

MONITORING REPORT

OF

**THE TECHNICAL ASSISTANCE
COMMITTEE**

IN THE CASE OF

BRIAN A. V. HASLAM

February 8, 2016

TECHNICAL ASSISTANCE COMMITTEE:

Steven D. Cohen
Senior Associate
Annie E. Casey Foundation
Baltimore, MD

Judy Meltzer
Deputy Director
Center for the Study of Social Policy
Washington, D.C.

Andy Shookhoff
Attorney
Nashville, TN

Paul Vincent
Director
Child Welfare Policy and Practice Group
Montgomery, AL

TECHNICAL ASSISTANCE COMMITTEE STAFF:

Michelle Crowley
Jamie McClanahan
Kelly Whitfield

Table of Contents

Introduction..... 1

Section VI Provisions: Placement and Supervision of Children (VI.A.1.h; VI.B; VI.D;
VI.E; VI.H) 3

Section VII Provisions: Planning for Children (VII.B; VII.K; VII.M) 41

Section VIII Provisions: Freeing a Child for Adoption VIII.A; VIII.C.1; VIII.C.2)..... 68

Section XVI Provisions: Outcome and Performance Measures (XVI.A.1)..... 74

Section XIX Provision: Establishment of an External Accountability Reporting Center
(XIX.A)..... 89

Child Death Review Process..... 90

Appendices

INTRODUCTION

This report was prepared by the Technical Assistance Committee (TAC) pursuant to the Modified Settlement Agreement and Exit Plan entered on October 24, 2012 in *Brian A. v. Haslam, Civ. Act. No. 3:00-0445 (Fed. Dist. Ct., M.D. Tenn.)*, a civil rights class action brought on behalf of children in the custody of the Tennessee Department of Children's Services (DCS). The "*Brian A. class*" includes all children placed in state custody because:

- (a) they were abused or neglected; or
- (b) they engaged in non-criminal misbehavior (truancy, running away from home, parental disobedience, violation of a "valid court order," or other "unruly child" offenses).

The Modified Settlement Agreement and Exit Plan (hereinafter referred to as the Settlement Agreement) requires improvements in the operations of the Department of Children's Services, establishes the outcomes to be achieved by the State of Tennessee on behalf of children in custody and their families, and provides for termination of court jurisdiction after the Department meets and maintains compliance with the provisions of the Settlement Agreement for a 12-month period.

The Role of the Technical Assistance Committee (TAC)

The TAC has three functions under the Settlement Agreement: first, it serves as a resource to the Department in the development and implementation of its reform effort (XIV); second, it monitors and reports on the Department's progress in meeting the requirements of the Settlement Agreement (XV); and third, it serves a mediation/dispute resolution function (XVIII).

This is the fourteenth monitoring report issued by the TAC.

In addition to these monitoring reports, the TAC has filed three reports related specifically to concerns raised about TFACTS, the Department's automated information system. The *Report of the Brian A. Technical Assistance Committee on its Evaluation of TFACTS* was filed on April 2, 2013; an *Update on Developments Related to the TFACTS Evaluation Findings and Recommendations* was filed on September 17, 2013, and an additional *Update* was filed on June 11, 2014.¹

The Focus and Organization of this Monitoring Report

At the request of the parties and with the approval of the Court, this monitoring report is focused on providing information on the Department's progress on the remaining 13 provisions of the Settlement Agreement that were not designated as "maintenance" in the Modified Settlement Agreement and Exit Plan entered by the Court on October 5, 2015. This monitoring report also

¹ Previous monitoring reports are available online at <http://www.tn.gov/dcs/topic/brian-a.-settlement-agreement>. The TFACTS Evaluation and Updates are also available at this link.

includes information on child deaths and near deaths of children that occurred during 2015 and the TAC's assessment of the current functioning of the Department's Child Death Review process.

This report presents information related to these specific provisions in the order in which those provisions appear in the Settlement Agreement.

SECTION VI PROVISIONS: PLACEMENT AND SUPERVISION OF CHILDREN

VI.A.1.h Prohibition Against Placing Aggressive Children with Non-Aggressive Children to Whom They Pose a Significant Threat

The Settlement Agreement requires that DCS “*not place any child determined by a DCS assessment to be at high risk for perpetrating violence or sexual assault in any foster care placement with foster children not so determined.*”

At the time that the TAC issued its July 2015 Monitoring Report, the Department was implementing a number of improvements in the processes intended to ensure that children who pose a high risk to the safety of other children are identified and that those children are not commingled with non-aggressive children to whom they would pose a safety risk.² As discussed below, those improvements are now in place and they have strengthened the Department’s management and oversight of “high risk placements” in significant ways. For ease of reference, the discussion below includes both these additional developments and the relevant information presented in the July 2015 Monitoring Report.

A. Identifying Children who are High Risk when they enter DCS custody

The Child and Adolescent Needs and Strengths (CANS) is the key formal assessment tool that the Department uses to identify children who pose a risk to the safety of other children. However, the Department recognizes that when a child first enters DCS custody, consideration should be given to whether a child poses a safety risk to himself or others, even in advance of the CANS completion, based on the information collected at the time of entry into custody from a variety of sources (family members, the juvenile court, providers that have worked with the child and family, as well as any prior contact with DCS) and from the circumstances surrounding the child’s entry into care. The “placement packet” that is shared with prospective providers when a child comes into care as well as the “placement checklist” shared with DCS resource parents at the time of placement are expected to include information about the child’s behaviors, including those that might pose a risk to others.³

The case manager is expected to complete the CANS assessment within seven business days of a child entering custody and route the CANS to the supervisor for approval. Pending approval,

² As discussed later in this subsection, the fact that a child has a high risk Child and Adolescent Needs and Strengths (CANS) score for aggressive behavior does not preclude placing that child with children to whom the child would pose little or no risk. For example, a young child who has exhibited aggressive behaviors towards younger children but gets along well with older children would not be precluded from placement in a home with a teenager. While the Department relies on the CANS to “flag” children who have exhibited aggressive behaviors and might pose a danger to other children, the Department appropriately considers the nature of a child’s behavior and the specific characteristics of the resource home and the other children in that home in determining whether this child, in the context of that specific placement, poses a danger to other children in the home.

³ The relevant behaviors specifically set forth in the checklist form include sexual acting out, sexual aggression, physical aggression, and assault.

any child that has scored a 2 or 3 on the standard “high risk” items is to be considered a “high risk” child for purposes of initial case planning and placement.

The case manager’s supervisor is expected to review the CANS and submit the CANS to the regional Assessment Consultant (formerly the CANS Consultant). The Assessment Consultant is expected to review and approve the CANS (or send it back to the case manager and supervisor if it needs additional work). Once the Assessment Consultant approves the CANS, the service intensity levels and scores for all items (including those related to the high risk determination) are finalized.

B. Formal Notification of Regional and Network Development Staff

Once the CANS is finalized, if a child is determined to be “high risk” based on the CANS assessment, the Assessment Consultant sends a formal notification to the appropriate regional staff (the case manager, the supervisor, and the regional high risk review team) and the Central Office (Network Development, the division responsible for placement and provider services). This notification includes information about the child and an explanation for the high risk designation.

C. The Regional High Risk Review Process

The Regional High Risk Review Team⁴ is expected to review the cases of newly identified high risk children (whether the high risk determination is made based on the Initial CANS or on a subsequent Reassessment CANS) within 30 days of that initial high risk determination.⁵ In addition, the High Risk Review Team is expected to continue to review those children at least once every three months as long as those children remain designated as “high risk.”

If a high risk child is placed in a resource home with children who are not high risk, the team is expected to review the appropriateness of the placement, to determine what, if any, efforts have been made through a safety plan or otherwise to mitigate any risks that child may pose to other children in the home, and to make recommendations as to whether any further actions, including considering a change in placement, should be taken.⁶

⁴ Each region has a specially designated High Risk Review team. The team includes the Regional Assessment Consultant (the master’s level “CANS Consultant” provided to each region by the Vanderbilt Center of Excellence to both support the CANS process and provide general assessment support). Other members of the High Risk Review Team may include the Regional Administrator or Deputy Regional Administrator, regional psychologist, team coordinators, team leaders, case managers, provider staff, and placement staff. Central Office Network Development staff also regularly participate in regional meetings.

⁵ Many regions review new cases weekly, some meet twice a week, some meet twice a month, and some regions’ high risk teams convene on an emergency basis as necessary.

⁶ While the High Risk Review Team is focused on assessing the appropriateness and safety of the child’s current resource home placement, the discussion often generates information relevant to evaluating the decision making that resulted in the commingling in the first place. The Central Office Network Development staff, who participate in the regional high risk reviews and who track high risk placements, use the information generated by the High Risk Review to identify and respond to factors that contribute to an inappropriate initial decision to commingle a high risk child with a non-high risk child.

To both support the work of the regional high risk review teams and facilitate QA oversight of that process, the Department has recently implemented a standardized approach to identifying cases for which a review is required, to documenting the high risk review, and to tracking those cases to ensure that reviews are occurring as required.

Utilizing a bi-weekly TFACTS report (the CANS High Risk Report) that identifies all children who have a current high risk CANS,⁷ Network Development staff provide each region an up-to-date spreadsheet with all children from that region who are subject to the review.⁸ This is a “rolling tracking log”—those who are newly identified as high risk are added to the spreadsheet, and those who were previously identified as high risk remain on the spreadsheet until they are no longer high risk (as determined by a subsequent CANS).

To help ensure that any child newly identified as high risk is reviewed within a month of the completion of the CANS (initial or reassessment) on which the high risk determination was based, the spreadsheet includes a column highlighting any new child added during the report period, whose cases would therefore require an initial high risk review.

To help ensure that, in addition to reviewing newly identified high risk children, the regions are conducting regular quarterly reviews of any child who continues to be high risk, the spreadsheet includes a column highlighting any child whose case has previously been reviewed but who remains high risk and is due for a quarterly high risk review.

The current regional high risk review process is well-designed and has been conscientiously implemented. The regional high risk teams are appropriately constituted and meet at least monthly.⁹ Central Office staff participate regularly in the regional reviews both to support the process and to monitor the quality of the reviews.¹⁰ The Central Office staff also maintain and update the high risk spreadsheets. Central Office staff, based both on the regional reviews they participate in and on reviews of the data captured in the spreadsheet, seek to identify and follow up on any cases that might raise either an individual or systemic concern.¹¹

⁷ This report, which has been validated by the TAC, lists all high risk children, regardless of placement location or the length of time the child has been high risk. If the most current CANS deemed a child high risk, the child will continue to appear on this report until a subsequent CANS indicates that they are no longer high risk.

⁸ The spreadsheet includes children placed in all placement settings and of all adjudications. The spreadsheet also shows the most current placement date for the child so it can be used to identify children who moved during the report period.

⁹ During November 2015, all regions held more than one high risk review meeting. Eight regions routinely hold high risk review meetings each week.

¹⁰ The two Central Office staff who support the review process have been intimately involved with the regions in designing and implementing the improvements to the high risk review process. Participation in the reviews has been a key strategy for helping ensure that the reviews are meeting expectations. While initially at least one Central Office staff person participated in every regional review, the Central Office staff are now adjusting the frequency of their participation to focus on those regions that can most benefit from some additional support and technical assistance.

¹¹ The TAC monitoring staff have reviewed the tracking documents from those reviews and have participated in at least one regional review for each region. The process ensures that all cases are receiving timely reviews.

D. The Role of Network Development

Network Development has developed a multifaceted process to ensure that regions and providers are aware of the specific risks presented by the high risk children for whom they are responsible so that the regions and providers can factor that information into placement decisions and ensure that the appropriate steps have been taken to mitigate the risks presented by those children in their placements.

First, Network Development staff use the information received from the Assessment Consultant (described in Subsection B above) to generate an additional formal notification, which Network Development sends (as applicable) to providers,¹² Resource Parent Support staff, the child's case manager and supervisor, and other staff designated by the regions to receive this notification. For the provider or DCS staff responsible for the child's placement, the formal notification provided by Network Development serves both as an alert that a child has been designated high risk and as a reminder that if the high risk child is in a resource home, a safety plan must be developed immediately (if one has not already been done) and shared with regional staff within five days of completion.¹³ The notification also states that if the child is in a residential placement, a safety plan must be completed prior to or at the time of step down into a resource home.¹⁴ When the child is in a provider placement, the notification also serves as a reminder to DCS staff to follow up with the provider if a safety plan has not been received from the provider within the five-day time frame.

Second, as described in the previous subsection, Network Development staff generate from the bi-weekly High Risk CANS Report the spreadsheets for each region that support the Regional High Risk Process.

Third, every two weeks when the High Risk CANS Report is produced, Network Development filters the report by provider (creating a spreadsheet for each provider that lists the high risk children who are placed with their agency at the time the report is generated) and highlights any children who have been added to the report since the previous report. Network Development then forwards each provider its own spreadsheet for reference when making new placements, planning step-downs, and ensuring safety plans have been completed when necessary.

Finally, Network Development staff maintain a list of all notifications received from the Assessment Consultants and forwarded to DCS and/or provider staff, which they then compare to the bi-weekly High Risk CANS Reports as a check to ensure that all notifications have been received from the Assessment Consultants and forwarded to the appropriate DCS and/or provider staff.

¹² This notification goes out to all providers, for all placement types, except temporary hospital settings (non-contract placements).

¹³ While safety plans have been part of the Department's practice for many years, the Department has provided updated training to staff on the use of a newly developed statewide safety planning tool to ensure uniformity and consistency in safety plan practice across the state. Private provider agency staff have also been trained on the new safety planning tool and are expected to incorporate the required elements of the DCS tool into their own safety plan tools or to adopt the Department's tool.

¹⁴ The Department currently requires safety plans only for high risk children in resource homes.

E. The Role of the Child and Family Team and Resource Parent Support Staff

The high risk reviews conducted by the regional teams provide important administrative oversight of high risk placements and serve an important quality assurance function; and the Network Development staff play an important role in both assuring that every high risk child is subject to a regional review and helping private providers keep focus on high risk children in private provider placements. However, these processes are not intended to relieve the Child and Family Team of its responsibility to ensure that individual children are in safe and appropriate placements.

The Department expects that in making any placement decision, the Child and Family Team will specifically determine whether the child is at high risk for aggressive behavior, and if the child is, that the Child and Family Team will consider whether the current placement or any proposed placement for the child is also serving child(ren) who are not aggressive.¹⁵ Conversely, the Department expects that in making any placement decision for a child who is not aggressive, the Child and Family Team will specifically determine whether any proposed placement is presently serving a child at high risk for aggressive behavior.¹⁶

Case managers are expected on an ongoing basis to identify and address any concerns about child safety in face-to-face contacts with children (including specific discussions outside the presence of the caregiver) and visits to the resource home or congregate care facility. Other members of the Child and Family Team who, based on interactions with the child or other sources of information, are concerned about a child's safety or a threat that a child poses to others is expected to raise those concerns.

In addition, resource parent support staff are expected to visit resource parents and be available to field questions and concerns from those resource parents, and they are expected to identify and address any safety concerns that arise from their contacts or conversations with resource parents.

Especially in cases in which the high risk behaviors were not apparent or readily identified until after the child's placement had been made, it is the ongoing day-to-day casework supported by the Child and Family Team process, combined with the work of the resource parent support staff, that is the "first line of defense" to ensure any emerging safety issues are identified and addressed appropriately.

F. Results of the Targeted Review of High Risk Children in Resource Homes

In order to determine the effectiveness of the Department's processes for ensuring that aggressive children are not commingled in resource homes with non-aggressive children to whom they would pose a threat, the TAC monitoring staff conducted a targeted review of high

¹⁵ The Settlement Agreement does not speak specifically to the commingling of aggressive children with each other; however, the parties certainly did not mean to suggest that safety concerns should not be considered in those cases as well.

¹⁶ In order to ensure that all children benefit from the review of the Child and Family Team, the Department continues to work with private providers to ensure that all placement moves are brought to the attention of the team.

risk children placed in resource homes. Using a combination of the October 16, 2015 High Risk Report and the October 19, 2015 Mega Report, the TAC monitoring staff identified all class members with high risk CANS scores (for danger to others, sexually reactive, or sexually aggressive) who were placed in resource homes as of October 19, 2015. There were 206 class members with high risk scores placed in 189 different resource homes. Of those 206 high risk class members:

- 81 (39%) were placed in a home with no other foster children;
- six (3%) were placed in homes with other children who also had high risk scores,
- 65 (32%) were placed in a home in which the only non-high risk children were their siblings; and
- 54 (26%) were placed with non-high risk children with whom they did not appear to be related.

TAC monitoring staff also identified any delinquent children with high risk CANS scores who were placed in resource homes with at least one non-high risk class member. As of October 19, 2015, there were three delinquent youth who were placed in resource homes with a total of eight non-high risk class members.

1. Review of High Risk Children Commingled with Unrelated Non High Risk Children

Of the 54 high risk class members who were placed with non-high risk children who were not their siblings, 30 had entered custody during 2015. A targeted review of the cases of those 30 children was conducted collaboratively by the TAC and the Department's Quality Assurance staff. The TAC and the Department reviewed the cases of the 30 high risk class members who entered custody during 2015 and also reviewed the cases of the two high risk delinquent children who entered custody during 2015 and who were commingled with five non-high risk class members,¹⁷ to determine the circumstances surrounding those instances of commingling and the extent to which the commingling poses a significant threat to the non-high risk children in the placements.¹⁸

The reviewers examined the documentation in TFACTS and information in the regional high risk review spreadsheets. In addition, reviewers interviewed at least one person responsible for (or otherwise actively involved in making) the original placement decision, and if needed, a knowledgeable representative of the regional high risk review team (to obtain any information that the regional review discussions generated related to the original placement decision). Reviewers also examined any relevant safety plans. Reviewers sought to distinguish, on the one hand, cases in which a reasoned choice was made to commingle a high risk child with non-aggressive children based on a thoughtful consideration of the strengths of the home, and the benefits to the children compared to the risks, from a case in which the commingling either occurred inadvertently (because of miscommunication, misunderstanding, or a failure to fully

¹⁷ The two high risk delinquent children were placed in separate resource homes, one with a sibling group of three non-high risk class members, and the other with two unrelated non-high risk class members.

¹⁸ Those 32 high risk children were being served in a total of 30 resource homes: there are two homes which each have two of those high risk children as well as a third non-high risk child in the home.

assess the proposed placement), or because of poor decision-making that simply ignored the risk presented.

In each of the 32 cases, the information gathered by the reviewers provided a reasonable basis for the conclusion of the regional high risk team that the high risk child did not present a safety risk to the non-high risk children in the home. For 31 of 32 cases (97%), the reviewers found that the decision-making process for placing the children together was appropriate. In some of these cases, the child's high risk behaviors were not present or were not known at the time of the decision; and in each of these cases, when the child was determined to be high risk, the child and family team acted promptly to determine whether the placement continued to be appropriate for the high risk child and safe for the other children in the home. In other cases, the child had a score of Danger to Others for a past altercation with a family member prior to custody, often his or her mother. In these cases, the team had no information related to aggression toward peers and deemed no safety risks to anyone involved in the placement.

In the one case in which the reviewer had concerns about the initial decision-making process, there was an apparent lapse in communication that occurred at the time that a child disrupted a placement with one provider and was placed with another provider, which resulted in a placement that was not appropriate. However, after a Child and Family Team Meeting was convened, the team learned of the child's past illegal activities and gang involvement and quickly moved the teen to a different neighborhood with less likelihood of recurrence of these behaviors.

2. Review of High Risk Children Placed Only With Siblings

Of the 63 high risk children who were placed in homes where the only non-high risk children were their siblings, 31 had entered custody in 2015. Because of the value the Department appropriately places on keeping siblings together, the decision to commingle a high risk child with non-high risk siblings requires a balancing of competing mandates.¹⁹ The TAC monitoring staff therefore reviewed the cases of those 31 children in this group who entered custody in 2015 to determine the extent to which the commingling reflected a reasonable judgment that the benefits of keeping the sibling group together outweighed the risk (if any) posed by the commingling. In each of those cases, the commingling of the high risk child with non-high risk siblings, given the nature of the risks involved and the circumstances of the placement (including

¹⁹ In a number of those cases, the behaviors which resulted in the high risk determination did not arise until after the sibling group was initially placed.

any relevant safety plans), appeared to the TAC to be a reasonable judgment and that the benefits of keeping the siblings together outweighed any risks.²⁰

G. Application of High Risk Commingling Provision in the Congregate Care Context

In addition to the 206 high risk children who were in resource homes on October 19, 2015, there were 240 children with high risk CANS scores for physical aggressiveness, sexual aggressiveness, or sexual reactivity in congregate care placements that also served at least one non-high risk class member. The congregate care placements serving one or more “high risk” children on that day ranged from psychiatric hospitals and residential treatment facilities to group homes. Fifty-four of those placements were serving both high risk and non-high risk children.²¹

It is the Department’s expectation that congregate care facilities, because they are generally intended to serve children with higher levels of need, including those who exhibit aggressive behaviors, have the capacity to safely serve the children in their program, including the capacity to separate children who cannot safely be in the same living unit together. The Department and the TAC interpret the provision of the Settlement Agreement as permitting the placement of a high risk child with non-high risk children in congregate care settings, as long as the congregate care facility provides therapeutic and other programming necessary to meet the child’s needs and as long as appropriate steps are taken to ensure the safety of both the child and those with whom the child is placed.

As discussed above, the Department has used the CANS scores for physical aggressiveness, sexual aggressiveness, and sexual reactivity as a “flag” for identifying children who might be at high risk for perpetrating violence or sexual assault. However, the Department recognizes that many children whose aggressive behaviors might well pose a “high risk for perpetrating violence” in a resource home placement, do not pose that high risk in a more highly structured congregate care setting. In the Department’s view, in congregate care settings, “commingling” of children with high risk CANS scores with “non-high risk children” does not run counter to the Settlement provision, because notwithstanding the behaviors that warranted a “high risk” CANS

²⁰ This is not to say that in every case the initial safety planning addressed the relevant risks as fully as it might have. However, in every case the placements currently appear to be appropriate and the risks posed by the high risk siblings reasonably managed by the resource parents. There is one case, involving a sibling group of three children (two of whom are high risk), in which the general supervisory challenges, rather than any specific concerns about risks posed by the high risk children in the sibling group, have been the subject of discussions by both the Child and Family Team and the Regional High Risk Review Team. However, at a recent CFTM, the Child and Family Team specifically considered whether some of the children should be moved to reduce the burdens on the resource parent but concluded, based on their assessment of both the children and the resource parent, that the children’s best interests are served by keeping them together in the current resource home.

²¹ In seven facilities (three Level IV facilities, three facilities providing residential sex offender treatment, and one Level III residential treatment center serving a total of 195 class members on October 19, 2015), more than half of the population served had high risk CANS scores for physical or sexual aggression or sexual reactivity. In 14 facilities (nine Level III residential facilities, two primary treatment centers and two Level II facilities serving a total of 189 class members) between one-third and one-half of the population had high risk CANS scores. And in 33 of those facilities (17 Level III treatment facilities, two primary treatment centers, and 14 Level II facilities serving a total of 281 class members), fewer than one-third of the population had high risk scores.

score, those children in the particular congregate care settings in which they are placed are not likely to be “at high risk for perpetrating violence” against the non-high risk children in that setting.

The Department’s reasoning is as follows:

- Congregate care facilities, by their nature, are dealing with children who have higher levels of therapeutic need and who often exhibit challenging behaviors (sometimes including aggressive behaviors). Those facilities are by their design, programming, and staffing, equipped to treat and manage those behaviors and therefore to reduce the “risk for perpetrating violence or sexual assault” on other children in that placement.
- Child and Family Team members, placement staff, regional administrators, and regional psychologists, in making (or approving) the placement of a child in a particular facility, take into account the capacity of the facility to manage the child’s aggressive behaviors in a way that keeps that child and other children within the facility safe, and if the child is particularly vulnerable, that the facility is able to ensure the child’s safety.
- Congregate care facilities, as part of their intake process, complete their own assessment which includes identifying any danger the child would present to other children and any special vulnerability the child would have. Treatment planning addresses safety risks and by contract provision (monitored by Program Accountability Review (PAR)), the child’s treatment plan must address any actionable CANS items (which would include any high risk CANS scores). When making living unit arrangements and arranging for an appropriate level of supervision, the congregate care staff take into account and address any identified safety risks.
- While the regional CANS High Risk Review process has been focused on the commingling of high risk children with other children in resource homes, high risk children in congregate care are now included in the quarterly reviews conducted by the regional high risk review teams. The focus of those reviews are on ensuring that those children are progressing towards step down from congregate care (including progress in addressing any aggressive behaviors) and that planning (including safety planning for any children with aggressive behaviors) is being done to ensure appropriate transition to a family setting, whether that step down is to a resource home or to a trial home visit. The quarterly reviews therefore provide regular review of the congregate care facilities’ capacity to safely manage and treat children with aggressive behaviors.
- The variety of provider oversight processes (PAR reviews; licensing reviews; unannounced visits; the review completed by Network Development evaluating the therapeutic approaches of each of the facilities, and based on the evaluation, describing the populations appropriately served by each facility; incident report (IR) monitoring; Special Investigations Unit (SIU) investigations) ensure that congregate care facilities are adequately addressing safety issues and that to the extent that there are any lapses, that those lapses are addressed appropriately. While the oversight processes do not specifically look at commingling of children with high risk CANS with non-high risk children, they do focus broadly on safety issues. The various monitoring activities

combined provide the Department with (a) general confidence in the basic safety of the congregate care facilities they contract with and their capacity to ensure that children with high risk CANS scores do not pose a high risk of perpetrating violence or sexual assault, and (b) confidence that when a facility falls short of expectations related to safety, that the Department would quickly be aware of any incidents and ensure that appropriate corrective action is taken.

In the TAC's view, especially in the congregate care context, the "high risk CANS score" is greatly "over-inclusive" in identifying children who are "*at high risk for perpetrating violence or sexual assault.*" The high risk CANS score is an appropriate way of flagging a case for heightened scrutiny, but it is simply a starting point for determining whether the child is "*at high risk of perpetrating violence or sexual assault*" on other children in highly supervised settings.

The TAC is satisfied from the extensive familiarity that TAC monitoring staff have gained with the congregate care placement process (including TAC monitoring staff's work with those DCS staff directly involved in the process of trying to match children with challenging behaviors with the congregate care placements best able to meet their needs), that when the Department is making a placement in congregate care, they consider a child's aggressiveness and the ability of the facility to manage aggressive behaviors in selecting a placement from among the range of available congregate care placements; and that the placement staff also consider a child's vulnerability and the ability of the facility to protect that child from self-harm or harm by others.

The Department also requires that every congregate care facility as part of their own intake process explicitly assess the child for both aggressive behaviors and vulnerability and that they specifically address through appropriate action and accommodation any child who is vulnerable to physical or sexual assault. Thirty-seven congregate care facilities that serve class members are also required by federal law to complete these intake assessments.²² Each of those facilities has been audited for compliance with this federal requirement and has passed its audit. There are an additional 46 congregate care facilities that serve class members, that are not subject to the federal requirements, but upon which the Department has nevertheless imposed comparable requirements. The Department has conducted its own review of 42 of those 46 placements and determined that each are appropriately screening for both aggressiveness and vulnerability and appropriately accommodating those who are vulnerable to physical or sexual assault.²³

Based on the long time and ongoing participation of TAC monitoring staff in the Provider Quality Team (PQT) process, the TAC is satisfied that the variety of oversight processes in place, the knowledge, experience, and conscientiousness of those staff with oversight responsibilities, and the level of communication and coordination among those staff across their various units reasonably ensures that in general children in congregate care facilities are

²² The federal requirement, included as part of the Prison Rape Elimination Act (PREA) requires screenings for any congregate care facility serving a population that is composed of 51% or more delinquent youth.

²³ There were four facilities that did not receive a review. One is located in another state and therefore that state is responsible for ensuring compliance with the requirement. The second is a facility that recently began contracting with DCS and has not yet had a review. The third did not receive a review involving a site visit, but reviewers did interview children placed at that facility while conducting a review at another facility operated by the same provider where the children attend school. The final facility is a psychiatric hospital that received a waiver for monitoring compliance with the requirement.

receiving the structure, supervision and programming to mitigate the risk of aggression that they might pose to others; and that when instances arise suggesting that structure, supervision or programming is lacking in that regard, appropriate corrective action is taken to address that.

H. Relevant QSR Data

The TAC, as part of its monitoring of this provision, has examined each year any Quality Service Review (QSR) case that received an “unacceptable” rating for Safety to determine whether that case involved commingling of a high risk child with a child not designated as high risk. There was a total of 18 cases that received unacceptable scores for safety in the 2010-11, 2011-12, 2012-13, and 2013-14 QSR reviews combined;²⁴ four involved a safety issue related to this kind of commingling. In three cases, according to the QSR case stories, the child was placed in a residential facility, and either the child posed a safety risk to others, or the behavior of another child (or other children) posed a safety risk to the child; in the fourth case, the safety issue related to this kind of commingling in a resource home.²⁵ As discussed in the July 2015 Monitoring Report, there were seven cases reviewed in the 2014-15 QSR that received unacceptable scores for Safety.²⁶ None of those cases involved a safety issue related to commingling.²⁷

VI.B Initial Assessment within 30 Days

The Settlement Agreement requires that all children in DCS custody receive an assessment, including a medical evaluation and, if indicated, a psychological evaluation, using a standardized assessment protocol. The assessment may take place prior to custody, but no later than 30 days after the child comes into custody. As soon as the assessment is completed, the child’s placement is to be reevaluated to ensure that it meets the child’s needs.

As discussed in previous monitoring reports, the Department has adopted as the “standardized assessment protocol” required by the Settlement Agreement a combination of the initial *Early Periodic Screening, Diagnosis, and Treatment (EPSDT)* exam (for all children) and the initial

²⁴ These 18 cases constitute 2% of the 817 cases reviewed over the course of these four years.

²⁵ See the May 2014 Monitoring Report at p. 69 for a more detailed description of these cases.

²⁶ These seven cases constitute 3% of the 206 cases reviewed for the 2014-15 annual QSR.

²⁷ See July 2015 Monitoring Report at pp. 51-53.

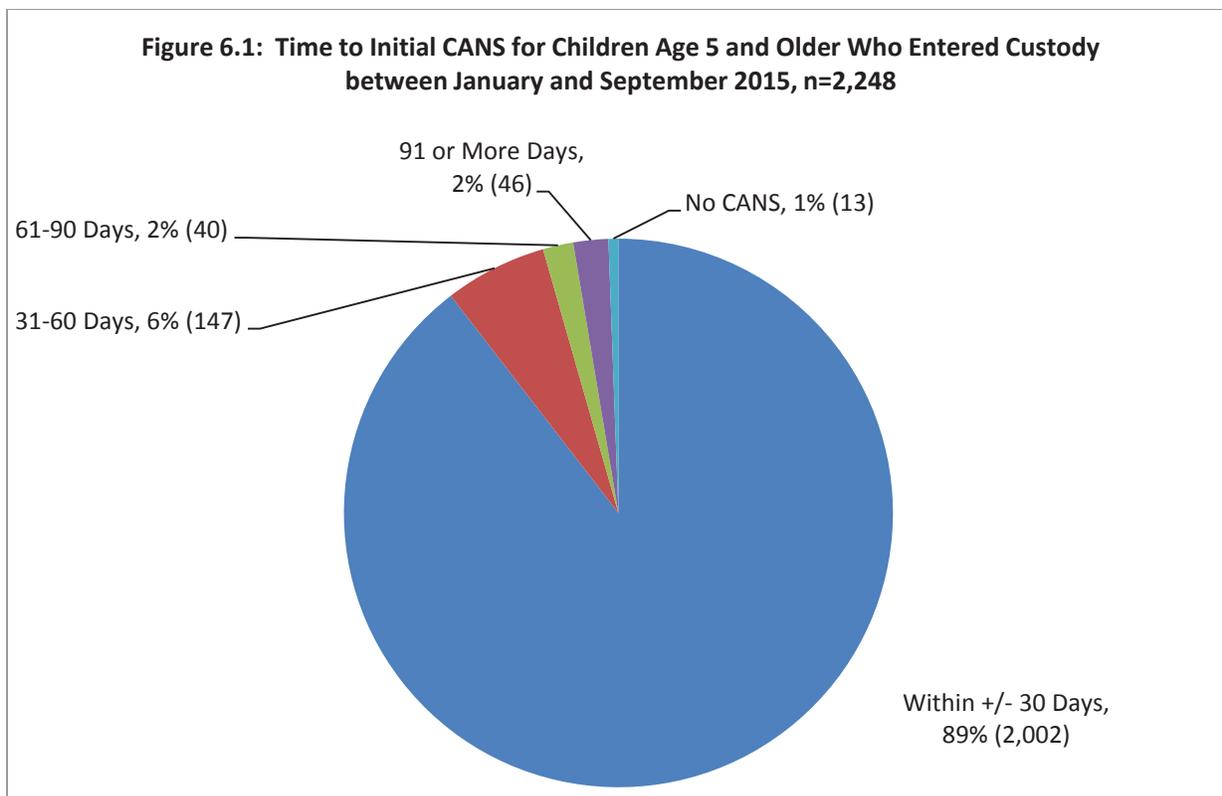
Child and Adolescent Needs and Strengths (CANS) assessment (designed to assess children age 5 and older).²⁸

A. Initial CANS Assessment

The Department's Office of Information Technology produces a report (*Timeliness of the Initial CANS Report*) that identifies all children age 5 or older who entered custody during the relevant reporting period and indicates whether those children had an initial CANS. TAC monitoring staff analyzed this entry cohort report for children who entered custody at any time between January 1, 2015 and September 30, 2015 to determine the time between the date each child entered custody and the date of the initial CANS. As Figure 6.1 below reflects, of the 2,248 class members age 5 and older who entered custody during the first nine months of 2015 and had custodial stays of 30 or more days, 89% (2,002) had an initial CANS completed either within 30 days prior to the start of the custodial episode or within 30 days after the start of the custodial episode,²⁹ and an additional 6% (147) had a CANS within 31 and 60 days.

²⁸ The Department has also embraced an ongoing functional assessment process to support planning, service provision, and placement decisions. The family functional assessment draws from "formal assessments" such as psychological and medical evaluations, including the EPSDT exam, and from formal assessment tools and activities, including the CANS. The family functional assessment also draws heavily from the insights and perspectives of Child and Family Team members (including the family), based on the team members' own observations, interactions, and experiences with the child and family. The functional assessment is used by the team to ensure that the child's placement is appropriate. The Department evaluates its performance related to this broader assessment process using the "Ongoing Assessment" indicator of the QSR. The TAC, as discussed further below, also examines this QSR indicator in evaluating the initial assessment and placement reassessment requirements of VI.B. The TAC looks specifically at those cases that score "unacceptable" for On Going Assessment and seeks to determine whether the failure to conduct an initial assessment or to reassess initial placement contributed in any way to the unacceptable score. The TAC similarly considers the QSR Indicator for Appropriate Placement in evaluating performance under VI.B.

²⁹ The CANS is used to help identify strengths and needs for both custodial and non-custodial children.



Source: Timeliness of the Initial CANS, December 1, 2015 Entry Cohort Report.

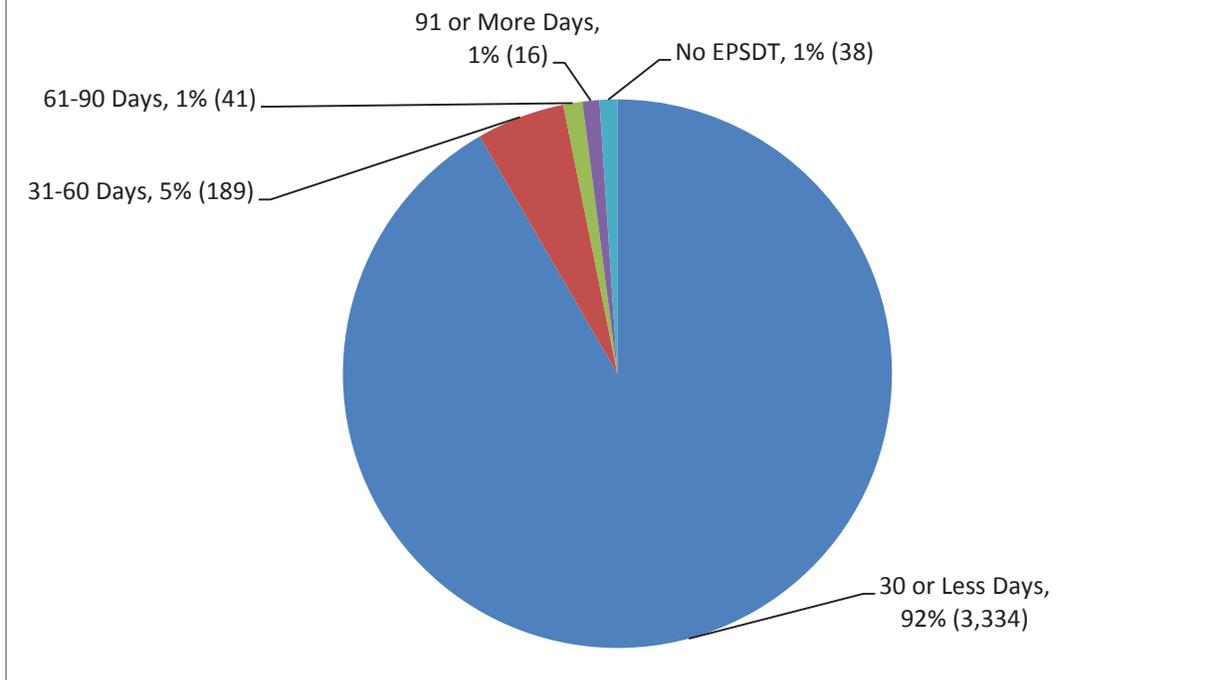
B. Initial EPSDT Screening

For purposes of its monitoring and reporting, the TAC utilizes the *New Custody EPSDT Cohort Report*, a TFACTS extract that includes all children who entered custody during the relevant time period and contains the information from which the time from date of entry into care to time of initial EPSDT screening can be calculated and aggregated. For this monitoring report, the TAC monitoring staff analyzed the *New Custody EPSDT Cohort Report* for all children who entered custody between January 1, 2015 and September 30, 2015. As Figure 6.2 reflects, of the 3,618 class members who entered custody during the first nine months of 2015 and had custodial stays of 30 or more days, 92% (3,334) had an EPSDT screening within 30 days,³⁰ and an additional 5% (189) had an EPSDT screening within 31 and 60 days.

³⁰ This includes 29 children who did not have an EPSDT within 30 days but for whom there was a “good cause” exception for the delay in receiving the EPSDT screen. Of the 29 children, 13 children were on runaway in the first 30 days, nine children had to have their EPSDT rescheduled (eight because of inclement weather and one at the request of the Health Department), five children were hospitalized for treatment for a specific medical or psychiatric condition during the first 30 days, one child was not stable enough to leave placement, and one youth who was placed in detention twice in the first 30 days.

An EPSDT was subsequently completed for 14 of those children; an additional, 12 children remain on runaway or exited custody while on runaway. The remaining three children, upon entering custody, were each placed in hospital settings for several weeks to address medical and psychiatric needs.

Figure 6.2: Time to Initial EPSDT for Children Who Entered Custody between January and September 2015, n=3,618



Source: New Custody January through September 2015 EPSDT Entry Cohort Report.

C. CANS and EPSDT Screening Combined for Children Age 5 and Older

Using a combination of the *Timeliness of the Initial CANS Report* and the *New Custody EPSDT Cohort Report*, TAC monitoring staff were able to determine the extent to which children age 5 and older who entered custody between January 1, 2015 and September 30, 2015 received **both** components of the initial assessment—the CANS **and** the EPSDT—within 30 days of entering custody.

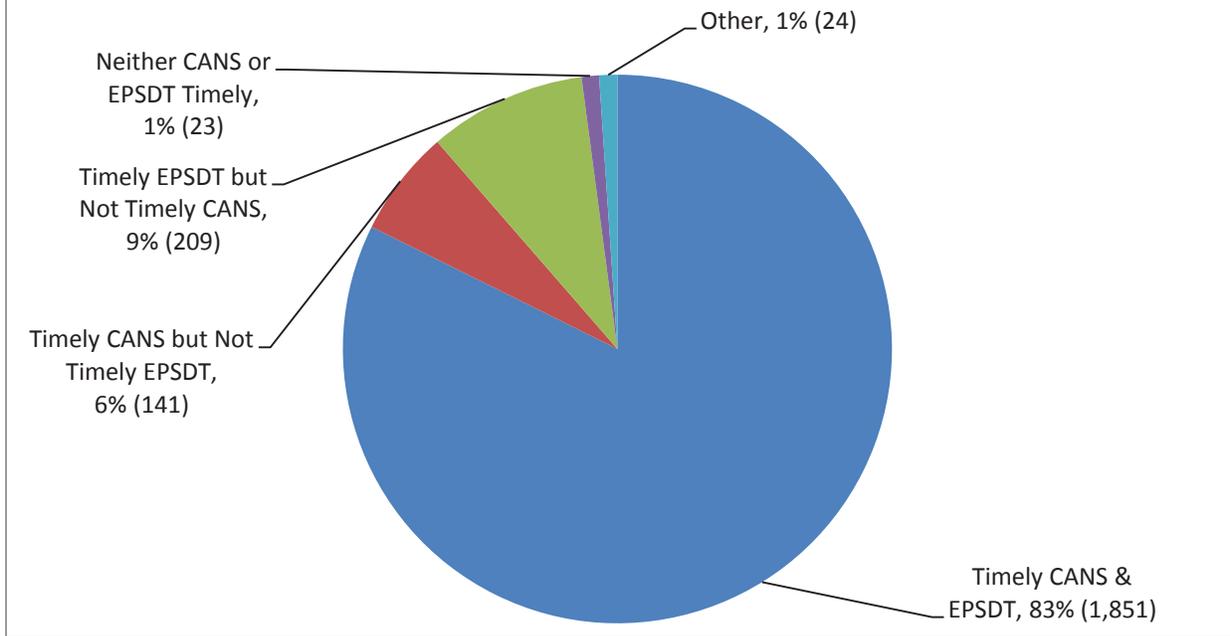
As Figure 6.3 below reflects, of the 2,248 children for whom both assessments were applicable, 83% (1,851) had both the initial CANS and EPSDT completed within 30 days of entering custody,³¹ and another 15% (350)³² had one of the assessments completed timely.³³

³¹ This includes 18 children who did not have an EPSDT within 30 days but for whom there was a “good cause” exception for the delay in receiving the EPSDT screen.

³² This includes six children who did not have an EPSDT within 30 days but for whom there was a “good cause” exception for the delay in receiving the EPSDT screen.

³³ The “Other” category in the figure includes: 11 children who had an EPSDT completed timely, but did not have a CANS completed; 10 children who had a timely CANS, but did not have an EPSDT completed; one child who did not have a CANS completed and for whom the EPSDT was completed more than 30 days after the children entered custody; one child who did not have an EPSDT completed and for whom the CANS was completed more than 30 days after the child entered custody; and one child who had neither assessment completed.

Figure 6.3: Timeliness of the Initial CANS and EPSDT for Children Age 5 and Older Who Entered Custody between January and September 2015, n=2,248

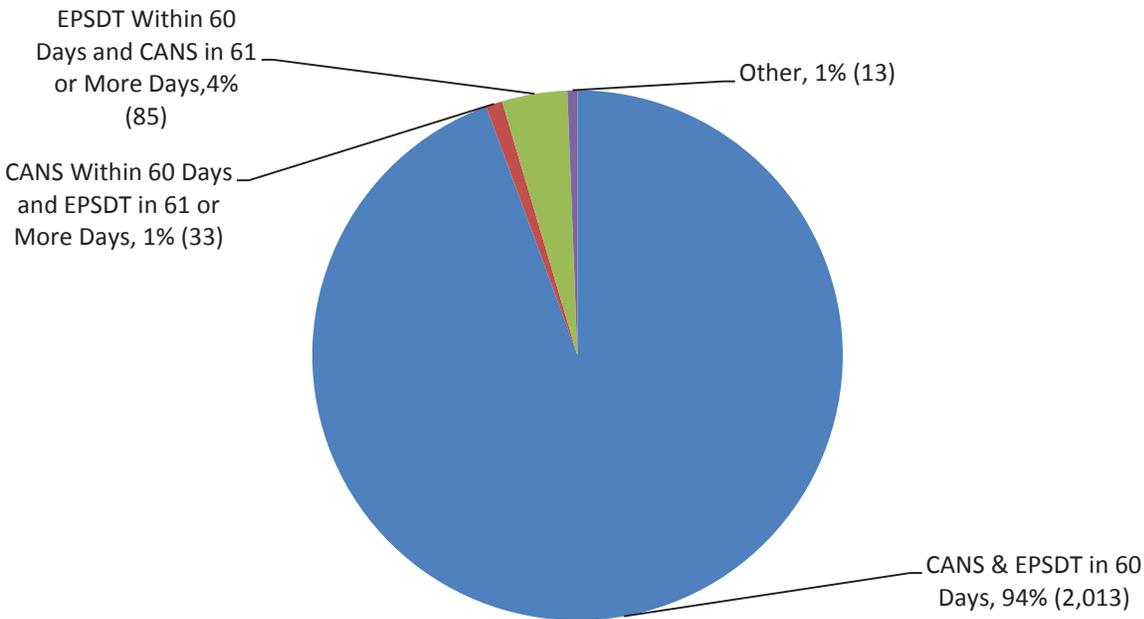


Source: Timeliness of the Initial CANS December 1, 2015 Entry Cohort Report and the New Custody January through September 2015 EPSDT Cohort Extract.

TAC monitoring staff conducted a similar analysis using a 60-day rather than a 30-day time frame.³⁴ As Figure 6.4 below reflects, of the 2,144 children for whom both assessments were applicable during this period, 94% (2,013) had both the initial CANS and EPSDT screening completed within 60 days of entering custody.

³⁴ This analysis includes all children who entered custody during this nine-month period and remained in custody for at least 60 days.

Figure 6.4: Initial Assessment Completed Within 60 Days of Entering Custody for Children Age 5 and Older Who Entered Custody between January and December 2015, and Who were in Custody for 60 or More Days, n=2,144



Source: Timeliness of the Initial CANS December 1, 2015 Entry Cohort Report and the New Custody January through September 2015 EPSDT Cohort Extract.

D. Strategies for Improving Timeliness of EPSDT and CANS and Identifying and Responding to Delays

The Department has recently implemented a number of strategies that already appear to have improved timeliness of the initial EPSDT and CANS assessments and that now ensure that where there are delays in completion, those cases are identified and subject to follow-up.

1. EPSDT

For many years, the Department has been providing case managers with weekly spreadsheets identifying all children with overdue and upcoming EPSDT screenings. In an effort to improve performance, the Department now generates a tracking report twice each month that alerts both DCS staff and private providers not only of those EPSDT appointments that are overdue or upcoming, but that also highlights any case that has remained overdue for more than two weeks. If a child with an overdue EPSDT remains on that overdue list for more than two reports, the Regional Administrator or identified agency staff member is notified. This process is maintained jointly by Network Development staff for children placed with private providers and Office of Child Permanency staff for children placed in DCS homes.

The process appears to have generated the improved performance that the Department intended. For example, according to the October 6, 2015 tracking report, there were 65 children who had entered custody in 2015 and had not yet received an EPSDT (41 children placed in a DCS placement and 24 who were placed in a private provider placement).³⁵ Of those 65 children, 20 remained in need of an EPSDT as of the November 3, 2015 spreadsheet, and five remained as of the December 1, 2015 spreadsheet.

2. CANS

In an effort to improve performance, the Department has developed a tracking report that is distributed twice a week to all assessment consultants and regional administrators that identifies all children in care who have not had a CANS assessment started (including children who will turn 5 years old within the next three months); those whose CANS assessments are “pending” (they are in some stage of completion but not fully approved); and those children who have a completed CANS assessment.³⁶ The report is designed to help assessment consultants manage the CANS assessment completion process and to assist field staff in identifying children for whom an initial CANS or a CANS reassessment is required.³⁷

This new tracking report appears to be having the desired impact on improving CANS completion. For example, according to the October 1, 2015 tracking report, there were 104 pending CANS for children who had entered custody in 2015, and there were 20 children who entered custody in 2015 and did not have a CANS assessment. Of the 104 children with a pending CANS as of October 1, 2015, there were 14 who remained in that category as of November 2, 2015, and eight who remained as of December 3, 2015. Of the 20 children with no CANS according to the October 1, 2015 tracking report, none appeared in that category on the November 2, 2015 tracking report.

E. The Reevaluation of Placement Following the Initial Assessment

The Settlement Agreement provides that “as soon as the assessment is completed, the child’s placement shall be reevaluated to ensure that it meets the child’s needs.”

³⁵ This point-in-time report will to some extent overstate the number of overdue EPSDTs at any given time, because, unlike the CANS which is completed directly in TFACTS, the EPSDT screening is completed by a health care provider and subsequently entered into TFACTS. Documentation of the EPSDT should be entered into TFACTS within 30 days of the completion of the screening.

³⁶ The third category of information allows staff to identify children requiring a CANS reassessment.

³⁷ The Department has also worked with the Vanderbilt Center of Excellence to develop monthly reporting from the twice weekly reports to help track timeliness of each step of the CANS process. The report includes data on the time from entry into custody to the CANS start date; the time from the CANS start date to the submission of the CANS by the case manager for supervisor approval; the time from submission of the CANS to the supervisor to the approval of the CANS and the submission of the approved CANS to the Assessment Consultant; and the time from submission of the CANS to the Assessment Consultant to the approval of the CANS by the Assessment Consultant. This reporting is designed to allow the Department to identify any bottlenecks in the CANS process, statewide, by region, and by county; and to identify case managers, supervisors, or Assessment Consultants who may be struggling to complete their CANS related responsibilities in a timely manner.

As discussed in previous monitoring reports, this language dates back to the entry of the original Settlement Agreement in 2001, when initial placement was too often focused primarily on finding an available “bed” for the child, even if only as an interim placement, rather than based on an effort to match the child to an appropriate placement. At that time, significant use was made of temporary placements, emergency shelters, and “observation and assessment” centers. Many children were placed initially in congregate care settings not because that was the least restrictive setting capable of meeting the child’s therapeutic needs, but because of a lack of available resource families and the administrative ease of accessing a congregate care bed. Because initial placement was not primarily focused on doing an assessment and finding the right match based on that assessment, language was included in the Settlement Agreement to require an initial assessment within 30 days and to compel a reexamination of a placement once there was a more formal assessment of the child’s needs. The assumption of this provision of the original Settlement Agreement was that, at least until placement practices changed, significant numbers of children placed under the then existing process would need to be moved to meet treatment needs as those needs were identified.

The current placement process is significantly different. It is designed to reduce the need to unnecessarily move children from placement to placement, a traumatic event for most children. The Department’s preferred approach is to place children in a resource family and then to respond to the child’s therapeutic needs by wrapping appropriate services around that child and that resource family.

Temporary and emergency placements are now rare rather than common. As discussed in previous monitoring reports, placement of a child in a congregate care placement larger than eight beds requires an assessment of appropriateness and review and approval by the Regional Administrator, and for any Level III or Level IV placement, a review by both the Regional Administrator and the Regional Mental Health Clinician.

The Department expects the initial placement decisions to be based on assessment information that is available at the time, including the information that is generated as the CANS is being completed. Notwithstanding the 30-day assessment period contemplated by the Settlement Agreement, the custodial assessment process now begins as soon as a child comes into custody, building on any information generated from DCS involvement prior to a child coming into custody and from any previous custodial episodes. Case managers are expected to complete the CANS and submit it to their supervisor for review within seven business days of a child entering custody, and the target time frame for completion of the initial EPSDT screening is now 72 hours.³⁸

The Child and Family Team process ensures that the appropriateness of an initial placement is reviewed based on assessment information that comes to light during the 30-day assessment period contemplated by the Settlement Agreement. As discussed in previous monitoring reports, the initial Child and Family Team Meeting is expected to occur within seven days of a child coming into custody and the Initial Permanency Planning CFTM is expected to occur within 30

³⁸ Because accomplishing this is dependent on the responsiveness of the health care providers, the Department is working with health care providers in the regions to make EPSDT screenings readily available on short notice.

days of the child coming into custody.³⁹ At each of these meetings, the appropriateness of the child's placement is reviewed based on the assessment information available to the team, including CANS and EPSDT related information, and, perhaps most importantly, information on how the child is functioning in the current placement. And because of the Department's commitment (supported by the Settlement Agreement) to serving children in resource family settings, if a particular therapeutic need is not being addressed in the resource home, the expectation is that the Department arrange to provide the child and resource home caregiver with additional services and supports to meet that need, not to move the child to a new placement.⁴⁰

F. Relevant Quality Service Review Data

The clearest indication that the Department is doing a good job of continually evaluating a child's placement to ensure that the placement meets the child's needs is the consistently high QSR scores for Appropriateness of Placement. To score "acceptable" on this indicator, the placement must be "acceptable for the child's age, ability, peer group, culture, language and religious practice;" it must be "the least restrictive, most appropriate placement necessary to meet most of the child's needs" and "at least a "fair match" for the child;" and it must be "a placement in which the child maintains at least some connections to his or her home community."

In the 2014-15 QSR review, 99% of the *Brian A.* cases reviewed scored acceptable for Appropriateness of Placement, and even one of the three cases that scored "unacceptable,"

³⁹ As fully discussed in the July 2015 Monitoring Report (and as reflected in the maintenance designations of relevant sections of Section VII), the Department is doing a good job of ensuring that Initial CFTMs and Initial Permanency Planning CFTMs are held timely. The CFT Process Review found that an Initial CFTM was held for 97% (89) of the 92 children included in the review, and that the failure to hold an Initial CFTM in three of the cases reviewed was understandable in light of the circumstances of each case, including the fact that a prompt Initial Permanency Planning CFTM was held in each. Aggregate reporting, which generally understates performance (see the July 2015 Monitoring Report, footnote 341 at p. 208), reflects similarly high performance. According to the aggregate reporting for 2014, Initial CFTMs were held for 93% of the children entering custody. The CFT Process Review found that an Initial Permanency Plan CFTM was held for every child included in the review. According to the aggregate reporting for 2014, Initial Permanency Planning CFTMs were held for 84% of the children entering custody during 2014. See the July 2015 Monitoring Report at pp. 223-224.

⁴⁰ The requirement (discussed in Section Six A.1.f of the July 2015 Monitoring Report) of Regional Administrator review and approval for any congregate care placement greater than eight beds and the additional requirement of a Mental Health Clinician review and approval of any Level III or Level IV congregate care placement means that it is unlikely that a child would initially be placed in higher levels of care than indicated necessary by the Initial CANS assessment. In that unlikely event, the utilization review process would provide an additional layer of reassessment of the appropriateness of the congregate care placement.

notwithstanding that rating, was found by the reviewers to reflect commendable ongoing evaluation of child's placement and an appropriate decision to change placement.^{41 42}

VI.D Requirements Related to the Administration of Psychotropic Medications

A. Introduction

The Department has devoted significant energy and resources to ensuring appropriate oversight of the use of psychotropic medication for children in DCS custody. Early on in the reform effort, the Department, in consultation with Tennessee providers and with technical support and assistance from national experts, developed policies and procedures that embraced best practices. The Department dramatically enhanced its in-house mental health expertise by creating and

⁴¹ That case involved a child who, at the time that he entered DCS custody, had pending felony charges. He was initially placed for assessment, ran from that placement, was apprehended and placed in detention by the juvenile court, and then placed in a Level III residential treatment facility. He was subsequently stepped down from the residential facility to a placement with a relative who was also a therapeutic resource parent, and then, in accordance with recommendations from a further assessment, was moved to a Level III resource home with intensive outpatient treatment. At the time of the QSR review, the team had just determined, based on continued behavior issues (some of which resulted in additional delinquent charges), that the child again needed residential treatment. At the time of the review, the child was awaiting residential placement, and, because the child was still in the resource home, the case was rated unacceptable for Appropriateness of Placement. The QSR reviewers noted the "numerous formal assessments for both the youth and the parents" and the case was scored "substantially acceptable" (5 out of a possible 6) on the Ongoing Assessment indicator.

The second of the three cases that scored "unacceptable" for Appropriateness of Placement did so because the child was in full guardianship, but placed in a resource home that was not a viable permanency placement. In the third case, the case was scored "unacceptable" because the young person's behavior, both in the resource home and at school, had deteriorated as the projected time for reunification with his father approached, and as of the time of the review, the resource parent did not feel that her efforts to control those behaviors were working.

⁴² The TAC, at the request of the Plaintiffs, also reviewed the QSR results for "Ongoing Assessment Process." The TAC considers this QSR indicator to be of limited value in evaluating compliance with the provisions of Section VI.B of the Settlement Agreement. Formal assessments of the child, such as the initial CANS and EPSDT that make up the standardized initial assessment required by VI.B, are certainly part of the Ongoing Assessment Process measured by the QSR. It is therefore reasonable to conclude that receiving an "acceptable" score for Ongoing Assessment Process reflects the general adequacy of formal assessments of the child (although it is unlikely that the initial EPSDT and CANS would be of significance in the overall scoring). For the 2014-15 QSR, 74% of the cases scored acceptable for this indicator (above the 70% threshold associated with well-functioning child welfare systems). The scope of the QSR indicator, however, goes well beyond formal assessments of the child, including both formal and informal assessments of the family, and emphasizing the extent to which the child and family team is successful in using the assessment information to address child and family needs and overcome the obstacles to achieving permanency. It is therefore not reasonable to draw any conclusions about compliance with the requirements of VI.B based on an unacceptable QSR score for Ongoing Assessment Process. This was confirmed by an effort by the TAC monitoring staff to glean information relevant to the initial assessment from the case stories of those cases in the 2014-15 QSR that scored unacceptable for Ongoing Assessment Process. The TAC monitoring staff found that the primary factors contributing to the cases being scored unacceptable related to ongoing assessment of parents or other caregivers, not the child; and in those cases in which reviewers referenced, among other factors, concerns about the assessment process related to the child, none referenced the initial EPSDT or CANS (or the failure to reexamine placement based on the results of that initial EPSDT or CANS) as a factor contributing to the unacceptable score. To the extent that EPSDT is mentioned by the reviewers, it is mentioned in the context of the Health/Physical Well Being indicator as contributing to the positive scoring on that indicator. (In the 2014-15 QSR, every case reviewed scored "acceptable" on the Health/Physical Well Being Indicator.)

filling (with well qualified professionals) the positions of Medical Director, regional and Central Office health nurses, and regional mental health consultants. The Department has supplemented that mental health expertise in general, and specific expertise related to psychotropic medications, through contracts with five Centers for Excellence.⁴³ The Department has benefited from TennCare's own improved oversight processes relating to prescribing of psychotropic medications and, through increased collaboration with TennCare, has been able to utilize TennCare pharmacy data to help monitor prescribing practices and track and analyze medication use for children in DCS custody.⁴⁴

B. Medical Director Oversight

The Settlement Agreement requires that the Medical Director oversee and ensure compliance with the Department's policies related to the administration of psychotropic medications.

Previous monitoring reports have described in detail the variety of activities, implemented by the previous Medical Director, that continue to be important to ensuring compliance with psychotropic medication policies:

- training of case managers, resource parents and relevant congregate care staff;
- development and distribution of detailed medication guidelines to private providers and prescribers, and ongoing work of the health unit nurses with mental health prescribers to ensure that they understand those guidelines;
- incorporating medication monitoring into provider oversight activities of the DCS Program Accountability Review ("PAR") Unit and the Licensing Unit, and integrating discussion of medication practice issues into the Provider Quality Team ("PQT") oversight;
- creation of processes to track, report and analyze the use of psychotropic medications, including review and analysis of pharmacy data received from TennCare; and
- conducting periodic reviews to monitor compliance with policies and identify opportunities for improvement.

⁴³ The Centers of Excellence—three tertiary care academic medical centers and two provider agencies possessing special expertise in children's physical and behavioral health—provide clinical consultations, evaluations, and limited direct services to children with complex needs, and also serve as training resources for the Department.

⁴⁴ As reflected in the annual analysis of TennCare pharmacy data that the TAC has presented in previous monitoring reports, in any given year between 25% and 30% of children in DCS custody received one or more psychotropic medications at some point during the year. During 2014, the number of children receiving medication during a given month ranged from a low of 1,591 to a high of 1,751. A total of 3,341 (33%) of the 10,092 class members who were in DCS custody at some time during 2014 received one or more psychotropic medications at some point during that time. See July 2015 Monitoring Report at pp. 61-62 and Appendix J to that report.

The current Medical Director (the Deputy Commissioner for Child Health)⁴⁵ has continued and built upon the Department's foundational work. The Department's network of Centers of Excellence provides the Department with access to six board certified child adolescent psychiatrists who are located grand regionally and affiliated with academic medical centers, and who are available to the regional nurses for consultation on psychotropic medication use and related treatment planning issues.

In December 2015, the Department expanded its contract with the Vanderbilt Center of Excellence to establish a psychotropic monitoring program to provide additional data analytic support and clinical consultation to the Deputy Commissioner and the Department's team of public health nurses as well as training and technical assistance for providers and DCS staff. In addition to continued access to the full network of six COE board certified experts across the state, this contract established a dedicated team consisting of a board certified family psychiatric/mental health nurse practitioner and a board certified child adolescent psychiatrist, supported by Vanderbilt biostatisticians, who will focus on tracking and analysis of psychotropic medication use and prescribing practices for youth in custody. The Department is also working with the Vanderbilt biostatisticians and TennCare to develop "real-time" reporting of prescription data from the TennCare pharmacy database that will supplement the annual data that TennCare is already providing, and will allow a level of additional medication monitoring that few, if any other, child welfare systems have.

The Department's monitoring of psychotropic medication use already benefits from the fact that the medications or medication combinations that the Department's nursing staff flag for heightened scrutiny and for review and/or approval by the Medical Director are also those that are "flagged" by TennCare's own processes and subject to heightened oversight and review.⁴⁶ These include any medication for a child under the age of six; any instance of a child receiving four or more medications; any prescribed dosages outside of recommended ranges; and certain "red alert" medications that are unusual or of limited appropriate application outside of recommended ranges, certain "red alert" medications that are unusual or of limited appropriate application. As a result of the enhanced tracking and analysis capacity that Vanderbilt now provides, and the addition of real time pharmacy data from TennCare, it is unlikely that any prescriptions that should receive heightened review would escape scrutiny.

C. Prohibition against use of psychotropic medication as discipline

Department policy, consistent with the Settlement Agreement, prohibits the use of psychotropic

⁴⁵ The current Deputy Commissioner for Child Health holds a PhD in Public Administration and is a Board Certified Family Psychiatric/Mental Health Nurse Practitioner.

⁴⁶ TennCare oversight includes three levels of point-of-sale controls that help ensure responsible prescribing behavior: prior approval requirements; Prospective Drug Utilization Review (PDUR); and Retrospective Drug Utilization Review (RDUR). Prior authorization is required for prescription of specific psychotropic medications with higher risk profiles. PDUR uses TennCare's electronic monitoring system to screen prescription drug claims to identify problems such as therapeutic duplication, drug-disease contraindications, incorrect dosage or duration of treatment, drug allergy, and clinical misuse or abuse. RDUR involves ongoing and periodic examination of claims data to identify patterns of fraud, abuse, gross overuse, or medically unnecessary care and implements corrective action when needed.

medication as a method of discipline or control of a child. The combined policies and procedures of the Department and TennCare related to the administration of psychotropic medications are well-designed to ensure compliance with this prohibition.

TennCare requires that any prescription for any psychotropic medications must be supported by an appropriate Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis and a treatment plan with measurable outcomes. In addition, the kinds of prescriptions that might suggest improper use of psychotropic medications—for example, prescriptions for two medications in the same class or for doses outside of recommended ranges—would likely be identified by the TennCare oversight processes discussed above and flagged by the Department’s own internal medication monitoring.

In addition to those processes, children in Level III and IV residential facilities are reviewed monthly by a Utilization Review (UR) team that includes regional psychologists. Issues of medication use are routinely discussed in the context of the overall treatment plan during those reviews. Any uses of medication that do not conform to DCS policy or that are otherwise concerning are expected to be brought to the attention of the Deputy Commissioner for Child Health or the Medical Director.

D. Requirement of Informed Consent

The Settlement Agreement requires informed consent for the administration of psychotropic medications. When possible, parental consent is to be obtained. If a parent is unavailable to provide consent, the regional health unit nurse is to review and consent to any medically necessary psychotropic medication and ensure appropriate documentation of that consent regarding psychotropic medications.

The Department’s policies reflect these requirements of the Settlement Agreement. However, separate and apart from the requirements of the Settlement Agreement governing the Department’s policies and procedures, every prescribing provider is under an independent obligation, established by professional standards governing the practice of medicine, to obtain informed consent from a person authorized to give consent before prescribing psychotropic medications for a child. While responsibility and authority for the informed consent process rests with the prescribers, the Department, through its outreach to the prescriber community and the oversight provided by the Department’s health nurses, has worked hard to ensure that the prescribers are both obtaining and documenting that consent consistent with Department policy.⁴⁷

⁴⁷ The strong relationships that the public health nurses have built with those mental health providers that regularly serve DCS children have been key in helping those who prescribe psychotropic medications understand and meet the policy expectations. The nurses periodically identify and address circumstances where practice falls short of policy expectations; however, in the Department’s experience, those circumstances tend to involve prescribers who are new to working with DCS children (*e.g.*, a new staff member at one of the mental health agencies that works with DCS children) or general practitioners not associated with mental health agencies (*e.g.*, a pediatrician who, in the course of providing primary care, may on occasion prescribe psychotropic medications).

1. Results of the TAC's Informed Consent Documentation Review

As discussed in the July 2015 Monitoring Report, the Department conducted a targeted review to examine documentation of informed consent for a sample of 120 children who had been prescribed psychotropic medications. In total, these 120 children had been prescribed 396 psychotropic medications. The Department reviewers found acceptable documentation for 346 (87%) of these prescriptions.

The TAC has since conducted its own review, using the sample of cases that were the subject of the Department's informed consent review,⁴⁸ but focused on the 57 children in the Department's sample who entered custody after January 1, 2014.

For a child who was on psychotropic medication when he or she came into care, reviewers looked for documentation that, at the time that the child came into care, those medications had been identified and that there was evidence that the parent, the health unit nurse, or the child if the child was over 16 had approved the continued administration of the medication.⁴⁹

For any child prescribed a psychotropic medication after entering custody, reviewers looked for documentation dated within 30 days of the date of the prescription that the parent or the child (if age 16 or older) consented to the medication; for children under the age of 16, in the absence of parental consent, the reviewers looked for documentation of consent by the regional health nurse.⁵⁰

⁴⁸ The Department's review differed from the TAC's review in two significant respects: first, the Department's reviewers did not require documentation of agreement for continued administration of medications that the child was taking at the time the child entered care; second, while the Department looked for evidence of informed consent for any medication first prescribed after a child come into custody, the Department did not consider the timeliness of the informed consent.

⁴⁹ While informed consent is required when a medication is initially prescribed, a new informed consent is generally not required for the continuation of the medication. The Department's requirement that there be "approval" for the administration of medication that a child is already taking when the child enters custody is something beyond what the medical profession's "informed consent" process requires. The "informed consent form" that the Department has developed can be used to document the child, parent, and/or nurses approval for administration of medications that the child is already taking at the time he enters custody. However, that approval might also be documented in case recordings, CFTM summaries, or permanency plan language.

⁵⁰ The Department expects prescribers to use the Department's informed consent form (or a comparable form) to document consent given by an older youth or a parent, and to furnish a copy of that form to the health nurse at the time the medication is prescribed. In these cases the form is being used to document consent that was obtained at the time of the prescription, and for purposes of the TAC's review, the Department considers the form to be "timely" if completed within 30 days of the date of the prescription (consistent with the 30-day time frame generally required for documentation of case activity). In cases in which informed consent is given by a health nurse, DCS policy envisions the nurse reviewing the medication recommendations, signing the consent form and furnishing the consent form "to the appropriate party so that the child can begin the mediation." Policy 20.24, Section H.3. While having the informed consent form signed (whether by the child, parent, or nurse) on the date that the medication is prescribed best ensures that the child does not begin taking the medication prior to the granting of informed consent, for purposes of this review, the TAC finds it reasonable to consider a consent form timely if it is signed within 30 days of the date of the prescription.

a. *Documentation of Informed Consent or Approval of Continued Administration of Medication*

The 57 children represented in the review sample were prescribed a total of 183 psychotropic medications between January 1, 2014 and February 28, 2015. This includes medications initially prescribed to the child prior to entering custody and those initially prescribed after entering custody. The TAC found the relevant documentation for 153 (84%) of those medications.⁵¹

The TAC also considered the degree to which each child in the sample had documentation of consent or approval of continued administration for *every* psychotropic medication prescribed during the review period. Of the 57 children reviewed, documented consent was found for all such medications, whether prescribed prior to or after entering custody, in 40 cases (70%).⁵²

The TAC further analyzed the data to distinguish between and report separately on performance related to medications prescribed prior to custody and those initially prescribed after the child came into custody.

- Of the 57 children in the review sample, 38 entered custody on at least one psychotropic medication, representing a total of 78 medications. The TAC found relevant documentation for 77 medications (99%), and in 37 cases (97%),⁵³ documentation was found for *all* psychotropic medications the child was taking at the time the child entered custody of the decision (by the parent, child, and/or health nurse, as appropriate to the circumstances) for the continued administration of the medication(s).
- Forty-six children were prescribed at least one psychotropic medication after entering custody, representing a total of 105 medications prescribed after the child entered custody. (Twenty-seven of these 46 children were also among the 38 children prescribed at least one medication prior to entering custody.) The TAC found documentation of

⁵¹ This includes all consents for which the TAC was able to find documentation dated within 30 days of the earliest documented prescription date. The TAC found documentation of consent for an additional nine medications outside of the 30-day time frame, bringing the total number of medications for which there was some documentation of consent to 163 (89%). (The TAC excluded any consent completed after commencement of the Department's review.) In addition to these medications in which consent was documented, there were three medications prescribed to one child for which the case file documents the exercise by the child of her right to refuse the medications. In one other case, the form signed by the child's parent documented both her consent for one medication and her decline to consent a second medication. In that case, the child turned 16 about a month after the parent declined to consent, and the youth subsequently consented to administration of that second medication. The prescriber varied the dosage in an attempt to address the side effects and ultimately that second medication was discontinued in favor of a different medication, to which there was documentation of informed consent by the youth. (Because the first documentation of the youth's consent to this medication was dated several months after she turned 16, the consent for this one medication was not considered to be timely.)

⁵² When including the additional nine consents signed outside of the 30-day time frame, the number of children for whom relevant documentation was found for *all* medications was 44 (77%).

⁵³ In the remaining case, the case file documentation was confusing. The reviewers found documentation that a child had been taking a particular medication at the time he entered custody; however, the consent form in the case file referenced a different, but similar medication. Furthermore, it was not clear from the documentation that the child had actually taken the medication listed on the consent form.

consent within 30 days of the prescription date for 76 medications (72%), and in 30 cases (65%), documentation of consent was found for *all* medications prescribed.⁵⁴

b. Circumstances Explaining Those Cases in Which the Nurse, Rather than a Parent, Gave Consent

The overall data from the TAC's review reflect well on the Department's efforts to engage parents in the informed consent process. There were a total of 85 medications prescribed after the child entered custody for which informed consent was documented.⁵⁵ For 32 (38%) of those medications, the informed consent was given by parents or other guardian; for 22 (26%), the informed consent was given by the youth; and for 31 medications (36%), consent was given by the health unit nurse.⁵⁶

To understand the circumstances of those cases in which the parent was not actively engaged in the informed consent process, the TAC relied on data from the Department's review, which collected information on the circumstances of those cases in which the nurse, rather than a parent, gave informed consent. In the large majority of the cases of those 23 children in the TAC's review for whom a nurse, rather than a parent, gave consent for one or more medications,⁵⁷ the reasons that parents were unavailable were readily apparent:

- one or both parents were unable to participate because they were either incarcerated, in a drug rehabilitation program, had been deported, their whereabouts were unknown, or their parental rights had been terminated;
- one or both parents refused to participate; and
- because of the nature of the conflict between the parents and the child, it was not appropriate to involve the parent in the informed consent (including "no contact" orders against a parent).

In eight cases, at least one medication consent did not fall into the categories above. For four of those children, documentation reflected multiple efforts to notify parents of appointments, or parents indicated that they would attend but failed to appear for the appointment. For four of those cases, the documentation was more limited, simply referencing the parent being unavailable and did not attend, unavailable by phone, or notified but did not attend the appointment.

⁵⁴ As noted in footnote 52, an additional nine consents were signed outside of the 30-day time frame. Were these consents included, there would be 85 medications (81%) for which consent was documented, and the number of children for whom consent was found for *all* medications would be 34 (74%). (This excludes any consent completed after commencement of the review.)

⁵⁵ This number includes all consents signed prior to commencement of the review. As discussed above, the TAC considered informed consent forms and other forms of documentation of informed consent.

⁵⁶ There were 13 youth (prescribed 26 medications) who were age 16 or older at the time the medication was prescribed. Of the 26 medications, 22 were consented by the youth and four were consented to by the parent or legal guardian.

⁵⁷ This includes all nurse consents, irrespective of the timeliness of those consents. Those consents represent a total of 31 medications.

For one child, the Department's review simply noted "parents not involved with the care of the child" as the reason for the nurse's consent.

Based on both the high percentage of cases in which informed consent is obtained from parents and older children, rather than nurses, and on the information from the Department's review of the circumstances of those cases in which nurses, rather than parents, give consent, the TAC is satisfied that the Department is making reasonable efforts to engage parents in the informed consent process, as required by the Settlement Agreement.

2. Program Accountability Review Findings Related to Informed Consent

The Program Accountability Reviews (PAR) include, as part of their case file review, a determination of whether there is an informed consent form in the child's agency case file for every psychotropic medication that the child is currently taking and whether the consent form was signed prior to the administration of the medication.

For the 2014-15 PAR reviews, a total of 155 files were reviewed for documentation of informed consent, and 140 (90%) of those files had the required timely documentation for every psychotropic medication that the child was taking. This is consistent with PAR findings from previous years: 88% (77/88) in 2011-12; 93% (150/162) in 2012-13; and 92% (132/144) in 2013-14).

Whenever PAR makes a finding that a child's agency case file did not have a signed informed consent form for one or more medications that the child was taking, PAR requires as a corrective action that the agency either obtain a copy of the informed consent form from the prescriber or other source (if the prescriber or other source has an executed form) or that the agency obtain a new informed consent form, signed by the parent, older child, or regional nurse, as appropriate.

VI.E Requirements Related to Use of Restraint and Seclusion

The Settlement Agreement (VI.E) requires that an appropriately qualified Medical Director be responsible for revising, updating, and monitoring the implementation of policies and procedures surrounding all forms and uses of physical restraint and isolation/seclusion of class members, and that the Medical Director be authorized to impose corrective actions when needed. The Settlement Agreement also requires that all uses of restraint in any placement, and all uses of seclusion in group, residential, or institutional placements, be reported to and reviewed by the quality assurance division⁵⁸ and made available to the Licensing Unit and the Medical Director for appropriate action.

The Department's present policies and procedures related to restraint and seclusion are the result of an extensive review and revision process conducted under the auspices of the Department's

⁵⁸ The Department's Quality Control (QC) Division oversees the Department's quality assurance function, utilizing both staff within that division as well as reviewers with special expertise from other divisions. For example, as discussed further below, the QC Division relies on the Psychology Director and mental health clinicians (MHCs) to review higher level uses of restraint and seclusion.

previous Medical Director. The policies only permit physical restraint and seclusion in congregate care settings and any use of physical restraint or seclusion is subject to clear limitations and mandatory reporting requirements. The Department has clearly communicated these policies both within the Department and to private providers.⁵⁹

The Department's policies require that an "Incident Report" (IR) must be filed and entered into the TFACTS system for any incident involving the use of restraint or seclusion.⁶⁰ The regional mental health clinicians (MHCs),⁶¹ under the supervision of the Psychology Director,⁶² are responsible for the initial review and investigation of incidents involving the use of restraints that last 15 minutes or more and seclusions that last 30 minutes or more. The responsible regional MHC is notified of the incidents that need his or her review, both by a TFACTS generated email initiated automatically when an IR relating to seclusion or restraint is filed and through a TFACTS screen that lists all currently pending incidents for review by that MHC. As part of that review, the regional MHCs are expected to examine the circumstances of the specific incident and take appropriate action in response to any concerns about this particular use of physical restraint or seclusion. If the MHC is concerned that the incident reflects a broader problem with the child's treatment plan or the therapeutic milieu of the facility, he or she refers the issue to the Psychology Director for follow-up, which can include a referral to the Provider Quality Team (PQT).⁶³ In addition, if a particular child is the subject of multiple incident reports, the regional MHCs are expected to review all prior incidents, without regard to the severity level of those previous IRs, to ensure that the child is receiving appropriate care.

⁵⁹ There has been some confusion at times about how to characterize and report instances in group homes or resource homes (which are forbidden by policy to use physical restraint) in which a staff person or resource parent has to intervene physically in order to keep a child or youth safe (*e.g.*, to separate two youth who are fighting). Although policy requires the reporting of these instances of physical intervention by group home staff or resource parents, these are not considered "physical restraint" under the DCS policy, although group homes have at times reported them as such. The Department has also found that treatment facilities that are authorized by policy to use physical restraint at times report as a "physical restraint" a brief physical contact that technically is not a physical restraint. The Department expects providers, when in doubt, to err on the side of filing an incident report. For this reason, the Department is not overly concerned that some providers may have a more expansive view of what constitutes physical restraint.

⁶⁰ Through a TFACTS enhancement, rolled out in a series of releases (the first of which occurred in September 2014), the Department has successfully implemented the redesigned Incident Reporting process discussed in the May 2014 Monitoring Report. This enhancement significantly improved the processes for entering, reviewing, and responding to IRs, and addressed the problems that had undermined the efficiency and reliability of those processes.

⁶¹ The position of "Regional Mental Health Clinician" has replaced the "Regional Psychologist" position, expanding the pool of eligible licensed clinicians beyond licensed psychologists. In 10 regions, the MHC positions are currently filled by licensed psychologists. In the remaining two regions, MHC positions are currently filled by licensed mental health clinicians.

⁶² The Psychology Director is a newly created Central Office position that provides direct supervision of the Regional Mental Health Clinicians and leadership around the DCS population's behavioral health needs and services. The current Psychology Director is a licensed clinical psychologist with 17 years of clinical experience working with vulnerable populations. The Psychology Director works closely with the Medical Director, keeping the Medical Director informed of concerns related to restraints and seclusion and assists the Medical Director in ensuring that policies and procedures are being implemented appropriately.

⁶³ In addition, responders, as part of the process of documenting their response in TFACTS, can select an option in TFACTS that refers the IR directly to Central Office. TFACTS automatically generates and sends an email to the Quality Control staff person responsible for IR; she logs the referrals and discusses them with the Psychology Director. They can also bring any cases to the PQT.

In addition to the front-end review and response conducted by MHCs of restraints lasting 15 minutes or longer and seclusion lasting 30 minutes or longer, any restraint or seclusion, regardless of duration, that results in an injury to a child requires review and response by the health unit nurses.⁶⁴

All incidents of restraint and seclusion that are not subject to review by the MHCs—restraints lasting less than 15 minutes and seclusion lasting less than 30 minutes—are reviewed by a QC staff member.⁶⁵ The QC reviewer examines the incident report to determine whether the facts set forth in the incident report supported the use of restraint or seclusion. In making this determination, the reviewer examines the behaviors leading up to the use of restraint and seclusion, efforts to deescalate those behaviors, and the duration of the restraint or seclusion (all of which are required to be set forth in the incident report). The reviewer also makes sure that the incident report identifies the staff members involved in the incident and reflects the required “debriefing” after the incident.

If the incident report is incomplete or provides insufficient information, the QC reviewer follows up with the appropriate person to seek the additional information. If, based on the review, the reviewer has concerns or questions about the appropriateness of the use of restraint or seclusion, she shares that information with the Psychology Director to determine what, if any, further action should be taken.⁶⁶

The Psychology Director, through regular participation in the Provider Quality Team, is able to ensure that a corrective action plan is imposed and corrective action taken if she feels that is necessary to address improper use of restraint or seclusion.⁶⁷ The Psychology Director is also responsible for approving corrective actions for any Program Accountability Review (PAR)

⁶⁴ The incident report form includes a field that captures whether the youth was injured during a restraint or seclusion.

⁶⁵ Review of the higher level incidents involving restraint and seclusion has been the responsibility of the Psychology Director (or her predecessor) and the MHCs for the past several years. Review of lower level incidents involving restraint and seclusion was implemented beginning in June 2015. Prior to that time, the QC staff compiled and analyzed aggregate data on lower level incidents involving restraint and seclusion but did not review each incident individually.

⁶⁶ The QC staff person conducting the review and tracking these “level 1” IRs is also responsible for 1) tracking IRs that responders refer to Central Office and PQT and 2) examining aggregate IR data to identify any concerning patterns or trends with respect to particular agencies or placements. She regularly shares and discusses this data with the Psychology Director and she regularly participates, with the Psychology Director, in the PQT process.

⁶⁷ As discussed in previous monitoring reports, the authority to impose a corrective action plan on a facility appropriately resides with the Provider Quality Team, rather than with any individual; however, on issues related to restraints and seclusion, the Provider Quality Team has in practice deferred to the Medical Director’s judgment. According to the person who served for more than eight years as Medical Director until her departure at the end of 2014, there has never been an instance of the PQT failing to impose a corrective action plan that she had determined appropriate in response to an issue related to use of restraint or seclusion. That continues to be the experience of the current Medical Director and Psychology Director.

findings related to restraint or seclusion.⁶⁸

The participation of the Psychology Director and the QC staff in the PQT process (described in the July 2015 Monitoring Report) ensures both that all other divisions with oversight responsibilities are aware of any significant concerns arising from the IR reviews of restraint and seclusion and that Psychology Director and QC staff are aware of significant concerns arising from the other oversight activities that might warrant closer scrutiny of a particular facility, if not corrective action.⁶⁹

The current processes effectively ensure that every incident report of restraint or seclusion is reviewed—with the MHCs and health unit nurses reviewing and responding to the higher level incidents directly and with the QC staff reviewing the lower level incidents and sharing the results with the MHCs and Psychology Director. For example, during the third quarter of 2015 (July 1 through September 30), 954 incident reports of restraint or seclusion involving a *Brian A.* child were submitted, 252 of which were higher level IRs reviewed directly by the MHCs and health nurses and 702 of which were lower level IRs reviewed by the QC staff. Tracking data maintained by the QC staff reflect that three of the lower level IRs and three of the higher level IRs were forwarded on to the Psychology and/or Nursing Director for additional review. One of the two IRs forwarded on to the Psychology and Nursing Directors was the subject of further follow-up through the PQT process because it appeared that it may have represented a more systemic issue at the agency.

The TAC is satisfied that the current processes meet the Settlement Agreement requirements of Section VI.E.

VI.H Case Manager Contacts with Children

In the July 2015 Monitoring Report, the TAC presented extensive data and thorough discussion and analysis of the frequency with which DCS and private provider case managers were having face-to-face contacts with children on their caseloads. Based on this information, the parties were able to agree that the provisions related to the required frequency of face-to-face visits by case managers should be designated in “maintenance.”⁷⁰ The TAC believes that the primary and most important components of the VI.H requirements are the provisions related to the frequency

⁶⁸ As discussed in greater detail in the July 2015 Monitoring Report, the Program Accountability Review (PAR) site visit protocols include inquiries into the use of restraint and seclusion (focused on compliance with both the substantive limits and the reporting requirements). PAR monitors for evidence that IRs are always entered into TFACTS when appropriate. Any findings on this monitoring item would result in corrective action through the PAR process. In addition, when an agency is under increased scrutiny for any reason, PAR or others with provider oversight responsibility may conduct “spot checks” to make sure incidents are being reported. For example, when the PQT was conducting a review of Special Investigations in facilities for purposes unrelated to the Incident Reporting process, the team also checked to ensure that corresponding incident reports were filed when the subject matter of those SIU investigations or other circumstances relating to those cases should have resulted in the filing of incident reports.

⁶⁹ While the individual incident reports in TFACTS (as well as the QC tracking data) are available to the Licensing Unit, the Medical Director, and the Psychology Director, it is the PQT process that ensures timely and meaningful communication of concerns related to restraints and seclusion and appropriate corrective action.

⁷⁰ This included maintenance on the provisions specifying the required frequency of visits at the child’s placement.

of face-to-face visits by case managers. However, as noted in the September 2015 Supplemental Report, the plaintiffs were interested in further data collection and the parties agreed to the TAC's plan to devote additional time to gather and present information related to two remaining elements of Section VI.H: (1) that the case manager spend time with the child outside the presence of the caretaker during each required face-to-face contact; and (2) that in cases managed by private providers, there be joint DCS-private provider case manager face-to-face contact with the child and the resource parent or other caretaker at least once every three months.

In November 2015, the TAC monitoring staff completed a targeted case file review of a sample of 102 children⁷¹ who entered custody prior to January 2015 and remained in custody through September 2015, drawn from the September 14, 2015 Mega Report and stratified by region.⁷² The case file review was designed to gather information for the four-month period from January 2015 through April 2015 on the extent to which case managers were spending time with the child outside the presence of the caretaker during face-to-face visits and the extent to which, in private provider case managed cases, the required joint contacts were occurring.

A. Time Spent With the Child Outside of the Presence of the Caretaker

The Department's policies on quality visitation as well as their training emphasize the importance of spending some time with a child outside the presence of the caretaker during face-to-face visits, and the TAC has no doubt that both DCS and private provider case managers understand this is a basic element of a quality visit with children.

The purpose of case managers spending some time with children without the caretaker present is "to ensure that they feel comfortable sharing information."⁷³ Children are often most comfortable sharing information when those opportunities occur naturally, during the course of other activities. Those opportunities for conversations outside the presence of the caretaker often arise when case managers are transporting children to family visits, doctor's appointments, child and family team meetings, or court hearings.

In designing the targeted case review, the TAC recognized the documentation challenges, especially when private interactions occur naturally during the course of a visit, and was concerned about being careful to assess actual practice as opposed to documentation. In these instances, case managers may not necessarily write in their case notes "spent time with the child

⁷¹ This sample size provides a confidence level of 95% and a confidence interval of plus/minus 10.

⁷² With the agreement of the parties, children who were age 2 or younger were excluded from the sample. An additional child was excluded from the sample because she was non-verbal and developmentally on the level of a 2-year-old. (The reviewer nevertheless reviewed the case and noted the conscientiousness with which the case manager approached her face-to-face contacts with this child.) Children who were on ICPC or on runaway status at any time during the review period were excluded from the analysis for any month that they were on ICPC or on runaway.

⁷³ Council on Accreditation (COA), Interpretation of Standard PA-FKC 12.01. The COA standards require that workers meet with children on their caseloads at least once a month. The interpretation states that "each meeting with children should include time for private discussion to ensure they feel comfortable sharing information." All DCS regions were reviewed by the Council on Accreditation and were found to have satisfactorily implemented the required standards for accreditation. All private providers with whom the Department contracts are also required to achieve COA accreditation, and this standard applies to private agency case managers as well.

without caretaker present” every time they do so.⁷⁴ For this reason, in designing the case file review, the TAC monitoring staff not only looked for specific language in case recordings stating that time was spent with the child when the caretaker was not present, but also sought to identify specific activities that necessarily involved some private time outside the presence of the caretaker—such as case manager visits that occurred at school or times that case managers provided transportation. The TAC monitoring staff also considered whether the nature or content of a discussion recounted in case recordings suggested that it occurred in private. For example, if a case manager noted that a child complained about some aspect of the placement, the reviewers might draw the inference that the complaint was made outside the presence of the caretaker or facility staff. The reviewers discussed with each other and reviewed with the TAC any cases in which a finding of “documentation of time outside the presence of the caretaker” was based on an inference drawn from the documentation in the case file.

For DCS case managed cases, *the reviewers looked for at least one face-to-face contact each month that included documentation of some time spent outside the presence of the caregiver and noted up to two such contacts each month.*⁷⁵ For private provider case managed cases, *the reviewers looked for at least one face-to-face contact by the private provider staff⁷⁶ that included some time spent with the child outside the presence of the caretaker (and noted up to two such contacts), and also looked for at least one such contact by the DCS case manager.*

1. Children in DCS Placements

The following table reflects for each month the number of children in the sample who were in DCS placements who received zero, one, or two or more visits during that month for which there was documentation that the visit included time spent outside the presence of the caretaker.⁷⁷ Also included in parentheses is the number of children who received zero, one, or two or more face-to-face contacts, without regard to whether there was documentation of time spent outside the presence of the caretaker. The second table contains the same data, presented as percentages.

⁷⁴ There is no current requirement that there be some specific documentation to this effect. In the TAC’s experience with other jurisdictions that have created “check boxes” to document time spent outside the presence of a caretaker, these check boxes serve no useful purpose for evaluating whether in fact there was an opportunity for the child to share any concerns outside the presence of their caretaker.

⁷⁵ Reviewers did not look for more than two visits per month that involved time outside the presence of the caretaker.

⁷⁶ For purposes of this provision, the TAC considered time spent outside the caretaker’s presence with the child’s private provider case manager, private agency counselor or therapist as meeting this requirement.

⁷⁷ There were eight cases in the review sample in which in a given month a child was in a DCS placement for part of the time and a private provider placement for part of the time. These cases are footnoted in the following tables.

Table 6.1: DCS Placements:				
Number of Visits with Documented Time Outside Presence of Caretaker (OPC Time)				
	January	February	March	April
2 or more visits by case manager with documented OPC time	15 (28)	13 (25)	14 ⁷⁸ (29)	14 ⁷⁹ (23)
1 visit by case manager with OPC time	16 (3)	16 ⁸⁰ (9)	10 ⁸¹ (3)	12 ⁸² (9)
0 visits by DCS case manager with OPC time documented	1 (1)	6 (1)	9 (1)	7 (1)
Total Cases	32	35	33	33

Source: 2015 TAC Review of Time Spent With Children Outside the Presence of a Caretaker During Visits.

Table 6.2: DCS Placements:				
Percentage of Visits with Documented Time Outside Presence of Caretaker (OPC Time)				
	January	February	March	April
2 or more visits by case manager with documented OPC time	47% (88%)	37% (71%)	42% (88%)	42% (70%)
1 visit by case manager with OPC time	50% (9%)	46% (26%)	30% (9%)	36% (27%)
0 visits by DCS case manager with OPC time documented	3% (3%)	17% (3%)	27% (3%)	21% (3%)
Total Cases	100%	100%	100%	100%

Source: 2015 TAC Review of Time Spent With Children Outside the Presence of a Caretaker During Visits.

2. Children in Private Provider Placements

The following table reflects for each month the number of children in the sample who were in private provider placements who received zero, one, or two or more visits during that month for which there was documentation of time spent outside the presence of the caretaker during that visit. It also shows the number of children in that private provider group who received at least one face-to-face contact with the DCS case manager for which there was documentation of time spent outside the presence of the caretaker. Also included in parentheses is the number of children who received zero, one, or two or more face-to-face private provider staff contacts, and at least one contact from the DCS case manager without regard to whether there was documentation of time spent outside the presence of the caretaker. The second table contains the same data, presented as percentages.

⁷⁸ This includes one case in which the child spent part of the month in a private provider placement.

⁷⁹ This includes one case in which the child spent part of the month in a private provider placement.

⁸⁰ This includes five cases in which the child spent part of the month in a private provider placement.

⁸¹ This includes one case in which the child spent part of the month in a private provider placement.

⁸² This includes one case in which the child spent part of the month in a private provider placement.

Table 6.3: Private Provider Placements: Number of Visits with Documented Time Outside Presence of Caretaker (OPC Time)				
	January	February	March	April
<i>Private Provider Visits</i>				
2 or more visits by private provider with documented OPC time	37 (56)	28 ⁸³ (64)	30 (58)	29 ⁸⁴ (60)
1 visit by private provider with documented OPC time	8 (5)	12 ⁸⁵ (4)	9 (5)	12 (3)
0 visits by private provider with documented OPC time	25 (9)	32 ⁸⁶ (4)	30 ⁸⁷ (6)	28 ⁸⁸ (6)
Total Cases	70	72	69	69
<i>DCS Case Manager Visits in Private Provider Cases</i>				
1 or more visits by DCS case manager with documented OPC time	49 (65)	44 (68)	49 (67)	51 (66)
0 visits by DCS case manager with documented OPC time	21 (5)	28 (4)	20 (2)	18 (3)
Total Cases	70	72	69	69

Source: 2015 TAC Review of Time Spent With Children Outside the Presence of a Caretaker During Visits.

⁸³ This includes one case in which the child spent part of the month in a DCS placement.

⁸⁴ This includes one case in which the child spent part of the month in a DCS placement.

⁸⁵ This includes two cases in which the child spent part of the month in a DCS placement.

⁸⁶ This includes two cases in which the child spent part of the month in a DCS placement.

⁸⁷ This includes two cases in which the child spent part of the month in a DCS placement.

⁸⁸ This includes one case in which the child spent part of the month in a DCS placement.

Table 6.4: Private Provider Placements: Percentage of Visits with Documented Time Outside Presence of Caretaker (OPC Time)				
	January	February	March	April
<i>Private Provider Visits</i>				
2 or more visits by private provider with documented OPC time	53% (80%)	39% (89%)	44% (84%)	42% (87%)
1 visit by private provider with documented OPC time	11% (7%)	17% (6%)	13% (7%)	17% (4%)
0 visits by private provider with documented OPC time	36% (13%)	44% (6%)	44% (9%)	41% (9%)
Total Cases	100%	100%	100%	100%
<i>DCS Case Manager Visits in Private Provider Cases</i>				
1 or more visits by DCS case manager with documented OPC time	70% (93%)	61% (94%)	71% (97%)	74% (96%)
0 visits by DCS case manager with documented OPC time	30% (7%)	39% (6%)	29% (3%)	26% (4%)
Total Cases	100%	100%	100%	100%

Source: 2015 TAC Review of Time Spent With Children Outside the Presence of a Caretaker During Visits.

The following table combines the data from both DCS case managed and private provider case managed cases and reflects the number and percentage of cases in the review for which in any given month children received zero, one, or two or more visits during that month from either a DCS case manager or a private provider case manager for which there was documentation of time spent outside the presence of the caretaker during that visit. The second table contains the same data, presented as percentages.

Table 6.5: All Placements: Number of Visits by Private Provider or DCS Case Manager with Documented Time Outside Presence of Caretaker (OPC Time)				
	January	February	March	April
2 or more visits with documented OPC	57 (91)	46 (92)	51 (94)	50 (89)
1 visit with documented OPC time	38 (9)	38 (8)	30 (5)	36 (10)
0 visits with documented OPC time	7 (2)	18 (2)	19 (1)	14 (1)
Total Cases	102	102	100	100

Source: 2015 TAC Review of Time Spent With Children Outside the Presence of a Caretaker During Visits.

Table 6.6: All Placements: Percentage of Visits by Private Provider or DCS Case Manager with Documented Time Outside Presence of Caretaker (OPC Time)				
	January	February	March	April
2 or more visits with documented OPC	56% (89%)	45% (90%)	51% (94%)	50% (89%)
1 visit with documented OPC time	37% (9%)	37% (8%)	30% (5%)	36% (10%)
0 visits with documented OPC time	7% (2%)	18% (2%)	19% (1%)	14% (1%)
Total Cases	100%	100%	100%	100%

Source: 2015 TAC Review of Time Spent With Children Outside the Presence of a Caretaker During Visits.

3. Comparison of TFACTS Documentation and Private Provider Case File Documentation

As discussed in previous monitoring reports, because the current SACWIS requirements prohibit the electronic transfer of data maintained by private providers in their case files into TFACTS and because private providers naturally place a priority on accuracy and completeness of their own case files, documentation in TFACTS of private provider case manager contacts with children (and documentation of time spent outside the presence of the caretaker during those contacts) is likely to understate the frequency of those contacts. To illustrate that point, the TAC monitoring staff compared data from the private provider case files for 24 children in the review sample who were served by a particular provider with the results of the TFACTS file review for those children. In the table below, the first number in each column reflects contacts involving some time outside the presence of the caretaker based on the TFACTS case file review. The second number reflects findings of the reviewers based on the information from the private agency case files. The second table contains the same data, presented as percentages.

Table 6.7: Time Outside Presence of Caretaker Documented in TFACTS vs. in Private Provider Files (Number of Cases)				
	January	February	March	April
2 or more visits by private provider with documented OPC time	13 / 23	9 / 23	12 / 24	10 / 23
1 visit by private provider with documented OPC time	2 / 0	3 / 0	3 / 0	2 / 0
0 visits by private provider with documented OPC time	8 / 0	11 / 0	9 / 0	11 / 0
Total Cases	23	23	24	23

Source: 2015 TAC Review of Time Spent With Children Outside the Presence of a Caretaker During Visits.

Table 6.8: Time Outside Presence of Caretaker Documented in TFACTS vs. in Private Provider Files				
	(Percentage of Cases)			
	January	February	March	April
2 or more visits by private provider with documented OPC time	56% / 100%	39% / 100%	50% / 100%	44% / 100%
1 visit by private provider with documented OPC time	9% / 0%	13% / 0%	13% / 0%	9% / 0%
0 visits by private provider with documented OPC time	35% / 0%	48% / 0%	38% / 0%	48% / 0%
Total Cases	100%	100%	100%	100%

Source: 2015 TAC Review of Time Spent With Children Outside the Presence of a Caretaker During Visits.

4. PAR Findings

The PAR reviewers examine private provider case files to determine if “all face-to-face visits have included a private meeting between the private provider case manager and the child out of the presence of the foster parent or other caregiver.” In rating private provider performance, PAR reviewers look for “clear documentation” in the private provider case file that the provider case manager spent time speaking privately with the child. PAR reviews require explicit reference to conversations with the child outside the presence of the caregiver, and unlike the TAC review, do not infer such conversations from the circumstances of the face-to-face contact. The PAR review also requires that the conversation clearly be “private,” while the TAC and the Settlement Agreement focus simply on whether the conversation occurred outside of the presence of the caregiver.

A PAR finding of “no evidence of need to improve” reflects consistent documentation of time spent outside the presence of a caretaker; a finding of “some evidence of need to improve” reflects documentation in some instances, but not in others; a PAR finding of “significant evidence of need to improve” reflects a general lack of documentation of private conversation with the child. For the state fiscal year 2014-15, 59% (139) of the 235 child case files reviewed during the PAR monitoring visits had no evidence of a need to improve; 23% (53) had some evidence of a need to improve; and 18% (42) had significant evidence of a need to improve.

Based on follow-up discussions with those providers whose case files lacked sufficient documentation of private time with the child during face-to-face visits, PAR has concluded that the agency case managers are generally spending time outside of the presence of a caretaker with children during face-to-face visits, but that the case managers are inconsistent in providing “clear documentation” of private conversations in their case recordings.

B. Joint DCS and Private Provider Case Manager Visit with the Child, Parents, and Resource Parent or Other Caretaker

Of the children in the sample who were in private provider placements for the entire four-month period covered by the review, the reviewers looked for evidence of at least one joint DCS and private provider meeting with the child and at least one joint visit with the resource parent or other caretaker.⁸⁹ The joint visit could be a single gathering of the case managers with both the child and the resource parent or other caretaker, or it could be separate joint visits.⁹⁰

Of the 64 cases in which the child was in a private provider placement for the entire four-month review period, a joint meeting with the child was documented in 51 (80%) and a joint meeting with the resource parent or other caretaker was documented in 53 (82%).⁹¹

⁸⁹ A four-month period was used to measure compliance with the quarterly joint visit requirement both because children enter and leave at varying times each month and because it seemed reasonable, in light of normal scheduling challenges, to allow a “cushion” of up to 30 days.

⁹⁰ Reviewers noted if there was a joint meeting in which one or more people participated by telephone.

⁹¹ There were an additional eight children who were in private provider placements for only part of the review period; joint visits were nevertheless documented with the child in five of these cases and with the resource parent or other caretaker in three of these cases.

SECTION VII PROVISIONS: PLANNING FOR CHILDREN

VII.B Participation in Child and Family Team Meetings

The Settlement Agreement (VII.B) requires that any child 12 years old and older participate in Child and Family Team Meetings (CFTM), unless extraordinary circumstances exist, and are documented in the case record, as to why the child's participation would be contrary to his or her best interests.

The Settlement Agreement further specifies that the Child and Family Team Meeting include the following members, as appropriate:

- (1) the private provider agency worker;
- (2) the guardian *ad litem* (GAL);
- (3) the court appointed special advocate (CASA);
- (4) the resource parents; and
- (5) the child's parents, other relatives, or fictive kin.

In addition, the Settlement Agreement requires that a trained, full-time or back-up facilitator participate in every Initial CFTM and Placement Stability CFTM.

DCS is also required to provide reasonable advance notice of CFTMs to the GAL and CASA worker in order to facilitate their participation.

The July 2015 Monitoring Report provided aggregate data, relevant QSR scores, and targeted review results related to attendance of team members generally, and reflecting that the Department was reasonably assuring participation of older children and parents in the Child and Family Team (CFT) process. The aggregate data was drawn from calendar year 2014 and the QSR data from the 2014-15 annual review. The targeted review data was generated from the Child and Family Team (CFT) Process Review, which was completed in June 2015. The review sample of 92 cases was drawn from the 2,008 children who entered out-of-home placement between January 1, 2014 and June 30, 2014 and remained in custody for at least 60 days.⁹² Reviewers examined each child's TFACTS case file to find information about the CFTMs held, including information about who attended those meetings.⁹³

For ease of reference, the relevant information from that Monitoring Report is included in the discussion below.

The July 2015 Monitoring Report did not include any data or discussion related to the requirement that the Department provide reasonable advance notice of the CFTMs to the GAL and CASA. While DCS policy embraces this requirement, the Department has recognized that

⁹² The 92 children in the sample included 64 who were still in DCS custody as of April 30, 2015.

⁹³ While the CFTM aggregate reporting is designed to draw from specific TFACTS check box fields to determine presence at a CFTM, reviewers were able to look beyond the check box fields to case recordings and CFTM signature pages to identify participants.

some GALs and CASAs have not been receiving reasonable notice of CFTMs. As discussed below, the Department has taken a number of steps to address that issue.

A. Participation by Children and Families in the CFTM Process

The table below reflects the frequency with which older children (youth age 12 and older), parents, and family and fictive kin attended Child and Family Team Meetings convened in their cases. For each CFTM type, the table presents two percentages.

The first percentage, presented in **bold type**, is the percentage reflected by the results of the CFT Process Review. The percentages of older youth participating in CFTMs reflect the experiences of the 40 youth in the review sample who were 12 years of age or older during the review period. For purposes of calculating the percentage of parents participating in CFTMs for the 92 children in the sample, parents whose parental rights had been terminated prior to the CFTM and parents who were deceased were excluded.⁹⁴ In the sample, there were four mothers (two at the time of the Initial and Initial Permanency Planning CFTMs, and two additional at Placement Stability CFTMs) and one father (at the time of the Placement Stability CFTM) whose parental rights had been terminated, and there were three mothers and three fathers who were deceased.⁹⁵

The second percentage (*italicized* and indicated in parentheses below the CFT Process Review data) is the percentage reflected by the *aggregate CFTM* reporting for 2014.⁹⁶ As discussed in previous monitoring reports, the TAC has found that the aggregate CFTM reporting generally understates the Department's performance⁹⁷ and therefore the CFT Process Review data would be expected to show higher levels of CFTM member participation than the CFTM aggregate reporting, and that is in fact reflected in Table 7.1 below.

⁹⁴ The language “*mothers who would have been expected to have participated*” and “*fathers who would have been expected to have participated*” reflects this exclusion.

⁹⁵ In addition, there was one mother who was alleged to have committed severe abuse; and there was one case in which children had been adopted from Haiti and there was no mention of them having had an adoptive father.

⁹⁶ For all CFTMs other than the Discharge CFTM, the percentage is based on four quarterly CFTM reports for calendar year 2014. Because of an oversight, the Office of Information Technology did not produce a Discharge CFTM aggregate participant attendance report for the first quarter of 2014. For this reason, the CFTM aggregate reporting percentages for Discharge CFTM participation is based on three quarterly reports rather than four.

⁹⁷ See July 2015 Monitoring Report, footnote 341 at p. 208.

Table 7.1: Child and Family Participation in CFTMs				
	Initial CFTM	Initial Permanency Planning CFTM	Placement Stability CFTM	Discharge Planning CFTM
Youth 12 and Older	84% ⁹⁸ (70%)	100% ⁹⁹ (76%)	75% ¹⁰⁰ (76%)	95% ¹⁰¹ (86%)
Mother	81% ¹⁰² (66%)	83% ¹⁰³ (65%)	66% ¹⁰⁴ (40%)	57% ¹⁰⁵ (42%)
Father	37% ¹⁰⁶ (29%)	38% ¹⁰⁷ (31%)	23% ¹⁰⁸ (15%)	40% ¹⁰⁹ (16%)
Kin	63% ¹¹⁰ (42%)	51% (33%)	36% (25%)	45% (27%)

Source: May 2015 Child and Family Team Process Review and Child and Family Team Meeting (CFTM) Summary reports for the four quarters of 2014.

A parent or a present or former relative caregiver was present at 82 (92%) of the 89 Initial CFTMs and at 82 (89%) of the 92 Initial Permanency Plan CFTMs. In 88 (96%) of the cases, a parent or a present or former relative caregiver was present for at least one of those CFTMs.

⁹⁸ Initial CFTMs were held for 38 youth 12 and older: 27 (71%) were physically present and five (13%) participated by telephone.

⁹⁹ Initial Permanency Planning CFTMs were held for 40 youth 12 and older: 32 (80%) were physically present and eight (20%) participated by telephone.

¹⁰⁰ Placement Stability CFTMs were held for 36 youth 12 and older: 23 (64%) were physically present and four (11%) participated by telephone.

¹⁰¹ Discharge CFTMs were held for 20 youth 12 and older: 18 (90%) were physically present and one (5%) participated by phone.

¹⁰² Mothers would have been expected to have participated in 84 of the 89 Initial CFTMs held. The 81% attendance number includes 59 (70%) who were physically present and nine (11%) who participated by phone.

¹⁰³ Mothers would have been expected to have participated in 87 of the 92 Initial Permanency Plan CFTMs held. The 83% attendance figure includes 62 (71%) who were physically present and 10 (12%) who participated by phone.

¹⁰⁴ There were 81 Placement Stability CFTMs held in the 92 cases reviewed (in some cases, one child had a number of Placement Stability CFTMs during the review period). Mothers would have been expected to participate in 70 of those CFTMs. The 66% attendance figure includes 36 (52%) who were physically present and 10 (14%) who participated by phone.

¹⁰⁵ Mothers would have been expected to have participated in 28 of the 31 Discharge Planning CFTMs held. The 57% attendance figure includes 15 (54%) who were physically present and one (3%) who participated by phone.

¹⁰⁶ Fathers would have been expected to have participated in 86 Initial CFTMs. Fathers participated in 32 (37%) of those CFTMs: 26 (30%) were physically present and six (7%) participated by telephone.

¹⁰⁷ Fathers would have been expected to have participated in 89 Initial Permanency Planning CFTMs. Fathers participated in 34 (38%): 28 (31%) were physically present and six (7%) participated by telephone.

¹⁰⁸ Fathers would have been expected to have participated in 73 Placement Stability CFTMs. Fathers participated in 17 (23%) of those CFTMs: 14 (19%) were physically present and 3 (4%) participated by telephone.

¹⁰⁹ Fathers would have been expected to have participated in 30 Discharge CFTMs. Fathers participated in 12 (40%) of those CFTMs: 11 (37%) were physically present and one (3%) participated by telephone.

¹¹⁰ At least one kin (relative or friend) was present at 56 (63%) of the Initial CFTMs held, 47 (51%) of the Initial Permanency Plan CFTMs, 29 (36%) of the Placement Stability CFTMs, and 14 (45%) of the Discharge Planning CFTMs.

B. Non Attendance of Older Children at CFTMs

The mantra “nothing about us without us” captures the importance that older youth in foster care place on having the right to actively participate in the case planning process. The Settlement Agreement embraces that right to active participation by requiring that older children attend their CFTMs unless “extraordinary circumstances” make such attendance “contrary to his or her best interests.”

Active participation of youth age 12 or older in the CFT process is a core element of the Department’s Practice Model and the Department takes an appropriately narrow view of what would constitute “extraordinary circumstances” that would justify excluding older youth from participating in a CFTM. An acute psychiatric crisis or a debilitating health condition might warrant proceeding with a scheduled CFTM without the child being present as it would if a young person had run away. In such cases, it might be important to proceed with the CFTM, while at the same time planning to reconvene the Child and Family Team at a point when the youth is able to participate.

However, there are often circumstances that make it inconvenient or difficult for a young person to attend a CFTM but that are not “extraordinary.” The fact that a youth is in a residential treatment center and that transporting the youth to the CFTM would be impractical may be a reason for arranging for the youth to participate by phone, but would not be a basis for excluding the youth.¹¹¹ If the subject matter to be discussed at a CFTM is likely to be upsetting to the young person, it may be important to spend time helping him or her prepare for that discussion in advance of the CFTM and to have a skilled facilitator facilitate the CFTM, but those difficult discussions are often the most important for the young person to participate in, and rather than avoiding those discussions, the focus should instead be on how to have them. Even in situations in which there is a “no contact” order against a parent or other CFTM participant, there are ways to bifurcate the CFTM to allow the young person to participate without violating the order.

The CFT Process Review data presented in Table 7.1 above represents a total of 134 CFTMs held in cases of children 12 and older. Those youth participated in the vast majority (118, or 88%) of those CFTMs; however, according to TFACTS documentation, youth were absent from 16 (12%) of those CFTMs. For each instance of non-attendance the CFT Process Review sought to determine from documentation in the case file and through follow-up with the region why the young person did not attend.¹¹²

There were six youth who did not participate in their Initial CFTM.

- In one case, the young person had been involuntarily committed to a psychiatric hospital, and the Initial CFTM was held during that acute hospitalization but prior to the young person coming into custody, because the parent indicated she was not willing for him to return to her home.

¹¹¹ It might also be a reason for considering holding the CFTM at the congregate care facility.

¹¹² The determination was made based on a combination of case file documentation and follow-up with regional staff.

- In the second, the young person came into care based on allegations of sexual abuse by a parent, and for a variety of reasons having to do with the ongoing investigation, including the desire not to interfere with the protocol for completing the forensic interview, it was appropriate to proceed with the Initial CFTM without the young person being present.
- In the third case, involving a young person with truancy issues, the choice was between scheduling the Initial CFTM during school hours to accommodate the grandparent and having the young person either miss school to attend the CFTM or miss the CFTM to attend school or scheduling the CFTM after school, which would have prevented the grandmother from participating. The decision was made to accommodate the grandmother but have the young person miss the CFTM rather than school.
- In the fourth case, while there was some reference to the child having threatened to run away around the time of the Initial CFTM and to a sibling being very upset at being placed in a residential facility, there was nothing to suggest that those challenges would have prevented the young person from being able to participate in the CFTM.
- In the fifth case, there was a no contact order against a parent; however, as discussed above, the Department expects accommodations to be made in those cases to allow the young person to participate without violating the no contact order.
- In the sixth case, the young person was at a congregate care facility which was a two and a half hour drive from her home county, and “scheduling issues” with the facility prevented her from participating by telephone.

In all six of these cases, the young person subsequently participated in the Initial Permanency Planning CFTM.

There were eight instances of youth who did not participate in a Placement Stability CFTM.

- In two instances, involving the same young person, the CFTM in each case was held prior to a move in which the young person was in an especially unstable state, moving into or out of a Level IV psychiatric facility. The young person participated in other CFTMs when she was more emotionally stable.
- In two instances, involving another young person, the young person had been requesting that she not be compelled to attend the CFTM because she did not want to see her mother. The young person’s therapist supported the young person’s decision not to attend these two CFTMs.
- In the fifth instance, the CFTM was convened to consider the request of the resource parent for additional assistance in order to maintain the placement; the resource parent was not seeking to have the young person moved and there was some concern that participating in the CFTM might unnecessarily upset the young person. There had been two Placement Stability CFTMs held during the prior month and one Placement Stability CFTM held two months later, and the child was present for each of those CFTMs.

- In the sixth instance, the young person was on runaway status at the time of the CFTM.
- In the seventh instance, what was labeled as a Placement Stability CFTM for a young person at a residential facility appeared to be more of a private provider staffing in advance of a CFTM to discuss discharging that young person from the facility. The CEO of the placement, multiple therapists, the DCS psychologist, the worker, and the mother were documented as being present. On follow-up, the DCS case manager indicated that she thought that the young person may have actually participated by telephone, but that it was not noted in the documentation. There was a reference to the young person having been asked to describe what he wants in a placement and to tell them what he wanted to include about himself in the placement packet. There was a subsequent CFTM held closer to his discharge at which the young person was present.
- In the eighth instance, the young person was present, but the young person went with a DCS staff member to the play room after the meeting started. The Department was attempting to salvage the placement for this young person and her siblings after an incident involving a youngest sibling hitting the resource parent with a belt and the children doing some damage to a wall of the house. The case manager felt that the discussion of the problematic behavior and the potential move would be better to have without the children present.

There was one instance in which reviewers were unable to find documentation of a young person's attendance at a Discharge Planning CFTM. However, in that case, the case manager distinctly remembers that the CFTM was held at the DCS regional office, that the young person attended, and that the trial home visit was specifically discussed with her. He believes that he simply neglected to document the young person's presence at the CFTM.

C. Non Attendance by Parents

For any instance of non-attendance of parents, the reviewers sought to understand the circumstances surrounding the non-attendance. For non-attendance at the Initial CFTM, the reviewers looked for documentation of efforts to ensure parental participation, including providing transportation or child care, or providing a brief rescheduling. For non-attendance at the Initial Permanency Planning CFTM, the reviewers looked for documentation of efforts to locate the parents, meet with the parents, and ensure parental participation in the CFTM.

For non-attendance at other CFTMs, the reviewers examined the circumstances surrounding the convening of the CFTM, including whether the parents were provided reasonable notice of the meeting and an opportunity to attend.

The CFT Process Review data presented in Table 7.1 above represents a total of 293 Initial, Initial Permanency Planning, Placement Stability, and Discharge CFTMs. For 24 of those CFTMs, the mother's parental rights had been previously terminated or the mother had been charged with severe abuse (12 CFTMs) or the mother was deceased (12 CFTMs). Of the remaining 269, mothers participated in 202 (75%) of the meetings; mothers were absent from 67

(25%) of the CFTMs,¹¹³ including 16 Initial CFTMs and 15 Initial Permanency Planning CFTMs.

For each of those Initial CFTMs and Initial Permanency Planning CFTMs, the CFT Process Review sought to determine from documentation in the case file, and from further follow-up if documentation was lacking, why the mother did not attend.

For the 16 Initial CFTMs which mothers did not attend, the circumstances were as follows:

- In nine cases, the mother was not the primary caretaker from whom the child had been removed, and in all but one of the cases, it is clear that the child's primary caretaker at the time of entrance into care was at the meeting.
- In two cases, the child's mother had been incarcerated. In one case the mother was incarcerated the night prior to the CFTM, and in the other case, the jail informed the Department that the mother was unable to participate in the meeting. Her attorney did attend.
- In two cases, there was a no contact order between the mother and the children at the time of the Initial CFTM. In both cases, the father was present for the Initial meeting, and the mothers were present at the Initial Permanency Planning meeting.
- In the fourteenth case, the mother's whereabouts were unknown ("the parents had absconded/left the state with the children"), and the Department was diligently searching for them.
- In the fifteenth case, the mother was not present, but her attorney and kin were, and she was present for the Initial Permanency Planning meeting.
- In the sixteenth case, the mother never arrived at the Initial CFTM after calling to say that she was on her way.

For the 15 Initial Permanency Planning CFTMs which mothers did not attend, the circumstances were as follows:

- In nine cases (eight of the same mothers who were absent from the Initial meeting, and one additional mother who had been present at the Initial meeting), the mother was not the primary caretaker from whom the child had been removed, and in all but one of the cases, it is clear that the child's primary caretaker at the time of entrance into care was at the meeting.
- In two cases, the child's mother was incarcerated; one had just been incarcerated at the beginning of the case, and the other, who was incarcerated after the Initial meeting (for

¹¹³ Mothers missed 67 CFTMs for 57 unique children. Five children had more than one Placement Stability CFTM.

which she had been in attendance), was able to discuss the plan with the case manager after the meeting. In both cases, the child's father was present for the CFTM.

- In the twelfth case, the mother's whereabouts were unknown ("the parents had absconded/left the state with the children") and the Department was diligently searching for them.
- In the thirteenth case, the child "did not wish to visit with her parents anymore."
- In the fourteenth case, the meeting had been planned in accordance with the parents' schedule, but they did not show up for the meeting.
- In the fifteenth case, the mother had attended the Initial CFTM, and was also present for other meetings later in the case, but despite numerous attempts to reach her before and during the meeting, she did not attend the Initial Permanency Planning meeting.

Six of the mothers who did not attend the Initial CFTMs as detailed above were present for the Initial Permanency Planning CFTM.

With respect to the presence of fathers, for 15 of the 293 CFTMs reflected in Table 7.1 above, the father's parental rights had been previously terminated (six CFTMs)¹¹⁴ or the father was deceased (nine CFTMs). Of the remaining 276 CFTMs, fathers participated in 95 (34%) meetings; and fathers were absent from 181 (66%),¹¹⁵ including 54 Initial CFTMs and 55 Initial Permanency Planning CFTMs. For each of those Initial CFTMs and Initial Permanency Planning CFTMs, the CFT Process Review sought to determine from documentation in the case file why the father did not attend.

For the 54 Initial CFTMs which fathers did not attend, the circumstances were as follows:

- in 15 cases, the father's whereabouts were unknown;
- in 11 cases, the father was incarcerated;
- in eight cases, the father had not been involved in the child's life at the time of removal;
- in four cases, the Department had attempted to contact the father or had invited him to the meeting;
- in two cases, the father's rights were believed to have been terminated;
- in one case, the father was at work; and
- in 13 cases, the reason for the father's absence was not documented.

Fathers were missing from 55 Initial Permanency Planning CFTMs:

- In 15 cases, the father's whereabouts were unknown;
- in 14 cases, the father was incarcerated;

¹¹⁴ This includes one case in which the children had been adopted from Haiti and a father had not been identified.

¹¹⁵ Fathers missed 181 CFTMs for 150 unique children. Fourteen children had more than one Placement Stability CFTM.

- in six cases, the father had not been involved in the child's life at the time of removal;
- in five cases, the Department had attempted to contact the father or had invited him to the meeting;
- in one case, the father's rights were believed to have been terminated;
- in two cases, the father was at work; and
- in 12 cases, the reason for the father's absence was not documented.

D. Participation of Resource Parents in CFTMs

The Department's policy is to encourage, but not require, resource parents to attend Child and Family Team Meetings. The CFT Process Review found that for children placed in resource homes at the time of their CFTM, resource parents participated in 68% (42 of 62) of Initial CFTMs, 72% (56 of 78) of Initial Permanency Planning CFTMs, 89% (57 of 64) of Placement Stability CFTMs, and 84% (16 of 19) of Discharge CFTMs.¹¹⁶

E. Participation of Guardians Ad Litem (GALs)

In the cases subject to the CFT Process Review, guardian *ad litem* (GAL) participation was 37% for Initial CFTMs, 50% for Initial Permanency Planning CFTMs, 17% for Placement Stability CFTMs, and 42% for Discharge Planning CFTMs.¹¹⁷ According to the CFTM aggregate reporting, in 2014, GALs participated in 23% of Initial CFTMs, 43% of Initial Permanency Planning CFTMs, 33% of Placement Stability CFTMs, and 23% of the Discharge Planning CFTMs.

F. Participation of Court Appointed Special Advocates (CASAs)

Because state law requires a GAL to be appointed in every dependent and neglect case, every class member should be actively represented by a GAL. However, for a variety of reasons, only a small percentage of class members are also assigned a CASA. First, unlike some states that have CASAs available in every county, Tennessee's 28 separate CASA programs collectively cover only 47 of Tennessee's 95 counties.¹¹⁸ Second, even in those counties that are served by CASA programs, the programs do not have sufficient volunteers (or staff to support those

¹¹⁶ Because one would not necessarily expect a resource parent to be on a Child and Family Team for a child who, for example, was initially placed in congregate care, data on resource parent participation is more meaningful when it is focused on those children who were in resource homes at the time of the CFTM.

¹¹⁷ These percentages are based on the total number of CFTMs held in each category, irrespective of whether a guardian *ad litem* had been appointed or was actively representing the child. The review was not designed to determine whether a guardian *ad litem* had in fact been appointed prior to the CFTM, nor was it designed to determine whether those guardians *ad litem* who had been appointed viewed Tennessee Supreme Court Rule 40 as requiring his or her participation in Child and Family Team meetings.

¹¹⁸ A 29th CASA program is about to open, which will bring to 48 the number of counties being served by a CASA program.

volunteers) to be able to assign a CASA to every child in DCS custody from that county.¹¹⁹ Third, because state law already requires appointment of a lawyer advocate (and provides funding, administered through the Administrative Office of the Courts, to compensate that lawyer advocate, if only modestly), the local courts¹²⁰ frequently prefer to appoint CASA volunteers to cases in which GALs are not appointed (*e.g.*, private party custody disputes) rather than DCS custody cases.¹²¹

In light of the relative infrequency of CASA appointments, the CFT review did not focus on participation of CASAs in CFTMs. However, where it was clear from the file that a CASA had been appointed prior to a particular CFTM, the reviewers noted whether the CASA was present at the CFTM. There were 14 cases in which reviewers found a CASA had been appointed in advance of the initial CFTM and in five of those cases, the CASA attended the initial CFTM. There were 19 cases (including the 14 just referenced) in which a CASA had been appointed in advance of the permanency planning CFTM and in nine of those cases, the CASA attended the permanency planning CFTM. There were 13 placement stability CFTMs held in cases in which a CASA had been appointed prior to the CFTM, and in six of those cases the CASA attended the CFTM. And there were two discharge CFTMs in cases in which a CASA had been appointed prior to the discharge CFTM and in neither of those cases was the CASA present for the discharge CFTM.

G. Participation of Private Provider Staff

When children are placed with private provider agencies, the Department expects agency staff to be active members of the Child and Family Team and to participate in Child and Family Team Meetings. The CFT Process Review gathered information about the child's placement at the time of the CFTM to determine whether the child was in a private provider placement, and if so, whether a private provider staff person participated in the CFTM.

There were 21 Initial CFTMs held for children in private provider placements, and private provider staff participated in 11 (52%) of those CFTMs.

There were 36 Initial Permanency Plan CFTMs held for children in private provider placements, and private provider staff participated in 24 (67%) of those CFTMs.

There were 54 Placement Stability CFTMs held for children in private provider placements, and private provider staff participated in 47 (87%) of those CFTMs.

¹¹⁹ The CASA programs are local non-profits that receive modest state funding, administered through the Tennessee Commission on Children and Youth, but depend on their own fundraising efforts to be able to support their programs. The local programs face significant challenges in recruiting volunteers who are willing and able to make the time commitment that is required to serve as a CASA and who have the temperament necessary to be effective advocates.

¹²⁰ This includes both Shelby County Juvenile Court, and until recently, Davidson County Juvenile Court.

¹²¹ As well-intentioned as the assignment of CASAs to non-DCS cases might be, such assignments are not consistent with National CASA Standards or with the primary mission of the local CASA programs. However, it is understandable that local CASA programs are inclined to accommodate the wishes of the juvenile court judges when appointed in a non-DCS custody case.

There were 15 Discharge CFTMs held for children in private provider placements, and private provider staff participated in 10 (67%) of those CFTMs.

H. Full-time or Back-Up Facilitators

As of June 17, 2015, the Department has a core of 64 full-time CFTM facilitators and six staff who facilitate part-time.¹²²

Since January 2014 the Department has provided four cycles of quarterly Advanced Skilled Facilitator training.

A trained, skilled facilitator is required to facilitate Initial CFTMs and Placement Stability CFTMs. The CFT Process Review found that 94% of the Initial CFTMs and 78% of the Placement Stability CFTMs were facilitated by trained facilitators.¹²³ According to the CFTM aggregate reporting for 2014, 90% of the Initial CFTMs and 74% of the Placement Stability CFTMs were facilitated by trained facilitators.

I. Participation by DCS Supervisors in CFTMs

The Settlement Agreement (VII.F) requires that the DCS supervisor assigned to a case participate in the Initial CFTM, the Initial Permanency Planning CFTM, and the Discharge Planning CFTM.

The CFT Process Review found the following levels of supervisor participation: 91% of Initial CFTMs, 82% of Permanency Planning CFTMs, and 71% of Discharge CFTMs.¹²⁴ According to the CFTM aggregate reporting for 2014, supervisors were present for 86% of the Initial CFTMs, 66% of the Initial Permanency Planning CFTMs, and 59% of the Discharge Planning CFTMs.¹²⁵

¹²² CFTM facilitators are expected to have the following skills: demonstrates preparation for meeting with the child and family; uses interpersonal helping skills to effectively engage the child and family; establishes a professional helping relationship by demonstrating empathy, genuineness, respect, and cultural sensitivity; uses a strengths-based approach to gather needed information; utilizes information gathered during the assessment process; draws conclusions about family strengths/needs and makes decisions around desired outcomes; facilitates the planning process by working collaboratively with family and team members; uses family strengths and needs to develop a plan that addresses safety, permanency, and well-being; prepares thorough and clear case recordings/written meeting summaries that follow proper format protocol; and creates case recordings/written meeting summaries that reflect the practice of family-centered casework.

¹²³ While trained facilitators are not required to be at other CFTMs, according to the CFTM aggregate reporting for 2014, 39% of the Initial Permanency Plan CFTMs and 48% of the Discharge Planning CFTMs were facilitated by trained facilitators.

¹²⁴ Generally when a supervisor is not present for the Initial CFTM in a case, the supervisor is present at the Initial Permanency Planning CFTM and vice versa. In the CFT Process Review there was only one case in which a supervisor was absent from both the Initial CFTM and the Initial Permanency Planning CFTM.

¹²⁵ According to the CFTM aggregate reporting for 2013, supervisors were present for 81% of the Initial CFTMs, 52% of the Initial Permanency Planning CFTMs, and 55% of the Discharge Planning CFTMs. According to the CFTM aggregate reporting for 2012, supervisors were present for 80% of the Initial CFTMs, 51% of the Initial Permanency Planning CFTMs, and 51% of the Discharge Planning CFTMs.

The Settlement Agreement provides that for all other CFTMs, the supervisor is to make a decision about his or her participation based on the complexity of the case; the availability of other supports, such as a full-time or skilled facilitator; and the case manager's experience. As one might expect, supervisors frequently decide to attend CFTMs when circumstances threaten or result in placement disruption. According to 2014 CFTM aggregate reports, supervisors attended 74% of the Placement Stability CFTMs held during 2014.

At a minimum, the supervisor is to participate in one CFTM every six months for each child on his or her supervisory caseload. For purposes of monitoring and reporting on this provision, the TAC provided a reasonable one-month "cushion" or "grace period" to account for CFTM scheduling challenges. The CFT Process Review found that in 70% (64 of 92) of the cases, a supervisor had participated in one CFTM every seven months for each child.

The Department is also required to develop a process for supervisors to review, monitor, and validate the results of CFTMs to ensure supervisors remain engaged and responsible for quality casework. The CFT Process Review found that for 98% (87 of 89) of Initial CFTMs, 97% (89 of 92) of Initial Permanency Planning CFTMs, 95% (77 of 81) of Placement Stability CFTMs, and 90% (28 of 31) of Discharge Planning CFTMs, a supervisor indicated that they had reviewed the CFTM in TFACTS.¹²⁶

J. Quality Service Review (QSR) Results Related to Team Composition and Participation in Team Meetings

The Department utilizes three QSR indicators, Voice and Choice for the Child and Family,¹²⁷ Engagement,¹²⁸ and Teamwork and Coordination, as the primary measures of both the extent to which teams are being formed with the right membership and the extent to which those members are actively involved in the Child and Family Team process, including participation in CFTMs.

The Voice and Choice indicator measures the extent to which the child and family are active and committed participants in the "change process."¹²⁹ The revised Engagement indicator now focuses on "the diligence of professionals in locating, reaching out to, building relationships with, and overcoming barriers of the child and family in order to ensure that the child and family are participating in the process of change."¹³⁰ The Teamwork and Coordination indicator "focuses on the structure and performance of the family team in collaborative problem solving, providing effective services, identifying the family's needs, and achieving positive results for the child and family."

¹²⁶ TFACTS provides a specific field to allow recording of the supervisor review of the CFTM summary. A designation of supervisor review is entered in that field when the supervisor either participated in the CFTM, or if he or she was unable to attend, reviewed and approved the content of the CFTM summary.

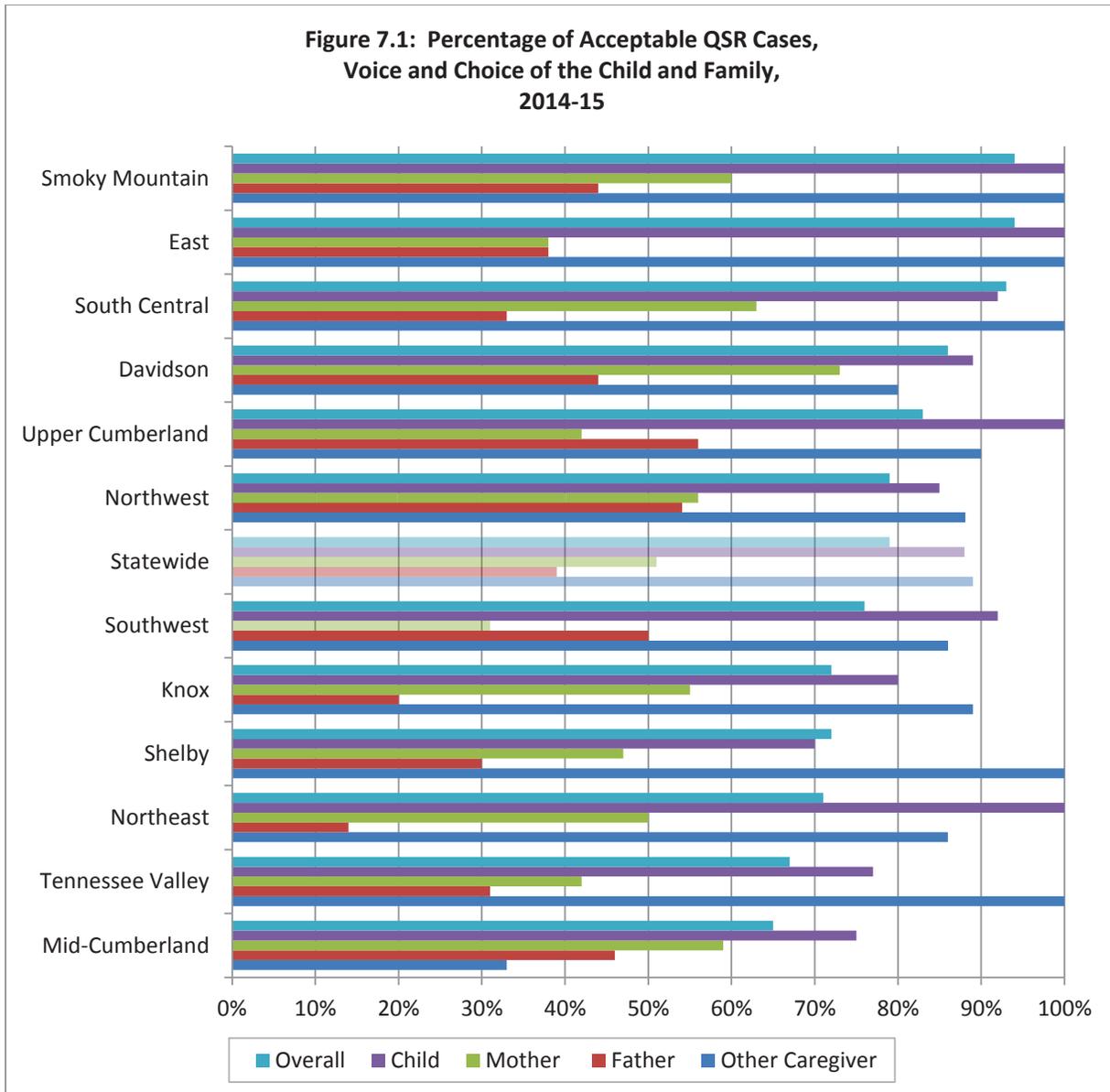
¹²⁷ As discussed in the May 2014 Monitoring Report, this was a new indicator which has been included in the protocol since the 2013-14 QSR.

¹²⁸ The Engagement Indicator was revised in 2013-14 in response to (and to avoid overlap with) the new Voice and Choice Indicator.

¹²⁹ See Appendix C of the July 2015 Monitoring Report for a more detailed description of the Voice and Choice of the Child and Family indicator.

¹³⁰ See Appendix C of the July 2015 Monitoring Report for a more detailed description of the revised Engagement indicator.

Figure 7.1 below presents the percentage of *Brian A.* cases receiving acceptable scores for Voice and Choice for the Child and Family, for the child, mother, father and “overall”¹³¹ in 2014-15. The “overall” statewide score increased from 72% (150/208) in 2013-14 to 79% (161/204) in the 2014-15 QSR.¹³²

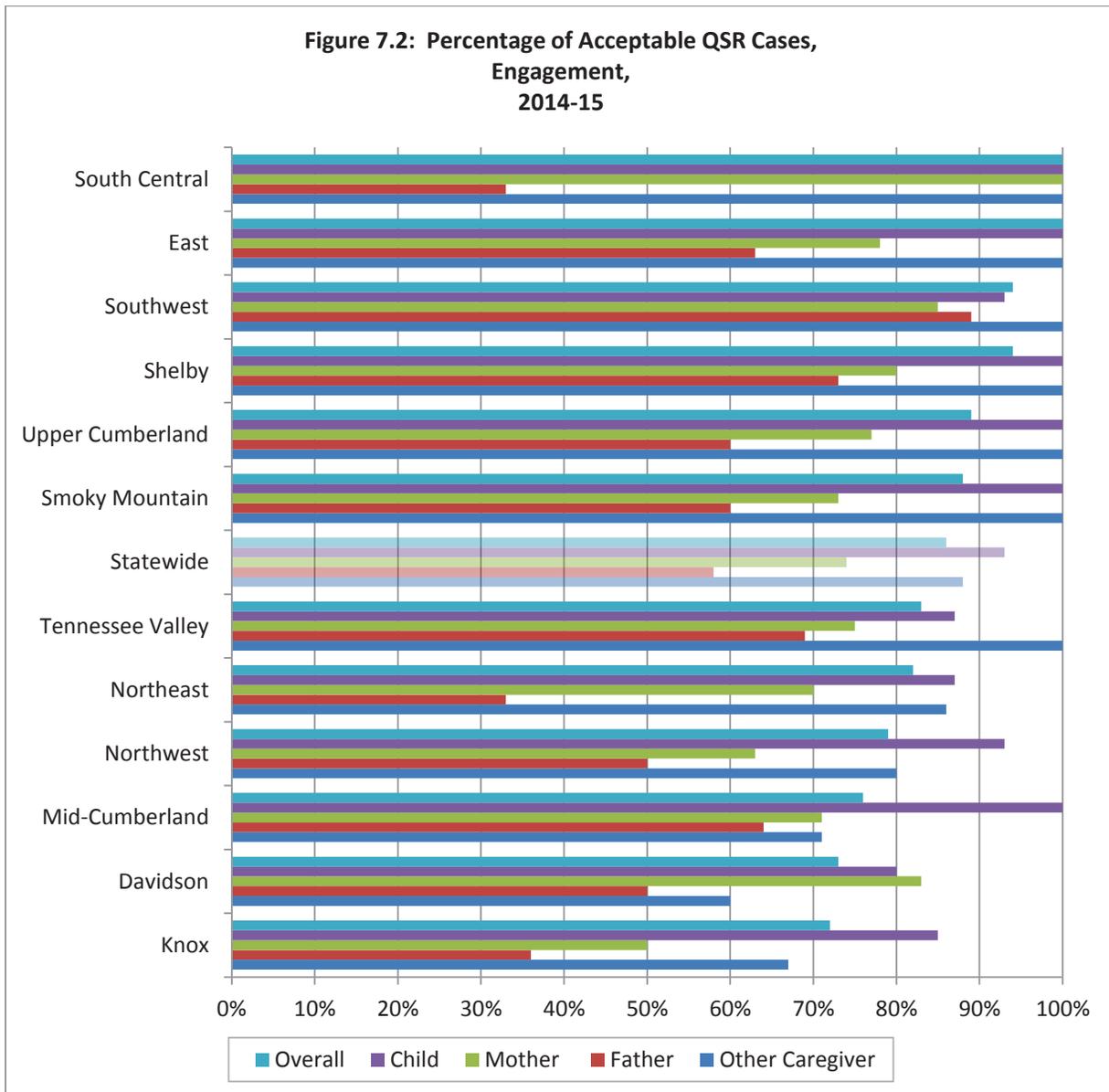


Source: QSR Databases

¹³¹ In coming to an overall score, reviewers are to consider each person’s level of “voice and choice,” which is the active and committed participation in the change process, and weighs the child and most impactful person(s) to that child and case more heavily.

¹³² The statewide Voice and Choice of the Child and Family scores for the child (87% in 2013-14 to 88% in 2014-15) and other caregiver (88% in 2013-14 to 89% in 2014-15) increased slightly. The scores for the mother (52% in 2013-14 and 51% in 2014-15) and father (52% in 2013-14 to 39% in 2014-15) both decreased.

Figure 7.2 below presents the percentage of *Brian A.* cases receiving acceptable scores for Engagement for the 2014-15 QSR. The statewide scores for the “overall”¹³³ Engagement indicator were 85% (163/209) in 2013-14 and 86% (177/206) in 2014-15.¹³⁴



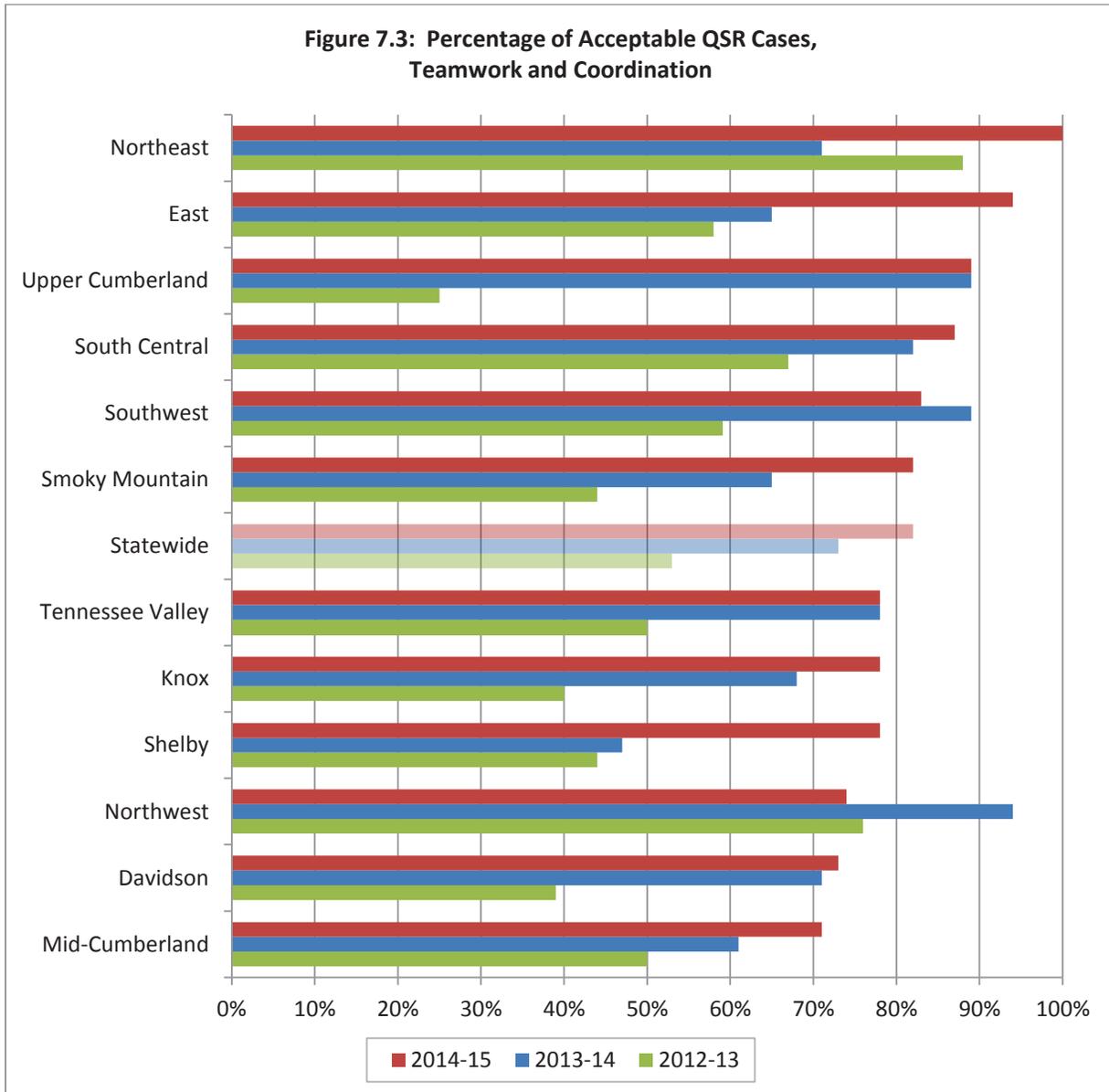
Source: QSR Databases.

Figure 7.3 presents the percentage of *Brian A.* cases receiving acceptable scores for Teamwork and Coordination in the past three annual QSRs. The statewide scores for Teamwork and

¹³³ In coming to an overall score, reviewers are to consider each person’s level of engagement in the change process, and weigh the child and most impactful person(s) to that child and case more heavily.

¹³⁴ The statewide Engagement scores for the child (85% in 2013-14 to 93% in 2014-15), mother (65% in 2013-14 to 74% in 2014-15), and other caregiver (85% in 2013-14 to 88% in 2014-15) have all increased. The Engagement scores for the father remained 58% in both 2013-14 and 2014-15.

Coordination have increased from 53% (113/213) in 2012-13 to 73% (154/210) in 2013-14 and to 82% (169/206) in 2014-15.



Source: QSR Databases.

K. Providing Notice of CFTMs to GALs and CASAs

Department policy requires that GALs and CASAs be provided notice of CFTMs.

In an effort to ensure that GALs are routinely receiving notice of CFTMs, the Department’s General Counsel, with the assistance of the Administrative Office of the Courts, contacted every attorney who accepts appointments in dependency neglect cases, affirming the importance of attorney and GAL participation in CFTMs, acknowledging that “lack of sufficient notice to

attorneys of CFTMs” has been a problem for some attorneys, and inviting attorneys to contact him to share any “issues and/or suggestions on how DCS can assist you in attending CFTMs.” The Department has been working with regional staff to address issues identified by the attorneys.

In an effort to ensure that CASAs are routinely receiving notice of CFTMs, the DCS Commissioner and the Executive Director of the Tennessee CASA Association (a membership association that helps promote, unite and support the development of local CASA programs) have provided each CASA program with a jointly signed letter, that, among other things, affirms the Department’s commitment to providing CASAs with reasonable notice of all CFTMs and invites them to contact either of them if they are not receiving reasonable notice. In addition to the work that the Commissioner is doing with and through the Tennessee CASA Executive Director, each of the Regional Administrators have met or will meet with each of the directors of the CASA programs serving their regions to make sure that any problems that CASAs are having receiving notice of CFTMs are addressed. These meetings are intended to lead to improved communication and development of clear mechanisms by which any problems that CASA workers are experiencing, including, but not limited to, problems getting notice of CFTMs, can be brought to the attention of and addressed by the regional leadership.

The Department recognizes that providing GALs and CASAs notice of a CFTM will not guarantee their presence. It is often difficult to find a time for a CFTM that is convenient for every member of the Child and Family Team, especially when circumstances require that a CFTM be convened quickly, and there will inevitably be times when it makes more sense to hold the CFTM promptly, at a time that works for other team members (particularly family members), but not for the GAL or CASA, rather than delay the CFTM. However, in both Shelby County and Davidson County, the Department is piloting approaches to improve communication with GALs and CASAs around the scheduling of CFTMs, not only to meet the notice requirement, but to increase the likelihood that GALs and CASAs will be able to participate, either in person or by telephone. In these pilot sites, the regions have shifted scheduling responsibilities to designated staff on the facilitator team and are utilizing a web based scheduling tool to solicit team member availability. Initial response to the process has been positive, and the Department will evaluate the effectiveness of these approaches in the coming months to determine whether they should be more broadly adopted.

VII.K CFTM to Review/Revise Permanency Goal

The Settlement Agreement requires that a Child and Family Team Meeting (CFTM) be convened whenever a child’s permanency plan goal needs to be revised. The Settlement Agreement also requires that the child’s permanency plan be reviewed and updated at CFTMs at least once every three months.¹³⁵ In recognition of the importance of accommodating the schedules of key CFTM members, particularly parents, older youth, resource parents, and providers, and the challenges of doing so, the TAC applies a 30-day “grace period” to the second requirement, monitoring and

¹³⁵ These meetings must be separate and distinct from any court hearings, foster care review board meetings, or other judicial or administrative reviews of the child’s permanency plan. The permanency plan shall be reviewed and updated if necessary at each of these CFTMs.

reporting using a four-month rather than a three-month period.

The July 2015 Monitoring Report presented data from the CFT Process Review relevant to these two requirements. The findings were mixed. With respect to the requirement that a CFTM be convened whenever a permanency plan goal needs to be revised, in each of the 54 cases for which there was a change in permanency goal during the review period, a CFTM had been convened to revise the goal. However, with respect to the requirement that a CFTM be convened to review and update the permanency plan at least once every three months (the “quarterly CFTM”), fewer than half the cases reviewed met that requirement.¹³⁶

A subsequent case review using a more recent cohort of cases¹³⁷ found improved performance on the quarterly review requirement: in 84 (82%) of the 102 cases reviewed, at least one CFTM was held during the four-month period (January through April 2015) covered by the review.

Based on discussions with regional staff, the Department concluded that regional staff were regularly holding progress reviews, but were often failing to properly document those reviews in TFACTS. As a result, the CFTM aggregate reports on quarterly reviews were understating actual performance. In an effort to both encourage greater attentiveness to documentation of quarterly reviews that are being held and to ensure prompt follow-up for any cases overdue for a quarterly review, the Department developed and now utilizes a special TFACTS report that tracks CFTMs and identifies cases for which a CFTM has not been held within the past three months.

This CFTM report, which includes all *Brian A.* class members in DCS custody, is updated daily and available daily to regional administrators and Central Office leadership. Each week the report, which includes a breakdown of data by region, team, and case manager, is sent to all case manager supervisors. Following receipt of the report, regional staff are expected to identify all CFTMs that have taken place but have not yet been documented in TFACTS. For those cases, staff report the date by which the documentation will be entered. If a CFTM has not yet taken place, staff identify the date by which a CFTM will be scheduled. All of this information is submitted to a Central Office director and incorporated into the next week’s report.

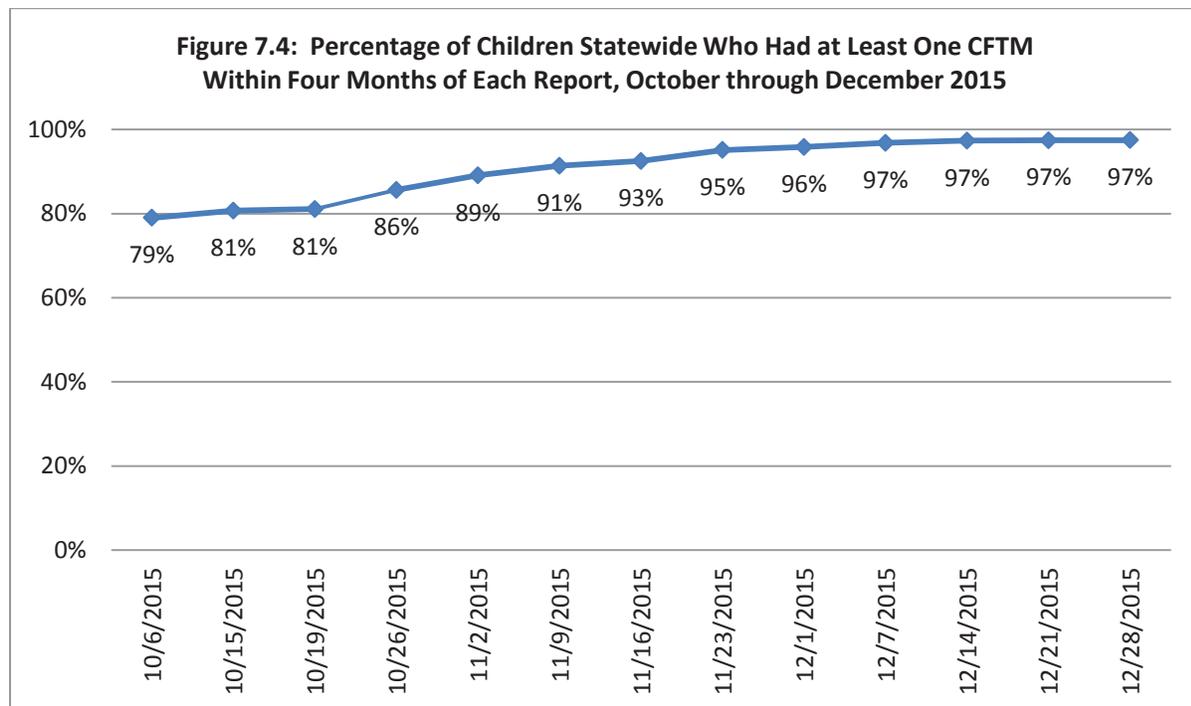
Since fully implementing this process in October 2015, the percentage of cases with overdue CFTMs has significantly declined. In most regions, it was determined that in about half of the cases that appeared on the report to have overdue CFTMs, the meetings had, in fact been held, but were not yet recorded in TFACTS. Providing weekly updates on this practice area has

¹³⁶ Of the 92 children who were subject to the CFTM Process Review, only 40 (43%) had documented CFTMs at least once every four months during the review period. The CFT Process Review drew its sample from children who entered out-of-home placement between January 1, 2014 and June 30, 2014 and remained in custody for at least 60 days. Documentation prior to and after the custodial episode through April 30, 2015 was reviewed.

¹³⁷ The review used the same sample of cases used for the review discussed in Section VI.H above. That sample of 102 children was drawn from the population of class members who entered custody prior to January 2015 and remained in custody through September 2015.

allowed supervisors to more closely monitor and coach staff performance, and as a result, the number of cases with overdue CFTMs or late documentation has substantially decreased.¹³⁸

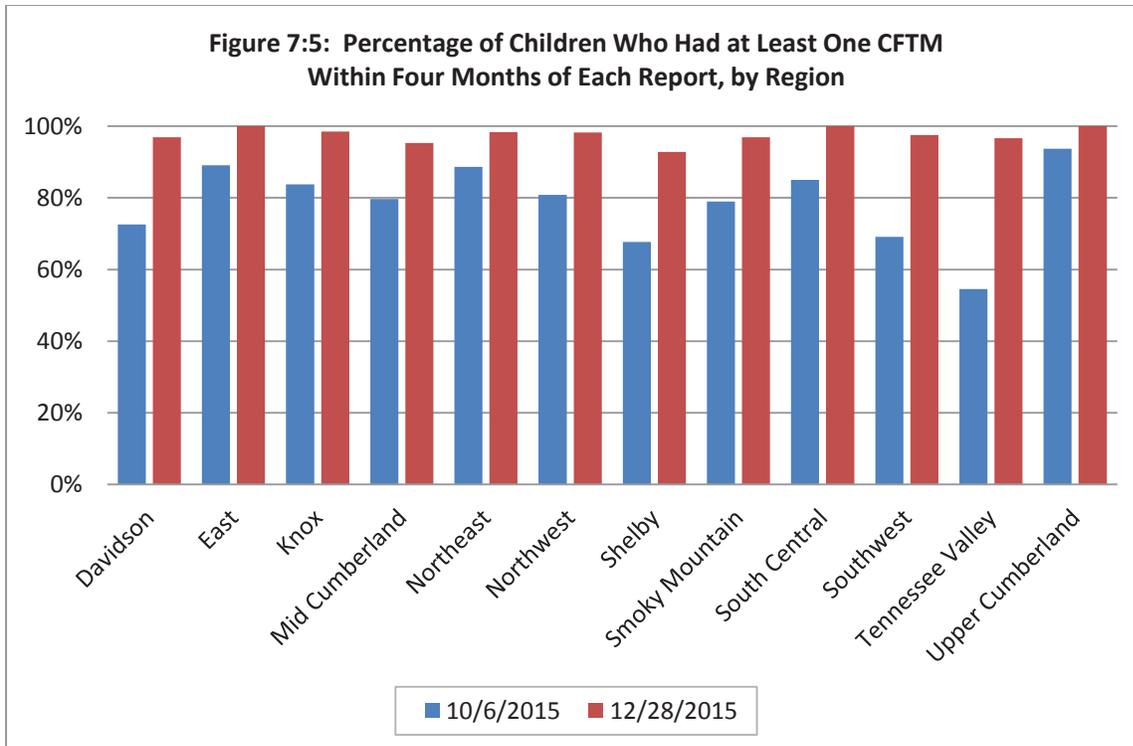
The following figure presents data from the weekly statewide quarterly CFTM tracking reports for the last quarter of 2015. The data presented therefore reflects the percentage of cases for which there has been at least one CFTM in the past four months. As reflected in Figure 7.4, by November 2015, the percentage of cases meeting this standard was over 90%, reaching 97% by the end of December 2015.



Source: The Department's weekly overdue CFTM tracking.

The following figure presents the improvement in performance by region by comparing for each region data from the first tracking report of the fourth quarter of 2015 to data from the last tracking report for that quarter.

¹³⁸ In the middle of December, after the tracking process had been implemented for a couple of months, the Central Office asked regional staff to identify the reasons for those cases that were still overdue to better understand any remaining challenges. As of December 18, 2015, of the 64 cases for which a CFTM was more than 90 days overdue according to TFACTS, 39 had actually had meetings that had not been entered into TFACTS, or they had been entered into TFACTS but were not reflected in reporting because of a TFACTS error. Of the remaining 25 cases, 12 were attributed to scheduling and planning issues, five to children being on runaway, two to issues working with parents, and in six cases, the reason was not identified.



Source: The Department's weekly overdue CFTM tracking.

Tables providing the relevant number of CFTMs that form the basis of percentages reflected in the above two figures are included in Appendix VII.K.

The TAC is satisfied that DCS practice meets the requirements of Section VII.K of the Settlement Agreement.

VII.M. Discharge Planning CFTM and Case Manager Responsibility during Trial Home Visit

As discussed in the September 2015 Supplemental Report, the parties agreed to the TAC's request for time to gather and present additional information related to the requirements of Section VII.M concerning Discharge Planning Child and Family Team Meetings (CFTMs) and case manager responsibilities during Trial Home Visits (THVs). To provide that additional information, TAC monitoring staff conducted additional targeted reviews, the results of which are discussed below.

A. Discharge Planning CFTMs

The Settlement Agreement requires that:

- a Discharge Planning CFTM be convened within 30 days of a child returning home on trial home visit, exiting custody to a newly created permanent family, or aging out of the system;
- participants identify all services necessary to ensure that the conditions leading to the child's placement have been addressed and that safety will be assured, and that participants identify necessary services to support the child and family and the trial home visit; and
- if exiting custody is determined inappropriate, DCS make the appropriate application to extend the child's placement in DCS custody before expiration of the trial home visit.

Department policy and revised training regarding the CFT process establish expectations for a Discharge Planning CFTM that are consistent with these requirements and the results of both the recently completed targeted reviews, and the previously reported CFT Process review, reflect that these expectations are generally being met.

1. Results of the THV Review

The first of the recently completed targeted reviews (referred to as the "THV Review") focused on a sample of 74 children who were on a THV as of the June 1, 2015 Mega Report and had been on that THV for at least 60 days.¹³⁹

Of the 74 children included in the THV Review, 68 (92%) had a Discharge Planning CFTM or a CFTM that served that function.¹⁴⁰ In 63 cases (85%) that CFTM occurred within 30 days of the beginning of the THV.

The THV Review also examined each case to determine the extent to which services necessary to support successful transition home were being provided. In 72 of the 74 cases, either services were being provided to the child and family to support their needs in the transition home (63 cases) or the family was not receiving services during the THV, but reviewers found no identified service need (nine cases).¹⁴¹ In the remaining two cases, referrals were made during the THV for services, but service provision was delayed until after the THV ended.

¹³⁹ The sample was taken from the 310 children who were on a THV as of the June 1, 2015 Mega Report and had been on that THV for at least 60 days. It was stratified by region and represents a 95% confidence level and a plus/minus 10 percent confidence interval. Reviewers examined permanency plans, CFTM summaries, and case recordings for relevant documentation. In a handful of cases, based on the insufficiency or ambiguity in case file documentation, reviewers obtained supplemental information through follow-up with field staff.

¹⁴⁰ The CFT Process Review discussed in the July 2015 Monitoring Report also reflected a high level of compliance. Of the 41 children in the CFT Process Review sample who were on THV or had exited custody, 31 (76%) had a Discharge Planning CFTM and an additional eight children (20%) were ordered released by intervention of the juvenile court rather than through the Department's normal discharge planning process.

¹⁴¹ These cases included children who were placed with grandparents who did not express or exhibit the need for formal supports, children who were home with parents who had completed required service requirements prior to the THV, and children for whom, based on recently completed assessments, there were no further service needs identified.

Finally, the THV Review examined whether any safety concerns were being appropriately addressed and whether THVs were being extended (or terminated) if, during the course of the THV, it appeared that exiting custody was inappropriate. The reviewers found that the decision to place the child on THV did not present any safety concerns to successful transition in 59 (80%) of the 74 review cases. In the 15 cases for which safety concerns were identified,¹⁴² the case manager and team were appropriately attending to and supporting the family with respect to those specific safety issues, and/or additional services were put in place (or maintained or increased) to address the specific concerns.

In three of the cases in which safety concerns were identified and in an additional 12 other cases in the review sample, the THV was extended to address concerns that arose during the course of the THV; in two of those cases the THV was terminated (and the child was returned to foster care) based on concerns that arose during the course of the THV.¹⁴³

2. Results of the CFT Process Review

The CFT Process Review discussed in the July 2015 Monitoring Report also reflected a high level of compliance. Of the 41 children in the CFT Process Review sample who were on THV or had exited custody, 31 (76%) had a Discharge Planning CFTM and an additional eight children (20%) were ordered released by intervention of the juvenile court rather than through the Department's normal discharge planning process.¹⁴⁴

¹⁴² The identified safety concerns are as follows (in four cases, there was more than one safety concern):

- in 10 cases, there were concerns about substance abuse (in seven cases, it was a parent who was struggling with substance abuse, and in three cases, the child was struggling with substance use);
- in three cases, there were concerns about appropriate supervision;
- in two cases, there were concerns about the child running away;
- in one case, the concern was about safe, stable housing;
- in one case, the concern was about domestic violence;
- in one case, the concern was about the parent with whom the child was on THV possibly having to go to jail as a result of criminal charges for filing a "false report" and not directly related to the health or safety of her child. The charges were resolved, and the child was divested to the mother's care; and
- in one case, the concern was about continued neglect. The child was on THV with the mother and father having joint physical custody. Concerns arose about the mother as the older children were "showing up to school dirty and hungry." The THV was continued with father alone, and the children exited to his care.

¹⁴³ In one of the cases in which the THV was revoked, it had first been extended in order to give the mother more time to find safe, stable housing.

¹⁴⁴ The TAC considers these court ordered releases to be a reasonable exception to the Discharge Planning CFTM requirement. The typical process for the release of a child from the Department's custody begins with a request from the Department to the Court for a Trial Home Visit (THV). In those cases, when the Department initiates the release of a child by submitting a request for approval of a THV, and the case proceeds in accordance with the recommendations of the Department and the Child and Family Team, it is reasonable to expect the Department to be able to convene a Discharge Planning CFTM prior to the child's release. However, in some instances, the Juvenile Court orders a child released from custody without a request from the Department (whether in response to a motion or petition by filed by a party other than the Department or on the Court's own initiative). In those cases, it is not reasonable to expect the Department to be able to convene a Discharge Planning CFTM in advance of the court ordered release. In fact, when release is initiated by the Court rather than by the Department, the Judge's actions effectively supersede the discharge planning authority of the Child and Family Team. Unless the Judge specifically directs the Department to convene a Discharge Planning CFTM, it might well be inappropriate for the Department to do so.

3. Results of the Exit Without THV Review

The second of the recently completed targeted reviews gathered data on the extent to which Discharge Planning CFTMs are held in cases in of children “exiting custody to a newly created permanent family, or aging out of the system.” This review focused on 85 cases drawn from among all children who exited custody during the second quarter of 2015 (April 1 through June 30, 2015) who had not been on a THV prior to exit to determine whether a Discharge Planning CFTM occurred.¹⁴⁵

Of the 85 children reviewed,¹⁴⁶ 65 (76%) had a Discharge Planning CFTM or a CFTM that served that function,¹⁴⁷ and in 56 (66%) of those cases, that CFTM occurred within 30 days of the child’s exit.

In an additional nine cases (11%), reviewers found case recordings reflecting conversations among team members focused on planning for discharge (but not labeled a CFTM), and in one additional case involving two children (2%), while there was no documentation of a Discharge planning CFTM, it was clear from the documentation at the time of the Initial CFTM that the plan was for the children to exit to the custody of the grandmother with whom they had already been placed at the time of that Initial CFTM (and they did in fact exit to their grandmother’s custody less than two months after their entry into DCS custody).

In an additional six cases (7%), the juvenile court, shortly after the child entered DCS custody, granted an intervening parent or other relative custody of the child, under circumstances that made a Discharge CFTM impractical or unnecessary.

- In four of those cases, the court granted custody to a petitioning relative shortly after the child entered custody (within three, four, 15, and 22 days of custody, respectively).
- In one case, the children were placed with the paternal grandparents upon entering DCS custody and the grandparents immediately filed an intervening petition for custody, which was heard and granted 50 days after the children entered custody.
- In one case, the child’s father, who lived in North Carolina, immediately requested that the children be released to his custody and attended the Initial Permanency Plan CFTM (15 days after entry). The Court, upon being advised that the father’s home had been approved through an ICPC home study and that DCS was simply waiting for the confirming ICPC paperwork from North Carolina, ordered that the children be released to the father upon receipt of the paperwork without the need for any further court action.

¹⁴⁵ The sample was taken from the 737 children who exited custody in April (according to the May 3, 2015 Mega Report), May (according to the June 1, 2015 Mega Report) and June (according to the July 6, 2015 Mega Report) 2015 with a “release reason” other than Trial Home Visit. It was stratified by region and represents a 95% confidence level and a plus/minus 10 percent confidence interval. Reviewers examined CFTM summaries and case recordings for relevant documentation.

¹⁴⁶ Those 85 children included 30 children who exited to adoption, 18 who exited to reunification, 15 who exited to a relative, 13 who aged out, eight who exited to permanent guardianship, and one who transferred to another agency.

¹⁴⁷ A CFTM was considered to serve the function of a Discharge Planning CFTM if the content of the discussion focused on discharge planning and the CFTM occurred shortly before discharge.

The Department transported the children to their father on the date the paperwork was received (57 days after entry into care).

In two other cases (2%), it was the Court, rather than DCS, that took responsibility for the discharge process:

- In the first of these cases, the Court, in response to an intervening custody petition filed by the child's sister and over the objection of the Department and the GAL, placed the child in the custody of the sister. (Several months later, the Court held a "status hearing" at which, at the urging of the GAL, the Court removed the child from the sister's home and returned her to DCS custody. The Department placed the child back in the same foster home that she had been in at the time that the Court had granted the sister's petition.)
- In the second case, the child came into custody for a month as the result of an order issued by the Juvenile Court Judge in a delinquency proceeding after the child's mother had been unsuccessful in obtaining approval from TennCare to pay for a treatment program that the child needed. The Judge placed the child in DCS custody so that the child could receive services while the mother appealed the TennCare denial. The TennCare appeal was successful and the child was released to the custody of the mother, who then enrolled the child in the treatment program.

Finally, there was one child (1%), who aged out of care for whom a Discharge CFTM was not held because the child was on runaway for the four months prior to his 18th birthday and he aged out while on runaway status.

B. Case Manager Responsibility During Trial Home Visit

During the THV, the case manager is required to:

- visit the child in person at least three times in the first month and two times a month thereafter, with each of these visits occurring outside the parent or other caretaker's presence;¹⁴⁸
- contact service providers;
- visit the school of all school-age children at least one time per month during the THV;
- interview the child's teacher; and
- ascertain the child's progress in school and whether the school placement is

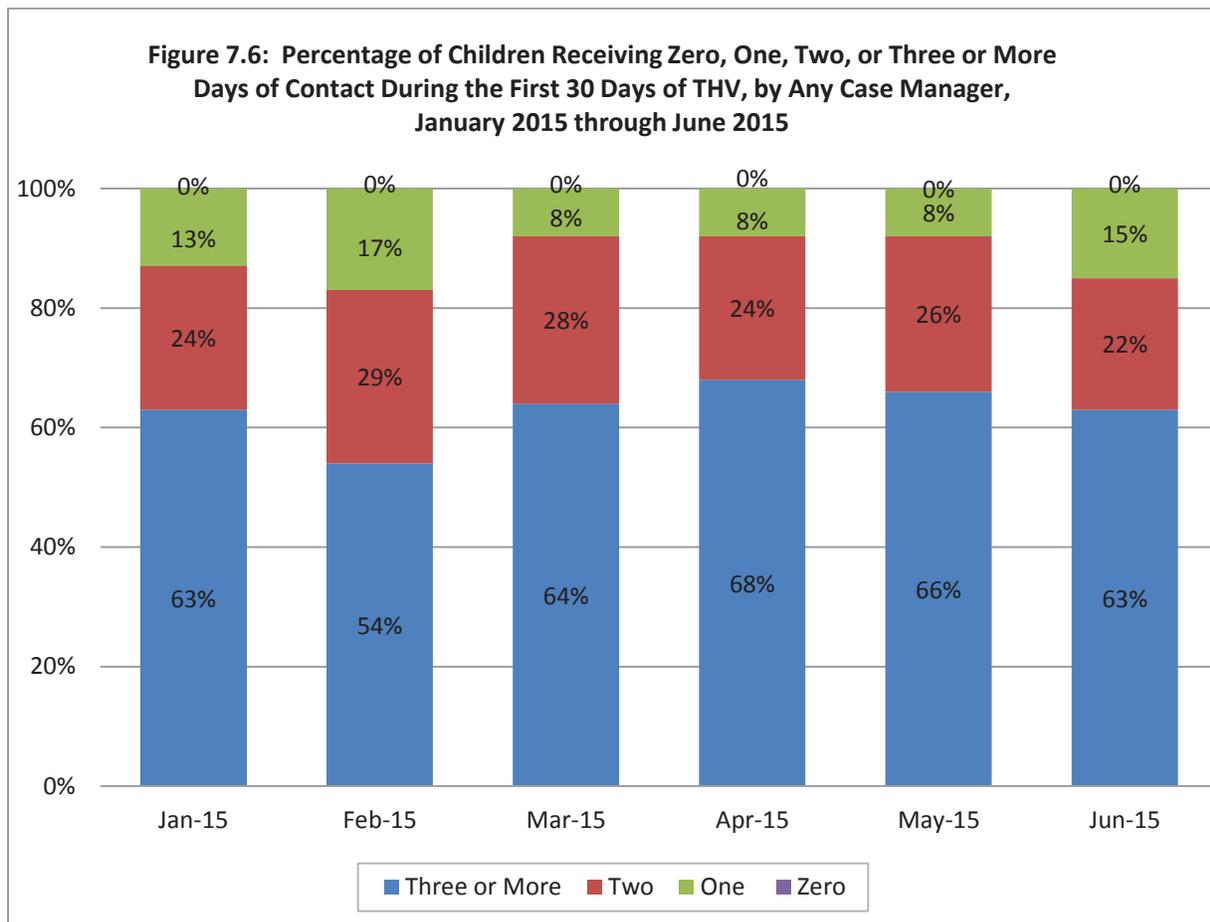
¹⁴⁸ This does not preclude the case manager from spending some additional time, either immediately before or immediately after the time spent with the child outside the presence of a caretaker, observing the child with the caretaker and/or having conversations with the caretaker and others in the household.

appropriate.¹⁴⁹ (VII.M)

1. Frequency of Case Manager Contact During THV

a. Aggregate Data

Figure 7.6 below presents aggregate data for the first six months of 2015 on the frequency of face-to-face contact, with a DCS or private provider case manager, *during the first 30 days of a child's trial home visit.*



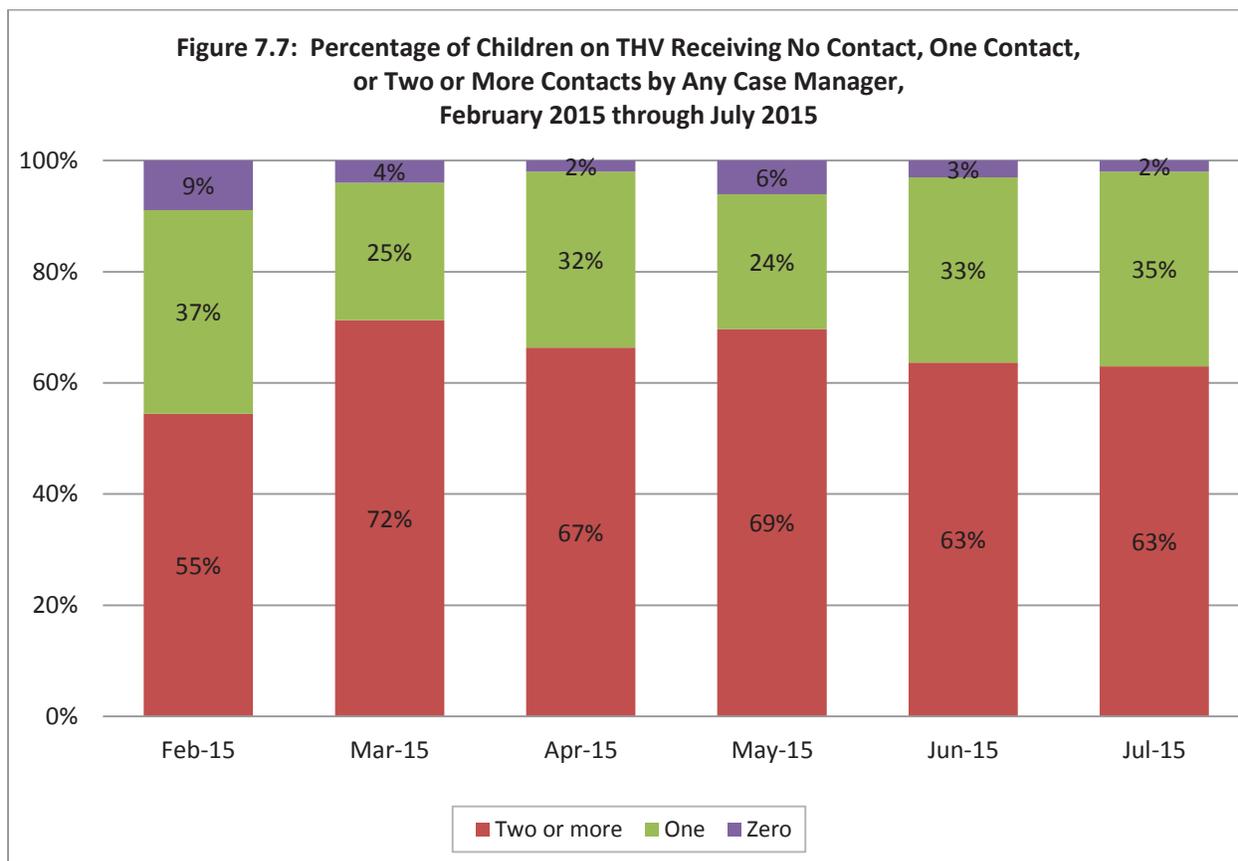
Source: Brian A. DCS Private Provider Face-to-Face Two Months Back Detail Reports

Figure 7.7 presents aggregate data for February through July¹⁵⁰ of 2015 on the frequency of face-to-face contact, with *any* case manager, during each month for all children on trial home visit

¹⁴⁹ If, prior to or during the trial home visit, exiting custody is determined to be inappropriate, DCS is to make the appropriate application to extend the child's placement in the custody of DCS before the expiration of the trial home visit.

¹⁵⁰ Because this data excludes children on their first 30 days of THV, in order to reflect a comparable population to the previous graph, the data presented is for the six months of THV visit data from February through July.

(including those served through private provider continuums), *excluding those children on the first 30 days of their THV.*



Source: Brian A. DCS Private Provider Face-to-Face Two Months Back Detail Reports

b. THV Review Results

In addition to the aggregate data discussed above, the THV Review also gathered data on the frequency of case manager contact during the THV period. For this part of the review, reviewers excluded from consideration the four children in the sample who were on THVs out of state pursuant to the Interstate Compact on the Placement of Children (ICPC) and under the supervision of the child welfare agency in the “receiving state.”

Of the 70 review children relevant to this aspect of the THV review, during the first 30 days of their THV, 47 (67%) received at least three case manager visits, and an additional 19 (27%) received two visits.

In the THV Review, reviewers analyzed the frequency of case manager visits for those children in the sample who were on THV during March (62 children), April (70 children), or May (70 children):

- 55 (89%) of those on THV in March received two or more case manager visits, and an additional six children (10%) received one visit;

- 63 (90%) of those on THV in April received two or more case manager visits, and an additional seven children (10%) received one visit; and
- 55 (79%) of those on THV in May received two or more case manager visits, and an additional 14 children (20%) received one visit.

2. Visiting with the Child Outside the Presence of the Parent

The THV Review also gathered information on the extent to which each child had an opportunity to spend time with his or her case manager outside the presence of the child's parent (or other caregiver to whom the child is expected to exit) during THV face-to-face contacts. Using the approach described in Section VI.H above (including excluding children under the age of 3), the reviewers found evidence of at least one contact outside the presence of the parent in 50 (80%) of the 60 relevant cases in the first 30 days, in 38 (70%) of the 54 cases in March, in 47 (78%) of the 60 cases in April, and in 44 (75%) of the 59 cases in May.¹⁵¹ (For reasons discussed in Section VI.H, the TAC is confident that case managers spend time with children outside the presence of the caretaker during face-to-face visits more frequently than they document in their case recordings.)

3. Contact with Service Providers During the THV

As discussed above, families were receiving services during the THV in 63 cases. In 42 (67%) of those cases, there was documentation of case manager contact with the service providers during the THV.

4. School Related Contacts

At the time that the Settlement Agreement was entered, the requirements that the case manager visit the child at school, interview the child's teacher, and "ascertain the child's progress and whether the school placement is appropriate" reflected the significant challenges that children in foster care at that time experienced in transitioning back into school in their home communities when exiting foster care. For the many children for whom placement in foster care meant going to a new school in a different county or attending an "in house" school associated with the child's placement, there was frequently a lack of curricular alignment between the schools that the children attended while in DCS custody and the schools in the child's home community. Few school systems made special efforts to accommodate children transitioning from foster care, and some school systems were resistant to serving these students. And there was no structure for ensuring coordination and cooperation between the Department and the school systems. Given those circumstances, it made sense to anticipate that the case manager would need to spend much of his or her time directly involved in school related activities.

¹⁵¹ The CFT Process Review also sought to capture the extent to which case managers were spending private time with children. Reviewers found documentation of private time spent with the child for nine of the 10 children who went on a trial home visit during the review period.

The circumstances are significantly different today. In large part because of the extremely effective work (discussed in previous monitoring reports) that the educational specialists have done, the Department now enjoys a good working relationship with most school systems and educational transitions for children on THV are generally not problematic. To the extent that problems arise in individual cases, the education specialists are available to help case managers address those problems.

As a result of this improvement, the Department (appropriately in the TAC's view) has not placed a high priority on case managers visiting children at school and talking directly with their teachers. While it is still important for case managers during the course of the THV to monitor the child's school situation, the case manager does not need to be an active presence at the child's school to do so. In most cases it is better practice to encourage and rely on the parent to be the active presence at the child's school, and for the case manager to only get involved in school issues if a problem arises. And with respect to visiting children at their school, current best practice, consistent with the feedback from children themselves, is for case managers to avoid routinely visiting children while they are at school; children frequently experience visits from case managers at school to be disruptive and stigmatizing.

Nonetheless, the THV Review gathered information on case manager school related contacts and communication during the THV period for the 55 school age children in the review sample.¹⁵² In 53 of the those cases 55 cases, the child's case manager had regular communication with the child and family about the child's school progress and school related issues throughout the course of the THV. In 36 of those 55 cases, the case manager spoke with school personnel (guidance counselors, principals and assistant principals, teachers, enrollment staff, *etc.*) during the child's THV. And in 36 of the 55 cases, the case manager visited the child's school at least once during the child's THV.¹⁵³

¹⁵² The CFT Process Review also sought to capture the extent to which case managers were spending time at each child's school. Of the 10 children who went on a trial home visit during the review period, eight were of school age. In all eight cases, the child's case manager had visited the child's school at least once. In one case, the children were on summer break, but the case manager took them to register for school. In two cases, reviewers documented one visit to the child's school during the review period. In the remaining five cases, the child's case manager visited the child at school on several occasions, to attend an IEP meeting, to talk with a counselor, to ascertain the child's grades, to ask the child about how school was going, and to observe the child in the classroom.

¹⁵³ In four of the cases in which the case manager did not visit the child's school, he or she did speak with school personnel on the telephone.

SECTION VIII PROVISIONS: FREEING A CHILD FOR ADOPTION

VIII.A General Requirement of Timely Pursuit of Adoption

The TAC has always viewed this provision of the Settlement Agreement as more of an introduction to the specific processes and measures contained in the remaining provisions of Section VIII. The provision is not so much a distinct measurable requirement than it is a general policy statement that is then fleshed out by specific language in the subsections that follow. For this reason, the TAC has taken the position that once the remaining provisions of Section VIII are in maintenance, Section VIII.A would also be in maintenance.

The first sentence of the provision states that the process of freeing a child for adoption and securing an adoptive placement “*shall begin as soon as adoption becomes the child’s permanency goal, but in no event later than as required by federal law.*” Subsections VIII.C.4 and VIII.C.5 (as well as XVI.B.4) capture the two aspects of the requirement (timely filing of TPR and ensuring compliance with federal law). By achieving maintenance on those subsections, the Department has met the requirements of the first sentence of VIII.A.

The second sentence of the provision states that the “*adoption process should begin immediately for all children for whom a diligent search has failed to locate either parent and for whom no appropriate family member is available to assume custody.*” Situations in which, at the outset of a case, the Department is unable to locate **either** parent **and** there is no potentially viable relative placement are quite rare.¹⁵⁴ The TAC is satisfied that the various processes required by VIII.C and VIII.D adequately ensure timely action to “free a child for adoption” in those rare instances when the Department, after a diligent search, has been unable to locate either parent and has also been unable to locate a viable relative resource.

VIII.C.1 Diligent Searches and Case Review Timelines

The Settlement Agreement (VIII.C.1) requires that diligent searches for parents and relatives be conducted and documented:

- by the case manager;
- prior to the child entering custody or no later than 30 days after the child enters custody; and
- thereafter as needed, but at least within three months of the child entering custody and again within six months from when the child entered custody.

The primary purpose of the diligent search is to identify potential placements and sources of support from within a child’s natural “circles of support:” relatives, friends, mentors, and others

¹⁵⁴ For example, not one of the 92 cases that were the subject of the Child and Family Team Process Review (discussed in the July 2015 Monitoring Report) fell into this category.

with whom the child has enjoyed a family-like connection, including those with whom the child has not had recent contact.¹⁵⁵

The Settlement Agreement requirements are set forth in Department policy,¹⁵⁶ and the Department has created a protocol for conducting diligent searches and developed a diligent search letter, a checklist, and a genogram template to assist case managers in conducting and documenting diligent searches. These forms are to be completed by the case manager and updated throughout the life of the case until the child achieves permanency.

As discussed in previous monitoring reports, the Department has been working to improve diligent search practice and case file documentation of diligent search activities, placing special emphasis on diligent searches for absent fathers and on meeting the expectations of federal law that every grandparent of a child in foster care be promptly identified, located, and contacted.

Over the past six months, DCS has created a new case recording type exclusively for the purpose of more clearly capturing documentation of diligent search activities and has developed and is utilizing a TFACTS report that, similar to the overdue and upcoming CFTM reports described in Section VII.K above, identifies cases that are due for periodic diligent search activity within the next 45 days and flags cases that are overdue for diligent search activity. This diligent search report, which includes all children who have entered DCS custody since January 1, 2015,¹⁵⁷ is updated daily and produced and distributed to the regions on a weekly basis.¹⁵⁸ The report allows the regional managers to drill down to the cluster, team and individual case manager levels to identify any particular clusters, teams or individual case managers whose cases are overdue for diligent search activity. Supervisors are expected to use this report to help them ensure that diligent search activity is being carried out at the required intervals and that the activity is being appropriately documented in TFACTS.

Through follow-up discussions with regional field staff about overdue cases, the Department has been able to identify and address situations in which diligent search activity was not occurring. In some situations, the shortfall in diligent search performance reflected a misunderstanding by field staff of the applicability of the diligent search requirement. For example, in some cases staff were unclear about what, if any, further diligent search activities are required at six months if a robust Child and Family Team with significant family member participation had already been assembled or if all identified family members had been previously identified and contacted.

¹⁵⁵ An aggressive approach to diligent search for parents and relatives from the outset of the case also ensures that the legal process can proceed quickly and efficiently. The Department expects that as the diligent search policy is effectively implemented, it will be reflected in increased utilization of kinship placements, reduction in delays in the Termination of Parental Rights (TPR) process, and improvements in Child and Family Team (CFT) data and Quality Service Review (QSR) data related to the participation of relatives and other informal supports in the CFT process.

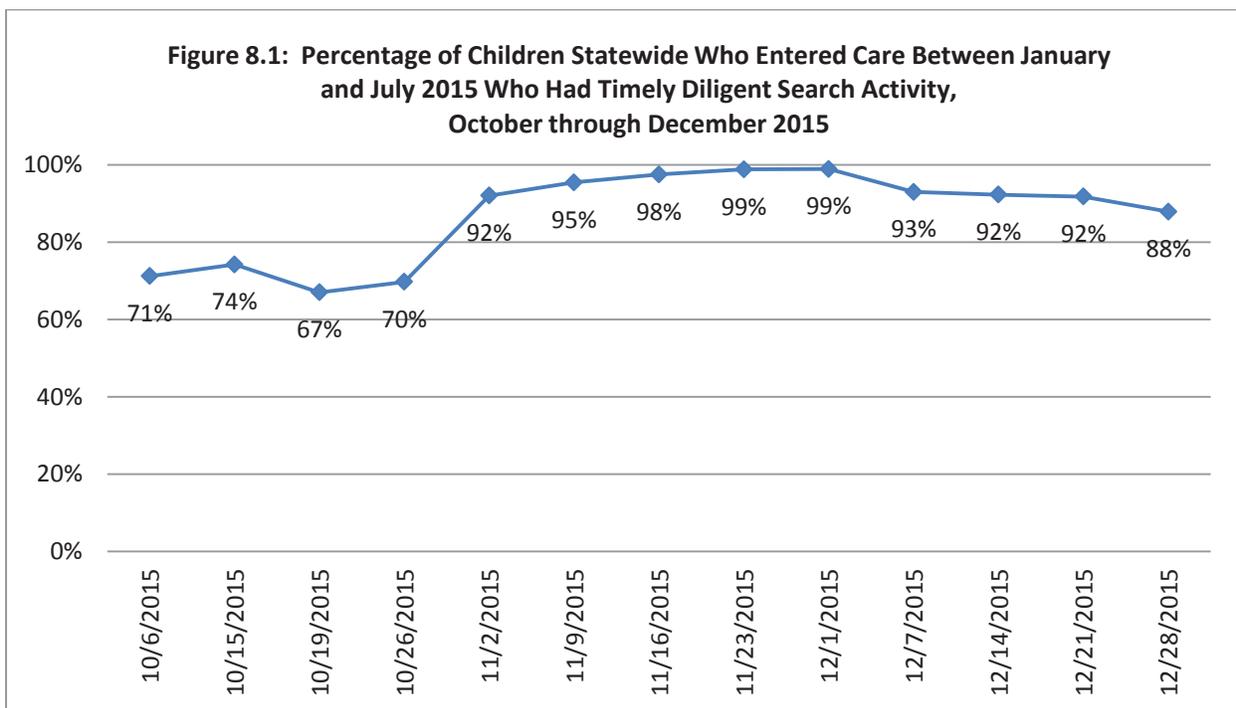
¹⁵⁶ Policy 16.48 Diligent Search and the various diligent search forms and tools have been revised to match the new diligent search and family notification requirements of H.R. 6893 Fostering Connections to Success and Increasing Adoption Act.

¹⁵⁷ For purposes of cleaning up documentation of diligent search, staff were asked to enter all diligent search activity completed in 2015 using the new case recording type.

¹⁵⁸ This process began in October 2015, and is ongoing.

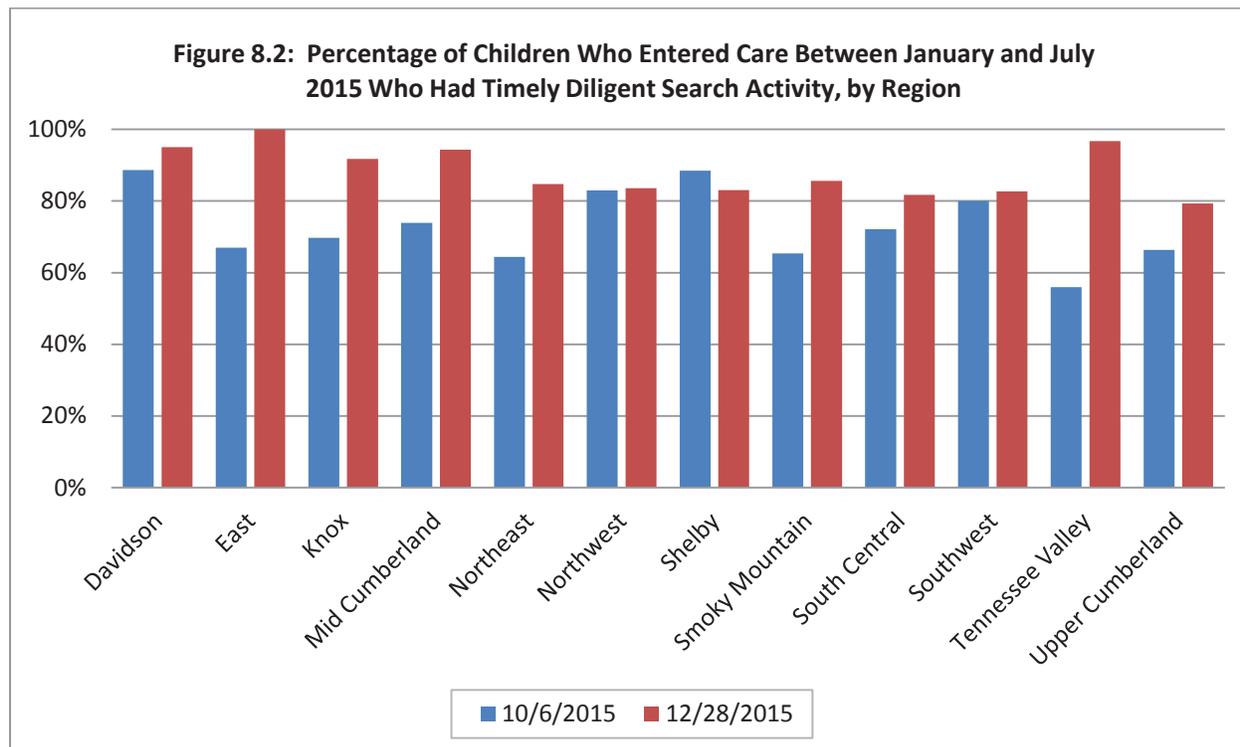
Central Office and regional leaders were able to convey the importance of revisiting discussions about possible placements and supports at periodic intervals in all cases, as families may have new suggestions for potential team members and may be able to reach out to family and other team members who may have previously disengaged from involvement in the case. Family member circumstances may change so that opportunities for relative placements or increased supports from relatives, not available during the child’s first months in care, may develop over time. For this reason, the Department expects that families will be periodically asked about any additional options or supports they may be able to provide for the children in care, even if only to confirm that they do not have anything new to propose.

The following figure presents the weekly statewide diligent search tracking data for the last quarter of 2015.



Source: The Department's Weekly Diligent Search Overdue Activity reporting.

The following figure presents the regional data for the same period.



Source: The Department's Weekly Diligent Search Overdue Activity reporting.

Tables providing the relevant number of diligent search activities that form the basis of percentages reflected in the above two figures are included in Appendix VIII.C.1.

To supplement the Department's aggregate tracking data, the TAC conducted a spot check of the cases of children who entered custody during October 2015¹⁵⁹ to look for documentation of efforts to identify, locate, and engage relatives either prior to or within the first 30 days of the child entering custody.

In 38 of the 40 cases reviewed, the documentation reflected contacts and interactions with relatives, including 17 cases in which a relative became the child's kinship resource home,¹⁶⁰ and five cases in which, after a short period in a non-relative resource home, the child either began a trial home visit (THV) with a parent or relative, or exited to their custody.¹⁶¹

¹⁵⁹ To select cases for the spot check, the TAC pulled a statistically significant sample of 77 cases from the 382 class members who entered custody during that month, stratified by region. The TAC then reviewed at least half of the cases from each region, but no fewer than three cases from any region. A total of 40 cases were reviewed.

¹⁶⁰ In two cases, after placement with a relative, the child later moved to a non-relative resource home. In one case, the child remains in that placement as of January 25, 2015, and in the other case, the child remained in the non-relative home until she aged out of care and returned to her family.

¹⁶¹ One child began a THV with a relative after just two weeks in custody, another exited to a grandmother after three weeks, and another returned home within the month. One child began a THV in Florida after a little more than two months, with a grandmother who had been working on an Interstate Compact on the Placement of Children (ICPC) since the child entered custody, and the other child returned home on a THV after about three months in custody.

In the two cases in which the Department had not engaged with relatives prior to or within the first 30 days of the child entering custody, there was documentation of attempts to identify and locate relatives.

VIII.C.2 Requirement of Attorney Review of Cases of Severe Abuse Within 45 Days

The Settlement Agreement (VIII.C.2) requires in cases in which parents have been substantiated for severe abuse that, within 45 days of that determination, a discussion take place with a DCS attorney to decide whether to file for Termination of Parental Rights (TPR) and that the decision is to be documented in the child's case record.

The Department produces a semi-monthly report, sorted by region, which identifies all children who fall within this category.¹⁶² The regional administrator or his/her designee is expected to meet with the regional general counsel (RGC) to discuss each of the recently filed cases that include a severe abuse allegation and decide whether to file for TPR. That attorney review is expected to be documented in the case conference notes and/or other case recordings, and those notes and/or recordings should provide sufficient information to:

- determine that the attorney in fact participated in the review; and
- establish that there was a specific discussion of whether to file TPR.

Each region has established a review process for these cases and is currently required to submit documentation of these reviews to Central Office. A Central Office staff member is responsible for the review of documentation submitted by each region to ensure that the expectations related to both the review itself and documentation of the review are being met.

In order to determine the extent to which cases of children in DCS custody are being reviewed with the DCS attorney within 45 days of the case being "substantiated" for severe abuse, the TAC monitoring staff conducted a targeted review of every class member for whom a severe abuse substantiation was made between August 1 and September 15, 2015 and who remained in custody for at least 45 days following the date that the case was substantiated for severe abuse. There were a total of 46 such children.

Of those 46 children, 40 (87%) received a timely¹⁶³ regional attorney review.¹⁶⁴ In an additional five (11%) cases, the attorney review occurred between 74 days and 86 days after the date of the

¹⁶² The TAC monitoring staff have validated the accuracy of this report.

¹⁶³ Recognizing that it is reasonable to allow a "grace period" to accommodate competing scheduling demands, the TAC considered a 45-day review timely if it occurred within 60 days of the date of the substantiation for severe abuse. Included among the 40 cases determined to be timely were seven that were held between 46 and 60 days after the substantiation date. Excluded from those 40 cases is the one case referenced below in which the review was held within 45 days, but the case conference notes did not specifically reference a discussion of whether to seek a finding of severe abuse or a discussion of TPR.

substantiation. In the one remaining case, an attorney review occurred within 45 days; however, the case conference notes did not specifically reference a discussion of whether to seek a finding of severe abuse or a discussion of TPR.

¹⁶⁴ In one of these cases, an attorney consultation that reflected a discussion of the severe abuse allegations and whether to seek TPR was documented in the file; however, that case consultation occurred 18 days after the child came into custody, but 131 days prior to the date that the case was formally classified as severe abuse. The TAC considered the early consultation with the attorney to have been the functional equivalent of the 45-day review and therefore counted it as “timely.”

SECTION XVI PROVISIONS: OUTCOME AND PERFORMANCE MEASURES

XVI. A.1 Permanency Outcome Measures

A. Introduction

In the 15 years that have passed since the original Settlement Agreement was entered in 2001, there have been considerable changes and growth in the child welfare field's understanding of permanency outcomes and the most useful methodologies for assessing a state's performance in achieving permanency for children in foster care. As explained more fully in Appendix XVI.A.1 of this report (*A Brief Orientation to the Data: Looking at Children in Foster Care from Three Different Viewpoints*), one can examine child welfare system performance by producing and analyzing the data from three different viewpoints depending on the questions being asked. Those three viewpoints are *point-in-time* data, *entry cohort* data, and *exit cohort* data. These three viewpoints are used differently to assess different areas of progress under the Settlement Agreement. With respect to permanency outcomes, the methodological approach now viewed as the most appropriate and accurate involves looking at the experience of *entry cohorts*—that is, identifying all children who enter foster care in a given year and tracking their progress over time toward permanency outcomes.

As discussed in the July 2015 Monitoring Report, when the original Settlement Agreement was entered in 2001, the parties adopted in Section XVI.A.1 what was at the time a common, but flawed, methodological approach to measuring time to permanency. The approach was to look at the cohort of children who exited to permanency (referred to as an “exit cohort”) and measure performance based on how long it had taken for that to occur. This was consistent with the approach to measuring permanency outcomes being taken at that time by the Department of Health and Human Services (HHS) and reflected in the early evolution of federal Child and Family Services Review (CFSR) report requirements.¹⁶⁵

¹⁶⁵ The Section XVI.A.1 exit cohort measure was retained in the Modified Settlement Agreement and Exit Plan that was entered in 2010. The Monitoring Report that immediately preceded the entry of the Modified Settlement Agreement reflected that the Department had met the 80% target for that reporting period and on that basis, provision XVI.A.1 was included among those provisions designated “maintenance” in the Modified Settlement Agreement.

The Department continued to meet that 80% target during calendar year 2010, as reported in the April 2011 Monitoring Report. However, as reported in the June 2012 Monitoring Report, during calendar year 2011, 72% of the children reunified with their parents or caretakers were reunified within 12 months; and as reported in the June 2013 Monitoring Report, during calendar year 2012, 67% of those children reunified during that year had been reunified within 12 months of the date that they had entered custody.

Based on this “decline in performance,” the parties agreed that the provision be moved “out of maintenance.” In the time since that provision was moved out of maintenance, the Department's “performance” on that measure has continued to be below the percentage called for by XVI.A.1 (69% for calendar year 2013 and 58% for calendar year 2014). As further explained here, the TAC feels strongly that trying to examine and account for changed performance using a flawed measure is not a useful path to pursue. The TAC has worked with Chapin Hall data experts to assist Plaintiffs in understanding why a search for an explanation for the seeming drop is viewed by the TAC as ultimately unproductive, as the Department exhibits adequate performance using the entry cohort approach (that is discussed in detail below).

For many years, however, the TAC has taken the position (consistent with that taken by the Chapin Hall Center for Children and other leaders in the field of child welfare data analytics) that using exit cohort data to assess permanency outcomes is not a valid way to measure the extent to which the Department was achieving timely permanency for children in its care.¹⁶⁶ For this reason, beginning with the first comprehensive monitoring report issued by the TAC in April 2005, the TAC has always supplemented the exit cohort data called for in the Settlement Agreement with entry cohort data that provided methodologically valid measures of the Department's permanency performance.

In the time since the original Settlement Agreement was entered, the child welfare field in general, and HHS in particular, have come to understand that one cannot validly assess permanency outcomes using exit cohort data. As explained in more detail below, measuring timeliness in achieving permanency by looking solely at a population that has exited to permanency during a particular time creates an invalid measure of system performance because it ignores the experiences of those children who remain in care.

HHS therefore changed its approach to measuring permanency performance in its Child and Family Services Review (CFSR) process, abandoning its previous exit cohort measures.

The TAC believes that, for the same reasons that the federal government and, to the TAC's knowledge, nearly every respected social scientist in the field, has shifted away from exit cohort measures, the parties should similarly abandon the original XVI.A.1 measure, and should rely instead on entry cohort measures to assess the timeliness of permanency outcomes.¹⁶⁷

B. The New Federal Permanency Outcome Measure

The federal government collects and publishes data on state performance on its CFSR measures in order to assess each state's performance by itself and in relation to all other states. The current CFSR permanency measure differs in three significant ways from the previous federal measure that is reflected in Section XVI.A.1. First, and most importantly, HHS shifted from away from the use of exit cohorts of children and youth as the basis for measurement. Second, in examining a state's performance in relation to other states, HHS risk adjusts each state's data based on the age of the child at admission and the state's placement rate per 1,000 children; and third, in measuring permanency outcomes, HHS now has established expectations for all acceptable exits to permanency as opposed to having separate standards for permanency through

¹⁶⁶ See, e.g., April 2005 Monitoring Report at pp. 10-12.

¹⁶⁷ There are two other measures in Section XVI that suffer from the same methodological invalidity as the permanency measure of A.1: the placement stability measure of A.3 and the reentry into placement measure of A.5. As is the case with the A.1 measures, both the A.3 and A.5 measures were based on prior federal measures which the federal government, recognizing their invalidity, has abandoned. While the Department's "performance," as measured by these invalid measures of placement stability and reentry, has resulted in the provisions receiving a maintenance designation, the TAC believes it is important to abandon these measures going forward in favor of measures based on the current federal measures, which use entry cohort data. The TAC, the state and plaintiffs are currently engaged in discussions about modifying those measures going forward and will inform the Court of the outcome of those discussions as soon as they are concluded.

adoption and permanency through reunification. The reason and importance of each of these changes is discussed in more detail below.

1. Entry Cohorts rather than Exit Cohorts

As mentioned in the introduction to this section, the shift in the child welfare field away from using exit cohort measures to using entry cohort measures reflects the growing appreciation for how to most effectively evaluate system performance. It starts with the principle that our understanding of how well a child welfare system meets the needs of the children it serves should be based on the experiences of all the children served and not merely the experience of some of the children, especially if the children whose experience is being evaluated are not a representative subset of all children. When using exit cohorts to measure permanency performance, *the only children being evaluated are the children who left the system*. Omitted from consideration are *all the children who were not discharged and remain in foster care*. Generally, the children who belong to the exit cohort represent a small subset of children relative to the children still in care. More importantly, the children who exit are not representative. Indeed they represent a very specific subset whose experience differs from other children by virtue of the fact that they left care.

An approach based on entry cohorts avoids the issues discussed above because the entry cohort accounts for all children and looks at the data about what happened to each of them. Put another way, the entry cohort perspective uses all the available data about children to assess performance, not just some of the data.

As an analogy, one would not judge high school graduation rates by looking only at children who graduate, nor would one judge the efficacy of a medical intervention by looking only at the individuals who left the study having been cured of their condition. One wants to look at everyone who entered school in a particular “class” to determine graduation rates or look at everyone who started treatment and observe their well-being over time to determine efficacy of treatment. Similarly, when it comes to measuring the system performance on achieving permanency for children, we need to look at all children who entered care (began treatment) at the same time and follow them over time to assess their outcomes.

2. Risk Adjustment

With regard to this second change, risk adjustment is a standard procedure in health and related human services measurement when you are trying to compare the performance of different entities. In the case of permanency outcomes of children served by state child welfare systems, risk adjustment of the raw data acknowledges and seeks to minimize the impact of underlying differences in whether children will achieve an outcome based on certain child characteristics.

Age is one of those factors. Young children are more likely to be adopted, a process that generally takes time to complete. All things being equal, states with a higher proportion of young children entering custody will have longer lengths of stay because adoptions will be a

more common permanency outcome than in states with higher proportions of older children for whom reunification or guardianship is a more likely permanency outcome. Risk adjustment by age of entry into care levels the playing field so that, for example, when Tennessee's performance is compared to the performance of other states, differences in the overall age distribution of their respective foster care populations can be accounted for. An example from health care illustrates the issue. If one were to compare hospital mortality rates following general surgery, one would want to take into account whether one hospital tends to serve more geriatric patients as opposed to young adults for the simple reason that base mortality rates are strongly correlated with age.

The federal government also risk adjusts for state placement rates. This risk adjustment accounts for the fact that states with high admission rates also tend to have higher exit rates. Without that adjustment, comparing a state with a low entry rate (perhaps one that effectively uses prompt provision of non-custodial services to keep children from less challenging situations from coming into care) to a state with a high entry rate (perhaps one that routinely takes children from less challenging situations into care, but quickly reunites them with their families) would be like comparing mortality rates for the two hospitals in the prior example.

3. Single Permanency Standard

The third change in the federal CFSR measure—going to a single permanency standard—reflects the fact that states cannot simultaneously get better on all three measures (reunification, adoption, and guardianship). For example, if 100% of the children admitted achieve permanency—1/3 adoption, 1/3 reunification with parents, and 1/3 guardianship with relatives—improvements to adoption outcomes can only come at the expense of the reunification and/or guardianship outcomes. This is an extreme example but it illustrates the point—a single permanency outcome standard avoids quantitative outcomes competing with one another when analyzing data. The Department's goal, and that of any other state, is to find and take actions to achieve the right permanency option for any given child regardless of how that plays out with the population level data. For some children, reunification is the preferred goal and the right outcome while for other children, adoption or guardianship is the appropriate outcome. Thus, judgment about the appropriateness of each individual child's permanency outcome is a qualitative decision, not one that can be appropriately measured through population level quantitative data.

C. The Department's Performance on Time to Permanency Using the Federal Measures

In determining the most appropriate way to measure permanency under the *Brian A.* lawsuit, the TAC first looked to the data produced by HHS on Tennessee's performance. Using the most recent data available, Tennessee ranks very well in comparison to other states on the timeliness and permanency of reunification.

The recently adopted federal CFSR includes three permanency outcomes measures, none of which are based on exit cohorts. The first measure uses an entry cohort: it looks at all children

who enter custody in a 12-month period and measures the percentage of those children who exit to permanency within 12 months. The second and third measures, rather than using entry cohorts, each begin with a “point-in-time” (the first day of a designated 12-month period) and with a subset of the children in custody as of that time period (for the second measure, children who, as of that first day, have been in custody between 12 and 23 months, and for the third measure, children who, as of that first day, have been in custody for 24 months or more). The measure then looks at the percentage of those children who have achieved permanency by the last day of that designated 12-month period.¹⁶⁸ In analyzing each state’s data, the federal government risk adjusts the data based on age of entry into care and then establishes a national average and ranks each state’s performance against that average. States whose performance is below the national average are required to develop and implement a Performance Improvement Plan (PIP).

Using the most recent available federal data, Tennessee’s performance on each of the three federal permanency measures is well above the national average. Tennessee is rated as in compliance with the national standard on each of the three permanency measures and has not been required to develop a PIP. For Permanency Performance Area 1 (permanency within 12 months for children initially entering care), Tennessee’s performance is 46% compared to a national average of 40.5%. This ranks Tennessee 13th best of all states measured. On Permanency Performance Area 2 (permanency in 12 months for children in foster care 12 to 23 months), Tennessee’s performance is 51% compared to a national average of 43.6%. This ranks Tennessee 9th best of all states measured. On Permanency Performance Area 3 (permanency in 12 months for children in foster care 24 months or more), Tennessee’s performance is 43% compared with a national average of 30.3%. This ranks Tennessee 3rd best of all states measured.¹⁶⁹

D. The Department’s Performance on Time to Permanency Using Chapin Hall Entry Cohort Analysis

While the TAC recognizes that the federal data, particularly data related to the first federal permanency measure, is a relevant indication of the strength of Tennessee’s permanency practice, the TAC has also had the benefit of being able to rely on data produced by Chapin Hall to further evaluate the Department’s performance. Chapin Hall has worked with the state for many years in assessing permanency progress using entry cohort data that, in the TAC’s view, is

¹⁶⁸ Because the second and third permanency measures reflect an abandonment of the exit cohort measures, they can be considered to be an improvement over the previous CFSR measures. However, measuring permanency performance based on a subset of children who happen to be in custody as of a certain date, while better than looking only at those who exit care, still does not accurately measure system performance as would entry cohort measures that examine the progress of all of the children in the total entry cohort over multiple years. For that reason, the TAC, while recognizing that the Department performs well on all three of the federal permanency measures, places much greater weight on Tennessee’s performance on the first permanency measure and on additional entry cohort analysis provided by Chapin Hall.

¹⁶⁹ Child and Family Services Reviews Information Portal. (2015). *CFSR Round 3 Statewide Data Indicator–Workbook*. Retrieved from http://kt.cfsrportal.org/action.php?kt_path_info=ktcore.actions.document.view&fDocumentId=75264.

Additionally, two to three states were excluded from the permanency measures data because of incomplete data or exceeding data quality limits.

more appropriate for *Brian A.* monitoring than the federal data. First, Chapin Hall produces entry cohort data not only to measure permanency rates within 12 months of entry into care (as the first federal measure does), but also produces entry cohort permanency rates for 24 months and 36 months. Second, the federal CFSR data includes information on all children in the state's custody including children adjudicated and placed through the juvenile justice system. While the state is clearly concerned about permanency for that group of children, the *Brian A.* Settlement covers a more narrowly defined group of children who are committed to the state's custody because of abuse and/or neglect or a status offense. The Chapin Hall data analysis narrows the focus to the *Brian A.* class of children.

At the TAC's request, Chapin Hall has conducted additional detailed analyses of the Department's permanency performance using methods most likely to provide an accurate picture of how well or poorly the Department is doing in achieving timely permanency for children. Chapin Hall manages a data sharing network, currently of 19 states, and can analyze state performance over time through its Multistate Foster Care Data Archive (FCDA). Because those states participating in the FCDA represent a good mix in terms of size, urbanicity, region of the country, and administrative structure, those states can confidently be considered representative of the nation as a whole for purposes of this analysis. Of the participating states, Tennessee is the seventh largest state in terms of population size; six of the states are county administered and the remaining states, including Tennessee, are state administered; and among the states, Tennessee has higher percentages of families living in poverty (second from the bottom in terms of its poverty rate). Overall, in the analysis, which covers calendar years 2010 through 2014, there were 453,593 children included in the FCDA database. Of those, Tennessee children accounted for 21,776.

The first set of results were presented in the July 2015 Monitoring Report (pp. 67-72) and showed that the Tennessee's child welfare system is among the best performing systems in the nation when it comes to achieving timely permanency for children. The second set of results, presented below in this monitoring report, provides a year-by-year analysis using the current federal entry cohort permanency measure. The data provide information on how Tennessee has performed year by year, using the 2010 entry cohort as a baseline. The data also provide a comparison of Tennessee's performance to the performance of each of the 18 other states participating with Tennessee in the Chapin Hall Multistate Foster Care Data Archive (FCDA) as well as a comparison against the performance of the entire group of states as a whole.¹⁷⁰

The findings presented in the July 2015 Monitoring Report are consistent with the findings using the federal measure:

- Among the group of states used in the comparison, permanency percentages in Tennessee are among the highest. This was the case in 2010 and is true for the most recent entry cohorts for which sufficient time has passed to produce relevant data (2013 and 2014).

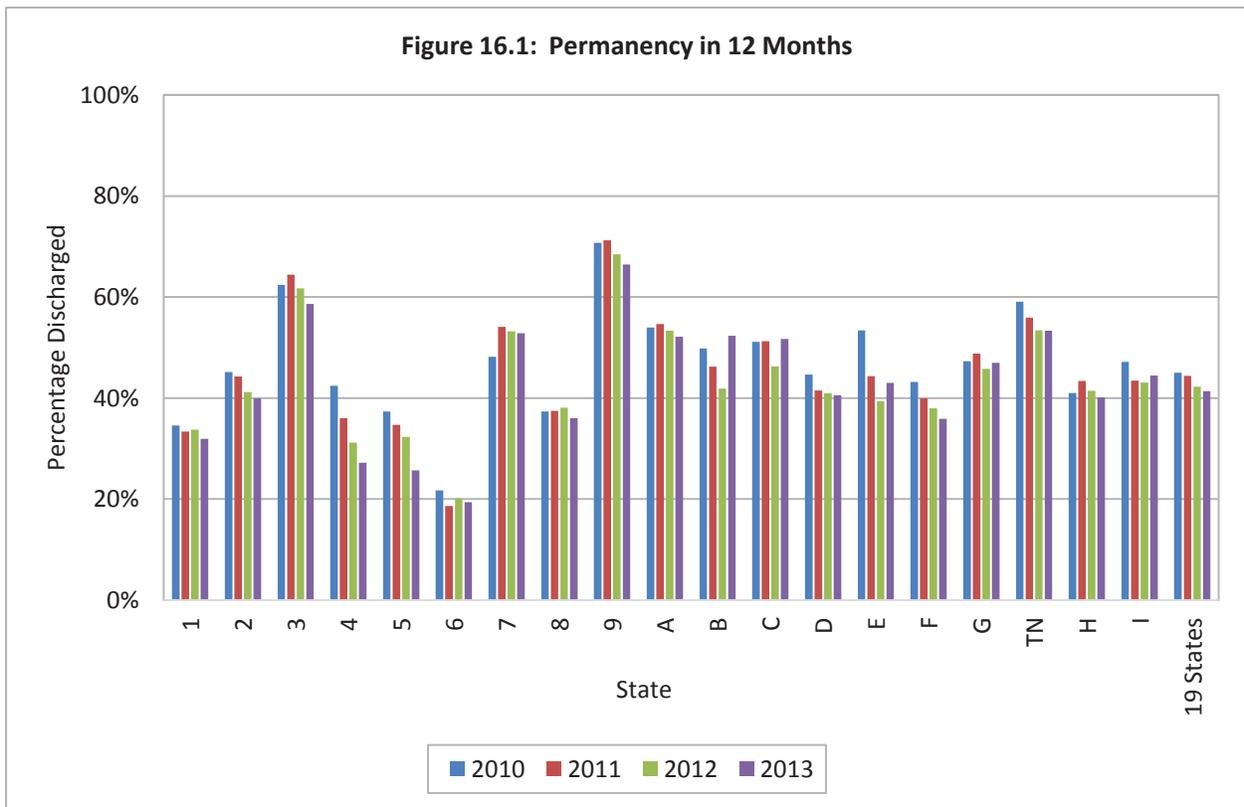
¹⁷⁰ As discussed in the July 2015 Monitoring Report, the standards that Chapin Hall applies to ensure the accuracy of data in the archive and the uniform definitions imposed on that data by Chapin Hall provided the TAC with a high level of confidence that the analysis would produce a valid "apples-to-apples" comparison. Unlike the federal data, which includes all children in state custody, including delinquents, Chapin Hall data can be filtered to allow a comparison of the experience of the *Brian A.* class with the comparable population from the other FCDA states.

- Percentages in Tennessee did decline from 2010 through 2014; however, this decline was observed in most of the comparison states as well.

These findings are discussed in more detail below.

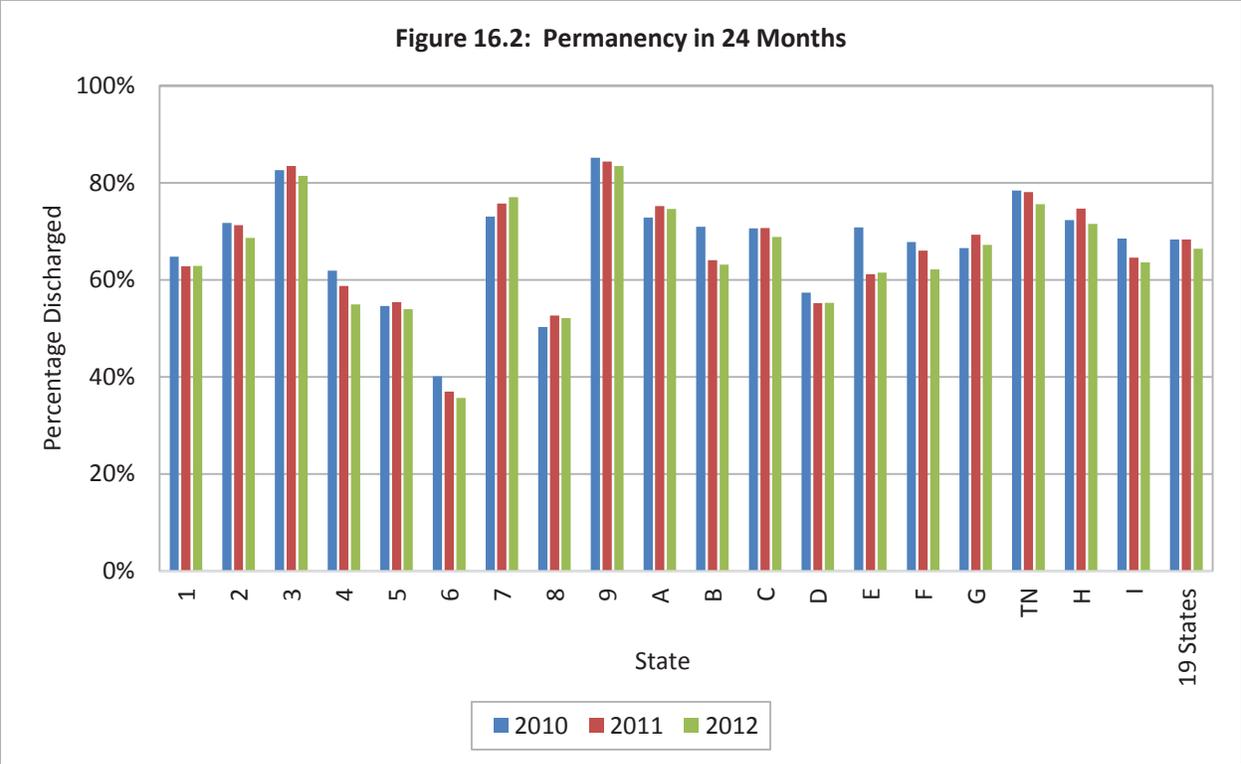
1. Overall Permanency in Tennessee and the Other Jurisdictions in the Data Archive

The following figures show the percentage of children who achieved permanency in 12 months or less, for Tennessee and each of the other 18 jurisdictions participating in the multi-state data archive for each relevant entry cohort. It also presents a combined performance of all 19 jurisdictions combined. In succession, the figures below show the percentage of children who achieved permanency within 12 months, 24 months and 36 months of entering care.¹⁷¹ The national standard for permanency within 12 months, as prepared for the third round of the Child and Family Service Reviews, is 40.5%.

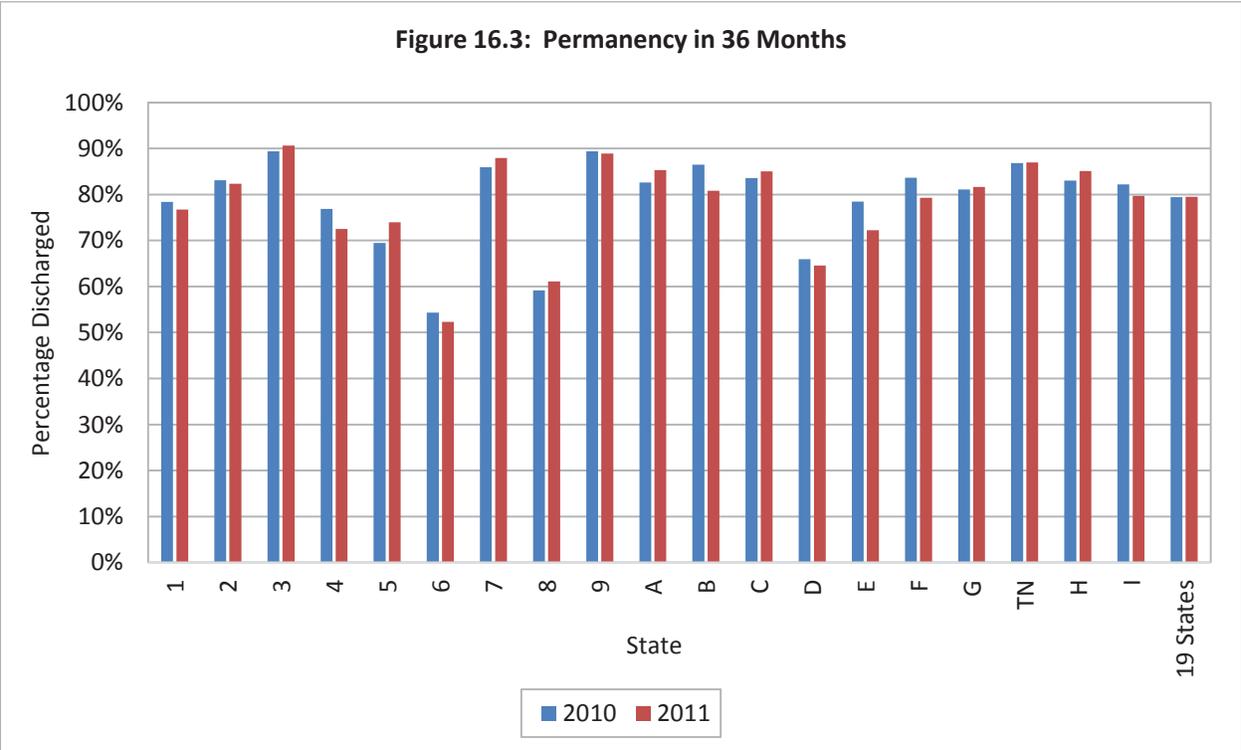


Source: Chapin Hall's Multistate Foster Care Data Archive.

¹⁷¹ There are four admission years in the comparison, beginning with those children who entered into custody in 2010. Using most recent data, children who entered custody in 2010 could have been in care for up to five years; children admitted in 2011 up to four years; children admitted in 2012, up to three years; and children admitted in 2013 up to two years. For this reason, the comparison of permanency within 12 months can be made for all four cohorts; permanency within 24 months for three of the cohorts; and permanency within 36 months for two of the cohorts.



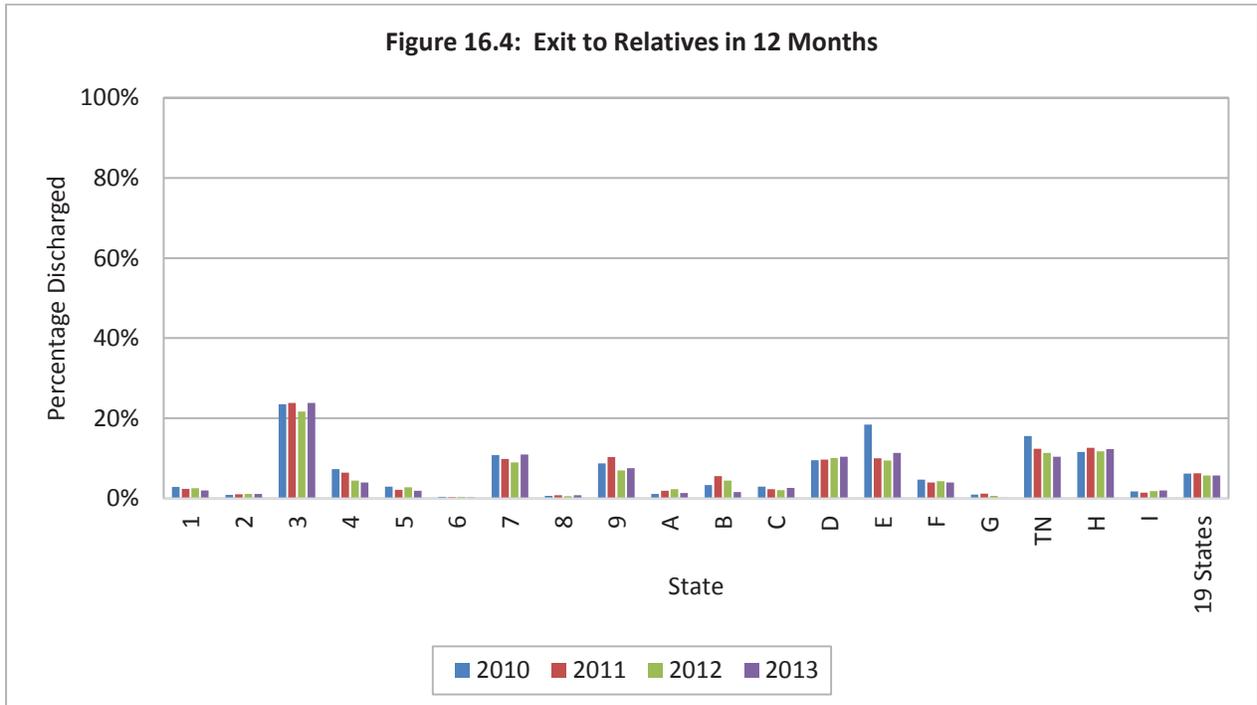
Source: Chapin Hall's Multistate Foster Care Data Archive.



Source: Chapin Hall's Multistate Foster Care Data Archive.

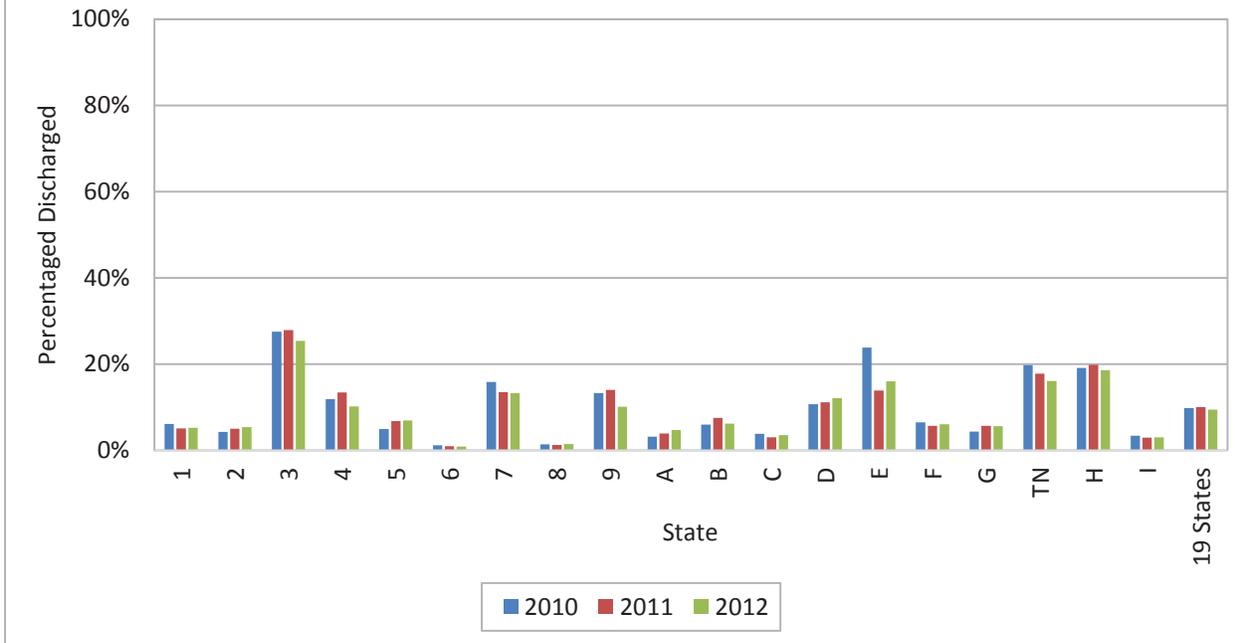
2. Permanency through Exit to Relatives

The following figures respond to the specific question about the extent to which exit to relatives account for the permanency exits for each of the cohort years. As reflected in the figures, Tennessee is among the states with the highest percentages of permanency exit to relatives.



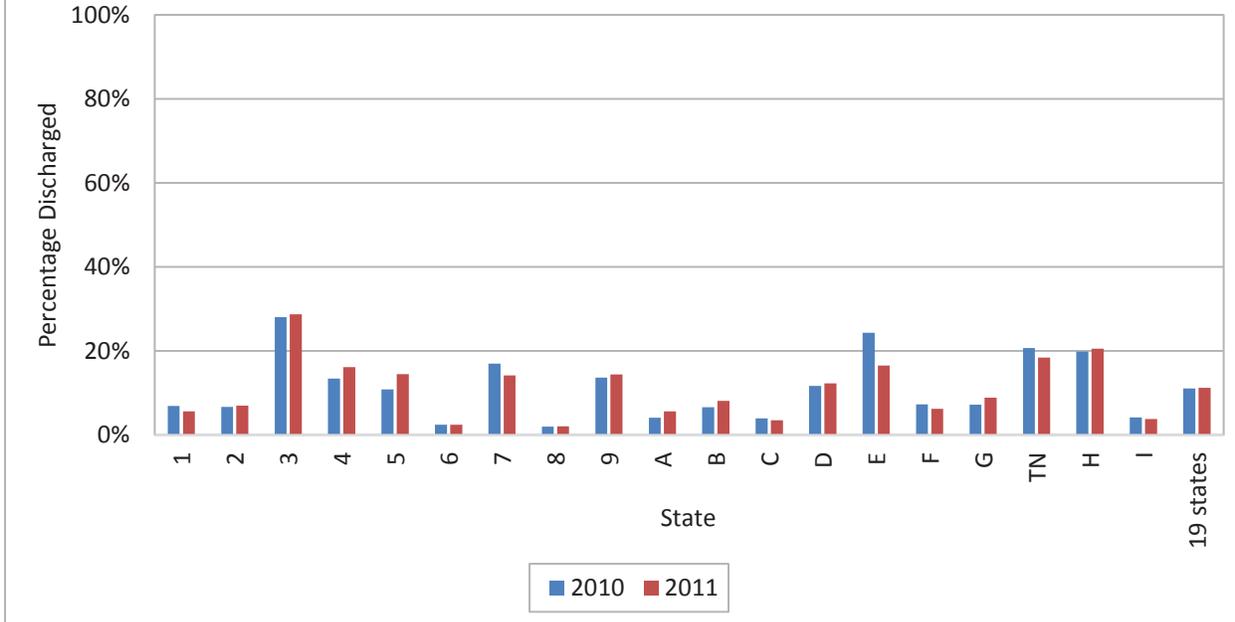
Source: Chapin Hall's Multistate Foster Care Data Archive.

Figure 16.5: Exit to Relatives in 24 Months



Source: Chapin Hall's Multistate Foster Care Data Archive.

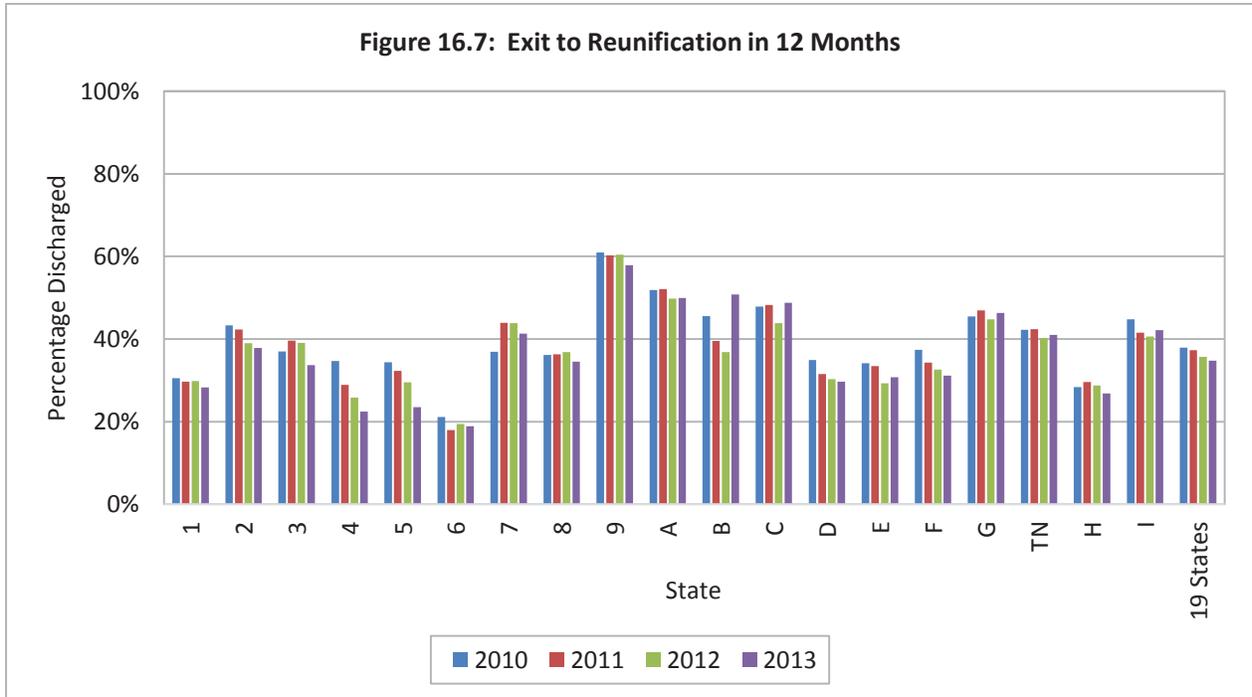
Figure 16.6: Exit to Relatives in 36 Months



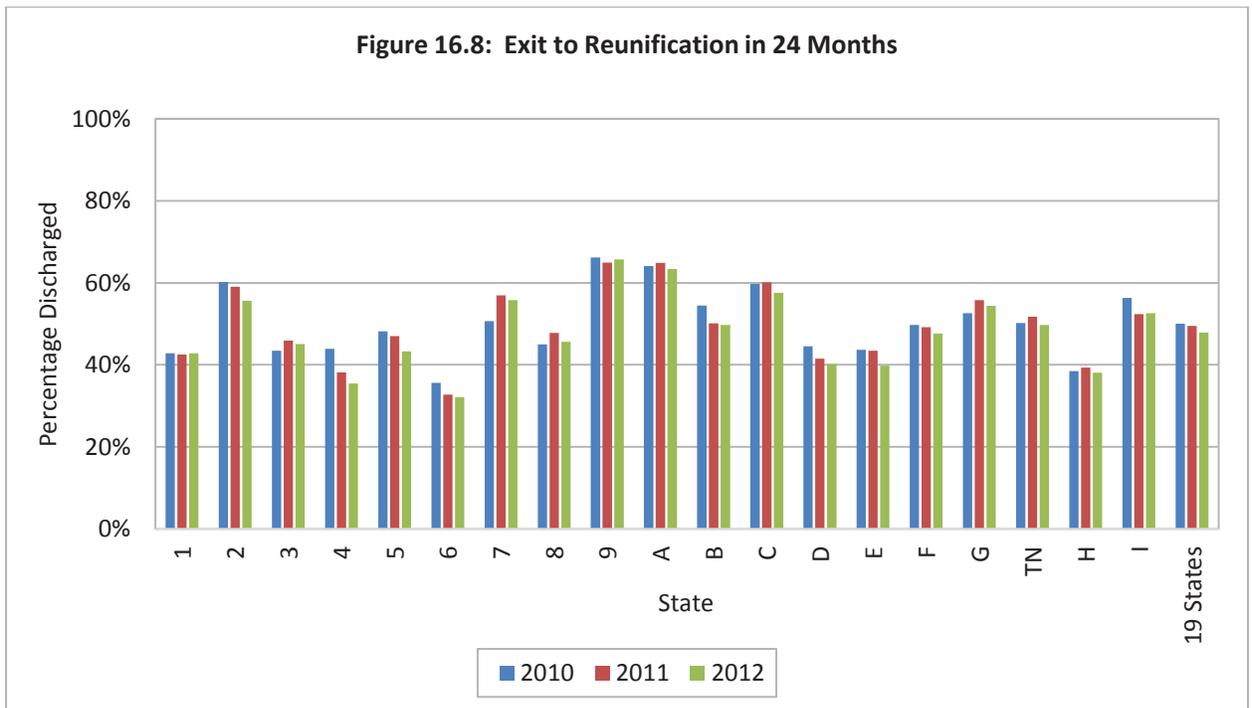
Source: Chapin Hall's Multistate Foster Care Data Archive.

3. Permanency through Exit to Parents

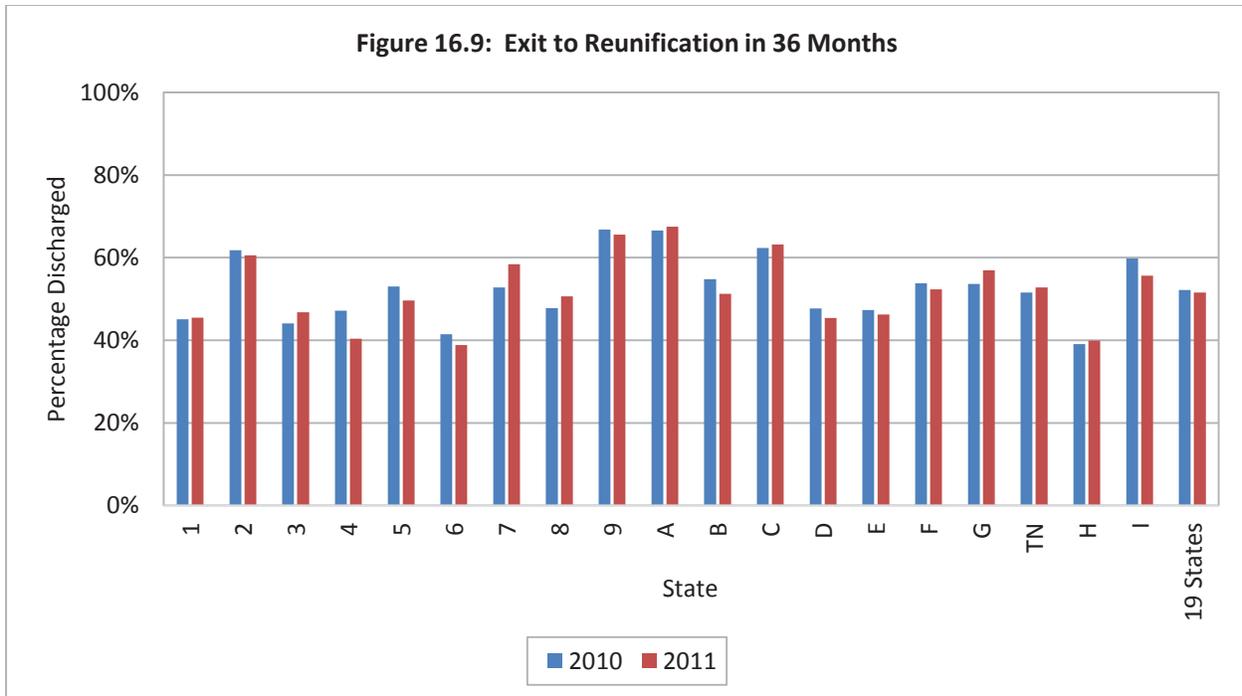
As might be expected, jurisdictions that discharge more children to relatives are less likely to return children to parents. The following figures reflect that to be the case with Tennessee.



Source: Chapin Hall's Multistate Foster Care Data Archive.



Source: Chapin Hall's Multistate Foster Care Data Archive.

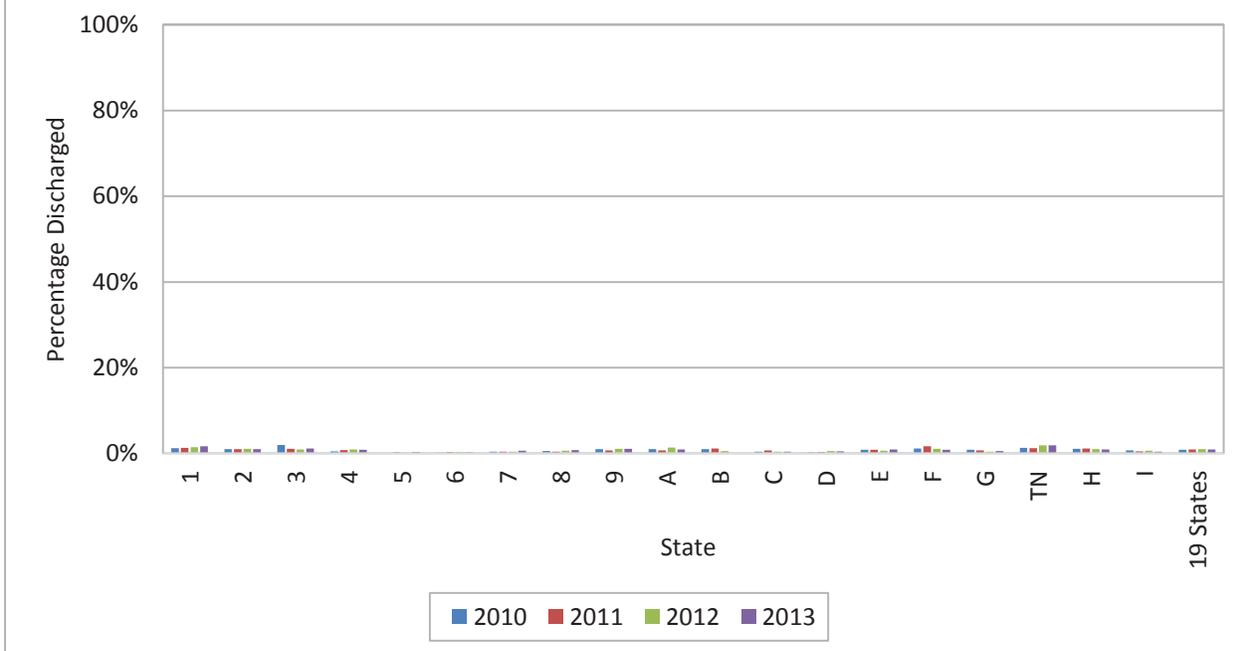


Source: Chapin Hall's Multistate Foster Care Data Archive.

4. Permanency through Exit to Adoption

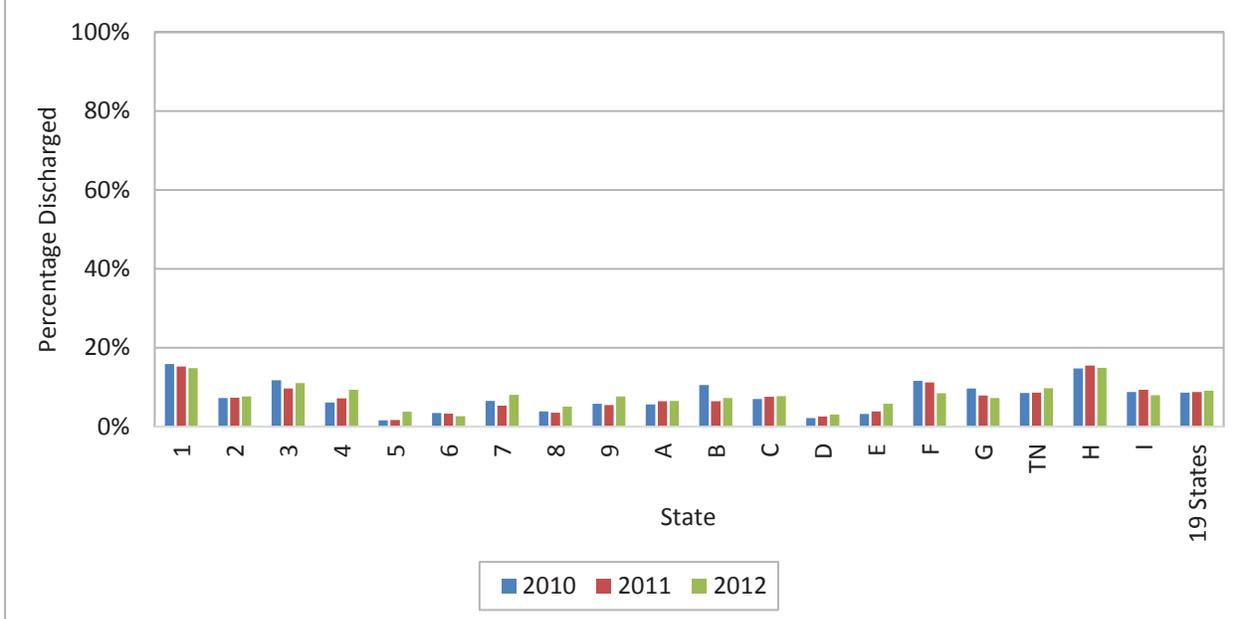
The following figures reflect the percentage of children who leave placement by way of adoption. As one would expect and as is reflected in the Figure 16.10, very few of the children who exit to permanency within 12 months of entering custody exit to adoption. For this reason, the federal measure of exit to permanency within 12 months is essentially a measure of permanent exits to parents (reunification) or to relatives.

Figure 16.10: Exit to Adoption in 12 Months

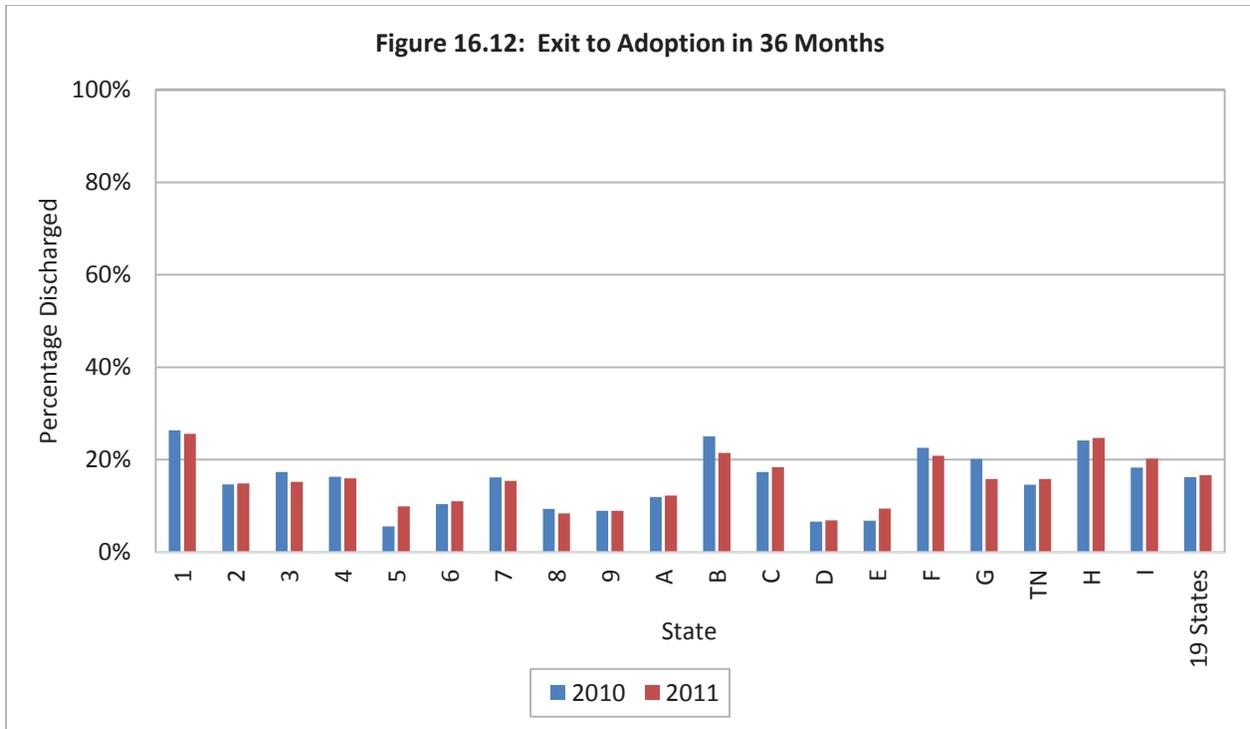


Source: Chapin Hall's Multistate Foster Care Data Archive.

Figure 16.11: Exit to Adoption in 24 Months



Source: Chapin Hall's Multistate Foster Care Data Archive.



Source: Chapin Hall's Multistate Foster Care Data Archive.

5. Summary of Tennessee's Performance Compared to the Permanency Rate for All States in the Foster Care Data Archive

Table 16.1 below summarizes the data presented in Figures 16.1, 16.2, and 16.3 above and reflects that Tennessee's permanency rates exceed the permanency rates observed for the group of states as a whole by a statistically significant margin. For example, in 2010, the average permanency rate at 12 months, for the combined group of states, was 47%; the comparable figure for Tennessee was 59%. These data show, as do the figures above, that Tennessee's permanency rates have been persistently above the rates of the comparison states at each checkpoint (*i.e.*, 12, 24, and 36 months).

Table 16.1: Average Permanency Rate			
	12 Months	24 Months	36 Months
All States			
2010	47%	67%	79%
2011	45%	66%	78%
2012	43%	65%	
2013	43%		
Tennessee			
2010	59%	78%	87%
2011	56%	78%	87%
2012	53%	76%	
2013	53%		

Source: Chapin Hall's Multistate Foster Care Data Archive.

SECTION XIX PROVISION: ESTABLISHMENT OF AN EXTERNAL ACCOUNTABILITY REPORTING CENTER

XIX.A Establishment of an External Accountability Reporting Center

The Settlement Agreement requires the Department, with input from the TAC and Plaintiffs' counsel, to develop an external accountability reporting center, with the capacity to report publicly on the Department's maintenance of program, policy and practice improvements. While the Center's reporting responsibilities do not begin until the Department successfully exits jurisdiction under XVIII.D, the Department is required to fund the Center and build the Center's reporting capacity in preparation for exit.

The Department, in consultation with the TAC and with input from Plaintiffs' counsel, has arranged for the Chapin Hall Center for Children to serve as the Accountability Reporting Center. The TAC has worked with Chapin Hall to produce aggregate data and analysis on the key outcome and performance measures regularly included in Section One of the TAC's monitoring reports. The TAC is already working with Chapin Hall and the Department to ensure a smooth transition in reporting responsibilities. Over the next several months, the parties and the TAC will be discussing both the content and format of the reporting that will be expected from the Accountability Center.

The TAC anticipates that at least one member of the TAC monitoring staff will transition from the TAC to the Accountability Center. The parties and the TAC have been discussing the possibility of including an in-state partner in the accountability center structure.

CHILD DEATH REVIEW PROCESS

A. Revisions to the Child Death Review Process

As discussed in the July 2015 Monitoring Report, the Department modified the review protocols to streamline the Child Death Review process, effective January 1, 2015. This was done in consultation with the TAC and with an opportunity for input from Plaintiffs. The TAC approved the revisions to the process.¹⁷²

Under the revised process, child deaths and near deaths meeting the following criteria qualify for review by the Child Death Review Team:

- a) Any child in state custody who dies or experiences near death for any reason;
- b) any child who has had contact with DCS within the three (3) years preceding their death or near death and their death or near death was investigated for an allegation of abuse or neglect;
- c) any child whose death or near death has been indicated (substantiated) for abuse or neglect, regardless of previous contact with DCS; or
- d) any child death or near death at the direction of the Commissioner, on the advice of the Medical Director or Deputy Commissioner Office of Child Safety (OCS).

The Office of Child Safety is responsible for determining Child Death Review eligibility for all child deaths and near deaths.

As described in DCS Policy 20.28, the Child Death Review process has two stages: Central Office Child Death Review Team (CO CDRT) and Systems Analysis. Each Death and Near Death of a child in custody is reviewed by the CO CDRT.¹⁷³ The Central Office review has two primary objectives: respond to any immediate concerns and recommend cases for a more in-depth Systems Analysis. If recommended for Systems Analysis, the case is further analyzed by the appropriate Grand Regional Systems Analysis Team (GRSAT).¹⁷⁴

¹⁷² The revised Child Death Review is outlined in DCS Policies 20.28 and 20.29, available online at <http://tn.gov/dcs/topic/policies-procedures>.

¹⁷³ The CO CDRT consists of the following people (or their designee): Deputy Commissioner of Child Health, Medical Director, Director of Nursing, Director of Safety Analysis, Child Safety representative with Child Protective Services (CPS) Investigations oversight, Continuous Quality Improvement (CQI) representative, Child Programs representative with CPS Assessment oversight, independent physician with training specific to children and adolescents, Safety Nurse, and Safety Analyst.

¹⁷⁴ Each Grand Regional Systems Analysis Team includes the following people (or their designee): safety analyst; safety nurse; regional administrator; Child Protective Services Assessment case manager; Child Protective Services Assessment team leader or team coordinator; Office of Child Safety investigator; Office of Child Safety lead investigator, program coordinator or investigative coordinator; at least one interested community partner, which may include representatives from law enforcement, an independent physician, Child Advocacy Center representative, Department of Health representative, domestic violence specialist, child abuse prevention specialist, substance abuse specialist, disability specialist, resource parent or other as deemed useful; and other internal DCS personnel as ad hoc members (such as the DCS Attorney, Family Service Worker, CANS Consultant, *etc.*) based on the program areas involved in the case(s) under review.

After OCS has determined that a child death or near death meets eligibility for review, OCS refers the case to the CO CDRT. The CO CDRT is expected to review the case and make a recommendation regarding further review by the regional Systems Analysis teams within 30 days of receipt of the referral from OCS.

Each month, the Safety Action Group Continuous Quality Improvement (CQI) Team meets to discuss opportunities to improve safety practice, including opportunities identified through the Child Death Reviews.¹⁷⁵

For reviews conducted each quarter, the Director of Safety Analysis is required to submit a report to the Commissioner within 30 days of the end of the quarter, including demographic information for the cases reviewed and findings, recommendations, and Department actions from the reviews. The Office of Child Health is required to produce an annual report by the end of the first quarter of each year (covering cases reviewed during the previous year), which includes demographic information and cause and manner of death/near death for each case as well as the findings, recommendations, and Department actions from the Child Death Reviews.

B. The TAC's Overall Assessment of the Department's Implementation of the Child Death Review Process

The TAC has reviewed and validated the processes for identifying and tracking child death and near death cases, from the Child Abuse Hotline intake process through the Central Office and Grand Regional reviews and is confident in that these processes accurately identify and count child death and near death cases, and ensure that each case is subject to the appropriate review process.

TAC members and TAC monitoring staff have attended the Central Office Child Death Review Team reviews, the Grand Regional Systems Analysis Team reviews, and the monthly Safety Action Group CQI Team meetings. Such participation in the review processes has allowed the TAC to conclude that the Department has implemented the Child Death Review Process with fidelity to the design, both in terms of the specific participants required for each of these meetings and in terms of the substance of the review process itself. The TAC has been impressed with the preparation of participants prior to the meetings, their active participation during the meetings, and the thoughtfulness of the discussions held. Reviews are scheduled well in advance and participants have the option of joining by telephone if they cannot attend in person. On the rare occasion when both a key member of the review team and his or her designee are unable to participate, rather than proceed with a review that lacks a key participant, the review is rescheduled. (In most reviews that the TAC has observed, both the key member of the review team and the person who would serve as designee in his or her absence has been present for the review.)

¹⁷⁵ The Safety Action Group CQI Team includes the following people (or their designee): Deputy Commissioner of Child Health, Deputy Commissioner of Child Safety, Deputy Commissioner of Child Programs, Director of Policy and CQI, and Director of Safety Analysis.

The TAC has also reviewed the relevant documents, including the materials circulated in advance of those reviews and meetings and the minutes of the reviews and meetings. The TAC has found these documents to provide a timely, thorough record of relevant case information and discussions held during the reviews.

In addition, the TAC is notified immediately by the Department when there is a death or near death of a child in custody. The TAC has specifically reviewed every case of a child who died in DCS custody during 2015 as well as every near death involving a child in DCS custody in 2015 in order to assess both the substantive quality of the review (for those cases for which the review process has been completed) and compliance with the procedural requirements and timelines of current Child Death Review process. TAC monitoring staff have reviewed the Child Death Review tracking documents and confirmed that all cases referred by OCS for review during 2015 were reviewed by the CO CDRT either prior to or within 30 days of the OCS referral.

Finally, the TAC has reviewed both the information posted on the Department's website, providing the public with the relevant facts and findings of each child death or near death case reviewed, and the Annual Child Death Review Report published by the Department and also available on the website. The TAC is satisfied that the quarterly and annual reports responsibly provide the information required under the revised process.

On the basis of this monitoring, the TAC has determined that child death cases and near death cases are being reviewed consistent with the Department's well-designed Child Death Review protocols, including compliance with the established timelines, and that the Child Death Review process continues to ensure that those cases are being identified and appropriately reviewed.

The TAC also finds that the timely posting of the results of each case that is reviewed on the Department's website combined with the information provided to the public in the Annual Report provide appropriate transparency and accountability.

C. Child Deaths and Near Deaths to be Included in the Child Death Review Annual Report for 2015

The Child Death Review Annual Report for 2015 will include information on 95 child deaths and 27 near deaths.¹⁷⁶ Of these:

- 85 were non-custody deaths;
- 10 were custody deaths, including nine *Brian A.* children;
- 26 were non-custody near deaths; and

¹⁷⁶ The Child Death Reviews conducted during 2015 do not correspond exactly to deaths that occurred during 2015—most deaths reviewed during 2015 occurred during that calendar year, but some of the deaths reviewed occurred during the previous calendar year.

In addition to producing an annual report that will be available online at <http://tn.gov/dcs/topic/child-death-and-near-death-public-notifications>, the Department provides redacted individual case summaries online, kept current every quarter.

- one was a custody near death.¹⁷⁷

D. Child Deaths and Near Deaths of Children While in DCS Custody

As discussed in previous monitoring reports, because of the heightened responsibility that the state assumes for children in its custody, the Department is particularly concerned that any death or near death of a child while in DCS custody involving an allegation that the death or near death was a result of abuse or neglect is subject to a prompt and thorough investigation. The Department has therefore implemented a set of processes to ensure that the Department's leadership is promptly made aware of such cases, and that those cases are promptly and thoroughly investigated by the Special Investigations Unit (SIU), with special oversight from the Central Office. These cases are also subject to the Child Death Review process that provides an additional layer of review, although the Department expects any appropriate immediate corrective actions identified by the SIU investigation will be implemented without regard to the Child Death Review process.

While a death or near death of a child in custody not involving an allegation of abuse or neglect does not automatically require an SIU investigation, all such cases are immediately brought to the attention of the Department's leadership and are subject to the Child Death Review Process.

Ten children died in custody in 2015. Seven of those children were medically fragile; one child committed suicide; one child was killed in a motor vehicle accident; and one child is preliminarily believed to have died as a result of physical abuse pending final autopsy results.¹⁷⁸ No custody death cases have received a substantiated classification, although the investigation for one case is still ongoing. All but three custody deaths will be included in the 2015 Child Death Review Annual Report. Those three cases will be included in the 2016 Child Death Review Annual Report.

There was one confirmed near death of a custody child in 2015. One additional custody case is pending physician review and has not yet been confirmed as a near death. The confirmed Near Death of a child in custody will be included in the 2015 Child Death Review Annual Report. The Near Death pending physician review, if confirmed, will be included in the 2016 Child Death Review Annual Report.

¹⁷⁷ Of the 10 custody deaths reviewed during 2015, one (a death that occurred at the end of 2014) received a full review under the previous process because the review had begun under that process. The remaining nine deaths were reviewed under the revised process (outlined in DCS Policy 20.28 and discussed in detail in Subsection 1), which requires that all cases be reviewed by the Central Office Child Death Review Team to determine whether a full systems analysis would be beneficial. Of these nine custody child deaths, three were referred for (and received) a full systems analysis. The custody near-death was also referred for (and received) a full systems analysis.

¹⁷⁸ Nine of these children were class members; the tenth child, who was killed in the motor vehicle accident, was a delinquent child.

APPENDICES

Appendix VII.K

Number and Percentage of Children Statewide Who Had At Least One CFTM Within the Last Four Months, Fourth Quarter 2015						
10/6/2015	10/15/2015	10/19/2015	10/26/2015	11/2/2015	11/9/2015	11/16/2015
5,448/6,896	5,566/6,896	5,592/6,896	5,904/6,896	6,137/6,888	6,293/6,888	6,373/6,888
79%	81%	81%	86%	89%	91%	93%
11/23/2015	12/1/2015	12/7/2015	12/14/2015	12/21/2015	12/28/2015	
6,552/6,888	6,528/6,813	6,595/6,813	6,645/6,825	6,608/6,783	6,572/6,742	
95%	96%	97%	97%	97%	97%	

Source: The Department's weekly overdue CFTM tracking.

Number and Percentage of Children by Region Who Had At Least One CFTM Within the Last Four Months, Beginning and End of Fourth Quarter 2015		
	10/6/2015	12/28/2015
Davidson	275/379 (73%)	348/359 (97%)
East	392/440 (89%)	402/402 (100%)
Knox	588/702 (84%)	668/678 (99%)
Mid-Cumberland	561/704 (80%)	655/687 (95%)
Northeast	585/660 (89%)	601/611 (98%)
Northwest	337/417 (81%)	393/400 (98%)
Shelby	458/677 (68%)	638/687 (93%)
Smoky Mountain	577/731 (79%)	690/712 (97%)
South Central	340/400 (85%)	454/454 (100%)
Southwest	190/275 (69%)	272/279 (96%)
Tennessee Valley	311/680 (55%)	638/660 (97%)
Upper Cumberland	779/831 (94%)	784/784 (100%)

Source: The Department's weekly overdue CFTM tracking.

Appendix VIII.C.1

Number and Percentage of Children Statewide Who Entered Care Between January and July 2015, Who Had Timely Diligent Search Activity, Fourth Quarter 2015						
10/6/2015	10/15/2015	10/19/2015	10/26/2015	11/2/2015	11/9/2015	11/16/2015
2232/3134	2326/3134	2100/3134	2185/3134	3107/3376	3223/3376	3292/3376
71%	74%	67%	70%	92%	95%	98%
11/23/2015	12/1/2015	12/7/2015	12/14/2015	12/21/2015	12/28/2015	
3336/3376	3581/3621	1933/2079	1893/2051	1860/2026	1763/2006	
99%	99%	93%	92%	92%	88%	

Source: The Department's Weekly Diligent Search Overdue Activity reporting.

Number and Percentage of Children by Region Who Had At Least One CFTM Within the Last Four Months, Beginning and End of Fourth Quarter 2015		
	10/6/2015	12/28/2015
Davidson	148/167 (89%)	96/101 (95%)
East	154/230 (67%)	122/122 (100%)
Knox	217/311 (70%)	201/219 (92%)
Mid-Cumberland	258/349 (74%)	201/213 (94%)
Northeast	163/253 (64%)	133/157 (85%)
Northwest	166/200 (83%)	107/128 (84%)
Shelby	261/295 (88%)	152/183 (83%)
Smoky Mountain	208/318 (65%)	173/202 (86%)
South Central	158/219 (72%)	116/142 (82%)
Southwest	76/95 (80%)	43/52 (83%)
Tennessee Valley	154/275 (56%)	179/185 (97%)
Upper Cumberland	280/422 (66%)	234/295 (79%)

Source: The Department's Weekly Diligent Search Overdue Activity reporting.

A BRIEF ORIENTATION TO THE DATA: LOOKING AT CHILDREN IN FOSTER CARE FROM THREE DIFFERENT VIEWPOINTS

Typically, when data are used to help convey information about the children who are served by the child welfare system, one of three viewpoints is presented. The “viewpoints” are: “*point-in-time*” data, “*entry cohort*” data, and “*exit cohort*” data. Each viewpoint helps answer different questions.

If we want to understand the day-to-day workload of DCS and how it is or is not changing, we want to look from a “*point-in-time*” viewpoint. For example, we would use point-in-time information to understand what the daily out-of-home care population was over the course of the year—how many children were in out-of-home placement each day, how many children in the system on any given day were there for delinquency, unruly behavior, or dependency and neglect, and how that daily population has fluctuated over this particular year compared to previous years. Point-in-time data also tell us whether the number of children in care on any given day is increasing, decreasing, or staying the same. A graph that compares snapshots of the population for several years on the same day every month (the same “point in time”) provides a picture of the day-to-day population and its change over time.

But if there is a trend—for example, in Tennessee, that the number of children in care on any given day has been increasing somewhat over time—it is hard to understand the cause(s) of the increase by looking at “point-in-time data.” For example, were more children committed to DCS custody in 2014 than in past years? Or is the increase the result of children staying in the system for longer time periods (fewer children getting released from custody during 2014) than in previous years? For this answer we need to look at “*cohort data.*”

The question whether more children entered custody in 2014 than entered in 2013 is answered by comparing the total number of children who entered custody in 2014 (the 2014 entry cohort) with the number of children who entered custody in 2013 (the 2013 entry cohort).

Entry cohort data is also especially helpful to assess whether the system is improving from year to year. Is the system doing a better job with children who entered in 2014 than with the children who entered in 2013? Comparing the experiences in care of these two groups (entry cohorts) of children—their stability of placement while in care, how often they were placed in family rather than congregate settings, how often they were placed close to their home communities rather than far away—is the best way of measuring year-to-year improvement in these and other important areas of system performance.

There are certain questions for which “*exit cohort*” data is most helpful. If we want to understand the population of children that may need services after they return to their families, we would need the exit cohort view. These are children with whom DCS would be working to make sure that reunification is safely and successfully achieved. Reentry into foster care is a sign of a failed reunification. It is therefore important to measure the percentage of children exiting care during any given year who reenter custody within a year of discharge. Comparing the reentry rates of children who exited care in 2013 (the 2013 exit cohort) with the reentry rates of those children who exited care in 2012 (the 2012 exit cohort) is one way of understanding whether the system is doing better when returning children to their families in ensuring that reunification is safe and lasting.

In general, the data that are most helpful for tracking system improvement over time are *entry cohort data*. If the system is improving, the children in the most recent entry cohort should have a better overall experience and better outcomes than children who entered in previous years. Since exit cohorts include children with a range of experience in the foster care system, some of which may extend back many years and precede recent improvement efforts, they are generally not useful for understanding trends over time.