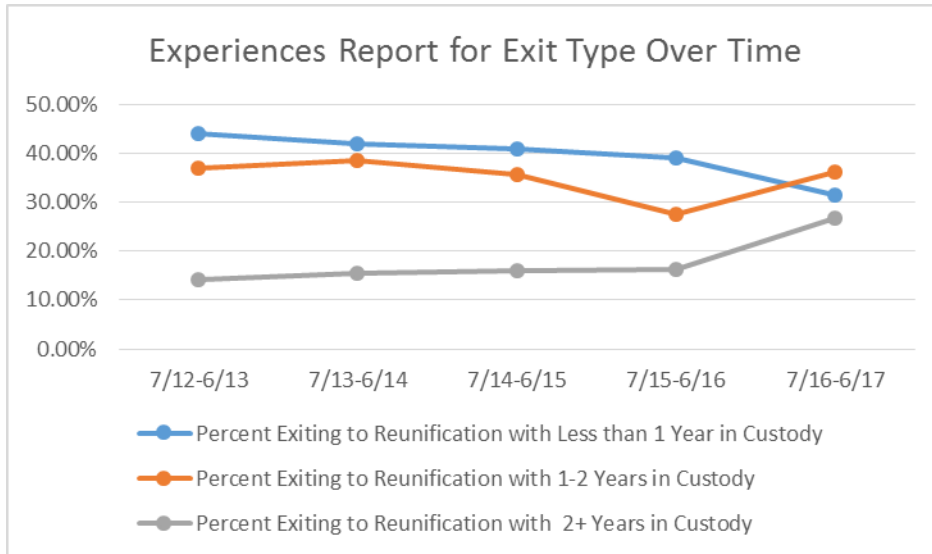
**Figure 28: Number of Children Exiting to Reunification**



Duncan, D.F., Kum, H.C., Flair, K.A., Stewart, C.J., Vaughn, J.S., Guest, S., Rose, R.A., Malley, K.M.D. and Gwaltney, A.Y. (2018). Management Assistance for Child Welfare, Work First, and Food & Nutrition Services in North Carolina (v3.2). Retrieved [4/19/18], from the University of North Carolina at Chapel Hill Jordan Institute for Families website. URL: <http://ssw.unc.edu/ma/>

Figure 29 below provides insight on the time children spend in care in North Carolina before experiencing reunification. The figure displays the percentage of children in North Carolina who were reunified with their families within one year of entering substitute care, those who reunified within one to two years of entering care, and those where reunification took longer than two years. The data indicates that the average length of time in care for North Carolina children who are reunified has been increasing in recent years.

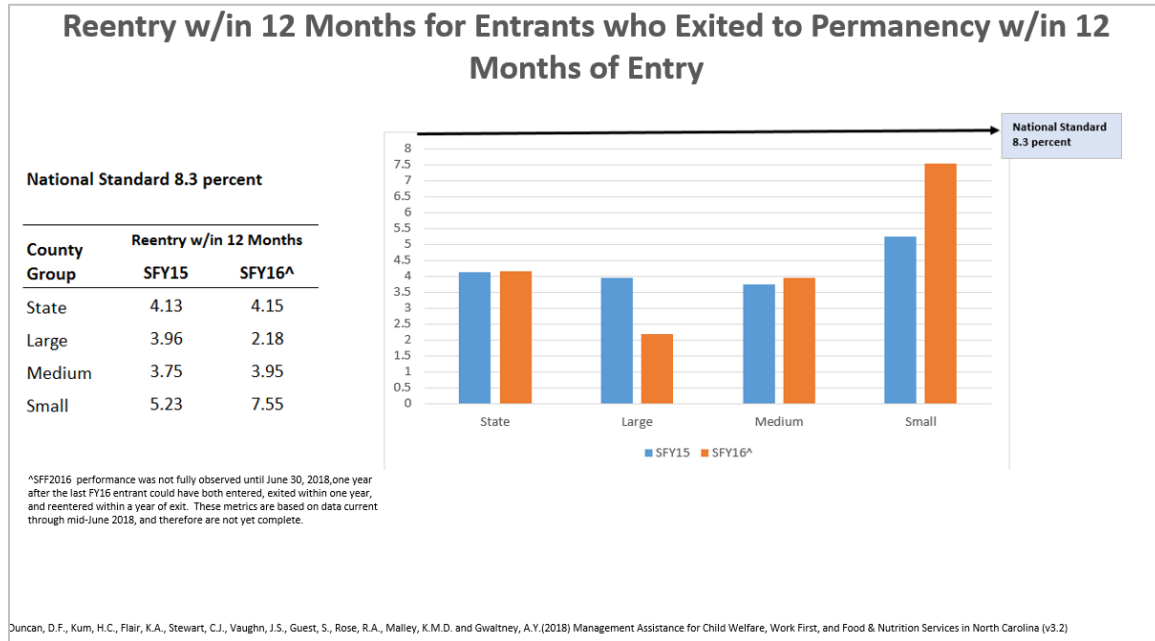
**Figure 29: Experiences Report for Exit Type Over Time**



Duncan, D.F., Kum, H.C., Flair, K.A., Stewart, C.J., Vaughn, J.S., Guest, S., Rose, R.A., Malley, K.M.D. and Gwaltney, A.Y. (2018). Management Assistance for Child Welfare, Work First, and Food & Nutrition Services in North Carolina (v3.2). Retrieved [4/19/18], from the University of North Carolina at Chapel Hill Jordan Institute for Families website. URL: <http://ssw.unc.edu/ma/>.

Figure 30 shows that North Carolina’s rate of re-entry into foster care is much lower than the national Round 3 CFSR standard of 8.3 percent, with large, medium, and small counties all having very low rates of re-entry into care. While the overall percentage of children re-entering care within 12 months of achieving permanency remained stable in North Carolina in state fiscal years 2015 and 2016, the percentage re-entering care from small counties increased while those from large counties decreased.

Figure 30: Reentry into Foster Care



### Sources of Information

- ◆ Administrative Data:
  - UNC Management Assistance website.
  - NC Legacy Data.
  - County Child Welfare Staffing Workbook Data.
- ◆ Case Review Data:
  - Program Monitoring Review Data.
  - OSRI Data.
- ◆ Meetings attended with state and county staff.
- ◆ Focus Groups:
  - Foster Care workers
  - Foster Care supervisors
- ◆ Surveys:
  - Foster Care Supervisors
- ◆ Other reports/information received:
  - Building Local Systems Report on summit meetings between DSSs and Behavioral Health LME/MCOs.
  - Child Welfare Outcomes 2015 Report to Congress.

**Detailed Findings**

<p><b><u>Primary Research Question:</u></b></p>	<p><i>Are foster children, their families, and caregivers receiving trauma-informed services and supports that facilitate family reunification?</i></p>
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Data gathered and analyzed by CSF suggest that foster children in North Carolina, as well as their families and caregivers, are not receiving the appropriate level of trauma-informed services and supports to facilitate timely reunification. To reach this conclusion, CSF reviewed administrative data on North Carolina’s performance and whether:

- Timely services are provided to parents who are seeking reunification with their child(ren).
- The safety of the home and family to which the child is to return is regularly and appropriately assessed and addressed with adequate follow-up after a child returns home.
- Parents and children are engaged throughout the case planning process and child and family team meetings held that are representative of the family’s voice.
- Progress is routinely monitored and adjustments in services made in partnership with the family.

Data indicate that the average length of time in care for North Carolina children who are reunified has been increasing in recent years and that only about one-third of the children who exited for reunification in FY 2017 had been in care less than 12 months. On the positive side, CSF observed that North Carolina has a very low rate compared to other states of children re-entering care post reunification.

North Carolina policy requires a great many activities with children, siblings, parents, placement providers, relatives, schools, service providers, and the courts to occur in the first 30 days of out-of-home placement. Some of the activities or services are critical to reunification efforts, including beginning parent-child visitation and developing a visitation (family time) plan, beginning shared parenting, and preparing participants for and then holding a CFT meeting. Across the board, counties are struggling to provide these services in a timely way.

Establishing and implementing timely parent/child visitation plans with input from the family sets the stage for meaningful case planning toward timely reunification and reduces family trauma that comes from being separated. Case review results found that parent-child visitation met a standard of occurring frequently and using a variety of methods in only 56 percent of cases reviewed.

A key indicator of working effectively toward reunification is engaging in regular face-to-face contact with parents in their home whenever possible, where the safety of the home and family unit can be assessed so that any necessary services can be put in place to facilitate reunification safely. Case review data indicates parents working toward reunification were receiving monthly face-to-face contact with their caseworker in less than 50 percent of the cases reviewed, with mothers receiving consistent monthly contacts 48 percent of the time and fathers only 30 percent

of the time. Similarly, mothers' well-being needs were identified in the strengths and needs assessment only 53 percent of the time and fathers' only 36 percent of the time. More positively, program monitoring found that services were in place prior to case closure 74 percent of the time. Program monitoring also found frequent use of trial home placements.

CFT meetings are a primary tool to allow the family to have a voice in the development and implementation of their own unique case plans and in the adjustment of services needed to meet the family's changing needs over time. Case review data indicates that initial CFTs are not consistently being held within 30 days of removal or on an ongoing basis as required by state policy. The use of initial and ongoing Family Reunifications Assessments as a tool to assess family readiness to reunify were only found to be present in 50 percent of applicable cases reviewed and documentation further indicates that Family Service Agreements (FSAs) are not being regularly reviewed and updated by the caseworker with the parents or whenever there are significant changes taking place within the family.

***Sub-Question 1:*** *Are timely services provided for parents seeking to achieve reunification?*

In 2017 OSRIs conducted by DHHS, Item 12b, which focuses on whether the needs of parents are appropriately assessed and services provided, was rated as a strength in just 50 percent of 34 applicable foster care cases, suggesting this is a continuing area in need of improvement.

Data from Program Monitoring Reviews of 534 foster care cases in 2017 suggest counties face challenges in meeting expectations in policy for providing services to help reunify parents with their children.

Data indicate that only about 56 percent of initial or ongoing parent visitation plans are being completed and updated in accordance with agency policy and that parent/child visitation is also occurring with expected frequency in only 56 percent of cases reviewed. Consistent in-person contact by the assigned worker with the parents of children placed in out-of-home care plays an important role in facilitating a collaborative working relationship toward achieving timely reunification. Data indicate that sufficient worker face-to-face contact with parents is a practice area in need of improvement with notable differences between mothers (48%) and fathers (30%). Similarly, well-being needs were identified in the FASN for mothers 53 percent of the time versus 36 percent of the time for fathers. On OSRI reviews for 2017-2018, Item 15 (worker visits with parents) was rated as a strength in only 44 percent of 34 applicable foster care cases.

***Key Findings:*** *Timely services provided to parents seeking to achieve reunification:*

- Parent/child visitation plans are not being completed and updated in accordance with agency policy.
- Monthly worker face-to-face contact with parents are not occurring with required frequency.
- Workers are more likely to meet standards for contacts and needs assessments with mothers than fathers.

<b>2017 NC Program Monitoring Review Data</b>				
<b>Select Questions – Foster Care Protocol</b>				
<b>Timely Services Provided to Parents to Achieve Reunification</b>	<b>State</b>	<b>Large</b>	<b>Medium</b>	<b>Small</b>
Has the (Initial) Parent Visitation Plan been completed, reviewed, updated and provided as per policy?	56.56% (276/488)	55.74% (34/61)	51.22% (105/205)	61.71% (137/222)
Has the (Ongoing) Parent Visitation Plan been completed, reviewed, updated, and provided as per policy?	55.34% (197/356)	48.84% (21/43)	52.70% (78/148)	59.39% (98/165)
Does visitation between the child and parent(s) occur frequently and include a variety of methods?	55.92% (203/363)	36% (18/50)	60.48% (101/167)	57.53% (84/146)
Does documentation of visitation include behavioral observations and actions?	67.52% (210/311)	77.50% (31/40)	66.44% (99/149)	65.57% (80/122)
Was there a shared parenting meeting between the parent and placement resource within 7 days of custody?	11.2% (54/182)	9.23% (6/65)	8.12% (17/207)	14.76% (31/210)
Are well-being needs identified in the Strengths and Needs Assessment for mother?	52.57% (225/428)	43.33% (26/60)	59.14% (110/186)	48.90% (89/182)
Are well-being needs identified in the Strengths and Needs Assessment for father?	35.56% (133/374)	27.45% (14/51)	37.89% (61/161)	35.80% (58/162)
Does the Services Agreement address the mother's identified needs?	71.72% (317/442)	68.42% (39/57)	69.43% (134/193)	75% (144/192)
Does the Services Agreement address the father's identified needs?	57.10% (189/331)	53.49% (23/43)	55.40% (77/139)	59.73% (89/149)
Were there ongoing monthly face-to-face contacts with Mother according to policy?	48.18% (238/494)	52.13% (34/65)	53.52% (114/213)	41.67% (90/216)
Were there ongoing monthly face-to-face contacts with Father according to policy?	30.45% (134/440)	27.59% (16/58)	31.55% (59/187)	30.26% (59/195)

In focus groups and meetings, county workers, supervisors, and leaders essentially confirmed that workers are not meeting standards, saying it is not possible to complete and document all of the activities required in a foster care case, even when caseloads are at state standards. Some comments were also made regarding needing to choose between seeing families, and documenting, and of prioritizing making contacts with children over other tasks. A clear weakness is holding shared parenting meetings in the first week, even though county workers reported in focus groups that their counties endorse the importance of shared parenting meetings. A barrier may be the high number of urgent child, placement, parent, and court activities for workers when children enter care.

When foster parents participating in focus groups were asked if they felt that the system was doing a sufficient job working with and providing services to help parents with reunification, the issue of shared parenting came up. All indicated that shared parenting is strongly advocated for in their counties, for example through modeling, including showing how to keep conversations flowing with parents, asking questions of the child, sharing videos, going along to appointments, telling parents about and inviting them to upcoming activities and giving them choices/input. Foster parents provided different perspectives. One shared that she did not like the practice at first but developed more empathy for birth families the more she tried it and was, therefore, better equipped to care for their children. Another shared that the process “isn’t working” but acknowledged that it is important for children to see their parents in the same room and to



interact with them. The same foster parent wished the foster and birth parents had time together without the child, in order to share tips so visits could be more successful, and felt this should be built into the shared parenting process. Other foster parents participating in the focus group discussed the challenges of dealing with no-contact orders and parents having transportation issues: “they don’t always show up.”

When asked about agency efforts to engage parents to achieve reunification, some foster parents felt that parents are very much engaged by the caseworker and given every opportunity to change, sometimes being provided too many opportunities and that workers can also push reunification when it might not be appropriate.

In focus groups, worker surveys, and the Building Local Systems summit meetings, county staff also reported being unable to access timely mental health and substance abuse services to help parents reunify with their children (or avoid having them removed). In the Building Local Systems summits, county DSS and the leaders of the regional organizations that manage behavioral health services agreed:

- ◆ Funding is very limited for services to adults who do not have Medicaid.
- ◆ Most parents of foster children do not have Medicaid because North Carolina has not closed the coverage gap and because Medicaid based on parenting status is lost when children enter foster care.
- ◆ As a result, evidence-supported services, such as medication-assisted treatment for opioid addiction cannot be accessed to support reunification efforts.
- ◆ Transportation is an additional barrier for parents living in sparsely populated parts of the state.

***Sub-Question 2:*** *Is the safety of the home and family to which the child is to return being regularly and appropriately assessed, are appropriate safety plans used and safety related services provided, and is adequate in-home follow-up after a child returns conducted to allow reunification to occur timely and safely?*

In OSRI reviews conducted in 2017-2018, Item 3 – which focuses on risk and safety management and includes conducting initial and ongoing safety assessments, putting safety plans and related services in place when appropriate – was rated as a strength in just 45 percent of 40 applicable foster care cases.

Another critical practice in assessing the safety of the home and family to which the child is to return is worker face-to-face contact with the parent(s) and in

***Key Findings:*** *Assessment of safety to facilitate and support timely and sustainable family reunification:*

- North Carolina’s foster care re-entry rate is low compared to other states.
- Trial home placements are frequently used prior to case closure.
- Supportive services are generally in place at the time of case closure
- The completion of risk re-assessments within 30 days of closure (42%) is an area in need of improvement.

the home whenever possible. As previously noted, program monitoring and OSRI review data indicates worker face-to-face contact with parents is not occurring on the minimum once per month basis as per agency policy.

<b>2017 NC Program Monitoring Review Data</b>				
<b>Select Questions – Foster Care Protocol</b>				
<b>Assessment of Safety</b>	<b>State</b>	<b>Large</b>	<b>Medium</b>	<b>Small</b>
Was there a trial placement prior to case closure?	93.33% (14/15)	100% (2/2)	100% (6/6)	66.67% (6/9)
Were the issues that brought the child into custody resolved?	80% (12/15)	50% (1/2)	66.67% (4/6)	58.33% (7/12)
Was a risk re-assessment completed within 30 days of closure?	41.67% (5/12)	0% (0/2)	42.86% (3/7)	16.67% (2/12)
Were supportive services in place for the family at the time of case closure?	73.68% (14/19)	100% (2/2)	62.50% (5/8)	63.64% (7/11)

As previously noted, North Carolina’s rate of children foster care re-entry rate is very low compared to other states. This suggests that North Carolina may be doing a good job of assessing the safety of homes to which children are returned and putting appropriate services in place. As discussed below, it could also be partly due to North Carolina’s use of trial home placements. After the courts return custody of children to parents, Child Welfare loses both funding and jurisdiction to remain involved. Program Monitoring data indicate counties generally arrange supportive services together with families (74%) that they can continue voluntarily after custody is returned; however, services provided by Child Welfare itself are very limited. Perhaps as a solution, courts in North Carolina used trial placements in the majority of the small number of cases reviewed to send children home while the county retained legal custody as well as authority and responsibility for providing services and monitoring the trial placement. Trial home placements lengthen the time that children in North Carolina spend in foster care. They may improve the safety of reunifications by making it more likely that families receive support and problems are responded to appropriately. Trial home visits may also be partly responsible for reducing the rate of re-entry into foster care, both by providing more support for parents and also because a failed home placement while the county maintains custody is not counted as a re-entry.

Focus groups with foster care workers from across the state indicated they primarily use their ongoing visits and conversations with children, parents, and caregivers as a way to observe and assess the safety of the home the children are to be returned to. Several workers cited being direct with parents since they know their children best, by asking them about what they have learned, applying what they have learned, and ensuring they understand their case plan.

Some workers discussed their reliance on various agency assessment tools. The Strength and Needs Assessment and Trauma Screening Tool were both cited as helpful. A few staff noted that the Strength and Needs Assessment as well as Risk Assessment need to be updated more often as the case plan is built on an earlier version of the form. Some cited the monthly contact form as a useful tool to help ensure safety while others found the form to be tedious. Some workers describe relying heavily on stakeholders, such as therapists, schools and community providers, as a way to help ensure child safety.

Finally, some workers described how many cases start out with restrictive supervised visits between parents and children and then they work to build a network for supervision and support so kin can observe visits instead and reunification progresses from there.

**Sub-Question 3:** *Are children, youth, parents, and caregivers engaged throughout the case planning process, and are Child and Family Team Meetings strength-based and representative of the family’s voice?*

OSRIs conducted by DHHS in 2017-2018 indicate just 56 percent of 39 applicable foster cases reviewed rated as a strength in the area of child and family engagement.

Data from Program Monitoring Reviews suggest similar findings in terms of engaging parents in case planning activities. For example, documentation in cases reviewed indicated issues regarding counties actually holding initial (45%) and ongoing CFTs (39%), as well as in actively engaging parents and children in the CFT process.

Children in particular were not found to be involved in their initial CFT (31%) nor having the opportunity to attend court, or have their input known to the court (50%). There was also little documentation found in the cases reviewed of families having been prepared to participate in the CFT process (39%). There was, however, documentation in 72 percent of cases reviewed of agency efforts to assist the family in achieving their goals.

**Key Findings:** *Engaging children and families throughout the case planning process:*

- In the majority of cases, initial CFTs are not held within 30 days of removal and do not involve the child.
- Ongoing CFTs are not being consistently held within timeframes.
- Preparation of families is documented in less than 40% of cases.
- Documentation suggests the agency does make efforts to assist families in achieving their goals.

2017 NC Program Monitoring Review Data				
Select Questions – Foster Care Protocol				
Child and Family Engagement in Case Planning	State	Large	Medium	Small
Is the child afforded the opportunity to attend court or have their input known to the court?	50% (113/226)	51.52% (17/33)	36.14% (30/83)	60% (66/110)
Is there documentation of preparing the family for the CFT?	38.49% (199/517)	35.82% (24/67)	40.18% (88/219)	37.66% (87/231)
Are CFT documentation instruments used to document CFT’s as prescribed in policy?	42.38% (203/479)	46.88% (30/64)	47.34% (98/207)	36.06% (75/208)
Were both the removal social worker and foster care social worker part of the initial CFT?	31.88% (124/389)	28.81% (17/59)	35.33% (59/167)	29.45% (48/163)
Are Initial CFTs held within 30 days of custody?	44.68% (231/517)	59.70% (40/67)	40.91% (90/220)	43.91% (101/230)
Are ongoing CFTs held according to policy?	38.79% (180/464)	44% (22/50)	37.81% (76/201)	38.50% (82/213)
Are CFTs held when there was a change in family circumstances?	30.58% (74/242)	24% (6/25)	29.35% (27/92)	32.80% (41/125)

2017 NC Program Monitoring Review Data				
<i>Select Questions – Foster Care Protocol</i>				
Child and Family Engagement in Case Planning	State	Large	Medium	Small
Was the child involved in the initial CFT?	31.25% (80/256)	32.43% (12/37)	31.58% (30/95)	30.65% (38/124)
Did the agency make efforts to assist the family in achieving their goals? (new: available for July-Dec only)	72.35% (157/217)	57.14% (12/21)	61.18% (52/85)	83.78% (93/111)

Most of the foster care workers who participated in focus groups cited the use of CFTs as the primary way to engage family members in the case planning process. Some discussed struggling with getting CFTs conducted every three months and finding the frequency excessive. Some workers cited the use of regular visitation with parents as the best way to engage the family, using a strengths-based approach and making diligent efforts. A few participants noted it is hard to engage families in case planning due to high caseloads.

***Sub-Question 4:*** *Is progress towards the goal of reunification routinely monitored, together with the family, and services adjusted to meet the changing needs and desires of the family?*

Program Monitoring Review findings indicate that initial and ongoing Family Reunification Assessments are only being completed, reviewed, and updated approximately 50 percent of the time. The Family Services Agreements (FSA) are not being consistently reviewed and formally updated with parents. There were only slight variances in the reviews of FSAs with mothers (52%) and fathers (39%) or in the formal updating every six months of FSAs with mothers (51%) and fathers (43%). As previously noted, the lack of consistent quality face-to-face contact between workers and parents can also pose a barrier to establishing relationships that help facilitate meaningful conversations with mothers and fathers around their changing needs and progress being made towards having their children returned to them.

***Key Findings:*** *Ongoing monitoring of progress towards goal of reunification:*

- Initial and ongoing Family Reunification Assessments are occurring per policy in 50% of cases reviewed.
- Family Service Agreements (FSAs) are not being regularly reviewed and updated with parents or whenever there are significant changes taking place in the family.

2017 NC Program Monitoring Review Data				
<i>Select Questions – Foster Care Protocol</i>				
Monitoring Progress towards Reunification	State	Large	Medium	Small
Has the (initial) Family Reunification Assessment been completed, reviewed, updated and provided as per policy?	52.05% (254/488)	64.52% (40/62)	50% (106/212)	50.47% (108/214)
Has the (ongoing) Family Reunification Assessment been completed, reviewed, updated and provided as per policy?	49.60% (184/371)	59.57% (28/47)	46.79% (73/156)	49.40% (83/168)

2017 NC Program Monitoring Review Data				
<i>Select Questions – Foster Care Protocol</i>				
Monitoring Progress towards Reunification	State	Large	Medium	Small
Was the FSA reviewed regularly with the mother as evidenced by notes on the agreement or other documentation in the record?	51.60% (210/407)	46.94% (23/49)	49.73% (91/183)	54.86% (96/175)
Was the FSA formally updated with the mother when there were significant changes and at least every 6 months? (new: available for July-Dec only)	51.33% (58/113)	66.67% (2/3)	50.91% (28/55)	50.91% (28/55)
Were well-being needs updated and addressed for the mother at each FSA update? (new: available for July-Dec only)	40.34% (48/119)	0% (0/3)	38.33% (23/60)	44.64% (25/56)
Was the FSA reviewed regularly with the father as evidenced by notes on the agreement or other documentation in the record?	39.37% (113/287)	34.29% (12/35)	36.89% (45/122)	43.08% (56/130)
Was it formally updated with the father when there were significant changes and at least every 6 months? (new: available for July-Dec only)	42.67% (32/75)	100% (1/1)	39.39% (13/33)	43.90% (18/41)
Were well-being needs updated and addressed for the father at each FSA update? (new: available for July-Dec only)	42.25% (30/71)	NA (0/0)	36.11% (13/36)	48.57% (17/35)

Most Foster Care workers who participated in focus groups cited the use of concurrent planning, communication around the delivery of services, scheduling regular visits, and making diligent efforts as the primary means of supporting and monitoring the progress with families toward the goal of reunification. While some staff indicated they found CFTs helpful in engaging families, others found them to not be helpful and that facilitators needed more training. The biggest barrier cited by participants was in not being able to spend enough time in the field with families and that the expectation for reunification within 12 months was not reasonable.

### ***F. Practices to Achieve Permanence Including Reunification, Adoption, and Guardianship***

#### **Overview**

Consistent with the Adoption and Safe Families Act, North Carolina policy prioritizes a child’s need to live in a permanent family. While the initial primary plan is usually reunification, counties are expected to develop and work concurrently with the family on at least one additional plan – usually adoption or custody or guardianship to a relative – so that work toward permanency will not have to start over if reunification efforts are unsuccessful. Additionally, the time that a county should be working on reunification as the primary plan is limited.

The overview for the previous section on Services to Children, Youth and Families to Achieve Reunification summarized court processes when children enter foster care, how counties are to engage families in service planning, and services to help parents reunify with children. The overview for this section summarizes North Carolina’s permanency options and additional policies and services to achieve permanency.

### **Reunification**

Defined as returning custody to the parent(s) or primary caretakers from whom a *child was removed, is typically the first option.*

### **Adoption**

Policy describes adoption as the most legally secure permanency option after reunification and therefore generally preferred. Adoption requires parents to formally relinquish parental rights or to have those rights terminated by the court, and North Carolina policy sets two years as the timeframe within which children should achieve permanence through adoption. According to a state adoptions leader, most children in North Carolina who are adopted are found eligible for adoption assistance, which provides a monthly cash payment equivalent to a foster care board payment until a child reaches 18 (age 21 for youth adopted at age 16 or 17) and may also provide funds to pay vendors for services not covered by Medicaid to address special needs identified before the adoption. North Carolina also has an adoption fund that pays bonuses to counties and private vendors for completed special-needs adoptions and is in the process of re-evaluating how to structure bonuses so that they incentivize and drive improved performance.

### **Legal Guardianship**

Policy describes legal guardianship as less secure than adoption but more secure than legal custody. The modified manual balances preferences for adoption and permanence with kin by stating that permanency options with relatives or kin should be explored when reunification has been determined contrary to the child's needs, and that guardianship must be offered to relative or kinship caregivers who are not willing to adopt. Until recently, monthly financial assistance was available only to relatives or kin who adopted, which required parental rights to be terminated. North Carolina recently established a guardianship assistance program (GAP) that was enabled by legislation requiring GAP to be cost neutral. Youth aged 14 and older are eligible for guardianship assistance with a relative or kinship caregiver if reunification and adoption have been ruled out and permanence is otherwise unlikely to be achieved. Siblings are eligible for GAP if placed in a guardianship arrangement with a sibling who meets the age requirement.

### **Legal Custody**

Policy describes legal custody as less secure than guardianship because it can be challenged later by showing a change of circumstances, whereas guardianship can only be challenged on the basis of the unfitness of the guardian. Legal custody can also be used by the courts to give custody to the noncustodial parent (the parent from whom the child was not removed).

### **APPLA**

Another Planned Permanency Arrangement (APPLA) can be used in North Carolina only for youth aged 16 or 17 who have been integrated into a family setting with mutual emotional commitment when both the youth and caretaker request the arrangement be made permanent and when other permanency options have been determined to be inappropriate.

### **Reinstatement of Parental Rights**

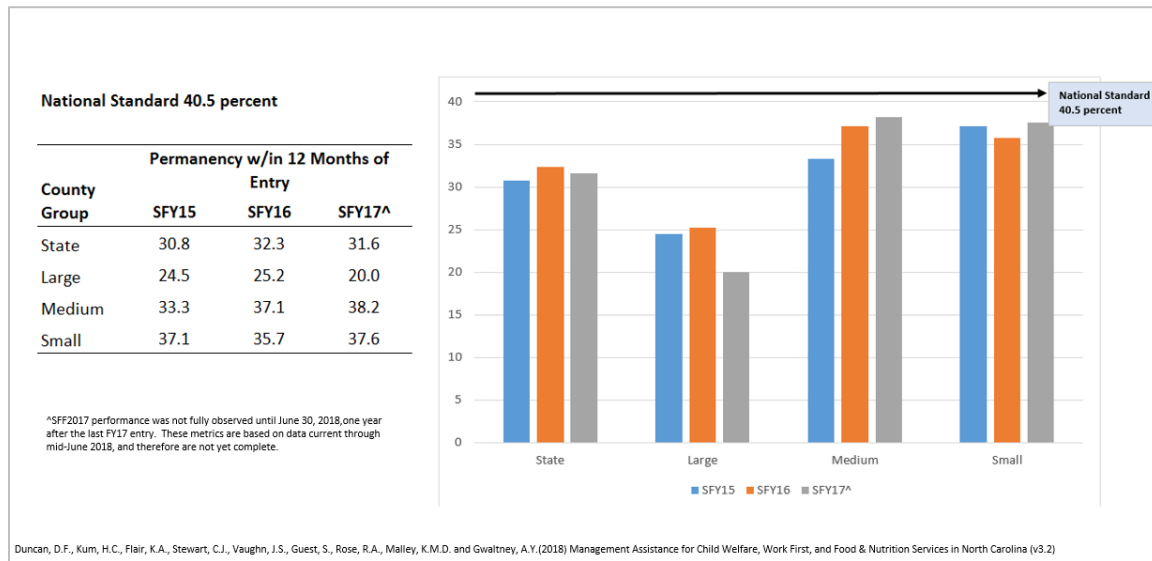
This refers to a permanency option for youth over 12 years old who no longer have a legal parent due to termination of parental rights and who are determined unlikely to be adopted in a reasonable time period or for whom adoption is no longer the plan.

North Carolina policy and practices include several strategies intended to promote permanency being achieved quickly. Child and Family Team meetings (described in Section 5.2.2(5) on reunification) are intended to engage parents, children, relatives, supports, and service providers in an ongoing planning process. Policy encouraging a single stable placement is intended to decrease placement disruptions which further traumatize children and families and make achieving permanency more difficult. North Carolina policy emphasizes finding, engaging, and placing with relatives and kin. Funded by the legislature, North Carolina has a Permanency Initiative (PI) with Children’s Home Society, a not-for-profit child placing latency, that has included child specific recruitment strategies, family finding strategies, and training for counties. In most North Carolina counties, a family is transferred to a foster care worker when the county assumes legal custody, though this is dependent on county size and practice. In some counties, children who are legally freed are transferred again to workers who specialize in adoption work while in other counties children who are legally freed remain with the same worker.

**Permanency Trends**

The figure below shows North Carolina’s overall performance achieving permanence for children within 12 months of their entering foster care since July 2012. The dark line represents the federal standard. The data indicate that North Carolina’s rate of achieving permanence for foster children within 12 months was below the national standard of 40.5 percent for Round 3 of the CFSR. Statewide performance has remained relatively consistent over the past three state fiscal years hovering at 32 percent in 2017. Children in small and mid-sized counties consistently left foster care for permanent homes more quickly than children in large counties.

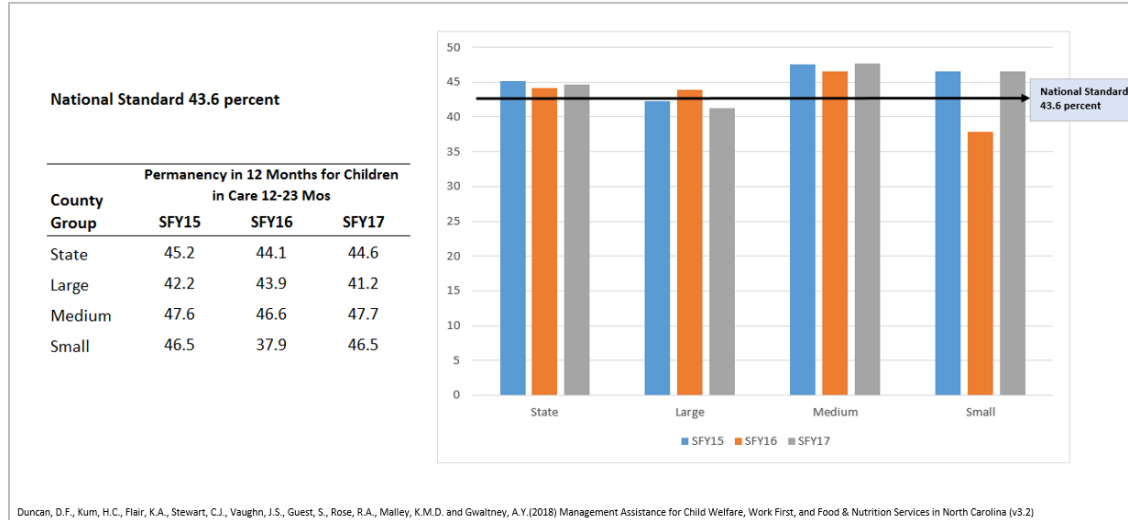
**Figure 31: Permanency w/in 12 Months for Children Entering Foster Care**



The chart below depicts North Carolina’s success achieving permanence within a year for children who have already been in foster care between 12 and 23 months. North Carolina’s performance achieving permanence for children within 12 months who had already been in care for 12 to 23 months has also stayed consistent over the past three state fiscal years and is currently at 45 percent, versus the Round 3 CFSR national standard of 43.6 percent. Children in

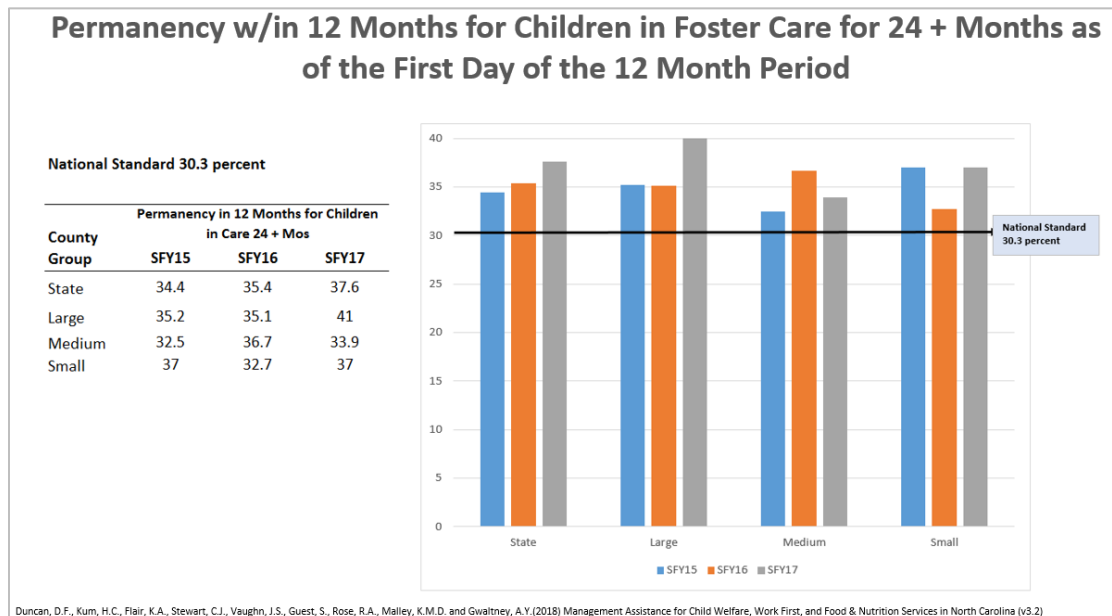
small and medium counties were somewhat more likely to achieve permanence in this timeframe, though the pattern was less consistent than in the first 12 months.

**Figure 32: Permanency in 12 Months for Children in Foster Care for 12-23 Months as of the First Day of the 12-Month Period**



The next figure depicts North Carolina’s performance on achieving permanence within a year for children who have already been in custody for two or more years. North Carolina’s performance achieving permanence for children already in care for over two years or more has consistently exceeded the national Round 3 CFSR performance standard of 30.3 percent, and is currently just over 37 percent. On this measure, larger counties have done as well as smaller counties.

**Figure 33: Permanency for Children in Foster Care for 24 or more Months**

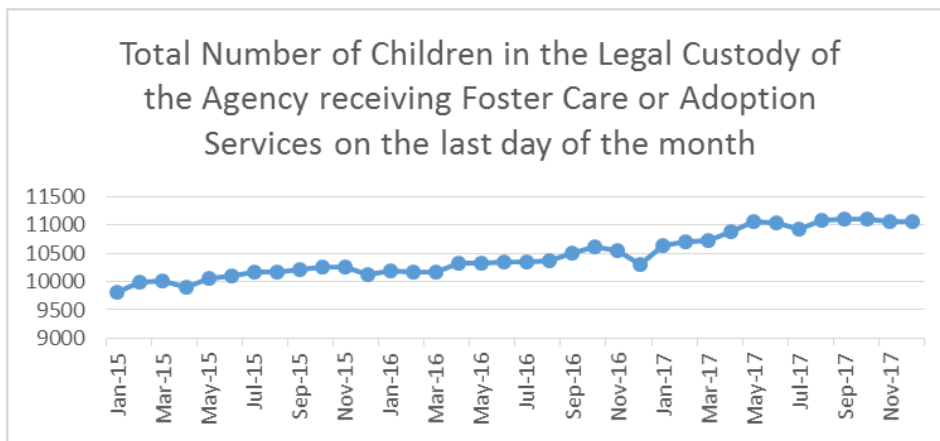




As previously noted in the Reunification section, North Carolina’s rate of re-entry into foster care has consistently been much lower than the national Round 3 CFSR standard of 8 percent. Large, medium, and small counties all have very low rates of re-entry into care.

Viewed together, North Carolina’s performance on the four CFSR measures indicates the state lags behind other states in achieving timely permanence, but it has a higher rate of achieving permanency for children who already have stayed in foster care a long time. Children who have left foster care for permanence in North Carolina are much less likely to reenter care. As seen in *Figure 34* below, the number of children in foster care has steadily increased over the last three years.

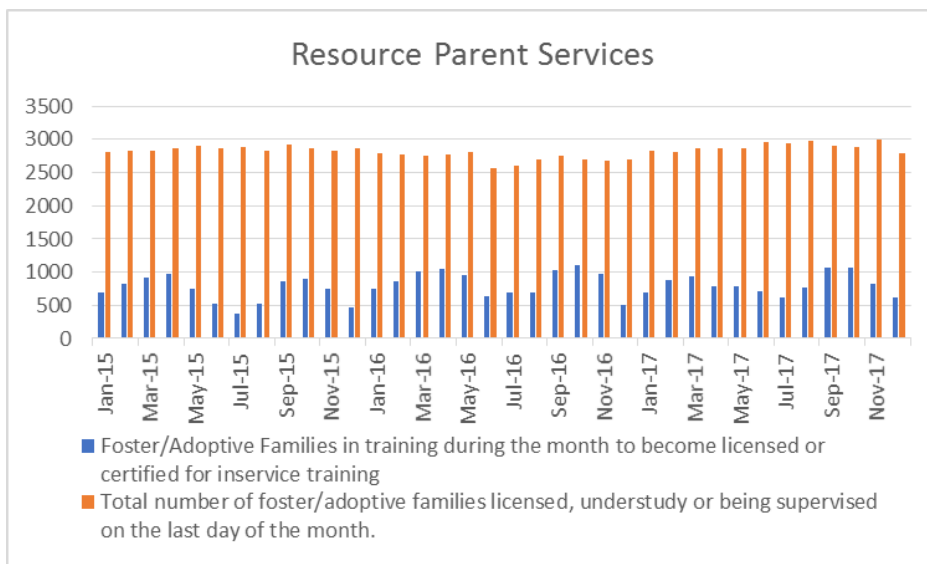
**Figure 34: Total Number of Children in Legal Custody of the Agency Receiving Foster Care or Adoption Services on Last Day of the Month**



Source: CW Staffing Data

The total number of foster/adoptive families has remained fairly constant over the last three years.

**Figure 35: Resource Parent Services**



**Sources of Information**

- ◆ Administrative Data:
  - UNC Management Assistance website.
  - NC Legacy Data.
  - County Child Welfare Staffing Workbook Data.
- ◆ Case Review Data:
  - Program Monitoring Review Data.
  - OSRI Data.
- ◆ Meetings attended with state and county staff.
- ◆ Focus Groups:
  - Foster Care workers
  - Foster Care supervisors
  - Licensing staff
  - Foster parents
  - Court-related personnel
- ◆ Interviews:
  - Parents, Youth, Kin Caregivers.
- ◆ Surveys:
  - Foster Care Supervisors
- ◆ Other reports/information received
  - Building Local Systems Report on summit meetings between DSSs and Behavioral Health LME/MCOs.
  - Child Welfare Outcomes 2015 Report to Congress.

**Detailed Findings**

<b><u>Primary Research Question:</u></b>	<b><i>Are children and youth in foster care receiving trauma-informed services and supports that facilitate timely permanency?</i></b>
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Data that was gathered and analyzed as part of the assessment process suggests that children and youth in foster care in North Carolina are not receiving an appropriate level of trauma-informed services and supports to facilitate timely permanency. To answer this research question, CSF examined the following core agency practices:

- ◆ Implementing concurrent planning practices;
- ◆ Conducting ongoing searches for absent parents and family members;
- ◆ Making child-specific recruitment efforts to identify and support potential adoptive placement;

- ◆ Working with the courts to avoid delays and to help children achieve timely permanency;
- ◆ Preserving family connections;
- ◆ Providing Licensing and guardianship options to relatives; and
- ◆ The role of supervision in guiding and supporting the permanency planning process.

As previously noted, CSF observed examples of positive practices in terms of ensuring timely reunification, such as the state's low re-entry rate and also the provision of supportive services at the time of case closure. Case review data also indicate that court reports are being tendered as required and ongoing permanency plan and case review hearings are held in accordance with state policies. North Carolina has launched and is currently seeking additional funding for an initiative to improve permanency outcomes for children through training for court and child welfare leadership and outcomes management.

Data also suggest, however, that the state faces a variety of challenges across other permanency-related practice areas, such as conducting concurrent planning activities where case review results indicated that secondary plans frequently go unidentified within Family Services Agreements (FSA) and in only half of applicable cases reviewed was there evidence of agency efforts toward achieving the secondary plan. One-third of foster care workers surveyed expressed the belief that concurrent planning in North Carolina is not effective, with the majority of workers responding to why concurrent planning was not effective pointing to court delays or lack of court support. Searching for absent parents and extended family members is essential to securing timely adoptions and guardianships for children and youth and this impacts the state's performance in terms of filing timely petitions for the termination of parental rights, locating potential relative adoptive placements, or simply in preserving vital family and community connections for older youth who will age out of the foster care system and into adulthood. Only 56 percent of foster care workers who were surveyed reported looking diligently for relatives throughout the life of a case.

CSF also analyzed data regarding the role played by supervisors in the achievement of timely permanencies. Case review data suggests that foster care supervisors are generally signing off on required agency documents; however, there was little documentation of regular supervisory/caseworker staffing taking place. When asked, though, in a survey administered by CSF as to the *extent to which foster care caseworkers feel supported by their supervisor*, 91 percent of 185 respondents indicated feeling somewhat to very supported.

***Sub-Question 1:*** *Is the safety of the home and family to which the child is to return being regularly assessed, through the use of appropriate safety plans and safety related services that allow reunification to occur timely and safely?*

*(See also 5.2.2[5]) Services to Children, Youth and Families to Achieve Reunification: Sub-Question 2)*

As previously noted, North Carolina has a foster care re-entry rate that is low in comparison to other states. Program Monitoring review results indicate that the use of trial home placement may have an impact on the state's re-entry rate and also that workers do a good job ensuring that

supportive services are in place at the time of case closure. The practice of conducting risk re-assessments in a timely basis is an area however in need of improvement.

Some foster parents felt they are not engaged at all in permanency planning. One shared that foster parents often see red flags and the needs of birth families before workers do, but they feel that they are not supposed to participate in the planning process. Another shared that it is on them as foster parents to reach out to the workers on the case, as they are not notified of permanency hearings and this leads to communication breakdowns.

***Sub-Question 2:*** *Are concurrent planning practices implemented to ensure timely permanency for the child?*

North Carolina’s 2015 Child and Family Services Review included several findings relevant to this question:

- ◆ Item 5 of the OSRI, which focuses on whether appropriate permanency goals were established for children in a timely manner, was identified as a strength in only 38 percent of 39 applicable cases reviewed by DHHS in 2017-2018.
- ◆ Similarly, Item 6 of the OSRI, which focuses on whether concerted efforts are being made to achieve reunification, guardianship, adoption, or other planned permanent living arrangement, was identified as a strength in 37.5 percent of 40 applicable cases reviewed.

***Key Findings:*** *Assessment of safety to facilitate and support timely and sustainable family reunification:*

- Children in NC are much less likely to re-enter foster care after achieving permanency than children in other states.
- Trial home placements are frequently used prior to case closure.
- Supportive services are generally in place at the time of case closure.
- The completion of risk re-assessments within 30 days of closure (42%) is an area in need of improvement.
- In focus groups, foster parents expressed differing perspectives on shared parenting and some expressed not feeling engaged in the permanency planning process.

Program Monitoring Reviews conducted throughout North Carolina in 2017 provide insight into concurrent planning practices. Documentation indicates that concurrent/secondary plans were identified in 68 percent of permanency planning court orders and in 72 percent of Family Service Agreements in the cases reviewed. There was evidence of agency efforts towards achieving the secondary plan in only 53 percent of the cases reviewed. There was higher performance in terms of conducting initial (74%) and ongoing (77%) Permanency Planning Action Team Meetings and case file documentation suggests court reports are submitted for each hearing 90 percent of the time.

Review results more specific to court- related procedures were mixed, with evidence of dispositional, review, and permanency planning hearings occurring on a timely basis, while documentation of a concurrent or secondary plan being identified in the court order (68%) or a TPR (25%) was not consistently evident in the applicable cases reviewed. Also, case file documentation indicated that children were being provided an opportunity to attend court or have their input known to the court in only half of the over 200 applicable cases reviewed.

**Key Findings:** *Concurrent planning practices:*

- Timeliness of selecting permanency goals and making concerted efforts to achieve permanency are both areas needing improvement.
- Court reports are tendered as required and ongoing permanency planning and case review hearings are held.
- A secondary plan is identified in court orders only two-thirds of the time.
- Children in foster care are not consistently given the opportunity for input at court hearings
- Children and parents are not consistently engaged in the development of case plans
- TPR petitions are not being filed timely.

<b>2017 NC Program Monitoring Review Data</b>				
<b>Select Questions – Foster Care Protocol</b>				
Concurrent planning practices	State	Large	Medium	Small
Is the concurrent/secondary plan identified in the permanency planning court order?	68.24% (232/340)	50% (21/42)	69.63% (94/135)	71.78% (117/163)
Were one or more secondary plans identified on the FSA?	71.69% (352/491)	65% (30/60)	67.79% (141/208)	77.13% (172/223)
Is the agency making efforts towards achieving the secondary plan?	53.09% (232/437)	57.14% (28/49)	52.72% (97/184)	52.45% (107/204)
Was the (Initial) Permanency Planning Action Team Meeting conducted as per policy:	73.67% (375/509)	67.21% (41/61)	74.55% (164/220)	74.56% (170/228)
Was the (Ongoing) Permanency Planning Action Team Meeting conducted as per policy:	76.84% (302/398)	82.22% (37/45)	75.30% (125/166)	76.92% (140/182)
Were court reports submitted for each hearing?	89.75% (438/488)	89.47% (51/57)	90% (180/200)	89.61% (207/231)
Court procedural practices	State	Large	Medium	Small
Was the dispositional hearing held within 30 days of the adjudication?	80.59% (357/443)	72.34% (34/47)	89.39% (160/179)	75.12% (163/217)
Were review hearings held within 90 days of the disposition and every 6 months thereafter?	78.26% (270/345)	64.86% (24/37)	81.56% (115/141)	78.44% (131/167)
Was a permanency planning hearing held within 12 months of custody?	88.34% (197/223)	92% (23/25)	94.32% (83/88)	82.73% (91/110)

2017 NC Program Monitoring Review Data				
<i>Select Questions – Foster Care Protocol</i>				
Concurrent planning practices	State	Large	Medium	Small
Did the court make findings of reasonable efforts to finalize a permanent plan at least yearly?	88.37% (228/258)	93.33% (28/30)	90.38% (94/104)	85.48% (106/124)
Was the child afforded the opportunity to attend court or have their input known to the court?	50% (113/226)	51.52% (17/33)	36.14% (30/83)	60% (66/110)
Is the concurrent/secondary plan identified in the court order?	68.24% (232/340)	50% (21/42)	69.63% (94/135)	71.78% (117/163)
Was there a TPR Petition?	25.17% (36/143)	0% (0/22)	38.71% (12/31)	26.67% (24/90)

The survey of foster care workers revealed significant concern with the effectiveness of North Carolina’s concurrent planning processes in achieving timely permanency. Of the 192 workers who responded to a question about the effectiveness of permanency planning to achieve permanence, only 15 percent reported the practices were very effective, 52 percent reported they were somewhat effective, and 33 percent reported they were not particularly effective or not effective at all. The majority of workers responding to why permanency planning was not effective cited court delays or lack of court support for the concurrent plan or concurrent planning process.

***Sub-Question 3:*** *Are searches for absent parents and relatives conducted early on and frequently throughout the life of the case?*

Data relevant to this sub-question can be found in the 2015 Child and Family Services Review OSRI results, the state’s program monitoring data, and foster care worker survey data. Item 10 of the OSRI, which focuses on whether concerted efforts are made to place children with relatives when appropriate, was rated as a strength on 79 percent of applicable cases. Subsequent OSRI reviews conducted by DHHS in 2017-2018 indicate significant improvement in this area with 90 percent of 39 applicable cases reviewed rated as a strength.

***Key Findings:*** *Searches for absent parents and relatives:*

- North Carolina struggles to comply with notification requirements of maternal and paternal relatives of the fostering connections act.
- Only 56% of foster care workers responding to a survey reported looking diligently for relatives throughout the life of a case.

Program monitoring data more directly addresses whether appropriate searches for relatives and absent parents are being conducted. Program monitoring data indicates that counties were generally not meeting the full requirements of the Federal Fostering Connections Act for relative notification within 30 days of taking custody. (This may be part of a pattern for counties to score poorly on measures of activity during the first thirty days in care.) When relatives expressed interest, counties documented follow up 80 percent of the time.

Of the almost 200 foster care workers who responded to a CSF survey, 56 percent reported they make diligent efforts to locate relatives throughout the life of a case. Most of the rest of the workers reported making efforts when children enter care, during the first few months, or as long as the goal is reunification.

2017 NC Program Monitoring Review Data				
<i>Select Questions – Foster Care Protocol</i>				
Searches for absent parents and relatives	State	Large Counties	Medium Counties	Small Counties
Was the maternal family notified within 30 days of the child coming into care per Fostering Connections?	17.61% (62/352)	38.89% (21/54)	11.56% (17/147)	15.89% (24/151)
Was the paternal family notified within 30 days of the child coming into care per Fostering Connections?	37.18% (158/425)	55% (33/60)	29.44% (53/180)	38.92% (72/185)
If relatives expressed interest in being involved with the foster child, is there follow-up?	79.48% (244/307)	78.38% (29/37)	79.70% (106/133)	79.56% (109/137)

***Sub-Question 4:*** Are child-specific recruitment efforts to identify and support potential adoptive placement undertaken where appropriate?

North Carolina’s modified policy manual requires a child-specific plan of recruitment within 30 days of a child being freed for adoption and for children not in an adoptive home to be registered on the North Carolina Adoption exchange. The state also funds some adoption-specific recruitment efforts through private vendors and has an Adoption Promotion Program that paid about \$6.5 million in adoption bonus payments annually to counties and private agencies intended to incentivize improved adoption performance and adoptions of children without identified adoptive homes. The state is concerned that adoption bonuses have increased in recent years without a corresponding improvement in the number of adoptions taking place. The Central Office is currently going through a process to reassess the Adoption Promotion Program strategy to better incentivize work that will improve adoption outcomes.

***Key Findings:*** Child-specific efforts to support potential adoptive placements:

- The state is currently reassessing its Adoption Promotion Program strategy because increased expenditures have not resulted in increased adoptions.

In focus groups, staff reported efforts in individual counties including permanency roundtables for children with long stays in care. Some staff said child-specific adoption efforts were mostly undertaken by adoption workers.

***Sub-Question 5:*** *Are concerted efforts made to work with the courts to avoid delays and to help children achieve permanence quickly?”*

The relationship with the courts was frequently cited as a challenge to achieving timely permanency in meetings and focus groups with state, county, and court personnel.

- ◆ A shortage of court time was consistently cited as an issue. Some counties have multiple available court days a week but too many cases for those days. Some counties have juvenile court as few as one day a month. When cases get continued for a variety of reasons, including parents’ attorneys not having met with their clients before court, they often cannot be rescheduled quickly. It is also difficult to find time for contested cases, which themselves can cause delays and continuances in other cases.
- ◆ Judges are perceived as bringing their individual perspectives to the bench, which may differ from child welfare policy. Caseworkers in one focus group complained their judge is impatient if they continue to recommend visitation after a parent fails a drug screen. Another judge reported that he is the problem – he is too slow to sever parental rights.
- ◆ County staff reported perceiving guardian ad litem volunteers as less trauma-informed, more reluctant to reunify, and more likely to recommend termination of parental rights.
- ◆ In one judicial district, county attorneys, parents’ attorneys, and the guardian ad litem administrator reported working together well because they have to, because they do not have enough court time for continuances, and only very limited time for contested cases. They highlighted complete and rapid sharing of case information so that there are no surprises and working to agree on stipulated findings as keys to success.
- ◆ Some North Carolina court districts have a family court that increases continuity by allowing one judge to follow a case from beginning to end, but which can result in longer continuances especially in rural districts. A few districts have funding for court improvement projects to expedite permanency.

***Key Findings:*** *Concerted efforts to work with the courts to achieve permanence and avoid delays:*

- The state has launched and is currently planning and seeking additional funding for an initiative to improve the working relationship between child welfare and the courts.
- Challenges include lack of court time and differing perspectives on what is best for children.

At the April meeting with the Children’s Bureau to review progress on North Carolina’s Program Improvement Plan (PIP), state Child Welfare and Administrative Office of the Courts officials described an effort to launch local teams in 20 counties to be co-captained by a district court judge and the DSS director to improve collaboration between Child Welfare and the courts. An initial meeting in February had 170 participants beginning with information and data sharing and moving to setting priorities and planning. This meeting, called a Court Convening, was a requirement of North Carolina’s PIP and introduced a document called the Permanency Profile, which provides a report on a district’s achievement of permanency for children. Follow-up meetings and expansion to all 100 counties is planned, and discussions with partners to seek additional funding are ongoing.



***Sub-Question 6:*** Are sufficient efforts made to preserve connections regardless of permanency outcome?

In OSRI reviews from 2017-2018, Permanency Outcome 2, which assesses counties’ efforts to preserve the continuity for children of family relationships and connections, was substantially achieved in 68 percent of 24 cases reviewed. Stronger items included placement with siblings (rated a strength in 86 percent of cases), Preserving Connections (79%) and Relative Placement (90%). Visiting with Parents and Siblings was rated a strength in 61 percent of cases, and Relationship of Child in Care with Parents was rated a strength in 58 percent of cases.

**Key Findings:** Sufficient efforts to preserve connections regardless of permanency outcome:

- OSRI reviews have found North Carolina to be in substantial conformity with this expectation about 70% of the time.
- Program Monitoring Reviews have found North Carolina is not in compliance with relative notification requirements during the first 30 days in care.

Program Monitoring Reviews assessing North Carolina’s compliance with the federal fostering connections act found poor performance on expectations that maternal and paternal relatives be notified within 30 days of a child entering care. The data is in the table below.

2017 NC Program Monitoring Review Data				
<i>Select Questions – Foster Care Protocol</i>				
Searches for absent parents and relatives	State	Large Counties	Medium Counties	Small Counties
Was the maternal family notified within 30 days of the child coming into care per Fostering Connections?	17.61% (62/352)	38.89% (21/54)	11.56% (17/147)	15.89% (24/151)
Was the paternal family notified within 30 days of the child coming into care per Fostering Connections?	37.18% (158/425)	55% (33/60)	29.44% (53/180)	38.92% (72/185)
If relatives expressed interest in being involved with the foster child, is there follow-up?	79.48% (244/307)	78.38% (29/37)	79.70% (106/133)	79.56% (109/137)

***Sub-Question 7:*** Are licensing and guardianship options appropriately offered and explained to relatives and caretakers when appropriate?

Program Monitoring Review data below suggest counties are not consistently engaging relatives in the opportunity to become licensed as foster parents or in assessing relatives in an ongoing basis, either for possible placement or other involvement in the child’s life. In focus groups, staff said some workers discourage licensing for relatives because the process takes too long, while others feel relatives would not want licensure except for the pay.

**Key Findings:** Licensing and guardianship options offered to relatives when appropriate:

- Program monitoring data indicates that relatives or kin are not consistently given the opportunity to be licensed.
- Most relatives and kin providing placements for children in foster care do not complete the licensure process and, therefore, do not receive the financial support available to them through a foster parent board payment.

2017 NC Program Monitoring Review Data				
<i>Select Questions – Foster Care Protocol</i>				
Licensing and guardianship options offered and explained to relatives/caretakers when appropriate	State	Large Counties	Medium Counties	Small Counties
Were relatives or kin given an opportunity to be licensed?	48.02% (170/354)	42.86% (18/42)	40.67% (61/150)	56.71% (91/162)
Is there ongoing assessment of relatives for placement or involvement in the child's life? <i>(New: Available for July-December only)</i>	53.30% (97/1820)	33/33% (7/21)	56.76% (42/74)	55.17% (48/87)

Feedback from the relatively small numbers of kinship caregivers who participated in focus group participants indicated that relative caregivers who were not licensed were informed of the licensing option, what it would entail, and what they would get from it. A few reported they opted not to pursue licensing because they did not have time for the classes and/or did not need the money. A few in one county reported starting the licensing process after being told that when DSS took custody they would need to become licensed or DSS would remove the children. The licensure process took as little as three months and as much as six to eight months.

Currently, most relatives caring for foster children in North Carolina are not licensed. A state child welfare data manager estimates that 6 percent of relatives providing placements for foster children in North Carolina are licensed foster parents receiving board payments.

***Sub-Question 8: Is supervisory involvement and oversight of these processes adequate?***

North Carolina policy has traditionally required that the most important child welfare decisions in every case be made by a worker and supervisor together and has required important forms to be co-signed by a supervisor. Program monitoring data indicates that family services agreements were cosigned 70 percent of the time and monthly foster care contact records were co-signed 76 percent of the time.

As part of its program improvement plan, North Carolina has made expectations for supervisory involvement in cases substantially more specific and detailed in the modified manual scheduled to be effective in September 2018. The new manual details the frequency with which each case must be staffed with a supervisor, what must be covered in the supervisory conference, and when two-level decision making must be conducted.

***Key Findings: Supervisory involvement and oversight:***

- Program monitoring data indicates supervisors are signing off on various required agency documents, with noted variance based on size of counties.
- Counties were not documenting a minimum of two supervisory conferences a month in 2017. This is a new requirement in the modified manual scheduled to be effective in the summer of 2018.

2017 NC Program Monitoring Review Data				
<i>Select Questions – Foster Care Protocol</i>				
<b>Permanency</b>				
Is supervisory involvement and oversight of these processes adequate?				
Data Indicators	State	Large Counties 3/10 reviewed	Medium Counties 16/39 reviewed	Small Counties 27/51 reviewed
Did the FSA include the signature of the supervisor? <i>(New: Available for July-December only)</i>	70.30% (142/202)	68.75% (11/16)	56.25% (45/80)	81.13% (86/106)
Did the social worker and supervisor both sign the Monthly Foster Care Contact Records?	75.98% (389/512)	57.81% (37/64)	79.17% (171/216)	78.02% (181/232)
Was there documentation of a minimum of two supervisor/social worker staffings/conferences each month? <i>(New: Available for July-December only)</i>	28.77% (63/219)	9.52% (2/21)	18.60% (16/86)	40.18% (45/112)

### ***G. Provision of Physical Health, Mental Health, Educational, and Developmental Services for Children in Out-of-Home Care***

#### **Overview**

The provision of physical health, mental health, educational and developmental services are paramount to ensuring the well-being of children placed in North Carolina’s foster care system. The effective delivery of such services is dependent upon many factors, including:

- ◆ Initial, timely screening exams conducted on every child who enters foster care;
- ◆ Additional formal, timely, comprehensive, strengths-based assessments conducted by DSS to understand needs of each family member;
- ◆ Availability and accessibility of culturally-competent, trauma-informed services delivered by private providers who accept Medicaid;
- ◆ The incorporation of assessments and screenings into goals and action steps in the family case plan; and
- ◆ DSS follow-up to ensure that identified physical, mental, educational, and developmental needs of children and families are met.

Prior to the removal of children, DSS policy outlines the Structure Decision-Making (SDM) process and tools to determine safety and risk of harm (see Chapter on CPS and In-Home Services). Among these tools is the Social activities, Economic situation, Environmental issues, Mental health needs, Activities of daily living, Physical health needs, and a Summary of strengths (S.E.E.M.A.P.S). If this assessment is done timely and in accordance with policy, DSS will already have identified the child’s needs. For families working with the department through CPS or In-Home Services, these services should be frontloaded to prevent the removal of children. For all other children for whom DSS considers seeking immediate custody, the S.E.E.M.A.P.S assessment should be completed prior to the case decision and/or after the child enters care.

Once a child comes into the custody of DSS, North Carolina NC law 7B-505.1 allows DSS to authorize routine medical and dental care and emergency medical, dental, and mental health treatment. For all other services, DSS must first obtain the consent of the child's parent/guardian or receive authorization from the court after a hearing. This other services include:

- ◆ Prescriptions for psychotropic drugs;
- ◆ Participation in clinical trials;
- ◆ Immunizations when a parent has a bona fide religious objection;
- ◆ Child Medical Evaluations not court-ordered;
- ◆ Comprehensive clinical assessments, or other mental health evaluations;
- ◆ Surgical, medical, or dental procedures or tests that require informed consent;
- ◆ Psychiatric, psychological, or mental health care or treatment that requires informed consent; and
- ◆ Establishment of an Individualized Education Plan (IEP) or 503 Educational Plan.

Additionally, the parents/guardians must receive prompt notification regarding all treatment services provided to the child.

DSS policy outlines service delivery expectations for the all children entering foster care or out-of-home placements. All children are to be seen by a medical provider within seven days of coming into the custody of DSS. A second medical appointment must take place within 30 days of custody for a medical provider to complete a comprehensive exam. If the child remains in care, a routine well-child medical appointment must occur at least once a year. Twice-annual dental checkups are required, as well as any needed follow-up. Finally, DSS must address the educational and developmental needs of children by completing an Initial Educational Status Component, an Updated Educational Status Component. All identified needs shall become a part of the Family Services Agreement, and goals are established to meet these needs, including the provision of physical health, mental health, educational, and developmental services.

For youth in care, ages 13 to 21, Transitional Living Plans (*see Chapter on Provision of Services for Older Youth*) and written service agreements are required. These agreements, written in consultation with the youth, specify the responsibilities of the agency and youth to accomplish immediate and intermediate goals that will assist in the youth's transition to adulthood. The agreements also include the implementation of services identified as needed by the youth and the department.

Other services for older youth include:

- ◆ Medicaid coverage until age 26 for all youth turning 18 in foster care;
- ◆ Education/training vouchers;
- ◆ NC Reach scholarships for students who attend state institutions;

- ◆ For youth 16 and older who have an IEP, a Vocational Rehabilitation assessment shall be completed; and
- ◆ Outreach efforts for young adults who aged out of care and who are not yet 21 to determine their current situations, their interest in continued services, and their need for resources through the LINKS Special Fund (to include Transitional Housing Funds).

Please see Provision of Services for Older Youth Section for more information on services provided to older youth.

**Sources of Information**

- ◆ Administrative Data:
  - UNC Management Assistance website.
  - County Child Welfare Staffing Workbook Data.
  - NC Legacy Data.
- ◆ Case Review Data:
  - Program Monitoring Review Data.
  - OSRI Data.
- ◆ Focus Groups:
  - CPS and Foster Care workers.
  - LINKS Coordinators.
  - Foster Care Supervisors.
  - Birth families.
  - Foster parents.
  - Youth.
- ◆ Surveys:
  - Foster Care workers and supervisors.

**Detailed Findings**

<b><u>Primary Research Question:</u></b>	<b><i>Are the needs of children in foster care being appropriately assessed, including exploring the history of trauma, and services being provided to address those needs and achieve case goals?</i></b>
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Data gathered and analyzed as part of the assessment process suggest that while some appropriate services do exist to address the needs of children being served in out-of-home care, significant barriers remain for these services to be provided timely and appropriately to achieve case goals. To answer this research question, CSF examined the provision of services and whether they are timely, trauma-informed, and address the identified needs of children, parents, caregivers, and foster and adoptive parents. In addition, the level of communication and

collaboration between child welfare workers and service providers was also examined. While high percentages of youth in out-of-home care are receiving their annual well-child check-ups, other areas, such as mental and behavioral health services, and provision of educational/developmental services face significant systemic barriers and practice challenges. Overall, the needs of children are more likely to be addressed than are the needs of their parents.

According to Program Monitoring Reviews, CSF found that initial Strengths and Needs assessments were more likely to be done according to policy (70%) than were updates (55%) and that well-being needs in those assessments were more likely to be identified for children (69%) than mothers (53%) or fathers (36%). Having foster children seen promptly after entering care by medical providers is a challenge. Only 38 percent of children were seen within seven days of custody and only 27 percent were seen for a second, comprehensive, medical appointment within the first 30 days. While 76 percent of children were seen at least annually for routine medical care, only 47 percent of children received twice-annual dental checkups. Program monitors found that both parents were provided the opportunity to participate in medical appointments with their children only 27 percent of the time; when a parent did not participate, status updates were given only about 30 percent of the time. Almost three-quarters of children were rated as having medical continuity.

The greatest challenges to service provision were observed in the area of mental and behavioral health. Eighty-one percent of surveyed DSS staff noted “some” or “significant” barriers to meeting mental health needs. They also indicated in focus groups that the LME/MCO service areas prevent access to services that may be located out-of-county. Additional trends were noted regarding challenges with the leveling process that prevent stabilization and may increase trauma for children and youth.

Educational services are also an area of concern. While some counties report having strong working relationships with their local school systems, nearly 40 percent of children do not get an Educational Status Component Assessment, and the rates of birth parent engagement in their children’s educational appointments was low.

When it comes to providing services to parents, caregivers, and foster and adoptive parents, DSS has some consistent trauma-informed practices occurring in some counties, such as Triple P and Broadcast. However, these programs have not been scaled to reach families in all counties. North Carolina is currently exploring a practice framework that is trauma-informed and can be implemented consistently across all 100 counties.

Quality and timely service provision depends greatly on the communication and collaboration between DSS staff and service providers. While some counties report strong working relationships with local service providers, most providers who were focus group participants indicated a desire for increased and improved communication. Some service providers also noted that there is a need for greater communication and collaboration with the state DSS Central Office as well.

***Sub-Question 1:*** Are formal assessments conducted that are timely, comprehensive, strengths-based, include the voices of the child, parents, and family members, and explore the family’s history of trauma?

Becoming a culturally-competent, trauma-informed, family-centered, and safety-focused child welfare system is a major goal for DSS as it seeks to reform its system. Assessing and understanding the family’s history of trauma is an essential component of formal assessments that allows DSS to address needs, while mitigating any potential system-induced trauma. Moreover, the timeliness of these assessments has a direct effect on timeliness to permanency for children and families. Program Monitoring data found that the Initial Strengths and Needs Assessment is more likely to be completed according to policy statewide, compared to updated strengths and needs assessments (69.5% vs. 55.4%). Children (69%) were also much more likely to have their needs identified in the Strengths and Needs Assessment than either their mothers (52.6%) or fathers (35.6%).

**Key Findings:** Provision of physical health services that are timely, trauma-informed and address child’s needs:

- Assessments more likely to be done according to policy initially than ongoing.
- Children more likely to have needs assessed than parents.

<b>2017 NC Program Monitoring Review Data</b>				
<b>Select Questions – Foster Care Protocol</b>				
Formal assessments that are timely, comprehensive, and strengths-based	State	Large Counties	Medium Counties	Small Counties
Have the following documents or activities been completed, reviewed, updated and provided as per policy?				
▪ Strengths and Needs Assessment (Initial)	69.52% (349/502)	81.54% (53/65)	70.78% (155/219)	64.68% (141/218)
▪ Strengths and Needs Assessment (Updated)	55.39% (226/408)	64.81% (35/54)	54.91% (95/173)	53.04% (96/181)
Are well-being needs identified in the well-being section of the Strengths and Needs Assessment for:				
▪ Child?	68.96% (311/451)	75.81% (47/62)	69.11% (132/191)	66.67% (132/198)
▪ Mother?	52.57% (225/428)	43.33% (26/60)	59.14% (110/186)	48.90% (89/182)
▪ Father?	35.56% (133/374)	27.45% (14/51)	37.89% (61/161)	35.80% (58/162)

***Sub-Question 2:*** Are physical health services provided that are timely, trauma-informed, and fully address the child’s identified needs?

As addressed in earlier sections on CPS Assessments and Prevention and CPS In-Home Services, access to trauma informed services designed to address a child’s identified physical health needs vary greatly from county to county. On a recent survey of Foster Care caseworkers, 63 percent of Foster Care reported “no” or “rare” barriers to physical health services. In some areas there are

not enough providers or providers who accept Medicaid. In comments, survey respondents noted that if there are barriers, a common one is that doctors do not always want to partake in the numerous medical screenings required by policy. Generally, however, respondents noted that physical health services for children are more accessible than physical health services for their parents. In general, children are much more likely to have Medicaid in North Carolina than their parents. When children enter foster care, those who did not previously have Medicaid become eligible with few exceptions; by contrast, adults who had Medicaid eligibility because of their parenting status lose that eligibility when their children enter care and cannot afford healthcare and related services.

The timely delivery of physical health services is vital to ensuring that needs are identified and met. Program Monitoring review data from 2017 indicates only 38 percent of children were seen by a medical provider within seven days of entering custody as per DSS policy. Only 27 percent were then seen within 30 days for a comprehensive exam. Once in out of home care, review data indicates that 76 percent of children are receiving annual well-child medical exams. For dental health, however, less than half of children who enter care are receiving twice-annual dental checkups.

2017-2018 OSRI data for Item 17 (Physical Health of the Child – which includes both physical and dental health needs), suggest that broadly speaking, children served in out-of-home care in North Carolina are being assessed and provided appropriate services relative to their physical health care needs with 75 percent of 40 applicable foster care cases reviewed rated as substantially achieved.

Identifying physical health needs should occur during initial and ongoing assessments conducted by DSS. In addition, these needs should be discussed at each CFT, so that the family can inform the department of known identified needs of the child and participate in the treatment planning to meet all needs. In focus groups with foster parents, some noted that there was a lack of communication regarding known identified needs and several noted a delay in receiving the child’s Medicaid card from DSS. This delay was especially troubling for a foster parent who had to take a newly-placed child to the emergency room to address a physical health need that was not disclosed to the foster parent, but known by the parent and DSS.

As the state experiences the transformation of Medicaid to a managed care system in 2019, particular attention needs to be focused on ensuring the ongoing access to physical health

***Key Findings: Provision of physical health services that are timely, trauma-informed and address child’s needs:***

- Physical health services are accessible but not timely for foster children
  - Nearly 63 percent of caseworkers and supervisors report “no” or “rare” barriers to physical health services.
  - Only 38 percent of children are seen within seven days of entering care and only 27 percent have a comprehensive second visit within 30 days.
  - Only 47 percent have twice annual dental checkups.
  - About three-quarters of youth receive annual well-child checkups.
- Both parents usually are not provided the opportunity to participate in their foster children’s medical visits.



services for youth in foster care as well as how parents may be able to maintain eligibility while their children are in the temporary custody of DSS.

Finally, it is important that child welfare agencies look for ways to be trauma-informed in the provision of services to the children and families they serve. This includes providing parents the opportunity to participate in their children’s medical appointments post-placement, as well as providing parents with status updates regarding their children’s medical care. Program Monitoring Reviews found that foster children’s caretakers participated in medical appointments in 71 percent of cases reviewed, but that both parents were given the opportunity to participate only 28 percent of the time. Parents who were not given the opportunity to actually participate in medical appointments for their children were provided status updates on medical appointments and treatment in slightly less than 30 percent of applicable cases reviewed. There was, however, documentation that children placed in out-of-home care in North Carolina are generally being provided with medical continuity (75%) based on the cases reviewed.

<b>2017 NC Program Monitoring Review Data</b>				
<b>Select Questions – Foster Care Protocol</b>				
Provision of physical health services that are timely, trauma informed and fully address the child’s identified needs.	<b>State</b>	<b>Large Counties</b>	<b>Medium Counties</b>	<b>Small Counties</b>
Was child seen within 7 days of custody by a medical provider?	38.26% (194/507)	36.36% (24/66)	37.50% (81/216)	39.56% (89/225)
Was the child seen for a second medical appointment, within 30 days of custody by the medical provider for a comprehensive visit?	26.85% (127/473)	21.88% (14/64)	28.43% (58/204)	26.83% (55/205)
Was the child seen for routine well-child medical appointments a minimum of annually? <i>(New: Available for July-December only)</i>	76.22% (109/143)	100% (6/6)	75% (42/56)	73.31% (61/81)
Are child’s dental needs addressed a minimum of twice annual dental checkups? <i>(New: Available for July-December only)</i>	45.68% (74/162)	66.67 (4/6)	42.42 (28/66)	46.67 (42/90)
Did the placement provider participate in medical appointments?	70.85% (367/518)	72.73% (48/66)	72.27% (159/220)	68.97% (160/232)
Were both parents given the opportunity to participate in medical appointments?	27.71% (133/480)	21.88% (14/64)	29.05% (61/210)	28.16% (58/206)
If not, are the parents provided status updates of medical appointments and treatment?	29.51% (108/366)	36% (18/50)	26.45% (41/155)	30.43% (49/161)
Was there medical continuity for the child?	74.32% (382/514)	78.46% (51/65)	78.24% (169/216)	69.53% (162/233)

***Sub-Question 3:*** *Are mental health and behavioral health services provided that are timely, trauma-informed, and fully address the child/youth’s identified needs?*

Delivery of timely, trauma-informed mental health and behavioral health services for youth is paramount to achieving permanency. Through the various SDM tools, DSS assesses needs and identifies appropriate services to meet those needs. In a recent survey of Foster Care caseworkers, 81 percent noted “some” and “significant” barriers to meeting mental health needs. The most common comment explaining the barriers was that adequate mental health services were too hard to locate, followed by barriers with Medicaid authorization, and working with the LME/MCOs. In focus groups of DSS staff some of these barriers noted include:

- ◆ Long waitlists for services;
- ◆ A perceived priority for providing these services to families involved in CPS and In-Home Services;
- ◆ Getting Medicaid to approve step-up intensive services when needed;
- ◆ Medicaid limiting the amount of time for youth to stabilize before stepping them down;
- ◆ Changes in therapists and counselors due to leveling process or placement moves;
- ◆ Substance abuse treatment not in every county;
- ◆ Need for more culturally-competent, trauma-informed, and appropriate services to address ODD, attachment disorders, ADD, and ADHD; and
- ◆ The regionalization of LME/MCOs restricts children/youth to service providers only in their particular service area. Thus, Medicaid may not cover the most appropriate service provider to meet the child’s specific needs.

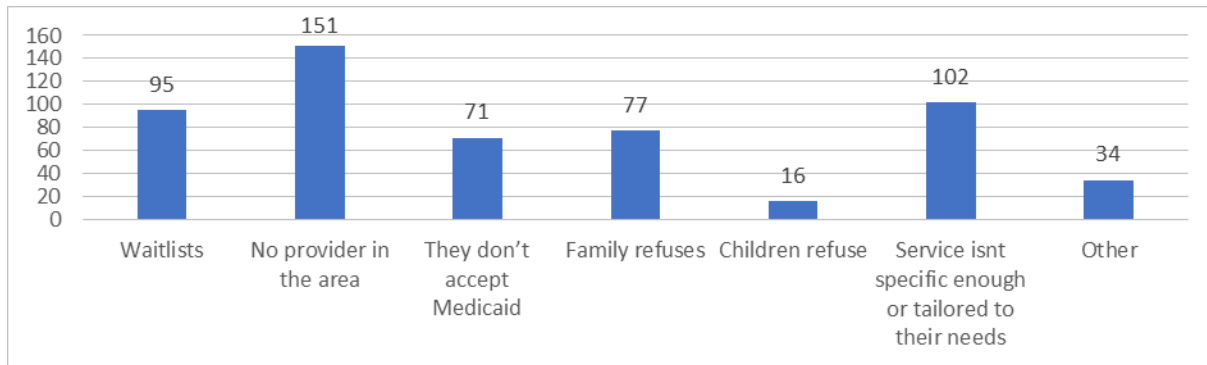
***Key Findings:*** *Provision of mental and behavioral health services that are timely, trauma-informed, and fully address the child/youth’s identified needs:*

- There are too many barriers to the provision of needed mental health services to children in care in NC.
  - 81% of surveyed DSS staff noted “some” or “significant” barriers to meeting mental health needs.
  - LME/MCO service areas prevent access to services out-of-county.
  - Medicaid leveling process prevents stabilization and increases trauma.

On a recent survey, DSS staff was asked “*If needed services are not being provided to the child and/or family, what are the three most common reasons as to why?*” The top three responses were:

- ◆ No provider in the area;
- ◆ Service isn’t specific enough or tailored to their needs; and
- ◆ Waitlists.

**Figure 36: DSS Staff Survey Responses: If Needed Services Are Not Being Provided to Child/Family, Why?**



When a mental health or substance abuse need is identified, time is of the essence. Waitlists often lead to parents disengaging or DSS no longer able to locate parents; and for youth, unaddressed mental and behavioral health needs often lead to disrupted placements and increased trauma.

To address these myriad challenges, NC DHHS collaborated with the North Carolina Institute of Medicine (NCIOM) to develop the Bridging Local Systems project. The project was funded by the Duke Endowment and guided by a statewide steering committee. Leaders from LME/MCOs and 100 county DSSs convened to strategize about:

- ◆ How to improve communication and collaboration;
- ◆ How to improve outcomes for children and families served by Child Welfare and Behavioral Health; and
- ◆ How to improve outcomes for adults served by Adult Protective Services and guardianships.

The barriers identified include difference in missions, cultures, separate budgets, as well as financial incentives, mandates, and rules that do not align and sometimes conflict. Some of the strategies that derived from the project include:

- ◆ Cross-training of DSS and LME/MCO staff;
- ◆ Establishing contact people who can resolve problems;
- ◆ Development of a service continua tailored to meet the needs of jointly served special populations;
- ◆ Funding service enhancements; and
- ◆ Integrating behavioral health strategies into traditional foster care.

Recommendations from the project included:

- ◆ Increase Cross-System Communication and Planning at the State Level;
- ◆ Support Cross-System and Cross-Region Communication and Collaboration;

- ◆ Work to Identify and Resolve Conflicts in Expectations and Performance Measures and to Establish Shared Outcome Measures;
- ◆ Build a Proactive System that Encourages Cross-System Collaboration on Prevention; and
- ◆ Support Efforts to Maintain and Reunite Families.

2017-2018 OSRI data for Item 18 (Mental/Behavioral Health of the Child, which includes the appropriate oversight of prescription medications) suggest that the majority of children served in out-of-home care in North Carolina are being assessed and provided appropriate services relative to their mental and behavioral health care needs with 78 percent of 27 applicable foster care cases reviewed being rated as substantially achieved.

***Sub-Question 4:*** *Are educational/developmental services provided that are timely, trauma-informed, and fully address the child's identified needs?*

Policy calls for educational/developmental needs to be assessed throughout the provision of child welfare services including assessment and In-Home Services. For children who come into foster care without previously having their educational and developmental needs assessed, DSS must move quickly in partnership with the family to assess the children's needs.

DSS policy requires educational documents to be completed, updated and provided for every child. However, 2017 Program Monitoring review data indicates that only 63 percent of counties completed the initial Educational Status Component and only 43 percent completed the Updated Educational Status. Also, while placement providers participated in educational appointments in 62 percent of cases reviewed, both birth parents were given the opportunity to participate in only 25 percent of cases and parents who were not given the opportunity to participate were given status updates in only 20 percent of cases. Engaging parents in the ongoing provision of educational services to their children while placed away from them in out-of-home care is an indicator of providing trauma-informed services. Finally, less than half of children in cases reviewed had "educational stability" while in foster care, with educational stability being defined as continuing to attend their old school after entering foster care or starting school and remaining in the same school while in foster care. While this is a new and challenging metric for the state, it is a vital measure of well-being for children.

In 2017-2018 OSRI reviews, Well-Being Outcome 2 (Children Receive Appropriate Services to Meet their Educational Needs) was rated as substantially achieved in 75 percent of 27 applicable foster care cases. Please note that these findings may be higher than those related results below from program monitoring because the OSRI reviews benefit from case specific interviews.

In addition to the Educational Status Component and Update, DSS is required to complete an Affidavit D to be submitted to the child's school. This enables the school system to coordinate service efforts with DSS. In interviews with school personnel, it was revealed that school systems provide a variety of services for children and families that may include weekend and summer food service, clothing banks, tutoring, and targeted educational services and accommodations. School personnel said that some of them participate in CFTs and most

participate in Best Interest Determination meetings. Some of the smaller counties expressed a greater ability to coordinate with DSS now that they had full-time school caseworkers on staff. One challenge revealed in focus groups with school personnel that may correlate with the low educational stability rating is that school personnel are often not informed of a child’s placement move. This become problematic for school records and, potentially, transitioning to new schools.

Other barriers to collaborative support of educational attainment for youth in foster care revealed in focus groups with school personnel, youth, and foster parents include:

- ◆ Perception that children are “safe” in school may lead to a lack of follow-up with school systems;
- ◆ School counselors and caseworkers not working together to understand the trauma the child has experienced;
- ◆ Schools being contacted at the end of an assessment instead of at the beginning;
- ◆ When children move from county to county, coordination with different school systems and different county DSS offices is extremely complicated and hard to navigate; and
- ◆ Services, CFTs and court hearing are often scheduled at the convenience of the service provider and DSS and school testing and other educational priorities are not considered.

<b>2017 NC Program Monitoring Review Data</b>				
<b>Select Questions – Foster Care Protocol</b>				
Provision of educational/developmental services that are timely, trauma-informed and fully address the child’s identified needs.	State	Large Counties	Medium Counties	Small Counties
Have the following educational documents been completed, updated and provided as per policy:				
▪ Initial Educational Status Component	62.60% (236/377)	60.71% (34/56)	61.54% (96/156)	64.24% (106/175)
▪ Updated Educational Status Component	42.92% (103/240)	38.89% (14/36)	53.68% (51/95)	34.86% (38/109)
▪ Provided to placement	41.59% (136/327)	24.39% (10/41)	42.22% (57/135)	45.70% (69/151)
Did the placement provider participate in educational appointments?	61.85% (167/270)	66.67% (22/33)	59.41% (60/101)	62.50% (85/136)
Were both parents given the opportunity to participate in educational appointments?	25% (62/248)	16.67% (5/30)	27.37% (26/95)	25.20% (31/123)
If not, are the parents provided status updates of educational appointments? <i>(New: Available for July-December only)</i>	19.72% (14/71)	33% (1/3)	13.33% (4/30)	23.68% (9/38)
Is there educational stability for the child? <i>(New: Available for July-December only)</i>	47.69% (62/130)	40% (2/5)	47.17% (25/53)	48.61% (35/72)

***Sub-Question 5:*** Are trauma-informed services provided to parents, caregivers, foster and adoptive parents that address their needs and support them in successfully caring for the children in their care and support them in achieving case goals and permanency for the child?

Provision of trauma informed services is a stated core principle and value upon which DSS approaches child welfare. During focus groups with service providers, many discussed that private provider staff are trauma-trained and that they conduct trauma-informed assessments. Some, however, shared that they do not feel DSS staff understand trauma at the level that they should. Currently, North Carolina DHHS does not have a comprehensive performance-based contracting system that diligently evaluates performance to remove all practices and providers who engage with youth in ways that are re-traumatizing.

DSS is currently exploring the selection of a practice model and/or framework that is safety-focused, culturally-competent, trauma-informed; supports preserving essential relationships that strengthen family functioning; prioritizes placement with related and non-related kin first to decrease broken placements; enhances biological and resource parents' ability to work with teams, meet special needs, and support permanency plans; and eliminates unnecessary removals by strengthening preventive in-home safety supports and services. Currently, some counties have developed practice models or have adopted nationally-known practice models that all include trauma-informed approaches. Other counties have emphasized trauma training for staff and caregivers. Some of the trauma-informed practices, which are being supported by the philanthropic community have been and continue to be evaluated with indications of positive results currently underway in different counties across the state include:

- ◆ **Child Health and Development Program:** a comprehensive health, developmental, educational, and behavioral health screening to every child entering foster care (and some entering In-Home Services), leading to development of a plan of care and connection of children to services;
- ◆ **Partnering for Excellence:** a trauma-informed collaborative between Child Welfare and Behavioral Health;
- ◆ **Project Broadcast:** a trauma informed demonstration project funded by a grant from the Administration for Children and Families;
- ◆ **Positive Parenting Program:** an evidenced based parenting program that provides practical strategies for parents to help care for their children.
- ◆ **Support for relative caregivers and family finding programs;** and
- ◆ **A collective impact initiative for older foster youth aimed at achieving permanence and successful transition to adulthood.**

***Key Findings:*** Provision of trauma-informed services to parents, caregivers, and foster and adoptive parents:

- DSS has some consistent trauma-informed practices occurring in some counties.
- Triple P and Project Broadcast are being implemented in multiple counties with some success.
- North Carolina is currently exploring a practice model or framework that is trauma-informed.

On OSRIs conducted during 2017-2018, counties scored higher on meeting the well-being service needs of foster parents than birth parents. Counties' assessment of needs and provision of services to foster and pre-adoptive parents was rated as a strength in 82 percent of 34 applicable cases; assessment of needs and provision of services to birth parents was rated as a strength in only 50 percent of cases.

***Sub-Question 6:*** *Does the child welfare caseworker actively communicate and collaborate with health, behavioral health and educational providers?*

Coordination and communication between child welfare caseworkers and health, behavioral health, and educational providers is vital to ensuring seamless services and follow-up. During a recent survey of foster care caseworkers, 95 percent of respondents indicated that they communicated with providers monthly and bi-monthly when working with children on their caseloads. The remaining 5 percent acknowledged communicating with providers every three months prior to meetings or prior to every court review. When working with parents, 86 percent reported that they communicated with providers monthly and bi-monthly.

Focus groups with service providers offered a different picture than the caseworker surveys. Some providers shared that they rarely get updates from DSS, and attributed this to high caseloads for DSS caseworkers. Some providers who had made CPS reports indicated that they may or may not receive screen-in/-out letters and rarely received case closure letters, both of which are mandated by North Carolina Law. However, overall, service providers interviewed and who participated in focus groups felt good about their working relationships with the county DSS offices. None of the participants reported a rapport with the state DSS Central Office.

***Key Findings:*** *Communication and collaboration between the child welfare caseworker and health, behavioral health and educational providers:*

- Communication and collaboration is occurring in some counties but needs to be improved.
  - Service providers reported a need for greater communication.
  - Strong working relationships with the county DSS offices.
  - Service providers report having no rapport with the state DSS office.

## ***H. Services to Older Youth in Foster Care and Those Who Have Aged Out of Foster Care***

### **Overview**

According to the National Association of State Legislatures, nearly a quarter of the 427,000 children in foster care are age 14 and older and approximately 18,000 children age out of care at age 18 every year in the U.S. (<http://www.ncsl.org/research/human-services/supports-older-youth.aspx>). In North Carolina, the number of youth aging out of foster care has increased over the past five years, while the median days in foster care before aging out have decreased. Research indicates that outcomes for youth who age out of foster care are dismal, with high rates of unemployment, homelessness, pregnancies, incarceration, and the need for public assistance.

The federal government and the state of North Carolina recognize the need for specialized services for older youth and support for those youth who age out of care. The 1999 Chafee Act was enacted by Congress to provide funding for services for older youth and specified key outcomes for states to address. In North Carolina, the LINKS program was established to adhere to the Chafee Act.

The philosophy of NC LINKS is that increased experiences will lead to positive independence. It is based on positive youth development principles. DSS engages youth ages 13-21 as partners and contributors as they assist and equip youth in developing their own Transitional Living Plans. NC LINKS tracks the following seven outcomes:

1. All youth leaving the foster care system shall have **sufficient economic resources to meet their daily needs.**
2. All youth leaving the foster care system shall have a **safe and stable place to live.**
3. All youth leaving the foster care system shall attain **academic or vocational/educational goals** that are in keeping with the youth's abilities and interests.
4. All youth leaving the foster care system shall have a **sense of connectedness** to persons and community. This means that every youth, upon exiting foster care, should have a personal support network of at least five responsible adults who will remain supportive of the young adult over time.
5. All youth leaving the foster care system shall **avoid illegal/high-risk behaviors.**
6. All youth leaving the foster care system shall **postpone parenthood** until financially established and emotionally mature.
7. All youth leaving the foster care system shall have **access to physical and mental health services**, as well as a means to pay for those services.

Transitional Living Plans include:

- ◆ The youth's anticipated living arrangement after discharge, as well as a fully-developed alternate discharge plan;
- ◆ Supportive adults who are working with the youth;
- ◆ Specific goals that relate to the youth's transition to self-sufficiency, including educational and vocational training, the development of a personal support system, building independent living skills, the assurance of safe and secure planned and alternative living arrangements after discharge, and steps toward assuring any other unmet desired outcome;
- ◆ The agreed-upon steps to be taken to meet the goals; and
- ◆ An Emancipation Plan (90 days prior to 18th birthday).

After discovering that foster youth were being targeted for credit fraud, North Carolina DSS set forth policy that requires child welfare agencies across the state to provide a credit report for each youth. DSS is then responsible for providing needed assistance to resolve discrepancies in the report.



In addition to NC LINKS, in January 2017, the state extended voluntary foster care benefits to 18-21 year olds consistent with the 2008 federal Fostering Connections Act. Prior to January 2017 DSS also offered Contractual Agreements for Residential Services (CARS) for youth who wish to remain or return to foster care after their 18th birthday and before their 21st birthday. Those CARS agreements signed before January 2017 may still be in effect.

Other resources provided to older youth in North Carolina’s foster care system include:

- ◆ The Education Training Voucher Program (ETVP) – grants up to \$5,000 toward cost of attending higher education or vocational programs.
- ◆ NC Reach – an Education Support Scholarship program for youth who were adopted from foster care after their 12th birthday or aged out of North Carolina foster care (this covers the balance of the costs of attendance at any state university or community college).
- ◆ SaySo (Strong Able Youth Speaking Out) – a statewide association of youth ages 14–24, that empowers young people to advocate for improvements to the foster care system while providing additional life skills and leadership development opportunities.

DSS policy acknowledges that limited resources prevent most counties from serving all youth who are eligible for these services and offers some guidance on prioritization. The policy dictates that young adults who “aged out” of foster care must be offered any needed assistance for which they are eligible. This includes transitional housing funds and special funds for non-housing expenses such as utilities, furniture, etc.

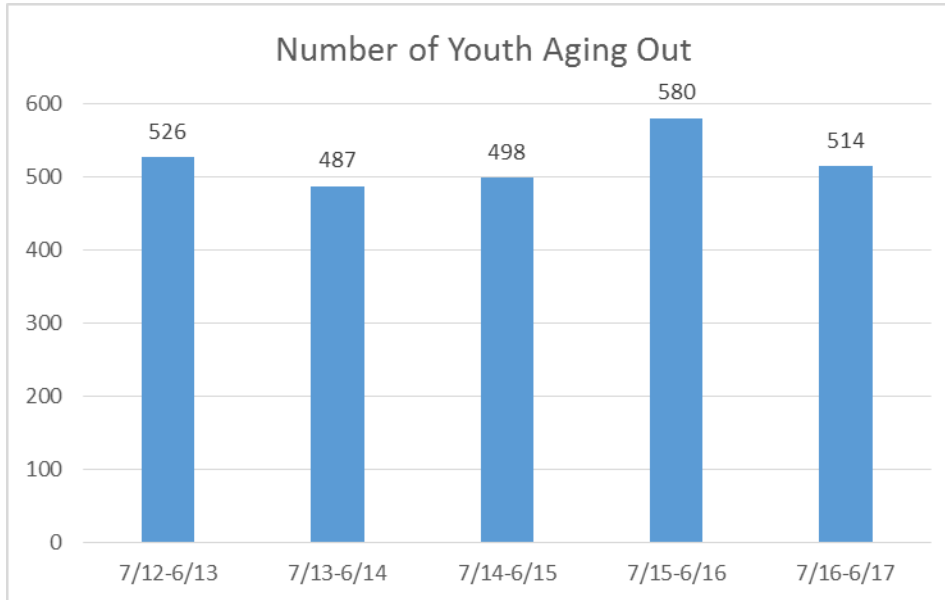
Specific timeframes in DSS policy for delivery of services to older youth include:

- ◆ Development of a service plan for youth 12 and older;
- ◆ Emancipation Plan at least 90 days prior to 18th birthday;
- ◆ Transitional Living Plans for all youth ages 13-21 must be in place by their 14th birthday; and
- ◆ For children with Individual Education Plans (IEP), Vocational Rehabilitation must complete an assessment for youth on or after their 16th birthday.

### **Older Youth - Performance Trends**

In North Carolina, the number of youth aging out of care over the past five years has ranged between 487 youth in fiscal year 2013-2014 and 580 in fiscal year 2015-2016. There was a drop from 580 youth aging out in 2015-2016 to 514 youth aging out from 2016-2017.

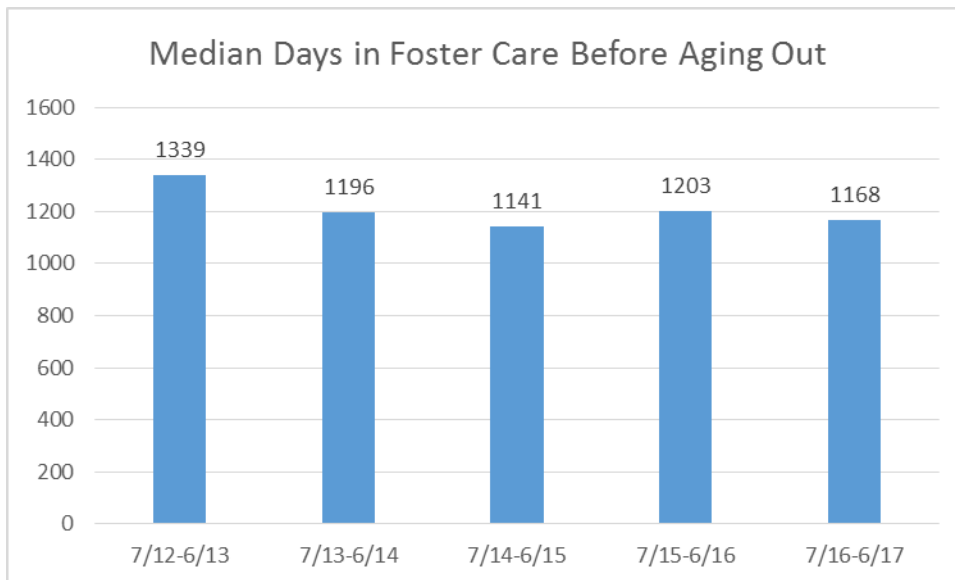
**Figure 37: Number of Aging Out**



Duncan, D.F., Kum, H.C., Flair, K.A., Stewart, C.J., Vaughn, J.S., Guest, S., Rose, R.A., Malley, K.M.D. and Gwaltney, A.Y.(2018).Management Assistance for Child Welfare, Work First, and Food & Nutrition Services in North Carolina (v3.2). Retrieved [4/19/18], from the University of North Carolina at Chapel Hill Jordan Institute for Families website. URL: <http://ssw.unc.edu/ma/>

The median number of days youth are in foster care has decreased over the last five years, as depicted in the graph below.

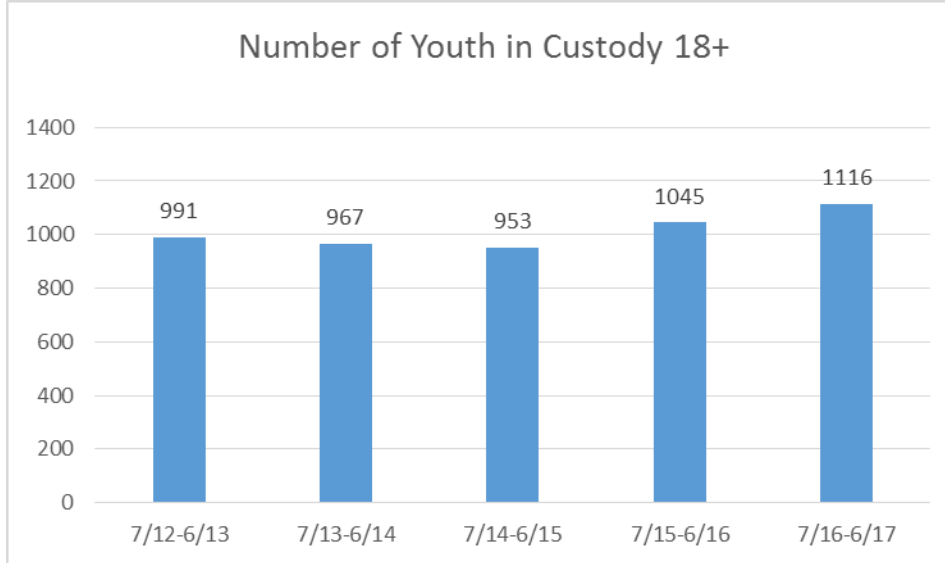
**Figure 38: Median Days in Foster Care Before Aging Out**



Duncan, D.F., Kum, H.C., Flair, K.A., Stewart, C.J., Vaughn, J.S., Guest, S., Rose, R.A., Malley, K.M.D. and Gwaltney, A.Y.(2018).Management Assistance for Child Welfare, Work First, and Food & Nutrition Services in North Carolina (v3.2). Retrieved [4/19/18], from the University of North Carolina at Chapel Hill Jordan Institute for Families website. URL: <http://ssw.unc.edu/ma/>

Looking at the number of youth in custody aged 18 and over, the number has increased from fiscal year 2012-2013 to 2016-2017, suggesting that more youth are choosing to voluntarily stay in the system to continue to receive services under the new foster care 18-21 program.

**Figure 39: Number of Youth in Custody 18+**



Duncan, D.F., Kum, H.C., Flair, K.A., Stewart, C.J., Vaughn, J.S., Guest, S., Rose, R.A., Malley, K.M.D. and Gwaltney, A.Y. (2018). Management Assistance for Child Welfare, Work First, and Food & Nutrition Services in North Carolina (v3.2). Retrieved [7/13/18], from the University of North Carolina at Chapel Hill Jordan Institute for Families website. URL: <http://ssw.unc.edu/ma/>.

Prior to the beginning of 2017, the program for older youth was named CARS and the new program beginning in 2017 is entitled Foster Care 18-21. Focus group participants suggested Foster Care 18-21 is a more popular program that has been receiving a lot of focus, particularly in allowing more flexibility in where a youth may live while receiving program benefits.

For those youth remaining in foster care after 18, the number participating in post-secondary education services has decreased from FY 2015 to 2017, regardless of county size. Large counties experienced a drop of over 50 percent from 81 youth receiving post-secondary education services in 2015 to 35 receiving the services in 2017. Medium counties dropped over 40 percent from 426 in 2015 to 221 in 2017.

**Figure 40: Number of Youth Who Received Post-Secondary Education Services**

SFY	County Size	Youth # Received Post-Secondary Education Services
15	Large	81
15	Medium	426
15	Small	31
16	Large	78
16	Medium	370
16	Small	31
17	Large	35
17	Medium	221
17	Small	21

Source: ServiceCodes132-140.xlsx (for an indicator of post-secondary education services), Services131-168.xlsx (for service date)

**Sources of Information**

- ◆ Administrative Data:
  - UNC Management Assistance website.
  - NYTD Data.
  - NC Legacy Data.
- ◆ Case Review Data:
  - Program Monitoring Review Data.
- ◆ Focus Groups/Interviews:
  - LINKS staff.
  - Foster Parents.
  - Youth.
  - Family Advisory Council.

**Detailed Findings**

<b><u>Primary Research Question:</u></b>	<b><i>Are older youth in foster care in being prepared for adulthood?</i></b>
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Data that was gathered and analyzed as part of the assessment process suggests that older youth served by DHHS/DSS in foster care are not consistently being prepared for adulthood. To answer this research question CSF examined the extent to which youth are engaged as part of a team of supports, whether youth are involved in the development of Transitional Living Plans, whether youth provide input in the selection of services, service providers, activities, and in evaluating their progress towards established goals, and whether youth are provided with opportunities for employment, internships, and obtaining a driver’s license. While some

examples of positive practices were observed regarding a team of support for youth, the services vary greatly from county to county, and relatives and fictive kin are not being fully engaged as part of the team. Program Monitoring results indicated the practice expectations for the development and evaluation of Transitional Living Plans are not being widely followed, and youth in focus groups reported having very little input in the selection of service providers and placements.

Youth reported to CSF favorable engagement through LINKS but varied engagement in other key meetings and planning sessions, such as CFTs. While the staff of LINKS were consistently given high marks for relatability, accessibility, and responsiveness, resources for programming vary greatly from county to county, with some counties meeting with LINKS participants monthly and others only a few times a year. Engaging family members, and other caring adults is vital for youth transitioning to adulthood; however, Program Review data indicate that only 50 percent of youth are supported in building these relationships and only 33 percent of cases indicate ongoing assessment of relatives for placement of involvement in a young person's life.

The Transitional Living Plan is the roadmap for successful transition into adulthood for older youth in foster care. This is the opportunity for youth to provide input on their strengths and needs and assist in developing their own goals. However, only 36 percent of applicable cases reviewed in the 2017 Program Monitoring Review documented completed plans.

CSF found that programs such as LINKS, SAYSO, and the Family Advisory Council provide excellent vehicles for youth engagement and youth input into the types of services and supports that they need and desire. SAYSO is not yet available in all counties across the state and the Family Advisory Council is currently only operationalized at the state level and in three counties. When it comes to selecting service providers and making placement decisions, youth report having little or no input into these decisions. This may contribute to placement instability with 28 percent of older youth reporting five or more placements prior to aging out of foster care on a recent Child Trends report.

Finally, CSF observed that LINKS and Foster Care 18-21 provide opportunities for youth to develop employment skills and obtain employment and internships. However, staff report that the lack of transportation options in most counties is a barrier. Moreover, the types of jobs available do not always allow for flexibility to attend therapy and other needed services. If youth are able to complete their high school education, NC Reach provides financial support for youth to attend higher education institutions. This opportunity may lead to higher-paying and more sustainable employment for youth. CSF also observed that while there is widespread support for youth obtaining driver's licenses, the responsibility of auto insurance has rested with the foster parents, some of whom cannot afford to add youth to their policies. To address this issue, Rylan's Law directed the Division of Social Services to establish a two-year pilot project to assist eligible foster youth in obtaining learner's permits or driver's licenses. A new program, Transportation Really is Possible (TRIP) includes first-come, first-served funding for costs associated with driving, including insurance.

***Sub-Question 1:*** Are youth part of a team of supports that are focused on helping them prepare for adulthood?

Older youth involvement in planning is described as critical in DSS policy. DSS policy stated that LINKS staff function as teachers, coaches, and advocates for older youth. In addition to LINKS coordinators, several youth in focus groups noted that they had strong relationships with their caseworkers and guardian ad litem (GAL).

During focus groups with county DSS staff described the following methods for engaging youth as part of a team to help prepare them for adulthood:

- ◆ Child and Family Team meetings (CFT);
- ◆ PPAT meetings before court;
- ◆ Quarterly peer group meetings; and
- ◆ Treatment team meetings;

Involvement in these key decision-making meetings seems to vary widely from county to county and sometimes from case to case. Some youth in focus groups reported attending these meetings, while others reported that they were not invited. One DSS staff member reflected that despite these team meeting, most decisions were being made for youth instead of youth being supported and coached to guide the decision-making process.

Family members and fictive kin should also be part of an older youth's team of supports. These important relationships must be maintained and nurtured while children are in foster care. During focus groups and interviews, some youth indicated that DSS was not doing anything to help maintain important connections to the people in their lives. However, they were visiting and maintaining these connections on their own (this included visits with their parents). One youth suggested that DSS should put forth more efforts in finding relatives when youth first enter care. In other instances, youth reported that DSS assisted them in remaining in their schools even when their new placements were located in different school zones. These peer relationships and connections with teachers were important for most youth focus group participants.

Data from 2017 Program Monitoring Reviews indicate only half of youth are supported in building relationships that will exist when they leave foster care and last into adulthood. Specifically there was documentation of an ongoing assessment of relatives for placement or involvement in the young person's life in 53 percent of the cases reviewed, with that percentage dropping to only 33 percent for the applicable cases reviewed from the larger counties.

***Key Findings:*** Engagement of youth as part of a team that is focused on preparations for adulthood:

- Youth report favorable engagement through LINKS but not as much with other key meetings and planning sessions.
- Foster youth reported a need for more resources, especially in smaller counties.
- Mixed opinions from youth in terms of their involvement in CFTs. Some youth reported being involved with CFTs.
- Some evidence that youth are being supported in building relationships.
- Review data suggests relatives are not being regularly assessed for placement or involvement in the child's life.

2017 NC Program Monitoring Review Data				
Select Questions – Foster Care Protocol				
Supporting youth in building relationships that will exist when they leave foster care and last into adulthood	State	Large Counties	Medium Counties	Small Counties
Is there ongoing assessment of relatives for placement or involvement in the child's life? <i>(New: Available for July-December only)</i>	53.3% (97/182)	33.3% (7/21)	56.76% (42/74)	55.7% (48/87)

***Sub-Question 2:*** Are youth involved in identifying their own strengths and needs and setting personal goals?

All youth involved in LINKS are asked to take the Casey Life Skills Assessment as well as a vocational assessment. These assessments are used in developing the Transitional Living Plan. DSS policy requires the following components in each of these plans:

- ◆ The youth’s anticipated living arrangements after discharge, as well as a fully-developed alternate discharge plan;
- ◆ Supportive adults who are working with the youth;
- ◆ Specific goals that relate to the youth’s transition to self-sufficiency, including educational and vocational training, the development of a personal support system, building independent living skills, the assurance of safe and secure planned and alternative living arrangements after discharge, and steps toward assuring any other unmet desired outcome; and
- ◆ Agreed-upon steps to be taken to meet the goals.

**Key Findings:** *Involvement of youth in identifying their own strengths and needs and setting personal goals:*

- The majority of NC youth, ages 14 and older, are not involved in identifying their own strengths, needs and goals:
  - Policy sets forth a clear process for involving youth in identifying their own strengths and needs and setting personal goals.
  - Only 36% of cases reviewed had completed transitional living plans.

This planning process and the assessments utilized to formulate the plan require direct involvement by youth in the process. More often than not, young persons 14 years of age or older do not have a completed Transitional Living Plan as only 36 percent of the applicable cases reviewed through the 2017 Program Monitoring Review process was there documentation of a completed Transitional Living Plan within the youth’s case record.

2017 NC Program Monitoring Review Data				
Select Questions – Foster Care Protocol				
Involvement of youth in identifying their own strengths and needs and setting personal goals	State	Large Counties	Medium Counties	Small Counties
Has a Transitional Living Plan been completed for the child who is of the age of 14 or older, concurrently with the Out of Home FSA?	36.43% (51/140)	33.33% (6/18)	32.73% (18/55)	40.30% (27/67)

***Sub-Question 3:*** Are youth providing input in the selection of potential services and service providers, activities, and in evaluating their progress towards established goals?

During focus groups with youth, approximately half felt like their voice was heard and the half did not. One of the hurdles that youth expressed about providing input, is that anything negative would not be kept confidential and would be shared with service providers. This was especially noted regarding the selection and maintenance of placements with foster parents and group homes. One youth shared feeling threatened with group home placement if they shared negative opinions about their foster home. Youth generally expressed a desire to be a part of the matching process for prospective foster parents. It is important to note that older youth in the North Carolina foster care system report experiencing placement instability at lower rates than foster youth across the U.S. However, with 28 percent of youth reporting having had five or more placements prior to aging out of foster care, the issue of stabilizing placements for older youth is significant and warrants focused improvement efforts by North Carolina.

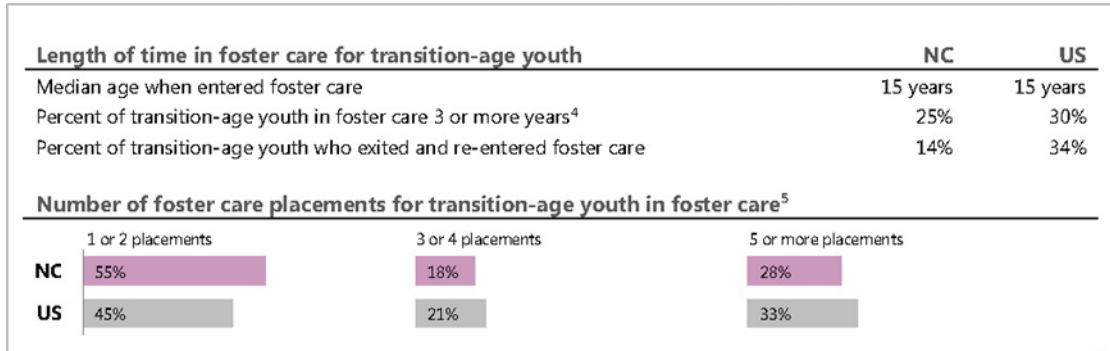
**Key Findings:** Youth input on the selection of potential services and service providers, activities, and in evaluating their progress towards established goals:

- Youth report providing input into services through LINKS, but not with regards to other services.
  - Focus groups with older youth report high levels of input into service decisions.
  - Placement decisions rarely involve input from youth.
  - Youth report no input in choosing service providers.

Although North Carolina struggles to meet the needs of older foster youth, *Figure 41* below shows that North Carolina does slightly better than the nation as a whole with respect to the length of time in care and placement stability for older youth. As can be seen, North Carolina has lower percentages of older youth in care three years or longer and lower percentages of youth who have exited and re-entered care. A larger percentage of older youth in North Carolina have experienced only one or two placements (55% versus 45%).



**Figure 41: Length of Time in Foster Care for Transition-Age Youth**



Child Trends. *Transition Aged Youth in Foster Care in North Carolina*. August 29, 2017. Retrieved from <https://www.childtrends.org/publications/transition-age-facts-northcarolina/> [4/19/18]

With regard to service providers, youth did not report having a voice in the selection process and were only told where they needed to go and when. One youth interviewed stated that his therapists were chosen based on location and availability as opposed to which therapist could best meet his needs and with whom he felt most comfortable working. All youth reported having their medical, dental, education, and vision needs met, but again not being part of the selection process for these services.

Youth generally reported high levels of input into the LINKS programs and services offered. LINKS coordinators often solicit input from youth participants regarding workshops and activities. In many instances youth reported participating in the planning process.

Youth participants provided the following insights regarding the foster care system and services:

- ◆ Need for the right (quality, length of care) mental health services, especially for ODD, attachment disorders, ADD, ADHD;
- ◆ Need for clear-cut curriculum for LINKS with consistent funding;
- ◆ Greater need for transportation, cars, cell phones, more money, freedom, normal life, transitional housing, emergency shelter for 18+, youth substance abuse, trauma resources;
- ◆ Need for greater placement stability: most foster parents won't take teens, group homes are a challenge;
- ◆ Need for foster parents to have more patience with teens and better understand adolescent development;
- ◆ More emphasis on the following skills: guide to employment, money management, basic skills, access services, problem solving, effective communication; and
- ◆ Need for funding for car insurance (currently this is the responsibility of the foster parent and some cannot afford to add youth to their insurance policies).

***Sub-Question 4:*** Are youth provided with opportunities to prepare for adulthood by having a job or an internship or a driver's license?

During focus group discussion, youth reported that DSS provides support for obtaining driver's licenses and encourages foster parents to support this process. However, in order for youth to drive, they need insurance. Currently, payment for insurance rests with the foster parents, many of whom cannot afford to add youth to their personal automobile insurance policies. Several youth reported having jobs and summer jobs. One youth indicated that DSS paid her to babysit the children of MAPP participants. The agency was able to do this through the LINKS program. Another youth indicated that she was enrolled in the dual degree program with her high school and the local community college. She will graduate with a high school diploma and a certificate in auto mechanics. Interviewing skills, resume workshops, and other employment-related training are included in the workshops that are offered to through LINKS and Foster Care 18-21.

***Key Findings:*** Youth input on the selection of potential services and service providers, activities, and in evaluating their progress toward established goals:

- Some youth are provided with these opportunities – especially through LINKS.
  - Some youth report getting support for obtaining a driver's license; however not being able to secure car insurance prevents them from being able to drive.
  - LINKS and Foster Care 18-21 provided employment services.
  - These services vary from county to county depending on resources.

### ***I. Workforce [5.2.2(9)]***

Building the confidence and competence of the child welfare workforce gives agencies a foundation that is essential for improving outcomes for children and families. The National Child Welfare Workforce Institute has outlined an approach for leadership and workforce development that includes several critical components including, but not limited to: creating minimum standards for positions; preparing the workforce through the formal educational opportunities; finding the right person for the job through recruitment and selection processes; creating monetary and non-monetary incentives to stay on the job; promoting a healthy organizational culture and climate; engaging in strong community partnerships; providing effective supervision; and offering ongoing professional development.<sup>23</sup> Further, we generally believe that developing and supporting the workforce through professional development should go beyond traditional classroom training to focus on the practical application of new information, receipt of feedback, and opportunities to practice new learning until confidence and mastery are sustained. Specific recommendations are outlined in Chapter 4 related to preparing and supporting the child welfare workforce in North Carolina.

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<sup>23</sup> National Child Welfare Workforce Institute. *Workforce Development Framework (WDF)*. Albany, NY: University at Albany (2015).

This section summarizes information gathered through our assessment about the educational background of child welfare employees in the state, current caseloads sizes and standards, turnover, and salaries.

**Educational Backgrounds**

Current job specifications can be found in the state classification system and from counties for their own systems.

In North Carolina, the great majority of child welfare caseworkers have bachelor’s degrees, with about 40 percent of those workers having bachelor’s degrees in social work, and 60 percent having a bachelor’s degree in another related field. A clear majority of supervisors also have bachelor’s degrees, though supervisors are slightly more likely to have a master’s degree. Across classifications, larger urban and more affluent counties have more staff with master’s degrees than smaller, rural counties.

Educational backgrounds of staff by county can be found in the 2017 Master Child Welfare Workforce Data Book. Aggregate data are shown below.

**Figure 42: Highest Degrees for Caseworkers, Supervisors, Program Managers, and Program Administrators**

<b>Highest Degree for Caseworkers</b>					
County	BSW	Other Bachelors	MSW	Other Masters	Higher Degrees
State	770.8	1,133.95	467	338	6

<b>Highest Degree for Supervisors</b>					
County	BSW	Other Bachelors	MSW	Other Masters	Higher Degrees
State	117.3	249.8	113	85	1

<b>Highest Degree for Program Managers</b>					
County	BSW	Other Bachelors	MSW	Other Masters	Higher Degrees
State	16.7	37.2	18.5	13.7	1

<b>Highest Degree for Program Administrators</b>					
County	BSW	Other Bachelors	MSW	Other Masters	Higher Degrees
State	5	10.8	17.5	5.75	0

The analyses are based on North Carolina’s current child welfare caseload standards of a maximum of 10 open CPS assessments, 10 open families for CPS In-Home Services, and 15 children in foster care. It should be noted that many county staff strongly believe the current

caseload standards are out-of-date because of new responsibilities for both client activities and documentation that have been added over the past 10 years as a result of CFSR PIPs, responses to adverse events, and the increased difficulty accessing services in the MH/DD/SA system. Many counties argue strongly that it is not possible for caseworkers with caseloads at the current standards to meet the current expectations for their positions.

Data from the analysis comes from the Master Child Welfare Workforce Data Book, which was developed by the state with input from the counties about six years ago. Counties are required to submit monthly data on workload and staffing on a quarterly basis for all child welfare functions. The survey also captures data on staff turnover and education. The state has worked extensively with counties to increase clarity of the data elements and consistent and accurate data submission. Data also comes from the county salary surveys and our interviews and focus groups with state and county officials.

### **Caseload Sizes and Standards**

In aggregate for all counties across all child welfare positions with established caseload standards, the child welfare staffing survey found that an average of 2,565.5 caseworkers would have been needed during calendar year 2017 to meet caseload standards. Counties in aggregate reported having more budgeted FTEs than needed to meet caseload standards across functions (2,833.68) but having slightly fewer caseworkers actually available each month to do the work (2,461.62). Reasons for budgeted FTEs being unavailable included vacancies, workers being in training, and workers being on sick, vacation or workman's compensation leave.

Statewide, the adequacy of staffing as compared to standards was markedly worse for CPS assessments than for other functions with caseload standards including CPS In-Home Services, foster care, and adoptions. According to the staffing survey, the average number of CPS assessors needed to meet standards for the workload statewide was 1,139.24 as compared to 1,086.05 budgeted FTEs and 891.05 available workers. The average numbers mask seasonal and other fluctuations in the numbers of CPS reports received, meaning that at times during the year the caseloads for individual workers would likely be much higher while at other times substantially lower. Another factor in the workload for CPS assessors is the length of time it takes to complete CPS assessments; when workers are assigned high numbers of assessments in a month, it can be more difficult to complete assessments in a timely way, leading to a snowball effect of higher caseloads. For other functions, the data from the survey found that, on aggregate, counties had adequate staff budgeted and available to meet the state's current caseload standards.

Perhaps not surprisingly, the aggregate statewide data indicated that the child welfare function that was least adequately staffed to meet the workload (CPS assessment) also had the highest average percentage of budgeted FTEs who were unavailable for work (18%), a rate that was 60 percent higher than for either foster care or in-home services.

We looked more closely at staffing in 15 counties that CSF in which CSF conducted site visits. The counties were chosen to represent a cross section of small, medium, and large counties (including the two largest); eastern, central, and western counties; and counties from the state's three economic tiers.

Analysis of individual counties found great variability in the adequacy of staffing compared to current caseload standards. Eight counties (Anson, Edgecombe, Greene, Halifax, Mecklenburg, Robeson, Swain, and Wake) reported having more staff budgeted and available than required by caseload standards. Two counties (Orange and Caldwell) reported available staffing that met but did not significantly exceed caseload standards. In these counties, staffing was typically adequate to meet caseload standards across program functions including CPS assessments. Five counties (Alamance, Alleghany, Caldwell, Johnston, Robeson, and Scotland) reported having had significantly fewer staff available than necessary to meet current caseload standards. In these counties, the staffing shortage was consistently concentrated in CPS assessor positions.

*Figure 43* summarizes staffing shortages compared to current standards for the five sampled counties for frontline caseworker positions.

**Figure 43: All Positions with Caseload Standards**

County	Budgeted FTES	Available FTES	FTEs Needed	Shortage
Alamance	34.75	29.4	39.4	10
Alleghany	4.7	3.9	5.5	1.6
Caldwell	35	32.0	38.4	6.4
Johnston	48.1	35.6	47.7	12.1
Scotland	13	10.6	12.8	2.2

*Figure 44* summarizes staffing shortages compared to current standards for the five sampled counties for CPS assessors.

**Figure 44: CPS Assessor Positions**

County	Budgeted FTES	Available FTES	FTEs Needed	Shortage
Alamance	15.5	12.2	23.7	11.5
Alleghany	1	.8	2.3	1.5
Caldwell	13	11.7	17.4	5.7
Johnston	17	11	17.4	6.4
Scotland	4.5	3.3	5.1	1.8

**Turnover**

According to the Master Child Welfare Workforce Data Book, the aggregate annual turnover rate for frontline social work positions in child welfare in 2017 was 32.1 percent. Of the 977 caseworkers who left their positions in 2017, 588 resigned voluntarily, 68 were involuntarily dismissed, 30 retired, and 166 made lateral job moves within the agency. A total of 106 were promoted within their department.

Although the Workforce Data Book does not give reasons for workers leaving their agencies or transferring within their agencies, several reasons were brought forward during interviews and focus groups with state and county workers including:

- ◆ Caseworker burnout exacerbated by stressful work, workloads that are perceived as impossible to complete within a 40-hour workweek, and difficulty maintaining a work-life balance.
- ◆ Caseworkers leaving to work for higher-paying counties after initially getting hired and trained in low-paying counties.
- ◆ Caseworkers with master's degrees (often in higher paying counties) leaving to work in other fields after getting their clinical license.

It was also agreed that the quality of a caseworker's relationship with his or her supervisor and the support received was an important factor in worker's decisions whether to stay in their jobs. The turnover rate for social work supervisors (19.2%) was substantially lower than the turnover rate for workers. Additionally, a higher proportion of turnover among supervisors was due to promotions within the agency and retirement.

### **Salaries**

For child welfare, data on the number of employees statewide was available in the 2017 Master Child Welfare Workforce Data Book, developed and maintained by the Central Office, with data provided by each of the 100 counties. The Workforce Data Book contained no information on child welfare salaries. We used the entry and high salary information on two child welfare positions, Social Services Director and Social Worker II, from the University of North Carolina's County Staffing Report as of December 31, 2017. We asked the 15 counties we were visiting, as part of our data collection effort, to provide us with position and salary information for their child welfare staff. We found additional position and salary information on county websites, for a total of 45 counties. Because we used data from multiple sources and were not able to validate some of the data with the counties, the information should be considered draft data, and used for general comparison purposes only. During Phase 2 of this project, we will work with the counties to fill in the gaps in our knowledge regarding county salaries.

We do know that salaries for front line child welfare workers vary widely throughout North Carolina. On the low end were three smaller, more rural counties with hiring rates below \$33,000 per year and average salaries for workers of below \$36,000 per year. On the high end were the three largest counties in the sample with hiring rates at or above \$42,000 and average salaries between \$46,000 and \$53,000. The Social Services Preliminary Reform Plan describes this in more detail along with a chart depicted salary ranges for other critical county child welfare positions.

## IV. DETAILED RECOMMENDATIONS

Given the broad scope of change identified in this reform effort, it is imperative to develop and agree on a theory of change for how to improve child and family outcomes in North Carolina. In our experience, it is not possible or effective to commit to implementing a laundry list of disconnected recommendations. CSF has found this, for example, to be a stumbling block in jurisdictions under federal class action lawsuits. The ones that have focused on a line-by-line, compliance-oriented approach to making progress have struggled. The evidence suggests that reaching agreement on the strengths and needs within a system and the underlying root causes that are impeding progress, is the first critical step in an effective change or improvement effort. It is also important to make desired outcomes clear to everyone involved – these are the results for Child-Welfare-involved children, parents, and extended families that everyone participating is hoping to achieve. These child and family outcomes must be agreed-upon and well-defined. Methodologies must be developed to understand baseline performance and how to track progress on these outcomes over time. The last step in developing a theory of change is to agree on the basic conditions that would need to exist within the broader system to address identified root causes and improve desired outcomes over time.

Creating a child welfare system in North Carolina that is experienced by children and families in all one hundred counties as being culturally-competent, trauma-informed, family-centered, and safety-focused will require a shift in organizational and system culture and mindset. It will also require a reliance upon proven and effective approaches to implementation. The envision session in Durham was a step in this direction. A draft theory of change was developed and refined during this two-day session on July 9 and 10. To promote more candid, open dialogue, CSF, with input from the Office of State Budget and Management (OSBM), made the determination that this session would be a small, internal meeting of public state and county child welfare leaders. CSF understands the critical importance of bringing families and child welfare leaders, stakeholders, advocates and other contributors into the process, and proposes that as a next step in Phase 2 of this project.

The recommendations described here reflect ideas and input from the theory of change session and from information gathered from our assessment, which included input from hundreds of DHHS employees, county Department of Social Services employees, and stakeholders. A review of best practices in child welfare also informed these recommendations. In addition, CSF carefully reviewed recent reports and recommendations including: 1) the Child Welfare Strategic Plan, S.L. 2016-94, Section § 12C.1. (b); 2) Report to the Joint Legislative Oversight Committee on Health and Human Services, by North Carolina Department of Health and Human Services; 3) the North Carolina Child and Family Services Review (CFSR) Program Improvement Plan (PIP); and the PCG study, which was also required by Section 12C.1.(f) of N.C. Session Law 2014-100.

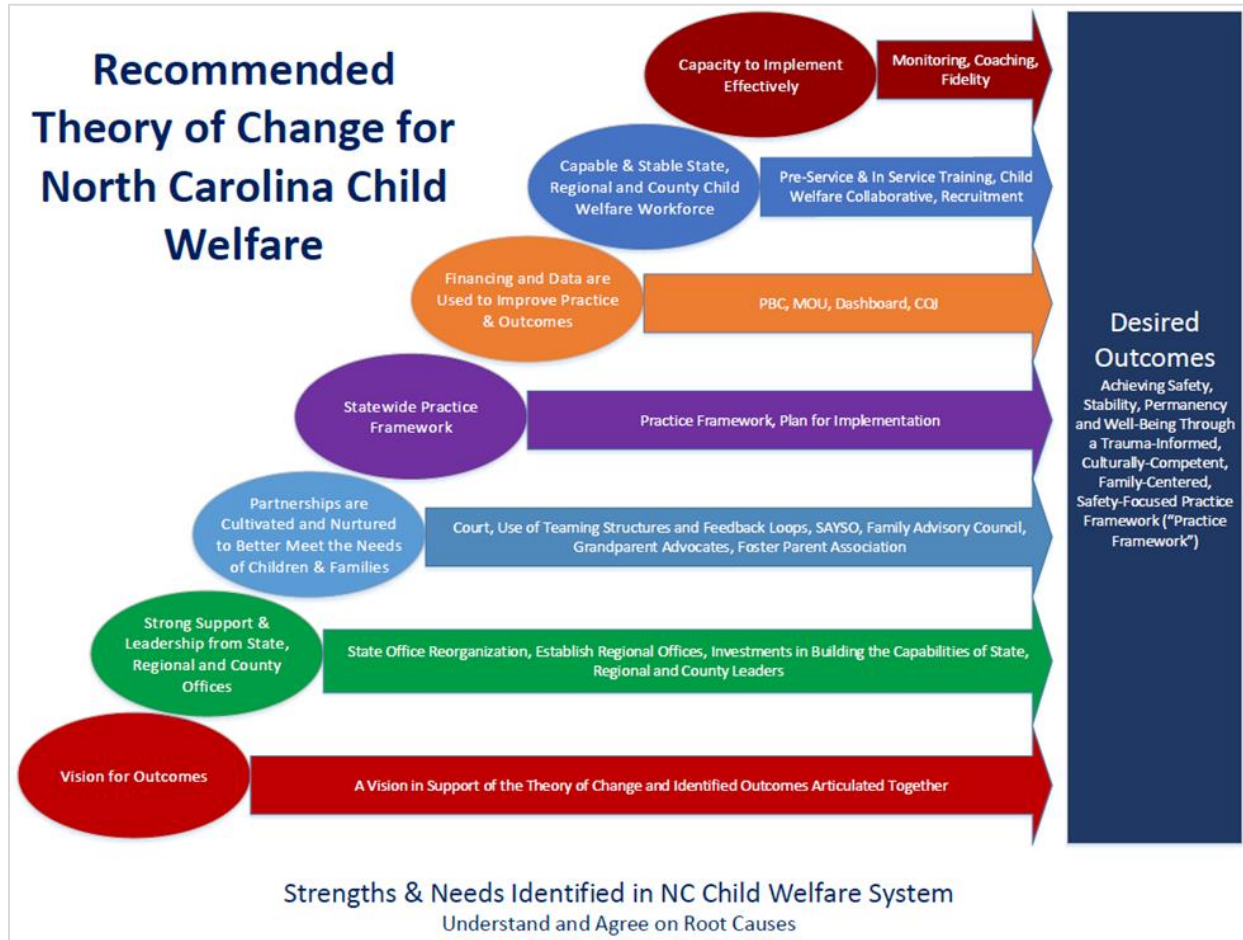
Many of these recommendations are cross-cutting and are intended to address needs identified in more than one child welfare program area. When recommendations are more directly linked to the findings in one of the program areas in particular, it has been noted.

CSF recommends as a first step the creation of a small, representative core implementation team to be identified and charged immediately with the responsibility for taking the recommendations to the next level – sorting them in priority order, making them actionable, and identifying the resources needed to implement them. We also recommend that DHHS recruit and select one person to be devoted full-time to lead this team and manage the implementation of these recommendations and the improvement effort overall. This would include the creation of a teaming structure to ensure the ongoing and regular engagement of a broader group of stakeholders. This core implementation team would be responsible for strategically sequencing and operationalizing the new vision using implementation science, including a focus on readiness goals and activities.

It should be noted that the U.S. Congress has set forth a path for all child welfare systems to place more focus on prevention and intervention to keep children safely with families through the Family First Prevention Services Act (FFPSA) beginning as early as October 2019. North Carolina is poised to jumpstart this process through implementation of its new vision and practice framework. These recommendations have been crafted to align and incorporate readiness activities identified as part of North Carolina’s effort to prepare for the implementation of the FFPSA. This process should help inform the prevention plan the state will be required to submit to the Children’s Bureau within the federal Administration for Children, Youth and Families (ACYF), and the notification the state must provide to the Children’s Bureau by November 9, 2018, about a timeline for opting into the FFPSA.



Figure 45: Recommended Theory of Change for North Carolina Child Welfare



The following preliminary recommendations are offered for consideration. Recommendations are made to create each of the basic conditions articulated in the draft theory of change that would need to exist within North Carolina’s Child Welfare system to address identified findings and improve desired outcomes over time. As depicted in the figure above, here are the basic conditions that need to be further developed and created:

- ◆ Vision for outcomes;
- ◆ Strong support and leadership from Central Office, regional office and county offices;
- ◆ Partnerships are cultivated and nurtured to better meet the needs of children and families;
- ◆ Statewide practice framework;
- ◆ Use of financing and data are used to improve practice and outcomes;
- ◆ Capable and stable state, regional, and County Child Welfare workforce; and
- ◆ Capacity to implement effectively.

The recommendations to develop and create each of the basic conditions for the draft theory of change are listed in order as depicted in the *Key for Recommendations* below, based on a

preliminary implementation timeline: short-term recommendations that can be implemented before the end of Phase 2 (February 28, 2019); mid-term recommendations that can be implemented before the end of Phase 3; and then long-term to be implemented beyond Phase 3. Although multiple entities (e.g. DHHS, General Assembly, Administrative Office of the Courts) will need to work together to implement almost every recommendation, we have listed the primary entity that has much of the responsibility for the specific recommendation. Some specific steps will need to be taken in earlier phases to prepare for the implementation of certain recommendations in the mid-term or longer-term timeframe.

**Key for Recommendations**

<i>Short-term = can be implemented before February 28, 2019 (Phase 2)</i>
<i>Mid-term = to be implemented after March 1, 2019 (Phase 3)</i>
<i>Long-term = to be implemented beyond Phase 3</i>
<i>Legislature</i>
<i>DHHS</i>
<i>Counties</i>
<i>Core Implementation Team (CIT)</i>

**A. Vision for Outcomes**

A clear vision for the child welfare system in North Carolina is necessary to realize positive, sustainable improvement to achieve outcomes. The two-day session with child welfare leaders from the state and counties, CSF, and the panel of experts developed basic tenets of a vision including being trauma-informed, culturally-competent, family-centered, and safety-focused. However, the vision needs to be articulated; supported by a new and enhanced infrastructure; and operationalized within DSS and in partnership with external stakeholders to achieve desired outcomes.

**Recommendations**

<b>1.</b>	<p><b>Recruit and hire one person with implementation experience and expertise to create a core, representative implementation team to guide the implementation of these recommendations.</b> CSF recommends as a first step the creation of a small, representative core implementation team to be identified and charged immediately with the responsibility for taking the recommendations to the next level – sorting them in priority order, making them actionable, and identifying the resources needed to implement them. We also recommend that DHHS recruit and select one person to be devoted to this full-time, to lead this team and manage the implementation of these recommendations and the improvement effort overall. This core implementation team would be responsible for strategically sequencing and operationalizing the new vision using implementation science, including a focus on readiness goals and activities.</p> <p>It is essential that this person is identified as soon as possible. A current position may need to be reclassified for this to happen in the urgent timeline required. An administrative support person will also need to be identified to support this team.</p>	<b>DHHS</b>
<b>Short-term</b>		

<p>2.</p>	<p><b>Convene a broad group of stakeholders to more fully develop a vision for improving outcomes in North Carolina – starting with the theory of change and identified outcomes developed in partnership with CSF on July 9 and 10 in Durham, North Carolina.</b> This will help create a process for feedback and buy-in internal to the state and county social services system and for external stakeholders. To create consistent child welfare practice and improve outcomes for children and families across the state of North Carolina, the state needs to adopt and communicate a clear vision. The vision should include keeping families safe, together, and supported through the practice framework set forth in S.L. 2017-41 and supported by child welfare research. With 100 county departments of social services, newly-established regional DSS offices, and the Central Office DSS, it is vital for leaders to set forth a common direction, with guiding principles and goals to achieve a set of statewide outcomes for families. A vision for Child Welfare outcomes to reach beyond DSS and be supported by all agencies and entities that impact the well-being of children, youth, and families. Through a well-developed implementation process, stakeholders should have the opportunity to participate in creating shared accountability and support for the vision, goals, and outcomes. Specific collaborative goals and recommendations for engaging and working with court systems, mental health systems, and children, youth, and families are delineated in the section below on Partnerships are Cultivated and Nurtured to Better Meet the Needs of Children and Families.</p>	<p>Core Implementation Team</p>
<p>Short-term</p>		
<p>3.</p>	<p><b>Ensure that the articulated vision supports a parallel process for shifting the culture of the workplace to provide culturally-competent, trauma-informed, family-centered, and safety-focused environments to support social services staff at the county, regional, and Central Office levels.</b> Deliberate efforts must be made to shift the internal culture of social services at state, regional, and county levels to support a work environment that is trauma-informed, family-centered, safety-focused, and culturally-competent to recruit, develop, and retain a robust workforce. The secondary trauma experienced by social services staff, the constant work-life balancing that workers must do to care for their own families, and the difficult environments and safety considerations inherent in the job must all be considered as social services shifts its internal culture. Staff cannot be expected to work with families differently if the workplace does not reflect these same values.</p>	<p>Core Implementation Team</p>
<p>Short-term</p>		
<p>4.</p>	<p><b>Develop and implement a communication plan to help ensure leaders at all levels and a broad group of stakeholders are receiving and providing needed information related to North Carolina’s vision for outcomes.</b> To operationalize a new vision for child welfare in North Carolina, the state needs to utilize implementation science to develop an infrastructure that creates buy-in, feedback loops, and outcome measures that align with the vision. A strong communication plan must be developed to engage leaders and stakeholders at the state, regional, and local levels.</p>	<p>CIT</p>
<p>Short-term</p>		

***B. Strong Support and Leadership from State, Regional, and County Offices***

This component of the theory of change is essential to prepare the Department of Social Services internally for implementation of the practice framework. It includes communicating and reinforcing the vision, educating around new and improved practice, and putting tools in place to

be able to measure progress towards outcomes. Findings from the assessment indicate a strong need for leadership and support across all levels of DSS.

Here are some of the identified needs upon which our recommendations focus.

- ◆ Clear definition of state and county roles in a state-supervised, county administered program.
- ◆ Clear plan and structure of implementation for policy, operations including roles.
- ◆ Timely and accurate policy guidance that is consistent across the Division of Social Services and new regional offices.
- ◆ Support of directors in non-program areas (fiscal, management, and leadership).
- ◆ Enhanced training for both county and state staff.
- ◆ Timely/integrated monitoring and corrective action or improvement plans tied to the family-centered, trauma-informed, culturally-competent, safety-focused framework.
- ◆ Enhanced technical assistance from the state tailored to the needs of individual counties.
- ◆ Increased staffing for county and state with appropriate skills, knowledge and experience.
- ◆ Enhanced communication with public and the legislature.

**Recommendations**

<b>5.</b>	<p><b>Create five new high-level positions in the state Division of Social Services at competitive salaries and then advertise, recruit, and select candidates qualified to lead.</b> This needs to be done in the very short-term through a reallocation of existing positions and/or resources within DHHS or state government. Implementation of these child welfare recommendations will only be possible with a state office child welfare section that is able and equipped to lead. These hires will help to ensure strong leadership for these areas of practice:</p> <ul style="list-style-type: none"> <li>▪ Office of Child Safety-Child Protective Services</li> <li>▪ Office of Family Support-Prevention and In-Home Services (CPS): Voluntary and Involuntary, Family First</li> <li>▪ Office of Child Permanency: Foster Care, Extended foster care for youth 18 to 21, Adoption, Guardianship, Reunification</li> <li>▪ Office of Professional Development: Implementation Support, Training, and Coaching</li> <li>▪ Office of Performance Improvement: OSRI, Program Monitoring, Performance Improvement, Fidelity, Data analysis, monitoring of provider performance</li> </ul>	<b>DHHS</b>
<i>Short-term</i>		
<b>6.</b>	<p><b>Ensure competitive salaries for Central Office Division of Social Services Child Welfare Section employees and prospective employees.</b> See Social Services Preliminary Reform Plan.</p>	<b>DHHS</b>
<i>Mid-term</i>		

7.	<p><b>Reorganize the Central Office Division of Social Services Child Welfare Section to align with the regional offices established under S.L. 2017-41.</b> This reorganization would include, but not be limited to, the creation of five (5) offices focused on ensuring children are psychologically and physically safe, keeping families together through Prevention and In-Home Services, timely permanency for children who enter foster care, professional development, and performance improvement.</p> <p><i>Office of Child Safety</i> – persons in this office would be responsible for providing leadership for Child Protective Services statewide, including the Initial Investigative and Family Assessments and ongoing safety assessment process. These persons would be responsible for this area of practice including, but not limited to: researching best practices; setting policy expectations; understanding performance statewide; using data effectively; and helping to improve practice and outcomes. Related information and support would need to be made available to the regional offices, county offices as well as persons responsible for policy, training, budgets, and legislation.</p> <p><i>Office of Family Support</i> – persons in this office would be responsible for providing leadership for prevention, voluntary family support services and CPS In-Home Services. These persons would be responsible for this area of practice including, but not limited to: researching best practices; setting policy expectations; understanding performance statewide; using data effectively; and helping to improve practice and outcomes. Related information and support would need to be made available to the regional offices, county offices as well as persons responsible for policy, training, budgets, and legislation. This office will also have a major role in the implementation of FFPSA.</p> <p><i>Office of Child Permanency</i> – persons in this office would be responsible for ensuring that important relationships are maintained for children and that placements are made with relative and kin caregivers to the extent possible, extended foster care for youth 18 to 21 or beyond, and for promoting permanency through adoption, guardianship, reunification. This office would have oversight and support responsibilities related to county and regional offices as well as the child placing agencies. These persons would be responsible for this area of practice including, but not limited to: researching best practices; setting policy expectations; understanding performance statewide; using data effectively; and helping to improve practice and outcomes. Related information and support would need to be made available to the regional offices, county offices as well as persons responsible for policy, training, budgets and legislation.</p> <p><i>Office of Professional Development</i> – persons in this office would be responsible for building the capabilities of the entire child welfare workforce in North Carolina, including those persons working in the state, regional, and county offices. This team would need to have the expertise and experience needed to manage the creation of a learning program aligned with North Carolina’s trauma-informed, culturally-competent, family-centered, safety-focused approach. This team would be responsible for working with universities and other resources to develop a skilled workforce pool for counties, regions and state.</p> <p><i>Office of Performance Improvement</i> – persons in this office would be responsible for monitoring performance, including federal reviews and program monitoring, ensuring needed local support and technical assistance and helping to manage change and improvement efforts throughout the child welfare system in North Carolina. These persons would be responsible for leading statewide strategic planning processes and overseeing state and county level strategies aimed towards ensuring data quality and supporting the use of quality data at all levels of the organization. This team would need to be steeped in knowledge of effective implementation science and change management.</p>	<p>Mid-Term</p> <p style="writing-mode: vertical-rl; transform: rotate(180deg);">DHHS</p>
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8.	<p><b>Create a centralized hotline for reports of all suspected abuse or neglect in North Carolina.</b> This hotline would need to be effectively managed, preferably by someone with experience managing a call center or hotline. The person must be able to use data effectively to ensure calls are answered in a timely manner and that Intake workers are meeting expectations for gathering needed information, making appropriate screening decisions, and determining next steps to ensure children are physically and psychologically safe. The timeline for implementation may need to be tied to NCFAST to ensure immediate access to information about any history of county DSS involvement with the child and his or her family. The strategy for implementation should be based on sound implementation science. [Child Protective Services]</p>	DHHS
<i>Long-term</i>		

9.	<p><b>Ensure each regional office is equipped with relevant child welfare programmatic and coaching expertise.</b> Each region will need one child welfare professional development specialist, one child safety representative, one child and family support representative, one permanency representative, and two child welfare performance improvement representatives.</p> <p>The child safety, child and family support, and permanency representatives in the regional office will be responsible for building relationships with county child welfare leaders and staff, being responsive to policy and practice questions, helping to coordinate services among counties to ensure needed supports and services for families, helping counties secure the right placements for children who enter foster care and helping to remove systemic barriers. These persons will be selected and hired by their respective offices in the Child Welfare Section – <i>Child Safety, Child and Family Support, Child Permanency</i> - and receive policy and program direction and support from that office. These persons will report to the Regional Director for ongoing personnel matters.</p> <p>The child welfare training and coaching specialist will be responsible for helping to build the capabilities of the child welfare workforce in the region in partnership with the Central Office, university partners, and identified trainers within the counties. These persons will be selected, hired, and supervised for policy and program direction by the <i>Office of Professional Development</i>. These persons will report to the Regional Director for ongoing personnel matters.</p> <p>The performance improvement representatives will be responsible for conducting case reviews, monitoring service delivery, gathering information about child welfare practice in the counties, and overseeing strategies aimed towards ensuring data quality, and supporting the use of quality data. These persons will be selected, hired, and supervised for policy and program by the <i>Office of Performance Improvement</i>. These persons will report to the Regional Director for ongoing personnel matters.</p> <p>Every member of the regional child welfare team will be responsible for participating in the CQI process designed to improve outcomes for children and families in the region.</p>	DHHS
<i>Long-term</i>		

### ***C. Partnerships are Cultivated and Nurtured to Better Meet the Needs of Children and Families***

An important component of our theory of change is about aligning community partnerships so that needed supports are in place for families as envisioned in the practice framework. If the system changes its practices without strengthening community partnerships, developing buy-in for the new way of work, and ensuring that needed supports are in place, the experiences of

children and families may not improve. As part of the assessment, CSF looked at the quality of the existing partnerships between service providers and State and county offices.

**Recommendations**

<b>10.</b>	<p><b>External stakeholders need to be engaged on a regular and ongoing basis as North Carolina develops a culturally-competent, trauma-informed, family-centered, and safety-focused child welfare system.</b> An effective child welfare system involves the collaboration, buy-in, and shared resources of all stakeholders who impact the lives of children, youth, and families, especially families themselves. DSS has existing collaborative partnerships and initiatives that must be further nurtured and expanded. Specific strategies and approaches should be developed for each stakeholder group to address their specific strengths and needs. These stakeholder groups need to be represented in the teaming structure that will be developed. External stakeholders should include the following:</p> <ul style="list-style-type: none"> <li>▪ Courts (judges/GAL/attorneys/AOC/clerks).</li> <li>▪ Behavioral Health including LME/MCOs that manage Mental Health and Substance Abuse services.</li> <li>▪ Families/Family Advisory Council/SAYSO.</li> <li>▪ Education: schools K-12, universities.</li> <li>▪ Law enforcement, probation, parole.</li> <li>▪ Legislators (state and federal).</li> <li>▪ County Commissioners/Managers, DSS boards, City Managers.</li> <li>▪ Medical Providers.</li> <li>▪ Child Advocacy Centers.</li> <li>▪ Birth parents, relative and kin caregivers, foster parents.</li> <li>▪ Community based provider agencies: non-profits, therapy, parenting, substance abuse treatment, domestic violence advocates.</li> <li>▪ Child Placing Agencies.</li> <li>▪ Federally- and State-Recognized Tribes.</li> <li>▪ Public Health.</li> <li>▪ Early Childhood partners.</li> <li>▪ Juvenile Justice.</li> <li>▪ Community Action Centers.</li> <li>▪ Advocacy groups.</li> <li>▪ Faith Community.</li> <li>▪ The Child Fatality Prevention system including state and local teams.</li> <li>▪ Transportation/housing.</li> <li>▪ Business community/philanthropy/foundations.</li> </ul> <p>[Prevention and In-Home; Child Protective Services; Provision of Physical, Mental Health, Educational Services, Reunification Services, Child Fatality]</p>	<b>Short-term</b>	<b>Core Implementation Team</b>
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<p>11.</p>	<p><b>Engage, collaborate, and coordinate with courts to address and remedy existing barriers, while creating buy-in for the new vision and jointly tracking key outcomes for children, youth, and families.</b> The court system is a vital partner that shares responsibility and accountability for ensuring that families are supported and that children can safely achieve timely permanency. Child welfare administrators and judges must be equipped with the information they need to make decisions that will improve child welfare outcomes for children. DSS cannot achieve better outcomes for families without a fully resourced court system.</p> <p>Recommendations include:</p> <ul style="list-style-type: none"> <li>▪ Dedicated and/or Juvenile Court Judges should be provided in all judicial districts; support should be provided for staff, attorneys, and judges who have knowledge of and provide services that are also culturally-competent, trauma-informed, family-centered, and safety-focused to foster a court system that supports the new vision and desired outcomes for children, youth, and families.</li> <li>▪ The state should explore increasing the number of judges or revising state statutes to add appointed juvenile court magistrates or associate judges. In addition, additional resources should be explored to increase support for GALs and parent attorneys. The state should explore increasing the number of judges, GALs, and parent attorneys who are certified through the national child welfare law certification process. This will assist in alleviating excessive continuances, creating more court time to move cases to permanency, and eliminating current practices that result in barriers to the desired outcomes for children, youth, and families.</li> <li>▪ DHHS, the Social Services Working Group, and the AOC should explore and implement new and joint state funding opportunities and pilot trauma-informed courts.</li> <li>▪ The courts and DSS should track outcomes together and consider judicial report cards or permanency profiles as part of that process. Champion Judges should be included in the visioning process and assist DSS in garnering support and buy-in from all judges across the state.</li> <li>▪ As the courts transition to raising the age of juvenile justice jurisdiction from age 16 to age 18 in 2019, efforts should be made to coordinate these efforts with the new DSS vision and FFPSA. The resources developed under FFPSA will include expanded community-based evidence-based services that all youth and families should be able to access.</li> <li>▪ The Central Office Division of Social Services should work with the AOC to incorporate the roll-out of the new vision and reform efforts into the current quarterly collaboration meetings and the current permanency push that convenes all child welfare stakeholders in regions across the state.</li> </ul>	<p>DHHS</p>
<p><i>Short-term</i></p>		
<p>12.</p>	<p><b>Strengthen partnership between the state Division of Social Services and the Divisions of Medical Assistance, and MH/DD/SAS to make sure behavioral health services are available to parents and ensure appropriate placements for children in foster care.</b> This would include an assessment of Managed Care Organization contracts, managing Medicaid transformation in North Carolina in a manner that keeps the needs of Child Welfare-involved children and families in the forefront, scaling up of trauma-informed CCA process for children and parents to drive service delivery; identifying preferred, quality, two-generation services and providers with a mechanism to pay them; and sharing with each other results of promising practices across counties. [Child Protective Service, Prevention and In-Home Services, Permanency Services, Reunification Services]</p>	<p>DHHS</p>
<p><i>Short-term</i></p>		



<b>13.</b>	<p><b>Finalize the criteria for readiness to implement the Family First Prevention Services Act.</b> The landscape for prevention services in North Carolina is poised to expand. The public private partnership between DHHS, Prevent Child Abuse NC, The Duke Endowment, and NC Child to convene over 200 stakeholders on June 5, 2018 to discuss a path forward for FFPSA is evidence of the will and capacity to undertake this major shift toward prevention and family preservation. A smaller group of approximately 40 diverse stakeholders met during the afternoon of the convening to discuss next steps for North Carolina. This group identified some beginning criteria for readiness criteria that could be used to help finalize the readiness criteria and determine a timeline for opting into the FFPSA.</p>	<b>DHHS</b>
<i>Short-term</i>		
<b>14.</b>	<p><b>Engage, collaborate and coordinate with birth families, youth, relatives, fictive kin, and foster parents to improve outcomes and effectively implement system reforms.</b> The engagement and input of these primary stakeholders is vital to operationalize the vision and improve outcomes for children youth and families. Adequate and additional resources and support should be provided to the following initiatives to improve communication and establish solid feedback loops that provide DSS with information needed to continue improving and enhancing its new way of work. Current promising practices that need to be scaled up to statewide impact include:</p> <ul style="list-style-type: none"> <li>▪ Provide funding and support for the expansion of the Family Advisory Council and Family Engagement Committees at the state and regional/county levels;</li> <li>▪ Increase funding and support expansion of SAYSO and LINKS in coordination with adoption of the FFPSA;</li> <li>▪ Support, and expansion of partnerships with Grandparents Support Organizations and other programs and entities that support relative caregivers; and</li> <li>▪ Support and the expansion of Foster Parents Associations at the county/regional levels.</li> </ul> <p>[Prevention and In-Home Services, Child Protective Services, Permanency Services, Reunification Services]</p>	<b>DHHS</b>
<i>Mid-term</i>		

***D. Statewide Practice Framework***

One way to create consistency in child welfare practice throughout North Carolina and to provide accountability is to develop or adopt a practice framework. In an effective practice framework, the practices are grounded in the values, principles, relationships, approaches, and techniques used at the system and caseworker level to enable children and families to achieve safety, permanency, and well-being goals. Organizing these practices into a trauma-informed, safety-focused, family-centered, and culturally-competent framework provides a standard for imitation or comparison; a structure that holds them together based on an underlying set of common ideas, agreements or policies.

**Recommendations**

15.	<p><b>The state and CSF should begin immediately to further explore the fit and feasibility of adapting and effectively implementing Safety Organized Practice (SOP) as the comprehensive statewide practice framework to create consistency in child welfare practice that is trauma-informed, culturally-competent, family-centered, and safety-focused throughout North Carolina.</b> DSS has been considering and analyzing possible practice models to develop a statewide, standardized functional protocol to be used for case planning, service referrals, and enhancing executive-level decision making around resource allocation and other system reform efforts. These DSS efforts have resulted in the identification and analysis of three possible practice models: Solution-Based Casework (SBC); Signs of Safety (SOS); and Safety Organized Practice (SOP). Currently several counties in North Carolina are implementing or exploring implementation of these three practice models. As CSF, members of the panel of national experts, and DSS (state level and county leadership) have discussed the theory of change to move North Carolina child welfare practice so that it is more trauma-informed, culturally-competent, family-centered, and safety-focused, CSF is prepared to begin work immediately with SOP’s developer/purveyor and DHHS/DSS leaders to explore the following fit and feasibility issues: definition of the essential functions of SOP; experiences adapting SOP in state child welfare systems so that the framework is trauma-informed, culturally-competent, family-centered, and safety-focused; demonstrated impacts on child welfare outcomes as outlined in NC’s theory of change; associated costs; recruitment and selection and organizational capacity implications (for staff involved in the consistent statewide implementation of the framework and staff implementing the framework with the families and children in their caseloads); training implications; coaching implications; fidelity assessment implications; decision support data system implications (specifically in reference to the NC FAST Child Welfare Module); experiences and implications of incorporating the framework with a state’s SDM process; implications of implementing the framework on current policy and level of revision to policy that will be needed; experiences of implementing the framework in a state similar to the size of North Carolina with 100 counties (what worked well and what barriers surfaced); leadership and stakeholder implications; and seeking from the SOP developer/purveyor relevant implementation references to inform the exploration of fit and feasibility. Once these issues are fully explored and considered, county DSS and DHHS can make a final decision if there is organizational capacity to move successfully forward with a statewide implementation effort of SOP. Pending the availability of the SOP developers/purveyors, the goal would be to make a final decision before the end of October 2018 about the fit and feasibility of implementing Safety Organized Practice as North Carolina’s statewide practice framework.<sup>24</sup></p>	<i>DHHS and Core Implementation Team</i>
<b>Short-term</b>		

<sup>24</sup> This list of fit and feasibility issues is informed by the “Innovation Developer Interview Tool” included in Volume 2 Exploration of the Guide to developing, implementing, and assessing an innovation. Permanency Innovations Initiative Training and Technical Assistance Project. (2016). Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Children’s Bureau.

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16.	<p><b>Include in the practice framework an expedited licensure process for foster parents, relative, and kin caregivers that has been streamlined.</b> This would include, but not be limited to the following:</p> <ul style="list-style-type: none"> <li>▪ Make decision about counties being able to fully license without requiring state approval;</li> <li>▪ Reduce time to licensure;</li> <li>▪ Eliminate barriers to general licensing requirements for therapeutic foster parents and foster parents. [Permanency Services, Reunification Services]</li> </ul>	DHHS & CIT
<i>Short-term</i>		
17.	<p><b>Include in the practice framework specific expectations related to the engagement of birth families in the planning processes and provision of services provided to their children while in foster care.</b> To be a family-centered, safety-focused, culturally-competent, and trauma-informed child welfare system, steps must be taken to increase birth family engagement. [Reunification Services, Permanency Services, Services to Older Youth, Services to Children]</p>	DHHS & CIT
<i>Short-term</i>		
18.	<p><b>Include in the practice framework the specific support that older youth in foster care need.</b> This would include, but not be limited to exploring the needs for more resources for LINKS programs, the need for additional staff and for services to reach all eligible youth, expand youth engagement through SAYSO, local Family Advisory Councils in each county/region; and the involvement of youth in the development of FFPSA. This would need to also include more emphasis on educational stability and planning for post-secondary educational opportunities and how to engage youth in the planning process and the importance of maintaining connections. [Services to Older Youth]</p>	DHHS & CIT
<i>Short-term</i>		
19.	<p><b>Include in the practice framework a specific approach to child and family teams or CFTs to align with a family-centered, culturally-competent, trauma-informed, safety-focused child welfare system.</b> The modified manual improves North Carolina’s CFT policy, but it still needs development. CFTs are a vital mechanism for engaging families in planning and decision making, should be strength-based and structured to promote genuine family voice and input.</p>	DHHS & CIT
<i>Short-term</i>		
20.	<p><b>Include in the practice framework the SDM process and tools as may be needed.</b> Current SDM are outdated and no longer being validated. DHHS is reviewing a proposal from the NCND Children’s Research Center related to these tools. [Child Protective Services, In-Home Services, Permanency Services]</p>	DHHS & CIT
<i>Short-term</i>		
21.	<p><b>Assess Project Broadcast or review assessments that have been done to understand the extent to which it has been implemented and its impact on children and families.</b> This will help leaders make decisions about what can be incorporated into the practice framework and those practices that need to be implemented throughout North Carolina.</p>	DHHS
<i>Mid-term</i>		

22.	<p><b>Create border agreements to ensure children can be with their relatives in neighboring states as soon as possible.</b> This would allow for more children in foster care to be cared for by their own family members in a timely manner. [Permanency Services, Reunification Services]</p>	DHHS
Mid-term		
23.	<p><b>Provide funding for more robust in-home services.</b> To be a family-centered, safety-focused, culturally-competent, and trauma-informed child welfare system, financing will need to be directed towards creating a stronger, more effective service system to meet the needs of children and their families. [Prevention and In-Home Services]</p>	DHHS
Mid-term		
24.	<p><b>Take concrete steps to increase the number and percent of children in foster care placed with relatives and kin caregivers, the percent of those kin who are licensed, and the numbers of children exiting to their care.</b> This would include, but not be limited to the following:</p> <ul style="list-style-type: none"> <li>▪ Modifying the Guardianship Assistance Program to be available for children of all ages and expanding the definition of relative or kin caregiver.</li> <li>▪ Making training more accessible and available to relatives and kin caregivers.</li> <li>▪ Ensuring this training is specialized to specific needs of relative and kin caregivers (i.e. grief and loss, relationship to parents, financial, child care, shared parenting in the context of these already existing relationships)</li> <li>▪ Creating a team charged with making this happen.</li> <li>▪ Developing streamlined licensing standards for relative and kinship caregivers consistent with requirements that the Family Services Prevention Act requires federal HHS to establish by October 1, 2018.</li> <li>▪ Ensuring all relatives who are caring for children in foster care are licensed and supported similar to foster parents.</li> </ul> <p>[Permanency Services, Services to Older Youth, Reunification Services]</p>	DHHS
Mid-term		

***E. Financing and Data Are Used to Improve Practice and Outcomes***

One clear message received throughout the assessment period is that county and state staff and leaders do not regularly or consistently incorporate the use of data resources into their daily work. County staff who participated in focus groups reported that most do not have access to data and, therefore, do not depend on data metrics to either monitor or strategize for performance improvement. Further probing revealed that some focus group participants were concerned that data metrics would be used punitively; others suggested that data metrics could be easily misunderstood or misconstrued by outside stakeholders. Other participants voiced concerns that data metrics insufficiently represented the experience of children and families themselves, or the workforce effort on behalf of the children and families who interacted with the child welfare system. Taken together, the focus groups’ responses suggest that North Carolina has neither a widespread reliance on data evidence nor a culture that embraces the proper use of data evidence in the effort to monitor and strategize for continuous performance improvement.

Survey results largely reinforced the focus group sentiments: while representatives from some counties, particularly larger counties, reported having processes and/or staff dedicated to use data to inform performance and decision-making, representatives from smaller counties reported having neither the time nor the staff resources to invest in using data routinely. Likewise, while almost half (31 of 66) of central office survey respondents indicated they spend some time (an average 13.6 percent of their time) using data in their work, 25 of 66 respondents identified using data to improve outcomes as one of the top three areas where they felt they should be spending more of their time. When speaking about data quality in general, Central Office survey respondents shared that data needs to be more consistent.

Interviews with state leaders revealed other concerns with data that extend beyond the known problems with NC FAST and the NC FAST rollout to the child welfare system. One primary concern is the lack of consistency across counties in how some data is entered into the system.

The concern that data are inconsistently entered coupled with little regular access to standardized data reports means that managers are neither confident in the quality of the data nor are they in the habit of consulting or relying on data resources. Unreliable data quality and inconsistent access to data evidence inevitably will lead to less frequent reliance on using data both to monitor performance and to make decisions.

Best practices in performance monitoring, performance management, and continuous improvement requires that both state and county leaders have regular access to timely, high-quality data evidence that is developed to adhere to best practices in the science of measurement. This is especially critical when undertaking systems change as the state embarks on wide-reaching reform that is based on a clearly articulated theory of change, which itself is only defensible when there is a well-articulated starting point (baseline), a clear set of interventions carefully implemented to produce an understood improvement (goal), and a measurement approach that clearly tracks both the process of implementation as well as the achievement of articulated goals (actuals).

In the sections below, we provide specific recommendations on the use of data based on our assessment. These recommendations fall into four primary categories:

1. Promoting use of quality data across the state;
2. Technical recommendations;
3. Identification of outcomes that are consistent with a safety-focused, family-centered, trauma-informed, culturally-competent child welfare system; and,
4. Dashboard development

Please note that we will not be making any recommendations specific to NC FAST and its utility, as that was beyond the scope of our assessment.

**Recommendations: Promoting Use of Quality Data Across the State**

The range of decisions that child welfare (and social services) staff must make in the daily demands of their jobs requires the purposeful reliance on properly generated quantitative and qualitative evidence. Reliance on properly produced data evidence is foundational to program monitoring and ongoing program improvement and is widely recognized as a best practice.<sup>25</sup> The Child Welfare Strategic Plan recognized this need and set forth the following goal: “Administrative infrastructure to operationalize a Continuous Quality Improvement (CQI) system using data to measure child and family outcomes.”<sup>26</sup> Our key recommendation is that North Carolina state leadership promote a culture in which data evidence is both reliable and willingly relied upon as a vital tool for understanding and supporting innovation and program improvement. Creating this culture requires a number of specific investments in training and the development of both data resources and specific data metrics. These include:

<b>25.</b>	<p><b>Develop a communication strategy at the state and local level that clearly expresses the expectation that staff rely on properly produced data evidence.</b> The communication strategy should emphasize that state stakeholders expect to rely on data evidence to assess progress toward desired outcomes and to support workload management and caseworker decision-making. Furthermore, the communication strategy, which should be developed with strong county participation, should reinforce the expectation that workers, supervisors and administrators across the system will be able to depend on a number of data resources and increased capacity to use them to track progress, establish goals, and support problem solving at both the micro and macro-level. The data dashboard is one such resource.</p>	<b>Core Implementation Team</b>
<b>Short-term</b>		
<b>26.</b>	<p><b>Train county, regional and statewide staff in the proper use of administrative data to support program monitoring and decision-making.</b> Currently, the use of data to monitor progress and to manage work is inconsistent across both counties and the state. In part, this may be attributable to the slow and interrupted transition to NC FAST with fewer than a dozen counties using the new system while most counties still rely on legacy data. Notwithstanding the database transition, there remains a notable lack of comfort in how data should be used and lack of clarity in how to access reliable data. Leadership at the state and county level should be trained in best practices in the use of administrative data to examine core program outcomes, and to strategize for county-specific improvement efforts. These skills will be essential for staff to successfully benefit from both the eventual migration to NC FAST and the development of the dashboard.</p>	<b>DHHS</b>
<b>Mid-term</b>		

<sup>25</sup> ACYF-CB-IM-12-07, Establishing and Maintaining Continuous Quality Improvement (CQI) Systems in State Child Welfare Agencies. issued August 27, 2012; available at <https://www.acf.hhs.gov/sites/default/files/cb/im1207.pdf>  
Wulczyn, F., Alpert, L., Monahan-Price, K., Huhr, S., Palinkas, L. A., & Pineseault, L. (2015). Research evidence use in the child welfare system. *Child Welfare*, 94(2), 141.

Lery, B., Haight, J. M., & Alpert, L. (2016). Four principles of big data practice for effective child welfare decision making. *Journal of Public Child Welfare*, 10(4), 466-474.

Wulczyn, F., Alpert, L., Orlebeke, B., & Haight, J. (2014). *Principles, language, and shared meaning: Toward a common understanding of CQI in child welfare*. Chicago: The Center for State Child Welfare Data, Chapin Hall at the University of Chicago.

<sup>26</sup> Child Welfare Strategic Plan, Session Law 2016-94, Section 12C.1.(b), p. 7.

27.		DHHS
<p><b>Offer ongoing training to staff on data entry and data extraction.</b> While this recommendation is further described in the workforce section, part of the training should focus both on improving the quality of data entry as well as building capacity at all levels of the workforce to use administrative data resources to correctly ask and answer questions. The more capacity individual workers have for generating the information that will promote critical thinking and strong decisions, the better the quality of the data at entry.</p>		
<i>Mid-term</i>		

28.		DHHS
<p><b>Conduct an analysis of how state and county child welfare contract for services and make recommendations on how to maximize the effectiveness of contracting to achieve child and family outcomes.</b> As state and local staff get more comfortable and accustomed to relying on data evidence to understand program performance, we recommend exploring incentives that more directly align system financing with core child welfare outcomes. This approach is often incorporated directly into performance-based contracts with service providers.</p>		
<i>Mid-term</i>		

**Recommendations: Technical Data**

Laying the groundwork for the transition to the functional reliance on data evidence requires immediate (or as close to immediate as possible) access to reliable information about basic system dynamics and core system outcomes. Largescale database transitions are frequently interrupted, delayed, and slow to complete. To bridge the transition to a new system (and sometimes to retain legacy data in new SACWIS systems) it is necessary to develop transitional approaches to the development of analytic data files. As described below, we strongly recommend exploring this option in order to begin the production of basic data metrics relevant to system reform and the development core child welfare system outcomes:

29.		DHHS
<p><b>Review and strengthen statewide protocols and procedures on how information is entered into the system and streamline methodologies to ensure data accuracy and consistency for identified variables that will be used in reports.</b> Counties have different protocols for completing forms and entering them into the legacy and NC FAST systems, and instructions are complicated for how data should be captured, particularly in instances where multiple factors apply (e.g., reasons for children coming into custody). Some protocols suggest entering all factors, some ranking the top three, and some yet other methodologies, which leads to inconsistency in how information is entered. We recommend reviewing the existing protocols and streamlining processes to improve consistency, training on standardized definitions and codes for recording data elements in the systems. We also recommend taking concrete steps to ensure there are no duplicate identifiers for children, adults, and families (cases). Counties should be engaged in developing the streamlined methodologies, and defining the rules to help ensure consistent data entry across the state, thereby increasing data accuracy and confidence in the information being produced. The goal is to establish and nurture an agency culture where staff at all levels understands and embraces their unique role in the development and use of quality data.</p>		
<i>Short-term</i>		

<p>30.</p>	<p><b>Continue to develop and regularly disseminate standard reports on basic information about the child welfare population.</b> While data and data reports currently exist or can be developed, they are not produced and disseminated regularly, and the reports used have limited rigor and flexibility. We recommend that a few key reports, particularly those containing basic information about entry, placement, and exit dynamics be regularly produced and disseminated across the counties and state. The list of regularly produced reports should be developed with county leaders based on what is possible now, and what leaders need to know to be able to make informed decisions about their jurisdictions. These reports should be considered essential information resources that leaders in each county should consult when they want to know and report on what is typically true about the children and families they serve. Here are some examples.</p> <ul style="list-style-type: none"> <li>▪ How many child-cases are typically opened each year?</li> <li>▪ How many children go on to be placed in foster care?</li> <li>▪ Where are they typically placed?</li> <li>▪ How much do they typically disrupt?</li> <li>▪ How long are they typically in care?</li> <li>▪ How do they exit?</li> <li>▪ Do they reenter?</li> </ul> <p>For the above questions, what is the distribution by age? What is the distribution by race and ethnicity?</p>	<p style="writing-mode: vertical-rl; transform: rotate(180deg);">DHHS</p>
<p style="text-align: right;"><i>Mid-term</i></p>		
<p>31.</p>	<p><b>Create an analytic data file, that can be periodically updated, that links NC FAST data with data from the legacy system.</b> Currently there is limited access to flexible, dynamic, statewide child welfare outcome data. The most accessible outcome data reports are available on the UNC management assistance website (<a href="http://ssw.unc.edu/ma/">http://ssw.unc.edu/ma/</a>) that use data primarily from the legacy systems, though has recently added information on the number of children in custody from the 11 counties using NC FAST. And, because the legacy and NC FAST data systems are currently not linked to one another, statewide reports on core child welfare outcomes over time cannot easily be generated. In addition, obtaining historical data for counties as they transition to NC FAST will be a challenge. Because we recommend that state and county leaders begin immediately to develop the capacity for use and reliance on data evidence, we also recommend investing in the development of a linked analytic file that can be the source of that basic outcome data. This would involve writing code to link the two data sets and executing that code on a regular (quarterly or semi-annual basis). This would create a source file from which the outcome data necessary for outcome monitoring and robust decision-making can be produced, including the data dashboard.</p>	<p style="writing-mode: vertical-rl; transform: rotate(180deg);">DHHS</p>
<p style="text-align: right;"><i>Mid-term</i></p>		



**Recommendations: Identification of Outcomes That Are Consistent with a Safety-Focused, Family-Centered, Trauma-Informed, Culturally-Competent Child Welfare System**

32.	<p><b>Adopt outcome measures aligned with a safety-focused, family-centered, trauma-informed, culturally-competent system.</b> As state leadership adopt a vision for how to improve services and outcomes for children and their families, the metrics by which these leaders measure and monitor progress and fidelity should be tied to that vision, and should be used to assess child welfare system performance. The outcomes specified will correspond to fundamental safety, permanency, and well-being for children and their families, and are consistent with federal child welfare outcomes. However, they are not duplicative of the federal measures. We recommend specifying outcomes that are rigorous with respect to the methods, and consistent with the vision represented in North Carolina’s theory of change.</p>	<b>DHHS &amp; CIT</b>
<b>Short-term</b>		

Below is a list of goals by program area, generated from the visioning session held with state and county leaders in July, that support the vision of a safety-focused, family centered, trauma-informed, and culturally-competent child welfare system. During Phase 2, we anticipate meeting with state and local leaders to refine the goals and specify the measures to be used as well as the associated key performance indicators. Where data quality and availability permits, it is expected that outcome measures and related indicators will be developed and reported (at various levels of disaggregation, i.e., statewide, region, county) on the Dashboard. Once the practice model has been articulated and modified to align with the vision and unique characteristics of the North Carolina system, the key performance indicators should be revisited to confirm that they line up with the core activities of the practice model and how it is implemented at the county level.

The goals specified below, which conform to the eight child welfare program areas, should be monitored through the Dashboard as much as possible. They should also be considered for inclusion in updated/reissued county Memorandum of Understanding and be used as part of the state and local CQI processes described in more detail in the Social Services Preliminary Reform Plan. To support the use of performance measurement data, we recommend that measures associated with each outcome be reported regularly (e.g. quarterly, semi-annually, annually), by age and race/ethnicity of subject population (e.g. children, parents, caregivers), and by geographical entity of interest (county, county size group, region, or state), we specify the program areas and the related outcome goal.

**CPS Assessment/Intake**

- ◆ **Goal 1:** Children in the community remain with their families and are not victims of maltreatment.
- ◆ **Goal 2:** Children who come to the attention of DSS will be safe.

**CPS In-Home and Prevention**

- ◆ **Goal 3:** Children who are referred to CPS In-Home Services will remain safely in their home and their cases will be closed timely.

- ◆ **Goal 4:** Children and parents will have continuity in relationships with service providers and caseworkers.

### Placement into Care

- ◆ **Goal 5:** Children who enter foster care will have stability in placement.
- ◆ **Goal 6:** Children who enter foster care are initially placed with relative or kin caregivers.
- ◆ **Goal 7:** Caregivers are recruited that are reflective of the population served.
- ◆ **Goal 8:** Children who enter foster care are placed in their own community whenever possible.

### Practices and Services to Achieve Permanency

- ◆ **Goal 9:** Children who enter foster care achieve sustained/lasting permanency swiftly.
- ◆ **Goal 10:** Children will maintain regular contact with their family while in out-of-home care.
- ◆ **Goal 11:** Caregivers work with children’s biological families whenever safe and possible.
- ◆ **Goal 12:** Children and Parents will have continuity in relationships with caseworkers.
- ◆ **Goal 13:** Children will have continuity in relationships with the court.

### Well-Being Services to Children and Youth

- ◆ **Goal 14:** For children identified as having federal or North Carolina recognized tribal heritage, every effort shall be made to involve the tribe.
- ◆ **Goal 15:** Children who enter foster care will have continuity in medical, mental health, and educational services.
- ◆ **Goal 16:** Children receiving services shall have those services routinely monitored and adapted as needed “through a statewide quality assurance system which will identify the strengths and needs of the service delivery system.”<sup>27</sup>
- ◆ **Goal 17:** Children and parents referred to medical, mental health, and educational services will receive timely and appropriate services.

### Services to Older Youth

- ◆ **Goal 18:** Youth who turn 18 while in foster care who need continued support will maintain eligibility for and participate in Foster Care 18-21.
- ◆ **Goal 19:** Youth leaving custody will be prepared for adulthood.
- ◆ **Goal 20:** Eligible youth 13-21 will have access to and participate in LINKS services.

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<sup>27</sup> Also a goal for Child Family Services Review – Program Improvement Plan as stated in the Child Welfare Strategic Plan, Session Law 2016-94, Section 12C.1.(b), p.4

33.	<p><b>Make investments in existing qualitative case review processes since they are so essential to monitoring and supporting efforts towards improving case practice and outcomes for children and families.</b> Move towards a regional-based OSRI review approach, where each region is reviewed on an annual basis and utilizes a county-size sampling methodology (based on current child welfare caseloads). North Carolina will have to ensure any revisions to their current OSRI sampling methodology are in compliance with CFSR standards set forth by the Children’s Bureau. Similarly, the current Program Monitoring Review process should be re-aligned to the newly configured regional structure, with each region being reviewed across the following program areas (i.e. CPS Assessments, In-Home, Foster Care, Screen-Ins and Screen-Outs) on an annual basis and including a sampling of cases from the respective counties utilizing a county-size sampling methodology (based on current child welfare caseloads and including a minimum number of cases per county). It is also recommended that North Carolina re-assess their current Program Monitoring review tools in an effort to enhance (revise as needed based on policy updates), streamline (eliminate questions that do not yield key performance information or are duplicative) and otherwise improve upon (add questions to other key practice or service populations such as older youth). Unlike the OSRI, where revisions to the instrument are restrictive and largely outside the scope of the state, DHHS’s Program Monitoring tools can and must be revised to fully support the state’s new practice framework and the 20 goals identified during the theory of change meeting, particularly those outcomes where NC does not have administrative data available to fully measure and monitor performance. Over time, these reviews could become more tailored and targeted based on emerging issues throughout North Carolina and even within individual regions, and include stakeholder interviews.</p>	DHHS & County DSS
<i>Mid-term</i>		
34.	<p><b>Track progress on identified outcomes based on individual county performance in recent years.</b> State and regional monitoring of county progress toward desired outcomes should be individualized based on a county’s own performance, not a state metric or similar sized county performance. Some measures currently being used are low frequency events in smaller counties, so the reliability of data or result may be misleading without providing context. Once outcome measures have been defined, baselines should be created for each geographic entity (county, region, state) and each county should be given an achievable performance improvement goal both with respect to each individual measure and aggregate achievement across all measures. Jurisdictions with high-performing results in certain areas should not be penalized for maintaining high performance that may be slightly lower than previous performance, however continued decreases in performance need to be monitored and addressed.</p>	DHHS & County DSS
<i>Long-term</i>		
35.	<p><b>Conduct an analysis of the financing structure of the child welfare system and make recommendations of how to maximize federal dollars, including tying performance to financing in order to support improvements.</b> As state and local staff get more comfortable and accustomed to relying on data evidence to understand program performance, we recommend exploring incentives that more directly align system financing with core child welfare outcomes.</p>	DHHS
<i>Long-term</i>		

**Recommendations: Social Services System Transparency and Wellness Dashboard**

See the Social Services Preliminary Reform Plan.

### ***F. Capable and Stable State, Regional and County Child Welfare Workforce***

This reform effort can only be successful if the workforce is ready and able to implement changes and is capable of sustaining improved practice. Key to being able to do this is to reduce turnover and build the skill set of the staff hired to do the job. This was a key goal in the Child Welfare Strategic Plan: “North Carolina’s child welfare workforce is culturally aware, supported in practice, and instrumental in the development of an improved, responsive system.”<sup>28</sup> Critical to the theory of change is developing and maintaining a stable, capable child welfare workforce that is well prepared to provide trauma-informed, family-centered, culturally-competent services that focus on safety, permanence and wellbeing. CSF gathered information on the workforce through the child welfare staffing survey and through multiple focus groups and interviews with state and county staff at all levels including DSS directors, child welfare supervisors, and child welfare line staff. Multiple strengths were apparent throughout including:

- ◆ The openness of staff and their commitment to serving children and families;
- ◆ The pride that directors, supervisors and staff have in the work they do; and
- ◆ The high percentage of staff who reported feeling supported by their supervisor.

CSF also learned of multiple challenges facing North Carolina including:

- ◆ Child Welfare staff feel overwhelmed, unable to complete the work they are assigned, and struggling to manage a work-life balance. This is true despite the fact that, with the notable exception of CPS assessment, Child Welfare met caseload staffing standards in 2017 and state caseload standards (10 CPS assessments; 10 In-Home families; 15 foster children) are largely in line with national standards.
- ◆ Over the past 10 years, multiple new requirements for activities and documentation have been added for workers providing CPS assessments, CPS In-Home Services and Foster Care. Many of the add-ons have a solid rationale as part of program improvement plans, in response to adverse events, or in response to external factors such as changes in the behavioral health system. However, nothing substantive has been taken away and the caseload standards have not been adjusted. The results include:
  - Staff burnout;
  - Staff trauma and turnover;
  - Staff feeling torn between working with families and completing paperwork; and
  - Failure to use critical thinking and to provide services that are trauma informed, family centered, and culturally competent.
- ◆ A statewide shortage exists in CPS assessment positions, exacerbated by higher turnover in those positions which is likely due to stress. Individual counties experience staff shortages in other functions despite statewide average. Many county DSS directors experience difficulty getting approval from county managers and commissioners for new positions when they are needed to meet rising caseloads. One reason is that – with the exception of federal IV-E funding, federal, and state child welfare funding is fixed and already fully utilized. A county

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<sup>28</sup> Child Welfare Strategic Plan, Session Law 2016-94, Section 12C.1.(b), p.6

receives some additional IV-E revenue when it adds foster care and CPS In-Home positions, but no new funding at all when it adds CPS assessment positions. The fact that new CPS assessment positions – absent a new state allocation – are funded entirely through county dollars is probably the reason that staffing shortages are focused in CPS assessment.

- ◆ An annual turnover rate among county child welfare line staff positions of 29 percent, based on the staffing survey. The turnover rate is not broken down by function but the percentage of budgeted FTEs unavailable for duty was highest (18%) of CPS assessment positions were unavailable for duty in 2017 and next highest (11%) in foster care and CPS In-Home Services.
- ◆ Counties vary in their ability to offer competitive compensation with starting salaries in the lowest paying counties in the low 30s compared to the high 40s or even 50s in the highest paying counties. The result is that low paying counties become feeder counties, hiring less qualified workers and losing them to neighboring counties after they have experience.
- ◆ The state is perceived as unable to pay salaries competitive enough to hire top county staff. Counties are concerned new regional office staff will not have the knowledge and competence needed to do the job and command respect.
- ◆ Although North Carolina has clear requirements for pre-service and ongoing training and the descriptions of the training seem the description of the approach to learning and the content offered sound effective and useful, the quality of the training programs described and the participants experience with these trainings are greatly disconnected.
- ◆ Although the description of the training is often described as ‘skill-based,’ feedback from participants and a review by the capacity building center suggests the training provides information rather than skills and lacks a CQI process for evaluating whether the training is effective, whether learning is transferred into practice, and whether training results in improved outcomes for children and families. Trainings appear too often to be implemented as stand-alone activities rather than being implemented into a process where participants are supported to practice over time.
- ◆ The state has multiple contracts involving significant resources with universities and others to develop and provide training. Satisfaction with that training is uneven.

### **Recommendations: Competitive Salaries**

Please see the Social Services Reform Plan for more details on salary recommendations.

**Recommendations: *Manageable Workloads***

<p>36.</p>	<p><b>Take concrete steps to reduce paperwork and streamline requirements (create a stop-doing list) to increase the time caseworkers have available to work with families.</b></p> <p>It is our observation that there is heavy emphasis on paperwork required for the primary purpose of demonstrating compliance. There has been a consistent message from counties that workers cannot complete requirements even with a manageable caseload that in CPS assessment worker caseloads are above standards, and that workers are checking boxes, choosing between making contacts and documentation, and failing to do critical thinking</p>	<p>DHHS &amp; County DSS</p>
<p style="text-align: right;"><i>Short-term</i></p>		
<p>37.</p>	<p><b>Consider strategies for organizing staffing or workloads to allow more intensive effort during the first 30-days of foster care.</b> A great deal is required of foster care caseworkers in the first 30 days of care with respect to the child, the placement provider, the parents, visitation, shared parenting, and relative search and notification, and going to court. It is a critical time for placement stability, engaging parents in reunification, and reducing trauma. Program monitoring makes clear that counties are not accomplishing all the required tasks, especially tasks such as relative notification and shared parenting.</p>	<p>DHHS &amp; County DSS</p>
<p style="text-align: right;"><i>Mid-term</i></p>		
<p>38.</p>	<p><b>Changes are necessary to allow CPS assessors, CPS In-Home caseworkers, and foster care caseworkers to meet job expectations when caseloads are at standard levels.</b> Because North Carolina’s current caseload standards are consistent with current national practices, CSF recommends that the state and counties begin by immediately conducting a review of the current job requirements prior to determining whether new standards need to be recommended. The review teams for each functional area should include leaders, supervisors, and front-line workers who engage in a structured “leaning” process to identify the activity and documentation requirements are truly necessary and which ones are duplicative or can be eliminated. The review should be conducted in the context of what activities are critically necessary to achieve safety, to provide effective trauma-informed, family-centered, and culturally-competent services, and to comply with federal and state law. After the “leaning” process, the state together with counties should conduct a study of the time necessary to meet the streamlined requirements and whether a recommendation to change caseload standards is needed.</p>	<p>DHHS</p>
<p style="text-align: right;"><i>Long-term</i></p>		

**Recommendations: *Professional Development and Training***

39.	<p><b>Pre-service training needs to be redesigned to better prepare a workforce, the majority of whom are coming to child welfare without a social work degree.</b></p> <ul style="list-style-type: none"> <li>▪ Preservice training needs to teach not only the “what” of child welfare but also the “why” and “how.”</li> <li>▪ Strong modules on safety-focused decision-making and trauma-informed, family-centered, and culturally-competent practice needs to be included in pre-service training that includes key values and teaches skills, behaviors, and critical thinking.</li> </ul>	DHHS
<i>Short-term</i>		
40.	<p><b>Training should be integrated into a larger strategy for professional development and a diverse, representative design team should be charged with co-creating an approach for designing and developing learning programs (preparation, training, coaching, transfer of learning and support) as opposed to stand-alone training modules.</b> The team should co-create clear roles and responsibilities of involved state, regional and county stakeholders (staff, supervisors, mentors, coaches, trainers, curriculum designers) for learning programs for new workers, experienced workers, new supervisors, experienced supervisors and county, regional, and state leaders.</p>	DHHS
<i>Short-term</i>		
41.	<p><b>Make necessary revisions to existing university contracts for training and professional development to align with the newly-developed learning program.</b> The Central Office should evaluate the performance and effectiveness of providers with current training contracts, and alignment of their contract deliverables with the learning program. Based on this evaluation and the new learning program, the Central Office can consider changes to its contracting strategy and its contracts.</p>	DHHS
<i>Mid-term</i>		
42.	<p><b>A process for continuous evaluation and revisions of learning programs should be integrated into professional development to determine what is needed, how well it is working, and to make improvements.</b> Continuous evaluation processes should measure feedback on training and development from participants, knowledge, and skill acquisition, key behaviors of staff, and child and family outcomes.<sup>29</sup> Continuous evaluation and DSS CQI data should be used throughout design, development, revision, and implementation of learning programs.</p>	DHHS
<i>Mid-term</i>		

<sup>29</sup> Kirkpatrick, D.L. (1996). Evaluation. In R.L. Craig, & L.R. Bittel (Eds.), *Training & Development Handbook*. American Society for Training and Development, New York: McGraw-Hill Book Co.

**Recommendations: Attracting and Retaining Workers**

43.	<p>The state needs to develop a recruitment and retention strategy for child welfare caseworkers that includes positive and realistic messaging about child welfare caseworkers and the role of child welfare supporting children and families. Too much of the current media coverage of child welfare is focused on tragedies and the removal of children from families.</p>	DHHS
<i>Mid-term</i>		
44.	<p>The Child Welfare Collaborative should be revived and retooled so that it benefits all counties, not just those neighboring state universities with collaborative programs. The collaborative, when it included stipends, was an extremely valuable tool for attracting and preparing well-trained child welfare workers. There should be an emphasis on the benefits for rural and small counties and focusing federal IV-E funds in this direction</p>	DHHS
<i>Mid-term</i>		
45.	<p>Strategies should be implemented to retain child welfare caseworkers. In addition to manageable workloads, workers need supportive leaders and supervisors who create a safe learning environment. Attention needs to be given to secondary trauma that workers experience and to creating a less stressful work environment that includes structured protected time in which workers can effectively manage the demands of their caseloads. Caseworkers seek effective tools to do their jobs (such as cell phones and laptops) and opportunities for professional growth. This varies greatly from county to county and the state should explore funding opportunities to assist smaller less resourced counties.</p>	DHHS
<i>Short-term</i>		

***G. Capacity to Implement Effectively***

The implementation process itself is critical to ensuring that the improvement initiatives are executed with fidelity to the desired improvement, that the groundwork and planning to support the initiatives are in place, and that the process of implementation occurs at a pace that allows for monitoring and adjustments along the way. These recommendations are designed to ensure the next phase of work in North Carolina is aligned with the evidence that exists about effective implementation.

**Recommendations**

46.	<p>Create a teaming structure for statewide decision making that will provide input and feedback loops from key stakeholders that will also allow for nimble and efficient decision-making at the state level. With several major system reforms taking place within DHHS and the Department of Juvenile Justice and Delinquency Prevention (DJJDP) (e.g. Medicaid transformation and Raise the Age for Juvenile Justice), this structure is needed.</p>	CIT
<i>Short-term</i>		



*H. Child Fatality Review Process*

**Recommendations**

47.	<p><b>CSF endorses the process that the state Child Fatality Prevention Task, with the full involvement of DHHS, is taking to work with participants and stakeholders of the child fatality review and prevention system to:</b></p> <ul style="list-style-type: none"> <li>▪ <b>Simplify the structure and processes of the system.</b></li> <li>▪ <b>Improve the use the data.</b></li> <li>▪ <b>Improve support of and collaboration between review teams.</b></li> </ul> <p>These steps are all logically connected to the system goal of using information from fatality reviews to make changes within and across systems that will reduce child deaths and promote child health and wellbeing.</p>	DHHS
<i>Mid-term</i>		
48.	<p><b>Consider consolidating state-level responsibility for child fatality reviews within a single entity of DHHS to create a central point of accountability for review processes and to simplify review reporting and feedback expectations.</b> At the August stakeholder meeting, ideas were proposed both for creating a new office and for locating responsibility within an existing system entity.</p>	DHHS
<i>Mid-term</i>		
49.	<p><b>Consolidate into a single review the state-led intensive and local team reviews required when children brought to the attention of the Child Welfare system within the previous 12 months die of suspected abuse or neglect.</b> The review can follow the current intensive review process, led by a state coordinator, with review team members appointed by the local team chair. Detailed and highly-personal information should continue to be excluded from publicly available findings and recommendations. However, DHHS should continue efforts to develop a mechanism for capturing, aggregating, and analyzing the rich, detailed information that is gathered about families and their contacts with community agencies so that it can inform statewide strategies for prevention, improvements within the child welfare system, and improved cross-system collaboration.</p>	DHHS
<i>Mid-term</i>		
50.	<p><b>Continue to explore options for streamlining local team structure with input from local teams.</b> Options to explore that were raised at the August stakeholder meeting include:</p> <ul style="list-style-type: none"> <li>▪ Separating the CCPT and/or the CRP responsibilities for reviewing active child welfare cases from the child fatality review process and having CCPTs and/or CRPs report directly to state DSS. This would have possible advantages of simplifying reporting and feedback loops and assuring a focus on review of active child welfare cases but might be seen as requiring additional local teams in some counties.</li> <li>▪ Consider giving smaller counties the option of forming regional local teams</li> <li>▪ Reconsider whether integrating CRPs into every local team is the most efficient and effective way of meeting the federal requirement for child welfare citizen review panels.</li> </ul>	DHHS
<i>Mid-term</i>		