The conclusions or interpretations expressed herein do not represent the conclusions, interpretations, or policies of Texas Department of Family and Protective Services (DFPS). Any data referenced in this report was compiled and calculated by Mission Capital and may not be aligned with the methodology used by DFPS.
EXECUTIVE SUMMARY

The Michael & Susan Dell Foundation and the Reissa Foundation supported Mission Capital in conducting a landscape analysis to identify how Region 7 might build on existing assets and collaborative practices to prepare for Community-Based Care (CBC). Using a variety of methods including interviews, focus groups, surveys, document review, and analysis of child-level data provided by the Department of Family and Protective Services, Mission Capital collected information on the challenges and opportunities across the region and assessed how they might impact CBC readiness. This report presents a summary of the findings from the landscape analysis, insights gained from stakeholders across the state, and recommendations for how communities might begin to expand their capacity to serve families and children.

WHAT IS COMMUNITY-BASED CARE?

Community-Based Care (CBC) is a coordinated regional approach to foster care and case management services that fully engages the community in serving children, youth, and families by creating an enhanced service delivery model. The goal of CBC is to coordinate care so that children can receive the services they need while they remain in their own communities. Remaining close to home helps keep children connected to family members, schools, and peers, thereby improving their overall well-being.

Under CBC, Texas is divided into designated geographic service areas, called catchment areas. Within a catchment service area, a single agency, known as a Single Source Continuum Contractor (SSCC), is responsible for developing a network of foster care placements, case management, wrap-around support services, kinship support, adoption services, and reunification services. Under CBC, Region 7 will be divided into two catchment areas, 7A and 7B, as shown above. There are current community collaborative groups in the process of completing assessments that may be used to inform existing catchment area boundaries, meaning there may be additional changes once those groups complete their work.

Although the Department of Family and Protective Services (DFPS) has not set a date for when CBC will expand to Region 7 in Texas, child placing agencies and community organizations in the region are already working together to create a network of services and placement options to improve the quality of care provided to children.
WHAT ARE KEY CHALLENGES IN REGION 7?

Over 68 percent of children and youth are currently placed outside of their home counties. Capacity constraints result in 43 percent of children and youth in foster care in Region 7 being placed beyond the boundaries of their home county, but in the region, and another 25 percent being placed outside of the region.

As foster care capacity is built within catchment areas, special consideration should be given to categories of youth who show higher rates of being placed out of the region, including:

- Youth ages 13 - 17
- Children and youth with higher needs
- Children and youth who have been in care three years or longer

There is a lack of service providers to meet the needs of children and youth, especially in small counties. There is a need for additional service capacity in all counties, but there is a particular need for increased service capacity in small counties with populations under 25,000. Key indicators of service capacity limitations include:

- 43% of Region 7 children/youth in foster care are placed outside home county.
- 25% of Region 7 children/youth in foster care are placed outside region.
- Over 68 percent of children and youth are currently placed outside of their home counties.
- There is a lack of service providers to meet the needs of children and youth, especially in small counties.
- Overall, there is a lack of accessible & quality resources for birth parents involved in the child welfare system.

The structure and contract requirements of CBC create challenges.

- The boundary between 7A and 7B does not reflect the mobility of children/youth and families or the fluidity of service delivery structures within the region.
- Federal requirements to keep children/youth within 50 miles of their place of removal may reduce the distance in which they are placed, but distance alone does not ensure that children/youth are kept within their own community.
- Despite the investment made by the Texas Legislature, state funding allocated to Single Source Continuum Contractors (SSCC) in other regions was consistently reported as inadequate to cover the full costs associated with implementing CBC.
There are additional considerations for meeting the needs of all children and youth.

- With Hispanic children and youth representing 36 percent of children in the child welfare system in Region 7, the necessity for Spanish speaking homes and service providers is evident.

- Disproportionate representation of African American children in substitute care suggests a need to educate staff and community members on how racial bias results in discriminatory decision-making.

- LGBTQ+ youth experience a larger number of disruptions and are more likely to be placed in a congregate care setting.

- Young adults ages 18-21 in foster care tend to live along the I-35 highway corridor and require additional assistance to transition out of care, suggesting the need for these counties to develop supports for these transition-age young adults.

- Youth in foster care are at increased risk for sex trafficking, indicating a need for organizations to learn the signs of exploitation and identify support programs in this area.

WHAT COMMUNITY ASSETS CAN REGION 7 BUILD ON?

An existing commitment to quality care for children and families in Region 7.

Communities across Region 7 are committed to ensuring families have the support and services necessary to provide children and youth safe, loving, and permanent homes. They have a shared vision where all communities:

- Have the capacity for children and youth to stay in their community while they are in substitute care, allowing proximity to family, school, and a strong network of support.

- Can connect children, youth, young adults, and families with resources and support services that are strengths-based, trauma-informed, and culturally and linguistically appropriate.

- Provide birth parents the opportunity to co-parent with the foster family while a child is in foster care.
Existing collaborative efforts across the region create a foundation for building a strong response Community Based Care.

Community-Based Care transfers most of the responsibilities currently held by DFPS to a Single Source Continuum Contractor (SSCC). Region 7 has a number of existing collaborative initiatives that are impacting service delivery. It is imperative that the community organizations continue to come together to begin the journey of preparing for Community-Based Care. This includes:

- Building their collective capacity to communicate effectively as a network
- Collecting and sharing data
- Establishing a common understanding of quality of care

The voices of children, youth & parents with lived experience are an asset that should be incorporated into planning and decision making at all levels.

Children, youth, and their parents involved in the child welfare system have insights based on lived experience that are incredibly important to creating a system of care that works for them. Parents in particular believe that opportunities for meaningful involvement in decision-making that affects their lives would impact their motivation, engagement with services, and overall case outcomes. In addition to having greater influence within their own cases, there is a significant need to include those with lived experience in decision-making for system-wide child welfare initiatives, including the implementation of CBC in Region 7.

High rates of kinship placements in Region 7 provide an opportunity for children to stay connected with their family and community.

Over 60 percent of children and youth who have been removed from their homes in Region 7 were placed with kinship caregivers or noncustodial parents, surpassing the state average of 46 percent. This indicates a significant need for communities to ensure there are support services available not only for paid foster families but also for relatives who are temporary caregivers while a child or youth is out of their parents’ home.

Lessons learned from Single Source Continuum Contractors (SSCC) that have implemented CBC can guide the way forward for Region 7.

SSCCs in other regions of the state have learned important lessons learned that can guide the work of Region 7, thereby preventing some of the pitfalls and challenges encountered. Specifically, SSCCs recommend:

- Conduct early research.
- Understand and build capacity to meet the unique needs of youth in foster care.
- Invest in staffing and salaries to provide quality care and safety for children and youth.
- Develop alternative funding sources to supplement reimbursement by the state.
- Build capacity to collect, manage, and use data that not only complies with state contract requirements but also supports program improvement and community decision-making.
WHAT ARE THE NEXT STEPS?

The information contained in this report is intended to provide communities across Region 7 with a common understanding of the opportunities and challenges related to increasing their capacity to care for children and youth in foster care. Using the detailed findings included in the body of the report as a platform for discussion, as well as county specific information that can be generated using the data sources included, community organizations, stakeholders and families should begin a planning process to prepare for the implementation of Community-Based Care in Region 7.

The Department of Family and Protective Service’s latest Implementation Plan for the Texas Community-Based Care System (issued December 2019) indicates that the current division of Region 7 into two catchment areas would remain in place. According to the plan, all areas of the state will have begun implementation of CBC by the end of state fiscal year 2027. As an immediate next step, it is recommended that the catchment areas begin to have conversations about how they might organize themselves for a community-led planning process to prepare for CBC. This would include the development of a leadership group that is representative of the counties and stakeholders in each catchment area, which would then guide the work moving forward.
LANDSCAPE ANALYSIS

Community-Based Care (CBC) is a coordinated regional approach to foster care and case management services that fully engages the community in serving children, youth, and families by creating an enhanced service delivery model. The goal of CBC is to coordinate care so that children and youth can receive the services they need while they remain in their own communities. Remaining close to home helps keep children and youth connected to family members, schools, and peers, thereby improving their overall well-being.

As CBC rolls out across the Texas, the Department of Family and Protective Services (DFPS) will sign contracts with a Single Source Continuum Contractor (SSCC) in each of its defined service areas. The SSCC then takes on many of the responsibilities formerly assigned to DFPS staff, including:

- Developing foster care capacity
- Building a network of providers
- Engaging the community to help
- Providing foster care and kinship care placement services
- Coordinating and delivering services to children and youth in foster care and their families
- Providing case management services

The purpose of this landscape analysis was to collect information on how Region 7 might build on existing assets and collaborative practices to develop an innovative, coordinated response when DFPS brings CBC to the region. Information sources included a region-wide survey, stakeholder interviews, focus groups, document review, internet research, child-level data from DFPS, regional data from the DFPS Data Portal and open records requests, provider contract information, and interviews with Single Source Continuum Contractors from catchment areas currently implementing CBC. Appendix C contains a summary of information gained through each of these sources as well as a list of organizations that participated.
SPECIFIC QUESTIONS INVESTIGATED DURING THIS PROCESS INCLUDED:

- What does data from the child welfare system tell us about the characteristics of children and youth in the region?

- What is the current service capacity across the region?

- What data is currently being collected and evaluated by organizations in Region 7 to assess quality and drive service decisions?

- How can lessons learned and best practices from existing CBC regions inform CBC in Region 7?

- What communication channels, networks, and collaborations exist in Region 7 that might be leveraged to share information and think strategically about implementing CBC in Region 7?

- What are the unique challenges and opportunities in Region 7, that will affect implementation of CBC and impact high-quality service delivery to children, youth, and families?

- How might the current division of Region 7 into two catchment areas affect the availability and quality of services necessary to help children, youth, and families engaged with the child welfare system achieve healing and permanency?

- Are there additional considerations for how Region 7 might be divided?

- What other factors, such as the Family First Prevention Services Act, affect CBC readiness and implementation?

Although this project was initially developed to provide a landscape analysis for how Region 7 could respond to CBC as defined by DFPS, the information and findings also serve to inform counties of opportunities to build their service capacity.
A SHARED VISION FOR SUCCESS

Although there is not a published date for when DFPS plans on bringing Community-Based Care to Region 7, child placing agencies and community organizations in the region are already working together to create a network of services and placement options that improve the quality of care provided to children and youth.

There are many existing collaborative efforts across the region that are working to improve the outcomes of children and youth in foster care and their families. Region 7 communities are committed to ensuring families have the support and services necessary to provide children and youth safe, loving, and permanent homes.

Through interviews, region-wide meetings, focus groups, and an online survey, a shared definition of successful community service capacity emerged:

Success = Homes that support the needs of children and youth + Accessible services that are strengths-based and trauma-informed + Support for birth families

As a result:

- **Children and youth stay in their community**, allowing proximity to family, school, and strong support network.

- **Linguistically and culturally responsive services and resources are accessible** in the community to:
  - Address the health and healing needs of children, youth, and young adults
  - Support foster families and kinship caregivers
  - Ensure placement in a least restrictive environment
  - Minimize placement disruptions and time in substitute care, as defined as foster or kinship care
  - Provide transition support services to youth aging out of care

- **The community connects families** with resources and support services that are strengths-based, trauma-informed, and culturally and linguistically appropriate.

- **Birth parents are provided the opportunity to co-parent with the foster family** while a child is in foster care.
CHARACTERISTICS OF REGION 7

Region 7 is located in Central Texas and borders seven of the 10 other Child Protective Services (CPS) regions. The state headquarters for the Department of Family and Protective Services is also located within the boundaries of the region.

The region is a 30-county area that includes both urban and rural communities. Counties in the region include Bastrop, Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Caldwell, Coryell, Falls, Fayette, Freestone, Grimes, Hamilton, Hays, Hill, Lampasas, Lee, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Travis, Washington, and Williamson.

To better understand county needs in this report, population size was used to identify small (under 25,000), medium (25,000 to 100,000), and large (over 100,000) counties. Using these criteria, there are 14 small counties, 10 medium counties, and six large counties in Region 7 as shown in the map below. The largest county in the region is Travis County with a population of over 1.2 million, and the smallest county is Mills County with a population of just over 5,000.

Throughout Texas, there are multiple child welfare organizations that cross county boundaries and provide services for larger territories. Those organizations that are represented in Region 7 include:

7 Local Mental Health Authorities (LMHA) that deliver mental health services to children, youth, and families.

9 Children’s Advocacy Centers where law enforcement, child protective services, prosecution, and medical and mental health professionals may share information and develop effective, coordinated strategies for each child.

12 Court Appointed Special Advocate (CASA) programs that support and promote court-appointed advocates for abused and/or neglected children and youth to provide them a safe and healthy environment in permanent homes.

24 juvenile probation departments that provide for public safety while addressing the needs of juvenile offenders, families, and victims of crime, and assist parents in collecting and distributing court-ordered child support.

186 school districts that provide educational services to students.
**SUBSTITUTE CARE**

Provided from the time a child is removed from their home due to abuse and/or neglect and placed in CPS conservatorship until the child returns home safely or is placed in another living arrangement that does not require CPS supervision.

**LICENSED FOSTER CARE**
Throughout this report, foster care refers to licensed foster placements, including licensed kinship care placements.

**RELATIVE CARE**
Relative care refers to unpaid placements with a relative or family friend.

---

**DEMOGRAPHICS OF CHILDREN AND YOUTH IN CARE IN REGION 7**

At the end of December 2019, there were 5,028 children and youth from Region 7 in substitute care.²

- 4 out of 5 children/youth in foster care are under 13, and nearly half are under 5.
- 48% are girls, and 52% are boys, nearly equal, mirroring the region’s gender ratio.³

The number of boys and girls in substitute care is nearly equal, mirroring the region’s gender ratio.³

**AGE OF CHILDREN/YOUTH IN REGION 7 SUBSTITUTE CARE**

- 18% ages 13 - 17
- 49% ages 0 - 5
- 52% ages 6 - 12
- 3% ages 18+

Source: December 31, 2019, child-level data provided by DFPS
The racial makeup of children and youth shows a disproportionate number of African American children/youth in substitute care compared to the general child population in the region.

Percent of children/youth in Region 7 foster care who are African American

[24%]

There are about 2.5 times as many African American children/youth in substitute care compared to their proportion in the population of Region 7.

Percent of children/youth in Region 7 who are African American

[10%]

Although language data were not available, the high proportion of Hispanic children/youth indicates a need for Spanish language services.

There are similar proportions of Anglo and Hispanic children/youth in substitute care.

Source: December 31, 2019, child-level data provided by DFPS
PLACEMENT INFORMATION

RELATIVE & FOSTER CARE

Fifty-eight percent (58%) of children and youth ages 0-17 in the region were placed with relatives, surpassing the state average of 46 percent. The race and gender diversity of children and youth placed in relative care mirrored that of those placed in foster care, though a higher percentage of children and youth are younger in relative placements.4

### CHILDREN/YOUTH PLACED IN FOSTER PLACEMENTS VS. WITH RELATIVES

<table>
<thead>
<tr>
<th>Age</th>
<th>Foster Placements</th>
<th>Relatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 5</td>
<td>45%</td>
<td>51%</td>
</tr>
<tr>
<td>6 - 12</td>
<td>27%</td>
<td>33%</td>
</tr>
<tr>
<td>13 - 17</td>
<td>25%</td>
<td>13%</td>
</tr>
</tbody>
</table>

The majority of Region 7 children/youth were placed with relatives.

For youth 13 and older, twice the proportion of youth were placed in foster placements, whereas a higher proportion of children 12 and younger were placed with relatives.

Source: December 31, 2019, child-level data provided by DFPS
The majority of children/youth in foster placements were categorized as needing **basic level of care**.

**LEVEL OF CARE, AGES 0 - 17**

Each child placed in foster care is assessed for the level of services they need. The assessment may be done by a third-party contractor or the CPS caseworkers and supervisor. The resulting level of care designation is then used to determine the most appropriate placement options for the child. Of the 2,087 children and youth ages 0-17 in Region 7 in foster placements at the end of December 2019, 64 percent were categorized as needing a basic level of care. 5 *(Definitions of each level of care can be found in Appendix D.)*

<table>
<thead>
<tr>
<th>Level</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTENSE</td>
<td>5%</td>
</tr>
<tr>
<td>SPECIALIZED</td>
<td>14%</td>
</tr>
<tr>
<td>MODERATE</td>
<td>10%</td>
</tr>
<tr>
<td>BASIC</td>
<td>64%</td>
</tr>
</tbody>
</table>

*Note: “Other” is not shown. Source: December 31, 2019, child-level data provided by DFPS*
While there are many factors to consider when identifying placement needs for children and youth in care, finding healing placements close to home is a significant priority. Many national child welfare experts, as well as local stakeholders, stress the need for developing a foster care network that is neighborhood and community based. The Children’s Bureau notes, "Keeping children within their own community and relying on the community for services and support have been a part of good child welfare practice for decades." Under CBC contracts, success in keeping children and youth close to home is based on the percentage of children and youth who are placed within 50 miles of their home. Keeping children and youth close to their community is critical in order to help ensure:

**Stability.** When children and youth are placed away from home, they are uprooted from everyone and everything they know in their lives. It is critical that the connections children and youth have to family, friends, and school be maintained to the extent possible.

**Access to birth family.** When it is in a child’s best interest, family reunification is the key goal for children and youth in care. Keeping children and youth in their home communities facilitates having more regular access to visits from their birth families.

**Access to caseworker, CASA, and services.** When children and youth are placed far from home, it also makes regular contact with their caseworker and advocates more challenging. During interviews and focus groups done as part of this landscape analysis, CASA staff and caseworkers shared that increased distance can equate to increased safety risks, especially when a child is placed in a residential setting.

While CBC contracts state that success in keeping children and youth close to home is based on the percentage of children and youth who are placed within 50 miles of their home, data provided by DFPS for use in this landscape analysis was limited to the county level; thus, placement within home county was used as a proxy measurement for “close to home” in this report.

Of the 2,143 children and youth in foster care from Region 7, only 31 percent were placed in their home county and 25 percent were placed outside of the region entirely. (See Appendix E for a breakdown of this data by county.)

An analysis of DFPS child-level data from December 31, 2019, indicates four factors are correlated with children and youth being placed outside of the county: age, time in care, level of care, and population of the home county.
As children and youth age, they are more likely to be placed further away from home. Only 11 percent of children ages 0-5 are placed out of region as compared with almost 50 percent of youth 13-17 years old.8 Children and youth who have been in care three or more years are twice as likely to be placed outside of the region than those who have been in care two or fewer years.9

Teenagers are more likely to be placed out of the region,

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Placement Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGES 0 - 5</td>
<td>11%</td>
</tr>
<tr>
<td>AGES 6 - 12</td>
<td>29%</td>
</tr>
<tr>
<td>AGES 13 - 17</td>
<td>49%</td>
</tr>
</tbody>
</table>

...as are children/youth who have been in care longer.

<table>
<thead>
<tr>
<th>Time in Care</th>
<th>Placement Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 MOS. OR LESS</td>
<td>17%</td>
</tr>
<tr>
<td>1 - 2 YEARS</td>
<td>15%</td>
</tr>
<tr>
<td>3 - 5 YEARS</td>
<td>32%</td>
</tr>
<tr>
<td>6+ YEARS</td>
<td>38%</td>
</tr>
</tbody>
</table>

Source: December 31, 2019, child-level data provided by DFPS
LEVEL OF CARE

Per DFPS level of care guidelines (definitions of each level of care can be found in Appendix C), children and youth needing higher levels of care need a structured and supportive setting, preferably in a family, in which most activities are designed to improve the child’s functioning.

Children and youth who required a basic level of care were the most likely to remain in their home counties, whereas those with moderate, specialized, or intense care needs were least likely to remain in their home counties. Only 8 percent of children and youth with intense needs were placed in their home counties. Furthermore, approximately half of children and youth with specialized or intense needs were more likely to be placed out of the region entirely. ¹⁰

Some age ranges showed particularly high needs. For example, almost half of the youth ages 13 - 17 who are placed out of the region were in a residential treatment center, suggesting the need to build the region’s capacity to care for teenagers with acute needs. ¹¹

Source: December 31, 2019, child-level data provided by DFPS, Children & Youth ages 0-21 in foster care
Region 7 encompasses a large and diverse 30-county area in Central Texas. Child-level data confirms that less-populous counties have larger percentages of children and youth leaving the county for foster placements. Child-level data from April 30, 2019, indicates that a significantly higher percentage of children and youth in the region’s six largest counties (all with populations larger than 100,000) are placed within their home county as compared with children and youth in small and medium counties with populations less than 100,000. Seventy-two percent (72%) of children and youth from small and medium counties that are placed out of their home county, but still within the region, are placed in one of the six most populated counties in Region 7.  

**SIZE OF COUNTY POPULATION**

**PLACEMENT BY COUNTY SIZE**

<table>
<thead>
<tr>
<th>County Size</th>
<th>IN COUNTY</th>
<th>OUT OF COUNTY / IN REGION</th>
<th>OUT OF REGION</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMALL COUNTIES</td>
<td>60%</td>
<td>14%</td>
<td>26%</td>
</tr>
<tr>
<td>MEDIUM COUNTIES</td>
<td>56%</td>
<td>16%</td>
<td>28%</td>
</tr>
<tr>
<td>LARGE COUNTIES</td>
<td>35%</td>
<td>35%</td>
<td>42%</td>
</tr>
</tbody>
</table>

72% of children/youth from small- and medium-size counties placed in the region, but out of their home county, are placed in a large county. 28% of children/youth from small- and medium-size counties placed in the region, but out of their home county, are placed in small or medium-sized counties.

*Source: April 30, 2019, child-level data provided by DFPS, Children & Youth ages 0-21 in foster care*
Research shows that school transitions significantly interfere with learning and that changing schools can impede a student’s academic progress when compared with their peers."13 The federal Every Student Succeeds Act (ESSA), signed into law in December 2015, promotes the educational stability of children and youth in foster care by specifying that children and youth should remain in their original school unless it is not in the best interest of the child. However, in a report released in October 2019, the United States General Accountability Office found that state educational agencies (SEAs) across the country were experiencing challenges in implementing educational stability for youth in foster care.14 Challenges included high turnover among local educational and child welfare agency officials who can monitor educational stability, and identifying and arranging transportation to schools for students.

Evaluating school stability for children and youth in Region 7 is difficult due to incomplete information regarding school district of origin and current school district placements. Data was not available to assess school stability, and of the 5,028 children and youth in substitute care on December 31, 2019, original school district and current school district information was only available for 811 (16%). For those 811 children and youth, only 23 percent of the children and youth in paid foster care were attending school in their original school district. The school district stability of children and youth placed in unpaid kinship or family care was greater, with 54 percent of the children and youth still attending in their school district of origin.15 There are 186 independent school districts within Region 7 (see Appendix I). Stakeholder interviews reveal that multiple school transitions cause many children in foster care to fall behind academically and lose credits in instances where they must transfer mid-school year. Furthermore, the repeated social disruption can cause emotional instability, which impacts their success inside and outside of the classroom.

In order to create a local priority of school stability for children and youth in foster care, stakeholders suggested using school district stability rather than the current 50 miles from point of removal as a measure of keeping children and youth in their home communities.
FOSTER HOME CAPACITY

Building foster home capacity has been an ongoing need for child welfare systems across the country. It is particularly important for ensuring the success of Community-Based Care. To keep children and youth close to home, foster home capacity must be increased in their home communities.

According to the July 2019 DFPS Foster Care Needs Assessment, Region 7 had 1,562 non-relative caregiver homes on August 31, 2018. Of these foster homes, 105 are DFPS homes and 1,457 are contracted child placing agency homes. Within this needs assessment, DFPS projects the following capacity gaps in Region 7 by fiscal year 2021:

% OF 2021 DEMAND MET BY CURRENT FOSTER HOME SUPPLY

<table>
<thead>
<tr>
<th>Specialized and Intense Level of Care, all ages</th>
<th>35%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth 14+ with a Basic or Moderate Level</td>
<td>92%</td>
</tr>
</tbody>
</table>

Because only 35 percent of the projected demand for children and youth with specialized and intense levels of care is projected to be met, there is an immediate and urgent need to increase capacity in the region if children and youth are to be kept in their communities. In addition, there is a clear need to increase the region’s capacity to support teenagers who have higher-intensity needs. Forty-nine percent (49%) of youth ages 10-17 who are placed out of region are in a residential treatment center (RTC), suggesting the need to increase the region’s capacity to provide therapeutic and healing care for teenagers.

Building foster care capacity by county is critically needed to keep children in their home communities. Increasing foster care capacity must include disaggregating current bed capacity by usage based on children and youth’s level of care and vacancy. Per the Texas Foster Care Needs Assessment from August 2019, foster homes may be verified for more children and youth than are actually placed in the home. In order to understand true capacity, identifying homes with an over count of available beds is imperative to understand true need and forecast future capacity.
In the large county category, the data showed the number of children and youth in foster care ranged from 49 to 544 per county, with a total number of 1,620. Across large-sized counties, 581 children and youth (36%) were actually placed in their home counties.

- 100 percent of all large counties have fewer than 50 percent of children and youth in foster care placed in their county of origin.
- 33 percent of large counties have fewer than 30 percent of children and youth in foster care placed in their county of origin.

In the medium county category, the number of children and youth placed in foster care ranged from 6 to 67 per county, with a total number of 315. Across medium-sized counties, 68 children and youth (22%) were placed in their home counties.

- 100 percent of all medium-sized counties had fewer than 37 percent of children and youth in foster care placed in their county of origin.
- 56 percent of all medium-sized counties had fewer than 20 percent of children and youth in foster care placed in their county of origin.

Across small counties, the number of children and youth placed in foster care ranged from 4 to 32 per county, with a total number of 208. Across small-sized counties, 24 children and youth (12%) were placed in their home counties.

Of the other 12 counties in the small sized category:

- 75 percent had fewer than 20 percent of children and youth in foster care placed in their county of origin.
- 33 percent had zero children and youth in foster care from their counties (Llano, Lee, Robertson, and Falls).
The county data includes an overestimation of homes available in each county. However, according to this data:

- **10%** of counties in Region 7 have more homes available than children and youth in foster care from their county.
- **90%** of counties have more children and youth in foster care than home capacity available.
- **60%** of counties have 10 or fewer foster/adoptive homes in their counties.

Focus groups and individual interviews were also conducted with stakeholders around the region, including child- and family-serving organizations, CASA, CPS, foster parents, and kinship caregivers.

Four important themes were noted throughout focus groups with kinship caregivers and foster parents.

- **Intentional Matching System.** A comprehensive placement matching system is needed to match children and youth entering foster care with the right family at the time of the initial placement. This should include a database of all available foster homes and families that can be accessed when a child needs a home. Foster parents emphasized that while a database system would add value, it would still require dedicated staff to ensure individual child and youth needs were prioritized throughout the matching process.

- **Network of Resources.** Kinship caregivers and foster parents noted a lack of community supports available for them. All reported that having a support group to build connections and receive guidance on how to navigate the child welfare system was important and currently lacking in most areas in Region 7. Access to respite care, babysitters, and transportation assistance was identified as being available to certain groups and in certain areas of the region.

- **Birth Parent Support.** Both kinship caregivers and foster parents want to be a support to birth parents. Foster parents would also like an opportunity to communicate with and mentor birth parents. Birth parents should also be provided with additional support beyond parenting classes, such as mentoring and budgeting. Reunification support for families was also noted as lacking.

- **Timely Access to Providers & Services.** All caregivers reported not being able to access physical and behavioral health providers that accept Medicaid and do not have a waitlist. Foster parents also noted that therapeutic services should be available early on in a placement to provide stabilizing wraparound supports. They shared that there is a general lack of providers in their counties, and that identifying and scheduling with specialists and mental health providers is especially difficult.
SERVICE CAPACITY FOR CHILDREN AND YOUTH

Children and youth in foster care have a variety of complex needs ranging from physical conditions to behavioral health challenges. According to the Center for Healthcare Strategies:

- **Nearly 90 percent** of children and youth entering the child welfare system nationally have physical health problems, and **more than half** have two or more chronic conditions.

- **Nearly half** of children and youth entering foster care have significant emotional and behavioral health conditions.

- **Rates of psychiatric medication use for youth in foster care are significantly higher (13-52%)** than they are for the general youth population (4%).

To meet the diverse needs of children and youth in foster care, a continuum of high-quality, timely services must be available in reasonable proximity to the child’s placement. Access to these critical supports over time is key to building health, promoting healing, and securing permanency.

ASSESSING CHILDREN AND YOUTH NEEDS

The Department of Family Protective Services has a “3 in 30” requirement that mandates that children and youth 3 years of age or older entering foster care complete the following three steps within 30 days:

1. See a doctor within three business days of entering care to assess injury or illness, and to receive any necessary medical treatment.

2. Receive the Child and Adolescent Needs and Strengths Assessment (CANS). The CANS assessment gathers information about a child’s strengths and needs. It is used to guide decisions for a child’s permanency planning and level of care. This comprehensive approach allows children and youth to be assessed, giving DFPS “a good review of their physical and behavioral health needs right away.”

3. Complete a Texas Health Steps medical checkup within 30 days.

The CANS assessment must be completed by a licensed clinician with Superior HealthPlan for STAR Health who must be certified in administering the CANS tool. A review of the Superior Health Plan/STAR Health data revealed there are only 71 STAR Health certified CANS providers in Region 7.
The low number of certified CANS providers confirms concerns about lengthy waitlists relayed by foster parent and kinship/relative caregivers during interviews and focus groups. To avoid the waitlists, some foster parents scheduled consecutive annual CANS assessments as soon as children and youth entered their homes. However, they did so without always knowing if children and youth would be still placed with them at the time of the annual review. Relative caregivers also expressed concerns about not knowing what the results were for their children’s CANS or how to begin to address children’s needs without the assessment results.

Because the CANS assessment was implemented along with "3 in 30" to assess children’s strengths and needs and inform permanency planning, increasing providers certified to administer the CANS in Region 7 counties is critical for both children, youth, and caregivers.
ACCESSING SERVICES: CHILDREN AND YOUTH

Most children and youth entering the foster care system are eligible to receive their healthcare services through Superior HealthPlan STAR Health. A description of the categories of children and youth not eligible for STAR Health services is included in Appendix E. These categories are not included in this report’s analysis for access to services for children and youth. STAR Health data was reviewed and analyzed to identify the number of service providers available for children and youth in the Region 7 foster care system. These service providers included primary care physicians, family practitioners, pediatric practitioners, vision practitioners, and specialty physicians. The array of accessible services in each county was also reviewed.

**BEHAVIORAL HEALTH PROVIDERS**

It is estimated that out of the 400,000+ children and youth in foster care nationwide, nearly 80 percent suffer from a significant mental health issue, making access to quality services essential for care.21 According to STAR Health, the category “Behavioral Health Providers” includes psychiatrists, advanced practice nurse practitioners, licensed psychologists, licensed clinical social workers, licensed marriage and family therapists, and licensed professional counselors.22 The following data on availability of service providers was sourced from the STAR Health Provider Directory for both the East and Central regions, as Region 7 has counties in both of these STAR Health regions.

Results of this analysis indicated that the six large counties in Region 7 contain the majority of behavioral health providers. Travis County showed the most (587), and the remaining five large counties in the region had fewer than 300 behavioral health providers, with two large counties showing fewer than 100. As county size decreased, the number of providers also decreased sharply: nine of the 10 medium-sized counties had fewer than 25 behavioral health providers. Eighty-five percent (85%) of the 15 small counties in Region 7 had fewer than five behavioral health providers, and one county (Freestone) had no providers.

Throughout the region there are also behavioral health facilities children and youth can access through STAR Health. However, seven counties in Region 7 (Blanco, Bosque, Falls, Freestone, Hill, Mills, and San Saba) do not have any behavioral health facilities that are accessible to children and youth in foster care.
Behavioral health providers appear to be lacking across most of the region, particularly for small and medium-sized counties. This finding is consistent with concerns shared by foster parents during focus groups indicating the need to travel to other counties to access services for foster children as well as experiencing delayed appointments due to waitlists. Increasing the amount of behavioral health providers in communities throughout the region is vital to meeting children’s behavioral health needs and keeping children and youth closer to home.

**SPECIALTY PROVIDERS**

Thirty percent (30%) to 80 percent of children and youth enter foster care with at least one medical problem. While not all children and youth in foster care will need access to specialty providers, having a sufficient number of specialists in each county or within close proximity allows for children’s medical needs to be served in a timely manner and alleviates the travel burden on foster parents and concern regarding waitlists.

According to STAR Health, specialty providers include a wide range of practitioners, from allergy and immunology providers to physical therapy, neurology, and speech therapy. Five of the six large counties in Region 7 have more than 450 specialty providers; Travis County has over 2,400. The number of specialty providers decreases significantly for medium and small-sized counties: 70 percent of medium-sized counties have fewer than 50 specialty providers, and 57 percent of small counties have fewer than 10 specialty providers.

**BILINGUAL PROVIDERS**

According to the American Medical Association Journal of Ethics, health disparities are exacerbated by inadequate communication caused by language barriers. Children and youth in foster care should have access to quality health care including bilingual providers. STAR Health data includes Spanish-speaking providers, but does not have information on additional languages spoken by providers. According to this data, 73 percent of counties in Region 7 have fewer than 10 Spanish-speaking providers across all disciplines, and four counties do not have any Spanish-speaking providers.

**DFPS PURCHASED CLIENT SERVICES PROVIDERS**

Purchased client services are services provided by outside entities under contract with DFPS. In 2019, each month an average of 905 children and youth were in substitute care and accessed purchased client services from CPS in Region 7. These services include but are not limited to evaluation and treatment services, substance abuse assessments and treatment (individual, family, and group counseling), adoption services such as adoption placement, post-adoption placement supervision, “Health, Social, Educational, and Genetic History” (HSEGH) reports, and other services such as “Preparation for Adult Living Training.”

DFPS active client service contracts for Region 7 were reviewed to determine which purchased client services families currently have access to in each of the Region 7 counties (see page 33 for a detailed review of active client service contracts). DFPS could not provide a breakdown of client services such as evaluation, treatment services, or counseling for children and youth in substitute care; therefore, analyses for this subpopulation were not conducted. While CPS does purchase client services for children and youth, it is unknown how many of the providers in each county serve both children and adults or serve only one population.
ENSURING SERVICES MEET THE NEEDS OF ALL CHILDREN AND YOUTH

LGBTQ+ YOUTH

It is unknown how many youth in the Region 7 child welfare system identify as LGBTQ+ or how that affects placement type and location because there is no mandate to track this information, thus data is not consistently available. However, research from other states has shown that LGBTQ+ youth are over-represented among the foster care population. For instance, a study of youth in the California foster care system revealed that 14 percent identified as lesbian, gay, bisexual, or questioning, and 13 percent reported some level of same-sex attraction. In this same study, 6 percent of the youth identified as transgender. In a research brief printed in the Journal of the American Pediatrics Society, youth identifying as LGBTQ+ were more likely to live in foster care (30%) and unstable housing (25%) than youth in a nationally representative sample (11%).

Knowing the difficulties many LGBTQ+ youth face, researchers are focusing more attention on their experiences. For example, Dr. Adam McCormick at St. Edward’s University documents the experiences of LGBTQ+ youth in the foster care system. His research suggests that LGBTQ+ youth in the system fare worse than other youth, experience more placement disruptions, and are more likely to be placed in a congregate care setting. Some of the factors McCormick identifies as creating disparities include:

- Lack of acknowledgement and pressure to remain invisible and silent.
- Lack of acceptance, including significant shifts in the way youth were treated in foster care, or loss of placement when caregivers learned of their sexual orientation or gender identity.
- Double standards of what is considered acceptable behavior, specifically when dating and pursuing romantic relationships.
- Bullying, teasing, and harassment exacerbated by what LGBTQ+ youth consider a systemic culture that enables stigmatization and homophobic behaviors.

In addition to these challenges that occur in foster care, many LGBTQ+ youth enter the foster care system due to family rejection and conflict stemming from their sexual orientation or gender identity, rather than issues impacting the family. This creates additional barriers to family reunification and healing that must be addressed.

The Human Rights Campaign’s All Children - All Families Initiative has outlined seven benchmarks of LGBTQ+ inclusion in their “Celebrating Everyday Change-makers” report that can help organizations and communities create a safe and healing environment for youth (see Appendix G).
CHILDREN & FAMILIES OF COLOR

Cultural dissimilarity, including race and language spoken, between foster parents and children contributes to poorer psychological adjustment, depression, loneliness, and conduct problems. With Hispanic children and youth representing 36 percent of those in the child welfare system in Region 7, there is a need for Spanish-speaking homes and service providers. There is also a need for families that meet the race and language diversity of other children in care whose primary language is not English.

Additionally, disproportionate representation of African American children and youth in the Region 7 foster care system that continues as they move through the system suggests a need to educate staff at all levels on how racial bias results in discriminatory decision-making.

YOUTH IN EXTENDED FOSTER CARE

At the end of April 2019 there were 141 young adults, ages 18-21, who were in extended foster care in Region 7. Of these, 43 percent were living in their home counties. Young adults, ages 18-21 who stay in foster care and do not live in their home counties, are primarily living along the I-35 highway corridor, with 50 percent living in Travis County. Counties in this area should ensure that they have adequate services and resources available to help young adults achieve service plan goals, such as housing assistance, career development, academic counseling, mentoring, and financial coaching. Additional information regarding support services for youth in extended foster care can be found in the Children's Bureau's report "Extension of Foster Care Beyond Age 18".
Federal law defines child sex trafficking as a commercial sex act that is induced by force, fraud, or coercion, or in which the person induced to perform is under 18 years of age.\textsuperscript{35} Sex trafficking is particularly relevant in the context of the foster care system. Most notably, Texas CASA's January 2020 Challenge to fight sex trafficking in Texas stated, "By listening to survivors, we’ve learned that many youth in foster care are drawn into commercial sexual exploitation by people they think are their friends and romantic partners, and often do not fully understand that they are victims."\textsuperscript{36} Similarly, the FBI found that 60 percent of child sex trafficking victims who were recovered through raids across the U.S. in 2013 were from foster care or group homes.\textsuperscript{37} Despite this, only a small percentage of youth who have run away while in foster care report being victims of trafficking.\textsuperscript{38}

In order to truly understand the magnitude of the problem, and be in a position to address it, communities across the region should encourage organizations that work directly with children and youth – especially those in foster care – to learn the signs of exploitation in victims and develop a supported response when trafficked youth are identified. For example, Allies Against Slavery has developed a tool, Lighthouse, that assists in identification. Concurrently, communities need to develop the resources necessary to support and protect youth who are at risk of sexual exploitation.\textsuperscript{39}

**CHILDREN AND YOUTH WITH TRAUMA-RESPONSE BEHAVIORS**

When preparing a community to meet the needs of children and youth with high level of care assessments, it is important to remember that trauma response symptoms that are disruptive to a child’s ability to function at home or at school may look very similar to symptoms of a mental health disorder. Children who have difficulty concentrating may be diagnosed with ADHD (attention deficit hyperactivity disorder). Children who appear anxious or easily overwhelmed by emotions may be diagnosed with anxiety or depression. Children who have trouble with the unexpected may respond by trying to control every situation or by showing extreme reactions to change. In some cases, these behaviors may be labeled ODD (oppositional defiant disorder) or intermittent explosive disorder (IED). Dissociation in response to a trauma trigger may be viewed as defiance of authority, or it may be diagnosed as depression, ADHD (inattentive type), or even a developmental delay.\textsuperscript{40}

It may be necessary to treat symptoms with traditional mental health approaches including the use of medications, where indicated. However, treating the underlying cause of behaviors by addressing the child’s experience of trauma may be more effective in the long-run. As a result, finding foster families and wraparound services that are able to provide a trauma-informed environment while a child is in care becomes imperative to ensuring the child welfare system is not undermining healing or creating additional harm to children and families.
In December 2019 only 22 percent of children and youth who were part of a sibling group were placed with their full sibling group.\textsuperscript{41} As seen in the Children’s Bureau bulletin from June 2019, Sibling Issues in Foster Care and Adoption, connections with siblings can serve as a protective factor and source of continuity for children and youth in the child welfare system. \textsuperscript{42} Sibling placements can provide positive support, and the preservation of sibling ties can help buffer children and youth from the trauma of being removed from their home. Examples of positive outcomes from sibling group placements in foster care are:

- Children/youth are less likely to exhibit internalizing behaviors such as anxiety or depression
- Improvement of children’s school performance.
- Children/youth are more bonded to foster caregivers during their time together.
- Higher rates of reunification, adoption, or guardianship are achieved.

According to DFPS’s Data Portal, the percentage of sibling groups placed together has significantly increased in Region 7 over time.\textsuperscript{43} This must continue to be prioritized unless there are risks associated with the placement. Strategies to support sibling group preservation are listed in the Children’s Bureau bulletin.

### YOUTH VOICE

A focus group of foster care alumni was conducted to inform the landscape analysis. Youth who reported significant barriers to healing and permanency, however, concurrently told stories of hope. The overall message youth gave was of the dichotomy of their individual experiences: those that included love and fear, enrichment and chaos, trauma and resilience. Specific challenges youth identified included:

- Lack of consistent guidance/nurturing; not having a person who could get to know them
- Having the system, and individuals within the system, treat foster care with as a “one size fits all” approach – not recognizing individual differences and needs
- Not having a voice and not being heard
- Feeling as though the system focuses on what is best for the foster family, not what is best for the child
- Inability to exert independence, even as a teenager and young adult
- Not having benefits of staying in foster care explained, such as the availability of tuition waivers and housing assistance in extended care
- Separation from siblings and extended family, so that reunification even as a young adult is hard – exacerbating the sense of isolation

Positive experiences that youth felt should be built upon and expanded included:

- Foster parents who genuinely express love and connection and support the child’s or youth’s individual needs, including interactions with birth families
- Caseworkers who would get to know the children and youth they worked with and vouch for them if an issue or concern came up in a placement
- Access to adults who can act as mentors and guides as a youth prepares to age out of care
SERVICES & SUPPORTS FOR BIRTH PARENTS

A regional landscape analysis would be incomplete without considering the needs and supports in place for birth parents and relative caregiver. As such, an analysis of provider services, a community survey, interviews, and focus groups was conducted with birth parents and relative caregivers.

Throughout the landscape analysis, professionals, kinship caregivers, foster parents, and birth parents discussed the lack of services and resources available for birth parents. It is apparent from reviewing client services DFPS provides for both children and adults that there are not enough providers in any county to support the volume of families involved with CPS. Communities must build supports for birth parents to not only encourage and sustain reunification but to prevent child welfare intervention.

ACCESSING SERVICES: BIRTH PARENTS

DFPS is required to provide family services to parents. Family services include a CPS caseworker engaging the family to “reduce the risk of abuse or neglect so that the child may return home and live safely for the foreseeable future.” This includes assessing the family’s strengths and needs, assisting the family with developing a safety network, arranging parent-child visitation, completing a Family Plan of Service, ensuring the family receives services, ensuring that initial services are scheduled no later than the 21st day after a child enters foster care, and documenting efforts toward family reunification.

CPS caseworkers connect families to services in multiple ways, including through the use of DFPS contracted providers, purchased client services, and referrals to community resources.

DFPS PURCHASED CLIENT SERVICES

DFPS purchases client services and enters into regional service contracts, which include but are not limited to: evaluation and treatment services, substance abuse assessments and treatment (individual, family, and group counseling), battering intervention and prevention, and parent and caregiver training. In 2019, each month an average of 3,470 adults utilized purchased client services in Region 7.
As part of this landscape analysis, CPS active client service contracts for Region 7 were reviewed to determine what families currently have access to in each of the Region 7 counties. DFPS could not provide a breakdown of client service contracts by population served; as such, providers were reviewed by county, and services represented are accessed by both adults and children. Therefore, as service providers are not solely serving adults, service gaps for parents may be greater than what is indicated.

Evaluation and testing services include both psychosocial assessments and psychological evaluations, which parents with children in CPS custody are frequently asked to take. A psychosocial assessment is also required to be completed in order to access treatment services, including individual, family, and group counseling.

Because evaluation is required to access treatment services, the lack of availability is concerning as it likely impedes families from accessing other crucial services.
**COUNSELING & THERAPY**

A CPS caseworker will refer families to counseling and therapy when there is an identified need for treatment in their family plan of service.

In Region 7, there are a total of 477 contracted providers for counseling and therapy.

- 34% of large counties had 50 or more providers.
- 30% of medium counties had more than 20 providers.
- 7% of small counties had 10 or more providers.

The total number of providers in Region 7 is quite small given the large population of families that could utilize these services, and, additionally, of those 477 providers, only 15 percent provided home-based therapy. Focus groups with professionals, birth parents, and kinship caregivers revealed that transportation was a common barrier to access for foster care services, making home-based therapy especially valuable.

**SUBSTANCE ABUSE SERVICES**

In a 2018 report to the House Select Committee on Opioids and Substance Abuse, DFPS cited substance abuse as a common factor in both removals of children and child fatalities. Caregiver substance abuse contributed to 68 percent of removals of children in fiscal year 2017.  

Unfortunately, parents often experience barriers to accessing substance abuse treatment including: scarcity of services, availability and location of services, waiting lists, and insurance coverage. A review of substance abuse services available in Region 7 indicates these barriers continue to exist.
Although the number and general availability of substance abuse services in each location is lacking, there is access to substance abuse services through the community. For example, Outreach-Screening-Assessment-Referral (OSAR) services are available in all 30 counties in Region 7 through Bluebonnet Trails Community Services. However, these services are available for Texas residents broadly and are not limited to families involved with CPS, indicating a need for further analysis on what barriers parents may be facing.

**BILINGUAL PROVIDERS**

DFPS does not categorize or collect information on which contracted providers are bilingual. As this information is not available it is unknown how many of the DFPS contracted providers speak and provide services in the families’ primary language. DFPS does require Evaluation & Treatment contracts to obtain a translator or interpreter for clients with limited English proficiency or communication impairment.52

**PARENTING & CAREGIVER TRAINING**

While it is possible for CPS to purchase parenting and caregiver training and homemaker services, CPS instead refers to community resources for these needs.53 Local agencies do contract with DFPS through the Prevention and Early Intervention Division to provide parenting classes and parent support. A review of parenting classes sourced from Help for Parents, Hope for Kids showed:

- 100 percent of large-sized counties had six or fewer organizations available to provide parenting classes.

- 100 percent of medium-sized counties had three or fewer organizations available to provide parenting classes, with 60 percent of counties only having access to one agency that provides this resource.

- 100 percent of small-sized counties had three or fewer organizations available to provide parenting classes, with 86 percent of counties only having access to one agency that provides this resource.
PARENTING & CAREGIVER TRAINING (cont.)

DFPS notes on their website that there is no statewide central agency that regulates parenting classes and instead directs parents to the Help for Parents, Hope for Kids website as well as suggesting the court and caseworkers can help locate parenting classes. While parents involved with the child welfare system have access to these services, these resources are also available to all parents, not just those involved with CPS, which further limits availability. There may be additional organizations in each county that parents may have access to, but that number is unknown as there is no central access point or online repository.

PARENT VOICE

Birth parents involved in the child welfare system often do not have avenues to voice concerns or make recommendations regarding their cases and most importantly, their children. Focus groups were conducted as part of this landscape analysis to ensure birth parents' voices were included, and the following themes were discussed:

- **Parents agreed with the goals of Community-Based Care in keeping children and youth in their home communities**, wanting their children to remain as close to home as possible. They were concerned that residential treatment centers are often too far away, and they stressed that their children's needs must be met, but the children also must to be close to their home community.

- **Parents shared that they feel they are dehumanized and that the child welfare system is stacked against them from the beginning.** They shared that communication is lacking from caseworkers and that they are frequently left out of decisions regarding whether their children are placed with relative caregivers or foster parents. Parents emphasized the need to have a voice in case planning both for themselves and for their children. Additionally, they urged that while their children are under the care of CPS, everyone involved in their children's lives should work together. Parents also want all professionals involved to listen to their voice and not disparage them when they ask for help.

- **Birth parents shared that no matter who is overseeing the CPS case, whether it is CPS or an SSCC, communication is key.** They want staff to be responsive and to facilitate building relationships with foster parents so they can have more interaction with their children. Parents shared that they would like consideration for FaceTime or Skype calls with their children. They said they understand the foster parent may not want the parent to have their phone number and suggested the caseworker could utilize FaceTime or Skype to call the parent when the caseworker was visiting the foster home.
Parents identified the following strategies to support family reunification:

**Keep children and youth close to home.** Parents indicated that if their children were placed farther from their home community or in another region, the children would be less likely to complete services and more likely to be confrontational due to extreme distress. Parents want to have regular visitation with their children and for their children to stay in their home communities. They suggested reviewing kinship caregiver policies that limit when children are eligible to be placed with relatives. This includes policies that prohibit placing a child with a family member who had a previous substantiated CPS case. Parents indicated that, in some instances, relatives had a substantiated case 10 or more years ago and were able to reunify successfully with their children, but because they had a CPS case at one point in time, they were immediately disqualified as a kinship caregiver.

**Celebrate reunification.** Adoption is an event that is celebrated across child welfare systems with parties, media coverage, and its own designated month of the year. While adoption should be celebrated, parents shared that reunification should also be fully recognized. Parents indicated they must overcome numerous barriers to complete services, including transportation issues and unresponsive caseworkers. Not surprisingly, parents are frustrated when after overcoming so many obstacles they finally are able to reunite with their children, and it is not celebrated. For example, a parent described how when their family was reunified in court, instead of celebrating the moment, the judge told the parent they never wanted to see her again and that she needed to make sure to keep her life together.

**Create opportunities for connection.** Parents shared that they want to be able to connect with other parents who are involved with CPS. Parents suggested a quarterly picnic at a local park for parents and children. CPS workers could observe parents interacting with their children, and parents said they could build relationships with other parents.

**Parents also shared that they want to be able to connect with foster parents.** Numerous parents indicated that this connection was not supported and that the CPS caseworker was often the barrier to this connection. In fact, some parents described caseworkers adamantly telling foster parents and kinship caregivers to not have contact with birth parents. Parents said they would like to be able to share information about their children and hear how their children are doing. One mother said she heard from the CPS caseworker that her daughter was in the hospital, and when she asked why, the CPS caseworker had to call the foster parent and then call the mother back. The mother reported that, had she been able to talk to the foster parent directly, she would have known right away how her child was doing, but instead had to wait anxiously worrying the worst had occurred.
SUPPORT SYSTEMS

PARENT SUPPORT GROUPS
In focus groups, birth parents shared that having a support group was important whether or not they were involved with CPS. Parents want to be able to build relationships with other parents to support and learn from each other. Although Region 7 is currently trying to establish more Parent Collaboration Groups, at this time there is only one Parent Collaboration Group in Bell County. These parent-led informational support groups allow parents the space to ask questions, share concerns, and learn from other parents that have been engaged with CPS.

BIRTH PARENT AND KINSHIP RELATIONSHIPS
Kinship caregiver focus groups were also conducted as part of this landscape analysis. Kinship caregivers shared concerns about birth parents having limited access to services as well as having to travel farther distances for drug testing. Some parents report not having transportation to reach drug testing facilities and, per the policy, receive an automatic positive result on their record due to missing their test. One kinship caregiver, a grandmother, shared how this created a spiraling effect for her daughter. She described how her daughter was unable to get to the testing site on time and as a consequence received an automatic positive test result, which counted against her visitation. Her daughter then became depressed and did not complete any services. The grandmother said her daughter suffered from mental health challenges, and while she should have completed her services, no empathy or support was offered to reengage her.

Other kinship caregivers expressed needing guidance on what kind of contact to have with birth parents. Some kinship caregivers shared that they were told not to have contact, while others said they received no guidance at all.

BIRTH AND FOSTER PARENT RELATIONSHIPS
The child welfare system does not adequately support birth and foster parent connection or collaboration. Foster parents report not knowing if they can establish relationships with birth parents and often receive conflicting messages about whether to engage with birth parents. For example, foster parents often aren’t informed about whether birth parents are deemed safe and have made enough progress in their case to be included in decision-making.

Birth parents are often given little to no information about their children’s foster parents. They also experience trauma when their children are removed and placed in foster care, but this is not consistently recognized or addressed. They are commonly seen as adversarial or confrontational and as someone who should not receive information about their children’s placement for safety reasons. While some birth parents may need to have restrictions due to safety issues, most birth parents involved with the child welfare system need support first and foremost and should receive information about their children’s foster parents. This can include basic information such as first names and whether they speak the same language as the children, and clear guidelines on how the birth parent and foster parent can share information about the child.

Birth parents and foster parents need training on how to interact, co-parent, and develop relationships with each other. Examples of approaches being used in other states to empower birth and foster parents to build healthy relationships are included in Appendix G.
Organizations in Region 7 collect a variety of data to assess quality and drive service delivery decisions. Most child- and family-serving organizations collect targeted data based on their internal programs and unique organizational needs. Child placing agencies and residential treatment centers are required to track and report specific data to DFPS and the Texas Health and Human Services Commission to meet minimum standard requirements. A few organizations are also collecting data on placement stability, sibling visitation, and foster parent retention and supports.

Despite the quantity and variety of information being collected across Region 7, very few organizations are already collecting data applicable to all of the performance measures that are required under Community Based Care and monitored by the SSCC, such as placement of children and youth in home communities, least restrictive placements, and maintaining connections.

In addition to the data required by CBC, this landscape analysis found several child and family demographic indicators that are not currently collected in a systematic way across the region but are essential for understanding the needs of the children, youth, and families engaged with the child welfare system. Specifically:

- Preferred/primary language — as reported by the child, youth, and family
- Gender identity — as reported by the child or youth
- School of origin and current school — intended to be updated every time a transition takes place
At the time of this report, Region 7 is divided into two catchment areas, 7A and 7B. Current Region 7 catchment areas were developed with input from stakeholders under “Foster Care Redesign,” a restructured service delivery model that preceded Community-Based Care.

DFPS developed a gap analysis that utilized DFPS data from its IMPACT database and its Child Placement database to identify proposed catchment areas using specific criteria, including:

- Proximity to existing service areas
- Local community support
- Regional readiness and stability
- Challenges with capacity
- Affordability
- Minimum of 500 new children entering care per year
- Placements in and out of the service area

For the purpose of this landscape analysis, qualitative and quantitative data were gathered to assess how the division of Region 7 into the two catchment areas might affect the quality and availability of services necessary to meet the needs of children and families engaged in the child welfare system.

The following themes emerged:

Community organizations do not have a shared perception of whether the division of the region will impact availability of services. Of the organizations that completed the Region 7 Stakeholder Capacity Survey, 30 percent were unsure whether CBC would affect the level of services received by children, youth, and families: 20 percent of respondents felt CBC would damage the level of services available in their county: 20 percent felt it would increase services: and 30 percent felt level of services would be unchanged.
The boundary between 7A and 7B does not reflect the mobility of children, youth, and families, or the fluidity of service delivery structures within the region. Since the boundary was initially created, the interconnectivity of the region has expanded. Children, youth, and families cross the border between catchment area 7A and 7B to work, go to school, access services, and connect with their social networks.

Focusing specifically on placements, 14 percent of the children and youth in catchment area 7A are placed in 7B; conversely, 22 percent of the children and youth in catchment area 7B are placed in 7A. Looking to the counties that border the 7A/7B dividing line, on average 7 percent to 8 percent of the children and youth were placed across the border into a neighboring county, with one county having 32 percent of its children and youth placed across the border. In addition to child placement, the boundary divides several jurisdictional regions, including:

- **One Child Protection Court**: The Child Protection Court of the Hill Country
- **Two CASAs**: CASA for the Highland Lakes Area and Voices for Children — CASA of Brazos County
- **Two Children’s Advocacy Centers**: Hill Country Children’s Advocacy Center and Scotty’s House/Brazos Valley Child Advocacy Center
- **Four Local Mental Health Authorities**: Bluebonnet Trails Community Services, Center for Life Resources, Hill Country Mental Health & Developmental Disabilities Centers, and MHMR Authority of Brazos Valley
- **Seven cities**: Austin, Cedar Park, Leander, Round Rock, Hutto, Coupland, and Elgin

Service providers and foster families are concerned about inconsistencies in how different Single Source Continuum Contractors implement CBC. Under the state’s legacy system of child welfare, contract requirements were standardized across the state, whereas under CBC each SSCC has the flexibility to create a unique contract with their group of service providers. While there are proponents of community control of service delivery, some service providers and families indicated that they are concerned that too much local control may result in different contract requirements, inconsistent quality of services, and unclear lines of accountability.

Service providers noted specific concerns about having multiple governing agencies; specifically, SSCCs and DFPS each have their own requirements and service agreements that are not always in alignment. Providers noted that managing multiple requirements and contracts is difficult to maintain and that adding two additional contracts with 7A and 7B would exacerbate this problem. Additionally, providers reported audits were duplicative, with each SSCC conducting an audit on the same information.

Foster parents in Region 7 relayed concerns about not knowing with whom to address their concerns. In the current state, when raising an issue, foster parents know to first reach out to the CPS supervisor, then program director and continue up to the regional director if needed.
ADDITIONAL CATCHMENT AREA CONSIDERATIONS

Additional considerations for how Region 7 might be divided were offered during community meetings, focus groups, and interviews.

LOCAL MENTAL HEALTH AUTHORITIES

One alternative approach aligned with the seven Local Mental Health Authority (LMHA) Regions, and created seven separate catchment areas.

This model might increase the difficulty in accessing services for children and youth in smaller counties that currently lack services and foster home capacity.

see Appendix I.7
School districts were identified as another potential consideration for catchment areas. Based on the Community-Based Care model of keeping children and youth within their home communities, if school districts were to become catchment areas, this would allow for a clearer definition of “home communities.” Ideally, this would also mean children and youth would remain closer to siblings, relatives, and friends, and maintain connections and relationships with their faith community and neighborhood resources.

Currently, there are 186 school districts in Region 7 and many of them have overlapping boundaries. Therefore, using the school district as a definition of “home community” is unrealistic, as it would create 186 different catchment areas.

**COLLABORATIVE CATCHMENT AREA**

Another consideration is a collaborative approach where multiple organizations in the region band together to submit a response to a request for proposal. This approach would include representation from different areas of the region to provide governance as an advisory council, which would recognize the unique needs for counties in the region as well as differences between counties with different population sizes. Boundaries for representation may be based on the Local Mental Health Authority regions, service areas for CASA, or other groupings the community and stakeholders feel best represent the needs of individual counties and communities.

This approach allows for all counties to have an equal voice and representation for all levels of decision-making. Smaller and medium counties reported a fear of larger counties in a catchment area dominating services and decision-making in the proposed split into two catchment areas; creating a collaborative catchment area could alleviate many of these concerns.

**REGION 7 AS SINGLE CATCHMENT AREA**

Some stakeholders recommended uniting Region 7 as a single catchment area. These stakeholders cited the boundary being drawn between 7A and 7B as divisive to services and providers, creating an unnecessary barrier to coordinated service delivery.
The Family First Prevention Services Act (FFPSA) was signed into federal law as part of Public Law (P.L.) 115–123 in 2018 and has several provisions to enhance support services for families to help children and youth remain at home, reduce the unnecessary use of congregate care, and build the capacity of communities to support children and families. The law enables states and territories to use funds for prevention services, such as:

- Evidence-based mental health programs
- Substance abuse prevention and treatment
- In-home parent skills-based programs
- Kinship navigator programs

In addition, the act puts qualifications on the residential treatment facilitates that may be used and limits the amount of time a child may be in a congregate care setting. Finally, the act extends the amount of time a child may receive support services after they are reunified with their family.

As part of the landscape analysis, we reviewed how DFPS is beginning to prepare for FFPSA and how FFPSA implementation may affect CBC readiness and implementation.

DFPS notified the Administration for Children and Families that Texas would delay implementation of FFPSA for the following reasons:

- Texas does not currently have enough providers who are accredited, and the three accrediting bodies in the country already stated that they did not have the bandwidth to accredit providers prior to October 2019.
- Texas does not have qualified residential treatment programs to serve the highest-needs kids and draw down federal money.
- Texas does not have enough providers who offer evidence-based services.
- Texas has not received guidance from the federal government on what evidence-based services will even be acceptable for draw down and cannot increase capacity until guidance is received.
DFPS has developed a Texas Child Welfare Changing Landscape Action Plan, which takes a comprehensive approach regarding FFPSA, and two Senate Bills (355 and 781) from the 86th Legislature in 2019. DFPS notes that both Senate bills reference FFPSA and therefore are creating a comprehensive plan that encompasses the federal legislation and the Senate bills.

- Senate Bill 355, 86R relates to developing a strategic plan regarding implementation of foster care prevention services and community-based care, and coordinating a study related to resources provided to foster parents.

- Senate Bill 781, 86R, relates to the regulation of child-care facilities and directs the department to develop a strategic plan to implement federal law regarding specified settings for placement of foster children and youth.

Currently, DFPS is holding forums to solicit feedback from stakeholders regarding FFPSA implementation and has provided a listing of FFPSA section requirements and how DFPS is addressing both the required and optional sections.

FFPSA connects with CBC as it will require partnerships among multiple stakeholders and communities to implement. CBC's community-based approach establishes these relationships among stakeholders and community to meet the needs of children and families.

One of FFPSA's fundamental principles is to ensure that children and youth in foster care can live with a family. CBC allows for individual communities to collaborate to build foster care home capacity including increasing wraparound services so children and youth can remain in their home counties. This must also include building resources and supports for kinship caregivers, including wraparound support, financial support, and all of the current supports foster parents receive.

FFPSA also aims to help families stay together safely when children are at risk of removal. In its initial phase, CBC requires SSCCs to focus on child placement and building foster home capacity; however, this is an optimal time for SSCCs to also analyze and understand supports in the community that are lacking for families and birth parents. SSCCs should include the birth parent voice from the beginning and focus on both building foster home capacity and strengthening supports for birth families.

FFPSA is also designed to align federal funding and policy with current research on what works best for children, youth, and families. CBC gives SSCCs the opportunity to identify what is needed for their specific communities. This allows for using evidence-based practices from the Title IV-E Prevention Services Clearinghouse, along with aligned interventions (e.g. Trust-Based Relational Intervention, already in use in Region 7) and culturally responsive practice.
LESSONS LEARNED FROM EXISTING TEXAS CBCs

At the time of this landscape analysis, DFPS has initiated or is engaging active Community-Based Care contracts in five catchment areas across Texas, and contracts are in various stages of implementation (see Appendix J for a description of implementation stages). Current catchment areas are listed below in order of implementation stage, beginning with the longest standing SSCCs.

- **Region 3B** (Tarrant, Erath, Hood, Johnson, Palo Pinto, Parker, and Somervell counties) - DFPS originally executed an SSCC contract with ACH Child and Family Services (ACH) in 2014 under Foster Care Redesign. This contract was renewed in 2018 to include new CBC requirements and transition of kinship and legal case management services. ACH’s Our Community Our Kids (OCOK) continued to provide services under Stage 1 of CBC until October 2019, when it began its six-month transition plan to Stage II. As of March 2020, OCOK is providing case management and all other Stage II services to approximately 1,200 children and youth.

- **Region 2** (Abilene/Wichita Falls) – In 2018, Texas Family Initiative, LLC, was awarded an SSCC contract and initiated a partnership with New Horizons Ranch and Center Inc. to form 2INgage. 2INgage began placing children in December 2018 as part of Stage I and received approval to begin a six-month transition to Stage II in December 2019. As of March 2020, 2INgage was providing services to approximately 750 children and youth.

- **Region 8A** (Bexar County) - The Children’s Shelter in San Antonio, Texas, was awarded an SSCC contract for Region 8A in August 2018. The shelter then created Family Tapestry to hold the contract and began placing children under Stage I in February 2019. As of March 2020, Family Tapestry was providing services to approximately 1,720 children and youth.

- **Region 1** (Amarillo/Lubbock) - St. Francis Community Services, Inc., was awarded an SSCC contract in July 2019 and began serving children as part of Phase I in January 2020. As of March 2020, St. Francis Community Services was providing services to approximately 740 children and youth.

- **Region 8B** (DFPS Region 8 counties surrounding Bexar County) – In May 2019 DFPS released a Request for Application for the Region 8B catchment area and the procurement closed in August 2019. At the time of this report, DFPS was reviewing proposals.

For this landscape analysis, multiple staff in executive leadership were interviewed from Our Community Our Kids, Family Tapestry, 2INgage, and TFI Family Services, Inc.
Several SSCCs in Texas began their early preparation phase by visiting out-of-state CBC sites and/or conducting a landscape analysis. While out-of-state models vary significantly and have key differences from Texas’ CBC structure, SSCCs spoke to the value of building relationships with out-of-state contract holders and learning from longer-standing experience with funding care, staffing, and data management, specifically. Stakeholders also found value in looking at successful out-of-state models for serving children, youth, and families in legacy (non-CBC) foster care systems and documenting best practices.

On a more local level, several SSCCs conducted landscape analyses at different scales to assess foster family capacity, foster family needs, foster family demographics, characteristics of children and youth in care, and special population needs (e.g. survivors of sex trafficking, homeless youth, youth identifying as LGBTQ+, etc.), as well as map services for children and families. Special emphasis was placed on understanding current foster family capacity and characteristics; in one case, an SSCC recruited the help of child placing agencies in sharing three years’ worth of data on their foster families, including demographics and success trends, and then tested this data with foster families through focus groups to confirm it was reflective of their experience. This data was used to help shape foster family recruitment campaign needs and priorities.

In another instance, the landscape analysis included surveying of targeted businesses and nonprofits outside of the foster care space to better understand their perspective on the local foster care system, and the role they might potentially play as a CBC stakeholder. Some SSCCs took on the role of conducting their own research and focus groups, while others partnered with university researchers to collect more in-depth data and solicited funding from local foundations to support this work.

All SSCCs emphasize the importance of engaging child placing agencies and service providers early and often throughout the preparation phase. Monthly meetings were held with networks of providers to hear and discuss concerns, to foster organizations’ investment in the process, and to allow time for providers to assess where they “fit” within their community’s new CBC structure and where they might need to adapt their service delivery in the future. With ongoing provider feedback, SSCCs were able to refine their preparation and implementation plans to be as responsive as possible to provider needs. For example, after hearing providers’ fears regarding one SCC needing to fundraise, potentially causing a rapid increase in competition for funds, the SCCC made a concerted effort to communicate with funders around a one-time gift to support startup costs and emphasized the importance of continued funding for providers.
Broad community stakeholder engagement was also crucial during early preparation. SSCCs made a point to travel to CPS offices and meet with leadership as well as caseworkers to share their agencies’ model and culture and answer questions, thereby laying a foundation for future recruitment efforts. Alliances were built with community organizations addressing crosscutting needs of children and youth in the foster care system, such as challenges transitioning into financial independence, youth homelessness, and sex trafficking. In addition to hiring designated staff to oversee community engagement efforts, some SSCCs built their boards strategically and leveraged their board members to assist in increasing awareness and understanding within their catchment area. These efforts were particularly important in catchment areas with sharp urban/rural divides, which required SSCCs to creatively deploy individuals with existing social capital in rural communities. Overall, interviewees emphasized the need for SSCCs to have direct partnerships with community stakeholders in rural parts of a catchment area, or the ability to quickly form relationships in rural areas well ahead of the start-up phase.

### FUNDING QUALITY CARE

SSCCs agree that the current funding structure for CBC does not fully cover the cost of quality care for children and youth, and access to additional capital is vital to ensure safety and permanency, as well as the SSCC’s overall financial viability. There is a critical need for SSCCs to work with their communities early on to define quality care and safety for their children and establish an unwavering commitment to this standard and its costs. Due to advocacy efforts, there is now more state funding available than before to support the cost of care; however, multiple SSCCs report facing significant deficits each month, especially through their first year, due to fully covering the cost of care for children and youth in their catchment area.

Under the blended rate system, SSCCs have flexibility in deciding the level at which they will pay providers for care; one SSCC gives the example of paying an additional sum for a provider to place a child assessed at a moderate care level given that the child had experienced multiple placements, in an effort to support stability. However, SSCCs report that there are multiple costs that are not factored into the blended rate. For example, indirect administrative costs for an SSCC are significantly greater than a state entity that is able to spread these costs out across an entire state. Separating placement and case management responsibilities throughout Phase 1 requires SSCCs to pay full overhead costs with only a portion of the CBC revenue-producing activities in place throughout Phase 1. Other examples include the cost of higher standards associated with being an accredited institution, as well as liability insurance to protect SSCCs in the case of legal prosecution.

Following House Bill 1 General Appropriations Act produced out of the 86th Texas Legislature, the Health and Human Services Commission (HHSC) is partnering with DFPS to evaluate the methodology for establishing foster care rates and to explore alternatives with the input of community stakeholders (Appendix K). HHSC and DFPS have committed to reporting on their findings no later than September 1, 2020.

With regard to fundraising, some SSCCs conducted little to no initial fundraising due to having access to an endowment or private capital as part of a larger for-profit provider network. However, in one instance, Family Tapestry, the SSCC in Region 8A, raised $8.1 million to create a full five-year budget. This was funded primarily by local foundations and included start-up costs for the SSCC as well as funds to close the delta in cost of care.
Family Tapestry is a division of the San Antonio Children’s Shelter and was created specifically to serve as a Single Source Continuum Contractor for Region 8A, covering Bexar County. The organization was built “from the ground up” with a fundraising campaign to deliver on an $8 million, five-year budget plan. Family Tapestry strategically leveraged data collected by a landscape analysis as well as expertise gained by existing SSCCs to build out its staffing structure and budget. It began by working closely with ACH Child and Family Services to understand its process for budgeting and began to conceptualize a five-year budget with the first two years incurring heavy costs from a focus on 1) building foster care capacity and 2) keeping children and youth close to home in the least restrictive environment possible. The last two years of the budget assumed more efficiencies after full implementation of case management and breaking even as early as the third year.

Budgeting strategies used by Family Tapestry include:

- Adjusting ACH’s budgeting framework to account for the unique makeup of children and youth in foster care in Region 8A, factoring in both current levels of care and child age.

- Examining trends in removals and placement to determine staffing structure for a well-resourced intake and placement team, including costs for transporting outside of the catchment area. The number of removals was intentionally over-projected by 10 percent to ensure sufficient service capacity.

- Establishing a 13-to-1 caseload ratio as a pillar in the budget, as well as ongoing training for staff and partners in trauma-informed care.

- Inclusion of services requested by former foster youth through focus groups, such as access to life coaching.

- Inclusion of capacity building support for providers in marketing “toolkits” to assist with recruitment of new foster families.
EXPANDING SERVICE CAPACITY

Community-Based Care clearly mandates expansion of service capacity to successfully place every child within his or her catchment area, which requires SSCCs to engage heavily in foster family recruitment efforts. Many SSCCs launched initial foster family recruitment campaigns and continue recruiting with the help of full-time staff positions as well as providers. SSCCs emphasized the challenge providers often face in transitioning from competing with one another to recruit families, to full-scale strategic collaboration. In one instance, providers were connected early on to fully funded trainings in building their communication strategy for recruitment, strengthening their brand, and managing social media. They were also asked to participate in joint “telethon-style” public outreach events to talk to community members about fostering.

Overall, SSCCs emphasized the need to dedicate additional resources to fostering collaboration among providers in their recruitment, and to closing the “urban/rural recruitment divide.” SSCCs sometimes struggle to persuade urban providers to expand their services to rural zones. To grow this capacity, SSCCs have released requests for information and have asked providers to bid on recruiting and training families in these areas, while offering to support them with funds to hire additional staff and plan satellite offices.

SSCCs have employed a variety of strategies to address the challenge of expanding therapeutic foster care capacity. Common measures include raising the payment to therapeutic foster families in tandem with increasing training requirements, creating professional foster care opportunities, and in some cases, traveling to residential treatment centers providers and recruiting them to locate in the catchment area. SSCCs also continue to develop creative emergency placement solutions in their communities, ranging from new children’s shelters to developing foster homes with a mixture of long-term and emergency placement beds available.
STAFFING

According to SSCCs, investing heavily in staffing and salaries is key to providing quality care and safety for children and youth. It can also provide much-needed stability as the organization experiences an inevitable level of transitional chaos. SSCCs must hire sufficient staff to meet the community’s standards of quality care. Existing SSCCs have found this often exceeds what is mandated in the contract and covered by the state’s reimbursement. Specific roles that were deemed crucial for success included mental health clinicians, physical health providers such as nurses, dedicated community relations staff, child transporters, “child advocates” or “care coordinators” to work between CPS caseworkers and provider staff as well as staff with strong data skills that can reconcile DFPS data and work with providers to secure clean, quality data over time.

With regard to recruiting CPS staff members, one SSCC has had success recruiting CPS staff throughout Phase 1, offering to hire staff in good standing after a cursory interview, and matching current salaries to counter the loss of state benefits and retirement. Other SSCCs did not actively recruit at CPS, but planned to do so before entering Phase 2 of CBC implementation. Recruitment of CPS staff was viewed as extremely valuable in providing continuity for children and families whose case is transferred into the CBC system. Still, interviewees reported that some former CPS staff face challenges in transitioning to a different organizational culture, and that turnover among this group can be high.

SSCCs cited multiple strategies to improve staff retention, including revising personal leave structures, instituting protected lunch hours, offering clinical supervision for staff seeking licensure, and tuition reimbursement.

DATA COLLECTION

Texas SSCCs have created data systems that run parallel to those at DFPS but remain separate. SSCCs emphasize the need for building capacity to collect, manage, and use data that both complies with state contract requirements and also supports program improvement and community decision-making. Significant staff time is dedicated to working with providers to improve their input of timely, accurate data. CBCs explain that positive, strong working relationships are key throughout this capacity building stage as provider staff unlearn old reporting processes and adopt new ones.

In addition to processing data related to foster family capacity and child placement, several SSCCs emphasize the importance of tracking internal process indicators that show how staff are using their time. This information allows the SCC to make informed decisions about staffing key roles. For example, tracking the percentage of time staff spend transporting children and youth informs the number of official child transporters that are hired.

Currently, there is a CBC Analytics Roundtable of data analysts from SSCCs across Texas as well as researchers from Texas Tech University working to improve data analysis within the context of CBC, and to work toward capacity for predictive analytics.
The information contained in this report is intended to provide communities across Region 7 with a common understanding of the opportunities and challenges related to increasing their capacity to care for children, youth, and families in the child welfare system. Using the findings as a platform for discussion, as well as more localized information that can be developed using the data sources included, community organizations, stakeholders, and families can begin a planning process designed to increase their capacity to provide services and readiness for when Community-Based Care comes to Region 7.

The Department of Family and Protective Services' latest Implementation Plan for the Texas Community-Based Care System (issued December 2019) indicated that the current division of Region 7 into two catchment areas would remain in place. According to the plan, all areas of the state will begin implementation of CBC by the end of state fiscal year 2027. Without a designated date for a request for proposal (RFP) being offered in Region 7, it is difficult to develop a full plan for preparing for implementation in either catchment area 7A or 7B. However, based on feedback from existing Single Source Continuum Contractors, continuing the information collection and collaboration building that this project has initiated will be imperative to the region being ready to respond.

There is an opportunity for community organizations and stakeholders to come together to determine how to best build that capacity and collectively support a response to an RFP.

As an immediate next step, it is recommended that each catchment area begin to have conversations about how they might organize themselves for a community-led planning process for preparing for CBC. This would include the development of a leadership group that is representative of the counties and stakeholders in each catchment area that would guide the work moving forward.
APPENDIX A

RESEARCH METHODOLOGY

The Michael & Susan Dell Foundation and the Reissa Foundation supported Mission Capital in conducting a landscape analysis to identify how Region 7 might build on existing assets and collaborative practices to prepare for Community-Based Care.

The specific questions investigated during this process included:

- What does data from the child welfare system tell us about the characteristics of children and youth in the region?

- What is the current service capacity across the region?

- What data is currently being collected and evaluated by organizations in Region 7 to assess quality and drive service decisions?

- How can lessons learned and best practices from existing CBC regions inform CBC in Region 7?

- What communication channels, networks, and collaborations exist in Region 7 that might be leveraged to share information and think strategically about implementing CBC?

- What are the unique challenges and opportunities in Region 7 that will affect implementation of CBC and impact high-quality service delivery to children and families?

- How might the current division of Region 7 into two catchment areas affect the availability and quality of services necessary to help children/youth and families engaged with the child welfare system achieve healing and permanency?

- Are there additional considerations for how Region 7 might be divided?

- What other factors, such as the Family First Prevention Services Act, might affect CBC readiness and implementation?

Our methodological approach encompassed both qualitative and quantitative methods, including interviews, focus groups, surveys, document review, and data analysis. The data analysis included data collected from the DFPS Data Book, regional data obtained through an open records request, regional child-level data obtained through a Memorandum of Understanding, Texas Education Agency, and STAR Health. All data sources are cited throughout the report.

Over 300 people, representing 90 agencies, organizations, and collaborations, were interviewed, participated in focus groups, completed a stakeholder capacity survey and/or attended community convenings.
GLOSSARY OF TERMS

**CANS Assessment:** According to the Department of Family and Protective Services, "the Child and Adolescent Needs and Strengths (CANS) assessment is a comprehensive trauma-informed behavioral health evaluation and communication tool. It is intended to prevent duplicate assessments by multiple parties, decrease unnecessary psychological testing, aid in identifying placement and treatment needs, and inform case planning decisions. CANS assessments help decision-making, drive service planning, facilitate quality improvement, and allow for outcomes monitoring." 62

**Congregate Care:** "A placement setting of group home (a licensed or approved home providing 24-hour care in a small group setting of seven to 12 children) or institution (a licensed or approved childcare facility operated by a public or private agency and providing 24-hour care and/or treatment typically for 12 or more children who require separation from their own homes or a group living experience). These settings may include childcare institutions, residential treatment facilities, or maternity homes." 63

**Kinship Care:** Refers to the care of a child by relatives or close family friends, also known as fictive kin. Kinship caregivers are the preferred placements for a child who must be removed from the child's home because it maintains the child's connections with their family and community. Kinship care may be paid or unpaid. 64

**Least Restrictive Setting:** "A placement for a child that, in comparison to all other available placements, is the most family-like setting." 65

**Noncustodial Parent:** "A noncustodial parent, for purposes of child placement, is a parent who is not primarily responsible for a child's care. Often the child is already familiar with his or her non-custodial parent. They may maintain an ongoing relationship. The non-custodial parent may have a personal interest in the child, and more significantly, has a constitutionally protected interest in the parent's relationship with the child (barring safety concerns about the non-custodial parent)." 66

**Paid Foster Care:** Paid foster care is used to refer to paid foster placements, including paid kinship care placements. 67

**Purchased Client Services:** Services provided by outside entities under contract with DFPS. 68

**Relative Care:** Used to refer to when children are in unpaid placements with a relative or family friend. Relative care also includes unpaid kinship placements. 69

**Substitute Care:** Provided from the time a child is removed from their home due to abuse and/or neglect and placed in CPS conservatorship until the child returns home safely or is placed in another living arrangement that does not require CPS supervision. 70
**Treatment Foster Care:** Treatment Foster Family Care is a program designed to provide innovative, multi-disciplinary treatment services to a child or youth in a highly-structured family home environment. Caregivers who participate in the Treatment Foster Family Care Program have specialized training in providing services to children with mental health and/or socio-behavioral needs that cannot be met in traditional foster care settings, including:

1. 24-hour supervision to ensure the child’s safety and sense of security, which includes frequent one-to-one monitoring with the ability to provide immediate on-site response;

2. Individualized, strengths-based therapeutic services and case management;

3. Time-limited services which include wraparound services designed to transition children to a permanent and stable placement; and

4. Other training specified in the contract.
This report was made possible through feedback gathered from 85 stakeholders representing all 30 counties in Region 7. Input was collected through the Region 7 Stakeholder Capacity Survey, community meetings, interviews, and focus groups. The following represents a summary of information collected.

**REGION 7 STAKEHOLDER CAPACITY SURVEY**

The Region 7 Stakeholder Capacity Survey was designed to collect information related to the availability of foster homes, family support services, and additional wraparound supports across the region.

The 42 participants in the survey included child placing agencies, residential treatment centers, emergency shelters, schools, foster parents, counseling centers, integrated healthcare providers, court systems (including attorneys, judges, and court staff), state and local government, child and family advocates, networks and collaboratives, child welfare boards, STAR prevention services, and resource organizations.

Participants were asked which of the following family support services and wraparound supports were available in each county:

- Advocacy
- Basic needs
- Battering intervention and prevention program
- Court-related services
- Disability services
- Educational support
- Family violence programs
- Fatherhood services or programs
- Independent living preparation
- Mental health services
- Mentoring
- Parenting classes
- Physical health services
- Prevention and early intervention services
- Respite services
- Reunification support
- Transitional living support
- Translation/interpretation
- Substance abuse services
- Supervised visitation services
Of the 20 service categories listed above, survey results show a greater diversity of services in the lower portion of Region 7.

- 66 percent of large counties have at least 18 of the service categories.
- 22 percent of medium counties were reported to have only one service category available.
- 60 percent of small counties have five or fewer service categories available.

All 30 counties were reported to have at least one service category. Twenty-three percent (23%) of all Region 7 counties had only one service category available within the county.

Additionally, survey respondents identified the following supports as lacking in their county:72

- 64 percent lack transportation services.
- 56 percent lack wraparound services.
- 40 percent lack transition-age youth services.
- 32 percent lack affordable child care and afterschool care.
- 32 percent lack supported employment services and supportive housing services for families.
- 20 percent lack substance abuse services.

Respondents also indicated counties were lacking mental health services and child psychiatry providers. In all counties, respondents indicated there was lack of services and resources for birth parent, kinship caregivers and post-adoption services.

**STAKEHOLDER MEETINGS**

As part of this landscape analysis, two region-wide convenings were held to further the conversation around preparing for CBC in Region 7. Attendees included staff from child- and family-serving organizations and diverse community stakeholders in the local child welfare system from all 30 counties. The service area capacity results by county were shared at one of the convenings and reviewed by participants to help validate the findings. The majority of services in the survey that were listed as lacking were confirmed by this group.

Stakeholders re-emphasized concerns for:

- Lack of transportation services
- Long waitlists for mental health services and parenting classes
- Lack of providers accepting Medicaid
- Barriers to scheduling, including limited after-school and weekend appointment availability
- Lack of services in Spanish

Additionally, stakeholders noted the need for LGBTQ+ services, services for youth and families experiencing homelessness, and the need for educational liaisons in schools and universities.73
### DATA PLACEMATS FROM STAKEHOLDER MEETINGS

#### CHILD PLACEMENT IN REGION 7

<table>
<thead>
<tr>
<th>Area</th>
<th># of Children</th>
<th>Stay In County</th>
<th>Out of County</th>
<th>Leave Catchment</th>
<th>Leave Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region 7</td>
<td>2,741</td>
<td>40%</td>
<td>22%</td>
<td>18%</td>
<td>20%</td>
</tr>
<tr>
<td>7A</td>
<td>1,571</td>
<td>36%</td>
<td>26%</td>
<td>15%</td>
<td>23%</td>
</tr>
<tr>
<td>7B</td>
<td>1,170</td>
<td>44%</td>
<td>17%</td>
<td>22%</td>
<td>14%</td>
</tr>
</tbody>
</table>

1 out of every 10 children in emergency shelters was placed in their county.

6 out of every 10 children in residential treatment centers were placed outside of Region 7.

**Placement by Level of Care**

- **Basic** (1,616 kids):
  - 43% (553 kids)
  - 26% (378 kids)
  - 19% (298 kids)
  - 12% (197 kids)

- **Moderate** (273 kids):
  - 30% (82 kids)
  - 25% (68 kids)
  - 24% (70 kids)
  - 21% (53 kids)

- **Specialized** (353 kids):
  - 47% (167 kids)
  - 20% (71 kids)
  - 17% (61 kids)
  - 16% (55 kids)

- **Intense** (106 kids):
  - 54% (57 kids)
  - 20% (21 kids)
  - 14% (15 kids)
  - 12% (12 kids)
YOUTH AGE 10-17 PLACED OUT OF REGION

LEVEL OF CARE
- Basic
- Moderate
- Specialized

Foster Home
- 44%
- 37%
- 19%

Emergency Shelter
- 59%
- 18%
- 24%

Total Time in Foster Care
- 5+ years 5%
- 2-4 years 20%
- Less than two years 75%

TOP 4 COUNTIES WHERE YOUNG ADULTS AGE 18-21 ARE LIVING
- Travis: 50%
- Bell: 12%
- Hays: 9%
- Williamson: 8%

Source: DFPS Online Data Book & April 30, 2019, child-level data, point in time

Source: DFPS Data Portal
April 30, 2019 child-level data as provided by DFPS
ADDITIONAL STAKEHOLDER FEEDBACK

Focus groups and individual interviews were also conducted with stakeholders around the region, including child- and family-serving organizations, CASA, CPS, foster parents, and kinship caregivers.

The following themes were noted throughout focus groups with kinship caregivers and foster parents.

- **Intentional Matching System.** A comprehensive placement matching system is needed to match children and youth entering foster care with the right family at the time of the initial placement. This should include a database of all available foster homes and families that can be accessed when a child needs a home. A system would add value on its own but would also require staff to ensure children’s needs are prioritized through the matching process.

- **Network of Resources.** Kinship caregivers and foster parents noted a lack of community supports available for them. All reported that having a support group to build connections and receive guidance on how to navigate the child welfare system was important and currently lacking in most areas in Region 7. Access to respite care, babysitters, and transportation assistance was identified as being available to certain groups and in certain areas of the region.

- **Birth Parent Support.** Both kinship caregivers and foster parents want to communicate with and be a support to birth parents. Birth parents should also be provided with additional support beyond the requisite parenting classes such as mentoring and budgeting. Reunification support for families was also noted as lacking.

- **Timely Access to Providers and Services.** All caregivers reported not being able to access physical and behavioral health providers that accept Medicaid and do not have a waitlist. Foster parents also noted that therapeutic services should be available early on in a placement to provide stabilizing wraparound supports. They shared that there is a general lack of providers in their counties, and that identifying and scheduling with specialists and mental health providers is especially difficult.

CASA and CPS staff focus groups identified another major theme.

- **Needs of children and youth increasing** - CASA and CPS staff reported that the needs of children and youth they serve become more acute each year, yet the provider network has not adapted to meet this demand for intensive services. There is a need to build capacity and ensure that staff and organizations engaging with high-need children and youth are appropriately responsive.
PARTICIPATING ORGANIZATIONS

Below are the names of organizations that participated in data collection through surveys, regional convenings, individual interviews, and focus groups. Note: Birth family, foster family, and former foster youth focus groups were conducted. Participant names are not included below to protect privacy.

- 126th Civil District Court
- 2INgage
- 395th District Court
- A World for Children
- Angelheart - Williamson County
- ARMS
- Arrow Child & Family Ministries
- Austin Angels
- Aware Central Texas
- Bastrop County Cares
- Bell County Ad Litems
- Bluebonnet Trails Community Services
- Bright Future
- Burnet County Child Welfare Board
- CASA for Kids of South Central Texas
- CASA for the Cross Timbers Area
- CASA for the Highland Lakes Area
- CASA of Bastrop, Fayette & Lee Counties
- CASA of Bastrop
- CASA of Bell & Coryell Counties
- CASA of Brazos Valley (Voices for Children)
- CASA of Central Texas
- CASA of Hill Country Texas
- CASA of McLennan County
- CASA of Travis County
- CASA of Williamson County
- Center for Child Protection
- Central Counties Services
- Central Texas Council of Child Protection Boards
- Central Texas Table of Grace
- Central Texas Youth Services
- Change 1
- Children's Advocacy Center of Bastrop, Lee & Fayette Counties
- Children's Advocacy Center of Central Texas
- Child Welfare Board - Hays County
- Citrus Family Care Network
- Department of Family and Protective Services (DFPS)
- DePelchin Children's Center
- Everyday Life
- Family Nurturing Center of Texas
- Family Restoration Coalition (Families Count)
- Family Tapestry
- Foster Angels of Central Texas
- Foster Community
- Fostering Hope Austin
- Foster Love Bell County
- Foster Texas
- Foster Village
- Giocosa Foundation
- Hays-Caldwell Women's Center
- Hays County Child Protective Board
- Heart of Texas Region MHMR
- Helping Hand Home for Children
- Hill Country Children's Advocacy Center
- Integral Care
- Kids In A New Groove
- LifeWorks
- Mauney & Associates LLC
- Methodist Children's Home
- Michael & Susan Dell Foundation
- National Association of Social Workers-Texas Chapter
- New Horizons
- Our Community Our Kids
- Partnerships for Children
- Pathways Youth and Family Services
- Presbyterian Children's Homes and Services
- Rock Solid Foundation
- Spirit Reins
- Stand Up Eight
- STARRY
- Texas Alliance of Child and Family Services
- Texas Baptist Children's Home
- Texas CASA
- Texas Department of Family Protective Services
- Texas Foster Care
- Texas Network of Youth Services
- TFI Family Services
- The Giocosa Foundation
- Therapeutic Family Life
- The Reissa Foundation
- The SAFE Alliance
- The Settlement Home for Children
- Travis County Civil Courts
- Travis County Health and Human Services
- Travis County Juvenile Probation
- Upbring
- Williams House
- Williamson County Child Welfare Board
- Williamson County Court
- Williamson County Drug Court
APPENDIX D

DESCRIPTIONS OF DFPS LEVELS OF CARE

Source: https://www.dfps.state.tx.us/Child_Protection/Foster_Care/Service_Levels.asp

BASIC SERVICE LEVEL

The Basic Service Level consists of a supportive setting, preferably in a family, that is designed to maintain or improve the child's functioning, including:

- Routine guidance and supervision to ensure the child's safety and sense of security.

- Affection, reassurance, and involvement in activities appropriate to the child's age and development to promote the child's well-being.

- Contact, in a manner that is deemed in the best interest of the child, with family members and other persons significant to the child to maintain a sense of identity and culture.

- Access to therapeutic, habilitative, and medical intervention and guidance from professionals or paraprofessionals, on an as-needed basis, to help the child maintain functioning appropriate to the child's age and development.

CHARACTERISTICS OF A CHILD WHO NEEDS BASIC SERVICES

A child needing basic services is capable of responding to limit-setting or other interventions.

The children and youth needing basic services may include:

- A child whose characteristics include one or more of the following:
  - Transient difficulties and occasional misbehavior;
  - Acting out in response to stress, but episodes of acting out are brief; and
  - Behavior that is minimally disturbing to others, but the behavior is considered typical for the child's age and can be corrected.

- A child with intellectual or developmental disabilities whose characteristics include minor to moderate difficulties with conceptual, social, and practical adaptive skills.
MODERATE SERVICE LEVEL

The Moderate Service Level consists of a structured supportive setting, preferably in a family, in which most activities are designed to improve the child's functioning including:

- More than routine guidance and supervision to ensure the child's safety and sense of security;
- Affection, reassurance, and involvement in structured activities appropriate to the child's age and development to promote the child's well-being;
- Contact, in a manner that is deemed in the best interest of the child, with family members and other persons significant to the child to maintain a sense of identity and culture; and
- Access to therapeutic, habilitative, and medical intervention and guidance from professionals or paraprofessionals to help the child attain or maintain functioning appropriate to the child's age and development.

In addition to the description in the section above, a child with primary medical or habilitative needs may require intermittent interventions from a skilled caregiver who has demonstrated competence.

CHARACTERISTICS OF A CHILD WHO NEEDS MODERATE SERVICES

A child needing moderate services has problems in one or more areas of functioning. The children and youth needing moderate services may include:

- A child whose characteristics include one or more of the following:
  - Frequent non-violent, anti-social acts;
  - Occasional physical aggression;
  - Minor self-injurious actions; and
  - Difficulties that present a moderate risk of harm to self or others.

- A child who abuses alcohol, drugs, or other conscious-altering substances whose characteristics include one or more of the following:
  - Substance abuse to the extent or frequency that the child is at-risk of substantial problems; and
  - A historical diagnosis of substance abuse or dependency with a need for regular community support through groups or similar interventions.

- A child with intellectual or developmental disabilities whose characteristics include:
  - Moderate to substantial difficulties with conceptual, social, and practical adaptive skills to include daily living and self-care; and
  - Moderate impairment in communication, cognition, or expressions of affect.

- A child with primary medical or habilitative needs, whose characteristics include one or more of the following:
  - Occasional exacerbations or intermittent interventions in relation to the diagnosed medical condition;
  - Limited daily living and self-care skills;
  - Ambulatory with assistance; and
  - Daily access to on-call, skilled caregivers with demonstrated competence.
SPECIALIZED SERVICE LEVEL

The Specialized Service Level consists of a treatment setting, preferably in a family, in which caregivers have specialized training to provide therapeutic, habilitative, and medical support and interventions including:

- 24-hour supervision to ensure the child's safety and sense of security, which includes close monitoring and increased limit setting;

- Affection, reassurance, and involvement in therapeutic activities appropriate to the child's age and development to promote the child's well-being;

- Contact, in a manner that is deemed in the best interest of the child, with family members and other persons significant to the child to maintain a sense of identity and culture; and

- Therapeutic, habilitative, and medical intervention and guidance that is regularly scheduled and professionally designed and supervised to help the child attain functioning appropriate to the child's age and development.

In addition to the description in the section above, a child with primary medical or habilitative needs may require intermittent interventions from a skilled caregiver who has demonstrated competence.

CHARACTERISTICS OF A CHILD WHO NEEDS THE SPECIALIZED SERVICES

A child needing specialized services has severe problems in one or more areas of functioning. The children and youth needing specialized services may include:

- A child whose characteristics include one or more of the following:
  - Unpredictable non-violent, anti-social acts;
  - Frequent or unpredictable physical aggression;
  - Being markedly withdrawn and isolated;
  - Major self-injurious actions to include recent suicide attempts; and
  - Difficulties that present a significant risk of harm to self or others.

- A child who abuses alcohol, drugs, or other conscious-altering substances whose characteristics include one or more of the following:
  - Severe impairment because of the substance abuse; and
  - A primary diagnosis of substance abuse or dependency.
CHARACTERISTICS OF A CHILD WHO NEEDS THE SPECIALIZED SERVICES (cont.)

- A child with intellectual or developmental disabilities whose characteristics include one or more of the following:
  - Severely impaired conceptual, social, and practical adaptive skills to include daily living and self-care;
  - Severe impairment in communication, cognition, or expressions of affect;
  - Lack of motivation or the inability to complete self-care activities or participate in social activities;
  - Inability to respond appropriately to an emergency; and
  - Multiple physical disabilities including sensory impairments.

- A child with primary medical or habilitative needs, whose characteristics include one or more of the following:
  - Regular or frequent exacerbations or interventions in relation to the diagnosed medical condition;
  - Severely limited daily living and self-care skills;
  - Non-ambulatory or confined to a bed; and
  - Constant access to on-site, medically skilled caregivers with demonstrated competencies in the interventions needed by children in their care.

INTENSE SERVICE LEVEL

The Intense Service Level consists of a high degree of structure, preferably in a family, to limit the child's access to environments as necessary to protect the child. The caregivers have specialized training to provide intense therapeutic and habilitative supports and interventions with limited outside access, including:

- 24-hour supervision to ensure the child's safety and sense of security, which includes frequent one-to-one monitoring with the ability to provide immediate on-site response.

- Affection, reassurance, and involvement in therapeutic activities appropriate to the child's age and development to promote the child's well-being;

- Contact, in a manner that is deemed in the best interest of the child, with family members and other persons significant to the child, to maintain a sense of identity and culture;

- Therapeutic, habilitative, and medical intervention and guidance that is frequently scheduled and professionally designed and supervised to help the child attain functioning more appropriate to the child's age and development; and

- Consistent and frequent attention, direction, and assistance to help the child attain stabilization and connect appropriately with the child's environment.
**INTENSE SERVICE LEVEL (cont.)**

In addition to the supports and interventions listed in the section above:

- Children and youth with intellectual or developmental disabilities needs require professionally directed, designed and monitored interventions to enhance mobility, communication, sensory, motor, and cognitive development, and self-help skills.

- Children and youth with primary medical or habilitative needs require frequent and consistent interventions. The child may be dependent on people or technology for accommodation and require interventions designed, monitored, or approved by an appropriately constituted interdisciplinary team.

**CHARACTERISTICS OF A CHILD THAT NEEDS INTENSE SERVICES**

A child needing intense services has severe problems in one or more areas of functioning that present an imminent and critical danger of harm to self or others. The children and youth needing intense services may include:

- A child whose characteristics include one or more of the following:
  - Extreme physical aggression that causes harm;
  - Recurring major self-injurious actions to include serious suicide attempts;
  - Other difficulties that present a critical risk of harm to self or others; and
  - Severely impaired reality testing, communication skills, cognitive, affect, or personal hygiene.

- A child who abuses alcohol, drugs, or other conscious-altering substances whose characteristics include a primary diagnosis of substance dependency in addition to being extremely aggressive or self-destructive to the point of causing harm.

- A child with intellectual or developmental disabilities whose characteristics include on or more of the following:
  - Impairments so severe in conceptual, social, and practical adaptive skills that the child's ability to actively participate in the program is limited and requires constant one-to-one supervision for the safety of self or others; and
  - A consistent inability to cooperate in self-care while requiring constant one-to-one supervision for the safety of self or others.

- A child with primary medical or habilitative needs, whose characteristics include one or more of the following:
  - Frequent acute exacerbations and chronic, intensive interventions in relation to the diagnosed medical condition;
  - Inability to perform daily living or self-care skills; and
  - 24-hour on-site, medical supervision to sustain life support.
The Intense-Plus Service Level is only available in Residential Treatment Centers and consists of a high degree of structure to support the child in his or her environment while intervening as necessary to protect the child. The caregivers have specialized training specific to the child’s characteristics. The therapists on staff have professional licensure or graduate level education to provide therapeutic services, intense therapeutic supports and interventions, including:

- 24-hour supervision to ensure the child’s safety and sense of security, including constant one-to-one monitoring during waking hours by an employee trained on the child’s therapeutic interventions and able to provide immediate onsite response.

- Participation in individual and group therapy sessions that are research-supported, reimbursable by Medicaid, and readily available in the community. These include but are not limited to specialized therapies such as Eye Movement Desensitization and Reprocessing Therapy, Applied Behavior Analysis (certified), Treatment for Anorexia/Bulimia/Eating Disorders, and others as appropriate.

- Use therapeutic programs that are documented as either well supported, supported, promising practice or evidence based and are appropriate to the child’s age and development to promote the child’s well-being. Therapy must address trauma and the behaviors resulting in the need for Intense-Plus level of care.

- Contact, in a manner that is deemed in the best interest of the child, with siblings, family members, and other persons significant to the child in order to maintain a sense of identity and culture.

- Services to help the child learn or improve skills and functioning for daily living.

- Medical intervention and therapy that is structured daily, and professionally designed and supervised to help the child attain functioning more appropriate to the child’s age and development and to address the behaviors resulting in the need for Intense-Plus services.

- Consistent and constant direction, intervention, and structured support to help the child attain stabilization and connect appropriately with the child’s environment.

- Professionally directed, designed, and monitored interventions for a child with intellectual or developmental disabilities, to enhance mobility, communication, sensory, motor, cognitive development, behavioral and self-help skills.
CHARACTERISTICS OF A CHILD THAT NEEDS INTENSE-PLUS SERVICES

A child needing Intense-Plus services has severe problems in two or more areas of functioning that present an extreme, imminent and critical danger of harm to self or others. The children and youth needing intense-plus services may include:

- A child whose characteristics include one or more of the following:
  - Has extreme and reoccurring episodes of physical aggression that causes harm;
  - Has extreme and reoccurring episodes of sexually aggressive behaviors;
  - Has assaultive, homicidal, suicidal, recurring major self-injurious actions;
  - Has chronic runaway behaviors;
  - Has severely impaired reality testing, communication skills, and cognition.

- A child who abuses alcohol, drugs, or other conscious-altering substances whose characteristics include a primary diagnosis of substance dependency in addition to being extremely aggressive or self-destructive to the point of causing harm.

- A child who has eating disorders causing concerns for health and well-being.

- A child with intellectual or developmental disabilities whose characteristics include on or more of the following:
  - Impairments so extreme in conceptual, social, and practical adaptive skills that the child's ability to actively participate in the program is limited and requires constant one-to-one supervision for the safety of self or others; and
  - A consistent inability or unwillingness to cooperate in self-care while requiring, constant one-to-one supervision for the safety of self or others;

- A child who is actively psychotic and has acted out on the psychosis.

- A child who is a survivor of human or sex trafficking.

- A child who has chronic criminal behaviors that result in current or recent involvement with the justice system.

- A child who has displayed animal cruelty in the last 90 days.
### APPENDIX E

#### CHILD PLACEMENT LOCATION BY COUNTY

<table>
<thead>
<tr>
<th>County</th>
<th># of Children</th>
<th>% in County</th>
<th>% out of County but in Region</th>
<th>% out of Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bastrop</td>
<td>61</td>
<td>25%</td>
<td>36%</td>
<td>39%</td>
</tr>
<tr>
<td>Bell</td>
<td>429</td>
<td>34%</td>
<td>38%</td>
<td>28%</td>
</tr>
<tr>
<td>Blanco</td>
<td>12</td>
<td>8%</td>
<td>59%</td>
<td>33%</td>
</tr>
<tr>
<td>Bosque</td>
<td>24</td>
<td>8%</td>
<td>63%</td>
<td>29%</td>
</tr>
<tr>
<td>Brazos</td>
<td>49</td>
<td>39%</td>
<td>22%</td>
<td>39%</td>
</tr>
<tr>
<td>Burleson</td>
<td>20</td>
<td>20%</td>
<td>60%</td>
<td>20%</td>
</tr>
<tr>
<td>Burnet</td>
<td>42</td>
<td>33%</td>
<td>43%</td>
<td>24%</td>
</tr>
<tr>
<td>Caldwell</td>
<td>28</td>
<td>11%</td>
<td>68%</td>
<td>21%</td>
</tr>
<tr>
<td>Coryell</td>
<td>67</td>
<td>16%</td>
<td>56%</td>
<td>28%</td>
</tr>
<tr>
<td>Falls</td>
<td>6</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Fayette</td>
<td>11</td>
<td>36%</td>
<td>19%</td>
<td>45%</td>
</tr>
<tr>
<td>Freestone</td>
<td>18</td>
<td>11%</td>
<td>61%</td>
<td>28%</td>
</tr>
<tr>
<td>Grimes</td>
<td>11</td>
<td>9%</td>
<td>73%</td>
<td>18%</td>
</tr>
<tr>
<td>Hamilton</td>
<td>14</td>
<td>14%</td>
<td>72%</td>
<td>14%</td>
</tr>
<tr>
<td>Hays</td>
<td>142</td>
<td>30%</td>
<td>45%</td>
<td>25%</td>
</tr>
<tr>
<td>Hill</td>
<td>38</td>
<td>16%</td>
<td>50%</td>
<td>34%</td>
</tr>
<tr>
<td>Lampasas</td>
<td>32</td>
<td>3%</td>
<td>75%</td>
<td>22%</td>
</tr>
<tr>
<td>Lee</td>
<td>13</td>
<td>0%</td>
<td>54%</td>
<td>46%</td>
</tr>
<tr>
<td>Leon</td>
<td>8</td>
<td>38%</td>
<td>49%</td>
<td>13%</td>
</tr>
<tr>
<td>Limestone</td>
<td>16</td>
<td>25%</td>
<td>50%</td>
<td>25%</td>
</tr>
<tr>
<td>Llano</td>
<td>26</td>
<td>0%</td>
<td>69%</td>
<td>31%</td>
</tr>
<tr>
<td>Madison</td>
<td>4</td>
<td>25%</td>
<td>25%</td>
<td>50%</td>
</tr>
<tr>
<td>McLennan</td>
<td>285</td>
<td>28%</td>
<td>43%</td>
<td>29%</td>
</tr>
<tr>
<td>Milam</td>
<td>35</td>
<td>26%</td>
<td>25%</td>
<td>49%</td>
</tr>
<tr>
<td>Mills</td>
<td>8</td>
<td>50%</td>
<td>37%</td>
<td>13%</td>
</tr>
<tr>
<td>Robertson</td>
<td>15</td>
<td>0%</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>San Saba</td>
<td>8</td>
<td>50%</td>
<td>37%</td>
<td>13%</td>
</tr>
<tr>
<td>Travis</td>
<td>544</td>
<td>43%</td>
<td>38%</td>
<td>19%</td>
</tr>
<tr>
<td>Washington</td>
<td>6</td>
<td>17%</td>
<td>50%</td>
<td>33%</td>
</tr>
<tr>
<td>Williamson</td>
<td>171</td>
<td>37%</td>
<td>43%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Source: DFPS child-level data, December 31, 2019
APPENDIX F

CHILDREN AND YOUTH NOT ELIGIBLE FOR STAR HEALTH SERVICES

Children and youth in the following categories are not eligible for STAR Health services and are not included in this report’s analysis for access to services for children and youth.  

- Youth adjudicated to the Texas Juvenile Justice Department (TJJD) are not eligible for Medicaid coverage and receive their healthcare through the TJJD system.

- Children and youth in Medicaid paid facilities such as nursing homes or state supported living centers (SSLCs) receive Medicaid coverage through Traditional (Fee-for-Service) Medicaid.

- A child placed out of state will transition to that state’s Medicaid or receive services from a medical provider who accepts Texas Medicaid.

- Children and youth who are placed in Texas from another state under the Interstate Compact for the Placement of Children (ICPC) agreement are not eligible for STAR Health.

- Children and youth declared manifestly dangerous and committed to an institution by a court order are not eligible for STAR Health.

- Children and youth who receive adoption assistance or permanency care assistance receive Medicaid coverage through the Medicaid STAR Program, which differs from STAR Health.
APPENDIX G

7 BENCHMARKS OF LGBTQ+ INCLUSION FROM ALL CHILDREN - ALL FAMILIES

The Human Rights Campaign’s All Children - All Families Initiative has outlined seven benchmarks of LGBTQ+ inclusion in their Celebrating Everyday Changemakers report that can help organizations and communities create a safe and healing environment for youth.

1. **Nondiscrimination**: Establishing written policies to protect LGBTQ+ clients and employees from discrimination.

2. **Staff training**: Creating a culture that is inclusive and affirming of everyone, regardless of their sexual orientation, gender identity and gender expression (SOGIE). When connected to policy changes, training can give staff the skills and knowledge needed to translate policy into practice.

3. **Rolling out the welcome mat**: Moving an organization beyond nondiscrimination to take concrete actions that explicitly welcome LGBTQ+ youth.

4. **Parent best practices**: Reviewing key practices at organizations that serve foster parents, adoptive parents, kinship caregivers and other caring adults to ensure that LGBTQ+ adults are welcomed and included.

5. **Youth best practices**: Working to improve and create affirming practices with LGBTQ+ youth and translating this commitment into a thorough scan of the agency environment and all areas of service provision.

6. **Sustainability and capacity building**: Supporting and building internal capacity for long-term and sustainable LGBTQ+ inclusion efforts while addressing challenges such as staff turnover, competing priorities and limited resources.

7. **Leadership and innovation**: Leading the broader child-welfare community forward by sharing lessons learned.

Source: Human Rights Campaign Foundation, All Children - All Families 2019 Report
APPENDIX H

APPROACHES FOR BUILDING BIRTH AND FOSTER PARENT RELATIONSHIPS

The following birth and foster parent strategies are being used in other states to empower birth and foster parents to build relationships.

- **Fostering Relationships**[^15]: Allows foster parents to provide real-time coaching to birth families during family visitations. The program’s goals are to strengthen relationships between foster parents and birth parents, help parents have successful visits, and improve the relationship between foster and birth parents. Fostering Relationships is an extension of the 10-week parent training program in the Attachment and Biobehavioral Catchup (ABC) model developed by Dr. Mary Dozier, the Amy E. du Pont Chair of Child Development at the University of Delaware.

- **Rising Ground**[^16]: Aims to introduce birth parents and foster parents within a week of the child’s placement. A facilitator makes the introduction and serves as a coach for both the birth parents and foster parents, helping them co-parent, communicate, and support the child’s needs.

- **Better Together: Building Blocks to Successful Partnerships Training**[^17]: A two-day experiential workshop that aims to foster equal, mutually respectful partnerships among foster parents, birth parents, and staff. The core components of the program include: 1) the benefits and key aspects of meaningful partnerships; 2) the value of interacting with other participants to learn from each other and understand others’ perspectives; and 3) exploring culture as it relates to foster care and meaningful partnerships.

- **Mockingbird Family™**[^18]: Seeks to provide a comprehensive approach that creates a support network around families of all kinds with the goal of keeping birth families together. The Mockingbird Family Model (MFM) uses groups called “MFM Constellations” to establish a sense of extended family and community. In each MFM Constellation, six to 10 families (foster, kinship, foster-to-adopt, and/or birth families) live in close proximity to a central, licensed foster or respite care family (Hub Home), whose role is to provide support. The support provided through the Hub Home includes assistance in navigating systems, peer support for children and parents, impromptu and regularly scheduled social activities, planned respite nearly 24 hours a day/7 days a week, and crisis respite as needed.[^18]
APPENDIX I

REGION 7 MAPS

1. REGION 7 COMMUNITY-BASED CARE CATCHMENT AREAS

Catchment
- A
- B

Source: Department of Family and Protective Services (DFPF)
2. REGION 7 COUNTY SIZE BY POPULATION

County Size (by Population)
- Large (100,000+)
- Medium (25,000 - 100,000)
- Small (under 25,000)

Source: DFPS FAD_09 Report
September 2019, child-level data
Provided by DFPS December 31, 2019
3. STAR HEALTH CANS CERTIFIED PROVIDERS

County Size (by Population)
- Large (100,000+)
- Medium (25,000 - 100,000)
- Small (under 25,000)

Children & Youth - Total number of children in the home county of legal conservatorship

CANS Provider - Total number of STAR Health Certified CANS Providers

Source: STAR Health Certified CANS Providers- Central & East
Counties in white have no providers
4. STAR HEALTH PROVIDERS - REGION 7

County Size (by Population)
- Large (100,000+)
- Medium (25,000 - 100,000)
- Small (under 25,000)

Children & Youth - Total number of children in the home county of legal conservatorship

CANS Provider - Total number of STAR Health Certified CANS Providers

Source: STAR Health Provider Directory - Central & East; Nov. 2019
5. YOUTH IN EXTENDED FOSTER CARE

Source: December 31, 2019 child-level data provided by DFPS
6. CPS CLIENT SERVICE PROVIDERS

County Size (by Population)
- Large (100,000+)
- Medium (25,000 - 100,000)
- Small (under 25,000)

P= Total number of CPS client services providers serving the county.

Source: DFPS DRIT 96018. CPS Client Services Contracts. Fiscal Year 2019 Services Authorized Region 7
7. LOCAL MENTAL HEALTH AUTHORITIES

Source: Texas Health & Human Services Commission - Local Mental Health Authorities
8. REGION 7 INDEPENDENT SCHOOL DISTRICTS

Source: Texas Education Agency - Intersecting School Districts by County - October 2019
9. REGION 7 INDEPENDENT SCHOOL DISTRICTS

Bastrop:
• Bastrop ISD
• Elgin ISD**
• Lexington ISD**
• McDade ISD
• Smithville ISD**

Bell:
• Academy ISD
• Bartlett ISD**
• Belton ISD
• Bruceville-Eddy ISD**
• Copperas Cove ISD**
• Florence ISD**
• Gatesville ISD**
• Holland ISD**
• Killeen ISD**
• Lampasas ISD**
• Moody ISD**
• Rogers ISD**
• Rosebud-Lott ISD**
• Salado ISD
• Temple ISD
• Troy ISD**

Blanco:
• Blanco ISD**
• Fredericksburg ISD
• Johnson City ISD**

Bosque:
• China Spring ISD**
• Clifton ISD**
• Cranfills Gap ISD**
• Crawford ISD**
• Hico ISD**
• Iredell ISD
• Jonesboro ISD**
• Kopperl ISD
• Meridian ISD
• Morgan ISD
• Valley Mills ISD**
• Walnut Springs ISD

Brazos:
• Bryan ISD**
• College Station ISD
• Navasota ISD**

Burleson:
• Caldwell ISD
• Snook ISD
• Somerville ISD

Burnet:
• Burnet Consolidated ISD**
• Lampasas ISD**
• Marble Falls ISD**

Caldwell:
• Gonzales ISD
• Hays Consolidated ISD**
• Lockhart ISD
• Luling ISD
• Prairie Lea ISD
• San Marcos Consolidated ISD**
• Waelder ISD

Corryell:
• Clifton ISD**
• Copperas Cove ISD**
• Crawford ISD**
• Evant ISD**
• Gatesville ISD**
• Jonesboro ISD**
• Killeen ISD**
• Lampasas ISD**
• Moody ISD**
• Ogleby ISD**
• Valley Mills ISD**

Falls:
• Bremond ISD**
• Bruceville-Eddy ISD**
• Chilton ISD
• Groesbeck ISD**
• Lorena ISD**
• Marlin ISD
• Mart ISD**
• Riesel ISD**
• Robinson ISD**
• Rosebud-Lott ISD**
• Troy ISD*
• Westphalia ISD

Fayette:
• Fayetteville ISD
• Flatonia ISD
• Giddings ISD**
• Round Top-Carmine ISD
• Schulenburg ISD
• Smithville ISD**
• Weimar ISD

Freestone:
• Buffalo ISD**
• Corsicana ISD
• Dew ISD
• Fairfield ISD
• Mexia ISD**
• Oakwood ISD**
• Teague ISD
• Wortham ISD**

Grimes:
• Anderson-Shiro Consolidated ISD
• Iola ISD
• Madisonville Consolidated ISD**
• Navasota ISD**
• Richards ISD

Hamilton:
• Cranfills Gap ISD**
• Evant ISD**
• Goldthwaite ISD**
• Hamilton ISD**
• Hico ISD**
• Jonesboro ISD**
• Star ISD**

Hays:
• Blanco ISD**
• Comal ISD
• Dripping Springs ISD**
• Hays Consolidated ISD**
• Johnson City ISD**
• San Marcos Consolidated ISD**
• Wimberley ISD

Hill:
• Abbot ISD
• Aquilla ISD
• Axtell ISD**
• Blum ISD
• Bynum ISD
• Coveing ISD
• Dawson ISD
• Frost ISD
• Grandview ISD
• Hillsboro ISD

Lampasas:
• Bremond ISD**
• Bruceville-Eddy ISD**
• Chilton ISD
• Groesbeck ISD**
• Lorena ISD**
• Marlin ISD
• Mart ISD**
• Riesel ISD**
• Robinson ISD**
• Rosebud-Lott ISD**
• Troy ISD*

Lee:
• Dime Box ISD
• Elgin ISD**
• Giddings ISD**
• Lexington ISD**

Leon:
• Buffalo ISD**
• Centerville ISD
• Leon ISD**
• Normangee ISD**
• Oakwood ISD**

Limestone:
• Axtell ISD**
• Coolidge ISD
• Groesbeck ISD**
• Hubbard ISD**
• Mart ISD**
• Mexia ISD**
• Mount Calm ISD**
• Wortham ISD**

Llano:
• Burnet Consolidated ISD**
• Johnson City ISD**
• Llano ISD

McLennan:
• Madisonville Consolidated ISD**
• Normangee ISD**
• North Zulch ISD

McMullen:
• Axtell ISD**
• Bosqueville ISD
• Bruceville-Eddy ISD**
• China Spring ISD**
• Connally ISD
• Crawford ISD**
• Gholson ISD
• Hallsburg ISD
• La Vega ISD
• Lorena ISD**
• Mart ISD**
• McGregor ISD
• Microwave ISD
• Moody ISD
• Oglesby ISD**
• Robinson ISD**
• Valley Mills ISD**
• Waco ISD
• West ISD

Milam:
• Bartlett ISD**
• Buckholts ISD
• Cameron ISD
• Gause ISD
• Holland ISD**
• Lexington ISD**
• Milano ISD
• Rockdale ISD
• Rogers ISD**
• Rosebud-Lott ISD**
• Thorndale ISD**

Milam:
• Zephyr ISD

Robertson:
• Bremond ISD**
• Bryan ISD**
• Calvert ISD
• Franklin ISD
• Groesbeck ISD**
• Hearne ISD
• Leon ISD**
• Mumford ISD

San Saba:
• Cherokee ISD
• Mason ISD
• Richland Springs ISD
• San Saba ISD

Travis:
• Austin ISD
• Coupland ISD**
• Del Valle ISD
• Dripping Springs ISD**
• Eanes ISD
• Elgin ISD**
• Hays ISD**
• Johnson City ISD**
• Lago Vista ISD
• Lake Travis ISD
• Leander ISD**
• Manor ISD
• Marble Falls ISD**
• Pflugerville ISD
• Round Rock ISD

Washington:
• Brenham ISD
• Burton ISD
• Giddings ISD**
• Hallettsville ISD

Williamson:
• Bartlett ISD**
• Burnet Consolidated ISD**
• Coupland ISD**
• Florence ISD**
• Georgetown ISD
• Granger ISD
• Hutto ISD
• Jarrell ISD
• Leander ISD**
• Liberty Hill ISD
• Round Rock ISD
• Taylor ISD
• Thorndale ISD**
• Thrall ISD

**Cross County Lines
Source: online community survey distributed as part of this landscape analysis
SSCCs gradually assume responsibilities from DFPS through a staged approach composed of three implementation phases. This process is intended to ensure the SSCC is meeting current contract requirements and is fully prepared before progressing to a new stage with added responsibilities. DFPS conducts a readiness review and certification before advancing an SSCC to a new phase of implementation. The DFPS 2019 Implementation Plan for the Texas Community-Based Care System (citation number) outlines three stages:

• **Stage I:** The SSCC is responsible for ensuring the full continuum of paid foster care services, as well as Preparation for Adult Living (PAL) Life Skills Training and purchased adoption services. While the transition from Stage I to Stage II is based on SSCC readiness, DFPS anticipates that Stage I implementation will last approximately 18 months following contract execution (including the six-month start-up period).

• **Stage II:** The SSCC continues responsibility for all Stage I services and becomes responsible for the provision of all substitute care services (kinship, reunification, etc.), Implementation Plan for the Texas Community-Based Care System 13 Interstate Compact on the Placement of Children (ICPC), some PAL aftercare services, as well as all case management services (establishing the permanency goal for the family, face-to-face visits with children and families, permanency/case planning activities, court activities, kinship services, etc.). The advance from Stage II to Stage III will occur 18 months after the SSCC begins serving all children and families in the catchment area.

• **Stage III:** The SSCC continues provision of services outlined in Stage I and II; and financial accountability through the use of incentives and remedies for the timely achievement of permanency for children.
RIDER EXCERPT REGARDING EVALUATION OF FOSTER CARE RATE METHODOLOGY

Sec. 32. Foster Care Rate Methodology.

(a) Evaluation. Out of funds appropriated above to the Health and Human Services Commission (HHSC) in Strategy L.1.1, HHS System Supports, and in consultation with the Department of Family and Protective Services (DFPS), HHSC shall evaluate the methodology for establishing foster care rates to determine whether there is an alternative methodology that would increase provider capacity capable of delivering appropriate and evidence-based services, incentivize quality improvements, and maximize the use of federal funds. HHSC shall also evaluate cost reporting requirements to identify opportunities to streamline reporting and ensure necessary information is included to support any alternative foster care rate methodology. HHSC may contract for the evaluation with a third party who has demonstrated capacity to develop residential child care rates and risk-based contracting in child welfare settings. HHSC and DFPS shall allow stakeholders the opportunity to provide input on the alternative rate methodology. If an alternative is identified, HHSC and DFPS may implement the revised methodology if doing so would not increase General Revenue expenditures for foster care payments in Strategy B.1.9, Foster Care Payments.

(b) Rate Methodology. It is the intent of the legislature that HHSC consider the following in evaluating a new rate methodology as outlined in subsection (a):

1. Accounting for differences in the individualized needs of children as determined by a best practice needs assessment tool capable of predicting foster care costs reliable enough to inform rate setting, such as the Child and Adolescent Needs and Strengths (CANS) Assessments;
2. Accounting for regional variation in costs, including differences in the individualized needs of children served in different regions and locally competitive wages to recruit and maintain qualified staff;
3. Incentivizing placing children in the least restrictive environment that can best meet their needs;
4. Maximizing the use of high-quality intensive home and community-based services;
5. Maximizing the efficient and effective use of federal funds to improve capacity and address gaps in care, including:
   A. Increasing access to current Medicaid benefits such as mental health rehabilitation and targeted case management services;
   B. Identifying Medicaid benefits offered in other states for foster youth that decrease hospitalization and lower costs; and
   C. Improving reporting and tracking of data to maximize Title IV-E Reimbursements;
6. Incorporating a viable and sustainable methodology for Community-based Care (CBC) rates, based on best practices and the experiences of other states;
7. Providing opportunities, at least semi-annually, to adjust the rates based on demonstrated fluctuations across CBC regions and population needs;
8. Including risk mitigation strategies that balance the risk to the state with the need to attract and maintain viable Single Source Continuum Contractors for each CBC region, such as time limited risk corridors; and
9. Being consistent with actuarially sound rate development principles to the fullest extent possible.
RIDER EXCERPT REGARDING EVALUATION OF FOSTER CARE RATE METHODOLOGY 81 (cont.)

Sec. 32. Foster Care Rate Methodology (cont.)

(c) Cost Reports. It is the intent of the legislature that HHSC consider the following in evaluating the cost reports as outlined in subsection (a):

1. Eliminating reporting requirements that are not required by state or federal law and are not currently being used by HHSC or DFPS to set rates;
2. Adding detail where needed to align rates paid with the quality and intensity of services across levels of care; and
3. Including additional or modified reporting requirements necessary to support implementation of any alternative rate methodology.

(d) Not later than September 1, 2020, HHSC and DFPS shall report on the evaluation of the methodology and cost-reporting requirements to the Governor, Lieutenant Governor, Speaker of the House, Chair of the Senate Finance Committee, Chair of the House Appropriations Committee, permanent standing committees in the House of Representatives and the Senate with jurisdiction over health and human services, and the Legislative Budget Board.

1. Texas Department of State Health Services. “Projected Texas Population by County, 2019.”
2. Child-level data was acquired through a data sharing agreement with the Texas Department of Family and Protective Services. Point-in-time information for demographics and placement was from December 31, 2019.
3. Ibid.
4. Ibid.
5. Ibid.
8. Ibid.
9. Ibid.
10. Ibid.
11. Ibid.
12. Child-level data was acquired through a data sharing agreement with the Texas Department of Family and Protective Services. Point-in-time information for county size correlation with placement was from 30 April 2019.
13. National Working Group on Foster Care and Education. “Education is the Lifeline for Youth in Foster Care.” October 2011.
15. December 31, 2019 Child-level data
SOURCES

SOURCES

45. Ibid.
46. Ibid.
47. Texas Department of Family and Protective Services. “CPS Average Monthly Children and Families Receiving Purchased Client Services. Fiscal Year 2019.” Texas Open Data Portal. https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/Purchased_Services/Permanency_Client_Services.asp. (This includes all adults referred for services by CPS and is not limited to birth parents or relatives whose children are in foster care.)
51. Ibid.
53. Texas Department of Family and Protective Services provided an Open Records response indicating they refer families to the community for parenting classes.
70. Ibid.
72. Written responses regarding lacking services and supports were only provided for 25 counties.
73. Texas statute requires each school district and open enrollment charter school to appoint at least one employee to act as a liaison. Stakeholders noted the need for individual schools and universities to have a liaison versus only one identified staff person per district or open enrollment charter school.  
https://statutes.capitol.texas.gov/Docs/ED/htm/ED.33.htm#33.904.
https://sainta.org/abc-v-is-now-fostering-relationships/.
76. “Co-Parenting in Foster Care: A First in New York City.” Rising Ground. 20 October 2019.  
https://www.risingground.org/coparenting/.
https://www.mockingbirdsociety.org/a-comprehensive-approach.
79. “The Mockingbird Family Model (MFM).” California Evidence-Based Clearinghouse, March 2020,  
https://www.dfps.state.tx.us/Child_Protection/Foster_Care/Community-Based_Care/documents/2019-08-26_Community-Based_Care_Implementation_Plan.pdf.