Moving Foster Care Forward

A plan to meet the needs of children and families
by improving the capacity of the Foster Care System

March 2008

Table of Contents

Introduction

Over the last four years, the Department of Family and Protective Services (DFPS) has implemented comprehensive reform efforts with the guidance, direction, and resources provided by the Texas Legislature and the input of stakeholders. The Child Protective Services (CPS) reforms of the 79th and 80th Legislative Sessions brought forth a renewed determination to increase accountability in foster care and provide the highest quality services to children and families. Every child in foster care deserves a safe, nurturing placement that will meet his or her needs and services to help him or her achieve permanency.

The purpose of this document is to outline the plan DFPS is enacting to continue to bring about change in the Texas Foster Care System and better serve children and families. The plan was conceived to integrate elements of CPS reform with DFPS' ongoing efforts to build foster care capacity into a single, directed effort. Reform efforts will continue over the next several years and as they do, DFPS will use this plan to unify capacity-building efforts. Through this plan, DFPS and contracted providers will work together to build a system with the full capability to meet the needs of the children and families of Texas.

Background

DFPS is charged with protecting children from abuse and neglect. CPS is the program within DFPS that is responsible for investigating cases of abuse and neglect of children and, whenever necessary, removing children from their home and placing them in substitute care to ensure their safety. Children will remain in DFPS' care until they can be safely returned to their home or family, adopted, or, in the case of older youth, adequately prepared to transition to adult independent living.

Substitute care is a broad term that includes relatives' homes, foster homes, emergency shelters, specialized group homes, residential treatment centers, and other facilities. *Foster care* is a term that represents paid placements; it excludes placements with friends or relatives, known as *kinship care.* CPS prioritizes placing children in the least restrictive, most home-like setting. Kinship caregivers are given first consideration whenever possible. Foster homes are considered prior to facility-type settings. (See Appendix C for data on placement of DFPS children)

Children in Substitute Care Placements
December 2007 (as of 3/1/08)

Type of Living Arrangement	Number of Children	Percentage of Total
Contracted Foster Homes	11,877	43.4%
Kinship Care	8,478	31.0%
DFPS Foster Homes	2,340	8.5%
Residential Treatment Centers	1,349	4.9%
General Residential Organization	819	3.0%
Emergency Shelters	570	2.1%
Other Substitute Care	584	2.1%
Private Adoptive Homes	471	1.7%
Other Foster Care	436	1.6%
DFPS Adoptive Homes	253	0.9%
Independent Living	193	0.7%
Total	**27,370**	**100.0%**

DFPS recruits and trains some of the foster families who care for children. DFPS contracts with Child Placing Agencies (CPAs) to recruit and train the majority of individual foster homes. DFPS contracts with other residential operations for additional placement services, such as residential treatment facilities for children with therapeutic needs. DFPS' Residential Child Care Licensing (RCCL) program regulates all CPAs and other residential child care operations to protect the health, safety, and well-being of children in care and provides technical assistance to providers on meeting minimum standards of care. (See Appendix A)

Children's Placement Needs

A child's service level, which can range from "basic" to "intense",is a significant factor in determining the most appropriate placement for a child (See Appendix B). Authorized Service Levels (ASL) for children in foster care with levels moderate through intense are individually assessed by a third party contractor who takes many factors into consideration including the supervision, medical and emotional needs, age, and other needs. The majority of children in foster care have an assessed level of "basic"; however, there are many children with higher levels of need.

Children in Foster Care by Service Level
December 2007 (as of 3/1/08)

Service Level	Number of Children	Percentage of Total
Basic	10,115	59.0%
Moderate	3,775	21.9%
Specialized	2,618	15.2%
Intense	296	1.7%
Blank/End dated*	381	2.2%
State Total	17,190	100.0%

***** *Policy allows 45 days to record ASL*

At any given time, there are approximately 18,000-20,000 children in foster care. There are approximately 9,500 foster family homes in Texas. Not all children in foster care are appropriate for placement in an individual foster home. Some children with higher needs require treatment provided by residential treatment centers and other residential facilities (See Appendix C). As a result of children's varying needs, simply comparing the number of foster homes to the number of children in foster care will not clearly define the shortage of available capacity for children in foster care. In addition, children have other placement needs, such as being placed with siblings and in close proximity to relatives and schools. Capacity needs must be considered by reviewing the individual needs of children in care with available, appropriate settings and the proximity of those settings to the home of the child.

The Current Capacity Situation

Finding appropriate placements for foster children, particularly those with special needs, is not a new challenge for DFPS. Nor is this challenge unique to Texas. It is a challenge faced by child welfare agencies across the country. Though the situation in Texas is improving, finding appropriate placements for children can be extremely difficult. The reasons are complex and a significant goal of this plan is to better understand the current capacity situation and challenges that impede DFPS and its providers from developing the resources that will better serve children.

Children in Foster Care (Ages 0-17) Placed Out of Legal Region
December 2007 (as of 3/1/08)

Legal Region	Children Placed Out of Region	Total in Foster Care by Region	Percentage Out of Region
001	263	1,329	19.8%
002	192	521	36.9%
003	509	3,366	15.1%
004	329	898	36.6%
005	103	461	22.3%
006	206	3,373	6.1%
007	404	1,978	20.4%
008	322	2,776	11.6%
009	348	599	58.1%
010	20	383	5.2%
011	231	1,506	15.3%
State Total	2,927	17,190	17.0%

The challenge of inadequate capacity impacts children in care and their ability to move through the system to a permanent setting in several ways, both short and long term. About 1 in 6 children are placed out of their home region, many more out of their home county. Sometimes children are placed out of region to be near relatives. There are also cases in which the placement is in a county that is nearest to the child's home, but happens to be in another region. Other times, this is not the preferred option, but placements in region are either not available or do not meet a child's needs. A common example is children from rural areas having to be placed across the state

in large urban centers because of a lack of residential treatment options in their home region. These distant placements make it difficult for the child to have regular contact with the child's family and maintain ties to his or her home community.

Another common challenge is finding adequate placement options for sibling groups. Brothers and sisters may have to separate while in foster care because their service needs are so dissimilar that they require different types of placements. In other situations, two or three beds in the same foster home are simply not available.

One of the more dramatic capacity challenges for foster youth includes a small, but highly publicized number who have had to stay overnight in DFPS offices (or other locations supervised by DFPS staff) because no immediate and appropriate placement was available. This group is comprised mostly of older youth with challenging behaviors that many foster care providers are reluctant to accept.

DFPS began tracking the number of youth without placements in January 2007. Prior to January, youth were known to stay overnight in offices on occasion, but the increasing occurrences led DFPS to develop a centralized database in order to determine the scope of the issue. In January 2007, 32 youth stayed overnight in a CPS office or other location. The placement challenge peaked in the month of May 2007 with 160 youth spending at least one night in an office. By the end of 2007, there was significant improvement with only 10 youth without placements in December 2007 and 19 in January 2008. February saw some increases.

Clearly, the capacity challenge is more than the need to develop more beds. It is developing the right resources for children in their home communities, with siblings and in settings that meet their individual and therapeutic needs. It is also about improving services for the families of children in foster care.

Goals and Objectives

DFPS is engaged across the agency and with other health and human services agencies to employ strategies that will build foster care capacity. The various strategies can be combined under one goal: *strengthening the ability of the Texas Child Welfare System to meet the needs of children in foster care and their families***.**

To achieve this goal, DFPS has established the following objectives:

- Plan and implement strategies for **community-based capacity development**.
- Work toward internal **coordination, program efficiencies, and communication practices that result in effective business and regulatory relationships** with providers and stakeholders
- Promote **best practices and innovations** in purchased service delivery

Objective 1

Plan and implement strategies for community-based capacity development.

This objective is intended to:

- Assess capacity needs at the local level through data analysis and stakeholder input.
- Identify barriers to capacity-building.

The various strategies can be combined under one goal: strengthening the ability of the Texas Child Welfare System to meet the needs of children in foster care and their families.

- Encourage local solutions to meeting the needs of children, youth and families in the community.
- Create a sense of ownership in communities for ensuring the well-being of local children.
- Build a broad array of placement options that ensure an appropriate placement for every child in every community.
- Support improvements to support services for children and families.
- Establish mechanisms for ongoing capacity assessment and improvement.

Assumptions:

- Building foster care capacity is essential to improving outcomes for children.
- The quality and availability of support services to children and families is critical to achieving children's permanency goals and impact placement needs.
- Understanding the unique capacity needs and resources of individual communities will lead to better solutions at the local level.
- Communities must participate in identifying solutions to systemic problems.
- Established mechanisms for ongoing data analysis will promote improved service quality and availability.

Objective 2

Promote internal coordination, program efficiencies, and communication practices that result in effective business and regulatory relationships with providers and stakeholders.

This objective is intended to:

- Analyze and streamline CPS, Purchased Client Services (PCS), Residential Child Care Licensing (RCCL), and Youth for Tomorrow (YFT) the third party contractor for service level authorization, processes to better define and clarify roles, promote coordination, and eliminate duplication.
- Strengthen fair, objective, customer-oriented practices within agency programs.
- Improve or increase technical assistance for providers.
- Streamline agency administrative functions to expedite verification of CPS foster homes.
- Streamline the processes between PCS and RCCL to reduce the time required for issuing a contract to a newly licensed facility.
- Continue improvements to centralized placement functions.
- Coordinate outreach efforts related to capacity-building among DFPS programs.

Assumptions:

- Coordination among CPS, PCS, RCCL, and YFT will help providers understand and meet expectations.
- Providing additional technical assistance to providers will promote the development of new resources and improve the quality of existing resources.
- Having an optimal number of DFPS foster homes will augment CPA foster home capacity to ensure appropriate placement for all children in care.
- Consistent, efficient placement practices help DFPS and providers make the best placement match.
- Coordination of communication and outreach efforts ensures DFPS is presenting a consistent message related to agency objectives.
- Increased use of available technology will improve communication with providers.

Objective 3

Promote best practices and innovations in purchased service delivery

This objective is intended to:

- Explore options for increasing the case management responsibilities of contracted providers.
- Continue to promote performance-based contracting practices in purchased client services.
- Explore options for contracting for residential services that produce better outcomes.

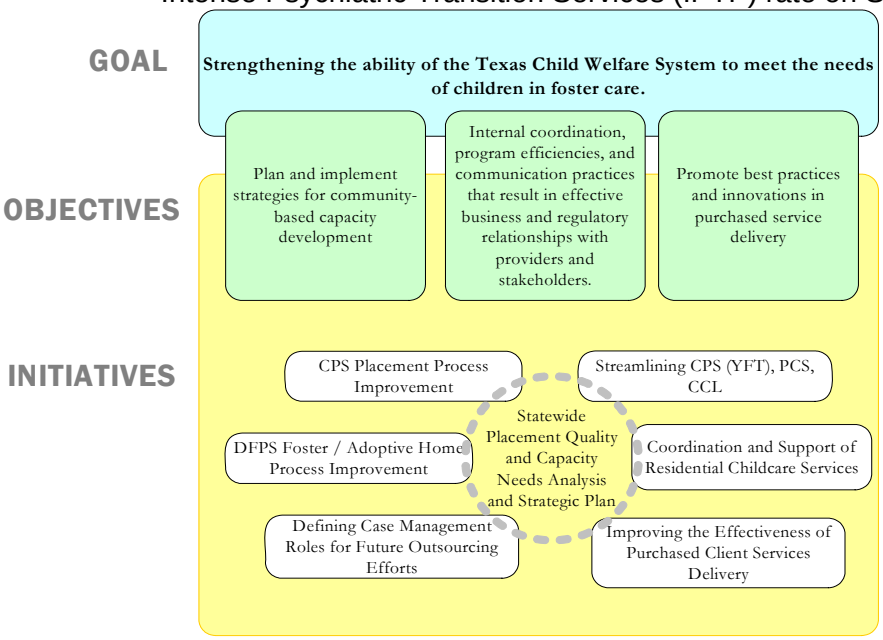
Assumptions:

- The foster care provider community has ideas on improving and adapting the current child welfare system.
- There is a desire on the part of some providers to assume a greater role in the "family work" of child welfare case management.
- The 81st legislative session will revisit the legislative requirement that DFPS outsource a portion of case management services.
- Performance-based contracting is essential to purchasing quality services that result in positive outcomes for children and families.
- It is possible that ideas around the current rate structure will arise out of the initiatives described in this plan. Such ideas will be compiled and considered for future implementation.

Initiatives

While the plan outlined in this document is the most comprehensive and coordinated approach yet, DFPS has worked diligently on capacity related issues over the last year on a variety of fronts. Actions that have been taken to address capacity and quality in foster care include:

- A Building Capacity Workgroup comprised of staff and providers was established in 2006 to collect and analyze data and provide guidance on strategies to address this issue and will continue to support this project.
- As of June 1, 2007 the DFPS web site provides regional statistical information packets that help identify placement needs and capacity by each region.
- Rules were created to allow implementation of the 4.3 percent increase in provider rates and the Intense Psychiatric Transition Services (IPTP) rate on September 1, 2007. DFPS successfully procured two IPTP contractors and has let an open enrollment procurement to obtain additional providers.



- DFPS leadership has met with providers to specifically address DFPS capacity needs, including meetings with in- and out-of-state providers who currently do not provide care to Texas CPS children to discuss barriers and small groups of providers around the state to understand their issues and present our needs.
- DFPS is working with communities around the state to recruit foster and adoptive parents, including the launch of

the “Why Not Me?” campaign in May, to recruit adoptive homes.

As DFPS moves forward with an organized strategy to improve foster care in Texas, the following initiatives will be the focus of the agency’s effort:

- Statewide Placement Quality and Capacity Needs Analysis and Strategic Plan
- CPS Placement Process Improvement
- DFPS Foster / Adoptive Home Process Improvement
- Coordination and Support of Residential Childcare Services
- Defining Case Management Roles for Future Outsourcing Efforts
- Improving the Effectiveness of Purchased Client Services Delivery

Each of these initiatives is described in detail below. Some underlying guiding principles for the initiatives are:

- Efforts will be focused on meeting the individual needs of children.
- Cross-agency involvement and communication of initiative progress will be ensured though executive-level oversight and dedicated project management resources.
- Stakeholders, including providers, advocates, and local communities will be involved in the development and implementation of this plan.
- Community-based strategies will be deployed.
- Federal Child and Family Service Review outcomes will be considered including:
    - placement close to home
    - stability of placements
    - placements with siblings
    - placements in least restrictive settings
- Measures for success will be included in all initiatives

Description of Initiatives

Statewide Placement Quality and Capacity Needs Analysis and Strategic Plan

- The purpose of the Statewide Placement Quality and Capacity Needs Analysis is to provide the foundation for developing a strategic plan that will result in the expansion and improvement of substitute care and adoptive placement quality and capacity in local communities. The plan must be aligned with Texas’ Child and Family Services Review Improvement Plan, the Title IV-B and Title IV-E State Plans, and all state and federal mandates. Details of the strategic plan will provide direction on: Recruiting providers through regionally targeted placement and service development efforts;
- Improving efficiencies in DFPS operations;
- Developing methods to cultivate community-based, market-driven placement capacity and creating a sense of ownership in communities for capacity; and
- Developing data-driven systems that enable DFPS to continually monitor, analyze, and improve substitute care placement quality and capacity.

The Statewide Placement Quality and Capacity Needs Analysis (statewide needs analysis) will compare existing placement quality and capacity to the specific needs of the current and projected substitute care population. The results of the comparison will be used to identify regional capacity shortages and gaps in services. In addition, the statewide needs analysis will identify barriers to capacity development and retention of existing capacity and provide alternatives and solutions to address current placement quality and capacity issues. Results of the analysis will also provide sufficient information to address the following placement quality and capacity issues:

- Children and youth without placements - children in settings supervised by CPS due to unavailability of appropriate placement resources and/or provider rejection of the referral;
- Children and youth placed out of their home regions due to unavailability of appropriate placement resources within their home regions;
- Children and youth not placed with their siblings due to unavailability of appropriate placement resources;
- Lack of available and appropriate placement options for children and youth with challenging service needs;
- Youth aging out of care and youth who are not prepared for independent living;
- Permanency risks associated with children and youth who remain in care more than three years;
- Disparate permanency and well-being outcomes between different races and ethnicities of foster children; and
- Disproportionality and lack of residential placement capacity for African American children.

Timeframe: *January – December 2008*

CPS Placement Process Improvement

DFPS supports placement of children in foster care through Centralized Placement Units (CPUs) in each region staffed with specialized placement coordinators who make initial and subsequent placements for children. Placement unit staff track placement vacancies, review children's information and determine the least restrictive option that best meets the child's needs. The structure has been well-received by providers and DFPS caseworkers and enables field staff to track and demonstrate efforts made to place children to DFPS leadership, the court system and other stakeholders. The purpose of this workgroup is to continue to promote effective placement practices and identify potential enhancements. Representation of placement staff on the team of initiative leaders will also be critical for their insight on placement needs and issues, particularly those related to children with challenging behaviors. Workgroup efforts will include:

- Business process mapping to identify areas for improvement and promote statewide consistency of practice;
- Provider and stakeholder input on relevant issues;
- Improving information sharing between CPS caseworkers and placement staff and between placement staff and providers; and
- Additional work efforts that result from process mapping results and practice analysis.

Timeframe: *Fall 2007 and ongoing*

DFPS Foster/Adoptive Home Process Improvement

The focus of this initiative is expediting verification of DFPS foster homes. The goal is for families to be able to submit an application and be ready to foster a child is less than 120 days. The initiative is occurring in two phases. The first phase entails business process mapping to identify ways to streamline and expedite the process. This phase is nearing completion. The process has yielded opportunities for role clarification, training on quality expectations, and increased accountability. The second phase of the initiative will focus on implementing the changes identified.

Timeframe: *Fall 2007 – Fall 2008*

Coordination and Support of Residential Childcare Services

DFPS will analyze common functions performed by Residential Contracts, Residential Child Care Licensing (RCCL), Child Protective Services (CPS) and Youth for Tomorrow (YFT) to identify opportunities for improving coordination and streamlining processes. The initiative will explore opportunities for:

- Collaboration in support of provider development and capacity building;
- Coordination and streamlining of common functions;
- Improvement of communication; and
- Support and technical assistance for strengthening current providers.

Timeframe: *Spring 08 – and ongoing*

Defining the Case Management Role for Future Outsourcing Efforts

Senate Bill (SB) 758 requires DFPS to develop a pilot program for the outsourcing of case management services in up to 5% of CPS cases. DFPS was directed to develop a pilot program for the competitive procurement in one or more geographic areas of the state on or before September 1, 2008. The estimated annual cost for this model was almost $14 million. Because no funding was received for this project, DFPS proposed an alternate approach. Prior to the next legislative session, DFPS will develop an alternative model for outsourcing case management services with the highest degree of possible success. Because DFPS will not be procuring services, the agency will be able to more actively solicit provider opinion. DFPS will conduct outreach to providers and other stakeholders around the state to gather perspectives on how a successful contracted case management model would be best structured and managed. Additionally, the Department will consider best practices from around the country in developing the proposed alternative model. This research of national best practices, coupled with comprehensive input from existing and potential Texas providers of child and family services, will result in a more planned, systemic and achievable approach to outsourcing of case management services. The resulting plan will be developed for the 81st Legislature to consider, along with a request for the funding to implement the program.

Timeframe: *January – November 2008*

Improving the Effectiveness of Purchased Client Services Delivery

DFPS will analyze business practices related to the purchase of client services with a focus on performance measurement and reporting, payment structures, and contracting models and will develop plans for internal process improvements that result in better outcomes for children and their families. The initiative will include a dialogue with external providers. A goal of the effort will be to communicate long term service and outcome expectations to providers.

In addition, it is anticipated that the work being done in the various DFPS initiatives and advised by the capacity strategic plan will lead to new or innovative services or ways of purchasing services. Such ideas will be compiled and considered for future implementation by this project team..

Timeframe: *Commencing in spring 2008 with work to continue as other projects dictate.*

Conclusion

Building Foster Care capacity in Texas is about more than recruiting additional placement resources. It will require internal and external shifts in a system of service delivery that needs to do better to meet the needs of children and families. It will require the dedication of DFPS and its providers to examine long established practices and trends with an eye toward doing better. DFPS' intention in establishing this project is to move forward in a coordinated effort to work toward short term and long term change.

Appendix A - Roles of the DFPS Program Areas

Child Protective Services (CPS) / Youth for Tomorrow (YFT)

DFPS contracts with YFT to assist in the implementation of the Texas Service System. These statewide services are provided according to procedures approved by DFPS which includes the use of service levels (See Appendix B).

YFT determines a child's authorized service level based on his or her service needs. Clinically trained professionals from YFT use these definitions to synthesize their knowledge about a child's psychological and social functioning and then make a service authorization (Moderate, Specialized, or Intense). The service authorization is determined in the context of a broad review of the clinical information submitted by the CPS caseworker about the child's social and medical history, symptomatology, behaviors at home or alternate placements, behaviors in school, and interpersonal relationships with children and adults.

In addition, the service level authorization process considers the child's developmental and chronological age in relation to various risk behaviors. For the most part, the process does not use a set of pre-defined behaviors to determine a child's service needs. One of the problems with a pre-defined list is that all behaviors are NOT the same risk. For example, all runaway behaviors are not considered the same risk. A 16-year-old adolescent who runs away once per month but returns by dinner time is not the same behavior as that of a 10-year-old who runs away once a month and does not return voluntarily.

The YFT contract does not contain any incentives that pertain to increases or decreases in authorized services. YFT does not benefit from high percentages of decreased service authorizations nor are there penalties for high percentage of increased authorized services. The contract is a cost-reimbursement contract based on a line-item budget which is negotiated and approved by the DFPS each fiscal year. The contract is competitively re-bid every four (4) years according to the State of Texas competitive procurement procedures.

Purchased Client Services (PCS)

The PCS division of DFPS purchases goods and services for CPS, Adult Protective Services (APS), and Prevention and Early Intervention (PEI) clients. Goods and services for clients purchased by PCS are provided by vendors under contract with DFPS.

When CPS, APS, or PEI identifies a need for goods or services, PCS solicits bids, applications, or proposals from vendors. Additionally, PCS performs program and contract related functions including planning for services, procurement, developing performance measures, contracting, contract administration, contract monitoring, and resolution of contracting issues.

Purchased Client Services is comprised of five divisions:

- Prevention and Early Intervention
- Regional Contracts
- Residential Contracts
- Contract Performance
- Procurement

Residential Child Care Licensing (RCCL)

A division of the Child Care Licensing program, RCCL regulates twenty-four hour child care to protect the health, safety, and well-being of children in care, largely by reducing the risk of injury, abuse, and communicable disease. Among other responsibilities, RCCL:

- Issues or denies licenses to persons applying to operate child care or child placing operations;
- Monitor operations and agencies for compliance with minimum standards of care;
- Informs parents and the public about child care and child placing and about the histories of specific homes, child-care operations, and child-placing operations in complying with minimum standards of care;
- Provides technical assistance to providers on meeting minimum standards of care; and
- Investigates allegations of abuse and neglect of children in regulated care.

Appendix B - Service Levels for Foster Care

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; and
- 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.

Children who need Basic Services
A child needing basic services is capable of responding to limit setting or other interventions. The children needing basic services may include one or more of the following characteristics:

- 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.

Developmental delays or mental retardation 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 above, a child with primary medical or habilitative needs may require intermittent interventions from a skilled caregiver who has demonstrated competence.

Children who need Moderate Services
A child needing moderate services has problems in one or more areas of functioning. The children needing moderate services may include:

- One or more of the following characteristics:
    - 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.

- Abuse of alcohol, drugs, or other conscious-altering substances and:
    - 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.

- Developmental delays or mental retardation marked by:
    - 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.

- Primary medical or habilitative needs including assistance with:
    - 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 competency.

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 above, a child with primary medical or habilitative needs may require regular interventions from a caregiver who has demonstrated competence.

Children who need Specialized Services
A child needing specialized services has severe problems in one or more areas of functioning. The children needing specialized services may include:

- One or more of the following characteristics:
    - 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.

- Abuse of alcohol, drugs, or other conscious-altering substances that results in:

    - severe impairment because of the substance abuse; and
    - a primary diagnosis of substance abuse or dependency.

- Developmental delays or mental retardation marked by:
    - 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.

- Primary medical or habilitative needs that require assistance with:
    - 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.

In addition to the description above, a child with developmental delays or mental retardation needs professionally directed, designed and monitored interventions to enhance mobility, communication, sensory, motor, and cognitive development, and self-help skills.

A child with primary medical or habilitative needs requires 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.

Children who need 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 needing intense services may include:

- 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, cognition, expressions of affect, or personal hygiene.

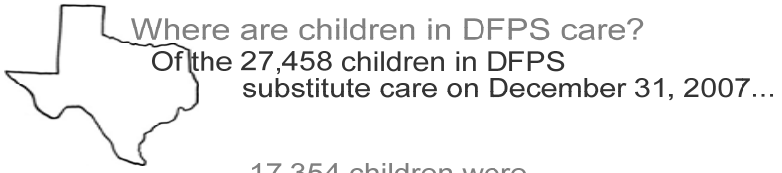
- Abuse of alcohol, drugs, or other conscious-altering substances that includes a primary diagnosis of substance dependency in addition to being extremely aggressive or self-destructive to the point of causing harm;

- Developmental delays or mental retardation marked by:
    - 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.

- Primary medical or habilitative needs that present an imminent and critical medical risk and 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
    - medical supervision, 24-hour on-site, to sustain life support.

Appendix C – Current Placement Types of DFPS Children

The chart of the following page gives a point in time representation of where children and youth in DFPS conservatorship are placed.



Where are children in DFPS care?
Of the 27,458 children in DFPS substitute care on December 31, 2007...

17,354 children were in Foster Care

11,732 children were placed in **Child Placing Agency (CPA) Foster Homes**

Foster homes are families who accept foster children into their homes. These foster homes are recruited, trained, verified and managed by private CPAs.

DFPS has contracts with just over 100 CPAs.

The majority of CPA foster homes are verified to provide *therapeutic* foster care services.

2,359 children were placed in **DFPS Foster Homes**

These are families who accept foster children into their homes and are recruited, trained, verified and managed by DFPS. The majority provide *basic* foster care services.

812 children were placed in **Basic Child Care**

These are typically cottage and campus type settings meeting basic child needs.

1,392 children were placed in **Residential Treatment Centers**

An RTC is a very structured setting for children with serious emotional disturbance or mental health issues.

625 children were placed in **Emergency Shelters**

These are intended for stays of less than 30 days.

434 children were placed in **other types of foster care**

such as camps, maternity homes hospitals, juvenile detention, ICF-MR, HCS homes, state schools & hospitals.

Texas Department of Family and Protective Services/CPC/Jan 2008
Source Data: DFPS Data Warehouse reports SA_05, SA_18 and PP_03s.

Notes:

a. This graphic represents children ***under the age of 18*** *in DFPS Substitute Care.*
b. There were also 541 youth ***over the age of 18*** *in foster care, but who had "aged-out" of the legal conservatorship of DFPS.*
c. There are a total of 29,823 children in DFPS legal responsibility. 2,365 are in the legal conservatorship of DFPS but ***not*** *in substitute care; the majority of these children are in a reunification stage and are living with their families of origin.*

10,104 children were in other types of Substitute Care

8,533 children were placed in **Kinship Care**

DFPS supports relative caregivers by assisting with initial costs of accepting a child and through ongoing case management.

477 children were in pending adoptions in **CPA Adoptive Homes**

286 children were in pending adoptions in **DFPS Adoptive Homes**

808 children were placed in **Other Substitute Care**

which includes independent living programs, unauthorized absences and court ordered placements.