New Directions for North Carolina

A Report of the NC Institute of Medicine Task Force on Child Abuse Prevention

Update 2008

North Carolina Institute of Medicine

Prevent Child Abuse North Carolina

North Carolina Institute of Medicine
In Collaboration With
Prevent Child Abuse North Carolina and the
Child Maltreatment Prevention Leadership Team
Presents

New Directions for North Carolina

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Prevent Child Abuse North Carolina

Dear Child Abuse Prevention Task Force members, Steering Committee members, and interested persons:

The purpose of this update is to inform policy makers, stakeholders, and the public on the progress of recommendations made by the Child Abuse Prevention Task Force resulting in the *New Directions for North Carolina* report. This update contains a description of progress on the recommendations from *New Directions* as well as other primary prevention efforts in child maltreatment in North Carolina. ***In the first two years since the report was issued, progress has been made on 75% of the Task Force's recommendations.***

This progress would not be possible without the time, energy, and commitment of individuals, public and private organizations throughout the state, and the generous funding and support of The Duke Endowment. Many of you have taken time in your busy schedules to contribute to this initiative—whether participating on the NC Institute of Medicine Task Force on Child Abuse Prevention, serving on the Child Maltreatment Prevention Leadership Team, and/or helping implement the recommendations as part of one of the work groups. In addition, hundreds of others have worked tirelessly to forge new partnerships to better serve North Carolina families. We want to thank all of the people who have dedicated themselves to the wellbeing of children throughout the state. In particular, the NC IOM would like to thank Catherine Joyner, Executive Director of the Child Maltreatment Prevention Leadership Team, for compiling much of the information included in this report.

Thank you again for your efforts to fully realize the goals of primary prevention of child maltreatment as outlined in the *New Directions* report.

Sincerely,

Pam Silberman, JD, DrPH
President and CEO
NC Institute of Medicine

TABLE OF CONTENTS

Topic	Page
Introduction **Child Maltreatment in North Carolina: An Update on the Data……...**	**2**
Leadership for Child Maltreatment Prevention.……...…….. Recs. 4.1, 4.2	**4**
Development of a Surveillance System for Child Maltreatment Incidence……... Rec. 5.1	**6**
Changing Social Norms to Support Healthy Parenting and Strong Families…... Recs. 6.1, 6.2	**8**
Increasing the Use of Evidence-Based and Promising Programs……... Recs. 7.1 – 7.7	**11**
Enhancing Practice within Systems and Programs Serving Families and Children……... Recs. 8.1 - 8.22	**20**
Increasing Funding for Child Maltreatment Prevention…… Recs. 9.1 – 9.3	**37**
Appendix A: Child Maltreatment Leadership Team……..	**44**
Appendix B: Surveillance Work Group…….....	**46**
Appendix C: Community Violence Prevention Work Group……	**47**
Appendix D: Maternal Depression Work Group……	**48**
Appendix E: Social Emotional Design Team……...	**49**
Appendix F: The Alliance for Evidence-Based Family Strengthening Programs	**50**
Appendix G: Alliance for Evidence-Based Strengthening Families Programs Logic Model……	**51**
Appendix H: Glossary of Programs and Activities……..	**52**
Appendix I: List of Acronyms……	**57**

INTRODUCTION
CHILD MALTREATMENT IN NORTH CAROLINA: AN UPDATE ON THE DATA

Maltreatment is a Public Health Epidemic

"The incidence of child maltreatment in North Carolina is so high that if it were an illness, it would be classified as an epidemic."[1]

Child maltreatment is a serious public health problem with extensive short- and long-term health consequences. The short-term effects of child abuse and neglect include the physical and emotional harm that abuse causes for the child; the disruption to family life and cohesion; and the strain on scarce community resources resulting from the response to reports of abuse. Long-term consequences are most costly in both human and monetary terms. Children who are abused are more likely to abuse their own children; experience lifelong chronic health and medical problems (e.g. obesity, drug abuse, heart disease); form broken and dysfunctional families; and draw on community resources for law enforcement, unemployment, social services, and health care.[2]

Child maltreatment is a problem affecting the lives of tens of thousands of children in North Carolina annually. In SFY 2007, 119,000 children were subject to an investigative or family assessment. 15,000 children were substantiated as abused or neglected under the investigative assessment and 13,000 children were found to need services in the family assessment. In addition, the Division of Social Services recommended that 28,000 children and their families receive services such as parent training, child care subsidies, or other supports to improve the safety and wellbeing of children in their homes and prevent future neglect or abuse.[3]

North Carolina is Making Progress

In 2005, the North Carolina Institute of Medicine and the Child Abuse Prevention Task Force issued a report, *New Directions for North Carolina*, that included 37 recommendations to enhance the capacity of North Carolina state and community-based agencies to strengthen families and prevent child maltreatment. The recommendations provide a vision for prevention activities in North Carolina, with a focus on developing coordinated efforts to improve prevention services across the state.

Since the report was issued, progress has been made on 75% of the recommendations. Although everything that has been accomplished is exciting and commendable, much remains to be done. To ensure that progress continues, the Child Maltreatment Prevention Leadership Team, a public-private partnership composed of 30 members who represent public agencies, state-level and community-based nonprofit agencies, parents, and university faculty, will continue to work with state and community-based agencies to oversee implementation of the rest of the Task Force recommendations to reach the goal of having a comprehensive child maltreatment prevention system in North Carolina.

Structure of the Report

The current report describes the actions that have been taken to implement the Task Force's recommendations since the 2005 release of the report. This update follows the same organizational structure as in the original report, with recommendations falling into six broad areas: leadership for child maltreatment prevention, development of a surveillance system, changing social norms to support healthy parenting and strong families, increasing the use of

evidence-based and promising practices, enhancing practice within systems and programs serving families and children, and increasing funding for child maltreatment prevention. The state has begun to implement many different evidence-based programs and promising practices. These programs, along with different agencies working directly or indirectly in child maltreatment prevention, are described in Appendix H. In addition, Appendix I includes a list of acronyms used in the report.

NORTH CAROLINA INSTITUTE OF MEDICINE
2005 TASK FORCE ON CHILD ABUSE PREVENTION
2007 UPDATES TO RECOMMENDATIONS

Total recommendations: 37
Priority recommendations: 14

- ***Fully implemented*:** 6 (16%) of all recommendations, 3 (21%) of priority recommendations
- ***Partially implemented*:** 22 (59%) of all recommendations, 8 (57%) of priority recommendations
- ***Not implemented*:** 9 (24%) of all recommendations, 3 (21%) of priority recommendations

LEADERSHIP FOR CHILD MALTREATMENT PREVENTION

Recommendation 4.1 (Priority Recommendation)
The NC General Assembly should establish a standing Child Maltreatment Legislative Oversight Council, with diverse membership representation and strong leadership from state and local agencies and community providers. The Child Maltreatment Legislative Oversight Council should specifically focus on preventing maltreatment before it occurs. The Task Force on Child Abuse Prevention supports SB 871/HB 1530 *Establish Child Maltreatment Prevention Council* which outlines membership and responsibilities of the Legislative Oversight Council.

A. Responsibilities of the Legislative Oversight Council should include:
   i. Overseeing implementation and evaluation of the NC IOM Task Force plan.
   ii. Ensuring high visibility and attention to the issue of child maltreatment prevention.
   iii. Ensuring shared planning, implementation, and accountability for child maltreatment prevention efforts among appropriate North Carolina state governmental agencies.
   iv. Identifying additional opportunities to enhance child maltreatment prevention efforts in existing state and local systems that serve families and children.
   v. Establishing and overseeing mechanisms to support evidence-based and promising child maltreatment prevention and family strengthening programs in North Carolina.
   vi. Ensuring sufficient funding for child maltreatment prevention activities identified in the Task Force on Child Abuse Prevention plan and the Child Maltreatment Prevention Legislative Oversight Council's ongoing work.

B. The NC General Assembly should appropriate $250,000 per year for the staffing and operational support of the Child Maltreatment Prevention Legislative Oversight Council. Staff for the Child Maltreatment Prevention Legislative Oversight Council will reside in the NC Division of Public Health and will include an executive director and staff support.

Not Implemented
SB 871/HB 1530 were introduced in the 2005 legislative session. These bills would have created a legislative oversight council.[4] These bills were not passed in the 2005 session and were not reintroduced in subsequent sessions.

Recommendation 4.2 (Priority Recommendation)
The NC Department of Health and Human Services, Division of Public Health should develop a Child Maltreatment Prevention Leadership Team to assist in supporting the work of the Child Maltreatment Prevention Legislative Oversight Council.

- **A. The Child Maltreatment Prevention Leadership Team should be a true public-private partnership between state and local agencies, nonprofits, and other community organizations that works to coordinate efforts, maximize funding, and promote shared accountability among governmental and private organizations.**
- **B. The Child Maltreatment Prevention Leadership Team will have primary responsibility for:**
  - **i. Providing expertise, technical assistance, and support to the Child Maltreatment Prevention Legislative Oversight Council.**
  - **ii. Implementing and evaluating the Task Force on Child Abuse Prevention plan and recommendations from the Child Maltreatment Prevention Legislative Oversight Council.**
  - **iii. Ensuring shared decision-making, planning, implementation, funding, and accountability of child maltreatment prevention efforts among appropriate state governmental agencies.**
  - **iv. Developing strategies to collaborate with local community providers in implementing the recommendations of the Task Force on Child Abuse Prevention.**
  - **v. Developing strategies to ensure collaborative decision-making, planning, implementation, and accountability at the state and local levels.**
  - **vi. Identifying and promoting funding strategies for child maltreatment prevention activities outlined in the Task Force for Child Abuse Prevention plan and its ongoing activities.**
  - **vii. Identifying trends, emerging issues, and best practices and bringing them to the attention of the Child Maltreatment Prevention Legislative Oversight Council.**
  - **viii. Reporting to the Child Maltreatment Prevention Legislative Oversight Council and the Secretary of the NC Department of Health and Human Services about its progress in achieving these goals. These reports should also be provided to the Superintendent of Public Instruction and to the Secretary of the NC Department of Juvenile Justice and Delinquency Prevention.**
- **C. The Child Maltreatment Prevention Leadership Team should include diverse representation from the NC Department of Health and Human Services, various state agencies and departments, universities, local agencies, nonprofits, other private organizations, and families.**
- **D. The Executive Director of the Child Maltreatment Prevention Legislative Oversight Council and a representative of PCA North Carolina should serve as co-chairs of the Child Maltreatment Prevention Leadership Team.**

<u>Fully Implemented</u>

The NC Division of Public Health and Prevent Child Abuse North Carolina (PCA North Carolina), with funding from the NC Division of Public Health and support from The Duke Endowment, convened the Child Maltreatment Prevention Leadership Team in January 2006. The Leadership Team is a multidisciplinary, interagency collaboration designed to oversee the implementation of recommendations from the NC Institute of Medicine's Task Force on Child Abuse Prevention. Co-chaired by Kevin Ryan, Chief of the Women's and Children's Health Section in the NC Division of Public Health, and Michelle Hughes, Vice President for Programs at PCA North Carolina, the Leadership Team is a public-private partnership composed of 30 members who represent public agencies, state-level and community-based nonprofit agencies,

parents, and university faculty. The General Assembly appropriated $90,000 in recurring funds in 2006 to the NC Division of Public Health to fund a staff member to serve as executive director of the Leadership Team.[5]

The Leadership Team began with two primary tasks. First, the Leadership Team prioritized the Task Force's 37 recommendations in order to establish the Leadership Team's work plan. Second, the Leadership Team developed an infrastructure to begin work on the recommendations of the Task Force.

The Leadership Team meets on a regular basis, approximately every 10-12 weeks. Five work groups have been formed, each of which meets on a more frequent basis. Other work groups will be formed as needed in 2008. The various work groups are composed of diverse membership and include members of the Leadership Team, experts in the various issues, community practitioners, and family or consumer representatives. A list of current members of the Leadership Team is included in Appendix A. The members of the work groups are listed in Appendices B-D.

DEVEOPMENT OF A SURVEILLANCE SYSTEM FOR CHILD MALTREATMENT INCIDENCE

Recommendation 5.1 (Priority Recommendation)
The NC Division of Public Health's Injury and Violence Prevention Branch should develop a North Carolina data collection system for monitoring child abuse prevention through the analysis of the incidence of maltreatment as well as through indicators, including risk and protective factors, that are associated with child maltreatment. A Technical Advisory Committee should be established by the Injury and Violence Prevention Branch and should include representatives from the NC Division of Social Services, NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, the NC Division of Child Development, PCA North Carolina, NC Division of Public Health - Women's and Children's Health Section, NC State Center for Health Statistics, law enforcement agencies, organizations housing relevant databases from which child maltreatment data will be collected, and other researchers. This system will:

A. Monitor the incidence of child maltreatment, including maltreatment perpetrated by family caregivers and non-family caregivers.
B. Monitor the incidence of child fatalities due to neglect.
C. Use multiple sources of data to provide a picture of child maltreatment in North Carolina.
D. Identify science-based measures for collecting indicators of, and risk and protective factors associated with, child maltreatment.
E. Collect, summarize, and report data at the state and county level on a yearly basis, to measure trends over time.
F. The NC Division of Public Health should work with the Child Maltreatment Prevention Leadership Team to secure funding for the surveillance system.

The NC Division of Public Health's Injury and Violence Prevention Branch should report progress toward implementing this recommendation to the Child Maltreatment Prevention Leadership Team by January 2006 and annually thereafter.

Partially Implemented
The Surveillance Work Group was convened in July 2006 to help implement this recommendation. The work group is co-chaired by Sharon Schiro, PhD, a contracted employee of

the Injury and Violence Prevention Branch within the NC Division of Public Health and UNC-CH faculty member, and Adam Zolotor, MD, from the UNC School of Medicine. The work group consists of representatives from various data collection systems as well as representatives from state agencies and universities. A list of current members of the Surveillance Work Group is included in Appendix B.

The Surveillance Work Group is charged with assisting the NC Division of Public Health in developing a more comprehensive child maltreatment surveillance system in North Carolina by linking existing sources of data and connecting existing surveillance strategies. Most data on child maltreatment comes from investigations by child protective services. This undercounts the true prevalence of maltreatment in the general population, as not all maltreatment incidences are reported and, even if reported, not all come within the legal jurisdiction of the Child Protective Services system. While there are many sources of data that include information on child deaths or morbidities caused by child maltreatment, these data sources are not all linked. Strengthening and linking these data sets could result in better data describing the prevalence and incidence of child maltreatment in North Carolina.

Child fatality data: The Surveillance Work Group first assessed the current surveillance mechanisms for child fatalities resulting from maltreatment. The Child Fatality Prevention Team, which is part of the Child Fatality Prevention System,[6] is located in the Office of the Chief Medical Examiner and is charged by statute with reviewing all deaths of children under 18 years old that are investigated by the NC Medical Examiner system.

The Surveillance Work Group worked with the North Carolina Child Fatality Prevention Team to review the current collection system for child fatalities. The State Child Fatality Prevention Team has been collecting exhaustive mortality data in North Carolina including deaths resulting from neglect. The 2005 report from the Child Fatality Prevention Team included child deaths due to neglect and 2006 report will also include this information. Despite limitations cited by the Child Fatality Protection Team in accurately reporting child deaths due to neglect, inclusion of this type of death provides a more accurate representation of deaths due to maltreatment. The State Child Fatality Prevention Team will customize data-driven reports which will guide recommendations for legislative and public policy initiatives for both the Child Maltreatment Prevention Leadership Team and the Child Fatality Task Force. The Surveillance Work Group will continue to work cooperatively with the Child Fatality Prevention Team to help support and strengthen existing surveillance mechanisms for child maltreatment fatality data.

Child morbidity data: Currently the Surveillance Work Group is focusing efforts on the morbidity data sources within North Carolina. Many cases of maltreatment are never reported to child protection agencies. Thus, it is important to examine other data sources to determine whether these are appropriate sources to identify unreported instances of child maltreatment. The Surveillance Work Group is currently identifying and determining the utility of various data sources, including the North Carolina Disease Event Tracking and Epidemiologic Collection Tool (NC DETECT), the North Carolina Emergency Department Database (NCEDD), the North Carolina Hospital Emergency Surveillance System (NCHESS), the Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Surveillance (YRBS), North Carolina Child Health Assessment and Monitoring Program (NC CHAMP), and other school system and law enforcement data. Additionally, the work group is developing uniform definitions of child maltreatment and is following the Centers for Disease Control and Prevention's development of uniform definitions of child maltreatment.

The work group has identified and begun to address limitations in these different data sources, such as the inability to use recidivism as a marker for potential abuse in the NCHESS dataset due to lack of identifiers, inability to link datasets, and the potential for duplicated counts across datasets due to lack of identifiers. The work group plans to complete the first phase of their work and make recommendations to the Leadership Team by March 2008.

The Centers for Disease Control and Prevention (CDC) awarded grants to five other states to develop and implement mortality and morbidity surveillance for child maltreatment.[7] Through these CDC grants, California, Michigan, Minnesota, Missouri, and Rhode Island will compare alternative approaches to state-level surveillance for fatal and nonfatal child maltreatment and will test methods for violence surveillance of all ages. This project is addressing the pressing need for a practical surveillance system that can be implemented at the state level. It will also assess the helpfulness of various data sources such as hospitals, child protective services, law enforcement, child fatality review, and medical examiner and coroner reports. The Surveillance Work Group will use the results from these other states to help guide the development of North Carolina's child maltreatment surveillance system.

Development of a comprehensive child maltreatment surveillance system will required a significant investment by North Carolina. Current cost estimates provided by the CDC range from $300,000 to $400,000 to develop the system. The estimates for the ongoing maintenance of a child maltreatment surveillance system have not yet been developed. Recommendations for required resources in order for it to be fully implemented were made to the NC Division of Public Health in October 2007.

CHANGING SOCIAL NORMS TO SUPPORT HEALTHY PARENTING AND STRONG FAMILIES

Recommendation 6.1 (Priority Recommendation)
PCA North Carolina, in partnership with the NC Division of Public Health, should take the lead in developing a public education and marketing campaign aimed at encouraging community members to support parents by promoting positive parenting behaviors and increasing public support for programs and resources aimed at strengthening positive family interaction. This initiative should use the latest research on public awareness efforts for child maltreatment prevention and should be coordinated with the efforts of the Child Maltreatment Prevention Leadership Team to promote positive parenting behaviors, increase protective factors, and reduce risk factors. PCA North Carolina and the NC Division of Public Health should report on the progress towards implementing this recommendation to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.

Partially Implemented
There are two ongoing projects in North Carolina which are strategies for implementing this recommendation: A strategic frame analysis reframing (a multi-disciplinary, multi-method approach to communications)[8] and the Period of PURPLE Crying.: Keeping North Carolina Babies Safe. PCA North Carolina has taken the lead role in addressing the reframing project.

Reframing: In fall 2005, with funding from the Children's Trust Fund, PCA North Carolina convened a small committee of communications experts and Leadership Team members to develop a set of print and television ads that asked parents to reach out for support when under

stress as a strategy to increase social support and reduce risk for maltreatment. The target population was middle-income mothers between the ages of 25 and 30 with at least one child under five years of age, who worked at least part-time outside the home. Several messages were tested including those that encourage mothers to join a parent education class, join a parent support group (e.g., a mom's group), or speak with their pediatrician. PCA North Carolina worked with a social marketing firm to test these ads with several economically and ethnically diverse focus groups. Originally, findings from these focus groups were going to be used to help direct a larger statewide campaign about positive parenting. However, the focus group findings did not find this message would be effective in reaching the targeted group of mothers, and PCA North Carolina decided to return to "framing" issues before developing another campaign.

Changing the public discourse on any given issue requires an appreciation of how issues are defined and interpreted by the public. PCA North Carolina felt that additional exploration of potential frames for child maltreatment prevention would be a wiser investment of communications resources and would inform future public awareness campaigns and increase their effectiveness.

PCA North Carolina is currently in conversation with PCA America and the FrameWorks Institute to see if these national partners will support further work around "reframing" at the national level and in North Carolina. In North Carolina, the goal would be for key stakeholders in the Leadership Team, along with other children's advocacy groups, to become familiar with strategic frame analysis—a multi-disciplinary, multi-method approach to communications—and to better understand how the messages being used by different stakeholders are complementary or dissimilar. A similar initiative called "study circles" is being facilitated by the FrameWorks Institute in other states. The FrameWorks Institute began working with North Carolina in February 2008.[9]

Period of PURPLE Crying Project: The Period of PURPLE Crying project is a joint project with the UNC-CH Injury Prevention Research Center, National Center on Shaken Baby Syndrome, and Center for Child and Family Health. This project is funded by the Centers for Disease Control and Prevention, Doris Duke Charitable Foundation, and The Duke Endowment. This statewide project, which will be implemented in three phases, is based on new educational materials for parents that were developed by the National Center on Shaken Baby Syndrome. The materials help parents understand the frustrating features of crying that can lead to shaking or other types of abuse, in order to create a change in the way that parents view crying. The goal of this project is to prepare parents to respond safely to infant crying and to reduce hospital admissions and deaths from abusive head trauma.

This project will introduce the Period of PURPLE Crying program to North Carolina parents after a hospital delivery. Parents will be given a DVD to take home for their own use, as well as to share with other caregivers. Additionally, the message of Period of PURPLE Crying will be reinforced at well-child visits. This message will be expanded using a statewide media campaign. Implementation of this project began in the Central Region with 30 hospitals in January 2008. The first phase will also include the pilot sites of Cape Fear, Asheville, Wolmack, and Onslow, all of which have military bases. This is critical as research indicates that counties with military bases have higher rates of child abuse deaths than do counties without military bases. A 2004 study funded by the North Carolina Governor's Crime Commission and the North Carolina Child Advocacy Institute found that the two counties in which Fort Bragg, Pope Air Force Base, Camp LeJeune, and New River Air Station are located had the highest rates of child abuse deaths in the state.[10] This is in contrast to 26 other counties that had no child abuse murders for children age 10 and under.

Recommendation 6.2 (Priority Recommendation)
PCA North Carolina, in collaboration with the NC Division of Public Health, NC Division of Social Services, NC Coalition Against Domestic Violence, NC Domestic Violence Commission, NC Partnership for Children, NC Department of Public Instruction, NC Department of Juvenile Justice and Delinquency Prevention, and Mediation Network of North Carolina should work with and support ongoing grassroots efforts (and establish new ones where necessary) to establish community norms that support families and healthy child development and that reduce social acceptance of violence as an appropriate response to interpersonal conflict. Issues such as the acceptance of corporal punishment in North Carolina schools, the glamorization of violence, and the presence of violence in the media should be examined in these efforts. PCA North Carolina, the NC Division of Public Health, and other appropriate agencies shall report on the progress towards implementing this recommendation to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.

Partially Implemented
The Task Force on Child Abuse Prevention understood that there are many commonalities, particularly at community and society levels, between multiple forms of violence. Though people tend to compartmentalize different types of violence, emerging national research suggests that domestic violence, sexual violence, child maltreatment, youth violence, and other violence subtypes share similar risk and protective factors and that select evidence-based strategies may be effective at decreasing risk across multiple subtypes of violence. Thus, the Leadership Team formed a work group, the Community Violence Prevention Work Group, to identify and pilot community-based strategies aimed at decreasing the rate of all types of violence in local communities. The Community Violence Prevention Work Group is currently chaired by Elizabeth Knight of the UNC Injury Prevention Resource Center and Gibbie Harris, director of the Wake County Department of Health. A list of current members of the Community Violence Prevention Work Group is included in Appendix C.

With support from The Duke Endowment, the work group contracted with an experienced violence researcher to investigate community- and society-level risk factors for violence and protective factors against violence. Particular attention was given to factors that are common among multiple subtypes of violence. The literature review was completed in May 2007. Using findings from the literature review, the work group developed a concept paper outlining specific public health strategies that was completed in February 2008. This concept paper will be used to guide the development of violence prevention strategies for communities. Additionally, the work group will develop violence prevention messages and violence prevention programs that will be piloted in two communities—an urban and a rural community. Finally, a subgroup is currently working on a social capital mapping toolkit[11] which will be made available to communities.

The work group is outlining short-term and long-term outcomes. Short-term outcomes include the concept paper and social capital toolkit. Long-term outcomes include violence prevention messages and pilot programs. This recommendation will require funding for in order for it to be fully implemented.

The overlapping of sexual violence, intimate partner violence, and child maltreatment produces fertile ground for collaboration. To avoid duplication of other prevention efforts and initiatives in North Carolina, the Community Violence Prevention Work Group is collaborating with the NC Sexual Violence Prevention Team (through the Rape Prevention and Education and EMPOWER

Program[a] located in the Injury and Violence Prevention Branch, NC Division of Public Health) and the NC Coalition Against Domestic Violence DELTA Program. [12]

INCREASING THE USE OF EVIDENCE-BASED AND PROMISING PRACTICES

Increasingly, policy makers, researchers, and practitioners are focusing on the link between policy, research, and funding. Promoting evidence-based and promising practices is one way to ensure that policies and funding are tied to programs and practices that have been evaluated through research. Evidence-based programs are those that have been studied in both controlled clinical trials as well as community settings and have demonstrated effectiveness in reducing risk factors, increasing protective factors, and preventing maltreatment. Promising programs have some evidence of effectiveness, but this evidence includes evaluations with less rigorous designs or methodological limitations. Thus, these programs need additional experimental evaluations in order to determine the program's effectiveness. It should be noted that the effectiveness of any program will depend upon selecting a model that is appropriate for the given population as well as implementing the program in a way that is consistent with the research.[13]

Although the field of child maltreatment prevention does not yet have an extensive body of scientifically proven programs, it is critical to incorporate what is known to be effective into the practices of the practitioners who work with families and children daily. If implemented correctly, the use of evidence-based practices will provide opportunities to strengthen family intervention programs.[13]

Recommendation 7.1 (Priority Recommendation)
PCA North Carolina, through its involvement with the Child Maltreatment Prevention Leadership Team, should continue the work begun by the Task Force on Child Abuse Prevention Program Subcommittee on evidence-based child maltreatment prevention practices by convening an Expert Work Group on Evidence-Based Practice.

- **A. The Expert Work Group on Evidence-Based Practice should include members of the Child Maltreatment Prevention Leadership Team, researchers, practitioners, and other experts.**
- **B. The responsibilities of the Expert Work Group on Evidence-Based Practice should include the following:**
  - **i. Reviewing prevention research literature and keeping abreast of ongoing studies and current findings.**
  - **ii. Identifying evidence-based and promising programs for child maltreatment prevention and family strengthening.**
  - **iii. Identifying strategies to disseminate this information to state and local policy makers, funders, and practitioners/community-based programs.**
  - **iv. Identifying ways to financially and programmatically support the use of evidence-based programs in North Carolina.**
  - **v. Identifying strategies and funding to further evaluate promising practices that merit more scientifically rigorous evaluation.**

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[a] Through a grant from the Centers for Disease Control and Prevention (CDC), the EMPOWER process has developed a State Capacity Building Team and the NC Sexual Violence Prevention Team to build statewide capacity in primary prevention of sexual violence.

A report on the progress towards implementing this recommendation should be provided to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.

Fully Implemented

The Alliance for Evidence-Based Family Strengthening Work Group, an expert work group, was convened in April 2006 to increase statewide implementation of evidence-based programs in North Carolina. The work group is facilitated by Dr. Kenneth Dodge, director of the Center for Child and Family Policy at Duke University and Michelle Hughes, vice president for programs at PCA North Carolina. Members included representatives from several public agencies that fund child abuse prevention and family support initiatives as well as researchers and practitioners. A list of current members of the Alliance for Evidence-Based Family Strengthening Work Group is included in Appendix E.

This work group's first efforts focused on increasing the use of evidence-based programs within family resource centers that are funded by the NC Division of Social Services. Members of the Evidence-Based Work Group, as well as stakeholders from the NC Division of Social Services and NC Partnership for Children supported local family resource centers, convened to do the following: review federal and state funding and policy objectives; conduct a literature review of research on family resource centers and their programs; research organizational capacity of family resource centers in North Carolina; and review current evaluation efforts. The Duke Endowment funding was used to contract with a researcher to conduct the literature review and present the research findings to the work group. A final report with the work group's findings and recommendations has been used by the NC Division of Social Services, NC Partnership for Children, and NC Children's Trust Fund in their funding proposals and efforts.

The collaboration in funding evidence-based programs within Family Resource Centers made many of the funders realize that they shared common goals, outcomes, and strategies despite their different approaches to on the issue of child and family wellbeing. Consequently, several funders—the NC Division of Social Services, NC Children's Trust Fund, and NC Partnership for Children—agreed to develop a set of shared research-based intermediate outcomes among their agencies to help strengthen collaboration, leverage limited resources, and strategically target programmatic efforts toward the most critical risk and protective factors for child maltreatment and school readiness. The group worked closely with the Early Childhood Comprehensive System initiative and used the Shared Indicators for School Readiness as a launching point for discussion. Soon several other funders, including the NC Division of Public Health; NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services; The Duke Endowment; and the Kate B. Reynolds Charitable Trust joined the group.

Currently the Alliance focuses on two primary, multi-faceted strategies to promote evidence-based family strengthening programs in North Carolina. First, the Alliance members share information, training, technical assistance publications, and strategies amongst themselves in order to support evidence-based programs. Second, in some instances where specific programs meet the needs of multiple funders, the Alliance is working to collaboratively fund and develop infrastructure at the state level for program implementation. The Alliance recently launched the NC Nurse Family Partnership initiative (with funding provided by The Duke Endowment and the Kate B. Reynolds Charitable Trust and leadership provided by the NC Partnership for Children and PCA North Carolina). The group is also currently exploring how to provide training, technical assistance and consultation for three evidence-based and promising programs (Incredible Years, Nurturing Parent Program, and Strengthening Families), as well as assessing the potential for other programs to be supported collaboratively.

Recommendation 7.2 (Priority Recommendation)
Public and private funders should place priority on funding evidence-based and promising child maltreatment prevention and family strengthening programs. When those programs are not available for a specific population, public and private funders should give funding priority to those programs that are theory-based and incorporate elements identified in the research literature as critical elements of effective programs. A report on the progress on this recommendation should be provided to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.

Partially Implemented
There has been significant progress since the release of the Task Force's report in implementing evidence-based programs in public programs and community-based prevention efforts. As noted in the update to Recommendation 7.1, the Alliance for Evidence-Based Family Strengthening Programs is working to target funding to support evidence-based programs. For example, The Division of Social Services, NC Children's Trust Fund, NC Partnership for Children, NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Division of Public Health, and other funders have all started to focus grant making on evidence-based programs.

DSS and Children's Trust Fund: The NC Division of Social Services (NC DSS) and NC Children's Trust Fund (located within the Department of Public Instruction) used evidence-based criteria in their Request for Applications (RFAs) for funding beginning July 1, 2007. Applications were scored based on the potential grantee's use of evidence-based or promising programs. The NC DSS awarded 31 Family Support/FRC grants using evidence-based or promising practice criteria, totaling $3.35 million Additionally, NC DSS funded nine "Special Initiative Programs" (Faith Based, Fatherhood, and Healthy Marriage) using evidence-based or promising program criteria totaling $525,000 in awards. In July 2007, the DSS request to revise the NC General Statutes regarding Family Resource Centers programming to include Promising Practice/Evidence-Based Practices programming was enacted by the General Assembly, demonstrating commitment to providing programming that has positive outcomes for children and families.[14] The Children's Trust Fund awarded 14 grants totaling $499,875, ranging from $7,000 to $152,935.

NC Partnership for Children (NCPC): The NCPC is moving toward implementation of evidence-based and promising practice models, which will be fully implemented in 2008-2009. In 2007, NCPC issued policy statements to their local partnerships on the use of evidence-based programs, as well as "Model Fidelity" papers for family support parenting education programs. NCPC issued an additional RFA in 2007 for an evidence-based family support program which specifically addresses reduction of child maltreatment—*The Incredible Years*. Six awards were made for *The Incredible Years* program, which will be implemented in 10 counties. The awards for this two-year grant totaled $304,937.

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS): MHDDSAS supports the provision of quality services that adhere to proven models through the Practice Improvement Collaborative (PIC). The Practice Improvement Collaborative is comprised of a panel of experts, practitioners, and consumers that considers science and recommends best practice and evidence-based programs and services to MHDDSAS. For example, MHDDSAS funds three local Strengthening Families sites through the Substance Abuse Prevention and Treatment Block Grant. Additionally, MHDDSAS is partnering with a number of stakeholders and collaboratively funding several evidence-based mental health initiatives, including Trauma Focused Cognitive Behavioral Therapy (TF-CBT). Trauma-focused

cognitive behavioral therapy is an evidence-based treatment approach shown to help children, adolescents, and their caregivers overcome trauma-related difficulties. It is designed to reduce negative emotional and behavioral responses following child sexual abuse and other traumatic events.[15] The treatment is based on learning and cognitive theories, which addresses distorted beliefs and an attribution related to the abuse, and provides a supportive environment in which children are encouraged to talk about their traumatic experience. TF-CBT also helps parents who were not abusive to cope effectively with their own emotional distress and develop skills that support their children. TF-CBT is available in 28 eastern North Carolina counties. Through initial MHDDSAS support and funding, The Duke Endowment funding was leveraged to expand this initiative and an outcomes-based evaluation.

Division of Public Health (DPH): In 2006, the Injury and Violence Prevention Branch of the DPH made the RFA for the Rape Prevention and Education Program (RPE) a competitive process and required population-based, data-informed evidence-based practice as criteria for awards. Through this process, DPH funded 17 community agencies at $50,400 for a total award of $856,800.[16] In 2007, the Women's Health Section of DPH issued an RFA for the Adolescent Parenting Program (APP), a competitive process that required outcomes which reduce the incidence of abuse and/or neglect of participants' children and encouraged the use of an evidence-based parenting curriculum. Awards will be made to six community agencies at $47,980, for a total award of $287,880.[17]

Other Community Efforts: The Period of PURPLE Crying, described earlier in the update of Recommendation 6.1, is an evidence-based early intervention and outreach campaign to reduce the incidence of shaking or other types of abuse. This project is based on new materials developed by the National Center on Shaken Baby Syndrome. These new educational materials for parents are based on extensive clinical trials with more than 4,200 parents in maternity departments, pediatric offices, prenatal classes, and nurse home visiting programs. In addition to randomized clinical trials, focus groups of parents were used to help develop the latest Period of PURPLE Crying booklet and DVD. This project will collaborate with a consortium of public health, child care, health care, child advocacy organizations, and military health services to evaluate the delivery of a specific abusive head trauma prevention program to the parents of every newborn in North Carolina.

The Duke Endowment: The Duke Endowment has adopted a specific grant-making strategy for disseminating evidence-based practices across North Carolina and South Carolina. The selection of interventions targeted for dissemination is being informed largely by the foundation's participation with the funders' Alliance for Evidence-Based Family Strengthening Programs.

Recommendation 7.3
PCA North Carolina should work with the NC Division of Medical Assistance, NC Division of Public Health, and Community Care of North Carolina to implement the Nurse Family Partnership Program in two to three additional sites in North Carolina. In implementing this program, these organizations should:

A. Target at least one of the Nurse Family Partnership programs toward the first-time adolescent mother population.
B. Attach at least one of the Nurse Family Partnership programs to a Community Care of North Carolina provider network and conduct a cost-benefit analysis to assess savings to the Medicaid Program.

A report on progress towards implementing this recommendation to the Child Maltreatment Prevention Leadership Team should be made by January 2006 and annually thereafter.

Partially Implemented
Initially, Prevent Child Abuse North Carolina assumed the lead role in implementing this recommendation. PCA North Carolina explored different funding strategies for the Nurse-Family Partnership, including looking at the Nurse-Family Partnership as a cost savings strategy for Medicaid. To that end, PCA North Carolina has led and facilitated the development of a collaborative partnership between the Guilford Child Health and Guilford Nurse-Family Partnership Programs, with the goal of collecting data that would demonstrate health care cost savings for the Medicaid program.

In winter 2005/spring 2006, The Duke Endowment and the Kate B. Reynolds Charitable Foundation asked members of the Alliance for Evidence-Based Family Strengthening Programs to consider supporting them in launching North Carolina's Nurse-Family Partnership Initiative. The foundations were planning to fund four to six sites in North Carolina with funding provided for five to seven years. Alliance members agreed to collaboratively support the Initiative, and PCA North Carolina and the NC Partnership for Children assumed lead oversight with guidance and support from the national Nurse-Family Partnership office. In November 2007, the Division of Public Health identified funding to add to this initiative.[18] The goal of the Initiative is to significantly improve the health and wellbeing of first-time, low-income mothers and their families.

Phase I of North Carolina's Nurse-Family Partnership Initiative began in July 2007 with 15 sites being invited to participate in an extensive community planning process in order to apply for the program.[19] Over the next year, six to eight sites will be funded through generous grants from The Duke Endowment and the Kate B. Reynolds Charitable Trust with additional funds provided by the Division of Public Health.[20] Simultaneously, efforts will be made at the state and federal policy levels to garner ongoing, long-term support for the expansion of the program across North Carolina. This recommendation will be fully implemented in July 2008.

Recommendation 7.4
PCA North Carolina and the NC Division of Public Health should work with the Education Begins at Home Alliance to develop a model of home visitation for families at high risk of maltreatment, based on the most current research of perinatal and early childhood home visitation programs and from an assessment of the current resources and infrastructure for home visiting programs in North Carolina. This collaborative effort should:

A. Integrate this model within a larger continuum of perinatal and early childhood home visitation programs;
B. Identify strategies to rigorously evaluate this model of home visitation; and
C. Develop a system for quality assurance and long-term funding.

A report on progress of the development of the home visitation model to the Child Maltreatment Prevention Leadership Team should be made in January 2006 and annually thereafter.

Partially Implemented
PCA North Carolina has taken the lead in implementing this recommendation. PCA North Carolina currently provides training and technical assistance to existing Healthy Families programs in North Carolina. Rigorous research on the Healthy Families program has been mixed. PCA North Carolina's own experience with the program revealed that despite its strength, it lacked solid research-based curricula and protocols, as well as a standardized way to deliver services and ensure model fidelity. Consequently, PCA North Carolina worked with the Durham Center for Child and Family Health, Appalachian Family Innovations, and researchers from Duke

University to address the programmatic limitations identified in the research. This is a three stage plan that includes model assessment, data analysis, and curriculum development. A work group involving these partners as well as staff from the University of North Carolina and staff from the Parents as Teachers Program have completed phase one of the project, which was to assess the model and recommend changes. Results from the Healthy Families program's randomized controlled trial in Durham will guide program re-design as well as determine future replication. At this time, PCA North Carolina continues to provide limited support for existing Healthy Families sites while waiting for the results of the Durham randomized trial.

Recommendation 7.5 (Priority Recommendation)
The Child Maltreatment Prevention Leadership Team should work with members to pilot or replicate promising child abuse prevention programs and to evaluate their effectiveness with a North Carolina population including, but not limited to:

A. **Parent-Child Interaction Therapy for families with children aged 4 to 12 years who are at risk for and who are already experiencing physical abuse.**
B. **The Strengthening Families Program as a selective prevention strategy for families with children aged 6 to 12 years.**
C. **The Chicago Child-Parent Center model for low-income children in preschool through third grade (aged 3 to 9 years) and their families.**

A report on the progress of this recommendation should be provided to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.

Partially Implemented

There has been some expansion of Parent Child Interaction Therapy (PCIT) in North Carolina. This was made possible due to the efforts of the Divisions of MHDDSAS and Medical Assistance (DMA) in implementing enhanced behavioral health service definitions which authorized reimbursement for these services. In addition, the Center for Child and Family Health, located in Durham, helped expand access to PCIT services by providing services directly and by training other providers. PCIT is an evidence-based model that works to improve the relationship between a child and parent by teaching the parent specific skills to use during interactions with the child. The parent is also taught effective behavior management techniques in order to reduce oppositional behaviors. PCIT is comprised of two halves—a child directed half and a parent directed half. In the first sessions, which are child directed, the parent is taught a set of skills to follow the child's lead in order to enhance the quality of the relationship and address minor behavioral issues through effective attention and ignoring. The second wave of PCIT is a parent directed interaction, where parents learn specific behavior management strategies. The parent is expected to practice these skills on a daily basis with the child in order for the parent to achieve mastery of the skills and to begin reshaping the child's behaviors. While PCIT was originally developed for children with Oppositional Defiant Disorder, it has been found to be effective with families affected by abuse and neglect, foster care situations, reunification with biological parents, and children with developmental delays.

Faculty at the Center for Child and Family Health (CCFH) is providing PCIT in clinic and home settings through the center's mental health clinic and as a component of a study designed to identify effective strategies for reducing repeated reports of maltreatment to child protective services. In addition, CCFH faculty members are helping train mental health professionals in North Carolina. CCFH is working with clinicians in the triangle, Elizabeth City, and six rural counties.[21]

The Alliance for Evidence-Based Family Strengthening Programs is currently assessing the Strengthening Families Program as a program that could be replicated statewide. The

Strengthening Families Program (SFP) is a parenting and family strengthening program for high-risk families. SFP is an evidence-based family skills training program found to significantly reduce problem behaviors, delinquency, alcohol and drug abuse in children, improve social competencies, improve school performance, and reduce child maltreatment. Currently the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services is funding three local Strengthening Families sites through funding from the Substance Abuse Prevention and Treatment Block Grant. Furthermore, the NC Division of Social Services has funded several additional programs for SFY 2007-08 through its Community-Based Program Team, and other funders are considering the program for future funding. Through a grant from The Duke Endowment, PCA North Carolina hired a staff person to help improve coordination and collaboration for training, evaluation, and other supports across Alliance members and other funding streams.

Little has been done with the Chicago Child-Parent Center model. The Chicago Child-Parent Center (CPC) model is a center-based early intervention that provides comprehensive educational and family-support services to economically disadvantaged children from preschool to early elementary school. The overall goal of the program is to promote children's academic success and to facilitate parent involvement in children's education.[22] The Task Force identified this as a promising program. However, there is no national infrastructure to replicate the program and the original program in Chicago has been partially dismantled due to funding cuts. Nevertheless key elements of the model—community-based schools, the intensive participation of parents in the school, the focus on the transition from preschool to kindergarten, and the comprehensive services provided in schools for children and their families—continue to be key themes in other work in the state, including in the Ready Schools Initiative.

Recommendation 7.6
The Child Maltreatment Prevention Leadership Team should work with:

A. **The NC Division of Social Services and the NC Partnership for Children to ensure that community-based family resource centers offer or link to evidence-based and promising prevention programs and to develop a model family resource center that uses evidence-based and promising prevention programming to address risk factors associated with child maltreatment and school readiness.**
B. **The NC Division of Social Services, NC Partnership for Children, and NC Children's Trust Fund should require use of social support and parent education programs that have been evaluated and show evidence of, or promise in, preventing maltreatment (e.g., the Nurturing Program) or in strengthening family functioning (e.g., The Incredible Years) and/or that incorporate critical components identified in the research literature.**
C. **The NC Division of Public Health, NC Children's Trust Fund, and other funding entities for child sexual abuse prevention programs to re-target funding for school-based child sexual abuse prevention programs to other more promising models of prevention, as recommended by the Expert Work Group on Evidence-Based Practice.**
D. **The Expert Work Group on Evidence-Based Practice, NC Partnership for Children, NC Division of Social Services, NC Children's Trust Fund, and other agencies as appropriate, in developing a shared set of research-based intermediate indicators of child maltreatment, nurturing parent-child interaction, and healthy child development to evaluate family support and child maltreatment prevention programs. This group should collaborate with the Technical Advisory Group on Surveillance to ensure that the intermediate indicators developed are consistent with**

the measures developed as part of the prevention measurement system, to the extent practicable.

A report on the progress of this recommendation should be provided to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.

Partially Implemented

Family Resource Centers: As noted in the update to Recommendation 7.2, at the request of the NC Division of Social Services, the Evidence-Based Work Group's first efforts focused on increasing the use of evidence-based programs within family resource centers funded by the NC Division of Social Services. The recommendations of the Evidence-Based Work Group have been used by the NC Division of Social Services, NC Partnership for Children, and NC Children's Trust Fund in their 2007 grant making. Additionally, the North Carolina General Statues amended the statute governing Family Resource Centers to require the use of evidence-based or promising programming.[23]

Parent Education and Training Programs: The NC Division of Social Services, NC Partnership for Children, and NC Children's Trust Fund have all incorporated language requiring or encouraging the use of evidence-based or promising parent training and social support programs in their RFA's or policies guiding funding decisions.

Sexual Abuse Prevention Programs: There has also been progress in changing the focus of existing school-based child sexual abuse prevention programs to other more promising models of prevention. In 2006, the Injury and Violence Prevention Branch of the NC Division of Public Health (NC DPH) made the Rape Prevention and Education Program (RPE) RFA a competitive process and required population-based, data-informed evidence-based practice. NC DPH funded 17 community agencies at $50,400 rather than 68 agencies at $14,280 as in previous years. Funding awards focused on primary prevention efforts. As recommended by the Task Force, the state stopped funding child sexual abuse prevention programs that teach children about sexual abuse in ways that make them responsible for preventing their own abuse. These programs, such as teaching "touching rules" and encouraging children to say "no" and report abuse, have not been shown to be effective prevention strategies. Rather, the RPE program is working to prevent perpetration from happening in the first place and to shift the onus of prevention onto the community as a whole. Community-based programs, such as Darkness to Light, are an allowable activity under this RFA. Darkness to Light is a public awareness campaign that seeks to raise awareness of the prevalence and consequences of child sexual abuse. Darkness to Light educates adults through a sexual abuse prevention training program that provides frontline training for organizations and corporations that serve children and youth.

The Children's Trust Fund has not funded school-based child sexual abuse prevention programs but is interested in doing more work in the field of child sexual abuse prevention in the future. Through three regional meetings held across North Carolina, PCA North Carolina surveyed prevention members to assess the child sexual abuse program currently being provided in local communities. The Child Maltreatment Prevention Leadership Team and PCA North Carolina will work cooperatively with the NC Department of Instruction to accomplish this recommendation in the next funding cycle (2008-2009).

Shared Intermediate Indicators: As noted in the update to Recommendation 7.1, the Alliance for Evidence-Based Family Strengthening Programs has developed a set of shared intermediate outcomes to help guide its discussion, inform Alliance members in their decision-making, and support collaborative efforts to fund specific evidence-based programs.

Recommendation 7.7
The Child Maltreatment Prevention Leadership Team should work with the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services and other agencies and private providers that provide oversight or treatment for children who have experienced abuse or neglect to encourage the use of evidence-based models (i.e., Parent-Child Interaction Therapy; Trauma-Focused-Cognitive Behavioral Therapy; Abuse Focused-Cognitive Behavioral Therapy) identified by the Kaufmann Best Practice Initiative, Substance Abuse and Mental Health Services Administration (SAMHSA), and Centers of Excellence. A report on the progress on this recommendation should be provided to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.

Partially Implemented
The Child Medical Evaluation Program has taken the lead in addressing this recommendation. Established in 1976, the Child Medical Evaluation Program is a cooperative effort of the UNC School of Medicine's Department of Pediatrics, NC Division of Social Services (NC DSS), the NC Division of MHDDSAS, the NC General Assembly, local departments of Social Services, and local medical and mental health providers. The staff of the Child Medical Evaluation Program has developed a statewide network of local providers who provide skilled diagnostic medical examinations and psychological assessments of children referred by local DSS agencies to help determine the presence or extent of abuse and neglect.

The NC Child Treatment Program (NC CTP) is a three year pilot project being administered by the UNC School of Medicine, Department of Pediatrics, in conjunction with the Child Medical Evaluation Program (CMEP) and the Center for Child and Family Health. Initial support and funding by the Division of MHDDSAS helped leverage additional funding by the Duke Endowment, Governor's Crime Commission and the Kate B. Reynolds Charitable Trust. This program is being piloted in 28 northeastern counties. The NC CTP provides evidence-based mental health treatment for sexually traumatized children (sexual abuse or sexual assault), regardless of NC DSS involvement. The program has developed an administrative infrastructure to support clinician recruitment, training, and retention, as well as to support mental health treatment of traumatized children. The program has developed a training curriculum and materials for the *NC CTP Advanced Training Institute in Trauma-Focused Cognitive Behavioral Therapy.* During the first 14 months of the program implementation, NC CTP has enrolled 135 children between the ages of 4- and 18-years-old who meet the clinical criteria for Post-Traumatic Stress Disorder. Children receive Trauma-Focused Cognitive Behavioral Therapy, an evidence-based mental health treatment that is shown to help children, adolescents, and their caretakers overcome trauma-related difficulties (see Recommendation 7.2 for more details about the program). Sixty-five licensed mental health providers have received an intensive 12-month training program, with a plan to train a second cohort of 65 licensed mental health providers. The NC CTP program's long term goals include expansion of the program to the remaining 72 counties. However, expansion will require additional state funding or fee-for-service contracts with private and/or public entities (such as the LMEs, local DSS offices, and children's advocacy centers).[24]

Recommendation 8.1
The Child Maltreatment Prevention Leadership Team should work closely with the Early Childhood Comprehensive System Initiative in the development of an integrated and comprehensive early childhood system that promotes the health and wellbeing of young children from birth through age 5. Specifically, stakeholders from both initiatives should identify common outcomes, identify common areas of focus, and integrate efforts whenever possible to maximize resources and prevent duplication. Leadership from both initiatives shall report back on their collaborative efforts to the full membership of the Child Maltreatment Prevention Leadership Team by January 2006 and annually thereafter.

Partially Implemented
Much of the work of this recommendation is being accomplished through the Alliance for Evidence-Based Family Strengthening Programs. The Alliance has used the Shared Indicators for School Readiness as a foundation to launch its work on shared intermediate outcomes for family strengthening programs. This collaborative work is captured in the attached "Alliance Logic Model." (See Appendix F)

Additionally, the Early Childhood Comprehensive System (ECCS) initiative has designed a collaborative decision-making and action-oriented group in the early childhood system, referred to as *FutureThink*. Members include some of the senior leaders in the five critical components of a comprehensive system: access to health insurance and medical homes; parent education; family support; early care and education; and social-emotional development. The Early Childhood Comprehensive System Grant Program in the NC Division of Public Health has convened and will manage *FutureThink.*

FutureThink has three components. It will provide a common venue for leaders to act collectively to achieve positive results in early childhood initiatives. It will create an efficient way to respond to requests for action by a variety of early childhood stakeholders operating in the community, including the Child Maltreatment Prevention Leadership Team. Finally, based on leaders' priorities, meetings will be designed with a clear focus and purpose on action items that address partners' shared outcomes.

Recommendation 8.2
The NC Division of Medical Assistance, NC Division of Public Health's Women's and Children's Health Section, PCA North Carolina, and other appropriate partners should work with the Education Begins at Home Alliance to ensure there is a coordinated and effective system of prenatal and early childhood home visitation programs across North Carolina that are voluntary, and that services appropriately match families' risks and needs. This collaborative effort should:

A. Determine the most strategic ways to align existing home visitation services and programs including but not limited to Maternity Care Coordination, Child Service Coordination, Parents as Teachers, the Parent Aide Program, Healthy Families, the Nurse Family Partnership, and Early Head Start to promote the outcomes of child safety, healthy child development, secure parent-child relationships, and school readiness.
B. Assess the need for and potential benefits of a universal postpartum home visiting program in preventing maltreatment in North Carolina.

The NC Division of Medical Assistance, NC Division of Public Health, and PCA North Carolina should report their progress in implementing this recommendation to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.

Partially Implemented

There have been several efforts focused on increasing of the availability of early childhood home visitation in North Carolina. First, the Education Begins at Home Alliance[25] has conducted a statewide survey of early childhood home visitation programs to better assess the number and type of early childhood home visitation programs in North Carolina. The results of the survey were made available in February 2008. However, due to the low number of respondents and ambiguity of several survey items, a new work group has been formed to redesign the survey. The revised survey will be administered to a larger audience. The ECCS Design Team[b] will assist with additional focus groups to inform the larger needs assessment being conducted by the Education Begins at Home Alliance. When completed, the full needs assessment will be incorporated into the work of the Child Maltreatment Prevention Leadership Team in addition to assisting with applying for federal funding for increased home visitation programs.

Additionally, the development of the NC Nurse Family Partnership Initiative—which will fund six to eight Nurse Family Partnership sites in North Carolina—is utilizing a community planning process which will help local stakeholders map out their services continuum for families with children beginning prenatally to age two. This process will help local communities and their state-level partners envision how the Nurse Family Partnership can become part of a larger service continuum and work collaboratively with Maternity Care Coordinators, Child Service Coordinators, and other early childhood home visiting programs. The learning and partnerships developed through these community planning processes can be used to help other counties and state-level agencies strengthen their early childhood service continuum.

Finally, the Durham Family Initiative will be testing a universal postpartum home visiting program as part of its work to reduce child maltreatment in Durham County by 50% in 10 years. The Durham Family Initiative is a community-based initiative funded by The Duke Endowment and led by the Center for Child and Family Policy at Duke University. In 2008, the Initiative will begin a new intervention to reduce maltreatment, called Durham Connects, which will be a universal postpartum home visiting program conducted by health department nurses. These nurses will visit new mothers and families one to three times and will connect these families to community-based health and family support services. Although several counties have a universal postpartum home visiting program, the Center for Child and Family Policy will be conducting a randomized trial of the Durham Connects Initiative, providing much needed outcome data on the impact of such an intervention on family functioning, child wellbeing, and community maltreatment rates.

Recommendation 8.3

The NC Division of Public Health and NC Division of Medical Assistance should request that child maltreatment prevention be included as a major goal for the Maternity Care Coordination and Child Service Coordination programs. Furthermore, these programs should be strengthened with regard to child maltreatment prevention by:

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[b] The ECCS Design Team is a cross-agency Social Emotional Design Team, chaired by Deborah Nelson, PhD, the Early Childhood Comprehensive Systems Coordinator located in the Women's and Children's Health Section of the NC Division of Public Health.

A. **Developing and implementing standardized intervention models for identified risk factors such as the Maternity Care Coordination Pathways process that is currently being piloted.**
B. **Requiring that Maternity Care Coordination and Child Service Coordination workers have regularly scheduled training in identifying risk factors and implementing appropriate interventions or referral processes.**

The NC Division of Public Health and NC Division of Medical Assistance shall report their progress in implementing this recommendation to the Child Maltreatment Prevention Leadership Team by January 2006 and annually thereafter.

Not Implemented

When the Task Force for Child Abuse Prevention was meeting, Task Force members believed that the state could augment the responsibilities of Maternity Care Coordinators and the Child Service Coordinators to focus on child maltreatment prevention in addition to their other responsibilities. However, the Deficit Reduction Act of 2005 limited the scope of permissible case management services that could be reimbursed using Medicaid funding. Thus, the state has no flexibility to implement this recommendation as written without additional guidance from the Center for Medicare and Medicaid Services (CMS) or a willingness to fund these services using 100% state funds. While CMS has provided some guidance about the provisions, the modifications are confusing and require further clarification.

Recommendation 8.4 (Priority Recommendation)

The NC Division of Public Health and NC Division of Medical Assistance should support the Children's Developmental Services Agencies to serve families who are maltreating or who are at high risk of maltreating their children by:

A. **Ensuring that Children's Developmental Services Agencies continue to serve at-risk children birth to age three.**
B. **Providing additional funding, training, and support to the Early Intervention System to ensure that families in the child abuse high risk category and families who enter the Early Intervention System through Child Protective Services can receive timely and appropriate services.**
C. **Exploring the possibility of broadening the community-based rehabilitative services definition to include work with caregivers around safety and health issues.**
D. **Providing additional training to community-based rehabilitative service providers and early intervention coordinators in healthy parent/child interaction and attachment.**
E. **Strengthening connections between Family Support Network Programs and Children's Developmental Services Agencies.**

The NC Division of Medical Assistance and NC Division of Public Health should report on the progress of this recommendation to the Child Maltreatment Prevention Leadership Team by January 2006 and annually thereafter.

Not Implemented

State administration of the NC Early Intervention Program is provided by the Early Intervention Branch, Women's and Children's Section, within the NC Division of Public Health, NC Department of Health and Human Services. The 18 Children's Developmental Services Agencies (CDSAs) manage the Program at the local level. The Program serves children ages birth to 3, with or at risk for developmental disabilities or delays, under Part C of the Individuals with Disabilities Education Act.

Prior to SFY 2003-2004, approximately 4,500-5,000 children were referred per year for early intervention services. In SFY 2004-2005, the CDSAs received an unprecedented number of referrals, with the number of referrals increasing to 17,263. The high number of referrals continued with 17,319 in SFY 2005-2006 and 17,727 in SFY 2006-2007. There were several reasons for the increased number of referrals. First, the Child Abuse Prevention and Treatment Act (CAPTA) mandated a referral of any child under the age of three years with a substantiated finding of abuse and/or neglect. In North Carolina, this is estimated at about 5,000 children per year. Secondly, physicians increased referrals due to changes in Medicaid policies that required physicians to perform periodic developmental screenings. Additionally, changes in the referral structure increased the number of referrals. The increase in the number of referrals to the CDSAs led to enrollment delays and a lag in the provision of services.

During SFY 2005-2006, North Carolina revised its policies and procedures for its Early Intervention Program to comply with requirements of the US Office of Special Education Programs. As of SFY 2006-2007, the program has seen improvements in its 45-day timeline from referral to enrollment and service planning, as well as in timeliness of services as listed on the service plan. North Carolina used three strategies in particular to get the NC Early Intervention Program in compliance with the Office of Special Education Programs. First, the program restricted eligibility to serve the children most in need and reduce the waiting list. This change in eligibility criteria was approved by the Office of Special Education Programs and implemented on July 1, 2006 for infants and toddlers referred on or after that date. Second, the NC Division of Public Health requested and received additional funding for the program (2005-2006) in order to evaluate and provide service coordination for the increased numbers of infants and toddlers referred to the program and its Children's Developmental Services Agencies (CDSAs). Third, the NC General Assembly appropriated funding for therapist positions (to be located in Children's Developmental Services Agencies) for counties where no appropriately qualified community-based service provider can be found (2006-2007).

The number of children enrolled in the NC Early Intervention Program continues to increase at the state level. In SFY 2005-2006, 15,160 children were enrolled, compared to 12,430 in SFY 2004-2005. The number of children served in SFY 2006-2007 was 15,048. Compliance with the 45-day timeline positively impacted the number of children who were enrolled in SFY 2005-2006; many infants and toddlers who had been waiting for services were evaluated and enrolled during that year. Statewide, there was a 22% increase in the number of children enrolled in SFY 2005-2006, the highest increase in the number of children enrolled in the history of the program. (Note: Not all children referred for an assessment are ultimately determined to be eligible for services or receive services.)

Because of the need to restrict eligibility to serve those most in need, the Task Force’s recommendation could not be implemented. Under the new eligibility definition children who do not have developmental delays or do not have a condition that would cause a significant risk of developmental delays are not eligible for services through CDSAs. The additional funding provided by the General Assembly positively impacted the Early Intervention Program and the infants and toddlers it serves, but was not adequate to provide funding for staff to meet this recommendation. In addition, broadening the community-based rehabilitative services definition to include work with caregivers around safety and health issues would require the NC Division of Medical Assistance to change its definition and also would require more staff and/or community providers, which equates to additional funding.

The NC Division of Public Health is considering revisiting the eligibility criteria based on current fiscal abilities. In 2007, the NC General Assembly reduced a portion of the funding for CDSAs

and appropriated $4 million in nonrecurring funding for SFY 2007-2008 and $3 million for SFY 2008-2009. CDSAs were directed to increase receipts from Medicaid and private insurers to offset nonrecurring appropriations.

While most of this recommendation was not implemented due to the unforeseen increase in children being seen by CDSAs, there have been some steps to strengthen the connections between Family Support Network Programs and CDSAs (subsection E of this recommendation). CDSAs continue to fund one Family Support Network affiliate in each CDSA catchment area to provide services to eligible families and those with concerns about their child's development.[26]

Recommendation 8.5
The NC Division of Medical Assistance, NC Office of Research, Demonstrations, and Rural Health Development,[c] and NC Division of Public Health should work together to explore ways to enhance the role of primary health care providers in child maltreatment prevention. Specifically:

- **A. The Task Force on Child Abuse Prevention supports the efforts of the NC Division of Medical Assistance to expand Community Care of North Carolina to ensure all children on Medicaid have access to medical homes and the efforts of the NC Division of Public Health to promote public awareness efforts to educate families about the importance of establishing a medical home for all children.**
- **B. The NC Division of Medical Assistance should support the Assuring Better Child Development Project to enhance the capacity of primary health care providers to reduce child maltreatment by:**
  - **i. Adopting child maltreatment prevention as a major goal of the program.**
  - **ii. Exploring ways in which it can further support community networks of prevention, early intervention, and family support services that help prevent developmental delays and child maltreatment.**

The NC Division of Medical Assistance, NC Office of Research, Demonstrations and Rural Health Development, and NC Division of Public Health should report on their progress in implementing this recommendation to the Child Maltreatment Prevention Leadership Team by January 2006 and annually thereafter.

<u>Partially Implemented</u>
The Community Care of North Carolina (CCNC) program has developed 14 regional community health networks comprised of community physicians, hospitals, health departments, departments of social services and other health, mental health, and community providers that are working together to improve care for Medicaid recipients. CCNC has established local systems of care that are needed to achieve long-term quality, cost, and access objectives in the management of care for Medicaid recipients. The medical providers participating in the program serve as a medical home and coordinate all the patient's health care needs. These networks include more than 3,500 primary care physicians spread across all 100 counties. This health care networks serve more than 765,000 Carolina ACCESS Medicaid patients and have recently been expanded to serve the children enrolled in SCHIP. Networks partner with primary care providers in the implementation of evidence-based care for patients with chronic conditions. CCNC received the 2007 Annie E. Casey Innovations Award in Children and Family System Reform and was one of seven winners of the 2007 Ash Institute for Democratic Governance and Innovation at Harvard University's John F. Kennedy School of Government.

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[c] The NC Office of Research, Demonstrations, and Rural Health Development is now the NC Office of Rural Health and Community Care.

CCNC, in collaboration with the Divisions of MHDDSAS, and Medical Assistance, as well as other provider stakeholders, has recently started a new initiative to coordinate and/or integrate mental health services with primary care. There are currently 44 primary care practices in 26 counties that have integrated mental health professionals into primary care practices.[27] The primary care practices involved in this co-location project help link parents and child with mental health issues, including depression, to appropriate mental health services. Brief therapy services can be provided directly in the physician's practice setting, whereas more complex cases may be referred to other professionals. Under the co-location programs, families and children who might not otherwise seek services or be identified as having mental health problems can be referred into care. Ideally, this early identification and referral into treatment can help prevent the stress or depression that might lead to instances of child maltreatment.

Recommendation 8.6
The Child Maltreatment Prevention Leadership Team and the Early Childhood Comprehensive System Initiative should work together to identify the needs of families and other caregivers in promoting young children's social-emotional health, develop effective strategies to meet these needs, and enhance the capacity of the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, as well as other provider systems (e.g., Early Intervention, Public Schools, Head Start, private practitioners) in coordinating and delivering services to those caregivers and children. The NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services and all other agencies working with the Early Childhood Comprehensive System Initiative shall report on their progress in implementing this recommendation to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.

Partially Implemented
A cross-agency Social Emotional Design Team, staffed by the Early Childhood Comprehensive Systems (ECCS) coordinator located in the Women's and Children's Health Section of the NC Division of Public Health, is addressing this recommendation. The Social Emotional Design Team has agreed that this work will focus on identifying sustainable best practices that support social and emotional development (prenatal to age three) through prevention or intervention efforts. A list of current members of the Social Emotional Design Team is included in Appendix D.

While there are a number of related initiatives underway (e.g., Nurse Family Partnership and co-location grants from Community Care of North Carolina) there is no comprehensive plan for promoting social and emotional development for infants and young children in North Carolina. The Social Emotional Design Team is in the process of developing a comprehensive plan and has requested technical assistance from the National Technical Assistance Center for Children's Mental Health at Georgetown. The National Technical Assistance Center is working with a number of states to develop a public health approach to promoting social and emotional development. This approach would strengthen parents and other caregivers' ability to promote young children's health and social and emotional development as well as address prevention, early intervention, and treatment. The ECCS grant will end in August 2008. Additional federal or state funding will be sought to continue the Early Childhood Comprehensive System initiative in North Carolina.

Recommendation 8.7
The NC Division of Child Development, NC Department of Public Instruction, Office of School Readiness in the Office of the Governor, and NC Partnership for Children should work with the Early Childhood Professional Development Institute to develop a plan for

increasing the training of childcare providers to better understand and to assist parents in understanding stages of child development and age appropriate child behavior and to promote infant/child mental health and social/emotional development. The NC Division of Child Development, NC Department of Public Instruction, and NC Partnership for Children should report on their progress in implementing this recommendation to the Child Maltreatment Prevention Leadership Team by January 2006 and annually thereafter.

Fully Implemented

The NC Division of Child Development (NC DCD) undertook four projects to fully implement this recommendation: Parenting with Parents, Promoting Healthy Social Behaviors, Infant/Toddler Quality Enhancement, and Early Foundations.

Parenting with Parents: NC DCD, in conjunction with the Leadership Team and other key stakeholders, implemented a project to assist child care providers in working with parents and families to reduce their risk for child maltreatment. With collaborative funding from the Early Childhood Comprehensive System Initiative, NC Partnership for Children, NC Children's Trust Fund, and the NC DCD, the NC DCD contracted and coordinated with ZERO TO THREE to provide Partnering with Parents training to a group of child care resource and referral staff, child behavior specialists, infant/toddler specialists, child care health consultants, local Smart Start NC Partnership for Children staff, NC Division of Child Development staff, and others. Partnering with Parents training is a research-based curriculum that focuses on increasing child care providers' knowledge and ability to handle child maltreatment in an effort to promote positive child development, develop positive relationships with parents, and establish child care center environments that facilitate the promotion of protective factors for children and their families. The goal of this training was to establish a cadre of trainers across the state who can train local child care providers in the Partnering with Parents curriculum. Twenty-six teams comprised of two experts in early care and education and child maltreatment were trained in the Partnering with Parents curriculum. Each team of trained facilitators will conduct at least three trainings by June 2008.

Promoting Healthy Social Behaviors Project: In SFY 2005, the NC DCD contracted with the statewide Child Care Resource and Referral (CCR&R) system to address the growing problem of children being expelled from child care due to behavior problems. The Promoting Healthy Social Behaviors Project is headed by a statewide project manager and staffed by 25 behavior specialists serving all 18 CCR&R regions across the state. This team of experienced early childhood professionals has expertise and training in facilitation of social/emotional competencies; strategies and techniques to minimize challenging behaviors; and social/emotional assessments. The program provides training and technical assistance to child care teachers to help them with overall strategies and techniques to promote healthy social/emotional development and reduce challenging behaviors, as well as one-on-one consultation to address the needs of individual children. The program also has developed (and continues to update) regional resource guides of mental health practitioners and other social/emotional supports. Each specialist authors a number of articles on social/emotional development and approaches to challenging behaviors for distribution through regional newsletters, and the project collects expulsion data and publishes an annual expulsion report. There are many possible negative outcomes to a child being expelled from child care, many of which contribute to risk factors for child maltreatment (i.e. extra stress placed on the family, loss of time from work, parents feeling rejecting and not knowing where to turn for help). By assisting child care centers in better promoting healthy social/emotional development in children, the behavioral health specialists contribute to family and child wellbeing.

Recommendation 8.8
PCA North Carolina should work with family support agencies, such as the Family Support Network and the NC Cooperative Extension, to increase the availability of respite care, parent support groups, including the Circle of Parents or Parents Anonymous and parent support strategies such as Parent to Parent, and to ensure that families in need of support are able to access services within their communities. PCA North Carolina should report on their progress in implementing this recommendation to the Child Maltreatment Prevention Leadership Team by January 2006 and annually thereafter.

Partially Implemented
There have been a number of activities to implement this recommendation. Most are local or regional respite or parent support groups.

Local Respite Programs: The NC Division of Social Services funded eight respite programs in 2007-2008 through a competitive RFA process. The total award allocation for respite services through NC DSS was $238,579.

Parent-to-Parent Program: The Family Support Network of North Carolina applied for and received funding from the NC DSS to establish and evaluate parent-to-parent match programs in seven target counties in the far western and eastern parts of the state. The Parent-to-Parent Program provides one-on-one emotional and informational support to a parent of a child who has a disability, chronic illness, or other special health care needs by a trained support parent who has had similar family and disability experiences. The programs will be offered through the Family Support Network of Region A[28] and the Family Support Network of Northeastern North Carolina.[29] The project activities began in July 2007.

NC Early Intervention Mentor Program: This program is dedicated to enhancing the knowledge and skills of service providers working with families in early intervention and provides support and promotes empowerment among families of children with special needs. The Family Support Network of Region A and the Family Support Network of Northeastern North Carolina programs have a contract to provide support to families involved in the Children's Developmental Services Agencies. They programs are both sponsored by local Smart Starts (Region A Smart Start and Albemarle Smart Start).

Parents Anonymous®: Parents Anonymous® is a community of parents, organizations, and volunteers committed to strengthening families and building strong communities; achieving meaningful parent leadership and shared leadership; and the reduction of child abuse and neglect. The weekly support groups are free of charge to participants and are based on shared leadership and mutual support. Parents Anonymous® currently operates groups in Wayne and Catawba counties. Wayne County has two general population groups and one domestic violence group. Catawba County has a general population group and a court-referred group. The National Council on Crime and Delinquency recently completed an independent, longitudinal study to assess the impact of parent mutual support-shared leadership groups on child maltreatment prevention that found encouraging results.[30]

Circle of Parents: PCA North Carolina currently provides support to 31 Circle of Parent programs located in 26 counties across North Carolina. This program provides weekly support groups for parents and other caregivers where they can find and share support.[31] A decision was made by the agency last year to stop expansion of the program for one year to focus on quality improvement and to await the results of an evaluation of the Parents Anonymous® program, which utilizes the same programmatic intervention as Circle of Parents. The evaluation report has

just been issued and PCA North Carolina, along with key stakeholders and funders, will consider findings from the report in discussions about further expansion of the program in North Carolina.

Recommendation 8.9
The NC Department of Health and Human Services should ensure that a research-based strengthening parenting component is included across departmental programs that serve families, and include culturally appropriate programmatic strategies that will support and strengthen parent-child relationships, especially during pregnancy and the first two years of the child's life. These parenting components should include, but not be limited to, skills designed to enhance parent-child communication, problem-solving, positive discipline behaviors, and social support. The NC Department of Health and Human Services should report progress on this recommendation to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.

Not Implemented
To date, no progress has been made on implementing this recommendation. However, the Centers for Disease Control and Prevention (CDC) is currently researching cultural attitudes and beliefs about parenting practices in Latino, Asian, African American, Native American, and Caucasian populations. Information is being gathered through a literature review and focus groups. The Child Maltreatment Prevention Leadership Team is following the progress of this research. Findings from the CDC formative research will help guide the work of the Child Maltreatment Prevention Leadership Team to guide the development of culturally appropriate child maltreatment prevention messages and programs in North Carolina.

Recommendation 8.10
The NC State Board of Education and NC Department of Public Instruction should identify strategies to increase support for children at risk of maltreatment and their families to ensure that children are able to fulfill their academic potential in traditional schools, alternative schools, or other educational settings. This includes, but is not limited to:

A. Expanding the availability of school health nurses, Child and Family Support Teams, school counselors, and school social workers.
B. Ensuring that school counselors and school social workers have adequate resources and time, based on national professional standards, within their positions to provide needed services for high-risk children and their families.
C. Identifying and encouraging schools to offer or link to evidence-based and promising child abuse prevention and family strengthening programs.
D. Ensuring that the Title I, Pre-K, and Exceptional Children's Services programs work with the Child Maltreatment Prevention Leadership Team and PCA North Carolina to strengthen their capacity to prevent child maltreatment.

The NC Department of Public Instruction should report on its progress in implementing these recommendations to the Child Maltreatment Prevention Leadership Team by January 2006 and annually thereafter.

Partially Implemented
Several components of this recommendation have been implemented. North Carolina expanded the number of school support personnel. In addition, the state established standards for school counselors and is in the process of doing so for school social workers.

Expanding number of school support personnel: The School Based Child and Family Support Team Initiative[32] has established 100 teams comprised of a social worker and a nurse in 101 North Carolina schools and in 21 Local Education Agencies (LEAs). The 2005 Appropriations

Act (Session Law 2005-276) provides legislative authority and funding for the School Based Child and Family Support Team Initiative. The Initiative's purpose is to identify and coordinate appropriate community services and supports for children at risk of school failure or out-of-home placement in order to address the physical, social, emotional, developmental, and legal factors that affect academic performance. In order to strengthen the linkage and coordination of services with these school nurse/social workers, 18 care coordinators located in the respective local MHDDSAS management entities and 14 child and family team facilitators located in the respective local department of social services were partially funded in SFY2006. This staffing in the community is strategic in assuring that school age children most at risk and their families receive the necessary supports to promote successful outcomes. The North Carolina General Assembly provided to the NC Department of Health and Human Services, Division of Public Health $2.7 million in SFY 2007-2008 and $3.3 million in SFY 2008-2009 to provide 65 additional school nurses. All school nurses funded with state funds are required to participate in Child and Family Teams as needed.[33]

Funding also was provided to the NC Department of Public Instruction (NC DPI) in the 2007 General Assembly session to support a state-level coordinator for the Positive Behavior Support Initiative. This initiative is an effort to improve the learning environment of all students and school personnel by establishing and reinforcing clear strengths-based behavioral expectations throughout the school building and school day. Additionally, an Education Consultant position was added to NC DPI to provide technical assistance to schools and LEAs on middle and high school counseling issues. This position will also monitor the centers providing after-school programs to at-risk students.

NC DPI received recurring funding for four additional military family counselors in four counties with military installations (Cumberland, Craven, Onslow and Wayne). The purpose of these positions is to provide assistance to families with issues related to deployment and family relocation. (For a more complete explanation of services to military families, see Recommendation 8.21).

Standards for school counselors and social workers: In 2006, the State Board of Education approved a new school counselor job description and standards, based on national best practices (the American School Counselor Association (ASCA) National Model). The General Assembly is also considering whether to change funding for school counselors based on these new standards.[34,35]

NC DPI is currently developing a revised school social worker job description. As with the school counselor job description, the school social worker job description will be based on national best practice models and will clarify the appropriate roles for school social workers.

Other preliminary discussions have occurred with NC DPI personnel on the other components of this recommendation, but no further action has been taken at this time. As stated in the update to Recommendation 7.2, the NC Children's Trust Fund used new evidence-based criteria in its RFAs submitted in spring 2007 for funding beginning July 1, 2007. The Children's Trust Fund awarded 14 grants totaling $499,875, ranging from $7,000 to $152,935. The Children's Trust Fund is interested in providing additional evidence-based programs within school settings.

Recommendation 8.11
The NC Division of Social Services, NC Association of County Directors of Social Services, and Children's Services Advisory Committee should explore ways to strengthen universal and selective child maltreatment prevention efforts by:

A. **Expanding prevention services through the Multiple Response System for all children;**
B. **Developing family strengthening and child maltreatment prevention strategies for the Work First population.**

The NC Division of Social Services should report on their progress on this recommendation to the Child Maltreatment Prevention Leadership Team by January 2006 and annually thereafter.

Partially Implemented

Prevent Child Abuse North Carolina took the lead on this recommendation and began work in July 2007 through a contract with the NC Division of Social Services (NC DSS). A public policy intern from Duke University conducted research on prevention strategies currently utilized by local departments of social services and held a meeting of stakeholders to discuss this research and identify opportunities for strengthening maltreatment prevention within local departments of social services. A work group was formed and is considering various strategies including the development of prevention units in local NC DSS without increased funding by the NC DSS and the use of evidence-based programming within these units.

Recommendation 8.12

The NC Division of Public Health and NC Division of Medical Assistance should pursue a more rapid roll-out of the federal Medicaid family planning waiver. The NC Division of Public Health shall report progress on implementing this recommendation to the Child Maltreatment Prevention Leadership Team by January 2006 and annually thereafter.

Fully Implemented

The NC Family Planning Medicaid Waiver (sometimes referred to as "Be Smart") was implemented on October 1, 2005. The NC Division of Medical Assistance was the lead state agency, working in collaboration with the NC Division of Public Heath. The Medicaid family planning waiver provides limited family planning services for women and men age 19 and older, with incomes up to 185% of the federal poverty guidelines. These services typically include annual exams, Pap smear tests for women, screening for sexually transmitted diseases (including treatment for positive results), and the birth control method of the patient's choosing. Services can be provided by any Medicaid enrolled provider. This program is available statewide. In the first year, 9,846 women and 122 men received services. Additionally, the NC General Assembly appropriated $200,000 of recurring funds for SFY 2007-2008 and SFY 2008-2009 for family planning providers to purchase long-acting contraceptives for uninsured women not eligible for Medicaid.

Recommendation 8.13

The NC General Assembly should:

A. **Appropriate additional, stable funding to the NC Division of Public Health to expand the Teen Pregnancy Prevention Initiative with particular attention to minority populations, who continue to have higher rates of teen pregnancies than non-minorities.**
B. **Revise G.S. 115C-81 (e3-8) to ensure that students are receiving medically accurate information and that schools are using evidence-based approaches to prevent unwanted pregnancies and the transmission of STDs and HIV.**

The NC Division of Public Health and NC Department of Public Instruction shall report the status of these recommendations to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.

Not Implemented

Although there has been some effort to implement these recommendations, little actual change has been made. In 2007, the NC General Assembly provided one-time funding to the NC Division of Public Health from the Temporary Assistance for Needy Families (TANF) block grant for adolescent pregnancy prevention programs. Although funds from the NC Division of Medical Assistance decreased by over $400,000, the total appropriations for the Teen Pregnancy Prevention Initiative projects remained unchanged through a one-time additional TANF appropriation.

With regard to revising G.S. 115C-81 (e3-8), during the 2007 legislative session bills were introduced in both the House and Senate to revise the current state law to allow, with a parent's permission, school districts to teach an abstinence-based comprehensive sex education program.[36] Despite the efforts of the bills' sponsors and coalition partners, the bills were never heard in the Senate and failed in committee in the House. However, a revision was made to G.S. 115C-81 (e3-8), which was ratified that required the NC Department of Health and Human Services to provide to the NC Department of Public Instruction the most current available information concerning the effectiveness and failure rates of contraceptives or prophylactics for preventing pregnancy and sexually transmitted disease, including HIV/AIDS, in actual use among adolescent populations at the beginning of each school year.

Recommendation 8.14 (Priority Recommendation)

The NC Division of Public Health should assess the potential costs and benefits to the state of providing some level of service to all pregnant adolescents and adolescent parents by reviewing evaluation data from programs serving these populations across the country. The NC Division of Public Health shall report progress on implementing this recommendation to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.

Partially Implemented

With support from The Duke Endowment, a graduate student research assistant conducted research to identify studies which evaluate the effectiveness of programs for pregnant adolescents and adolescent parents. The Child Maltreatment Leadership Team is working with the NC Division of Public Health and the Adolescent Pregnancy Prevention Coalition to create a work group that will use the findings from the research project to explore the expansion of evidence-based programs to a broader segment of the adolescent parent population. The work group is expected to meet in late 2007 or early 2008 to begin its work. While evidence-based programs are not well defined for this population, the literature does agree that the Nurse Family Partnership is an effective program for this population. The NC Division of Public Health has concurred that local programs may elect to use grant funds awarded for the Adolescent Parenting Program (APP) to contribute to the Nurse Family Partnership Initiative if their community chooses to apply for this initiative.

The APP, administered through the NC Division of Public Health, was established as a secondary prevention program to provide services to pregnant and parenting adolescents. The program contributes to the reduction of repeat pregnancies in the target population of Medicaid-eligible teens and has been found to be effective by research completed by UNC-CH, School of Social Work. The NC Division of Public Health and other partners are interested in further, more rigorous evaluations of these programs. A subgroup has been convened to begin planning and consider evaluation options. Funding will need to be identified for further evaluation of these programs.

Recommendation 8.15 (Priority Recommendation)
The Child Maltreatment Prevention Leadership Team should work with the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services and other nonprofit substance abuse treatment organizations to increase the number of substance abuse treatment programs, with a particular focus on gender specific programs for pregnant women and women with children and increase outreach to identify women in need of these services. The NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services shall report progress on implementing this recommendation to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.

Fully Implemented
In 2007, the NC General Assembly appropriated $6 million in new recurring funds for regionally purchased, locally-hosted substance abuse programs. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services has funded the following Cross Area Service Programs as a result of these funds: one new perinatal residential program, one new CASAWORKS for Families program, expansion of four existing perinatal/maternal residential programs, four new adult substance abuse comprehensive community treatment capacity and supportive housing programs, two new children/adolescent substance abuse comprehensive community treatment capacity and residential progams, two residential programs with a vocational component, expansion of the Oxford House programs statewide, and one statewide project to expand Substance Abuse Prevention Coalitions statewide. In addition, the NC General Assembly asked the NC Institute of Medicine to study the substance abuse services system. The IOM Substance Abuse Task Force has been meeting monthly and will submit its first report to the General Assembly in the May 2008 session. Further recommendations to address substance abuse may be forthcoming out of this new NC IOM Task Force.

Recommendation 8.16 (Priority Recommendation)
The NC Division of Public Health should work with the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, NC Division of Social Services, NC Division of Medical Assistance, professional associations including the NC Pediatric Society, NC Academy of Family Physicians, and NC College of Obstetricians/Gynecologists, Area Health Education Centers program, and appropriate health professional training schools to jointly develop a strategy to assess the prevalence of maternal and postpartum depression for North Carolina women and examine the issues regarding screening, access to, and availability of services for this condition. The NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services and the NC Division of Social Services should report on their progress in implementing this recommendation to the Child Maltreatment Prevention Leadership Team by January 2006 and annually thereafter.

Partially Implemented
Maternal depression was identified by the Task Force on Child Abuse Prevention as a critical risk factor for child maltreatment. The Leadership Team prioritized maternal depression as an issue to address during the 2006 planning session. The work is moving forward in two phases. The first phase was a study phase, during which a small number of stakeholders including the NC Division of Public Health, NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, PCA North Carolina, NC Pediatric Society, community practitioners, and researchers reviewed research compiled by a public health intern and discussed policy and practice options. The work group presented these findings to the Leadership Team and is expected to present them to the Perinatal Health Committee of the Child Fatality Task Force in

the next few months. The material compiled by the public health intern included background information about screening practices, treatment options, reimbursement issues, community education, provider education strategies, and initiatives from other states. The intern's work was funded by The Duke Endowment.

The second phase, which began in January 2008, involves identification of some specific recommendations for implementation. The work group will be expanded to a larger group of researchers, practitioners, and policy makers who can facilitate implementation. A list of present members of the Maternal Depression Work Group is included in Appendix D.

Recommendation 8.17
The Child Maltreatment Prevention Leadership Team should work with the NC Coalition Against Domestic Violence and other domestic violence advocates, PCA North Carolina, NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, and NC Division of Public Health's Injury and Violence Prevention Branch to identify and pilot evidence-based or primary prevention strategies for domestic violence and child maltreatment. The Child Maltreatment Prevention Leadership Team should report on its progress in implementing this recommendation by January 2006 and annually thereafter.

Partially Implemented
This recommendation is being implemented, in part, by the NC Coalition Against Domestic Violence (NCCADV). NCCADV focuses on services and systems advocacy, statewide planning, public awareness and education, intimate partner violence (IPV) prevention, and direct services.[37] NCCADV has increased its focus on preventing IPV with funding from the Centers for Disease Control and Prevention. North Carolina was one of 14 state coalitions to receive funding to launch the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) program.

NCCADV has also coordinated a variety of training events designed to build the skills to develop and sustain prevention activities in the state. In 2006, 25 training activities related to prevention or capacity building were offered and attended by more than 1,000 participants.[38] In addition to training and technical assistance, NCCADV has focused on building statewide collaborations to enhance prevention efforts. The partnership between NCCADV and the NC Department of Public Instruction (NC DPI) was strengthened in 2004 with the passage of legislation that mandated a study of ongoing violence prevention efforts in state schools. Since that time, NCCADV has worked with NC DPI to improve the quality and frequency of prevention efforts in schools, as well as to support enhanced collaboration between local school districts and domestic violence programs.

A statewide steering committee has been convened to develop a 10-year plan to prevent IPV in North Carolina. Members of the steering committee are from diverse backgrounds, representing key stakeholders in the areas of domestic violence and primary prevention. The 22 member committee includes representatives from the NC Division of Public Health, NC Lieutenant Governor's Office, NC Office on Disability and Health, NC DPI, and the UNC system.

NCCADV partnered with NC DPI in 2007 to implement a plan to ensure that within three years every school principal in North Carolina has received information about domestic violence and how schools can partner with local domestic violence programs and Coordinated Community Response (CCR) teams in primary prevention activities. NCCADV will provide training and technical assistance to educators in local domestic violence programs to ensure that they have the capacity to effectively partner with the school system on primary prevention efforts. Additionally,

the NC Division of Social Services received $2.2 million in appropriations from the TANF Block Grant for the provision of domestic violence counseling support and other direct services to clients. While these funds primarily focus on secondary prevention, many of the funded programs focus on child maltreatment prevention.

A new work group was formed in November 2007. The objective of this work group is to develop a strategy for researching current domestic violence screening measures and protocols for the purpose of developing and testing screening measures, protocols, and training for home visitation services in North Carolina which can be used across multiple disciplines.

Recommendation 8.18
The NC Office of Education Services should work with PCA North Carolina to strengthen early intervention services with regard to parent/child interaction and child maltreatment prevention for families of children with special needs enrolled in their services. The NC Office of Education Services shall report on its progress in implementing this recommendation to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.

Not Implemented
No action has been taken on this recommendation by the Leadership Team. The Leadership Team will engage the Office of Educational Services in 2008 to begin work toward implementation of this recommendation.

Recommendation 8.19 (Priority Recommendation)
The Child Maltreatment Prevention Leadership Team should work with the Early Childhood Comprehensive System Initiative, NC Partnership for Children, PCA North Carolina, NC Division of Child Development, and other appropriate organizations to identify strategies to increase the availability of affordable, quality childcare. The Child Maltreatment Prevention Leadership Team should immediately:

A. **Request that the NC General Assembly increase funding for childcare subsidies to county departments of social services to ensure that 1% of additional families needing childcare subsidies are served each year until at least 50% of eligible families are being served.**
B. **A report on the progress towards implementing this recommendation should be provided to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.**

Partially Implemented
Substantial progress was made on this recommendation. For SFY 2006-2007, the NC General Assembly approved an increase of about $30 million in state and federal Temporary Assistance for Needy Families (TANF) funds for child care subsidy services. This funding increased the number of children served from 154,764 in SFY 2005-06 to a total of 157,288 in SFY 2006-07. About $6.7 million of the additional funds were used to adjust market rates for three, four, and five star rated licensed child care facilities in specific counties based on the results of the 2006 market rate survey. This allowed providers to receive a higher subsidy payment rate to help support the costs associated with providing higher quality care.

Additionally, during the 2007 legislative session, the NC General Assembly approved an increase of $8.4 million in recurring funds for child care subsidy services. Of this amount, $5.7 million was earmarked to use for market rate increases for three, four, and five star rated licensed child care facilities in specific counties based on the results of the 2007 market rate survey. The

remainder of the funds is projected to serve approximately 1,520 children on the child care subsidy waiting list. In addition, the NC General Assembly approved an increase of $56 million in More at Four Pre-K funding to support an expansion of 10,000 additional slots and to increase the per child payment amount by $40 per month.

Recommendation 8.20
The Child Maltreatment Prevention Leadership Team should work with the State Emergency Management Services, North Carolina disaster response professionals, and rapid response professionals (Critical Incidence teams, FEMA, etc.) to raise awareness of the increased risk for child maltreatment in young children, particularly Shaken-Baby Syndrome, immediately after and up to six months following a natural disaster and to ensure that appropriate parent support services are in place for those families at highest risk. The Child Maltreatment Leadership Team should report on its progress toward implementing this goal by January 2006 and annually thereafter.

Not Implemented
Little progress has been made on implementing this recommendation. The Leadership Team has begun discussions with the Injury and Violence Prevention Branch, NC Division of Public Health about a possible role in implementing this recommendation. Additionally, the Leadership Team has been researching strategies on preventing child maltreatment after a natural disaster, including using materials created by the Centers for Disease Control and Prevention. In 2008, the Leadership Team, in collaboration with other agencies, and current initiatives such as the Period of Purple Crying, plans to bring together key stakeholders to assess specific emergency preparedness activities that can help reduce child maltreatment during, and in the months following, natural disasters and build upon current efforts to prepare and respond to natural disasters. The Leadership Team will also seek technical assistance from the National Traumatic Stress Network

Recommendation 8.21
The Child Maltreatment Prevention Leadership Team should work with state and local nonprofit organizations to increase the capacity of local communities to identify and implement research-based strategies focused on the primary prevention of child maltreatment among military families and communities. The Child Maltreatment Prevention Leadership Team should report on its progress toward implementing this goal by July 2006 and annually thereafter.

Partially Implemented
North Carolina has one of the largest active duty military populations in the country with more than 120,000 active-duty personnel. Additionally, over 770,000 veterans of the armed forces reside in North Carolina. North Carolina's National Guard and Reserve populations are also among the highest, with more than 10,000 in the ranks who have been in active deployment and reentry over the past five years. Approximately, 1,000 military personnel leave NC and return from active duty every month. While the Leadership Team has not specifically addressed this recommendation, there are several initiatives addressing the needs of military families. A survey from the National Governor's Association shows North Carolina has some of the nation's most comprehensive support programs for National Guard and Reserve family members.[39]

In 2006, the *Governor's Summit on Returning Combat Veterans and their Families* was held. This summit was the beginning of an ongoing process which identified the mental health and substance abuse service needs of veterans and their families. Through the *Governor's Focus on*

Returning Combat Veterans and their Families, North Carolina is developing new programs and building on existing ones to address the needs of North Carolina's veterans and their families.

In the 2007, the NC General Assembly provided funding to support several initiatives to support military families. These include:

- The *Returning Support for Veterans Program* (RSVP): RSVP is a one-stop location where veterans and their families can get information they need via the NC Department of Health and Human Services' CARELINE and NCcareLINK, a web-based county service/support directory. CARELINE is available 24 hours/day, 7 days/week. Trained staff are available for returning veterans and their families to address reentry to civilian life.
- Mental Health Services for Returning Veterans: The Division of Mental Health, Developmental Disabilities and Substance Abuse Services received both recurring and nonrecurring appropriations for mental health services for returning veterans.[40] Part of the funds will also be used to train health, behavioral health, and human service providers to address the mental health and substance abuse service needs of returning veterans and their families. Education for providers on treating disorders such as post traumatic stress will be developed and presented through a cooperative relationship with the federal Veterans Administration, Department of Defense, state Division of Veterans Affairs, NC Area Health Education Centers, and Local Management Entities (county or regional local mental health, developmental disabilities, and substance abuse organizations), primary health care providers, and faith communities.
- Additional Military Family Counselors: The NC Department of Public Instruction received recurring funds from the North Carolina General assembly to hire four additional military family counselors in the four counties with military installations (Cumberland, Craven, Onslow, and Wayne). The purpose of these positions is to provide assistance to families with issues related to deployment and family relocation.
- Funds to Support Morale, Welfare, and Recreation Activities for Military Personnel and their Families: One million dollars will be distributed to the seven military bases and installations to expand programs that support on-base community services and quality of life programs.
- National Guard Family Assistance Centers: Recurring funding was appropriated to establish three National Guard Family Assistance Centers to provide benefit and planning services to families of deployed National Guard members. The centers serve as a one-stop-shop for information on topics such as health care benefits, support groups, and other benefits and entitlements available to military families. The state-funded centers will augment the five existing federally funded centers, giving more Guard members access to vital services.
- Extending *More at Four* so more at-risk kids and children of deployed military are ready to learn. An additional 10,000 *More at Four* program slots were added, payments were increased by 10% to ensure quality, and children of deployed military were made eligible for *More at Four*.

Other initiatives that address the needs of military personnel and their families include:

- The Citizen-Soldier Support Program (CSSP): CSSP is a national demonstration program funded by the Department of Defense and spearheaded by the Odum Institute, University of North Carolina at Chapel Hill. CSSP promotes community support for citizen-soldiers and their families by enhancing the awareness, knowledge, and interest of civilian agencies and programs to better serve the needs of these soldiers and families before, during, and after mobilization and deployment.
- The NC National Guard Family Readiness Program: This non-profit program assists members of the National Guard and their families by providing comprehensive information and referral services on a variety of family-related programs and services, particularly when

guard families face the stress of extended foreign deployments. Services include crisis intervention, financial management advice, relocation assistance, spouse employment assistance, parenting education, and deployment support programs.

- The NC Department of Public Instruction (NC DPI) has a variety of resources to help public schools be supportive of military families. NC DPI sponsored three *Supporting Families and Children of the Guard and Reserve Institutes* in an effort to help school staff better understand the unique challenges faced by children and families of deployed family members and how to address those challenges. NC DPI plans to hold three additional *Supporting Families and Children of the Guard and Reserve Institutes* in 2008.

Recommendation 8.22
The Child Maltreatment Prevention Leadership Team should work with the NC Department of Corrections to examine whether incarcerated parents have a higher risk of future child maltreatment and, if so, develop recommendations to address this issue. The Child Maltreatment Prevention Leadership Team should report on its progress toward implementing this goal by July 2006 and annually thereafter.

Not Implemented
No progress has been made towards implementing this recommendation. Based on current resources, the Leadership Team will assess if action steps can be taken in 2008 to begin implementation of this recommendation. It is anticipated, however, that funding or realignment of staff time will be necessary to fully address this recommendation.

INCREASING FUNDING FOR CHILD MALTREATMENT PREVENTION

Recommendation 9.1
The NC Department of Public Instruction should ensure that funds from the NC Children's Trust Fund are used to support a full-time administrator for the NC Children's Trust Fund whose responsibilities are solely dedicated to child maltreatment prevention efforts. These efforts should be associated with managing, promoting, and increasing resources for the NC Children's Trust Fund and with serving in a leadership role for maltreatment prevention in the state. The NC Department of Public Instruction should report back its progress in implementing this recommendation to the Child Maltreatment Prevention Leadership Team by January 2006 and annually thereafter.

Fully Implemented
The NC Department of Public Instruction (NC DPI) has created a new position that is solely dedicated to efforts related to the NC Children's Trust Fund. NC DPI currently supports 1.5 positions with full responsibility for the NC Children's Trust Fund. These two employees manage the Children's Trust Fund and serve in statewide leadership roles for child maltreatment prevention.

Recommendation 9.2 (Priority Recommendation)
The NC General Assembly should make necessary funds available to implement the recommendations of the Task Force on Child Abuse Prevention with a specific focus on the support of child maltreatment prevention programs identified by the Task Force on Child Abuse Prevention as evidence-based and promising. Specifically, the Task Force on Child Abuse Prevention recommends that the NC General Assembly:

A. **Impose an additional fee of $10 on all birth certificates and allocate funds to the NC Children's Trust Fund.**
B. **Increase the existing fee on all marriage licenses from $5 to $10 and allocate funds to the NC Children's Trust Fund.**
C. **Impose an additional fee of $10 to all applications for divorce decrees and allocate funds to the NC Children's Trust Fund.**
D. **Provide a check-off on income taxes of $5 to be used for child abuse prevention programs. Funding from this check-off should be allocated to the NC Children's Trust Fund.**
E. **Appropriate funds for replication of the following programs identified by the Task Force on Child Abuse Prevention as evidence-based and/or promising in preventing maltreatment and strengthening families:**
    i. **Parent-Child Interaction Therapy - $50,000 for providing training to three sites involving three or four providers with follow up for model fidelity and skill mastery.**
    ii. **Strengthening Families Program - $1.57 million to fund three additional programs for three years.**

A report on the progress on this recommendation should be provided to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.

<u>Not Implemented</u>
The Children's Trust Fund is developing an advisory committee to help address this recommendation, which will be supported by the Leadership Team. The Children's Trust Fund is exploring the feasibility of partnering with child advocacy groups in order to determine their ability to introduce legislation to implement these recommendations and/or receive a larger state appropriation for funding.

Recommendation 9.3
The Child Maltreatment Prevention Leadership Team should work to increase funds available to implement the recommendations of the Task Force on Child Abuse Prevention, with a specific focus on the support of evidence-based and promising child maltreatment prevention programs. Specifically, the Task Force on Child Abuse Prevention recommends that the Child Maltreatment Prevention Leadership Team:

A. **Work with all NC Department of Health and Human Services divisions to ensure that the Task Force on Child Abuse Prevention recommendations are viewed as funding priorities within existing funding streams for child maltreatment prevention and within the following block grants to the NC Department of Health and Human Services: Temporary Assistance for Needy Families, Social Services, Mental Health, Substance Abuse, Maternal and Child Health.**
B. **Explore with the NC Division of Medical Assistance various strategies to reduce long-term health costs associated with child maltreatment trauma. Strategies should focus on reimbursement changes within the Maternity Care Coordination programs, Child Service Coordination programs, postpartum home visit efforts, and other home visiting programs.**
C. **Prioritize the following funding proposals that would help decrease risk factors that significantly contribute to child maltreatment, including funding to:**
    i. **Shorten the rollout timeframe of the Medicaid family planning waiver to decrease the number of unplanned and unwanted pregnancies in North Carolina.**
    ii. **Expand the number of programs funded by the Teen Pregnancy Prevention Initiative to decrease the number of adolescent pregnancies.**

iii. **Expand the number of perinatal and maternal substance abuse treatment programs to decrease the number of mothers with substance abuse problems.**
iv. **Increase the capacity of the Children's Developmental Services Agencies to ensure that children at-risk of or experiencing developmental delays are receiving timely assessments and services.**
v. **Increase the number of School-Based Child and Family Support Teams, school nurses, school social workers, and school counselors to ensure that high-risk children and their families receive appropriate services to reduce risk and increase protective factors.**
vi. **Increase the availability of childcare subsidies to reduce the number of children without access to quality, affordable childcare.**

D. **Work with the NC Children's Trust Fund to support its efforts to increase the sale of the KIDS FIRST license plate.**
E. **Identify funding from non-governmental sources to pilot and evaluate new initiatives.**
F. **Work with local communities and governmental organizations and partner with private foundations and funders to promote funding for evidence-based and promising programs as identified in the Task Force on Child Abuse Prevention plan and by the Child Maltreatment Prevention Leadership Team and to ensure that program evaluation activities are provided through the grant-making process.**

A report on the progress on this recommendation should be provided to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.

Partially Implemented

The Leadership Team made this recommendation a priority for 2007-2008. While progress has been made, there is still much work to be done in order to accomplish this recommendation in its entirety. First, as reported in the updates to Recommendations 7.1-7.7, 8.4, and 8.10, several state agencies have made evidence-based programs a funding priority. While there is still much work to be accomplished in this area, progress has been made. In addition, progress has been made in implementing other parts of this recommendation (as described in the updates to Recommendations 8.4, 8.10, 8.12, 8.15, and 8.19). No progress has been made in expanding the number of teen pregnancy prevention programs (see Recommendation 8.13).

To date, no work has been done by the Child Maltreatment Leadership Team to explore with the NC Division of Medical Assistance's various strategies to reduce long-term health costs associated with child maltreatment trauma with regards to reimbursement changes within the Maternity Care Coordination programs, Child Service Coordination programs, and postpartum home visit efforts. This is due to current federal Medicaid case management service definitions.

The Child Maltreatment Prevention Leadership Team and Prevent Child Abuse North Carolina have been promoting the Children's Trust Fund in a campaign to increase the sale of the KIDS FIRST license plate. Each order of the KIDS FIRST license plate adds $15 to the Children's Trust Fund. Revenue from the sales of the KIDS FIRST license plate doubled from 2003 to 2006, from 606 to1,324 plates issued. Revenue continues to increase. Actual revenues to the Children's Trust Fund are: $9,090 (2003), $7,680 (2004), $15,045 (2005), and $19,860 (2006).

Finally, as previously reported, the Child Maltreatment Prevention Leadership Team via the Alliance for Evidence-Based Family Strengthening Programs has been working with The Duke Endowment and the Kate B. Reynolds Charitable Trust to provide funding for the Nurse Family Partnership Initiative. The Duke Endowment has also been working with Prevent Child Abuse North Carolina to provide funding to several of the task force recommendations.

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[1] Action for Children. *North Carolina Child Protective Services Data Card 2002-2003*. http://www.ncchild.org/images/stories/cpscard1.pdf. Accessed online March 28 2008.
[2] English, DJ, Upadhyaya, M, Litrownik, A, Marshall, J, Runyan, DK, Graham, JC, Dubowitz, H. (2005). *Maltreatment's wake: The relationship of maltreatment dimensions to child outcomes*. Child Abuse & Neglect 29: 597-619. The Centers for Disease Control and Prevention. (2007). *Child Maltreatment Prevention*. Retrieved, October 16, 2007 from http://www.cdc.gov/ncipc/dvp/CMP/default.htm. Thompson, R, Briggs E, English, DJ, Dubowitz, H, Lee, L, Brody, K, Everson, MD, Hunter, WM. (2005). *Suicidal ideation among 8-year-olds who are maltreated and at risk: Findings from the LONGSCAN studies*. Child Maltreatment 10(1): 26-36.
[3] Of the approximately 40,000 children and families referred to services, 13,000 were required to receive services. Duncan, D.F., Kum, H.C., Flair, K.A., Stewart, C.J., Weigensberg, E.C., and Lanier, III, P.J. (2008). NC Child Welfare Program. Retrieved March 26, 2008 from University of North Carolina at Chapel Hill Jordan Institute for Families website: http://ssw.unc.edu/cw/.
[4] HB 1530 was sponsored by Representatives Weiss and Earle and cosponsored by Representatives Alexander, B. Allen, Carney, Insko, and Wainwright. SB 871 was sponsored by Senator Purcell; (primary) and Senators Atwater and Dannelly (Co).
[5] The Leadership Team was staffed by a part-time coordinator until funding was secured to hire a full time executive director. Prior to the 2005-2006 legislative session, the NC Child Fatality Task Force, a legislative study commission, agreed to include the recommendation of funding a staff position for the Child Maltreatment Leadership Team on its legislative agenda. Senator William Purcell, an appointed member of the Child Fatality Task Force, introduced Senate Bill 1249 and championed the appropriation of $90,000 in recurring funds for the purpose of creating such a position. Under the leadership of Child Fatality Task Force members and with the strong support of advocacy partners including PCA North Carolina and the Covenant with North Carolina's Children, Senate Bill 1249 passed and funding was secured.
[6]The Child Fatality Prevention System was established in 1991 in North Carolina. The purposes of the North Carolina Child Fatality Prevention System (NCGS § 7B-1406-1413) include: developing a community approach to the prevention of child abuse and neglect; understanding and reporting the causes of child deaths; identifying gaps in services to children and families; and making and carrying out recommendations for changes to laws, rules, and policies to prevent future child deaths, especially those from abuse and neglect. There are 4 components to this system: the Local Child Fatality Prevention Teams (CFPTs), Community Child Protection Teams (CCPTs), the State Child Fatality Prevention Team ("State Team"), and the North Carolina Child Fatality Task Force (CFTF).
[7] The NC Division on Public Health did submit a letter of intent to apply for this grant; however, it was unable to meet one application requirement (i.e., the indirect cost cap for the grant).
[8] A Strategic Frame Analysis™ is a proprietary approach to communications research and practice that pays attention to the public's deeply held worldviews and widely held assumptions. This approach was developed at the FrameWorks Institute using a multi-disciplinary approach to evaluate the effects of various frame elements on support for social policies. Recognizing that there is more than one way to tell a story, Strategic Frame Analysis™ taps into decades of research on how people think and communicate. The result is an empirically-driven communications process that makes academic research understandable, interesting, and usable to help people solve social problems.
[9] FrameWorks has agreed to work with PCA North Carolina and other stakeholders. A number of stakeholders have been invited to participate in this process including the NC Partnership for Children, NC Division of Public Health, NC Department of Public Instruction, NC Division of Social Services, NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, and others. The Duke Endowment and Division of Public Health are providing funding for this project.
[10] The North Carolina Child Advocacy Institute. *Reducing Collateral Damage on the Home Front*. Raleigh, 2004. http://www.ncchild.org/action/images/stories/collateral_damage.pdf Accessed online March 28 2008.
[11] Social capital is seen as potentially having a significant role in addressing a variety of problems (for instance, crime and under-employment), by harnessing the capacity that exists within deprived

communities to utilise the social networks they already have to find solutions to their problems, in the process engendering what is termed 'community cohesion'. Mapping employs Geographical Information Systems (GIS). In its most basic form, a GIS involves the integration of two tools: a standard statistical database, and a mapping package which contains data on spatial boundaries.

[12] The North Carolina Coalition Against Domestic Violence (NCCADV) Domestic Violence Prevention Enhancement Through Alliances (DELTA) project is working to build intimate partner violence (IPV) prevention capacity within the state and local communities. Specifically, NCCADV has recruited a diverse group of stakeholders to develop an IPV Prevention Plan. This plan will focus on the strategies needed to prevent IPV and build the infrastructure required to support the integration of primary prevention principles into operating structures and processes, develop primary prevention resources, and provide primary prevention training and technical assistance to various partners throughout North Carolina. The Community Violence Prevention Work Group is following this process. The DELTA program is a three year grant from the CDC. North Carolina was one of 14 state coalitions to receive funding for the DELTA Program.

[13] Barth,R. The Move to Evidence Based Practice: How Well Does it Fit Child Welfare Services? Paper presented for the O'Leary lecture at Ohio State University, School of Social Work, October 18,2007. http://www.csw.ohio-state.edu/pdf/The%20Move%20to%20EBP%20in%20CWS%20_O'Leary%20leccture%20RPB_%20final.pdf. Accessed online on March 28, 2008.

[14] Bills were introduced in both the Senate (by Senator Boseman) and the House (by Representatives Glazier, Goodwin, Barnhart, and Parmon) in 2007 that proposed to amend § 143B-152.10—Family Resource Center Grant Program—to require the use of evidence-based or promising practice models. House Bill 696 - "An Act to ensure family support grants are provided to community-based agencies to implement only family support programs that are research-based and have been evaluated for effectiveness under the laws pertaining to the family resource center grant program" passed in 2007, adding "prevent child abuse and neglect by implementing program models that have been evaluated and found to improve outcomes for children and families" to the intent of Family Resource Centers.

[15] "Treatments that Work." National Child Traumatic Stress Network. http://www.nctsnet.org/nccts/nav.do?pid=ctr_top_trmnt. Accessed March 28, 2008.

[16] In the past, DPH funded more programs at a much lower funding level. In FY 2005, DPH provided funding of $14,280 to 68 community agencies.

[17] Awards are effective July 1, 2008. This is the first RFA from The Teen Pregnancy Prevention Initiatives (Adolescent Parenting Program) which encouraged local communities to incorporate the use of an evidence-based curriculum as a part of the program plan.

[18] Funds are contingent on approval from the NC General Assembly.

[19] Applicant sites must be approved by the Nurse Family Partnership National Office by demonstrating community capacity for implementation of the NFP model prior to funding awards.

[20] DPH funds are contingent on approval from the NC General Assembly.

[21] CCFH faculty provide training to triangle area clinicians, most of who are agency or directly enrolled Medicaid providers. PCIT training using a learning collaborative approach is being conducted as a component of a Governor's Crime Commission Grant to Kids First of Elizabeth City in which CCFH conducts a total of five days of direct training accompanied by detailed session review for treatment fidelity and adherence for clinicians affiliated with Child Advocacy Centers in six rural North Carolina counties.

[22] The CPC program was established in 1967 through funding from Title I of the landmark Elementary and Secondary Education Act of 1965. It is the second oldest (after Head Start) federally funded preschool program in the US and is the oldest extended early childhood intervention. Initially implemented in four sites and later expanded to 25, the program is designed to serve families in high-poverty neighborhoods that are being served by other early childhood programs.

[23] See Footnote #8 for details on the amendment of § 143B-152.10 - Family Resource Center Grant Program.

[24] The NC Child Treatment Program Pilot is currently seeking legislative support for increased funding to transition from a grant-funded project serving 28 northeastern counties to a permanent, state-funded program serving 100 counties through advocacy groups.

[25] The Education Begins at Home Alliance is a collaborative group of agencies, including: Parents As Teachers, NC Partnership for Children, Prevent Child Abuse North Carolina, NC Division of Public Health

(Early Intervention, MCC, and CSC), Head Start, Early Start, Cooperative Extension, UNC-CH, Duke University- Center for Child and Family Policy, Guilford Child Development, Appalachian Family Innovations, Division of Mental Health, Developmental Disabilities, and Substance Abuse, and the Office of School Readiness. These groups came together to increase the quality and availability of home visitation programs. A goal of this collaborative is to position NC to apply for federal home visitation funds (The Education Begins at Home Act (S. 503), if legislated.

[26] Through a different contract with DSS, FSN affiliates are able to serve families with infants who are medically fragile and children who have special needs to provide a variety of supportive services. These services are funded by DSS for the purpose of child abuse and neglect prevention.

[27] CCNC has implemented a mental health integration pilot (*North Carolina Co-Location Project*), which integrates behavioral health services with medical primary care. This project is a result of an increasing number of Medicaid enrollees presenting at primary care provider practices with both behavioral and physical health care needs. The pilot began in July 2005 with 4 CCNC networks working with Local Management Entities (LMEs). The Mental Health Integration pilot is a collaborative effort between the NC Division of Mental Health, Development Disabilities and Substance Abuse Services, NC Division of Medical Assistance, NC Office of Rural Health and Community Care, and NC Foundation for Advanced Health Programs, Inc.

[28] Family Support Network of Region A covers the seven most western counties of North Carolina (Cherokee, Clay, Graham, Haywood, Jackson Macon, and Swain); the Parent-to-Parent Program will be offered in Haywood, Jackson, and Macon.

[29] Family Support Network of Northeastern North Carolina covers Brunswick, Columbus, Duplin, New Hanover and Pender counties; the Parent-to-Parent Program will be offered in Currituck, Gates, Hertford, and Pasquotank.

[30] A National Outcome Study of Parents Anonymous® was conducted by the National Council on Crime and Delinquency funded by the Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice. This longitudinal study is the only independent outcome research conducted nationwide to assess the impact of parent mutual support-shared leadership groups on child maltreatment prevention. While the outcomes of this research were encouraging with regards to the program's effectiveness in key child maltreatment outcomes, the reach methodology did not include a randomized control group. The comparison group used in this study was parents who dropped out of the program.

[31] Circle of Parents program model is rooted in the principles of mutual self-help groups. Groups are facilitated by a trained group facilitator and parent leader and provide a friendly, supportive environment where anyone in a parenting role can openly discuss the successes and challenges of raising children.

[32] Through the leadership of the Office of the Governor, the Initiative brings together the NC Department of Health and Human Services, NC Department of Public Instruction, NC State Board of Education, NC Department of Juvenile Justice and Delinquency Prevention, NC Administrative Office of the Courts, and other state agencies that provide services for children to share responsibility and accountability to improve outcomes for these children and their families.

[33] House Bill 1446- would allocate $13 million in the 2007-08 school year and $26 million for the 2008-09 school year from the General Fund to the NC Department of Health and Human Services, Division of Public Health. These funds would be used to bring the nurse-to-student ratio to 1:1,641 in 2007-08 and 1:1,309 for the 2008-09 school year. This bill was referred to the Appropriations Committee, and while not ratified in the 2007 session, it will be considered in the 2008 short session.

[34] Session Law 176, enacted in August 2007, requires that the State Board of Education report to the legislature by November 1, 2007 on the implementation of the new school counselor job description in North Carolina public schools (grades K-12). The NC General Assembly requested this information to "determine whether adjustments should be made in funding for school counselors or assigned duties of school counselors." This report has been submitted to the Joint Legislative Education Oversight Committee and will be available for public review in November 2007. The full report is available at: www.ncpublicschools.or/studentsupport/counseling.

[35] Two bills (Senate Bill 1151, House Bill 228) proposed funding for Test Coordinators, which would protect school counselors' time. Both bills were referred to the respective Appropriations Committee. Senate Bill 450- Testing K-8 National Form Test, included language that would prohibit school counselors from coordinating or administering the test program for more than 10 days during the school year. This bill was referred to the Committee on Education/Public Instruction.

[36] Senate Bill 1182 was introduced on March 22, 2007 by Senator Garrou along with 5 co-sponsors. This bill, as written, required that public schools offer comprehensive, medically accurate, non-discriminatory sexuality education in grades 7 and 8 and once in high school.
House Bill 879 was introduced on March 16, 2007 by Representatives Fisher, Coleman, Jeffus, and Goodwin. This bill requiring public schools to offer comprehensive, medically accurate, non-discriminatory sexuality education passed through the House Health Committee "without prejudice" and was sent to the Education Committee. This bill did not abolish "abstinence-only" education at all, but it expanded the current curriculum to include abstinence instruction and honest, realistic sex-education. HB 879 explicitly stated instruction and materials should teach respect for marriage and committed relationships.
[37] NCCADV provides the following services: a resource library; a training institute; Immigrant Outreach and Communities of Color support; Project Rainbow Net for lesbian, gay, bisexual, and transgender partner violence; public policy advocacy; Coordinated Community Response (CCR) for preventing IPV; technical assistance; and The Silent Witness Initiative to memorialize domestic violence homicide victims.
[38] Training topics included Building and Maintaining a Coordinated Community Response Team, Empowering Teens to Promote Change, and Engaging the Faith Community in IPV Prevention. In addition, NCCADV partnered with several national organizations to support other training events.
[39] The National Governors Association surveyed the 50 states and Puerto Rico about programs and benefits they provide to National Guard and Reserve members in six categories: family support; education; licensing and registration; tax and financial; state employees; and protections, recognition and employment. Fifty-one states and territories offer some type of family support while 43 offer educational benefits. Thirty-nine states offer tax or financial relief and about half offer state employees' additional benefits. North Carolina provides benefits in all six categories, and the survey pointed out North Carolina is especially aggressive in the area of family support.
[40] This included funding for a mental health program manager to lead the Division's response to the mental health services needs of veterans and their families. This funding also provided for the expansion of the NC Health Information Portal, which is part of UNC-Chapel Hill's Health Sciences Library, to include a specific, easy-to-use website for veterans and their families. The Health Information Portal will be a comprehensive online resource for health services and information for veterans and their families throughout North Carolina.

APPENDIX A
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APPENDIX F
THE ALLIANCE FOR EVIDENCE BASED STRENGTHENING FAMILIES MEMBERS

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Michelle Hughes (Co-Chair)
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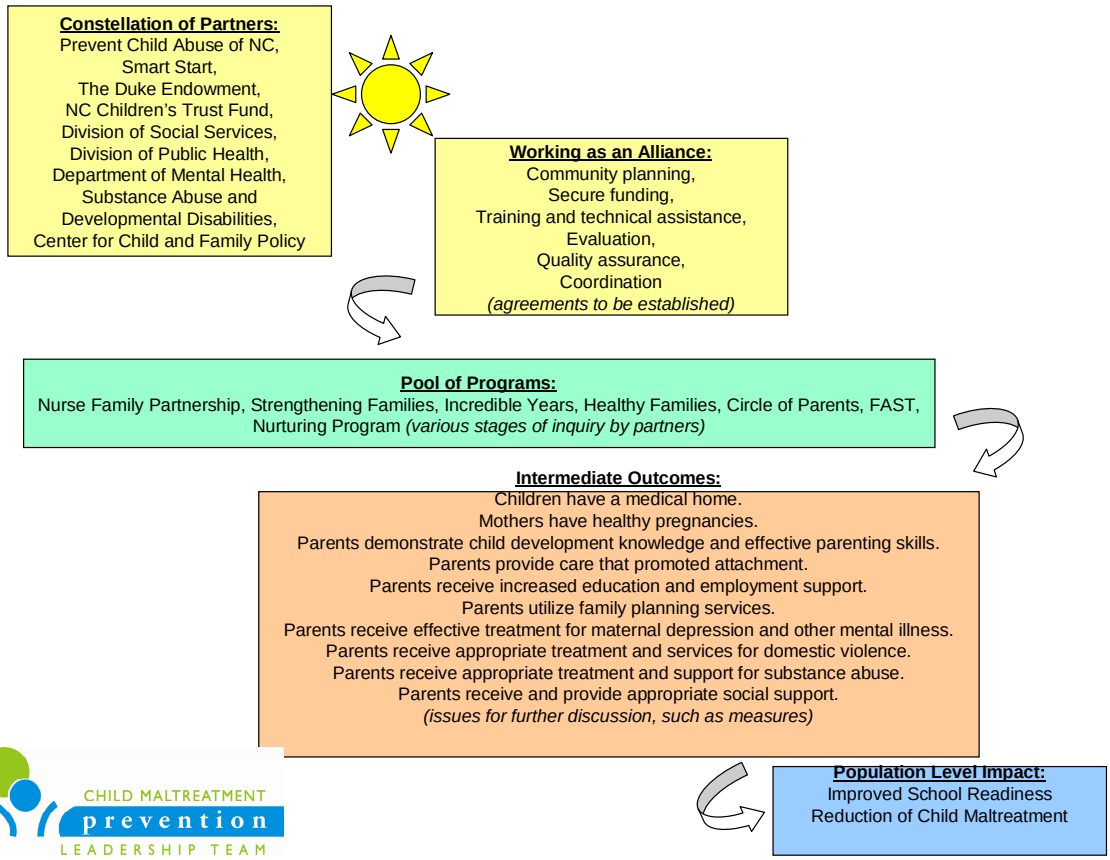
APPENDIX G
THE ALLIANCE FOR EVIDENCE BASED STRENGTHENING FAMILIES PROGRAMS
LOGIC MODEL



APPENDIX H
GLOSSARY OF PROGRAMS AND ACTIVITIES

The Alliance for Evidence-Based Family Strengthening Programs: Prevent Child Abuse North Carolina and the Duke Center for Child and Family Policy co-chair a group of funders and state agencies that are working together to target the most critical risk and protective factors for child maltreatment and school readiness. The organizations that are part of the Alliance include: the NC Division of Social Services, NC Children's Trust Fund, NC Partnership for Children, NC Division of Public Health, NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, The Duke Endowment, and the Kate B. Reynolds Charitable Trust. These organizations are working together to promote evidence-based family strengthening programs in North Carolina.

Adolescent Parenting Program (APP): The APP is a grant program developed to fund grants for local agencies to provide services for Medicaid eligible pregnant and parenting teens throughout North Carolina. The State Legislature and Medicaid fund the APP. In accordance with NC General Statute 130A-131.15A and Session Law 2001-424 Section 21.89, this program is administered by the Women's and Children's Health Section, Division of Public Health, within the NC Department of Health and Human Services.

Center for Child and Family Health (CCFH): Located in Durham, the CCFH is a collaborative effort between Duke University, the University of North Carolina at Chapel Hill, and North Carolina Central University. CCFH offers diagnostic, treatment, and preventive services for children at risk of experiencing trauma. CCFH also offers home visiting and support groups.

Chicago Child-Parent Center (CPC) Model: The CPC model is a center-based early intervention program that provides comprehensive educational and family support services to economically disadvantaged children from preschool to early elementary school. The overall goal of the program is to promote children's academic success and to facilitate parent involvement in children's education. The CPC program was established in 1967 through funding from Title I of the landmark Elementary and Secondary Education Act of 1965. It is the second oldest federally funded preschool program in the US (after Head Start) and is the oldest extended early childhood intervention. Initially implemented in four sites and later expanded to 25, the program is designed to serve families in high-poverty neighborhoods that are being served by other early childhood programs.

Children's Development Services Agencies (CDSA): Formerly know as Developmental Evaluation Centers (DEC), the CDSA provides evaluation, case management, and intervention services through 18 single or multi-county areas. Children who are suspected of or known to have a developmental disability and are under age three are seen in these clinics. Developmental disabilities include spina bifida, autism, mental retardation, and other childhood developmental difficulties involving movement or communication. Case management and evaluation services are provided to help determine eligibility and developmental needs. Once eligibility has been determined, case management and intervention services such as physical therapy, occupational therapy, speech/language services, and community-based rehabilitative services are authorized and provided with parental approval and involvement.

Child Medical Evaluation Program (CMEP): Established in 1976, the Child Medical Evaluation Program is a cooperative effort of the UNC School of Medicine's Department of Pediatrics, NC Division of Social Services (NC DSS), the NC General Assembly, local

departments of social services, and local medical and mental health providers. The staff of the Child Medical Evaluation Program has developed a statewide network of local providers who provide skilled diagnostic medical examinations and psychological assessments of children referred by agencies of the NC DSS to help determine the presence or extent of abuse and neglect.

Circle of Parents Programs: Circle of Parents is a support program that provides weekly support group for parents and other caregivers where they can find and share support. The model is rooted in the principles of mutual self-help groups. Groups are facilitated by a trained group facilitator and parent leader and provide a friendly, supportive environment where anyone in a parenting role can openly discuss the successes and challenges of raising children.

Community Care of North Carolina (CCNC): CCNC is composed of 14 regional community health networks comprised of community physicians, hospitals, health departments, local management entities for mental health, developmental disabilities and substance abuse services, departments of social services and other health, mental health, and community providers that are working together to improve care to Medicaid recipients.

Darkness to Light: Darkness to Light is a public awareness campaign that seeks to raise awareness of the prevalence and consequences of child sexual abuse. Darkness to Light educates adults through a sexual abuse prevention training program that provides frontline training for organizations and corporations that serve children and youth.

Domestic Violence Prevention Enhancement and Leadership Through Alliance (DELTA) Program: DELTA is a federal grant, administered by the Centers for Disease Control and Prevention, which seeks to create community-based, sustainable sexual and domestic violence prevention efforts through the development of local collaborations. Communities are provided with training and resources to develop prevention plans appropriate for their locality. These plans address the issues of sexual and domestic violence at four levels: the individual, relationship, community, and societal. North Carolina is one of the 14 funded sites for this project.

Durham Connects: Durham Connects is a universal postpartum home visiting program conducted by health department nurses. Nurses visit families between one and three times and help link families to community-based health and family support services.

Early Childhood Comprehensive System (ECCS): The Maternal and Child Health Bureau launched the state Maternal and Child Health Early Childhood Comprehensive Systems Initiative in 2003. The purpose of ECCS is to support states and communities in their efforts to build and integrate early childhood service systems that address access to comprehensive health services and medical homes; social-emotional development and mental health of young children; early care and education; parenting education; and family support. In North Carolina, the ECCS Initiative is located within the Division of Public Health.

Education Begins at Home Act (S. 503): The Education Begins at Home Act is federal legislation introduced in 2007 that would establish the first dedicated federal funding stream to support parents with young children through quality home visitation at the state and local level.

Education Begins at Home Alliance: The Education Begins at Home Alliance is an early childhood visitation collaborative formed in 2005 with the aim of strengthening and increasing quality early childhood home visitation programs in North Carolina. Four work groups have been formed from the Education Begins at Home Alliance to complete a needs assessment of early

childhood home visitation services in North Carolina, address training and professional development, develop an advocacy plan, and develop an intensive home visiting model for North Carolina with the goal of preparing North Carolina as a viable applicant for federal funding should the federal Education Begins at Home Act (S. 503) be enacted.

EMPOWER Project: Through a grant from the Centers for Disease Control and Prevention, the EMPOWER process has developed a State Capacity Building Team and the NC Sexual Violence Prevention Team to build statewide capacity in primary prevention of sexual violence.

Family Resource Centers: Family Resource Centers provide services that promote both the strengthening of families through formal and informal services and the restoration of a strong sense of community. Family Resource Center services may include parent skill training, drop-in centers, home visiting, job training, substance abuse prevention, violence prevention, services for children with special needs, mental health or family counseling, child care, literacy skills training, respite and crisis care services, assistance with basic economic needs, and housing. Family Resource Centers work with community members to develop specific services that meet the needs of the people who use the center and the community that surrounds it. This is accomplished by involving parents in design, implementation, and evaluation. Many centers require that advisory boards oversee the day-to-day operation of the centers, and that more than half of the board members be parents. Family Resource Centers are located in a variety of community settings and serve diverse populations. Depending upon the resources available in the community, Family Resource Centers may be located in churches, schools, hospitals, housing projects, or a variety of other community settings. Based in the places where families naturally congregate, Family Resource Centers serve as a central support within the community around which families can build their lives, regardless of the challenges they face. Family Resources Centers receive funding from a variety of sources.

Family Support Network of North Carolina (FSN NC): FSN NC promotes and provides support to families with children who have special needs. The FSN NC (state office) is located within the University of North Carolina at Chapel Hill and is a unit of the School of Medicine. The organization operates in collaboration with the Clinical Center for the Study of Development and Learning. The state office facilitates the activities of the local affiliates, maintains the central directory of resources, and coordinates and conducts educational activities. Through all of these programs, the Family Support Network of North Carolina serves thousands of families and service providers across North Carolina each year.

FrameWorks Institute: FrameWorks is a private, nonprofit organization with a mission to advance the nonprofit sector's communications capacity by identifying, translating, and modeling relevant scholarly research for framing the public discourse about social problems.

Incredible Years: Incredible Years is an evidence- and developmentally-based intervention curriculum with components for parents, teachers, and children (aged 2-12). The program is designed to prevent and treat emotional and behavioral problems in young children by promoting children’s social, emotional, and academic competence; strengthening parental competence and family relationships; promoting teacher competence in managing classroom behavior; and strengthening school-home connections. Interventions use a group format and deliver content through multiple methods.

Local Management Entity (LME): LMEs are regional or county public agencies that are responsible for managing, coordinating, facilitating, and monitoring the provision of mental health, developmental disabilities, and substance abuse services in the catchment area served.

LME responsibilities include offering consumers 24/7/365 access to services, developing community needed services/supports, endorsing and overseeing providers, and handling consumer complaints and grievances.

North Carolina Child Treatment Program (NC CTP): The North Carolina Child Treatment Program is a three-year pilot project being administered by the UNC School of Medicine, Department of Pediatrics, in conjunction with the Child Medical Evaluation Program. This program is being piloted in 28 northeastern counties. The NC CTP provides evidence-based mental health treatment for sexually traumatized children.

Nurse Family Partnership: Nurse Family Partnership is an evidence-based prenatal and early childhood home visitation program designed to improve maternal and child health and wellbeing. Home visits are conducted by an experienced, well-trained, and supervised nurse who works intensively with first time, low-income mothers and their families over a period of two years.

Nurturing Parent Program©: Nurturing Parent Program© is a promising practice home- and group-based education curriculum designed to treat child maltreatment, prevent recurrence of child maltreatment, and build nurturing parenting skills in at-risk families. Fifteen separate curriculums exist based on the age of the child and family needs (i.e. substance abusing families or foster families) and includes activities for both parents and children.

Parents Anonymous® Program: Parents Anonymous® is a support program that provides weekly support groups for parents based on shared leadership and mutual support. Program goals include strengthening families and building strong communities; achieving meaningful parent leadership and shared leadership; and the reduction of child abuse and neglect.

Parent Child Interaction Therapy: Parent Child Interaction Therapy is an empirically-supported treatment for conduct-disordered young children that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. Parent Child Interaction Therapy works to improve the relationship between a child and parent by teaching the parent specific skills to use during interactions with the child. The parent is also taught effective behavior management techniques in order to reduce oppositional behaviors.

Parent Education and Training Programs: Parent education and training programs are courses (or curricula) to improve and/or correct a person's parenting skills. Programs may be general, covering the most common issues parents may encounter, or specific for infants, toddlers, children, teenagers, and/or for parents who are at risk for, or have already, maltreated their child(ren). These courses may also be geared towards parents who are considering having a child, adopting one, or are pregnant.

Parent to Parent Programs: Parent to Parent programs provide one-on-one emotional and informational support to a parent of a child who has a disability, chronic illness, or other special health care needs by a trained support parent who has had similar family and disability experiences. This program is administered through the North Carolina Family Support Network.

Period of PURPLE Crying--Keeping North Carolina Babies Safe: The Period of PURPLE Crying project is a joint project with the UNC Chapel Hill Injury Prevention Research Center, the National Center on Shaken Baby Syndrome, and the Center for Child and Family Health. This project is funded by the Centers for Disease Control and Prevention, the Doris Duke Charitable Foundation, and The Duke Endowment. This statewide project is based on new educational materials for parents developed by the National Center on Shaken Baby Syndrome. The materials

help parents understand the frustrating features of crying that can lead to shaking or other types of abuse. The goal of this project is to prepare parents to respond safely and explicitly to infant crying to reduce hospital admissions and deaths from abusive head trauma.

Practice Improvement Collaborative (PIC): The Practice Improvement Collaborative is comprised of a panel of experts that considers science, practitioners, and consumers who recommended best practice and evidence-based programs and services to the NC Division of MHDDSAS.

Reframing: In general, reframing is changing the context or representation of a problem. In context to Recommendation 6.1 the term "reframing" refers to *Strategic Frame Analysis*™. [41]

Shared Indicators for School Readiness: The set of shared indicators for school readiness measures indicators across multiple agencies and domains, all of which affect early school readiness. School readiness indicators can help communities assess whether their community, schools, families and children are prepared to ensure all children enter kindergarten ready to succeed.

Strengthening Families© Program (SFP): SFP is an evidence-based parenting and family strengthening program for high-risk families. The aim of SFP is to significantly reduce problem behaviors, delinquency, alcohol, and drug abuse in children, improve social competencies, improve school performance, and reduce child maltreatment.

Trauma Focused Cognitive Behavioral Therapy (TF-CBT): TF-CBT is an evidence-based treatment approach shown to help children, adolescents, and their caretakers overcome trauma-related difficulties. It is designed to reduce negative emotional and behavioral responses following child sexual abuse and other traumatic events. The treatment, based on learning and cognitive theories, addresses distorted beliefs and attribution[42] related to the abuse, and provides a supportive environment in which children are encouraged to talk about their traumatic experience. TF-CBT also helps parents who were not abusive to cope effectively with their own emotional distress and develop skills that support their children.

Zero to Three: Zero to Three is a nonprofit, multidisciplinary organization with a mission to support the healthy development and wellbeing of infants, toddlers, and their families through informing, educating, and supporting adults who influence the lives of infants and toddlers.

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[41] A Strategic Frame Analysis™ is a proprietary approach to communications research and practice that pays attention to the public's deeply held worldviews and widely held assumptions. This approach was developed at the FrameWorks Institute using a multi-disciplinary approach to evaluate the effects of various frame elements on support for social policies. Recognizing that there is more than one way to tell a story, Strategic Frame Analysis™ taps into decades of research on how people think and communicate. The result is an empirically-driven communications process that makes academic research understandable, interesting, and usable to help people solve social problems.

[42] Attribution theory is a social psychology theory developed by Fritz Heider, Harold Kelley, Edward E. Jones, and Lee Ross. The theory is concerned with the ways in which people explain (or attribute) the behavior of others or themselves (self-attribution) with something else. It explores how individuals "attribute" causes to events and how this cognitive perception affects their usefulness in an organization.

APPENDIX I
LIST OF ACRONYMS

AF-CBT: Abuse-Focused Cognitive Behavioral Therapy

CAC: Children's Advocacy Centers

CAPTA: Child Abuse Prevention and Treatment Act

CCFH: Center for Child and Family Health

CCNC: Community Care of North Carolina

CCR: Coordinated Community Response

CDC: Centers for Disease Control and Prevention

CDSA: Children's Development Services Agencies

CMS: Centers for Medicare and Medicaid Services

CTF: Children's Trust Fund

DELTA: Domestic Violence Prevention Enhancement and Leadership Through Alliances

DMHDDSAS: NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

DPH: NC Division of Public Health

DSS: NC Division of Social Services (state) or NC Departments of Social Services (local)

ECCS: Early Childhood Comprehensive System

EMPOWER: Enhancing and Making Programs and Outcomes Work to End Rape is a federal grant administered CDC grant for Rape Education Prevention to provide state level strategic planning (Getting to Outcomes). North Carolina (NC DHP) is a grant recipient.

IPV: Intimate partner violence

LME: Local Management Entity

NCCADV: North Carolina Coalition Against Domestic Violence

NC CTP: NC Child Treatment Program

NC DCD: North Carolina Division of Child Development

NCPC: North Carolina Partnership for Children

NFP: Nurse Family Partnership

PIC: Practice Improvement Collaborative

PCA North Carolina: Prevent Child Abuse North Carolina

PCIT: Parent Child Interaction Therapy

RPE: Rape Prevention and Education Program

RSVP: Returning Support for Veterans Program

RFA: Request for Application

SFP: Strengthening Families Program

TF-CBT: Trauma Focused Cognitive Behavioral Therapy