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ACKNOWLEDGMENTS

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CARL B. & FLORENCE E.
KING FOUNDATION
INTRODUCTION

In one year, Child Protective Services (CPS) investigates over 225,000 reports of abuse and neglect in Texas. Over 66,000 children were confirmed to have been abused and neglected in 2015 alone. In those cases where the risk of abuse and neglect is high, or where the abuse and neglect is severe and a child is in immediate danger, a child may be removed and placed in the foster care system. Before considering removal, CPS must make reasonable efforts to prevent a removal from occurring\(^a\) by offering services while the child remains in the home, seeking short-term placement with a family member, friend or by removing the perpetrator from the home. Unfortunately, for many children, removal from their family of origin is the only way to ensure their safety. In 2015, 17,151 children were removed from their homes in Texas and on any given day, over 27,000 children are wards of the state in “substitute care”: foster care or kinship care.\(^b\) Nationally, removals are decreasing by 1.25% each year\(^c\) and by 11.5% since 2006. However, in Texas, while removals comprise only 6.9%\(^c\) of the children investigated for abuse compared to national averages of 8.7%\(^c\), removals have increased by 4.5% on average each year, and by 41% in total since 2006\(^b\).

Figure 1: Children Entering Foster Care Texas vs. National 2006-2015\(^b, c\)

While there is often more than one reason or type of abuse and neglect cited when a removal occurs, the most common abuse type leading to children entering foster care is consistently some form of neglect or abandonment. Neglectful supervision contributed
to 76.8% of all removals between 2010 and 2013 in Texas. Physical abuse and physical neglect were the next most common reasons cited for removal.

**Figure 2: Top Reasons for Removals in Texas 2010-2013**

Children from 0 to 2 and children between the ages of 14 and 17 make up the largest age groups of children in foster care, while the population of children that elect to remain in foster care after they turn 18 to their 21st birthday remains relatively low, around 3-4% of foster children around the past three years.

**Figure 3: Ages of Children in Foster Care 2015**

The majority of children in substitute care are placed in foster family homes or kinship (relative caregiver) homes. Other types of placements in which a foster child may be placed include emergency shelters, where children can stay for up to 30 days while
DFPS locates a foster family for the child; residential treatment centers, where children with higher behavioral health needs are placed; and basic child care, which includes cottage- or campus-style living for children with basic needs.

**Figure 4: Children in Care by Placement Type**

When a child is removed from their family of origin, the state becomes their Temporary Managing Conservator (TMC) and children become “wards of the state.” As of August 2015, 60.1% of children under DFPS legal responsibility were in TMC. During TMC, a conservatorship (CVS) caseworker is assigned to the child’s case and creates a case plan to establish a structured, time-limited process for providing services to a child and their family of origin. A permanency goal is established. Often this goal is to reunify the child and the family from which the child was removed. If the family is unable to make the changes necessary to ensure a safe environment for the child, an alternative permanency goal is established. This can be to seek permanency either with a relative caregiver or an adoptive caregiver, or in some circumstances, the permanency goal is for the child to age out of foster care. A caseworker has 12 months from the time of removal to establish permanency for a child and can request an extension of six months from the court overseeing the child’s case, if needed.
Different Types of Permanency Defined

- **Family Reunification**: Reunifying a child with their biological family. This is the primary permanency goal for every child in foster care except when a court has determined that reunification efforts are not possible due to aggravated circumstances, for example if the parent has committed homicide to a sibling of the child or continuously sexually abused the child.

- **Adoption (Relative or Non Relative)**: Adoption in most circumstances involves the termination of parental rights and is an alternative only if family reunification is not possible. Relative adoption is preferred over non-relative adoption. Relative caregivers can also include fictive kinship caregivers, non-relatives who may have an established relationship with the child prior to adoption. Non-relative adoption can occur when a child in foster care is adopted either by the foster family currently providing care for the child or by a family that is seeking to adopt a child.

- **Relative Custody with Permanency Care Assistance (PCA)**: In some situations, relative adoption may not be possible, or may not be in the best interest of the child. This can be court determined or because the parties in the case agreed not to terminate parental rights. This type of permanency involves the relative caregiver being appointed as Permanent Managing Conservator (PMC) of the child, while the parents retain possessory conservatorship only. Through federal funding made available in 2009, through the Permanency Care Act, relatives can access monthly support payments if they become a licensed kinship home and have had the child in their home for a minimum six consecutive months. Licensing involves the relative caregivers completing the training required to become a foster parent and passing a comprehensive study of their home and background.

- **Relative Custody without Permanency Care Assistance**: Similar to Relative Custody with PCA, this type of permanency occurs when one or both parents still retains possessory rights to the child while the relative is appointed conservatorship (PMC). For some caregivers, the licensing process and trainings required to qualify for PCA may be too burdensome to meet and/or complete. Some relatives may not qualify if they have had the child placed in their home fewer than six months. In this situation the relative may obtain PMC but does not receive monetary support once permanency is achieved and the case is closed.
- **Emancipation or “Aging Out” of Foster Care**: Unfortunately, for those children who do not achieve permanency through reunification, placement with a relative or adoption, DFPS is appointed as their Permanent Managing Conservator and parental rights are terminated. While the optimal goal for these children is to secure permanency through adoption, either relative or non-relative, often these children languish in the foster care system for several years as they seek permanency. Emancipating out of foster care at age 18 is the least preferred outcome for a child, given the high rates of social, educational, health and other issues plaguing those who “age out.” In 2015, 1,180 children aged out of foster care, often with little support or structure and at high risk for negative outcomes.

**Figure 5 Exits to Permanency by Type**

<table>
<thead>
<tr>
<th>Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Reunification</td>
<td>30.40%</td>
</tr>
<tr>
<td>Relative Custody without PCA</td>
<td>15.60%</td>
</tr>
<tr>
<td>Non-Relative Adoption</td>
<td>15.10%</td>
</tr>
<tr>
<td>Relative Adoption</td>
<td>6.60%</td>
</tr>
<tr>
<td>Aging Out</td>
<td>4.20%</td>
</tr>
<tr>
<td>Custody to Relative with PCA</td>
<td>1.10%</td>
</tr>
</tbody>
</table>

**HEALTHCARE**

Children in foster care often experience multiple traumatic events before they enter foster care, including the abuse and neglect they endured which precipitated their removal. Placement in foster care and any subsequent placement move thereafter exacerbates the physical and behavioral symptoms associated with trauma. Children that have been abused and neglected and are in the foster care system are more likely
than others to have adverse physical and behavioral outcomes impacting their entire lives, including higher rates of depression, post-traumatic stress disorder, attention deficit hyperactivity disorder, suicide and premature death. An assessment of the foster care population in Texas in 2015 identified that approximately 1 in 8 foster children are defined as “high needs,” meaning they have at least one complex medical, behavioral or emotional indicator and the number of children requiring an intensive level of care in Texas is increasing every year, up 52.4% between 2006 and 2015.

**Figure 6: Number Children in Foster Care Classified as “Intensive” Level of Care**

The federal ruling against the Texas foster care system revealed that many of the children that were party to the suit had case files that were missing important health information. As children transition from placement to placement, their records indicated that they were not seen by medical professionals timely, or even at all in some instances. The suit also noted on several occasions that children did not receive physical and sexual abuse examinations when abuse was suspected in foster care. It was noted in a report released by the federally appointed Special Masters that “incomplete and missing healthcare information was a common feature in the records.”

**Access and Utilization of Healthcare**

When a child enters the foster care system in Texas, they are provided access to Medicaid health insurance coverage starting on their first day of care. Their eligibility for this benefit is processed through their CPS caseworker and ultimately through a contract with one statewide managed care organization, Superior Health. The health
insurance plan in which all children in foster care are enrolled is Star Health in Texas. Health insurance for a foster child, like all other types of Medicaid, is funded jointly by the federal and state government.

As part of federal law, foster children up to the age of 20 qualify for preventative well-being exams through a service called the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). The EPSDT schedule is frequently relied upon by foster parents and medical providers as the guide for how often children are seen.

While the screenings are more frequent in a child’s first three years of life, for children that are above the age of 3, those that may have been in foster care for a longer period of time and for teens, the screening schedule only allows for one exam a year after the age of 3 (see Figure 7).

For children entering foster care, DFPS policy requires that a child receive their EPSDT exam within 30 calendar days of entry into care. The screenings in their current form are not comprehensive in addressing the unique issues a traumatized child may experience. The American Academy of Pediatrics (AAP), however, recommends that children have an initial health screening within 72 hours of being placed in foster care. The goals of the health screening should be to assess for all forms of abuse and/or neglect, assess any behavioral health conditions, ensure the child has current medications and foster parents have the equipment and support needed to provide care for the child. For children with chronic medical conditions, the initial screening should be within 24 hours. The AAP also recommends that ongoing screenings should be more often. Screenings should be monthly for infants 0-6 months and every three months thereafter until the age of 6, where screenings should be every six months. More frequent screenings can allow a physician to monitor a child’s adjustment to their placement, identify emerging needs and support the caregiver in meeting the child’s needs.

In November 2016, the special masters appointed to oversee the implementation of Judge Janis Jack’s ruling requested that DFPS develop and implement a healthcare plan.

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Figure 7: Texas Health Steps Screening Guidelines

<table>
<thead>
<tr>
<th>Infants and toddlers:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Newborn (before 5 days old)</td>
</tr>
<tr>
<td>- 2 weeks</td>
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<tr>
<td>- 2 months</td>
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<tr>
<td>- 4 months</td>
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<tr>
<td>- 6 months</td>
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<td>- 9 months</td>
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<tr>
<td>- 12 months</td>
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<tr>
<td>- 15 months</td>
</tr>
<tr>
<td>- 18 months</td>
</tr>
<tr>
<td>- 2 years</td>
</tr>
<tr>
<td>- 2 ½ years</td>
</tr>
<tr>
<td>- 3 years</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children 3 and older, teens, and young adults:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Once a year</td>
</tr>
</tbody>
</table>
for children in the Permanent Managing Conservatorship (PMC) of the state and recommended that they utilize the AAP’s guidelines for screenings. It is recommended that Texas adopt screening guidelines that are more aligned with national standards.

Additionally, screenings should adopt a trauma informed approach to medical care, one that, through a network of care, addresses the physiological needs that arise in children that have experienced trauma. Trauma informed care involves an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. This should include the monitoring of trauma symptoms, mental health symptoms, child development, caregiver’s needs, disabilities, infectious disease and emerging chronic conditions. Training for medical professionals in recognizing abuse and neglect and treating trauma is also needed.

**Ensuring a Child’s Medical History Is Complete**

Typically, when a child has to be removed from their biological family, the child’s caseworker collects a history of the child from the child’s caregivers. This can include asking about the child’s medical history including past and current conditions, the family’s medical history, any allergies the child may have and any medications the child is prescribed. The quality of information collected at the time of removal can vary based on multiple factors, such as a caregiver’s absence at the time of removal, a caseworker’s skill or experience in interviewing or if the removal occurred so quickly that there was insufficient time to gather this information. This often occurs when conflict arises at the time of removal between the CPS caseworker and the caregivers of the child.

When a caseworker removes a child, they must secure a foster placement immediately following the removal. A child’s medical history is summarized in a placement application that is submitted to the Centralized Placement Unit (CPU), whose job it is to locate a foster home best able to fit a child’s needs. A complete and thorough medical history is important to include when seeking placement, because it ensures that the child is matched with a foster parent who will be best able to meet the child’s needs.

Beyond the placement application, a child’s medical history is entered in several placement forms, submitted in legal documents to the court overseeing the child’s legal case and entered in multiple places in DFPS’s case record system, referred to as IMPACT. Following the removal, a child’s case is transferred from the investigative or
family preservation caseworker to a conservatorship worker, who will work the case until the child achieves permanency (or ages out). Often, if a child’s medical history is not documented thoroughly, this information can be lost in the caseworker transition. For children with chronic conditions, this can be dangerous as their new caseworker may not know about pre-existing conditions, upcoming medical appointments or how to assess for a caregiver’s capabilities.

Furthermore, as a child moves through the foster care system and into different placements, a child’s medical history is not consistently passed on from one caregiver to the next. A child’s health passport should be easily accessible to medical providers seeing the child, foster parents, caseworkers, Court Appointed Special Advocates (CASAs) and the courts. The information contained within the passport should be comprehensive, accessible and easy to understand.

**Involving Medical Professionals in Placement Planning**

Ideally, when a child enters the foster care system, they should only have one placement. On average children in foster care experience 1.9 placements before exiting, but for those children with complex needs, they will move an average of 5-6 times to various placements. Medical professionals are rarely notified until after a placement move occurs. For children with specialized medical needs, there may be a staffing in which medical professionals are invited to participate; however, no notification is given when a child actually moves to a new placement. For physicians seeking to establish continuity of care, this can be difficult to accomplish. Physicians should be notified of placement moves in order to contact the child’s new caregivers and possibly new medical providers of the child’s needs.

**Capacity**

A main factor directly impacting the foster care system’s ability to meet a child’s complex educational and medical needs is a lack of placement capacity, meaning the right types of foster placements for each child’s unique needs in the areas where the children need them. A federal court ruling in December 2015 came to the same conclusion and ordered DFPS to complete a statewide capacity assessment and address the lack of placement options available to children across the state. Because of inadequate placement array and distribution, children are often placed out of county
and more frequently over the last four years, out of region. However, children placed out of county in Texas has dropped from 70% to 61% of all foster children.

Figure 7: Placement Proximity for Children in Foster Care in Texas

Placement array, meaning the different types of placements available for children in foster care, and their geographical distribution across the state of Texas are not meeting the needs of children in their home communities. This results in children placed farther away from home. This can be impacted by a number of factors, one of which is cost of living. Just as cost of living impacts DFPS’s ability to recruit and retain CPS caseworkers, it impacts the quality and cost of care as it pertains to foster homes in areas where services may cost more or cost of living is higher. Foster care reimbursement should reflect not only quality of care provided, but also cost of living differentials.

To develop capacity in the areas where there is need, DFPS should overlay zip-code level risk maps to identify areas of the state with high foster care demand (where removals are occurring at higher rates) and contrast those results with a zip-code level assessment of current foster care capacity. DFPS would then be able to target foster care recruitment and capacity development, including higher foster parent reimbursement rates, in the areas with highest need.
For youth aging out of care, the ruling brought to light disturbing conditions in Residential Treatment Centers (RTCs), which are congregate care facilities providing 24-hour supervision to children with higher behavioral needs.

The geographical distribution of RTCs is not evenly dispersed across Texas, with the largest concentration occurring in the Houston area. When children are placed outside of their home county, their primary caseworker (Conservatorship caseworker) is often not the caseworker who has the most frequent contact with these children. Instead, “I See You” workers are local caseworkers with high caseload whose primary task is to ensure a child in state conservatorship is literally “seen” once per month to meet Federal standards. Children are also less likely to maintain contact with their biological families when they are placed further away from home, especially when placed out of region. CPS is often unable to facilitate frequent face-to-face contact, if any at all, with the child’s siblings, parents and potential relative caregivers, which may compromise the goal and process of family reunification.

It has also been noted that many children placed in RTCs have difficulty transitioning to less restrictive placements, such as a foster family home. There is a need for intensive, wraparound services to help children placed in the most restrictive settings, like RTCs, transition to less restrictive environments. Evidence-based programs, such as Multidimensional Treatment Foster Care (MDTF), are ideal for this higher-need population. By providing an intensive-level, single child to a specially trained foster parent in a 1:1 ratio, with one constant caseworker with a capped caseload of five cases combined with comprehensive wraparound services, children can be provided the chance to heal and improve in foster care. MDTF is essential because the number of children with higher needs is growing each year. This need is even greater for those children who have viable kinship placement options that have not been explored, which is partly due to the child’s level of care. Moreover, MDTF is more cost effective compared to costly juvenile delinquency or residential treatment centers. Econometric analysis has shown that MDTF’s outcomes can yield a state savings of over $14,000 for $8,300 invested.

Moreover, the current reimbursements for foster care providers only increase as a child’s level of care increases. While the cost of caring for a child with higher needs is higher than a child with basic needs, improving a child’s overall well-being results in decreasing a child’s level of care, resulting in a decrease in a foster care provider’s (and the child placing agency’s) overall reimbursement. This creates a disincentive in the
current foster care system to promote a child’s overall well-being. To address this, a base rate plus payments made for improved child outcomes, aka performance-based contracting for foster care providers, seeks to improve the quality of care provided to foster children by establishing child-specific metrics into their evaluations. Outcomes such as confirmations of abuse and neglect in foster care or a youth’s completion of Preparation for Adult Living classes are examples of what is currently assessed. Expanding these measurements to additionally capture well-being outcomes via tools such as the Child and Adolescent Needs Assessment (CANs) will help DFPS identify those providers that are doing the best job at healing foster children in the least restrictive environment and allow the free market to work by guiding more cases to the best providers.

EDUCATION AND THE NEEDS OF THOSE AGING OUT

For teenagers, the transition from childhood to adulthood can be a challenging experience, but for foster youth, these challenges are often magnified. Teenagers in foster care are less likely to be adopted and as a result, are more likely to age out of the foster care system when they turn 18 years old. While there has been an increased movement towards fostering permanency for these teenagers, roughly 1,200 foster youth age out of foster care each year in Texas (nationally, over 22,000 foster youth age out of care each year). Numerous studies have shown that emancipated foster youth, once victims of abuse and neglect in their childhood, are at higher risk for poverty, homelessness, incarceration, teen pregnancy, substance abuse and human trafficking when they age out of care. While supports like tuition and fee waivers, life skills training, transitional housing and extended foster care are available, these programs continue to be underutilized by current and former foster youth, for a variety of reasons.

The field of developmental science has identified an in-between period of late teens and early twenties, referred to as “emerging adulthood,” which is distinct from adolescence or true adulthood. This time period is characterized by self-discovery and growing independence. Aspects of higher brain functioning continue to develop in young adults and are not fully mature until their mid-twenties. In addition to this, foster youth may lack strong relationships and connections to their caregivers due to the frequency at which they experience placement moves or because of the types of placements they are in. If healthy relationships were not established in childhood with parents, or in foster
care, it can be difficult to form healthy relationships with peers in adolescence and adulthood. This time period is critically important for honing social skills and fostering healthy relationships in addition to providing educational and life skills development support.

Support for Youth, Early and Ongoing

Educational Stability
When a child enters foster care, they are rarely placed in their immediate home community. As of November 2016, 60% of children in foster care were not even placed in their home county. Removal and every placement that occurs thereafter disrupts a child’s educational stability, often involving a change of schools with each move. Similar to medical history, as a child moves schools, lack of information sharing between schools can result in delays in enrollment, missed assessments and delays in children receiving special education services. In one study, 42% of foster children did not begin school immediately upon entering foster care. Nearly half of youth surveyed in the same study indicated they were kept out of school because of lost or misplaced school records. Children in foster care also have to miss school for parent-child visitation, court hearings, doctor’s appointments and therapy. The further a child is placed from their county of origin, the further the distance the child must travel for these appointments. This can be especially detrimental to a child’s education if the absence occurs weekly, as often occurs with weekly parent-child visits.

Given that foster youth aging out of CPS conservatorship average nine placements (different foster homes) over their period of time in foster care, foster children experience great instability in their educational, social, intellectual, emotional and mental health development. Each move from one foster home to the next has shown to set back a foster youth’s education by on average four months. For an average emancipating youth, this amounts to 36 months or three years of education lagging behind their non-foster child peers. In addition, foster youth are robbed of the early childhood stages of bonding with critical caregivers and other stable adult figures (many suffering from attachment disorders). Multiple moves to different homes, caregivers, cultures, schools, teachers, sports or after-school activities, and faith-based connections without the stability of other family members often lead to distrust and relational difficulties in subsequent adult and authority figure relationships (educational, medical, sports, social, therapeutic, law enforcement, etc.)
Understandably, by the time an average foster youth is eligible to apply for secondary education, they are educationally, emotionally and socially equivalent developmentally to an 11-14 year old. Emancipating youth at this true age of maturity not only are unlikely to navigate the application and financial aid process for tuition waivers but are also more unlikely to desire yet another move away from stability to be housed with, yet again, more strangers.

Federal and state legislation has sought to address educational outcomes by requiring school districts and states to do more to stabilize a child’s education. The Fostering Connections and Increasing Adoptions Act (FCA) of 2008 required all children to have educational stability plans. In Texas, these are included in the child’s service plan in the “education” section. It also required CPS to consider a child’s proximity to their school of origin when making placement decisions and required that children remain at their school of origin unless it is not in their best interest. Unfortunately, since 60% of children in Texas are not placed within their home county due to a lack of placements, it is often not in the child’s best interest to spend so much time in transport to and from school each day.

One promising program, Foster Care Redesign, which is being piloted in the western part of North Texas, seeks to develop placement capacity in a child’s home community so that a child can remain in their school of origin when they enter foster care. Redesign has been able to increase the number of children placed within 50 miles of home from 71% to 83% since the pilot’s launch in 2014. Redesign is also utilizing special software that assists in matching children to the placement best able to meet their needs, with placement proximity as one of the top considerations.

State legislation passed in 2011 (HB 826), 2013 (SB 832) and 2015 (HB 3748) – aimed at better supporting foster children and youth – required that liaisons be appointed for each school district, charter school and higher education system. At the school district level, liaison responsibilities include streamlining the enrollment process, inputting data so that outcomes for children can be tracked, ensure children are on track to graduate and supporting foster children and their families with services at the district’s disposal. There may be multiple liaisons for one school district, however, legislation requires at least one liaison per district. Ideally for larger school districts, this legislation
sought to establish liaisons with the sole responsibility of supporting foster children. In practice, school counselors and data controllers are often designated as the foster care liaison for a particular school or district in addition to fulfilling their basic job demands. Their full time duties can prevent these “double-duty” liaisons from providing what is needed to ensure a foster child is able to thrive in their district. Correct data entry is critical to ensure the Texas Education Agency (TEA) is able to accurately track educational outcomes for children in foster care. Liaisons are able to utilize the TEA’s resources regarding their roles and responsibilities, but additional training may be needed to ensure this is occurring. Initially, districts were slow to appoint liaisons and many foster parents did not know who their liaison was. Liaisons for each district are now listed on the TEA website and can be accessed by foster parents or caseworkers.

While HB 826 and SB 832 focused on primary and secondary educational support, HB 3748 aimed to establish the same support and accountability at the post-secondary level. Since its passage in 2015, the Texas Higher Education Coordinating Board (THECB) has appointed a liaison within their own department, but has also received liaison designations from 77 higher learning institutions in Texas. These liaisons are also listed on THECB’s website. Another component of HB 3748 sought to improve data sharing between THECB and CPS of former foster youth. As data sharing and collection improves, CPS will be better able to guide what supports youth may need to succeed. More students are utilizing tuition reimbursements and vouchers than in the past, as seen in the significant increase between 2004-2015 depicted in Figure 8. However, the agencies lack data on how many foster youth successfully complete their studies. In one national study, while 43% percent of former foster youth completed some postsecondary education, only 2% were able to attain at least a bachelor’s degree.
Preparation for Adult Living

Preparation for Adult Living (PAL) is a program offered through DFPS available to youth ages 16+ in foster care. Youth are assigned a PAL caseworker, in addition to their conservatorship caseworker. The PAL caseworker should ideally assist the youth in preparing to age out of care by developing and building life skills. The most common service utilized by youth through the PAL program is life skills training. This classroom-based curriculum focuses on developing six core skills: health and safety, housing and transportation, job readiness, financial management, life decisions and responsibilities, and personal and social relationships. PAL can also assist youth with services such as SAT or ACT exam prep, driver’s education classes and vocational training.

While federal and state funded programs to support foster youth have grown significantly in the last decade, these programs continue to be underutilized and in many instances, youth have expressed that they were not aware of these resources and that the life skills training was not useful to them. Evaluating the efficacy of programs, such as the PAL program, will be critical in ensuring youth are receiving meaningful and practical tools to achieve self-sufficiency when they age out of care. PAL classes should start earlier, at age 14, and should be an ongoing life skills development. Currently, PAL services are only offered to youth 14 and up when funding is available. Ideally, skills like financial management or how to prepare and cook meals should be taught by caregivers. The reality for many teenagers is placement in a Residential Treatment Center (RTC), where youth are bereft of a nurturing and lasting relationships.
with a caregiver who could teach these skills. Transitioning more youth out of restrictive, non-familial placements like RTCs and into foster family care can ensure youth develop the life skills and relationships with supportive adults that will help them transition into adulthood.

**Support for Pregnant and Parenting Foster Youth**
Foster youth are particularly vulnerable to becoming teenage parents due to several contributing factors which include: an unresolved trauma history; inconsistent therapeutic services and supports; and low self-worth leading to poor boundary setting. The teen birth rate for girls in foster care is *twice* that of girls in the general population. Also, while many abused children do not go on to abuse their own children, they are six times more likely to harm their own children, perpetuating the cycle of child maltreatment. While there are programs in place aimed at assisting foster youth in transitioning to independent living, these programs do not place enough emphasis on pregnancy prevention.

It is unknown how many pregnant and parenting foster youth have access to evidence-based parent education home visiting (HV) programs, which could provide valuable support to these vulnerable and high-risk youth. HV programs are “2Gen” or two-generational programs that can prepare foster teens for parenthood; provide education, coaching and therapeutic services; and offer skill-building to help youth create safe, healthy and functioning homes for their children while breaking the intergenerational cycle of abuse, violence and neglect. Unfortunately, placement options for pregnant and parenting foster youth are often limited due to capacity issues. Increasing the availability of placement options for pregnant and parenting foster youth, including those that offer structured support for youth in extended foster care, can reduce the number of youth who often end up placed separately from their child or placed far away from their county of origin.

**Extended Foster Care**
For those youth that do not attain permanency prior to their 18th birthday, emancipation becomes their permanency goal. Youth have the option to 1) remain in foster care; 2) leave care altogether or; 3) leave for a six-month period with the option to return,
referred to as Trial Independence. If youth choose to remain in care, this is referred to as Extended Foster Care. Youth can remain in their current placement if their placement will accept them or seek placement in another foster family home. They can also agree to work or participate in school and live in an independent living arrangement with some structure, referred to as Supervised Independent Living. All of these options are contingent upon availability and the placement provider’s willingness to accept a youth that may have post-traumatic, behavioral or emotional issues. Often, the lack of placement options for youth aging out results in youth leaving the system altogether rather than being placed several hundred miles away from their home.

For those that do elect to remain in care after turning 18 years old, caseworkers provide the assistance needed in Extended Foster Care to assist the young adult in transitioning to a more independent and responsible adult role while addressing individual needs. Although not offered adequately currently, opportunities should be offered to allow the young adult to learn appropriate and meaningful independent living skills. Caseworkers and providers must respect the status of young adults in Extended Foster Care and the need for a supportive environment that allows them to practice, improve and enhance their life skills so that they can become well-adjusted, functioning adults as they leave care. Young adults in Extended Foster Care should have greater responsibility for activities; they need to be empowered to manage their lives. This transfer of responsibility can include, for instance: initiating caseworker contacts; identifying settings and topics for caseworker monthly contacts; participating in independent living activities; and participating in age-appropriate life skills activities.

While casework requirements (such as monthly caseworker contacts) are the same for the Extended Foster Care population as they are for those in foster care under age 18, how the caseworker required contacts are implemented should allow for more flexibility and responsiveness to requests from the young adult.

According to the outcomes study by Chapin Hall, young people who remained in care to age 21 fared far better than those who left care at age 18.

- Those required to leave care at age 18 were 2.7 times more likely to become homeless.
- Remaining in care more than doubled the odds that young people would be working or in school at age 19.
- Those remaining in care were twice as likely to have completed at least one year of college by age 21.
- Young women remaining in care experienced a 38% reduction in the incidence of pregnancy before age 20.
- Those remaining in care were more likely to access independent living services.

**Expanding Supervised Independent Living**

Supervised Independent Living (SIL) is a type of extended foster care, available to youth when they turn 18 years old. Young adults placed in SIL settings have minimal supervision and are provided case management. This arrangement allows young adults to practice necessary independent living skills and achieve self-sufficiency in a supportive environment before leaving foster care.

In order to be eligible, foster youth must be 18-22 years old and enrolled in high school, a GED program, college, a vocational program, working at least 80 hours a month or have a medical condition that prevents participation in these activities. In addition, the youth must demonstrate maturity and the ability to meet the work/educational requirements. Youth must be able to provide documentation of their coursework, pay stubs and proof of employment in order to remain eligible. Eligibility, however, does not indicate that an SIL placement will accept a youth. Determining if a youth is mature enough to participate in extended foster care can often be a subjective process that does not always accommodate youth with troubled backgrounds. If youth have previous juvenile offenses or behavior that concerns the placement provider, the provider has the right to refuse the youth for placement at their facility.

There are only eight sites in Texas offering this service and on average, these programs are only serving 32 youths a month, compared to roughly 600 youth that are in need of this support service. There are currently no sites in Dallas and only one program in Texas, housed on a college campus. As noted above, low college enrollment among foster youth, despite tuition exemption, indicates that monetary support alone is not the primary obstacle for higher education success. Informal panels with foster youth have pointed to a lack of support and structure as a barrier to success, much of which could be provided through an SIL program. By restricting this program to only those with the best educational and behavioral records, many youth find themselves seeking trial independence, which often leads to homelessness.
CONCLUSION

The federal suit against the Texas foster care system has brought our broken foster care system to the forefront of the Legislature and public’s consciousness. The children and youth party to the suit represent only a sample of the large population of children in care who have experienced negative health and educational outcomes, and at times extraordinary secondary abuse and neglect, as a result of being abused/neglected and removed from their families of origin in the first place. Reforms to the foster care system over the past two decades have made strides, but have fallen short of the responsibility of the agency, the Legislature and indeed, all Texans to care for not only our most vulnerable children, but our most fragile, victimized and degraded citizens, mistreated with indifference due to no fault of their own.

For those children who have no alternative other than foster care placement, we must create a safe, supportive and nurturing environment akin to what our non-abused and non-foster children experience. Abused, neglected, abandoned foster children require caregiving and therapeutic services that are trauma-informed across all systems: medical, mental health, child welfare, foster, kinship, adoptive care, law enforcement, legal, faith-based, educational and other systems which together can contribute to the healing of foster children from their original maltreatment, and often, subsequent systemic maltreatment in state care. Rather than a system that repeatedly re-traumatizes our most fragile youth, we must create one that sets them on a promising upward trajectory so that they have the hope of becoming well-adjusted, productive adults who in turn, create the next generation of productive and thriving adults.

As the 85th Legislative Session commences, it is incumbent upon all elected officials and agency leaders to make our wards of the state, children in foster care, our number one priority. The goal of Texas must be to strive for high quality services to families and children involved in the foster care system and set the precedent for the rest of the nation to emulate.
REFERENCES


f Greeson, J., Briggs, E., Kiseil, C., Layne, C. and Ake, G., Complex Trauma and Mental Health in Children and Adolescents in Foster Care: Findings from the National Child Traumatic Stress Network. (2011). Retrieved from: http://search.proquest.com/openview/130e5ecc58ec6e2991e0345cd961a34b/1?pq-origsite=gscholar


3 Substance Abuse and Mental Health Services Administration, Guide for Trauma Interventions; Retrieved from: https://www.samhsa.gov/nctic/trauma-interventions

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APPENDIX A: FLOWCHART OF CURRENT SERVICES FOR YOUTH AGING OUT

14 years old

Preparation for Adult Living (PAL)
- Youth and caseworker form Circle of Support, write up Transition Plan

16 years old

Complete Life Skills Assessment and Life Skills Classes

Additional PAL Services:
- GED Classes
- Driver’s Education
- Help obtaining identification documents
- Preparation for college entrance exams
- Counseling

18 years old

Life Skills Class
- 30 hours, 6 skills topics

Criteria for Extended Foster Care:
All youth in foster care at 18, up to age 21, while:
- In school (high school, college, technical school)*
- Working (80 hours per month)
- In an employment training program
- Or afflicted by a medical condition that prevents the above activities
- *up to age 22, while finishing high school or GED

GROUP OF CARING ADULTS THE YOUTH CHOOSES AS A SUPPORT SYSTEM TO CRAFT TRANSITION PLAN FOR LEAVING FOSTER CARE (CASEWORKER HAS APPROVAL OF LIST).

TRANSITION PLAN
Youth-driven plan addressing safety, well-being, and permanency; strengths, talents, interests, and skills; needs, concerns, and goals regarding education, health and personal relationships, family, community, and caring adult networks, employment and source of income, living arrangements and housing.
Extended Foster Care

DFPS conservatorship ends at 18, but youth can apply for Extended Foster Care. DFPS continues services including monthly payments to foster parents or other substitute care provider so the youth can stay at home after 18. (OR Supervised Independent Living)

Extended Court Jurisdiction

Court jurisdiction continues during Extended Foster Care until the youth’s 21st birthday. Review hearings every 6 months to ensure the youth meets the criteria.

Supervised Independent Living

Available to certain youth who can demonstrate maturity and responsibility. DFPS pays living expenses, but placement is less restrictive than traditional foster care, allowing youth to practice independent living skills.

Can return to Extended Foster Care any time until 21 if criteria are met.

Available to ALL current and former foster youth, whether in EFC or after aging out:

- Medicaid
  Free health insurance until 26.

- Education and Training Voucher
  Up to $5000 per year while in school or employment training program.

- College Tuition Exemption
  No tuition or fees at any state-funded college (university, community college, technical program, high school dual enrollment). Must enroll by 25.

- Higher Education Foster Care Liaison
  Every public college designates a “Foster Care Liaison” to shepherd current and former foster youth and connect them with available resources (tuition waiver, housing options, etc.).

- 21 years old

Aging Out

Youth no longer in conservatorship of DFPS.

Trial Independence

Court jurisdiction continues for 6 months after conservatorship ends at 18 or after Extended Foster Care, up to age 21.

Aftercare Case Management

Case management provided to youth that have aged out of care until the age of 21.

Aftercare Room & Board

Financial help if youth is in need and is working, in school, or looking for work.
Up to $500 per month, for a total of up to $3000.

Medicaid

Free health insurance until 26.

Education and Training Voucher

Up to $5000 per year while in school or employment training program.

College Tuition Exemption

No tuition or fees at any state-funded college (university, community college, technical program, high school dual enrollment). Must enroll by 25.

Higher Education Foster Care Liaison

Every public college designates a “Foster Care Liaison” to shepherd current and former foster youth and connect them with available resources (tuition waiver, housing options, etc.).

21 years old
APPENDIX B SPECIAL MASTER’S RECOMMENDATIONS TO THE FEDERAL COURT

Recommendation #1:
• Require caseworkers’ visits with children include quality time with the child, separate from the caregiver(s) and other children
• Require monthly face-to-face visits with children in Permanent Managing Conservatorship (PMC)

TexProtects Recommendations:
Policy currently requires a caseworker to have a face-to-face visit with the child at least once a month and it be conducted with the child alone and in privacy away from the caregiver. The federal goal is for 90 percent of children in care to be visited monthly with the majority of visits in the child’s residence (https://www.dfps.state.tx.us/handbooks/CPS/Files/CPS_pg_6300.asp#CPS_6311). Court should require the current policy be adhered to immediately. Third-party oversight, monitoring and evaluation are needed for a certain period to ensure compliance with policy and procedures, as well as to identify barriers and remedy them.

Training adequately provides procedures for a monthly face-to-face visit that includes “quality time with the child separate from the caregiver.” This requirement is not being satisfied due to high workloads, lack of supervision and lack of qualified caseworkers. Training is not the barrier.

Reporting needs to include the number of face-to-face visits in a month, not simply that there was one. It is imperative the report include the location of the contact and exclude attempted contacts. Additionally, while federal standards require only one face-to-face contact a month with a child, to ensure a child’s needs are met and a child remains safely in the system, additional contact is essential and would result in better outcomes for highest-needs children.

Recommendation #2:
• Keep orderly case files

TexProtects Recommendations:
Placement paperwork, court documents, service plans, evaluations, assessments and medical records should be integrated in the “Contacts” section of IMPACT, where there is already chronological flow instead of entry into separate tabs in IMPACT or being placed in the physical case file. All paperwork should be scanned electronically into the case file in IMPACT as a replacement for retaining information in a physical case file. Possibly explore hospital case management systems for ideas on how to implement.

Recommendation #3:
• DFPS shall include an updated photograph of each child in their respective case files
TexProtects Recommendations:
Policy currently requires an initial photo followed by annual photo be included in the case file of a child. Barriers include: workloads, lack of supervision, etc. Improved technology providing a streamlining of the process of uploading images to IMPACT and lower supervisor-to-caseworker ratios can ensure proper compliance with already existing policies.

Given that all caseworkers have smartphones, it wouldn’t be too burdensome for them to include a photo in their monthly contacts. IMPACT needs to be updated to allow for a quick way to upload photos into the monthly contact section of a subcare stage.

Recommendation #4:
- DFPS must establish and maintain a 24-hour hotline to which foster children will be allowed access, free of observation

TexProtects Recommendations:
Statewide reporting hotline for children in the system could be the existing hotline, but provide special routing to the Ombudsman.

RCCL should report total number of reports, those screened out – including the reason – and those assigned for INV for each year. The division should also report completed investigations by the allegation type and the number of reports which were Closed at Intake, Ruled Out, UTD, UTC and RTB each year for all investigations, not only those pertaining to PMC children. Fatality reviews for all deaths occurring in foster care, not only those that were determined by RCCL to be related to abuse and neglect, are also needed. Additionally, deferring to DFPS on how the agency will complete their case review formula and reporting requirements does not allow for transparency.

There are concerns on how this will be implemented in a family home. Concerns were raised regarding the repercussions that will occur if a child requests to use the line. Issuing cell phones or designating a neutral and safe place a child can report abuse (e.g. at school) may be more realistic options in ensuring a child is not deterred from reporting and is able to report without retaliation.

Although this is currently in statute and policy, it is not adhered to. Providing clear guidelines and a unique training for foster parents, specifically on all of the incidents that shall be reported, may be helpful. It is unknown if DFPS is most qualified to implement this training as the agency is currently responsible. This recommendation does not explore the reasons for underreporting. Third-party oversight, monitoring and evaluation are needed for a certain period to ensure compliance with policy and procedures, as well as to identify barriers and remedy them.

Recommendation #5:
- DFPS shall improve its program and outreach for children who age out of foster care so that more children take advantage of these programs
• Within six months of a child entering PMC, DFPS must ensure the child’s birth certificate has been secured and placed in the child’s case record

TexProtects Recommendations:
The role of a PAL worker in a child’s life needs to be re-evaluated. If CVS caseloads were truly manageable, the caseworker could and should be the one helping with the child’s permanency planning through their teen years. Right now, PAL’s role varies based on region and the type of case. Some simply involve processing their PAL class paperwork. Also, preparing a foster youth for adult living is best accomplished when the youth has an opportunity to live in a familial setting. We must focus on transitioning youth out of restrictive settings, such as residential treatment centers, and into those that facilitate learning critical life skills that will prepare a youth for adulthood. Programs like multidimensional treatment foster care pair one child with one family and offerwraparound supports in the home and have been successful improving a child’s overall well-being.

See Family Code Sec. 264.121. Transitional Living Services, which includes among many other requirements, access to certified copy of birth certificate, social security card and personal identification certificate on or before 16 years of age. Follow through on the caseworker’s part is required to ensure the certificate is obtained. Barriers may include: lack of manageable workloads for conservatorship workers. Additionally, this could be a component of the eligibility worker’s job duties, since they do the initial processing of the request and any other applications to benefits and Title IV-E funding.

Notifying youth about the benefits available to them is currently in policy at the Department and it is known that simply informing the youth about their benefits has not increased their ability to utilize those benefits. Creating additional flexibility in terms of waivers, so that more youth are able to access educational benefits, is important. The portal for their case records and documents is a great idea, and given the population and technology already in place, this should not take that long to implement.

Recommendation #6:
• All PMC children are entitled to an attorney ad-litem and a CASA volunteer

TexProtects Recommendations:
This initiative will need investment by the state. Texas CASA and local counties are not able to fund the expansion.

Recommendation #7:
• DFPS will implement a HealthCare Plan for PMC children with specific timeframes subject to review and approval of the Court. The following are included in the HealthCare Plan:
  a) Annual medication examinations for children in the PMC class
  b) The establishment of a medical home for all children in the PMC class
c) The provision of necessary follow-up treatment and medical care, including for acute and chronic illnesses

d) The provision of up-to-date immunizations

e) The provision of annual dental examinations for PMC children 3 years and older

f) Establishment of a complete medical record in the child’s case record, which is updated timely and shared with the child’s caregivers at the time of placement and replacement

g) The establishment of Informed Consent protocols for the administration of psychotropic medication by prescribing physician to a PMC child, based upon documented evaluation and diagnosis, and the routine, independent review of psychotropic medications by a qualified physician

**TexProtects Recommendations:**

Many of the provisions outlined in this recommendation are in statute, specifically the health passport, assessments and protocols for mental health assessments. See Family Code Sec. 266.003. Medical Services for Child Abuse and Neglect Victims and Family Code Sec. 266.0042. Statutes already in place regarding medical care for foster children are included here: [http://www.statutes.legis.state.tx.us/Docs/FA/htm/FA.266.htm](http://www.statutes.legis.state.tx.us/Docs/FA/htm/FA.266.htm) (Consent for Psychotropic Medication).

The health passport remains an incomplete and inefficient tool because it is limited to billing codes. The passport needs more detailed information and should be in a readable format for parties, including foster families, to understand and use. Additionally, physicians do not always input data accurately.

This recommendation should be more prescriptive. In addition, the recommendation assumes DFPS is aware and is in agreement that children in foster care not only experience further trauma, but the systems and policies in place actually cause the additional trauma. Deferring to DFPS to devise a plan on how they will identify and address trauma may not be the best method. It may be more productive through third-party evaluation and recommendations. Furthermore, traumatic events should not only be identified but reported and tracked.

**Recommendation #8:**
- DFPS must track primary CVS caseworkers’ caseloads on a child

**Recommendation #9:**
- DFPS must complete a workload study to determine the time required for caseworkers to adequately perform their tasks.

**Recommendation #10:**
- DFPS must hire and maintain enough primary CVS caseworkers to ensure the caseloads are manageable in each county in the State
Recommendation #11:
• DFPS must submit a plan with specific timeframes, subject to Court approval, to ensure that CVS staff who serve children in the PMC class have caseloads between 14 and 17 statewide

TexProtects Recommendations:
It is important to note the math is based on the time study provided by DFPS, but there was not an independent verification to measure what these workers’ workloads truly were (noted in red). Additionally, the time study only measured the caseworker’s time spent on contacts they entered into IMPACT. (e.g. if the caseworker visited a child, she entered that visit into IMPACT and noted that it took 2.5 hours). Many tasks caseworkers complete that are necessary to meeting a child's needs are not documented in IMPACT and tracked per this study. Also, as a side note, we have never heard of a part time conservatorship worker, unless they’re using the FTEs and overtime again to come up with their calculations.

Recommendation #12:
• DFPS must significantly lower its primary CVS caseworker turnover rate

TexProtects Recommendations:
Mentors do not carry reduced caseloads currently. When mentoring rolled out statewide, the goal was for reduced caseloads. Unfortunately, the Department was unable to carry out policy for mentors to have reduced caseloads because 40% of the workforce required a mentor (workforce that is under one year of tenure).

Recommendation #13:
• To reduce the risk of harm to PMC children, DFPS should decrease the significant number of PMC child placements out of children’s home regions and catchment areas
• A review of a Work Study of I See You Workers should be done before determining whether I See You Workers should be maintained

TexProtects Recommendations:
This speaks to addressing a larger issue, of capacity and array. In terms of reporting semi-annually, it seems the report below would be a good place for DFPS to start adding these other metrics we would like reported: https://www.dfps.state.tx.us/PCS/Regional_Statistics/

It's highly recommended, even for the short term, that these I See You positions be moved from the “Program Support” strategy and chain of command into the conservatorship direct service delivery substrategy. The disconnect between I See You and CVS can be linked to where they report. I See You workers should be embedded within CVS units. They are composed mostly of former conservatorship workers, and in order to stay in touch with new policies and best practices, they should report to conservatorship. Lack of supervision and accountability could be addressed if the I See You worker had to submit their monthly contact narratives to an actual Conservatorship supervisor instead of the current method of submitting nothing at all.
Recommendation #14:
• The Special Master shall recommend other provisions deemed necessary to ensure that primary CVS caseworkers are able to protect foster children from an unreasonable risk of harm

Recommendation #15:
• DFPS must complete a workload study to determine the time required for investigators and inspectors to adequately perform their tasks

Recommendation #16:
• To reduce the risk of harm to PMC children, DFPS must identify a discrete cohort of staff and exclusively assign them to the work of maltreatment investigations, except for remote, rural or substantially less populated areas of the State where exclusive assignment is impractical

Recommendation #17:
• PMU will conduct case readings and report results to the Court semi-annually

TexProtects Recommendations:
Consider adding in a requirement for multiple referrals. When there are multiple referrals received in a CPS investigation, it is sent to a secondary case reader (Child Safety Specialist) to review and make recommendations. RCCL needs this same safety net for its frequently reported-upon families.

Recommendation #18:
• DFPS should make public on the agency’s website all of the completed licensing inspections conducted by RCCL and/or its successive entities, redacting child identifying information and other information deemed confidential under law and regulation

Recommendation #19:
• DFPS must require all CPAs report to DFPS, and document all allegations of sexual abuse committed by a child against another child
• DFPS should conduct an individualized needs assessment for every PMC child who has been sexually abused by an adult or another youth to determine their needs

Recommendation #20:
• DPS should propose a plan with specific timeframes, which strengthens its monitoring and oversight of PMC children’s placements using its full array of regulatory and contractual tools
Recommendation #21:
• DFPS shall not allow unrelated children that are more than one service level apart to be placed in the same room in any residential facility

Recommendation #22:
• Unrelated PMC children with different service levels should only be placed in the same room after a thorough and document assessment by DFPS staff that certifies the placement is safe and appropriate for each PMC Child
• DFPS should not allow unrelated children more than three years apart in age to be placed in the same room in any residential facility unless DFPS deems it safe and appropriate after a thorough and documented assessment

Recommendation #23:
• DFPS should provide a plan with specific timeframes documenting how it will track available “single child homes”, and how it will match those placements to PMC children

Recommendation #24:
• DFPS must submit to the Court its 2016 statewide Placement Needs Assessment which DFPS expects to produce by January 2017

Recommendation #25:
• DFPS shall track how many children are in each residential facility, including biological and adopted children, as well as each facility's licensed capacity
• DFPS should publish this information on its website

TexProtects Recommendations:
This could be a report completed monthly in conjunction with the current report published monthly on the DFPS site regarding where children in foster care are placed by county. It would be helpful to do this by county/region to help guide capacity development efforts.
https://www.dfps.state.tx.us/PCS/Regional_Statistics/

Recommendation #26:
• DFPS can continue to pursue Foster Care Redesign, but only if the special master recommends, and the Court agrees that the Redesign meets the statewide needs assessment

Recommendation #27:
• DFPS should submit to the court a Foster Care Redesign plan
• The plan should include DFPS’ analysis of the resources required, main strategies and actions to be taken, key benchmarks, and any known challenges to achieve statewide implementations as DFPS intends
TexProtects Recommendations:
The implementation plan needs to include and consider realistic time frames for roll out. The eight catchment areas proposed in DFPS’s LAR are very different in terms of their resources. There is concern that rollout is not feasible in the time frames allotted. Considerable time for community based assessment must be included in any redesign effort.

Recommendation #28:
• DFPS must report to the Court semi-annually on PMC children’s placement moves

TexProtects Recommendations:
A potential issue with this recommendation is the current system does not differentiate between TMC and PMC children; therefore, DFPS is not able to easily retrieve data on children classified as PMC.

Recommendation #29:
• The Special Master shall recommend if FGHs should continue to operate based on whether FGHs can be improved to the extent that they will not cause an unreasonable risk of harm to foster children

Recommendation #30:
• No more than eight children should reside in a foster group home

Recommendation #31:
• DFPS must verify and certify semi-annually to the Court that all foster group homes have 24-hour awake-night supervision until such time as there are no more foster group homes

TexProtects Recommendations:
The intent of a foster group home should move toward facilitating large sibling groups, not large groups of unrelated children of varying ages. Also, as noted previously, the number of adopted, kin and biological children in the home needs to be tracked by DFPS and CPU (who play a role in making placement decisions for foster children). If the CLASS system is integrated into IMPACT, this would be able to provide a more complete record.