[IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
CORPUS CHRISTI DIVISION

M.D., b/n/f Sarah R. Stukenberg, et al.,	§	
	§	
Plaintiffs,	§	
v.	§	
	§	Civil Action No. 2:11-CV-00084
GREG ABBOTT, in his official capacity as	§	
Governor of the State of Texas, et al.,	§	
	§	
Defendants.	§	

The Court Monitors' Update Regarding Safety of Settings Housing Children Without Placement and Site Visits

The Monitors filed a report with the Court documenting serious safety concerns related to settings housing Children Without Placement (CWOP Settings) on September 13, 2021 (September 2021 Update).[1] The Court held a hearing on September 14, 2021, on the concerns raised in the Monitors' reports, and considered a response filed by the Department of Family and Protective Services (DFPS) on September 13, 2021. In its response, DFPS pointed to a "capacity infusion" via "extensive and ongoing outreach efforts and partnerships with both in-and-out-of-state providers" to address the shortage of licensed placements for children.[2] DFPS also pointed to an increase in the number of "Temporary Emergency Placement" (TEP) beds with licensed operators as part of its capacity infusion.[3]

This report updates information related to the safety of CWOP Settings by analyzing Serious Incident Reports for children in CWOP Settings for July 2021 through September 2021. It also summarizes visits made by the monitoring team to three CWOP Settings that DFPS leases from private entities, a type of setting the Monitors had not previously visited.[4] This report also examines the impact of DFPS's "capacity infusion" on the placement crisis and includes a summary of the monitoring team's site visits for two types of settings (two TEP programs, and two out-of-state facilities), which DFPS now uses more frequently for children in response to the lack of safe, licensed placements in Texas. Finally, the report provides a brief update regarding the children profiled in the Monitors' September 2021 Update, examining children's placements

[1] Deborah Fowler & Kevin Ryan, The Court Monitors' Update to the Court Regarding Children Without a Placement Housed in CPS Offices, Hotels, and Other Unlicensed Settings, September 13, 2021, ECF 1132.
[2] DFPS, Children Without Placement, September 2021, September 13, 2021, ECF 1130.
[3] *Id*. at 21.
[4] The visits made by the monitoring team to CWOP Settings in the Summer of 2021 included sites DFPS obtained via an MOU with a community partner or leased from a licensed entity but did not include a CWOP Setting DFPS obtained via a residential lease with a private entity.

after leaving the prior CWOP Settings where they resided when the monitoring team visited in the summer of 2021.[5]

I. Updated Information Regarding Safety of CWOP Settings

The Monitors' September 2021 Update identified significant safety problems across all CWOP Setting types. Concerns included: the impact on workloads for caseworkers providing supervision in CWOP Settings; the lack of appropriate training for DFPS staff providing supervision; and the lack of information DFPS staff received regarding the youth they were supervising.[6] The Monitors found that the combination of the dearth of appropriate residential facilities and lack of appropriately trained staff presented significant safety problems for children housed in CWOP Settings.[7] To update the Court regarding children's safety in CWOP Settings, the Monitors reviewed and analyzed data from Serious Incident Reports for July 2021 through September 2021, and visited three CWOP Settings that DFPS had leased from private entities.

A. Analysis of Serious Incident Reports for July – September 2021

Between July and September 2021, 161 children were identified among 290 Serious Incident Reports (SIRs) related to CWOP Settings. Sixty-one percent of children (98 of 161) were involved in one serious incident during the period, while 39 percent (63 of 161) were involved in two or more serious incidents. The highest number of serious incidents reported for a single child between July and September 2021 was eight. Three children were involved in eight SIRs reported during the period.[8]

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[5] The monitoring team visited 25 CWOP Settings between June 22, 2021, and July 22, 2021.

[6] Deborah Fowler & Kevin Ryan, *supra* note 1, at 65-88.

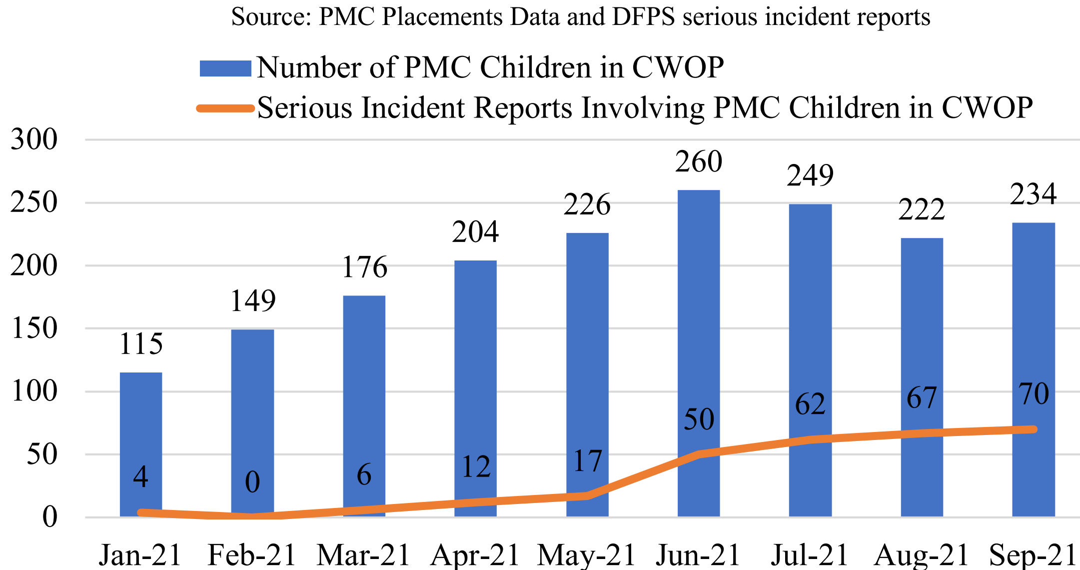
[7] *Id*. at 88-108.

[8] The three children with eight SIRs are: G, a 14-year-old PMC youth who first entered foster care in 2010 and has since had 42 placements, including one in an RTC (Children's Hope) that has had its licensed revoked, two in an RTC (Carter's Kids) that closed but reopened under a different name and was subsequently placed under Heightened Monitoring, and another in a GRO (Hands of Healing) also placed under Heightened Monitoring. G's placements include at least ten psychiatric hospitalizations, and four periods without placement in 2021. G is currently placed in an RTC in Tennessee. G has significant mental and behavioral health needs and is prescribed a list of four psychotropic medications. M, a 16-year-old PMC youth who first entered foster care in 2006 and has had 49 placements. M's fifth placement was in an adoptive home where she stayed for just over seven years before the adoption disrupted in 2016; her subsequent 44 placements were made after she re-entered care in 2016. After reentering care, M made an outcry alleging her older adoptive brother and his friend sexually abused her between the ages and seven and eight years old, which has since been substantiated. M's placements include 15 psychiatric hospitalizations, and 13 periods without placement. During three of her periods without placement, she was housed at Family Tapestry/Whataburger. She was placed in one emergency shelter (The Bridge) that was subsequently placed under Heightened Monitoring. She had one TEP placement at Promise House but was discharged after assaulting a staff member and being taken to juvenile detention, where she spent one night before being discharged to a CWOP Setting. M's current placement is in an HCS group home. M has significant mental and behavioral health needs and is prescribed three psychotropic medications. D, the third child, is a 17-year-old PMC youth who re-entered foster care in 2018. Since re-entering care, D has had 38 placements, including at least six psychiatric hospitalizations, and eight periods without placement (all in 2021). D's placements include one RTC (Houston Serenity – Morrow St.) that closed after being placed under Heightened Monitoring, multiple placements in another RTC (Gulf Winds) that was subsequently placed under Heightened Monitoring, and multiple placements in Hector Garza RTC, which has closed due to safety problems. D's most recent placements include an RTC that has just been given notice of a license revocation, and a TEP placement at Adiee Emergency Shelter. D also spent one night in jail after he got into an altercation with another youth at a CWOP Setting and knocked a DFPS staff person to the ground when he was trying

As reporting of incidents improved for CWOP Settings, SIRs involving PMC children increased between March and July 2021, then remained steady between July and September 2021, even after a slight decrease in the number of PMC children placed in CWOP Settings since June 2021.

Figure 1: Number of PMC Children Active in CWOP Settings and Serious Incident Reports Involving PMC Children in CWOP by Month, January to September 2021

Source: PMC Placements Data and DFPS serious incident reports



Most SIRs involved children housed in a CPS office or unlicensed cottage or home, though DFPS began to move children out of CPS offices and into other unlicensed settings. As children were moved to other settings, the proportion of SIRs involving children housed in CPS offices decreased.

to get to the other youth. D is diagnosed as bipolar, and is prescribed medication to address this diagnosis, as well as two other psychotropic medications for anxiety and mood disorder. D is currently without placement. D will age out of care on May 3, 2022. D's most recent Common Application (which is still pending approval) indicates that he has completed Preparation for Adult Living (PAL) classes, but D "has expressed a desire to no longer be in foster care. He has stated that he plans on aging out of foster care. [D] does not have a set plan on what he wants to do once he ages out." The Monitors do not find an IMPACT contact note indicating that D had a Circles of Support meeting in 2021 to assist the youth in developing a plan for his transition out of care.

Figure 2: Number of Serious Incident Reports by Location Type, July to September 2021

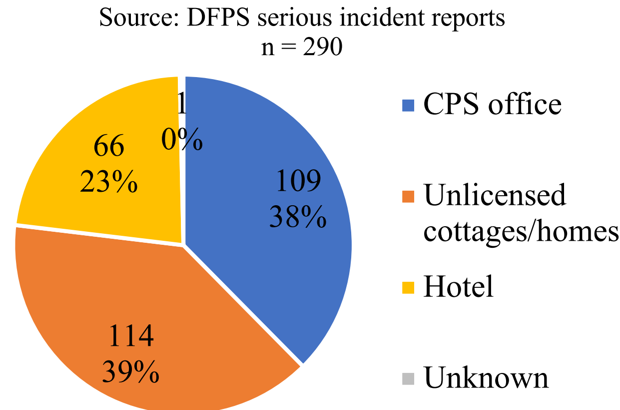
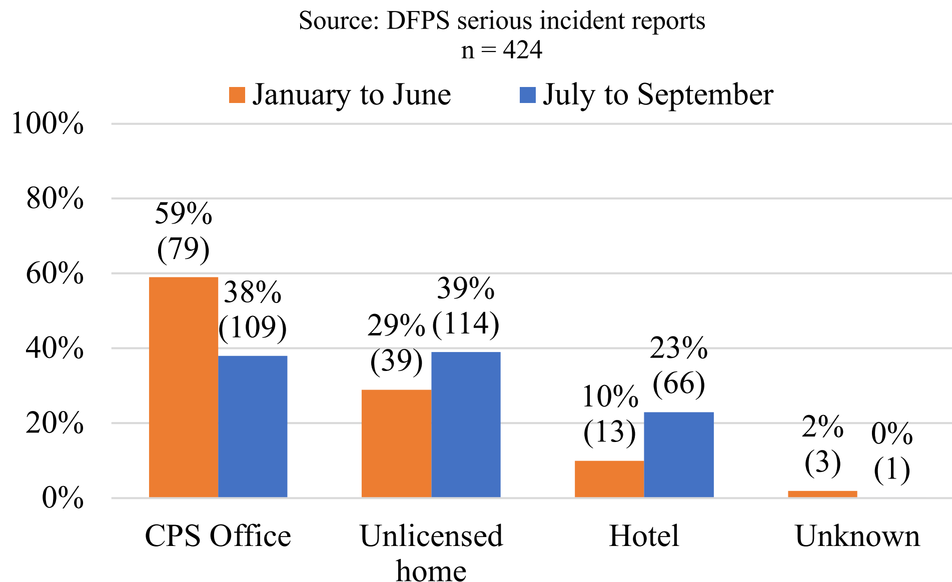


Figure 3: Number of Serious Incidents by Location Type, January to September 2021



Mental health episodes continued to be the most reported issue in an SIR, followed by physical aggression towards staff and children running away. However, 28% (21 of 74) of SIRs reporting physical aggression toward staff also involved a mental health episode.[9]

[9] One SIR clearly documents the role that a child's trauma history plays in aggressive behavior. A nine-year-old child had physically assaulted a staff member after the staff member told her she could not take a staff person's phone into the restroom with her. Later, the staff person asked the child what caused her to become so angry and hit her, and the child "got calm…She told me in that moment she just blackout; I continue to ask her why did she feel the need to put her hands on me and attack me, she said because I 'wouldn't let her talk' and I ask her what causes her to blackout…[M] told me about how long she had been in CPS, and how abusive her mother was toward her. I told her I was sorry she had to go through that at a early age, then she stop for a while said can I tell you something I said yes and [M] said 'she have never told this to anyone else before not even her caseworker, but she have been sexually

Table 1: Type of Issues Identified in Serious Incident Reports, July to September 2021

Types of Issues Involved in Incident	N	% of incidents with issue (n = 290)
Mental health episode	84	29%
Physical aggression towards staff	74	26%
Runaway or left facility without permission	63	22%
Property destruction	61	21%
Disruptive behavior	59	20%
Self-harm or suicide attempt	53	18%
Threatened staff or verbally aggressive	52	18%
Threatened to self-harm or suicidal ideations	42	14%
Illness	23	8%
Fight (between children)	19	7%
Child-on-child physical aggression	18	6%
Possession of drugs or alcohol	9	3%
Issues with medication	6	2%
Inappropriate sexual behavior towards staff/adult	4	1%
Consensual child-on-child sexual activity	3	1%
Injury due to accident	2	1%
Nonconsensual child-on-child sexual activity	2	1%
Other	5	2%
Total Issues Identified	579	-
Total Number of Serious Incidents	290	-

SIRs continued to document the dangers associated with children running away from the CWOP Settings, including an SIR that detailed a child who returned to a CWOP Setting after having run away told DFPS staff upon her return that she had been raped. Shortly after this SIR,

abused by her mother boyfriend. She even went into a little bit of details of where it happened…I hug her and told her I understand and I'm sorry that happen to her…[M] told me she was sorry for attacking me, it was nothing I did but at that moment she blackout she thinks about her past which causes her to blackout and become physically abusive."

another SIR for this same child indicated she had engaged in a significant self-harming incident. Another SIR indicates that three girls ran from a CWOP Setting after meeting a 24-year-old male online and engaging in a sexually explicit video chat with him. SIRs also documented child-on-child sexual activity, but one SIR documented a new problem: a 15-year-old TMC child suspected of having a sexual relationship with a hotel clerk in the CWOP Setting where she was housed.[10]

The most common response to an incident reported via an SIR was the intervention of law enforcement. The second most common response was an Emergency Medical Services (EMS) call, followed by a child being transported to the hospital.

One of the SIRs reviewed by the monitoring team for this report showed the mismatch between the use of law enforcement as a response to a child's behavioral challenges in these settings, as well as the challenges that staff who are not trained in behavioral management experience in supervising children in CWOP Settings. The child involved was an eight-year-old PMC child:

> [Child] was asked to brush her teeth. She brushed her teeth then went to the couch and refused to get up and go to bed. Multiple staff asked her to go to bed. She grunted at staff and refused. Staff…tried to get her to stand up. Child would not stand up. [Staff person] carried her to the hallway and child attempted to spit on [staff person]. [Staff person] set child on the floor due to spitting and wiggling. Child started spitting on staff…Child then took her shirt off. Staff requested she put it back on. She would not put it back on and threw it at staff. Child continued spitting on staff. Child took pants off. Staff request child put pants back on. Child refused and threw pants at staff. Child continued spitting on staff. Child continued to sit in hallway with no clothing for several minutes. [Another child] was asleep in her room, the child's behavior disturbed her, and she went in the common area very upset. [Staff person] called On-Call Supervisor…who advised to keep line of sign on the child and ignore behavior. Staff all went to end of hall and kept line of sight. Child went into [other children's] room. [Staff] walked to the doorway of the room. Child began hitting her head on the wall. Staff asked child to stop, she did not. [Staff person] got a pillow to put behind her head. Child took the pillow and tried to throw it and began hitting elbows on the wall. Child hit head on the wall again. [Another child] was trying to go to sleep in the room next to this and was upset that the child was making the noise…Child then got into [another child's] bed, still with no clothes on and began spitting on everything and throwing [the other child's] things off [her] bed. Child did not listen…[Staff] called On-Call

[10] The SIR documents the child running from the hotel room where she was housed. Staff searched the hotel but could not find her and could not find the male hotel employee who was usually at the front desk. Later, after the child returned, she told a DFPS staff person that "she wanted to go get a plan B medication. When asked why she stated that she had sex with the hotel staff. She stated that she had sex with him in one of the hotel rooms. She stated that she did not want to leave because she did not want other teenagers placed here and he do [sic] the same thing to the other children…[A] was taken to Children's Hospital of San Antonio, where she was able to get a plan B, a SANE exam, and the police completed a report." The child's Sexual Victimization page in IMPACT now documents this report, though it does not appear as though any report was made to SWI about the incident. A police investigation involving the hotel clerk was opened. The child's IMPACT records indicate that DFPS suspects she is a trafficking victim, and that she has also made an outcry of sexual abuse by her grandfather. She was placed in an RTC on October 12, 2021.

> Supervisor again who stated to call 911 and have a staff sit with child at the ER. Child began biting herself on the arms and legs during this phone call. [Staff] called 911 and requested an ambulance to get assistance with the child's self-harm behavior…Law enforcement arrived, not an ambulance like requested. Law Enforcement observed naked child banging head on the wall and spitting at law enforcement. Child threw poker chips at law enforcement. Another officer showed up. Law enforcement asked child why she didn't want to go to bed. Child stated she wants her brother, law enforcement asked where he was. Child stated in hospital, CPS put him there. Child started crying. Law enforcement continued to speak to child about going to bed and asked to see her bedroom. Child took them to her room. Child put clothes on, and law enforcement read her a bedtime story and left.

Other SIRs reveal on-site police officers using force during interventions with children in CWOP Settings, which is deeply concerning for any child, and particularly so for children with histories of trauma. One SIR documents an on-site officer using pepper spray "multiple times" on two 13-year-old girls,[11] another SIR documents an on-site officer using a Taser on a child[12] to break up a fight between the child and another youth, and a third documents an on-site security officer slapping a child across the face[13] in response to the child's profanity.

B. Site Visits to Leased CWOP Settings

The Monitors' September 2021 Update detailed that in response to the growing number of children without placement who were being housed in CPS offices, the Texas legislature passed a bill during the 2021 regular legislative session that included language prohibiting housing children in offices.[14] In an effort to move children out of offices and into alternative settings, in addition to housing more children in hotels, DFPS entered into additional MOUs and leases for unlicensed

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[11] This SIR also shows the inability of the police officer to deescalate a child. The children did not want to return to the hotel room after being in the pool. One of the children was restrained by the officer when she would not get up from the floor to go up to the room. At that point, the other child walked up behind the officer and attempted to reach for the officer's weapon; he released the restraint on the other child and attempted to restrain the second child. The first child began hitting the officer with "large sticks" and the second child also began hitting the officer. The officer "pepper sprayed both of the girls multiple times." The SIR notes that the girls were taken to juvenile detention and that the officer "had his glasses broke[n] and some scratches from the sticks." The SIR does not note whether staff followed proper decontamination procedures after the officer pepper-sprayed the children.

[12] The SIR notes: "[M] and [I] got up like they were going to fight, they were beside [M's] bed. Staff attempted to redirect the youth but had to move out of their way to prevent worker from being caught between them. Officer…instructed Caseworker…and Admin…to remain in the sitting area as he attempted to get control of the situation in the bedroom area. Officer…stated that he was unsure who hit who first, but the situation quickly escalated. The officer instructed [the DFPS staff] to call 911 and he also asked dispatch for backup from…PD. [DFPS staff person] heard the officer tell the youth he had his taser and was going to use it, but both youths ignored him. [DFPS staff person] could hear the youth hitting each other and she went back into the bedroom area and [I] was on the ground with the officer beside him. Officer…had tased [I]. Officer…reported that he warned of the taser and neither boy complied."

[13] The SIR indicates, "The security guard was standing in front of [F] and told him that he cannot talk to people like that. [F] threw the plastic spoon and pint of ice cream towards the worker and started to yell at the worker and security…The security guard slapped [F] across the face."

[14] SB 1896, 87th Tex. Leg. Reg. Sess. (2021). The legislation took effect on June 14, 2021, the date it was signed by Governor Greg Abbott.

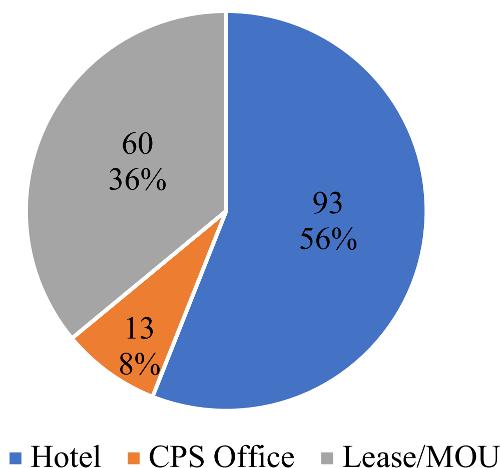
settings. In its September response, DFPS indicated that as of September 1, 2021, "DFPS had 20 active MOUs with a capacity to serve 98 youth across Texas, an increase of more than 200% from September 2020."[15] A table in the report also indicates new capacity in the form of residential leases, providing for 76 additional beds.[16] On October 28, 2021, DFPS provided the Monitors with an updated list of the entities with which DFPS either had a residential lease or an MOU for housing children without placement. At that time, DFPS reported:

- Four residential leases with private entities.
- Two residential leases with licensed entities.
- An MOU with a licensed entity for locations in five cities.
- Nine MOUs with unlicensed entities for locations in cities across the state.[17]

Despite DFPS' report of increased beds provided through residential leases and MOUs, most PMC children without placement between November 29, 2021, and December 26, 2021, were housed in hotels. An analysis of the type of CWOP Setting children were housed in during this time period shows that some PMC children remain housed in CPS offices, despite the legislative prohibition that became effective in June 2021.

Figure 4: Type of Setting for PMC Children in CWOP, November 29 to December 26, 2021[18]

Source: Weekly PMC CWOP Child Lists, November 29 - December 26, 2021
n=166



[15] DFPS, *supra* note 2, at footnote 28.
[16] *Id.*
[17] E-mail from Trevor Woodruff, Deputy Director, DFPS, to Deborah Fowler and Kevin Ryan, October 28, 2021 (on file with the Monitors).
[18] Children were counted once per episode and location. Children entering CWOP multiples times during the period and children changing locations during the period were counted once per first night date and location.

To update the Court on the new CWOP Settings, the monitoring team made site visits to three CWOP Settings that DFPS leases from private entities. The three leased settings visited included:

- "The Villas," a group of houses that DFPS leased in Von Ormy;
- two duplexes leased by DFPS in Houston; and
- a house ("Penelope House") leased by DFPS in Belton.[19]

During the visits, the monitoring team interviewed five children and 10 caregivers, and also reviewed records kept on-site for 14 children. Caregivers interviewed included nine DFPS staff and one person contracting with DFPS specifically for supervision in CWOP Settings.

The children's interview responses were consistent with interviews conducted by the monitoring team during the first set of visits to CWOP Settings in the summer of 2021, discussed in the Monitors' September 2021 Update. Problems identified by the children interviewed included:

- **Problems with medication**: All the children interviewed took prescription medications, however only one child reported receiving the medication every day as prescribed. One child reported being without a psychotropic medication after running out of the medication, and another child reported that they did not receive medication for three days after arriving at the CWOP Setting. A third child reported that she had been taking prescription medications for mood, anxiety, ADHD and sleep prior to arriving at the CWOP Setting, but had not been able to get in touch with her caseworker to schedule an appointment with a psychiatrist to get her prescriptions updated.[20]

- **Frequent runaways**: At the time of the monitoring team visit, one of the children interviewed reported that four children had run away from The Villas the day before, and only one child had returned. Caregivers at the CWOP Setting confirmed children frequently run away or attempt to run away. SIRs indicate that in some instances, the children appeared to have called someone to pick them up, since they got into a car with someone when they left.

- **Enrolling in school**: Four of the five children interviewed reported they were not attending school. Of these four children, three indicated that they had not been enrolled in school since arriving at the CWOP Setting. One child expressed considerable frustration at the delay in enrolling her in school and noted that she had attempted to reach her caseworker, but her caseworker did not respond to her calls. Failure to enroll children in school also contributes to safety problems associated with CWOP Settings: as discussed in the

[19] DFPS indicated to the Monitors that the owners of Penelope House are seeking a license, but that the licensing process had not yet been initiated. As of January 3, 2022, a search of the CLASS database did not reveal an entry for Penelope House.

[20] SIRs include examples of problems with medication. One SIR for a child without placement housed at Glen Eden, the unlicensed setting used by OCOK, shows that the child may not have been given Loratadine for as prescribed. The SIR notes the prescription was "[f]illed 09/03/2021 and 09/06/2021 there are 29 pills out of the original 30 pills filled so the medication has not been given for at least 3 days."

Monitors' September 2021 Update,[21] a lack of structure and routine, particularly when combined with unmet treatment needs and staff who are not appropriately trained, can contribute to a chaotic setting.

As was true of the children interviewed for the September 2021 Update, almost all children interviewed in the CWOP Settings reported feeling safe when the monitoring team visited; only one of the five children interviewed reported feeling unsafe.

Interviews with caregivers, however, revealed some progress in addressing problems reported by the Monitors in the September 2021 Update, particularly related to training:

- All 10 caregivers interviewed reported having received the basic online training required for those supervising CWOP Settings.

- Eight of the 10 caregivers interviewed (80%) reported having had training related to administration of medication, four (40%) reported having been trained in management of children's medication, and five (50%) reported having been trained in both medication administration and management.

- Four of the 10 caregivers interviewed (40%) also reported having received training in both behavior management and de-escalation techniques, though these techniques were not provided as part of the training caregivers received specific to supervision of CWOP Settings.

Despite these improvements, one of the staff members who reported no training in medication administration or management expressed frustration that she had nonetheless been asked to administer medication. She indicated she declined to do so. In addition, the monitoring team documented many of the same problems with the information included in (or missing from) children's medication logs that were previously documented in the Monitors' September 2021 Update.

Of the 14 children whose on-site records were reviewed, eight children's records included medication logs. Of these, the monitoring team found that none indicated the child "always" received their medication as prescribed: five of the eight "sometimes" received their medication as prescribed, two did not receive their medication as prescribed, and one child's file was missing medication logs from the first part of their stay at the CWOP Setting.

Staff consistently documented the date and time that children's medication was given for most of the eight children whose records contained medication logs, but the medication count and person administering medication was less consistently documented.

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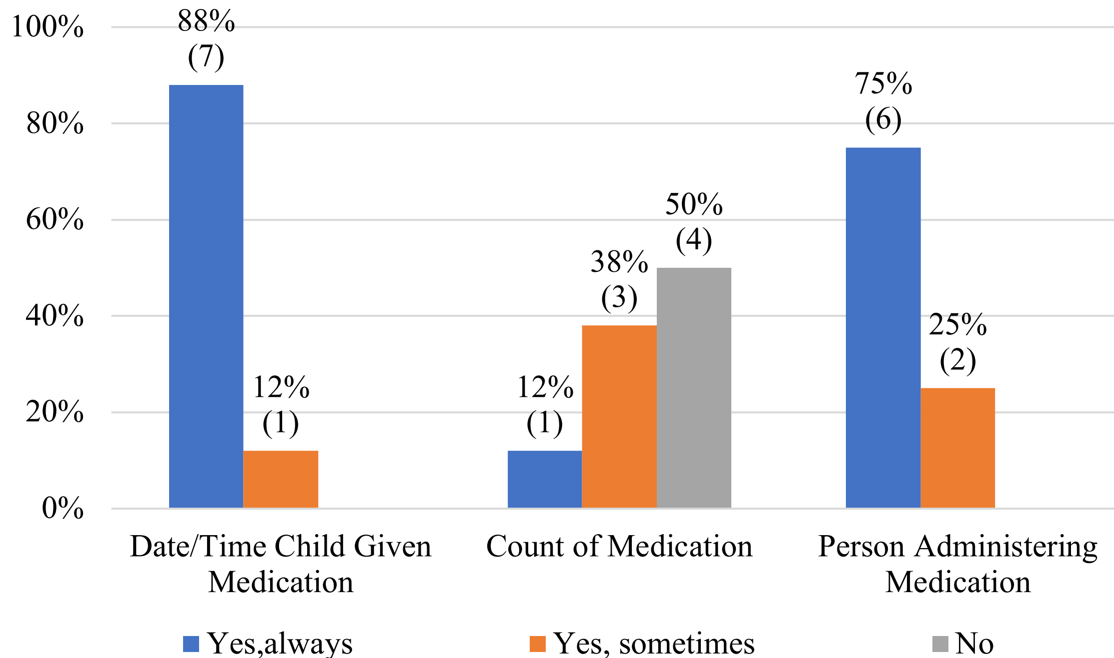
[21] Deborah Fowler & Kevin Ryan, *supra* note 1, at 89-92.

Figure 5: Information Included in Medication Logs for Children in CWOP



Caregivers also continued to report problems with safety. Four of the 10 caregivers interviewed (40%) reported that they did not feel safe when supervising CWOP Settings, a slightly lower percentage (42%) than reported in the Monitors' September 2021 Update.[22] Three of those caregivers provided supervision at CWOP Settings that provided on-site security. One caregiver reported that she was so concerned about her safety, particularly given her pregnancy, that she had recently resigned her position with DFPS. Four staff reported that there had been a serious incident at the CWOP Setting they supervised during one of their shifts; three of these staff provided supervision at sites that always had security present. Staff again reported that police or security were often asked to intervene with youth who became dysregulated: six (60%) said that law enforcement had been called to intervene with youth, and four reported on-site security had been asked to intervene.

Eight of ten (80%) caregivers interviewed reported that they were always informed when a child was a victim of sexual abuse or had an indicator for sexual aggression,[23] however, only half (5 of 10) indicated that they were always told when a child had a history of physical aggression.

[22] Deborah Fowler & Kevin Ryan, *supra* note 1, at 71.
[23] However, one of the caregivers who reported they were "always" told later indicated that they did not know whether any of the children they were currently supervising were victims of sexual abuse or had an indicator for sexual aggression. In addition, the monitoring team reviewed records kept on-site for 14 children and found that the Attachment A was missing from the records for one of the children.

Only four of the ten staff interviewed (40%) said that they were always told when a child had high mental health needs.

While six caregivers reported that at least one child under their supervision in the CWOP Setting was a victim of sexual abuse and two caregivers reported supervising a child with an indicator for sexual aggression, half (5 of 10) indicated that they were not given any instruction in how to supervise a child who was a sexual abuse victim or who had an indicator for sexual aggression. This is concerning, since 80% of the caregivers interviewed (8 of 10) indicated that there were times during their shifts at the CWOP Setting when children were not in the direct line of sight of the worker. Even fewer caregivers (4 of 10, or 40%) reported having received instruction related to supervising children with high mental health needs.

Frustrations expressed by the caregivers included:

- Lack of training in restraints, and lack of appropriate training in de-escalation and behavioral interventions;
- Feeling overworked;[24]
- Difficulty of implementing consistent routines and structure in the CWOP Setting due to the inconsistency in caregivers;
- Inability to provide appropriate interventions in CWOP Settings for children with high mental health needs. Staff also reported challenges associated with keeping children with autism and non-verbal children safe in CWOP Settings.

i. The Villas

In October 2021, the monitoring team visited The Villas, a group of four houses[25] in Von Ormy, Texas, that DFPS has leased from a private entity. Von Ormy is in a rural area southwest of San Antonio. The Villas are located on a street that ends in a cul-de-sac off Highway 16, in an area with few neighboring houses or businesses. The monitoring team had a great deal of difficulty finding The Villas, because the address provided by DFPS was inaccurate.[26]

Perhaps the most striking feature of The Villas is their proximity to an abandoned housing development. Though the houses that DFPS has leased appear to be new construction and in good

[24] Eight of the nine DFPS staff interviewed indicated that they were expected to supervise CWOP Settings in addition to their regular job requirements. Staff that worked shifts in addition to their regular job were required to work between two and eight shifts in a CWOP Setting per month (half (5) were required to work eight shifts per month). Seven staff reported that shifts were four hours long and three reported eight-hour shifts. One supervisor was interviewed and indicated that in addition to her required eight shifts, she was required to be on-call once a month.

[25] The day of the visit, DFPS staff providing supervision at the site indicated that while DFPS leased four houses, only three were occupied because a child had broken a window in the fourth house, rendering it uninhabitable for safety reasons.

[26] This may be because the houses have never been sold by the developer and may not have addresses that have been registered with the postal or emergency services. Searching MapQuest and Google Maps for the address subsequently provided by DFPS on the street off Highway 16 where the houses are located does not identify the address. An SIR reviewed by the monitoring team shows that on at least one occasion in September 2021, Emergency Medical Services (EMS) had difficulty locating the houses. A DFPS Staff person called EMS when a child housed at The Villas began to vomit uncontrollably, but "Dispatch could not find [the location]" and EMS "circled the highway until [the] caseworker met them up the road."

condition, just across the street from the houses where foster children are living is a neighborhood that is completely abandoned. While the houses immediately adjacent to those leased by DFPS appear to be in good repair, few of them appeared to be inhabited aside from those leased by DFPS.

The abandoned neighborhood across the street is blighted. The houses' windows are broken, garage doors are caved in, doors are missing from the houses, and the insides and outsides of houses are covered with graffiti. The houses are surrounded by tall, unattended grass. This abandoned neighborhood is easily accessible from The Villas, and the dangerous condition of the houses poses a significant safety risk to children. In addition to a history of running away, many of the children placed at The Villas have histories of self-harm and suicidal ideation; a neighborhood of abandoned houses, that are unsecured and contain broken glass and other objects that could be used to self-harm, pose a risk.[27] The monitoring team easily walked across the grass to the abandoned neighborhood to view its condition and took a number of photographs, some of which are included below. The first two were taken while standing in the driveway to the houses leased by DFPS and show the proximity of the abandoned neighborhood to the CWOP Setting.

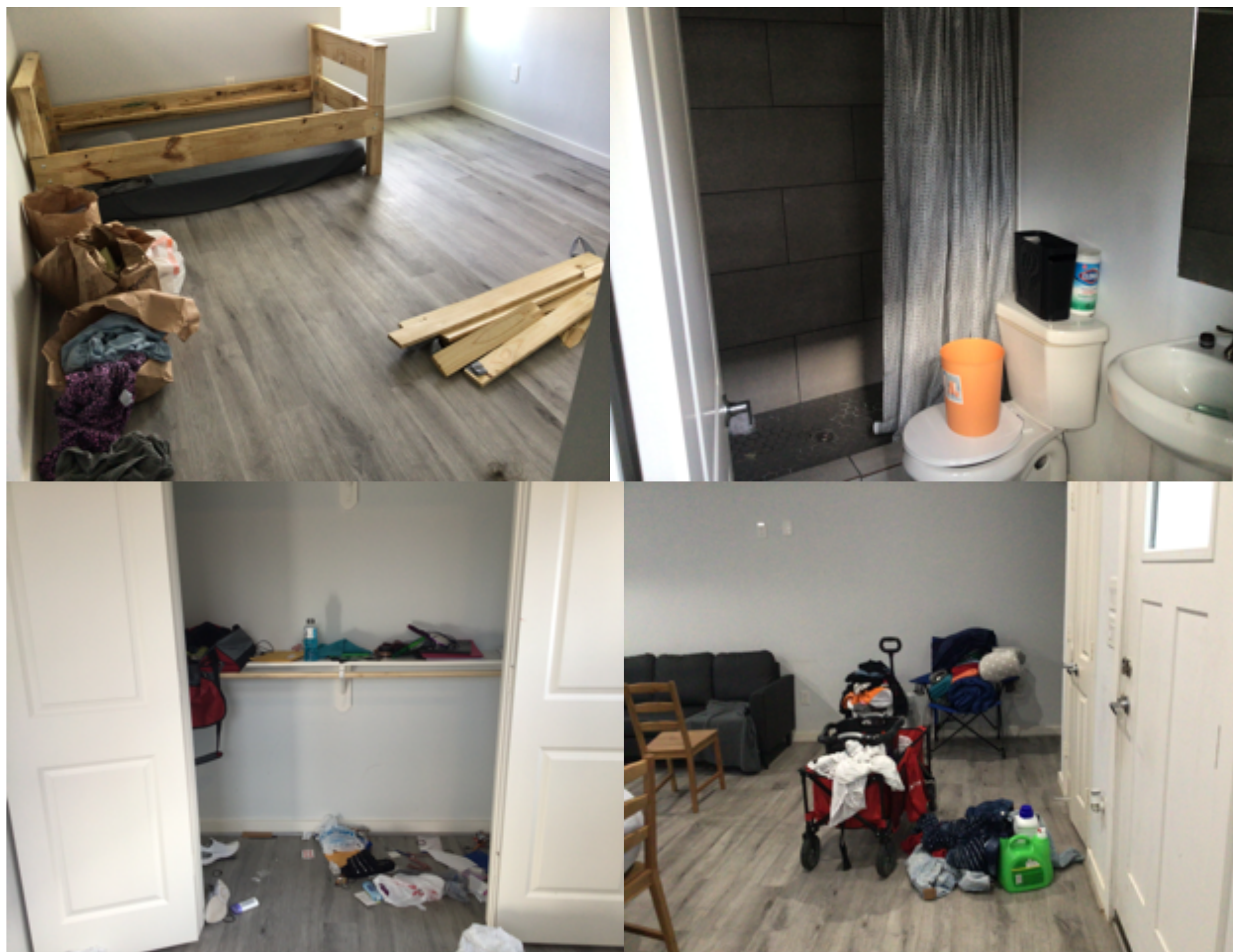
[27] During the monitoring team's visits, a staff person acknowledged the risk, noting that she had expressed a preference to DFPS that they placed girls at The Villas, but not boys. She explained that she did not believe girls would be as likely to be interested in going into the area with the abandoned houses. Despite this, one of the Serious Incident Reports reviewed by the monitoring team indicated that after a staff person confronted a child who had engaged in self-harm (cutting) about the self-harm, the child walked outside and "continued to walk through the grass down a dirt road on the street over with abandoned houses."

A security officer is always present on-site at The Villas. The monitoring team observed the security officer sitting in the open garage of one of houses for the entirety of the visit, and caregivers confirmed that this is where the security guard generally stays.

ii. Houston Duplexes

DFPS has leased two duplexes in Houston; at the time of the monitoring team's visit in October 2021, children without placement were being housed in three of the four two-bedroom duplex units, with the fourth used for storage. Each bedroom had its own bathroom. When the monitoring team arrived, staff and children were present in two of the units, and a staff person had just arrived at the third unit, but children were not present.

The units appeared to have been somewhat hastily furnished; bedrooms were furnished only with a bed, and the living rooms had a couch, some chairs, a small table where the staff was observed sitting, and a television. In one of the bedrooms, the bed did not appear to have the supportive slats for the mattress installed; the mattress was on the floor inside the bed frame. While the duplexes appeared to have been built recently and were in good condition, staff reported there were pending, unresolved work orders for four of the bathrooms due to plumbing problems. In one bathroom, one of the sinks did not work, in another, neither the sink nor the shower drained properly, in another, the toilet and sink were not working properly, and in a fourth, the toilet did not flush.



At the first duplex the monitoring team visited, staff indicated that one PMC child was present in the unit, but was asleep in her bedroom, was not feeling well, and would be taken for a COVID test later in the day. Staff reported the child had been suspended from school but did not know why or for how long. The monitoring team found binders for other children in the units; staff did not appear to know whether other children housed at the CWOP Setting were in school or on runaway status. At the other duplex, another PMC youth was asleep on the couch. Staff indicated the child had recently returned from being on runaway status. During the monitoring team's visit, an investigator arrived to interview this child, and when the child was awakened by staff, this child also reported not feeling well.

Children's records at this location were not well-kept, and staff did not always appear knowledgeable about the children they were supervising or have the information needed to ensure safe supervision:

- Children's medication logs were missing information, and in some cases appeared to show instances in which medications were not administered without documenting a reason. Staff also did not document the medication count on the medication logs and instead only

documented how many pills were administered each time. One child's binder did not contain any medication log, and when asked, the staff could not locate them. The staff ultimately said that the child "probably" refused her medications, explaining the lack of a medication log.

- For some records reviewed, staff signed the sheet indicating that they reviewed Attachment A, but an Attachment A could not be located.

- One of the staff could not tell the monitoring team where the medications were located. There was an open, empty lock box on the floor in the kitchen. Before the monitoring team left, the second staff person rolled out a box with a double padlock that contained the children's medications and other medical supplies. Staff did not know the combination to unlock the box and were making calls to try to obtain the combination.

- Staff acknowledged they had not reviewed children's binders and relied principally on information relayed to them verbally by the staff from the previous shift.

There were no security officers present at this site.

iii. Penelope House

The monitoring team visited Penelope House, located in Belton, Texas, in November 2021. The house is an older home; the exterior was cluttered with a broken chair, file cabinets, and broken glass and other trash. The interior appears to have been recently updated; the furnishings were adequate and in good repair. Though the interior of the house was in good condition, the monitoring team noticed that the windows appeared to be screwed shut.[28] In several of the bedrooms, furniture was pushed in front of a window despite a sign indicating that the window should not be blocked for fire code reasons.

The monitoring team observed that the locks to the cabinets where medicine was stored seemed to be faulty or broken, and it took staff some time to find the right key to open one of them. When the monitoring team requested the children's on-site records, staff were seen to be quickly signing documents that should have been signed at the start of their shift. Security was provided by a private security company. In the photos, below, the signs on windows state that the windows should not be blocked.

[28] The monitoring team attempted to open windows that appeared to be screwed shut from the outside and could not open them.

II. Impact of DFPS's "Capacity Infusion"

In DFPS's September 13, 2021, response to the Monitors' September 2021 Update, the department identified four factors affecting timely, appropriate placement of foster children:

- The loss of beds in congregate care placements, particularly residential treatment centers (RTCs), at a rate higher than capacity gained in those settings;

- the impact of the COVID-19 pandemic on the workforce, resulting in a staffing shortage for congregate care placements;
  the reluctance of providers to accept children with complex treatment needs; and
- the shortage of subacute care providers in Texas.[29]

The DFPS report next identified several ways that the department intended to address those factors, including:

- Use of funds appropriated by the legislature to address the placement crisis by providing targeted supplemental payments and grants to providers to retain and increase capacity;
- an "infusion" of capacity intended to eliminate overnight stays in DFPS offices and to generate and sustain capacity in "children's home communities."[30]

In a table within the report, DFPS listed the new residential capacity it had gained to eliminate office stays for children without placement.[31] The table showed that DFPS:

- Entered into residential leases for 76 beds in Houston, San Antonio, and Wallis.[32]
- Entered into new contracts with GROs, gaining a total of 33 beds in Houston and Terrell.
- Entered into new MOUs with community partners, gaining a total of 24 beds in Houston, El Paso, Kingwood, San Antonio, and Henderson.
- Entered into contracts with providers for Temporary Emergency Placement (TEP) beds, gaining 20 beds in San Antonio and Oklahoma.
- Entered into contracts for subacute care, gaining 18 beds in San Antonio and Texarkana.
- Entered into a contract with an RTC, gaining 11 beds in Houston.[33]

DFPS also indicated that it was engaged in "extensive and ongoing outreach efforts and partnerships with both in-and-out-of-state providers" to plan for a "quality capacity infusion in several programs to serve youth with complex treatment needs," listing subacute inpatient treatment, an intense plus pilot program targeting treatment to youth who have experienced trafficking, and a qualified residential treatment program pilot.[34]

On October 3, 2021, DFPS provided the Monitors with an updated document entitled "Capacity Growth Plan and Current Status."[35] The document indicated that it had increased its subacute beds to 34, had increased its capacity in TEP programs (discussed below), was engaging in an intensive review of each child in CWOP, and was examining long-term strategies to address the placement crisis.[36] The update also showed DFPS had increased GRO beds, gaining 47 (up from 33 in

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[29] DFPS, *supra* note 2, at 10-18.
[30] *Id*. at 18-27.
[31] *Id*. at Table 2.
[32] DFPS entered into a lease for the former Prairie Harbor facility in Wallis, Texas. However, children are no longer being housed in that location.
[33] *Id*. at Table 2.
[34] *Id*. at 21-24.
[35] DFPS, *Capacity Growth Plan and Current Status* (undated) (on file with the Monitors).
[36] *Id*.

September).[37] DFPS included the chart, below, related to increased capacity in congregate care settings, and showing "total bed capacity by type that did not contract with DFPS as of May 2021."[38]

GRO Service Types	Total Capacity	**Projected daily DFPS utilization Rates**
Child Care Services Only	6645	**831**
Emergency Care Services Only	1456	**716**
Multiple Services	1179	**495**
Residential Treatment Center	699	**384**
Grand Total	9979	**2426**

The Monitors examined updated placement information for the 52 PMC children whose records the Monitors reviewed prior to the September 2021 Update to determine whether the infusion of congregate care capacity had resulted in increased placement stability for those children. The monitoring team also visited two TEP programs, and two Michigan facilities where DFPS placed PMC children.

A. Updates to Placement Information for Children Profiled in September 2021 Update

As part of the research for the September 2021 Update, the monitoring team conducted an extensive record review for 52 PMC children.[39] For this report, the Monitors reviewed updated placement information for these 52 children to determine where they were placed as of October 31, 2021 (the most recent placement data available at the time of writing), and how many placements followed the CWOP Setting where they were housed when the monitoring team visited.

As of October 31, 2021, 12 of the 52 children (23%) were placed in an RTC. Three of these RTCs are under Heightened Monitoring, and two are located outside of Texas. Seven children (14%) had aged out of care by October 31, 2021. As many of the 52 children were in juvenile detention or jail on October 31, 2021 (5) as were living in a GRO or kinship placement, and the number of children on runaway status (4) was tied with the number of children in foster homes. The table below shows the types of settings the 52 children were living in on October 31, 2021.

Table 2: Type of Placement as of October 31, 2021, for PMC Children Profiled

Type of Placement as of October 31, 2021	**Number of Children**
Residential Treatment Center	12 (23%)
Exited PMC (aged out)	7 (14%)
GRO	5 (10%)
Juvenile detention or jail	5 (10%)

[37] *Id*. at 2.
[38] *Id*. at 3.
[39] The Monitors included profiles for 51 of these children in the body of the report or an appendix.

Kinship (relative or return home)	5 (10%)
Runaway	4 (8%)
Foster home	4 (8%)
TEP (emergency placement)	4 (8%)
CWOP	3 (6%)
Unauthorized placement	2 (4%)
HCS Group 1-4	1 (2%)
Total	**52**

Between the time that the monitoring team visited the 25 CWOP Settings where these children were housed (between June 22, 2021, and July 22, 2021) and October 31, 2021, most of the 52 children continued to experience the chronic placement instability that characterized their time in foster care prior to being without a placement. The average number of placements for these children during this time period was three; twelve children (23%) had five or more placements during this period.[40]

In addition, the children continued to experience periods without a placement. More than half of the children (28 of 52, or 54%) had at least one additional period without placement during the period; thirteen children (25%) had two or more periods without placement. Ten of the children (19%) had a Temporary Emergency Placement (TEP), and eight (15%) had an unauthorized placement.[41] A summary of the placements for each of the children is included in the table, below.

[40] Includes runaway, unauthorized, and jail/detention.

[41] The CPS Handbook appears to describe an "unauthorized living arrangement" as a living arrangement chosen by a youth who has run from care, indicating that "[w]hen a youth…begins living in an unauthorized living arrangement a youth's caseworker must…[t]ry to persuade the youth to return to substitute care." DFPS, *CPS Handbook* §4310. However, only one of the placements labelled "unauthorized" for the eight children who had at least one unauthorized placement appears to fit that description. In other cases, the "placement" appeared to be a weekend visit with a family member, or a longer-term placement with family member or fictive kin. The Monitors requested clarification from DFPS regarding the use of this label via e-mail. E-mail from Deborah Fowler and Kevin Ryan to Michelle Mattalino, Director of Project Management, DFPS, December 27, 2021 (on file with the Monitors). DFPS responded on December 31, 2021, as follows: "DFPS utilizes the living arrangement, 'unauthorized placement' when a child or youth begins residing with an individual, relative or kin, whom DFPS has not approved as a caregiver. Unauthorized living arrangements can result from a youth running away to live at a biological parent or significant other's home. These arrangements could also be the result of court orders. Currently, DFPS does not consider these living arrangements to be formal placements. While the living arrangement is not a paid or DFPS-approved placement, the adult in the home assumes the responsibility of caring for the child/youth by default." E-mail from Ingrid Vogel, Program Specialist, Foster Care Litigation Compliance, DFPS, to Deborah Fowler and Kevin Ryan, re: Unauthorized Placements (December 31, 2021) (on file with the Monitors). This is not consistent with the Monitors' review of IMPACT records for the children whose records were reviewed for this report; in many cases, children appear to be placed in an "unauthorized placement" without a court order. **TEP placements included only those placed by DFPS as SSCC placements to TEP were not identifiable in the data.**

Table 3: Profiled PMC Children's Placements, July to October 2021

Children Profiled	Summary of Placements Since CWOP Placement in July 2021	Placement as of October 31, 2021
AS	**CWOP** > TEP	Exited PMC
YY	**CWOP** > Jail > CWOP > Unauthorized > CWOP > Unauthorized > CWOP > Unauthorized > CWOP > Unauthorized > CWOP	CWOP
MM	**CWOP** > Unauthorized > CWOP > Unauthorized > CWOP > Unauthorized	Unauthorized placement
AU	**CWOP** > Runaway > CWOP > Runaway	Runaway
II	*Aged out of conservatorship while in CWOP*	Exited PMC
SS	**CWOP** > TEP > Jail > CWOP > Unauthorized > CWOP > Unauthorized > CWOP > Unauthorized > CWOP > Runaway	Runaway
AI	**CWOP** > out-of-state psychiatric hospital > CWOP > GRO	GRO
VV	**CWOP** > CWOP (different location) > CWOP (different location) > RTC	Residential treatment
AH	**CWOP** > TEP > RTC	Residential treatment
AE	**CWOP** > Unauthorized > CWOP > Runaway	Runaway
AG	**CWOP** > Hospital > Psychiatric hospital > CWOP > CWOP (different location) > TEP > out-of-state RTC	Residential treatment out-of-state
AC	**CWOP** > Runaway > CWOP > RTC	Residential treatment
XA	**CWOP** > Foster home*	Foster home
AM	**CWOP** > GRO	GRO
BB	**CWOP** > Runaway > CWOP > Juvenile detention > CWOP > Juvenile detention	Juvenile detention
AQ	**CWOP** > Kinship	Kinship (relative)
AD	**CWOP** > HCS Group 1-4	HCS Group 1-4
AF	**CWOP** > Hospital > Psychiatric hospital > CWOP > Runaway > CWOP	CWOP
KK	**CWOP** > Unauthorized > CWOP > Juvenile detention	Juvenile detention
OO	**CWOP** > Foster home*	Foster home
AL	**CWOP** > Kinship	Kinship (return home)

EE	**CWOP** > Kinship	Kinship (relative)
GG	**CWOP** > HCS Group 1-4 > Psychiatric hospital > CWOP > RTC*	Residential treatment
ZZ	**CWOP** > Juvenile detention > CWOP > Juvenile detention > CWOP > RTC > Psychiatric hospital > RTC	Residential treatment
DD	**CWOP** > Juvenile detention > CWOP > Hospital > CWOP > Psychiatric hospital > CWOP > TEP	TEP
AT	**CWOP** > Hospital > CWOP > Foster home*	Foster home
XB	**CWOP** > out-of-state RTC	Residential treatment out-of-state
FF	**CWOP** > GRO > GRO (different location)	GRO
AR	**CWOP** > Unauthorized > CWOP > Unauthorized	Unauthorized placement
NN	**CWOP** > out-of-state RTC > GRO > out-of-state RTC > CWOP	CWOP
TT	**CWOP** > Foster home* > Psychiatric hospital > Foster home	Foster home
AN	**CWOP** > Kinship (relative's home) > GRO	GRO
CC	**CWOP** > Unauthorized > CWOP > RTC*	Residential treatment
AX	**CWOP** > Psychiatric hospital - substance abuse treatment > Independent living	Exited PMC
AP	**CWOP** > Kinship	Kinship (relative)
HH	**CWOP** > RTC > Kinship	Kinship (return home)
LL	**CWOP** > Psychiatric hospital > CWOP > Psychiatric hospital > CWOP (aged out of conservatorship)	Exited PMC
XX	*Aged out of conservatorship while in CWOP*	Exited PMC
WW	**CWOP** > Psychiatric hospital > CWOP > CWOP (different location) > TEP	TEP
AA	**CWOP** > RTC	Residential treatment
PP	**CWOP** > Hospital > CWOP > County jail > CWOP > TEP > Runaway > CWOP > County jail	County jail

AO	**CWOP** > Hospital > Psychiatric hospital > Psychiatric hospital (different location) > RTC	Residential treatment
AJ	**CWOP** > Kinship > RTC	Residential treatment
AK	**CWOP** > Runaway > CWOP (aged out of conservatorship)	Exited PMC
QQ	**CWOP** > Foster home* > Psychiatric hospital > Foster home* > CWOP > Juvenile detention	Juvenile detention
JJ	**CWOP** > Unauthorized > Unauthorized (different location)	Exited PMC
RR	**CWOP** > Hospital > Psychiatric hospital > CWOP > Hospital > Juvenile detention > CWOP > TEP	TEP
AV	**CWOP** > CWOP (different location) > TEP > GRO > Juvenile detention	Juvenile detention
AB	**CWOP** > GRO	GRO
UU	**CWOP** > CWOP (different location) > Psychiatric hospital	Exited PMC
AY	**CWOP** > GRO > RTC*	Residential treatment
AW	**CWOP** > RTC > Psychiatric hospital > CWOP > TEP > Runaway	Runaway

*Indicates operation is currently on Heightened Monitoring.

In addition, the Monitors' analysis of data for children placed in CWOP Settings between July 2021 and October 2021 shows that they had a higher number of overall placements and periods without placement than children placed in CWOP Settings between March 2021 and June 2021. Twenty percent of PMC children placed in a CWOP Setting between July 2021 and October 2021 (96 of 488) had three or more periods without placement, compared to 13% (67 of 512) of children placed in a CWOP Setting between March 2021 and June 2021.

Figure 6: Total Number of Placements Between March 1 and June 30 and Between July 1 and October 31 for PMC Children with a CWOP Placement

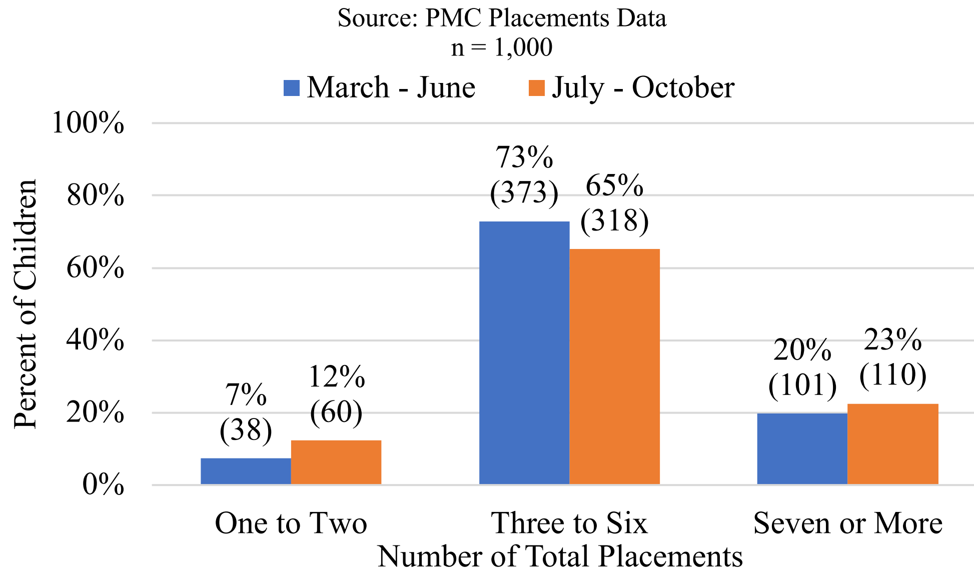
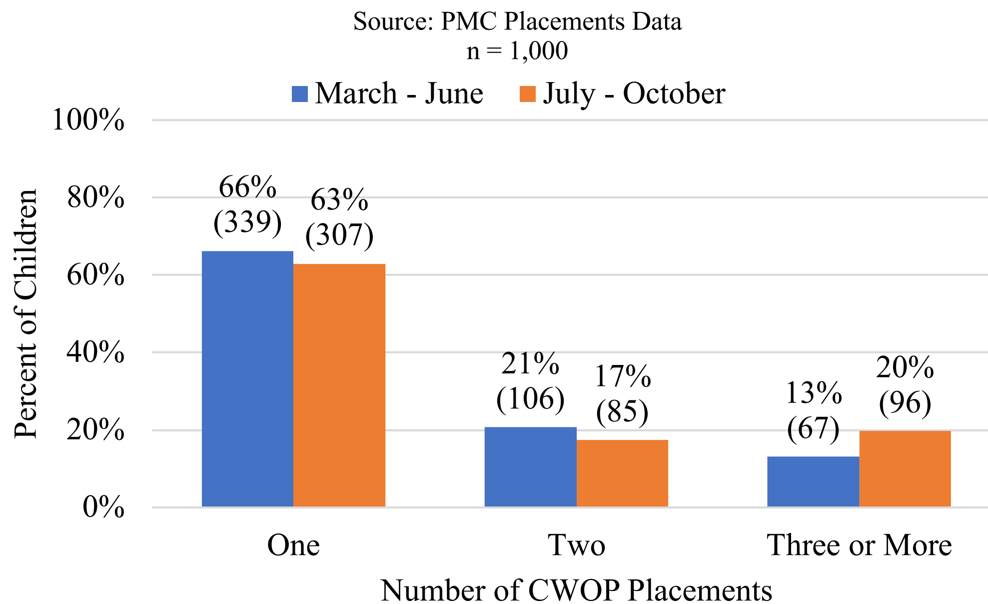


Figure 7: Number of CWOP Placements Between March 1 and June 30 and Between July 1 and October 31 for PMC Children with a CWOP Placement



B. Site Visits to Temporary Emergency Placements

According to DFPS, the TEP program, "provides emergency, short-term, highly structured quality residential care and services for children while CPS placement staff continue searching for

a more suitable and longer-term placement."[42] The contracts with providers for TEP beds are "no-eject, no-reject,"[43] meaning that the providers cannot refuse a placement or discharge a youth, and are paid at a higher rate.[44] According to DFPS's September 13, 2021 report, the agency then had contracts for a total of 20 beds, listing the regions where the beds were located as San Antonio and Oklahoma.[45]

DFPS's "Capacity Growth Plan and Current Status," sent to the Monitors on October 3, 2021, listed a "two-pronged strategy" related to TEP beds, indicating: "DFPS is continuing to work to expand TEP beds at the established rate. Second, DFPS will work to move children out of TEP slots quickly to other licensed placements to create room for children in CWOP."[46] In the document, DFPS reported it had 28 TEP beds "with plans to continue expansion."[47] However, on October 5, 2021, in response to an inquiry from the Monitors, DFPS reported its current TEP providers, and the number of beds contracted for, but listed only 26 beds:

- Unity Children's Home – Girls – 8 (female)
- Adiee Emergency Shelter – 6 (male)
- Promise House – 8 (female)
- Boysville – 6 (female).[48]

After hearing concerns from community members about the way that Single Source Continuum Contractors (SSCCs) were using TEP beds in Community Based Care (CBC) regions,[49] the

[42] DFPS, *supra* note 2, at footnote 29.
[43] *Id*.
[44] DFPS, *FY 22 Legacy Supplemental Payments for Providers* (listing the current legacy rate as $400.72 per day and the supplemental add-on as $46.08, for a total of $446.80, the highest rate paid, and the same rate paid for intense psychiatric treatment beds in an RTC or GRO), *available at* https://www.dfps.state.tx.us/Doing_Business/Purchased_Client_Services/Residential_Child_Care_Contracts/Rates/supplemental_payments.asp ; *see also* Deborah Fowler & Kevin Ryan, *supra* note 1, at footnote 56.
[45] *Id*. at Table 2. Despite having listed Oklahoma as a region with TEP beds, the Monitors have not received any information related to an out-of-state provider of TEP beds.
[46] DFPS, *Capacity Growth Plan and Current Status* (undated) (on file with the Monitors), attached as Exhibit 1.
[47] *Id*.
[48] E-mail from Trevor Woodruff to Deborah Fowler and Kevin Ryan, re: Updated list of CWOP Settings, October 5, 2021 (on file with the Monitors).
[49] Among issues raised by stakeholders was the concern that SSCCs are frequently moving children between TEP beds in order to avoid listing them as children without placement. The Monitors examined placement data for SSCC regions to determine whether the data validated these concerns. However, SSCCs do not use a "TEP" flag or label in IMPACT when entering the type of living arrangement for children placed in TEP beds, as DFPS does. DFPS utilizes this in order to identify rate of pay; because SSCCs are paid a blended rate by the State, SSCCs are not using this flag in IMPACT. DFPS explained, "We have not required SSCCs to mark or 'flag' a child in IMPACT as a STEP/TEP placement. A specific provider 'flag' will not work as a residential provider that has a STEP agreement with an SSCC may have a regular GRO type of agreement with another SSCC or DFPS legacy. The resources created for residential providers is based on license type and any combination of services the operation is licensed to serve needs to be available. The CBC team will work on the best way to note the STEP placements in IMPACT for the SSCCs youth placed under a TEP agreement." E-mail from Trevor Woodruff to Deborah Fowler and Kevin Ryan, re: Updated list of CWOP Settings, December 3, 2021 (on file with the Monitors). The Monitors examined placements in the entities listed as providing TEP beds by SSCCs and found that they constitute 21% (52 of 249) of SSCC placements in August and September 2021; at least 33% (17 of 52) of these placements lasted two weeks or less (few of the September placements included an end-date). Six of the 52 children (12%) had multiple placements during those two months in operations listed as providing TEP beds to SSCCs. By contrast, TEP placements made by DFPS constituted only 4%

Monitors asked DFPS whether SSCCs also contracted with providers for TEP beds for children under their care. DFPS responded with the following information for the SSCCs:

- 2INgage Region 2 SSCC – Harmony Family Services Emergency Shelter
- OCOK Region 3b SSCC – Promise House
- SFCS Region 1 SSCC – Youth in View, Jae's Helpers, and Guiding Light CPA[50]

DFPS did not provide information related to contracts for TEP for children in Region 8b, which is also a CBC region.

On November 23, 2021, after the Monitors e-mailed DFPS asking about the use of a placement resource apparently referred to as "TEMP" beds by SSCCs, DFPS responded that "TEMP and STEP may be used interchangeably," and then included an updated (and greatly expanded) list of providers used by OCOK, which DFPS said the SSCC provided "in response to [DFPS's] questions about CWOP locations and TEP bed usage."[51] DFPS noted that OCOK had "reserved bed agreements" with:

- Agape Manor Home
- CK Family Services
- Kids First
- Perfection Children Services
- RISE Services Texas[52]

The e-mail noted that OCOK "has additionally made temporary placements with the following providers" and pasted a table (titled, "Paid TEP Days – December 2020 – September 2021") into the e-mail with the following information:[53]

Row Labels	**Sum of days**
ACH Child and Family Services	323
Agape Manor Homes Inc	43
Camp Worth LLC	1
CK Family Services	815
Everyday Life Inc	7
Hidden Cove Residential Treatment	188
IMDC Pinecrest Emergency Care Services	153
Kids First Inc	450

of its placements during the same period. However, because DFPS indicates that SSCCs are also making non-TEP placements in some of the same operations, the analysis for SSCCs may be over-inclusive. Because SSCCs do not capture TEP placements in IMPACT in the same way DFPS does, it is impossible for the Monitors to determine how SSCCs are using TEP beds using placement data.

[50] E-mail from Trevor Woodruff to Deborah Fowler and Kevin Ryan, re: Updated list of CWOP Settings, November 17, 2021 (on file with the Monitors). DFPS also reported that SSCCs use the acronym "STEP" for these placements.

[51] Encrypted e-mail from Trevor Woodruff to Deborah Fowler and Kevin Ryan, re: Updated list of CWOP Settings, November 23, 2021 (on file with the Monitors).

[52] *Id.*

[53] *Id.*

Make a Way Inc	500
Perfection Children Services	19
Rise Services Texas Inc	273
The Refuge for DMST	113
VisionQuest National Ltd	4
Youth in View	15
Grand Total	**2,904**

Finally, the e-mail noted that OCOK "has a paid bed agreement with Promise House – GRO,"[54] as had previously been reported.

At least five of the providers[55] that DFPS or the SSCCs have used for temporary placements are currently under Heightened Monitoring due to a history of safety violations: Harmony Family Services Emergency Shelter, Jae's Helpers, Agape Manor Homes Inc, Kids First Inc, and Youth in View. Promise House is not under Heightened Monitoring, but is on Probation, according to CLASS records.

In order to gain a better sense of the impact of TEP on PMC children, the monitoring team made site visits to two TEP providers:

- Unity Children's Home – Girls; and
- Promise House

The Monitors' site visits to Unity Children's Home – Girls and Promise House and review of the IMPACT records for the children housed in these facilities when the monitoring team visited raise several concerns with the TEP program, discussed below.

i. Length of Stay in TEP programs

Though DFPS indicated it was working to ensure the children's stay in TEP programs were brief, most of the children in the two programs the monitoring team visited had been in the placement for a month or longer.[56] However, during the monitoring team's visits to Unity Children's Home and Promise House, the team met and reviewed records for children who had stayed in the TEP program at those operations for considerably longer. For example, of the 14 PMC children who were placed in the TEP program at Unity Girls or Promise House when the monitoring team visited, six had been in the TEP program for well over 34 days:

- BG was placed in the TEP program at Unity Girls on July 27, 2021, and was not discharged until October 14, 2021, when she was moved to an RTC that is currently under Heightened Monitoring. The placement has since disrupted, she was without placement for almost two weeks, and recently was placed in a therapeutic foster home licensed by a CPA that is also under Heightened Monitoring.

[54] *Id.*
[55] ACH Child and Family Services CPA is also under Heightened Monitoring; it is not clear whether the list provided by DFPS refers to the CPA, or the ACH Child and Family Services GRO, which is not under Heightened Monitoring.
[56] The average length of stay for children by DFPS in a TEP program is 34 days.

- DD, who was one of the children profiled in the Monitors' September 2021 Update, was placed in the TEP program at Unity Girls on September 23, 2021, and was not discharged until December 17, 2021, when she was moved to another RTC.
- RA moved from a CWOP setting, where she had stayed for 42 days, to the TEP program at Unity Girls. She stayed at Unity Girls for just over three months, before being moved to an RTC in San Antonio that was closer to her siblings. That placement disrupted, and she is currently placed in a foster home, however, the home is temporary and is licensed by Jae's Helpers, which is under Heightened Monitoring.
- TR was placed in the TEP program at Promise House on November 1, 2021, where she remained as of January 2, 2022.
- PMY, a transgender male PMC youth, was placed in the TEP program at Promise House on October 28, 2021, where he remained as of January 2, 2022.
- AD was placed in the TEP program at Promise House on October 31, 2021, where she remained as of January 2, 2022.

A review of January 2021 through October 2021 placement data shows that 40% (56 of 140) of children placed by DFPS in a TEP program stayed in the program for more than 30 days, with more than 18% staying up to 90 days or longer.

Table 4: Length of Stay in a TEP for Children Placed by DFPS, January to October 2021

Length of Stay Category	**Number of Children**	**Percent**
2 weeks or less	59	42%
Up to 30 days	25	18%
Up to 60 days	30	21%
Up to 90 days	9	6%
More than 90 days	17	12%
Total	**140**	**-**

The number of days that a child placed by DFPS in a TEP program stayed in the placements ranges from a low of one day to a high of 177 days.

Children placed by SSCCs in one of the placements they identified as providing TEP care[57] were slightly less likely to have long stays. Of these children, approximately 28% (51 of 180) stayed in the placement for more than 30 days, and 13% (24 of 180) stayed up to 90 days or longer.

[57] As discussed, SSCCs do not flag placements in IMPACT as TEP placements. For this analysis, the Monitors evaluated placements by SSCCs in the programs they identified as providing TEP care. The high percentage of children staying in these placements for 30 days or less suggests they were TEP placements. However, without a flag identifying a placement as a TEP placement, it is not possible to distinguish between a TEP Placement and a placement that was made by the SSCC that was not intended to be temporary.

Table 5: Length of Stay in a TEP for Children Placed by SSCCs, January to October 2021

Length of Stay Category	Number of Children	Percent
2 weeks or less	80	44%
Up to 30 days	49	27%
Up to 60 days	27	15%
Up to 90 days	11	6%
More than 90 days	13	7%
Total	**180**	**-**

Like children placed in TEP programs by DFPS, the number of days that a child stayed in a placement identified by an SSCC as providing TEP care ranged from a low of one day to a high of 216 days.

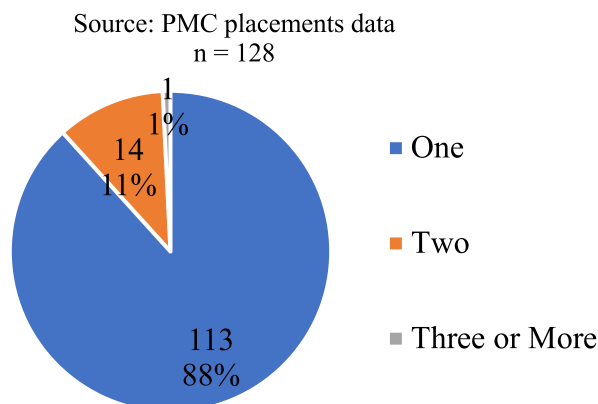
ii. Repeated Placement in TEP Programs.

Though most children placed in a TEP program between January 2021 and October 2021 were only placed in a TEP program once, many children had repeated placements in TEP programs, increasing the placement instability and disruptions that children experience and that (as documented by the Monitors in previous reports) can have profound consequences for children's safety, particularly for those with acute mental and behavioral health needs. For example, of the children placed in the TEP program at Unity Girls or Promise House when the monitoring team visited, five of the 14 children had previously been placed in a TEP program:

- BG, whose placement in the Unity Girls TEP program was one of the 20 placements she had been in over the course of her three years in care (only one of which lasted more than 60 days) had previously been placed in the TEP program at Promise House.
- DS, whose placement at Unity Girls TEP program was also one of 20 placements in during her 19 months in foster care, had been placed in a TEP program twice before.
- AS, whose placement in the TEP program at Unity Girls was one of her more than 20 placements since re-entering foster care in late 2018, had been in a TEP placement at Unity Girls once before.
- MM, whose placement in the TEP program at Promise House was one of at least 34 placements since re-entering foster care in 2016, had been in a TEP program at Promise House once before. Her second TEP placement at Promise House was made within a year of her first.
- DD, who has experienced 20 placements since entering foster care in 2020, had three TEP placements prior to being placed in the TEP program at Promise House. Three of her four TEP placements had been in Promise House; the other TEP placement was at Unity Girls.

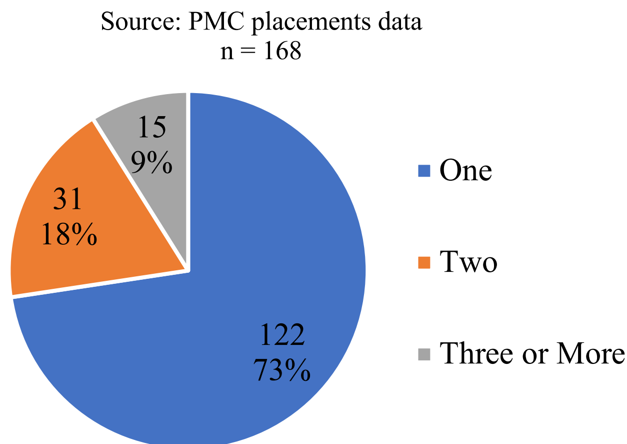
Of children placed in a TEP program by DFPS between January 2021 and October 2021, most (88%, or 113 of 128) were only placed in a TEP program once. However, 12% (15 of 128) were placed in a TEP program two or more times during the time period.

Figure 8: Number of TEP Placements for PMC Children Placed in a TEP by DFPS, January to October 2021



During the same period, children placed in operations that SSCCs contract with for TEP placements were more likely to be placed in operations with a contract with the SSCC for TEP more than once. Of children placed in a program that an SSCC contracted with for TEP placements, 73% (122 of 168) were placed in one of these operations once, while 27 % (46 of 168) were placed in one of these operations two or more times during the time period.

Figure 9: Number of TEP Placements for PMC Children Placed in a TEP by SSCCs, January to October 2021



The monitoring team's review of IMPACT records for the PMC children who were placed in the TEP programs at Unity Girls or Promise House on the date of the site visit revealed that they shared the kind of troubling histories in the foster care system experienced by the children profiled in the Monitor's September 2021 Update. For example, all the children who were in the TEP programs visited by the monitoring team had histories of extreme placement instability and

disruption; one child had been in over 80 placements since entering foster care in 2015. Many had been placed in one or more operations that had a troubling history of safety violations, including multiple placements in operations subsequently placed on Heightened Monitoring, or that have since closed due to safety violations or license revocation.

All the children also had significant mental and behavioral health challenges arising out of the trauma they experienced both prior to and after entering foster care and shared a history of declining mental and behavioral health since entering care, likely exacerbated by the placement instability and disruptions they had experienced. Many had been trapped in a cycle like those highlighted by in-depth child profiles included in the Monitors' previous reports, between RTCs that failed to meet their mental and behavioral health needs and psychiatric hospitals, driven by either self-harm or suicidal ideation or dysregulation that resulted in physical aggression. Adding to their placement instability and disruption hampers the stable, consistent, structured treatment needed (and these needs are documented prolifically in service plans and psychological evaluations in their IMPACT records) to ensure their safety. As discussed below, it is also not clear that the mental and behavioral health programs provided in the two TEP programs visited are as robust as their website and materials claim.

Further, a review of IMPACT for one of the 15 children placed more than three times in an operation that an SSCC (in this case, St. Francis) has an agreement with for TEP beds raises deep concerns about the potential for the type of continual movement between TEP placements raised by stakeholders who reached out to the Monitors. This 15-year-old PMC child had 16 placements between the time that a three-month return home disrupted on April 22, 2021, and September 15, 2021, when he was placed at an RTC in Arkansas, as shown in the table below.

Placement Name	Dates of Placement
Guiding Hope RTC (STEP)	April 22, 2021 – May 6, 2021
SSCC-Saint Francis (Office)	May 6, 2021 – May 7, 2021
Therapeutic Foster Home (STEP)	May 7, 2021 – May 10, 2021
SSCC- Saint Francis (Office)	May 10, 2021 – May 11, 2021
Therapeutic Foster Home (STEP)	May 11, 2021 – May 26, 2021
Therapeutic Foster Home	May 26, 2021 (child did not stay)
SSCC – Saint Francis (Office)	May 26, 2021 – May 28, 2021
Therapeutic Foster Home (STEP)	May 28, 2021 – June 15, 2021
Therapeutic Foster Home	June 15, 2021 – June 24, 2021
Therapeutic Foster Home (STEP)	June 24, 2021 – June 27, 2021
Dallas Behavioral Psych Hosp	June 27, 2021 – July 21, 2021
Therapeutic Foster Home (STEP)	July 21, 2021 – July 30, 2021
Therapeutic Foster Home (STEP)	July 30, 2021 – August 13, 2021
Therapeutic Foster Home (STEP)	August 13, 2021 – August 19, 2021
Dallas Behavioral Psych Hosp	August 19, 2021 – September 10, 2021
Therapeutic Foster Home (STEP)	September 10, 2021 – September 15, 2021

Each of the foster homes the child was shuffled through during this period is licensed by entities that are under Heightened Monitoring. Thus, each time the child was placed in one of these homes, DFPS had to review the placement and approve it. The form documenting the placements in IMPACT include the e-mail approving it by DFPS.[58]

Review of the placement history of another child, for whom care is provided by OCOK, shows a similarly troubling six-month period of moving from temporary placement to temporary placement before finally being placed in an RTC in Arkansas. This child had 11 temporary placements between June 2, 2021, and December 15, 2021, including one psychiatric hospitalization. A third 16-year-old PMC child, whose care is provided by St. Francis, has had eight placements between the time that a seven-month return home disrupted on August 16, 2021, and her current placement, which started December 7, 2021. Two of those have been stays in psychiatric hospitals; the rest have been in STEP beds in foster homes. Her current foster home is also licensed by one of the STEP providers, but she has been in the placement for almost a month; it is not clear from the Monitor's review of the placement records whether it is intended to be a long-term placement.

A. Unity Children's Home – Girls

Unity Children's Home is a private, for-profit entity that describes its mission as "to assist youth in developing a mind-set that supports a desire to model a spiritual approach; designed to promote a purposeful living and spiritual healing."[59] It expands on its mission by describing the organization's philosophy as follows:

> Unity Children's Home believed [sic] that every child is entitled to reside in a [sic] environment that promotes spiritual enrichment, emotional stability and appropriate physical, social growth and development.
>
> Unity believes that every child should be encouraged to achieve at their maximum potential; replacing negative life experiences with spiritual enrichment and guidance designed to create a definitive vision for the future.[60]

Unity Children's Home has two campuses: Unity Children's Home - Girls (Unity Girls), an RTC located in Spring, Texas, and Unity Children's Home – Boys, an RTC located in Houston.[61]

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[58] One of these, for the June 15, 2021, placement, notes: "Approved HM as a placement ***option*** for [child] with the [foster home] as it appears capable of supporting best interest of a least restrictive environment within the region of removal, ***however*** based on my review of CLASS, there is a pending INV which involved [the child] as an alleged victim. His documented interview in CLASS indicated [he] denied the allegations and stated he felt safe in the [foster home]. It appears likely based on documentation in CLASS that this INV will not be substantiated but staff need to ensure [the child] agrees to this placement given that he was an alleged victim in a pending INV." The "Placement Discussion" box in IMPACT that documents the child's reaction to the placement says, "[St. Francis] reported child was okay at pickup, just another sullen teenage[r], disappointed he didn't get to go to the water park. At drop off, he turned into a runner. Got several people involved and convinced him to stay at placement for the night."

[59] Unity Children's Home, *Mission Statement and Philosophy* (undated) (on file with the Monitors).

[60] *Id*.

[61] CLASS includes an entry for a second Houston location that appears to be approximately five minutes from the boys' campus. However, notes for the most recent RCCR inspection, conducted June 29, 2021, indicates there were no children placed at the location on the date of the inspection.

The boys' campus also houses the administrative offices for the operation and a charter school that educates all the children housed at both campuses. Unity Girls is licensed to serve 32 girls between the ages of 6 and 17 years old, but at the time that the monitoring team visited housed only 24 children, eight of whom were in the TEP unit. Seven of the eight children in the TEP unit were PMC children.

A review of the compliance history for the facility for the last five years shows 48 citations for minimum standards deficiencies over that period, eight of which were reversed after an administrative review. Unity Girls is not under any type of enhanced monitoring or corrective action, and has had only one confirmed finding of abuse, neglect, or exploitation in the last five years. On March 24, 2021, DFPS found two staff had physically abused a child (RTB for Physical Abuse) who was being transported to a psychiatric facility in December 2020. Staff at the psychiatric facility witnessed the first staff member pull the child out of the van, saw the second staff member hit her, and then saw the first staff member put her in an improper restraint. The staff member who restrained the child placed her face down on the ground, and then laid atop of her while the child cried out in pain. Unity Girls also received a citation for violation of the minimum standard prohibiting corporal punishment as a result of this investigation.

The monitoring team visited the RTC in mid-October 2021. During the visit, the monitoring team conducted a late-night visit, toured the facility, and interviewed three awake-night staff, three administrators, nine staff, and eleven children. In addition, the monitoring team reviewed records for 18 employees and 18 children.[62] The monitoring team's observations include:

- The TEP program at Unity Girls appears ill-equipped to manage children who are at high risk for running away, and DFPS does not appear to be screening out children for placement at Unity Girls who have a history of running away. Of the children placed at Unity Girls when the monitoring team visited, four ran away during their placement at Unity Girls:

    - JP ran away from Unity Girls on October 22, 2021 and was recovered by the Houston Police Department five days later. Upon her return to care, JP reported that during the time that she was on runaway status, she stayed with her sister and a male in his 20s and used marijuana and "lean" (a mix of cough syrup and soda pop). JP was then without placement from October 27, 2021, until December 14, 2021, when she was arrested after she and three other children destroyed property in the hotel room where they were housed, and assaulted staff.

    - JB, who had a history of running away, ran from the TEP program at Unity Girls a little more than a month after her placement there. When she left, she called her father, who drove from Dallas to Houston to pick her up. Her father was then designated as an unauthorized placement, and because he was not part of DFPS' original abuse and neglect findings, PMC was transferred to him.

    - DS and two other youth (JP and AS) ran from Unity Girls upon returning from school on October 22, 2021. The children pushed past their peers when they got

[62] A full analysis of the interview answers and record reviews will be included in future reports from the Monitors detailing data gleaned from site visits relevant to each remedial order.

off the bus and ran to the highway. Staff called police, and notes in the intake for the investigation reveal that the law enforcement officer who reported the runaway incident to SWI said that law enforcement had responded to calls from Unity Children's Home numerous times and law enforcement officers "do not feel staff appropriately supervise or care for the children at the facility." The officer told SWI that "[c]hildren often run away when getting off the bus. Staff are sometimes forgetful and leave the door open." DFPS Ruled Out Neglectful Supervision on the part of Unity Girls' staff. DS and the other youth were recovered by police five days later, when a gas station clerk called the police after noticing the girls. DS was then without placement and housed in a CWOP Setting, until she ran again four days later. She was returned to the CWOP Setting after being found by police but has run away twice since then.

  - As noted, above, AS also ran away from Unity Girls. IMPACT notes reveal that while she was on runaway status, she tried to admit herself to a psychiatric hospital. The hospital refused to admit her, and law enforcement picked her up. Upon her return, AS told her caseworker that if she had not run from Unity Girls on October 22, 2021, she had planned to commit suicide. AS was transferred to a psychiatric hospital on October 28, 2021, for suicidal ideation.

- Based on interviews and observation, restraints may be used, at times, for the convenience of the staff rather than to protect youth or staff from harm. However, none of the children interviewed complained of staff using excessive force during restraints. One of the staff indicated that children may be restrained to prevent them from running away, rather than following other protocols. During the visit, the monitoring team observed a restraint involving a youth who was pacing back-and-forth near the front gate of the operation, holding a short stick in her hand. Three staff members surrounded her, and she was restrained.

- Staff and youth reported that the therapy room is used for what may be, in essence, seclusion. Staff and youth reported that children are placed in the therapy room and prevented from leaving by staff. There were inconsistent reports regarding whether a staff person was always in the room with the child. The room itself does not comply with minimum standards associated with seclusion rooms,[63] and the monitoring team did not find any serious incident reports complying with minimum standards related to documenting seclusion, including documentation of a verbal order by a licensed professional.[64] Further, while some staff seemed to described what was, in effect, seclusion, they did not appear to understand that it constituted seclusion.[65] Yet, in

[63] *See* 26 TEX. ADMIN. CODE §748.2651. None of the therapy rooms had a mat or bedding, and one had dozens of staples sticking out of the wall, which presents a safety hazard, particularly for children who self-harm.
[64] *See* 26 TEX. ADMIN. CODE §748.2651 & §748.2503.
[65] *See* TEX. ADMIN. CODE §748.43(59) (defining seclusion as "A type of emergency behavior intervention that involves the involuntary separation of a child from other residents and the placement of the child alone in an area from which the resident is prevented from leaving by a physical barrier, force, or threat of force."). It is possible that staff do not believe this to be a seclusion because if staff are present in the room with the child, RCCR does not consider it to be seclusion, even if the only purpose for staff remaining in the room is to physically prevent the child from leaving.

September 2020, Unity Girls received technical assistance from RCCR related to the minimum standard associated with the time period allowed for seclusion after a youth reported she had been kept in a locked room for more than three hours.[66]

- The monitoring team toured the school, located on the boys' campus, that all the children attend. The classrooms are in several portable buildings on the campus. The day that the monitoring team visited, at least two teachers were absent, and it appeared that staff were having difficulty covering all the required classes. A staff member showed the monitoring team the computer room where students were completing work; few of the students were engaged in work. Some of the girls were restricted from using the computers because, in the absence of appropriate supervision, they were discovered to be able to access inappropriate websites.

The monitoring team made one report to Statewide Intake (SWI) based on the visit to Unity Girls. The call involved a report of neglectful supervision and medical neglect. A youth reported that she was being administered her medication inappropriately; she reported that one of her medications, Hydroxyzine (Xanax), was to be administered "as needed" to address her anxiety. However, she indicated that her legal guardian had not consented to the administration of the medication and that she was being given the medication routinely three times daily, implying it was administered whether needed or not. She also reported an attempt to commit suicide in the presence of a staff member who did not intervene or seek medical attention as well as being assaulted by another youth in the presence of staff who did not immediately intervene. The investigation was closed on November 23, 2021, with dispositions of Ruled Out for Neglectful Supervision, Medical Neglect, and Physical Abuse. Investigation and documentation appear as "complete" as of November 23, 2021, but does not yet appear as closed as of November 30, 2021.

There is not much to distinguish the treatment children receive at Unity Girls from treatment programs at other RTCs the monitoring team has visited. Based on the monitoring team's interviews, children receive individual therapy once or twice a week, depending on their assessed level of need, and group therapy once a week. The RTC uses a level system, ranking children on four levels, with one being the lowest level and four the highest. Children earn privileges, including being able to go on outings and a later bedtime, as they progress to the next level. They are also given a weekly allowance, based on their level, of up to $8.00 per week. Children can lose levels, and though they "level up" once a week, they may "level down" any time they have a major rule violation or have three or more minor rule violations. During interviews, though the children

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However, those interviewed were inconsistent in reporting whether a staff person was always in the room with the child; some reported that children were left alone in the room.

[66] At that time, the children and staff interviewed for the investigation indicated an office was being used as the seclusion or "isolation" room. When RCCI transferred the case to RCCR after ruling out abuse, neglect, or exploitation, the investigator noted the following concern, "There are concerns regarding the children being placed in the seclusion room for more than an hour consecutively. A collateral child also stated that staff will sometimes lock a child in the seclusion room and make them sleep there." The next contact in the chronology indicates RCCR opted to provide technical assistance rather than cite the operation for a minimum standards violation "due to the case contacts being inconsistent." HHSC-RCCR, CLASS contacts dated October 26, 2020 & October 27, 2020, Investigation No. 2652684, Unity Children's Home – Girls. Based on the notes in CLASS, it does not appear that RCCR examined the operation's compliance with other minimum standards associated with seclusion before providing technical assistance related to the time restrictions associated with placing a child in seclusion.

expressed that they understood that they would lose levels for undesirable behavior, they had difficulty explaining how they could earn higher levels. There were no posters or handouts explaining what specific behaviors result in earning levels or losing levels, and the children's on-site records did not contain any additional information on the level system.[67]

The TEP program at Unity Girls admits children 24-hours a day, and perhaps because they are not allowed to refuse a placement, often does not receive any information about the child until after they have been admitted. A child housed at a TEP location may be discharged only if they run away or are admitted to a psychiatric hospital. Based on interviews and on-site record reviews, children with a TEP placement do not appear to receive any different treatment services while at Unity Girls, except that since they are considered to need intensive services, they receive individual therapy twice a week, rather than once a week.[68] They are also housed in a separate unit.

B. Promise House

Promise House is a non-profit entity that provides crisis intervention, transitional housing, pregnant and parenting teen services, counseling, education, and outreach to neglected, abused and

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[67] Unity Girls provided the monitoring team with its policies, which include a "Program Overview and Description" for its residential treatment program. According to this description, "[a] full spectrum of treatment services is offered to clients, dependent on their individual needs as assessed at referral, intake, and throughout their participation in the program." Unity Children's Home, *Policy 2.A.1-35: Program Overview and Description* (undated) (on file with the Monitors). It lists the following services: 24-Hour Monitoring, Individual Counseling, Case Management, Educational Groups, Groups. *Id*. The document describes Unity's "Treatment Services" as follows:

> Residents receiving treatment services are involved in a variety of behavioral and therapeutic interventions. All residents receiving treatment services are involved in the agency's Behavior Modification Program built around a Level System offering rewards and consequences. A resident's cognitive abilities are taken into consideration as expectations are formulated for them regarding their performance in the Behavior Modification Program and the Level System. Child care staff provides the structure that each resident must adhere to as they work on recovery from past life situations that have helped to create emotional and behavioral difficulties for them. There are four (4) levels within the agency's Behavior Modification Program. Residents entering the program are automatically entitled to privileges of Level 1, as long as they exhibit the appropriate behaviors that one is expected to exhibit in order to obtain that particular level. Each resident has an individual "point sheet." The point sheets reflect behavioral goals/tasks for a resident. A resident will earn points on a graduated scale. They must accumulate a total number of points each week to attain a particular level, with each level requiring a greater number of points as they maintain the appropriate behaviors/tasks of the previous level(s). As a resident moves up from one level to another, they earn greater privileges that reflect their ability to display and maintain appropriate behavior in a variety of settings, with adjustments in their levels of supervision provided them by the agency. There is a list of possible consequences for inappropriate behaviors, which is discussed with each resident upon admission and intermittently throughout their stay in the program. Consequences are administered in accordance with the agency's discipline policy.

Id. at 6-7.

[68] According to Unity's Program Overview and Description, the frequency of individual counseling is dependent on the child's length of treatment and level of care, "sessions may be initially scheduled for several times a week; as the client progresses through treatment the frequency of sessions may be reduced." *Id*. at 1. Group therapy is described as *either* educational or treatment groups, with treatment groups described as "process groups, allowing for interaction, processing and/or cross discussion between the facilitation and group members." *Id*. at 2. Educational groups are "primarily non-process, interactive groups." *Id*.

at-risk youth in Dallas, Texas.[69] In addition to its other programs, Promise House runs an emergency shelter for youth. Though there is no description of the TEP program or a treatment-focused program on the Promise House website, and the staff did not provide any information to the monitoring team describing its treatment modality, the organization's website indicates that the shelter provides a "highly individualized program" that includes mental health care (group and individual counseling and on-site psychiatric care) in addition to educational services and life and job skills training.[70]

The website also includes a page devoted to trauma-informed care, indicating that the organization "recently embarked on a 3-5 year journey to achieve certification by the Sanctuary Institute," explaining that the Sanctuary Model "is a theory-based, trauma-informed, trauma-responsive, evidence-supported, whole culture approach to organizational transformation."[71] The website indicates Promise House uses three clinical assessments (the Adverse Childhood Experience Questionnaire (ACEs), Coping Scales, and Trauma Inventories) to develop an individualized treatment plan, and lists several treatment modalities for delivering trauma-informed care: Eye Movement Desensitization and Reprocessing (EMDR), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and Sensorimotor Therapy.[72] The website promises that the assessment instruments will be used to develop counseling goals to "guide and pace a client's healing process."[73]

Promise House is licensed to serve 42 residents ages 0-17 whose level of care is Specialized, Intense, Intense Plus-IPTP, or TEP. The building that houses the emergency shelter also houses the TEP program; children in the TEP unit are housed on the second floor of the building. When the monitoring team visited, there were seven girls and one male-identified youth on the TEP unit, and two boys housed in the emergency shelter. One female youth from the TEP unit was on one-to-one supervision and housed in the emergency shelter downstairs. All the children in the TEP program on the date of the monitoring team's visit had been placed at Promise House by DFPS.

Children attend school on-site, with the Dallas Independent School District (DISD) providing educational programming. There are two classrooms on the campus, and staff reported that children go to school in shifts, with children housed in the emergency shelter attending school for about two hours in the morning, and children from the TEP unit attending school for two hours after the children from the emergency shelter finish. The classroom schedule for Fall 2021 showed only English Language Arts and Social Studies instruction, along with reading time. Some of the youths were completing STAAR testing while the monitoring team was on-site. Youth who were not being tested were not attending school and did not have any school-related activities planned for those days.

Promise House has been under multiple RCCR enforcement actions in the last two years. On November 1, 2019, the operation was given a warning letter by RCCR. This was followed by

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[69] Promise House, *Our Story*, *available at* https://promisehouse.org/our-story/
[70] Promise House, *Emergency Youth Shelter Program*, *available* at https://promisehouse.org/our-programs/emergency-youth-shelter-program/ .
[71] Promise House, *Trauma-Informed Care*, *available at* https://promisehouse.org/trauma-informed-care/
[72] Promise House, *Assessments* (Pop-Up Box), *available at* https://promisehouse.org/trauma-informed-care/
[73] Promise House, *Attainable Therapeutic Goals* (Pop-Up Box), *available at* https://promisehouse.org/trauma-informed-care/

being placed under a voluntary Plan of Action (POA) on January 27, 2020, due to repeated non-compliance with standards associated with medication administration, the physical site, and admission, discharge, and service plan deficiencies. Because the COVID-19 pandemic prevented inspections in April and May 2020, the POA period was extended to September 28, 2020. The POA ended unsuccessfully, and the operation was placed on Probation by RCCR on April 7, 2021, with a planned end-date of April 7, 2022. The operation was also assessed six Administrative Penalties (fines) by RCCR between June 21, 2019, and March 5, 2020, due to findings that medication was administered incorrectly.

A review of the facility's compliance history over the last five years shows it was cited for 142 minimum standards deficiencies, more than half of which (74) occurred in the last two years. Five RCCI investigations of abuse, neglect, or exploitation have resulted in RTBs over the last two years, four for Neglectful Supervision and one for Physical Abuse. Three of the five involved children residing in the TEP unit:

- A February 14, 2020, report to SWI resulted in two RTBs for Neglectful Supervision and five citations for minimum standards violations. A youth whose service plan required line-of-sight supervision due to a history of sexually aggressive behavior was able to sexually abuse another youth because a staff person left her shift before relief staff arrived. Her departure left only one staff person to supervise all the children on the TEP unit, and that staff person was writing incident reports when the incident occurred and did not have the child in his line of sight. After the investigation, in order to comply with the minimum standards that were violated, staff were retrained in supervision and the operation submitted a proposal to temporarily suspend the TEP program (the follow-up date in CLASS documenting this step is May 12, 2020) to "redesign the facility and retrain staff on all policies and procedures."[74]

- An April 21, 2020, report to SWI resulted in two RTBs and five minimum standards violations for Neglectful Supervision, after four children left the main building and went to the gym, where they engaged in sexual behavior. Two children, both from the TEP unit, came back to the main building, and two staff members failed to allow the two children back into the facility, though the children were ringing the front doorbell. The youth slept in the gym, without any supervision. Though the two staff denied the children's allegations, video footage confirmed them, showing the children continually ringing the front doorbell for a 30-minute period before giving up and returning to the gym.

- A June 18, 2020, report to SWI resulted in two RTBs for Neglectful Supervision and five minimum standards violations, when a therapist and the program director failed to remove a child with an indicator for sexual aggression from sharing a room with a child with a history of sexual abuse. Both children were housed in the TEP unit. The child who was the victim of inappropriate touching ran away because she did not feel safe at the facility due to the sexual abuse. The child told the therapist about the abuse prior to running away, but the therapist did not take any action to ensure the child's safety, aside from alerting the

[74] The redesign resulted in the TEP unit being moved to the second floor of the main building. It had previously been housed in another building on the campus. According to staff at Promise House, this has reduced the number of youths who run away. Promise House also requires all staff working with TEP youth to have a bachelor's degree.

program manager. The therapist told the program manager, who acknowledged being told, but said they did not move the child to another room because they were "looking into what was happening" and could not move the girls because they were too young to share a room with older youth.

- A February 28, 2021, report to SWI resulted in an RTB for Physical Abuse and an RTB for Neglectful Supervision, as well as seven citations for minimum standards violations, after a staff person physically abused a child by placing her in a chokehold and hitting her in the face, and a second staff person failed to intervene. The child suffered injuries to her face which required medical intervention, including a stitch to her lip. The child in this case was in the emergency shelter, rather than the TEP unit.

- A March 30, 2021, report to SWI resulted in an RTB for Neglectful Supervision against the same staff member for failing to intervene in the case above. The RTB in this case resulted from her failure to properly supervise youth at night, resulting in two children (a 14-year-old boy and an 11-year-old boy) being able to engage in sexual behavior. The 11-year-old alleged it was non-consensual. The staff person was not conducting bed checks every 10 minutes, as policy required, and had pre-filled her bed check log.

The monitoring team visited Promise House in mid-December 2021. During the visit, the monitoring team conducted a late-night visit to both the emergency shelter and TEP unit, toured the entire campus, interviewed two late-night staff, three program administrators, eight direct-care staff, a treatment staff, a case manager, two staff responsible for distribution of medication, and eight children. The team reviewed records for 18 staff members and nine children.[75] Concerns observed by the monitoring team included:

- One of the TEP staff members charged with conducting bed checks at night did not appear to be doing so every ten minutes, per Promise House policy, during the monitoring team's late-night visit. During the interview with the staff member, when the monitoring team members asked whether she needed to stop the interview to conduct bed checks, the staff member said she did not and just wanted to complete the interview. The interview lasted 45 minutes; at no time did the staff person check on the six youth under her supervision. When the monitoring team looked at the late-night logs for the evening, they had not yet been started. The monitoring team noticed that in late-night logs for previous dates, the staff person initialed the first 10-minute block in the log, noted that the children were asleep, then drew a line from that block through to the completion of the shift to indicate the checks had been completed. There were no breaks in the line – it was a continuous line from the top of the page through the end of the shift on the next pages.

- The monitoring team's review of the late-night logs also showed that on the night of December 14, 2021, into the early morning of December 15, 2021, the same staff member completed logs for all the TEP children, including the TEP child on one-to-one supervision housed downstairs. The night that the team visited, after an 11:00 shift change, there was

[75] An analysis of the interview responses and records reviewed relevant to each remedial order will be included in future reports.

only one staff person left downstairs in the emergency shelter. This staff person confirmed that she was the only staff supervising the children downstairs overnight. She indicated they expected another staff person to arrive at midnight to supervise the TEP child who was on one-to-one supervision but was not sure who was supervising her until then.

- Staff reported that there had been several instances in which TEP youth were brought to the facility without their medication. They reported that this is an issue if the youth previously had a 30-day supply that is not yet supposed to be finished, and indicated Star Health will not pay for more medication until the filled prescription is supposed to have finished.[76]

- Despite the Promise House website's description of trauma-informed care, when interviewed, staff could not provide details regarding how trauma-informed care or treatment is delivered.

- Staff reported they are regularly working overtime hours because they are understaffed, even with support from part-time "as needed" staff. Staff reported they sometimes had to work unexpected overtime or double shifts when other staff are late or do not come in for their shifts. Administrators acknowledged that hiring and retaining staff has been challenging.

- The monitoring team's review of educational programming and educational needs for children show that the education provided by DISD may not be sufficient for children to maintain educational progress, particularly given the period the children appear to be staying in the TEP program. The placement instability experienced by the PMC children placed in the TEP program at the time of the visit has resulted in frequent moves between schools or periods without being enrolled in school; this has placed several of the children behind. Several of the children interviewed qualified for Special Education; their service plans in IMPACT showed individual education plans listing a range of services and supports but based on the monitoring team's review of on-site records, it was not clear that

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[76] In its feedback to a draft of this report, HHSC provided the following clarification:

> [T]here are safeguards in place to make sure that a child can get the prescriptions they need in the event that a youth enrolled in STAR Health moves placements without their prescribed medication. STAR Health and the related pharmacy claims system has an override function available to bypass the claim rejection alert and allow the claim to fully process. The process relies on DFPS to contact the service manager to alert the STAR Health managed care organization (MCO). The MCO has processes in place to pay for needed prescribed medications if a child covered by STAR Health loses or misplaces their medications prior to the end of the prescription period. The MCO also has an escalation process in place by which the pharmacy department can work to implement an override as described above. The pharmacy system is real time and the MCO should be able to put through the override very quickly (within the same day) provided that they are made aware of the situation and there is a valid prescription on file. HHSC also understands that the MCO works to educate DFPS staff as well as staff from child placing agencies about these available processes.

HHSC, HHSC Comments on Monitors' January 10, 2022 Draft Report (on file with the Monitors). While the Monitors note that this is the policy that applies, records and interviews indicate that implementation is inconsistent.

DISD was providing these at Promise House. On-site records for one of the children, placed at Promise House approximately one week prior to the monitoring team's visit, showed that she was not yet enrolled in school.

- An investigation involving a child who had wrapped a vacuum cleaner chord around her neck and expressed suicidal ideation, which closed in April 2021, resulted in Promise House implementing a safety plan that required the facility to purchase a cordless vacuum; until such time, the vacuum was required to be immediately placed in the laundry room when not in use, and the laundry room door kept locked. When the monitoring team walked through the TEP unit, a vacuum was observed in the kitchenette in the TP unit that was not cordless, was not locked in the laundry room, and was accessible to youth.

- One of the PMC children interviewed by the monitoring team had been kept completely isolated from other youth. She was placed on one-to-one supervision by Promise House staff due to her disruptive behavior and was not allowed to have any contact with other youth. Even when participating in outings and activities, she was not allowed to interact with other children; outings and activities for this child involved only the child and the staff person assigned to supervise her. When the monitoring team visited, she had already been isolated for two weeks, and Promise House records indicated plans to continue the restrictions for the foreseeable future.

As was true of Unity Girls, the only difference in the treatment program for youth in TEP versus youth housed in the emergency shelter appeared to be an additional individual therapy session each week. The youth housed in the emergency shelter reported they attended individual therapy once a week, and group therapy once a week. The TEP youth indicated that they received individual therapy once or twice a week, lasting from 30 minutes to an hour. They received group therapy once a week at most, with one youth reporting that in their six weeks at Promise House, they had only had one group therapy session. Though the facility's website indicates a battery of assessments are used to create individualized treatment plans that include several different treatment modalities, the interviews with staff and children, and the records reviewed on-site, did not support the use of multiple therapeutic modalities.

Promise House does not appear to implement positive behavior intervention practices, despite the claim on its website that it engages practices that emphasize social-emotional health. The Promise House website notes that as part of the therapeutic goals it assists clients in achieving, Promise House engages clients in crisis intervention by "implementing a collaborative and comprehensive plan to keep them safe, both physically and emotionally."[77] In practice, the behavioral intervention program at Promise House is inconsistent with what is described on the organization's website. Children and staff reported that Promise House addresses negative behaviors by restricting youths' privileges. Privileges are reinstated after the restriction period ends. "House Rules" were posted on the wall in the TEP unit listing behavior that was prohibited, and reminding youth to be "Positive, Friendly, and Optimistic!!"

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[77] Promise House, *Attainable Therapeutic Goals* (Pop-Up Box), *available at* https://promisehouse.org/trauma-informed-care/

Children's records included "Behavior Reports" which listed negative behaviors and the number of days on restriction that the behavior earns, allowing staff to put a check in the box corresponding to a child's behavioral infraction. Restriction ranged from one-to-five days, some behaviors earn a "mandatory restriction," some "total restriction" and some also list loss of outings. There is no explanation of how "mandatory" or "total" restriction differs from a regular restriction or what the consequences of being on restriction will be. For example, "Having Contraband" results in "5 days mandatory restriction & loss of next outing" whereas "Property Damage" results in "3 days total restriction & loss of next outing" but "Cussing" results in "1 day restriction."

Most of the children that were placed at the TEP program at Promise House when the monitoring team visited are still in the placement. Only one child has been discharged, as of January 1, 2022; that child was placed in an RTC. As was true of children placed in TEP at Unity Girls, the children stay in the TEP program at Promise House for a significant period. Four of the children who were in the TEP unit when the monitoring team visited have been in the TEP unit at Promise House for two months or more. One child has been there for approximately a month. The child who was discharged to an RTC had been at Promise House for a little over three weeks when she was discharged.

C. Site Visit to Evart Youth Center and New Hope Youth Center in Northern Michigan

i. Increase in Out-of-State Placements

DFPS and SSCCs have also increased the number of PMC youth placed out-of-state as the placement crisis has worsened.[78] The average number of out-of-state placements of PMC youth per month was 38 between January 2021 and October 2021, compared to an average of 21 per month between January 2020 and October 2020. Between January 2020 and October 2021 (22 months), a total of 651 out-of-state placements of PMC youth were made. Of those, 80 (12%) were made by SSCCs.

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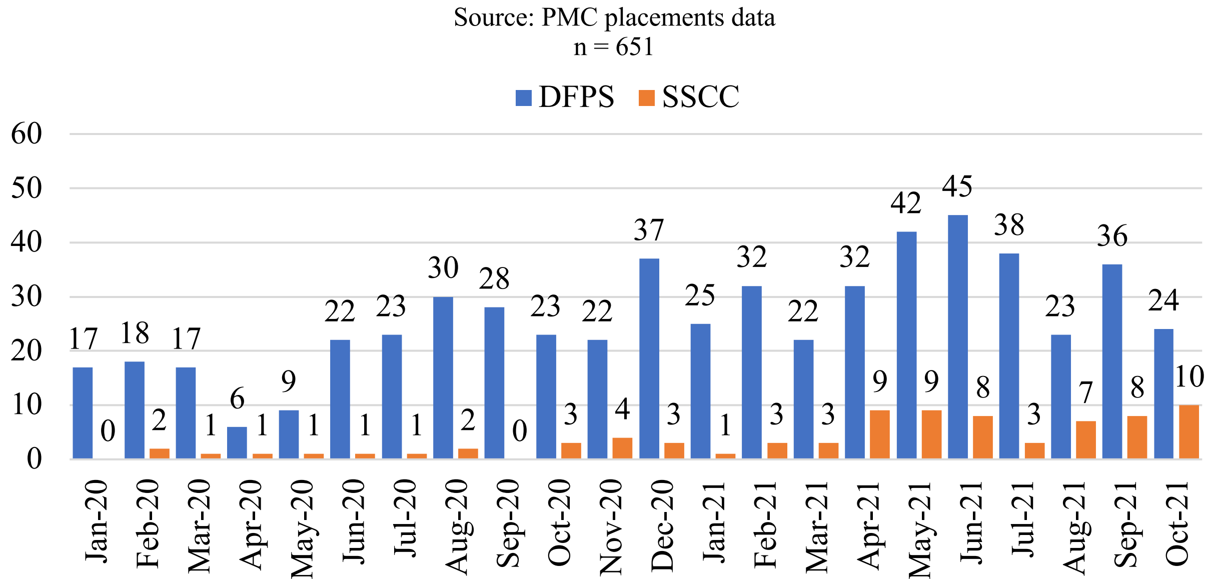
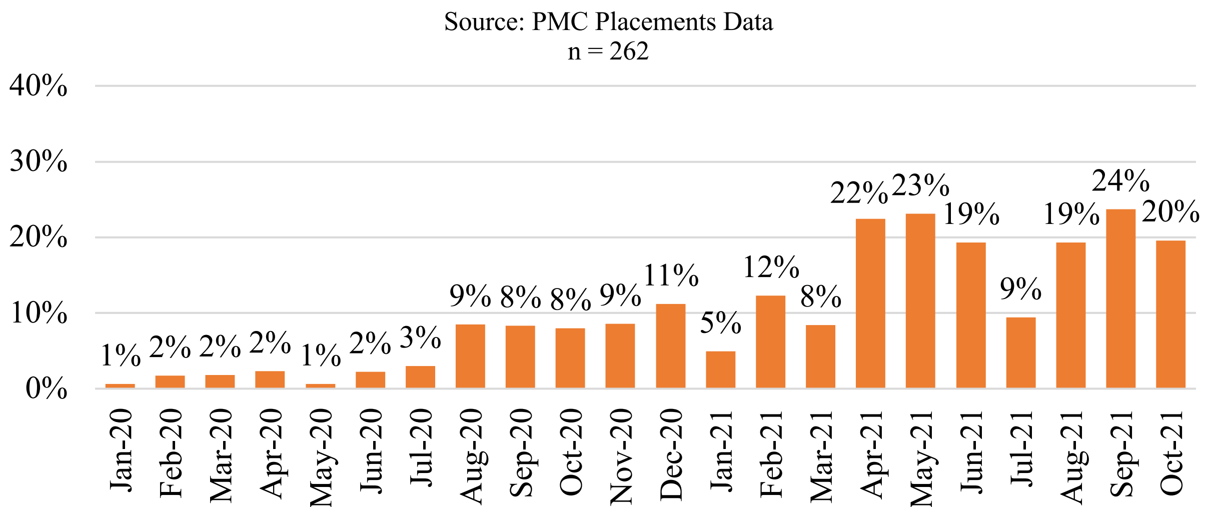
[78] On October 29, 2020, after having previously raised the issue of the applicability of the Court's remedial orders to out-of-state placements during a meeting with DFPS, the Monitors asked DFPS via e-mail to clarify its position regarding the issue with respect to each of the remedial orders. E-mail from Kevin Ryan and Deborah Fowler to Audrey Carmical, General Counsel, DFPS, re: Follow up to 10/21 meeting, October 29, 2020 (on file with the Monitors). DFPS provided a written response on November 20, 2020, and attached a spreadsheet listing each remedial order, indicated whether or not it believed the remedial order applied to out-of-state placements, and explained the basis for its position. E-mail from Audrey Carmical to Deborah Fowler and Kevin Ryan, re: Follow-up to 10/21 meeting, November 16, 2020. Rather than summarize the response, the Monitors have attached it as Exhibit 2 to this report.

Figure 10: Out-Of-State PMC Placements in Foster Homes, Congregate Care, or Psychiatric Hospitals, January 2020 to October 2021



As Texas' placement crisis worsened, the proportion of children placed in out-of-state RTCs increased. This also corresponds to the reduction in RTC capacity in Texas caused by the closure of unsafe RTCs, discussed in the September 2021 Update.[79] Not only did the closure of irreparably unsafe facilities cause an increase in the number of children without placement, but it also led to an increase in reliance on out-of-state placements.

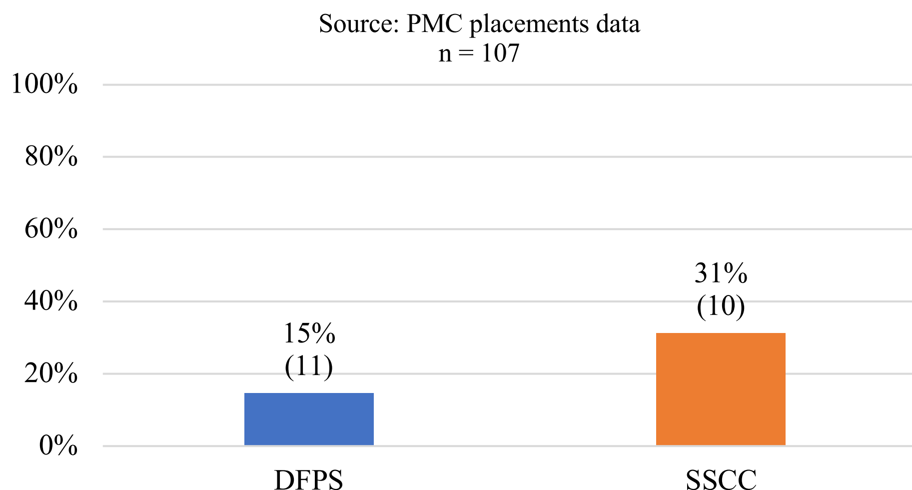
Figure 11: Proportion of PMC Placements in RTCs that are Out of State, January 2020 to October 2021



[79] Deborah Fowler & Kevin Ryan, *supra* note 1, at 36-45.

A particularly high share of RTC placements by SSCCs are outside of Texas. In October 2021, 15 percent of DFPS placements in RTCs (11 of 75) were out-of-state, compared to 31 percent of SSCC placements in RTCs (10 of 32).

Figure 12: Proportion of PMC Placements in RTCs that are Out of State by Placement Entity, October 2021



ii. Site visits to Evart Youth Center and New Hope Youth Center

The monitoring team made its first out-of-state visits to two residential treatment centers in early December 2021. These two Michigan RTCs, operated by the same entity (Youth Opportunity Investments, LLC) housed 14 Texas children when the monitoring team visited in early December 2021; another Texas child had been discharged from New Hope the day before the monitoring team arrived at that operation.

a. Evart Youth Center

Evart Youth Center (Evart) is in Evart, Michigan, a rural community approximately 80 miles northeast of Grand Rapids. When the monitoring team visited in early December 2021, there were 27 youth housed at the operation. All the youth housed at Evart on the dates the monitoring team visited were male; the facility had recently transferred female youth previously housed at the Evart facility to another campus, New Hope Youth Center (New Hope), about 45 minutes away.[80] Of the 27 male youth at the facility, 10 were from Texas; eight were PMC youth. Of the 10 Texas

[80] Three of the four Texas girls who were housed at New Hope when the monitoring team visited were first placed at Evart, as discussed in the section related to New Hope, *infra*.

youth, eight were placed at Evart by DFPS, one by OCOK, and one by 2INgage. The child placed by OCOK has since been discharged from Evart at the facility's request.[81]

According to Evart's Youth and Parent Handbook, Evart provides "clinical/treatment services including skills-based curricula."[82] The handbook lists nine curricula that is claims to use in its programming, and also indicates that individual and family counseling is provided to all youth "including using Trauma Focused Cognitive Behavioral Therapy (TF-CBT) and Dialectical Behavior Therapy."[83] Evart tells youth "Today you will embark on a journey that will change the way you see yourself, your family, and the choices you have made. You will be presented with several options designed to challenge the way you look at the world and respond to demands put on you."[84] The handbook tells youth that they have "only three options:"

- You can look at the issues in your life that have put you into this situation and make a decision to change the thoughts that lead to negative behaviors. It is these negative behaviors that led you here in the first place.
- You can look at this situation as just another obstacle that gets in the way of the lifestyle you have chosen. As a result, you will then jump through hoops and try to fool staff into thinking you have changed enough to get released back into the community and return to your old life style.
- You can reject the notion that you have any problems or issues to deal with and actually reject any attempt to make changes in your life or behavior.[85]

Evart's handbook next tells youth they can "create a way out of this situation or continue to move in and out of institutions built only to control the behavior of those who will not control themselves."[86] The handbook goes on to describe the "iChoose System" described as a "Behavior Motivation System" that incentivizes youth by earning points that allow them to access privileges.[87] The handbook describes major rule violations, and explains behavioral definitions and gives examples of prohibited behavior and consequences. It devotes a single paragraph to a positive reinforcement strategy called the "Gotcha/Positive Citizen!" explaining that a youth who is "exhibiting appropriate behavior" will be given a "Gotcha!" award, and have their name placed in a fish bowl for a drawing (for what, it does not say) every two weeks.[88] The handbook indicates

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[81] The child's most recent Common Application, completed December 20, 2021 (but still pending approval), describes the behavior that led to his discharge: on November 14, 2021, facility staff called the child's caseworker and said "he and two teens jumped out of their room windows and ran around the facility yard screaming, the staff stated he was asked to return to the building and stop the screaming, but it was reported he began swinging on the staff and had to be put in a safe restraint until he called down…once back in the building, he waited about an hour or so, and he…jumped out of his bedroom window again, ran around the yard screaming, and again, he was restrained and returned to the building." Another contact from the facility on December 17, 2021, indicated he continued to go outside without permission, in 20-degree weather, without a coat or shoes, and engaged in aggressive behavior with peers and staff. Another contact from the facility on December 20, 2021, indicated he started running in and out of the facility that morning, with no shoes or coat, and climbed on the roof, yelling.
[82] Evart Youth Academy, *Youth & Parent Program Handbook*, at 4 (undated) (on file with the Monitors).
[83] *Id*. at 4-5.
[84] *Id*. at 5.
[85] *Id*.
[86] *Id*. These statements seem fundamentally at odds with Evart's claim to provide trauma-based treatment.
[87] *Id*. at 7-8.
[88] *Id*. at 24.

that each youth has a Treatment Plan "developed with input from an inter-disciplinary team" that is completed "by evaluating past delinquent behaviors; conducing a personal interview with…the youth; and reviewing assessments that were completed at other programs."[89]

During the site visit, the monitoring team conducted a late-night visit, toured the facility again during the day, reviewed records for 10 children, and interviewed two direct caregivers, four late-night staff, a program administrator, the treatment director, a case manager, and a member of the medical staff. The monitoring team also interviewed eight of the Texas PMC children.[90] The Monitors do not have access either to Evart's complete history of compliance with Michigan minimum standards for licensing, or to the facility's history of investigations for abuse, neglect, or exploitation. However, a media article originally published May 10, 2021, and updated September 29, 2021, about another facility (Buena Vista) that had its license revoked, refers to Evart Youth Center as having the second-highest number of safety-related investigations over a 2-year period and indicates that the facility was "also pending revocation."[91]

The monitoring team also reviewed publicly available inspection and investigation reports for Evart Youth Center, available on the Michigan Department of Health and Human Services website. For Evart Youth Center, these reports are divided between the program for girls (Girls' Facility),[92] which has since been eliminated, and the program for boys (Boys' Facility).[93] The reports documenting violations in 2021 include:

- A violation cited on January 22, 2021, for the Girls' Facility for failing to conduct variable interval checks of residents during sleeping hours; the room check logs showed the checks were not variable but were completed every ten minutes.
- The same report noted violations of standards associated with timely initial treatment plans, and updated treatment plans for youth.
- Two violations cited February 23, 2021, for the Girls' Facility related to placing children in the secure part of the facility without authorization or court order. This report notes that "[t]here has already been existing concern with youth being placed in secure parts of the facility."
- A violation cited in a June 23, 2021, for the Girls' Facility related to an allegation that two youth were "sneaking out of the facility to meet up and make out." During the investigation, multiple staff reported the facility was understaffed, affecting supervision of youth. The investigator determined that the facility was not complying with requirements related to daytime or night-time staff-to-youth ratios.

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[89] *Id*. at 38.

[90] An analysis of the record reviews and interviews relevant to each Remedial Order will be included in future reports filed by the Monitors.

[91] Rily Murdock, '*I don't know what else we're supposed to do': Wolverine Human Services CEO speaks on licensing issue*, Michigan Live, May 10, 2021 (Updated September 29, 2021), *available at* https://www.mlive.com/news/saginaw-bay-city/2021/05/i-dont-know-what-else-were-supposed-to-do-wolverine-human-services-ceo-speaks-on-licensing-issue.html

[92] The licensing reports reviewed by the monitoring team are available at https://cwl-search.apps.lara.state.mi.us/Home/FacilityProfile/289

[93] The licensing reports reviewed by the monitoring team are available at https://cwl-search.apps.lara.state.mi.us/Home/FacilityProfile/207

- A violation cited on September 16, 2021, for the Girls' Facility related to a staff person's failure to tell anyone that a youth confided that she had witnessed a youth touch another youth inappropriately. The staff person reported they did not want to betray the youth's confidence.
- A violation cited due to a renewal inspection for the Girls' Facility completed on November 4, 2021, for failing to complete a discharge plan for a youth whose file was reviewed. The same inspection resulted in a citation for failure to document a dental exam for a child whose file was reviewed.
- Violations cited due to a renewal inspection completed on June 24, 2021, for the Boys' Facility related to a late criminal history check for one staff member, and a late central history check (for history of child abuse or neglect) for a staff member.
- Violations cited June 8, 2021, for the Boys' Facility after an investigation of allegations made May 11, 2021, that the front door to the facility was missing, and there had been no heat for 24 hours, despite 28-degree weather. The investigation determined that the door was missing on one of the units for 24 hours after a youth ripped it off its hinges, and the facility staff did not re-cover the door opening. Michigan investigators also determined that the unit was missing a thermostat and had no heat for approximately 48 hours. Staff did not call maintenance to fix either the thermostat or the door, failed to provide the youth with extra clothing or blankets to stay warm, and did not move the youth to another unit.
- Violations cited June 24, 2021, for the Boys' Facility related to the failure to appropriately report physical restraints for a child, and appropriately report law enforcement intervention with a child at the facility.
- Violations cited for the Boys' Facility on February 23, 2021, detailed a youth was moved to the secure part of the facility without authorization or court order.

In addition, in 2020, the Boys' Facility was cited for failing to appropriately report the hospitalization of two children, for violating minimum standards prohibiting seclusion after a youth was confined to his room for four-and-a-half hours, for violation of minimum standards prohibiting verbal abuse of children, and for a repeat violation of the requirements for variable room checks. A violation also was cited for the Boys' Facility on October 23, 2020, after an investigation determined that two staff engaged in inappropriate conversations with youth about their sexual encounters.

Today, the only units on the Evart campus that are occupied are "staff secure" units. The campus formerly housed a secure (lockdown) unit for children who were juvenile justice involved, but according to staff interviewed during the monitoring team's visit, the operation lost its license for that unit. The monitoring team walked through the former lockdown unit to verify that there were no youth housed in the unit, after having reviewed licensing reports citing the facility for housing children in the secure unit who were not authorized to be held in a secure facility. Staff indicated that the lockdown unit would be renovated to remove locks on the doors from the children's bedrooms and noted that the high fencing around the outdoor area would be removed.

Based on interviews and record reviews, and the late-night and daytime walk through of the units on the campus, the monitoring team observed the following:

- During the monitoring team's late-night visit, the team observed several units on the campus that were sparsely furnished. There appeared to have been no real effort to furnish some of the units' common areas. Though the units that are currently occupied by youth are staff secure units, the children's rooms resembled juvenile cells, with little-to-no furniture aside from a built-in, concrete or wood platform bed, covered by a plastic-covered mattress. What furniture there is on all but one of the units (Owl, a newer building on the campus) is damaged. The units were dirty; the floors looked like they had not been cleaned nor the carpets either cleaned or vacuumed in some time. The monitoring team observed numerous safety hazards and items providing potential opportunities for youth to self-harm.

- Staff reported having to work overtime due to staffing shortages. Staff also reported a great deal of staff turnover.

- Children reported a single phone is shared between all units, which they reported resulted in inconsistent access to a phone.

- One of the Texas children (who has a history of self-harming and was later determined to be on one-to-one supervision) was sleeping on the floor of his bedroom, with his door cracked open and his head partially visible through the open door. He did not appear to be

sleeping on a mattress. The monitoring team later determined this was done to allow staff to maintain line-of-sight supervision of the youth while he was sleeping.

- Youth described a chaotic environment, with frequent fights, youth running from the facility, running around the facility (including climbing onto the roof of buildings), and engaging in disruptions in their unit that also involved physical aggression toward staff.

- Youth reported staff bully them and make derogatory comments about them and their families.

- Though the monitoring team did not witness any staff sleeping during the late-night visit, a witness report that was perhaps inadvertently included in the incident reports provided to the monitoring team reported that two staff sleep in the children's rooms during their shifts or "take their mattresses in another room."

The Monitors noted children's consistent reports regarding excessive and improper use of restraints. Children reported restraints were painful, and particularly complained of a restraint they referred to as the "chicken wing" restraint, that involved pulling the youths' arms up and behind their backs. As reflected in the reports made by the monitoring team to the Michigan abuse and neglect hotline, discussed below, inappropriate and harmful restraints were a frequent complaint

of the Texas children interviewed by the monitoring team. In addition, one Texas PMC child was the alleged victim in a Michigan investigation initiated October 6, 2021, regarding a rough, supine restraint. The investigation considered allegations that the staff member grabbed the child by the throat, took him to the ground, and held his knee to the youth's chest, near the child's throat. The child's earring was ripped out during the restraint, causing his ear to bleed. The report did not result in a substantiated finding of abuse, though a staff person came forward during the investigation to report having witnessed the restraint and provided details that closely corroborated those provided by the youth.

Internal reviews of incident reports were provided to the monitoring team by the facility for the months of September and October. Those two reports showed trends in incidents and restraints and included restraint numbers for both months. In September, the report shows a total of 25 "reportable" physical restraints; the October report showed a total of 12 "reportable" physical restraints.[94] Notably, the September report evaluating incidents for the facility indicated that "23 of the 30 incidents (77% of all incidents) involved 'out of state' youth placed at Evart." Similarly, the October report noted "15 of the 19 incidents (79% of all incidents) involved 'out of state' youth placed at Evart."[95]

The Monitors are also deeply concerned by notations in IMPACT for CA, a child who aged out of foster care while placed at Evart. When a caseworker completed a monthly face-to-face visit with him at Evart on November 16, 2021, notes in IMPACT indicate that CA, who was about to age out of care upon turning 18 years old on December 12, 2021, told the caseworker "that he [had] met several people in the facility that are willing to help him and he is no longer interested in returning to El Paso." The contact note also says that CA indicated a female staff member had suggested he live with her after turning 18; the caseworker who visited suggested this was inappropriate and CA "said others do it and children even get hire[d] to work there. [CA] asked worker not to let everyone know about his plan as he is aware that the person can get in trouble." CA suggested he would "refuse to get on the plane when it is time to go back to El Paso." A subsequent contact note in IMPACT, made on December 1, 2021, indicates that his caseworker called the Michigan abuse and neglect hotline to report that CA alleged that a female staff person at Evart offered to allow him to stay with her once he turned 18 years old. On December 13, 2021, when a caseworker went to Evart to pick CA up and bring him back to Texas, when the caseworker asked CA again about the staff member's offer, CA told the caseworker that "he had a sentimental relationship with her, that she voiced that no one had made her feel like he does and that she wanted to give [CA] a good life...[CA] stated that he was a little scared to find out that she was married

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[94] A table included later in the report shows the number of restraints by month for an 11-month period. Based on this, "reportable" restraints appear to be restraints requiring hands-on interventions with youth. The most reported restraint across many of the months included in the charts is a "Supine Floor Assist Technique," the restraint that one of the youths reported resulted in bruising to his hands when his hands were pushed to the floor. The total number of restraints reported between November 2020 and October 2021, according to these reports, was 184. Evart Youth Center, *Evart Youth Center Incident Report: September 2021*, at Table 14 (on file with the Monitors); Evart Youth Center, *Evart Youth Center Incident Report: October 2021*, at Table 14 (on file with the Monitors). Individual incident reports provided to the monitoring team documenting incidents involving Texas children showed a total of 21 restraints for nine children between August 2021 and the date of the site visit in early December 2021.

[95] Despite the reports' emphasis on the share of incidents for which "out of state" youth were responsible, when the monitoring team visited, only one of the children on campus was from Michigan. The rest were from Texas and other states.

before and that her husband was recently deceased. [CA] shared with the worker that he kissed with the staff several times." A contact note entered into IMPACT on December 16, 2021, states "On this day worker called Michigan's CPS hotline [number excluded] to updated them on the new information shared by [CA]. The report made on December 1st did not meet criteria for investigation and because he is now 18 years old and no longer at the facility a case won't be open[ed]. They did not take the information from worker and asked her if [she had] further concerns to file a police report." CA returned to El Paso; the face-to-face note in IMPACT indicates that he was to meet with a PAL worker the day after his return for assistance in finding stable housing, and that he planned to stay in a shelter until he had other housing. He did not wish to remain in extended foster care.

After returning to Texas, the monitoring team made several reports to the Michigan abuse and neglect hotline:

- A report was made to the hotline related to separate allegations of restraints resulting in injuries to three children. One Texas child alleged (and another child confirmed) that he suffered a broken nose after the staff person pushed his face into the floor while he was being restrained face-down, despite Michigan's prohibition of prone restraints. Staff claimed the broken nose was the result of the fight between the youth and another child that resulted in the restraint. The facility provided the monitoring team with an incident report documenting the fight and restraint, and that indicates the child was taken to the emergency room (but does not describe the injury). The facility later provided the monitoring team with documents from the Emergency Room visit, but they do not describe how the child's nose was broken.

- A report was made to the hotline related to a child's allegations that restraints at the facility were rough, and that during one of his restraints, the staff person restraining him had their knee on his throat. An SIR for the same child indicated that he suffered rug burns to his face and shoulder as a result of a supine restraint, but the report does not explain how the supine restraint resulted in rug burns to the child's face.

- A report was made related to the hotline related to another child's allegation that a supine restraint had resulted in bruises to the backs of his hands. The same child alleged that staff engaged in horseplay with youth, then restrain them when they get tired of the horseplay.

- A report was made to the hotline related to a child's allegation that a restraint resulted in bruising up and down his forearms, and severe pain in his wrist. An incident report for November 19, 2021, documented a restraint and reports redness and bruising on the child's arm because of the restraint. The child indicated he requested medical attention for his wrist but did not receive any. He also alleged that he had witnessed other children being dragged on the ground during restraints. He reported bullying by staff and other children to the monitoring team and said that staff do not intervene. A witness statement included with an incident report for the child indicated that a staff person told the youth that the next time he was disrespectful, he would "have some of the older black boys deal with this." The statement notes that the same staff person then told two students who were walking down the hallway to "handle [the child] next time he is disrespectful."

- A report was made to the hotline related to multiple children's reports of a restraint they referred to as the "chicken wing" restraint. One of the girls who has since been moved to New Hope reported that while she was at Evart, she was restrained in this manner, her feet were lifted off the ground during the restraint, and that it was very painful. Another youth at New Hope reported she was restrained this way at New Hope, by a staff person who normally worked at Evart. The monitoring team also reported that multiple children alleged suffering verbal abuse and threats by staff at Evart; one child alleged that a staff person told him his was going to "milk him" and rape his mother. Another youth also alleged staff made fun of his family.

When the monitoring team returned to Texas, the Monitors shared the concerns outlined above with DFPS, along with the reports made to the Michigan abuse and neglect hotline.[96] In addition, the Monitors shared concerns related to face-to-face visits for children placed in Michigan, based on a review of the children's IMPACT records:

- 2INgage made back-to-back visits to the children placed at Evart who are under their care on the last and first day of consecutive months (for example, 9/30/21 & 10/1/21 and 11/30/21 & 12/01/21) so that they could count these back-to-back visits on consecutive days as the face-to-face visits for two months.

- The Monitors could not find face-to-face visits for one of the children, who was a subject of one of the reports to the Michigan hotline. documented in IMPACT for September, October, or November 2021. Similarly, the Monitors could not find face-to-face visits for one of the girls, moved from Evart to New Hope, for November 2021. Nor could the Monitors find a face-to-face visit for another child, a TMC youth, since being placed at Evart September 22, 2021.

- The Monitors noticed that the note for the face-to-face visit for another TMC youth, dated November 30, 2021, indicated that it had to be completed via Zoom due to a "14-day quarantine for COVID," and that his caseworker cancelled her trip to Michigan for this reason. The monitoring team was on site just days later, and none of the staff at Evart mentioned that the facility was under quarantine due to COVID. In fact, the monitoring team was told by staff that the last time they had to quarantine due to COVID was in August 2021. During the monitoring team's interview with this child, he reported to that he is very unhappy at the facility, that the chaotic environment triggers his PTSD, and that he was cutting because he was unhappy there. This is the same child who the monitoring team witnessed sleeping on the floor of his room.

b. New Hope Youth Center

After completing the visit to Evart, the monitoring team drove to Mt. Pleasant, the rural community where New Hope Youth Center (New Hope) is located. Mt. Pleasant, Michigan is

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[96] E-mail from Deborah Fowler and Kevin Ryan to Jaime Masters, Commissioner, DFPS, Re: Michigan Visit, December 7, 2021 (on file with the Monitors).

approximately 80 miles northwest of Grand Rapids, and approximately 46 miles southeast of Evart, Michigan. New Hope Youth Center is in what was once a single-family home. According to licensing reports from the MDHHS, New Hope has a licensed capacity of 15. When the monitoring team visited, there were 10 girls placed at New Hope, four of whom were from Texas. Of the four Texas girls, one had been placed by an SSCC (2INgage), and the rest had been placed by DFPS.

The monitoring team was not able to complete a full visit to New Hope, but toured the home, formally interviewed one staff and informally interviewed two more, interviewed four children, and reviewed records for four children. As was true of Evart, the monitoring team does not have access to the complete compliance or abuse, neglect, and exploitation history of New Hope. However, the monitoring team reviewed publicly available MDHHS inspection and investigation reports for the facility.[97] Violations documented by MDHHS in 2021 included:

- A renewal inspection completed October 21, 2021, cited New Hope for several violations related to the completeness of children's records. File reviews revealed a pre-dated initial treatment plan, failure to complete a discharge plan for a youth, unsigned service plans, and failure to complete a clothing inventory at discharge.

- An inspection completed January 15, 2021, cited New Hope for violations associated with employee records. Among other things, records reviewed revealed missing documentation related to employee training. The inspection also resulted in a violation cited due to the failure to appropriately complete discharge documentation for two children.

Violations cited in 2020 included a violation associated with an incident in which a staff person "threatened/antagonized" a youth and failed to deescalate a situation, a violation based on the failure of New Hope to ensure that a child who had asthma had access to a nebulizer while she was at school, and a violation associated with the facility's failure to provide a child with prescribed medication.

Based on a tour of the facility, interviews with youth and staff, and record reviews, the monitoring team observed the following:

- Staff who were informally interviewed complained of being short staffed and being unable to meet required staff-to-youth ratios.

- Children's records were incomplete. Many were missing basic documents like the Common Application, service plans, and medical histories. One binder included information for two different youth.

- Bedrooms were small and cramped, with up to four girls sharing a single room.

- One Texas PMC child placed at New Hope, who weighs 403 pounds, had difficulty walking on the date of the monitoring team's visit because of a hairline fracture in her left

[97] These reports are available online at https://cwl-search.apps.lara.state.mi.us/Home/FacilityProfile/255

leg. The child had arrived at New Hope on September 30, 2021, but had not yet begun physical therapy by the date of the monitoring team's visit in early December. A review of IMPACT shows she continues to complain of pain in her leg, though "extensive diagnostics" showed the leg "appears to have healed," and it is unclear whether she is receiving consistent physical therapy. Her mental health also appears to be deteriorating. A monthly evaluation completed on December 30, 2021, indicates she is defecating on herself, refusing to clean it up, and refusing to get up from bed to go to the restroom; she intentionally wets the bed.

III. Conclusion

Despite improvements in the training provided to DFPS Staff responsible for supervising CWOP Settings, safety problems persist. In addition to those documented in the Monitors' September 2021 Update, SIRs reviewed for this report revealed new concerns, including the use of force by on-site police officers and security on foster children housed in CWOP Settings, and a child's sexual relationship with a hotel clerk. Though DFPS reported having infused the system with added capacity to address the placement crisis, the number of children without placement remains high. In October, the number of PMC children without placement was 202, approximately

22 percent lower than the peak in June 2021, but still unacceptably high given the serious safety risks that housing children in unlicensed settings (regardless of setting type) poses.

The Monitors' site visits to TEP programs and two Michigan facilities also reveal the shortcomings associated with relying on temporary placements or out-of-state facilities to address the capacity shortage. In particular, poor conditions at the Evart Youth Center coupled with inconsistent face-to-face visits by Texas caseworkers, leaves children vulnerable in an unfamiliar state without proximity or regular contact with the adults they rely on to ensure their safety.