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TEXAS CENTER FOR CHILD AND FAMILY STUDIES

POST-ADOPTION SERVICES IN TEXAS:

A Research and Policy Overview

October 2025

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INTRODUCTION AND OVERVIEW

In recent decades, federal and state child welfare policies have increasingly prioritized and incentivized adoption as the desired permanency alternative for children in the foster care system who cannot be reunified with their parents. The promotion of adoption as a permanency option for all children in care opened a new pathway to permanency for children and youth who may have been previously overlooked for adoption due to older age or special needs. In fact, adoptions from foster care increased 35 percent in the five years after the passage of the Adoptions and Safe Families Act of 1996, which provided states with financial incentives for completed adoptions from foster care. This led to a higher proportion of older children and children with special needs among those adopted from foster care, which in turn led to higher rates of adoption breakdowns (Coakley & Berrick, 2008; Festinger, 2014; Reilly & Platz, 2004).[1]

Adoption breakdown is costly on many levels. Most importantly, it creates additional traumatic exposure and attachment disruption for children who are adopted from foster care and end up returning to care. This can have many downstream implications. It may reduce the likelihood that children will be adopted again, create difficulties finding appropriate placements after the return to care, and create mental and emotional challenges that can persist into adulthood (Coakley & Berrick, 2008; Orsi, 2015; Selwyn, Wijedasa, & Meakings, 2014).

Post-adoption services are meant to support durable adoptions of children from the foster care system to strengthen adoptive families and prevent adoption breakdowns. This report, prepared by the Texas Center for Child and Family Studies, a supporting arm of the Texas Alliance of Child and Family Services, documents findings from a review of research literature and existing post-adoption policies toward the goals of documenting the prevalence of adoption breakdown, common causes of adoption breakdown, best practices in post-adoption services, and the landscape of current post-adoption service provision in Texas. The report ends with recommendations for strategies to close gaps between current service provision policies and research-driven best practices.

PREVALENCE AND TIMING OF ADOPTION BREAKDOWN

The Texas Center for Child and Family Studies (The Center) requested data from the Texas Department of Family and Protective Services (DFPS) on return-to-care rates among all adoption exits from care between 2013 and 2024, broken out by relative and non-relative adoptions. The highlights are summarized below, and the full data set is displayed in a table in Appendix C.

5 YEARS By 5 years out from an adoption exit, **about 1%** of children have returned to care.

10 YEARS By 10 years out, **about 3%** of children have returned to care.

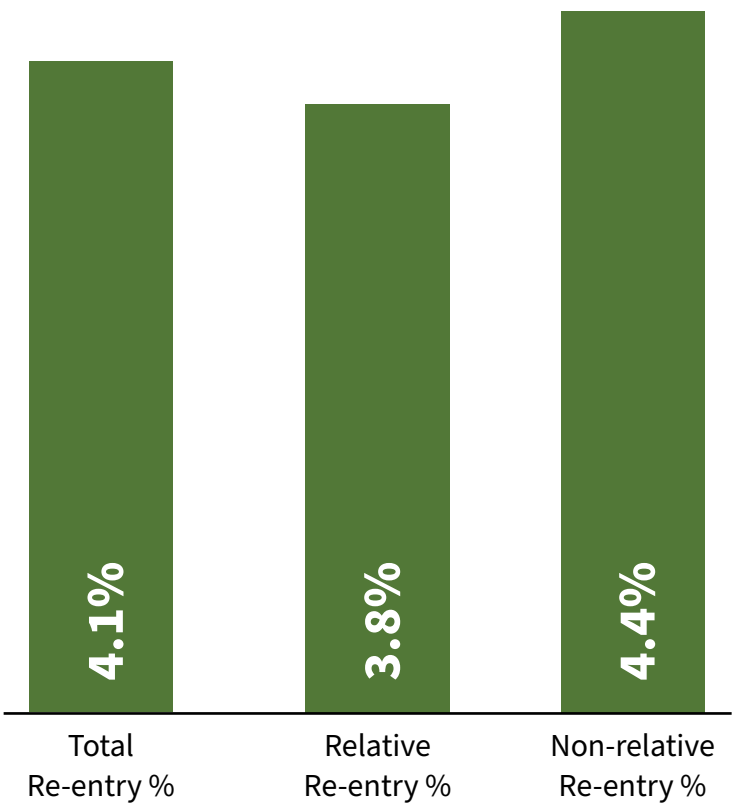
12 YEARS By 12 years out, **about 4%** have returned to care.

- For nearly every year included in the data, a higher percentage of non-relative adoptions have re-entered care compared to relative adoptions.
- For the exit years with the longest follow-up period, average time from adoption consummation to re-entry is around five years.
- After about five years from adoption finalization, the average child age at re-entry stays between 10 and 12 years. Children in non-relative adoptions re-enter care at a slightly older age on average.

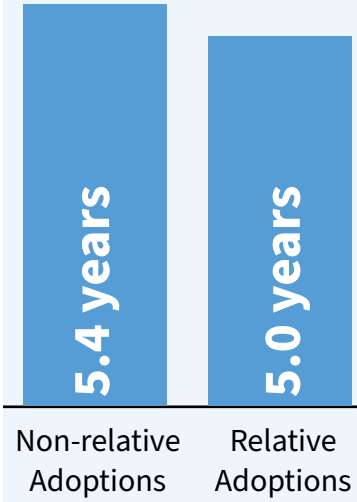
1 Note about terminology: The research literature on children who return to foster care after an adoption exit uses many terms, which can have slight but important differences in meanings. Terms for adoptions that do not last until adulthood include disruption, dissolution, discontinuity, failed adoptions, and breakdown, among others. We have chosen to use the term adoption breakdown to refer to finalized adoptions of children from foster care in which children later return to foster care.

The most reliable figures on post-adoption re-entries to care are related to the exit year with longest follow-up window (2013), as these children have had the most opportunity to re-enter. The following charts display DFPS re-entry data, focusing only on exit year 2013, with a 12 year follow-up period.

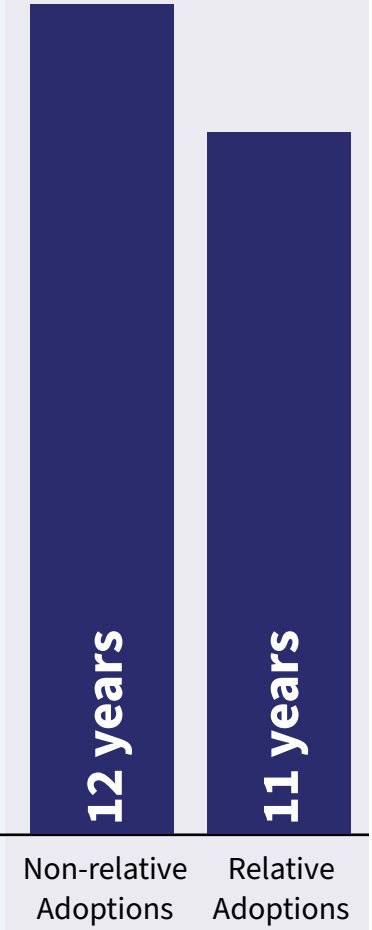
2013 Adoption Exits that Returned to Care by 2025



Average Time Between 2013 Adoption Exit and Return to Care



Average Age at Re-Entry to Care Among 2013 Adoption Exits



Research on the prevalence of re-entry following adoption from foster care can be challenging. In some cases, it can be difficult to identify whether children who enter care had a previous entry because they likely re-enter care under their adoptive last name, which may not be linked to prior records (Coakley & Berrick, 2008; Dellor & Freisthler, 2018; Palacios et al., 2019). Further, different studies on the prevalence of adoption breakdown may have different follow-up time periods, which makes comparing figures challenging. A final complicating factor in estimating adoption breakdown is that some studies take all adoptions into account, including international and private adoptions, without isolating adoptions from foster care.

Because of these issues, figures reflecting estimates of adoption breakdown vary considerably across prior research literature. Some estimates are stronger than others due to the use of stronger measurement methodology, and a focus specifically on adoptions from foster care. One of the more robust estimates comes from a 2018 study that examined a multi-year sample of more than 38,000 children adopted from foster care in Illinois and New Jersey, and that found that a total of five percent of adopted children re-entered care during the follow up window (minimum follow-up period was 5 years and average follow-up period was 8.8 years) (Rolock et al., 2018). A slightly older study on children in Illinois found that between one and two percent of children re-entered care within two years of adoption, four percent re-entered within five years, and 9-10 percent re-entered within ten years (Testa & Rolock, 2008). The figures from these two studies are both higher than the re-entry rates captured in DFPS

data reflecting Texas-specific adoption breakdowns, suggesting that Texas performs relatively well at placing children in stable adoptions.

A finding that is consistent across prior research studies as well as DFPS internal data is that, while adoption breakdowns can occur at any point after adoption, they most typically occur many years after the adoption is finalized. According to DFPS data, in the years with the longest follow-up period, the average time from adoption to breakdown is around 5 years. Rolock and colleagues (2018) similarly found that, depending on the state examined, the risk of re-entry is highest from 4 to 11 years after the adoption.

PREDICTORS OF ADOPTION BREAKDOWN

Toward the goal of stabilizing adoptions, it is necessary to understand the risk factors that research has shown increase the likelihood of an adoption breakdown, so that policymakers know where to target resources for preventing breakdowns. Risk factors for adoption breakdown are present at the child, family, and system levels. There are a handful of risk factors that are consistent across studies, while others are mixed or less consistent.[2]

Looking across the totality of the research literature, the strongest predictor of adoption breakdown is child age at the time of adoption (Coakley & Berrick, 2008; Faulkner et al., 2017; Palacios et al., 2019; Rolock & White, 2014; Rolock et al., 2018). The older a child is at the time of adoption, the higher the risk of adoption breakdown. According to one recent high-quality study, children adopted from foster care at age 3 or older were 128 percent more likely to return to care than children adopted from foster care under age 3 (Rolock et al, 2018). This is likely the result of the cumulative effects of traumatic exposure. For children who have experienced abuse or neglect, longer exposure to adversity may create attachment disturbances and trauma-related emotional and behavioral challenges that create strain in the context of an adoptive family (Palacios et al., 2019).

Another robust risk factor for adoption breakdown also related to the age of the child is when an adopted child is approaching adolescence (Coakley & Berrick, 2008; Faulkner et al., 2017; Lee et al., 2020; Palacios et al., 2019; Rolock & White, 2014[3]; Rolock et al., 2018 Waid & Alewine, 2018). Some studies have identified 13-14 specifically as the age when adoption breakdown is most likely (Palacios et al., 2019; Rolock & White, 2014) while others find more generally that the transition to adolescence is the critical developmental stage that creates adoption breakdown risk (Lee et al., 2020). According to researchers, the developmental changes that occur during adolescence can amplify behavioral, emotional, and attachment-related difficulties for children who experienced trauma and can place adoptions at risk of being destabilized. Challenging child behaviors at any age are a risk factor for adoption breakdown (Faulkner et al., 2017; Lee et al., 2020; Palacios et al., 2019, Testa et al., 2015), but entering adolescence appears to create conditions where those behaviors are most likely to disrupt the adoption.

Other child-level risk factors have also been identified with either less frequency or with mixed findings across the research literature:

The transition to adolescence is not the only developmental period that creates an increased risk of adoption breakdown. Other periods of developmental life changes, such as stressful family events, moves, or transitioning to school age, also create risk for re-entry to care (Dhami, Mandel, & Sothmann, 2007; Lee et al., 2020; Wind, Brooks, & Barth, 2007).

One study located in this review examined adoption breakdown among children with disabilities, finding that children with disabilities (defined as having intellectual disability, physical disability, vision or hearing disability, emotional disturbance, or another medical condition) who were adopted from foster care were 2.6 times more likely to re-enter care than children without disabilities (Slayter, 2016).

Findings on breakdown risk for adopted sibling groups are mixed (Faulkner et al., 2017; Festinger, 2014; Palacios et al., 2019). Some older research going back

2 Several researchers have undertaken literature reviews that are longer and more comprehensive than the review conducted for this report. See Coakley & Berrick, 2008; Faulkner et al., 2017; and Palacios et al., 2019 for longer and more in-depth summaries of the research literature on adoption breakdown.

3 Rolock and White (2014) also included children who exited care to permanent kin guardianship in their analysis alongside children formally adopted by relatives or non-relatives.

to the 1970s, as well as some international research, has shown that adoptions of sibling groups are more likely to disrupt than single child adoptions (Coakley & Berrick, 2008; Faulkner et al., 2017; Festinger, 2014; Palacios et al., 2019). A more recent study, however, found that being adopted with siblings decreases the likelihood of breakdown by 15 percent compared to adoptions of children without siblings (Rolock & White, 2016). Smith and colleagues (2006), examining adoptive placement disruption prior to adoption consummation, found that being placed with between one and three siblings increased the likelihood of the placement disrupting before the adoption occurred, while being placed with four or more siblings decreased the likelihood of the placement disrupting. Still others have found that siblings adopted together is not a relevant predictive factor in either direction (Dellor & Freisthler, 2018; Hegar, 2005).

The association between child demographics and adoption breakdown is also mixed among research studies. Some studies suggest that Black children may be at higher risk of re-entry to care after adoption. Rolock and White (2016) found that Black children were 39 percent more likely than White children to experience adoption breakdown among a large sample of more than 50,000 children adopted from foster care and followed for at least 10 years. In a later study from 2018, examining a sample of more than 38,000 children, the same researchers found that Black children were 30 percent more likely than White children to return to care after adoption. Smith and colleagues (2006) found that, compared to Black children, White children were 35 less likely and Hispanic children were 12 percent less likely to have their adoptive placement disrupt before the adoption occurred among a sample of more than 15,000 children adopted from foster care in Illinois. In a less robust study with a much smaller sample (N=99), Berry et al. (2007), also found that White children were more likely than Black children to be in intact adoptions at 6 months and 12 months post adoption. Other older studies, however, have found no association between race and adoption breakdown (Faulkner et al., 2016). Examinations of child gender and adoption breakdown have also produced mixed findings, with some studies showing boys more likely, some studies showing girls more likely, and other studies showing no difference (Faulkner et al., 2016; Palacios et al., 2019).

Some, but not all, studies have found that children's experiences while in care, including placements and time spent in care, may correlate with differential risk of breakdown. Rolock and colleagues (2016) found that each additional placement while in foster care was associated with a 15 percent increase in the likelihood of adoption breakdown, but having at least one congregate placement while in care was not related to breakdown risk. Other studies have found that placement changes while in care create from 5 percent (Rolock & White, 2016) to 51 percent (Dellor and Freisthler, 2018) increases in likelihood of subsequent breakdown of the adoption in their respective samples. Time spent in care prior to adoption is more mixed as a predictor of breakdown across the literature. Smith et al. (2006) found a small but statistically significant decrease in the risk of an adoptive placement breaking down prior to adoption for each additional year spent in care. Similarly, Rolock and White (2016) found that children who spent three or more years in care prior to adoption were 14 percent less likely to later return to care than children who spent less than three years in care. These findings may reflect that additional preparation time increases family stability prior to adoption finalization. Conversely, Rolock et al. (2018) did not find that time in care prior to adoption had any relationship with later adoption breakdown.

Looking across the literature, the child-level factors discussed above have the strongest association with adoption breakdown risk. But there are also less robust risk factors for re-entry to care after adoption at the caregiver and systems levels. These findings have been less examined in prior research so they should be viewed with more caution as to whether they represent durable predictors of adoption breakdown:

Dellor and Freisthler (2018) found that several aspects of children's reasons for entering foster care were associated with their risk of adoption breakdown. Specifically, children who entered care due physical abuse (rather than neglect), drug use in the home, or parental relinquishment or incarceration were more likely to return to care after adoption. These researchers also found that the adoptive family's prior child welfare system involvement increased the odds of adoption breakdown.

Though this finding is not consistent among all prior research, some studies have found that relative adoptions are less likely to breakdown than non-relative adoptions (Dellor & Freisthler, 2018; Smith et al., 2006; Testa et al., 2015). This appears to hold true not just for family members, but for other adoptive parents who had a stable, longer-term relationship with the child prior to adoption, including fictive kin or foster parents (Faulkner et al., 2016). These findings are consistent with DFPS data discussed above, which shows that non-relative adoptions are more likely to result in re-entries than relative adoptions.

Several studies and reviews of adoption breakdown literature have identified unrealistic expectations among adoptive parents as a risk factor for adoption breakdown (Coakley & Berrick, 2008; Faulkner et al., 2016; Palacios et al., 2019). In some instances, unrealistic adoptive parent expectations may be related to receiving insufficient information and/or preparation for the adoption by child welfare organizations. Relatedly, adoptions may be more likely to break down when adoptive parents have lower commitment to the adoption, have thoughts of ending the adoption, or are primarily motivated to adopt in order meet their own needs (Coakley & Berrick, 2008; Faulkner et al., 2016; Testa et al., 2015).

POST-ADOPTION SERVICES IN TEXAS

With a contextual understanding of child and family factors that may increase the likelihood of adoption breakdown, this section summarizes the post-adoption services currently offered in Texas to families who adopt children from foster care.[4]

OVERVIEW OF CURRENT POST ADOPT SERVICES IN TEXAS

Texas provides a range of financial and supportive services to promote adoption, particularly for children adopted from the state's child welfare system. Per state and federal policy, adoptive families may receive monthly subsidies, Medicaid coverage, and up to $1,200 per child to reimburse non-recurring adoption-related expenses such as legal and court fees.

Contracted post-adoption services complement but are distinct from these benefits. They serve as the state's only dedicated and state-funded support system focused on helping families navigate the complex and lasting impacts of trauma and loss experienced by children adopted from the Texas child welfare system. According to DFPS, these services aim to stabilize adoptive placements, reduce placements in residential treatment centers (RTCs), and prevent re-entry into the child welfare system by:

- Assisting families in adjusting to adoption
- Addressing histories of abuse or neglect
- Managing any mental health needs child may have
- Preventing permanent or long-term removal from the home

CORE SERVICES AND ELIGIBILITY

Post adoption core service categories include information and referral, case management, 24/7 crisis intervention, counseling (family, individual, or group, including diagnosis/assessment), respite care, parent training, support groups, therapeutic camps, day treatment, and residential treatment when necessary. Additional services outside of these categories may be approved by DFPS by request.

To be eligible for post-adoption services, the adoption must be finalized, the child must have been placed by Texas DFPS or a licensed Texas child-placing agency with DFPS providing Title IV-E assistance, the family must request services, and the child must be under 18 (services may continue up to 90 days past the 18th birthday). Residency in Texas is not required at the time of the service request.

POST-ADOPTION SERVICES SUMMARY

The table below summarizes post-adoption service categories, detailing service types, activities, eligibility, utilization limits, and other key information. The information in this table is based on DFPS scopes of work and contractual requirements, not the services as actually delivered by providers. In practice, providers may primarily make referrals or provide financial support rather than directly delivering all listed services, and service availability may vary by agency.

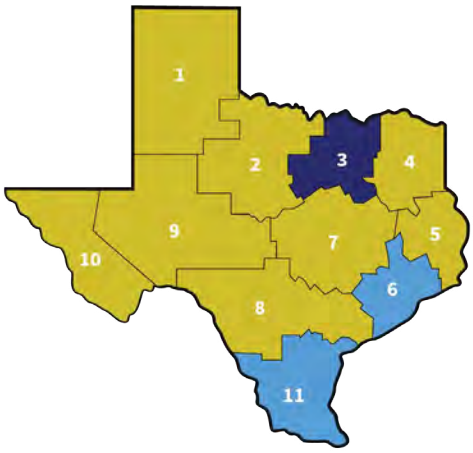
4 Sources of information used in this section include: DFPS 2020 Request for Proposals for Child Protective Post Adoption Services (RFP No. HHS0007514); DFPS 2022 RFP Scope of Work Amendment N502 FORM-9077, Contract Amendment No. 7; DFPS 2020 Post Adoption Invoicing Procedures: Child Protective Services- Purchased Client Services (K909-Form 5500PA); DFPS Policy Handbook sections 6900, 6960, 8000, and 8400, DFPS Adoption Assistance web page; DFPS Adoption Support web page; Texas Family Code §162.306, Texas Administrative Code §700.1728

Post-Adoption Services At-a-Glance

Service	Key Activities	Who's Eligible	Maximum Units	Additional Information
Case Management & Service Planning	Determine eligibility, assess needs, create/update service plans, make referrals, arrange service supports, maintain records.	Parents, adopted child, siblings <18	60 hours every 6 months	Service plans are reviewed every 6 months; services continue as long as family/ child remains eligible.
24/7 Crisis Intervention	24/7 telephone support available via after-hours number, including risk assessment and face-to-face follow-up as needed.	Parents, adopted child, siblings <18	N/A	CPS notified within 3 business days of crisis contact, out-of-state service provided via phone only.
Family Counseling	Session with 2+ family members to address adoption-related, trauma, or disability issues.	Parents, adopted child, siblings <18	12 hours every 6 months	Services must be provided by a licensed clinician.
Group Counseling	Group sessions (2+ unrelated participants); topics such as attachment, anger, domestic violence.	Parents, adopted child, siblings <18	Varies	Services must be provided by a licensed clinician.
Individual Counseling	One-on-one therapy to meet treatment goals.	Parents, adopted child, siblings <18	12 hours every 6 months	Services must be provided by a licensed clinician.
Diagnosis & Assessment	Psychological, psychiatric, developmental evaluations.	Adopted child only	12 hours every 6 months	Only allowed if school services are unavailable (unless for RTC review).
Parent Training	Education on child development, communication, behavior, & adoption issues.	Adults in adoptive family; other interested individuals if space	N/A	No service plan required to participate.
Support Groups	Peer support for adoption or special needs.	Adoptive/prospective adoptive family; other interested individuals if space	N/A	No service plan required to participate.
Therapeutic Camps	Day or residential camps to build skills, self-esteem, or talents.	Adopted child only	6 weeks max	Must be licensed or pre-approved (by state) camp.
Respite Care	Short-term in-/out-of-home care to relieve stress & maintain family functioning.	Child with special needs, must have active service plan	no more than 5 consecutive 24-hour periods per occurrence	No relative reimbursement unless approved; $50/day max; documentation of need required to repeat services monthly; ≤10% of total post-adopt budget.
Day Treatment	Short-term intensive therapy (≥4 hours a day) in licensed setting.	Adopted child only	Up to 2 weeks	For emotional, behavioral, or substance use needs.
Residential Treatment	Specialized care in licensed residential, foster, or hospital setting; reunification goal ≤12 months	Adopted child only, must be planning to return home and ineligible for state hospital or supported living care	12 months max	≥20% of entire allocated post adopt budget must be reserved for RTC services
Other Services	DFPS may approve services outside the above listed categories	Varies	Varies	Written request and Regional Liaison approval required.

DELIVERY MODEL AND PROVIDERS

Post-adoption services in Texas are administered by the DFPS through regional contracts with licensed child placing agencies or other social service providers. While DFPS retains authority to deliver services directly, in the current contract cycle, three providers are responsible for service delivery across the 11 DFPS regions:



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Arms Wide Adoption Services

Contracts are initially awarded for a five-year term and may be extended up to 18 months to ensure service continuity. Contractors are required to provide services in or near the family's community, conduct regional needs assessments, address service gaps, engage in continuous outreach, and coordinate with community partners.

REFERRAL AND ACCESS

DFPS and SSCC caseworkers do not authorize post-adoption services but are responsible for referring families to the appropriate regional contractor by providing contact information. Families are informed about the availability of post-adoption services during the adoption finalization process and are required to sign a written acknowledgment of receiving this information.

Families are generally expected to initiate contact with providers but may authorize DFPS to share their contact information with their regional provider in some instances. Licensed Child Placing Agencies (CPAs) are also contractually required to inform adoptive families about post-adoption support.

Once contacted, post-adoption contractors are responsible for:

- Conducting outreach and accepting referrals
- Providing application packets
- Verifying eligibility
- Conducting written intake assessments
- Authorizing services
- Developing individualized service plans
- Ongoing Case management/Support

Initial service planning requires a face-to-face meeting (exceptions must be approved by DFPS), and services must begin within 14 days of plan development. Services are typically authorized in six-month increments and may be extended based on ongoing needs.

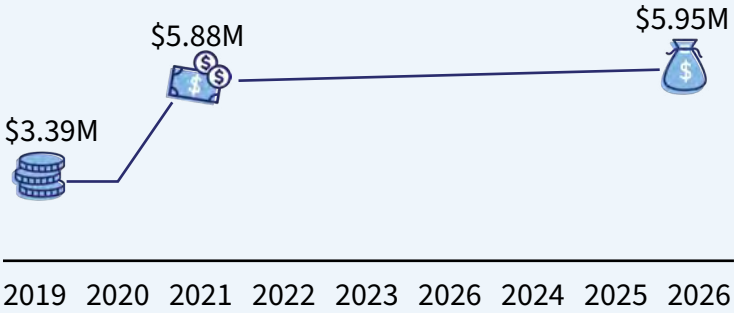
SPENDING

Post Adopt and Post Permanency services in Texas are funded through a combination of:

- State General Revenue
- Federal Title IV-B, Part 2 funds (administered through Promoting Safe and Stable Families program)

The Texas Center for Child and Family Studies collected and aggregated budget data from the three contracted post-adoption providers for FY 2019–FY 2026. Prior to 2021, annual allocation for contracted post adoption services statewide was around 3.39 million dollars total. In 2020, DFPS petitioned the Legislature for additional funding after consistently exceeding its appropriation. Beginning in FY 2021, allocations increased to about $5.8–$5.9 million, where they have remained level through FY 2026.

Total Allocated Funding for Contracted Post Adopt Services 2019-2026



DFPS allocates post-adoption funds to various regional areas based on the average number of adoptions consummated in each region. Contracts operate on a cost-reimbursement basis, with no guaranteed referrals or fixed compensation. Agencies are required to reserve at least 20 percent of their total budget for residential treatment center (RTC) placements, and to limit respite care expenditures to 10 percent of the total budget.

HEART GALLERIES OF TEXAS POST-PERMANENCY GRANTS

The Heart Galleries of Texas (HGTX) is a statewide initiative launched with support from the 88th Texas Legislature. HGTX serves as a statewide hub focused on ensuring children find permanency, and that children and families touched by adoption and permanency have access to ongoing support. HGTX has three main strategies to achieve this:

- Engaging statewide Heart Galleries to display photo exhibits that highlight the stories and voices of children awaiting adoption and promote community awareness and involvement,
- Strengthening post-adoption and post-permanency supports for families throughout the state, by providing families with resources and connections to reduce disruptions, and
- Providing training and technical assistance to local Heart Galleries, as well as caregivers and professionals, equipping them with tools and education to build capacity and effectively support families' needs.

In 2024, HGTX conducted a statewide survey of caregivers and professionals (discussed in the next section) and used the findings to inform efforts to provide grants to providers for supplemental post-adoption and post-permanency services to align with the unique needs of local communities.

During FY 2024-2025, HGTX distributed $3.4 million in legislatively appropriated funding to expand statewide post-adoption/post-permanency services through a grantmaking process. HGTX released a Request for Applications to community services providers, which resulted in grants to a total of 42 providers who serve adoptive families, with the intent of helping adoptive families thrive and reducing the number of children returning to care. Services funded through HGTX grants include caregiver, parent, and teen support groups; family camps; individual, family, and sibling counseling; EMDR therapy; respite care; legal services; parent training (including Trust-Based Relational Intervention); educational support; medication management; psychoeducation; virtual intensive outpatient programs; mentoring; and tutoring.

STATEWIDE NEEDS ASSESSMENT ON POST-PERMANENCY SERVICES

In March 2024, HGTX partnered with the Texas Institute for Child and Family Wellbeing at the University of Texas at Austin and the Texas Center for Child and Family Studies to conduct a comprehensive community needs assessment on service gaps in post-permanency[5] supports. The needs assessment surveyed 388 caregivers and 175 service providers[6] across all 11 DFPS regions, focusing on levels of service awareness, access, utilization, unmet needs, and training priorities. This section discusses some of the key findings from the survey.[7]

Caregiver respondents were primarily experienced foster parents, with 69 percent reporting that they had been parenting for five or more years. Among service provider respondents, more than three quarters worked directly with families and most had extensive child welfare experience, with 66 percent reporting over a decade of service. Providers represented professionals from a diverse set of organizations, including child placing agencies, post-adoption service providers, DFPS, Single Source Continuum Contractors, schools, shelters, and mental health providers.

AWARENESS OF SERVICES

The survey revealed substantial gaps in awareness of post-permanency services among both caregivers and providers. Less than half of both groups (42% of caregivers and 38% of providers) indicated that they were "very or extremely familiar" with post-adoption supports in their region. Even more striking, 42 percent of caregivers and 62 percent of professionals could not correctly identify their region's contracted post-adoption services provider. In several regions, more respondents could name the provider than were familiar with the services they offered, highlighting a disconnect between name recognition and functional understanding of available support.

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Among caregivers who were at least somewhat familiar with services, sources of information varied. DFPS/CPS (36%), child placing agencies (28%) and post-adoption services providers (28%) were the most common sources for information about post-permanency services. Peer-to-peer networks also played a key role, with 27 percent of caregivers reporting they were made aware of services by another adoptive parent or caregiver. Fewer respondents cited social media, online searches, or informal community referrals. Importantly, there were caregivers in every region who reported not knowing where to go for support or being unaware that support services were available to families formed through adoption or conservatorship, underscoring the need for expanded and consistent outreach efforts.

5 The needs assessment examined post-permanency services, which includes families in which relatives have permanent custody in addition to adoptive families.

6 In the context of these assessment findings, "service provider" refers broadly to child and family-serving professionals working in agencies providing direct services, rather than narrowly referring to one of the three contracted providers of post-adoption services discussed in the section above.

7 The findings summarized here were sourced from a publicly available online dashboard of the survey findings, which can be found here. The survey findings were also previously summarized in the Heart Galleries of Texas Annual Report, which can be found here.

SERVICE USE AND SATISFACTION

Despite fairly low levels of awareness about available services, caregiver satisfaction with post-adoption services is high once families engage with a provider. Among the 53 percent of caregivers who reported accessing post-permanency services, two-thirds indicated they were "very or extremely satisfied" with the support they received, and more than three-quarters said they would seek services again in the future.

Mental health services emerged as the top area of dissatisfaction in every region, with over 60 percent of caregivers expressing dissatisfaction. Other commonly cited areas of dissatisfaction in many regions include respite care and childcare services. Satisfaction levels were generally highest for medical, developmental, and school-based services, though regional variation suggests differences in access, quality, or alignment with family needs.

BARRIERS TO SERVICE ACCESS

When providers were asked how often post-permanency needs were being met in their region, many reported service gaps. Only about a third (36%) said these needs were met "most of the time" or "all of the time." For specific populations, such as families of color, kinship caregivers, or youth with large sibling groups, no group had more than 42 percent of providers who believed the needs of that group were consistently met.

Caregivers were also asked to rate how easy or difficult it was to access services across sectors. Medical services were generally considered the easiest to access, while mental health care was consistently rated as the most difficult, followed by respite care.

Open-ended responses to the survey revealed several consistent barriers across the state. The most frequently cited was the lack of trauma-informed and adoption-competent mental health services (including individual therapy, family therapy, and residential treatment) with strong calls for these services to be covered by Medicaid or other insurance. As several caregivers emphasized:

"We need more psychologists, counselors and behavioral therapists within our area that do not have a 3-plus month wait for services for children who are on Medicaid." - Caregiver, Region 4

"More in-home training and support, more adoption-competent providers (especially ones who accept Medicaid)." - Caregiver, Region 8

Caregivers also stressed the need for respite care, childcare, and therapeutic camps, particularly for children with complex trauma histories. Many described these supports as unavailable or inaccessible in their communities:

"Childcare for children with special needs/ trauma behaviors and respite. Both have been nonexistent." - Caregiver, Region 9

"The waitlist for respite is like 2 years? But every time I've tried to get respite, there have been no respite providers in the area willing or able to take her." - Caregiver, Region 9

Funding was another common concern: caregivers cited the need for financial support for services across medical/mental health, educational, respite, and other supports, while providers pointed to the need for increased funding to expand post-adoption service capacity. As one provider put it:

"More providers, less red tape, more funding to support families for what they actually need, not what the state decides they might need." - Provider, Region 7

Lastly, both caregivers and providers identified a persistent information gap. This lack of clear, accessible information for caregivers seeking services or for providers seeking to refer families continues to limit families' ability to find and benefit from the resources they need. As one caregiver explained:

"It would be great to receive occasional information about what's available in the area or even a letter asking how or if help is needed and a number to call that actually goes to a person." - Caregiver, Region 7

A provider echoed this need, sharing:

"Sometimes families are not aware of the services. Sometimes support is just knowing the parent has someone to call and ask for help in the sense of brainstorming, listening, referrals, etc." – Provider, Region 11

TRAINING ACCESS AND UTILIZATION

When caregivers were asked about their use of training related to adoption or caregiving, more than 21 percent reported being unaware of available training opportunities or believed no such training existed in their area. Still, nearly half percent of caregivers used training occasionally or frequently.

When asked about helpful training topics, around half of caregivers reported interest in trauma-informed topics (like brain development, understanding child behavior, and helping children process their stories) as well as practical subjects (such as navigating Medicaid). About one-third were interested in parenting teens and supporting youth transitioning to adulthood. More specialized topics, such as parenting LGBTQIA+ children, youth who've experienced trafficking, and expectant teens, received lower interest.

When asked about their participation in training related to adoption and permanency, 16 percent of provider respondents had never attended post-permanency training, and more than a third (38%) reported being not at all or only slightly satisfied with the training they had received. Top provider-identified training needs included the unique challenges of working with adoptive or conservatorship families (79%), supporting families in crisis (77%), and engaging kinship caregivers (74%).

TEXAS POST-ADOPTION SERVICE PROVIDER FOCUS GROUPS

In June 2025, the Texas Center for Child and Family Studies held focus groups with program leaders from the three agencies currently contracted to provide post-adoption services in Texas. The most prominent themes that emerged from the focus groups are presented below.[8]

Theme 1: Inadequate funding resources and contract rigidity result in denial of needed services for families.

There are not sufficient funds in providers' budgets to meet the demand for all requested post-adoption services, in particular for the most requested services - therapy sessions and respite care. Therapy is sometimes rationed or denied when providers have to decide whether to serve a smaller number of families with more sessions, or to serve more families with fewer sessions. This means that sometimes therapy is not available at all or is insufficient to meet families' acute needs. As one provider stated about having to limit therapy sessions:

> *"That has an impact on the family's ability to heal. If they are really needing more therapy, but we're only able to support them by paying for two sessions, and they need four or five, then it's going to impact their ability to be strengthened, to be preserved, and it's not meeting the therapeutic need."*

> *"This year, we've had to cut off funding for kids that need continued treatment because we've expended that budget and we can't move things around because there's no more."*

The contract limits on respite care expenditures also lead to denial of these services for families who request them. Providers are capped at ten percent of their total budget for respite care services, which does not meet demand. Further, contract changes in recent years have narrowed the eligibility for respite care to children with "special needs," and there are restrictions on the number of days these services can be provided to families who do meet the eligibility criteria. Providers see respite care as a critical service, and they feel that state leaders may not fully appreciate the necessity of respite care in preserving adoptions for some families. Some of their comments included:

> *"Our purpose, our mission is to prevent recidivism and to prevent kids from going back into the system or being in out-of-home care, and respite is one of the things that we can do to meet that goal, but it's so restricted. It doesn't make sense to me as to why there is a limit put on it when it's such a vital piece of our contract."*

8 In this section, "provider(s)" refers specifically to the three organizations contracted with the state to provide post-adoption services. Passages in italics reflect direct quotes from the representatives from the three provider organizations that took part in focus groups and/or interviews. See Appendix B for information on the focus group and interview methodology.

"There's a disconnect of how we view respite versus how maybe contracts or other people view respite and the need for respite and the importance of respite."

"The funding [for respite] is so small… A lot of our families that desperately need respite cannot afford to get it still with the small amount that we can help with."

Contract inflexibility can also pose problems for delivering adequate services to strengthen and preserve adoptive families. Families that are in immediate need sometimes have to wait weeks for state approvals for services that fall into the "other services" category[9], which require the state's pre-approval on a case-by-case basis. As one provider put it:

"You have to go through this process of requesting to the state and waiting for them to get back to us to say yes. These families need the stuff. They need it now. They don't need it three weeks from now when we're able to get an answer after we've submitted a request."

One provider has experienced multiple instances where a service in the "other" category is approved by the post-adoption liaison (DFPS or the SSCC), so the provider pays for the service, but when they submit the expense for reimbursement, the state's contract manager disagrees with the approval and denies reimbursement for it. When this occurs, the provider must cover the cost of the service that was already paid for. Approval patterns can also be inconsistent based on the specific person in the approver role.

Providers also struggle with the inability to move funding between service categories without state approval. In general, providers expressed a feeling that they are professionals on the ground working directly with these families, and they should have the latitude to make budget adjustments without waiting for bureaucratic approvals that can take weeks or even months. In their own words, providers described their perspectives:

"Allow us the flexibility and the authority to manage the budgets in the way that we need to manage them to provide the services that families need and not have to get all of these extra approvals to do those things."

"The post-adopt contract is restrictive and doesn't take into consideration the unique needs of each child and family – but tries to put them in a box that is easily audited and billable for the state."

"Just allow us to create some flexibility in the contract and not prescribe the amount that we are to provide for each service. We know that these are the services that are provided in post-adoption. Let us make those determinations based on family needs."

The allocation of funding to providers based on geographical location also creates disparities in service receipt based on where families live. A family who lives on one side of a regional boundary could get a service that a neighbor on the other side of that boundary cannot get if the available funding in that area has already been depleted.

9 Examples given of services that might fall into the "other" category include medication monitoring, educational support, or specialized therapeutic modalities like art, equine, or music therapy.

Theme 2: The 20 percent mandated budget reserve for residential treatment center (RTC) services is not aligned with needs on the ground and prevents providers from paying for other needed services.

A major pain point for providers is the amount of money that must be earmarked for RTC services, without flexibility to move it to other service categories if it is not getting used. Post-adoption service provider contracts require that providers reserve 20 percent of their total budget (not just 20 percent of their pass-through amounts) to pay for residential care. Provider personnel who participated in interviews and focus groups universally found this amount to be too high, especially given that it cannot be moved to other categories where demand for services is higher. In fact, when asked what they would change about post-adopt service contracts if they could, all three providers said that they would change the 20 percent RTC budget requirement.

All of the providers reported that they have lapsed funding in this category at some point because they have not been able to spend it, whether due to lack of demand from families, lack of youth meeting criteria for an RTC placement, or lack of available placements for families who request residential services and meet eligibility. Further, the fact that they have lapsed funding back to the state from the RTC category has been used as justification for denying budget increases.

After paying for overhead such as staffing and administration, providers only have about 40-45 percent of their total budget left for pass-through for concrete services for families. At 20 percent of the total budget, the RTC reserve amount represents around half of all the funding providers have to pay for the services that families need.

> *"Our contract states that we have to keep 20 percent in our RTC budget. We only have one youth currently in RTC. That youth is not going to eat up that whole 20 percent. That means we're going to have money remaining in that budget line that we could have actually used in therapy or respite. Unfortunately, because the contract states we have to keep 20 percent in that budget line, that money's just going to sit there."*

> *"If we're going to keep that category at 20 percent, let's really increase the other ones. Because if our goal is to keep the families together and keep a child in the home, we don't have the funding to do those wraparound services. We don't have the funding to really provide those services. If that's our true goal, why is a majority of our budget on getting one kid in an RTC?"*

> *"Last year we had to cancel families that were in counseling, but we had thousands of dollars in RTC that we couldn't move over. We had families not getting services because this other amount was untouchable."*

Providers are not even sure that RTC funding for adoptive families should be under their purview. If RTC service provision was moved elsewhere, such as under LMHAs or in the YES Waiver program, it would free up post-adoption service budgets for funding services that can stabilize families further upstream, before there is a crisis. One provider put it this way:

> *"My preference, in a perfect world, is that RTC would be handled completely outside of post-adoption. We could focus on preventative services because we can move the money around and meet the needs of more families."*

Theme 3: Often families get connected to services when they are already in a crisis, and often many years after the adoption

One of the most common referral pathways to post-adoption services is when an adoptive family is in a crisis that is threatening the ability for the child to remain in the home, often when there is an open Child Protective Investigations case and there are limited options for what providers can do. Consistent with the research literature on adoption breakdown, providers often see these crises arise many years after the adoption, when children are at or approaching adolescence. Some comments from providers include:

> *"[Adoptive parents] are thinking they can handle it on their own, and then they get to that crisis moment where we have this teenager, where I adopted this kid at 4 or 5 and this was like the perfect prince or princess, and now they're a teenager, and it's like, 'Okay, now I need help.'"*

> *"By the time we get those families, when they're at Family Team Meetings, they're in major crisis. The goal is for us to get these families as early as possible."*

> *"I do feel that if we were able to have contact with their family prior to [crisis], where they're just at their wits' end, it probably could have helped preserve the family. I think that's ultimately what we're trying to do is bridge that gap, to see how we can make contact with the family sooner before they're in crisis mode."*

Post-adoption providers feel that their role is to prevent a crisis that may lead to adoption breakdown; their case managers are less equipped to provide crisis intervention. If families were connected to supports earlier, providers might be able to prevent some of the crisis situations, but there is a paradox with earlier referrals. While providers want to be involved earlier to catch families further upstream, they already do not have adequate funding to provide services to everyone. Earlier and better outreach could reach more families sooner, but this would mean higher caseloads that further stretch their already inadequate budgets to pay for services. In other words, connecting with more families sooner would mean even fewer resources to allocate among families who need them. Providers summed it up like this:

"There is also the concern that while we would like more referrals and families to open for post-adopt services, our budget is not sufficient to meet the needs of more families than we currently serve. We would like to have a more robust outreach program to ensure all families that qualified for post-adopt services knew about our program, however that would stretch the budget so thin we would not be able to accommodate the number of families open and needing assistance."

"I love getting the word out. I love enrolling new families. Our budget is stretched so thin. The more families that join, the fewer dollars we have per family. That's the catch-22."

Another motivation for earlier outreach is that, if a newly adoptive family doesn't connect with a provider early on, they may not know who to call by the time crisis arises years later. As one provider put it:

"Once they get past that consummation, we're reliant on community stakeholders [for referrals], or another investigation coming in, and families being at that point where it's tough."

In recent years, the state has started sending two of the three providers lists of families with recently consummated adoptions when families consent to have their contact information shared. This allows those providers to reach out to try and connect families to services sooner, but there is inconsistency in the frequency of this practice among the two providers who do receive a list, and one of the providers has never gotten a list of consummated adoptions.

Providers feel that families are not always receiving adequate information about post-adoption services at the time of the adoption, and child placing agencies in particular could be doing a better job making sure families understand that there are resources available to them and that they know who to contact to access them. One provider summed it up this way:

"Their likelihood of learning about post-adoption services at that point [after the adoption is finalized] is depending on word of mouth, attending an adoption support group that knows about it, or when they are seeking resources to help when in crisis down the road."

Theme 4: There are barriers other than funding that keep families from consistently getting the services they need.

There are barriers other than funding constraints for families. One is that post-adopt services are reimbursement-based, which means that even when there is funding available to pay for a service, a family must pay out of pocket and wait several months for reimbursement. This is a barrier for families with limited resources to pay out of pocket. One provider stated:

"Families can't pay $150 or $200 to see a therapist every week and then wait for reimbursement, a partial reimbursement, a month later. That's just not an option for many of our families. Then they don't get the services, which is detrimental."

Some of the post-adoption providers articulated a wish that their budgets could include funding to hire their own staff clinicians to be able to provide direct clinical services to families experiencing acute needs. Since the funding for therapy services is so limited and cannot cover all the demand, having staff clinicians would allow them to bridge the gap and do more intensive work with families experiencing crises that threaten to disrupt the adoption. To achieve this goal, however, they would need much more funding, as these providers articulated:

"I would love to have a staff full of case managers, but then also hire licensed therapists. The families that need more intensive intervention could be assigned a therapist that would oversee their therapeutic part, the mental and behavioral health part of their services. We can't get a therapist on staff for $40,000. That's what we pay our case managers, because that's what the budget allows. You really only get entry-level case managers at the salary that we can offer."

"If we had the money to spend, the sky was the limit, we would have case management staff and clinical staff that could work in tandem with the family, especially the higher need families. The therapists don't want to handle the case management aspect. Case management aren't qualified to handle the therapy aspect. That would be my ideal post-adoption program."

Other barriers include communication with families without email addresses and with families who speak a language other than English. Further, some families only reach out because they want RTC treatment, and if that's not available (due to lack of available placements or lack of eligibility), they don't follow up for other services. Other times, families are ready to be done with DFPS after the adoption, and they do not understand that post-adoption service providers are not part of DFPS, so they decline services. They're afraid that workers will be in their homes, looking for compliance issues or conducting oversight.

BEST PRACTICES FOR POST-ADOPTION SERVICES

LITERATURE REVIEW OF SERVICE NEEDS AND BEST PRACTICES

This section summarizes the results of a review of the limited research literature on best practices in post-adoption services. In 2007, Berry and colleagues stated that there was "a general lack of research regarding the prevalence or effectiveness of post-adoption services" (p. 44). The same year, Dhami and Mandel noted the "limited research on the effectiveness of post-adoption services" (p. 164). A scan of research conducted over the past 20 years suggest that this is still true. Nonetheless, researchers have developed some insights and understanding of components of these services that constitute best practices.

Research suggests that services should be offered preventatively, and when service resources must be allocated, providers should give preference to those with known risk factors for breakdown. As Rolock and White (2017) stated: "There is a need for these services to be offered preventatively because services offered when the family is at the point of crisis may be too late. Furthermore, scarce state and federal dollars to address the needs of these families suggest the need for targeted prevention efforts for those most at risk for post-permanency discontinuity" (p.426).

Best practices for preventing adoption breakdown start before the adoption is finalized. Foster care agencies should develop comprehensive, standardized methods for matching and assessing the fit of the child and family prior to adoption consummation to avoid placing children in adoptions likely to break down (Palacios et al., 2019). Adoptive parents also need better preparation to understand true needs of the child and the unique complexities of adoption adjustment. Wind and colleagues (2007) suggest that better pre-adoption preparation may even increase future service utilization, stating, ""We propose that parent knowledge of their child's at-risk history and behavioral difficulties likely enhances parent understanding of past events and creates and expectation of the need for services."

Since research indicates that post-adoption service needs increase, not decrease, over time, help must be available and accessible in the moment it is needed, even many years after the adoption (Berry et al., 2007; Lee et al, 2020; National Center for Enhanced Post-Adoption Support, 2025; Waid & Alewine, 2018; Wind et al., 2007). Palacios and colleagues (2019) emphasized the clear research finding that children adopted after toddlerhood are at much higher likelihood for experiencing adoption breakdown than children adopted as infants and suggested that post-adoption services are especially critical for these children. They also stress that post-adoption service must include clinical care provided by those with specialized expertise in adoption and the needs of adoptive children and families.

To achieve the goal of reaching families when service needs arise, service agencies must increase the visibility of available services. Parents must know that they are entitled to services, and how to access them. To be effective, this must go beyond verbal information at time of the adoption, using information dissemination methods such as the internet, libraries, or medical providers, in addition to adoption agencies (Dhami, Mandel, & Sothmann, 2007).

NATIONAL CENTER FOR ENHANCED POST-ADOPTION SUPPORT: MODEL PROGRAM

The National Center for Enhanced Post-Adoption Support (NCEPAS), a federally funded hub for information and resources on post-adoption services, recently released a manual describing a "model program" for post-adoption services that is aligned with research on family needs and best practices in service delivery. The model program identifies eight critical program components, which rest on five "core pillars" (NCEPAS, 2025).

According to the program manual, the model program is "designed to be a comprehensive program with eight components operating together, offering an array of supports for adoptive and guardianship families who are experiencing challenges…. [T]he model itself entails all of these components operating cohesively. An individual family may not want or need every service in the program model, but once they are enrolled in the program, every family should be able to easily access each service that they do need" (NCEPAS, 2025, p. 46). The program components are described briefly below, and in-depth explorations of each component with real-world examples can be found in the program manual.[10]

1 **Pre-permanency support:**
Consistent with prior research, this component stresses that services should begin before the adoption is finalized by ensuring that families understand adoption dynamics, know how to access services in the future, understand the child's history, and have realistic expectations.

2 **Comprehensive assessment:**
When a family engages in services, a trained clinician should thoroughly assess the child and family and develop a tailored treatment plan for services.

3 **Counseling services:**
Adoption-competent clinicians should provide evidence-based counseling services to the family to increase skills, strengthen attachment, build resilience, and improve functional outcomes.

4 **24-hour phone support:**
Post-adoption service providers should have trained professionals available to respond to parents 24 hours a day in order to provide in-the-moment emotional support and advice, give information and referrals, and determine the need for immediate crisis intervention.

5 **Crisis intervention:**
These services should be available to families at acute risk of adoption breakdown due to a crisis, and should include counseling, navigation, advocacy, and emotional support.

6 **Educational advocacy:**
Staff with specialized knowledge should be available to provide support to parents in attaining educational supports, addressing school challenges, developing advocacy skills, and to communicate with the educational system about issues common to children who have experienced trauma and loss.

7 **Support groups:**
Post-adoption services should include facilitated groups for parents and children to obtain education, peer support, resources, and problem solving.

8 **Respite care:**
Adoptive parents should have access to short-term respite services that allow them to recharge and reduce stress and burnout.

10 NCEPAS Model Program Manual: https://postadoptioncenter.org/wp-content/uploads/2025/08/Post-Adopt_Manual-2025_8.2025.pdf

The core pillars of the model program represent a framework in which the program components are embedded.

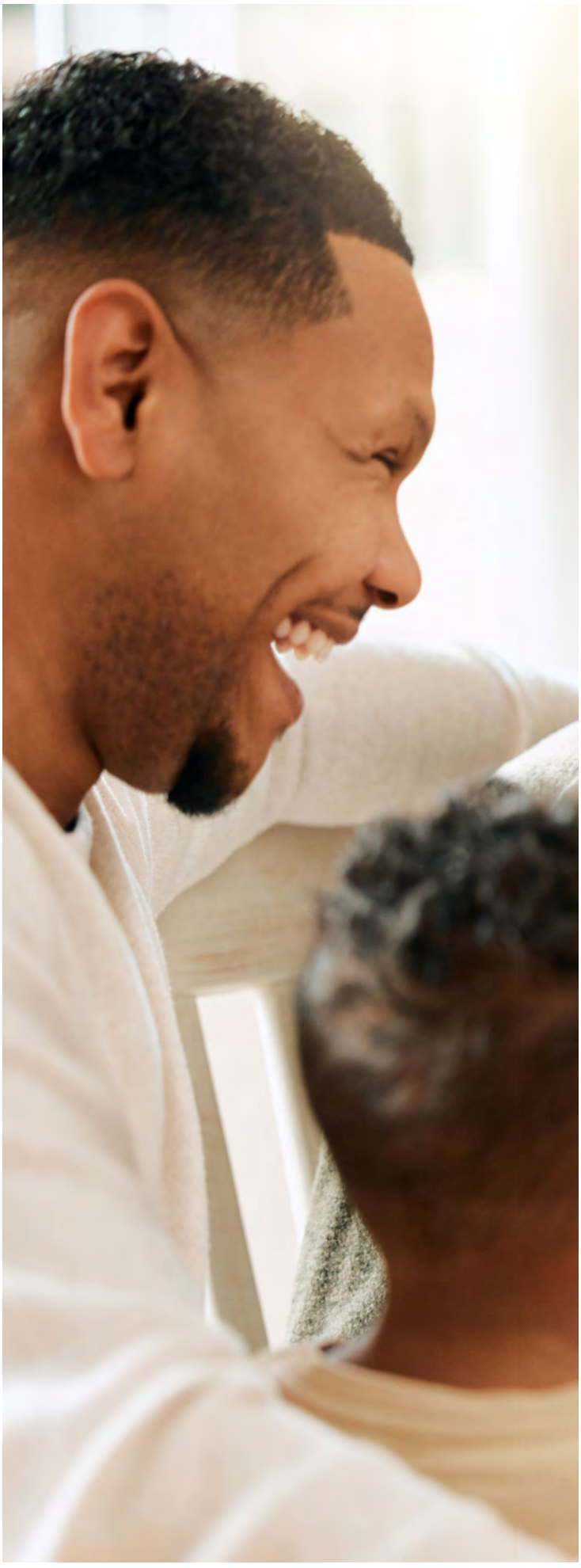
1. **Services are available and accessible:** Parents know what services are available and can easily access them without barriers or costs.

2. **Engage families over time:** Since service needs increase over time and may peak in adolescence, programs should serve families throughout their lifespan, starting with a warm handoff from the adoption agency to the post-adoption service provider, and entailing broad and consistent outreach.

3. **Focused on parent-child relationships:** Services should be relationship-focused, rooted in attachment, and provide parents with the information to understand trauma and triggers.

4. **Able to assess family outcomes:** Service providers should be engaged in continuous quality improvement to track outcomes and service effectiveness.

5. **Services are community responsive:** Services should be welcoming and rooted in a trusting relationship with the local community.



RECOMMENDATIONS

Our focus on gathering research-driven insights on predictors of adoption breakdown, as well as service needs and best practices for post-adoption services, identified several gaps between best practices and current practices and policies in Texas. These gaps are identified, accompanied by recommendations on how to close them.

Gap 1: Service needs are likely to increase over time after an adoption, so services must be available and accessible when needed, which is often many years after the adoption. Families may not know where to get services when they need them.

Recommendation 1: The visibility of post-adoption services should be increased. Strategies for promoting the visibility of services can take place on many fronts and should go beyond just informing the family at the time of the adoption. Strategies to consider include:

- A central online hub describing the availability of post-adoption services and how to connect to them. Heart Galleries of Texas is well positioned to create and maintain this system.
- Disseminate flyers, pamphlets, ads, or other physical sources of information about post-adoption services widely. This should go beyond the agencies responsible for completing foster care adoptions (DFPS, SSCCs, CPAs) and include community sources such as school districts, pediatric medical providers, courts, and adoptive parent support groups.
- Automatically enroll families in post-adoption support (opt-out rather than out-in) to reduce enrollment barriers, ensure education and connection from the start of the adoption process, and provide a “pre-post-adopt” orientation before finalization.

Gap 2: Service availability is not equally accessible to all families who adopt a child from conservatorship. Where families reside, the timing of help-seeking, and the nature of service needs can all play a role in whether a family receives the help they need.

Recommendation 2: Consider changes to how funds move from the state to post-adopt providers to families in need of services. Develop an updated funding allocation methodology that reflects not only current regional adoption consummations, but also historical demand for post-adoption services, and updated average service costs. Pool funds statewide rather than by region or streamline existing processes for moving funds between regions, providers, and service categories, so that all families are equally able to access services paid by available funding regardless of location and service type needed.

Gap 3: Services should be preventative, offered before families reach a crisis point. Additional outreach and earlier enrollment in services would help with prevention, but providers already don't have sufficient resources to support the current level of families seeking services.

Recommendation 3: Make increased investment in post-adoption services a legislative policy priority so that more families can be served earlier in their adoption journey to stabilize adoptions and prevent breakdowns that occur during a crisis.

Gap 4: The mandate that 20 percent of providers' budgets be reserved for residential (RTC) services keeps providers from being able to pay for upstream, preventative services.

Recommendation 4: Several strategies could help close this gap. One is to simply remove or substantially reduce the 20 percent earmark requirement for RTC services. Another option is to give providers the flexibility to move funds earmarked for RTC to other categories when needed to best serve the most families. A final option is to take RTC services out of the purview of post-adoption service providers altogether, and fund RTC stays for adoptive families who need them through the YES Waiver or other existing channels outside of post-adoption services. This latter approach may also help address challenges arising from post-adoption RTC rate allocations not keeping pace with rate increases under the RTC Project and the Texas Child-Centered Care system, which has made it even more difficult to find RTCs willing work with the post-adoption service providers.

Gap 5: Clinical services, which experts agree are key to stabilizing adoptions and preventing adoption breakdowns, are being rationed and/or denied because there is not enough funding to meet demand. The limited funding that is available for clinical services is reimbursement-based, which does not help families without resources to pay out of pocket and wait for reimbursement.

Recommendation 5: Advocate for increased funding for clinical services, either by allowing RTC-earmarked funding to be flexibly used for preventative clinical services, or by increasing the total allocation for these services to providers. Advocacy should include the development of feasible mechanisms for up-front payment (rather than reimbursement-based payment) for families who do not have the resources to pay for clinical services out-of-pocket.

Foster an adoption-competent clinical workforce through trainings and certifications such as the National Adoption Competency Mental Health Training Initiative (NTI) and the Training for Adoption Competency (TAC) offered by the Center for Adoption Support and Education.

Maintain a statewide directory of adoption-competent providers, including options for telehealth service delivery.

When services must be rationed or denied due to lack of resources, providers can develop decision tools to prioritize families with empirical risk factors for adoption breakdown.

To address the shortage of clinical professionals competent to serve children with trauma histories, continue advocating for legislation that would allow licensed professionals who are currently under clinical supervision to bill Medicaid at 50 percent of the Medicaid rate for professionals with full clinical licenses.

Gap 6: Respite care is a core need for adoptive families, but there is too much gatekeeping and not enough funding to meet demand.

Recommendation 6: Remove post-adoption services contract stipulations that create barriers to providing respite care. These stipulations include the 10 percent funding cap on paid respite and the eligibility restriction to children with "special needs."

Gap 7: Families may not have adequate information about their children's risk histories at time of adoption, and this may keep them from anticipating that there may come a time when they need help in the future.

Recommendation 7: Agencies who play a role in adoptions from foster care, including DFPS, SSCCs, and CPAs, should provide realistic views of parenting children with histories of traumatic exposure from the first touchpoint with prospective adoptive families.

Professionals who come into contact with adoptive families should also understand trauma, grief and loss, and other unique strengths and challenges of adoptive families. Resources for these topics include the National Adoption Competency Mental Health Initiative and the Texas Permanency Outcomes Practice Model.

Gap 8: The model program components recommended by the National Center for Enhanced Post-Adoption Support are not currently fully in place in Texas. Aspects of the model program that may not be consistently present in Texas post-adoption services include comprehensive assessment for families seeking services, adoption-competent clinical services, 24-hour phone support, crisis intervention, and accessible respite care for all families who need it.

Recommendation 8: Fully fund and implement all core components and pillars of the National Center's model program in Texas. The National Center recently worked directly with DFPS leaders to assess Texas' strengths and challenges on each of the core components and pillars. Their final report on their assessment has specific recommendations for bringing Texas into alignment and can be used as a roadmap for closing identified gaps to strengthen post-adoption services.

Gap 9: DFPS manages post-adoption service contracts, and HGTX funds community-based support, but these efforts largely operate in parallel with limited coordination. This lack of service coordination can limit service reach, create redundancies and gaps, and hinder a comprehensive understanding of statewide needs.

Recommendation 9: DFPS and HGTX should engage in streamlined planning, including aligning strategies, coordinating outreach, and sharing data on service requests and utilization. Such collaboration would help ensure families can access the full continuum of support regardless of funding source, reduce duplication, address regional gaps, and provide a clearer statewide view of service needs and investment priorities.

APPENDIX A: METHODOLOGY

DFPS DATA

The Texas Center for Child and Family Studies obtained aggregate data on re-entry rates following adoption via an Open Records Request to DFPS. We requested information on the number and percent of children who re-enter care after a consummated adoption from substitute care in Texas for each fiscal year from 2013 to 2024, including: total number of consummated adoptions from substitute care, broken out by relative and non-relative adoption; the number that subsequently re-entered substitute care at any later point, broken out by relative and non-relative; the average number of months between adoption consummation and subsequent re-entry, broken out by relative and non-relative adoption; and the average child age at re-entry, broken out by relative and non-relative adoption.

LITERATURE REVIEW

For the literature reviews on predictors of adoption breakdown and best practices, we searched for quantitative research studies using combinations of the search terms “adoption dissolution”, “adoption disruption”, and “post-adoption services”, followed by hand review of the reference lists of the most relevant studies. Because child welfare policy contexts and service delivery structures vary so widely between counties, we limited the search to American studies. We also limited the search to research conducted in the past 20 years to prioritize up-to-date information, except for limited cases when a study was cited so widely it seemed important to include.

FOCUS GROUPS

We conducted two focus groups with leaders from the three contracted providers of post-adoption services – Arms Wide, Centers for Children and Families, and CK Family Services. In total, two people from each agency participated in a focus group. The focus groups were recorded and transcribed verbatim using a professional transcription service. All participants gave verbal informed consent to participate.

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APPENDIX C: DFPS DATA ON RE-ENTRIES TO CARE AFTER ADOPTION EXIT

DFPS DATA: RE-ENTRIES TO SUBSTITUTE CARE AFTER ADOPTION EXIT								
Exit Year	Years of Follow Up	Overall re-entry %	Relative adoption re-entry %	Non-relative adoption re-entry %	Average time to re-entry: relative adoptions	Average time to re-entry: non-relative adoptions	Average child age at re-entry: relative adoptions	Average child age at re-entry: non-relative adoptions
2013	12	4.1	3.8	4.4	5.0	5.4	11	12
2014	11	3.9	3.2	4.5	4.9	4.8	12	13
2015	10	3	3.1	2.9	4.6	4.6	12	13
2016	9	2.8	2.4	3.2	3.6	3.9	12	12
2017	8	2.7	2.7	2.7	3.2	3.3	11	12
2018	7	2	1.5	2.4	3.0	3.0	10	12
2019	6	1.7	1.7	1.7	2.7	2.6	10	12
2020	5	1.1	1.2	1	2.1	1.7	11	11
2021	4	0.8	1.2	0.5	2.1	1.7	9	11
2022	3	0.8	0.9	0.7	1.2	1.4	7	11
2023	2	0.2	0.2	0.3	1.3	1.0	5	13
2024	1	0.2	0.3	0.2	0.3	0.5	6	8