Lessons Learned from Child Welfare Class Action Litigation: A Case Study of Tennessee's Reform

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Ideas into Action

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Tennessee's success occurred because of the hard work and dedication of many people.

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Introduction

Since the 1970s, many state child welfare systems have been the subject of legal controversies, contentious politics, and broad-based reform efforts. The State of Tennessee is no exception. Concerns about its Department of Children's Services' (DCS) policies, programs, and outcomes led in 2001 to a class action lawsuit and ultimately resulted in transformational reforms over a period of almost two decades. This case study is intended to help child welfare system leaders, policymakers, and advocates who are engaged in comprehensive system improvement learn from Tennessee's experience, whether those improvement efforts take place within the confines of class action litigation or are driven by other interests and priorities in their respective states.

The State of Tennessee stands out because, after years of progress (and despite early difficulties and setbacks along the way), it durably improved the ways the Department serves children and families and achieves outcomes, leading to successful exit from a Settlement Agreement and federal court supervision. Tennessee's experience illustrates both the hard work that it takes to produce better results for children and youth and the many challenges that state child welfare systems face in designing, implementing, and sustaining improvements in system performance and outcomes. In the interest of capturing and sharing Tennessee's experience with practitioners and policymakers in the child welfare field, the Center for the Study of Social Policy (CSSP) coordinated the development of a case study and organized a symposium with many of the key stakeholders involved in Tennessee's reform.[1] This study is based on a review of the documented history of Tennessee's reform and informed by the reflections and perspectives of many who played key roles in the litigation and related system improvement efforts (including, but not limited to, those who participated in the symposium).[2]

Although the timeline of efforts in any state or locality will differ based on local circumstances, there are lessons to be learned from understanding how Tennessee's reform proceeded over time. For this reason, Part One of this case study discusses Tennessee's reform chronologically, including significant accomplishments as well as the prominent challenges, framed by six developmental stages:

- **Filing and negotiating the 2001 *Brian A. Settlement Agreement:*** the circumstances leading to litigation and the entry of a court-ordered agreement
- **Beginning the work:** diagnosing problems, enlisting allies, weathering early struggles, and celebrating successes (2001-2004)
- **Gaining momentum:** the challenges of setting priorities and demonstrating progress (2004-2010)
- **Creating a path to exit:** modifying the Settlement Agreement to reflect changing realities and conditions for exit (2010)
- **Final Stages:** unanticipated setbacks, demonstrating improvements, and moving towards exit (2011-2015)
- **Sustainability and exit** (2016-2018)

Part Two of the case study identifies and examines the history and examines how cross-cutting themes played out during different stages of the reform.[3]

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[1] CSSP's Executive Vice President as well as consultants retained by CSSP served as both technical assistance providers and monitors under the terms of the Settlement Agreement.

[2] See Appendix A for a list of participants attending April 2018 symposium.

[3] In many respects, this case study provides an opportunity to examine in the context of one specific jurisdiction many of the themes discussed from a variety of perspectives in *For the Welfare of Children: Lessons Learned from Class Action Litigation, The Center for the Study of Social Policy,* January 2012. https://cssp.org/resource/for-the-welfare-of-children-lessons-learned-from-class-action-litigation/

PART ONE

Tennessee's Path to Successful Child Welfare System Reform

SECTION I.

Filing and negotiating the 2001 *Brian A. Settlement Agreement:* the decision and consequences of structuring a court-ordered Agreement

On May 10, 2000, Children's Rights, a non-profit public interest advocacy organization specializing in child welfare impact litigation, along with Tennessee based co-counsel attorneys and law firms in Nashville, Memphis, and Knoxville,[4] filed a class action lawsuit against the Governor of Tennessee and the Commissioner of the Tennessee Department of Children's Services (DCS) "on behalf of all foster children who are or will be in the custody of DCS." The case (and the reform efforts that followed) would often be referred to simply by the pseudonym of the first named plaintiff—*Brian A.*

Well before the *Brian A.* lawsuit was filed, Tennessee had made efforts to improve its child welfare system. Through leadership in the executive and legislative branches (and spanning both Democratic and Republican administrations), Tennessee had already enacted some meaningful reforms designed to improve services to children in state custody. In 1994, the state adopted a strategic plan (the Tennessee Children's Plan) focused on both better coordination of services for families and children and ensuring the quality of those services. The Children's Plan also included structural reforms that allowed Tennessee to better utilize federal Medicaid funding to serve children, including those in state custody.[5]

A significant part of the implementation of the Children's Plan was the creation of the Department of Children's Services (DCS) in 1996, which consolidated under a single department all of the responsibilities previously distributed among six different state departments.[6] Any child coming into state custody for any reason—from an infant who suffered abuse and neglect to a teenager charged with delinquency offenses—was now the responsibility of the new Department.

The savings resulting from the consolidation of what had been redundant bureaucracies and the new Department's increased ability to draw down federal funds meant that more resources were potentially available to support improved services. The consolidation also eliminated time-consuming and often unproductive negotiations to determine which department was responsible for providing

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[4] In addition to attorneys at Children's Rights, the Tennessee co-counsel team includes David Raybin of Raybin & Weissman in Nashville; Jacqueline Dixon of Weatherly, McNally & Dixon in Nashville; Wade Davies of Ritchie, Fels & Dillard in Knoxville; and Robert Louis Hutton of Glankler Brown in Memphis. Counsel on the original filing also included civil rights lawyer Richard Fields of Memphis, who passed away in 2013.

[5] Tennessee also pioneered the use of "continuum contracts" through which a provider contracts to provide a full continuum of foster family and congregate care placements and services for the children and families it serves (including aftercare services to support successful reunification). Under the continuum contract, the private provider receives a per diem rate based on the level of care established by the Department when the child enters placement. The per diem is fixed based on the level of services the child needs, not on where the child is when those services are delivered. The contracted rate therefore provides a fiscal incentive for the provider to deliver that care whenever possible in less expensive foster family settings rather than in higher cost congregate care. Tennessee's continuum of care contracts included provisions designed to prevent continuum providers from "creaming"—accepting easier to serve children and rejecting children with more challenging needs. The continuum contracts also required an 80% success rate following discharge (defined as the child successfully remaining in the home to which the child was discharged for at least nine months), thus both encouraging providers to deliver aftercare services to ensure a smooth transition from foster care and discouraging providers from prematurely discharging children who were proving more difficult or more costly to serve. Tennessee began using continuum contracts in 1995 and about 40% of children in foster care were being served by continuum providers at the time that the *Brian A.* lawsuit was filed. Tennessee's experience implementing continuum contracting in many ways laid the foundation for the successful implementation of performance based contracting as part of the *Brian A.* reforms. See *State Innovations in Child Welfare Financing, Tennessee: Continuum of Care (US Department of Health and Human Services,* 2002) available on line at https://aspe.hhs.gov/report/state-innovations-child-welfare-financing/tennessee-continuum-care.

[6] These custodial and related non-custodial services had previously been distributed among the State's departments of: Education, Youth Development, Finance and Administration, Health, Mental Health and Mental Retardation, and Human Services.

services when a child's presenting conditions (as was so often the case) did not neatly fit within the responsibilities of any single department.

Notwithstanding the benefits of the consolidation, the newly formed Department found itself confronting a set of challenges that had been building over time. One challenge the new Department faced was integrating staff who had previously worked for one of the predecessor agencies (each of which had their own distinct organizational culture and practice approaches) into a cohesive workforce guided by a common set of best practice principles. The leadership of the new Department was initially dominated by those with experience in juvenile corrections not child welfare, even though 80% of the custodial population and the vast majority of children being served in non-custodial cases were abused and neglected children.

Between 1991 and 1995, the total number of Tennessee children in custody increased by nearly 3,000 to over 11,000.[7] Staffing and resources (including foster home recruitment) did not keep pace with this increase and a large percentage of the children had a documented mental health need. Tennessee overused congregate care facilities, including restrictive residential psychiatric placements, notwithstanding the recognition that the large majority of children are better served (and at lower cost) in family settings.

Acknowledging these and other challenges (and aware that Children's Rights was considering filing a lawsuit), the Department sought technical assistance from the Child Welfare League of America (CWLA) to develop a three-year reform plan. The Department received the CWLA recommendations in late 1999 and early 2000. The DCS Commissioner and his leadership team hoped that Children's Rights would postpone a decision to file suit so that the Department could have the opportunity to implement the CWLA recommendations and achieve results.

Children's Rights attorneys, however, were not inclined to delay filing. Their attorneys had conducted a substantial investigation into the state's practices, talked with many stakeholders, identified a significant number of systemic issues (most of which were widely acknowledged both within and outside the Department) and had concluded that without the catalyst of litigation, there was little likelihood that the Department would be able to address the deficiencies exemplified by the circumstances of the named plaintiffs.[9]

The experiences of the named plaintiffs recounted in the *Brian A.* complaint[10] presented a troubling mosaic of the failings of Tennessee's child welfare system at that time—and highlighted situations and systemic challenges that unfortunately are not unique to Tennessee. At the time the lawsuit was filed, Brian A. was nine years old and had spent the previous

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[7] One of the Department's priorities after the entry of the Settlement Agreement was to improve the accuracy of the Department's data and the methodology for collecting, analyzing, and reporting those data. In light of this, legitimate questions can be raised about the accuracy of much of the data from the years preceding the entry of the Settlement Agreement. In any event, because of changes in methodology made after the filing of the lawsuit, data produced prior to the Settlement (including some of the data cited in the complaint) are not comparable to the data produced once the reform effort was well underway. With this caveat, pre-settlement data can provide a general understanding of the magnitude of the problems that Tennessee faced at the time the lawsuit was filed.

[8] DCS Commissioner George Hattaway had previously signaled his commitment to system reform by hiring a General Counsel to lead the reform effort who was a former juvenile court magistrate (trained and experienced in both law and social work) and who had been a critic of the agency. The Commissioner also hoped that the proactive engagement of CWLA might dissuade those contemplating a lawsuit from filing; and if a suit were filed, might dissuade a judge from intervening.

[9] When a child welfare agency is already moving forward with its own improvement efforts, litigation risks displacing the agency's internal reform efforts, leaving it with an incomplete, agency-led effort and shifting its role from a proponent of needed changes to a defendant arguing against similar changes in court. On the other hand, litigation, particularly if conducted by diligent lawyers and overseen by a conscientious judge, can speed and help sustain the internal process in the agency.

[10] The named plaintiffs represented a class of all foster children who were currently or would be in the custody of DCS. The plaintiffs' attorneys also identified a sub-class of African American children in the state's care. The complaint defined the class to include abused and neglected children (sometimes referred to as "dependent"), children who had been adjudicated with a status offense (e.g., truancy, running away from home, habitual disobedience), and children who were voluntarily placed into custody by their parents or guardians (for example, children with significant mental health or developmental disabilities that required residential care that parents were otherwise unable to access). Using the Tennessee Comptroller of the Treasury's report from 1999, the complaint argued that abused and neglected children made up 86% of the class, the status offense population—referred to as "unruly" children under Tennessee law—made up 11%, and the children voluntarily placed in custody made up the remaining 2%.

seven months in an emergency shelter in Memphis. That shelter was developmentally inappropriate for several reasons—there was no mental health treatment, caseworker services, or meaningful, regular educational services. Brian was also housed with boys significantly older than he, including some who had been accused of serious delinquency offenses. The other named plaintiff children also had experiences that are common to struggling child welfare systems including multiple placements, grossly inadequate care and treatment while in state custody, and failure to achieve permanency.[11]

The complaint, which named Tennessee's Governor (Don Sundquist) and the Commissioner of Tennessee's Department of Children's Services (George Hattaway), in their official capacities, as defendants, alleged that Tennessee had systematically failed to provide children in DCS custody with legally required services, in violation of their rights under the U.S. Constitution, federal statutes and federal common law.[12] In their factual allegations, the plaintiffs' lawyers included detailed systemic deficiencies using data and evaluations conducted or commissioned by the Tennessee state government.[13]

Tennessee's experience in negotiating the *Brian A. Settlement Agreement* suggests that settlement discussions are more likely to be effective when the court provides active support and structure to the negotiations. In November of 2000, after denying the state's motion to dismiss,[14] the district court judge ordered the parties to enter mediation in hopes that they could settle the case without the need for a trial.[15] From December 2000 to May 2001, the plaintiffs and the State of Tennessee engaged in active settlement talks. A high level of hostility and mistrust pervaded the early negotiations. Without the judge's insistence on mediation and without the engagement of skilled mediators with child welfare expertise to facilitate discussions, it is unlikely the case would have been successfully settled. During this period, the Court had to order the parties twice to continue mediation.[16] The judge also imposed a gag order during the mediation process, which was important to the atmosphere of the negotiations, but also prohibited any involvement of other key stakeholders in the negotiation process, including private providers who served many of the children.[17]

Typically, in negotiating a settlement agreement on behalf of a state government, the agency's General

[11] Tracy B. was a 14 year old who had endured 15 foster care placements despite only being in the state's custody for one year. Jack C. and Charles C., 14 and 9 years old respectively, were brothers who had been taken into state custody because of their mother's long-term substance abuse. Jack was in his 23rd foster placement when the lawsuit was filed and Charles had suffered violent seizures and permanent brain damage when, after being returned to his mother's care, he ingested some of his mother's drugs. Amy D., a 16 year old, had experienced significant abuse and neglect and 14 different foster care placements, only to experience serious health-related issues from psychotropic medication prescribed by foster care facility staff. Denise E., an 8 year old, and Charlette F., a 5 year old, had both spent their entire lives in state custody. Both children had experienced significant abuse and neglect, but the Department had failed to take meaningful steps to place them in permanent, nurturing homes. Terry G., a 17 year old, was living in a congregate care facility and had lost a pregnancy following a violent assault at the facility.

[12] Specifically, the complaint alleged that the defendants had violated plaintiffs' rights under the First, Ninth, and Fourteenth Amendments of the U.S. Constitution, the Adoption Assistance and Child Welfare Act of 1980 (AACWA), as amended by the Adoption and Safe Families Act of 1997 (ASFA), 42 U.S.C. §§ 620-627, 670-679a, the Americans with Disabilities Act (ADA), 42 U.S.C. § 12101 *et seq.*, the Rehabilitation Act of 1973, 29 U.S.C. §§ 794, 794a, Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d *et seq.* (as to the sub-class of African American children), and under federal common law as third-party beneficiaries to Tennessee's contract with the federal government under the Adoption Assistance Act (AACWA and ASFA). In total, the plaintiffs brought six claims under federal law and an additional Title VI claim on behalf of the sub-class of African American children.

[13] Children's Rights specifically argued that children were routinely placed in emergency shelters for months; that children in care routinely experienced several foster placements; that more than one-third of children had been in custody for over two years and half of those had been in custody for more than four years; and that the state had failed to move thousands of children into permanency either through returning them to their families or helping them get adopted.

[14] The Court denied Tennessee's motion on all grounds save one: the Court dismissed the plaintiffs' claim based on the Americans with Disabilities Act, 42 U.S.C. § 1201 *et seq.*

[15] Like many other federal district courts, the Middle District of Tennessee encourages the parties to enter mediation.

[16] At a critical impasse, the mediator Paul DeMuro, correctly perceiving that he needed to build greater trust in the mediation process, brought in a co-mediator who was well respected by the plaintiffs to help facilitate the discussions. That co-mediator, John Mattingly, played a significant role not only in helping the parties reach an initial settlement but in supporting early implementation efforts and resolving disputes between the parties that arose during the early years of the reform.

[17] After a settlement was reached, many of the private service providers, who are an essential part of the state's system of care, complained that they should have been involved in the settlement process. Although it is possible, as some private providers argued, that the ability to provide input into the settlement discussions would have accelerated their understanding and support for the goals of the reform, it is also likely that their participation would have made the negotiations more difficult.

Counsel is involved along with other attorneys representing the Governor, either through the Attorney General's office or the Governor's office itself. In some cases (though not in *Brian A.*), the state also engages outside legal counsel.[18] The team of attorneys negotiating the *Brian A.* case on behalf of the state felt it was important to have a program staff representative of the Commissioner—someone trusted by the Commissioner and with a deep working knowledge of the Department's child welfare operations—present for and actively involved in the discussions. That person did not necessarily have all the answers but knew whom to ask in the various offices within the Department. Even the most informed attorney for the child welfare agency will need to lean on program staff during negotiations of a settlement agreement. This practice reflected the importance of making sure that program knowledge rather than litigation strategy drives decisions about what is or is not included in a settlement agreement.[19]

The State of Tennessee and class counsel reached a tentative Settlement Agreement in May 2001. In July, the Court conducted a fairness hearing and, notwithstanding concerns voiced by a coalition of private providers who filed objections to some aspects of the proposed Settlement Agreement,[20] entered the *Brian A. Settlement Agreement* as the Court's Order. Once signed, DCS leaders needed to devote substantial time and effort to explaining both to staff and outside stakeholders what was included in the agreement, why the Department had agreed to it and what they hoped would be accomplished through implementing its provisions. In addition to the various actions the Department agreed to take, the *Brian A. Settlement Agreement* established a set of performance standards and outcomes for children that the Department was required to meet.[21] Workers needed to understand what the agreement's provisions meant for them in order to be enlisted in supporting the goals and requirements of the reform, a process that would take time and multiple efforts. As an initial step, the same DCS staff members who participated in the settlement negotiations were charged with explaining it to DCS staff through a series of 60 regional workshops.

Two external mechanisms were created by the Settlement Agreement to support the reform: an independent court monitor to track compliance with the Agreement and a Technical Assistance Committee (TAC). The TAC members, five experts in the child welfare field selected by agreement of the parties, were to serve as a resource to DCS in the development and implementation of its reform efforts.[22]

While it was important to have these external resources, the parties recognized that the Department needed its own internal capacity to monitor its performance and develop improvement strategies. The Settlement Agreement therefore required the development of a Quality Assurance (QA) unit within the Department; it contemplated that the TAC would assist in developing that QA unit and that, over time, the external monitoring would increasingly rely on data and analysis produced by that unit.[23]

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[18] In the last few years of the Settlement Agreement, the State hired Jon Lakey as outside counsel.

[19] This program knowledge also may be found in mediators with child welfare system expertise, such as those who mediated *Brian A*.

[20] The primary objection of the private providers, many of whom operated congregate care facilities, were to provisions that called for significant reduction in use of congregate care and strict requirements for utilizing facilities with capacity that exceeded eight children.

[21] The Settlement Agreement included performance measures and outcome targets focused on parent-child visits, placing siblings together and ensuring sibling visits when siblings were separated, placement stability, length of stay, re-entry into care, achievement levels of youth who turn 18 while in DCS custody, placement in or near a child's home county, and timeliness of the termination of parental rights process

[22] The original five TAC members were Andy Shookhoff, Steve Cohen, Paul Vincent, Judith Meltzer, and Carolyn Lapsley. In addition to providing technical assistance, the TAC was given responsibility to resolve a number of issues that were left open by the Settlement Agreement including the reviewing and approving of policies related to use of seclusion, restraint, and administration of psychotropic medications; making recommendations (which the Department was required to implement) with respect to the development of an assessment protocol and the modification of continuum contracts; and overseeing the annual Needs Assessments required by the Settlement Agreement.

[23] The *Brian A. Settlement Agreement* required that specified outcome and performance targets had to be achieved by DCS by the end of specific periods. As defined by the Settlement Agreement Period I covered the 18-month period between September 1, 2001 and February 28, 2003. Period II began on March 1, 2003 and ended on August 31, 2004.

The Settlement Agreement was framed by principles of professional child welfare practice that were to guide the state's implementation efforts to meet dozens of *Brian A.* benchmarks and performance measures.[24] The principles remained important throughout the implementation and established guideposts for assessing policies, practices, and the quality of care.

The Settlement Agreement's substantive commitments were organized under separate sections addressing: (1) organizational structure;[25] (2) reporting abuse and neglect;[26] (3) the availability of services in every region of the state; (4) staff qualifications, training, caseloads, and supervision; (5) placement and supervision of children; (6) planning for children; (7) the adoption process; (8) foster parent recruitment, retention, and approval; (9) the statewide information system; (10) quality assurance; (11) supervision of contract agencies; (12) financial development; and (13) outcome and performance measures.

These Settlement Agreement categories provided a reasonably coherent way of grouping and understanding the interrelationship of the 141 separate requirements that the Department agreed to meet and were detailed in the Agreement. For purposes of this case study, the requirements have been reframed to emphasize six areas of work that were particularly important to Tennessee's reform trajectory:

- Ensuring a trained and supported workforce;
- Creating an appropriate array of high quality placements and placement supports;
- Achieving stability, permanency, and child well-being;
- Obtaining additional funding for child welfare services through "needs assessment" dollars and maximizing federal funding opportunities to better serve children;[27]
- Improving data management; and
- Developing quality assurance capacity.[28]

The *Brian A. Settlement Agreement* required that DCS devote significant resources to **expanding, hiring, training, and supporting its workforce.** DCS agreed to develop pre-service and an in-service training program for case managers and specific training and competency requirements for case manager supervisors. The Department simultaneously had to examine and improve aspects of workforce development like salary, training incentives, and caseloads. The Department was required to establish a training unit with "sufficient staffing, budget funds, and other resources to ensure that it can provide comprehensive child welfare training so that all persons responsible for children in the plaintiff class will have sufficient training to permit them to comply with the relevant mandates of this Settlement Agreement, DCS

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[24] The *Brian A.* practice principles included: all children should have the opportunity to grow up in a safe, nurturing family; the state should make reasonable efforts to avoid foster care placement by providing services to the biological family whenever reasonably possible; family ties should be nurtured and children should be placed with relatives and siblings when possible; foster care should be as temporary as possible, aimed at providing a permanent home for the child as quickly as possible; the state has primary responsibility for the care and protection of children in foster care and private providers providing care must do so according to standards set by and monitored by the state; all children in need of child welfare services should receive full and equal access to the best available services, regardless of race, religion, ethnicity, or disabilities; children in foster care shall be placed in accordance with their individual needs, as close to home and community as possible, in the least restrictive, most family-setting possible; children shall have stable placements and services to address both the trauma of foster care and the problems surrounding their removal from their family; and children in foster care shall have timely decision-making and implementation about where and whom they will spend their childhood.

[25] The focus was on ensuring that improvements in policies, procedures, and practices were uniformly applied across the state.

[26] While the Settlement Agreement specifically covered reporting and responding to incidents of abuse and neglect of children while in foster care, the Department's reform efforts also included improvements in the pre-custodial child abuse reporting and investigation process, and related data monitoring.

[27] There are other major areas of concern reflected in the *Brian A.* litigation. For instance, the Settlement Agreement required the Department to undertake a review of the policies and procedures surrounding the use of psychotropic medications, as well as the forms and use of restraint and seclusion/isolation of children in the plaintiff class. (Sections VI.F and VI.G) Also, as discussed later, the Settlement Agreement required the Department to hire an independent expert jointly agreed to by the parties to evaluate the Tennessee foster care system to assess for racial disparities in treatment and outcomes of African American children and to make recommendations for change that the Department would implement. (Section XI.6)

[28] There are other ways to organize the provisions of the Settlement Agreement that can be helpful understanding and evaluating performance related to the different kinds of requirements. For example, for purposes of post-exit external accountability center reporting, Chapin Hall has reframed the Settlement Agreement provisions using four categories: (1) outcomes; (2) processes; (3) quality of care; and (4) capacity.

policy, and reasonable professional standards."[29]

The Settlement Agreement further sought to **transform the patterns of placement of children in foster care**—moving to a system where the vast majority of children placed would be in family homes close to the communities in which they had lived and the parents with whom the state would work toward reunification. This would require a major shift and improvement in the relationship between DCS and the state's private providers. The Settlement Agreement set several conditions for Tennessee's use of congregate care, for example, prohibiting DCS from placing children in emergency or temporary facilities for more than 30 days and in more than one emergency or temporary facility over any 12-month period. Furthermore, a caseworker could only place a child in a congregate care facility with eight or more beds if they first obtained approval of the relevant Regional Administrator. DCS was also prevented from using correctional or detention settings for children who had not been charged with delinquency offenses or placing children under six years old in a congregate care setting. In addition to these strict prohibitions, the Settlement Agreement required DCS to place children in the least restrictive setting—one that was as close to home and school as possible, with their siblings when appropriate, and with family members whenever possible. To ensure that contract provisions, including financial incentives, were aligned with this practice shift, DCS was required, in collaboration with the TAC and other experts, to review the delivery of services and payment structure of continuum contracts with private providers, some of whom ran congregate care facilities.[30] Meeting these placement requirements would require radically changing how DCS interacted and partnered with private providers.

As part of its efforts to **promote permanency planning,** the Settlement Agreement required DCS to create and maintain a statewide, regional, and local program of adoptive and foster parent recruitment and training, using nationally accepted standards for approval of foster and adoptive parents.[31] It also included specific outcomes and process requirements to ensure timely adoption for those children who needed to achieve permanency through adoption.

The Settlement Agreement also required that DCS improve the quality of its data. Further, the Department had to develop and implement a **statewide quality assurance program, in consultation with and subject to the approval of the TAC.**[32] Importantly, the Agreement also required DCS to conduct **annual needs assessments** under the supervision of experts designated by the TAC in the first two years and by the TAC thereafter.[33] Finally, the Settlement Agreement mandated that DCS develop and implement policies and procedures by which the state could **maximize federal funding** for child welfare services.

Each of the 141 requirements of the Settlement Agreement was reasonably responsive to weaknesses in Tennessee's child welfare system and seemed feasible to the negotiating team. The provisions themselves, however, did not create a clear path to implementing the many changes that those provisions required. The early challenge for the Department was creating the infrastructure to support the requirements and figuring out how to prioritize and sequence the resources and actions necessary to transform the system.

SECTION II.

Beginning the work: diagnosing problems, enlisting allies, weathering early struggles, and celebrating successes (2001-2004)

Notwithstanding "start-up" challenges, during the first year and a half after the entry of the Settlement

[29] See Section V.E of the Settlement Agreement.

[30] See Section VI.L of the Settlement Agreement.

[31] See Section IX.C of the Settlement Agreement.

[32] See Sections XI.A and XI.E of the Settlement Agreement.

[33] See Section VI.A of the Settlement Agreement.

Agreement the Department took some significant steps towards implementing key elements of the Settlement Agreement.[34] Leadership made key infrastructure investments, including:

- Increasing the Department's legal staff from 11 attorneys[35] to 66 attorneys, including at least one attorney in each region with expertise in education law;
- Hiring educational specialists for each region to help with educational planning for children in foster care and serve as liaisons to local school systems to ensure that those children were being appropriately served;
- Completing a salary comparability study which provided the basis for raising case manager salaries;[36] and
- Hiring for newly created positions of a Director of Compliance, Medical Director, and Quality Assurance Director.

The newly hired educational specialists played a key role in the Department's success in closing many in-house schools attached to congregate care facilities. Working with local school districts, they were able to ensure that the vast majority of children in foster care would be served by public school systems.[37]

The Department also began to innovate with casework models, including piloting the use of family team conferencing by implementing the "Family to Family" (F2F)[38] team conferencing model in three counties. It would take multiple efforts over many years to fully embed team conferencing into quality case practice; however, these pilots informed development of the Department's Child and Family Team (CFT) process and case practice model, discussed in depth later in this document.

Among the most important actions taken by the Department shortly after the entry of the Settlement Agreement was the closing of Tennessee Preparatory School (TPS). The Tennessee Preparatory School (originally called the Tennessee Industrial School when it was founded as an orphanage in 1886) was a large residential institution located in Nashville funded by the state legislature and available to juvenile court judges around the state as a placement option for children and youth. At the time that the lawsuit was settled, TPS housed more than 250 class members. It had the support of important elected officials, many juvenile court judges, and a small but influential alumni group (a number of whom had served in the state legislature). There was significant opposition to its closing, both publicly and behind closed doors. The conventional wisdom was that the children placed at TPS, often far from their families and home communities, simply had no other viable options for placement.

The commitment in the Settlement Agreement to limit the use of congregate care settings and expand the use of family placements was controversial. During the July 20, 2001 Fairness Hearing, the only expressions of concern about the *Brian A. Settlement Agreement* came from private providers, many of whom operated congregate care facilities serving children in the class. They feared (correctly) that under the Settlement, the types of children that they were used to serving would no longer be placed in group settings, but would instead be served in foster homes.[39] Some DCS officials believed that Tennessee had to demonstrate quickly to private providers that the Department was committed to

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[34] Commissioner Hattaway retired less than a year after the Settlement Agreement was entered and Dr. Page Walley, a psychologist by training who, as a member of the state legislature, had been supportive of the Department, was appointed as the new Commissioner.

[35] These 11 attorneys were theoretically responsible for representing the Department and its case managers in the 95 counties, each with its own juvenile court (or courts). The reality was that case managers were regularly appearing in juvenile court and prosecuting petitions on their own (and thus practicing law without a license).

[36] Case manager salaries were raised in three stages over three consecutive budget years beginning with the 2003-04 budget with base starting salaries rising from $22,000 to $29,000 over that three-year period.

[37] *Id.* at 1-2. The Settlement Agreement required that children in DCS custody receive "access to a reasonable and appropriate education" and that they be placed "in community schools whenever possible." See Section VI.E.

[38] Family to Family was an initiative of The Annie E. Casey Foundation to improve child welfare systems. The initiative sought to expand family and community involvement in child protection and introduced and pioneered innovative models of team decision-making.

[39] See Transcript of July 20, 2001 Fairness Hearing of *Brian A. v. Sundquist* at 19.

reducing the use of congregate care and that they could not do that unless they moved quickly to close TPS, the largest state-operated congregate care facility serving neglected and abused children.

Closing TPS helped dispel the myth that children were in congregate care because family alternatives were not available or appropriate or because the children themselves preferred TPS to other options. The fact was, in most cases, DCS had not actively involved the child or family in the search for placement options, or had rejected those options arbitrarily, or made decisions based on dubious screening criteria.[40]

Closing TPS was critical to the Department's credibility as it sought to enlist the private provider community in helping DCS ensure that most children in foster care could be appropriately served in foster homes. DCS needed providers who understood that they would need to limit their use of congregate care and support targeted foster homes, kinship homes, and community services capable of serving children in DCS custody if they wanted to continue to contract with DCS. There were a few influential private providers in the State that were already moving in the direction of serving children in family homes and close to their communities. Many others, however, were still heavily invested in serving children in congregate care and remained skeptical. Closing TPS clearly signaled that the Department was committed to "walking the walk" and opened the way for new partnerships with those private providers willing to be the champions of change and allowed DCS to credibly require others to follow along or stop doing business with them.

At the same time as placing fewer children in congregate care settings, DCS needed to expand the array of family-based resources through improved recruitment, support, and retention of foster families; expanded use of kinship resources; and promotion of community-based care for higher needs children through the continuum contracts with private providers. Effective foster family recruitment required intensive work over several years with regional staff and regional stakeholders to develop and implement targeted recruitment and support plans.

> **"In the work to close TPS, except for about 30 of the 250 children placed there, it was not that difficult to find suitable homes. We looked at who the children were visiting on weekends, made phone calls, and it turned out that finding home placements was not a problem. The majority of the kids at TPS had existing relationships and connections to family members who wanted them."**
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> **—Elizabeth Black, former DCS Administrator**

Notwithstanding these noteworthy accomplishments, there was a general sense that change in other areas covered by the Settlement Agreement was moving too slowly.[41] Tennessee's early experience mirrors other states that have been involved in wide-ranging reform efforts: there is an urgent need to begin to show staff, partners, and critics that change is happening, *and* a growing understanding of the many layers of work that need to happen before results can be seen.

The slow pace of reform in the beginning was exacerbated by a disruption in leadership and a loss of focus that accompanied a change in gubernatorial administrations in January 2003, just 18 months into the reform. Additional factors identified by those actively involved in the early years of the reform as impeding progress included:

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[40] The Department used the Child and Family Team process as the key mechanism for finding alternative placements for the 250 children at TPS. With active involvement and team meeting facilitation by central office staff, children, and families were provided the opportunity to identify other placement options (including returning home). The Department made a commitment to explore any alternative placement that the child preferred to TPS. By the time the process was complete, all but a handful of the 250 children had been either returned home, placed with relatives or members of the child's informal support system, or placed in foster homes (some with former TPS staff members with whom they had developed relationships).

[41] Adding to the pressure, in 2002, the Department failed to obtain substantial conformity to any of the federally identified safety, permanency, and well-being outcomes and seven areas of system infrastructure and performance assessed through the federal government's Child and Family Services Review (CFSR) to measure and promote compliance with federal law. A state that does not meet CFSR standards is required by the federal government to develop a Program Improvement Plan (PIP), and Tennessee incorporated some *Brian A.* requirements into its PIP.

- **There was a continuing struggle between the differing philosophies of child welfare and juvenile corrections,** and between the "old guard" and the "new guard" for control of the culture within the newly created DCS.
- **Department leaders and frontline staff lacked a shared understanding and a clear path to achieve the ambitious goals of the reform.** As a result, the Department initially tried to focus on meeting specific individual requirements of the Settlement Agreement without a vision for how the requirements would be integrated into a coherent strategic plan for overall system improvement. These early efforts often ended up being disjointed, sometimes conflicting, and largely ineffective.
- **There was too much focus on the DCS central office driving the reform without engaging the regions and allowing them to take ownership.** Regional staff felt that they were constantly doing things to serve the DCS central office or the Court Monitor, without getting anything in return and while many of their pressing needs were being ignored.
- **Between the approval of the Settlement Agreement in July 2001 and November of 2003, the Department was led by five different Commissioners and Acting Commissioners,** creating organizational instability and contributing to the challenges of mounting a comprehensive reform agenda.[42]
- **Many private providers felt disconnected from the Department** and even those that were ready to be a partner in the reforms found it difficult to productively engage in planning and implementation, particularly after the change in administration in 2002.
- **There was dissatisfaction with the Court Monitor's approach to compliance monitoring** and confusion between the role of the Court Monitor and the parallel accountability functions of the Technical Assistance Committee (TAC).

> **"In the early stages of reform, the changes most likely to be accomplished are those that can be accomplished by order (hire more staff, close an institution), while those that require improvements in quality or changes in understanding are virtually certain to take longer. In this context, closing TPS may have been important not just because it said 'we really mean to reduce congregate care' but also to say more broadly 'we will really change the system as a whole, even if you can't yet see all the other changes.'"**
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> **—Steve Cohen, Member *Brian A.* Technical Assistance Committee**

In November of 2003, the Court Monitor submitted a report finding that Tennessee had failed to comply with the majority of the Settlement Agreement provisions. Sixteen days later, class counsel filed a contempt motion in the District Court. Two days prior to the filing, the Governor had removed the current DCS Commissioner and designated the commissioner of another department to simultaneously serve as Acting Commissioner of DCS. The Court scheduled a hearing on the contempt motion for early January 2004, providing strong impetus for the efforts by the Governor and the state to negotiate further with plaintiffs to avoid a showdown in court and a finding of contempt that might invite a more intrusive level of court oversight.

After the monitoring report was released, and while the parties negotiated to resolve the contempt motion, two other reports were released that highlighted the Department's challenges. The first report, issued by Dr. Ruth McRoy (the expert hired to conduct a racial disparity study required by the Settlement Agreement), found that—among other disparities—African American children typically remained in foster care twice as long as white

[42] See Appendix B for a timeline that includes the tenure of each of the commissioners who led the department during the reform.

children.[43] *Brian A.* was one of the first lawsuits to explicitly call out racial disparities in treatment and outcomes for children and youth in child welfare and Dr. McRoy's work confirmed the extent of the disparity issues and made recommendations for change that the Department was to implement.[44]

The second, a status report issued by the TAC, which had been working with the Department leaders in parallel with the Court Monitor,[45] observed that "in a number of areas the Department has worked consistently, conscientiously, and constructively with the TAC on specific tasks and made significant progress."[46] The TAC emphasized, however, that in many areas, the Department had "not made the kind of progress in implementing reforms that might reasonably have been expected over a two-year period."[47] Highlighting the key finding and recommendation of the initial needs assessment (required by the Settlement Agreement),[48] the TAC pointed to the failure to adopt and implement a new practice model as a key obstacle. The Department had hired consultants with whom they worked to develop a case practice model and practice standards that reflected the new practice model and the TAC had reviewed and endorsed both the practice model and the standards.

"Child and Family Teams (CFTs) are now a core part of the practice model but, at the time, there was internal debate about particular initiatives. There were different constituencies with different positions about what types of processes and meetings should be used to carry out the work. These differences were immobilizing to the system. We were caught in the quagmire of who had the authority to make the decision. Once there was a leader to say, 'This is the DCS practice model,' then the system shifted from 'What do we do?' to 'How are we going to implement this?'"

—Elizabeth Black, former DCS Administrator

The TAC believed that moving forward with the new practice model would provide much-needed coherence to the overall reform.[49] A change in Governors, however, brought in new Departmental leadership that did not fully appreciate the importance of this work.

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[43] Dr. McRoy also concluded that black children were less likely to have "permanency plans" and significantly less likely to receive necessary services. See Bonna de la Cruz, "Black Kids Fare Worse in Foster Care," THE TENNESSEAN (Dec. 3, 2003). The Department has since that time commissioned two further studies of race disparity, both conducted by Chapin Hall. The results of the first of those studies are reported in Fred Wulczyn et al., *Entry and Exit Disparities in the Tennessee Foster Care System,* Chapin Hall Disc. Paper (Dec. 2006), which was included as an appendix to the January 2007 TAC Monitoring Report. The results of the second study were reported as part of the December 2019 Report of the External Accountability Center.

[44] Five recommendations related to foster home recruitment and support, with special emphasis on expanding kinship placements and providing financial services and supports to relative caregivers; three related to strategies for building a diverse and culturally competent workforce; one related to developing the capacity to use data to identify, understand, and respond to racial disparity; and one required the Department to explore whether DCS staff engaged in or supported practices which divert dependent and neglected African American children into the juvenile justice system, and address any such practices. By November 2010, the Department had sufficiently implemented those recommendations to support that provision being designated "maintenance" in the Modified Settlement Agreement and Exit Plan approved and entered by the Court on November 10, 2010.

[45] Status Report of the Technical Assistance Committee in the Case of *Brian A. v. Sundquist* to the Parties and the Monitor (Dec. 10, 2003).

[46] *Id.* at 1. Among these areas cited by the TAC were closing the Tennessee Preparatory School, moving from in-house schools to public schools, and beginning the development of performance-based contracting.

[47] *Id.* at 2. Among the areas the TAC identified as falling short of expected progress were: "[d]evelopment and implementation of a new practice model; effective use of additional state funds to develop the resources needed to assist children and families; staff training and supervision; foster and adoptive parent recruitment and retention; quality assurance; and the development of a substantially improved management information system." The TAC went on to say that "[i]n some of these areas, there has been little meaningful consultation to date; in others, there has been periodic consultation, but not the sustained effort required to develop and implement a plan for change; and in still others, the TAC has made recommendations that have not yet been implemented, even when the implementation is required by the Settlement Agreement."

[48] Tennessee Department of Children's Services Needs Assessment prepared for the *Brian A. Settlement Agreement* Technical Assistance Committee by Shared Goals LLC and Metis Associates, Inc., July 1, 2002.

[49] The Settlement Agreement itself had not contemplated a practice model, but its absence presented perhaps the biggest obstacle to progress in the early years of *Brian A.* No collective vision of the work existed among DCS staff, including top administrators. There was no common understanding of what they were trying to accomplish and what core practices they needed to focus to achieve the end results. This lack of a coherent vision extended beyond DCS to key stakeholders including the juvenile courts, private providers, and foster parents as well as parents and youth served by the system.

The TAC highlighted the Department's failure to implement the new casework practice model, even though a proposed practice model had been sitting on the Commissioner's desk since January 2003. The TAC report also identified the failure to properly train frontline staff, the unwillingness of the Department to properly use available state funds, the lack of quality assurance mechanisms, and the delays in developing a robust data management system. The

> **"Before the lawsuit, when I was a caseworker and then a supervisor in the Department, I never had a clear direction for the Department's work. We didn't have a clear direction, and we were just trying to do good social work. The lawsuit, the new leadership, and the case practice model gave us that direction."**
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> **—Sheri Lawson, DCS Deputy Commissioner for Child Programs**

TAC acknowledged that the Settlement Agreement provision to create a separate monitor and technical assistance committee with distinct but related roles and responsibilities had created additional confusion and some uncertainty as to which entity the Department leadership should look for guidance. In its report, the TAC pointed out that coordinating efforts between itself and the court monitor "each with independent, court-enforceable responsibilities, has been a complicating factor in the effort to reform Tennessee's child welfare system."[50]

Shortly before the contempt motion was scheduled to be heard, the parties—with the assistance of John Mattingly, a mediator in whom all parties had great confidence (and who had assisted in the negotiation of the original Settlement Agreement)—agreed to a new timeline and modifications to the Agreement to get the reform effort back on track. As part of the response to the contempt motion, Governor Philip Bredesen hired Viola Miller as the new DCS Commissioner, and brought her directly into the negotiations even before she officially assumed her role. In contrast to her immediate predecessor's reluctance to engage with class counsel, Miller adopted a direct, open, and candid posture with Children's Rights, working to gain their trust as a partner toward common goals. Like many leaders of state agencies under federal oversight, the new Commissioner saw the opportunities inherent in the Settlement Agreement: *Brian A.* offered her Department tools and support needed for systems change.[51] Commissioner Miller and her leadership team immediately embraced the proposed practice model and became champions for implementing it.[52]

SECTION III.

Gaining momentum: the challenges of setting priorities and demonstrating progress (2004-2010)

In the six-year period following the resolution of the contempt proceeding, Tennessee made meaningful improvements to its child welfare system through a range of important structural, cultural, and practice changes. The Stipulation of Settlement of Contempt Motion on December 29, 2003 gave the Department the responsibility for developing (in consultation with plaintiffs and with approval by the TAC) an implementation plan through which the Department would incorporate and sequence the various requirements of the Settlement Agreement in ways that made sense to the Department's leadership. Under the stipulation, the TAC, in addition to its original role, assumed the monitoring responsibilities. The stipulation required the TAC to monitor and report on the state's performance under its implementation plan and under the original agreement for a 26-month period beginning

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[50] *Op cit.* Status Report of the Technical Assistance Committee in the Case of *Brian A. v. Sundquist* to the Parties and the Monitor (Dec. 10, 2003) at 8.

[51] Commissioner Viola Miller was not the only one who perceived the value of building trust with the plaintiffs' counsel. Commissioner Hattaway, who had negotiated the Settlement and who retired shortly after the Settlement Agreement took effect, took the unusual step of periodically insisting on having dinner with the plaintiffs' counsel unaccompanied by any of his staff or, to the consternation of the Attorney General, without the presence of his lawyers.

[52] *TDCS Standards of Professional Practice for Serving Children and Families,* officially adopted in November 2003.

January 1, 2004.[53] The TAC agreed to these additional responsibilities with the understanding that it would have some flexibility to determine how best to carry them out.[54] This flexibility was especially important given the inevitable tension between the prescriptive nature of a Settlement Agreement and the Department's need for some latitude in designing and carrying out reform strategies.

The TAC's assumption of both the monitoring and technical assistance roles removed some of the confusion and duplication of functions between the TAC and the court monitor. The TAC also brought a different approach to monitoring, seeking as much as possible to align the monitoring with the Department's own management needs, and minimizing the extent to which the Department's time and energy was devoted to tasks that, while arguably relevant to a Settlement Agreement provision, would not otherwise make sense to prioritize. The TAC sought to provide sufficient monitoring and reporting to inform the parties and the Court about the progress being made and the work yet to be done, but did not report every time on every provision. Finally, the TAC spent much of its time focusing on improving communication between the parties and rebuilding trust.

The Stipulation gave the Department, in consultation with the TAC, the responsibility to develop its own implementation plan. The TAC used its authority to give the Department the time and space it needed to develop that plan and to prioritize and sequence its actions in ways that recognized that meeting some Settlement Agreement provisions needed to take precedence over others and provided greater flexibility in defining and meeting requirements. The question of how to best sequence and prioritize actions in a reform as comprehensive as that envisioned by *Brian A.* remained a key issue throughout the years of the Department's work.

In August 2004, the Court approved the state's implementation plan, The *Path to Excellence,* which laid out the steps that DCS would take over several years to implement the requirements of *Brian A.* Importantly, over the next six years, the implementation plan was supplemented and modified periodically to reflect achievements and make mid-course corrections.

> **"One of the constant challenges in reforming a system in the context of litigation is the balance that has to be struck between urgency and the time needed for change to take hold. Balance also has to be achieved between the need to reassure plaintiffs and the Court on progress while minimizing interference with and burdens on state agency leadership and staff."**
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> **—Judith Meltzer, TAC Member, Center for the Study of Social Policy**

The TAC's authority to comment on and approve the state's implementation plans was seen by plaintiffs as a key accountability mechanism. Some found this role unnecessarily intrusive and as undermining of the Department's expertise and authority. The TAC members understood that external monitoring of any kind is intrusive and, even when done well is experienced by agency leaders as an obstacle.

Even those Department leaders who agreed the TAC's monitoring role was essential acknowledged that program staff in the Department had reason to be skeptical of the role of those external to the Department. DCS leaders and program staff committed to the reform also found it difficult to implement policies that would simultaneously satisfy

[53] The Stipulation of Settlement of Contempt Motion extended Period II by 15 months, to November 30, 2005. A Stipulation extending monitoring was entered on February 28, 2006, extending the TAC's monitoring role and responsibilities through August 31, 2007. Further stipulations extending monitoring were entered on May 8, 2007, extending the TAC's monitoring role and responsibilities through September 30, 2008, on October 1, 2008, extending the TAC's role through June 30, 2010, and on June 29, 2010, extending the TAC's role through December 31, 2010.

[54] Under the new stipulation, the TAC now had three primary functions under the Settlement Agreement: (1) to serve as a resource to the Department in the development and implementation of its reform effort, (2) to monitor and report on the Department's progress in implementing the plan, and (3) to mediate and resolve disputes between the parties. See Sections XIV, XV, and XVIII of the Settlement Agreement.

"You learn you can't do it alone—you have to buy in to your team and trust they are speaking with your voice. There are so many things that a commissioner doesn't know, you have to trust other people. If Regional Administrators and staff could understand and know the directions and changes in culture being pursued by the Commissioner, then they could engage in a parallel process that filtered down to the workers and families."

—Viola Miller, DCS Commissioner (2004-2011)

various *Brian A.* benchmarks.[55]

The responsibility for the implementation planning required by the Stipulation fell to a DCS Commissioner and leadership team that were as impatient as the plaintiffs to achieve meaningful change. They were open to acknowledging the problems and barriers to progress and willing to engage others outside the Department to promote change. The leadership team was willing to examine their assumptions, worked to establish a productive partnership with the private sector, and welcomed outside technical assistance as well as the opportunity to work collaboratively with the TAC and plaintiffs.

Particularly important was the parallel development of regional implementation plans, which recognized the centrality of the regional role and, over the long term, made it possible for regional staff to buy into the practice model and own the reform.

"Once we got past explaining *Brian A.* to everyone, the key moment was when change wasn't about *Brian A.*, it was about what good practice looks like."

—John Mattingly, Former Director, Family to Family, The Annie E. Casey Foundation and *Brian A.* mediator

Starting in 2004, despite the remaining significant challenges, Tennessee began to make sustained gains across various *Brian A.* practice areas. By 2010, DCS saw real benefits from the infusion of new resources that began with the settlement of *Brian A.* and continued through the course of the reform. Tennessee had made significant improvements in the infrastructure necessary to support good child welfare practice.

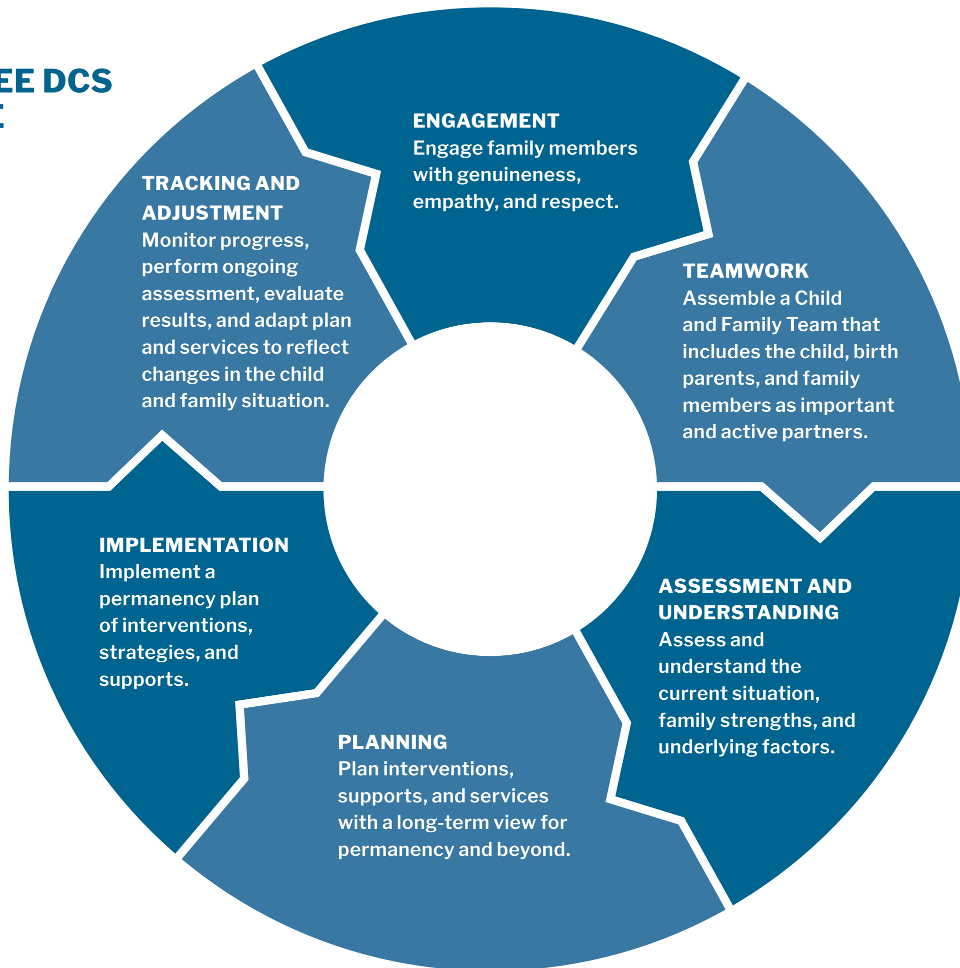
Implementing the DCS Practice Model

By 2010, Tennessee had adopted a core set of policies and procedures for working with children and families that were consistent with their practice model. These guidelines emphasized engagement of the family, thorough assessment of a family's unique strengths and needs, and the centralized role of the family and youth in case planning and decision-making processes. At the center of the practice model was the Child and Family Team (CFT) process built around six core activities (often referred to as the "Practice Wheel"): engagement of the family; formation with the family of a well-constituted child and family team; assessment of the family strengths and needs; development of a case plan that builds upon those strengths and responds to those needs; plan implementation; tracking implementation progress; and adjustment to ensure that the goals of the plan are being met. The Department believed that a focus on improving these six core activities, if done well and consistently over time, would lead to improvement in all of the many benchmarks set out in the Settlement Agreement; and, conversely, that if the Department were unable to improve these core activities, it was unlikely to be able to achieve the Settlement Agreement goals by other means.

The Department's efforts to develop and implement a family team conferencing model in pilot sites began during Commissioner Hattaway's tenure and the Child and Family Team (CFT) process was

[55] When the TAC took over the monitoring responsibilities (including the supervision of the monitoring staff employed by the previous court monitor), the Commissioner hired the lead staff person of the previous monitor to be Director of Quality Assurance for the Department. Two other members of the prior monitor's staff were subsequently hired to work with her. Thanks in part to this movement of staff, the TAC and the QA team were able to develop a very productive working relationship, with the TAC trusting the information it was given by the Department and the Department appreciating how the TAC's work could contribute to its own interest in quality improvement. Within a relatively short period of time, the TAC staff and DCS QA staff were collaborating on projects that both supported the Department's management of the reform and informed the TAC's monitoring.

TENNESSEE DCS PRACTICE WHEEL



fully articulated in the practice standards adopted in 2003. It was under Commissioner Viola Miller that the Department leadership took multiple steps to clearly establish the CFT process as the centerpiece of case planning and decision-making. The CFT process was the case practice foundation for moving all cases forward and to achieving the desired outcomes for children and families served by the Department. Embedding the CFT process firmly into DCS casework practice required simultaneous actions around messaging, training, coaching, supervision, financing, data management, and quality assurance. It also required better assessment of the underlying needs of children and their families, and the ability of workers and providers to use assessments to drive case planning and monitor case progress. The Department therefore replaced the multiple assessment tools (that at one time included eight separate and overlapping assessments) with a single protocol, the Child and Adolescent Needs and Strengths Assessment (CANS).[56]

Other critical changes were essential to ensure that the CFT process was effective, especially developing readily accessible and flexible funding pools for individualized services planning; streamlining the placement process to minimize trauma experienced by children at risk of entering care; and reducing caseload sizes so that workers could provide the enhanced casework services required.

Investing in training and staff development

Communicating and implementing the new practice model required a significant training investment. Initially, training drew heavily on advice and resources made available through the TAC, including training

[56] Originally developed to help support evidence-based decision making related to psychiatric services, CANS has been adapted for use by many child welfare and juvenile justice systems. CANS is designed to help case managers and others gather and analyze relevant information on the strengths and needs of children and their families and is particularly well suited to systems that utilize a child and family team conferencing model for case assessment, planning, and placement decisions. A detailed description and discussion of the most recent refinements to the CANS used in Tennessee can be accessed online at: https://files.dcs.tn.gov/policies/chap11/CANS2.0.pdf

on child and family team meetings and on using Quality Services Reviews (QSRs) to provide feedback on practice and outcomes. In August 2004, the Department formed a partnership with a consortium of colleges and universities, led by the Tennessee Center for Child Welfare established at Middle Tennessee State University (MTSU). Through this creative partnership, the Department was able to leverage federal Title IV-E training dollars and existing higher education infrastructure to support a wide range of training improvements.

By 2010, working in collaboration with the MTSU training center, the Department's training curricula had been thoroughly revised, and the training consortium of colleges and universities across the state expanded the breadth and depth of resources available to support both pre- and in-service training for staff and foster parents, as well as ongoing professional development. Beginning in 2005, a number of those colleges and universities in the consortium had, in collaboration with the Department, established a child welfare specialization BSW program, supported by a stipend for those who agreed to work for DCS for at least two years upon graduation.

Reducing caseloads and creating a stable workforce

Between 2004 and 2010, the Department addressed two critical barriers to maintaining a well-qualified workforce: the historically low pay of DCS case managers relative to comparable positions in the public and private sector, and the historically high caseloads that precluded case managers from being able to provide the level of attention that children and families need and deserve. The Department substantially increased its starting salaries for every class of case manager position and dramatically decreased foster care case manager caseloads. Over a three year period beginning in 2003, salaries for case managers and supervisors were raised to competitive levels for the region, and across the board pay raises for state employees increased salaries further over the next three years. The workforce size was increased, and caseloads that prior to the entry of the Settlement Agreement routinely exceeded 40 cases were limited to no more than 20 and were often lower. By 2010, 90% of DCS case managers at any given time had caseloads that were within the Settlement Agreement's caseload limits.[57] It is hard to imagine the state making this very substantial additional investment in child welfare, absent the prescriptive demands of the Settlement Agreement.

> **"To move from good intentions to reform, a child welfare system needs a well-trained, supported, and resourced workforce with reasonable caseloads. Workers need a safe environment where risk-taking is supported and rewarded. A big part of fixing the workforce is taking away excuses. Fix the salary, fix the caseloads, and fix the physical facilities. Make sure workers get travel reimbursements paid timely. Treat staff like professionals and create an environment in which they can respond to situations like professionals. Social workers are dedicated and if we give them what they need to do the job, they will."**
>
> **—Viola Miller, DCS Commissioner (2004-2011)**

Implementing Performance Based Contracting (PBC) and changing the relationship with private providers

The state and its private providers[58] with assistance from both Chapin Hall and the TAC worked to implement performance-based contracting (PBC) with incentives built-in for improved outcomes.

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[57] At the beginning of the lawsuit, caseloads of over 40 children were not unusual. By 2010, *Brian A.* caseload standards were met and then generally sustained. In 2017, between 92 and 96% of caseworkers had caseloads within standards set by *Brian A.* of between 15 and 20 cases; and in June 2017, for example, 92% of children had two or more monthly visits with a case manager. See Tennessee Accountability Center Report 1, The Center for State Child Welfare Data, Chapin Hall, December 2017.

[58] The Department benefited greatly from the commitment of several of the largest and most respected providers who embraced the concept of PBC and welcomed the opportunity to be actively involved in the development of the PBC approach.

The TAC completed a study of the continuum contracts and in March 2003 made recommendations to ensure that those contracts were aligned with the shift away from congregate care and structured to identify and reward performance consistent with the state's priorities and outcomes. The Department also worked closely with Chapin Hall to help regional and central office staff use existing data to understand the performance of contract providers. Continuum and performance-based contracts became the norm and, increasingly, DCS and providers understood and experienced their relationships as partners working toward the shared goals of decreasing use of congregate care, increasing supports for family placements, and improving placement stability and permanency.

The Department also began to work with the private providers to enhance contract oversight to provide the Department feedback on provider performance in areas beyond those covered by PBC. The Department had a long standing annual "Provider Accountability Review" process to monitor compliance with basic contract provisions. In consultation with the TAC, DCS introduced the "Provider Scorecard" as a vehicle for highlighting areas not covered by PBC and helping providers understand how they were performing, both relative to their prior performance and to the performance of other providers. The scorecard was used not to penalize providers but instead to provide a basis for conversations about how to understand and improve their performance. This work ultimately led to an improved "Provider Accountability Review" that served not simply to ensure compliance with basic contract provisions but, most importantly, as a support for quality improvement.[59]

> **"Just telling someone to do something won't change anything; the private providers needed to change the way they thought about keeping kids in the home and not facilities even if there were some risks. During this period, Tennessee had great leadership who worked with providers and put systems in place to hold providers accountable through performance based contracting."**
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> **—Pat Lawler, Chief Executive Officer, Youth Villages**

Improving data quality and capacity

The Department also had moved over that six year period from an organization that had been largely unable to produce basic data about the children in its custody to one that was increasingly data driven. With the assistance and expertise of Chapin Hall, the Department had incrementally built the capacity of its TNKids data system to provide a wealth of data that it had not originally been designed to produce.[60] At the same time, DCS anticipated implementing a new SACWIS[61] system, the Tennessee Family and Child Tracking System (TFACTS), which would utilize the advances in web-based technology and could be designed to better support Tennessee's new practice model.

The Department began using its increased data capacity to build the evidence needed to understand its performance, develop improvement strategies and set goals, and then track progress toward achieving those goals—both the Settlement Agreement performance measures and others that the Department had established for its own management purposes. The Department created a quality improvement structure, at the state level and

[59] The Department could adopt this more collaborative and problem-solving approach to contract monitoring because the provider community was generally quite strong, especially in areas affecting health and safety. Nevertheless, when significant health or safety concerns were identified, or when a particular provider proved unable or unwilling to address a significant issue, the Department retained the capacity to impose appropriate corrective action including suspending admissions, closing a facility, or terminating (or not renewing) a contract with the provider.

[60] The data produced for and relied upon by the original monitor prior to 2004 had to be hand-collected from a sample of case files, an extremely laborious process that provided limited reliable information. In contrast, by 2010, the TAC's monitoring reports routinely contained a "Data and Outcomes and Overview" of over 50 pages that relied heavily on automated reports and data analysis generated by both the Department and Chapin Hall from data in the Department's information system.

[61] SACWIS is an acronym for State Automated Child Welfare Information System.

within each of its regional offices, led by an Office of Performance Quality Improvement and supported by regional staff with responsibilities to support and facilitate continuous quality improvement (CQI) efforts in the regions. The Department also adopted a well-designed Quality Service Review (QSR) process as an ongoing method for gathering information on the quality of service delivery for children and families and data on both child and family outcomes and system performance.[62]

Improving stability and permanency

The *Brian A.* lawsuit also focused attention on children who were languishing in care and on the instability of many of those same children. In their complaint, Children's Rights cited that the Department could not accurately track placement changes for children and youth and asserted that in May 2000, over 2,000 of the children who were in care at that time had experienced 10 or more foster care placements.

The evidence from the 2001 and 2010 entry cohorts shows that DCS made significant improvements in both areas. With respect to placement stability, of those children who entered foster care in 2010, 77% experienced no more than one move while in care, compared to 61% of children who entered care in 2001. And while 15% of those entering care in 2001 experienced four or more moves, only 8% of those entering care in 2010 moved four or more times.[63]

Eighty-eight percent of the children entering care in 2010 exited to adoption, reunification, or placement with relatives, compared to 81% of those who entered in 2001; and only 11% experienced non-permanent exits (aging out or running away) compared to 19% of those who entered care in 2001.[64]

> **"We developed strategies to maximize federal revenue. Without extra federal revenue, we wouldn't have been able to do what we did. Educating and getting regional staff on board with understanding their part in documenting eligibility, activities, and services was essential to getting us able to generate and maximize that revenue."**
>
> **—Doug Swisher, DCS Assistant Commissioner, Finance and Budget**

Increasing investments and shifting funding streams to better serve children

With essential support from the Governor's office and state legislature, *Brian A.* stimulated substantially increased investments in child welfare services over many years through budget enhancements, redeploying existing resources more efficiently, and creative financing strategies.[65] The lawsuit stimulated an infusion of resources to DCS but even more importantly, the Department became very skilled at using those resources to the best advantage by maximizing federal funding available through Titles IV-E and Medicaid and deploying state needs assessment funds to fill in the gaps. The commitments made by the state in the Settlement Agreement and the evidence of progress helped the Department make the case to a succession of governors and legislators to sustain and, ultimately, increase those investments over the course of the reform, despite downturns in the state's economy and budget cutting pressures.

In responding to a lawsuit that is brought on behalf of children in foster care, there is always a danger that resources shift to supporting placements and services for children in custody at the expense of other critically important functions of the child welfare system, such as abuse and neglect reporting and investigations, preventive services, and in-home

[62] The Quality Service Review (QSR) is a case-based quality review process that assesses child and family outcomes and system performance developed by Ray Foster and Ivor Groves of Human Services and Outcomes. It includes interviews with children, youth, families, staff, and providers to assess the quality of child welfare work in key domains.

[63] Chapin Hall Foster Care Data Archive

[64] Chapin Hall Foster Care Data Archive

[65] The 2002 Needs Assessment directed the state to establish and fund up to $4 million in the first year and $8 to $12 million over two years to create a "needs assessment" fund to be used flexibly to carry out its recommendations. This budget item, importantly, was preserved throughout the reform.

and community-based support services for families whose children are at risk of coming into care. However, agency leaders that understand the impact of the pre-custodial functions of a child welfare system on the custodial functions, will intentionally invest resources and supports in the front end. In the end, if the pre-custodial functions of the child welfare system are short changed, children who might have been safely served in the home will come into care, a serious concern in itself, and further undermine the improvements in services for children in custody.

Department leaders and plaintiffs' counsel recognized this potential problem and the Department included pre-custodial services and supports as part of its overall improvement plan. The Department's leadership made it clear that in doing so, they were not expanding the scope of the litigation or adding to the commitments contained in the Settlement Agreement. They readily shared information on CPS caseloads and pre-custodial processes and services and remained committed to providing financial resources to the entire Department.[66] The TAC and plaintiffs supported this decision and remained comfortable throughout with the Department's commitment to provide data to the TAC who would publicly report on CPS caseloads and practices without expanding the terms of the lawsuit.

By 2010, DCS had made and sustained measurable progress in key areas covered by the *Brian A. Settlement Agreement*.

- **Children coming into foster care were much more likely to be placed with families than in congregate care facilities,[67] less likely to be separated from their siblings,[68] and much more likely to be able to attend public schools with their peers.** The Department had achieved a high level of success in placing children unable to return to family in adoptive homes, gaining national recognition for impressive increases in the number of children for whom it had successfully found adoptive homes;[69] in eliminating the use of "long-term foster care" as a permanency goal and in placing strict limits on approval of "other planned permanent living arrangement" goals, which had previously excluded many adolescents from efforts to find them permanent families and increased the likelihood of their leaving care at age 18 without adult supports.
- **Those children who achieved permanency were achieving it more quickly than they had in the past,[70]** and the emphasis on permanency for older youth in care had reduced the number and percentage of children "aging out" of care without a permanent family.
- **Of the 11 separate Settlement Agreement outcome measures related to Reunification, Adoption Finalization, Number of Placements, Length of Time in Placement, Reentry, and Achievement Upon Discharge, the Department had met or exceeded the required percentage** for five of those measures and was within between one and four percentage points of the required percentage for the remaining six measures.

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[66] In the early years of the reform, there were legitimate concerns that the focus on complying with the Settlement Agreement would benefit children in foster care at the expense of other areas of the Department's responsibility, most notably non-custodial investigations and services and juvenile justice services and supports. In terms of policy development and information systems support, *Brian A.* related issues were often given priority, especially during the early stages of the reform. Over the course of the last decade, however, significant improvements have been made in the other areas of DCS responsibility. There is no evidence that the gains for children in foster care have been at the expense of the other children for whom the Department is responsible. Rather, a persuasive case can be made that those children have significantly benefited by many of the reforms implemented by DCS under the auspices of *Brian A*. It is, of course, possible that if children committed to state custody based on a delinquency adjudication had been the responsibility of a different Department, they might not have experienced that benefit.

[67] Of children who entered care in 2010, 87% were initially placed in family settings, compared to 67% of those entering care in 2001.

[68] By 2010 the Department was consistently placing between around 85% of siblings together.

[69] See Monitoring Reports of the *Brian A.* Technical Assistance Committee.

[70] For example, for children who entered care in 2001 and reached permanency through adoption, only 19% were adopted within two years of coming into care. For the comparable 2010 cohort, 44% of those exiting to adoption were adopted within two years. For those exiting to reunification with parents or placement with relatives, the time to permanency improved more modestly: from 61% within one year for those entering in 2001 to 63% within one year for those entering in 2010.

- **The Department had met or was within a percentage point of meeting performance targets related to** placing siblings together, limiting planned permanent living arrangements, increasing in-region placements, and had met one of the two targets for timely filing of termination of parental rights petitions.

SECTION IV.

Creating a path to exit: modifying the Settlement Agreement to reflect changing realities and a shared view of conditions for exit (2010)

By 2010, while there was general consensus that the Department's achievement was substantial and impressive, there was also an understanding of remaining requirements to be met and sustained. The State and the Plaintiffs' counsel wanted to renegotiate the Agreement to publicly acknowledge the progress made and to provide a meaningful path to exit. No state agency under federal court oversight can help but wonder what it will take and how long it will take to exit a lawsuit as complex and comprehensive as *Brian A.* The question was whether the court, the parties, and the Settlement Agreement itself could create the conditions that aligned exiting the lawsuit with substantial, sustained compliance.

Because of the relationship building and trust that had developed among Plaintiffs, DCS leadership and the TAC over the prior six years, the parties agreed to negotiate with the TAC serving as the mediator. In November 2010, the District Court approved a Modified Settlement Agreement and 2010 Exit Plan that recognized the progress that DCS had made and outlined the steps that were necessary for DCS to exit the lawsuit. The exit plan did not just require additional improvements in the operations of DCS and detailed outcomes to be achieved by Tennessee, it also required that DCS maintain compliance with each of those provisions for a 12-month period—or what the TAC referred to as the "Maintenance Year." If DCS could show that it had achieved maintenance of all of the provisions, and then sustained that achievement for a full year, DCS would exit the lawsuit and the District Court would only retain jurisdiction necessary to ensure an 18-month public reporting period that had been negotiated by the Parties as an additional support to sustainability and public accountability. The 2010 Modified Settlement Agreement and Exit Plan also recognized that some of the original provisions of the Agreement were not consistent with the Department's current views on effective child welfare practice and those provisions were appropriately changed or eliminated.

> **"At some point in a litigation driven reform effort, the momentum generated from the push of the litigation begins to lessen and it is the pull of the prospect of exit that becomes important to maintaining the agency's energy and focus."**
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> **—Andy Shookhoff, Chair, *Brian A.* Technical Assistance Committee**

In an unusual departure from child welfare consent decrees in other states, the Exit Plan authorized the TAC to determine when the Department had reached and demonstrated "maintenance" status with a Settlement Agreement provision. The Exit Plan thus established an iterative, creative process that demanded sustained engagement from and interaction among the parties and the TAC. First, the TAC issued monitoring reports with data and analysis on the Department's progress in meeting the remaining *Brian A.* requirements and sustaining those already met. Then, based on its review of the data and any additional supporting and validated information, the Department identified provisions for which it believed it had achieved maintenance status. Plaintiffs were given time to concur or object with the Department's conclusion. As a next step, the TAC mediated discussions between plaintiffs and DCS to attempt to reach agreement on provisions that had achieved maintenance status. If, at the conclusion of this process, the parties were unable to agree on which provisions warranted a maintenance designation, the Settlement Agreement gave the TAC the authority to resolve the disagreement

and a make a binding decision. Importantly while the Exit Plan gave the TAC the ultimate authority to decide whether a provision should be moved to maintenance, the TAC understood that this authority is most effective when you do not use it.

> **"Transparency and trust among the parties and the TAC were critical factors that accelerated reform and minimized enforcement litigation. The mediation role of the TAC paired with clear requirements for durability to achieve exit were game changers in the modified Agreement. That Agreement and the exit process took flexibility and risk on both sides that would likely not have occurred without a foundation of trust and transparency."**
>
> **—Ira Lustbader, Litigation Director, Children's Rights**

At this late stage in *Brian A.*, the negotiations that created this exit provision and the structure of the exit plan itself benefited immensely from the trust between the parties and the quality of the evidence provided by the TAC and its staff. It was also helpful that the exit plan gave the TAC the authority to make the decision about whether to move a provision into the maintenance category if the parties could not agree. Over the course of seven years and multiple monitoring periods, however, the TAC only used this authority on two occasions and with respect to only a handful of provisions.[71]

SECTION V.

The final stages: unanticipated setbacks, demonstrating improvements, and moving toward exit (2011-2015)

Even after the path to exit was crafted, the parties agreed that there were major hurdles to overcome to meet all of the remaining requirements, sustain those already met, and demonstrate to the Court that the lawsuit should be terminated. Among things that remained, the Department committed to improving the quality of case practice (as measured by the QSR); continuing to invest in foster family recruitment and retention (with continued emphasis on utilizing kinship resources); understanding and improving outcomes for those children who experience long stays in foster care; better supporting youth transitioning to adulthood; and implementing its new SACWIS system (TFACTS).

As it turned out, unanticipated challenges in the TFACTS implementation threatened to derail the reform. TFACTS was intended to equip case managers with better tools to manage and document their work and provide managers with better tools to track the Department's progress. The Department's leadership team, however, while highly skilled in addressing child welfare practice issues, lacked the information technology (IT) expertise necessary to manage the development of a new IT system, and was largely dependent on the expertise of the contractor that the state had selected through the procurement process to develop and implement the new system. The Department's own IT staff were well-equipped to operate and support the TNKids system, but did not have the capacity to work effectively with the contractor and the state's contract oversight turned out to be inadequate. As a result, the process for developing and implementing TFACTS lacked the strong partnership among program staff, IT staff, and external contract staff needed to ensure a smooth transition from TNKids to TFACTS.

Almost from the start, the transition from TNKids to TFACTS was plagued with problems, attributable to shortcomings of the contractor and DCS contract oversight. The Department did not immediately recognize that there were significant problems with the TFACTS design, and took even longer to develop a credible plan to identify and address those problems. The Department's shift from

[71] Most importantly, the exit plan provision set the stage for eventual exit; by the end of 2017, the TAC certified that all provisions had been met and maintained for 12 months, and the state had met the conditions for exit from court jurisdiction.

TNKids to TFACTS occurred months prior to the end of a gubernatorial administration and many of those who had been involved in the design and roll out of the new system (both the contractors and DCS staff) had maintained that the problems were transition issues. After a relatively short time, Commissioner Kate O'Day, hired in 2011, recognized that the problems were more serious and hired an IT specialist to review the system. That review confirmed that significant work and investment were needed and required both utilizing external IT expertise (especially in the short run) and building internal IT capacity.

The TFACTS' problems came under more intense public scrutiny when the Department's new leadership was unable to produce accurate data on the number of fatalities of children who had contact with the Department and there was no mechanism for ensuring that child fatality cases were receiving the required review and response (including notification of relevant legislators).[72] TFACTS' implementation problems and the Department's failed child fatality review process garnered the attention of both the public (through extensive media coverage) and the Court,[73] and ultimately exposed leadership weaknesses that led to the replacement of the Commissioner.

The Governor promptly appointed Jim Henry as DCS Commissioner in 2013. Commissioner Henry's unique qualities made him ideally suited for getting the reform back on track.[74] The Commissioner and the leadership team he assembled (composed of both new and existing staff) responded quickly to the immediate challenges. With the support of the Governor and the legislature, they added significant IT resources to address the TFACTS' problems. As important, the Commissioner implemented processes to ensure that the IT staff and field staff worked collaboratively to develop and implement TFACTS fixes and enhancements, and that the leadership team, including both program and IT directors, were actively involved in overseeing and prioritizing the TFACTS work.

Simultaneous with the work to make TFACTS fully functional, the Department worked closely with plaintiffs and the TAC to develop a child death review process that has become a model for other states. This work was prompted in part from the intense media scrutiny to child deaths, but moved forward swiftly because of the DCS leadership's interest in creating both a state and regional level process that would analyze and identify systemic issues that may have contributed to a child's death.

> **"Whether it was immediately responding to any formal enforcement request by Plaintiffs or keeping the parties publicly accountable to sustained progress through public status conferences, the federal court—and Judge Campbell specifically—played a critical role in the overall reform effort."**
>
> **—Ira Lustbader, Litigation Director, Children's Rights**

[72] As it turned out, the problems around reporting and reviewing child deaths were largely unrelated to problems with TFACTS, although the media reports and some of the discussions during several court hearings conflated the two. The TAC filed three reports with the Court that together detail the problems with TFACTS and the Department's ultimately successful response to those problems: *Report of the Brian A. Technical Assistance Committee on its Evaluation of TFACTS,* filed on April 2, 2013; an *Update on Developments Related to the TFACTS Evaluation Findings and Recommendations,* filed on September 17, 2013, and an additional *Update,* filed on June 11, 2014.

[73] Plaintiffs' counsel filed pleadings with the Court raising concerns about both the fatality reporting and the problems with TFACTS. The parties and the TAC were able to resolve the litigation through a series of agreed upon remedies approved by the Court that resulted in the implementation of a deepened fatality review process, and fixes to TFACTS.

[74] Commissioner Henry was well known and widely respected by the legislature (in which he had previously served) and by the private provider community (of which he had been a member as head of a large, innovative non-profit agency serving families and children). At the time of his appointment, Henry had been serving as commissioner of another state department that, under his leadership, was finally obtaining exit from federal court oversight. His appointment was immediately reassuring to those both inside and outside the Department. He reached out to and followed up with each constituency that had become disaffected. He took various actions to build back staff morale, including retaining, and further empowering, Bonnie Hommrich, the well-respected Deputy Commissioner who had so capably served in the two previous administrations (and who, with Henry's support and encouragement, would ultimately succeed him as Commissioner and successfully preside over the exit from court jurisdiction). Commissioner Henry's tenure as Commissioner ended when Governor Haslam appointed him to be his Deputy and Chief of Staff.

Henry also quickly reached out to the private provider community and worked with them to make needed adjustments to the Performance Based Contracting (PBC) system. Henry also understood the critical importance of engaging with the Legislature and the Governor to underscore the importance of DCF's mission and maintain their support for the work.

As the Department moved closer to exit, the parties and the TAC engaged in a series of candid discussions about how to treat a number of provisions of the Settlement Agreement. These provisions, while originally well intentioned, were no longer seen as being particularly relevant or important to the overall reform. For some of the quantitative outcome and performance measures, the original methodology for calculating compliance percentages was flawed. For others, the child welfare field had developed more meaningful measures. The guiding principles of the Settlement Agreement remained relevant, but a number of provisions, if rigidly interpreted, posed technical obstacles to exit. The parties ultimately were able to reach an accommodation that preserved the durability of the Settlement Agreement's basic principles, outcomes and commitments while building flexibility to recognize alternative approaches to measuring compliance.[75] After the TAC issued its February 2016 Monitoring Report, the parties agreed that the Department had "achieved maintenance" on all of the provisions of the Settlement Agreement.

> **"The Department outgrew the *Brian A.* lawsuit. The science grew and the Settlement Agreement didn't. At the start, they were looking at the right things, but in the end they were looking at process to the detriment of outcomes. It was, 'Did we do the process?' rather than, 'Did the process result in the desired outcomes?'"**
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> **—Britany Binkowski, DCS Special Assistant to the Commissioner**

SECTION VI.

Sustainability and exiting court jurisdiction: 2016 to 2018

On April 11, 2016, the District Court entered an order finding that as of December 31, 2015, DCS had achieved maintenance on all relevant provisions of the *Brian A. Settlement Agreement*. Under the terms of the Settlement Agreement, the Department was entitled to seek exit from all of the substantive reform requirements as of January 1, 2017, if it remained "in maintenance" on all those requirements at that time.

The parties continued to communicate throughout 2016, meeting periodically to receive updates from the TAC on the Department's performance. In addition, toward the end of 2016 and into 2017, the parties engaged in discussions with Chapin Hall to flesh out the plans for Chapin Hall to assume the responsibilities of an External Accountability Center created to provide 18 months of post-exit public reporting on the Department's performance.[76]

Following the TAC's March 2017 Monitoring Report, the parties agreed that the Department had remained "in maintenance" on all of the reform requirements for 12 months, the final durability test under the Agreement. On July 17, 2017, the District Court entered an order finding that Tennessee had achieved maintenance with all relevant provisions of the 2017 Exit Plan no later than December 31, 2015 and had sustained maintenance with those provisions throughout the full calendar year of 2016. The District Court terminated its jurisdiction over *Brian A.* and dismissed the case with prejudice

[75] The staff at Chapin Hall, led by Fred Wulczyn, played a key role in helping the parties reach agreement. From the earliest days of the reform, Chapin Hall had been providing technical assistance to the Department to help develop and use its quantitative data to understand and improve performance. Chapin Hall also worked with the TAC to design the data overview section of the monitoring reports and provided most of the quantitative data included in the TAC's monitoring reports. Chapin Hall staff helped the parties and the TAC understand the flaws and limitations in some of the measures, and proposed alternative approaches as substitutes or for additional context for determining how much weight to give to those measures.

[76] See Section XIX of the Settlement Agreement. This post-exit reporting would be conducted not by the TAC, but by the External Accountability Center housed at Chapin Hall at the University of Chicago. One of the key TAC staff transitioned to Chapin Hall to support the External Accountability Center's work.

in all respects except the external accountability reporting requirements.

Since the entry of that Order, the External Accountability Center has published three public reports at six month intervals covering the 18 month period from January 1, 2017 through June 30, 2018.

The final Accountability Center report, issued on December 18, 2018, presents relevant data related to key outcomes, case work processes, quality of care, and system capacity in 63 tables and figures and accompanying discussion and analysis, including information on how the Department is responding to areas of concern raised by the data. It also includes, in a companion report, the results of a separate analysis conducted by the Accountability Center of the extent to which there are disparities in the experience of African American children in foster care compared to white children.[77]

For purposes of this case study, there are several key "takeaways" from the final Accountability Center report:

- **DCS, with support from Chapin Hall, continues to use data thoughtfully and skillfully** to understand its performance and is able to identify concerning trends quickly.
- **Most of the evidence presented in the report reflects sustained performance** over the 18 month post-exit period.
- **Notwithstanding the stability of performance in most areas, there are some trends of concern that the Department has identified and is responding to:** an increase in admissions, an increase in caseloads, a decrease in placement stability, and an increase in congregate care placements for teens.
- **In virtually every area in which there was a decline in performance, the decline is not apparent in every county or region** and some regions or counties had experienced improved performance. The key to developing effective strategies to address these trends lies in understanding which counties and regions are driving those trends, and, using CQI processes, developing specific approaches for those counties and regions.
- **Significant regional variation is also apparent in the racial disparity data.** While statewide data reflect that racial disparity in Tennessee's foster care system is relatively modest compared to systems in many other states, there are significant disparities in certain counties and regions in some aspects of the foster care experience. Therefore efforts to reduce disparity should be concentrated on those counties and regions. The Accountability Center Report concludes that the data and analysis do not suggest a simple path to understanding and reducing those disparities.[78]

The Accountability Center has served its function of providing a transition period of on-going public reporting following the successful exit from court jurisdiction.

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[77] Because of the parties continuing recognition of the importance of fashioning and implementing strategies to reduce racial disparity, the work plan for the External Accountability Center included a renewed look at the extent to which the foster care experiences of African American children and white children differ. As previously discussed, the original Settlement Agreement required that the Department to commission a racial disparity study and implement the recommendations coming out of that study. The Racial Disparity Study was completed in 2003 and the 10 recommendations coming out of that study were sufficiently implemented to be designated "in maintenance" in 2010 when the Modified Settlement Agreement and Exit Plan was entered. See footnote 43. However, in the years since the Racial Disparity Study was conducted, researchers, policymakers, and practitioners have increasingly recognized how complicated it is to separate out the effect of race (including the effect of implicit bias in child abuse reporting and judicial and pre-custodial decision making) from other factors that impact outcomes (e.g., poverty, family structure, age distribution of the at-risk population), and how challenging it is, in light of the interplay of these factors, for child welfare systems to implement strategies to reduce disparity. Tennessee has the advantage of a robust data system and analytic support available through its partnership with Chapin Hall to help guide its continued efforts in this important area.

[78] The Chapin Hall Accountability Center Report argues against seeking a single cause or solution to racial disparity findings. As stated in its report, "In sum, if the results pointed to a single narrative, the list of recommendations would be somewhat easier to imagine. That, however, is simply not the case. Whether the topic is admission disparity or exit disparity, the only persistent theme is how much variation there is. Because one part of Tennessee does not resemble other parts, a single solution applied across the state is unlikely to have uniform, intended benefits and could make matters worse in some parts of the state. Going forward, the best problem-solving model would involve systematic application of the Department's CQI model." Tennessee Accountability Center Report 3 and Disparity Report, December 2018, p. 101.

PART TWO

Cross Cutting Themes and Lessons

As Tennessee's experience reflects, the path to any major reform effort is never one of steady improvement from beginning to end. Even the most successful reforms tend to be developmental; certain types of challenges and opportunities typically present at the early stages of the reform and others surface at later stages. There are, however, certain lessons to be learned from Tennessee's experience that are relevant to every stage of a successful reform effort.

LESSON I.

You cannot succeed without committed and talented leadership

Effective leadership is essential to the success of any major child welfare system improvement effort. What constitutes effective leadership, however, will likely differ at different stages of a reform effort. Tennessee's DCS was led by seven different commissioners (and two acting commissioners) during the course of the reform.[79] They differed in their level of experience and expertise in child welfare practice and administration, their political affiliation, their commitment to the Settlement Agreement requirements, and in their management styles. Some had relevant experience in the private non-profit sector, others in government service, and some had both. To the extent that they were successful in advancing the reform effort, they shared important characteristics:

- **They understood the strengths that they brought to the position, as well as areas in which they needed to draw on the expertise and experience of others.** As a result, they assembled leadership/management teams whose experience and expertise supplemented theirs and were willing and able to provide candid advice.
- **They were effective advocates for the Department** with both the Governor's office and with the legislature, and were able to secure necessary resources, advocate for key legislative and regulatory policy and practice changes, and respond appropriately to issues of public concern.
- **They recognized the importance of engaging regional leadership and front-line staff in the development and implementation of improvement plans.** Leadership recognized that, while the central office needed to provide policy guidance, practice support, and resources to the field, in the end, success of the reform depended on the skill and commitment of the front-line staff.
- **They recognized that private providers were essential partners in the child welfare enterprise.** Thus, they effectively engaged private providers and worked collaboratively with the provider community to align the array of services, supports, and placements with the needs of the families and children served by the Department.
- **They understood the importance of creating candid and collaborative relationships with juvenile courts, other state departments, and with their biggest critics, including lawsuit plaintiffs.** By not defining plaintiffs as the adversary, they were able to constructively solve problems.
- **They made strategic use of technical assistance,** including ensuring that the work of multiple technical assistance providers

[79] See Appendix B.

was integrated, seamless, and responsive to the Department's needs, and was available to the regions to help with regional planning and implementation.

- **They learned to correctly interpret and use data to manage and measure their work,** making appropriate use of both quantitative and qualitative data.
- **They understood that the durability of the reforms required major and difficult shifts** in organizational culture and they focused the attention necessary to facilitate, manage, and sustain culture change.

Each of Tennessee's DCS Commissioners brought something unique to the reform that ended up being particularly helpful at the stage of the reform over which they presided. For example, Commissioner George Hattaway was particularly well-suited to lead the initial push to shift the Department's approach to child welfare policy and practice (which had been heavily influenced by the traditional juvenile/criminal justice perspective) to an evidence-based orientation grounded in social work values and advancements in the field regarding how to work more effectively with families and children. Because his professional background and experience was in the juvenile justice/criminal justice area, he brought credibility and weight to the shift that he endorsed.[80]

While initial steps of the reform were successfully led by a Commissioner with limited expertise in child welfare, it was critical to the successful resolution of the contempt proceedings at the end of 2003 that the Governor appointed Commissioner Viola Miller who had experience and demonstrated expertise managing a child welfare system, and who was capable of developing a credible improvement plan and providing the active leadership to support its implementation.[81]

> **"You can fool yourself that you have the right policies in place, but you need to have the perseverance and willingness to hear that there needs to be improvement. You need to bring the resources to bear to carry out the vision—it's not good enough to say you have a vision, you have to live it, and keep sending a clear message that you're here for the long term."**
>
> **—Bonnie Hommrich, DCS Deputy Commissioner for Child Programs (2004-2014), Commissioner (2015-2018)**

Tennessee's experience is unusual in that Bonnie Hommrich, who began her tenure in 2004 as Deputy Commissioner under Commissioner Viola Miller, remained with the Department through January 2018, as Deputy Commissioner under Commissioners O'Day and Henry,[82] and then as Commissioner. The impact that the continuity of her skilled and committed leadership had to the success of the reform cannot be overstated.

It is unlikely that a single Commissioner can preside over a multi-year litigation-related reform effort from beginning to end. Based on Tennessee's experience, it may be that there are advantages to having different leaders with different skill sets at different stages of the reform. The challenge is balancing continuity of vision and direction with the skills needed at different stages of reform. Early on it was helpful for Tennessee to have leaders who were impatient for change and willing to make unpopular decisions; as the system stabilized it was important to have leaders who could focus on the policy, infrastructure, relationships, and quality improvement capacity needed to sustain improved outcomes over time.

[80] His political relationships were also important in persuading the Governor and legislative leaders to approve the Settlement Agreement and thus establish the principles and key commitments that provided the broad contours of the reform and drove the development of the practice model.

[81] Tennessee was fortunate that Miller came into office a year into the first term of the two-term Governor and was therefore able to serve for a seven-year period. The continuity of her leadership with her Deputy Commissioner Bonnie Hommrich was particularly important because of the sustained energy and focus required to develop and implement the improvement plan statewide.

[82] It is not unusual, when there is a change in administrations (especially when it involves a governor from a different political party takes office), for the new Commissioner to bring a new leadership team. Both Commissioners O'Day and Henry deserve credit for retaining Hommrich as Deputy Commissioner. And it was Commissioner Henry who helped ensure that Hommrich succeeded him as Commissioner.

LESSON II.

Top-down and bottom-up: pay attention to front line staff and the roles of state office and regional leadership

At the beginning of any litigation-driven reform effort, it is easy for the state agency leadership to be so focused on how to move the reform forward that they become oblivious to the impact of early decisions and activities on regional and field staff. Ultimately, success depends on the ability of front line case managers to engage effectively with children and families and help connect them to appropriate services and supports. Despite the tendency of central office staff to drive court-ordered reform from the top down, Tennessee's experience demonstrates the importance of not doing so. Just as telling families what they must do rarely produces the engagement necessary to promote behavior change, issuing directives to the field about what is needed to comply with a lawsuit is rarely successful.

In the early days of Tennessee's reform, the central office staff were still coming to terms with their own differing views about the various commitments made by the Department in the Settlement Agreement. Even those who enthusiastically embraced the new directions were overwhelmed trying to figure out where to begin working on a reform effort that had so many different moving parts, each of which appeared, from reading the Settlement Agreement, to be urgent priorities. It is therefore understandable that the central office leadership initially paid little attention to the needs and perspectives of the front line staff in the regions.

The central office also failed to appreciate the very different way the regional leadership was experiencing the demands of the reform. From the perspective of central office, there were many tasks to attend to, but each had a responsible leader or unit within the Department who could focus on it. From the perspective of regional leaders, however, all of those many changes came together in one place, and the regional administrator was supposed to attend to all of them, without much in the way of additional support. And, of course, the failure to make progress could then be seen as a failure of the regions.

Moreover, in the years leading up to the Settlement Agreement, regional front line staff had already experienced the burnout, frustration, and high turnover rates caused by unmanageable caseloads, lack of resources, and the other deficits that prompted the lawsuit. The adverse publicity that attended the filing of the lawsuit, while nominally directed at the Governor and the Commissioner, was perceived by the public and experienced by the DCS workforce as a broad indictment of everyone.[83] Even those workers who were hopeful that the lawsuit would bring much needed resources and policy changes could not escape the impact of the bad press on morale. Notwithstanding their hopes, the early days of the lawsuit did not produce an immediate dramatic positive impact on the front-line staff in the regions, and in many respects the lawsuit requirements added to their burden.

One of the clear lessons from Tennessee's success was making workforce improvements to ensure that workers have the commitment, values, and skills to do what is required. As previously discussed, this involved: changing job requirements to hire people with degrees or backgrounds relevant to the work; raising salaries substantially and creating career paths for advancement; revamping pre-service and in-service training; creating a university partnership to promote professional development; removing barriers to doing the work; and, importantly, focusing on supervision.

At the beginning, the regional staff experienced much of their relationship with the central office as a one-way street, with the central office setting expectations, making demands, foisting and then

[83] While negative media coverage played a crucial role in raising public awareness and creating political support for the reform effort, it is important to recognize that it invariably further undermined staff morale. When asked about his biggest challenge, Commissioner Jim Henry, who took over in 2013 after a spate of negative press coverage, responded "staff morale" without skipping a beat. It is also worth noting that, as a result of the trust and transparency that over time came to characterize the parties' relationships, plaintiffs' counsel often exercised restraint in their public comments when they believed that the Department was behaving responsibly and needed space to move forward with reforms.

abandoning initiatives and new programs, with limited consultation or input. Regional staff found themselves responding to central office demands to hand-collect data on caseloads and staff turnover rates that the Court Monitor needed for reporting, while not getting the benefit of increased salaries and lower caseloads, which took several years to achieve.

Most importantly, the Department's central office leadership was unable initially to benefit from the expertise of the regional leadership and front line staff in designing and implementing the reform. Central office leadership typically would describe practice in terms of Department policies and directives, often with little knowledge of how day-to-day practice was actually being carried out, the barriers to staff compliance with official policy, and the accommodations or compromises staff made just to make it through the day.

Over time, the dynamic changed. Beginning in 2002 and continuing through the remaining years, central office leaders made themselves visible and responsive to regional staff and the involvement and experience of regional staff and community members became central to improved performance.

> **"Every region is different in terms of learning how to implement changes and how to use data appropriately. Understanding and using our data gave us ownership of what was happening in the region without feeling like the reform was happening to us."**
>
> **—Sherri Lawson, DCS Deputy Commissioner for Child Programs**

This is not to say that communication and collaboration between the regions and central office was perfect. Periodically the central office's enthusiasm for a particular new initiative or technical assistance (TA) opportunity was not met with equal enthusiasm in the regions. The central office leadership, particularly the Information Technology leaders, were slow to acknowledge and respond to the frustrations that the regional staff experienced with the initial TFACTS roll out. It is not surprising that a key step toward "fixing TFACTS" was bringing in staff with field experience to work with the IT Team, creating both a help desk and a group of regionally-based IT customer support staff to receive and respond to complaints.

In any large reform effort, the actions needed to build the infrastructure to support good practice inevitably take more time than is expected or desired. Some of the promised relief to the field, whether increasing staffing to reduce caseloads, adding resources to support families, or getting a new computer system to streamline paper work, may be delayed. If the relationship between the state office and the regions is characterized by open communication and collaborative planning, field staff are more likely to be able to accept and work through delays in implementation and challenges along the way until they can get the relief that they need to serve children and families more effectively.

LESSON III.

The central role of private providers

The best functioning child welfare systems owe much of their success to partnership with a strong private provider network who can deliver services and supports to children and families, including providers that operate residential facilities, foster homes, and community-based care. While half of the children in foster care in Tennessee are currently served in DCS foster homes,[84] the transformation of Tennessee's child welfare system depended in large part on the ability to engage private providers in that transformation and to build on the strength of several champions for the reform in the private sector.

As discussed in Part One, the Settlement Agreement negotiation process precluded the involvement of

[84] On December 31, 2018, 50% of all children in DCS custody, including delinquent children, were served by private providers; and 49% of the children in DCS custody, excluding delinquent children, were served by private providers.

providers, so there was considerable unease and distrust within the provider community about a court-ordered Agreement that had significant implications for them without any participation or input from the providers themselves.

In Tennessee, many of the private providers were heavily invested, both financially and philosophically, in serving children in congregate care facilities and in being reimbursed based on beds filled and services provided, rather than on outcomes achieved. They were also focused on serving individual children, rather than working with families. They relied on the Department to work with the parents directly, or utilize other providers to work with parents.[85]

> **"Youth Villages was a residential provider until 1994—the idea was to remove children from their families for two to three years and then return them. We realized outcomes data didn't look good, though, so we redid our model and created a Continuum of Care. When the lawsuit was first filed, we felt like plaintiffs were attacking my friends and my state, but then I came to love them, realizing that, philosophically, we were aligned."**
>
> **—Pat Lawler, Chief Executive Officer, Youth Villages**

Well before the entry of the Settlement Agreement, the state had put in place a contracting mechanism that incentivized providers to start to think and act differently about their array of services, and to reduce their reliance on congregate care. And there were several providers in the State that had already begun to make changes consistent with the Settlement Agreement's principles. Nevertheless, when the proposed Settlement Agreement became

> **"Having private agencies like Youth Villages and Omnivisions saying this was what's best for kids was huge. Once people signed their names to the goal of serving children in home and communities, then we could move forward to implementation."**
>
> **—Elizabeth Black, former DCS Administrator**

public and it was clear that the Department had committed to reducing the use of congregate care and to instituting Performance Based Contracting (PBC), many providers were worried about their continued viability. The membership organization of private provider agencies, the Tennessee Association for Child Care (TACC), lobbied against and testified in opposition to the proposed Settlement Agreement and voiced its opposition to the Settlement Agreement before legislative committees and at the federal Court Fairness Hearing.[86]

Fortunately, Youth Villages, an innovative and influential private agency, and one of the largest in terms of numbers of children served, had already adopted many of the practice principles to which the Department was now committed, and had already made the transition from heavy investment in congregate care to increasing reliance on serving children in family settings with intensive in-home services. This agency was also already focused on outcomes as the measure of its success.

Notwithstanding Youth Villages' membership in the TACC, its Executive Director Pat Lawler was a vocal and important supporter of the Settlement Agreement, and provided a persuasive response to the objections voiced by other agencies. Youth Villages, under Lawler's direction, remained a significant and effective partner for DCS throughout the reform.

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[85] Under the Settlement Agreement, while the Department's case managers continued to have casework responsibilities for children in private provider placements, the private providers were also responsible for assigning their own case managers to the children and families they served and to ensuring that the case management requirements of the Settlement Agreement were met.

[86] The recent federal Family First Preservation Services Act will make these conversations with providers of congregate care services a lot easier. Federal policy now requires states to serve the vast majority of children in family settings and therefore has lessened the debate in the field about the asserted merits of congregate care for children who could be safely served in family settings with supportive services Under the Family First Prevention Services Act, federal financial participation in congregate care settings is drastically curtailed while funding for evidence-based in-home and community services to prevent foster care placement is made available to states.

Once the Settlement Agreement was approved and entered by the Court, DCS invested considerable time meeting with private provider agency leaders and staff to explain the rationale for the Department's new approach and encourage providers to shift and align their agency's philosophy and practice principles with those embraced by the Department.[87] The Department committed to working with those agencies that made a commitment to the philosophy and practice principles to make the necessary transition over time. The Department was equally clear in acknowledging and accepting that there were some agencies that could not or would not make the transition.

The result was that the DCS dramatically reduced the number of individual agencies under contract but the agencies that remained (some of which absorbed or developed subcontracts with smaller programs that could not "go it alone") were committed to working collaboratively to create the service array that children and families needed.

DCS also recognized that if agencies were to deliver high-quality services associated with improved outcomes for children and families, they needed to be compensated sufficiently to allow them to do so and still remain in business.

The process by which Tennessee developed and implemented performance based contracting (PBC), though not without challenges, provides a model in how to effectively engage providers. The Department convened meetings with the providers early on and ensured that they had an opportunity to hear from and ask questions of the DCS staff and consultants leading that effort. Continued direct interaction between Chapin Hall, DCS staff, and the private providers was built into the PBC design.

The initial implementation was phased in over a three-year period, allowing agencies to choose whether they wanted to be part of the vanguard or whether they wanted to wait and learn from the agencies that went first. The Department structured PBC implementation so that in the first year of PBC contracts, an agency would be eligible for bonuses for exceeding outcome targets, but would not be financially penalized for falling short of those targets. This allowed the agencies time to learn from their performance and refine their practice, with the support of the Department and without fear that they would suffer economically.

The collaborative engagement with providers continued to be important over the course of reform. For example, in 2013 the PBC providers helped the Department recognize that the original design of PBC had achieved all that it could at that point, and that the incentive and penalty structure needed to be adjusted accordingly. Commissioner Henry, as one of his first acts, collaborated with providers to make needed changes.

Through active outreach to private providers at the beginning of the reform, and through the collaboration that characterized the development and implementation of PBC, the Department strengthened its relationship with the provider community. DCS established a practice of actively engaging the providers in designing and revising contract monitoring and handling critical incident reporting and response. The improved relationship with the provider community also resulted in providers being inclined to extend themselves when the Department was facing a particularly challenging situation.[88]

Collaboration also led to improvements in serving older youth transitioning to adulthood. Youth Villages had already demonstrated success in this area[89] and the Department drew on their expertise and range of services they offered. Through creative funding, including a grant from a private foundation to match

[87] Members of the Department's leadership team traveled across the state to meet with providers in each of the regions and, at the Department's request, members of the TAC participated in many of these meetings, listening to concerns, answering questions, and sharing relevant lessons gleaned from their work in other states.

[88] These challenging situations were not limited to cases of specific children. For example, when DCS started to experience a spike in caseloads because of an unanticipated increase in children coming into care, the Department was able to contract with Omnivisions to provide case management teams to handle the overflow cases, until either the spike subsided or DCS was able to hire additional case managers to handle the increase.

[89] See *Making Their Way, Summary Report on the Youth Villages Transitional Living Evaluation* by Erin Jacobs Valentine, Melanie Skemer, and Mark F. Courtney, MDRC, December 2018.

the Department's funding dollar for dollar, Youth Villages was able to provide a range of transition services and supports available to all older youth interested in receiving them, including young adults in extended foster care. The Youth Villages model, now known as YVLifeset, is a nationally recognized evidence-based program now being adopted in multiple states.

Tennessee's leaders reaching out to the private provider community early, enlisting the support of providers who are already inclined toward the envisioned changes, understanding the challenges faced by providers, especially those who must significantly change their approach to align with the new practice, and working collaboratively with interested providers to make that transition feasible provides a roadmap for other jurisdictions seeking to implement sustainable reform.

LESSON IV.

Importance of a practice model

The *Brian A.*-driven Tennessee reform was framed from the start by a vision of radically changed practice. The Settlement Agreement began with a list of guiding principles that all parties thought and hoped would be achieved by meeting its many specific requirements. The reality was that it would take many years and multiple actions to infuse those principles into the experiences of children and families.

The work to develop and put forth a written practice model provided the critical foundation for the reform. One of the findings from the 2002 Needs Assessment was that "the fundamental obstacle to improvement [was] the absence of a clear and universally accepted practice model." A practice model was defined as the combination of shared values, methods, and skills that establishes how the system will interact to support children and families—how families, agency staff, providers, and other stakeholders can use specific practice skills to work together to achieve shared case goals for children and families.[90] The Department couldn't just produce a statement of values or mission statement and expect everyone to understand it as more than a slogan or know how to make it operational.

The first step was sharing the values and getting input from staff and stakeholders on the detailed elements of good practice. The harder challenge was translating the vision into action. This required consistent messaging from the top and throughout the system and a focus on practice in all aspects of every element of the work previously discussed.

Especially important was the development of training and coaching to support the Child and Family Team process anchored by a clearly defined practice wheel that was communicated to staff and partners. This was essential but not sufficient. Consistent implementation also required modifying supervision to be consistent with the tenets of the practice model and reinforcing it through the Quality Service Review protocols and process. As described by TAC member Paul Vincent, the approach taken in the Tennessee Practice Standards and in the QSR protocol helped to create "behavioral anchors" to operationalize the Department's practice principles.[91]

LESSON V.

Making good use of technical assistance

Tennessee made extensive and generally effective use of technical assistance (TA) throughout the reform, becoming increasingly strategic and

[90] Tennessee Department of Children's Services Needs Assessment prepared for the *Brian A. Settlement Agreement* Technical Assistance Committee by Shared Goals LLC and Metis Associates, Inc., July 1, 2002.

[91] The TAC played a key role in getting the Department to recognize the importance of the development and implementation of the practice model. It is not clear that the Department would have reached this conclusion on its own. By establishing a committee of national experts to provide technical assistance, the Settlement Agreement significantly increased the likelihood that the State would be informed and influenced by experience elsewhere in the country, through the technical assistance role of the TAC. In the experience of TAC members, reforms that focused on trying to use the specific provisions of a Court Order as a strategic plan had largely failed, while those that stepped back and created an overarching approach to system improvement and then sought to address the specific requirements of a Court Order within that broader framework had experienced significant improvements. Consequently the TAC consistently urged the Department to think of the Tennessee reform in the context of their practice model.

sophisticated about its use over time. In the early years, faced with so many deficiencies and with staff resources already stretched thin, the Department looked for almost any opportunity to access technical assistance, particularly if available at low cost or no cost to the Department.

The Settlement Agreement anticipated the importance of technical assistance, establishing the Technical Assistance Committee (TAC) whose members were child welfare experts and who would be generally available to consult with and advise DCS leadership. The Settlement Agreement also identified specific areas of work for which the Department was expected to consult with the TAC.

The Department used TA made available by or through the TAC to conduct assessments and generate recommendations that helped chart the early course of the reform.[92] With encouragement from the TAC, the Department also made an early investment in what developed into a long-term relationship with Chapin Hall, utilizing Chapin Hall to develop the Department's capacity to understand and use its data. Chapin Hall also played a central role in developing and implementing PBC.

The Department also made good use early on of some narrowly-focused and time-limited TA. For example, the Department was required to develop policies and procedures to ensure appropriate prescription and administration of psychotropic medication, and to ensure appropriate use of restraint and seclusion. The Department enlisted the Child Welfare League of America to convene, facilitate, and support the DCS staff work group charged with drafting the new policies. The Department also contracted with a nationally recognized child psychiatrist to develop protocols to ensure the appropriate use of medications, restraint, and seclusion for children in state custody.

The Department relied heavily on TA in the process by which it developed and drafted the practice standards that reflected DCS' new practice model, introducing and developing its approach to child and family team (CFT) meetings, and building the facilitation skills of DCS staff.

While the Department benefited from taking advantage of available expertise to jumpstart reform in the early years, they also experienced some of the downsides of external TA. First, some TA providers are better than others and the Department found some of the TA unhelpful. Second, the TA providers were often working in isolation from each other, rather than working together in a clear and consistent way. Over time, the Department became better at knowing how to use TA effectively and ensuring communication and coordination among DCS staff utilizing TA and the TA providers themselves so that efforts were better aligned and more consistent.[93]

Over the course of the reform, Tennessee outgrew much of its need for technical assistance. It developed a strong enough leadership team, backed by sufficient staff capacity, to be able to make good decisions on its own in areas in which it would have previously needed expert help. Staff also learned to leverage technical assistance strategically to supplement their internal expertise. This transition did not happen all at once, and negotiating the change was not easy; it was, however, essential to moving the state towards exit from the lawsuit.

[92] As previously discussed, a year prior to Children's Rights filing the lawsuit, the Department had already availed itself of TA available from the Child Welfare League of America to conduct an assessment of its performance and make recommendations for improvement.

[93] Technical assistance was also used strategically in the later stages of the reform to help address and provide reassurance to plaintiffs and others about areas of heightened concern (e.g. addressing problems with TFACTS, which involved both external TA obtained by DCS for IT staff and TA obtained by the TAC to review and report to the Court on the status of TFACTS as the Department worked to address the problems). TA was also used to address particular obstacles to exit (e.g. Chapin Hall's TA in renegotiating certain outcome and performance measures; and the child psychiatrist's TA in helping DCS develop its medication, restraint and seclusion policies, as well as TA to help the parties and the TAC assess the sufficiency of the Department's efforts to ensure informed consent).

LESSON VI.

Generate the resources to sustain the work: the importance of resource development and funding

One of the most important contributors to the success of Tennessee's reform was the shift in the focus of the DCS' Finance and Budget Division. Prior to the Settlement Agreement, the Division operated as if its top priorities were to spend as little of the Department's budget as it could and to avoid audit findings related to control of the budget.

Over time, the Budget and Finance Division changed and saw its top priority as ensuring that the Department could make maximum use of its budget to effectively serve children and families. The Assistant Commissioner for Budget and Finance was still obligated to live within the Department's budget, but success was redefined from having budget surpluses to making sure foster parents, case managers, and the children and families they were serving had access to needed resources.

This change in the Division's view of its role was stimulated in part by Settlement Agreement requirements that the Department maximize its use of federal funds and helped by the designation of additional annual funding specifically earmarked for implementing the recommendations of periodic needs assessments that the Department was required to conduct. Even though Tennessee had made much better use of some federal funding streams than some other states had,[94] like many other states, DCS was "leaving a lot of money on the table" by failing to claim reimbursement for expenses related to training, case management, and other services and supports for which federal Title IV-E or other funding was available. It became imperative that the Assistant Commissioner for Budget and Finance not only had good general financial management skills, but also was able to immerse himself in the intricate details and constant new developments in federal funding.

> **"If you do the right work, the money will follow. The right work becomes an end in itself rather than a means to an end—the end is better outcomes for kids rather than saved funds. Tennessee was using fiscal strategies to get to outcomes. In a lot of states, fiscal and social policy are turning in opposition."**
>
> **—Fred Wulczyn, Director of the Center for State Child Welfare Data, Chapin Hall**

Also essential was that the Assistant Commissioner took it upon himself to understand more about the field work and develop strong working relationships with program staff and with other state agencies including the Medicaid agency that could support DCS' work. This allowed for effective collaboration in identifying and pursuing opportunities for additional federal funding (or flexibility in spending federal funds) resulting in Title IV-E waivers that allowed the Department to pursue innovative strategies. It also allowed the Assistant Commissioner to find ways to streamline some of the processes through which case managers obtained certain services and supports for families.[95]

> **"It is rare for people to be working together at the highest level—to have DCS talking to Medicaid and to the mental health system is usually taboo—but it's how we developed community based services and kept kids out of care."**
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> **—Pat Lawler, Chief Executive Officer, Youth Villages.**

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[94] Tennessee benefitted from its use of Medicaid targeted case management that long preceded the *Brian A.* litigation.

[95] For example, in the early days of the reform, case managers expressed frustration that they were not able to access certain services and supports because they did not know how to categorize their requests to match the fund categories associated with various budget lines. The Finance and Budget Division developed a process for accessing "flex funds," which relieved the worker of the burden of figuring out from what pot of money the expenditure should come. The result not only made it easier for case managers, but it also allowed the division to more efficiently draw on the most cost efficient budget lines and funding sources.

Child welfare systems cannot function without adequate state funding and all of the states and local jurisdictions that have been subject to litigation have had inadequate funding at the start. Moreover, it is a lot easier to secure increased state funding when the agency can make the case that it is leveraging federal reimbursement to the maximum for every eligible expenditure and using the funds effectively to produce results.

LESSON VII.

Quality Assurance and the ability to generate and use quantitative and qualitative data

The *Brian A. Settlement Agreement* required the Department to establish a Quality Assurance (QA) division with responsibility for, among other things, generating the data to measure performance related to key parts of the Settlement Agreement and support improvement efforts. At the beginning, this was a major challenge. The Department's data system had limited ability to produce accurate data on key outcome and system performance measures. Much of the aggregate data produced was "point in time" data that are not particularly useful in understanding performance or improvement over time. In response to lawsuit demands, the newly created QA division quickly became focused on responding to requests for data production from the Court Monitor, who was focused on provision-by-provision compliance reporting to the parties and the court.

Data collection is often a burden for front line workers without providing a comparable benefit for the additional time required for data entry and documentation when they are already pressed for time. Not all data collection will benefit caseworkers directly, but workers at least need to know that the data are actually useful. Too often, the data that are collected are either not well-used by or not useful to Department managers, which was Tennessee's experience in the early days of the reform.

With TA from Chapin Hall (and freed from some demands of the Court Monitor when the TAC took over the monitoring responsibilities), the Department was able to develop a more rational approach to data collection, a more sophisticated approach to data production and analysis, and a more accurate database from which to draw evidence. The QA division increasingly saw its role as helping the Department to ask the right questions and to figure out how to generate the evidence necessary to answer those questions.

Because of improvements in the automated information systems used by child welfare agencies today, most child welfare systems are able to generate quantitative data, often down to the case manager level, on many of the processes that the workers engage in with children and families. Child welfare systems often struggle, however, to measure the quality of the work with children and families.

While most modern businesses invest significant resources in soliciting and analyzing feedback from their customers, most child welfare systems pay very little time and attention to getting feedback from consumers and stakeholders, particularly from children, parents, and foster parents. To measure the quality of case practice, and to provide a vehicle to solicit feedback from children, parents, foster parents, and service providers on their respective experiences with the Department, Tennessee developed and implemented a Quality Service Review process. The QSR became a vehicle for communicating key components and expectations of quality case practice and for measuring and providing feedback on the extent to which practice was meeting those expectations.

Tennessee's QSR as it developed and matured through the reform provided opportunities for collecting and "quantifying" these qualitative data on the subjective experiences of children, parents, and foster parents. It also became a vehicle for Regional Administrators to better understand their practice, and to design and implement improvement strategies.

LESSON VIII.

Role of lawyers, monitors, and the courts in promoting and sustaining reform

Even skeptics of court oversight and child welfare class action reform acknowledge that Tennessee children in foster care are in a demonstrably better situation than when the *Brian A.* lawsuit began. The vast majority of children in care are placed with families, closer to homes and relatives. Despite periodic spikes, workers generally have caseloads at levels that permit them to do quality work. Access to community-based services and supports has expanded across the state. The opportunities for older youth in care have been transformed through extended care and well-resourced independent living and post-care services.

The Federal District Court exercised court oversight effectively, facilitating the negotiations that led to the original Settlement Agreement, providing judicial pressure for a negotiated resolution of the Contempt filing, and holding periodic status hearings in response to Plaintiff's filings and to inquire about and provide oversight of the state's progress. Plaintiffs' lawyers began as adversaries and fierce advocates for change. Over time, they continued to push the Department to do things faster and more reliably but they learned and grew with the state and benefited from the willingness of Tennessee's leaders to allow them to participate in problem-solving. Their tactics became less adversarial as reform progressed and, by the end, they were willing to work collaboratively with the state and the TAC to focus on sustaining the changes.

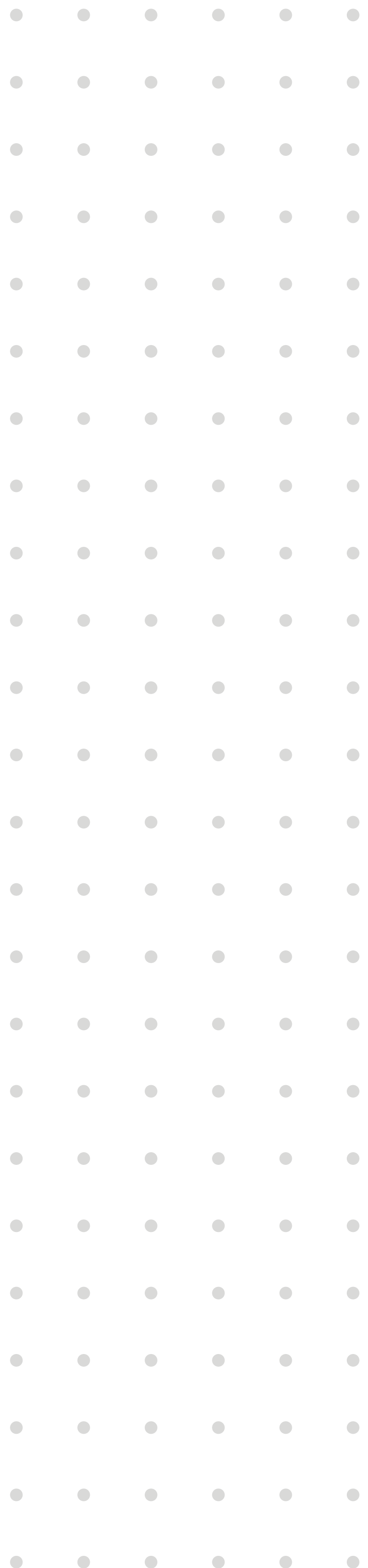
While there remains debate in the child welfare field over the pros and cons of litigation as a strategy for sustainable reform, the Tennessee Commissioners who had the longest tenures and experienced the greatest success all agreed that it is unlikely that the reform would have succeeded in the absence of litigation. The Settlement Agreement offered a durable framework for promoting and sustaining reforms across administrations and provided the initial impetus for the legislative and executive commitments of resources needed to support the Department's work.[96]

It is also true that monitoring and court oversight have some costs and that at times during Tennessee's history, the concerns of and focus of the Court Monitor, the TAC, the Court, and Plaintiffs were sometimes misplaced—emphasizing the wrong areas of practice or the wrong solution to a problem. Tennessee's success depended in part on the plaintiffs, monitors, and ultimately the court, recognizing the commitment and ability of the Department's leaders and that the Department needed some flexibility to set priorities consistent with its overall strategic vision and latitude to sequence and manage the reform effort.

The ability of the parties to work collaboratively was essential in getting to a successful exit. One of the strengths of a court-ordered Settlement Agreement is its durability; it is also one of its weaknesses in that over time, its provisions invariably need to be reassessed and revised. It was only through mutual respect, candor, and a shared commitment to the outcomes that the parties were able to successfully renegotiate some of the terms of the Agreement. The unique role of the TAC as monitor, technical assistance advisor, and ultimately neutral mediator facilitated this process. The TAC had trust and leverage to promote compromise and used it to help bring *Brian A.* to a successful conclusion.

[96] The Settlement Agreement served as an important check on the tendency for new commissioners to want to bring their own agendas and implement their own initiatives, and to de-emphasize if not discard the work of their predecessors. Because it took sustained effort and considerable time for many of the positive changes that Tennessee made to demonstrate impact, the constraints of the court order helped ensure that those efforts were supported and sustained through changes in administrations.

Conclusion



Tennessee's child welfare system is certainly not perfect. However, as the result of many years of hard work by capable, committed, and caring individuals, Tennessee's Department of Children's Services has significantly improved system performance and outcomes for Tennessee's abused and neglected children.

The Department of Children's Services is much better at helping families identify the changes that they need to make and the supports they can rely on in making them, and it provides children and families with a broader range of services, more tailored to individual circumstances, than it did when the *Brian A.* lawsuit was filed almost two decades ago.

The Department is also much better in understanding the extraordinary pressures of frontline child welfare work and has taken actions not only to lessen those pressures, but also to convey respect and appreciation for the staff who deal with them.

Tennessee deserves the national recognition that it has received for its significant accomplishments and other states can benefit from the "lessons learned" in the course of Tennessee's successful reform. However, the complex and difficult nature of child welfare work makes it all too easy for reform to unravel. The success of Tennessee's reform required continued focus and hard work by DCS leadership, front-line staff, private providers, foster parents, and advocates and consistent support for that work from the Governor and the Legislature. Sustaining and building upon that success will require no less.

Appendix A

Symposium on Tennessee Child Welfare Reform, April 2018

List of Participants

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Big Brothers Big Sisters
Nashville, TN

Fred Wulczyn
Senior Research Fellow
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Chicago, IL

Appendix B

Commissioners of the Tennessee Department of Children's Services (DCS) During *Brian A.* Reforms

January 1996 to March 2002	George Hattaway
March 2002 to January 2003	Dr. Page Walley
January 2003 to February 20013	Ken Steverson, Acting
February 2003 to November 2003	Michael Miller
November 2003 to December 2003	Gina Lodge, Acting
January 2004 to December 2011	Dr. Viola Miller
January 2011 to February 2013	Kate O'Day
February 2013 to June 2015	Jim Henry
July 2015 to December 2018	Bonnie Hommrich