REGION 6A
COMMUNITY-BASED CARE

Comprehensive Assessment and Environmental Scan

THE HACKETT CENTER

FOR MENTAL HEALTH

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Executive Summary

The Texas child welfare system is in the midst of a historic transformation centered on the Department of Family and Protective Services' (DFPS) incremental rollout of the Community-Based Care (CBC) model across the state. Under CBC, foster care and case management functions previously administered centrally through Child Protective Services (CPS) at DFPS transition to a regional Single Source Continuum Contractor (SSCC) that is responsible for contracting with child placement agencies, coordinating and delivering services to children and youth in foster care and their foster families, developing foster care capacity, and engaging the community to achieve positive outcomes for children and families served.

While DFPS has not yet decided when CBC will be introduced in Harris County, Houston-area community leaders and child welfare providers in Harris County (DFPS Region 6a) have come together to develop a baseline understanding of the community's capacity to serve its children and youth in foster care, identify areas for systems change, and initiate considerations for reimagining Region 6a's foster care system as part of CBC.

Through the generous support of Houston Endowment and the Hackett Family, The Hackett Center (THC) at the Meadows Mental Health Policy Institute was selected to conduct a community needs assessment and environmental scan, using qualitative and quantitative data to identify and describe the needs of children and youth in care in Region 6a and assess the current capacity of providers (including health, mental health, child welfare, and community partners) to address those needs. This work was supported by an Executive Committee of local child welfare leaders and an Advisory Committee that more broadly involved local service providers and experts in education, health care, faith-based initiatives, criminal and juvenile justice, and child welfare. This report summarizes all project findings and provides planning considerations based on data, stakeholder insights, and national best practices to help the community prepare for and succeed in its CBC planning and systems change.

The community leaders and partners that came together to support this project articulated the following shared goals for children and youth in foster care in Region 6a to guide the community's efforts to implement the Community-Based Care model:

- Children and youth who have been removed from home are placed with well-matched kinship or foster families that are able, trained, and supported to meet each child's unique needs.
- Siblings remain together.
- Children and youth are placed in the least restrictive and most supportive environment possible.

- Out-of-home placements are close to home to help children and youth maintain personal ties, stay in the same school when possible, and maintain a sense of familiarity during a difficult and, for many, traumatic time.
- Disruptions in placements are minimal and permanency is achieved quickly.
- Hardship associated with removal and out-of-home placement is minimized through a system that makes sure a network of supportive caretakers and caring individuals is in place to ensure a broad range of developmental needs are addressed.
- Young people who may age out of foster care are aware of the supports available to them as they plan for and execute their goals for adulthood.

These shared community goals align with the guiding principles that are reflected in the performance measures established by the state for the Single Source Continuum Contractor, which are:

- Children and youth are safe from abuse and neglect,
- Children and youth have stability in their placements,
- Children and youth are placed in the least restrictive environment,
- Children and youth are placed in their home communities,
- Children and youth are placed with siblings, and
- Children and youth are prepared for successful adulthood.

Findings from the Community Assessment and Environmental Scan

The findings in this full report and in the executive summary are presented in five sections, which cover:

1. Characteristics of children and youth from DFPS Region 6a who are or have been involved in the foster care system;
2. The types and amounts of foster care placements in Region 6a that are available, and those that need to be developed, based on child and youth needs;
3. A summary of additional services and supports for caregivers, children, and youth that are available, and those that need to be developed;
4. System level considerations related to planning for CBC implementation; and
5. Financial considerations to ensure successful CBC implementation.

1. Characteristics of Children and Youth in Foster Care from Region 6a

Community stakeholders agreed that the well-being of children and youth in foster care should drive CBC planning for Region 6a, and planning must involve how best to respond to the unique characteristics of children and youth living in the region. In state fiscal year (FY) 2018, there were 1,632 children and youth removed from home by Child Protective Services (CPS) in Harris County. Some of these children and youth were placed with a relative and some were placed in non-relative foster care. The same year, there were 5,457 foster care placements made in the

region. This count includes initial placements for children and youth first entering foster care and subsequent placements for children and youth already in care who experienced one or more placement disruptions. To provide a sense of the number of children and youth in foster care at a single point in time, on August 31, 2018, a total of 3,725 children and youth were in substitute (foster) care in Region 6a.

Reviewing data from FY 2017 (the most recently available data at the time of this analysis), certain characteristics and trends are particularly noteworthy. Specifically, children and youth in Region 6a are less likely to enter foster care than in previous years. For those children and youth who do enter care they are:

- Are more likely to be male (53% male and 47% female);
- Are disproportionately under the age of six years (about half);
- Are disproportionately African American (39% of youth in substitute care are African American versus 17% of the general child population in the region);
- Are frequently separated from their siblings (only 57% of sibling groups were placed together);
- Remain in foster care longer than those in many other parts of the state (averaging just over two years versus 17.4 months as the statewide average);
- Are more likely than then their same age peers in the general population to experience a complex mental health challenge;
- Are more likely than their same age peers in the general population of to be lesbian, gay, bisexual, transgender, queer or questioning (LGBTQ); and
- Are more frequently (12%) placed with relatives than in the past, but still at rates lower than the state average (44%, compared to the state average of 47%).

The community planning process identified five factors that need particular attention in preparation for CBC:

1. **There is a substantial unmet need for foster home placements for infants and young children, and their needs are often complex.** Infants and young children enter care at a higher rate than any other age group, and the special demands of parenting an infant with complex health and cognitive needs will require intentional recruitment efforts, such as those identified by the Capacity Think Tank.
2. **Special attention should be paid to the needs of African American youth**. There is a particular need for more culturally appropriate, moderate intensity, and specialized placements.
3. **Capacity is particularly challenged by the large number of youth ages 14 to 17 years who are at higher risk of aging out of care, many of whom have complex needs.** Overall, more than two thirds of these youth are in a higher level of care, and more than

half are in Specialized or higher levels, creating additional challenges in identifying permanent placement options, and placing them at a higher risk of aging out of care.

4. **The high number of children and youth in care with complex mental health and educational needs require access to well-trained foster care placements that are supported by a continuum of services and supports.** Children and youth in foster care are five times more likely to have anxiety, six times as likely to struggle with behavioral problems, and seven times as likely to have depression, and unmet mental health and educational needs frequently lead to placement in more restrictive settings.
5. **The number of LGBTQ children and youth in foster care requires the region to develop placements and community-based services and supports that are safe, affirming, and support permanency and success.** Prior to entering foster care, LGBTQ children and youth experience a number of adverse or traumatic events such as violence and homelessness that are associated with their sexual orientation and gender identity. They also may struggle with further biases and discrimination while in care, which can have an impact on their placement stability and create barriers to permanency.
6. **Address the high number of sibling groups in Region 6a that are currently placed apart by reducing barriers to placing sibling groups together.** This is a CBC quality indicator that must be addressed.

2. Foster Care Capacity and Demand

Community stakeholders also agreed that the characteristics and needs of children and youth in foster care should guide the development of foster care capacity in Region 6a. Overall foster care placement demand in Region 6a declined by nearly one fifth (18%) from FY 2016 to FY 2017, primarily due to increases in the number of children going into kinship placements and a decrease in removals. In FY 2017, 44% of children and youth who were removed were placed with kinship care providers. However, the decline in new cases entering foster care were offset by the demand for subsequent placement of children and youth who entered care in previous years.

Based on current and forecasted placement capacity demands and community leaders' insights, the community planning process identified four key areas that need particular attention as Harris County plans and works on developing its placement capacity in preparation for CBC:

1. **Better address the needs of the two thirds of youth in care who end up in more than one placement.** This reflects a lack of capacity for children and youth with complex needs, capacity that matches individualized needs (including cultural and age-specific needs), and systemic factors, including poor placement decisions and staff turnover.
2. **Better address the needs of older youth emancipating from care**, including foster care capacity development efforts focused on more culturally appropriate foster placements and older youth with complex needs.

3. **Develop treatment-focused alternatives to residential care, especially crisis capacity to better support placement stability** given the region's frequent placement breakdowns, overcapacity of residential treatment center (RTC) beds, and over-reliance on restrictive RTC placements.
4. **Begin considering Family First Prevention Services Act (FFPSA) requirements now**, with a focus on "right sizing" local RTC capacity, improving the quality of RTC care, and increasing stepdown/aftercare services.

3. Community Capacity to Support Foster Parents and Children / Youth in Care

This section addresses two sets of factors that affect placement stability and permanency: (1) foster parent capacity and (2) community capacity to provide services and supports.

Foster Parent Capacity

The CBC Advisory Committee and key community stakeholders highlighted the importance of expanding Region 6a's foster parent capacity and stressed the need to recruit foster parents and prepare them to care for children and youth with complex mental and physical needs, and develop services that promote reunification as well as adoption. Key factors that must be incorporated into CBC planning include the following:

1. **Use Region 6a's Capacity Think Tank to develop a recruitment plan for the region, using its recommendations for young children and building on them for other priority groups in need of more capacity**. The Capacity Think Tank for DFPS Region 6 has identified barriers to meeting the placement needs of young children in the region, and a similar strategy for identifying barriers to recruiting and retaining foster parents. Establishing objectives to address identified barriers should be employed for children and youth with complex mental health needs, children and youth of color, older youth, and children and youth in large sibling groups.
2. **The planning process must prioritize increased training and support to birth parents, kin, and foster parents to address challenging behaviors that currently lead to a disproportionate number of placement disruptions.** Readily available, high-quality training and hands-on coaching can provide the tools and skills that parents and caregivers need to support the children and youth in their care who have complex mental health, educational, and other needs that result in behaviors that challenge placement stability.
3. **Centers of excellence should be developed to organize the sharing of resources and coordination of training and technical assistance that all foster parents can access, regardless of the capacity of their supporting agency.** The Advisory Committee recommended identifying centers of excellence to provide training and technical assistance and share resources on best practices in child welfare in Harris County.

4. **Develop and retain more foster parent capacity to support children and youth with complex medical conditions and intellectual and developmental disabilities (IDD).** In 2015 (the most recent year for which data were available), there were 314 children and youth in Region 6 who were identified as having a medical characteristic and 282 identified as having an intellectual or developmental disability. Today, foster and kinship parents in Region 6a are not typically recruited, prepared, or trained to meet the needs of children and youth with medical, intellectual, or developmental disabilities.

Community Capacity to Provide Services and Supports

Children and youth in foster care, and their families, need a broad range of services and supports, which in turn requires a diverse set of skilled partners to meet their needs. Fortunately, Region 6a has a comprehensive array of service providers working through schools, health care systems, foster care agencies, faith communities, juvenile justice systems, and other community systems. System leaders and stakeholders involved in the planning process identified multiple opportunities to work together more effectively, create opportunities for shared learning and collaboration, and expand Region 6 foster care and provider capacity, including:

1. **CBC planning should continue to engage the Advisory Committee convened for this project, foster youth, and families to support planning and build supports outside of the foster care system.** The Advisory Committee has been active in the initial CBC planning process and should continue to be engaged to strengthen coordination between child welfare providers; children and youth in foster care and their foster families; the community, including schools, faith-based organizations, health care providers, and the judiciary; and others.
2. **CBC planning should consider working with community partners and schools to operationalize the recommendations made by the Supreme Court of Texas Permanent Judicial Commission for Children, Youth, and Families outlined in *The Texas Blueprint: Transforming Education Outcomes for Children & Youth in Foster Care*.**
3. **Partner with health systems to expand the use of integrated behavioral health (IBH) throughout Region 6a.** Providers in Region 6a should develop primary care with integrated behavioral health care capacity, like the Harris County Protective Services (HCPS) Integrated Healthcare Clinic. Senate Bill (SB) 11 (86th Legislative Session, 2019) established the Texas Child Mental Health Care Consortium to support this goal.
4. **Region 6a should work with the STAR Health managed care organization to ensure that foster families and child placement agencies (CPAs) know about their benefits and how to access providers**, especially when providers are not available or do not have timely availability.
5. **The CBC planning process should explore ways to utilize and potentially expand in-home parenting services for foster parents of young children through current programs**, including Parents As Teachers (PAT), Nurturing Parent, Home Instruction for

Parents of Preschool Youngsters (HIPPY), and Nurse Family Partnership (NFP) services. DFPS forecasts needing additional foster home placements willing to care for young children in Basic (24%) and Moderate (39%) levels of care.

6. **The CBC planning process should explore ways to work with current intensive home and community-based service providers to drive the expansion of Medicaid Targeted Case Management (TCM) and Mental Health Rehabilitation (MHR) services.** DePelchin Children's Center, Pathways Youth and Family Services, Inc., The Harris Center for Mental Health and IDD, and Youth Advocacy Program can bill Medicaid for TCM and MHR services. CBC planning should engage these partners in planning how to utilize available Medicaid services to expand capacity for intensive services and supports.
7. **The CBC planning process should consider aligning child welfare, juvenile justice, and mental health crisis response resources; identify opportunities to expand the crisis respite service array; and make this array available across systems.** There are strong crisis programs, but they typically serve children and youth only within their own "silo" or system. If better aligned, existing resources could serve more children and youth with better options during a crisis.
8. **CBC planning should engage Region 6a's residential treatment facilities (RTCs) to develop a regional plan that includes youth voice to coordinate care for children and youth with the most complex needs.** This plan should address the characteristics of the children and youth currently in residential treatment, the forecasted decrease in RTC placement demand, and changes mandated by the Family First Prevention Services Act (FFPSA).

4. System-Wide and Community Based Planning Considerations

CBC reforms will shift responsibility for care capacity to the local community. Although the selected SSCC will be responsible for achieving specific performance measures, the following system-wide and community-based care-specific planning considerations span multiple systems and community organizations. The scope of these planning considerations is too extensive to be addressed by a single agency or organization. They require system-level assessment and planning to effect change.

The following system-wide strategies should be considered by local leaders and organizations involved in the CBC design and rollout for Region 6a:

1. **The CBC planning process should develop a plan to address the long lengths of stay in care.** A core group of CBC community leaders should engage the region's judicial leadership and key stakeholders to develop a plan to improve the permanency outcomes of children and youth in foster care in Region 6a, and to strengthen relationships between courts, providers, and Child Protective Services (CPS).
2. **Engage the Supreme Court of Texas Permanent Judicial Commission for Children, Youth, and Families (Children's Commission) for education and support**, particularly

through the updated version of the *Texas Child Protection Law Bench Book*, which engages judges to improve the law, legal system, and the administration of justice related to child protection cases.

3. **Engage kinship caregivers early to begin the foster parent certification process and address barriers that cause kinship families to delay, decline, or discontinue the foster parent certification process.** Too often today, kinship caregivers are not adequately educated and prepared to begin the foster parent certification process.
4. **Implement child- and trauma-friendly court settings.** Research has shown that better permanency outcomes are reached when children and youth are active participants in their court hearings and are included throughout the decision-making process; trauma-informed processes are essential to this strategy.
5. **Explore ways to increase efficiency and effectiveness in court hearing procedures.** The efficiency and effectiveness of court hearings are one of several factors that influence how quickly children or youth, and their parent(s), receive the services they need and how quickly a child or youth returns home or is placed in a permanent home. Currently, a child or youth in Harris County remains in care an average of 24 months, compared to a national average of 19 months and a statewide average of 17 months.
6. **Explore ways to increase access to family-focused supports**. Families require training and support, but training is not enough. Foster parents must be supported by an infrastructure that includes hands-on support and diverse resources.
7. **Establish timely and expanded communication between community partners and service providers regarding a child or youth's needs.** Delays in communication regarding a child or youth's needs can impede access to needed care and, in some cases, lead to breakdowns in placement. Strategies should include planning to increase cross-system communication and collaboration as well as expanding access to information to improve child and youth transitions within and out of the system.
8. **Youth in foster care should have access to the support, training, information, and resources they need to be successful.**

The following additional CBC planning strategies should also be considered based on lessons shared from the three Single Source Continuum Contractors (SSCCs) that are currently working in Texas:

1. **Build community engagement for improving collaboration using the flexibility allowed under CBC**. The success of CBC relies on engaging community providers, schools, the judiciary, mental health and primary care professionals, faith-based organizations, community leaders, philanthropists, and donors to improve collaboration through the flexibility and new ways of working together allowed under CBC.
2. **Promote increased transparency regarding potential Single Source Continuum Contractor (SSCC) intentions so that collaboration and partnerships can be developed**

in advance of the rollout in Region 6a. Representatives of the current SSCCs in Texas noted that it is critical for potential SSCCs to voice their intentions as soon as possible.

3. **Establish informed and realistic timelines that consider state-level processing requirements, which can be lengthy.** The state has a complex and time-consuming process for finalizing contracts. To minimize delays in assuming new responsibilities, contractors should initiate paperwork and state contracting requirements as early as possible.
4. **Explore strategies to improve access to more timely and accurate data to support all planning, implementation, and monitoring processes.** Access to real-time, accurate data is critical to the CBC planning and implementation process and supports performance-based contracting.

5. Fiscal Best Practices and Financial Sustainability

Perhaps the most crucial aspect of community-based care (CBC) planning involves anticipating changes in how services are funded, particularly for the Single Source Continuum Contractor that bears financial risk. This latter point is particularly important in Region 6a, given its sheer size. The total DFPS budget for foster care payments in FY 2020 will be just over $575 million, and about one in five (19%) of all cases reside in Region 6 (versus 16% in Region 8, which includes Bexar County). More importantly for risk management, in Region 6 nearly one in four (23.5%) of identified placements are Specialized or Intense, versus only 16.2% in Region 8 (more than 45% more). To support system development in Region 8a (Bexar County), the SSCC had to raise $7.28 million dollars in funding. Even if the risk methodology is updated and improved, additional funds will be needed, both to protect against unexpected risks that still remain and to fund system improvements. This means that risk mitigation is especially essential in Region 6 (particularly in Region 6a), and that the strategies considered for Region 6a may need to be different than those for any other region of the state.

The following fiscal risk management strategies should be considered by local leaders and organizations involved in the CBC design and rollout for Region 6a:

1. **Expand access to Medicaid-funded and other intensive, community-based supports.** SSCCs can manage the cost of providing care by increasing access to Medicaid-funded services to help children and youth achieve permanency in the least restrictive, most appropriate setting.
2. **Negotiate value-based purchasing (VBP) contracts between the SSCC and its contracted providers.** VBP is a reimbursement model that utilizes alternative payment models (APMs) to pay for services based on outcomes. VBP contracting can help promote outcome-driven relationships with foster care providers that support high quality, efficiently delivered care.
3. **Negotiate Medicaid STAR Health VBP contracts.** The SSCC could also work with the STAR Health managed care organization (MCO) to negotiate VBP contracts to cover

intensive, home and community-based alternative health services for children and youth in foster care instead of more expensive and restrictive Medicaid placements, such as inpatient care.

4. **Collaborate with other CBC regions.** It is possible to gain efficiencies and reduce costs for both the SSCC and for other regional providers by joining collaborative efforts with other CBC providers. This is especially important given that many providers provide services in multiple regions in the state.
5. **Explore partnerships among CPAs serving Region 6a and Harris County Protective Services (HCPS) to share risk.** Given the unique level of financial risk likely to be faced by the SSCC serving Region 6a, system leaders in the region should consider an array of partnerships to share and manage risks that likely will exceed the ability of any single agency to manage. Multiple strategies could be considered.
6. **Closely monitor the development of the new rate methodology and advocate for the unique needs of Region 6a.** As noted above, HHSC has been charged with developing a new rate methodology during the next biennium, in partnership with DFPS and stakeholders. System leaders in Region 6a should closely monitor this process and work with a wide array of stakeholders to advocate for an approach that is able to predict and adequately support fiscal risk management in Region 6a.

Overview and Background

Overview of Community-Based Care

The Community-Based Care (CBC) model for delivering foster care services is being rolled out across Texas. CBC was established as part of a larger, 2011 legislative directive to redesign the foster care system. The goal of CBC is to improve safety, permanency, and well-being by allowing communities greater flexibility to customize how foster care services are administered, while ensuring quality standards through performance-based contracts. CBC shifts certain functions and services previously provided by the Department of Family and Protective Services (DFPS) to a single contractor, called a Single Source Continuum Contractor (SSCC). The SSCC is responsible for contracting with community providers, placing children and youth, and ensuring they have access to a continuum of services and supports. Through CBC, SSCCs partner with community-based organizations to develop foster care capacity and facilitate and oversee foster care placements.

As of May 2019, three DFPS service areas have SSCCs in place that are contracting with community-based providers to deliver services, and plans are underway to implement CBC in Region 1 and Region 8B. In the first stage of implementation, SSCCs are responsible for developing a network of foster care providers and community supports that allow children and youth to remain in their communities and connected to their families. In the second stage, the SSCC's responsibilities expand to include case management, kinship, and reunification services. In the final phase, SSCCs are expected to meet specific performance metrics and payments will be tied to outcomes.

DFPS considers many factors in establishing CBC catchment areas and in determining the order of rollouts. These include the number of children and youth in care, regional readiness and stability, local community supports, and capacity challenges. Because of the large size and diversity of the region, DFPS Region 6, which encompasses Harris County and many surrounding counties, is divided into two catchment areas under CBC, Region 6a (Harris County) and Region 6b (Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Liberty, Matagorda, Montgomery, Walker, Waller, and Warton counties). This report focuses on Region 6a.

Project Overview and Purpose

Texas Child Welfare system leaders are implementing CBC as a key initiative in their effort to improve the larger child welfare system. Although there are no immediate plans to rollout CBC in Harris County, there is value in collaborating today to strengthen and improve the current foster care system while thinking through and planning for potential CBC implementation. Child welfare leaders and partners in communities around Texas that have implemented CBC have rallied around CBC as a catalyst to improve the system.

The Hackett Center (THC) at the Meadows Mental Health Policy Institute was selected by the community to support planning efforts in Region 6a. The purpose of the project is to gather and analyze relevant baseline information to help decision makers and stakeholders in DFPS Region 6a improve foster care outcomes. The project formally began in July 2018 and concluded at the end of August 2019. The Executive Committee (EC), which represented ten organizations, provided ongoing guidance for and input into the analysis.[i] To engage a broader group of stakeholders, the EC formed an Advisory Committee (AC), including 98 members from 65 organizations who met four times over the course of the project (see Appendix A for a list of Advisory Committee members).

Project Design and Methodology

With the guidance and support of the Executive and Advisory Committees, a community assessment and environmental scan was conducted to help Region 6a gain a clear understanding of the local child welfare landscape and to direct foster care system improvement efforts. The assessment and scan included information on the needs of the children and youth involved in the foster care system and their foster families, the capacity of current providers to address these needs, the alignment of these needs with existing resources, and strategies to address gaps and barriers (including those related to funding and policies) to service provision.

The community assessment and environmental scan entailed quantitative analysis drawing from available data sets, including the DFPS Data Book, the Foster Care Needs Assessment, and the American Community Survey 5-year estimates. Seventy-two (72) people, representing 42 agencies, organizations, or groups, were interviewed. These groups included child placement agencies (CPAs), judges, experts on education and health care systems, foster families, and other child- and youth-serving organizations. Additional qualitative information was gathered through focus groups with youth in foster care, foster families, Advisory Committee meeting table talk sessions, and a survey sent to fifty local CPAs. The environmental scan and community assessment also included research on best practices in child welfare and system financing. Throughout the project, preliminary findings were discussed with the Executive and Advisory Committees.

Both the qualitative and quantitative components of the project sought to answer questions related to how CBC should be designed and implemented in Region 6a:

- Who are the children and youth in foster care in Region 6a and what are their emotional, developmental, educational, and personal needs?
- What is the capacity of the region's current foster care system, and will it meet the forecasted needs of the children and youth in care?
- What changes could improve foster care placement options for children and youth in foster care?

- What community supports are available to help children and youth in foster care, and their foster families, and what additional services and supports would enhance their well-being?
- How can the information that was gathered be used to focus and strengthen collaborative efforts to improve the local foster care system and prepare the region for implementation of CBC?
- What financing mechanisms and fiscal sustainability practices can be used to help children and youth in foster care as well as their birth and foster families?

Findings from the community assessment and environmental scan were combined with research on best practices, as well as lessons learned from previous CBC rollouts, to help the community focus its planning efforts and resources. The report is broken into five core sections. The first three are focused on the foster care system and address:

1. Characteristics of children and youth from DFPS Region 6a, with an emphasis on those involved in the foster care system;
2. The capacity of the current foster care system, including available foster placements and the expected demand for placements; and
3. Community capacity to support the needs of children and youth in foster care, their families, and their foster families.

For each of these areas, this report summarizes relevant data collected through the assessment and includes findings and planning considerations.

The fourth section of this report focuses on considerations for financing and sustaining CBC. The final section summarizes system-wide considerations and findings that are especially relevant for CBC implementation.

Guiding Principles and Values

Becoming involved in the foster care system and receiving foster care services is often the result of a complex set of social and community factors, with different and changing levels of influence on individual lives. These complex factors also affect the delivery of foster care services and can have an impact on the success of the child welfare system. Considering the broad range of societal and community influences, there are many ways to improve the foster care system and child welfare outcomes as a whole. For example, child welfare outcomes will improve if communities are able to reduce the need for foster care involvement by providing access to prevention and early childhood services and supports, and programs that address parent/caregiver stability. While all of these considerations should be addressed, this report focuses on areas with the most relevance to CBC implementation and children and youth already in the foster care system.

Through the input of the Executive and Advisory Committees and other key stakeholders, several core community beliefs emerged:

- All children and youth in care are better served through cross-system partnerships between the juvenile justice, education, health, and mental health care systems.
- All children and youth in foster care should be provided every opportunity to experience normal, positive childhood experiences.
- All children and youth in care need strong, positive connections to caring adults.
- All children and youth in care should have access to the services and supports they need, when and where they need them, in order to prevent placement in a higher level of care.

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[i] Comerica Bank, Department of Family and Protective Services, DePelchin Children's Services, Family Houston, Harris County Protective Services, Houston Endowment, Justex, Texas Alliance of Child and Family Services, Texas Network of Youth Services, and Upbring.

Characteristics of Children and Youth

Characteristics of Children and Youth in Foster Care in Region 6a and 6b

The CBC model encourages communities to be innovative and flexible in meeting the unique needs of children, youth, and families. It engages community partners to develop foster care capacity and coordinates the delivery of services to children and youth in foster care through a network of community-based providers. Under CBC, foster care capacity refers to the supply of foster families and other foster placements. Ideally, foster care capacity is not only large enough to serve all children and youth in care, but also includes diverse, high-quality options to meet each individual child and youth's needs. The local foster care system should include placements, services, and supports that meet the needs of all children, youth, and families, especially those in DFPS care. No child or youth is responsible for any harm they experience. However, individual factors such as age, developmental disabilities, mental health issues, and chronic medical conditions can enhance the risk for abuse and neglect.[1]

This section uses DFPS data, community demographic information, and mental health prevalence estimates to describe the characteristics and needs of the children and youth in Harris County and those involved with the foster care system in DFPS Region 6 (6a and 6b). Community-based care (CBC) is rooted in the belief that communities are in the best position to meet the unique needs of the children and youth who live in them. A successful transition from a state-led foster care system to CBC requires an understanding of who is served by the system and what are their needs, which can then inform the development of foster care placement and community services capacity to meet those needs.

The following characteristics for children and youth involved with the foster care system in DFPS Region 6a were obtained for this assessment:

- Ethnic background, age, and sex;
- Where children and youth from the region are placed;
- Where they attend school; and
- What their assigned authorized service levels (ASLs) suggest about their needs.

The prevalence of mental illness for all children and youth in Harris County was also analyzed, focusing on the prevalence of mental and behavioral health conditions for children and youth in foster care. Children and youth with a mental health condition are more likely to be placed in foster care.[2] Understanding the mental health needs of children and youth with the highest risk for out-of-home placement in Region 6a helps the community anticipate the demand for mental health services.

Data and Observations

Although the focus of this report is DFPS Region 6a (Harris County), the available monthly snapshot data cover all of DFPS Region 6, including the outlying area known as 6b (Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Liberty, Matagorda, Montgomery, Walker, Waller, and Warton counties). For these analyses, the most recently available information was from September 2018. The demographic data on all children and youth in Harris County (Region 6a) were obtained from the American Community Survey (ACS) 2016 5-Year Estimates.

Data Analysis Time Frame
August–November 2018

Data Sources
- DFPS Data Book
- Monthly Snapshot, September 2018
- FY 2017 Data
- ACS 2016 5-Year Estimates

Number and Demographics of Children and Youth in DFPS Custody

Number of Children and Youth in DFPS Custody

As shown in Table 1 below, about 70% of children and youth served through the Region 6 foster care system were from Region 6a.

Table 1: Number of Children and Youth in Foster Care in Region 6 – Fiscal Year (FY) 2017[3]

Region	Number of Children in Foster Care During FY 2017
Region 6a (Harris County)	**3,829**
Region 6b	1,658
Region 6 Total	5,487

Demographics of Children and Youth in DFPS Custody

When comparing race and ethnic backgrounds, sex, and age, the demographics of children and youth in foster care in Region 6 differ from the general population (Table 2). Among the total child and youth population in Region 6, 51% of children and youth are male and 49% are female. However, among those in care, there are slightly more boys (53%) than girls (47%).

Across DFPS Region 6, nearly half (1,354) of the children and youth in foster care were under the age of six years, one quarter (809) were infants between the ages of zero (0) and two years, and one fifth (670) were between the ages of 14 and 17 years.

The race and ethnic composition of children and youth in foster care in Region 6 diverges from the general child and youth population. While Hispanic/Latino children and youth comprise the

majority of all children and youth (45%) in Region 6, followed by Non-Hispanic white children and youth (30%), African American children and youth (17%), and Asian American children and youth (6%), within the foster care system in the same area, African American children and youth are over-represented (39%). In contrast, children and youth of other racial categories are under-represented in foster care: Hispanic/Latino children and youth make up 30% of children and youth in foster care while comprising the majority of all children and youth in the region, Non-Hispanic white children and youth make up 24%, and Asian American children and youth make up just 1%.

Table 2: Demographics of Children and Youth in DFPS Custody in Region 6a (Snapshot – September 2018*)[4]

Population	All Foster Children	Percentage of Total Foster Children
Children and Youth (0–17)	3,131	100%
Age		
Ages 0–2	809	26%
Ages 3–5	545	17%
Ages 6–9	599	19%
Ages 10–13	508	16%
Ages 14–17	670	21%
Sex		
Male	1,663	53%
Female	1,467	47%
Race/Ethnicity		
Non-Hispanic White	744	24%
African American	1,231	39%
Asian American	22	1%
Native American	1	<1%
Multiple Races	146	5%
Hispanic/Latino	943	30%

*Table 2 is based on totals from one month, September 2018. Table 1 is based on fiscal year totals.

Sibling Groups in Foster Care

Nationally, two thirds of children and youth in foster care have one or more siblings who are also in care.[5] For children and youth in foster care, the companionship of a sibling can enhance

well-being and provide natural support. For many children and youth, a shared history with a sibling is a protective factor that promotes resilience. Separating siblings can add to the traumatic consequences of removal, including additional grief, loss, and anxiety over their sibling's well-being.[6] A snapshot of children and youth in foster care on August 31, 2018, indicated that there were 888 sibling groups in care. **Only 57% of those siblings were placed together;** the state level at this point in time was 65%. (Table 3)

Table 3: Sibling Groups in Care (August 31, 2018)[7]

Substitute Care	Harris County	Texas
Number of Sibling Groups	888	7,253
Percent Placed Together on August 31st	57%	65%

Lesbian, Gay, Bisexual, Transgender, Queer or Questioning (LGBTQ) Children and Youth in Foster Care

In Texas, the percentage of LGBTQ-identifying youth in foster care is unknown. A national study found that approximately 6 to 8% of youth ages 12 to 18 years in the general population identify as sexual minority – gay, lesbian, or bisexual (LGB), whereas 29.5% of those in the foster care system identify as LGB.[8] The study did not include data on gender minority youth (including transgender youth). In a recent California-based study, which included estimates for gender and sexual minority youth, researchers found that 30.4% of foster care youth identified as gay, lesbian, bisexual, transgender, queer or questioning (LGBTQ). [9] If this percentage were applied to the Texas Region 6 and 6a foster care populations from 2017, there would be an estimated 500 LGBTQ youth in the Texas foster care system in Region 6, and 300 LGBTQ youth in the Texas foster care system in Region 6a.

Pregnant and Parenting Youth in Foster Care

Texas youth in foster care ages 13 to 17 years are at higher risk for teen pregnancy than the same age youth who are not in foster care.[10] Pregnant and parenting teens, regardless of their involvement in the foster care system, need strong support networks and access to an array of resources to be effective parents. Pregnant and parenting youth in foster care face additional challenges that result from maltreatment, multiple placements, and being separated from important adults. These youth are less likely to finish school, more likely to suffer from a mental illness, and struggle with homelessness and unemployment.[11] In FY 2017, 75 (almost 2%) of the youth ages 13 to 17 years in DFPS conservatorship in Region 6a were pregnant or parenting – 47 youth were pregnant and 28 youth were parents. During this same time period, four of the

children born to youth in care were also placed in conservatorship. When compared to the statewide totals – 332 pregnant youth, 218 parenting youth, and 48 children taken into care – 14% of pregnant youth, 13% of youth parents, and 8% of children of youth parents taken into DFPS conservatorship were from Region 6a.[12]

Average Length of Stay in Foster Care

Foster care is intended to be a time-limited placement until a child or youth can safely return home or be placed permanently with another family. The longer children and youth remain in foster care, the more likely they will experience multiple placements.[13,14] In Region 6a, the average time spent in care was just over two years, which is higher than the national average of 19.2 months [15] and the state average of 17.4 months. African American, white, and Hispanic children and youth experienced similar lengths of stay in foster care. Asian American children and youth represented a small minority of children and youth in the local foster care system, yet they experienced longer lengths of stay in the system (see table 4 below).

Table 4: Average Months in Substitute Care by Race/Ethnicity (August 31, 2018)[16]

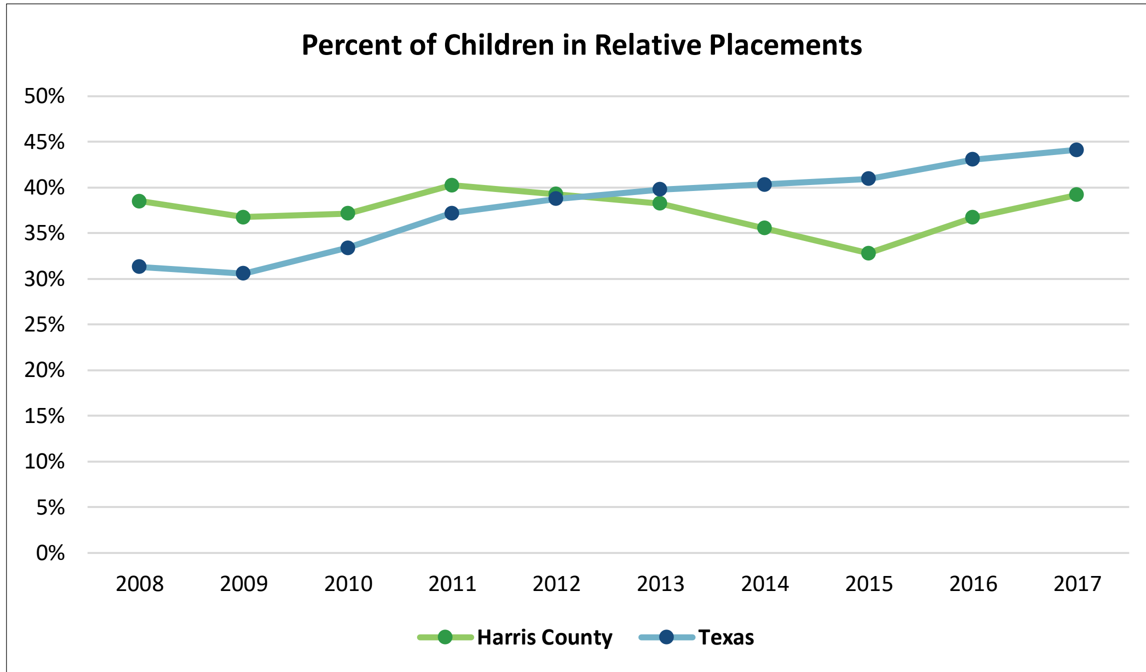
Race/Ethnicity	Harris County		Texas	
	Children / Youth in Care	Average Months in Care	Children / Youth in Care	Average Months in Care
All Children / Youth in Placements	3,619	24.6	29,876	17.4
African American	1,711	24.8	6,714	18.6
White	534	22.6	8,852	16.3
Asian	17	42.1	75	22.1
Hispanic	1,150	22.6	12,302	18.4
Native American	<6	N/A	26	21.1
Other	202	24.4	1,887	15.9

Children and Youth Placed in Kinship Care

Children and youth placed in relative or kinship placements are less likely to experience placement instability and have behavior problems, and more likely to have better mental health and well-being than children and youth placed in non-relative foster homes.[17] Texas has worked toward increasing the overall number of children and youth who are placed in relative and kinship care. The number of children and youth in Region 6a placed in kinship care (with

relatives) increased to 39% in 2017 after dipping to 33% in 2015. However, since 2012, Region 6a has not kept pace with state increases in kinship placements.

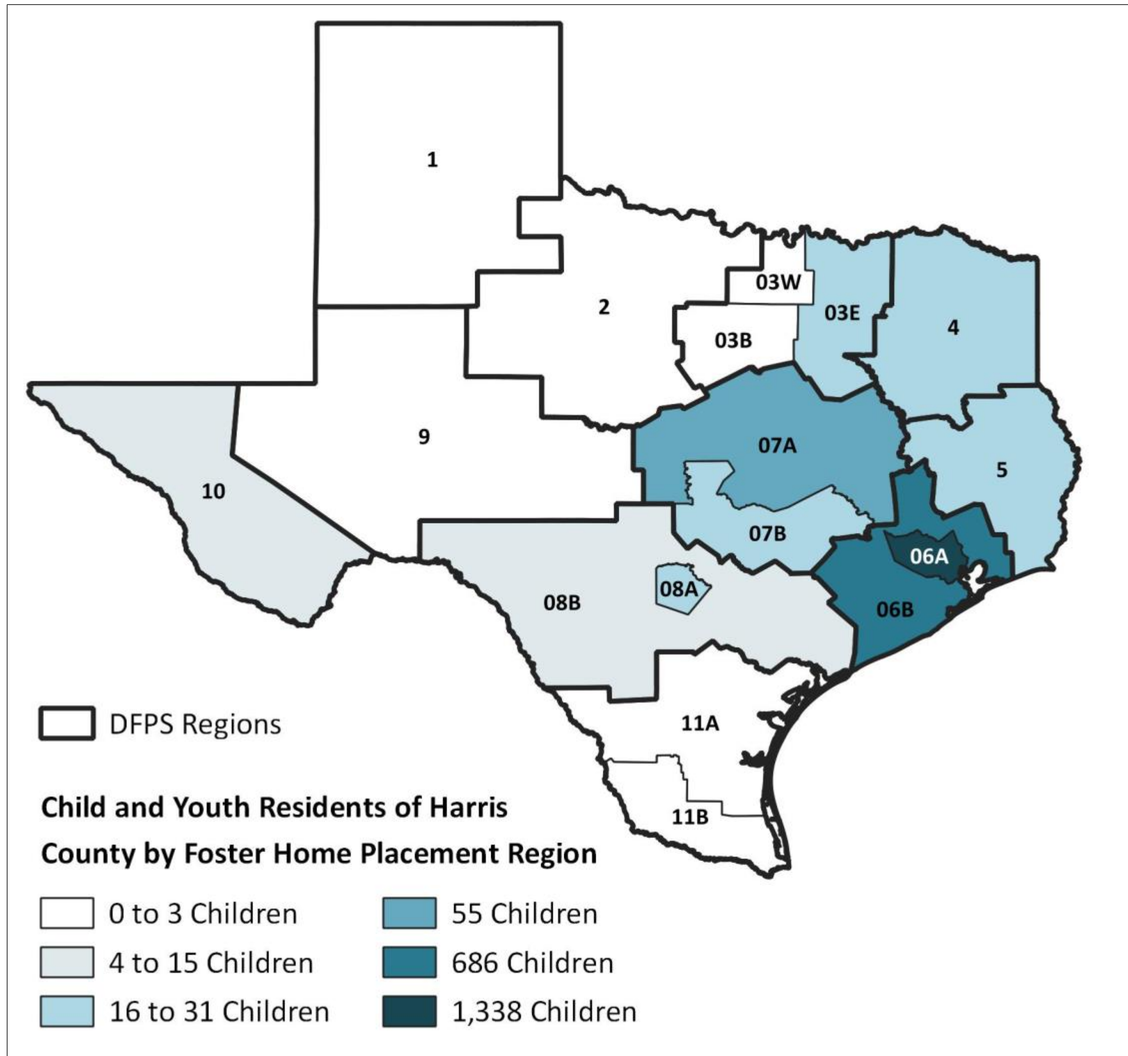
Graph 1: Percentage of Children and Youth in Relative Placements Out of All Children and Youth in Substitute Care – FY 2008 to FY 2017[18]



Placement Trends for Children and Youth from Region 6a

The majority of Harris County children and youth are placed in Region 6a or Region 6b. The map below shows where children and youth in foster care from Harris County were placed on October 31, 2018. More than half were placed within Harris County. The majority of children and youth who were placed outside of the county were placed in the immediately surrounding region (6b). A small number of children and youth were placed further away, in DFPS Regions 8 (San Antonio), 7 (Austin), 3E (Dallas), 4 (Tyler), and 5 (Beaumont). An even smaller number were placed as far away as Region 10 (El Paso).

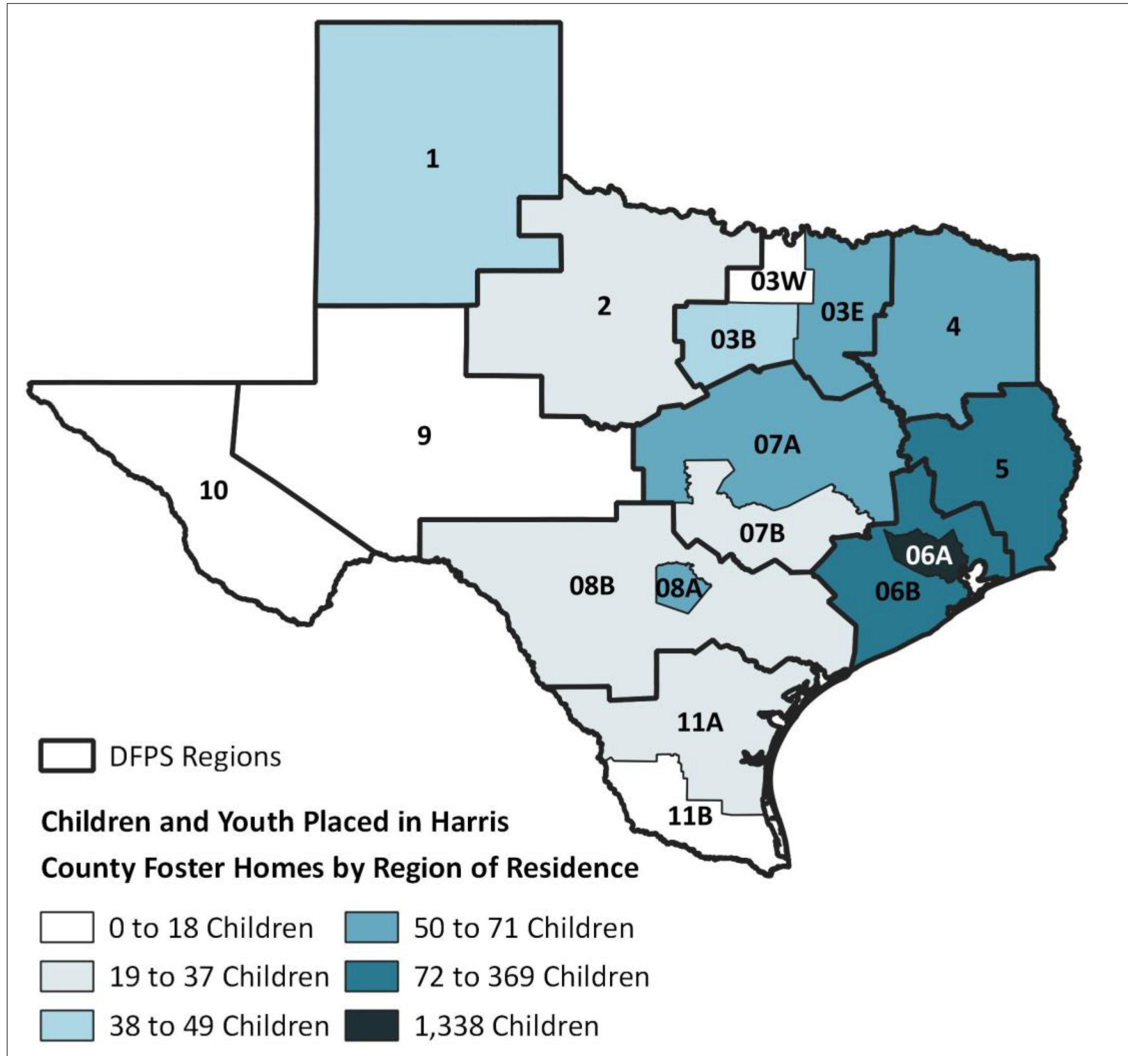
Map 1: Legal Residents of Harris County by Foster Home Placement Region



Many children and youth from other regions are placed in residential placements located in Region 6a. About 40% of the children and youth in foster care in Harris County are from other regions of the state. Children and youth are much more likely to move from other regions into Region 6 for placement than they are to move out of Harris County for placement. The flow of children and youth from other areas into Harris County may reflect a lack of general residential operations (GRO), residential treatment centers (RTC), and emergency shelters in other areas. For example, as of October 21, 2018, Beaumont, North Texas, Austin, and San Antonio each placed more than 100 children and youth in Harris County. To illustrate where children and youth in Harris County placements come from, Map 2 below shows the DFPS region of legal residence (place of origin) of all children and youth who were placed in foster homes in Harris

County. A table that lists the number of children and youth placed in Region 6a foster homes is located in Appendix B.

Map 2: Children and Youth Placed in Harris County Foster Homes by Region of Legal Residence



Where Do Children and Youth from Region 6a Attend School?

Foster Care Children and Youth by Independent School District (ISD)

The majority of school age children and youth in foster care in Region 6a are enrolled in the Houston Independent School District (HISD). However, significant discrepancies were noted between school district and DFPS data. The discrepancies are not surprising; numerous challenges prevent schools from knowing and tracking if a student is in foster care making it

difficult to obtain information on how many children and youth in foster care are able to remain at their home school after being placed in care.

Table 5 provides the number of children and youth in foster care by school district, according to DFPS. The data were extracted from a single school day in 2017. Although these data reflect how children and youth in care are distributed across area school districts, the accuracy of these data are limited. Accurate counts of school district attendance require up-to-date records in the Information Management Protecting Adults and Children in Texas (IMPACT) system, DFPS's electronic case management system. For a variety of reasons, IMPACT does not always contain complete and current information, leading to imprecise counts of students in the foster care system.

The Texas Education Agency (TEA) also provides aggregated counts of students in foster care for each school year. When compared to the data provided by DFPS, the TEA counts should be higher than the DFPS counts since they reflect an entire school year rather than a single day. However, in most cases, the TEA counts of foster students are about equal to, or lower than, those of DFPS.

DFPS and TEA both report high counts (more than 100) of students in the foster care system in these ISDs: Houston ISD, Cypress-Fairbanks ISD, Klein ISD, Aldine ISD, Spring ISD, and Humble ISD.

Table 5: DFPS and TEA Counts of Children and Youth in Foster Care[19]

ISD Name	DFPS Foster Care Count[20]	TEA Foster Care Count[21]
Houston ISD	533	168
Cypress-Fairbanks ISD	190	331
Klein ISD	210	305
Aldine ISD	220	298
Clear Creek ISD	20	69
Alief ISD	88	46
Spring ISD	202	169
Pasadena ISD	57	30
Tomball ISD	16	38
Humble ISD	109	124

ISD Name	DFPS Foster Care Count[20]	TEA Foster Care Count[21]
Channelview ISD	28	16
Crosby ISD	11	23
Spring Branch ISD	30	19
Waller ISD	13	24
Goose Creek ISD	56	47
Katy ISD	50	59
Deer Park ISD	15	7
Galena Park ISD	48	43
Huffman ISD	9	14
La Porte ISD	19	23
Sheldon ISD	18	22

What Do the Authorized Service Levels Tell Us About the Needs of the Children and Youth in Care in Region 6a?

Certain characteristics of children and youth in foster care determine the level of care they receive. This section describes different levels of assumed need among children and youth in foster care and provides a general overview of those identified as having the highest need. These data were drawn from DFPS' September 2018 monthly snapshot data of authorized service levels (ASLs).

Overview of DFPS Service Level System's Authorized Services Levels

All children and youth who enter DFPS care are assigned an ASL.[22] ASLs are assigned based on the behaviors and needs of children and youth in care, which is why they were used as a general indicator of aggregate levels of need. An ASL determines the type of placement that would be best matched to a child or youth's characteristics and service needs. The Texas service level system includes four ASLs – Basic, Moderate, Specialized, and Intense (including Intensive-Plus). A child protective service (CPS) caseworker or supervisor can assign a child or youth to a Basic Service Level. A third-party review by Youth for Tomorrow (YFT), a behavioral health care company contracted by DFPS to do quality assurance and utilization management and review, is required to assign a child to a higher level of need. YFT also conducts regular reviews of assigned ASLs. When children and youth enter foster care, most are assigned to the Basic Service Level, regardless of the reason they were removed. They can be placed in higher

services levels once their level of need is assessed or their needs change. Table 6 provides descriptions of the behaviors of children or youth who would be appropriate for placement at each ASL, and the type of living situation appropriate for that level.

Table 6: Overview of Authorized Services Levels (ASLs)

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

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

Children and Youth in Region 6, by Authorized Service Level

Almost two thirds of children and youth were placed at a Basic ASL, though older youth were more likely to be placed in higher ASLs. The September 2018 snapshot shows the majority of children and youth (64%, or 1,957) were placed in a Basic Service Level (they were assessed as requiring a minimum amount of support to maintain or improve their level of functioning). Almost 14% (420) of children and youth were identified as struggling with behaviors, developmental delays, or health issues that required a Moderate Service Level. More than one fifth of all children and youth over the same period were placed in a Specialized (18%, or 559) or Intense Service Level (4%, or 120).

A breakdown of ASL by age revealed that more youth ages 14 and older were placed in higher ASLs than their younger peers. Two hundred and twenty-nine (229) youth ages 14 to 17 – more than one third of all youth in this age group – were identified as needing a Specialized Service Level and another 74 were identified as needing an Intense Service Level. Youth ages 14 to 17 represented more than 40% of the children and youth placed at a Specialized Service Level and 62% of the children and youth placed in an Intense Service Level.

African American children and youth are far more likely than children and youth of other races to be placed in a higher ASL that requires specialized caregiver training and higher levels of supervision. In September 2018, there were 250 African American children and youth in the Specialized Service Level and 63 in the Intense Service Level. When compared to the children and youth of other races, there are more African American children and youth in these higher ASLs – 45% of all children and youth in Specialized and 54% of all children and youth in Intense Service Levels.

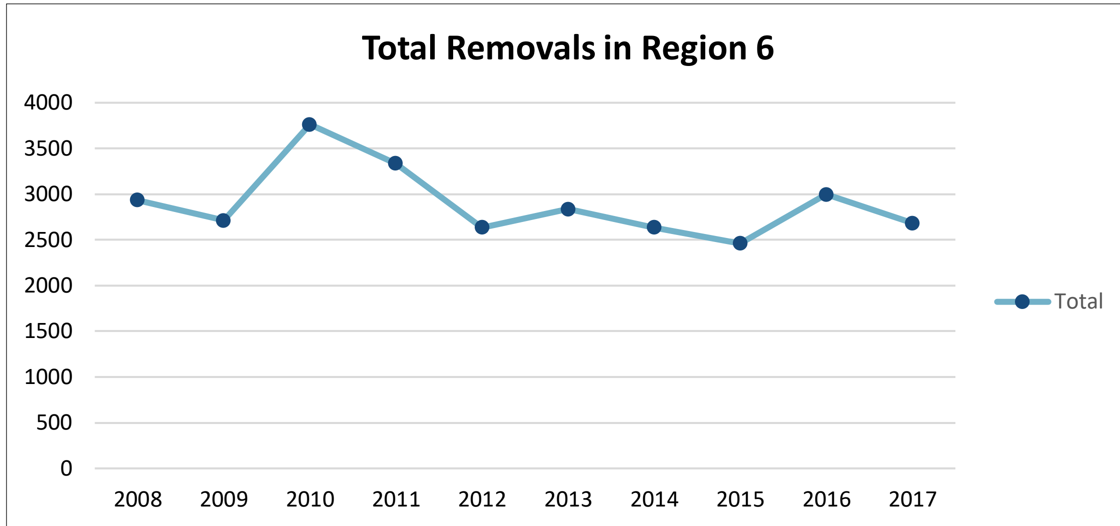
Table 7 provides an overview of the demographic characteristics of the children and youth in foster care in Region 6 by ASL in 2018.

Table 7: Demographics of Children and Youth in Foster Care by Authorized Service Level – September 2018[23]

Population	Authorized Service Level				
	Basic	Moderate	Specialized	Intense	Psychiatric Transition
Children and Youth (0–17)	1,957	420	559	120	4
Percentage in Service Level Out of All ASLs	64%	14%	18%	4%	<1%
Age					
Ages 0–2	715 (37%)	30 (7%)	44 (8%)	5 (4%)	N/A
Ages 3–5	449 (23%)	49 (12%)	38 (7%)	7 (6%)	N/A
Ages 6–9	388 (20%)	113 (27%)	89 (16%)	6 (5%)	N/A
Ages 10–13	224 (11%)	85 (20%)	159 (28%)	28 (23%)	N/A
Ages 14–17	181 (9%)	143 (34%)	229 (41%)	74 (62%)	4 (100%)
Sex					
Male	987 (50%)	246 (59%)	348 (62%)	42 (35%)	N/A
Female	970 (50%)	173 (41%)	211 (38%)	78 (65%)	4 (100%)
Race/Ethnicity					
Non-Hispanic White	464 (24%)	98 (23%)	145 (26%)	24 (20%)	1 (25%)
African American	688 (35%)	189 (45%)	250 (45%)	63 (53%)	2 (50%)
Asian American	12 (1%)	5 (1%)	4 (1%)	N/A	N/A
Native American	N/A	N/A	1 (<1%)	N/A	N/A
Multiple Races	92 (5%)	22 (5%)	21 (4%)	7 (6%)	N/A
Hispanic/Latino	671 (34%)	105 (25%)	131 (23%)	23 (19%)	N/A

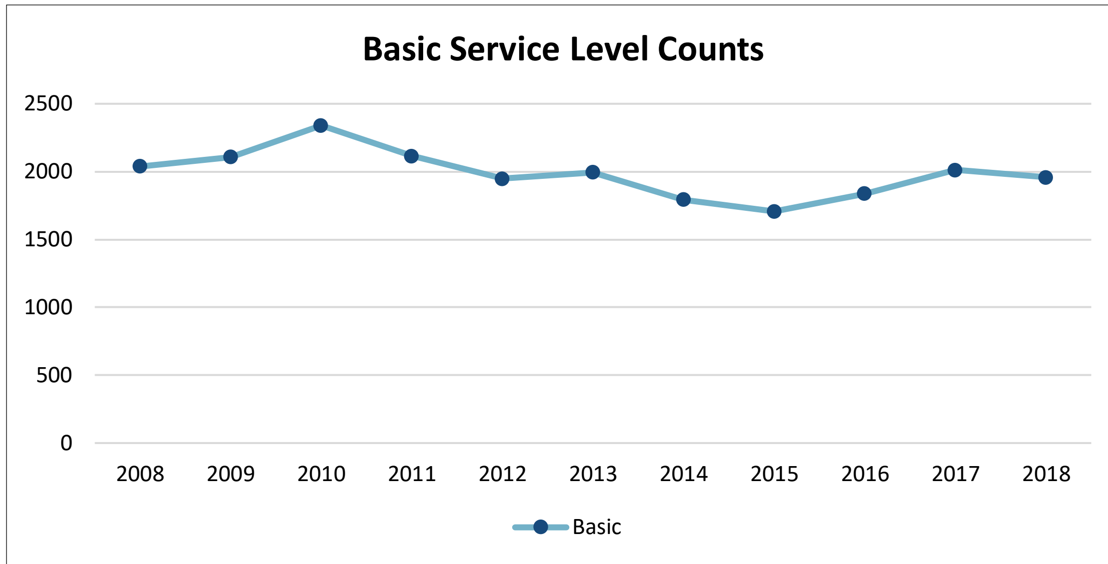
Over the last decade, there was a slight decrease in the number of children and youth in Region 6 who were removed from their homes (despite increases in 2010, 2013, and 2016). This is reflected in Graph 2, below, showing the number of removals in Region 6 from 2008–2017.

Graph 2: Total Number of Removals per Year in Region 6 – 2008 to 2017



When children and youth enter the foster care system, they are assigned an initial service level within one working day. A DFPS caseworker or supervisor can assign a child or youth to a Basic Service Level based on their assessed needs, or to provide foster care payments at a basic rate until YFT can assess and assign a higher ASL. The majority remain at a Basic Service Level. This is reflected in Graph 3, which shows the number of children and youth in Region 6 in the Basic Service Level from 2008–2018.

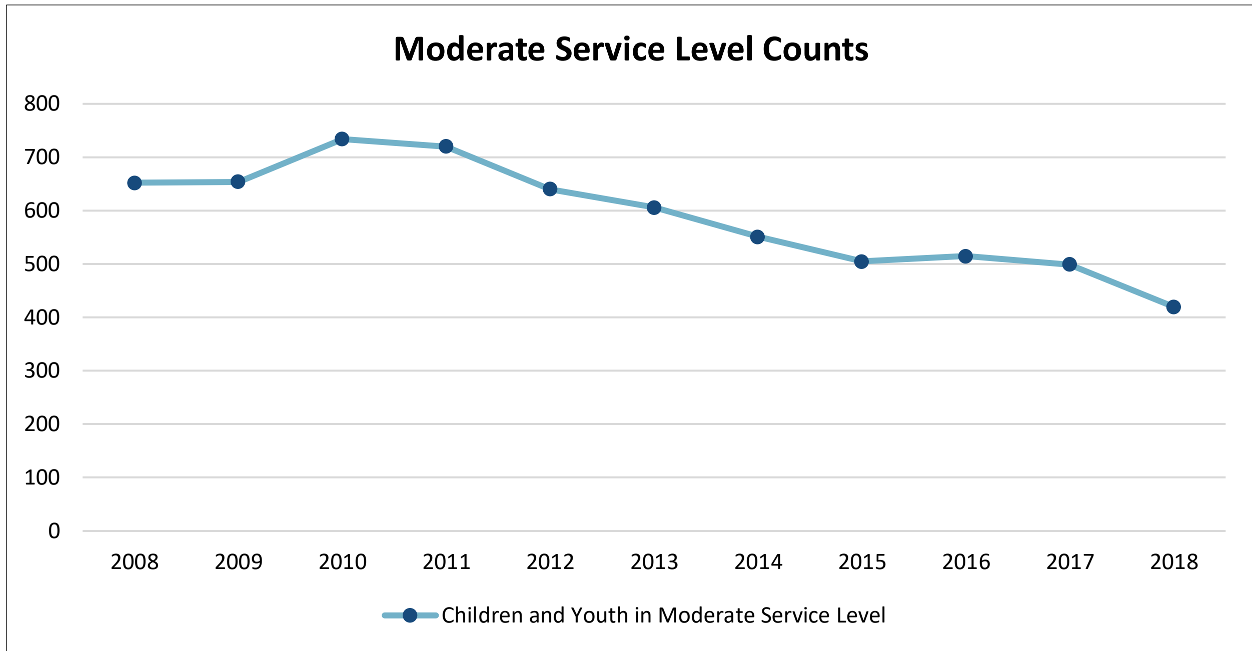
Graph 3: Basic Service Level – 2008 to 2018 (September Months Only)[24]



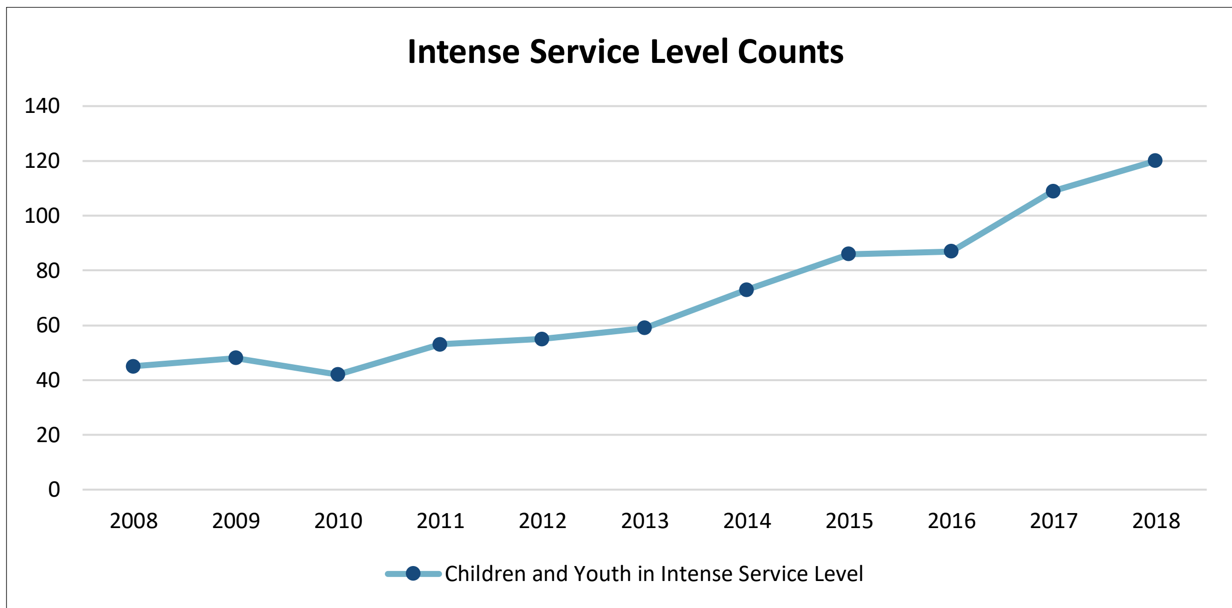
The information presented in Graphs 2 and 3 show a similar trajectory, with peaks in late 2009, a decline in 2015, and a rise again in 2016–2017.

Graphs 4 and 5 show the trends in the number of children and youth in Moderate and Intense Service Levels during the same time period from 2008 to 2018. Using a single month of data (September) from each year from 2008 to 2018, it was determined that the numbers of youth in the Moderate Service Level declined (from 20 % to 13 %) and the numbers in the Intense Service Level increased (from 1.3% to 3.8%). This suggests that, as the overall number of children and youth in care decreases, the children and youth who remain in care are there longer and require higher levels of care. Other service levels did not reveal any long-term trends and were not included in this report.

Graph 4: Moderate Service Level – 2008 to 2018 (September Months Only)[25]



Graph 5: Intense Service Level – 2008 to 2018 (September Months Only)[26]

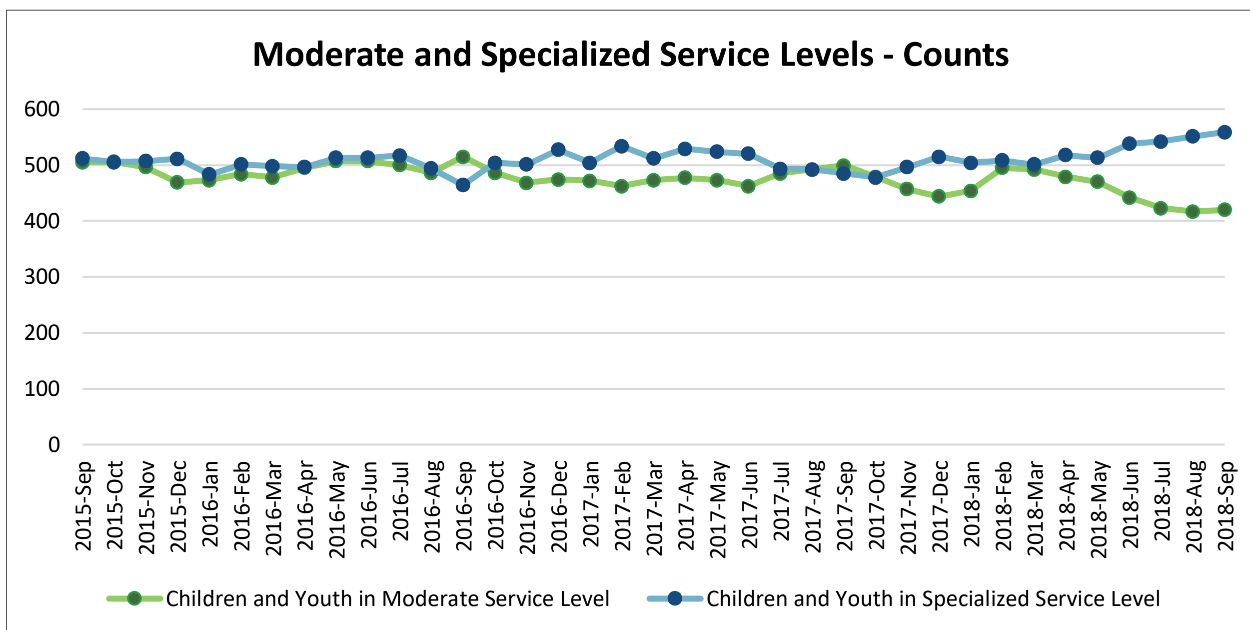


The trends depicted in Graph 6 show the percentage of children and youth in the Moderate Service Level compared to those in the Specialized Service Level. When the percentage of children and youth in the Moderate Service Level are compared to the percentage of children and youth in the Specialized Service Level, there appears to be an inverse relationship (see

September 2016, December 2017, and September 2018) – as the percentage of children and youth in one level decreases, the percentage in the other increases. The largest gap between service levels occurred in the most recent months, with an increase in the percentages of youth in a Specialized Service Level and a corresponding decrease in children and youth in a Moderate Service Level. It is difficult to identify the cause of the fluctuation without a more in-depth analysis. Potential causes could include:

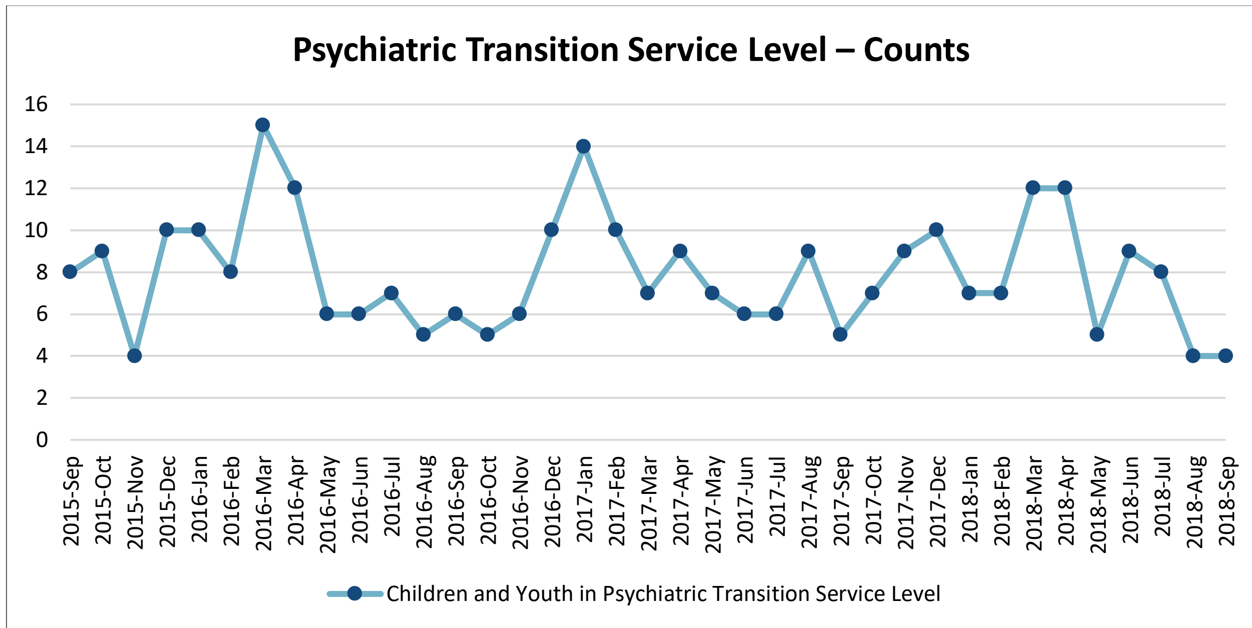
- Naturally occurring fluctuation in the needs of children and youth entering care,
- The rapidly changing needs of the children and youth already in care, or
- Assigned ASLs being reassessed to match a child or youth's access to an available foster care placement. For example, decreasing an ASL to support a placement in an available foster home or increasing it to access a group home or residential treatment center (RTC).

Graph 6: Moderate and Specialized Service Levels (Month to Month) – September 2015 to September 2018[27]



Placements in the Psychiatric Transition Service Level have not grown, with four to 15 children and youth in this level of care at any given time. Graph 7 shows the fluctuation in the number of children and youth in this level of care between September 2015 and September 2018.

Graph 7: Psychiatric Transition Service Level (Month to Month) – September 2015 to September 2018[28]



Prevalence of Mental and Behavioral Health Conditions

The prevalence of mental and behavioral health conditions were examined because children and youth in foster care are more likely to have a mental health issue. Up to 80% of children and youth who enter care have a significant mental health need and at least one in two have more than one mental health diagnosis.[29,30] CBC planning should address the mental health needs of children and youth in foster care. When mental health needs go unmet, children and youth in care are less likely to be placed in a permanent home. They are more likely to experience a placement breakdown and rely on more restrictive – and more expensive services – such as RTCs and emergency rooms.[31]

Mental Health Needs of All Children and Youth in Region 6

Across child welfare systems, more than two thirds of the children and youth entering foster care have a documented history of maltreatment.[32] A majority have been exposed to violence, including domestic violence, and many have parents with histories of substance use, criminal justice involvement, and mental illness.[33] For many children and youth in care, these traumatic experiences are compounded by factors that include homelessness, unsafe neighborhoods, poor schools and school attendance, poor child care, and a lack of normal childhood experiences. These traumatic experiences and adversities can result in poor emotional regulation, aggression, hyperactivity, inattention, impulsivity, and dissociation between

thoughts and emotions.[34] Further, removal and placement in foster care can be traumatic – loss of contact with family and friends, separation from siblings, changes in school, and unstable foster care placements can result in emotional and behavioral problems.

Understanding the mental health needs of children and youth with the highest risk for out-of-home placement in Region 6a helps the community anticipate the demand for mental health services. To more precisely anticipate local needs, the number of all children and youth with mental health needs across Region 6 was estimated, and the number of children and youth with mental health needs in Region 6a was compared to the number of children and youth with mental health needs in the surrounding area (Region 6b). This comparison was made because many children and youth from region 6b are served in 6a, which has an impact on the region's demand for mental health services. This assessment is based on the latest epidemiological research, which indicates that one in three children ages six to twelve, and two in five youth ages 13 to 18, experience a mental health issue or substance use disorder each year.[35]

Across all mental health needs – mild, moderate, and severe – about 320,000 children and youth in Region 6a (and an additional 160,000 in Region 6b) experience mental health disorders each year. Within the total child and youth population that experiences a mental health or substance use disorder, those living in poverty are at the highest risk for out-of-home or out-of-school placement.[36] Living in poverty or low income households has been linked to increased risk for mental health problems in children and youth that persist into adulthood.[37] It has been estimated that 95,000 children and youth ages six to 17 in Region 6 have a serious emotional disturbance (SED), approximately 50,000 of whom live in poverty.[38] The majority of these children – 35,000 – live in Region 6a. SED is defined as a mental, behavioral, or emotional disorder that lasts long enough to impair functioning and substantially interfere with the child or youth's ability to function in their family, school, or community.[39] While about one in 12 children and youth overall and one in 11 children and youth living in poverty experience such a severe mental health need (and the rate climbs to one in ten by adolescence), the research noted above shows that rates are generally higher for children and youth served in the foster care system.

Table 8: 2016 Demographics of All Children and Youth in Region 6 (SED and Poverty)

Population	Total Population	Total Population With SED	Total Population in Poverty	Total with SED in Poverty[40]
Children and Youth (6–17)	1,250,000	95,000	550,000	50,000
Age				
Ages 6–11	630,000	50,000	290,000	25,000
Ages 12–17	610,000	45,000	260,000	25,000
Sex				
Male	640,000	50,000	280,000	25,000
Female	610,000	45,000	270,000	25,000
Race/Ethnicity[41]				
Non-Hispanic White	370,000	25,000	70,000	6,000
African American	210,000	15,000	110,000	10,000
Asian American[42]	80,000	5,000	20,000	2,000
Native American[43]	2,000	100	600	50
Multiple Races	25,000	2,000	8,000	700
Hispanic/Latino	560,000	45,000	340,000	30,000

Table 9 provides additional information on mental illness prevalence among all children and youth in Region 6, by age group and mental health diagnosis. This table also includes estimates on poverty and numbers of children and youth who are at risk for out-of-home or out-of-school placement. While the analysis above showed that rates of mental health need in the overall child population are lower than those for children and youth in foster care, the relative prevalence of different mental health needs can help support community planning for children and youth in foster care. The prevalence of mental health needs for the total region is provided as well as the prevalence for Region 6a, including percentages of overall need represented by each diagnostic breakout. The relative prevalence of different mental health needs in the surrounding region has an impact on the demand and availability of services in 6a, and need in 6a drives service utilization in 6b. The primary focus is on the subset of children and youth in poverty who are at the highest risk for out-of-home or out-of-school placement – 4,000 in Region 6a and 1,000 in Region 6b, many of whom are served in the foster care system. While the overall rate of mental illnesses is high, planners should be mindful that up to two thirds of children and youth with mild to moderate needs (including children and youth with mild to moderate needs in the foster care system) can be served by their pediatric primary care

providers through best practice, integrated behavioral health services, allowing communities and health systems to focus specialty resources on children and youth with complex mental health needs.

Table 9: Twelve-Month Prevalence of Mental Health Disorders in Children and Youth in Region 6 (2016)

Mental Health Condition – Children and Youth	Age Range	Harris County (6a)[44]	Region 6 Total	Proportion of 6a MH Needs
Population in Poverty[45]	6–17	410,000	550,000	N/A
All Behavioral Health Needs (Mild, Moderate, and Severe) [46]	**6–17**	**320,000**	**480,000**	**100%**
Mild	6–17	180,000	280,000	57%
Moderate	6–17	70,000	110,000	22%
Severe – Serious Emotional Disturbance (SED)[47]	6–17	65,000	95,000	21%
SED in Poverty	6–17	35,000	50,000	N/A
At Risk for Out-of-Home/Out-of-School Placement [48]	6–17	4,000	5,000	N/A
Specific Disorders – Youth (Unless Otherwise Noted)[49]				
All Anxiety Disorders – Children	6–11	45,000	70,000	14%
Depression	12–17	35,000	50,000	11%
Bipolar Disorder	12–17	8,000	15,000	3%
All Anxiety Disorders – Children	6–11	45,000	70,000	14%
Obsessive-Compulsive Disorder – Children/Youth[50]	6–17	15,000	25,000	5%
Post-Traumatic Stress Disorder	12–17	15,000	25,000	5%
Substance Use Disorders[51]	12–17	20,000	35,000	6%
Schizophrenia[52]	12–17	900	1,000	0.3%
First Episode Psychosis (FEP) Incidence – New Cases per Year[53]	12–17	200	200	N/A
Eating Disorders[54]	12–17	3,000	5,000	N/A
Self-Injury/Harming Behaviors[55]	12–17	40,000	60,000	N/A
Number of Deaths by Suicide (2016)[56]	0–17	30[57]	42[58]	N/A

What is the Prevalence of Mental and Behavioral Health Conditions for Children and Youth in Foster Care in Region 6a?

DFPS provides monthly snapshots of the number of children and youth in foster care with certain identified characteristics, including “physical,” “medical,” “emotional,” “drug/alcohol,” and “learning” needs, dating back to 2008. While the “emotional” and “drug/alcohol” characteristics are based on caseworker notes, not diagnostic interviews, they are the best available measure of the number of children and youth in foster care with behavioral health conditions.

The “emotional” characteristic was used as a measure of SED, and the “drug/alcohol” characteristic was used as a measure of substance use disorders (SUD). Note that children and youth can have more than one characteristic, and many are included in more than one month of data, so these snapshots cannot be used to obtain a yearly unduplicated total of children and youth with each characteristic. However, monthly snapshots can be used to determine the percentage of children and youth with each characteristic and understand the changes in prevalence of certain characteristics over time, allowing the community to potentially forecast the need for mental health and SUD services.

Table 10: Estimated Prevalence of SED and SUD in Children and Youth in Foster Care in Region 6, 6a, and 6b – 2017

Population	Harris County (6a)	Region 6b	Total in Region 6
Children and Youth in Foster Care (0 to 17)[59]	3,829	1,658	5,487
With Emotional Characteristics (SED)[60, 61]	700	300	1,000
Percent of Total in Foster Care	18%	18%	18%
With Drug/Alcohol Characteristics (SUD) [62]	200	100	300
Percent of Total in Foster Care	5%	5%	5%

The analysis of DFPS data from 2017 revealed that the percentage of children and youth with an SED in foster care in Region 6a was significantly higher than the rate in the general population (17% compared to 7% across the general child population).[63] Using this rate (17%), an estimated 1,000 children and youth in foster care in Region 6 struggle with SED, 700 of whom resided in Harris County. DFPS monthly snapshot data between September 2015 and 2018 showed a four percent decline. These estimates are based on case worker report and may under-report the number of children and youth with an SED.

The prevalence estimates for all children and youth with an SED in Region 6a (8% for all children and 9% for those in poverty) did not include children under age six because SED is generally more prevalent in children over age six and prevalence estimates do not account for this age group. However, DFPS child characteristic data included children younger than six years old. Excluding this age group from our estimate increases the rate of SED to as high as 30%.

Substance use disorders are higher among youth in the child welfare system. Current research suggests that the national prevalence of substance use disorders in youth in the child welfare system can range anywhere from 11% to 19%.[64] Based on DFPS monthly snapshots from September 2015 to 2018, an estimated 3% of all youth ages 12 to 17 years in Region 6a had a substance use disorder. In comparison, 6% of children and youth in foster care in the region had an identified drug/alcohol characteristic. DFPS monthly snapshots from September 2015 to 2018 indicated a slight decline in the presence of the drug/alcohol characteristic. As noted earlier, age breakouts were not available to determine the age distribution of children and youth in foster care who had this characteristic. If children under the age of 10 years are excluded from the denominator, the rate of SUD among youth in foster care in Region 6a would be 15%.

Table 11 shows children and youth in Region 6a in each ASL who were identified as having characteristics – emotional, learning, medical, physical needs, special needs – that require specialized supports. DFPS uses the following key indicators to describe these characteristics:

- Emotional – Animal cruelty, assaultive behavior, bipolar disorder, depression, eating disorder, emotional disturbance, fire setting, gang activity, oppositional defiant disorder, post-traumatic stress disorder, self-abuse, sexual acting out, and other behavior problems.
- Learning – Attention deficient disorder/attention deficit hyperactively disorder, intellectual and developmental delays, autism spectrum disorder, and speech and learning disabilities.
- Medical – Enuresis and encopresis, failure to thrive, medically complex or medically fragile, traumatic brain injury, terminal illness, sexually transmitted disease and HIV/AIDs, and hearing and visually impaired.
- Physical Needs – Mobility impairment, physically disabled, spina bifida.
- Special Needs – Developmental disability, Down syndrome, reactive attachment disorder, bipolar disorder, depression, emotional disturbance, enuresis/encopresis, failure to thrive, medically complex, hearing impaired, HIV positive/AIDS, medically fragile, intellectual and developmental disability, mobility impaired, oppositional defiant disorder, post-traumatic stress syndrome, psychotic disorder, and terminal illness.

- Drug/Alcohol – Substance use or abuse.

Among children and youth in foster care with these identified characteristics, the majority had emotional and learning needs, and most of these children were placed in Specialized Service Levels. Fewer children and youth were identified as having needs related to drug and alcohol use, and the majority of those appeared to have been served within the Basic Service Level.

Table 11: Characteristics of Children and Youth in Foster Care by Authorized Service Level – September 2018[65]

Characteristic	Authorized Service Level						
	Basic	Moderate	Specialized	Intense	Psychiatric Transition	Blank or End Dated	All Service Levels
Physical	4	7	24	4	0	1	40
Medical	29	40	93	23	0	5	190
Drug/Alcohol	89	28	33	18	0	6	174
Emotional	66	141	278	73	3	26	587
Learning	87	179	310	70	1	25	672

Key Findings on Child and Youth Characteristics

Child and Youth Key Characteristic (CYKC) Finding 1: Nearly half of all children in Region 6a in DFPS care were under the age of six years.

Nearly half (1,354) of the children in foster care in Region 6a were under the age of six years, and one quarter (809) were infants between the ages of 0 and 2 years. National estimates indicate that more than 40% of the children in care are under the age of six years.[66] Infants and toddlers are twice as likely to enter foster care than older children and youth, and they have the highest victimization rates.[67] The most commonly reported reasons for removal are neglect and parent drug use. Infants are most affected when a parent has a diminished capacity to provide care since they have the lowest levels of independence.[68]

CYKC Finding 2: There are more African American youth and older youth in higher ASLs.

While African Americans make up less than 20% of the total population in Region 6a, the monthly snapshot from September 2018 showed that nearly twice that proportion (more than 39%) of the children and youth in foster care were African American. The over-representation of African American children and youth was reflected in the higher number of African American children and youth in the higher ASLs – Moderate, Specialized, Intense, and Psychiatric

Transition.[69] Approximately 20% of African American youth in foster care were between the ages of 14 and 17 years. This trend is not mirrored among youth from the Latino/Hispanic community, which has the highest number of children living in poverty and the highest rates of estimated SED in Region 6, yet it has lower numbers of children and youth in foster care, and those in care are less likely to be placed in higher ASLs.

In addition, a review of children and youth across all ASLs for fiscal year (FY) 2017 revealed that youth ages 14 years and older were more likely to be placed in a higher ASL than younger children.

CYKC Finding 3: Most Harris County children and youth are served nearby, but the Harris County foster care system also serves many children and youth from other areas of the state.
The majority of the children and youth from Region 6a (Harris County) are placed in Region 6. More than half are placed in Region 6a. However, many children and youth from other areas are placed in Harris County. About 40% of the children and youth in foster care in Harris County are from other regions of the state. This primarily reflects a lack of foster care and residential capacity in other regions. For example, as of October 21, 2018, Beaumont, North Texas, Austin, and San Antonio each placed more than 100 children and youth in Harris County.

CYKC Finding 4: Region 6a includes a significant number of children and youth with complex mental health needs.
Harris County's population density and large number of children and youth living in poverty have contributed to a high prevalence of mental health conditions. While mental health needs can complicate the delivery of foster care services, the vast majority of these needs can be served in primary care, with the right supports. However, there are an estimated 4,000 children[70,71] and youth with the most serious emotional disturbances (SED) living in poverty in Harris County (6a) – plus an additional 1,000 children and youth with such needs in Region 6b. Their needs make it less likely they will stay in their foster homes or schools. According to 2017 data, for all ASLs, 18% of children in foster care had an "emotional" characteristic.[72] Using this percentage, an estimated 1,000 children and youth in foster care in Region 6 have a serious emotional disturbance, 700 of whom reside in Harris County.

CYKC Finding 5: Fewer children and youth are entering foster care because of a higher use of kinship placements. Therefore, of those children and youth who are in care, a higher percentage of them are in the lowest and highest levels of care.
The number of children and youth entering care has declined over the last ten years. Moreover, their distribution across ASLs has changed. Over the past decade:

- The percentage of children and youth in a Moderate Service Level declined by 7%.

- The percentage of children and youth in a Specialized Service Level remained stable at 18%, while the percentage of children and youth in Intense Service Levels increased from 1.4% to 3.8%.
- Additionally, the percentage of children and youth with a Basic Service Level increased by 4% over the last ten years.

These variations may reflect the large number of very young children in care who require Basic Service Levels and the number of older youth and African American children and youth who are placed in higher authorized levels.

CYKC Finding 6: Children and youth in Region 6a remain in care longer and are less likely to be placed with relatives. Both placement in non-relative foster homes and longer lengths of time in care have a negative impact on placement stability and permanency. A snapshot of children and youth in care indicated that the average length of time in care was 24.6 months; higher than the national average of 19.2 months and state average of 17.4 months.[73] More than 60% of youth in care were placed with non-relative caregivers. Regions 6a's percentage of relative placements (44%) has been increasing since 2015, but has not reached the state average (47%).

CYKC Finding 7: More than 40% of children and youth in Region 6a are not placed with their siblings. Children and youth being placed with their siblings is a community-based care (CBC) quality indicator. A snapshot of children and youth in foster care on August 31, 2018, indicated that fifty-seven percent (57%) of the sibling groups in care in Region 6a were placed together, which was below the statewide percentage of 65%. Placing siblings together is a protective factor for mental health and well-being and reduces the traumatic stress of removal.

CYKC Finding 8: There are an estimated 500 LGBTQ children and youth in foster care in Region 6, of which 300 are estimated to be from Region 6a. Prior to entering foster care, LGBTQ children and youth are likely to experience a number of adverse or traumatic events such as violence and homelessness that are associated with their sexual orientation and gender identity. They also may struggle with further biases and discrimination while in care, which can have an impact on their placement stability and create barriers to permanency.[74,75] Nationally, LGBTQ youth are overrepresented in child welfare, foster care, and out-of-home placements. Estimates indicate that they are 2.5 times more likely to be involved in the foster care system and, once in care, they are less likely to exit to a permanent placement than their heterosexual and gender-conforming peers.[76] LGBTQ youth in foster care are also more likely to experience violence or be victimized, and struggle with poor mental health.[77] A study conducted in Los Angeles County found that LGBTQ youth living in foster care had a higher than average number

of placement moves and were more likely to be placed in a group home, hospitalized for emotional reasons, or experience homelessness or be kicked out of home.[78] Barriers that LGBTQ youth face in achieving permanency in the foster care system include placement instability, group home placement, unmet mental health needs, and homelessness.[79]

Children and Youth Characteristic Planning Considerations

CYKC Planning Consideration 1: There is a substantial unmet need for foster home placements for infants and young children, and their needs are often complex. Nationally, and in Region 6a, infants and older youth represent the largest groups of children and youth in care. Moreover, infants and young children enter care at a higher rate than any other age group. Many have experienced maltreatment and have been exposed to drugs and alcohol prenatally, putting them at risk for cognitive and behavioral challenges and developmental and social and emotional delays.[80,81] The demands of parenting an infant with complex health and cognitive needs, coupled with the fact that many foster parents are employed outside the home, highlights the need for intentional recruitment efforts.

The Capacity Think Tank[82], a collaboration between Region 6 and DFPS to develop the region's capacity strategic plan, recognized these challenges and identified the need to increase the number of Basic Service Level foster homes for preschool age children in its 2018 Capacity Strategic Plan.[83] The group identified the frequency and location of scheduled visitation, underutilization of current Basic Service Level foster homes, the number of employed foster parents, and recruitment challenges as barriers to meeting the placement needs of young children in the region. National studies on recruiting and retaining foster parents for infants and young children identified lack of access to quality child care and respite, and lack of early childhood parent training as additional barriers. The Capacity Think Tank participants identified four objectives to meet this goal: (1) centralize visitation, (2) utilize existing placements, (3) explore day care opportunities, and (4) increase data sharing. A detailed description of each of these objectives can be found in the DFPS' Capacity Strategic Plan (October 2018).

CYKC Planning Consideration 2: Pay special attention to the needs of African American youth, and consider how to provide more culturally appropriate, moderate intensity, and specialized foster care placements. African American youth in Region 6a are removed at higher numbers, are older, and are placed in higher levels of care than their white or Hispanic peers. Meeting the cultural, mental health, behavioral, and physical health needs of these youth requires child placement agencies in Region 6a to develop foster placements that deliver a higher level of care and are culturally appropriate. One way to address these issues would be to implement foster parent recruitment strategies that target specific ethnic and racial groups in neighborhoods

where entry rates are high. Successful approaches engage community leaders, build relationships with community organizations, include community members in recruitment efforts, involve faith-based institutions, and assess the cultural competence of the recruiting agency. Barriers to engaging foster parents of color include income requirements, background checks, and other licensing standards.[84]

CYKC Planning Consideration 3: Capacity is particularly challenged by the large number of youth ages 14 to 17 years who are at higher risk of aging out of care, many of whom have complex needs. Overall, more than two thirds of youth ages 14 to 17 years are in a higher level of care, and more than half are in Specialized or higher levels, placing them at a higher risk of aging out of care. Age, placement type, number of placement breakdowns, and ethnicity all increase the likelihood that youth, especially those with complex needs, will age out of care. In addition, youth who experience a change in their level of care or who have spent most of their time in congregate care are at a higher risk for aging out of care.[85]

- **Age:** More than a quarter of youth who enter care at age 16 years or older turn 18 while in care, compared to a little over 10% of youth who enter care at age 15 years and less than 5% who entered care at 14 years of age or younger.
- **Placement Type:** One in five youth (20%) who experience more than one type of placement will age out of care compared to less than 10% of youth placed in kinship care.
- **Number of Placements:** More than 20% of the youth who have experienced six or more placements will turn 18 years old while in care.
- **Ethnicity:** Permanency rates of African American youth are 20% lower than their white or Hispanic peers.

In 2018, nine percent (9%) of youth in care in Region 6a turned 18 years old while in care, compared to 6% statewide. These transition-age youth are more likely to experience mental health disorders than their same-age peers, and these challenges are exacerbated by placement instability. Given the prevalence of mental health challenges in older youth, CBC needs to encourage close collaboration between schools, the judiciary, health, and the behavioral health and child welfare systems to ensure older youth in care are screened for mental illness and services are provided.[86] To promote permanency, recruitment efforts should start with kin and foster parents who are willing to provide care for older youth. Targeted recruitment should be coupled with community-based supports, foster family coaching and training, and respite options.

CYKC Planning Consideration 4: The high number of children and youth in care with complex mental health and educational needs require access to well-trained foster care placements that are supported by a continuum of services and supports. Children and youth in foster care are far more likely to have a mental health condition than their peers who are not in care. They are five times more likely to have anxiety, six times as likely to struggle with behavioral problems, and seven times as likely to have depression.[87] In fact, children and youth who are placed in foster care have been found to be in poorer mental and physical health relative to children in every other type of family situation, including poverty[88]. In Region 6a, the majority of children and youth with an "emotional" or "learning" characteristic are in a Moderate or Specialized ASL, with the greatest number being placed at a Specialized ASL. Unmet mental health and educational needs frequently lead to placement in more restrictive settings. Success for these children and youth and their foster families requires a strong continuum of mental health services and supports that is integrated with child welfare and physical health services. These services and supports are addressed in the *Community Capacity to Support Foster Parents and Children and Youth in Care* section of this report.

CYKC Planning Considerations 5: Address the high number of sibling groups in Region 6a that are currently placed apart by reducing barriers to placing sibling groups together. This is a CBC quality indicator that must be addressed. Planning should address barriers to placing siblings together that include: (1) size of sibling group, (2) large age gaps between siblings, (3) differences in the needs of siblings, (4) types of placements – kinship placements are more likely to take sibling groups, (5) behavior problems, (6) organizational policies and procedures, and (7) agency rules regarding the maximum number of children who can be placed in a foster home.[89]

CYKC Planning Consideration 6: Address the needs of LGBTQ children and youth in foster care by identifying placements and community-based services and supports that are safe, affirming, and supportive of permanency and success. The CBC planning process should acknowledge the presence of LGBTQ children and youth in foster care and build in strategies to address the specific needs of this population, improve placement stability, and reduce barriers to permanency.

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[1] Center for Disease Control and Prevention (n.d.). *Violence Prevention: Risk and Protective Factors*. Retrieved from https://www.cdc.gov/violenceprevention/childabuseandneglect/riskprotectivefactors.html#Risk%20Factors%20for%20Victimization

[2] Lehmann, S., Haviks, O.E., Havik, T., & Heiervang, E.R. (2013). Mental disorders in foster children: A study of prevalence, comorbidity and risk factors. *Child Adolescent Psychiatry Mental Health.* 7:39.

[3] Texas Department of Family and Protective Services Data & Decision Support. (2019, February 8). *CPS 8.1 foster care placements by fiscal year and county – FY08–FY18.* Retrieved from https://data.texas.gov/Social-Services/CPS-8-2-Foster-Care-Placements-By-Fiscal-Year-And-/sxsx-qqtg
[4] These data reflect a snapshot of children and youth in Region 6 in September 2018. Data were obtained from the Texas Department of Family and Protective Services. (n.d.). *Regional statistics about children in DFPS care*. Retrieved from https://www.dfps.state.tx.us/Doing_Business/Regional_Statistics/default.asp
[5] Child Welfare Information Gateway (2013, January). *Sibling Issues in Foster Care and Adoption.* Washington DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from https://www.childwelfare.gov/pubpdfs/siblingissues.pdf
[6] Child Welfare Information Gateway (2013, January).
[7] Data reflect a snapshot of children and youth in the foster care system on August 31st in FY 2018. Data obtained from the Texas Department of Family and Protective Services Data Book: Child Protective Services (CPS) Length of Time in Substitute Care on August 31st. Data available at: https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/default.asp
[8] Fish, J.N., Baams, L., Wojciak, A.S., & Russell, S.T. (2019). Are sexual minority youth overrepresented in foster care, child welfare, and out-of-home placement? Findings from nationally representative data. Child Abuse & Neglect, 203–211.
[9] Baams, L., Wilson, B.D.M., & Russell, S.T. (2019). LGBTQ youth in unstable housing and foster care. *Pediatrics, 143*(3): e20174211
[10] Texas Care for Children (2018, April). *Fostering healthy Texas lives: Strategies to prevent teen pregnancy in foster care and support teen parents in foster care*. Retrieved from https://static1.squarespace.com/static/5728d34462cd94b84dc567ed/t/5ad4aa001ae6cfce64d7316f/1523886600659/fostering-healthy-texas-lives.pdf
[11] Casey Family Programs. (2018, November). *What are some strategies for supporting pregnant and parenting teens in foster care?* Retrieved from https://caseyfamilypro-wpengine.netdna-ssl.com/media/SF_Pregnant-parenting-teens-in-foster-care.pdf
[12] Department of Family and Protective Services. (2017). *Youth parents and pregnant youth in DFPS conservatorship: Fiscal year 2017–attachment*. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/CPS/documents/2017/2017_Pregnant_and_Parenting_Youth_Report_By_County_FY17.pdf
[13] Child Welfare Information Gateway. (2017). *Foster care statistics 2016.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. https://www.childwelfare.gov/pubPDFs/foster.pdf
[14] Casey Family Programs (2018, Updated August). *What impacts placement stability?* Strategy Brief: Strong Families. Retrieved from https://caseyfamilypro-wpengine.netdna-ssl.com/media/SF_Placement-stability-impacts.pdf
[15] Children's Bureau (2018, October). *The AFCARS Report, No. 25*. U.S. Department of Health and Human Services, Administration of Children and Families, Administration on Children, Youth and Families, Children's Bureau. Retrieved from https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport25.pdf
[16] Data reflect a snapshot of children and youth in the foster care system on August 31 in FY 2018. Data obtained from the Texas Department of Family and Protective Services Data Book: Child Protective Services (CPS) Length of Time in Substitute Care on August 31. Data available at: https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/default.asp
[17] Casey Family Programs. (2018, Updated September). *How can we improve placement stability for children in foster care?* Strategy Brief: Strong Families. Retrieved from https://caseyfamilypro-wpengine.netdna-ssl.com/media/SF_Strategies-to-improve-placement-stability.pdf
[18] Relative placements include CPA relative foster homes, DFPS relative foster homes, and kinship care. Data obtained from the Texas Department of Family and Protective Services Data Book: CPS 8.2 Children in Substitute Care on August 31 by Relative Placement. Placement Type and County FY08-FY17. Data available at: https://data.texas.gov/Social-Services/CPS-8-2-Children-In-Substitute-Care-On-August-31-B/p39g-siwr

[19] MMHPI credits the office of former Harris County Judge Ed Emmett and his staff member, Bill Schnapp, for providing this data.
[20] B. Schnapp (personal communication, February 2017). Data reflect a single day from early 2017. Daily rates are approximately half of the annual number of children and youth in foster care. Data were compiled by DFPS.
[21] Texas Education Agency. (2019, March 6). *Student program reports for Harris County, 2017–2018 school year*. Retrieved from https://rptsvr1.tea.texas.gov/adhocrpt/adspr.html
[22] Texas Department of Family and Protective Services, Child Protective Services. (2018, January). *Texas service level resource guide*. Retrieved from http://www.dfps.state.tx.us/handbooks/CPS/Resource_Guides/Texas_Service_Levels_Resource_Guide.pdf
[23] These data reflect a snapshot of children and youth in Region 6 in September 2018. Data were obtained from the Texas Department of Family and Protective Services. (n.d.). *Regional statistics about children in DFPS care*. Retrieved from https://www.dfps.state.tx.us/Doing_Business/Regional_Statistics/default.asp
[24] These data reflect a snapshot of children and youth in Region 6 in September 2018. Data were obtained from the Texas Department of Family and Protective Services. (n.d.). *Regional statistics about children in DFPS care*. Retrieved from https://www.dfps.state.tx.us/Doing_Business/Regional_Statistics/default.asp
[25] These data reflect a snapshot of children and youth in Region 6 in September 2018. Data were obtained from the Texas Department of Family and Protective Services. (n.d.). *Regional statistics about children in DFPS care*. Retrieved from https://www.dfps.state.tx.us/Doing_Business/Regional_Statistics/default.asp
[26] These data reflect a snapshot of children and youth in Region 6 in September 2018. Data were obtained from the Texas Department of Family and Protective Services. (n.d.). *Regional statistics about children in DFPS care*. Retrieved from https://www.dfps.state.tx.us/Doing_Business/Regional_Statistics/default.asp
[27] These data reflect a snapshot of children and youth in Region 6 in September 2018. Data were obtained from the Texas Department of Family and Protective Services. (n.d.). *Regional statistics about children in DFPS care*. Retrieved from https://www.dfps.state.tx.us/Doing_Business/Regional_Statistics/default.asp
[28] These data reflect a snapshot of children and youth in Region 6 in September 2018. Data were obtained from the Texas Department of Family and Protective Services. (n.d.). *Regional statistics about children in DFPS care*. Retrieved from https://www.dfps.state.tx.us/Doing_Business/Regional_Statistics/default.asp
[29] Lehmann, S., Haviks, O.E., Havik, T., & Heiervang, E.R. (2013). Mental disorders in foster children: A study of prevalence, comorbidity and risk factors. *Child Adolescent Psychiatry Mental Health.* 7:39.
[30] Szilagyi, M. A.; Rosen, D. S.; Rubin, D.; Zlotnick, S.; the Council on Foster Care, Adoption, and Kinship Care; the Committee on Adolescence; & the Council on Early Childhood. (2015, October). Health care issues for children and adolescents in foster care and kinship care. *Pediatrics, 136,* 4, e1142-66
[31] Stagman, S., Cooper, J.L. (2010, April). *Children's mental health: What every policymaker should know*. National Center for Children in Poverty, Mailman School of Public Health Columbia University. Retrieved from: http://www.nccp.org/publications/pdf/text_929.pdf
[32] Szilagyi, M. A.; Rosen, D. S.; Rubin, D.; Zlotnick, S.; the Council on Foster Care, Adoption, and Kinship Care; the Committee on Adolescence; & the Council on Early Childhood. (2015, October). Health care issues for children and adolescents in foster care and kinship care. *Pediatrics, 136,* 4, e1142-66.
[33] Szilagyi, M. A., et.al. (2015, October).
[34] Szilagyi, M. A., et.al. (2015, October).
[35] Kessler, R. C., et al. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 617–709. Kessler, R. C., et al. (2012). Prevalence, persistence, and sociodemographic correlates of DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry, 69*, 372–380.
[36] Based on our work in multiple states that have developed community-based service arrays in response to system assessments and EPSDT legal settlements(WA, MA, CT, NE, and PA), and based on the input of leading national experts on the need for wraparound services, MMHPI estimates that in a given 12-month period, one in 10 children and youth with SED living at or below 200% of the poverty level would require time-limited, intensive home and community-based services to avoid or reduce risk of juvenile justice system involvement, or other out-of-home or out-of-school placement. Meadows Mental Health Policy Institute (2015). *Estimating the percentage of*

lower-income youth with severe emotional disturbances who need time-limited, intensive home/family/community-based services. Unpublished documents and data.

[37] Hodgkinson S, Godoy L, Beers, L.S., & Lewin, A. (2017). Improving Mental Health Access for Low-Income Children and Families in the Primary Care Setting. *Pediatrics, 139*(1), e20151175. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5192088/pdf/PEDS_20151175.pdf

[38] Defined as total household income at 200% of the federal poverty level or below.

[39] Department of Family and Protective Services and Department of State Health Services Joint Report on Senet Bill 44 (2014, December).

[40] "In poverty" refers to the number of people below 200% of the federal poverty level for the specified region.

[41] The Substance Abuse and Mental Health Services Administration's (SAMHSA) language was used as a guideline for reporting race and ethnicity categories. This language was taken from the SAMHSA website on racial and ethnic minority populations – https://www.samhsa.gov/specific-populations/racial-ethnic-minority. In some cases, slightly revised language was used and further explanations were provided in a footnote, when necessary.

[42] The category of "Asian American" also includes people identifying as Native Hawaiians and/or Pacific Islanders. In Texas, these population numbers are very small, so the term "Asian American" was used for simplicity of reporting.

[43] The term "Native American" was intended to be synonymous with "American Indian" or "Alaskan Native," terms that are sometimes used instead of "Native American" in other states or in national reporting.

[44] All Texas prevalence and population estimates are rounded to reflect uncertainty in the underlying American Community Survey population estimates. Row totals are calculated with unrounded figures and may not match totals calculated with the reported rounded figures.

[45] "In poverty" refers to the number of people below 200% of the federal poverty level for the specified region.

[46] National estimates of prevalence and severity breakouts, unless otherwise cited, are drawn from Kessler, R. C., et al. (2012). Severity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of Gen Psychiatry, 62*(6), 617–627. The data were from a study with youth. Kessler et al. provide estimates of mild and moderate levels of severity for youth ages 13–17 years old. Absent any data on the severity of conditions among children and youth, this rate has been applied to all children and youth ages 6–17. However, children aged 12 and under likely have a lower prevalence of mental health disorders.

[47] Estimates of SMI and SED are taken from the following source: Holzer, C., Nguyen, H., & Holzer, J. (2016). *Texas county-level estimates of the prevalence of severe mental health need in 2016*. Dallas, TX: Meadows Mental Health Policy Institute. The incorporation of specific county-level demographics makes Holzer's estimate of SED more precise than Kessler's.

[48] MMHPI estimates that 10% of children and youth with SED are most at risk for school failure and involvement in the juvenile justice system.

[49] Kessler, R. C., et al. (2012). Prevalence, persistence, and sociodemographic correlates of DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry, 69*, 372–380. Estimates for depression, post-traumatic stress disorder, and bipolar disorder were calculated by multiplying the estimate of the population of 12–17-year-old youth by the prevalence estimate for each respective disorder. Kessler and colleagues did not include some specific diagnoses, such as schizophrenia and obsessive-compulsive disorder; other sources were used for estimating the prevalence of those and other conditions not reported in Kessler et al., 2012.

[50] There is no definitive study of obsessive-compulsive disorder (OCD) prevalence among children and youth. On the weight of the epidemiological evidence, a 12-month estimate of 2% among children and youth ages 6–17 was chosen. See: Boileau, B. (2011). A review of obsessive-compulsive disorder in children and adolescents. *Dialogues in Clinical Neuroscience, 13*(4), 401–411; Peterson, B. et al. (2001). Prospective, longitudinal study of tic, obsessive-compulsive, and attention-deficit/hyperactivity disorders in an epidemiological study. *Journal of the American Academy of Child & Adolescent Psychiatry, 40*(6), 685–695; and Douglas, H. M., et al. (1995). Obsessive-compulsive disorder in a birth cohort of 18-year-olds: Prevalence and predictors. *Journal of the American Academy of Child & Adolescent Psychiatry, 34*(11), 1424–1431.

[51] Center for Behavioral Health Statistics and Quality. (2015). *Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health* (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Retrieved from http://www.samhsa.gov/data/
[52] Androutsos, C. (2012). Schizophrenia in children and adolescents: Relevance and differentiation from adult schizophrenia. *Psychiatric, 23*(Supl), 82–93 (original article in Greek). Androutsos estimates that among adolescents ages 13–18, 0.23% meet criteria for the diagnosis of schizophrenia. Another study from Sweden reported that 0.54% of adolescents were treated for psychotic disorders at least once during the ages of 13–19: Gillberg, C., et al. (2006). Teenage psychoses-epidemiology, classification, and reduced optimality in the pre-, peri-, and neonatal periods. *Journal of Child Psychology and Psychiatry, 27*(1), 87–98.
[53] Kirkbride, J. B., Jackson, D., Perez, J., Fowler, D., Winton, F., Coid, J. W., Murray, R. M., & Jones, P. B. (2013). A population-level prediction tool for the incidence of first-episode psychosis: Translational epidemiology based on cross-sectional data. *BMJ Open, 3*(2), 1–12. Estimates of the incidence of first episode psychosis are extrapolated from studies by Kirkbride and colleagues that used a range of ages (14–35 years) during which the first episode of psychosis is likely to occur.
[54] Swanson, S. A., Crow, S. J., Le Grange, D., Swendsen, J., & Merikangas, K. R. (2011, July). Prevalence and correlates of eating disorders in adolescents. Results from the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry, 68*(7), 714–723. The prevalence estimate for eating disorders encompasses only Anorexia Nervosa and Bulimia Nervosa.
[55] Muehlenkamp, J. J., et al. (2012). International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. *Child and Adolescent Psychiatry and Mental Health,* doi: 10.1186/1753-2000-6-10
[56] The number of deaths from suicide includes suicide mortality for all mental health conditions, ages 0–17, in 2016. Data obtained from Centers for Disease Control and Prevention, Underlying Cause of Death 1999–2016 on CDC WONDER Online Database. (Released December 2017). Data are from the Multiple Cause of Death Files, 1999–2016, as compiled from data provided by the 57 vital statistics jurisdictions through Vital Statistics Cooperative Program. Retrieved May 30, 2018, from http://wonder.cdc.gov/ucd-icd10.html
[57] Data available at: https://wonder.cdc.gov/controller/saved/D76/D47F353
[58] Data available at: https://wonder.cdc.gov/controller/saved/D76/D47F355
[59] Texas Department of Family and Protective Services Data & Decision Support. (2019, February 8). *CPS 8.1 foster care placements by fiscal year and county – FY08–FY18.* Retrieved from https://data.texas.gov/Social-Services/CPS-8-2-Foster-Care-Placements-By-Fiscal-Year-And-/sxsx-qqtg
[60] These estimates are based upon month-to-month counts of children in foster care who have an emotional characteristic for all months in 2017 in Region 6. Emotional characteristics are added by the child's caseworker. A DFPS Management Reporting and Statistics report created a list of composite indicators that group together related characteristics. Emotional needs included reactive attachment disorder, bipolar disorder, depression, eating disorders, emotionally disturbed – DSM, oppositional defiant disorder, post-traumatic stress syndrome, among others. See The Stephen Group (2015). Meeting the needs of high needs children in the Texas child welfare system. Manchester, NH: Available at:
https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/CPS/documents/2015/2015-12-03_Stephen_Group_High_Needs_Assessment.pdf
[61] The SED rate of 17% was calculated using these data and was then applied to the count of children in foster care in FY 2017. Data obtained from Texas Department of Family and Protective Services. (n.d.). *Regional statistics about children in DFPS care.* Retrieved from
https://www.dfps.state.tx.us/Doing_Business/Regional_Statistics/default.asp
[62] These estimates are based upon month-to-month counts of children in foster care who have a drug/alcohol characteristic for all months in 2017 in Region 6. The SUD rate of 6% was calculated using these data and was then applied to the count of children in foster care in FY2017. Data obtained from Texas Department of Family and Protective Services. (n.d.). *Regional statistics about children in DFPS care.* Retrieved from
https://www.dfps.state.tx.us/Doing_Business/Regional_Statistics/default.asp
[63] Department of Family and Protective Services and Department of State Health Services Joint Report on Senet Bill 44 (2014, December).

[64] Narendorf, S. C., & McMillen, J. C. (2010, January). Substance use and substance use disorders as foster children transition to adulthood. *Child Youth Service Review, 32*(1), 113–119. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2786185/pdf/nihms136963.pdf
[65] These data reflect a snapshot of children and youth in Region 6 in September 2018. Data were obtained from the Texas Department of Family and Protective Services. (n.d.). *Regional statistics about children in DFPS care*. Retrieved from https://www.dfps.state.tx.us/Doing_Business/Regional_Statistics/default.asp
[66] Szilagyi, M. A.; Rosen, D. S.; Rubin, D.; Zlotnick, S.; the Council on Foster Care, Adoption, and Kinship Care; the Committee on Adolescence; & the Council on Early Childhood. (2015, October). Health care issues for children and adolescents in foster care and kinship care. *Pediatrics, 136,* 4, e1142-66.
[67] Williams, S. C., & Sepulveda, K. (2019, March). Infants and toddlers are more likely than older children to enter foster care because of neglect and parental drug abuse [Web log post]. *Child Trends.* Retrieved from https://www.childtrends.org/infants-and-toddlers-are-more-likely-than-older-children-to-enter-foster-care-because-of-neglect-and-parental-drug-abuse
[68] Williams, S., C., & Sepulveda, K. (2019, March).
[69] These data reflect a snapshot of children and youth in Region 6 in September 2018. Texas Department of Family and Protective Services. (2018, October 15). *Regional statistics about children in DFPS care: Children in foster care age 0–17 placed out of region, September 2018*. Retrieved from https://www.dfps.state.tx.us/Doing_Business/Regional_Statistics/default.asp
[70] Estimates of serious mental illness (SMI) and SED are taken from the following source: Holzer, C., Nguyen, H., & Holzer, J. (2016). *Texas county-level estimates of the prevalence of severe mental health need in 2016*. Dallas, TX: Meadows Mental Health Policy Institute. The incorporation of specific county-level demographics makes Holzer's estimate of SED more precise than Kessler's.
[71] MMHPI estimates that 10% of children and youth with SED are most at risk for school failure and involvement in the juvenile justice system. These youth need intensive family- and community-based services.
[72] These estimates are based on month-to-month counts of children in foster care with an emotional characteristic for all months in 2017 in Region 6. Emotional characteristics are added by the child's caseworker. DFPS Management Reporting and Statistics created a list of composite indicators that group together related characteristics. Emotional needs included reactive attachment disorder, bipolar, depression, eating disorders, emotionally disturbed – DSM, oppositional defiant disorder, post-traumatic stress syndrome, among others. See The Stephen Group (2015). *Meeting the needs of high needs children in the Texas child welfare system*. Available at: https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/CPS/documents/2015/2015-12-03_Stephen_Group_High_Needs_Assessment.pdf
[73] Children's Bureau. (2018, October). The AFCARS Report, No. 25.
[74] Human Rights Campaign (n.d.) *LGBTQ youth in the foster care system.* Retrieved from https://assets2.hrc.org/files/assets/resources/HRC-YouthFosterCare-IssueBrief-FINAL.pdf?_ga=2.101196801.1286681881.1565792541-781220405.1562959491
[75] Martin, M., Down, L., & Emey, R. (2016). *Out of the shadows: Supporting LGBTQ youth in child welfare through cross system collaboration.* Washington, DC: Center for the Study of Social Policy.
[76] Fish, J.N., Baams, L., Wojciak Stevenson, A., Russell, S.T. (2019). Are sexual minority youth overrepresented in foster care, child welfare, and out-of-home placement? Findings from nationally representative data. *Child Abuse & Neglect, 89*, 203–211.
[77] Baams, L., Wilson, B., Russell, S.T. (2019). Youth in unstable housing and foster care. *Pediatrics, 1*:43, (3).
[78] Wilson, B.D.M., Cooper, K., Kastanis, A., Nezhad, S. (2014). *Sexual and gender minority youth in foster care: Assessing disproportionality and disparities in Los Angeles*. Los Angeles: The Williams Institute, UCLA School of Law. Retrieved from http://williamsinstitute.law.ucla.edu/wp-content/uploads/LAFYS_report_final-aug-2014.pdf
[79] Wilson, B.D.M. et. al. (2014).
[80] Cooper, J.l., Banghart, P., & Aratani, Y. (2010, September). Addressing the mental health needs of young children in child welfare: What every policymaker should know. *National Center for Children in Poverty.*

[81] Marcenko, M., Brennan, K., & Lyons, S. (2009, May). *Foster parent recruitment and retention: Developing resource families for Washington State's children in care.* Seattle: Partners for our Children. Retrieved from https://partnersforourchildren.org/sites/default/files/2009._foster_parent_recruitment_and_retention.pdf

[82] Chapter 264.1261 of the Texas Family Code states that in regions where CBC has not be rolled out, the child protective services management staff should collaborate with foster care providers, faith-based entities, and child advocates to use the foster care needs assessment to develop a plan to address subsititue care capacity needs.

[83] Texas Department of Family and Protective Services (2018, October). Capacity Strategic Plan Region 6a and 6b.

[84] Marcenko, M., Brennan, K., & Lyons, S. (2009, May). *Foster parent recruitment and retention: Developing resource families for Washington State's children in care.* Seattle: Partners for our Children. Retrieved from https://partnersforourchildren.org/sites/default/files/2009._foster_parent_recruitment_and_retention.pdf

[85] Wulczyn, F., Huhr, S., Schmits, F., & Wilkins, A. (2017, November). Understanding the differences in how adolescents leave foster care. *The Center for State Child Welfare Data,* Chapin Hall at the University of Chicago. Retrieved from https://fcda.chapinhall.org/wp-content/uploads/2018/01/Understanding-the-Differences-in-How-Adolescents-Leave-Foster-Care_FCDA_ChapinHall_Nov17.pdf

[86] Courtney, M.E., Charles, P. (2015). *Mental health and substance use problems and service utilization by transition-age foster youth: Early findings from CalYOUTH.* Chicago, IL: Chapin Hall at the University of Chicago. Retrieved from https://www.chapinhall.org/wp-content/uploads/CY_MH_DP0515.pdf

[87] Tirney, K., Wildeman, C. (2016, August). Mental and Physical Health of Children in Foster Care. *Pediatrics, 138* (5).

[88] Tirney, K., Wildeman, C. (2016, August).

[89] Child Welfare Information Gateway, (2013). *Sibling issues in foster care and adoption.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Foster Care Placement Capacity Assessment Region 6a

THE HACKETT CENTER
FOR MENTAL HEALTH

Foster Care System Placement Capacity Assessment Region 6a

The Community-Based Care (CBC) model aims to improve the well-being and permanency of children and youth in substitute care and keep them connected to their siblings, home, and community.[1] This requires access to a variety of well-supported foster care placement options that meet their unique needs. Currently, Child Protective Services (CPS) ensures children and youth in foster care receive support in safe, family-like settings until they return to their family or are placed with another permanent family. Under the CBC model, the Single Source Continuum Contractor (SSCC) assumes the responsibility for placements and for connecting children and youth to all needed services, including educational, health, mental health, and recreational resources.

A review was conducted of the placement needs of the children and youth in Texas Department of Family and Protective Services (DFPS) care in Region 6a as well as the community's current and projected capacity to meet these needs. DFPS's Texas Foster Care Needs Assessment informed this analysis (August 2018).[2] Information was collected from key informants, who provided first-hand knowledge of the needs of children and youth in Region 6a and the reported capacity of the local provider community.

The Foster Care System Placement Capacity section provides a brief description of the types of substitute care provided by CPS, an overview of the foster care placements available in the region, and responses to the following questions:

- What is the current demand for foster care placements in Region 6a?
- What is Region 6a's current supply of foster care placements?
- Will the Region's supply of foster care providers meet the forecasted demand?
- How do children and youth exiting foster care affect supply and demand?

Types of Substitute Care

Substitute care is provided to children or youth who have been removed from home and placed under the conservatorship of CPS. Different types of placements contribute to overall foster care capacity. Ideally, a variety of high-quality placement options match the needs of the children and youth in care and evolve as needs change. Substitute care includes kinship (or relative) care, placement with a non-custodial parent, an independent living situation, or any residential care facility (foster home, foster group home, adoptive home, general residential operation).[3]

Foster homes, foster group homes, adoptive homes, and general residential operations (GROs) fall under the broad category of "regulated foster care.[4] The most highly used types of regulated foster care providers are:

- **Kinship Care:** A relative, extended family member, or person with a long-standing and significant relationship with the family (fictive kin). The majority of these placements are not regulated by DFPS.
- **Family Foster Home:** A family who provides care in its home to six or fewer children and youth and is under the regulation of a child placement agency.[5]
- **Foster Group Homes (FGH):** A foster group home is the primary residence of the foster parent and provides care to seven (7) to 12 children, youth, or young adults under the regulation of a child placement agency. FGHs tend to be more appropriate for children or youth who need experience living with groups, show a need for services supported by the group home, or need to make the transition from an institution.[6] The Family First Prevention Services Act (FFPSA) reduces access to congregate care settings by limiting the use of federal funds to pay for these settings, including foster group homes. See Appendix K for information on Texas's implementation of the FFPSA.
- **General Residential Operation (GRO):** A GRO is a residential child care operation that provides care for 13 or more children, youth, or young adults. GROs include emergency shelters, shelter assessment centers, operations providing basic child care, residential treatment centers, and halfway houses.[7] FFPSA reduces access to GROs by increasing standards and requiring accreditation.

Overview of Foster Care Placements in Region 6a

At the time of this review, 43 child placement agencies (CPAs) have at least one foster home licensed by the CPS Residential Child Care Licensing (RCCL) Division in Harris County (Region 6a). Four CPAs – Arrow Child and Family Ministries of Texas, DePelchin Children's Center, Pathways Youth and Family Services, Inc., and Heart of the Kids Social Services Inc. – license almost half of the foster family homes in the region. The remaining 40 CPAs report having between one and 60 open homes. As of April 2019, there were approximately 1,875 open foster homes. Harris County also has 50 GROs, including basic shelters and residential treatment facilities. These facilities report a total capacity of more than 1,800 beds. The numbers of open foster homes, by child placement agencies and bed capacity of area GROs, are provided in Tables 1 and 2 in Appendix C.

Data and Observations

The DFPS foster care needs assessment is based on foster placement data.[8] Each time a child is placed in a new foster care setting during a fiscal year, the placement data tracks and records

the move. This count captures the living arrangement, age, authorized service level (ASL), and location of placement. Placement arrangements included in the count are non-relative foster homes, general residential operations, basic child care, emergency shelters, and residential treatment centers (RTCs). Kinship placement and all other contracted and unpaid/uncontracted placements are not included but should be considered when evaluating overall capacity.

What is the Current Demand for Foster Care Placements in Region 6a?

As a result of a decrease in removals and an increase in kinship placements in recent years, Region 6a has seen a decrease in demand for children and youth needing a first foster care placement. However, this decrease in demand is offset somewhat by the number of children and youth already in care who need subsequent placements. Foster care demand – the need to place a child or youth in a foster home or general residential operations – is influenced by a child or youth's first placement in care as well as any subsequent placements during that year or subsequent years. DFPS's foster care needs assessment reported that 2,960 children and youth needed a placement in fiscal year (FY) 2017. Of that number:

When compared to other regions, Region 6a had the largest demand for subsequent placements for children and youth who were already in care.

- Thirty-five percent (35%) were placed for the first time,
- Sixteen percent (16%) entered care in FY 2017 (the year these data were collected) and required an additional placement in that same year (2017), and
- Another 49% entered care in a previous fiscal year (2016) and required another placement in FY 2017.

When compared to other DFPS regions, Region 6a had the largest demand for subsequent placements for children and youth already in care. Demand for subsequent placements or placement instability can be attributed to many factors such as a mismatch between the needs of the child and the foster family's abilities. Lack of appropriate supports for the child or foster parents, placement setting characteristics, or system factors such as case worker turnover. Multiple placements can lead to difficulties in achieving permanency, academic struggles, and trouble developing meaningful attachments.[9]

Despite the relatively high number of children and youth requiring multiple placements in Region 6a, overall foster care placement demand decreased by 13% from 2016 to 2017. At the same time, Region 6a experienced a large decrease in removals (18%) and increased use of kinship placements (44%), though these changes did not result in an equally large decrease in

demand (13%). Overall, the decline in removals and increase in kinship placements were offset by the number of children and youth previously placed who required an additional placement.

What Is Region 6a's Current Supply of Foster Care Placements?

There was a decrease in Region 6a's supply of foster homes and emergency shelter beds, and an increase in RTC and GRO basic placements in FY 2017. DFPS defines the supply of foster care homes as the number of children or youth who were accepted into a placement during a fiscal year, not the number of licensed beds, facilities, or homes. DFPS calculated Region 6a's FY 2017 foster care supply at 2,979 placements. This number reflects a 15% decrease in the supply of foster homes, an 8% increase in GRO basic child care placements, a 5% increase in RTC placements, and a 16% decrease in emergency shelter placements from the previous fiscal year. Because supply is calculated by counting only the foster care or licensed facility beds that a child or youth was actually placed in, Harris County's decrease in foster care and emergency shelter supply may not mean that there was a decrease in available beds; rather, it may reflect an increase in kinship placements and a shift away from emergency shelter use.

Will the Region's Supply of Foster Care Placements Meet the Forecasted Demand?

DFPS Region 6a does not have a sufficient supply of foster care placement options to meet its forecasted demand or future need. Region 6a shares capacity with its neighbor, Region 6b, and relies on placements in that area to bolster its capacity. A review of Region 6a's capacity indicated that there is a shortage of foster home/GRO basic child care placement (-11%) and shelter capacity (-20%), and almost twice as much RTC capacity as the region needs (48%). Harris County uses 31% of adjacent counties' (Region 6b) GRO basic child care supply, 17% of nearby RTC supply, and 43% of nearby shelter care to meet its foster care placement needs.

The analysis of supply and demand across levels of care and age groups points to the following needs in Harris County:

- Increase its Basic Service Level foster placements by 24% (206 foster homes) for preschool children (ages 0–5); when adjusted for capacity sharing with adjacent regions, this drops to 54 (24%) Basic Service Level foster care placements.
- Increase its Moderate Service Level foster placements by 39% (11 foster homes) for preschool children (ages 0–5).
- Increase its specialized foster home placement capacity by 18% (26 beds) for all age groups.

How Do Children and Youth Exiting Care Affect Foster Care Placement Supply and Demand?

Children and youth can exit care through reunification, adoption, or aging out of the foster care system. When analyzing foster care capacity, it is important to consider exits from care as well as lengths of stay and number of placements. In FY 2018, more children and youth in Region 6a exited than were placed in care (1,881 compared to 1,632). Table 10 summarizes exits and entrances from care. A summary of children and youth in foster care during FY2018 in Region 6a reveals:

- More than 1,000 children and youth were reunified with their families or placed with relatives,
- 637 were adopted either by a relative or a non-relative, and
- 171 were emancipated or aged out of care.

The fewer entrances than exits is offset by the length of time children and youth remain in care and the number of placements they experience. Most notably, youth who age out of the foster care system in Harris County remain in foster care almost 64 months and experience an average of 7.4 placements compared with the state average of almost 47 months in care and 6.4 placements (Table 11). Youth aging out of the foster care system use a large share of the available foster care placements because they spend more time in care and experience a larger number of placements.

Table 10: Exits Versus Entrances to Care – FY 2018

Exits Versus Entrances to Care	Harris County		Texas	
Total Number of Home Removals During FY 2018[10]	**1,632**		**20,685**	
Total Number of Exits from DFPS Conservatorship[11]	**1,881**		**19,961**	
Exits from DFPS Conservatorship by Exit Type	**Exits**	**% of All Exits**	**Exits**	**% of All Exits**
Custody to Relatives with Permanency Care Assistance (PCA)	95	5%	867	4%
Custody to Relatives without PCA	472	25%	5,480	27%
Family Reunification	474	25%	6,532	33%
Non-Relative Adoption Consummated	292	16%	2,889	14%
Relative Adoption Consummated	345	18%	2,789	14%
Youth Emancipation	171	9%	1,211	6%
Other	32	2%	193	1%

Table 11: Average Months in Care and Average Placements per Exit – FY 2018[12]

Exit Type	Harris County		Texas	
	Average Months in Care	Average Placements Per Exit	Average Months in Care	Average Placements Per Exit
Family Reunification	15	2.1	12.7	1.8
Custody to Relatives with PCA	24.6	1.9	24	1.9
Custody to Relatives without PCA	16.9	1.9	12.9	1.9
Relative Adoption Consummated	29.4	2.1	24.6	2.1
Non-Relative Adoption Consummated	31.1	2.5	27.5	2.7
Youth Emancipation	63.9	7.4	46.9	6.5
Other	14.8	1.6	13.6	1.7
Total	**25.5**	**2.6**	**19.1**	**2.3**

Foster Care System Capacity Findings

The community planning process identified key themes related to the alignment of foster care placement need and capacity. These emerged from a review of DFPS data and discussions with local stakeholders and subject matter experts.

Foster Care Capacity (FCC) Finding 1: The majority of foster care demand in Region 6a is for subsequent placements of children and youth already in care. In fiscal year (FY) 2017, 35% of the foster care placements in Region 6a were first placements for children and youth entering care and 16% were subsequent placements for children and youth who entered care earlier in the same fiscal year. The remaining placements (49%) were subsequent placements for children or youth who previously entered care in the current or any prior year. When taken together, almost two thirds of Region 6a's foster care capacity demand is for children and youth who have had a prior placement and need a subsequent placement. This suggests that a high proportion of initial placements are not meeting the needs of children and youth who are placed.

FCC Finding 2: Youth that emancipate or age out of care in Region 6a are in care longer and have experienced more placements than any other group of children or youth exiting care. A subset of the children and youth driving the demand for subsequent placements are youth who emancipate from DFPS care. In Region 6a, these youth spend on average more than five years in DFPS conservatorship and have experienced more than seven placements. Despite

representing only 9% of the exits from care, their length of stay, coupled with the number of subsequent placements they experience, has a large impact on the foster care placement system's capacity.

FCC Finding 3: In FY 2017, the demand for non-familial foster care placements decreased as a result of lower rates of removal and increase in kinship placements. Region 6a experienced a decrease in the percentage of removals (-18%) and an increase in the number of kinship placements (6%). There was also a decrease in the supply of foster homes (-15%) and emergency shelter beds (-16%), and a small increase in the supply GRO basic child care and RTC placements.[13] This general decline in overall non-familial placements reflects the decrease in removals and increase in kinship placements.

FCC Finding 4: The types of foster care placement options available in Region 6a do not meet the needs of all children and youth in the region; however, placement options in 6b currently help meet some demands. DFPS capacity forecasts for Region 6a compared the demand for foster care placement for children and youth in Region 6a to the supply of available foster care placements. These forecasts indicated a need to increase foster care and basic GRO capacity by 11% and to increase emergency shelter care by 20% to address a dependence on surrounding areas for services. Conversely, the forecasts showed a 48% surplus of RTC placement capacity (which largely serves children and youth from other parts of the state). When capacity forecasts are adjusted for sharing with adjacent counties, Region 6a has close to sufficient capacity at Basic and Moderate Service Levels to meet the needs of children ages 6–17, but insufficient placements for younger children (ages 0–5).

FCC Finding 5: Region 6a needs more treatment or therapeutic foster care homes to place children and youth with more complex needs in the least restrictive placement. Treatment foster care models are evidence-based approaches that provide foster parents with the specialized skills and training they need to support children and youth with serious emotional and behavioral issues. There is a need to increase the number of foster parents who have been trained, supervised, and supported to provide a therapeutic environment for young children who have an increased level of need and children and youth with the most complex needs. The Foster Care Assessment indicated that, without including resources in Region 6b, there is a need to increase the supply of moderate foster homes for preschoolers by 39% and specialized foster homes by 18%. If the number of treatment/therapeutic foster homes is not increased, children and youth may be placed in overly restrictive RTC settings due to the surplus of RTC capacity. Arrow Child and Family Ministries is the only CPA that provides treatment foster care in the region.

Foster Care System Planning Considerations

Under CBC, or any enhanced foster care system, available foster placement options should meet the diversity of local foster care needs. This section addresses planning considerations for foster placement availability.

FCC Planning Consideration 1: The CBC plan, and any other efforts to improve the system, should focus first on addressing the region's high use of subsequent placements for children and youth currently in care or entering care. Almost two thirds of children and youth in care end up in more than one placement. The planning process should address the key factors driving this placement instability, including:

1. The current inadequate system for making placement matches;
2. A need to increase foster family recruitment to better fit the cultural, age, and individual needs of the children and youth in care in the region;
3. Access to needed supportive services for foster families, children, and youth once a placement is made; and
4. Systemic problems such as child welfare staff training and turnover affecting placement stability.

Placement stability may be hindered when caseworkers do not adequately understand a child's needs and culture, which underscores the importance of training and support for caseworkers.[14] Research on permanency indicates that caseworker turnover during critical junctures in the placement process can lead to foster parents losing the support they need to maintain a placement, as well as escalating child behaviors.[15]

FCC Planning Consideration 2: Better address the needs of older youth emancipating from care, including foster care capacity development efforts focused on more culturally appropriate foster placements and older youth with complex needs. This overlaps with Consideration 1, as these youth often end up emancipating from care because of repeated failures of placements to meet their needs – Harris County youth emancipating from care are in DFPS custody longer and experience more placement changes than the state average. Capacity building must include culturally appropriate foster homes and well-trained foster parents who are willing and able to care for older youth, as well as improvements in the available array of community supports and services.[16]

System improvement efforts should help DFPS caseworkers, Court Appointment Special Advocates (CASAs), attorneys, and judges understand the value of placing children and youth in

their community with culturally similar foster parents and peers, where their parents can visit easily, and where they have access to the services and supports they need to succeed.

Why is Cultural Relevancy Important in Foster Care Placements?

Ethnic identity – a positive connection to one's ethnic group – is predictive of higher self-esteem, academic achievement, psychological adjustment, coping abilities, and lower levels of depression and anxiety. African American children and youth in foster care who are placed in foster homes whose culture is dissimilar from their biological family are more likely to experience depression, loneliness, and social dissatisfaction, and their foster parents are more likely to report disruptive behaviors.

Anderson, M., & Linres, L.O. (2012, April). The role of cultural dissimilarity factors on child adjustment following foster placement. *Child Youth Services Review, 34*(4), 597-601. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4498390/pdf/nihms-343600.pdf

FCC Planning Consideration 3: Develop treatment-focused alternatives to residential care, especially crisis capacity to better support placement stability, given the region's frequent placement breakdowns, overcapacity of RTC beds, and over-reliance on restrictive RTC placements. The community should consider how service capacity can be re-aligned to most appropriately meet the need of children, youth, and their foster families. For example, some of the region's current RTC capacity could shift to crisis respite beds, emergency shelter capacity, or aftercare services once a child or youth is discharged from a hospital or RTC. The availability of these services and supports, as well as expanded access to treatment foster care and intensive home and community-based services, would support placement stability and decrease the need for RTC placements.

FCC Planning Consideration 4: Begin considering Family First Prevention Services Act (FFPSA) requirements now, with a focus on "right sizing" local RTC capacity, improving the quality of RTC care, and increasing stepdown/aftercare services. The FFPSA will require decreased reliance on congregate care placements, including RTCs. See Appendix K for an overview of FFPSA.

Family First Prevention Services Act and Aftercare Services

The FFPSA pays for six months of aftercare services and supports for children, youth, and their families to support stability after a child or youth is discharged from care or permanently placed. These services could reduce the multiple placement and recidivism issues in Harris County's foster care system. Harris County could work with local providers and the state to define how aftercare services will function locally.

In particular, the requirement that all RTCs must become Qualified Residential Treatment Programs (QRTPs) to receive federal funding will eliminate facilities that are unable to meet this standard. CBC planning should ensure that quality RTCs meet the established standards, shift resources to develop non-residential capacity to meet the region's needs, expand programming to meet the complex needs of children and youth in care, and increase access to aftercare services. When assessing current RTC capacity for improvements, Region 6a should consider whether or not these providers demonstrate the characteristics of an effective RTC. See Appendix D for characteristics of effective residential treatment facilities and a review of agency-wide philosophical approaches for delivering residential treatment programs.

FFPSA-Qualified Residential Treatment Programs

- Use a trauma-informed treatment model to address the needs of children and youth with serious emotional or behavioral disorders/disturbances;
- Have nursing or other licensed clinical staff on site during business hours with 24-hours-a-day/seven-days-a-week availability, in accordance with the required trauma-informed treatment model;
- Involve family in the treatment process;
- Document the integration of family, including sibling connections;
- Are licensed by the state and accredited; and
- Provide discharge planning and family-based aftercare for at least six months post-discharge.

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[1] Department of Family and Protective Services. (2018, September 28). *Child protective services business plan, fiscal year 2019*. Downloaded from https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/CPS/documents/2018/2018-09-28-CPS_Business_Plan_Report.pdf

[2] Texas Department of Family and Protective Services. (2018, August). *Foster care needs assessment.* Retrieved from https://tffa.org/wp-content/uploads/2018/08/Foster-Care-Needs-Assessment-August-_2018.pdf

[3] Department of Family and Protective Services. (2018, January). *Child protective services placement process resource guide*. Downloaded from https://www.dfps.state.tx.us/handbooks/CPS/Resource_Guides/Placement_Process_Resource_Guide.pdf

[4] Department of Family and Protective Services. (2018, January).

[5] Texas Health and Human Services Commission, Child Care Licensing. (2018, January). *Foster and licensed facility placement resource guide*. Retrieved from https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/protective-services/ccl/min-standards/chapter-748-gro.pdf

[6] Department of Family and Protective Services. (2018, January). *Child protective services placement process resource guide*. Downloaded from https://www.dfps.state.tx.us/handbooks/CPS/Resource_Guides/Placement_Process_Resource_Guide.pdf

[7] Health and Human Services Commission, Child Care Licensing (2018, July). *Minimum standards for general residential operations*. Retrieved from https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/protective-services/ccl/min-standards/chapter-748-gro.pdf
[8] Texas Department of Family and Protective Services (2018, August). *Foster care needs assessment*. Retrieved from http://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/CPS/documents/2018/2018-08-10_Foster_Care_Needs_Assessment.pdf
[9] Casey Family Programs. (2018, August). *Strategy brief – strong families: What impacts placement stability?* Retrieved from https://caseyfamilypro-wpengine.netdna-ssl.com/media/SF_Placement-stability-impacts.pdf
[10] Texas Department of Family and Protective Services Data & Decision Support. (2019, February 8). *CPS 7.1 removals – by county FY08–FY18.* Retrieved from https://data.texas.gov/Social-Services/CPS-7-1-Removals-by-County-FY08-FY18/xmtn-e5c8
[11] Texas Department of Family and Protective Services Data & Decision Support. (2019, February 8). *CPS 7.8 Exits from Conservatorship –- by exit type and county FY08–FY18*. Retrieved from https://data.texas.gov/Social-Services/CPS-7-8-Exits-from-Conservatorship-By-Exit-Type-an/c9t3-btn2
[12] Texas Department of Family and Protective Services. (n.d.). *CPS conservatorship: Children exiting DFPS legal custody*. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/Conservatorship/Exits.asp
[13] The Texas Department of Family and Protective Services defines the supply of foster care homes as the number of children or youth who were accepted into a placement during a fiscal year, not the number of licensed beds, facilities, or homes.
[14] Casey Family Programs. (2018, August). *Strategy brief – strong families: What impacts placement stability?* Retrieved from https://caseyfamilypro-wpengine.netdna-ssl.com/media/SF_Placement-stability-impacts.pdf
[15] Casey Family Programs. (2018, August).
[16] Anderson, M., & Linres, L.O. (2012, April). The role of cultural dissimilarity factors on child adjustment following foster placement. *Child Youth Services Review, 34*(4), 597-601. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4498390/pdf/nihms-343600.pdf

Community Capacity to Support Foster Parents and Children and Youth in Care

THE HACKETT CENTER

FOR MENTAL HEALTH

Community Capacity to Support Foster Parents and Children and Youth in Care

Attending to the diverse and ever-changing needs of children and youth requires multiple caring adults, and this is the underlying philosophy behind community-based care (CBC). To meet the needs of these children, youth, and their foster and kinship families, communities must partner to provide responsive, trauma-informed services delivered by a network of providers in collaboration with caring adults who share responsibilities, information, and a sense of ownership.

As a result of CBC, the responsibility for successfully supporting children and youth in care, and their foster and kinship families, moves from the state to the local community. In communities that have implemented CBC already, this has broadened the community's role for youth in care and included important partnerships with faith-based organizations and the health, mental health, education, judicial system, and juvenile justice systems, all of whom can help to provide community supports. Harris County has a diverse network of partners that can deliver a broad range of services – partnerships that address major service needs like behavioral health.

This section addresses two sets of factors that affect placement stability and permanency: (1) recruiting and retaining foster parents, and (2) resources to support the child or youth, and their foster family. The overarching goal of CBC is to ensure Texas children and youth in foster care are placed in their community, with their siblings, in a stable placement that can meet their needs to achieve permanency. A permanency-oriented foster care system requires a sustained sense of urgency starting the moment a child or youth comes in contact with the system, and an understanding that a child or youth's sense of belonging is fundamental to their well-being.[1] Placement stability is key to establishing permanency and one of the most critical goals for any foster care system. It is emphasized in Texas' goals for the CBC model.

This section is divided into two parts. Part I: Foster Parent Capacity focuses on the capacity of the system to develop and maintain a diverse pool of foster parents who are able to meet the needs of children and youth in Region 6a. Part II: Community Capacity assesses the current system of services and supports for children and youth with social, emotional, health, and behavioral health needs, and their foster families.

Part I: Foster Parent Capacity

The CBC Advisory Committee (Advisory Committee) and key community stakeholders highlighted the importance of expanding Region 6a's foster parent capacity. The Advisory Committee stressed the need to recruit foster parents and prepare them to care for children and youth with complex mental and physical needs, and also develop services that promote reunification as well as adoption. Accordingly, the planning process assessed the region's ability to recruit and retain high quality foster parents and support placement stability and permanency, focusing on the services and supports necessary to increase and retain a pool of high-quality foster parents who have the skills and supports needed to ensure the safety, well-being, and permanency of the children and youth in their care. Successful foster parents understand the needs of children and youth in care; have access to quality trauma-informed pre-service training; participate in ongoing training, coaching and support; and have access to a continuum of community-based services and supports.[2]

This section pulls together information from the Advisory Committee and local stakeholders, survey findings from child placement agencies (CPAs) in Region 6a (12 responded[3]), and interviews with key informants. This section provides an overview of Region 6a's current recruitment strategies and the training and supports provided to foster families, asking:

- What are the key strategies to building and maintaining foster parent capacity?
- How are foster and kinship families recruited in Region 6a?
- What training, support, and resources are available to support foster and kinship families in Region 6a?
- What strategies support foster parents of young children?

What Are the Key Strategies to Building and Maintaining Foster Parent Capacity?

An ideal foster care system supports placement stability and permanency. Permanency for a child or youth in foster care is defined as reunification, guardianship, adoption, or a stable, lifelong family or family-like relationship that provides physical, emotional, and social support.[4] A permanency-oriented foster care system minimizes the number of times a child is placed by recruiting, developing, and supporting kin and foster parents.

Before permanency is established, placement stability is one of the most critical goals for any child welfare system, and it is emphasized in the goals Texas has established for the CBC model. System-wide support that bolsters placement stability can prevent negative outcomes, including increased risk for behavioral problems, academic difficulties, and loss of meaningful attachments.[5] Placement stability also promotes consistency in relationships, predictability in routine, and continuity of access to services and supports. Some children and youth require

additional supports to achieve placement stability. Factors that may indicate a child or youth needs additional supports include history of physical or sexual abuse, age (older youth specifically), disability, and the presence of a serious emotional disturbance.[6]

A community-based foster care system, designed to promote placement stability and permanency, ensures that all children and youth in care have access to stable and nurturing homes with relatives or foster parents who are trained to respond to unique needs and behaviors. A community-based model uses the following strategies to provide safe, stable, permanent foster families that foster the well-being of the children and youth in their care.

- **Identifying and engaging potential relative caregivers.** Children and youth who are placed with kin have more stable behavior and mental health, a stronger sense of well-being, and are more likely to have placement stability than children placed in non-relative care.[7] Placement entities must prioritize kin placements, with policies and practices to identify and engage relative caregivers.
- **Recruiting high-quality foster parents.** Kin care placements are not always available or appropriate. In these cases, it is critical to have a strong network of culturally competent, committed foster parents.[8]
- **Addressing foster parent retention.** Increasing the retention rate of prospective foster families requires that systems are easy to navigate, provide support throughout the licensing process, and are deliberate in matching the child and foster family. To ensure prospective foster parents are successfully licensed, the training and home study process should be easy to understand. Agencies should be thoughtful when making matches between children and families, ensure foster families feel listened to and supported, and celebrate their contribution to the agency. Tools that support placement matching include:[9]
  - Child and Adolescent Needs and Strengths Treatment Outcomes Package,
  - Structured Decision Making (SDM®) Model in Foster Care and Placement Support,
  - Every Child a Priority (ECAP), and
  - Child and family team meetings.
- **Developing skills for foster and kinship care families.** Most placements disrupt because foster parents lack the understanding, skill, and support to address the difficult, trauma-related behaviors of the children and youth in their care.[10] Placement stability increases when kin and foster parents are trained to manage the challenging behaviors of older children, and children and youth who struggle with mental health or behavioral problems.[11] Kinship and foster families are most successful when they have access to quality pre-service training and ongoing training and development.

- **Providing ongoing support for foster and kinship families** including an infrastructure that includes hands-on support and access to diverse resources. Training is not enough for sustainable foster placements. Foster parents must be supported by an infrastructure that includes hands-on support and diverse resources. The primary reason why foster parents stop fostering within the first two years of service is lack of support.[12] A continuum of foster parent supports includes crisis intervention services, foster parent mentors and support group, respite care, and adequate financial support.[13, 14]
- **Addressing adequate financial support for families.** Financial supports for families include adequate reimbursement rates; child care allowances; and money for clothing, school activities, and special needs.[15]

How Are Foster and Kinship Families Recruited in Region 6a?

Foster parent recruitment efforts should be anchored in a customer service model that treats prospective parents with respect.[16] Recruitment events should be welcoming, provide honest information on the needs of children and youth in care, and ensure in-person or telephone follow-up to answer questions and provide information on next steps. This lays the foundation for a trusting partnership between the prospective foster parent and the CPA.

Increasing the retention rate of prospective foster families requires that systems are easy to navigate, provide support throughout the licensing process, and are deliberate in matching the child and foster family. To ensure prospective foster parents are successfully licensed, the training and home study process should be easy to understand. Barriers to completing the licensing process should be identified and addressed. Foster families who are waiting to be licensed can be linked to other waiting families, connected to foster parent support groups, or matched with a mentor family. To maintain committed foster parents, agencies should be thoughtful when making matches between children and families, ensure foster families feel listened to and supported, and celebrate their contributions to the agency.

Based on responses to the CPA survey, most kinship and foster parent recruitment efforts in Region 6a have not changed in recent years, relying heavily on word-of-mouth from currently licensed foster families. One CPA reported paying currently licensed foster families a stipend for referring a family if it completes the licensing process and accepts a child into its home. Other existing methods for recruiting foster families in the region include:

- Using agency websites and social media – Facebook, Instagram, and Google – to raise awareness;
- Attending DFPS monthly collaborative information meetings;

- Hosting agency “meet and greets”;
- Attending community fairs and church activities; and
- Using advertising campaigns – billboards, flyers, and spots in local magazines.

The CBC Advisory Committee participants and agencies that replied to the CPA survey identified strategies for increasing their pool of foster parents; however, none of them have a fully-developed recruitment plan. Despite this, most agencies saw an increase in the number of foster homes they licensed, with a few exceptions. The environmental scan identified one organization that provides support groups for kinship parents in Region 6a – the Kinship Navigator Program – and two organizations that employ targeted recruitment strategies – Collaborative Family Engagement (CFE) and Cultivating Families. In addition, two child placement agencies – Upbring and Arms Wide – were trained to implement Wendy’s Wonderful Kids Child Focused Recruitment Model. These programs are described in Appendix E.

What Training, Support, and Resources Are Available to Foster and Kinship Families in Region 6a?

Most placements disrupt because foster parents lack the understanding, skill, and support to address the difficult, trauma-related behaviors of the children and youth in their care.[17] Placement stability increases when kin and foster parents are trained to manage the challenging behaviors of older children, and children and youth who struggle with mental health or behavioral problems.[18] Kinship and foster families are most successful when they have access to quality pre-service training and ongoing training and development. Pre-service training provides the foundational information foster and kinship parents need to be successful, and ongoing training and development helps foster parents build additional skills and apply what they learned during pre-service training with the children or youth in their care.

The training, support, and resources available to foster parents vary across CPAs in the region. Most agencies provide some pre-service and in-service training beyond Minimum Standards. Most foster parents in Region 6a are trained in trauma-informed interventions during pre-service training. Ongoing in-service training and refreshers provide a range of training related to trauma and behavior management. All but one of the responding CPAs indicated that they trained their foster parents in Trust-Based Relational Interventions (TBRI) as well as other trauma-informed trainings. Caseworkers in almost all CPAs provide in-home support, supervision, and coaching to help foster parents transfer skills they learned in training. One CPA stated:

> "We introduce our families to Trust-Based Relational Intervention and whole-brain approaches to connect parenting and discipline. Our caseworkers work closely with a small caseload of foster parents to provide individualized support based on the needs of the foster home."

Another noted:

> "We help foster parents to learn how they can use approaches that simultaneously deepen the foster parent–child connection, empower the children with constructive choices and learning how to self-regulate and communicate constructively, and, at the same time, immediately address any problem behaviors with correcting principles that help instill healthier behavioral responses, rather than just being punitive by giving consequences to the children."

Other pre-service and in-service training provided by CPAs covered behavior management, parenting, and burnout. CPA survey respondents reported that they offer training on avoiding power struggles, how to deal with burnout/stress, working with troubled teens, exploring strategies for children with challenging behaviors, grief and loss, single parenting, attachment, handling setbacks, cultural competency, talking to children about adoption, transitions for kinship care, and crisis intervention. Arrow Child & Family Ministry also trains treatment foster care parents in the Together Facing the Challenge (TFTC) curriculum. CPAs in the region recognize the barriers to training that many foster families face, including work schedules, family needs, child care, and transportation. Survey respondents indicated that they offer flexible training hours (evenings and morning sessions), in-home training – especially for kinship families – and internet-based interactive training.

Training is not enough. Foster parents must be supported by an infrastructure that includes hands-on support and diverse resources. The primary reason that foster parents stop fostering within the first two years of service is lack of support.[19] Foster parent supports include crisis intervention services, foster parent mentors and support group, respite care, and adequate financial support.[20, 21]

All 12 CPAs that responded to the survey indicated that their caseworkers were primarily responsible for in-home support and coaching for foster families. One CPA reported that it assigns a caseworker to support the child or youth and a separate caseworker to support the foster family. Two CPAs – DePelchin Children's Center and Pathways Youth and Family Services – reported that they provide intensive case management/wraparound services for foster families that support children and youth with the most complex needs.

Other types of support provided by CPAs in Region 6a include:

- **Respite Care:** Paid respite/relief care (provided by one agency)[22,23]
- **Community Supports**: A contract with a community-based provider that offers flexible hours (including weekends), access to a home and community-based therapist, connection to community counselors who are certified in TBRI, and crisis intervention 24 hours a day, seven days a week (24/7).
- **Parent Supports:** Support groups, holiday gatherings, coordinator support, open communication and ongoing support, and opportunities for experienced foster parents to mentor other foster parents.
- **Access to Resources**: Financial supports and gifts for Christmas and other holidays and back to school supplies.
- **Foster Parent Recognition**: Foster parent appreciation, such as foster parent of the month and foster family events.

Despite additional trainings in TBRI, trauma-informed care, and the provision of other foster parent supports, key informants and Advisory Committee members cited inadequate training and supports for foster families as a major factor in placement breakdowns.

What Strategies Support Foster Parents of Young Children?

Nationally, as well as in Region 6a, infants and older youth represent the largest groups of children and youth in care. Infants and young children enter care at a higher rate than any other age group. Many have experienced maltreatment and have been prenatally exposed to drugs and alcohol, putting them at risk for cognitive and behavioral challenges as well as developmental, social, and emotional delays.[24, 25] Maltreatment at an early age puts young children at high risk for developmental and mental health problems.[26]

Meeting the mental health needs of young children in the child welfare system requires intervention strategies that promote caregiver-child relationships and foster healthy attachment. Effective strategies include parent-child therapy, parent/caregiver-child interaction guidance, coaching and supports, relationship-based approaches, empirically-supported parent education strategies, and social-emotional competency development and skills building. Examples of effective programs include Parent Child Interaction Therapy (PCIT), Positive Parenting Program (Triple P), Infant Parent Psychotherapy (IPP), Child-Parent Psychotherapy (CPP), and Treatment Foster Care Oregon for Preschoolers. An overview of these programs is provided in Appendix F.

Foster Parent Capacity Findings

Foster Parent Capacity (FPC) Finding 1: Most CPAs in Region 6a do not have a foster parent recruitment plan that uses data to drive universal, targeted, or child-specific recruitment to meet the cultural and unique needs of the children and youth in care. The region's CPAs rely heavily on word of mouth, social media, and regional recruitment events to engage new foster families. None of the participants in the Advisory Committee, or agencies that replied to the CPA survey, indicated that they have a fully-developed recruitment plan that includes strategies tailored to the unique culture and needs of the children they serve or that takes into consideration their current foster parent capacity.

FPC Finding 2: Many foster parents do not have access to the resources, support, and training they need to ensure they can support the children and youth in their care who have complex mental health needs. Many foster parents receive some training outside of that required by DFPS Minimum Licensing Standards and have some support to address the trauma and mental health needs of the children and youth in their care. Despite this, key informants cited inadequate training and supports for foster families as a major factor in placement breakdowns.

All but one CPA indicated that they train their parents in Trust Based Relational Interventions (TBRI). While TBRI has been shown to help address the needs of child and youth who have experienced trauma, additional training and resources are necessary. As noted in the Meadows Mental Health Policy Institute's 2018 system assessment of *Harris County Mental Health Services for Children, Youth, and Families,*[27] implementing the Keeping Foster and Kin Parents Supported and Trained (KEEP) program could help foster parents, children, and youth learn coping skills and ways to address challenging behaviors. The Together Facing the Challenge (TFTC) model of treatment foster care also offers extensive training and support to foster parents to assist them in supporting the children and youth in their care. Community capacity for TFTC needs to be expanded to meet current demand.

FPC Finding 3: Most foster families in Region 6a have little or no access to intensive in-home supports to help them care for children and youth with the most complex needs. As noted above, research indicates that the primary reason why foster parents stop fostering and placements break down is a lack of training, hands-on support, and resources. Three of the largest CPAs in Region 6a – Arrow Family and Children's Ministries, DePelchin Children's Center, and Pathway's Family and Children's Services – provide intensive case management and wraparound services, intensive in-home coaching, and access to crisis services. However, most of the remaining agencies do not offer foster families this level of support and intervention.

Intensive in-home services are generally time-limited, delivered in the child or youth's home or foster home, and are designed to meet their unique needs. The primary goal of intensive in-home services is to prevent out-of-home placement or to provide transition services from an out-of-home placement to a child or youth's home or foster home. Intensive in-home services and supports include crisis management, intensive case management, counseling, family therapy, and skills training. Intensive in-home services can be provided by the CPA that supports the foster family, a community-based agency, or through a partnership with other CPAs in the community. Evidence-based intensive services and supports such as Wraparound, Multisystemic Family Therapy, Treatment Foster Care Oregon, or Together Facing the Challenge have all been proven to increase placement stability.

Foster Parent Capacity Planning Considerations

Community stakeholders and key informants identified community strengths and service gaps as well as areas the community should consider when preparing for community-based care, which informed their development of the following four considerations for foster parent capacity planning.

Foster Parent Capacity (FPC) Planning Consideration 1: Use Region 6a's Capacity Think Tank[28] to develop a recruitment plan for the region, using its recommendations for young children and building on them for other priority groups in need of more capacity. The Capacity Think Tank for DFPS Region 6 recognized the high volume of young children in foster care and identified the need to increase the number of basic foster homes for preschool age children in its 2018 Capacity Strategic Plan.[29] It identified barriers to meeting the placement needs of young children in the region, including the frequency and location of scheduled visitation, underutilization of current basic foster homes, the number of employed foster parents, and recruitment challenges. Participants identified three objectives to remove these barriers – centralize visitation, explore day care opportunities, and increase data sharing. National studies on recruiting and retaining foster parents to care for infants and young children identified a lack of access to quality child care and respite, and a lack of early childhood parent training as additional barriers.[30,31] A similar strategy for identifying barriers to recruiting and retaining foster parents and establishing objectives to address identified barriers should be employed for children and youth with complex mental health needs, children and youth of color, older youth, and children and youth in large sibling groups.

Stakeholders emphasized that recruitment of diverse foster parents that reflect the cultural needs of the children and youth in care can require a more targeted approach. Before recruiting

foster parents, child placement agencies (CPAs) should establish a clear picture of the children and youth they care for, including removal location, demographics, and unique characteristics such as complex medical or mental health needs; lesbian, gay, bisexual, transgender, queer or questioning (LGBTQ) status; pregnant or parenting youth; or special education needs.[32]

Targeted recruitment efforts should be embedded in communities that reflect the diverse culture of the children and youth in care. These efforts should include partnering with community groups (e.g., military and faith communities).[33] CPAs should also engage in child-specific recruitment to locate prospective foster and adoptive parents to meet the unique needs of a specific child or youth. A good example of child-specific recruitment is New York City's You Gotta Believe (YGB) initiative, which works to recruit foster and adoptive parents for older youth by identifying people in their social circle through trust building and then supporting the development of a relationship that will lead to a physical placement.[34]

Engaging foster parents as recruiters is also an effective strategy. The Leaders at Children's Community Program of Connecticut rewards existing foster parents with $1,500 for each new family they recruit who meet licensing requirements and commit to at least one year of service.[35]

FPC Planning Consideration 2: The planning process must prioritize increased training and support to birth parents, kin, and foster parents to address challenging behaviors that currently lead to a disproportionate number of placement disruptions. Currently, parents and caregivers too often lack access to the resources, support, and training they need to successfully support the children and youth in their care who have complex mental health, educational, and other needs that result in behaviors that challenge placement stability. Local non-profits and other types of community providers can play an important role in supporting family stability by providing training and supports for birth parents, kin care providers, and foster parents. Readily available, high-quality training and hands-on coaching can provide the tools and skills to support the children and youth in care and help them successfully reach permanency. The following examples of evidence-based caregiver training help foster parents and kinship caregivers improve their skill in supporting the children and youth in their care (see Appendix F for more detail on these programs).

- **Keeping Foster and Kin Parents Supported and Trained (KEEP)** was created by the developers of the Treatment Foster Care Oregon (TFCO) model. KEEP is a skills development program for foster parents and kinship parents of children ages zero to five years and teenagers (KEEP SAFE).[36] KEEP is implemented in New York City and Tennessee.

- **Trauma System Therapy (TST)** is a comprehensive, three-phase treatment program for children and youth ages four to 21 years who experience traumatic events or live in environments with ongoing stress and reminders of trauma.[37] TST is recognized by the Annie E. Casey Foundation and is used in Washington County, Maryland and Richmond County, Ohio.
- **Attachment, Self-Regulation, Competency (ARC) Treatment Framework** is an intervention for families who have experienced multiple or prolonged traumatic stress.[38] ARC is recognized by the Annie E. Casey Foundation and identified as a promising practice by the National Child Traumatic Stress Network (NCTSN). ARC is used by Bethany Christen Services, in Grand Rapid Michigan.
- **Connect for Foster Parents©** promotes building relationships with youth in care by providing foster parents with the support they need to understand the impact of trauma on the youth's behaviors and equipping them to respond with sensitivity to challenging behaviors.[39]

FPC Planning Consideration 3: Centers of excellence should be developed to organize the sharing of resources and coordination of training and technical assistance that all foster parents can access, regardless of the capacity of their supporting agency. The Advisory Committee recommended identifying centers of excellence to provide training and technical assistance and share resources on best practices in child welfare in Harris County. Committee members noted that the University of Houston's Child Welfare Education Project (CWEP) houses a lot of foster care education and training resources and could provide an infrastructure for sharing information. The Texas Network of Youth Services (TNOYS) also provides youth service professionals with quality, affordable training, including Solution-Focused Brief Therapy, motivational interviewing, and Trust-Based Relational Intervention (TBRI) as well as other evidence-based practices. CPAs, child welfare organizations, and other community-based organizations that work with children and youth in foster care could consider pooling resources to support a shared training and technical assistance entity.

An example of a national best practice that brings together child welfare and mental health to share resources, coordinate training and technical assistance, and build workforce capacity is Partnering for Success (PfS). PfS is an integrated, cross-systems workforce competency model that improves mental health outcomes for children and youth involved in the child welfare system.[40] The model is available to agencies at the state, county, and municipal levels. It is designed to build the capacity of public child welfare and mental health workforces, including foster parents, to implement trauma-informed, evidence-based practices through professional development such as specialized learning, clinical and peer consultation, coaching, and

organizational support. It focuses on data-driven continuous improvement processes and uses Cognitive Behavioral Therapy Plus (CBT+), which addresses depression, anxiety, trauma, and behavior problems. Sites implementing PfS are located in New York City, Maine, Maryland (Baltimore County), and Oklahoma. An overview of each program is provided in Appendix G.

FPC Planning Consideration 4: Develop and retain more foster parent capacity to support children and youth with complex medical conditions and intellectual and developmental disabilities (IDD). Approximately 10% of the children and youth entering foster care are medically fragile and between 30% and 60% experience developmental delays.[41] Research on children with intellectual disabilities in foster care estimate that almost 2% of children ages zero to five and approximately 3% of children and youth ages six and older have an intellectual disability.[42] In 2015 (the most recent year for which data were available), there were 314 children and youth in Region 6 identified as having a medical characteristic and 282 identified as having an intellectual or developmental disability. One hundred and eleven (111) were specifically identified as having an IDD.[43]

Foster and kinship parents are not typically recruited, prepared, or trained to meet the needs of children and youth with medical, intellectual, or developmental disabilities.[44] Children and youth with IDD and medically complex conditions require well supported foster or kinship parents who can meet their unique needs. Foster and kinship parents need to navigate the child welfare, health and education systems; understand the child's unique medical and developmental needs; and, for those children and youth with medical needs, provide direct interventions related to the child's medical care.[45] They also need to allow other professionals and treatment providers into their home as part of their daily routine – this includes physical therapists, occupational therapists, and in-home nurses.

CBC planning in Region 6a should include recruitment and retention efforts that target foster and kinship parents who are willing to care for children and youth with IDD and medically complex needs. For example, recruitment efforts specific to children and youth with medically complex needs should target health care professionals and staff working at children's hospitals or pediatric nursing homes; these individuals can be some of the best foster parents or respite care providers. Once recruited, these families will need ongoing fiscal and personal support. Planning efforts should engage The Harris Center for Mental Health and IDD for home and community-based services and community supports such as local contractors to equip a house or a neighborhood church congregation to help with recruitment. Retention and on-going support of these foster and kinship parents includes training on development, medically specific topics, and special education; access to 24/7 support if an emergency arises; financial support for the medical expenses that are not covered by Medicaid; and respite care.[46]

Part II: Community Capacity

As described in earlier sections of this report, children and youth in foster care are far more likely to struggle with a mental health condition and educational and special medical needs than their peers.[47] In fact, children and youth who are placed in foster care have been found to be in poorer mental and physical health relative to children in every other type of family situation, including those who are in economically disadvantaged families.[48] In Region 6a, most children and youth with an "emotional" or "learning" characteristic are in Moderate or Specialized Service Levels, with the greatest number at a Specialized Service Level (see the section on the Characteristics of Child and Youth). When the needs of this group of children and youth go unmet, challenging behaviors are likely to escalate and affect placement stability, often leading to more restrictive placements. Success for these children and youth and their foster families requires a strong continuum of community-based services and supports that are integrated with child welfare, mental health, juvenile justice, education, and health services.

This section describes the current capacity for supporting high-need youth, with a focus on the system framework for children and youth that was developed for the Meadows Mental Health Policy Institute's 2017 Houston Endowment funded report, *Harris County Mental Health Services for Children, Youth, and Families: 2017 System Assessment and Extended Report*.[49]

A coordinated service delivery framework for children and youth should be rooted in close coordination across child-serving agencies and collaboration between primary care, specialty care, home and community-based supports, crisis services, and inpatient health care providers. But health systems today – in Texas and across the nation – tend to be fragmented and difficult to access, especially for children and youth in foster care and their biological, kin, and foster families. The system framework referenced in this document includes five main components, briefly summarized below.

- **Component 0: Life in the Community.** This refers to the broad range of prevention activities that happen outside health care settings – in daycares, schools, faith-based communities, and other places in the community where children, youth, and families spend time. These touch-points provide opportunities to promote healthy child development and prevent mental health and substance use disorders. The typical activities, relationships, and opportunities that children, youth, and families experience as members of a community, church, team, or peer group are especially important for the healthy social, emotional, and cognitive development of children and youth in foster care.[50] These activities allow them to take risks in a safe environment; engage in learning opportunities; make decisions and mistakes; practice and master skills that

develop social, behavioral, and coping skills; and develop enduring social relationships.[51] Participation in extracurricular and recreational activities is associated with academic success, mental health, positive social relationships and behaviors, identity development, and civic engagement.[52]

- **Component 1: Integrated Behavioral Health in Pediatric Primary Care Settings.** Pediatric primary care providers can detect developmental and behavioral health needs sooner and successfully treat routine, and even some moderately severe needs, related to behavior, anxiety, and depression. Integrating behavioral health within all pediatric primary care settings is an essential strategy for increasing access to behavioral health services for children and youth. Children and youth entering foster care are required by DFPS to be medically screened within three days of placement and complete a full Texas Health Steps medical checkup within 30 days. When completed in an integrated behavioral health setting, these requirements provide the opportunity to detect, screen, and possibly treat identified behavior health needs.[53]

- **Component 2: Specialty Behavioral Health Care.** When behavioral health concerns arise, receiving care in an office-based clinical setting may become necessary, particularly for children and youth with moderate to severe needs. Ideally, most children and youth would receive care before symptoms reach this level, and those who do require specialty services would receive it sooner and in a more coordinated way. If more routine anxiety and depressive disorders are treated in integrated primary care settings, specialists can focus on the treatment of more complex depression, bipolar disorder, posttraumatic stress, addiction, and other conditions.

- **Component 3: Rehabilitation and Intensive Services.** About one in ten children and youth struggle with behavioral health needs that are so severe that their functioning is impaired across multiple life domains. These children and youth require team-based care that generally includes a prescriber, a skilled therapist, and a broader team focused on treating symptoms and building on individual, family, and community strengths to restore functioning and promote healthy development. These highly specialized and intensive supports need to be coordinated and should include a broader range of evidence-based, home and community-based services, including services designed to specifically meet the needs of children and youth in foster care, and their foster families.

Component 4: A Crisis Care Continuum. This continuum of services is needed when urgent stabilization is necessary. Even with optimal levels of the right kinds of

prevention, primary care, specialty behavioral health, and intensive home and community-based services, health conditions can become acute and require urgent intervention. Accordingly, health systems must respond to the full range of episodic, intense needs that will occur over the course of care and include mobile teams to respond to urgent needs outside of the normal delivery of care, as well as placement options ranging from crisis respite to acute inpatient and residential care. A crisis care continuum for children and youth has the following core service components:

- **Crisis intervention options to provide immediate and ongoing crisis interventions.** These include: (1) Mobile crisis teams with the capacity to provide limited, ongoing in-home support, case management, and direct access to out-of-home crisis supports;[54] (2) Screening, assessment, triage, ongoing consultation, time-limited follow-up care, and linkages to transportation, supported by protocols and electronic systems to communicate results across professionals and systems to determine the appropriate level of services; (3) Coordination with emergency medical services; and (4) Crisis telehealth and phone supports.
- **Acute psychiatric inpatient facilities** when the child or youth's needs are too dangerous or complex to address in a less restrictive treatment setting.
- **An array of crisis placements** tailored to the needs and resources of the local system of care, including options such as:
    - In-home respite;
    - Crisis foster care (placements ranging from a few days up to 30 days);
    - Crisis respite (one to 14 days);
    - Crisis stabilization (15 to 90 days) with capacity for 1:1 supervision;
    - Acute inpatient care; and
    - Linkages to a full continuum of empirically supported practices such as MST, FFT, and Wraparound.
- **First Episode Psychosis (FEP) identification and treatment.** Too often, youth who experience psychosis do not receive services until their symptoms reach a point of crisis.

No community in Texas or across the nation has a system framework that meets these benchmarks. Instead, Region 6a, like most communities, delivers most behavioral health services at the specialty or crisis levels of care. Few services are delivered in the primary care or the rehabilitation components of the continuum due to limited supports for primary care providers to address mental health needs and limited availability of rehabilitation services. The current service delivery system can keep biological, kinship, and foster families from accessing care until conditions worsen. Too many children and youth – including those in foster care –

first receive behavioral health care services in an emergency room or in a juvenile justice facility. For a child or youth in foster care, this can result in placement breakdowns and longer lengths of stay and can have a negative effect on long-term physical and emotional well-being.

The Hackett Center's assessment of the current system of care for children, youth, and their foster families in Region 6a builds on the Meadows Mental Health Policy Institute's report, *Harris County Mental Health Services for Children, Youth, and Families: 2017 System Assessment*. Qualitative and quantitative information was gathered from a number of key informants, Advisory Council members, and databases. The following overview of the current system uses the components of the ideal system as a framework.

How Adequate is Community Support Capacity (Component 0)?

Children, youth, and foster families depend on a variety of community members, programs, and systems. These supports include friends and neighbors, faith communities, schools, community-based providers, recreational programs, and other community-based organizations. Many of these programs and organizations are members of the Advisory Committee.

Over the last six months, Advisory Committee participants stressed their commitment to supporting children, youth, and foster families and highlighted available community supports, including the Boys and Girls Club, Disabilities Rights Texas, the Salvation Army, and other community agencies. In addition to identifying available supports and services, participating community partners committed to expanding the community's service array, strengthening collaboration and seeking a way for foster families to more easily access information on services and supports.

Advisory Committee participants also identified five areas – school, juvenile justice, faith communities, mentors, and daily living supports – where children and youth in foster care in foster care and their foster families can receive additional support.

1. Schools. Educational success is essential to the well-being of children and youth. Many children in foster care struggle with developmental delays and learning disabilities. More children and youth in Region 6a had an identified "learning" characteristic than an "emotional" or "substance abuse" characteristic. The Texas Education Agency (TEA) and Department of Family and Protective Services (DFPS) struggle to identify children and youth in foster care and share information on needed supports and services. Placement breakdowns and frequent moves have a negative effect on educational success. This is exacerbated when children or youth are not connected to the educational services and supports they need, when they need

them. Advisory Committee participants voiced the need to engage schools in a systematic way, including sharing resources and providing training on trauma and other evidence-based treatments, and establishing a school liaison to support foster youth.

2. Juvenile Justice. Youth involved in the child welfare and juvenile justice systems have higher rates of mental health and substance use problems and are more likely to be placed in higher levels of care in both of these systems. They are also more likely to come from a family with a history of criminal behavior, mental health, or substance abuse problems.[55] The Harris County Youth Collective (HCYC) estimates that 250 cases annually in Harris County involve "dually involved" youth, or youth who are involved in both the child welfare and juvenile justice systems. HCYC indicates that these youth are generally between the ages of 14 and 16, were removed from home as a teenager, are in permanent managing conservatorship status, and are involved in the juvenile justice system for minor offenses – fifty-one percent are African American.

HCYC prioritizes youth who are in DFPS temporary or permanent conservatorship and are pre- or post-adjudicated or on probation with the Harris County Juvenile Probation Department. Youth identified as dually involved work with a single prosecutor and have a specialized Probation Officer and CPS caseworker. HCYC focuses on data sharing and integration, coordinated case management, education, mental health, placement, and family inclusion.

3. Faith Communities. Faith communities can support kinship and foster parents and can help child placement agencies in targeted recruitment. Engaging faith communities in recruiting African American families and other families of color is a proven strategy for engaging and retaining foster parents who meet the cultural needs of children and youth. Advisory Council members indicated that the community lacked faith-based partners and would like to develop a network of faith-based organizations.

4. Mentors. Advisory Council members identified the need to expand the community's capacity to provide mentors for children and youth in care and train experienced foster parents to be mentors for those new to fostering. Mentors can help mediate the challenges of being in foster care, model critical thinking skills and strategies, and connect children and youth in care to community services. The child-mentor relationship promotes resiliency by creating opportunities to increase self-esteem and self-efficacy, and by providing opportunities for change.[56] Big Brother's Big Sisters-Houston, area faith-based communities, and Houston reVision provide mentors for children and youth in the region.

5. Daily Living Supports. Foster families who care for large sibling groups and children and youth with special needs often feel overwhelmed by the transportation and basic care needs of the children and youth in their care. Advisory Council members identified the need for transportation support, centralized visitation for ease of access, respite, and babysitting services for these families.

How Adequate is Integrated Pediatric Primary Care Capacity (Component 1)?

Children and youth in foster care in Region 6a have very limited access to foster care-friendly integrated health care settings that offer access to behavioral health services. Between 30% and 80% of children enter foster care with one physical illness and up to 80% enter with a significant mental health issue. Children and youth in care should be seen "early and often" in a pediatric primary care medical home where the pediatrician recognizes and understands the effects of childhood trauma.[57] Integrated pediatric and mental health care provided in a pediatric medical home ensures that children and youth in care are screened and treated for their physical and mental health conditions. The American Academy of Pediatrics[58] identifies a foster care-friendly integrated primary care setting as a trauma-informed practice that:

- Schedules longer appointment for initial screenings,
- Conducts comprehensive and subsequent preventative visits,
- Provides health summaries/care plans to caregivers,
- Has a system for communicating to the child's caseworker,
- Validates the child's feelings about seeing the pediatrician and being in foster care,
- Speaks with compassion about the birth parent, and
- Focuses on the child's strengths and assets.

Children and youth entering foster care in Texas are required to be medically screened within three days of placement and to complete a full Texas Health Steps medical checkup within 30 days. When these requirements are completed in an integrated behavioral health setting, they provide the opportunity to detect, screen, and possibly treat identified physical and behavior health needs.

Advisory Committee members reported that there are a limited number of physical and behavioral health care providers in areas with a high concentration of children and youth in care. This makes it difficult to meet DFPS's requirements for screenings within three days of placement and medical checkups through Texas Health Steps within 30 days, and to ensure that children and youth in care have access to providers that understand the impact of trauma and can treat mental health conditions. Community Health Choice and Superior HealthPlan Medicaid managed care organizations – also members of the Advisory Committee – assert that

they can coordinate medical and behavioral health care and provide case management services. Superior HealthPlan also provides members with access to nurses 24 hours a day, seven days a week (24/7).

The assessment identified only two integrated primary care programs that provide care specifically tailored to the needs of children and youth in foster care – Harris County Protective Services Clinic and Texas Children's Hospital-Public Health Pediatrics – and only three integrated pediatric primary care providers that could tailor their services to this population – Legacy Community Health, Memorial Herman School-Based Health Center, and Vecino Health Center. While this assessment is by no means exhaustive, the largest health systems in Region 6a and those identified by key informants were interviewed. An overview of these clinics is provided in Appendix I.

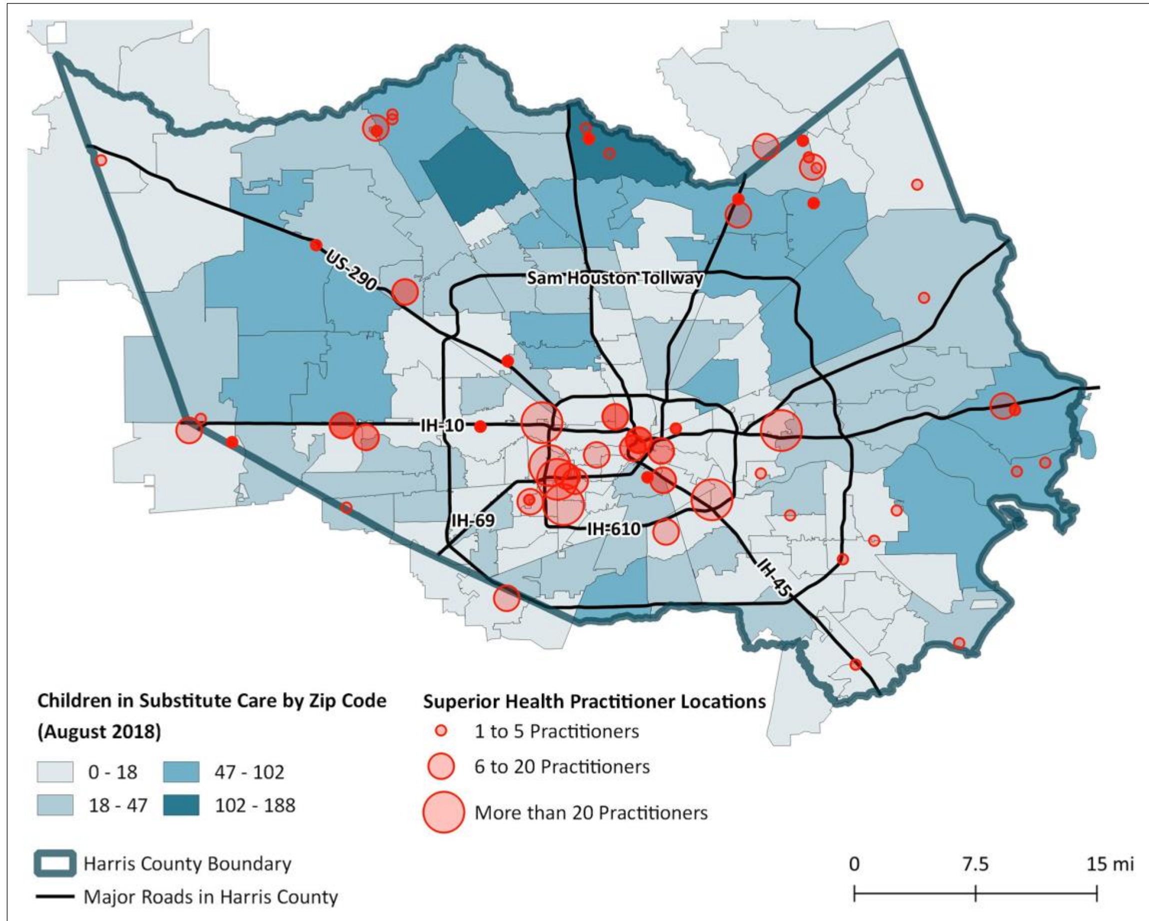
How Adequate is Behavioral Health Specialty Care (Component 2)?

Region 6a has many behavioral health specialty providers. However, their locations too often make it difficult for many foster families to access care, and evidence-based care is broadly lacking. Behavioral health specialty services include individual, group, and family therapies including evidence-based practices such as cognitive behavioral therapy (CBT), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Parent-Child Interaction Therapy (PCIT), Parent Child Relationship Therapy (CPRT), Dialectical Behavioral Therapy (DBT), and Brief Strategic Family Therapy (BSFT). These services are generally delivered at outpatient mental health clinics, counseling centers, and in school-based mental health settings. Medicaid rehabilitation services or skills training services can be provided by behavioral health providers certified to deliver Medicaid services by the Health and Human Services Commission (HHSC) and enrolled in Medicaid managed care plans. There are several behavioral health clinics, community centers, and Federally Qualified Health Centers (FQHCs) that provide behavioral health specialty services in Region 6a, in addition to school-based behavioral health clinics and private practitioners. The Harris Center for Mental Health and IDD, Legacy Community Health, Harris Health System, and Memorial Hermann Health System all provide behavioral health specialty services.

Superior HealthPlan (Superior) is the managed care organization that provides health care to children and youth in foster care through the STAR Health program. Superior credentials about 1,100 behavioral health providers in Region 6a. Map 3 shows their locations and concentrations. The map reflects the Advisory Council members' concerns regarding a lack of behavioral health specialty providers outside of Highway 610. There is a noticeable decrease in the number of Superior HealthPlan credentialed providers outside of Highway 610 and a lack of providers in areas with the highest concentration of children and youth in substitute care.

Consequently, even though Superior HealthPlan has many credentialed behavioral health specialty providers, the location of providers makes it difficult for foster families to access behavioral health supports. Advisory Committee members recommended that Superior expand the current network of providers to increase access to care and flexibility in scheduling appointments, as well as to include providers who are trained in trauma-informed care and understand how to work with children and youth in foster care and their foster families.

Map 3: Superior HealthPlan Behavioral Health Specialty Provider Locations in Region 6a



How Adequate is Rehabilitation / Intensive Behavioral Health Services Capacity (Component 3)?

Harris County's capacity to deliver rehabilitation and intensive services is increasing, but it is not sufficient to meet the needs of children and youth, specifically those in foster care struggling with serious emotional disturbances. The consensus of the Advisory Council was that there is a lack of access to home and community-based services that work with the family system. It recognized that this gap in services – along with inadequate respite care and access to mobile

crisis outreach services– can lead to placement breakdowns and increased use of more restrictive settings. Advisory Council members recommended increasing targeted training for foster parents, home and community-based services, intensive time-limited in-home supports, mobile response and stabilization services (MRSS), and wraparound services. Advisory Committee members also identified the need for better care coordination so that foster families know what services are available and how to access them.

The rehabilitation and intensive service continuum includes evidence-based and non-evidence-based rehabilitation, specialized intensive home and community-based services, therapeutic foster care, and intensive case management. In Region 6a, DePelchin Children's Center (DePelchin); The Harris Center for Mental Health and IDD (The Harris Center); Harris County Juvenile Justice Center; Pathways Youth and Family Services' Mosaic Behavioral Health Services (Pathways); Youth Advocacy Program (YAP); and Arrow Child and Family Ministries (Arrow) have increased their capacity to provide rehabilitation and intensive services to the children and youth in their care. The services provided by these organizations are described in Appendix I.

How Adequate is the Behavioral Health Crisis Continuum (Component 4)?

Despite available mobile crisis response, few children and youth in care and their foster and kinship families access these services during a crisis. Strong mental health service systems include a crisis management structure that supports a wide range of needs, from a single traumatic event to developmental trauma or complex mental health challenges.[59] For many children, youth, and their foster families, crisis services act as the front door to mental health services.[60]

Mobile Crisis Response Team Intervention Options

Harris County does not have a robust crisis continuum, which leads to overuse of emergency room services and reliance on more restrictive levels of care. The CBC Advisory Committee emphasized access to 24/7 crisis care for foster parents, children, and youth within the foster care system to maintain permanency and prevent unnecessary or excessive use of more restrictive levels of care.

There are two agencies in Region 6a that provide Mobile Crisis Outreach Team (MCOT) services to children and youth in foster care. The Harris Center for Mental Health and IDD serves all children and youth in the region, regardless of their system involvement. It reported that only 1–2% of the children and youth it serves are involved with child welfare. Turning Point, a Superior Health Plan STAR Health program delivered by Pathways' Mosaic Behavioral Health

Program, provides MCOT services specifically to children in foster care. Both providers provide 24/7 access and ongoing crisis intervention services. In 2018, Turning Point provided MCOT services to 60 children, youth, and their families in Harris County. Advisory Team members and Turning Point staff report that these programs are underutilized by foster families. Appendix I provides an overview of each of these service providers.

Additional Crisis Intervention Services

Foster families, children, and youth experiencing a psychiatric crisis can access three walk-in crisis intervention services – The Harris Center for Mental Health and IDD's Psychiatric Emergency Services (PES), the Triad Prevention Program, and Memorial Hermann Health System's crisis clinics. Families also use Ben Taub Hospital's emergency care and other emergency departments. See Appendix I for a description of these providers.

Acute Psychiatric Inpatient Treatment

Superior HealthPlan contracts with ten hospitals to provide acute inpatient psychiatric treatment for children and youth in foster care in Region 6. These facilities have 254 beds for children and adolescents. Ben Taub Hospital was included in this count because of the number of children and youth who present for care in its emergency room, require psychiatric assessment, and remain in the facility until a more appropriate placement can be made. Table 13, below, provides a breakdown of the number of available beds.

Table 13: Superior HealthPlan Hospital Network Services and Capacity

Superior HealthPlan Hospital Network Services and Capacity					
Hospital	Mental / Behavioral Health Inpatient Services?		Total Number of Beds		Intensive Outpatient Treatment
	Children	Youth	Children (ages 5–12)	Youth (age 13–17)	Children and Youth
Behavioral Hospital of Bellaire	No	Yes	None	22 beds	No
Cypress Creek Hospital	No	Yes	None	32 beds	Partial hospital program (PHP), youth only

Superior HealthPlan Hospital Network Services and Capacity

Hospital	Mental / Behavioral Health Inpatient Services?		Total Number of Beds		Intensive Outpatient Treatment
	Children	Youth	Children (ages 5–12)	Youth (age 13–17)	Children and Youth
Houston Behavioral Healthcare Hospital	No	Yes	No, maybe in next couple mos.	18 beds	PHP for youth only
IntraCare Hospital North	Yes	Yes	40 beds for children and youth ages 5–17		Yes for youth only
Kingwood Pines Hospital	Yes	Yes	16 beds	34 beds, ages 13–18	15–20 at a given time
The Right Step*	NA	NA	NA	NA	NA
UT Harris County Psychiatric Center	Yes	Yes	21 beds for children and youth		No
West Oaks Hospital	Yes	Yes	60 beds (3 units), accept children starting at age 5		3-5

Map 4, below, shows the location of inpatient psychiatric hospitals that are credentialed by Superior HealthPlan. As with other Superior credentialed practitioners, all but two facilities are located inside loop 610.

Map 4: Superior HealthPlan Credentialed Acute Inpatient Psychiatric Hospitals in Region 6a

US-290
Sam Houston Tollway
IH-10
IH-69
IH-610
IH-45

Harris County Boundary
Major Roads in Harris County

Children in Substitute Care by Zip Code (August 2018)
0 - 18
18 - 47
47 - 102
102 - 188

Hospital Locations by Agency
Behavioral Hospital Of Bellaire
Ben Taub General Hospital
Childrens Medical Center Of Dallas
Cypress Creek Hospital
Harris County Hospital District
Houston Behavioral Healthcare Hospital
Intracare Hospital North
Kingwood Pines Hospital
Ut Harris County Psychiatric Center
West Oaks Hospital

0 7.5 15 mi

*Locations have been slightly adjusted for visibility.

Short-Term Residential Crisis Supports and Residential Treatment Centers

An ideal crisis continuum offers children, youth, and families short-term residential crisis support that is less intense than psychiatric hospitalization and can provide a brief period of separation or respite in order to de-escalate a crisis situation. The CBC Advisory Council

reported a need for additional short-term crisis respite options. This need is reflected in the DFPS Foster Care Needs Assessment. The assessment estimated that there are 338 emergency shelter beds available in the region and projected that need would exceed capacity by 69 beds. This was based on the patterns of current use. If access to MCOT services and intensive in-home crisis care were increased, the region could see a decrease in current demand. Two of the short-term crisis placements in Region 6a that were mentioned by key informants and Advisory Council members are described below – Harris County Protective Services' Kinder Emergency Shelter and Turning Point's crisis stabilization beds. See Appendix I for an overview of these programs.

Community Capacity Findings

Community Capacity (CC) Finding 1: Insufficient communication and coordination between child welfare providers and community organizations are barriers to accessing needed supports. Inadequate communication and coordination from child welfare providers to schools and community providers can negatively affect school success, foster parent recruitment and retention, healthy child development, and feelings of community connectedness. Advisory Committee members and community stakeholders reported that not knowing if a child or youth is in foster care, not having timely access to school records and medical information, and a general lack of communication between the child welfare staff and community agencies makes it difficult to effectively support a child or youth in care. The result is often a child or youth who exhibits challenging behaviors. These behaviors affect stability in placement and strain their ability to form connections needed for healthy development. In addition, failure to engage faith-based organizations, community mentors, recreation programs, and other community-based supports in the CBC planning process risks leaving kinship and foster families, and the children and youth they support, without the natural supports and services many families rely on to thrive.

CC Finding 2: School Districts and campuses lack information on children and youth in foster care, delaying access to needed educational services and supports. Schools report no contact from DFPS or CPAs regarding the identity of foster youth, so they are not aware of foster placements. Educational success is essential to the well-being of children and youth in foster care. Advisory Committee participants voiced the need to engage schools in a systematic way, including sharing resources, providing training on trauma and other evidence-based treatments, and establishing a structure that embeds a school foster care liaison in schools to support foster youth.

CC Finding 3: Broader implementation of integrated behavioral health in Region 6a is needed. Harris County Protective Services (HCPS), in partnership with the University of Texas Medical School, has an HCPS Integrated Healthcare Clinic that offers physical, mental, psychiatric and dental health services in one location to ensure easy access for kinship/relative, guardians, and foster parents. This clinic is a proven model as outlined by the American Academy of Pediatrics. However, it does not have the capacity to meet the needs of all children and youth in foster care in Region 6a. Broadening the range of interventions in current settings and increasing the number of providers using integrated behavioral health will require systematic education and supports over time as well as funding reforms to promote sustainability of integrated models.

CC Finding 4: Children and youth in foster care do not have an information steward that ensures important health information is shared with foster families and primary care providers. STAR Health's Health Passport is designed to contain information on diagnosis, doctor and dentist visits, hospital stays, prescriptions, and shot records. However, it is often incomplete, and it does not serve as a full electronic medical record. This leaves pediatricians without the information they need to treat a child or youth in foster care. Timely access to health information is critical when a child enters care or is placed in a new foster home.

CC Findings 5: There are little or no specialty care or in-home parenting programs that address the challenges of parenting young children in foster care. DFPS has several prevention and early intervention programs including Parents as Teachers (PAT), Nurturing Parents, Nurse-Family Partnerships (NFP), Home Instruction for Parents of Preschool Youngsters (HIPPY) and Incredible Years. DePelchin is a Parents as Teachers provider through the DFPS's Prevention and Early Intervention (PEI) program, Healthy Outcomes through Prevention and Early Support (HOPES). These programs target families at risk of child abuse and neglect, and/or families with an open CPS case such as when a child continues to be placed with the biological family and it is not funded to support participation by foster families. These services should be expanded to foster and kinship parents of young children. Other recommended services and supports that could benefit foster parents and kinship parents of young children include Parent Child Interaction Therapy (PCIT), Infant Parent Psychotherapy (IPP), and Treatment Foster Care Oregon for Preschoolers (TFCO-P).

CC Finding 6: Harris County lacks intensive home and community-based service capacity for children and youth in care with serious emotional disturbances (SEDs), and their foster families. Harris County has a surplus of residential placements but limited access to intensive home and community-based services and supports for children and youth with complex mental and behavioral health needs. This gap prevents children and youth from timely and well-executed transitions from more to less restrictive levels of care (step-down). Without access to

step-down services, children and youth remain in residential care longer than medically necessary or are released to a level of support that does not meet their needs. It likely also contributes to placement failure and the high rates of repeat placements.

There are several providers in Harris County with intensive home and community-based services, including DePelchin, Youth Advocacy Programs (YAP), Pathways Youth & Family Services' Mosaic Behavioral Health Program (Pathways), and The Harris Center for Mental Health and IDD (The Harris Center). These providers use Medicaid funding to invest in developing and growing their capacity to provide more intensive mental health services. DePelchin, YAP, and Pathways completed the Medicaid credentialing process and have developed and expanded their internal capacity to deliver Targeted Case Management (TCM) and Mental Health Rehabilitative (MHR) services. DePelchin obtained funds appropriated by the legislature (House Bill 13, 2017) to expand its Family Integrated Relational Services Treatment (FIRST) program to provide intensive in-home therapeutic supports, crisis intervention, and wraparound to the children and youth in its care. Pathways plans to expand its capacity to deliver MHR and TCM services in the Houston area to 300 children and youth who require community-based skills training or wraparound services.

CC Finding 7: Crisis supports in Harris County are limited and fragmented. Access to appropriate services and supports by families, children, and youth in crisis can reduce unnecessary use of the foster care system as well as reduce placement failures and restrictive placements. Harris County's crisis continuum includes two MCOT service providers, an emergency shelter/crisis respite facility, psychiatric emergency stabilization beds, and a variety of inpatient hospital and RTC placements. However, these services have limited capacity, are disconnected, and are over- or under-utilized. In terms of underutilization, only 1% of the children and youth served by Harris Center MCOT services are involved with child welfare. Pathways' Turning Point program has seen a gradual increase in the number of children and youth it serves, but it rarely serves more than 20 youth and families per month. Limited emergency stabilization beds for children and youth contributes to frequent overutilization of emergency rooms and care in restrictive settings such as inpatient psychiatric hospitals and RTCs.

CC Finding 8: The region's residential treatment capacity, unlike emergency shelter/short-term crisis residential care, is forecast to exceed demand by 381 beds (48%). Even if the forecasted demand is adjusted for use from nearby regions, the estimated supply for RTC placement far exceeds demand. Like emergency shelter capacity, this estimate is based on current use. The region could experience a further drop in demand if access to less restrictive, more intensive services increases. If capacity continues to exceed demand, Region 6a runs the

risk of placing children in restrictive settings because they are available. The Family First Prevention Services Act (FFPSA) requires decreased use of congregate care settings and increased quality standards for RTC care, which may decrease available placement capacity.

Community Capacity Planning Considerations

Community Capacity (CC) Planning Consideration 1: CBC planning should continue to engage the Advisory Committee convened for this project, foster youth, and families to support planning and build supports outside of the foster care system. The Advisory Committee has been active in the initial CBC planning process and should continue to be engaged to strengthen coordination between child welfare providers; children and youth in foster care and their foster families; the community, including schools, faith-based organizations, health care providers, and the judiciary; and others. The Advisory Committee can help to develop and expand community resources. There are many examples of how communities can support children, youth, and foster parents. For example, schools have used the school district foster care liaison function to ensure a child or youth in care makes a smooth transition in or out of school. The school district foster care liaison facilitates enrollment or transfer of a child or youth who is in DFPS conservatorship to a public school. Another example is a DFPS faith-based initiative that engages organizations in support activities that include providing basic needs support for foster parents.

Casey Family Programs Educational Objectives

- Provide school placement stability.
- Secure and maintain accurate and accessible school records.
- Facilitate collaboration and training among all involved systems.
- Train caregivers to be education advocates at school and at home.
- Give youth access to supplemental educational supports and services.
- Address special education needs as appropriate to the youth.
- Decrease disparate outcomes for youth of color.
- Ensure that youth are literate, acquire basic skills, and have extracurricular opportunities.
- Prepare youth to achieve their postsecondary education, training, and career goals.
- Promote public policies that support education during and after care.

Casey Family Programs (2004). A road map for learning: Improving educational outcomes in foster care. Retrieved from *https://humanrights.iowa.gov/sites/default/files/media/Casey%20-%20RoadmapForLearning1.pdf*

CC Planning Consideration 2: CBC planning should consider working with community partners and schools to operationalize the recommendations made by the Supreme Court of Texas

Permanent Judicial Commission for Children, Youth, and Families outlined in *The Texas Blueprint: Transforming Education Outcomes for Children & Youth in Foster Care*.[61] This landmark report recommends the following steps to improve education outcomes for children and youth in foster care:

- Establish policies regarding the identification of students in foster care upon enrollment in school including appropriate safeguards to ensure confidentiality and privacy, and expedite the delivery of services and interventions.
- Determine a method of alerting the child's school of origin (or former school) of the child's enrollment in a new school to allow transfer of information.
- Improve timeliness and efficiency of transfer of accurate school records to new school placements.
- Improve child-specific information sharing to ensure that schools, CPAs, foster parents, and stakeholders have the necessary information to serve the educational needs of children in foster care.
- Develop a method to track and exchange child-specific information between juvenile justice, TEA, the school district, and CPAs about school-related offenses and school disciplinary actions of children and youth in care.
- Find funding for new use of existing technology to produce an electronic education portfolio.
- Enhance training available to schools on trauma, the child welfare system, and the needs of the children and youth in care.
- Utilize Education Service Center (ESC) resources to support local school district foster care liaisons to gather and train school staff.
- Expand the routine exchange of aggregated data between child services systems agencies to determine how children in foster care fare educationally and evaluate improvement in those educational outcomes over time.

CC Planning Consideration 3: Partner with health systems to expand the use of integrated behavioral health (IBH) throughout Region 6a. Providers in Region 6a should develop primary care with integrated behavioral health care capacity, like the Harris County Protective Services (HCPS) Integrated Healthcare Clinic. Senate Bill (SB) 11 (86th Legislative Session, 2019) established the Texas Child Mental Health Care Consortium to support this goal, as well as to foster collaboration among state medical schools, promote and coordinate mental health research, and help address workforce issues. It also establishes the following under the consortium's oversight:

- Child Psychiatry Access Network (CPAN) – A network of comprehensive child psychiatry access centers to provide consultation services and training opportunities for

pediatricians and primary care providers operating in the center's geographic region to better care for children and youth with behavioral health needs.

- Texas Child Health Access Through Telemedicine (TCHATT) – Telemedicine or telehealth programs for identifying and assessing behavioral health needs and providing access to mental health care services for children and youth.
- Child Psychiatry Workforce Expansion – Funding for psychiatrists who treat children and adolescents to serve as academic medical directors for community mental health providers as well as new resident rotation positions under the academic medical director's supervision.
- Child and Adolescent Psychiatry Fellowships – Funding for physician fellowship positions that will lead to a medical specialty in child and adolescent psychiatry.

The legislature appropriated $100 million in state funding in the 2020–21 biennium to support the consortium and its activities. With these resources to help, medical schools in the region – including Baylor College of Medicine, UT Health Houston, and UT Medical Branch – are poised to implement CPAN supports to improve access to behavioral health care through primary care practices across the region. As CPAN providers, these medical schools would support primary care practices by providing access to consultation from pediatric psychiatrists, behavioral health clinicians, and referral specialists. The teams would also support patients by providing care coordination for making appropriate community mental health referrals and support primary care providers by providing continuing professional education.

The same "hub and spoke" concept used in CPAN to expand access to care through remote site consultation is also applicable to other models of care. Although there are a growing number of foster care centers of excellence recognized through the Superior managed care organization (MCO), capacity is still limited. The majority of children and youth in foster care receive care from pediatric primary care providers, many of whom are not experienced in responding to the types of trauma and medical complexity frequently present among children and youth in foster care. In such cases, telehealth and telemedicine arrangements with expert foster care teams from children's hospitals, or through university-affiliated foster care specialty centers, can support pediatricians, nurse practitioners, and other pediatric primary care staff in key clinical activities such as conducting appropriate health assessments, communicating with foster families, and creating appropriate linkages to behavioral health services. Improving foster families' access to tailored health care services through consulting arrangements with "hub" sites is expected to reduce interactions that could inadvertently re-traumatize children or youth, improve medication management (including reducing overreliance on medications), and ensure behavioral health needs are identified and addressed.

CC Planning Consideration 4: Region 6a should work with the STAR Health MCO to ensure that foster families and child placement agencies (CPAs) know about their benefits and how to access providers, especially when providers are not available or do not have timely availability. For example, the STAR Health MCO could provide families and CPAs with the following types of technical assistance:

- Information about how to access STAR Health service coordination and service management. The STAR Health MCO is required to notify all members, caregivers and medical consenters about the availability and functions of service coordination and service management and encourage them to use these services. The MCO must provide additional outreach to members identified as having special healthcare needs.
- Information about health home services. The STAR Health MCO is required to provide health home services to address the needs of persons with multiple chronic (or complex) conditions or a single serious and persistent mental or health condition.
- Information about Disease Management. The STAR Health MCO is required to provide disease management services that relate to chronic (or complex) conditions that are prevalent in members.
- Information about the behavioral health network and how to access emergency and crisis behavioral health services, including crisis stabilization, the hospitalization diversion program, and YES waiver services. The STAR Health MCO is required to contract with behavioral health providers specializing in the treatment of conditions common to children and young adults in STAR Health such as abuse, neglect, sexual offender behavior, and exposure to complex and multiple traumas. The MCO must also ensure coordination between the behavioral health provider and primary care physician and provide access to a 24/7 behavioral health hotline and emergency services.
- Information about Community First Choice (CFC) services. CFC provides community-based long-term services and supports to eligible members with physical or cognitive disabilities, or serious emotional disturbances, as an alternative to living in an institution. The MCO must make the array of services allowable under CFC available to members who meet eligibility requirements.
- Information about the nurse and member hotline. The STAR Health MCO must provide access to a nurse and member hotline.
- Information about the STAR Health Liaisons. The MCO must employ a team of dedicated STAR Health Liaisons who are responsible for coordinating with Regional DFPS Well-Being Specialists to promptly resolve issues identified by the MCO, DFPS, or HHSC that arise related to STAR Health or to the individual healthcare of a member.

Region 6a should also collaborate with the STAR Health MCO to develop protocols with CPAs to track referrals to STAR Health providers to ensure accountability and facilitate better access to Medicaid services.

CC Planning Consideration 5: The CBC planning process should explore ways to utilize and potentially expand in-home parenting services for foster parents of young children through current programs, including Parents As Teachers (PAT), Nurturing Parent, Home Instruction for Parents of Preschool Youngsters (HIPPY), and Nurse Family Partnership (NFP) services. DFPS forecasts needing additional foster home placements willing to care for young children in Basic (24%) and Moderate (39%) levels of care. The CBC planning process should build on the Region's Think Tank plan to recruit and retain foster parents willing to provide care for young children by engaging community providers to develop capacity for evidence-based therapeutic services for young children and home visiting programs for foster parents. Examples of these evidence-based programs and strategies include Parent Child Intervention Therapy (PCIT), Positive Parenting Program (Triple P), Infant Parent Psychotherapy (IPP), Nurturing Parents for Caregivers, and Parents as Teachers (PAT). A description of each these strategies is included in Appendix F.

CC Planning Consideration 6: The CBC planning process should explore ways to work with current intensive home and community-based service providers to drive the expansion of Medicaid Targeted Case Management (TCM) and Mental Health Rehabilitation (MHR) services. DePelchin, Pathways, The Harris Center, and YAP can bill Medicaid for TCM and MHR services. DePelchin, Pathways, and YAP have expanded capacity to deliver these services to children and youth in foster care. These providers, as well as The Harris Center, should be encouraged to collaborate to deliver these services and supports to families served by smaller CPAs in the region. CBC planning should engage these partners in planning how to utilize available Medicaid services to expand capacity for intensive services and supports. Options for increasing community capacity include expanding the current capacity of DePelchin and Pathways to support foster families in smaller CPAs, engaging Harris Center and YAP to expand services to target children and youth in foster care, or supporting additional providers in developing the capacity to deliver these services.

CC Planning Consideration 7: The CBC planning process should consider aligning child welfare, juvenile justice, and mental health crisis response resources; identify opportunities to expand the crisis respite service array; and make this array available across systems. There are strong crisis programs, but they typically serve children and youth only within their own "silo" or system. If better aligned, existing resources could serve more children and youth with better options during a crisis. However, until additional intensive, evidence-based resources are

available, the crisis system will be over-burdened and contribute to continued overreliance on inpatient and crisis care. Hawaii, New Jersey, and Illinois are examples of states that have developed their capacity to provide Mobile Response and Stabilization Services (MRSS) to children and youth in care. MRSS services are available 24/7 and include an initial face-to-face intervention within one hour and follow-up interventions for up to 72 hours. If additional support is needed, the child or youth and their family are linked to stabilization services. Milwaukee, Wisconsin, Seattle/King County, Washington, and Pima County Arizona are examples of counties that have implemented MRSS.[62]

CC Planning Consideration 8: CBC planning should engage Region 6a's residential treatment facilities (RTCs) to develop a regional plan that includes youth voice to coordinate care for children and youth with the most complex needs. This plan should address the characteristics of the children and youth currently in residential treatment, the forecasted decrease in RTC placement demand resulting from the rollout of CBC, and changes mandated by the Family First Prevention Services Act (FFPSA). A review of national trends on child welfare utilization of residential treatment indicated that fourteen percent of children who receive services through the child welfare system are placed in residential or congregate care settings, including group homes and institutions.[63] A 2016 study of child maltreatment and mental health predictors of admission to Psychiatric Residential Treatment Facilities (PRTF) suggests that children and youth involved with the child welfare system are admitted to PRTFs based on clinical need, such as major depression, affective psychoses, and conduct disorders, along with trauma.[64] In contrast, youth who are placed with relatives tend to have less intensive behavioral health needs.[65] The link between child welfare and behavioral health conditions emphasizes the importance of addressing trauma from maltreatment in all treatment settings and helping biological, kinship, and foster families support children and youth with challenging behavioral health conditions.

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[1] Casey Family Programs. (updated 2018, August). *What are some effective strategies for achieving permanency?* Retrieved from https://caseyfamilypro-wpengine.netdna-ssl.com/media/SF_Effective-strategies-for-achieving-permanency.pdf

[2] Redlich Horwitz Foundation. (n.d.). *Foster & kinship parent recruitment and support best practice inventory.* Retrieved from https://static1.squarespace.com/static/5c3e3494e2ccd19ef929d5f7/t/5c58dfc9e5e5f0dc036b9bee/1549328332700/FosterAndKinshipInventory.pdf

[3] The twelve (12) Child Placement Agencies who replied to the survey include: America's Angels, Arms Wide, DePelchin Children's Shelter, Good Hearts Youth & Family Services, Homes with Hope, Houston Achievement Place, Houston Serenity Place, Loving Houston, Methodist Children's Home, Monarch Family Services, Presbyterian Children's Homes and Services, and Safe Haven Community Services.

[4] Casey Family Programs. (2018, October 3). *What impacts placement stability?* [Strategy Brief: Strong Families]. Seattle, WA: Author. Retrieved from https://caseyfamilypro-wpengine.netdna-ssl.com/media/SF_Placement-stability-impacts.pdf
[5] Casey Family Programs. (2018, October 3).
[6] Casey Family Programs. (2018, October 3).
[7] Casey Family Programs. (2018, October 3). *How can we improve placement stability for children in foster care?* [Strategy Brief: Strong Families]. Seattle, WA: Author. Retrieved from https://www.casey.org/strategies-improve-placement-stability/
[8] Redlich Horwitz Foundation. (n.d.). *Foster & kinship parent recruitment and support best practice inventory.* Retrieved from https://static1.squarespace.com/static/5c3e3494e2ccd19ef929d5f7/t/5c58dfc9e5e5f0dc036b9bee/1549328332700/FosterAndKinshipInventory.pdf
[9] Casey Family Programs. (2018, October 3). *How can we improve placement stability for children in foster care?* [Strategy Brief: Strong Families]. Seattle, WA: Author. Retrieved from https://www.casey.org/strategies-improve-placement-stability/
[10] Redlich Horwitz Foundation. (n.d.). *Foster & kinship parent recruitment and support best practice inventory.* Retrieved from https://static1.squarespace.com/static/5c3e3494e2ccd19ef929d5f7/t/5c58dfc9e5e5f0dc036b9bee/1549328332700/FosterAndKinshipInventory.pdf
[11] Connell, C. M., Vanderploeg, J. J., Flaspohler, P., Katz, K. H., Saunders, L., & Tebes, K. J. (2006). Changes in placement among children in foster care: A longitudinal study of children and case influences. *Social Service Review 80*(3), 398–418.
[12] Redlich Horwitz Foundation. (n.d.). *Foster & kinship parent recruitment and support best practice inventory.* Retrieved from https://static1.squarespace.com/static/5c3e3494e2ccd19ef929d5f7/t/5c58dfc9e5e5f0dc036b9bee/1549328332700/FosterAndKinshipInventory.pdf
[13] Redlich Horwitz Foundation. (n.d.).
[14] Casey Family Programs. (2018, October 3). *How can we improve placement stability for children in foster care?* [Strategy Brief: Strong Families]. Seattle, WA: Author. Retrieved from https://www.casey.org/strategies-improve-placement-stability/
[15] Marcenko, M., Brennan, K., & Lyons, S. (2009, May). *Foster parent recruitment and retention: Developing resource families for Washington State's children in care.* Seattle: Partners for our Children. Retrieved from https://partnersforourchildren.org/sites/default/files/2009._foster_parent_recruitment_and_retention.pdf
[16] Casey Family Programs. (2018, September 24). *What are some effective strategies for achieving permanency?* [Strategy Brief: Strong Families]. Seattle, WA: Author. Retrieved from https://www.casey.org/effective-strategies-achieving-permanency/
[17] Redlich Horwitz Foundation. (n.d.). *Foster & kinship parent recruitment and support best practice inventory.* Retrieved from https://static1.squarespace.com/static/5c3e3494e2ccd19ef929d5f7/t/5c58dfc9e5e5f0dc036b9bee/1549328332700/FosterAndKinshipInventory.pdf
[18] Connell, C. M., Vanderploeg, J. J., Flaspohler, P., Katz, K. H., Saunders, L., & Tebes, K. J. (2006). Changes in placement among children in foster care: A longitudinal study of children and case influences. *Social Service Review 80*(3), 398–418.
[19] Redlich Horwitz Foundation. (n.d.). *Foster & kinship parent recruitment and support best practice inventory.* Retrieved from https://static1.squarespace.com/static/5c3e3494e2ccd19ef929d5f7/t/5c58dfc9e5e5f0dc036b9bee/1549328332700/FosterAndKinshipInventory.pdf
[20] Redlich Horwitz Foundation. (n.d.).

[21] Casey Family Programs. (2018, October 3). *How can we improve placement stability for children in foster care?* [Strategy Brief: Strong Families]. Seattle, WA: Author. Retrieved from https://www.casey.org/strategies-improve-placement-stability/

[22] Respite Care programs can reduce stress and prevent placement disruptions by giving foster and kinship parents a break from the demands of caregiving. This is particularly important for foster parents who are caring for children and youth with challenging behaviors, mental health issues, or special needs. The continuum of respite care includes in-home care, group child care, mentor relationship experiences, camps, and therapeutic care.

[23] Jerve, J., Jorgenson, K., Leidner, S., Martin-Hushman, D., Boo, M., & Romo, C. (2013, June). *Taking a break: Creating foster, adoptive, and kinship respite care in your community.* North American Council on Adoptable Children (NACAC), the National Foster Parent Association (NFPA), and the Collaboration to AdoptUSKids. Retrieved from http://www.adoptuskids.org/_assets/files/NRCRRFAP/resources/taking-a-break-respite-guide.pdf

[24] Cooper, J. l., Banghart, P., & Aratani, Y. (2010, September). *Addressing the mental health needs of young children in child welfare: What every policymaker should know*. National Center for Children in Poverty, Mailman School of Public Health, Columbia University.

[25] Marcenko, M., Brennan, K., & Lyons, S. (2009, May). *Foster parent recruitment and retention: Developing resource families for Washington State's children in care.* Partners for Our Children. Retrieved from https://partnersforourchildren.org/sites/default/files/2009._foster_parent_recruitment_and_retention.pdf

[26] Cooper, J. l., Banghart, P., & Aratani, Y. (2010, September). *Addressing the mental health needs of young children in child welfare: What every policymaker should know*. National Center for Children in Poverty, Mailman School of Public Health, Columbia University.

[27] Meadows Mental Health Policy Institute. (2018, November 1). *Harris County mental health services for children, youth, and families: 2017 system assessment and extended report.* Houston, TX: Houston Endowment.

[28] Convened by DFPS in October 2018 to address the region's capacity needs and develop a strategic plan. Membership was made up of thirteen CPAs and general residential operations from Regions 6a and 6b.

[29] Texas Department of Family and Protective Services. (2018, October). *Capacity strategic plan Region 6a and 6b*.

[30] Marcenko, M., Brennan, K., & Lyons, S. (2009, May). *Foster parent recruitment and retention: Developing resource families for Washington State's children in care.* Partners for Our Children. Retrieved from https://partnersforourchildren.org/sites/default/files/2009._foster_parent_recruitment_and_retention.pdf

[31] Cooper, J.L., Banghart, P., & Aratani, Y. (2010, September). *Addressing the mental health needs of young children in the Child Welfare System: What every policymaker should know.* National Center for Children in Poverty: Columbia University.

[32] Casey Family Programs. (2018, September 24). *What are some effective strategies for achieving permanency?* [Strategy Brief: Strong Families]. Seattle, WA: Author. Retrieved from https://www.casey.org/effective-strategies-achieving-permanency/

[33] Casey Family Programs. (2018, September 24).

[34] Casey Family Programs. (2018, September 24).

[35] Redlich Horwitz Foundation. (n.d.). *Foster & kinship parent recruitment and support best practice inventory.* Retrieved from https://static1.squarespace.com/static/5c3e3494e2ccd19ef929d5f7/t/5c58dfc9e5e5f0dc036b9bee/1549328332700/FosterAndKinshipInventory.pdf

[36] Child Trends. (n.d.). *KEEP program*. Retrieved from https://www.childtrends.org/programs/keep-program/

[37] California Evidence-Based Clearinghouse for Child Welfare. (2017, March). *Trauma Systems Therapy (TST)*. Retrieved from https://www.cebc4cw.org/program/trauma-systems-therapy-tst/detailed

[38] Trauma Center at Justice Resource Institute. (2007). *Attachment, regulation, and competency (ARC)*. Retrieved from http://www.traumacenter.org/research/ascot.php

[39] Connecting Parent Group. (2018). *Connect*. Retrieved from http://connectparentgroup.org

[40] National Center for Evidence-Based Practice in Child Welfare. (n.d.). *Partnering for Success.* Retrieved from http://www.ncebpcw.org/partnering-for-success

[41] Foster Family-based Treatment Association and Therapeutic Foster Care at the Kennedy Krieger Institute. (2013). *Best practices in treatment foster care for children and youth with medically fragile conditions.* Retrieved from https://cdn.ymaws.com/www.ffta.org/resource/resmgr/files/Publications/medicallyfragile.pdf
[42] Slayter, E., & Springer, C. (2011, February). Child Welfare-involved youth with intellectual disabilities: Pathways into and placements in foster care. *Intellectual and Developmental Disabilities, 49,(*1), 1-13.
[43] The Stephen Group. (2015, November). *Meeting the needs of high needs children in the Texas Child Welfare System.* Retrieved from https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/CPS/documents/2015/2015-12-03_Stephen_Group_High_Needs_Assessment.pdf
[44] United Cerebral Palsy. (2006). *Forgotten children: A case for action for youth with disabilities.* Retrieved from https://www.childrensrights.org/wp-content/uploads/2008/06/forgotten_children_children_with_disabilities_in_foster_care_2006.pdf
[45] Foster Family-based Treatment Association and Therapeutic Foster Care at the Kennedy Krieger Institute. (2013). *Best practices in treatment foster care for children and youth with medically fragile conditions.* Retrieved from https://cdn.ymaws.com/www.ffta.org/resource/resmgr/files/Publications/medicallyfragile.pdf
[46] Foster Family-based Treatment Association and Therapeutic Foster Care at the Kennedy Krieger Institute. (2013).
[47] Tirney, K., & Wildeman, C. (2016, August). Mental and Physical Health of Children in Foster Care. *Pediatrics, 138*(5), e20161118.
[48] Tirney, K., & Wildeman, C. (2016, August).
[49] Available at https://www.texasstateofmind.org/wp-content/uploads/2018/04/Harris-County-Mental-Health-Services-for-Children-2017-Assessment-abridged-1.pdf
[50] Annie E. Casey Foundation. (2015). *Leveraging the Strengthening Families Act to promote normalcy.* Baltimore, Maryland. Retrieved from http://www.aecf.org/m/resourcedoc/aecf-whatyoungpeopleneedtothrive-2015.pdf
[51] Annie E. Casey Foundation. (2015).
[52] Witt, P.A., & Caldwell, L.L. (2010). *The rationale for recreation services for youth: An evidenced based approach.* Ashburn, VA: National Recreation and Park Association. Retrieved from https://www.nrpa.org/globalassets/research/witt-caldwell-full-research-paper.pdf
[53] Straus, J. H., & Sarvet, B. (2014). Behavioral health care for children: The Massachusetts Child Psychiatry Access Project. *Health Affairs*, *33*(12), 2153–2161.
[54] For more information, see http://wraparoundmke.com/programs/mutt/.
[55] Lenhoff, C., Jones-Kelley, H., & Abbot, S., (2017). CYPM in brief: Engaging court appointed special advocates to improve outcomes for crossover youth. *The crossover youth practice model (CYPM).* Center for Juvenile Justice Reform, Georgetown University. Retrieved from https://cjjr.georgetown.edu/wp-content/uploads/2017/08/CYPM-In-Brief-CASA.pdf
[56] Office of Justice and Delinquency Prevention. (n.d.). Mentoring youth in foster care: The technical assistance and training program for mentoring system-involved youth. Retrieved from http://reachga.org/wp-content/uploads/2016/08/Mentoring-Youth-in-Foster-Care.pdf
[57] Szilagyi, M.A., et.al. (2015, October). Health care issues for children and adolescents in foster care and kinship care. *Pediatrics, 136,* 4, e1142-66.
[58] Szilagyi, M.A., et.al. (2015, October).
[59] Pires, S.A. (2010). *Building a system of care: A primer* (2nd edition). Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development.
[60] Burns, B. J., Hoagwood, K., & Mrazek, P. J. (1999). Effective treatment for mental disorders in children and adolescents. *Clinical Child and Family Psychology Review, 2*(4), 199–254.
[61] Supreme Court of Texas Permanent Judicial Commission for Children, Youth and Families. (2012, March). *The Texas blueprint: Transforming education outcomes for children & youth in foster care. The final report of the education committee, March 21, 2012.* Retrieved from http://texaschildrenscommission.gov/media/1119/thetexasblueprint.pdf

[62]National Association of Mental Health Program Directors. (2018, August). *Making the case for a comprehensive children's crisis continuum of care.* Retrieved from https://www.nasmhpd.org/sites/default/files/TACPaper8_ChildrensCrisisContinuumofCare_508C.pdf

[63] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2015). *A national look at the use of congregate care in child welfare*. Washington, DC: U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.

[64] Rose, R. A., & Lanier, P. (2017, September). A longitudinal study of child maltreatment and mental health predictors of admission to psychiatric residential treatment facilities. *Int. J. Environ. Res. Public Health, 14*(10), 1141. doi: doi.org/10.3390/ijerph14101141

[65] Rose, R. A., & Lanier, P. (2017).

System Wide and Community Based Planning Considerations

System-Wide and Community-Based Care Planning Considerations

The following system-wide and community-based care-specific planning considerations cannot be addressed by a specific agency or organization and have to be looked at a system level. These considerations promote system improvements that will help the community improve its local system of care in preparation for CBC.

System-Wide Planning Considerations

System-Wide (SW) Planning Consideration 1: The CBC planning process should develop a plan to address the long lengths of stay in care. A core group of CBC community leaders should engage the region's judicial leadership and key stakeholders to develop a plan to improve the permanency outcomes of children and youth in foster care in Region 6a, and to strengthen relationships between courts, providers, and Child Protective Services (CPS). This plan should include efforts to cross-train judges, attorneys, and child welfare staff to ensure a common foundation of knowledge and understanding and tools to support practices.

SW Planning Consideration 2: Engage the Supreme Court of Texas Permanent Judicial Commission for Children, Youth, and Families (Children's Commission) for education and support, particularly through the updated version of the *Texas Child Protection Law Bench Book*,[1] which directly engages judges to improve the law, legal system, and the administration of justice related to child protection cases. Published by the Children's Commission, the handbook highlights the basic understandings and practices of trauma-informed care, the importance of including youth voice, factors to determine the best interest of the child throughout the legal process as well as a toolkit on how Texas judges could address the issues surrounding disproportionality.[2]

SW Planning Consideration 3: Engage kinship caregivers early to begin the foster parent certification process and address barriers that cause kinship families to delay, decline, or discontinue the foster parent certification process. Too often today, kinship caregivers are not adequately educated and prepared to begin the foster parent certification process. Adoption or permanency plans can be delayed because kinship caregivers begin the process too late or encounter barriers in the certification process.

Kinship caregivers are required to complete a foster home certification process that includes extensive criminal and CPS background checks, risk assessments, and home study for foster home verification. These requirements limit the ability of the judge overseeing the case, as kin who are not certified have fewer resources to support a placement. CBC planning should address the barriers to licensing kinship families and strengthen communication between CPS,

CPAs, and kinship caregivers on the benefits and impact of beginning the foster care licensing process early.

SW Planning Consideration 4: Implement child- and trauma-friendly court settings. Research has shown that better permanency outcomes are reached when children and youth are active participants in their court hearings and are included throughout the decision-making process.[3] Unfortunately, Harris County court rooms do not feel safe and welcoming and are not child friendly. This includes a court process that requires children to testify before a courtroom full of adults, which in many cases includes the parents or caregivers who have been accused of abusing the children. Bexar County, for example, addressed this problem by developing a Children's Court that includes a safe room, a visitation room, and conference and mediation rooms as well as video technology that permits a child to testify without being present inside the court room.[4]

SW Planning Consideration 5: Explore ways to increase efficiency and effectiveness in court hearing procedures. The efficiency and effectiveness of court hearings and docket practices, among several other factors, influence how quickly children and youth, and their parent(s), receive the services they need and how quickly the child or youth returns home or is placed in a permanent home. Currently, a child or youth in Harris County remains in care an average of 24 months, compared to a national average of 19 months and a statewide average of 17 months.

Harris County Family and Juvenile courts handle CPS cases in 12 courts – nine of those are designated family law courts and three are designated juvenile courts. Each court has an associate judge appointed by the elected district court judge, for a total of 24 judges. In addition to these courts, there is a dedicated Permanent Managing Conservator (PMC) Court. The child, the child's caregivers, CASA, attorney ad litem, and the CPS caseworker could appear before any one of 25 different judicial officers making it difficult to know court requirements and expectations and plan accordingly.

It may be necessary to look at the organization of the 13 courts (and 25 judicial officers) that currently have jurisdiction over family and juvenile courts and to engage Harris County leadership in discussions regarding this. For example, establishment of a lead court with multiple associate judges helping share a coordinated case load could help expedite proceedings and streamline processes for both the court and families. In addition, the Department of Justice, the Department of Health and Human Services, and the National Council of Juvenile and Family Court Judges (NCJFCJ) created the *Toolkit for Court Performance Measures in Child Abuse and Neglect Cases*, which includes guidelines and resources to help cases move along more quickly and safely.[5]

One example of how court procedures can be changed to improve time to permanency involves Collaborative Community Court Teams (CCCT) model. The National Quality Improvement Center for Collaborative Community Court Teams is funded by the Children's Bureau and is a national initiative that aims to address the needs of infants and families affected by substance use disorders and prenatal substance exposure. Harris County has been chosen as one of 15 demonstration sites. The goal of CCCT is to improve the outcomes for these infants, young children, and their families, including mitigating the risk of abuse and neglect and reunification.

SW Planning Consideration 6: Explore ways to increase access to family-focused supports. Families require training and support, but training is not enough. Foster parents must be supported by an infrastructure that includes hands-on support and diverse resources. The primary reason that foster parents stop fostering within the first two years of service is lack of support.[6] Foster parent supports include crisis intervention services, foster parent mentors and support groups, respite care, and adequate financial support.[7, 8] Best practice supports for families are described in the Community Capacity section and included in Appendix F.

SW Planning Consideration 7: Establish timely and expanded communication between community partners and service providers regarding a child or youth's needs. Delays in communication regarding a child or youth's needs can impede access to needed care and, in some cases, lead to breakdowns in placement. Foster parents, community providers, schools, judges, and juvenile justice agencies identified that this communication is fragmented and incomplete. Youth and foster families stressed that lack of communication can increase child or youth stress and exposure to trauma, which, among other negative outcomes, reduces trust in their current system of supports. Advisory Committee members agreed on the need to improve communication through data sharing; formalizing the relationship between schools, community providers, and DFPS; providing access to a database with available resources such as the 211 system; and improving the accuracy of Health Passport.

Strategies should include planning to increase cross-system communication and collaboration and as well as expanding access to information to improve child and youth transitions within and out of the system. Child and youth transitions within and out of the system are too often inadequately managed, leaving children and youth without stability, resources, and support to be successful. Youth in care and foster parents reported that they often had little to no prior knowledge of a change in care. Youth stated that these unexpected transitions resulted in lost personal belongings and high levels of anxiety. Foster parents echoed these concerns and added that poorly managed transitions resulted in limited information about the child or youth's needs, triggers of past traumatic experiences, and discontinuation of helpful

interventions. CBC planning should engage CPS caseworkers, CPA staff, foster families, and youth to identify strategies to address these issues.

Communities have addressed fragmented communication by adopting a system of care approach.

The system of care approach was developed to coordinate the care of children and youth with serious mental health conditions, and their families, who are receiving services from multiple child-serving systems. Three examples of child welfare system of care sites are located in Colorado, Pennsylvania, and Iowa. Colorado and Pennsylvania both have state-supervised, county-administered child welfare systems. All three sites have demonstrated success in cross-system communication and collaboration built on a set of shared core principles, community engagement, collaboration/communication, and data sharing. Lessons learned include:

- Data are key in communicating that these children are involved in multiple systems.
- Having a tool to gather data that can also track outcomes is important. In Colorado, for example, having data regarding crossover youth in multiple systems was key to making the case that systems should work together to better serve these youth, rather than each system working in silos.
- Iowa uses data to identify where high-need youth live and to align its system. It also shares data to build buy-in among residential care providers to make some difficult changes to their contracts.
- Using data dashboards, Pennsylvania tracks the needs of the children, youth, and families being served.

Casey Family Programs. (2018, January). Can you tell us about a few agencies that have systems of care? *Information Packet: Supportive Communities.* Retrieved from https://caseyfamilypro-wpengine.netdna-ssl.com/media/SComm_Systems-of-Care.pdf

SW Planning Consideration 8: Youth in foster care should have access to the support, training, information, and resources required to be successful. Foster parents and youth expressed concerns that many youth lacked the skills they needed to be successful when exiting care and were not always aware of available resources and supports. Multiple resources could support this goal. Advisory Committee members suggest that the Preparation for Adult Living (PAL) program should be made available to more youth at a younger age, perhaps even at a younger age than the current age of 14. Texas has implemented extended foster care, made it easier for youth in care to get a state ID or driver's license, and has lowered the age for enrollment in the PAL program to 14. However, these strategies alone cannot address the needs of transition-age youth. CBC planning should build on these improvements and consider strategies that:

- Support engagement in post-secondary education;
- Improve access to education and career development services;
- Develop financial management skills;

- Ensure access to safe, stable and affordable housing;
- Help manage health and mental health care needs; and
- Establish permanent relationships with supportive adults.

The Texas Youth Permanency Study provides a set of recommendations for supporting transition-age youth.

The Texas Youth Permanency Study (TYPS) proposes a new way to think about permanency based on interviews with 30 youth who have been in foster care. Three key findings are: (1) authentic relationships matter most, (2) every child needs to feel normal, and (3) authentic relationships and feeling normal foster well-being in young adulthood. These findings form the conceptual model with normalcy as its core. Normalcy is the feeling of being "like everyone else." This feeling allows youth to build authentic relationships that move beyond permanency and support them in their transition into young adulthood. TYPS believes that through informal and formal relationships youth can begin to create relational permanency. When relational permanency is established, youth are able to achieve safety, education, health, life skills, and vocation – the five key markers to well-being.

TYPS divides relationships into informal and formal. Formal relationships are formed with the people that are paid to be in their lives. Informal relationships are formed with other supportive adults and friends. Examples of informal relationships include:

- Youth have honest and open communication with birth families.
- Youth have supportive adults in their life such as teachers who encourage personal growth.
- Youth are allowed to have friends and participate in age-appropriate social activities.
- Youth are allowed to have age-appropriate romantic relationships.

Examples of formal relationships include:

- Foster caregivers treat youth as one of their own, allowing freedom and honoring cultural history.
- Caseworkers prioritize youth voice in case planning and challenge and hold youth accountable when appropriate.
- Mental health professionals maintain confidentiality and honor youth voice about medication.
- Youth have support from adults who advocate for them when needed.

Texas Youth Permanency Study. (2019, May). *Authentic Relationships Matter Most: TYPS Sheet for Foster Families.* Retrieved from https://www.upbring.org/wp-content/uploads/2019/04/TYPS-Sheet-FosterFamiles_FINAL_4.26.19.pdf

Community-Based Care Planning Considerations

Taking into account the lessons shared from the three Single Source Continuum Contractors (SSCCs) that are currently working in Texas, the community planning process identified a set of community-based care-specific planning considerations to inform community efforts to improve the local system of care in the short and long term.

Community-Based Care (CBC) Planning Consideration 1: Build community engagement for improving collaboration using the flexibility allowed under CBC. The success of CBC relies on engaging community providers, schools, the judiciary, mental health and primary care professionals, faith-based organizations, community leaders, philanthropists, and donors to improve collaboration through the flexibility and new ways of working together allowed under CBC. The CBC planning process should engage community partners, key stakeholders, and organizations that are willing to develop a community of support for foster families and the children and youth in their care. Collaborative relationships and discussions will help identify and address gaps in services and may encourage innovative options for expanding care.

An *Our Community. Our Kids. (OCOK)* community collaboration success story:

> *In one of our rural counties, we had 81 kids in county who were in foster care and we had three foster homes. We immediate[ly] did two things. First, we went to providers and said 'we want to work [with] agencies who are willing and able to build capacity in Mineral Wells.' The second thing we did was to explore why we didn't have enough homes there. We determined there wasn't enough recruitment and it was difficult for families to become licensed if they did express interest. Some families expressed interest and agencies weren't being responsive in doing home studies and initiating the licensing process.*
>
> *We put out an RFP to identify providers that could do this. Providers proposed different approaches. One provider said they would open an office and do training locally; another provider had a good relationship with a pastor at church… who was going to give space to recruit families. Sometimes the agencies just need to be assured if they open an office, you are going to place your kids there with those families. Another advantage to addressing problems is we had specific information on what we needed. We knew we had 22 teenagers, nine babies, 24 girls. We had very specific data on the types of homes we needed. From a planning standpoint, they had confidence that OCOK would place [the] child if they do this.*
>
> *The other exciting thing is that OCOK has community engagement staff – one function is to engage community. Our community engagement folks started getting to know Mineral Wells and starting to tell their stories – the idea that this is your community and these are your kids. A group of pastors shared what was going on in their congregations; they said 'we are here to serve these kids.' This group of people who had a captive audience every Sunday and started communicating the need…. [W]e started having training and today we have 30 families in Paulo Pinto County. The fun thing for that*

group is that because faith communities got involved, they communicated to families 'you are joining a team of people to help you; we are coming together to help our kids.' It is a powerful message to a family considering being a foster parent but scared of doing it.

CBC Planning Consideration 2: Promote increased transparency regarding potential Single Source Continuum Contractor (SSCC) intentions so that collaboration and partnerships can be developed in advance of the rollout in Region 6a. Representatives of the current SSCCs in Texas noted that it is critical for potential SSCCs to voice their intentions as soon as possible. The earlier in the process a potential SSCC makes its intentions known, the sooner it can begin to gain community trust and confidence and develop or strengthen relationships with other partner agencies.

Openness and transparency are the responsibility of the potential SSCC(s). The potential SSCC(s) should emphasize collaboration and cooperation throughout the planning process. This includes facilitating community engagement meetings to share information, increasing public understanding of the changes associated with CBC, receiving feedback, and securing community support for implementation.

CBC Planning Consideration 3: Establish informed and realistic timelines that consider state-level processing requirements, which can be lengthy. The SSCC should establish timelines that account for lengthy processing periods at the state level. The state has a complex and time-consuming process for finalizing contracts. To minimize delays in assuming new responsibilities, contractors should initiate paperwork and state contracting requirements as early as possible. Also, because there are many actors involved in the contracting process, contractors should be proactive in communications with state employees and also obtain key information and agreements in writing. Planning for a multi-month start-up period should also be incorporated into the process.

CBC Planning Consideration 4: Explore strategies to improve access to more timely and accurate data to support all planning, implementation, and monitoring processes. Access to real-time, accurate data is critical to the CBC planning and implementation process and supports performance-based contracting. The SSCC must reconcile the state's data system with its internal systems and the local systems used by community providers. DFPS uses IMPACT for data collection, which is not interoperable with other agencies, does not collect outcome data, and does not allow SSCCs to enter data. There have been many issues with the quality and reliability of IMPACT data, which means SSCCs should track and manage their own data. All three SSCCs in Texas use Texas Provider Gateway (Gateway) for data management. The

Gateway allows direct providers to input data, provides real-time data on available capacity, and supports providers in contracting with multiple SSCCs.

In the spirit of cooperation and to promote a unified vision to advance child welfare in the state, all three SSCCs in Texas invested in the development of a shared data platform called the Texas Provider Gateway (Gateway). Created by Five Points Technology Group, the Gateway bridges data from all the SSCC provider networks and merges them into a centralized location. It also connects with and receives data from other data management systems, meets HIPAA compliance requirements, and other privacy requirements. This central data platform with cross-system integration functions to strengthen the validity and reliability of data by eliminating double entry errors by providers, and also enables the SSCCs to control and standardize data collection requirements across regions.

- **Types of data collected.** Providers are able to log in and input information on individual home preferences, bed capacities, discharges, child placement information, and other data fields that measure child placement outcomes.
- **Performance-based contracting.** In December 2018, the Gateway began collecting additional data for DFPS's Performance Management Evaluation Tool (PMET), used to evaluate the region's performance. PMET's new measures for fiscal year 2019 include whether youth ages 16 and older have obtained a driver's license or state ID, and whether youth of all ages are attending their court hearings.
- **Ongoing expansion of the Gateway.** As of 2019, Gateway's functions were expanded to match the capabilities of their previous software system, CareMatch, which uses algorithms to match the child's characteristics and needs to the providers who are best suited to care for them. These expanded functions will enhance Gateway's abilities to confirm open beds as well as capture other important information, such as sibling data and attributes and behaviors of individual children.

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[1] Supreme Court of Texas Permanent Judicial Commission for Children, Youth, and Families. (2018, November). *Texas Child Protection Law: Bench book.* Retrieved from http://texaschildrenscommission.gov/media/83951/2018-cw-bench-book-online-print.pdf

[2] Supreme Court of Texas Permanent Judicial Commission for Children, Youth, and Families. (2018, November).

[3] The Supreme Court of Texas Children's Commission. (2016, May). Youth Presence in Court Proceedings: Round table report on the child's presence in court. Retrieved from http://texaschildrenscommission.gov/media/1324/41718-youth-presence-in-court-proceedings-report_final.pdf

[4] The Supreme Court of Texas Children's Commission. (2016, May).

[5] Office of Juvenile Justice and Delinquency Prevention. (2009, April). *ToolKit for court performance measures in child abuse and neglect cases.* Retrieved from https://www.ojjdp.gov/publications/courttoolkit.html.

[6] Redlich Horwitz Foundation. (n.d.). *Foster & kinship parent recruitment and support best practice inventory.* Retrieved from

https://static1.squarespace.com/static/5c3e3494e2ccd19ef929d5f7/t/5c58dfc9e5e5f0dc036b9bee/1549328332700/FosterAndKinshipInventory.pdf
[7] Redlich Horwitz Foundation (n.d.).
[8] Casey Family Programs. (2018, October 3). *How can we improve placement stability for children in foster care?* [Strategy Brief: Strong Families]. Seattle, WA: Author. Retrieved from https://www.casey.org/strategies-improve-placement-stability/

Fiscal Best Practices and Financial Sustainability

Fiscal Best Practices and Financial Sustainability

Perhaps the most crucial aspect of community-based care (CBC) planning involves anticipating changes in how services are funded, particularly for the Single Source Continuum Contractor (SSCC) that bears financial risk. This will be particularly important for Region 6a, as the financial risk in this region is much higher than that of even the biggest regions (Tarrant County and Bexar County) that have implemented CBC to date.

Anticipating some of the key financial challenges for potential SSCCs, this section begins with a summary of the evolving financial requirements in each stage of the CBC rollout, followed by a summary of national best practice funding. Finally, several risk mitigation strategies that could help support the financial stability of the Region 6a CBC, once implemented, are suggested.

What Funding Streams Support CBC in Texas?

CBC in Texas is funded through a blended rate combined with additional funding to cover administrative costs incurred during the three stages of CBC implementation start-up. The Department of Family and Protective Services (DFPS) pays SSCCs a blended foster care rate that is calculated based on previous payments to foster care providers. The additional funding streams paid to the SSCC by DFPS cover the various administrative costs accrued by the SSCC during start-up, the transfer of resources from DFPS to the SSCC, the development of a community-based care network, and the delivery of case management. CBC is rolled out in three stages:[1]

- Stage I: The SSCC is responsible for finding foster homes or other living arrangements for children and youth who are in state care and for providing them with services to meet their identified need.
- Stage II: The SSCC is responsible for expanding its services to include relative or “kinship” placement; the SSCC has sole responsibility for case management.
- Stage III: The SSCC is held financially responsible through the use of incentives and remedies for the achievement of permanency for children and youth 18 months after case management functions have transferred from the state to the CBC.

Blended Foster Care Rate

The blended foster care rate is the rate paid to the SSCC for each day of service provided to a child or youth in foster care. The blended rate is equal to the weighted average rate paid across all placement types. This rate is meant to be cost neutral and is based on the projection of how much it would cost a CBC provider to serve children in its care under the legacy system. The methodology for setting the blended rate uses the legacy foster care rates and projections of how many children and youth will need to be served – by service level and placement setting –

to determine a statewide average blended rate. This rate is then translated to different rates for each CBC provider by applying a strata based on the child or youth's age at entry and length of stay in care. Strata include:

- Strata A: Age at time of entry is < 1 year;
- Strata B: Age at time of entry is 1–13 years, time in care is < 2 years;
- Strata C: Age at time of entry is 1–13 years, time in care is > = 2 years;
- Strata D: Age at time of entry is 14–17 years.

The blended rate assumes that the strata criteria meaningfully capture the financial risk of providing care to the current children and youth in the system and that the past rates in aggregate were adequate.

Start-Up Funding (Stages I–II)

DFPS provides each SSCC with a one-time payment to cover the start-up costs incurred during Stages I and II. The start-up funding amount, which is based on legislative appropriations, covers the six-month period in which the SSCC performs its readiness activities. Start-up funding has varied across SSCCs and is based on independent cost studies.

- Region 3b start-up funding for Stage I implementation in 2014 was about $208,000. The region is negotiating higher start-up costs for Stage II.
- Bexar County negotiated $997,000 for Stage I and Stage II.

During the start-up process, the SSCC must provide DFPS with a detailed budget report that outlines how it will spend awarded start-up funds. The SSCC is also required to submit a final report to DFPS on actual expenditures. The start-up process places strict rules on how start-up funds can be used.

Resource Transfers (Stage I–II)

Resource transfers are intended to cover the cost of providing functions that are traditionally performed by DFPS but will shift to the SSCC during each of the CBC implementation stages. The amount determined for each transfer is based on the number of staff estimated to support the reassigned functions and the blended rate for the number of children and youth served by the SSCC. These funds are transferred to the SSCC quarterly. CBC providers have not always agreed that the number of full-time equivalents (FTEs) that DFPS transfers to SSCCs are sufficient to support the new required functions.

Community-Based Care Network Support (Stages I–III)

DFPS pays the SSCC each month for the costs incurred for procedural system enhancements and efficiencies. These are additional payments made to the SSCC to support capacity, network development and oversight, and community engagement as well as new IT system requirements based on the CBC model. The amount established in the current CBC contracts was determined by multiplying the annual forecasted FTEs that will be needed to serve each child and youth in paid foster care per fiscal year by $1,900 per child FTE. The SSCC is paid in equal monthly installments. At the end of each state fiscal year, DFPS performs a reconciliation based on the actual child FTEs for the catchment area and pays the SSCC for underpayments or requires the SSCC to remit overages based on the actual number of children and youth served.

Case Management (Stage II–III)

Before the Stage II implementation begins, the SSCC and DFPS negotiate the funding that will be provided to the SSCC to perform the case management services that were formerly provided by DFPS staff. The SSCC invoices DFPS monthly for case management services, based on a daily rate for case management days, for each child and youth. The case management days are forecasted for each fiscal year by catchment area and subjected to legislative appropriation.

What National Best Practices Strategies Fund Community-Based Care?

While many states contract with community-based providers for direct services, fewer states delegate the case management of services for children and youth in foster care to community providers. To understand the lessons learned from other states, a literature review was conducted, which revealed five states that have implemented or are implementing community-based models – Florida, Kansas, Louisiana, New York, and Milwaukee County, Wisconsin. These states and counties were selected because they provide important lessons for Texas as it expands the CBC model.

Florida, Kansas, Louisiana, New York, and Milwaukee County, Wisconsin, rely on CBC models that contract for case management and service delivery for children and youth in foster care. All use a braided funding approach to finance behavioral health services that align federal Title IV-E funding for foster care placement costs,[2] federal and state Medicaid funding for services (particularly mental health services), federal block grants for mental health and substance use supports, state general revenue funding, and private or philanthropic funding. The rules for applying funding from each source are clearly articulated.

In general, all national best practice funding models follow the same methodology. Medicaid pays first for all covered health care services, Title IV-E funds pay for monthly maintenance

costs for the daily care and supervision of children and other child welfare-related costs, and state and local funds pay for children and youth who were not eligible for services that were not covered by federal funds. Because most philanthropists are moving away from financing services covered by other funding sources, philanthropy can be used to subsidize innovation, one-time expenses, training and certification costs of implementing evidence-based practices that are not otherwise reimbursed by payers, and to provide flexible funds.[3]

Most of these states also require partnerships between foster care providers and their Medicaid managed care organizations (MCOs) to coordinate the delivery of behavioral health services to the foster care population. Medicaid managed care is utilized by most of the comparison states to build active networks of providers that deliver services and supports to children and youth in foster care. While there are gaps in access to child psychiatrists and licensed practitioners throughout the country, the comparison states found that reliance on health plans and MCOs helps expand provider networks and increases access to Medicaid services.

The experiences of these states reveal opportunities to provide a broader array of effective services to children and youth in foster care while limiting the overall cost of care to the state by effectively braiding public and private funding sources. Some recommendations provided below are based on other state research in the fiscal risk mitigation strategies. However, in Texas most of these opportunities require action at the state level. CBCs can advocate for change with the state but cannot make these fundamental funding methodology changes at the CBC level.

Planning for Financial Risk When Implementing a CBC

In general, organizations implementing CBC have mitigated financial risk by supporting youth in the least restrictive levels of care, negotiating value-based contracts, and collaborating with other CBC providers. As community-based care has begun to roll out across Texas, even though the starting point for rate calculation assumes cost neutrality with the legacy system (that is, costs should not increase), early adopter communities have generally experienced increased costs based on a number of fiscal risks associated with being a CBC provider. The Texas Association of Child and Family Services engaged MMHPI and Deloitte Consulting in 2018 to carry out an analysis of these risks for DFPS and HHSC, and recommend potential changes in the rate methodology to address them. This report, plus an additional report identifying additional sources of federal revenue that can potentially increase available funding, was completed in May 2019 and served as the basis for a budget rider (HHSC Budget Rider 32) that will require DFPS and HHSC to develop an updated methodology over the next biennium for

implementation in the fiscal year (FY) 2022–23 budget cycle. Stakeholders are hopeful that the new methodology will better ensure that state and federal funding is adequate to support needed services and that local funds (including philanthropic support) can be used for system improvements rather than to subsidize inadequate rates.

Nonetheless, until the updated methodology is completed and its adequacy demonstrated, regions considering CBC implementation should bear in mind several risks inherent in the current model, including the following:

- The CBC model is not transparent about all financial risks, in particular risks related to inadequate legacy foster care rates, needs in the local region that may differ from statewide averages, and changes in the number of children and youth in need and the types of needs they have over time.
- As a result, all SSCCs to date have had to raise millions of additional dollars to fund gaps in financing. Additional funds would be needed to support CBC implementation even if rates were adequate to support ongoing care, as there is a need to build and ramp up new and improved services at the same time that services through the legacy system must be maintained. However, given the inadequacy of the current model to predict accurate rates for each CBC region, SSCCs have found themselves using these millions of dollars of additional funds – much of it raised through local philanthropy – to subsidize care.
- Organizations that are contemplating becoming an SSCC need to consider their capacity for accepting and managing risk and to recognize that risks are designed to grow over time across the three phases of implementation.

This means that risk mitigation is especially essential in Region 6 (particularly in Region 6a), and that the strategies considered for Region 6a may need to be different than those for any other region of the state. The stakeholder planning process identified several potential risk management strategies that organizations considering becoming the SSCC for Region 6a should keep in mind, including:

- Expanding care capacity support to help children and youth remain in the least restrictive, most appropriate setting while minimizing moves in care;
- Negotiating value-based contracts with key providers in their networks;
- Collaborating with other CBC providers to develop additional risk mitigation strategies, both locally and statewide;
- Exploring partnerships among child placement agencies (CPAs) and Harris County Protective Services to share risk; and

- Closely monitoring the development of the new rate methodology by DFPS and HHSC during the next biennium and advocating for an approach that is able to predict and support risk management in Region 6a.

Fiscal Risk Management (FRM) considerations are described below.

FRM Consideration 1: Expand access to Medicaid-funded and other intensive, community-based supports. SSCCs can manage the cost of providing care by increasing access to Medicaid-funded services to help children and youth achieve permanency in the least restrictive, most appropriate setting. Increasing access to intensive community-based services and supports for children and youth with higher needs and their foster families can stabilize placements and minimize placement disruptions, reducing the time needed to achieve permanency outcomes.

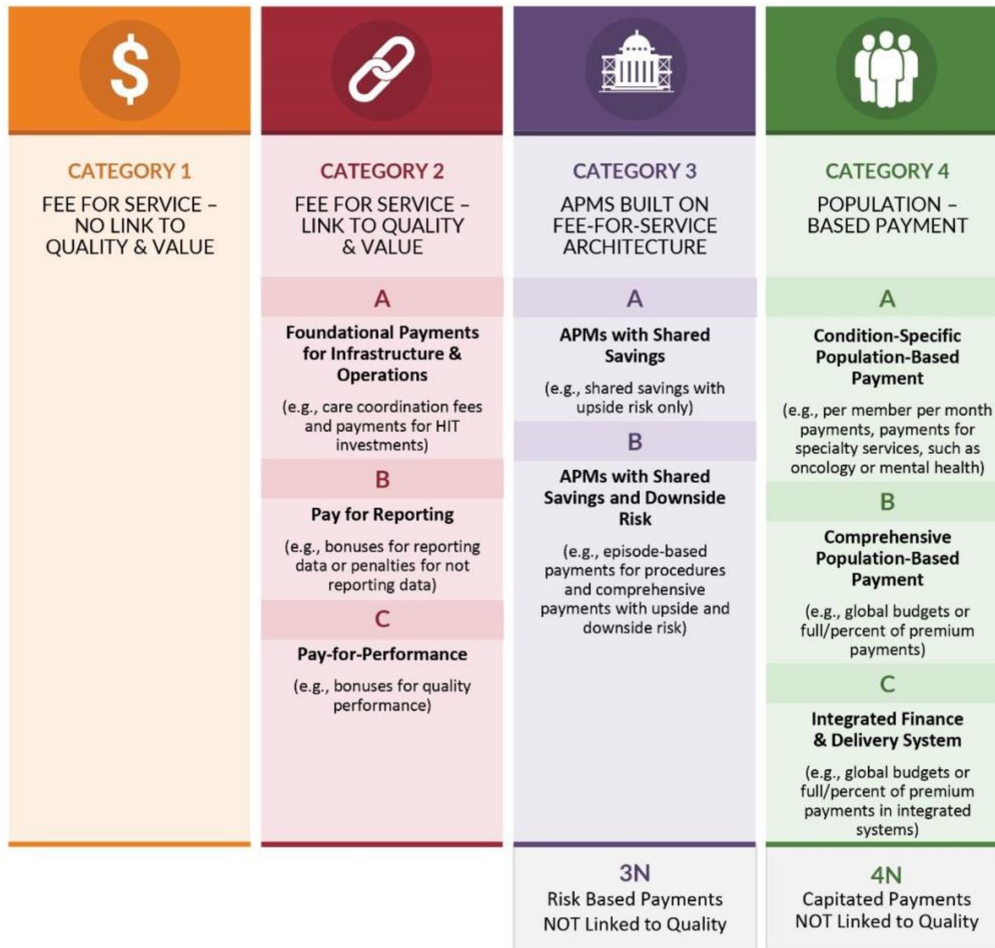
- Increasing use of Medicaid-funded supports. In the other states and the one county that were reviewed, Medicaid was found to be an essential funding source for covered services for Medicaid-eligible children and youth in foster care. This contrasts with Texas where many services are being provided without accessing Medicaid and are instead funded through Title IV-E and local and state general funds. The SSCC could work with STAR Health Medicaid to provide a wider array of services for children and youth in foster care. Child placement agencies could enroll to become Medicaid providers (this can be a nine- to 12-month process) to access reimbursement for billable services, explore partnership models for providers who do not have the administrative resources to bill Medicaid, or establish a referral process with existing community STAR Health providers. This would facilitate timely access to needed Medicaid services for children and youth and avoid the use of CPA funding to pay for outpatient behavioral health services covered by STAR Health such as therapy and psychiatry.
- Increasing the number of CBC providers that are willing to provide currently covered community-based and intensive Medicaid services such as Mental Health Targeted Case Management, Mental Health Rehabilitative Services and mental health crisis services, to ensure that all children and youth in foster care have access to currently covered Medicaid services.
- Increasing referrals to the YES waiver, Community First Choice, and other community-based Medicaid intensive services to prevent more costly inpatient hospitalization admissions, re-admissions, and residential treatment placements.
- Collaborating with STAR Health to increase regional access to psychiatric hospital diversion programs like Turning Point. The Turning Point program offers emergency assessment crisis intervention 24 hours a day, seven days a week (24/7); in-home crisis support; intervention planning; and alternative care setting services.

- Working with the state Medicaid Agency and STAR Health to increase coverage of evidence-based practices in STAR Health. Senate Bill 1177 of the 86th Texas Legislature (Regular Session) makes intensive, evidence-based practices known to have good outcomes for children and youth with mental health needs available in Medicaid managed care programs. The EBPs can be provided "in lieu of" other current Medicaid mental health services.
- Increasing the regional capacity for Treatment Family Foster Care (TFFC) for foster family placements that serve children and youth at higher service levels to prevent unnecessary admissions and readmissions to costly settings such as inpatient hospitals and residential treatment centers.

FRM Consideration 2: Negotiate value-based purchasing (VBP) contracts between the SSCC and its contracted providers. VBP is a reimbursement model that utilizes alternative payment models (APMs) to pay for services based on outcomes (see Figure 1 below).

- VBP contracting can help promote outcome-driven relationships with foster care providers that support high quality efficiently delivered care.
- The SSCC would need to give providers early access to performance, financial, and demographic data to allow them to collaborate with the SSCC to establish an accurate and timely data collection process and assess the appropriateness of chosen outcome measures before VBP contracts could be negotiated;
- The SSCC would also need to gather provider input on how to develop outcome measures that are meaningful enough to eliminate disincentives for serving children and youth with higher needs.

Figure 1. Learning and Action Network (LAN) Alternative Payment Model (APM) Framework[4]



FRM Consideration 3: Negotiate Medicaid STAR Health VBP contracts. The SSCC could also work with the STAR Health managed care organization (MCO) to negotiate VBP contracts with APMs for its foster care providers who are already enrolled and credentialed in Medicaid managed care. The APMs could cover intensive, home- and community-based alternative health services for children and youth in foster care instead of more expensive and restrictive Medicaid placements, such as inpatient care. Youth with complex needs remain in inpatient hospitals longer than is medically necessary because of a lack of alternative placements. The current STAR Health Medicaid managed care program allows MCOs to contract with providers utilizing VBP contracts with APMs that reward providers with incentive payments for the quality of care they provide, instead of a typical fee-for-service arrangement that reimburses providers based on services rendered regardless of the outcome.

FRM Consideration 4: Collaborate with other CBC regions. It is possible to gain efficiencies and reduce costs for both the SSCC and for other regional providers by joining collaborative efforts with other CBC providers. This is especially important given that many providers provide services in multiple regions in the state. Existing CBC providers are collaborating in the following ways:

- Shared gateways for provider data submission – This allows each provider to use the same portal to enter data and to collect the same type of data for each child across the CBC regions. This decreases the administrative burden and administrative costs for CBC providers who would otherwise have to enter data and interface with multiple systems depending upon the CBC region with whom they contract. This also makes it easier for SSCCs to share data between each region.
- Common standard contract terms and monitoring requirements between the SSCCs when they contract with the CBCs – This lessens the administrative burden and administrative costs to CBC providers who could potentially have different standards and monitoring requirements for each CBC region with whom they contract.
- Forums for SSCCs and CBC providers to communicate lessons learned and brainstorm solutions to current challenges – Since the SSCCs are all responsible for the development of provider networks and outcomes for the children and youth in their regions, they could greatly benefit from working collaboratively across regions to increase the capacity to serve children and youth with more intensive needs in the community in order prevent placement disruptions and inpatient stays beyond medical necessity.

FRM Consideration 5: Explore partnerships among CPAs serving Region 6a and Harris County Protective Services to share risk. Given the unique level of financial risk likely to be faced by the SSCC serving Region 6a, system leaders in the region should consider an array of partnerships to share and manage risks that likely will exceed the ability of any single agency to manage. Multiple strategies could be considered, including:

- **Working together to advocate for additional risk protection measures for Region 6a.** System leaders should consider engaging as a group to explore and negotiate additional risk mitigation strategies for the region. For example, the Deloitte Report just submitted to DFPS and HHSC recommended a reconsideration of risk sharing and the development of a revised risk corridor arrangement that would initially expose the SSCC to less risk and let DFPS and HHSC bear more risk during the initial phases of CBC implementation. For Region 6a, leaders may want to advocate for even more risk to be borne by the state initially.

- **Exploring contractual risk mitigation partnerships.** Currently, a single agency bears risk as the SSCC in other regions, but this is not a requirement of the model. Agencies within a region could decide to share risk contractually, with a single agency taking the lead, but contractually sharing risk for a subset of the population with other agencies. There are many approaches for this, including the value-based purchasing methods noted above, and the degree of risk sharing could vary across agencies based on the populations they are able to serve, the service mix they provide, and their financial size and risk-bearing capacity.
- **Developing a more formal partnership.** Agencies could also explore deeper partnerships, including development of a partnership-based model in which a new entity is formed to bear risk and agencies share in governance based on the level of risk and responsibility they take on. While no current SSCC employs this model, it has been used in other regional risk-sharing arrangements, especially for health care and mental health services.

FRM Consideration 6: Closely monitor the development of the new rate methodology and advocate for the unique needs of Region 6a. As noted above, HHSC has been charged with developing a new rate methodology during the next biennium, in partnership with DFPS and stakeholders. System leaders in Region 6a should closely monitor this process and work with a wide array of stakeholders to advocate for an approach that is able to predict and adequately support fiscal risk management in Region 6a. Ideally, this would include shared advocacy, as noted in the prior strategic consideration, but each agency in the region with a stake in the new system should also monitor developments and advocate for its own needs independently.

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[1] Texas Department of Family and Protective Services. (2019, February). *DFPS Rider 21 Report for Community Based Care.* Retrieved from https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/Rider_Reports/documents/2019/2019-02-01_Rider_21_Community_Based_Care.pdf

[2] Title IV-E is a subpart of Title IV of the federal Social Security Act. This program provides federal reimbursement to states for the costs of children placed in foster homes or other types of out-of-home care under a court order or voluntary placement agreement.

[3] Senate Bill 7 from the 2013 Texas Legislature required the Health and Human Services Commission to put in place a cost-effective option for attendant and habilitation services for people with disabilities who have STAR+PLUS Medicaid coverage.

[4] Healthcare Payment Learning and Action Network. (2018). APM measurement: Progress of alternative payment models: Methodology and results report. Retrieved from https://hcp-lan.org/workproducts/apm-methodology-2018.pdf

Appendix A: Region 6a Community-Based Care Collaborative Advisory Committee Participant List

The initial members of the Advisory Committee were invited to participate by the Executive Committee. Membership on the Advisory Committee is open to any community provider that is interested in planning for CBC.

Community-Based Care Advisory Committee Participants	
Name	**Organization**
Antonvich, Diane	Texas Children's Hospital
Armstrong, Mary	Centene
Bagwell, Wendy	Department of Family Protective Services
Belcher, Kristina	Department of Family Protective Services
Bezecny, Amy	Cultivating Families
Blackshear, Cornelius	United Way of Greater Houston
Blackstone, Kristene	Department of Family Protective Services, Region 6a
Bonton, April	Health and Human Services Commission
Booher, Jesse	Texas Alliance of Child and Family Services
Brewer, Robert	Children's Protective Services
Broussard, CJ	Department of Family Protective Services, Region 6a
Byers, Katherine	Texas Network of Youth Services
Cano, Aaron	Houston Endowment
Cardoza-Oquendo, Juan	Harris County Precinct One
Carlson, DeAnna	Harris County Attorney's Office
Carr, Meredith	Harris County Attorney's Office
Caruthers, Jamie	Children at Risk
Chamberlin, Lynn	Harris County Attorney's Office
Cloud, Amanda	The Simmons Foundation
Dawes, Jeanice	Harris County Attorney's Office
DeMontrond, Marilyn	Harris County Protective Services Board Member
Diaz, Jessica	County Attorney's Office
Drake, Jason	Upbring
Duru, Glenda	Harris County Attorney's Office

THE HACKETT CENTER
FOR MENTAL HEALTH

Community-Based Care Advisory Committee Participants	
Name	**Organization**
Eckert, Gerald	The Salvation Army of Greater Houston
Edwards, Tonyel	Houston Endowment
Endley, Shubhra	Communities in School Houston
Ewing, Stephanie	Harris County Attorney's Office
Fields, Ashley	The Way Home Adoption
Finley, Vikki	Arms Wide Adoption
Flores, Sandra	Trinity Charter Schools
Fordice, Susan	Meadows Mental Health Policy Institute
Foutz, Tori	Superior Health Plan
Fuller, Lisa	Community Health Choice
Funk, Sadie	First3Years
Galvan, Sonya	Child Advocates
Gore, Taryn	Harris County Juvenile Probation
Goudeau, Jeniece	University of Houston
Greeley, Dr. Christopher	Texas Children's Hospital
Green, Mary	Children's Protective Services
Griffith, Judge Katrina	Harris County District Courts
Guillen, Jesus	Harris County Attorney's Office
Harper, Michelle	Meadows Mental Health Policy Institute
Hicks, Regenia	Harris County Juvenile Probation
Hoevker, Michelle	Presbyterian Homes and Services
Houston, Madison	Houston Health Department
Inayatali, Imara	Meadows Mental Health Policy Institute
Jackson, Valarie	Monarch Family Services
Jarriel, Jenifer	DePelchin Children's Center
Jernigan, DeJuana	DePelchin Children's Center
Johnson, Dan	Pathways Youth and Family Services
Jones, Amanda	Harris Center
Kapnick, Becca	Good Reason Houston
Keefe, Rachael	Texas Children's Hospital

Community-Based Care Advisory Committee Participants	
Name	**Organization**
Kim, Song	Meadows Mental Health Policy Institute
Knull, Bill	DePelchin Children's Center
Kumar-Misir, Debbie	Department of Family Protective Services, Region 6a
Levine, Joel	Harris County Protective Services
Lovett, Pam	Comerica
Lundy, Scott	Arrow Child and Family Ministries of Texas
Martinez, Lorraine	Superior Health Plan
McGee, Marshall	Houston Community College
Melvin, Marcellina	Meadows Mental Health Policy Institute
Migura, Michael	Evolve Health
Murphy, Deb	Montrose Center
Narendorf, Dr. Sarah	University of Houston
Newlin, Elizabeth	Texas Medical Center
Olse, Katie	Texas Alliance of Child and Family Services
Opot, Kelly	Harris County Youth Collective
Owens, Charla	Superior Health Plan
Pozmantier, Janet	Mental Health America Greater Houston
Rangel, Kristi	Houston City
Reedy, Tiffany	County Attorney's Office
Riley, Cynthia	Meadows Mental Health Policy Institute
Robinson, Phaedra	Superior Health Plan
Rodriguez, Annette	The Children's Shelter
Ross, Celeste	Presbyterian Homes and Services
Rynders, Dustin	Disability Rights Texas
Sarango, Rafael	The Salvation Army of Greater Houston
Schwab, Britta	Boys and Girls Club Greater Houston
Schwarzwald, Dr. Heidi	Texas Children's Hospital
Scovill, Terry	IntraCare
Serrano, Christy	First3Years
Smalls, Ashley	Department of Family Protective Services, Region 6a

Community-Based Care Advisory Committee Participants	
Name	**Organization**
Stavinoha, Shannan	Parks Youth Ranch
Stolte, Elaine	Children's Assessment Center
Titcombe, Dan	Rockwell Fund
Tomaka, Lisa	Meadows Mental Health Policy Institute
Usanga, Andrea	Network of Behavioral Health Providers
Valladares, Gaby	Health Care Service Corporation
Vittoria, Katy	Children's Protective Services
Wade, Lawrence	Good Hearts Youth and Family Services
Walijarvi, Corrine	DePelchin Children's Center
Welch, Victoria	Harris County Attorney's Office
Weldon, Charly	Family Houston
Wells, Kathy	Children's Assessment Center
Wendy, Noah	Superior Health Plan
Whitman, Hank	Department of Family Protective Services, Region 6a
Wooten, Sheelah	Harris County Attorney's Office
Workman, Logan	Superior Health Plan
Wotkyns, Donna	Communities in School Houston
Young, Staci	The Women's Home
Young, Wayne	Harris Center

Appendix B: Summary Data on the Number of Children and Youth Placed in Harris County Foster Homes

Table 1: Children and Youth Placed in Harris County Foster Homes from DFPS Region 6

Region	Number of Children from Region Placed in Foster Homes in Harris County	Number of Children from Harris County Placed in Region
001	49	2
002	26	1
03B	49	3
03E	66	25
03W	12	1
004	65	24
005	110	27
06A	1,338	1,338
06B	369	686
07A	70	55
07B	30	31
08A	71	23
08B	37	14
009	18	0
010	9	15
11A	34	1
11B	10	2
Unknown	0	45
Total	**2,363**	**2,293**

Appendix C: Capacity of Region 6a Licensed General Residential Operations and Child Placement Agencies

Table 1: General Residential Operations (GRO)[1]

GRO Name	Capacity[2]
Service Type: Child Care Services Only	
Southwest Key – Casa Quetzal	236
Southwest Key Programs, Inc. – Casa Sunzal	223
Southwest Key Programs, Inc. – Casa Montezuma	191
Boys & Girls Country of Houston	88
Today's Harbor for Children	88
Southwest Key Programs, Inc. – Casa Houston	75
St. Michael's Home for Children	40
St. Michael's Home for Children II	24
Youth Reach Houston	18
Service Type: Multiple Services	
Southwest Key Programs, Inc.	54
Freedom Place	38
Hands of Healing	25
Houston Serenity Place GRO	23
Hearts with Hope Foundation – GRO	19
Hope Village	16
Minola's Place of Texas, Inc.	16
Turning Point Children's Social Service	16
Westfield Residential Treatment Center	16
Renewed Strength, Inc. – East	14
Embracing Destiny Foundation	13
Service Type: Residential Treatment Center	
Sheltering Harbour	75
Houston Serenity Place, Inc.	71
Center for Success and Independence	44
L'Amor Village Residential Treatment Center	42

GRO Name	Capacity[2]
Good Shepherd Residential Treatment Center	40
Positive Steps, Inc.	35
Unity Children's Home – Girls	32
A Fresh Start Treatment Center	30
Guardian Angels I Residential Treatment Center	24
Shamar Hope Haven Residential Treatment Center	22
Have Haven, Inc.	16
Kirby's Place	16
Unity Children's Home – Boys	16
Hearts With Hope Foundation	14
Miracal's Place	14
Promise Rose Residential Care Home, Inc.	14
Discovery Practice Management, Inc.	13
Embracing Destiny Foundation RTC	13
Hold My Hand Residential Treatment Center	13
Renewed Strength, Inc.	13
The Lighthouse For The Betterment of Life	13
Unity Children's Home	7
Total Capacity	**1,810**

Table 2: Child Placement Agencies (CPA)[3]

CPA Name	Capacity[4]
Depelchin Children's Center (Houston, TX and Spring, TX)	351
Arrow Child and Family Ministries of Texas	231
Pathways Youth and Family Services, Inc.	189
Safe Haven Community Services	99
Heart of the Kids Social Services Incorporation	97
Lonestar Social Services, LLC	65
Lutheran Social Services of the South	62
Azleway, Inc.	49
Monarch Family Services	47

CPA Name	Capacity[4]
Children of Diversity	46
A World For Children	39
Good Hearts Youth & Family Services	37
Have Haven Child Placing Agency	37
Circles of Care	33
America's Angels, Inc.	31
Homes With Hope	30
Houston Serenity Place CPA	30
Kidz 2 Kidz Child Placing Agency	29
Loving Houston Adoption Agency	28
Agape Manor Home Child Placing Agency	26
Houston Achievement Place	24
Presbyterian Children's Homes and Services	24
Ascension Child and Family Services	23
Therapeutic Family Life	23
Casa De Esperanza De Los Ninos	22
Arms Wide Adoption Services	21
Guardian's Promise, LLC	21
Tejano Center for Community Concerns	21
Hands of Healing	20
Circle of Living Hope	19
Catholic Charities of the Archdiocese Of Galveston – Houston	18
Trinity Foster Care	17
Children's Hope Residential Services, Inc.	15
Lifeline Children & Family Services	12
Methodist Children's Home	12
Transitions for Tomorrow	10
Passion For Families, Inc.	8
Youth in View	5
Caring Adoptions	3
Total Capacity	**1,874**

Appendix D: Characteristics of Effective Residential Treatment Facilities and Residential Treatment Agency-wide Philosophical Models

Characteristics of Effective Residential Treatment Facilities

While there is some research evidence that children and youth make gains while in residential care, most of these gains are made within the first six months of treatment, are frequently lost after the child or youth returns to the community, and are not predictors of long-term outcomes.[5] Residential treatment centers (RTCs) vary in the services and supports they provide making some programs more successful than others. Three common factors have been identified in treatment facilities with the most successful treatment outcomes.[6,7,8,9]

Family Involvement – The best programs partner in a meaningful way with families. They see themselves as a support to families that are struggling rather than a substitute for families who have failed. A family-centered service philosophy emphasizes partnerships, focused on the family as the decision-maker, and recognizes parents as the experts on their children. This requires RTC's to forge and maintain relationships with families, support families participating in the daily lives of youth, and share responsibility for outcomes through shared decision making and active partnerships with families. Finally, family-centered care offers support and guidance to families in the context of their everyday lives. When families are fully involved in treatment, RTC stays are shorter and outcomes are improved.

Discharge Planning – Research suggests that post-discharge success relies on family involvement during treatment and being able to return to a stable, supportive environment. In successful programs, families, youth, and staff prioritize discharge planning from the time of admission. The youth and family's needs for a youth to be successful when they return home are determined during the planning process. Barriers to meeting those needs are addressed, and the residential and community-based supports needed for success are identified. Specific practices include (1) ensuring stability in the place where the child or youth goes to live after discharge, (2) connecting to peer and youth advocates, (3) identifying funding to continue work with the youth and family post discharge, (4) coordinating community-based and residential services to provide a seamless transition, and (5) supporting youth in maintaining meaningful connections with their friends (with caregiver permission) while in care.

Community Involvement and Services – Residential and community services have historically functioned as discrete components. This fragmentation has limited family participation, weakened discharge planning, and limited continuity of care. A residential treatment program should be as near to a youth's home as possible to anchor services in the community, cultures, and web of social relationships that surround a youth and their family. Effective RTCs involve youth in the community while in care, teaching them the skills they need to reintegrate once

they are discharged. Characteristics shared by communities that have successfully linked residential services to their community include (1) a belief that residential care is not a destination where a youth goes to live for an extended period of time; (2) a capacity to rapidly stabilize, treat, analyze, triage, and plan discharge; (3) an emphasis on family involvement and the identification of natural supports when families are unavailable or unable; and (4) the ability to ensure that services that begin in residential can be continued in the community.

The evidence that most of the gains in residential care happen during the first six months of treatment supports shorter lengths of stay. Effective short-term programs focus on treatment rather than placement. The three factors mentioned above are the keys to their success, in combination with a strong focus on the problems that precipitated admission and active monitoring of a youth's progress toward identified outcomes.

In addition to these common success factors, the Association of Children's Residential Centers (ACRC) stresses the importance of using a comprehensive assessment process to ensure residential treatment is used only when determined necessary. They also recommend a shift in culture and perception away from RTC placement as a treatment of last resort to a need-based specialized opportunity to stabilize a child or caregiver's situation, create space for planning, and/or address safety concerns.[10]

Residential Treatment Agency-Wide Philosophical Model

Building Bridges Initiative (BBI): Short-Term Residential Practice Models for Engaging & Supporting Families with Complex Challenges in their Home & Communities[11,12]

The Building Bridges Initiative (BBI) is a national effort to achieve positive outcomes for children, youth, and families served in residential and community programs. It promotes a framework to improve residential care through consistent and coordinated principles and practices across residential and community-based services. BBI drives policies and practices to create partnerships between families, youth, communities, residential treatment programs, and service providers.

The first BBI summit (2006) ended with a joint resolution of principles and values consistent with community-based system of care and strengthened the partnership between residential and community-based care. The resolution championed the following principles:

- Youth guided;
- Family driven;
- Culturally and linguistically competent;
- Comprehensive, integrated, and flexible;
- Individualized and strength-based;
- Collaborative and coordinated;

- Research based;
- Evidence and practice informed; and
- Sustained positive outcomes.

The *Performance Guidelines and Indicator Matrix (Matrix)* was developed to help organizations assess their conformance with the BBI's principles and to build on and foster linkages between residential and community services across the continuum of care. The matrix assumes that (1) basic standards in residential and community services are monitored by other regulatory standards, (2) in-depth self-assessment instruments exist to address specific principles such as cultural competency and wraparound fidelity, and (3) responsibility for successfully implementing these practices and guidelines is shared by residential and community service sectors. The concept of child and family teams (CFT) is embedded throughout the matrix and is integral to implementing BBI principle and practices.

The Performance Guidelines and Indicator Matrix provided the structure for a self-assessment tool (SAT). The tool corresponds to the performance indicators in the matrix and has been extensively piloted. Together the Matrix and the SAT assist organizations in achieving the vision and mission set forth by the BBI Joint Resolution.

Children and Residential Experiences: Creating Conditions for Change (CARE)[13,14,15,16]

Children and Residential Experiences (CARE) is a model developed by the Residential Care Project at Cornell University in 2005. It targets child care staff, clinical staff, and agency administrators working with children, youth, and young adults ages six through 20 living in a residential setting. CARE is a multi-level program based on research-informed principles and child development that uses an ecological approach. CARE is designed to enhance an organization's social dynamics through staff development and staff interactions with clients, other staff, and community organizations.

The framework provides consistency in message and approach with children and families and congruency throughout the organization. The six practice principles provide the foundation for organizational change. They state that child care practices must be:

- **Developmentally Focused** – Developmentally appropriate activities are designed to allow a child to succeed in tasks they find challenging. The program teaches developmentally appropriate skills and provides opportunities to practice these skills, build a child's self-efficacy, and improve their overall self-concept.
- **Family Involved** – Research indicates that children need contact with their families and communities to succeed in treatment and remain connected to their ethnic and cultural identity. Building and retaining a child's connection with family and community increases resiliency, improves self-concept and is essential to transitioning the child

home.

- **Relationship Based** – Healthy child-adult relationships help children develop healthy attachments and trusting relationships. Children respond to people they trust. Trust and attachment are essential for increased social and emotional competence.
- **Trauma Informed** – Many children in congregate care settings have been affected by trauma. Trauma-informed care practices provide a consistent, predictable environment, build trusting respectful relationships, provide future oriented activities that allow children to contribute, and avoid environmental factors that trigger a stress response.
- **Competence Centered** – Competence centered practice consists of matching activities and expectations to the child's strengths and abilities. Interactions and activities are goal oriented and focused on teaching skills, setting high expectations and helping the child meet those expectations.
- **Ecologically Oriented** – The environmental factors that protect children include caring relationships, high-expectation messages, opportunities to contribute, and participation. The program is designed so that children can meet expectations and participate fully, by adjusting activities so that children can succeed and progress, and motivating children to participate and interact with adults and peers through the social and physical environment.

The CARE model has earned a Scientific Rating of 3 (Promising Research Evidence) and a rating of High Child Welfare System Relevance by the California Evidence-Based Clearinghouse for Child Welfare (CEBC).

The Sanctuary Model[17,18]

The Sanctuary Model is a trauma-informed, whole system approach to develop organizational structures to counteract the effects of trauma. It was originally developed in the mid-to-late 1980s to treat adults who had experienced trauma in short-term psychiatric settings. It has been adapted for a variety of settings, including those that serve children, youth, and young adults. The Sanctuary Model is a theory-based, evidence-supported system change process that is based on the creation and maintenance of a non-violent, democratic, therapeutic community in which staff and clients are key decision-makers in building a socially responsive, emotionally intelligent community that fosters growth and change.

The Sanctuary Model helps an organization develop a culture that creates a sound treatment environment while counteracting the impact of chronic stress. This cultural change is grounded in seven dominant characteristics:

- Culture of non-violence,
- Culture of emotional intelligence,
- Culture of social learning,

- Culture of shared governance,
- Culture of open communication,
- Culture of social responsibility, and
- Culture of growth and change.

Fundamental to the Sanctuary Model is the S.E.L.F implementation tool. An acronym for Safety, Emotional Management, Loss, and Future, this conceptual tool guides assessment, treatment planning, individual and team discussion, and psychoeducational group work. This non-linear method for addressing complex challenges represents the fundamental domains that can disrupt a person's life. The S.E.L.F Psychoeducational Group is described as an easy to use cognitive framework for change.

The Sanctuary Model requires extensive leadership, staff, and client involvement in every level of the change process. The model assumes a trauma-informed culture will produce less violence, improved staff morale, lower staff turnover, fewer staff injuries, a collaborative treatment environment, elimination of coercive forms of intervention, and better client outcomes.

Appendix E: Summary of Current Region 6a Foster Parent Capacity Supports

Foster Parent and Kinship Recruitment and Support Programs

Kinship Navigator Program

The Department of Family and Protective Services (DFPS) applied for and received a grant from the U.S. Administration for Children and Families to develop a kinship navigator program. Kinship navigator programs offer support groups or peer support programs designed to assist kinship caregivers with managing the stress of parenting, negotiating the child welfare system, and accessing available resources and supports. DFPS funds regional kinship support groups and kinship collaborative groups. Other states that have implemented programs to support relative caregivers include New York, New Jersey, Washington, and Ohio.

Collaborative Family Engagement (CFE)

Texas Court Appointed Special Advocate's (CASA) Collaborative Family Engagement (CFE) creates better outcomes for children and youth in the care of DFPS by identifying, locating, and engaging family members and other committed adults to be involved in a child or youth's care and permanency planning. Harris County recently implemented CFE for youth who are in permanent managing conservatorship (PMC). CFE is a structured approach to extensively search for and engage adult relatives and family friends to provide additional support to children and youth in foster care. At the time of this report, Child Advocates, Inc., of Houston had selected 16 youth to be involved in this program.

Cultivating Families

Cultivating Families is a non-profit corporation that works to equip faith communities in the greater Houston area to care for foster and adopted children. Its focus is to raise awareness of the need for foster and adoptive families and provide them with proper training and preparation to care for the unique needs of these children and youth. Cultivating Families' Adoption/Foster Care Program provides consultation and coaching services to congregations to help them determine the best adoption/foster care activities for their community. Cultivating Families has helped 20 congregations successfully engage in an adoption/foster care ministry and is actively working with 10 new faith communities. The organization's vision is a future where all faith communities in the greater Houston area provide enriching support systems for foster and adoptive families; no child will be left to navigate life along. Cultivating Families recommends Empowered to Connect trauma-informed parenting, based off of the trauma-informed intervention Trust-Based Relational Intervention (TBRI), but it promotes any reputable trauma-informed model.

Wendy's Wonderful Kids (WWK)

Wendy's Wonderful Kids (WWK) is a child-focused adoption recruitment model that uses the child's history, experience, and needs to find an adoptive family. It is designed to serve children and youth for whom it has been traditionally difficult to place with adoptive families due to age, size of sibling group, or disability. WWKs has eight main components: (1) An initial case referral; (2) A trusting and open relationship with the child or youth; (3) An in-depth review of the case file; (4) An assessment of the child or youth's strengths, challenges, desires, and preparedness for adoption; (5) Prepare the child or youth for adoption; (6) Build a network of significant adults; (7) Develop a recruitment plan; and (8) Complete a diligent search.

Programs in Region 6a that Provide Training, Support, and Resources to Foster and Kinship Families

Texas Network of Youth Services (TNOYS)

TNOYS is a membership organization that helps strengthen critical services that promote the success of Texas' youth and families. TNOYS does that through a three-pronged approach encompassing policy, practice, and participation – advocating for policies that benefit providers and the youth they service, providing high quality training and technical assistance to youth services professionals, and working in partnership with youth to ensure their voices are heard in decisions that affect their lives. Each year, TNOYS offers its Annual Conference, which brings together hundreds of youth, professionals, and other stakeholders to learn with and from each other as well as PEAKS Camp, an opportunity for transition-age youth to build skills and relationships and for youth services professionals to experience youth-adult partnerships. TNOYS has a strong presence in the Houston area, where it has hosted its Annual Conference for the past three years, and currently heads Houston Area Partners for Youth, a group dedicated to advocating for policy changes that benefit Houston youth.

Programs in Region 6a that Provide Support to Child Welfare related Agencies and Organizations

The Texas Alliance of Child and Family Services (TACFS)

The Texas Alliance of Child and Family Services (TACFS) is a statewide network of organizations that serve vulnerable children and families. They are working together to improve care, services, and outcomes across Texas. The mission is to strengthen and improve the services, practices, and care for at-risk children, youth, and families. TACFS achieves this mission through research and education, collaboration, and advocacy.

TACFS has multiple members in Houston. In addition to member-specific support (which can include individualized advocacy and networking), TACFS offers:

- Ongoing training on emergency preparedness and leadership resilience;

- Grants and technical assistance to organizations affected by Hurricane Harvey;
- Technical assistance and training to organizations providing services to child victims of sex trafficking;
- Convenings for staff whose job duties include strategic planning, program evaluation, or data analysis; and
- Convenings for staff whose job duties include anything related human resources.

TACFS is developing a FFPSA Needs Assessment for preventive services that would qualify for IV-E funds under the new law.

Appendix F: National Best Practices for Supporting Foster Parents

A community-based foster care system designed to promote placement stability and permanency ensures that all children and youth in care have access to stable and nurturing homes with kin or foster parents who are trained to respond to unique needs and behaviors. A community-based model that uses the strategies outlined below will promote safety, stability, permanency, and well-being of children and youth in care. These strategies include:

- Identifying and engaging potential relative caregivers,
- Recruiting high-quality foster parents,
- Addressing foster parent retention,
- Developing skills for foster and kinship care families,
- Providing ongoing support for foster and kinship families,
- Addressing adequate financial support for families, and
- Equipping families to care for the unique needs of young children involved in the system.

Recruiting Foster and Kinship Parents

Placement stability depends on the recruitment of caring relative caregivers and high-quality foster parents. Successful recruitment of foster and kinship parents requires strategies that meet cultural, developmental, and emotional needs. The strategies must identify, engage, support, and develop kin and foster parents.[19]

Identify and Engage Kinship Caregivers for First Placements

Children and youth who are placed with kin have more stable behavior and mental health, a stronger sense of well-being, and are more likely to have placement stability than children placed in non-relative care.[20] However, identifying an appropriate and willing family member to assume parenting responsibilities can be more challenging than establishing a non-kinship foster placement. Child placement entities must make a conscious effort to prioritize kin placements through policies and creative practices to identify and engage relative caregivers. For example, the **Baltimore County Department of Social Services** instituted a memorandum of understanding (MOU) with the local school system to access the emergency contacts identified by parents for potential connections for children in care.

Search engines, social media, genograms, and other resources can be used to compliment family engagement strategies. Organizations that are successful in engaging kinship families employ family search and engagement (FSE) strategies at the start of every case. For example, **Missouri** uses **30 Days to Family®**, a short-term intensive intervention developed by the Foster & Adoptive Care Coalition in Missouri. The goals of the model are to increase the number of the

children placed with relatives when they enter the foster care system and to ensure natural and community supports are in place to promote stability.[21]

Policies and procedures that prioritize kinship placements can also decrease reliance on non-kinship placement. Nationally, agencies have implemented relative preference policies to restrict non-relative placements, modified caseworker decision-making to prioritize kinship placements, and established dedicated kinship support and family finding units.[22] Tennessee requires a *Kinship Exemption Request* to be completed and approved by a regional kinship coordinator or program manager before a child or youth can be placed in a non-kinship placement.

Recruit High Quality Foster Parents

Kin care placements are not always available or appropriate. In these cases, it is critical to have a strong network of culturally competent, committed foster parents with the skills to meet the needs of the children and youth in care. Successful foster parent recruitment requires a comprehensive, targeted approach that is data-informed and accounts for the needs of the children and youth in care and the type and status of potential foster parents.[23]

Successful recruitment of a diverse pool of foster parents that reflect the cultural needs of the children and youth in care can require a more targeted approach to recruitment. In recruiting foster parents, child placement agencies (CPAs) should understand the children and youth they care for including their location, demographics, and needs. They should also understand the unique characteristics of these children and youth such as complex medical or mental health needs, LGBTQ status, or special education needs.[24]

Targeted recruitment efforts should be embedded in communities that reflect the cultures of the children and youth in care. Recruitment should partner with community groups (e.g., military and faith communities) that can help develop a pool of foster and adoptive parents that match the characteristics and needs of children and youth in care.[25] CPAs should also engage in child-specific recruitment to locate prospective foster and adoptive parents to meet the unique needs of a specific child or youth. A good example of child-specific recruitment is New York City's You Gotta Believe (YGB) initiative, which works to recruit foster and adoptive parents for older youth by identifying people in their social circle through trust building and then supporting the development of a relationship that will lead to a physical placement.[26]

Engaging foster parents to recruit prospective parents has also been shown to be an effective strategy. The **Leaders at Children's Community Program of Connecticut** rewards existing foster parents with $1,500 for each new family they recruit who meet licensing requirements and commit to at least one year of service.[27]

Address Foster Parent Retention

Foster parent recruitment efforts should be anchored in a customer service model that treats prospective parents with respect.[28] This lays the foundation for a trusting partnership between the prospective foster parent and the CPA. Increasing the retention rate of prospective foster families requires that systems are easy to navigate, provide support throughout the licensing process, and are deliberate in matching the child and foster family. To maintain committed foster parents, agencies should be thoughtful when making matches between children and families, ensure foster families feel listened to and supported, and celebrate their contribution to the agency. Tools that support placement decision making and matching include:[29]

- Child and Adolescent Needs and Strengths Treatment Outcomes Package,
- Structured Decision Making (SDM®) Model in Foster Care and Placement Support,
- Every Child a Priority (ECAP), and
- Child and family team meetings.

Develop Skills for Kinship and Foster Families

Kinship and foster families are most successful when they have access to quality pre-service training and ongoing training and development. Pre-service training provides the foundational information foster and kinship parents need to be successful, and ongoing training and development helps foster parents build additional skills and apply what they learned during pre-service training with the children or youth in their care. Evidence-based caregiver training models include:

- **Keeping Foster and Kin Parents Supported and Trained (KEEP):** Created by the developers of the Treatment Foster Care Oregon (TFCO) model, KEEP is a skills development program for foster parents and kinship parents of children ages zero to five years and teenagers (KEEP SAFE). The 16-week program is taught in 90-minute group sessions to seven to 10 foster or kinship parents. Facilitators draw from an established protocol manual and tailor each session to address the needs of the parents and children.[30] The goal of the program is to teach parents effective parenting skills, including appropriate praise, positive reinforcement, and discipline techniques.[31]
- **Trauma System Therapy (TST):** A comprehensive, three-phase treatment program for children and youth ages four to 21 years who experience traumatic events or live in environments with ongoing stress and reminders of trauma. TST is implemented with children and youth involved in the child welfare system who may be in birth, foster, or kinship homes. TST aims to stabilize the child or youth's environment while enhancing their ability to regulate emotions and behaviors.[32]
- **Attachment, Self-Regulation, Competency (ARC) Treatment Framework:** An intervention for families who have experienced multiple or prolonged traumatic stress. The ARC framework is built around the following core targets of intervention: attachment, regulation, and competency. Each of these targets is addressed in an

individual client- and system-specific way to support the child, youth, and their caregiver in engaging in the moment in a thoughtful present way.[33]

- **Connect for Foster Parents©:** A program that builds relationships with youth in care by providing foster parents with support to understand the impact of trauma on the youth's behaviors and equipping foster parents to respond with sensitivity to challenging behaviors.[34]

Strategies for Supporting Foster Parents

Foster parent supports include crisis intervention services, foster parent mentors and support group, respite care, and adequate financial support.[35, 36]

Continuum of Services and Supports for Foster Parents

Crisis intervention services are important supports for foster parents. The model is exemplified by the New Jersey Department of Child and Families **Mobile Response and Stabilization Services (MRSS)** program.[37] New Jersey's MRSS program provides crisis response services to children, youth, and families experiencing reactions, behaviors, or escalating emotions that disrupt the typical function of a family. Services are available 24 hours a day, seven days a week (24/7) and include an initial face-to-face intervention within one hour and follow-up interventions for up to 72 hours. If additional support is needed, the child or youth and their family are linked to stabilization services.

Respite Care programs can reduce stress and prevent placement disruptions by giving foster and kinship parents a break from the demands of caregiving. This is particularly important for foster parents who are caring for children and youth with challenging behaviors, mental health issues, or special needs. Effective respite programs involve parents in the implementation and evaluation of the program and build on family strengths; are flexibly funded, individualized, community-based, culturally competent, and easily accessible by caregivers; and collaborate across systems. The continuum of respite care includes in-home care, group child care, mentor relationship experiences, camps, and therapeutic care.[38]

Treatment foster care provides foster families with specialized skills and training to support children and youth with serious emotional and behavioral issues. Two evidence-based treatment foster care models are:

- **Treatment Foster Care Oregon (TFCO)**: A well-established evidence-based practice that has demonstrated positive outcomes and cost savings when implemented with fidelity. Research supports its efficacy with white, African American, and American Indian youth and families.[39] TFCO emphasizes interpersonal skills and participating in positive social activities, including sports, hobbies, and other forms of recreation. Placement in TFCO

homes typically lasts about six months. Aftercare services remain in place for as long as the parents want, but typically last about one year.[40]

- **Together Facing the Challenge:** An evidence-based approach to training treatment foster care supervisors and foster parents that includes a parent-training manual, take-along "cheat sheets," and a manual for supervisors to provide ongoing supervision to staff working directly with treatment parents. The intervention model encourages better implementation of proactive behavior management, supervision and support of foster parents, and better adult-child relationships in the home.[41]

Strategies for Supporting Foster Parents of Young Children

Effective strategies for supporting foster parents of young children include parent-child therapy, parent/caregiver-child interaction guidance, coaching and supports, relationship-based approaches, empirically-supported parent education strategies, and social-emotional competency development and skills building. Examples include:

- **Parent Child Interaction Therapy (PCIT):** A training program for parents with young children who have emotional and behavioral challenges. PCIT reduces behavioral problems at home and school, decreases caregiver stress, and improves how caregivers listen, talk, and interact with the child in their care.[42]
- **Positive Parenting Program (Triple P):** A program that teaches parents strategies to prevent emotional, behavioral, and developmental problems in their children. It includes five levels of intensity (from the dissemination of printed materials to eight- to ten-session parenting programs and more enhanced interventions for families experiencing higher levels of relational stress). Using social learning, cognitive-behavioral, and developmental theories supported by studies on risk and protective factors for these problems, Triple-P aims to increase the knowledge and confidence of parents in dealing with their children's behavioral issues.[43]
- **Infant Parent Psychotherapy (IPP):** A therapeutic approach designed for caregivers of young children ages zero to three years who have not formed a secure attachment because of domestic violence and trauma. During the sessions, caregivers talk about their experiences as children, their expectations for their children's future, and their relationship to other people. The goals of IPP include providing consistent, nurturing, and predictable care.[44]
- **Child-Parent Psychotherapy (CPP):** A therapeutic approach designed for children ages zero to five years who have experienced at least one traumatic event or who are experiencing mental health, attachment, or behavioral problems. The treatment is based on attachment theory and its primary goal is to support and strengthen the relationship between a child and his or her caregiver.[45]
- **Treatment Foster Care Oregon for Preschoolers:** A foster care treatment model designed for children ages three to six years old whose behaviors make it difficult for

them to be maintained in regular foster care. TFCO-P is a team-based approach to providing training and on-going coaching to foster parents, skills training to children through therapeutic playgroup, and family therapy to birth parents. TFCO-P is effective at promoting secure attachments in foster care and facilitating successful permanent placements.[46]

Appendix G: Evidence-Based Programs for Children and Youth in Foster Care

Appendix G summarizes evidence-based practices used by the states listed in Appendix C.

Attachment and Biobehavioral Catch-Up (ages six months to three years) teaches foster and adoptive parents how to nurture children and provide a safe, stable environment. Attachment and Biobehavioral Catch-Up increases attachment security, decreases attachment disorganization, decreases foster parents' stress, and improves foster parents' ability to provide nurturing and committed care.[47]

Family Advocacy and Support Tool (FAST) is the family version of the Child and Adolescent Needs and Strengths (CANS) assessment and the Adult Needs and Strengths (ANSA) tools. The purpose of the FAST is to focus interventions to support the entire family. The FAST is most commonly used for families at risk of child welfare involvement.[48]

Cognitive Behavioral Therapy Plus (CBT+) is a strategy for training community mental health providers in CBT for depression, anxiety, trauma, and parent management training. Providers that are trained in all four strategies can support most of the children and youth seen by child welfare.[49]

Functional Family Therapy (FFT) and FFT-Child Welfare serve at-risk youth and their families, targeting youth between the ages of 11 and 18. FFT targets multiple areas of family functioning and ecology for change.[50] Family alliance and involvement in treatment is a main focus of FFT, with an initial emphasis on motivating the family to engage in treatment. The treatment model is deliberately respectful of individual differences, cultures, and ethnicities – it aims for obtainable change with specific and individualized interventions that focus on risk and protective factors. Interventions incorporate community resources for maintaining, generalizing, and supporting family change.[51]

High Fidelity Wraparound is an integrated care coordination approach delivered by professionals, alongside youth and family partners, for children and youth who are involved with multiple systems and at the highest risk for out-of-home placement.[52] Wraparound is not a treatment per se. It is a care coordination approach that fundamentally changes the way individualized care is planned and managed across systems. The wraparound process aims to achieve positive outcomes through a structured, creative, and individualized team planning process that, compared to traditional treatment planning, results in plans that are more relevant to the child or youth and family. Through the team-based planning and implementation process, wraparound develops the problem-solving skills, coping skills, and

self-efficacy of the child or youth and family members. Finally, it emphasizes integrating the child or youth into the community and building the family's social support network.[53]

HOMEBUILDERS is an intensive family preservation program designed for children and youth from birth to 17 years who are at imminent risk of out-of-home placement or who are scheduled to reunify with families within a week.[54] The program uses intensive, on-site interventions aimed at teaching families problem-solving skills to prevent future crises. HOMEBUILDERS is structured around a quality enhancement system, QUEST, which supports a three-part methodology (delineation of standards, measurement and fidelity of service implementation, and development of quality enhancement plans), offers training for state agencies, and reports a high success rate (86%) avoiding placement in state-funded foster care and other out-of-home care.[55] HOMEBUILDERS generally intervenes when families are in crisis and provides an average of 40 to 50 hours of direct service on a flexible schedule.[56]

Incredible Years is a program for infants to school-age children that focuses on preventing conduct problems from developing and intervening early in the onset of these behaviors. This is accomplished through three coordinated programs aimed at improving the skills of the child (in the areas of academic and social achievement), parent (to increase communication and approaches to nurturing), and teacher (promoting effective classroom management and instruction on social skills).

Keeping Foster and Kin Parents Supported and Trained (KEEP) was created by the developers of the Treatment Foster Care Oregon (TFCO) model. KEEP is a skills development program for foster and kinship parents of children ages zero to five years. There is also a version for teenagers called KEEP SAFE. KEEP groups typically include seven to ten foster parents who attend 16 weekly 90-minute sessions that focus on practical, research-based parenting techniques. KEEP does not use a "one size fits all" curriculum. While the facilitators draw from an established protocol manual, they tailor each session to the specific needs, circumstances, and priorities of participating parents and their children.[57] The goal of the program is to teach parents effective parenting skills, including appropriate praise, positive reinforcement, and discipline techniques.[58]

Mobile Response and Stabilization Services (MRSS) provide mobile, on-site and rapid interventions for children and youth experiencing a behavioral health crisis. MRSS provide immediate de-escalation in the least restrictive setting possible followed by time-limited crisis stabilization services. Crisis intervention can be provided in the home, school, or the emergency room. The goal of MRSS is to improve behavioral health outcomes by avoiding emergency room visits and preventing unnecessary hospitalizations.[59]

Multidimensional Family Therapy (MDFT) is a family-based program designed to treat emotional problems, substance use, and delinquency in children and youth ages 11 to 18 years old.[60] Treatment usually lasts from four to six months and can be used alone or with other interventions. MDFT assesses and intervenes with the adolescent and youth individually, the family as an interacting system, and individuals in the family relative to their interactions with influential social systems (e.g., school, juvenile justice). MDFT interventions are solution-focused and emphasize immediate and practical outcomes in important functional domains of the child or youth's everyday life.

Multisystemic Therapy for Child Abuse and Neglect (MST-CAN) is a treatment for children and youth in the child welfare system who are between the ages of six and 17 years and whose families are under the guidance of child protective services (CPS). MST-CAN is a six- to nine-month intensive therapy that tailors its interventions to the specific risk factors that contribute to child physical abuse and neglect. The major goals of MST-CAN are to keep families together, assure children are safe, prevent abuse and neglect, reduce mental health difficulties, and increase natural supports.[61]

Nurturing Parenting Program (NPP) for the Caregiver is a family-centered program designed for the prevention and treatment of child abuse and neglect. NPP is designed for children aged zero to five years and their caregivers. The program's lessons focus on decreasing inappropriate expectations, increasing empathy, providing alternative discipline strategies, clarifying parents' roles and responsibilities, and providing choice and autonomy.[62]

Parents as Teachers (PAT) is a comprehensive home-visiting parent education program that serves children from preschool to kindergarten and their parents. Through home visits, group connections, resource networks, and child screenings, PAT's home visiting staff work to increase parents' knowledge of early childhood development, detect developmental delays, prevent child abuse and neglect, and increase children's school readiness and success.[63]

Positive Parenting Program (Triple P) teaches parents strategies to prevent emotional, behavioral, and developmental problems. It includes five levels of varying intensity (from the dissemination of printed materials to eight- to ten-session parenting programs and more enhanced interventions for families experiencing higher levels of relational stress). Using social learning, cognitive-behavioral, and developmental theories (supported by studies on risk and protective factors for these problems), Triple-P aims to increase the knowledge and confidence of parents in dealing with their children's behavioral issues.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is effective with children and youth ages three to 18 years and their parents.[64] TF-CBT is a treatment intervention designed to help

children, youth, and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence; or exposure to disasters, terrorist attacks, or war trauma. It integrates cognitive and behavioral interventions with traditional child abuse therapies, focusing on enhancing children and youth's interpersonal trust and sense of empowerment. TF-CBT addresses issues commonly experienced by traumatized children and youth, such as poor self-esteem, difficulty trusting others, mood instability, and self-injurious behavior, including substance use.[65]

Appendix H: National Best Practices in Child Welfare

Overview of National Best Practices in Foster Care

A review of community and state efforts to improve the outcomes of children and youth who are involved in the child welfare system highlighted the importance of building or expanding the array of community-based services and supports available to children and youth in care, and their foster families.[66, 67] This section describes enhancements that child welfare systems can adopt to improve outcomes, independent of how services are delivered.

First, a high-level summary of recent state-level efforts to improve foster care services and supports is provided.

- **Hawaii** and **Illinois** are developing their capacity to provide mobile response and stabilization services (MRSS) to children and youth in care.
- **Illinois** and **Maryland** are expanding their foster parent training to include parent education, therapeutic supports, and home-visiting models for foster parents of infants and young children.
- **Pennsylvania** and **Tennessee** are increasing their capacity to train and support foster parents of children and youth with challenging behaviors. **Pennsylvania** is also enhancing its assessment process.
- **Illinois** provides foster parents with access to flexible funding. **Pennsylvania** and **Illinois** are increasing foster parents' access to a number of trauma-informed, office-based therapies and intensive in-home interventions.
- **California, West Virginia, and Hawaii** are implementing wraparound**.**
- **Oklahoma, Maine, Maryland,** and **New York City** all put in place a program called Partnering for Success (PfS), a process that provides child welfare and mental health providers with opportunities to enhance their interagency collaboration and cross-system partnerships by jointly participating in implementation teams and leadership learning series, and integrating training opportunities. More information on this model is provided below.

Communities across the country are also engaged in innovate work to better address foster care changes. The following summaries highlight several noteworthy examples of such efforts.

Partnering for Success (PfS)

Mental health care is increasingly being incorporated into child welfare along with efforts to help early childhood professionals better serve children and families who have experienced trauma or mental health issues. The Children's Bureau within the U.S. Health and Human Services Administration for Children and Families funded the National Center for Evidence-Based Practice in Child Welfare (NCEBPCW) to bring the child welfare and mental health

systems together to more efficiently integrate and coordinate treatment. NCEBPCW launched in October 2013 and created the Partnering for Success (PfS) model, an evidence-based approach that uses cognitive behavioral treatments.[68]

Partnering for Success is an integrated, cross-systems workforce competency model that improves mental health outcomes for children and youth involved in the child welfare system.[69] The model is available to agencies at the state, county, and municipal levels. It is designed to build the capacity of public child welfare and mental health workforces to implement trauma-informed, evidence-based practices through professional development, including specialized learning, clinical and peer consultation, coaching, and organizational support. It focuses on data-driven continuous improvement processes and uses Cognitive Behavioral Therapy Plus (CBT+), which addresses depression, anxiety, trauma, and behavior problems. As mentioned above, sites implementing PfS are located in New York City, Maine, Maryland (Baltimore County), and Oklahoma. An overview of each program is provided below.

New York City (NYC)

New York City initiated a five-year Title IV-E waiver demonstration project in January 2014, called Strong Families NYC. Its four project components are:

- Caseload and supervisory ratio reductions,
- Use of Child and Adolescent Needs and Strengths-New York (CANS-NY) tool,
- Attachment and Biobehavioral Catch-up (ABC), and
- Partnering for Success (PfS).

The New York City Administration for Children's Services (ACS) adapted PfS to the local context and ACS's Workforce Institute provided trainers who delivered the NYC PfS curriculum to 17 contracted foster care agencies and their mental health clinician partners.

Maine

Maines' Office of Child and Family Services / Children's Behavioral Health Services (OCFS/CBHA) works within one organizational structure, supporting effective collaboration between child welfare and children's behavioral health professionals. It has targeted evidence-based practices, including Multi-Systemic Therapy (MST), Functional Family Therapy (FFT), Treatment Foster Care Oregon (TFCO), Trauma-Focused CBT (TF-CBT), and Applied Behavior Analysis (ABA). Its key partners include the Maine Department of Corrections, the Office of MaineCare Services (OMS) (Medicaid), and the Maine Department of Education.

Oklahoma

The Oklahoma Department of Human Services (DHS) was awarded a five-year grant through the Initiative to Improve Access to Needs-Driven, Evidence-Based/Evidence-Informed Mental and

Behavioral Health Services in Child Welfare. Oklahoma DHS implemented a universal behavioral health screening in 2016, with associated professional development. They chose the Pediatric Symptom Checklist-17 (PSC-17) as the foundation for Comprehensive Home-Based Services and integrated with the existing Oklahoma Heath Care Authority tool. Oklahoma used the PfS model to deliver coordinated professional development support for child welfare and mental health professionals in the Tulsa region.

Baltimore County, Maryland

The state of Maryland implemented PfS in the Baltimore County Department of Social Services (DSS) in 2014. Through this project, DSS implemented evidence-based practices, including MST, FFT, and Brief Strategic Family Therapy. FFT therapists are embedded with child welfare staff. DSS staff learned about the impact of trauma, how to use standardized assessments to identify trauma, how to effectively refer children and youth to treatment, and how to effectively monitor progress. DSS chose the PSC-17 assessment tool. Baltimore County's work through PfS led to an application for a Title IV-E waiver with the state to expand cross-systems collaboration.

Appendix I: Behavioral Health Framework for Children and Youth

Component 1: Foster Care-Specific Integrated Pediatric Primary Care Clinics

Harris County Protective Services Clinic

Harris County Protective Services (HCPS), in partnership with the University of Texas Medical School, offers an integrated health care clinic for children and youth who are involved with the Texas Department of Family and Protective Services. The HCPS Integrated Healthcare Clinic was designated as the Foster Care Center of Excellence for Harris County by Superior Health Plan. Located at the Harris County Youth Services Center, the clinic offers physical, mental, psychiatric and dental health services to ensure easy access for kinship/relative, guardians, and foster parents. A clinician with the Harris Center for Mental Health and IDD is embedded within the clinic to complete the CANS assessments. The clinic has partnered with the Department of Family and Protective Services (DFPS) to take the lead on the 3 for 30 initiative in Harris County.

Texas Children's Hospital – Public Health Pediatrics

Texas Children's Hospital's Foster Care Clinic provides care to children and youth who are in foster care and those at risk of abuse and neglect. The clinic provides 72-hour medical evaluations for children who are new to foster care as well as assessments for abuse and neglect, and acute and chronic mental and physical illnesses.

Integrated Pediatric Primary Care Clinics

Memorial Hermann School-Based Health Centers

Memorial Hermann Health System (Memorial Hermann) is the largest not-for-profit health system in Southwest Texas. It has 16 hospitals and numerous specialty programs and services located throughout the greater Houston area. Through its Community Benefits Corporation, Memorial Hermann partners with five independent school districts (ISDs) – Houston, Pasadena, Lamar Consolidated, Alief, and Aldine – to operate 10 school-based health centers. The Memorial Hermann Health Center for Schools program acts as a medical home for uninsured and underinsured children and youth, and serves as a secondary health care access point for insured children. The school-based clinics support educational success by providing medical, mental health, nutritional, and dental care that allows students to stay in school and learn. Houston and Aldine ISDs both house school-based clinics – they each also have a large number of students reported to be in the care and custody of DFPS. By following a coordinated approach with these districts, Memorial Hermann's Health Center for School programs and DFPS may improve access to integrated primary care for these students while encouraging coordination of care between schools, mental health and primary care providers, foster families, and DFPS.

Legacy Community Health

Legacy Community Health (Legacy) is a Federally Qualified Health Center (FQHC) system that provides a continuum of health care services in the areas of adult primary care, pediatrics, obstetrics and gynecology, dental care, vision services, behavioral health services, nutrition, and comprehensive HIV/AIDS care. Legacy has locations across Houston, Baytown, and Beaumont. It operates 13 integrated primary care clinics with on-site behavioral health specialists and 18 school-based integrated care clinics. Legacy is a Superior HealthPlan provider and currently operates more integrated primary care clinics for children and youth than any other Harris County provider. Legacy does not operate any foster care-specific integrated primary care clinics. However, it does place a high priority on addressing social determinants of health and is recognized as a community leader. This, coupled with the scope and reach of its services, makes Legacy uniquely positioned to develop foster care-specific service capacity.

Vecino Health Center

Vecino Health Center (Vecino) is an FQHC that provides primary care, mental health, and dental services at two Houston locations (Airline Children's Clinic and Denver Harbor Family Clinic) as well as health outreach at four Houston schools. Vecino's behavioral health staff includes licensed professional counselors (LPCs) who provide individual, group, and family/couples therapy in both English and Spanish. Last year, all counselors became certified in Dialectical Behavior Therapy (DBT) to help meet the more complex needs of the children and youth they treat.

Although it does not have a contract with DFPS to provide health services, Vecino receives numerous referrals on behalf of families with CPS involvement, especially for mental health services. As part of its intake process, Vecino asks all new families if they are working with or have ever had a relationship with CPS. In addition to mental health services for children and youth, Vecino offers families counseling support on a broad range of issues pertinent to child welfare system involvement, including the reasons for CPS involvement and important elements for successful reunification. Vecino receives reimbursement through STAR Health for services to children and youth in CPS conservatorship. Vecino will also provide services to parents and caregivers on a sliding-fee scale basis if they are uninsured and otherwise unable to pay for services.

Component 2: Region 6a Community and School-Based Specialty Behavioral Health Providers

Key informants and Advisory Committee members reported that the specialty behavioral health providers described below serve children and youth in foster care or have the capacity to meet the needs of this population and should be considered when planning for community-based care (CBC).

Children's Assessment Center

The primary focus of the Children's Assessment Center (CAC) is on the prevention, assessment, care coordination, and treatment of children and youth who have been sexually abused. The CAC's mental health treatment team serves the child and family members and uses a trauma-informed approach for the delivery of all services. The mental health services CAC provides include medication management, Trauma-Focused CBT, Eye Movement Desensitization and Reprocessing Therapy, art therapy, and directed and non-directed play therapy. The CAC is a community leader in cross-agency collaboration, a source for information on preventing and recognizing child sexual abuse, and a resource for training on trauma-informed evidence-based practices.

Communities In Schools of Houston

Communities In Schools (CIS) of Houston provides Integrated Student Supports to empower students to succeed in school and achieve in life. For the current 2018–2019 school year, CIS of Houston is serving in 160 schools, from pre-kindergarten to community college in four ISDs, one charter school system, one community center, and six community college campuses. During the 2017–2018 school year, CIS of Houston served 117,814 students and their families, 5,846 of whom received individual case management services. The CIS Mental Health Initiative provided mental health services to 6,743 students by CIS Mental Health Specialists and 844 students by CIS Mental Health community partners. CIS of Houston reports that 98% of the students it served showed "marked improvement" in academics, attendance, and behavior.

Case management and other services offered by CIS partners, such as individual and group counseling, are provided at no cost to students and families. Historically, schools that are served through the CIS program share 60% of the cost with CIS. However, most new schools wishing to add CIS must cover 100% of the cost.

Community Youth Services

The Youth Services Division of Harris County Protective Services (HCPS) operates the Community Youth Services (CYS) program. CYS has almost 60 workers located in 14 Harris County ISDs, the Pasadena Police Department, and the Harris County Juvenile Probation Department. CYS workers provide school-based interventions, counseling services, and case coordination to address parent-child conflicts, school performance issues, mental health concerns, substance abuse, runaway or homelessness, pregnancy and teen parenting, adolescent development, and grief.

Council on Recovery

The Council on Recovery's (Council) mission is to help all people who are affected by substance abuse and related disorders including mental health issues and high-risk compulsive disorders.

For children and youth, the Council's focus is on the early stages of substance use, offering prevention services to address substance abuse, internet addiction, gambling, and other related challenges. The Council provides therapeutic services for children; its child therapists work with children ages 12 and younger who are affected by a family member's addictions, and address issues such as self-esteem, shame, and communication.

The adolescent services team offers a 12-week program for youth who engage in high-risk behaviors (e.g., substance abuse, gambling, engaging in unsafe sexual behaviors). The program includes a parallel parent course to coach parents on how to address these issues. The Council also offers individual and family therapy, and Council staff coordinate referrals to other services based on a youth's needs.

Family Houston

Family Houston has provided counseling for adults, children and youth for over 80 years. It offers counseling services for children and youth between the ages of three and 18 years, including play therapy, evidence-based Parent-Child Interactive Therapy (PCIT), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Spanish language counseling services are also available. Family Houston also provides parent education, financial coaching, benefits navigation, veteran's support, community outreach, and mental health services. The organization prioritizes serving those in need, regardless of their ability to pay.

Family Houston emphasizes mental health services to children and youth, including many who have recently entered the foster care system. It employs about 21 licensed professional counselors in Central Houston, the Woodlands, Fort Bend, and Clear Lake. Family Houston estimates that it can meet about 85% of the mental health needs of the children and youth it serves. When Family Houston identifies mental health concerns that it is unable to address through internal resources, it refers to other providers. In addition to traditional therapy programs, Family Houston provides life skills support, including help completing school and identifying employment opportunities. Family Houston provided counseling services to 1,350 children during its last fiscal year.

Houston: reVision

Houston: reVision is a non-profit program that focuses on children and youth who are directly involved with the criminal or juvenile justice systems or are at the highest risk for future involvement in these systems. Houston: reVision partners with churches, schools, and other organizations to support youth by "meeting them where they are" and provides a host of supportive services, including mentoring, case management, peer support, skills training, and outreach and support for youth with juvenile justice or criminal justice system involvement. Houston: reVision is a partner organization with the Harris County Youth Collective, which

supports children and youth who are involved in the child welfare and juvenile justice systems. Houston: reVision accepts direct referrals of youth who are concurrently involved in the juvenile justice and child welfare systems.

The Montrose Center

For over thirty years, the Montrose Center has been addressing the needs of lesbian, gay, bisexual, transgender, queer or questioning (LGBTQ) youth through a variety of services, supports, and interventions. Hatch Youth, a social group for LGBTQ youth, provides youth ages 13 to 20 years with a safe, self-affirming social environment; access to education on health issues; and peer support and role models. Hatch Jr. serves children ages 7 to 12 years and their parents. Project Remix provides education, referrals for medical care, emergency shelter, crisis intervention, food and clothing, protective services and advocacy, and HIV/STI prevention for homeless and at-risk LGBTQ youth and young adults ages 13 to 24 years. Vision Quest provides mentorship with an assigned coach to youth ages 13 to 17 years who are interested in developing the self-efficacy needed to work towards self-identified goals. Project NEST is a city-wide collaborative dedicated to ending LGBTQ homelessness.

The Trauma and Grief Clinic

The Trauma and Grief Clinic at Texas Children's Hospital's Trauma and Grief Center is a Substance Abuse and Mental Health Services Administration-funded Category II Treatment and Services Adaptation Center of the National Child Traumatic Stress Network (NCTSN). It provides evidence-based risk screening, assessment, and interventions for youth ages seven to 17 years who have experienced trauma or losses, including the death of loved ones. Clinic staff use state-of-the-art, empirically validated screening tools to assess youth, and then provide the most appropriate and effective interventions. The clinic's primary treatments include Trauma and Grief Component Therapy, Multidimensional Grief Therapy, and Trauma-Focused Cognitive Behavioral Therapy.

TRIAD Prevention Program

TRIAD is a consortium of Harris County Protective Services, Harris County Juvenile Probation, and The Harris Center. The TRIAD Prevention Program provides parenting education, truancy prevention, individual and family therapy, and psychosocial assessments for children, youth, and families in Harris County. TRIAD Mental Health services target youth ages 10 to 17 years (and their families) who struggle with a serious emotional disturbance or a behavioral problem. TRIAD Mental Health provides mental health assessments and individual and intensive family therapy. The Parenting with Love and Limits (PLL) program, a six-week evidence-based parenting program, is available to parents who are struggling with rule setting and need support restoring a nurturing parent-child relationship. HCPS is a licensed PLL Center for Excellence in Texas. The Parent/Teen Survival program is a five-week program for youth ages 10

to 17 years and their parents. The weekly two-hour sessions address topics such as negotiating and setting boundaries, understanding and managing anger, developing communication skills, and problem solving.

Component 3: Rehabilitation and Intensive Behavioral Health Services

Arrow Child and Family Ministry

In fiscal year 2018, Arrow Child and Family Ministry was one of three agencies statewide that was awarded a contract with DFPS to provide its Treatment Foster Family Care (TFFC) program. Arrow is implementing the Together Facing the Challenge (TFTC) model for treatment foster care. The program employs professional foster parents trained in the TFTC curriculum and supported with in-home access to a team of specialists, including a master-level specialist, and 24 hours a day, seven days a week (24/7) access to support services. Arrow also offers Restoration Foster Care. This program is tailored to meet the needs of youth who have been sex trafficked and provides foster parents with wraparound in-home supports, including a therapist, a trauma-informed specialist, and behavioral support staff. Foster families also have access to 24/7 on-call assistance, in-home coaching sessions, and flexible in-home assistance from a trauma-informed specialist.

DePelchin Children's Center

DePelchin Children's Center (DePelchin) is expanding the home and community-based services it provides to families with complex needs. In the greater Houston area, DePelchin serves about 500 children and youth each year through the FIRST (Family Integrated Relational Service Team) Program, which has 17 clinical case managers and a specialized team with two licensed practitioners of the healing arts, a crisis responder, and a wraparound coordinator. This team serves children and youth with complex mental health needs. DePelchin estimates that about 20% of the children and youth that the FIRST Program serves require comprehensive services, including intensive in-home family-based services and crisis support, and that about 5% of these children, youth, and their families will need wraparound facilitation. Staff who work with the families with the most complex needs have or will obtain training in wraparound.

HAY Center

The HAY Center, a Harris County Protective Services program, provides a broad spectrum of services and supports for youth ages 14 to 25 years who are either currently or formerly involved in foster care. The HAY Center has a contract with DFPS to deliver the Preparation for Adult Living (PAL) program and a contract with the Texas Workforce Commission to provide training and employment services. Youth who receive services at the HAY Center can obtain a broad range of supports at its central Houston location, including mentoring, housing, education support, life skills, and mental health services.

The Harris Center

The Harris Center is currently the largest provider of intensive community-based care in Region 6a. Its child and youth programming is administered through the YES waiver program. Eligible children and youth have access to medication management, rehabilitation skills training, counseling, and targeted care management (High Fidelity Wraparound). The Harris Center has the capacity to serve approximately 240 children and youth at any given time. It has 24 wraparound coordinators, each of whom carry a caseload of 10 to 13 children or youth. Additional child and family team members may include Community Living Supports (CLS) staff, therapists, doctors, Certified Family Partners, and other staff who are able to provide needed services. Children and youth in foster care are eligible for YES waiver services. The Harris Center continues to work with regional DFPS staff to increase awareness of YES waiver services.

Pathways Youth and Family Services – Mosaic Behavioral Health Services

Mosaic Consulting (Mosaic) is a division of Pathways Youth and Family Services, which delivers behavioral health services to children and youth, with a focus on community-based care, counseling, and psychiatry. Mosaic is staffed by board certified psychiatrists who work with families to develop individualized treatment plans, conduct psychiatric evaluations, and provide medication management and consultation. Mosaic's clinical therapists provide initial assessments as well as therapeutic treatment to address a wide range of behavioral health needs. These therapists have had specialized training in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Parent-Child Interaction Therapy (PCIT), and play therapy. Mosaic's behavioral health team includes Qualified Mental Health Professionals who directly deliver valuable skills development as well as in-home and community support to benefit the entire family. The team utilizes evidenced-based practices such as Seeking Safety, Nurturing Parenting, Aggression Replacement and Preparing Adolescents for Young Adulthood (PAYA) to work through a vast array of behavior concerns ranging from significant aggression to social skills development. Mosaic Consulting also provides in-home crisis response and interventions, and connects families to long-term care or crisis services, as needed. Its wraparound approaches focus on working with the child or youth within the family unit as a whole. In the last fiscal year, Mosaic provided behavioral health specialty services to 140 children, youth, and their families, more than half of whom are from Region 6a.

Youth Advocate Program (YAP) Harris County

Youth Advocate Program (YAP) serves youth in Harris County and surrounds communities through its Behavioral Health and Juvenile Justice Programs. Being in and from the neighborhoods it serves, YAP is accessible to families at the places, times and days they need. YAP partners with families to map out a family-focused, comprehensive plan to meet their needs and build upon their unique strengths and interest. Services include, but are not

limited to biopsychosocial assessments, therapy, skills training, mentoring, psychiatric evaluations, parent support, respite, advocacy, and tracker services.

YAP's work is built on a foundation of research demonstrating that people do better throughout life when they get support to strengthen their social, emotional, financial and physical well-being from where they live, work, learn and play. The YAP model is informed by best practices in wraparound, mentoring, and positive youth development. Its mission is to safely keep young people and families at risk of separation due to incarceration, hospitalization or other residential, out of home placements together in their homes and communities. Located in 23 states and DC, YAP is one of the largest non-profit Youth and Family Support agencies working with high-risk youth and their families in the United States.

Component 4: The Crisis Continuum

Mobile Crisis Response Teams

The Harris Center Crisis Line

The Harris Center Crisis Line provides access to mobile crisis response and stabilization services for children, youth, and adult residents of Harris County. It is staffed by licensed professionals of the healing arts (LPHA) and qualified mental health professionals (QMHPs) who are trained in crisis intervention and available at all times. Crisis Line staff respond to calls from a variety of sources, including parents/caregivers, schools, youth, and law enforcement. They triage calls based on their assessment of risk, designate the need as "emergent" or "urgent," and dispatch the mobile crisis outreach team (MCOT) when necessary.

The Harris Center MCOT operates as a multi-disciplinary team of mental health professionals that responds to crises in homes and in the community. The program comprises 50 dedicated staff members, including a medical director, a program director, clinical team leads, a psychiatrist, licensed master-level clinicians, bachelor-level case managers, registered nurses, and paraprofessional staff. Individual clinical team members carry an average case load of eight to ten clients – both adults and youth – to maintain the goal of promoting stability while arranging ongoing treatment services, as needed. These services are offered for up to 90 days to provide follow up and link people to other services. The Harris Center MCOT averages about 330 referrals per month that are related to children, youth, and families, and about 200 become part of the follow-up case load.

Turning Point

Turning Point is a crisis intervention, acute stabilization, and psychiatric diversion program offered in Harris County by Superior HealthPlan to serve children and youth in foster care. The primary goal of this program is to prevent placement disruptions and divert children and youth from inpatient hospitalization. Pathways Youth and Family Services contracts with Superior

HealthPlan to offer this program. During FY 2017, Turning Point completed 69 mobile crisis contacts. At the time these data were collected for this report, Turning Point was on track for similar contact volume for 2018.

Additional Crisis Supports

The Harris Center Psychiatric Emergency Services (PES) – Children and Adolescent Psychiatric Emergency Services (CAPES)

The Harris Center's Children and Adolescent Psychiatric Emergency Services (CAPES) unit provides assessment services, medication, stabilization, and connections to services 24 hours a day, seven days a week for children and youth who are experiencing a psychiatric crisis. The PES/CAPES unit is located in central Houston and serves children up to age 18 on a voluntary and involuntary basis. Children and youth who come to CAPES are assessed by a psychiatrist, nurse, and licensed therapist to determine the level of care needed. CAPES puts a strong emphasis on family involvement. If a crisis cannot be resolved and the child or youth needs to be hospitalized or is unable to return home, program staff seek out inpatient or residential options. CAPES has the physical space to serve up to six children and youth, but is staffed to serve no more than four at any given time. The demand for PES/CAPES often exceeds capacity. When PES/CAPES goes on diversion, families often seek services from Ben Taub Hospital's emergency room, which does not have pediatric bed capacity.

Ben Taub Hospital Emergency Care

Ben Taub Hospital (Ben Taub) operates one of the anchor, locked adult psychiatric facilities in the region, **but the hospital does not have any pediatric medical or psychiatric beds**. Psychiatric services for children and youth are only provided by consult. However, when a child or youth presents at the emergency room (ER) for medical or behavioral health crisis, the ER is required to treat them. Key informants report that, on average, 42 children and youth come into the ER each month. Two issues were identified as contributing factors to the large number of children and youth seen by Ben Taub Hospital: (1) the community perception that Ben Taub is the safety net provider for children and youth in Harris County, and (2) its location next to The Harris Center's Psychiatric Emergency Services. When The Harris Center is on diversion for children and youth, which is common, families often seek services from Ben Taub Hospital.

Children and youth who require inpatient psychiatric services are transferred to The University of Texas Health Science Center at Houston (UTHealth) Harris County Psychiatric Center or a private hospital. If a bed is not available, the child or youth remains in the ER. Key informants report that there are occasions when they have had three to four children and youth in the ER overnight. They described children and youth being housed on stretchers with curtains pulled between them while they wait for a bed. Children and youth who lack insurance coverage and those who struggle with co-occurring mental illness and developmental disabilities are more

difficult to place, which results in longer stays in the ER. Key informants indicated that they have had children and youth wait in the ER for as long as four to five days.

Memorial Hermann Health System's Crisis Clinics

Memorial Hermann operates crisis clinics at three locations across Houston and the surrounding area – Spring Branch, Meyerland Area, and its Northeast Mental Health Crisis Clinic. The clinics provide mental health assessments and evaluations, initiate services when appropriate, or refer families to the appropriate level of care. The clinics are staffed by a multidisciplinary team of psychiatrists, mental health nurse practitioners, physician assistants, social workers, licensed professional counselors, and medical assistants. The goal of these clinics is to increase access to mental health treatment during a crisis or a mental health treatment need, in order to decrease unnecessary use of emergency rooms for mental health care. The hours vary across locations.

TRIAD Prevention Program – Intake Diversion Program

The Intake Diversion Program provides 24/7 access to crisis intervention services at the Youth Services Center for youth who have been detained by the police for status offenses such as runaway or truancy, or who are brought in by their parents and need crisis intervention. Youth can stay at the center for up to 24 hours and receive crisis intervention services, service planning and referral to resources, administration of the Children and Adolescent Needs and Strengths (CANS) assessment, and, if involved with Child Protective Services, screening and placement in the onsite Kinder Care Emergency Shelter. The program is jointly funded and staffed by the Harris County Juvenile Probation Department, Harris County Protective Services, and the Harris Center.

Short-Term Crisis Supports and Residential Treatment Centers

Kinder Emergency Shelter

In 2017, the Kinder Emergency Shelter provided residential shelter care to 355 youth, 266 of whom were from Harris County and in DFPS care. The number of youth in care decreased between January 2018 and November 14, 2018, to a total of 133 youth in care (83 from Harris County and in DFPS care).

Turning Point Crisis Stabilization Beds

The Turning Point program offered through Pathways Youth and Family Services provides access to two crisis stabilization beds for families and caregivers of children who have the most acute needs. To qualify for the crisis beds, a family or caregiver must agree to take their child or youth back home within 14 days. The child or youth must also meet the appropriate level of care and be at least 10 years old.

Appendix J: Stakeholder List

Community-Based Care Stakeholders		
Organization	**Name**	**Title**
ACH Child and Family Services	Wayne Carson, LCCA, LCSW, PhD	CEO
Arms Wide Adoptive Services	Vikki Finley	President & CEO
	Arianne Riebel, LMSW, LCPAA	Director of Adoption and Foster Care Programs
	Shelly Webster, LMSW, LCPAA	Director of Post Adoption and Post Permanency Services
Arrow Child & Family Ministries	Scott Lundy	President & CEO
	Kellee Walker, LPC	VP of South Texas
Attucks Middle School	Nyela Bolden	Harris County CPS
	Tisha Wilson	School-Based Programs Administrator, reVision
Ben Taub	Asim Shah	Chief of Psychiatry
CASA Texas	Leslie Cocke	CFE Manager Region 3b
	Anna McDonnel	CFE Manager Region 6
Center for Success and Independence	Dr. Mary Lou Erbland	Executive Clinical Director
Children's Assessment Center	Kathy Wells	Program Director
City of Houston, Houston Health Department	Kristi Rangel, MEd	Public Health Education Chief
Communities in School of Houston (CIS)	Lisa Descant, LPC-S, LMFT	Chief Executive Officer
	Donna Wotkyns, LCSW	Director of Development
	Shubhra Endley, LCSW	Director of Mental Health and Wellness
Covenant House	Victor Hay	Director of Shelter and Community Services
Cultivating Families	Amy Bezecny, MDiv	Founder & CEO
DePelchin Children's Center	Corrine Walijarvi	Vice President of Child Welfare and Strategic Planning
	Bill Knull	Board Chair of DePelchin

Community-Based Care Stakeholders		
Organization	**Name**	**Title**
Disability Rights Texas	Dustin Rynders, JD, MPAff	Supervising Attorney, Education Team
Family Houston	Liz Green	Vice President of Development
	Jessica Cisneros	Vice President of Behavioral Health Services
	Charley Weldon	President and CEO
Family Tapestry	Annette Rodriguez	President & CEO
Harris County District Courts, Juvenile Justice Center	Katrina Griffith, JD	Judge, CPC Family Court
Harris County Juvenile Probation Department	Diana Quintana, PhD	Deputy Director, Health Services Division
Harris County Protective Services for Children and Adults Children's Crisis Care Center (4C)	Joel Levine, MA, LCSW	Executive Director
Harris County Youth Advocate Programs	Naomi Chargois Edwards, MS	Southwest Regional Director of Behavioral Health services
Harris County Youth Collective	Kelly Opot	Executive Director
	Megan Davis	Case Worker
	Valerie Bockstette	Consultant
Kinder Emergency Shelter	Evelyn Emdin	Program Manager
Memorial Hermann Health System, Behavioral Health Services	Keri Jackman	Psych Response Case Management Manager
	Sabina Pomykal, LCSW-S	Memorial Hermann Mental Health Crisis Clinics (MHCC), Clinical Manager
Menninger Clinic	Stephanie Cunningham	Vice President, Business Development, and Interim Vice President, Philanthropy
	Tony Gaglio	Interim Chief Executive Officer; Senior Vice President and Chief Financial Officer
Monarch Family Services	Valerie Jackson, PhD	Founder and Owner

Community-Based Care Stakeholders		
Organization	**Name**	**Title**
New Horizons Ranch & Center, Inc.	Michael Redden, LPC, LMFT, LCCA	CEO New Horizons
Pathways Youth and Family Services	Nicole Elbrecht, LPC-S, NCC	Clinical Treatment Director, Mosaic Consulting
	Stacey Lofstad, MS, LPC, LCPAA	Regional Program Director
	Jacqueline Marks, MS, LCPC, CHP	Quality Improvement and Compliance Director
ProUnitas	Adeeb Barqawi	President & CEO
reVision	Charles Rotramel	CEO
TFI, Family Services	Michael Patrick	CEO
Texas CASA	Anna McDonnell	Collaborative Family Engagement Coach, Region 6
	Leslie Cocke	Collaborative Family Engagement Coach, Region 3b
	Cathy Cockerham	Liaison of Family Development
Texas Department of Family and Protective Services	C.J. Broussard-White	Regional Director, Child, Youth and Family Services, Region 6A
Texas Children's Hospital (TCH)	Bethanie Van Horne, DrPH, MPH	Assistant Professor, Pediatrics- Public Health, Baylor College of Medicine
	Christopher Greeley, MD, MS, FAAP	Chief, Section of Public Health and Child Abuse Pediatrics
	Erica Figueroa, LCSW	Social Worker
	Kimberly Lopez, DrPH, MPH, BA	Assistant Professor, Pediatrics-Public Health, Baylor College of Medicine
	Rachael Keefe, MD, FAAP	Assistant Professor, Pediatrics- Public Health, Baylor College of Medicine
The Center for Success and Independence	Robert Woods, MEd	Co-Founder, CEO & Executive Director
	Mary Lou Erbland, PhD	Co-Founder & Clinical Director
Texas Children's Health Plan, Baylor College of Medicine	Heidi Schwarzwald, MD, MPH	CMO Pediatrics, Associate Vice Chair of Community Health

Community-Based Care Stakeholders		
Organization	**Name**	**Title**
The Council on Recovery	Mary H. Beck	Chief Strategy Officer
The Harris Center for Mental Health and IDD	Ezmir Zepeda, LCSW	Practice Manager, Substance Use and Recovery Services
	Stella Olise, LPC	Practice Manager, YES Wavier
	Sarah Strang, MEd, LPC	MCOT Program Director
	Amanda Jones, JD	Director of Governmental Relations
	Michael Downey, MA, MBA, LPC	Deputy Director, Outpatient Services (Civil)
	Tiffanie Williams-Brooks, MA, LPC	Regional Practice Manager, Children & Adolescent Mental Health Services
The Houston Alumni and Youth (HAY) Center, Council for Recovery	Mary Green	Director of Transition Services
The Trauma and Grief Center, Texas Children's Hospital	Julie Kaplow, PhD, ABPP	Director, Trauma and Grief Center; Chief of Psychology, Texas Children's Hospital
Texas Network of Youth Services (TNOYS)	Katherine Byers, PhD	Director of Child Welfare Policy
TRIAD Prevention Program, Harris County Protective Services	Ramiro Guzman	TRIAD Intake & CYD Manager
	James Whitehead, LCSW	Program Manager, TRIAD Prevention Program
UpBring	Jason Drake, LCSW, LCCA	Regional Executive Director
Vecino	Clara Rosenzweig	Director Behavioral Health Services
Youth For Tomorrow	Janis Lehman	Executive Director
	Amy Saladin	Program Director
	The Honorable John J. Specia, Jr.	Former Commissioner of the Texas Department of Family and Protective Services

Appendix K: Family First Prevention Services Act Overview

The Family First Prevention Services Act (FFPSA) was signed into law on February 9, 2018. The purpose of FFPSA is:

> "To enable States to use Federal funds available under parts B and E of title IV of the Social Security Act to provide enhanced support to children and families and prevent foster care placements through the provision of mental health and substance abuse prevention and treatment services, in-home parent skill-based programs, and kinship navigator services."[70]

FFPSA also works to improve the well-being of children already in foster care by providing states with incentives to reduce placement of children in congregate care.[71] In the following sections, FFPSA sections that are most relevant to Harris County community-based care decision making are summarized.

Foster Care Prevention Services and Programs (Sec. 50711, 50712, 50713)

States have the option of using open-ended federal Title IV-E funding for evidence-based prevention services for children and youth who are at risk of foster care placement, and their families. The timing for implementing the provision of prevention services is aligned with the Qualified Residential Treatment Program (QRTP) provision (see placement section below). New federal funds for prevention services are intended to augment, not supplant, state funding for prevention services – Maintenance of Effort (MOE) requirements exist. States must submit a prevention and services program as part of the state's Title IV-E plan.

In general, states may provide behavioral health (mental health and substance use disorder) prevention and treatment services and in-home skill-based programs for parents for up to 12 months. Specific services/programs must be trauma-informed, promising, and supported or well-supported in the California Evidence-based Clearinghouse of Child Welfare (CEBC) to qualify for federal reimbursement. There is no limit on how many times a child and family can receive prevention services; new prevention plans may begin an additional 12 months of services for children, youth, and families who are once again identified as candidates for services. There is no income test for eligibility. States must collect and report child-level information on services and expenditures to analyze how well they meet performance measures.

FFPSA supports evidence-based kinship navigator programs.

Elimination of Time Limit for Family Reunification Services (Sec. 50721)

FFPSA enhances support under Title IV-B by eliminating the time limit for family reunification services while the child is in foster care and allowing 15 months of reunification services when a child returns home from foster care.

Ensuring Appropriate Placements in Foster Care (Ensuring the Necessity of a Placement That is Not in a Foster Family Home) (Sec. 50741, 50742, 50743, 50744, 50745, 50746)

Placement options allowable under current Title IV-E and continuing under FFPSA are:

- Foster family home (defined) – No more than six children in foster care, with some exceptions;
- Facility for pregnant and parenting youth;
- Supervised independent living for youth 18 years and older; and
- Specialized placements for youth who are victims of or at-risk of becoming victims of sex trafficking.

Placement option changes under FFPSA include:

- **Residential Family-Based Treatment Facility.** Title IV-E foster care maintenance payments can be made for a child or youth in foster care placed with their parent(s) in a licensed residential family-based treatment facility for up to 12 months – no income test applies.
- **Qualified Residential Treatment Program (QRTP).** Title IV-E federal support will be available for foster care maintenance payments for eligible children or youth placed in a Qualified Residential Treatment Program (QRTP). A Qualified Residential Treatment Program (QRTP):
  - Has a trauma-informed treatment model and registered or licensed nursing and other licensed clinical staff onsite/accessible, consistent with the QRTP's treatment model;
  - Facilitates outreach and engagement of the child or youth's family, which is included in the treatment plan;
  - Provides discharge planning and family-based aftercare supports for at least six months; and
  - Is licensed and accredited.

  There are no time limits for how long children or youth can be placed in a QRTP, as long as the placement continues to meet their needs, as determined by an assessment. Assessment of children and youth who are placed in a QRTP must occur within 30 days and meet federal requirements.

States must assure non-impact on the juvenile justice system. This includes a certification that states will not enact or advance any policies or practices that would result in a significant increase in the population of youth in the state's juvenile justice system.

Additional Items to Promote Safety, Permanency, and Well-Being (Miscellaneous) (Sec. 50731, 50732)

FFPSA also includes:

- **Foster Parent Licensing Standards.** States must align with foster parent licensing standards identified by the Department of Health and Human Services.
- **Child Abuse and Neglect Fatalities.** States must develop a statewide plan to track and prevent child abuse and neglect fatalities.

Texas FFPSA Implementation

Texas is delaying implementation of certain provisions of the FFPSA until 2021:[72]

- 472(k)(2) of the Act: Limitations on Title IV-E foster care maintenance payments for placements that are not foster family homes.
- 472(c) of the Act: Limit on the number of children in a foster family home.
- 472(k)(1)(B) and 475A(c) of the Act: Qualified Residential Treatment Programs (QRTPs).
- 471(a)(37) of the Act: Certification preventing increases to the juvenile justice population.

The Texas Department of Family and Protective Services (DFPS) made this decision because:

- Texas does not have QRTPs to serve children and youth with the highest needs.
- Texas does not have enough providers that offer evidence-based services and is awaiting federal guidance on which evidence-based services will be included in the clearinghouse to qualify for federal reimbursement.

Preschool Development Birth through Five Grant Project Overview

The Texas Education Agency (TEA) was awarded a $1,789,455 Preschool Development Birth through Five (PDG B-5) grant award for 2019,[73] which is called the Texas Preschool Development Grant (TPDG). The PDG B-5 grant is intended to analyze and strengthen state's early childhood systems, with a focus on collaboration, coordination, and efficient service delivery and use of resources. States were encouraged to think broadly about what their early childhood systems comprise, including early learning and development, family support, and health. The grant requires states to work within five areas of activity: (1) comprehensive statewide needs assessment, (2) strategic planning, (3) maximizing parent choice and knowledge, (4) sharing best practices, and (5) improving overall quality. The target populations are underserved children, families, geographic regions, and the early childhood providers and supporting system.

Texas PDG B-5 Implementation

TEA is leading the TPDG project with support from six other agencies, including the Texas Department of Agriculture, DFPS, Texas Department of State Health Service, Texas Head Start State Collaboration Office, Texas Health and Human Services Commission, and the Texas Workforce Commission. Through the PDG B-5 grant, Texas plans to carry out several projects that are focused on fulfilling Texas's vision for its early childhood system – thriving children in strong Texas families empowered by state and local systems.[74]

The state's grant application and logic model included goals and objectives inclusive of child welfare in the broader early childhood system.[75]

Activity	Goal	Objectives
1. Needs Assessment	Clear picture of current landscape of Texas's early childhood system	• Identify needs of the early childhood system • Identify opportunities for coordination and alignment
2. Strategic Plan	Coordinated statewide system of early childhood programs and services	• Obtain buy-in from stakeholders • Create a coordinated governance structure for Texas's early childhood system
3. Maximizing Parent Choice and Knowledge	Families empowered by state and local systems	• Increase families' awareness of programs/ services • Increase families' access to programs/ services • Increase families' knowledge to support their children's development
4. Sharing Best Practices	Efficient state and local early childhood systems	• Increase utilization of shared services • Increase capacity and connected strategic plans for local systems • Increase coordination between child care providers and Early Childhood Intervention
5. Improving Overall Quality	High-quality early childhood programs and services	• Expand and enhance continuous quality improvement structure • Increase targeted professional development

The TEA site does not include additional information about TPDG implementation status.

FFPSA and TPDG Harris County Community-Based Care Considerations

Both the FFPSA and TPDG project could have significant implications for Harris County's community-based care implementation. Because both initiatives are developing/in progress, these considerations are speculative and general. Harris County should engage with DFPS and TEA to influence analysis and decision making occurring through these initiatives.

Prevention Focus

One of the primary goals of FFPSA is to shift the child welfare system from one that primarily responds to crises to one that is able to avert crises by strengthening individuals, families, and communities. This shift in the child welfare system from a focus on crisis response to a focus on prevention and strengthening people is profound and should have a significant impact on the structure and functioning of child welfare and the broader early childhood and family support system. Through FFPSA, families who are identified as being at risk for having their children removed from their home are eligible for evidence-based mental health prevention and treatment services, substance use disorder prevention and treatment services, and family support services. Prevention services are not income-tested. The prevention services should be successful in keeping more children and youth at home and in their communities, which would decrease the need and demand for foster care placement.

The federal government and Texas are defining what prevention services and supports will be allowable and used. Harris County could engage with the state to help define the menu of evidence-based prevention services that will be included in the state's prevention plan.

TPDG work within Activity 4 – sharing best practices – could potentially be used to support professional and organizational development efforts that are needed to increase capacity in selected evidence-based prevention services.

Aftercare Services

The FFPSA pays for six months of aftercare services and supports for children, youth, and their families to support stability after a child or youth is discharged or permanently placed. These services could reduce the multiple placement and recidivism issues in Harris County's foster care system. Harris County could work with local providers and the state to define how aftercare services will function locally.

Placement Capacity and Quality

A goal of FFPSA is to limit the use of congregate care. FFPSA is shifting the landscape of foster placements by modifying the definition of the family foster home and adding the residential family-based treatment facility option and the Qualified Residential Treatment Program (QRTP). QRTPs are similar to residential treatment centers (RTCs), but must also:[76]

- Use a trauma-informed treatment model to address the needs of children and youth with serious emotional or behavioral disorders/disturbances;
- Have nursing or other licensed clinical staff on site during business hours, in accordance with the required trauma-informed treatment model, and 24-hours-a-day/seven-days-a-week availability;
- Involve family in the treatment process;

- Document the integration of family, including sibling connections;
- Be licensed by the state and accredited; and
- Provide discharge planning and family-based aftercare for at least six months post-discharge.

Statewide changes to family foster care and QRTP/RTC regulations and policy will affect Harris County providers and possibly change capacity. Harris County should engage with state policy makers to help define the congregate care decisions for the state.

System Coordination

TPDG is highly focused on improving early childhood system coordination, including child welfare. Needs assessment findings and strategic planning efforts could address opportunities for increasing and improving coordination among child welfare, early childhood care and education, behavioral health, physical health, home visiting, early intervention, and other early childhood sectors and providers. Findings and recommendations could affect governance, funding, regulations, policies, and processes at the state and local level. This could have a variety of implications for Harris County. Harris County should ensure it participates in the needs assessment and strategic implementation and evaluation planning efforts led by the Texas Education Agency.

Using Data to Support Continuous Improvement

FFPSA and TPDG have requirements for data deduplication and increased/improved use of data in decision making to support continuous improvement processes. The goal is to be able to easily view and analyze data regarding the full suite of services and supports used by children, youth, and families; connect interventions to outcomes; and better coordinate service delivery. There will likely be opportunities to participate in data-related projects through TPDG or FFPSA planning efforts.

Family Engagement and Support

The TPDG will increase engagement of families and caregivers, including foster families and kinship care providers, through increased provision of information and other mechanisms. TPDG could be a mechanism for increasing foster family training to help them address the trauma and mental health needs of children and youth in their care.

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[1] Texas Department of Family and Protective Services. (2019, April). *Residential (24) hour operations*. Retrieved from https://www.dfps.state.tx.us/Child_Care/Search_Texas_Child_Care/ppFacilitySearchResidential.asp
[2] Operations without a listed capacity (including all listings for emergency services only) are not included.
[3] Texas Department of Family and Protective Services. (2019, April).
[4] CPAs with a listed capacity of one (1) or none are not included.

[5] Magellan Health Services (2010). Perspectives on residential and community-based treatment for youth and families: Magellan Health Services Child Services Task Force. 23rd Annual Children's Mental Health Research & Policy Conference. https://www.magellanhealth.com/media/445489/innovativeapproach2.pdf
[6] Wittacker, J., et.al. (2016). A consensus statement of the international work group on therapeutic residential care. *Residential Treatment for Children & Youth, 33*(2), 89-106.
[7] Magellan Health Services (2010). Perspectives on residential and community-based treatment for youth and families: Magellan Health Services Child Services Task Force. 23rd Annual Children's Mental Health Research & Policy Conference. https://www.magellanhealth.com/media/445489/innovativeapproach2.pdf
[8] Blau, G., Caldwell, B., Lieberman, R.E. (2014). *Residential Interventions for Children, Adolescents, and Families: A Best Practice Guide*. Routledge. NY.
[9] Geurts, E.M.W, Bobby, J., Noom, M.J., & Knorth,E.J. (2012). Family-centered residential care: The new reality? *Child & Family Social Work*, 17, 170-179. Doi: 10/1111/j.1365-2206.2012.00838.x
[10] Association of Children's Residential Centers. http://togetherthevoice.org.
[11] Blau, G.M., Caldwell,B., Fisher, S.K., Kumppinger, A., Levison-Johnson, J., & Lieberman, R. (2010). The Building Bridges Initiative: Residential and community-based providers, families, and youth coming together to improve outcomes. *Child Welfare, 89*(2), 21-38.
https://www.researchgate.net/publication/46392288_The_Building_Bridges_Initiative_Residential_and_Community-Based_Providers_Families_and_Youth_Coming_Together_to_Improve_Outcomes
[12] Building Bridges Initiative. (July 2017). Implementing Effective Short-Term Residential Interventions: A Building Bridges Initiative Guide. Retrieved from
http://www.buildingbridges4youth.org/sites/default/files/BBI%20Short%20Term%20Residential%20Intervention%20Guide.pdf
[13] Cornell University. College of Human Ecology. (n.d.) CARE overview. Retrieved from:
http://rccp.cornell.edu/care/care_main.html
[14] The California Evidence-Based Clearinghouse for Child Welfare: Information and Resources for Child Welfare Professionals. (2018, June). Child and Resident Experience (CARE). Retrieved from
http://www.cebc4cw.org/program/children-and-residential-experiences-care/
[15] Residential Child Care Project, Cornell University. (n.d.). *Children and residential experiences: Creating conditions for change.* Information Bulletin. http://rccp.cornell.edu/_assets/CARE_INFO_BULLETIN_2016.pdf
[16] The California Evidence-Based Clearinghouse for Child Welfare: Information and Resources for Child Welfare Professionals. (2018, June). Child and Resident Experience (CARE). Retrieved from
http://www.cebc4cw.org/program/children-and-residential-experiences-care/detailed
[17] Sanctuary Web. (n.d.). The Sanctuary Model. Retrieved from http://sanctuaryweb.com/TheSanctuaryModel.aspx
[18] Bloom, S.l. (2005). The Sanctuary Model of Organizational Change for Children's Residential Treatment. *Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations, 26*(1), 65-81.
[19] Redlich Horwitz Foundation. (n.d.). Foster & kinship parent recruitment and support best practice inventory. New York, NY: Author. Retrieved from https://www.bcny.org/wp-content/uploads/2019/02/EMAIL-VERSION-Inventory_links.pdf
[20] Casey Family Programs. (2018, October 3). *How can we improve placement stability for children in foster care?* [Strategy Brief: Strong Families]. Seattle, WA: Author. Retrieved from https://www.casey.org/strategies-improve-placement-stability/
[21] Foster & Adoptive Care Coalition. (n.d.) *30 days to family: Achieving results for children, families, and child welfare*. Retrieved from https://www.foster-adopt.org/wp-content/uploads/2017/08/2016_30DaystoFamily_Results_Updated.pdf
[22] Casey Family Programs. (2018, October 3). *How can we improve placement stability for children in foster care?* [Strategy Brief: Strong Families]. Seattle, WA: Author. Retrieved from https://www.casey.org/strategies-improve-placement-stability/
[23] Redlich Horwitz Foundation. (n.d.). Foster & kinship parent recruitment and support best practice inventory. New York, NY: Author. Retrieved from https://www.bcny.org/wp-content/uploads/2019/02/EMAIL-VERSION-Inventory_links.pdf
[24] Casey Family Programs. (2018, September 24). *What are some effective strategies for achieving permanency?* [Strategy Brief: Strong Families]. Seattle, WA: Author. Retrieved from https://www.casey.org/effective-strategies-achieving-permanency/

[25] Casey Family Programs. (2018, September 24).
[26] Casey Family Programs. (2018, September 24).
[27] Redlich Horwitz Foundation. (n.d.). Foster & kinship parent recruitment and support best practice inventory. New York, NY: Author. Retrieved from https://www.bcny.org/wp-content/uploads/2019/02/EMAIL-VERSION-Inventory_links.pdf
[28] Casey Family Programs. (2018, September 24). *What are some effective strategies for achieving permanency?* [Strategy Brief: Strong Families]. Seattle, WA: Author. Retrieved from https://www.casey.org/effective-strategies-achieving-permanency/
[29] Casey Family Programs. (2018, October 3). *How can we improve placement stability for children in foster care?* [Strategy Brief: Strong Families]. Seattle, WA: Author. Retrieved from https://www.casey.org/strategies-improve-placement-stability/
[30] Oregon Social Learning Center. (n.d.). *KEEP based on research conducted at OSLC*. Retrieved from http://www.oslc.org/projects/keep/
[31] Child Trends. (n.d.). *KEEP program*. Retrieved from https://www.childtrends.org/programs/keep-program/
[32] California Evidence-Based Clearinghouse for Child Welfare. (2017, March). *Trauma Systems Therapy (TST)*. Retrieved from https://www.cebc4cw.org/program/trauma-systems-therapy-tst/detailed
[33] Trauma Center at Justice Resource Institute. (2007). *Attachment, regulation, and competency (ARC)*. Retrieved from http://www.traumacenter.org/research/ascot.php
[34] Connecting Parent Group. (2018). *Connect*. Retrieved from http://connectparentgroup.org
[35] Redlich Horwitz Foundation. (n.d.).
[36] Casey Family Programs (2018, October 3). *How can we improve placement stability for children in foster care?* [Strategy Brief: Strong Families]. Seattle, WA: Author. Retrieved from https://www.casey.org/strategies-improve-placement-stability/
[37] Shannahan, R., & Fields, S. (2016, May). *Services in support of community living for youth with serious behavioral health challenges: Mobile crisis response and stabilization services*. National Technical Assistance Network for Children's Behavioral Health. Retrieved from http://www.wraparoundohio.org/wraparoundohio.com/wp-content/uploads/2018/01/MobileCrisisResponseStabilizationServicesMay2016.pdf
[38] Jerve, J., Jorgenson, K., Leidner, S., Martin-Hushman, D., Boo, M., & Romo, C. (2013, June). *Taking a break: Creating foster, adoptive, and kinship respite care in your community.* North American Council on Adoptable Children (NACAC), the National Foster Parent Association (NFPA), and the Collaboration to AdoptUSKids. Retrieved from http://www.adoptuskids.org/_assets/files/NRCRRFAP/resources/taking-a-break-respite-guide.pdf
[39] Chamberlain P., & Reid, J. B. (1991). Using a specialized foster care community treatment model for children and youth leaving the state mental hospital. *Journal of Community Psychology*, *19*, 266–276.
Hoagwood, K., Burns, B. J., Kiser, L., Ringeisen, H, & Schoenwald, S. K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, *52*, 1179–89.
Kazdin, A. E., & Weisz, J. R. (Eds.). (2003). *Evidence-based psychotherapies for children and youth*. New York: Guilford Press.
[40] Weisz, J. R., Doss, J. R., Jensen, A., & Hawley, K. M. (2005). Youth psychotherapy outcome research: A review and critique of the evidence base. *Annual Review of Psychology*, *56*, 337–363.
[41] Murray, M., Culver, T., Farmer, B., Jackson, L.A., & Rixon, B. (2014). From theory to practice: One agency's experience with implementing an evidence-based model. *Journal of Child and Family Studies, 23*(5), 844-853. Retrieved from https://sites.duke.edu/tftc/files/2015/11/Murray-et-al.-2014.pdf
[42] Casey Family Programs. (2018, October 3). *How can we improve placement stability for children in foster care?* [Strategy Brief: Strong Families]. Seattle, WA: Author. Retrieved from https://www.casey.org/strategies-improve-placement-stability/
[43] Triple P: Positive Parenting Program. (n.d.). *Triple P takes the guesswork out of parenting*. Retrieved from https://www.triplep.net/glo-en/home/
[44] Sage Neuroscience Center. (2019). *Infant-Parent Psychotherapy (IPP)*. Retrieved from https://sageclinic.org/infant-parent-psychotherapy-ipp/
[45] National Child Traumatic Stress Network. (2012). *Child Parent Psychotherapy*. Retrieved from https://www.nctsn.org/interventions/child-parent-psychotherapy
[46] California Evidence-Based Clearinghouse for Child Welfare. (2015, December). *Nurturing Parenting Program for Parents and their Infants, Toddlers, and Preschoolers*. Retrieved from

https://www.cebc4cw.org/program/nurturing-parenting-program-for-parents-and-their-infants-toddlers-and-preschoolers/
[47] Casey Family Programs. (2018, October 3). *How can we improve placement stability for children in foster care?* [Strategy Brief: Strong Families]. Seattle, WA: Author. Retrieved from https://www.casey.org/strategies-improve-placement-stability/
[48] The John Praed Foundation. (2015). *Family Advocacy and Support Tool (FAST)*. Retrieved from https://praedfoundation.org/tools/the-family-advocacy-and-support-tool-fast/
[49] National Center for Evidence-Based Practices in Child Welfare. (n.d.). *What is CBT+?* Retrieved from http://www.ncebpcw.org/cbt
[50] Alexander, J., Barton, C., Gordon, D., Grotpeter, J., Hansson, K., Harrison, R., et al. (1998). *Blueprints for violence prevention series, book three: Functional family therapy (FFT).* Boulder, CO: Center for the Study and Prevention of Violence.
[51] Rowland, M., Johnson-Erickson, C., Sexton, T., & Phelps, D. (2001). A statewide evidence-based system of care. Paper presented at the 19th Annual System of Care Meeting. Research and Training Center for Children's Mental Health.
[52] Bruns, E. J., Walker, J. S., Adams, J., Miles, P., Osher, T. W., Rast, J., VanDenBerg, J. D. & National Wraparound Initiative Advisory Group. (2004). *Ten principles of the wraparound process*. Portland, OR: National Wraparound Initiative, Research, and Training Center on Family Support and Children's Mental Health, Portland State University.
Aos, S., Phipps, P., Barnoski, R., & Lieb, R. (2001). *The comparative costs and benefits of programs to reduce crime.* Olympia: Washington State Institute for Public Policy.
Hoagwood, K., Burns, B. J., Kiser, L., Ringeisen, H, & Schoenwald, S. K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services, 52*(9), 1179-89.
[53] For additional information on the phases of the wraparound process, see information at http://www.nwi.pdx.edu/NWI-book/Chapters/Walker-4a.1-(phases-and-activities).pdf
[54] Washington State Department of Social and Health Services. (n.d.). *HOMEBUILDERS intensive family preservation*. Retrieved from https://www.dshs.wa.gov/node/3303
[55] Institute of Family Development. (n.d.). *Programs: HOMEBUILDERS – IFPS*. Retrieved from http://www.institutefamily.org/programs_ifps.asp
[56] The California Evidence-Based Clearinghouse for Child Welfare (2018, May). *Homebuilders*. Retrieved from http://www.cebc4cw.org/program/homebuilders/detailed
[57] Oregon Social Learning Center. (n.d.). *KEEP based on research conducted at OSLC*. Retrieved from http://www.oslc.org/projects/keep/
[58] Child Trends. (n.d.). *Keep program*. Retrieved from https://www.childtrends.org/programs/keep-program/
[59] Shannahan, R., & Fields, S. (2016, May). *Services in support of community living for youth with serious behavioral health challenges: Mobile crisis response and stabilization services*. The Technical Assistance Network. Retrieved from http://www.wraparoundohio.org/wraparoundohio.com/wp-content/uploads/2018/01/MobileCrisisResponseStabilizationServicesMay2016.pdf
[60] Hoagwood, K., Burns, B. J., Kiser, L., Ringeisen, H, & Schoenwald, S. K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, *52*, 1179–89.
Hogue, A. T., Liddle, H.A., Becker, D., & Johnson-Leckrone, J. (2002). Family-based prevention counseling for high-risk young youth: Immediate outcomes. *Journal of Community Psychology*, *30*(1), 1–22.
Liddle, H. A., Dakof, G. A., Parker, K., Diamond, G. S., Barrett, K., & Tejeda, M. (2001). Multidimensional Family Therapy for adolescent drug abuse: Results of a randomized clinical trial. *American Journal of Drug and Alcohol Abuse*, *27*, 651–687.
[61] MST Services. (2017). *MST-CAN's Child Welfare Program*. Retrieved from http://www.mstservices.com/mst-can-child-welfare-program.
[62] California Evidence-Based Clearinghouse for Child Welfare. (2015, December). *Nurturing Parenting Program for Parents and their Infants, Toddlers, and Preschoolers*. Retrieved from https://www.cebc4cw.org/program/nurturing-parenting-program-for-parents-and-their-infants-toddlers-and-preschoolers/
[63] Parents as Teachers. (2019). *Evidence-based model.* Retrieved from https://parentsasteachers.org/evidence-based-model

[64] Cohen, J. A., & Mannarino, A. P. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child & Adolescent Psychiatry*, *35*(1), 42–50.
King, N., Tonge, B., Mullen, P., Myerson, N., Heyne, D., Rollings, S., Martin, R., & Ollendick, T. (2000). Treating sexually abused children with posttraumatic stress symptoms: A randomized clinical trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, *39*(11), 1347–1355.
Mannarino, A. P., & Cohen, J. A. (1996). A follow-up study of factors that mediate the development of psychological symptomatology in sexually abused girls. *Child Maltreatment*, *1*(3), 246–260.
Stein, B., Jaycox, L., Kataoka, S., Wong, M., Tu, W., Elliott, M., & Fink, A. (2003). A mental health intervention for school children exposed to violence: A randomized controlled trail. *Journal of the American Medical Association*, *290*(5), 603–611.
[65] Ford, J. D., Steinberg, K. L., Hawke, J., Levine, J., & Zhang, W. (2012). Randomized trial comparison of emotion regulation and relational psychotherapies for PTSD with girls involved in delinquency. *Journal of Clinical Child & Adolescent Psychology*, *41*(1), 27–37.
[66] James Bell Associates. (2018, July). *Profiles of the active Title IV-E Child Welfare Waiver Demonstrations*. Arlington, VA: Author.
[67] Casey Family Programs. (2015, October 15). *Research evidence and benefit-cost data for Title IV-E Waiver interventions* [Research Brief, Third Edition, Safe, Strong, Supportive]. Retrieved from https://www.casey.org/title-iv-e-research/
[68] Baldwin, M. J., & Rozeff, L. (2016, January–February). Partnering to improve mental health outcomes in child welfare. *Children's Bureau Express, 16(*10). Retrieved from https://www.cbexpress.acf.hhs.gov/index.cfm?event=website.viewArticles&issueid=173&articleID=4658&keywords=national%20center%20evidence%20based%20practice%20child%20welfare
[69] National Center for Evidence-Based Practice in Child Welfare. (n.d.). *Partnering for Success.* Retrieved from http://www.ncebpcw.org/partnering-for-success
[70] Bipartisan Budget Act of 2018, HR 1892—169, Title VII—Family First Prevention Services Act, Subtitle A—Investing in Prevention and Supporting Families, Sec. 50702. Purpose. Retrieved from https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf
[71] First Focus Campaign for Children. (March 2018). *Family First Prevention Services Act: Section by section*. Retrieved from https://campaignforchildren.org/wp-content/uploads/sites/2/2016/06/FFCC-Section-by-Section-FFPSA.pdf
[72] Texas Department of Family and Protective Services. (n.d.). *Family First Prevention Services Act*. Retrieved from https://www.dfps.state.tx.us/Child_Protection/Family_First/default.asp
[73] Administration for Children and Families, Office of Child Care. (2018, August 23). *Preschool Development Grant Birth through Five grant competition*. U.S. Department of Health and Human Services. Retrieved from https://www.acf.hhs.gov/occ/resource/pdg-b-5-initiative
[74] Texas Education Agency. (n.d.). *ECE grants: Preschool Development Grant Birth-Five*. Retrieved from https://tea.texas.gov/Academics/Early_Childhood_Education/ECE_Grants/
[75] Texas Education Agency. (n.d.).
[76] Texas Department of Family and Protective Services. (n.d.). *Family First Prevention Services Act*. Retrieved from https://www.dfps.state.tx.us/Child_Protection/Family_First/default.asp