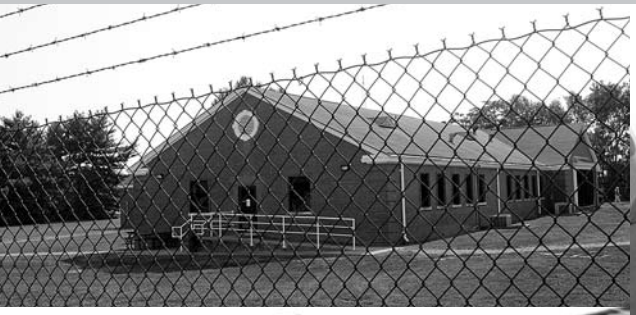

WHAT WORKS IN CHILD WELFARE REFORM:

REDUCING RELIANCE ON CONGREGATE CARE IN TENNESSEE

EXECUTIVE SUMMARY

JULY 2011

CHILDREN'S RIGHTS

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INTRODUCTION

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.

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 setting[2]—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]

1 Janchill, M. P. (1981). *Guidelines to decision-making in child welfare.* New York: Human Services Workshop.

2 Foster Family-Based Treatment Association. (2004). *What is treatment foster care?* Retrieved December 10, 2010, from http://www.ffta.org/whatis.html

3 Fischer, P. A., Gunnar, M. R., Chamberlain, P., & Reid, J. B. (2000). Preventive intervention for maltreated preschool children: Impact on children's behavior, neuroendocrine activity, and foster parent functioning. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*(11), 1356-1365.

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.[4] 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.[5]

Additionally, social science research has documented that in many circumstances, children placed in foster homes have better outcomes than children placed in group settings,[6] 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.[7]

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.[8] 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,[9] in 2009, 10 states placed between 12 and 20 percent of newly entering foster children age 12 and younger in group settings.[10] 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.

4 Child Welfare League of America. (2005). *Position statement on residential services.* Washington, DC: Author. Retrieved October 6, 2010, from http://www.cwla.org/programs/groupcare/rgcpositionstatement.pdf

5 Janchill, op. *cit.*: 1.

6 Lee, B. R., Bright, C. L., Svoboda, D. B., Fakunmoju, S., & Barth, R. P. (2011). Outcomes of group care for youth: A review of comparative studies. *Research on Social Work Practice, 21*(2), 177-189. Note: Studies in this meta-analysis include samples from child welfare and juvenile justice populations.

7 Barth, R. P. (2002). *Institutions vs. foster homes: The empirical base for the second century of debate.* Chapel Hill, NC: University of North Carolina School of Social Work, Jordan Institute for Families. Retrieved December 10, 2010, from http://www.dbhds.virginia.gov/documents/CFS/cfs1-9RefDocs-RPBarth-vs-FosterHome.pdf

8 United States Department of Health and Human Services. (2009). *The AFCARS report: Preliminary FY 2009 estimates as of July 2010 (17).* Retrieved October 13, 2010, from http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report17.pdf. 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).

9 Janchill, op. *cit.*: 1.

10 United States Department of Health and Human Services. (no date). Child welfare outcomes report data. Retrieved April 21, 2011, from http://cwoutcomes.acf.hhs.gov/data/

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.[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.[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?

11 Annie E. Casey Foundation. (2010). *Rightsizing congregate care: A powerful first step in transforming child welfare systems.* Baltimore, MD: Author. Retrieved October 6, 2010, from http://www.aecf.org/-/media/Pubs/Topics/Child%20Welfare%20Permanence/Foster%20Care/RightsizingCongregateCareAPowerfulFirstStepin/AECF_CongregateCare_Final.pdf

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[13] 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."[14] 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,"[15] assessing such things as children's safety, mental health, and social and developmental functioning, as well as

13 State of Tennessee Department of Children's Services. (2003). *Standards of professional practice for serving children and families: A model of practice.* Retrieved August 19, 2010, from http://www.state.tn.us/youth/dcsguide/DCS_PracticeModel11.24.03.pdf

14 *Ibid*, pp. 97-98, 100.

15 State of Tennessee Department of Children's Services. (no date). *Policy attachment: 11.1, CANS case protocol. Effective 11/1/08*, p. 1. Retrieved July 1, 2010, from http://www.state.tn.us/youth/dcsguide/policies/chap11/CANSProtocol.pdf

caregivers' strengths and needs.[16] 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.

16 State of Tennessee Department of Children's Services. (2008). *Child and Adolescent Needs and Strengths (CANS) comprehensive multisystem assessment manual, Tennessee version.* Retrieved July 2, 2010, from http://tennessee.gov/youth/dcsguide/manuals/CANSAssessmentManual.pdf

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.[17] 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 in the full report 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,

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.*: 8.

21 *Brian A.* Technical Assistance Committee. (November 6, 2010). *Monitoring report of the Technical Assistance Committee in the case of* Brian A. v. Bredesen. Nashville, TN: Author. Retrieved November 30, 2010, from http://www.childrensrights.org/wp-content/uploads//2010/11/2010-11-10_tn_tac_monitoring_report.pdf

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.

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[24]—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.

24 Smith, B. D. (2010). Service technologies and the conditions of work in child welfare. In Y. Hasenfeld (Ed.), *Human services as complex organizations* (pp. 253-267). Thousand Oaks, CA: Sage Publications.

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.

Full report available at www.childrensrights.org/congregatecare

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