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A COMMUNITY PERSPECTIVE AND OVERVIEW OF THE FOSTER CARE SYSTEM IN THE GREATER HOUSTON AREA

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INTRODUCTION

In 2022, the Division of Public Health Pediatrics at Texas Children's Hospital (TCH) and Baylor College of Medicine (BCM) conducted a community needs assessment of the foster care system in the Greater Houston area, specifically the Texas Department of Family and Protective Services (DFPS) Region 6. This report includes general background information about the foster care system in Texas and describes demographic and placement information for DFPS Region 6. In our needs assessment, we interviewed key stakeholders with experience in the Texas foster care system and assessed the quality of the behavioral health directory for children in foster care. The goal of this report is to build upon prior work, better understand the perspectives of individuals working in the foster care system, report on access to behavioral health care in Region 6, and share information and recommendations to help improve the system of care for the children of and all who are engaged with the foster care system in Texas.

BACKGROUND

Children in the foster care system are an especially vulnerable population and are at higher risk of poor outcomes related to physical health, mental health, educational attainment, and social outcomes compared to youth who have not spent time in the foster system.

Size and Scope

Children and youth enter foster care when their parents or guardians are no longer able or allowed to care for them, which can be a result of neglect, physical or sexual abuse, parental drug use, and other reasons.[1] Approximately 391,098 children in the United States were involved in the child welfare system in 2022.[1] Texas has the second largest population of children under age 18 with almost 7.6 million children living in Texas in 2022.[1] As such, Texas's foster care system serves a large number of children, with over 38,000 having been in the legal custody of DFPS during FY 2022.[2]

Physical Health Needs

Children in the foster care system often enter it with untreated or undertreated physical health problems. Prior to entering the system, many of these children have only received fragmented and sporadic health care. Approximately 50% of children in foster care have chronic physical problems and 10% are medically fragile or complex.[3] Specifically, children in the foster care system are twice as likely to have developmental delays, asthma, obesity, and speech problems, and three times as likely to have hearing impairments and vision problems compared to youth who have not spent time in the foster system.[4] Further, approximately 22% of children in foster care in DFPS Region 6 receive in-home medical services, accounting for 59% of all outpatient services provided to children in foster care.[5]

Mental Health Needs

Many of the children entering the child welfare system, especially those who have experienced maltreatment, have experienced a variety of traumatic experiences. Research has identified long-lasting effects of this trauma including the demonstration of externalizing behaviors. Externalizing behaviors include disruptive behaviors, poor impulse control, attachment issues, and mental health conditions such as post-traumatic stress disorder.[6,7] If these behaviors are left unaddressed, they are risk factors for an increased number of foster home placements, which further lead to increasingly severe behaviors and contribute to long-term negative outcomes for the child, including decreased likelihood of reunification.[8]

Children and youth in foster care are more often diagnosed with mental health disorders. This could be a response to either the experiences that led to them being removed from their homes and/or the experiences of being in foster care.[9] Studies examining the mental health among children who have spent time in foster care have shown that these children are 2.5 times more likely to have a mental health or developmental disorder diagnosis. This illustrates that approximately 20% of children in foster care have a mental health diagnosis as compared to approximately 10% of children not in foster care.[10] Further, approximately 60% of these children have a lifetime prevalence of mental health disorders, with as many as half of children having

clinically significant mental health difficulties while in care.[11-13] Untreated mental health disorders have both immediate and long-term consequences. In addition, children in foster care receive psychotropic medications at higher rates than children not in foster care.[14-17] Specifically, in our research, we found that children in foster care are 6.9 times more likely to be dispensed psychotropic medications when compared to children not in foster care.[14] But even further, children in foster care who have *no* mental health or developmental diagnosis are 6.8 times more likely to be dispensed psychotropic medications than their nonfoster peers.[14]

Educational Outcomes

Children and youth in the foster care system demonstrate lower educational outcomes and more behavioral problems in academic settings compared to their peers not in the foster care system.[18] The long-term educational outcomes for foster children include poor educational and occupational achievement and decreased high school completion,[19] and they are 2.5 times more likely to receive special education services.[20] Many factors are associated with the academic success of children in foster care including the age the child entered foster care, race and ethnicity, length of time in care, number of placement changes, and special education status. To overcome these challenges, children need significant support in the home and through the school system. Unfortunately, all too often schools do not receive enough, if any, information about these children's social, emotional, and educational backgrounds.[21]

In the state of Texas, there are approximately 17,000 school-aged students in the foster care system who attend public school.[20] In the school year 2019-20, nearly 20% of all the children in the foster care system in Texas changed schools at least once mid-year.[20] Children and youth in Region 6a (Harris County only) require more subsequent placements than any other region in the state.[22] Frequent changes in school placements are correlated with poor academic achievement, loss of educational records, disruption in ongoing relationships, and inability to participate in extracurricular activities.[23] According to the Texas Education Agency, only 62.6% of foster youth graduate from high school, and 25% of youth completely drop out of school.[20]

FOSTER CARE IN TEXAS AND REGION 6

The Texas foster care system is divided into 11 regions (Figure 1).[24] The geographic focus area of this needs assessment encompasses the Greater Houston area, or DFPS Region 6, which includes Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Harris, Liberty, Montgomery, Matagorda, Walker, Waller, and Wharton counties (Figure 2).[24] Region 6 is further divided into Region 6a, which consists of Harris County, and Region 6b, which includes the remaining Region 6 counties. Region 6 is the state's second largest region in terms of child population, with an estimated 1,368,422 children under the age of 18 in 2022. [25] During FY 2022, 4,794 children from Region 6 were in DFPS custody at some point during the year. Of those, the majority (2,984, or 62.2%) were in Harris County (Region 6a).[2]

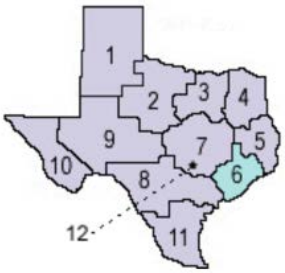

Figure 1. Map of DFPS Regions

Figure 2. Map of DFPS Region 6

Demographics

The demographic distribution of children in foster care at the end of FY 2022 in DFPS Region 6 compared to the population of children in foster care statewide is detailed in Table 1.[26] A few noteworthy points about the demographics of DFPS Region 6 as compared to the entire state's foster care population include:

- A higher proportion of the foster care population is male, (53%) in Region 6 and (52%) statewide.
- A higher percentage of the children in foster care in Region 6 are African American (37%) as compared to statewide (22%). A lower proportion of children in foster care in Region 6 are Hispanic (33%) as compared to statewide (41%).
- A higher proportion of children in foster care in Region 6 require more complex levels of care than the population statewide.

Table 1. Demographic data of Texas youth in substitute care (placed in the location outside of their home) at the end of FY 2022 [26]

	Region 6 N=2835	%	Statewide N=20,613	%
Age of Children in Care (yrs)				
Birth - 2	703	25%	5969	30%
3-6	605	17%	4594	18%
7-9	351	17%	2641	18%
10-13	450	16%	3111	15%
14-17	576	20%	3659	18%
18-21	150	5%	639	3%
Sex				
Female	1332	47%	9959	48%
Male	1502	53%	10,653	52%
Not recorded	1	0%	1	0%
Ethnicity				
African American	1057	37%	4556	22%
Hispanic	895	32%	8863	43%
Anglo	695	25%	5826	28%
Native American	6	0%	20	0%
Asian	23	0%	96	1%
Other	159	6%	1252	6%

Note. Count of children on August 31, 2022.

Disproportionality

Disproportionality is a known issue in the child welfare system. Disproportionality occurs when there is over- or underrepresentation of a group within a social system at a rate or percentage that is not proportionate to their representation in the general public.[27] That is, there are more or fewer individuals of a specific subpopulation than one would expect based on their numbers in the general population. Specifically in Harris County, from 2020-2022 African American children comprised 18% of the child population under 18 years but made up 47% and 40% of children who were removed from their homes in 2020 and 2022, respectively.[28] More broadly, in Texas, African American children were:

- 1.9 times more likely to be reported to Child Protective Services (CPS),
- 2.0 times more likely to be investigated by CPS, and
- 1.7 times more likely to be removed from their home.[28]

Placements

Children in the custody of DFPS are placed in substitute care, meaning they are placed in a location outside of their home. Kinship care, one type of substitute care, is when a child is placed with a relative or someone with a meaningful relationship to the child or the family. If a kinship placement is not available, children are placed in licensed foster care locations, which can include foster homes, general residential operations (GROs), emergency shelters, residential treatment centers (RTCs), or juvenile facilities (Table 2). When a child is removed from a home, efforts should be made to maintain stability and continuity of care for the child by keeping them in the same school or area.[29] Due to the limited number of available placements, this is not always possible. If a placement is not available within the immediate region, a location can be found outside of the immediate region. However, this practice is expected to be discontinued with the implementation of the Community Based Care model in Texas. Community Based Care transfers functions related to foster care services from DFPS to a leading nonprofit organization and its network of organizations. Unfortunately, when DFPS is unable to find a placement, children will be monitored by a CPS caseworker in an alternative location, often a hotel, until a longer-term solution can be found. The state of Texas has received criticism for the number of children across the state who remain in hotel rooms or other no licensed locations. This is commonly known as children without placement (CWOP).[30]

In terms of where children in foster care are placed (Table 3):[31]

- A higher percentage of children in foster care were placed in private child-placing agencies (CPAs) and independent homes in Region 6 (51.8%) as compared to statewide (42.9%).
- Fewer children in Region 6 are in kinship care (27.3%) versus statewide (34.2%).
- A higher proportion of children in Region 6 were placed within the region (86.2%) as compared to statewide (75.2%).
- An average of 11 children per day are CWOP in Region 6 versus 54 children statewide.

Table 2. Definitions of Placement Types[32]

Placement type	Description
Kinship family	A relative or fictive kin who provides care for a child. A relative is a member of the child's biological family. A fictive kin is a person who has a longstanding and significant relationship with a child in DFPS conservatorship or with the child's family.
Licensed foster home	A state-licensed home (usually temporary) for children in foster care. Caregivers known as "foster parents" receive a reimbursement for providing room, board, and transportation for children living in their home.
Residential treatment center (RTC) or general residential operation (GRO)	A licensed facility where multiple youth live. Staff oversee the facility and children who live there 24/7 and are regulated by DFPS. Some locations specialize in certain treatments.

Table 3. Children in Substitute Care by Living Arrangement Category[31]

Living arrangement	Region 6 N=2835	%	Statewide N=20,613	%
Licensed foster care home	1468	52%	9434	46%
Government residential operation (GRO)/ Residential treatment center (RTC)	196	7%	1868	9%
Kinship home	804	28%	7182	35%
Other	367	13%	2129	10%

Placement Stability

Children need consistency, predictability, and secure attachments to thrive. Unfortunately, stability in foster care placements has been an ongoing issue in Texas. In FY 2022, children and youth in the Texas foster care system spent on average 24 months in care, and on average had 2.8 placement changes.[33] Children who were emancipated while in care or aged out of the foster care system had the highest number of placements. Specifically, across Texas in FY 2022, these children spent an average of 44 months in care and had an average of 6.5 placements.[33] With each placement disruption, children not only experience a new home with new caregivers, but often enter a new school and new neighborhood and have new providers.[34]

Consequently, placement instability has been found to be associated with increased behavioral disruption, poor executive functioning, and poor academic achievement while limiting a child's ability to form secure attachments.[35] In a 2019 study examining factors related to placement disruptions, Leathers et al found that the experiences (both positive and negative) of foster parents with the child were a strong predictor of placement outcomes, highlighting the need for foster parents to have realistic expectations and adequate training and preparation to navigate their experiences. Additionally, a shortage of placement availability, particularly for children with significant health needs, may also be a contributing factor to high turnover in placements.[35]

Foster Parent Preparation

The quality of training for foster parents is an essential component to increasing placement stability. Foster parents who have received adequate training can help decrease a child's behavioral challenges and increase permanency either through reunification or through adoption.[36,37] In addition, training around trauma principles has shown significantly lower scores for conduct problems, hyperactivity/ inattention, and emotional problems, as well as increased prosocial behavior.[38]

In Texas, foster parent training is regulated by DFPS. All parents are required to receive an orientation, pre-services training, and first-aid/CPR certification. Annually, foster parents are required to attend 20 hours of training, whereas group foster homes require 30-50 hours, depending on the number of parents in the home. The pre-service training, Parent Resource for Information, Development, Education (PRIDE) covers child attachment issues, loss and grief, discipline, behavior intervention, effects of abuse and neglect, sexual abuse, working with the child welfare system, and effects of fostering and adopting children. Other annual training requirements include Medical Consent Training for Non-DFPS Employees, Psychotropic Medication Training, and Normalcy Training for Foster Parents.[39]

Coming Changes and Current Challenges with the Texas Foster Care System

In 2010, DFPS began an effort known as "Foster Care Redesign", which expanded the role of community providers within the Texas foster care system.[40] Over multiple legislative sessions, the Texas legislature has formalized the transition that is now being incrementally rolled out across the state. Known as Community-Based Care (CBC), this new model transitions the management of foster and kinship care placements, case management, and reunification services from DFPS to a single source continuum contractor (SSCC). Texas has been divided into 16 communities, with the intent of having one SSCC for each community that will create community networks, leverage community strengths, and have the flexibility to meet the individual and unique needs of children,

youth, and families at the local level. Multiple regions in the state have started the transition process, including the Texas Panhandle (Region 1), Big Country and Texoma (Region 2), Metroplex West (Region 3b), and South Central and Hill Country (Region 8b). The request for SSCC applications for the Houston region was expected to be released in the fall of 2023.[40]

In addition to the planned system redesign, the Texas foster care system has come under increased public and political scrutiny in recent years due to an ongoing lawsuit alleging children being abused while in foster care.[41] In March 2011 a New York-based national advocacy group filed a federal class-action lawsuit against the governor of Texas, the Texas Health and Human Services Commission, and DFPS regarding lack of oversight of foster care placements on behalf of approximately 12,000 children in the Permanent Managing Conservatorship of DFPS. The final injunction against Texas went into effect in July 2019, and since then, a court-appointed monitoring team has been assessing the state's compliance with the provisions of the injunction. Per the latest published compliance status report in January 2022,[42] the state has made substantial policy and practice improvements. However, these improvements have not come without added challenges. For example, the state developed a program to provide increased oversight and tracking of residential and childcare operations. This has successfully led to the closing of unsafe facilities, but has increased challenges related to capacity.

An Examination of the Foster Care System in Region 6: Highlights from the Hackett Center Report [22]

In preparation for the transition to CBC and considering issues found within the ongoing lawsuit, a significant amount of work has been done in Region 6 to identify and address concerns within the foster care system. In 2019, various community leaders and stakeholders published a report through The Hackett Center for Mental Health titled "Region 6A Community-Based Care: Comprehensive Assessment and Environmental Scan."[22] The report thoroughly examined the state of the foster care system in Region 6. Key findings from this report are listed below.

Child and Youth Characteristics

- Nearly half of all children in Region 6a in DFPS care were under the age of 6 years.
- There are more African American youth and older youth in higher Authorized Service Levels, indicating higher levels of care needed.
- Most Harris County children and youth are served nearby, but the Harris County foster care system also serves many children and youth from other areas of the state.
- Region 6a includes a significant number of children and youth with complex mental health needs.
- Fewer children and youth are entering foster care because of higher use of kinship placements. Therefore, of those children and youth who are in care, a higher percentage of them are in the lowest and highest levels of care.
- Children and youth in Region 6a remain in care longer and are less likely to be placed with relatives. Both placement in nonrelative foster homes and longer lengths of time in care have a negative impact on placement stability and permanency.
- More than 40% of children and youth in Region 6a are not placed with their siblings.
- An estimated 500 LGBTQ children and youth are in foster care in Region 6, of which 300 are estimated to be from Region 6a.

Foster Care System Capacity

- The majority of foster care demand in Region 6a is for subsequent placements of children and youth already in care.
- Youth that emancipate or age out of the care in Region 6a are in care longer and have experienced more placements than any other group of children or youth exiting care.
- In FY 2017, the demand for nonfamilial foster care placements decreased as a result of lower rates of removal and an increase in kinship placements.
- The types of foster care placement options available in Region 6a do not meet the needs of all children and youth in the region; however, placement options in Region 6b currently help meet some of demand.
- Region 6a needs more therapeutic treatment foster care homes to place children and youth with more complex needs in the least restrictive placement.

Foster Parent Capacity

- Most child placement agencies (CPAs) in Region 6a do not have a foster parent recruitment plan that uses data to drive universal, targeted, or child-specific recruitment to meet the cultural and unique needs of the children and youth in care.
- Many foster parents do not have access to the resources, support, and training they need to ensure they can support the children in their care who have complex mental health needs.
- Most foster families in Region 6a have little or no access to intensive in-home supports to help them care for children with the most complex needs.

Community Capacity

- Insufficient communication and coordination between child welfare providers and community organizations are barriers to accessing needed supports.
- School districts and campuses lack information on children and youth in foster care, delaying access to needed educational services and supports.

- Broader implementation of integrated behavioral health in Region 6 is needed.
- Children and youth in foster care do not have an information steward that ensures important health information is shared with foster families and primary care providers.
- There are little or no specialty care or in-home parenting programs that address the challenges of parenting young children in foster care.
- Harris County lacks intensive home and community-based service capacity for children and youth in care with serious emotional disturbances (SEDs) and their foster families.
- Crisis supports in Harris County are limited and fragmented.
- The region's residential treatment capacity, unlike emergency shelter/short-term crisis residential care, is forecast to exceed demand by 381 beds (48%).

Following this report, Region 6 developed a Community-Based Care Readiness Initiative with the goal of establishing collaborative work partnerships across child-serving sectors to address key areas of need in the region.

METHODS

Data Collection and Results

To build upon the work being done, this needs assessment included two approaches to data collection: key informant interviews with a variety of stakeholders in the foster care system and an assessment of STAR Health behavioral health services and providers in Region 6.

Methods: Stakeholder Interviews

To gain a better understanding of the strengths and challenges of the foster care system for children and families, we conducted 85 semistructured interviews with stakeholders who interact with the foster care system in the greater Houston area (DFPS Region 6). Prior to beginning the interviews, we identified specific categories and agency types to target for interviews including foster care families, birth families, youth in the foster care system, child welfare staff and leadership, support agencies to the system, CPAs, the legal system, the educational system, healthcare, and funding agencies. The interview protocol was reviewed and approved by the Baylor College of Medicine Institutional Review Board (H-50020). To obtain permission to interview child welfare workers and foster youth, we needed additional approval from DFPS. The research request was submitted to DFPS in July 2021 but was not reviewed or approved during the assessment period. As a result, we did not interview current child welfare workers and foster youth in this study.

Potential interviewees were identified through professional and personal contacts, publicly available lists of organizations and service providers, and using a snowball approach to obtain recommendations from interviewees. The only inclusion criterion was that the stakeholders must interact with the foster care system in DFPS Region 6 in some capacity. Interviewees were contacted about their willingness to participate in an interview either over the phone or via email. Prior to beginning the interview, the stakeholders completed a research informed consent form. Two team members conducted the interviews (individually). The interviews were completed via Zoom, over the phone, or in person. The interviews were semistructured and based on a predetermined set of 19 questions designed to elicit views about many facets of the foster care system (Table 4). Interviewers took notes to record stakeholder responses during the interview. Each individual interview lasted 15 to 60 minutes.

Data Analysis: Stakeholder Interviews

We used content analysis to analyze the interviewer notes from each interview. A study team of five individuals, including two interviewers and three non-interviewers, each read a portion of the notes with at least one person reading the notes from every interview. The group developed a list of codes to use in the content analysis, allowing for a deductive approach to the coding. For example, in reading through the notes, coordination of care and services was a concern brought up by many stakeholders so coders used this code across all of the interview notes. Two coders then coded the first 15 interviews together to ensure internal consistency. In addition, coders also used an inductive approach as additional codes naturally emerged through the coding process. Coders met to discuss their findings regularly and used an iterative process and consensus building to determine the final code set. Interview questions were grouped into categories (Table 4). One team member coded the questions related to helpful elements in the foster care system and the system as a whole, and the other coded the questions related to challenges in the foster care system, policy, and questions specific to the TCH Foster Care Clinic to guide clinic expansion initiatives. We used the qualitative data analysis software, MAXQDA, to code and analyze the data. A summary of themes from each category and supporting quotes were presented to a team of subject-matter experts, including the interviewers, for verification and review.

Table 4. Stakeholder interview questions

Category	Interview question
Helpful/ Supportive	In your experience, what type of services are most beneficial for foster families and children in the foster care system?
	What services have been offered that help enhance the ability of children in foster care to receive quality medical care?
	What supports would be helpful when a child makes a transition in care?
	What is working well with the foster care and support system?
	When supporting children in foster care, what have you found helpful to improve behaviors and address their trauma?
Barriers/ Challenges	What are the biggest barriers for children in foster care and foster care families receiving the services that they need?
	What are the biggest barriers for children in foster care to receive quality medical care?
	What barriers do you find the most challenging for children in foster care to receive a quality education?
	What are the most significant challenges when making a transition in care?
Systems-related	How can our system better support children in the foster care system? Foster parents? Foster agencies?
	How can our system better support children in foster care's transition in schools?
	What is missing from the foster care system that would better support children in foster care, birth parents, and/or foster care families?
	Any other thoughts or suggestions on how to improve the foster care system for children and families?
Policy-related	What policy changes could be enacted to impact health outcomes for children and foster care?
	What policy changes could be enacted to impact education outcomes for children in foster care?
Texas Children's Foster Care Clinic Specific*	At Texas Children's Hospital (TCH), we run a foster care clinic. How can our staff, providers, and clinic support kids, families, and agencies in the foster care system?

**Responses related to the Texas Children's Foster Care Clinic are not included in this report.*

Findings: Stakeholder Interviews

We conducted 85 interviews with key stakeholders in the foster care system. Respondent demographics are in Table 5. Notably, nearly half of those interviewed had 10 or more years of experience interacting with the foster care system. Many respondents had experience in multiple positions/sectors (e.g., prior foster parent now CASA worker, prior CPS caseworker now social worker). Listed in Table 5 are their current sector and role.

Table 5. Interviewee Demographics (N=85)

Interviewee Demographics	N	%
Type		
Foster parent	23	27%
Legal system (incl. child advocates)	21	25%
Healthcare	16	19%
Social services	13	15%
Child placing agency (CPA)	8	9%
Residential treatment center (RTC)	2	2%
Education system	2	2%
Role		
Foster/adoptive parent	23	27%
Administrator	20	24%
Lawyer/guardian ad litum	13	15%
Social worker	10	11%
Medical provider	6	7%
Child advocate	5	6%
Behavioral health provider	4	5%
School foster care liaison	2	2%
Other	2	2%
Age		
20-29	10	12%
30-39	36	42%
40-49	21	25%
50-59	15	18%
60-69	3	4%
Gender		
Female	71	84%
Male	14	17%
Race/ethnicity		
Asian	2	2%
Black	14	17%
Hispanic	6	7%
Non-Hispanic White	61	72%
Other	2	2%
Years of experience within foster care system		
0-4	18	21%
5-9	25	29%
10-19	22	26%
20+	20	24%

Overarching Themes. We identified four overarching themes from the 85 stakeholder interviews:

- Better prepare, train, and support families
- Connection across the system

- Access to quality services
- Trauma-informed approach

Better prepare, train, and support families: Participants shared that often foster families are unprepared to care for a child in foster care, and there is a need to better prepare and support all types of families across the continuum of care (i.e., with birth families prior to foster care entry, kinship placements, foster families, and through adoption)**.** The need for and potential benefits from providing better support for families was a predominant theme across all categories. Participants shared that the foster care system needs to provide a better history and the needs of the child to help prepare foster families, additional trainings for families particularly around trauma, supports to help navigate the system, and both instrumental and social supports. Specific services and resources mentioned included:

- Childcare
- Tutoring
- Support and mental health services for birth families
- Parenting classes and support groups for all types of families
- Support during admission, review, and dismissal (ARD) committees, especially for families who do not speak English
- Family therapy

Voices from the Community

Bio families don't have connection to organizations that are visible, seen, [and] that are willing to help them truly. They need resources to help them be successful.

[We need] full level support, children and families that continue even post adoption. [We need] avenues for real time support during events of escalation and planning. I think the training you get as a foster parent is around the process of fostering but not on the strategies to make it successful.

We need [to] increase training that foster parents receive. We need a much larger support network. [Foster families] bring their support system with them. You need to have your own respite care, back-up providers, time off from work ... We set families up to fail. We are asking them to be their own village, but we should be their village.

The parents need to be informed. Most of the training is minimal and does not apply. Foster parents need to be more informed in trauma and seeing behavior through that lens.

Better training for the parents is needed. These children come to these homes after so many horrible experiences and [the parents] saying, "Oh my, we didn't know any of this." [Parents] can gain the skills. But how do we send these complex kids into a home with minimal training? We must support [parents] through their own [emotions], so they can be the best support to these children. The brain has plasticity, and it can heal, but the [relationship] with the parent is important to [help the child] heal.

Connection across the system: Respondents discussed the need for better connection across the system in a multitude of ways. This gap was communicated in statements related to the need for child history and record sharing, continuity for children in foster care, coordination of care and services, collaboration among various providers and entities, and communication among various parties.

Child history and record sharing: Respondents overwhelmingly agreed that the incomplete history of the child (social, medical, and educational), lack of a unified record, and challenges in information sharing were a huge barrier for the families and professionals trying to care for children in foster care. Respondents noted that a child's records are often incomplete and do not always transfer with the child from one placement to the next or from one provider to the next. This disjointedness leads to care and support starting over, missed opportunities for directly meeting the child's needs, and ultimately placement breakdown. Examples of issues include repeating previously performed tests or procedures (e.g., redundant imaging, vaccines, screening and assessments, developmental testing, etc.) and missing necessary follow-up care (e.g., not responding to an abnormal test result, not treating a child for a medical condition diagnosed by a previous provider because the current provider does not know the diagnosis) as well as major delays in getting educational services (e.g., not having access to previous services) and providing better support (e.g., a child who may need to be in a home not with younger children, or a child responds to helpful strategies). Several respondents suggested having a centralized system for tracking as a possible solution to this issue.

Voices from the Community

The problem with transition in placements is usually everything is lost. Whether it's prior medical history, vaccination records, [or] management plans for behavioral/psychiatric issues, the children often arrive with no information transferred to the new caregiver, which leaves the medical team at a loss as to how to begin.

The documentation does not transition, so they have nothing. There needs to be a centralized place for information.

The challenge is making sure the information and what's already been done for them follows the child. I've had cases where a child moves between placements and between school districts, and all the work being done to address the child's special education needs gets lost and takes time to redo.

Continuity: The lack of continuity (disruptions or changes in homes, caseworkers, schools, medical providers, therapies, and relationships) was often cited as a barrier impacting children's education, medical care, social connectedness, trust, and overall well-being. While change is inherent when children are brought into care, the amount of change and the impact of those changes on the child were underscored as a major challenge. Respondents specifically mentioned the need for continuity and stability in school and keeping the same providers (e.g., doctor, social worker, counselor, CASA worker, mentor, etc.). Comments related to reliability and stability for the child were common. Suggestions to help children included reducing the number of transitions and having a person or team of people who prepared, supported, and ideally remained with them through the transition. This could include pre-placement visits to learn what worked well and the challenges experienced in the previous placement, allowing children to say "good-bye" if they change schools, making introductions before moving, and helping children maintain contact with friends from previous placement. Children lack the understanding of why and when they are being moved. This makes it difficult for them to truly feel comfortable in their placement.

Voices from the Community

Every time a child moves placements, they get all new therapists and doctors. There is nothing consistent, and we wonder why children don't connect [with people].

The barriers are that they've been moved so many times, [so] they get so behind academically. They're emotionally behind because of their trauma, which makes their academic success impossible to obtain. I have 14- or 15-year-olds frequently who cannot read. I have a kid who was 3 years old—within 2 years he was moved 28 times.

The most important thing is consistent, reliable supervision and attention (whether a therapist, caseworker, etc.). Kids can bounce around a lot, and even if they don't have a history of trauma related to abuse/neglect, the lack of stability/permanence can be debilitating.

The bigger answer is stable, consistent, trustworthy relationships with adults [so that children can] form secure attachments. They need that in order to build healthy, stable relationships for the rest of their lives.

Ideally, I would like to see the transitions cut down and only have a transition if absolutely necessary. There needs to be more consistency all around, even just with caseworkers. Maybe [there can be] a "care team" that can transition with the child between placements.

Coordination: Respondents talked about the importance of coordination of care across a variety of services, including healthcare services and wraparound services through schools. They mentioned that support systems need to work together, that there should be someone on staff (such as a social worker) to help families and children follow up with referrals, and that there are so many benefits to providers coordinating and working together.

Voices from the Community

[We need]..better monitoring outcomes of services when kids are in care/more oversight and a centralized person/reporting body to take in the information because so much is siloed into different systems and not integrated.

[The] root [of the problem] is collaboration and coordination of resources. The fragmented system makes it hard to assess needs. When the system works together in a coordinated way, families can get what they need. This is really hard to get everyone on the same page and know each other. When people know their role and how to work together, they can truly support the families.

Collaboration: Respondents talked about the need for organizations to collaborate and work together for the benefit of the child. Respondents gave examples of where collaboration was working well between specific organizations but also expressed frustration with the system itself being disjointed and hampering collaboration on a wider scale.

Voices from the Community

More CPAs, judges, caseworkers, [and] foster families are getting on calls together to really see what is going on. This collaboration is promoting [the] best practices.

Collaboration is going well. From a professional point of view, we don't have people who are unwilling to work with each other to meet the best needs of the children.

At least from where we sit, I see a shift in how the players in this space are starting to work together in a way we haven't seen before, a willingness for all the key players to try something different, and moving away from the things that are not working. [They are] implementing children's voices into this situation, not just seeing a system but seeing them as individuals. This is a shift at the ground level that is beginning to show. We have a lot of work to do here, but it is a start. We also see more of an emphasis on trauma informed care. But we are still seeing kids as "bad kids" vs "kids with trauma," but this is slowly getting better. We are starting to move upstream.

Communication: Respondents noted the importance of communication across the various individuals and systems working in the interest of the child and the lack of communication negatively impacting the child.

Voices from the Community

I think more communication on the ground with the families and the kids over what's happening in the kids' lives [is needed]. There's so much disconnect between administrators and the kids. We need mediation—sitting around the table with the family. [We should] give the kids a voice, especially if they're older—what does the kid want for their life? The relationship with the kids is everything. Everyone is just trying to "cover their butts," and everyone is running scared with the lawsuits right now.

I think there is a lack of communication between CPS and families about what is being provided and offered. There are so many different people coming to my home, and one hand doesn't know what the other is doing. My sister is a CPS caseworker. I work in the field and even with that knowledge, it was really hard for me to understand what was going on and what resources are available.

I think more communication on the ground with the families and the kids over what's happening in the kids' lives [is needed]. There's so much disconnect between administrators and the kids. We need mediation—sitting around the table with the family. [We should] give the kids a voice, especially if they're older—what does the kid want for their life? The relationship with the kids is everything. Everyone is just trying to "cover their butts," and everyone is running scared with the lawsuits right now.

Access to quality services. Access to services was identified as a dominant theme from the stakeholder interviews. The importance of access to quality care and services was highlighted for healthcare, with a specific emphasis on mental healthcare as well as education. Many respondents shared frustrations on their perception of high-quality services not being available to children in the foster system.

Healthcare: The need for access to quality healthcare was emphasized for children and their caregivers. Several respondents called out the need for biological families to have adequate access to healthcare, in particular mental healthcare, as a component to help them retain or regain custody of their children. Respondents also discussed the need for Medicaid (STAR Health) to ensure there are enough quality providers who accept patients with Superior HealthPlan and who are appropriately trained to handle complex trauma and offer services at times and in locations accessible for families. All children in the foster care system are enrolled in the Superior HealthPlan for their health insurance.

Voices from the Community

[We need more] availability of quality providers. There are huge wait lists for good providers.

[It would help] having enough providers who accept Medicaid/quality providers who are trauma informed.

[A barrier is] having appointments from only 8-5. These are working parents. We need more convenient hours and [services] in a location that is close to them.

Sometimes it's difficult for us to find therapists, so it would be helpful if that was easier.

Respondents highlighted their perception that low reimbursement rates, limitations on the types of services covered, and the process for becoming a provider for STAR Health are possible reasons for access issues.

Voices from the Community

Access has a lot to do with it. Finding medical caregivers that accept the insurance and getting them in a timely manner. They need a medical home.

Reimbursement rates are hard—so many providers will not take Superior insurance. You have to take these kids to other providers than your own children. When kids need therapies, they were constantly dropped because therapist stopped using Superior due to the challenges. The therapeutics that truly support trauma, Superior doesn't cover (i.e., parent coaching, trauma therapies). We find scholarships for kids to get these services, but then CPS refuses to allow them to go. So families are forced to continue with ineffective therapies. There are therapies that are supported by the state, and CPAs use [them] because Superior pays for it. However, these programs are shown not to be effective for kids with developmental trauma, yet we still use [them] because this is all that Superior will pay for. Yet programs that focus on connection and show high effectiveness are not approved by the state.

Access issues and long wait times coupled with requirements were discussed as causing a situation where children get substandard care.

Voices from the Community

You get a foster kid and you have every intention to take the kid to the best doctor, but that doctor isn't available for 18 months. Since you are state mandated, you take them to a worse doctor, and then you get substandard care.

The biggest barrier is time. So many service providers are on timelines. There are too many children and not enough providers who are educated on what these children are going through who have time. We don't have enough professionals who can help these children heal. These professionals need to make a living, so they have to see so many kids and then they don't get the [quality] time to truly spend with them.

Education: Transitions in care were noted as a challenge for receiving any service and a major barrier to kids getting needed services, particularly with respect to education. The need for tutoring to help kids catch up was mentioned by multiple people.

Voices from the Community

[We need] access to affordable tutors [especially in the context of the disruption caused by] frequent transitions. We have foster youth who have to repeat grades because they moved in the middle of the school year. The fluidity of foster care is a huge barrier.

Trauma-informed approach: The need for a trauma-informed approach across the system was mentioned in each of the categories and was a dominant theme emerging from both the helpful/supportive and systems categories. Responses included:

- Trauma-informed care awareness and training
- Trauma-informed mental healthcare
- Trauma-inducing experiences within the foster care system

Trauma-informed care awareness and training: Respondents talked about the need for trauma-informed care generally by all families, providers, staff, and systems interacting with the child, including foster parents and those in the healthcare, education, justice, and child welfare systems. Many respondents talked about how taking a trauma-informed approach means changing the way we approach and react to children who have experienced trauma. More efforts need to be made to help establish trust and build relationships with the child. Several noted that progress has been made, but there are still ongoing challenges around trauma-informed care training.

Voices from the Community

[We need] more trauma-informed education for everyone (educators, caseworkers, families).

I do not feel schools are properly informed with trauma. They don't get it, and many are really resistant to implementing 504 and IEP [Individualized Education Program] for kids who really need it. We need to enhance the schools' understanding.

[We need] the kids to be given a voice in any medical situation. I know I had a 2-year-old who had been exposed to sexual trauma and when I took her to the doctor, the doctor lifted her shirt without asking her. Everyone being trauma-informed and asking before examining the child would be great. Everyone being trauma-informed and helping the child build better relationships would be great.

We need trauma training for judges and attorneys.

I do believe we have made some progressive strides in recognizing the effects of trauma and working with foster parents who support these kids [to help the foster parents] understand that trauma and how to work them. I think there is a lot more humanization of these kids. We see less locks on refrigerators because we understand this more. We put prioritization on normalization (job, sleepovers, extracurricular activities).

Less regulation in contracts .. trust your providers. Example: everyone was TBRI trained [for] 40 plus hours, but they got dinged because they didn't have 2-hour CPS trauma care. They had better. What is the intent of the standard, and what is the provider doing to meet that intent?

Trauma-informed mental health care: With respect to trauma-informed therapy and treatment, respondents stated the need for evidence-based practices, and some stated that providers should be certified. Collectively they named several approaches: Trust-Based Relational Intervention (TBRI), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Parent-Child Interaction Therapy (PCIT), Parent-Child Care (PC-CARE), Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), Eye Movement Desensitization and Reprocessing (EMDR) therapy, and equine therapy. They also noted challenges in the availability of and access to these services.

Voices from the Community

[We need] access to behavior therapy and parenting help/counseling that is trauma informed.

[In therapy, we need to use] evidence-based practices that have been shown to help kids cope with trauma and increase resiliency.

[We should use] evidence-based trauma treatment including trauma-focused CBT with a certified provider and parent-child interaction therapy with a certified provider.

TBRI is helpful. Helping foster parents understand that their behaviors are based on trauma vs the kids. These are all the things we can work on. [We can work on] reframing parents' perspectives and having evidence-based parenting practices.

[We need] trauma-informed therapy (not always easy to find, often need someone to come into home since have multiple foster children and may not be feasible to drive child somewhere).

Trauma-inducing experiences within the foster care system: Many respondents commented on the fact that children not only experience trauma prior to entering foster care, but many also experience trauma while in foster care. One poignant remark underscored this sentiment: "*Foster care doesn't happen for kids, it happens to kids*." Focusing on trauma-informed care, mental healthcare in general, and continuity of care were some of the ways respondents suggested for minimizing the trauma occurring while in foster care.

Voices from the Community

Any way we can increase stability in these kids' lives would be helpful. Obviously if we can make sure the kids are not hurt/traumatized while in the system, that'd be great.

The system is so broken that kids are being continually re-traumatized while in the system. I think that more representation for these kids is so desperately needed. I think it would be better if therapists could be included in the system. I wish children had a bigger voice and their needs were taken into consideration because then many of these problems wouldn't exist. There's so much burnout and senseless re-traumatization of the kids. There's just not enough support to advocate for them.

Methods: Behavioral Health Services

Access to high-quality healthcare, particularly mental health care, was identified during our stakeholder interviews as a major challenge for children in foster care. However, when looking at the directory of providers for the Greater Houston area for children in foster care, it appears that there are a significant number of providers servicing the area with mental/behavioral health services. To better understand and describe this discrepancy, we added a component to our assessment that included contacting behavioral health providers in the Greater Houston area. The purpose of this component was twofold: 1) to generate quantitative data regarding access to mental health care in the Greater Houston area for children in the foster care system and 2) to create a directory of confirmed mental/behavioral health providers that will see children in foster care. This directory was given to our foster care clinic social workers to use with patients needing referrals for mental/behavioral health services.

In Texas, all children in the foster care system are provided health insurance through the Medicaid managed care health plan, STAR Health, operated statewide by Superior HealthPlan. STAR Health has a provider directory, located on Superior HealthPlan's website, to help families identify behavioral health providers in the network. This directory is updated monthly. We used the behavioral health provider directory for the Harris Service Area "updated February 2022" to identify the list of providers/organizations to contact for this component of the assessment. The Harris Service Area includes Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Waller, and Wharton counties. The directory was a 115-page PDF document organized by listing providers alphabetically by geographic sub-area within the service area (Baytown, Galveston, Webster, etc.). Providers serving multiple areas were listed in each of those areas. When available, the listings included provider name and academic credentials, address(es), phone number(s), type(s) of therapy, languages spoken, and symbols to indicate if the provider was a Texas Health Steps Provider, Child and Adolescent Needs and Strengths (CANS) certified, only accepting current patients, and/or provided telemedicine services. While some listings had all this information, others had minimal information (e.g., name and address only). Facility names by area were also included but did not include any contact information (phone or web address).

In order to contact and verify services for each provider listed, a uniform script and question set was developed and used (Figure 3). In total, eight staff members performed calls between February and July 2022. A staff member called each phone number on the list at least two times during regular business hours. They asked the provider/organization to confirm their availability and acceptance of STAR Health as well as additional information about the services provided.

Messages were left by voicemail when available. Notes and question responses on each phone call were recorded in REDCap.

Data Analysis: Behavioral Health Services

The directory was organized by listing providers alphabetically by geographic area. Some providers practice within a larger organization with multiple locations while others have independent practices with one location. Some also use telemedicine. Given this, we focused on the *phone numbers* listed to help distinguish potentially unique "practices" or organizations. By using this method, we were able to more closely simulate the experience of an end user/caregiver trying to access services. This allowed us to more efficiently reach out to all providers on the list without duplicating calls to the same provider or team of providers within an organization. For example, if a provider had locations in Galena Park and Pasadena, but only one phone number, we treated the phone number as one entry or "practice." Similarly, if a group of providers from one organization used the same phone number to schedule appointments, we treated the phone number as one point of entry or "practice." Note that a practice could have multiple locations and multiple providers. After we attempted to contact all the unique numbers on the directory at least twice, each record was examined and coded with a final disposition (e.g., accepted STAR Health, unable to confirm, not a working number, etc.). Counts and proportions were used to describe the results. Data were analyzed using STATA v15.

Figure 3. Behavioral Health Phone Call Questionnaire

- Does this practice currently accept patients with Superior STAR HealthPlan insurance?
- If yes, are you currently accepting new patients with Superior health insurance?
- If yes accepting Superior STAR HealthPlan and new patients…
- We know there is a large demand for behavioral health services right now. If one of our patients were to call you today, approximately how long would the wait time be until the first available appointment?
- How many providers in this practice see children with Superior Health Coverage (STAR Health-Medicaid for children in foster care)?
- What is the approximate number of patients on Superior (STAR Health) you can accommodate on your caseload at one time? How many evening appointment slots do you have available during an average work week?
- How many weekend appointment slots do you have available during an average weekend?
- Do you offer visits in person, via telehealth, or both?
- What is the age range of patients that the behavioral health providers in this practice see?
- What therapy modalities are offered at this practice?
- What therapy modalities are the providers at this practice certified in?
- Are any providers at this practice CANS certified?
- What languages does this practice offer behavioral health services in?
- Do you offer other supports for foster families at this practice?

Results: Behavioral Health Services

The 115-page PDF directory of Superior HealthPlan's STAR Health Behavioral Health Providers for Harris Service Area (updated as of February 2022) included 3061 listings for behavioral health providers (Table 6). Of these, 81% (2472) were unique provider names. The list contained 999 unique phone numbers. One-third of the original list were unique numbers and the other two-thirds were duplicates. Of note, 365 provider names (11.9% of the total number of listings) were listed without a phone number, making it challenging to contact that provider for services.

Table 6. Summary of the Provider Directory (February 2022)—Star Health Behavioral Health Providers for Harris Service Area

Outcomes	N
Provider names on the list (duplicates included)	3061
Unique provider names	2472
Phone numbers listed (duplicates included)	2919
Unique phone numbers	999
Provider names without phone numbers	365
Duplicate listings	Numbers were listed 1-190 times; 683 phone numbers only listed once

For our analyses, we attempted to contact all 999 unique phone numbers. During the calls, 6 phone numbers were corrected or added to the list, making the final total 1005 phone numbers contacted. Of these 1005 unique phone numbers, we were able to connect with and categorize 77%. We were unable to reach 23% of the practices despite calling at least two times during business hours and leaving messages when possible (Table 7). Slightly more than a third of the providers (34.6%) on the list could be confirmed as currently accepting Superior HealthPlan STAR Health for behavioral health services for children and youth in foster care. One in every 6 unique numbers was not working (e.g., out of service, consistent busy signal, etc.), a wrong number, or connected to an inappropriate healthcare provider type (e.g., gynecology, imaging, plastic surgery, etc.) or organization (e.g., pizza delivery).

Table 7. Outcomes of phone calls

Outcomes	N	%
Accepts Star Health for mental/behavioral health services	348	34.6%
Does not accept STAR Health, does not see children under 18 for services, and/or does not see patients from Region 6	209	20.8%
Unable to confirm services (could not reach anyone)	232	23.1%
Other outcomes:		
Not a working number	95	9.5%
Combined with other record (multiple numbers for same agency)	65	6.5%
Wrong number/inappropriate provider type	50	5.0%
Practice closed	6	0.6%

Note. N=1005

Of the 348 that accepted STAR Health for mental/behavioral health services, 80% were taking new clients at the time of the call (Table 8). Consequently, a caregiver using the list would need to call 3-4 phone numbers in order to reach 1 provider who was accepting new patients for therapy and who accepts STAR Health. A total of 6% of the providers listed provided selective or restricted services such as medication management only or providing services only to those already within their agency.

The locations of Region 6 behavioral health providers listed in the directory are mapped in Figures 4 and 5. Figure 4 displays the locations of all behavioral health providers listed in the directory. Figure 5 displays the locations of behavioral health providers in the directory who we reached and verified they accept Superior Healthcare for behavioral health services at that time.

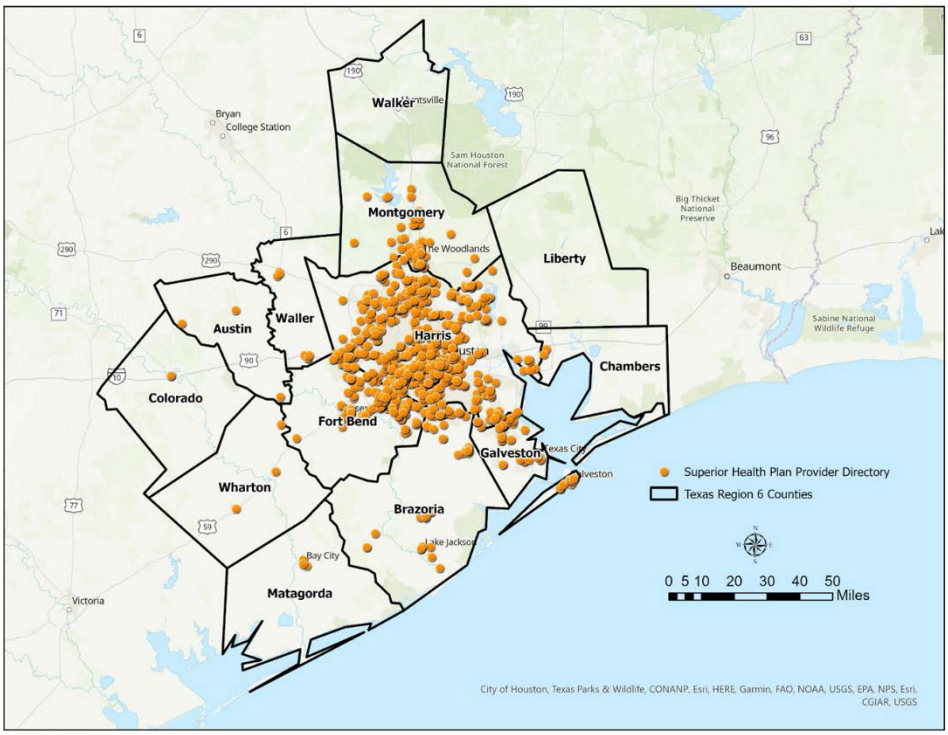

Figure 4. Locations of all behavioral health providers listed in the directory

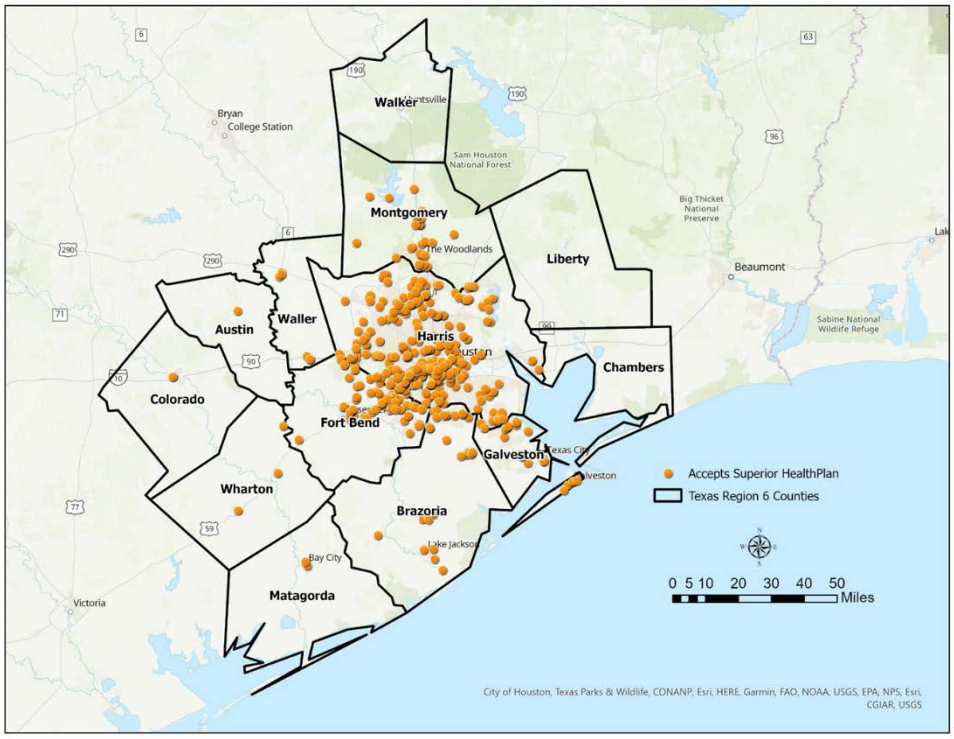

Figure 5. Locations of behavioral health providers in the directory who we reached and verified they accept Superior Healthcare for behavioral health services at that time.

Table 8. Practices accepting new patients (of those who accept STAR Health) (N = 348)

	N	%
Accepting new patients	280	80.5%
Not accepting new patients	40	11.5%
Accepting status unknown	7	2.0%
Selective/restricted/limited	21	6.0%

While the majority (60%) of phone numbers represented a sole provider at a practice, 19% of the phone numbers represented 5 or more providers at a practice who accepted STAR Health (Table 9). Many of these larger practices had multiple locations across the Greater Houston area, increasing access for families.

Table 9. Number of providers at this phone number who provide services to children on STAR Health (not including those with restricted/limited services)

No. of Providers	N	%
1	155	60.3%
2-4	53	20.6%
5+	49	19.1%

Note: 257 provided a response to the question regarding the number of providers at the practice

The wait time to get an appointment varied across providers from the same day to 6 months (Table 10). Of note, this appointment was not necessarily for therapy as many required an assessment prior to scheduling any therapy appointments. The average time to an appointment was just under 2 weeks. Of the 250 who answered the question, nearly 70% of respondents stated they had appointments available after 5 pm and 50% had at least some weekend appointment slots.

Table 10. Appointment availability for practices accepting new patients (not including those with restricted/limited services) (Mean, 12.85 days)

Availability of appointments	N	%
0-1 day	22	9.1%
2-7 days	145	59.7%
8-14 days	26	10.7%
15-21 days	13	5.3%
22-30 days	21	8.6%
31-60 days	11	4.5%
61-180 days	5	2.1%
Evening appointments available	172	68.8% (of 250 answering question)
Weekend appointments available	134	53.2% (of 252 answering question)

Note: 243 provided a response to the question about appointment availability

The vast majority of the providers offered telehealth services (92%), while only 8% were providing care exclusively in person (Table 11).

Table 11. Types of visits offered

Visit Type	N	%
In-person only	22	8.1%
Telehealth only	59	21.8%
Both in-person and telehealth	190	70.1%

Note: 271 provided a response to the question about types of visits offered

We also asked the behavioral health providers about the ages of patients they accepted and 11% of practices accepted patients under 3 years. When asked if the behavioral health provider if they accepted patients 5 and under, 60% of practices would accept patients 5 years of age and under. This illustrates that many of these providers only provide care for children ages 4 and 5.

Although we asked questions regarding the type of therapies offered, therapy certifications, and languages spoken for the practice, many who answered the phone could not answer these questions, and we were unable to draw accurate conclusions from these data.

LIMITATIONS

While this assessment adds valuable information for foster-care-serving organizations and agencies, there are several noteworthy limitations:

- We were not able to include perspectives of current child welfare workers or children currently in care because DFPS did not approve our research request during the study period.
- We were unable to identify biological parents willing to be interviewed.
- The stakeholders we interviewed were not randomly selected, and many were found through professional and personal contacts. To expand the range of stakeholders interviewed, we used a snowball approach and asked each interviewee to recommend other stakeholders we could contact. Further, we tried to expand our stakeholder pool by calling or emailing all known organizations in the area that provide services to foster families through their publicly available contact information, but we found relatively few people willing to participate. We particularly struggled in recruiting workers at residential treatment centers.
- Though individuals of many different racial/ethnic backgrounds are represented in our interviewee pool, the majority of those we interviewed self-identified as white.
- We were unable to reach 23% of the phone numbers on the Superior HealthPlan Star Health Behavioral Health Providers for Harris Service Area list, despite calling all phone numbers at least twice during business hours. Consequently, services are likely undercounted. Additional staffing would have been helpful in allowing us to make more than 2-3 attempts for each number.
- We were unable to use any data about types of therapies provided, languages offered, and certifications of providers because much of this information was unknown to a large proportion of the individuals answering the phone.

RECOMMENDATIONS

Expand and improve access to quality physical and mental/behavioral healthcare for children in foster care.

- Stakeholders overwhelmingly stated that access to quality services was a system-wide challenge and barrier but is something that is helpful and positive when available. Stakeholders noted this need specifically for physical and mental health care. A key finding of the mental health provider analysis was supported by key informants in that despite there being a STAR Health provider guide available online, it is difficult to identify a mental health provider who accepts new patients and has openings. These barriers could be addressed through:
- Incentivizing high-quality providers to join/remain in the STAR Health network as well as to offer evening and weekend appointments that are more convenient for families.
- Convening a panel or workgroup of physical and behavioral health providers to describe what is needed for mental and behavioral health providers to care for children in foster care. This may include access to training and acceptance of specific treatment modalities or trauma-informed approaches, evaluation of reimbursement rates given the complexity of the children, ease of provider credentialing, etc.
- Improving the process through which the STAR Health provider guide is maintained and updated. Providers reported difficulties updating their information, and in multiple cases the information included was not intended to be patient facing (e.g., P.O. boxes and personal cell phone numbers).
- Creating a parent-friendly guide for mental and behavioral health therapies and treatment options, including a brief explanation of each, for whom they work best, and what to expect if your child receives this type of therapy.

Improve access to quality training for all families involved in the foster system, and review and revise training requirements to better align with their needs and the needs of the children in their care.

Navigating the foster care system and state and agency rules/regulations, along with balancing the needs of children who have experienced trauma, can be extremely challenging for families engaged in the foster care system. Training is intended to prepare families for these challenges. However, respondents indicated that while there were many training requirements, they were not always aligned with what was needed. Suggestions from stakeholders for improvements to the trainings required/offered included:

- Reviewing and revising the training requirements
- Offering parenting classes and support for all families: birth, foster, kinship, and adoptive families
- Offering parenting classes specific to a child's age and history (i.e., type of abuse experienced)
- Providing training in trauma-informed care and practices

Expand and improve access to quality support services for families involved in the foster care system to better respond to the needs of the entire family and facilitate successful placement.

Stakeholders overwhelmingly stated the need for high-quality support services for all families involved in the foster care system. Improved family support was cited as a preventative measure to help families potentially avoid child welfare involvement altogether, as a way to shorten the time children spend in foster care, and as a means of improving placement stability. A wide range of services is needed to ensure that appropriate supports are in place for children and their caregivers, including:

- Behavioral health services for the entire family
- Childcare, especially assistance with establishing childcare during a transition
- Social and instrumental supports to meet the social and basic needs of the family
- In-home (or virtual) crisis intervention services

Provide continuous supportive educational services for children in or with a history of foster care to ensure appropriate progress in school.

Transitions in care lead to many disruptions for children, including that of their education. There is a need for increased communication from one school to another and among parents, teachers, caseworkers, and providers. Recommended improvements to the system include:

- Providing tutoring services for children throughout the transition period (for as long as needed).
- Establishing defined role requirements for foster care liaisons in schools and oversight to ensure schools meet state requirements. Requirements should include educational and training requirements.
- Providing trauma-informed training to school counselors and teachers so they may better respond to and support children in foster care and ensure their educational needs are met in an appropriate way.

Increase communication, planning, and transparency to support transitions in care and minimize unnecessary disruptions.

There is a need for improved communication, particularly during transitions, so new families, providers, teachers, and others have the information they need to support the child and ensure their needs are met without any gaps in services. While challenging, to achieve this recommendation it is necessary to:

- Review policies to minimize transitions.
- Ensure families, educators, and providers have appropriate training and support in place so they are better equipped to care for the child and meet their needs.
- Ensure foster care liaisons are in communication with all parties throughout a transition in schools so all necessary services are continued (the new school does not need to start from "ground zero" with learning history and background, assessments, etc.).
- Appoint a person to be responsible for overseeing the transition from start to finish to minimize confusion and information loss and increase the likelihood of success in the next placement.
- Include the child in transition planning and discussions.

Align training opportunities, needs, and requirements to better meet the needs of professionals working with children in foster care, particularly with respect to trauma-informed approaches and care.

While many training courses are required for stakeholders across the foster care system, the training received is not always adequate or appropriate for a particular situation. Training opportunities should include:

- Trauma-informed care for all stakeholders.
- A review of current training requirements and opportunities to improve alignment with what is actually needed while being mindful of burdensome requirements.

Develop a system to better maintain, track, and share relevant information, while ensuring appropriate levels of confidentiality and security.

The need for improved record sharing across various systems (i.e., child welfare, healthcare, education, etc.) was repeated throughout our interviews. Information specific to a child's history is not always available to new families, providers, and educators expected to care for and support the child. While confidentiality and privacy are of utmost concern, a new system with appropriate levels of permissions for various parties is needed.

CONCLUSION

Children and youth in the foster care system are an especially vulnerable population. Many of these children have experienced many adversities during a period of growth that needs stability and consistency. The vast number of individuals and agencies that support these children create as many opportunities as they do challenges. To better serve these children we must: expand access to high-quality physical and behavioral health services; offer high-quality training and services for birth, foster, kinship, and adoptive families that meet their needs; prioritize a child's education, particularly during transitions; and create systems that allow for better communication and coordination. Organizations supporting child welfare in Region 6 are beginning to lay the foundation for strong collaboration and support, but our transition to a CBC model will require significant support, resources, and collaboration from local and state partners.

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