Voices from Providers: Enhancing Foster Care Capacity and Quality in Community Based Care

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The Texas Center for Child and Family Studies

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Executive Summary

Beginning in 2021, the four Single Source Continuum Contractors (SSCCs) currently operating in Texas embarked on an initiative to build placement capacity for children in substitute care in Texas. With funding from the Texas Legislature, the SSCC capacity building initiative consists of six individual projects, each of which is spearheaded by one or two SSCCs.

One of the capacity building projects is Specialized Consultation and Support for Providers. For this project, the SSCCs are developing support services for providers to strengthen services and build and maintain placement capacity. As part of this initiative, The Texas Center for Child and Family Studies (the Center), the supporting organization of the Texas Alliance of Child and Family Services (TACFS), partnered with the SSCCs to:

1. Provide immediate assistance to providers to help support safety enhancement and risk reduction, and
2. Conduct a qualitative assessment among provider organizations to identify the perceived causes of capacity challenges and identify potential strategies that the SSCCs can employ to support providers.

As the first component of providing specialized support for providers, the SSCCs partnered with the Center and Praesidium to bring a package of safety-related trainings and resources to Community Based Care and legacy-serving providers designed to mitigate risk and ensure maximum safety for children in care. The suite of services included:

- *Praesidium Abuse Risk Management Training for Organizational Leaders*. In all, 88 agency leaders participated in this training.
- *Praesidium Online Self-Assessment Tool.* Approximately 60 organizations are in process of completing the organizational self-assessment.
- *TACFS Bystander Intervention Training.* Over 100 participants from 20 organizations attended this live virtual training.

As the second component of providing specialized support for providers, the Center's research and evaluation team conducted a qualitative study to collect data from providers to assess: the perceived causes of unplanned placement changes; the behaviors that most commonly lead to placement disruptions; and tangible changes or supports the SSCCs can offer providers to stabilize placements, build capacity, and enhance service quality.

This qualitative study entailed key informant interviews with administrator-level personnel from all four SSCCs, an anonymous online survey sent directly to every provider with an SSCC contract, and focus groups with General Residential Operation (GROs) and Child Placing Agencies (CPAs) who opted-in to discuss their survey responses in more depth.

We received 56 unique survey responses from providers, reflecting a response rate of about 25 percent. Respondents represented a wide range of providers, including both GROs and CPAs, large and small, caring for a broad array of children and youth in substitute care.

These are some of the key findings from the study:

- **GROs are experiencing a staffing crisis.** Consistent with a national trend that cuts across industries, many GROs are having substantial difficulties finding and maintaining staff, resulting in reduced capacity due to staff shortages.
- **Recruitment and retention (of both GRO staff and foster parents) are affected by the current regulatory environment.** According to many providers, intensified regulatory processes (such as court monitoring, licensing actions, contract actions, abuse/neglect investigations, and heightened monitoring) are creating a climate that staff and foster parents do not want to be part of, leading to both attrition and difficulty recruiting new staff.
- **There is a link between staffing shortages and provider-initiated placement disruptions.** When organizations are already struggling to maintain supervision ratios due to understaffing, having a child with serious behavioral challenges can magnify the problem. Because staff are leaving for less stressful jobs for equal or higher pay in the current economy, providers sometimes request discharges on higher-needs youth to retain the staff they have.
- **Overwhelmingly, the most common reason for provider-initiated discharge notices among both CPAs and GROs is behavioral issues among children in placement.** The specific behaviors most likely to lead to a discharge notice are violence and aggression, self -harm and other serious psychiatric symptoms, sexually aggressive behavior, runaway episodes, and oppositional behavior.
- **The lack of thorough and accurate information about children's needs and characteristics at the time of the placement leads to disruptions.** Without accurate information, providers cannot make sound matches reflecting a good fit between needs and setting.
- **CPA providers struggle to find foster parents who are open to taking older or more challenging children.** Narrow age and gender preferences, motivation to adopt, and "unrealistic expectations" of some foster parents results in unused foster home capacity among 86 percent of CPA respondents.
- **There is a widespread lack of needed therapeutic resources to support caregivers.** Providers are struggling to locate needed clinical services, such as child psychiatrists, therapists qualified to work with child trauma, behavioral intervention providers, and clinicians who work with specialty populations. The lack of qualified therapeutic services to meet the complex needs of the children in care puts placements at risk of breakdown.
- **Foster parents need additional resources to stabilize placements, especially for higher-needs children.** Providers experience considerable difficulty locating respite

care, including daycare and babysitting, to give foster parents needed breaks and keep placements stable. Transportation assistance and behavioral support are also scarce.

For this study, we did not just ask providers to describe the challenges they are experiencing, we also asked them to help the SSCCs identify solutions, and providers answered. The responses from participants directly informed the following recommendations, which have the potential to create improvements in foster care capacity and quality for all types of children.

1. Expand efforts to assist providers with staffing. Potential approaches include:
   a. Creating a PRN staffing pool [1]
   b. Paying a daily stipend for empty GRO beds
   c. Establishing relationships with colleges and universities to recruit early-career applicants
   d. Holding recruitment events and assisting with advertising
2. Exhaust all means for getting accurate and thorough information on children at the time of the placement request.
3. Implement enhanced disruption mitigation and care coordination staffings when a placement is at risk of breakdown or a provider requests a discharge related to child behaviors.
4. Act as a broker and an advocate for locating therapeutic mental and behavioral health services and linking providers with these resources.
5. Increase direct support for foster parents, including:
   a. Create a system for helping CPAs locate respite care
   b. Create a system of transportation assistance
   c. Facilitate access to concrete supports in the community
6. Look for opportunities to standardize some processes and requirements for providers across CPAs.
7. Offer trainings for provider staff and foster parents in different formats, particularly on mental health and behavioral management topics.
8. Hold staff accountable for responding to providers.
9. Create thoughtful policies around mandatory reporting.
10. Consider all opportunities to support providers as they navigate the regulatory climate.

The findings of the study are discussed in depth in this report, including the issues that providers defined as well as the recommended provider support strategies. The child welfare landscape is complex and shifting, and no single recommendation presents a fix for all of the issues identified by providers, but in total, these may present opportunities to make meaningful improvements in capacity, service quality, and ultimately, child outcomes.

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[1] PRN: as-needed coverage provided by on-call staff, not regular employees

Introduction and Background

Beginning in 2021, the four Single Source Continuum Contractors (SSCCs) currently operating in Texas embarked on an initiative to build placement capacity for children in substitute care in Texas. With funding from the Texas Legislature, the SSCC capacity building initiative consists of six individual projects, each of which is spearheaded by one or two SSCCs.

One of the capacity building projects is Specialized Consultation and Support for Providers, described as follows in the SSCCs' final project plan:

> *The SSCCs in current catchment areas will focus on supporting and stabilizing provider networks for the purpose of preserving and expanding capacity. This will include the development of support services for providers who may experience challenges with licensing/contract compliance or therapeutic enhancements. The SSCCs will conduct a survey of providers to identify supports and services that providers would find helpful. Using information from this survey, service options will be developed. The overall goal is to make tools to create better environments and improved outcomes for our children and families available to network providers.*

The Texas Center for Child and Family Studies (the Center), the supporting organization of the Texas Alliance of Child and Family Services (TACFS), partnered with the Specialized Consultation and Support for Providers project team (Belong and Saint Francis) to:

1. Provide immediate assistance to providers to help support safety enhancement and risk reduction, and
2. Conduct a qualitative assessment among provider organizations to identify the perceived causes of capacity challenges and identify potential strategies that the SSCCs can employ to support providers.

These two project activities are summarized below.

Immediate Assistance to Providers

As the first component of providing specialized support for providers, the SSCCs partnered with the Center to bring a package of safety-related trainings and resources to Community Based Care and legacy-serving providers. Mitigating risk and ensuring maximum safety is an ongoing effort of SSCCs and was even more timely in the wake of recent high-profile incidents involving allegations of abuse and neglect of youth by staff in a GRO in Texas. In response, the SSCCs took proactive steps to support their provider networks. The package of safety trainings and resources included:

Praesidium's Abuse Risk Management Training for Organizational Leaders. This training is geared toward administrators, program directors, and supervisors who play unique and essential roles in the prevention of organizational abuse. As described by Praesidium:

> *Leadership can implement strategic, empirically-based prevention methods designed to reduce the likelihood of abuse and false allegations and create a culture of safety within organizations. The training teaches research-based abuse risk management techniques, such as: what types of policies should be formalized into practice; how to screen for abuse risk during the hiring process; how best to equip and train employees, supervisors, and caregivers with appropriate abuse prevention knowledge and skills; monitoring and supervision best practices for ensuring safety within facilities, staff-client interactions, and high-risk activities, and; how to prevent drift from standards by identifying risk trends through incident information. This training guides participants through the process of identifying risks specific to their organizations so leaders can develop practical risk reduction plans.*

Approximately 88 provider leaders participated in the Abuse Risk Management Training for Organizational Leaders.

The online self-assessment tool was also offered to all SSCC network providers. This component allows organizations to learn the strength of their policies and practices designed to keep those in their care safe from abuse. This self-assessment helps organizations identify their abuse prevention strengths and weaknesses based on the Praesidium Safety Equation and access sample resources to improve their culture of safety. Approximately 60 organizations are in process of completing the organizational self-assessment. Results of the self-assessments will be shared directly with each individual participating organization, along with coaching from Praesidium. Aggregated results of the assessments will be shared with the Center and SSCCs to help identify additional safety-related trainings and support that providers may need.

A free virtual **Bystander Intervention training** for providers was offered by the TACFS Director of Clinical Practice Initiatives in April 2022, and the recording of the training remains available on our Online Learning Center.[2] Bystander intervention is when a person who notices a problematic, unsafe, or inappropriate situation takes on the personal responsibility to take some type of action to intervene. This training was open to any person within a residential or foster care organization, regardless of role. Staff were given tools to feel empowered to take action in potential abuse or harmful situations. Over 100 participants from 20 organizations attended the live virtual training.

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[2] https://center-onlinelearning.tacfs.org/courses/bystander-intervention-training. TACFS also offers other free or low-cost trainings in our Online Learning Center.

Provider Support Assessment

As the second component of providing specialized support for providers, the Center's research and evaluation team conducted a qualitative study to collect data from key stakeholders to answer these questions:

1. What do SSCCs perceive are the causes of unplanned placement changes initiated by providers?
2. What do providers perceive are the causes of unplanned placement changes that they initiate?
   a. When providers give notice to SSCCs to move a child from a placement for "child behaviors," what are those behaviors?
3. How do providers perceive that SSCCs can best work with them to:
   a. Prevent unplanned disruptions?
   b. Enhance service quality?
   c. Support their work in general?
4. What changes or supports could SSCCs offer that would be of value to providers in stabilizing placements, preventing unplanned changes, and maintaining capacity?

This study used qualitative methods to answer the questions of interest. There were three main steps:

1. *In-depth interviews with administrative personnel from each SSCC.* The Center conducted a 45-60 minute Zoom interview with an agency leader from each SSCC who has knowledge of placements and discharges within their contracted operations.

2. *An anonymous online survey sent directly to every provider with at least one SSCC contract.* The survey was emailed to 226 unique providers of residential child welfare services. The survey used open ended questions to solicit input from providers on issues related to capacity, quality, and placement disruptions. The survey was anonymous; respondents were not asked to provide any identifying information. We chose this method so that participants would feel empowered to share their thoughts freely. At the end of the survey, respondents were given the chance to voluntarily opt-in to participate in a follow-up focus group. Those who chose to participate provided their name, contact information, and organization, but we did not link survey responses to individual identities.

3. *Online focus groups with GRO and CPA[3] provider personnel*. We held focus groups with those who opted-in to dive deeper into the issues asked about in the survey. In all, we held two focus groups of GRO personnel and one focus group of CPA personnel.

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[3] GRO: General Residential Operation (includes Residential Treatment Centers [RTCs]; CPA: Child Placing Agency

All interviews and focus groups were recorded and transcribed verbatim using a transcription service. The transcripts were themed and coded using thematic content analysis. All participants (interview, survey, and focus group) gave informed consent to participate and were informed that they could end their participation at any time. Recordings from the interviews and focus groups were deleted after transcription. In reporting the findings below, we omitted any information from the responses that could potentially identify a specific person or organization.

Provider Characteristics

We received 56 unique survey responses from providers, reflecting a response rate of about 25 percent.[4]

We asked survey respondents to provide some general information about their organizations, including provider type (CPA, GRO, or both), capacity (number of homes), levels of care served, and current or past heightened monitoring episodes.

We received survey responses from both CPA and GRO providers; some of these providers contract for both types of services.

PROVIDER TYPE

GRO ONLY	BOTH	CPA ONLY
27	11	18
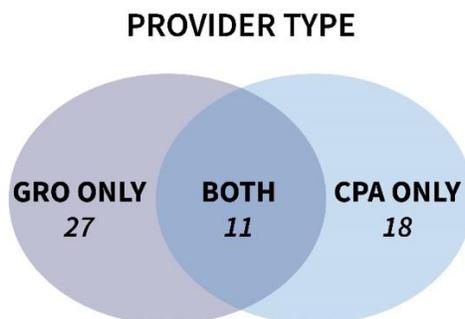
Eight CPAs (27%) and five GROs (13%) reported that they are currently[5] on heightened monitoring. Of the agencies who stated they are not currently on heightened monitoring, four CPAs (13%) and five GROs (13%) have been on heightened monitoring at some point within the past 3 years.

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[4] In reviewing the findings below, it is important to consider that (as with all survey research) there could be systematic differences between those who responded to the survey and those who did not. We do not know the extent to which the perspectives of the respondents represent the perspectives of all providers.

[5] Throughout this report, "currently" refers to April-May 2022, when the data was collected.

**NUMBER OF CHILDREN IN DFPS
CONSERVATORSHIP CURRENTLY PLACED
WITH RESPONDING PROVIDERS**

| NUMBER OF CHILDREN	Fewer than 25	25-50	51-100	101-250	250+
NUMBER OF PROVIDERS	32	16	12	4	4
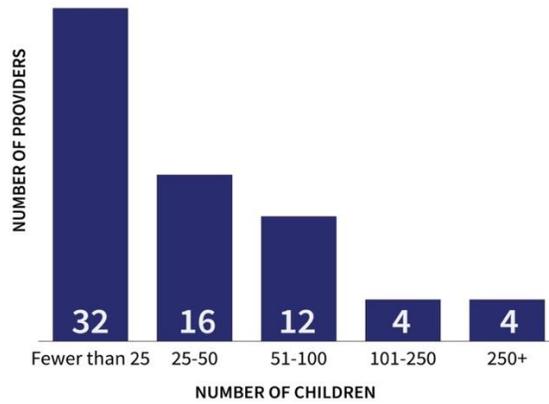
The number of children and youth in DFPS conservatorship that providers are currently providing placement for varies widely by organization, from zero among some agencies at the time of data collection, to several hundred by some larger organizations.

The median number of *active* foster homes reported by CPAs was 41, ranging from two homes in the smallest agency, to 351 homes in the largest. All but two CPAs reported that they have foster homes currently in the process of development toward verification, ranging from one home to more than 100.

Of the 29 CPA respondents, 25 (86%) reported that they currently have unused foster care capacity, defined as licensed foster care beds that are not filled.[6]

PROVIDER CONTRACTS

	2INgage	Belong	OCOK	Saint Francis
GRO	23	25	19	22
CPA	20	17	24	19

GRO ■ CPA ■

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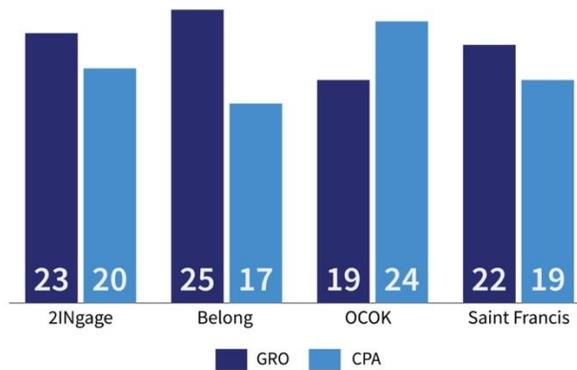
[6] CPAs were asked to explain the main reasons for having unused foster home capacity; responses are discussed in the findings section, page 17.

Survey responses represent CPAs and GROs[7] who contract with all four SSCCs. Over two thirds of the organizations contract with more than one SSCC concurrently.

All CPAs serve children with Basic and Moderate levels of care. Most also serve children with Specialized levels of care and nearly half serve Intense or Intense Plus. More than half of CPAs also reported that they serve some type of special populations, such as children with primary medical needs, survivors of sex trafficking, high need adolescents, children with autism, and children with intellectual disabilities.

Almost all GROs also serve special populations, such as youth with high behavioral needs including physical aggression and emotional disturbance, intellectual disabilities, psychiatric or substance abuse step-downs, sibling groups, youth aging out of care, survivors of sex trafficking, pregnant youth, LBGTQ youth, and children with autism or intellectual disabilities.

Key Themes Emerging from Interviews, Survey Responses, and Focus Groups

After coding and analyzing four SSCC interviews, 56 open ended survey responses, and three focus groups (entailing 14 individual participants), core themes emerged that reflect participants' views on capacity challenges and potential solutions.[8] These themes are discussed below in two overarching categories: *defining the issues* and *generating solutions*. The second category translates participants' input on solutions into actionable recommendations for SSCCs to support providers in building capacity, maintaining capacity, and enhancing service quality.

Defining the Issues: Perceived Causes of Capacity Challenges

For GROs, the biggest challenge to maintaining capacity is staffing, by an overwhelming margin; nearly three quarters of GRO respondents identified staffing as their biggest challenge. Simply put, **GROs are experiencing a staffing crisis**.

Many providers have had to reduce their census, sometimes by half or even more, because they cannot recruit and/or retain direct care staff. One participant summarized: "Every time we have had to reduce capacity or hold at a lower capacity is all due to staffing." Providers reported increasing hourly pay, offering hiring bonuses, improving benefits, and increasing advertising with little or no success in addressing the staffing problem.

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[7] Numbers in the figure below equal more than the number of responses because respondents could select more than one SSCC.
[8] To ensure applicable and actionable findings, we intentionally focused interview/survey/focus group questions on issues that are subject to control at the SSCC or provider level, not on state-level policy issues such as funding rates.

One provider shared illustrative details about their most recent hiring:

> "We had 122 applicants. Out of the 122, only 12 responded. Of the 12 that responded, we liked them and we offered jobs. Out of those 12, only 2 showed up for training. I cannot understand why people are just not showing up, I have no idea. Unless we're going to be paying more than $20 an hour, I have no idea."

With potential employees so scarce, the quality of available staff also becomes an issue: "The pay we are capable of offering is too low, so finding QUALIFIED people to work for such a wage is burdensome and ineffective." With the staffing shortages that providers experience, some are left with the hard decision of hiring anyone who comes through their doors and passes a background check over the ideal of hiring well-qualified staff who are willing and ready to work with challenging children. One participant summarized the scope of the problem like this:

> "24 -hour overnight supervision is a consistent challenge. Pay is a consistent challenge. Turnover is a consistent challenge. When we don't have enough qualified staff, we cannot, in best practice, bring more youth into our facility - even if we would technically be meeting the ratio requirements."

Some noted that the staffing difficulties reflect a larger economic condition – low unemployment leading to high wages – that is not specific to child welfare, such as the participant who put it bluntly: "The Great Resignation is real." Many providers referenced comparable, or even higher, wages that potential employees can currently get working less challenging jobs in retail or food service. Put simply: "The stress of the job does not match the pay." Others stated:

> "I think that this is, in every industry, the discussion. Hopefully, we'll see it go back to being able to retain and recruit, and not have to struggle, but capacity has been significantly impacted by the economy. It's very hard to say, 'Hey, come work with these really, really tough kids but I can't pay you what Amazon and Walmart can pay you.'"

> "It's really rather interesting actually how it seems to be a much more widespread issue and not limited to a particular area…. We all know the workforce saw record numbers of people walk away from jobs and not come back, apparently. I don't know what everybody's doing to pay their bills, but it's apparently not working residential."

Participants described a **link between the current regulatory environment (such as court monitoring, licensing actions, contract actions, abuse/neglect investigations, and heightened monitoring) and staffing issues**. According to some providers, the intense scrutiny that residential providers are currently under has created an environment that employees do not want to work in. Several providers specifically mentioned the lawsuit and related monitoring. Many others mentioned the significant increase in licensing and/or DFPS investigations related to allegations of abuse and neglect, which are often seen as

unreasonably punitive and creating a culture of fear among staff. One provider summed up this frustration, stating: "I've been in this field for a long time, but it's a little different now with this lawsuit and the heightened monitoring and you feel you're just being nitpicked to death right now."

A common sentiment in responses is that the current climate is negatively influencing recruitment and retention. As one provider said: "Increasing salaries has not proven to be enough. Staff have left because of the current foster care climate." Another stated: "HHSC/DFPS employees acting very accusatory and unprofessional during investigations has driven employees away. The current culture of foster care makes it hard to retain staff… [and] caused a decrease in capacity."

One focus group participant contrasted the current climate with an ideal one that would help with staffing:

> "The best way to find good staff is for your staff to be out in the community talking about the wonderful things that are happening, how you're changing lives, and you find other staff that way. The reverse is also true. When the environment is terrible, nothing you do is okay. Everyone comes in and points their finger at you and tells you what you're doing is terrible. *No one wants to do this*."

Participants also articulated a **close connection between GRO staffing shortages and putting discharge notices on children and youth**, which is one of the major drains on overall placement capacity in the system. When organizations are already struggling to maintain ratios due to understaffing, having a child with severe behavioral issues can magnify the problem in several ways. If a child's level of need rises to the level of needing more than standard supervision, such as 1:1, placing a dedicated staff member on that child may put the facility out of compliance on their ratios with the rest of the residents, leading to a need to have that one child moved elsewhere. One GRO provider stated: "Right now, it really comes down to, we're so short-staffed that we have everybody working and it's harder to keep the kids that need that upgraded supervision on a regular basis, so we put in notice."

In instances where a resident's behavior is aggressive or even violent, providers face direct care staff leaving to take less stressful jobs. In other words, **providers sometimes put discharge notices on kids to retain their existing staff**. As one participant put it: "If I'm going to lose staff over one child, that's going to be a decision-maker." Another stated: "We want to help the children, obviously, we don't want the disruption, but… when it becomes retaining staff or retaining the one child when you don't have the resources, then we just can't keep them."

Though staffing appears to play a role in negative (i.e., not planned or desirable) discharges[9], particularly for GROs, it is not the primary reason articulated by providers. Both CPAs and GROs were asked to speak directly to the issue of discharge notices, which SSCCs have identified as one of the primary issues contributing to capacity problems.

Overwhelmingly, the most **common reason for provider-initiated discharge notices among both CPAs and GROs is children's behavioral issues**.[10] In the survey and in focus groups, participants were asked to drill down and articulate the precise behaviors that most often lead to discharges. The themes captured in these responses are summarized in the table below.

Theme	Description	Quotes
Violence and aggression	- Physical abuse or assault of staff, foster parents, or other children - Threats of harm - Bullying - Fighting - Homicidal ideation - Verbal abuse of others - Destruction of property	"Basically, the criteria we have if they are presenting aggressive behaviors that are putting other children or my staff at risk that we take then obviously we're going to ask for a discharge." "[I]t can be a lot of physical aggression, whether it's towards peers or my staff, because the same thing, staff get exhausted and they're tired of getting hit and kicked and spit on and slapped and all the above."
Self-harm and psychiatric issues	- Psychiatric hospitalization, especially when repeated - Suicidal ideation - Suicide attempts - Intentional self-injury - Emotional meltdowns - Psychosis symptoms - Long-term psychiatric needs - Medication refusal - Substance use or abuse	"Most of ours come by way of the hospitalization. Their aftercare plan when they're coming out of that setting generally is not something that can come back into basic and moderate level care in our setting and meet their needs and keep them safe." "The situations that bring us to the point of having to ask for a discharge certainly are psychiatric, need for stabilization." "[T]he majority of our 24-hour discharge notices come from if a child is admitted into a psychiatric facility, we typically do submit the 24 hours. We don't typically take them back because we try to exhaust all of our options."

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[9] This does not refer to discharges that are considered positive, such as children exiting care to reunification or adoption or being moved to a kinship home.

[10] Though discharge notices come from both CPAs and GROs, the majority are coming from RTCs, according to SSSCs. When one SSCC interview participant was asked where the most discharge requests come from, they replied "RTCs hands down. Hands down." Another said, "Where we think we can do the most work is unfortunately where the most discharges are, which is with our kids in RTC."

Sexual aggression or acting out	- Sexually aggressive behaviors - Sexually acting out - Sexual perpetrator behavior	"[I]f they're hyper sexually aggressive, and there's other youth in the placement that may be at risk, we may get those types of discharges."
Runaway events	- Chronic or repeated runaway episodes	"That's our measuring stick. Then if they run away from the facility, we will go ahead and do a discharge notice because typically, they won't stay if they are brought back by [the local police department]."
Defiance or refusal to follow rules	- Disrupting the milieu - Interfering in the therapeutic progress of other children - Ongoing oppositional behavior - Delinquent behavior - School problems, such as truancy or suspension - Refusal to participate in treatment or programming	"They are making it difficult for the other children in the shelter to live, basically. They're being ugly to the other children, or they're being ugly to staff, or they're leaving the building and coming back and leaving the building and coming back. We operate on a stance of…. you don't have to be a good kid or a perfect kid or whatever, just be cooperative, don't make it miserable for everybody living here." "[B]ecause we're in a small rural community, relationship with the community is pretty important and if we have kids that run away, and steal vehicles, or break into homes at a level that the community concern gets way up there, sometimes that has to weigh into our decision." "Once a child becomes a continuous disruption to other [residents] that really are trying to work their program, that's when our treatment team is getting together and saying, 'Okay, we're not able to meet their needs.' They're really not trying to work a program, and now they're affecting every other [resident] that is trying to work a program."

A major theme that emerged in the discussion of discharges due to child behaviors pertains to the accuracy of information provided by SSCCs at the time of placement.[11] Many providers reported that the **lack of thorough and accurate communication about children's needs and characteristics at the time of the placement leads to disruptions** because the placements are mismatched from the beginning. More than a quarter of CPAs cited inaccurate information on children's behaviors as the most common reason for placement disruption. Without accurate information, providers cannot make sound matches reflecting a good fit between needs and setting. As one provider stated: "We often find out very important details that were left out before placement. Then all these serious things come out after

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[11] This applies equally to DFPS in legacy regions but for the purposes of this report, the focus is on SSCCs.

placement that would have affected whether or not the family would have accepted." Another CPA provider shared:

> "[M]ost often it is because the issues that the children have were not presented upon placement request and therefore we were unable to match them with an appropriate family. The family they were placed with may not have the training or experience to work with the children, and if it was communicated to us at placement request, we could have found a family suited for the child or passed on the placement."

There were some mixed perceptions about the reasons for mismatches in placements due to information that was not communicated at the time of the placement request. Though some participants acknowledged that sometimes there is just a lack of information about a child at the SSCC and/or DFPS level, a few others suspect that there are times when information is intentionally withheld. As one provider stated: "If there's significant information that they're not putting in there because someone's afraid we'll say 'no' if we actually knew, I don't know. We get really, really outdated information." Another provider said that when they do not get the full picture of a child's behaviors, it "ends up backfiring for the youth, because they typically end up in another discharge."

Though behavioral challenges were by far the most cited reason for unplanned discharges, participants also described other reasons why discharges occur. For GROs, one that came up several times was **children being moved as soon as their level of care decreases or behaviors improve**. As one stated: "The children move rapidly with the slightest behavioral decrease." Some providers view it as counterproductive when children are moved just as they become stabilized in their current setting. For example, one GRO provider referred to this as children "being punished for good behavior" and wanted policies that "allow the child to remain at the facility creating stability and consistency for the child if the child is flourishing."

With CPAs in particular, a theme that emerged related to placement disruptions was the **unrealistic expectations of some foster parents regarding the challenges of fostering**. As one CPA provider stated: "Often times the behaviors are very different than what the family was prepared for." Speaking on this theme, one SSCC leader stated:

> "I think, honestly, for me, the biggest struggle is when you see foster parents or CPAs disrupting on behaviors that really are age-appropriate, are expected to be typical, are not surprising for kids who've had trauma. And you're thinking to yourself, how did we not expect some of these reactionary behaviors from a kid who's had A, B, and C experiences? Can we move past that? Sometimes, it just really feels like, what did we tell these foster parents before they started fostering about trauma and the impacts of trauma and what they should expect to see?…. They're going to have some behaviors that maybe you wouldn't see otherwise as a result of the trauma that they've been through. It just seems like sometimes we're missing that connection for families."

On the other hand, some CPA providers articulated that behaviors are sometimes so severe that it might not be possible for many foster parents to maintain these children in their homes. One provider described this situation: "[T]his kid literally ripped the door off, had torn it apart of this lady's house… you're basically asking these parents to become RTCs in their house. What do you do with that?"

The ability and willingness of foster parents to accept older or more challenging children is closely connected to overall capacity. Eighty-six percent of CPA survey respondents reported that they currently have unused foster care capacity. In some cases, unused capacity is simply related to foster parents going on vacation or taking a break between placements. In a handful of other cases, CPAs reported having unused capacity due to low referrals. However, **the most common reason for unused capacity is that children who need placement are not aligned with the placement preferences of foster parents**. One third of survey responses regarding reasons for unused capacity reflect lack of alignment between foster home preferences and children needing placement. Several participants stated that the foster homes without current placements only want to foster children they can adopt. Others noted that the foster parents have specific preferences for young children and/or specific genders. Multiple participants also stated explicitly that the behaviors and needs of available children are higher than their available foster parents are willing to accept. As one SSCC leader stated: "We have capacity, but is it the right capacity? Is it the appropriate capacity? There's empty beds out there. To say we have a capacity shortage is not really the case. It's the right capacity. The mix is not correct."

Providers described foster parents who *are* successfully able to take and maintain high needs children as those who have strong support systems, "a passion to foster," who understand trauma, who are patient and flexible, and have a "higher understanding of children's behaviors and development needs."

Participants also perceive that **some foster parents decide to stop fostering, decline to take challenging kids, or request discharges on kids due to difficult behavior because the current regulatory climate is negative, even punitive**. As one participant put it: "The increased stress level with compliance and fear of investigations have lowered the capacity of what a family will manage." Another CPA provider stated:

> "The environment, the attitude of monitors, DFPS, HHSC monitors coming into our facilities, coming into our foster homes, which are a direct result of the pressure on them from the court monitors and the judge, everything is negative. They come in with an expectation to find what foster parents or staff are doing wrong. They're not reasonable in the way that they look at normal experiences of kids and staff."

Many GRO providers also spoke about **the increased risk of accepting and keeping challenging children in residential settings in the current regulatory environment**. The theme of risk was prevalent as a reason why placements are turned down or disrupted. As

one provider perceives it: "Licensing is looking for ways to cite." One GRO provider's input highlights this theme: "We are also more selective on what [children] we will take due to the current lawsuit, heightened monitoring, etc. So many facilities have been shut down and we are trying to certainly be proactive to prevent that from happening to our facility." As described by that provider and others, fear of closure or punishment leads directly to facilities refusing or discharging placements for children that are considered high-risk due to their behaviors. Providers risk disrupting placements for all the children in their care and the stability of the operation as a whole if the behavior of higher-needs youth generates additional regulatory action.

A few providers placed some responsibility for this on the shoulders of SSCCs, who they see as too quick to report incidents that do not rise to the level of needing an abuse/neglect investigation. One GRO provider gave this anecdote to illustrate:

> "I have a girl that pre-lawsuit, pre-heightened monitoring, I would've kept this child… we just discharged her yesterday. Pre all of that, I would've kept this child, but right now she's in literally four investigations in a matter of three weeks because her team calls in every little thing that happens or that she does. We can't keep that here anymore at this point. This is a child I completely would have kept before all of this, but now when you have everybody watching every little thing… that becomes a big piece of it too."

Another expressed a similar frustration:

> "It wouldn't be an investigation if they did not have teams that chose to call in everything as an investigation…. [W]e had a girl the other day that had scratched on her neck and scratched her arm. Didn't even break skin, didn't even bleed. We have this caseworker calling all of our phones, 'This is a serious incident report, this has to be called in.' I said, 'No, ma'am, this isn't a suicide attempt… this is self-harm.' If we called that in, we'd be calling the hotline, two, three times a day, every day, just for self-harm type stuff.… We were just going back and forth… They were adamant."

A final theme prevalent among both CPAs and GROs is the **lack of needed therapeutic resources to support providers caring for children with high needs**. In survey responses and focus groups, providers stressed the difficulties of finding qualified professionals, such as therapists and psychiatrists, to serve their children. According to participants, **having these vital supportive services available could make the difference between a disruption and being able to successfully maintain a child in placement**. These difficulties are even more pronounced in rural areas and in circumstances where a specialty practitioner is needed. As one provider said: "If there are other therapeutic services needed such as substance treatment or victim of human trafficking treatment, we lack providers in region (and statewide) making it difficult to engage those services for youth." Even when these types of services are located, providers face long wait lists and may have to travel outside their area to access them.

Clinicians who are qualified to treat high needs children with trauma are scarce enough, and according to numerous participants, it is even harder to find ones who take Medicaid. One provider stated: "The area in which we are located does not have a high-quality psychiatric hospital and other services in this area are limited due to the youth's Medicaid. Many specialists do not accept Superior/Medicaid in this area." A GRO provider stated:

> "We are in a rural area with very limited resources for therapeutic services. Teams/judges are asking for more and more specialty services such as EMDR, sexual aggression, transgender, etc. We have reached out to Superior Health, but they say they aren't having much luck either or don't have time to look for these providers."

Other participants also reported difficulties with using Superior Health to locate therapeutic resources. One described the need for "A person that specializes in trauma informed care for children with autism. I have asked Superior Behavioral Health reps and they have never gotten back to me regarding this request." A GRO provider described this experience about looking for therapists who specialize in specific populations or issues:

> "We have a specific lady at Superior Health that we email when we're needing these things. Her emails will tell you, 'I am swamped. I'm inundated. I've got to pass this on to this person. Let me know if they don't get back with you.' We don't hear back from someone for a couple of weeks and we'll reach out again. If they do maybe find some resources, we'll reach out to those people and no one ever answers the phone or we don't get a response back."

Medical and mental health practitioners who are qualified and accessible are not the only resources that providers are lacking. Provider after provider spoke about the **scarcity of resources that they need to be able to support high needs children in their placements and prevent disruptions**. The most common themes from the responses are:

- *Respite care for foster parents*. This category includes formal respite care as well as babysitting and daycare. Respite care as a needed resource for foster parents was brought up dozens of times by participants. Respite, including daycare and babysitting, can help a struggling family get a needed break that will enhance their capacity to maintain children without a placement breakdown. Often CPAs do not have the homes available and do not know where to turn to locate available respite from other agencies, especially when the need is for respite that is qualified to take kids with high levels of care. One SSCC leader described a scenario of a sibling group placement potentially breaking down because of the lack of respite options for a family going on vacation. Daycare is similarly hard to secure for foster families. One SSCC participant gave this anecdote to illustrate:

> "Daycare, oh my gosh. Daycare is a huge, huge issue for providers…. You've got families who are working 36 hours a week and because it wasn't 40,

because they took 4 hours off, because they had to take their kid, their own bio kids, to an appointment during the week… the paystub they have available is 36 hours and DFPS is like, 'I'm sorry, you don't work 40 hours. Therefore, you cannot have childcare.' It just doesn't make any sense. There's no consideration for the practicality of what's needed to maintain kids."

- *Transportation assistance*. CPAs, SSCCs, and GROs all discussed the difficulty of transportation to get children to and from visits, activities, and appointments. This is especially difficult for CPAs and their foster parents, and the need is enhanced when visits and appointments are located in other counties or regions, which can take the majority of the day for a foster parent, case manager, or staff member. One CPA provider explained: "[T]he conversation that sometimes [SSCCs] have with our parents just discourages them and really puts it on them like, 'I don't care if you have to work, they've got to be there' type thing. There's no sharing in that conversation. That really discourages our families."

- *Crisis stabilization support for foster parents*. When there is an acute behavior issue in a foster home that could lead to a disruption, foster parents and CPAs need access to in-home support to help stabilize the situation, even after hours. This same need also applies to GROs. Some providers described being unable to reach members of the SSCC team when urgent situations have arisen outside of business hours. Others also talked about the need for upstream support to prevent crises through training and assistance for foster parents to learn to manage challenging behavior.

Generating Solutions: Supporting Providers in Building and Maintaining High-Quality Capacity

For this study, we did not just ask providers to describe problems, we also asked them to help the SSCCs identify solutions, and providers answered. The responses from participants directly informed the following recommendations[12], which have the potential to create improvements in foster care capacity and quality for all types of children.

1. **Expand efforts to assist providers with staffing.**

   Nationwide and across many industries, employers are struggling to find staff. We recognize that the staffing crisis in the foster care system, particularly for GRO direct care

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[12] With nearly 56 participants asked to give suggestions for changes, services, or supports the SSCCs could provide in multiple domains, we are not able to include all of them as recommendations in this report. TACFS staff reviewed the study findings and created these recommendations based on what we believe to be the most feasible and have the most potential for meaningful impact. So that all providers' voices have the opportunity to be heard, a de-identified brief summary of all survey respondent suggestions is in Appendices A and B.

staff, is a problem without an easy solution. Nonetheless, some recommendations emerged from the findings that are offered as possible strategies:

a. **Explore the feasibility of creating a PRN pool of direct care staff that providers can access as needed to make up for short-term staffing gaps.** A close analog of this approach is substitute teaching, where school districts create a pool of pre-trained, background-checked professionals to be deployed to schools needing short-term coverage. It is also a model already used in other direct care settings, such as hospitals and home health nursing. SSCCs could consider creating pools of community members who are interested in working with children (for example, retired teachers, retired military, or CASA volunteers) who would be available for as-needed work. When GRO staff quit unexpectedly, are out sick, or take vacation, providers could maintain coverage by accessing staff from the PRN pool.

b. **Pay GRO providers for empty beds to maintain capacity when providers have to reduce census due to staff shortages**. Residential providers are forced to reduce capacity when there are not enough staff to maintain supervision. Providers have fixed costs, and if there are empty beds due to lack of staffing, they struggle to pay those costs. Unused capacity creates a financial burden and may lead to closures or lower quality services as organizations struggle to maintain operations. Paying GROs a daily stipend for unused beds may prevent lost capacity until staffing stabilizes.

c. **Establish relationships with colleges and universities to funnel potential employees to careers in child welfare.** Engaging with schools of social work, education, counseling, and other human services programs to talk about jobs in child welfare could bring new qualified applicant pools into the field. Young people exiting school could get meaningful entry-level career experiences in child welfare, whether in direct care or case management. Many school programs host job boards, and college instructors often invite professionals to speak to classes about post-degree career paths.

d. **Host recruitment events and assist with enhanced advertising.** As applicant pools get smaller, organizations are having to increase spending on job advertising, straining budgets that are often already strained from unused capacity. Helping in small ways through advertising or job fairs could relieve some pressure in the search for qualified staff.

2. **Exhaust all means for getting accurate and thorough information on children at the time of the placement request.**

Whether it means tracking down documentation from previous providers, combing through records, requesting more and better information on the common application, or just making sure CPAs and GROs have *all* known information about a child prior to placement, better information will result in better matches with a higher chance of success and stability.

3. **Implement enhanced disruption mitigation and care coordination staffings when a placement is at risk of breakdown or a provider puts in a discharge notice related to child behaviors.**

This recommendation arose dozens of times from providers, with acknowledgements that SSCCs are already doing this work to varying extents. One SSCC participant described their push to implement discharge mitigation policies with providers:

> "[W]hen we started trying to put these staffings into play… there was a lot of pushback. There was like, 'Well, I already put the notice in.' Yes, you did, but we're going to talk about it. I'm thankful to say that [now]… we'll still have a little bit of pushback, but it's becoming common. I want it to be common that a discharge mitigation staffing should be normal."

On the provider end, the discharge mitigation practices are valued, but they also have to involve SSCC follow-through. A provider described their appreciation for an SSCC that they feel does a good job with staffing and coordination to stabilize placements:

> "They're very supportive. If we talk about a 14-day [notice] or we put one in, they're immediately going to set up a meeting. In that meeting, they're going to have everybody they can think of that's ever had contact with the child, even transported them here or there and built a relationship with them. They had all of us on there. Then they had follow-up meetings and they actually followed through on what they said they were going to do. That's been our biggest issue. We have other places that might have a mitigation, disruption mitigation meeting, but they don't follow through on their end."

The hope among both providers and SSCCs is that collaboration and coordination can prevent disruptions from occurring if everyone involved can work together to problem-solve and find stabilizing resources. Even when placements disrupt, however, this collaborative process can help prevent future breakdowns by gathering information that will help make the next placement a better match. As described by an SSCC participant:

> "[W]e want to know the 'why'. We want to know. And maybe this isn't the right placement for the kid, maybe you're absolutely right… but let me find the right one. I don't just want to move them across to somewhere else the first person that says yes, because that's not going to help that kid in the long run so at least give me the information and have a follow-up."

4. **Act as a broker and an advocate for locating therapeutic mental and behavioral health services and linking providers with these resources.**

Providers are struggling to locate needed clinical services, such as child psychiatrists, therapists qualified to work with child trauma, behavioral intervention providers, and clinicians who work with specialty populations (LGBTQ, autism, etc.). Simply put, providers often cannot locate desperately needed clinical providers necessary to meet the complex needs of the children in their care. These resources are scarce to begin with, and many do not accept Medicaid. The need is amplified among providers in rural areas. Although telehealth opens some opportunities to less-resourced areas of the state, some services (for example, crisis stabilization) must be delivered in person.

Though it is within Superior Health's purview to identify providers for these services, providers report that they cannot reach Superior or that Superior is not following through with requests. The SSCCs can be strong advocates by developing relationships with the right people and ensuring that Superior follows through with providing a Service Coordinator or Service Manager for every child who needs clinical care.[13] SSCCs could also potentially play a role in locating and formalizing relationships with clinical providers around the state who will prioritize serving network providers.

Further, Local Mental Health Authorities (LMHAs) have mobile crisis intervention services that can be deployed 24 hours a day for stabilization services when there are acute needs. To the extent possible, SSCCs could seek out ways to strengthen and potentially formalize relationships with LMHAs to ensure that providers can access these services. Managing acute psychiatric or behavior situations may prevent disruptions by getting immediate treatment in place in the moment it is needed.

5. **Increase direct supports for foster parents.**

Providers from CPAs gave clear feedback that they would benefit from more direct SSCC involvement in supporting foster families. CPAs are struggling with obtaining the resources to provide tangible supports that would help foster parents accept and maintain placements. Direct supports can help build capacity in multiple ways, including stabilizing placements to prevent disruptions for children with challenging behavior and retaining homes that might otherwise stop fostering. There is also the possibility of converting unused capacity (homes that are licensed but do not currently have placements) into new capacity through additional supports to assist families in shifting into accepting placements for older children with more complex needs. The SSCCs can

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[13] Service Management is available when children demonstrate chronic/complex conditions such as having multiple hospitalizations, intent to harm self or others, explosive type behaviors (aggression, impulsivity, depression), pregnancy, etc. Service Coordination is available to provide medical case management on request for *any* child in care. See page 49 of the STAR Health Handbook.

play a role by leveraging their connections and capacity building resources to help CPAs provide these supports. Among the domains of direct supports to consider:

a. **Play a bigger role assisting CPAs with locating respite care, including daycare and babysitting.** Many CPAs are struggling with locating qualified respite to relieve pressure on foster parents. Some potential strategies SSCCs could use are: vet and train babysitters to maintain a pool that CPAs can draw on, make warm handoffs to other agencies who have available respite resources, create a centralized repository of up-to-date respite availability across SSCC provider networks to assist CPAs with searches, and/or engage and fund local nonprofits and churches to fill in gaps in respite care and other concrete support services for foster parents. SSCCs could also hold recreational activities – such as camps, sports leagues/events, or special outings – to provide both respite and opportunities to connect as a foster care community.

b. **Create a system of transportation assistance.** For foster parents and CPA staff, transporting children to visits or appointments can create a substantial strain that may threaten placement stability, especially when visits or appointments involve long-distance travel. This recommendation could also help GROs in similar situations, given the widespread staffing shortages they are experiencing. Some or all SSCCs are already doing some transportation assistance, but there could be opportunities to strengthen or expand these efforts. SSCCs could hire floating transporters to deploy when foster parents and/or provider staff in SSCC networks do not have the resources to manage transports. Further, SSCCs can maximize Medicaid medical transport services by ensuring providers are aware of this benefit and how to access it.

c. **Facilitate access to concrete supports in the community.** SSCCs could tap into Care Portal[14] or other systems to connect foster and kinship caregivers with needed supplies, goods, and services. Child Welfare Boards, faith-based partners, and other community groups can be coordinated to directly support foster and kinship caregivers across the SSCC network. With an understanding of the concrete needs of foster parents and kinship caregivers, SSCCs can play a linkage and coordination role with community organizations willing to help.

6. **Look for opportunities to standardize some processes and requirements for providers across SSCCs.**

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[14] Care Portal is an online resource that matches the needs of families with local individuals and community groups who can provide concrete assistance.

This was one of the most common suggestions from participants. Providers who contract with more than one SSCC have multiple different sets of standards, forms, and timeframes to keep track of, which takes time away from the focus on supporting kids and caregivers. SSCCs might consider looking for opportunities to create consistency among some forms, monitoring activities, time frames, and/or documentation requirements to reduce the administrative burden on providers and create more time for case management and direct care.

7. **Offer trainings for provider staff and foster parents in different formats.**

Many providers asked for the SSCCs to help with securing high-quality training. The number one topic for requested training is managing challenging behaviors. Responses suggest that ensuring that foster parents have training that provides *realistic* information on the behaviors associated with trauma might create better alignment with their expectations of how children placed with them might behave.

Providers were mixed about how they would ideally like training to be delivered. For example, one provider stated: "We find that a lot of the online training is not very effective and staff report back to us that they are not learning anything from it. They prefer face-to-face training, where they can ask questions and role play." Other providers, however, want the opposite – online trainings or webinars that foster parents and staff can view on the schedule that works best for them. One provider stated:

> "We almost really need training on demand like Netflix – I can order when I want it. because having a webinar at a certain time of day, and only offering it once during a timeframe is not convenient for all the staff. We almost need that on-demand training that has an unlimited timeframe on it, so everybody has an opportunity to get that training at a convenient time. That would be super beneficial."

8. **Hold staff accountable for responding to providers.**

Numerous providers reported being unable to get in touch with both DFPS and SSCC staff, especially when there are urgent issues that arise outside business hours. Even when they can be reached, they are not always responsive to needs and concerns. On top of creating a culture where responsiveness is always expected, SSCCs could explore systems such as having staggered shifts for workers to ensure that even late in the day or evening, there is better coverage for urgent needs. To the extent possible, SSCCs can also look for ways to better coordinate with DFPS staff to identify emergency contacts or ensure full time coverage for time sensitive decisions.

9. **Create thoughtful policies around mandatory reporting.**

Mandatory reporting is a fine balance between reporting the things that are necessary to protect children in care and recognizing that in a population of children with trauma experiences, some risk behaviors are normative and do not rise to the level of reporting as a serious incident. Distinguishing between these is not an easy task for any mandated reporter.

Through seeking out relevant research and training[15] on mandatory reporting, SSCCs can ensure that there are internal policies and processes in place (among SSCCs and provider agencies) for making reporting decisions systematically and with intention. For example, determining in advance who should be involved in staffings about scenarios that may need a report, who makes the final decision on whether reports are made, and how to document decision-making factors can be part of a larger strategy for managing risk and reporting. This recommendation is in alignment with a national conversation on examining reporting practices[16]; it is not meant to deter anyone from reporting abuse or neglect to all appropriate entities, and providers/SSCCs should work with DFPS and Statewide Intake to ensure compliance with mandatory reporting laws.

10. Consider all opportunities to support providers as they navigate the regulatory climate.

One of the key themes in this study's findings is that morale is low and negative public perception about providers is taxing. There is no easy solution for this. A few providers, however, had some suggestions. Smaller providers who don't have attorneys or legal supports need navigation and assistance for monitoring, investigations, administrative reviews, and other regulatory processes. SSCCs could be in the room during meetings with monitors and investigators to provide support, advocate, and ensure due process. When corrective action plans or heightened monitoring plans are in place, the SSCCs could help the provider access resources and options for meeting those plan requirements. More than one provider also suggested that there should be public relations campaigns to counter the negative views about providers and foster parents in the news. One provider also suggested inviting politicians to visit providers so that they have a firsthand view of what foster care is really like. Finally, the responses of many providers suggest that simple acts such as positive reinforcement, recognition, and acknowledgement of good stories and successes of providers, staff, and caregivers could increase feelings of partnership and collaboration.

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[15] TACFS offers trainings on Serious Incidents Reporting and Documentation for CPAs and GROs. These trainings cover some topics that SSCCs and providers may find relevant, such as suicide attempt vs. ideation and when psychiatric hospitalization is reportable, but they are not meant to be a comprehensive resource for a larger process of making reporting determinations.
[16] See, for example, this summary from Casey Family Programs: https://www.casey.org/a2a-unwarranted-reports/

The child welfare landscape is complex and shifting, and no single recommendation presents a fix for all of the issues identified by providers, but in total, these may present opportunities to make meaningful improvements in capacity, service quality, and ultimately, child outcomes.

Appendix A: CPA Provider Suggestions

Accurate information on child at placement

Outreach/recruitment to educate community about fostering

Consistent expectations and requirements across SSCCs

Consistent requirements across SSCCs

Praise/recognition for foster parents and staff

Better communication about processes and between departments

Gather info on child prior to placement

Allow foster parents to voice needs and concerns and speak in court

After hours crisis support for youth

Transportation for visits

Therapeutic services for foster families and youth

Training on DSM diagnoses for foster parents

An SSCC position for keeping providers off HM

Respite/babysitting

A way to disagree with an admin review outcome

Rewards for foster parents

Take provider's side in situations with DFPS

Transportation

SSCC staff more responsive, especially after hours

Better communication about SSCC requirements

Accurate common apps

Collaborative relationships

SSCCs understanding minimum standards

Moderator for problem resolution

Improved training on collaboration

Consistent requirements and rates across SSCCs

Transportation assistance

Better engagement to understand what the CPA can offer

Don't ignore CPAs that can't take Intense LOC kids

Therapeutic support and training

Advertising

Foster parent recognition

Promotion to CPUs

Provide home study contractors

PR campaigns to recruit foster parents and counter negative media from lawsuit; jointly all SSCCs

Hold recruitment activities

Non-judgmental operational feedback and support

Streamlined training requirements for kinship families

Bridge organizations that collaborate for recruitment and training

SSCCs and DFPS should have same guidelines, trainings, and requirements

Sharing best practices among providers

Fund CPAs based on number of homes, not number of children placed

Support families with camp, activities, clothing

Add level of care between basic and specialized

Work as a team, not adversarial

Listen to provider concerns

Resource lists of service providers

Help getting documentation from past providers

Allow foster parents more role in advocating for the child

Training for parents and staff that address challenging behaviors

Transportation that providers can pay into and share

More collaboration with kinship needs and licensing

Better communication between SSCC workers and CPA workers

Respite for foster families

Transportation

Therapy services

Emergency support services

SSCC staff available and answers calls and emails

Daycare funding

Psychiatry services

Invitations to ICM meetings

Trainings on evidence based practices

Training for staff

More consistency between SSCCs to comply with contracts

Collaboration between SSCCs and providers

Support kinship families through licensure

Communication in foster parent recruitment to set realistic expectations

Case mining to look for kinship and adoptive placements

Incentives for retention

Resources for rural families

Training support for foster families, in Spanish

Single set of SSCC requirements for providers

Coordinate with DFPS for fewer audits

Therapy, behavior support

Respite

Transportation for visits

Better communication

Understand services CPAs provide

Have hard conversations about kinship families that do not meet standards

Joint monitoring and processes

Grants for staff to help raise pay

Free trainings

Ongoing training related to orientation, SSCC requirements, and service provision

Provide paraprofessionals to support families

Align trainings across SSCCs

Collaboration between CPA staff and SSCC staff

Service plans less often

Transportation for visits

Professional development training

Consistent and clear guidelines from SSCCs

Timely and accurate information

Training employees on contract and licensing requirements

Recruitment job fairs

Training

SSCCs should take on some of the verification work

DFPS or SSCC workers could go to homes and support families instead of just the CPA

In home therapy

Easy access to psychiatric services, crisis intervention, family support

More therapy services

Training on appropriate discipline,
parenting skills, development

Advocate for CPAs and foster parents
at legislative level

Quality behavioral health services

Accurate communication before placement

Align trainings

Extra staff for in-home trauma focused plan

Respite care

Training on how to care for youth
with different diagnoses

Accurate information on kids needing placement

Respite options

Collaboration

Training for SSCC staff on trauma and standards

Open respite options with other agencies

Training for therapeutic families

Increased clinical staffing on higher level
of care children

Honest information during placement requests,
look at all history on behavior

Resources for foster parents – gas, transportation,
behavior specialists, childcare, recreation

Hands on training

Be on the same page with parents and providers

Respite homes for kids with challenging behavior

In home behavior specialists

In home coaching and training for foster and
kinship parents

Appendix B: GRO Provider Suggestions

More input from SSCC permanency specialists when youth are struggling

Accurate information in placement requests

Help with staff recruitment

Provide staff, therapists, nurses

Transportation

Clinical resources for RTC population

Fund activities for kids

PRN staff pool

Don't limit providers to certain geographical radius

Work collaboratively – HHSC, RCCL, DFPS

Training and support for staff

Free trainings

Trainings in formats that allow direct care staff to participate

Trainings

Better communication

Specialty therapy services

Move kids when they are ready

Use RTCs as treatment, not shelter

Help with grantwriting to expand

Provide all information on youth prior to placement

Support during crisis related to behaviors

Accurate information at placement

Better collaboration

Accurate and up to date documentation

Training

Point out differences in contracts

Advertising help

Hire attorneys and PR to respond to negative media

Trainings for police and communities

Correct information on placement applications

Override YFT to allow kids to remain in stable placements when LOC goes down

Transportation

Use shelters to keep kids in local community

Joint monitoring

Help finding community resources

Standardize SSCC requirements for auditing

Training available for all shifts

Provide therapists, medical specialists

Locate agencies providing mentoring for girls

Help for children with school problems

Clinical PRN pool

Advocate with HHSC and Star Health to speed process for clinicians who serve foster care

Training to encourage retention

Specialty providers – recreation, music, art

Mental health case management, life skills

Staff training on mental health and behavioral issues

More specialists and resources

Autism specialist

All information at referral

Help with regulatory issues

- Access to therapists

- Access to therapists, behavioral health, substance abuse

- Respite

- Training on EBPs

- Planned transitions

- Better communication and collaboration

- Training

- Resources for rural areas

- Every child in a program should be paid at the same rate rather than level system

- Assistance finding therapists

- Contracts with service providers when Medicaid doesn't have any

- Funding for extracurricular activities

- Therapy

- Allowing visits from important people in children's lives

- Staff training at facility or webinars

- SSCCs should be more familiar with providers' services; visit campus

- Thorough and accurate information in placement request

- Funnel staff to providers

- Reduce ratios

- Provide money for staff bonuses

- PRN staffing pools

- Marketing

- Training for staff retention

- Support services for agencies to address areas of need

- Professional training opportunities, including mental and behavioral health

- Reduce supervision ratios

- More training onsite

- Communicate effectively

- Free training

- Emergency PRN staff

- Help with regulatory pressure

- Job boards, job fairs, staff incentives

- Training for staff

- Respite

- Incentives

- Training

- In person training

- Onsite training on high needs children and mitigating risk of investigations

- Hiring fairs

- Universal form for documentation and reporting

- Additional emergency staffing

- Funnel potential staff to providers

- Groups for anger management, grief, drug counseling, skill building

- More support from SSCC case managers

- Move youth to RTC faster when violent or self-harmful

- Nursing staff, doctors, therapists for autism

- Free trainings

- More social activities in the summer

- Provide staff for 1:1 supervision

- Uniform contract requirements for all SSCCs

More recreation funding

More case manager involvement when disruption is a risk; use planning team

Better collaboration and communication when behaviors are affecting stability of placement

More professional training – mental and behavioral challenges

Communication and support from SSCC legal teams; less blaming, more understanding

Behavioral services and training

All information from the beginning

Help with regulatory oversight

Provide school advocate for kids

Crisis intervention training

More onsite support

Availability of SSCC team during crisis

All information included at the time of referral

Shorten discharge waiting times to replace inappropriate placements with better fits

More therapy providers, psychiatrists, onsite crisis assistance

Training in TBRI and other TIC methods

More staffings and assistance

More communication with permanency specialists

More accurate info on common application

Review documentation of child history when allegations are made

Support more restrictive school settings

Trainings

Access to RTC or psychiatric stabilization services