DESCRIPTION OF CHILD WELFARE SERVICES

a. The following section describes an array of child welfare services including abuse prevention, intervention, and treatment services; foster care, kinship care and other permanent living arrangements. It also reports on the specific accomplishments and progress achieved toward meeting the goals and objectives.

Child Abuse and Neglect Prevention, Intervention, and Treatment Services

Child Protective Services (CPS) is a mandated program for the protection of all children in the state alleged to be abused and neglected. The CPS receives, screens and investigates allegation of child abuse and neglect, performs assessments of child safety, assesses the imminent risk of harm to the children and evaluates conditions that support or refute the alleged abuse or neglect and need for emergency intervention. It also provides services designed to stabilize a family in crisis and to preserve the family by reducing safety and risk factors. This program provides an array of prevention, intervention and treatment services including:

- operating a single, statewide toll-free telephone number for receiving child abuse/neglect (CA/N) reports;
- conducting CA/N investigation, family assessment and preventive services screenings;
- providing newborn crisis assessment and services;
- providing background screening checks on current or prospective employees and volunteers for children/youth serving agencies;
- Healthy Children and Youth Program;
- preventive and protective child care services; and
- Family Centered Services.

Child Abuse and Neglect Hotline

During SFY 2006, the Child Abuse/Neglect Hotline Unit (CANHU) received over 123,000 calls. This is an increase from the 107,000 calls from SFY 2005 due to the new Family and Children Electronic System (FACES) automation implemented at the hotline on June 28, 2005. This implementation date affected the entire 2006 fiscal year. Calls counted in the new FACES automation but were not counted in previous years included: calls from people wanting numbers to their local CD offices, callers wanting other states' hotline numbers, wrong numbers and calls for prior CA/N checks.

These calls are taken by Children's Service Workers, who meet the same job qualifications as CD field investigators. Hotline workers use a protocol screening tool for conducting interviews that is designed to assure greater consistency in the assessment, classification, and prioritization of calls. This screening tool incorporates decision trees for assessing child safety and establishing response times.

The Hotline uses Call Management System technology to manage calls effectively and provide optimum service. This system provides real-time call data for workers and supervisors. Since implementation of this call system in 2004, the Hotline has, on average; answered 94% of calls offered and has given fewer than 300 busy signals per month.

As required in the PIP, the CANHU in conjunction with the QA Unit developed a peer review system at the hotline unit. Ten percent of all calls classified as child abuse/neglect reports are sampled for peer review and automatically forwarded to a hotline worker for review. In October 2005, a Peer Record Review (PRR) tool was added for CANHU. In January 2006, CD began collecting and analyzing results for improved outcomes. The analysis revealed that the tool seemed to achieve the goal of being a quick-to-complete instrument for reviewing calls. Dual reviews (each case being reviewed by two staff) were completed in mid-2006 to measure conformity among hotline reviewers and to assure that the PRR results were reliable to use for quality improvement. The review agreement rate would be at least 90 percent for each question before the review data could be used to properly inform the agency on strengths or needs in practice at the hotline.

In August 2006, the conformity level had reached an average of 95% on the six items being reviewed. Dual reviews were concluded during the 4th quarter of 2006. Beginning in November 2006, all peer review cases failing any one of the six items being reviewed were forwarded to the original call taker's supervisor for practice improvement. The hotline PRR process has been a learning experience for both the workers completing peer reviews as well as for workers whose errors were identified. Additionally, it has been an effective tool for hotline supervisors and trainers for identifying individual and group training needs. The outcomes for calendar year 2006 confirmed the hotline staff are making consistent and accurate call decisions and classifications. The accuracy level on the six questions reviewed was 98%, 96%, 97%, 97%, 95%, and 100% respectively.

Child Abuse/Neglect Reports

There were 51,396 CA/N incident reports made involving 74,545 children in Calendar Year (CY) 2006. Victims were found to have been neglected in almost 50 percent. Physical abuse was determined in about 25 percent. Sexual maltreatment was determined in less than 24 percent. This is a relatively small difference in the type of reports from CY 2005 where there were 54,108 CA/N reports made involving 80,577 children. Victims were found to have been neglected in 47.8 percent. Physical abuse was determined in 25.3 percent. Sexual maltreatment was determined in 24.1 percent.

In CY 2006, 57 percent of children in substantiated CA/N reports were abused and or neglected by one or both (biological/adoptive) parents. Stepparent, grandparent, sibling, or other relatives were responsible for 17 percent of these cases. Approximately 5.5 percent of these cases, the perpetrators were of an unknown relationship to the child. In CY 2005, 60.5 percent of children in substantiated CA/N

reports were abused and or neglected by one or both (biological/adoptive) parents. Stepparent, grandparent, sibling or other relatives were responsible in 15.3 percent of these cases. In 5.3 percent of these cases the perpetrators were of an unknown relationship to the child.

The National Standard for CA/N recidivism is 6.1 percent or less. Missouri's performance at the time of the CSFR was 8.3 percent. The CD had developed several strategies to improve performance for this measure. According to the Outcomes Report, the division has consistently met national standard for all eight PIP quarters for this measure.

The National Standard for incidences of CA/N in foster care is .57 percent or less. The CD passed this data measure during the CFSR and has continuously maintained the goal of reduced incidence of CA/N in foster care.

CA/N Investigations/Family Assessments

An Investigation is a classification of response by the CD to a report of abuse or neglect, based upon structured decision making protocols, and based upon the reported risk and injury to the child, where the acts of the alleged perpetrator, if confirmed, are criminal violations and/or where the action/inaction of the alleged perpetrator may not be criminal, but which if continued, would lead to the removal of the child or the alleged perpetrator from the home. Investigations are completed jointly with all co-investigators to gather/obtain relevant data and evidence. In 2006, almost ten percent of CA/N reports were substantiated and about 25 percent were unsubstantiated. Preventive services were indicated in more than five percent of the unsubstantiated findings.

A Family Assessment is a classification of response to a child abuse or neglect report for allegations of mild, moderate, or first-time non-criminal allegations of abuse or neglect. These will include reports where a law enforcement co-investigation does not appear necessary to ensure the safety of the child. Families who are investigated and those who receive a Family Assessment are entitled to prompt and effective delivery of services in order to address their individual child/family needs. In 2006, just under 60 percent of the CA/N reports were screened as Family Assessments.

The above CA/N report or Family Assessment definitions are not applicable on some cases, including Unable to Locate; Inappropriate Report; Located out of State; and Home Schooling. These miscellaneous determinations account for approximately over six percent of the CA/N reports.

The nominal differences reported between 2005 and 2006 for the CA/N reports and Family Assessment referrals are due to no significant changes in legislation and the consistency in our practice.

Preventive Services/Non-CA/N Referrals

While about 50 percent of the child abuse/neglect reports received met statutory requirements for child abuse and neglect, approximately 30 percent of the calls did not meet the criteria and were accepted as non-CA/N referrals including Mandated Reporter Referrals, Non-Caretaker Referrals, Newborn Crisis Assessment Referrals, Preventive Services Referrals and Non-CA/N Fatalities. Approximately one-fourth of these referrals were forwarded for Preventive Services. The decrease in the percentage of ca/n reports and non ca/n referral figures is due to the implementation of SACWIS in Missouri. The Research and Evaluation Unit is noting difficulties accessing all of the relevant fields to provide as accurate data as previously submitted. Additionally, some field staff are reporting improved ability to identify reports and referrals as duplicates. Both of these factors are potentially impacting data submissions.

The CD continues to focus attention and resources on its core functions. Investigations and assessments for CA/N remain a top priority for the division. The CD has increased its efforts in this area by providing additional field support to staff from its Central Office to ensure and increase efforts of timely completion of child abuse and neglect reports. Additionally, technical assistance has focused on identified staff and supervisory training needs to improve performance in the timely completion of child abuse and neglect reports that adhere to CD policy and best practice. Timely completion of CA/N reports supports the efforts of providing identified services in a timely manner to children and families.

The CD continues to discuss the non-caretaker referrals practice change and its impact on local communities with the CD Administration, the Office of State Court Administrators, the Missouri Juvenile Justice Association and its Task Force on Children's Justice (formally CJA). Presently, no policy or practice changes have been implemented.

Newborn Crisis Assessment and Services

Pursuant to Chapter 191 RSMo, the division must respond to calls to the child abuse/neglect hotline in which a home assessment is requested by a physician or other medical personnel when they have serious reservations about releasing an infant from the hospital who may be sent home to a potentially dangerous situation. There may also be other non-drug related situations in which a physician/health care provider is concerned about releasing a newborn infant from the hospital. Non-drug involved referrals are accepted until the child is one year of age.

The process of how the family is contacted, assessed, and referred for services to the local DHSS/Special Health Care Needs (SHCN) Regional Office remains unchanged. Therefore, the 2,347 assessments the CD responded in CY 2006 was very similar to the 2,341 assessments in CY 2005.

Out of Home Investigations

The Out of Home Investigations Unit (OHI) is a special investigations unit administered from the CD Central Office. OHI is responsible for investigating referrals alleging child

abuse and neglect in licensed and unlicensed residential facilities, licensed and licensed exempt day care facilities, public and private schools, and agency and contract agency foster homes. OHI has no direct responsibility or administrative authority over any of the entities investigated. OHI gathers information, makes investigative conclusions and shares the information with those responsible for regulating the particular child caring facility being investigated. Below are examples:

- When there is an investigation of a licensed residential facility, information is shared with the state Residential Program unit that licenses and regulates residential treatment centers.
- During an investigation in a school, information is shared with the superintendent of schools and the school board.
- During an investigation of a licensed day care facility information is shared with the Bureau of Child Care who licenses and regulates day care facilities.
- During an investigation of a foster home, information is shared with CD or contract agency staff who license and regulate that home.

The OHI investigation is a collaborative effort between the OHI staff and other agencies. OHI attempts to utilize a multi-disciplinary approach to each investigation. Examples of this are:

- Law enforcement is invited to co investigate each hotline report with OHI.
- Bureau of Child care usually assigns a licensing worker to co investigate referrals with OHI staff in licensed day care facilities.
- OHI staff involves facility administrators in the information gathering and investigation process at their facility.

The OHI Unit investigates approximately 2,200 reports annually. These reports are spread roughly evenly across the program areas we investigate. Of the four broad program areas where OHI investigations occur, approximately 25 percent of the investigations are in foster homes, 25 percent in day care facilities, 25 percent in schools and 25 percent in residential treatment facilities. This distribution of reports has remained relatively consistent over time. The percentage of Preponderance of Evidence (POE) findings for investigations in each program area tends to be lower than that rate in family investigations. The difference may be attributed to the fact that alleged perpetrators investigated by the OHI Unit are professional, trained staff who have been screened prior to employment and then supervised in the performance of their jobs.

In the past an alleged perpetrators name was entered in the central registry when an investigation was concluded with a finding of child abuse or neglect. The central registry is a registry of persons where the CD has found a POE to believe abuse or neglect has occurred or a court has substantiated through court adjudication that the individual has committed child abuse or neglect.

There are on going policy discussions regarding the POE issue. A recent policy change is that POE findings are now preliminary until the individual has had an opportunity to appeal this decision. As these policy discussions progress, this may affect the manner and timing of information sharing with other agencies.

Background Screening and Investigation Unit

The Background Screening and Investigation Unit (BSIU) conducts checks through the CA/N Central Registry. These background checks are requested by employers on current or prospective employees/volunteers who have responsibility for child care/supervision (day care providers, residential care providers, schools, mental health providers, Boy/Girl Scouts, etc.) for assessing if the employee is appropriate to be caring for children. The checks may also be requested by parents/legal guardians for prospective childcare providers for their children.

During 2006, BSIU processed 110,389 screenings. This is a substantial decrease from the139,744 processed in 2005. This difference is attributed to the adult and child care providers and in home caregivers becoming more compliant in using the Family Care Safety Registry established through the Department of Health and Senior Services, especially the child care contracted providers used by the Early Childhood Section of CD.

Healthy Children and Youth Program

The Healthy Children and Youth Program (HCY) renamed from the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT) continues to provide services for eligible children and youth, ages 0-20 years.

Previously treatment services were limited to those covered under the Medicaid/MC+ state plan. The expansion of HCY provides that all medically necessary services identified as a result of a HCY screen must be covered by the state. As a result, services have been enhanced and several new provider groups have been added.

HCY program:

- Counseling/social worker services
- Case management
- Private duty nurse
- Speech, occupational and physical therapy
- Environmental assessments for lead

Additional benefits have been added for children in the following programs:

- Personal care
- Home health
- Orthodontic care
- Durable medical equipment

During Federal Fiscal Year (FFY) 2006, 28 percent of children screened were referred for corrective medical treatment and 26 percent were referred for dental services.

Child Care

The CD is the lead agency for the federal Child Care and Development Fund and administers the state child care subsidy program for low income and protective services families served through both the CD and the FSD. Recently the Governor announced due to $19.5 million in projected savings from reducing waste, fraud, and abuse,

Missouri will be increasing its income eligibility limits from 110% of the federal poverty level (FPL) for low income families to 126% of the FPL, and increasing child care subsidy rates to licensed and inspected (faith-based) child care providers by five percent. This is the first child care subsidy rate increase child care providers serving preschoolers and school-age children have received since 1991.

This savings was the result of several cost containment and improper payment/fraud prevention activities instituted by DSS. These include the establishment of a Monitoring and Compliance Unit within the DSS Budget and Finance Division. To date, this unit has completed on-site monitoring of 1,600 of the approximately 5,200 child care providers that receive payment on a monthly basis. As a result 140 contracts have been closed. The Early Childhood and Prevention Services Section has also instituted a variety of new systems edits and reports targeted at identifying and preventing improper payments.

While child care subsidy provides a necessary service to families within the child welfare system, it is also essential in ensuring that children in low income families are not left in dangerous or inappropriate child care situations that may ultimately result in reports of abuse or neglect. Maximizing funding for child care subsidy ensures that DSS is able to serve the greatest number of families in need. Timely and accurate payment ensures that higher quality providers are willing to accept DSS subsidized children.

Building Healthy Families (BHF)

In 2006 the pilot counties of Jasper, Newton and McDonald changed the name of the pilot from Chronic Neglect to *Building Healthy Families (BHF*). The new name would be more family-friendly, descriptive, and marketable to potential community partners, believing that the key to success in working with this population was to provide services and supports that would promote healthier family functioning.

The success of BHF program efforts will be measured by the ability of the family, state agency, and community to protect children from harm. The division will look at the number of substantiated child abuse/neglect findings during the first three, six and twelve months following the BHF initial intervention.

BHF services are intended to achieve safety for children by strengthening family and child functioning. These goals are better met by keeping families intact. When decisions need to be made to remove a child from the home, the BHF case manager will facilitate this decision-making process in a timely and respectful manner that supports the best interest of the child. The division will look at the number of children removed from the home during the first three, six and twelve months following initial intervention.

Bolstering family empowerment is a key element to improving and sustaining healthy family functioning. Families need to feel that they have the strength, capability and resources available to meet every obstacle that comes their way. A Family Self

Assessment will provide a good measure of how the family rates their own capabilities, family functioning and perceived available resources. The division will look at how the family rates themselves after 30 days of intervention and after 60 days on the families perception of 1) relationship with community; 2) problem solving; 3) relationships and support from family and friends; 4) sense of accomplishment and task completion; and 5) parenting and parent child relationships.

McDonald and Newton Counties began screening families for the BHF pilot on September 11, 2006, and accepted the first family on September 20, 2006. Between September 11, 2006 and January 11, 2007, 18 families were screened for the BHF program and seven were accepted for BHF case management. Jasper County screened the first family on November 20, 2006 and accepted the first BHF case on November 27. 2006. Between November 20, 2006 and January 25, 2007, 11 families were screened and five families were accepted for BHF case management.

In total, there were 29 families screened in the pilot sites and 12 accepted for BHF case management. One family accepted into BHF case management, transferred to another county. Of the 12 families accepted, four were opened from a family assessment, six from an investigation and two were opened as a result of a newborn crisis assessment. Fifty percent of the families accepted in to BHF had abuse allegations in the initiating hotline and 67 percent had allegations of neglect. Thirty-three percent of BHF families had some history of a newborn crisis assessment. BHF families averaged seven prior child abuse/neglect reports per family in comparison to an average of 4.2 priors from families not accepted into the program.

From the time of initial implementation there have been five subsequent hotlines. Only one of these was from families involved in BHF case management. Of the 29 families, three families had children removed from the home during this time. None of those families were involved in the BHF case management.

Newton and McDonald Counties report a donation of food by a community organization for the purposes of this BHF program and anticipate being able to continue this monthly. Early Head Start has donated cleaning supplies. Another community partner donated bug spray. A new community doctor participated in a staffing of one of his clients. He was very supportive of this program and intents to promote it. Another community source donated a storage unit. There has also been excitement and support from the school systems as well. Jasper County also reports strong buy-in from the school system, which has been active in making referrals and requests to staff families.

Family-Centered Services

Families entering the child welfare system due to reports of child abuse or neglect receive case management services that are referred to as Family-Centered Services (FCS). FCS may also be provided if the family requests preventive treatment services. Services are available to families, including expecting parents, who request services that might prevent child maltreatment or family dysfunction. FCS seeks to empower the family and minimize its dependence upon the social service system. During SFY 06

there were 19,408 active FCS cases compared to 20,685 during SFY 05. There were 8,975 were new cases opened and 10,296 cases closed during SFY06. These include service cases with intact families and families with child(ren) in out of home care. Approximately 29.8 percent of FCS families served were the result of substantiated child abuse/neglect reports and 19.1 percent were the results of Family Assessments. Family requests for preventive services were 36.5 percent.

It appears that quality and timely services to children and families are occurring based on the slight increase in desired goals achieved and the increase in the number of cases being closed.

Foster Care Services

Children enter foster care primarily through child protective services as a result of abuse or neglect where removal of children from the home is necessary to ensure safety. Services to promote permanency, stability and continuity of care are provided. Services build upon family strengths and community support. Services include, but are not limited to case management, permanency planning, safe and appropriate placements, family-centered services to families and assistance to young adults in transition form adolescence to adulthood.

Out-of-home resource placements include emergency shelter care, family foster homes, therapeutic foster homes, group homes, and residential treatment centers. All out-of-home resource providers are required to licensed, contracted, pass a child abuse/neglect background screening and a criminal background check. The electronic fingerprint live scan systems are designed for ease of use and for capturing high quality fingerprint images, helping to ensure superior acceptance rates and accurate criminal history information. The first time prints are submitted for processing to State and Federal AFIS systems. Staffs of group homes and residential treatment centers are also required to submit to the background screenings and checks.

Partnering with both formal and informal community organizations to support families involved in child welfare is necessary to build stronger families and stronger neighborhoods. The CD believes child welfare services can best be provided through public/private partnerships, including:

- St. Louis City based Family to Family Initiative provides the CD with an opportunity to develop culturally sensitive family foster homes which are located primarily in the communities in which the children live.
- An extensive array of purchased services from local public and private contractors.
- A comprehensive children's mental hearth services system to meet mental health needs of children and divert children from going into foster care based solely on the need to access clinically indicated mental health services.
- Funding streams such as psychiatric diversion to reduce barriers to obtaining needed services and preventing unnecessary psychiatric hospital placements.
- Community-Based Child Abuse Prevention (CBCAP) services.

- Performance based Specialized Care Management Contract to serve children with multiple placement disruptions and requiring more restrictive levels of care.
- Kinship Care to allow children to remain living within their extended family structure.
- Transitional Living Program to offers different living situations for older youth to allow for autonomy while still receiving the needed support, services and supervision.

During the past year, several policies were developed and disseminated to staff as required by the PIP. The new policies and practice enhancements addressed:

- preserving and improving familial, sibling and community connections;
- enhancing worker visits with children, parents and placement providers;
- scheduling and completing federally required Administrative Reviews;
- filing Termination of Paternal Rights (TPR) in a timely manner;
- enhanced diligent search for a biological parent, step parent, adoptive parent, legal guardian, or a relative of a child in the custody of the CD whose identity or location is unknown;
- designed a handbook for parents to understand what it means for them when their children are placed in out-of-home care; and,
- Revised the "Learning Guide for the Caregiver Who Knows the Child" training manual and Family Assessment Tool to better meet the needs of caregivers.

The CD has worked closely with the National Resource Center for Family-Centered Practice and Permanency Planning on improving recruitment and retention of foster parents and improving placement stability. The recommendations from the Recruitment and Retention Workgroup have been given to the CD director and the approved recommendations are beginning to be implemented. Refer to the Foster and Adoptive Parents Recruitment section under Additional Required Supporting Information for specific recommendations. The Placement Stability workgroup continues to meet to develop recommendations for policy and practice improvements to address placement disruptions.

The required 27 hours of pre-service Foster STARS (Specialized Training Assessment Resources and Support/Skills) and 12 hours of pre-service Adopt STARS training and curriculum used remain unchanged. However, CD is working on incorporating more discussion and information into the Foster STARS training regarding the relationship between the foster family and biological family. This was a recommendation of the recruitment and retention workgroup to improve the working relationship between the foster and birth family. This improved relationship will expedite reunification and safety of children.

AS a requirement of the PIP, the CD introduced the Professional Family Development Plan (PFDP) in April, 2006. After completing STARS training and becoming licensed, foster parents meet with their local licensing worker to complete the PFDP. The PFDP is the training plan for the family. It is designed to help strengthen skills already in place and develop those areas that families find challenging. This plan is developed within 30 days of the family becoming licensed and renewed every two years. The plan may be

updated at anytime during the two year licensing period as the needs and interests of the family change but it must be reviewed a minimum of once a year.

It is the goal of the CD to develop resource family skills to improve retention of resource homes and reduce moves for children in foster care. Staff have expressed concern the PFDP is not family-friendly or beneficial and they are not utilizing the PFDP as intended. Therefore, there have been discussions of revising the PFDP and providing additional trainings for licensing staff.

The CD promulgated new foster home licensing rules. Included in the new rules were requirements for CD staff to develop a foster family profile to be shared with the FST when making placement decisions. Implementation of this rule will assist in achieving better placement matches for children. The impact of the foster family profile is not yet known as policy is being introduced in regard to this change.

There are currently no major planned changes for respite services.

Purchased Services/Case Management

The CD administers an extensive array of purchased services. These are purchased from local public and private providers. Contracted providers play a major role in extending services to client families throughout the state.

Currently, approximately 2,200 children and their families are case managed by private providers through the Performance Based Contract (PBC). The case management contracts include performance measures related to safety, stability, and permanency. Seven consortiums provide case management services. During Year One of the contract (September 1, 2005-September 30, 2006) all contracted providers met the re-entry and stability targets. The permanency outcomes were achieved by the two contracted providers in the Kansas City region. Approximately 196 new resource homes were developed by the seven consortiums.

In September 2006, 105 cases were assigned in the Springfield Region to include two additional circuits, encompassing 5 counties (Barry/Lawrence/Stone and Christian/Taney). An additional 127 cases were assigned to the other regions as expansion cases and to help CD meet accreditation standards.

During March and April 2007, the CD plans to meet individually with each contracted provider to discuss the strengths and challenges encountered during the first contract period. Lessons learned to date have included: assigning cases to replace those children that do not achieve permanency, but leave the child welfare system through the court dropping jurisdiction due to age, etc; preparation of cases for return to the CD to continue adoption/guardianship subsidy; and logic associated with coding for the outcomes reporting is very complex and relies heavily on workers understanding the importance of data input.

Specialized Care Management Contract

This contract was implemented originally in 1999 and referred to as the Interdepartmental Initiative for Children with Several Needs. As this initiative ceased to be fully "interdepartmental" in nature, the CD developed a replacement contract. The "Specialized Care Management" contract awarded to Missouri Alliance for Children and Families (MACF) in April 2006 continues to reflect an individualized, comprehensive and family-focused approach to meeting the needs of youth from the child welfare system who present with complex behavioral health issues. The contract was created to address the specific needs of children and youth between the ages of 6 and 20 who have experience increasingly more restrictive levels of care and multiple placement disruptions. The contract is capped to serve a maximum of 350 youth in care and is to provide intensive wraparound services and supports by ensuring a maximum case management ratio of 1 to 10, although some caseloads are beneath this limit. The Specialized Care Management contract differs from the Interdepartmental Initiative in the following ways:

- There are no financial performance incentives or penalties built into the contract
- MACF is responsible for all case management functions, unless otherwise specified
- Enrolled children have access to Medicaid for services outside of what is provided through the comprehensive community support menu
- Stability measurements increased from 90 to 120 days, before disenrollment can occur.

Outcome objectives are outlined in the contract and relate to child well being, permanency and stability. Current performance indicates the MACF is meeting the outcome objectives in all areas except for the measure on unplanned moves and lowering the score on the Childhood Severity of Psychiatric Illness scale.

Comprehensive Children's Mental Health Services System

In 2004 the passage of Senate Bill 1003 (the Children's Mental Health Reform Act) directed the Department of Mental Health (DMH) to partner with other child service agencies, both public and private, in developing a plan for a "Comprehensive Children's Mental Health Services System." (Section 630.097 RSMo.)

Section 630.097 RSMo further called for the formation of a "Comprehensive System Management Team" (CSMT) to establish the system detailed by the plan. The existing state System of Care Team was deemed appropriate to fulfill such a function and has thus been so designated and re-named. The CSMT has formalized it structure with the adoption of by-laws and continues to meet once per month. A strategic planning meeting was held in March 2007 to further define the priorities of the team.

The statewide implementation of the Custody Diversion Protocol in partnership with the Department of Mental Health mandates timely response to any parent voicing the intention to surrender custody so that his/her child may receive clinically indicated mental health services. Circuit-specific training has occurred to address identified concerns, and the continued approach and recommendation are to leverage resources and problem solving at the local level. Regional Mental Health Coordinators have been

appointed in each geographic region of the state and meet on a quarterly basis with Department of Mental Health partners to help address local issues.

Likewise, utilization of the Voluntary Placement Agreement continues to increase throughout the state as efforts to serve e children in need of mental health services focus on a collaborative partnership with the juvenile court, the Department of Mental Health, and the CD. Combined, these initiatives have resulted to date in 50 children whose legal custody has been restored to the parent under the provisions of SB 1003.

Residential Treatment Services for Children

Residential treatment provides specialized treatment for children need more structure and intervention than a foster home can provide. Placement is time limited and treatment focused so the child can transition to a lesser restrictive setting in family or community-based care. The CD Residential Program Unit (RPU) has the responsibility for licensure, supervision and re-licensure for the Residential Child Care Agencies (RCCA) and Child Placing Agencies (CPA).

Throughout SFY 06, 3,855 children received residential treatment services. This is a decline from SFY 05 when 4,033 children received residential treatment services. This decline is attributed to the general decline in children and youth entering into CD custody. There has been a policy in effect to get younger children out of residential treatment and into a lesser restrictive setting. There has also been an on-going effort to get older youth into specialized foster care settings. This is a positive trend when fewer children are coming into CD custody and those who are coming into custody are being placed in lesser restrictive settings.

Residential services provided include: individual, group and family counseling, recreational therapy, educational services, medical and psychiatric services, transitional living and life skill training for older youth, family focused reunification services and a closely supervised, structured place to live. These children received services through 85 licensed residential agencies operating at 135 separate sites, and 77 CPAs providing foster care and/or adoption services at 94 separate sites. Twenty four RCCAs are dually licensed to provide child placing services. In 2006, there were three initial RCCA and one initial CPA licenses awarded. Thirty-one RCCAs and 37 CPAs renewed their licenses in 2006.

In 2006, of the 85 licensed RCCAs, 35 were accredited through nationally recognized accrediting bodies (Council on Accreditation, Joint Commission on Accreditation of Healthcare Organizations, Commission on Accreditation of Rehabilitation Facilities). Thirty-three of the 77 CPAs are accredited. Three additional RCCAs and three CPAs are actively seeking accreditation at this time. Such accreditation in Missouri serves as prima fascia evidence that an accredited agency meets state licensing standards.

Licensed RCCA staff are required to have initial orientation and a minimum of 40 hours of on-going training per year while licensed CPA staff must have a minimum of 20 hours. RPU continues to encourage RCCAs and CPAs to use the “Strengthening the

Culture of Care" (COC). The goal of COC is to assist agencies in providing safer, more nurturing, child-centered practices that reduce the need for physical restraint and/or locked isolation.

While the initial COC "train-the-trainer" curriculum was developed in conjunction with the National Resource Center for Youth Services (NRCYS) and the sessions were conducted by NRCYS in 2004, it has gained momentum and support by the Child Welfare League of America (CWLA). At the encouragement of CWLA, Missouri and the NRCYS entered into a collaborative effort with agencies in Minnesota, Michigan, Massachusetts, Washington, and Indiana to field-test COC for three years. NRCYS is collecting data on the use of physical restraints and/or locked isolation, the incidence of injuries, child abuse/neglect reports, and results of client satisfaction surveys from the six agencies. NRCYS conducted three (3) "refresher" train-the-trainer programs in 2006 and included staff from the all of the field test agencies. CD believes that the COC initiative will improve safety and nurturance of children in a residential care setting. This improvement is measured quarterly through a reduction in the number of CA/N reports with a positive finding (Preponderance of Evidence) received by residential treatment facilities. RPU also conducts twice yearly meetings with administrative staff of RCCAs that focus on information sharing and performance enhancement.

Interstate Compact on the Placement of Children

The specific accomplishments and progress achieved in this fiscal year have included adopting timeframes for completing home assessment in a timely matter based on Public Law 109-239. Missouri has also developed new policy to inform CD staff and Performance Based Contractors of the guideline to successfully complete an assessment on homes for children who are removed from a caretaker. Developing clearer policy will strengthen the worker's ability to accomplish tasks within the 60-day timeframe and meet the established goals developed by P.L.109-239.

In SFY-06, 2953 children were served, which included 796 requests for services from other states for Missouri children, and 679 out-of-state requests for Missouri services on behalf of children from other states.

Missouri continues to honor border agreements with the states of Illinois and Kansas in coordination with the Interstate Placement Compact (ICPC).

Kinship Care

Kinship care in Missouri generally refers to children in foster care placed with a relative or suitable adult who has a kinship bond with the child. The CD provides specialized training to both relative and kinship providers. The STARS for the Caregiver Who Knows the Child training curriculum, a version of the Foster STARS, is used with relatives and non relative persons who have a close emotional relationship with the child but do not want to become a licensed provider. It focuses on the same competencies but addresses issues of changing relationships with relatives and kin when providing out-of-home care as well as understanding permanency goals,

managing new responsibilities, managing stress, staying healthy, and the grievance process. Revisions were made to the curriculum to better address these areas and were introduced into training in September, 2006.

Other Permanent Living Arrangements

The FST may determine during an administrative review or at the permanency court hearing there is compelling reason the four most viable permanency options of reunification, adoption, guardianship or relative placement are not in the child's best interests. Children are placed in another planned permanent living arrangement (APPLA) only in cases where the division believes and has discussed with the FST and documented to the court this placement will endure until the youth becomes independent.

When a youth is in APPLA, all case management services are afforded the youth including working with the resource or birth family to assess risk and treatments, participating in the development of the permanency plan, identifying and providing needed services and meeting with the youth and family to ensure desired outcomes are attained.

The PBC for case management services and the CD have formed a workgroup to identify youth in an APPLA within the PBC population and to develop outcomes which reflect the positive work being done with these youth. Outcomes include increasing positive adult connections, successful completion of academic and vocational goals, access to physical and mental health services and safe and stable living arrangements. This workgroup's first meeting occurred on April 16, 2007 and is developing outcomes to include in the FY 2008 contract.

The Independent Living Arrangement (ILA) is a living situation for older youth age 17 years and older who has been deemed suitable to live independently. There have been no changes to this service provision. The Transitional Living Program (TLP) offers another living situation for youth in APPLA. The CD has been developing and working towards issuing a new TLP contract in FY 2007. Within this new contract the CD has built in structure/placement requirements as well as Chafee service requirements and outcomes, congruent to what will be expected from National Youth in Transition Database.

The TLP contract was awarded on March 15, 2007, to 16 different agencies within the state of Missouri. These agencies will provide transitional living group home and/or transitional living scattered site apartment living for approximately 150 youth in the CD custody during the end of FY 2007 and FY 2008.

Progress towards meeting PIP goals and objectives
Many of the PIP activities relating to child safety were completed during the first PIP year and reported in 2006 APSR. The process steps and objectives for the remaining activities related to safety have been met:

- *S1.1.6 – Policy and practice related to non CA/N referrals and how the division can better address its core functions and statutory mandates*.

  Missouri has, by policy, accepted calls to the CA/N Hotline Unit that do not rise to the statutory definition of child abuse and neglect. Calls that do not meet the statutory requirement of a CA/N report, fall mostly into the Non-CA/N Referral category. During the past year, CD considered a change in current practice regarding how these calls are handled. The change would redirect reporters to local resources if their concern does not meet statutory requirements. The change was proposed to CD Regional Directors, the Children's Justice Taskforce and other community stakeholders. The CD has made a decision to continue responding to these non CA/N referrals per the recommendation of community stakeholders. No additional policy changes will be made at this time, but the division will continue to explore with community partners other ways to address these referrals.

- *S1.2.3 - Strengthen policy regarding assessment of safety at and throughout placement*. The Visitation Workgroup completed their review of safety and visitation policies in the child welfare manual and submitted recommendations to the Executive staff for policy changes. A series of three memorandums were developed and disseminated to staff to address safety of children at and throughout placement and visitation. Central Office staff met with Staff Development and Training to discuss, policy implications, and how to incorporate this information into BASIC and In-Service trainings.

- *S1.2.5* – Strengthen policy and practice relating to chronic neglect and accumulation of harm. Activities related to this action step are indicated above in the Building Healthy Families initiative.

- *S2.3.3* –Improve supervisory capacity to monitor enhanced practice relating to case planning. During July 2006, the first sample of cases to be reviewed was sent out to each circuit manager for front line supervisors to begin completing monthly case reviews using the Supervisory Case Review Tool to a randomly selected sample of cases. The case review tool will assist staff support the mission and guiding principles of the CD, enhance clinical supervision, support the CQI environment, increase consistency of practice, provide worker accountability and improve outcomes for children and families.

- *P1.6.6* - The Stability Workgroup was convened during August 2006 and met with the National Resource Center for Family Centered Practice and Permanency Planning consultant to begin identifying barriers associated with placement stability. The consultant provided the group with information on how to be successful in achieving placement stability through lessons learned from other states. Finally, the group identified areas to improve and developed subgroups to concentrate on the five problematic areas and the expected deliverable.

Targeted case reviews were scheduled with circuits falling short of their placement stability goal and needing additional supports for purposes of developing circuit specific action plan.

- *P1.6.7* – Based on input from relative/kinship providers, the *Caregiver Who Knows the Child* curriculum was updated and focused the improvements on *Understanding Permanency Goals; Managing New Responsibilities; Managing Stress & Staying Healthy; Information regarding the Grievance Process.*

- *P1.10.4* – To increase older youth involvement in service planning and delivery, policy and the Adolescent FST Guide and Individualized Action Plan protocol was developed. Field tests of the training and protocol were conducted. Staff in the test sites were surveyed for the protocol usability.

- *WB1.18.3* – A parent's handbook was developed and made available to be distributed to parents at the point of their child's removal to educate them on their rights, responsibilities, court procedures, etc.

- *WB1.19.1* – Policy for worker visits with children was updated requiring workers to meet face to face with children in foster care the next business day following placement when possible and a minimum of two times per month, no less than seven calendar days apart. The visit the next business day and at least one visit per month thereafter must occur in the placement setting.

b. The steps the agency will take to expand and strengthen the range of existing services and develop and implement services to improve child outcomes.

<u>OHI Staff Expansion</u>
The OHI Unit has added two additional field staff and one field supervisor this past year. This has allowed us to keep pace with increasing numbers of reports in a timely, efficient manner. This has strengthened the ability to make a quick response to referrals to develop plans to ensure child safety pending the completion of an investigation. The OHI Unit continues to dialogue with other agencies and other CD staff about how to ensure child safety when there have been allegations of abuse or neglect. Good communication among all the partners is key to this effort. OHI has begun utilizing e-mail as well as personal and telephone as a communication method. E-mail allows for a real time transfer of information, and at the same time documents information for all parties.

<u>Child Care Efforts</u>
The CD released an RFP in April, 2007, to develop an electronic time and attendance system for child care subsidy utilizing a biometrics application, specifically fingerprinting imaging of both the child and the parent. The child will be checked into and out of child care by placing a finger on a pad on a purchase of service (POS) device located at each child care facility. This device will capture a logarithm of the fingerprint to verify that the child is indeed in care and calculate the time the child is in care. This information will be

transmitted back to the DSS child care subsidy system which will calculate payment. Allowing for development and roll out time, we expect this system to be fully operational in late 2008.

Case Management Efforts

PBC expansion plans for FY 08 have not yet been finalized, but there is the possibility of providing approximately 105 cases to the Springfield region to help meet accreditation standards.

The CD contracted with the University of Missouri-Columbia (UMC) to perform an evaluation of the PBC process. In addition, the UMC assisted the CD in the equalization of caseload assignment during the implementation phase of contracting. The equalization process used variable such as age, race, sex and length of time in foster care which resulted in similar caseloads for each consortium. At the end of UMC's first year, an activities report described evaluation events, such as focus groups, interviews, evaluation of pilot units, and the case load equalization process. A second year report will provide outcome data analysis, PBC barriers and successes, as well as recommendations for improvement. This report is rescheduled to be completed in June 2007.

The evaluation process will continue for the next several years through the Southern Region Quality Improvement Center (QIC) Performance Based Contracting grant received on January 1, 2006. This grant will continue Missouri's current PBC assessment and expand to a cross-state evaluation. The continued grant efforts will explore collaboration, implementation and practice successes within the public-private partnerships.

Missouri's QIC study, entitled *Maintenance Needs in Performance-Based Contracting Success: The Missouri Project on Privatization of Out-of-Home Care for Children,* will examine the processes necessary for maintaining public and private partnerships in support of performance-based contracting of child welfare out-of-home beyond the initial contract implementation process. Using a mixed method design, the project expects to determine those public/private contracting and contract monitoring processes which provide a best-practice model for ongoing use of performance-based contracting in the delivery of out-of-home care that lead to the optimal positive outcomes for children needing such services. Both qualitative and quantitative data will be used in the development of this best practices model.

Specialized Care Management Contract

Negotiations were held with MACF to change the outcomes for the renewal of the Specialized Care Management contract in July 2007. Some outcomes will be changed (i.e. worded differently) and some targets will be raised.

Kinship Care

The Kinship Care program is a successful component of the CD's practice. The enhancement to the data system to allow for the 90 days to complete the licensure

process will assist in assuring that relative and kinship providers are able to meet the needs of the children and reduce the financial and emotional stress of the addition to the household. The number of children in relative and kinship care has steadily increased over the last five years and should continue to do so as CD continues to focus on locating these placements for children entering out-of-home care.

Older Youth Efforts

Within the Older Youth Program there are services and funding provided through the Chafee Foster Care Independence Program (CFCIP). During FY 08 the CFCIP will be contracted to private providers to administrate and deliver services and funding to youth in foster care and former foster care youth. Within this contract there is language about the Four Core Principles - positive youth development, collaboration, cultural competence and permanent connections. The expectations and requirements are that Chafee contracted providers will engage the youth in their case planning, design life skills instruction specific to the youth's needs with youth input, offer a variety of methods in which youth can gain competency in each life skill. The Chafee contracted provider is expected to promote youth leadership, provide the opportunity or assist the youth in gaining this experience whether through school functions, community organizations or the development of local foster care youth advisory boards. The youth must have the opportunity to lead with their peers and advocate for issues that are important to them.

Accreditation Efforts

The CD is in the process of developing its accreditation implementation plan for FY08 and FY09. In September, 2006, the remaining 31 circuits provided updated self-assessments using the established readiness criteria. The updated information was used to determine the order and years in which the remaining 31 circuits will be visited by COA. Sixteen circuits will be reviewed in FY08, and 15 circuits will be reviewed in FY09, contingent upon appropriations and COA's ability to accommodate the division's desired time frame.

c. This section updates the goals and objectives to incorporate areas needing improvement identified in a CFSR, IV-E, AFCARS, SACWIS or other reviews and activities proposed and completed in subsequent PIPs.

At the onset of the two-year PIP process, CD identified eight key strategies to address areas needing improvement in order to achieve the core outcomes for the children and families who come into the child welfare system. Through targeted strategies and action steps, the division has addressed and completed the 600+ individual process steps and met the agreed upon data goals for the six national standards.
We have been working on increasing the integrity of the PRR data for nearly two years. During the refining process a decline in the PRR performance data was expected. While the division is pleased with the improvements made, there are several measures we are strategically focusing on to improve to exit the PIP.

Timeliness of initial contact

Current Performance per the *Outcomes Report* = *75.2%* *Goal = 80.4%*

For all investigations and family assessments, Missouri statutes require the child(ren) to be seen immediately in emergency situations and within 24 hours for non-emergency cases. Immediately is defined per policy as within 3 hours. For educational neglect reports, the victim must be seen within 72 hours. The expectation for change requires Circuit Managers to review measure #1 of the FY 07 Outcomes Report and develop an action plan for improvement for any circuit performing below the state goal. A recent review of conclude CA/Ns indicated performance may be improved by additional policy clarification and training, as well as a system edit which will simplify initial contact reporting, whether, made by a multi-disciplinary team member or a CD staff person. CD has begun addressing these changes.

Family participated in the development and signed the service plan
Current Performance *per PRR Results* = *74.3%* Goal = *75.3%*
The Family-Centered approach is the division's philosophical base of child welfare practice. Parents and children will be given the opportunity for full inclusion in all phases of the assessment and service planning process. When the parents sign the plan, they convey their agreement to the goals and requirements of the plan. The expectation for change requires staff to make every effort to involve the family in the assessment and planning process are essential in developing a therapeutic relationship and in empowering parents to make the necessary changes. Circuit Managers will work with staff to ensure that families are actively involved in the planning process. Service plans will be developed by focusing on the strengths and needs of the family and reviewed for signatures of family involvement.

Services being provided to the family are adequate to meet their needs as identified in the assessment
Current Performance *per PRR Results* = *86.8%* Goal = *89.9%*
In Family-Centered techniques recognition is given that families are more likely to change when they are invested in a plan for change, rather than being asked to comply with the mandates of others. Family-Centered practice empowers the family and encourages self-sufficiency, while meeting the children's needs. Flexible funding is provided to facilitate meeting the needs of families, when they can not otherwise be obtained. Expectation for change necessitates the worker to initiate the family-centered practice by explaining the purpose of division's involvement, establishing rapport and treating the family with honesty and respect. Full inclusion will give parents and children an equal and active voice in identifying the issues and need for services. The supervisor is responsible for assuring the assessment is complete and discussing with the worker the best way to access needed resources.

Worker visits with the family and caretakers at least one time per month
Current Performance *per PRR Results* = *81.6%* Goal = *85.4%*
CD policy expects staff to meet in the family's home one time per week during the first 30 days, but a minimum of one time per month. Ongoing case management after the initial 30 days requires a minimum of one home visit per month. This visit should not be included with any supervised visitation between parents and children that occur in the

home. Expectation for change – To ensure the safety of children in foster care, it is imperative for staff to conduct visits with parents and placement providers. Circuit Managers will review PRR results for current circuit performance and develop a plan for improvement if their performance is below the state goal. The improvement plan will include strategies within the next 90 days for worker visits with the family and caretaker to take place at least one time per month and documented in the case record via the worker.

Child placed in close proximity to family
Current Performance *per PRR Results* = *85.6%* Goal = 90*.9%*
CD strives to preserve and maintain family and community connections for all children and families served. For children in out-of-home care, diligent efforts are made to place the child and/or sibling group together with other relatives, maintain the child and/or sibling group in their own schools and communities and ensure close proximity to his/her parents when possible and appropriate. In an effort to improve this outcome, Family Centered Out-of-Home supervisors and Circuit Managers will conduct administrative reviews in the next 60 days to evaluate whether all viable placement options have been explored and exhausted in efforts to place the child in the same community and within close proximity of their parents.

Visitation plan in place to facilitate reunification
Current Performance per *PRR Results* = *84.8%* Goal = *86.8%*
Child visits with parents and siblings should occur within the first week of placement, and then weekly thereafter, when possible. The Visitation Plan developed through the FST process should include the frequency of the visits. It is recommended that a visit between a parent and child occur weekly or as frequently as possible in efforts to preserve the bond between a parent and child. It is the worker's responsibility to assure that the child is present for the visits and that a location is secured. Visits should not be canceled or rescheduled because of unexpected problems with the worker's schedule; a backup plan should be in place. The expectation for change will require Circuit Managers to work with staff to ensure there is a visitation plan developed for each child or the visitation plan allows for visitation per policy.

An analysis of Outcomes data indicates children placed with relatives/kin have greater placement stability than children in foster care placements. However, data analyses also indicate children in these placements take longer to achieve reunification. The Stability Workgroup are reviewing policy to determine what may attribute to barriers to placement with kin/relatives and assess if practice is clear and enables workers to get to a permanency outcome?

The CD made a decision to revise and rename the Independent Living Program to the Older Youth Program. The new changes will better reflect the specific philosophy and services that are offered to youth, ages 14 and older, in the custody or previously in the custody of the CD. The changes will improve how serves are provided to youth and will address:

- The philosophy of youth permanency and positive youth development

- The responsibilities of case managers of older youth, ILP Contractors,
- TLP Contractors, Older Youth Contract Coordinators;
- The role of the Older Youth Transition Action Teams
- procedures for using the Ansell-Casey Life Skills Assessment and the Adolescent FST Guide & Individualized Action Plan (formerly the CS-1 Attachment)
- Helpful resources to engage youth in their permanency and education planning

Within this policy change will be a revision to the current CS-1 Attachment. This form will become the Adolescent FST Guide & Individualized Action Plan. It will assist workers and youth in the planned transition of a youth becoming an adult and leaving the foster care system. It will detail the goals of the youth and facilitate the involvement of identified adults in the youth's life.

d. Describe the services to be provided in FY 2008, highlighting any changes or additions in services and program design.

CA/N Changes

There are no major changes or additions to CA/N Prevention, Intervention, and Treatment Services

Foster Care Strategies

A redesign of the Behavioral and Career Foster Care programs has been under discussion by a subcommittee of the Placement Stability Workgroup. This subcommittee is in the process of formulating a recommendation for a pilot project to begin during SFY 2008. The pilot is being proposed as research has shown children in these types of placements do not have better outcomes and may, in fact, have more placement disruptions than children in traditional foster homes. The pilot will look at ways to enhance the skills of the current placement providers to meet the needs of children with specialized need rather meeting their needs by moving them to a different placement.

Kinship Care

There are no planned changes or additions to the Kinship Care program for FY 2008.

Older Youth Efforts

Within the Older Youth Program there are services and funding provided through the Chafee Foster Care Independence Program (CFCIP). During FY 08 the CFCIP will be contracted to private providers to administrate and deliver services and funding to youth in foster care and former foster care youth. Within this contract there is language about the Four Core Principles - positive youth development, collaboration, cultural competence and permanent connections. The expectations and requirements are that Chafee contracted providers will engage the youth in their case planning, design life skills instruction specific to the youth's needs with youth input, offer a variety of methods in which youth can gain competency in each life skill. The Chafee contracted provider is expected to promote youth leadership, provide the opportunity or assist the youth in gaining this experience whether through school functions, community organizations or

the development of local foster care youth advisory boards. The youth must have the opportunity to lead with their peers and advocate for issues that are important to them.

These contracts will need support and monitoring. Seven regionally based, CD worker positions, called Older Youth Contract Coordinators will perform this task and be the gatekeeper for Chafee and TLP services and determine ETV eligibility.

Upon the Governor's signature, Senate Bill 577 will establish the Missouri Health Improvement Act of 2007, which modifies various provisions relating to the state medical assistance program and changing the name of the program to MO HealthNet. This act extends Missouri HealthNet coverage for foster care children from the age of 18 to 21 without regard to income or assets. It offers transitional health care to youth aging out of foster care. Currently foster care youth, aged 18-21, who leave the custody of the CD are unable to access or may not qualify for Missouri Medicaid. These young adults may no longer have available health care services or medications necessary to maintain a successful level of functioning. Youth leaving foster care at age eighteen often need supports, including health care, to transition to a successful adulthood. Offering transitional coverage would impact approximately 970 young adults.

e. Report the population to be served, geographic areas where services will be available and the estimated number of individuals and or/families to be served.

The above CA/N services are available to all children and families statewide that come to the attention of the CD in need of child protective services.

When the removal of a child from the home is necessary to ensure safety, foster care services to promote permanency, stability and continuity of care are provided to the child and his/her family. The total number of children entering CD custody during SFY 06 was 16,470. It is anticipated the same approximate amount of children will be entering CD custody and receiving foster care services statewide during SFY 07.

Kinship care is preferred and given first consideration when court intervention is necessary to ensure the safety of the child. Preferably, the child's initial out-of-home placement will be with kin, unless the court has determined that relative placement is contrary to the best interest of the child. Approximately 27 percent of the children is CD custody during SFY 06 was placed with relatives/kin. This percentage or higher is anticipated for SFY 07.

Older Youth Program services will be made available to youth ages 14 years and older on a statewide basis. It is anticipated that at minimum 2,000 youth will be served during SFY 08.

f. Indicate if there are no planned changes to the program.

There are no planned changes to Child Abuse and Neglect Prevention, Intervention, and Treatment Services; foster care or kinship care services.

Systematic steps have been taken to revamp the Older Youth Program. See above sections.