

# Wake County Human Services Public Health Quarterly Report July–September, 2015 Injuries



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Cover photo depicts a *Never Leave Your Child Alone in a Car* heatstroke awareness and education event. The event, conducted by Safe Kids shows parents and caregivers the very real dangers that hot vehicles pose to children.

## 1.0 Introduction

Information about the many types of injuries is complex and is gathered from several data sources such as death certificates, medical examiner reports, law enforcement reports, hospital admissions and emergency department visits. Deaths are the most severe outcome from injuries but are the “tip of the iceberg” (Figure 1) when evaluating the burden of injuries. Many injuries are either treated by medical providers during outpatient visits and not reported or no medical treatment is sought for the injury. Thus, the total societal burden of injuries from all causes is unknown. This report provides an overview of deaths, hospitalizations and emergency department visits from the leading causes of injuries among residents in Wake County and presents emerging issues related to drug overdoses and suicides.



**Figure 1**

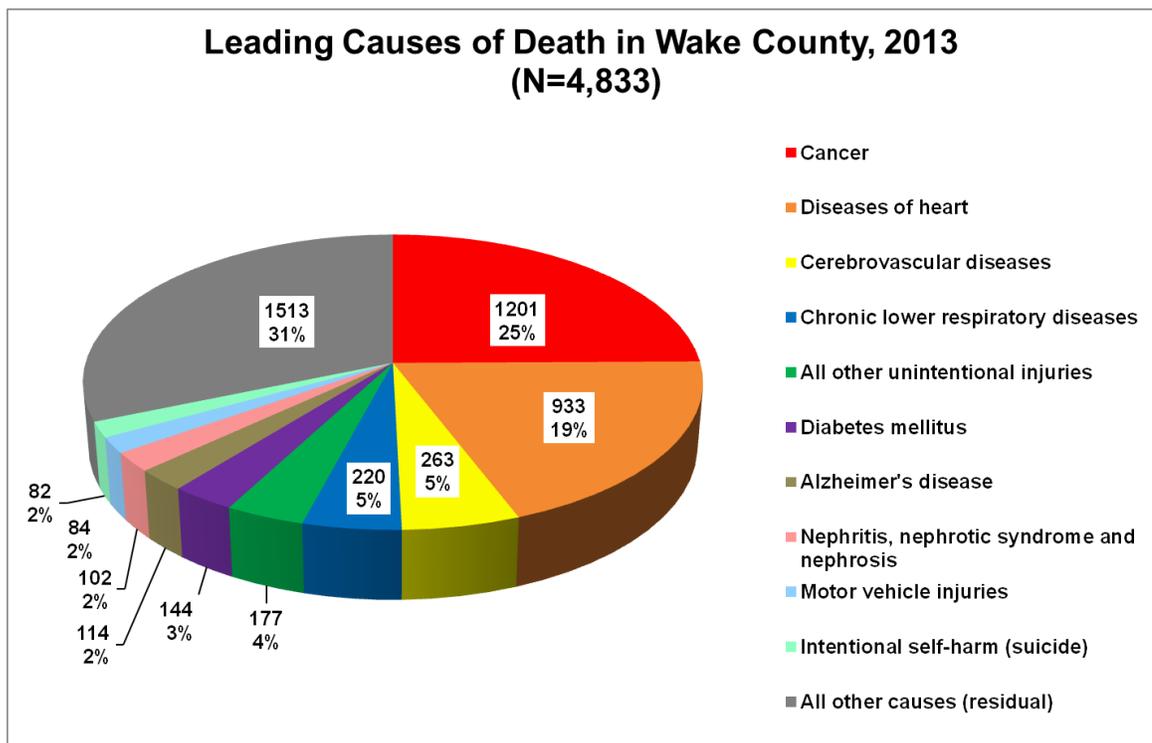
Source: Injury and Violence Prevention Branch, NC DHHS <http://www.injuryfreenc.ncdhhs.gov/injuryIceberg.htm> (accessed 8-24-15)

## 2.0 Overview and Trends

### 2.1 Leading Causes of Death in Wake County

In 2013, injuries were among the top 10 causes of death in Wake County. Unintentional injuries ranked #5, motor vehicle injuries ranked #9, and intentional self-harm (suicide) ranked #10 (Figure 2).

**Figure 2**



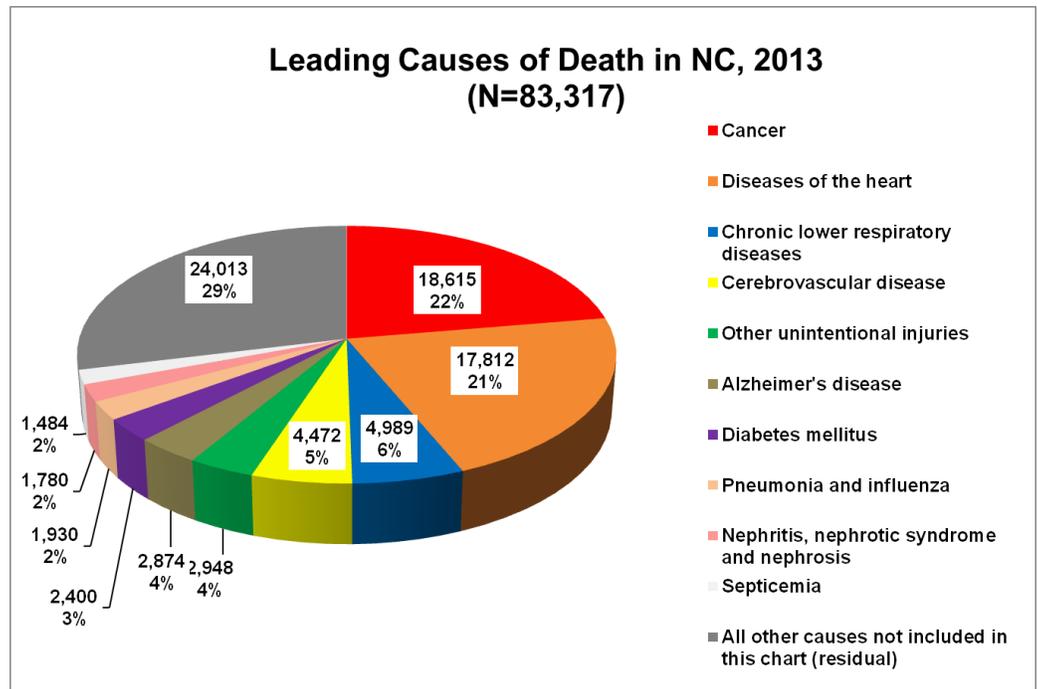
Residual causes are all other causes not otherwise categorized here.

Source: State Center for Health Statistics. <http://www.schs.state.nc.us/schs/data/lcd/getleadcauses.cfm>, accessed 7/10/2015

For North Carolina overall, as in Wake County, other unintentional injuries ranked #5 (Figure 3).

**Figure 3**

Residual causes are all other causes not otherwise categorized here.  
Source: State Center for Health Statistics



## 2.2 Leading Causes of Death, Hospitalizations, Emergency Department Visits by Injury

The five leading causes of death, emergency department visits and hospitalizations by injury are displayed in Table 1. Motor vehicle traffic (MVT) is the number one cause of death while falls are the number one cause of hospitalizations and emergency department visits.

**Table 1**

Top Five Leading Causes of Injury in Wake County, 2008-2013						
Injury	Number of Deaths	Rank	Number of hospitalizations	Rank	Number of ED visits	Rank
MVT, Unintentional	439	1	2,457	2	38,922	2
Fall, Unintentional	319	2	9,486	1	69,450	1
Poisoning, Unintentional	277	3				
Firearm, Self-Inflicted	220	4				
Suffocation, Self-Inflicted	112	5				
Other Spec/Class*, Unintentional			1,943	3		
Unspecified**, Unintentional			1,876	4		
Poisoning, Self-Inflicted			1,734	5		
Struck, Unintentional					31,152	3
Overexertion, Unintentional					20,306	4
Cut/Pierce, Unintentional					15,160	5

\*Other Spec/Class--intent established and specific mechanism identified but does not fall into major categories.  
\*\*Unspecified--intent established, mechanism is unclear or not documented.  
Source: NC DHHS, Division of Public Health, Injury and Violence Prevention Branch

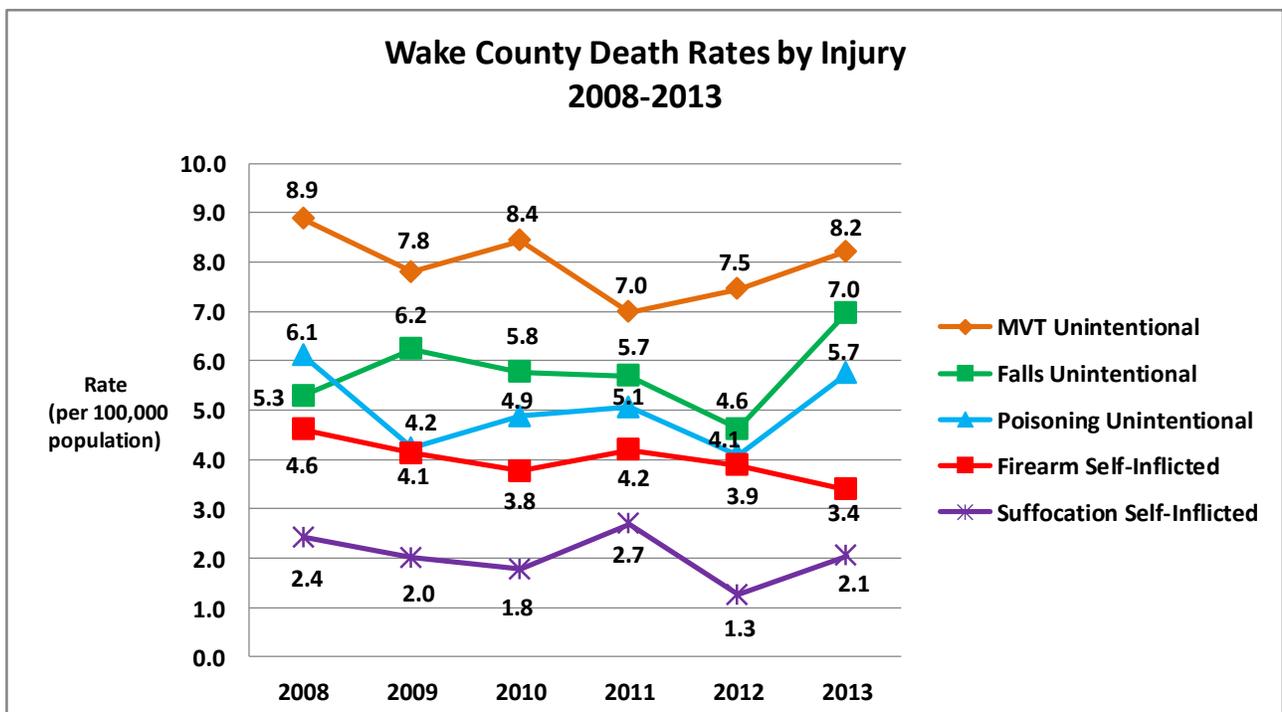
## 2.3 Deaths by Injury

The top five leading causes of death from injuries for all ages are attributed to:

- motor vehicle traffic--unintentional (#1)
- falls--unintentional (#2)
- poisonings--unintentional (#3)
- firearms--self-inflicted (#4) and
- suffocation--self-inflicted (#5)

From 2008-2013, there were 439 motor vehicle traffic deaths (80 were in 2013) in Wake County. The death rate (deaths per 100,000 population) generally trended downward from 2008 to 2012, but increased slightly from 2012 to 2013 (7.5 to 8.2). Death rates from both falls and poisonings had more significant increases from 2012 to 2013; the death rate due to falls increased from 4.6 to 7.0, and that of poisonings increased from 4.1 to 5.7 (Figure 4).

Figure 4



Source: NC DHHS, Division of Public Health, Injury and Violence Prevention Branch

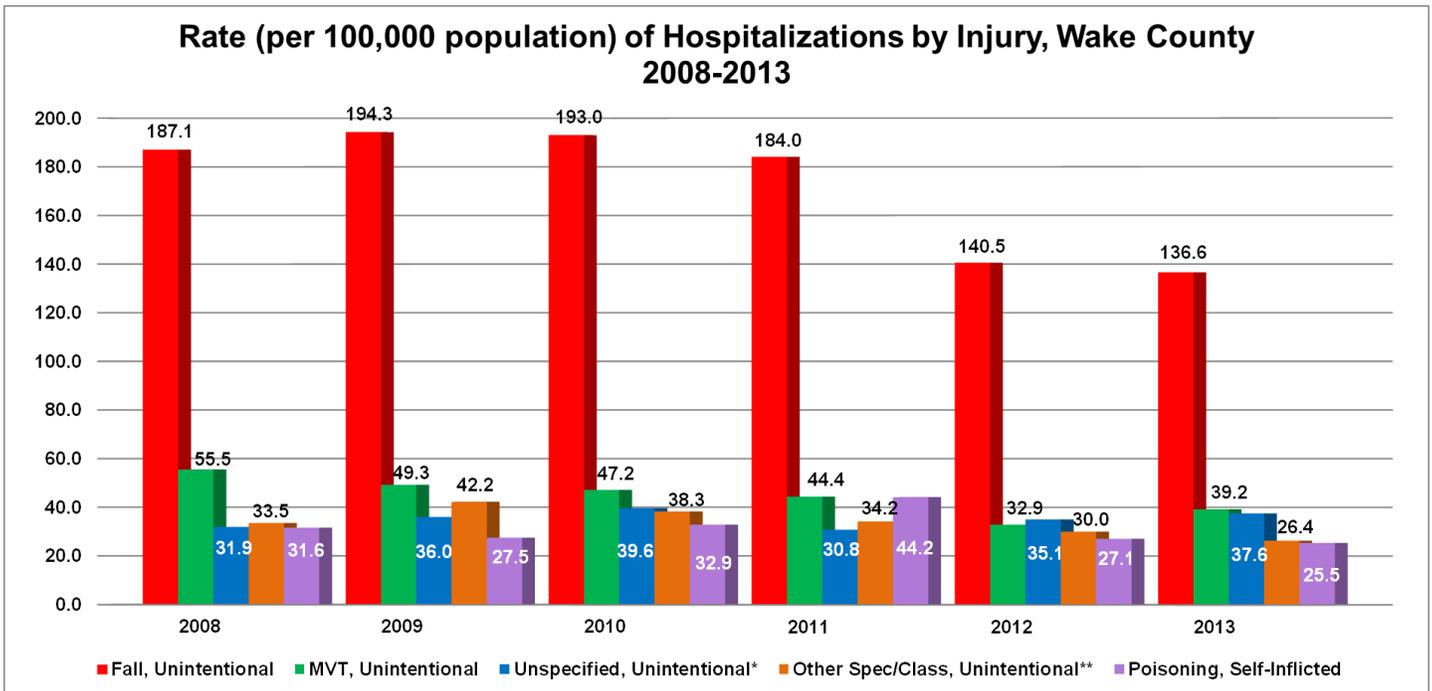
## 2.4 Hospitalizations by Injury

The five leading causes of hospitalizations due to injury were:

- falls--unintentional (#1)
- motor vehicle traffic--unintentional (#2)
- other specific/classification--unintentional (#3);
- unspecified--unintentional (#4)
- and poisonings (self-inflicted) (#5)

As Figure 5 shows, the rate of hospitalizations due to falls is consistently much higher than all other causes although hospitalization rates due to falls have steadily fallen from 2009 to 2013. Hospitalization rates due to poisonings have fallen noticeably from 2011 to 2013 (from 44.2 to 25.5/100,000 population).

Figure 5



\*Unspecified--intent established, mechanism is unclear or not documented

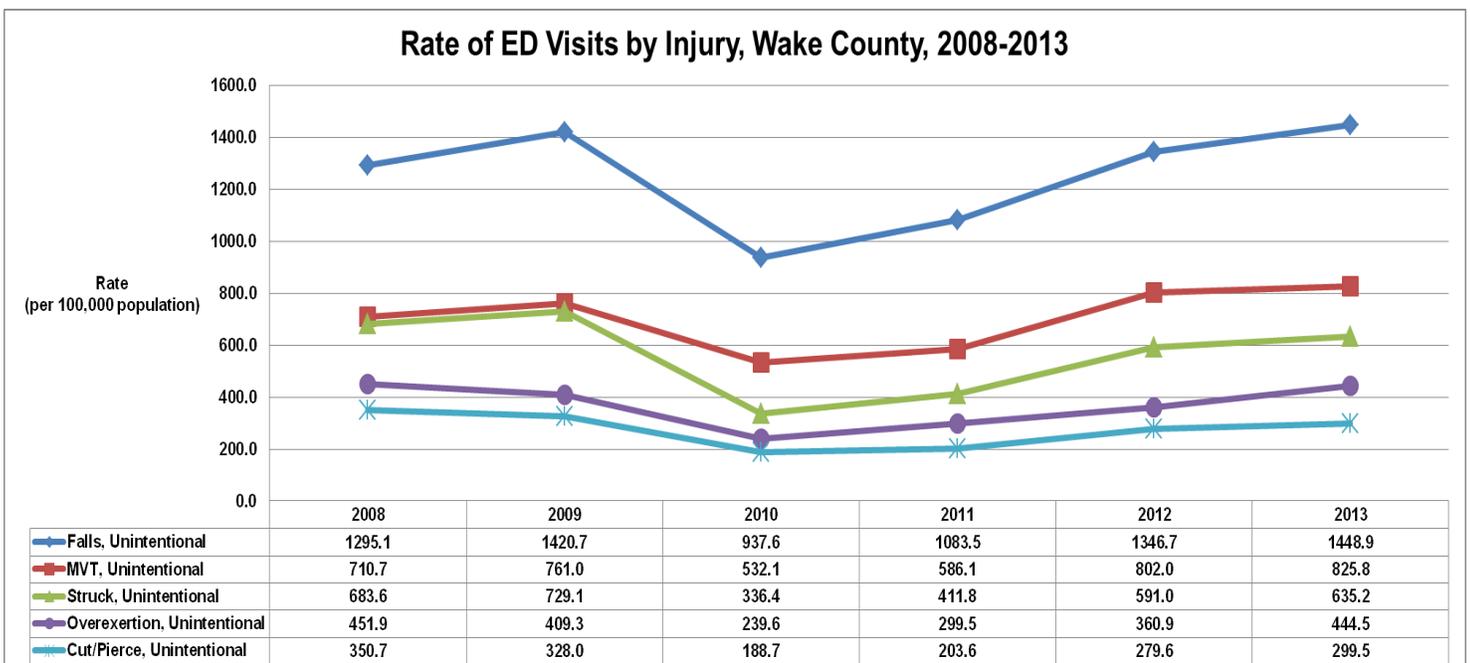
\*\* Other Spec/Class--intent established and specific mechanism identified but does not fall into major categories

Source: NC DHHS, Division of Public Health, Injury and Violence Prevention Branch

## 2.5 Emergency Department (ED) Visits by Injury

Since 2010, rates for the top five causes of ED visits by injury all increased every year (Figure 6). Falls and motor vehicle traffic (the top 2) accounted for 62% (108,372) of the ED visits from 2008 to 2013 (NC DHHS, Division of Public Health, Injury and Violence Prevention Branch).

Figure 6



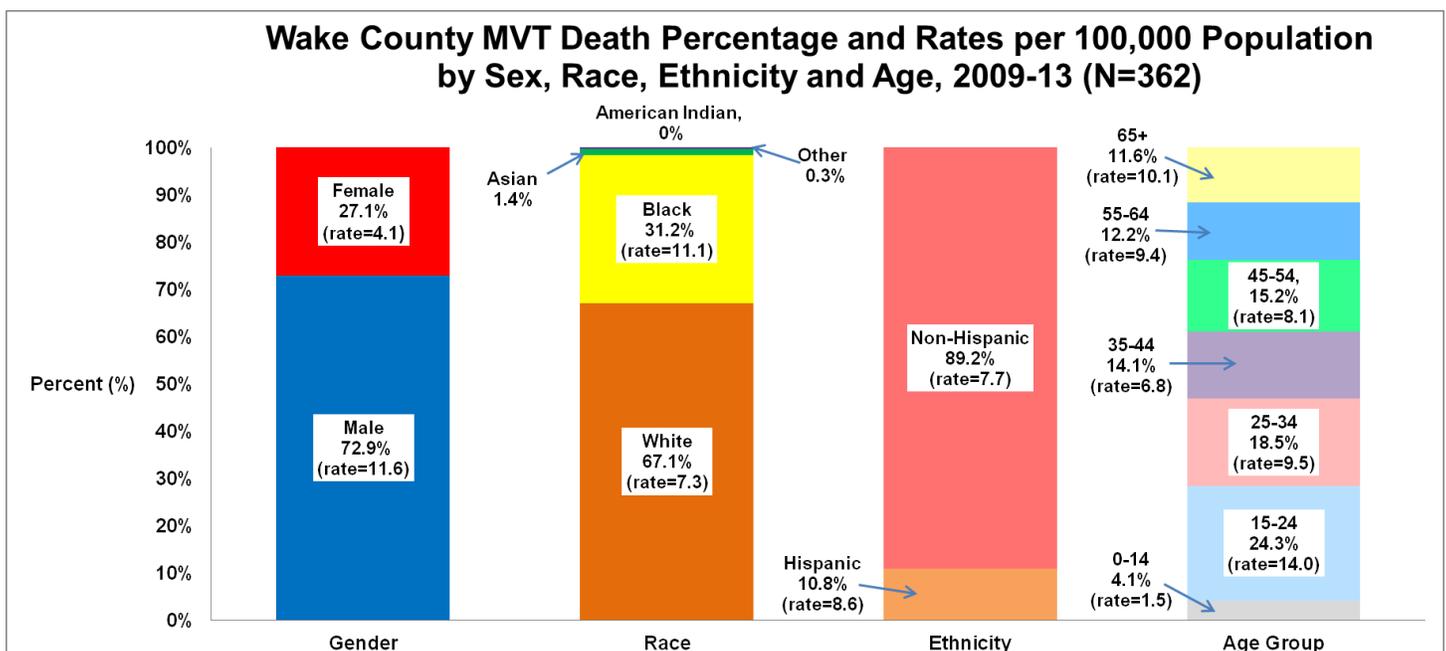
Source: NC DHHS, Division of Public Health, Injury and Violence Prevention Branch

## 3.0 Motor Vehicle Traffic

### 3.1 Demographics and Risk Factors

The leading cause of death by injury is due to motor vehicle traffic (MVT). A significantly higher percentage of males (72.9%) die from MVT than females (27.1%), with the MVT death rate for males (11.6) almost triple that of females (4.1) ( Figure 7). The percentage of Whites (67.1%) who die from MVT injuries is higher than Blacks (31.2%), yet Blacks have a higher death rate from MVT injuries (11.1). Similarly, while the percentage of MVT deaths is much higher for non-Hispanics (89.2%) than Hispanics (10.8%), Hispanics have a higher death rate(8.6). Among age groups, the highest MVT death rates occur in ages 15-24 (the youngest drivers on the road) (14.0) and 65+ (the oldest drivers on the road) (10.1).

Figure 7



Where rates are not shown, numbers of deaths were too small to calculate accurate rates.

Source: NC DHHS, Division of Public Health, Injury and Violence Prevention Branch

The top risk factors associated with MVT deaths are:

- distracted driving (including talking on a cell phone, texting or emailing while driving)
- young, inexperienced drivers (less than 20 years of age)
- older drivers (greater than 70 years of age) and
- impaired drivers

Notably, according to the **County Health Rankings & Roadmaps**, the portion of driving deaths with alcohol involvement in Wake County was higher (36%) compared to the state of North Carolina (33%) and those in the nation with the lowest percentages (14%) [<http://www.countyhealthrankings.org/app/north-carolina/2015/rankings/wake-county/outcomes/overall/snapshot> (accessed 8-28-25)]. This is an area that needs more attention and, for this reason, an objective in the Wake County Action Plan is: “ By 2016, reduce the portion of driving deaths with alcohol involvement in Wake County to 33%”.

Distracted driving is increasingly a factor in MVT deaths. Data on distracted driving and motor vehicle crashes is not available for Wake County. According to the American Automobile Association (AAA), 60% of teen crashes involve some form of distracted driving. The most common forms of distraction leading to a teen driver crash are as follows:

- interacting with one or more passengers-15%
- using a cellphone-12%
- looking at something in the vehicle-10%
- looking at something outside the vehicle-9%
- singing/dancing to music-8%
- grooming-6%
- reaching for an object-6%

[Source: <http://newsroom.aaa.com/2015/03/distraction-teen-crashes-even-worse-thought> (8-11-15)].

In a 2011 study, the Centers for Disease Control and Prevention (CDC) compared the prevalence of distracted driving (talking on a cell phone, reading/sending texts or emails while driving) between the U.S. and several European countries. Sixty nine percent of U.S. drivers ages 18-64 reported that they had talked on their cell phone while driving within 30 days before they were surveyed, a higher percentage than all seven of the European countries. Thirty one percent of U.S. drivers ages 18-64 reported reading/sending text messages while driving within 30 days before being surveyed, a higher percentage than every European country in the study except Portugal (also at 31%). Texting while driving is considered particularly dangerous because it involves all three major types of distraction in relation to driving:

- visual--taking your eyes off the road
- manual--taking your hands off the wheel
- cognitive--taking your mind off driving

[Source: <http://www.cdc.gov/features/dsdistracteddriving/index.html> (accessed 8/11/15)]

### 3.2 Motor Vehicle Safety and Children

According to Safe Kids Worldwide:

- Motor vehicle crashes are the number one cause of death among children ages 1 to 19.
- Children ages 2 to 5 who use safety belts prematurely are four times more likely to suffer a serious head injury in a crash than those in child safety seats or booster seats.
- Of those children ages 12 and under who died in vehicle crashes in 2011, 31 percent were unrestrained.

[Source: <http://www.safekids.org/child-passenger-safety> (accessed 9/1/2015)]

#### WCHS “Love Us and Buckle Us” Program

Wake County Human Services developed the “Love Us and Buckle Us” Program in 2001. This Child Passenger Safety Program was developed to provide consumers the opportunity to receive education on the proper transportation of children. This program consists of 13 nationally certified Child Passenger Safety Seat technicians and 1 nationally certified Child Passenger Safety Seat instructor.



Child Passenger Safety Seat Technician instructs parents on child safety seat use.

The program has expanded to become a certified Permanent Checking Station where the public may have car seats checked anytime Monday-Friday by appointment. Education is provided on the proper selection, direction and harnessing of children based on their height, weight and developmental needs.

Additionally this program provides a Child Passenger Safety Diversion Site at 10 Sunnybrook Road, Raleigh. This site is for residents, who get child restraint violations (tickets) from law enforcement officers, to receive education and proof that they obtained an appropriate restraint for their child passenger. This proof is then taken to the Wake County District Attorney so that they will not be held liable for the violation.

Presently this program has resources such as posters, pamphlets and other training materials in English and Spanish that can be used for clients. Staff are available to speak on the following injury prevention topics:

- child passenger safety
- distracted driving
- pedestrian safety
- fire safety
- falls prevention
- water safety
- children in and around vehicles
- home safety
- poison prevention
- bike safety
- ATV safety and
- pool safety



Checking child passenger safety seats in the community.

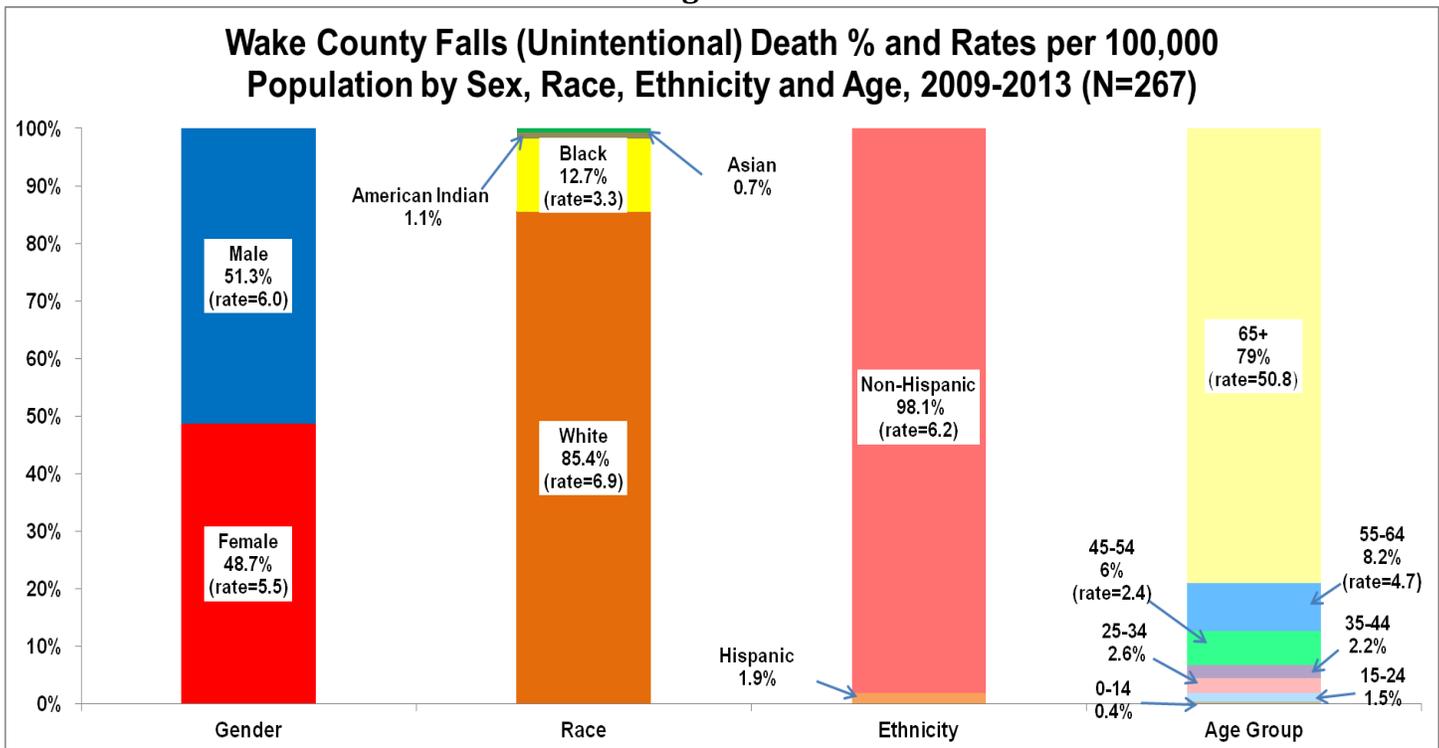
## 4.0 Falls

The percentage and rate of deaths due to falls is essentially the same for males and females (Figure 8). While Whites account for a much higher percentage of deaths due to falls than Blacks (85% vs. 13%), the death rates (per 100,000 population) between these two groups is significantly closer (6.9 for Whites, 3.3 for Blacks). When taking into account that Wake County's senior population (65+) continues to increase, this age group's death rate due to falls (more than ten times that of any other age group at 50.8 per 100,000 population) is of significant concern.

While advanced age is the number one risk factor attributed to falls (1), the following are all associated with increased fall injuries that result in death:

- side effects from medicine that cause dizziness and drowsiness
- outdated eye prescriptions
- tripping hazards
- poor lighting
- lack of exercise, calcium, and vitamin D to strengthen bones in case of a fall
- osteoporosis(2)

Figure 8



Where rates are not shown, numbers of deaths were too small to calculate accurate rates.  
 Source: NC DHHS, Division of Public Health, Injury and Violence Prevention Branch.

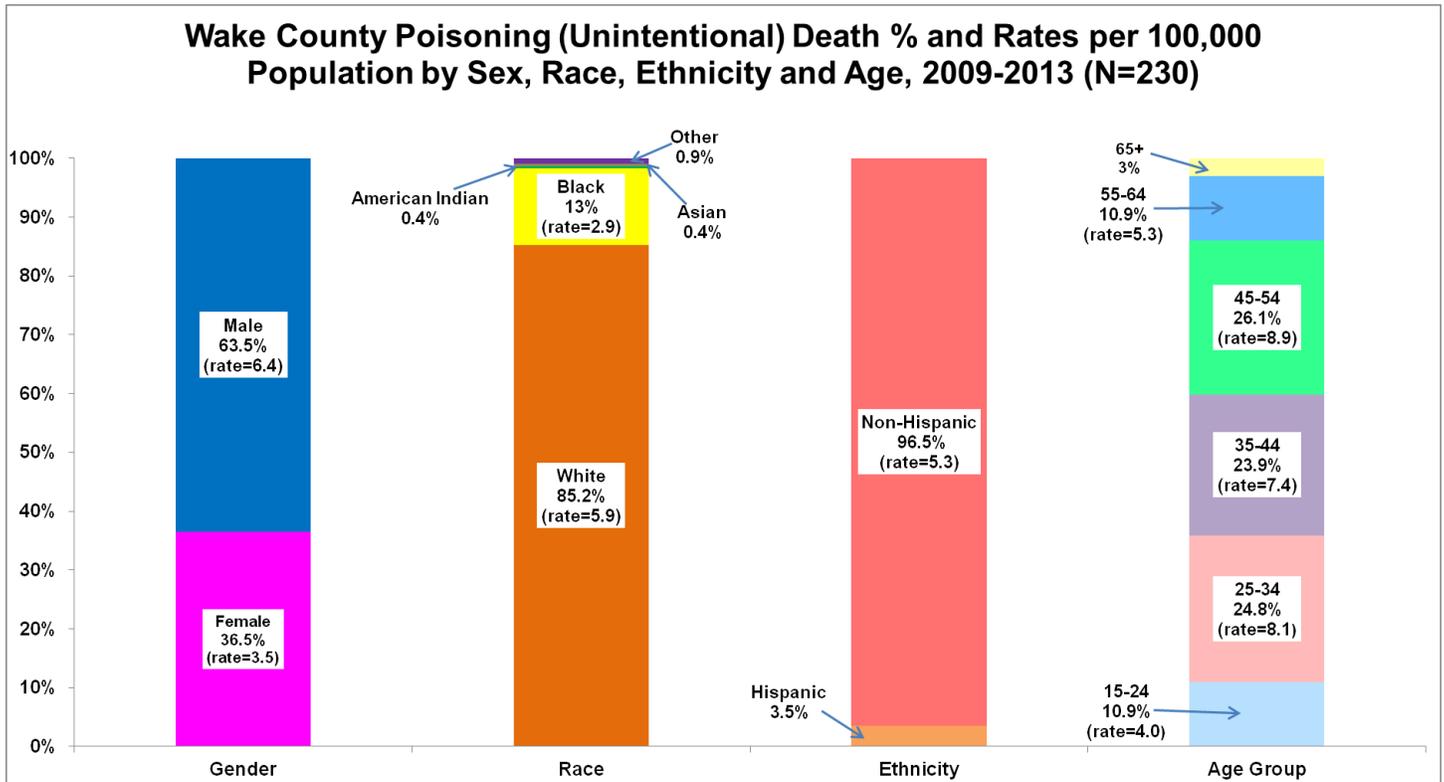
## 5.0 Poisonings

The percentage and death rates due to unintentional poisonings is higher for males than females. (Figure 9). While Whites account for a much higher percentage of deaths due to poisonings than Blacks (85% vs. 13%), the death rates between these two groups is closer (5.9 for Whites, 2.9 per 100,000 population for Blacks). Among age groups, the two groups with the highest death rates due to poisonings are age 45-54 (8.9) and 25-34 (8.1).

Most unintentional poisoning deaths are due to unintentional overdose of prescription, over the counter or illegal drugs (3). The rate of emergency department visits for unintentional drug overdoses has increased 49% since 2010 in Wake County (Figure 10).

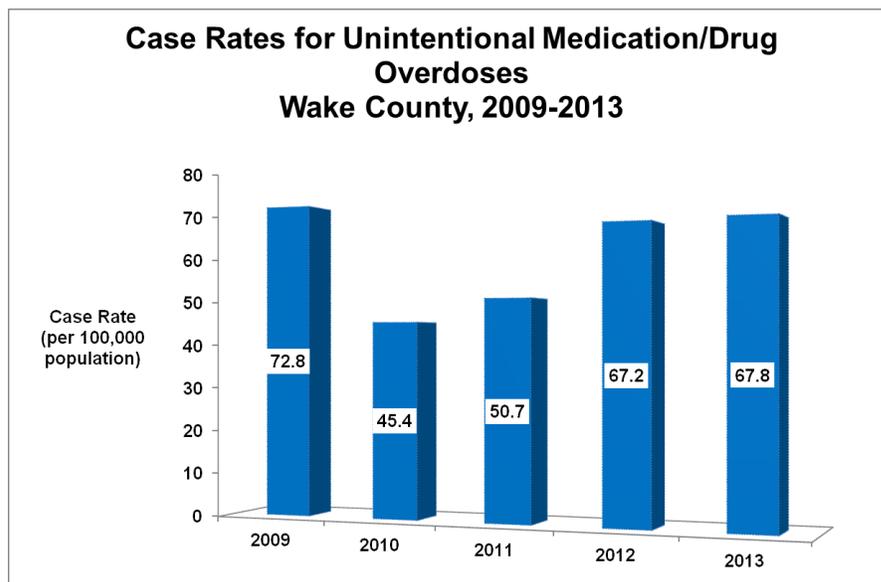
Another indication that drug overdoses continue to be a problem in Wake County is the frequency that Naloxone (Narcan), a medication used to reverse opioid overdoses, is administered by emergency medical personnel. Figure 11 displays the number of times Naloxone was used for persons transported to emergency departments (ED) in Wake County. It does not capture the number of times Naloxone was used for persons who were not transported to the ED, such as successful reversal not requiring transport, refusal to be transported, use by non-medical personnel or the person died and was transported directly to the medical examiner.

Figure 9



Where rates are not shown, numbers of deaths were too small to calculate accurate rates.  
 Source: NC DHHS, Division of Public Health, Injury and Violence Prevention Branch.

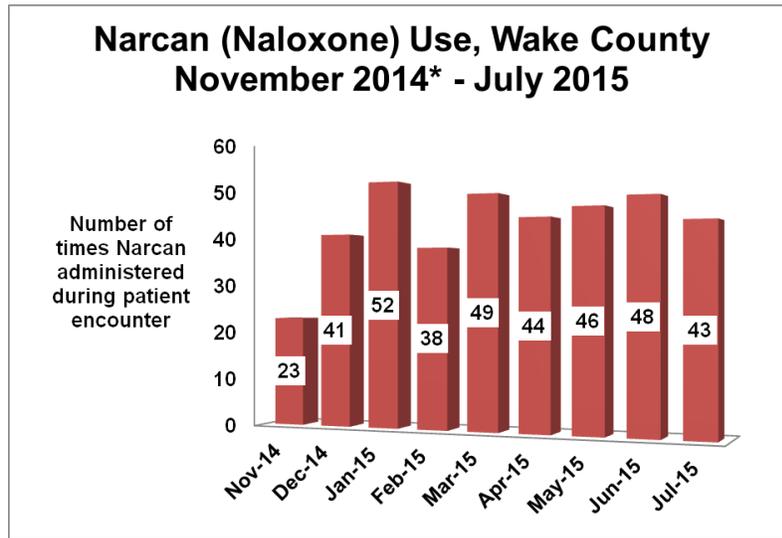
Figure 10



Case rates capture emergency department visits for a medication or drug overdose. An unintentional medication or drug overdose is defined as an injury in which a person is exposed to a medication or drug without the attempt to cause harm to himself/herself or to others. This definition includes overdoses due to drugs taken involuntarily or for recreational purposes. It excludes visits due to medical misadventures and/or the adverse effects of medications or drugs properly administered in therapeutic or prophylactic dosages.

Source: NC DETECT (NC Disease Event Tracking and Epidemiologic Collection Tool)

**Figure 11**

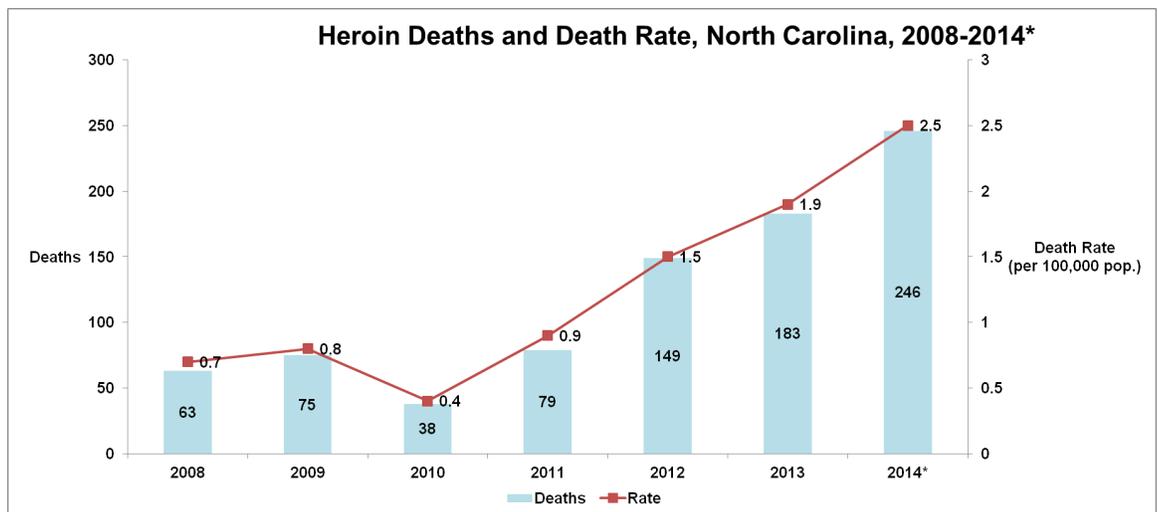


The case definition is "Narcan or naloxone included as a medication administered by the EMS agency during the patient encounter."

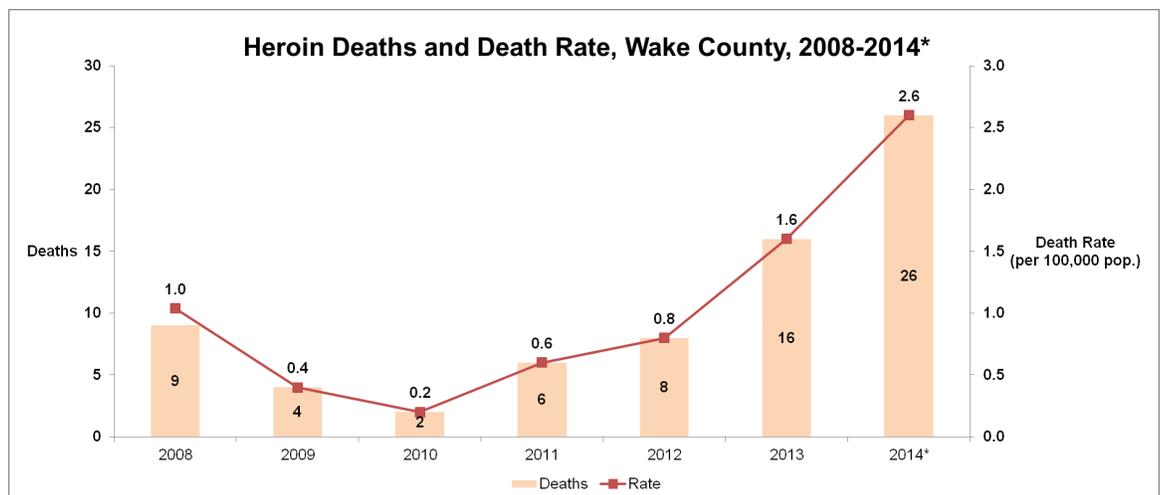
Source: NCDETECT. \*Narcan data in NCDETECT only available from November 2014.

### 5.1 Heroin

**Figure 12**



**Figure 13**



\* 2014 data is provisional for Figures 12 and 13.

Source for Figures 12 and 13: NC DHHS, Division of Public Health, Injury and Violence Prevention Branch.

Recently the use of heroin has increased because it is cheaper and easier to acquire than other illegal drugs and over the counter pain medications. Consequently, the increase in heroin deaths from 2010 to 2013 is a substantial concern at both the state and local level. Statewide, there has been an astounding 547% increase in number of heroin deaths from 2010-2014 (Figure 12). The same trend is noted in Wake County (Figure 13).

Also of concern is the risk of acquiring infectious diseases due to needle sharing among those who inject heroin. Other states have reported an increase in cases of acute hepatitis C coincident with increasing cases of heroin overdose. This has not been observed in Wake County as of this report. The WCHS Epidemiology Program is monitoring for trends in cases of acute and chronic hepatitis C.

## 5.2 Project Lazarus

A promising community-based overdose prevention model in the United States is Project Lazarus. Project Lazarus, Inc. is a secular public health nonprofit organization which was established in 2008 in response to the extremely high drug overdose death rates in Wilkes County, North Carolina (four times higher than the state average). Project Lazarus uses a set of nine strategies to mobilize communities, educate and support providers and patients, reduce drug supply and diversion, reduce harm from available drugs, promote safer clinical practice and prescribing, and evaluate program activities.

Evaluation of Project Lazarus showed a 69% reduction in drug overdose deaths in Wilkes County between 2009 and 2011. These successes led to a partnership with Community Care of North Carolina (CCNC) to expand the Project Lazarus strategies to all 100 counties in North Carolina. The CCNC expansion of Project Lazarus provides staff, resources, and technical support to counties in North Carolina to implement the expansion of Project Lazarus.

Here in Wake County, collectively we have accomplished the following:

- Convened a diverse committee to exchange information and learn about community needs. The committee is composed of various sector representatives i.e. SAFE Kids, Wake County Public Affairs, Community Cares of NC, WCHS Sections (including Health Promotion, Epidemiology, HIV/STD, Communicable Disease, Finance, Contracts and Pharmacy) and other invited guests i.e. NC Harm Reduction.
- Designed and posted 3 billboards (see next page) which have been strategically located throughout Wake County
- Prepared 100 Naloxone kits with medical supplies and printed materials
- Developed a Medical Standing Order and Memorandum of Understanding with community/medical partners to prescribe, dispense and distribute Naloxone
- Conducted Naloxone Distributor training for 23 participants facilitated by the NC Harm Reduction Coalition Coordinator
- Scheduled an Operation Medicine Drop event on October 27, 2015 from 10:00 am - 2:00 pm at the WCHS Sunnybrook parking lot. This is being co-sponsored with Wake County Sheriff's Office and Wake County Safe Kids.
- Scheduled a presentation on the Project Lazarus expansion and Operation Medicine Drop in Wake County for the Wake County Board of Commissioners in October 2015, along with airtime on WakeGOV TV and WRAL TV

**R Awareness!** SAFE USE, SAFE STORAGE, SAFE DISPOSAL

**KEEP OUT OF REACH**    **CHECK EXPIRATION**    **DON'T FLUSH**    **SAFELY DISPOSE**

To safely dispose of your prescription drugs, call: 919-212-8376  
 For more information visit [www.wakegov.com/humanservices](http://www.wakegov.com/humanservices)  
 Follow Wake County Human Services on Facebook

WAKE COUNTY  
 NORTH CAROLINA

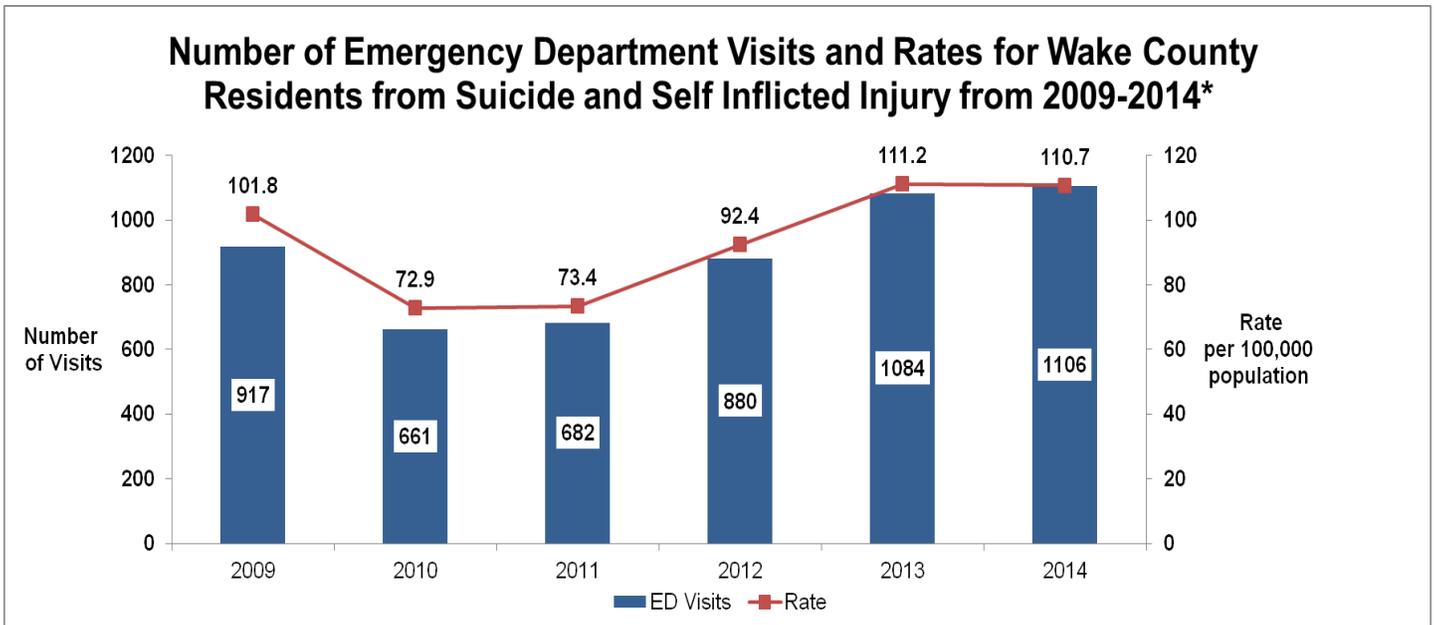
Safe use and disposal of prescription drugs billboard.

## 6.0 Suicides: An Emerging Issue

Overall, there has been a 62% increase in emergency department visits among Wake County residents from suicides and self-inflicted injuries from 2011 to 2014 (Figure 14).

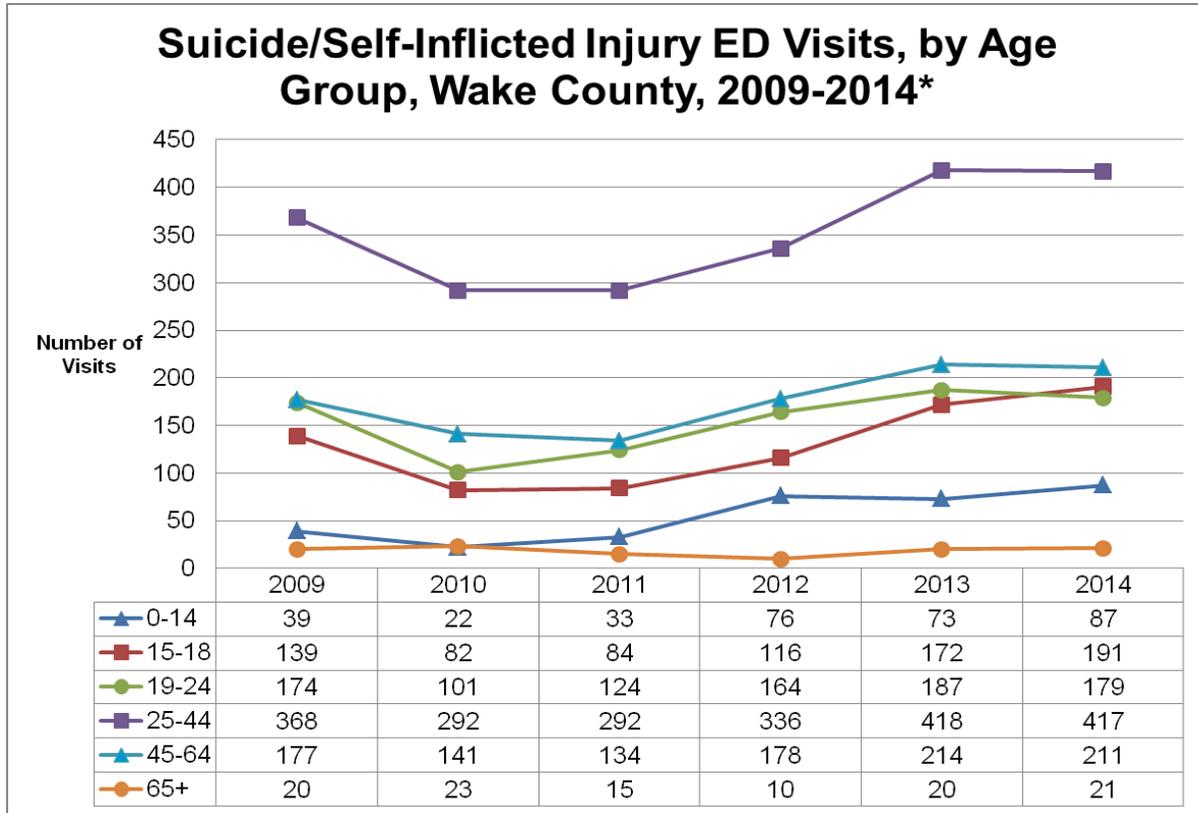
By age, the highest number of emergency department visits for suicide and self-inflicted injuries were among 25-44 year olds (Figure 15). Visits by 15-18 year olds exceeded those of 19-24 year olds in 2014. Figure 16 shows the number of visits by children among the 0-14 age group.

Figure 14



\* 2010 and 2011 numbers may be artificially low for all groups due to underreporting  
 Source: NCDETECT

Figure 15

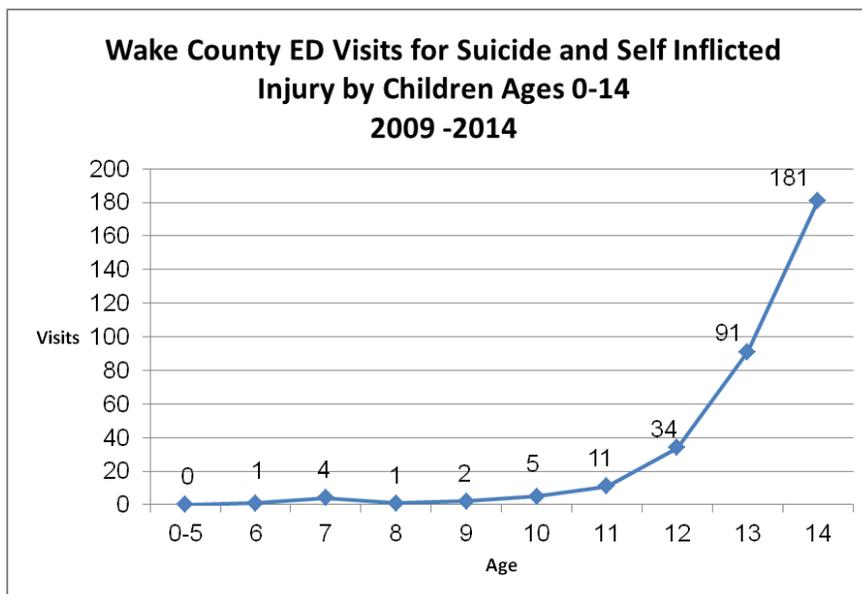


\* 2010 and 2011 numbers may be artificially low for all groups due to underreporting

Source: NCDETECT

The number of visits tripled between ages 11 and 12 and continued to increase during the early teenage years, which may warrant further investigation into the risk factors for this subset of 0-14 year olds.

Figure 16



Source: NCDETECT

## 7.0 Child Maltreatment

Child maltreatment is defined as any act or series of acts of commission or omission by a parent or other caregiver (i.e. clergy, coach, teacher) that results in harm, potential for harm, or threat of harm to a child. While the words abuse and neglect are often used interchangeably, each type of maltreatment is distinct. Abuse is the intentional maltreatment of a child and can be physical, sexual, or emotional in nature. Neglect, on the other hand, is the failure to give children the necessary care they need.

North Carolina law (NCGS 7B-301) mandates that any person or institution that suspects a child is being abused or neglected, or has died from being mistreated, must report what they know to the county Department of Social Services.

In Wake County those reports are received by the Wake County Human Services Child Welfare Division. A Child Protective Services (CPS) intake social worker receives the report and utilizes a structured tool to determine if the information meets the state requirements for acceptance and the Multiple Response System (MRS) track for investigation. The MRS affords CPS the ability to assign CPS assessments to two different tracks (investigative assessment and family assessment) based on the allegations found in the report. This

- protects the safety of children by not treating all reports in the same way
- engages families in services that could enable them to better parent their children
- focuses on the family's strengths, supports, and motivation to change
- serves many of the families reported to CPS better by helping rather than "punishing" them

All reports of abuse must be taken as an investigative assessment. Certain reports of neglect must also be taken as an investigative assessment. These include (but are not limited to): child fatalities, a child in the custody of DSS, or any child taken into protective custody by a physician or law enforcement personnel. A complete list of the types of reports subject to the investigative assessment can be found at <http://info.dhhs.state.nc.us/olm//manuals/dss/csm-60/man/CS1408-02.htm>. For all other reports of neglect or dependency\*, the family assessment track is utilized.

CPS uses a structured decision-making tool to make the final determination concerning the allegations in a report. In making these decisions, CPS takes into consideration:

- the specific behavior of the caretaker that resulted in harm to the child or clarification that there is no risk of harm
- current safety issues that may or may not be present
- any future risk of a child's safety should they remain in the home
- whether a child is in need of protection.

In 2014, a total of 4498 reports were accepted, with 20% resulting in either a substantiation of abuse, neglect or dependency. Since 2007 there has been an increase in the annual number of reports, with the highest number occurring in 2008. During the same time, the percentage of reports either found in need of services or substantiated has decreased (Table 2).

\*Dependency—when a child is in need of assistance or placement because:

- There is no parent or guardian responsible for their care
- The parent or guardian is unable to provide care and there is no other child care arrangement

**Table 2**

<b>Reports of Child Maltreatment, Wake County 2007 –2014</b>																
	2007		2008		2009		2010		2011		2012		2013		2014	
	Number	%	Number	%	#	%	#	%	#	%	#	%	#	%	#	%
<b>Services Needed**/ Substantiated*</b>	969	26%	1298	24%	1133	23%	1112	23%	1033	23%	1026	23%	977	24%	864	20%
<b>Services Not Needed***/ Unsubstantiated</b>	2711	74%	4083	76%	3735	77%	3662	77%	3438	77%	3331	77%	3936	76%	3634	80%
<b>Total</b>	3680	100%	5381	100%	4868	100%	4774	100%	4471	100%	4357	100%	4913	100%	4498	100%

\*Substantiation: Denotes a finding of abuse, neglect or dependency at the conclusion of an Investigative Assessment

\*\*Services Needed: Denotes a finding of neglect at the conclusion of a Family Assessment

\*\*\*Services Not Needed, Denotes that there was no finding of neglect in a Family Assessment

Source: University of NC at Chapel Hill Jordan Institute for Families

Table 3 identifies the types of maltreatment that were reported and found to have occurred.

**Table 3**

<b>Child Maltreatment Case Decisions, Wake County 2007-2014</b>																
	2007		2008		2009		2010		2011		2012		2013		2014	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
<b>Abuse &amp; Neglect</b>	35	4%	47	4%	24	2%	22	2%	39	4%	50	5%	58	6%	56	6%
<b>Abuse</b>	39	4%	49	4%	39	3%	47	4%	39	4%	34	3%	63	6%	37	4%
<b>Neglect</b>	893	92%	1197	92%	1068	94%	1039	93%	946	92%	940	92%	853	87%	767	89%
<b>Dependency</b>	2	0%	5	0%	2	0%	4	0%	9	1%	2	0%	3	0%	4	0%
<b>Total</b>	969	100%	1298	100%	1133	100%	1112	100%	1033	100%	1026	100%	977	100%	864	100%

Source: University of NC at Chapel Hill Jordan Institute for Families

While the majority of families are found in need of services (this number has steadily decreased from 57% in 2007 to 48% in 2014), there has been an increase in the number of more serious abuse and neglect reports.

Protective services are provided to help families keep children who have been abused or neglected safely at home whenever possible. Children are taken into foster care when no other means are adequate to protect them. Every effort is made to quickly reunify children with their families whenever possible. Although there has been a decrease in the number of reports with families who were found in need of services or the allegations in the reports were substantiated, the annual number of children in foster care in Wake County has increased substantially from 795 in 2009 to 953 in 2014 (Table 4).

**Table 4**

Wake County Youth in Foster Care 2007-2014								
	2007	2008	2009	2010	2011	2012	2013	2014
Annual number of children in foster care	878	875	795	814	854	933	917	953
Rate per 1000 in general population	4.2	4	3.5	3.4	3.6	3.9	N/A	N/A

Source: North Carolina Department of Health and Human Services

## 7.1 Child Maltreatment Prevention

### The Treatment Outcome Package

In partnership with the Annie E. Casey Foundation, The Duke Endowment and Kids Insight, Wake County is beginning to assess the wellbeing of children in foster care using the Treatment Outcome Package (TOP), an empirically validated instrument developed by Outcome Referrals, Inc. The bottom line question we seek to answer is: “How can we be sure that the supports and services provided for children involved with the child welfare system match their needs and set them on the path to success?” TOP uses statistically validated questions to identify children’s strengths and challenges and track their progress over time using simple, web-based tools.

It features a short checklist completed by the child and those closest to him or her — birth and foster parents, clinicians, teachers, caseworkers — paired with immediate results and easy-to-follow reports. We believe that implementation can improve placement stability for our children in care, reduce disruptions, and enhance reunification or other permanency efforts.

### Triple P

Triple P is an evidence based parenting program that has reduced child injuries from maltreatment. Project Enlightenment has received a \$2 million grant from the John Rex Endowment for a community wide implementation of Triple P for parents of young children in the city of Raleigh. A total of 18 agencies, including WCHS, are joining with Project Enlightenment to implement Triple P. Our WCHS Parent Educators, select Child Welfare Workers, Foster Care Licensing Workers and Social Work Aides are being trained and accredited in the use of the Triple P model.

## **KIPS and Triple P**

KIPS is an evidence based, parent-child observational tool which identifies specific parenting strengths and areas for growth. Supervised visitations are a valuable opportunity to provide brief parent coaching prior to a visit and allow for observation and feedback of practice skills. Child Welfare and Safe Spaces staff are being trained in Triple P, an evidence based parenting program. KIPS is used in conjunction with Triple P to guide staff observations; inform family goals; open dialogues with families about parenting strategies that promote their child's development and learning and monitor changes in parenting behavior. We are partnering with NC State University Department of Psychology to develop the evaluation plan.

## **The Parent Evaluation Program**

WCHS has partnered with UNC Healthcare-Department of Psychiatry and Alliance Behavioral Healthcare to develop and implement a specialized, comprehensive clinical assessment for parents whose child(ren) have been placed in the custody of WCHS. These assessments will address a parent's mental health issues and impact on parenting; will inform (and be informed by) their child(ren)'s assessments; and are intended to engage parents more quickly in case planning and evidence based treatments. The integration of the parent and child assessment process will improve case planning efforts by 1) helping the family and team members develop targeted strategies to address both the parent and child's needs for a successful reunification; 2) enhance the child's placement stability; 3) and address intergenerational trauma experienced by many of the families in which we are involved.

## **8.0 References**

1. *Deaths by Sex, Race, Ethnicity, and Age in Wake County from 2008 to 2012 Due To Fall Injury*. (2014). North Carolina Injury and Violence Prevention Branch. North Carolina Injury and Violence Prevention Branch. Accessed 9/3/2015 from <http://www.injuryfreenc.ncdhhs.gov/DataSurveillance/FallsData.htm>
2. *Older Adult Falls: Get the Facts* (2015). Centers for Disease Control and Prevention. Accessed 9/3/2015 from <http://www.cdc.gov/homeandrecreationalafety/falls/adultfalls.html>.
3. *The Burden of Unintentional Poisonings in North Carolina*. Department of Health and Human Services, Division of Public Health, North Carolina Injury and Violence Prevention Branch. Accessed 9/2/2015 from [http://www.ncdoi.com/OSFM/safekids/Documents/OMD/NC\\_UnintentionalPoisoningData.pdf](http://www.ncdoi.com/OSFM/safekids/Documents/OMD/NC_UnintentionalPoisoningData.pdf).

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