WHAT WORKS IN CHILD WELFARE REFORM:

REDUCING RELIANCE ON CONGREGATE CARE IN TENNESSEE
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EXECUTIVE SUMMARY
When Children's Rights launched a massive campaign in 2000 to reform the child welfare system in Tennessee, one of the campaign's primary targets was the state's heavy reliance on group homes and institutions in caring for and treating the thousands of abused and neglected children in state foster care. At the time, the Tennessee Department of Children's Services (DCS) was placing children in group settings at an extremely high rate. Many children remained in emergency shelters and other “temporary” placements for six months or more. And the state’s inability to recruit and retain a sufficient number of foster families left few obvious avenues for getting children out of congregate foster care and into family homes.

Today, the story is dramatically different. The reform effort spurred by the class action lawsuit Children's Rights brought on behalf of Tennessee’s foster youth has produced dramatic declines in the number of children placed in shelters, group homes, and institutions. And while, over the years, many factors have undoubtedly contributed to improved outcomes with respect to safety, permanency, and well-being among children in Tennessee foster care, many observers familiar with the state’s child welfare system report that Tennessee’s reduced reliance on congregate care has played an especially important role in bringing about these improvements.

In this report, we go behind the scenes to explore the factors that enabled Tennessee to make and sustain this critical systemic change, the lessons that can be learned from the experiences of those who carried out the reforms, and how similar progress can be made by other child welfare systems struggling with similar challenges.

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Background

Federal law and best practices both dictate that children in foster care be placed in the least restrictive, most family-like environments available and capable of meeting their needs. For most children, foster families are the most appropriate placements, providing individualized attention in a normalized family setting and increasing children’s likelihood of achieving permanency—exiting state custody to reunification, adoption, or legal guardianship.¹

For children with special medical, developmental, or mental health needs, placing children in the least restrictive environment means that caseworkers must make every effort to provide the treatment services that children require while sustaining them in normalized family settings. Treatment foster care—in which specially trained foster parents provide active and structured treatment in the context of a family setting²—has emerged in recent years as an appropriate placement for such children. Compared to traditional foster parents, treatment foster parents have been found to display more appropriate parenting behaviors toward such demanding children, including better monitoring, consistent discipline, and the use of appropriate positive reinforcement.³

Sometimes, however, a child needs more intensive treatment or supervision than even a treatment foster home can provide. Under such circumstances, it may be necessary to place him or her in a congregate care setting—a non-family placement where a large number of children receive specialized care and/or treatment. Congregate care facilities include diagnostic and assessment centers, group homes, and residential treatment centers. Emergency shelters are also considered a form of congregate care, but they do not provide any therapeutic services and are normally used when no other placement can be found.

Because some children in foster care express difficult behaviors due to extreme physical and mental trauma resulting from abuse or neglect, congregate care is a necessary and important part of the foster care continuum. When used appropriately, it can provide the level of service that high-need children require. But contemporary social work philosophy holds that congregate care should never be considered a long-term placement for any child; rather, it should be used to deliver critical, time-limited therapeutic services while caseworkers plan for the child’s reintegration into a family setting as soon as possible. The philosophy also holds that no child should be placed in a congregate facility that does not provide therapeutic services or enhanced supervision; ‘general’ institutions, like the orphanages of the past, have no place within the modern continuum of child welfare placements.

Additionally, social science research has documented that in many circumstances, children placed in foster homes have better outcomes than children placed in group settings, and it is widely known that institutional care is far more expensive than family foster care, with one study estimating that congregate care can cost public child welfare systems between two and 10 times as much as family-based placements.

Despite these factors that should push child welfare systems away from congregate care use, approximately 16 percent of the 423,773 children in out-of-home care in the United States—more than 65,000 children—are currently placed in group settings. Too often, these children end up in group facilities when their needs can be met in less restrictive family environments. For example, although congregate care is normally viewed as inappropriate, if not harmful, for young children, in 2009, 10 states placed between 12 and 20 percent of newly entering foster children age 12 and younger in group settings. Some children are placed in congregate care because of flawed assessment processes that inaccurately evaluate their treatment needs; others find themselves in group care simply because there are no foster homes available or willing to take them in.

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5 Janchill, op. cit.: 1.
9 Janchill, op. cit.: 1.
Given this climate, there is a compelling need for public child welfare agencies to monitor their use of congregate care closely. Many states have gone to great lengths in recent years to align the use of these facilities with the needs of the children they serve.\textsuperscript{11} Tennessee is one of them.

**Brian A. v. Sundquist**

Children's Rights filed the class action lawsuit known as *Brian A. v. Sundquist* (today, *Brian A. v. Haslam*) in May 2000. The suit alleged that, among other flaws, DCS's routine placement of children in congregate care settings was contrary to the children's best interests, causing them serious harm. Children's Rights asserted that DCS suffered from an egregious lack of foster homes, too often placed children in overcrowded shelters, failed to provide children in congregate care with an appropriate education, and failed to keep children in group care facilities safe. Further, the suit alleged that by inappropriately placing children in congregate care facilities—and especially keeping children too long in emergency shelters and other temporary facilities—the Department slowed children's progress toward permanency.

In July 2001, the parties arrived at a settlement agreement enforceable by a federal court. The agreement required DCS to undertake widespread reforms, including a number of initiatives aimed specifically at limiting congregate care use.\textsuperscript{12} Since then, the Department has been extremely successful in meeting these placement-related goals. In 2000, 28 percent of children entering foster care were placed directly into congregate care settings. By 2003, that figure had dropped to 13 percent, and it has remained around that level or lower ever since. Point-in-time calculations show a similar trend. On January 1, 2001, 22 percent of Tennessee's foster children were placed in group settings. On January 1, 2009, only 9 percent were living in congregate care.

**Purpose of the case study**

This project goes beyond quantitative trends in the use of congregate care to take a close look at the policies, practices, and organizational structures that enabled DCS to accomplish this sweeping systemic reform. Our goal was to produce a case study of one state's reform process so that other jurisdictions facing similar challenges could learn from Tennessee's success and apply those lessons to their own efforts at deinstitutionalization.

To accomplish this, we conducted and analyzed in-depth interviews with 51 Tennessee child welfare stakeholders, including current and former DCS administrators, private service providers, advocates, legislators, and former foster youth. We also used available quantitative data to provide context for and an understanding of the themes that emerged.

The study addressed two main questions:

1. How, since the 2000 filing of the *Brian A.* lawsuit, did DCS reduce its use of congregate care?

2. How has this change affected the safety, permanency, and well-being of children and youth in foster care?


\textsuperscript{12} In addition to highlighting DCS's overuse of congregate care, the *Brian A.* settlement agreement required the Department to make numerous other reforms and meet service and outcome benchmarks related to: the structure of the agency; processes for reporting child abuse and neglect; regional services; staff qualifications, training, caseloads, and supervision; case planning for children; freeing children for adoption; statewide data collection systems; quality assurance procedures; and financial development.
MAJOR FINDINGS

Factors that enabled deinstitutionalization

1. Mandates of the *Brian A.* lawsuit

In Tennessee, the *Brian A.* class action litigation acted as a catalyst for reform. It took Children’s Rights’ lawsuit targeting DCS’s egregious misuse of congregate care, and the force of a federal court order, to hold the Department accountable for its overuse of group facilities.

Some provisions of the consent decree that settled the lawsuit required DCS to develop new organizational structures, such as a foster home recruitment and retention plan and a system for reviewing the cases of children placed in group care for extended periods of time. The settlement agreement also mandated improvements to various elements of service delivery: for example, it required the state to limit children’s stays in emergency shelters to 30 days and to secure administrative approval before placing a child in congregate care, and it prohibited the placement of dependent/neglected children in correctional or detention facilities.

The Department drew on technical assistance and consultation from a variety of sources to meet these expectations. Periodic monitoring by the *Brian A.* Technical Assistance Committee and Children’s Rights staff ensured that DCS made timely progress.

2. Closing of the Tennessee Preparatory School

When Children’s Rights filed *Brian A.*, there were approximately 300 foster youth placed at the Tennessee Preparatory School (TPS), a large, public, residential school that had been serving children in state custody for over a century. Most residents were teenagers who had neither a history of delinquency nor major mental health problems. Early in the reform process, the Department realized that if it was going to call for a system-wide reduction of congregate care—a move that would not only force limitations on DCS-run institutions but also require the state’s contracted private service providers to reduce their reliance on group care—it would have to lead by example and close its largest facility.

The Department encountered intense opposition to the closure from family court judges, legislators, and TPS alumni. However, through intensive, child-by-child casework and focused recruitment of foster families, the Department, with the help of the youth who resided at the facility, identified family-based placements for almost all of the TPS residents over a period of four months. Many of the youth went home safely to their parents. For those who could not return home, many youth helped to identify family members, friends, and others willing to take them in.

3. New leadership

Between 2001 and 2003, DCS had three different child welfare commissioners, none of whom had experience running a state child welfare agency for abused and neglected children. By the end of 2003—more than two years after the settlement agreement was put into place—DCS was still out of compliance with the majority of the court-ordered reforms. Spurred by a contempt motion, and driven by a desire to implement new approaches and actions that would lead to the needed improvements, Governor Phil Bredesen appointed Dr. Viola Miller as DCS Commissioner.
Miller, who had previously served as Secretary of the Kentucky Cabinet for Families and Children, was both highly knowledgeable of appropriate child welfare practice and a skilled manager. She was deeply committed to placing children with families whenever possible and expediting permanency for children in care, and she implemented a number of administrative reforms designed to realize these objectives. She had a hands-on management style and personally monitored the use of congregate care placements throughout the state. She held DCS and provider staff accountable for placing children in family settings and strongly resisted opposition from those who clung to the system's long-held reliance on congregate care. Through her unwavering commitment to deinstitutionalization and principled leadership, she sparked a true culture change within the Department.

4. Foster home development for targeted populations

To move children out of congregate care successfully and prevent children from unnecessarily entering congregate care, DCS needed to ensure that it had a sufficient number of foster parents who were equipped and willing to care for many children who had unique or high-level needs. In particular, the Department had to focus on recruiting homes for children with special needs and teenagers, as both of these populations were overrepresented in group facilities. One popular solution for high-need children was providers’ enhanced use of treatment foster homes. For teens, both DCS and providers engaged in targeted recruitment efforts aimed at debunking stereotypes about adolescents in care and highlighting their need for families. Toward both of these ends, DCS and providers reported that existing foster parents were the best recruiters of new foster homes. They also noted that intensive foster-parent training and casework staff support of foster parents was essential if high-need children were to stabilize in family settings.

5. Changes in infrastructure and frontline practice

Numerous reforms to DCS policies, practices, and infrastructure contributed to the Department’s decreased use of group care.

Development of a practice model. The Department devoted considerable resources to the creation of its Practice Model, a foundational document that aligned casework practices with DCS’s newly articulated core principles. This extensive manual enumerated DCS’s standards for all aspects of work in child welfare and the rationale for each. Standards pertaining to the use of congregate care included commitments to “ensure that all children in the custody of the Department are placed in the least restrictive, most family-like settings appropriate to their strengths and needs,” “make diligent efforts to place children with families that can, reasonably, be expected to provide permanent homes if necessary,” and “ensure that all nondestructive ties to family and community will be preserved and nurtured while a child is in foster care.” Each of these standards was accompanied by a detailed commentary that discussed how it was to be implemented.

Identifying least restrictive placements. The Department made a number of changes aimed at ensuring that children were placed in the least restrictive environments suitable for meeting their needs. It implemented a system-wide, validated child assessment tool—the Child and Adolescent Needs and Services (CANS)—and trained workers and supervisors to incorporate it into practice. The CANS fit well with “strength-based, culturally responsive, family-focused casework,” assessing such things as children's safety, mental health, and social and developmental functioning, as well as


\[14\] Ibid., pp. 97-98, 100.

Caregivers’ strengths and needs. The CANS suggests the intensity of service a child needs but does not recommend a specific type of placement setting for the child, leaving it to caseworkers to meet the indicated level of care in the most appropriate, least restrictive setting.

The Department also instituted Child and Family Team Meetings, a case planning model that brings all individuals associated with a child together to evaluate a family’s needs and strengths and to determine how best to move the child toward permanency. Incorporating more people central to the child’s life—particularly biological parents and other family members—led to the development of more family-based placement options for children in care.

In addition to these tools, the Department created several new units and collaborative forums for maximizing regional knowledge about placement options for children. Regional Placement Units were tasked with becoming experts on which foster parents in the region were willing and equipped to care for children with certain needs and which regional providers offered various specialized services. Well-Being Units—staffed with specialists in social work practice, education, health, and other disciplines—were installed at the regional level to provide consultation to caseworkers and supervisors on specific child issues. Cross-Functional Teams and Community Action Boards provided forums for DCS staff, providers, and leaders of other community-based programs to work together to ensure that regions had the full array of placements types and services that children in foster care needed.

Limiting entries into and lengths of stay in congregate care. To ensure that children entered congregate care settings only when their needs indicated that a more intensive and restricted placement setting was necessary, DCS instituted a policy fulfilling the consent decree requirement that casework staff receive approval from a Regional Administrator before placing a child in any facility containing eight or more beds. In addition to this gatekeeping procedure, the Department instituted a rigorous Utilization Review, a process through which upper-level Regional and Central Office administrators could monitor cases to ensure that case planning and service delivery were moving children toward permanency. Although all children’s cases are subject to Utilization Review, stakeholders noted that the process has been particularly useful when children are placed in group care, because it enables administrators to ask tough questions about whether DCS and provider staff are doing all they can to move children out of congregate care and into family settings as quickly as possible.

Building a supportive infrastructure. Prior to Brian A., DCS had an inadequate statewide electronic data archive. Child welfare officials struggled to obtain an accurate accounting of where children were living on any given day, much less any nuanced information about their placement types or placement histories. The development of an enhanced information system allowed for this, and has since been used to provide targeted placement guidance at the regional level. With the capacity to see where and with what frequency regions were using congregate care, DCS administrators focused on regions with high levels of use and provided technical assistance and oversight to reduce dependence on group placements.

DCS also bolstered its staff training. It partnered with universities in the state to develop and administer new pre-service and in-service training for DCS employees that focused on the dangers of institutionalization, barriers to permanency associated with placement in congregate care, and the importance of placing children in family settings. DCS also worked with universities to refine the curricula of their human services degree programs according to the family-centered, strengths-based principles promoted by the Department. The state also began to draw down federal funds to provide a tuition reimbursement program for students willing to commit to DCS employment after graduation.

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6. Changing relationships with private providers: the Continuum model and performance-based contracting

Throughout its history, DCS has contracted with private agencies to provide placement and treatment services for high-need children in foster care. These providers, many of which were established when orphanages were an accepted model of caring for children, had a longstanding tradition of relying on congregate care. To encourage the development of alternative child-caring arrangements, the Department created financial incentives for providers to cut back their use of group facilities.

DCS used two main contracting tools to provide these incentives. The first was the Continuum model, which was initiated prior to Brian A. and refined and strengthened over the last decade. Under this model, DCS pays providers based on the level of service that a child needs, and only for the days that the child is in the care of that provider. The model also requires providers with residential contracts to maintain an array of services (e.g., residential treatment facility, group home, therapeutic foster care, and in-home services), rather than just residential care. Because providers are paid the same rate no matter where they choose to place a child, and because congregate care is so much more expensive than serving a child with ancillary services in a foster home, providers can save money under the Continuum model by placing children with families. Those savings can then be reinvested into the types of programs—for example, therapeutic foster care and wraparound services—necessary for sustaining children in foster homes.

The Department also implemented performance-based contracting, which further motivated private agencies to place children with families. DCS's performance-based contract rewards providers financially for achieving three goals: reducing the number of days children spend in foster care (thereby expediting permanency and saving the state money), increasing permanent exits from care, and reducing reentries into care. Baseline performance on these outcomes is calculated for each agency at the start of the contract; if a provider improves its performance over its baseline, DCS returns a percentage of the savings to the agency. However, if the provider’s performance worsens, it must pay DCS a portion of the overage. Thus, because it is much easier to get a child to permanency if he or she is placed with a family, avoiding the use of group care became one strategy for achieving the Department’s performance goals.

Impact of deinstitutionalization on outcomes for children in foster care

This study was designed to elicit stakeholders’ perspectives on the extent to which decreased group care use has improved safety, permanency, and well-being for children in foster care. By and large, stakeholders felt that DCS’s reduction in the use of congregate care had a positive effect on these outcomes. They talked about the risks associated with group care placement, and said that these risks were reduced as group care placements declined.

Further, data reported by the Brian A. court monitor and other quality assurance procedures suggest that during the period DCS was reducing its use of group care, a number of indicators of safety, permanency, and well-being for children in care were also improving.

However, because numerous factors undoubtedly influence outcomes for children in foster care—including the quality of the placement and the services received from the supervising agency, provision of appropriate ancillary services, and performance of the court—it is not possible to attribute improved outcomes for children solely to reductions in DCS’s use of congregate care. Because this study did not

17 See Chapter 4 and Appendix E for details on the establishment of baseline performance and the assessment of rewards and penalties under DCS’s performance-based contract.
collect quantitative data on safety, permanency, and well-being, and was not designed to support causal statements regarding the direct impact of group care use on these outcomes, conclusions regarding the relationship between the reduction in group care and child outcomes must be drawn very cautiously.

**Safety.** A number of interviewees attributed improvements in children's safety to deinstitutionalization because it is generally easier to keep children safe in foster homes than it is to keep them safe in congregate care. In particular, they noted that conflicts tend to escalate when many teens, especially those with mental health or emotional issues, are placed together in highly structured environments. Former foster youth with whom we spoke recalled serious threats to their safety when they lived in congregate care settings, describing aggressive and abusive staff, and drug use on the part of residents.

Two ancillary quantitative data sources suggest that as DCS reduced its use of congregate care, measures of children's safety while in foster care improved concurrently. Tennessee's federally reported rate of maltreatment in foster care has been decreasing since 2005—and, in fact, the rate in 2009 was half of what it was four years prior. Additionally, data from the state’s Quality Service Reviews (QSR)\(^{18}\) indicate that since the 2005-2006 evaluation year, the percentage of children whose cases were rated adequate for safety has increased from 91 to 98.

**Permanency.** Many respondents noted that as group care use has decreased, opportunities for permanency have increased. They called attention to the degree to which group placements hinder reunification, highlighting that the often great distance between facilities and children's homes makes parent-child visitation—an essential component of successful reunification\(^{19}\)—very difficult. Additionally, they noted that parents of children in foster homes are more likely to be involved in the care and treatment of their children than those whose children are placed in group care, allowing for a smoother transition from foster care to home.

Respondents also said group care placement decreases the likelihood of adoption. Most children adopted from foster care are adopted by their foster parents;\(^{20}\) because children in group care do not normally have foster parents, such adoptions are impossible. And because congregate care living often isolates children from the community, group placements make it difficult for children to develop relationships with other people who might become adoptive parents, including coaches and church members.

Quantitative data collected for the purposes of monitoring DCS's compliance with the **Brian A.** settlement agreement suggest positive changes in permanency trends during the time period under study. For example, the **Brian A.** Technical Assistance Committee’s (TAC) most recent monitoring report provides entry cohort data showing that since FY 03/04, the proportion of children exiting to permanency within six months and within two years of entering foster care has increased modestly.\(^{21}\) Further, point-in-time data on children's length of stay in foster care show that for all children in care in May 2004,

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\(^{18}\) A Quality Service Review (QSR) is a process that analyzes the cases of a sample of children in state custody and/or children with open preventive cases in order to determine the quality of a state's child welfare services. Samples are normally collected randomly and are intended to be representative of the state's custody/preventive services population. Reviews include the analysis of case records as well as qualitative interviews with stakeholders in each child’s case (e.g., family members, child welfare staff, service providers, educators, attorneys, etc.). For information on Tennessee's Quality Service Review process, see State of Tennessee. (no date). Children’s Program Outcome Review Team. Retrieved December 13, 2010, from http://www.state.tn.us/tccy/cport.shtml

\(^{19}\) Numerous researchers have arrived at this conclusion. For the earliest study of this issue, see Fanshel, D., & Shinn, E. B. (1975). Children in foster care: A longitudinal investigation. New York: Columbia University Press.

\(^{20}\) United States Department of Health and Human Services, op. cit., op. cit.: B.

the mean length of stay was 22.3 months (median = 12.5 months), and that by July 2010, the mean length of stay had dropped to 14 months (median = 9.3 months)—a significant change.²², ²³

**Well-being.** Finally, interviewees expressed a belief that decreasing the use of residential facilities and placing children in family settings removes a number of risks to well-being associated with group care. They highlighted the fact that living in congregate care limits children’s ability to develop lasting relationships with adults, and that the intense structure of group settings hinders normal adolescent development. Interviewees also observed that facility-based schools do not provide children with a normal school environment when school is often the only stabilizing factor for a child experiencing the tumult of foster care. And the former foster youth we interviewed recalled threats to their health and physical well-being during their stays in group care.

A minority of interviewees did not agree that the reduction in the use of group care has been good for children and youth in Tennessee foster care. They focused on the needs of adolescents in care and suggested that, particularly for those who are “burnt out” after years in foster care, being integrated into new families is not what some older youth want or need. These individuals felt that rather than “force” older youth into homes, DCS should use group care as settings in which youth can focus on independent living skills and prepare for adulthood. These respondents felt that congregate care had an important role to play in the child welfare service array, and expressed regret that so many facilities have been closed over the years.

Quantitative QSR data suggest that during the period of time that DCS was reducing its use of congregate care, some indicators of child well-being—particularly those pertaining to education—were also improving. For example, since the 2005-2006 QSR evaluation, the percentage of children’s cases rated adequate for ‘Learning and Development’ has improved from 67 to 81. The data also show a small increase in the proportion of cases rated adequate for ‘Health/Physical Well-Being’ and a very recent increase in the proportion of cases rated adequate for ‘Emotional/Behavioral Well-Being.’

**LESSONS LEARNED**

While there are still areas that need improvement in Tennessee’s child welfare system, DCS’s process of deinstitutionalization exemplifies how policy, practice, and infrastructure reform, brought about by a class action lawsuit, can lead to large-scale improvements in a public child welfare system. Whether a jurisdiction wishes to reduce its own use of congregate care or faces some other pressing need for systemic reform, Tennessee’s experience offers valuable lessons in how to bring about change.

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²² Point-in-time data overestimate the experiences of those who have been in foster care for a long time. Therefore, one could suggest that the decrease in length of stay referenced here (see Figure 6.4 in the main report) is the result of increasing numbers of long-staying youth aging out of the system. However, statistical analyses available from the author show that this is not the case; DCS’s exit rates to non-permanent settings (including emancipation) remained relatively flat during this time period.

²³ This difference in mean length of stay is statistically significant at p < .001.
1. Class action litigation can bring about systemic reform. Collaboration between plaintiffs and state agency defendants helps to create change.

Children’s Rights’ class action litigation acted as a catalyst for reform. Prior to Brian A., DCS, private providers, and judges alike accepted the degree to which they placed children in congregate care settings, and no incentive existed to shift away from the status quo. As many stakeholders noted, without the lawsuit, DCS would not have acted on its own to address its overuse and misuse of congregate care.

2. External consultants can provide valuable assistance in creating systemic reform.

Over the course of its reform process, DCS engaged a number of consultants who provided specific expertise and outside perspectives on how the Department could reduce its reliance on congregate care. For example, DCS contracted researchers at the Chapin Hall Center for Children to develop its performance-based contracting program and to assist with data management and analysis. The Department also brought in consultants to evaluate the placement appropriateness of children in residential sex offender programs, and a private service provider hired consultants to help revamp its staff and foster parent training curricula.

3. In undertaking systemic reform, the state child welfare agency should thoughtfully redefine its interagency partnerships, when necessary.

DCS’s move away from congregate care challenged longstanding practice in Tennessee’s child welfare system. For decades, the Department, its contracted service providers, and the state legislature and judiciary had all coalesced around congregate care as an acceptable and desirable way to care for children in state custody. As a result, the relationships among these parties took for granted the expectation that congregate care would continue to play a key role in the system. DCS’s decision to reduce its use of group care turned that expectation on its head and required the Department to redefine and renegotiate its interagency relationships. In particular, DCS had to establish a new type of partnership with its contracted private service providers. While some providers could not adjust to the new service environment, many others thrived within and profited from it.

4. In setting a course toward a new vision, the state agency must lead by example.

A state agency must be perceived as upholding the values and strategies that it wishes its contract agencies to emulate. DCS’s decision to close the Tennessee Preparatory School was critical in this reform effort for it allowed the Department to directly convey its attitude, values, and conviction regarding congregate care use to its private service providers. DCS knew that it could not ask the providers to reduce their use of congregate care if it was running a large group care institution of its own. In shutting down TPS—a large, public congregate care facility—the Department sent a clear message to the providers that reducing reliance on congregate care was the right thing to do, and that it was possible to serve many children effectively without such facilities.

5. The state agency must have an enthusiastic leader who is appropriately oriented to the work of the agency and deeply committed to the reforms to be made.

With the arrival of Commissioner Viola Miller, DCS gained a stable leader who “knew the work” and could build on and institutionalize the gains that had begun under her predecessors. Her depth of knowledge, her unwavering commitment to family-based care and timely permanency for children, and her strong organizational, management, and leadership skills made her exceptionally well-suited for the job. She was able to both articulate a vision for DCS and convey it to her staff. She provided a detailed road map for reaching the goals she envisioned. And she was able to maintain close supervision of a complex organizational system while adhering to regulations, processes, and government standards.
6. **The state agency must align its contracting protocols with its desired systemic outcomes.**

The Department developed new contracts that created incentives for its provider agencies to achieve its newly articulated goals. Specifically, DCS made family-based placements and timely permanency more financially rewarding than placing children in congregate care through the development of the Continuum model and the institution of performance-based contracting. This new contractual infrastructure not only rewarded providers who met the Department’s goals, but it penalized—and ultimately helped to eliminate—those who did not meet the state’s expectations.

7. **The state agency must select service technologies compatible with its desired systemic outcomes and institute policies that promote their implementation.**

DCS introduced numerous service technologies—practices, tools, and approaches involved in service delivery—designed to minimize its use of congregate care. Among other things, it developed a comprehensive practice model that set out the principles of family-based practice and least restrictive placement, and implemented a uniform child assessment tool. The Department developed Child and Family Team Meetings as the central mechanism for case planning and enhanced the use of highly staffed treatment foster homes. And, along with the private providers, DCS embarked on efforts to recruit and retain families who could provide specialized care for those children who needed it.

8. **The state agency should develop opportunities for collaboration with local communities in addressing the needs of children and families.**

The development of active and robust community partnerships underscores the message that the protection of children is a shared responsibility. DCS developed Cross-Functional Teams and Community Action Boards, structures that bridged the Department’s work with that of private providers and other community organizations. These units bolstered the relationships between DCS, providers, and community-based programs, and provided forums for various sectors to identify placement and service needs and to brainstorm strategies for fulfilling them.

9. **The state agency must maintain a reliable electronic data management system, select valid measures of child and family outcomes, and use the results of sophisticated data analyses to inform decision making.**

Prior to Brian A., the Department’s inability to extract accurate, basic information on children in care, including where children were placed on any given day, hampered its efforts to reduce its use of congregate care. Among other things, improving its data collection and analysis enabled DCS to reduce its use of group care because it enabled the Department to manage children’s placements and regional placement use more rationally.

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CONCLUSION

The story of deinstitutionalization in Tennessee provides valuable lessons about large-scale child welfare reform that can cut across jurisdictions. It underscores the power of class action litigation as a catalyst for change and highlights the effectiveness of strategies that reduce child welfare systems’ reliance on institutional placements. And Tennessee’s experience speaks to the importance of precision, not only in selecting the policies and practices to implement within a jurisdiction and its subdivisions, but also in monitoring and evaluating those initiatives.

Although all state child welfare agencies continually have room to improve, Tennessee’s campaign to reduce its reliance on congregate care deserves praise. The reforms spurred by Children’s Rights and implemented by DCS were truly comprehensive, shaking up entrenched ways of thinking and affecting all operations of the child welfare system—from agency leadership and frontline practice to contracting and community involvement—and introducing approaches that reflected the Department’s new perspectives on how best to serve the vulnerable children in its care.

The campaign was also inclusive and broad-based, fostering a new type of partnership among child welfare administrators and staff, private service providers, legislators, advocates, foster parents, and others to address a problem that had previously seemed unsolvable.

Most important, the reform’s impact has been felt widely and deeply. In implementing these changes, Tennessee ushered in a new model that not only improved services and contributed to better outcomes for the many thousands of children in state custody at the time, but one that continues to ensure better care and results for children in foster care today and the countless others coming into care in the future.

Children’s Rights hopes that through the dissemination of this report the lessons learned in Tennessee may be applied to other jurisdiction’s efforts aimed at addressing similar problems, so that the impact of these efforts may be felt more broadly still, and so that many more children and families may benefit from them.
CHAPTER 1
INTRODUCTION
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In 2000, Children's Rights filed a class action lawsuit to bring about reform in Tennessee's public child welfare system. Among other pervasive flaws, the suit alleged that the state's Department of Children's Services (DCS) routinely placed children in congregate care settings contrary to their best interests. Since then, the state has been extremely successful in reducing its use of congregate care, and many observers familiar with the state's child welfare system say that Tennessee's reduced reliance on such placements has played an important role in improving outcomes for children in foster care.

In this report, we explore the factors that enabled Tennessee to make and sustain this critical systemic change. We highlight the major lessons from Tennessee's experience in the hope that other child welfare systems struggling with similar challenges may learn from Tennessee's experience as they embark on their own reform efforts.

BACKGROUND AND PURPOSE OF THE STUDY

When children need to be removed from their homes due to maltreatment, the settings in which they are placed affect the type of care and services they receive and, therefore, their well-being. Experts consider foster homes to be the best placements for most children because they provide individualized attention in a normalized family setting and because they are thought to promote permanency (i.e., exiting state custody to reunification, adoption, or legal guardianship). Some children, however, need more intensive services than a family foster home can provide. Under these circumstances, it may be necessary to place a child in some form of congregate care—a non-family-based setting in which a larger number of children receive specialized care and/or treatment. Such facilities include diagnostic and assessment centers, group homes, and residential treatment centers. Emergency shelters are also considered a form of congregate care but are normally used when no other placement can be found for a child, and should therefore be used for only short periods of time. According to the most recent national statistics, approximately 16 percent of the 423,773 children in out-of-home care in the United States—more than 65,000 children—live in congregate care settings.

Congregate care is a necessary and important part of the foster care continuum; when used appropriately, it can provide children with structure and treatment services they need. But when children are placed in facilities when their needs can be met in less restrictive family settings, they may experience unnecessary isolation from the community and lack of normalized relationships common to institutional care. Child welfare systems must therefore monitor the use of group placements to ensure that they are used only when appropriate.

25 In recent years, the terms 'resource home' and 'resource parent' have replaced 'foster home' and 'foster parent' in the child welfare field. This shift in nomenclature reflects the view that the role of foster parents is not simply to take care of children, but also to be a resource for parents working toward reunification with their children. Though 'resource' is fast becoming the more popular term, this report, with the exception of some quoted material, uses 'foster' because this was the word most commonly used by the people we interviewed.

26 Janchill, op. cit.: 1.

27 United States Department of Health and Human Services, op. cit.: 8. Note: The 16 percent reported here represents children placed in 'Group Homes' (6 percent) and 'Institutions' (10 percent), the definitions of which can be found at the Children's Bureau website (http://www.acf.hhs.gov/programs/cb/systems/afcars/guide/appc.htm).

28 Janchill, op. cit.: 1.
The use of congregate care for dependent children in the United States has evolved over the course of history, with concerns about its use emerging only in the last century. In the 1700s and 1800s, society relied primarily on orphanages to meet the needs of children whose parents were unable to care for them. The advent of foster care in the mid-1800s introduced alternatives to institutional care, and in the early 1900s, federal support for the care of poor children created more opportunities for children who would have otherwise found themselves in orphanages or other group facilities to remain at home.29 By the 1960s and 1970s, the greater deinstitutionalization movement30 and specific fears around the developmental outcomes of children reared in group care31 highlighted the importance of limiting facility-based care for children in state custody.

These concerns led child welfare theorists and best practice experts in the United States to come to a firm philosophical conclusion regarding the use of congregate care. They conceptualized child welfare placements as points along a continuum of restrictiveness, with community-based services delivered in a child's own home at the least restrictive pole and residential treatment facilities at the most restrictive. When children cannot remain safely at home, the philosophy dictates placing them in family settings whenever possible; congregate care should only be used to deliver time-limited services to children whose special needs require more intensive treatment in a restricted setting;32 'general' institutions—congregate facilities, such as orphanages, that do not provide therapeutic services or enhanced supervision—are never an appropriate placement.33

Federal child welfare policy has embraced this perspective, incorporating the importance of family-based placements into its requirements for state child welfare agencies. In 1980, the Adoption Assistance and Child Welfare Act (AACWA; P.L. 96-272), which differentiated federal foster care funds from financing for other social service programs, emphasized that children in foster care should be placed in the least restrictive, most family-like setting possible.34 Though it was largely silent on the specific use of congregate care, AACWA was clear that "[r]esidential care was to be a short-term intervention for troubled children and youth who were on their way to more permanent, family-based settings."35

In addition to the practice-based rationale for controlling the use of congregate placements, serving a child in group care is significantly more expensive than serving a child in a family setting, even with extensive ancillary services. One report, for example, estimates that congregate care placements can cost public child welfare systems between two and 10 times more than family-based placements.36

Along with these firm philosophical and fiscal reasons for limiting the use of group care, social science research, which in the past has been plagued with methodological problems, is beginning to produce solid evidence that placement in family foster homes leads to better outcomes for children than placement in group settings. For example, research has been clear that placement in congregate care often

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30 Ibid.
33 Janchill, op. cit.: 1.
34 The mandate that states place children in the least restrictive environment possible remains in place today. Specifically, in order to be eligible for federal foster care funds, state child welfare agencies must have in place a “case review system” that ensures that “[each child in foster care] has a case plan designed to achieve placement in a safe setting that is the least restrictive (most family-like) and most appropriate setting available.” (Title IV of the Social Security Act (SSA) § 475(5)(a), 42 U.S.C. § 675(5)(a)).
35 Courtney & Hughes-Heuring, op. cit.: 29, p. 182.
36 Barth, op. cit.: 7.
leads to poor developmental outcomes in very young children. For older children, qualitative studies have raised concerns about the negative impact of group care settings, especially in terms of their safety. In addition, the most recent federal data indicate that placement in congregate care can influence adoption. In FY2009, 54 percent of children adopted from foster care were adopted by their foster parents, because children in congregate care normally do not have foster parents, their placements deprive them of the very opportunity that produces the majority of public adoptions.

Studies comparing congregate care to foster home placements are becoming more sophisticated. A 2011 meta-analysis of the field’s most rigorous studies supports the belief that family-based placements lead to better outcomes for children, highlighting findings that, when compared to children placed in congregate care, children placed with families experience better outcomes such as: fewer subsequent placement moves, less time spent in out-of-home care, increased likelihood of being placed with siblings over time, placement nearer to the child’s town of origin, decreased likelihood of re-abuse, fewer problematic sexual behaviors, and decreased likelihood of juvenile delinquency.

Given this climate, public child welfare agencies have gone to great lengths in recent years to appropriately align their use of group care facilities with the needs of the children they serve. This report presents a case study of one such jurisdiction.

In the late 1990s, in response to reports from local child advocates of systemic failures within Tennessee’s Department of Children’s Services (DCS), Children’s Rights undertook an extensive investigation of that child welfare system. The investigation revealed that, among other pervasive flaws, DCS routinely placed children in congregate care settings contrary to their best interests, and that this misuse of group facilities was harmful to children. Consequently, in 2000, Children’s Rights and a team of Tennessee attorneys from Nashville, Memphis, and Knoxville filed a class action lawsuit, *Brian A. v. Sundquist*. The suit alleged numerous deficiencies within the state’s child welfare system, including its severe overreliance on group care. When the case settled in 2001, a number of provisions requiring DCS to limit its use of congregate care facilities were incorporated into the consent decree.

Reducing its use of group placements was one of DCS’s early and sustained successes. In 2000, 28 percent of children entering foster care were placed directly into congregate care; by 2003, that figure had dropped to 13 percent, and it has remained around that level or lower ever since. Currently, on any given day, only 9 percent of Tennessee’s foster children are placed in a group setting.

This report takes a retrospective look at how Tennessee accomplished this sweeping systemic change. Our purpose was to go beyond the quantitative data and determine what factors enabled the transformation. Toward this end, we conducted interviews with 51 stakeholders in Tennessee’s child welfare system.

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37 e.g., Harden, *op. cit.:* 31.
40 Lee et al., *op. cit.:* 6. Note: Studies in this meta-analysis include samples from child welfare and juvenile justice populations.
41 Annie E. Casey Foundation, *op. cit.:* 11.
43 In addition to highlighting DCS’s overuse of congregate care, the *Brian A. v. Sundquist* complaint alleged numerous other systemic flaws including: inadequate child assessments and case plans; failure to provide children in foster care with an appropriate education; failure to provide services necessary to establish permanency for children in care; high caseloads and turnover among caseworkers; inadequate training and supervision of caseworkers; an inadequate information management system; and casework practices that led to African American children receiving lower quality services than White children received.
system that addressed two main questions: (1) How, since the 2000 filing of the Brian A. lawsuit, did DCS reduce its use of congregate care; and (2) how has this change affected the safety, permanency, and well-being of children and youth in foster care.44

The people we interviewed represented the spectrum of child welfare stakeholders, and included former and current DCS administrators, contracted service providers, advocates, attorneys, legislators, former foster youth, and others. Representative quotes from these individuals are interspersed throughout this report.45

TENNESSEE’S DEPARTMENT OF CHILDREN’S SERVICES: A BRIEF HISTORY

To fully understand DCS’s reduction in congregate care, one needs to understand the agency’s history. Prior to its creation in 1996, children in Tennessee could be remanded to state custody through any of five government departments: the Department of Human Services (which was responsible for abused and neglected children), the Department of Education, the Department of Youth Development (which dealt with children entering custody through the juvenile justice system), the Department of Mental Health, or the Department of Health. Each department oversaw its own out-of-home placements (all maintained some form of congregate care), and provided and contracted for its own services to children and families.

All of these departments drew resources from the state’s Department of Finance and Administration (F&A). Because each department operated independently, F&A had difficulty reconciling the rationales behind their expenditures for out-of-home care, and consequently, justifying how funds were disbursed to each. In 1991, in an attempt to manage the disparate budgets, F&A established what became known as the Children’s Plan. Among other things,46 the Children’s Plan created a division within F&A to act as a coordinating body for child welfare activities across custodial departments,47 and established regional, quasi-governmental offices that would act as the “single point of entry for all children entering into or at risk of entering into state custody.”48

44 Although Tennessee’s juvenile justice system is subsumed under the greater DCS, and although delinquent youth have much in common with dependent/neglected and unruly children in state custody, delinquent youth and the settings in which they are placed are not the focus of the present study. The primary reason for this is that the class in the Brian A. lawsuit does not include children adjudicated delinquent. Specifically, the class is defined as “[a]ll foster children who are or will be in the legal custody of DCS. Foster children’ shall mean all children who are or will be in the legal custody of DCS, excluding children who are or will be in the legal custody of DCS upon an allegation or adjudication of a delinquent or criminal act. Children who are or will be in the custody of DCS upon an allegation or adjudication of an unruly or status offense shall be included in the class, and children who are or will be in the custody of DCS upon an allegation of a delinquent or criminal act and which allegation is subsequently dropped or fails to result in an adjudication of a delinquent or criminal act and who remain in the legal custody of DCS, shall be included in the class” (See Modified Settlement Agreement and Exit Plan at 5 Brian A. v. Bredesen, No. 00-445 (M.D.Tenn. filed November 10, 2010, Dkt. No. 411)). As such, the Brian A. settlement agreement only mandated reforms to DCS’s juvenile justice population insofar as they affected foster children in the class (i.e., children adjudicated dependent/neglected and unruly).

45 When there was considerable agreement among stakeholders on a particular issue, we selected quotes that best reflected that consensus. When a quote represents the perspective of only one or a small number of stakeholders, this is noted.


47 Ibid. This division was called the Office of Children’s Services Administration.

48 Ibid, p. 40. These regional, quasi-governmental offices were called Community Health Agencies.
These regional offices set up Assessment and Care Coordination Teams (ACCTs), which developed individual contracts for placement and intervention services with private providers. The ACCTs were tasked with assessing children entering custody and selecting placements and services for them, regardless of the department to which they were remanded. ACCT case managers entered child information (e.g., demographic, medical, educational, behavioral, etc.) into a computerized system called Qualifacts, which would then provide a list of placements for the case manager to consider.49

This structure remained in place for several years, and although it brought some financial organization to children’s services, problems remained. Bifurcated reporting lines created a bureaucratic tension between the ACCTs and the custodial departments; while each department had a Commissioner who reported to the Governor, the regional entities, which worked with the very same children and families, reported to F&A.50 And, ideologically, as long as multiple government departments each maintained their own custodial divisions, there could be no truly unified structure to the state’s work with children needing out-of-home care and their families.

For these reasons, the Department of Children’s Services (DCS) was created in 1996. Established by an act of the state legislature, DCS combined the child welfare divisions of the five separate state offices. However, developing cohesion within the new Department proved to be a challenge.51 Despite the fact that most of the children in DCS’s custody were adjudicated dependent/neglected or unruly (i.e., status offenders), a large proportion of staff and administrators in the new agency were from the juvenile justice system. This professional mismatch created dissonance within the new department—here was a new agency devoted to child welfare with therapeutic and permanency goals, wanting to adopt a strengths-based orientation, being run by individuals with experience and training in an inherently punitive treatment model. Institutional care, a prominent model in juvenile justice, was a prime example of the dissonance; although congregate care was usually not appropriate for abused or neglected children, the corrections-oriented staff’s comfort with this type of placement contributed to its pervasive use.

**Brian A. v. Sundquist**

Children’s Rights filed the *Brian A. v. Sundquist* (later, *Brian A. v. Bredesen*; currently *Brian A. v. Haslam*) lawsuit in May 2000. As noted above, the suit alleged a range of systemic flaws and harmful casework practices, among which was a severe misuse and overuse of congregate care for children and youth in state custody. The complaint included the following allegations:52

- DCS had an egregious lack of appropriate foster care placements. As a result, children were often placed in overcrowded emergency shelters, Observation and Assessment Centers, and other temporary placements for many months.
- DCS had failed to recruit and retain a sufficient number of adequate foster families. The families they did have were insufficiently trained, especially regarding how to handle children with serious

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49 L. Burton, former DCS Central Office administrator (personal communication, August 9, 2010).


51 In January 1999, in an effort to streamline the work of the new agency, the first Commissioner, George Hattaway, contracted the Child Welfare League of America (CWLA) to conduct a needs assessment of DCS, and to develop and implement strategies to strengthen the system. CWLA helped DCS create a three-year plan for its foster care and adoption programs. However, this plan was never fully implemented because by the time it was proposed, the *Brian A.* lawsuit was underway; DCS would later use CWLA’s recommendations as talking points in negotiating the settlement agreement.

52 Complaint, *Brian A. v. Sundquist*, No. 00-445 (M.D.Tenn. filed May 10, 2000, Dkt. No. 1). The following bulleted elements are summarized from the original document.
behavioral and emotional problems. In particular, the Department lacked treatment foster homes and, as a result, often placed children in homes with foster parents who were ill-equipped to care for them.

- While awaiting more appropriate placement, maltreated children entering care were often placed in the same facilities as dangerous children with histories of violence.
- Due to a lack of supervision, children in congregate care were often harmed by other children or by facility staff. Many incidents went unreported or inadequately reported. Additionally, congregate care facilities often misused psychotropic medication and physical restraint practices as methods of discipline.
- DCS failed to place children with serious treatment issues in the least restrictive environment capable of meeting their needs.
- DCS failed to provide children placed in emergency congregate care settings with adequate educational services. The complaint cited the common occurrence of single “classrooms” in which one or two teachers oversaw large numbers of children of varying ages, educational development, and ability, thus eliminating the opportunity for meaningful instruction.
- DCS's data management system, which, among other things, was supposed to match children with appropriate placement resources and track their progress, had major problems collecting and producing reliable and valid data.

Box 1: Brian A. Named Plaintiffs' Experiences in Congregate Care

The lawsuit’s named plaintiffs represented examples of the worst of DCS’s congregate care practices. For example, the eponymous Brian A. was a nine-year-old boy who, at the time of the complaint, had lived in an emergency shelter for seven months due to DCS’s failure to provide an appropriate placement. This overcrowded facility held 20 other boys ranging in age from six to 16, some of whom were alleged to have committed violent crimes. Although he had been in DCS custody for four years, Brian had no active permanency plan.

Amy D., a 16-year-old girl, also lived in a congregate care setting at the time of the filing. Due to an inadequate assessment of Amy’s needs, she had been in 14 separate placements, including 10 congregate care facilities, in less than three years. Throughout her time in care, Amy experienced mental and physical problems exacerbated by over-medication and frequent placement transitions. During her 13th placement—a 30-day hospital evaluation—her Court Appointed Special Advocate found her in a dirty room with food and garbage on the floor; she was so overmedicated that her speech was slurred.

Another teenager, 17-year-old Terry G., had lived in several congregate care placements during her two years in DCS custody. During these placements, she was not provided with appropriate services to meet her special education needs, nor was she provided with necessary independent living services. She became pregnant by another youth living in her congregate care facility, received no maternity services other than medical check-ups, and subsequently lost the pregnancy when she was assaulted by a peer in the facility. Terry had been inappropriately medicated, causing her to sleep through the majority of the day and, at one point, to experience violent rages. Additionally, DCS had neglected to help Terry maintain ties with her mother while she was in care; the Department failed to provide family therapy for Terry and her mother, despite their repeated requests for these services.

53 Treatment foster care (also known as therapeutic foster care) “is a clinically effective and cost-effective alternative to residential treatment facilities that combines the treatment technologies typically associated with more restrictive settings with the nurturing and individualized family environment” (Foster Family-Based Treatment Association, op. cit., 2). Treatment foster homes employ foster parents who are specially trained to care for children with mental health, emotional, and behavioral problems. This type of placement is discussed further in Chapter 4.
In short, the case against DCS, particularly with regard to dangerous and inappropriate placements and supervision, was compelling. The federal court denied the state’s initial attempt to have the case dismissed on legal grounds. Shortly after the discovery process began, rather than proceed through years of discovery, trial preparation, and a trial, the parties engaged in months of intensive settlement negotiations. In July 2001, the parties came to an agreement to be enforced by a federal court.

The consent decree required DCS to make numerous reforms, including a number related specifically to its use of congregate care. For example, the settlement agreement prohibited DCS from:

- placing children in emergency or temporary facilities for more than 30 days, and from placing children in more than one emergency or temporary facility within any 12 month period, except in extraordinary cases;
- placing children in jails or correctional or detention facilities unless they have been charged with delinquency or otherwise ordered to such a placement by the court;
- placing children under six years old in a congregate care setting, except in extreme cases; and
- placing children in group care settings with a capacity of eight or more beds without approval by the Regional DCS Administrator.

And the settlement agreement required the Department to:

- immediately conduct a needs assessment to determine the number and types of foster care placements and service resources that the system needed to serve children appropriately;
- place children in foster care according to their needs in the least restrictive, most family-like setting possible, making efforts to avoid non-family placements, especially for young children;
- place children as close to home as possible;
- make efforts to place children with their siblings when appropriate;
- have children attend community schools whenever possible;
- evaluate all congregate care facilities’ in-house schools to determine whether they were providing children in foster care with appropriate education services, and subsequently to terminate contracts with any agencies providing an in-house school that did not implement recommendations for improvement;
- employ a full-time Medical Director to oversee the implementation of policies regarding the administration of psychotropic medication to and the use of restraint and seclusion practices with children in DCS custody;
- maintain statewide, regional, and local adoptive and foster parent recruitment programs; and
- establish procedures for DCS’s quality assurance unit to review all cases in which a child has been in congregate care contrary to the terms of the settlement agreement.

54 Modified Settlement Agreement Brian A. v. Sundquist, No. 00-445 (M.D.Tenn. filed July 27, 2001, Dkt. No. 111). The following bulleted elements are summarized from the original document. These bullets represent provisions in the original consent decree. Since the initial settlement, the consent decree has been modified a number of times to meet the evolving needs of the Department and to reflect the state’s progress in meeting the outcomes required in the decree. In November 2010, a federal court approved an exit plan that supersedes the most recently modified settlement agreement and outlines the steps DCS must take and the outcomes it must maintain to exit from federal court oversight. These steps are discussed further in Chapter 9.

55 The settlement agreement not only required the state to conduct this needs assessment, but also required that the state set aside four million dollars over each of five years to execute it.
A court monitor and Technical Assistance Committee (TAC)\textsuperscript{56} were put in place to oversee and offer guidance to DCS during its reform process, as well as alternate dispute procedures that provided the parties a forum for resolving disagreements over noncompliance without returning to court.

DCS set out to make the required changes, but in November 2003, when the court monitor released a report evaluating the Department's progress, the findings were dismal. Twenty-seven months after entering into the settlement agreement, DCS's progress was severely limited. Of the 140 provisions in the consent decree, the Department was in compliance with only 24, in partial compliance with 28, and in outright noncompliance with 84.\textsuperscript{57}

Although progress had been made in some areas regarding congregate care, and the number of children in such facilities had decreased, a number of the monitor's 2003 findings pertained to continued concerns in this area. For example, the report noted that 13 percent of foster children had stays in emergency placements exceeding 30 days and that 38 percent had multiple stays in such placements without a permitted exception documented.

The Department had also failed to collect aggregate data on a number of provisions related to group care. Relying on a case record review, the monitor determined that:

- children's assessments were often untimely;
- when children's assessments were timely, placement decisions were frequently not aligned with the assessments' recommendations; and
- of the children who had both been assessed timely and whose records indicated whether they had been placed according to the assessment, only 30 percent had been placed appropriately.

Additionally, the monitor found DCS to be out of compliance with virtually all of the provisions surrounding adoptive and foster parent recruitment and retention, which could have increased the likelihood of finding family-based placements for children living in congregate care.\textsuperscript{58}

Children's Rights took DCS back to court, filing a motion to hold the Department in contempt. The parties quickly settled with a stipulation mandating that DCS formulate an implementation plan to prioritize and carry out the reforms required in the settlement. The contempt motion signaled a turning point for DCS, not only because it hastened the Department's reform efforts, but also because at this time the Governor appointed a new Commissioner, Dr. Viola Miller, who would, over the course of her administration, bring numerous systemic improvements to fruition.\textsuperscript{59}

\textsuperscript{56} At the time of the settlement, the Brian A. Technical Assistance Committee was instituted as a body that would provide consultation to the Department as it undertook the reforms set forth in the consent decree. In 2003, after the release of the first monitoring report, the separate court monitor was excused and the TAC was assigned to take on monitoring duties in addition to its consultation role.

\textsuperscript{57} Findings were deferred for two provisions and no finding was made for two other provisions (Memorandum in Support of Motion for Contempt of Consent Decree and Further Remedial Relief Brian A. v. Sundquist, No. 00-445 (M.D.Tenn, filed November 20, 2003, Dkt. No. 175)).

\textsuperscript{58} Ibid.

\textsuperscript{59} Dr. Viola Miller was the DCS Commissioner at the writing of this report and remained Commissioner through the end of 2010. In January 2011, the new Governor, Bill Haslam, appointed Kathryn O'Day to take Dr. Miller's place.
Overview of DCS operations

Tennessee’s state-run, state-administered child welfare system consists of three main divisions: Protection and Permanency, Juvenile Justice, and Administration and Training. The Division of Protection and Permanency, which deals with children who are either at risk of child abuse or neglect or are unruly, includes offices focused on child safety and services to children and families, including foster care, adoption, and child and family well-being.

Over the past decade, the number of children in foster care in Tennessee has been shrinking. Figure 1.1 shows that entries into foster care peaked in 2004 at just over 5,000 and have been decreasing steadily since then. Figure 1.2 shows point-in-time data for the number of children served on January 1 of each year since 2001; the trend indicates that the in-care population has also been decreasing since 2004.

It was in this context that DCS implemented a multi-faceted, court-ordered campaign to reduce its use of congregate care. The following chapters explore the factors that laid the groundwork for limiting the use of group placements and the numerous policy, practice, and organizational reforms that enabled DCS’s successful and sustained deinstitutionalization.

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CHAPTER 2

METHODOLOGY
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METHODOLOGY

This study sought to answer two main questions: (1) How, since the 2000 filing of the Brian A. lawsuit, did DCS reduce its use of congregate care; and (2) how has this change affected the safety, permanency, and well-being of children and youth in foster care? The majority of the data was collected during interviews with stakeholders in Tennessee’s child welfare system. Information gleaned from these interviews was supplemented with analyses of numerous official DCS documents, quantitative administrative data, performance monitoring data, and ad hoc conversations with those involved with the system.61

DEFINITIONS

The term ‘congregate care’ takes on varying definitions depending on the child welfare system in which it is used. In this study, congregate care includes the types of settings DCS used during the time period covered in this study:62, 63

- **Residential treatment centers**: Campus-like facilities providing care and treatment for children with serious mental health, emotional, and behavioral problems. Residents may attend local public schools, but typically attend schools on the center’s campus. Therapeutic services are provided on-site.

- **Group homes**: Facilities in residential communities that house a maximum of 12 youth at a time, normally older youth with moderate behavior problems who are not stable enough to be served in family settings but who can be maintained in the community. Residents typically attend local public schools but may attend on-site schools, and receive outpatient therapeutic services in the community.

- **Observation & Assessment (O&A) Centers/Primary Treatment Centers (PTC)**: Facilities designed to provide psychological and behavioral assessments of children either upon entry into foster care or during their spell in care. Stays in these settings are not intended to exceed 30 days.

- **Emergency shelters**: Facilities similar to O&A Centers /PTCs except that they do not include an assessment component; they are places where children are sent when no other placement can be found. They may be used for children first entering care and for children whose placements have disrupted.64

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61 See Appendix A for a detailed description of the research methods and analyses employed in this study.


63 For this study, the definition of congregate care excluded Supervised Independent Living Programs, which are dormitory or apartment style facilities for older youth transitioning from foster care to emancipation. The definition also excluded Youth Development Centers (YDCs), which are DCS’s juvenile detention facilities, and DCS-run group homes solely for youth stepping down from YDCs, because the Brian A. class does not include children adjudicated delinquent.

64 Emergency shelters existed when the Brian A. lawsuit was filed but no longer exist as of this writing. Although from time to time, an O&A center may be used to place a child in an emergency, there are no facilities specifically designated as emergency shelters. Former shelters have either shut down or been repurposed for other services.
• **Hospitals**: In-patient facilities used for children experiencing symptoms that require 24-hour access to medical/psychiatric staff.

• **Tennessee Preparatory School**: A state-run residential school housing approximately 300 children at the time of the *Brian A.* filing that provided a congregate living environment and educational services.65

### SAMPLE SELECTION

Interviewees for the study were recruited using a comprehensive list of stakeholders who were active during the time of the *Brian A.* lawsuit. This list was shared with a number of key stakeholders with a breadth of knowledge about Tennessee’s child welfare system who provided feedback regarding individuals’ appropriateness to be interviewed and whether the list represented the array of stakeholder groups in the state. A small number of additional interviewees were recruited by snowball sampling—either: (1) interviewees recommended other appropriate participants who later provided interviews; or (2) an interviewee invited a colleague (or colleagues) to join in his or her interview. Of 63 prospective interviewees invited to participate, 51 provided an interview.

The sample consisted of seasoned professionals who had an average of 19 years of experience working within Tennessee’s child welfare system.66 Participants included DCS officials, private provider executives, advocates, attorneys, state legislators, former foster youth, and others with knowledge of the child welfare system and its use of congregate care. Forty-five respondents (88 percent) were involved in the Tennessee child welfare system at the time of the interview.

### DATA COLLECTION

Participants received a pre-interview survey (see Appendix C) that collected basic demographic information and served to prepare the interviewees for the types of questions that would be asked during the interview. The interview protocol (see Appendix D) contained open-ended questions designed to capture stakeholders’ perceptions of DCS’s use of congregate care prior to 2000; steps the Department took to reduce its use of group settings; the difference between congregate care use prior to 2000 and at the time of the interview; and the effect of that change on the safety, permanency, and well-being of children in foster care. All interviews were conducted by the same researcher, a Children’s Rights senior policy analyst, between February and April of 2010.67 Thirty-six participants were interviewed on site in Tennessee; the remainder were interviewed by phone. All interviews were audio recorded and transcribed.

To provide a quantitative context for stakeholders’ qualitative responses, DCS provided Children’s Rights with two large datasets containing information from the Department’s statewide electronic data archive, TNKids,68 on children’s placements in foster care during the study period. These files were produced by the Chapin Hall Center for Children at the University of Chicago, a research organization.

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65 The Tennessee Preparatory School existed when the *Brian A.* lawsuit was filed but no longer exists at the time of this writing. The process of its closure is discussed in detail in Chapter 3.

66 n=45; for six interviewees years of experience were not available.

67 The exception to this was two participants who were interviewed in February 2011.

68 As of August 2010, the TNKids system has been upgraded and converted to a new system called TFACTS. For further information on TFACTS and its features, see State of Tennessee. (no date). TFACTS. Retrieved June 3, 2011, from https://tfacts.tn.gov/sacwis/logon.do?command.do%28overview%29=1
with whom DCS contracts to provide data management and analysis. The first, an entry cohort file, contained placement data for all children in the Brian A. class entering foster care between 2000 and 2008. The second, a point-in-time file, contained placement data for all children in the class on January 1 of each year from 2001 through 2009.

Additionally, data from Brian A. monitoring reports (periodic reports published by the Brian A. TAC outlining the Department’s progress in meeting the mandates of the settlement agreement) and third party Quality Service Reviews, were analyzed to explore whether they would provide additional quantitative support for the qualitative interview findings.

**DATA ANALYSIS**

To analyze the qualitative data, a coding structure was developed by extracting and organizing themes from transcripts until no new themes were identified. Then, all transcripts, including the ones that had been used to create the coding structure, were coded using NVivo 8 software. Quantitative analyses of the two administrative databases noted above were run using SPSS 18.0 software.

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69 It is important to note that point-in-time data provide a distorted picture of the experiences of children in foster care because they over-represent long-stayers and fail to account for many children who enter and exit care quickly. Though point-in-time data provide a snapshot of children in foster care at any given moment, successive point-in-time samples are not ideal for measuring change over time, and should be used in conjunction with entry cohort data whenever possible. For a discussion of the limitations of point-in-time data, see Courtney, M. E., Needell, B., & Wulczyn, F. (2004). Unintended consequences of the push for accountability: The case of national child welfare performance standards. *Children and Youth Services Review, 26*, 1141–1154.

70 The entry cohort database contains includes only children entering foster care for the first time. A child may appear more than once in the point-in-time dataset if he or she exited and subsequently reentered to foster care.

71 A Quality Service Review (QSR) is a process that analyzes the cases of a sample of children in state custody and/or children with open preventive cases in order to determine the quality of a state’s child welfare services. Samples are normally collected randomly and are intended to be representative of the state’s custody/preventive services population. Reviews include the analysis of case records as well as qualitative interviews with stakeholders in each child’s case (e.g., family members, child welfare staff, service providers, educators, attorneys, etc.). For information on Tennessee’s QSR process, see State of Tennessee. (no date). *Children’s Program Outcome Review Team*. Retrieved December 13, 2010, from http://www.state.tn.us/tccy/cport.shtml
CHAPTER 3
SETTING THE STAGE FOR REFORM
CHAPTER 3
SETTING THE STAGE FOR REFORM

UNDERSTANDING DCS’S USE OF CONGREGATE CARE PRIOR TO BRIAN A.

At the start of our interviews with child welfare stakeholders, we asked respondents to talk about how DCS made decisions to place children in congregate care prior to the filing of the Brian A. lawsuit in 2000. They described a disorganized system with few standards regarding the use of group care, and talked about how practice at the time contributed to a misuse and overuse of residential facilities.

Bed-driven placement

When asked to describe the decision-making process for placing children in congregate care prior to Brian A., many interviewees replied with some variation of “It was just easier.” They described the process as “entirely bed-driven,” “haphazard,” and “disjointed.” When a child entered foster care, caseworkers scrambled to “find a bed, any bed,” and made placement decisions without consideration of whether the setting was appropriate for child’s particular needs.

At the time, DCS had a severe shortage of family foster homes, and the Department did not routinely reach out to relatives to encourage them to become formal foster parents. As a result, when children entered care, the most readily available placement was often in a group facility. DCS staff had longstanding relationships with the Department’s private service providers—most of which specialized in group care—and it was often easier to call on such a facility for a placement rather than to find a foster home for the child. Said one former DCS Central Office administrator:

I would say that administrative convenience, unfortunately, drove most of the placement decisions prior to 2000.... It was the least amount of work for some overworked caseworker to just pick up the phone and call [a facility] because they just got off the phone with that person 45 minutes ago about some [other child] and heard that there were X number of beds available [there]. It was not individually tailored placement.

Some people said that there were attempts at thoughtful placement matching during those days, noting that children did receive assessments; however interviewees also noted that the assessment tools used at the time were untested and that DCS did not have a single instrument that it used uniformly across the state. In the end, those who mentioned efforts at thoughtful decision making described the attempts as half-hearted or not fully effective. Ultimately, as one interviewee put it, attempts at assessment “almost became irrelevant because [placement decisions were] shaped by the choices or lack of choices.”

Congregate care as an accepted solution

Though interviewees described the process of finding placements as frenzied, they did not describe the Department’s overuse of congregate care as something about which caseworkers or administrators were particularly concerned. In fact, defaulting to congregate care placements was an accepted practice.
Respondents said that the use of group care was “just the culture” at DCS, that placing children in facilities was “a way of life…the way we did business as an agency.”

Moreover, there was a widespread belief that congregate care placements were actually good for children—that group care was the “silver bullet.” And, because there was no consistent assessment occurring for children, caseworkers chose placements based on their knowledge and experiences with the various providers. Tennessee’s group facilities had been providing what was perceived as good care for years. Members of the child welfare community admired them for their beautifully appointed grounds and respected them for their attempts at creating “family-like” environments. In this context, group care institutions were attractive. As one legislative staffer for the State Assembly’s Joint Committee on Children and Youth described it:

Because [the group care facilities] were very well-known and respected placement options, I don’t think we really thought twice in terms of, ‘Oh, that’s a congregate care setting so it should be lower down on our option list.’...We also viewed those settings as very wholesome, family[like], especially the faith-based associated settings.... They were doing as much as they possibly could to emulate family settings by the fact that they would have the cottage setup. They would have house parents that lived there as opposed to rotating staff, and...while they were on a campus per se, they operated very much [as] a family.

Observation & Assessment Centers and emergency shelters

A number of interviewees spoke specifically about the overuse of emergency shelters and Observation and Assessment (O&A) Centers prior to 2000. It was a common, and often preferred practice at the time to place a child entering custody into an O&A Center for evaluation, and then to move that child to another placement once the assessment was completed. Some talked about this practice as an accepted way to assess children's needs before placement; others simply described O&A Centers as places to put children when nobody knew where to send them. Regardless of the perception of these facilities, the practice of using them as initial placements created a number of problems.

First, O&A Centers were designed to evaluate children, and placements there were not supposed to exceed 30 days. However, children often stayed in these facilities for much longer periods of time because caseworkers were unable to find suitable subsequent placements. As a result, they became “holding tanks” for children for whom DCS could not find homes.

Second, O&A Centers sometimes acted as pipelines to congregate care. One person noted that because O&A Centers were often divisions of larger residential treatment facilities, it was not uncommon for a child to be assessed in one and then placed directly in that Center's congregate care facility. A former DCS Central Office administrator noted that a child's escalating behavior during a stay in an O&A Center often led to his or her subsequent placement in group care:

[If children] presented with any behavioral issues during that 30-day time period, that would bump up the level of treatment [the evaluators said] they needed. I don’t think we were clinically adept in looking at why a young person may have been acting out in those 30 days.

Emergency shelters were akin to O&A Centers, except that they did not have an assessment component. These facilities functioned simply as shelters: places where children were sent when no other placement could be found. DCS used them for children first entering care as well as for children disrupting from placements. As with O&A Centers, children often stayed in emergency shelters for long periods of time.
The congregate care population prior to Brian A.

Because of DCS’s placement process prior to Brian A. and its relatively positive perception of congregate care, a wide variety of children landed in group settings. In certain cases, attempts at thorough assessment and placement matching meant that children with high-level mental health and behavioral needs were sent to residential treatment appropriately. But respondents also noted that because of the dearth of foster homes and appropriate services, DCS placed “anyone who had a problem”—from mild to severe—in an institutional setting. Older children routinely wound up in congregate facilities because foster homes for teens were particularly difficult to find. As one Tennessee Commission on Children and Youth staff member said:

Ten years ago, and before that, you would have found many more dependent/neglected adolescents...in congregate care largely because they were adolescents and not because they needed that level of structure.

In fact, teens entering foster care were often placed in group settings automatically, without any attempt to search for a foster home. One former foster youth with whom we spoke believed that this is what happened when she entered care:

I think that I ended up in a group home because I was 16 years old. And I didn’t have exhaustive behaviors or anything like that. I don’t think that that is as quick to happen nowadays...

DCS commonly placed young children in group settings, and sibling groups were also more likely to go to group care because it was often the only way to keep them together. There was also a greater use of congregate care prior to Brian A. because children were more likely to come into foster care for educational reasons. Those who were habitually truant or who exhibited disruptive behaviors in school were often sent to residential facilities that had in-house schools; it was thought that, in such placements, these youth could focus on their education in an environment that fostered discipline.

In summary, on the eve of Brian A., the congregate care population in Tennessee was heterogeneous. Children with varying levels of need went to residential facilities, including many who could have thrived in family foster homes. As one former DCS administrator said, “What kind of kid [got placed in congregate care]? An unlucky one. I mean, a child who just happened to kind of roll up and there were beds to fill.”

EARLY INITIATIVES: BUILDING A FOUNDATION FOR REDUCING THE USE OF GROUP CARE

We asked interviewees the general question, “Since the year 2000 and the filing of the Brian A. lawsuit, how has Tennessee’s Department of Children’s Services decreased its reliance on congregate care placements for children and youth in foster care?” It was clear from their responses that three major events laid the groundwork for the state’s ability to reform its policies and change its practice on the ground: Children’s Rights’ filing of the Brian A. class action lawsuit, the closing of the Tennessee Preparatory School, and the leadership of Commissioner Viola Miller.
Mandates of the *Brian A.* settlement agreement

Children's Rights and DCS attorneys negotiated the terms of the *Brian A.* settlement agreement for several months. Though these conversations were arduous and intense, they were, according to plaintiffs' attorneys, relatively good-spirited. From the outset, those negotiating for the Department were constructive and took an active role in crafting the terms of the settlement. The lead Children's Rights attorney attributed this proactive posture in part to George Hattaway, the DCS Commissioner at the time, who saw the lawsuit as an opportunity to push forward needed systemic reform:

The initial Commissioner who was [in office] when we filed the lawsuit...got out in front of this case and made very clear, public decisions not to fight what he saw as a need for reform. Instead [he got] behind it and used it both as a tool to own what the reform plan would look like and to get more of what he wanted and needed for the agency....[T]his wasn't a settlement that was jammed down any agency's throat at all. This was months of negotiations and collaboration and the Department very much owning what they were committing to.

A number of people noted that the *Brian A.* settlement agreement played an essential role in DCS's congregate care reduction. This connection is an obvious one; as noted in Chapter 1, the court order plainly required the Department to limit its use of group settings in a variety of ways. But mere compliance with the consent decree was not the only force affecting DCS's reduction of group care. Also at play were DCS's professional commitment to respond to the unacceptable placement practices uncovered by the lawsuit and a desire to institute best practices within the Department.

Respondents differed in their perceptions of how each of these factors played a role in policy reform. Specifically, they varied on the extent to which they believed DCS's efforts at compliance were aligned with a clearly articulated, intrinsic, agency-wide shift in philosophy regarding the use of congregate care. Some reported that DCS officials agreed to restrictions on congregate care during the settlement negotiations to put the force of law behind systemic changes that they had long hoped to make. As one private provider executive said, the settlement required the Tennessee child welfare system to “do things that we should have done on our own, but [that] there [had previously been] no incentive” to do. Thus, the Department began to frame the *Brian A.* settlement as the rationale for reducing group care use, and, for many, compliance with the settlement agreement became synonymous with solving DCS's congregate care problem.

One consequence of conflating the two was that it communicated to many that compliance with the decree—and not a DCS-intrinsic agenda or strategic decision—was driving congregate care reform. A legislative staff member of the State Assembly's Joint Committee on Children and Youth recalled that DCS's initial message to the public was that, in light of *Brian A.*, it had no choice but to limit the use of congregate care. Only later, she said, did the Department announce that it had adopted a new philosophy that involved a drastically limited use of group placements. As she put it, the mandate to reduce group care “was delivered more in an edict kind of way, rather than [DCS saying], ‘We're changing our practice and philosophical [approach and] we think we need to change.’”

Regardless of whether the change in DCS's attitude toward group care stemmed merely from its desire to comply with the consent decree or from a true change in practice philosophy, reform in this area was essential in light of the poor practices uncovered by the lawsuit. As one former DCS Central Office administrator said:

> When you have a lawsuit that says there's an overreliance on congregate care in your jurisdiction, somebody needs to respond to that. And if the response is [to say that we're reducing the use of group care] only because of this federal lawsuit...I'll take that.
CHAPTER 3: SETTING THE STAGE FOR REFORM

Closing the Tennessee Preparatory School

Another early step that laid the foundation for reform was the closing of the Tennessee Preparatory School (TPS). TPS, founded as the Randall C. Cole Industrial School in February 1885, was the result of a 12-year campaign on the part of Probate Judge John C. Ferriss to fund a boarding school for children made homeless by Tennessee’s 1873 cholera epidemic. In its earliest years, TPS admitted children in state custody who had been orphaned, abandoned, or relinquished by their parents, some of whom were as young as fourth graders.72 The school’s population changed when state legislation allowed the court to commit children to state custody for offenses such as “incorrigible or vicious conduct” and being “vagrants,”73 and in its final years, TPS served older youth adjudicated dependent, neglected, or unruly. Over the course of more than a century, TPS was under the jurisdiction of various state departments, shifting from the now-defunct Department of Institutions74 to the Department of Education, and finally to the Department of Children’s Services. Though it changed over the years, TPS grew to be an iconic Tennessee institution. When the Brian A. lawsuit was filed in 2000, the school housed approximately 300 residents. DCS realized that if it was going to decrease its use of group care, it would have to lead by example and shut down its own large congregate care facility.

Opposition to closing TPS and political considerations. Shutting down TPS was highly contentious. At the time, many argued that youth were thriving at the facility, that the residents had made the school their home, and that they were receiving a quality education there. Physically, TPS appeared to be a great place to live and learn. Set on acres of land in middle Tennessee, it had swimming pools, athletic programs, small class sizes, and devoted teachers and staff. People pointed to graduates of TPS who went on to become pillars of the community. The school was regarded by many as a time-honored establishment and a fixture in Tennessee’s history. Not surprisingly, therefore, the Department encountered intense pushback from a number of groups as it embarked on “the very arduous, politically sensitive if not explosive process of shutting it down.”

TPS’s alumni association advocated feverishly to keep the facility open. Alumni appeared in the media and lobbied their state representatives, some expressing that TPS had “turned their lives around.” One alumna, who attended the school during the late 1960s and early 1970s, described her experience this way:

TPS had its own...elementary and high school on campus. We had our own place to go worship and to go watch movies. Just about everything we needed was right there on the campus. I went from making failing grades at home to being an honor roll student at TPS. I would have never gotten the education I received in a foster home being thrown back into the public school system. I went from being the little poor girl that everyone made fun of in the public schools I attended before going to TPS, to becoming a cheerleader, working on the school newspaper, etcetera, with tons of friends. We learned responsibility and taking responsibility for our actions,... This school gave many of us the hope and opportunities and a home that we would have never received otherwise.

In addition to resistance from the school’s alumni, DCS encountered a “huge uproar” from juvenile court judges. Despite the fact that TPS was now under DCS’s control and judges could no longer commit children directly to the facility, they continued to “strongly recommend” that youth, particularly truant or otherwise unruly teens, be sent there. Several interviewees talked about how judges in each county had an unwritten “quota” of children that they could send to TPS, and how county judges felt they each held a share of the facility. Said one member of the Brian A. Technical Assistance Committee (TAC):

Judges loved [TPS] because they owned a certain kind of sense that there was bed space allocated, at least in theory, by county. They could commit the kids there pretty easily.

TPS also had its champions among legislators, some of whom had lived there and saw it as a place that helped them become productive members of society. TPS alumni and staff were also well connected to their state representatives, and those representatives shot back at DCS on behalf of their constituents. One legislator who opposed the closing recalled:

I had people that were coming in here that were 30 years old or that were 70 years old saying, ‘Please, please don’t close [TPS].’...[These people] were a little community of their own and we just did away with that. In some instances, [TPS was]...just a good place for kids to be. And I just thought it was an extremely bad move to take those kids that were doing well out there and force them [to leave].

DCS administrators remembered being called to late night meetings where they were reprimanded by lawmakers and made to defend their plans to close the school. As one recalled:

I got called in...to several legislators’ offices and scolded and told, you know, ‘Why are [you] doing this?... I got constituents that are really angry about this. We may stop it.’ I mean, we got threatened several times. We had to make the case about why this made sense not just politically, but [why] this was good practice.

In the lead up to closure, legislative hearings were held at which prominent Tennesseans, TPS alumni, and other powerful constituents came forward to talk about the importance of keeping the facility open. The Department stood its ground, bringing in people to testify about the importance of closing it. DCS officials realized that they would need considerable political cover to shut down the facility.

Fortunately, several forces were at play that allowed for that protection to emerge. One such force was that Governor Donald Sundquist was nearing the end of his term and could therefore support closing TPS without major concern for political fallout. In turn, the DCS Commissioner, George Hattaway, could rely on the Governor’s support, which might not have been forthcoming at a different point in time. Moreover, as several people described, Hattaway was someone who wanted to leave a positive legacy, and it was important to him that DCS increase its commitment to best practices and accountability; closing TPS was a step toward achieving that goal.

Commissioner Hattaway was shrewd at leveraging the Brian A. lawsuit to make important changes in the child welfare system, and he used this tactic in his decision to close TPS. One interviewee recalled an internal conversation with the Commissioner during the settlement negotiations about the effect of limiting the use of facilities with eight or more beds on TPS. In short, DCS officials noted to the Commissioner that if the “eight beds or less” provision were included in the settlement, TPS would have to close. Hattaway, supportive of closing the school but keenly aware of the potential political ramifications, understood that if the consent decree limited the use of large facilities, he could use it as a justification for “having” to close TPS.
A key group of high-ranking DCS administrators, who had long been committed to shutting the school down, was also instrumental in initiating the school’s closure. During interviews for this study, they recalled that at the time of the settlement negotiations, DCS’s Assistant Commissioner of Juvenile Justice oversaw TPS and opposed the closure. The DCS administrators described this person as running the school using a corrections model rather than a child welfare model—someone who “did not remotely understand the words ‘best practice’ in any way,” and who was more concerned with “the benefits of running an institution to the department that ran it, not about the families and children that were being affected” by its use. Therefore, TPS had to be moved out from under this person’s jurisdiction in order to proceed with closing it.

The DCS staff member charged with facilitating the closure recommended to Commissioner Hattaway that the TPS superintendent report to the Commissioner’s Executive Assistant—a person who had a background in education and favored closing TPS—instead of to the Assistant Commissioner of Juvenile Justice. The rationale presented to Commissioner Hattaway was that TPS, which was truly an educational facility, should not be overseen by someone with a corrections orientation. Commissioner Hattaway approved this reorganization. With TPS now overseen by individuals committed to its closure, the Department could proceed with shutting it down.

**TPS residents at the time of Brian A.** When *Brian A.* was filed in 2000, there were 313 children living on the TPS campus, and several interviewees noted that permanency planning for them was essentially nonexistent; a substantial proportion of the school’s residents had been living there for years. Some interviewees said that children placed at TPS were expected to simply grow up there and age out of foster care upon graduation.

Respondents described the residents as teenagers who had neither a history of delinquency nor any major mental health, behavioral, or other treatment needs. Many were there only for educational reasons. Others were there because DCS had been unable to find foster homes willing to take them. In short, many stakeholders agreed that “these kids didn’t need to be there.”

Not only did they not need to be there, they did not, by and large, want to be there. According to one executive of an ancillary service program, “there were some kids who really saw [TPS] as an artificial everything. It wasn’t just an artificial living environment; it was an artificial educational environment.” A former DCS official who helped engineer the closure of TPS remarked that when he would visit the school, youth would call to him from across the campus and say, “Hey, man, can you get me out of here?” Though many of those interviewed acknowledged that there were some children at TPS who wished to stay, they also reported that the majority preferred to leave. One member of the TAC recalled:

> What happened was, you had all the kids agreeing that Tennessee Preparatory School was, in fact, very important because there were some kids for whom it was the best placement. [But] you couldn’t find any kid that thought that they were one of those kids.

Because the residents of TPS did not have major treatment needs, many at DCS thought that these youth could easily be moved into family placements without serious concern about maintaining their well-being, their safety, or the safety of others in the community. And so in late 2002, with a solidified commitment to closing TPS, the Department began the task of moving children from the campus.

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75 E. Black, former Executive Director, DCS Office of Child Permanency (personal communication, August 11, 2010).
76 One interviewee suggested that the lack of permanency planning at TPS was a vestige of the days when youth placed at TPS were in the custody of the Department of Education, where children did not have permanency plans, as opposed to the Department of Children’s Services, where they did.
77 The Department had been slowly moving children out of TPS prior to this date, but the major thrust began in late 2002 (E. Black, op. cit.: 75).
CHAPTER 3: SETTING THE STAGE FOR REFORM

Closing TPS. To many, the logistics of closing TPS felt incredibly daunting. Though DCS believed shutting the school down was the right thing to do, workers and administrators worried that it would be impossible to find families for all of the youth who lived there. DCS partnered with Vanderbilt University and assembled teams of DCS staff, law students, and social work students who were tasked with the job of finding appropriate homes for each child at TPS. Several stakeholders described these teams as precursors to the present-day Child and Family Teams.78 Though the Child and Family Team model was in its infancy at the time, the teams staffing the cases at TPS employed several of its principles; multiple people associated with the child were brought to the table to evaluate whether group care was necessary for the child and to brainstorm, when appropriate, potential routes to a permanent placement in a family-like setting.

Ultimately, the youth themselves were most influential in this process. Those staffing the cases started by simply asking the residents, “Who would you identify as your resources in the community?” or “Is there someone close to you with whom you’d like to live?” Much to the staff’s surprise, the residents had answers, identifying family members, friends, and others who they had been visiting on weekend passes. Some noted that many youth proffered resources whom had previously been ignored by judges and DCS staff as potential foster parents.

DCS staff were surprised at how readily the youth identified viable resources for themselves, causing many to realize that the youth had been previously ignored in case planning. The process was an “eye opener about how many resources [DCS staff] weren’t aware of,” and once DCS started using the youth as sources of information, finding placements for the majority of them was “a complete no brainer.” One former DCS official reflected on the process this way:

This was one of the most shocking things I’ve learned in my life…. I mean, we [went in] thinking it’s gonna be physically impossible…to find good placements for 250 kids…. Because, you know, one of the assumptions was that [the youth at TPS] wouldn’t be there if there were a lot of resources out there in terms of families that were accessible, who were still in contact [with the youth]…. [We thought] that at least it would take some effort to unearth some of these human resources that were, you know, connections to these young people. And it was disturbingly easy to find good placements.

Indeed, the process of moving youth out of TPS went relatively quickly, with most placement moves occurring over the course of fewer than four months.79 Many went to kin or to the care of individuals with whom they had strong relationships. Others returned home to their biological families.80 Regardless of where the youth went, DCS staff worked hard to create smooth transitions, contracting with service providers to ensure that children’s needs would be met in the communities to which they were moving. They paid special attention to moving the youth at the end of the academic year so that they would not experience the double transition of changing homes and schools.

In the end, DCS was unable to find placements for only about 30 TPS residents.81 These were youth who either did not have anywhere else to go, or for whom it was ultimately decided that TPS was truly the best placement. The Department was thoughtful about dealing with those who could not be placed

78 The Child and Family Team model centers around bringing multiple stakeholders to the table, including casework staff, clinicians, family members, and others, to devise tailored case plans for families and promote collaborative decision making. The model is discussed further in Chapter 4.

79 E. Black, op. cit. : 75.

80 A considerable number of children were at TPS solely for educational reasons, not because they had been victims of abuse or neglect. These children were easily returned to their homes through work with parents and educators to install the educational supports that they needed.

81 E. Black, op. cit. : 75.
elsewhere, and did not force youth to leave the campus if they really wanted to stay. Meanwhile, however, TPS continued to shut down operations; the facility shrunk its staff, closed cottages, and grouped the remaining residents into the most appropriate combinations possible. Some of these youth ultimately moved to foster homes with foster parents they did not know; a small number were transferred to other facilities.

Several people mentioned the critical importance of perseverance throughout this process. Staff and administrators had to stay committed to exploring every option for every child, one child at a time. They also had to persist in the face of opposition from TPS staff who were afraid of losing their jobs. For example, one former DCS Central Office administrator recalled that when the individuals staffing the cases attempted to arrange planning meetings on the campus, the reaction of TPS staff was often, “Here come the people that are trying to close us down,” and that they sometimes made it difficult for the transition teams to do their jobs. In this environment, the drive to keep returning to the campus to get the job done was essential. “It’s a matter of how hard you try and how determined you are to make it work,” said one respondent. “You know, it’s the old level of commitment. The chicken and the pig as it relates to breakfast.”

“Sending a message.” Practically speaking, shutting down TPS was a key step in DCS scaling back its use of congregate care, for it removed a very large group placement option for children in foster care. But, as many were eager to point out, the closure of TPS also played a significant symbolic role. For one thing, it solidified the position that children should not come into state custody purely for educational reasons. Shutting down TPS “put a greater responsibility on the Department to work more closely with the school systems” and to provide the interventions necessary to maintain them in public schools. Said one DCS Regional Administrator:

I think that closing TPS forced the state to examine...that educational needs should not be the reason to set up congregate care for children. We should be able to [provide for] that within either the child’s community or within the region.

But perhaps more important, in closing TPS, the Department sent a message to the private service providers—with whom it had long been contracting to provide congregate care—that it was moving away from group placements. With the Brian A. settlement requiring drastic reductions in the use of congregate care, and a leadership committed to that goal, DCS was about to require its contracted providers to shift their longstanding business models and make major reductions in their use of group facilities. Justifying that change would have been impossible if DCS were still operating its own large institution. As one former DCS Commissioner said:

TPS is important because it’s symbolic and it’s real. If we’re going to ask the provider community to change business models, we’re going to have to change business models.

A member of the Brian A. TAC agreed:

As long as Tennessee Preparatory School was in existence, it was like [DCS saying to providers], ‘Do as I say but not as I do.’

And finally, though initially a “tough pill to swallow,” closing TPS (as well as other facilities for children with minimal needs) helped change caseworkers’ mindset—when closing TPS did not “produce the calamity that people were expecting,” it gave workers confidence that appropriate, family-based placements could be found, and that congregate care should rarely be a placement of choice.

82 This colloquialism refers to a fable often used to describe different types of contributors to a project. In preparing a breakfast of ham and eggs, the chicken only makes a contribution, whereas the pig makes a “total” commitment.
New leadership

For several years after the filing of Brian A., DCS experienced considerable turnover in leadership. George Hattaway, the first person appointed to the role of Commissioner when DCS was created in 1996, still held this position when the suit was filed in 2000. He embraced the consent decree and pioneered the reform process. However, like many other upper level DCS administrators at the time, Hattaway came to the new agency with a background in corrections,83 which a number of interviewees said limited the Department’s ability to develop an appropriate program for children and families experiencing maltreatment.

When Hattaway retired in 2002, his position was filled by Dr. Page Walley, a former state legislator and clinical psychologist who had previously acted as a consultant to DCS. During his short tenure, Walley strove to maintain the process of systemic reform that Hattaway had set in motion, including the closure of TPS. However, when a new Democratic Governor, Phil Bredesen, was elected to office in 2002, Walley was replaced with a new Child Welfare Commissioner, Michael Miller.

Many interviewees noted that Mr. Miller’s administration was fraught with problems, describing his leadership as ineffective and as undoing whatever strides had been made since the settlement agreement. One former DCS Central Office administrator described him as

pretty much an unmitigated disaster from start to finish.... He made the message real clear that he didn’t agree with the TPS closing.... And in so many ways, he started undermining all the other efforts to...convert to a practice model that would improve the way that young people are placed.

In November 2003, Children’s Rights filed a contempt motion alleging the Department’s noncompliance with the consent decree. By the end of the year, the parties agreed to a stipulation that outlined new requirements designed to push DCS toward progress.84 One consequence of this process was the removal of Michael Miller as DCS Commissioner. In his place, Governor Bredesen appointed Dr. Viola Miller.85

Many were quick to describe the ways in which this Commissioner Miller breathed new life into DCS and set it on a track for real success, especially when it came to vigilance over the use of congregate care.86 Whereas previous DCS Commissioners did not have experience running a child welfare system, Viola Miller “knew the work” prior to taking on the position, as she had previously served as Secretary of the Kentucky Cabinet for Families and Children.87 Miller had extensive knowledge of prevailing child welfare practices, and impressed upon the Tennessee child welfare community that “she could talk the talk and she had walked the walk.” A “very kind-hearted lady, but tough as nails,” her dynamism and no-nonsense character engaged others.


85 In fact, Michael Miller left his position during the contempt negotiations. The new Commissioner, Viola Miller, stepped in at that time and immediately became immersed in mediation meetings regarding the contempt motion.

86 Though many discussed Commissioner Miller’s leadership and vision as central to DCS’s ability to wean itself from group care, one should note that, according to the administrative data referenced in Chapter 5, the most precipitous decrease in congregate care use post-Brian A. occurred between 2000 and 2003, prior to the Commissioner’s arrival. Time lags in perceptions are not unusual. Often a successor gets full credit for work done prior to their taking office, particularly when the gains are institutionalized, built upon, and maintained.

Stakeholders also noted that from the moment she arrived, Commissioner Miller insisted on a renewed effort to place children according to their needs. She emphasized the importance of using Child and Family Team Meetings as a way to inform comprehensive, rational placement decision making, and installed procedures to hold workers accountable for good practice. She insisted that children in foster care be placed with families whenever possible, and that congregate care be viewed as a way for children to receive time-limited, intensive treatment. Indeed, a number of interviewees said that prior to Miller’s arrival, DCS had a problem of children lingering in residential treatment settings for years, and that these facilities had become places where children were “just sort of housed.” One DCS Regional Administrator explained:

> When Commissioner Miller started, we really started putting a lot more thought and care into finding a placement that was actually going to meet the child’s needs.... Before [Commissioner Miller] there just wasn’t as much of a sense of treatment for children [or] care about their experience in foster care. It was more about availability and just kind of making sure that we had somewhere that was safe versus somewhere that was also meeting their well-being needs, that was also warm and caring and more of a family setting.

In her interview, Commissioner Miller noted that when she first came into office, people in the child welfare community felt she opposed congregate care writ large. “That could not be further from the truth,” she explained:

> If a child needs an intensive spell of residential treatment, if his needs demand that, then I want those resources available to meet those needs. Now at the same time, I want us from day one to be planning that exit, what has to happen to get this child back within the context of a family.

That drive to find families for children as quickly as possible was aligned with her commitment to achieving permanency for every child in foster care. Whereas previous Commissioners had been focused mostly on the safety of children in state custody, Miller hammered home the importance of decreasing length of stay in care and getting children home to their families, adopted, or into another permanent arrangement as quickly as possible. Her introduction of a number of administrative reforms addressing the state’s contracts with private agencies was one way in which she accomplished this; her close oversight of permanency planning for children in congregate care was another. No matter the initiative, interviewees honed in on Miller’s persistent messaging that DCS “was about getting permanency for children.” Said one private service provider executive:

> Commissioner Miller was just tenacious about [permanency]. Like a bulldog. You know, ‘permanency, permanency, permanency.’ [She would say,] ‘I don’t want to hear anything but permanency. ‘There’s no place for this child?’ I don’t want to hear it. Find a place.’ I mean, her tenacity just infuriated everybody, but basically she had a sense that that was the only way to make it happen. Because, you know, there’s always a ‘but, what about—‘ and there are always excuses and all.

Several respondents said that one of Miller’s major accomplishments was that she spearheaded a true culture change within DCS. Through her leadership and initiatives, she was able to implement her philosophy and approach at the ground level, convincing frontline workers that institutional care was not in children’s best interests. When asked what it takes to effect a culture shift on such a grand scale, Miller said:

> Changing those core values about what is good for kids [is what] really makes the long-term difference. If you have a child welfare agency that really believes that kids deserve a ‘forever family,’ then that’s the system that you’re gonna have. That’s the system you’re gonna build.
But exactly how does one change an entrenched system of values within a giant bureaucracy? Miller explained:

> What you have to do first is almost fake it till you make it. [You say,] ‘We’re not going to do this [i.e., default to congregate care] anymore.’ You just do it. You issue directives because you have to stop some of that behavior very quickly.... Then you begin to build a culture. And there’s a lot of pushback.... The concept has to be [that] safety is not enough. Children deserve to grow up in a ‘forever family.’

> ... The first thing we did, of course, was really define a clear practice model and clear core values—strengths-based, family-focused, culturally responsive. I bet you if I said those three things one time I bet I said them several million. You just say it over and over and over again, and then [you provide] examples because it’s much easier to learn to say it than it is to begin to live it.... Then I think the second thing that was really important was getting really good data together to use to say [to individual regions], ‘You are, too, putting kids in emergency shelters. Here are your numbers.’ And that took a while because we really didn’t have any good data sets at the beginning. [Now] I can certainly tell you down to the region who still puts kids in [those kinds of settings].

> ... You teach that [practice model] over time and then you assess it. You assess the implementation.... I meet with the regions, and we go one child at a time, and we talk about that child, and we talk about permanency, and we talk about what that child’s needs are. It’s not easy. It really takes that down in the weeds, each child, each day, each family, until folks begin to embrace those principles.... And then once you’ve got that, that then drives [the staff’s] behavior. And then when you’ve got good data so they know [that their new behavior is] resulting in better outcomes for kids...then, folks begin to come along.

It was clear that Miller’s approach, coupled with her choice of competent people to carry out her mandates, was noticed by others. As one Children’s Rights attorney on the Brian A. case noted:

> I think it’s difficult to over [state] how much impact the change in leadership culture, and Commissioner Miller coming in, and [members of her management team had]. That also was absolutely instrumental, not just on the issue of congregate care, but really across the board in terms of settlement implementation and...improving practice.

In summary, three distinct but interrelated and cascading occurrences—the filing of the Brian A. lawsuit, the closing of the Tennessee Preparatory School, and the instillation of a new leader committed to changing the Department’s reliance on congregate care—set the stage for multiple reforms that led to a dramatic reduction in the use of congregate care as a placement option for children in Tennessee foster care.
CHAPTER 4
REFORMING DCS’S APPROACH TO PLACEMENT: PRACTICES, POLICIES, AND INFRASTRUCTURE
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With a firm foundation for deinstitutionalizing its foster care system, DCS implemented numerous policies and practices, and developed new organizational structures, that enabled it to control the initial placement of children in congregate care and move children who had already been placed in group facilities to family settings. Both the public agency and the private providers with whom it contracted took approaches that redefined their practices, as well as their relationships with one another. Business as usual changed as the system realigned itself with a set of appropriate goals that conformed to both the settlement agreement and best practices.

FOSTER HOME DEVELOPMENT FOR TARGETED POPULATIONS

To prevent children from unnecessarily entering congregate care and move children already in group care successfully to family settings, DCS needed to ensure that it had a sufficient number of foster parents who were equipped and willing to care for children with unique or high-level needs. The Department had to pay attention to two populations, both of whom were overrepresented in group facilities: children with special needs and teenagers.

One way DCS and the private providers met these children's placement needs was by enhancing their use of treatment foster care (TFC). TFC (also known as therapeutic foster care) is a type of specialized foster care used for children with high-level emotional, behavioral, physical, or developmental needs. TFC is different from traditional foster care in that it uses specially trained foster parents to provide active and structured treatment in the context of the family setting, in addition to any interventions a child may receive outside of the home. As such, TFC is an important family-based placement alternative for children who are most likely to be placed in congregate care settings.

Box 2 outlines the major components of the TFC program at Youth Villages, one of Tennessee’s largest and most successful private providers. Small caseload size—eight to ten cases per worker—is one critical element of the program. Also essential is that treatment foster parents are considered to be partners in case planning and in execution of case plans for the youth in their homes. In addition, treatment foster parents provide feedback to the provider through quarterly surveys and monthly conversations with staff; in these forums, the agency obtains foster parents’ perspectives on what techniques or tools are working well and collaborates with foster parents to develop ongoing behavior plans for the youth in their homes.

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88 Foster Family-Based Treatment Association, op. cit.: 2.

89 In Tennessee, treatment foster care is largely the province of the private service providers, as these agencies normally manage the cases of children in state custody with special needs.
Box 2: Treatment Foster Care: A Family-Based Option for Children with Special Needs†

The major difference between regular foster care and treatment foster care is the integration of ongoing treatment in the context of the family setting. Whereas regular foster parents are expected to provide care in a family environment, treatment foster parents are also expected to help execute rigorous therapeutic plans for the youth in their care. In keeping with this model, Youth Villages, one of DCS’s largest private service providers, emphasizes counseling in its treatment foster care program, with treatment plans that typically include the following:

- At a minimum, individual therapy sessions with youth occur on a weekly basis. These sessions target issues that drive or influence the youth’s current behaviors. Youth who present with symptoms of traumatic stress may receive Trauma Focused Cognitive Behavioral Therapy (TF-CBT). Therapy sessions may also target anger management, relationship difficulties, coping strategies, etc.

- Typically, at least two therapy sessions per month take place in the foster home and one takes place at the youth’s school or elsewhere in the community. Spending such a substantial amount of time delivering services in the foster home enables counselors to facilitate communication between the family and the foster youth. It also provides the counselor the opportunity to assess the youth in his/her home environment, which enables the counselor to tailor the treatment plan to the individual child and to support the foster parent’s implementation of it as time goes on.

- With the support of counselors, treatment foster parents often implement a behavior plan or behavior contract to track the youth’s progress. This plan normally includes a set of rewards and consequences, with an emphasis on rewarding desired behaviors and establishing “replacement” behaviors—positive behaviors that replace negative ones.

- To promote individualized and continuous service, a single counselor is responsible for each treatment foster home. Caseloads are kept small at eight to 10 cases per worker.

- Counselors are on call 24 hours a day, seven days per week, to provide immediate crisis response, if necessary.

- Provider staff identify a youth’s permanency plan at admission and work diligently to establish permanency as quickly as possible. When a youth’s permanency goal is reunification, two counseling sessions per month take place with the biological family. For youth in need of adoption, many treatment foster parents eventually become adoptive parents.

Youth Villages uses the term “professional parenting” to describe the role of their treatment foster parents. The agency, therefore, devotes resources to foster parents’ professional development. When foster parents identify areas in which they struggle to care for the children in their homes, the agency provides support, education, or other resources to help them manage those challenges.

In addition, a recursive process of quality assurance that constantly measures fidelity to the program’s model is critical to the program’s success. Every six months, on average, Youth Villages uses specifically designed tools to identify areas in which the program is being executed as intended and areas in which staff are drifting from the model. Results of the reviews are shared with program staff and supervisors, and action plans are created to address ways in which fidelity can be improved. These action plans are not only monitored, but the relationship between fidelity scores and program outcomes is also examined to ensure that improved fidelity is associated with improved outcomes for children and families.

† Youth Villages. (no date). Youth Villages program models: Development and implementation and Youth Villages. (no date). Youth Villages treatment foster care principles. Provided to Children’s Rights by Youth Villages, February 27, 2011; N. Truhe, Government Relations and Public Policy Manager, Youth Villages (personal communication, March 15, 2011).
Along with children with special treatment needs, older youth—including those without major treat-
ment needs—made up (and continue to represent) a sizeable proportion of the congregate care popula-
tion. Just as treatment foster parents must be equipped to handle the special needs of the children in
their care, foster parents caring for teenagers must be prepared to handle the unique developmental
needs of adolescents. As a number of stakeholders pointed out, teens in foster care often exhibit dif-
ficult behaviors, as they are dealing with the psychological damage resulting from maltreatment and
the separation from their families at the same time as they are experiencing the need for independence
characteristic of normal adolescent development.

**Foster home recruitment and retention**

Finding homes for these types of children required both DCS and private providers to adjust their
recruitment efforts. One private provider, for example, conducted an extensive survey of its existing
foster parents to understand what kind of foster parents it currently attracted and what types of people
to target in its new recruitment efforts. It then undertook a major, multi-strategy marketing campaign
designed to bring in new foster parents (See Box 3).

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**Box 3: Recruitment and Retention of Treatment Foster Parents: One Provider’s Approach†**

Youth Villages undertook extensive marketing research to determine the best ways to recruit treatment foster
parents. Among many findings, this research revealed that the agency’s foster parents took an average of 2.5
years before deciding to become foster parents. The “final push” that most often motivated them to call Youth
Villages was hearing a personal story of a child needing help or seeing some sort of outreach commu-
nication from the agency (news story, yard sign, outdoor board, etc.). Virtually all cited a love for children as their
reason for taking on the role.

Using knowledge from their marketing research, including their existing foster parents’ opinions on how best
to engage new recruits, Youth Villages developed a recruitment and retention campaign involving 21 strate-
gies. Among these are:‡

- Develop a strategic publicity campaign to recruit foster parents. Target radio, print, TV, and influential
  websites and blogs.
- Utilize National Foster Care Awareness Month in May to promote Youth Villages’ foster care program and
  attract new foster parents.
- Provide tools for recruiting through churches. Begin by involving churches in praying for foster children
  and foster parents, and offer churches a variety of ways to help.
- Develop cause-related marketing partnerships with businesses.
- Enhance the foster care search engine optimization on www.youthvillages.org so that the Youth Villages
  website is the first that people encounter when searching for foster parenting opportunities and/or infor-
mation.
- Explore the use of a celebrity spokesperson to help attract foster parents.
- Target teachers and nurses, who naturally encounter children needing help.
- Explore cross-marketing partnerships for ‘Baby Boomers’ and ‘empty nesters.’
- Target younger, unconventional foster parents (e.g., 25- to 40-year-olds).

(continued on page 52)
New procedures for planning and tracking the progress of recruitment and retention strategies were also put in place at DCS. DCS regions were required to develop their own region-specific recruitment plans outlining the demographics of the children in foster care in the area, the types of homes that need to be recruited to meet those children’s needs, and the region’s existing and proposed recruitment activities. Regional and Central Office staff now meet at six-month intervals to review progress and plan for the coming six months. In addition, regions created new staff positions specifically intended to provide support and guidance to foster parents (see Box 4).
Box 4: DCS Foster Parent Recruitment and Retention Processes: One Region’s Experience†

The Tennessee Valley region of DCS, which encompasses one of Tennessee’s largest cities as well as rural areas, has determined that, although it currently has a need for homes for all types of children, it specifically needs more homes for children with mental health needs and for African American male teenagers.

The region’s most successful recruitment method, both for general and targeted recruiting, has been to have existing foster parents recruit others by word of mouth. The strategy is most successful in areas where there are strong, active foster parent associations—local nonprofit organizations with elected officers consisting of foster parents, community providers, and others working together to help foster children in the area. The region also reports using other strategies including:

- Permanency Convenings—meetings designed to educate foster parents and other community members about children in need of permanent families.
- ‘Match up’ meetings, where regional permanency specialists and resource parent support teams collaborate to find adoptive homes for children in need.
- Segments on local news programs highlighting children awaiting adoption.
- Adoption fairs.
- Quarterly newsletters to foster parents.

Regional staff have also learned about strategies that have not been particularly successful in their area, including:

- Setting up information booths at community events.
- Approaching local churches, ladies groups, and ministerial associations for help.
- Eliciting the help of high school teachers to recruit homes for teens.
- Using mental health professionals to help recruit homes for high-need children.

This region reports that its Resource Parent Support staff are key to maintaining strong working relationships between DCS and its resource parents, and thus enhance retention. In addition to visiting the child in the home once a month, the Resource Parent Support worker makes sure that foster parents are up to date on training and license renewal, assists with locating respite placements when needed, and acts as a liaison that resource parents can contact whenever they need help. Resource Parent Support staff also regularly attend foster parent association meetings, both to field questions and concerns from foster parents, and to notify local foster parents of their specific recruitment needs.

Both private providers and DCS Regional Administrators acknowledged that specialized recruitment efforts are necessary when recruiting homes for teenagers. Box 5 delineates one such initiative within the public sector. Other recruitment strategies mentioned included demystifying the challenge of caring for teenagers, preparing new foster parents for the fact that they are likely to be asked to care for teens, and using foster parents currently parenting teens as recruiters. For example, one DCS Regional Administrator noted:

> Once we got a few [foster parents] that really became committed to treating and caring for teenage clients, they were able to share that message with other foster parents in a way that [DCS staff] couldn’t.

A private service provider executive mentioned the importance of managing new foster parents’ expectations:

> We have changed some of our recruitment strategies into more targeted recruitment towards families that can deal with teens. We’re not going to recruit them and train them with them believing they might get a younger child, because they’re not.... [When] we have 20 [new foster] parents,... 17 know that they’re going to get teenagers.

**Box 5: Families for Tennessee Teens†**

One new statewide effort, Families for Tennessee Teens, addresses recruitment and retention of families for teenagers in care. As part of this program, staff from each DCS region are charged with assessing their regions’ needs for both targeted recruitment (i.e., homes for teens) and child-specific recruitment (i.e., homes for specific teens) and developing strategies to meet those needs. Every six months, the regional staff meet to report on their progress and to discuss barriers to recruitment. The DCS Central Office has provided technical assistance to regional staff in assessing the trends relevant to their specific regions and creating measurable goals. One result of this process has been that several regions have identified a greater need to recruit kinship caregivers for teens. Toward this end, some have established the role of Kinship Coordinator, a member of the staff specifically dedicated to identifying these resources. Thus far, the program is believed to have yielded some increase in the number of foster homes available for teens.

† T. Davis, DCS Regional Administrator (personal communication, November 22, 2010).

The degree to which these recruitment efforts are successful must be tracked more rigorously, particularly at the public agency level. It is clear that DCS and the private providers are doing a great deal to recruit more families for the children who are in or at risk of entering congregate care. But it is also clear that additional efforts and initiatives will have to be undertaken if the reduction in the use of congregate care is to be maintained and enhanced.
Foster parent training and support

Foster parents caring for children with medical or mental health needs require in-depth knowledge about the nature of children's disorders and how to manage them. Those caring for teens have to be aware of the unique developmental needs of adolescents. Therefore, the training that DCS and the private providers supply to foster parents is critical if those foster parents are to be retained and the children's needs are to be met.

In addition to the standard training required to become a DCS foster parent (a curriculum called Parents as Tender Healers, or PATH) and the ongoing required in-service training, the Tennessee Center for Child Welfare provides online courses, allowing foster parents to learn more about topics most relevant to the children in their care. These include Attention Deficit Hyperactivity Disorder/Attention Deficit Disorder/Oppositional Defiant Disorder, anger outbursts, childhood anxiety disorders, stealing, eating disorders, and fire setting. Some courses, such as those on teen depression or teen aggression and violence, are geared specifically toward work with older youth.

Training for treatment foster parents is typically more intensive and covers more topics than training for traditional foster parents. For example, in addition to the DCS-required training, Youth Villages' treatment foster parents participate in extra sessions to attain certification. Prior to being certified, foster parents must complete 15 hours of therapeutic training, which includes classes on topics such as behavior management, child sexual abuse, discipline, and working with birth families. Those wishing to care for medically fragile children take up to 15 hours of medical-needs training, which includes information on topics such as growth and development, diabetes, pediatric obesity, and substance abuse. Once certified, foster parents must complete 15 additional hours of ongoing training on other topics such as engaging and parenting teens, and cultural awareness. All foster parents must take a course on parenting youthful offenders in their first year of certification. Many of these foster parent training classes are co-led by veteran foster parents.

The executive director of Omni Visions, one of Tennessee’s largest and most successful private providers, described her agency’s efforts to revisit its foster parent training procedures so that recruited foster families had the tools they needed to care for the children coming into their homes:

We approached [foster home development] from the standpoint of ‘we can’t ask our staff and our foster parents to step up unless we give them additional tools…. What tools can we give them so that we can increase the likelihood that community placements will be successful?’

Omni Visions contracted with consultants from Duke University to revamp that its foster parent training modules. The consultants helped the agency adapt an existing curriculum so it specifically addressed behavior management strategies and independent living skills for teens, as well as the importance of self-care for foster parents. The agency now has both an updated curriculum for foster parents and a curriculum for staff who train and supervise foster parents.

DCS itself also provides some specialized training for foster parents caring for children with unique needs. For example, the region noted in Box 4 also offers a course on parenting youthful offenders for foster parents interested in caring for youth who have been involved in the Juvenile Justice system; DCS staff find that the course is also helpful for those parenting teens in general. Trainings on more specific child needs are provided as needed.

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90 DCS contracts with the Tennessee Center for Child Welfare at Middle Tennessee State University to provide its foster parent training program, as well as other educational opportunities for foster parents and DCS staff. For more information see Tennessee Center for Child Welfare. (no date). Learning opportunities. Retrieved June 3, 2011 from http://www.tccw.org/index.php?option=com_content&view=article&id=10&Itemid=16

CHAPTER 4: REFORMING DCS’S APPROACH TO PLACEMENT: PRACTICES, POLICIES, AND INFRASTRUCTURE

Changes in Infrastructure and Frontline Practice

While recruitment and retention of a cadre of willing and able foster parents was critical to the Department’s effort to reduce its reliance on congregate care, these actions would have been meaningless had the Department not also developed and implemented a set of frameworks, case practices, and procedures that kept staff focused on using congregate care for only those children who needed it. The 2003 contempt proceedings highlighted the need for such efforts, revealing that DCS had not only failed to develop a plan for implementing the requirements of the consent decree, but that it did not have clear policies and guidelines directing its daily operations, in the first place.

Toward this end, the Department devoted considerable resources to the creation of its Practice Model, a foundational document that aligned casework practices with DCS’s new core principles. This extensive manual enumerated DCS’s standards for all aspects of work in child welfare and the rationale for each. Box 7 provides examples of standards pertaining to the use of congregate care.

Box 6: Creating a Supportive Environment for Foster Parents‡

One essential element of foster parent retention is creating an agency environment in which foster parents feel valued and supported. One private service provider, Omni Visions, focuses on the following to create such an atmosphere:

- Keeping small caseloads that enable staff to spend meaningful time with each foster family.
- Providing comprehensive pre-service and ongoing training and foster parent mentoring.
- Having staff go to foster families’ homes rather than requiring families to travel to agency offices.
- Ensuring that foster parents have 24/7 accessibility to staff, including access to the middle and upper management of the agency.
- Arranging meetings and trainings around foster parents’ schedules.
- Treating foster parents as part of a clinical team.
- Valuing foster parents’ ideas and suggestions regarding the care and treatment of the children in their homes.
- Providing adequate foster care maintenance payments.
- Providing respite services.
- Delivering wraparound services in the home to help manage children’s special needs.

‡ K. Joyner, Executive Director, Omni Visions (personal communication, March 21, 2010).
With these standards established, DCS developed a number of new policies and procedures aimed at implementing the principles of the Practice Model.

**Improvements to staff training**

In 2004, the Department began working with a consortium of universities throughout the state to develop and administer new pre-service and in-service training for DCS employees. As part of this new training, DCS staff were instructed about the negative effect of group care on children, the effects of institutionalization, and the barriers that congregate care creates to permanency. Communicating this information to frontline workers helped dispel previous beliefs that group care was an appropriate long-term placement for a child. The new message was that children needed to grow up in families. As one Regional Administrator recalled:

> The Department went through an overhaul process of training for staff... As far as moving in a direction where we were trying to reduce the numbers in congregate care, we had to really dig deep internally to figure out if [what was lacking was] a knowledge issue, [or] a practice issue—and it was both of those things. And it [was] a supervisory issue. We found out that many of our supervisors didn't have the training necessary to help guide casework, or an understanding of best practice, or an understanding of what congregate care can do to youth and the whole realm of being institutionalized.

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The Department also improved the qualifications of its staff by partnering with the universities to refine the curricula of their human services degree programs according to the principles promoted by the Department. This meant enhancing degree programs to focus more on family-centered, strengths-based practice. As one former DCS official noted, the “programs that are offered out there [today] are much more in tune with what the Department needs now.”

### Box 8: Orienting Residential Facility Staff to New Models of Intervention†

Adjusting models of intervention with children and families requires training, supervising, and supporting staff as they take on new approaches. One of DCS’s contract providers, Centerstone, altered its approach to residential treatment significantly when it shifted from a staff-driven, rules-based program to a youth-directed approach that gave residents increased responsibility and a stronger voice in their own treatment—a change that facilitated smooth transitions of youth from congregate care to family settings (see Box 12). In making this shift, program staff had to change their mindset in several important ways. They had to:

- adjust their perspective of what could be expected of youth;
- learn how to help youth use their setbacks as learning experiences;
- move to a paradigm in which a youth’s specific behavior led to an individualized consequence;
- move away from a model in which youth were expected to be compliant to one in which youth were expected to be responsible for their own behaviors; and
- give up the perceived control associated with a structure in which staff enforced a rigid system of rules and consequences for breaking them.

Because moving to this approach required a significant culture shift, the agency put considerable effort into staff training and development, giving their personnel time to adjust to the new model. Some staff resisted the transition, resulting in power struggles with the agency’s management, but the management stood firm in their resolve. As the director put it, his message to the staff was clearly, “This is the direction we are moving in. Either you are in the boat with us or you are on the dock waving goodbye. If this is not for you, I will respect that and this may not be the place for you to work.”


In addition to collaborating with the universities on academic content, in the mid-2000s, as required by the Brian A. settlement agreement, the state began to offer tuition reimbursement for current staff to return to school to receive advanced degrees and for undergraduate students willing to commit to DCS employment after graduation. These incentives are funded in large part by federal child welfare funds specifically designated for this purpose.93

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Improve assessment: CANS

Before Brian A., DCS did not have an instrument that it used systematically to assess the needs and strengths of children in care and their families; workers used a variety of tools with varying degrees of validity. The Brian A. settlement agreement required DCS to implement a uniform assessment tool. As a result “the sophistication of [the Department’s] assessment tools has changed dramatically” over the years.

Working closely with Dr. John Lyons at Northwestern University, the leadership decided to adopt the Child and Adolescent Needs and Strengths (CANS) tool, a validated instrument commonly used in child welfare and other child- and family-serving systems. DCS chose the CANS because it felt that it was “the assessment tool which best exemplifies strength-based, culturally responsive and family focused casework,” and that it “produces the least stigma...for the children and families served.”94 The tool assesses such things as child safety (e.g., self-harm, danger to others), child mental health (e.g., psychosis, depression, attachment issues); child life functioning (e.g., social functioning, physical development, school achievement), caregiver characteristics (e.g., substance abuse history, mental health status, ability to supervise child), and child acculturation (e.g., spiritual/religious life, social support).95

According to DCS policy,96 every child age five and older receives CANS assessments, the first of which must be completed within five days of the child entering custody.97 The CANS is then administered at regular intervals throughout the child’s time in care,98 as well as at specific events such as revision of a child’s permanency plan, placement moves, trial home visit, and discharge. The CANS may also be re-administered if an incident occurs that requires reevaluation of a child’s mental or behavioral health.

Normally, the child’s primary caseworker administers the CANS. Once completed, a supervisor must approve it. Finally, the assessment is submitted to the regional CANS consultant—a Master’s-level clinician contracted by DCS through the Centers of Excellence for Children in State Custody (COEs).99 These consultants act as third-party reviewers on CANS assessments. Though CANS consultants review every CANS for each child, the extent of the feedback they provide to frontline staff and supervisors varies; consultants spend the most time working with the CANS of children who have multiple or very serious needs. In addition to their role on specific cases, CANS consultants provide training on the instrument; DCS staff receive annual training on the tool and are required to maintain certification for its administration.

Implementing the tool throughout the system was initially a challenge. Administrators had to contend with longtime employees who, because they had lived through several DCS administrations and numerous systemic reform efforts, saw the CANS as “just another initiative.” One DCS Central Office administrator explained:

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94 State of Tennessee Department of Children’s Services, op. cit.: 15.
95 State of Tennessee Department of Children’s Services, op. cit.: 16.
96 State of Tennessee Department of Children’s Services, op. cit.: 15.
97 Recent statistics show that 92 percent of children receive their first CANS within 30 days of entering custody, but that only 63 percent have a completed CANS within five days of entering custody, as required by DCS policy (Brian A. Technical Assistance Committee, op. cit.: 21).
98 According to DCS policy, most children must receive a CANS reassessment at least every six months and/or upon revision of the child’s permanency plan. Children whose severe needs require them to receive the most intensive and restrictive level of custodial services must receive a CANS reassessment every three months or at the request of the regional psychologist (State of Tennessee Department of Children’s Services, op. cit.: 15).
99 “There are three Centers for Excellence (COEs): University of Tennessee’s Boling Center in Memphis serves West Tennessee, Vanderbilt University Medical Center in Nashville serves Middle Tennessee, and Cherokee Behavioral Health Center in Knoxville serves East Tennessee. These Centers provide mental health evaluation and consultation services for children in DCS custody” (Brian A. Technical Assistance Committee, op. cit.: 21, p. 188).
The big thing when this first came out was [that] we had workers... [who thought,] ‘Well, it’s just going to go away. The whole thing, it’ll just go away.’ They were resisting it from day one. They’re going to resist it to now because [they think] things are going to change, and they’re fed up with every four years or eight years having to do something new.

But implementation of the CANS has become smoother over time and has led to more informed placement decisions. Interviewees who talked about the importance of the CANS said that the tool gives workers information critical to selecting the most appropriate placement for a child, such as the mental health services a child might need, behavioral issues to be addressed, and whether or not it is appropriate to place the child in a home with other children.

It is important to note that the CANS produces a suggested intensity of service for the child, not a specific type of placement setting. The task for caseworkers, therefore, is to meet the indicated level of care in the least restrictive setting that is appropriate. Workers are trained to consider all CANS outcomes when developing case plans and to use their clinical judgment to determine the types of service and supervision the child needs. As a child’s CANS results evolve over time, case decision making, especially with respect to assessing the appropriateness of the child’s placement, is adjusted accordingly.

### Child and Family Team Meetings

DCS policy states that the purpose of the Child and Family Team model is

> to engage a group of committed individuals who will work to strengthen the family and help it craft an individualized case plan. This model of practice emphasizes family strengths, mobilizes community resources, and involves all concerned with the child and family in developing and monitoring plans that will maximize the safety, permanence, and well-being of the children involved.\(^\text{100}\)

Child and Family Teams are composed of the child (when age appropriate), parents and other family members, the frontline worker and supervisor, and foster parents or facility staff; they may also include other service providers, attorneys, Court Appointed Special Advocates, and others working with the child and family.

DCS policy mandates that Child and Family Team Meetings (CFTMs) be held at regular intervals as well as at certain junctures in the life of a child's case.\(^\text{101}\) For example, a CFTM must be held whenever a child’s placement changes.\(^\text{102}\) Interviewees often identified the CFTM as integral to improved placement decision making and reduced use of group care facilities.

Prior to implementing CFTMs, DCS held “staffings” to determine children’s placements. Interviewees described these meetings as similar to CFTMs in that they involved several people coming together to make case-planning decisions, but different in that they usually did not involve the range of individuals that participate in CFTMs. Interviewees also noted that before CFTMs, case plans—including placement decisions—were often developed without input from the family, and thus were perceived as a list of directives dictated to families, rather than as a comprehensive strategy to address family needs that built on the family’s strengths.

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102 A Placement Stability CFTM must be held “within 15 days of any change of placement – preferably prior to any change of placement, and no longer than 15 days after a move has occurred” (State of Tennessee Department of Children’s Services, (no date). Child & Family Team Meeting protocol, p. 10. Retrieved July 9, 2010, from http://www.state.tn.us/youth/dcsguide/policies/chap31/CFTProtocol.pdf).
The Department introduced CFTMs in 2003, at a time when it was moving toward more a family-centered, strengths-based practice. The CFTM became a mechanism workers could use to learn more about families’ needs and strengths. And parents, extended family members, fictive kin, and children now had a forum for identifying resources for children. With more people around the table, a greater variety of potential family-based placements could emerge and be explored. As one executive of an ancillary service program noted:

[With CFTMs] there’s at least an attempt to cull together the people who could be important in a kid’s life, which could then result in multiple placement options… Before, [when] children came into care, the placement options were the list of placements on somebody’s desk. The way it’s supposed to be is that the list of options on the desk is a backup and the [resources] that families come up with ought to be the first placements tried.

Within this new pool of placement options were kinship foster parents—family members stepping forward to care for their young relatives who had come into state custody. A number of interviewees talked about DCS’s increased recruitment of kinship caregivers as one factor that contributed to the Department’s decreased reliance on group care. Indeed, between 2000 and 2009, as congregate care use decreased, the use of kinship foster homes increased. Figure 4.1 shows that initial placements with kin rose from 7 percent in 2000 (253 children) to 15 percent in 2008 (560 children). Figure 4.2 shows a similar trend in point-in-time data; on January 1, 2001, 7 percent of children in care were placed with kinship foster parents (472 children) while on January 1, 2009, 20 percent of children were living in such placements (942 children). Although there has been a decrease in the proportional use of kinship foster homes in recent years, the rate of initial placement in such homes in 2008 was still more than twice as high as it was in 2000, and the rate of placement in a kinship foster home was still nearly three times as high on January 1, 2009 as it was on January 1, 2001.

Figure 4.1: Initial Placements with Kinship Foster Parents

![Figure 4.1: Initial Placements with Kinship Foster Parents](image1)

Figure 4.2: Children Placed with Kinship Foster Parents on January 1

![Figure 4.2: Children Placed with Kinship Foster Parents on January 1](image2)

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103 System-wide implementation of CFTMs began in January of 2005.

104 DCS’s definition of “kin” includes “fictive kin,” who may include friends or community members with whom the child has a close relationship.
Those with whom we talked described four different kinds of professional collaborations that improved placement decision making and reduced worker reliance on congregate care. Two of these relate to the work of specialized units within DCS—Regional Well-Being Units and Regional Placement Units. The other two, Cross-Functional Teams and Community Action Boards, are mechanisms that DCS uses to communicate needs to and problem solve with private providers and community partners.

Regional Well-Being Units. Regional Well-Being Units exist in each DCS region and consist of a psychologist, education specialist, nurse, Health Advocacy Representative (i.e., Medicaid/TennCare105 advocate), Master’s-level Social Work Practice Specialist, Interdependent Living106 specialist, and Services and Appeals Tracking Coordinator.107 These professionals are often brought in to CFTMs to consult on cases when a child has issues that fall within their area of expertise and need troubleshooting. Interviewees noted that the analysis and input of the Well-Being Units help workers to better understand children's clinical needs and make the most appropriate placement decision. As one DCS Regional Administrator explained, the Well-Being Unit is

a clinical team or a support team in each region that staff in that region could kind of get with and talk about difficult to place kids, kids at risk of disruption, that type of thing. So [Well-Being Units] added some clinical support to decisions that the regions were making.

The Well-Being Units can also act as a counterpoint to private providers. In her interview, one DCS Regional Administrator talked about how her region's Well-Being Unit improved conversations with providers regarding the need for certain children to stay in congregate care. When she first came into her position, she found that her staff often felt intimidated by the providers; because providers seemed to have more clinical expertise, DCS staff did not feel empowered to question them or their claims about the type of services that children needed. With the introduction of the Well-Being Unit, DCS workers had a resource to which they could turn to assess a provider’s judgment and question a case plan if necessary:

We had [residential treatment providers] that told us,... 'This is what this child [needs to achieve] and he's not meeting [that] so he needs to stay here for a little while longer.' But now we have...our own Well-Being Unit. We have our own psychologists, we have our own educational specialists, we have our own nurse, so...we're able to bounce [the provider's assessment] off of our own internal people and say, 'Hey, take a look at this. Something just doesn't seem right. I think they're wanting to keep this kid a little longer than what is required. So...could you please go and have a conversation with that provider to see what's going on?'

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106 DCS defines an ‘Interdependent Living Plan’ as “a plan that consists of a series of developmental activities that provide opportunities for young people to gain the skills required to live healthy, productive, and responsible lives as self sufficient adults. The provision of Interdependent Living Services is required for any child in DCS custody age 16 years of age or older.” Such services include those that promote “educational progress, maintenance of physical and mental health care, housing opportunities, the formation of supportive adult relationships, knowledge of, and access to, community resources, the acquisition of skills to increase financial viability, and daily life skills” (State of Tennessee Department of Children’s Services. (no date). Department of Children’s Services glossary, p. 35. Retrieved August 18, 2010, from http://www.Tn.gov/youth/dcsguide/glossary.pdf).

107 The Services and Appeals Tracking Coordinator is responsible for tracking the referral to and receipt of health services, and monitors insurance appeals when children and families are denied coverage for services.
Finally, Regional Administrators noted that Well-Being Units also play a role in preventing disruptions of family-based placements. For example, when a child is having behavioral difficulties in school, the school may threaten expulsion, leaving no alternative but to place the child in a group care facility with an in-house school. In these cases, DCS regions often deploy the Educational Specialists from their Well-Being Units to work with educators to identify children’s specific needs and advocate for services that can be initiated in the existing school setting. By implementing the appropriate services and preventing the school disruption, the Education Specialist also prevents the child’s placement in congregate care. Said one DCS Regional Administrator:

We do have education specialists who really work closely with the schools and seem to be really respected by the school systems. And that has really helped a lot, especially those kids that are severely emotionally disturbed and have the behaviors [that the] school [has] a hard time dealing with.

Regional Placement Units. Regional Placement Units play a similar role, but instead of providing expertise on clinical matters, staff from these units—known as Placement Specialists—provide expertise on placement options. The Placement Specialists’ task is to be familiar with all of the placements available within their region. They know which foster families are capable of caring for children with different types of needs and which residential programs provide what types of services. Similar to the Well-Being Units, Placement Units also consult with frontline workers, helping to identify the most appropriate placements for children. As one Regional Placement Specialist Team Leader noted:

[Placement specialists’] knowledge of what’s out there in the community as far as homes and least restrictive environment helps a lot. We’re able to [offer] input at the Child and Family Team Meetings or when we’re making placement decisions....We can...say, ‘Hey you know, I know this home. This home has worked well with this type of child before. Let’s give them a try before we go to congregate care.’ We are seen as the experts in the placements and what they [provide]...and definitely the [frontline workers] value our opinions.

Cross-Functional Teams. Cross-Functional Teams consist of Regional DCS staff and representatives of the private providers serving the region. The groups meet to discuss the progress of certain cases and to share information about where in the region DCS needs to develop specific resources. For example, during a Cross-Functional Team meeting, DCS may share with providers that a change in the demographics or needs of children in care requires the recruitment of additional treatment foster homes. Or, DCS may tell the providers that certain mental health services are needed in a specific part of the region. Providers are then able to inform DCS staff of what they are currently able to supply and brainstorm ways they might be able to meet remaining needs.
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Community Advisory Boards. Community Advisory Boards (CABs) serve a similar purpose, except instead of limiting the conversation to DCS and its provider agencies, CABs engage other individuals such as religious leaders, educators, and those running other community-based programs. Several respondents, including both Regional Administrators interviewed, said that the CABs helped establish a working relationship between DCS and the communities they serve. The CABs enable DCS to convey to the public that the community as a whole must be able to meet the needs of children and families touched by the child welfare system. One Regional Administrator provided several examples of how her CAB has generated resources and fostered collaboration between DCS and local citizens:

Sometimes [DCS staff will] take a profile of a child [to the CAB]...and say ‘This is the type of child that we need a home for. Can anybody help us recruit a home through your church or through your agency?’ That’s been effective in some cases.... We just all work together to see if that community can somehow come up with a way to meet the needs in that particular community, no matter what it is. For instance, we have one small county that had a need for some after-school tutoring. It’s a poor county and so there is not a lot of money up there, but then somebody [in the CAB meeting] said, ‘We just got a grant for that. We can provide [tutoring in] the school up there.’ Nobody knew about it until we were all together in that meeting.

Another Regional Administrator noted that community-based support is especially critical when cases close and DCS and its attendant services withdraw from a family’s life. She said that DCS must educate CABs about the types of children coming through the child welfare system, and especially the different needs those children are likely to have when they return home or get adopted. As she noted, some children need mentors; others need to be engaged to access their cultural backgrounds. Regardless of what the child and his or her family needs,

when we pull out, when the providers pull out, when the continuum people pull out, [we need to know] who’s going to be there for that family long term. It shouldn’t be us. It should be the community that’s going to wrap around that entire family.

Box 9: Using Cross-Functional Teams to Share Resources

One Regional Administrator spoke about how Cross-Functional Team meetings allow DCS and providers to make use of each other’s foster homes. During these sessions, DCS and private providers update each other on what their current needs are. For example, though DCS primarily maintains family foster homes for children with minimal needs, the region may have a foster family who is capable of providing a higher level of care. In this situation, the region may “give” that foster home to the provider, whose clientele are in need of such homes. The opposite may also occur; a provider agency may recruit a foster family that is only capable of providing the lowest intensity level of care, in which case the provider will pass that home along to the Department.

Cross-Functional Team meetings are also an opportunity for DCS and providers to identify the need for a ‘shared home.’ A shared home may be used to place a child with high-level needs in the same home as his or her sibling whose needs are not as great. In such situations, both siblings are placed in the provider home—the home equipped to provide the high-need child’s specialized care. The provider agency supplies all necessary services to the higher-need child, and DCS provides services to the sibling needing the lower level of care.
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Improved administrative oversight of congregate care use

**Gatekeeping procedures.** In addition to the attrition of group facilities and new policies that emphasized least restrictive placement, new gatekeeping procedures reframed group care settings as places where only the most troubled children would go, and then, only for only short periods of time.

In 2003, DCS instituted a policy mandating that caseworkers receive permission from the regional psychologist before placing a child in a hospital setting; in 2009, this sign-off protocol expanded to include placements in lower level residential treatment centers. With this new requirement in place, workers would have to demonstrate that a child recommended for group care had a level of need that could not be met through community-based services. In her interview, the DCS Medical Director—a position created by the Brian A. consent decree— noted that in addition to setting up a needed screening system, requiring the regional psychologist to sign off on congregate care placements served to teach workers about which types of special needs required residential treatment and helped sensitize frontline staff and supervisors to clinical issues that affect children:

> The psychologist is the gatekeeper and I think that has greatly helped educate the system in terms of [congregate care being] only for clinical needs—[that it is] only when those clinical needs can't be met with community services that this youth may even enter this program.

**Utilization Review.** If gatekeeping procedures control the front-end process that can lead to a child entering congregate care, Utilization Review (UR) controls the back end, keeping watch to make sure children do not stay in group care longer than necessary. DCS’s UR is an oversight process in which children's cases are reviewed to ensure that planning and service delivery are moving children towards permanency.\(^1\) UR is also a mechanism through which the DCS Central Office can provide technical assistance to regions that might be struggling with certain cases or types of cases.

UR occurs at the Central Office and regional levels. The Central Office holds quarterly meetings with the UR specialists in each region to discuss the UR process and ways it can be improved. In addition, the Commissioner and Deputy Commissioner personally review all cases of children in residential treatment centers and hospital settings after 120 and 90 days, respectively, of being placed in such settings. Regional UR is ongoing and normally involves the review of cases by the Regional Administrator, Social Work Practice Specialist, and Placement/UR Specialists. Private providers are required to participate in URs every 90 days. These meetings include the provider and a DCS regional office representative—usually either a Regional Placement Specialist or a UR specialist specifically designated to work with providers.\(^2\)

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\(^1\) Utilization Review does not replace regular Child and Family Team Meetings as the focal point for case planning and decision making; UR is a separate oversight process designed for accountability purposes.

Whether at the Central Office or regional level, UR is a forum for administrators to ask important questions about whether DCS and provider staff are doing all they can to meet children’s specific treatment needs and move them to foster homes or to their own homes as quickly as possible. For example, UR allows staff to address cases in which children are approaching the maximum 30-day stay in an Observation & Assessment Center. UR is also a mechanism for examining instances in which children reside in group treatment settings for long periods of time without improving. In such situations, staff must determine why the setting is not meeting the child’s needs and whether a better placement or plan is needed. One DCS Central Office administrator described UR in this way:

[UR is] more of a placement review. So we’re looking at everything. We’re looking at appropriate placements, are [the children] making progress? What are the barriers to permanency? If I’m sitting at [a facility that] has a kid for 300 days and...multiple CANS shows the child getting worse or staying the same, I’m going to ask a lot of hard questions to that agency about what needs to be done: ‘What’s not working? What’s your plan in the future? I mean, this child can’t be here forever. What have you guys done to make him or her successful and where’s the family?’
Several respondents noted that Commissioner Miller’s hands-on approach to UR has been essential to its success. They commented that her UR holds Regional Administrators accountable, ensuring that congregate care is used as a short-term solution for children needing intensive treatment, and that plans are in place to step children down and expedite permanency. As one DCS Central Office administrator said:

Commissioner Miller is very involved with our UR.... She wants to know the number of kids that are in our [various] settings.... How long have they been there? What work are we doing, what actions are we taking to make sure that we find an appropriate placement for them? I know she’s been very hands on,...which I think is really great, having that leadership involved in that piece. And it’s not like [the Commissioner is simply saying,] ‘Tell me the numbers’—we’re actually walking through the cases and that’s very valuable.... The child’s just not a number; we’re actually sitting down and working through the cases.

Using data to track and improve placements

A number of stakeholders discussed how improvements in DCS’s ability to manage and analyze data enabled targeted efforts to reduce group care use, particularly the use of O&A Centers and emergency shelters. Interviewees noted that prior to Brian A., it was difficult to obtain an accurate accounting of where children were on any given day, much less retrieve any nuanced information about their placement type or placement history. The development of an enhanced information system (TNKids; later, TFACTS) allowed for this and has since been used to provide targeted placement guidance at the regional level.

With the capacity to see where and with what frequency regions were using congregate care, DCS administrators focused on regions with high levels of use and provided technical assistance and oversight to reduce dependence on these placements. One member of the Brian A. TAC provided an example:

The improvements in the data allowed [DCS] to say, ‘Everybody around the state seems to be able to cut down and keep kids from staying in these emergency shelters. [If] ten regions are doing it, well, what’s the story in East Tennessee? Why are they [using emergency shelters more frequently]?... You could have a conversation with the Regional Administrator [and ask], ‘Is it something that your kids need that other kids don’t? Is it that there is some resource issue in East Tennessee?’

The Department continues to develop its electronic data archive. It is anticipated that an upcoming version will improve workers’ ability to select appropriate placements, as it will allow the workers to match information on children’s needs directly to available placements particularly suited to meet those needs.

CHANGING RELATIONSHIPS WITH PRIVATE PROVIDERS: THE CONTINUUM MODEL AND PERFORMANCE-BASED CONTRACTING

The development of specialized foster homes and the numerous structures, policies, and practices designed to support children in those homes was spurred in large part by a decrease in available congregate care beds resulting from an important shift in the way DCS contracted with its private sector providers. As noted throughout this report, private providers have always been essential to Tennessee’s ability to provide care and treatment to children in state custody. But private providers in Tennessee
had historically favored institutional care as the placement of choice. Therefore, if DCS was going to reduce its use of group placements, it was going to have to insist that its contractors adjust their philosophies of care, their business ideologies, and the ways in which they managed their finances.

**Working through providers’ initial opposition**

Many private providers, particularly those that were faith-based, had been running group homes, residential treatment centers, or other institutions for decades—some for well over a century. Because of the role they historically played in the provision of care, DCS was still supporting these providers and their congregate care facilities on the eve of Brian A., despite the fact that the greater child welfare field had come to view group care as an inappropriate placement for most maltreated and dependent children. Generally, administrators and caseworkers continued to view the group care facilities as doing good work and perceived the institutions as reasonable, if not ideal, placement options for children.

DCS knew it would be difficult to get providers to cut back on their use of congregate placements and provide care to children in family settings. When it announced that it would no longer purchase group care services in the way it once did, many providers were offended—suddenly DCS was telling them that the work they had been doing (and that DCS had been paying them to do) no longer represented the appropriate way to care for children. Additionally, many providers were worried that they would not be able to supply the kinds of services DCS was now demanding. After all, group care was what they had specialized in for years; changing from a congregate care orientation to one that focused on foster family care and community-based services would require investment in new resources, reorganization of operations, and changes in staff and staff training. In an October 2001 hearing of the state legislature’s Joint Committee on Children and Youth, several private providers expressed concern that they would not be able to serve high-need children appropriately in community settings. One put it this way:

> For me to disperse my residential treatment center [services] out into home communities, I have serious questions about whether I can provide the level of security for those children that I can provide in my residential treatment campus. I doubt I can provide the level of psychiatric and nursing care. I know that those children will not be well received into their homes and into their school districts in the area. They will be stigmatized, they will not be wanted, they will not receive appropriate special education services.

So, the Department worked closely with providers, brainstorming with them ways in which they could retool the resources they already had and acquire the ones they needed. DCS administrators engaged providers in a series of meetings to inform them of how the contracting priorities would be changing and help them to prepare for the shift.

In addition to opposition from the providers themselves, DCS encountered considerable pushback from members of the state legislature at the providers’ urging. One former DCS Central Office administrator described heated interchanges between DCS staff and state lawmakers:

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110 Janchill, op. cit.: 1.
111 See also Casey Family Programs, op. cit.: 92.
I think it’s important to know it was not easy in those early days, politically, to do this. Even with the cover of a lawsuit. You’re talking about decades of relationships that had been established with providers...and now you had an administration telling these providers, ‘We’re not going to place large numbers of kids in your facilities.’ When you sit...in a meeting with providers and they bring the Chair of the Senate Finance Committee with them, you have to be bold and courageous. There has to be bold and courageous leadership on the ground that will do the right thing and accept the consequences that come with doing the right thing. [We] would get calls from legislators... [and] from providers who would say, ‘Well, when the Sundquist administration is over and the new administration comes in we’re going to turn this thing back around. We have relationships with people who are going to be coming in power.’ ... There needs to be some political cover for the leaders who are going to have to make these tough decisions.

DCS also fought opposition from juvenile court judges. For many of the same reasons that they opposed the closing of TPS, judges, in general, did not favor a reduction in congregate care use. During the October 2001 hearing noted above, for example, a Davidson County referee talked about the importance of large institutions, particularly for children adjudicated unruly:

Those are very difficult children to deal with. What we find is in many instances we’re able to meet those children’s needs in a setting that is larger than eight beds. And the reason for that is very simple—you need someone to monitor that child.... [A child can] can wear down a group home parent.... The whole beauty of a larger institution is you may wear down one [staff] person but we have four more behind him that you’re not gonna wear down. For those children, we need to modify their behavior. If we don’t do that we have not served them.... So we’re very concerned that [limiting the use of facilities with more than eight beds] is going to place a limit on our ability to meet those children’s needs.113

During this period of unrest among private contractors, a number of stakeholders noted that one individual in the provider community stood in favor of the reforms—Pat Lawler, founder and CEO of Youth Villages.114 Established in 1986, Youth Villages began as a merger of two residential campuses in the Memphis area. In the seven years that followed, the organization focused solely on group care, expanding its network of facilities around the state. Then, in 1993, the agency conducted a needs assessment of children’s services in west Tennessee and found that the greatest need was not for more congregate care but for intensive services delivered to children in family settings. Armed with this information, the organization embarked on an ideological and structural reorganization. In 1994, with a new mission of serving children in the most appropriate, least restrictive environment, Youth Villages began to invest in family-based programs such as Multisystemic Therapy,115 Intercept,116 and treatment foster care. By 1995, the agency was operating a full spectrum of services, from high-end residential care to foster homes to in-home services designed to prevent placement in foster care.

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113 Hearing Before the Joint Comm. on Children and Youth, 102nd Gen. Assem. (Nashville, TN, October 18, 2001) (Statement of Michael O’Neil, Juvenile Court Referee, Davidson County).
114 See also Casey Family Programs, op. cit.: 92.
115 Multisystemic Therapy (MST) is a family- and community-based mental health treatment intervention that has been successful in preventing out-of-home placement for children with serious clinical problems. Developed by Scott Henggeler at the Family Services Research Center at the Medical University of South Carolina, the treatment focuses on the influence of the child’s environment (e.g., family, peer groups, school) on the child’s symptoms and vice versa. MST is an intensive intervention delivered in the child’s home or community by therapists with low caseloads. For further information on Youth Villages’ delivery of MST, see Youth Villages. (no date). Multisystemic Therapy (MST). Retrieved June 1, 2011, from http://www.youthvillages.org/what-we-do/intensive-in-home-treatment/mst.aspx
116 Intercept is a Youth Villages in-home services program that provides treatment to children with serious emotional and behavioral problems. The program is implemented with families with children who are at risk of out-of-home placement as well as with families preparing to reunify with their children placed in foster care. For additional information on this program, see Youth Villages. (no date). Intercept: Helping families stay together. Retrieved June 1, 2011, from http://www.youthvillages.org/what-we-do/intensive-in-home-treatment/intercept.aspx
By the time DCS started its effort to reduce congregate care in earnest, Youth Villages had been “wearing DCS out for years about [having] too many kids in congregate care.” When DCS announced its move to decrease its use of group care, Lawler spoke out publicly in support of the new policy, reinforcing the Department’s position. Several interviewees spoke about how critical it was to have one well respected provider on DCS’s side. As one member of the Brian A. TAC remembered:

[Pat Lawler was] saying ‘I buy into this. It works. Let me tell you, it was hard for us to do. We had to reorient our staff. It was not easy but, I tell you, we would never go back.’ And that was essentially what he said to the legislature. When the rest of the private providers were coming in telling us how bad this part of the decree was, Pat was out saying [the opposite]... [The other providers were] making their efforts to stem the tide, but were also hearing Pat.

But it would take more than cultivating ideological buy-in to bring the providers to DCS’s new vision for contracted services; the Department would need to offer providers financial incentives to change their practices. DCS accomplished this by using two tools: the Continuum model and performance-based contracting.

The Continuum model

As previously noted, in the early 1990s, before DCS existed as an independent entity, children could be placed in state custody through any number of public social service departments. In those days, the different custodial departments purchased services from private providers by the bed—that is, they purchased a certain number of slots per facility and paid for those beds whether or not they were utilized.

This system was problematic, particularly because it gave the private providers considerable control over the rates they charged for contracted services; with the various state departments competing with one another for a limited number of placement slots and services, providers could take advantage of a seller’s market. Different providers charged different rates for essentially the same service, leaving the state in the awkward position of having to justify paying different prices for the same product based solely on the vendor.

Providers also controlled the types of services they provided. Because the departments did not have clear expectations about the types of services they needed from the private agencies, and did not demand that family-based services be developed, the providers continued to offer the service they knew best—congregate care. As a consequence, these programs became the only placement options for children with mental health, behavioral, and other special needs because they were the only settings receiving rates that would allow for the provision of specialized services.

DCS revised its contracting system in 1996 in an effort to remedy this situation. Under the new method, the Department established rates based on individual children’s needs and the number of days they spent in care, rather than on the type of setting in which they were placed. In other words, instead of paying perpetually for a bed in a facility (that would sometimes go empty), DCS would now pay a provider based on the child’s needs and the number of days the provider served that child.


118 E. Black, op. cit.: 75.
This system allowed the Department more control over reimbursement rates, but other problems persisted. First, the payment structure did not address the fact that children continued to linger in congregate care when family-based services were unavailable. Second, because most providers continued to provide discrete services (e.g., residential treatment facilities) and not a full array of placements or services, a child would often have to transfer between agencies to access a new service or placement. With children moving between providers, holding the contracted agencies accountable for high-quality casework was difficult.

The Continuum model was developed to address these remaining issues. Under this new model, contracted providers would continue to be reimbursed based on the child’s need rather than on the type of setting in which the child was placed. However, providers would be required to diversify the services they offered; they would have to develop a continuum of services. For example, to secure a contract to provide residential treatment services, a provider would also need to offer less restrictive services that could meet the needs of these and other children (e.g., group home, treatment foster care, in-home services, and adoption services).\footnote{119} In addition, Continuum providers were given an enhanced case management obligation and required to provide services to family members and others identified as possible discharge resources.

Because it paid providers one rate based on the child’s needs regardless of the setting in which that child was placed, the Continuum model established a strong incentive for providers to place children with families; as family settings—even with ancillary services—were less expensive, a provider would make more money if it served a child in a family setting than it would serving a child in a group facility. The savings realized could then be reinvested to improve the provider’s capacity to deliver treatment in family settings. Thus, the Continuum model did more than just encourage the use of family-based care—it forced providers to build a continuum of services and it freed funds so that providers could do so.

The Continuum model brought relatively quick changes in children’s placements. In a 2003 report, the Brian A. TAC found that the Continuum model had been “successful in meeting its original goals—making it possible for providers to serve even children with complex needs in family settings, and controlling the high cost of congregate care.”\footnote{120} The TAC went on to state that “if the reimbursement system in use prior to the development of the Continuum model were still in place, far more of these children would be in congregate care.”\footnote{121}

Many stakeholders with whom we spoke echoed the sentiment that the Continuum model was a powerful tool for reducing the state’s reliance on group care. As one DCS Central Office administrator said, the Continuum model provides financial incentives for providers to get kids into the least restrictive environment…and provide either foster care or in home services. At that point, [providers] are,…for lack of a better word, making money on the system. Every day they have the kid in a congregate care setting in the Continuum model, is a day that they are not making money in the system.

\footnote{119} Today, a small number of providers still maintain contracts for congregate care, only. These contracts are usually for very specialized residential services for special populations of children such as sexual offenders and those with addiction disorders.

\footnote{120} Brian A. Technical Assistance Committee, op. cit.: 117, p. 4.

\footnote{121} Brian A. Technical Assistance Committee, op. cit.: 117, p. 6.
CHAPTER 4: REFORMING DCS’S APPROACH TO PLACEMENT: PRACTICES, POLICIES, AND INFRASTRUCTURE

At one point early in the Brian A. monitoring process the TAC recommended that by May 2005, Continuums be required to serve at least 75 percent of moderately disturbed children in their care and at least 50 percent of the severely disturbed children in their care in family foster homes. DCS incorporated these standards into their manual for Continuum providers, and the providers have met them; on December 31, 2009, 95 percent of children served through Continuum contracts for moderately disturbed children and 75 percent of those served through Continuum contracts for severely disturbed children were placed in family settings.

Performance-based contracting

Continuum contracts encouraged congregate care providers to focus on family-based services. However, they did not address the goal of expediting permanency for children in care. To address this issue, the Department instituted performance-based contracting (PBC). Working with consultants from the Chapin Hall Center for Children, DCS began developing its PBC program in 2004. Phase 1 of PBC began with a pilot group of providers in July 2006, and by July 1, 2009, all of DCS's contracted vendors were working under the PBC protocol.

Performance-based contracting “is a form of contract between the government and private sector that exchanges increased performance for the necessary resources and flexibility needed to achieve...higher performance benchmarks.” In DCS’s case, the Department created a PBC program that rewarded providers for three main outcomes: (1) decreasing length of stay; (2) increasing permanent exits (e.g., reunification, adoption, or guardianship); and (3) reducing reentries into foster care.

Through these contracts, a provider’s baselines for each of the three outcome measures are established based on the provider’s recent historical performance, and then improvement targets are set for each provider. Providers are evaluated on an annual basis to determine their performance relative to their baselines and whether they have met their target outcomes. Baseline and target outcomes are re-evaluated and reset for each provider every three years.

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122 Brian A. Technical Assistance Committee, op. cit.: 21.
124 Brian A. Technical Assistance Committee, op. cit.: 21.
128 Once an agency’s baseline performance is established, targets are set at the following standards for performance on the three PBC outcomes: achieving a 10 percent increase in number of children achieving a permanent exit; achieving a 10 percent decrease in number of care days used during the period; and staying within a specified corridor for number of reentries (State of Tennessee Department of Children’s Services, op. cit.: 125). Baseline and target outcomes and are based on a rolling population that includes performance data from the most recent new entries. Children and youth already receiving care from prior years are assessed relevant to their original baselines.
The most critical component of DCS’s PBC formula is that it primarily rewards providers who reduce the number of days that they serve children in state custody (‘care days’), thereby saving the state money. If the provider has improved over its baselines, DCS returns a percentage of the amount saved to the provider. If the provider meets or exceeds its higher target outcomes, the financial reward is further increased. Conversely, if the provider shows outcomes that are worse than its established baselines, the provider must return money to DCS. Box 11 provides the schedule of rewards and penalties based on varying degrees of provider success in exceeding baseline performance and meeting target outcomes.

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129 After determining the degree of improvement with respect to care days, agency performance regarding permanent exits and reentries are factored into a formula, and the provider’s total progress with respect to its baseline is calculated. See the DCS private provider contract template in Appendix E for details on how improvements in permanent exits and reentries are factored into the reward and penalty schedule over and above progress with respect to care days.

130 PBC rewards and penalties are based on the difference in the state share of funds paid to providers. DCS does not include federal funds paid to providers in determining the amount of the reward paid to/penalty levied against the provider as a function of the PBC formula.
### Box 11: Performance-Based Contracting†

The schedule below outlines the various scenarios in which private provider agencies are either rewarded or assessed penalties under DCS’s performance-based contract. Percentages reflect the proportion of the state’s share of funds that the Department either pays to the provider or that the provider must pay to the Department after performance with respect to baseline and target outcomes is calculated.

<table>
<thead>
<tr>
<th>YEAR TWO FORWARD‡</th>
<th>Care Days Equal to or Greater than Baseline</th>
<th>Care Days Less than Baseline</th>
<th>Care Days Equal to or Less than Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exits to permanency less than baseline and re-entries greater than baseline</td>
<td>-100%</td>
<td>80%</td>
<td>90%</td>
</tr>
<tr>
<td>Exits to permanency less than baseline and re-entries less than baseline range and greater than targeted re-entries</td>
<td>-90%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>Exits to permanency less than baseline and re-entries less than or equal to targeted re-entries</td>
<td>-85%</td>
<td>95%</td>
<td>105%</td>
</tr>
<tr>
<td>Exits to permanency greater than baseline and less than targeted exits to permanency and re-entries greater than baseline range</td>
<td>-90%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>Exits to permanency greater than baseline and less than targeted exits to permanency and re-entries less than baseline range and greater than targeted re-entries</td>
<td>-80%</td>
<td>100%</td>
<td>110%</td>
</tr>
<tr>
<td>Exits to permanency greater than baseline and less than or equal to targeted re-entries</td>
<td>-75%</td>
<td>105%</td>
<td>115%</td>
</tr>
<tr>
<td>Exits to permanency greater than targeted exits to permanency and re-entries equal to or greater than baseline range</td>
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<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>Exits to permanency equal to or greater than targeted exits to permanency and re-entries less than baseline range and greater than targeted re-entries</td>
<td>-75%</td>
<td>105%</td>
<td>115%</td>
</tr>
<tr>
<td>Exits to permanency greater than targeted exits to permanency and re-entries equal to or less than targeted re-entries</td>
<td>-70%</td>
<td>110%</td>
<td>120%</td>
</tr>
</tbody>
</table>

† Contract between the State of Tennessee Department of Children’s Services and [Contractor Name]. Provided to Children’s Rights by DCS, March 19, 2010.

‡ In a provider’s first year of PBC, no penalties are assessed if the provider fails to decrease its baseline number of care days. Starting in its second year, the provider is held responsible for reducing care days.
Providers have discretion as to how they spend any bonus funds they receive. Those who want to capitalize on the incentives present in the PBC might direct additional funds toward building the infrastructure they need to continue to achieve PBC goals. This means investing in programs that help children step down from congregate care in a way that helps to ensure placement stability. Thus, success under PBC helps supply the capital that providers need to continue to take advantage of the incentives in their contract. One DCS Central Office administrator described it this way:

If you're smart, you will use that incentive money to enhance the professional qualifications of your staff and build in-home capacity.... If you sit there and you hold on to your residential, you are going to be in trouble five years from now.

Though somewhat more indirect than the effect of the Continuum model on the use of congregate care, there is a link between PBC and DCS's efforts to minimize placements in congregate care facilities. As many noted, it is difficult to achieve permanency for children placed in group settings. Said one DCS Central Office administrator:

The connection [between PBC and] congregate care is this—you cannot get a kid to timely permanency if you've got them wasting away in a congregate care facility. You have got to be working to get them in family settings so they're successful [and can be stabilized] in family settings. You've got to be providing in-home services to really support those reunifications.... Even though performance-based contracting is not necessarily directly measuring placements in congregate care, it is measuring timely permanency. You can't get that without significant shifts in how you're utilizing congregate care.

In addition to requiring providers to meet certain outcome standards, PBC mandated that contractors demonstrate additional evidence of high-quality services. For example, under DCS's PBC, providers must show the Department that they have an evidence-based treatment model guiding their practice. Providers also must have 60 days of operating capital in the bank. In short, all the parts of PBC clarified and held providers accountable for the kind of work that the Department needed them to do. In the end, stakeholders agreed that despite the incentives, PBC was not really about making money but rather about using best practices in working with children and families. One private service provider executive said:

[PBC] really professionalized to some extent a system that...really focused on the maintenance of children in congregate care.... It's not like we could fool ourselves. We knew that the things [PBC] identified that needed to be done were in fact things that need to be done.

A DCS Central Office administrator concurred:

I do think that...continuing with that Continuum model and combining that with performance-based contracting—what that means is that we have a system that in no uncertain terms financially incentivizes our private providers to provide care for kids within family settings with very limited utilization of higher-end treatment facilities and incents very strong engagement with birth families to support timely reunification and other permanency options.

**Trimming the pool of providers**

Between the business adjustments required by the Continuum model and the accountability to outcomes mandated by PBC, providers had to make major changes to keep their contracts with DCS. This took time, and not all of the providers succeeded.
According to one DCS official, in the beginning some contract providers “were Continuum in name only;” though they worked somewhat to develop the required range of programs, they continued to rely heavily on their congregate care services. Some of these providers eventually realized that working this way would lead to monetary losses, while others stuck to their residential programs and found themselves in financial trouble.

Interviewees also noted that when it came to some smaller providers, many did not have the resources to transition to the Continuum model. As a result, several “mom and pop” providers lost their contracts, as did providers that did not have the administrative infrastructure or sophistication to change course. Performance-based contracting further reduced the pool of provider agencies as those that could not maintain improved outcomes ultimately faded out of the picture. Several interviewees spoke about the ways in which providers survived — and didn’t survive — the complicated transition. One private service provider executive talked about how her agency adjusted to DCS’s changing needs:

Some of those agencies who didn’t see how the changes were coming, who dug their heels in and refused to change, those agencies did eventually close. [Our agency] has always been very much about ‘who is our customer?’ From the business side of things, our customer is the Department of Children’s Services. And so we know that as the Department changes and has new initiatives that we can either get on the bus or we can dig our heels in…. We’ve been able to adapt and change all along, and that really has been one of our strengths.

Another talked about providers that were unable to adapt to the reforms:

[The provider community] probably kicked and screamed because before [the reforms] there was very little accountability as far as outcome measurements and records and files and documentation and things like that. And once all those things became mandated, there were [providers] that literally were not able to continue to function because they didn’t have the sophistication to actually document and maintain that information and update it and give it back to the Department in a timely fashion. And so those people fell by the wayside.

Despite these growing pains, trimming down the number of contractors with whom DCS did business was seen as essential to improving the oversight and management of providers. One DCS Central Office official noted:

[When I started my position in 2004,] we had about 85 to 90 providers…. There was no way I could know all those providers. [At that point,] the only way I knew about them was [from] getting calls and complaints about them…. I realized…that we could not get anywhere trying to manage that many providers…. You had to know them personally. You had to know what their facilities looked like. You had to be able to pick up the phone and when you talked to them, imagine their facility…. We knew that performance-based contracting would kind of move us to the place where we could pare that down. Really get to a manageable size where we could actually, intimately know these agencies, know what the product is, know where their weaknesses are. And really begin to partner with them, do a lot of technical assistance, things like that, to really get them where they need to be.

Interviewees estimated that around the time of the Brian A. filing, DCS contracted with between 80 and 100 separate providers. Currently, DCS contracts with 31 private agencies.

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131 The exact number of providers contracted at the time of the Brian A. filing was unavailable. A recent related report notes that in the period prior to implementing PBC, the Department contracted with approximately 70 private providers (Casey Family Programs, op. cit.: 92).

132 Data provided to Children’s Rights by DCS, March 15, 2010.
Enhanced performance contracting

DCS is currently experimenting with a new type of contract in which the state’s two top-performing private providers, Omni Visions and Youth Villages, will receive an increased reimbursement rate to provide care for children with special needs. The expectation is that these two providers are best equipped to step high-need children down to family settings.

REINFORCING SUCCESS

As DCS staff and private providers began to come on board with the new approaches to service delivery described in this chapter, something else happened: success begat confidence, which begat additional success. Once DCS caseworkers and private providers began to see that children with high-level needs could be served well in family foster homes, they felt less and less that they needed to rely on congregate placements. As two different private service provider executives said:

[In] stepping [children] straight from residential [care] to in-home [services] we’ve had tremendous success. As that started to happen we kind of shifted our services, and we’re doing more in-home than ever before.

Having success at doing this made us want to do it more.... As we had success, as we were able to convince our staff of what we were doing, as DCS saw, as judges saw, then more people got on the bandwagon.

In short, being compelled to work in a new way made workers change their practices, but seeing positive results for children in care made them believe, slowly but surely, that DCS’s policies constituted best practice for children in care. Commissioner Miller put it succinctly: “Nothing succeeds like success. Nothing.”
CHAPTER 5
TRENDS IN DCS’S USE OF CONGREGATE CARE SINCE BRIAN A.
CHAPTER 5: TRENDS IN DCS'S USE OF CONGREGATE CARE SINCE BRIAN A.
Over the course of the past decade, the major events and systemic reforms described in Chapters 3 and 4 enabled a dramatic reduction in DCS’s use of congregate care. This chapter provides a quantitative description of that decrease and briefly explains how the demographics of the congregate care population have changed over the years.133

INITIAL PLACEMENTS

Prior to 2000, it was common for children entering foster care in Tennessee to be placed directly in a congregate care setting. Figure 5.1 shows children’s initial placements for each entry cohort from 2000 through 2008. In 2000, 28 percent of children entering care experienced a group setting as their first placement. Only 60 percent of children were first placed in a family setting (i.e., kinship or non-kinship family foster home). Initial placements in congregate care have decreased over time, but have crept up slightly since 2007. Nonetheless, in 2008, the rate of initial placement in congregate care was 57 percent of what it was in 2000.

Figure 5.1: Initial Placements upon Entry into Foster Care

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133 The quantitative findings in this section are based on analyses of the two datasets described in Chapter 2. The statewide database from which these data were drawn, TNKids, allows workers to record children’s placement types in a variety of detailed ways. For example, separate codes differentiate general residential treatment programs from those specializing in alcohol and drug rehabilitation or sex offender treatment. The system also records the degree of intensity of care that the child receives in his or her placement. The Chapin Hall Center for Children collapses these nuanced descriptions of congregate care placements into three main categories, and for the purposes of this study, all three of these categories are considered to be congregate care. Chapin Hall’s three categories are: (1) ‘Congregate care’—this category encompasses various types of group settings including general residential treatment centers and group homes and those specializing in certain services, such as addiction rehabilitation, sex offender therapy, or services for children with developmental disabilities. (Chapin Hall’s ‘Congregate care’ category also includes DCS-run group homes and Youth Development Centers, settings that are intended exclusively for youth who have been adjudicated delinquent. DCS policy indicates that youth adjudicated delinquent may not be placed in settings with those adjudicated dependent/neglected or unruly. Thus, the total number of Brian A. class members placed in DCS Group Homes and Youth Development Centers was very small, ranging between three and 15 on January 1 of any census year from 2001 to 2009. For this study, we did not collect data on the reasons for children’s placements; therefore, we cannot report on why these few children were placed where they were. However, because these children were members of the Brian A. class at the time of the census, they are included in the quantitative analyses as children in ‘congregate care’); (2) ‘Emergency’—this category includes Primary Treatment Centers (also known as Observation and Assessment Centers) where children are placed on a time-limited basis in order to receive a mental health or behavioral evaluation; and (3) ‘Hospital’—this category is comprised of hospital and hospital-like settings that provide in-patient physical or psychiatric health treatment. Children whose placements were categorized by Chapin Hall as ‘Independent Living’ or ‘Detention’ were not considered as being placed in congregate care for the purpose of this study. Children whose placement type was classified as ‘unknown’ were also excluded from analyses.
It is important to note that lengths of time spent in initial placements can vary widely. As mentioned above, particularly during DCS’s earlier years, children were frequently sent to Observation and Assessment (O&A) Centers for evaluation immediately upon entering care. Whereas many children who were placed in O&A Centers remained there for much longer than intended, others stayed in these facilities for only a matter of days before moving to another placement. For this reason it is helpful to look at trends in children’s predominant placements over time.

**PREDOMINANT PLACEMENTS**

For each entry cohort, Chapin Hall calculates children’s predominant placement type — the type of setting in which the child spent more than 50 percent of his or her time in care. Figure 5.2 shows that the trends in predominant placement type are similar to those for initial placement, though they show an even more dramatic decrease in the use of congregate care over time.

Figure 5.2: Predominant Placement Type, by Entry Cohort

<table>
<thead>
<tr>
<th>Year</th>
<th>Family Setting</th>
<th>Congregate Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>65%</td>
<td>26%</td>
</tr>
<tr>
<td>2001</td>
<td>75%</td>
<td>21%</td>
</tr>
<tr>
<td>2002</td>
<td>84%</td>
<td>13%</td>
</tr>
<tr>
<td>2003</td>
<td>90%</td>
<td>9%</td>
</tr>
<tr>
<td>2004</td>
<td>90%</td>
<td>8%</td>
</tr>
<tr>
<td>2005</td>
<td>91%</td>
<td>7%</td>
</tr>
<tr>
<td>2006</td>
<td>92%</td>
<td>7%</td>
</tr>
<tr>
<td>2007</td>
<td>92%</td>
<td>7%</td>
</tr>
<tr>
<td>2008</td>
<td>91%</td>
<td>8%</td>
</tr>
</tbody>
</table>

**POINT-IN-TIME PLACEMENTS**

Point-in-time data show a similar downward trend in the use of group settings since the filing of *Brian A.* Figure 5.3 shows that on January 1, 2001, 22 percent of children in foster care were placed in congregate care. By January 1, 2006, this figure had dipped to 7 percent, but it has been increasing slightly since then. In 2009, the proportion of children placed in congregate care was still less than half of what it was in 2001.

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134 When there is no single placement type in which the child has lived for more than 50% of his or her time in foster care, predominant placement type is classified as “Mixed.”
The analyses above all show a slight increase in the proportion of children placed in congregate care since 2007. One should bear in mind that the overall number of children entering foster care in Tennessee has been decreasing in recent years, so even if the number of children in group settings has been relatively stable during this period of time, those children would constitute an increasingly larger proportion of the children in care. As it happens, the administrative data bear this out; though the absolute number of children in group care has been relatively constant in recent years, their proportional representation has increased slightly due to the decrease in the total number of children in or entering care (see Figures 5.4 and 5.5, below).

135 The percentage in parentheses equals the number of children initially placed in congregate care settings divided by the total number of children in the entry cohort.

136 The percentage in parentheses equals the number of children placed in congregate care on January 1 of the census year divided by all children in care on the date of the census.
DEMOGRAPHIC COMPOSITION OF THE CONGREGATE CARE POPULATION

Race and ethnicity

Figure 5.6 shows that between 2001 and 2009 African American children entered foster care directly to congregate care with slightly greater frequency than they entered the foster care system in general. For example, in 2008, African American children made up 23 percent of the children entering foster care, but 27 percent of the children initially placed in congregate care.

Figure 5.6: Entries into Foster Care and Initial Placements into Congregate Care, by Racial/Ethnic Background

Point-in-time data (Figure 5.7) show that between 2001 and 2007 African American and White children were represented in congregate care settings in roughly the same proportions that they were represented in the general foster care population. In 2008 and 2009, African American children were represented in congregate care settings at somewhat higher rates than they were represented in the general foster care population.

Figure 5.7: Racial/Ethnic Background of Children in Foster Care and in Congregate Care on January 1
Sex

Entry cohort data (Figure 5.8) show that males enter foster care directly to congregate care with greater frequency than they enter foster care in general. Point-in-time data show a similar trend (Figure 5.9); this overrepresentation of males increased between 2002 and 2005, plateaued between 2005 and 2008, and dropped somewhat in 2009.

Figure 5.8: Male and Female Entries into Foster Care and into Congregate Care

Figure 5.9: Males and Females in Foster Care and in Congregate Care on January 1
Figure 5.10 shows that between 2000 and 2008, children entering care directly to group settings were significantly older at the time of initial placement than children entering care directly to family settings.\textsuperscript{137} As shown in Figure 5.11, point-in-time data reveal similar findings.\textsuperscript{138}

Figure 5.10: Mean Age of Children at Entry into Foster Care, by Initial Placement Type\textsuperscript{139}

Figure 5.11: Mean Age of Children on January 1, by Placement Type

\textsuperscript{137} In each cohort year, the difference in mean age between children initially placed in congregate care and children initially placed in family settings was statistically significant at $p < .001$.

\textsuperscript{138} In each census year, the difference in mean age between children placed in congregate care and children placed in family settings was statistically significant at $p < .001$.

\textsuperscript{139} The mean age of children initially placed in congregate care has decreased since 2000 because young children have represented an increasingly large proportion of children entering foster care directly to group settings. In 2000, 13 percent of children initially placed in congregate care were ages zero through four; in contrast, in 2008, 39 percent of children initially placed in congregate care were within this age range (analyses available from author). As shown in Figure 7.2, this is due to the fact that zero- to four-year-olds’ likelihood of initial placement in congregate care has remained flat over the years while the likelihood of older children being initially placed in congregate care has dropped dramatically.
CHAPTER 6

THE EFFECT OF REDUCING CONGREGATE CARE USE ON OUTCOMES FOR CHILDREN IN FOSTER CARE
In scaling back its use of congregate care placements, DCS made significant strides in meeting the mandates of the Brian A. consent decree. But has the change led to improved safety, permanency, and well-being for children in foster care? Most of the people with whom we spoke said that overall, it has.

Of course, numerous factors in addition to placement type contribute to positive outcomes for children—among other things, quality of the placement and the services received from the supervising agency, provision of appropriate ancillary services, and performance of the court all play a role in determining how children fare in the foster care system. Indeed, some interviewees noted that although reducing the use of congregate care contributed to improved outcomes for children, it was DCS’s improved assessment and placement decision-making procedures—which included thoughtful limitations on the use of congregate care—that led to better outcomes for children. These respondents believed that attributing DCS’s performance solely to its use of group care would be short-sighted and struggled somewhat to identify a direct link between DCS’s decreased use of congregate care and the safety, permanency, and well-being of children in foster care.

Indeed, one cannot directly attribute the outcomes of children in DCS’s care over the past 10 years to the extent to which the Department diminished its use of congregate care. And this study was not designed to measure the direct impact of group care use on these outcomes. Nonetheless, data collected through the Brian A. monitoring process and other quality assurance procedures suggest that during the period when DCS was reducing its use of group care, indicators of safety, permanency, and well-being for children in care were improving, as well.

**SAFETY**

Several interviewees believed that children in foster care are safer now that congregate care is used sparingly because it is generally more difficult to keep a child safe in a group facility than it is to keep a child safe in a foster home. Although they acknowledged that bad foster parents do exist and that children are sometimes mistreated in foster homes, they highlighted particular characteristics of congregate care settings that increase the likelihood of safety problems. Specifically, they noted that placing multiple youth—often older youth with behavioral problems—in the same environment increases the potential for conflict; the exploitation of one resident by another is more frequent in congregate care settings than in foster homes, and conflicts are exacerbated by the fact that residents in group facilities receive less individual attention than they would receive from foster parents. A member of the Brian A. TAC explained:

> Anytime you get eight, nine, ten teens in [a facility], it’s a different dynamic [than when a teen is placed in a foster home]. And when you have kids coming in and out of place it’s a different dynamic. And when you have staff coming in and out of a place it’s a different dynamic. So...as you start multiplying the number of teenagers you get all sorts of different dynamics, all sorts
of abilities for kids ganging up on other kids. And set aside the assaultive behavior—even just the dynamic around the psychological pressures [can be destructive]. [A] range of kids, range of need, range of personalities—[it’s] much more difficult to manage eight kids...than to manage one or two kids in a home, or to manage it when it is happening in school during the day.

Former foster youth in particular pointed out that placing youth in group facilities, especially highly restrictive ones, often results in their being branded as “bad,” and that this label perpetuates behavior problems. DCS’s “Level” system, which is used to identify the severity of children’s disorders and needs, plays a key role in this labeling phenomenon; Level 1 children are those considered to have minimal needs, Level 2 children as having more serious needs, and so on through Level 4. As two former foster youth attested, youth in care are highly aware of how the child welfare system categorizes them, and these powerful labels act as self-fulfilling prophecies. One recalled her personal experience:

They just moved me [from my foster home to a group home]. They didn’t tell me why.... I found out I was Level 2 when [the group home staff] said that...I was a ‘run risk’ and that they needed to take my shoes. I was like, ‘How am I a ‘run risk’ when I am a Level 1 and I have never run away?’ So then, that’s when I kinda got the picture. ‘Ok, you know what? You’re gonna treat me like a Level 2, you’re gonna say I did this, you’re gonna say I did that? Well guess what, I’m gonna act like a Level 2. You wanna put a label on me, I’m gonna show you what a label can do.’

Two young women who had lived in the same group home spoke about ways in which the restrictive environment contributed to the residents finding creative ways to get away with bad behavior:

I had a roommate...[who] was taking her [prescription] medication, borrowing the hairspray bottle of the guy across the hall and saying, ‘I’ve got to spray my hair.’ The hairspray bottle would come across to our room. She would [put the] medicine that she didn’t take in the lid, do her hair, put the lid [back on, and send] it back across the hall. And here’s this [other] kid getting this controlled substance.... What I’ve learned about people in general is that they’re highly inventive and generally walls and struggles create more innovative and creative ways to...get what you want to get done. And so kids find a way.... [Trying to] get around [the restrictions] kind of creates, I think, almost a manipulative type mentality.

The guys figured that if they turned on the shower and sprayed their rooms [with air freshener] and started smoking in their rooms, that it couldn’t be smelled. Well, what they failed to realize was that their bathrooms were attached to [the girls'] bathrooms downstairs and our vents were connected.... Therefore, it smelled like a shower up[stairs] ...but it smelled like smoke in our room[s]. [The girls were] sitting there trying to lie ‘cause we didn’t want to get [the boys] in trouble.

Several former foster youth described experiencing major risks to their safety when they lived in group care. Two recounted incidents of facility staff instigating, and in some cases insisting on, fights between residents. Two reported bizarre and aggressive treatment by facility staff, likening their placements to “boot camp” or “prison.” One young man lived in a group care placement that he described as “corrupt,” saying that the staff used no “principles of teaching other than meanness.”

One young woman remembered an instance at her group home when she was playing with a small toy made of glass; when she would not show a staff member what she was holding, he crushed the toy in her hand, cutting her and requiring her to go to the hospital. She also recalled that when she moved to a more restrictive facility, she was manhandled when she would not submit to a strip search:
They made me strip and I was like, ‘You want me to what?!’ I was like, ‘I am not in jail. I didn’t come in no handcuffs, I came in by my DCS worker…. I feel uncomfortable, so if y’all think I’m getting undressed, that is out of the question.’ So we struggled. They actually had to literally force me down to the ground…. That’s where you cross the line. If the state honestly gives anyone permission to put their hands on anyone, any child, any way—the system is all screwed up. Now maybe in prison because you’ve got convicted felons and everything, fine. But you’ve got a child and you restrain them like that?… You’re taking kids [into custody] because their parents whooped them…. Then you put them in a group setting and then some stranger puts their hands on them?

Another young woman, who lived at that same locked facility, recalled a bizarre form of punishment that the staff would use:

What they would do as a form of punishment was allow the girls to call what they would call ‘the huddle.’ You would have to stand military style in a circle while another teenager—who was, like, a Level 3 or 4 in some circumstances, mostly [they were Level] 2—called you out for something they perceived was wrong and you would get punished for it. That system’s very flawed. I mean you can imagine what kind of wreckage would go on with a bunch of girls with their own issues that could just be vindictive and get people in trouble.

Despite the themes that emerged from many of the interviews, several people did not believe that a decrease in the use of group care led to any sort of change—positive or negative—in the safety of children in care. They noted that if children in care were safer today, the Department would have experienced a decrease in Serious Incident Reports (SIRs)—reports of children in care involved in incidents such as running away from their placements, attempting suicide, or perpetrating acts of violence against other children, caregivers, or facility staff. They noted that there has been no change in the number of SIRs since the use of group care was reduced. While these respondents might interpret this as meaning that there has been no change in the level of safety of children in care, it might also be argued that the fact that there was no change in SIRs is actually a positive finding; stability in the number of these reports, despite a decrease in the use of group care, seems to indicate that the same level of safety can be achieved and maintained when children are placed in less restrictive environments.

Two former foster youth felt that congregate care facilities were actually safer for youth when safety was defined in terms of the risk of being thrown out of one’s placement. Both said that they were glad that they had lived in congregate care settings because they felt more secure there than they would have in a foster home, where at any moment their foster parents might decide they no longer wanted them. As one explained:

I didn’t have to worry about where I was going to be the next day. I didn’t worry about somebody getting mad at me or something happening in their life and they couldn’t take care of me anymore. I mean, I knew I was there and I could stay there.

**Quantitative measurement of safety**

Two quantitative data sources suggest that while DCS was reducing its use of congregate care, measures of safety of children in foster care were improving concurrently. Although a causal relationship between decreased group care use and improved safety cannot be demonstrated, these analyses show that indicators of safety improved during the time that DCS was reducing its use of group placements. Figure 6.1 shows that the federally reported rate of maltreatment in foster care has been decreasing since 2005 and that, in fact, the rate in 2009 was half of what it was in 2005.
CHAPTER 6: THE EFFECT OF REDUCING CONGREGATE CARE USE ON OUTCOMES FOR CHILDREN IN FOSTER CARE

Figure 6.1: Proportion of Children Maltreated while in Foster Care\(^{140}\)

Data from statewide Quality Service Reviews (QSR)\(^{141}\) (Figure 6.2) show that since the 2005-2006 evaluation year, the proportion of children whose cases were rated adequate for safety has increased to nearly 100 percent.

Figure 6.2: Cases Rated “Adequate” for Safety (QSR)\(^{142}\)

PERMANENCY

Because congregate care facilities are not places that children can call home indefinitely, they are, by definition, not permanent. Many interviewees agreed that being placed in a congregate care setting also has a negative impact on permanency planning for children in care. Whether a child’s permanency goal is reunification with parents, adoption, or legal guardianship, as one interviewee put it, “you can’t even think about permanency if you have a child in residential [care].”

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\(^{140}\) Data are derived from the measure, “Absence of maltreatment in foster care,” reported by the federal Child Maltreatment report by subtracting the rate of absence of maltreatment in foster care from 100 percent. (United States Department of Health and Human Services. (2010). Child maltreatment 2009. Washington, DC. Author. Retrieved June 1, 2011, from http://www.acf.hhs.gov/programs/cb/stats_research/index.htm#can). Prior to 2005, data for Tennessee were not available in the annual Child Maltreatment report. Note that this figure includes children in state custody through the juvenile justice system for states whose child welfare systems also have jurisdiction over youth adjudicated delinquent, including Tennessee.

\(^{141}\) A Quality Service Review (QSR) is a process that analyzes the cases of a sample of children in state custody and/or children with open preventive cases in order to determine the quality of a state’s child welfare services. Samples are normally collected randomly and are intended to be representative of the state’s custody/preventive services population. Reviews include the analysis of case records as well as qualitative interviews with stakeholders in each child’s case (e.g., family members, child welfare staff, service providers, educators, attorneys, etc.). For information on Tennessee’s QSR process, see State of Tennessee, op. cit.: 71.

\(^{142}\) Brian A. Technical Assistance Committee, op. cit.: 21.
Effect of congregate care on reunification

Research has shown that frequent parent-child visitation increases the likelihood and timeliness of children returning home to their natural families. Visitation allows parents and children to maintain and strengthen their family bonds. It also provides the time and space for parents to practice their parenting skills, initially under the supervision of a caseworker, so that it can be determined when a child can return home safely. Several of those whom we interviewed noted that congregate care facilities are often far from families' homes, which makes visitation difficult. Said one member of the Brian A. TAC:

Very few [congregate care facilities] were located in the communities where these kids lived. It’s very hard to work on reunification and maintain those family bonds when kids are placed in congregate settings. Placing kids with families that can facilitate visitation in a more natural setting promotes most reunifications.

In addition to visitation, parents need to be able to work closely with their children's caseworkers and caregivers toward reunification. When a child is placed in a family setting, foster parents can become mentors to children's parents, modeling positive parenting behaviors and providing support. When parents share what they know about their own children with foster parents, and foster parents update parents on children's adjustment and progress in foster care, a collaborative relationship is created in which both sets of caregivers are working toward the same goals that are in the children's best interest. A DCS Central Office administrator put it this way:

Keeping kids close to home...supports the ability [of] the biological parent to work with the resource parent. Where I think it affects reunification is that if the biological parent can communicate with the resource parent and the resource parent can offer observations or experiences that they’ve learned in terms of being successful with the child, that can translate, I think, more easily to the biological parents.

A DCS Regional Administrator agreed:

The majority of our resource parents work closely with the birth families as mentors.... I definitely think it plays a big role in the reunification process because they are very heavily interacting—the birth families and the resource family together.

Some people with whom we spoke said that congregate care settings do not cultivate the same type of collaborative relationship that can be established with foster families. Though facilities may have dedicated staff and clinicians, and though congregate care providers are required to work with families toward permanency, these interviewees noted that reunification-focused work with parents tends not to be as intensive as it is when a child is placed in a foster home; parents whose children are in congregate care are less involved in their children's care and treatment, and the parents' own needs sometimes go unaddressed. As one DCS Regional Administrator described:

What I saw happening, from my own experience, when the child was in a congregate care setting [was that] the parents [were] kind of off the hook, and so there wasn’t a lot of push to force the parents to address the issues that they had that brought the child into care because the child was being taken care of [in the group facility and] everything was kind of okay.

143 Numerous researchers have arrived at this conclusion. For the earliest study of this issue, see Fanshel & Shinn, op. cit.: 19.
144 This parent-foster parent collaboration is central to current trends in child welfare casework, and a focal point of such programs as the Anne E. Casey Foundation’s Family to Family initiative (see Annie E. Casey Foundation. (no date). Family to Family. Retrieved December 13, 2010, from http://www.aecf.org/majorinitiatives/family%20to%20family.aspx).
Although it is essential that all parents of children in foster care be involved with their children’s care and treatment when possible, this is particularly critical for parents of children in congregate care; when used appropriately, children in group care have high levels of mental health or behavioral needs, and bringing these challenging children home requires their parents to have even more knowledge about their children’s issues and greater skills to address their particular behaviors once they are reunified.

**Effect of congregate care on adoption**

Placement in congregate care also hinders adoption efforts. Recent reports show that more than 80 percent of children adopted from foster care in Tennessee are adopted by their foster parents. Since children in congregate care usually do not have foster parents, such adoptions are impossible. When children are not adopted by foster parents, they are sometimes adopted by individuals in the community with whom they have a connection (e.g., a member of the child’s church, an educator, or a coach). But as a number of interviewees commented, when a child lives in a facility, opportunities for making those social connections are limited. Said one Tennessee Commission on Children and Youth staff member:

[A child is] much more likely to be adopted by people who have been serving as their foster parents and have fallen in love with them. Group placements don’t adopt children. They don’t provide long term placements. They don’t become either adoptive or surrogate grandparents for their children. They don’t provide places to go to for Thanksgiving and Christmas. I think it would have been much more challenging to move anything like the number of children we’ve moved into adoptive placements for the last three to four years if we had not had such a push for getting children in foster homes.

**Quantitative measurement of permanency**

Data that would enable a quantitative analysis of the relationship between DCS’s use of congregate care and indicators of permanency for children in foster care were not collected in this study. However, data collected for the purposes of monitoring DCS’s compliance with the *Brian A.* settlement agreement provide permanency trends during the period of time under review. Figure 6.3, which appears in the *Brian A.* TAC’s most recent monitoring report, provides entry cohort data showing that the rate of children exiting to permanency has increased modestly since SFY03/04. As the TAC notes:

The increasingly steeper curves for entry cohorts subsequent to state fiscal year 2003-2004 indicate that children in later cohort years are exiting to permanency more quickly than did children in the state fiscal year 2003-2004 entry cohort. For example, while 38% of children entering care in state fiscal year 2003-2004 exited to permanency within six months, 42% of children entering care in state fiscal year 2008-2009 exited to permanency within six months. Similarly, while 72% of children entering care in state fiscal year 2003-2004 exited to permanency within two years, 76% of children entering care in state fiscal year 2007-2008 exited to permanency within two years.

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146 *Brian A.* Technical Assistance Committee, op. cit.: 21, p. 82.
Figure 6.3: Cumulative Percentage of Children Discharged to Permanent Exit, First Placements by Cohort Year

Figure 6.4 shows point-in-time data on children’s length of stay in foster care. For all children in care in May 2004, the mean length of stay was 22.3 months (median = 12.5 months). By July of 2010, the mean length of stay had dropped to 14 months (median = 9.3 months), a significant change.

Figure 6.4: Length of Stay in Foster Care

147 Ibid. Note: Exit types included in this analysis are reunification, discharge to a relative, and adoption.
148 As noted earlier, point-in-time data overestimate the experiences of those who have been in foster care for a long time. Therefore, one could suggest that the decrease in length of stay shown in this figure is the result of increasing numbers of long-staying youth aging out of the system. However, statistical analyses available from the author show that this is not the case; DCS’s exit rates to non-permanent settings (including emancipation) remained relatively flat during this time period.
149 This difference in mean length of stay is statistically significant at p < .001.
150 Data obtained from Brian A. class lists provided monthly to Children’s Rights by the Brian A. Technical Assistance Committee, May 2004 through July 2010. Point-in-time data on length of stay prior to May 2004 and for August and October 2004, April through December 2005, January through September 2006, and June 2009 were unavailable.
Finally, Figure 6.5 provides another look at length of stay, showing that since October 2006 (the most recent date for which these data are available), fewer and fewer children in foster care have been in care for three years or longer.

**Figure 6.5: Proportion of Children in Foster Care for Three Years or Longer**

These quantitative data suggest that over the period of time during which DCS was reducing its use of congregate care, measures of permanency for children in care were improving. Although a causal relationship cannot be inferred from these data, the data suggest that the decrease in the use of congregate care and improvement in permanency outcomes are related.

## WELL-BEING

### Effect of congregate care on children’s ability to develop lasting relationships with adults

Some respondents mentioned that group care minimizes opportunities for children to develop lasting emotional relationships with adult caregivers. Whether a child’s goal is reunification, adoption, or guardianship—or that child is transitioning to emancipation—it is critical that children leave foster care connected to an adult upon whom they can rely for support. Though facilities may have staff with whom children develop meaningful relationships, “permanency is relationships that last over time, not over a shift.” One Brian A. TAC member explained:

> It’s very hard to develop lasting relationships with even wonderful staff... It’s much more common for you to hear kids keeping in touch with their foster parents, foster parents keeping in touch with kids. You having your picture on a mantelpiece doesn’t happen [in congregate care]. [If] you call your old group home when you get married, they won’t even know you... You call the person that you stayed with when you get married, she’ll know you, he’ll know you.

Others alluded to the fact that group care does not allow children to attach to adults or impairs their ability to do so, a subtle but important difference to the point made above. Said one DCS Central Office official:

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151 Data obtained from Brian A. class lists provided monthly to Children’s Rights by the Brian A. Technical Assistance Committee, October 2006 through July 2010.
The other thing I think that's so terribly dangerous about residential care is that, you know, relating is hard, and it’s so easy in a residential system to sort of follow the rules but not connect, not do that hard work of relating to people. And we worry a lot here around kids [in congregate care]...not feeling that they’re valued by an adult because [the adults they are with are] just [on] another shift. The more you sort of disconnect from those relationships, and if you do it for extended periods of time, the outcomes are not good for those kids. So that’s why we think it’s so important to not overuse residential care.

Not all former group care residents with whom we spoke shared this view; some said that it was possible for a child to develop meaningful relationships to supportive adults while living in group care and talked about maintaining friendly relationships with their facility caregivers after exiting foster care.

**Effect of congregate care on child and adolescent development**

Another issue that people raised was a concern that congregate care settings are not conducive to healthy social/emotional development. They noted that children living in group settings may not experience the shared responsibility and compromising inherent in family life. Several reflected specifically on how group care does not allow teens to assert independence, take risks, and test boundaries in the way that life in a family does. As one Brian A. TAC member noted:

Life in a group facility especially for an adolescent is disempowering, demeaning, and runs contrary to all the things you’re supposed to be doing as an adolescent, which is being with peers, having a certain amount of freedoms, developing a certain amount of responsibility. All those things that one associates with normal adolescent development are very hard to do in a group facility where you have rules that are [implemented] across the board for everybody there. Usually [the rules are] geared to the lowest common denominator because of issues of fairness.

A DCS Central Office administrator agreed:

A part of growing up is children having an opportunity to take risks and learn from that risk taking.... And it’s very hard for children to learn some of those safety lessons if they’re in an overly structured protected environment.... If one of our [foster] kids gets ticked off and goes running out the front door and down the road then our [caregivers] call the police. That’s what they have to do. I understand that. I lived in the country when my children were growing up. My daughter would...go slamming out the front door and walking off down the street. Well, we didn’t call the police. We didn’t even think much about it. We knew she was blowing off steam.... Well, our kids don’t get that kind of learning experience that kids in a permanent environment, in a family setting have.... Congregate living is such an aberrant experience. Being in state custody is aberrant across the board. But being in a congregate environment without that stable family out there is really an aberrant life for a child.

Several expressed concern about children in congregate care becoming institutionalized, believing that when children spend too much time in group care, they grow to feel safe in that environment, making it difficult for them to integrate later into a family or community setting. Two people who compared the institutionalization resulting from congregate care to that which occurs among prison inmates. One DCS Central Office administrator stated:

[Children experience congregate care] just like adult correctional inmates. The longer they are in prison, the tougher it is for them to make their transition back to the community. The same way with kids. The longer they are in institutional care, the tougher it is for them to make that transition back into a family community setting.
And several talked about the importance of children “learning” to live in a family environment after experiencing abuse or neglect. They spoke about family settings as the most “normal” settings and characterized that normalcy as critical for children in care. As one private service provider executive explained:

I think it’s always better when a child can be in a home situation where they incorporated into a family that functions like a family. You know,... you go to school, you go out to eat together, you sit around the table and you eat supper, you watch TV, you go to football games. I mean, the family unit [is] the basic building block of our community or society.

**Box 12: Empowering Youth in Residential Care as a Precursor to transitioning to Family Settings†**

It is critical for children whose mental health and behavioral needs require the intensity and supervision of a residential treatment program to be able to return to family-like settings as soon as it is appropriate. Centerstone, one of DCS’s private service providers, offers two small, community-based residential treatment programs for children in DCS custody with high-level mental health needs. These programs are based on an innovative approach to service delivery which, according to program staff, leads not only to children’s rehabilitation but to their success and stability once they have stepped down to less restrictive placements.

Traditional models of residential treatment are based on the principle that if children learn to comply with program rules, they will cease to exhibit aggressive or dangerous behaviors. Such programs use tools such as token economies, point systems, and other kinds of rewards and punishments to train residents to conform to expected behaviors. But Centerstone has found that although rule compliance may extinguish problematic behaviors, it does not equip children for the relationships they will encounter living in the “real world.” Rather, the agency believes that through rule compliance, youth become accustomed to the expectations and consequences of the artificial, staff-controlled environment and are therefore less capable of functioning in a more normalized, but also more unpredictable, family setting.

With this understanding, in the mid-2000s, Centerstone shifted its treatment approach from one that was staff-controlled and rules-based to one that was youth-driven and focused on empowerment. Although programs continued to contain the same group and individual therapeutic interventions, they contained new components, including:

- focusing on trusting staff-youth relationships as the foundation of successful treatment;
- involving youth in the creation of their own treatment plans;
- having youth write their own progress notes;
- engaging youth in task analysis to improve problem-solving skills and promote self-responsibility;
- responding to youths’ aggressive behaviors with support and understanding, rather than through directives or demands; and
- determining individually appropriate consequences for bad behavior, as opposed to one-size-fits-all, agency-determined punishments.

Centerstone has found that this youth-directed approach gives their residents a greater sense of control and self-respect, which leads to fewer behavioral problems and better self-regulation. Moreover, they have found that highly individualized staff-youth relationships enable youth to navigate relationships when they move to family settings.

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Two of the former foster youth with whom we spoke described group home experiences that did not fit the stereotypical view of group homes as “institutions.” Though they agreed that family settings were preferable, they believed some group homes could approximate normal teenage life. One young woman recalled having a relatively positive experience at one of her group homes, remembering cookouts and basketball games. She said that the facility staff “didn’t treat us like residents, they didn’t treat us like a file—they treated us like kids.” Another former foster youth who spent time living in the same group home also recalled that her experience there was a relatively positive one:

It was a group home, but it was an awesome group home.... It was really kind of weird [to think of your] home [as] a place that is [made of] concrete blocks.... It just looked like you were living in a jail ’cause of all the cement and gray. I mean group homes don’t really have a lot of money or funds accessible to turn it into a home setting so what could I expect? It’s not The Ritz or anything, but it was a good experience as far as a group home could go.

The TPS alumna whom we interviewed felt even more strongly that her group care experience did not have an institutional feel. She felt that she was able to have a normal adolescent life while living at the school, describing friends and young romances, going to sporting events, and being part of TPS’s robust school spirit. Especially when reflecting on her school and social life, she felt that TPS provided a better environment than the one she left. Before moving to TPS, she was picked on at school for being poor; by the time she was in sixth or seventh grade, she did not want to go to school at all. At TPS, she felt that she finally fit in. She credited the school with affording her opportunities that she felt she never would have had if she had remained in a community public school.

### Effect of congregate care on children's experience in school

This positive perception of in-house schools, however, was a minority view. Indeed, the third major theme that arose regarding child well-being in congregate care settings was that children's inability to attend a community school compromises their social lives and academic development. As one attorney for the plaintiffs recalled:

One of the significant and harmful byproducts of [DCS's] overuse of both large group homes and particularly emergency placements were these sort of single room in-house schools. I can remember during the investigation...learning from the providers and advocates and kids of single-room schools in shelters with one teacher and maybe an aide for kids ages six to 16 or plus with no age appropriate or developmentally appropriate curriculum. Kids really talking about reading magazines and taking cigarette breaks and that was school. Just really a gross deprivation of any sort of basic education needs.

Several of the former foster youths with whom we spoke described the schools at the facilities where they lived as wholly inadequate. One young woman recalled that at her in-house school,

[e]veryone was on a different level, everyone was in a different grade. You had one teacher trying to teach different grades, different subjects. I got so lost I probably would have flunked if I went into a regular school the next day.

Another former foster youth, who lived in a group home when she was 16 years old, recalled that her peers who attended the in-house school were learning material that she had covered in sixth or seventh grade. She felt lucky that special arrangements were made for her to continue attending the magnet school she had been enrolled in at the time she entered care. Yet another former group care resident recalled a similar experience: She attended the in-house school at her facility, and felt that she was only able to pursue a real education because a certain teacher looked out for her:
There was a lady [at the facility] who was really, really cool because the school there was set up where we were just doing simple math, like adding two plus two and learning fractions. I would finish my work...and we would have like five hours left of school. And this was kind of like remedial level stuff. She got books from the college and let me do whatever classes I wanted to take. She was awesome.... She was like, ‘Even if you don’t like being here, get in a book—it’ll take you somewhere else.’

The Brian A. settlement agreement mandated that DCS conduct an evaluation of all in-house schools run by both the Department and its contracted providers. As a result of this process, in-house schools were either improved, so that they provided residents with an appropriate education, or phased out. In-house schools do remain today; contractors providing residential treatment facilities must maintain one. But these in-house schools are to be used only in the event the children in their care cannot go to school in a community setting.

In addition to academic concerns, interviewees focused on the inability of in-house schools to provide normal school environments for children. They spoke about school as a stabilizing factor in a child’s life and how allowing children in care to stay in their home schools allows them to keep important friendships and community ties.

**Effect of congregate care on children’s health and physical well-being**

Two former foster youth noted that their physical health was not addressed appropriately while they were in congregate care; specifically, they recalled not having serious medical conditions addressed. One remembered having a seizure and hearing the staff member attending to her say, “I’m not going to call the ambulance. I’m just going to put her back in bed.” Another, who contracted an eye infection while at a highly restrictive facility, recalled that when she complained about her condition, staff thought that she was simply looking for attention and special privileges:

I got this really bad eye infection and had to wear sunglasses.... I [said to the staff], ‘I need to go to the doctor.’ They did not take me to the doctor for a week, and it turned into [a very serious condition], and the [doctors] were like, ‘You might lose your eye.’ And it’s still damaged. [At the time, the staff said,] ‘You just want to wear your sunglasses.’ And I was like, ‘No, I really don’t want to wear my sunglasses, this is just an extremely painful thing.’ They didn’t care. It didn’t matter. They thought that every child was unruly...[and that] we were all just bad kids.

**Quantitative measurement of well-being**

QSR data suggest that during the period of time that DCS was reducing its use of congregate care, some indicators of child well-being—particularly those pertaining to education—were also improving. For example, Figure 6.6 shows that since the 2005-2006 QSR evaluation year, the proportion of children’s cases rated adequate for ‘Learning and Development’ has improved greatly. The data also show a small increase in the proportion of cases rated adequate for ‘Health/Physical Well-Being’ and a very recent increase in the proportion of cases rated adequate for ‘Emotional/Behavioral Well-Being.’ Again, though a causal relationship between the decrease in congregate care and improvements in well-being cannot be inferred, the fact that these trends occurred simultaneously suggests that they are related.
It is important to note that in the child welfare field today, questions persist about how best to measure children’s well-being. For example, statewide QSRs and the federal Child and Family Service Review (CFSR) measure the extent to which children’s physical, mental, and educational well-being is addressed appropriately by the child welfare agency. Some do not believe that this is an adequate way to address well-being, and point to the fact that individualized assessments using validated tools can more directly measure children’s emotional and psychological functioning and adjustment (acknowledging that to do so for all children, or even a sample of children, in foster care would be extremely costly). Further, although safety, permanency, and well-being are widely referred to as the three main outcome areas to be measured in child welfare research, some researchers suggest that this is a false categorization, and that safety and permanency themselves are elements of a child’s well-being. In summary, interviewees most directly connected DCS’s reduction in the use of congregate care to improved permanency outcomes for children in foster care. They also connected limited congregate care use with improved opportunities for children to establish meaningful relationships with caregivers, improved opportunities for normal child and adolescent development in the context of family and school, and a decreased likelihood of experiencing safety problems associated with group placements.

The conundrum here is similar to that which is present in the existing social science literature: It is extremely difficult to account for all of the factors influencing safety, permanency, and well-being so as to tease out the influence of congregate care placement on children’s outcomes. As one Children’s Rights attorney said with respect to the effect of reduced congregate care use on safety:

Certainly there were a lot of concerns over abuse in care and poor supervision in a lot of the group homes and the like when we brought the case, and so by eliminating those placements we’ve certainly eliminated those problems. But...in terms of causation, that [relationship between group care use and safety] strikes me as hard to draw.

Nonetheless, as can be seen above, there are both quantitative and qualitative data suggesting that the safety, permanency, and well-being of children in foster care have improved since 2000; it is likely that the Department’s reduction in congregate care played a role in that change.

152 Brian A. Technical Assistance Committee, op. cit.: 21.
CHAPTER 7
TENNESSEE CONGREGATE CARE TODAY: CURRENT USE AND AREAS NEEDING IMPROVEMENT
By and large, the people with whom we spoke believed that DCS’s congregate care reforms since 2000 improved both the foster care system and outcomes for children in care. As a result of the policy, practice, and infrastructure changes, they said, congregate care is used much more appropriately today than it was in the past. However, respondents also raised a number of challenges that the Department continues to experience in its efforts to control group care use.

QSR data support the claim that group placements are used more appropriately today than they were in years prior; as shown in Figure 7.1, the trend in the proportion of children rated as appropriately placed has generally been positive since the 2005-2006 evaluation.

**Figure 7.1: Cases Rated “Adequate” for Appropriateness of Placement (QSR)**

Another way to assess the degree to which group care is used appropriately is to look at the age of children placed in such settings; when it is used correctly, one should expect low numbers of young children placed in group care. Figure 7.2 shows that, since 2000, the likelihood of initial placement in group care has, indeed, decreased for children ages five through 12. In 2000, 20 percent of children in this age group entering care were initially placed in group facilities; by 2008, this proportion had shrunk to 2 percent.
Figure 7.2: Initial Placements in Congregate Care, by Age Group

Point-in-time data reveal a similar trend. As Figure 7.3 shows, the proportion of children ages five through 12 placed in congregate care at any point in time has decreased since 2000. Very few children under four years old have been placed in congregate care at any point in time throughout the period under review.

Figure 7.3: Placements in Congregate Care on January 1, by Age Group

Although analyzing the age of children in group care is one way to determine if such placements are being used appropriately, other variables should be considered as well. Unfortunately, this study did not collect administrative data on whether children’s placements were in the least restrictive environments to meet their needs or on the myriad other factors that play into placement decision making, such as efforts to place children in their home communities, with relatives, or with siblings.

156 These analyses are based on the administrative datasets described in Chapter 2. Whereas the likelihood of zero- to four-year-olds initially placed in congregate care has remained relatively flat over the years (between 8 and 12 percent), the likelihood of children in this age range residing in congregate care at any point in time has held steady over the years at 1 percent or lower (see Figure 7.3). This trend is likely due to these children’s short initial stays in group facilities before placement in a family setting.

157 These analyses are based on the administrative datasets described in Chapter 2.
WHO IS PLACED IN CONGREGATE CARE TODAY?

The profile of children in Tennessee’s congregate care population today should be examined in the context of the state’s general foster care population. A number of interviewees remarked that over the years, as the number of children entering foster care has gone down, the severity of the needs of children in foster care has gone up because by controlling foster care entries, only the children who have been the most seriously victimized are the ones who enter state custody.

DCS’s analysis of children’s CANS assessments may shed light on the level of intensity of care that children in foster care have required in recent years. Interestingly, the available data contradict the stakeholders’ perception that children in care are currently presenting with more difficult profiles. Figure 7.4 shows the distribution of first CANS scores for children in three successive entry cohorts. Over these years, more children have actually been recommended for the lowest level of care (Level 1) and fewer children have been recommended for higher levels of care. This finding suggests that, on the whole, children entering care in recent years are actually coming in with slightly fewer risk factors and troubling behavior patterns, not more.

Figure 7.4: First CANS Recommended Level of Care

<table>
<thead>
<tr>
<th>Entry Cohort</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/18/08-4/2/08 N=378</td>
<td>56%</td>
<td>25%</td>
<td>13%</td>
<td>5%</td>
</tr>
<tr>
<td>2/18/09-4/2/09 N=376</td>
<td>63%</td>
<td>23%</td>
<td>11%</td>
<td>4%</td>
</tr>
<tr>
<td>2/18/10-4/5/10 N=435</td>
<td>65%</td>
<td>19%</td>
<td>12%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Figure 7.5 shows the average first CANS score for children in the same three entry cohorts. Again, the data show that the recommended level of intensity of care has decreased slightly over the last few years.

Figure 7.5: Average First CANS Recommended Level of Care

158 Because the CANS was not archived electronically until 2008, CANS data are only available for part of 2008, all of 2009, and part of 2010. Point-in-time data could not be analyzed because data were not available for the same date in all three years. Therefore, DCS provided entry cohort data for three constructed entry cohorts: Children entering care between 2/18/08 and 4/2/08, children entering care between 2/18/09 and 4/2/09, and children entering care between 2/18/10 and 4/5/10.

159 Data provided to Children’s Rights by DCS, November 3, 2010.

160 Data provided to Children’s Rights by DCS, November 3, 2010.
Regardless of whether children’s CANS scores have actually increased in recent years, interviewees agreed that, for the most part, children placed in congregate care today are the most troubled children in state custody. These are children with serious emotional and behavioral problems who might pose a danger to themselves or others. Young people in need of therapy for sexual offending or those with addiction disorders were particularly mentioned as likely to be placed in treatment facilities, as were those with ‘dual diagnosis’ needs (i.e., comorbid mental health and substance abuse disorders). There was consensus among respondents that when these children enter residential settings, it is because they “need to be there”—that is, that they require the intensity of treatment and/or the restrictiveness that congregate care settings provide.

However, interviewees said that although children in congregate care may initially be placed there appropriately, they often remain there longer than necessary. Interviewees talked at length about the continuing difficulty in moving these “hard to place” children into family settings, stating that family placements are hindered by the fact that few foster parents are willing and able to take in children in

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**Box 13: Providing Intensive, Time-Limited, Residential Substance Abuse Treatment†**

Residential treatment facilities have made efforts to design therapeutic programs that allow children to step down from congregate care settings in a timely way. In 2008, the Florence Crittenton Agency began piloting Youth Summit of Recovery, a time-limited, high-intensity residential treatment program for youth with substance abuse disorders. The goals of the program were to have youth successfully complete treatment within 60 days and then either be discharged to home or stepped down to a less restrictive group home or foster home.

Youth Summit of Recovery employs a rigorous curriculum. Youth attend eight therapeutic and skill-building groups throughout the day (for example, early recovery skills, anger management, 12-step work, and psycho-educational groups) and participate in support groups and independent living skills programs. Adolescents receive individual counseling three times per week, group counseling five times per week, and family counseling once per week. Individual and family therapy sessions are conducted by Master’s-level clinicians who use two main types of therapeutic models: Trauma-Focused Cognitive Behavioral Therapy, a highly structured model in which clients process the trauma they have experienced and develop coping skills to deal with that trauma, and Motivational Interviewing, a client-centered method that helps clients identify intrinsic motivations for changing their problematic behaviors.


‡ Youth Summit of Recovery was primarily designed for youth entering state custody through the juvenile justice system.

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161 This sentiment has been echoed by participants in a recent Casey Family Programs study of Tennessee’s foster care system (Casey Family Programs, op. cit. 92).

162 Interviewees also highlighted that a large proportion of children and youth in state custody placed in congregate care today are those who have been adjudicated delinquent. These are youth who have committed crimes and are placed either in secure, locked Youth Development Centers (YDCs), or in DCS-run group homes for youth stepping down from YDCs. Though they often have similar histories and treatment needs as children adjudicated dependent/neglected or unruly, delinquent youth, as noted above, are not the focus of the present study.

163 Unfortunately, due to the format of the CANS data we received, it was not possible to identify the placements for all children in the sample. Thus, we were unable to analyze whether children placed in congregate care had higher CANS scores than children placed in foster homes.
need of “high-end” care. The persistent challenge of finding homes for such children may explain interviewees’ perception that children entering foster care are “more difficult” today than they have been in the past.

A number of people noted that foster parents can be intimidated by the intensity of care that these types of children require in a family setting. Caring for a child with serious needs often means managing special education, psychotropic medications, and appointments with various mental health services. It also may mean maintaining a relationship with the residential facility from which the child steps down, as children with serious psychiatric problems may need periodic spells in group settings for acute care. Said one DCS Central Office administrator:

There is that small group of kids where we know [they will be involved in some way with group care facilities for] their whole life. And we’ve got to work with these families that we hope to be permanent to understand this, that that child periodically may well need a two-week stay in a high-end residential facility...[to] get his meds managed, to get him stabilized. And that may just be the course of his particular illness.... But that doesn’t mean that [when residential care is needed], that [that foster family isn’t] still home for that child.

Caring for a child with complex needs is also costly. Thus, lack of financial resources emerged as an impediment to maintaining high-need children in family rather than congregate care settings. Several people noted that rates paid to foster families often are insufficient to cover the cost of everything that a child requires. As one psychologist who consults with DCS noted, foster parents must often supplement their foster care maintenance payments:

There’s no way [to care for very ill children] without the money.... There has to be enough so that the foster parents that are willing to accept these children don’t have to worry about finances...because there are going to be exceptional needs of time, of effort, of everything else that goes along with working with the children. And so even if there are foster parents that might be willing to work with the children, there’s still that financial need that’s there. The foster parents that I know of personally that have...high-maintenance kids...hold part time jobs just so they can pay the medical expenses of these children.

In short, foster parents of children with special needs must be committed, resourceful, and dedicated to the children for whom they are caring. Because the pool of such families is small, sometimes an appropriate family is not available when a high-need child enters care or when such a child is ready to step down from congregate care. One interviewee described the lengths workers went to in order to find a home for a child who had been sexually violent in the past, but was now stabilized:

This poor kid and his poor history. I just couldn’t blame anybody for not wanting this kid in their home.... [The staff] worked so hard to find this kid this great placement and really we could see all the stuff they had done for this kid. Really working to step him down.... [But] there [have been] several instances where there is...a really thoughtful step down process but no homes.

A guardian ad litem talked about how difficult it was to find a foster home for a client who had very specific needs:

She needed a home with a single mom, no animals, no other children, [and the foster parent needed to be able to] attend to all of the school issues that she had. It’s just hard to find a person that fits those criteria.
Finding homes for teens without mental health needs also remains a challenge. Unfortunately, there continue to be many instances of older youth without high-end needs who are living in group settings because foster parents are frequently unwilling to take in teenagers. As noted earlier, teens are perceived as hard to control, not only because of the behaviors that stem from their histories of abuse or neglect but because of their behaviors that constitute the acting out and boundary pushing of normal adolescent development. As one guardian ad litem said:

It’s relatively easy to get foster parents who want a well-behaved child who needs a place to stay. It’s another question to [find] foster parents who will deal with children, especially teenagers, who have behavioral issues in addition to the fact that they’re teenagers.

**FOSTER HOME RECRUITMENT EFFORTS**

Despite their commitment to the foster home recruitment and retention practices described in Chapter 4, foster home development remains a persistent problem for both DCS and the private providers. With numerous agencies looking for new foster parents all over the state, competition to find new homes is “just fierce.” Whereas some felt that the system has made progress in this area in recent years, others felt more defeated. For instance, one Court Appointed Special Advocate said, “I’ve never known a time when anyone said we have enough foster homes.” A DCS Central Office administrator agreed that maintaining a sufficient cadre of foster homes is a persistent challenge:

We are struggling a little bit with foster home capacity.... I think we have made tremendous strides, but I cannot say that we are there. I don’t know that any part of the country will ever be there. It’s the kind of work that you have to do continuously.

The Brian A. TAC has echoed the concern about DCS’s foster home capacity. In fact, in its most recent monitoring report, the TAC listed resource family recruitment and retention as one of five main areas upon which the Department still must improve. It noted that in recent years, the number of foster homes available to DCS has decreased, and that while the foster care population has also decreased, “that reduction...has been outpaced by the...reduction in the number of resource homes.” The TAC reported that to address this issue, DCS has decided to focus its efforts on two main areas—increasing foster parent retention through better engagement with foster parents, and increasing its use of kinship foster homes through improved engagement with relatives. Of course, improving recruitment and retention of foster homes is not solely about increasing the number of foster parents but also about improving their qualifications. Finding individuals who are willing to become foster parents is one challenge, but finding foster parents who are equipped to care for children with special needs—particularly teens and children with serious treatment issues—is entirely another.

164 Brian A. Technical Assistance Committee, op. cit.: 21, p. 9.
QUALITY OF FOSTER HOMES

Fitness of foster parents

A number of people noted that the foster homes that do exist range in quality. Several felt that, in their efforts to enlarge their cadre of foster families, DCS and the private providers have licensed foster parents who are ill-equipped to care for the children placed in their homes. This is of particular concern when foster parents are expected to care for high-need children stepping down from congregate care. A legislative staffer for the State Assembly’s Joint Committee on Children and Youth noted:

I believe that in today’s world you have a maximum pool of families who can create those positive outcomes [for children]... When we force ourselves to go all the way with [family-based care], as has kind of been the philosophy here...[we] pull in more foster families that can’t deliver the good outcomes...

In some instances, stakeholders related the diminished abilities of foster parents to DCS’s recruitment of kinship foster parents. While several applauded DCS’s increased use of kin,165 with some saying that the Department could even do a better job of recruiting relatives to step in as foster parents, two members of the judiciary expressed concern that kinship foster parents are not always prepared to take care of their relatives. They also reported that kin do not always receive the support they need from DCS:

I do think they’ve made a real effort to locate relatives. I’m not sure they ever give the relatives the support [that they need].

I don’t know that the kin that they are using really understand all of the benefits that they can access through [the Department].

Foster parent training and support

A number of interviewees said that foster parents need better training so that they can be knowledgeable about the needs of the children in their care and how to address them. A child and family advocate reported:

A lot of times what we hear from [foster parents]...is [that] they receive training, obviously a lot on the procedure, which they need to have, [but they don’t have]...an idea of how to effectively deal with the kids they’re going to see... And what we hear from them is if you’re better prepared, if you know that a child who has a certain diagnosis and know a little bit about their background, you can anticipate some things. Be prepared for that. Plan for that so that you can handle it.

Several respondents spoke about foster parents needing specialized training so that they can address the specific needs of a child. For example, they noted that foster parents do not receive adequate preparation for parenting teens or children addicted to methamphetamine. According to one of DCS’s consulting psychologists:

165 Kinship placements are often considered optimal because, among other reasons, they provide some continuity of care and are presumed to minimize trauma by allowing children to keep important family and cultural ties while in state custody (Shlonsky, A. R., & Berrick, J. D. (2001). Assessing and promoting quality in kin and nonkin foster care. Social Service Review, 75(1), 60-83).
There are some issues associated with working with an 11-year-old who may have an addiction to methamphetamines that are unique. To have those services in place, to know where to go to get the help immediately and to be able to have the effective intervention—that would actually help the placement, [and] help the child stay in that placement.

Interviewees also said that foster children often do not receive recommended therapeutic services and that foster parents do not receive the supports they need to care for the children in their homes. Some noted that inadequate support leads not only to substandard care for children but to difficulties in maintaining placements; when foster parents do not receive needed services, rather than fight for resources, they may refuse to continue caring for the child. As one child and family advocate said, when foster parents “do run into a crisis, the type of support that’s provided could be enhanced. The option to move [the child] shouldn’t be the first step.” A foster parent advocate agreed that more children could be stabilized in family settings if foster parents received more support from the Department:

There are homes out there that if they had the proper training, the proper resources...[and felt] that they are a part [of a team] and [that] somebody is listening to them, I think they would be more open to take kids that they are turning away from their doors.

**INCORPORATING ASSESSMENTS INTO PLACEMENT DECISION MAKING**

As noted above, DCS’s implementation of the CANS contributed to casework staff making more informed and appropriate placement decisions for children in care. However, DCS’s CANS Director noted that the Department is still struggling somewhat in getting frontline workers and supervisors to integrate the CANS into their daily practice. Whereas more and more workers are using a child’s CANS in case planning, there are still some who complete the assessment simply because it is required, without using it to inform their decision making. As one DCS Central Office official noted, ongoing training continues to address this issue, focusing on how supervisors can use the CANS in working on case plans with their frontline staff:

We do...lots of meetings with the [casework] team[s]... [We ask supervisors,] ‘How would you use [the CANS] in supervision? What do you see?’ Trying to get them critically thinking and saying,... ‘You can do this with your workers when you use this information. You can ask more focused questions based off of what you see here.’ So that’s been a struggle but we’re trying to, every day, improve that piece.

The extent to which the CANS is incorporated into daily casework relates to a larger problem that the TAC continues to identify in its monitoring of DCS’s reforms: that the Department’s general case practice is still in need of significant improvement. In its most recent monitoring report, the TAC criticized the “quality of front-line casework—the critical day-to-day interactions between children, families, case managers, helping professionals, and the community that are needed to make sure that children are safe, healthy, and able to succeed.”

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166 The Brian A. TAC has noted the same barrier in CANS implementation. In its most recent monitoring report, the TAC stated that “there appears to be considerable variation in the extent to which the CANS is presently integrated into the planning process. For some case managers, the CANS is a valuable way of processing and sharing information with the Child and Family Team to support the assessment and planning process. For others, it is viewed as yet another required form that gets ‘filled out’ and ‘sent off’ to the Centers of Excellence, but that does not add value to the planning process” (Brian A. Technical Assistance Committee, op. cit.: 21, p. 188).

167 Brian A. Technical Assistance Committee, op. cit.: 21, p. 6.
In particular, the TAC focused on the Department’s use of CFTMs; despite the fact that DCS has built a strong infrastructure and supportive policies for implementing CFTMs, it still struggles to complete them in a timely manner and to include the variety of family members, caregivers, and other stakeholders whose presence is critical to the success of case planning. Figure 7.6, which provides QSR results on measures pertaining to case practice, shows the areas of casework that need considerable improvement.

**Figure 7.6: Cases Rated “Adequate” on Quality of Case Planning Indicators (QSR)**

The quality of frontline casework affects the experience of all children in foster care; but specifically for children placed in congregate care, poor-quality case planning can lead to serious problems, including inappropriate placements, failure to explore family-based options, or failure to monitor children and families’ progress in required services.

Indeed, several former foster youth reported being placed in facilities that were overly restrictive given their moderate needs. Four said that they had experienced moves in and out of congregate care settings but were never told why they were moved. One young woman believed that her foster mother and case manager decided to move her from the foster home to a group home simply because she resisted going to counseling:

> I was making good grades in school, I was doing my homework, I was doing everything that I should have done. But my foster mom wanted me to go to counseling for my mom dying, and I didn’t want to. I would go and talk about anything other than that. I guess I wasn’t doing therapy the way she wanted me to.... [Since then] I tried to talk to her about it, and she was like, ‘That’s what you needed. We couldn’t get you in therapy, we couldn’t get you to talk about any issues, so I figured maybe [sending you to a group home] would work.’ I guess she meant well, but it was a really negative way to deal with it.

In response to concerns regarding inadequate case planning and casework, DCS has committed to enhancing its Performance Management System—a multifaceted process designed to evaluate and improve the skills of supervisors and case managers through the creation and monitoring of performance plans. According to the *Brian A. TAC*, “the Department is committed to taking statewide and regional data related to core performance measures and outcomes, breaking it down by supervisory units, and using this data to inform judgments about supervisory effectiveness.” DCS is currently developing a plan to roll out these new evaluation tools that will begin with the assessment of supervisors.

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168 *Brian A. Technical Assistance Committee, op. cit.*, p. 21. Note: The indicators shown are those for which the *Brian A. settlement agreement* uses the QSR as a primary measure of practice/performance.

169 *Brian A. Technical Assistance Committee, op. cit.*, pp. 7-8.
CHAPTER 7: TENNESSEE CONGREGATE CARE TODAY: CURRENT USE AND AREAS NEEDING IMPROVEMENT

SYSTEM-WIDE CAPACITY TO PROVIDE WRAPAROUND SERVICES

Children stepping down from congregate care need community-based services to meet their unique needs. Just because a child is ready to leave a residential setting does not mean that the conditions that led to his or her placement in congregate care have been fully resolved—it means that caseworkers and clinicians have determined that, with the appropriate supports in place, the child can succeed in a family setting.

The people with whom we spoke had mixed opinions about whether Tennessee’s child welfare system currently has the capacity to provide the community-based, wraparound services that children stepping down from congregate care need. Several reported that the private providers are better able to meet the service needs of children in family settings today than they were in the past. Much of the success in administering wraparound services was attributed to the work of the state’s two largest private providers. Respondents noted that these agencies have been able to provide enhanced services due to their ability to garner revenues over and above their payments from the Department.

Others felt that community-based services still have a long way to go to meet the needs of children moving out of congregate care. Some believed that as it currently stands, the system is able to meet the wraparound needs of children with moderate clinical issues, but that it still struggles to provide home-based services to the highest-need children. One guardian ad litem said:

> For children that don’t need intense therapy—and by intense I mean more than once a week—I think that [wraparound services] have met that [need] well. But for kids who, [for example] need to be in intensive outpatient treatment four times a week,… for children that would fall under that level of services, no, I don’t think that the wraparound community services have been successful.

In many cases, people felt that with improved program quality and improved access to community-based services, more children currently placed in congregate care could be cared for in family settings. In fact, a number said that, with the exception of a small number of very ill children, most children placed in group care today could be well served in family settings given the appropriate ancillary services.

Unfortunately, interviewees reported that access to wraparound services is not uniform throughout the state; rural counties often struggle to provide them. Though it remains a challenge to provide these services in “resource poor” areas, the DCS Medical Director noted that the Department, in collaboration with service providers and TennCare, is attempting to fill service gaps:

> Just as within any state...there are pockets where there may be less availability of services. So we work very closely with TennCare, Tennessee’s version of Medicaid. It’s a managed care system. We work very closely with them in identifying areas of need that may not be sufficiently met in the community, and then they work with the managed care companies in bolstering up those clinical services in those areas. For example, through telepsychiatry or just increasing numbers of providers that are TennCare providers...

According to the TAC’s most recent monitoring report, the Department is currently planning to have each region conduct its own needs assessment to determine the ways in which regional service arrays should be enhanced.\footnote{Brian A. Technical Assistance Committee, op. cit.: 21.}
In addition to improving their capacity to recruit foster homes and provide community-based wrap-around services, interviewees spoke about other ways in which providers could further limit their use of group care.

**Use of Continuum services**

Despite the existing incentives to move children into family settings as quickly as possible, some providers still use congregate care more heavily than others. For example, one provider executive noted that some contract agencies remain ideologically committed to starting all their referred children in group care and stepping them down over time. Others expressed that even though the Continuum model requires providers to offer a variety of services, resulting service arrays may still be insufficient to
meet the needs of children in care. Their concern was that while Continuum agencies may offer a diversity of placement settings, services within each of these settings may not be customizable for individual families. One child and family advocate noted that when children need something that falls outside of their provider’s fixed menu of services, they cannot access that additional service without “totally leaving all [the] support” that they receive from their current provider. She added:

The idea behind [Continuums] is good—having that array and being able to move as needs arise.... But at the same time we’ve really closed off the opportunity to individualize [services].

**Transitioning children from facility to family setting**

Several people said that, ideally, DCS and/or provider staff should identify a family placement once a child enters a residential treatment facility so that they have a step-down resource with whom to work while the child is in congregate care. Not surprisingl,y the challenge of recruiting foster families hinders such a practice. But even when foster parents are available, interviewees said that providers must enhance the way they incorporate them into a child’s treatment while he or she is in residential care. In this way, foster parents can communicate with the facility’s therapeutic staff regarding what caring for that child will ultimately entail so that they are ready to receive the child when he or she is ready to leave the group setting. A DCS Regional Placement Specialist Team Leader described how her unit deals with such scenarios:

On day one when we place a child in congregate care...if we know the child will not be able to return home after that placement, we do get a resource home contract agency involved in the treatment of that child as well—to start looking at resource homes for that child and also to get a resource home involved so that we can make [the step-down] transition a lot smoother and hopefully a lot quicker.

Sometimes, the step-down resource is the child’s biological parents. In these cases, parents should not only be incorporated into their child’s treatment, but their own needs must be addressed simultaneously. One Regional Administrator mentioned that the transition from group care to home can be complicated when providers do not work with a child’s parents concurrently with their work with the child:

I think that family treatment needs to start earlier. A lot of what I see is that the children go to the congregate care placement and the placement really works on the child’s issues and then waits until the child’s almost finished with their treatment before bringing the family in to do that work...[so that the family will] be able to provide whatever the child needs [when the child goes home]. If [providers] started that [work with families] on the front end, I think then we could all feel more comfortable getting children home more quickly.

**Reducing referrals to DCS from the school system**

A handful of interviewees noted that one way to further minimize the use of congregate care is for DCS to work more closely with the education system so that children do not enter group care simply because their local public schools cannot cope with their behavior. While children do not enter state custody for educational reasons with the same frequency that they did in the past, a pipeline from the schools to congregate care still exists, as some youth are still referred to state custody because of truancy or unmanageable behavior in school. Some of these youth have been deemed “zero tolerance,” meaning
they have committed a “serious violation of school policy resulting in an expulsion of up to 180 days.” Interviewees who talked about this issue said that the practice of referring these youth to court varies by county and school district; in some counties, judges are more willing to bring young people into state custody because their schools do not want them there. According to one Tennessee Commission on Children and Youth staff member:

[We still see] schools dumping children on the state custody system. The custody system has been the placement of last resort for children who have mental health problems, who have substance abuse problems, who have behavioral problems. And schools have been historically major referral sources to the courts and they still are to some extent.

In some counties, truancy boards act as intermediaries between schools and the juvenile court. Rather than send truant or unruly children directly to court, truancy boards bring the child, family, school personnel, and, sometimes, DCS staff together to attempt to resolve the child’s behavior issues and divert the child from entering care. One DCS Regional Administrator described the importance of truancy boards in this way:

Some of our courts have truancy boards, which has really helped.... They will bring the parents and the kids into truancy court at the school and talk to them and try to get them to commit to going to school or sending their kids to school.... In the counties where we have a lot of issues with them not wanting the kids in their schools, they don’t have truancy boards. [Having more] might help since we don’t have them in all counties. [In] some of our counties, if they just don’t like the behavior of the child, they’ll take ‘em to court and sometimes the judges, because of pressure from the school, just put ‘em in our custody.

REGIONAL DIFFERENCES IN REDUCING CONGREGATE CARE USE

A number of interviewees noted that some regions have experienced greater challenges to reducing their use of congregate care than others. DCS is divided into thirteen regions. Figure 7.7 depicts regional differences in initial placements in congregate care. Although all regions have decreased their proportions of initial placements in congregate care since 2000, the degree of that decrease has varied widely among regions.

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171 State of Tennessee Department of Children’s Services, op. cit.: 106, p. 69.

172 All data in this section are derived from the two datasets described in Chapter 2. Since the start of this case study, two of the regions—Hamilton (the urban county containing the city of Chattanooga) and Southeast—were combined to create one region, now called the Tennessee Valley region. Because the data provided by DCS and Chapin Hall represent regional trends when the two regions were distinct, they are treated as distinct regions in this chapter.

173 As in Chapter 5, ‘congregate care’ includes settings categorized by Chapin Hall as ‘congregate care,’ ‘emergency’ placements, and ‘hospitals.’
Figure 7.7: Initial Placements in Congregate Care, by Region

<table>
<thead>
<tr>
<th>DCS Region</th>
<th>2000</th>
<th>2008</th>
<th>Percent change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knox*</td>
<td>75.60%</td>
<td>14.90%</td>
<td>-60.70%</td>
</tr>
<tr>
<td>Northwest</td>
<td>46.21%</td>
<td>10.17%</td>
<td>-36.04%</td>
</tr>
<tr>
<td>Hamilton*</td>
<td>44.09%</td>
<td>15.04%</td>
<td>-29.04%</td>
</tr>
<tr>
<td>Northeast</td>
<td>38.64%</td>
<td>10.68%</td>
<td>-27.96%</td>
</tr>
<tr>
<td>Smoky Mountain</td>
<td>31.76%</td>
<td>11.35%</td>
<td>-20.41%</td>
</tr>
<tr>
<td>Davidson*</td>
<td>28.40%</td>
<td>11.60%</td>
<td>-16.80%</td>
</tr>
<tr>
<td>East Tennessee</td>
<td>26.64%</td>
<td>11.19%</td>
<td>-15.45%</td>
</tr>
<tr>
<td>Southwest</td>
<td>25.97%</td>
<td>17.19%</td>
<td>-8.78%</td>
</tr>
<tr>
<td>Southeast</td>
<td>25.20%</td>
<td>9.30%</td>
<td>-15.90%</td>
</tr>
<tr>
<td>Shelby*</td>
<td>23.00%</td>
<td>15.60%</td>
<td>-7.40%</td>
</tr>
<tr>
<td>Upper Cumberland</td>
<td>14.43%</td>
<td>14.23%</td>
<td>-0.20%</td>
</tr>
<tr>
<td>Mid Cumberland</td>
<td>13.75%</td>
<td>5.68%</td>
<td>-8.08%</td>
</tr>
<tr>
<td>South Central</td>
<td>11.40%</td>
<td>7.80%</td>
<td>-3.60%</td>
</tr>
</tbody>
</table>

*Major urban region consisting of only one county. Knoxville is in Knox County, Chattanooga is in Hamilton County, Memphis is in Shelby County, and Nashville is in Davidson County.

Figure 7.8 shows a similar downward trend in the number of children in congregate care on January 1 of each year. For the most part, the regions with the greatest proportion of children in group care on January 1, 2001 have shown the largest proportional decreases in group care use over time. As of January 1, 2009, all regions had fewer than 17 percent of children placed in congregate care, and most had fewer than 10 percent.

Figure 7.8: Placements in Congregate Care on January 1, by Region

<table>
<thead>
<tr>
<th>DCS Region</th>
<th>1/1/01</th>
<th>1/1/09</th>
<th>Percent change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hamilton*</td>
<td>33.17%</td>
<td>8.90%</td>
<td>-24.27%</td>
</tr>
<tr>
<td>Northwest</td>
<td>31.68%</td>
<td>16.92%</td>
<td>-14.76%</td>
</tr>
<tr>
<td>Knox*</td>
<td>31.12%</td>
<td>9.57%</td>
<td>-21.55%</td>
</tr>
<tr>
<td>Southwest</td>
<td>29.82%</td>
<td>13.66%</td>
<td>-16.15%</td>
</tr>
<tr>
<td>Davidson*</td>
<td>28.90%</td>
<td>15.96%</td>
<td>-12.94%</td>
</tr>
<tr>
<td>Smoky Mountain</td>
<td>23.18%</td>
<td>7.56%</td>
<td>-15.62%</td>
</tr>
<tr>
<td>Mid Cumberland</td>
<td>18.89%</td>
<td>8.43%</td>
<td>-10.46%</td>
</tr>
<tr>
<td>South Central</td>
<td>18.73%</td>
<td>9.64%</td>
<td>-9.09%</td>
</tr>
<tr>
<td>Shelby*</td>
<td>17.87%</td>
<td>6.66%</td>
<td>-11.22%</td>
</tr>
<tr>
<td>Southeast</td>
<td>17.69%</td>
<td>11.76%</td>
<td>-5.03%</td>
</tr>
<tr>
<td>Northeast</td>
<td>17.08%</td>
<td>8.25%</td>
<td>-8.83%</td>
</tr>
<tr>
<td>East Tennessee</td>
<td>16.24%</td>
<td>8.96%</td>
<td>-7.29%</td>
</tr>
<tr>
<td>Upper Cumberland</td>
<td>11.84%</td>
<td>8.12%</td>
<td>-3.71%</td>
</tr>
</tbody>
</table>

*Major urban region consisting of only one county. Knoxville is in Knox County, Chattanooga is in Hamilton County, Memphis is in Shelby County, and Nashville is in Davidson County.
Interviewees offered several explanations for regional differences in congregate care use, citing variations in resource availability and practice culture and philosophy. They also noted that a region’s continued use of congregate care depends on the approach of the private service providers in that area and the relationships those providers have with DCS regional staff.

**Resource availability**

Several people we interviewed explained the tendency to use congregate care by holding to the notion that “if you build it, they will come.” That is, if a congregate care setting existed in a region, that region used that facility and its beds were filled. Thus, in the view of some, regions that have more group care facilities continue to have a more difficult time developing and using other types of placements. Said one DCS Central Office official:

> You know, if there’s an emergency shelter down the road and you get kids late in the afternoon,... it’s that default position. And interfering in those behavioral habits [of relying on congregate care] was harder [in such areas] than [in] a region where there really wasn’t an emergency shelter or they were not in the habit of using it.

Several people noted that reducing reliance on congregate care is especially difficult in regions that do not have a sufficient number of family foster homes. Regions in this predicament may be forced to continue using group settings because family placements do not exist in their area. Similarly, some noted that regions lacking community-based wraparound services struggle to move children out of congregate care. As one executive of a private ancillary service program described, “resource poor” areas are likely to cling to group care because such facilities remain the only places that can accommodate the clinical needs of children who require a high level of care:

> I think it’s been easier [to reduce reliance on congregate care] in resource rich regions. That’s always the case. There are places like Northwest Tennessee where there just aren’t resources. So, if you don’t have a lot of supportive wraparound resources, placing a kid in a foster home [in Northwest Tennessee] is going to present more challenges than if you’re in Shelby County.

**Rural versus urban regions**

People disagreed on whether a region being rural or urban influences its ability to reduce its use of congregate care. Some believed that the rural parts of the state are more likely to rely on group care because they are more “resource poor” than urban areas, lacking community-based services and the ability to recruit foster families. One former DCS Central Office administrator suggested that recruiting foster families is more difficult in rural areas because the small towns are very tightly knit, allowing stigma and negative judgments about families involved in the child welfare system to travel quickly among the community members who would likely be tapped as potential foster parents:

> I think for some of the urban areas, it may have been a little bit easier [to reduce congregate care use] than in the rural areas, where everybody sort of knows everybody else. You [go into] the country community and you start talking about recruiting family foster homes [for a child], and well, you know, they know the history of [that child’s] family, and they’ve seen them in the community, and so it’s maybe more difficult in some respects to recruit family foster homes in rural areas, where everybody does know everybody else’s business.
In contrast, another person suggested that the intimacy of rural communities actually makes it easier to recruit homes in these areas because family members are more likely to live near one another and church communities are comparatively strong in these areas.

In short, there was agreement that rural areas are less likely to have a sufficient array of programs, and that this dearth of services contributes to rural regions’ struggle to place children appropriately. However, there did not seem to be consensus on whether rural or urban regions have more of a proclivity to use congregate care. Moreover, there does not appear to be quantitative evidence that rural regions necessarily perform worse than urban regions in terms of group care use.\textsuperscript{174}

\textbf{Differences in practice culture and philosophy}

A number of people noted that variation in regional child welfare culture influences the use of congregate care. For example, two advocates noted that regional DCS staff still differ in the extent to which they deliver strengths-based, family-centered casework. Although the child welfare practice philosophy has shifted in recent years to one in which children's family members are highly valued members of the Child and Family Team, some regional staff have incorporated those values better than others. When parents are perceived as the problem rather than as part of the solution, they are not able to contribute information that might lead to a child’s most appropriate placement. As one child and family advocate said:

\begin{quote}
[The use of congregate care is influenced by] how people view the biological parents and the resources that the parents could have or the strengths that they do have, and if those [strengths] are acknowledged, if parents are included in the discussion.... DCS has gone from being very child-specific to being more family-driven or family-centered. We need to move more toward family-driven. But historically that has not been [DCS’s] approach. And so in changing that, change takes time. And there are some people that embrace it and some people that don’t.\end{quote}

One DCS official noted that some county juvenile court judges are more apt to commit teenagers to state custody. Since teens are more likely than younger children to be placed in congregate care, a county that commits more teens is likely to have a higher proportion of youth in group care. One advocate said that there are regions in which there is still a feeling that troubled youth need to “go away” in order to “get better”:

\begin{quote}
Some of the difference [between regions] is a difference in attitude toward whether kids need to be sent away still, and that is some of the culture of the courts in some [regions]. There’s still a bit of... ‘send them away and fix them’ sort of attitude—a difference between [regions regarding] how people interpret safety for the community and how much they’re willing to embrace children that have challenging behaviors.\end{quote}

And several interviewees talked about the importance of leadership, saying that in regions where Regional Administrators bought into the importance of reducing reliance on group care, the transition was easier than in those where Regional Administrators resisted the change. One private service provider executive recalled:

\textsuperscript{174} For example, in January 2009, Shelby, the urban region containing the city of Memphis, had the lowest proportion of children placed in congregate settings and Northwest, a rural region, had the highest, a finding that supports the idea that rural counties are more reliant on group care. However, in 2008, three of the four urban regions (Knox, Hamilton, and Shelby) were among the regions with the greatest proportion of initial placements into group care.
You had some [Regional Administrators] that just weren’t even necessarily philosophically there. For instance, you had people that thought in-house schools in separated facilities was the best thing for these kids. So you can imagine, if your leader’s not on board, even if they’re forced to try to promote certain practices or at least fill out forms that suggest they’re promoting certain practices, you know how it is—you model [your buy-in] through so many ways. Your body language or anything else can sabotage [the practices]. So I think that the diversity of leadership in terms of philosophy among the various Regional Administrators [influenced regions’ use of group care].

In addition, some said that a region's use of group care facilities depended in part on the service philosophy of the local providers. As one child and family advocate observed, providers’ philosophies “vary from region to region.” Although she noted that many providers have adopted the perspective “that it does really work to wrap services around families” as opposed to placing children in group care, she added that the wraparound approach has not taken hold with all providers.

The working relationship between a DCS region and its providers is also key to a region’s ability to reduce its reliance on congregate care. One Regional Placement Specialist noted that in areas where providers and DCS staff have trusting relationships, providers are more willing to take regional placement staff members’ recommendations that children be placed in family settings. She observed that when providers do not believe DCS is giving them all the information it has about the children being referred, providers tend


to request... a congregate care setting just [so they] see the child [and] determine [for themselves] what that child needs, as opposed to letting the Child Family Team make that decision.

CONCERNS ABOUT SUSTAINING REFORMS

Some interviewees felt that DCS's success in reducing congregate care was so explicitly dependent upon Commissioner Miller’s leadership that they were concerned that the Department would backslide with a change in administration. A few people felt that there are likely some private providers who are hopeful that the next administration will lose interest in key initiatives such as the Continuum model and performance-based contracting. Others wondered if the policies instituted during Commissioner Miller’s tenure had taken strong enough hold throughout the Department to be sustained under a new administration. As two DCS Central Office administrators remarked:

[The Commissioner’s and Deputy Commissioner’s heavy involvement in Utilization Review is] a short term fix. I mean, a new administration comes in, you know, they may not do that exact chunk of work, and the system is not sturdy enough right now where it wouldn't just buoy right back to a reutilization of those [congregate care] facilities.

Before [Commissioner Miller arrived,] it was all about the money—everything being driven by the fiscal piece. And the first thing she did when she came [was say that] fiscal isn’t as important as program. Program has to set the direction. To me, that was the most transformative piece of this work. I just hope we could maintain that. Because I think we could easily slide back. And I really wish we could maintain that focus strictly on kids and families.

175 As noted above, with the election of a new Governor in Tennessee, DCS has a new Commissioner as of January 2011, Kathryn O’Day.
In contrast, some believed that these recent initiatives had been entrenched sufficiently, particularly at the regional level, to withstand a change in leadership. They felt that a new philosophy has been “embedded in the Regions” and that “people really believe that family homes are where kids need to be.” One DCS Central Office official pointed to the success of Utilization Review as an example of how recent DCS policies have taken root throughout the system:

[The DCS Central Office is] doing a good set of work with regional staff to embed a strong and robust Utilization Review process within each region.... That’s the kind of thing that outlives an administration because you’ve got it more deeply embedded within your structure.

It is unclear at this point how these issues will play out in the future. Time will tell as to whether policies and practices instituted over the last decade will be upheld in the next administration and whether DCS will be able to sustain the progress it has made to date.

**IS MORE CONGREGATE CARE NECESSARY?**

A handful of respondents talked about negative aspects of DCS’s reduction in the use of group care. These individuals felt that in its drive to decrease the use of these facilities, the Department had erroneously framed all congregate care as negative, and that the reforms ignored a critical role that congregate care plays in the child welfare system. Said one State Representative:

There’s definitely a place for those sorts of [group] homes, at least in this state I believe, [a place] for really well-run centers. I was really disappointed that we closed TPS, and I’m disappointed that even though the Department has the discretion to use [congregate care settings], they don’t and they’ve closed them. I think that’s a big mistake. It’s a big mistake.

One legislative staffer said that DCS had been portraying congregate care in an overly negative light ever since the early days of the Brian A. reforms. She recalled that when the Department began implementing restrictions on the use of group care, it did not effectively communicate that these restrictions could be waived under certain circumstances. Thus, group care came to be perceived as forbidden, a perception that persists today:

I really think that there’s probably some potential in some of the congregate settings...that we’re not reaching because I think we still are operating in the mindset of, ‘it’s banned,’ and [there’s] a negative connotation to it.

**Benefits of congregate care for older youth**

As noted above, DCS has made a major effort in to establish permanency for every child, and Commissioner Miller has expressed a strong commitment to finding homes, particularly for children who had previously been thought of as “hard to place” or “unadoptable,” such as teenagers. Indeed, this initiative addresses a major topic of conversation in the greater child welfare world today—decreasing the number of youth aging out of care by working with them and their families toward reunification, adoption, or legal guardianship. This mission is reinforced by ongoing research showing that youth aging out of care fare far worse than their contemporaries in the general population on numerous developmental and socioeconomic outcomes.176

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Despite this widespread approach to promoting permanency, stakeholders who recommended bringing back some congregate care capacity believed in a different approach to meeting the needs of teens in foster care. Rather than emphasizing teenagers’ need for families, they felt that the more pressing need for many adolescents in care is high-quality independent living skills and support in making decisions for themselves. They argued that many older youth, particularly those who have been in the foster care system for years, are not looking for “new families” and they bristled at the idea of “forcing” older youths into family environments.\(^{177}\) One guardian ad litem, for example, said that congregate care can be a good option for

children who don’t have any available relatives or who have exhausted all the relative placements, who have taken care of themselves way too long, who are burnt out on foster care, aren’t 18, need independent living skills, need a place to live, often with their own child—but the concept of a mom and a dad is just not—they’re beyond that. They’ve been burnt out too long.

This perspective resonated with the experiences of two of the former foster youth we interviewed. While living at a group home, one young man had a staff member offer to become his foster parent. The staffer and her partner treated him as their child and were very committed to him, but the young man was not looking for a family:

They [took] me in, and to them, I was their kid. It was great. Christmas, birthday, special occasions, they got me a car, they taught me how to drive, got [me] my license. It was a really great environment… Having said that, when I turned 18, you know, I wasn’t ready to be in a family. So I just cut all ties to them out of pure randomness.

Another woman, who was placed at the Tennessee Preparatory School as a teenager and still felt strong ties to her biological family, was glad that she was not forced to be integrated into a new home:

I wasn’t looking for another family. I mean, I had a family, you know? And, I think once a kid gets to a certain age, they’re not looking for a new mommy and daddy. I mean, they’re looking for a place where they’ll feel safe and secure.

This view is reinforced in some of the literature on out-of-home care:

Older children and adolescents may be found to do better in group homes…than in foster homes, in some situations, if they are resistive even with adequate preparation and exposure to options. In this regard, it should be noted that for some adolescents who are working with strong needs for emancipation, group home or group residence placement may actually be experienced as less restrictive than foster family care, which may be perceived as more controlling and more limiting.\(^{178}\)

\(^{177}\) Five interviewees expressed the idea that congregate care could be an important resource for older youth in foster care: one state legislator, one legislative staffer, one attorney with experience representing youth in care, and two former foster youth who felt they had positive experiences living in congregate care settings. It is interesting to note that none of these individuals was a child and family services professional. Further research comparing child welfare service professionals and legal professionals may illuminate occupational differences among the two groups’ perspectives on the needs of teens in foster care and the role teens should play in identifying and advocating for their particular needs.

\(^{178}\) Janchill, op. cit.: 1, pp. 59-60.
CONGERGATE CARE AS A BETTER VENUE FOR MEETING CHILDREN'S HIGH-END NEEDS

Some people said that there are children in congregate care today who cannot be placed in family settings—that their needs for around-the-clock treatment and supervision are so great that no family setting, no matter how well-resourced, could truly accommodate them. As one DCS Regional Administrator put it:

I would love all of our kids to be able to function in a family-like setting, I wish that was possible. But some of our kids require so much care and clinical intervention that it's not possible to [provide] that [intensity of service] at that level.

In a system centered on the belief that children “belong” with families, such a position can be hard to reconcile. In her interview, Commissioner Miller said that even though children with serious treatment needs are often the most difficult to place in homes, “we have to take those risks, even with those [who are] very, very, very sick...We've got to try [to place them in family settings].” However, she added, “we’re not always going to be successful.”

Indeed, when it came to discussing the appropriateness of group care for children with serious treatment needs, a handful of interviewees noted that children are sometimes placed in family settings when residential treatment would serve them better. A guardian ad litem observed:

Lots of kids can be in a foster home and receive higher level services, which I think is a great thing to at least try. But [I recall a child who]...needed...a lot of structure.... She had sex with adult men, [ran] away, and that kind of stuff.... Obviously [her] foster parent's not a bad parent, she's a normal parent, but [a foster home was] obviously not a good fit for that child. [The case-work staff] were trying to put an array of services into the foster home. [To] give her a higher level of service but keep her in a [foster home] setting.... All the attorneys, all the social workers, nobody really wanted to see her put in [a] group home. I think a lot of it was emotion, just trying to root for her to do well in a traditional setting.

One former foster youth, who was more cynical than many people who worked in the system, thought that more group care was needed. Although he approved of adoptive families (and felt that more were needed throughout the system), he felt that foster families that do not adopt cannot truly be considered “families”— that foster families are an “illusion” because their ultimate commitment to children is limited or conditional. Though he acknowledged that good foster parents exist and found it “hard to criticize” individuals who become foster parents, he questioned their ability to truly and totally care for children in foster care, stating that a family that relies on the state to provide the resources to raise a child in foster care cannot ever have sufficient resources to provide everything a child in foster care needs. He said that group care facilities are better equipped to meet those needs because they can hire professionals with higher levels of education and more experience in the field. He contrasted these resources with the “crash course” that DCS and providers give to foster parents, saying that “there's just no way” this type of training can prepare foster parents to care for children in the same way that group care facilities can.

In summary, most of the people with whom we spoke said that DCS places children in group care much more appropriately today than it did prior to Brian A. However, many noted that there are still a number of ways in which the Department’s use of congregate care needs improvement. Much of the system's current limitations centered on the insufficient number of family foster homes for teens and children with serious treatment needs. A small group of interviewees felt that over the past ten years, DCS has eliminated too many congregate care options and that the system should make more group placement opportunities available, particularly for older youth in care.
CHAPTER 8
LESSONS LEARNED
CHAPTER 8
LESSONS LEARNED

DCS’s reduction of congregate care use exemplifies how policy, practice, and infrastructure reform, brought about by a class action lawsuit, can lead to large-scale improvements in a public child welfare system. Whether a jurisdiction wishes to reduce its own use of group care, or whether it is faced with some other major need for systemic reform, Tennessee’s experience offers valuable lessons in how to bring about change.

Lesson 1: Class action litigation can bring about systemic reform. Collaboration between plaintiffs and state agency defendants helps to create change.

In Tennessee, the *Brian A.* class action litigation acted as a catalyst for reform. Children’s Rights’ suit over DCS’s egregious misuse of congregate care, and the force of a federal court order, held the Department accountable for its overuse of group facilities. The settlement agreement provided a structure of benchmarks for improvement, and the Department drew on technical assistance and consultation from a variety of sources to meet those expectations. Periodic monitoring by the *Brian A.* Technical Assistance Committee and Children’s Rights staff ensured that DCS made progress in a timely way.

Tennessee is not the only jurisdiction in which class action litigation has led to child welfare system reform. Indeed, in its review of 35 child welfare consent decrees throughout the United States, the Child Welfare League of America concluded broadly that “class action lawsuits can definitely effectuate large-scale systemic change for child welfare systems,” listing a number of Children’s Rights’ lawsuits among these successes. For example, before *Joseph A. v. Bolson* was filed in New Mexico, only 10 percent of children in that state’s custody had an established permanency goal; by 2005, 100 percent of New Mexico’s foster children had permanency goals in place. The state also experienced a 67 percent increase in adoptions from foster care between 1995 and 2004. As a result of *Marisol v. Giuliani* in New York City, protective service worker caseloads decreased from an average of 27 families per worker in 1994 to 12.5 families per worker ten years later. Parent-child visitation improved, as well. In 1996, 39 percent of children with a goal of reunification had biweekly visits with their parents; 69 percent visited with this frequency in 2006.

Class action suits brought by others have also spurred child welfare reform. In Alabama, for instance, it is reported that the *R.C. v. Hornsby* case sparked a holistic, bottom-up reform of the state’s child welfare system that resulted in tailored case planning and reduced lengths of stay for children in foster care.

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In New Hampshire, the *James O. v. Marston* consent decree led to improved access to special education services for children in care.\(^{182}\) As a result of *Bates v. McDonald* in Illinois, the state implemented new policies to increase the frequency of parent-child visitation.\(^{183}\)

But a consent decree cannot succeed without state level leadership that believes in its provisions. In the inherently adversarial relationship between plaintiffs and defendants, engendering the state agency’s cooperation is extremely difficult. As Borgerson explains:

> Even caring and competent public servants resist letting litigation set their priorities or divert resources from other equally pressing problems. They are likely to be advised by their lawyers to proceed very cautiously when it comes to making commitments that might be enforceable by a court....The challenge for governmental defendants is to break out of that box and risk embracing their adversaries as constituents, and partners in the difficult work of child protection.\(^{184}\)

Tennessee’s story illustrates the importance of such a partnership. When *Brian A.* was filed, it was Commissioner George Hattaway’s sense of ownership in negotiating the terms of the settlement that fostered DCS’s buy-in to the resulting provisions. Later, Commissioner Viola Miller also took a collaborative approach, leveraging the lawsuit to support her policy and practice initiatives while being forthcoming with plaintiffs about the Department’s strengths and weaknesses.

The importance of state administrator cooperation with plaintiffs has been identified in other cases, as well. For example, in the Children’s Rights case, *Jeannine B. v. Doyle*, when the Bureau of Milwaukee Child Welfare (BMCW) was still noncompliant with a number of consent decree provisions years after settling the case against it, Reggie Bicha, the newly-designated Secretary of Wisconsin’s Department of Children and Families, embraced a cooperative working relationship with Children’s Rights. Though the consent decree did not require it, he allowed Children’s Rights full access to BMCW data and staff so that Children’s Rights’ Policy Department could conduct a needs assessment of the Milwaukee system. The resulting report identified the Bureau’s main impediments to progress and served as a basis for the subsequent negotiation of a corrective action plan designed to resolve the issues.\(^{185}\) Having implemented that plan, Milwaukee has, to date, exited from all but two of the requirements of its consent decree.\(^{186}\)

Similarly, in Missouri, the success of the consent decree in *G.L. v. Stangler* has been attributed in part to Gary Stangler, the director at the time of Missouri’s Division of Family Services, who collaborated with plaintiffs to produce a set of “realistic and pragmatic” requirements for reform.\(^{187}\) It is also reported that in the *R.C. v. Hornsby* case, defendants and plaintiffs worked together to craft a settlement agreement around shared goals for the Alabama child welfare system.\(^{188}\)

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182 Child Welfare League of America, op. cit.: 179.
183 Ibid.
185 E. Thompson, Children’s Rights senior litigation counsel (personal communication, November 2, 2010).
188 Bazelon Center for Mental Health Law, op. cit.: 181.
Lesson 2: External consultants can provide valuable assistance in creating systemic reform.

Over the course of its reform process, DCS engaged a number of consultants who provided outside perspectives and specific expertise on how the Department could reduce its reliance on congregate care. The Brian A. Technical Assistance Committee provided guidance to the Department throughout. DCS contracted with researchers at the Chapin Hall Center for Children to develop the Department’s performance-based contracting program and to help organize and analyze its administrative data. DCS brought in consultants to evaluate the placement appropriateness of children in residential sex offender programs, and one private provider collaborated with an outside organization to revamp its foster parent training curriculum.

Consultants have been conceptualized as “sector specialists” who have knowledge or expertise pertaining to a specific industry (“sector”) and play off clients’ existing industrial and organization-specific knowledge to diagnose and provide solutions to organizational problems.189 Acknowledging the important role of outside experts in improving child welfare systems, the federal government has, in recent years, developed a number of national resource centers190 to which state agencies can return for technical assistance on a variety of topics.

Lesson 3: In undertaking systemic reform, the state child welfare agency must thoughtfully redefine its interagency partnerships, when necessary.

DCS’s move away from congregate care challenged the status quo in Tennessee’s child welfare system. For decades, the Department, its contract providers, and the state legislature and judiciary had all coalesced around congregate care as an acceptable and desirable way of caring for children in state custody. As a result, the expectation that congregate care would continue to play a key role in the system was inherent to each party’s understanding of how it related to the other. When DCS initiated its reduction in congregate care use, it was therefore forced to redefine and renegotiate many of its interagency relationships.

In outlining the components of effective partnerships within human service organizations, Gray describes a three-part model that requires partners to “(1) establish communication, (2) develop a shared vision, and (3) establish permanence [of the partnership] through trust.”191 Conflict is a necessary part of all these steps, as consensus building invariably uncovers collaborators’ different motivations and perceptions of how best to proceed.192 DCS’s successful reduction in the use of congregate care illuminates each of these processes, particularly as the Department redefined its relationship with its contract service providers. Throughout the transition, DCS spent considerable time communicating with providers about forthcoming policy and practice shifts, attempting to convince them of the importance and

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190 e.g., the National Child Welfare Resource Center for Organizational Improvement (http://muskie.usm.maine.edu/helpkids/); the National Quality Improvement Center on the Privatization of Child Welfare Services (http://www.uky.edu/SocialWork/qicpcw/); and the National Quality Improvement Center on Differential Response in Child Protective Services (http://www.differentialresponseqic.org/).


usefulness of the reforms. The Department also listened to the providers’ concerns about, and in many cases deeply set resistance to, the pending change. Accounting for these concerns allowed a shared vision for family-based placements to begin to emerge. Critical to this shift was the fact that DCS gained the providers’ trust, promising to support them with the time, technical assistance, and financial incentives needed to be successful under the new model. Through this process, change came to be seen as a joint endeavor on behalf of children rather than as a dictum from the state.

However, DCS’s new relationship with providers could not have come about without expending time, energy, and resources to overcome significant political hurdles. Congregate care providers, who operated under the assumption that their business would always be needed, had champions in the state legislature and the support of many juvenile court judges. These alliances created a major barrier to the implementation of DCS’s reforms. Although DCS officials stayed strong in the face of political pressure, they could not have succeeded without their own powerful allies. The staunch support of Governors Sundquist and Bredesen was essential. The Department also had an important friend in Pat Lawler, a highly respected provider who could act as a bridge between DCS and its dissenting contractors.

Thus, in system change efforts, state agencies should be prepared for political conflicts as they renegotiate interagency relationships, especially when proposed reforms challenge longstanding methods of child welfare practice. And one should not underestimate the need for political cover in undertaking the overhaul of an entrenched approach to service delivery.

Lesson 4: In setting a course toward a new vision, the state agency must lead by example.

When partnering with private providers, a state agency must uphold the values and strategies that it wishes its contract agencies to emulate. As Van Slyke notes, the identification of shared values and goals is critical if contractors are to be true stewards of a public agency’s mission. Trust is built upon the parties’ mutual understanding of collective interests, and “the attitudes, values, and trust dispositions of public managers about contractors, program areas, and clients” affect how that trust is fostered. As noted, building trust takes time and develops “through extensive interaction and involvement focused on communicating each other’s goals and approaches to service intervention.”

In the relationship between DCS and its contractors, closing the Tennessee Preparatory School became a key initiative through which the Department conveyed its attitudes and values regarding congregate care to the private providers. DCS knew that it could not ask its providers to reduce their investments in congregate care if it was running its own large facility. Thus, shutting down TPS during this period of restructuring was critically symbolic. By closing its largest institution, DCS communicated to the providers that congregate care reduction was the right thing to do and that it was possible to serve many children effectively without such facilities.

194 Ibid, p. 171.
Lesson 5: The state agency must have an enthusiastic leader who is appropriately oriented to the work of the agency and deeply committed to the reforms to be made.

DCS’s early years were plagued by a crisis of leadership. The Department was headed by individuals who had backgrounds in youth corrections, an inappropriate orientation given that the majority of children in the Department’s care entered custody because of maltreatment. DCS also experienced considerable leadership turnover, having three different Commissioners in the three-year period following the Brian A. filing. In such a volatile environment, true reforms could not take place.

With the arrival of Commissioner Viola Miller, DCS gained a stable leader who “knew the work” and could build on and institutionalize the gains that had begun under her predecessors. Her depth of child welfare knowledge and her organizational and leadership skills, coupled with her fierce commitment to family-based care, made her an exceptional leader for the job.

Vision and strategic management are essential qualities in a leader of any human service organization. Commissioner Miller was both able to articulate a “realistic, credible, attractive, and inspiring future” for DCS, and to convey to her staff that her vision was attainable “with time and enough of the right kind of work.” She was strategic in that she was able to provide a road map for reaching the goals set forth in her vision. And her ability to articulate the right vision and select the right strategies was tied inextricably to her understanding of the needs of children and families involved in the system and the day-to-day processes involved in meeting those needs.

In addition to vision and strategy, child welfare agencies require leaders who maintain close supervision of complex organizational systems while adhering to regulations, processes, and government standards. Such organizations need task-oriented and internally focused leaders—people who emphasize the achievement of systemic goals and focus on developing the infrastructure to accomplish them. Commissioner Miller was described by many as such a leader; her goals were clear in all aspects of her management, and her unwavering commitment to family-based care and timely permanency for children underscored the initiatives she undertook, the policies she implemented, and the oversight she maintained.

Finally, exemplary leaders “model the way” by “clarifying [their] personal values and setting an example by aligning values with actions.” When leaders are honest, forward-looking, competent, and inspiring, others believe that they will do what they say they will do. By showing congruence between her beliefs and her actions, Commissioner Miller gained the support of her employees. The rank-and-file staff were proud to work for her and the private providers wanted to partner with her.

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198 Packard, op. cit.: 196.


201 Ibid.
Lesson 6: The state agency must align its contracting protocols with its desired systemic outcomes.

DCS administrators knew that asking the state’s private providers to scale back their use of group facilities would be asking them to turn away from a major source of revenue. The Department would have to develop new contracts that supplied incentives to the providers to achieve DCS’s newly articulated goals; specifically, it would have to make family-based placements and timely permanency more financially rewarding than placing children in congregate care for extended periods of time. Toward this end, DCS implemented the Continuum model and performance-based contracting (PBC). Though not a classic example of performance-based contracting, the Continuum model did incentivize family-based placements. This new contractual infrastructure not only rewarded providers who met the Department’s goals, but also penalized—and ultimately helped to eliminate—those who did not meet the expectations set by the state.

DCS’s PBC was successful because it contained a number of essential components. First, it contained self-enforcing financial incentives. Second, it was designed to address the Department’s specific objectives (i.e., decreasing length of stay, increasing permanent exits, and reducing re-entries into care), “not an arbitrary sense that performance need[ed] to be improved across the board.” Third, the contract took into account the providers’ existing resources and ways to enhance them so that the expectations embedded in the contract could be realized. Fourth, the providers themselves were able to provide feedback on the contract to DCS; through collaborative discussions, the Department and the providers were able to “craft consensus around the fact that improving performance was absolutely necessary, and that everyone would be equipped for success.”

As important as quantifiable benchmarks are in assessing contractor performance, “using outcome measures as a wholesale substitute for requirements governing such things as staff qualifications [and] case planning...can be literally very dangerous to children.” In other words, state child welfare agencies must not hold contractors to performance outcomes while ignoring contractors’ adherence to other key elements of quality case practice. As such, performance-based contracts must be monitored rigorously. The state agency must have mechanisms in place to review providers’ compliance with state and federal regulations, fiscal activities, and quality of case decision making.

With increased privatization of services and the implementation of the federal Child and Family Services Reviews (CFSRs), state agencies have been forced to develop new methods of improving and monitoring the outcomes of their private service providers, and PBC has gained popularity as a result. Moreover, PBC has led, in some cases, to widespread improvements in systemic child welfare outcomes. For instance, in Cook County, Illinois, a county in which 70 percent of the foster care

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202 Though not a classic example of performance-based contracting, the Continuum model did incentivize family-based placements. The Continuum model did not explicitly offer bonus payments or levy penalties based on a provider’s ability to place children in family settings, but it did create the opportunity for providers to profit if they did so.

203 Taylor & Shaver, op. cit.: 127.


208 Shaver, op. cit.: 204, p. 3.

caseload was managed by private providers, the average rate of permanency improved from 6.7 percent to 20 percent within one year of implementing a PBC centered around that goal. By 2000, permanency rates had jumped to 34 percent in kinship foster care and 25 percent in non-relative foster care.210 Philadelphia, which adopted the Illinois model in 2003, also saw improvements after introducing PBC; between 2002 and 2005, the city’s permanency rate rose by 84 percent, and placement stability increased by 50 percent. Also during this time, the average length of stay in foster care decreased from 44 months to 34 months, and reentry into care within one year decreased, as well.211

PBC will remain an important tool for state child welfare agencies that contract with private providers because it offers a useful response to today’s economic challenges.212 Given the foreseeable future, in which resources for child welfare are likely to stagnate or shrink, PBC provides a system that can preserve resources and improve performance.213

Lesson 7: The state agency must select service technologies compatible with its desired systemic outcomes and institute policies that promote their implementation.

DCS introduced numerous service technologies—practices, tools, and approaches involved in service delivery214—designed to minimize its use of congregate care. For example, the Department implemented the CANS as its uniform child assessment tool and instructed caseworkers to use it to inform the selection of the least restrictive placement suitable to meet children’s needs. It established the Child and Family Team Meeting as the central mechanism for case planning so that multiple perspectives could be incorporated into placement decision making. The Department enhanced its use of highly staffed treatment foster homes and, along with the private providers, focused on ways to recruit and retain families who could care for children needing these specialized placements. And on the whole, the Department adopted a family-centered approach to casework, directing workers to focus on family strengths in permanency planning. At the same time, the Department implemented policies to hold staff accountable for the execution of these practices as they were designed.

In selecting and implementing these service technologies, DCS’s challenge was twofold: to choose practices that were aligned with the Department’s goal of reducing the use of congregate care and to overcome the barriers to their successful implementation. After all, just because specific policies and practices are adopted by an agency’s administration does not mean that they are implemented fully or with fidelity by the frontline staff; accountability procedures need to be installed to promote the execution of desired practices.215 At the same time, administrators need to make sure that accountability procedures do not encourage service delivery that is purely “by the book.” Some degree of discretion in implementation is necessary to foster creativity and excellence, and burdensome procedures and paperwork can lead staff to focus more on completing administrative tasks than on insightful practice with children and families.216

210 Shaver, op. cit.: 204.


212 Courtney & Hughes-Heuring, op. cit.: 29.

213 Ibid.

214 Smith, op. cit.: 24.

215 Ibid.

216 Ibid.
Adams and Chandler suggest that the risk of rote casework may be magnified in jurisdictions working toward exit from a consent decree. In their analysis of possible barriers to implementing Family Group Conferencing, they note that court surveillance may decrease fidelity to the ideology behind casework practices while increasing attention to procedures and practices that meet the quantifiable specifications of the consent decree. Ironically, oversight may stymie “creativity and reform even though that may be what is required and often what the suit is demanding.”

To ensure thoughtful decision making, state child welfare agencies should also develop structures that allow multidisciplinary collaborations. DCS accomplished this by instituting new professional units at the regional level. Regional Placement Units decentralized and fine-tuned the existing knowledge of regions’ available resources, enabling frontline workers to make better placement decisions. Regional Well-Being Units inserted onsite consultants who could both get to know the region’s cases and develop close relationships with the area’s providers. As liaisons, they fostered communication between DCS and provider staff around children’s progress and the appropriateness of their placements. Such multidisciplinary work has been recognized by others as important in the delivery of child welfare services. When representatives from many disciplines work together, caseworkers are more likely to take advantage of community services and resources and to develop comprehensive case plans for children and families.

And finally, caseworkers should incorporate children’s perspectives into case planning whenever possible. DCS learned this lesson when it closed the Tennessee Preparatory School, finding that the youth who lived there were often able to identify their own family-based placements. The Department went on to embrace CFTMs, meetings at which children’s participation is encouraged, when appropriate. Collaborative decision making in child welfare goes by a variety of names (i.e., Team Decision Making, Family Group Decision Making), but all models share the value that children’s voices should be heard in case planning. Because caseworkers must strive to create “viable, workable and transparent plans for children, …[children’s] role in the development and implementation of any plan is essential.”

**Lesson 8: The state agency should develop opportunities for collaboration with local communities in addressing the needs of children and families.**

As social service agencies shift from a ‘government’ model, in which the public agency is responsible for identifying the need for and delivery of services, to a ‘governance’ model, in which the public agency’s role is to harness resources from a variety of sectors, social work administrators must find ways to develop responses with input from the communities being served. Within child welfare, the concept of community partnerships reflects the increasingly popular opinion that child protection is a responsibility shared by the government agency, other social service providers, social institutions, and the public.


218 Ibid, p. 108.


222 Ibid, p. 29.

at large. In other words, “[c]hild protection is not about how any one agency operates, but about how a community operates both formally and informally to protect children.”

DCS adopted this approach when it developed Cross-Functional Teams and Community Action Boards, structures that bridged the Department’s work with that of private providers and other community organizations. These units bolstered the relationships between DCS, providers, and community-based programs, and provided forums for various sectors to identify placement and service needs, and brainstorm strategies for fulfilling them.

Lesson 9: The state agency must maintain a reliable electronic data management system, select valid measures of child and family outcomes, and use the results of sophisticated data analyses to inform decision making.

Prior to Brian A., DCS had an inadequate electronic data system and little ability to track children over time. The Department’s inability to extract accurate, basic information on children’s cases (such as where the children were on a given day) hampered efforts to reduce the use of congregate care. The need for an improved child welfare data system became immediately evident in the early days of Brian A. monitoring because the Department had to track and report on numerous data indicators, including many pertaining to group care use.

Administrative data enable child welfare agencies to be reflexive organizations that learn from their own experiences. As such, maintaining a reliable and accessible electronic database is a critical component of any type of systemic reform. Child welfare agencies must collect information on families, track outcomes over time, and use these analyses to adjust service delivery as necessary.

But even a high-quality electronic data archive cannot be used to its full potential unless valid indicators are selected to measure child and family outcomes. As noted earlier, whereas permanency has concrete indicators, and measures of safety are generally agreed upon, identifying and selecting appropriate measures of child well-being is a matter of ongoing discussion in the child welfare field. Should we measure whether children’s well-being is addressed appropriately by the child welfare agency, as is common in statewide Quality Service Reviews and the federal Child and Family Services Review, or should we measure children’s emotional and psychological characteristics directly, a task requiring the delivery of a battery of lengthy assessments, which would be extremely difficult to implement? More generally, there is question as to whether well-being should be categorized as a child welfare outcome in the same way as safety and permanency are. Some researchers, for example, suggest that “safety and permanency are integral components of well-being, not two discrete legs of a three-legged stool that treats well-being in a somewhat disconnected way.”


227 Hartnett & Bruhn, op. cit.: 153.

228 Wulczyn et al., op. cit.: 154, p. 3.
Once appropriate indicators are selected, administrators must analyze them to understand current performance, set targets for the future, and evaluate progress. Analyzing administrative data by characteristics such as child age, race, ethnicity, family structure, or reason for entering foster care enables state agencies to measure the effectiveness of service initiatives for different subgroups of the populations they serve. Examining trends at various organizational levels (e.g., worker, office, county, region, contract provider) is also essential. This was especially relevant in Tennessee, where the Department faced the challenge of monitoring 13 separate regions’ efforts to reduce their reliance on congregate care. Because resource availability was not uniform across the state, and because different regional offices had different practice cultures and philosophies regarding the use of facilities, regions varied in their progress toward the goal of increasing family-based care. The DCS Central Office was well aware of this issue, used data to monitor regions’ progress, and targeted technical assistance to those regions that needed more support. Similarly, the regional offices used data to monitor their own progress and to target children who needed extra attention.

229 Moore, op. cit.: 225.
230 Moore, op. cit.: 225; Reidy et al., op. cit.: 226
231 Moore, op. cit.: 225.
CHAPTER 9

CONCLUSION
Because of this study’s design, generalizations to other jurisdictions should be made very cautiously; it cannot be assumed that a particular strategy perceived as effective in Tennessee will yield the same results in other jurisdictions. Any effort undertaken to bring about broad reform in a given child welfare system must employ strategies tailored specifically to address that system’s unique deficiencies, account for the cultural and political climate in which the system operates and the reforms will take place, and address the specific needs of the population of children and families that the system serves.

Nonetheless, the story of deinstitutionalization in Tennessee offers valuable lessons about large-scale child welfare reform that transcend jurisdictional boundaries. It underscores the power of class action litigation as a catalyst for change. It highlights the effectiveness of strategies that can reduce foster care’s reliance on institutional placements. And it speaks to the importance of precision, not only in selecting the policies and practices to implement within a jurisdiction and its subdivisions, but also in monitoring and evaluating those initiatives.

Although all state child welfare agencies continually have room to improve, Tennessee deserves praise for its campaign to reduce its reliance on congregate care. The reforms spurred by Children’s Rights and implemented by DCS were truly comprehensive, shaking up entrenched ways of thinking and operating in all corners of the child welfare system—from agency leadership and frontline practice to contracting and community involvement. The effort introduced new approaches reflecting more current perspectives on how best to serve the vulnerable children and families dependent on the Department.

The campaign was also inclusive and broad-based, fostering a new type of partnership among child welfare administrators and staff, private service providers, legislators, advocates, foster parents, and others to address a problem that had previously seemed unsolvable.

Most important, the reform’s impact has been felt widely and deeply. In implementing these reforms, Tennessee ushered in a new model that not only improved services and contributed to better outcomes for the many thousands of children in state custody at the time, but one that continues to ensure better care and results for children in foster care today and the countless others coming into care in the future.

DCS’s reduction of congregate care use should not be considered in a vacuum. An overuse or misuse of group care is a symptom of a child welfare system that has larger problems in the way it serves children and families. Although closing many of the state’s congregate facilities and installing limits on the use of those remaining were absolutely necessary to meet the Department’s goals for controlling the use of group care, these steps were not sufficient to address the deficiencies of DCS’s placement process. Limitations on the use of facility-based placements had to be combined with a renewed, holistic, system-wide commitment to permanency planning and its attendant philosophies and practices. In order to place children more appropriately, the Department needed to embrace simultaneously a variety of new approaches and initiatives—including family-centered and strengths-based practice, tailored case plans, the development of new resources enabling placements in the least restrictive environments available, thorough and ongoing assessments, and multidisciplinary and collaborative decision making.

Some child welfare administrators may fear that drastically reducing congregate care options before fully attending to these other practice and infrastructural improvements could risk the welfare of children already living in group care. Tennessee’s story shows that an early focus on reducing congregate care is consistent with, and may in fact contribute to, broader systemic improvements when carried out as part of a balanced, comprehensive effort—and even when carried out prior to other reforms.
CHAPTER 9: CONCLUSION

EPILOGUE

Reducing DCS's reliance on congregate care was just one of many reforms required by the Brian A. consent decree. In addition to its success in this area, the Department has made great strides over the past decade in a number of other areas. The state now has a Practice Model that outlines the agency's values and sets forward policies and procedures designed to put those values into practice. The Department has also improved the quality and training of its workforce and enhanced its electronic data collection system so that it can collect information and report on children's cases in a way that it could not when the lawsuit was filed.232

As DCS has made these reforms, the consent decree has been modified to reflect the Department's progress and evolving needs. In November 2010, the court approved an exit plan that supersedes the most recently modified settlement agreement and outlines the remaining improvements DCS must make and the outcomes it must sustain in order to request exit from federal court oversight. Most of the requirements pertaining to the use of congregate care are currently classified in the exit plan as in 'maintenance,' meaning that the Department has achieved the benchmarks set forth in the settlement agreement.233 Some provisions regarding group care have still not been met. For example, DCS has not yet fully streamlined its procedures for justifying and documenting placements in congregate care that classify as permissible exceptions to the standards for using group settings.

Although most of the areas set forth in the exit plan as needing additional improvement pertain to issues other than congregate care, they are critical to case planning for all children in foster care, including those placed in group settings. For example, the exit plan requires DCS to improve its ability to find permanent homes for children who have been in care for more than two years; this issue is of particular importance to older youth in group care, many of whom have grown up in state custody. The state must also improve its recruitment and retention of foster families—a development that is critical to the Department’s continued ability to move children out of group settings. And in general, the Department must continue to improve the quality of its case practice, including ongoing assessment, family engagement, and case planning and tracking, all of which pertain to children in group settings.

Given the state's progress and momentum to date, Children's Rights is hopeful that the Department will be able to sustain the achievements it has made and address the elements of its system that still pose concerns. If the recently appointed administration is able to build upon the progress of its predecessors and achieve these goals, DCS will be able to emerge from federal court oversight as a dramatically improved agency prepared to meet the needs of the children and families it serves. In the meantime, Tennessee is already a beacon for other states that struggle with the need to reduce their unnecessary and inappropriate use of congregate care.

232 Brian A. Technical Assistance Committee, op. cit.: 21.
233 In order to request termination of federal court jurisdiction, DCS must sustain 'maintenance' status on all exit plan provisions simultaneously for 12 months.
APPENDIX A
METHODOLOGY IN DETAIL
This study sought to answer two main questions: (1) How, since the 2000 filing of the Brian A. lawsuit, did DCS reduce its use of congregate care, and (2) how has this change affected the safety, permanency, and well-being of children and youth in foster care? The majority of the data was collected through interviews with stakeholders in Tennessee’s child welfare system. Information gleaned from these interviews was supplemented with analyses of numerous official DCS documents, quantitative administrative data, performance monitoring data, and ad hoc conversations with those involved with the system.

DEFINITIONS

The term ‘congregate care’ takes on various definitions depending on the child welfare system in which it is used. For our purposes, it included the types of settings DCS used during the time period covered in this study.234

- **Residential treatment centers**: Campus-like facilities providing care and treatment for children with serious mental health, emotional, and behavioral problems. Residents may attend local public schools, but typically attend schools on the center’s campus. Therapeutic services are provided on-site.
- **Group homes**: Facilities in residential communities that house a maximum of 12 youth at a time, normally older youth with moderate behavior problems who are not stable enough to be served in family settings but who can be maintained in the community. Residents typically attend local public schools but may attend on-site schools, and receive outpatient therapeutic services in the community.
- **Observation & Assessment (O&A) Centers/Primary Treatment Centers (PTC)**: Facilities designed to provide psychological and behavioral assessments of children either upon entry into foster care or during their spell in care. Stays in this type of setting are not intended to exceed 30 days.
- **Emergency shelters**: Facilities similar to O&A Centers/PTCs except that they do not include an assessment component; they are places where children are sent when no other placement can be found. They may be used for children first entering care and for children whose placements have disrupted.235
- **Hospitals**: In-patient facilities used for children experiencing symptoms that require 24-hour access to medical/psychiatric staff.
- **Tennessee Preparatory School**: A state-run residential school housing approximately 300 children at the time of the Brian A. filing that provided a congregate living environment and educational services.236

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235 Emergency shelters existed when the Brian A. lawsuit was filed but no longer exist as of this writing. Although from time to time, an O&A Center may be used to place a child in an emergency, there are no facilities specifically designated as emergency shelters. Former shelters have either shut down or been repurposed for other services.

236 The Tennessee Preparatory School existed when the Brian A. lawsuit was filed but no longer exists at the time of this writing. The process of its closure is discussed in detail in Chapter 3.

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As defined for this study, congregate care excluded Supervised Independent Living Programs, which are dormitory or apartment style facilities for older youth transitioning from foster care to emancipation; Youth Development Centers (YDCs), which are DCS’s juvenile detention facilities; and DCS-run group homes for youth stepping down from YDCs, because the Brian A. class does not include children entering foster care through the Juvenile Justice system.

SAMPLE SELECTION

Interviewees for the study were recruited using a comprehensive list of stakeholders who were active during the time of the Brian A. lawsuit. This list was shared with Children’s Rights attorneys on the Brian A. case, a DCS administrator, and a representative of the Brian A. Technical Assistance Committee who provided feedback regarding individuals’ appropriateness to be interviewed, whether there should be additions or omissions to the list of people generated, and whether the list represented the variety of stakeholder groups in the state. A small number of additional interviewees were recruited by snowball sampling—either: (1) interviewees recommended other appropriate participants who later provided interviews, or (2) an interviewee invited a colleague (or colleagues) to join in his or her interview.

Prospective participants were sent an email describing the study, explaining the procedures for consent (see Appendix B), and inviting them to participate. Of 63 prospective interviewees who were invited to participate, 51 provided an interview (five declined and seven failed to respond), yielding a response rate of 81 percent.

The sample consisted of seasoned professionals who had an average of 19 years experience working within Tennessee’s child welfare system. Participants were also professionally diverse; current and former DCS administrators and private providers represented the largest groups of respondents. Forty-five participants (88 percent) were involved in the Tennessee child welfare system at the time of the interview. Figure A.1 shows the number of participants in each stakeholder group.

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237 In cases in which an interviewee invited a colleague (or colleagues) to join in the interview, the additional interviewees (n = 4) were provided with an explanation of the study and consent procedures just prior to beginning the interview. They are included in the 63 prospective interviewees invited to participate.

238 n = 45; for six interviewees years of experience were not available.
**Figure A.1: Number of Participants, by Stakeholder Group**

<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Number of Interviewees</th>
<th>Percent of Sample</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocate</td>
<td>5</td>
<td>10%</td>
<td>Administrator of a child, family, or foster parent advocacy organization</td>
</tr>
<tr>
<td>Brian A. attorney</td>
<td>4</td>
<td>8%</td>
<td>Children's Rights attorney for plaintiffs in the <em>Brian A.</em> lawsuit</td>
</tr>
<tr>
<td>Brian A. Technical Assistance Committee</td>
<td>2</td>
<td>4%</td>
<td>Member of group of child welfare experts assigned by the court to provide guidance to DCS and monitor its compliance with the consent decree</td>
</tr>
<tr>
<td>Current DCS administrator</td>
<td>11</td>
<td>22%</td>
<td>Current DCS administrator, Central or Regional Office</td>
</tr>
<tr>
<td>Former DCS administrator</td>
<td>4</td>
<td>8%</td>
<td>Former DCS administrator, Central Office</td>
</tr>
<tr>
<td>Former foster youth</td>
<td>5</td>
<td>10%</td>
<td>Former Tennessee foster youth placed in congregate care during his/her time in foster care</td>
</tr>
<tr>
<td>Guardian <em>ad litem</em></td>
<td>3</td>
<td>6%</td>
<td>Attorney for children in foster care</td>
</tr>
<tr>
<td>Judiciary</td>
<td>2</td>
<td>4%</td>
<td>Juvenile court judge or magistrate</td>
</tr>
<tr>
<td>Private service provider</td>
<td>7</td>
<td>14%</td>
<td>Administrator of private agency contracted with DCS to provide placement and services for children in foster care</td>
</tr>
<tr>
<td>State legislature</td>
<td>3</td>
<td>6%</td>
<td>State Representative or legislative staff</td>
</tr>
<tr>
<td>Tennessee Committee on Children and Youth</td>
<td>2</td>
<td>4%</td>
<td>Staff of independent state agency with the mission of child and family advocacy</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>51</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

**INSTRUMENT DESIGN**

**Pre-interview survey**

The pre-interview survey (see Appendix C) provided the opportunity for the researcher to collect basic demographic information about the participants. It also served to prepare the interviewees by cueing them to the types of questions that would be asked during the interview.

The pre-interview survey contained a number of Likert scale questions that asked respondents to rate the role certain types of change agents played in DCS's process of reducing its use of congregate care. The categories were selected based on an extensive review of DCS policy documents and based on Departmental activities described in the *Brian A.* monitoring reports—periodic reports produced by the *Brian A.* Technical Assistance Committee that detail Tennessee's progress in achieving the goals set

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239 Proportions do not total 100% due to rounding.

240 Of the five former foster youth we interviewed, four spent time living in congregate care settings during the mid-late 1990s and 2000s. One, who was very positive about her experience at TPS was there during the late 1960s and early 1970s.

241 Guardians *ad litem* may represent children in other types of proceedings not related to foster care such as juvenile delinquency or custody cases. All guardians *ad litem* interviewed for this study had experience representing children and youth in foster care.

242 Respondents were asked to rate the categories on a scale of 1 through 6, with “1” labeled “Did not play a role” and “6” labeled “Played a very important role.”
forth in the settlement agreement. At the end of the pre-interview survey, respondents were asked to write a brief synopsis of the three factors that they believed had the greatest influence on DCS’s reduction in congregate care use.

These pre-interview activities were intended to start respondents thinking about the different change agents that they thought were most important. They were intentionally vague so that interviewees could anticipate the types of issues the researcher was interested in without being guided to particular responses.

**Interview protocol**

The interview protocol (see Appendix D) was semi-structured. It contained open-ended questions designed to capture stakeholders’ perceptions of DCS’s use of congregate care prior to 2000, steps the Department took to reduce its use of group settings, the difference between congregate care use prior to 2000 and at the time of the interview, and the effect of that change on safety, permanency, and well-being for children in foster care. A DCS administrator, two Children’s Rights attorneys on the Brian A. case, and the Executive Director of Children’s Rights provided feedback on the protocol questions before they were finalized.

**DATA COLLECTION**

**Pre-interview survey**

One-hour interviews were scheduled with those who consented to participate. At the time of scheduling, respondents were sent the pre-interview survey and asked to return the completed survey prior to their scheduled interviews.243 Figure A.2 provides data on the number and timely completion of pre-interview surveys.

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243 There were two exceptions to this process. The four interviewees who were invited to participate by another interviewee and not by the researcher were asked to complete the survey after the interview. Six other interviewees received an abridged pre-interview survey that asked only for information pertaining to the length and nature of their involvement in the Tennessee child welfare system. These six interviewees—five former foster youth and one DCS administrator—were not asked to complete the Likert scale and ‘top three’ items because they were considered as ‘targeted’ interviewees—individuals who were interviewed solely for the purpose of learning about their specific roles in the child welfare system.
Figure A.2: Number and Timely Completion of Pre-Interview Surveys

<table>
<thead>
<tr>
<th>Pre-interview survey</th>
<th>Number of Interviewees</th>
<th>Percent of Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-interview survey given prior to interview</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completed and returned prior to interview</td>
<td>36</td>
<td>71%</td>
</tr>
<tr>
<td>Completed and returned after interview</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Pre-interview survey given after interview</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completed and returned after interview</td>
<td>4</td>
<td>8%</td>
</tr>
<tr>
<td>Abridged pre-interview survey received</td>
<td>6</td>
<td>12%</td>
</tr>
<tr>
<td>(demographics only; n = 6 targeted interviewees)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-interview survey never returned</td>
<td>4</td>
<td>8%</td>
</tr>
<tr>
<td>Total</td>
<td>51</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Interview protocol**

All interviews were conducted by the same researcher, a Children's Rights senior policy analyst, between February and April of 2010. The exception to this was two participants who were interviewed in February 2011. In the remaining nine cases, interviewees who worked for the same agency were interviewed together, either because they preferred to participate in this way or because time constraints made a joint interview more efficient. The length of interviews ranged from 13 minutes to one hour and 25 minutes (mean length = 40 minutes; median length = 38 minutes). All interviews were audio recorded.

At the beginning of each interview, the researcher clarified the terms of confidentiality and the definitions of congregate care being used in the study. During the interview, the researcher used the respondent’s pre-interview survey (when available) to direct the conversation. In this way, the researcher was able to use the respondent’s previously articulated thoughts to direct the discussion.

Thirty-six (71 percent) participants were interviewed in Tennessee. In these cases, the researcher was accompanied by an assistant who took verbatim notes during the interview. These notes were used in three ways: (1) as a back-up in the event that audio recordings failed; (2) as a tool for reflecting on and processing interviewee comments directly after the interview; and (3) as a reference for correcting transcriptions. When interviews could not be conducted in person, they were conducted by phone and recorded; no assistant was on the line during the interview.

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244 Proportions do not total 100% due to rounding.
245 The exception to this was two participants who were interviewed in February 2011.
246 The remaining nine participants were interviewed two at a time (three interviews) or three at a time (one interview).
247 The six targeted interviewees did not receive the standard protocol questions during their interviews; they were asked questions about their specific role and experience and protocol questions not relevant to their experiences were omitted.
248 Results from the pre-interview Likert scale and ‘top-three’ questions were not analyzed. Interviewees’ responses were used solely as a prompting tool for the researcher during the actual interviews.
QUALITATIVE DATA ANALYSIS

Audio recordings were transmitted electronically to a professional transcription service. With the help of two research assistants, the researcher fixed errors in the returned transcripts by editing them while listening to their paired original audio recordings. Cleaned transcripts were uploaded to the qualitative data analysis software, NVivo 8. A coding scheme was developed by extracting themes from the transcripts of a variety of stakeholders and organizing them into nested categories. This process was repeated until the transcript analysis yielded no new relevant themes. Then, all transcripts, including the ones that had been used to create the coding structure, were coded. The researcher who conducted the interviews coded all of the transcripts. Unfortunately, time and budget constraints prohibited the use of additional coders, and therefore no check of the reliability of the coding process was conducted.

QUANTITATIVE DATA ANALYSIS

DCS provided Children’s Rights with two large datasets containing information on children’s placements in foster care between the years 2000 and 2009. These files were produced and delivered by the Chapin Hall Center for Children at the University of Chicago, with whom the Department contracts for assistance with data management and analysis. The data in these files were drawn from Tennessee’s State Automated Child Welfare Information System at the time, TNKids, and transmitted in Microsoft Excel format. The Excel spreadsheets were imported into the software SPSS 18.0 (also known as PASW Statistics 18), which was used to run all statistical analyses.

LIMITATIONS

Beyond the fact that what occurred in Tennessee was unique to that state and that this report represents a single case study, other limitations existed in the design and execution of this research.

Although efforts were made to survey an appropriate number and variety of individuals, the findings are limited by the fact that, given restraints of time and resources, more interviews could not be conducted. Thus, the opinions expressed by certain types of interviewees should not be understood as representing the perspective of all stakeholders with the same background or experience.

In addition, it is clear that certain voices are not sufficiently represented in the study. For example, it became clear during the synthesis of the interviews that it would have been helpful to include supervisors and frontline workers in our sample, as these perspectives were not tapped during data collection. Also, additional former foster youth who had been placed in group settings would have given greater voice to this group and added richness to the data regarding the discussion of the effect of congregate care reduction on safety, permanency, and well-being outcomes.249

Finally, the change agents and perceived outcomes described in this report are highlighted because interviewees considered them to be meaningful, not because they necessarily caused DCS’s reduction in congregate care. Scientific, quantitative studies that track the implementation of policies and practices and control for intervening variables are needed to make a causal conclusions.

249 We attempted to contact former foster youth through organizations such as Foster Care Alumni of America, FosterClub, Youth Villages, and Tennessee Youth Connections. We also followed up on recommendations from individual interviewees and others in the Tennessee child welfare community to whom we were referred.
APPENDIX B
INTERVIEWEE CONSENT FORM

Case Study: The Reduction of Congregate Care Use by Tennessee’s Department of Children’s Services
Children’s Rights

CONSENT FORM FOR STUDY INTERVIEWEES

Children’s Rights is conducting a case study examining how Tennessee’s Department of Children’s Services has been able to reduce the proportion of children in foster care placed in congregate care settings. Information will be collected via interviews with a range of stakeholders in Tennessee’s child welfare system. Relevant quantitative child welfare system data will also be reviewed and analyzed. The information gathered during the interviews and the system data analyzed will be incorporated into a final report that reflects the various perspectives that may exist on the change process and the effect of the change on children in foster care. The report will be disseminated widely so that other child welfare systems may benefit from learning about Tennessee’s experience and in order to inform national child welfare policy.

By participating in an interview for this project you understand and agree to the following:

• Your participation is voluntary. If you choose to participate, you may decide to stop participating at any time.

• Interviews will be audio recorded and transcribed, and notes will be taken during the interview.

• The information you provide will be incorporated into a final report and may be attributed to you directly in the report. If there is information that you wish to share, but do not want attributed to you, you may indicate this during the interview and your anonymity with respect to that information will be honored.

• The final report will be distributed publicly.

I have read and understand the above information and I agree to participate in an interview for Children’s Rights’ case study on the reduction of congregate care use by Tennessee’s Department of Children’s Services.

Interviewee – Print Name

Witness – Print Name

Interviewee – Signature

Witness – Signature

Date

Date
APPENDIX C
PRE-INTERVIEW SURVEY

Case Study: The Reduction of Congregate Care Use by Tennessee’s Department of Children’s Services
Children’s Rights

Stakeholder Pre-Interview Survey

<table>
<thead>
<tr>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Current Job Title and Affiliation</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>Phone Number</td>
</tr>
<tr>
<td>Email</td>
</tr>
</tbody>
</table>

1. How many years have you been involved in the Tennessee child welfare system?
Number of years: ___________

2. What year did your involvement in the Tennessee child welfare system begin?
Year: ___________

3. Are you currently involved in the Tennessee child welfare system?
☐ Yes  ☐ No
If not, in what year did your involvement end?   Year: ___________

4. In the space below, list the job titles and affiliations that you have held since 2000. In the columns provided, write in the years during which you held the position, your job title or role, the name of the organization, and the type of organization. (Add extra rows as needed.)

<table>
<thead>
<tr>
<th>Years position held (e.g., 2000-2003)</th>
<th>Job title or role</th>
<th>Name of organization</th>
<th>Type of organization (e.g., DCS, community service provider, congregate care provider, advocate, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
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<tr>
<td>4.</td>
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</tbody>
</table>
The remaining questions will help us prepare for the upcoming interview, and will help you get a sense of what sort of questions we will be asking. Generally, the interview will focus on two main questions: (1) How, practically speaking, did Tennessee DCS decrease its use of congregate care placements for children in foster care between 2000 and the present, and (2) what effect did this change have on children in foster care? Here, the term “congregate care” will refer to a variety of settings including group homes, residential treatment centers, emergency facilities and temporary shelters, youth development centers, and the Tennessee Preparatory School.

5. Below is a list of general factors that may have played a role in Tennessee DCS’ reduction of congregate care placements for children in foster care. Using the scale, rate the extent to which you think these factors were influential in making the change. A rating of “1” indicates that the factor did not play a role in the change at all; a rating of “6” indicates that the factor played a very important role in the change. If you think of other factors that are not on the list, please write them in the space(s) marked “Other.” During the interview, we will ask you to expand on your answers here.

<table>
<thead>
<tr>
<th>Factor</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>New policies</td>
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<tr>
<td>New practice approaches</td>
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<tr>
<td>New services</td>
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<tr>
<td>Changes in funding structures</td>
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<tr>
<td>New DCS leadership</td>
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<tr>
<td>Legislative leadership</td>
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<tr>
<td>Public-private initiatives</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Improvements to statewide information/data systems</td>
<td></td>
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</tr>
</tbody>
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Other (explain): .................................................

<table>
<thead>
<tr>
<th>Other (explain): .................................................</th>
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<tbody>
<tr>
<td>1</td>
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Other (explain): .................................................

<table>
<thead>
<tr>
<th>Other (explain): .................................................</th>
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<tr>
<td>1</td>
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Other (explain): .................................................

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<th>Other (explain): .................................................</th>
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<tr>
<td>1</td>
</tr>
</tbody>
</table>

6. In your opinion, what were the three most important changes that enabled Tennessee DCS to reduce its use of congregate placements for children in foster care (with #1 being the most important)? Please be specific.

1. 

2. 

3. 

I’m going to start recording now, so as noted in the consent form, if there’s anything from this point on that you don’t want attributed directly to you, just indicate that.

We’re here today to talk about how Tennessee has been able, since 2000, to reduce its use of congregate care for children in foster care, and the extent to which that change has affected children. Since there are many different definitions of congregate care, I want to clarify what kind of settings I’m referring to. Here I’m talking about group homes and residential treatment centers, but also emergency facilities and temporary shelters, youth development centers, and the Tennessee Preparatory School.

The interview will focus on two main questions: How, practically speaking, did DCS achieve this reduction in the use of congregate care placements, and how did this change affect children in foster care? In answering these questions, I’ll ask you to be as specific as possible.

I’m aware that different regions in Tennessee had different experiences with using congregate care placements. In some areas, the agency relied heavily on group homes and institutions; others relied more heavily on emergency placements such as diagnostic centers. I’m interested here in the use of all of these types of placements. You may have different things to say about different types of settings, and you should feel free to differentiate them as you respond. And of course, if there is a question you feel you can’t answer, that’s fine.

As you may know, the settlement of the Brian A. lawsuit, which was filed in 2000 and settled in 2001, put in place several requirements for the reduction of congregate care placements for children in foster care. Therefore, this interview will use the year 2000 as a marker of the starting point for this change in practice. So, to start off the conversation, I want to ask you a bit about DCS’s use of congregate care prior to that date.

1. Prior to 2000, how were decisions made to place children in congregate care settings in the Tennessee child welfare system? What types of children were placed in congregate care?

PROMPTS:
  a. The authority under which they entered care (D/N/U or JJ)?
  b. Special needs? Mental health/behavioral/psychological?
  c. Children first entering care vs. moving to congregate care during spell?
2. How, practically speaking, did DCS decrease its use of congregate care? (What actions were
taken? Were there challenges that had to be overcome?) Here I’m asking a couple of ques-
tions, and you may have different answers:

   How did DCS reduce the usage of group homes and institutions versus the use of emergen-
cy facilities?

   How did DCS reduce the use of congregate care as initial placements versus “step up” place-
ment moves?

PROMPTS:

a. Use the answers to the pre-interview survey as a springboard

   i. New policies?
   ii. New practice approaches?
   iii. New services?
   iv. Changes in funding structures or new funding streams?
   v. New DCS leadership?
   vi. New legislative leadership?
   vii. Public-private initiatives? (If so, who were the collaborators? Were there barriers to working
together?)
   viii. Improvements to statewide information systems?
   ix. Other?

   Note: Possible specific examples include:
   • Continuum contracts
   • Performance based contracting
   • Unified Placement Process
   • Path to Excellence/Road to Reform
   • Practice Model/Practice Wheel (Engagement, Teaming, Assessment, Long-Term View, Planning,
Implementation, and Tracking/Adaptation)
   • Dual approval for foster parents and adoptive parents
   • Implementation of the CANS
   • Legislative oversight committees
   • Select Committee on Children and Youth (legislative)

3. Has this process been easier for some regions than others? What accounts for this differ-
ence? [Note when talking to stakeholders in Knox, Hamilton, and Southwest that these had the
largest % change; but these were among the regions that had more room for improvement.]

4. How, specifically, did the closing of the Tennessee Preparatory School play a role in the
change process? What was the process for moving children out of that facility and to where
were those children moved?

5. What types of children are placed in congregate care today? Are there options available that
would enable these children to be served in the community?
6. Are there any types of services that are no longer being provided (or being provided sufficiently) in Tennessee since the reduction in congregate care placements? (i.e., services that c.c. used to provide that are now unavailable elsewhere)

7. In your opinion, is congregate care now being used appropriately for children in foster care? Are there still areas for improvement or challenges that still need to be overcome?

PROMPTS:

a. Are there areas for improvement in
   i. How children are placed?
   ii. Over/under utilization?
   iii. Length of stay?
   iv. Permanency planning for children in these settings?

8. How has the decrease in congregate care affected children? By this I mean, has it affected safety, permanency, and well-being outcomes for children in care? In what way?

9. Is there anything else that you would like to mention that we have not discussed?

10. Can you refer us to any other individual(s) who could provide helpful information for this project?
APPENDIX E

EXCERPT FROM TENNESSEE DEPARTMENT OF CHILDREN’S SERVICES PRIVATE PROVIDER CONTRACT REGARDING PERFORMANCE-BASED CONTRACTING
APPENDIX E
EXCERPT FROM TENNESSEE DEPARTMENT OF CHILDREN’S SERVICES PRIVATE PROVIDER CONTRACT REGARDING PERFORMANCE-BASED CONTRACTING

The text below is excerpted from the contract DCS uses with its private service providers. This section outlines the various scenarios through which provider agencies are either rewarded or assessed penalties under DCS’s performance-based contract and describes how the reward and penalty structure is phased in over the course of a provider’s involvement in such a contract. It also defines DCS’s performance outcomes as well as key terms regarding the assessment of progress with respect to baseline and target outcomes.

C. PAYMENT TERMS AND CONDITIONS:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed WRITTEN DOLLAR AMOUNT ($NUMBER). The payment rates in Section C.3 shall constitute the entire compensation due the Contractor for the Service and all of the Contractor’s obligations hereunder regardless of the difficulty, materials or equipment required. The payment rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor. The Contractor is not entitled to be paid the maximum liability for any period under the Contract or any extensions of the Contract for work not requested by the State. The maximum liability represents available funds for payment to the Contractor and does not guarantee payment of any such funds to the Contractor under this Contract unless the State requests work and the Contractor performs said work. In which case, the Contractor shall be paid in accordance with the payment rates detailed in Section C.3. The State is under no obligation to request work from the Contractor in any specific dollar amounts or to request any work at all from the Contractor during any period of this Contract.

C.2. Compensation Firm. The payment rates and the maximum liability of the State under this Contract are firm for the duration of the Contract and are not subject to escalation for any reason unless amended.

C.3. Payment Methodology. The Contractor shall be compensated based on the payment rates herein for units of service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in Section C.1.

a. The Contractor’s compensation shall be contingent upon the satisfactory completion of units, milestones, or increments of service defined in Section A.

b. The Contractor shall be compensated for said units, milestones, or increments of service based upon the following payment rates:

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Description</td>
<td>$ NUMBER per client per day</td>
</tr>
</tbody>
</table>


* NOTICE: The amount(s) per compensable increment detailed above shall be contingent upon the State’s receipt of an invoice (as required in section C.5., below) for said service(s) within thirty (30) days after the end of the calendar month in which the service(s) were rendered. At the sole discretion of the State, the amount per compensable increment of any service for which the State receives an invoice later than prescribed herein shall be subject to a reduction in amount of up to 100%. In the case of an untimely invoice, before any payment will be considered by the State, the Contractor must submit a written request regarding the untimely invoice, which shall detail the reason the invoice is untimely as well as the Contractor’s plan for submitting all future invoices no later than prescribed herein, and it must be signed by an individual empowered to bind the Contractor to this Contract.

c. The Contractor shall not be compensated for travel time to the primary location of service provision.

d. A “day” shall be defined as any period of time in the 24-hour period of a calendar day. The Contractor shall be paid the full rate per day per client placed with the Contractor, EXCEPT the Contractor shall NOT be paid any amount for the day that the client is removed from the placement with the Contractor.

Reinvestment Methodology. The State shall reinvest state dollar savings with the Contractor based on the achievement of outcomes. The percentage of state dollar savings to be reinvested with the Contractor and the Contractor paybacks for failure to achieve outcomes are defined in the following table:
<table>
<thead>
<tr>
<th>YEAR ONE</th>
<th>Contractor Reinvestment of State Dollar Expenditure</th>
<th>State Reinvestment of State Dollar Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Care Days Equal to or Greater than Baseline</td>
<td>Care Days Less than Baseline</td>
</tr>
<tr>
<td>1</td>
<td>Exits to permanency less than baseline and re-entries greater than baseline</td>
<td>0%</td>
</tr>
<tr>
<td>2</td>
<td>Exits to permanency less than baseline and re-entries less than baseline range and greater than targeted re-entries</td>
<td>0%</td>
</tr>
<tr>
<td>3</td>
<td>Exits to permanency less than baseline and re-entries less than or equal to targeted re-entries</td>
<td>0%</td>
</tr>
<tr>
<td>4</td>
<td>Exits to permanency greater than baseline and less than targeted exits to permanency and re-entries greater than re-entry baseline range</td>
<td>0%</td>
</tr>
<tr>
<td>5</td>
<td>Exits to permanency greater than baseline and less than targeted exits to permanency and re-entries less than baseline range and greater than targeted re-entries</td>
<td>0%</td>
</tr>
<tr>
<td>6</td>
<td>Exits to permanency greater than baseline and less than targeted exits to permanency and re-entries less than or equal to targeted re-entries</td>
<td>0%</td>
</tr>
<tr>
<td>7</td>
<td>Exits to permanency greater than targeted exits to permanency and re-entries equal to or greater than baseline range</td>
<td>0%</td>
</tr>
<tr>
<td>8</td>
<td>Exits to permanency equal to or greater than targeted exits to permanency and re-entries less than baseline range and greater than targeted re-entries</td>
<td>0%</td>
</tr>
<tr>
<td>9</td>
<td>Exits to permanency greater than targeted exits to permanency and re-entries equal to or less than targeted re-entries.</td>
<td>0%</td>
</tr>
</tbody>
</table>
Performance will be evaluated semi-annually and compensation for reinvestment dollars will be paid to the Contractor annually. Contractor paybacks will be netted against payments.

All performance (Exits, Care Days and Re-entries) will continue to be monitored throughout the term of the contract. Performance expectations will continue to be based on historical performance of the original base line population.

<table>
<thead>
<tr>
<th>YEAR TWO FORWARD</th>
<th>Contractor Reinvestment of State Dollar Expenditure</th>
<th>State Reinvestment of State Dollar Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Care Days Equal to or Greater than Baseline</td>
<td>Care Days Less than Baseline</td>
</tr>
<tr>
<td>10</td>
<td>Exits to permanency less than baseline and re-entries greater than baseline</td>
<td>-100%</td>
</tr>
<tr>
<td>11</td>
<td>Exits to permanency less than baseline and re-entries less than baseline range and greater than targeted re-entries</td>
<td>-90%</td>
</tr>
<tr>
<td>12</td>
<td>Exits to permanency less than baseline and re-entries less than or equal to targeted re-entries</td>
<td>-85%</td>
</tr>
<tr>
<td>13</td>
<td>Exits to permanency greater than baseline and less than targeted exits to permanency and re-entries greater than baseline range</td>
<td>-90%</td>
</tr>
<tr>
<td>14</td>
<td>Exits to permanency greater than baseline and less than targeted exits to permanency and re-entries less than baseline range and greater than targeted re-entries</td>
<td>-80%</td>
</tr>
<tr>
<td>15</td>
<td>Exits to permanency greater than baseline and less than targeted exits to permanency and re-entries less than or equal to targeted re-entries</td>
<td>-75%</td>
</tr>
<tr>
<td>16</td>
<td>Exits to permanency greater than targeted exits to permanency and re-entries equal to or greater than baseline range</td>
<td>-90%</td>
</tr>
<tr>
<td>17</td>
<td>Exits to permanency equal to or greater than targeted exits to permanency and re-entries less than baseline range and greater than targeted re-entries</td>
<td>-75%</td>
</tr>
<tr>
<td>18</td>
<td>Exits to permanency greater than targeted exits to permanency and re-entries equal to or less than targeted re-entries</td>
<td>-70%</td>
</tr>
</tbody>
</table>
Performance Based Reinvestment Definitions

In Care Population — The population in care as of July 1, 2009 will be established from a TNKIDS census of all active cases on August 1, 2009. DCS will establish an interim census count of all active TNKIDS cases from a June 1, 2009 data snapshot. The population in care will be adjusted to reflect the August 1, 2009 data on or before August 15, 2009.

Baseline — The baseline expresses how the Contractor would be expected to perform (i.e., achieve safety and permanency for children) under a “business as usual” scenario. The baseline is created using historical TNKIDS data and reflects the traditional or normal pattern of paid care day utilization for a specific provider.

Baseline Admissions — The expected number of children admitted to the Contractor during the fiscal year, based on the historical number of annual admissions.

Baseline Care Days — The expected number of bed days a Contractor would be anticipated to use within one fiscal year, based on the number of children in the in care population, the number of admissions, and the average placement duration for the children in the in care and admission populations. The initial baseline care days will be based on the number of children in the in care population, the historical number of admissions and the historical average of care days. This baseline will be adjusted at the end of each fiscal year to reflect actual admissions and actual average care days.

Baseline Exits to Permanency — The number and percent of children, from the corresponding in care and admission populations, a Contractor would be expected to exit from out-of-home care, within the fiscal year, to permanency (as defined in this section).

Baseline Re-entries — The number and percent of children discharged to permanency who may be expected to return to care, given historical performance. For purposes of estimating the reentry to care, return to out-of-home care means any child who returns to out of home care within a year of the child’s permanent exit, whether the foster home is supervised by DCS, or a Contractor. For purposes of calculating the re-entry rate, the base includes children discharged to permanency from either the in care or admission population within the fiscal year, who returns to care within a year. Reentries (as defined above) will continue to be tracked against the historical performance in the next fiscal year.

Baseline Re-entries Range — A plus or minus range built around the baseline reentry rate that captures variation in the reentry rate observed at the agency level. The range is intended to reflect the fact that factors beyond the control of an agency (e.g., sibling groups) may influence the reentry rate.

Targeted Care Days — The total number of paid care days a Contractor is expected to provide given improvements in outcomes for children (i.e., safety and permanency). The difference between the target care days and the baseline caredays, expressed as a percentage, is the performance improvement for purposes of calculating the reimbursement.

Targeted Exits to Permanency — The number and percent of children for whom a Contractor can be projected to achieve a permanent exit, given improvement in performance.

Targeted Re-entries — The number and percentage of returns to out of home care after a successful exit to permanency within the fiscal year.

Re-entry to Custody — Any child that has a permanent exit from care and returns to custody within one (1) year.

Exits to Permanency — All exits that are intended to provide the child with a stable, permanent family: reunification, guardianship and adoption.

Non-permanent Exits — All exits (e.g., transfers, runaway) that are not permanent.
APPENDIX F
DEMOGRAPHIC OVERVIEW OF CHILDREN IN FOSTER CARE IN TENNESSEE

Race and ethnicity

The racial and ethnic backgrounds of children entering foster care in Tennessee have remained relatively stable since 2000 at approximately 65 percent white, 25 percent African American, and 5 percent Latino. Figure F.1 shows that during this time, the proportion of African American children entering care has dropped slightly and the proportion of Latino children entering care has increased slightly.

Figure F.1: Racial/Ethnic Background of Children Entering Foster Care

As is the case nationwide (though less dramatically in Tennessee than nationally\textsuperscript{250}), African American children are overrepresented in foster care relative to their presence in the general statewide population; in Tennessee, 69 percent of children are white, 20 percent are African American, and 7 percent are Latino.\textsuperscript{251} The point-in-time data tell a somewhat promising story about the African American foster care population in the state. Figure F.2 shows that since 2001, the proportion of African American children in foster care has decreased steadily from 39 percent on January 1, 2001 to 26 percent on January 1, 2009. In the earlier years, the proportion of African American children \textit{in care} far exceeded the proportion of African American children \textit{entering} care; for example, in 2001, although 28 percent of children entering foster care were African American, 39 percent of children in foster care on January 1, 2001 were African American. In contrast, in 2008, 23 percent of children entering care were African American, and 27 percent of children in care on January 1, 2008 were African American—a much smaller difference.

\textsuperscript{250} Whereas African American children make up 14 percent of the national child population, they make up 30 percent of the national foster care population; whereas white children make up 68 percent of the national child population, they make up 40 percent of the national foster care population (American FactFinder. (no date). U.S. Census. Retrieved May 5, 2011, from http://factfinder.census.gov/servlet/STTable?_bm=y&qr_name=ACS_2009_5YR_G00_50901&-geo_id=01000US&-ds_name=ACS_2009_5YR_G00_&-_lang=en&-format=&-CONTEXT=st; United States Department of Health and Human Services, op. cit.: 8)

This finding suggests that while at the beginning of this decade African American children were more likely to remain in care longer than white children, in recent years the proportions of African American and white children remaining in care are about the same as the rates at which they enter care.\textsuperscript{252}

Figure F.2: Racial/Ethnic Background of Children in Foster Care on January 1

<table>
<thead>
<tr>
<th>Census Year</th>
<th>African American</th>
<th>White</th>
<th>Latino</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>56%</td>
<td>39%</td>
<td>2%</td>
</tr>
<tr>
<td>2002</td>
<td>57%</td>
<td>37%</td>
<td>2%</td>
</tr>
<tr>
<td>2003</td>
<td>59%</td>
<td>34%</td>
<td>3%</td>
</tr>
<tr>
<td>2004</td>
<td>59%</td>
<td>34%</td>
<td>3%</td>
</tr>
<tr>
<td>2005</td>
<td>60%</td>
<td>32%</td>
<td>4%</td>
</tr>
<tr>
<td>2006</td>
<td>60%</td>
<td>31%</td>
<td>4%</td>
</tr>
<tr>
<td>2007</td>
<td>60%</td>
<td>30%</td>
<td>5%</td>
</tr>
<tr>
<td>2008</td>
<td>63%</td>
<td>27%</td>
<td>5%</td>
</tr>
<tr>
<td>2009</td>
<td>64%</td>
<td>26%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Sex

Entry cohort data show that since 2000, children entering foster care have been roughly 50 percent male and 50 percent female. The point-in-time data show a similar picture; the in-care population has been split roughly evenly by sex since 2001.

Age

Figure F.3 shows the age of children entering foster care since 2000. The median age at entry dropped from 10 years old in 2000 to eight years old in 2003, where it has remained. Figure F.4 shows a similar trend in the point-in-time data; the median age of children in care dropped from 11 years old on January 1, 2001 to nine years old on January 1, 2009.

\textsuperscript{252} The Brian A. complaint also alleged unlawful discrimination in the care, treatment, and services delivered to a subclass of all African American children in foster care. This claim was settled in the consent decree by requiring a funded study of racial disparities within the system and DCS’s commitment to implement the recommendations of that study. One recommendation pertaining to the use of congregate care was the suggestion that key monitoring outcomes be analyzed by race.
Figure F.3: Mean and Median Age of Children Entering Foster Care

Figure F.4: Mean and Median Age of Children in Foster Care on January 1