Tennessee
Department of Children's Services
Case Review Study

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Executive Summary

Approximately 10,000 children are in the custody of the Department of Children's Services in Tennessee. The Department is investigating new and better ways to provide the most effective help for children in the system so that they can find permanency quickly. This study provides an in-depth look at a random sample of children in state custody to determine the necessary steps to achieve the goal of permanency. Recommendations are also presented to address systemic issues raised by the study.

Going into this study, it was estimated that approximately 50% or more of the youth in DCS custody who were placed out of the home could be successfully reunified with their families *if services proven to effectively address barriers to reunification were made available to them*. After embarking on the study, it became evident that additional young people could achieve permanency through enhanced adoption services or through transitional living services for older youth aging out of the system.

For the study, DCS selected 108 children at random from all regions of the state and in all levels of care. Children who had been in state custody between one and two years were excluded from the study because other initiatives were being carried out with this particular group.

To complete the assessments, Youth Villages' staff interviewed each child, the child's DCS case manager, and family members when available. In the process of assessing the needs of each youth, information was also obtained regarding the services being provided by private agencies, DCS Youth Development Centers, group homes, and foster homes. The assessment included visits to 34 facilities and foster care agencies.

The Children in the Study

The sample was composed of nearly equal numbers of males and females. Approximately two-thirds of the youth were White and one-third Black/African-American. Nearly 60% of the youth were over 13 years old.

About 75% of the youth had been placed into state custody under Dependent/Neglected status, with more than 70% coming into state custody due primarily to family problems rather than child behavior problems. The rights of fewer than 30% of the parents had been terminated or were pending termination.

At the time of the study, about 17% of the youth were in DCS non-relative foster homes. Another 25% were in private agency placements and 17% were in DCS Youth Development Centers or group homes. There were 16% on trial home visits or in adoptive homes and 25% in DCS foster home relative placements.

Key Findings

The state can quickly make a dramatic change in the child welfare system in Tennessee by putting an emphasis on preventing children from entering state custody through evidence-based treatment services provided to children and families when concerns about abuse, neglect, or delinquency first arise.

It is evident from the findings that the Department of Children's Services should put additional emphasis on preventing children from coming into custody, much as it has recently increased the urgency of its adoption efforts. The Department has worked diligently in concert with private providers to enhance the provision of adoption services to children in state custody. This is allowing for many more children to be prepared for adoption more quickly and thus to achieve final and stable permanency. A similar intensive team effort to prevent children from entering state custody unnecessarily could yield incredible dividends, not the least of which would be decreasing the overall number of children in state custody.

The majority of children in the study entered state custody due to parental problems rather than their own behavior problems. Intensive services targeted specifically to the family's issues could, in many cases, prevent removal of the child from her or his family and help ensure long-term stability for them. The findings indicate that there is tremendous room for growth and impact in the area of preventive services. Strong empirical evidence exists that suggests that, with appropriate services that focus on improving family functioning, parental supervision of the adolescent, and engagement in pro-social activities, many delinquent youth can be successfully served in their homes to achieve long-term positive outcomes for the youth, family, and community (Henggeler, Melton, Brondino, et. al., 1997; Henggeler, Schoenwald, Borduin, et. al., 1998; Huey, Henggeler, Brondino, et. al., 2000).

Evidence from the study indicates the importance not only of putting emphasis on prevention but also selecting the right type of prevention services. There was a time when states would try any programs that sounded like they might make a difference for children and families. Now across the country, states are shifting to evidence-based programs that can show proof of success in helping children improve their behaviors, helping families improve supervision, monitoring, and overall functioning, and increasing the safety of the community through decreased recidivism. The state has too few resources – and childhood is too short – to allow unproven programs, or programs that cannot demonstrate positive outcomes, to drain resources to no effect.

If a child must be taken away from his parents for his own protection or because of behavioral problems, the state should turn first to the child's own family to avoid placement in state custody. The case assessments indicate that at the time of entry into state custody, more than 80% of the sample had significant family resources (family members who, with appropriate services, may have provided potentially viable placements). Although locating extended family members during a crisis requires additional time and resources, the potential positive impact of appropriately placing

children with relatives instead of in non-relative foster homes can be tremendous, not only for the child and family but for the Department as well.

Due to the large number of children with viable families, it appears that more than half the children in the sample could have been prevented from entering state custody. Many other children could have returned home shortly after entering state custody had they received appropriate services.

The findings show that Department resources have historically been allocated more toward out-of-home placements and treatment for the child rather than toward evidence-based services that directly target barriers to permanency.

During the time of this assessment, only 28% of families reported receiving any services designed to help them meet requirements necessary to regain custody of their children. In fact, more emphasis seemed to be placed on the children's meeting behavioral goals in their out-of-home placements than on any type of reunification assistance. This emphasis may be changing, as recent steps by the Department indicate a move away from more restrictive placements toward serving children in the least restrictive, most appropriate setting while maintaining a high level of community safety.

The emphasis on children's behavior may be understandable given the challenges of maintaining youth in stable placements. However, clinical research does not indicate that children who adapt successfully to a facility's behavior management system achieve better long-term outcomes (United States Public Health Service, 1999). On the contrary, evidence suggests that these placements can increase deviant behaviors by exposing youth to the anti-social behaviors of other youth in the facility. Despite this, in residential treatment programs and group homes surveyed for this study it was common to find that discharge dates were set based on the child's performance within the facility's point and level behavior management systems rather than on the family's readiness to undertake reunification.

By providing more interventions that effectively target family barriers to reunification, DCS can drastically reduce the time children spend in out-of-home placements.

Study data suggest that many children in state custody have available family resources. This provides an opportunity for DCS to shorten the time that children spend in state custody by providing effective family reunification services.

More than 20% of the youth in this study who had been adjudicated as Dependent/ Neglected had spent almost half of their lives to date in state custody. In some settings, it is not uncommon for children to stay four to six years or even ten years. Some programs may need strong encouragement and additional resources from DCS in order to increase their services to families for the purpose of reunification.

Forty percent of youth who have been in custody more than two years have had five or more placements. Perhaps not coincidentally, it appeared that the behaviors of more than

one-third of the youth in the sample became more problematic *after* they had been placed into state custody. Providing effective family preservation and family reunification services could both shorten the amount of time spent in state custody and avoid multiple placements for children, thus reducing the likelihood that children develop increased negative behavior.

Reducing the time that children spend in state custody will have positive impacts on the children and their families and will also result in cost savings, making funds available to increase the quality of services provided to children who need to remain in the custody of the state.

Recommendations

Two types of recommendations will be made in this report. Recommendations for services and placements that are needed to help the particular children assessed in the study are presented. Detailed information on those recommendations is located in the Case Review Findings section. Each recommendation is further discussed in both the Assessment Summaries and in the Case Assessments. Recommendations designed to accomplish system reform are also included. Specific recommendations described below will enable the Department to address the broader issues gleaned from this study.

One finding stands above all else in this study: many of the children currently in state custody would be better off at home with their families and out of custody. Some children assessed were already at home with relatives, living stable lives. Many others had parents or other family members who were willing to take responsibility for them. Most of these families need some help – intensive, effective services that will assist them in stabilizing their situation and creating a sustainable support system to see them through the process of raising a child.

Clearly, there are children who need the full protection that only the Department of Children's Services can provide, and there are youth who need highly restrictive placements due to the threat they pose to community safety. The key to assuring that DCS has the resources to provide excellent care in the most appropriate setting to these youth is to help those children who can live successfully with their parents or relatives reunify with their families as soon as possible.

Two objectives must be met in order to further the goal of having only those children in custody who need to be there. First, DCS must stem the tide of children inappropriately entering state custody. This can be accomplished by completing a thorough assessment and family search for each child and by providing intensive services directly aimed at family preservation to those families whose children are at highest risk of being placed into state custody. Second, DCS must significantly increase the emphasis on family reunification and adoption in order to find permanency for these children as quickly as possible.

These objectives can be accomplished through the implementation of three specific recommendations. These recommendations work in concert to accomplish the goal of assuring that all children in state custody are there because it is the safest and best situation for them and for the community. The goal will not be realized if only one or two of these recommendations are enacted. All three pieces must be in place in order for DCS to meet the objectives, and thus realize the goal.

- ***Case Supervision***: First, it is recommended that DCS implement a case supervision process to assure adherence to the practice model and to increase accountability for actions directed at family preservation, reunification, or adoption.

- ***Care Management Model for Utilization Review***: Second, it is recommended that DCS contract with a professional care management organization to provide utilization review services that will monitor efforts to achieve permanency for children and assess the work of providers and facilities serving children in state custody.

- ***Redirection of Resources to Expand Services***: Finally, it is recommended that DCS redirect resources toward services that address the most pressing issues affecting children and families while maintaining a high level of community safety, including barriers to family preservation and reunification, preparation for entry into adulthood for those aging out of custody, and initiation and/or completion of the adoption process.

By implementing these three recommendations, the Department will be able to make quick progress toward the goal of assuring that all children in state custody are in the most appropriate setting. By structured monitoring of both family preservation efforts and actions directed at finding permanency for these children the Department will have a significant positive impact on the lives of children, families, and communities in the state of Tennessee.

Specific action steps required to implement each recommendation are listed below in the Recommendations Summary and are further explained in the Recommendations section of the report. Based on generalizations of the findings from the in-depth case reviews to the wider population of children in DCS custody, it appears that as many as 6,000 children could be successfully released from state custody. DCS can achieve this goal through its commitment to helping all children and families find permanency by refocusing its energies and resources to emphasize family preservation, family reunification, and permanency for all children in state custody.

Recommendations Summary

1. **Develop a structured case supervision process to increase accountability, assure adherence to the practice model, and support the effective utilization of resources.**

   1.A. Implement a supervision structure that allows for frequent review of family reunification, transitional living, or adoption activities on all active cases in order to increase accountability for achieving permanency for children.

   1.B. Utilize the supervision process to assure that all case activities adhere to the practice model.

   1.C. Provide training to case managers and supervisors concerning the interface between case supervision, the utilization review process, and in-home services to enable effective use of the process to achieve reunification, adoption, or successful emancipation, more quickly, while maintaining focus on safety for the child and community.

2. **Contract with a professional care management organization for utilization review services to monitor all family preservation, family reunification, adoption, and transitional living services provided to youth and families.**

   2.A. Employ a professional care management organization to conduct utilization review in order to assess services provided to children and families.

   2.B. Monitor implementation of services to prevent children from entering state custody.

   2.C. Assess efforts to achieve permanency for children either through family reunification services, adoption services, or transitional living services.

   2.D. Review each provider, including YDCs and DCS group homes, to assure accountability for services provided, as specified by contract requirements and DCS standards.

3. **Redirect resources toward evidence-based intensive in-home services, transitional living services, and assistance with all aspects of the adoption process for the purpose of achieving positive long-term outcomes and maintaining a high level of safety for children and for the community.**

   3.A. Address the needs of children and families by funding only services that have demonstrated evidence of achieving the desired outcomes.

3.B. Contract with private providers for evidence-based intensive in-home services to prevent children from entering state custody and to return children home or to permanency as quickly as possible.

3.C. Utilize intensive in-home services to complete an exhaustive search for viable relatives prior to the child's placement into state custody, whenever biological parents are not a viable option.

3.D. Prioritize intensive in-home services to youth at most immediate risk of placement into state custody and to those who are most likely to return home quickly and successfully.

3.E. Redistribute resources currently assigned to foster care and residential treatment in order to expand intensive evidence-based prevention services.

3.F. Develop a mechanism that offers financial assistance to relatives who provide placements without requiring children to remain in state custody.

3.G. Fund services for youth aging out of the foster care system to assist them in transitioning successfully into adulthood.

3.H. Assess the process of terminating parental rights to identify families who could keep their children if appropriate services were available.

3.I. Contract with private providers to assist with all phases of the adoption process.

3.J. Provide adoptive families with access to in-home services as needed for stabilization.

3.K. Assure that each child receives adequate advocacy in the court system.

Conclusion

These recommendations will have favorable impacts on the lives of tens of thousands of children and families in Tennessee.

This study describes the experiences of 108 children in state custody, including information about their parents and families. The data provide evidence that, with the right kind of assistance from DCS, these parents and families can often care for their own children safely and successfully. Few of the services currently offered have scientifically-based evidence of long-term success in addressing the challenges faced by these families. But there is hope.

In recent years, positive advances have been made in the child welfare field. Several new service models are now recognized among leading researchers as highly effective and substantially less expensive than the current system of services, which is built upon long-

term foster home placement and residential treatment. The newer service models are grounded in empirical evidence and incorporate in their design high levels of accountability for both costs and outcomes.

Given the information in this report, the state has the opportunity to dramatically shift its resources to help children and families live successfully and independently. DCS can substantially improve outcomes for children and families, reduce the number of children in custody, increase the safety of children and the community, and improve the quality of life for youth remaining in custody.

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Introduction

Approximately 10,000 children are in the custody of the Tennessee Department of Children's Services. These children sometimes live transient lives, moving between foster homes, detention centers, group homes, and residential treatment centers. Recent research confirms that the long-term outcomes for youth who spend a significant portion of their childhood in the foster care system are bleak (Pecora, Kessler, Williams, et. al., 2005). A focus on preventing children from entering state custody unnecessarily and on reducing the amount of time spent in out-of-home care can minimize the negative consequences often associated with the foster care system. With the implementation of empirically-validated, intensive services that target the multiple systems affecting family functioning, it is likely that more than half of these youth can successfully exit state custody to a permanent home while a high level of community safety is maintained.

The most basic principles of the child welfare system in this country emphasize the fundamental importance of the family in a child's life. As described in the *CWLA Standards of Excellence for Services for Abused or Neglected Children and Their Families*, core values of an effective child protection system include the recognition that "the most desirable place for children to grow up is in their own caring families, when those families are able to provide safe and nurturing relationships" (Child Welfare League of America, 1998). Within the core values, it is acknowledged that most parents want to provide adequately for their children, but sometimes need assistance in meeting their children's needs, and that "appropriate services should be available to assist them in accomplishing needed changes" (Child Welfare League of America, 1998).

Balancing child safety and the need for permanency is, at best, a daunting task. Families who are facing multiple challenges such as unstable housing or employment, substance abuse, mental health issues, and medical needs sometimes become dangerous places for children. The first charge of DCS is to secure the safety of children. At the same time, they must help these children find permanency within a family which will provide safety and security.

Providing appropriate services to struggling families to prevent child maltreatment may be the most effective way to meet the twin goals of safety and permanency for children. Intensive in-home services that target basic needs such as stable housing, employment, food, and transportation and that also address barriers to successful functioning such as substance abuse and mental health issues have demonstrated positive long-term outcomes for children and families. Such services have also been successfully employed to address barriers to reunification with parents or relatives.

Under the direction of Commissioner Viola Miller, the Department of Children's Services has made significant progress in achieving both safety and permanency for children in state custody. Recent reforms have substantially increased the number of children moving from temporary foster placements to permanent adoptive homes. This study examines the lives of children in state custody in an effort to illuminate strategies

that will bring about further improvements in the system caring for the most vulnerable children and families.

Proposal

In January 2004, Youth Villages proposed a project to DCS to assess approximately 100 randomly selected youth in state custody. The purpose of the study was to evaluate case activities directed toward achieving permanency and estimate the number of children in state custody who could be successfully reunified with parents or relatives if intensive, evidence-based services were provided. Based on our experience in providing in-home services over the past 10 years, and on the results of a similar study in the state of Alabama, we anticipated that as many as 50% of youth assessed for the study could be successfully returned home.

In ongoing discussions regarding the goals of the study, Department leadership decided to focus the study on two specific groups of children in state custody based on length of stay. The first group had been in state custody for less than one year and could potentially move fairly quickly to permanency. The second group of youth, which included those in state custody for over two years, presented an opportunity to assess cases that have possibly become "stuck in the system." Children currently being served by Youth Villages were excluded from the study to avoid a conflict of interest. An intensive review of services provided to these children and families was conducted in order to evaluate if Department resources were being effectively utilized to achieve permanency. This included a review of agency providers, Department practices and procedures, and the efficacy of implemented services.

Implementation

Commissioner Miller approved the proposal after it was reviewed by various parties within the Department. DCS regional staff members were briefed on the project, and case assessments began shortly thereafter. Department leadership staff, Randal Lea and Bonnie Hommrich, provided ongoing guidance and support to the process and helped ensure full access to case managers, team supervisors, and other DCS information sources. Department staff members were cooperative in providing case information, even though some had only been assigned to these cases for a short time. Randal Lea was also instrumental in notifying provider agencies of the project and troubleshooting access issues.

More than 70 Youth Villages staff members (see Appendix VI) participated in data collection and case assessment. Each assessment includes information gathered from a wide variety of sources knowledgeable about the child's situation, including the family, the child, the DCS case manager, and agency providers, if applicable. On average, over 50 hours of staff time were devoted to each assessment.

Report Structure

This report presents information on all aspects of the study. Following this introduction, a detailed description of the case review methodology is presented. Findings from analysis of data generated by the case reviews are found in the subsequent section. Recommendations for system changes, based on the evidence from the study, are presented last. A number of appendices containing assessment instruments, additional data analysis, information by DCS region, supporting research references, and a list of participating staff follow the report.

Case Review Methodology

This study was conducted to estimate the number of children in the custody of the state of Tennessee that could be successfully reunified with parents or relatives. A random sample of children in state custody was selected, and information was gathered from a variety of sources for the purpose of case assessment. Recommendations for appropriate placement of the child and services to the family were made based on the individual circumstances of each case. Analysis of information abstracted from the case assessments provided information on the current status of children in state custody and formed the basis for recommendations for reform of this system.

Elements that contribute to the safety and permanency of children were examined in each case. The availability of family resources, the reasons for initial placement into custody, the services provided to families both prior to custody and currently, and the activities of the Department targeted toward achieving permanency were assessed. Adherence to widely accepted standards of practice (Child Welfare League of America, 1998) in several areas was assessed including search for viable family, permanency planning, termination of parental rights, and reunification services. A detailed description of each element examined in the study is provided below.

There are a number of elements which may affect safety and permanency for children which were beyond the scope of this study. Issues such as the availability and accessibility of services in various locations, the practice patterns of DCS including staffing and caseload, and the interface between DCS and other child-serving agencies such as juvenile court were not examined in this study.

In order to determine the most appropriate placement for children who have come into state custody, it was necessary to gather information on a variety of factors: the circumstances of the child and family both prior to placement and during the placement of the child into state custody, and the current situation of the child and family. Once these factors were understood, it was possible, using a decision matrix, to better assess the most appropriate placement for the child and to suggest the nature and length of services likely to produce a positive long-term outcome for the child and family.

A clear picture of the circumstances under which the child was removed was essential in determining the appropriateness of placement into state custody. An essential factor to understand was if the child had viable family at the time of placement out of the home. In other words, were there family members, either the parents or other relatives, who were available and willing to work to provide a safe home for the child? This is not to say that these viable family members were capable of caring for the child without outside assistance, but that, with the appropriate services, they could have cared for the child, thus avoiding the trauma of out-of-home placement. In addition to determining whether there were viable family resources available for the child, it was important to examine the reasons that a child was removed from the home. The particular reason for removal has a significant impact on defining the type of service that might have been successful in preventing placement of the child out of the home. Likewise, it was important to know the types of services that had been provided to each family prior to a child's removal from the home in order to fully understand each individual case. These factors allowed for a determination of the likelihood of state custody prevention had appropriate evidence-based services been available to the family.

A number of factors surrounding initial placement into state custody were important in determining whether the current placement is appropriate. First, was a full family search completed in each case? That is, did DCS conduct a thorough investigation in order to locate all family resources available to the child at the time? Cases were coded as having a complete, partial, or no family search. A complete family search involved DCS' contacting all identified family members in order to assess their viability as an appropriate placement for the child. A partial family search was defined as contact with some, but not all, identified family members. Cases were coded as having no family search when DCS made no reported attempt to assess family members as viable placements. The purpose of such a family search is to facilitate placement with a relative instead of with someone outside of the child's natural support system. Such placements can be much less traumatic for children and can result in fewer negative experiences over the long term. Thus, another important factor to examine was whether placement with relatives was actually attempted at the time the child entered state custody. Additional factors that shed light on the circumstances of each child's case included the original Permanency Plan goal established for the child, as well as the types of services (such as parenting or anger management classes) recommended for the family in order for them to achieve the permanency goal and have their child returned to them.

To understand each child's and family's current situation, several important variables were considered. It was essential to establish whether the child currently has viable family. That is, are there family members who desire to work toward the goal of reuniting permanently with the child in their home? Current viable family includes not only biological parents but also relatives of the child. Once the status of the child's family was known, then the actions of DCS were examined to understand the process through which the Department intended to achieve permanency for these children. The current Permanency Plan goal provided an indication of DCS' intentions in working with the family. Identifying the current services the family was receiving was important in defining the level of assistance provided by DCS toward achieving the permanency goal.

The existence of a projected step-down date for the child indicated that there was a reasonable expectation that the child would make progress toward the permanency goal within an established timeframe. Another indicator of real efforts being made toward the permanency goal was the number of visits by the child with the family in the last 30 days. Taken together, these four indicators (Current Permanency Plan, Current Services to the Family, Projected Step-down Date, and Number of Family Visits in the Last 30 Days) provided important information on the work being done with the child and family in order to achieve reunification.

Once each case was clearly understood in terms of the circumstances prior to placement into state custody, at initial placement, and currently, then it was possible to make a case recommendation. There were two parts to each recommendation, including an indication of the appropriate placement of the child and a recommendation for services that the child and family should receive in order to assure a reasonable chance of long-term success.

A retrospective case review was completed for each case, involving interviews with multiple sources and reviews of existing case records. Assessment tools were established for each type of source (child, family, DCS case manager, agency provider) to assure that all necessary information was gathered during the interviews (see Appendix I for Assessment Tools). Data was then abstracted from the case reviews for further analysis. A detailed explanation of the sample selection process and the case review methodology is provided below.

Sample Selection

In selecting a sample for this study, consideration was given to several concerns. First, it was important to recognize efforts already underway by DCS to address the reunification of children with their families. Current initiatives are specifically aimed at children who have been in state custody between 12 and 24 months. For this reason, this group of children was excluded from the study. Another consideration was the ability to generalize findings from the study to the population of interest, that is, to children in state custody. The issue of regional variation was also considered, which led to a stratified sampling design based on DCS region. Because reporting by region on some variables was desired, a minimum of five cases per region was required. To accommodate all of these considerations, a sample size of 108 was chosen, which yielded confidence limits within approximately $\pm$ 5% at the 95% level of confidence.

Given these parameters, the Office of Performance Enhancement at DCS provided a random sample of active cases as of July 1, 2004, stratified by region. The initial sample contained records of 126 children. This represented a 20% oversample to allow for cases in which children had left care prior to assessment (children who had exited state custody at the time of the assessment were not included in the study). A larger-than-expected number of children had indeed left custody, requiring an additional sample of five cases per region. The total number of cases provided by the state was 186, with a total of 108 included in the study. Demographic information (date of birth, gender, race/ethnicity), adjudication type, name and type of placement as of July 1, 2004, date of entrance into

state custody, months in state custody, and start date of current placement were also provided by the state for each child in the sample. Comparisons were made between the sample and the population of active custody cases as of June 30, 2004. No significant differences were found based on race, gender, age group, region, or adjudication type. Similarity of the sample to the population based on months in state custody was not examined due to omitting children from the sample who had been in custody between 12 and 24 months. Further information on the sample can be found in Appendix III.

Upon receipt of the sample from DCS, staff members immediately began to locate children and initiate the assessment process. They worked down the sample list for their region to determine custody status and current location. The number of assessments needed in each region had been previously determined based on information from the state concerning the number of children in state custody in each region. Once the appropriate number of children in state custody in each region had been located, staff focused on assessing those children, regardless of the number of cases that remained on their sample list.

Case Review Process

Experienced mental health professionals were dispatched to complete a thorough assessment of each case. Using the assessment tools (see Appendix I), information was gathered from DCS case managers, the identified child, the child's primary caregiver, and the child's family. In addition, for those children in placements with private agencies, an additional assessment was conducted with agency personnel.

A wide variety of information was sought from each source. From DCS case managers, data was gathered on the current placement, placement history, and the permanency planning process for the child, including the original and current goals. Permanency Plan goals were examined to determine both the child's and parents' actions required in order for DCS to close the case. In applicable cases, actions to promote reunification were assessed with the case managers, including ongoing assessment of viable family, projected step-down date, visits with the family, and services provided to the family. The case managers also provided detailed information concerning the circumstances under which the child entered state custody. In addition, DCS records were reviewed with the case managers to find information on the number of times the child had been in state custody, the number of placements during state custody, whether a family search had been completed, and if placement with a relative had been attempted at the time the child entered state custody.

The child interview was based on the age and developmental status of the child and included information regarding the child's perception of his or her current placement, knowledge of the circumstances of her or his placement into state custody, and understanding of the Permanency Plan goals. When appropriate, children were asked what they needed to do to return to their parents.

Family members were contacted in each case in which the child's parents' rights had not been terminated or were not in the process of termination. In those cases in which DCS could not provide family contact information, an extensive search was conducted by study staff members, using all available resources, including neighbors, former neighbors, co-workers, schools, and Internet databases. Identified family members were interviewed to determine their current level of involvement with the child, participation in permanency planning, current treatment services, and current actions directed at bringing their child back home. Information was also obtained concerning the family's involvement with the child's schooling and with the child's peer group. A substantial portion of the interview was directed toward gaining an understanding of the social history of the family and their current life circumstances. To this end, factors including legal involvement, parental substance abuse and treatment history, and parental mental health status were examined with each family. Questions were also asked regarding the status of the family in terms of housing, income, employment, and supervision of the child.

Following completion of interviews in a case, information was reviewed by all staff members who participated in assessing the child, family, DCS case manager, and/or agency providers. Follow-up questions were often posed to information sources to clarify information, reconcile inconsistencies, or gather additional information about a particular area of concern.

In order to determine case recommendations for services and placement, a decision matrix was completed on each case (see Appendix I for a sample decision matrix). The safety of the child and others, supervision, mental health status, and viability of the family were examined to determine the least restrictive, most appropriate placement for the child. The length of services recommended was also determined by objective criteria (see Appendix I). Both the length of service needed to transition the child to the home and the length of service required after the child returns home in order to ensure a high likelihood of long-term success for the child and family were examined. All case summaries and recommendations were reviewed by leadership staff in each region for adherence to the standardized criteria for placement and service recommendations.

With more than 70 staff members (see Appendix VI) collecting information through interviews with children, families, foster parents, DCS case managers, and agency staff across the state, the issue of inter-rater reliability was of major concern. This was addressed through a group process in which all staff assessing cases in a region met to discuss each case. Discrepancies between information gathered from various sources were revealed during these discussions, and further information was sought as necessary. Once additional information was obtained, the case was again brought before the group for discussion. This process was repeated until all discrepancies were resolved.

All cases in which a child was placed with an agency provider were subject to additional scrutiny by the licensed staff member who completed assessments of each agency. Assessments for all children whose parents' rights had been terminated or were pending termination were reviewed by a professional with significant experience in the field of

adoption for the purpose of examining the process of ending parental rights and securing permanency for these children. Case assessments for children with problem sexual behaviors were examined by a staff member who is a Tennessee Sex Offender Treatment Board Provider. All cases in which a diagnosis of Mental Retardation was reported were reviewed by a staff member with significant experience in the MR/DD field. Finally, staff from the Youth Villages Research Department compared the abstracted information with the case assessments to ensure the accuracy of the data.

Case Review Findings

Findings from analysis of data derived from the case reviews are presented in this section. The sample characteristics are provided, along with information on differences in characteristics by adjudication type and by length of time in state custody. Children adjudicated Delinquent or Unruly are combined into one group, as there were only four cases in the sample with an adjudication type of Unruly. Length of stay is described, for purposes of this report, as those in state custody less than one year and those in state custody more than two years.

Presentation of the findings is divided into sections by type of case activities. Following a description of the demographic characteristics, information is provided on prevention services and the process of placement into state custody, initial placement and services to the family, current placement and casework activities, and case recommendations. Information is also presented on agencies serving children in the sample. The final section presents information on a cost analysis, which examines potential savings to the Department if case recommendations are implemented.

Additional information on characteristics of sample cases by region may be found in Appendix II. Further information on a number of issues raised in the Findings section may be found in Appendix III, including graphs describing the characteristics of the sample and population and characteristics of children whose parents' rights have been terminated. In addition, Appendix III contains graphs displaying information derived from the agency assessments. Finally, Table 5 in Appendix III shows values for each variable in the study for the sample, by length of time in custody (Less than One Year; More than Two Years) and by adjudication type (Dependent/Neglected; Delinquent or Unruly).

Characteristics of the Sample

Information is provided concerning the demographic characteristics of the sample including gender, race, ethnicity, and age. Characteristics of the length of time in care are discussed. Additional variables of interest including Level of Care (see Appendix IV for descriptions of DCS continuum levels), placement type, Permanency Plan goal, and TPR status are also provided.

Demographic Characteristics

The demographic characteristics of the sample are shown in Table 1. Slightly over half of the sample is male, and most in the group are white. Within the sample, 56% of the children in state custody longer than two years are female, which may be partially explained by the variation in adjudication status. Males were more likely to enter state custody adjudicated as Delinquent, which usually results in a shorter length of time in state custody. Thus, it is not surprising that those in state custody more than two years are predominantly female.

Over half of the sample is in the 13- to 18.9-year-old age group. The average age of children adjudicated as Dependent/Neglected was 10.9 years, while those adjudicated as Delinquent or Unruly tended to be older, with an average age of 16.6 years.

Table 1
Demographics of
the Sample

	Number	Percent
Gender		
Male	55	50.9%
Female	53	49.1%
Race		
Black/African American	36	33.3%
White	72	66.7%
Ethnicity		
Hispanic Origin	3	2.8%
Age Group (as of 7/1/04)		
0 to 1.9 Years	4	3.7%
2 to 4.9 Years	13	12.0%
5 to 12.9 Years	28	25.9%
13 to 18.9 Years	63	58.4%

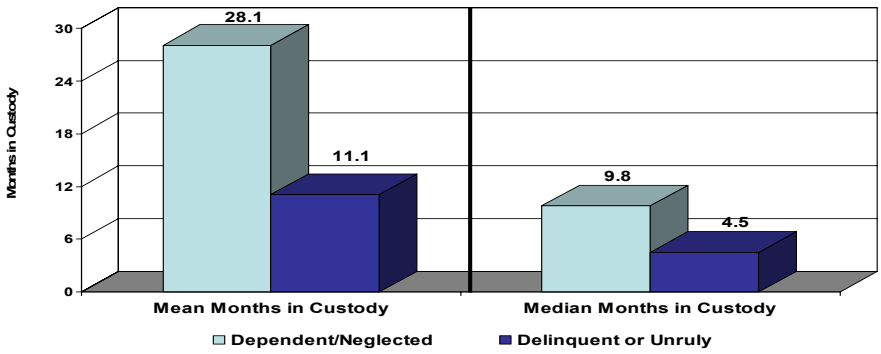
Characteristics of Time in Care

The cases in the sample were remarkably similar to the total DCS population in terms of adjudication type, with a large majority of cases, 75%, entering state custody for dependent and/or neglect issues. The length of stay in state custody for those adjudicated as Dependent/Neglected is quite different from those adjudicated as Delinquent or Unruly.

In Figure 1, the average number of months in state custody is shown for each adjudication type, with those in the Dependent/Neglected type having spent an average of 28 months in state custody, and those with Delinquent or Unruly adjudication spending an average of less than half that time, only 11 months, in state custody. The median number of months for each group is also shown in Figure 1. The dramatic difference in the mean and median is explained by outliers, especially in the group adjudicated as Dependent/Neglected, which has a maximum of 210 months in state custody, compared to a maximum of 81 months in the group adjudicated as Delinquent or Unruly.

Figure 1

Average Months in Custody by Adjudication Type

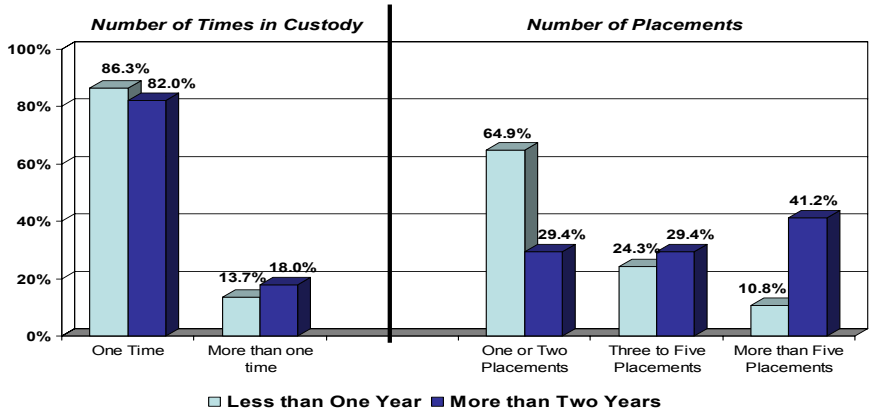


Dependent/Neglected: n = 81
Delinquent: n = 22
Unruly: n = 4

Figure 2 shows that the vast majority of children in the sample have been in state custody only one time. The sample had significant variation in placement stability by length of time in state custody, with less than 30% of those in state custody over two years having two or fewer placements, while 65% of those in state custody less than one year had two or fewer. Over 40% of those in state custody more than two years had five or more placements.

Figure 2

Number of Times in Custody and Number of Placements by Length of Time in Custody



Less than one year: n = 74
More than two years: n = 34

Level of Care

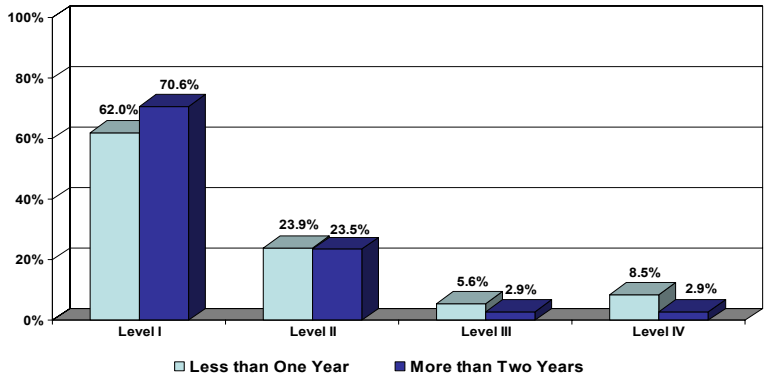
Level of care can be considered an approximate indicator of current behavioral or emotional acuity. Cases with long lengths of time in state custody (the maximum is 17.5 years in the sample) would perhaps be justified if the youth had significant mental health issues. These data reflect the inverse with only 11% of youth currently classified as Level III or IV. When youth in Level II were included, higher acuity cases increase to only 34%. Thus, it is apparent that the behavior of most youth in this sample is probably not problematic. This bolsters the argument for providing services to them and their families in their own homes and communities.

When level of care was examined in light of length of time in state custody, Figure 3 demonstrates that most youth in state custody longer than two years were classified as Level I (71%), which indicates some behavioral and emotional stability. For cases only recently entering state custody, 62% were classified as Level I. Cases at this level are thought to be the most appropriate for adoption or reunification with parents or relatives due to the lack of behavioral problems. The issue then becomes whether services are being provided that will increase the rates of reunification or adoption. Service provision is typically a function of placement, which, by contract, dictates the type of interventions that are to be implemented to achieve permanency.

Figure 3

Level by Length of Stay in Custody

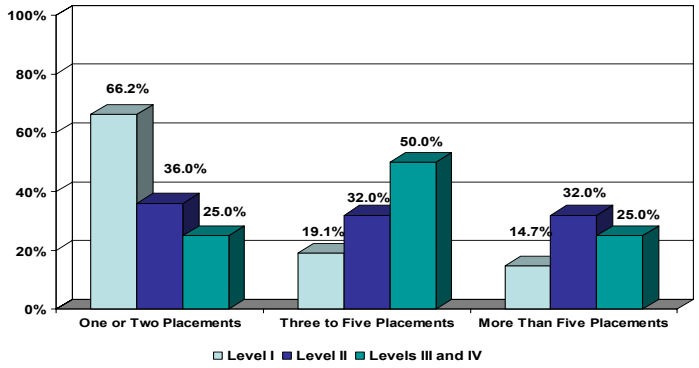
Does not include children on runaway



Less than One Year: n = 71
More than Two Years: n = 34

Approximately 35% of children classified as Level I have experienced more than two placements during their stay in state custody. As shown in Figure 4, children classified at higher levels generally have more placements, as would be expected.

Figure 4
Number of Placements by Level

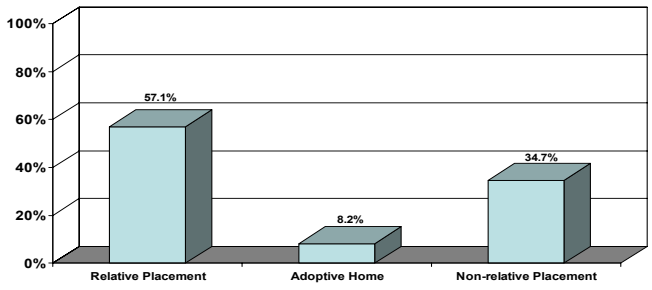


Level I: n = 68
Level II: n = 25
Levels III and IV: n = 12

Placements

More than 75% of the youth in the sample were placed in community settings, either in DCS foster homes, agency foster homes, trial home placements, or in adoptive homes. As shown in Figure 5, within DCS foster homes, 57% of the children are actually in relative placements that, according to sources at DCS, almost always receive kinship care funding within 120 days of the child's placement. Another 8% are in a pending adoptive home.

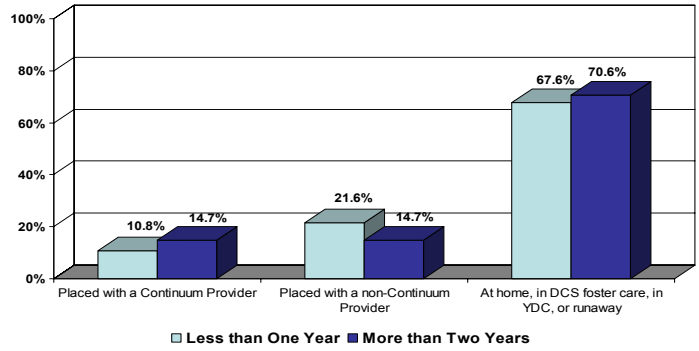
Figure 5
Placement Type for Children in DCS Foster Homes
n = 49



Youth placed in DCS and agency foster homes demonstrate the ability to live successfully in the community. The types of services provided to these youth and families are key to achieving permanency, either through reunification or adoption. Continuum providers are required by contractual obligations to offer more of the types of

services that help children achieve permanency. As seen in Figure 6, 11% of children in the sample who have been in state custody less than a year are placed with a continuum provider, while a slightly larger percentage (14.7%) of those in state custody longer than two years are placed with such an agency. The remaining children in the sample are with non-continuum providers or are in DCS placements. (Please note: children served by Youth Villages, a continuum provider, were excluded from the study.)

Figure 6
Continuum Placement by Length of Time in Custody

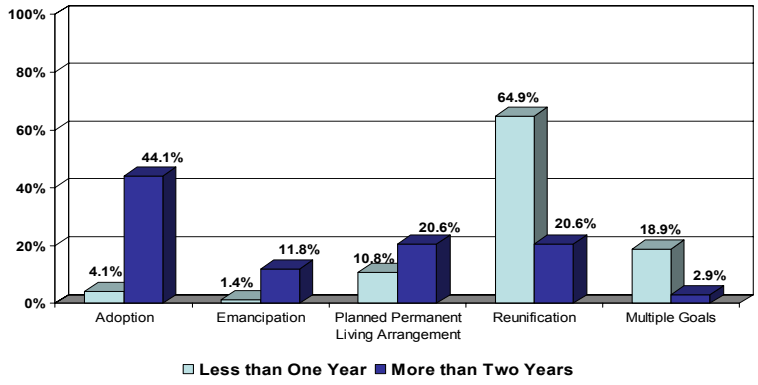


Less than one year: n = 74
More than two years: n = 34

Permanency Plan Goals

Figure 7 shows that almost 65% of the youth who entered state custody within the last 12 months have reunification as a permanency goal. However, for children in state custody more than two years, only 20% have a goal of permanently reuniting with their families. Decisions regarding family reunification involve an ongoing assessment of family viability, including not only parents but also other involved relatives.

Figure 7
Current Permanency Goal
by Length of Time in Custody



Less than one year: n = 74
More than two years: n = 34

The plans for over 90% of the youth adjudicated Delinquent or Unruly are to return home. Given the nature of the situations that led to youths' being placed into state custody, family services are indicated to prevent continued problems. This assessment is also supported by agency staff and is discussed below in the Agency Assessments section.

Termination of Parental Rights (TPR) Status

The parents of over 70% of youth in the sample had intact parental rights, suggesting that reunification is a possibility for most youth. However, those youth whose parents' rights have been terminated present a special challenge, as they no longer have the familial assets available to most children. These children have been in state custody much longer than those in the overall sample, averaging over five years in custody.

Youth who are placed in a DCS non-relative foster home and who have a TPR designation have spent an average of 7.8 years in state custody, compared with an overall average of just over five years in state custody for all children in the sample whose parents' rights had been terminated (see Appendix III for further information on this group).

Prevention Services and the Process of Placement into State Custody

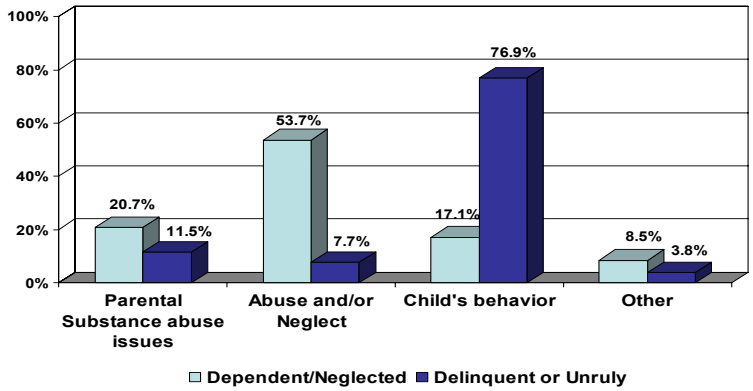
The case review process included an in-depth review of the state custody process and the efforts that were made to prevent entry of children into state custody. Specifically, an appraisal of services provided prior to placement into state custody, as reported by multiple parties, was conducted. Also noted were the key drivers of the decision to place a child into custody.

Reasons for Removal from Home

Figure 8 shows the types of referral issues present at the time of placement into state custody for each adjudication type. A large percentage of cases were brought into state custody for reasons other than child-specific behaviors.

Figure 8

Reason for Removal from Home
by Adjudication Type

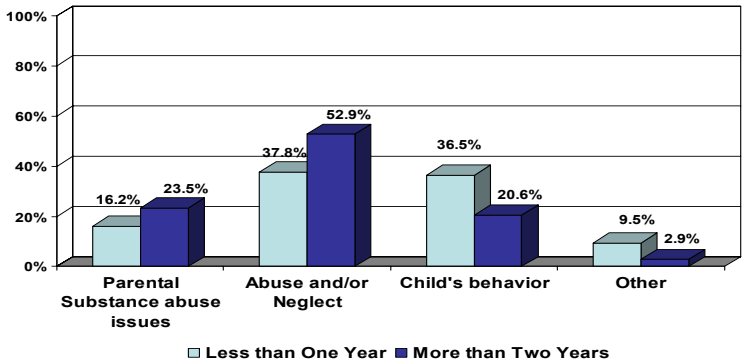


Dependent/Neglected: n = 82
Delinquent or Unruly: n = 26

In examining this factor by length of stay in state custody, it appears that children who enter state custody due to family issues are likely to remain longer than those who enter due to their own behavior (see Figure 9). Over 35% of those entering state custody in the last 12 months were placed there primarily because of the child's behavior, while approximately 20% of those in state custody longer than two years were placed for that reason. The majority of children entered state custody due to problems in the home environment. Effective services that directly target improvement in family functioning could have a significant impact on the number of children in state custody as well as the length of time spent in state custody.

Figure 9

Reason for Removal from Home
by Length of Time in Custody



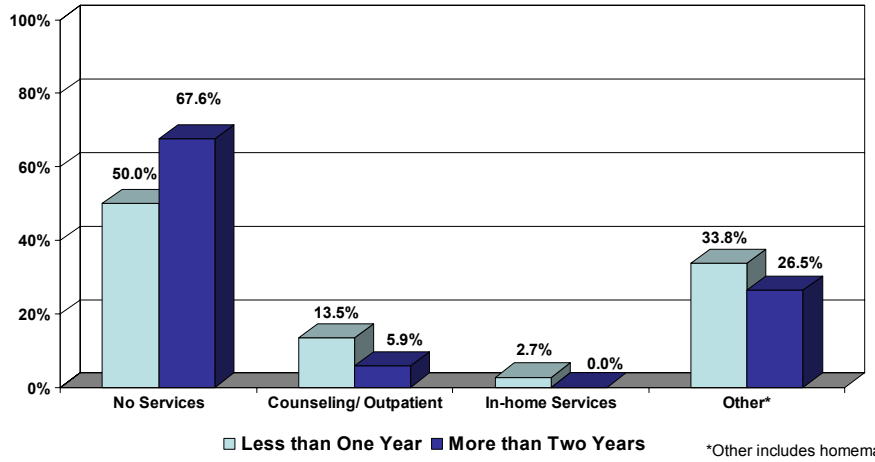
Less than One Year: n = 74
More than Two Years: n = 34

Services Prior to Placement

Figure 10 shows that most families reported that no services were in place prior to the child's placement into state custody. The number receiving no services was somewhat less for those youth entering state custody in the last 12 months. Though the majority of children were brought into state custody for family-related issues, there appeared to be limited implementation of services specifically designed to address those challenges. It is also noted that 63% of families whose children entered state custody for dependent and/or neglect issues reported receiving no services prior to their children's placement. This finding presents a major opportunity for DCS to have a significant impact on securing the safety and well-being of children in the state by providing more effective services to families aimed at preventing children from entering state custody.

Figure 10

Services Prior to Placement
by Length of Time in Custody



*Other includes homemaker services, financial assistance, probation, multiple services, and medication management

Less than one year: n = 74
More than two years: n = 34

Family Search

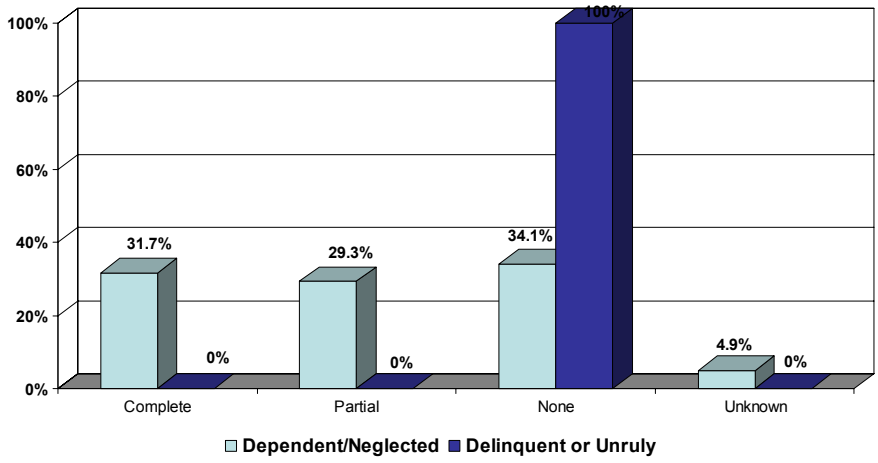
One element of maintaining youth in families who are facing difficult challenges involves a review of all potential relatives who have an ongoing relationship with the family or child. Youth often live in an extensive network of relatives, friends, and other supportive adults who are potentially viable placements. To understand this issue, an intensive search for such individuals was conducted as part of each case review.

Figure 11 provides information on family searches completed by DCS staff. At least a partial family search was completed in almost two-thirds of the cases in the sample. In cases of children adjudicated as Dependent/Neglected 61% had either a full or partial search completed. None of the cases adjudicated Delinquent or Unruly had a search completed. Youth adjudicated as Delinquent or Unruly typically entered state custody with viable family resources, but more thorough family searches may uncover previously untapped resources that could positively impact recidivism and long-term outcomes.

Figure 11

Family Search by Adjudication Type

Does not include children in YDCs



Dependent/Neglected: n = 82
Delinquent or Unruly: n = 18

State Custody Prevention

Case reviews included a delineation of family issues at the time of entry into state custody to determine if the implementation of evidence-based family interventions would have increased the chance of the child's remaining at home. To determine the likelihood of state custody prevention, the case review included intensive scrutiny of the situation in the home at the time the child was placed into state custody. (Cases in which parental rights had been terminated or were pending termination were not assessed for the likelihood of custody prevention.) A variety of issues were examined, including barriers to success in the home (e.g. substance abuse of parents, limited support available to parents, school problems, etc.), risk level of the child and family, risk to the community posed by the child, and viability of family resources available at the time. Case reviewers were familiar with the service models that have repeatedly been shown to be effective in helping families resolve such problems. Those families whose issues were likely to have been successfully resolved with such services were determined to have a high likelihood of avoiding their child's placement into state custody.

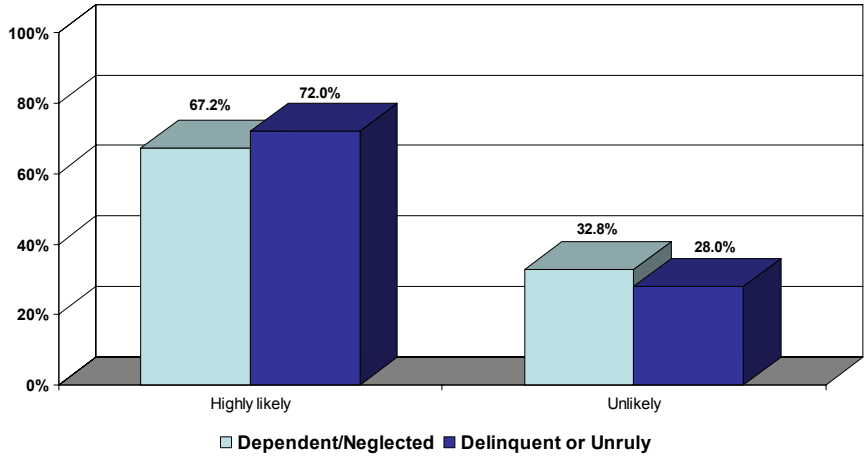
Based on evidence from these cases, almost 70% of the sample, excluding TPR cases, may have effectively been provided services without the need for state custody. This is true regardless of the reason for entering state custody as shown in Figure 12.

Figure 12

Likelihood of Custody Prevention by Adjudication Type

Does not include children with TPR or pending TPR

Case reviewers judged the likelihood that entry into state custody could have been prevented if intensive in-home services had been available to the family prior to DCS intervention.



Dependent/Neglected: n = 58
Delinquent or Unruly n = 25

Initial Placement and Recommended Services

The state custody process and the accompanying court appearances can easily overwhelm families and children. Given that over 75% of youth enter state custody for dependent and/or neglect issues, the need to provide an initial placement with a familiar, safe adult is paramount. The family search data yielded information regarding whether family members were available for involvement. The case reviews included data regarding the frequency of placements with viable relatives.

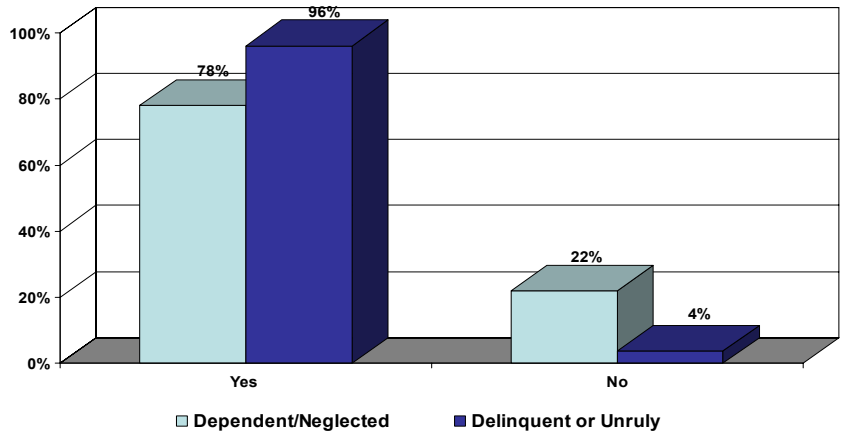
Viable Family at Time of Placement into State Custody

The study process included a review of available evidence concerning family factors at the time of the child's placement into state custody, with close professional scrutiny of whether these families were indeed viable given the effectiveness of available treatment models.

The results of these assessments, shown in Figures 13 and 14, indicate that, regardless of adjudication type or length of time in state custody, over 80% of youth in the study had family resources that could have been utilized, provided that effective in-home services were available to them. Following entry into state custody, the key issue then becomes whether casework activities and placement sites actively involved these family resources.

Figure 13

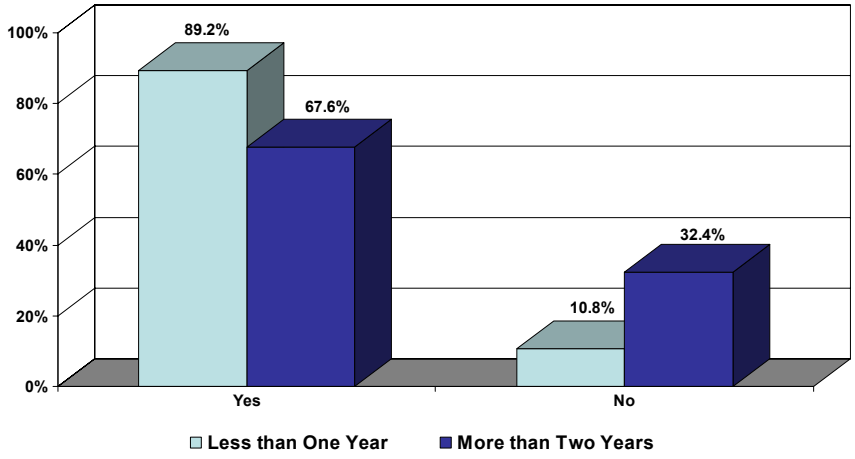
Viable Family at Custody by Adjudication Type



Dependent/Neglected: n = 82
Delinquent or Unruly: n = 26

Figure 14

Viable Family at Custody by Length of Stay in Custody

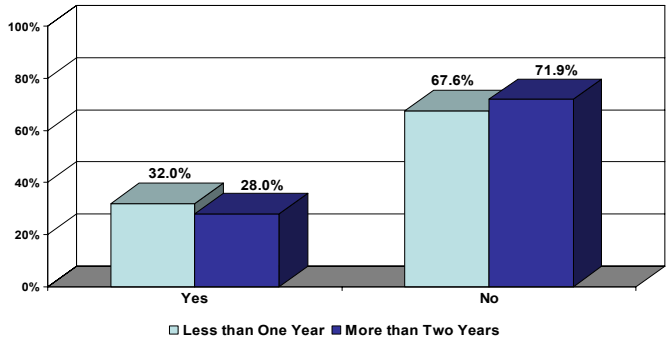


Less than One Year: n = 74
More than Two Years: n = 34

Relative Placement at Time of Placement into State Custody

For children in the study who have been in state custody less than 12 months, 32% were placed with relatives at the time of placement into state custody, as shown in Figure 15, with 28% of children in state custody more than two years placed with relatives initially. It is important to remember that over 80% of children in the sample were found to have available family resources at the time of entry into state custody.

Figure 15
Relative Placement Attempted at Custody
by Length of Time in Custody
Does not include children in YDCs

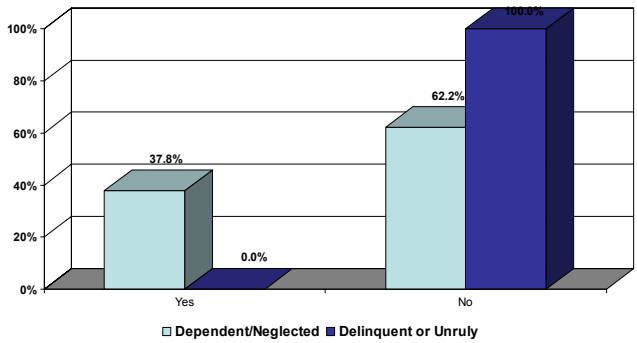


Less than one year: n = 68
More than two years: n = 32

As shown in Figure 16, every child in the sample who had been adjudicated as Delinquent or Unruly was initially placed outside the home. This is the case even though there is evidence that these children could be served at home with intensive, evidence-based interventions that would likely result in more positive, long-term results, including greater community safety through a reduction in recidivism rates.

The limited placement with relatives prior to placement into state custody could be reflective of the dearth of in-home services available to courts and caseworkers, or, as noted in the family search data, it could be that appropriate family members were not pursued as potential placements. Either way, this is an area with significant opportunity for improvement.

Figure 16
Relative Placement Attempted at
Custody by Adjudication Type
Does not include children in YDCs



Dependent/Neglected: n = 82
Delinquent or Unruly: n = 18

Parenting Classes and Anger Management Classes

Parenting classes and anger management classes continue to be popular service recommendations, with over 50% of families reporting recommendations for parenting classes, and more than a third reporting recommendations for anger management classes. The data also showed that these interventions are more frequently recommended for parents of children adjudicated as Dependent/Neglected (66% in this group received such a recommendation), with approximately 30% of parents whose children were adjudicated as Delinquent or Unruly receiving a recommendation for one of these services. It is noted that DCS leadership has recognized that neither service has empirical evidence to demonstrate positive long-term impacts on families whose children have been placed in state custody. While it is generally accepted that there is a significant need for an increase in parenting and anger management skills, substantial evidence points to intensive in-home services as a more effective way to achieve the desired increase in positive family functioning.

Current Placement and Casework Activities

Once a child has been placed into state custody, several factors come into play that are primary drivers of eventual case outcomes. These include ongoing assessments of viable family resources, Permanency Plan goals, placement sites with accompanying services, and actual services provided to families and youth.

Casework activities include the continuous review of case developments and decision making that occurs weekly or sometimes daily. These practices, and resulting decisions, are the "guts" of casework and often involve multiple parties with competing agendas. How these decisions are made, the core philosophy and practice model, and the supervision and guidance provided to caseworkers are the primary source of achieving positive outcomes. The interplay of this process with the key elements eventually dictates whether DCS achieves the ultimate goal of a permanent, safe, and healthy setting in which youth can grow and prosper.

Current Viable Family

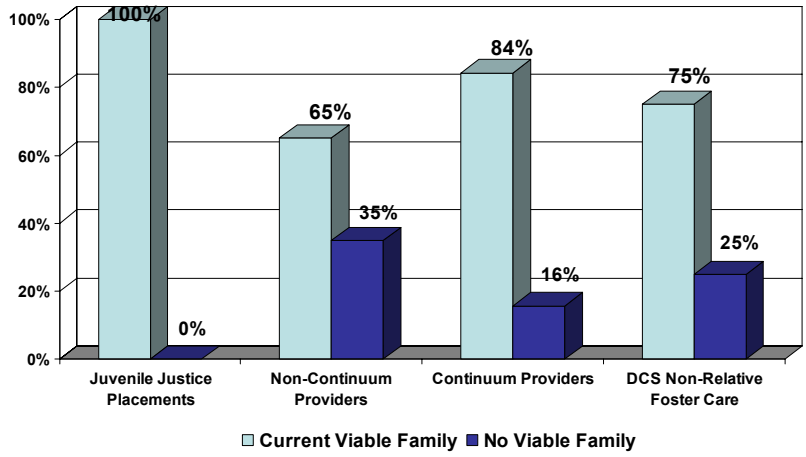
A review of current barriers to family reunification suggested that over 90% of youth in state custody less than one year have available family resources. This finding is encouraging, provided that appropriate interventions and services are implemented to increase the likelihood of reunification. The key driving factors in determining which services are implemented involve case decisions regarding permanency goals and placement site.

The majority of children, regardless of placement type, have current viable family, as shown in Figure 17. All of the children in juvenile justice placements, including YDCs, DCS group homes, and a halfway house, have family resources currently available to them.

Figure 17

Current Viable Family by Placement Type

Does not include children already at home with parents or relatives, or those on runaway.



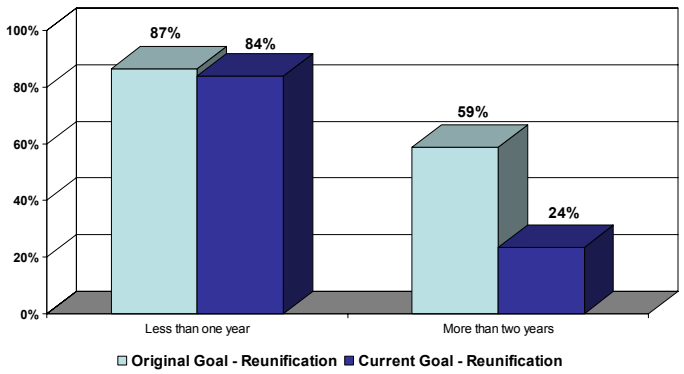
Juvenile Justice Placements: n = 11
Non-Continuum Providers: n = 20
Continuum Providers: n = 19
DCS Non-Relative Foster Care: n = 16

Permanency Goals

Integral to casework activities is the determination of Permanency Plan goals and how this process drives both placements and services. As noted previously, most youth enter state custody both with viable family and through Dependent/Neglected adjudication. Typically these cases are prime candidates for implementation of effective services to address family barriers and have a high likelihood of successful reunification.

The ongoing review of placement goals and associated changes should provide some indication of the effectiveness of interventions with individual children and families. Figure 18 shows that among children in the study who had been in state custody more than two years, 59% had a Permanency Plan goal of reunification at the time of entry into state custody and 24% of them currently have reunification as a goal. Explanations of the reasons for this decrease are beyond the scope of this study; however, it is possible that the provision of effective services that address barriers to reunification would allow parents to remain the most viable option for placement of their children.

Figure 18
Original and Current Permanency Plan Goal
by Length of Time in Custody



Less than one year: N = 74
More than two years: N = 34

The impact of the permanency goal designation is seen in the placement of youth and the services that accompany each placement.

Current Placement Characteristics

The type of placement is a key element in determining the range of services available to a child and family. Private agency providers have contractual requirements to provide specific services to children in their care. These services often have a significant impact on the length of time in state custody, placement stability, and long-term outcomes.

Table 2 shows characteristics of youth in state custody by type of placement. These data indicate that youth in DCS non-relative foster homes have been in state custody longer than youth in most other placement types and have spent, on average, 27% of their lives in state custody. This information is particularly notable when coupled with the finding that 78% of these youth have current viable family resources and that 50% of these children have a goal of reunification. Most families of these youth (61%) reported receiving no family services. In addition, 44% of these youth have no projected step-down date. Youth who are placed in a DCS non-relative foster home appear likely to remain in care for a significant period of time. The case reviews showed that 67% of these youth could likely be successfully reunified with their families.

Table 2

Current Placement Characteristics

	DCS Relative Placement n = 27	DCS Non-Relative Foster Home n = 18	Private Agency Placements n = 27	Trial Home Visit/Adoptive Home n = 17	YDC Group Home n = 19	TOTAL N = 108
Length of Time in State custody						
Three or More Years in State Custody						
Number	5	5	6	10	3	**29**
Percent	*18.5%*	*27.8%*	*22.2%*	*58.8%*	*15.8%*	*26.9%*
More than Half of Life in State Custody						
Number	7	3	2	6	0	**18**
Percent	*25.9%*	*16.7%*	*7.4%*	*35.3%*	*0.0%*	*16.7%*
Average Percent of Life in State Custody to Date (Nov. 1, 2004)						
Mean	*28.8%*	*26.9%*	*19.1%*	*36.9%*	*8.1%*	***23.7%***
Current Case Characteristics						
Current Viable Family						
Number	27	14	20	13	17	**91**
Percent	*100.0%*	*77.8%*	*74.1%*	*76.5%*	*89.5%*	*84.3%*
Current Permanency Goal of Reunification						
Number	8	9	13	8	17	**55**
Percent	*29.6%*	*50.0%*	*48.1%*	*47.1%*	*89.5%*	*50.9%*
No Current Services to the Family						
Number	11	11	16	11	16	**65**
Percent	*40.7%*	*61.1%*	*59.3%*	*64.7%*	*84.2%*	*60.2%*
No Projected Step-down Date						
Number	1	8	17	N/A	10	**36**
Percent	*3.7%*	*44.4%*	*65.4%*		*52.6%*	*33.3%*
Case Recommendations						
Recommended to Go Home						
Number	1	12	21	N/A	16	**50**
Percent	*3.7%*	*66.7%*	*77.8%*		*84.2%*	*46.3%*
Recommended In-home or Transitional Living Services						
Number	18	16	22	11	17	**84**
Percent	*66.7%*	*88.9%*	*84.6%*	*64.7%*	*89.5%*	*77.8%*

Based on data from the sample, almost 75% of youth in private agency placements had current viable family, although only 48% had a current goal of reunification. Sixty percent of the families of youth in private agency placements reported receiving no family services and 65% of youth in these placements had no projected step-down date. The case recommendations suggest that 78% of these youth could be returned home within six months. These data indicate that there may be significant room for improvement in the process by which providers are held accountable for the provision of effective services to children and families.

Current Services and Outcomes

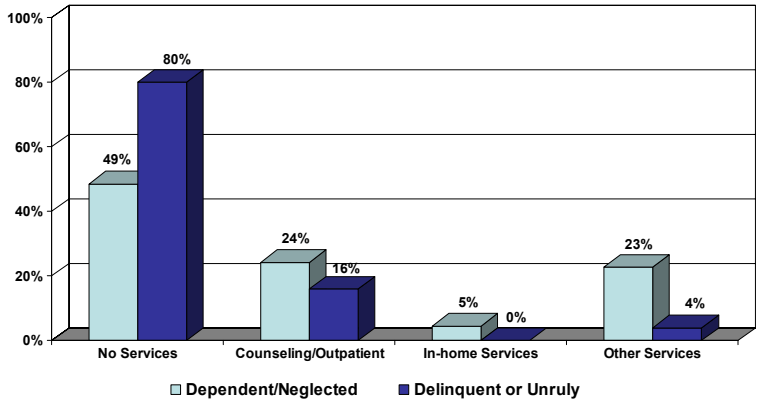
As noted earlier, multiple placements and types of placement impact length of time in state custody and long-term outcomes due to the configuration of services available to children and their families. Continuums have, by contract, agreed to offer a menu of services, the provision of which is dictated by the permanency goals and clinical needs of each child and family. All providers are required to work with DCS case managers to meet the outcomes noted in each individual program plan.

Reports from families, providers, and case managers interviewed during the study suggested that these services are not being provided to all children and families. Figure 19 shows that, even with identified current family, 49% of families of children adjudicated as Dependent/Neglected reported no family services. Eighty percent of families of those adjudicated as Delinquent or Unruly reported receiving no services at the time of the assessment.

Figure 19

Current Services to Family by Adjudication Type

Includes only children with identified current family



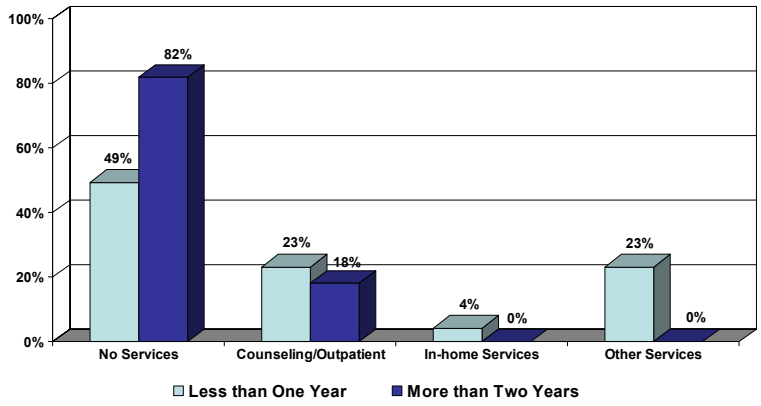
Dependent/Neglected: n = 66
Delinquent or Unruly: n = 25

Staying in state custody over two years seemed to decrease the likelihood of receiving family services, with 82% of families whose children had been in state custody more than two years reporting no family interventions (see Figure 20).

Figure 20

Current Services to Family by Length of Stay in Custody

Includes only children with identified current family

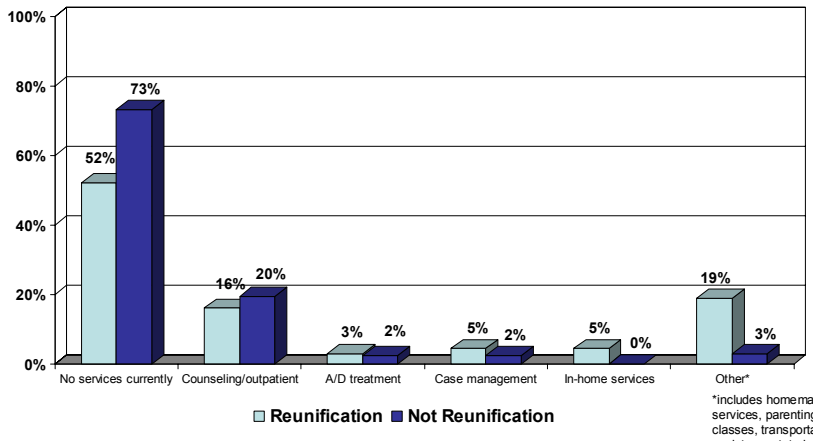


Less than One Year: n = 69
More than Two Years: n = 22

The findings noted above could perhaps be explained by the current permanency goal, as some cases may have viable family members, but, for a variety of reasons, have a goal other than reunification. However, Figure 21 shows that even with a Permanency Plan goal of reunification, over half of the families reported that they are not receiving any services.

Figure 21

Current Services by Current Permanency Goal



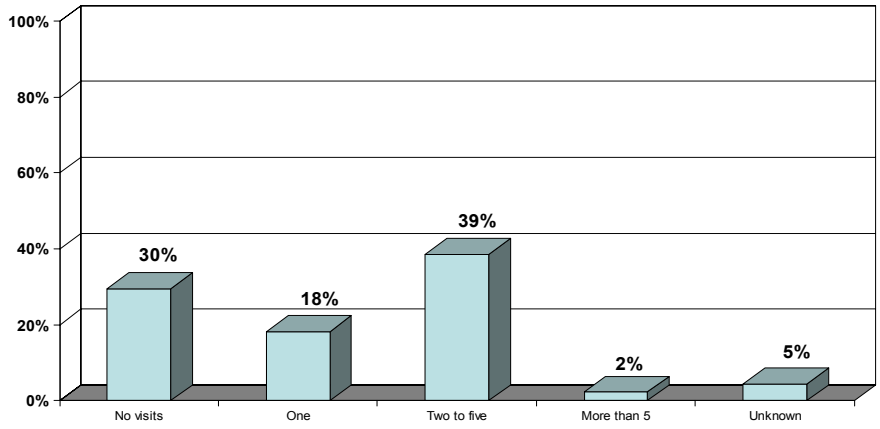
*includes homemaker services, parenting classes, transportation assistance, tutoring services, and financial assistance

Reunification: N = 67
Not reunification: N = 41

Services provided to children and families should result in tangible positive outcomes. If family services are effective, it would be expected that children who have a goal of reunification would have frequent family visits and that the length of time to reunification would be minimal. Figure 22 shows that, for children with a goal of family reunification, 30% had no family visits in the last 30 days, while 18% had one visit. It was encouraging that almost 40% had two or more visits. Services and visits should increase the likelihood of step-down to family reunification with careful and consistent case planning. However, without an established step-down date, there may not be consistent movement toward reunification. Among those whose goal was reunification, half of the children had no identified step-down date.

Figure 22

Number of Family Visits in Last 30 Days
for Children with Permanency Goal of Reunification



N = 39
Does not include children currently at home, with relatives, in adoptive homes, on runaway, or those whose parents' rights have been terminated.

Case Recommendations

Recommendations were made in each case both for the most appropriate placement for the child and for the services that were likely to ensure a positive long-term outcome for the child and family while maintaining a high level of community safety. Recommendations to return home were based on the assumption of the availability of intensive in-home services for these families.

Overall, it was recommended that over 45% of the sample return home with parents or relatives. Intensive in-home or transitional living services were recommended for over 75% of the sample. Referring back to Table 2, it was recommended that two-thirds of those in DCS non-relative foster care return home and that more than 80% of those in juvenile justice placements return home. Of those in private agency placements, it was recommended that more than 75% return to live with parents or relatives.

While 51% of those children adjudicated as Dependent/Neglected were already home (in relative placements, on trial home visits, or in adoptive homes), another 37% were

recommended to reunite with their parents or relatives, leaving only 12% of children in this group in foster homes. Of those adjudicated as Delinquent or Unruly, 85% were recommended to go home. Only two of the 26 youth in this group were recommended to stay in out-of-home placements. For those adjudicated as Delinquent or Unruly, recommendations were based on clinical necessity for placement and community safety issues but did not take into account other factors such as determinate sentences or judicial decisions concerning placement.

Agency Assessments

In order to provide a comprehensive assessment of each youth, program staff members in contract agencies were interviewed regarding agency practices and treatment approaches. Three main areas were addressed: behavior management/therapeutic issues, family involvement, and discharge planning. The first area focused on environmental factors, level and point systems, therapeutic model, and use of restraints and seclusion. The second area, family involvement, focused on the youth's contact with the family, availability of family therapy, and the family's involvement in the treatment planning process. The final area was discharge planning, which focused on the discharge planning process, the length of stay, and the clinical necessity for continued stay. The standards of care in each of these areas are drawn from outcome research and best-practices guidelines discussed below.

Research (United States Public Health Service, 1999) clearly indicates that little positive long-term behavioral change results from lengthy stays in residential treatment facilities, particularly when it is the only intervention provided. While residential treatment might be a necessary step to ensure safety in the short term, plans for discharging youth to either in-home services or to a foster home should be aggressively pursued. Furthermore, to increase likelihood of success, residential programs should use cognitive-behavioral interventions that are positively focused. Also, programs with a strong ecological foundation, such as the Re-Education of Emotionally Disturbed Youth (Re-ED) model, are more likely to enhance level of functioning within the residential treatment setting (see Appendix IV for further information on Re-ED). Finally, residential treatment programs should provide significant coordination with aftercare and community resources. Both therapeutic foster care and certain in-home treatment models can be much more effective and less costly than residential treatment (United States Public Health Service, 1999). Home-based services and therapeutic foster care should, therefore, be the primary mode of service delivery for youth with emotional disturbance. It is also apparent that not all in-home services produce successful outcomes, and funds should be spent only on those with proven efficacy.

The assessment included visits to 34 facilities and foster care agencies to review the care provided to 50 children. In most cases, this involved meeting with the primary therapist or case manager for the identified child. In some cases, it included a meeting with directors and a tour of the facility. Most staff members openly discussed the programs as well as the progress of identified youth. In cases where direct-care staff members were

interviewed, the information reported may not represent official agency policy but is instead a reflection of practice. In cases where management staff members were interviewed, the information may reflect agency policy rather than actual practice. This is because management staff members typically are aware of "big picture" issues and know the company's policy. Often, direct-care staff members were more focused on their jobs and, therefore, responded to the interview from a practice perspective. Some information was gleaned from observation.

Behavior Management and Therapeutic Issues

A level or point system is often in place to facilitate improvement in behavior, especially in residential treatment programs. The behavior management system should reward positive behaviors, with no punitive measures used. Sound clinical practice suggests that punishment does not change behavior in the long term and once the threat of punishment is removed, the behavior often returns. Using punitive measures may make behavior worse. Rewarding positive behavior is a much more effective way to bring about long-term change. Often, level systems are used to manage a youth's behavior while in a program, with little regard for how that behavior will generalize to the community. As previously noted, research (United States Public Health Service, 1999) suggests that residential treatment should only be used as a short-term safety intervention. Level and point systems should, therefore, be designed to support community integration and target the riskiest behaviors.

Restraint and seclusion are interventions that should be used only when less restrictive interventions are unsuccessful, as they pose an inherent risk to the physical safety and psychological well-being of youth and staff (Joint Commission on Accreditation for Healthcare Organizations, 2001). Restraint and seclusion have the potential to produce serious consequences, such as physical and psychological harm, loss of dignity, violation of an individual's rights, and even death. Therefore, organizations should strive to reduce the use of these interventions and monitor their use carefully. Rooms used for seclusion and restraints should be designed to protect the health, safety, and well-being of the youth.

The environment should be clean and well-maintained. It should not have a generic institutional look. Posted materials, such as rules and expectations, should be positively worded. Adequate personal space should be provided for all youth. Interaction between staff and youth should be positive and supportive.

Family Involvement

Research (United States Public Health Service, 1999) suggests that a youth's success in a residential treatment program depends on coordination of aftercare as well as the healthy functioning of the environment to which the youth returns. Family involvement is critical to safely and quickly stepping youth down to a less restrictive environment. Youth should have access to telephones and should be able to freely send and receive mail. Family visitation should be encouraged, and passes should be allowed frequently regardless of

level, so that youth can practice generalizing the skills they are learning in the program. Passes should be considered an integral part of the treatment and should only be restricted for safety reasons. Agencies should be willing to assist families with transportation for passes. When safety issues in the home are identified, the program should address and resolve those issues with the family so that passes can continue. Families should be encouraged to participate in treatment planning and discharge planning. Frequent family contact and involvement are critical, allowing the youth and family to maintain hope for treatment success and facilitating movement home. Families who continue to be involved and feel a sense of responsibility for a child are more likely to make the changes necessary to have that child return home. While therapeutic foster care is more likely than residential treatment to create long-term behavior change, the same interventions are necessary in foster care to move youth back home quickly.

Family therapy should be a priority and should occur as often as weekly if family members are amenable. If family members cannot attend meetings or sessions during the day due to work schedules, efforts should be made to conduct sessions when attendance is possible, such as on weekends or at night. If the family cannot come to the facility, agencies should be willing to take youth to the home to conduct family therapy or should offer to pay for transportation. Referral behaviors of youth are frequently the result of issues in the home, and family therapy is the only way to address those issues. Youth who progress behaviorally in residential treatment often cannot generalize what they learn to an environment that has not changed. For example, a youth using drugs in the home may stop in a residential treatment program because the drugs are not available. When that youth returns to a home where drugs are available again, the skills he learned in residential treatment will probably not be sufficient to prevent further drug use. The same concepts apply to foster care. If a youth is managing well in a stable home, returning to an unstable home can quickly result in reoccurrence of negative behaviors.

If the agency is a continuum provider, in-home services should be intensive and should use a model which has been proven effective. Research (Texas Department of Mental Health and Mental Retardation, 2003) shows that family therapy conducted in the home does not necessarily produce better results than outpatient family therapy or other similar services. However, there are models that have been demonstrated to be effective in rigorous clinical trials (United States Public Health Service, 1999). These models should be implemented when indicated.

Discharge Planning

In order to move youth to a less restrictive environment as quickly as possible, discharge planning should begin on the day of admission and should then be addressed at each treatment plan review. Research (Texas Department of Mental Health and Mental Retardation, 2003) shows that extended stays in residential treatment are not generally effective at bringing about long-term success, so there should be a sense of urgency to move youth home. Specific criteria for continued stay should be developed, and youth should be discharged as soon as they no longer meet the criteria. Discharge should not be based on a youth's reaching a certain level or obtaining a certain number of points. This

often frustrates youth who are unable to attain these goals but could otherwise be maintained in the community. Typically, a youth who does not require restraints or 24-hour supervision can be treated in the community. Sometimes, a judge must approve a discharge, which can be a barrier to ensuring that only youth who clinically need residential care are served in that setting. In these situations, agencies should advocate for appropriate services for the youth.

Youth who do not make progress should be assessed frequently to determine how the program should be altered to facilitate progress or to determine if another program is needed. Programs should continuously assess necessity for continued stay, and youth should be stepped down as soon as they are able to function successfully in the community. If a youth is not making progress, it is important to understand why and change the course of treatment within a few months. If a youth does not make progress within six months, it should be assumed that the program is not meeting the child's needs, and he or she should be placed elsewhere. Often, youth engage in negative behavior in a residential setting because they are with negative peers or because they are not at home. It should not always be assumed that this negative behavior will carry over to the community. If, for example, a youth continually runs away from residential or foster homes but runs to his or her home, the easiest way to stop that behavior is to step the youth down to the home with in-home services.

Findings from Agency Assessments

For purposes of this report, agencies were grouped into four categories: Youth Development Centers and DCS Group Homes, Non-Continuum Residential Providers, Non-Continuum Foster Care Providers, and Continuum Providers.

Youth Development Centers and DCS Group Homes

Number of Agencies Assessed: 7
Number of Children in Study in this Group: 11
Average Length of Stay: 15.5 months
Range of Length of Stay: Less than 1 month to 80.8 months

The three trends seen in published reports (National Mental Health Association, 1998) regarding juvenile justice services are the lack of efficacy of congregate care placement, problems associated with a punitive model for youthful offenders, and problems associated with providing effective mental health interventions within this model. It appears from this research that the juvenile justice system should provide mental health interventions to prevent juvenile offenses and provide mental health services in the community to many offenders in lieu of placement in a developmental center. Also, the systems should strive to make the environment of developmental centers less punitive and provide more intensive aftercare services.

Many of the themes seen in the reports regarding juvenile justice were also seen at the four Youth Development Centers (YDCs) in Tennessee. It appeared that there was a "get tough" attitude that manifested itself in a variety of ways. For example, in all

developmental centers, the responsibility for change was placed on the youth. This became evident in staff comments such as "he is not working the program." In addition, all YDCs employed punitive behavior management programs that required earning points to obtain release. Staff members consistently did not see changing the youth's behavior as the program's responsibility. Staff reports also were consistent with research findings (American Youth Policy Forum, 2001) regarding the poor success rate. Although no data were available for these developmental centers, staff members consistently estimated that only 25 to 30% of youth released are successful and 70 to 75% either returned to juvenile corrections or entered the adult system.

The most consistent theme seen throughout the YDCs related to the gaps in services; specifically, a need was identified for more family services while youth are in the program and for effective in-home support following discharge. Every single staff member interviewed stated that regardless of how well youth do in the program, they have a very difficult time trying to succeed when they go home to the environment that fostered the illegal behavior prior to placement. Quotes from staff included the following:

- "Students come back because they are in the same environment."
- "They go home and have a lot of freedom."
- "We can't change behavior by putting them back in the same environment. We are not equipping them with the tools to be successful when going home because the parents are unemployed and on drugs."
- "You can't change the home front."
- "We are only dealing with part of the problem. Some make a lot of progress when they are here, but when they go home to the same environment, they lack the support and go back to their old ways."

When the staff members were asked about how the process would improve if the home environment were changed, they agreed that it would be beneficial for youth but were skeptical that it could be done. It seemed that changing the home environment was not a concept that they had considered to be possible.

The same issues identified for the YDCs were seen in the DCS group homes and the halfway house for youth involved in the juvenile justice system. Interviews with the case managers in these facilities also supported the need for family services and in-home aftercare, with staff members again stating this as a need in every single case. As one staff member said, "Once they walk out the door, they are on their own." It is also possible that many youth placed in the group homes or in the halfway house could be better served with in-home services. Not all youth assessed seemed to need 24-hour supervision and in many cases went to school or had jobs independently. If youth in this category do not have families, then this type of placement may be appropriate to prepare them to live independently. However, with family involvement, the resources would be better spent on in-home services that have more positive and longer-lasting effects. In general, it appeared that these facilities provide an acceptable level of care for youth, even if that care does not result in long-term change. One in particular, however, had an extremely punitive behavior management system in which youth are given points weekly

that they then lose for infractions. This system not only results in lack of progress but may cause long-term negative effects on behavior and overall functioning.

Non-Continuum Residential Providers

Number of Agencies Assessed: 8
Number of Children in Study in this Group: 9
Average Length of Stay: 13.6 months
Range of Length of Stay: Less than 1 month to 49.3 months

Another group of agencies consisted of non-continuum residential programs and included Level II residential facilities, one Level III and Level IV residential facility, and one serving a youth subcontracted through another Level III provider. For many of the youth assessed at these agencies, it did not appear that congregate care was necessary. In most cases (especially in the Level II programs), the youth could be maintained in a foster home or at home with appropriate services. These agencies also did not seem to reflect a sense of urgency to move the youth to a less restrictive environment. These programs were the least likely to encourage passes or family contact by assisting with transportation, and in most cases, youth had to reach a certain level to earn a pass. In all cases but one, some family therapy was offered, but in no case was it reported that staff would take the child home to do family therapy or offer to pay for transportation for the family. In no case was in-home family therapy available. In the majority of these agencies, discharge was reported to be based on a youth's earning a certain number of points for maintaining positive behavior. Therefore, length of stay was not related to clinical necessity. Only in the Level III and IV programs was clinical justification given for the youth to remain in congregate care. None of the agencies appeared to take responsibility for affecting change within the family system. It was repeatedly stated that families need to accomplish their goals in order for the child to return home. Many of these agencies also did not express a sense of responsibility for changing the behavior of the child. There was a sense that the youth should "work the program" and if he or she is not "working the program" then he or she will remain until motivated to change. "Working the program" was often defined as making daily points and/or doing written treatment work. It was reported that youth earn points for doing hygiene, taking medications, cleaning their rooms, and other generic behaviors. Those behaviors are typically not related to referral behaviors and, therefore, discharge should not be contingent on them.

In one of the facilities serving youth with a primary diagnosis of Mental Retardation, it was reported that the lengths of stay range from six months to 10 years. The staff member interviewed reported that there were approximately nine youth at the facility who have no active discharge plans and who will probably remain in the program until their 22nd birthdays. It was reported that the Permanency Plan goal for some of those youth was reunification and for others it was Permanent Planned Living Arrangement (PPLA). For those with the goal of reunification, no work was being done with the family to ensure transition home.

Non-Continuum Foster Care Providers

Number of Agencies Assessed: 9
Number of Children in Study in this Group: 11
Average Length of Stay: 22.7 months
Range of Length of Stay: Less than 1 month to 157.1 months

The third group of agencies consisted of non-continuum foster care providers. It should be noted that some of these providers also have continuum contracts but are listed with this group because the youth assessed was not in a continuum but in Level I or II foster care. There was a great deal of variability within this group. There were a few cases in which the agency staff members were working with the biological parents and providing family therapy. In most cases, the agencies were not working with family members or advocating for reunification. Most of the agencies in this category did not actively work to set up passes or family contact and instead left scheduling and transportation up to DCS. While most offered limited family therapy, only two agencies reported that they would go to a child's home to conduct family therapy when transportation is a barrier. All of the agencies appeared to have safe and stable foster homes available, and most seemed to take responsibility for necessary behavior change of the youth in their care. It appeared that in general, however, agencies in this category (with the exception of two) saw themselves as only responsible for services to the child rather than to the child and the family. This was especially apparent with youth in Level I placements. While working with the family should be an expectation of foster care providers as part of the Permanency Plan, there did not appear to be a mechanism for providing intensive services to families of youth in Level I. The parents needed interventions typically provided to Level III youth, but this level of intensive treatment was not available to them. Follow-up in-home treatment was rare, even though almost all of the staff interviewed recognized the need for such services and said that youth often were not successful because they returned to the same environment that led to the referral behaviors.

Because of this focus on the child rather than the family, it appeared that Level I youth in foster homes were much less likely to return to a parent. In one case, two youth classified as Level I in the same facility were assessed. One adolescent had been in the same non-adoptive foster home since infancy. His Permanency Plan goal was PPLA and the plan was for him to remain in that home. While he has spent his life there and considers it home, the foster parents reportedly will not adopt him because they want to be "fair" to their biological children. The second youth assessed was four years old. Her Permanency Plan was reunification, but neither the agency nor the DCS case manager was working with the mother to help her achieve her goals. A previous DCS case manager ensured that visits occurred, but it was reported by agency staff that visitation had been inconsistent since the change in case managers. Without different interventions, this young girl may remain in foster care for most of her life.

Continuum Providers

Number of Agencies Assessed: 11
Number of Children in Study in this Group: 18
Average Length of Stay: 20.1 months
Range of Length of Stay: Less than 1 month to 59.3 months

The fourth group consisted of continuum providers. Some used contract agencies for one or more of the services provided, and a few provided all services within the continuum. While the continuum providers seemed to be more focused on family involvement and reunification than the non-continuum providers, in many cases there still did not seem to be a sense of urgency about moving youth home or to a less restrictive environment. It also appeared that in some of these agencies, the concept of the continuum model was not embraced and in one case seemed to be misunderstood.

Most of the agencies did encourage passes and family contact and assisted with transportation to ensure that passes occurred. All offered some family therapy, but few of the agencies reported a willingness to take a youth to his or her home to conduct family therapy if transportation was a barrier and/or to offer family therapy during non-business hours. In-home services were provided when a child returned home, often through a contract with another agency. Most of the in-home services consisted of a one-time per week visit to the home for a period of three to four months post-discharge. Most agencies were able to justify the clinical necessity for continued stay and seemed to take responsibility for behavior change with the child, but few of these agencies appeared to take responsibility for change within the family. In general, families were expected to meet their permanency goals without the support of the agency.

One case in particular raised serious concerns about the length of time in treatment. One youth assessed for this study was in treatment for a sexual offense and was placed in a residential treatment program. Agency records reviewed during the assessment indicated that after one year of treatment, during which no apparent progress was made, his discharge date was reset so that he would remain in the program for two more years. After a year of no progress, it should have been determined why the program wasn't working and if another program was more appropriate for this youth. After almost three years and little or no success, a judge ordered that he be placed elsewhere for evaluation.

Another case demonstrated that DCS had some success in altering the services provided by the agency. In this case, it was reported that the agency only had residential beds until DCS asked them to move youth out of residential treatment and into foster homes. This was effective, and now DCS youth are rarely placed in residential treatment through this agency. However, it now appears that instead of remaining in the residential treatment program unnecessarily, youth remain in foster homes unnecessarily, despite the fact that they are in a continuum contract. This agency contracted for in-home services, but these services were implemented in the foster home rather than in the biological family's home. It was stated that the agency's main concern was the foster family. It appeared that in this situation, the purpose of the continuum was misunderstood. This agency also cares for youth who are in their parents' custody, without plans to return the youth home, and

without providing any type of treatment. The staff member being interviewed reported that it "is like an orphanage."

It appeared that there was a difference between the continuum providers who provided all services within the agency and those who contracted for some services. Many of the full-continuum providers seemed to feel a sense of urgency regarding the need for youth to be at home and could provide clinical justification as to why the youth continued to require the current placement. It appeared that these agencies fully embraced the concept of the continuum, and as a result, the families and youth benefited. There seemed to be a value system based on the fact that youth belong at home with their families. This was supported by their understanding that residential treatment programs are an artificial environment and, for long-term change to occur, work must be done with the family. In these agencies, levels and points were not the basis for discharge but were instead used to reward positive behavior. In one case, one of the youth was making only minimal progress in residential treatment, so the agency moved her to a foster home after determining that the residential environment was contributing to her problems. This type of decision making is evidence that the agency takes responsibility for behavior change with the child rather than placing that responsibility solely on the child.

Relationship Between DCS, Providers, and Families

While assessing various programs and agencies, a trend became apparent. There was a great deal of variability in services, case planning and decision making, and the apparent sense of urgency to move children toward permanency. The speed with which children returned home or stepped down often appeared to be driven almost exclusively by the random assignment of a case manager or agency. If a youth was assigned to a DCS case manager who focused on the needs of the child and family, the case was handled very effectively and the parents were more likely to get the support and help they needed. Sometimes agency staff could step up and take the lead in helping to move children as quickly as possible toward permanency. The children who seemed to fare best in the system either had a case manager who focused on their needs or were served by an agency that focused on family therapy and a quick return home. In cases where neither the agency nor the case manager aggressively worked to move the youth through the system, the process was unnecessarily slow.

It also appeared that there were differing perceptions among providers of the qualities of a "good" case manager. In one case, a provider reported that the child's new case manager was "good" because she responded quickly to phone calls and always signed and returned monthly paperwork. The child, however, had not had a family visit in six weeks. The previous case manager, who reportedly did not complete paperwork so efficiently, was able to arrange for visits and provide transportation for the child every other week. Adherence to current case practices does not necessarily produce positive outcomes for youth and families. "Doing a good job" was defined as being responsive to the provider. In only a few cases was the ability of the case manager to quickly move a child home mentioned by providers as a desirable trait.

It appeared that in many cases, DCS and families were not aligned. In these cases, it was often incumbent upon the parent to meet Permanency Plan requirements without support or assistance. In other cases, the provider's alignment with the family was weak, resulting in limited services to the family. Many programs do not work with families, focus on discharge to a permanent placement, or provide any in-home services. In some cases where the provider was aligned with the family and provided support or services, they seemed to have to advocate for the family just to get services that are available under the current policy set by DCS leadership. This supported the notion that the effectiveness of the system is random and often based on selection of the case manager and/or the agency.

Youth who had a less effective DCS case manager and were placed with an agency that did not assist the parents were more likely to remain in the system. In other words, the system itself was not sufficient in reunifying families. A youth must have at least one self-motivated person to advocate for him or her, whether it is a staff member at the agency or the DCS case manager. Ideally, DCS, the provider, and the family should be aligned to do what is best for the child.

Potential Cost Savings

An estimate of the potential cost savings associated with implementing the case recommendations concerning custody and placement was completed. All children in the study who were under 18, did not have an established step-down date, and for whom in-home services were recommended were included in these calculations. For each of these children, the cost of providing the recommended services was calculated, including the cost of the current placements until reunification with family could be accomplished. This was compared to the estimated cost of these children's remaining in their current placements until age 18 (based on the State Rate for each service plus the cost of DCS case management). The only exception to the formula is the estimate of the cost of DCS Foster Care, which came from information provided by DCS staff, as there is no State Rate for this service (see Table 3 for further details).

Table 3
Estimated Cost of Services

	State Rate for Services	DCS Case Management Cost	Total Estimated Cost Per Day of Services
DCS Foster Homes	$18.96	$17.72	$36.68
Level I Foster Care	$50.04	$17.72	$67.76
Level II	$98.26	$17.72	$115.98
Level II Continuum	$87.18	$17.72	$104.90
Therapeutic Foster Care	$94.71	$17.72	$112.43
Level II Special Population	$103.38	$17.72	$121.10
Level III	$192.44	$17.72	$210.16
Level III Continuum	$149.45	$17.72	$167.17
Level IV	$312.00	$17.72	$329.72

Estimates derived from state rate sheet and from information provided by DCS leadership staff.

The cost of recommended placement and services was calculated as follows: the estimated length of transition time to home, as per the case recommendation, was multiplied by the cost of the current placement plus the cost of the proposed in-home service. This figure was then added to the cost of services after transition to the home, which was calculated by multiplying the number of days of recommended service by the daily cost of the recommended service. This calculation yields the total cost of providing care for each child, from the time that transition work begins until the in-home service is completed. It includes the cost of time spent in the current placement until the transition is made to the home.

As an example to help clarify the methodology, the steps in calculating costs for a 14-year-old child in a DCS non-relative foster home with no step-down date are presented below.

Calculation of cost of remaining in current placement:

$36.68 - Cost per day of current placement
x 1460 - Days remaining until 18th birthday
$53,552.80 - *Total cost of remaining in current placement until age 18*

Calculation of cost of implementing service and placement recommendations:

$36.68 - Cost per day of current placement
x 60 - Days until transition to home
$2,200.80 - Cost of remaining in current placement during transition period

PLUS

$82.00 - Cost per day of intensive in-home services
x 240 - Days of service recommended, including 60 days of transition
$19,680.00 services and 180 days of service following return home

$21,880.80 **-** *Total cost of implementing recommendations*

$53,552.80 - *Total cost of remaining in current placement until age 18*
- ***$21,880.80*** **-** *Total cost of implementing recommendations*
$31,672.00 - Potential cost savings for this child

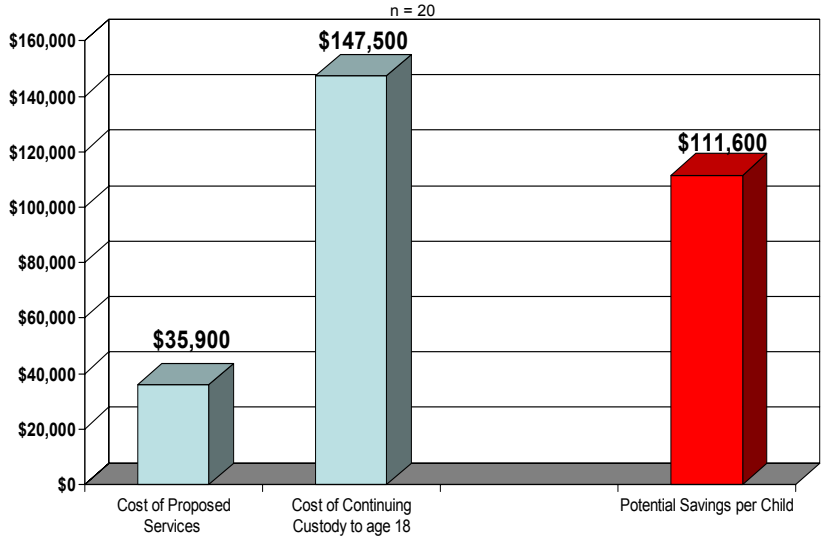
Based on cases from the sample in which the child was under 18 years old, had no established step-down date, and had a recommendation to receive in-home services, Figure 23 depicts a comparison of the average cost of implementing the proposed recommendations and the average cost of the youth remaining in state custody until age 18. The graph also shows the cost difference between the two. Average cost of the proposed recommendations is estimated to be $35,900 per child, while the average cost of a child's remaining in custody until age 18 is approximately $147,500. Implementation of the proposed recommendation is projected to result in an average cost savings per child of $111,600. These savings would be realized over several years.

Figure 23

Potential Savings Realized by Implementation of Case Recommendations

Includes children with no established step-down date and recommendation to go home

n = 20



This analysis is presented for the purpose of suggesting that significant costs savings could potentially be realized from implementing the case recommendations provided by this study. Several limitations should be noted. First, aside from including the cost of the intensive in-home services which were recommended in each case, costs for other community services that might help assure the success of children and families were not included, such as substance abuse treatment programs and medication management services. Second, calculations assume that children currently in state custody will remain there until age 18. This may have the effect of inflating the estimated cost of not implementing the recommendations, as not all children currently in state custody will remain there until age 18. Further study is recommended to more closely examine the estimated costs for children currently in state custody, based on the likely length of stay for these children. A variety of characteristics, including reason for entering state custody, age at entry into state custody, and type of placement would need to be taken into account in computing an estimated cost of services.

Recommendations

The most exciting finding in the study, which drives all of the recommendations and which presents tremendous opportunities for DCS, is that nearly 85% of the youth in the study were found to have available family resources that, with appropriate services, may be able to care for these youth safely and successfully in their homes. Among youth in state custody for less than one year, 93% were found to have family resources, while 65% of those in state custody more than two years had such resources. These families may include either biological parents, adoptive parents, or relatives who have the potential to take custody of the child (see Appendix I for the decision matrix used to assess the safety of each potential placement).

It is recommended that 46% of youth in the sample return home. Another 41% are already home with parents or relatives. By contracting for evidence-based intensive in-home services for the majority of these youth and families and transitional living services for youth aging out of state custody, DCS could ultimately work toward releasing all 87% of these youth from state custody (see Appendix IV for detailed description of intensive in-home services and transitional living services).

More than half of the children in the sample probably could have been prevented from entering state custody if services with a proven record of effectively addressing family preservation issues had been available for their families. Many more youth likely could have returned home with appropriate services shortly after entering state custody. Extrapolating to the larger population of children in state custody, the evidence from this study strongly suggests that, with effective, intensive in-home services, transitional living services, and other targeted interventions, potentially 6,000 youth could be successfully released from state custody.

Given the enormous potential to reduce the number of children in state custody, the data indicate that DCS can redirect resources toward helping families achieve independence and empowering them to raise their own children successfully, while maintaining a high degree of safety within communities. In most of the cases in the sample, the problems in the home were usually difficult but not insurmountable if addressed using effective treatment strategies.

The changes needed in the behavior of these families cannot be accomplished simply by giving families a list of expectations and assuming that they will make these changes alone. These families can improve their parental supervision, family cohesion, communication with schools, monitoring of their child's peers, stability of employment and housing, support from relatives, and other areas. They can increase their overall level of responsible behavior, reduce their dependence on the state, and do a better job at protecting and providing for their children. But to achieve long-term improvements, the state must be prepared to fund intensive services in the home that are highly structured, measurable, and grounded in science. The outcome will be healthier, happier children, more independent, resolute, and responsible parents and families, and safer, more secure communities.

The formal recommendations of this report are compatible with and strongly support DCS' direction over the past several years to shift to the philosophy outlined in the Brian A. Settlement Agreement, which focuses on moving youth quickly through the system to the least restrictive environment and using data to support decisions. Also, these recommendations fully support the philosophy of DCS as expressed in the Path to Excellence Implementation Plan, which was designed to encourage every possible effort by case managers and providers to empower families. The recommendations include creating a case supervision process within DCS, contracting with a professional care management organization for utilization review services to monitor case activities and service providers, and redirecting resources to expand services that are directed toward preventing children from entering state custody unnecessarily and providing quicker permanency for children in state custody through reunification, adoption, or successful emancipation.

These recommendations provide DCS with a very specific and effective vehicle to directly address these goals and achieve the desired outcomes already identified by DCS through Brian A. It is recognized that not all youth can remain in the home safely and that DCS, as well as all treatment providers, maintain as their ultimate responsibility the protection and welfare of children. In addition, maintaining a high level of community safety requires that youth who pose a significant threat be placed in appropriately secure facilities. Most of the youth in the sample were removed from the home due to problems within the family, yet most of the services seemed to be directed at the youth. The recommendations made as a result of this study provide a highly effective means to increase services for families, achieving safety, permanency, and success in the home whenever possible for all children in Tennessee.

By significantly reducing the number of children in state custody, DCS can dramatically improve the overall quality of care provided by case managers and private providers. This will enhance the capacity of the Department to achieve full implementation of the vision of the Brian A. Settlement Agreement, with emphasis on highly individualized services to each child and family that empower them to resolve their own problems and be more productive citizens.

With fewer children in state custody, more resources will be available for the children who need, despite all attempts at permanency, to remain in state custody. DCS case managers will have smaller caseloads, allowing them to provide more attention to each child and family. Families will receive significantly more services to help them reduce conflict in the home, improve supervision and family relations, redirect youth to pro-social activities, and ultimately achieve independence from the state. Children aging out of state custody with the support of transitional living services will move productively into adulthood, becoming responsible and productive members of society. By having fewer children in its custody, DCS will free significant resources to dramatically enhance the quality of child protective services, utilization management of DCS and provider services, case management services, and the overall care given to each child.

Specific steps are outlined under each recommendation. Additional justification and explanation follow each action step. Implementation of each step within the three recommendations will further the Department's goals of preventing children from entering state custody unnecessarily while maintaining community safety and minimizing the time children spend in state custody.

1. **Develop a structured case supervision process to increase accountability, assure adherence to the practice model, and support the effective utilization of resources.**

    1.A. Implement a supervision structure that allows for frequent review of family preservation, family reunification, transitional living, or adoption activities on all cases in order to increase accountability for achieving permanency for children.

Based on interviews conducted as part of this study, DCS staff members appear to operate with a fairly high degree of autonomy regarding decisions about each child's situation, including the child's removal from the home, type of placement, length of stay, and Permanency Plan goals. Given the significance of the case managers' roles in the outcomes for children and families, a structured case supervision process would provide additional support to these staff members while at the same time increasing the accountability of the Department concerning their efforts toward family preservation, family reunification, or adoption.

    1.B. Utilize the supervision process to assure that all case activities adhere to the practice model.

The addition of a strong case supervision process that regularly monitors all case activities will help hasten the change in DCS culture that is necessary to fully embrace the goal of family preservation, as expressed in the Department's practice model. These changes are already under way with the most recent Brian A. Settlement Agreement and the Path to Excellence Implementation Plan. A supervision model built around the philosophy of family preservation evident in these documents would further encourage all case managers and supervisors to continue to adopt these values, using them as a consistent basis for decision making.

Regular and frequent team supervision would provide a mechanism to hold DCS staff directly accountable for follow-through on case activities directed toward family reunification, adoption, or successful emancipation. Similar to the supervision practices found in evidence-based models, it is recommended that case managers report on their cases to a practice model expert whose role is to ensure that they follow a systematic process in working with families. Thus, the supervision process would monitor case activities that include engaging with families, developing shared goals, completing a thorough, multi-system assessment, developing a clear understanding of the reasons for the child's and family's problems, and developing appropriate interventions that include periodic reassessment of the effectiveness of services.

The supervision process should also ensure that case managers adhere to the principles of the practice model that include making decisions based on identified reasons for the child's behaviors within the full context of each family's situation, utilizing family strengths to develop child and family plans, and designing interventions that promote responsible behaviors. In addition, interventions developed by case managers should be appropriate to the child's and family's abilities, should address the current behaviors and issues of the family, and should be continuously evaluated for effectiveness in improving family functioning. By developing interventions that will generalize to the future, families will learn to resolve problems independently after the case manager's involvement has ended.

1.C. Provide training to case managers and supervisors concerning the interface between case supervision, the utilization review process, and in-home services to enable the effective use of the process to achieve reunification, adoption, or successful emancipation more quickly, while maintaining focus on safety for the child and community.

For services directed at family preservation or reunification to be successful, the cooperation of the case managers, court staff, and other key players is essential. Given the risk factors and safety issues surrounding decisions about child placement, all parties need to reach an agreement about how to best meet the child's and family's needs. By having a structured supervision model based on effective evidence-based practices, a consensus between in-home providers and case managers is more likely to develop. Without this consensus, financial resources could potentially be wasted on barriers imposed by those with philosophical disagreements about this approach.

DCS supervisors should be held accountable for assisting case managers in completing case planning that adheres to the principles and analytical process above, preparing thoroughly for weekly case supervision by the practice model expert, and following through on recommended interventions. Supervisors should also be held accountable for working with the practice model expert, targeting each case manager's individual strengths and needs, and training the case managers accordingly.

Given case managers' high caseloads, the importance of the case supervision practices described above are eclipsed only by the need of the state to ensure that families receive evidence-based services that utilize the principles described above. In doing so, the state will enable case managers and agencies to work cooperatively to provide effective services specifically designed to meet the needs of the children and families they serve.

2. Contract with a professional care management organization for utilization review services to monitor all family preservation, family reunification, adoption, and transitional living services provided to youth and families.

An independent utilization review process, based on a care management model, is needed to evaluate entry into state custody, all placement decisions, and the quality of services provided by both DCS and private agencies.

2.A. Employ a professional care management organization to conduct utilization review in order to assess services provided to children and families.

The goal of implementing an independent utilization review process using a care management model is to institute an effective accountability mechanism for DCS case managers' activities directed toward family preservation, family reunification, and adoption. This process would set clear guidelines for case managers to complete a series of actions aimed at preventing children from entering state custody, either through provision of effective services to the family or placement of the child with relatives. For those children who enter state custody despite the provision of services to the family and attempts at relative placement, efforts of DCS case managers would be immediately directed toward providing permanency either through provision of more intensive services for the purpose of reunification with the family, through the movement of the child toward a non-relative adoptive home, or through provision of transitional living services in order to facilitate successful emancipation.

It is recommended that the utilization review process be implemented through a professional care management organization that is held strictly accountable for achieving defined measurable outcomes directly related to the success of children and families who are served by DCS. The organization should monitor the progress of each child as she or he moves through the system to prevent stagnation in what are designed to be temporary placements. They should also be responsible for monitoring data on each youth, such as length of stay in each placement and all services attempted to help children achieve permanency.

2.B. Monitor implementation of services to prevent children from entering state custody.

Every family, prior to losing custody of their children, should have the opportunity to receive evidence-based, effective prevention services. A process is needed to provide an in-depth assessment of each family, including an exhaustive relative search, recommend a package of effective prevention services, complete the evaluation process, and ultimately determine the necessity of placement into state custody. In cases where children are removed from the home on an emergency basis, a mechanism should be developed to keep children in the parents' custody while the child is placed out of the home temporarily. Such a mechanism would allow the utilization review and case supervision processes time to ensure that all attempts have been made to provide effective prevention services to the parents or relatives prior to official custody transferring to DCS. While we understand that there may be potential legal barriers to this recommendation, this process will provide the best opportunity for DCS to assure that children do not enter state custody unnecessarily.

2.C. Assess efforts to achieve permanency for the child either through family reunification services, adoption services, or transitional living services.

DCS needs part of the care management organization's effort to be intensively focused on moving youth successfully out of state custody. Case managers and supervisors, with high caseloads and a large variety of responsibilities, would likely benefit from such efforts to ensure all available resources are directed toward the goal of successful family reunification or adoption. This process would also ensure that agency standards of care are implemented uniformly across the state. DCS leadership would have access to important information concerning the performance of each of its offices and could use the information to improve outcomes for children, families, and communities through targeted training and staff development.

Currently, most of the pressure in the DCS system is focused on removing children from families who are perceived to be a danger to them. DCS needs an equal amount of pressure pushing in the opposite direction toward successful family reunification, adoption, or emancipation. A strong care management model that has real leverage to guide the movement of youth to the least restrictive, most appropriate environment that assures safety for the child and community (especially back to their families when possible) would provide the necessary pressure to accomplish the goal of moving children to permanency more quickly.

2.D. Review each provider, including YDCs and DCS group homes, to assure accountability for services provided, as specified by contract requirements and DCS standards.

Each provider should be held strictly accountable for contractual requirements established by DCS. Facilities managed by DCS, including YDCs and group homes, should meet clearly defined standards for treatment and care of youth in state custody. Providers and DCS facilities should be monitored periodically by the care management organization through retrospective case reviews to assess adherence to those criteria.

The standards and contractual requirements should focus on the effectiveness of services in the quick transitioning of youth home or to a less restrictive environment. Agencies should be required to provide clinical justification for the necessity of continued stay in their program and should actively and aggressively plan for discharge or step-down to a less restrictive environment. Point or level systems should in no way relate to discharge date. If a youth is not making progress, an agency should be held accountable for revising the treatment plan accordingly.

The review of providers should monitor key practices that contribute to youths' remaining in placements and state custody rather than achieving quick and successful permanency with their families. The agency assessments conducted as part of this study revealed a number of areas that may need to be closely monitored by the care

management organization. Brief descriptions are provided here; more information on agency practices can be found in the Agency Assessments.

Agencies and facilities should be monitored in areas including but not limited to the following:

- *Family involvement* - The lack of family involvement is by far the most prominent feature that generalizes across almost all programs. For example, an agency that provides both foster care and residential treatment services reported that staff contact with the family typically takes place only in court. Few agencies reported offering transportation for passes or family therapy.
- *Institutional treatment practices* - At a residential facility, staff reported that youth are restrained for a minimum of 45 minutes when they are aggressive.
- *Length of stay* - At a residential treatment program, the typical length of stay varies from six months to 10 years. Despite having a permanency goal of reunification and family members who could provide viable placement when appropriate services are provided, it appeared that many youth will probably remain in the program until age 22.
- *Accountability for results* - At a Level III program, treatment plans for the child being assessed were reviewed. The plans were generic in nature and did not appear to address the child's lack of progress. After a year of no progress in the program, the child's discharge date had been changed to May 2003, a full two years away.
- *Focus on services for viable families* - At a Level II Continuum provider, the program's case manager reported "our main concern is the foster family." The youth being assessed at this program had no targeted date for return home, and the length of stay was "indefinite." A barrier is the mother's reported "mental health problems," yet in-home services were implemented in the foster home placement rather than the permanent family placement.
- *Appropriateness of placement given youths' behaviors* - At a Level II residential facility, it was reported that youth must have 100,000 points to be discharged but that discharge can be cancelled if the youth fails to follow the program. Key behaviors expected before discharge include doing chores, cleaning one's room, and following house rules. These behaviors have little to do with most children's referral behaviors and, therefore, should not affect discharge decisions. Such behaviors are more appropriately addressed in the home environment.
- *Services targeting a narrow aspect of the key drivers of problems in the community* - At one residential program, the child assessed for this study is in the facility for drug abuse, yet he will likely return home to his mother who has a history of substance abuse. Enhancing her ability to avoid relapse and to provide structure and consistency for him will be a far bigger driver of his success than teaching him coping skills that work inside the facility.
- *Effectiveness of behavior management system* - At one group home, youth must earn 10,000 points to be discharged. The youth being assessed actually had negative points at the time of the assessment. Staff said youth must "work the

program" to be discharged and that the youth needed to make progress before family therapy would be beneficial.

- *Discharge planning based on child and family treatment needs* - At several YDCs, services focus on the youth's learning to behave in the institution, rather than learning to behave in the community. For example, it was reported to take 44 weeks to move through the level system, yet staff indicated that "you can't change the home front" and that "when they go home to the same environment, they lack the support and go back to their old ways." Thus, this highly structured program appeared to affect only the youths' functioning within the treatment facility, without addressing family issues that may have a significant impact on them once they return home.

Research in the field of juvenile justice (American Youth Policy Forum, 2001; National Institute of Mental Health, 1998) supports three system needs. Communities should provide mental health services in the community in lieu of placement in a developmental center, strive to make the environment of developmental centers less punitive, and provide more intense aftercare services. Currently, services for youth in juvenile justice placements are not in line with these recommendations. Youth placed in YDCs and DCS group homes are not likely to receive treatment that fosters long-term change. Periodic monitoring of these facilities by the care management organization would assure compliance with the Department's standards, thus increasing the likelihood of positive outcomes for children and families.

3. <u>Redirect resources toward evidence-based intensive in-home services, transitional living services, and assistance with all aspects of the adoption process for the purpose of achieving positive long-term outcomes and maintaining a high level of safety for children and for the community.</u>

3.A. Address the needs of children and families by funding only services that have demonstrated evidence of achieving the desired outcomes.

Implementation of a care management model will not be effective unless evidence-based services are accessible to facilitate successful family reunification or adoption. Among the youth in the sample, 62% have a permanency goal of reunification. Among these youth, only half of their families reported receiving services at the point of this assessment, indicating a substantial opportunity for the Department to serve more families.

The services that families were receiving included outpatient counseling, case management, substance abuse treatment, in-home services, financial assistance, anger management classes, and parenting classes. Few of these services have been demonstrated to be effective in producing long-term positive outcomes in the area of family preservation and reunification. The Department can increase the probability of improving family functioning by requiring providers to adopt program models that have evidence that they are effective in addressing the needs of the children and families they serve.

3.B. Contract with private providers for evidence-based, intensive in-home services to prevent children from entering state custody and to return children home or to permanency as quickly as possible.

Current DCS procedures seem to emphasize removing children from all situations that are deemed to pose a threat to children's safety, health, or well-being. However, many of these situations could be resolved with effective interventions aimed at keeping children with their families. Families with serious problems, such as mental illness, alcohol and drug abuse, and domestic violence, are unlikely to implement recommendations such as attending counseling, parenting classes, or anger management classes. Without effective interventions, more children than necessary may be removed from their families, and those in state custody may remain there longer than necessary as their families struggle to make changes without adequate support.

While 29% of the children in the sample were placed into state custody due primarily to their own behaviors, the overwhelming majority of children entered state custody due to their parents' problem behaviors, such as substance abuse, abuse and/or neglect of the children, or a combination of these. To succeed with these parents, intensive services are needed that can directly target the parents' problems. By working with the family several times per week in the home over several months, many problems are likely to be resolved.

Intensive in-home services that have been shown effective in enabling families to find long-term success are delivered by one counselor or therapist with a small caseload (four to six cases), which enables the counselor to go into the home on each case at least three times per week (daily if necessary) in addition to providing on-call support to the family 24 hours a day, 7 days a week. Counselors address all major areas of the family's life, including family structure, support, affect among family members, the school, the child's peers, extended family and community support, psychiatric and other health needs, and basic needs such as employment and housing.

It is understandable why DCS case managers have been reluctant in many of the cases in the sample to return the children to homes with the kinds of problems that were found. However, in the majority of these cases, the family problems can probably be resolved with appropriate services. These same types of problems are, in fact, resolved on a daily basis by intensive in-home service programs currently serving youth classified as Level II and Level III. There is no reason that these same types of problems cannot be resolved for children across the entire spectrum of DCS custody placements, allowing them to be reunified with their families.

3.C. Utilize intensive in-home services to complete an exhaustive search for viable relatives prior to the child's placement into state custody, whenever biological parents are not a viable option.

According to in-depth case assessments, a complete family search was conducted in 24% of cases, while a partial family search occurred in another 22% of cases. In an intensive

in-home services program, the counselors, with caseloads of just four to six families, are equipped to complete exhaustive searches for relatives and also to provide the intensive support these families need to ensure a successful temporary placement, while efforts at reunification with the parents are immediately initiated. There are a variety of means to locate parents and relatives. Two families in the study were located through the use of an Internet search service. In another case, the DCS case manager reported having no valid contact information for the family of a child who was on a trial home pass. Study staff located the family by calling the school the child was believed to be attending. The school confirmed the child's attendance, and, after contacting the child, the location of the parent was obtained.

3.D. Prioritize intensive in-home services to youth at most immediate risk of placement into state custody and to those who are most likely to return home quickly and successfully.

Intensive services delivered in the home would be of greatest benefit to the most seriously troubled families who are at highest risk of having their children placed into state custody. Such services have also been shown to be of benefit to communities by effectively reducing recidivism among delinquent youth. These services address the multitude of problems these children and families often experience - substance abuse, domestic violence, mental illness, and concrete problems such as housing and employment. While DCS does provide some prevention activities, funds are limited and are often allocated toward services such as anger management classes, parenting assessments, parenting classes, counseling, respite care, homemaker services, and mentoring. More intensive services may be needed to effectively address the challenges these families face.

At first glance, it might appear that DCS would reap the largest cost savings by targeting children in residential placements for reunification services. However, this might not always be true. A child in long-term foster care might cost the state less per year than a child in residential treatment, but if the child in foster care stays in the system for several years, it could easily cost the state as much or more than the child in the shorter-term residential placement. In addition, analysis of data from children in the sample indicates that a much larger percentage is in long-term foster care (15% in DCS non-relative foster homes plus another 22% in agency foster homes for a total of 37%) than is in higher-cost residential treatment facilities (7%). Thus, greater savings may be realized from focusing on avoiding long lengths of stay for a large number of children than by concentrating on a small number of high-cost cases.

Contracting with an in-home provider to assess the anticipated speed of step-down, likelihood of success in the home, and potential future placement cost savings would provide the state with adequate information to prioritize youth to receive services targeted at resolving the issues that brought them into state custody. The youth given the highest priority should be those with the greatest likelihood of successful long-term outcomes and those whose cases represent the greatest long-term cost savings.

In order to fully realize the potential cost savings from this strategy, the care management organization must have the leverage to ensure that the providers and case managers follow the practice model, particularly concerning the placement of each child in the least restrictive, most effective setting that ensures the safety of the child and the community. Otherwise, not only will potential cost-savings be lost, but, more importantly, children will continue to be suspended in temporary placements without the permanency that only a family - biological or adoptive - can provide.

Regardless of the availability of family services, out-of-home placements are sometimes necessary for the safety of both the youth and the community. With a careful assessment of each child, their family, and the systems that affect their behavior, it is more likely that children will be served in the least restrictive, most effective environment. For most of the children in this study, services could be effectively provided in their homes. If such services are extended to the larger population of children in state custody, then the number of children served in out-of-home placements could be reduced, thus making adequate slots available for the small minority of violent and delinquent youth who actually need highly restrictive placements. Intensive in-home services could also benefit these youth as they transition from restrictive placements back into their communities, as such services have been shown to reduce recidivism.

3.E. Redistribute resources currently assigned to foster care and residential treatment in order to expand intensive evidence-based prevention services.

A potential barrier may exist to funding intensive in-home services with savings realized from avoiding unnecessary placements and making rapid reunifications possible. In many systems, demand generally increases to meet capacity. In this case, the slots that have become available as children return home may simply fill up with other children. Thus, no financial savings are garnered by the state to help pay for the in-home services. This trend may prove true even for DCS foster homes. Evidence for the need to reduce the number of slots in foster care and residential treatment – rather than simply leaving slots empty – comes from many years of experience in this field. Anecdotal reports indicate that in a portion of cases where the decision to remove a child from the home is not clear-cut, children are not placed into state custody when no slots are available. However, when foster homes or residential beds are open, children may be more likely to be removed from the home and placed into state custody.

To combat this phenomenon, it is recommended that the state develop a plan to gradually reduce the number of contracted beds as well as state-run foster homes as children are successfully returned home. The diverted funds should be used to prevent children from being removed from the home and to keep families together. This strategy would likely have to be implemented in increments, over a period of several years, based on slot allocations for state-run and contracted residential and foster care placements in each DCS region. It seems reasonable to reduce residential and foster care slots rather than continuum slots, as most of the continuum providers are already making efforts to provide services consistent with practice-model guidelines. Providers would have time to adjust to the change in slots. Increased services that have proven effective in successfully

reunifying children with their families while maintaining community safety could then be funded through the savings from the reduced slots.

3.F. Develop a mechanism that offers financial assistance to relatives who provide placements without requiring children to remain in state custody.

As stated above, 41% of youth in the sample were already home at the point of the assessment, mostly with relatives and in some cases with parents or adoptive parents. Many of those are living in stable, probably permanent placements with relatives, most of whom are receiving kinship funds. By keeping the youth in state custody, DCS resources are being absorbed unnecessarily.

Based on review of these cases, it is recommended that the state remove these children from state custody while finding more creative means to provide the financial support necessary to maintain these children in stable placements with relatives. Assistance with childcare costs, housing expenses, medical care and insurance, and education and transportation costs may reduce the burden on relative caregivers and could continue to be provided, if necessary, after the child leaves state custody. Recent proposals regarding establishing a status of "subsidized guardianship" in such cases may prove an effective means of addressing these issues.

It is important to develop criteria for financial assistance to relatives who provide placement for children in state custody based on the family's income, financial status, risk level, and other burdens imposed by the placement of the child in the home. The goal of assistance provided to relatives who care for these children is to work with them to develop the resources to provide a safe, stable, permanent, and sustainable environment for the child without dependence on the state. Creative solutions will be required, given the systemic barriers to changing the current system of distributing kinship funds. However, it is an issue that has major implications on the numbers of children in state custody and should be prioritized accordingly.

3.G. Fund services for youth aging out of the foster care system to assist them in transitioning successfully into adulthood.

DCS should contract with private providers for services to successfully transition youth from foster care to independent adulthood. Among youth in the sample, 16% were recommended to receive transitional living services. These youth will soon be turning 18 and will need support to ensure a successful transition from state custody into adulthood. Transitional living services should begin prior to a youth's leaving her or his placement and/or leaving state custody to allow for preparation in areas such as housing, employment, education, and family supports.

The national statistics for outcomes of youth who age out of state foster systems are dismal. A 1997 study (Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001) conducted in Wisconsin of youth aging out of out-of-home care examined the lives of youth in state custody both during and after their time in foster care programs. Eighteen months after

leaving foster care, nearly 40% of the youth had neither completed high school nor received a G.E.D. Only 9 % were attending college. A significant portion of youth was homeless (12%) and another 20% were living in an institution or without family or relatives. Eighteen percent had been incarcerated at least once after discharge from foster care.

Transitional living services offer hope to these youth by addressing a variety of areas that help them achieve independence. Services should be strength-based and focused on long-term generalization. Thus, counselors should target systems that will affect the youths' behaviors and functioning over the long term, such as employment, education, vocational training, family support, social and problem-solving skills, pro-social peers, and concrete needs such as housing and healthcare.

Transitional living services are somewhat different from intensive in-home services. Because these youth have become young adults, some degree of self control is expected. However, with caseloads of 10 to 12, the transitional living counselors can still provide 24/7 on-call support and guidance, along with crisis management as needed. The goal for each youth is to develop healthy relationships, stable housing and employment while continuing their education or vocational training. Transitional living services are less intensive than in-home services but usually last longer (up to one year) until the youth can establish adequate sources of support in the community.

The state has acknowledged an obligation to youth raised in foster care to help them age out successfully by providing some post-custody services. It is in the best interest of the youth, the Department, and the community to provide broader and more intense services that are likely to produce far more positive outcomes for these young people. The rates of failure with this population are real. By funding transitional living services, the state will have met its responsibility to these youth and reduced the likelihood of future generations of children entering the child welfare system.

3.H. Assess the process of terminating parental rights to identify families who could keep their children if appropriate services were available.

The TPR cases that have been reviewed reveal that in most instances the termination of the parents' rights was justified. However, TPR was often not achieved for several years after the children had entered state custody. In the interim, the children often experienced a number of moves among highly restrictive environments, adding to the children's difficulties in coping with the loss of family and with other emotional and behavioral issues.

In some cases, TPR may have been the result of insufficient services to assist the parents and/or biological family members to overcome significant parenting deficiencies. Enabling families to achieve and maintain an adequate level of parenting requires intensive services to the family. Also, the courts often require evidence of the parents' ability to provide safety and protection for the child and to maintain, throughout the child's remaining minor years, an adequate home for the child. The inability of the

parents to sustain the efforts necessary to provide adequate parenting is often the major obstacle to the avoidance of TPR. Preservation of the biological family for a child through intensive services will often, in the long term, be the most beneficial circumstance for the child.

In order to avoid the termination of parental rights when there is a potential to preserve the biological family, it will be necessary to make effective in-home and other supportive services available to the parents and perhaps also to other family members. These parents will require long-term, structured treatment in order to develop the skills necessary to adequately care for their children.

To further attempt to avoid the permanent removal of a child from his or her biological family, it is important to conduct a thorough investigative search for any relatives who might be willing and able to parent the child either for as long as is required for the parents to achieve the ability to adequately parent or for the remainder of the child's minor years. Conducting such thorough searches requires a substantial amount of expertise and time. This activity could be contracted to agencies that have the ability to complete these searches expediently and to make the findings known to DCS and others closely involved with the child's care.

3.I. Contract with providers to assist with all phases of the adoption process.

If intensive service efforts with the parents or other family members fail to provide safety and adequate well-being for the child, termination of parental rights becomes necessary and adoption becomes the goal. Achieving TPR and adoption as quickly as possible becomes essential if the child is not to be further emotionally harmed. In order to accomplish this, DCS could enter into contractual relationships with private agencies in the community that can assist with the TPR process, achieve adoption for the child, and provide the continuing therapeutic and other support services needed. In addition to providing the full scope of adoption services, private service agencies can assist DCS with expediting the completion of the extensive documentation necessary to complete the adoption.

It is important that DCS create a structure for the delivery of adoption services that allows adoptions to be accomplished in the most expedient manner and with the least risk of disruption. Adoption services are highly specialized due to the complexity of the process – both therapeutically and legally – and, therefore, the service is best delivered within a structure that allows for specialists to focus exclusively on the adoption process. The model that has been repeatedly demonstrated as being most successful in these regards is one that establishes a unit of adoption specialists who have the direct and complete responsibility for achieving the adoptions of children. Such units can accomplish substantially more adoptions because they have the knowledge to move quickly through the complex processes of adoptions and because they are not distracted by addressing the needs of a child's daily care. Adoption specialists work with the child's existing case manager, thus assuring continuity of care for the child, while

providing the expertise needed to accomplish true permanency for the child as quickly as possible.

3.J. Provide adoptive families with access to in-home services as needed for stabilization.

Achieving an adoptive placement for youth in this study has taken a prolonged period of time for some, while adoption remains yet to be achieved for others. When adoptions did occur successfully, the children began to experience stabilization, improved behaviors, and improved overall functioning. Unfortunately, by the time an adoption is finalized, the youth's negative behaviors are sometimes entrenched, as they are often related to unresolved experiences and issues prior to the adoption. For this reason, it is essential to provide children and adoptive families with therapeutic and other services that are needed even after the adoption. Such services could stabilize the adoptive home, thus avoiding yet another possible disruption in the child's life.

3.K. Assure that each child receives adequate advocacy in the court system.

In this study, the amount of legal support or advocacy children may have received before or after entering state custody was not quantified. However, it would be in the interest of the state, both financially and in terms of providing the best services for children, to ensure that each child receive reasonable legal advocacy as another check and balance against the process of removing children from the home and keeping them out of the home.

In order to achieve the objectives of reducing the number of children entering custody and minimizing the length of time children remain in custody while maintaining a high level of community safety, three recommendations have been made. Both the case supervision process and the work of the care management organization are designed to assure that all necessary steps are taken in each child's case to provide a safe and permanent home for the child. Providing intensive in-home services is also necessary to assist families in establishing sustainable support networks and improving their skills so that they can raise their own children. The Department could add an additional support to these processes by investing in significantly more legal advocacy for each child. Given the pitfalls of keeping children in long-term placements, competent legal support for each child at risk of placement or who has already been placed into state custody could provide enough additional leverage to override bureaucratic processes that remove children from the home too quickly and then prevent them from returning home. In order to maximize the gains realized through this recommendation, DCS should prioritize additional legal advocacy for youth, based on criteria concerning the length of time in custody, the existence of viable family, and the provision of appropriate services directed toward reunification or adoption.

Conclusion

In this study, the cases of 108 randomly selected children in the custody of DCS were reviewed. Information was obtained from children, parents, foster parents or caregivers, as well as DCS supervisors and case managers and representatives of private agencies who were providing services for the children. Although DCS has made progress in many areas, particularly in the last year under the direction of Commissioner Viola Miller, the findings indicate that the Department can make even more dramatic progress in meeting its reform goals by consistently providing intensive, evidence-based services to families.

Most of the children in the study came into state custody because of parental or family problems or behavioral problems they developed because of difficult and inappropriate family situations. Still, the study found that there was little emphasis on helping their families so that the children could either avoid entering state custody or return home quickly. The services provided were not evidence-based programs but rather were referrals to services such as parenting or anger management classes, homemaker services, or counseling, which were not likely to be effective. In fact, it appeared that none of the children and families in the study received intensive, evidence-based help.

The study shows that more effective, intensive help to families – prevention services for family preservation, intensive home-based services addressing the issues of reunification and family functioning, and transitional living services for successful emancipation – is still the missing piece to solving Tennessee's child welfare problems. Putting that piece in place should be the Department's top priority. The study projects that strengthening families and enabling them to care for their own children would have a dramatic impact on the Department's census, perhaps releasing as many as 6,000 children from state custody. An emphasis on prevention services, along with the state's adoption focus, should reduce the number of children in the system by more than half.

Think of how different the Department would be if there were 4,000 children in the system rather than 10,000. A reduced caseload would allow DCS staff and the Department's private providers to focus on the children who have the greatest needs and no family resources.

However, simply introducing in-home services for families is not enough. To make this caseload reduction a reality, it is recommended that the state create a case supervision process within the Department, contract with a professional care management organization for effective monitoring of case activities and provider services, and finally, fund intensive in-home services that are based on models with demonstrated effectiveness in addressing the challenges these families face.

By implementing these recommendations, the Department will be able to better meet the needs of children and families and accomplish its Brian A. Settlement Agreement obligations. It will also change the culture of the Department and the perception of Tennessee in the nation. Instead of being forced to reform, Tennessee can become a national leader, showing the way for others to follow.

The study has uncovered a tremendous opportunity for helping troubled children and families find success. The scientific evidence shows that only a few treatment models for seriously troubled youth and families have demonstrated positive results over the long term. Most of the other models simply do not work any better than if the child or family was receiving no services at all. The real lesson here is that the use of the ineffective service models should be reduced or eliminated while increasing use of the effective models.

Think of the American job market. At one time the majority of Americans were employed through farming. As recently as 1890, 43% of all jobs in America were farm jobs. By 1960, farm jobs had dropped to 1.7%. Similarly, production workers in manufacturing accounted for 26% of U.S. workers in 1952. The number had dropped to 8% by 2002. As American farmers and manufacturers became more efficient and productive through new technologies (e.g. machinery, chemicals, robots, computers), they progressively produced more and better products with less manpower, and fewer jobs in those sectors were needed. New jobs opened in other areas of the economy.

A similar kind of churning drive for results, efficiency, and continuous improvement does not seem to exist in the child welfare field. Unlike in the farming and manufacturing industries that continuously increase efficiency and productivity in a dynamic marketplace, change seems to occur much more slowly in the child welfare system. The reasons probably have to do with the difficulty of measuring results in social services and because the consumers (the children and families) do not directly purchase the services. Thus, they have no 'buying power' to force daily adjustments in products, services, and prices in the child welfare marketplace the way they can in, say, the retail sector. As a result of the inability to create a retail-style marketplace of consumer choices and accountability for price and quality, the state is forced to take on the gigantic role of directly managing services for thousands of children and families each day.

The solutions, the new technologies if you will, that are most needed to improve the lives of these children are highly publicized and available. However, implementing these new technologies also involves eliminating some of the old technologies. The new technologies involve working intensively in homes with families, addressing in a highly structured, analytical way virtually every aspect of a child's and family's life. Counselors or therapists with very low caseloads address all systems affecting the child, including the family, school, peers, individual, and community. They are held accountable for developing specific action plans based on data, making clear assessments, and giving evidence and understanding of ongoing successes and failures throughout each case. Supervision and training are intense, and individuals at multiple levels are held strictly accountable for adherence to the model and long-term success rates.

In Tennessee, this highly effective approach to serving families and achieving high long-term success rates is already established with some providers. Research continues to demonstrate the effectiveness of this approach with the child welfare, juvenile justice, and mental health populations. Since children in DCS custody often fit into all three

groups, services that address these multiple challenges must be implemented to secure more positive outcomes. Furthermore, there is evidence that youth aging out of state custody are more likely to end up homeless, unemployed, or in jail unless effective transitional living services are provided to help them successfully achieve independence.

The Department has taken many steps to improve services to children in state custody. The findings from this study clearly indicate the need for a more intense focus on family preservation and reunification to achieve permanency for children and families as quickly as possible while consistently maintaining the safety of children in state custody and the safety of the community. We are confident that the Department has both the will and the capability to accomplish the work that needs to be done.

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Appendix I
Assessment Tools

Data collection tools and related criteria for decision making for the DCS Case Review Study are presented in Appendix I. These include the following:

1. DCS Interview
2. Family Assessment
3. Child Interview
4. Issues Addressed in Agency Assessment
5. Sample Decision Matrix
6. Definition of Viable Family
7. Criteria for Determining Length of Services for Case Recommendations

DCS Interview

Permanency Plan/Family

When did the child enter custody and for what reasons?

How often is the Permanency Plan updated?

What are the strengths and needs of this child and family?

Does the child have viable extended family?

Does the family participate in the Permanency Plan process?

Does the family state that they want for their child to be at home?

What is the permanency goal for this child?

What goals need to be accomplished in order for this child to be treated in the home or less restrictively?

What needs to happen in order for DCS to close this case?

Describe the home and/or community-based services that have been made available to this family.

Any school or potential court barriers to reunification?

Current Placement

What circumstances (child behavior, family behavior, etc) make the current placement the most suitable for this child?

How many times has this child been placed out of the home? How many different locations?

How long has the child been placed out of the home? At the current location?

Are you involved in the treatment planning process at this child's current location on a week to week basis? Are the parents?

How often do you see the child?

How often do the parents see the child?

What is the targeted date for step-down?

Family Assessment

Date of Assessment:
Date of Update: (please indicate updated information using bold letters)
Child's full legal name:
Date of birth:
Social Security Number:
Legal Guardian:
Home phone number:
Can a message be left at this number?
If not, provide an alternate number:
Home address:

Is a DCS worker involved with the family?
If yes, provide the name of the DCS worker:

Information Obtained From
Identify individuals and documents from which information was obtained

Persons present during face-to-face assessment:

Admitting Diagnosis:
Please use codes for Axis 1 and 2 if available.

Axis I
Axis II
Axis III
Axis IV
Axis V Current:
Highest in the past year:

Diagnosing clinician:

Identifying / Presenting Problems
Problem behavior 1: Identify any behavior that has led to the need for counseling.
Last known incident and what occurred:

How severe is the behavior (mild, moderate, extreme)?	How often has this behavior been occurring?	How long has behavior been occurring?

Suspected trigger leading to behavior and original event that started behavior (if known):

Problem behavior 2: Identify any behavior that has led to the need for counseling
Last known incident and what occurred:

How severe is the behavior (mild, moderate, extreme)?	How often has this behavior been occurring?	How long has behavior been occurring?

Suspected trigger leading to behavior and original event that started behavior (if known):

Problem behavior 3: Identify any behavior that has led to the need for counseling.
Last known incident and what occurred:

How severe is the behavior (mild, moderate, extreme)?	How often has this behavior been occurring?	How long has behavior been occurring?

Suspected trigger leading to behavior and original event that started behavior (if known):

Problem behavior 4: Identify any behavior that has led to the need for counseling.
Last known incident and what occurred:

How severe is the behavior (mild, moderate, extreme)?	How often has this behavior been occurring?	How long has behavior been occurring?

Suspected trigger leading to behavior and original event that started behavior (if known):

Continue with presenting behavior issues as needed.

Suicidal/ Homicidal/Psychotic Behaviors:
Is the child currently showing any suicidal, homicidal, or psychotic behaviors?
If yes, describe:
Has Mobile Crisis been involved during noted episodes?
If so, what was the outcome of their evaluation? Hospitalization, respite, return home, etc.

Is the child at risk of being placed outside of the home?
At risk of state custody? Why and according to whom?
At risk of hospitalization or a higher level of care? Why and according to whom?

Identify any need for psychiatric consultation and results of such consultation or is child under a psychiatrist's care?

Current Treatment
Current Mental Health Case Management: - Name:
- Mental Health Center Location:
- Date started services:

Current Outpatient Counseling: - Name:
- Mental Health Center Location:
- Date started services:

Current Medication Management: - Name:

- Mental Health Center Location:

Other current community or support services that the child/family receives:

History and Effectiveness of Previous Treatment
All previous outpatient or home-based therapy, inpatient, and residential treatment:

Date of Treatment	Location	Type of Treatment	Effectiveness	Reason for discharge

Medications
Current use of medication:

Name	Dosage	Frequency	Date started	Prescribing Physician

- Trial medications (dates started and stopped):
- Name of MD following pt.:
- Is pt. complying with medication regime:
- Are medications effective:

Medical History
Any known allergies:
Current medical problems:
Current nutritional problems:
Any medical hospitalizations within the past twelve months:
Any apparent or suspected medical or nutritional problems:
Current primary care physician:
Last physical:

Runaway History
Frequency and duration of runaway or attempt:
Any known or suspected triggers:

Drug and Alcohol Involvement
Child's drug involvement:
Parental or sibling drug involvement:
Types of drugs used:
Longevity, frequency, and severity of use:
Do current conditions seem to promote continued A/D use?

Legal History
Current Legal Involvement/Charges:
Past Legal Involvement/Charges:

Child status with court system:
Probation Officer's Name:
Family status with court system:
Status with Custodial Departments:

DCS Involvement
How often do you talk to your DCS worker?
When was the last Permanency Plan?
Have you had input into the Permanency Plan goals?
Is there anything on the Permanency Plan that you have questions about? Has the worker answered those questions?
What have you done to complete the Permanency Plan goals?
Do you have a copy of the current Permanency Plan?

Step down process
Have passes started with your child?
What are the barriers to your child coming home?
What is your child working on in placement?
Are you involved with treatment? What does that look like?
What is your part in bringing your child home?
If your home is not a viable placement are there any other family members/friends/teachers that would be willing to take the child?

Family Relations
Family members in the home:
If applicable, list size of identified client and siblings:
Family member interaction:
Parental support:
Amount of family involvement in previous therapy:
Psychiatric history of family members:
Legal involvement of family members:
Leisure and recreational activities:
Social, ethnic, or cultural factors:
Other factors that may have an impact on the child's status or which may affect prognosis for improvement:
Identify the parent's ability to provide structure through rules, rewards and consequences:
Describe the degree of warmth and affection demonstrated between family members:
If child is not residing with biological parents, likelihood of reunification:
Any there other family members or resources for support?

Financial Status and Employment
Financial resources:
Employment status:
Material well-being:
Describe ancillary difficulties related to financial or employment matters:

Neighborhood Environment
Safety level within community:
Availability of community resources near the family's home:

Spiritual / Religious Involvement
Religious Affiliation of child and family:
Factors that may become relevant to the treatment of the child or family:

Educational Functioning
Name of School:

Grade placement:
Special Education:
Special resources utilized:
Degree of parental monitoring:
School Counselor involvement:
Other information indicating the child's academic functioning:
Grades:

Peer Relations
Child and Family's involvement with peers:
Degree of parental monitoring:
Child's ability to establish and maintain relationships:
Age preferences of friends:
Sexual orientation:
Preference of social activities:

Gang Involvement
Identify any level of suspected or confirmed gang involvement:

Summary and Recommendations
Brief Summary of above information:
Diagnostic Impressions:
Recommendations for specific therapeutic interventions:
Recommendations for type of services:
Long term outcomes desired:
Barriers that may limit functioning in the community:

Child Interview

Personal Information on Child

What are things you like to do? (favorite food, hobbies, and personal goals)
What are positive things about you?
How do you manage your anger?
Do you take your medication?

Assess for any past suicidal or homicidal ideations:

Progress on Treatment Goals

What are your treatment goals?
What has been your progress toward those goals?
What objectives need to be achieved for step-down?
What have you learned from current placement?
How well do you comply with rules and program expectations?

Behavior Management and Therapeutic Issues

What do you like about the program?
If you could change one thing about the program, what would it be?
How do you manage your negative behavior?
What support people can you access?
Have you ever been put in a restraint/hold?
If yes, what happens when you are put into a restraint/hold?

Outside Contact

How often do you talk to your DCS worker?
How often do you see your DCS worker?
How often do you get to call someone and who is called?
How often do you get to see family?
How often do you receive mail?

Preparation for Step-down

With whom did you live with when removed?

Assess their understanding of why they were removed:

Do you like school?
What do you enjoy about school?

Assess if the child able to attend public school:
If no, why not

How long have you been here?

Where are you going when you leave here?
What do you have to do in order to leave?

Assess child's willingness to be part of a family, i.e., doing chores, going on family outings, etc.
Assess ability to get along with other children in the home:

Daily Routine

What is your weekday and weekend routine?
How do you comply with daily routine?
What is your level?

Assess if child a leader or follower:
Assess peer involvement (gang activity, negative peers):

Mental Status Exam

Identify results of child's mental status screen with regard to alert (yes/no):
Orientation to person, place, time (yes/no for each):
Appearance (appropriate, disheveled):
Mood (normal, depressed, elevated, irritable):
Affect (broad, restricted, flat, labile):
Speech (normal, slow, rapid):
Thought content and process (coherent, illogical, irrational):
Memory – remote, recent, immediate (intact, impaired):
Insight (poor, fair, good):
Impulse Control (poor, fair, good):

Issues Addressed in Agency Assessment

Behavior Management and Therapeutic Issues:

- Treatment philosophy
- Restraint/seclusion policy and practice
- Point system
- Observation of appearance of the facility (institutional/decorated, clean/dirty, well-maintained/poorly maintained)
- Observation of staff/child interactions (high affect/low affect, active interaction/aloof)

Family Involvement:

- Phone contact/policy
- Family visits/policy
- Family involvement in the treatment process
- DCS worker contact/policy
- Mail policy

Discharge Planning:

- Typical length of stay
- Typical discharge location
- Alternative discharge locations
- Use of Permanency Plan
- Necessity of continued stay

Sample Decision Matrix

Case Review Methodology

Name:		Reviewer:	

High Risk Indicators	**Assessment** Results - Yes, No, or NA	Comments - Only when needed
Harm to self		
Indicators	**Results**	**Comments**
Recurrent episodes of significant depression with physical symptoms		
History of self-mutilating behaviors requiring medical attention		
Recent history of suicidal gestures requiring crisis services or medical attention		
Step-down from acute setting with stabilization of self-harming behaviors		
Step-down from residential treatment setting with stabilization of self-harming behaviors		
Harm to others		
Indicators	**Results**	**Comments**
Recent episodes of unpredictable aggression requiring physical intervention		
Recent history of aggression towards small children		
Consistent acts of aggression toward family members		
Recent and serious episodes of property destruction with risk of harm to others		
Ability to attend public school settings		
Evidence of ability to respond to behavioral interventions		
Requires intense medical supervision		
Indicators	**Results**	**Comments**
Has complex medical needs that require supervision by medical staff		
Has ongoing serious illnesses with high potential for rapid deterioration		
Has serious illness with limited evidence of compliance to treatment by child and family		
Current psychotic symptoms		
Indicators	**Results**	**Comments**
Symptoms and episodes have been stabilized by medications for more than 30 days		
Currently displays disordered thought processes not stabilized by medications		
Symptoms and episodes are intermittent but currently stabilized with medications		
Problem Sexual Behaviors		
Indicators	**Results**	**Comments**
Treatment for problem sexual behaviors was not completed or was unsuccessful		
Viable Family Review		
Indicators	**Results**	**Comments**
Low risk of abuse based on caregiver history and results of trial visits		
No evidence of caregiver substance abuse that interferes with monitoring		
Housing is sufficient for child placement		
No evidence of caregiver mental health issues that interferes with monitoring		
Caregiver demonstrates willingness to provide adequate supervision		
Caregiver demonstrates evidence of ability to comply with program staff		

Definition of Viable Family

The case review methodology outlines the high-risk indicators that are assessed in determining whether a child can safely return home. These indicators include both child and family behaviors. The indicators for family viability are the following:

- Low risk of abuse based on caregiver history and results of trial visits
- Evidence of caregiver substance abuse that interferes with monitoring
- Housing is sufficient for child placement
- Evidence of caregiver mental health issues that interfere with monitoring
- Caregiver demonstrates willingness to provide adequate supervision
- Caregiver demonstrates evidence of ability to comply with program staff

The information from these indicators is considered in the context of the child's high-risk indicators, which fall under the categories:

- Harm to self
- Harm to others
- Requires intense medical supervision
- Current psychotic symptoms
- Problem sexual behaviors

Criteria for Determining Length of Services for Case Recommendations

For each case in this study, recommendations were made for placement and services based on the characteristics of the child, available family resources, and additional clinical factors. For those children who were assigned a recommendation to transition home with intensive services, specification was provided for the length of transition from their current placement to home and for the length of services after the transition home. Listed below are the criteria for determining both the length of transition services and the length of services after transition which are required to achieve positive long-term outcomes for the child and family. Please note that home may include biological parents' home, relative's home, or potential adoptive home.

Length of Transition

1 – 2 Months – Minimal barriers exist within the family that may affect their ability to appropriately care for the child.

3 – 4 Months – Moderate barriers exist within the family that may affect their ability to appropriately care for the child. Examples of such barriers are a history of parental substance abuse without current use, lack of social support, lack of stable housing or lack of employment. This length of transition may also be recommended if the child is transitioning to the home of a relative with whom he or she has not previously lived.

5 – 6 Months – Assigned only with a qualified recommendation of return home. Indicated major barriers exist within the family that are likely to affect their ability to appropriately care for the child. With appropriate, intensive in-home services there is a substantial likelihood that these barriers can be overcome and that the family can achieve positive long-term outcomes. Examples include parental mental illness, continued intermittent drug abuse that may require additional treatment and/or support from extended family, no history of stable housing or employment but parental desire to work toward regaining custody of child, or a combination of two or more of the barriers listed under '3 – 4 Month Transition.'

Length of Services After Transition to Home

4 – 6 Months – Most children and families can achieve long-term positive outcomes following intensive in-home services that last four to six months. During this time, families can increase parenting skills, positive relationships within the home, communication with the child's school, monitoring of the child's peers, and can build a sustainable social support system for themselves and their child.

6 – 9 Months – Families who have significant barriers, including parental mental illness or parental developmental delay, may require intensive in-home services of a long duration in order to assure a reasonable likelihood of long-term success.

Appendix II
Sample Data by Region

Graphs depicting information by DCS region are included in this appendix. The sample size for this study precludes meaningful discussion of regional variations. The information presented here is intended only to display data gathered from case reviews within each region.

The first six graphs (Figure 24 through Figure 29) show the number of cases in each region by a variety of characteristics. The total number of cases in each region is shown on most of these graphs. Figures 30 through 48 are proportional bar graphs that show the proportion of particular characteristics for cases in each region. The number displayed in each segment of a region's bar represents the number of cases with the designated characteristic. For example, in Figure 30, in the Mid Cumberland region, six cases have had one or two placements, one case had three to five placements, and five cases had more than five placements. Because of the proportional nature of the display, it is easy to see that 50% of the cases in the study from the Mid Cumberland region had only one or two placements.

Graphs include the following:

Figure 24

Gender by Region

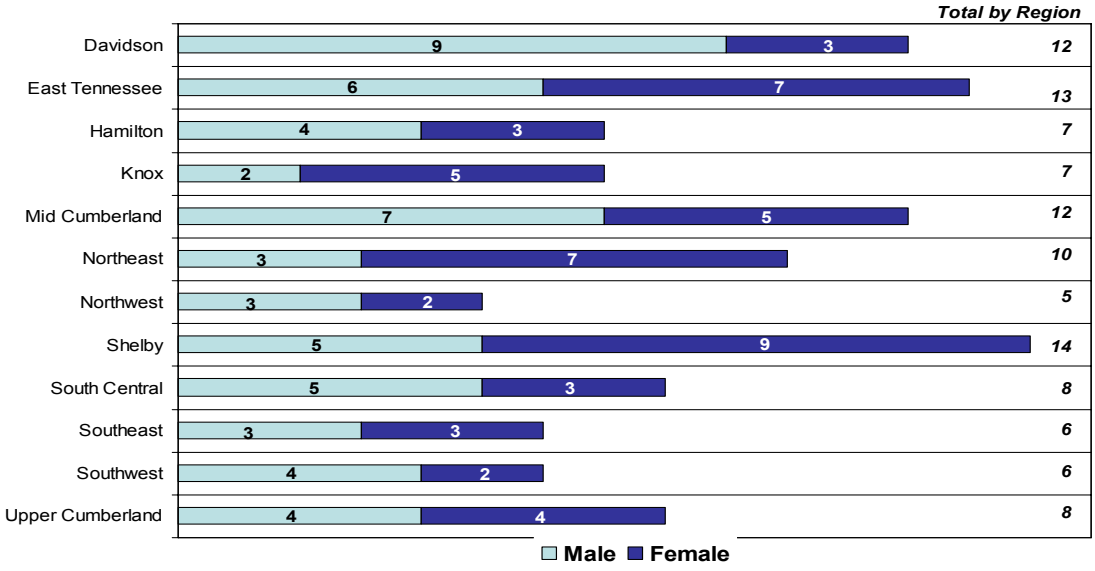


Figure 25

Race by Region

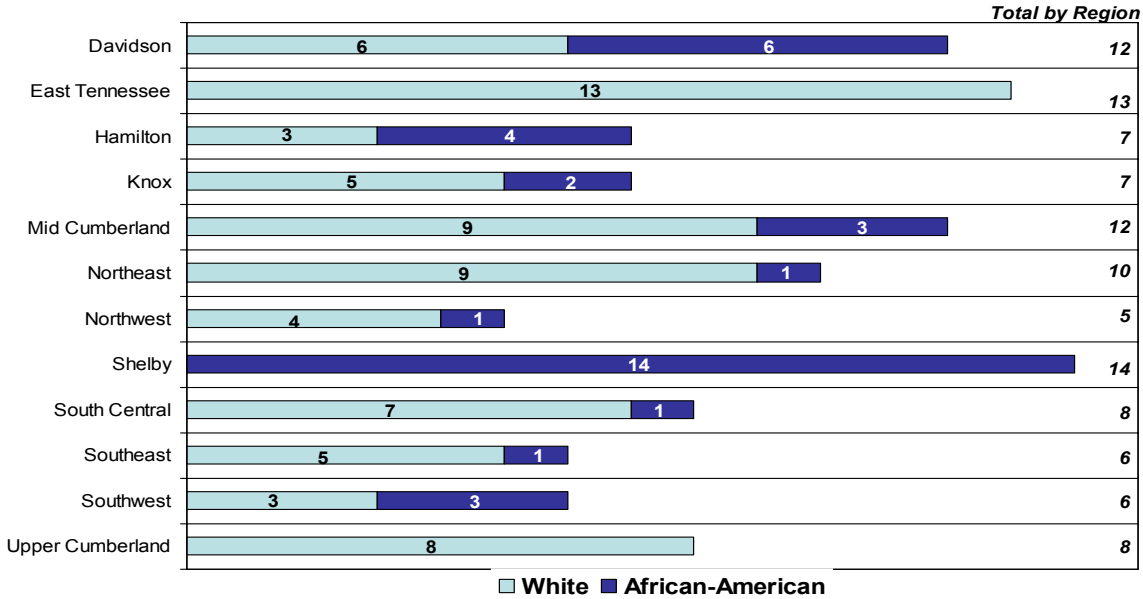


Figure 26

Age Group by Region

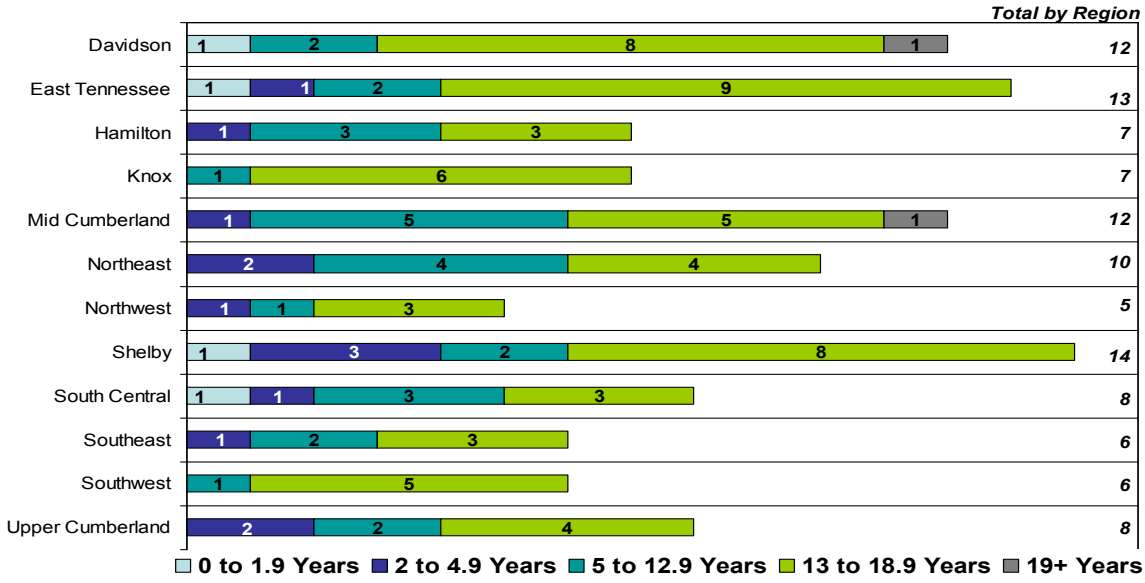


Figure 27

Length of Stay in Custody by Region

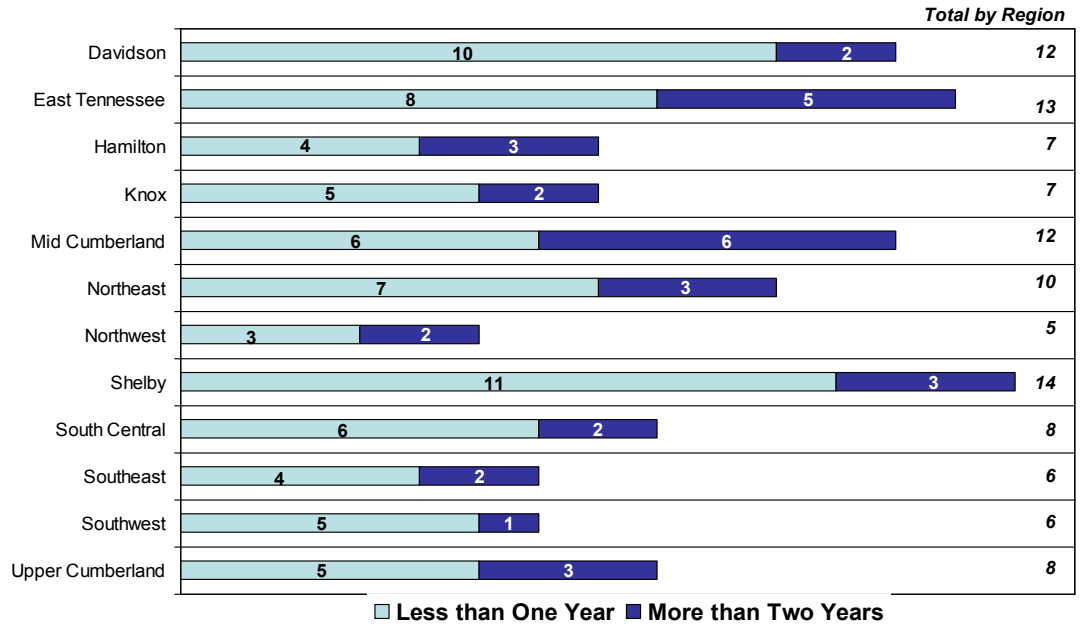


Figure 28

Adjudication Type by Region

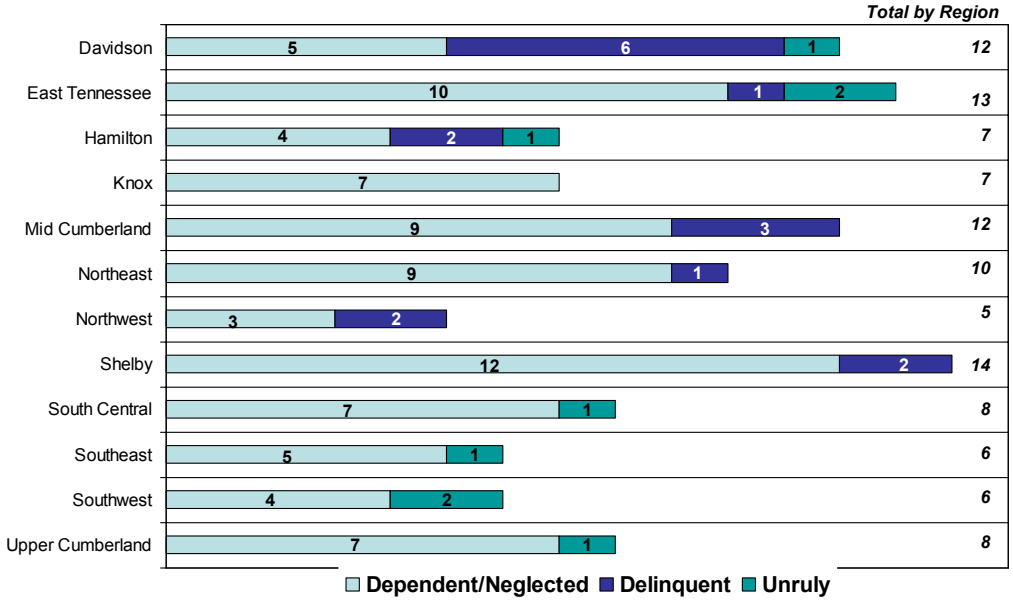


Figure 29

Number of Children with TPR by Region

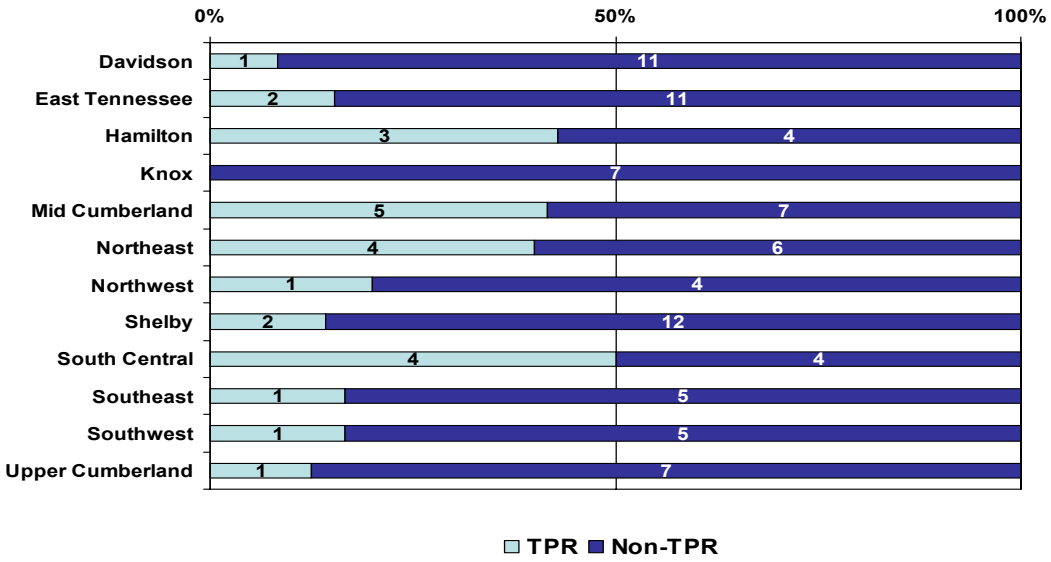


Figure 30

Number of Placements by Region

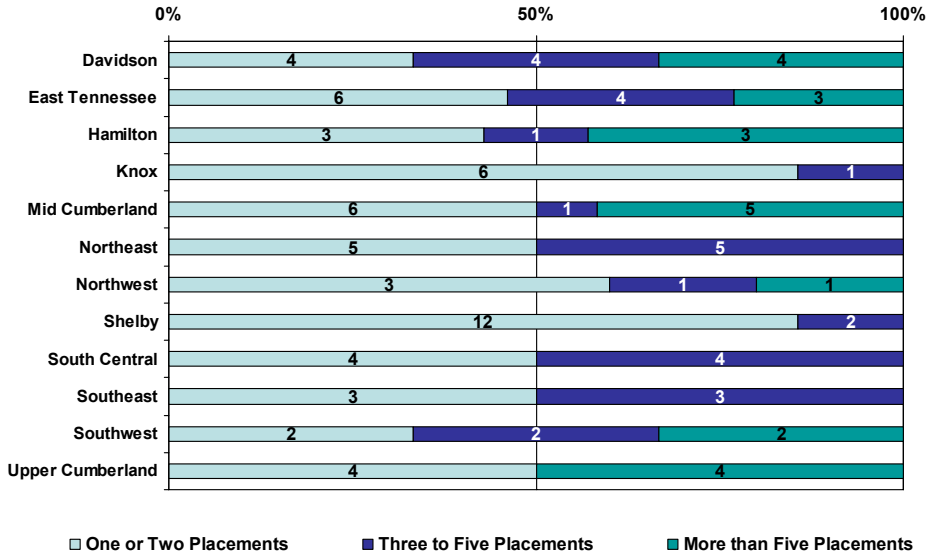


Figure 31

Level of Care by Region

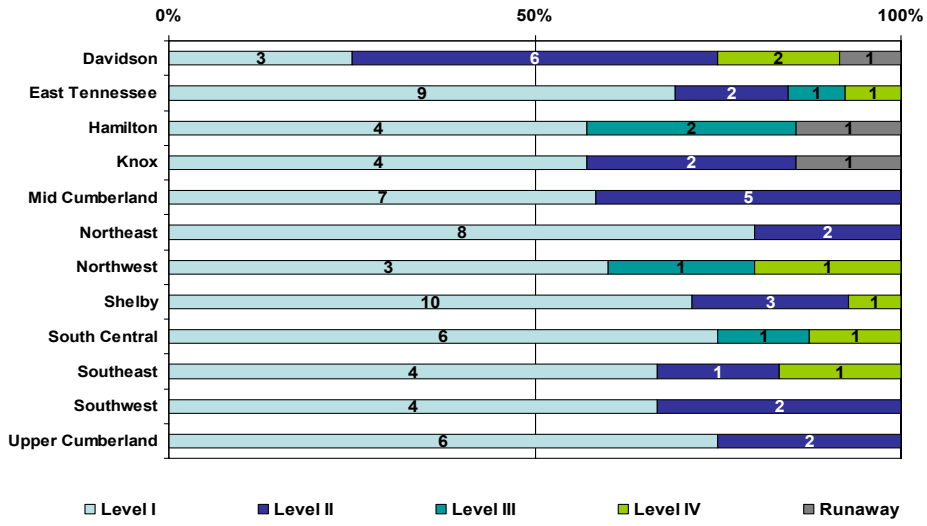


Figure 32

Placement Type by Region

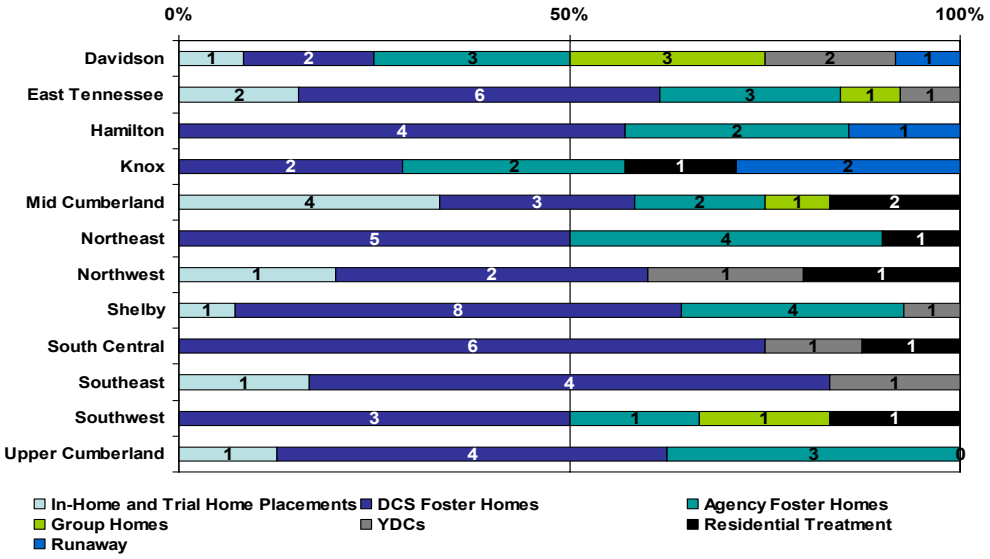


Figure 33

Continuum Placement by Region

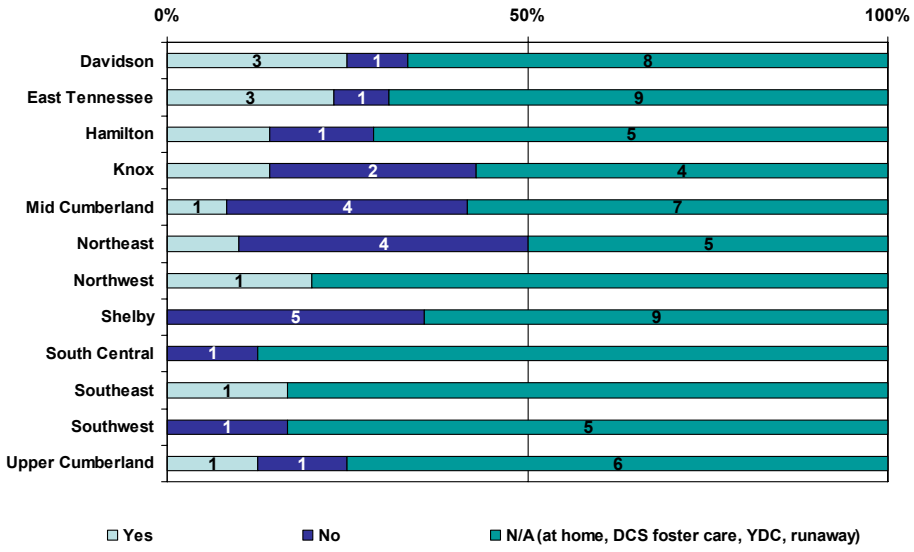


Figure 34

Current Permanency Goal by Region

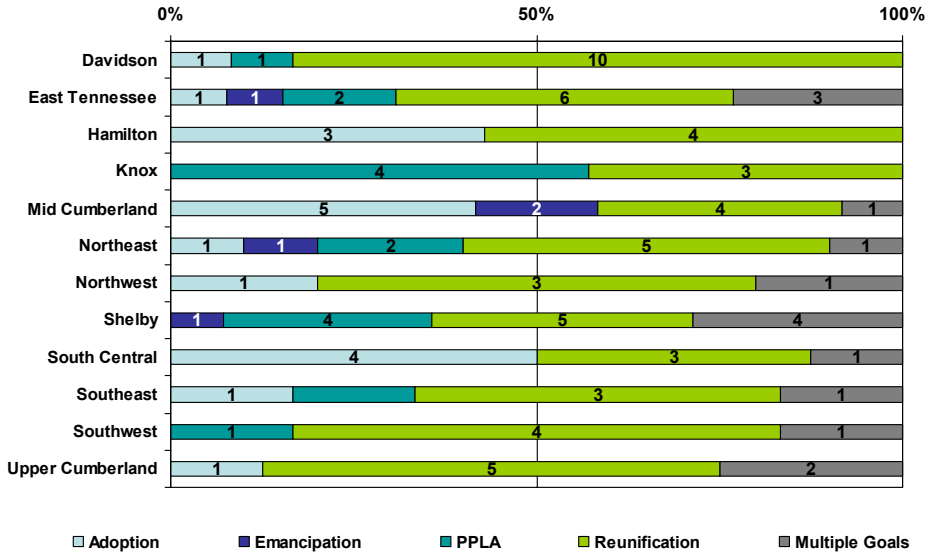


Figure 35

Original Permanency Goal by Region

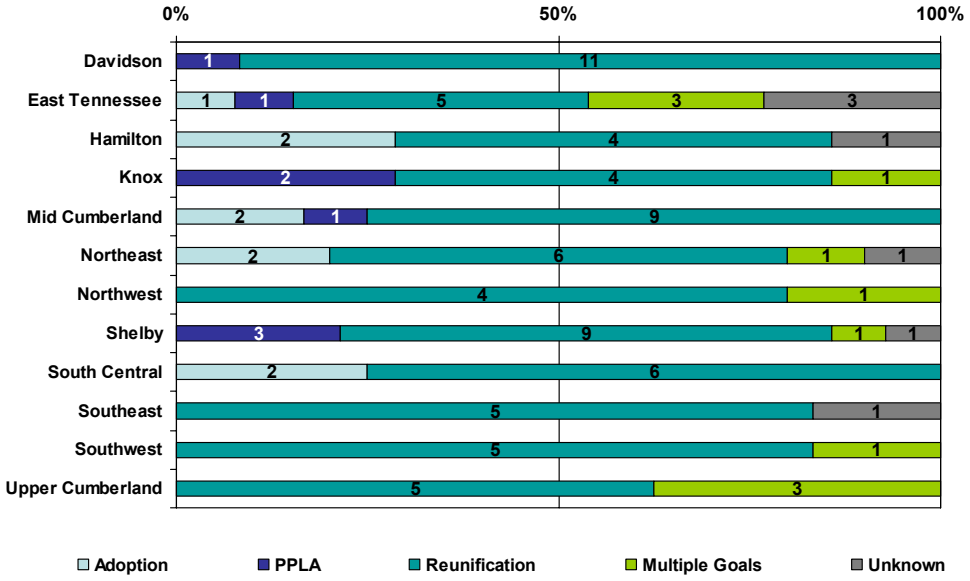


Figure 36

Reason for Removal from Home by Region

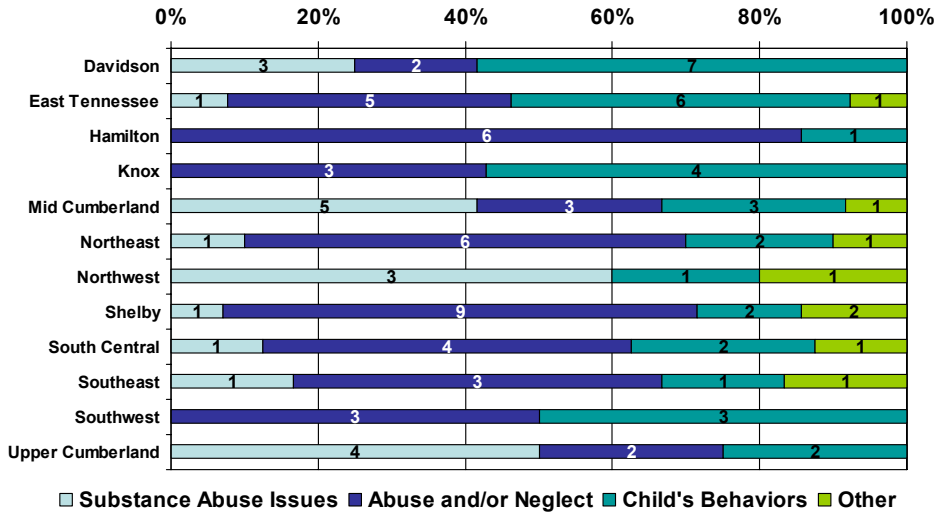


Figure 37

Family Services* Prior to Placement by Region

*as per Family Report

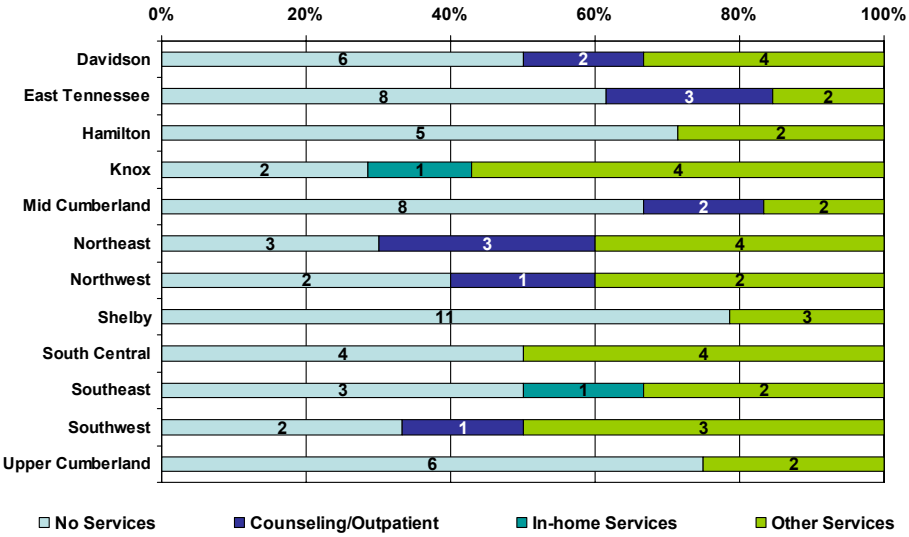


Figure 38

Family Search by Region

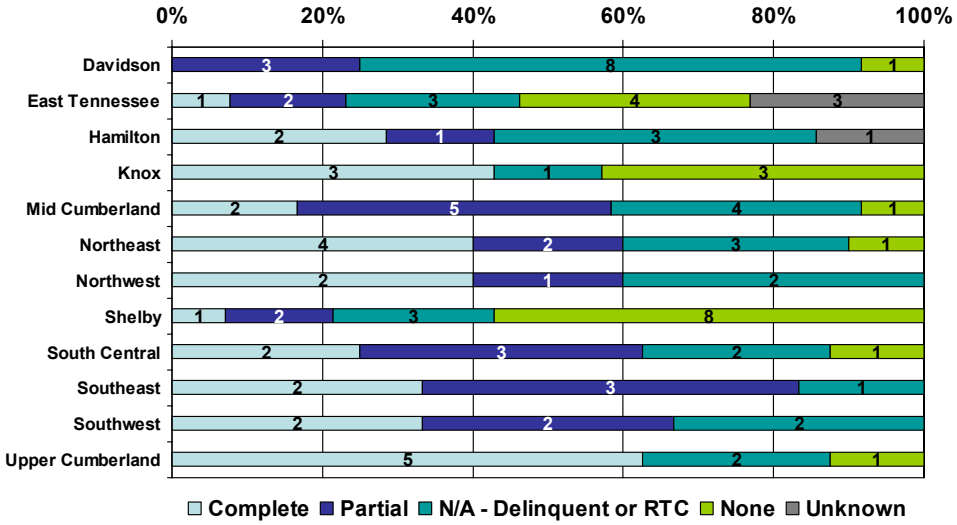


Figure 39

Likelihood of Custody Prevention by Region

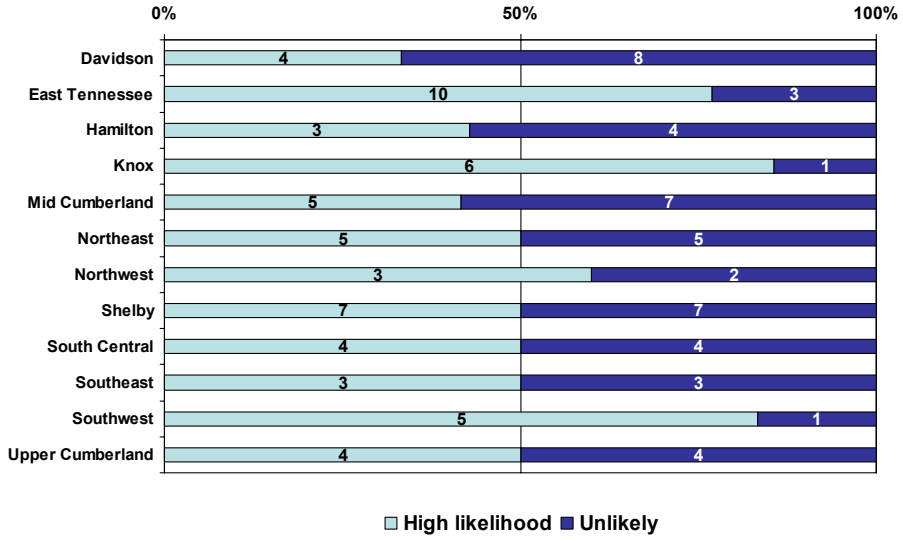


Figure 40

Viable Family at Time of Entry into Custody by Region

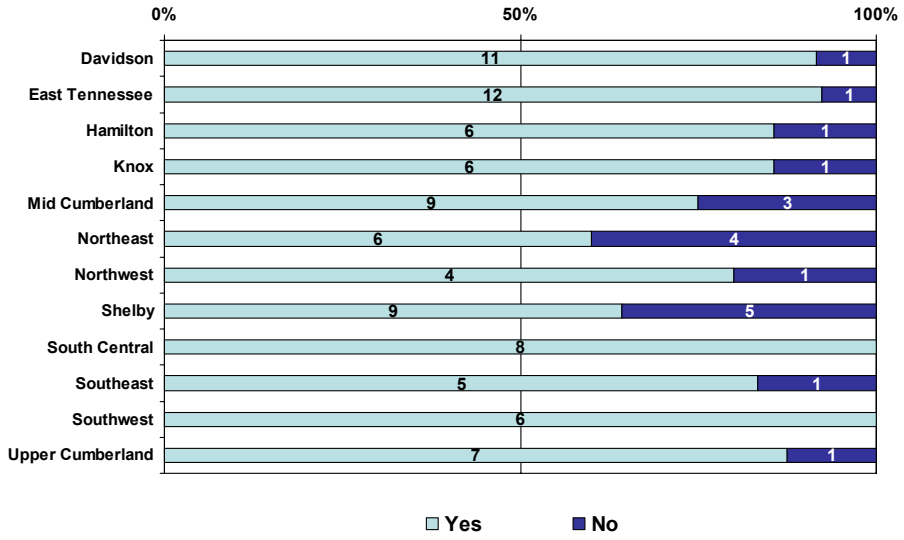


Figure 41

Relative Placement Attempted at Custody by Region

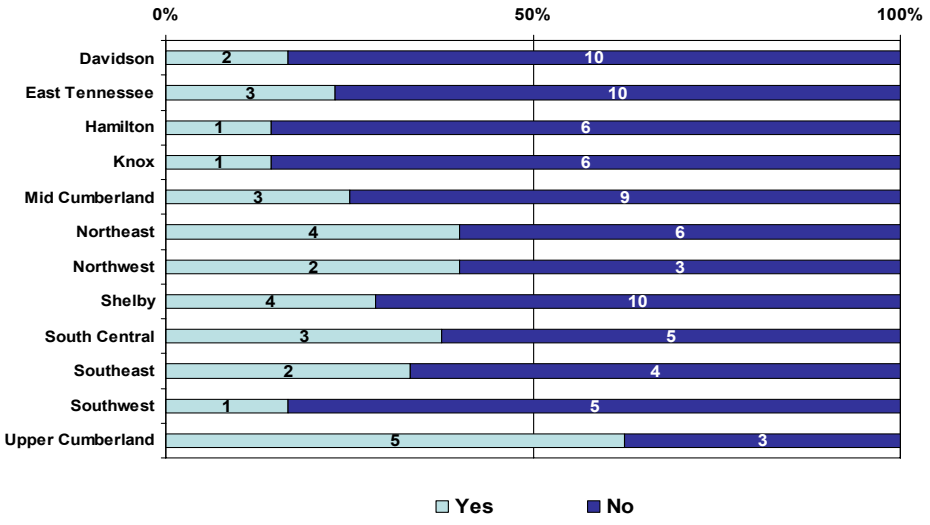


Figure 42

Current Viable Family by Region

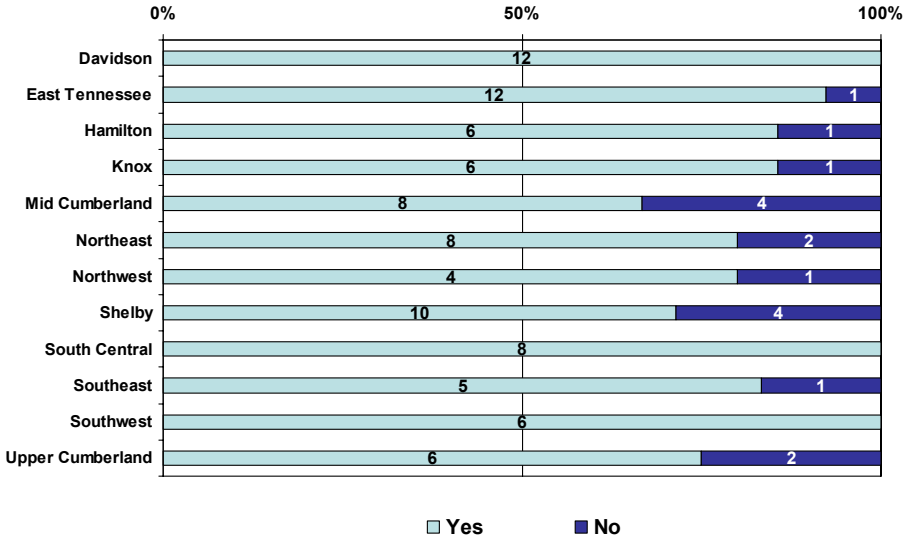


Figure 43

Current Services to Family* by Region

*as per Family Report

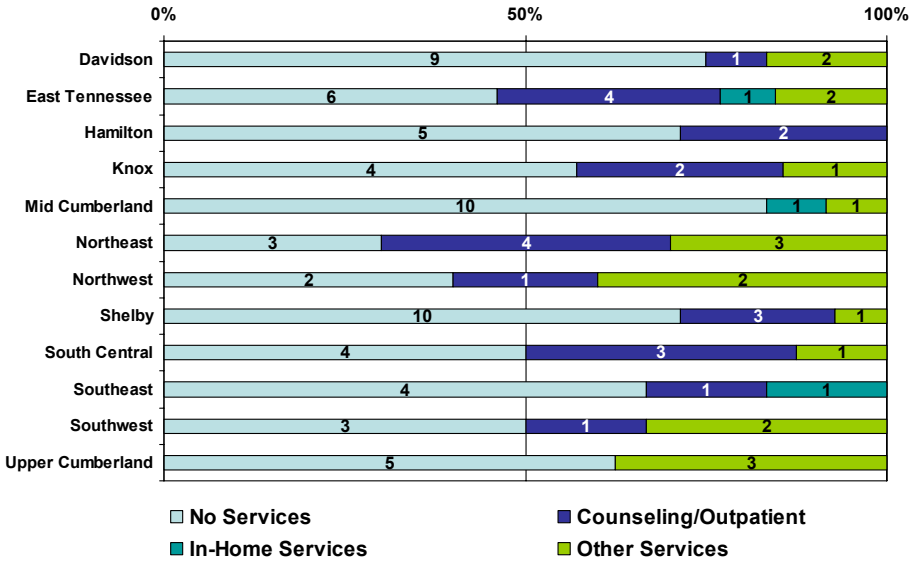


Figure 44

Projected Step-Down Date by Region

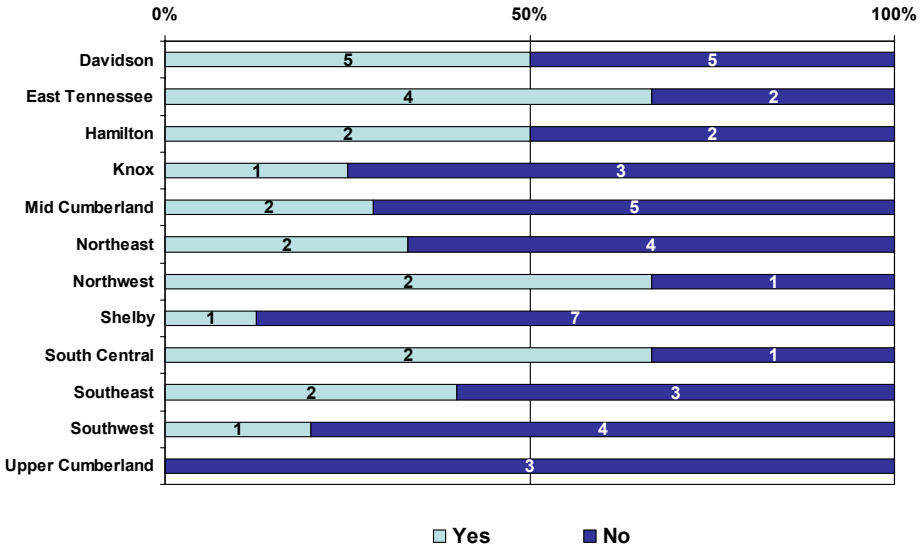


Figure 45

Parenting Classes Recommended by DCS by Region

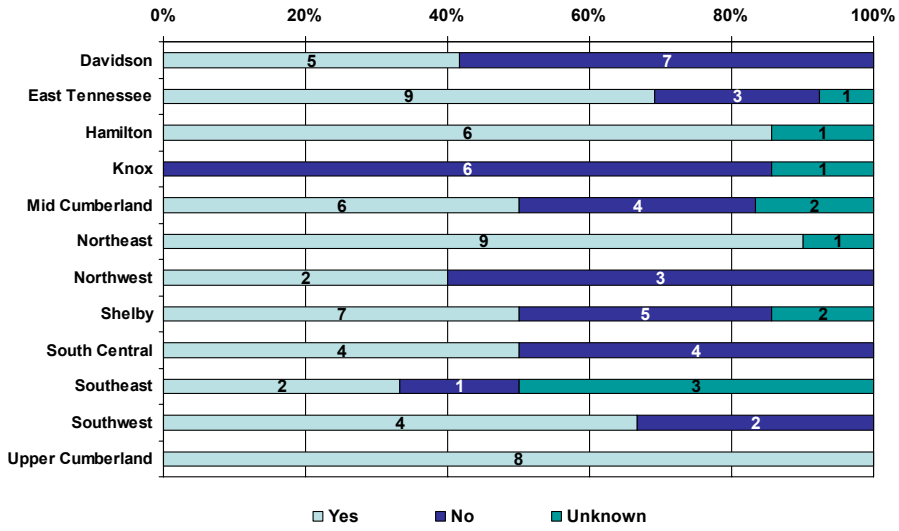


Figure 46

Anger Management Classes Recommended by DCS by Region

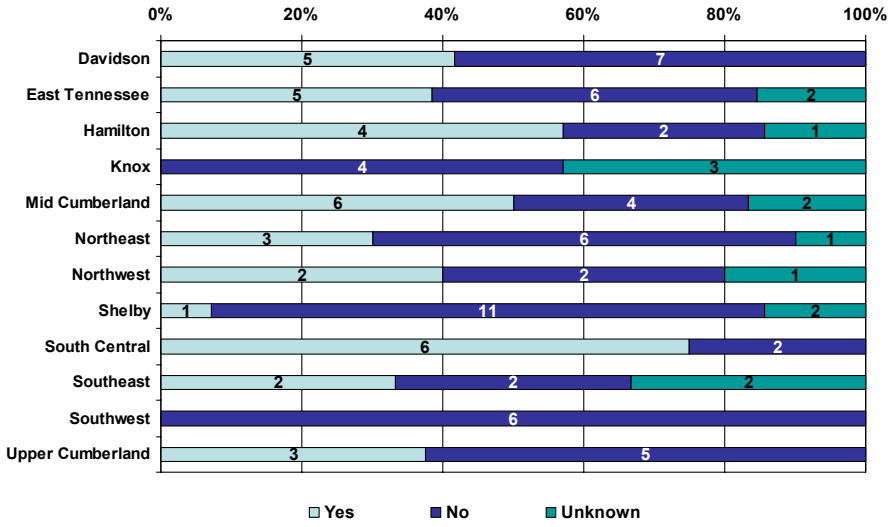


Figure 47

Case Recommendations for Service by Region

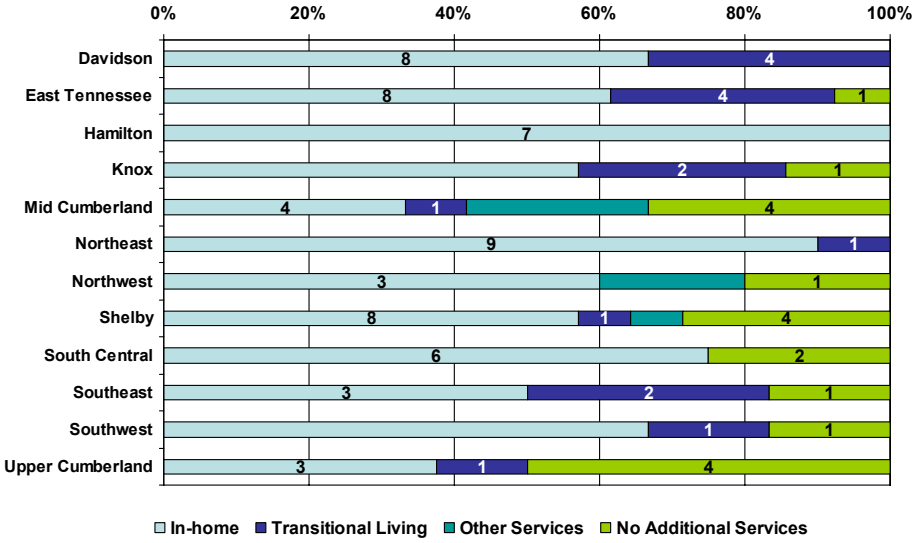
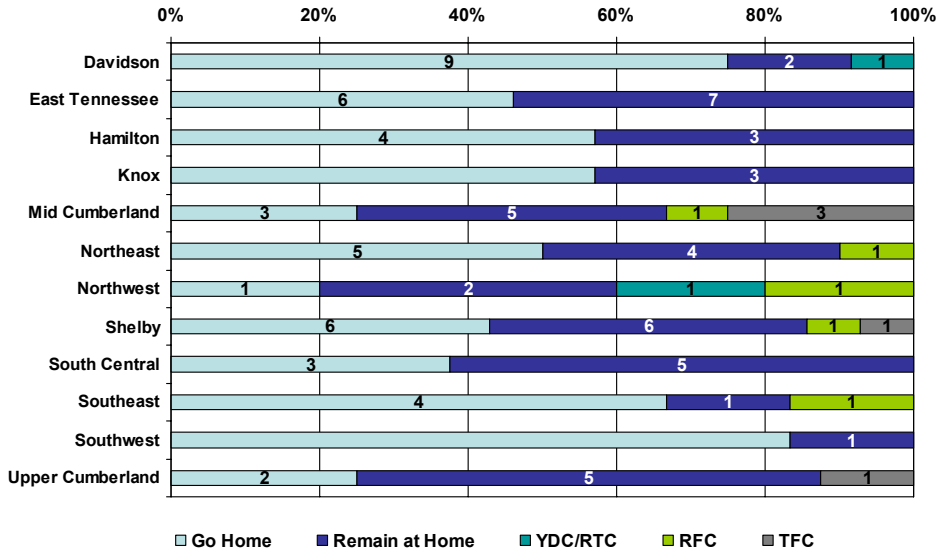


Figure 48

Case Recommendations for Placement by Region



Appendix III
Additional Analysis of Sample Data

This section presents additional data analysis from the study including:

- comparison of the sample and population
- examination of agency assessment data
- presentation of information on youth whose parents' rights had been or were pending termination
- cross-tabulation of study variables by length of time in custody and by adjudication type

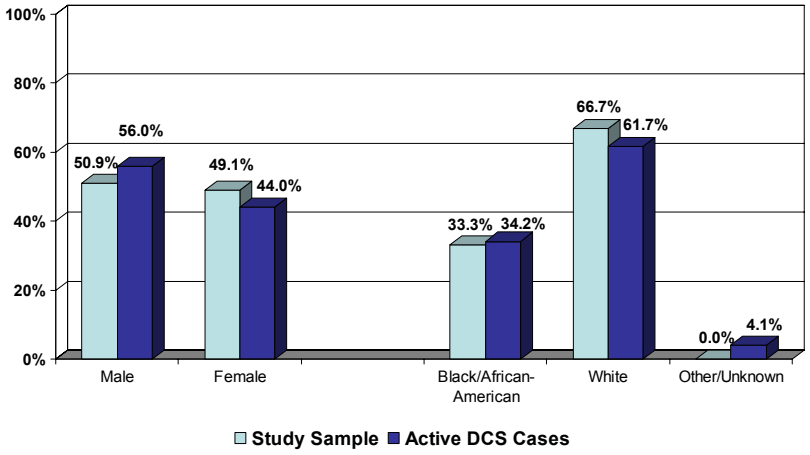
In support of these analyses, the following figures appear in this appendix:

Comparison of Sample and Population

Characteristics of the sample, including gender, race, age, adjudication type, and region were compared to the population of active DCS custody cases as of June 30, 2004. Using a one-sample test for a binomial proportion, no significant differences were found between the sample and population. It should be noted that the group from which the sample was actually drawn did not include children who had been in custody between 12 and 24 months. These children were excluded because the Department has recently implemented a special initiative with this group. Because they were excluded solely on the basis of length of stay, there is no reason to think that they differed significantly from other population members on other characteristics. Therefore, comparison of this sample to the entire population of active DCS cases seems reasonable.

Figure 49

Demographics - Sample and Population

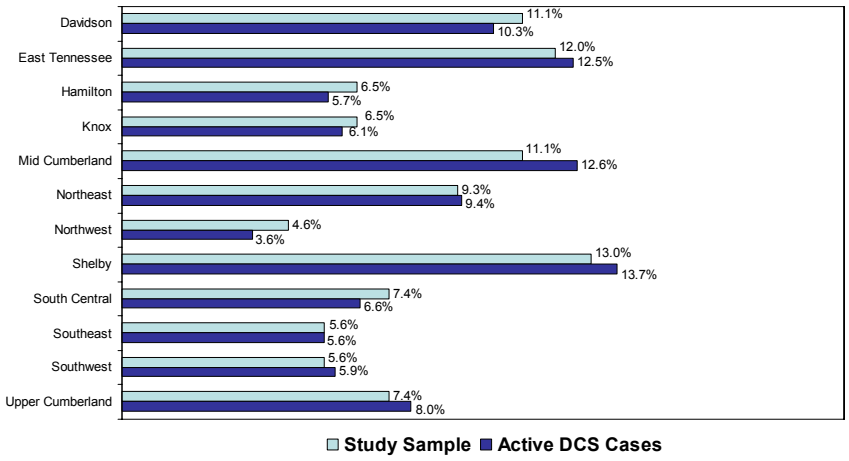


Sample n = 108

Active DCS Cases N = 10,329

Figure 50

Number of Cases by Region – Sample and Population

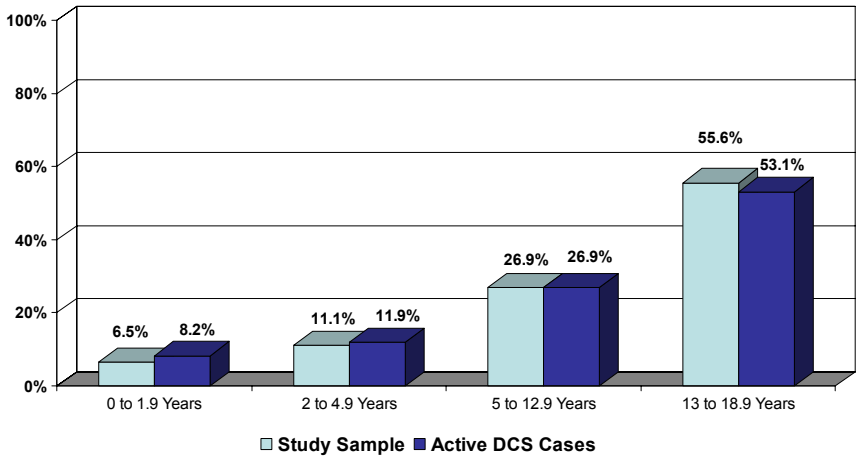


Sample n = 108

Active DCS Cases N = 10,329

Figure 51

Age Group - Sample and Population

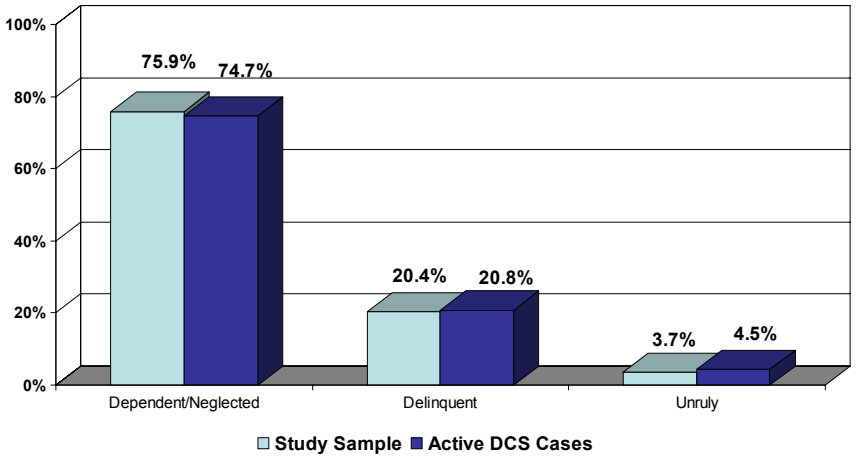


Sample n = 108

Active DCS Cases N = 10,329

Figure 52

Adjudication Type - Sample and Population



Sample n = 108

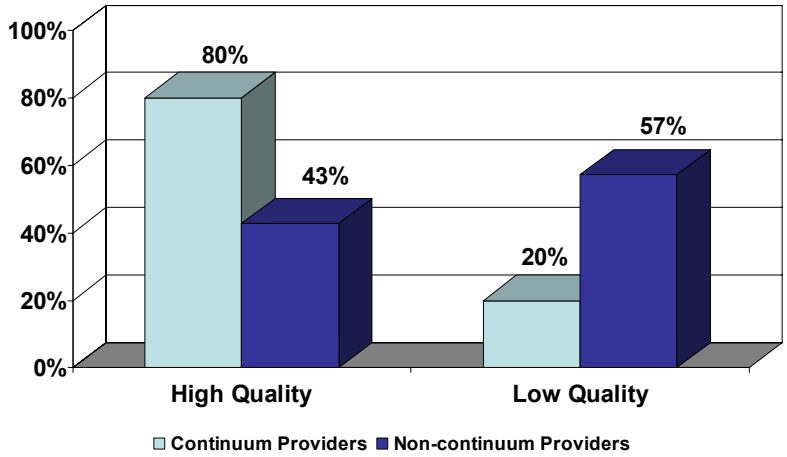
Active DCS Cases N = 10,329

Examination of Agency Assessment Data

Graphic displays of the information presented in the Agency Assessment portion of the Findings section can be found below.

Figure 53

Quality of Facility Environment
by Provider Type

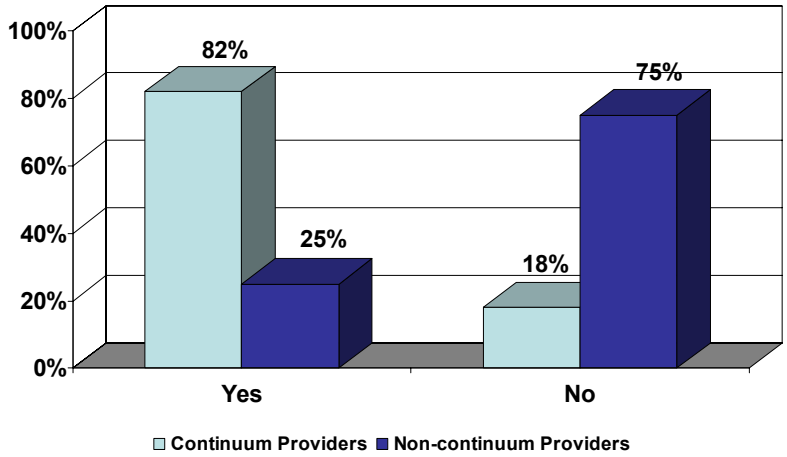


High quality environment defined as clean, well maintained, and not 'institutional' in appearance.

Includes only group homes and residential treatment centers.
Continuum providers: n = 4
Non-continuum providers: n = 7

Figure 54

Family Passes and Visitation Actively
Encouraged* by Provider Type

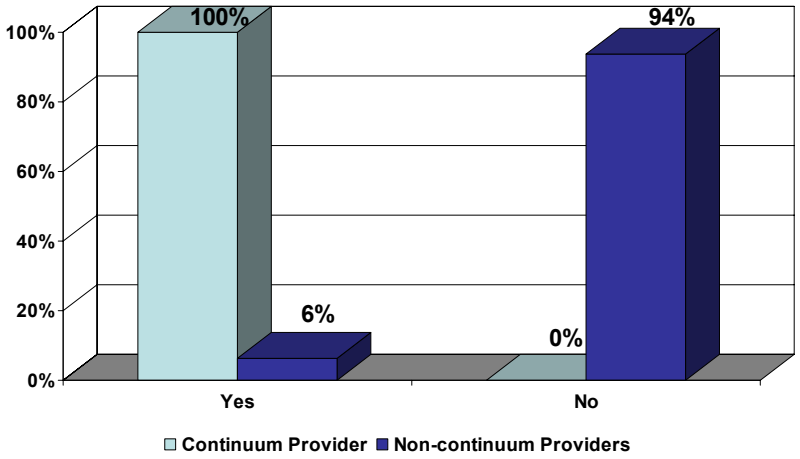


Continuum Providers: n = 11
Non-continuum Providers: n = 16

**Passes not based on level or points achieved; transportation assistance available.*

Figure 55

In-home Services* Offered by Provider Type



*Provides in-home services during transition from facility to home and after discharge from the facility.

Continuum Providers: n = 11
Non-continuum Providers: n = 16

Figure 56

Family Therapy Offered

n = 34

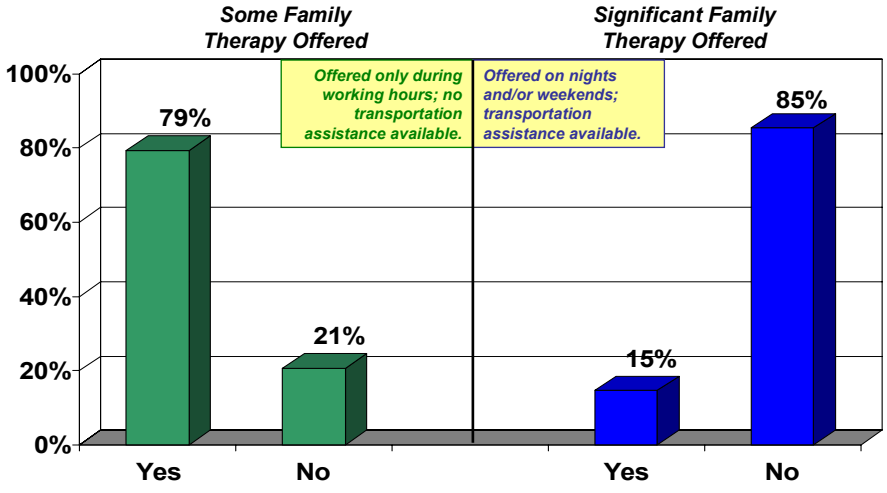


Figure 57

Basis for Discharge/Continued Stay

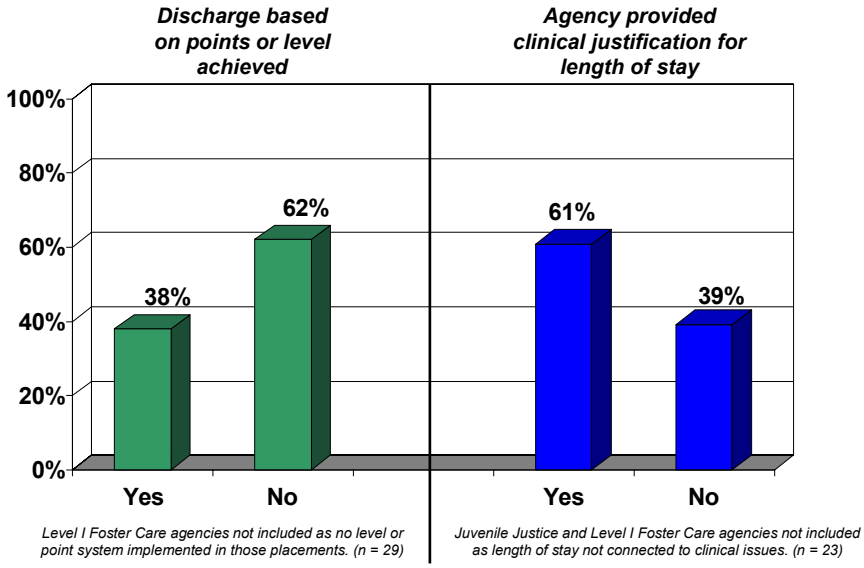
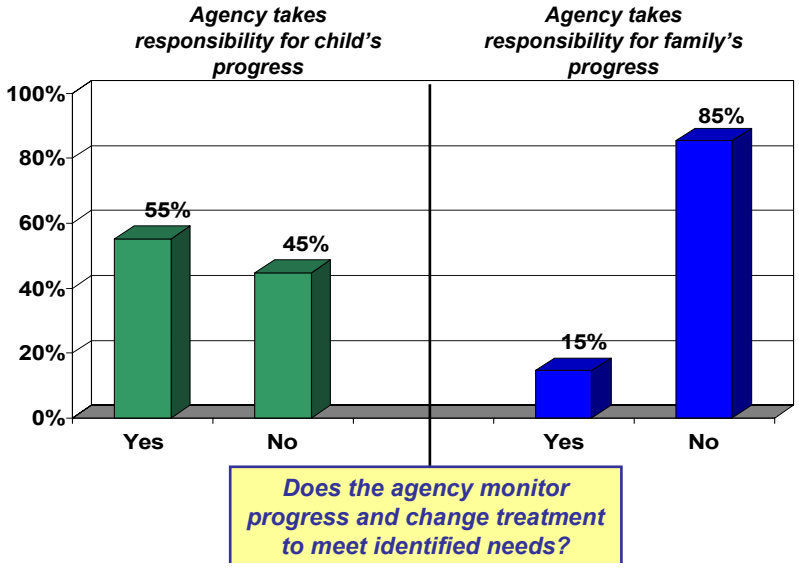


Figure 58

Agency Responsible for Change

n = 34

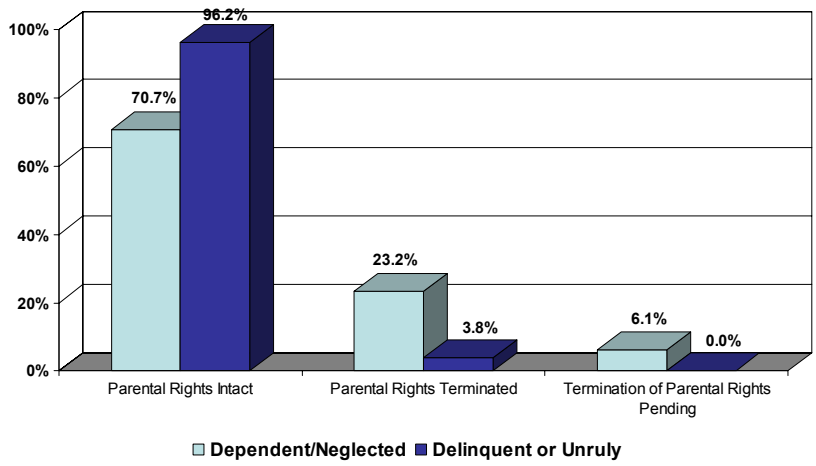


Information on Youth whose Parents' Rights had been Terminated or were Pending Termination

The findings section presents information on the situation of children in state custody whose parents' rights have been terminated. Below are graphs that further describe characteristics of this group.

Figure 59

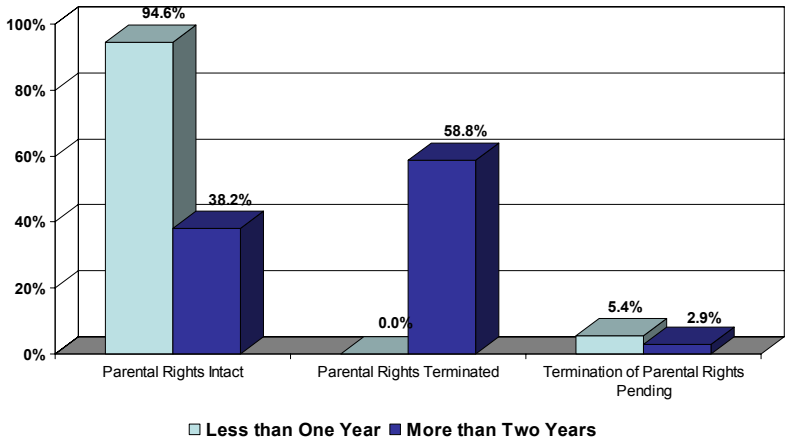
Status of Parental Rights by Adjudication Type



Dependent/Neglected: n = 81
Delinquent: n = 22
Unruly: n = 4

Figure 60

Status of Parental Rights by Length of Time in Custody



Less than one year: n = 74
More than two years: n = 34

Figure 61

Placement Type for Children Whose Parents' Rights Have Been Terminated

Includes both completed and pending TPR (n = 25)

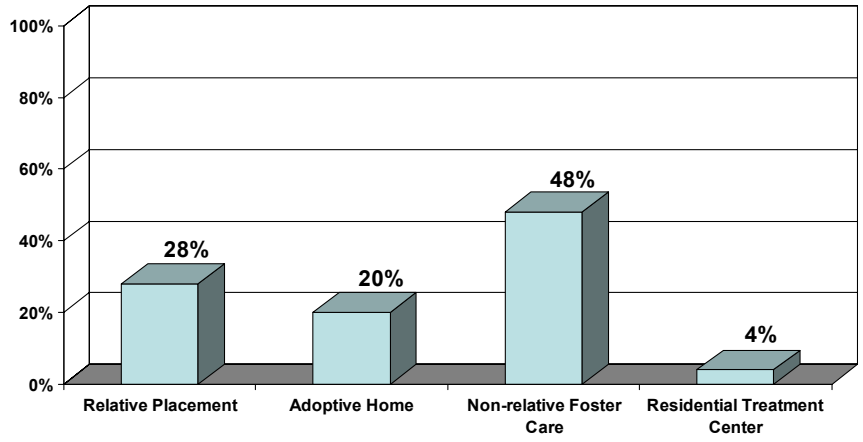


Figure 62

Agency Type for Children Whose Parents' Rights Have Been Terminated

Includes both completed and pending TPR (n = 25)

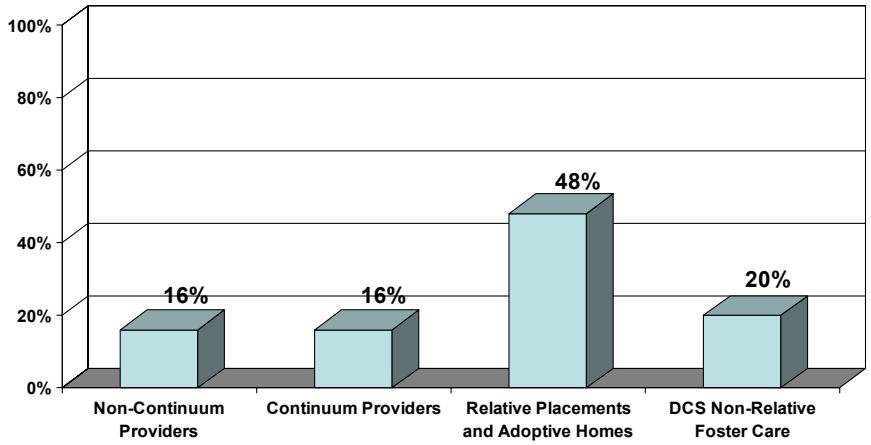


Table 4
Average Length of Time in Custody (as of July 1, 2004)
by Placement Type - For TPR cases only

	N	Mean	Median	Standard Deviation
DCS Relative Foster Care Placement	6	60.0	55.6	53.7
DCS Non-relative Foster Care Placement	5	94.3	86.7	74.6
Private Agency Placement	6	45.5	29.7	56.0
Trial home visit/Adoptive Home	6	68.0	49.7	39.7
YDC, Group Home, Halfway House	2	44.8	44.8	6.3
Total	***25***	***64.1***	***48.1***	***53.2***

Cross-tabulation of Study Variables by Length of Time in Custody and by Adjudication Type

This table provides detailed information on the distribution of variables discussed in the Findings section of the report. The distribution of each variable is displayed for the total sample, by length of time in state custody (Less than one year or More than two years) and by adjudication type (Dependent/Neglected and Delinquent or Unruly).

Table 5
Cross-tabulation of Study Variables by Length of Time in Custody and by Adjudication Type

GENDER

		Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
Female	**N**	***53***	34	19		47	6
	Percent	***49.1%***	45.9%	55.9%		57.3%	23.1%
Male	**N**	***55***	40	15		35	20
	Percent	***50.9%***	54.1%	44.1%		42.7%	76.9%
Total	***N***	***108***	*74*	*34*		*82*	*26*
	Percent	***100.0%***	*100.0%*	*100.0%*		*100.0%*	*100.0%*

RACE

		Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
Black/ African American	**N**	***36***	25	11		23	13
	Percent	***33.3%***	33.8%	32.4%		28.0%	50.0%
White	**N**	***72***	49	23		59	13
	Percent	***66.7%***	66.2%	67.6%		72.0%	50.0%
Total	***N***	***108***	*74*	*34*		*82*	*26*
	Percent	***100.0%***	*100.0%*	*100.0%*		*100.0%*	*100.0%*

AGE GROUP (Current Age as of July 1, 2004)

		Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
0 to 1.9 Years	**N**	***4***	4	0		4	0
	Percent	***3.7%***	5.4%	0.0%		4.9%	0.0%
2 to 4.9 Years	**N**	***13***	13	0		13	0
	Percent	***12.0%***	17.6%	0.0%		15.9%	0.0%
5 to 12.9 Years	**N**	***28***	17	11		27	1
	Percent	***25.9%***	23.0%	32.4%		32.9%	3.8%
13 to 18.9 Years	**N**	***61***	39	22		38	23
	Percent	***56.5%***	52.7%	64.7%		46.3%	88.5%
19+ Years	**N**	***2***	1	1		0	2
	Percent	***1.9%***	1.4%	2.9%		0.0%	7.7%
Total	***N***	***108***	*74*	*34*		*82*	*26*
	Percent	***100.0%***	*100.0%*	*100.0%*		*100.0%*	*100.0%*

(Table 5, continued)

AVERAGE AGE (As of July 1, 2004)

	Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
Mean	***12.3***	11.4	14.3		10.9	16.6
Median	***14.4***	13.6	15.3		12.2	16.5
Standard Deviation	***5.6***	6.0	3.9		5.7	1.6

AVERAGE MONTHS IN CUSTODY (As of July 1, 2004)

	Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
Mean	***24.1***	5.2	65.0		28.1	11.1
Median	***8.9***	4.7	49.4		9.8	4.5
Standard Deviation	***37.0***	3.7	43.5		40.5	18.3

NUMBER OF PLACEMENTS

		Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
One or two placements	**N**	***58***	48	10		49	9
	Percent	***53.7%***	64.9%	29.4%		59.8%	34.6%
Three to five placements	**N**	***28***	18	10		19	9
	Percent	***25.9%***	24.3%	29.4%		23.2%	34.6%
More than five placements	**N**	***22***	8	14		14	8
	Percent	***20.4%***	10.8%	41.2%		17.1%	30.8%
Total	***N***	***108***	*74*	*34*		*82*	*26*
	Percent	***100.0%***	*100.0%*	*100.0%*		*100.0%*	*100.0%*

NUMBER OF TIMES IN DCS CUSTODY

		Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
One time	**N**	***93***	64	29		73	20
	Percent	***86.1%***	86.5%	85.3%		89.0%	76.9%
Two times	**N**	***11***	7	4		7	4
	Percent	***10.2%***	9.5%	11.8%		8.5%	15.4%
Three times	**N**	***4***	3	1		2	2
	Percent	***3.7%***	4.1%	2.9%		2.4%	7.7%
Total	***N***	***108***	*74*	*34*		*82*	*26*
	Percent	***100.0%***	*100.0%*	*100.0%*		*100.0%*	*100.0%*

(Table 5, continued)

LEVEL

		Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
Level I	**N**	***68***	44	24		65	3
	Percent	***63.0%***	59.5%	70.6%		79.3%	11.5%
Level II	**N**	***25***	17	8		14	11
	Percent	***23.1%***	23.0%	23.5%		17.1%	42.3%
Level III	**N**	***5***	4	1		2	3
	Percent	***4.6%***	5.4%	2.9%		2.4%	11.5%
Level IV	**N**	***7***	6	1		0	7
	Percent	***6.5%***	8.1%	2.9%		0.0%	26.9%
Runaway	**N**	***3***	3	0		1	2
	Percent	***2.8%***	4.1%	0.0%		1.2%	7.7%
Total	***N***	***108***	*74*	*34*		*82*	*26*
	Percent	***100.0%***	*100.0%*	*100.0%*		*100.0%*	*100.0%*

PLACEMENT TYPE (DCS Categories)

		Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
In-Home and Trial Home Placements	**N**	***11***	7	4		9	2
	Percent	***10.2%***	9.5%	11.8%		11.0%	7.7%
DCS Foster Homes	**N**	***49***	32	17		47	2
	Percent	***45.4%***	43.2%	50.0%		57.3%	7.7%
Agency Foster Homes	**N**	***24***	15	9		21	3
	Percent	***22.2%***	20.3%	26.5%		25.6%	11.5%
Group Homes	**N**	***6***	5	1		0	6
	Percent	***5.6%***	6.8%	2.9%		0.0%	23.1%
YDCs	**N**	***7***	6	1		0	7
	Percent	***6.5%***	8.1%	2.9%		0.0%	26.9%
Residential Treatment	**N**	***7***	6	1		3	4
	Percent	***6.5%***	8.1%	2.9%		3.7%	15.4%
Runaway	**N**	***4***	3	1		2	2
	Percent	***3.7%***	4.1%	2.9%		2.4%	7.7%
Total	***N***	***108***	*74*	*34*		*82*	*26*
	Percent	***100.0%***	*100.0%*	*100.0%*		*100.0%*	*100.0%*

(Table 5, continued)

PLACEMENT TYPE (Provider Type)

		Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
YDC	**N**	***8***	6	2		0	8
	Percent	***7.4%***	8.1%	5.9%		0.0%	30.8%
DCS Group Homes and Halfway House	**N**	***3***	3	0		0	3
	Percent	***2.8%***	4.1%	0.0%		0.0%	11.5%
Non-Continuum Residential Providers	**N**	***9***	7	2		4	5
	Percent	***8.3%***	9.5%	5.9%		4.9%	19.2%
Non-Continuum Foster Care Providers	**N**	***12***	9	3		11	1
	Percent	***11.1%***	12.2%	8.8%		13.4%	3.8%
Continuum Providers	**N**	***18***	10	8		14	4
	Percent	***16.7%***	13.5%	23.5%		17.1%	15.4%
Home (with relative, parents, or adoptive parents)	**N**	***40***	28	12		38	2
	Percent	***37.0%***	37.8%	35.3%		46.3%	7.7%
DCS Non-Relative Foster Home	**N**	***16***	9	7		15	1
	Percent	***14.8%***	12.2%	20.6%		18.3%	3.8%
Runaway	**N**	***2***	2	0		0	2
	Percent	***1.9%***	2.7%	0.0%		0.0%	7.7%
Total	***N***	***108***	*74*	*34*		*82*	*26*
	Percent	***100.0%***	*100.0%*	*100.0%*		*100.0%*	*100.0%*

(Table 5, continued)

CURRENT PERMANENCY GOAL

		Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
Adoption	**N**	***18***	3	15		17	1
	Percent	***16.7%***	4.1%	44.1%		20.7%	3.8%
Emancipation	**N**	***5***	1	4		3	2
	Percent	***4.6%***	1.4%	11.8%		3.7%	7.7%
Planned Permanent Living Arrangement (PPLA)	**N**	***15***	8	7		15	0
	Percent	***13.9%***	10.8%	20.6%		18.3%	0.0%
Reunification	**N**	***55***	48	7		32	23
	Percent	***50.9%***	64.9%	20.6%		39.0%	88.5%
Multiple goals	**N**	***15***	14	1		15	0
	Percent	***13.9%***	18.9%	2.9%		18.3%	0.0%
Total	***N***	***108***	*74*	*34*		*82*	*26*
	Percent	***100.0%***	*100.0%*	*100.0%*		*100.0%*	*100.0%*

ORIGINAL PERMANENCY GOAL

		Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
Adoption	**N**	***9***	1	8		9	0
	Percent	***8.3%***	1.4%	23.5%		11.0%	0.0%
Planned Permanent Living Arrangement (PPLA)	**N**	***8***	6	2		8	0
	Percent	***7.4%***	8.1%	5.9%		9.8%	0.0%
Reunification	**N**	***73***	54	19		50	23
	Percent	***67.6%***	73.0%	55.9%		61.0%	88.5%
Multiple goals	**N**	***11***	10	1		11	0
	Percent	***10.2%***	13.5%	2.9%		13.4%	0.0%
Unknown	**N**	***7***	3	4		4	3
	Percent	***6.5%***	4.1%	11.8%		4.9%	11.5%
Total	***N***	***108***	*74*	*34*		*82*	*26*
	Percent	***100.0%***	*100.0%*	*100.0%*		*100.0%*	*100.0%*

STATUS OF PARENTAL RIGHTS

		Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
Intact	**N**	***83***	70	13		58	25
	Percent	***76.9%***	94.6%	38.2%		70.7%	96.2%
Termination Pending	**N**	***5***	4	1		5	0
	Percent	***4.6%***	5.4%	2.9%		6.1%	0.0%
Parental Rights Terminated	**N**	***20***	0	20		19	1
	Percent	***18.5%***	0.0%	58.8%		23.2%	3.8%
Total	***N***	***108***	*74*	*34*		*82*	*26*
	Percent	***100.0%***	*100.0%*	*100.0%*		*100.0%*	*100.0%*

(Table 5, continued)

FAMILY SERVICES PRIOR TO ENTRY INTO STATE CUSTODY PER FAMILY REPORT

		Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
No Services	**N**	***60***	37	23		52	8
	Percent	***55.6%***	50.0%	67.6%		63.4%	30.8%
Counseling/Outpatient	**N**	***12***	10	2		10	2
	Percent	***11.1%***	13.5%	5.9%		12.2%	7.7%
In-home Services	**N**	***2***	2	0		2	0
	Percent	***1.9%***	2.7%	0.0%		2.4%	0.0%
Other Services	**N**	***34***	25	9		18	16
	Percent	***31.5%***	33.8%	26.5%		22.0%	61.5%
Total	***N***	***108***	*74*	*34*		*82*	*26*
	Percent	***100.0%***	*100.0%*	*100.0%*		*100.0%*	*100.0%*

FAMILY SEARCH

		Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
Complete Search	**N**	***26***	16	10		26	0
	Percent	***24.1%***	21.6%	29.4%		31.7%	0.0%
Partial Search	**N**	***24***	16	8		24	0
	Percent	***22.2%***	21.6%	23.5%		29.3%	0.0%
No Search	**N**	***54***	39	15		28	26
	Percent	***50.0%***	52.7%	44.1%		34.2%	100.0%
Unknown	**N**	***4***	3	1		4	0
	Percent	***3.7%***	4.1%	2.9%		4.9%	0.0%
Total	***N***	***108***	*74*	*34*		*82*	*26*
	Percent	***100.0%***	*100.0%*	*100.0%*		*100.0%*	*100.0%*

LIKELIHOOD OF CUSTODY PREVENTION

		Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
High likelihood	**N**	***57***	48	9		39	18
	Percent	***52.8%***	64.9%	26.5%		47.6%	69.2%
Unlikely	**N**	***26***	22	4		19	7
	Percent	***24.1%***	29.8%	11.7%		23.2%	26.9%
Unable to assess (TPR cases)	**N**	***25***	4	21		24	1
	Percent	***23.1%***	5.4%	61.8%		29.3%	3.8%
Total	***N***	***108***	*74*	*34*		*82*	*26*
	Percent	***100.0%***	*100.0%*	*100.0%*		*100.0%*	*100.0%*

(Table 5, continued)

VIABLE FAMILY RESOURCES AT TIME OF ENTRY INTO STATE CUSTODY

		Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
Yes	**N**	***89***	66	23		64	25
	Percent	***82.4%***	89.2%	67.6%		78.0%	96.2%
No	**N**	***19***	8	11		18	1
	Percent	***17.6%***	10.9%	32.3%		21.9%	3.8%
Total	***N***	***108***	*74*	*34*		*82*	*26*
	Percent	***100.0%***	*100.0%*	*100.0%*		*100.0%*	*100.0%*

RELATIVE PLACEMENT ATTEMPTED AT TIME OF ENTRY INTO STATE CUSTODY

		Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
Yes	**N**	***31***	22	9		31	0
	Percent	***28.7%***	29.7%	26.5%		37.8%	0.0%
No	**N**	***77***	52	25		51	26
	Percent	***71.3%***	70.3%	73.5%		62.2%	100.0%
Total	***N***	***108***	*74*	*34*		*82*	*26*
	Percent	***100.0%***	*100.0%*	*100.0%*		*100.0%*	*100.0%*

PARENTING CLASSES RECOMMENDED BY DCS PER FAMILY REPORT

		Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
Yes	**N**	***62***	41	21		54	8
	Percent	***57.4%***	55.4%	61.8%		65.9%	30.8%
No	**N**	***35***	28	7		19	16
	Percent	***32.4%***	37.8%	20.6%		23.2%	61.5%
Unknown	**N**	***11***	5	6		9	2
	Percent	***10.2%***	6.8%	17.6%		11.0%	7.7%
Total	***N***	***108***	*74*	*34*		*82*	*26*
	Percent	***100.0%***	*100.0%*	*100.0%*		*100.0%*	*100.0%*

ANGER MANAGEMENT CLASSES RECOMMENDED BY DCS PER FAMILY REPORT

		Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
Yes	**N**	***37***	26	11		22	15
	Percent	***34.3%***	35.1%	32.4%		26.8%	57.7%
No	**N**	***57***	43	14		49	8
	Percent	***52.8%***	58.1%	41.2%		59.8%	30.8%
Unknown	**N**	***14***	5	9		11	3
	Percent	***13.0%***	6.8%	26.5%		13.4%	11.5%
Total	***N***	***108***	*74*	*34*		*82*	*26*
	Percent	***100.0%***	*100.0%*	*100.0%*		*100.0%*	*100.0%*

(Table 5, continued)

CURRENT VIABLE FAMILY RESOURCES

		Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
Yes	**N**	***91***	69	22		66	25
	Percent	***84.3%***	93.2%	64.7%		80.5%	96.2%
No	**N**	***17***	5	12		16	1
	Percent	***15.7%***	6.8%	35.3%		19.5%	3.8%
Total	***N***	***108***	*74*	*34*		*82*	*26*
	Percent	***100.0%***	*100.0%*	*100.0%*		*100.0%*	*100.0%*

CURRENT FAMILY SERVICES PER FAMILY REPORT

		Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
No Services	**N**	***65***	38	27		44	21
	Percent	***60.2%***	51.4%	79.4%		53.7%	80.8%
Counseling/Outpatient	**N**	***22***	17	5		18	4
	Percent	***20.4%***	23.0%	14.7%		22.0%	15.4%
In-home Services	**N**	***3***	3	0		3	0
	Percent	***2.8%***	4.1%	0.0%		3.7%	0.0%
Other Services	**N**	***18***	16	2		17	1
	Percent	***16.7%***	21.6%	5.9%		20.7%	3.8%
Total	***N***	***108***	*74*	*34*		*82*	*26*
	Percent	***100.0%***	*100.0%*	*100.0%*		*100.0%*	*100.0%*

REPORTED STEPDOWN DATE (does not include children already at home with parents, relatives, or adoptive parents)

		Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
No Stepdown Date Established	**N**	***40***	23	17		28	12
	Percent	***62.6%***	50.0%	94.4%		70.0%	50.0%
Within Six Months	**N**	***17***	17	0		11	6
	Percent	***26.5%***	36.9%	0.0%		27.5%	25.0%
Six to Twelve Months	**N**	***6***	6	0		1	5
	Percent	***9.4%***	13.0%	0.0%		2.5%	20.8%
More than Twelve Months	**N**	***1***	0	1		0	1
	Percent	***1.6%***	0.0%	5.6%		0.0%	4.2%
Total	***N***	***64***	*46*	*18*		*71*	*26*
	Percent	***100.0%***	*100.0%*	*100.0%*		*100.0%*	*100.0%*

(Table 5, continued)

CASE RECOMMENDATIONS FOR SERVICES

		Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
Recommend intensive in-home services	**N**	***67***	52	15		49	18
	Percent	***62.0%***	70.3%	44.1%		59.8%	69.2%
Recommend transitional living services	**N**	***17***	10	7		11	6
	Percent	***15.7%***	13.5%	20.6%		13.4%	23.1%
Recommend no additional services	**N**	***19***	11	8		18	1
	Percent	***17.6%***	14.9%	23.5%		22.0%	3.8%
Other	**N**	***5***	1	4		4	1
	Percent	***4.6%***	1.4%	11.8%		4.9%	3.8%
Total	***N***	***108***	*74*	*34*		*82*	*26*
	Percent	***100.0%***	*100.0%*	*100.0%*		*100.0%*	*100.0%*

CASE RECOMMENDATIONS FOR PLACEMENT

		Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
Home with parents, relatives, or adoptive parents	**N**	***52***	43	9		30	22
	Percent	***48.1%***	58.1%	26.5%		36.6%	84.6%
Already home with parents, relatives, or adoptive parents	**N**	***44***	28	16		42	2
	Percent	***40.7%***	37.8%	47.1%		51.2%	7.7%
YDC or Residential Treatment Program	**N**	***2***	1	1		0	2
	Percent	***1.9%***	1.4%	2.9%		0.0%	7.7%
Regular Foster Care	**N**	***5***	1	4		5	0
	Percent	***4.6%***	1.4%	11.8%		6.1%	0.0%
Therapeutic Foster Care	**N**	***5***	1	4		5	0
	Percent	***4.6%***	1.4%	11.8%		6.1%	0.0%
Total	***N***	***108***	*74*	*34*		*82*	*26*
	Percent	***100.0%***	*100.0%*	*100.0%*		*100.0%*	*100.0%*

(Table 5, continued)

NUMBER OF FAMILY VISITS IN THE PAST 30 DAYS

		Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
No family visits	**N**	***16***	14	2		6	10
	Percent	***14.8%***	18.9%	5.9%		7.3%	38.5%
One to three family visits	**N**	***20***	17	3		14	6
	Percent	***18.6%***	23.0%	8.8%		17.0%	23.0%
Four or more family visits	**N**	***9***	8	1		5	4
	Percent	***8.3%***	10.9%	2.9%		6.1%	15.3%
Not applicable (home with parents, relatives, or adoptive parents; runaway; TPR)	**N**	***60***	32	28		55	5
	Percent	***55.6%***	43.4%	82.3%		67.0%	19.2%
Unknown	**N**	***3***	3	0		2	1
	Percent	***2.8%***	4.1%	0.0%		2.4%	3.8%
Total	***N***	***108***	*74*	*34*		*82*	*26*
	Percent	***100.0%***	*100.0%*	*100.0%*		*100.0%*	*100.0%*

PRIMARY REASON FOR REMOVAL FROM HOME

		Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
Family Substance Abuse	**N**	***20***	12	8		17	3
	Percent	***18.5%***	16.2%	23.5%		20.7%	11.5%
Abuse and/or Neglect	**N**	***46***	28	18		44	2
	Percent	***42.6%***	37.8%	52.9%		53.7%	7.7%
Child's Behaviors	**N**	***34***	27	7		14	20
	Percent	***31.5%***	36.5%	20.6%		17.1%	76.9%
Other	**N**	***8***	7	1		7	1
	Percent	***7.4%***	9.5%	2.9%		8.5%	3.8%
Total	***N***	***108***	*74*	*34*		*82*	*26*
	Percent	***100.0%***	*100.0%*	*100.0%*		*100.0%*	*100.0%*

(Table 5, continued)

YEARS IN CUSTODY

		Total	Less than One Year	More than Two Years		Dependent/ Neglected	Delinquent or Unruly
Less than One Year	**N**	***74***	74	0		53	21
	Percent	***68.5%***	100.0%	0.0%		64.6%	80.8%
Two or Three Years (24 to 47 months)	**N**	***14***	0	14		10	4
	Percent	***13.0%***	0.0%	41.2%		12.2%	15.4%
Four Years (48 to 59 Months)	**N**	***9***	0	9		9	0
	Percent	***8.3%***	0.0%	26.5%		11.0%	0.0%
Five Years or More (60 months or more)	**N**	***11***	0	11		10	1
	Percent	***10.2%***	0.0%	32.3%		12.2%	3.8%
Total	***N***	***108***	*74*	*34*		*82*	*26*
	Percent	***100.0%***	*100.0%*	*100.0%*		*100.0%*	*100.0%*

REPORTED STEPDOWN DATE BY PERMANENCY GOAL
(does not include children already home with parents, relatives, or adoptive parents)

		Total	Reunification	Goal other than Reunification
No Stepdown Date Established	**N**	***40***	22	18
	Percent	***62.5%***	50.0%	90.0%
Within Six Months	**N**	***17***	15	2
	Percent	***26.6%***	34.1%	10.0%
Six to Twelve Months	**N**	***6***	6	0
	Percent	***9.4%***	13.6%	0.0%
More than Twelve Months	**N**	***1***	1	0
	Percent	***1.6%***	2.3%	0.0%
Total	***N***	***64***	*44*	*20*
	Percent	***100.0%***	*100.0%*	*100.0%*

Appendix IV
Definitions and Descriptions

This appendix contains the following definitions and descriptions:

- Transitional Living Services
- Intensive In-home Services
- The Re-ED Model for Residential Treatment
- Population Served in Level I through Level IV Continuums

Transitional Living Services

Transitional living services are provided to young adults between the ages of 17 and 21. Services are tailored to the individual needs of each young adult served, but many of the young adults receive assistance with obtaining employment, maintaining stable housing, and budgeting. Transitional living services provide skills, support, and counseling to young adults who are aging out of state custody. These services are often essential to ensure that youth transition to adulthood successfully. A successful transition includes maintaining stable and suitable housing, remaining free from legal involvement, participating in an educational/vocational program, and developing the life skills necessary to become a successful citizen.

Many older youth aging out of state custody are facing the transition to adulthood with little preparation and are not succeeding. It has been estimated that at least one in four foster children exits care unsuccessfully due to runaway, incarceration or psychiatric hospitalization. Studies have found that children who have been in state custody are often unable to be self-sufficient upon leaving custody and have difficulty maintaining acceptable behavior. Most often they return to a relative placement of some sort, but these family environments may be the very ones from which they were originally removed, possibly due to abuse or neglect. For this reason in particular, youth aging out of custody need programs that address family/support system issues as well as independent living skills.

Transitional living services engage key family members and non-relatives who provide social support to young adults. Counselors who provide transitional living services ensure that the family and friends of the young adults are closely connected to the young adults so that they can assist them in maintaining independence long-term. Transitional living services are initially provided to young adults on a weekly basis in the communities in which they live. Interventions focus on the individual and all the systems that affect the individual (e.g. community, peer group, family, and school/work).

Transitional living counselors are responsible for teaching skills and lessons associated with the focal areas, and they ensure that youth are capable of accessing community resources such as medical attention and financial support, if necessary. Counselors are available to their clients 24 hours a day, 7 days a week. They also make a minimum of

one face-to-face contact per week with the individuals. The number of sessions can be increased based upon the individual needs of each client.
Particular emphasis is placed on occupational goals and skills as it is essential that young adults learn the skills necessary to obtain employment and support themselves financially. Many of the young adults who need transitional living services have histories of drug and alcohol abuse, behavioral and emotional problems, and other factors affecting their ability to live independently. Transitional living program staff can address these mental health problems through counseling either by directly providing individual and family therapy or by referring the young adults to local mental health centers for individual treatment and medication management. Transitional living services can effectively address mental health problems that can be resolved quickly and are directly pertaining to lack of success at work or in the community. If the problems are more severe and long-term in nature, a referral to an outpatient therapist would be more appropriate.

Transitional living services offer clients many opportunities to practice the new skills that they acquire. Because services are delivered in the young adults' natural environments, many of the sessions produce hands-on experiences to test their skill level with tasks such as grocery shopping, paying bills, interviewing for jobs and developing a resume. This practical experience is necessary to ensure that clients are actually able to apply their knowledge in a real-world setting.

These young adults need strong support systems in their communities to help them maintain success long-term. Since systems include the families/caregivers with whom these clients live, emphasis is placed on how these support people can help the clients generalize what they learn across all areas of their lives (e.g. socially, financially, and vocationally).

Intensive In-Home Services

The following are the core components of intensive in-home services:

- Low caseloads - Family counselors maintain caseloads of about four to six families, allowing counselors to see families at least three times a week and daily as needed - and be on-call 24/7
- Length of treatment - Treatment usually lasts from four to six months after a child returns home
- Single family therapist accountable for delivering the majority of services to the youth and family
- Training and supervision - Highly structured training and supervision for counselors
- Accountability - Counselors and clinical supervisors should be held accountable for daily and weekly changes on each case
- Empowerment - The overriding goal is to help families resolve future problems independently

Essential components of a therapist's treatment strategy generally include:

- Conducting individual and family therapy
- Teaching parenting skills - including consistency, discipline, communication, and coping strategies
- Facilitating educational achievement - including the role of the family in building positive student/school and parent/teacher relationships
- Facilitating the development of positive peers and monitoring by parents
- Offering special strategies concentrating on issues of sexual problem behaviors and substance abuse
- Teaching age-appropriate personal habits and social skills
- Helping the family access community resources for the entire family and develop a social support network in their natural environment (extended family, neighborhood, church, school, etc.). Counselors often assist family members with access to psychiatric services and ongoing medication management

Family needs generally include skill building in at least some of the following areas:

- communication
- limit-setting
- affective relations
- monitoring of the child's peers
- interactions with the school
- marital relations
- problem-solving skills
- support from extended family and community
- concrete needs such as housing, employment, and health care

Other components include:

- 24-hour Crisis Intervention
- Goal Development- Services provide both parents and children with skills necessary to set goals and to problem solve difficult situations (e.g. dealing with negative peers, getting along with teachers, etc…), including support with educational and employment/career goals.
- Services for Unruly and Delinquent Behavior - Services include parent training, assistance with schools, and access to mentoring, tutoring, community service, sports and other activities.
- Curfew Monitoring by Parents - Families are taught to develop strict monitoring and supervision plans for their children. However, since they often lack the skills to follow through with these plans initially, counselors will provide support to families and will focus on teaching families how to more effectively manage their children's problem behaviors.
- Alcohol and Drug Abuse - Youth may be requested to take random drug/alcohol screens when substance abuse is a primary referral behavior. Treatment will focus on structure in the home, positive pro-social activities, family support, identifying triggers to substance abuse, close supervision of the youth, and success in school. When parents have substance abuse problems, counselors focus both on helping the parent address the problem while also seeking additional support and possible placement options for the youth with extended family members.
- Community Mentors/Volunteers - Families will be primarily responsible for modeling positive behavior for their children, but identifying support people within the family's natural environment can provide other positive influences on a child. Teachers, counselors, and community leaders such as church ministers are examples of positive role models who can mentor a child.
- Educational Services - Counselors help families access tutoring programs, and parents will learn to advocate for their children's educational needs in the school system. Services also focus on family attitudes toward school attendance and completion in order to reduce truancy and drop-out rates.
- Transportation - Transportation needs of families and youth are assessed, and counselors can provide youth and families with necessary transportation. Families are educated to access transportation for themselves to promote long-term success.

Comprehensive Treatment Approach

Few service approaches have demonstrated effectiveness in clinical research with seriously troubled youth. One reason is that many models address problems in a fragmented fashion, thus missing many of the factors that drive the youth's problems. Also, individual treatment may be totally ineffective if the youth's problems include deviant peers, school problems and family conflict. Effective, intensive in-home services should address all the youth's and family's needs in one cohesive strategy, with the in-home counselor directly accountable for intervention success on a daily and weekly basis.

Therapist as Primary Provider of Services with Direct Accountability for Outcomes

Many non-residential service providers are case managers who focus on linking youth and families to services. No clinical research supports this model. Generally, the

services accessed by the family do not address the core of the problems within the home. Also, these multiple services are not held accountable for outcomes or coordinated in a cohesive way to achieve change in the home and community. Moreover, families with multiple workers in and out of their homes tend to avoid such services to reduce the disruption in their homes.

Training and Structure

The following training and supervision components are found in evidence-based models:

- Five-day program model training and comprehensive treatment manual
- Quarterly 1.5-day booster trainings
- Weekly clinical consultation on each case
- Weekly individual supervision and professional development by the supervisor, including reviews of taped family sessions
- Weekly team supervision and training
- Feedback from model-adherence surveys completed on each counselor
- Weekly or biweekly field supervision (in-home) by the supervisor

Concrete Support Services and Case Management

Counselors not only provide family therapy but also work intensively in the home, school, and community to help the family achieve lasting change. Counselors may help the family with housing, employment, healthcare, and other needs if these needs are identified as a driving factor contributing to the parents' lack of structure in the home. Counselors serve as both therapist and case manager to maximize the effectiveness of treatment interventions.

Preserving the Family Unit and Enhancing Family Strengths

Intensive in-home services programs should do whatever it takes to keep families together. That should be the credo upon which all in-home therapists base their efforts. Utilizing family strengths as leverage for change should be one of the principles of the in-home services model. Family can be defined not only as the biological family but also relatives, friends, neighbors, or any person taking a vested interest as a permanent placement for the child. The in-home provider's assessments, engagement processes, and treatment plans should be based largely on family strengths. The program, if nothing else, is about preserving the family unit. Helping children return home and remain with their families successfully is the essence of the treatment model. Counselors should devote large amounts of time each week to not only providing family therapy and supporting the child's immediate family but also to locating relatives, friends, neighbors and others who might serve as support for the parents or even step up as an alternate placement if the child's birth family placement is not successful. In many cases, a birth family may be successfully caring for the child but needs occasional respite and support from friends and relatives. Counselors should develop plans from the outset of each case to ensure back-up plans are in place to support the family in any way possible.

Utilizing Community Resources

A major focus of in-home therapists should be empowering families to resolve problems independently, even after the counselor is no longer involved with the family. Counselors spend large amounts of time helping families:

- Find support from relatives, friends, neighbors, church, and school
- Locate employment, housing and other basic needs
- Access healthcare and mental health services

The most frequent form of ongoing support outside a family's natural environment is medication management. Both children and parents are often involved with the mental health system and require consistent medication management and assistance. Counselors should focus intensively on ensuring that families have learned to continue accessing these resources.

The Re-education of Emotionally Disturbed Children (Re-ED) Philosophy

The Re-ED model emphasizes the child as a developing person who must learn new and improved ways of living and relating to others in the world. Re-Ed is a practical tool for those who want to help and do a good job at helping children. The ideal characteristics of an individual who can bring the Re-ED model to life are competency and enthusiasm along with a life history of interest in children (shown by volunteer and professional work). Ideal Re-ED-focused employees are able to sustain their commitment to "do good" in the face of serious challenges and difficulties.

Re-ED focuses on the need for children to live in an environment that they are proud of. It is important that children feel a sense of ownership for their environment. Individual living areas should reflect the unique qualities of the people living there. Children should learn to take pride in their surroundings, greet visitors, and take them on a tour through their home. The environment should not only be well kept and structured but also fun and exciting. Taking an active interest in their surroundings promotes pride, which encourages children to care for their environment.

Groups should function as a democracy. It is important to teach children to face the consequences of their own actions. The program should teach young people to set up their own rules and to hold each other accountable. In a democracy, there are checks and balances. In Re-ED, huddles and evaluation meetings are designed to be the checks and balances. Everyone in the group is valuable and should give input in all situations.

Within the Re-ED philosophy, the child and family are seen as partners with professionals in working to find solutions that will create more successful interactions for the child. Working with the child's family is a desirable, and even necessary, component of treatment using this model.

The 12 principles of Re-ED

1. **Life is to be lived now, not in the past** and lived in the future only as a present challenge.
2. **Trust between child and adult is the foundation on which all other principles rest,** the glue that holds teaching and learning together, the beginning point for re-education.
3. **Competence makes a difference**; children and adolescents should be helped to be good at something, especially at schoolwork.
4. **Time is an ally,** working on the side of growth in a period of development when life has a tremendous forward thrust.
5. **Self-control can be taught,** and children and adolescents help to manage their behaviors without the development of psychodynamic insight; symptoms can and should be controlled by direct address, not necessarily by an uncovering therapy.
6. The cognitive competence of children and adolescents can be considerably enhanced; they can be taught generic skills in the management of their lives as well as strategies for coping with the complex array of demands placed on them by family, school, community, or job; in other words, **intelligence can be taught.**

7. **Feelings should be nurtured**, controlled when necessary, expressed when too long repressed, and explored with trusted others.
8. **The group is very important to young people**; it can be a major source of instruction in growing up.
9. **Ceremony and ritual give order, stability and confidence** to troubled children and adolescents whose lives are often in considerable disarray.
10. **The body is the armature of the self**, the physical self around which the psychological self is constructed.
11. **Communities are important for children and youth**, but the uses and benefits of the community must be experienced to be learned.
12. In growing up, a **child should know some joy in each day** and look forward to some joyous event in the morrow.

Population Served in Level I through Level IV Continuums

Source: DCS Provider Manual, 2005 (see Reference List)

Level I

Foster Care is a program for children, youth, and their families whose special needs can be met through services delivered primarily by fosters parent trained, supervised, and supported by agency staff with the goal of permanency based on the best interest of the child.

1.0 POPULATION SERVED

1.1 Children accepted for the service are determined to be unable to receive the parental care they need in their own homes. They are potentially capable of accepting family attachments; and able to participate in family and community life without danger to themselves or other.

1.2 Children in this level of care are not actively suicidal, homicidal, have not had violent acts of aggression within the past year, nor are children with extreme behavioral, physical, or emotional problems.

Level II

Continuum of Care is a service model with a focus on achieving the outcome of successful permanency for children in a family setting. Continuums have flexibility to design services, in coordination with a Child and Family Team, which are individualized for children and families and the ability to customize the delivery of services to each child and family in the least restrictive manner. A Level II Continuum is an array of services for children with moderate mental health and behavioral issues and their families, which includes residential services, foster homes with wraparound services, in-home services, and support and services to the child's family. The goal of all continuum services is timely permanency and well being for the children served.

1.0 POPULATION SERVED

1.1 Children eligible for this level program have been identified by a mental health professional as having at least moderate emotional and/or behavioral problems and be in need of treatment.

1.2 Children may also have the following behavioral characteristics and/or treatment needs:

- Substance abuse treatment needs that require intervention and targeted services but do not indicate a need for acute services or detoxification
- Children may be adjudicated delinquent, unruly, or dependent/neglect and there may be specific court imposed expectations for program intervention
- Children may have a history of chronic runaway, manipulative behaviors, have difficulty maintaining self-control, display poor self-esteem, have difficulty in securing and maintaining close relationships with others, be habitually truant from school, have difficulty in accepting authority, and may have delinquent charges or court involvement history. Some children may be in need of psychotropic medication and follow up. At this level, children typically have need of behavioral, and treatment intervention to be able to function in school, home, or the community because of multiple problems. Children requiring Level II have a need for constant adult supervision, behavioral intervention and counseling.
- Children may have treatment needs due to sexual, physical, and or emotional abuse or neglect that require outpatient therapy and coordination of interventions and services. This supercedes the problem solving approach of the individual or group counseling components that is needed by every child with it rises to the level of specialized therapy. Such therapy is provided by a licensed independent practitioner and coordinated through the provider.

Level III

Continuum of Care is a service model with a focus on achieving the outcome of successful permanency for children in a family setting. Continuums have flexibility to design services, in coordination with a Child and Family Team, which are individualized for children and families and the ability to customize the delivery of services to each child and family in the least restrictive manner. A Level III Continuum is an array of services for children with moderate mental health and behavioral issues and their families, which includes residential services, foster homes with wraparound services, in-home services, and support and services to the child's family. The goal of all continuum services is timely permanency and well being for the children served.

Accessing MCO and BHO services

With some limited exceptions, Children in DCS care are eligible for TennCare. While in custody, and for six months after leaving custody, the MCO assignment for TennCare eligible children is TennCare Select. The MCO provides all medically necessary medical services. The Level III provider should coordinate with the MCO for these services. The BHO provides behavioral services on an outpatient basis. Because DCS residential providers are providing residential behavioral services, coordination of outpatient services is required.

The Level III residential or continuum provider may coordinate with the BHO for the provision of the following services for TennCare eligible children. These services are not included as a component of the DCS Level III residential or continuum services.

d. Psychiatric services:
   Outpatient Psychiatric office visits for medication evaluation and medication management.

e. Psychological testing
   Outpatient psychological assessments for testing and psychological testing.

f. Specialized Therapeutic Treatment
   If a child is classified as having level three needs because of a special treatment need such as Alcohol and Drug Addiction or Sexual Offending history, and is referred to a program that specializes in such treatment, the provider is bound to provide those services as part of their scope of care. The Child Placement and Private Provider Division of DCS maintains a current listing of such programs. Other specialized outpatient therapy, including sex offender treatment and alcohol and drug treatment, and may include other individualized specialty services when such therapy is not a specialized component of the Level III residential or continuum provider, may be sought by the provider through the BHO.

Level III (continued)

1.0 POPULATION SERVED

1.1 Children eligible for this level program have been identified by a mental health professional as having serious emotional and/or behavioral problems and be in need of treatment.

1.2 Children may also have the following behavioral characteristics and/or treatment needs:

- Children have mental and behavioral health issues that require 24-hour intervention and supervision.
- Children have been identified as having moderate to severe mental health treatment needs.
- There is evidence of an impairment of functioning in the following settings: family, school, and community. Children in this population may have significant disturbances in environmental relationships such as severe disruptions of relationships within the family or with significant others and persistent maladjustment of peer and other social relationships or other influencing systems that interfere with learning and social development.
- Children may have serious disturbance of affect behavior or thinking -- the potential for danger to self or others. There may be the evidence of serious developmental disturbances such as a failure to achieve or behavioral patterns with destructive psychological physical or social consequences.
- The need for a staff secure setting where continuous supervision is provided.
- The need for a therapeutic milieu to provide re-education, re-socialization, and/or psychotherapy.
- Children may be of any adjudication type.
- Children appropriate for this level of care may have medical or psychiatric disorders that require constant adult supervision such as an eating disorder, disordered thought process, brittle unstable diabetes, suicidal ideations, sexual impulse disorders or impulsive acts of aggression. Not all programs will be designed to meet all aspects of specialized care regarding these issues. The DCS provider will be responsible for the adult supervision and coordination of services, however MCO, BHO, and flex funding may be a component of the overall care plan.
- Children in need of this level of care may have substance abuse treatment needs but are not in need of medical detoxification. Specialized alcohol and drug treatment may be identified as a service that the provider may access on an outpatient basis through the BHO when such specialized therapeutic service is not a component of the Level III program.
- Children in this service type may need evaluation and assessment for medication and medication management.
- Children may pose high risk for elopement, instability in behavior and mental health status, or acute episodes.
- Children with primary diagnosis of mental retardation are evaluated on a case-by-case basis. Children with an IQ lower than 55, or who have adaptive functioning indicating moderate to severe mental retardation are not appropriate unless the agency is licensed for this service type.
- Children appropriate for this level of care are not acutely suicidal, homicidal or have psychosis not controlled with medication. They do not have major acts of violence or aggression such as rape, arson, assault with a deadly weapon, murder or attempted murder within the past six (6) months.

Level IV

Level IV programs provide non-acute psychiatric hospitalization, which is a physician-directed level of care focused on those clinical issues that cannot be addressed in a less restrictive setting and/or that must be addressed/resolved in order for the child to move to a less restrictive setting. All admissions to Level IV programs meet the criteria for voluntary admission subject to the availability of suitable accommodations as defined by the hospital. The child's treatment team under the leadership of the physician makes decisions regarding which clinical issues are addressed on the plan of care, the sequence in which they are addressed and discharge recommendation. The use of isolation or restraint in Level IV programs shall be directed by a physician and must be in compliance with applicable statutory, Department of Children's Services, licensure, and JCAHO requirements.

1.0 POPULATION SERVED

1.1 Children eligible for this level program have been identified by a mental health professional as having serious emotional and/or behavioral problems and be in need of treatment.

1.2 Level IV programs operated under terms of this agreement shall be designed to serve children in the custody of the Department of Children's Services (DCS) who do not meet criteria for acute psychiatric hospitalization, but who continue to require specialized mental health services which are highly structured, therapeutically intensive, and provided within a hospital environment.

Appendix V
Additional Resources on Evidence-Based Practices

The American College of Mental Health Administration. (2003). *Turning Knowledge into Practice : A Manual for Behavioral Health Administrators and Practitioners About Understanding and Implementing Evidence-Based Practices*. Boston: The Technical Assistance Collaborative, Inc. Retrieved January 20, 2005, from http://www.acmha.org/publications/EBPManual.pdf

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Appendix VI
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