



# The Community-Based Solution for Texas Foster Children

## *Local Control and Community Ownership of Child Welfare Services*

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### Key Points

- The paradoxical takeaway from the *M.D. v. Abbott* decision is that DFPS makes a terrible parent.
- Texas must make fundamental changes to CPS that focus on protecting children in their families when possible or in their communities.
- Texas should fully commit to community-based foster care as the vehicle for CPS reform.
- Texas should transfer the full continuum of child welfare services to regional providers.
- Texas should transfer case management responsibility to regional providers.

In March 2011, Children’s Rights, Inc., a national child advocacy organization, sued the Texas Department of Family and Protective Services (DFPS) on behalf of children in permanent foster care, alleging that Texas policies and practices expose foster children to an unreasonable risk of harm (*M.D. v. Abbott, 12*). In December 2015, the federal court issued a decision against DFPS, concluding Texas children “uniformly leave State custody more damaged than when they entered” (*M.D. v. Abbott, 254*).

The court found that Texas foster children experience an unreasonably high risk of physical abuse, sexual abuse, suicide, and poor supervision in congregate care (*M.D. v. Abbott, 239*). The DFPS agency responsible for ensuring the safety of children in state care and investigating allegations of abuse and neglect against them “simply doesn’t work [and is] broken” (*M.D. v. Abbott, 202*).

By “placing children hundreds of miles from all that is familiar, separating siblings, housing children in facilities that are inappropriate for their needs, leaving children in facilities where they have been abused, and placing sexualized children in the same room as other children without proper oversight,” DFPS subjects foster children to a “substantial risk of serious harm” (*M.D. v. Abbott, 228-229*).

The paradoxical takeaway from the *M.D. v. Abbott* decision is that DFPS makes a terrible parent. Unfortunately for them, DFPS provides care and makes decisions for approximately 30,000 children in its temporary or permanent custody. Ironically, the same findings made by the court in *M.D. v. Abbott*—that children were exposed to un-

reasonable risk of harm by their caregiver—would result in termination of the rights of a parent ([Texas Family Code §161.001\(b\)\(1\)\(D\),\(E\)](#)).

Where a parent cannot be trusted to safely care for a child, the state removes the child and looks for another caregiver. Shouldn’t the same thing happen if the state cannot be trusted to safely care for the children in its care?

At a minimum, with what has been revealed about government-run foster care, the state should reexamine and recommit to efforts that keep children with parents or relatives. Foster care should be a last resort. When needed, communities should take responsibility for that care and the government should yield control to principal community agencies.

Because the state has repeatedly failed Texas foster children, the primary responsibility for service delivery and case management should be transferred from the centralized state agency to private providers in the communities where children live. A community-based system has proven to increase child safety and family reunification and reduce the recurrence of child abuse and neglect (Yampolskaya et al., 100).

### CPS Legacy System and Legacy Thinking

The current Texas child welfare system lacks a coherent mission and a meaningful, organizing practice model that clearly identifies outcomes and measures progress. The practice model formalized by Child Protective Services (CPS) from “a series of unwritten rules” ([CPS](#)) is little more than a

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set of non-specific, aspirational goals. Because CPS lacks a roadmap, opinions vary on how close or far away Texas is from its destination of an effective child welfare system, or whether it is even on the right road.

The various functions related to child protection (i.e., prevention, family services, foster care services, post-adoption services) are scattered across the geography of the state and among state agencies. CPS is a disorganized and disjointed enterprise whereby administration and case management are inefficiently divided between state agencies and agency offices.

Hypothetically, Texas DFPS is divided into 12 semi-autonomous regions. Although DFPS's regional structure could provide flexibility to account for geographic differences in culture and resources, statewide administration prevents regional offices from functioning independently, including by identifying and meeting unique regional needs.

For instance, case management decisions (i.e., placement decisions, treatment decisions, reunification decisions) are supposed to be made regionally. However, the Health and Human Services Commission (HHSC) is responsible for procurement of goods and services on behalf of DFPS, including most of the client services upon which case management decisions rely. Regional staff may only refer to state-contracted services, which may be inferior to others locally available. Also, rather than building local capacity where services are unavailable, families go without and children are shuffled throughout the state.

To forestall federal management and to protect our children, Texas must focus on protecting children in their families when possible or in their communities. In reforming foster care, the state must make fundamental changes to CPS by committing to a model that recognizes the relative limitations and strengths of the state and the community in the temporary care of children and support of families. An initial framework for that model exists in the form of Foster Care Redesign (FCR).

### Foster Care Redesign

FCR began in 2011 with [SB 218](#), which gave DFPS authority to implement the redesign of foster care services in two catchment areas—one rural and one urban. Under the legacy system, approximately 20 percent of foster care services were provided directly by DFPS and 80 percent were provided by various open enrollment contractors (i.e., emergency shelters, residential treatment centers, child placing agencies) ([DFPS 2011, 48](#)).

FCR shifts to single source providers, which are responsible for providing all foster care services within the catchment area they serve. This Single Source Continuum Contractor (SSCC) is the only provider in the catchment, directly contracting with DFPS. The contract between the SSCC and DFPS requires the SSCC to achieve outcomes related to child well-being. Performance-based contracting has proven successful in increasing efficiency, service quality, and innovation ([Martin 2005, 74](#)).

Under FCR, the SSCC is not responsible for case management. The case management responsibility remains with CPS. That is, CPS decides the nature and amount of services to be provided to children in foster care and their parents. The SSCC is contractually responsible for providing the services specified by CPS without input. In this way, FCR separates administration from case management in much the same way as the legacy system it seeks to replace.

### Early Setbacks

DFPS Regions 2 and 9, comprising the 60 counties that form west-central Texas (including Midland/Odessa, Abilene, San Angelo, Wichita Falls, and hundreds of smaller communities), were combined into a single “Region 2/9” rural catchment area. In January 2013, Providence Services Corporation of Texas (Providence) was awarded the FCR contract for Region 2/9. Placements under the contract began in August 2013. A year later, Providence exercised the opt-out provision of its contract and ceased providing services in Region 2/9.

The setbacks in Region 2/9 are less the result of the FCR model than of the SSCC and the catchment area itself. Providence submitted the only qualifying bid for the rural catchment contract ([PCG, 4](#)). Although Providence had served the Austin area as a child placing agency, it was new to Region 2/9 and had few relationships with local foster care agencies or service providers. Additionally, the size of Region 2/9 made it difficult to develop those relationships, build capacity, and provide services across what amounts to more than a quarter of the state's land mass.

In August 2016, DFPS released a new request for proposals (RFP) for an SSCC to replace Providence, shrinking the rural catchment to be served to the 30 counties comprising Region 2.

### Redesign Success and Promise

A sub-region of Region 3 made up of Erath, Hood, Johnson, Tarrant, Palo Pinto, Somervell, and Parker Counties, designated “Region 3b,” was selected as the urban catch-

ment area. In December 2013, ACH Child and Family Services (ACH) was awarded the FCR contract for Region 3b. ACH began accepting children for placement in September 2014.

As of August 2016, ACH was responsible for 1,354 children under the SSCC contract, representing 97 percent of all foster children in Region 3b and 8 percent of foster children statewide ([DFPS 2016, 2](#)). Outcomes for children under the care of ACH are significantly better compared to children in the legacy system outside Region 3b ([DFPS 2016, 6-7](#)).

### **Improved Child Outcomes**

Unlike the legacy system, redesigned foster care is outcome focused. Metrics for success were developed by an advisory group, called the Public-Private Partnership (PPP), made up of representatives of 26 child advocacy organizations. PPP recommended eight quality indicators to serve as the basis of performance-based SSCC contracts. As a result, the following outcome measures serve as the basis for success under FCR:

- “first and foremost, children are safe in their placements
- children are placed in their home communities
- children are appropriately served in the least restrictive environment that supports minimal moves for the child
- connections to family and others important to the child are maintained
- children are placed with siblings
- services respect the child’s culture
- to be fully prepared for successful adulthood, children and youth are provided opportunities, experiences and activities similar to those experienced by their non-foster care peers
- children and youth are provided opportunities to participate in decisions that impact their lives” ([PPP, 2](#))

On each of these indicators, children under redesigned foster care in Region 3b fare better than their counterparts in the state-run legacy system ([DFPS 2016, 6-7](#)). More children entering foster care and currently in foster care live in home-like settings than under the legacy system. Fewer are in congregate care. Over 80 percent of children entering foster care in Region 3b live within 50 miles of their family home, compared to 61.5 percent statewide. Children in foster care in Region 3b are less likely to experience more than two different placements than before FCR.

### **Benefits to CPS Workforce**

FCR has also positively impacted CPS workforce in Region

3b, resulting in a 70 percent decrease in turnover for CPS foster care caseworkers ([DFPS 2016, 7](#)). Changes in staff workload as a result of FCR have led to significant time savings and improved service delivery. At a March 2016 focus group, CPS foster care staff in Region 3b reported the following benefits of FCR:

- more timely documentation
- better quality narratives
- returning calls timely
- spending more quality time with children above and beyond required monthly visits
- better quality relationships with parents and children
- more time to follow up on the extras such as access to extracurricular activities for youth ([DFPS 2016, 7](#))

### **Increased Efficiency**

The anticipated cost savings related to the transfer of resources from CPS to the SSCC and the efficient utilization of those resources by the SSCC served as a primary motivation of FCR. While significant cost savings are anticipated under FCR, many of those savings have yet to materialize due to an incomplete transfer of resources from the state system to the SSCC, resulting in confusion and duplication of the tasks each performs ([PCG, 4-5](#)). Direct cost savings are expected to increase with continued clarification of the relationship between CPS and the SSCC ([PCG, 14,33](#)).

In addition to direct cost savings, FCR leads to significant economic benefits in both redesigned catchment areas and statewide and to a \$3.44 return on investment for every dollar directed to FCR ([Perryman, 12-13](#)).

FCR in its current iteration is additive, introducing a new entity into the foster care milieu while retaining much of the legacy system. To maximize cost savings, a reformed foster care system must be subtractive. At a minimum, the redesigned tasks and related funding must be completely transferred to the SSCC ([PCG, 5](#)).

Even better, the entire continuum of services and the case management function should be transferred to the SSCC and the legacy system should cease to operate as foster care is redesigned throughout the state. The Perryman Group estimates that a transfer of case management into FCR would result in economic benefits to the region and the state over and above those already realized under FCR ([12](#)). The system resulting from a complete transfer would be more child-centered, more community-oriented, and more efficient.

## Community-Based Care

The transfer of the full continuum of child welfare services and of case management responsibilities from the state agency to community-based agencies results in a system located in the communities where children and their families live. This community-based model of practice acknowledges the essential components in healthy child development.

### Developmental Ecology of Children

Children exist in families, which exist in communities. They grow and develop within a developmental ecology comprised of the individual (i.e., biological, genetic characteristics) within progressively more complex, hierarchically nested social systems, ranging from immediate (e.g., home, school, peers) to proximate (e.g., neighborhood, community, mass media) to remote settings (e.g., policy, culture, society) ([Bronfenbrenner 1979a, 3](#)). Child development is indivisible from the concentric social systems surrounding children. To improve child outcomes is to improve community capacity and vice versa.

Positive short- and long-term outcomes for maltreated children hinge on the development of resilience, or good patterns of adaptation in a context of risk (Flynn, Dudding, & Barber, 4). Resilience depends, in large part, on strong relationships in a supportive community network. Factors associated with resilience include strong connections with parents, bonds with other prosocial adults (e.g., mentors, elders, teachers), connections with prosocial and competent peers, and connections to prosocial community organizations (e.g., sports teams, clubs, religious groups) (Flynn, Dudding, & Barber, 7). Fundamental adaptive systems such as family, cultural and religious systems, and community safety and service systems organically produce the factors related to resilience (Flynn, Dudding, & Barber, 7).

The parent-child relationship is the first and most enduring developmental context. “The family is the most powerful, the most humane and, by far, the most economical system known for making and keeping human beings human” (Bronfenbrenner 2005, 262). At the same time, other close relationships with family, teachers, coaches, mentors, and friends significantly affect a child’s development.

The developmental potential of a childrearing setting increases with the number of supportive links between that setting and other contexts involving the child or persons responsible for his or her care (Bronfenbrenner 1979b, 848). For too long our system has operated under the mistaken belief that it could address the best interests

of children without addressing the interests and needs of their parents and their families in the communities where they live.

### Community Engagement

One artifact of the centralization of child welfare services has been the crowding out and detachment of community involvement with vulnerable children and fragile families ([Daro & Dodge, 73](#)). Shifting to single-source contractors dispersed among communities does not necessarily restore the civic commitment to children in foster care and their parents. Rather, the engagement of communities should be intentional ([Flaherty et al., 815-16](#)).

Community child welfare services currently lack coordination. Programs exist in silos, which prevents a comprehensive understanding of community need and capacity, and planning to link the two. Community stakeholder groups are necessary to provide a focal point for community interest and capacity building ([Daro & Dodge, 73](#)). Community partnerships have been implemented successfully to:

- Prevent child maltreatment and reduce its recurrence.
- Offer a network of support and a range of services for families in which maltreatment has occurred or is at risk of occurring.
- Provide individualized responses tailored to a family’s strengths and needs.
- Encourage shared responsibility for ensuring safety, permanency, and well-being ([HHS 2010, 7](#)).

In the current system, barriers to participation hinder community members and groups from providing meaningful support to biological and foster parents and children in the system ([Brown, 12](#)). For example, those willing to babysit, take children on an outing, or keep them overnight must be vetted by the state, which significantly limits the options of full-time caregivers. Engaged stakeholders and community supports enhance permanency for children by filling gaps in care and service delivery ([Crampton et al., 74-75](#)).

Community-based care requires diverse opportunities for community members to support children who need safety and stability. For example, the Safe Families Program allows families to care for children on a temporary basis and provide support and mentorship to natural parents, without the formalities and legal proceedings of paid foster care ([Brown, 5-6; Eckholm](#)).



### ***Community-Based Decision Making***

Under the legacy system, almost 40 percent of foster children are placed more than 50 miles from home ([DFPS 2016, 6](#)). When children are removed from their communities, they lose contact with friends, teachers, and extended family. Any protective or supportive relationships that existed are strained or broken. Regular visitation with parents often depends on the convenience or capriciousness of CPS, making family reunification less likely and problem behaviors more likely ([McWey & Mullis, 297](#)).

Protecting and strengthening relational networks for at-risk children and fragile families requires community-level decision making and sufficient flexibility to meet unique local needs. FCR contracts currently demand results from community providers that depend on decisions over which they have no control. For example, where an SSCC identifies a service need threatening placement stability (e.g., behavioral health services, education services, transportation), the SSCC cannot provide the service without authorization from the CPS caseworker, who may have to obtain approval from one or more bosses. This system essentially removes case management decisions from those with the most information about foster children and their circumstances and gives them to those who know the least.

The transition to community-based care in Texas requires transferring family preservation services, post-adoption services, and services for youth aging out of care to the SSCC and fully transferring case management responsibilities to the SSCC.

### ***The Transfer of Case Management Back to Communities***

“Until well into the 20th century, mutual aid and faith-based charities provided child protection, institutional placements, and foster homes” ([HHS 2008, 3](#)). Governments gave grants or subsidies, but these programs were provided by community agencies ([HHS 2008, 3](#)). States gained more control over child protection services with increasing federal funding, which tied dollars to mandates ([HHS 2008, 3](#)). To ensure federal compliance, states gradually became more involved in foster care between the 1930s and 1970s, to the extent that states became exclusively responsible for the care of foster children. Reversal of this trend began in the 1990s through the use of community contractors to provide services in the state system and continued with early efforts in Florida and Kansas to return foster care management to communities ([HHS 2008, 3](#)).

Definitions of case management vary across the country together with the extent those functions are performed by government or community agencies. Some states allow for limited case management by community agencies in the form of day-to-day decisions about services and coordination, with case planning conducted by government caseworkers ([HHS 2008, 3](#)). This dual approach results in overlapping responsibilities, can be costly and duplicative, and requires extensive coordination and legislative oversight ([HHS 2008, 4](#); [PCG, 12](#)).

Other states, like Florida, grant lead community agencies primary responsibility for case planning including decisions about placement levels and visitation, with oversight by courts and the state ([HHS 2008, 3](#)). This paper argues for transfer to community-based agencies in Texas based on this latter definition of case management.

### ***The Florida Example***

Two decades ago, Florida child welfare services were in the same state of danger and disarray in which Texas currently finds itself—foster homes and shelters filled to capacity, children sleeping in agency offices, skyrocketing caseloads, and children at risk from the system designed to protect them (Ingram, 7). In 1997, Florida committed to a painful full-thickness debridement of its child welfare system that, once fully implemented, would prioritize services around children and families, create accountability, increase transparency, and produce more budget predictability (Ingram, 7).

Florida began by piloting the community-based care model in four local communities. The pilots were used to test and increase community support, capacity, and accountability. Despite setbacks in some piloted areas, Florida went forward with reform by requiring the transfer of all child welfare services to a single community-based provider in each of 20 geographic areas between January 2000 and December 2002. However, it took until 2005 before the state had contracted with lead agencies in all areas and fully transferred child welfare services to communities.

Florida continues to utilize statewide agency investigators and local sheriffs to investigate child abuse and neglect. However, once a child enters the system, the lead community agency is responsible for providing, procuring, coordinating, integrating, and managing all child welfare and foster care services.

Rather than tying funding to the number of children served, length of time in care, or number of services

provided, which creates perverse financial incentives at odds with children's interests, Florida allocates a specified share of the state's child welfare budget to each lead agency, which they may carry forward if unused. Each lead agency is responsible for producing measurable results toward the following goals:

- "Children are first and foremost protected from abuse and neglect
- Children are safely maintained in their homes, if possible and appropriate
- Services are provided to protect children and prevent their removal from their home
- Children have permanency and stability in their living arrangements
- Family relationships and connections are preserved for children
- Families have enhanced capacity to provide for their children's needs
- Children receive appropriate services to meet their educational needs
- Children receive services to meet their physical and mental health needs
- Children develop the capacity for independent living and competence as an adult" ([Florida Statutes](#))

The combination of capped funding and results-based contracting makes local lead agencies risk-bearing entities. However, because lead agencies have no control over the number of children coming into care, the state maintains a risk pool in the event of an unpredictable spike in removals in an area.

Over the last 10 years, Florida has become a model system for the care and protection of maltreated children (Ingram 23). More children have been adopted into permanent homes with less waiting (Ingram 10-12). Children are being reunified with their families more often and in less time, with less recurrence of maltreatment (Ingram 12-13). Foster family and caseworker morale are higher, improving recruitment and resulting in less turnover and burnout (Ingram 17-18).

The flexible funding mechanism utilized in Florida's community-based model has provided local communities the opportunity to employ innovative programs that reduce the utilization of and length of time children spend in out-of-home care ([Armstrong et al., 1717](#)). Those programs have proven successful. Unlike many other states during the same period, Florida experienced a substantial reduction in the number of children living in and coming into out-of-home

placements ([Armstrong et al., 1716](#)). In 2005, the state experienced a 27 percent reduction in the number of children coming into care and a 31 percent reduction in the number of children in state custody ([Armstrong et al., 1714](#)).

Although outcomes have dramatically improved, total state spending has remained flat (Ingram, 19). Rather, spending has shifted, with the state spending more on in-home services to prevent removal and less on out of home foster care (Ingram, 20).

In 2012, Florida's child welfare system ranked fourth in the nation, while Texas ranked thirty-second (Bragdon, 9).

## Recommendations

Community-based foster care can work in Texas. It will take time and there will be setbacks in decentralizing the behemoth state child welfare agency. However, over the past decade, outcomes for children in Florida foster care have slowly improved while Texas has subjected its foster children to unreasonable risk and been sued for it. The nation is paying attention to how Texas responds to this challenge, as a federal judge stands poised to place Texas CPS under federal oversight.

### *Texas should fully commit to community-based foster care as the vehicle for CPS reform*

A redesigned foster care system is demonstrating results in Region 3b and promises a solution to Texas' daunting child welfare dilemmas. Texas should fully commit to this community-based model as the path forward. Child welfare services have been in a near constant state of reorganization and reform for a decade. Communities will hesitate to build the necessary capacity to address local child welfare needs without clear signals that Texas is committed to the future of community-based foster care.

### *Texas should transfer the full continuum of child welfare services to community-based providers*

Although the investigation of child abuse and neglect and protection of children from immediate harm should remain a function of government, community-based providers should provide and coordinate all other child welfare services. Those services include adoptive services, independent living programs, shelter care, residential group care, foster care, therapeutic foster care, intensive residential treatment, post placement supervision, permanent foster care, family reunification, and family preservation.

Furthermore, Texas should decentralize and transfer services for prevention and early intervention of child abuse

and neglect back to the community. Factors precipitating the need for child welfare services vary across the state. So do the unique ways in which communities can address those factors. Efforts to prevent child abuse and neglect, to decrease risk, and to increase protective factors should be coordinated by community-based contractors and provided in communities.

***Texas should support community efforts to build capacity and coordinate services***

The state should provide a basic infrastructure for community engagement and, then, get out of the way. The shift to community-based foster care must include autonomous stakeholder groups to connect need with capacity in unique and innovative ways. Such groups serve as a focal

point for community responsibility and an important local check on the state agency and its vendors. At the same time, state efforts to dictate to or micromanage these community groups will undermine their effectiveness.

***Texas should transfer case management authority to the community-based providers***

Case management should transfer along with the responsibility to provide services. Principal community providers must be able to deliver quality and efficiently allocate resources by making case planning determinations necessary to meet goals for children and families in their catchment. Next to parents, community-based providers possess the best information with which to inform significant decisions, including safety and permanency. ★

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