North Texas Community-Based Care Environmental Assessment

DFPS REGIONS 3W (NON-CBC) AND 3E

MARCH 2021

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Acknowledgements

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Executive Summary

Project Purpose and Context

The implementation of Community-Based Care (CBC) represents a critical opportunity for communities in Texas to find innovative and locally tailored solutions to improve outcomes for children and youth who spend time in foster care. However, the shift to CBC from the state-run legacy foster care system entails significant changes requiring careful and deliberate planning efforts. The purpose of this environmental assessment is to provide region-specific information and insights to support the communities in Texas Department of Family and Protective Services (DFPS) Regions 3W (non-CBC) and 3E in preparing and making programmatic decisions for CBC implementation. As depicted in Figure A, the two catchment areas and 12 counties included in the environmental assessment are:

- DFPS Region 3W (non-CBC) – Cooke, Denton, and Wise counties
- DFPS Region 3E – Collin, Dallas, Ellis, Fannin, Grayson, Hunt, Kaufman, Navarro, and Rockwall counties

The remaining seven counties in DFPS Region 3W are already operating under CBC and are not the focus of this assessment. However, we reference data from the entire DFPS Region 3 at times to provide a macro-level view of the region and offer a point of comparison.

Figure A. DFPS Region 3 Counties by Catchment Area
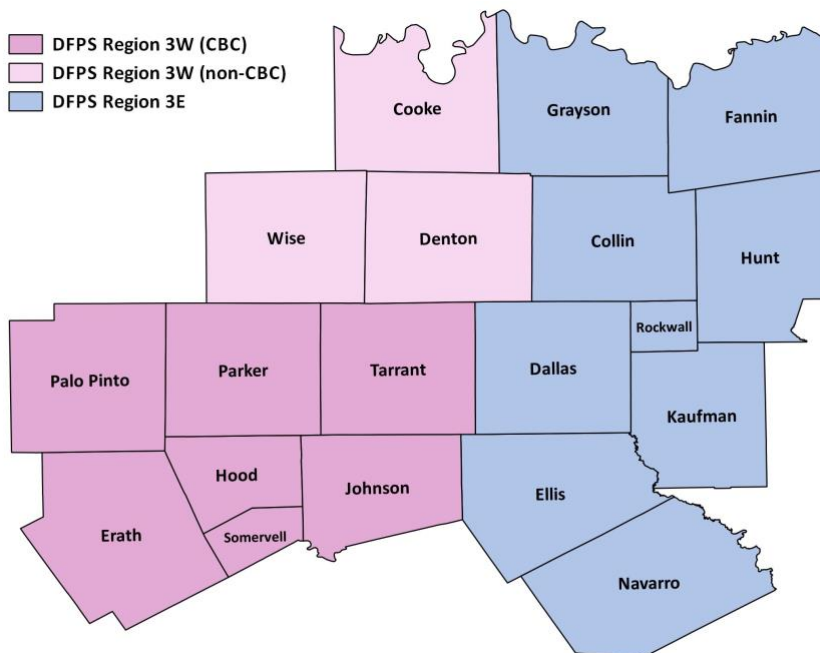
In order to offer informed and strategic guidance to DFPS Regions 3W (non-CBC) and 3E, we (the Meadows Mental Health Policy Institute or the Meadows Institute) leveraged our past work and our team's expertise as well as collected, analyzed, and synthesized information and input from: key stakeholders and agencies working within and adjacent to the child welfare system in Region 3; discussions with youth, foster parents, and relative caregivers with lived experience in the local child welfare system; datasets from DFPS and other state and federal

agencies; and complementary best practice research and resources. We worked in close partnership with the CBC Readiness Steering Committee for DFPS Regions 3W (non-CBC) and 3E (Steering Committee) and Texas Alliance of Child and Family Services in this effort.

Assessment Overview and Focus Areas

This Executive Summary is designed to provide a focused and consolidated look at the key findings and recommendations that are of pressing importance as the communities in DFPS Regions 3W (non-CBC) and 3E prepare for and succeed in their CBC implementation and child welfare system change efforts. Here, we offer a snapshot of each of the six major chapters of the North Texas CBC Environmental Assessment and a preview of the detailed analysis, discussion, and direction found in the full report. The six chapters of the report—with their corresponding findings and recommendations—are presented in the following order:

1. Data Trends and Characteristics of Children and Youth
2. Substitute Care Capacity
3. Youth and Caregiver Lived Experiences
4. Mental Health
5. Courts and the Judiciary
6. Education

Key Findings and Recommendations Summary

Chapter 1: Data Trends and Characteristics of Children and Youth

In this chapter, we use quantitative data from DFPS to describe: the number of children and youth in substitute care in DFPS Regions 3W (non-CBC) and 3E; key characteristics of these children and youth; where they are placed within the foster care system; and post-placement outcomes. In the subsequent chapter on *Substitute Care Capacity*, we integrate this information with qualitative data collected from interviews and a survey of local CPAs to identify areas of alignment and service gaps in the foster care system across DFPS Regions 3W (non-CBC) and 3E.

The 12 counties in DFPS Regions 3W (non-CBC) and 3E range considerably in population size and child welfare trends may vary between counties as well. The region includes Dallas County, which has the second highest population in Texas as well as small counties, such as Fannin, with under 26,000 residents. The portion of children and youth in substitute care who are placed with relatives is consistent across the region, but the number of children and youth placed within their home county varies greatly depending on the county's population size. For example, in Fannin and Kaufman counties, less than 30% of children and youth remained in their home county while 59% of those from Dallas were placed in county.

All 19 counties that, together, comprise the entire DFPS Region 3 serve more children and youth in substitute care than any other DFPS region in the state. The 12 counties in DFPS

Regions 3W (non-CBC) and 3E account for 73% of all children and youth in substitute care from DFPS Region 3. In fiscal year (FY) 2019, Dallas County had the third highest number of children and youth in substitute care in the state, and Denton County was 10th on the list.

The discussion below highlights some of the most significant findings identified within the *Data Trends and Characteristics* chapter of the full report.

Numbers in Substitute Care

On August 31, 2019 there were 29,242 children and youth in substitute care statewide and 21% of those children and youth were from DFPS Region 3 (Table A). Despite minor fluctuations, these totals have remained fairly steady in recent years. FY 2020 data that was released just prior to the publication of this assessment shows a slight decrease in the total number of children and youth in substitute care, both statewide and in DFPS Region 3. However, more striking is a substantial decline in the number of children and youth removed statewide and in DFPS Region 3. **For example, removals declined more than 20% in FY 2020 in DFPS Region 3 compared to FY 2019 and by 32% compared to FY 2018 regional removals.**

Table A. Children and Youth in Substitute Care in DFPS Region 3 (August 31, 2019)[1]

Subregion	In Substitute Care			% of Region 3 Total
	Total	**Foster Care**	**Other Sub. Care**	
3E	**3,520**	2,203	1,317	58%
3W (CBC)	1,741	1,311	430	29%
3W (non-CBC)	**799**	475	324	13%
Region 3 Total	**6,060**	**3,989**	**2,071**	**100%**

Who Is in Substitute Care?

DFPS point-in-time data from May 31, 2020 provides a snapshot of children and youth in substitute care across DFPS Regions 3W (non-CBC) and 3E. As shown in Table B, 4,474 out of 6,386 total children and youth in substitute care in DFPS Region 3 are from non-CBC counties (or counties that have yet to implement CBC). Across DFPS Region 3, the number of males is slightly higher than females, particularly in DFPS Region 3W (CBC and non-CBC).[2] **In all three catchment areas of DFPS Region 3, Black children and youth are significantly overrepresented in substitute care.** For example, in DFPS Region 3E, Black children and youth comprised 41% of those in substitute care; yet, according the 2019 U.S. Census Bureau annual population

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[1] Texas Department of Family and Protective Services (2020, June 28). Children in substitute care by placement type on August 31 FY2010–2019. Retrieved December 2020, from https://data.texas.gov/Social-Services/CPS-3-2-Children-in-Substitute-Care-by-Placement-T/kgpb-mxxd

[2] DFPS does not include non-binary gender identities in its data.

estimates, only 17% of the general population in those counties combined is Black. Likewise, only 15% of the general population in DFPS Region 3W (non-CBC) is Black, yet 29% of children and youth in substitute care from the area are Black. In contrast, in DFPS Regions 3W (non-CBC) and 3E, the proportion of White and Hispanic children and youth in substitute care was lower than their representation in the general population.

Table B. Basic Information on Children and Youth in Substitute Care in DFPS Region 3[3]

	Region 3E	Region 3W		Region 3
	(n=3,633)	Non-CBC (n=841)	CBC (n=1,912)	Total (n=6,386)
Age				
Current age, average	7.4	6.7	7.8	7.4
Age at removal, average	5.8	5.4	6.2	5.9
Sex				
Male (%)	1,839 (51%)	467 (55%)	1,046 (55%)	3,352 (52%)
Female (%)	1,794 (49%)	374 (45%)	866 (45%)	3,034 (48%)
Race/Ethnicity				
Black (%)	1,479 (41%)	219 (26%)	550 (29%)	2,248 (35%)
White (%)	881 (24%)	359 (43%)	735 (38%)	1,975 (31%)
Hispanic (%)	1,014 (28%)	172 (21%)	446 (23%)	1,632 (26%)
All Other (%)	259 (7%)	91 (11%)	181 (10%)	531 (8%)

Key Themes From the Data

Below are the key themes that emerged during our analysis of the quantitative data on substitute care that are highly relevant to and important for CBC planning. Each theme is anchored to the goals of CBC, as defined in the DFPS Implementation Plan.[4]

Data Key Theme 1: Location of Placement

CBC Goal: Increase the number of children and youth placed in their home communities.
A key guiding principle of CBC is that children and youth in substitute care are placed within their home communities. On May 31, 2020, just over one-third (36%) of children and youth from DFPS Region 3W (non-CBC) were placed within their home county and just over half (52%)

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[3] Data were obtained from the Texas Department of Family and Protective Services and reflect a point-in-time count of all children in foster care from Region 3 on May 31, 2020.

[4] Texas Department of Family and Protective Services. (2019). *Implementation plan for the Texas Community-Based Care system*. http://www.dfps.state.tx.us/Child_Protection/Foster_Care/Community-Based_Care/documents/2019-08-26_Community-Based_Care_Implementation_Plan.pdf

of children and youth from DFPS Region 3E were placed within their county. Whereas in DFPS Region 3W (CBC), 54% of children and youth were placed within their home county. The factors most consistently associated with being placed out of county among children in DFPS Region 3 substitute care include being older at time of removal, having a service level beyond "basic," and having more than two total placements.

Data Key Theme 2: Number of Placements

CBC Goal: Decrease the number of moves children and youth experience while in foster care.

Older children and youth and those with more complex needs experience more placements while in substitute care. For example, in DFPS Regions 3W (non-CBC) and 3E, 70% of children at an "intense" level of service had four or more placements, compared to 14% of children at a "basic" level of service. On May 31, 2020, over 60% of all children and youth across all of DFPS Region 3 experienced at least two placements (Table C).

Table C. Number of Placements by DFPS Catchment Area (May 2020)[5]

	Region 3E	Region 3W		Region 3
	Non-CBC (n=3,633)	Non-CBC (n=841)	CBC (n=1,912)	Total (n=6,386)
Number of Placements (current removals)				
1 placement (%)	1,367 (38%)	307 (37%)	691 (36%)	2,365 (37%)
2 placements (%)	1,041 (29%)	281 (33%)	545 (29%)	1,867 (29%)
3 placements (%)	495 (14%)	111 (13%)	254 (13%)	860 (14%)
4+ placements (%)	730 (20%)	142 (17%)	422 (22%)	1,294 (20%)

Data Key Theme 3: Length of Time in Substitute Care

CBC Goal: Decrease the duration and intensity of services that children and youth need while in foster care due to improved well-being and behavioral functioning.

In FY 2019, children and youth in DFPS Region 3W (non-CBC) spent an average of 15.2 months in substitute care, those in DFPS Region 3W (CBC) spent an average of 18.4 months in substitute care, and those in DFPS Region 3E spent 18.5 months in substitute care. Across DFPS Region 3, the factors most consistently associated with longer substitute care stays include a child or youth being older at time of removal, having a service level beyond "basic," having two or more placements, being in a placement more than 100 miles from their home county, and having a "high need" characteristic as determined by their caseworker. Additionally, as shown

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[5] Data were obtained from the Texas Department of Family and Protective Services and reflect a point-in-time count of all children in foster care from Region 3 on May 31, 2020.

in Figure B, Black and Hispanic children and youth in substitute care on May 31, 2020 spent longer in substitute care than did White children and youth.

Figure B. Average Months in Substitute Care by Race/Ethnicity (May 2020)[6,7]

Chapter 2: Substitute Care Capacity

The CBC model requires the Single Source Continuum Contractor (SSCC), the organization contracted to oversee foster care in a given region, to engage the community in building substitute care capacity and developing a strong network of service providers to support children and youth in care as well as their foster and biological parents. Building substitute care capacity requires a multi-pronged approach that increases the number of children and youth placed with a relative, decreases the number of placement disruptions, ensures children and youth are placed close to home, and recruits and retains high quality foster parents. Sustaining foster and relative caregiver capacity requires access to a strong continuum of community services and supports customized for children, youth, and foster and kinship caregivers. The recommendations below highlight opportunities for those involved in CBC planning to expand substitute care capacity in order to better meet child and youth placement needs.

Capacity Key Recommendation 1: Build and sustain kinship caregiver capacity to allow more children and youth to be safely placed with relatives in DFPS Regions 3W (non-CBC) and 3E.

A key goal for CBC is to place children and youth with relatives. DFPS data show that, across DFPS Region 3, children and youth placed with relatives spent about half as many days on average in substitute care as those in other placement types (356 days vs. 607 days). National data also shows that children and youth who are placed with relatives or kin are more likely to develop permanent relationships with a caring adult, less likely to age out of care, and more

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[6] Statistical tests for differences in time spent in care by race were conducted using the Kruskal-Wallis H test.

[7] Data were obtained from the Texas Department of Family and Protective Services and reflect a point-in-time count of all children in foster care from Region 3 on May 31, 2020.

likely to obtain legal permanency compared to their peers who have not been placed with family.[8] However, the percentage of children and youth in DFPS Region 3 placed with relatives is lower than the statewide percentage (44% in Region 3 vs. 51% statewide in FY 2019). Additionally, **placements with relatives in DFPS Region 3 have fallen in the past two fiscal years (FY 2019 and FY 2020).**

Of children and youth in substitute care who are placed with relatives, very few are placed in a licensed kinship care placement despite the ability of most CPAs in the area to license relative caregivers as foster parents. Additionally, stakeholders representing CPAs in DFPS Regions 3W (non-CBC) and 3E indicated that they often rely on DFPS to link them to kinship caregivers, rather than actively locating kin and recruiting for such placements. **Actively recruiting kinship care families and supporting them in becoming licensed foster homes could increase those families' access to available training, resources, services, and supports.**

Those involved in CBC planning can build kinship care capacity by adopting and expanding upon related goals and objectives in the *DFPS Capacity Strategic Plan: Region 3 West and East (Catchment 3A and 3C)*.[9] These goals and objectives were locally developed and are relevant; they support capacity building as well as the successful transition of children and youth in non-relative placements to family settings by strengthening family supports. For example, the Plan speaks to supporting relative placements by ensuring access to wraparound services; quickly identifying relative providers and referring them to CPAs for licensing; and connecting relatives to a DFPS Kinship Development Worker. The Plan also stresses the need to place older youth in family settings close to home or with relatives.

CBC planners in DFPS Regions 3W (non-CBC) and 3E can help realize the core goals in the Capacity Strategic Plan by agreeing to the Plan's central areas of focus and adding additional detail as well as by **adopting specific and measurable goals, outcomes, and timelines for building kinship capacity locally**. As part of these efforts, CBC planners should identify organizations and entities responsible for implementing identified strategies and develop a plan to track progress toward each goal. To be most successful, those involved in planning should remain engaged during implementation as well, with the SSCC overseeing activities.

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[8] Casey Family Programs. (2018, November). *The impact of placement with family on safety, permanency, and well-being*. Report Series, Volume 2. https://caseyfamilypro-wpengine.netdna-ssl.com/media/1896-CS-From-Data-to-Practice-2018.pdf
[9] See: https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/CPS/documents/2019/2019-11-15-Region3_Strategic_Plan.pdf

Capacity Key Recommendation 2: Build substitute care capacity to address the placement needs of children and youth who have experienced multiple placement breakdowns, those with complex behavioral health needs, and older youth.

Placement stability is impacted by a child's needs and the ability of the caregiver to effectively address those needs.[10] The more placements a child or youth experiences, the longer they remain in substitute care and the more likely they are to develop behavioral health challenges.[11] **Behavioral challenges are one of the main causes of placement breakdowns.[12]** More than 60% of the children and youth in care during May 2020 in DFPS Regions 3W (non-CBC) and 3E had experienced two or more placements, and approximately one-third experienced three or more placements (refer back to Table C). Prior to emancipating from care (aging out), older youth were in care longer and experienced more placement breakdowns: transition-age youth ages 18 to 20 from Region 3W (non-CBC) had been in care an average of 3.25 years and youth of the same age in Region 3E were in care an average of 4.4 years.

DFPS Regions 3W (non-CBC) and 3E do not have adequate foster home capacity to meet the complex behavioral health challenges and ensure placement stability for the majority of children and youth in care. There is also an insufficient number of placements for children and youth designated at higher levels of care ("specialized" or "intense"). This lack of capacity is reflected in the fact that more than two-thirds of the children and youth placed outside of DFPS Regions 3W (non-CBC) and 3E are placed in a residential treatment center (RTC). RTCs provides 24-hour supervision and intensive therapeutic interventions for children and youth with complex behavioral health needs that put them at imminent risk of harming themselves or others.

A core set of strategies have been proven to improve placement stability and meet the complex behavioral health needs of the children and youth in substitute care. [13] Those involved in CBC planning should attend to these strategies:
- Adopt assessment tools and decision-making processes that effectively match children and youth to optimal placements, such as: Every Child is a Priority, Treatment Outcomes

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[10] Casey Family Programs. (2018, September). *How can we improve placement stability for children in foster care?* Strategy Brief: Strong Families. https://caseyfamilypro-wpengine.netdna-ssl.com/media/SF_Strategies-to-improve-placement-stability.pdf

[11] Casey Family Programs. (2018, August). *What impacts placement stability?* Strategy Brief: Strong Families. https://caseyfamilypro-wpengine.netdna-ssl.com/media/SF_Placement-stability-impacts.pdf

[12] Casey Family Programs. (2018, August). *What impacts placement stability?* Strategy Brief: Strong Families. https://caseyfamilypro-wpengine.netdna-ssl.com/media/SF_Placement-stability-impacts.pdf

[13] Casey Family Programs. (2018, September). *How can we improve placement stability for children in foster care?* Strategy Brief: Strong Families. https://caseyfamilypro-wpengine.netdna-ssl.com/media/SF_Strategies-to-improve-placement-stability.pdf

Package, and the Structured Decision-Making Model in Foster Care and Placement
Support.[14]

- Increase access for children and youth with complex behavioral health needs and their
  birth and foster families to a full continuum of mental health and substance use services
  and supports that are integrated into the child welfare system and well-coordinated
  with the broader health, education, and juvenile justice systems. An **ideal continuum of
  mental health services for children and youth** includes integrated primary care;
  specialty outpatient mental health and substance use services; rehabilitative care such
  as community-based skill-building, therapeutic interventions, and intensive evidence-
  based practices (EBPs); and urgent assessment and crisis stabilization services and
  supports.
- Ensure a well-trained, stable child welfare workforce by providing pre-service and
  ongoing training, supervision, and coaching; ensuring reasonable caseloads;
  continuously improving organizational culture and climate at child and youth serving
  agencies; and promoting shared responsibility for supporting children in substitute care.

The aforementioned efforts and strategies to improve placement stability will be most
successful if they incorporate state and local resources. Those involved in CBC planning and
implementation should consider the following:

- Using the DFPS Child Placement Portal[15] to more effectively match children and youth to
  appropriate foster placements.
- Identify a CPA with experience developing specialized capacity to lead regional
  recruitment strategies.
- Engage community mental health providers and CPAs that offer a strong continuum of
  supports to develop strategies to increase regional capacity to support children and
  youth with higher needs, partnering to expand the region's capacity to deliver the full
  continuum of mental health services included in the Ideal Children's Mental Health
  System that is detailed in the Meadows Institute's *Dallas County Mental Health Service
  Delivery System for Children, Youth, and Families: 2019 System Assessment Report*.

Chapter 3: Youth and Family Lived Experiences

A critical part of our environmental assessment process was to hear from youth and caregivers
(both foster and kinship) with lived experiences in the child welfare system in DFPS Regions 3W
(non-CBC) and 3E to complement the feedback by other key stakeholders, such as service
providers and program administrators. The stories, perspectives, insights, and priorities

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[14] Casey Family Programs. (2018, September). *How can we improve placement stability for children in foster care?* Strategy
Brief: Strong Families. https://caseyfamilypro-wpengine.netdna-ssl.com/media/SF_Strategies-to-improve-placement-
stability.pdf

[15] DFPS's Child Placement Portal has not yet been released.

highlighted by youth and caregivers are summarized here as well as integrated into the recommendations provided throughout the report.

Key Themes From Former Foster Youth

Youth who recently had aged out of the foster care system reflected on the critical importance of relationships, recovery, and ongoing support:

- Young people in foster care seek deep, authentic relationships with their foster families and **want to maintain a strong connection with their birth parents and siblings.**
- Their ability to thrive is grounded in a strong social support network comprised of foster parents, caseworkers, mental health professionals, Court Appointed Special Advocate (CASA) volunteers, and other mentor figures who must be willing to invest long term in their well-being and provide guidance and support throughout their lives.
- The perception of social stigma associated with being in foster care weighs on youth with lived experience and they seek a sense of normalcy and not being defined by their time spent within the child welfare system.
- Youth in foster care benefit when those providing care facilitate their recovery from trauma, value their voice, **actively engage them throughout case planning**, and provide more creative and effective mental health services to support their healing and growth.

Key Themes From Foster Parents

Foster parents discussed logistical, practical, and regulatory challenges as well as the need for supportive partnerships:

- Foster parents **need support identifying, vetting, and accessing behavioral health services** for the children and youth in their care.
- The logistical challenges of coordinating and transporting children in their care to all of their appointments, court appearances, and school and extracurricular activities can be a significant strain.
- Foster parents need more guidance on how to partner with birth parents.
- While they appreciate the training they have received, foster parents feel **training would be more impactful if bolstered by follow-up coaching and peer support** for them as well as complementary training for school professionals.
- Easier access to respite services, such as after-hours babysitting, and fewer restrictions on in-home visitors may prevent foster parent burnout.
- Better communication and coordination between Child Protective Services (CPS), CPAs, and foster parents would improve placement and child outcomes.

Key Themes From Kinship Caregivers

Kinship caregivers described a markedly different experience with the foster care system than the non-relative foster parents we interviewed as well as a need for targeted guidance and support:

- Kinship caregivers are less likely to be working with a CPA and some expressed **feeling lost without advocates, peers, or system navigators** they could identify early on to guide them through the foster care process.
- Because the sudden removal of a child from home often initiates their engagement with the foster care system, kinship caregivers lack time to train or prepare for fostering, are unfamiliar with administrative requirements for fostering, and feel ill-equipped to locate providers for the services mandated by the courts for the children or youth in their care.
- Kinship families may receive more support if they go through the foster parent licensing process. However, the process to become licensed is optional and can be challenging, so few kinship families go through this process; therefore, they don't have the benefit of monetary assistance or other supports.[16]
- Kinship caregivers identified accountability for birth parents and birth parent access to services as lacking.
- Both kinship caregivers and foster parents **praised their CASA workers as playing a crucial role** in supporting them and the child in their care, leading to placement stability and retention.

Chapter 4: Mental Health

Up to 80% of children and youth who enter foster care have a significant mental health need and at least 50% have more than one mental health diagnosis.[17,18] Children and youth in substitute care are more likely to experience anxiety, depression, and behavioral problems; in addition, **those in care use mental health services at a rate that is roughly 10 times higher than rates for children and youth in the general community.**[19,20] Children and youth in foster care often have uniquely complex needs and challenges that require dedicated resources and coordinated attention.

[16] Texas Department of Family and Protective Services (n.d.). *CPS placements: Child's first placement type after removal. Fiscal Year 2019.* Data Book. Retrieved December 2020, from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/Placements/First_Placement_after_Removal.asp

[17] Lehmann, S., Havik, O. E., Havik, T., & Heiervang, E. R. (2013). Mental disorders in foster children: A study of prevalence, comorbidity and risk factors. *Child Adolescent Psychiatry Mental Health, 7*(39), 1–12. http://www.capmh.com/content/7/1/39

[18] Council on Foster Care, Adoption, and Kinship Care; Committee on Adolescence; & Council on Early Childhood. (2015, October). Health care issues for children and adolescents in foster care and kinship care. *Pediatrics, 136*(4), e1142–e1140. https://pediatrics.aappublications.org/content/136/4/e1131

[19] Laurel, K. L., Landsverk, J., Ezzet-Lofstrom, R., Tschann, J. M., Slymen, D. J., & Garland, A. F. (2000). Children in foster care: Factors influencing outpatient mental health service use. *Child Abuse and Neglect, 24*, 465–476.

[20] Turney, K., & Wildeman, C. (2016, August). Mental and physical health of children in foster care. *Pediatrics, 138*(5), e20161118. https://doi.org/10.1542/peds.2016–1118

Understanding the important role that mental health and related services and supports play in the lives of children and youth in substitute care, the Steering Committee identified mental health as one of the three main areas to explore in depth as part of our environmental assessment. We identified key strengths and challenges for children, youth, and families involved in the child welfare system as well as strengths and challenges for the mental health providers working to meet the needs of this population. This report chapter highlights our findings and presents opportunities for building on local strengths in order to address the challenges as the community moves towards CBC implementation. For more background on the needs, resources, and developing opportunities to better serve children and youth with mental health conditions in North Texas, see the Meadows Institute's *Dallas County Mental Health Service Delivery System for Children, Youth, and Families: 2019 System Assessment Report*.

Mental Health Key Recommendation 1: Expand the availability of intensive home- and community-based behavioral health services by supporting expansion of providers credentialed to deliver Medicaid Targeted Case Management (TCM) and Mental Health Rehabilitation (MHR) services, pursuing alternative payment options with managed care organizations (MCOs), and taking advantage of recent state legislation expanding EBPs.

Those involved in CBC planning should focus on developing capacity for intensive home- and community-based services. The primary goal of these services is to prevent out-of-home placement or provide transition services as a child or youth returns home or to a foster home after a residential placement. Intensive home- and community-based services and supports can include crisis management, intensive case management, counseling, family therapy, and skills training; they also include EBPs, such as Multisystemic Therapy for Child Abuse and Neglect (MST-CAN), Treatment Foster Care, Keeping Foster and Kin Parents Supported and Trained (KEEP), and others. Unfortunately, children and youth with complex behavioral health needs, and their foster and kinship caregivers, currently have limited access to these types of services across Regions 3W (non-CBC) and 3E.

Medicaid-funded TCM and MHR services are the most common way intensive services are provided and funded. These services are unique, providing the flexibility and resources to support a range of individual needs, many of which cannot be addressed through traditionally reimbursable office-based clinical services. However, TCM and MHR services can only be delivered by providers credentialed through the Texas Health and Human Services Commission (HHSC). **Those involved in CBC planning should prioritize efforts to increase the number of CBC providers credentialed for TCM and MHR services to improve access.**

Those involved in CBC implementation should also consider ways to work with Superior HealthPlan (Superior) to negotiate value-based purchasing (VBP) contracts with alternative payment methodologies (APMs) for its foster care service providers enrolled and credentialed

in Medicaid managed care. Superior is the MCO overseeing STAR Health, which provides health care services to children and youth in substitute care. The APMs could cover intensive home- and community-based alternative health services for children and youth in foster care instead of more expensive and restrictive placements, such as inpatient care. Youth with complex needs remain in inpatient hospitals longer than is medically necessary because of a lack of alternative placements.[21] The current STAR Health Medicaid managed care program allows MCOs to contract with providers utilizing VBP contracts with APMs that **reward providers with incentive payments for the quality of care they provide, instead of a typical fee-for-service arrangement** that reimburses providers for services rendered regardless of outcome.

Another strategy to expand the availability of intensive EBPs is by taking advantage of Texas Senate Bill (SB) 1177 (86th Regular Session, 2019), which gives Medicaid MCOs the option to reimburse for delivery of intensive EBPs provided in lieu of other mental health services (e.g., hospitalization) for children and youth. SB 1177 directs HHSC to approve a list of EBPs that can be added as "in lieu of" services to managed care contracts. Implementation has been broken down into two phases: Phase One includes services in lieu of inpatient hospitalization; Phase Two includes services in lieu of outpatient services. Phase One is nearly complete, and the committee has approved the following EBPs to add to MCO contracts by September 2021:

- Coordinated Specialty Care;
- crisis outreach/outpatient team;
- crisis respite;
- crisis stabilization units/extended observation units;
- partial hospitalization; and
- intensive outpatient programs.

Outpatient services for Phase Two are being evaluated for cost effectiveness. HHSC plans to add these approved services to MCO contracts no later than September 2022. Providers already enrolled in the STAR Health network are best positioned to benefit from this initiative. Therefore, providers who are not yet enrolled in STAR Health and are able to deliver needed evidence-based intensive services should begin the process of enrolling in Medicaid and also in the Superior network.

Finally, a funding strategy to increase delivery of intensive services not currently reimbursed could be to **blend or braid funding from multiple systems or funding streams**. Braided funding pools funds from multiple, separate streams for one purpose, but tracks the use of each funding source separately; blended funding combines multiple funding streams for one purpose without differentiating or tracking how money from each individual stream is spent. Blending or

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[21] Substance Abuse and Mental Health Services Administration. (2020, February 24). *National guidelines for behavioral health crisis care: Best practice toolkit*. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

braiding funds would allow cross-system partnerships that could more efficiently target intensive services to children and youth who need them most, specifically, those with multi-system involvement. It would also allow one or more providers to specialize in delivering an intensive EBP and create a path to access intensive services for children and youth being served by other providers who are part of the funding agreement. This funding strategy could strengthen the array of mental health services available by offering providers a path to add other intensive home- and community-based services and supports that are needed across DFPS Regions 3W (non-CBC) and 3E, including KEEP, MST-CAN, FFT, and others.

Mental Health Key Recommendation 2: The CBC planning process for DFPS Regions 3W (non-CBC) and 3E must include specific strategies to improve mental health-related data collection and analysis.

As noted, the array of available mental health services does not address the full range of needs of children and youth in substitute care. CBC implementation presents an opportunity to use data to identify the broad range of mental health needs among children and youth in substitute care and their caregivers. Using needs data can help CBC planners ensure that appropriate and effective treatments, with a focus on trauma-informed care, are available and matched to the needs of each child or youth to achieve the best possible outcomes and connect children and youth with the providers best suited to deliver the services.

Superior is required to administer the Child and Adolescent Needs and Strengths (CANS) 2.0 to determine the needs of each child and youth in substitute care. In many regions, Superior designates a local service provider to administer the CANS 2.0 on its behalf. Additionally, Superior receives documentation of the services utilized by health plan members (i.e., children and youth in substitute care) when providers submit claims for reimbursement for services provided. Those involved in CBC planning can examine whether children and youth in substitute care are receiving the appropriate services by **matching and comparing the needs identified through the CANS 2.0 assessment with the services provided according to the utilization data**.

In addition, data from education and juvenile justice system partners can also provide insight into the treatment needs of children and youth in substitute care as well as the effectiveness of those treatments. Within the education system, CBC planners may wish to look at rates of disciplinary referrals among children and youth in substitute care across DFPS Regions 3W (non-CBC) and 3E, including suspensions, expulsions, and referrals to alternative education programs.[22] Rates of school absenteeism can also correlate with unmet mental health needs;[23]

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[22] Courtney, M., Terao, S., Bost, N. (2004). *Midwest evaluation of the adult functioning of former substitute youth: Conditions of youth preparing to leave state care.* Chicago: Chapin Hall at the University of Chicago. https://www.chapinhall.org/research/conditions-of-youth-preparing-to-leave-state-care/

[23] Zetlin, A., Weinberg, L. & Kimm, C. (2004). Improving education outcomes for children in foster care: Intervention by an education liaison. *Journal of Education for Students Placed at Risk*, *9*(4), 421–429.

however, CBC planners should be aware and consider that absentee rates may also be due to placement changes.[24] Within the juvenile justice system, CBC planners could look at dually-involved children and youth whose juvenile justice intake screening or other assessments indicated a mental health need and data on the types of services the child or youth is (or is not) receiving. In addition, recidivism rates may also provide important information about the effectiveness of treatment.[25]

Mental Health Key Recommendation 3: Maximize use of the Child Psychiatry Access Network (CPAN) to address mental health needs across DFPS Regions 3W (non-CBC) and 3E.

In urban areas, there is often a six-week wait for an appointment with a psychiatrist. In addition to long waiting lists, children and youth residing in rural areas experience the added challenge of longer travel time and fewer transportation options for psychiatric evaluations. Delays in psychiatric care can exacerbate existing mental health conditions and result in challenging behaviors that contribute to placement breakdowns, the use of more restrictive placements, and overutilization of emergency room visits in times of crisis. SB 11 (86th Regular Session, 2019) established the Child Psychiatry Access Network (CPAN), which expands the use of integrated pediatric primary care, simplifies service navigation for families and caregivers, and improves access to mental health care.[26]

CPAN improves detection of and care for mental health needs in primary health care settings through a network of behavioral health consultation hubs located at Texas medical schools. The hubs serving DFPS Regions 3W (non-CBC) and 3E include the University of North Texas Health Science Center,[27] University of Texas Southwestern Medical Center,[28] and Texas A&M University Health Science Center.[29] Each hub supports pediatric and family medicine providers in meeting their patients' mental health needs through the provision of clinical consultation, care coordination, assistance with referrals to specialty outpatient providers, and continuing education. It is important that mental health providers who can address intensive needs be included in the database being developed for the CPAN referral network. Additionally, those involved in CBC planning should **work in partnership with Superior to ensure STAR Health providers are educated about CPAN.**

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[24] Pecora, P.J., Kessler, R.C., Williams, J., O'Brien, K., Downs, A.C., English, D., White, J., Hiripi, E., White, C.R., Wiggins, T., & Holmes, K. (2005). *Improving family substitute care: Findings from the Northwest Substitute Care Study*. Casey Family Programs. https://caseyfamilypro-wpengine.netdna-ssl.com/media/AlumniStudies_NW_Report_FR.pdf

[25] White, L. M., Lau, K. S. L., & Aalsma, M. C. (2016, June). Detained adolescents: Mental health needs, treatment use, and recidivism. *Journal of the American Academy of Psychiatry and the Law Online, 44*(2), 200–212.

[26] Senator Jane Nelson filed Senate Bill (SB) 10, which ultimately passed as a component of Senator Larry Taylor's SB 11.

[27] The counties within Regions 3E and 3W (non-CBC) served by University of North Texas Health Science Center CPAN hub include Cooke, Erath, Palo Pinto, Parker, Tarrant, and Wise.

[28] The counties within DFPS Regions 3E and 3W (non-CBC) served by University of Texas Southwestern Medical Center CPAN hub include Collin, Dallas, Denton, Ellis, Fannin, Grayson, Hunt, Kaufman, and Rockwall.

[29] The counties within DFPS Regions 3E and 3W (non-CBC) served by Texas A&M University Health Science Center CPAN hub include Hood, Johnson, Navarro, and Somervell.

Chapter 5: Courts and the Judiciary

Given that the court is involved at almost every stage of a child's time in the child welfare system, from removal to case resolution, the Steering Committee and other key stakeholders identified the judiciary as one of the three main areas to explore in depth as part of our environmental assessment. Judges are not simply partners, but are the gatekeepers and ultimate decision-makers in the child welfare system. The courts have considerable influence on the direction of case progress, length of time to permanency, and other key outcomes. This chapter in the report recognizes the critical role of the courts in CBC readiness efforts and presents opportunities for involving judicial and legal stakeholders in DFPS Regions 3W (non-CBC) and 3E early in the planning process and at every step of the way to full CBC implementation.

Judiciary Key Recommendation 1: CBC preparation and transition planning should serve as a catalyst for the identification of systemic opportunities to expand child welfare expertise in the courts, including the creation of specialized dockets.

Child protection cases are highly complex and require significant resources (including time) and diverse types of expertise to best represent the children and youth involved. Many counties in DFPS Regions 3W (non-CBC) and 3E assign CPS cases to their district or county-level courts of general jurisdiction. These courts oversee CPS cases in addition to a wide variety of other case types, making it difficult for generalist judges to maintain the level of knowledge and specialization required for child welfare law.

Because the organization and structure of how CPS caseloads are divided varies widely across the counties in DFPS Regions 3W (non-CBC) and 3E, it is challenging for those involved in these cases to travel between courts and navigate different structures and courtrooms. CPS caseworkers, CASAs, and attorneys are regularly working with multiple judges who often have differing philosophies and expectations, or who request different types of information in court reports.

DFPS Regions 3W (non-CBC) and 3E may find benefit in **narrowing down the number of judges and courts overseeing CPS cases.** Consolidating these cases into a few specialized courts with a dedicated team of attorneys trained in child welfare law builds expertise and an ability to focus efforts and resources. This also reduces the burden on child welfare workers as well as on attorneys, children and youth, and caregivers by creating a more predictable court experience because the cases are dispersed among fewer judges, with less travel between multiple courtrooms, and a narrower range of judicial requirements with which to become familiar.

DFPS Regions 3W (non-CBC) and 3E are home to courts with child welfare specialization and examples of best practice. Those involved in CBC planning efforts should consider convening a roundtable with judges, attorneys, and other child welfare stakeholders in each county to evaluate the local court system's structure and identify opportunities for expanding child welfare expertise and specialization.

There are excellent and diverse examples of court structures and practices within DFPS Regions 3W (non-CBC) and 3E to learn from and build upon:

- Both Collin and Denton counties have taken steps to consolidate CPS cases into fewer courts, with judges who explicitly choose to preside over child welfare cases.
- Fannin County has only one judge who sees CPS cases, allowing that judge to have a deep level of specialization and devote time to further education in this area of the law.
- In some rural areas, such as Cooke, Grayson, Wise (and soon Kaufman) counties, **child protection cluster courts have been established to focus solely on CPS cases** with the specialized judge traveling to each jurisdiction on specified days. Child protection cluster courts employ a non-elected Associate Judge who is paid by the Office of Court Administration, which can result in cost savings to the participating counties.
- DFPS Regions 3W (non-CBC) and 3E's urban areas are home to trauma-informed specialty courts that serve as model courts in the state, including family substance use treatment courts in Denton, Collin, and Dallas counties.

Judiciary Key Recommendation 2: Build capacity for and enable access to effective programs and support services that demonstrate positive outcomes for birth parents, and involve judges in the process so that court-ordered service requirements are achievable.

Many birth parents face barriers to reunification with their children because of service plan requirements that are difficult achieve. We found that, in many communities within DFPS Regions 3W (non-CBC) and 3E, CPS requires treatments and services for birth parents that are either not locally available or ineffective, particularly for those in rural areas. **Uncoordinated or unattainable court-ordered services for birth parents can jeopardize reunification.** The courts typically order birth parents—at the request of CPS—to complete a psychological assessment, random drug testing, parenting classes, and individual or group counseling. CPS provides few services directly to parents, so families generally rely on community-based providers for their court-ordered services. The SSCC can use their extensive access to data on community needs and their inventory of local providers and services to partner with judges in crafting realistic service plans and develop local capacity with community providers to implement more evidence-based programs to meet identified needs.

Because the CBC model enables SSCCs to address the needs of children and youth in innovative ways, an SSCC that determines a need for particular services can work with their network of

For more information on how to address the mental health and emotional needs of students in substitute care, please see the Meadows Institute *Mental and Behavioral Health Roadmap and Toolkit for Schools*.

Education Key Recommendation 1: Child welfare and education-related agencies in DFPS Regions 3W (non-CBC) and 3E must collaborate to develop solutions for increasing school stability.

Numerous studies have found that children and youth in foster care experience excessive school changes and that school mobility has negative effects on school achievement and high school graduation rates.[32,33,34] On the other hand, remaining at the same school after a removal or placement change is shown to support positive relationships and prevent loss of academic achievements.[35,36]

By working across systems, stakeholders in DFPS Regions 3W (non-CBC) and 3E can ensure that even more students in substitute care can remain in their school of origin. **By emphasizing local placements, CBC naturally lends itself to increasing school stability** since it is easier for a child to attend their school of origin (home school) if they remain in their community. This dynamic is evidenced in DFPS data from February 2020, which shows that 31% of students in substitute care in the CBC counties in DFPS Region 3W remained in their school of origin vs. 14% in the non-CBC counties.[37]

During this assessment, we found that **lack of access to transportation was the most frequently cited educational challenge for students in substitute care**. While state law requires transportation services for students in substitute care, the responsibility is shared by CPS and school districts. Moreover, there is a lack of dedicated funding to reimburse either party for the costs. As a result, students in substitute care frequently cannot access the transportation they need, forcing additional school moves.

By coordinating across agencies and sharing resources, those involved in CBC planning and implementation in DFPS Regions 3W (non-CBC) and 3E can examine all of the factors that

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[32] South, S., Haynie, D., Bose, S. (2007). Student mobility and school dropout. *Social Science Research, 36,* 68–94

[33] Clemens, E.V., Helm, H.M., Myers, K., Thomas, C., & Tis, M. (2017). The voices of youth formerly in foster care: Perspectives on educational attainment gaps. *Children and Youth Services Review, 79*, 65–77.

[34] Levy, M., Garstka, T. A., Lieberman, A., Thompson, B., Metzenthin, J., & Noble, J. (2014).The educational experience of youth in foster care. *Journal of At-Risk Issues, 18*(2).

[35] Pecora, P.J., Kessler, R.C., Williams, J., O'Brien, K., Downs, A.C., English, D., White, J., Hiripi, E., White, C.R., Wiggins, T., and Kate Holmes, K. (2005). *Improving family foster care: Findings from the Northwest Foster Care Study*. Casey Family Programs. https://caseyfamilypro-wpengine.netdna-ssl.com/media/AlumniStudies_NW_Report_FR.pdf

[36] Pecora, P. J. (2012). Maximizing educational achievement of youth in foster care and alumni: Factors associated with success. *Children and Youth Services Review, 34*, 1121–1129.

[37] Data were obtained from the Texas Department of Family and Protective Services and reflect a point-in-time count of all children in foster care from Region 3 on February 1, 2020.

prevent school stability and identify creative and viable solutions to help more students remain in their schools of origin after removal or a placement change. In order to achieve this, **local entities, such as school districts, CPAs, and the SSCC, can develop formal local agreements** (e.g., a Memorandum of Understanding or MOU) with one another. These agreements can acknowledge the shared goal of maintaining school stability and include strategies to overcome barriers, such as how transportation should be provided and funded when it is needed. The more agencies and entities that serve and support children in the community that CBC planners engage in these collaborative efforts, the more likely communities will be to identify additional resources and innovative practices to support shared goals.

Education Key Recommendation 2: CPAs contracted by the SSCC must be trained and expected to work with the student, the student's caregivers, and the school and school district to identify, address, and continually support the student's academic goals and interests.

Communication and coordination between all key parties, personalized school connections, and educational advocacy is necessary to support students in overcoming academic difficulties and maximizing their success in school. Students in substitute care experience multiple challenges that can significantly impede their academic success, if unaddressed. Their education is best supported when key information on their behavioral needs, academic needs and strengths, and personal learning styles is recognized, verified, and shared among all key stakeholders—the student, their caregivers, caseworkers, judges and others involved with the court, and school staff.

In order to develop strong and effective educational plans for students recently removed, experiencing a change in placement, or being reunified with their families, there must be **solid communication between those with previous experience with the student's schooling and those who will be involved moving forward**. This type of communication is important regardless of if the student changes schools. Caseworkers should have open discussions with foster and kinship caregivers, as well as birth parents if applicable, about the level of caregiver involvement needed in a student's schooling, and work to find solutions if the caregiver needs support. To the extent possible, CPAs and schools should be prepared to provide extra support and guidance to caregivers, especially those new to fostering as well as families caring for students with significant learning challenges, performing below grade level, or in need of special education services and help navigating the special education system.

Students in substitute care need a caring and supportive adult in addition to their caregiver who is monitoring, advocating for, and supporting their school progress and is trained and willing to engage with the school if an academic, disciplinary, or emotional matter requires

attention.[38] If a foster or kinship caregiver is already actively engaged in a student's education, having an additional adult involved in this way can reinforce the caregiver's efforts. And if the caregiver cannot be involved consistently, another caring and supportive adult can help ensure the student stays on track and receives the academic attention needed to be successful. There are many people and organizations that can help connect a student to someone who can play this role. Those involved with CBC planning and implementation, as well as the SSCC, should work with school districts and campuses to raise awareness regarding the needs of students in foster care and to identify school or school-affiliated personnel to provide support.

To equip contracted CPAs in DFPS Region 3W (non-CBC) and 3E to support students and caregivers with educational advocacy and navigation, the SSCC should help ensure CPA staff are trained and prepared to help intervene when pivotal school challenges arise. For example, when a child or youth in substitute care experiences barriers to prompt enrollment in a new school, navigating the special education process, recovering past credits, or obtaining support for their emotional needs on campus, CPA staff can make connections to others in the community who can help. CPAs can draw upon several available resources for education-related challenges. Public school districts are required to have at least one designated foster care liaison to help with such matters. Additionally, the regional DFPS Education Specialists and staff focusing on highly mobile and at-risk student populations within the regional Education Service Centers (ECSs) can also help. (DFPS Regions 3W [non-CBC] and 3E are served by ESCs 10, 11, and 12.) Individuals involved in educational aspects of CBC planning in DFPS Regions 3W (non-CBC) and 3E should work with the SSCC to share information on these resources and collaborate to ensure that CPAs understand how to support positive educational outcomes.

Moving Forward

CBC has the potential to ignite a child welfare system transformation, and planning for system change requires collaboration and prioritization from local communities and stakeholders who will lead the effort. This Executive Summary provides a brief overview and shares select recommendations from the *North Texas CBC Environmental Assessment* that can further regional collaboration and provide actionable strategies to accelerate CBC planning efforts. The full report which follows offers more in-depth analysis, findings, recommendations, and resources for implementing CBC successfully. Stakeholders throughout DFPS Region 3 must come together with each other and with the larger community to determine how they wish to use and prioritize the information and data. We hope the community will begin implementing these recommendations immediately to both improve conditions for children and youth who have experienced abuse and neglect, and to proactively prepare for local rollout of CBC.

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[38] Zetlin, A., Weinberg, L. & Kimm, C. (2004). Improving education outcomes for children in foster care: intervention by an education liaison. *Journal of Education for Students Placed At Risk, 9*(4), 421–429.

Overview and Background

Contents

Project Background

Through the generous support of six funders,[39] the Meadows Mental Health Policy Institute (the Meadows Institute) partnered with the Texas Alliance of Child and Family Services (TACFS) beginning in the fall of 2019 to support local efforts in North Texas to plan and prepare for the eventual transition from a foster care system administered by the state to one led locally. The Meadows Institute's role in the project was to conduct an environmental assessment, gathering and analyzing qualitative and quantitative data to identify and describe the needs of children and youth in substitute care across the target region, and to assess providers' capacity to optimally support key aspects of child, youth, and family well-being. To inform the community about ongoing efforts and changes related to the North Texas child welfare system, and to build a framework for future collaborative work, TACFS created a communication plan and developed strategic partnerships to address the recommendations in this report. The work of TACFS and the Meadows Institute has been supported by the local child welfare leaders that comprise the Community-Based Care (CBC) Readiness Steering Committee for DFPS Regions 3W (non-CBC) and 3E (Steering Committee) and by the North Texas Foster Care Consortium, a diverse group of service providers and child welfare experts dedicated to addressing a broad range of child welfare issues. This report summarizes the findings from the environmental assessment and provides relevant and timely recommendations based on quantitative data, stakeholder insights, and national best practices that will help the North Texas community improve their local foster care system.

Overview of Community-Based Care in Texas

The Texas child welfare system is undergoing a transformation centered on the Department of Family and Protective Services' (DFPS) incremental rollout of the CBC model across the state. CBC enables the innovation and flexibility needed to significantly improve regional foster care systems through locally-driven strategies led by community organizations, by service providers, and—ideally—by children, youth, and families involved in the system. Under the CBC model, DFPS contracts with a regional Single Source Continuum Contractor (SSCC) that is responsible for foster care and case management functions previously administered by the state. The SSCC assumes responsibility for contracting with child placing agencies (CPAs), coordinating and delivering services to children and youth in substitute care and their foster families, developing foster care capacity, and engaging the community to achieve positive outcomes for the children, youth, and families served.

The design of the Texas CBC model is based on over a decade of work by subject matter experts, DFPS, and policymakers to improve outcomes for the 30,000+ children and youth in Texas in substitute care at any given time. Together, these groups established guiding principles

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[39] Project funders include: The George and Fay Young Foundation, The Hoglund Foundation, The Meadows Foundation, The Rees-Jones Foundation, Sister Simmons Fund, and an anonymous funder.

(highlighted below) and specific goals to improve service quality and system capacity under CBC. As stated by DFPS,[40] the goals of CBC are as follows:

- Increase the number of children and youth placed with their siblings and in their home communities.
- Increase the number of children and youth who remain in their school of origin.
- Decrease the average time children and youth spend in foster care before achieving positive permanency.
- Decrease the number of moves children and youth experience while in foster care.
- Decrease the duration and intensity of services that children and youth need while in foster care due to improved well-being and behavioral functioning.
- Create robust and sustainable service continuums in communities throughout Texas.

GUIDING PRINCIPLES OF COMMUNITY-BASED CARE

- *Above all, children and youth are safe from abuse and neglect.*
- *Children and youth are placed in their home communities.*
- *Children and youth are appropriately served in the least restrictive environment.*
- *Children and youth have stability in their placements.*
- *Connections to family and others important to the child are maintained.*
- *Children and youth are placed with their siblings.*
- *Services respect the child's culture.*
- *Children and youth are provided opportunities, experiences, and activities similar to those enjoyed by their peers who are not in foster care.*
- *Youth are fully prepared for successful adulthood.*
- *Youth have opportunities to participate in decisions that affect their lives.*
- *Children and youth are reunified with their biological parents when possible.*
- *Children and youth are placed with relative or kinship caregivers if reunification is not possible.*

More information is available on the [DFPS Community-Based Care web page](#).

While substitute care services have historically been administered through 12 DFPS regions of the state, many of these regions have been subdivided into catchment areas for the purposes of CBC implementation. These catchment areas are intended to reflect existing community relationships and are also determined based on service needs and capacity, and other factors related to CBC implementation. This analysis focuses on two distinct catchment areas within DFPS Region 3. Region 3 as a whole covers 19 counties in North Texas, including a mix of rural communities, suburban areas, and the large urban hubs of Fort Worth and Dallas.

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[40] Texas Department of Family and Protective Services. (n.d.). *Community-Based Care.* Retrieved February 4, 2021, from https://www.dfps.state.tx.us/Child_Protection/Foster_Care/Community-Based_Care/default.asp

CBC Stages

CBC implementation is enacted in stages to minimize risks associated with system transition and to provide SSCCs and communities with sufficient time to prepare for the more difficult components of the model. In **Stage I**, SSCCs are responsible for developing a network of foster care providers and community supports for foster care services, Preparation for Adult Living, and purchased adoption services, and for increasing the number of children and youth who are placed close to home. In **Stage II**, the SSCC's responsibilities expand to include case management, kinship, and reunification services. In **Stage III**, SSCCs are expected to meet specific performance metrics and they begin receiving performance-based payments.

Status of CBC Implementation

To date, the CBC model has been initiated in five areas of the state, covering a total of 106 of the 254 counties in Texas. The first successful CBC program was established in 2014 in a portion of DFPS Region 3 West (referred to hereafter as DFPS Region 3W CBC) through Our Community Our Kids (OCOK), a division of ACH Child and Family Services. The OCOK CBC program covers a total of seven counties (Tarrant, Parker, Hood, Johnson, Somervell, Erath, and Palo Pinto) of the 10 total counties in Region 3W (Figure 1). In addition, CBC programs are active in:
- DFPS Region 1 (Texas Panhandle area) through Saint Francis Ministries
- DFPS Region 2 (North Central Texas) through 2INgage
- DFPS Regions 8A and 8B (Greater San Antonio area) through Family Tapestry

Currently, only DFPS Region 3W (CBC) and Region 2 have entered Stage II and no area has progressed to Stage III (full implementation). However, with more state experience building new CBC models, the timeline for SSCCs to progress between stages is expected to become more condensed with about 18 months for Stage I (including 6 months for startup) and 18 months for Stage II.

While the timing of CBC rollout is still unknown in many areas, DFPS recently provided a timeline for CBC implementation for all the counties covered in this report in their annual *Implementation Plan for the Texas Community-Based Care System*,[41] published in December 2020. In that document, DFPS proposes to expand CBC to four additional catchment areas in the next two-and-a-half years and to initiate CBC in all areas of the state by 2026. **Specifically, the plan indicates that the three counties in DFPS Region 3W not currently under CBC (Cooke, Wise, and Denton) will be integrated with the other counties in DFPS Region 3W already under CBC; the SSCC contract will be re-procured in September 2023. Additionally, DFPS proposes to roll out CBC in the nine counties of DFPS Region 3 East (3E) within the 2022–2023**

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[41] Texas Department of Family and Protective Services. (2020, December). *Implementation plan for the Texas Community-Based Care system.* https://www.dfps.state.tx.us/Child_Protection/Foster_Care/Community-Based_Care/documents/2020-12-31_CBC_Implementation_Plan.pdf

biennium (which could begin as soon as September 2021). DFPS' ability to implement CBC in the 12 remaining non-CBC counties in DFPS Region 3 is subject to funding approved by the Texas Legislature, which began its 87th legislative session in January 2021. Funding appropriations from the 87th legislative session should be certain by the end of the session in May 2021, creating more certainty about the specifics of CBC expansion across DFPS Region 3.

Assessment Overview and Purpose

The focus of this environmental assessment is on 12 of the 19 counties of DFPS Region 3. As Figure 1 indicates, these include three (3) counties in DFPS Region 3W (non-CBC) (Denton, Cooke, and Wise), and the 9 counties of DFPS Region 3E (Collin, Dallas, Ellis, Fannin, Grayson, Hunt, Kaufman, Navarro, and Rockwall). The remaining seven counties in DFPS Region 3W (CBC) are sometimes referenced, but are not the focus of this report.

Figure 1. Map of DFPS Region 3
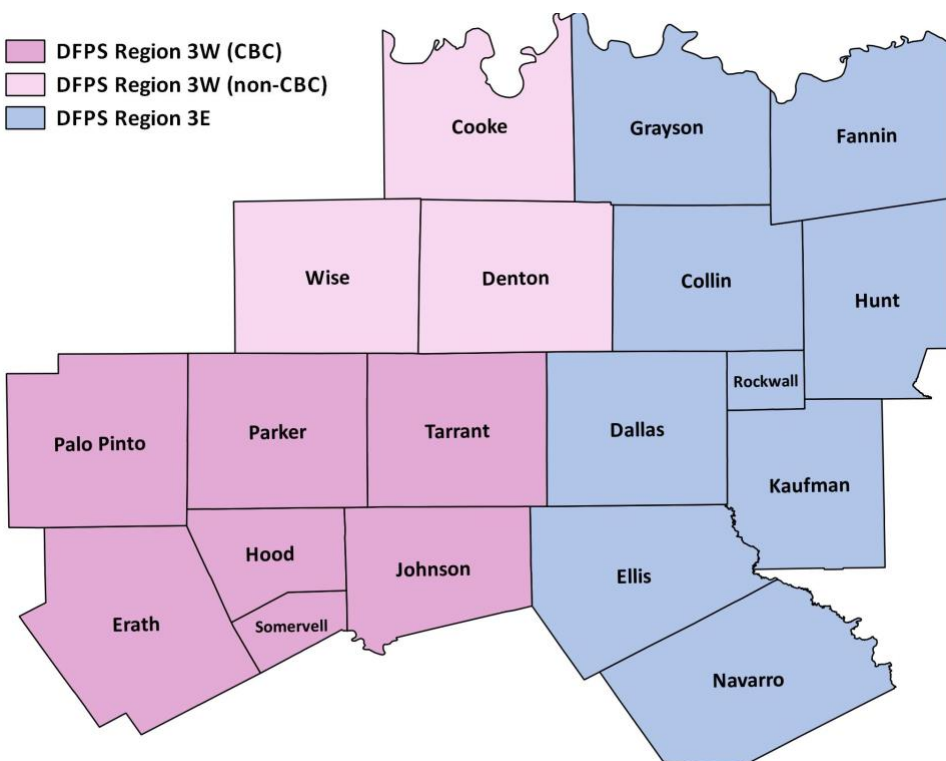
The implementation of CBC represents a critical opportunity for communities to find innovative and locally tailored solutions to improve outcomes for children and youth who spend time in foster care. However, the shift to CBC from a state-run foster care system entails significant changes requiring careful and deliberate planning efforts. **The purpose of this environmental assessment is to provide region-specific information and insights to support the communities in DFPS Regions 3W (non-CBC) and 3E in preparing and making programmatic decisions for CBC implementation.**

Data Collection and Analysis

This environmental assessment draws upon both qualitative and quantitative data. It entailed quantitative analysis of available data sets, including, but not limited to, the DFPS Data Book, the Foster Care Needs Assessment, and the American Community Survey 5-year estimates. Beyond that, the Meadows Institute research team interviewed 72 stakeholders, representing 42 agencies, organizations, and groups. This included CPA staff, judges, experts on education and healthcare systems, and other child- and youth-serving organizations (See *Appendix A*). We gathered additional qualitative information through focus groups and interviews with youth who had been in foster care as well as with foster and kinship caregivers. We also sent a survey to 34 CPAs that jointly cover 90% of local placements (see *Chapter 2* and *Supplement 2B* at the end of Chapter 2 for more about our CPA survey approach and responses). The data used to inform this assessment were collected, analyzed, and synthesized between September 2019 and October 2020. We also engaged the Steering Committee, TACFS, and key informants for ongoing input and support in this project to help us interpret and refine the findings.

One of the most challenging tasks in sorting through the data and interpreting the information available was to determine what to include in this report—and what to leave out. The child welfare system intersects with many other systems and, like all people, the children and families served have numerous and diverse needs. Because the purpose of this report is to provide information to support CBC planning and implementation efforts, we made the decision to focus on presenting information and findings with clear ramifications or possibilities related to CBC. We hope the information included in this report will empower action in communities across DFPS Region 3 concerning the key areas we address.

Steering Committee Guiding Principles and Values

Because the lives of young people who spend time in foster care are affected by so many dynamics, we worked with the Steering Committee to develop a project vision, values, and guiding principles to help sharpen the focus of the assessment. In October 2019, the Steering Committee collaboratively drafted the following **vision** to guide CBC planning efforts, decisions, and actions.

> **STEERING COMMITTEE'S VISION FOR CBC**
>
> *Across DFPS Region 3, community-based care (CBC) is a whole family intervention that keeps children and youth safe, builds resilience, supports healing, and promotes reunification as a shared goal between foster and birth families. CBC is supported and sustained by strong community partnerships, collaboration, transparency, information sharing, and trust, with the central goal of ensuring children and their families receive the support they need to thrive.*

Core Values

The Steering Committee also identified the following core values to guide how CBC is planned for, designed, and implemented.

- **Child, youth, and family focus** – The best interests of children, youth, and families are at the center of all CBC planning, decisions, and actions.
- **Children and youth have voice and choice** – Children and youth are included in all appropriate decisions regarding their care and well-being.
- **Children and youth are best served in their communities** – Whenever possible, children and youth remain in their communities and schools, and maintain access to their families, siblings, and friends.
- **Relationship driven** – Children and youth need nurturing relationships that are reliable, unconditional, and enduring.
- **Trauma-informed and culturally responsive providers and services** – The community recognizes the impact of trauma and respects the cultural and linguistic diversity among children, youth, and families.
- **Cross-system information sharing** – Through strong communication systems and the use of appropriate technologies, all providers have the information they need to make the best decisions and provide the right services to children and youth in substitute care and their families.
- **Transparency, openness, and trust** – Community organizations are open to teaching, learning, and sharing the challenges associated with system change to support providers, large and small, in developing quality care.
- **Partnership and solution-oriented collaboration** – There is a unified community focus on working together to do the right thing for children and youth in substitute care and their families.
- **Data-driven decision making** – The system establishes core operating standards and outcomes based on data.

Guiding Principles

The Steering Committee also identified the following guiding principles for those contributing to CBC planning, implementation, and oversight in DFPS Region 3:

- Create a self-sufficient community that is able to serve its children, youth, and families.
- Promote communication, collaboration, and transparency in the development and implementation of CBC.
- Work outside agency silos to meet the needs of children and youth in substitute care.
- Build community knowledge of the needs of children and youth in substitute care.
- Understand the local foster care capacity and available community services, supports, and resources.
- Make appropriate and nurturing matches. Align the needs of children and youth in substitute care with the strengths and skills of foster parents.
- Clearly define positive outcomes, use data to measure progress, and consistently strive for improvement.
- Prevent children and youth from entering substitute care or from returning to care if they have been removed from home.
- Promote permanency for children and youth in substitute care.

Report Focus and Deep-Dive Areas

Given the expansiveness of the foster care system, we asked Steering Committee members to identify key areas of interest for the environmental assessment. With their input, we selected the following areas as the focus of this report:

- Data trends related to children and youth in substitute care
- Foster care system capacity
- Youth and family experiences and perspectives

Additionally, Steering Committee members selected the following issue areas for in-depth analysis:

- Mental health needs and supports
- The courts and role of the judiciary
- Schools and the education system

The report also includes county profiles for each of the 12 counties included in the assessment. The county profiles provide a snapshot of local demographic and economic information. Additionally, the report includes a glossary of key terms and their definitions (see *Appendix B*).

Overall, this report includes a wealth of data and information to support local CBC strategic planning efforts, and it is incumbent on stakeholders and communities in DFPS Region 3 to collaborate to determine how they wish to use this information and what particular outcomes

to prioritize. The prospect of such activities successfully occurring in North Texas is strong because stakeholders are already highly collaborative and united in their mutual purpose to improve the lives of children, youth, and families with child welfare involvement.

County Profiles

The following set of infographics highlight demographic, economic, and child well-being information for each of the 12 counties in DFPS Regions 3W (non-CBC) and 3E that are the focus of this report and assessment. Because CBC implementation involves providers and stakeholders organizing services across the entire region, including in counties that may be new or unfamiliar to them, these profiles are intended to provide a quick reference for those beginning to learn about new areas within their CBC catchment area. For more a more detailed exploration of the local child welfare data, see *Chapter 1: Data Trends and Characteristics of Children and Youth*.

County Profiles

Collin COUNTY

Largest City: Plano
LMHA: Lifepath Systems — McKinney, TX
CASA: Collin County CASA
CAC: Children's Advocacy Center of Collin County;
The Bridge - Children's Advocacy Center
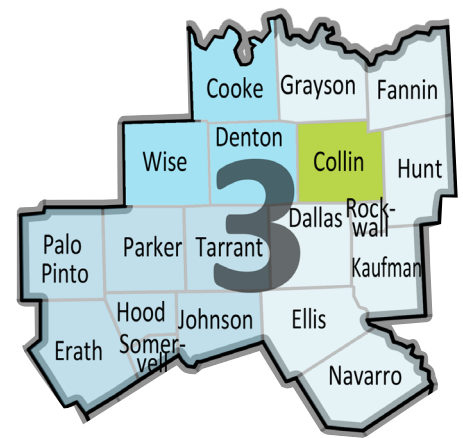
Cooke | Grayson | Fannin
Wise | Denton | Collin | Hunt
3
Palo Pinto | Parker | Tarrant | Dallas | Rock-wall | Kaufman
Hood | Johnson | Ellis
Erath | Somer-vell | Navarro

DEMOGRAPHICS

Total Population	Total Child Population (under 18)	Rural	Language Other Than English Spoken at Home	Single Parent Households	Children in Poverty
1,010,828	**255,641**	**5%**	**28%**	**19%**	**7%**

RACE

Total Population by Race

- AIAN 1%
- Asian 17%
- Latino 16%
- Black 11%
- White 55%

% Children in Poverty by Race

- White 4%
- Black 12%
- Latino 18%
- Asian 3%
- AIAN 6%

AIAN-American Indians/Alaska Natives

CHILD WELFARE DATA

53%
Children **Placed Out** of their **Home County,** May 31, 2020

5,030
Child Abuse and **Neglect Victims-Cases Confirmed** by CPS, FY 2019

37%
Children **Placed** with **Relatives,** FY 2019

603
Children in **Substitute Care,** FY 2019

1,132
Children Receiving **Family Preservation Services,** FY 2019

HEALTH & EDUCATION

1,141
Mental Health Providers in the County

1 of **244**
in **Texas County Health Outcomes** Ranking
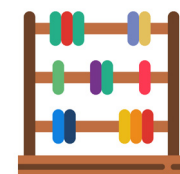
15
Public School Districts

52%
Bachelor's Degree or Higher

Cooke COUNTY

Largest City: Gainesville
LMHA: Texoma Community Centers — Sherman, TX
CASA: CASA of North Texas
CAC: Abigail's Arms - Cooke County Family Crisis Center

(Map of Texas counties, Region 3, with Cooke highlighted. Counties shown: Cooke, Grayson, Fannin, Wise, Denton, Collin, Hunt, Palo Pinto, Parker, Tarrant, Dallas, Rockwall, Kaufman, Hood, Somervell, Johnson, Ellis, Navarro, Erath)

DEMOGRAPHICS

Total Population	Total Child Population (under 18)	Rural	Language Other Than English Spoken at Home	Single Parent Households	Children in Poverty
39,595	8,993	59%	15%	31%	25%

RACE

Total Population by Race

(Pie chart)
- White 75%
- Latino 19%
- Black 4%
- Asian 1%
- AIAN 1%

% Children in Poverty by Race

(Bar chart)
- White 17%
- Black 18%
- Latino 42%

AIAN-American Indians/Alaska Natives

CHILD WELFARE DATA

79%
Children **Placed Out** of their **Home County,** May 31, 2020

562
Child Abuse and **Neglect Victims-Cases Confirmed** by CPS, FY 2019

35%
Children **Placed** with **Relatives,** FY 2019

196
Children in **Substitute Care,** FY 2019

215
Children Receiving **Family Preservation Services,** FY 2019

HEALTH & EDUCATION[4]

24
Mental Health Providers in the County

43 of **244**
in Texas County Health Outcomes Ranking

8
Public School Districts
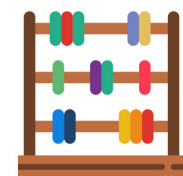
21%
Bachelor's Degree or Higher

Dallas COUNTY

Largest City: Dallas
LMHA: Metrocare Services — Dallas, TX
CASA: Dallas CASA
CAC: Dallas Children's Advocacy Center

Map showing region 3 with counties: Cooke, Grayson, Fannin, Wise, Denton, Collin, Hunt, Palo Pinto, Parker, Tarrant, Dallas, Rockwall, Kaufman, Hood, Somervell, Johnson, Ellis, Erath, Navarro
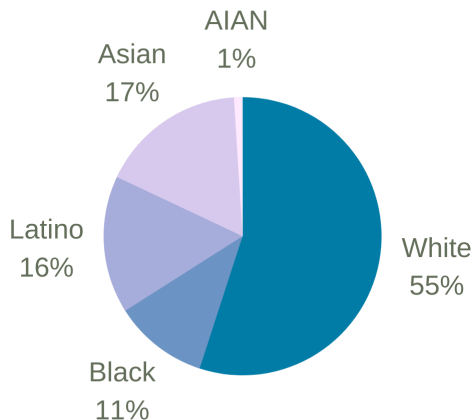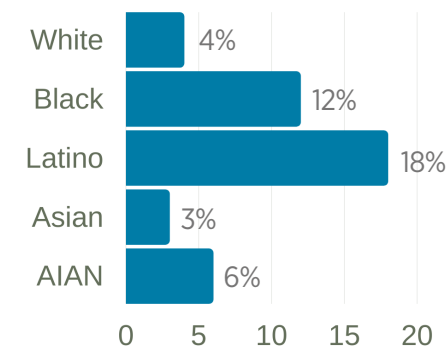
DEMOGRAPHICS

Total Population	Total Child Population (under 18)	Rural	Language Other Than English Spoken at Home	Single Parent Households	Children in Poverty
2,697,424	721,254	1%	43%	39%	21%

RACE

Total Population by Race

- Asian 6%
- AIAN 1%
- White 27%
- Black 24%
- Latino 42%

% Children in Poverty by Race

- White 11%
- Black 30%
- Latino 30%
- Asian 12%
- AIAN 20%

AIAN-American Indians/Alaska Natives

CHILD WELFARE DATA

41%
Children **Placed Out** of their **Home County,** May 31, 2020

22,191
Child Abuse and **Neglect Victims-Cases Confirmed** by CPS, FY 2019

39%
Children **Placed** with **Relatives,** FY 2019

4,568
Children in **Substitute Care,** FY 2019

6,327
Children Receiving **Family Preservation Services,** FY 2019

HEALTH & EDUCATION[4]

3,885
Mental Health Providers in the County

45 of **244**
in Texas County Health Outcomes Ranking
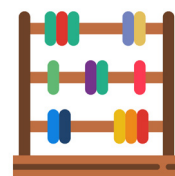
46
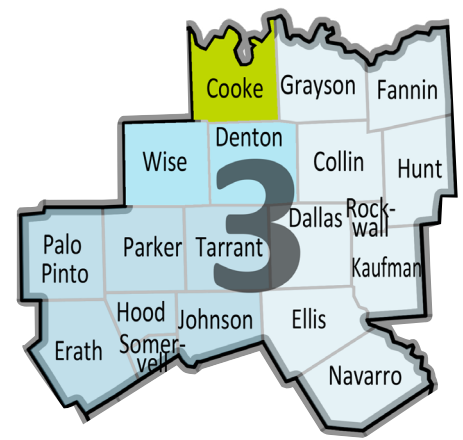Public School Districts

31%
Bachelor's Degree or Higher

MEADOWS MENTAL HEALTH POLICY INSTITUTE

Denton COUNTY

Largest City: Denton
LMHA: Denton County MHMR Center — Denton, TX
CASA: CASA of Denton County
CAC: Children's Advocacy Center for Denton County

Cooke | Grayson | Fannin
Wise | Denton | Collin | Hunt
Palo Pinto | Parker | Tarrant | Dallas | Rock-wall
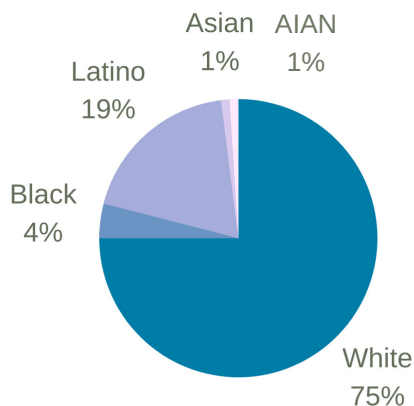Hood | Johnson | Ellis | Kaufman
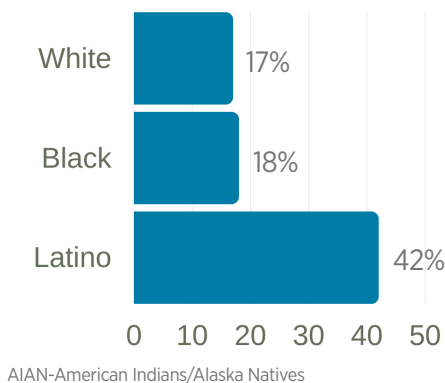Erath | Somer-vell | Navarro

DEMOGRAPHICS

Total Population	Total Child Population (under 18)	Rural	Language Other Than English Spoken at Home	Single Parent Households	Children in Poverty
870,845	208,408	7%	23%	22%	8%

RACE

Total Population by Race

- Asian 10%
- AIAN 1%
- Latino 20%
- Black 11%
- White 58%

% Children in Poverty by Race

- White 4%
- Black 13%
- Latino 18%
- Asian 8%
- AIAN 5%

AIAN-American Indians/Alaska Natives

CHILD WELFARE DATA

62% Children **Placed Out** of their **Home County,** May 31, 2020

4,854 **Child Abuse** and **Neglect Victims-Cases Confirmed** by CPS, FY 2019

42% Children **Placed** with **Relatives,** FY 2019

1,064 **Children** in **Substitute Care,** FY 2019

1,013 Children Receiving **Family Preservation Services,** FY 2019

HEALTH & EDUCATION[4]

962 Mental Health Providers in the County

3 of **244** in Texas County Health Outcomes Ranking
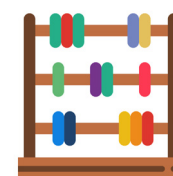
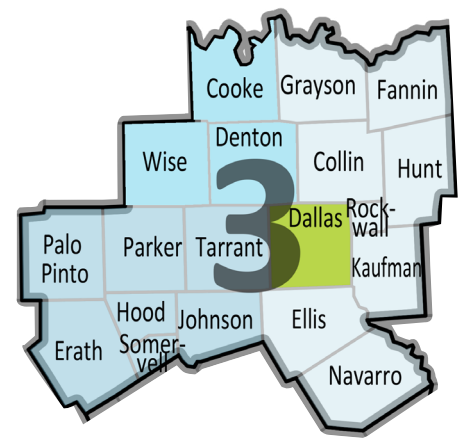**15** Public School Districts

45% Bachelor's Degree or Higher

Ellis COUNTY

Largest City: Waxahachie
LMHA: Lakes Regional Community Center — Terrell, TX
CASA: CASA of Ellis County
CAC: Ellis County Children's Advocacy Center

Map showing Region 3 counties: Cooke, Grayson, Fannin, Wise, Denton, Collin, Hunt, Palo Pinto, Parker, Tarrant, Dallas, Rockwall, Kaufman, Erath, Hood, Somervell, Johnson, Ellis, Navarro
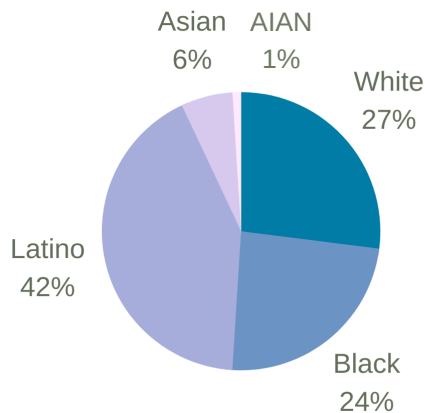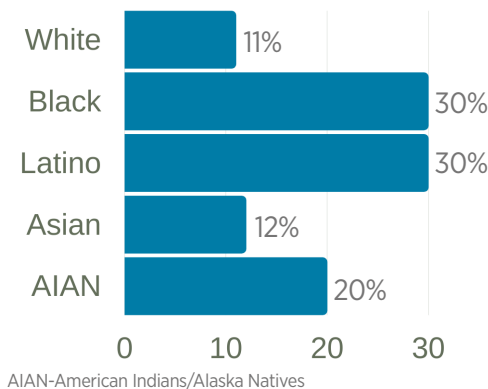
DEMOGRAPHICS

Total Population	Total Child Population (under 18)	Rural	Language Other Than English Spoken at Home	Single Parent Households	Children in Poverty
174,749	44,628	32%	19%	22%	14%

RACE

Total Population by Race

Pie chart:
- White 59%
- Latino 27%
- Black 12%
- Asian 1%
- AIAN 1%

% Children in Poverty by Race

Bar chart:
- White 8%
- Black 23%
- Latino 22%
- Asian 9%
- AIAN 7%

AIAN-American Indians/Alaska Natives

CHILD WELFARE DATA

55% Children **Placed Out** of their **Home County,** May 31, 2020

1,341 **Child Abuse** and **Neglect Victims-Cases Confirmed** by CPS, FY 2019

34% Children **Placed** with **Relatives,** FY 2019

120 **Children** in **Substitute Care,** FY 2019

**463** Children Receiving **Family Preservation Services,** FY 2019

HEALTH & EDUCATION[4]

114 Mental Health Providers in the County

14 of **244** in Texas County Health Outcomes Ranking
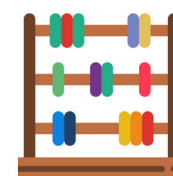
11 Public School Districts

23% Bachelor's Degree or Higher

Fannin COUNTY

Largest City: Bonham
LMHA: Texoma Community Centers — Sherman, TX
CASA: Fannin County Children's Center
CAC: Fannin County Children's Center

(Map showing region 3 with counties: Cooke, Grayson, Fannin, Wise, Denton, Collin, Hunt, Palo Pinto, Parker, Tarrant, Dallas, Rockwall, Kaufman, Hood, Somervell, Johnson, Ellis, Erath, Navarro)

DEMOGRAPHICS

Total Population	Total Child Population (under 18)	Rural	Language Other Than English Spoken at Home	Single Parent Households	Children in Poverty
34,524	6,981	71%	10%	25%	20%

RACE

Total Population by Race

- White 78.8%
- Latino 12.1%
- Black 7.1%
- Asian 1%
- AIAN 1%

% Children in Poverty by Race

- White 12%
- Black 40%
- Latino 17%

AIAN-American Indians/Alaska Natives

CHILD WELFARE DATA

395
Child Abuse and **Neglect** Victims-Cases Confirmed by CPS, FY 2019

107
Children in **Substitute Care,** FY 2019

71%
Children **Placed Out** of Their **Home County,** May 31, 2020

45%
Children **Placed** with **Relatives,** FY 2019

101
Children Receiving **Family Preservation Services,** FY 2019

HEALTH & EDUCATION[4]

36
Mental Health Providers in the County

173 of **244**
in Texas County Health Outcomes Ranking
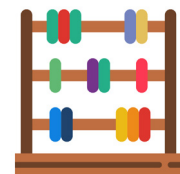
8
Public School Districts

17%
Bachelor's Degree or Higher

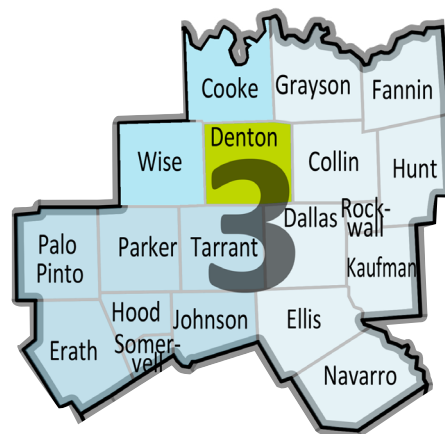# Grayson COUNTY

Largest City: Sherman
LMHA: Texoma Community Centers — Sherman, TX
CASA: CASA of Grayson County
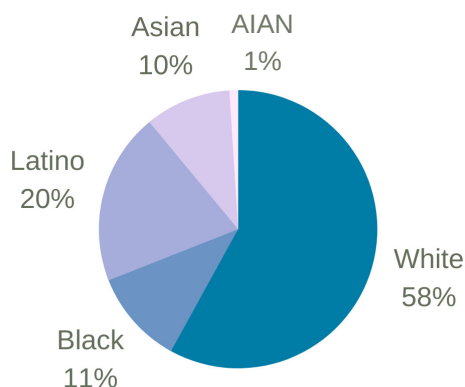**CAC:** Grayson County Children's Advocacy Center
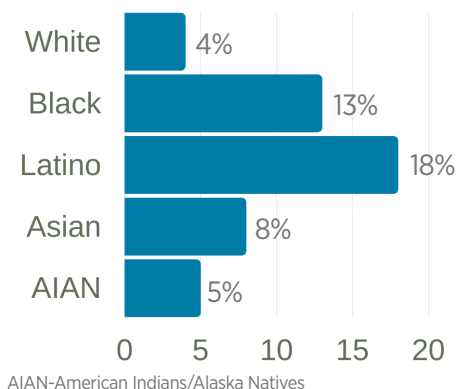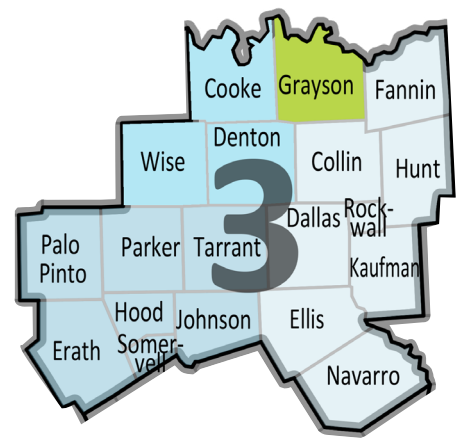

DEMOGRAPHICS

Total Population	Total Child Population (under 18)	Rural	Language Other Than English Spoken at Home	Single Parent Households	Children in Poverty
130,657	30,447	43%	11%	32%	17%

RACE

Total Population by Race

- AIAN 2%
- Asian 3%
- Latino 14%
- Black 6%
- White 75%

% Children in Poverty by Race

- White 16%
- Black 42%
- Latino 25%
- AIAN 22%

AIAN-American Indians/Alaska Natives

CHILD WELFARE DATA

56%
Children **Placed Out** of their **Home County,** May 31, 2020

1,549
Child Abuse and **Neglect Victims-Cases Confirmed** by CPS, FY 2019

39%
Children **Placed** with **Relatives,** FY 2019

308
Children in **Substitute Care,** FY 2019

456
Children Receiving **Family Preservation Services,** FY 2019
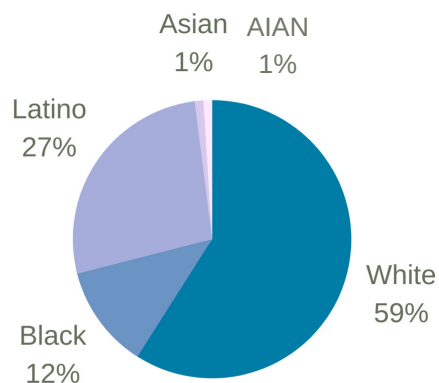
HEALTH & EDUCATION[4]

164
Mental Health Providers in the County

120 of **244**
in Texas County Health Outcomes Ranking
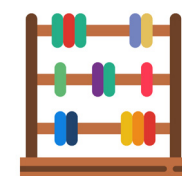
13
Public School Districts

21%
Bachelor's Degree or Higher

Hunt COUNTY

Largest City: Greenville
LMHA: Lakes Regional Community Center — Terrell, TX
CASA: Hunt County CASA
CAC: Hunt County Children's Advocacy Center

Cooke Grayson Fannin
Wise Denton Collin Hunt
Palo Pinto Parker Tarrant Dallas Rockwall
Hood Somervell Johnson Ellis Kaufman
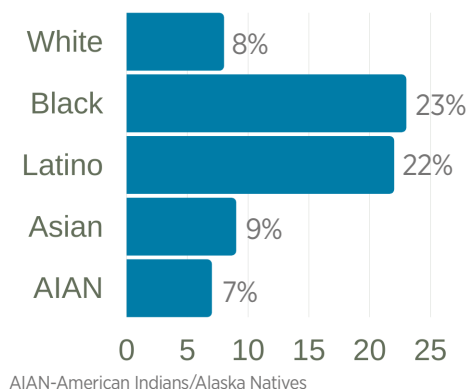Erath Navarro

3

DEMOGRAPHICS

Total Population	Total Child Population (under 18)	Rural	Language Other Than English Spoken at Home	Single Parent Households	Children in Poverty
94,285	21,702	57%	14%	29%	20%

RACE

Total Population by Race

Asian 2%
AIAN 1%
Latino 18%
Black 8%
White 70%

% Children in Poverty by Race

White 16%
Black 45%
Latino 40%
Asian 26%
AIAN 24%

0 10 20 30 40 50

AIAN-American Indians/Alaska Natives

CHILD WELFARE DATA

70%
Children **Placed Out** of their **Home County,** May 31, 2020

1,170
Child Abuse and **Neglect Victims-Cases Confirmed** by CPS, FY 2019

32%
Children **Placed** with **Relatives,** FY 2019

359
Children in **Substitute Care,** FY 2019

359
Children Receiving **Family Preservation Services,** FY 2019

HEALTH & EDUCATION[4]

75
Mental Health Providers in the County

157 of **244**
in **Texas County Health Outcomes** Ranking
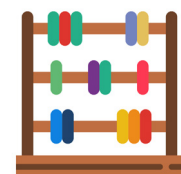
10
Public School Districts

19%
Bachelor's Degree or Higher

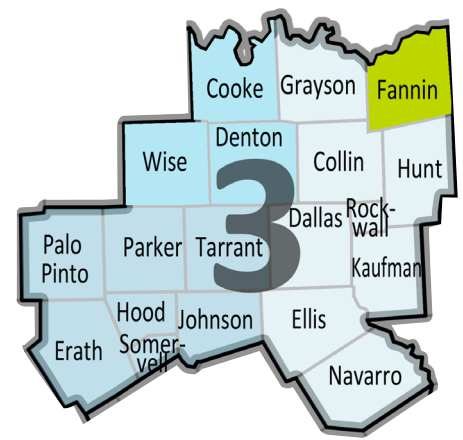MEADOWS
MENTAL HEALTH
POLICY INSTITUTE

Kaufman COUNTY

Largest City: Terrell
LMHA: Lakes Regional Community Center — Terrell, TX
CASA: Lonestar CASA
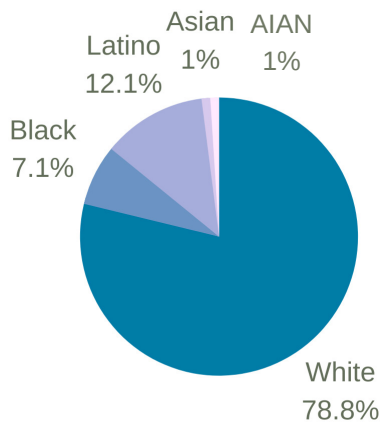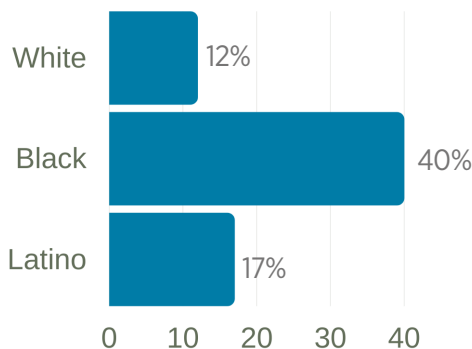**CAC:** Children's Advocacy Center for Kaufman County
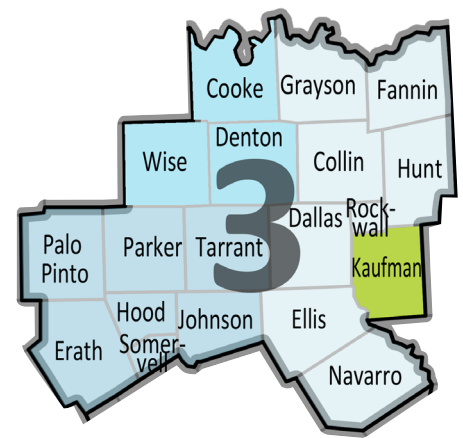
DEMOGRAPHICS

Total Population	Total Child Population (under 18)	Rural	Language Other Than English Spoken at Home	Single Parent Households	Children in Poverty
122,724	31,254	49%	17%	27%	15%

RACE

Total Population by Race

Asian 2%
AIAN 1%
Latino 23%
Black 14%
White 60%

% Children in Poverty by Race

White 10%
Black 28%
Latino 27%
Asian 5%
AIAN 62%

AIAN-American Indians/Alaska Natives
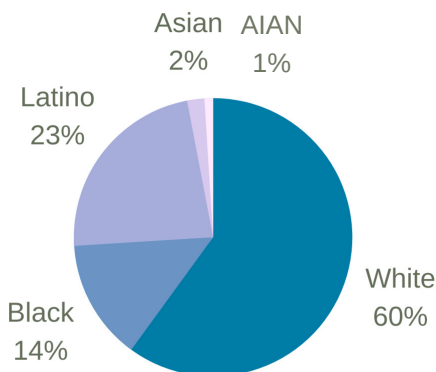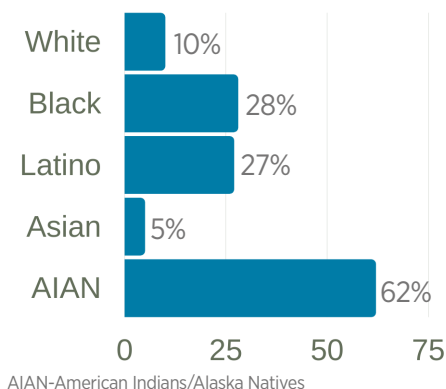
CHILD WELFARE DATA

75%
Children **Placed Out** of their **Home County,** May 31, 2020

1,339
Child Abuse and **Neglect Victims-Cases Confirmed** by CPS, FY 2019

37%
Children **Placed** with **Relatives,** FY 2019

160
Children in **Substitute Care,** FY 2019

497
Children Receiving **Family Preservation Services,** FY 2019

HEALTH & EDUCATION[4]

118
Mental Health Providers in the County

55 of **244**
in Texas County Health Outcomes Ranking

7
Public School Districts

21%
Bachelor's Degree or Higher

MEADOWS
MENTAL HEALTH
POLICY INSTITUTE
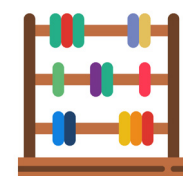
Navarro COUNTY

Largest City: Corsicana
LMHA: Lakes Regional Community Center — Terrell, TX
CASA: CASA of Navarro County
CAC: Child Advocates of Navarro County

Cooke Grayson Fannin
Wise Denton Collin Hunt
Palo Pinto Parker Tarrant Dallas Rockwall
Hood Somervell Johnson Ellis Kaufman
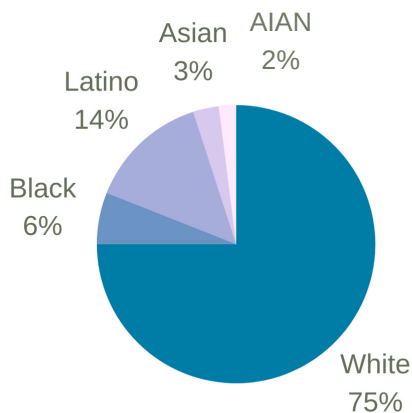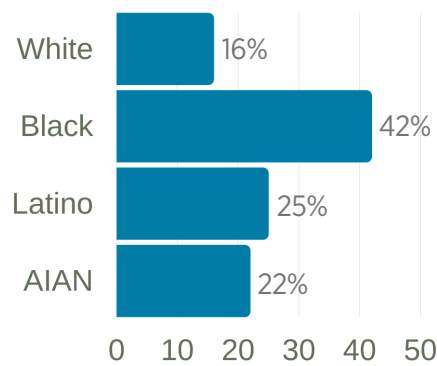Erath Navarro

3

DEMOGRAPHICS

Total Population	Total Child Population (under 18)	Rural	Language Other Than English Spoken at Home	Single Parent Households	Children in Poverty
47,977	11,574	53%	24%	35%	28%

RACE

Total Population by Race

Asian 1%
AIAN 1%
Latino 30%
White 55%
Black 13%

% Children in Poverty by Race

- White 19%
- Black 42%
- Latino 27%
- Asian 24%

0 10 20 30 40 50
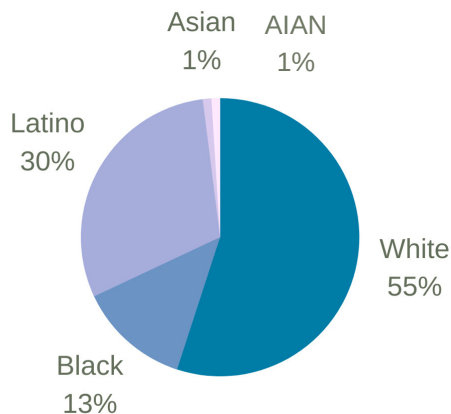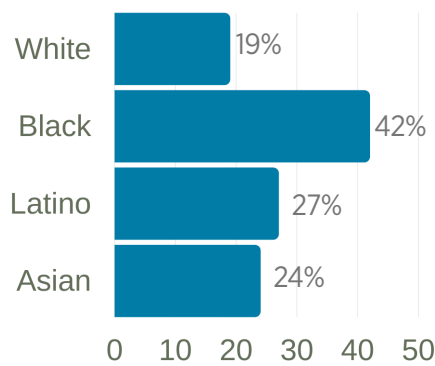
AIAN-American Indians/Alaska Natives

CHILD WELFARE DATA

67%
Children **Placed Out** of their **Home County,** May 31, 2020

535
Child Abuse and **Neglect** Victims-Cases Confirmed by CPS, FY 2019

21%
Children **Placed** with **Relatives,** FY 2019

79
Children in **Substitute Care,** FY 2019

150
Children Receiving **Family Preservation Services,** FY 2019

HEALTH & EDUCATION[4]

32
Mental Health Providers in the County

184 of **244**
in **Texas County Health Outcomes** Ranking
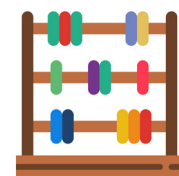
7
Public School Districts

16%
Bachelor's Degree or Higher

Rockwall COUNTY

Largest City: Dallas
LMHA: Lakes Regional Community Center — Terrell, TX
CASA: Lonestar CASA
CAC: Children's Advocacy Center for Rockwall County

DEMOGRAPHICS

Total Population	Total Child Population (under 18)	Rural	Language Other Than English Spoken at Home	Single Parent Households	Children in Poverty
99,619	24,265	16%	16%	17%	7%

RACE

Total Population by Race

- Asian 3%
- AIAN 1%
- Latino 19%
- Black 7%
- White 70%

% Children in Poverty by Race

- White 5%
- Black 11%
- Latino 13%
- Asian 7%

AIAN-American Indians/Alaska Natives
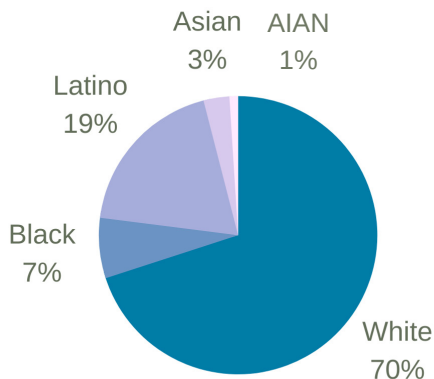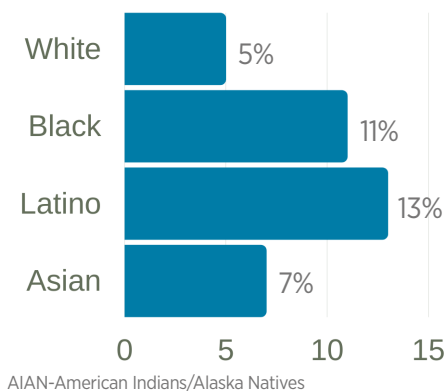
CHILD WELFARE DATA

82% Children **Placed Out** of their **Home County,** May 31, 2020

624 Child Abuse and Neglect Victims-Cases Confirmed by CPS, FY 2019

32% Children **Placed** with **Relatives,** FY 2019

106 Children in Substitute Care, FY 2019

**139** Children Receiving Family Preservation Services, FY 2019

HEALTH & EDUCATION[4]

126 Mental Health Providers in the County

5 of **244** in Texas County Health Outcomes Ranking
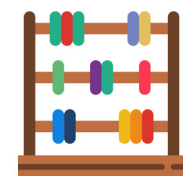
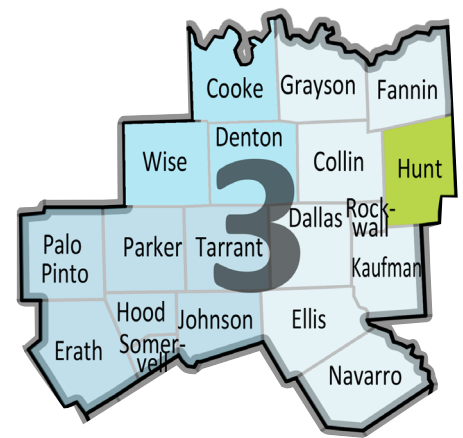**2** Public School Districts

40% Bachelor's Degree or Higher

Wise COUNTY

Largest City: Decatur
LMHA: Helen Farabee Centers — Wichita Falls, TX
CASA: CASA of Wise and Jack Counties
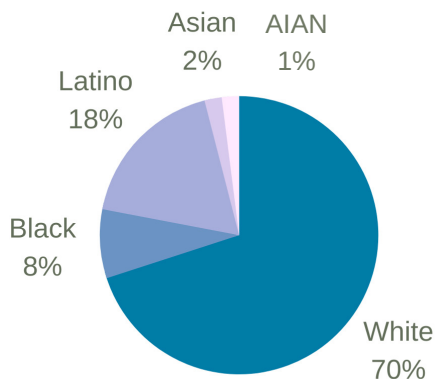**CAC:** Children's Advocacy Center for Denton County
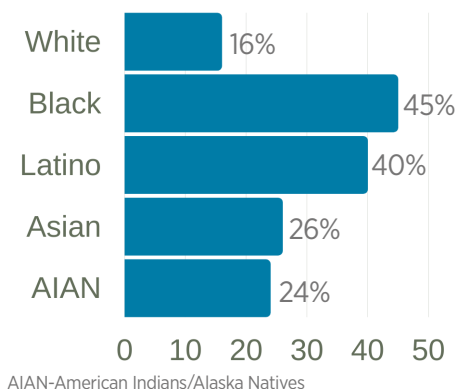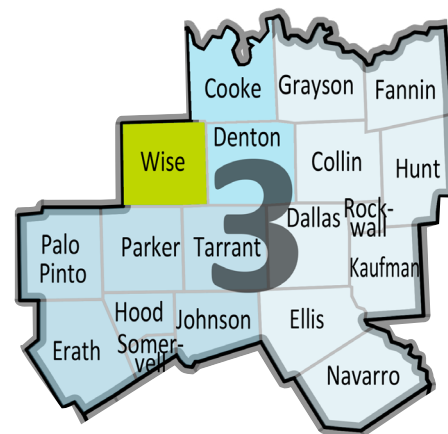

DEMOGRAPHICS

Total Population	Total Child Population (under 18)	Rural	Language Other Than English Spoken at Home	Single Parent Households	Children in Poverty
65,160	14,800	72%	15%	25%	14%

RACE

Total Population by Race
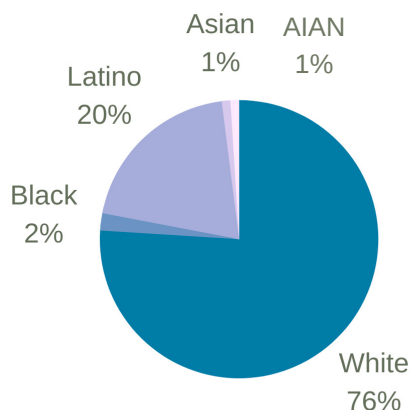
Asian 1%
AIAN 1%
Latino 20%
Black 2%
White 76%

% Children in Poverty by Race

White 13%
Black 19%
Latino 36%

AIAN-American Indians/Alaska Natives
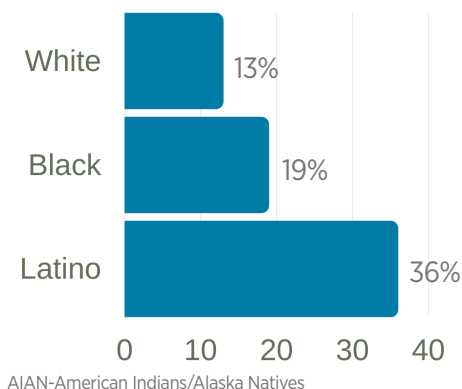
CHILD WELFARE DATA

62%
Children **Placed Out** of their **Home County,** May 31, 2020

685
Child Abuse and **Neglect Victims-Cases Confirmed** by CPS, FY 2019

27%
Children **Placed** with **Relatives,** FY 2019

128
Children in **Substitute Care,** FY 2019

201
Children Receiving **Family Preservation Services,** FY 2019

HEALTH & EDUCATION[4]

16
Mental Health Providers in the County

47 of **244**
in Texas County Health Outcomes Ranking
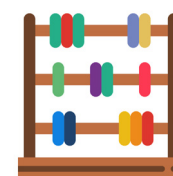
7
Public School Districts

36%
Bachelor's Degree or Higher

County Profile Citations

Demographics
Total Population
Texas Department of Family and Protective Services. (2019). *Child protective populations at risk: Texas child population.* DFPS Data Book. Retrieved December 2020, from
https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Investigations/Populations_at_Risk.asp

Total Child Population
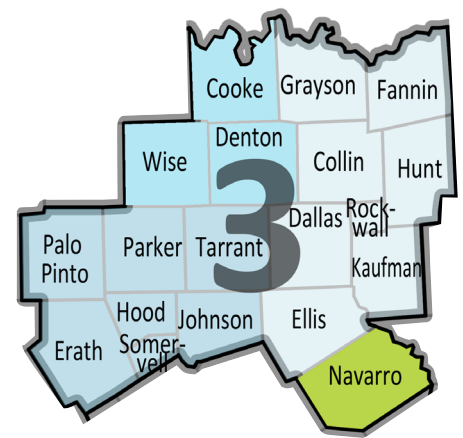Texas Department of Family and Protective Services. (2019). *Child protective populations at risk: Texas child population.* DFPS Data Book. Retrieved December 2020, from
https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Investigations/Populations_at_Risk.asp

Rural
Robert Wood Johnson Foundation. (2010). *Percentage of population living in a rural area.* County health rankings & roadmaps. https://www.countyhealthrankings.org/app/texas/2020/measure/factors/58/data

Language Other Than English Spoken at Home
United State Census Bureau. (2019, July 1). *Language other than English spoken at home.* U.S. Census Bureau QuickFacts. Retrieved December 8, 2020, from https://www.census.gov/quickfacts/fact/table/US#

Single Parent Households
Robert Wood Johnson Foundation. (2014–2018). *Single parent households.* County health rankings & roadmaps. https://www.countyhealthrankings.org/app/texas/2020/measure/factors/82/data?sort=sc-0

Children in Poverty
Robert Wood Johnson Foundation. (2018). *Children in poverty.* County health rankings & roadmaps. https://www.countyhealthrankings.org/app/texas/2020/measure/factors/24/data

Race
Total Population by Race
United State Census Bureau. (2019 July 1). *Total population by race.* U.S. Census Bureau QuickFacts. https://www.census.gov/quickfacts/fact/table/US#

% Children in Poverty by Race
Robert Wood Johnson Foundation. (2018).*Children in poverty.* County health rankings & roadmaps. https://www.countyhealthrankings.org/app/texas/2020/measure/factors/24/data

Child Welfare Data
Child Abuse and Neglect Victims – Cases Confirmed by CPS, Fiscal Year (FY) 2019
Texas Department of Family and Protective Services. (2019). *CPI completed abuse/neglect investigations: Victims.* DFPS Data Book. Retrieved December 2020, from
https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Investigations/Investigations/Victims.asp

Children in Substitute Care, FY 2019
Texas Department of Family and Protective Services. (2019). *CPS substitute care: Placement types during fiscal year.* DFPS Data Book. Retrieved December 2020, from
https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/Placements/Substitute_Care_During_Fiscal_Year.asp

Children Placed Out of Their Home County, May 31, 2020
Data were obtained from the Texas Department of Family and Protective Services and reflect a point-in-time count of all children in foster care from Region 3 on May 31, 2020.

Children Placed with Relatives, FY 2019
Texas Department of Family and Protective Services (2020, June 28). *Children in substitute care by placement type on August 31 FY2010–2019*. Retrieved December 2020, from https://data.texas.gov/Social-Services/CPS-3-2-Children-in-Substitute-Care-by-Placement-T/kgpb-mxxd

Children Served With Family Preservation Services, FY 2019
Texas Department of Family and Protective Services. (2019). *CPS Family Preservation (FPR): Children served*. https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/Family_Preservation/Children_Served.asp

Health & Education

Mental Health Providers in the County
Robert Wood Johnson Foundation. (2019). *Mental health providers in the county*. County health rankings & roadmaps. https://www.countyhealthrankings.org/app/texas/2020/measure/factors/62/data

County Health Outcomes Ranking
University of Wisconsin Population Health Institute. (2020). *Texas: 2020 county health rankings report*. https://www.countyhealthrankings.org/sites/default/files/media/document/CHR2020_TX_0.pdf

Public School Districts
Texas Education Agency. (2020). *Public school districts [AskTED]*. http://tea4avholly.tea.state.tx.us/TEA.AskTED.Web/Forms/SearchScreen.aspx?orgType=County

Bachelor's Degree or Higher
United State Census Bureau. (2019, July 1). *Bachelor's degree or higher, percent of persons age 25 years+, 2015–2018*. U.S. Census Bureau QuickFacts. https://www.census.gov/quickfacts/fact/table/US#

Chapter 1: Data Trends and Characteristics
of Children and Youth

Contents

Introduction

To create a successful Community-Based Care (CBC) model, those involved in CBC planning and implementation must have an in-depth understanding on who the child welfare system serves in order to develop the appropriate capacity for substitute care placements and make connections with community service providers to meet those needs. Individual characteristics of children and youth, such as age, sex/gender, race/ethnicity, previous time spent in substitute care, and mental and physical health, all factor into a child's risk for abuse and neglect and can impact time to permanency.[42,43,44] The purpose of this chapter is to provide information on how children and youth enter substitute care, describe who is served through the child welfare system in Department of Family and Protective Services (DFPS) Regions 3W (non-CBC) and 3E, and provide a high-level analysis of outcomes for those in substitute care. We considered the following questions when collecting, analyzing, and synthesizing the data:

- What drives entry into substitute care?
- Where are children and youth in substitute care from the target regions placed, and with whom are they placed?
- What factors influence length of time in care and permanency outcomes?

The answers to those questions inform our findings on system capacity and service needs in subsequent report chapters, and complement the findings gleaned from our other qualitative and quantitative data sources.

This chapter includes seven sections, all focused on data about DFPS Regions 3W (non-CBC) and 3E. The first section describes the **methodology** used to collect and analyze the data, followed by these six sections:

- **Part 1** – How children and youth enter substitute care
- **Part 2** – Numbers in substitute care
- **Part 3** – Who is in substitute care
- **Part 4** – Placement trends
- **Part 5** – Anticipated needs for children and youth in substitute care
- **Part 6** – Review of child and youth outcomes

Methodology

This chapter focuses on the counties that have not yet implemented CBC in DFPS Region 3W (Cooke, Denton, and Wise) and DFPS Region 3E (Collin, Dallas, Ellis, Fannin, Grayson, Hunt, Kaufman, Navarro, and Rockwell). In addition, DFPS Region 3 includes Region 3W (CBC), which is made up of Tarrant, Palo Pinto, Parker, Erath, Johnson, Hood, and Somervell counties. Some

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[42] Centers for Disease Control and Prevention (n.d.) *Violence prevention: Risk and protective factors.* https://www.cdc.gov/violenceprevention/childabuseandneglect/riskprotectivefactors.html#Risk%20Factors%20for

[43] Madden, E.E., Aguiniga, D.M., (2017, March). *Achieving permanency for children in care: Barriers and future directions.* Upbring. https://www.upbring.org/wp-content/uploads/2015/02/Achieving_Permenancy_040417.pdf

[44] See the Glossary of Terms in *Appendix B* for definitions of permanency and other key child welfare system terms.

data were available at a county or subregional level (e.g., for Region 3E); however, other data were only available for DFPS Region 3 as a whole. Additionally, in some instances, we elected to provide data for each of the three subregions within DFPS Region 3 to show and compare broader trends. The data in this chapter are sourced from:

- DFPS Data Book
- Regional Data from the DFPS Data Warehouse from August 2020
- American Community Survey Data (general population data)
- Point-in-time data provided by DFPS for May 31, 2020.

Part 1 – How Children and Youth Enter Substitute Care

This section outlines what happens in the child welfare system prior to children and youth being removed from home and entering substitute care. A review of how and why children and youth enter substitute care (allegations and investigations) is important to offer context on how the system functions as a whole and who is—and is not—served in substitute care. (See *Chapter 5* for more about how children and youth enter care via the court system.)

Child Abuse and Neglect Allegations, Investigations, and Findings

Children and youth in substitute care are a small subset of the children and youth who have contact with the larger child welfare system. Statewide, about 11% of abuse and neglect investigations resulted in a child being removed or the family being referred to Child Protective Services (CPS) for ongoing services (Figure 2).[45]

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[45] Texas Department of Family and Protective Services (n.d.). *CPI intakes: Initial priority, screening, and assignment.* Data Book. Retrieved December 2020, from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Investigations/Intakes.asp

Figure 2. From Allegations to Removal Statewide (FY 2019)[46]

294,739 Allegations Reported (Intakes)

163,029 Investigations

41,975 Findings of Abuse and/or Neglect

18,615 Removals
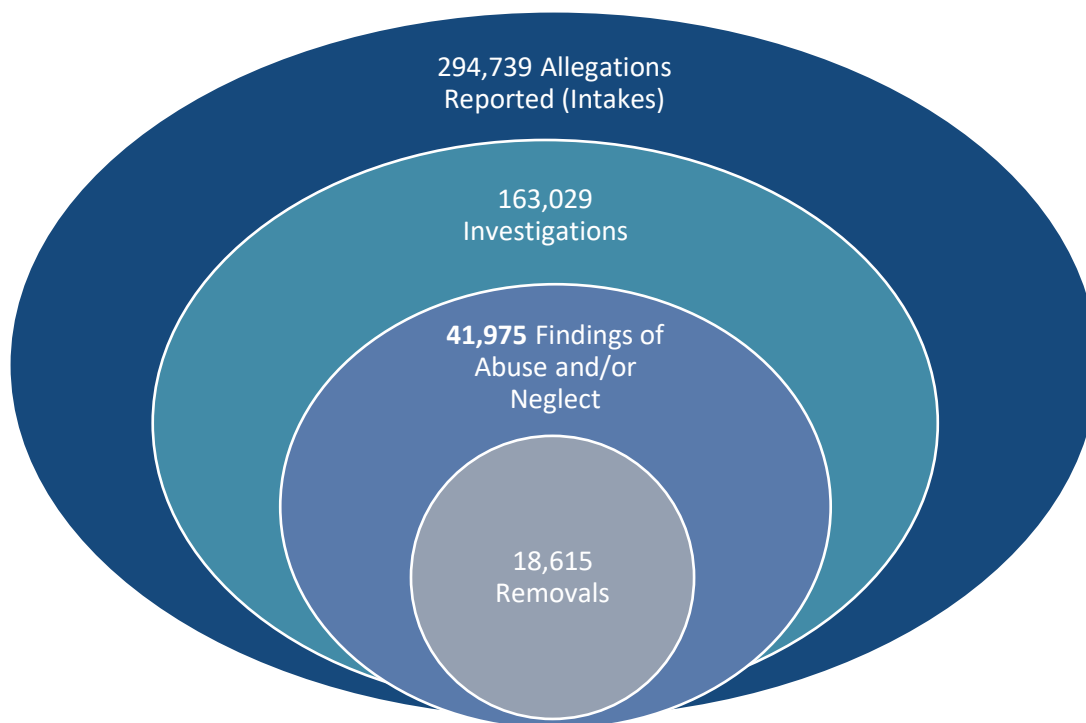
Focusing on just DFPS Region 3 (as a whole), fiscal year (FY) 2019 data from DFPS indicates:

- A total of 40,127 allegations were investigated by Child Protective Investigations (CPI). Of these reports, 59% (23,637) were ruled out. Cases are closed either when (1) abuse or neglect is ruled out or (2) when there is reason to believe abuse or neglect did occur, but no further CPS involvement is required to ensure the safety of the child or youth.[47]
- Approximately 30% (12,007 of 40,127) of these allegations resulted in a finding of "reason to believe" abuse or neglect.[48]
- In the same period, 4,238 cases were referred to family preservation services and 1,939 cases resulted in a removal.[49]

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[46] Texas Department of Family and Protective Services (n.d.). *CPI intakes: Initial priority, screening, and assignment.* Retrieved December 2020, from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Investigations/Intakes.asp

[47] Texas Department of Family and Protective Services (n.d.). *CPI completed abuse/neglect investigations.* Data Book. Retrieved December 2020, from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Investigations/Investigations/Activity.asp

[48] Texas Department of Family and Protective Services (n.d.). *CPI completed abuse/neglect investigations: Findings.* Data Book. Retrieved December 2020, from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Investigations/Investigations/Findings.asp

[49] Texas Department of Family and Protective Services (n.d.). *CPI completed abuse/neglect investigations: Case actions.* Data Book. Retrieved December 2020, from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Investigations/Investigations/Case_Actions.asp

Removals

A total of 551 children and youth from DFPS Region 3W (non-CBC) and 2,220 from DFPS Region 3E during FY 2019 (Table 1) were removed from their homes. The majority of children and youth in DFPS Regions 3W (non-CBC) and 3E (89% and 88%, respectively) were removed from their homes during the course of a CPS investigation rather than at another time. The remaining children and youth had previously been identified by CPS and were removed while receiving family preservation services from DFPS. Statewide in FY 2019, 78% of children and youth were removed during the investigation stage and 22% removed in the family preservation stage. **When compared to the statewide average, fewer children and youth from DFPS Regions 3W (non-CBC) and 3E were removed during the family preservation stage**. There are no data available to indicate why removals during the family preservation stage were lower than the statewide average, but one possible reason could be effective family preservation services in the area.

Table 1. Number of Removals by Removal Stage in DFPS Regions 3W (non-CBC) and 3E (FY 2019) [50]

Region	Removal Stage		
	Investigation	**Family Preservation**	**Total**
DFPS Region 3W (non-CBC)	490 (89%)	61 (11%)	551 (100%)
DFPS Region 3E	1,944 (88%)	276 (12%)	2,220 (100%)
Texas	14,598 (78%)	4,017 (22%)	**18,615 (100%)**

Part 2 – Numbers in Substitute Care

The information presented in the following section highlights removal trends over time and characteristics of children and youth from DFPS Regions 3W (non-CBC) and 3E placed into substitute care.

Removal Trends Over Time

Removal data from the past 10 years shows various trends in DFPS Region 3. Over this decade, removals in DFPS Region 3W (non-CBC) remained fairly stable between 2010 and 2015, but increased overall between FY 2015 and 2018 and then declined in the last two years (Figure 3). In contrast, removals in DFPS Region 3E varied more by year, with a significant drop from FY 2018 to 2019 and again in FY 2020.

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[50] Texas Department of Family and Protective Services (2020). *Removals by county FY2010–2019*. Retrieved December 2020, from https://data.texas.gov/Social-Services/CPS-2-1-Removals-by-County-FY2010-2019/xmtn-e5c8

This drop is consistent with a statewide decline in removals over the same period, however the rate of removals per 1000 children and youth has consistently been lower in DFPS Region 3 than the statewide rate. For example, in FY 2018 the rate of removals per 1000 children and youth was 2.23 in DFPS Region 3 and 2.8 statewide. In FY 2020, rate of removal per 1000 children and youth declined to 1.48 in DFPS Region 3 in contrast to 2.2 statewide.

Figure 3. Number of Removals by DFPS Region 3 Subregion (FY 2010–2019) [51]
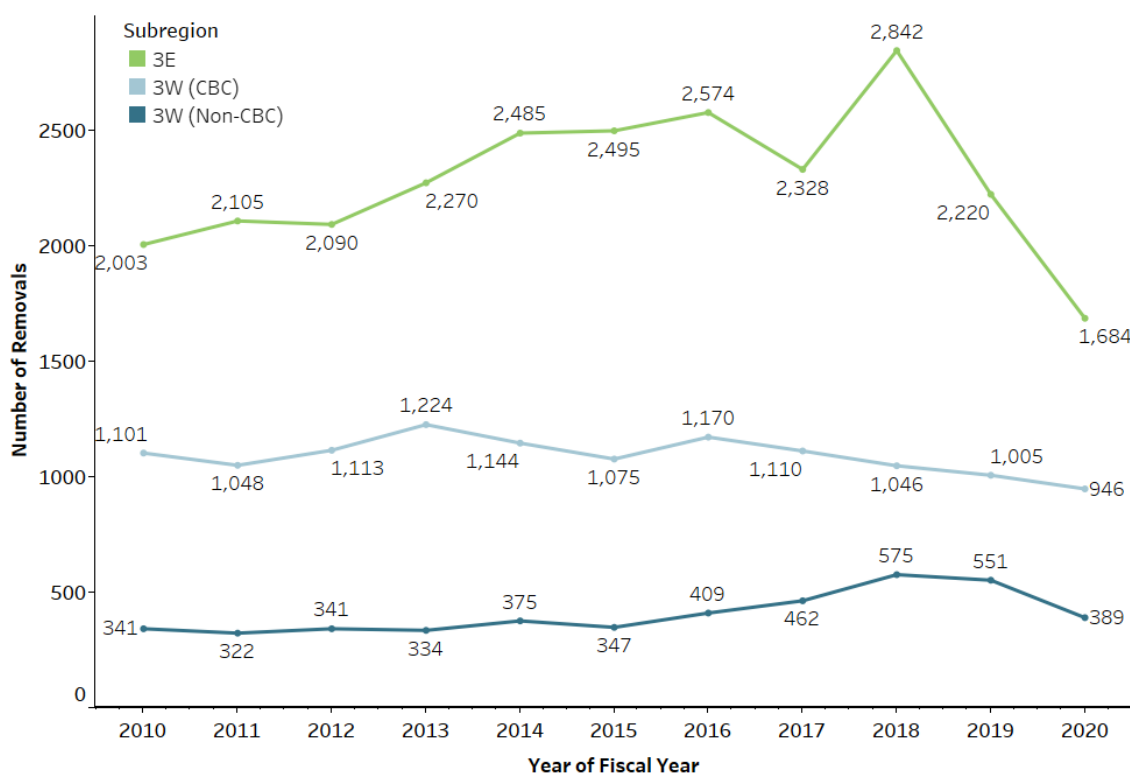
Number of Children and Youth in Substitute Care

Removals are one of several factors that contribute to the total number of children and youth in substitute care at any point in time. In this section, we further analyze other significant factors that influence this total, such as the trends on how and when children and youth leave substitute care. There are also different ways to parse the available data on the total number of children and youth in DFPS substitute care—and to pinpoint trends over time. In the DFPS Data Book, for example, there are figures on all children or youth who have entered DFPS custody at any point in a year, which in some cases may include duplicates (children who entered more than once). However, DFPS also has point-in-time data, which indicates how many children and youth are in substitute care on one single day.[52]

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[51] Texas Department of Family and Protective Services (2020). *Removals by county FY2010–2019*. Retrieved December 2020, from https://data.texas.gov/Social-Services/CPS-2-1-Removals-by-County-FY2010-2019/xmtn-e5c8

[52] DFPS conservatorship data includes children and youth in additional living arrangements beyond settings that are considered substitute care. The additional living arrangements in that dataset include very short-term arrangements and children/youth

On August 31, 2019, there were 29,242 children and youth in substitute care statewide. Of these, 6,060 children and youth were from DFPS Region 3 (Table 2), nearly 21% of the state total.

Table 2. Children and Youth in Substitute Care in DFPS Region 3 (August 31, 2019)[53]

Subregion	In Substitute Care			% of Region 3 Total
	Total	**Foster Care**	**Other Sub. Care**	
3E	3,520	2,203	1,317	58%
3W (CBC)	1,741	1,311	430	29%
3W (non-CBC)	799	475	324	13%
Region 3 Total	**6,060**	**3,989**	**2,071**	**100%**

In DFPS Region 3 as a whole, trends in recent years have been fairly consistent (Figure 4). However, recently released data for FY 2020 shows a continued decline in the total number of children and youth in substitute care across DFPS Region 3 from FY 2019, leading to the lowest numbers of children and youth in substitute care since FY 2013.

Figure 4. Children and Youth in Substitute Care Over Time in DFPS Region 3 (FY 2015–2019)[54]

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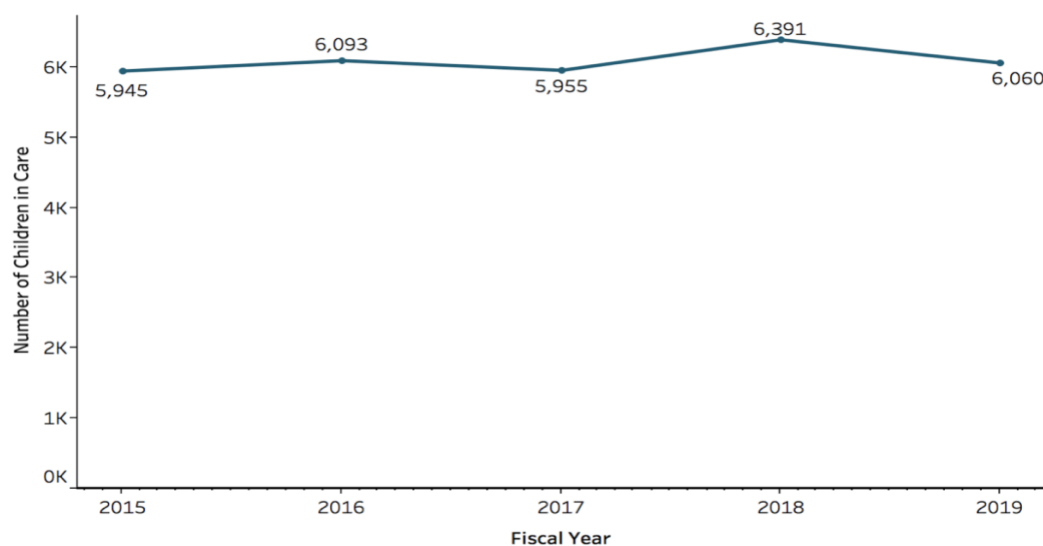
who have returned home but are still being monitored by DFPS. Despite the differences in the datasets, the majority of children and youth in DFPS custody fall within the umbrella of substitute care.

[53] Texas Department of Family and Protective Services (2020, June 28). *Children in substitute care by placement type on August 31 FY2010–2019*. Retrieved December 2020, from https://data.texas.gov/Social-Services/CPS-3-2-Children-in-Substitute-Care-by-Placement-T/kgpb-mxxd

[54] Texas Department of Family and Protective Services (2020, June 28). *Children in substitute care by placement type on August 31 FY2010–2019.*

County-Specific Differences in Number of Children and Youth in Substitute Care

In addition to state and regional trends, it is valuable to drill down to the county level, identifying both raw numbers for children and youth in substitute care (Figure 5) as well as a county comparison relative to each county's population size.

Figure 5. Number of Children and Youth in Substitute Care by County in DFPS Regions 3E and 3W (non-CBC) (May 31, 2020)[55]
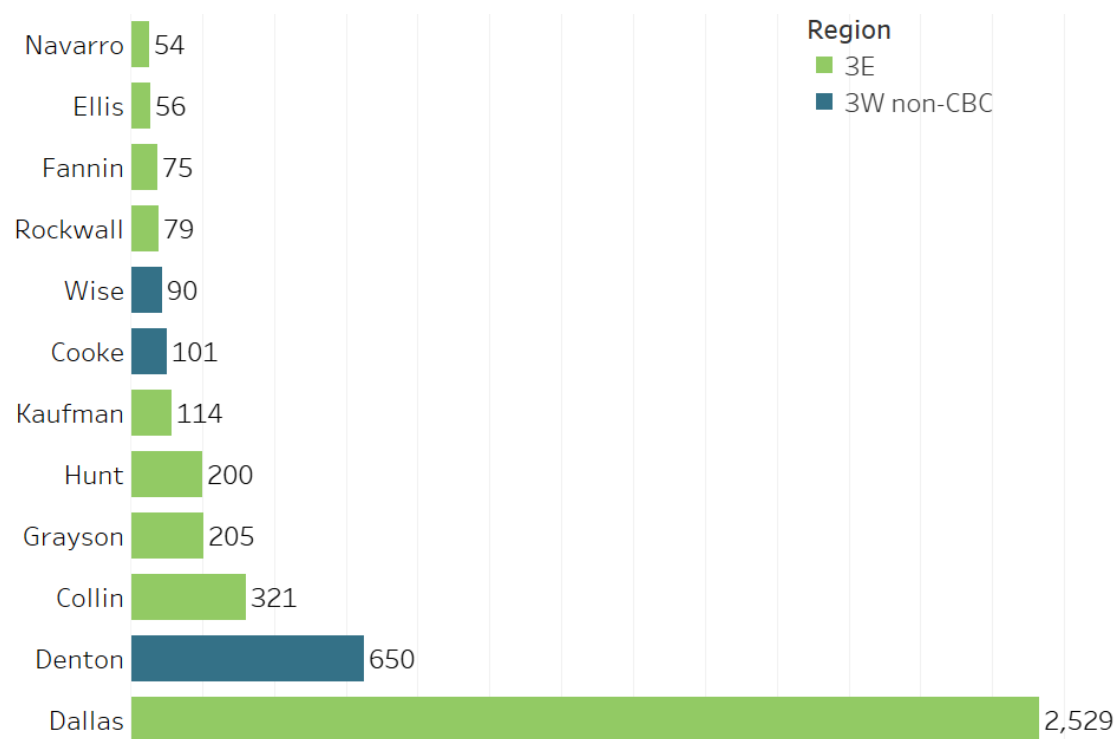
Given the vastly different population sizes in the different counties within DFPS Regions 3W (non-CBC) and 3E, one way to understand the relative population of those in substitute care in contrast to the overall child population is to examine the **rate per 1,000 children and youth**. These data show that, in most counties the rate of children and youth in substitute care either increased or remained fairly level between 2015 and 2019, and that there are relative differences in the overall rates per county (Figure 6).

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[55] Data were obtained from the Texas Department of Family and Protective Services and reflect a point-in-time count of all children in foster care from DFPS Region 3 on May 31, 2020.

Figure 6. Children and Youth in Substitute Care per 1,000, by County in DFPS Regions 3E and 3W (non-CBC) (FY 2015–2019)[56]
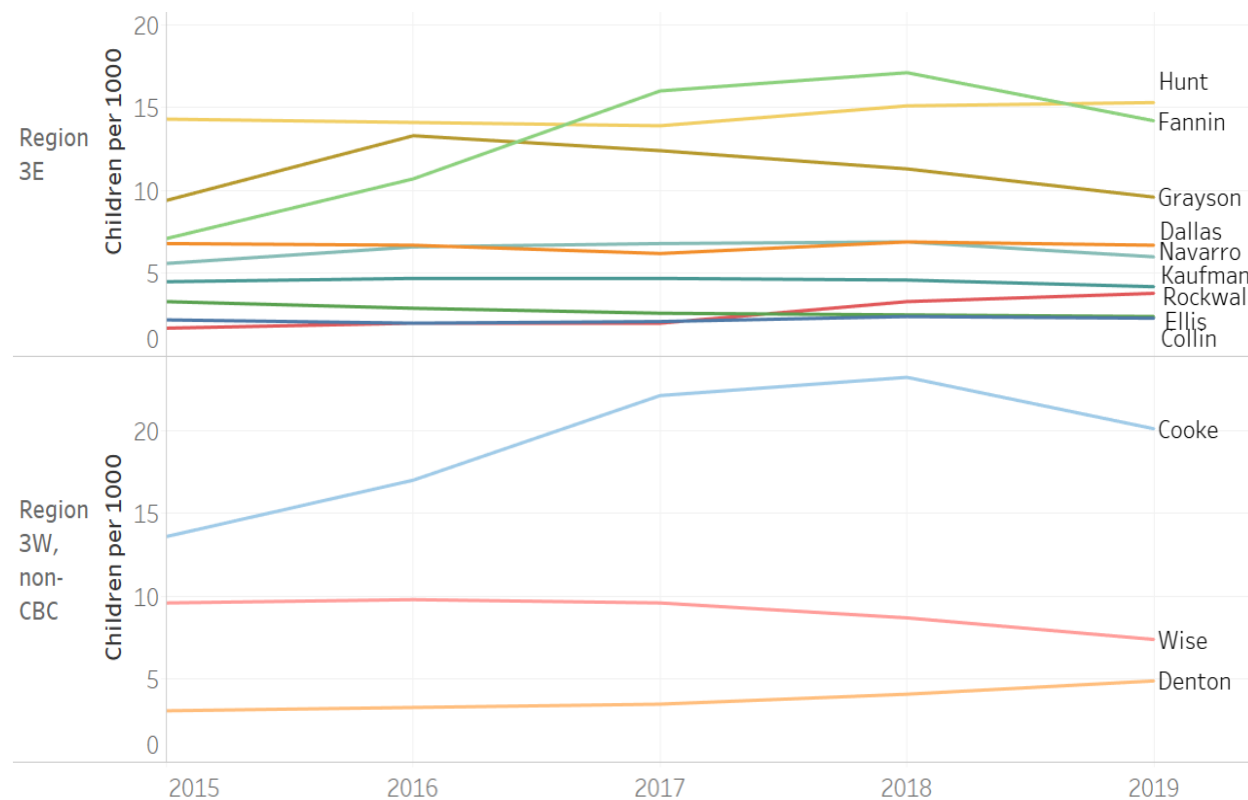
Beyond the general trends, counties within DFPS Regions 3W (non-CBC) and 3E experienced their own unique fluctuations in certain years. Between August 31, 2015 and August 31, 2019, the number of children and youth in substitute care decreased in Dallas, Ellis, and Wise counties. In the remaining nine counties within DFPS Regions 3W (non-CBC) and 3E, the number of children and youth in substitute care rose between August 31, 2015 and August 31, 2019. With some notable exceptions, the decreases or increases between these two dates were minor in many of the counties. When more significant fluctuations are present, it is worth exploring potential causes, which can include circumstances such as a new judge, policy changes, or other factors that influence the number of children and youth entering or exiting substitute care.

Present Realities Affecting Regional Trends

Related to the two-year decline in removals previously mentioned, the total number of children and youth in substitute care from DFPS Region 3 declined by about 10% from January 2019 to October 2020 (Figure 7).

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[56] Department of Family and Protective Services (2020) *CPS 3.2: Children in substitute care by placement type on August 31, FY 2015-2020.* Retrieved December 2020, from https://data.texas.gov/Social-Services/CPS-3-2-Children-in-Substitute-Care-by-Placement-T/kgpb-mxxd

Figure 7. Number of Children in Substitute Care in DFPS Region 3 (January 2019–October 2020)[57]
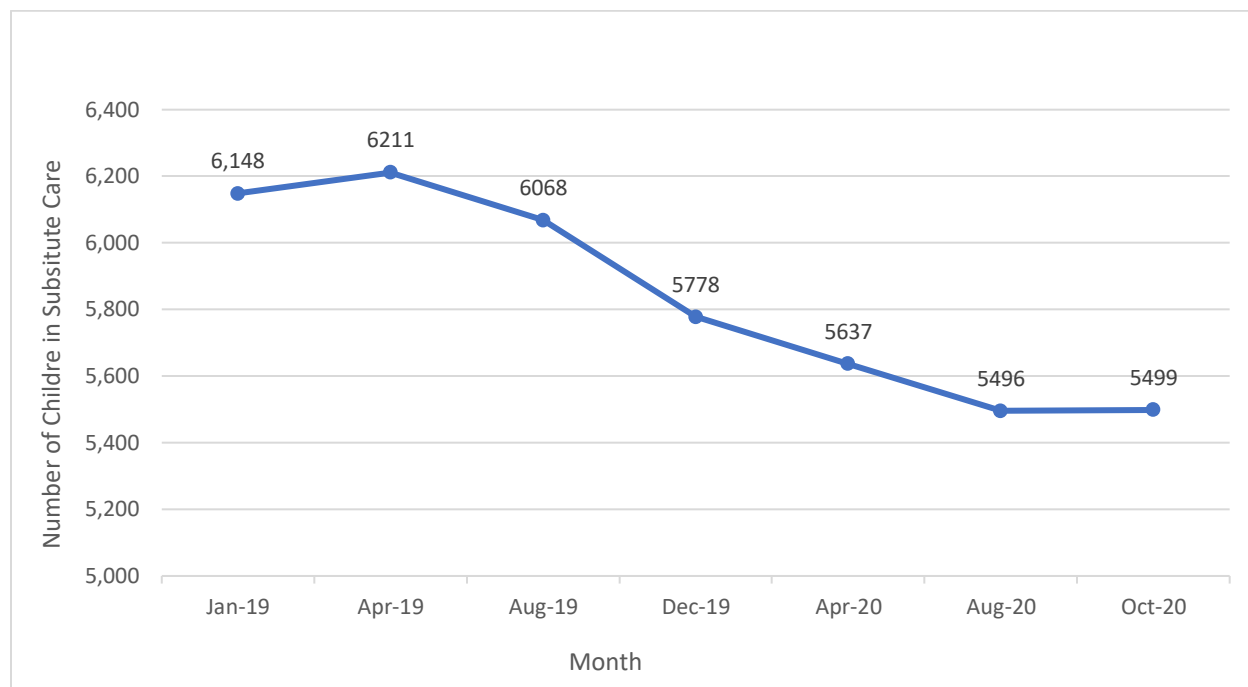
Given the COVID-19 pandemic and unprecedented dynamics of 2020 and beyond, it is reasonable to expect the need for substitute care to increase. The effects of social isolation and rising unemployment are expected to increase substance abuse and family violence, key factors in child abuse, neglect, and removals.[58] The pandemic also appears to be prolonging child welfare cases. For example, child welfare providers in North Texas as well as from other parts of the state have reported that the pandemic is delaying the case process and the ultimate resolution of cases, and it is complicating efforts to recruit new foster families. These combined factors are likely to strain the child welfare system and impede permanency goals for the children, youth, and families it serves. Early efforts to collaborate around CBC planning in North Texas may serve as a catalyst for tracking COVID-related impacts on the child welfare system and the families involved. CBC presents new opportunities for communities to develop proactive strategies to overcome these challenges.

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[57] Texas Department of Family and Protective Services. (2020). *Regional statistical information about children in the Texas Department of Family Protective Services (DFPS) care, January 2019–October 2020*. Retrieved December 2020, from https://www.dfps.state.tx.us/Doing_Business/Regional_Statistics/archive.asp

[58] Meadows Mental Health Policy Institute. (2020, April). *Projected COVID-19 MHSUD impacts, volume 1: Effects of COVID-induced economic recession*. COVID-19 Response Briefing. https://mmhpi.org/topics/policy-research/covid-impact-series-volume1/

Part 3 – Who is In Substitute Care

This section summarizes some of the basic characteristics (age, sex, and race/ethnicity) of children and youth from DFPS Region 3 in substitute care. The data show that the demographic characteristics of children and youth in substitute care are *not* representative of the general population in the geographic area. As discussed further in this section, younger children (under age 6) are in substitute care at higher rates than older children and youth. And, while the difference is minor, boys are also more likely to be in substitute care than girls.

It is also critical to note the striking *racial and ethnic differences* in who is in substitute care as data reveal that Black children and youth in DFPS Regions 3W (non-CBC) and 3E are significantly over-represented in substitute care in contrast to other racial and ethnic groups. While the focus of CBC is on children and youth once they come into the custody of DFPS, one of the most significant global child welfare issues is the disproportionate involvement of families of color in the foster care system. Racial and ethnic disparities in child welfare are the result of systemic policies and biases that harm families of color and must be addressed universally in order to reverse these persistent trends.

Ages of Children and Youth in Care

Younger children are especially vulnerable to parental neglect and the impacts of substance abuse. Both nationally and in Texas, more babies, toddlers, and preschool-age children are in substitute care than other age groups.[59] The data summarized below show the age breakdowns of children and youth in DFPS Regions 3W (non-CBC) and 3E in substitute care on May 31, 2020. More than half of these children were first removed from their homes when they were five years old or younger, and a much smaller proportion (15% and 12% in each subregion of DFPS Region 3, respectively) were first removed as teenagers (Figure 8).

Figure 8. Age at First Removal by DFPS in Regions 3E and 3W (non-CBC) (May 2020)[60]

Looking at a full year of data, roughly the same age breakdowns persist. Among the population of children and youth in substitute care across all of DFPS Region 3 in FY 2019, half (51% or 5,303) were five years old and under, 29% were infants and toddlers up to age two years, and 13% were between the ages of 14 and 17 years (Table 3).

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[59] Williams, S.C., & Sepulveda, K. (2019, March 12). Infants and toddlers are more likely than older children to enter foster care because of neglect and parental drug abuse. *Child Trends.* https://www.childtrends.org/infants-and-toddlers-are-more-likely-than-older-children-to-enter-foster-care-because-of-neglect-and-parental-drug-abuse

[60] Data were obtained from the Texas Department of Family and Protective Services and reflect a point-in-time count of all children in foster care from DFPS Region 3 on May 31, 2020.

Table 3. Breakdown by Age for Children and Youth in Substitute Care in DFPS Region 3 (FY 2019)[61]

Age	All Children in Substitute Care	% of Total Children in Substitute Care
Ages 0–2	3,005	29%
Ages 3–5	2,173	21%
Ages 6–9	1,904	18%
Ages 10–13	1,525	15%
Ages 14–17	1,374	13%
Age 18	262	3%

Racial/Ethnic Differences Among Children and Youth in Care

Black children and youth make up one-third (33%) of the children and youth in substitute care in DPFS Region 3, followed by non-Hispanic White children and youth at 31% (Table 4). Hispanic/Latino children make up a little over one-fourth (27%) of the children in care. Asian and Native American children combined make up less than 1% of the children and youth in care and are classified in the remainder of this section under the label "Other."

Table 4. Breakdown by Race/Ethnicity for Children and Youth in Substitute Care in DFPS Region 3 (FY 2019)[62]

Race/Ethnicity	All Children in Substitute Care	% of Total Children in Substitute Care
African American/Black	3,457	33%
White	3,237	31%
Hispanic/Latino	2,805	27%
Other	794	8%
Asian American	60	0.6%
Native American	15	0.1%

Looking at the race and ethnicity of children and youth in substitute care in contrast to the general population also highlights notable differences. In nine (9) of the 12 counties in DFPS Regions 3W (non-CBC) and 3E, Black children and youth were in substitute care at significantly higher rates per 1,000 children and youth than any other racial/ethnic group (Figure 9). The data show that, while in both DFPS Region 3E and Region 3W (non-CBC) there are 13 Black

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[61] Texas Department of Family and Protective Services (2020, April 16). *CPS 3.1 children in substitute care by fiscal year and region with demographics FY2010–2019*. Retrieved December 2020, from https://data.texas.gov/Social-Services/CPS-3-1-Children-in-Substitute-Care-by-Fiscal-Year-/nhcj-etqt

[62] Texas Department of Family and Protective Services (2020, April 16). *CPS 3.1 children in substitute care by fiscal year and region with demographics FY2010–2019*.

children and youth in substitute care for every 1,000 children and youth in the population as compared to 4–5 children per 1,000 in care for all other racial/ethnic groups.

Figure 9. Race/Ethnicity of Children and Youth in Substitute Care per 1,000, by DFPS Region 3 Subregion (FY 2019)[63,64]

3W non-CBC		
Black		13
Hispanic		5
Other		5
White		5
3E		
Black		13
Hispanic		4
Other		4
White		4
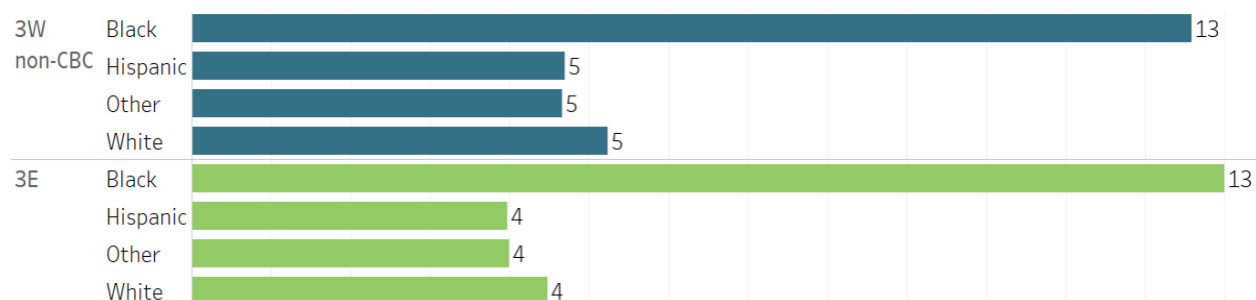
The contrast between the rate of Black children and youth in substitute care in DFPS Region 3 versus the Black population in the community as a whole is striking. For example, in FY 2019 there were 4,568 children and youth in substitute care in Dallas County. Of these children and youth, close to half (2,177) were Black despite the fact the county is only 25% Black. In the same year, 1,505 Dallas County children and youth were removed and placed into substitute care. Of those, 716 were Black and 187 were White. Looking more broadly across Region 3, there is consistent disproportionality: Black children and youth are overrepresented in substitute care (Figure 10).

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[63] Texas Department of Family and Protective Services (2020, June 28). *Children in substitute care by placement type on August 31 FY2010–2019*. Retrieved December 2020, from https://data.texas.gov/Social-Services/CPS-3-2-Children-in-Substitute-Care-by-Placement-T/kgpb-mxxd

[64] U.S. Census Bureau annual population estimates.

Figure 10. Comparison of Race and Ethnicity Between Children in Care and in the General Population, by DFPS Region 3 Subregion (2020)[65,66]
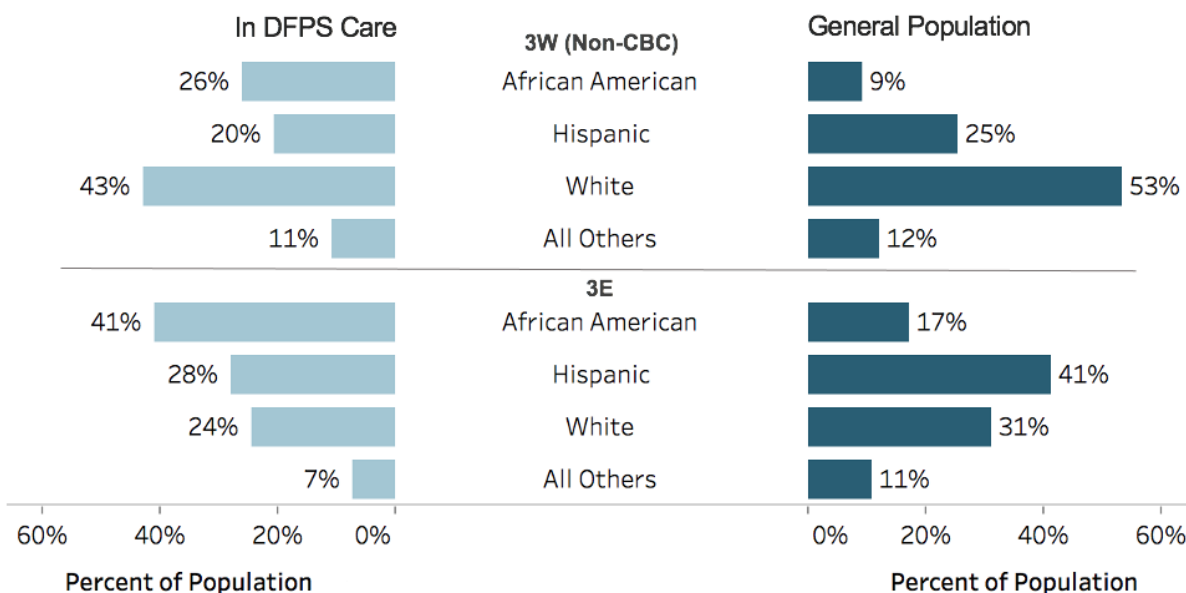
Black children are represented in substitute care at almost three times (3x) the rate they are represented in the general population in DFPS Region 3W (non-CBC) and at well over twice (2x) the rate of the general population in DFPS Region 3E. In contrast, Hispanic and White children and youth are underrepresented in substitute care relative to their representation in the general population. Fully understanding the factors that result in such striking racial disparities is beyond the scope of this report. However, implications of racial and ethnic disproportionality in substitute care are discussed in subsequent chapters.

Part 4 – Placement Trends

The focus of the remainder of this chapter is on what happens to children and youth in DFPS Regions 3E and 3W (non-CBC) once they are in substitute care and how factors such as age, sex, and race/ethnicity affect a child's outcomes. The information included depicts:

- Where children and youth in substitute care are placed, including placement type and location.
- How many children and youth are placed with siblings.
- How long children and youth spend in substitute care and their number of placements.
- How children and youth exit substitute care.

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[65]Data were obtained from the Texas Department of Family and Protective Services and reflect a point-in-time count of all children in foster care from DFPS Region 3 on May 31, 2020

[66] U.S. Census Bureau annual population estimates.

These findings are pertinent to several of the core goals for CBC, which include:
- The overarching goals of reunification and permanency.
- Placing children and youth in their home community.
- Placing children and youth in the least restrictive setting to meet their needs.
- Reunifying children and youth with their biological parents when possible.
- Placing children and youth with relative or kinship caregivers if reunification is not possible.

Later in this chapter, we provide additional context on the relationship between different characteristics of children and youth and the outcomes prioritized through CBC.

Children and Youth From DFPS Region 3 in Substitute Care by Placement Type

Children and youth are placed in many different types of substitute care settings ranging from family homes to institutional environments. Federal law (42 U.S.C. 657(5)) requires children and youth to be placed in the least restrictive, most family-like setting available.[67] CBC also emphasizes this goal. **A fully developed continuum of placement options that aligns with federal law, meets the unique needs of individual children and youth, and prioritizes keeping children with their families or in a family-like setting includes:**[68]
- birth families who receive supportive services;
- kinship or relative families;
- non-relative foster families when relatives are not available;
- treatment foster care families equipped to handle more intensive needs; and
- residential treatment centers (RTCs) for the small number of children and youth whose need for safety requires a more restrictive level of care. RTC placements should be time limited, family-driven, youth guided, and provide support during and after placement to the child, youth, and their family or foster family.

As described next, there are various types of placement arrangements that exist for children and youth in substitute care in DFPS Region 3.

On May 31, 2020, there were 4,474 children and youth in substitute care in DFPS Regions 3E and 3W (non-CBC) (Table 5). They were in many different types of placements, and the distribution of children and youth among different placement types was similar in Regions 3W (non-CBC) and 3E. Most often, children were placed in contracted foster homes, followed by kinship placements. About 40% of children in substitute care were placed in foster or adoptive homes. Just under one-third lived with family (kin) or friends (also referred to as fictive kin), and

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[67] National Conference of State Legislatures (2019, November 3). *The child welfare placement continuum: What's best for children?* https://www.ncsl.org/research/human-services/the-child-welfare-placement-continuum-what-s-best-for-children.aspx

[68] The Annie E. Casey Foundation (2015). *Every kid needs a family: Giving children in the child welfare system the best chance for success.* Policy Report: KIDS COUNT. http://www.aecf.org/m/resourcedoc/aecf-EveryKidNeedsAFamily-2015.pdf

fewer than 10% of children and youth in substitute care were placed in congregate settings (i.e., residential treatment facilities, group homes, and emergency shelters).

Table 5. Placement Type Among Children and Youth in Regions 3E and 3W (non-CBC) (May 31, 2020)[69]

	Region 3E	Region 3W		Region 3
	non-CBC (n=3,633)	non-CBC (n=841)	CBC (n=1,912)	Total (n=6,386)
Placement Type	**Number of Children in Care (%)**			
Contracted Foster Care	1,454 (40%)	360 (43%)	1,053 (55%)	2,867 (45%)
Kinship	1,090 (30%)	271 (32%)	379 (20%)	1,740 (27%)
Non-Certified Person	442 (12%)	81 (10%)	119 (6%)	642 (10%)
Residential Treatment	155 (4%)	33 (4%)	163 (9%)	351 (6%)
Adoptive Home	208 (6%)	32 (4%)	19 (1%)	259 (4%)
Other/Unspecified	144 (4%)	28 (2%)	50 (3%)	222 (3%)
Adoptive Home	62 (2%)	14 (2%)	36 (2%)	112 (2%)
Group Home	43 (1%)	9 (1%)	77 (4%)	129 (2%)
Emergency Shelter	35 (1%)	13 (2%)	16 (1%)	64 (1%)

Relative/Kinship Placements

Following national trends and in line with a significant body of research, Texas has increased support for relative (kinship) placements over the past decade. Kinship placements can be verified or unverified. Relatives placements include placements with biological family, legal family (including marriage), and fictive kin. **In DFPS Region 3W (non-CBC), 32% of children and youth in substitute care on May 31, 2020 were placed with relatives versus 30% in DFPS Region 3E. These rates are below the statewide average of approximately 37% of placements with relatives.**[70] Additional data on kinship placements is provided in *Chapter 2: Substitute Care Capacity.*

County-level comparisons across DFPS Regions 3W (non-CBC) and 3E indicate similar rates of relative placements, but with some notable exceptions (Table 6). For example, Fannin and Denton counties both placed over 40% of children and youth with kin, whereas only about one-fifth (21%) of children and youth from Navarro County were placed with kin.

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[69] Data were obtained from the Texas Department of Family and Protective Services and reflect a point-in-time count of all children in foster care from Region 3 on May 31, 2020.

[70] Texas Department of Family and Protective Services (2020, May 6). *First placement after removal*. Retrieved December 2020, from: https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/Placements/First_Placement_after_Removal.asp

Table 6. Relative vs. Non-Relative Placements by Region (August 31, 2019)[71]

	Placed With Relatives	Placed With Non-Relatives
	Number of Children Placed (% of county total)	
Region 3E (n=3,520)		
Collin	115 (37%)	194 (63%)
Dallas	966 (39%)	1,532 (61%)
Ellis	21 (34%)	41 (66%)
Fannin	27 (45%)	33 (55%)
Grayson	75 (39%)	116 (61%)
Hunt	63 (32%)	136 (68%)
Kaufman	30 (37%)	51 (63%)
Navarro	9 (21%)	35 (80%)
Rockwall	24 (32%)	52 (68%)
Region 3E Total	**1,330 (38%)**	**2,190 (62%)**
Region 3W (non-CBC) (n=799)		
Cooke	35 (35%)	64 (65%)
Denton	258 (42%)	363 (59%)
Wise	21 (27%)	58 (73%)
Region 3W (non-CBC) Total	**314 (39%)**	**485 (61%)**

First Placement in Substitute Care

In addition to the point-in-time placement data referenced above, DFPS also provides information on where children and youth are placed initially after they are removed. In many cases, an initial placement is intended to be short-term while child welfare professionals look for the most appropriate longer-term placement. However, where a child or youth is initially placed after they have been removed can have long-term implications for their outcomes. There is evidence to suggest that children and youth who are initially placed with relatives are less likely than those initially placed in other settings to experience subsequent placement changes.[72]

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[71] Data were obtained from the Texas Department of Family and Protective Services Data Book, CPS 3.2: Children in Substitute Care by Placement Type on August 31, 2019. Retrieved December 2020, from https://data.texas.gov/w/kgpb-mxxd/7v57-4sdh?cur=eUTLGfBZm0S&from=dxIlVQwTvt2

[72] Wulczyn, F., Chen, L., & Hislop, K.B. (2007). *Foster care dynamics 2000–2005: A report from the Multistate Foster Care Data Archive.* Chicago: Chapin Hall Center for Children at the University of Chicago. https://fcda.chapinhall.org/wp-content/uploads/2013/10/Foster-Care-Dynamics-2000-2005.pdf

As shown in Table 7, across all counties non-relative foster homes are the most common first placement type, but between counties there is notable variation in first placement types. For example, kinship homes range from 7% (Navarro County) to 46% (Ellis County) of first placements. However, these are both small counties and when looking at the larger counties (Collin, Dallas, and Denton), placements with kin average between 24–32% of first placements.

Table 7. First Placement After Removal by County in DFPS Regions 3E and 3W (non-CBC) (FY 2019)[73]

	Emergency Shelter	Family/ Kinship Foster Home	GRO* Basic	Non-Relative Foster Home	Other	RTC	Total
Region 3E							
Collin	21 (9%)	73 (32%)	0 (0%)	96 (42%)	39 (17%)	0 (0%)	229 (100%)
Dallas	160 (11%)	372 (25%)	7 (0%)	750 (50%)	215 (14%)	1 (0%)	1,505 (100%)
Ellis	5 (10%)	22 (46%)	0 (0%)	17 (35%)	3 (6%)	1 (2%)	48 (100%)
Fannin	8 (20%)	10 (25%)	0 (0%)	16 (40%)	6 (15%)	0 (0%)	40 (100%)
Grayson	26 (21%)	26 (21%)	0 (0%)	56 (46%)	14 (11%)	0 (0%)	122 (100%)
Hunt	23 (14%)	21 (14%)	1 (0%)	88 (59%)	14 (9%)	3 (2%)	150 (100%)
Kaufman	11 (21%)	12 (23%)	1 (0%)	24 (45%)	5 (9%)	0 (0%)	53 (100%)
Navarro	2 (7%)	2 (7%)	0 (0%)	15 (50%)	11 (37%)	0 (0%)	30 (100%)
Rockwall	11 (26%)	7 (16%)	0 (0%)	22 (51%)	3 (7%)	0 (0%)	43 (100%)
Total	**267 (12%)**	**545 (25%)**	**9 (<1%)**	**1,084 (49%)**	**310 (14%)**	**5 (0%)**	**2,220 (100%)**
Region 3W							
Cooke	10 (19%)	6 (11%)	0 (0%)	27 (50%)	11 (23%)	0 (0%)	54 (100%)
Denton	55 (12%)	110 (24%)	1 (0%)	217 (48%)	68 (15%)	0 (0%)	451 (100%)
Wise	5 (11%)	5 (11%)	0 (0%)	30 (65%)	6 (13%)	0 (0%)	46 (100%)
Total	**70 (12%)**	**121 (22%)**	**1 (<1%)**	**274 (50%)**	**85 (15%)**	**0 (0%)**	**551 (100%)**

*GRO = General Residential Operation

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[73] Department of Family and Protective Services (2020, April 17). *CPS 3.5 1st children in substitute care first placement type after removal.* Retrieved December 2020, from https://data.texas.gov/Social-Services/CPS-3-5-1st-Children-in-Substitute-Care-First-Plac/inxw-xxif

Children and Youth in Substitute Care by Legal Region and Placement County

There are numerous benefits to placing children and youth in substitute care as close to their home of origin as possible. Proximity to home improves their ability to stay connected with their family of origin and increases the chances that they can maintain other important relationships, remain at their school, and continue to see their healthcare providers. However, as will be discussed later in this report, placing children and youth close to home can be challenging, especially when multiple siblings are involved, when youth are older, or if a child has behavioral or medical complexities.

Among children and youth in substitute care from DFPS Regions 3E and 3W (non-CBC) there are notable differences between how many remain within DFPS Region 3 as a whole versus in their home counties, and differences between specific counties. **The majority of children and youth from DFPS Regions 3W (non-CBC) and 3E are placed within DFPS Region 3, but significantly fewer children and youth are placed in their home county—36% in DFPS Region 3W (non-CBC) and 52% in DFPS Region 3E** (Figure 11).[74]

Figure 1. Placement Distance From County of Origin in DFPS Regions 3W (non-CBC) and 3E (May 2020)
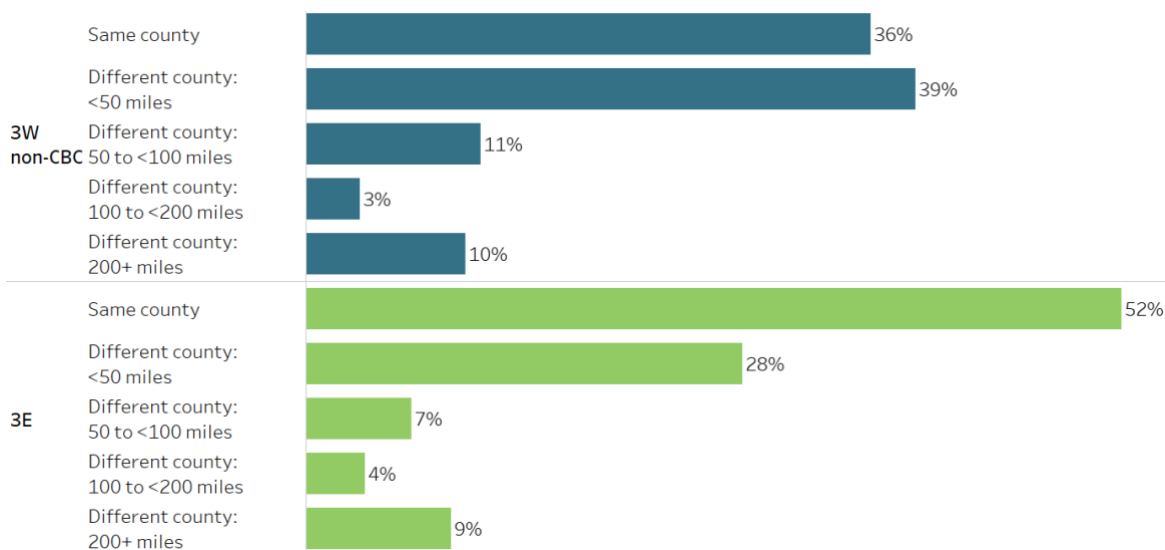
In CBC, a key performance measure is how many children and youth remain **within 50 miles of their home**. DFPS point-in-time data from May 2020 show that 80% of children and youth in substitute care on that date from DFPS Region 3E were placed within 50 miles of their county of origin at that time as well as 75% in DFPS Region 3W (non-CBC). Of these children, more than half (52%) were placed within their home county in DFPS Region 3E whereas only 36% remained within their home county in DFPS Region 3W (non-CBC). **Statewide, 39% of children and youth were placed in their home county.** Further, as Figure 11 shows, 20–25% of children

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[74] Data were obtained from the Texas Department of Family and Protective Services and reflect a point-in-time count of all children in foster care from Region 3 on May 31, 2020.

and youth in substitute care in DFPS Regions 3W (non-CBC) and 3E were placed further than 50 miles from home.[75]

A review of monthly DFPS data from August 2020 showed significant differences in placement distance depending on county population size.[76] As expected, due to fewer placement and foster home options, smaller counties placed children further from home. DFPS data from August 2020 indicates that more than 90% of the children and youth in substitute care from Fannin, Hunt, Kaufman, Rockwall, and Cooke counties were placed outside of the county. During the same time period the largest counties, Collin, Dallas, and Denton, placed at least half of their children and youth in substitute care placements located outside of their respective counties.

Children and Youth Placed In and Out of the Region by Placement Type

Certain placement types correlate with placements out of county and out of region. For example, only 9% of children placed in a private/contracted foster home and 13% of those placed with kin were placed out of region. In contrast, of children and youth from DFPS Region 3, nearly two-thirds (63%) of those placed in an RTC were out of region. Of the 321 children and youth from DFPS Region 3 who were placed in an RTC, 37% (119) were placed within their own region, 37% (120) were placed in DFPS Region 6 (Houston), and 17% (54) were in placed in DFPS Region 7 (Austin). The remaining 9% were scattered between DFPS Regions 4, 5, 8, and 11.[77] Table 8 shows the breakdown of placement types and their location in/out of Region 3.

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[75] The distance between a child's home and substitute care placement is calculated by comparing the geographical midpoint of origin and placement counties. Because children do not reside at the geographic center of a county, this metric is an approximation of placement distance from home.

[76] Texas Department of Family and Protective Services (n.d.). *Children in substitute care placed in/out of legal region by living arrangement category and placement region*. August 2020. Retrieved December 2020, from https://www.dfps.state.tx.us/About_DFPS/Monthly_Data/default.asp

[77] Texas Department of Family and Protective Services (n.d.). *Children in substitute care placed in/out of legal region by living arrangement category and placement region*. August 2020. Retrieved December 2020, from https://www.dfps.state.tx.us/About_DFPS/Monthly_Data/default.asp

Table 8. Number of Children From DFPS Region 3 by Living Arrangement Placed in Region (August 2020)[78]

Children Placed in and Out of the Region by Living Arrangement				
Living Arrangement	**Total Children**	**Placed in Region**	**Placed Out of Region**	**% Placed Out of Region**
DFPS Foster Homes	222	166	56	25%
Private Child Placing Agencies (CPAs) and Independent Homes	2,807	2,568	239	9%
GRO: Child Care Services Only	118	80	38	32%
RTC	321	119	202	63%
Emergency Shelter Services	79	49	30	38%
Other Foster Care	135	87	48	36%
Kinship	1,605	1,392	213	13%
Adoptive Home	85	60	25	29%
Independent Living	2	2	0	0%
Other Substitute Care	122	65	57	47%
All Placements	**5,496**	**4,588**	**908**	**17%**

Siblings in Substitute Care

Placing siblings together is an important quality indicator for CBC as well. For many children and youth in substitute care, the connection and companionship of a sibling, especially one with a shared history, can enhance their well-being, provide natural support, and promote resilience. Separating siblings can add additional grief, loss, and anxiety to the already traumatic consequences of removal.[79] Young adults with lived experience in substitute care interviewed for this assessment indicated being with siblings was their most valued placement goal (See *Chapter 3*). They also shared that, if they were significantly older than their sibling(s), or if their sibling set was big, they knew remaining together was unlikely. This concern is consistent with national data that indicates sibling groups of three or more children are less likely to be placed together than sibling groups that are smaller.[80]

National estimates indicate that two-thirds of children and youth in substitute care have one or more sibling also in care.[81] In examining how many Texas children and youth in substitute care are placed with their siblings, different data sets measure sibling placements differently.

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[78] Texas Department of Family and Protective Services (n.d.). *Children in substitute care placed in/out of legal region by living arrangement category and placement region*. https://www.dfps.state.tx.us/Doing_Business/Regional_Statistics/default.asp

[79] Child Welfare Gateway (2013, January). *Sibling issues in foster care and adoption.* Washington DC: U.S. Department of Health and Human Services, Children's Bureau. https://www.childwelfare.gov/pubpdfs/siblingissues.pdf

[80] Texas Department of Family and Protective Services (2020, May 5). *Siblings placed together, FY 2019*. Data Book. Retrieved December 2020, from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/Placements/Siblings_Placed_Together.asp

[81] Child Welfare Gateway (2013, January). *Sibling issues in foster care and adoption.*

Publicly available data through the DFPS Data Book for August 31, 2020 suggest that about two-thirds of sibling groups in DFPS Region 3 are placed together (Table 9). A review of county-level data related to DFPS Region 3 show that joint sibling placements ranged from 50% in Wise county to 75% in Ellis and Navarro counties in FY 2019.

Table 9. Sibling Groups Placed Together (August 31, 2019)[82]

Substitute Care	3E	3W (non-CBC)	3W (CBC)
Number of Sibling Groups	504	129	260
Percent Placed Together	63%	66%	66%

Across DFPS Region 3, joint sibling placements have gone up and down slightly since 2014. Joint sibling placements peaked in FY 2014 in DFPS Region 3E, whereas were the highest in FY 2019 in DFPS Region 3W (non-CBC). Figure 12 illustrates these variations in more detail.

Figure 2. Sibling Groups Placed Together, Trends Over Time (FY 2010–2019)[83]

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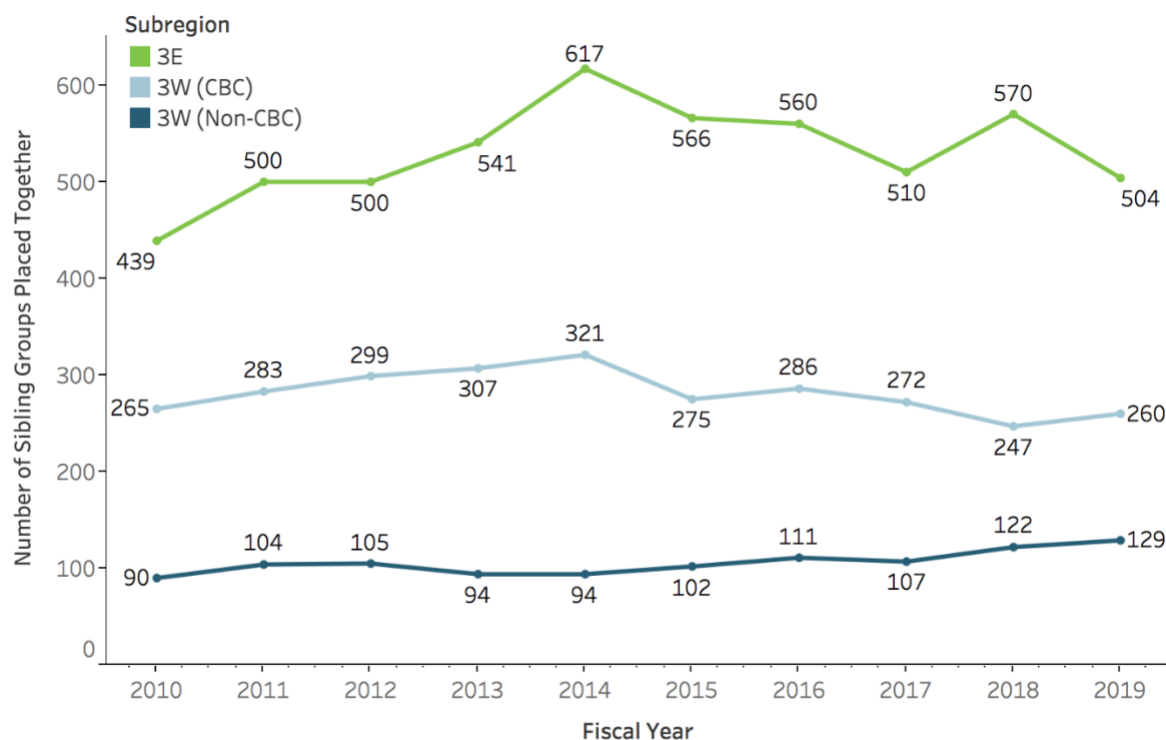
[82] Texas Department of Family and Protective Services Data Book. (2020, May 5). *Siblings placed together, FY 2019*. Data Book Retrieved December 2020, from
https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/Placements/Siblings_Placed_Together.asp
[83] Texas Department of Family and Protective Services Data Book. (2020, May 5). *Siblings placed together, FY 2019*.

Length of Time in Substitute Care

Beyond placement type, distance from home, and placements with siblings, length of time in substitute care and total number of placements are two additional important outcome measures for CBC. In Texas as a whole, and in DFPS Region 3 as a whole, the average number of months children and youth spend in substitute care has varied between 19 and 21 months over the past five years, with those in DFPS Region 3 averaging slightly less time in care than the state average.[84]

Among children and youth in substitute care in DFPS Region 3, and according to point-in-time data from May 31, 2020, the factors most consistently associated with longer substitute care stays include:

- being older at time of removal;
- having an authorized service level beyond "Basic;"
- having two or more placements;
- being in a placement more than 100 miles from their county; and/or
- having a "high need" characteristic.[85]

Children with high needs who originated from DFPS Region 3E had the greatest odds of spending longer in care (compared to children in DFPS Region 3W [non-CBC or CBC]).

Additionally, there are racial and ethnic differences in how long children and youth spend in care with Black children again facing more challenges and disparities. As shown in Table 10, differences in average months of care across different racial and ethnic groups were less significant in DFPS Region 3W (non-CBC); however, across DFPS Region 3 as a whole, Black children and youth averaged more months spent in substitute care than any other racial or ethnic group. As expected, children and youth in older age groups on May 31, 2020 in each county had spent more months in care than younger age groups. A review of annual data in Part 5 of this chapter considers the relationship between exit type and total months spent in substitute care.

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[84] Department of Family and Protective Services (2020, September 20). *Children exiting DFPS legal custody, FY 2019*. Retrieved December 2020, from
https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/Conservatorship/Exits.asp

[85] "High need" includes having an emotional disorder, intellectual disability, pervasive development disorder, or primary medical needs or an "intense," "psychiatric transition," or "specialized" authorized service level.

Table 10. Average Months in Substitute Care, by Current Age, Race/Ethnicity as of May 31, 2020[86]

	Region 3E	Region 3W		Region 3
	non-CBC (n=3,633)	non-CBC (n=841)	CBC (n=1,912)	Total (n=6,386)
	Average Months in Care			
Race/Ethnicity				
Black	20.2	15.2	19.6	19.6
White	16.7	14.4	17.7	16.7
Hispanic	17.9	15.6	17.3	17.5
All Other	16.8	17.3	20.2	18.1
Age Group				
Age 0–5	12.2	12.2	12.2	12.2
Age 6–12	17.9	16.0	16.5	17.2
Age 13–17	23.4	21.2	26.8	26.0
Age 18–20	52.5	38.8	53.4	52.2
Total (all ages)	**18.5**	**15.2**	**18.4**	**18.0**

Number of Placements

Based on point-in-time data from May 31, 2020, across DFPS Regions 3E and 3W (non-CBC), over two-thirds of children in substitute care had experienced just one or two total placements (Figure 13). Placement instability is believed to negatively impact permanency, safety, and well-being of children and youth.[87] In DFPS Regions 3W (non-CBC) and 3E, children who have had four or more (4+) placements were more likely to be older (either currently or at time of removal), had an authorized service level beyond Basic, and/or were Black. Boys and girls were equally likely to have four or more placements. Children with a "high need" characteristic[88] had increased odds of multiple placements in DFPS Regions 3E and 3W (non-CBC).

Figure 3. Number of Placements in DFPS Regions 3E and 3W (non-CBC) (May 2020) [89]

3W non-CBC	1 placement (37%)	2 placements (33%)	3 placements (13%)	4+ placements (17%)
3E	1 placement (38%)	2 placements (29%)	3 placements (14%)	4+ placements (20%)

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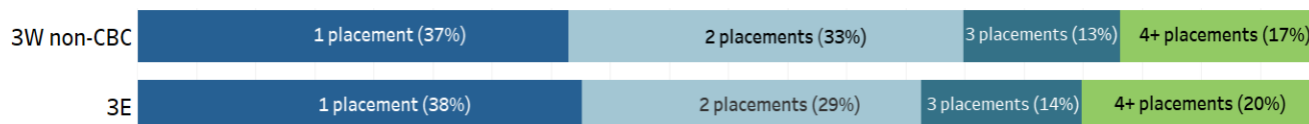
[86] Data were obtained from the Texas Department of Family and Protective Services and reflect a point-in-time count of all children in foster care from Region 3 on May 31, 2020.

[87] Casey Family Programs. (2018). *Strategy brief: Strong families*. https://caseyfamilypro-wpengine.netdna-ssl.com/media/SF_Placement-stability-impacts.pdf

[88] "High need" includes having an emotional disorder, intellectual disability, pervasive development disorder, or primary medical needs or an "Intense," "psychiatric transition," or "Specialized" ASL.

[89] Data were obtained from the Texas Department of Family and Protective Services and reflect a point-in-time count of all children in foster care from DFPS Region 3 on May 31, 2020.

Exits From Substitute Care

Children and youth exit substitute care for many different reasons. Exits to reunify with their birth family, to relatives, or to an adoptive home are considered positive. In other cases, youth age out of foster care or run away. These are considered negative exits because they entail more instability which, in turn, increases a young adult's risk of homelessness, unemployment, and unintended pregnancy.[90] Nationally and in Texas, about half of children and youth who enter substitute care after a removal eventually reunify with their biological parents.[91] See Figure 14 below for the breakdown of exits from substitute care in DFPS Regions 3E and 3W (non-CBC).

Figure 4. Number of Exits by Exit Type in DFPS Regions 3E and 3W (non-CBC) (FY 2019)[92]

3W Non-CBC		
Custody to Relatives with PCA	12	2%
Custody to Relatives without PCA	123	25%
Family Reunification	185	37%
Non-Relative Adoption Consummated	76	15%
Relative Adoption Consummated	65	13%
Youth Emancipation	25	5%
Other	13	3%

3E		
Custody to Relatives with PCA	193	7%
Custody to Relatives without PCA	799	30%
Family Reunification	956	36%
Non-Relative Adoption Consummated	330	12%
Relative Adoption Consummated	256	10%
Youth Emancipation	129	5%
Other	29	1%

PCA = Permanency Care Assistance, which provides financial support to kinship caregivers when reunification or adoption is not possible.

In 2019, 35% of children exiting DFPS custody in DFPS Region 3E and 37% of children in DFPS Region 3W (non-CBC) were reunited with their families, and another 37% and 27%, respectively, were in the custody of relatives. In both Region 3E and Region 3W (non-CBC), the proportion of children who exit substitute care to be reunited with their families has increased. In DFPS Region 3E, the proportion of children who exit to the custody of relatives (with Permanency Care Assistance) or who exit to other placements decreased. All other placement types remained steady over time. (Figures 15 and 16)

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[90] Rosenberg, R. & Abott, S. (2019, June 3). *Supporting older youth beyond age 18: Examining data and trends in extended foster care.* Child Trends. https://www.childtrends.org/publications/supporting-older-youth-beyond-age-18-examining-data-and-trends-in-extended-foster-care

[91] The Annie E. Casey Foundation (2020). *Children exiting foster care by exit reason in the United States.* KIDS COUNT Data Center. https://datacenter.kidscount.org/data/tables/6277-children-exiting-foster-care-by-exit-reason

[92] Texas Department of Family and Protective Services. (2020). *Exits from DFPS custody by exit type, FY2010–2019.* Retrieved December 2020, from https://data.texas.gov/Social-Services/CPS-2-8-Exits-from-DFPS-Custody-by-Exit-Type-Avg-P/k3di-36u5/data

Figure 5. Children Exiting DFPS Legal Custody in Region 3W (non-CBC), by Exit Type (FY 2015–2019)[93]
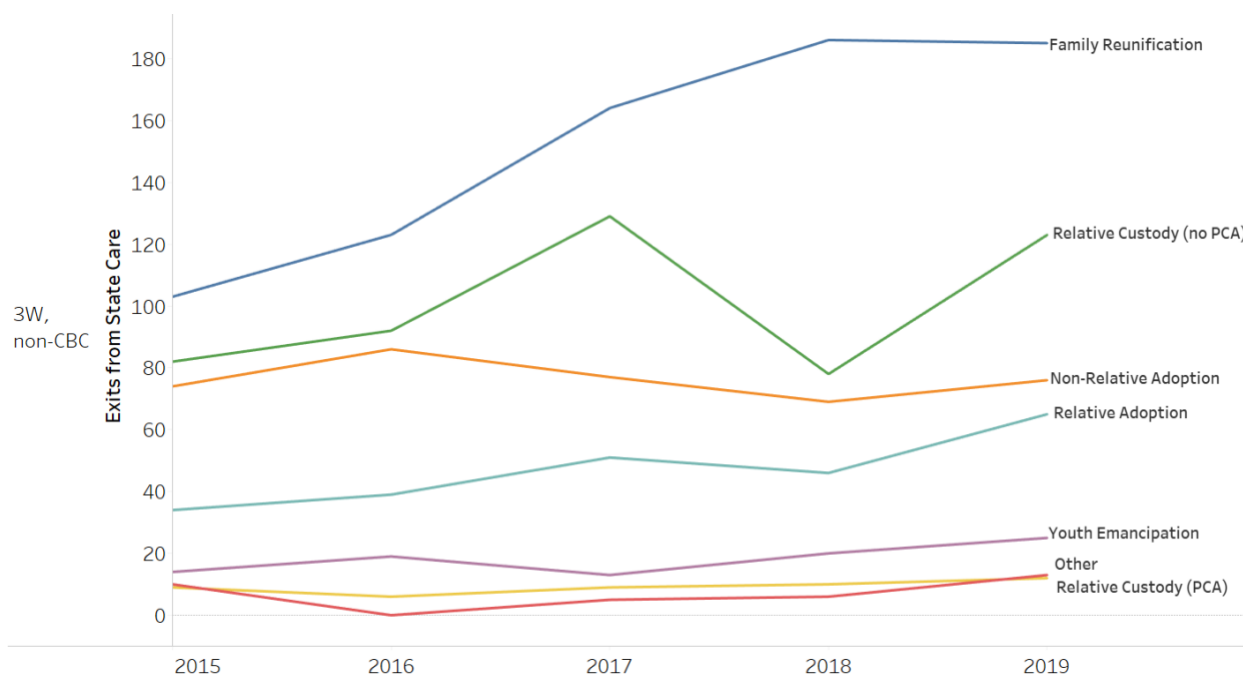
Figure 6. Children Exiting DFPS Legal Custody in Region 3E, by Exit Type (FY 2015–2019)[94]
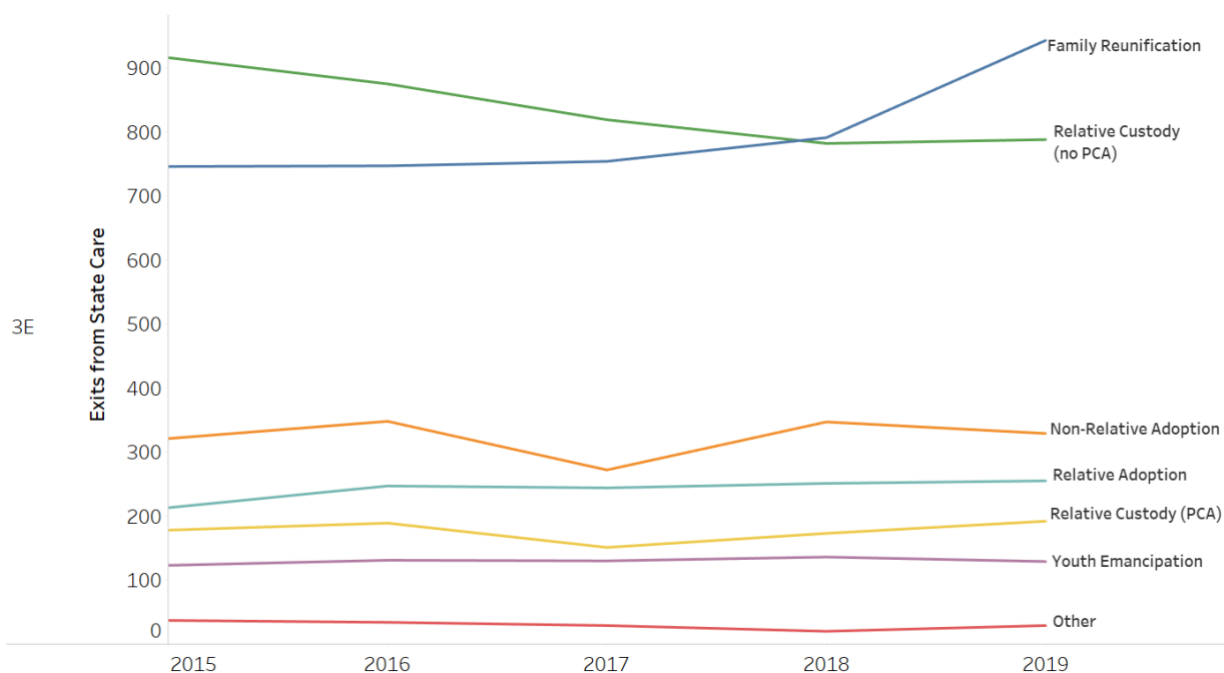
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[93] Texas Department of Family and Protective Services (2020). *Children exiting DFPS legal custody for FY2015–2019*. Retrieved December 2020, from https://data.texas.gov/Social-Services/CPS-2-8-Exits-from-DFPS-Custody-by-Exit-Type-Avg-P/k3di-36u5/data

[94] Texas Department of Family and Protective Services. (2020). *Children exiting DFPS legal custody for FY 2015–2019.* Retrieved December 2020, from https://data.texas.gov/Social-Services/CPS-2-8-Exits-from-DFPS-Custody-by-Exit-Type-Avg-P/k3di-36u5/data

Part 5 – Anticipated Needs for Children and Youth in Substitute Care

In this section, we examine the available datasets to better understand the individual needs of children and youth in substitute care. In subsequent report chapters, we will expand on these needs by analyzing them and integrating them with the findings from our qualitative research with key child welfare stakeholders in Texas and within DFPS Region 3 that informs this needs assessment.

Authorized Service Levels (ASLs)

This section describes different levels of documented need among children and youth in substitute care, the limitations and changes to the current assessment system, and a general overview of which children and youth have been identified by DFPS as having higher needs. The primary source of this information is based on data on authorized service levels (ASLs). All children and youth who enter substitute are assigned an ASL based on observations and information on their behaviors and needs. An ASL is intended to determine the type of placement that would best match a child's characteristics and service needs. The Texas service level system includes four ASLs—Basic, Moderate, Specialized, and Intense (including Intensive-Plus). A CPS caseworker or supervisor can assign a child or youth to a Basic service level. A third-party assessment by Youth for Tomorrow, a behavioral healthcare company contracted by DFPS to do quality assurance and utilization management reviews, is required to assign a child to a higher ASL.

When children and youth enter substitute care, most are assigned to the Basic service level, regardless of the reason they were removed. They can be placed into higher services levels once their level of need is assessed further or their needs change. We have provided additional details and definitions of ASLs in *Supplement 1A* at the end of this chapter. While ASL data can be used as a broad indicator of aggregate levels of needs, the information should be interpreted with caution. Many North Texas experts note instances of complex needs among children and youth assigned the Basic service level. There are understandable reasons why a child may be assigned to an ASL that underrepresents their needs, especially if they are new to substitute care. **However, as a result of this issue, child welfare system stakeholders must assume that the actual needs of children and youth are higher than indicated through the lens of ASLs alone**. Furthermore, DFPS no longer utilizes the ASL system for children who are removed from regions of the state implementing CBC. Thus, those planning and implementing CBC must find other ways to monitor individual and aggregate needs as they transition to CBC. A broader perspective of the behavioral health needs of children and youth in substitute care in DFPS Regions 3E and 3W (non-CBC) is discussed in *Chapter 4: Mental Health*.

Children and Youth by ASL

DFPS August 2020 data for DFPS Region 3 show that the majority of children and youth (75%) were assigned to a Basic ASL (they were assessed as requiring a minimum amount of support to

maintain or improve their level of functioning).[95] At the same time, 22% were identified as having behaviors, developmental delays, or health issues that required a Moderate or higher ASL (Table 11). However, some of these numbers should be viewed with caution. ASL data are only available for a full DFPS region. Since CBC does not use the ASL system, all children and youth from DFPS Region 3W (CBC) are likely to have been coded as "Basic" in this dataset, which would inflate the proportion of children and youth with a Basic ASL.

Table 11. Breakdown by ASL in DFPS Region 3 (August 31, 2020)[96]

Population	All Service Levels	Authorized Service Level				
		Basic	Moderate	Specialized	Intense	TFFC*
Children and Youth (0–17 years)	3,552	2,647 (75%)	339 (10%)	320 (9%)	84 (2%)	26 (1%)

*TFFC = Treatment Foster Family Care

A breakdown of ASL by age (Figure 17) shows that older children and youth are more likely to be assigned to a higher ASL. For example, while 92% of children ages 0–2 and 85% of children ages 3–5 were at a Basic ASL, 54% of youth ages 14–17 were at a Basic ASL and the remainder at a higher level.

Figure 7. ASL by Age in DFPS Region 3 (August 31, 2020) [97,98]
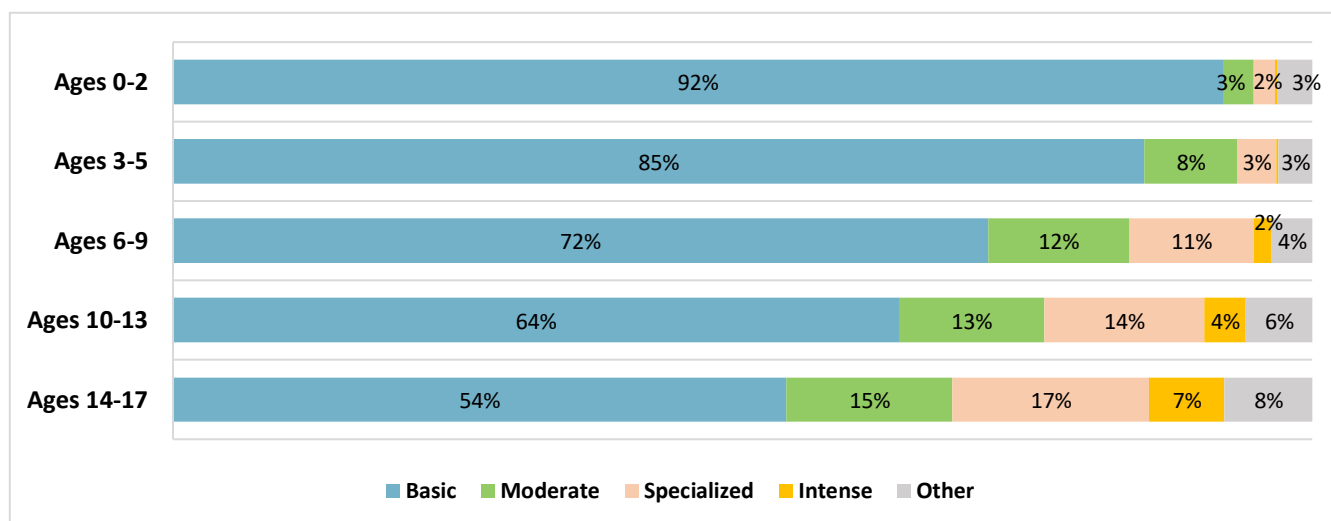
[95] Texas Department of Family and Protective Services (n.d.). *Regional demographics of children in foster care by authorized service level for children age 0–17, FY 2019*. Retrieved December 2020, from: https://www.dfps.state.tx.us/Doing_Business/Regional_Statistics/default.asp

[96] Texas Department of Family and Protective Services (n.d.). *Regional statistics about children in DFPS care*. Retrieved December 2020, from: https://www.dfps.state.tx.us/About_DFPS/Monthly_Data/default.asp

[97] "Other" service levels include Treatment Foster Family Care, Intense Plus, and blank entries. As of August 2020, a very small number of children and youth (26) were in Treatment Foster Family Care.

[98] Texas Department of Family and Protective Services (n.d.). *Regional demographics of children in foster care by Authorized Service Level for children Age 0–17, FY 2019*. Retrieved December 2020, from https://www.dfps.state.tx.us/About_DFPS/Monthly_Data/default.asp

There are also racial/ethnic differences in the percentage of children and youth assigned to the Basic ASL vs. higher ASLs. As shown in Figure 18, more Black children and youth were assigned to an ASL higher than Basic compared to children from any other racial or ethnic group. In contrast, the distribution of ASLs among White and Hispanic children and youth were almost exactly equal.

Figure 18. ASL by Race/Ethnicity in DFPS Region 3 (August 2020)[99,100]
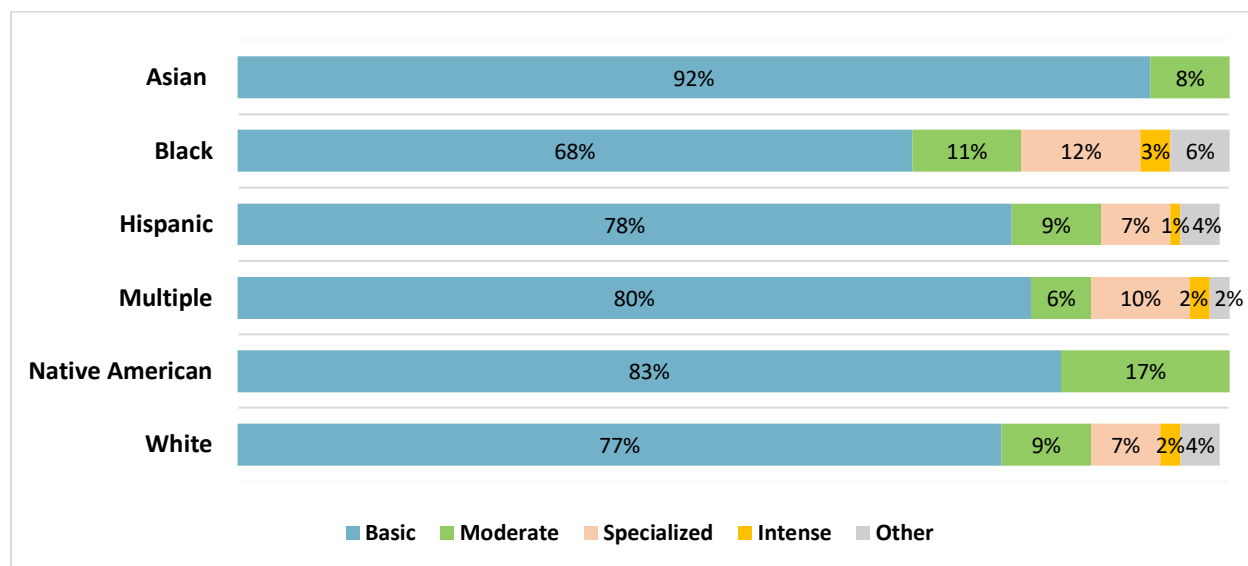
Part 6 – Substitute Care Outcomes for DFPS Region 3

This section highlights recent trends in DFPS Region 3 related to some of the most significant outcomes for children and youth in substitute care. It is notable that both a child's age at removal as well as their identified ASL or needs are associated with key outcomes. While the information presented in this section highlights certain correlations, our analysis does not delve into causes. We have considered the following outcomes in this section:

- placement distance;
- placement type;
- length of time in care;
- number of placements; and
- permanency trends.

The section concludes with a high-level snapshot of permanency outcomes by county.

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[99] "Other" service levels include Treatment Foster Family Care, Intense Plus, and blank entries. As of August 2020, a very small number of children and youth (26) were in Treatment Foster Family Care, 13 of whom were Black.

[100] Texas Department of Family and Protective Services (n.d.). *Regional demographics of children in foster care by Authorized Service Level for children Age 0–17, FY 2019*. Retrieved December 2020, from https://www.dfps.state.tx.us/About_DFPS/Monthly_Data/default.asp

Placement Distance

The factors most consistently associated with being placed out-of-county among children and youth in substitute care in DFPS Region 3 include being older at time of removal, having a higher ASL (beyond Basic), and having more than two total placements. Children and youth from more rural counties were also more likely to be placed out of county. Given these trends, CBC planners should consider implementing targeted strategies to develop localized capacity for children and youth with these characteristics.

Placement With Relatives

DFPS data show that, across DFPS Region 3, children and youth placed with relatives had spent about half as many days on average in substitute care as those in other placement types (356 days vs. 607 days) as of May 31, 2020. In DFPS Region 3W (non-CBC), the number of children and youth placed with relatives/kin increased between FY 2015 and FY 2018, then declined slightly in FY 2019. **However, in DFPS Region 3E, despite annual fluctuations, the portion of children and youth placed with kin has not increased overall since 2014.** A review of relative placements on August 31, 2019 showed county-level variation in placements with relatives within DFPS Region 3. While under 30% of children and youth were placed with relatives in Navarro county (21%) and in Wise county (27%), over 40% were placed with relatives in Denton county (42%) and in Fannin county (45%). On the same day, an average of 38% of all children in substitute care across Texas were placed with relatives.

Length of Time in Care

The factors most consistently associated with longer substitute care stays among children and youth in DFPS Region 3 include being older at time of removal, having a higher ASL (beyond Basic), having two or more placements, being in a placement more than 100 miles from their county of origin/home, and having a "high need" [101] characteristic as determined by their caseworker. Children with a "high need" designation who originated from DFPS Region 3E had the greatest odds of spending longer in care (compared to children across DFPS Region 3W). Additionally, as shown in Figure 19, White children and youth spent less time in substitute care than other racial/ethnic groups in the area. Notably, Black children and youth from DFPS Region 3E had been in substitute care for the most time (20 months). Figure 20 shows how many months on average children and youth had spent in substitute care as of May 31, 2020 broken down by age.

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[101] "High need" involves having an emotional disorder, intellectual disability, pervasive development disorder, or primary medical needs, or an "Intense," "psychiatric transition," or "Specialized" ASL.

Figure 19. Average Months in Substitute Care by Race/Ethnicity and DFPS Region 3 Subregion (May 2020)[102]

	Race/Ethnicity	Months
3W non-CBC	Black	15
	Hispanic	16
	White	14
	Other	17
3W CBC	Black	20
	Hispanic	17
	White	18
	Other	20
3E	Black	20
	Hispanic	18
	White	17
	Other	17
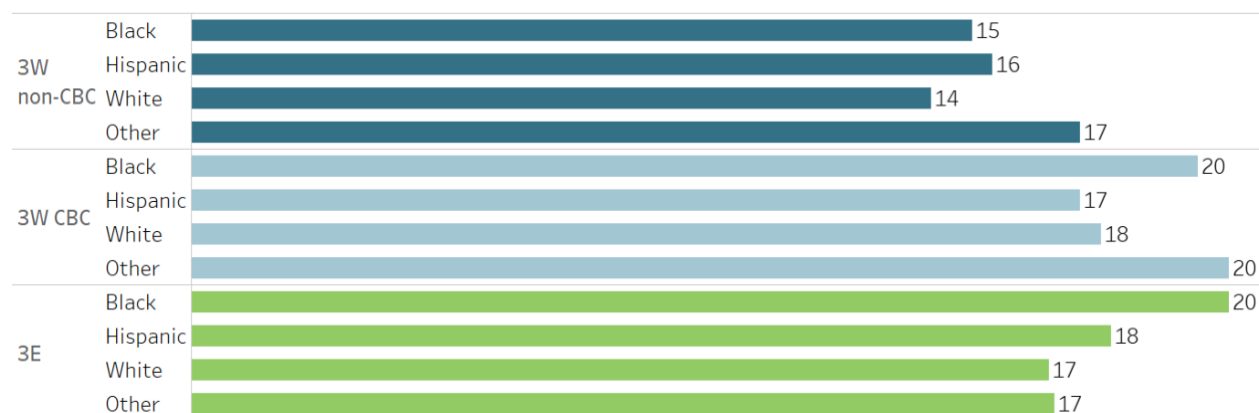
Figure 20. Average Months in Substitute Care by Age and DFPS Region 3 Subregion (May 2020)[103]

	Age	Months
3W non-CBC	Age 0-5	12
	Age 6-12	16
	Age 13-17	21
	Age 18-20	39
3W CBC	Age 0-5	12
	Age 6-12	17
	Age 13-17	27
	Age 18-20	53
3E	Age 0-5	12
	Age 6-12	18
	Age 13-17	23
	Age 18-20	53
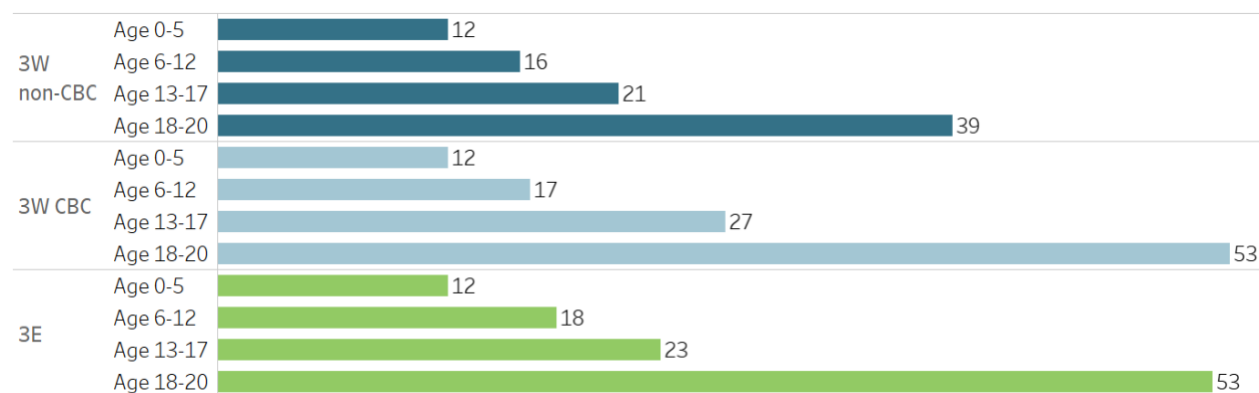
Number of Placements

The factors most consistently associated with an increased number of substitute care placements among children and youth from DFPS Region 3 include being older at time of removal, having an ASL beyond Basic, and being placed outside of the home county. In FY 2019, children and youth exiting care statewide and in DFPS Region 3 had 2.3 placements on average. Children and youth exiting substitute care from most counties within DFPS Regions 3E and 3W (non-CBC) experienced close to that statewide, ranging from 2.0 placements for those from Denton County to 3.2 placements for those from Fannin County.

Looking at point-in-time data from May 31, 2020, 66% of children in substitute care on that date were on their first or second placement, but more adolescents (ages 13–20 years) were on

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[102] Data were obtained from the Texas Department of Family and Protective Services and reflect a point-in-time count of all children and youth in foster care from Region 3 on May 31, 2020.

[103] Statistical tests for differences in time spent in care by age group were conducted using the Kruskal-Wallis H test. Data were obtained from the Texas Department of Family and Protective Services and reflect a point-in-time count of all children in foster care from Region 3 on May 31, 2020.

a third or higher placement. **In general, the older a child in substitute care is, the more placements they are likely to have experienced.** In DFPS Region 3E, Black children in general also experienced more placements than children in other racial/ethnic groups. Additionally, children with a "high need" characteristic in DFPS Regions 3E and 3W (non-CBC) had increased odds of multiple placements.

The type of placement is also tied to average length of time spent in substitute care as well as to the number of placements a child has had thus far. As shown in Table 12, youth who aged out of substitute care (i.e., were emancipated) had spent more time in care on average than any other group. They also had experienced more placements than any other group in care. These data also show that children and youth who ended up reunifying with their families had spent the least amount of time in substitute care and experienced fewer placement changes than other groups. The implications of these trends are discussed in *Chapter 2: Substitute Care Capacity.*

Table 12. Average Months in Care and Average Number of Placements by Exit Type and DFPS Region 3 Subregion (FY 2019)[104]

Exit Type	3E (n=2,692)		3W non-CBC (n=499)		3W CBC (n=1,106)	
	Average Months in Care	Average Placements	Average Months in Care	Average Placements	Average Months in Care	Average Placements
Family Reunification	12.3	1.8	12.5	1.5	15.0	2.1
Custody to Relatives With PCA*	28.6	2.2	22.3	2.5	26.7	2.6
Custody to Relatives Without PCA	13.0	1.9	14.6	2.3	16.1	2.4
Non-Relative Adoption	26.7	2.6	28.9	2.5	25.6	2.8
Relative Adoption	25.6	2.2	23.0	2.0	23.2	2.4
Youth Emancipation	40.8	5.7	30.9	5.5	43.3	6.8
Other	5.9	1.4	9.2	1.0	20.7	2.3

*PCA = Permanency Care Assistance (funding)

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[104] Texas Department of Family and Protective Services. (2020). *Exits from DFPS custody by exit type, avg placements, and avg months in care FY2010–2019.* Retrieved December 2020, from https://data.texas.gov/Social-Services/CPS-2-8-Exits-from-DFPS-Custody-by-Exit-Type-Avg-P/k3di-36u5

Permanency Trends

In DFPS Regions 3W (non-CBC) and 3E, most exit trends have remained steady since FY 2015 with the following two exceptions. In DFPS Region 3W (non-CBC), the portion of children who exited substitute care to be reunited with their families has increased since FY 2015. In DFPS Region 3E, the proportion of children who exited to the custody of relatives (with Permanency Care Assistance [PCA] funding) or who exited to other placements has decreased.

A review of the FY 2019 permanency outcomes[105] for children and youth in care in DFPS Regions 3W (non-CBC) and 3E indicate that:

- Permanency outcomes vary by county.
- A majority of the counties, with a few exceptions, are able to reunify families within 12–18 months.
- Time in substitute care varies for youth who emancipate (age out)—they are in care anywhere from 2–5 years, depending on the county, and they have longer average stays in care and more placements overall.

While regional trends are simplest to track and will be used most widely for CBC planning and implementation purposes, there are significant differences in county population and in child welfare trends among the 12 counties included in DFPS Regions 3W (non-CBC) and 3E. To highlight some of these differences, additional information on permanency trends by county is provided below.[106]

DFPS Region 3E Counties

Collin County

The majority of children and youth exit care through reunification. This is followed by custody to relatives without PCA and non-relative adoptions. Family reunification takes slightly more than a year (13.2 months) in Collin County. Youth who emancipate have 6.5 placements on average and spend an average of almost 4 years (47.4 months) in care.

Dallas County

The majority of children and youth are reunified with their families or exit to custody with relatives without PCA. It takes on average slightly less than a year (11.8 months) to reunify a child with their family. Youth who emancipate have experienced an average of 5.6 placements and spent a little over three-and-a-half years (42.5 months) in care.

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[105] Department of Family and Protective Services. (2020, April 20). *DFPS custody by exit type, average # of placements, and average months in care FY2010–2019.* Retrieved December 2020, from https://data.texas.gov/Social-Services/CPS-2-8-Exits-from-DFPS-Custody-by-Exit-Type-Avg-P/k3di-36u5

[106] Department of Family and Protective Services. (2020, April 20). *DFPS custody by exit type, average # of placements, and average months in care FY2010–2019.*

Ellis County

Equal numbers of youth exit from care to a relative without PCA or through a non-relative adoption. This is followed by a relative adoption. On average, children and youth in Ellis County are reunified in a little more than 9 months. Youth who emancipate from care have had an average of 5 placements and were in care an average of almost 5 years (57.7 months).

Fannin County

The largest number of children and youth in Fannin County exit care through family reunification, followed by non-relative adoption. It takes an average of almost 2 years (21.1 months) for a child or youth to be reunified in Fannin County. Youth who emancipate from care have had an average of 7.3 placements and were in care an average of 2 years (24.1 months).

Grayson County

Almost equal numbers of children and youth exit to relatives without PCA or are reunified with their families. Time to reunification in Grayson County is a little over a year (12.8 months). Youth who emancipate from care have had an average of seven (7) placements and spent a little more than three years (38.1 months) in care.

Hunt County

Slightly more children and youth are reunified with their families than exit to relatives without PCA. It takes a child or youth from Hunt County one year (11.8 months) on average to be reunified with family. Youth who emancipate from care have experienced 5.9 placements on average and spent an average of two years (23.3 months) in care.

Kaufman County

The majority of youth exit care through relative adoptions followed by non-relative adoptions. Family reunification can take an average of a year-and-a-half (16.6 months) in Kaufman County. On average, youth who emancipate from care have had only two (2) placements and were in care just over two-and-a-half years (32.5 months).

Navarro County

The majority of children and youth exit care to family reunification or through a relative adoption. The average length of time it takes for a child or youth to return home is a little over two years (26.8 months). Youth who are emancipated have had an average of five (5) placements and spent an average of almost two-and-a-half years (29.4 months) in care.

Rockwall County

A slight majority of children and youth exit care through family reunification. This is followed by custody to relatives without PCA. The average time for a child or youth to be reunified in

Rockwall County is just over a year (13 months). No youth from Rockwall County emancipated from substitute care in the year covered in the dataset.

DFPS Region 3W (non-CBC) Counties

Cooke County

The majority of children and youth are reunified with their families or custody is granted to a relative without PCA. The average time for a child or youth to be reunified with their family is slightly over a year (12.8 months). Youth who emancipate from care have experienced an average of four (4) placements and were in care of a little less than two years (21.2 months).

Denton County

The largest number of children and youth exit care through family reunification or to relatives without PCA. Family reunification in Denton County takes an average of one year (12 months). Youth who emancipate from care have had an average of 6.1 placements and spent an average of almost three years (34.5 months) in care.

Wise County

The majority of children and youth from Wise County are reunified with their families or custody is granted to relatives without PCA. Family reunification takes on average a little less than a year-and-a-half (16.7 months). Youth who emancipate from care have experienced an average of 5.5 placements and were in care an average of two-and-a-half years (30.7 months).

These county comparisons show similarities and differences in outcomes for children and youth in substitute care from DFPS Regions 3W (non-CBC) and 3E. In most cases children and youth exited substitute care through reunification with their family, custody with a relative without PCA, or a non-relative adoption. Of children and youth who reunified with their families, there was significant variation in how long they spent in substitute care on average, ranging from nine (9) months (Ellis County) to 26.8 months (Navarro County). Similarly, the number of placements and total time spent in care for youth who aged out of substitute care (were emancipated) from DFPS Regions 3W (non-CBC) and 3E varied greatly by county.[107] For example, youth who aged out of substitute care from Kaufman county averaged 2 placements whereas youth who aged out of substitute care from Fannin county averaged just over 7 placements. The average time spent in substitute care for youth who emancipated from substitute care ranged from 21 months (Cooke County) to 57.7 months (Ellis County).

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[107] Note: In some counties, the total number of cases was very small; thus, individual cases more heavily influenced the averages.

Conclusion

The datasets and other research we referenced for this chapter can inform the creation of CBC performance benchmarks and support progress tracking by those involved in implementing CBC and their community partners. The metrics we have discussed align with many of the CBC guiding principles[108] established by the Texas Legislature and DFPS. There is broad consensus on overarching goals of CBC, such as keeping children and youth in substitute care in their home communities, minimizing placement disruptions, ensuring siblings are together, and placements with kin. However, enabling case-based flexibility remains critical. In some instances, system goals may be at odds with the decisions a community or provider makes and strategies that reflect the best interests of a child or family. For example, a placement with a trusted relative may require relocation away from the child's home community. In other cases, a placement change may be a reflection of moving the child or youth to a setting that is more ideal for them. These nuances stress the importance of communities working together to envision their child welfare system and designing and establishing processes that address overall system outcomes while also maintaining support for case-specific flexibilities.

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[108] Available at: https://www.dfps.state.tx.us/Child_Protection/Foster_Care/Community-Based_Care/default.asp

Supplement 1A: Overview of Authorized Service Levels (ASLs)

All children and youth who enter DFPS care are assigned an Authorized Service Level (ASL).[109] ASLs are assigned based on their behaviors and needs, which is why they we have used them as a general indicator of aggregate levels of need. An ASL determines the type of placement that would be best matched to a child's characteristics and service needs. The Texas service level system includes four ASLs – Basic, Moderate, Specialized, and Intense (including Intensive-Plus). A Child Protective Service (CPS) caseworker or supervisor can assign a child or youth to a Basic ASL. A third-party assessment by Youth for Tomorrow, a behavioral healthcare company contracted by DFPS to do quality assurance and utilization management reviews, is required to assign a child to a higher ASL. YFT also conducts regular reviews of assigned ASLs. When children and youth enter foster care, most are assigned to the Basic service level, regardless of the reason they were removed. They can be placed in higher service levels once their level of need is assessed or their needs change. Table 13 below summarizes each ASL and its placement implications.

Table 13. ASL Definitions and Considerations[110]

ASL	Child/Youth Behaviors and Needs	Appropriate Living Situation
Basic	• Capable of responding to limit setting or minimal interventions. • May experience temporary difficulties or misbehaviors, brief acting out as a response to stress, or mild-to-moderate developmental delays.	Supportive services in a family setting designed to maintain or improve the child's functioning.
Moderate	• Participates in nonviolent antisocial acts, is occasionally physically aggressive, uses substances, or is considered a moderate risk to self or others. • Experiences substantial developmental delays or primary medical needs that require some daily assistance or intervention.	Supportive services in a family setting designed to maintain or improve the child's functioning.
Specialized	• May include unpredictable or frequent nonviolent antisocial acts and physical aggression, social isolation or withdrawal, suicide attempts or major self-injurious behaviors, a diagnosis of substance abuse, or severe developmental delays.	Requires intensive services and supports from caregivers with specialized therapeutic, habilitative, or medical training.
Intense	• Behaviors, developmental delays, or primary care needs that require a high degree of structure because of an imminent risk of danger to self or others.	Requires intensive services and supports from caregivers with specialized therapeutic, habilitative, or medical training.

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[109] Texas Department of Family and Protective Services, Child Protective Services. (2018, January). *Texas service level resource guide*. http://www.dfps.state.tx.us/handbooks/CPS/Resource_Guides/Texas_Service_Levels_Resource_Guide.pdf

[110] Texas Department of Family and Protective Services, Child Protective Services. (2018, January). *Texas service level resource guide.*

ASL	Child/Youth Behaviors and Needs	Appropriate Living Situation
Psychiatric Transition	• At least one psychiatric hospitalization in the preceding 12 months, is being discharged from a psychiatric hospital, is at imminent risk of a subsequent psychiatric hospitalization, or is in crisis and in need of acute stabilization.	Requires short-term mental health treatment and placement at the time of release from a psychiatric hospital or as an alternative to a psychiatric hospital.

Chapter 2: Substitute Care Capacity

Contents

Introduction

Community-Based Care (CBC) allows the Single Source Continuum Contractor (SSCC) and the community flexibility to develop innovative services and supports that reflect local strengths and draw upon local resources. CBC's success requires the SSCC to have access to a full array of substitute care placement and service options. At the foundation, there should be a robust, sustainable continuum of community-based services that improves the well-being of children and youth by keeping them connected to their siblings, schools, homes, and communities.[111] The ultimate goal of this continuum is to improve permanency outcomes, decrease the number of days children and youth spend in substitute care, and reunite children and youth with their families or lead to placement with a permanent and loving adoptive home, preferably with a relative.

This chapter focuses on the current and future capacity of the substitute care system across the counties in DFPS Regions 3W (non-CBC) and 3E to meet the needs of all children and youth in care. The chapter is divided into three parts:

- **Part 1** describes substitute care settings, provides an overview of the number of foster care placements in DFPS Regions 3W (non-CBC) and 3E and addresses the key considerations that affect substitute care capacity.
- **Part 2** focuses on the current and forecasted capacity needs for children and youth in substitute care in DFPS Regions 3W (non-CBC) and 3E (formerly identified as DFPS catchments 3A and 3C),[112,113].
- **Part 3** summarizes key findings and recommendations for CBC planning based on data collected and analyzed for this report.

The information used to inform these findings comes from the following data sources:

- DFPS 2019 and 2020 Foster Care Needs Assessments and DFPS Data Book
- Regional Data on placements from the DFPS Data Warehouse from August 2020
- The Meadows Institute spring 2020 survey of Child Placing Agencies (CPAs) operating within DFPS Regions 3W (non-CBC) and 3E and key informant interviews with community stakeholders, both administered specifically for this environmental assessment. We reviewed survey responses and confirmed them for accuracy during the informant interviews. See *Supplement 2B* at the end of this chapter for further information on our CPA survey approach and responses.

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[111] Texas Department of Family and Protective Services. (2019, December). *Implementation plan for the Texas Community-Based Care System*. https://www.dfps.state.tx.us/Child_Protection/Foster_Care/Community-Based_Care/documents/2019-12-20_Community-Based_Care_Implementation_Plan.pdf

[112] DFPS catchment 3A includes Collin, Cooke, Denton, Fannin, Grayson, Hunt, and Wise counties; catchment 3C includes Rockwall, Dallas, Ellis, Kaufman, and Navarro counties. Together, these catchments comprise the counties now designated as DFPS Region 3W (non-CBC) and Region 3E, though split up differently.

[113] Catchments or counties are used in Part 2 of this chapter to align with the data presented in the 2019 and 2020 DFPS Foster Care Needs Assessments.

Part 1 – Substitute Care Placement Capacity in DFPS Regions 3W (non-CBC) and 3E

The express goal of substitute care is to place children and youth in a safe family setting close to home until they can be reunited with their family or achieve permanency through adoption or permanent placement with a relative.[114] When a child or youth enters substitute care, the first placement choice is with relatives (a kinship placement). When placement with a relative is not possible, children and youth are placed in a foster home that is in the closet possible proximity to their home of origin. Children and youth with complex needs (medical or behavioral) who require a higher level of care should be placed in a setting that best meets these needs in the least restrictive way possible. **Ideally, community substitute care capacity should maximize kinship or relative placements, maintain non-relative foster care capacity for times when a relative placement is not possible, and include an array of services and supports that meet the varied needs of the children and youth in care and their foster and relative caregivers.**

The goal of this section is to identify current substitute care capacity in DFPS Regions 3W (non-CBC) and 3E, and to describe core attributes necessary for building substitute care capacity that meets the needs of **all** children and youth who need placement. Additionally, using available data from DFPS, our CPA survey, and insights from local experts, we describe capacity needs and challenges identified in DFPS Regions 3W (non-CBC) and 3E.

Overview of Local Substitute Care Capacity

At the time of this environmental assessment, DFPS Regions 3W (non-CBC) and 3E are served by 44 CPAs with at least one foster home licensed by the state.[115] Dallas County is home to approximately 70% of the CPAs in DFPS Regions 3W (non-CBC) and 3E with 1,139 licensed foster homes. Table 14 shows the total number of CPAs and licensed homes in DFPS Regions 3W (non-CBC) and 3E. The four largest CPAs in the region are: CK Family Services, Lonestar Social Services, Buckner Baptist Children's Homes, and Refugee House.

Table 14. CPAs and Licensed Foster Homes in DFPS Regions 3W (Non-CBC) and 3E (July 2020)[116]

DFPS Region	Number of CPAs	Number of Licensed Homes
Region 3W (non-CBC)	3	90
Region 3E	41	1,596

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[114] Department of Family and Protective Services (2020, November). *Foster care needs assessment.* https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/CPS/documents/2020/2020-11-19_Foster_Care_Needs_Assessment.pdf

[115] Licensing is granted through by the Child Care Regulation (CCR) Division at the Texas Health and Human Services Commission (HHSC).

[116] Department of Family and Protective Services. (n.d.). *Search for child placing agencies for foster care*. https://www.dfps.state.tx.us/child_care/search_texas_child_care/ppfacilitysearchfoster.asp

To augment licensed foster home capacity, DFPS Regions 3W (non-CBC) and 3E also have 24 facilities licensed as General Residential Operations (GROs), settings that provide some type of group foster care. Table 15 summarizes the licensed services available via these GROs.

Table 15. DFPS Regions 3W (Non-CBC) and 3E Licensed General Residential Operation (GRO) Capacity (July 2020)[117]

Licensed Services	# of GROs	Licensed Bed Capacity
Residential Treatment Center (RTC)	9	201
Multiple Services (With RTC)	3	93
Emergency Care Services	3	84
Multiple Services (no RTC) – Emergency Services, GRO, Transitional Living Services	9	167
All Licensed Services	**24**	**545**

The total number of licensed foster homes and bed capacity among local GROs does not fully reflect a region's capacity to place children and youth; actual capacity is often less. Most foster homes and GROs are licensed for a certain number of children and youth across various age ranges and service levels. However, in practice, some licensed foster homes are not actively providing foster care, and many foster homes and GROs are providing care below their allowable capacity or are only providing care to a select group of children or youth.[118] **One of the biggest challenges faced by all DFPS regions in Texas is building and maintaining a sufficient number of foster homes to care for children and youth with complex mental health needs, those with challenging behaviors, and older youth.**[119]

Present Realities Affecting Substitute Care Capacity

The effects of the COVID-19 pandemic and the larger context of current events—including social distancing requirements, a mental health crisis, social and political unrest, and an economic recession—are directly impacting child welfare needs and services and will likely continue to have an effect for months and years ahead. According to a recent Dallas Morning

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[117] Department of Family and Protective Services. (n.d.). *Search for child placing agencies for foster care*. https://www.dfps.state.tx.us/child_care/search_texas_child_care/ppfacilitysearchfoster.asp

[118] Department of Family and Protective Services. (2020, November). *Foster care needs assessment.* https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/CPS/documents/2020/2020-11-19_Foster_Care_Needs_Assessment.pdf

[119] Department of Family and Protective Services. (2020, November).

News article, [120] the number of children without placements statewide is higher than at any point in the last ten years. Some of system's current challenges are discussed below.

Reduced entries into care. As discussed in more depth in under "Present Realities Affecting Regional Trends (in *Chapter 1*), recent data show an overall decline in removals over the past two fiscal years. Child welfare experts forecasted similar trends, with a decline in abuse and neglect reports resulting from school closures in the spring. As more children and youth return to in-person school and other activities outside the home, numbers in substitute care may increase as children are seen by more adults who traditionally make allegations of abuse and neglect.

Reduced exits from care. Although fewer children and youth entered substitute care in 2020, there were also fewer who exited to permanency. This is largely due to the delays in court proceedings and difficulties families faced in obtaining court-ordered services and completing their service plans.

Foster home recruitment and retainment. As noted by many CPAs surveyed for this project, in-person events have been one of the main strategies used to recruit foster families, and these were upended with COVID-19 social distancing requirements. Organizations are pivoting and trying new, remote strategies for connecting with potential foster parents, but, like any new process, finding effective strategies can take time. These challenges have been exacerbated by the loss of previous placement options from families hesitant to accept new children or youth due to health and safety concerns related to the pandemic.

Impact on group or residential care. Organizations caring for children in group settings have also struggled to retain direct care staff for a variety of reasons related to the pandemic. This has had a negative effect on overall capacity as organizations must continuously adjust census levels to stay within required child-to-adult licensing ratios. In addition, if there is a COVID-19 case among children or staff, it may be necessary to quarantine sections of a facility in order to contain the virus spread, which can further impact capacity.

Lawsuit implications. Another factor that many believe has impacted substitute care capacity is the implementation of orders from the **federal foster care lawsuit *M.D. v. Abbott,*** originally filed in 2010. This lawsuit and the resulting orders are focused on improving the safety of children in Texas foster care. A new process implemented as part of the lawsuit is **heightened monitoring,** which brings additional scrutiny to organizations that serve children and youth in substitute care through additional monitoring visits, documentation requirements, and safety

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[120] Garrett, R. (2020, December 18). *Abused, neglected children again sleeping in CPS offices in repeat of Texas foster care crisis*. The Dallas Morning News. https://www.dallasnews.com/news/politics/2020/12/18/abused-neglected-children-again-sleeping-in-cps-offices-in-repeat-of-texas-foster-care-crisis/

plans to address concerns. While the aim of the judicial order is to improve the safety of children and youth in substitute care, some stakeholders interviewed for this project believe it may also create unintended negative consequences for placement options available to older youth or children with complex needs. These concerns are rooted in the experience that older youth and those with challenging behaviors often carry a history of trauma-induced behaviors (e.g., running away and violent or self-harming tendencies). Some providers are concerned they will be held liable for those behaviors despite their best efforts to support the child. Citations and violations related to serving children and youth that display these behaviors can lead to additional monitoring, scrutiny, and even the closure of a program.

Ongoing Factors That Influence Substitute Care Capacity

Beyond the number of children and youth entering the system and requiring a placement, and the number of placements available, there are many other factors that can help determine if a location has appropriate substitute care capacity. These factors include the ability to safely place children and youth with a relative; the individual needs of children and youth in care; the level of placement stability a child or youth experiences in substitute care; and the length of time it takes to exit substitute care. A summary of each of these factors is provided below. Additionally, when possible we include relevant data from DFPS Regions 3W (non-CBC) and 3E to highlight local trends.

Relative Placements

In general, the need for non-relative foster parents is related to how many placements are made with relatives. **A decrease in available kinship placements is expected to result in a need for more non-relative foster homes.** A review of placement trends in DFPS Regions 3W (non-CBC) and 3E indicates that, despite ongoing efforts by Child Protective Services (CPS) to prioritize relative or kinship placements, the number of children and youth placed with a relative decreased between 2018 and 2019. This decrease has resulted in a corresponding increase in the number of children and youth in non-relative foster care placements (Figure 21). Likewise, we expect that a growth in kinship placements in the months and years to come will reduce the need for non-relative placements.

Figure 21. Relative vs. Non-Relative Placements by Region on August 31st (by Year)[121]
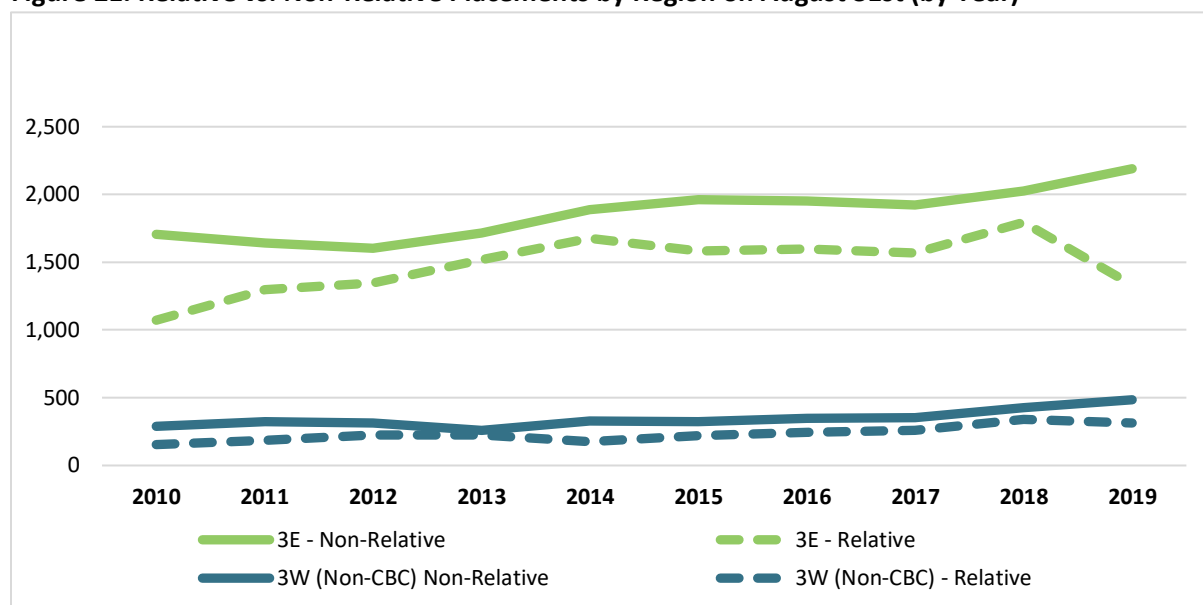
Service Needs of Children and Youth

Robust substitute care capacity requires a variety of placement options to match the unique needs of each child or youth the system serves. Key informants for this report agree that there are far fewer placement options for older children and youth as well as for those with behavioral complexities; as a result, these groups are more likely than others in substitute care to experience undesirable placement outcomes. According to August 2020 DFPS data, 63% of the children and youth with complex needs who required increased supervision and more intensive services and supports were placed in an RTC <u>outside the region</u>. Thirty-eight percent (38%) of children and youth waiting for an appropriate placement were also placed outside of the region (see Table 8, repeated from *Chapter 1*). **These outcomes reflect the region's limited placement capacity for children and youth in care with complex needs.**

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[121] Texas Department of Family and Protective Services Data & Decision Support. (2020, June 28). *CPS 3.2 children in substitute care by placement type on August 31 FY2010-2019*. https://data.texas.gov/Social-Services/CPS-3-2-Children-in-Substitute-Care-by-Placement-T/kgpb-mxxd

Table 8. Number of Children from DFPS Region 3 by Living Arrangement Placed in Region (August 2020)[122]

Children Placed in and Out of the Region by Living Arrangement				
Living Arrangement	**Total Children**	**Placed in Region**	**Placed out of Region**	**% Placed out of Region**
DFPS Foster Homes[123]	222	166	56	25%
Private CPA and Independent Homes[124]	2,807	2,568	239	9%
GRO: Child Care Services Only	118	80	38	32%
RTC	321	119	202	63%
Emergency Shelter Services	79	49	30	38%
Other Foster Care	135	87	48	36%
Kinship	1,605	1,392	213	13%
Adoptive Home	85	60	25	29%
Independent Living	2	2	0	0%
Other Substitute Care	122	65	57	47%
All Placements	**5,496**	**4,588**	**908**	**17%**

The Role of Age and Ethnicity on Service Needs

Those working to build local capacity for substitute care must give special attention to meeting the needs of children and youth with known negative outcomes correlated with their age or race/ethnicity. A review of authorized service levels (ASLs)[125] by race/ethnicity and age highlights the need in DFPS Regions 3W (non-CBC) and 3E to strengthen foster care capacity for older youth and Black children and youth. As indicated in Figure 17 (repeated from *Chapter 1*), youth ages 14–17 years are more likely to be assigned a higher ASL (Specialized or Intensive) than are children 13 years and younger. Similarly, as indicated in Figure 18 (repeated on the next page), Black children and youth are more likely to be assigned to a higher ASL than those of all other racial and ethnic groups. As a result, **older youth and Black children and youth are at a higher risk than other groups of being placed further from their homes and communities**

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[122] Texas Department of Family and Protective Services. (n.d.). *Regional statistics about children in DFPS care. Fiscal year 2020, August 2020. Children in substitute care placed in/out of legal region by living arrangement category and placement region*. Retrieved on December 7, 2020 from, https://www.dfps.state.tx.us/Doing_Business/Regional_Statistics/default.asp

[123] An independent foster family home is not affiliated with a CPA, but is monitored and regulated directly by the DFPS Licensing Division.

[124] A CPA is a licensed residential child-care operation that may verify and regulate its own foster homes subject to DFPS minimum standards.

[125] See *Supplement 1A. Overview of Authorized Service Levels (ASLs)* at the end of Chapter 1 for more information.

Figure 17. ASL by Age in DFPS Region 3 (August 2020)[126,127]
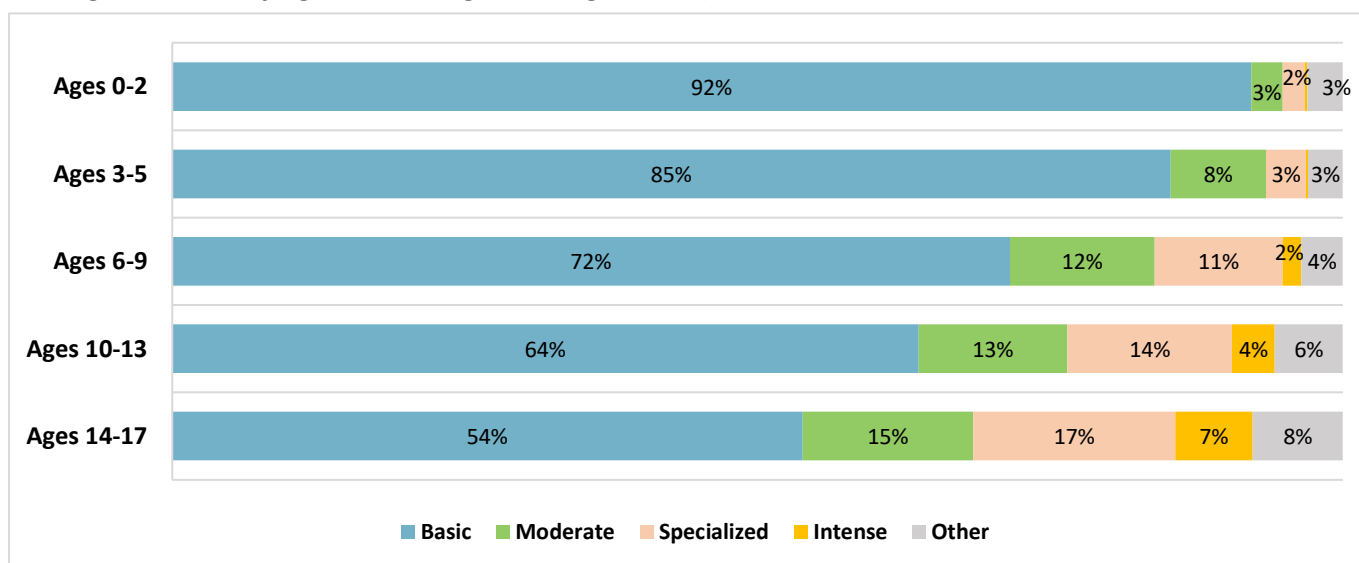
Figure 18. ASL by Race/Ethnicity in DFPS Region 3 (August 2020)[128,129]

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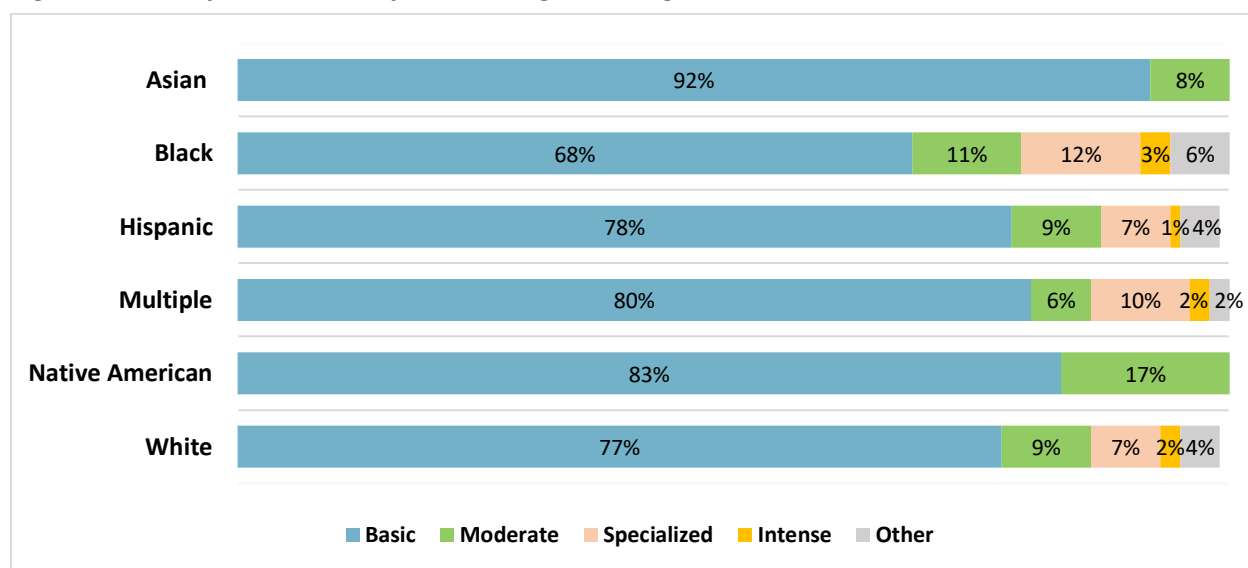
[126] "Other" service levels include Treatment Foster Family Care, Intense Plus, and blank entries. As of August 2020, a very small number of children and youth (26) were in Treatment Foster Family Care.

[127] Texas Department of Family and Protective Services. (n.d.). *Regional Statistics about children in DFPS care. Fiscal year 2020, August 2020. Regional demographics of children in foster care by authorized service level for children age 0–17.* Retrieved December 7, 2020, from https://www.dfps.state.tx.us/Doing_Business/Regional_Statistics/default.asp

[128] "Other" service levels include Treatment Foster Family Care, Intense Plus, and blank entries. As of August 2020, a very small number of children and youth (26) are in Treatment Foster Family Care, 13 of whom are Black.

[129] Texas Department of Family and Protective Services. (n.d.). *Regional statistics about children in DFPS care. Fiscal Year 2020, August 2020. Regional demographics of children in foster care by Authorized Service Level for children age 0–17.* Retrieved December 7, 2020, from https://www.dfps.state.tx.us/Doing_Business/Regional_Statistics/default.asp

Foster Home Recruitment and Retention

The care provided by foster parents is the primary intervention for a child who has been removed from their parents.[130] According to the CPA survey we conducted for this environmental assessment, the primary barrier to recruiting foster parents are perceived concerns about caring for children and youth with more challenges, including behavioral needs. Additional recruitment challenges include language barriers, limited funding to CPAs for outreach efforts, the ability of families to meet DFPS foster home licensing standards, and foster parent training requirements.

Placement Stability

The quality and availability of support for foster parents has a direct impact on placement stability and other outcomes for children and youth in care. **The ability to recruit and retain appropriate foster homes is one key way to support placement stability for children in less restrictive settings.** Multiple placements can lead to difficulties in achieving permanency, academic struggles, and trouble developing meaningful attachments.[131] At the community level, placement instability may also limit available substitute care capacity by delaying the speed of exits from care, which can also **negatively impact the experiences of caregivers, making them more reticent to foster in the future.** DFPS data from May 2020 shows that of the children and youth in substitute care at that time, approximately one-third of the children and youth in substitute care in DFPS Regions 3W (non-CBC) and 3E had experienced three or more (3+) placements.

Exits From Substitute Care

Reviewing the relationship between the total number of children and youth in substitute care and exits from substitute care can help those planning and implementing CBC and the larger community to anticipate service demand. Between FY 2013 and FY 2018 exits generally increased despite a dip in FY 2017 in DFPS Region 3E and a slight decrease in FY 2018 in DFPS Region 3W (non-CBC) (Figure 22). This was accompanied by the steady growth in the number of children and youth in substitute care in DFPS Region 3W (non-CBC) and a decrease in the total number in substitute care since 2018 since FY 2018 in DFPS Region 3E. This trend in DFPS Region 3E is, at least in part, the result of an increase in the total number of children and youth in substitute care from Dallas County in FY 2018, followed by a decline in those entering care and an increase in exits from Dallas County in FY 2019. Across DFPS Region 3, recent data shows exits decreased between FY 2019 and FY 2020.

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[130] The Annie E. Casey Foundation. (2016, November 15). *A movement to transform foster parenting*. https://www.aecf.org/resources/a-movement-to-transform-foster-parenting/

[131] Casey Family Programs. (2018, August). *What impacts placement stability?* Strategy Brief: Strong Families. https://caseyfamilypro-wpengine.netdna-ssl.com/media/SF_Placement-stability-impacts.pdf

Figure 22. Children and Youth in Substitute Care and Exits in DFPS Region 3E and 3W (non-CBC), by Region and Fiscal Year[132,133]
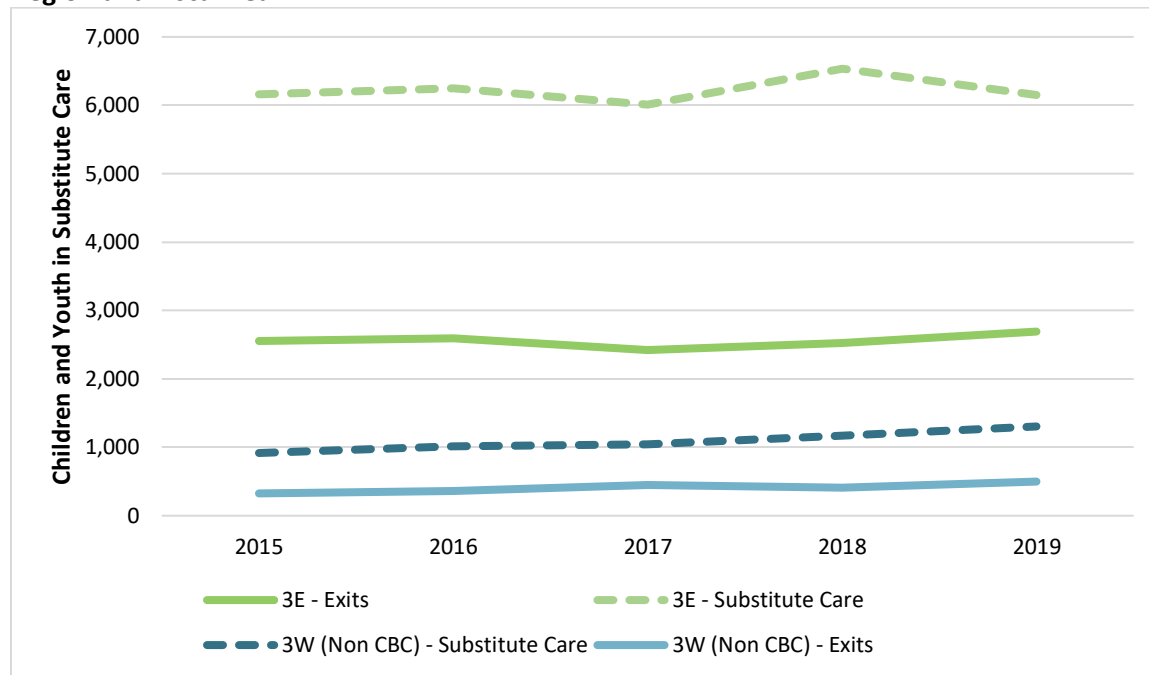
Children and youth exit care through reunification, adoption, a relative gaining custody, or by aging out of the system (emancipation). Table 16 shows the breakdown of these exit types for FY 2019 (also displayed graphically in Figure 16 in *Chapter 1*). These data show comparable trends in how children and youth exit substitute care between DFPS Regions 3W (non-CBC) and 3E.

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[132] Texas Department of Family and Protective Services Data & Decision Support. (2020, June 28). *CPS 3.1 placement types of children in substitute care during the fiscal year by county with demographics FY2010-2019*. https://data.texas.gov/Social-Services/CPS-3-1-Placement-Types-of-Children-in-Substitute-/nhcj-etqt

[133] Texas Department of Family and Protective Services Data & Decision Support. (2020, June 26). *CPS 2.8 exits from DFPS custody by exit type, avg # placements, and avg months in care FY2010-2019*. https://data.texas.gov/Social-Services/CPS-2-8-Exits-from-DFPS-Custody-by-Exit-Type-Avg-P/k3di-36u5

Table 16. Exits From Substitute Care in DFPS Regions 3W (non-CBC) and 3E (FY 2019)

	DFPS Region 3W (non-CBC)		DFPS Region 3E	
Exits Versus Entrances to Care				
Total Number of Home Removals (Entrances to Care)[134]	551		2,220	
Total Number of Exits from DFPS Conservatorship[135]	499		2,692	
Exits From DFPS Conservatorship by Exit Type[136]	**Exits**	**% of all Exits**	**Exits**	**% of all Exits**
Custody to Relatives With Permanency Care Assistance (PCA)	12	2%	193	7%
Custody to Relatives Without PCA	123	25%	799	30%
Family Reunification	185	37%	956	36%
Non-Relative Adoption	76	15%	330	12%
Relative Adoption	65	13%	256	10%
Youth Emancipation	25	5%	129	5%
Other	13	3%	29	1%

How children and youth leave substitute care affects not only individual outcomes, but also overall system capacity. Most notably, children and youth who age out of the system remain in care more than 30 months in DFPS Region 3W (non-CBC) and more than 40 months in DFPS Region 3E (see Table 17). In contrast, children and youth who are reunified with their family generally exit DFPS conservatorship in a little over a year. As a result, youth who age out of the foster care system, though only a small number, use a larger share of the available capacity because they spend more time in care. Additionally, the average length of time in substitute care for children and youth who exit to relative custody varies significantly depending on if the relative obtains Permanency Care Assistance (PCA) funding. Children and youth who exit to relatives without PCA spent on average less than half the time in substitute care as those with relatives who obtained PCA prior to assuming custody.

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[134] Texas Department of Family and Protective Services. (n.d.). *CPS conservatorship: Children exiting DFPS legal custody*. Retrieved December 2020, from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/Conservatorship/Exits.asp

[135] Texas Department of Family and Protective Services Data Decision and Support. (2020, June 26). *CPS 2.8 exits from DFPS custody by exit type, avg # placements, and avg months in care FY 2010–2019*. https://data.texas.gov/Social-Services/CPS-2-8-Exits-from-DFPS-Custody-by-Exit-Type-Avg-P/k3di-36u5

[136] Texas Department of Family and Protective Services Data Decision and Support. (2020, June 26). *CPS 2.8 exits from DFPS custody by exit type, avg # placements, and avg months in care FY 2010–2019*.

Table 17. Average Months in Substitute Care by Exit Type in DFPS Region 3 (FY 2019)[137]

Exit Type	Average Months in Care			
	Region 3E	Region 3W		Region 3 Total
		Non-CBC	CBC	
Custody to Relatives With PCA	28.6	22.3	26.7	28.0
Custody to Relatives Without PCA	13.0	14.6	16.1	13.8
Family Reunification	12.3	12.5	15.0	12.9
Non-Relative Adoption	26.7	28.9	25.6	26.5
Relative Adoption	25.6	23.0	23.2	24.5
Youth Emancipation	40.8	30.9	43.3	40.8
Other	5.9	9.2	20.7	9.6
Total	**18.0**	**18.0**	**21.8**	**19.0**

Part 2 – Key Information and Insights on Forecasted Capacity

Findings in this section are informed by the DFPS 2019 and 2020 Foster Care Needs Assessments and the DFPS Data Book data. The DFPS Foster Care Needs Assessments focus on the areas of the state that have not yet initiated CBC and analyze data based on DFPS catchment areas which in the case of DFPS Region 3 do not align with the current regional breakdown (3W and 3E). To align this analysis with DFPS data and analysis, we report most of the data in this **section of the report** by previously used catchment areas rather than by DFPS region or subregion. Where available, we also provide county-level data or regional data also. See Table 20 in *Supplement 2A* at the end of this chapter for a crosswalk of counties in these catchment areas as they coincide with DFPS Regions 3W (non-CBC) and 3E; see *Supplement 2A* and *Supplement 2C* for additional regional capacity data as well as a listing of all Child Placing Agencies (CPAs) and General Residential Operations (GROs) in DFPS Regions 3W (non-CBC) and 3E.

In the DFPS Foster Care Needs Assessment, Region 3 was divided into catchments 3A, 3B, and 3C. This classification system has since changed. Currently, DFPS Region 3W (CBC) includes the counties in **catchment 3B**.

The counties in 3A and 3C are listed below and comprise our areas of focus—Region 3W (non-CBC) and Region 3E—though split up differently.

- **Catchment 3A**: Collin, Cooke, Denton. Fannin, Grayson, Hunt, and Wise
- **Catchment 3C**: Rockwall, Dallas, Ellis, Kaufman, and Navarro

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[137] Texas Department of Family and Protective Services Data and Decision Support. (2020, June 26). *CPS 2.8 exits from DFPS custody by exit type, avg # placements, and avg months in care FY2010–2019*. https://data.texas.gov/Social-Services/CPS-2-8-Exits-from-DFPS-Custody-by-Exit-Type-Avg-P/k3di-36u5

Need for Relative or Kinship Placements

Despite a slight decline in relative and kinship placements in DFPS Region 3 between FY 2018 and 2019, DFPS forecasts that the need for relative placements will remain stable through FY 2022.[138] The percentage of children and youth placed in kinship care in the counties in DFPS catchments 3A and 3C is similar to the statewide average of 43%.

- In FY 2019, approximately 42% of children and youth in substitute care in DFPS catchment 3A were placed with a relative, a 1% decrease compared to FY 2018.
- In FY 2019, approximately 44% of children in youth in substitute care in DFPS catchment 3C were placed with a relative, a more significant decrease of 4% from FY 2018.

Need for Non-Relative Foster Care

The *2020 Foster Care Needs Assessment* forecasts that the number of children and youth who need a non-relative foster care placement of any type (foster homes, GROs, RTCs, and emergency shelters) will remain relatively stable through FY 2022.[139] **In FY 2019, more than 75% of children and youth with a Basic or Moderate ASL were in a non-relative foster care placement.** A comparison of the estimated daily number of children and youth, service mix, and placement types for those in care in DFPS catchments 3A and 3C between FY 2018 and FY 2019 shows only small variations between years (Table 18).

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[138] Texas Department of Family and Protective Services (2020, November). *Foster care needs assessment.* https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/CPS/documents/2020/2020-11-19_Foster_Care_Needs_Assessment.pdf
[139] Texas Department of Family and Protective Services (2020, November).

Table 18. Comparison of the Estimated Daily Number of Children and Youth and Mix of Service Levels/Placement Types Between FY 2018 and FY 2019[140,141]

Estimated Daily Number of Children in Non-Relative Foster Care						
Service Level and Placement Type	**Catchments in DFPS Region 3W (non-CBC) and 3E – FY 2018**			**Catchments in DFPS Region 3W (non-CBC) and 3E – FY 2019**		
	Catchment 3A	**Catchment 3C**	**Total**	**Catchment 3A**	**Catchment 3C**	**Total**
Basic and Moderate – Foster Home	584	1,067	1,651	637	1,000	1,637
Specialized and Intensive – Foster Home	58	163	221	66	166	232
Specialized and Intensive – GRO	5	8	13	8	8	16
Specialized and Intensive – RTC	72	101	173	57	111	168
Emergency Shelter	29	41	70	24	61	85
Intensive Psychiatric Transition Program	4	4	8	4	5	9
Child Specific Contract	4	17	21	5	12	17
Total	**756**	**1,401**	**2,157**	**801**	**1,363**	**2,164**

Non-Relative Foster Care Need Versus Available Placements in DFPS Region 3

DFPS strives to place children and youth with a Basic or Moderate ASL in a foster home as opposed to any other setting when a relative (kinship) placement is not available, and the *2020 Foster Care Needs Assessment* indicates that the foster home supply for children and youth with these ASLs is close to or fully sufficient for DFPS catchments 3A and 3C. The estimated need and forecasted supply of Basic and Moderate foster care placements is broken down by catchment in Table 19. There was no significant change in the estimated supply and demand for these non-relative foster care placements between the 2019 and 2020 DFPS assessments.

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[140] Texas Department of Family and Protective Services. (2020, November).

[141] Texas Department of Family and Protective Services. (2019, July). *Foster care needs assessment.* https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/CPS/documents/2019/2019-08-06_Foster_Care_Needs_Assessment.pdf

Table 19. Forecasted Demand and Estimated Supply of Non-Relative Foster Care Placements on August 31, 2019, for Children and Youth with a Basic or Moderate ASL[142]

	Catchment 3A	Catchment 3C
Forecasted Daily Demand	676	1,084
Estimated Non-Relative Foster Home Supply	613	1,029
Estimated GRO Supply	20	9
Total Estimated Supply in Region	633	1,038
Percentage of Forecasted Demand Met by Supply	94%	96%
Number of Non-Relative or GRO Beds Needed to Meet Demand	43	46

Initial Placement Trends

In general, the counties in DFPS Regions 3W (non-CBC) and 3E have placed an increasing number of children and youth into emergency shelters when they first enter care. First placement trends between FY 2010 and FY 2019 show some annual fluctuations, but an overall increase in the use of an emergency shelter as a first placement option for children and youth entering substitute care in DFPS Regions 3W (non-CBC) and 3E (Figures 23 and 24). The use of emergency shelter beds could reflect a lack of Basic and Moderate non-relative foster care capacity, unsuccessful attempts to identify kinship or relative placements, efforts to place sibling groups together, and/or an inability to quickly access or manage non-relative foster home capacity.

Figure 23. First Placement in Emergency Shelter After Removal for DFPS Region 3W (non-CBC) (FY 2010–2019)[143]

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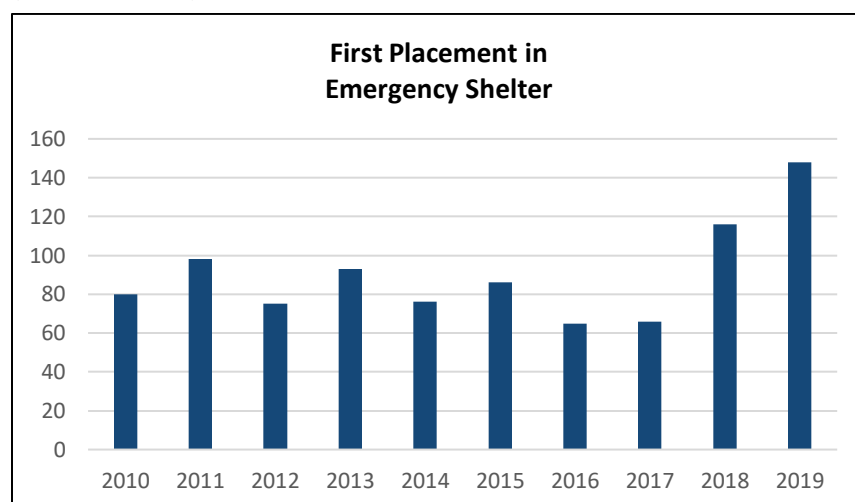
[142] Department of Family and Protective Services (2020, November).

[143] Texas Department of Family and Protective Services (n.d.). *CPS placements: Child's first placement type after removal. Fiscal Year 2019.* Data Book. Retrieved December 2020, from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/Placements/First_Placement_after_Removal.asp

Figure 24. First Placement in Emergency Shelter After Removal for DFPS Region 3E (FY 2010–2019)[144]
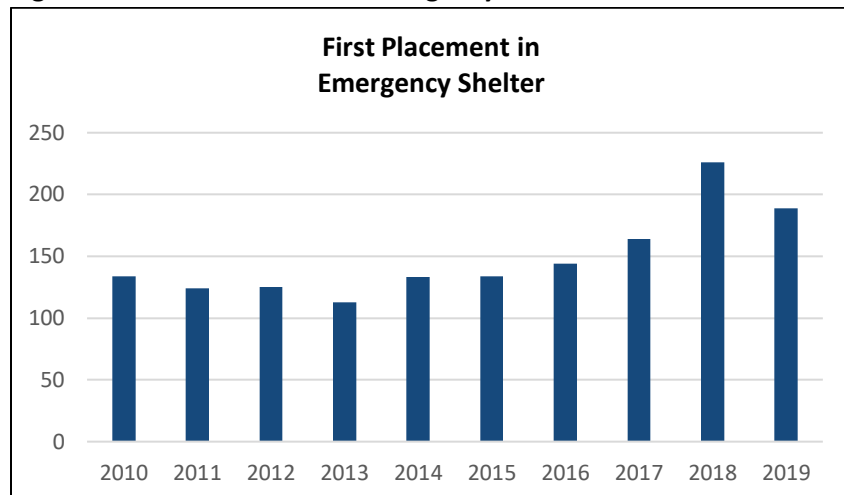
Rural and Non-Rural Capacity Differences

Non-CBC rural counties in DFPS Region 3 do not have sufficient capacity to place children and youth of all service levels. Most children and youth from DFPS Regions 3W (non-CBC) and 3E are placed within DFPS Region 3, though significantly fewer children and youth are placed in their home county. **Placement outside a child's home county is most prevalent in the region's smaller rural communities.** Such a move, even within the region, limits a child's access to their home school, friends, and family. Placement data from March 2020 indicate that more than 90% of the children and youth in foster care from Fannin (97%), Hunt (90%), Kaufman (93%), Rockwall (94%), and Cooke (92%) counties were placed outside of the county. The three largest counties in Regions 3W (non-CBC) and 3E, though less rural, also struggle to keep children and youth near home. During the same time period, Collin (57%), Dallas (50%), and Denton (71%) counties all placed more than half of their children and youth in foster care placements located outside their respective counties. The percentage of children and youth placed out of their home county statewide is 61%.

Capacity Considerations for Children and Youth With Greater Complexity

DFPS strives to place children and youth with more complex needs in kinship and foster homes that meet their therapeutic needs and are as geographically close to their homes of origin as possible. However, a small number of these children and youth, those with the most complex needs, may at least temporarily require RTC or GRO placements to ensure safety.[145] Placing children and youth with Specialized or Intense ASLs in foster homes and minimizing the time

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[144] Texas Department of Family and Protective Services (n.d.). *CPS placements: Child's first placement type after removal. Fiscal Year 2019.*

[145] Texas Department of Family and Protective Services. (2020, November). *Foster care needs assessment.* https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/CPS/documents/2020/2020-11-19_Foster_Care_Needs_Assessment.pdf

they spend in RTCs and GROs requires that the counties in DFPS regions 3W (non-CBC) and 3E (catchments 3A and 3C) have an array of non-relative foster care placements that meet the complex behavioral, mental health, and supervision needs of these children and youth. **However, the estimated supply of non-relative foster care placements in DFPS Regions 3W (non-CBC) and 3E that can meet the needs of children and youth with a Specialized or Intense service level does not meet the forecasted demand for FY 2022.** DFPS estimates that DFPS catchment 3A has the capacity to meet 62% of its forecasted need for Specialized and Intense placements in 2022 (a shortfall of 48 beds). DFPS catchment 3C has the capacity to meet 70% of projected demand during this same timeframe (a shortfall of 96 beds).[146]

Part 3 – Findings and Recommendations for Building and Sustaining Substitute Care Capacity

There are needs and challenges across the entire child welfare system that are important to systematically address to develop comprehensive and sustainable substitute care capacity. Some systematic strategies are detailed in the following recommendations. Additionally, the input we received from the North Texas CPAs surveyed for this environmental assessment highlighted the many areas of consideration and individual roles for those planning and implementing CBC and addressing substitute care capacity in DFPS Regions 3W (non-CBC) and 3E. According to our CPA survey respondents, the groups and roles listed below are key considerations for all local capacity building efforts.

1. **Child Placing Agency Staff** – CPAs indicated that they are better able to retain foster parents when their staff have manageable caseloads, allowing them to build relationships and be responsive to foster parent needs. They also noted that staff training and solid customer service practices were key to ensuring that foster parents felt supported.

2. **Community** – Community resources and access to an array of services and supports that meet the complex needs of the children and youth in care were identified as key to retaining foster parents. CPAs specifically mentioned therapeutic services and supports as critical.

3. **Foster Parent Supports** – The CPAs noted that the availability of quality ongoing training and development, faith-based supports, respite care services, on-call supports, on-call case managers, one-to-one foster parent support, and funding to provide additional benefits to the families were essential to retaining foster parents.

4. **Child Protective Services** – Poor experiences with CPS, placement discharges, and stressful investigations and licensing monitoring visits can all negatively impact a foster parent's desire to continue fostering.

5. **Foster Families** – The CPAs noted that narrow foster parent placement preferences can result in no children or youth being placed with a family and that, regardless of

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[146] Texas Department of Family and Protective Services. (2020, November). *Foster care needs assessment*.

preferences, some parents are just not a good fit for foster parenting. CPAs also indicated that, once a foster family adopts, they often close their home.

6. **Children and Youth** – When left unaddressed, the challenging or scary behaviors of children and youth in care with complex mental health needs or unidentified trauma can affect a CPA's ability to retain foster parents.

In the remaining portion of this chapter, we consider the implications of data previously presented, findings from our CPA survey specific to this environmental assessment, and insights from literature on best practices to provide recommendations for addressing key substitute care capacity issues and priorities in DFPS Regions 3W (non-CBC) and 3E. Our recommendations are grouped into the following themes:

- **Theme 1** – Promoting placement stability
- **Theme 2** – Supporting placements with relatives
- **Theme 3** – Strengthening services and supports for children and youth with complex behavioral health needs

Theme 1: Placement Stability

A permanency-oriented foster care system requires a sustained sense of urgency starting the moment a child or youth comes into contact with the system, and an understanding that a child's sense of belonging is fundamental to their well-being. Permanency for a child or youth in foster care is defined as reunification, guardianship, adoption, or a stable, lifelong family or family-like relationship that provides physical, emotional, and social support.[147] However, before permanency is established, placement stability is one of the most critical goals for any child welfare system, and it is emphasized in the goals Texas has established for the CBC model. A system that emphasizes stability minimizes the number of times a child is placed by recruiting, developing, and supporting relative/kinship caregivers and foster parents. However, as discussed in *Chapter 1: Data Trends and Characteristics of Children and Youth*, DFPS data from DFPS Regions 3W (non-CBC) and 3E show that over 60% of children and youth in substitute care have experienced two or more placements and about one-third have experienced 3 placements or more.

Systemwide support that bolsters placement stability can prevent negative outcomes among children and youth, including increased risk for behavioral problems, academic difficulties, and loss of meaningful attachments.[148] Placement stability also promotes consistency in relationships, predictability in routine, and continuity of access to services and supports. The recommendations outlined in Theme 1 are aimed at reducing the number of children and youth

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[147] Casey Family Programs. (2018, August). *What impacts placement stability?* Strategy Brief: Strong Families. https://caseyfamilypro-wpengine.netdna-ssl.com/media/SF_Placement-stability-impacts.pdf
[148] Casey Family Programs (2018, August). *What impacts placement stability?*

in substitute care in DFPS Regions 3W (non-CBC) and 3E that experience multiple placements by developing strong networks of foster parents, supporting those parents as well as the children and youth in their care, and identifying and addressing specific vulnerabilities in achieving placement stability.

Recommendation 1: Develop a strong network of support for foster parents.

Foster parents in DFPS Regions 3W (non-CBC) and 3E, especially those caring for children and youth with more complex behavioral health needs, often do not have access to the services and supports they need to feel successful. Nationally, a primary reason that foster parents stop fostering within the first two years of service is lack of support.[149] In order to retain quality foster parents who are well-equipped to care for children and youth with complex needs, it is critical to have an infrastructure to provide caregivers with ongoing and hands-on support as well as access to a diverse set of resources for child and caregiver mental health and wellness.

The CPAs we surveyed for this environmental assessment identified strategies that have helped them retain quality foster parents. These strategies, listed below, align with best practice frameworks for supporting foster and kinship caregivers. The stakeholders and organizations responsible for CBC capacity-building efforts in DFPS Regions 3W (non-CBC) and 3E should coordinate to ensure that all foster families, including kinship caregivers, have access to the following opportunities and supports:
- dedicated foster parent support staff within the CPA who offer kinship and non-relative foster parent support groups and mentorship;
- opportunities to recognize and celebrate foster parents;
- robust pre-service training and ongoing learning opportunities;
- targeted intensive training and hands-on coaching for foster parents who care for children and youth with more complex needs;
- access to trauma-informed interventions;
- financial support (e.g., stipends, increased substitute care rates, school supply costs);[150]
- respite care; and
- crisis services.

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[149] Redlich Horwitz Foundation. (n.d.). *Foster & kinship parent recruitment and support best practice inventory.* https://static1.squarespace.com/static/5c3e3494e2ccd19ef929d5f7/t/5c58dfc9e5e5f0dc036b9bee/154932833270
[150] Redlich Horwitz Foundation. (n.d.). *Foster & kinship parent recruitment and support best practice inventory.* https://static1.squarespace.com/static/5c3e3494e2ccd19ef929d5f7/t/5c58dfc9e5e5f0dc036b9bee/154932833270

Recommendation 2: Minimize placement disruptions and promote a shared sense of safety and stability within families.

A core set of strategies have been proven to bolster placement stability and meet the complex behavioral health needs of the children and youth in substitute care. [151] Those involved in CBC planning and implementation should attend to these strategies, which include the following:

- Adopt assessment tools and decision-making processes that effectively match children and youth to optimal placements, such as Every Child is a Priority, Treatment Outcomes Package, and the Structured Decision-Making Model in Foster Care and Placement Support.[152]
- Recruit foster parents who better fit the needs, age, and cultural backgrounds of the children and youth in care in the region.
- Increase access for children and youth with complex behavioral health needs and their birth and foster families to a full continuum of mental health and substance use services and supports. These services and supports should be integrated into the child welfare system and well-coordinated with the broader health, education, and juvenile justice systems.
- Ensure a well-trained, stable child welfare workforce by providing pre-service and ongoing training, supervision, and coaching; ensuring reasonable caseloads; addressing organizational culture and climate that undermine job satisfaction and commitment; and promoting shared responsibility amongst child welfare staff for supporting children in substitute care.[153]

Recommendation 3: CBC planning efforts should also build on existing resources and opportunities to create robust local capacity in DFPS Regions 3W (non-CBC) and 3E and involve frequent input from diverse child welfare stakeholders and agencies.

The aforementioned efforts and strategies to improve placement stability will be most successful if they incorporate state and local resources that help to maximize foster care capacity, expand kinship and foster parent recruitment tactics, and engage community mental health providers. These efforts must also account for the obstacles and challenges, as well as the strengths and insights, that individuals and agencies responsible for developing and sustaining substitute care capacity experience and share.

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[151] Casey Family Programs. (2018, September). *How can we improve placement stability for children in foster care?* Strategy Brief: Strong Families. https://caseyfamilypro-wpengine.netdna-ssl.com/media/SF_Strategies-to-improve-placement-stability.pdf

[152] Casey Family Programs. (2018, September). *How can we improve placement stability for children in foster care?* Strategy Brief: Strong Families.

[153] Casey Family Programs. (2018, September). *How can we improve placement stability for children in foster care?* Strategy Brief: Strong Families.

Those involved in CBC planning and implementation should consider the following in their capacity-building efforts:

- Use the DFPS Child Placement Portal[154] to more effectively match children and youth to foster placements.
- Identify a local CPA with experience developing specialized capacity that can lead regional kinship and foster parent recruitment strategies in partnership with DFPS and other CPAs in the region.
- Engage community mental health providers and CPAs in Regions 3W (non-CBC) and 3E that offer a strong continuum of supports to partner to develop strategies that expand regional capacity for youth with more complex needs and regional capacity to deliver the full continuum of mental health services included in the Ideal Children's Mental Health System detailed in the Meadows Institute report *Dallas County Mental Health Service Delivery System for Children, Youth, and Families: 2019 System Assessment*.[155]
- Adopt assessment tools and decision-making processes that effectively match children and youth to optimal placements, such as Every Child is a Priority, Treatment Outcomes Package, and the Structured Decision-Making Model in Foster Care and Placement Support.[156]
- Create opportunities to identify the needs of children and youth in substitute care and the current system's challenges and vulnerabilities in meeting those needs.
- Compare the data in this report with CPA agency data to develop a foster parent recruitment plan that includes targeted and individual recruitment strategies and expands overall capacity to meet the diverse needs (including culture, language, age, and behavioral health needs) of the children and youth in care.
- Consider ways to include and support current foster parents in developing foster parent recruitment strategies. These efforts will be most valuable if they focus on recruiting caregivers who align with child and youth needs and demographics in the region.
- Consider how larger CPAs can partner with smaller and less-resourced CPAs in order to provide training, technical assistance, in-home services, and crisis support to kinship and foster families.
- As is frequent practice in DFPS Region 3, continue to nurture partnerships with faith-based communities and continue with ongoing discussions on how faith-based organizations can support evolving system capacity-building goals.

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[154] At the time of this report, DFPS's Child Placement Portal had not yet been released.

[155] Meadows Mental Health Policy Institute. (2020, March). *Dallas County mental health service delivery system for children, youth, and families: 2019 system assessment report.* https://www.texasstateofmind.org/uploads/reports/2019DallasCountyAssessment.pdf

[156] Casey Family Programs. (2018, September). *How can we improve placement stability for children in foster care?* Strategy Brief: Strong Families. https://caseyfamilypro-wpengine.netdna-ssl.com/media/SF_Strategies-to-improve-placement-stability.pdf

- Identify ways to increase the retention rate of prospective foster families by creating systems that are easy to navigate and developing strategies to support foster families throughout the licensing process.
- Consider tools and strategies to support parent/child matching processes. Tools that support placement matching include Children and Adolescents Needs and Strength (CANS) Treatment Outcome Package, Structured Decision Making (SDM) Model in Foster Care and Placement Support, Casebook, and Every Child is A Priority (ECAP).

Recommendation 4: Forge strong relationships with foster parents and include them in capacity planning efforts.

The strength and well-being of foster parents is one of the most critical elements of substitute care capacity. Likewise, relationships between foster parents and individuals working in the child welfare system are critical. As a result, foster parents and relative/kinship caregivers must be regarded as full and respected partners in the local child welfare process. Those involved in planning and implementing CBC can adopt the following practices to involve foster parents, including relative caregivers, in key systemic and individual decisions which will in turn support foster parent satisfaction and retention in local communities:

- Establish foster parent advisory boards and expand their participation in local and statewide planning groups.
- Encourage foster parent advocacy and leadership opportunities in CBC planning and implementation activities.
- Ensure that foster parents are consulted and supported in funding decisions.
- Regularly update foster parents on critical decisions that affect the child welfare agencies and policies.
- Promote broader community understanding of foster parent authority.

Theme 2: Supporting Placements With Relatives

Children and youth who are placed with relatives or kin are more likely to develop permanent relationships with a caring adult, less likely to age out of care, and more likely to obtain legal permanency compared to their peers who have not been placed with family.[157] For these reasons, national best practices and DFPS policy prioritize relative placements.

However, the practice of placing children and youth with relatives takes time and commitment to facilitate and support and CPAs and other system stakeholders can take proactive measures to increase kinship placements. Participants in our CPA survey indicated that they often rely on DFPS to link them to kinship caregivers (relatives), rather than actively recruiting for such

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[157] Casey Family Programs. (2018, November). *The impact of placement with family on safety, permanency, and well-being*. From Data to Practice Report Series, Volume 2. https://caseyfamilypro-wpengine.netdna-ssl.com/media/1896-CS-From-Data-to-Practice-2018.pdf

placements. Additionally, of children and youth placed with relatives, very few are in a licensed kinship home despite the ability of most CPAs in the area to license relative caregivers as foster parents. Without licensure from the state, kinship caregivers often don't have access to the same services and supports as other foster parents.

The recommendations in this section are aimed at increasing the number of relative placements and fortifying stability for relative caregivers. A final recommendation focuses on another aspect of keeping strong familial ties, with **the goal of keeping siblings together**. We included this recommendation based on input from youth with lived experience in the foster care system who we interviewed for this assessment (*Chapter 3*); national research also emphasizes the importance of maintaining sibling bonds to improve overall substitute care outcomes.[158]

Recommendation 5: Develop a regional philosophy and strategies to prioritize and support relative placements to expand kinship capacity.

Prior to developing overall strategies to build capacity for substitute care, those involved in CBC planning in DFPS Regions 3W (non-CBC) and 3E should formally agree to the shared goal of prioritizing, facilitating, and supporting kinship care placements *above other types of placements*. The region's CPAs and key stakeholders should adopt a kin-first philosophy

The U.S. Children's Bureau has a series of videos and discussion questions for child welfare program administrators to use in working with and supporting kinship families. Their website includes the videos and discussion guides.

that recognizes and addresses the challenges faced by relative caregivers, including little time to prepare for the placement of a child or youth in their home, the financial burden of providing care, and inadequate living space or the inability to meet licensing standards. Once the mutual goal of prioritizing kinship placements is broadly agreed upon, CBC planners should identify strategies to bolster kinship placements when developing policies, procedures, and practices.[159]

Recognizing the importance of placing children and youth in substitute care with their relatives, kinship navigator programs are being developed and implemented across the country. Navigator programs offer support groups or peer support programs designed to assist kinship caregivers in managing the stress of parenting, negotiating the child welfare system, and accessing available resources and supports. The Families First Prevention Services Act (FFPSA) gives states the option to receive a federal match for the costs of establishing a kinship

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[158] Herrick, M. & Piccus, W. (2005, July). Sibling connections: The importance of nurturing family bonds in the foster care system. *Children and Youth Services Review,* 27(7). https://doi.org/10.1016/j.childyouth.2004.12.013

[159] Casey Family Programs (Update, 2020, July). *How can we prioritize kin in the home study and licensure process, and make placement with relatives the norm?* https://caseyfamilypro-wpengine.netdna-ssl.com/media/SF_Adapting-Home-Studies-for-Kin.pdf

navigator program, provided the program is recognized as evidence-based through the federal [Title IV-E Prevention Services Clearinghouse](#) established by the Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services.

At the time of this publication, no kinship navigator programs have been deemed by ACF as supported or promising. Those planning and implementing CBC in DFPS Regions 3W (non-CBC) and 3E should remain engaged in state-level conversations about the possible development of a Texas program and begin considering what attributes would benefit their local communities. Some identified best practices to consider in developing systems to support relative caregivers include: resources to ease the material strain of an unexpected arrival (bedding, clothes, etc.), coaching and support on relationship building with the child and establishing boundaries with birth parents, and initiating early conversations about reunification goals.[160]

Recommendation 6: Work as a community to create specific and actionable plans to increase recruitment and retention of kinship caregivers in DFPS Regions 3W (non-CBC) and 3E.

Once an overarching philosophy is adopted, the next step is for those planning and implementing CBC to collaboratively determine the best ways to identify, support, and retain relative or kinship caregivers. This must be done by **adopting specific and measurable goals, outcomes, and timelines for building kinship capacity**.

Strategies to recruit, engage, and support kinship care providers that are anchored in a kin-first philosophy or prioritize kinship care include:
- Having family search and engagement efforts at the start of a case.
- Using targeted search engines, social media, genograms, and other resources to build on standard family engagement efforts, such as interviews with children and birth parents to identify kin.
- Expediting home studies.
- Providing support for licensing and access to financial resources.
- Creating an infrastructure that requires a higher level of system approval for a child to have a non-kinship placement.[161]

In any efforts to focus on kinship capacity, those involved in CBC planning should also consider adopting and expanding upon related goals and objectives in the [DFPS *Capacity Strategic Plan:*](#)

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[160] Redlich Horwitz Foundation (n.d.). *Foster and kinship parent recruitment and support best practice inventory.* http://www.grandfamilies.org/Portals/0/RHF%20Foster-Kin%20Inventory%202017.pdf
[161] Redlich Horwitz Foundation (n.d.). *Foster and kinship parent recruitment and support best practice inventory.* http://www.grandfamilies.org/Portals/0/RHF%20Foster-Kin%20Inventory%202017.pdf

Region 3 West and East (Catchment 3A and 3C).[162] For example, there are recommendations to **support children and youth transitioning from non-relative foster care to kinship placements by providing relative caregivers with resources and supports, communicating the need for wraparound services and pre-placement visits, involving the child or youth in planning, and ensuring safety plans are in place to address challenges.** The goals and strategies in the Capacity Strategic Plan also stress the need to:

- Quickly identify relative or kinship caregivers and refer them to CPAs for licensing.
- Continue to seek kinship or relative connections throughout the time a child or youth is in substitute care.
- Connect relatives to a DFPS Kinship Development Worker to ensure ongoing communication and support.

See _Supplement 2D: Overview of the Capacity Strategic Plan for Regions 3W (non-CBC) and 3E (Catchments 3A and 3C) (September 2019)_ for more information on the DFPS plan.

These efforts to engage and support kinship caregivers will be most successful if communities within DFPS Region 3W (non-CBC) and 3E have strong plans and strategies in place to stay in communication with those caregivers. Specifically, case workers and other service providers can check in with relative caregivers frequently to make sure they understand the services and supports available to them, how to access those services, where to go and who to ask for help, and how to receive support in the foster home licensing process.

Recommendation 7: Develop strategies to support placement of larger sibling groups.
Youth with lived experience in substitute care interviewed for this project (_Chapter_ 3) emphasized the importance of children and youth remaining with their siblings while in care. However, national research and input provided from CPAs in DFPS Regions 3W (non-CBC) and 3E indicate that the larger a sibling set, the less likely they are to remain together.[163] Barriers to placing siblings together include: (1) size of sibling group; (2) large age gaps between siblings; (3) differences in the needs of each sibling, including behavioral challenges; (4) types of placements—kinship placements are more likely to take siblings together; (6) organizational policies and procedures (for example, restrictions on things like age or allowable ASLs); and (7) licensing standards regarding the maximum number of children placed in a foster home.[164] Caring for multiple siblings does require additional space, time, expenses, and skills to respond to different types of needs simultaneously. For these reasons, capacity-building efforts in DFPS Regions 3W (non-CBC) and 3E should include strategies that specifically address supporting

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[162] Department of Family and Protective Services. (2019, September 26). _Capacity strategic plan: Region 3 West and East (Catchments 3A and 3C)._
https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/CPS/documents/2019/2019-11-15-Region3_Strategic_Plan.pdf
[163] Child Welfare Gateway (2019, January). _Sibling issues in foster care and adoption._ Washington DC: U.S. Department of Health and Human Services, Children's Bureau. https://www.childwelfare.gov/pubPDFs/siblingissues.pdf
[164] Child Welfare Gateway (2019, January).

larger sibling groups. These strategies may range from working with supportive organizations to help families caring for multiple siblings buy necessary items (e.g., extra beds and room dividers) to waiving licensing standards on a home's approved capacity to allow a foster home to take a larger sibling group.

Theme 3: Strengthening Services and Supports for Children and Youth With Complex Behavioral Needs and Their Caregivers

National studies and findings from this environmental assessment indicate that, left unaddressed, challenging child and youth behaviors are key drivers for placement breakdowns.[165] There are many indications that children and youth in substitute care and their caregivers in DFPS Regions 3W (non-CBC) and 3E lack access to the types of mental health services and supports that prevent the escalation of challenging behaviors known to increase the risk of placement disruption. Those planning and implementing CBC should consider strengthening therapeutic foster care services, increasing access to crisis services, and partnering with mental health providers and other community stakeholders to increase foster parent support and, in turn, strengthen the local system's capacity to support children and youth with complex behavioral health needs. The following recommendations center on expanding access to the types of mental health services and supports most likely to prevent placement disruptions.

Recommendation 8: Foster parents caring for children and youth with challenging behaviors or complex mental health issues need access to a robust continuum of services and supports.

Many children and youth end up in restrictive, institutional settings after in-home placements fail. Often these disruptions occur because foster families do not receive comprehensive and sufficient training, services, and supports to respond to challenging behaviors. Necessary services and supports include therapy, psychiatric care and medication management, crisis response and crisis respite, caregiver education and training, skills training, mentoring, and other caregiver supports (e.g., funding, school supplies, peer mentors, and foster parent support groups). The array of mental health services, resources, and foster parent supports that CPAs offer may not be sufficient for children and youth with complex mental and behavioral health challenges and their caregivers. While some larger CPAs have well-developed family services, many smaller ones provide few direct services to foster parents. Those planning and implementing CBC should work with trusted community partners to create linkages to key services for those who don't have access through their CPA. Coordination across CPAs and with

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[165] Fisher, P. A., Stoolmiller, M., Mannering, A. M., Takahashi, A., & Chamberlain, P. (2011). Foster placement disruptions associated with problem behavior: Mitigating a threshold effect. *Journal of Consulting and Clinical Psychology*, *79*(4), 481–487. https://doi.org/10.1037/a0024313

community-based mental health providers can increase the continuum of support available to children and youth in care and foster families.

Therapeutic foster care and treatment foster care are models that give foster parents the specialized skills and training they need to support children and youth with serious emotional and behavioral issues. DFPS makes a clear distinction between therapeutic foster care and treatment foster care. DFPS defines Treatment Foster Care or Treatment Foster Family Care (TFFC) as a time-limited service in which a provider is responsible for reducing a child's level of need in a family like setting. TFFC requires one full-time stay-at-home parent and no more than two children placed in the home; the CPA is required to train TFFC parents in trauma-based models of parenting. TFFC families are supported by a team of professionals and they have access to supervision and support 24 hours a day, seven days a week. CPAs contracted by DFPS to provide TFFC are required to implement an evidence-based model for treatment foster care (e.g., Together Facing the Challenge or Treatment Foster Care Oregon). CK Family Services is contracted by DFPS to provide TFFC in Regions 3W (non-CBC) and 3E. Arrow Child and Family Ministries and The Bair Foundation provide TFFC in other DFPS regions in Texas. Conversely, DFPS does not have a clear set of standards or requirements for therapeutic foster care and does not require agencies to use an evidence-based model. Consequently, how therapeutic foster care is defined and implemented varies by agency.

The respondents to our spring 2020 CPA survey reported that 468 (or 36% of the total homes) were treatment and therapeutic foster homes in DFPS Region 3 in the most recent fiscal or calendar year. Of the total homes in the region, 7% (93) were treatment foster homes, and 29% (375) were therapeutic foster homes. The number of reported treatment and therapeutic foster homes suggests that Region 3 has the capacity to serve 468 children and youth with a Specialized or Treatment Foster Care ASL. March 2020 service levels indicated that 23 children and youth were assigned a Treatment Foster Care level and another 340 were assigned to a Specialized service level. Based on the number of licensed homes reported by the survey respondents, DFPS Regions 3W (non-CBC) and 3E appear to have sufficient treatment and therapeutic foster care capacity.

However, according to the survey, caregivers in therapeutic foster homes discharge children and youth at a higher rate than other foster parents (i.e., they inform DFPS that they can no longer meet the needs of a child in their care, issuing a discharge notice). Survey respondents reported that more than 40% (133 of 313) of children and youth placed in therapeutic foster care received discharge notices, while only 10% of those in traditional foster homes and kinship homes combined received discharge notices (99 of 1,002 children and youth in traditional foster care; 12 of 115 in kinship care). Children and youth in treatment foster care received the lowest number of discharge notices (2 of 92 or 2%). This difference may be caused by variations

in the therapeutic foster care service delivery model that do not necessarily adhere to evidence-based practices.

Those planning and implementing CBC can increase the effectiveness of therapeutic foster homes in the region by encouraging providers to adopt an evidence-based model or by engaging a small group of CPAs to develop a set of standards for local therapeutic foster care to include a shared definition of therapeutic foster care, a core set of foster parent skills and competencies, a defined target population of children and youth who are best served by this approach, and the services and supports that should be available to therapeutic foster parents.

Recommendation 9: Expand access to 24-hour crisis support services for children and youth in substitute care, and their foster and kinship caregivers.

Not all foster families have access to 24-hour crisis support services, and few have access to crisis stabilization services. Only half of the surveyed CPAs indicated that they provide 24/7 crisis support services. These ranged from on-call staff to a crisis hotline and mobile support, including in-home crisis services and case management. Three of the CPAs (22% of survey respondents) indicated that they provide crisis respite services; one has a dedicated emergency relief home where a child or youth can be placed while a crisis is stabilized, and the other two respondents indicated that they use licensed foster homes with an opening and a caregiver willing to provide respite in a crisis. None of the respondents indicated that they provided any additional crisis stabilization services.

Strengthening crisis services and supports for children and youth in substitute care and their families is expected to curb avoidable placement disruptions that often occur when a family does not feel equipped to respond to a child's behavioral health needs. Those planning and implementing CBC have a key opportunity to examine substitute care crisis services and supports in DFPS Regions 3W (non-CBC) and 3E—and address gaps. The Substance Abuse and Mental Health Services Administration (SAMHSA) provides practice guidelines for crisis services[166] which can help communities within DFPS Regions 3W (non-CBC) and 3E identify strengths in gaps in their current crisis service array. The SAMHSA values and guidelines emphasize the following five elements: **rapid response, safety, crisis triage, active engagement of the individual in crisis, and reliance on natural supports.**

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[166] Substance Abuse and Mental Health Services Administration. (2009). *Practice guidelines: Core elements in responding to mental health crises*. Office of Consumer Affairs, Center for Mental Health Services. https://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/sma09-4427

North Texas has several crisis services and programs, and we recommend they be utilized to the fullest extent possible to support children and youth in substitute care, as well as their foster families. Those planning and implementing CBC can increase access to these options. They can begin with efforts to expand access to mobile crisis services and stabilization services by educating CPS caseworkers, CPA staff, and foster families on the availability of these services, including Turning Point, and by developing partnerships between CPAs and mental health service providers where access to crisis services is currently limited.

ACH's **Turning Point Program** is a 14-day, therapeutic residential crisis intervention for children and youth, ages 10 to 17, in foster care, who are at risk of being admitted to a psychiatric hospital. When a child or youth is admitted to the Turning Point program, foster parents are asked to:

1. Commit to take the child back into the placement after the intervention. Foster parents cannot end the placement once the child enters Turning Point.
2. Participate in a minimum of bi-weekly phone calls with program staff.
3. Visit the child or youth on weekends while they are enrolled in the program.
4. Be an active participant in the child's treatment.

ACH's Turning Point Program reports a low return rate and success maintaining foster placements. Turning Point is funded by STAR Health.

Conclusion

CBC requires that communities have access to a full array of quality substitute care options to be able to place all children and youth, regardless of their service level, in a family setting that is close to home and meets their therapeutic needs. Children and youth achieve permanency and experience improved well-being when substitute care is anchored in a robust, sustainable, continuum of community-based services and supports that keep them connected to their siblings, home, and community.

Part 1 of this chapter identified external, regional, and system factors that influence foster care capacity. Relative care placements in DFPS Regions 3W (non-CBC) and 3E have recently decreased, increasing the reliance on non-relative placements. Counties in DFPS Region 3 place more than 60% of children and youth that need RTC placements out of the region. Black children and youth and older youth are more likely to require a higher service level and are less likely to be placed in a family-like setting in the region. Finally, children and youth who have experienced multiple placements and those who emancipate from care are in care longer, negatively impacting substitute care capacity. The impact of the COVID-19 pandemic will further complicate system factors, such as: relative placements; the service needs, ages, and ethnicity of the children and youth in substitute care; placement stability; and exits from care.

Part 2 addressed four overarching themes that influence the overall ability of the local substitute care system to meet the needs of all children and youth served. The themes and related recommendations and goals are informed by a combination of national research and findings from this environmental assessment specific to DFPS Regions 3W (non-CBC) and 3E. These themes/goals include:

- Identifying and implementing strategies to strengthen substitute care capacity as a whole.
- Increasing placements with relatives.
- Promoting placement stability.
- Strengthening services and supports for children and youth with complex behavioral health needs.

There are many resources, agencies, and other assets within DFPS Regions 3W (non-CBC) and 3E that align with these goals and can be strategically expanded to increase foster family supports and placement stability. By collaborating across the area, those involved in CBC planning and implementation in DFPS Regions 3W (non-CBC) and 3E can increase the array of placement options and services and anchor the local system in a continuum of community-based services. These efforts will be most successful if they actively engage foster families, CPAs, and community service providers to strengthen the array of mental health services, foster parent supports, and resources available.

Supplement 2A: Substitute Care Capacity Tables

Table 20. Crosswalk of Catchments and Corresponding Regions

Crosswalk of Counties Catchment Areas and Regions	
Counties in 3A	**Corresponding Regions**
Collin	Region 3E
Cooke	Region 3W (non-CBC)
Denton	Region 3W (non-CBC)
Fannin	Region 3E
Grayson	Region 3E
Hunt	Region 3E
Wise	Region 3W (non-CBC)
Counties in 3C	**Corresponding Regions**
Dallas	Region 3E
Ellis	Region 3E
Kaufman	Region 3E
Navarro	Region 3E
Rockwell	Region 3E

Table 21. Estimated Daily Number of Children and Youth in Kinship Care Placement (FY 2018 and 2019)[167,168,169]

Kinship Care by Catchment Area				
Catchment	Total Children in Substitute Care	Children in Unverified Kinship Placements* (% of total kinship placements)	Children in Kinship Foster Care (% of total kinship placements)	Rate of Kinship Placements
Fiscal Year 2018				
3A	1,509	574 (89%)	70 (11%)	43%
3C	3,079	1,296 (87%)	194 (13%)	48%
Texas	24,026	9,828 (92%)	1,152 (8%)	46%
Fiscal Year 2019				
3A	1,558	571 (88%)	81 (12%)	42%
3C	2,761	952 (80%)	252 (20%)	44%
Texas	29,242	11,027 (88%)	1,537 (12%)	43%

[167] Department of Family and Protective Services. (2020, November). *Foster care needs assessment.* https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/CPS/documents/2020/2020-11-19_Foster_Care_Needs_Assessment.pdf

[168] Department of Family and Protective Services (2019, July). *Foster care needs assessment.* https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/CPS/documents/2019/2019-08-06_Foster_Care_Needs_Assessment.pdf

[169] Department of Family and Protective Services Data Book. (n.d.). *CPS placements: Children in substitute care on August 31, 2019.*

Table 22: Estimated Daily Number of Children and Youth in Kinship Care in on August 31, 2019, by County

Kinship Care by County					
County	Children in Substitute Care	Children in Unverified Kinship*	Children in Verified Kinship Care*	Total in Kinship Care	% of Children in Kinship Care
Collin	309	111	30	141	46%
Cooke	99	34	9	43	43%
Dallas	2,498	870	248	1,118	45%
Denton	621	247	25	272	44%
Ellis	62	20	2	22	35%
Fannin	60	26	4	30	50%
Grayson	191	72	7	79	41%
Hunt	199	61	5	66	33%
Kaufman	81	30	0	30	37%
Navarro	44	8	1	9	20%
Rockwall	76	24	1	25	33%
Wise	79	20	1	21	27%
Total	**4,319**	**1,523**	**333**	**1,856**	**43%**

*Definitions of Verified and Unverified Kinship Care

Verified Kinship Foster Care

A verified kinship placement is a relative or kinship home that has been licensed as a foster home by Child Care Licensing (CCL). Verified kinship foster homes are held to the same standards as non-relative foster homes and are eligible for the same financial resources, including the daily foster care rate and additional services and supports provided by a CPA.

Unverified Kinship or Relative Placements

Unverified kinship homes are not licensed as a foster home. To ensure that the children and youth placed in unverified foster homes are safe, CPS conducts a home assessment that includes a check on the criminal and abuse and neglect history of all persons 14 years or older living in the household. Unverified foster homes whose total income is below 300% of the poverty level may be eligible to receive a monthly payment equal to 50% of the basic daily foster care rate.[170]

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[170] Texas Department of Family and Protective Services. (2017, September 1). *Letter to caregiver: New payments for caregivers.* https://www.dfps.state.tx.us/Child_Protection/Kinship_Care/documents/Letter_to_Caregivers.pdf

Table 23: First Placement After Removal by County in Catchments 3A and 3C FY 2019[171]

Catchment	County	Emergency Shelter Placements
Catchment 3A	Collin	21
	Cooke	10
	Denton	55
	Fannin	8
	Grayson	26
	Hunt	23
	Wise	1–5*
Total First Placements		**148**
Region 3C	Dallas	160
	Ellis	1-5
	Kaufman	11
	Navarro	1–5
	Rockwall	11
Total First Placements		**189**

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[171] Texas Department of Family and Protective Services Data Decision and Support. (2020, June 26). *CPS 3.5 1st children in substitute care first placement type after removal FY 2010–2019*. https://data.texas.gov/Social-Services/CPS-3-5-1st-Children-in-Substitute-Care-First-Plac/inxw-xxif

Supplement 2B: Child Placing Agency Survey Overview and Response
Child Placing Agency Survey Overview

At the time of this review, the 12 counties in DFPS Regions 3W (non-CBC) and 3E are home to 55 Child Placing Agencies (CPAs) with a total of 1,689 licensed homes. Fifty-one (51) of these CPAs are located in Region 3E and the remaining four (4) are located in Region 3W. We distributed our CPA survey between April and June 2020, via Survey Monkey, to 34 CPAs with a total of 1,512 licensed homes. We selected these CPAs because the DFPS registry of CPAs indicates that they had 10 or more licensed homes.

A total of 18 CPAs provided information on the number and type of licensed homes they support and the population of children and youth they serve. Fourteen (14) of the 18 respondents completed all survey questions. This is a response rate of 53% for the first part of the survey and a 41% response rate for all of the survey questions. Table 24 provides more information about the survey approach and responses.

Table 24. Overview of CPA Survey Respondents

CPA Survey	
All CPAs in the Region[172]	
Total number of CPAs in DFPS Regions 3W (non-CBC) and 3E	55
Total number of licensed homes in both regions	1,686
CPAs That Received the Survey	
Number of CPAs that received the survey	34
Total number of licensed homes among survey recipients	1,603
Percentage of CPAs that received the survey	62%
Percentage of licensed homes represented by the surveyed CPAs (Only 5% of the licensed homes were not represented in this survey.)	95%
Response Rate and Number and Percentage of Homes Represented by the Survey Responses	
Total Responses: 18 unduplicated respondents completed the information on number and types of licensed homes and target population.	**53%**
Number of licensed homes represented by the responding CPAs	1,145
Percentage of licensed homes represented by the CPAs that received the survey.	76%
Percentage of total number of licensed homes in the region	68%
Responses to Service Questions: 14 of the 18 unduplicated respondents completed all of the questions.	**41%**
Number of licensed homes represented by the CPAs responses to the program questions.	759
Percentage of the licensed homes included in the survey	47%
Percentage of the total licensed homes in the region	45%

Current Foster Care Capacity

Eighteen CPAs provided information on the number and type of licensed homes they supported and the population of children and youth they served. Fourteen of the 18 respondents completed survey questions related to services and support provided.

Licensed Relative Foster Homes

There are very few licensed (verified) kinship placements in Regions 3W (non-CBC) and 3E, despite most CPAs reporting that they licensed relative caregivers. Seventy-eight percent (78%) of the CPAs indicated that a portion of their homes were licensed kinship homes. Yet, even with

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[172] Texas Health and Human Services (n.d.). Search for child placing agencies. Retrieved December 2020, from
   https://www.dfps.state.tx.us/Child_Care/Search_Texas_Child_Care/ppFacilitySearchFoster.asp

the large percentage, respondents only reported licensing and overseeing a total 105 kinship homes (8% of the total reported foster homes) across the region.

Licensed Relative and Non-Relative Foster Homes

Fourteen of the CPAs surveyed in spring 2020 indicated that they oversaw 1,310 licensed foster homes in the most recent FY or calendar year. Of these, more than half (56% or 737) were traditional homes, another 8% (105) were licensed kinship care homes, 7% (93) were treatment foster homes, and 29% (375) were therapeutic foster homes. Respondents reported an increase in the number of licensed treatment foster homes during the most recent calendar (2019).

The 14 CPA survey respondents had licensed 588 new foster homes in 2019. Approximately 9% of these newly licensed homes were kinship homes, and 9% were treatment foster homes (53 and 52 homes, respectively). Another 30% (175) were therapeutic foster homes, and the remaining 52% (308) were traditional foster homes. The number of foster homes newly licensed during 2019 represented approximately 45% (588 of 1,310) of the total licensed foster homes, whereas the number of homes closed during the same period made up only 23% (300). Nearly half of the homes that were closed were traditional foster homes (49% or 148); of the remaining homes closed, 26% (77) were therapeutic foster homes, 21% (62) were kinship homes, and a small portion were treatment foster homes (4% or 13).

Approximately 43% of the CPAs surveyed saw an increase in their number of licensed homes over the last year, whereas 36% saw a decrease, and the remaining 21% reported experiencing no change in their number of foster homes. Respondents indicated that an organizational focus on recruiting, homes transferring from other agencies, and treatment foster care recruitment efforts resulted in an increase in homes. Reasons noted by those CPAs that experienced a decrease in licensed homes included families closing after an adoption, families relocating, the time it takes to verify a family, and change in agency personnel.

Table 25 on the next page lists the CPA survey respondents and basic information about their organizations.

Table 25. Child Placing Agency Survey Respondents

CPA Survey Respondents			
Organization	Respondent	Title	No. of Licensed Beds[173]
A World for Children	Mary Grace Curry Ashleigh Wilkes	Regional Director, Executive Director	33
Assuring Love Child Placement Agency	Lyle Matthis	Executive Director	21
Buckner Children and Family Services	Andi Harrison	Regional Director of Foster Care & Adoption	103
Cherished Impressions*	Karina Green	LCPAA	47
Children's Hope Residential Services	Tammy Johnson	Area Director	39
CK Family Services	Karen Lund	Executive Director	251
Circle of Living Hope (COLH)	Samantha Williams	Administrator	20
Harbor of Hope	Jami Wampler	Executive Director	47
Johnathan's Place	Elizabeth Mosman	Chief Program Officer	59
Kids Grace	Robyn Moore	Licensed Child Placing Agency Administrator	19
Lonestar Social Services*	Alyssa Ramirez	Regional Director	227
Make A Way, Inc. Child Placing Agency	Kristina Williams	Administrator	10
Passage of Youth, Inc*	Terrance Perkins	Director	50
Pathways Youth and Family Services, Inc.*	Brad Brush	State Director of Residential Services	62
Presbyterian Children's Homes and Services	Cynthia R. Hileman	DFW Regional Director	44
Texas Baptist Home for Children	Jami Hogan	Executive Program Administrator	26
The Bair Foundation	Glenna Bilberry	State Director	18
Upbring	Frank Lopez	State Director-Foster Care & Adoption	69
Total Number of Licensed Homes Represented			**1,145**

*Submitted a partial response.

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[173] Texas Health and Human Services. (n.d.). *Search for child placing agencies for foster care*. Retrieved June 24, 2020, from https://www.dfps.state.tx.us/Child_Care/Search_Texas_Child_Care/ppFacilitySearchFoster.asp

Supplement 2C: Child Placing Agencies (CPAs) and General Residential Operations (GROs)

Table 26. Child Placing Agencies in DFPS Regions 3W (Non-CBC) and 3E

Child Placing Agencies by Region and County [174]		
Region 3E **Forty-four (44) CPAs are located in Region 3E with a total of 1,596 licensed foster homes.** There are no CPAs located in Fannin or Grayson counties.		
Name	**County**	**Licensed Homes**
CK Family Services, Inc. ^ *	Collin	184
Rise Services Texas, Inc.	Collin	11
The 2 CPAs with an office/branch office in Collin County have a total of **195** licensed foster homes.		
A Heart with Hope Family Services	Dallas	5
A Place Called Home	Dallas	4
A World for Children *	Dallas	33
Agape Manor Home, CPA*	Dallas	34
Amazing Grace Child and Family Services*	Dallas	41
Assuring Love Child Placement Agency*	Dallas	21
Benchmark Family Services*	Dallas	33
Buckner Baptist Children's Home*	Dallas	103
Circles of Care	Dallas	7
CK Family Services, Inc. ^ *	Dallas	67
Faithworks*	Dallas	28
Guiding Light	Dallas	2
Hope Cottage*	Dallas	28
Jae's Helpers	Dallas	12
Johnathan's Place Foster Family Program*	Dallas	59
Kids Grace CPA*	Dallas	19
Lifeline Children & Family Services*	Dallas	13
Lonestar Social Services*	Dallas	227
Make A Way, Inc*	Dallas	10
Methodist Children's Home	Dallas	6
Open Hearts Children and Family*	Dallas	27
Passage of Youth Family Center*	Dallas	50

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[174] Texas Health and Human Services. (n.d.). *Search for child placing agencies for foster care*. Retrieved June 24, 2020, from https://www.dfps.state.tx.us/Child_Care/Search_Texas_Child_Care/ppFacilitySearchFoster.asp

Child Placing Agencies by Region and County [174]		
Region 3E (continued)		
Name	**County**	**Licensed Homes**
Pathways Youth and Family Services, Inc.*	Dallas	62
Perfection Children Services	Dallas	8
Radcliff Youth and Family Services	Dallas	1
Refugee House*	Dallas	78
Texas Baptist Home for Families	Dallas	9
Tomorrows Children	Dallas	4
Upbring*	Dallas	69
Urban Neighborhood Initiative for Families and Youth (UNIFY)*	Dallas	11
Vessels with Purpose	Dallas	10
Youth in View*	Dallas	58
The 32 CPAs with an office/branch office in Dallas County have a total of **1,139** licensed foster homes.		
Benevolent House Child Placing Agency*	Ellis	34
Cherished Impressions*	Ellis	47
Circle of Living Hope*	Ellis	20
Heart to Heart Family Services*	Ellis	27
Presbyterian Children's Home & Services*	Ellis	44
Texas Baptist Home for Children*	Ellis	26
The 6 CPAs with an office/branch office in Ellis County have a total of **198** licensed foster homes.		
Children's Hope Residential Services, Inc.*	Hunt	39
The CPA with and office/branch office in Hunt County has a total of **39** licensed foster homes.		
REACH Child Placing Agency	Kaufman	4
The CPA with an office/branch office in Kaufman County has a total of **4** licensed foster homes.		
Lifeline Children & Family Services*	Navarro	6
The CPA with and office/branch office in Navarro County has a total of **6** licensed foster homes.		
Anchor Family Services, Inc.*	Rockwall	15
The CPA with and office/branch office in Rockwall County has a total of **15** licensed foster homes.		

Child Placing Agencies by Region and County [175]		
Region 3W (non-CBC) **Three (3) CPAs are located in Region 3W (non-CBC) with a total of 90 licensed foster homes.** *There are no CPAs located in Cooke and Wise County.*		
Name	**County**	**Licensed Homes**
Harbor of Hope, Inc.*	Denton	47
Texas Family Initiative LLC*	Denton	25
The Bair Foundation*	Denton	18
The 3 CPAs with an office/branch office in Denton County have a total of **90** licensed foster homes.		

^CK Family Services has locations in Collin and Dallas County

*CPAs that received our Environmental Assessment CPA Survey

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[175] Texas Health and Human Services. (n.d.). *Search for child placing agencies for foster care*. Retrieved June 24, 2020, from https://www.dfps.state.tx.us/Child_Care/Search_Texas_Child_Care/ppFacilitySearchFoster.asp

Supplement 2D: Overview of the DFPS Capacity Strategic Plan for Regions 3W (non-CBC) and 3E (Catchments 3A and 3C) (September 2019)[176]

The *Capacity Strategic Plan for DFPS Regions 3W (non-CBC) and 3E* was informed by the August 2019 DFPS Foster Care Needs Assessment and was developed in collaboration with foster care providers, faith-based entities, and child advocates in DFPS Region 3. The strategic plan is anchored in the belief that children and youth deserve to be part of a permanent home with a caring, committed individual and that they must be able to maintain a positive connection to their family and community supports. It also recognizes that building foster care capacity has a multi-pronged approach that includes recruiting new foster homes, decreasing placement disruptions, and ensuring children and youth are placed in the most appropriate setting.

The Capacity Strategic Plan identifies four goals that support the successful transition of child and youth to family settings: supporting children during all living transitions, placing sibling groups together in placements closer to home, supporting caregivers in meeting the needs of the children and youth in their care, and ensuring capacity needs are communicated to providers. The strategies identified to address these goals include providing kinship families with resources and supports, data-driven and targeted recruitment strategies for kinship and foster families, cross-provider information sharing, communication between DFPS and provider community on capacity needs, access to an array of supports and therapeutic interventions, and support for step down services for children and youth after residential treatment center (RTC) care.

Plan Goals and Objectives

Goal 1: Support children and youth transitioning to family settings (by strengthening family supports).

Objective 1.1: Support the transition of youth from paid foster care to kinship or other placements (provide kinship families with resources and supports, communicate need for wraparound services and pre-placement visits, involve the child in planning, and ensure safety plans are in place to address issues).

Goal 2: Maintain sibling groups, building capacity for sibling groups and older youth to be placed closer to home (children and youth should be able to maintain family connections and be placed in a permanent home with a committed, caring individual).

Objective 2.1: Ensure Centralized Placement Unit (CPU) searches remain active until siblings are placed together and close to home (within 50 miles) or with relatives. (Communicate the need

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[176] Texas Department of Family and Protective Services. (2019, September 26). *Capacity strategic plan: Region 3 West and East (catchments 3A and 3C).*
https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/CPS/documents/2019/2019-11-15-Region3_Strategic_Plan.pdf

for targeted recruitment and increased sibling placements, educate on the importance of sibling connections and sibling dynamics during placement transitions, ensure siblings can visit when placed apart.)

Goal 3: Build capacity for older youth to be placed closer to home and in a family like setting
Objective 3.1: Ensure older youth are placed close (within 50 miles) to home or with relatives. Encourage placements by building the confidence of caregivers to parent older youth, having frank conversations with youth, and offering pre-placement visits.

Goal 4: Identify supports to caregivers to meet children's needs (support caregiver, children, and youth to ensure children have the opportunity to be placed in the least restrictive placement and support transitions between settings).
Objective 4.1: Cross-provider education and information sharing (share information to help address barriers regarding transportation, therapies, and doctor's appointments. Engage services such as in-home therapy, YES Waiver, Early Childhood Intervention (ECI)/ECI Hopes, staff nurse practitioners, network doctors, and transportation).
Objective 4.2: Support transition of youth from RTCs to less restrictive settings. (Plan for child's post-RTC needs by engaging appropriate step-down services such as respite care, YES Waivers, therapy, and psychological evaluation. Facilitate pre-placement meetings and allow step-down visits. Develop safety plans.)

Goal 5: Keep the provider community informed of CPS capacity needs (discuss needs and trends and progress to meeting objectives).
Objective 5.1: Ensure communication from CPS on what is needed is relayed. Allow provider to relay to CPS what the plan is for growth while allowing opportunity for questions and concerns. (CPS and providers will exchange information on capacity at the quarterly provider meetings.)

Chapter 3:
Youth and Caregiver
Lived Experiences

Contents

Overview and Background

A critical part of our environmental assessment process was to hear from youth and caregivers with lived experiences in the child welfare system in DFPS Regions 3W (non-CBC) and 3E to complement the interview and survey data we collected from other key stakeholders, such as service providers and program administrators. The Meadows Institute hosted five (5) virtual focus groups and individual in-depth interviews with a total of 25 foster parents, six (6) kinship caregivers, and six (6) youth who had recently aged out of foster care. Their personal stories and perspectives deepen our understanding of how to strengthen the services and supports for children, caregivers, and families involved in the system and, ultimately, create better experiences and outcomes. This chapter presents our analysis of the key themes that emerged from this qualitative research. The insights and priorities highlighted by these stakeholders with lived experience are reflected and integrated into the recommendations provided in the other chapters of this report as well.

Originally, we planned to host in-person focus groups on multiple dates in April 2020. We partnered with local organizations that serve children and youth in substitute care as well as foster and kinship caregivers for recruitment. However, while we were recruiting participants throughout DFPS Regions 3W (non-CBC) and 3E, Texas went on lockdown due to the COVID-19 pandemic. Because of this, we shifted to a virtual format, conducting all focus groups by video conference and some individual interviews by phone in May and September 2020. We were able to obtain meaningful feedback using these formats, despite the fact that families were less connected to service providers during this time which presented obstacles to recruitment. Each focus group lasted 60 to 90 minutes, led by one facilitator from the project team and supported by another project team member who took notes and also monitored the chat feature. We asked participants to discuss both *what is going well* and *what needs to be improved* for youth and caregivers involved with the child welfare system in DFPS Regions 3W (non-CBC) and 3E. We have chosen to highlight the themes below that led to the most substantive discussions during the focus groups and interviews; we provide direct quotes from participants in italics to illustrate and contextualize the themes that emerged.

Themes From Youth

In September 2020, we conducted individual interviews and a focus group with youth with past foster care experience for this assessment. Of those youth, five had aged out of foster care within the last three years and one had been adopted. Some of the key insights gained through these conversations are summarized and discussed in this section. These perspectives highlight important considerations for those planning for a CBC system that provides for the diverse needs and personal goals of children and youth in substitute care.

Youth Theme 1: Deep, Authentic Relationships

Young people in foster care seek deep, authentic relationships with their foster families and a strong social support network. There was consensus among the youth participants that their ability to experience deep, authentic relationships with their primary caregivers was central to their sense of well-being in foster care. They talked in depth about the importance of having a permanent, parent-like relationship and their desire to be placed with foster parents who could ensure both physical and emotional safety and stability, and they made the connection that these needs are universal to all children and youth, not just those in foster care.

> *Still to this day, I'm in touch with my foster mom. She was over here two days ago. When we first got there, my sister and I had babies. My son was one, and [my sister] had a newborn. But when we got there, the foster mom invited all of us in. It was five of us total. We went into her house, and we were there ever since. She never made us feel uncomfortable. There was never issue with her buying stuff. She made us feel at home. Still to this day, I go to her for advice for anything.*

> *My principal and teachers all rallied together to keep me here [at school]. In three months, my art teacher became my kinship caregiver. I loved living with my art teacher. She was someone I already knew really well and trusted.*

Moreover, youth participants described a yearning to feel seen, heard, and wanted by their foster parents. They recounted both positive experiences of foster parents with whom they forged deep, trusting bonds as well as negative experiences, including isolation due to differential treatment in comparison to biological children in the home or feeling treated as a job for payment and receiving only what was required by Child Protective Services (CPS).

Having a strong social support network is also a key protective factor and plays an important role in a youth's transition out of foster care. Youth described the various relationships that they forged during their time in foster care, some that continued to endure even after they aged out of the system. The valued relationships they mentioned included foster parents, caseworkers, counselors, teachers, and CASA (Court Appointed Special Advocate) volunteers. While participants discussed the difficulties they faced after leaving foster care, they also noted how key relationships offered the critical support and guidance they needed to navigate and overcome many challenges as they transitioned towards independence.

> *The CPS Investigator's wife was a mentor figure to me. I could tell her anything, and I really trusted her. She loved me and helped me heal.*

> *After I aged out of care, I got a Transition Resource Action Center (TRAC) coach who has really been there for me and helped out a lot. I talk to her almost every day or every other day, and we also do a visit every three months. I think every CPS kid should be worked with after exiting care, not just the kids who age out of care after they turn 18.*

Youth Theme 2: Sibling Connections

Maintaining and strengthening connections between a child and their family of origin and siblings is critically important to a child's sense of well-being. Youth described their need for connection to their family of origin and the importance of maintaining ties to their culture and knowledge of their family as a necessary part of their mental health and healthy identity formation.

> *Because my mom led me to become a victim of sex trafficking, many of my caseworkers and foster parents wouldn't allow me to stay in touch with her. Caseworkers and foster parents can forget that we actually need our parents. Yes, it's true our parents weren't there for us, but you can never replace a broken spirit of not having a mother.*

We heard specific appreciation for foster parents and caseworkers who facilitated connections between a child or youth and their birth family. These activities included ensuring family visitations occurred and making connections to services that strengthened family bonds, such as family counseling.

> *I just wish that other family members were involved when I got taken away because, now that I started researching, nobody was really around when my mother passed away and when I was going through this. I have no way of getting in touch with them. I'm not sure if my grandmother or aunt is alive. I wish that they could keep my other family members involved.*

The amount of contact a child or youth has with their siblings also plays a significant role in their ability to adjust to foster care. Sibling contact strengthens their overall emotional support system. Youth reinforced the importance of keeping sibling groups together, and multiple participants insisted that this should be the highest priority in making placement decisions. They recounted how difficult and overwhelming it was to be separated from their parents and enter an unfamiliar environment. They described the fears and worries they felt after being placed in a home with strangers and how their own siblings created a layer of protection that eased their transition into foster care.

> *My siblings and I were initially all placed together. But my sister started acting out because she didn't like the home. And the parents couldn't handle her, so the home didn't work out, and I became separated from them. I wished they had been able to place us together in the right home. My siblings were all I needed. Being with my family was all I needed.*

They discussed the challenges of maintaining connection with their siblings once they were separated, which became further exacerbated when they experienced multiple moves.

I wish there was a system or at least a person who could have told me where my siblings were or where they last were. My oldest sister always kept in contact with my foster parent because she didn't change her phone number. But after she turned 13, I never heard from her again because she moved around so much.

Youth Theme 3: Normalcy

Normalcy is important for young people in foster care, and they desire increasing levels of independence and opportunities to practice autonomy. Youth formerly in foster care described their need for normalcy and how the social stigma of being in foster care weighed heavily on them. Their desire to feel like a "normal kid" was important, and they described disappointments when they missed opportunities to participate in the same social activities as their peers. They also expressed frustration about a system that did not seem to encourage typical adolescent development, which involves building trust with caregivers to support the need for increased independence.

There is a trauma of not being normal. Of being labeled as a "CPS kid." I wished CPS and my foster parents put more effort into creating normalcy for me and not just focusing on my safety. There are a lot of CPS guidelines that prevent normalcy from happening. I wanted to go to the mall with my friends and have sleepovers. I wanted to be able to have a phone and use social media. My older brother wanted to pick me up and take me out, but I wasn't allowed to because of CPS guidelines.

Children and youth in foster care have many strengths and remarkable resilience. Enhancing their time in foster care with extracurricular and community service opportunities will help them develop important social skills, build a deeper connection to their community, and instill self-confidence and self-worth. Youth described both their struggles as well as a deep sense of gratitude and a desire to find value and create positive meaning from their experiences in the child welfare system.

I want to share my lived experiences with others and use it to make the foster care system better.

They also described how participating in activities that allowed them to serve their community, using their lived experience to mentor other children and youth in foster care, and other types of volunteering helped them to discover their own value and strengths, reduce their depression and feelings of isolation, and develop deeper community connections.

I discovered my love for volunteering during school, and It helped me get out of my depression, which was really bad while I was in foster care. It might seem small to you, and even I, but it's these little things that might make a world of a difference. Helping load up the food pantry, decorating the town square, sorting out the toys for the toy drive. Even something small like that might help someone get out of their funk, even for just a couple hours. It's one of those things that helps you feel like you're a part of the community.

Youth Theme 4: Trauma-Informed Care

When the child welfare system is responsive and equipped to address the unique trauma and grief of children and youth in foster care, it can be a powerful conduit for facilitating a healing process for their trauma. Youth described their grief and feelings of isolation after being removed from home and family as well as their experiences trying to cope with the trauma that brought them into foster care (i.e., abuse and neglect). They described their desire for healing and for a system that would be responsive to their grief and trauma and equipped to treat it appropriately and effectively.

> *When I left to CPS, one night you go from being surrounded by family to suddenly being in a room with strangers with clip boards. I didn't feel safe going from home to home, stranger to stranger. It affected me growing up with people telling me that they cared about me and then passing me on.*

To support the healing process, youth in foster care desire more rapport-building opportunities with their caseworkers. Youth participants described the significant role their caseworkers played in their case progress and the importance of developing a collaborative and trusting relationship with them. They described the caseworker as the gatekeeper to resources, holder of key information and knowledge about their case, and the main communication bridge between their foster parents, birth families, and other stakeholders involved in case progress. Youth emphasized that caseworkers must be able to invest adequate time and attention into each case and prioritize more meaningful interactions and visits with each child in order to maintain an accurate understanding of the child's needs.

> *My last caseworker was sweet. She came out when she needed to. She didn't put us on the spot. We could come and vent to her. I don't know how she did it, but there wasn't any tension in the house. My caseworker and I went out to eat about once a month and talked about what was going on. She made sure we had our visitation on time. She made sure that her colleagues would help us get to where we needed. I didn't have a bad experience with her at all.*

For youth participants, more meaningful interactions would also promote stronger collaboration and cooperation between the child and caseworker throughout case planning.

> *CPS caseworkers should keep asking us how we are feeling or what we're thinking or why we went through what we went through. It takes some kids time to open up. They're like a little Jack in the Box—you got to keep rotating and rotating. But eventually, they'll open up when they hear you continuously asking those questions because they'll know you're actually concerned.*

Youth Theme 5: Mental Health and Transition Services

Youth in foster care seek more personalized mental health services and additional guidance on how to access the benefits available to them. Youth participants advocated for more effective psychological assessments and mental health treatment options that better matched their individual needs and preferences. Some said psychological assessments felt rushed and could result in inaccurate diagnoses and medication prescriptions. Several of the participants also reported that the mental health services they received while in care were inadequate or ineffective.

> *For the counselors, they should have more people who I can relate to. My counselor was kind of older, and she didn't really talk to me. We should have more involvement in who we choose. I had an actual connection with my second counselor. And it really makes a difference.*

They observed their foster parents struggling to navigate the mental health system and identify how to obtain appropriate support when caring for children and youth with complex needs and challenging behaviors. Youth participants believed that the child welfare system tends to over-rely on medication to manage challenging behaviors.

> *Children should just be worked with—their only medicine should be therapy. It shouldn't be actual medication in high doses to make them tolerable and easier for the foster parents. My siblings were really bad. I am not going to lie. So often, my CPS placements would put them on meds just to calm them down and make their jobs easier. In these situations, you need to raise their level of care for the children, not put them on medication and put them to sleep. Kids are going to be kids. And they're going through a grieving process because they miss their parents.*

Youth found the Preparation for Adult Living (PAL) Program helpful for equipping them with practical skills and knowledge necessary for their transition out of foster care. Participants saw the opportunity to improve and clarify communication and guidance on how to access and utilize these benefits. Youth viewed the PAL program as an important opportunity for developing skills to achieve independence and to advance toward their educational or career goals. According to participants, the aftercare services and supports they received once they transitioned out of foster care were critical and had positive impacts on their lives.

> *Kids really enjoy the PAL program because it's really practical and teaches them independent living skills, like how to drive or use public transportation, and helps them get a job. I love it because I am able to go college and get tuition waiver assistance. I think kids should be able to start the program earlier, at age 15 instead of 16.*

Some participants, however, felt that the PAL program could be stronger. For example, the program could be more valuable if it offered more in-depth education and training on topics such as relationships and intimate partner abuse and violence. Also, some participants felt that

CPS should provide clearer information to youth in foster care on program eligibility and ensure they know how to access medical, educational, and social services after exiting care.

> *The PAL program was beneficial. It taught me how to do banking, manage time and relationships, and about life when you age out of care. I went through that class and they gave me $1,000, too. I feel like they should go in more detail about things. For example, they noted that they would pay $500 a month up to $3,000 on your rent, but once you get out of care, you find out all these [new] details of what you need to have in order to qualify for these benefits. But PAL was good, it was worth it. I get free college. Now it's what I'm trying to do. They just need to go through more details.*

Themes From Foster Parents

In May and September 2020, we conducted three focus groups with a total of 25 foster parents. We recruited caregivers with a mix of backgrounds and experiences, and from various locations within the region to try to get both in-depth and representative information. The foster parent perspectives we collected highlight important considerations for those planning for a CBC system that supports the diverse parenting needs and goals of foster parents.

Foster Parent Theme 1: Support With Behavioral Health Services

Foster parents need support identifying, vetting, and accessing behavioral health services for the children and youth in their care. Foster parents shared that most of the children in their care were referred by CPS or ordered by the courts to receive certain types of mental and behavioral health services. A shared experience among participants was that the foster parent would receive a list (often a short list) of mental health providers from their caseworker and be expected to call each listing until they found a practice open to new patients and able to take Medicaid (STAR Health), the child's health insurance. Sometimes the caseworker would provide a "warm handoff" by making the introduction between the family and provider and ensuring the service was a good fit, which participants noted as helpful. However, foster parents reported that warm handoffs were the exception rather than the rule. Thus, many foster parents felt lost and overwhelmed trying to connect children in their care to all the behavioral health services needed.

The most common barriers to behavioral health care for children and youth, as reported by the foster parents, were a lack of provider capacity in rural areas, lack of providers who accepted Medicaid (STAR Health), being placed on a waiting list for needed therapies, and delays in the child receiving timely medication refills during a foster care placement change. These foster parents also struggled to find providers who offered non-traditional office hours and home-based services. Finding providers was particularly difficult if the foster care placement was in a different county than the child's home and previous services, or if the child had multiple health care needs/services, such as for speech therapy, specialty care, and counseling.

> *Our oldest toddler has a PTSD diagnosis, but we literally could not get someone to give the number of a therapist who would accept Medicaid. Got two numbers and they didn't work. Thankfully, I knew where to start finding resources because I worked in the system. We can't have a toddler running around with PTSD with no support. That is asking for trouble, and when trouble occurs it falls on you. You are the one that gets questioned. You are the one they drill for all the answers.*

Foster parents who were able to connect with one of the full-service health care programs or CPAs in the area reported that they had a better experience navigating services. Participants mentioned local providers—such as the Rees-Jones Center for Foster Care Excellence, Pathways Youth & Family Services, and CK Family Services—who offer one-stop shops with effective and supportive approaches to youth and family services. When the provider was able to connect these foster parents with a full array of child welfare, basic needs, and mental and behavioral health services, the foster parent felt they had what it would take to succeed in supporting the children and youth in their care. Some parents who had been fostering for a number of years shared that mental and behavioral health services in the region seemed to be getting more accessible and higher quality than in the past.

> *Rees-Jones Foster Clinic has been a great asset to us; not sure we could function without them. They have been the launchpad for every service we receive: counseling, occupational therapy, feeding therapy, medical care. My one-year-old has a lot of medical needs. To have that wraparound support in one place really close to us has been a huge asset.*

Foster Parent Theme 2: Partnering With Birth Parents

Foster parents identified the need for more guidance on how to partner with birth parents. Participants in our focus groups and interviews felt that it was up to them to navigate the complicated relationship with birth parents, and many felt ill-equipped to do so. Some foster parents received guidance on working with birth parents that helped them have a better experience with fostering overall. For example, they were educated by caseworkers about the potential risks and challenges as well as the various strategies for partnering with birth parents, such as passing a journal back and forth between visitations and court hearings to share information about the child's daily routine and experiences. A few participants described being trained to serve as mentors to the birth parents or taking the initiative to find strategies for co-parenting. Some families had participated in structured programs such as Collaborative Family Engagement, a partnership between CPS and Texas CASA that brings foster families, birth parents, and other family and supportive individuals together in a team approach. While this model is not yet available in all counties of DFPS Region 3, those who had participated found it valuable.

Other participants shared that they had been discouraged from interacting with birth parents by their caseworkers or by other foster parents who had negative or unsafe interactions in the

past that colored their attitudes. When caseworkers provided clear and timely information about the birth parent's situation and guidance on how to best engage with them, the foster parents we spoke with felt informed and empowered.

> *The only time I interact with her bio parent is during visitation, but that's my kids' time with them. I'm not going to insert myself and be part of that and take time away. Would be nice if there was something like a supervised visit but for bio parents and foster parents. A "get to know you."*

Some foster parents we spoke to wished that the goal of reunification was more clearly articulated to all parties and more frequently reinforced with the birth parent. Strained relationships with birth parents and foster parents sometimes resulted because birth parents did not understand that reunification was the primary permanency goal, thus saw the foster parent as competition or as a threat to their family. When caseworkers explain the role of the foster parent and set expectations with birth parents early on, that can set up the relationship for success. In the absence of clear messages on longer-term goals for the child, some birth parents felt the foster parent was there to replace them or that the caseworker and other parties were not working toward parent-child reunification.

> *Once he understood we weren't trying to steal his child…that we were there to love on and nurture her until he could get to a spot to get her back, then he understood we were on his team and rooting for him. After that he made a complete 180.*

Foster Parent Theme 3: Training, Coaching, and Peer Support

Foster parents appreciated the training they received, but felt it would be more impactful if bolstered by follow-up coaching and peer support for them as well as complementary training for school professionals. Foster parents praised the quality of the training they received from the state and the CPAs that licensed them to foster. Participants valued the local momentum for foster parent training on trauma-informed approaches to working with children who have experienced abuse and neglect. After receiving such training, they felt empowered and equipped to deal with behavioral issues that a child or youth in their care exhibited that stemmed from trauma. Participants also felt that some of the cultural competency trainings they received were helpful when they were new to fostering, though their experience varied by which agency delivered the training. Foster parents also noted they could benefit from additional in-home coaching once a child from a different race, ethnicity, or cultural background was placed in their home.

> *To throw them into a cross-cultural home and hope for best and hope the person intercepting them knows what's up—we wouldn't send a kid with asthma to a home without an inhaler. For the sake of the child, there needs to be more training and support following placement.*

Participants also reported that they wanted to see more training for school administrators, teachers, and counselors about the child welfare system and the impact of trauma on behavior. Many parents cited examples of harm caused to their foster children in the school setting, including stigmatizing practices or harsh discipline practices, bullying, and unnecessary restrictions that had an impact on normalcy. Some foster parents we spoke to were willing to volunteer to provide training in schools themselves if system stakeholders could arrange such opportunities with the schools or at the district level.

> *My experience with the school system: there is not enough support there. They are taught to teach, but have no knowledge of the foster care system at all. I know we have a special advocate [for youth in foster care] for the region, but it takes time to get those people in place. It would be beneficial as part of teacher training to let us [foster parents] go into the schools and give basic information about foster care and the needs of our kids.*

Beyond the formal trainings from their licensing agencies, participants shared praise for and a reliance on their peer support networks when they had a question or needed to learn how to do something in the system. Most foster parents were connected with some form of peer support (i.e., other foster parents), which they saw as a crucial component of their overall support system. For example, foster parents reported that a peer was almost always the first person they would go to with a need, concern, or question before reaching out to a caseworker or other professional. The foster parents we met mentioned various avenues for connecting with peers who had personal experience with foster care, including private online forums, in-person informal affinity groups focused on a particular topic, church-sponsored groups, and formal peer support programs organized by CPAs. Peer support was particularly useful for foster parents looking to connect with others who shared their same cultural background or circumstances, such as LGBTQ+ parents or single mothers.

Foster Parent Theme 4: Respite Services and Preventing Burnout

Easier access to respite services, such as after-hours babysitting, and fewer restrictions on in-home visitors may prevent foster parent burnout. Some foster parents expressed frustration with the difficulty of hiring a babysitter for a few hours of occasional respite because of licensing requirements. Some CPAs require anyone who babysits to have a current background check as well as training in CPR and first aid, and be certified only through their specific agency. Foster parents in the focus groups and interviews who were licensed to foster directly with DFPS (instead of through a private agency) said they did not experience the same barriers. Foster parents without extended family in the area reported that they were particularly in need of a respite network, and found it difficult to establish one. A number of the participants had been advised by peers to take a few months off between placements in order to avoid burnout caused by a lack of respite.

If you need someone standing on the steps of the Capitol in Austin to try to get the law changed to allow the babysitting situation to get better, I'm there. The biggest issue foster parents have is babysitting restrictions.

Similarly, foster parents reported that restrictive limitations on family and friend visitation were also a source of frustration and burnout for them and for other foster parents they knew. Not only do frequent visitors have to go through the same extensive background check, training, and licensing steps as respite providers and babysitters, they are sometimes limited in the number of times they can visit the home in a certain timeframe. One mother said she had a wonderful experience with the children she fostered, her caseworker, her agency, and her CASA, but explained that she still found it too hard to continue fostering under these conditions, as described in the quote below.

I actually don't think we are going to foster for a while after this placement because I'm so frustrated with the babysitter and visitor policies and hoops we have to jump through. I would love to have friends and family over more than twice a month. I literally have to check my calendar and tell them they can't come over because we have already seen them too much.

Foster Parent Theme 5: Better Communication and Coordination

Better communication and coordination between CPS, CPAs, and foster parents would improve outcomes. Under the legacy child welfare system, private CPAs are not directly involved in the child's legal case or with the birth parents, which some foster parents believed resulted in their CPA caseworker being out of the loop and unable to provide the timely case information the foster parent needed. Multiple participants said they preferred to interact directly with CPS to save time and to have access the most up-to-date information on the child's legal case, service plan, and other information about potential moves. Beyond that, the foster parents we spoke to sometimes felt like unpaid intermediaries in the child's case when the paid professionals, such as attorneys and caseworkers, would look to them for information. Some foster parents even found these interactions to be an added stressor. Further, high turnover of both CPA and CPS caseworkers throughout the course of a child's case led to miscommunication and inconsistencies in care preferences and in how child welfare rules were enforced.

While some foster parents we spoke to felt like a go-between, participants also lamented that their voice was not valued enough and that they were not often included in important decisions about the child or youth in their care. Even though a child or youth lives with them and full responsibility for the child rests with the foster parent, participants reported that they were rarely able to provide feedback on service plans or in court hearings. We heard many examples where children were moved without much communication with the foster parents and without a collaborative plan for a nurturing transition. Based on our interviews and focus group

discussions, foster parents want to be part of the team with agency staff to support children and youth, which means having a voice in case planning.

> *Train caseworkers to set appropriate expectations with foster families, don't speculate [on case outcomes] and set them up for heartbreak. Be honest about what you don't know. Train new caseworkers in humility, listening to the lived experience of foster parents who may have a lot more experience in the system than they do.*

Many foster parents praised CASA volunteers and supervisors for treating them as equal partners, doing a good job facilitating communication among key parties, and serving as a resource. When the parent had a question, their CASA volunteer was seen as a reliable, well-connected point-of-contact and someone the foster parent could count on to do the work necessary to obtain information if they did not readily have an answer. The [Quality Parenting Initiative](#) through Our Community Our Kids in DFPS Region 3W (CBC) was also cited as a valuable resource to help foster parents understand the system and promote system transparency. Hosted by a local judge, these quarterly gatherings bring together mental health providers, kinship and foster families, attorneys, caseworkers, and others in an open forum to answer questions about the law and to dispel myths around key child welfare issues, such as birth parent relationships and confidentiality.

Some participants felt that local CPA staff did not have the capacity to offer the support foster parents need, either because of the size of their caseloads or because of the way the system was structured, which prevented their direct access to the most up-to-date information about the child's legal case. When asked what they received from their CPA caseworkers, some described the interactions as rote, with monthly visits mostly focused on compliance, requesting paperwork from the foster family, and checking off their monitoring lists rather than offering a service or concrete support. Participants reported that they spent a significant amount of time collecting and submitting documentation, and that paperwork was sometimes lost in the system. The foster parents we spoke to wanted to see a more streamlined, paperless system for managing court reports, incident reports, and other required documentation. They would also like to see CPA staff as more proactive in reaching out to offer support, less oriented toward compliance, and better funded to be able to do the work of connecting them to resources and navigating the system.

Foster parents did value the CPA for the security it offers during difficult situations, such as an investigation or a placement breakdown. CPAs were seen as a sounding board and extra level of protection if anything went wrong with a placement. Those foster parents who were connected to the larger CPAs in the region that provide a full-service array had positive things to say about supplemental services, such as behavioral health supports and respite programs. Many

participants said they felt comfortable calling their caseworker in the middle of the night or during a crisis, and most had experience doing that in the past.

> *We have always had a great relationship with our agency. They have been available when we needed them. We also steer that boat ourselves. Caseworker, advocates, attorneys: if we email one, we email everybody. We [as foster parents] make sure we were all a team. We didn't wait to be invited to do that.*

Foster Parent Theme 6: Logistics, Appointments, and Transportation

The logistical challenges of coordinating and transporting children and youth in their care to various appointments, court appearances, and school and extracurricular activities can strain foster parents. Foster parents—particularly those who had multiple children in the home—indicated a need for more support with transportation. Many of the parents we spoke with were responsible for transporting the children in their care to numerous appointments each week. For example, family visitation often involves multiple locations for mother, father, and sibling visits. Family visits, combined with school and extracurricular activities, court hearings, psychological and other assessments, and any number of physical and mental health appointments, require a significant investment of time, money, and energy. If an issue arose at school for one child (which it often did), a caregiver's unscheduled trip to that campus could compromise their ability to get other children to mandatory appointments, and could result in the foster parent being out of compliance with licensing minimum standards.

> *Our kids have a lot of needs, as any child does in foster care. Our case is pretty extreme: 17 appointments per week. My biggest complaint with the whole process is getting them to the services.*

The focus group and interview participants who had multiple children and youth in the home, or children with services or family visitation outside of their county, found managing those logistics to be the most difficult part of their role. Though they understood the importance of appointments and activities, they also expressed anxiety around not being able to meet the expectations placed on them. A few participants shared positive experiences with a program in Tarrant County that facilitates visitation by providing transportation, but few had access to such supports. And even when appointments were virtual, caregivers faced logistical challenges.

> *It has been a nightmare to get my children services. Because I took my children during COVID, it was even more challenging. My bio kid has to be in a different room for virtual visits. But as a single parent, I can't facilitate virtual visits with one kid while others are running around the house.*

Themes From Kinship Caregivers

In September 2020, we conducted one focus group with six kinship caregivers who shared their perspectives and lived experiences with the child welfare system. Each was caring for at least one grandchild, niece, or nephew placed in substitute care in DFPS Region 3. Two prevailing themes were dominant in the kinship caregiver focus group discussions and are summarized below. These perspectives highlight important considerations for those planning for a CBC system that supports relative caregivers.

Kinship Caregiver Theme 1: Limited Guidance and Support

Kinship caregivers were less likely to be working with a CPA than foster parents, and some expressed feeling lost without advocates, peers, or system navigators they could identify early on to guide them through the foster care process. Kinship caregivers described a markedly different experience with the foster care system than the non-relative foster parents we interviewed. Because the sudden removal of a child from home often initiates their engagement with the foster care system, kinship caregivers lack time to train or prepare for fostering, are unfamiliar with administrative requirements for fostering, and feel ill-equipped to locate providers for services mandated by the courts for the children and youth in their care.

> *We need more resources for kinship. The caseworker does not always have time to explain things or to go over things with you. They gave me a stack of papers and told me to sign them. I had to read through the papers myself and figure them out. We need a better explanation of things and how things work.*

Kinship families may receive more support if they go through the foster parent licensing process, including a stipend from the state and ongoing assistance from a CPA. However, the process to become licensed is optional and can be challenging, so few kinship families in the state (and in our research) have gone through this process.[177] As a result, they do not have the benefit of monetary assistance or other supports. The kinship caregivers we spoke with, similar to the foster parents, praised CASA workers for playing a crucial role in supporting them and their foster children.

> *Most people don't know enough of the system to be able to know where to go, or who to call, or what to ask. So, the sad part is, if you're not working with a placement agency, it's harder. The agency should be working to open those doors for you. But my CASA has been my rock.*

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[177] Texas Department of Family and Protective Services (2020, June 28). *CPS 3.2: Children in substitute care by placement type on August 31, FY 2010–2019.* Data Book. https://data.texas.gov/Social-Services/CPS-3-2-Children-in-Substitute-Care-by-Placement-T/kgpb-mxxd

Kinship Caregiver Theme 2: Birth Parents Relationships

Kinship caregivers identified accountability and access to services for birth parents as lacking.
Because of their familial connection to the birth parent, the kinship caregivers in our focus
group had a variety of experiences and emotions about how to navigate this relationship in the
best interests of the children in their care. The caregivers shared stories that highlighted a
complex dynamic they had with birth parents and a relationship that was often strained. A few
described the pain of having to watch as their adult children or siblings were separated from
their children, while also having the responsibility to uphold rules and court orders that limited
visitation and information sharing.

> *You asked if I had a magic wand? It would be that my daughter wouldn't be on the street and on
> drugs and I didn't have to do this. That was one of the hardest parts—having to be in court and
> hear all this about your child.*

Participants felt they experienced an added emotional toll beyond what non-relative foster
parents face because of this relationship.

> *My advice to kinship caregivers is to be ready emotionally to separate yourself from the relative
> and set boundaries with extended family.*

Kinship caregivers we spoke to take the responsibly of upholding the court orders very
seriously, while recognizing the emotional strain it placed on them. A few also encountered
caseworkers, attorneys, and judges who displayed mistrust or skepticism about whether they
would be able to keep the child safe.

> *You hear their disbelief, "Well I don't know, are you sure you're going to be able to keep her
> away from your daughter?" I had to stand there and fight for my grandkids and tell them, "I kept
> these kids away from my daughter long before your court ever said to do so."*

Participants also felt the available substance use treatment services in the region were not
sufficient to help their relative get to a place of recovery that would enable reunification. Some
did not trust the quality of the parenting classes either, and experienced some court-ordered
services a "box checking" instead of connecting the birth parent with effective services
matched to their individualized needs. While all six kinship caregivers agreed that reunification
should be the primary goal of the system, they felt the requirements for a birth parent to regain
custody of their child were not sufficient, and that this could result in trauma to the child due to
lack of stability and moving in and out of substitute care.

> *It's failing the kids. They are holding them to the bare minimum. Parents need to be held to the
> same standards as we are as relatives.*

Conclusion

Youth and caregivers must be involved in foster care system planning and have a real voice. There must be a mechanism to engage them in the process in meaningful ways and an opportunity for them to weigh in on CBC readiness and planning efforts. The lived experiences and perspectives we offer here from select youth and caregivers in DFPS Regions 3W (non-CBC) and 3E provide descriptive information that contextualizes and complements the findings in other areas of this report, and provides more details on existing trends in the region. These findings set the stage for our analysis of other research and data as well as for our recommendations throughout the report to support CBC planning and implementation.

Chapter 4:
Mental Health

Contents

Introduction

The Community-Based Care (CBC) Readiness Steering Committee for DFPS Regions 3W (non-CBC) and 3E and other key stakeholders identified mental health as one of the three main areas to explore in depth as part of our environmental assessment. Mental health providers play a crucial role in supporting children and youth in substitute care, their families, and their foster families. For many families involved in the child welfare system, mental health support can positively impact reunification, permanency, and educational stability. In this chapter, we highlight the critical role of mental health in CBC readiness efforts and presents opportunities for involving mental health stakeholders in DFPS Regions 3W (non-CBC) and 3E early in the planning process, and at every step of the way toward full CBC implementation.

In **Part 1** of this chapter, we provide an overview of the mental health needs seen in the child welfare system nationally, across Texas, and throughout DFPS Regions 3W (non-CBC) and 3E, as well as the mental health services and supports currently available. Following this overview, **Part 2** summarizes the top themes and findings that emerged from the data we collected and analyzed, and we provide recommendations for CBC planning and implementation in relationship to the functions of mental health services and supports. In *Supplement 4A: Mental Health Best Practices for Children, Youth, and Families* at the end of this chapter for more information on interventions that may be provided to children and youth involved in the child welfare system.

Methodology

To examine the strengths and needs in DFPS Regions 3W (non-CBC) and 3E with respect to mental health, we incorporated multiple data sources into our analysis. To start, we analyzed prevalence data to understand the behavioral health needs among children and youth in DFPS Regions 3W (non-CBC) and 3E. We then engaged with individuals in the community who represent organizations that provide mental and behavioral health services to children, youth, and families involved in the child welfare system. This group of organizations included local mental health authorities (LMHAs), Child Placing Agencies (CPAs), nonprofit mental health providers, primary care providers, residential treatment centers (RTCs), emergency shelters, faith-based service providers, and school districts. Finally, we referenced our review of regional providers conducted less than one year prior to the start of this environmental assessment.

Part 1 – Mental Health Needs, Trends, and Findings

The majority of children and youth entering substitute care have been exposed to violence, and many have parents with histories of substance use, criminal justice involvement, intimate partner violence, and mental illness.[178] These experiences are often compounded by other traumatic factors that include homelessness, unsafe neighborhoods, poor quality schools and child care, inconsistent school attendance, and a lack of typical childhood experiences. Removal from home and placement into substitute care is in itself a traumatic experience. It can be accompanied by loss of contact with family and friends, separation from siblings, school changes, and unstable substitute care placements, which can lead to emotional and behavioral difficulties.

Given this, it is not surprising that children and youth in substitute care are far more likely to have a mental health condition than their peers who are not in care. In fact, children and youth in substitute care use mental health services roughly 10 times more than children and youth in the general community.[179] Further, over 80% of youth aging out of substitute care have received a psychiatric diagnosis.[180,181,182] In addition, children and youth in substitute care have been found to have poorer mental and physical health relative to children in every other type of family situation, including those in poverty.[183] The combination of poor physical and mental health can result in poor emotional regulation, aggression, hyperactivity, inattention, impulsivity, and dissociation between thoughts and emotions.[184] Considering the elevated and complex mental and behavioral health needs of children and youth in the child welfare system, CBC provides an opportunity for communities to address these needs strategically while designing a system that supports a child's overall well-being, including their mental health.

This section of the report offers an overview of national and state data on the mental health needs of children and youth in substitute care with a focus on children and youth in DFPS

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[179] Laurel, K. L., Landsverk, J., Ezzet-Lofstrom, R., Tschann, J. M., Slymen, D. J., & Garland, A. F.(2000). Children in foster care: Factors influencing outpatient mental health service use. *Child Abuse and Neglect, 24*, 465–476. https://doi.org/10.1016/S0145-2134(00)00116-2

[180] American Academy of Pediatrics. (2015). *Helping foster and adoptive families cope with trauma*. https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/Guide.pdf as cited in Salisbury A. L., Ponder, K. L., Padbury, J. F., & Lester, B. M. (2009). Fetal effects of psychoactive drugs. *Clinics in Perinatology*, *36*(3), 595–619.

[181] Greeson, J. K., Briggs, E. C., Kisiel, C. L., Layne, C. M., Ake, G., S., Ko, S. J., Gerrity, E. T., Steinberg, A. M., Howard, M. L., Pynoos, R. S., & Fairbank, J. A. (2011). Complex trauma and mental health in children and youth placed in foster care: Findings from the National Child Traumatic Stress Network. *Child Welfare*, *90(*6), 91–108.

[182] Salazar A. M., Keller, T. E., Gowen, L. K., & Courtney, M. E. (2013). Trauma exposure and PTSD among older youth in foster care. *Social Psychiatry and Psychiatric Epidemiology, 48*(4). https://doi.org/10.1007/s00127-012-0563-0

[183] Turney, K., & Wildeman, C. (2016, August). Mental and physical health of children in foster care. *Pediatrics, 138*(5), e20161118. https://doi.org/10.1542/peds.2016-1118

[184] Council on Foster Care, Adoption, and Kinship Care, et al. (2015, October). Health care issues for children and adolescents in foster care and kinship care. *Pediatrics, 136*(4), e1131–e1140. https://doi.org/10.1542/peds.2015-2655

Regions 3W (non-CBC) and 3E. The focus of this chapter of the report is on the mental health needs of children and youth in substitute care; however, it is important to acknowledge that we frequently heard about the need for biological parents and caregivers to have better access to mental health and substance use disorder services as well. Indeed, supporting the whole family is essential to achieving reunification. While we do not address access issues for biological parents and caregivers in this chapter, we do recognize this as a significant barrier to reunification and permanency and recommend CBC planners include these access issues in their implementation planning. As such, in this section we review the current service options available to children and youth in substitute care with complex mental health needs specifically, compare that to the robust array of mental health services shown to have successful outcomes for children and youth, and highlight opportunities for improving mental health outcomes through CBC implementation. For more background on the needs, resources, and developing opportunities to better serve children and youth with mental health conditions in North Texas, see the Meadows Institute's _Dallas County Mental Health Service Delivery System for Children, Youth, and Families: 2019 System Assessment Report_.[185]

National Trends

Children and youth in substitute care are far more likely to have a mental health condition than their peers who are not in care. They are five times (5x) more likely to experience anxiety, six times (6x) more likely to struggle with behavioral problems, and seven times (7x) more likely to struggle with depression.[186] As noted above, up to 80% of children and youth in substitute care have a significant mental health need; in addition, at least one in two (50%) have more than one mental health diagnosis.[187,188]

Addressing the mental health needs of children and youth in substitute care is critical for a number of reasons, including for placement stability, permanency, and, most importantly, a child's long-term health and well-being. Placement stability—a short-term target outcome of the CBC model—impacts a child's mental health _and_ is impacted by their mental health. Children and youth with a diagnosis of serious emotional disturbance (SED),[189] for example,

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[185] Meadows Mental Health Policy Institute. (2020, March). _Dallas County mental health service delivery system for children, youth, and families: 2019 system assessment report._ https://mmhpi.org/project/dallas-county-mental-health-service-delivery-system-for-children-youth-and-families/

[186] Turney, K., & Wildeman, C. (2016, August). Mental and physical health of children in foster care. _Pediatrics, 138_(5), e20161118. https://doi.org/10.1542/peds.2016-1118

[187] Council on Foster Care, Adoption, and Kinship Care, et al. (2015, October). Health care issues for children and adolescents in foster care and kinship care. _Pediatrics, 136_(4), e1131–e1140. https://doi.org/10.1542/peds.2015-2655

[188] Lehmann, S., Haviks, O. E., Havik, T., & Heiervang, E. R. (2013). Mental disorders in foster children: A study of prevalence, comorbidity and risk factors. _Child Adolescent Psychiatry Mental Health, 7_(39), 1–12. http://www.capmh.com/content/7/1/39

[189] Serious emotional disturbance (SED) is defined as a mental, behavioral, or emotional disorder that lasts long enough to impair functioning and substantially interfere with the child's or youth's ability to function in their family, school, or community.

experience more placement instability than their peers.[190] And, regardless of mental health status upon entering substitute care, children and youth who experience multiple placements are at increased risk for behavior problems (up to 63% more likely than their peers with fewer placements), which can impact permanency.[191] The earlier any child with a mental health need can access services, the better their outcomes overall. Children, youth, and families experience better outcomes when they are connected to services and supports at the onset of symptoms.

Needs of Key Subgroups

In order to understand how to address the mental health needs of *all* children and youth in substitute care, it is important to acknowledge the unique needs of various subgroups of children and youth. By being aware of these unique needs, those planning and implementing CBC can ensure that children and youth have access to developmentally appropriate care as well as other specialized interventions. The following sections summarize these needs using both national and local data.

Young Children

National trends indicate that children are increasingly younger when they enter the child welfare system. The median age of children entering substitute care nationwide dropped from 9.8 years to 7.6 years between 2008 and 2018.[192] In DFPS Region 3 as a whole, almost half (45%) of the children entering care are under five years old; of those, 27% are under the age of two.[193] The cognitive and emotional development that occurs in the early years—especially the first five years of life—is rapid, critical, and foundational.[194,195] Unmet developmental needs have a profound impact on a child's immediate and ongoing mental health and overall resiliency as well as on their educational, relational, and social aptitude. Early exposure to stressors, such as abuse and neglect, can impact a child's language acquisition, health, and ability to establish healthy attachments to caregivers.[196] Healthy brain development and parent-child attachment occur when a child's developmental needs are continually met over an

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[190] Casey Family Programs. (2018, August). What impacts placement stability? *Strategic Brief: Strong families.* https://caseyfamilypro-wpengine.netdna-ssl.com/media/SF_Placement-stability-impacts.pdf

[191] Rubin, D. M., O'Reilly, A. L., Luan, X., & Localio, A. R. (2007). The impact of placement stability on behavioral well-being for children in foster care. *Pediatrics*, *119*(2), 336–344. https://doi.org/10.1542/peds.2006-1995

[192] Children's Welfare Information Gateway. (2020, May). *Foster care statistics 2018.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. https://www.childwelfare.gov/pubPDFs/foster.pdf

[193] Texas Department of Family and Protective Services. (2020, August). *Regional statistics about children in DFPS Care.* https://www.dfps.state.tx.us/Doing_Business/Regional_Statistics/default.asp

[194] American Academy of Pediatrics. (2000). *Helping foster and adoptive families cope with trauma*. https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/Guide.pdf as cited in Salisbury A. L., Ponder, K. L., Padbury, J. F., Lester, B. M. (2009). Fetal effects of psychoactive drugs. *Clinics in Perinatology*, *36*(3), 595–619.

[195] Boyce, W. (2015). Fostering early brain development. *Journal of the American Medical Association*, *313*(15), 1564–1565. https://doi.org/10.1001/jama.2015.34

[196] Robinson, L. R., Bitsko, R. H. Thompson, R. A., Dworkin, P. H., McCabe, M. A., Peacock, G., & Thorpe, P. G. (2017). CDC Grand Rounds: Addressing health disparities in early childhood. *Morbidity and Mortality Weekly Report, 66*, 769-772. http://dx.doi.org/10.15585/mmwr.mm6629a1

extended period of time. These reinforcing, nurturing experiences can be both reparative and preventative.[197] One key strategy to encourage the healthy development of young children involved in the child welfare system during this important period of growth is to build skills in foster and biological parents related to understanding, forming, and supporting healthy attachments with the children in their care.

Survivors of Trauma

Based solely on their removal from home and placement into substitute care, *all* children and youth in the custody of DFPS have experienced trauma. In addition, children and youth who are involved in the child welfare system are significantly more likely than the general population of children and youth to have experienced adverse childhood experiences (ACEs).[198] ACEs include abuse or neglect, having incarcerated parents, witnessing intimate partner violence, substance misuse in the household, and having someone with a mental illness in the home. Based on the 2011–2012 National Survey of Children's Health,[199] 76% of all youth in substitute care (or previously in substitute care) experienced one or more ACEs, compared to 33% of children without involvement in the foster care system. For many, these traumatic experiences lead to behaviors that are misunderstood and misdiagnosed, resulting in disruptions in care, suspension or expulsion from school, as well as juvenile justice involvement. This is not surprising given that stressful and traumatic events correlate with a range of health problems throughout a person's life, including substance misuse, mental health conditions, and physical health conditions.[200] A system-wide, strategic approach to recognizing and addressing trauma among children and youth in substitute care—including the traumatic experience of being removed from home—should be a central component of CBC planning. In 2017, the Children's Commission, which was established by the Supreme Court of Texas in 2007, launched the Statewide Collaborative on Trauma-Informed Care (SCTIC). The SCTIC's mission is to elevate trauma-informed policies and practices in the child welfare system. In February 2019, the Children's Commission published a final report based on the SCTIC's work that provides a framework for Texas to advance trauma-informed care practices in the child welfare system. This report may be of use to CBC planners as they develop their own framework for a trauma-informed child welfare system across DFPS Regions 3W (non-CBC) and 3E.

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[197] American Academy of Pediatrics. (2000). *Developmental issues for young children in foster care*. *Pediatrics*, *106*(5), 1145–1150. https://doi.org/10.1542/peds.106.5.1145

[198] Turney, K., & Wildeman, C. (2016). Adverse childhood experiences among children placed in and adopted from foster care: Evidence from a nationally representative survey. *Child Abuse & Neglect*, 64, 117–129.

[199] Turney, K., & Wildeman, C. (2016). Adverse childhood experiences among children placed in and adopted from foster care: Evidence from a nationally representative survey. *Child Abuse & Neglect*, 64, 117–129.

[200] Substance Abuse and Mental Health Services Administration (2015, July). *SAMHSA's concept of trauma and guidance for a trauma-informed approach.* https://store.samhsa.gov/system/files/sma14-4884.pdf

Lesbian, Gay, Bisexual, Transgender, and Queer or Questioning (LGBTQ+) Youth

Children and youth who identify as LGBTQ+ also have specialized mental health needs. LGBTQ+ youth tend to be overrepresented in the foster care system, often because of experiences of rejection and abuse that occur after disclosing their sexual orientation or gender identity to family members.[201,202,203] It is estimated that 30% of youth in substitute care identify as LGBTQ+, as opposed to 11% of youth in the general population,[204] so it is essential that specialty programming be expanded to serve the needs of these youth. In general, LGBTQ+ youth are four times (4x) more likely to consider suicide, make a plan for suicide, and attempt suicide than their non-LGBTQ+ peers.[205,206] Given these statistics, it is critical that those involved in CBC planning efforts devote time and attention to expand access to specialized treatment and ensure broad-based education of their networks to address the unique treatment needs of this population.

Older Youth in Care

Older youth, ages 14 to 17, in substitute care are more likely to have mental health conditions than their same-age peers who are not in care, and these challenges both impact placement stability and are exacerbated by placement instability.[207] Age, placement type, number of placement breakdowns, and race/ethnicity all increase the likelihood that older youth, especially those with complex needs, will age out of the foster care system instead of achieving permanency.[208] This risk increases for youth who have experienced long stays in congregate care. Further, older youth, especially those who have experienced five or more placements, are

[201] Friedman, M. S., Marshal, M. P., Guadamuz, T. E., Wei, C., Wong, C. F., Saewyc, E., & Stall, R. (2011). A meta-analysis of disparities in childhood sexual abuse, parental physical abuse, and peer victimization among sexual minority and sexual nonminority individuals. *American Journal of Public Health*, *101*(8), 1481–1494. https://doi.org/10.2105/AJPH.2009.190009

[202] Baams, L. (2018). Disparities for LGBTQ and gender nonconforming adolescents. *Pediatrics*, *141*(5), e20173004. https://doi.org/10.1542/peds.2017-3004

[203] Sullivan, C., Sommer, S., & Moff, J. (2001). *Youth in the margins: A report on the unmet needs of lesbian, gay, bisexual, and transgender adolescents in foster care*. Lambda Legal Defense and Education Fund.

[204] Baams, L., Wilson, B., & Russell, S. T. (2019). LGBTQ youth in unstable housing and foster care. *Pediatrics*, *143*(3), e20174211. https://doi.org/10.1542/peds.2017-4211

[205] Johns, M. M., Lowry, R., Andrzejewski, J., Barrios, L. C., Demissie, Z., McManus, T., Rasberry, C. N., Robin, L., & Underwood, J. M. (2019). Transgender identity and experiences of violence victimization, substance use, suicide risk, and sexual risk behaviors among high school students–19 states and large urban school districts, 2017. *Morbidity and Mortality Weekly Report*, *68*(3), 67–71. https://doi.org/10.15585/mmwr.mm6803a3

[206] Kann, L., McManus, T., Harris, W. A., Shanklin, S. L., Flint, K. H., Queen, B., Lowry, R., Chyen, D., Whittle, L., Thornton, J., Lim, C., Bradford, D., Yamakawa, Y., Leon, M., Brener, N., & Ethier, K. A. (2018). Youth Risk Behavior Surveillance - United States, 2017. *Morbidity and Mortality Weekly Report. Surveillance Summaries (Washington, D.C.: 2002)*, *67*(8), 1–114. https://doi.org/10.15585/mmwr.ss6708a1

[207] Sepulveda, K., & Williams, S. C. (2019, May). *Older youth in foster care need support to make a successful transition to adulthood*. Child Trends. https://www.childtrends.org/blog/older-youth-in-foster-care-need-support-to-make-a-successful-transition-to-adulthood

[208] Wulczyn, F., Huhr, S., Schmits, F., & Wilkins, A. (2017, November). *Understanding the differences in how adolescents leave foster care.* The Center for State Child Welfare Data, Chapin Hall at the University of Chicago. https://fcda.chapinhall.org/wp-content/uploads/2018/01/Understanding-the-Differences-in-How-Adolescents-Leave-Foster-Care_FCDA_ChapinHall_Nov17.pdf

more likely to be involved in the juvenile justice system.[209] They are also at higher risk of falling behind academically or dropping out of school than those in the general population.[210] Given the prevalence of mental health challenges among older youth in care, those involved in CBC planning and implementation must encourage close collaboration between the education, judiciary, health, behavioral health, and child welfare systems to address the needs of this group, namely ensuring that they are screened for mental illness and receive services.[211]

Mental Health Needs Among Children and Youth in DFPS Regions 3W (non-CBC) and 3E

Understanding the mental health needs of children and youth who are at the highest risk for out-of-home placement can help the community—and those planning for CBC—to anticipate the demand for mental health services. In Texas, system-wide data on the number of children and youth in the child welfare system who receive mental health services is not publicly available. DFPS does provide data on the number of children and youth in substitute care with certain identified characteristics.[212] Although the "emotional" and "drug/alcohol" needs characteristics are based on caseworker notes, not diagnostic interviews, they are the best available measure of the number of children and youth with behavioral health challenges and conditions. Therefore, we use the "emotional" characteristic as a measure of SED[213,214] and the "drug/alcohol" characteristic as a measure of substance use disorder (SUD). Using counts of children and youth in substitute care with these characteristics across all months of data in fiscal year (FY) 2018, we calculated a rate to approximate SED and SUD among the entire foster care population (ages 0–17) in the state. We then applied those rates to the population of DFPS Region 3 as a whole (see Table 27).

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[209] Krinsky, M. (2010). Disrupting the pathway for foster care to the justice system – A former prosecutor's perspectives on reform. *Family Court Review, 48*(2), 322–337. https://doi.org/10.1111/j.1744-1617.2010.01313.x

[210] National Working Group on Foster Care and Education. (2014, January). *Fostering success in education: National Factsheet on the educational outcomes of children in foster care*.

[211] Courtney, M. E., & Charles, P. (2015). *Mental health and substance use problems and service utilization by transition-age foster youth: Early findings from CalYOUTH.* Chicago, IL: Chapin Hall at the University of Chicago. https://www.chapinhall.org/wp-content/uploads/CY_MH_DP0515.pdf

[212] The DFPS characteristics include "physical," "medical," "emotional," "drug/alcohol," and "learning" needs.

[213] Serious emotional disturbance (SED) is defined as a mental, behavioral, or emotional disorder that lasts long enough to impair functioning and substantially interfere with the child's ability to function in their family, school, or community.

[214] Texas Department of Family and Protective Services and Texas Department of State Health Services. (2014, December). *Joint report on Senate Bill 44.* https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/Agencywide/documents/2014/2014-12-01_SB44_DFPS_DSHS_Joint_Report.pdf

Table 27. SED and SUD Among Children and Youth in Substitute Care in DFPS Region 3 (FY 2018)[215]

Population	Children/Youth in Foster Care (0–17)
Total Population	**7,745**
with Emotional Characteristic (SED)	1,000 (13%)
with Drug/Alcohol Characteristic (SUD)	600 (8%)

Among all children and youth in substitute care across DFPS Region 3, we estimate that 1,000 (or 13%) have SED; however, this is likely underreporting the actual number with SED.[216] We estimate that approximately 600 (or 8%) children and youth in substitute care in DFPS Region 3 have SUD; however, this is likely underreporting as well. Current research suggests that, nationally, 11% to 19% of youth in the child welfare system experience SUD.[217] By comparison, among the general population of youth in Texas, we estimate approximately 7% experience SED[218] and 3% experience SUD.[219] In addition, we estimate that 172 (or 2%) children and youth in DFPS Region 3 experience *both* SED and SUD.[220] Again, this is likely underreporting the actual

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[215] Estimates are rounded to reflect uncertainty. We obtained these rates and estimates as follows:
- Emotional Characteristic/SED estimate is based on actual month-to-month counts of children in foster care with an emotional characteristic from FY 2018 in DFPS Region 3. Emotional characteristics were added by the child's caseworker, which included emotional needs included reactive attachment disorder, bipolar disorder, depression, eating disorder, emotionally disturbed – DSM, oppositional defiant disorder, and posttraumatic stress disorder, among others. See: The Stephen Group (2015). *Meeting the needs of high needs children in the Texas Child Welfare System*. https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/CPS/documents/2015/2015-12-03_Stephen_Group_High_Needs_Assessment.pdf
- Drug/Alcohol Characteristic (SUD) estimate is based on actual month-to-month counts of children in foster care with a drug/alcohol characteristic from FY 2018 in DFPS Region 3.
- Each rate (SED and SUD) were applied to yearly totals of children and youth in foster care in Region 3.
- The estimates were rounded to reflect uncertainty. Data (monthly and yearly totals for the region) were obtained from: https://www.dfps.state.tx.us/Doing_Business/Regional_Statistics/default.asp

[216] Age breakouts were not included in foster child characteristics data, so we used the total foster care population to calculate rates and applied this to that total population. SED prevalence studies were based on older children and youth and, because of challenges in accurately diagnosing pre-verbal children, we anticipated much lower rates of diagnosis for very young children. We do not know how many children identified by DFPS with an "emotional" characteristic were under the age of six, if any. Therefore, by using the total number of children in foster care (all ages) in our calculation, we likely underreported the rate of children in foster care with SED.

[217] Narendorf, S. C., & McMillen, J. C. (2010, January). Substance use and substance use disorders as foster children transition to adulthood. *Child Youth Service Review, 32*(1), 113–119. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2786185/pdf/nihms136963.pdf

[218] Local prevalence estimates of SED were drawn from Holzer, C., Nguyen, H., & Holzer, J. (2018). *Texas county-level estimates of the prevalence of severe mental health need in 2018*. Meadows Mental Health Policy Institute

[219] SUD prevalence rates were based on the 2017–2018 National Survey on Drug Use and Health: Model-Based Prevalence Estimates—Texas.

[220] The prevalence of co-occurring emotional problems and substance use disorder among children and youth in DFPS Region 3 is based on the national estimate for the number of children and youth in foster care with both emotional needs and who experienced substance dependence or abuse in the past year (17.2%). We applied this rate to the number of children and youth in foster care in Region 3 with emotional characteristics to reach the estimate of 172. National estimate of co-occurring emotional problems and substance use disorder was obtained from Substance Abuse and Mental Health Services Administration (SAMHSA)'s restricted online data analysis system (RDAS). National Survey on Drug Use and Health: 2-Year RDAS (2017 to 2018). https://rdas.samhsa.gov/#/survey/NSDUH-2017-2018-RD02YR/crosstab/?column=YFOST&results_received=true&row=UDPYILAL&run_chisq=false&weight=DASWT_1

prevalence, but is still higher than would be expected in the general population of youth in Texas, which is less than 1%.[221,222] It is not surprising that the estimated rates of SED and SUD are higher among children and youth in substitute care than in the general population, as the types of stressful and traumatic events they experience correlate with a range of health problems that occur throughout a person's life, including substance use and mental and physical health conditions.[223]

While the data used to inform our estimate of the prevalence of SED or SUD in DFPS Region 3 were from FY 2018, we don't expect that the prevalence estimates have dramatically changed since that time. In fact, an evaluation of Authorized Service Levels (ASLs) from August 2020 largely supports the FY 2018 estimates. ASLs are assigned to each child or youth based on their behaviors and needs and used to identify an appropriate substitute care placement. The more support or supervision a child or youth needs to maintain or improve their level of functioning, the higher or more intensive their ASL.[224] Therefore, an ASL higher than Basic could also indicate that emotional or behavioral health needs are present.

As shown in Table 28, in August 2020, there were 3,552 children and youth in substitute care in DFPS Region 3 as a whole.[225] Of those children and youth, 905 (or 25%) required more than a Basic level of care and, thus, could potentially have SED, which is consistent with the estimated prevalence of 1,000 children and youth with SED listed in Table 27.

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[221] The prevalence of comorbid major depression and substance use disorder among youth ages 12–17 is based on intersection between the national prevalence rate of major depressive episodes (MDE) and SUD, as reported in SAMHSA's 2019 report, *Behavioral Health Trends in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Publication No. PEP19-5068, NSDUH Series H-54), and the 2017–2018 National Survey on Drug Use and Health (NSDUH) sub-state rates of MDE for Texas.

[222] To calculate prevalence SED for children and youth in DFPS Region 3, we looked at the total population of children and youth ages 0–17; for the general population, we only had access to data for ages 6–17. For youth experiencing SUD in DFPS Region 3, we used diagnostic data for ages 0–17; the percentage of prevalence likely underrepresents the actual prevalence among youth age 12–17, the age range typical of youth SUD.

[223] Substance Abuse and Mental Health Services Administration (2015, July). *SAMHSA's concept of trauma and guidance for a trauma-informed approach.* https://store.samhsa.gov/system/files/sma14-4884.pdf

[224] A child can be assigned the following authorized service levels (ASLs): Basic, Moderate, Specialized, Intense, or Intense-Plus.
- Children and youth with a Basic ASL display behaviors that may include acting out, but are considered typical for their age, and tend to respond well to limit-setting.
- An ASL of Moderate or higher indicates a need for increased supervision and support and also increases the likelihood that a mental health need is present.
- An ASL of Specialized or Intense could include extreme aggression, major self-injury behavior or suicide attempts, serious risk of harm to themselves or others, or a primary diagnosis of SUD; caregivers must have specialized training and skills to provide appropriate supports.

[225] Texas Department of Family and Protective Services. (2020, August). *Regional statistics about children in DFPS Care.* https://www.dfps.state.tx.us/Doing_Business/Regional_Statistics/default.asp

Table 28. ASLs for Children and Youth in Foster Care in DFPS Region 3 (August 2020)[226]

Authorized Service Level (ASL)	Total Children/Youth
All Service Levels for Children and Youth in Substitute Care (ages 0 to 17)	**3,552**
Basic	2,647 (75%)
Moderate	339 (10%)
Specialized	320 (9%)
Intense	84 (2%)
TFC (Treatment Foster Care)	26 (0.7%)
Intense Plus	2 (-)
Blank or End Dated	134 (4%)
N/A	0
Psychiatric Transition	0

Table 29 shows the number of children and youth in substitute care by living arrangement.[227] Notably:

- 309 (or 9%) were placed in a residential treatment center (RTC). Of those children and youth, nearly two-thirds (201) were placed out of the region.
- 1,538 (or 43%) children and youth were placed in a private Child Placing Agency (CPA) and Independent Living arrangement that was identified as supporting emotional disorders.

Table 29. Substitute Care Placements in DFPS Region 3 by Living Arrangement (August 2020)[228]

Living Arrangement Categories	Total Children/Youth
All Living Arrangements (ages 0 to 17)	**3,552**
DFPS Foster Homes	222
Private Child Placing Agency (CPA) and Independent Living	2,761
Private CPA and Independent Living – Emotional Disorder	1,538
General Residential Operations	569
General Residential Operations – Residential Treatment (RTC)	309
Placed Out of DFPS Region 3 in RTC	201

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[226] Data were obtained from the Texas Department of Family and Protective Services and reflect a point-in-time count of all children in substitute care from Region 3. Data obtained from https://data.texas.gov/Social-Services/CPS-8-2-Foster-Care-Placements-By-Fiscal-Year-And-/sxsx-qqtg

[227] Texas Department of Family and Protective Services. (2020, August). *Regional statistics about children in DFPS Care.* https://www.dfps.state.tx.us/Doing_Business/Regional_Statistics/default.asp

[228] Texas Department of Family and Protective Services. (2020, August). *Regional statistics about children in DFPS Care.* https://www.dfps.state.tx.us/Doing_Business/Regional_Statistics/default.asp

The ability of foster parents to address the problematic behaviors of older children and youth in their care is a persistent challenge in the child welfare system. Problematic behaviors are often *externalizing behaviors*, which are those that disrupt daily living and are among the most challenging for foster parents to manage. Studies have shown that children and youth with more severe diagnoses and externalizing behaviors, such as children in foster care who are admitted to a psychiatric hospital, are known to have a particularly poor response to mental health treatments and greater placement instability.[229] When the needs of this group of children and youth go unmet, challenging behaviors are likely to escalate and affect placement stability, often leading to more restrictive placements.

Table 30 shows the number of children and youth in Region 3 who exited DFPS legal custody in FY 2019. In FY 2019, 248 youth exited foster care through emancipation (aging out). These youth spent an average of 40.7 months in care and averaged 6.1 placements prior to their exit. In comparison to those with other exit types, these youth were in care much longer and averaged significantly more placements while in care. In general, youth who remain in care longer require higher levels of care and are more likely to have a mental health need.

Table 30. Children and Youth Exiting DFPS Legal Custody (FY 2019)[230]

DFPS Region 3			
Exit Type	**Average Months in Care**	**Average Placements per Exit**	**Number of Exits**
Family Reunification	12.9	1.8	1,439
Custody to Relatives With Permanency Care Assistance (PCA) funding	28	2.3	244
Custody to Relatives Without PCA	13.8	2	1,171
Relative Adoption	24.5	2.3	458
Non-Relative Adoption	26.5	2.7	685
Youth Emancipation	40.7	6.1	248
Other	9.6	1.5	52
Total	19	2.3	4,297

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[229] Brinkmeyer, M. Y., Eyberg, S. M., Nguyen, M. L., & Adams, R. W. (2004). Family engagement, consumer satisfaction, and treatment outcome in the new era of child and adolescent in-patient psychiatric care. *Clinical Child Psychology and Psychiatry, 9*, 553–566.

[230] DFPS Data and Decision Support. (n.d.). *Child Protective Services (CPS): Children exiting DFPS legal custody.* https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/Conservatorship/Exits.asp

Given the high number of children and youth in substitute care with complex mental health needs, the local child welfare system must ensure access to well-trained substitute care placements that are supported by a strong continuum of community-based services and supports that are integrated within the child welfare, mental health, juvenile justice, education, and physical health systems. Understanding that children and youth with child welfare involvement are impacted by trauma is critical to designing a local system that can identify, support, and effectively treat the children and youth it has been entrusted to protect.

The Role of Medicaid STAR Health

In order to effectively address the mental and behavioral health needs of children and youth in substitute care, it is important for CBC planners to understand the health benefits available to them and how these operate. Every child or youth in DFPS conservatorship is covered by the Texas Medicaid's STAR Health Insurance Plan (STAR Health) and this is the sole health benefits plan for these children and youth.[231] Superior HealthPlan (Superior) is the managed care organization (MCO) that currently contracts with the Texas Health and Human Service Commission (HHSC) for STAR Health services.

Benefits, Providers, and Access

Through STAR Health, children and youth (and their caregivers) have access to the following benefits, as eligible and appropriate:

- **Service coordination and service management**. Superior must notify all child/youth members, caregivers, and medical consenters about the availability and functions of STAR Health service coordination and service management and encourage them to use these services, with additional outreach required to children and youth identified as having special healthcare needs.

- **Home health services**.[232] Superior is required to ensure the provision of home health services to address the needs of children or

> **STAR Health** is the Medicaid managed care program that covers children and youth in the child welfare system in Texas who meet the following criteria:
> - Children and youth in DFPS conservatorship (0–17 years).
> - Children and youth in the Adoption Assistance or Permanency Care Assistance programs who are transitioning from STAR Health to STAR or STAR Kids.
> - Youth age 21 years and younger in voluntary extended foster care placements.
> - Youth age 20 and younger were formerly in foster care.

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[231] Texas Children's Commission. (2019). *Health care for Texas children in foster care: STAR Health.* Texas child protection law bench book. http://benchbook.texaschildrenscommission.gov/pdf/Bench%20Book%202017%20Health%20Care%20for%20Texas%20Children%20in%20Foster%20Care%20STAR%20Health.pdf

[232] Home health services are provided by a public agency or private organization that predominately provides skilled nursing services and other therapeutic services (e.g., physical therapy, occupational therapy, speech-language pathology, and home health aide services).

youth with multiple chronic or complex conditions—or a single serious and persistent mental health or health condition.

- **Behavioral health network.** This includes information on how to access emergency and crisis behavioral health services, including crisis stabilization, the hospitalization diversion program (where available), and Youth Empowerment Services (YES) Waiver services. Superior is required to contract with behavioral health providers specializing in the treatment of conditions common to children and young adults in substitute care, such as abuse, neglect, sexual offender behavior, and exposure to complex and multiple traumas. Superior must also ensure coordination between the behavioral health provider and primary care physician and provide access to a 24/7 behavioral health hotline and emergency services.

- Information about **Community First Choice** (CFC) services. CFC provides community-based long-term services and supports to eligible child/youth members with physical or cognitive disabilities, or serious emotional disturbances, as an alternative to living in an institution. Superior must make the array of services allowable under CFC available to members who meet eligibility requirements.

- **A nurse and member hotline**. Superior must provide access to the nurse advice line where members can access a nurse to get answers to health questions, ask about referrals, or seek specialty consultations. Superior must also provide access to member services. A member services representative can help individuals find a doctor, schedule an appointment, get a new identification card, or access benefits and services.

- **STAR Health Liaisons**. Superior must employ a team of dedicated STAR Health Liaisons who are responsible for coordinating with Regional DFPS Well-Being Specialists to promptly resolve issues identified by Superior, DFPS, or HHSC that arise related to STAR Health or to the individual healthcare of a child/youth member.

STAR Health's primary goal is to ensure children and youth in substitute care in the state have access to the medical and behavioral health services they need. Health and mental health services are covered benefits regardless of where in the state eligible children and youth are living;[233] STAR Health does not cover those placed outside of Texas.[234]

Medicaid, through STAR Health, pays for a range of behavioral health services, including therapy services, psychiatric services and medication management, intensive services, crisis response and crisis respite, parent education, and skills training for both the child or youth and caregiver. Many of these services can be delivered by providers enrolled in Medicaid. Some

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[233] For more information, see: https://www.dfps.state.tx.us/child_protection/Medical_Services/default.asp

[234] Texas Children's Commission. (2019). *Health care for Texas children in foster care: STAR Health.* Texas child protection law bench book.
http://benchbook.texaschildrenscommission.gov/pdf/Bench%20Book%202017%20Health%20Care%20for%20Texas%20Children%20in%20Foster%20Care%20STAR%20Health.pdf

services, such as Targeted Case Management (TCM) and Mental Health Rehabilitation (MHR) services, can only be delivered by providers that undergo additional credentialing with Superior HealthPlan.

For each service area of the state, Superior has a directory of providers that are in their covered network for STAR Health. Caregivers may find a provider through the member directory or work with an assigned service manager to find an appropriate provider for the child or youth in their care. **Despite this resource, foster families and CPAs both report challenges in securing mental health services for children and youth in their care.** In part, this is due to a provider directory that becomes out-of-date as soon as a provider joins or leaves the network. In most areas of the state, it is also a challenge to find a provider who is accepting new clients, especially those accepting STAR Health. To further complicate matters, and a caregiver's search for appropriate services, the directory does not indicate the range and types of services each provider delivers.

Needs Assessments and Health Records

Within 30 days of placement, and annually thereafter,[235] DFPS requires that children and youth in substitute care be assessed using the Child and Adolescent Needs and Strengths (CANS 2.0) assessment.[236] Superior is required to administer the CANS 2.0 to determine the needs of each child or youth. In many regions, Superior designates a local service provider to administer the CANS 2.0 on its behalf. There are 89 assessors across DFPS Regions 3W (non-CBC) and 3E that can administer the CANS 2.0. **The CANS 2.0 assessment covers the child's mental health symptoms and behaviors, substance use and misuse, trauma history, challenges with education, and juvenile justice involvement as well as caregiver needs and strengths.** It is intended to prevent duplicate assessments

Number of CANS Assessors in DFPS Regions 3W (non-CBC) and 3E:	
• Collin	9
• Cooke	0
• Dallas	54
• Denton	7
• Ellis	5
• Fannin	1
• Grayson	3
• Hunt	1
• Kaufman	1
• Navarro	4
• Rockwall	3
• Wise	1

by multiple providers, identify placement and treatment needs, decrease unnecessary psychological testing, and inform care planning.[237] The CANS 2.0 is also a communication tool that can establish a shared understanding of a child's needs among multiple service providers. Another tool used by DFPS to improve care coordination and communication among providers and caregivers is the **Health Passport**, an online system that contains health data about

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[235] The frequency of administering the CANS 2.0 may vary. DFPS requires annual updates; however, the CBC Single Source Continuum Contractor (SSCC) provider may choose to update the CANS 2.0 more frequently. For example, Our Community, Our Kids, the SSCC for DFPS Region 3B (Region 3W CBC) has opted to update every 90 days.

[236] For a list of local DFPS-contracted providers who can do a CANS assessment, see: https://www.fostercaretx.com/for-members/find-a-provider.html

[237] For more information, see: https://www.dfps.state.tx.us/Child_Protection/Medical_Services/CANS_Assessment.asp

children and youth covered by the STAR Health program. A child's Health Passport has information on diagnoses, health history, prescriptions, shot records, and more.[238]

Ideal Continuum of Mental Health Services for Children and Youth in Substitute Care

Addressing mental health is critical to achieving long-term and short-term CBC outcomes. As discussed earlier, placement stability and permanency are often directly related to a foster or kinship caregiver's ability to successfully address the behavioral health needs of a child or youth in their care. CPAs report that challenging externalizing behaviors (e.g., physical/verbal aggression or defiance) are a factor in a foster parent's decision to terminate a placement. Externalizing behaviors, however, can be symptoms of unaddressed mental health needs, including trauma.

Another barrier to effective mental health treatment for children and youth in substitute care is continuity of services after removal. When children and youth are placed in the foster care system, their mental health treatment is often disrupted. Most children and youth have to change providers and many stop receiving services altogether. In mental health treatment, the therapeutic relationship is critical, and this disruption can impact a child's progress towards healing. In addition to the challenges caused by disruption in treatment, the providers we spoke with for this environmental assessment also discussed challenges they encounter when trying to communicate with a child's previous providers, which impact their ability to continue care with as little disruption as possible. In many cases, the new provider does not have a complete history of the child's background and treatment, including active prescriptions the child or youth may have.

The ideal system of care for children and youth in substitute care includes strategies that support service and treatment continuity with their providers; in the event a child or youth cannot continue with an existing provider once they enter substitute care, there must be a smooth and immediate transition to new providers. The implementation of CBC presents an opportunity for the community to plan for and deliver the **full range of mental health services necessary to maintain placement stability, decrease time to permanency, and support life-long outcomes** for the children, youth, and families being served.

An ideal behavioral health system is anchored in trauma-informed care and offers a continuum of mental health services for children and youth in substitute care, their families, foster

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[238] For more information, see: https://www.dfps.state.tx.us/Child_Protection/Medical_Services/Health_Passport.asp
Note that unlicensed kinship care providers do not have access to the Health Passport; however, the child's physician does have this access.

families, and kinship caregivers. This includes prevention services,[239] integrated behavioral health care, specialty behavioral health care, and highly specialized and intensive support services. In addition, the local child serving system can also support children, youth, and families by providing access to an array of crisis response services when a mental health crisis does occur. The following section describes a framework for the ideal continuum of services to best support children and youth with mental health needs and their families involved in the foster care system—or at risk of becoming involved.

Integrated Primary Care

Most children and youth can get the help they need when access to behavioral health support is integrated into pediatric primary healthcare. Since children and youth are likely to see their primary care doctor at least annually for a well-child visit and within 30 days of substitute care placement, this point of access can be key to early identification of complex behavioral health needs and effective referral and coordination of care for treatment. As such, **behavioral health integration in pediatric primary care settings is in many ways a core component of the ideal system of mental health care and an essential strategy for increasing access** to behavioral health services for children and youth. Integrated behavioral health in pediatric primary care settings can help treat routine and even some moderately severe needs related to behavior, anxiety, and depression while providing caregivers with referrals to community-based providers when a child or youth has more complex needs.

Integrated care settings provide an opportunity for children and youth in substitute care to have their mental health, trauma, and physical health needs identified and addressed in a single setting. This is especially beneficial for those in substitute care whose service providers may be inconsistent because of frequent moves, but whose access to pediatric primary care is often prioritized. For this environmental assessment, foster families and providers both discussed delays in treatment as a result of incomplete medical records and communication challenges between a child's current and previous providers. For example, physicians and psychiatrists may need or want to communicate with a child's previous provider to gather treatment history prior to refilling or changing a psychiatric prescription. However, physician-to-physician connections can be difficult, resulting in delays in care or challenges with medication management. And, when physicians cannot connect promptly, the new provider often must rely on the child's memory or the caseworker's knowledge, both of which may be limited, resulting in an inadequate medical history. While physicians are able to access STAR Health's Health Passport to see the prescriptions filled previously for each child or youth in substitute care, there is often a lag in what is recorded in that system. As a result, there can be multiple

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[239] Local CBC oversight and planning does not include prevention services, which are supported by DFPS, and therefore excluded from our analysis. However, prevention services play an important role in supporting children, youth, and families who are *at risk* of child welfare involvement and, as such, are part of an ideal continuum of services and supports.

prescriptions prescribed and filled and an incomplete understanding of the child's history with each medication.

The DFPS Psychotropic Medication Utilization Parameters is one form of guidance that can help a prescribing provider navigate and determine medications indicated appropriate for certain needs.[240] However, physicians treating children and youth with more complex mental health needs, such as children and youth in substitute care, will find more support by accessing the regional Child Psychiatry Access Network (CPAN) hub, an initiative to support pediatric primary care providers. The regional CPAN hub provides real-time psychiatric consultation for enrolled physicians who identify a mental health treatment need for a child or youth in their care. Support and consultation are available for both specialty care referrals and prescribing. CPAN teams include child psychiatrists, mental health clinicians, referral specialists, and program coordinators.

Another example of an integrated primary care setting that specializes in bringing together pediatric primary care and behavioral health care specifically for children and youth in substitute care is the Rees-Jones Center for Foster Care Excellence, which is located in North Texas. The Rees-Jones Center for Foster Care Excellence offers a structured team approach that includes primary care and behavioral health providers as well as a nurse coordinator and a CPS liaison. All members of the care team are co-located and fully collaborative. They provide trauma-informed primary care services along with evidence-based therapies, including Parent-Child Interaction Therapy (PCIT), cognitive behavioral therapy (CBT), and Trauma-Focused CBT, among others. They also provide trauma-informed developmental and psychological assessments. Notably, all staff are trained in trauma-informed care and the Rees-Jones Center regularly undergoes evaluations to ensure its programming meets trauma-informed care standards.

Specialty Behavioral Health

Children and youth with moderate-to-severe mental and behavioral health needs may require specialty behavioral health care to receive therapy, psychiatric services, parent/caregiver education and training, and other services. Specialists focus on treatment of more complex anxiety, depression, bipolar disorder, posttraumatic stress, addiction, and other conditions that require more specialized interventions. Often providers use CBT or Trauma-Focused CBT as their primary therapeutic interventions. Though less common, some providers may offer other therapeutic interventions as well, such as Eye Movement Desensitization Reprocessing (EMDR). Psychiatric services in a specialty outpatient setting usually focus on psychiatric evaluation,

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[240] For more information, see: http://www.dfps.state.tx.us/Child_Protection/Medical_Services/documents/reports/2016-03_Psychotropic_Medication_Utilization_Parameters_for_Foster_Children.pdf

medication management, and psychoeducational services. Typically, these services occur in clinics and providers' offices.

Intensive Home- and Community-Based Services

The subset of children and youth with the most severe mental and behavioral health needs in substitute care require highly specialized and intensive services and supports. These services are most appropriate when behavioral health symptoms and challenges impair a child's functioning across multiple life domains; addressing these needs requires team-based care that generally includes a prescriber, a skilled therapist, and a broader team focused on both ameliorating symptoms and building on individual, family, and community strengths to restore a child's functioning and promote healthy

Intensive Home- and Community-Based Evidence-Based Practices:
- Functional Family Therapy
- Intensive In-Home Child and Adolescent Psychiatric Services
- Treatment Foster Care Oregon
- Multidimensional Family Therapy
- Multisystemic Therapy
- Wraparound Facilitation
- Coordinated Specialty Care for First Episode Psychosis

skills development. Intensive services are often delivered through STAR Health (Medicaid), specifically through **Targeted Case Management (TCM)** and **Mental Health Rehabilitation (MHR)** services. In addition, the Medicaid YES Waiver program is another option for children and youth who need intensive services.

TCM is care coordination that connects children and youth to necessary services; it encompasses both routine case management and intensive case management. While routine case management is used most frequently for children and youth with mild-to-moderate needs, intensive case management is typically for children and youth with more serious mental health needs. HHSC requires providers of TCM to use an intensive case management approach called **wraparound service coordination**. Although not a treatment modality, wraparound is an essential care coordination process that aims to achieve positive outcomes by providing a structured, individualized, and creative team-based planning process. The model emphasizes community integration and works to strengthen a family's social support network; this results in plans of care that are more effective and relevant for each child or youth and family.

MHR services are intended to help a child, youth, or caregiver improve or acquire the skills needed to function as independently as possible in the community. MHR services include certain crisis services, medication training and support, and skills training and development. HHSC has approved five curriculums for credentialed providers to use when delivering skills training and development services. The curriculums to address trauma (Seeking Safety), parenting skills (Nurturing Parenting), coping and social skills (Aggression Replacement Training, Barkley's Defiant Child/Teen), and needs of youth transitioning to adulthood (Preparing

Adolescents for Young Adulthood). The interventions in these curriculums are selected to broadly meet the needs of children and youth with mental health conditions and do not specifically address the specialized needs of children and youth in substitute care.

STAR Health is required to ensure that its members have access to TCM and MHR services.
These services are most often available through the LMHA or local behavioral health authority

(LBHA). There are six LMHAs that serve various catchment areas within DFPS Regions 3W (non-CBC) and 3E. Additionally, two CPAs—Pathways and CK Family Services—provide TCM and MHR in these regions. (This is not necessarily typical for CPAs; it is important to note that, while most CPAs provide some type of mental health support service, they are not required to provide mental health services or enroll as providers in STAR Health.)

The local mental health authorities that serve DFPS Regions 3W and 3E:
- Denton County MHMR Center
- Helen Farabee Centers
- LifePath Systems
- My Health My Resources (MHMR) of Tarrant County
- North Texas Behavioral Health Authority (NTBHA)
- Texoma Community Center

The **Medicaid YES Waiver** program[241] is another option for eligible children and youth with intensive needs, as noted earlier. The program provides access to a range of traditional and non-traditional services (e.g., animal assisted therapy, nutritional counseling, recreational therapy) as well as wraparound service coordination. The YES Waiver is available to eligible children and youth with intensive needs, including children and youth in substitute care. A child or family can access the program through the LMHA assigned to their area. While there are a maximum number of children and youth that can be enrolled in the program at any given time, the LMHAs serving DFPS Regions 3W (non-CBC) and 3E have reported that they have open spots in the program most of the time.

At the time this report's publication, the evidence-based treatments eligible for reimbursement through Texas Medicaid are limited to those named above. However, **more evidence-based treatments will become available in 2021 and 2022**. Texas Senate Bill (SB) 1177 (86th Regular Session, 2019) gives Medicaid MCOs, including Superior, the option to reimburse for delivery of intensive evidence-based practices (EBPs) used in lieu of other mental health services, such as psychiatric hospitalization for children and youth. SB 1177 directs HHSC to utilize the Medicaid Managed Care Advisory Committee to approve a list of EBPs that can be added as "in lieu of" services to managed care contracts. Implementation has been broken down into two phases: Phase One includes services in lieu of inpatient hospitalization; Phase Two includes services in lieu of outpatient services. Phase One is nearly complete and the committee has approved the

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[241] For more information on the YES Waiver, see: https://hhs.texas.gov/services/mental-health-substance-use/childrens-mental-health/yes-waiver

following EBPs to be added to MCO contracts by September 2021: Coordinated Specialty Care; crisis outreach/outpatient team; crisis respite; crisis stabilization units/extended observation units; partial hospitalization; and intensive outpatient programs. Outpatient services for Phase Two are being evaluated for cost effectiveness and HHSC plans to add approved services to MCO contracts effective September 2022. At this time, both **Multisystemic Therapy (MST) and Functional Family Therapy (FFT)** are under consideration for Phase Two.

MST is a well-established EBP for youth with severe behavior problems with involvement, or risk of involvement, in the juvenile justice system. MST has been adapted for a child welfare population. MST-Child Abuse and Neglect (MST-CAN) has been proven effective in reducing youth mental health symptoms, parent emotional distress, parenting behaviors associated with maltreatment, and youth out-of-home placements.[242] FFT addresses a range of behavior problems, including violence, drug use/abuse, conduct disorder, and family conflict, and has also been adapted for a child welfare population (FFT-Child Welfare). Whereas the traditional model is most effective with children and youth ages 11–18, FFT-Child Welfare includes all ages (0–18 years).[243]

Another avenue through which children and youth can access intensive services is their CPA. **Treatment Foster Family Care** (TFFC) is an evidence-based program for children and youth in substitute care that provides foster families with specialized skills and training to support children and youth with serious emotional and behavioral health conditions. In 2018, DFPS awarded three contracts for TFFC across the state.[244] In DFPS Region 3, CK Family Services is the one CPA contracted with DFPS to provide TFFC. DFPS currently pays for TFFC for children ages 10 and under; yet CPAs contracted to provide TFFC can expand their programs to serve older youth with the model. If they do, the reimbursement rate for youth over age 10 is based on their assigned service level and not the TFFC rate.[245] A number of providers in Region 3 also offer wraparound service planning, and most child welfare providers in the regions use Together Facing the Challenge and Trust-Based Relational Intervention (TBRI). Together Facing the Challenge is an approach that aims to build therapeutic relationships, perform/teach cooperation skills, implement effective parenting techniques, teach youth independence skills, and create a positive home environment in therapeutic foster care settings.[246] TBRI addresses

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[242] Swenson, C. C., Schaeffer, C. M., Henggeler, S. W., Faldowski, R., & Mayhew, A. M. (2010). Multisystemic Therapy for Child Abuse and Neglect: A randomized effectiveness trial. *Journal of Family Psychology, 24*(4), 497–507. https://doi.org/10.1037/a0020324

[243] For more information, see: http://fftllc.com/fft-child-welfare/model-effectiveness.html

[244] Texas Department of Family and Protective Services. (2020, April). *DFPS Rider 24 report for utilization of appropriate levels of care in foster care*. http://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/Rider_Reports/documents/2020/2020-04-30_Rider_24_Report.pdf

[245] Texas Department of Family and Protective Services. (n.d.). *24-hour residential child care reimbursement rates.* https://www.dfps.state.tx.us/Doing_Business/Purchased_Client_Services/Residential_Child_Care_Contracts/Rates/default.asp

[246] For more information see https://www.cebc4cw.org/program/together-facing-the-challenge/detailed.

the complex needs of children and youth who have experienced harm, toxic stress, or trauma. For more information on interventions that may be provided in child welfare settings, please see *Supplement 4A* at the end of this chapter.

Crisis Continuum

Even with optimal levels of appropriate, evidenced-based prevention, primary care, specialty, and intensive services, health conditions can become acute and require urgent intervention to respond to crises that threaten both safety and functioning. Strong mental health service systems include a crisis management structure that supports a wide range of needs—from a single traumatic event to developmental trauma or complex mental health challenges.[247] **Children and youth, and their parents or foster families, must have access to a full range of crisis services**. These services consist of mobile teams that are able to respond to urgent needs outside of the normal delivery of care as well as a continuum of placement options, including emergency shelter/crisis respite facilities, psychiatric emergency stabilization beds, and a variety of inpatient hospital and RTC placements. Important crisis intervention services currently provided by each LMHA serving DFPS Regions 3W (non-CBC) and 3E include a 24/7 crisis hotline and mobile crisis outreach teams (MCOT) that will deescalate the crisis at home or in the community. MCOT will assist families in assessing the severity of the need and whether inpatient hospitalization is needed; they will also provide referrals for follow-up services. Access to 24/7 crisis care can help maintain a child's living arrangement, prevent overuse of emergency room services, and prevent unnecessary or excessive use of more restrictive levels of care.

Foster families are not consistently aware of or utilizing crisis resources. While crisis intervention is available from the LMHA that serves their area, many foster families are unaware of this resource. TurningPoint is another crisis response resource offered by STAR Health. While TurningPoint services are offered within DFPS Region 3, they are provided through ACH Child and Family Services, which primarily serves the counties in DFPS Regions 3W (CBC).[248] The TurningPoint program provides in-home crisis intervention, acute stabilization, a psychiatric diversion program, and follow-up services. The primary goal of this program is to prevent placement disruptions and divert children and youth from inpatient hospitalization.

Crisis respite services are another important part of the crisis continuum. Crisis respite can offer caregivers a brief period of separation (or respite) from a child or youth in crisis and a safe environment in a licensed foster home or facility in which trained staff can de-escalate a crisis

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[247] Pires, S. A. (2010). *Building a system of care: A primer* (2nd edition). Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development.

[248] Turning Point is a collaboration of ACH Child and Family Services, Cenpatico, and Empirica. For more information, see: https://www.fostercaretx.com/content/dam/centene/fostercare/pdfs/SHP_20161544-Foster-Care-Turning-Point-Flyer-M-EN-ES-06102016.pdf

situation with the child or youth. It can be used as an alternative to hospitalization depending on the acuity of the crisis, the needs of the child or youth, and the resources available to support the child or youth and their caregivers at the respite location. As noted earlier, crisis respite is on the list of services approved for inclusion in Phase One of SB 1177 implementation.

Residential treatment is another component of the crisis care continuum for children and youth whose behavior cannot be managed safely in a less restrictive setting. RTCs are one of the most restrictive mental health service settings for children and youth. As such, they should be reserved for situations where less restrictive placements are not appropriate, including for children and youth with highly complex needs or dangerous behaviors (e.g., fire setting) who is not responding to intensive, nonresidential service approaches.[249] **When they are utilized, residential services should be evidence-based, brief, intensive, family focused, and as close to home as possible.** Residential care must only be used to meet treatment needs, *not* as a substitute care placement.

Throughout DFPS Region 3, there are 42 agencies that provide residential treatment; the RTCs are licensed to provide a total of 484 beds, and an additional 832 beds are available for agencies to provide multiple services to children and youth (including emergency care, assessment, childcare, respite child care, and transitional living).[250] However, it is important to note that these numbers may overrepresent availability of residential treatment. While an agency is licensed for a specific number of beds, they may be operating at a lower capacity due to supervision requirements (especially when there is a mix of ages or severity of needs in the unit) or they may only be available to children and youth meeting specific criteria (e.g., those with juvenile justice involvement).

DFPS Regions 3W (non-CBC) and 3E have some options for residential placement, but limited access to intensive home- and community-based services and supports (step-down services) for children and youth with complex mental and behavioral health needs. This gap prevents timely and well-executed transitions to less restrictive levels of care when children and youth leave the RTC setting—or the option to avoid residential treatment entirely. Without access to step-down services, children and youth remain in residential care longer than medically necessary or are released to a level of support that does not meet their needs. This gap likely also contributes to placement failure and the high rates of repeat RTC placements.

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[249] Stroul, B. (2007). *Building bridges between residential and nonresidential services in systems of care: Summary of the special forum held at the 2006 Georgetown University Training Institutes*. Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

[250] These data were determined using the DFPS Search for Residential (24 hour) Operation database and include Collin, Cooke, Dallas, Denton, Ellis, Erath, Fannin, Grayson, Hood, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, Tarrant, and Wise counties. Data obtained from https://www.dfps.state.tx.us/Child_Care/Search_Texas_Child_Care/ppFacilitySearchResidential.asp

Part 2 – Findings and Recommendations for Improving Local Mental Health Services and Support Through CBC

This section offers a review of the major mental and behavioral health challenges in the child welfare system in DFPS Regions 3W (non-CBC) and 3E that we have identified through this needs assessment as well as through our ongoing efforts and leadership to improve the mental health system statewide. We also present our recommendations for those planning and implementing CBC in the region to be able to work in partnership with others in the community to improve the local mental health system in the short term and long term for the benefit of all local children and youth, but specifically those in substitute care.

Six topical themes, listed below, emerged from the data and can inform future CBC planning efforts.

- **Theme 1**: Expand the availability of intensive home- and community-based behavioral health services.
- **Theme 2**: Maximize use of the Child Psychiatry Access Network (CPAN) and support increased access to telemedicine and telehealth.
- **Theme 3**: Ensure that foster families, relative caregivers, and Child Placing Agencies (CPAs) know which behavioral health benefits are available to children and youth in substitute care and how to access needed providers.
- **Theme 4**: Design specific strategies to improve mental health-related data collection and analysis to support data-driven decision making.
- **Theme 5**: Provide caregivers with more support and training.

Theme 1: Expand the availability of intensive home- and community-based behavioral health services.

Those involved in CBC planning should focus on developing capacity in DFPS Regions 3W (non-CBC) and 3E so that more intensive home- and community-based services are available. The primary goals of intensive home- and community-based services are to (1) provide the level, or dose, of clinical intervention and support necessary to successfully return each child or youth to a healthy developmental trajectory within their home and community and (2) prevent inpatient hospitalization or placement in an RTC, or provide transition services as a child or youth returns home or to a foster home after a placement in one of those settings. In general, intensive home-and-community-based services are provided directly in the child's home and community.

These types of treatments and support services are provided in a context that is person-centered, family-focused, strengths-based, culturally competent, and responsive to each individual's psychosocial, developmental, and treatment needs. They can give the clinical team the opportunity to observe the child or youth in a home setting; identify what is important to the child or youth and family; understand the roles of language, culture, and religion; and

consider whether extended family or friends are available to support the child or youth. The availability of additional intensive services would help alleviate the need for more restrictive placements such as shelters, RTCs, and psychiatric inpatient hospitals.

As discussed earlier, intensive home- and community-based services and supports can include crisis management, intensive case management, counseling, family therapy, and skills training; they also include EBPs, such as Multisystemic Therapy for Child Abuse and Neglect (MST-CAN), Treatment Foster Family Care (TFFC), Keeping Foster and Kin Parents Supported and Trained (KEEP), and others. Children and youth with complex behavioral health needs, and their foster and kinship families, currently have limited access to these types of services across DFPS Regions 3W (non-CBC) and 3E.

Recommendation 1: Support the expansion of providers credentialed to deliver Medicaid Targeted Case Management (TCM) and Mental Health Rehabilitation (MHR) services.

Medicaid-funded TCM and MHR services are the most common way intensive services are provided and funded. These services are unique, providing the flexibility and resources necessary to support a range of needs a child, youth, and family might have, many of which cannot be addressed through traditionally reimbursable office-based clinical services. However, TCM and MHR services can only be delivered by providers credentialed through HHSC. Those involved in CBC planning should prioritize efforts to increase the number of local providers credentialed to offer TCM and MHR services. This will ensure that all children and youth in substitute care have access to currently covered intensive services through Medicaid.

Recommendation 2: Support Medicaid-enrolled providers in pursuing alternative payment options with managed care organizations (MCOs) for the delivery of intensive home- and community-based EBPs.

The current STAR Health Medicaid managed care program allows MCOs to contract with providers utilizing value-based purchasing (VBP) contracts with alternative payment methodologies (APMs) that reward providers with *incentive payments for the quality of care they provide*, instead of a typical fee-for-service arrangement that reimburses providers for services rendered regardless of the outcome. Those involved in CBC planning and implementation in DFPS Regions 3W (non-CBC) and 3E should also consider ways to work with Superior HealthPlan to negotiate VBP contracts with APMs for its foster care service providers who are enrolled and credentialed in Medicaid managed care. The APMs could cover intensive home- and community-based alternative health services for children and youth in foster care instead of more expensive and restrictive services, such as inpatient care. Parent-Child Interaction Therapy (PCIT) is an example of one EBP for which providers have successfully negotiated alternative payment methodologies with Superior HealthPlan.

CBC planners should also monitor potential payment or reimbursement opportunities available through the Texas Healthcare Transformation Improvement 1115 Demonstration Waiver extension announced by HHSC on January 15, 2021. The 10-year extension allows the state to develop and implement directed-payment programs for Medicaid managed care services which could include funding to hospitals, physicians, rural health clinics, and community behavioral health providers. The announcement by HHSC also noted that Texas has been approved for a new uncompensated care program that will help offset costs associated with providing care, including behavioral health care, for uninsured people. The program will provide $500 million annually beginning in the fall of 2021 and will provide funding to publicly owned and operated community mental health centers, local mental health and behavioral health authorities, local health departments, and public health districts.

Recommendation 3: Encourage providers to enroll with MCOs and take advantage of recent state legislation (SB 1177, 86th **Legislative Session) expanding the availability of evidence-based services in lieu of other more restrictive services.**

Another strategy to expand the availability of intensive EBPs is by taking advantage of Texas SB 1177 (86th Regular Session, 2019) which, as noted earlier, gives Medicaid MCOs the option to reimburse for delivery of intensive EBPs in lieu of other mental health services, such as psychiatric hospitalization for children and youth. CBC planners and local service providers should continue to monitor the approval of EBPs eligible to be used in lieu of more restrictive services. Both MST and FFT are currently under consideration for inclusion and would be appropriate for use in a child welfare setting. For more information on the scheduled implementation of SB 1177, please refer to the section, *Intensive Home- and Community-Based Services*.

Providers already enrolled in the STAR Health network are best positioned to benefit from this legislation. Therefore, providers, who are not yet enrolled in STAR Health and are able to deliver needed evidence-based intensive services should begin the process of enrolling in Medicaid and also in the Superior HealthPlan network.

Recommendation 4: Explore opportunities to blend or braid local funds from multiple systems (e.g., mental health, child welfare, juvenile justice, education) to pay for intensive services.

A funding strategy to increase delivery of intensive services that are not currently reimbursed could be to *blend or braid funding* from multiple systems or funding streams. Braided funding pools funds from separate sources for one purpose; however, tracking and reporting on each source of funding occurs separately (e.g., each contributor would see exactly how their funds were spent to achieve the shared goal). In contrast, blended funding combines multiple funding

streams for one purpose without differentiating or tracking how money from each individual stream is spent. Using a blended funding strategy, multiple organizations could contribute or raise money to make available a service that is otherwise not reimbursed. Blending or braiding funds would allow for cross-system partnerships that could more efficiently target intensive services to children and youth who need them most, specifically those with multi-system involvement. It would also allow one or more providers to specialize in delivering an intensive EBP and create a path to access intensive services for children and youth being served by other providers who are part of the funding agreement. This funding strategy could strengthen the array of mental health services available by offering providers a path to add other intensive home- and community-based services and supports that are needed across DFPS Regions 3W (non-CBC) and 3E, including KEEP, MST-CAN, FFT, and others.

Theme 2: Maximize use of the Child Psychiatry Access Network (CPAN) and support increased access to telemedicine and telehealth.

With the increasing prevalence of mental and behavioral health needs among children and youth across Texas, child and adolescent psychiatry is needed to provide psychiatric evaluations, diagnoses, and treatments, which at times can include prescribing and monitoring medication. However, access to child and adolescent psychiatrists is a national challenge, and particularly so outside of major urban hubs. Children and youth in foster care are especially challenged by limited access to psychiatric care, despite having some of the most complex psychological needs.

We found that there is often a six-week wait for an appointment with a psychiatrist. In addition to long waiting lists, children and youth residing in rural areas of the region experience the added challenge of longer travel time and fewer transportation options to receive psychiatric evaluations. The shortage of psychiatrists delays the start of care, not only for children and youth needing an initial evaluation, but also for those who must re-establish care with a new psychiatrist after moving to a new placement. The resulting unmet needs may trigger behaviors that, in turn, could contribute to placement breakdowns, the use of more restrictive placements, and overutilization of emergency room visits in times of crisis.

Recommendation 5: Maximize use of the Child Psychiatry Access Network (CPAN) to address mental health needs across DFPS Regions 3W (non-CBC) and 3E.

SB 11 (86th Regular Session, 2019) established the Child Psychiatry Access Network (CPAN), which expands the use of integrated pediatric primary care, simplifies service navigation for families and caregivers, and improves access to mental health care.[251] CPAN improves detection of and care for mental health needs in primary health care settings through a network of behavioral health consultation hubs located at Texas medical schools. The hubs serving DFPS

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[251] Senator Jane Nelson filed Senate Bill (SB) 10, which ultimately passed as a component of Senator Larry Taylor's SB 11.

Regions 3W (non-CBC) and 3E include the University of North Texas Health Science Center,[252] University of Texas Southwestern Medical Center,[253] and Texas A&M University Health Science Center.[254] Each hub supports pediatric and family medicine providers in meeting their patients' mental health needs through the provision of clinical consultation, care coordination, assistance with referrals to specialty outpatient providers, and continuing education. It is important that mental health providers who can address intensive needs be included in the database that is being developed for the CPAN referral network. Those involved in CBC planning should work in partnership with Superior HealthPlan to ensure STAR Health providers are educated about CPAN.

Recommendation 6: Support increased access to psychiatry and other mental health services through the use of telemedicine and telehealth.

Another major barrier to ensuring access to mental health care across DFPS Regions 3W (non-CBC) and 3E is availability of providers within the STAR Health provider network. In many parts of the region, especially rural, those we talked to as part of this environmental assessment reported there are no STAR Health psychiatrists or other providers within a 30-mile radius. HHSC requires MCO provider networks to comply with distance or travel time standards to ensure timely access to care. Depending on whether a child or youth member is considered to be in a metro area (Denton, Collin, Dallas, Ellis, Grayson, Hunt, Kaufman, Rockwall), a micro area (Wise), or a rural area (Cooke, Fannin, Navarro), HHSC considers 30–75 miles an acceptable distance to travel for care, with rural members driving greater distances. Distance analysis from HHSC shows that 95% of all members statewide are within the required distance of at least two primary care providers and 90% are within the required distance of at least one of each provider type, which includes mental health providers.[255] Even though most areas meet the standards set forth by HHSC, that does not eliminate burdens experienced by families attempting to access care. In rural areas, there is often no public transportation available to take families to appointments. In addition, when families are required to travel long distances (or long periods of time as is often the case in metro areas), caregivers must take time off from work to attend appointments, creating another barrier to care.

While CPAN helps improve access to services through primary care, it relies upon a specialty provider network to deliver services for children and youth whose needs are more complex and

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[252] The counties within DFPS Regions 3W (non-CBC) and 3E that are served by the University of North Texas Health Science Center CPAN hub: Cooke, Erath, Palo Pinto, Parker, Tarrant, and Wise.

[253] The counties within DFPS Regions 3W (non-CBC) and 3E that are served by University of Texas Southwestern Medical Center CPAN hub: Collin, Dallas, Denton, Ellis, Fannin, Grayson, Hunt, Kaufman, and Rockwall.

[254] The counties within DFPS Regions 3W (non-CBC) and 3E that are served by Texas A&M University Health Science Center CPAN hub: Hood, Johnson, Navarro, and Somervell.

[255] Health and Human Services Commission. (2020). *Report on Medicaid Managed Care Provider Network Adequacy*. https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/sb760-medicaid-managed-care-provider-network-adequacy-dec-2020.pdf

cannot be fully met in a primary care setting. As such, a strong network of providers that are easily accessible to children, youth, and families in all parts of the region should be a goal of both STAR Health and CBC planners. For areas within DFPS Regions 3W (non-CBC) and 3E where mental health providers are not currently easily accessible, either due to network adequacy or other access barriers, CBC planners should explore with providers how to expand access to mental health services through telehealth and telemedicine.

Indeed, the COVID-19 pandemic thrust everyone into the virtual space. While this was a challenging shift, providers report that they've been able to increase their reach, serving children and youth who they otherwise would not be able to serve. As a result of the increased focus on virtual services, more reimbursement options have become temporarily available for many services delivered via telehealth and telemedicine. These options may be extended over a longer period or permanently extended by the 87th Legislature. However, because of their rural nature, parts of the region may experience challenges with broadband internet service, which providers will have to account for as they increase the services offered via telehealth and telemedicine.

Theme 3: Ensure that foster families, relative caregivers, and Child Placing Agencies (CPAs) know which behavioral health benefits are available to children and youth in substitute care and how to access needed providers.

Access to community-based services and supports by families, children, and youth can reduce unnecessary hospitalizations and improve placement stability. Families experience better outcomes when they are connected to services and supports at the onset of symptoms. Unfortunately, because the mental health care system is difficult to navigate, many families first encounter treatment in an emergency room during a crisis, which presents a unique set of system navigation challenges. Children, youth, and families need help navigating and accessing the benefits available to them before reaching a stage of crisis. Foster parents face challenges in identifying a mental health provider and securing an appointment when a child or youth in their care has a mental health need. Many are unsure what type of service the child or youth needs and are referred from one provider to another until they eventually find the most appropriate provider. Foster parents experience frustration, feel overwhelmed, and are uncertain of how to best advocate for and support the children or youth they are caring for. Foster families need a clear description of who provides services and what types of services they provide.

Recommendation 7: Work with STAR Health to ensure that foster families, relative caregivers, and CPAs know about available behavioral health benefits and how to access outpatient providers.

Providers and foster families reported challenges in obtaining access to mental health services. One challenge is that the member directory is often not up-to-date on whether providers are still enrolled with STAR Health. They also frequently encounter providers listed in the member directory that are not accepting new clients. Keeping a directory of service providers current is a well-known challenge; however, given the critical need for children and youth in the child welfare population to have quick access to mental health services, additional efforts must be made to ensure up-to-date information is available. In addition, both providers and foster families also report a need for more information about the service providers. The directory could be more useful if it included the specialty areas for each provider, for example, whether they provide trauma-informed interventions or evidence-based practices that could be matched to a specific need. Those involved in CBC planning should partner with STAR Health to develop strategies to ensure up-to-date and relevant information is available to both providers and foster and kinship families. In addition, CBC planners may wish to coordinate with STAR Health around the use of the service coordinator's role in helping foster families access mental health services for children and youth in their care. CPAs or foster families can also engage the DFPS Well-Being Specialist to work with STAR Health on their behalf if they have issues accessing benefits or finding providers.

Recommendation 8: Ensure that foster families, relative caregivers, and CPAs know the crisis services available in the area and how to access crisis services when needed.

When a child or youth experiences a mental health crisis, access to 24/7 crisis support and stabilization services can be a determining factor in whether a child or youth remains in their home or is placed in a more restrictive setting. In DFPS Regions 3W (non-CBC) and 3E, many foster parents and providers were unaware of how to access the 24/7 crisis supports available through their LMHA and TurningPoint (where available).[256] For many caregivers, the first place they turn to is their CPA caseworker. In our survey, seven CPAs indicated they have a staff member on-call 24/7 and two CPAs indicated they have mobile crisis support. Often, however, CPA staff do not have the skills needed to manage a mental or behavioral health crisis and are not aware of the community resources available to assist the family. As a result, foster families end up using the emergency department as their primary support during a crisis. CBC planners should implement strategies similar to those discussed in earlier recommendations to improve awareness of the crisis services available to children and youth in substitute care and their families as well as how to access those supports during a crisis.

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[256] Turning Point is a collaboration of ACH Child and Family Services, Cenpatico, and Empirica. For more information, see: https://www.fostercaretx.com/content/dam/centene/fostercare/pdfs/SHP_20161544-Foster-Care-Turning-Point-Flyer-M-EN-ES-06102016.pdf

Recommendation 9: Support continuity of care and ensure children and youth remain with their current providers if they get a new placement and, when that's not possible, better facilitate the transfer of relevant health information to new providers.

Whenever possible, children and youth who are receiving mental health treatment at the time of their placement into substitute care should continue to see their current providers. When that is not possible, the child or youth should initiate with a new service provider as quickly as possible and a complete treatment history should be available to the new provider. CBC planners should ensure the SSCC has policies and procedures in place to facilitate a connection with a new provider as quickly as possible to ensure continuation of care.

It is challenging to ensure a complete medical and mental health treatment history for a child or youth who presents for treatment. For children and youth in substitute care, the Health Passport is the primary way that providers receive information about a child or youth under their care. HHSC requires that the Health Passport contains certain information, such as demographics on the child/youth member; information about medical consenters and the primary care physician; contact information for the CPS caseworker, the Superior Care Manager and Service Coordinator; medication records, including past and current prescriptions; information on other health issues; and more. Despite these requirements, those we spoke with for this environmental assessment indicated that the Health Passport rarely contains this level of detail. Moreover, the child's caseworker may not have the necessary information to supplement what is missing in the Health Passport, or have the ability connect a new provider to a previous one. Those planning and implementing CBC have an opportunity to develop strategies to improve the exchange of pertinent health information.

Recommendation 10: Engage a broad range of organizations and stakeholders to work together to better coordinate services, align resources, and maximize mental health supports available across the regions.

We found strong mental health services and supports available across DFPS Regions 3W (non-CBC) and 3E; however, in certain areas there is a lack of coordination and collaboration among providers. In some cases, providers across child-serving systems are operating in silos without meaningful connections to one other. This disconnect results in a lack of awareness of what services or resources are available in the community. Enhanced collaboration can support an effort to better match children and youth with appropriate services that are effective in meeting their needs, thereby maximizing limited resources. Despite limited collaboration in some areas, nearly every provider we reviewed for this assessment expressed a desire to better understand the services and resources available throughout their community as well as a willingness to partner with other organizations to better meet the needs of children and youth

in substitute care. This collaborative spirit is certainly a strength of in the region and will serve the area well.

CBC planning presents an opportunity for the community to meaningfully engage with local system leaders in mental health, child welfare, juvenile justice, and education in system planning efforts and build upon the existing infrastructure to maximize the resources, services and supports that they each have to offer. In addition, engaging faith-based organizations, community mentors, recreation programs, and other child, youth, and family-focused organizations in the CBC planning process further ensures that kinship and foster families, and the children and youth in their care, will receive the natural supports and services they need to thrive within and outside systems. Importantly, CBC planners should engage foster and kinship caregivers in the planning process to hear from them what would best meet their needs. Enhanced communication and collaboration among community members can help create a child welfare system that works in a more interdisciplinary manner; this is also an avenue to work more collaboratively at the local level in general.

Theme 4: Design specific strategies to improve mental health-related data collection and analysis to support data-driven decision making.

Each of the child-serving systems that impact children and youth in substitute care provides some level of mental health service delivery and support. In fact, children and youth receive mental health treatment and supports from mental health, child welfare, juvenile justice, and education providers. While each system is equally committed to providing quality care, no system alone is fully equipped to meet the mental health needs of children and youth in substitute care and their families, foster families, and relative caregivers. The implementation of CBC presents an opportunity for these systems to partner and work together to plan for and ensure availability of and access to a full array of mental health services, treatment modalities, and supports that best meet the needs of the children and youth in substitute care. However, the data necessary to inform treatment decisions—and to monitor outcomes—from each of these systems is currently lacking. Improved data collection and analysis within and across these child-serving systems can help the community better understand the population's mental health needs and target specific system improvements to address those needs.

Recommendation 11: The CBC planning process for DFPS Regions 3W (non-CBC) and 3E must include specific strategies to improve mental health-related data collection and analysis.

CBC implementation presents an opportunity to use data to identify the broad range of mental health needs among children and youth in substitute care and their caregivers. Using needs data can help CBC planners ensure that appropriate and effective treatments, with a focus on trauma-informed care, are available and matched to the needs of each child or youth to

achieve the best possible outcomes and connect children and youth with the providers best suited to deliver the services. Superior HealthPlan, as discussed earlier, is required to administer the CANS 2.0 to assess the needs of each child and youth in substitute care. Additionally, Superior receives documentation of the services utilized by its child/youth STAR Health members when providers submit claims for reimbursement for services provided. Those involved in CBC planning can examine whether children and youth in substitute care are receiving the appropriate services by matching and comparing the needs identified through the CANS 2.0 assessment with the services provided according to the utilization data.

Data from education and juvenile justice system partners can also provide insight into the treatment needs of children and youth in substitute care as well as the effectiveness of treatments. Within the education system, CBC planners may wish to look at rates of disciplinary referrals among children and youth in substitute care across DFPS Regions 3W (non-CBC) and 3E, including suspensions, expulsions, and referrals to alternative education programs.[257] Rates of school absenteeism can also correlate with unmet mental health needs;[258] however, CBC planners should be aware and consider that absentee rates may also be due to placement changes.[259] Within the juvenile justice system, CBC planners could look at dually-involved children and youth whose juvenile justice intake screening or other assessments indicated a mental health need and review information on the types of services the child or youth is (or is not) receiving. In addition, recidivism rates may also provide important information about the effectiveness of treatment.[260]

It is important that the those planning and implementing CBC also look at which evidence-based interventions are shown to successfully address the particular needs identified through the CANS 2.0 and other assessments and whether utilization data show children and youth as receiving these evidence-based interventions. Placement disruptions are more likely to occur when children and youth do not have access to effective treatment that matches their needs.

Theme 5: Provide caregivers with more support and training.

Foster and kinship caregivers need more in-depth knowledge, tools, and coaching to support the mental health of the children and youth in their homes. Foster parents do receive some training on how to recognize and intervene when a child or youth experiences a specific mental

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[257] Courtney, M., Terao, S., Bost, N. (2004). *Midwest evaluation of the adult functioning of former substitute youth: Conditions of youth preparing to leave state care.* Chicago: Chapin Hall at the University of Chicago. https://www.chapinhall.org/research/conditions-of-youth-preparing-to-leave-state-care/

[258] Zetlin, A., Weinberg, L. & Kimm, C. (2004). Improving education outcomes for children in foster care: Intervention by an education liaison. *Journal of Education for Students Placed at Risk, 9*(4), 421–429.

[259] Pecora, P.J., Kessler, R.C., Williams, J., O'Brien, K., Downs, A.C., English, D., White, J., Hiripi, E., White, C.R., Wiggins, T., & Holmes, K. (2005). *Improving family substitute care: Findings from the Northwest Substitute Care Study*. Casey Family Programs. https://caseyfamilypro-wpengine.netdna-ssl.com/media/AlumniStudies_NW_Report_FR.pdf

[260] White, L. M., Lau, K. S. L., & Aalsma, M. C. (2016, June). Detained adolescents: Mental health needs, treatment use, and recidivism. *Journal of the American Academy of Psychiatry and the Law Online, 44*(2), 200–212.

health need or symptom; however, they struggle to apply that knowledge in the moment. Foster and kindship caregivers can be better supported, and some placement breakdowns prevented, if caregivers are not only trained to recognize a need, but also trained to anticipate a child's behaviors based on their history of trauma. Foster and kinship caregivers need a solid understanding of trauma and how it manifests; more importantly, they need practical strategies to support children and youth in their care who have experienced trauma—and ongoing coaching while they practice applying those strategies.

Recommendation 12: Foster and kinship caregivers need more practical guidance and coaching on how to respond to some of the more challenging behaviors presented by children and youth in substitute care.

While foster families reported receiving adequate training on trauma and support developing skills to manage behaviors that may occur in the home, they did not feel equipped to apply those skills when needed. Local nonprofits and other types of community providers can play an important role in supporting family stability by offering, *not only training, but also follow-up support and coaching* for kinship caregivers and foster parents—as well as for birth parents. Readily available, high-quality training and hands-on coaching, including in the home, can provide the tools and skills needed to support the children and youth in substitute care and help them successfully reach permanency. The following list has examples of relevant evidence-based caregiver training that emphasizes skill building:

- Keeping Foster and Kin Parents Supported and Trained (KEEP) was created by the developers of the Treatment Foster Care Oregon (TFCO) model. KEEP is a skills development program for foster parents and kinship parents of children ages zero to five years as well; as caregivers of teenagers (KEEP SAFE).[261]
- Trauma System Therapy (TST) is a comprehensive, three-phase treatment program for children and youth ages four to 21 years who have experienced traumatic events or live-in environments with ongoing stress and reminders of trauma.[262]
- Attachment, Self-Regulation, Competency (ARC) Treatment Framework is an intervention for families who have experienced multiple or prolonged traumatic stress[263] as well as an organizational framework to support trauma-informed care.
- Nurturing Parenting® is a family-centered intervention designed to build nurturing parenting skills in families where there has been abuse and neglect.[264]
- Parent Child Interaction Therapy (PCIT) is a training program for parents/caregivers of young children who have emotional and behavioral challenges. PCIT reduces behavioral

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[261] Child Trends. (n.d.). KEEP program. https://www.childtrends.org/programs/keep-program/.

[262] California Evidence-Based Clearinghouse for Child Welfare. (2017, March). Trauma Systems Therapy (TST). https://www.cebc4cw.org/program/trauma-systems-therapy-tst/detailed

[263] Trauma Center at Justice Resource Institute. (2007). Attachment, regulation, and competency (ARC). http://www.traumacenter.org/research/ascot.php

[264] Nurturing Parenting Programs. (n.d.). *Nurturing Parenting*. About Us. https://www.nurturingparenting.com/about.html

       problems at home and school, decreases caregiver stress, and improves how caregivers listen, talk, and interact with the child in their care.[265]

- Positive Parenting Program (Triple P) teaches parents/caregivers strategies to prevent emotional, behavioral, and developmental problems in their children and aims to increase the knowledge and confidence of caregivers in dealing with their children's behavioral issues.[266]
- Child-Parent Psychotherapy (CPP) is a therapeutic approach designed for children ages zero to five years who have experienced at least one traumatic event or who are experiencing mental health, attachment, or behavioral problems. Its primary goal is to support and strengthen the relationship between a child and their caregiver.[267]
- Treatment Foster Care Oregon for Preschoolers (TCFO-P) is foster care treatment model designed for children ages three to six years old whose behaviors make it difficult for them to be remain in a regular foster care placement. TFCO-P is effective at promoting secure attachments in foster care and facilitating successful permanent placements.[268]

While most of the interventions named above are not currently eligible for reimbursement through STAR Health, providers who are credentialed to deliver TCM and MHR can be reimbursed for the Nurturing Parenting Program. Providers may also negotiate with Superior to receive reimbursement for PCIT. In addition, providers may be able to bill Superior for components of the other best practices noted above, such as counseling, education, or skill building. However, while these best practices include discrete services like counseling, they also include additional services that are not able to be directly reimbursed. Therefore, providers who want to offer family-focused interventions will need to develop reimbursement strategies to support the additional costs that this approach entails. Blended or braided funds from multiple child-serving systems or funding streams, as discussed in Mental Health Recommendation 4, could serve to supplement providers delivering evidence-based interventions that are not fully funded at this time. The value-based purchasing contracts discussed in Mental Health Recommendation 2 could also be considered to increase the availability of these services and supports.

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[265] PCIT International. (n.d.). *Parent-Child Interaction Therapy (PCIT)*. http://www.pcit.org /

[266] Triple P: Positive Parenting Program. (n.d.). Triple P takes the guesswork out of parenting. https://www.triplep.net/glo-en/home/

[267] National Child Traumatic Stress Network. (2012). Child Parent Psychotherapy. https://www.nctsn.org/interventions/child-parent-psychotherapy

[268] California Evidence-Based Clearinghouse for Child Welfare. (2015, December). Nurturing Parenting Program for Parents and their Infants, Toddlers, and Preschoolers. https://www.cebc4cw.org/program/nurturing-parenting-program-for-parents-and-their-infants-toddlers-and-preschoolers/

Supplement 4A: Mental Health Best Practices for Children, Youth, and Families

Overarching Framework: Quality Improvement and Health Care

In 2001, the Institutes of Medicine (IOM) fundamentally changed the national dialogue regarding the design of health care systems through the landmark publication of its "Crossing the Quality Chasm"[269] report, which became the first in a series of IOM publications that have underscored the need to fundamentally shift operational priorities and the commitment from health care delivery organizations to ongoing quality improvement. In many ways, the premise of the report is quite simple: the health care industry must move from a traditional "command and control" model to a continuous quality improvement model. These are lessons that the U.S. manufacturing sector had to learn and apply in the 1980s and 1990s, building on the work of pioneers such as Edward Deming and leading to a variety of standards and frameworks now widely used across industry (e.g., ISO 9001:2008[270]).

The "Quality Chasm" report and subsequent IOM reports built upon prior reports from the late 1990s to demonstrate the serious quality gaps in the U.S. health care system. Many of these quality gaps have been associated with the shift in treatment to greater numbers of chronic illnesses (versus acute illnesses), an important subset of which includes addictions, serious mental illnesses for adults, and serious emotional disturbances for children and youth. The series of IOM reports focuses on applying the broader framework of performance and quality improvement to the delivery of health care services. The "Quality Chasm" report argues convincingly that these quality gaps cost the U.S. upwards of $750 billion in 2009 in poor, inefficient, wasteful, and ineffective care. The need for systematic change was clear and stark.

In 2006, the IOM focused its attention on mental health and substance use disorders,[271] documenting severe system-level quality gaps and describing a framework for improving them. The resulting report was explicit in its findings, both in demonstrating the existence of effective treatment and the woeful inadequacy of most mental health/substance use disorder delivery systems in effectively promoting it:

> *Effective treatments exist and continually improve. However, as with general health care, deficiencies in care delivery prevent many from receiving appropriate treatments. That situation has serious consequences – for people who have the conditions; for their loved ones; for the workplace; for the education, welfare, and justice systems; and for the nation as a whole.[272]*

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[269] Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st Century*. The National Academies Press.

[270] For example, see: http://www.iso.org/iso/06_implementation_guidance.pdf

[271] Institute of Medicine. (2006). *Improving the quality of health care for mental and substance-use conditions*. The National Academies Press.

[272] Institute of Medicine. (2006). *Improving the quality of health care for mental and substance-use conditions*. The National Academies Press.

The report notes that the challenges facing mental health/substance use disorder systems are, in many ways, more severe than those facing the broader health system because of "a number of distinctive characteristics, such as the greater use of coercion into treatment, separate care delivery systems, a less developed quality measurement infrastructure, and a differently structured marketplace."[273] Nonetheless, the IOM recommended clearly that the advised shift from command and control models of quality assurance to customer-oriented quality improvement was both necessary and possible within behavioral health systems; these systems have capacity similar to that of health care systems to produce better outcomes with lower costs.

The implications of the IOM's recommended shift from command and control models to continuous quality improvement is not just about improving the quality of care delivery; it is also essential to controlling costs, as documented in one of the latest reports in the Quality Chasm report and related report series.[274] The report states the matter in its characteristically direct manner, as quoted below:

> *Consider the impact on American services if other industries routinely operated in the same manner as many aspects of health care:*
> - *If banking were like health care, automated teller machine (ATM) transactions would take not seconds but perhaps days or longer as a result of unavailable or misplaced records.*
> - *If home building were like health care, carpenters, electricians, and plumbers each would work with different blueprints, with very little coordination.*
> - *If shopping were like health care, product prices would not be posted, and the price charged would vary widely within the same store, depending on the source of payment.*
> - *If automobile manufacturing were like health care, warranties for cars that require manufacturers to pay for defects would not exist. As a result, few factories would seek to monitor and improve production line performance and product quality.*
> - *If airline travel were like health care, each pilot would be free to design his or her own preflight safety check, or not to perform one at all.*
>
> *The point is not that health care can or should function in precisely the same way as all other sectors of people's lives; each is very different from the others, and every industry has room for improvement. Yet if some of the transferable best practices from banking, construction, retailing, automobile manufacturing, flight safety, public*

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[273] Institute of Medicine. (2006). *Improving the quality of health care for mental and substance-use conditions*. The National Academies Press.

[274] Institute of Medicine. (2012). *Best care at lower cost: The path to continuously learning health care in America*. The National Academies Press.

utilities, and personal services were adopted as standard best practices in health care, the nation could see patient care in which:

- *Records were immediately updated and available for use by patients;*
- *Treatments were proven reliable at the core and tailored at the margins;*
- *Patient and family needs and preferences were a central part of the decision process;*
- *All team members were fully informed in real time about each other's activities;*
- *Prices and total costs were fully transparent to all participants;*
- *Payment incentives were structured to reward outcomes and value, not volume;*
- *Errors were promptly identified and corrected; and*
- *Results were routinely captured and used for continuous improvement.*[275]

Defining Best Practices

There are hundreds of evidence-based practices (EBPs) available for mental health and substance use disorder treatment, and the most definitive listing of these practices was provided by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) through the National Registry for Evidence-Based Programs and Practices (NREPP).[276] While much of the NREPP website was discontinued as of 2018, it has been replaced by the Evidence-Based Practices Resource Center, which now provides information and tools to incorporate evidence-based practices into community or clinical settings rather than a comprehensive listing of EBPs. Other definitive listings of EBPs are provided by the Society of Clinical Child and Adolescent Psychology,[277] Evidence-Based Behavioral Practice,[278] Blueprints for Health Youth Development,[279] and, for child welfare populations, the California Evidence-Based Clearinghouse for Child Welfare.[280] Additionally, with the passage of the Family First Prevention Services Act (FFPSA), the federal Administration of Children and Families (ACF) is also developing and populating a clearinghouse on evidence-based and promising practices.[281]

The terms "evidence-based practice," "evidence-based treatment," or "empirically-supported treatment" are meant to refer to psychological treatments that have undergone scientific evaluation. There are five levels used to evaluate the evidence base for psychosocial treatments

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[275] Institute of Medicine. (2012). *Best care at lower cost: The path to continuously learning health care in America*. The National Academies Press.

[276] The NREPP's database was located at https://www.samhsa.gov/ebp-resource-center

[277] The Society of Clinical Child and Adolescent Psychology's website is located at https://effectivechildtherapy.org/therapies/

[278] The Evidence-Based Behavioral Practice's website is located at https://ebbp.org/

[279] The Blueprints for Health Youth Development's website is located at https://www.blueprintsprograms.org/

[280] The California Evidence-Based Clearinghouse for Child Welfare's website is located at https://www.cebc4cw.org/search/by-topic-area/

[281] The Administration of Children and Families' website is located at https://preventionservices.abtsites.com

for children and adolescents.[282, 283] On the first level are "well-established" treatments that have undergone at least two randomized clinical trials (RCTs) and have been studied by independent teams working at different research settings. The second level includes "probably efficacious" treatments that have strong research support, but treatment may not have been tested by independent teams; or, only one study shows the treatment is much more effective than a well-established treatment; or, if at least two studies show it is better than no treatment. Interventions in the third level are treatments considered "possibly efficacious" in that there may be one study showing that the treatment is better than no treatment, or there may be a number of smaller clinical studies without highly rigorous methodological and procedural controls (e.g., randomization). The fourth level contains treatments considered "experimental" in that they have not been studied carefully, and the fifth level are treatments that have been tested and do not work.

Successful promotion of best practices also requires understanding of the real-world limitations of each specific best practice, so that the understandable stakeholder concerns that emerge can be anticipated and incorporated into the best practice promotion effort. This process is sometimes called "using practice-based evidence" to inform implementation and is a core feature of continuous quality improvement. The reasons for such concerns at the "front line" implementation level are well documented and significant.[284] One major issue is that the literature prioritizes RCTs that address efficacy in controlled research settings, whereas practitioners require research evidence on effectiveness in typical practice settings. This "efficacy-effectiveness gap" was clearly defined in the 1999 U.S. Surgeon General's report on mental health services in America[285] and centers on the much more complex realities that practitioners face in the field. Research that addresses the complexities of typical practice settings (e.g., staffing variability due to vacancies, turnover, inconsistent quality of providers' training, and inconsistent fidelity to existing models) is lacking, and the emphasis on RCTs is not amenable to exploration of clinically relevant constructs like engagement and therapeutic relationships. Related uncertainties about implementing best practices include a lack of clarity about the interactions of development and ecological context with the interventions. While it is generally accepted that development involves continuous and dynamic interactions between individuals and their environments over time, and is inextricably linked to natural contexts, the

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[282] Chambless, D. L. & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66*, 7–18.

[283] Chorpita, B. F., Daleiden, E. L., Ebesutani, C., Young, J., Becker, K. D., Nakamura, B.J. & Starace, N. (2011). Evidence-based treatments for children and adolescents: An updated review of indicators of efficacy and effectiveness. *Clinical Psychology: Science and Practice, 18*, 154–172.

[284] Waddell, C., & Godderis, R. (2005). Rethinking evidence-based practice for children's mental health. *Evidence-Based Mental Health, 8*, 60–62.

[285] U.S. Surgeon General. (1999). *Mental health: A report of the Surgeon General*. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

efficacy research literature is largely silent on these relationships.[286] Because of this, practitioners must in many cases extrapolate from the existing research evidence.

One of the biggest concerns about best practices — and one that is certainly highly relevant for a state as diverse as Texas — involves application of practices to individuals and families from diverse cultural and linguistic backgrounds. There are inherent limitations in the research base regarding diversity that often lead providers, people receiving services, and other stakeholders to question the extent to which the research evidence supporting best practices is applicable to their communities and the situations they encounter daily. Further, there is wide consensus in the literature that too little research has been carried out to document the differential efficacy of best practices across cultures.[287] Given that few best practices have documented their results in sufficient detail to determine their effectiveness cross-culturally, it makes sense to implement best practices within the context of ongoing evaluation and quality improvement efforts to determine whether they are effective – or more accurately, how they might need to be adapted to be maximally effective – for the local populations being served. The California Institute for Mental Health has compiled an analysis regarding the cross-cultural applications of major best practices.[288] There is also increasing recognition of best practices for refugee and immigrant communities.[289]

It is critical to ground best practice promotion in specific standards for culturally and linguistically appropriate care. The most well-known national standards related to health disparities focus on services for members of underrepresented groups. The National Standards for Cultural and Linguistically Appropriate Services in Health Care (CLAS Standards)[290] were adopted in 2001 by the U.S. Department of Health and Human Services' Office of Minority Health with the goals of "equitable and effective treatment in a culturally and linguistically appropriate manner" and "as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers" in order "to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans." Updated in 2013, the CLAS Standards now include 15 standards addressing the broad themes of culturally competent care, language

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[286] Hoagwood, K., Burns, B. J., Kiser, L., Ringeisen, H, & Schoenwald, S. K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, 52, 1179–1189.

[287] U.S. Surgeon General. (2001). *Mental health: Culture, race, and ethnicity: A supplement to Mental health: A report of the Surgeon General*. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

[288] For more information, see: https://www.cibhs.org/sites/main/files/file-attachments/final_summary_matrix.pdf

[289] American Psychological Association, Presidential Task Force on Immigration. (2012). *Crossroads: The psychology of immigration in the new century*. http://www.apa.org/topics/immigration/immigration-report.pdf

[290] U.S. Department of Health and Human Services (USDHHS), Office of Minority Health. (2001, March). *National standards for cultural and linguistically appropriate services in health care*. https://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

access, and organizational supports for cultural competence;[291] the CLAS standards are most widely recognized in the broader health field. In mental health, a set of SAMHSA standards for African American, Asian American/Pacific Islander, Hispanic/Latino, and American Indian groups is also available.[292] Guidance for multicultural applications is available as well.[293]

Major Evidence-Based Practices for Children, Youth, and Families

Integrated Primary Care

Integrated primary care (IPC) programs provide the opportunities to improve outcomes and promote a broader culture of medical care that includes physical, emotional, and behavioral health in treatment approaches. Annual well-child visits with primary care providers provide an excellent opportunity for children and youth to access both physical and behavioral health care, especially within comprehensive integrated primary care settings. Collaborative care programs, where primary care providers, care managers, and behavioral health specialists work as a team to provide patient care, can have a positive impact. A 2015 meta-analysis in the *Journal of the American Medical Association (JAMA) Pediatrics* indicated that "the probability was 66% that a randomly selected youth would have a better outcome after receiving integrated medical-behavioral treatment than a randomly selected youth after receiving usual care." [294]

A Meadows Mental Health Policy Institute 2016 report[295] proposed that IBH programs should include the following seven core components:
- Integrated organizational culture,
- Population health management,
- Structured use of a team approach,
- IBH staff competencies,
- Universal screening for the most prevalent primary health and behavioral health conditions,
- Integrated person-centered treatment planning, and
- Systematic use of evidence-based clinical models.

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[291] U.S. Department of Health and Human Services. (2013). *National standards for culturally and linguistically appropriate Services (CLAS) in health and health care.*
https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf

[292] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2001). *Cultural competence standards in managed care mental health services: Four underserved/underrepresented racial/ethnic groups.*

[293] For more information, see: https://www.cibhs.org/overview/adopting-culturally-competent-practices-accp-project for the overall site and https://www.cibhs.org/sites/main/files/file-attachments/final_summary_matrix.pdf for specific best practices demonstrated in California.

[294] Asarnow, J. R., Rozenman, M., Jessica Wiblin, J., & Zeltzer, L. (2015, October). Integrated medical-behavioral care compared with usual primary care for child and adolescent behavioral health: A meta-analysis. *JAMA Pediatrics*. *169*(10), 929–937. http://jamanetwork.com/journals/jamapediatrics/fullarticle/2422331

[295] Meadows Mental Health Policy Institute (2016, June). *Best practices in integrated behavioral health: Identifying and implementing core components.* http://texasstateofmind.org/wp-content/uploads/2016/09/Meadows_IBHreport_FINAL_9.8.16.pdf

Effective IBH programs utilize evidence-based treatment interventions to achieve better outcomes and more cost-effective care. They track primary health and behavioral health outcomes and use health information technology to manage population outcomes in order to use interventions that ensure quality care.

Behavioral health integration in primary care settings increases access to behavioral health services for children and youth with mild-to-moderate mental health conditions. About 75% of children and youth with psychiatric disorders can be seen in the pediatrician's office.[296] Importantly, however, there are often significant limitations. Pediatricians typically do not deliver mental health services because of limited time during each patient visit, minimal training and knowledge of behavioral health disorders, concern about prescribing psychotropic medications, gaps in knowledge of local resources, and lack of knowledge about or limited access to behavioral health specialists.[297] However, a fully-scaled implementation example suggests that two thirds of behavioral health care could be provided in pediatric settings with the right integration supports.[298]

Behavioral health integration in primary care settings also aligns with the concept of the "medical home." According to the American Academy of Pediatrics, the pediatric health home — sometimes called the "pediatric medical home" — refers to "delivery of advanced primary care with the goal of addressing and integrating high quality health promotion, acute care, and chronic condition management in a planned, coordinated, and family-centered manner."[299]

Providing additional perspective, the American Academy of Child and Adolescent Psychiatry (AACAP) has developed "Best Principles for Integration of Child Psychiatry into the Pediatric Health Home." AACAP identifies key components of the behavioral health integration framework within the pediatric medical home.[300] These include the following strategies:[301]

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[296] American Academy of Child and Adolescent Psychiatry. (2012, June). *Best principles for integration of child psychiatry in the pediatric health home*. http://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration _of_child_psychiatry_into_the_pediatric_health_home_2012.pdf

[297] American Academy of Child and Adolescent Psychiatry. (2012, June). *Best principles for integration of child psychiatry in the pediatric health home*. http://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration _of_child_psychiatry_into_the_pediatric_health_home_2012.pdf

[298] Straus, J. H., & Sarvet, B. (2014, December). Behavioral health care for children: The Massachusetts Child Psychiatry Access Project. *Health Affairs*, *33*(12), 2153–2161.

[299] American Academy of Pediatrics. (2017). *Medical home*. https://www.aap.org/en-us/professional-resources/practice-transformation/medicalhome/Pages/home.aspx

[300] American Academy of Child and Adolescent Psychiatry. (2012, June). *Best principles for integration of child psychiatry in the pediatric health home*. http://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration _of_child_psychiatry_into_the_pediatric_health_home_2012.pdf

[301] American Academy of Child and Adolescent Psychiatry. (2012, June).

- Screening and early detection of behavioral health problems;
- Triage/referral to appropriate behavioral health treatments;
- Timely access to child and adolescent psychiatry consultations that include indirect/curbside consultation as well as face-to-face consultation with the patient and family by the child and adolescent psychiatrist;
- Access to child psychiatry specialty treatment services for those who have moderate-to-severe psychiatric disorders;
- Care coordination that assists in delivery of mental health services and strengthens collaboration with the health care team, parents, family, and other child-serving agencies; and
- Monitoring outcomes at both an individual and delivery-system level.

Examples of Integrated Primary Care Models

Massachusetts Child Psychiatry Access Project (MCPAP) offers one promising approach to integrated care. Established in 2004, MCPAP is a national leader and model that has inspired many other states to create similar programs. It supports over 95% of the pediatric primary care providers in Massachusetts. MCPAP has six regional behavioral health consultation hubs, each with a child psychiatrist, a licensed therapist, and a care coordinator. Each hub also operates a dedicated hotline that can include the following services: timely over-the-phone clinical consultation, expedited face-to-face psychiatric consultation, care coordination for referrals to community behavioral health providers, and ongoing professional education designed for primary care providers. In 2014, following a MCPAP consultation, primary care providers reported managing 67% of the types of problems that they typically would have referred to a child psychiatrist before they enrolled in the program. The MCPAP model was so instrumental in providing accessible behavioral health care for children and youth that it expanded to develop MCPAP for Moms. Created in 2014, MCPAP for Moms is a collaborative model that involves obstetricians, internists, family physicians, and psychiatrists. Its mission is to promote maternal and child health for pregnant and postpartum women for up to one year after delivery to prevent, identify, and manage mental health and substance use disorders.[302]

Seattle Children's Partnership Access Line (PAL) is another leading model of integrating behavioral health care into primary care for children and youth. PAL is a telephone-based mental health consultation system that provides services to Washington and Wyoming. It is available to primary care physicians, nurse practitioners, and physician assistants. Users of this model receive a child mental health care guide and advice from a child psychiatrist that includes a summary of the consult conversation. In addition, the PAL program includes a social worker who can provide a list of local resources tailored to an individual patient and their insurance. If

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[302] Straus, J. H., & Sarvet, B. (2014, December). Behavioral health care for children: The Massachusetts Child Psychiatry Access Project. *Health Affairs*, *33*(12), 2153–2161.

a child needs to be evaluated in person, PAL helps link families to providers in their respective communities. PAL can assist with identifying locations that have telemedicine appointment available. The PAL team also provides educational presentations to primary care providers on aspects of managing behavioral health issues in the primary care setting. Primary care providers reported that in 87% of their consultation calls, they usually received new psychosocial treatment advice. They also reported that children with a history of foster care placements experienced a 132% increase in outpatient mental health visits after the consultation call. Feedback from primary care provider surveys also reported "uniformly positive satisfaction" with PAL.[303] In 2017, following the implementation of PAL, antipsychotic prescriptions for children enrolled in Washington State's Medicaid program decreased by nearly half.[304]

The **Health Care Management** program at Children's Health in Dallas, formerly Children's Medical Center, provides a promising approach to behavioral health care for children and youth. In 2013, Children's Health began an IBH program within its pediatric outpatient clinics. In July 2015, it was fully implemented with care managers covering all 18 Children's Health Pediatric Group clinics. As of January 2017, the team included 10 licensed master's-level behavioral health clinicians (LPCs, LCSWs, and LMFTs) and two clinical psychologists. The behavioral health team provides consultation and direct treatment to patients who receive primary care in the outpatient clinics. Behavioral health screening tools for monitoring depression are administered and tracked with every well-child visit, starting at age 11. Implementation of these tools has contributed to studies that have shown excellent results, such as more than a 50% reduction in symptoms of depression. One strength of the program is a shared electronic medical record system that offers both primary care and specialty behavioral health providers access to a patient's records, enabling better care coordination. In addition, members of the behavioral health team are co-located with their primary care colleagues in the pediatric clinic setting, increasing accessibility to behavioral health care. The behavioral health team conducts educational presentations for primary care providers on topics such as depression, attention-deficit hyperactivity disorder, and parenting skills. Moreover, the behavioral health team meets internally every two weeks for formal case discussions and treatment planning. Finally, the program uses telemedicine to deliver primary care services to children and youth in local schools to increase access.

The Rees-Jones Center for Foster Care Excellence, located at Children's Health in Dallas, is another Texas-based best practice program. The Rees-Jones Center for Foster Care Excellence uses a specialized integrated health care model that addresses the needs of children and youth

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[303] Hilt, R. J., Romaire, M. A., McDonell, M. G., Sears, J. M., Krupski, A., Thompson, J. N., & Trupin, E. W. (2013, February). The partnership access line evaluating a child psychiatry consult program in Washington State. *JAMA Pediatrics*, *167*(2), 162–168.

[304] Barclay, R. P., Penfold, R. B., Sullivan, D., Boydston, L., Wignall, J., & Hilt, R. J. (2017, April). Decrease in statewide antipsychotic prescribing after implementation of child and adolescent psychiatry consultation services. *Health Services Research*, *52*(2), 561–578.

in foster care as they often need additional supports. One of its promising practices is the structured use of a team approach with a care team of primary care and behavioral health providers as well as a nurse coordinator and a child protective services (CPS) liaison. All members of the care team are co-located and fully collaborative, and they provide evidence-based, trauma-informed primary care and therapeutic services. Center staff described the nurse coordinator and CPS liaison positions, specifically, as central and critical to the model. Other core IBH components of The Rees-Jones Center for Foster Care Excellence include the use of a shared electronic medical records system, which allows all team members to access a child or youth's record and document clinical observations and recommendations in one place; implementation of daily and weekly formal case discussions and treatment planning; and regular staff trainings.

School-Based Mental Health Services

Prevention efforts shift as children (ages six to 12) enter school to focus on increasing positive social interactions, decreasing aggression and bullying, and increasing academic motivation. The education and mental health systems in the United States have a long history of providing mental health services to children. With the passage of the Education of All Handicapped Children Act in 1975 (reauthorized in 1990 as the Individuals with Disabilities Act, or IDEA), education systems were given greater responsibility to meet the needs of students with mental and behavioral health concerns.[305] Schools provide a natural setting for mental health services, including prevention.[306, 307] In fact, studies show that for many children and youth, schools seem to be their primary mental health system (one finding showed that for children who receive any type of mental health service, over 70% receive the service from their school).[308] Schoolwide prevention and services that promote behavioral health reduce violence and create a positive school climate that benefits all students.[309]

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[305] Pumariega, A. J., & Vance, H. R. (1999). School-based mental health services: The foundation for systems of care for children's mental health. *Psychology in the Schools*, *36*, 371–378 as cited in Kutash, K., Duchnowski, A., & Lynn, N. (2006, April). *School-based mental health: An empirical guide for decision-makers*. University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies, Research and Training Center for Children's Mental Health.

[306] Lever, N., Stephan, S., Castle, M., Bernstein, L., Connors, E., Sharma, R., & Blizzard, A. (2015). *Community-partnered school behavioral health: State of the field in Maryland*. Center for School Mental Health. http://csmh.umaryland.edu/media/SOM/Microsites/CSMH/docs/Resources/Briefs/FINALCP.SBHReport3.5.15_2.pdf

[307] Hoover, S., Bracey, J., Lever, N., Lang, J., & Vanderploeg, J. (2018). Healthy students and thriving schools: A comprehensive approach for addressing students' trauma and mental health needs. Child Health and Development Institute of Connecticut. https://www.chdi.org/index.php/publications/reports/impact-reports/health-students-and-thriving-schools

[308] Barrett, S., Eber, L., & Weist, M. (2013). *Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support*. https://www.pbis.org/resource/advancing-education-effectiveness-interconnecting-school-mental-health-and-school-wide-positive-behavior-support

[309] Barrett, S., Eber, L., & Weist, M. (2013). *Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support*. https://www.pbis.org/resource/advancing-education-effectiveness-interconnecting-school-mental-health-and-school-wide-positive-behavior-support

School-based behavioral health and prevention are best implemented through a public health approach.[310] The public health model could provide a framework that spans the broad range of age groups and challenges seen in public school systems and could support the following recommendations for enhancing school-based mental health services models:

- Implement schoolwide prevention programs and acknowledge that this will require new roles for community workers and school staff.
- Improve the educational outcomes of students by using evidence-based and empirically supported selective and indicated prevention programs, with particular attention to the academic needs of students with emotional disturbances served in special education.

Other sources point out emerging trends and practices in school mental health that highlight successful collaboration between schools, communities, and families.[311] As such, several EBPs build on prevention efforts and provide diverse community-based approaches for addressing mental health needs within a school environment. These approaches are summarized below.

Community-Partnered School Behavioral Health (CP-SBH) is a term used for supporting student behavioral health along the full prevention-intervention continuum by bringing together community behavioral health providers with schools and families. These community providers augment existing school resources to provide a more comprehensive array of services (e.g., trauma-informed care, medication management, substance use prevention) within the school building.[312] These partnerships allow schools to expand their behavioral health capacity through enhanced staffing, resources, skills, and knowledge. Comprehensive service provision through CP-SBH can include screening prevention for students identified as at risk for behavioral health problems, and specialized intervention services such as clinical assessment and treatment. CP-SBH programs share several best practice policies and procedures, including establishing and maintaining effective partnerships, integrating community-partnered school behavioral health into multi-tiered systems of support (universal prevention, targeted prevention, individualized intervention and supports, specialized support for substance use and abuse problems), and utilizing empirically supported treatments. In addition, CP-SBH programs also focus on facilitating family-school-community teaming; collecting, analyzing, and utilizing

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[310] Barrett, S., Eber, L., & Weist, M. (2013). *Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support*. https://www.pbis.org/resource/advancing-education-effectiveness-interconnecting-school-mental-health-and-school-wide-positive-behavior-support

[311] Weist, M. D., & Murray, M. (2007). Advancing school mental health promotion globally. *Advances in School Mental Health Promotion, Inaugural Issue,* 2-12. http://dx.doi.org/10.1080/1754730X.2008.9715740 as cited in Barrett, S., Eber, L., & Weist, M. (2013). Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support. https://www.pbis.org/resource/advancing-education-effectiveness-interconnecting-school-mental-health-and-school-wide-positive-behavior-support

[312] Lever, N., Stephan, S., Castle, M., Bernstein, L., Connors, E., Sharma, R., & Blizzard, A. (2015). *Community-partnered school behavioral health: State of the field in Maryland*. Baltimore, MD: Center for School Mental Health.

data; and obtaining, sustaining, and leveraging diverse funding streams.[313] Some of the advantages of this approach include improving access to behavioral health services, reducing the stigma of seeking services, being able to generalize treatment to the child's school environment, and having an impact on attendance and educational outcomes.

Schoolwide initiatives such as **Positive Behavioral Interventions and Supports** (PBIS) have significantly decreased aggressive incidents among students and have increased the comfort and confidence of school staff within the school environment. PBIS is a school-based application of a behaviorally based systems approach to enhance the capacity of schools, families, and communities to design effective environments that improve the link between research-validated practices and the environments in which teaching and learning occurs. The model includes primary (schoolwide), secondary (classroom), and tertiary (individual) systems of support that improve functioning and outcomes (personal, health, social, family, work, and recreation) for all children and youth by making problem behavior less effective, efficient, and relevant – while making desired behavior more functional. PBIS has three primary features: (1) functional (behavioral) assessment; (2) comprehensive intervention, and (3) lifestyle enhancement.[314, 315, 316, 317] The value of schoolwide PBIS integrated with mental health services and supports, according to the Bazelon Center, lies in its three-tiered approach. Eighty percent (80%) of students fall into the first tier. For them, schoolwide PBIS creates "a social environment that reinforces positive behavior and discourages unacceptable behaviors."[318] A second tier of students benefits from some additional services, often provided in coordination with the mental health system. This, the report notes, makes it "easier to identify students who require early intervention to keep problem behaviors from becoming habitual"[319] and to provide that intervention. Finally, tier-three students, who have the most severe behavioral-support needs, can receive intensive services through partnerships between the school, the mental health system, other child-serving agencies, and family. For more information about this approach and its specific interventions, see: https://www.pbis.org/

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[313] Lever, N., et al. (2015). *Community-partnered school behavioral health: State of the field in Maryland*. Baltimore, MD: Center for School Mental Health.

[314] Adelman, H. S., & Taylor, L. (1998). Reframing mental health in schools and expanding school reform. *Educational Psychologist*, *33*, 135–152.

[315] Horner, R. H., & Carr, E. G. (1997). Behavioral support for students with severe disabilities: Functional assessment and comprehensive intervention. *Journal of Special Education*, *31*, 84–104.

[316] Koegel, L. K., Koegel, R. L. & Dunlap, G. (Eds.). (1996). *Positive behavioral support: Including people with difficult behavior in the community*. Paul H. Brookes.

[317] Positive Behavior Interventions and Supports website is located at https://www.pbis.org

[318] Bazelon Center. (2006). *Way to go: School success for children with mental health care needs*. http://www.bazelon.org/wp-content/uploads/2017/01/Way_to_Go.pdf

[319] Bazelon Center. (2006). *Way to go: School success for children with mental health care needs*. http://www.bazelon.org/wp-content/uploads/2017/01/Way_to_Go.pdf

Multi-Tiered System of Supports (MTSS) is an approach based on a problem-solving model that documents students' performances after changes to classroom instruction have been made as a way to show that additional interventions are needed. It ensures that instruction and interventions are matched to student needs. PBIS is consistent with the principles of MTSS, which include research-based instruction in general education, universal screening to identify additional needs, a team approach to the development and evaluation of alternative interventions, a multi-tiered application of evidence-based instruction determined by identified need, continuous monitoring of the intervention, and parent involvement throughout the process.[320]

- In Colorado, MTSS is a prevention-based framework for improving the outcomes of all students. The essential components of this multi-tiered approach include team-driven shared leadership; data-based problem solving; partnerships with families, schools, and communities; a layered continuum of supports matched to the student's need (from universal to targeted to intensive); and instruction, assessment, and intervention that are evidence-based.[321]
- In California, the MTSS framework has resources and initiatives to address all students' needs. It organizes academic, behavioral, and social and emotional learning into an integrated system of supports for all students. It encompasses Response to Instruction and Intervention and PBIS, and aligns those supports to better serve each student.[322] The model integrates data collection and assessment to inform decisions.

The Interconnected Systems Framework (ISF) helps expand the MTSS framework by including community providers in key roles, such as decision-making, selection and implementation of EBPs, monitoring, and ongoing coaching. ISF brings together Response to Intervention,[323] PBIS, and school mental health services in a framework that enhances all approaches, extends the array of mental health supports for students and families, and meets the need for an overarching framework for implementing evidence-based interventions through collaboration between schools and community providers.[324] ISF addresses limitations of PBIS' insufficient development in targeted prevention and specialized intervention for students with more complicated behavioral health concerns. ISF also targets the lack of structure in the implementation of school mental health services (which contributes to high variability in services and school staff not being aware of these services), the poor use of data, and the

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[320] Positive Behavioral Interventions and Supports OSEP Technical Assistance Center. (n.d.). *Tiered framework*. https://www.pbis.org/pbis/tiered-framework

[321] Colorado Department of Education. (n.d.). *Multi-tiered System of Supports (MTSS)*. https://www.cde.state.co.us/mtss

[322] California Department of Education. (2019, July). *Definition of MTSS*. https://www.cde.ca.gov/ci/cr/ri/mtsscomprti2.asp

[323] Response to Intervention is an approach that assists in the identification of students with learning and behavioral needs. For more information, see: https://www.cde.ca.gov/ci/cr/ri/

[324] Barrett, S., Eber, L., & Weist, M. (2013). *Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support*. https://www.pbis.org/resource/advancing-education-effectiveness-interconnecting-school-mental-health-and-school-wide-positive-behavior-support

general disconnect between mental health and targeted prevention and specialized intervention services.[325]

Restorative Justice is a practice based on an intervention from the criminal justice field that holds people convicted of crimes accountable by having them face the people they have harmed. Within schools, restorative justice programs use a similar process of holding students accountable for their behavior and providing them with opportunities for making amends and repairing relationships. The overall goals of this practice are to help decrease challenging behaviors among students and reduce rates of suspensions.[326]

- One example of a model restorative justice program is Restorative Justice for Oakland Youth (RJOY), created in 2005 to support collaboration in developing restorative practices in schools, the juvenile justice system, and the greater Oakland community. RJOY engages families and communities to positively impact school discipline, racial disparities, and school climate in order to interrupt punitive school discipline and criminal justice policies. This program provides education, training, and technical assistance and, since 2010, has focused on helping schools build capacity for their own restorative justice programs.[327] Outcomes for RJOY include the following: [328]
  - Since the 2011–12 school years, Oakland Unified School District schools that received RJOY training reduced the suspension rate of African American boys by 25%.
  - According to state and local data, RJOY's West Oakland Middle School pilot project eliminated expulsions and reduced suspensions by over 75%.
  - In 2010, the Oakland Unified School District adopted restorative justice as a system-wide alternative to zero-tolerance practices, largely influenced by RJOY.
- The Denver Public Schools Restorative Justice Project also serves as a model example.[329] In the 2007–2008 school year, over 1,000 referrals were made for restorative justice services (unduplicated count of 812 students), with almost 180 of these cases being provided in lieu of suspension or for reduced out-of-school suspension as a result of the referral. Over half (52%) of the cases resulted in a "restorative agreement." Students, parents, and teachers all gave strong endorsement for the restorative justice process, noting its fairness and helpfulness with resolving conflicts as well as its influence on

[325] Barrett, S., et al. (2013). *Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support*. https://www.pbis.org/resource/advancing-education-effectiveness-interconnecting-school-mental-health-and-school-wide-positive-behavior-support

[326] Owen, J., Wettach, J., & Hoffman K. C. (2015). *Instead of suspension: Alternative strategies for effective school discipline*. Duke Center for Child and Family Policy and Duke Law School. https://web.law.duke.edu/childedlaw/schooldiscipline/downloads/instead_of_suspension.pdf

[327] RJOY. (n.d.). *About us. Our history.* https://rjoyoakland.org/about-us/

[328] Jain, S., Bassey, H., Brown, M., & Kalra, P. (2014). Restorative justice in Oakland schools: An effective strategy to reduce racially disproportionate discipline, suspensions and improve academic outcomes. https://www.ousd.org/cms/lib/CA01001176/Centricity/Domain/134/OUSD-RJ%20Report%20revised%20Final.pdf

[329] Baker, M. L. (2008). *DPS restorative justice project executive summary*. Denver Public Schools.

students' improvements in listening skills, empathy, anger control, respect, and appropriate reparative action planning. All participating schools showed reductions in out-of-school suspensions and expulsions compared to the prior year's total.[330]

Interpersonal Psychotherapy for Adolescents Skills Training (IPT-AST) is a manualized program delivered by mental health clinicians at schools. The program aims to decrease depressive symptoms by helping youth improve their relationships and interpersonal interactions. The psychotherapy group teaches youth communication strategies and interpersonal problem-solving skills that they can apply to their relationships. In order to implement IPT-AST to fidelity, training must be received through the treatment developers. For more information about IPT-AST, see: https://policylab.chop.edu/people/jami-young

The **Cognitive Behavioral Intervention for Trauma in Schools** (CBITS) program focuses primarily on reducing symptoms of posttraumatic stress disorder, depression, and behavioral problems for children and youth in grades three through eight. CBITS, which was first used in the 2000–2001 school year in the Los Angeles Unified School District, adopts a school-based group and intervention focus. Although primarily directed toward younger children, CBITS has been expanded to include high school students who have experienced notable trauma. Structurally, the program uses a mix of session formats, featuring group sessions, individual student sessions, parent psychoeducational sessions, and a teacher educational session. The program is administered by mental health clinicians and claims effectiveness with multicultural populations.[331] In order to implement CBITS to fidelity, training and certification must be received through the treatment developers. For more information about CBITS, see: https://cbitsprogram.org/

Teacher-Child Interaction Therapy (TCIT) is a professional development, train-the-trainer-model designed to strengthen teacher-child relationship skills for children with disruptive behavior or those at risk of developing disruptive behavior. It is a prevention and intervention program. TCIT is implemented in elementary schools or early childcare settings. In order to implement TCIT to fidelity, training and certification must be received through the treatment developers. For more information about TCIT, see: http://www.tcit.org or https://pcit-training.com/teacher-child-interaction-training-training-calendar/

Promoting Alternative Thinking Strategies (PATHS) is a program designed to reduce aggressive behavior and increase social competencies in children ages four to 12 years. The curriculum is designed to be used by educators to help children with poor classroom behavior and performance. Although primarily focused on the school setting (small groups and classroom),

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[330] Baker, M. L. (2008). *DPS restorative justice project executive summary*. Denver Public Schools.
[331] Treatment and Services Adaption Center (n.d.). *Cognitive behavioral intervention for trauma in schools*. https://traumaawareschools.org/cbits

information and activities are also included for use with parents. In order to implement PATHS to fidelity, training and certification must be received through the treatment developers. For more information about PATHS, see: http://www.pathstraining.com/main/

Think:Kids is a program that uses a collaborative problem solving approach with students in a school environment. The program teaches skills related to problem solving, flexibility, and frustration tolerance. Unlike traditional models of discipline, this approach avoids the use of power, control, and motivational procedures; instead, it focuses on building helping relationships and teaching children and youth the skills they need to succeed. Documented outcomes included reductions in time out of the classroom, detentions, suspensions, injuries, teacher stress, and alternative school placement. In order to implement Think:Kids to fidelity, training and certification must be received through the model developers. For more information about Think:Kids, see: http://www.thinkkids.org/train/certification/

Clinic and Home-Based Interventions

There is growing evidence that in most situations, children and youth can be effectively served in their homes and communities and that community-based treatment programs are often superior to institution-based programs. Studies show that except for children and youth with highly complex needs or dangerous behaviors (e.g., fire setting or repeated sexual offenses), programs in community settings are more effective than those in institutional settings; intensive, community-based, and family-centered interventions are the most promising.[332] Even children and youth with serious emotional disturbances and longstanding difficulties can make and sustain larger gains in functioning when treatment is provided in a family-focused and youth-centered manner within their communities.

The development and dissemination of evidence-based psychosocial interventions for children and youth has rapidly expanded in recent years. The ideal system would have well-established treatment protocols offered in clinics, schools, or homes with the objectives of (1) decreasing problematic symptoms and behaviors, (2) increasing youth and parent skills and coping, and (3) preventing out-of-home placement. This section describes EBPs for specific referral problems. This list is not meant to be exhaustive; rather, it provides examples that can be used as resources. In addition, a host of clinical trials are underway and treatment protocols are being developed that will continually inform and improve the use of EBPs in the months and years to come. The EBPs discussed below fall under the umbrella categories of behavioral therapy or cognitive behavioral therapy in that the focus of intervention is on the cognitions, emotions, or behaviors of the child, youth, caregiver, or teacher, and on the variables that predict these outcomes.

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[332] Blau, G. M., Caldwell, B., & Lieberman, R. (eds.) (2014). Residential interventions for children adolescents and families: A best practice guide. Routledge Press.

Disruptive Behaviors

The Incredible Years[333] focuses on reducing disruptive behavior and preventing conduct problems, targeting infants to school-age children. This is accomplished through an interaction of three programs aimed at improving the skills of the child (in the areas of academic and social achievement), parent (to increase communication and nurturing approaches), and teacher (promoting effective classroom management and instruction of social skills). This curriculum particularly targets risk factors for conduct disorder and promotes a positive environment for the child both in the home and at school. In order to implement the Incredible Years program to fidelity, training and certification must be received through the treatment developers. For more information about the Incredible Years, see: http://www.incredibleyears.com/

Positive Parenting Program (Triple P)[334] is aimed at teaching parents strategies to prevent emotional, behavioral, and developmental problems in their children. Triple P includes five levels of varying intensity (from the dissemination of printed materials to eight- to 10-session parenting programs and more enhanced interventions for families experiencing higher levels of relational stress). Using social learning, cognitive behavioral, and developmental theories in combination with studies of risk and protective factors for these problems, Triple P aims to increase the knowledge and confidence of parents in dealing with their children's behavioral issues. In order to implement Triple P to fidelity, training and certification must be received through the treatment developers. For more information about Triple P, see: www.triplep.net

Parent Management Training – The Oregon Model (PMTO) promotes social skills and prevents, reduces, and reverses the development of moderate-to-severe conduct problems in children and youth. PMTO focuses on parent training, classroom behavior management, and peer interventions. In order to implement PMTO to fidelity, training and certification must be received through the treatment developers. For more information about PMTO, see: https://www.generationpmto.org/

Coping Power Program reduces disruptive behavior in school and home settings. Originally it was developed as a school-based program and has since been adapted to be delivered in outpatient mental health settings. The program is offered to late elementary and middle school students. Its curriculum components focus on skills to enhance emotional awareness, organizational skills, problem solving, goal setting, and social skills. These skills are taught in cognitive behavioral group sessions provided in schools, individual sessions at clinics, and

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[333] Webster-Stratton, C. (1984). A randomized trial of two parent-training programs for families with conduct-disordered children. *Journal of Consulting and Clinical Psychology, 52*(4)*,* 666–678.

[334] Sanders, M. R., Markie-Dadds, C., Tully, L. A., & Bor, W. (2000). The Triple-P positive parenting program: A comparison of enhanced, standard, and self-directed behavioral family intervention for parents of children with early onset conduct problems. *Journal of Consulting and Clinical Psychology, 68*(4)*,* 624–640.

behavioral training groups for parents and guardians. In order to implement the Coping Power Program to fidelity, training and certification must be received through the treatment developers. For more information about the Coping Power Program, see: https://www.copingpower.com

Problem Solving Skills Training (PSST) reduces oppositional, aggressive, and antisocial behavior in children ages seven to 14 years. The program uses a cognitive behavioral method to teach parents and children more skillful behavior. Children are typically given homework to help them practice implementing these skills. Most sessions are individual, but parents may be brought in to observe and to learn how to assist in reinforcing new skills. In order to implement PSST to fidelity training must be received through the treatment developers. For more information about PSST, see: https://yaleparentingcenter.yale.edu/

Parent-Child Interaction Therapy (PCIT) has strong support as an intervention for use with children ages three to six who are experiencing oppositional disorders.[335, 336, 337] PCIT works by improving parent-child attachment by coaching parents on how to manage their child's behavior. It uses structural play and specific communication skills to help parents implement constructive discipline and limit setting. PCIT teaches parents how to assess their child's immediate behavior and give feedback while an interaction is occurring. In addition, parents learn how to give their children direction toward positive behavior. A therapist guides parents through education and skill-building sessions and oversees practice sessions with the child. PCIT has been adapted for use with Hispanic/Latino and American Indian families. In order to implement PCIT to fidelity, training and certification must be received through the treatment developers at PCIT International. For more information about PCIT, see: http://www.pcit.org/

Multisystemic Therapy (MST) is a well-established EBP for youth living at home with more severe behavioral problems related to willful misconduct and delinquency , and it has proven outcomes and cost benefits when implemented with fidelity.[338, 339] In addition, the developers are currently working to create specialized supplements to meet the needs of specific sub-groups of youth. MST is an intensive, home-based service model provided to families in their

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[335] Chaffin, M., Silovsky, J., Funderburk, B., Valle, L., Brestan, E., Balachova, T., Jackson, S., Lensgraf, J., & Bonner, B. (2004). Parent-child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology*, *72*(3), 500–510.

[336] Eyberg, S. M. (2003). Parent-child interaction therapy. In T. H. Ollendick & C. S. Schroeder (Eds.) *Encyclopedia of Clinical Child and Pediatric Psychology*. Plenum.

[337] Querido, J. G., Eyberg, S. M., & Boggs, S. (2001). Revisiting the accuracy hypothesis in families of conduct-disordered children. *Journal of Clinical Child Psychology*, *20*, 253–261.

[338] Huey, S. J. Jr., Henggeler, S. W., Brondino, M. J., & Pickrel, S. G. (2000). Mechanisms of change in multisystemic therapy: Reducing delinquent behavior through therapist adherence and improved family and peer functioning. J*ournal of Consulting and Clinical Psychology*, *68*(3), 451–467.

[339] Schoenwald S. K., Henggeler S. W., Pickrel S. G., & Cunningham, P. B. (1996). Treating seriously troubled youths and families in their contexts: Multisystemic therapy. In M. C. Roberts (Ed.), *Model programs in child and family mental health*, 317–332. Lawrence.

natural environment at times convenient to the family. MST has low caseloads and varying frequency, duration, and intensity levels. It is based on social-ecological theory that views behavior as best understood in its naturally occurring context and was developed to address major limitations in serving juvenile offenders, focusing on changing the determinants of antisocial behavior in youth.[340] At its core, MST assumes that problems are multi-determined and that to be effective, treatment needs to impact multiple systems, such as a youth's family and peer group. Accordingly, MST is designed to increase family functioning by helping parents improve how they monitor their children, reducing familial conflict, improving communication, and related factors. Additionally, MST interventions focus on increasing the youth's interaction with "prosocial" peers and reducing their association with "deviant" peers, primarily through parental mediation.[341] **MST-Psychiatric** (MST-P) uses a similar approach to MST but is adapted for youth with serious emotional disorders. **MST-Child Abuse and Neglect** (MST-CAN), adapted for a child welfare population, has been proven effective in reducing youth mental health symptoms, parent emotional distress, parenting behaviors associated with maltreatment, and youth out-of-home placements.[342] In order to implement MST, MST-P, or MST-CAN to fidelity, training and certification must be received through the treatment developers at MST Services. For more information about MST, see: http://www.mstservices.com/

Multidimensional Family Therapy (MDFT) is a family-based program designed to treat a range of problem behaviors in youth, such as "substance abuse, delinquency, antisocial and aggressive behaviors, school and family problems, and emotional difficulties."[343] MDFT has good support for White, African American, and Hispanic/Latino youth between the ages of 11 and 18 across urban, suburban, and rural settings.[344, 345, 346] Treatment usually lasts four to six months and can be used alone or with other interventions. MDFT is a multi-component and multilevel intervention system that assesses and intervenes at three levels: (1) with the youth and parents individually, (2) with the family as an interacting system, and (3) with individuals in the family relative to their interactions with influential social systems (e.g., school, juvenile justice) that affect the youth's development. MDFT interventions are solution-focused and

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[340] Henggeler S. W., Weiss, J., Rowland M. D., Halliday-Boykins, C. (2003). One-year follow-up of Multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*(5), 543–551.

[341] Huey, S. J. Jr., Henggeler, S. W., Rowland, M. D, Halliday-Boykins, C. A., Cunningham, P. B., Pickrel, S. G., Edwards, J. (2004). Multisystemic therapy effects on attempted suicide by youths presenting psychiatric emergencies. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43(2), 183–190.

[342] Swenson, C. C., Schaeffer, C. M., Henggeler, S. W., Faldowski, R., & Mayhew, A. M. (2010). Multisystemic Therapy for Child Abuse and Neglect: A randomized effectiveness trial. *Journal of Family Psychology, 24*(4), 497–507. https://doi.org/10.1037/a0020324

[343] For more information see: http://www.mdft.org/MDFT-Program/What-is-MDFT

[344] Hoagwood, K., Burns, B. J., Kiser, L., Ringeisen, H, & Schoenwald, S. K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, *52*, 1179–89.

[345] Hogue, A. T., Liddle, H.A., Becker, D., & Johnson-Leckrone, J. (2002). Family-based prevention counseling for high-risk young youth: Immediate outcomes. *Journal of Community Psychology*, *30*(1), 1–22.

[346] Liddle H. A., Dakof, G. A., Parker K., Diamond G. S., Barrett K., Tejeda, M. (2001). Multidimensional Family Therapy for adolescent drug abuse: Results of a randomized clinical trial. *American Journal of Drug and Alcohol Abuse*, *27*, 651–687.

emphasize immediate and practical outcomes in important functional domains of the youth's everyday life. MDFT can operate as a standalone outpatient intervention in any community-based clinical or prevention facility. It also has been successfully incorporated into existing community-based drug treatment programs, including hospital-based day treatment programs. In order to implement MDFT to fidelity, training and certification must be received through the treatment developers. For more information about MDFT, see: http://www.mdft.org/

Treatment Foster Care Oregon (TFCO) is a program that provides youth with (1) a consistent reinforcing environment where they are mentored, (2) daily structure, (3) close supervision of their whereabouts, and (4) help to avoid deviant peer associations while providing them with the support and assistance needed to establish prosocial peer relationships. TFCO also has program versions for children and youth ages three to 18 years. In order to implement TFCO to fidelity, training and certification must be received through the treatment developers. For more information about TFCO, see: https://www.tfcoregon.com

Autism Spectrum Disorders

Applied Behavior Analysis (ABA) has good support for the treatment of autism, particularly in young children.[347, 348, 349, 350, 351, 352] ABA can be used in a school or clinic setting and is typically delivered between two and five days per week for anywhere from two weeks to 11 months. ABA is one of the most widely used approaches with children and youth with autism. The ABA approach teaches social, motor, and verbal behaviors as well as reasoning skills. ABA teaches skills through the use of behavioral observation and positive reinforcement or prompting to teach each step of a behavior. Generally, ABA involves intensive training for therapists, extensive time spent in ABA therapy (20 to 40 hours per week), and weekly supervision by experienced clinical supervisors known as certified behavior analysts. It is preferred that a parent or other caregiver be involved in helping generate these skills outside of school. In the ABA approach, developing and maintaining a structured working relationship between parents and professionals is essential to ensure consistency of training and maximum benefit. In order to implement ABA to fidelity, ABA therapists must obtain certification as a Board Certified

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[347] Harris, S. L., & Delmolino, L. (2002). Applied behavior analysis: Its application in the treatment of autism and related disorders in young children. *Infants and Young Children*, *14*(3), 11–17.

[348] Smith, T., Groen, A. D. & Wynn, J. W. (2000). Randomized trial of intensive early intervention for children with pervasive developmental disorder. *American Journal on Mental Retardation*, *105*(4), 269–285.

[349] McConachie, H. & Diggle, T. (2007). Parent implemented early intervention for young children with autism spectrum disorder: A systematic review. J*ournal of Evaluation in Clinical Practice*, *13*(1), 120–129.

[350] Sallows, G. O. & Graupner, T. D. (2005). Intensive behavioral treatment for children with autism: Four-year outcome and predictors. *American Journal on Mental Retardation*, *110*(2), 417–438.

[351] Eikeseth, S., Smith, T., Jahr, E., & Eldevik, E. (2002). Intensive behavioral treatment at school for 4- to 7-year-old children with autism: A 1-year comparison controlled study. *Behavior Modification*, *26*(1), 49–68.

[352] Shook, G. L., & Neisworth, J. T. (2005). Ensuring appropriate qualifications for applied behavior analyst professionals: The behavior analyst certification board. *Exceptionality*, *13*(1), 3–10.

Behavior Analyst® (BCBA® or BCBA-D). For more information about ABA, see:
https://www.bacb.com

Anxiety

Cognitive Behavioral Therapy (CBT) has demonstrated significant and enduring treatment outcomes, and effects lasting for a minimum of one year after treatment.[353] Furthermore, researched CBT interventions showed the greatest amount of diversity among study participants, treatment format, treatment setting, and therapist background. CBT is most frequently provided in individual or group therapy, parent training, or teacher consultation. These protocols involve a *cognitive* component — sessions dedicated to psychoeducation, recognizing the physical signs of anxiety, direct work on cognitive distortions, and instructions on coping skills. These protocols also involve a *behavioral* component, which is referred to as exposure and response prevention. Generally, the younger the child, the more parent training is involved in these protocols. There is typically more emphasis on exposure and response prevention than on cognitions, which can be difficult to assess in young children.

CBT protocols are effective for many different kinds of anxiety disorders (e.g., separation anxiety, phobias, obsessive-compulsive disorder). For these different diagnoses, the focus of the treatment differs, but all of the protocols will gradually and systematically help children approach their fears and decrease their avoidance (e.g., avoiding separation from caregivers in the case of separation anxiety, or avoiding social situations in the case of social anxiety).

- Social Effectiveness Therapy for Children and Adolescents (SET-C) [354] is an exposure and response prevention protocol for children and youth ages seven to 17 years that targets social phobia. This protocol includes group social skills training, peer generalization sessions, and individual exposure therapy sessions.
- FRIENDS[355] is a family-based, group cognitive-behavioral treatment for children and youth ages seven to 16 years who meet criteria for depression or generalized anxiety disorder, social phobia, or separation anxiety disorder. Although primarily developed for implementation in a group format by trained mental health providers, it can also be delivered in individual session format and implemented by teachers, counselors, and youth workers who have undergone accredited training.
- Coping Cat Parents[356] is a 16-session, cognitive behavioral protocol for children ages seven to 13 years who meet criteria for generalized anxiety disorder, social phobia, or

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[353] *Higa-McMillan, C. K., Francis, S. E., Rith-Najarian, L., & Chorpita, B. F. (2015). Evidence-based update: 50 years of research on treatment for children and adolescent anxiety. Journal of Clinical Child & Adolescent Psychology, 45(2), 91–113.* http://www.tandfonline.com/doi/full/10.1080/15374416.2015.1046177

[354] Beidel, D. C., Turner, S. M., Sallee, F. R., Ammerman, R. T., Crosby, L. A., et al. (2007). SET-C versus fluoxetine in the treatment of childhood social phobia. *Journal of the American Academy of Child and Adolescent Psychiatry, 46,* 1622–1632.

[355] Shortt, A. L., Barrett, P. M., & Fox, T. L. (2001). Evaluating the FRIENDS program. *Journal of Clinical Child Psychology, 30*, 525–535.

[356] For more information about Coping Cat Parents, see: https://www.copingcatparents.com

separation anxiety disorder. The protocol involves individual sessions with the child or youth, and parent training sessions. There is an adolescent version of this protocol (C.A.T. Project) for youth ages 14 to 17 years.

- Acceptance and Commitment Therapy (ACT)[357] is considered a "third wave" CBT protocol. This approach differs from traditional CBT in that the aim is not better control of thoughts, emotions, sensations, memories, but rather mindfulness to and acceptance of these private experiences. ACT demonstrates greater changes in psychological flexibility, mindfulness, and valued living as compared to CBT. ACT has been studied in youth with social anxiety, obsessive-compulsive spectrum disorders, and depression. There are a variety of protocols for ACT depending on the setting or target population.

These protocols are most frequently taught in doctoral programs for clinical child psychologists. Continuing education in CBT for already licensed professionals can be obtained through the following organizations:

- The Beck Institute for Cognitive Behavioral Therapy (https://beckinstitute.org/certification/),
- The Academy of Cognitive Therapy (https://www.academyofct.org/page/Certification), and
- The National Association of Cognitive-Behavioral Therapists (http://www.nacbt.org/certifications-htm/).

Mood Disorders

CBT[358, 359, 360] has been the most widely researched treatment for **adolescent depression**. There are many individual protocols for CBT for youth. These protocols are most frequently taught in doctoral programs for clinical child psychologists. As noted above, continuing education in CBT for already licensed professionals can be obtained via the following organizations:

- The Beck Institute for Cognitive Behavioral Therapy (https://beckinstitute.org/certification/),
- The Academy of Cognitive Therapy (https://www.academyofct.org/page/Certification), and

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[357] Forman, E. M., Herbert, J. D., Moitra, E., Yeomans, P. D., & Geller, P. A. (2007). A randomized controlled effectiveness trial of acceptance and commitment therapy and cognitive therapy for anxiety and depression. *Behavior Modification*, *31*(6), 772–799.

[358] March, J., Silva, S., Petrycki, S., et al. (2004). Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression: Treatment for Adolescents with Depression Study (TADS) randomized controlled trial. *Journal of the American Medical Association, 292*(7), 807–20.

[359] March, J., Silva, S., Petrycki, S., et al. (2007). The Treatment for Adolescents with Depression Study (TADS): Long-term effectiveness and safety outcomes. *Archives of General Psychiatry, 64*(10), 1132–1143.

[360] Klein, J., Jacobs, R., & Reinecke, M. (2007). Cognitive-behavioral therapy for adolescent depression: A meta-analytic investigation of changes in effect-size estimates. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*(11), 1403–1413.

- The National Association of Cognitive-Behavioral Therapists
  (http://www.nacbt.org/certifications-htm/).

Family Focused Treatment for Adolescents (FFT-A) is a psychosocial treatment for youth with bipolar disorder that consists of 21 sessions (12 weekly, six biweekly, and three monthly) for nine months. Sessions involve the youth with bipolar disorder, their parents, and available siblings. The focus of the first seven to 10 sessions is psychoeducation. Later, the focus is on communication enhancement training and problem-solving skills training. In order to implement FFT to fidelity, training must be received through the treatment developer at **David Miklowitz, PhD,** who can be contacted at dmiklowitz@mednet.ucla.edu.

Multi-Family Psychoeducational Psychotherapy (MF-PEP) is an eight-session (90 minutes per session) group treatment for children ages eight to 12 years old with mood disorders. Sessions begin and end with children and parents together; the bulk of each session is run separately for parents and children. In order to implement MF-PEP to fidelity, training must be received through the treatment developer Mary A. Fristad, PhD, ABPP, whose background and contact information can be found at this link: https://wexnermedical.osu.edu/neurological-institute/researchers/mary-fristad-phd-abpp

Interpersonal Psychotherapy for Adolescents (IPT-A) is a treatment for adolescent depression that focuses on how interpersonal issues are related to the onset or maintenance of depressive symptoms. The treatment addresses emotion regulation, communication, and problem-solving skills. In order to implement IPT-A to fidelity, training must be received through the treatment developer Laura Mufson, PhD, whose background and contact information can be found at this link: https://www.columbiapsychiatry.org/profile/laura-mufson-phd

Trauma-Related Disorders

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) has strong support for efficacy with children and youth ages three to 18 years and their parents.[361, 362, 363, 364] It can be provided in individual, family, and group sessions in outpatient settings. TF-CBT addresses anxiety, self-esteem, and other symptoms related to traumatic experiences. This treatment intervention is designed to help children, youth, and their parents overcome the negative effects of traumatic

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[361] Cohen, J. A., & Mannarino, A. P. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child & Adolescent Psychiatry*, *35*(1), 42–50.

[362] King, N., Tonge, B., Mullen, P., Myerson, N., Heyne, D., Rollings, S., Martin, R., & Ollendick, T. (2000). Treating sexually abused children with posttraumatic stress symptoms: A randomized clinical trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, *39*(11), 1347–1355.

[363] Mannarino, A. P., & Cohen, J. A. (1996). A follow-up study of factors that mediate the development of psychological symptomatology in sexually abused girls. *Child Maltreatment*, *1*(3), 246–260.

[364] Stein, B., Jaycox, L., Kataoka, S., Wong, M., Tu, W., Elliott, M., & Fink, A. (2003). A mental health intervention for school children exposed to violence: A randomized controlled trail. *Journal of the American Medical Association*, *290*(5), 603–611.

life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence; or exposure to disasters, terrorist attacks, or war trauma. It integrates cognitive and behavioral interventions with traditional child abuse therapies to enhance children and youth's interpersonal trust and re-empowerment. TF-CBT has been applied to an array of anxiety symptoms as well as intrusive thoughts of the traumatic event, avoidance of reminders of the trauma, emotional numbing, excessive physical arousal/activity, irritability, and trouble sleeping or concentrating. It also addresses issues commonly experienced by traumatized children and youth, such as poor self-esteem, difficulty trusting others, mood instability, and self-injurious behavior, including substance use. TF-CBT has been adapted for Hispanic/Latino children and youth and some of its assessment instruments are available in Spanish.[365] In order to implement TF-CBT to fidelity, training and certification must be received through the treatment developers at the TF-CBT National Therapist Certification Program: https://tfcbt.org/

Prolonged Exposure Therapy for Adolescents (PE-A) is a treatment that facilitates adolescents' processing of trauma through in vivo and imaginal exposure techniques. PE-A emphasizes psychoeducation and behavioral relaxation training. In order to implement PE-A to fidelity, training and certification must be received through the treatment developers at: https://www.med.upenn.edu/ctsa/pe_certification.html

Cognitive Processing Therapy is a treatment for trauma that uses cognitive modification, exposure, and behavioral activation techniques. In order to implement cognitive processing therapy to fidelity, training and certification must be received through the treatment developers at: https://cptforptsd.com/achieving-provider-status/

Suicidal and Self-Injurious Behaviors

Dialectical Behavior Therapy (DBT) is an evidence-based form of cognitive behavioral therapy for people who experience significant trouble managing their emotions, thoughts, and behaviors. DBT is well supported for adults and adolescents (DBT-A),[366, 367, 368] and has moderate support for children (DBT-C) with severe emotion dysregulation. DBT-A includes parents or other caregivers in the skills training group. This inclusion allows parents and caregivers to coach their adolescents in developing skills and also improve their own skills for

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[365] Ford, J. D., Steinberg, K. L., Hawke, J., Levine, J., & Zhang, W. (2012). Randomized trial comparison of emotion regulation and relational psychotherapies for PTSD with girls involved in delinquency. *Journal of Clinical Child & Adolescent Psychology*, *41*(1), 27–37.

[366] Miller, A. L., Wyman, S. E., Huppert, J. D., Glassman, S. L., & Rathus, J. H. (2000). Analysis of behavioral skills utilized by suicidal youth receiving DBT. *Cognitive & Behavioral Practice*, *7*, 183–187.

[367] Rathus, J. H. & Miller, A. L. (2002). Dialectical Behavior Therapy adapted for suicidal youth. *Suicide and Life-Threatening Behavior*, *32*, 146-157.

[368] Trupin, E., Stewart, D., Beach, B., & Boesky, L. (2002). Effectiveness of a Dialectical Behavior Therapy program for incarcerated female juvenile offenders. *Child and Adolescent Mental Health, 7*(3), 121–127.

interacting with their adolescent. Therapy sessions usually occur twice a week. DBT strategies include both acceptance-oriented (validation) and more change-oriented (problem-solving) approaches. DBT proposes that comprehensive treatment needs to help children and youth develop new skills, address motivational obstacles to implementing these skills, and generalize what they learn to their daily lives. It also needs to keep therapists motivated and skilled. In standard outpatient DBT, these four functions are addressed through four different modes that support treatment delivery: group skills training, individual psychotherapy, telephone coaching between sessions, and a therapist consultation team meeting. Skills are taught in four modules: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. In order to implement DBT to fidelity, training and certification must be received through the treatment developers at Behavioral Tech: https://behavioraltech.org/

Eating Disorders

Dialectical Behavior Therapy: Specific adaptations of the original DBT model have been developed for eating disorders. In order to implement DBT to fidelity, training and certification must be received through the treatment developers at Behavioral Tech: https://behavioraltech.org/

Family-Based Therapy (FBT or "Maudsley Approach") is an intensive outpatient treatment where parents play an active role in helping their youth restore their weight to normal levels. In order to implement FBT to fidelity, training and certification must be received through the treatment developers at: http://train2treat4ed.com/fbt-for-anorexia-nervosa

Substance Abuse

Multidimensional Family Therapy: See our summary in the Disruptive Behaviors subsection and, for more details, see: http://www.mdft.org/

Multisystemic Therapy: See our summary in the Disruptive Behaviors subsection and, for more details, see: http://www.mstservices.com/

Dialectical Behavior Therapy: See our summary in the Suicidal and Self-Injurious Behaviors subsection for more details. Specific adaptations of DBT have been developed for substance abuse. In order to implement DBT to fidelity, training and certification must be received through the treatment developers at Behavioral Tech: https://behavioraltech.org/

Brief Strategic Family Therapy is a problem-focused, family-based approach to eliminating substance abuse risk factors. It targets problem behaviors in children and youth ages six to 17 years and strengthens family functioning. Brief Strategic Family Therapy provides families with tools to decrease individual and family risk factors through focused interventions that improve

problematic family relations and skill-building strategies to strengthen family relationships. It targets conduct problems, associations with anti-social peers, early substance use, and problematic family relations; it also has support for use with Hispanic families.[369, 370] In order to implement Brief Strategic Family Therapy to fidelity, training and certification must be received through the treatment developers at: http://www.bsft.org/

Functional Family Therapy (FFT) is a short-term (approximately 30 hours) family therapy intervention and juvenile diversion program for children and youth ages of 11 and 18 who are at risk of substance abuse, and their families, targeting a range of behavior problems, including violence, drug use/abuse, and conduct disorder as well as family conflict. FFT targets intervention toward multiple areas of family functioning and ecology and features well-developed protocols for training, implementation (i.e., service delivery, supervision, and organizational support), and quality assurance and improvement.[371] FFT focuses on family alliance and involvement in treatment. The initial focus is to motivate the family and prevent dropout from services. Intervention incorporates community resources for maintaining, generalizing, and supporting family change.[372] FFT has also been adapted for a child welfare population (FFT-Child Welfare). Whereas the traditional model is most effective with children and youth ages 11–18, FFT-Child Welfare includes all ages (0–18 years).[373] In order to implement FFT or FFT-Child Welfare to fidelity, training and certification must be received through the treatment developers at: https://www.fftllc.com/

Motivational Interviewing (MI) is an evidence-based approach to help people address their ambivalence to change. There are four core principles: express empathy, roll with resistance, develop discrepancy, and support self-efficacy.[374] Multiple disciplines use MI and much of the literature focuses on reducing the use of substances and addressing co-occurring (mental health and substance use) disorders.[375]

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[369] Szapocznik J., & Williams R. A. (2000). Brief strategic family therapy: Twenty-five years of interplay among theory, research and practice in adolescent behavior problems and drug abuse. *Clinical Child and Family Psychology Review*, *3*(2), 117–135.

[370] Szapocznik, J., Hervis, O., Schwartz, S. (2003). Therapy manuals for drug addiction. Brief strategic family therapy for adolescent drug use. U.S. Department of Health and Human Services. http://www.nida.nih.gov/pdf/Manual5.pdf

[371] Alexander, J., Barton, C., Gordon, D., Grotpeter, J., Hansson, K., Harrison, R., et al. (1998). *Blueprints for violence prevention series, book three: Functional family therapy (FFT)*. Center for the Study and Prevention of Violence.

[372] Rowland, M., Johnson-Erickson, C., Sexton, T., & Phelps, D. (2001). *A statewide evidence based system of care.* Paper presented at the 19th Annual System of Care Meeting. Research and Training Center for Children's Mental Health.

[373] For more information, see: http://fftllc.com/fft-child-welfare/model-effectiveness.html

[374] Cole, S., Bogenschutz, M., & Hungerford, D. (2011). Motivational interviewing and psychiatry: Use of addiction treatment, risky drinking and routine practice. *Focus: The Journal of Lifelong Learning in Psychiatry, (9)*1, 42-54. https://focus.psychiatryonline.org/doi/abs/10.1176/foc.9.1.foc42

[375] Cole, S., et al. (2011). Motivational interviewing and psychiatry: Use of addiction treatment, risky drinking and routine practice. *Focus: The Journal of Lifelong Learning in Psychiatry, (9)*1, 42-54. https://focus.psychiatryonline.org/doi/abs/10.1176/foc.9.1.foc42

Risk of Out-of-Home Placement

Parents play a major role in these empirically-supported treatment protocols. Without a stable caregiver, many of the protocols described above would be difficult to implement effectively. Therefore, for children and youth who are at risk for out-of-home placement, the following programs should be considered in addition to the EBPs discussed above.

Wraparound Service Coordination (based on the standards of the National Wraparound Initiative) is an integrated care coordination approach delivered by professionals, alongside youth and family partners, for children and youth involved with multiple systems who are at the highest risk for out-of-home placement.[376, 377, 378] Wraparound is not a treatment per se. Instead, wraparound facilitation is a care coordination approach that fundamentally changes the way in which individualized care is planned and managed across systems. The wraparound process aims to achieve positive outcomes by providing a structured, creative, and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. Additionally, wraparound plans are more holistic than traditional care plans in that they address the needs of the child or youth within the context of the broader family unit and are also designed to address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to develop the problem-solving skills, coping skills, and self-efficacy of children and youth and their family members. Finally, there is an emphasis on integrating children and youth into the community and building the family's social support network. The wraparound process also centers on intensive care coordination by a child and family team (CFT) coordinated by a wraparound facilitator. The family, the youth, and the family support network comprise the core of the CFT members, who are joined by parent and youth support staff, providers involved in the care of the family, representatives of agencies with which the family is involved, and natural supports chosen by the family. The CFT is the primary point of responsibility for coordinating the many services and supports that are involved with the family, with the family and child/youth ultimately driving the process. The wraparound process involves multiple phases, with responsibility for care coordination increasingly shifting from the wraparound facilitator and the CFT to the family.[379]

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[376] Bruns, E. J., Walker, J. S., Adams, J., Miles, P., Osher, T. W., Rast, J., VanDenBerg, J. D. & National Wraparound Initiative Advisory Group. (2004). *Ten principles of the wraparound process*. National Wraparound Initiative, Research, and Training Center on Family Support and Children's Mental Health, Portland State University.

[377] Aos, S., Phipps, P., Barnoski, R., & Lieb, R. (2001). *The comparative costs and benefits of programs to reduce crime.* Washington State Institute for Public Policy.

[378] Hoagwood, K., Burns, B. J., Kiser, L., Ringeisen, H., & Schoenwald, S. K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, *52*, 1179–1189.

[379] For additional information on the phases of the wraparound process, see information at http://www.nwi.pdx.edu/NWI-book/Chapters/Walker-4a.1-(phases-and-activities).pdf

Coordinated Specialty Care (CSC) for first-episode psychosis (FEP) is delivered by a multi-disciplinary team of mental health professionals, including psychiatrists, therapists and substance use disorder counselors, employment specialists, and peer specialists. Early detection of psychosis is important since people with psychoses typically do not receive care and treatment until five years after the onset of symptoms.[380] The CSC team provides community education activities and develops strategic partnerships with key entities in the community, which are critical elements of the program. The team also plays a role in detecting emerging psychosis and creating channels through which youth and young adults can be referred for treatment. CSC is individually tailored to the person experiencing early psychosis and it actively engages the family in supporting recovery. CSC provides effective treatments for psychosis, including medication management, individual therapy, and illnesses management as well as other less common evidence-based approaches such as Supported Education and Supported Employment that are known to help people with serious mental illnesses retain or recover a meaningful life in the community. The ultimate goal of CSC is to provide effective treatment and support as early in the illness process as possible so that people can remain on a healthy developmental path. A 2016 study by Kane and colleagues on the multi-site Recovery After an Initial Schizophrenia Episode (RAISE) study (conducted across 34 clinics in 21 states) showed that study participants had a better quality of life and were more involved in work and school, especially when they received CSC within the first 17 months of the onset of psychosis.[381] CSC was better than care as usual at helping people remain on a normal developmental path. Researchers have also compared the costs of CSC to care as usual and found that CSC was less expensive per unit of improvement in quality of life.[382] According to the CSC model on which the two RAISE programs are based,[383] teams should, at a minimum, consist of the following:[384]

- A team leader or coordinator (PhD or master's degree) who is responsible for the client's overall treatment plan and programming as well as the team's coordination and functioning;

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[380] Wang P. S., Berglund P. A., Olfson M., Kessler R. C. (2004). Delays in initial treatment contact after first onset of a mental disorder. *Health Services Research, 39*(2), 393–415.

[381] Kane, J. M., et al. (2015). Comprehensive versus usual community care for first episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. *American Journal of Psychiatry*, *AJP in Advance*, 1-11.

[382] Rosenheck, R., et al. (2016). Cost-effectiveness of comprehensive, integrated care for first episode psychosis in the NIMH RAISE early treatment program. *Schizophrenia Bulletin* (Advance Access, https://doi.org/10.1093/schbul/sbv224)

[383] McNamara, K., et al. (n.d.) *Coordinated specialty care for first episode psychosis, manual I: Outreach and treatment*. National Institute of Mental Health. http://www.nimh.nih.gov/health/topics/schizophrenia/raise/csc-for-fep-manual-i-outreach-and-referral_147094.pdf

[384] Please note that these models only describe an outpatient or community-based team. All teams will need to develop collaborative working relationships with inpatient providers that will enable them to ensure continuity of care as well as timely and comprehensive discharge planning.

- A psychiatrist385 trained in treatment of early psychosis, who provides medication management, actively monitors and helps ameliorate medication side effects, and coordinates treatment with primary care and other specialty medical providers;
- A primary clinician (PhD or master's degree), who provides in-depth individual and family support, suicide prevention planning, and crisis management, and, along with the team leader and other clinicians, assists with access to community resources and supports as well as other clinical, rehabilitation, and case management-related services; and
- A Supported Employment specialist (occupational therapist or master's level clinician) to help consumers re-enter school or work.
- Recent developments in FEP care have increasingly led to the expectation that a peer specialist should also be included on the team.[386] This position should be filled by a person who has experienced serious mental illness and has been able to recover from it or develop a productive and satisfying life while continuing to receive treatment.

Assertive Community Treatment (ACT) for Transition-Age Youth uses a recovery/resilience orientation that offers community-based, intensive case management and skills building in various life domains. It also includes medication management and substance abuse services for youth ages 18 to 21 with severe and persistent mental illness. More broadly, ACT is an integrated, self-contained service approach in which a range of treatment, rehabilitation, and support services are directly provided by a multidisciplinary team composed of psychiatrists, nurses, vocational specialists, substance abuse specialists, peer specialists, mental health professionals, and other clinical staff in the fields of psychology, social work, rehabilitation, counseling, and occupational therapy. Given the breadth of expertise represented on the multidisciplinary team, ACT provides a range of services to meet individual consumer needs, including (but not limited to) service coordination, crisis intervention, symptom and medication management, psychotherapy, co-occurring disorders treatment, employment services, skills training, peer support, and wellness recovery services. Most ACT services are delivered to the consumer within their home and community rather than provided in hospital or outpatient clinic settings, and services are available around the clock. Each team member is familiar with each consumer served by the team and is available when needed for consultation or assistance. The most recent conceptualizations of ACT include peer specialists as integral team members. ACT is intended to serve individuals with severe and persistent mental illness, significant functional impairments (such as difficulty with maintaining housing or employment), and

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385 Some programs might choose to utilize advanced psychiatric nurse practitioners, but the University of Texas Southwestern (UTSW) Psychosis Center plans to employ psychiatrists in this important role.

386 Dr. Nev Jones (personal communication, July 6, 2016). For a comprehensive explication of the role of peers in FEP Care programs, see: Jones, N. (2015, September). *Peer involvement and leadership in early intervention in psychosis services: From planning to peer support and evaluation*. SAMHSA/CMHS. https://doi.org/10.13140/RG.2.1.4898.3762

continuous high service needs (such as long-term or multiple acute inpatient admissions or frequent use of crisis services).[387, 388, 389]

The **Intensive In-Home and Child and Adolescent Psychiatric Services** (IICAPS) model was developed by Yale University to provide a home-based alternative to inpatient treatment for children and youth returning from out-of-home care or who are at risk of requiring out-of-home care because of psychiatric, emotional, or behavioral difficulties. Services are provided by a clinical team that includes a master's-level clinician and a bachelor's-level mental health counselor. The clinical team is supported by a clinical supervisor and a child and adolescent psychiatrist. IICAPS services are typically delivered for an average of six months. IICAPS staff also provide emergency crisis response 24 hours a day, seven days a week.

HOMEBUILDERS is an intensive family preservation program designed for children and youth from birth to 17 years who are at imminent risk of out-of-home placement or scheduled to reunify with their families within a week. The program uses intensive, on-site intervention aimed at teaching families problem-solving skills that might prevent future crises. HOMEBUILDERS is structured around a quality enhancement system, QUEST, which supports a three-part methodology (delineation of standards, measurement and fidelity of service implementation, and development of quality enhancement plans), offers training for state agencies, and claims a significant success rate (86%) of children and youth who have avoided placement in state-funded foster care and other out-of-home care.[390] HOMEBUILDERS generally intervenes when families are in crisis and provides an average of 40 to 50 hours of direct service on a flexible schedule.[391]

Partners with Families & Children: Spokane (Partners)[392] is a service that relies on referrals from child welfare, law enforcement, or public health agencies. As such, Partners' main goal is to assist children, youth, and their families in situations of persistent child neglect or those in which briefer interventions are unlikely to be effective.[393] The program is a community-based family treatment program based on wraparound principles and focused on enhancing parent-child relationships through case management, substance abuse and mental health services, and parenting resources provided by an individualized family care team. These components aim to better assist the whole family in the cessation or prevention of neglect and maltreatment, working toward recovery through the combined efforts of an assigned family team coordinator,

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[387] Allness, D. J., & Knoedler, W. H. (2003). *A manual for ACT start-up*. National Alliance for the Mentally Ill.

[388] Morse, G., & McKasson, M. (2005). Assertive Community Treatment. In R. E. Drake, M. R. Merrens, & D. W. Lynde (eds.). *Evidence-based mental health practice: A textbook*. W. W. Norton & Co.

[389] Center for Evidence-Based Practices. (n.d.). *Practices: Assertive Community Treatment.* Case Western Reserve University. https://www.centerforebp.case.edu/practices/act

[390] Institute of Family Development. (n.d.). *Programs: HOMEBUILDERS – IFPS*. http://www.institutefamily.org/programs_ifps.asp

[391] Institute of Family Development. (n.d.). *Training for Practitioners*. http://www.institutefamily.org/training_practitioners.asp

[392] Partners with Families & Children. (n.d.). *About us.* https://partnerswithfamilies.org/about-us

[393] Partners with Families & Children. (n.d.). *About us.* https://partnerswithfamilies.org/about-us

a core team (which involves partnerships with community organizations such as schools and Head Start programs), and family team meetings.[394] Partners' approach is designed to place parents at the center of a teamwork-driven model that creates therapeutic change to address immediate and anticipated problems that might otherwise lead to neglect, abuse, and removal.[395]

Out-of-Home Treatment

Residential treatment is no longer considered the most beneficial way to treat children and youth with significant difficulties. The 1999 Surgeon Generals' Report on Mental Health states, "Residential treatment centers (RTCs) are the second most restrictive form of care (next to inpatient hospitalization) for children and youth with severe mental disorders. In the past, admission to an RTC was justified on the basis of community protection, child protection, and benefits of residential treatment. However, none of these justifications have stood up to research scrutiny. In particular, youth who display seriously violent and aggressive behavior do not appear to improve in such settings, according to limited evidence."[396]

Residential treatment represents a necessary component of the continuum of care for children and youth whose behaviors cannot be managed effectively in a less restrictive setting. However, as residential treatment is among the most restrictive mental health services provided to children and youth, this level of intervention should be reserved for situations when less restrictive placements are ruled out. For example, specialized residential treatment services are supported for youth with highly complex needs or dangerous behaviors (e.g., fire setting) that may not respond to intensive, nonresidential service approaches.[397] Yet, on a national basis, children and youth are too often placed in residential treatment because more appropriate community-based services are not available.

The Substance Abuse and Mental Health Services Administration (SAMHSA) created the National Building Bridges Initiative (BBI) to identify and promote best practices and policies.[398] BBI is now an independent 501(c)3 organization devoted to developing strong and closely coordinated partnerships and collaborations between families, youth, community- and

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[394] Partners with Families & Children. (n.d.). *About us.* https://partnerswithfamilies.org/about-us
[395] Partners with Families & Children. (n.d.). *About us.* https://partnerswithfamilies.org/about-us
[396] U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General.* U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.
[397] Stroul, B. (2007). *Building bridges between residential and nonresidential services in systems of care: Summary of the special forum held at the 2006 Georgetown University Training Institutes*. Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.
[398] Stroul, B. (2007). *Building bridges between residential and nonresidential services in systems of care: Summary of the special forum held at the 2006 Georgetown University Training Institutes*. Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

residential-based treatment and service providers, advocates, and policymakers.[399] Resources, tip-sheets and tools to ensure best practices can be found at: www.buildingbridges4youth.org.[400]

Although it is typically preferable to treat children and youth in their homes and communities, they sometimes need to be placed outside of their homes for their own safety or the safety of others. Safety should be the primary determinant in selecting out-of-home treatment as an option, as the evidence-based community interventions described above allow for even the most intensive treatment services to be delivered in community settings. Whether the child or youth is facing a temporary situation or a crisis or requires longer-term care, the ideal residential intervention should be based on the core values and principles outlined in the BBI Joint Resolution, which focus on the following:

- Family-driven and youth-guided care and engagement,
- Cultural and linguistic competence,
- Clinical excellence and quality standards,
- Accessibility and community involvement,
- Transition planning,
- Workforce development, and
- Evaluation and continuous quality improvement.[401]

When residential treatment is provided, there should be extensive family involvement. Residential (and community-based) services and supports need to be thoroughly integrated and coordinated, and residential treatment and support interventions need to work to maintain, restore, repair, or establish relationships between the child/youth and their family and community. Family involvement is essential throughout the course of residential treatment, especially at admission, in the development of the treatment plan, when milestones are reached, and in discharge planning.

Treatment foster care is another promising area, particularly Treatment Foster Care Oregon (TFCO). TFCO, formerly Multidimensional Treatment Foster Care, is the most well-known and well-researched intensive foster care model. TFCO has demonstrated effectiveness as a cost-effective alternative to group or residential treatment, incarceration, and hospitalization for

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[399] Stroul, B. (2007). *Building bridges between residential and nonresidential services in systems of care: Summary of the special forum held at the 2006 Georgetown University Training Institutes*. Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

[400] Stroul, B. (2007). *Building bridges between residential and nonresidential services in systems of care: Summary of the special forum held at the 2006 Georgetown University Training Institutes*. Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

[401] Building Bridges Initiative. (2006). *Building bridges between residential and community-based service delivery providers, families and youth: Joint resolution to advance a statement of shared core principles.* http://www.buildingbridges4youth.org/sites/default/files/BB-Joint-Resolution.pdf

youth who have problems with chronic antisocial behavior, emotional disturbance, and delinquency. TFCO is a well-established EBP that has demonstrated outcomes and cost savings when implemented with fidelity and with research support for its efficacy with Caucasian, African American, and American Indian youth and families.[402,403,404,405] There is an emphasis on teaching interpersonal skills and on participation in positive social activities including sports, hobbies, and other forms of recreation. Placement in foster parent homes typically lasts about six months. Aftercare services remain in place for as long as the parents choose, but typically last about one year. In order to implement TFCO to fidelity, training and certification must be received through the program developers at:
https://www.tfcoregon.com/index.php/implementation/.

Keeping Foster and Kin Parents Supported and Trained (KEEP) was developed by the developers of the TFCO model. KEEP is a skills development program for foster parents and kinship parents of children ages zero to five years and youth (KEEP SAFE). The 16-week program is taught in 90-minute group sessions to seven to 10 foster or kinship parents. Facilitators draw from an established protocol manual and tailor each session to address the needs of parents and children.[406] The goal of the program is to teach parents effective parenting skills, including appropriate praise, positive reinforcement, and discipline techniques.[407] Child care and snacks are provided as part of the sessions. A small study of the program funded by the U.S. Department of Health and Human Services Children's Bureau showed fewer placement breakdowns, fewer behavioral and emotional problems, and fewer foster parents dropping out from providing care.[408] A larger randomized study in San Diego showed that biological or adoptive parents who participated in the KEEP program were reunified with their children more frequently. The study also showed fewer disruptions from foster placements. KEEP has been implemented in Oregon, Washington, California, Maryland, New York City, and four regions in Tennessee, as well as in Sweden and Great Britain. In order to implement KEEP to fidelity, training and certification must be received through the program developers at:
https://www.keepfostering.org/.

The Crisis Continuum

Developing a full continuum of crisis response has been shown to keep children and youth safely in their homes, schools, and communities and helps avoid unnecessary placements in

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[402] Chamberlain P, & Reid J. B. (1991). Using a specialized foster care community treatment model for children and youth leaving the state mental hospital. *Journal of Community Psychology, 19*, 266–276.

[403] Hoagwood, K., Burns, B. J., Kiser, L., Ringeisen, H, & Schoenwald, S. K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services, 52*, 1179–1189.

[404] Kazdin, A. E., & Weisz, J. R. (Eds.) (2003). *Evidence-based psychotherapies for children and youth*. Guilford Press.

[405] Weisz, J. R., Doss, J. R., Jensen, A., & Hawley, K. M. (2005). Youth psychotherapy outcome research: A review and critique of the evidence base. *Annual Review of Psychology, 56*, 337–363.

[406] Oregon Social Learning Center. (n.d.). KEEP – based on research conducted at OSLC. http://www.oslc.org/projects/keep/

[407] Child Trends. (n.d.). *KEEP Program*. https://www.childtrends.org/programs/keep-program/

[408] KEEP. (n.d.). *Outcomes*. https://www.keepfostering.org/outcomes-2/#research

hospitals and residential settings.[409] Examples of crisis response includes warm lines; 24 hours a day, seven days a week hotlines; mobile crisis supports; short- to intermediate-term in-home supports; and local out-of-home options such as respite care, 23-hour stabilization/observation beds, and short-term residential interventions.

Often, the first strategy to address a behavioral health crisis is the use of phone support or telehealth support. In these situations, it is important that the service provider has the ability to screen, assess, and triage as well as the capacity to provide ongoing consultation, time-limited follow-up care, and linkages to transportation resources. These activities should be supported by protocols and electronic systems that communicate results to professionals and systems to determine the appropriate level of services.

In some circumstances, it may be necessary to provide a mobile response. A mobile crisis service has the capacity to go into the community to begin the process of assessment and safety and treatment planning. Mobile crisis teams should also have the capacity to provide limited ongoing in-home supports, case management, and direct access to out-of-home crisis supports. For a national example, see Wraparound Milwaukee's Mobile Urgent Treatment Team/MUTT.[410] Mobil crisis service teams should also have the ability to link and coordinate with emergency medical personnel, as needed.

Summary Statement

The focus of this supplement is on the use of evidence-based practices (EBPs) in children's mental health. Its purpose is to help clinicians, agencies, and decision-makers identify what works when treating various mental health conditions and disorders. As demonstrated in this supplemental document, there are many programs, practices, and techniques that have evidence of effectiveness, and using these EBPs have been shown to improve outcomes. The list of EBPs is always changing as new research is conducted and new data are obtained. Currently, there are a host of clinical trials underway that will continue to add information to this growing field. The good news is that we are getting better at knowing what works. Unfortunately, knowing what works and doing what works are two separate issues. The goal is for practitioners and policymakers to have the best available scientific evidence to make informed decisions about what to do and when.

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[409] Substance Abuse and Mental Health Services Administration. (2014). *Crisis services: Effectiveness, cost effectiveness, and funding strategies.* HHS Publication No. (SMA)-14-4848.
[410] For more information, see: http://wraparoundmke.com/programs/mutt/

Chapter 5:
Courts and the Judiciary

Contents

Introduction

The CBC Readiness Steering Committee for DFPS Regions 3W (non-CBC) and 3E and other key stakeholders identified courts and the judiciary as one of the three main areas to explore in depth as part of our environmental assessment. Judges are not simply partners, but are the gatekeepers and ultimate decision-makers in the child welfare system. The courts have considerable influence on the direction of case progress, length of time to permanency (i.e., the goal of a "forever home"), and other key outcomes for children and youth in substitute care. In this chapter, we recognize the critical role of the courts in CBC readiness efforts, and present opportunities for involving judicial and legal stakeholders in DFPS Regions 3W (non-CBC) and 3E early in the planning process, and at every step of the way toward full CBC implementation.

In **Part 1** of this chapter, we describe the role of the courts within the child welfare system, who is involved, and how the judicial process unfolds from the removal of a child through a series of hearings to permanency. We also outline the regional variations among court systems across the 12 counties within DFPS Regions 3W (non-CBC) and 3E and highlight how things will change under CBC. Following this overview, **Part 2** includes our analysis of the results of a series of key informant interviews and court observations. We summarize the top themes and findings that emerged from the data we collected for this environmental assessment and provide recommendations for those planning and implementing CBC in relationship to the functions of the courts. In *Supplement 5A* and *Supplement 5B* at the end of this chapter, we conclude with a roadmap for working with the courts to prepare for CBC implementation as well as a reference list of key organizations and entities shaping policies and practices in child welfare courts.

Methodology

In order to inform these findings and analysis, we conducted key informant interviews with judges, attorneys, Court Appointed Special Advocate (CASA) supervisors, community leaders, foster and kinship caregivers, youth with lived experience in the foster care system, and Texas Department of Family and Protective Services (DFPS) staff to gain a better understanding of organizational and system issues to consider when preparing for CBC in DFPS Regions 3W (non-CBC) and 3E. Our team also conducted live virtual courtroom observations to further understand court processes in the region.

Part 1 – The Child Protection Court Process and Regional Variations
The Child Protection Court Process

The court is involved at almost every stage of a child's time in substitute care, from removal to case resolution. In order to remove a child or youth from their home following an allegation of abuse or neglect, DFPS must file an emergency order or schedule a non-emergency hearing and obtain authorization from a judge. The judge schedules an initial hearing upon receiving a petition from DFPS. Then a DFPS Child Protective Services (CPS) division caseworker is assigned

to the case and is responsible for working collaboratively with all parties, including the child or youth, birth parent(s), attorneys, judges, CASAs, and foster parent(s). As discussed in the Overview and Background section of this report, CBC implementation is rolled out in three stages. In Stage 2, case management responsibilities and the CPS caseworker role will transfer to the Single Source Continuum Contractor (SSCC) overseeing CBC in the region.

Once a removal is authorized, CPS or the SSCC begins working immediately with its network of Child Placing Agencies (CPAs) to find the child or youth placement in substitute care. When a child or youth is removed from home, parents are entitled to monitored visitation within 48 hours of removal. After a judge grants temporary custody of the child to DFPS, the parent's visitation schedule is set at the initial adversary hearing, which takes place within 14 days and is usually the first court hearing the parent attends.[411]

When a child is removed from their home and placed in the temporary custody of the state, that is called Temporary Managing Conservatorship (TMC). During TMC, DFPS is responsible for locating a safe, stable, and permanent home for the child within one year. The primary goal will almost always be reunification of the child or youth with their parent. During TMC, the child or youth enters substitute care, which includes placements outside their home with relatives or fictive kin, in a licensed paid foster home, in an emergency shelter, or in a group residential setting.[412]

There are approximately **eight required hearings in the first year** of a child protection case while a child or youth is in TMC, as outlined in Table 31.

Table 31. Child Protection Court Hearings[413]

Hearing	Timing	Description
Emergency Hearing	Within 1 day of removal	• Held if removed without a court order. • Parent may or may not attend. • CPS attorney presents allegations from the Child Protective Investigations division of DFPS. • Judge decides if child remains with CPS until the adversary hearing.

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[411] Supreme Court of Texas Children's Commission. (2015). *Child Protective Services parent resource guide*. http://parentresourceguide.texaschildrenscommission.gov/library_item/gov.texaschildrenscommission.parent_resource_guide/11

[412] Texas Department of Family and Protective Services. (2020, August). *Permanency options and efforts*. https://www.dfps.state.tx.us/Child_Protection/Adoption/permanency_options.asp

[413] State Bar of Texas. (2020). *A handbook for parents and guardians in child protection cases*. https://www.texasbar.com/AM/Template.cfm?Section=Consider_a_State_Bar_Committee&Template=/CM/ContentDisplay.cfm&ContentID=28735

Hearing	Timing	Description
Adversary Hearing (Show Cause)	Within 14 days of removal	• Parent can explain their situation. • Judge returns child, determines if child can be placed with friends or family, or orders TMC.
Initial Permanency Planning Team (PPT) Meeting	Initial PPT meeting occurs within 45 days of removal	• Not a court hearing and the judge is not present. • Attorneys, the child (if 13 years or older), foster parents, parents, CPS staff, and family members can attend. • Develop initial Family Plan of Service and Visitation Plan to present to the court.[414]
Status Hearing	Within 60 days of temporary order giving CPS TMC	• Discuss Family Plan of Service. • Judge confirms parental compliance with the service plan.
Initial Permanency Hearing	With 180 days of TMC	• Evaluate the Permanency Plan for the child. • Judge determines the safety and well-being of the child and whether their needs are being met in substitute care. • Judge confirms parental compliance with the service plan and may amend it. • Child may be returned to parent or remain in substitute care. • Judge sets case dismissal date.
Additional PPT Meetings	5th month, 9th month, and every 4th month in TMC thereafter[415]	• Progress on Family Plan of Service is evaluated.
Permanency Hearing	Every 120 days until final order	• Judge decides if child's plan should be changed from parental reunification to adoption or other permanent arrangement.
Mediation	Any time before the 1-year deadline	• If all parties involved do not reach an agreement on their own, the judge may order them to go to mediation. The parties themselves or the judge will choose a mediator from an approved mediator list.
Final Hearing (Trial)	Final order required 1 year after TMC	• Testimony and evidence will be offered regarding the child's best interests. • Judge enters final order to return child to parents or appoint an individual or CPS as Permanent Managing Conservator (PMC) with or without terminating parental rights.
Placement Review Hearings	Every 180 days in PMC	• Status check for children in PMC awaiting adoption.

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[414] Texas Department of Family and Protective Services. (2019, May). *Child Protective Services handbook*. https://www.dfps.state.tx.us/handbooks/CPS/Files/CPS_pg_6200.asp#CPS_6250

[415] Texas Department of Family and Protective Services. (2019, May). *Child Protective Services handbook*. https://www.dfps.state.tx.us/handbooks/CPS/Files/CPS_pg_6200.asp#CPS_6250

From the first moment a child or youth enters substitute care, all stakeholders are focused on helping the child find a "forever home," referred to as achieving permanency. Permanency in the context of the child welfare system means a legally permanent, nurturing family for every child involved in the system. Federal and state law provide only **four acceptable permanency goals:**

1. Family Reunification
2. Adoption (relative/kinship or unrelated)
3. Permanent Managing Conservatorship (relative/kinship or unrelated)
4. Another planned permanent living arrangement (APPLA), which includes a foster family with DFPS conservatorship, independent living, or community care[416]

If a child or youth in care is not reunited with a parent, placed with a relative, or adopted within 12 to 18 months after removal while in TMC, the court appoints Permanent Managing Conservatorship (PMC) to DFPS.[417] PMC can be granted with or without termination of parental rights. A child or youth will remain in PMC until they find a permanent home or age out of care (emancipate).

Stakeholders Involved in Child Protection Court

The courts are responsible for issuing the key decisions in a child protection case, and those decisions have significant bearing on outcomes for a child or youth. To make these critical decisions, judges rely on information from many different stakeholders. One of the first participants in a child protection case is an attorney for the child, also known as the attorney ad litem, whom the judge appoints from their counsel list or "attorney wheel" as mandated by state law. The judge also has the option to appoint a CASA volunteer from the community to work alongside the attorney ad litem and caseworkers to advocate for the best interests of the child. Parents must also have an attorney appointed to them if they can prove they cannot afford one (indigence), but this is not mandated until the adversary hearing that takes place up to 14 days after removal. An additional attorney, the DFPS attorney, works with the CPS or SSCC caseworker representing the state's case for removal of the child. This attorney may be a member of the local community (a district or county attorney) or a regional attorney employed by DFPS. Key parties involved in child protection cases are described in Table 32. For a list of organizations, structures, and individuals that shape child protection court policies and practices, see *Supplement 5B* at the end of this chapter.

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[416] Texas Department of Family and Protective Services. (2020, August). *Permanency options and efforts*. https://www.dfps.state.tx.us/Child_Protection/Adoption/permanency_options.asp

[417] Texas Appleseed. (2010). *Improving the lives of children in long-term foster care: The role of Texas' courts & legal system*. https://www.texasappleseed.org/sites/default/files/34-FosterCareExecutiveSumWeb.pdf

Table 32. Stakeholders Involved in Child Protection Court

Stakeholder	Characteristics and Role
Judge	• Typically, a District Judge (elected), Associate Judge (appointed), or County Court at Law Judge (elected).
Child/Youth in Conservatorship	• At the center of all actions and decisions. • Statute (Texas Family Code § 263.302) requires youth over the age of four to be present in the courtroom during each permanency hearing unless the court finds it is not in the child's best interests.
Child's Attorney Ad Litem (AAL)	• Court-appointed from child protection attorney wheel immediately to represent the interests of the child or youth. • May serve dual role of child's AAL and guardian ad litem (GAL).
Parent	• Reunification with the parent is the primary goal in most cases. • Attorney appointment to a parent is discretionary until an adversary hearing.
Parent's Attorney	• There may be a separate attorney for each parent. • Court-appointed public defender or private counsel.
CPS or SSCC Caseworker or Case Manager	• DFPS employee in the legacy system, or SSCC worker in CBC (Stage 2). • Meets with child monthly and is responsible for preparing court reports, testifying in court, and coordinating services with the child's placement.
DFPS Attorney	• County or District Attorney's Office or Regional Attorney employed by the State of Texas.
Court Appointed Special Advocate (CASA)	• Charged with representing the child's best interests. • May replace attorney to serve as guardian ad litem (GAL) once the child or youth is placed in Permanent Managing Conservatorship (PMC).
Foster Parents, Kinship Caregivers, and their Child Placing Agency (CPA) or residential caseworker	• Statutorily allowed in the courtroom; no explicit role and rarely speak in court. • Able to provide written information to the court. • Able to hire a private attorney and "intervene" or participate as another party to the ongoing CPS case.[418]
DFPS or SSCC	• Under the legacy system, DFPS has legal responsibility and oversight of the child's case and will be present in the courtroom. • In CBC (Stage 2), the SSCC will take over DFPS' responsibility. DFPS will only provide oversight and will not be present in the courtroom (unless requested).

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[418] Morgeson, T. M. (2011). *Two-stepping in a mine field: Intervening in CPS cases*.
http://www.texasbarcle.com/Materials/Events/9201/134604_01.pdf

County Variation Among Child Protection Courts in the Region

Most child protection cases in DFPS Regions 3W (non-CBC) and 3E are heard by elected district or county judges or appointed associate judges operating out of local district or county courts of general jurisdiction.[419] Some counties in the area also hear CPS cases in specialty courts, such as juvenile courts, family drug courts, and permanency courts. Between DFPS Regions 3W (non-CBC) and 3E, there is one specialized child protection "cluster court" for Cooke, Grayson, and Wise counties. Cluster courts are mobile dockets with a specially-trained child protection associate judge who travels to multiple counties hearing only child protection cases. These judges are appointed by the regional administrative presiding judge but are state employees of the Texas Office of Court Administration.[420] Table 33 outlines the regional variation in which courts see child protection cases by county. Approximately 44 judges across DFPS Regions 3W (non-CBC) and 3E hear child protection cases: 30 district judges, three (3) county court at law judges, six (6) associate judges in Dallas County, and five (5) associate judges in specialty courts.

Table 33. Child Protection (CP) Court Structure by County, DFPS Regions 3W (non-CBC) and 3E

County	Judges Over CP Cases	Docket	Cases (FY 2019)[421]	Specialty Courts for CP
Collin	6 of 13 District Judges	3 Family Law 3 General Jurisdiction	5,030	1 Family Preservation Drug Court
Cooke	1 CP Associate Judge	CP Cluster	562	Trauma-Informed Cluster Court With Grayson, Wise
Dallas	7 Family Court Judges and 5 Associate Judges; 2 Juvenile Court Judges and 1 Associate Judge	Family (Civil) & Juvenile (Criminal)	22,191	1 Permanency Court 1 Family Drug Court
Denton	6 of 9 District Judges	General Jurisdiction	4,854	1 Family Drug Court
Ellis	1 County Court at Law Judge	General Jurisdiction	1,341	None
Fannin	1 District Judge	General Jurisdiction	395	None
Grayson	1 CP Associate Judge 3 District Judges	CP Cluster	1,549	Trauma-Informed Cluster Court With Cooke, Wise

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[419] National Center for State Courts. (2016). *Texas Child Protective Services workload assessment*. https://www.txcourts.gov/media/1436073/texas-child-protective-workload-final-report-2016.pdf

[420] National Association of Counsel for Children. (2009). *The abuse and neglect case: A practitioner's guide*. http://texaschildrenscommission.gov/media/1147/txtrainingmanual.pdf

[421] FY stands for fiscal year.
Data source: Department of Family and Protective Services. (2019). Child Protective Investigations (CPI) Victims. *DFPS Data Book.* Child Abuse and Neglect Victim Cases Confirmed by CPS, FY 2019. https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Investigations/Investigations/Victims.asp

County	Judges Over CP Cases	Docket	Cases (FY 2019)[421]	Specialty Courts for CP
Hunt	2 District Judges	General Jurisdiction	1,170	None
Kaufman	1 County Court at Law Judge	General Jurisdiction	1,339	Child Protection Cluster Court being considered
Navarro	1 County Court at Law Judge; 1 District Judge	General Jurisdiction	535	None
Rockwall	2 District Judges	General Jurisdiction	624	None
Wise	1 CP Associate Judge	CP Cluster	685	Trauma-Informed Cluster Court With Cooke, Grayson

Transition From DFPS to the SSCC Under CBC

In the legacy system, DFPS is legally responsible for children and youth in their care or "in their conservatorship" (TMC and PMC). The implementation of CBC Stage 2 marks a significant shift to local control in that the SSCC becomes legally responsible for children and youth in conservatorship, in addition to contracting with CPAs and residential facilities and coordinating and delivering services to children and youth in care, their birth parents, and foster and kinship families. The state's role reduces over time as each stage of CBC is implemented.

The SSCC can be a great source of support and act as the single point-of-contact for judges and attorneys in CBC Stage 2. Given the SSCC's connection to the community and ownership of the child's case from the moment the child or youth enters care to the child's transition out of care, there is more local control over what happens in the child welfare system under CBC. In the courts, DFPS will continue to be the party to the lawsuit, but in CBC Stage 2 the SSCC will act as its agent.[422] This significant shift will mean that the SSCC will no longer focus singularly on children in care and foster caregivers, but will be responsible for outcomes for the entire family, including relatives providing kinship care and birth parents. The SSCC will become responsible for establishing the primary and secondary permanency goals for the child, face-to-face visits with children and families, case planning activities, court activities, and kinship services.[423] The SSCC caseworker, often referred to as a Permanency Specialist or Conservatorship Caseworker, will write court reports and present an update on the case (evidence) during each court hearing. DFPS staff will no longer be present in the courtroom unless requested. Their role will be to help with dispute resolution and provide oversight to ensure the SSCC provides quality

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[422] Supreme Court of Texas Children's Commission. (2019). *Texas child protection law bench book*. http://texaschildrenscommission.gov/media/84165/2019-bb-master-final-online.pdf

[423] Texas Department of Family and Protective Services. (2019). *Implementation plan for the Texas Community-Based Care System*. http://www.dfps.state.tx.us/Child_Protection/Foster_Care/Community-Based_Care/documents/2019-08-26_Community-Based_Care_Implementation_Plan.pdf

case management and adheres to statutory duties.[424] The SSCC will need to work closely with the judge on placement recommendations to meet their CBC performance metrics, such as placement within 50 miles of a child's home, minimal placement disruptions, siblings placed together, and minimal use of congregate care.

Part 2 – Findings and Recommendations for Improving the Court System Through CBC

Like in all counties and regions of the state, the courts in DFPS Regions 3W (non-CBC) and 3E have strengths, challenges, and opportunities for growth. This section includes a review of our key findings in the region related to the legal system's oversight and administration of the child welfare system, and highlights opportunities for improvement through local CBC planning and implementation.

Six topical themes, listed below, emerged from the data and can inform future CBC planning efforts.

- **Theme 1**: Expand child protection specialization in the courts.
- **Theme 2**: Examine access and decisions around court-ordered services for parents.
- **Theme 3**: Improve the quality of legal representation for children and parents.
- **Theme 4**: Prioritize reunification through shared values.
- **Theme 5**: Improve courtroom processes to reduce length of time in care.
- **Theme 6**: Focus support for youth in Permanent Managing Conservatorship.

Theme 1: Expand Child Protection Specialization in the Courts

Child protection cases are highly complex and require significant resources (including time) and diverse types of expertise to best represent children and youth served. Many counties in DFPS Regions 3W (non-CBC) and 3E assign CPS cases to their district or county-level courts of general jurisdiction. These courts oversee CPS cases in addition to a wide variety of other case types, making it difficult for generalist judges to maintain the level of knowledge and specialization required for child welfare law.

Because the organization and structure of how CPS caseloads are divided varies widely across the counties in DFPS Regions 3W (non-CBC) and 3E, **it is challenging for those involved in child welfare cases to travel between courts and navigate different structures and courtrooms**. CPS caseworkers, CASAs, and attorneys experience challenges when working with multiple judges who often have differing philosophies and expectations, or who request different types of information in court reports.

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[424] Texas Department of Family and Protective Services. (2019). *DFPS statement of work for Region 3b Single Source Continuum Contractor*. https://www.dfps.state.tx.us/Doing_Business/Purchased_Client_Services/Community-Based_Care_Contracts/documents/2019-09-01_Exhibit_A_3b_SOW_V_4.pdf

Recommendation 1: CBC preparation and transition planning should serve as a catalyst for the identification of systemic opportunities to expand child welfare expertise in the courts, including the creation of specialized dockets.

DFPS Regions 3W (non-CBC) and 3E may find benefit in narrowing down the number of judges and courts overseeing CPS cases. Consolidating these cases into a few specialized courts with a dedicated team of attorneys trained in child welfare law builds expertise and an ability to focus efforts and resources. This also reduces the burden on child welfare workers as well as attorneys, children and youth, and families by creating a more predictable court experience because the cases are dispersed among fewer judges, with less travel between multiple courtrooms, and a narrower range of judicial requirements with which to become familiar.

DFPS Regions 3W (non-CBC) and 3E are home to courts with child welfare specialization and examples of best practice. Those involved in CBC planning efforts should consider convening a roundtable with judges, attorneys, and other child welfare stakeholders in each county to evaluate the local court system's structure and identify opportunities for expanding child welfare expertise and specialization.

There are excellent and diverse examples of court structures and practices within DFPS Regions 3W (non-CBC) and 3E to learn from and build upon:
- Both Collin and Denton counties have taken steps to consolidate CPS cases into fewer courts, with judges who explicitly choose to preside over child welfare cases.
- Fannin County has only one judge who sees CPS cases, allowing that judge to have a deep level of specialization and devote time to further education in this area of the law.
- In some rural areas, such as Cooke, Grayson, Wise (and soon Kaufman) counties, child protection cluster courts have been established to focus solely on CPS cases with the specialized judge traveling to each jurisdiction on specified days. Child protection cluster courts employ a non-elected Associate Judge who is paid by the Office of Court Administration, which can result in cost savings to the participating counties.
- DFPS Regions 3W (non-CBC) and 3E's urban areas are home to trauma-informed specialty courts that serve as model courts in the state, including family substance use treatment courts in Denton, Collin, and Dallas counties.

Recommendation 2: Engage the Supreme Court of Texas Permanent Judicial Commission for Children, Youth, and Families (Children's Commission) for specialized judicial training and professional networking and support opportunities to elevate the expertise and CPS specialization of judges in the region.

A wide variety of trainings and conferences are available for judges and attorneys to further hone their knowledge and expertise in child welfare practice. These opportunities include an

annual Trial Skills Training program for attorneys and optional training programs for judges provided through the Children's Commission and the State Bar of Texas which are free for Texas judges.[425],[426] Texas law requires judges to complete 12 total hours of training within their first full term or four years of being in office and at least five hours for each additional term served.[427] Judges who hear child welfare cases are required to dedicate four (4) of the 12 required hours to specialized training in child abuse and neglect.[428] While many judges are deeply invested and dedicated to obtaining ongoing judicial training in child welfare law, some judges miss out on valuable learning every year, which creates inconsistency in the child welfare law expertise judges have. Judges listen readily to other judges; as part of CBC planning efforts, community stakeholders can help judicial leaders facilitate a peer-to-peer learning collaborative to encourage a greater number—if not all—of child welfare judges in the region to participate in training and events specific to child welfare as well as learn from one another. The annual Children's Commission Child Welfare Judges Conference is an important opportunity for judges to network and collaborate with other child welfare judges, stay current on evolving child welfare laws and regulations, and advance their knowledge of the latest innovative courtroom practices.[429] Additionally, at a time when many court hearings are being held virtually, judges can learn from their fellow judges by **observing specialty court models live online.**

Theme 2: Examine Access and Decisions Around Court-Ordered Services for Parents

The Texas Family Code requires every CPS case to be resolved within one year, with a possible court-approved six-month extension for extraordinary circumstances.[430] During this timeframe, CPS works with birth parents to develop a Family Plan of Service (service plan) if the primary goal is reunification. The service plan includes birth parents participating in treatment, parenting classes, or fulfilling other requirements. The judge plays the critical role of reviewing and approving the service plan, ensuring birth parents are making progress and staying in compliance, and determining if any appropriate revisions need to be made. Failure of birth parents to complete their required service plan within this 12-month timeline can lead to termination of their parental rights. Though family reunification is essential for child well-being and the preferred primary permanency goal for every child and youth in substitute care, many

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[425] Supreme Court of Texas Children's Commission. (2020). *Judicial training.* http://texaschildrenscommission.gov/for-judges/judicial-training/
[426] Supreme Court of Texas Children's Commission. (2020). *For Attorneys.* http://texaschildrenscommission.gov/for-attorneys/
[427] Texas Center for Judiciary. (2020). *Continuing Judicial Education guidelines.* https://www.yourhonor.com/web/Online/Education/CJE_Guidelines/Online/Education/CJE_Guidelines.aspx?hkey=2da55d58-1efe-431f-82e7-8d12ccba101c
[428] Texas Family Code § Sec. 22.110. (2015.) https://statutes.capitol.texas.gov/Docs/GV/htm/GV.22.htm#22.110
[429] Supreme Court of Texas Children's Commission. (2020). *Judicial training: Child Welfare Judges Conference (CWJC).* http://texaschildrenscommission.gov/for-judges/judicial-training/
[430] Texas Family Code § 263.401. (2015). https://statutes.capitol.texas.gov/StatutesByDate.aspx?code=FA&level=SE&value=263.401&date=5/18/2015

birth parents face barriers to reunification with their children because of service plan requirements that are difficult achieve.

Below are some of the challenges birth parents in DFPS Regions 3W (non-CBC) and 3E face when trying to meet their service plan requirements:

- **Service provider identification and access**. The courts typically order birth parents—at the request of CPS—to complete a service plan that can include a psychological assessment, random drug testing, parenting classes, and individual or group counseling. CPS provides few services directly to parents, so families generally rely on community-based providers for their court-ordered services. Finding a place to receive these services, transportation to the services, taking time off from work, and other logistical challenges can make fulfilling the various obligations very difficult for birth parents. We found that, in many communities within DFPS Regions 3W (non-CBC) and 3E, CPS requires treatments and services for birth parents that are not locally available, particularly for those in rural areas.

- **Service quality**. Judges in DFPS Regions 3W (non-CBC) and 3E described inconsistency in the level of quality across service providers and, as a result, they spend valuable time trying to assess service quality and efficacy.

- **Service appropriateness.** We found CPS requirements are sometimes "generic" and not sufficiently customized to a parent's specific needs, are selected by CPS only because the provider was a familiar entity who already had a contract with the state, or are ordered because there were no other local options.

- **Flexibility of service requirements**. Many requirements placed on birth parents have a disproportionately negative impact those with few resources and inflexible work schedules. For example, birth parents may struggle to maintain stable employment while also participating in drug treatment and other services that often co-occur during work hours. Steady income is also typically part of the service plan but, paradoxically, sustaining a steady income may be a challenge for those with intensive mental health or substance use treatment needs.

- **Substance use treatment services**. There is an insufficient number of evidence-based substance use treatment services for birth parents in every county in the region. For those who are able to access substance use treatment services, the nature of recovery (which often involves relapse) does not always align with the court's timelines.[431] In some cases, a parent may remain on a waiting list for a treatment program for months before a slot becomes available, leading to delays in reunification.

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[431] Casey Family Programs. (2017, December). *What are some of the strategies being used to reunite families with substance use disorders?* https://www.casey.org/what-are-some-of-the-strategies-being-used-to-reunite-families-with-substance-use-disorders/

- **Transportation**. Transportation is one of the most significant barriers parents face to successfully completing court-ordered services. Many providers will discharge a client if the client misses more than two sessions, which is likely to occur without consistent access to transportation. Frequent drug testing, which necessitates adherence to strict timelines, is a hardship for those without reliable transportation as well. Many counties do not have buses, and some of the rural counties in the region do not have access to ride-sharing services (e.g., Uber or Lyft), even if the parent could afford to use them.

Recommendation 3: Build capacity for and enable access to effective programs and support services that demonstrate positive outcomes for birth parents, and involve judges in the process so that court-ordered service requirements are achievable.

Because the CBC model enables SSCCs to address the needs of children and youth in innovative ways, an SSCC that determines a need for particular services can work with their network of local providers to design programs to meet those needs. They can also educate judges about which programs are proven effective, so judges make informed selections. Those involved in CBC planning in DFPS Regions 3W (non-CBC) and 3E should use data to identify the gaps in services that most frequently jeopardize reunification and prioritize building up those services. **Judges have a birds-eye view of their community and should be at the table to help verify community needs.**

Judges can also use the power of the bench to negotiate with providers to ensure parents at risk of losing custody of their children have access to effective substance use treatment and mental health services. Judges can be effective advocates among providers to help ensure a family is seen in a timely manner. For example, one judge in Dallas took the initiative to build a relationship with a mental health provider that families on her docket had trouble accessing for care. She was able to establish a structured referral pathway from the child protection court directly to the provider to ensure parents, youth, and children on her docket were able to obtain psychological assessments within 24 hours.

Theme 3: Improve the Quality of Legal Representation for Children and Parents

High-quality legal representation for both children and their parents is essential for families to achieve permanency goals. The level of training and experience a child welfare attorney has can have significant influence over the outcome of a case.[432] By serving as legal expert, advisor, advocate, and voice in court, the attorney is responsible for defending the best interests of the child/youth or parent they represent and, according to Texas statute, providing "undivided

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[432] Wood, S., Trowbridge, S., Blomquist, M.-E., Sicafuse, L., & Summers, A. (2013). *Exploring outcomes related to legal representation for parents involved in Mississippi's juvenile dependency system, preliminary findings*. National Council of Juvenile and Family Court Judges. https://www.ncjrs.gov/pdffiles1/ojjdp/grants/244704.pdf

loyalty, confidentiality, and competent representation to them."[433,434] Attorneys are tasked with understanding the complex areas of child welfare law that govern the rights of parents and children, which include federal laws, state statutes and regulations, DFPS policies and procedures, and knowledge of the programs and services within CPS. They also have to adapt to and understand the individual courtroom dynamics and preferences that come with each presiding judge.

Despite the weight of this important function, under current Texas law, an attorney only has to complete six continuing legal education (CLE) hours in child protection law to be eligible to represent a child or parent in court. However, **there is no formal or statewide tracking of an attorney's completion of even these minimal CLE requirements**, and oversight and fulfilment of the attorney's statutory duties is placed on the individual courts and judges. This leads to variation in the level of knowledge, dedication, and experience among child welfare attorneys from county to county.[435]

While Texas law requires an attorney to be appointed to every child in the temporary conservatorship of DFPS, the appointment of a parent's attorney is discretionary upon proof of their indigence. The timing of the appointment of a parent's attorney in DFPS Regions 3W (non-CBC) and 3E varies by county. In some counties, attorneys are appointed to parents at the earliest opportunity, which is considered best practice; in other counties, attorneys are appointed at the adversary hearing; and in some courts, attorneys are appointed much later in the case. **Parents rarely come into court understanding the legal aspects of their child abuse and neglect case and cannot effectively represent themselves in the proceedings.**

Recommendation 4: Ensure every parent and child has high-quality legal representation, including appointment of an attorney knowledgeable about, and with specialized certification in, child welfare law.

CBC presents the opportunity for child welfare leaders in DFPS Regions CBC 3W (non-CBC) and 3E to strategically engage judges and attorneys and identify ways to elevate the quality of legal representation in child welfare cases. By increasing the number of birth families with access to high-quality legal counsel, birth parents can improve their understanding of what they must do to address CPS concerns in order to reunify with their children.

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[433] Texas Family Code § 107.001. (2015). https://statutes.capitol.texas.gov/Docs/FA/htm/FA.107.htm

[434] Orlebeke, B., Zhou, X., & Skyles, A., & Zinn, A. (2016). *Evaluation of the QIC- ChildRep best practices model training for attorneys representing children in the child welfare system*. Chapin Hall at the University of Chicago. https://www.chapinhall.org/wp-content/uploads/QIC-ChildRep_Chapin_Hall_Evaluation.pdf

[435] Supreme Court of Texas Children's Commission. (2018). *2018 study of legal representation in child protective services cases*. http://texaschildrenscommission.gov/media/83923/2018-legal-representation-report-final-online.pdf

In most courts in Texas, judges appoint attorneys from a pre-approved attorney wheel (or list). A judge may establish a separate attorney wheel specifically for CPS cases and include attorneys with additional training on child welfare requirements and standards. In Collin County, for example, six district court judges have dedicated themselves to hearing all CPS cases in addition to the other cases on their docket. They ensure that only attorneys with sufficient expertise in family law and child protection are assigned these types of cases, and also incentivize the CPS attorneys to build their child welfare law specialization.

In Collin and Grayson counties, judges host a series of CPS roundtable discussions with the key courtroom players to share information and resources available in their communities, as well as collaboratively address issues that commonly arise in their cases. These judges make it a requirement for their attorneys working CPS cases to attend the roundtable, which fulfills their required CLE training hours. Courts can also support child welfare attorneys by establishing formal and informal **mentoring relationships** between senior attorneys and new or less experienced attorneys, as well as by offering opportunities for attorneys to gain knowledge and experience through direct (or virtual) courtroom observation and participation in court hearings.

In 2017, Texas became one of the first states to establish **a specialized board certification in child protection law**. In order for an attorney to obtain this legal specialization, they must complete at least three years of direct practice experience, obtain 60 CLE hours of training in child welfare law, and pass a six-hour exam. There are currently 92 board-certified child welfare lawyers in Texas.[436] Providing incentives for attorneys in DFPS Regions 3W (non-CBC) and 3E to pursue this certification is one way to encourage them to build expertise in this complex area of the law.

Those leading CBC planning efforts in DFPS Regions 3W (non-CBC) and 3E can also seek guidance from the Children's Commission's Legal Representation Committee, which is currently focused on identifying opportunities for statutory and systemic reforms to create a system of oversight and accountability for attorney appointments in CPS cases for the state. Moreover, the American Bar Association's national practice standards for attorneys working in the child welfare system another excellent resource for developing local standards for ensuring high quality legal representation.[437]

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[436] Texas Board of Legal Specialization. (2020). *Child welfare law*. https://www.tbls.org/specialtyarea/CW
[437] American Bar Association. (2020, January). *Practice standards & tools*.
   https://www.americanbar.org/groups/public_interest/child_law/resources/practice-standards/

Recommendation 5: Standardize the practice of early or immediate appointment of parent attorneys across the region.

An early or immediate attorney appointment enables child welfare cases to proceed faster, minimizes the length of separation between parent and child, and clears the way for delivery of needed services. Recent studies show children and parents who received high-quality legal representation had fewer unnecessary removals and were more likely to participate in court hearings, complete their service plans, have frequent family visitation, minimize time in foster care, achieve permanency sooner, and reunify more successfully.[438] In line with our recommendation, several judges in DFPS Regions 3W (non-CBC) and 3E already have policies to ensure parents have legal representation at the very first court hearing.

Theme 4: Prioritize Reunification Through Shared Values

Though child welfare leaders and stakeholders at the state level and locally share the goal of reunification, only 35% of children exiting DFPS custody in DFPS Region 3E and 37% of children in DFPS Region 3W (non-CBC) were reunited with their families upon exiting care in FY 2019.[439] Reunification, a central goal of CBC, often takes more time than termination of parental rights and requires collaboration with the child or youth and their family, CPS, the judge, the CASA, and each party's attorney. Reunification and other positive permanency outcomes can be hampered by a punitive or adversarial atmosphere in the courtroom when decision-makers are unaware of—or don't account for—the impact of trauma, mental health, poverty, and substance use disorders on children, youth, and their parents.

Recommendation 6: Build consensus within the judicial and legal community around a set of regional values and practices that prioritizes family reunification.

Among the many components of effective judicial decision-making, the judge's philosophy or vision for what child welfare is designed to accomplish is at the center of how they practice law and affects child and family outcomes. Judges across DFPS Regions 3W (non-CBC) and 3E vary greatly in terms of their philosophies and how their beliefs translate into action. Some judges will avoid terminating parental rights at all costs and will schedule ongoing mediation to encourage creative solutions for achieving reunification or kinship adoption. In some counties, judicial perception seems to be shifting with increasing awareness of the challenges many birth parents face. In these counties, removals are declining and we found growing efforts to direct birth parents to family-based safety services from the start of a case. The **awareness of trauma-informed and family-centered approaches to judicial decision-making** can help shape judges'

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[438] Gerber, L. A., Pang, Y. C., Ross, T., Guggenheim, M., Pecora, P. J., & Miller, J. (2019, July). Effects of an interdisciplinary approach to parental representation in child welfare. *Children and Youth Services Review*, *102*, 42–55. https://doi.org/10.1016/j.childyouth.2019.04.022

[439] Data were obtained from the Texas Department of Family and Protective Services Data Book, CPS 2.8 Exits from DFPS Custody by Exit Type, Avg # Placements, and Avg Months in Care FY2010–2019.

views on substance use disorder as a disease that needs therapeutic intervention rather than a moral failure that requires rigid and punitive measures.[440] This increased awareness can serve to support reunification.

The beliefs and actions listed below are strategies used by judges in the region that prioritize the child-family relationships, promote reunification, and ensure youth and family voice is at the center of decision-making:

- Actively pursue specialized training and education in child welfare practice.
- Use the power of the bench to broker and strengthen services and resources available to parents.
- Set an attitude and tone in the courtroom where parents are viewed with compassion and empathy so that the courtroom is part of a system of support.
- Establish a trauma-informed court setting where all stakeholders are trained and share a collective understanding of how abuse and trauma impact the lives of children, youth, and families involved in the child welfare system.
- Understand and examine their own implicit biases and how their attitudes or stereotypes affect their understanding, actions, and decisions in a subconscious manner.
- Review outcomes data to identify opportunities for system improvements, with particular attention to developing strategies that address the disproportionate representation of Black families in the child welfare system in Region 3 described in *Chapter 1: Data Trends and Characteristics of Children and Youth* of this report.
- Conduct thorough hearings that fully explore the need for a child or youth to be put in a foster care placement to ensure that substitute care is utilized only when it is the only appropriate option to protect the safety of a child or youth.[441]

In addition to these approaches, judges in DFPS Regions 3W (non-CBC) and 3E shared specific practices that help them make better decisions for the child or youth and family involved. They cited the ability to spend more time on a case and having more hearings than what is statutorily required to ensure progress. Some judges are committed to creating an environment where the court is an ally to the parent and the judge uses a problem-solving stance to help them overcome barriers and challenges related to their service plans.

Judges can engage with parents in a way that is grounded in collaboration and mutual partnership while critically examining the reunification requirements placed on parents. Research shows that parents are more likely to accept and abide by a court ruling when they believe they have been heard, particularly in decisions related to assessment and treatment

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[440] Carnochan, S., Lee, C., & Austin, M. J. (2013). Achieving timely reunification. *Journal of Evidence-Based Social Work*. 179–195. https://doi.org/10.1080/15433714.2013.788948

[441] National Council of Juvenile and Family Court Judges. (2010). *Right from the start: the CCC preliminary protective hearing benchcard.* http://centerforchildwelfare.org/kb/cls/Benchcard-ReducingDisproport.pdf

plans.[442] Judges can provide space for the parents to share their ideas openly in court, agree on what services are needed, and develop a customized and realistic plan that aligns with available services. Additionally, when judges set conditions, they can ask parents to explain those back to them to show comprehension and address potential miscommunication or barriers to access then and there.[443]

Lastly, judges noted that **involving children and youth as active participants** in their court hearing process is critical to making sound decisions and increasing the likelihood of reunification. Judges who engage children and youth in a meaningful way do so by meeting with the individual child or youth either inside or outside the courtroom and using that time to develop a trusting relationship, seek to understand their current situation, and give them increased ownership of the case outcomes by incorporating the child's voice, preferences, and ideas into case decisions.[444]

BENCH BOOK AND SUPPORT TO ADDRESS DISPROPORTIONALITY

Utilizing the Children's Commission's Texas Child Protection Law Bench Book *and Bench Cards will inform and enhance judicial practice. The Bench Cards cover a number of different topics, such as how judges can address the issues surrounding disproportionality and implicit bias in the courtroom. This topic is particularly critical because it permeates all aspects of a child welfare case. The work of the Courts Catalyzing Change: Achieving Equity and Fairness in Foster Care Initiative, a partnership between the National Council of Juvenile and Family Court Judges and Casey Family Programs, led to the development of the* Preliminary Protective Hearing Bench Card*. The Bench Card is unique in that it contains reflection questions for judges to ask themselves before a hearing as well as key inquiries that the court should make in order to respect the child's family, culture, and language in order to ensure due process to protect against disparate treatment in the child welfare system.*

Theme 5: Improve Courtroom Processes to Reduce Length of Time in Care

Many judges and attorneys in DFPS Regions 3W (non-CBC) and 3E are challenged by administrative hurdles that lead to longer stays in foster care for children and youth. Cases in child protection court can be extremely complicated and typically involve a lengthy legal process, requiring judges to hold multiple hearings and review extensive documentation.[445] Many of the rural courts with mixed dockets have particular challenges in keeping up with case

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[442] Casey Family Programs. (2012). *Strategies to increase birth parent engagement, partnership, and leadership in the child welfare system: A review.* https://www.casey.org/media/BirthParentEngagement.pdf

[443] Casey Family Programs. (2019, September). *How can family-based residential treatment programs help reduce substance use and improve child welfare outcomes?* https://www.casey.org/family-based-residential-treatment/

[444] The Supreme Court of Texas Children's Commission. (2016, May). *Youth presence in court proceedings: Round table report on the child's presence in court.* http://texaschildrenscommission.gov/media/1324/41718-youth-presence-in-court-proceedings-report_final.pdf

[445] Child and Family Research Partnership, LBJ School of Public Affairs at The University of Texas at Austin. (2020). *Child and family outcomes.* https://childandfamilyresearch.utexas.edu/research-child-welfare

demand; some did not have policies to prevent hearing postponements or to ensure cases move through the court in an expedient manner. Caseworkers, CASA volunteers, attorneys, and parents/caregivers often have to spend a full day in court, and sometimes the case does not end up being heard on the day it was scheduled, which wastes time and scarce resources.

Recommendation 7: Regularly review court data and develop data-driven strategies to increase efficiency and effectiveness in court hearing procedures to reduce length of time in care.

The efficiency and effectiveness of court hearings and docket practices is one of several factors that influences how quickly children, youth, and their parents receive the services they need and how quickly the child or youth returns home or is placed in a permanent home. For jurisdictions with multiple judges and mixed dockets, standardization of policies, procedures, and expectations across the courts may help all parties involved with the legal case more clearly understand expectations, and reduce inconsistencies and confusion. When planning for CBC, judges, attorneys, CASA chapters, and caseworkers should jointly discuss and try to align court processes in the following ways:

- Develop ways to improve monitoring of progress on service plans, swiftly address barriers and challenges that hinder progress, and strengthen oversight to ensure family visitations occur to improve the permanency outcomes of children and youth in foster care.
- Cross-train judges, attorneys, and child welfare staff to ensure that all parties involved in cases have a common foundation of knowledge and shared understanding of the court's expectations, the Texas Family Code, and how the local child welfare system will operate under CBC.
- Develop a system for tracking attorney training and performance to elevate the effectiveness and quality of legal representation.
- Capitalize on the efficiencies created by the move to virtual court proceedings during the COVID-19 pandemic and allow routine case status hearings to be conducted over video conference, even after courtrooms reopen. This allows scheduling to be more precise and predictable, and reduces both transportation barriers and the need for parents to take time off work to attend an in-person hearing (which may last only minutes).

Recommendation 8: Use mediation as a tool to minimize the length of time children are in temporary placement.

Mediation can often speed up case resolution, which reduces time in care, and can be helpful in reaching better overall outcomes for the child or youth. For example, a recent study of child protection in Michigan showed that the cases that used mediation were almost twice as likely to be closed (i.e., reach permanency) as cases that did not, permanency was achieved faster,

and the most common outcome was reunification with parents.[446] Most judges in DFPS Regions 3W (non-CBC) and 3E order their CPS cases to be sent to alternative dispute resolution or mediation at some point during the process. Mediation is not a court hearing, but a meeting to attempt to reach an agreement about how to resolve the case collaboratively in the best interests of the child or youth instead of going to trial.[447] Mediation parties may include the parent, parent's attorney, the agency caseworker (CPS, CPA, and/or SSCC), the child, the child's attorney, foster/adoptive parents, relatives, and the state's attorney, and others.

Mediation is typically provided through a neutral third party, such as a private mediator or a county-run Alternative Dispute Resolution Program. Both Dallas and Denton have alternative dispute resolution centers that supply mediators to the region. One judge in DFPS Regions 3W (non-CBC) and 3E described how **mediation allows for more creativity and brings more people to the table**. This judge encourages family members and potential caregivers to be at the mediation. Even if the child or youth is not able to be reunified with their parent, mediation can often help to negotiate arrangements that allow for children to maintain a relationship with extended family or birth parents after adoption.

The Children's Commission has established a task force focused on mediation and will be promoting best practices that will benefit CBC planning. And now with virtual court hearings, some barriers to quality mediation services across the state (such as travel costs and accessibility) have been removed.

Theme 6: Focus Support for Children and Youth in Permanent Managing Conservatorship (PMC)

As noted earlier, if a child or youth in care is not reunited with a parent, placed with a relative, or adopted within 12 to 18 months after removal while in TMC, the court appoints PMC to DFPS.[448] Once the state of Texas takes permanent legal custody of the child or youth, hearings are only statutorily required to be held by the court every six months. A child has an attorney ad litem when in TMC; however, this is not a statutory requirement once the child is moved to PMC. Children and youth in PMC experience less oversight from the court and CPS than those in TMC. Some PMC hearings may last as few as five minutes twice a year, which is not enough time to identify barriers to stability. **Children and youth in PMC are at heightened risk for**

[446] Kierkus, C. A., & Johnson, B. R. (2019). *Child protection mediation in Michigan*. Grand Valley State University, College of Community & Public Service, School of Criminal Justice. https://courts.michigan.gov/Administration/SCAO/OfficesPrograms/ODR/Documents/CPM%20FINAL%20REPORT%202019.pdf

[447] State Bar of Texas. (2020). *A handbook for parents and guardians in child protection cases*. https://www.texasbar.com/AM/Template.cfm?Section=Consider_a_State_Bar_Committee&Template=/CM/ContentDisplay.cfm&ContentID=28735

[448] Texas Appleseed. (2010). *Improving the lives of children in long-term foster care: The role of Texas' courts & legal system*. https://www.texasappleseed.org/sites/default/files/34-FosterCareExecutiveSumWeb.pdf

negative outcomes, such as experiencing multiple placement changes and aging out of foster care. Fewer court hearings and fewer people involved in the lives of youth in PMC can result in less accountability and a loss of the urgency to achieve permanency.

Recommendation 9: Better serve youth in PMC by studying successful court models and build a knowledge base of best practices and strategies to get them to permanency faster.

The judiciary plays a critical role in creating a sense of urgency for children and youth in PMC to achieve permanency. By enacting steps to put focused attention on the needs of these children and youth, judges in DFPS Regions 3W (non-CBC) and 3E can ensure youth do not slip through the cracks or languish in the child welfare system without a stable, loving family. Current strategies that support this recommendation include:

- Courts can establish a **Community Advisory Committee** to focus on the needs and challenges of youth in PMC.
  - This practice is already ingrained in some courts in DFPS Regions 3W (non-CBC) and 3E. This committee can identify opportunities to improve courtroom practices across the region as well as develop innovative solutions to better support the children and youth who are in PMC and get them into a family faster.
  - Members can include former and current judges, attorneys, CASA, philanthropy, representatives from the district attorney's office and public defender's office, as well as representatives from different youth-serving and child welfare organizations.
- Use judicial discretion to standardize the practice of designating **specialized attorneys** to represent youth in PMC.
  - In the Dallas juvenile courts, the judges assign most of their PMC cases to a specialized guardian ad litem attorney wheel of attorneys trained to focus specifically on PMC cases. Because these attorneys are knowledgeable about CPS policies and procedures that specifically apply to children and youth in PMC and what specialized services are available to these youth, they can better assist the caseworkers advocating on the child's behalf.
- Based on the needs of the child or youth and family, the judge can decide to have **more frequent hearings than required by statute and prioritize youth voice**.
  - In Fannin County, PMC hearings are typically held monthly to ensure deadlines are being met and that all parties supporting youth in PMC maintain a sense of urgency.
  - The cluster court in Cooke, Grayson, and Wise counties holds PMC hearings more often than required (at least every three months) and ensures that youth are involved and engaged in all hearings.
  - The Permanency Court in Dallas holds a minimum of four PMC hearings per year with all parties involved, and the youth has a direct communication line with the judge.

- The county can establish **a special permanency court or dedicated docket** in a court of general jurisdiction that is focused on youth in PMC.
  - In Dallas, the County Commissioner's Court funded the Dallas County PMC Specialty Court modeled after a similar court in Harris County and customized it to meet the unique needs of the Dallas community. Currently, five of the nine family and juvenile courts that see CPS cases in Dallas refer to this court, and the court has the capacity to receive referrals from all nine. This unique model focuses on the specific needs and challenges of children and youth in PMC who are most at risk of aging out of foster care.
- Courts can **dedicate a special day** to hear cases on specific PMC areas of need, bringing experts in that topic area into the courtroom to assist the judge and attorneys in making informed and appropriate decisions that are in the best interests of the child or youth. The following is an example from one Dallas court.
  - Has a special disabilities docket day where a Disability Specialist from DFPS attends court to assist in CPS cases involving youth with disabilities.
  - It also has a dedicated Preparation for Adult Living (PAL) docket where a PAL worker is present in court to share their specialized expertise for relevant cases.
  - There is also a specific docket day to hear cases for youth in residential placements outside of Dallas County where the judge dedicates her time to engage with each youth through video conference (or in person where possible), partnering with them to make sure their voice is heard through the legal process and that there is progress on their case.

Next Steps for Working With the Judiciary and Courts

The courts are the keystone to success for achieving the ultimate goal of positive permanency for children and youth in substitute care. Courts play a critical role and have the power to effectuate successful systemic changes. For this reason, judges and attorneys must be meaningfully and actively engaged in all CBC planning activities and efforts to identify opportunities for system improvements. Judicial and child welfare stakeholders in DFPS Regions 3W (non-CBC) and 3E need to come together to address systemic issues. The local courts can employ innovative solutions that play a big role in determining whether a child or youth in foster care is successful in achieving permanency as quickly as possible. Next, see *Supplement 5A*: *CBC Readiness Roadmap for Working With the Courts* following this chapter, which outlines a process that those involved in CBC planning and implementation efforts can adapt in DFPS Regions 3W (non-CBC) and 3E.

Supplement 5A: CBC Readiness Roadmap for Working With the Courts

We recommend that those involved in CBC planning and implementation efforts form a subcommittee focused on the judiciary and courts to lead the efforts described here using a structured change management approach. Below is a sample roadmap to guide the implementation of the recommendations offered in this CBC environmental assessment.

1. **Engage all judges who hear CPS cases early in the CBC readiness process, bringing them together to provide education and raise awareness about how things will change under CBC.**
   – Articulate the "who, what, when, where, and why" of CBC.
   – Dispel myths and share lessons learned from CBC implementation in other regions.

2. **Convene judges and the legal community to build a professional support network to enable coordination and idea-sharing across the region during the CBC transition.**
   – *See **Themes 1 and 3** for recommendations around peer-to-peer support and training for judges and attorneys.*

3. **Build consensus around a set of regional values and put in place an accountability mechanism for monitoring data related to the values.**
   – Once values are established, arrange specialized training for the community, including judges and attorneys, on topics that will reinforce the region's values, including core values of trauma-informed care, reunification, youth and parent engagement, and race equity.
   – *See **Theme 4** for recommendations around value setting.*

4. **Identify a judicial champion in each of the 12 counties to convene CBC stakeholders in that county and build trust, communication, and a strong network of support.**
   – As elected officials, many district judges are already well connected and visibly out in the community. This gives them access to a variety of potential allies in this effort.
   – Use this forum to build relationships and clarify roles with the new SSCC staff as they take over duties from DFPS staff.
   – Use judicial leadership to ensure everyone is heard, and that the loudest voices are those who are directly impacted by the system (e.g., youth and families).
   – *See **Theme 2** for recommendations around completing a community-wide inventory of services and building a coordinated array of program options.*

5. **Establish a training program to ensure all parties work effectively with the courts throughout the transition to CBC, including incoming SSCC staff, CASAs, and attorneys.**
   – Hire a former judge or court liaison dedicated to coordinating with the courts and providing court-specific training across the region.

— Train all parties who have a role in the court system on judicial expectations, court procedures and hearings, child welfare laws, and the Texas Family Code.
— Establish and standardize court reporting procedures to elevate the quality and accuracy of information, and ensure the child's records are up-to-date and filed on time.

6. **Convene county-specific roundtables with judges, attorneys, and other child welfare stakeholders to evaluate the local court system's structure and propose changes prior to CBC implementation.**
   — Options include partnering with neighboring jurisdictions to consolidate child protection cases into one child protection cluster court, establishing a specialty family drug treatment court or permanency court, or setting up docket days dedicated to special populations, such as children with disabilities.
   — *See* **Theme 1** *for recommendations around court restructuring and examples of local best practices to draw upon.*

7. **Collaborate with the Children's Commission and the Office of Court Administration to support local courts in adopting procedural changes to improve efficiency under CBC.**
   — Evaluate how the court's workflow, operations, communication mechanisms, policies, and procedures need to be adapted to prepare for CBC.
   — *See* **Theme 5** *for recommendations around court efficiencies.*

8. **Develop a strategic action plan for DFPS Regions 3W (non-CBC) and 3E to improve child welfare court processes, using the findings and recommendations articulated in this CBC readiness assessment as a guide.**
   — Select a small number of actionable recommendations from this assessment to focus on in the first year of the plan.
   — Document a calendar of activities with clear designation of responsibility.
   — *See* **Theme 6** *for recommendations on supporting youth in PMC, which may be a good place to start this process, focusing on youth with the highest needs and achieving early wins together as a community.*

9. **Monitor outcomes and develop a feedback loop between the courts, the SSCC, and DFPS regional and staff office staff during CBC rollout.**
   — Identify opportunities to advocate for policy changes and work with DFPS to improve processes and procedures at the state level.

Supplement 5B: State Judicial and Legal Organizations

In Texas, several organizations are involved with the implementation of policy related to child protection courts and the day-to-day activities that are necessary to support court services for families involved in the child welfare system. This supplement lists major statewide judicial and legal organizations, individuals, and structures that can be valuable to consult or engage for CBC planning and implementation.

Children's Commission

The Supreme Court of Texas Permanent Judicial Commission for Children, Youth, and Families (Children's Commission) is the premier organizing body and resource in the state for judges who preside over child welfare cases. The Children's Commission is funded by the federal Court Improvement Project, which has awarded the state $40 million dollars over the last 25 years to accomplish improvements and reforms.[449] Members include DFPS executive leadership, attorneys, legislators, judges, nonprofit leaders, and other child welfare stakeholders, including a number of local representatives from Region 3. The work is also guided by a Collaborative Council of child welfare stakeholders and child and parent advocates who inform Commission members of local and statewide activities and issues that affect judicial and court practices in CPS cases.[450] The Children's Commission's current projects and committees include: [451]

- Statewide Collaborative on Trauma-Informed Care Task Force and Blueprint
- Normalcy Roundtable
- Foster Care and Education Convening and Blueprint
- Texas Board of Legal Specialization
- Mediation Roundtable
- Child Protection Law Bench Book and Bench Cards
- Legal Representation Committee
- Child Welfare Judges Conference
- Child Protection Courts Convening

More information is available at: http://texaschildrenscommission.gov/

Texas Board of Legal Specialization

Every year, the Texas Board of Legal Specialization (TBLS) recognizes attorneys who have demonstrated mastery of their specialized areas of practice. In 2017, the Supreme Court of Texas officially established a board-certified legal specialization in Child Welfare Law through

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[449] Supreme Court of Texas Children's Commission. (2019). *2019 Children's Commission annual report to the Supreme Court of Texas*. http://texaschildrenscommission.gov/media/84193/cc-annual-report-2019-final-online.pdf

[450] Supreme Court of Texas Children's Commission. (2020). *Collaborative council*. http://texaschildrenscommission.gov/about-us/collaborative-council/

[451] Supreme Court of Texas Children's Commission. (2019). *2019 Children's Commission annual report to the Supreme Court of Texas*. http://texaschildrenscommission.gov/media/84193/cc-annual-report-2019-final-online.pdf

TBLS. This board certification improves the quality of representation by raising professional standards and recognizing to their peers and the public those attorneys who have dedicated a significant amount of time to handling child welfare cases and have demonstrated a high level of competency. To earn the recognition, lawyers must meet a number of qualifications, which include practicing law full time for at least five years, at least three years of experience in child welfare law, completing 60 hours of TBLS-approved continuing legal education in child welfare law, and passing a comprehensive six-hour exam.[452] In 2018, there were 45 lawyers with this legal specialization. In 2021, the number grew to 92 lawyers.

More information is available at: https://www.tbls.org/specialtyarea/CW

State Bar of Texas
All attorneys who are licensed to practice law in Texas are members of the State Bar of Texas. In 2018, the State Bar of Texas Board of Directors approved the Child Protection Law Section as a stand-alone section of the State Bar, which supports lawyers working on child welfare cases with legal education and opportunities to share professional experiences. The Child Protection Law Section hosts annual conferences in Advanced Child Protection Law.

More information is available at: https://childprotectionlawtx.com/

Texas Office of Court Administration
Under the supervision of the Supreme Court of Texas and the Chief Justice, the Office of Court Administration (OCA) provides information and research, technology services, budgetary and legal support, and other administrative assistance to a variety of judicial branch entities and courts. They publish annual statistical reports for the Texas judiciary that contain state-level data trends, court-level data trends, and detailed statistics across the courts and case types in the state. The OCA also administers specialized child protection court programs.

More information is available at: https://www.txcourts.gov/oca/

County Commissioners Court
Each of the 254 Texas counties has a County Commissioners Court that serves as their local governing body. Every court is comprised of a total of five elected officials—four Commissioners and a County Judge. This body is responsible for overseeing the county's financial matters, which includes setting the county budget and tax rate as well as setting the salaries and expenses for elected and appointed officials. According to the Texas Family Code,[453] the Commissioners Court is also responsible for authorizing associate judge

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[452] Texas Board of Legal Specialization. (2020). *Child welfare law*. https://www.tbls.org/specialtyarea/CW
[453] Texas Family Code § 201.001. (2015). https://statutes.capitol.texas.gov/Docs/FA/htm/FA.201.htm

appointments. As the heads of local county government, the Commissioners Court plays a significant role in the creation of specialized courts and in supporting the adoption of new and innovative practices in courtrooms.

Presiding Judges of Administrative Judicial Regions

Texas is divided into 11 administrative judicial regions (AJR) and a presiding judge is appointed by the Governor to each of these regions. The duties of the presiding judge include implementing regional rules of administration, advising local judges on judicial management, making recommendations to improve judicial administration to the Supreme Court, and acting for local administrative judges in their absence.[454] The presiding judge also holds the authority to appoint visiting judges and associate judges to hear child protection cases exclusively.[455] Currently, the three DFPS Region 3W (non-CBC) counties are under AJR 8, eight of the Region 3E counties are under AJR 1, and Hunt County falls under AJR 10.[456]

More information is available at: https://www.txcourts.gov/organizations/policy-funding/administrative-judicial-regions/

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[454] Texas Judicial Branch. (2020). *Administrative judicial regions*. https://www.txcourts.gov/organizations/policy-funding/administrative-judicial-regions/

[455] Texas Judicial Branch. (2020). *Children's courts*. https://www.txcourts.gov/about-texas-courts/childrens-courts/

[456] Texas Judicial Branch. (2017). *Court jurisdiction maps*. https://www.txcourts.gov/judicial-directory/court-jurisdiction-maps/

Chapter 6: Education

Contents

Introduction

Education is a critical component for successfully supporting children and youth in substitute care. The experience students in substitute care have with school has a significant bearing on their immediate well-being and their lifelong opportunities. For children and youth experiencing disruption at home, school can be a positive and safe environment where they can have consistent and meaningful relationships. Both learning and participation in school-based activities can also be important to support personal growth and give students practice working toward their goals and ambitions.

The importance of strengthening educational outcomes for students in substitute care is recognized on a national level. The passage of the federal Fostering Connections to Success and Increasing Adoptions Act of 2008 (Fostering Connections Act) was a significant step towards promoting the importance of school stability for children and youth in substitute care (see *Supplement 6B* at the end of this chapter for more information on this and other relevant policies). The legislation requires child welfare agencies to do the following:

- Collaborate with educational agencies to keep students in substitute care in the same school when living placements change, if remaining in that school is in their best interests.
- Ensure that students in substitute care who do change schools are promptly enrolled in a new school with the relevant school records.

Seven years after the passage of the Fostering Connections Act, Congress passed Every Student Succeeds Act (ESSA), which includes the following additional provisions:

- It emphasizes collaboration between education and child welfare agencies to better achieve the goal of school stability for children and youth in substitute care.
- It requires states to confidentially gather and report data on students in substitute care, including graduation rates, in order to expand data collection on their educational outcomes.

Despite these efforts, many students in substitute care experience significant educational challenges. National data and the limited amount of relevant state data that is available paint a sobering picture of school outcomes for children and youth in substitute care. Students in substitute care experience higher rates of participation in special education[457] and greater exclusionary discipline than the general student population.[458] In contrast to their peers, there

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[457] Berliner, B. & Lezin, N. (2016). *Policy perspectives: Building a research agenda to improve education outcomes for children and youth in substitute care*. WestEd. https://www.wested.org/resources/building-a-research-agenda-to-improve-education-outcomes-for-children-and-youth-in-foster-care-what-the-experts-say/#

[458] Courtney, M., Terao, S., & Bost, N. (2004). *Midwest evaluation of the adult functioning of former substitute youth: Conditions of youth preparing to leave state care.* Chicago: Chapin Hall at the University of Chicago. https://www.chapinhall.org/research/conditions-of-youth-preparing-to-leave-state-care/

are certain subgroups of children and youth within the child welfare system whose risk for educational instability is even higher, including those with frequent school moves and chronic absenteeism in earlier grades.[459] Texas data show high rates of non-completion for students in substitute care during high school, and low entry into post-secondary education programs.[460]

In **Part** 1 of this chapter, we provide data and outcomes for students identified as being in substitute care in Texas Department of Family and Protective Services (DFPS) Regions 3W (non-CBC) and 3E and, in **Part 2**, we offer information and recommendations for communities in North Texas to improve educational outcomes by leveraging the opportunity the transition to CBC presents. While the full range of educational needs for children and youth in substitute care begins in early childhood and extends beyond high school graduation, we focus on kindergarten through high school, the timeframe most vital for educational success.

Part 1 – Student Enrollment Data and Educational Outcomes
Data on Student Enrollment in DFPS Region 3

There are 64 Independent School Districts (ISDs) within DFPS Regions 3W (non-CBC) and 3E, in addition to numerous charter schools. Most students in substitute care from those areas do attend school within DFPS Region 3 at-large, with the majority attending schools in the larger counties (Dallas, Tarrant, Collin, and Denton). However, there are also a number of students in substitute care from DFPS Region 3 who attend school in the Gulf Coast area (145 in Harris County and 18 in Fort Bend County), presumably due to placements in out-of-area residential treatment centers (RTCs).

Table 34 shows the counties where children and youth in substitute care from DFPS Regions 3W (non-CBC), 3W (CBC), and 3E attend school according to data from DFPS. These data were extracted from a single school day in February 2020 and should be interpreted with caution.[461] Exact counts of school district attendance require up-to-date records in the DFPS electronic case management system, the Information Management Protecting Adults and Children in Texas (IMPACT) system.[462]

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[459] Zorc, C.S., O'Reilly, A.L.R., Matone, M., Long, J., Watts, C.L., & Rubin, D. (2013). The relationship of placement experience to school absenteeism and changing schools in young, school aged children in substitute care. *Children and Youth Services Review, 35*(5), 826–833.

[460] Texas Education Agency. (August 2020). *Secondary school completion and dropouts in Texas public schools, 2018–2019.* https://tea.texas.gov/sites/default/files/dropcomp_2018-19.pdf

[461] Data were obtained from the Texas Department of Family and Protective Services and reflect a point-in-time count of all children in foster care from DFPS Region 3 from February 2020.

[462] For a variety of reasons, IMPACT does not always contain complete and current information, leading to imprecise counts of students in substitute care.

Table 34. School Locations for Students in Substitute Care From DFPS Regions 3W and 3E (February 2020)[463]

Rank	3W (CBC)		3W (non-CBC)		3E	
	School District County	Count of Children and Youth	School District County	Count of Children and Youth	School District County	Count of Children and Youth
1	Tarrant	465	Dallas	852	Denton	104
2	Dallas	74	Collin	172	Dallas	41
3	Johnson	74	Ellis	97	Collin	31
4	Harris	59	Harris	75	Tarrant	22
5	Parker	37	Denton	59	Cooke	19
6	Erath	34	Tarrant	59	Wise	16
7	Palo Pinto	34	Grayson	57	Grayson	14
8	Ellis	18	Hunt	51	Harris	11
9	Denton	11	Navarro	40	Ellis	8
10	Fort Bend	10	Kaufman	35	Fort Bend	8

School Continuity in DFPS Regions 3W (non-CBC) and 3E

A key theme in this report is school stability, which emphasizes ensuring that students in substitute care remain in their school of origin after removal from home or a change in placement. No available data in Texas indicate how many students in substitute care remain in their school following removal or a placement change. However, using location information from DFPS point-in-time data from May 31, 2020, we had the ability to view a small sample of school enrollment data (Table 35). The data show the portion of students in substitute care who remained enrolled in their school district of origin but do not indicate how many of these students remained at their original school. These data show that about half of students from DFPS Region 3W (non-CBC) remained in their district of origin vs. about one-third from DFPS Region 3E. The data in Table 35 also show that, across DFPS Regions 3W (non-CBC) and 3E, **the majority of students changed schools, even when placed within the same county.**

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[463] Data were obtained from the Texas Department of Family and Protective Services and reflect a point-in-time count of all children in foster care from DFPS Region 3 from February 2020.

Table 35. School Stability Data (May 2020)[464]

	DFPS 3W (non-CBC) n = 21 (%)	DFPS Region 3E n = 184 (%)
Stayed in same school district	10 (48%)	61 (33%)
Placed in same legal county, but changed school district	11 (52%)	123 (67%)

Texas Data on Educational Outcomes for Students in Substitute Care

In recent years, Texas Education Agency (TEA) and DFPS have coordinated at the state level to track outcomes data for students in substitute care. However, these efforts are stymied by persistent challenges in data collection and reporting at the student level; thus, there are ongoing challenges to achieving a comprehensive statewide understanding of academic outcomes for students in substitute care. However, TEA provides data on high school outcomes for many groups of learners, including those in substitute care. This section focuses on those outcomes, which are the best source of aggregated Texas data on outcomes for students in substitute care.

Texas and national data indicate that high school students in substitute care are more likely to receive a GED than obtain a diploma, have elevated dropout rates, and are less likely to go to college upon graduation.[465] Even youth in substitute care who enroll in college and professional training programs face numerous challenges in attempting to complete these programs.

TEA has longitudinal data[466] comparing high school outcomes for various groups of public high school students. The most recent data available include outcomes from four years of high school for the graduating class of 2019. The outcomes reported include the rates of those who:
- graduated high school;
- continued with their education after high school;
- received the Texas Certificate of High School Equivalency (TxCHSE, also known as the GED);
- dropped out; and
- those who either graduated, continued, or received a TxCHSE (combined).

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[464] Data were obtained from the Texas Department of Family and Protective Services and reflect a point-in-time count of all children in substitute care from Region 3 on May 31, 2020. Only children and youth with data for school district prior and post placement are considered in the table's count.

[465] Clemens, E. V., Helm, H. M., Myers, K., Thomas, C & Tis, M. (2017). The voices of youth formerly in substitute care: Perspectives on educational attainment gaps. *Children and Youth Services Review, 79*, 65–77.

[466] Texas Education Agency. (August 2020). *Secondary school completion and dropouts in Texas public schools, 2018–2019.* https://tea.texas.gov/sites/default/files/dropcomp_2018-19.pdf

Students are identified as "at-risk" by TEA for factors that include learning challenges, primary language (non-native English speakers), homelessness, and other types of adversity, including time spent in substitute care. Of the specific "at-risk" groups of learners, students with involvement in substitute care are reported by TEA in two groups:

- those in the class of 2019 who were in substitute care at any time in grades 9–12; and
- those who were in substitute care during the 2018–2019 academic year specifically.

Table 36 provides outcomes data for some of these groups. **These data show that children and youth in substitute care are one of the most at-risk populations academically, and they are underperforming when compared to other at-risk learners**. For example, students in substitute care had the highest rates of dropping out and the lowest rates of either graduating, continuing, or receiving a TxCHSE (GED). Most striking, of the class of 2019 seniors, over a quarter (27%) of those in substitute care in their senior year dropped out. Further, in the 2018–2019 academic school year, less than 11% of Texas students who spent time in substitute care in high school continued their education after graduation and, of those still in substitute care in their senior year, under 6% continued their education. These figures show a decline in positive outcomes (graduation, completion of the TxCHSE, or academic continuation) from the 2017–2018 academic year. When available, figures from the school year ending in 2020 may be worse as a result of academic disenfranchisement resulting from the COVID-19 pandemic.

Table 36. Longitudinal Outcomes by Program Participation and Student Characteristics, Class of 2019 at Graduation

Outcome Rates by Student Group				
Group	**Graduation Rate**	**Academic Continuation**	**Received TxCHSE**	**Non-Completion (Drop Out)**
Students in Substitute Care				
Substitute care any time in grades 9–12	63%	11%	2%	25%
Substitute care in 2018–19 school year	65%	6%	2%	27%
Other At-Risk Groups				
Dyslexia	93%	2%	<1%	4%
English learner in grades 9–12	78%	8%	<1%	13.7
Homeless in grades 9–12	80%	7%	<1%	13%
Immigrant	73%	4%	<1%	20%

Part 2 – Findings and Recommendations for Improving Educational Outcomes Through CBC

The implementation of CBC presents new opportunities for communities in DFPS Regions 3W (non-CBC) and 3E to address educational needs and improve educational outcomes for students in substitute care through collaboration and coordinated efforts. Students and their families, school districts, schools, and educators all need to be included in CBC planning efforts to strengthen important relationships and pave the way for creative ideas and plans that best support local students in substitute care. Below are recommendations on how families, students, child welfare stakeholders, and education leaders within the region can collaborate to help students in substitute care achieve success. The strategies mentioned are not exhaustive but provide ideas on starting points for those establishing educational priorities within the CBC system. The recommendations included are grouped into four overarching themes which include:

- educational stability;
- student-focused support;
- data collection and use; and
- strengthening school environments.

> Beginning with Fostering Connections, federal and state policy and programmatic efforts to address education for students in substitute care share many assumptions and goals. **These goals and assumptions are often tied to the overarching goal of school stability**. Fostering Connections emphasizes that decision-makers keep students in their schools of origin when they experience a placement change, provided that doing so is in the student's best interests.

Theme One: Educational Stability

School changes entail a difficult transition for children and youth in substitute care, leading to the loss of important relationships and interruptions in academic progress. **School stability entails minimizing school moves and ensuring continuity in educational plans, services, and goals when a student must change schools**. Either by facilitating continued enrollment at the school of origin, or by ensuring that school changes are well supported and kept to a minimum, school stability is believed to:

- promote better educational outcomes, including higher test scores and grades;
- help students form and keep deeper social ties and relationships;[467] and
- decrease negative educational outcomes, such as absenteeism, lost credit, and disciplinary issues.[468]

Despite the known benefits of keeping a student in substitute care enrolled in the same school after removal from home or a change in placement, studies have found that children in

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[467] Pecora, P.J., Kessler, R.C., Williams, J., O'Brien, K., Downs, A.C., English, D., White, J., Hiripi, E., White, C.R., Wiggins, T., & Holmes, K. (2005). *Improving family substitute care: Findings from the Northwest Substitute Care Study.* Casey Family Programs. https://caseyfamilypro-wpengine.netdna-ssl.com/media/AlumniStudies_NW_Report_FR.pdf

[468] Clemens, E.V., Lalonde, T.L., & Sheesley, A.P. (2016). The relationship between school mobility and students in substitute care in earning a high school credential. *Children and Youth Services Review, 68,* 193–201.

substitute care experience excessive school changes and that school mobility has negative effects on school achievement and high school graduation rates.[469,470,471] A focused study in Colorado on graduation outcomes showed that the more school moves high school students in substitute care experienced, the lower their graduation rates.[472] Additional research suggests that even when accounting for other adversities that affect school outcomes, mobility remains associated with higher rates of high school non-completion (dropping out).[473] Moreover, research indicates that students in substitute care who are Black or involved with the juvenile justice system have higher school mobility rates.[474]

Because of differences in how school and child welfare data are collected and reported, pinpointing how many students in substitute care in DFPS Regions 3W (non-CBC) and 3E remain in their school of origin after removal or a placement change is difficult, as touched on earlier. The limited data we could access on school stability (shown in Table 35) indicate substantial room for improvement in the region, which in turn will improve academic and emotional outcomes for students in substitute care.

A successful CBC system contributes to the goal of school stability by placing children and youth closer to home and by facilitating coordinated efforts to help students remain at their school of origin following a change in living arrangement. However, under certain circumstances, a school change is unavoidable or most appropriate. For example, if a child is placed with known and trusted kin who are further away, the value of living in that home may outweigh the value of remaining in the child's original school with an unknown and unrelated foster family. When a school change is inevitable, minimizing the impact of the disruption is extremely important.

Minimizing disruptions when a school change is necessary requires:
- communication between the previous school and new school;
- diligent school credit recovery efforts;
- working with the kinship or foster caregivers and the student to obtain input about educational goals and challenges;
- listening to the student to understand and address specific needs they mention related to their schooling;

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[469] South, S., Haynie, D., & Bose, S. (2007). Student mobility and school dropout. Social Science Research, 36, 68–94

[470] Clemens, E.V., et al. (2017). The voices of youth formerly in substitute care: Perspectives on educational attainment gaps. *Children and Youth Services Review, 79*, 65–77.

[471] Levy, M., Garstka, T. A., Lieberman, A., Thompson, B., Metzenthin, J., & Noble, J. (2014). The educational experience of youth in substitute care. *Journal of At-Risk Issues, 18*(2). 190-211

[472] Clemens, E.V., Lalonde, T.L., & Sheesley, A.P. (2016). The relationship between school mobility and students in substitute care in earning a high school credential. *Children and Youth Services Review, 68*, 193–201.

[473] Gasper, J., DeLuca, S., & Estacion, A. (2012). Switching schools: Reconsidering the relationship between school mobility and high school dropout. *American Educational Research Journal, 49*(3). 487–519

[474] Gasper, J., et al. (2012). Switching schools: Reconsidering the relationship between school mobility and high school dropout. *American Educational Research Journal, 49*(3). 487–519

- enrollment in extracurricular activities they have previously enjoyed; and
- clearly defining roles for who will support the child's ongoing educational needs.

Also, **because children and youth in substitute care have higher rates of special education participation, it is essential that pertinent information related to a student's Individualized Education Program (IEP) or other accommodations is also shared with the foster or kinship caregivers, new school, and other trusted adults who support the emotional and educational needs of the child.**

The following recommendations address opportunities to support school stability through implementation of CBC in DFPS Regions 3W (non-CBC) and 3E.

Recommendation 1: Work with schools to identify and recruit local foster care placements for school-aged children and youth to increase school stability.

As discussed previously in this report, identifying placements for children and youth in substitute care is challenging, especially for older youth, those with complex behavioral challenges, and larger sibling groups. However, CBC planning and implementation presents an opportunity to form and strengthen local relationships to target foster parent recruitment efforts while promoting school stability. Working with schools, school-linked organizations, and religious institutions can help child placement agencies (CPAs) identify local placement options to enable students in substitute care to remain in their school of origin by staying closer to home. While schools and affiliated organizations are not set up to support broad foster parent recruitment efforts, they can be effective partners CPAs in helping to identify potential placement options for individual students.

Recommendation 2: Develop creative transportation solutions to help students remain in their schools of origin.

Enabling students in substitute care to remain at their school of origin, or to attend a school that is otherwise in their best interests, usually requires transportation as these campuses are seldom in close proximity to the foster home or placement. Federal law requires that education and child welfare agencies coordinate to arrange transportation so that students in substitute care can remain in their schools of origin. However, neither Child Protective Services (CPS) nor local education agencies receive dedicated funding to provide this service. In some cases, school districts use their own resources to cover additional transportation costs for students in substitute care, but others do not.

In our research for this environmental assessment, we found lack of access to transportation to be a widespread barrier to enabling students in substitute care to remain in their schools of origin in DFPS Regions 3W (non-CBC) and 3E. Through CBC planning efforts, child welfare agencies should work with school districts to identify clear systems for identifying students who

need transportation assistance to remain in their school. These efforts should ensure clear delineation of responsibilities for coordinating and arranging transportation, and for covering the costs. For example, in New York, local child welfare agencies and school districts develop Local Transportation Agreements for Students in Substitute Care. The agreements reflect transportation procedures and arrangements. They also include specific details on shared responsibilities for covering the costs of transportation for students in substitute care so long as the student is located within 50 miles of their school. Local education agencies and child welfare agencies in North Texas should consider creating similar agreements to promote and support school continuity for students in DFPS Regions 3W (non-CBC) and 3E.

There is no realistic one-size-fits-all method to ensure that students in substitute care receive the transportation support they need to remain in their school, but there are creative solutions that can help. Below are strategies to consider:

- An inter-district agreement through which the new school and old school share transportation responsibilities. For example, one covers pick up and the other drop off. This type of agreement could also be supported through a template both parties can use to establish joint transportation agreements.
- Using flexible funds through the Single Source Continuum Contractor (SSCC), Child Placing Agency (CPA), or a local fund to reimburse foster parents for mileage and gas.
- Focusing transportation resources on students who will benefit most from remaining in their school of origin, such as high school juniors and seniors, to ensure that they can graduate with their class.
- Working with a school to enable at least some virtual schooling.
- Partnering with a ridesharing company to provide transportation at a discounted cost.
- Leveraging Title IV-E funds–federal law allows states to use Title IV-E funds to cover transportation costs for students in substitute care. CBC planners in DFPS Regions 3W (non-CBC) and 3E may consider working with DFPS to identify ways to access these funds.

Recommendation 3: Support efforts to ensure prompt enrollment following a school change.

In instances in which a school change is necessary, prompt enrollment in the new school is imperative so that student attendance is not negatively impacted. Prompt enrollment is a positive outcome stemming from close coordination between the caseworker, foster or kinship caregiver, CPA, school of origin, and new school. If child protection caseworkers or substitute caregivers experience difficulty enrolling in a new school, they should contact the foster care liaison within the school district for support (see *Supplement 6A* at the end of this chapter for information on foster care liaisons). CBC planners in DFPS Regions 3W (non-CBC) and 3E should also consider working with the CPS Regional Education Specialists to map and create a joint

process for timely sharing of school records and develop strategies to overcome administrative hurdles. **These efforts should include communication and training for school registrars and clerks, who play a vital role in the enrollment process.**

School districts may also find ways to strengthen enrollment support by reviewing and aligning processes for migrant students, those experiencing homelessness, and students in substitute care. Flagging these students' records helps school staff know which families may need targeted support with a transfer. For example, schools can provide copies of documents a parent or substitute caregiver may need to enroll in a new school.

Recommendation 4: Adopt and support widespread use of the educational portfolio to facilitate information gathering and sharing.

The educational needs of students undergoing a transition can best be supported when key information about their transition, behavioral needs, academic needs and strengths, and personal learning styles is articulated, verified, and shared with the right parties. When a student moves to a new school, educational portfolios[475] can help convey such information; however, they are currently used inconsistently, are not always well maintained, and often require context and explanation.

Using the educational portfolio as a tool for transferring critical information and ensuring it is regularly maintained, accessed, and discussed by the right parties (parents/caregivers, previous schools, new schools, CPAs, and other key child welfare staff) is a concrete way to increase coordination to support the education of students in substitute care. But for educational portfolios to be effective, local child welfare and education agencies must agree they will be widely used, maintained, and shared with the right parties. Once a community decides to prioritize use of the educational portfolio, judges can also help promote their use by asking for a copy during court proceedings. In one community in DFPS Region 3E, child advocates saw a significant improvement in the maintenance and use of educational portfolios after judges began routinely inquiring about the documents in their engagement with parents and child welfare staff.

The widespread use of technology and remote learning as a result of the COVID-19 pandemic also introduces new opportunities for supporting students in foster care who change schools. For example, teachers and staff from the old and new school could be part of an introductory video call, along with the student and their caregivers. **This type of convening would demonstrate to the student that their education is supported by a community of caring**

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[475] According to DFPS "The Education Portfolio is a compilation of a child's school records and is intended to follow the child to his or her foster home placement, including staying with the child if and when the child changes foster home or school placements. It serves as a valuable resource for tracking appropriate educational and ancillary services, assessments, report cards, and transcripts."

individuals and could ease anxiety and uncertainty related to starting at the new school as well as aid in information sharing during the school transition.

Theme Two: Student-Focused Support

Students in substitute care must overcome numerous challenges to remain academically on track with their peers. The challenges these students and their caregivers face in navigating school systems are amplified now as a result of the COVID-19 pandemic, which has disrupted school and home life routines. Multi-party communication and coordination, personalized school connections, and educational advocacy are all necessary to help students in substitute care overcome academic challenges and maximize their success in school. Those who should be involved in a student's school-related communications include the student, their caregivers, caseworkers, judges and others involved with the court, and school staff. The more coordination and educational advocacy a student in substitute care receives, the higher the likelihood they will advance academically. CBC planners can play a key role in promoting this type of coordination and participation.

Recommendation 5: Train child welfare staff and community partners to support caregivers on educational matters.

Educational planning for students recently removed, experiencing a change in placement, or being reunified with their families requires strong communication between those with previous experience with the student's schooling and those who will be involved moving forward. This includes foster and kinship caregivers, as well as birth parents in some situations. Caseworkers should have open discussions with caregivers about the level of involvement needed in a student's schooling and help identify support for the student based on what the caregiver thinks they can handle.

The SSCC and CPAs can also support families and caregivers with schooling issues by creating tools and resources. For example, these organizations can collaboratively create and work with caseworkers to provide youth and their caregivers with checklists of actions and events that should occur for smooth and successful school transitions. This should include information for caregivers on how to most effectively intervene or advocate when identified actions do not occur. The SSCC is in a position to offer or ensure offer trainings to child welfare staff and community partners on educational processes, navigation, and advocacy so they, in turn, can support caregivers.

To the extent possible, child welfare agencies should provide extra support and guidance on navigating the education system to caregivers new to fostering, as well as to those caring for students with more significant learning challenges or performing below grade level and needing extra support. Research indicates that students with disabilities and those with juvenile justice

involvement also need extra support to overcome academic barriers.[476] Educational advocates and child welfare leaders should create **opportunities for caregivers and child welfare staff to learn about the special education process and how to navigate that system.** These efforts should include training and coaching on the ARD (Admission, Review, and Dismissal) process and coordinating with the juvenile justice system.[477]

Navigate Life Texas has many resources to help parents and caregivers understand and work with the special education process in Texas. These resources include questions families can ask to help support their child's learning needs.
• **Questions to Ask at Your ARD Meetings**
• **Special Education Advocates and Advocacy**

Further, schools and education systems often use terms that are unfamiliar to many families, adding confusion for those new to navigating school processes and services. Caseworkers and others supporting the educational needs of students in foster care should work with the student and their caregivers to provide clear information on educational tools, processes, and opportunities in plain language. Familiarizing students and caregivers with educational terms and programs will ease their ability to navigate the system and ease some of the challenges inherent to school transitions.

Recommendation 6: CPAs contracted by the SSCC need to work with the student, the student's caregivers, and the school and school district to identify, address, and continually support the student's academic goals and interests.

Communication and coordination between all key parties, personalized school connections, and educational advocacy are all needed to support students in overcoming academic challenges and maximizing their success in school. Students in substitute care experience multiple challenges that can significantly impede their academic success, if unaddressed. The education of students in substitute care is best supported when key information on behavioral needs, academic needs and strengths, and personal learning styles is recognized, verified, and shared among all key stakeholders—the student, their caregivers, caseworkers, judges and others involved with the court, and schools. CPAs are in a key position to support this type of coordination, communication, and advocacy for student and caregiver needs.

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[476] Clemens, E.V., et al. (2016). The relationship between school mobility and students in substitute care in earning a high school credential. *Children and Youth Services Review, 68*, 193–201.

[477] The ARD process involves a series of meetings between various parties responsible for a child's education who, together, develop an IEP for students who are approved for special education services.

Students in substitute care need a caring and supportive adult in addition to their caregiver who is monitoring and supporting their school progress and is trained and willing to engage with the school if an academic, disciplinary, or emotional matter requires attention.[478] If a foster or kinship caregiver is already actively engaged in a student's education, having an additional adult involved in this way can reinforce the caregiver's efforts. If caregivers are not as involved in school matters or do not have the capacity to be regularly involved, another caring and supportive adult can help ensure the student stays on track and receives the academic attention needed to be successful. There are many people and organizations that can help connect a student to someone who can play this role. The caring and supportive adult can be a school employee, such as a counselor or other staff, or someone from a community organization that partners with the school. **Those involved with CBC planning and implementation, as well as the SSCC, should work with school districts and campuses to raise awareness regarding the needs of students in foster care and to identify school personnel to provide this individualized type of support.**

The Legal Center for Foster Care and Education's *Blueprint for Change* provides educational goals and corresponding benchmarks for supporting the success of students in foster care. Included in the paper are practical tips for caregivers, school personnel, and child welfare agencies. A few noteworthy tips from the paper include:
- Ensuring caregivers and caseworkers are encouraged to participate in all aspects of the school experience, including academic programs, extracurricular activities, and social events, and students are not excluded because of being in out-of-home care.
- Appointments and court appearances for the child or youth are scheduled to minimize their impact on education, and children are not penalized for school time or work missed because of court or child welfare case activities.
- Youth are routinely asked about their educational preferences and needs, including their view on whether to change schools when their living situation changes.
- Students should have a knowledgeable and trained education advocate who reinforces the value of the child's investment in education and helps youth plan for post-school training, employment, or college.

Having an advocate for students in substitute care amid the COVID-19 pandemic is especially important as students, caregivers, and schools experience new challenges and barriers related to schooling. These challenges include increased difficulty with enrollment since online systems require documents not always available to students in substitute care; issues engaging in virtual learning, especially for younger students, those with disabilities, or those without reliable internet; and caregiver oversight of remote lessons, especially for those with multiple children or youth in the home or unfamiliar with remote learning technologies.

Even when there is an involved caregiver or another caring and supportive adult involved in a student's education, the SSCC in DFPS Region 3W (non-CBC) and 3E should help ensure staff

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[478] Zetlin, A., Weinberg, L. & Kimm, C. (2004). Improving education outcomes for children in foster care: intervention by an education liaison. *Journal of Education for Students Placed At Risk, 9*(4). 421-429.

from contracted CPAs are trained and prepared to help intervene when pivotal school challenges arise. For example, when a child or youth in substitute care experiences barriers to prompt enrollment in a new school, navigating the special education process, recovering past credits, or obtaining support for their emotional needs on campus, CPA staff can make connections to others in the community who can help. There are several important resources to support CPAs when they are working on education-related

The City Square Transition Resource Action Center (TRAC) has locations in Dallas and Fort Worth to support youth transitioning from substitute care. TRAC a local resource that can be used to help identify youth to provide input on PAL and post-secondary planning efforts.

challenges. As noted earlier, public school districts are required to have at least one designated foster care liaison to help with such matters, though that individual's training, capacity, and subject matter expertise can vary depending on the size of the school district and their other responsibilities. Additionally, the regional DFPS Education Specialists and staff focusing on highly mobile and at-risk student populations within the regional Education Service Centers (ECSs) can also help. (DFPS Regions 3W [non-CBC] and 3E are served by ESCs 10, 11, and 12.) Individuals involved in educational aspects of CBC planning in DFPS Regions 3W (non-CBC) and 3E should work with the SSCC to share information on these resources and collaborate to ensure that CPAs understands what they should do to support positive educational outcomes.

Recommendation 7: Incorporate youth voice in CBC planning efforts pertaining to the Preparation for Adult Living (PAL) program and academic transition planning.

CBC planning is an opportunity for stakeholders in DFPS Regions 3W (non-CBC) and 3E to identify strategies to increase high school graduation and enrollment in secondary education among students aging out of substitute care. These efforts will be most successful if youth with lived experience in substitute care are actively involved in relevant CBC planning efforts so they can identify challenges and strategies to help overcome barriers to completing high school and successful transitions to independent living. Through local focus groups and cross-agency planning meetings initiated through CBC planning efforts, young people with first-hand experience can share powerful insights regarding what has been helpful for them and indicate areas of struggle.

In the first phase of CBC implementation, SSCCs assume oversight of PAL classes, which provide youth with resources, information, and skills to successfully transition to adulthood. The PAL program is a popular and highly useful program for many youth as youth reported in the focus groups we conducted for this project. These same youth had concrete ideas to further strengthen the program and increase participation, supporting positive outcomes for youth who transition out of care and into adulthood.

SSCCs should also find ways to engage youth in post-secondary planning. North Texas is home to at least two university programs focused on students who have been in substitute care, the PUSH program at the University of North Texas (UNT) and the Frontiers Program at Texas Women's University (TWU). The PUSH program began in 2011 to support UNT students with histories in substitute care or homelessness and offers mentorship, university resources navigation, and other types of support. Those involved with the program are highly attuned to the challenges such college students have while enrolled in higher education. The Frontiers Program at TWU supports students who have lived experience in substitute care as well through encouragement, a sense of community, and available financial assistance. Students in the Frontiers Program meet individually with a mentor for help navigating college, identifying resources, and setting goals. Organizations involved in CBC planning and implementation should consider partnering with these programs—and with a broad range of additional institutions of higher education in North Texas—to implement strategies to help students with backgrounds in substitute care be successful. **These efforts will have the most benefit if youth themselves are actively engaged in identifying barriers and in vetting potential solutions.**

Theme Three: Data Collection and Outcomes Monitoring

Nationwide, there are persistent challenges related to data collection and information sharing between child welfare and education systems. Texas is not unique in this regard. DFPS and TEA each have their own large-scale data systems which are not interoperable, and neither agency has a system that captures and tracks most educational outcomes for students in substitute care. Ideally, child welfare and education data would be collected and exchanged in a manner that can be easily aggregated and analyzed to provide information on a variety of educational outcomes for students in substitute care as well as to facilitate the successful exchange of individual information to better track and support each of these students. Currently, it is difficult to monitor and measure key academic outcomes for students in substitute care or have the baseline data necessary to develop academic supports to overcome key barriers to student success. One notable success in Texas is the high school outcomes data provided earlier in this chapter. The availability of those data is the result of very concerted efforts between DFPS, TEA, and the Supreme Court of Texas Children's Commission. Those data demonstrate how—with the right investments across agencies—target outcomes can be captured and reported. While child welfare and education agencies within DFPS Regions 3W (non-CBC) and 3E can't alone remedy statewide data exchange, they can take meaningful steps to improve the exchange of educational data for students in substitute care.

Recommendation 8: Support information sharing and collaboration among the child welfare and education agencies in DFPS Regions 3W (non-CBC) and 3E to identify, track, and monitor key educational outcomes.

CBC planning in DFPS Regions 3W (non-CBC) and 3E can be used as a way to identify data points that could improve the community's understanding of academic challenges for students in substitute care, and to find locally-driven ways to collect and report on those data as a community. Data points that would help increase regional understanding of core academic challenges and considerations for students in substitute care include the frequency of:

The Oregon Treatment Substitute Care Program has one of its primary focus areas as supporting school success through an environment that focuses on daily school attendance and homework completion. Program outcomes demonstrate better school engagement and grade completion among students.

- students who remain in their school of origin;
- number of previous school moves;
- students behind grade level or repeating coursework;
- students with juvenile justice involvement;
- students with a high number of absences;
- disciplinary actions; and
- special education participation.

Once collected and tracked, these data must be examined by CBC planners to develop targeted strategies to support students in foster care with more vulnerabilities.

The SSCCs selected in DFPS Regions 3W (non-CBC) and 3E can support and promote efforts to collect and share this type of information. They can do so by providing training and guidance on data sharing with school districts, including information on allowable practices under the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA). SSCCs will be most successful in promoting the collection and sharing of new academic data by working with education agencies and other key community stakeholders to increase awareness of the value of data collection and by jointly determining which pieces of data are most meaningful and practical to obtain and monitor.

Recommendation 9: Prioritize tracking data on school attendance and support targeted efforts to minimize missed school days.

Studies show that children and youth who enter substitute care often have missed a number of school days and that, once in substitute care, they often have higher rates of absenteeism than

their peers.[479] A recent California study showed that 25% of students in substitute care were chronically absent.[480] Across the board for all student populations, chronic absenteeism is highly predictive of diminished academic outcomes in any grade, and it ultimately impacts graduation rates.[481]

The ability to track and monitor absenteeism for students in substitute care across DFPS Regions 3W (non-CBC) and 3E would enable the region

> The **school-to-prison pipeline** describes a pattern of increased risk for future involvement with the juvenile and adult criminal justice systems as a result of educational practices. These practices include so-called zero tolerance policies and the use of police in schools, and also include the school climate as well as the school's everyday responses to normal classroom misbehavior.

to identify which students in substitute care are most vulnerable to missed school days and use targeted strategies to increase their attendance. For example, if data indicate that children and youth with more placement changes also experience higher rates of absenteeism, schools and child welfare agencies can focus resources on working with those students to overcome barriers to consistent attendance. There is also evidence suggesting that absenteeism may persist after reunification,[482] which points to a need for schools, judges, and social services providers to work with birth families to develop plans for ensuring a child's attendance and educational success after they exit substitute care.

Theme Four: Collaborate to Strengthen School Environments

CBC planning and implementation efforts can be used as a catalyst to bring together diverse stakeholders—from schools, districts, and their community partners—across DFPS Regions 3W (non-CBC) and 3E to make improvements to support vulnerable groups of students, including those in substitute care. Stakeholders can learn from each other and discuss strategies that have successfully supported academic success, addressed mental health needs and trauma, and curbed the school-to-prison pipeline.

Several existing resources and opportunities can advance collaborative efforts to strengthen school environments for vulnerable students. For example, as part of their job requirements regional CPS Education Specialists are required to conduct at least three regional education meetings each year to address education-related issues for students in foster care. These

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[479] Wulczyn, F., Smithgall, C., & Chen, L. (2009). Child well-being: The intersection of schools and child welfare. *Review of Research in Education, 33*(1), 35–62.

[480] Tiano, S. (2017, December 21). A quarter of California's substitute students are chronically absent from school. *Chronicle for Social Change.* https://chronicleofsocialchange.org/news-2/quarter-californias-foster-students-chronically-absent-school/29060

[481] Jacob, Brian A. and Lovett, Kelly. (2017, July 27). *Chronic absenteeism: An old problem in search of new answers*. Brookings Institute. https://www.brookings.edu/research/chronic-absenteeism-an-old-problem-in-search-of-new-answers/

[482] Zorc, C.S. et al. (2013). The relationship of placement experience to school absenteeism and changing schools in young, school aged children in substitute care. *Children and Youth Services Review, 35*(5), 826–833.

meetings include school district staff, CPS, CASA staff, CPAs, and other community stakeholders. The purpose is to make connections between agencies and increase collaboration and coordination. These meetings could also provide a starting point for discussions on how to strengthen school environments in ways that will benefit highly mobile groups, including students in foster care. The ESCs serving DFPS Regions 3W (non-CBC) and 3E (Region 10, 11, and 12 ESCs) can also contribute to such efforts by facilitating connections between schools, school partners, and child welfare agencies. ESCs also often have meeting space open to the public that could be used to host meetings on strengthening school mental health systems.

Recommendation 10: Examine school mental health frameworks in North Texas and support district-level efforts to implement positive behavioral management programs and evidence-based frameworks.

Students of color, especially Black students, and students with disabilities, are more likely to experience serious disciplinary actions at school than the general population.[483] Research shows that Black students are three times (3x) more likely to be suspended or expelled as their White counterparts.[484] As discussed in *Chapter 1* of this report, Black children and youth are significantly over-represented in substitute care in DFPS Regions 3W (non-CBC) and 3E. And as discussed earlier in this chapter, students in substitute care are in special education at higher rates than the general student population.[485] National research also indicates that students with child welfare involvement are suspended and expelled at higher rates than the general student population.[486]

One way to curb the use of harmful effects of exclusive school disciplinary practices on students in substitute care is to expand the use of strategies to improve school climate and positive behavior management techniques. The *Mental and Behavioral Health Roadmap and Toolkit for Schools* published by the Meadows Institute provides Texas school campuses, school districts, and ESCs with actionable information on evidence-based approaches to the delivery of behavioral health services in educational settings. This body of work provides detailed information on implementing tested and trusted strategies, including **Multi-Tiered System of Supports (MTSS)** and the **Interconnected Systems Framework (ISF)**. MTSS is an organizing framework for school behavioral health plans to address any type of student needs broadly

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[483] *Castillo, A., Abalogu, J. & Linder, L. (2020). Reversing the pipeline to prison in Texas: How to ensure safe schools and safe students*. Texas Criminal Justice Coalition. https://www.texascjc.org/system/files/publications/Reversing%20the%20Pipeline%20Report%202020.pdf

[484] U.S. Department of Education Office for Civil Rights. (2014, March). *Civil rights data collection, data snapshot: School Discipline.* Issue Brief No. 1. https://www2.ed.gov/about/offices/list/ocr/docs/crdc-discipline-snapshot.pdf

[485] Zetlin, A., Weinberg, L., & Shea, N. (2006). Improving prospects for youth in foster care: The Education Liaison Model. *Intervention in School and Clinic, 41*(5) 267–272.

[486] American Bar Association, Education Law Center, and Juvenile Law Center (2014). *School discipline and youth in foster care: New federal guidance from the U.S. departments of education and justice can help*. Legal Center for Law and Education. https://www.fostercareandeducation.org/portals/0/dmx/2014/06/file_20140623_160924_bGK_0.pdf

through early identification and intervention. MTSS is also the optimal approach for organizing efforts to address specific mental and behavioral health needs. MTSS takes into account the fact that districts, schools, and students have different needs and resources, and it helps schools identify and address the unique needs of students through the resources available in local communities. The MTSS includes three tiers of supports. Tier 1 is **universal** interventions and supports for all students, Tier 2 is **targeted** interventions and supports, and Tier 3 is **intensive** interventions and supports (see Figure 25). Together, the three tiers in the MTSS model create a foundation and structure for providing a range of evidence-based behavioral health interventions, increasing the likelihood that students will have access to these supports.

Figure 25. Multi-Tiered System of Supports (MTSS) Framework
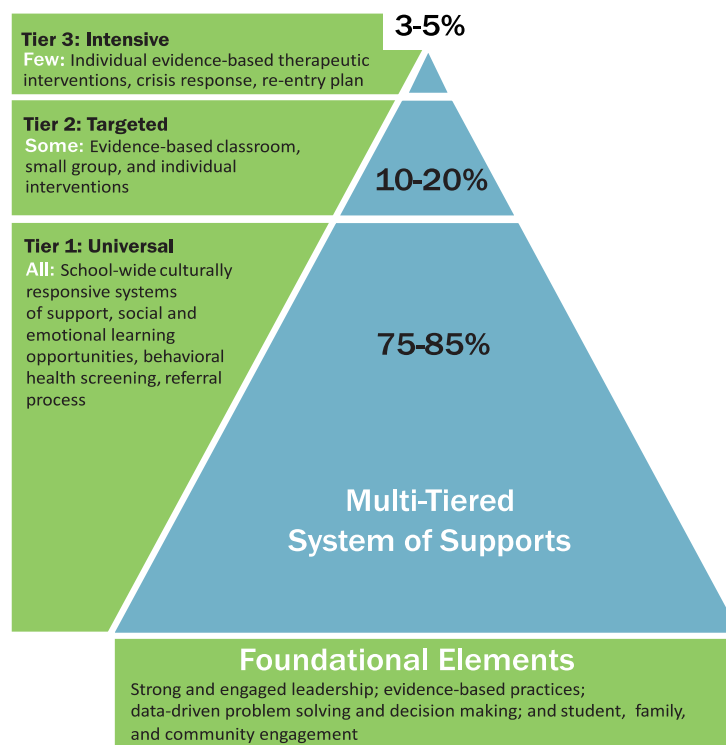
The ISF extends the MTSS framework by providing a structure and process for efficient and effective interactions between the school/education system and the community mental health system to improve educational and life outcomes for students. Taken together, MTSS and ISF can make significant improvements in school cultures, which leads to long-term improvements in student behavior, school safety, and academic outcomes. These strategies will benefit all students, especially students in substitute care and other vulnerable groups of learners.

CBC planners should consider familiarizing educators, child welfare agencies, and caregivers with these models so they can all use a common language when discussing supports for

students. Once all of these parties establish a shared understanding of supports for student mental and behavioral health, they can jointly track the supports available through school and the supports available from child welfare to ensure there is no duplication of effort or major service gaps. They can then begin to maximize treatment and supports for each student.

Recommendation 11: Implement trauma-responsive approaches to prevent behavior problems at school.

Children and youth in substitute care have experienced trauma—parental drug exposure, family violence, neglect, abandonment, physical abuse, sexual abuse, and/or frequent changes in custodial care, including placement disruptions—all of which place them at risk for developing physical, emotional, or behavioral problems that impede learning.[487] Even the very act of removing a child from their home is traumatic. When these traumas are unaddressed, a child's ability to learn and thrive at school is severely hindered.

One of the most impactful things schools and service providers working with students in substitute care can do is to establish frameworks and practices that identify and address trauma responses. A trauma-responsive approach to working with children and youth involves acknowledging the prevalence and impact of trauma and actively working to create a sense of safety for all students and staff. It helps adults move away from asking, *"What's wrong with this child?"* to asking, *"How can I support this child who is acting out because something is not ok?"* instead. The need for trauma-responsive school environments and personnel was noted by the foster parents who were interviewed for this environmental assessment. Some of these parents mentioned the psychological harm they felt has resulted from experiences the children and youth in their care experienced at school, including bullying and unnecessary use of restrictive disciplinary practices. The same parents advocated for increased training on trauma for teachers and staff and even indicated they would be willing to volunteer to provide or arrange such trainings.

TEA identifies trauma- and grief-informed practices as critical components for students who have experienced trauma.[488] Schools and others working with children and youth who have experienced trauma can promote healing and avoid behaviors and actions that further traumatize the student. Information supporting these requirements, including on grief- and trauma-informed practices is available on the TEA website.

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[487] Burns, B. J., Phillips, S. D., Wagner, H. R., Barth, R. P., Kolko, D. J., Campbell, Y., & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child & Adolescent Psychiatry, 43*(8), 960–970. https://doi.org/10.1097/01.chi.0000127590.95585.65

[488] Texas Education Agency. (n.d.). *Grief informed & trauma informed practices.* Mental and Behavioral Health. https://tea.texas.gov/about-tea/other-services/mental-health/grief-informed-trauma-informed-practices

Establishing a trauma-responsive approach requires a re-examination of policies and procedures (which may require a culture shift), training staff to be welcoming and non-judgmental, and modifying physical environments. Becoming trauma-responsive also involves minimizing perceived threats, avoiding re-traumatization, and supporting healing from trauma. The following are resources and programs designed for schools to embed trauma-informed practices:

- The Meadows Institute's *Mental and Behavioral Health Roadmap and Toolkit for Schools* addresses the relationship between trauma and learning and provides a wealth of information for Texas schools and those working with schools to address the mental health and emotional needs of students.
- The National Child Traumatic Stress Network provides a wealth of content for a broad audience on implementing trauma-responsive services. Their informational modules and trainings include strategies for creating trauma-informed schools and can be accessed online.
- Texas laws passed in the 86th Legislative Session (2019) require the expansion of school mental health efforts, with an emphasis on trauma and grief.
  - House Bill (HB) 18 requires training (on suicide prevention, recognizing mental health conditions and substance abuse, strategies for positive relationships, and grief and trauma-informed care) for certain school employees as well as curriculum requirements, counseling programs, and educational programs.
  - HB 19 puts a non-physician mental health professional at each of the 20 regional ESCs throughout the state to focus on social and emotional well-being by supporting school personnel and facilitating their training in mental health and trauma-informed care.
  - Senate Bill (SB) 11 includes multiple provisions to address school safety and student wellness. Among these was the creation of the Texas Child Mental Health Care Consortium and requirements for school districts to implement trainings and programming on trauma-informed practices.

Next Steps for Partnering With Schools

Collaborative efforts between schools and child welfare agencies can benefit students in foster care in numerous and significant ways. Despite the challenges associated with coordinating between two large systems (education and child welfare), at the local level there are many ways partner to support the success of students in substitute care. To provide a sense of who can contribute to such efforts, we have included *Supplement 6A: Organizational and Individual Roles to Addressing the Educational Needs of Students in Substitute Care* following this chapter. Additionally, a growing body of research demonstrates the added challenges students in substitute care face with their schooling and confirms the importance of school stability. These realities are recognized in recent public policy efforts, many of which we have highlighted in *Supplement 6B*.

Supplement 6A: Organizational and Individual Roles to Address Educational Needs of Students in Substitute Care

Below is an overview of the agencies and individuals with a role in meeting the educational needs of children and youth in substitute care.

Department of Family and Protective Services

DFPS has staff positions to support education at its state office and at the regional level.

Education Specialist

Each DFPS region has at least one Education Specialist to support collaboration between families, schools, and DFPS. The regional CPS Education Specialists have many duties, including:

- **Case-specific consultation and support** for individual students, which involves a range of activities, including attending student-related meetings at schools, supporting community and school re-entry following a psychiatric hospitalization, and troubleshooting challenges (e.g., the transfer of school records).
- **Building collaborative networks** to strengthen resources for students in substitute care.
- **Training** substitute caregivers, schools, and child welfare agencies to increase knowledge and awareness of educational needs and supports for students in substitute care.
- **Supporting CPS caseworkers and caregivers** by providing them with information on applicable laws, policies, and resources as well as training them on key actions they should take to support the educational needs of the children and youth in their care.

The DFPS state office also has one Education Specialist working under the Director of Permanency who coordinates with TEA on education matters, works on policy matters, and coordinates with regional staff. Whereas the regional CPS Education Specialists report to regional leadership, the individual in this position reports to state office leadership within CPS.

CPS Caseworker

In the legacy foster care system (state-run, non-CBC model), the CPS caseworker is responsible for determining where students on their caseload attend school, with the input of the student and their caregivers. CPS caseworkers are also responsible for updating the educational portfolio and providing it to the substitute caregiver. In many cases, foster families know little about the new child or youth they are fostering, and caseworkers can be an important information source by sharing a child's strengths, goals, and challenges. This can include key educational information, such as information on previous special education assessments and whether the child has a special education Individualized Education Program (IEP) or 504 accommodation plan in place, what supports may help the child with their schooling, whether the child has historically responded well to certain academic or behavioral approaches, and if the child enjoys an extracurricular activity.

Texas Education Agency

The Texas Education Agency (TEA) includes a division responsible for providing information and guidance to support students in foster care. The federal Every Student Succeeds Act (ESSA) mandates that all state education agencies have at least one foster care coordinator to support school districts in addressing the requirements in the ESSA. Information on this division, their guidance, and contact information for the Foster Care Education & Policy Coordinator is provided on the TEA website.

Education Service Centers

There are 20 ESCs located throughout Texas. The ESCs are intended to support school districts with operational efficiency, implementing policy changes, and providing training and supports to improve student performance. Each ESC is intended to have a foster care liaison. These roles are unfunded and foster care liaisons usually have additional roles, most commonly supporting coordination for students experiencing homelessness. The counties in DFPS Regions 3W (non-CBC) and 3E are supported by ESC 10 (Collin, Dallas, Ellis, Fannin, Grayson, Rockwall, Hunt, and Kaufman), ESC 11 (Denton, Wise, and Cooke), and ESC 12 (Navarro).

School Districts and Campuses

Each school district and open enrollment charter school is required (by Education Code, Sec. 33.904) to appoint at least one employee as a **foster care liaison**. The role of a district foster care liaison is to facilitate enrollment when a student in substitute care changes schools and ensure student records and other important information is transferred and communicated. Texas law does not address which employees should serve as foster care liaisons; in practice, the time and ability that district foster care liaisons have to focus on students in substitute care varies greatly depending on the size, resources, and discretion of the individual school district. Each school district is required to provide the name of their foster care liaison to TEA. The AskTed function on the TEA website enables the public to search for the appointed foster care liaison for all districts and open enrollment charter schools. Chapter 5 in the TEA Foster Care & Student Success guide provides information on district foster care liaisons.

While school districts are responsible for supporting transfers and enrollment, the individual school campus is essential in providing needed supports to students in substitute care. The most comprehensive and effective support involves collaboration between multiple parties in the district, ranging from registrars and administrative staff familiar with assisting students in substitute care, to teachers, counselors, and social workers who can help support a student's academic and emotional needs.

Students in Substitute Care

To the extent it is developmentally appropriate, children and youth in substitute care should have voice and agency in the decisions that affect their education. This includes being provided with a clear explanation of who is involved in educational decisions made on their behalf as well as having input on where they want to attend school, in establishing academic goals, and in determining extracurricular activities.

Education Decision-Makers

State law requires DFPS to ensure that all students in substitute care have a designated education decision-maker. In most cases the education decision-maker is the foster parent, but in rare instances if deemed to be more appropriate by CPS, the child's caseworker can fulfill this role (for example, if the child is in an RTC). This education decision-maker is responsible for:

- Meeting with the student to discuss their educational goals and accounting for those goals before making educational decisions.
- Reviewing key information regarding the student's education, including their educational portfolio and school records.
- Communicating regularly with the student's CPS caseworker and providing them with updated academic records and forms.
- Keeping the CPS caseworker informed of any disciplinary actions involving the student, as well as any decisions regarding special education services.

Supplement 6B: State and Federal Policy Developments

Over the past 12 years, state and federal policymakers have adopted numerous measures to address education-related issues for children and youth in substitute care. Through these efforts, policymakers have promoted increased collaboration and coordination between education and child welfare agencies and established certain educational objectives. Table 37 provides a non-exhaustive list of highlights from some of the most significant state and federal endeavors and policies enacted in recent years.

Table 37. Key Policies Addressing the Intersection of Substitute Care and Education

Timeline of Key Education Policies		
Year	Policy Development	Summary
2008	Federal – Fostering Connections to Success and Increasing Adoptions Act	Calls for increased collaboration between child welfare and education agencies
2009	Texas – SB 939 (81st Regular Legislative Session)	Requires DFPS and TEA to enter into an MOU for data sharing
2009	Texas – SB 2248 (81st Regular Legislative Session)	Places requirements on TEA for assisting students in substitute care with school transfers
2010	Children's Commission forms Education Committee	An order by the Supreme Court of Texas to focus on improving educational outcomes for students in substitute care
2011	Texas – HB 359 (82nd Regular Legislative Session)	Establishes reporting requirements for the use of restraints on school campuses
2011	Texas – HB 826 (82nd Regular Legislative Session)	Requires all school districts to appoint a substitute care liaison to support students in substitute care
2012	Publication – The Texas Blueprint: Transforming Education Outcomes for Children & Youth in Substitute Care	Includes guiding principles and recommendations to improve educational outcomes from early childhood through post-graduation
2013	Federal – Uninterrupted Scholars Act	Assures that child welfare professionals are able to view educational records for students in substitute care
2013	Texas Substitute Care and Education Summit	200 stakeholders convened to discuss needs and solutions to improve educational outcomes for students in substitute care

Timeline of Key Education Policies		
2015	Federal – Every Student Succeeds Act (ESSA)	Requires collaboration between state education and child welfare agencies, including prioritizing keeping children in their schools of origin when they enter substitute care
2015	Texas – HB 3748 (84th Regular Legislative Session)	Requires the appointment of substitute care liaisons at Texas institutions of higher education, and establishes requirements on the exchange of information on behalf of youth/young adults formerly in substitute care to support service coordination in higher education
2017	Texas – SB 1220 (85th Regular Legislative Session)	Establishes and clarifies educational decision-making rights for students with disabilities in substitute care and substitute parent training requirements to support the educational needs of students with disabilities
2019	Texas – SB 11 (86th Regular Legislative Session)	Created the Texas Child Mental Health Care Consortium, a network of academic hubs to: • Provide telemedicine-based consultation and training to pediatricians to assist them with identifying mental health issues in their patients through the Child Psychiatric Access Network (CPAN). • Establish or expand existing telemedicine or telehealth programs to assist school districts with direct care, referrals, and training through the Texas Child Access Through Telemedicine (TCHATT) program. Also requires school districts to integrate trauma-informed practices in schools.
2019	Texas – HB 18 (86th Regular Legislative Session)	Requires training (suicide prevention, recognizing mental health conditions and substance abuse, strategies for positive relationships, and grief and trauma-informed care) for certain school employees, and includes curriculum requirements, counseling programs, educational programs.
2019	Texas – HB 19 (86th Regular Legislative Session)	Supports the placement of a non-physician mental health professional at each of the 20 regional ESCs throughout the state to focus on social and emotional well-being by supporting school personnel and facilitating their training in mental health and trauma-informed care.

Appendices

Appendix A: Key Informant Interview and Project Stakeholder List

We are particularly grateful to the 37 young adults, foster parents, and kinship caregivers who participated in focus groups and interviews. We ensured their anonymity and appreciate the honest personal experiences and valuable insights they provided to inform this report.

Report Contributors		
Organization	**Name**	**Title**
2Ingage	Dr. Linda Garcia	Senior Vice President
336th Judicial District Court, Fannin County	Judge Lauri Blake	Presiding Judge
469th Judicial District Court, Collin County	Judge Piper McCraw	Presiding Judge
ACH Child and Family Services	Wayne Carson, PhD	Chief Executive Officer
	Daniel Pectol	Director, Residential Services – Wedgewood
Advantage Adoptions – One Church One Child	Jeanette Willis	Executive Director
Buckner Children and Family Services	Joann Cole	President/CEO
	Andi Harrison	Regional Director for Foster Care and Adoption for North Texas and Rio Grande Valley
CASA of Denton County	Debbie Jensen	Executive Director
CASA of Grayson County	Wanda Kauffman	Former Executive Director
CASA of Navarro County	Jenny Bratton	Executive Director
CASA of North Texas	Vicki Robertson	Executive Director
	Niki Willis	Program Director
CASA of Wise and Jack Counties	Elizabeth Randle	Executive Director
	Mike Darst	Recruitment & Training Specialist
Child and Family Guidance Center	Andy Wolfskill	Chief Executive Officer
Child and Family Guidance Center of Texoma	Brenda Hayward	Executive Director
City House	Sheri Messer	Chief Executive Officer
	Jennifer Lajoie	Director of Programs
CK Family Services	Shawn Wilson, LCPAA	Chief Business Development Officer

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Communities in Schools of the Dallas Region	Monica Ordonez	Chief Strategy Officer
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	Gregory Southworth, MBA, MS, LPC-Supervisor	Clinical Director
Cook Children's Fostering Health Program	Lorie Palacio, LMSW	Care Coordinator/ Health Navigator
Cumberland Presbyterian Children's Home	Courtney Banatoski, MS	President and Chief Executive Officer
Dallas CASA	Kathleen M. LaValle	President and Chief Executive Officer
	Chad Frymire, MPA	Program Director, Projects and Partnerships
Dallas County 303rd Family District Court	Judge Graciela Olvera	Associate Judge
Dallas County Child Protection and Permanency Court	Judge Delia Gonzales	Associate Judge
Dallas County Public Defender's Office, Child Protection Division	Rhonda Rieken, JD	Assistant Public Defender
Denton County 393rd District Court	Judge Doug Robison	Presiding Judge
Denton County MHMR Center	Pam Gutierrez	Chief Operating Officer and Executive Director
	Brittany Waymack	Administrator of Mental Health Services
Denton Independent School District	Barb Haflich	Coordinator of Social Services
Eighth Region North Child Protection Court (Cooke, Grayson, Jack, and Wise counties)	Judge Cheryl Vaughan	Associate Judge
Fannin County Children's Center	Sandy Barber	Executive Director
Garland Independent School District	Annette Himmelreich, LMSW	Case Manager, Family and Community Engagement
Gladney Center for Adoption	Mark Melson, MBA	President and Chief Executive Officer

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Jewish Family Service of Greater Dallas	Cathy Barker	Chief Executive Officer
	Deizel Sarte	Chief Operations Officer
Jonathan's Place	Allicia Graham Frye	Chief Executive Officer
	Sheila Kirksey, LCSW	Clinical Director
	William Hunter, LMSW	RESET Therapist
	Cas Rice, LMSW	Treatment Services Therapist
Kaufman County Children's Emergency Shelter	David Asbill	Director
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Letot Center	Albert Cervantez	Assistant Superintendent, Collin County Juvenile Detention
	Sarita Esqueda	Program Manager/Assistant Superintendent Dallas County Juvenile Probation
LifePath Systems	Tammy Mahan, MA, LPC-S	Chief Executive Officer
Lonestar CASA	Lauren Rowe	Executive Director
Lonestar Social Services	Alyssa Ramirez	Region 3 & 4 Director
Metrocare Services	Kelli Laos	Chief Clinical Officer
MHMR Tarrant	Laura Kender	Chief of Early Childhood Services
North Texas Youth Connection	Natasha Hayden	Executive Director
Our Community Our Kids	Dr. Gary Buff	President
Promise House	Regina Levine	Chief Program Officer
Rees-Jones Center for Foster Care Excellence, Children's Health	Jill McLeigh, PhD	Director of Policy, Advocacy, and Research
	Laura Lamminen, PhD, ABPP	Pediatric Psychologist
	Patricia Rittgers MSN, RN, CPN	Nurse Coordinator
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	Renee Castillo-De La Cruz	Staff Attorney
Texas Department of Family and Protective Services	The Honorable John J. Specia, Jr.	Former Commissioner
Texas Department of Family and Protective Services, State Office	Liz Kromrei	Child Protective Services (CPS) Director of Services
	Carol Self	Director of Permanency
	Anna Blake	Director of Faith Based and Community Engagement
	Lesley Guthrie	Former Deputy Director, Office of Faith-Based and Community Engagement
Texas Department of Family and Protective Services, Region 3 East (3E)	Sheryl Smith	CPS Regional Director, Region 3 East
	Tanya Gaines	Program Director for Region 3 East Southern Outlying Counties
	Carolyn Marshall	Education Specialist, Region 3 East
	Bridgette Brown	Conservatorship Supervisor, Ellis County
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	Paula Lee	Conservatorship Supervisor, Navarro County
	Pamela Martinez-Tobar	Conservatorship Supervisor, Kaufman County

Report Contributors		
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	Melissa Moffitt, LMSW	CVS[489]/FBSS[490]/FAD[491] Program Administrator, Region 3 West
	Ruth Ann Pope, LMSW	CVS Program Director, Denton, Cooke and Wise Counties
	Jennifer Ware	CPS Supervisor II, Cooke County
	Norma Eaves	Education Specialist, Region 3 West
	Starla Abraham	Faith-Based Program Specialist, Region 3 West
Texas Education Agency	Kelly Kravitz	Director of Highly Mobile and At-Risk Students
Texas Network of Youth Services	Fedora Galasso	Executive Director
	Lauren Rose	Director of Public Policy
Texoma Community Centers	Loren Hervey, LPC-S	Director of Children's Mental Health Services
	Whytney Mask	Director of Crisis Services
The Meadows Foundation	Cindy Patrick	Former Senior Program Officer
The Perrone Law Firm, PLLC	Christina Wade Perrone, JD	Court-Appointed Attorney for Fannin, Hunt, Rains, & Rockwall District Courts
Uplift Education	Amanda Larkins, MS, LPC	Director of Counseling Services
	Rebecca Snyder	Prevention and Support Services Coordinator
	Tony Walker, PhD	Senior Director
University of North Texas, PUSH Program	Delaney Farris	Graduate Assistant, Division of Student Affairs
	Taylor Thompson	Special Project Coordinator, PUSH Co-Advisor
	Brenda Sweeten	Clinical Associate Professor

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[489] Conservatorship (CVS)
[490] Family-Based Safety Services (FBSS)
[491] Foster/Adoptive Home Development (FAD)

Appendix B: Glossary of Terms

Term	Definition
Admission, Review, Dismissal (ARD)	In Texas, a child's eligibility for special education services and most of the major decisions about a child's special education program are made by an Admission, Review, and Dismissal (ARD) committee.[492]
Adoption	An order of adoption creates a legal parent-child relationship between the adoptive parent and the child for all purposes.[493]
Attorney ad litem	An attorney who provides services for the purposes of the legal action only related to child welfare cases, including representation of a child. Their duties are undivided loyalty, confidentiality, and competency.[494]
Authorized Service Levels (ASLs) for foster care	Texas Department of Family and Protective Services (DFPS) uses Authorized Service Levels (ASL) to help identify and connect children and youth in substitute care with placements and supports to meet their individual service needs. The main ASLs are: Basic, Moderate, Specialized, Intense, or Intense-Plus. All children and youth are initially assigned the Basic ASL when they first enter care. Then a third party contracted by DFPS assesses if the level should increase based on the child's needs. ASLs are *not* assigned under CBC.
CANS 2.0 (Child and Adolescent Needs and Strengths Assessment)	The CANS 2.0 assessment is used for all children and youth in DFPS custody and covers a range of possible needs, including a child's mental health symptoms and behaviors, substance use and misuse, trauma history, challenges with education, and juvenile justice involvement as well as caregiver needs and strengths. It is used to identify placement and treatment needs, decrease unnecessary psychological testing, and inform care planning.

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[492] Texas Education Agency. (2020, July). *Parent's guide to the admission, review and dismissal process.* https://framework.esc18.net/Documents/ARD_Guide_ENG.pdf

[493] FAMILY CODE CHAPTER 162. ADOPTION, 162 Family Code § 162.017 (2005). https://statutes.capitol.texas.gov/Docs/FA/htm/FA.162.htm

[494] Supreme Court of Texas Children's Commission. (2016). *Bench Book 2016: Common acronyms and abbreviations.* Retrieved January 20, 2021, from http://benchbook.texaschildrenscommission.gov/pdf/Bench%20Book%202016%20Common%20Acronyms%20and%20Abbreviations.pdf

Term	Definition
Child Placing Agency (CPA)	An organization, other than the parents of a child or youth who plans for the placement of or places a child in a child-care operation (including a foster home) or an adoptive home. A CPA is a DFPS-licensed residential child-care operation that may verify and regulate its own foster homes or facilities subject to DFPS minimum standards.[495] CPAs verify and oversee non-agency foster placements.[496]
Child Protective Services (CPS)	A division of Texas DFPS that investigates reports of abuse and neglect of children and youth. It also: provides services to children and families in their own homes; places children in foster care; provides services to help youth in foster care make the transition to adulthood; and places children in adoptive homes.[497]
Community-Based Care (CBC)	In 2017, the 85th Texas Legislature through Senate Bill 11, built off of the foundation of the Foster Care Redesign model to further advance the system through the establishment of the Community-Based Care (CBC) model. Under CBC, DFPS is required to purchase case management and substitute care services from Single Source Continuum Contractors (SSCCs) for children, youth, and young adults who are in DFPS conservatorship, or who are receiving services through the extended foster care program. Substitute care includes all foster care, relative/kinship care, family reunification, and adoption services. Implementation of the CBC model transitions the Texas child welfare system from a statewide, "one size fits all" approach to a community-based model designed to meet the individual and unique needs of children, youth and families in Texas at the local level.[498]
Conservatorship (CVS)	Legal care, custody, and control of a child or youth given by court order.[499]

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[495] Texas Department of Family and Protective Services. (2017, October). *Definitions of terms*. https://www.dfps.state.tx.us/handbooks/CCI/Files/LPPH_px_Definitions_of_Terms.asp

[496] Supreme Court of Texas Children's Commission. (2016). *Bench Book 2016: Common acronyms and abbreviations.* Retrieved January 20, 2021, from http://benchbook.texaschildrenscommission.gov/pdf/Bench%20Book%202016%20Common%20Acronyms%20and%20Abbreviations.pdf

[497] Supreme Court of Texas Children's Commission. (2016). *Bench Book 2016: Common acronyms and abbreviations.* Retrieved January 20, 2021, from http://benchbook.texaschildrenscommission.gov/pdf/Bench%20Book%202016%20Common%20Acronyms%20and%20Abbreviations.pdf

[498] Hall, C. (DFPS). (2019). *Implementation plan for the Texas Community-Based Care system*. Texas Department of Family and Protective Services. p. 59. Retrieved from https://www.dfps.state.tx.us/Child_Protection/Foster_Care/Community-Based_Care/documents/2019-08-26_Community-Based_Care_Implementation_Plan.pdf

[499] Supreme Court of Texas Children's Commission. (2016). *Bench Book 2016: Common acronyms and abbreviations.*

Term	Definition
Court Appointed Special Advocate (CASA)	A specially screened and trained volunteer, appointed by the court, who advocates for the best interests of a child or youth. CASAs spend time getting to know the child or children they are assigned and provide information to the judge overseeing the child's case to help the courts make informed decisions.
DFPS custody	Children in DFPS custody are those for whom a court has appointed DFPS legal responsibility through Temporary or Permanent Managing Conservatorship or other court ordered legal basis. These children may be residing in substitute care or may be living with a parent (referred to as a "return and monitor"). DFPS legal responsibility terminates when a court orders DFPS custody ended or a youth turns 18, whichever comes first.
Educational portfolios	A student portfolio is a compilation of academic work and other forms of educational evidence assembled for the purpose of (1) evaluating coursework quality, learning progress, and academic achievement; (2) determining whether students have met learning standards or other academic requirements for courses, grade-level promotion, and graduation; (3) helping students reflect on their academic goals and progress as learners; and (4) creating a lasting archive of academic work products, accomplishments, and other documentation.[500]
Emancipation	Emancipation (also known as "aging out") occurs when a young adult exits state conservatorship after being legally recognized as an adult. This typically occurs at age 18.
Exits from DFPS custody	A child or youth exits from DFPS custody when a court terminates DFPS legal responsibility or a youth turns 18, whichever comes first. The following are the categories of exits from DFPS custody: reunification; relative as a Permanent Managing Conservator (PMC); adoption; aging out; other
Family Based Safety Services (FBSS), aka Family Preservation	Services provided through DFPS to families who have been investigated for abuse and neglect but are not determined as an immediate safety risk. The goal of these services is to prevent the need for a child's removal.

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[500] Great Schools Partnership. (2016, February 18). *Portfolio definition*. https://www.edglossary.org/portfolio/

Term	Definition
Foster care	A subset of substitute care that includes all children living in a placement that has been verified to provide 24-hour residential care for a child, in accordance with Chapter 42 of the Human Resources Code and related regulations. These placements include foster homes, including kinship care where the caregiver has been verified, general residential operations (GRO), emergency shelters, residential treatment centers (RTC), and juvenile facilities.
Foster family home	A family that provides care in its home to six or fewer children and youth and is under the regulation of a Child Placing Agency (CPA).
General residential operation (GRO)	A child-care facility that provides care for more than 12 children/youth for 24 hours a day, including facilities known as children's homes, halfway houses, residential treatment centers, emergency shelters, and therapeutic camps.[501] This broad designation includes basic child-care services, emergency shelters, shelters as assessment centers, transitional living services, and residential treatment. GROs provide a variety of services, including treatment services, primary medical needs, emergency care, and assessment programs.
Guardian ad litem (GAL)	A person appointed by a judge to represent the best interests of an allegedly abused or neglected child; in many counties the GAL is the CASA.
Individual with Disabilities Education Act of 2014 (IDEA)[502]	The federal law that governs the special education process.
Individual Education Program (IEP)	An IEP is a written statement or plan for a child with a disability that is developed, reviewed, and revised in a meeting in keeping with certain requirements of law and regulations.[503]
Kinship care	A subset of substitute care that includes all children in DFPS custody who are living with a legal or blood relative, or with another individual who has a significant relationship with the child or the child's family known as "fictive kin."
Paid foster care	A subset of foster care where DFPS is making foster care payments to caregivers.

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[501] Texas Department of Family and Protective Services. (2017, October). *Definitions of terms*. https://www.dfps.state.tx.us/handbooks/CCI/Files/LPPH_px_Definitions_of_Terms.asp

[502] Texas Education Agency. (2020, July). *Parent's guide to the admission, review and dismissal process*. https://framework.esc18.net/Documents/ARD_Guide_ENG.pdf

[503] Center for Parent Information and Resources. (2017, November 9). *Contents of the IEP*. https://www.parentcenterhub.org/iepcontents/

Term	Definition
Permanency	Permanency refers to a child exiting from DFPS custody into a safe, appropriate, and permanent setting. Planning for permanency begins the moment DFPS makes contact with a child and family.[504]
Permanent Care Assistance (PCA)	Monthly financial assistance is available to help kinship foster parents who sign an agreement with DFPS and subsequently take permanent, legal custody of a child.[505]
Permanent Managing Conservatorship (PMC)	Permanent Managing Conservatorship (PMC) occurs when a judge appoints a person to be legally responsible for a child without adopting the child. The court can give PMC to someone other than a parent, including DFPS, a relative, a close family friend, or a foster parent.
Reunification	A type of exit from DFPS custody when a court terminates DFPS legal responsibility and the child returns to the home of the parent from whom they were removed.[506]
Residential Treatment Center (RTC)	An operation that exclusively provides care and treatment services for emotional disorders for 13 or more children up to the age of 18 years.[507]
Single Source Continuum Contractor (SSCC)	DFPS contracts within a geographic service area with a single contractor, officially known as a Single Source Continuum Contractor, or SSCC. The SSCC is responsible for finding foster homes or other living arrangements for children in state care and providing them a full continuum of services.[508]
STAR Health	A Medicaid managed care program serving all children and youth in foster care. Superior HealthPlan is the only health program offering this coverage in Texas.
Substitute care	All children who are living in a DFPS out-of-home placement. It does not include children in DFPS custody who are living with a parent on a return and monitor. Unless otherwise noted, it does include youth over age 18 who are in extended foster care but not in DFPS custody.

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[504] Texas Department of Family and Protective Services. (2020). *Permanency planning resource guide*. https://www.dfps.state.tx.us/handbooks/CPS/Resource_Guides/Permanency_Planning_Resource_Guide.pdf

[505] Texas Department of Family and Protective Services. (n.d.). *Permanency care assistance: The Fostering Connections Act*. https://www.dfps.state.tx.us/Child_Protection/Kinship_Care/documents/PCA-Handout.pdf

[506] Texas Department of Family and Protective Services. (n.d.). *DFPS Data Book: CPI/CPS glossary*. Retrieved January 20, 2021, from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/Resources/glossary.asp

[507] Texas Department of Family and Protective Services. (2017, October). *Definitions of terms*. https://www.dfps.state.tx.us/handbooks/CCI/Files/LPPH_px_Definitions_of_Terms.asp

[508] Department of Family and Protective Services. (n.d.). *Community-Based Care contracts*. Retrieved January 12, 2021, from https://www.dfps.state.tx.us/Doing_Business/Purchased_Client_Services/Community-Based_Care_Contracts/default.asp

Term	Definition
Temporary Managing Conservatorship (TMC)	The awarding of conservatorship (temporary custody) of a child or youth to Texas DFPS. This may include children remaining in their home with orders from the court for particular requirements to ensure the safety of the child or the removal of a child from the family for safety and well-being purposes.[509]
Treatment Foster Family Care (TFFC)	TFFC is defined by DFPS as "a time-limited service through which a provider is held accountable for reducing" a child's level of need in a "family-like setting." DFPS has issued three contracts for TFFC services in Texas. Unlike therapeutic foster care, TFFC requires the use of an evidence-informed practice model.[510]
Unverified Kinship or Relative Placements	Unverified kinship homes are not licensed as a foster home. To ensure that the children and youth placed in unverified foster homes are safe, CPS conducts a home assessment that includes a check on the criminal and abuse and neglect history of all persons 14 years or older living in the household. Unverified foster homes whose total income is below 300% of the poverty level may be eligible to receive a monthly payment equal to 50% of the basic daily foster care rate.[511]
Verified Kinship Foster Care	A verified kinship placement is a relative or kinship home that has been licensed as a foster home by Child Care Licensing (CCL). Verified kinship foster homes are held to the same standards as non-relative foster homes and are eligible for the same financial resources, including the daily foster care rate and additional services and supports provided by a CPA.

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[509] Supreme Court of Texas Children's Commission. (2016). *Bench Book 2016: Common acronyms and abbreviations.* Retrieved January 20, 2021, from http://benchbook.texaschildrenscommission.gov/pdf/Bench%20Book%202016%20Common%20Acronyms%20and%20Abbreviations.pdf

[510] Texas Department of Family and Protective Services. (2020). *DFPS Rider 24 for Utilization of appropriate levels of care in foster care.* https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/Rider_Reports/documents/2020/2020-10-30_Rider_24_Report.pdf

[511] Texas Department of Family and Protective Services. (2017, September 1). *Letter to caregiver: New payments for caregivers.* https://www.dfps.state.tx.us/Child_Protection/Kinship_Care/documents/Letter_to_Caregivers.pdf